ALTARUM
HEALTHCARE VALUE HUB

RESEARCH BRIEF NO. 12 | JUNE 2016

# Advocates' Guide to Health Insurance Merger Remedies

The nation's health insurance industry is in the midst of significant consolidation, with national carriers pursuing large-scale mergers and local insurance companies examining other merger and acquisition opportunities. Industry stakeholders argue that consumers will benefit from greater efficiency and innovation if these mergers are approved, but results from previous industry mergers suggest that consumers are more likely to experience the harms of reduced competition, including higher premiums, high cost-sharing and fewer plan choices.


## SUMMARY

This paper examines regulators' efforts to mitigate possible consumer harms from insurance company mergers—such as higher premiums and cost-sharing and reduced access and choice of health care professionals. Specifically, this brief uses case studies and expert interviews to examine the role of remedies in health insurance merger approvals. Remedies cannot substitute for market competition nor are they likely to fully ameliorate the consumer harms that characterize a less competitive marketplace, but advocates can use remedies to ensure that consumers derive some benefit from the merger negotiation process and to advance improvements in their state's health care system. Consumer advocates and others will find actionable information on these strategies to better protect consumers faced with health plan mergers in their market.


In many cases, the most consumer-friendly decision regulators can make will be to block a merger, but regulators do not always have the legal authority, adequate evidence, or sufficient autonomy to do so. When advocates find that this avenue is closed off, they must look for other tools, such as robust remedies, to protect consumers' interests. Advocates will need to evaluate which types of remedies are most appropriate for their state, considering the likelihood of blocking a merger, remedies' relative effectiveness, their regulators' enforcement powers, and other state-based conditions. The information in this brief can help local consumer advocates work with their state regulators in an effort to minimize consumer harms and, where possible, to add consumer benefits.

## Background

The United States' health financing system relies on insurance companies to spread financial risk, negotiate payment rates with individual and institutional providers, facilitate access to primary and specialty services, and improve enrollees' health outcomes. This industry is experiencing significant change.

Within this context, regulators are scrutinizing proposed mergers between insurance issuers, including the significant mergers of Aetna with Humana, and Anthem with Cigna, which would further consolidate the health insurance market in many states.

When health insurance companies consolidate, firms that formerly competed against each other, or could have competed against each other, combine into a single corporate entity through merger or acquisition.[1] After a significant round of mergers and other affiliations during the 1990s[2] the health insurance industry appears to be entering another period of consolidation.[3] The likely result will be more heavily concentrated health insurance markets.

Researchers have found that health insurer mergers and market concentration can have important implications for consumers—particularly higher premiums and out-of-pocket costs. For example, the 1999 merger between Aetna and Prudential resulted in an average of seven percent higher premiums across multiple markets.[4] In addition, premiums for silver plans in the federal health insurance exchanges, or Marketplaces, experienced eight percent lower growth in counties with an increase in competition compared to counties that maintained or lost insurers between the first and second year of Marketplace coverage.[5] Similarly, a merger between two of the five largest health insurers in Nevada—United Healthgroup and Sierra—resulted in higher premiums for consumers in Las Vegas and Reno.[6]

A market dominated by a handful of large insurance companies may not only result in more limited consumer choice of plans at higher prices, but also more limited consumer choice of healthcare providers. Health insurers with a large market share wield significant negotiating leverage with hospitals, physicians and other healthcare professionals and institutions. These companies can use narrow networks to reward providers who accept the issuer's terms with a higher volume of patients. Lower provider payments can benefit consumers if they result in lower premiums or lower out-of-pocket costs, but consumers who wish to go outside these narrower networks, or cannot find a network provider who meets their needs, will face higher out-of-network cost-sharing.

### Regulators' Role in Mergers and the Use of Remedies

When health insurance companies propose a merger, the United States Department of Justice (DOJ), the state attorney general or the state insurance commissioner—or sometimes all three—may review the merger to ensure that it will not restrict competition within the insurance market and harm consumers.[7] Depending on the characteristics of the state's insurance market and their findings regarding the proposed merger, regulators may simply disapprove it or oppose it in court. They could also approve the merger conditioned on "remedies" designed to ameliorate the harm to competition and, by extension, the likelihood that consumers will suffer increased costs or decreased access to coverage or health services.

*These remedies typically fall into three categories: structural remedies, conduct or behavioral remedies and "other conditions."*

These remedies typically fall into three categories. First, regulators may use **structural remedies** to maintain competition within the affected health insurance market. For example, the DOJ has required merging companies to sell off, or divest, part of their business to a third issuer. This issuer will then compete for enrollees within the same geographic area. These divestitures may have the short-term effect of maintaining the number of insurance companies—and hence the level of competition—within a given market. However, the remedy cannot ensure that the new company succeeds in the market, require the new issuer to remain in the market, or prohibit the merged entity from taking back the enrollees it turned over to the new competitor. The remedy is therefore unlikely to maintain competition over the long run. Other proposed structural remedies have included requiring the merging insurance company to relinquish a consumer-preferred brand or trademark, such as the Blue trademark, which would allow another insurance company to enter the market and compete for enrollees using the Blue Cross or Blue Shield brand.[8]

Second, through **conduct or behavioral remedies**, regulators try to ameliorate consumer harms by constraining the companies' behavior once they have merged. (These remedies are called "undertakings" in California.) These remedies may include restrictions on rate increases, to counter a company's likely anti-competitive pricing post-merger, or performance targets for process or outcomes measures, which would encourage issuers to maintain or improve quality post-merger.

Third, regulators may also use **other conditions**, such as requiring the issuer to make targeted investments or charitable contributions designed to improve other aspects of the state's healthcare system or to help populations affected by the merger. These conditions may have a less direct

relationship to consumer harms resulting from the merger, but further other public goals for the state's healthcare system and attempt to ensure that consumers derive some benefit from the merger through the approval process.

## Types of Conduct Remedies and Other Conditions

### Recent remedies and conditions

Over approximately the last decade, state regulators have applied a wide range of conduct remedies and other conditions to health insurance mergers. These remedies can be grouped into six categories (see Table 1):

- pricing restrictions;
- expansion into new markets within the state;
- performance improvements;
- health infrastructure investments within the state;
- charitable giving requirements; and
- maintaining or expanding a corporate presence within the state.

Through **pricing provisions,** regulators try to address the consumer-facing consequences of reduced competition—specifically, premium and cost-sharing increases. Consent agreements, stipulations and other approval documents have placed limits on premium increases and changes in cost-sharing amounts for a specified period of time after a merger. In 1994, for example, the Missouri Department of Insurance prohibited United Healthgroup from raising overall small group premiums faster than the rate of increase in the consumer price index for medical services (CPI-medical), and no more than 10 percent annually for any specific small group, for two years after the issuer acquired GenCare.[9] In other states, insurance commissioners have specified that merged entities cannot roll transaction costs from the merger into premiums.[10] In states with little leverage over premium rates—such as states with file-and-use regulations—regulators have adopted language that asks insurance companies to "commit" to not building transaction costs into premiums or, as in recent mergers in California, directs the company to negotiate with regulators if regulators find that issuers' rate filings include "excessive" rate increases.[11]

Regulators that have prior approval authority over insurance rates may find price restrictions relatively simple to enforce, particularly when proposed rate increases can be compared to a clear standard, such as CPI-medical. On the other hand, if issuers do not provide adequate data and a regulator cannot determine whether the company has incorporated transaction costs into the rates, or the regulator cannot prohibit a company from using proposed rates, these provisions will be harder to enforce and less effective.

Through a new type of conduct remedy, which requires Aetna to **expand into additional counties within the state**, the Florida Department of Insurance appears to offset reduced competition in some market segments or geographic areas with increased competition in other areas. This remedy specifically requires Aetna to sell coverage in five additional counties through the federally-facilitated Florida Marketplace.[12] This may strengthen competition and consumer experience within the Marketplace in these counties, but will neither impact the large group market across the state nor improve competition within the Marketplace in other Florida counties. The Department of Insurance will be able measure Aetna's compliance—the issuer either will or will not enter these five counties—but it is unclear whether there is an effective enforcement mechanism should Aetna offer new coverage in fewer than all five counties. Nor does the remedy require Aetna to offer policies at affordable rates, or offer coverage that is comparable to or better than coverage offered by other issuers. These limitations could be important if Aetna offers anything less than competitively-priced quality coverage in these new markets.

**Performance improvement requirements** offer another approach to measurable remedies. California regulators have repeatedly applied undertakings that require issuers to improve quality of care measures, such as screening rates for sexually-transmitted infections, star ratings awarded by the Office of the Patient Advocate Quality Report Card, or Total HEDIS Scores for accredited products.[13,14] Regulators can compare performance on

**Table 1 - Common Conduct Remedies and Other Conditions Placed on Health Insurance Mergers**

| Pricing Restrictions | Improve or Retain Consumer Choices in Sub-Market | Improve Performance | Invest in Health Infrastructure | Charitable Giving Requirements | Maintain/Expand Corporate Presence Within State |
|---|---|---|---|---|---|
| • Limits on rate increases<br>• Prohibit issuer from financing merger costs through higher premiums<br>• Prohibit increases in administrative costs<br>• Restrict issuer from making "material variation" in rate-setting methods<br>• Require issuer to negotiate with state if regulators determine that submitted rate increases are excessive | • Require issuer to offer policies on Marketplace in additional counties<br>• Establish expectation that issuer will expand presence in commercial market<br>• Require issuer to continue serving public programs or individual/ small group market | • Require issuer to strengthen provider network<br>• Require issuer to improve performance on specific quality or access measures<br>• Require issuer to reduce the rate of disputes going to independent review<br>• Require issuer to establish internal patient advocate program | • Require issuer to finance service improvements, such as rural health access or telemedicine<br>• Require issuer to fund consumer assistance programs, enrollment outreach, language access programs or other activities that help consumers acquire and use coverage<br>• Require issuer to pay for encounter data collection or develop a provider database<br>• Require issuer to fund health-sector employment development | • Require issuer to establish or augment a health care foundation<br>• Require issuer or corporate foundation to increase in-state charitable giving<br>• Sometimes related to state nonprofit conversion law | • Require issuer to maintain in-state corporate headquarters<br>• Require issuer to open a provider call center or otherwise create jobs within the state<br>• Issuer promise to retain in-state jobs |

*Source: Authors' summary*

these conditions to standards articulated in the undertakings or consent agreements—for example, in its 2016 approval of the Centene-HealthNet merger, the California Department of Insurance and the California Department of Managed Health Care specified that each product must improve its Total HEDIS Score by 0.8 points per year, on average.[15] The undertakings also stipulate that should the issuer fail to improve these Total HEDIS Scores, it must increase its financial investment in quality improvement, using a formula specified in the agreement. With this remedy, California regulators require the company to get better as it gets bigger.

Other remedies related to performance require issuers to improve their provider networks, improve customer service, or reduce the number of billing or coverage disputes that go to independent review.[16] These requirements also focus on requiring issuers to get better as they get bigger. Unlike quality performance ratings such as HEDIS, which are measured by an outside arbiter, compliance with these remedies is often self-certified by the issuer.

Regulators take a wide range of approaches to the **health**

**infrastructure investments** they sometimes require a condition of merger approval. These conditions may require issuers to invest in data development that will aid future policymaking, such as encounter data collection or the development of claims databases,[17] or they may require issuers to invest in programs or services that directly benefit consumers. For example, the California Department of Managed Health Care recently required Blue Shield of California and Care1st to provide $2 million per year in funding to consumer assistance programs. The Department's undertakings specified which consumer assistance organizations were eligible for this funding and directed the insurance company to make these payments for five years after the merger.[18] These programs will not ameliorate the consumer harms of a more concentrated health insurance market, but they may help consumers choose their health plan and, if consumers have coverage disputes or billing problems, these groups can advocate on consumers' behalf to better ensure that insurers pay appropriately for necessary healthcare.

California regulators have also required health insurance companies to contribute financing and expertise towards improving data infrastructure. For example, undertakings in the Blue Shield-Care1st transaction require Blue Shield to contribute $50 million towards the development of a statewide, centralized provider database and standardized encounter data submissions.[19]

Similarly, regulators in Georgia have required insurance companies to make substantial contributions toward telemedicine infrastructure as a condition of merger approval, while regulators in several states—including Georgia, Colorado and California—have required insurers to help build rural health infrastructure.[20] Other infrastructure investments have included language access initiatives and other investments targeted at improving health within traditionally underserved populations.

In addition, regulators sometimes require issuers to maintain or increase **charitable giving** within the state. Some transactions—such as the Montana Blue Cross Blue Shield acquisition by HCSC in 2013—involve not only a merger but also the conversion of a nonprofit health issuer to a for-profit company. Under state law and long-standing precedent, the non-profit must convert its assets to a public good, such as a new and independent foundation.[21]

In other instances, regulators may seize on charitable giving as an avenue for directing some portion of anticipated merger proceeds towards the broader community, although the company's charitable gifts may have only a tangential relationship, if any, to potential harms resulting from the merger. These conditions also need to be carefully specified; late last year, Blue Shield of California and the California Department of Managed Health Care differed over the charitable contribution requirements included in the Blue Shield-Care1st transaction. This disagreement could result in Blue Shield contributing $140 million less to healthcare delivery in California than the regulator had intended.[22]

Finally, regulators may also specify that the merged entity must **maintain a corporate presence** within the state**, maintain employment and service levels** within the state, or **increase employment** within the state by opening a call center or customer service center. State authority over the merged entity, particularly with regard to consumer protections, may be facilitated by the continued presence of a corporate office within the state. This state presence may be especially helpful in states with complex regulatory environments. Employment requirements, however, may be difficult to enforce. For example, when the Montana Commissioner of Securities and Insurance approved HCSC's 2013 acquisition of Blue Cross Blue Shield of Montana, it required HCSC to create a provider call center and 100 new jobs. HCSC opened the call center in 2014 with 45 employees, saying it planned to employ up to 120 workers.[23] But should HCSC's plans change, the state cannot practically force them to hire more people than they say they need to staff this endeavor. Regulators who seek to maintain insurance industry employment within their state may similarly find they have few enforcement tools. In addition, even when insurance companies abide by these requirements and create a benefit to the state economy, these remedies will have little impact on most consumers' plan choices.

### New Approaches to Conduct Remedies

Some experts have suggested other potential remedies that could be helpful to consumers and regulators, even if they do not directly ameliorate the loss of competition within the health insurance marketplace.

A potentially valuable component of a consent agreement would be the creation and funding of **an independent entity**—such as a non-profit or an independent commission—**that monitors market competitiveness.** This entity would track the performance of health insurance markets in the state. Part of this entity's mission would be to evaluate effects of insurance mergers, new entry, and exit, by studying changes in premiums, consumer cost-sharing responsibilities and plan benefits, and regularly disseminating this analysis.[24] This entity could also assess issuer performance against other objectives, including any remedies on which merger approval was conditioned, thus increasing insurance companies' accountability for promises made during merger negotiations. By comparing on-the-ground developments in the state's insurance market with pre-merger projections, this analysis would also contribute to better policymaking for future mergers. Insurance issuers could be required to share data with this entity to facilitate the analysis.

Another approach could **increase issuers' accountability for the improvements** they argue would be made possible by a larger corporate platform, such as value-based healthcare, or more favorable prices from hospitals, drug manufacturers and other providers. First, experts suggest that merger conditions should require issuers to measure and report on these initiatives. Next, should these promised benefits be realized, the conditions would require companies to pass the resulting savings on to enrollees through reduced premiums or cost-sharing. This approach could also be combined with the monitoring function described above to provide transparency about whether issuers achieve promised savings and establish accountability for passing these savings on to consumers.

### Enforcement is Critical

Conduct remedies and other conditions can be difficult to enforce. Regulators may not have the capacity or information they need to monitor compliance with conduct remedies, and they may not have appropriate enforcement tools should a company not comply. For example, a regulator in a state that relies on "file and use" to monitor premium prices will have less effective recourse if a company does not abide by a limit on premium increases. Or, if an insurance company later claims the remedy is counter-productive or not cost-effective, it may be difficult to find and agree on an effective substitute remedy.

On the other hand, compliance with some remedies is relatively easy to monitor, such as a requirement that an issuer meets performance targets as determined by an independent report card. In addition, regulators can set out consequences for noncompliance in the consent order, such as a fine or a moratorium on additional enrollment. Proposed remedies that are clearly articulated, measurable—ideally with validated information an issuer must submit to a third party—and tied to specific consequences are more likely to effectively address consumer concerns.

## Varying Perceptions of Conduct Remedies

Just as state regulators have applied a range of remedies to health insurance mergers, state consumer advocates and antitrust experts hold a range of views on conduct remedies. Most agree that mergers which overly consolidate a state's health insurance market, reducing competition and imposing costs on consumers, should be blocked if at all possible. And some argue that structural remedies such as divestiture, which is designed to maintain competition within the health insurance market, can potentially do more to protect consumer interests than conduct remedies—although divestiture, as previously noted, is also an imperfect remedy.[25]

Beyond these views, however, advocates and experts hold differing perspectives on the role and effectiveness of conduct remedies and other types of remedies in health insurance mergers.

### Viewpoint: Conduct Remedies Have Little Effect

Some antitrust experts express skepticism that conduct remedies can ameliorate the core consumer harms posed by corporate mergers. These experts argue that conduct remedies require companies to act in a manner inconsistent with their inherent profit-making motives as well as their post-merger structure and market power. This makes remedies inherently difficult for the firm to follow and for the regulator to enforce, and "ineffective at preventing harm to consumers and competition."[26] In the healthcare context, this means that limits on premium increases, requirements to enter new markets, and other remedies targeted to alleviate the consequences of insurance market consolidation would likely have little impact.

In addition, experts contend that antitrust agencies and regulators have few enforcement resources or authorities they can apply after a merger goes forward if the merged entity fails to comply with remedy requirements. As a practical matter, regulators cannot easily reverse a merger once it has been completed. Sometimes, depending on the remedy in question, regulators do not have the authority to fine or otherwise punish a health insurer that does not live up to the commitments it made while pursuing a merger approval. Relying on issuer self-certification or consumer complaints to determine whether insurance companies have made good on their commitments within merger agreements has also proved of limited utility.

Moreover, many of the conditions are time-limited, which means that even if issuers limit premium increases or other profit-maximizing behavior for the duration of the agreement, consumers are likely to eventually experience enduring harm as a result of the consolidation.

Finally, a subset of advocates and experts – particularly antitrust experts—argue that conduct remedies do not directly address the anti-competitive effects of mergers and are therefore of limited value. Some remedies may advance other policy agendas, but consumers are still likely to face higher premiums and cost-sharing, fewer health insurance choices, and more limited access to healthcare professionals in the wake of insurance company mergers. In their view, this is not an appropriate trade-off.

### Viewpoint: An Opportunity

Conversely, some advocates and regulators view health insurance mergers—when likely to be approved—as an opportunity for regulators to require issuers to improve their practices, or to extract some of the anticipated new insurer profits for state needs. When regulators are inclined to approve a merger, then adding conditions or undertakings—such as infrastructure investments, charitable contributions or quality improvements—can ensure that consumers derive some benefit from the merger.

*Remedies should be clearly articulated, measurable—ideally with validated information an issuer must submit to a third party – and tied to specific consequences.*

These benefits can be specific, such as the programs or outcomes that result from charitable gifts, infrastructure improvements that advocates have sought for many years, or data systems that will support better care management.

Conduct remedies can address advocates' current concerns about issuers within their state. As issuers grow through mergers, and cover a higher proportion of enrollees within the state insurance market, company deficiencies could loom larger, too. Requiring issuers to "get better as they get bigger" by correcting known problems or improving their quality performance metrics would at least ensure that consumers who enroll in the post-merger entity will purchase a plan that meets or exceeds some minimum standards. These requirements may also appeal to regulators if they have been unable to ensure company compliance through traditional enforcement measures.

Merger negotiations also provide an opportunity to look ahead, and advocates should think broadly about needs in their state. During these negotiations, advocates can bring these issues to regulators' attention and educate

*Important steps for consumer advocates include information gathering, strategy development and leveraging advocacy opportunities.*

them about these concerns. In the words of one advocate, "We think it's a really important [opportunity] to move our various agendas forward, on transparency, delivery system reform, equity, rates, timely access and network adequacy."[27]

## Steps for State Consumer Advocates

Because health insurance mergers may cause considerable consumer harms, and because the review process also may provide an opportunity for advancing health policy goals, many state-based consumer advocates want to engage on mergers pending before their state regulators. Important steps include information gathering, strategy development and leveraging advocacy opportunities.

### Information Gathering

Advocates should assemble as much information as they can about the pending merger. Using data available through their state regulator and other sources, advocates can determine whether the merging companies have any outstanding compliance problems, such as high rates of consumer or provider complaints, or significant provider directory errors. If both parties currently operate in the state, where do they compete, and where does only one party offer coverage? Which markets—such as individual coverage, group coverage, or public programs—do they specialize in? Does their geographic reach exclude certain populations, such as low-income residents? If one of the companies does not currently operate in the state, which markets do they serve in other states, and do they have compliance problems in these states? Advocates in California describe developing a "rap sheet" on each insurance company involved in a proposed merger to inform their strategy during merger consideration.[28]

Although every merger has different characteristics, advocates can also look at past mergers in the state, if possible, to provide concrete information on likely consumer harms. How did premiums or cost-sharing change? Can you identify consumers who were hurt by these changes? Did administrative costs increase? Is there evidence that access to care was reduced by changes in provider networks? Do you know consumers who could no longer see their providers? Did appeals processes become more complicated? Did enrollees wait longer for resolution of appeals? Was there a failure to effectively enforce the remedies employed last time?

### Strategy and Timing—Opposing Mergers, Proposing Remedies

Advocates will need to determine whether they should focus on stopping the merger as the only acceptable option for protecting consumers, or to simultaneously plan for the prospect that the merger will be approved by preparing and sharing remedy requests with regulators. This strategic choice may be determined by insurance market conditions in the state, particularly how concentrated the insurance market is already and how concentrated it is likely to be post-merger. The merger review process in the state may also determine strategy and timing. Some states use a single-step process, which considers whether to approve the merger simultaneously with an evaluation of potential remedies. In this scenario, advocates may have a single opportunity for input. In other states, regulators may use a two-step process, first deciding whether to approve a merger and then considering possible remedies. In most situations, even when advocates are opposing the merger, they should also be prepared with remedy requests in case they fail to block it; the state process may determine when they wish to share these proposals. Mergers generally cannot be unwound, so advocates need to be prepared for all contingencies.

In pushing for remedies, advocates will want to identify which remedies may be more effective given state conditions. For example, in a state that has little regulatory authority over rate increases—such as a "file and use" state—remedies that require issuers to limit premium

increases may have a modest effect. Advocates should also recognize that remedies that require insurance companies to embark on business strategies they would not otherwise implement could be undermined in future years. For example, if an issuer finds it is not making a satisfactory profit serving a new population or a new geographic market as required by a merger condition, the company may stop doing so when the condition expires. Advocates may want to balance these strategies with other approaches that are more enforceable or may have a more lasting impact.

Other considerations could include:

- Emphasizing remedies that are clear, measurable and enforceable. In the words of one expert, conditions that require issuers to make their "best effort" to hold down premiums or serve a vulnerable population are "window dressing."[29] Remedies that include clear measures and specific consequences, such as a fine or a particular sanction or enforcement action, written into the consent order will be more enforceable.
- Targeting remedies to documented state needs, such as language access programs, data infrastructure or health plan quality improvement.
- Developing a broad range of remedies, recognizing that not all will necessarily be approved, in order to increase the likelihood of securing a meaningful number and breadth of remedies.
- "Flooding the zone" with significant remedy requests in the hopes that illuminating what would need to be done to fix the merger will ultimately cause the merger to be disapproved or abandoned.

### Advocacy Tactics

Regulators have noted that consumer interests are not always represented before state agencies considering pending mergers. Fortunately, consumer advocates have many pathways for influencing these deliberations. Successful state advocacy tactics have included:

- Requesting that state regulators hold hearings on a pending merger (when state law does not always require hearings);
- Testifying at hearings on the merger to highlight consumer concerns and potential remedies;
- Submitting written statements explaining concerns with the merger, or outlining existing problems with the merging companies, and proposing specific remedies (if strategic);
- Meeting with regulators to explain concerns and discuss remedies; and
- Enlisting the support of state legislators at various stages in the regulatory review process. Legislators could ask regulators to hold hearings, or could hold their own. Legislators can also weigh in on blocking the merger or on specific remedy requests.

Other tactics might include:

- Outreach to community members, including through social media, to identify additional concerns and engage public opinion;
- Identifying policyholders—including those harmed by previous mergers—who can testify at hearings; and
- Educating the media about prior insurance mergers and what is now at stake for consumers.

## Conclusion

Consumer advocates should not view remedies as a substitute for blocking a merger that is likely to result in great consumer harms. However, they may face circumstances where it is not possible, or not strategic, to block the merger. Therefore, advocates should also be ready to propose robust remedies to ameliorate consumer harms related to market consolidation and use the merger negotiation process to apply pressure for good market conduct commitments and/or investments in the state's healthcare infrastructure. The ultimate success of these efforts will depend on crafting remedies that are clear, measurable and enforceable, and may require new mechanisms for tracking and measuring insurance company performance against these commitments. ■

**Table 2 - Transactions Examined for this Analysis**

| Transaction | State(s) | Year |
|---|---|---|
| UnitedHealth Group-GenCare | MO | 1994 |
| Maine Health Partners-Central Maine Health Partners | ME | 1997 |
| Anthem-Wellpoint | CA, GA | 2004 |
| UnitedHealth Group-Oxford | CT, NJ | 2004 |
| UnitedHealth Group-Pacificare | CA, CO | 2005 |
| Highmark-Independence Blue Cross | PA | 2007 (abandoned 2009) |
| UnitedHealth Group-Sierra | NV | 2008 |
| Partners Health System-Neighborhood Health Plan | MA | 2011 |
| Blue Cross Blue Shield of Montana-Health Care Service Corporation | MT | 2013 |
| Blue Shield of California-Care1st | CA | 2015 |
| HealthNet-Centene | CA | 2016 |
| Aetna-Humana | FL | 2016 |
| Anthem-Cigna | FL | 2016 |

## Notes

1. Healthcare Value Hub, *Addressing Consolidation in the Health Insurance Industry*, Research Brief No. 10 (January 2016). http://www.healthcarevaluehub.org/files/2614/5452/4976/Addressing_Consolidation_in_Healthcare.pdf.
2. Changes in Health Care Financing and Organization, *Health Plan Concentration and Consolidation* (October 2011). http://www.hcfo.org/publications/health-plan-concentration-and-consolidation.
3. This paper uses the terms "health insurance companies," "insurers" and "issuers" interchangeably; the term "plan" refers to a specific arrangement of health benefits, cost-sharing and provider network that issuers make available to employers or consumers.
4. Dafny, Leemore, Mark Duggan and Subramaniam Ramanarayanan, "Paying a Premium for Your Premium? Consolidation in the U.S. Health Insurance Industry," *American Economic Review,* Vol. 102, No. 2 (2012).
5. Sheingold, Steven, Nguyen Nguyen and Andre Chappell, *Competition and Choice in the Health Insurance Marketplaces 2014-2015: Impact on Premiums*, United States Department of Health and Human Services (July 2015). https://aspe.hhs.gov/basic-report/competition-and-choice-health-insurance-marketplaces-2014-2015-impact-premiums.
6. Guardado, Jose R., David W. Emmons and Carol K. Kane, "The Price Effects of a Large Merger of Health Insurers: A Case Study of UnitedHealth Sierra," *Health Management, Policy and Innovation*, Vol. 1, No. 3 (2013).
7. This primer has additional detail on the federal regulator roles: Healthcare Value Hub, *A Primer: How Antitrust Law Affects Competition in the Healthcare Marketplace*, Research Brief No. 4 (April 2015). http://www.healthcarevaluehub.org/advocate-resources/publications/primer-how-antitrust-law-affects-competition-health-care-marketplace/.
8. The Pennsylvania Insurance Commissioner proposed this structural remedy to maintain competition within the Philadelphia market area in the proposed Highmark-Independence Blue Cross merger. The two companies

did not agree to this condition and ultimately withdrew their merger application. Stouffer, Eric, "Highmark, Independence Blue Cross Cancel Merger Plans," *Pittsburgh Tribune (*Jan. 22, 2009). http://triblive.com/x/pittsburghtrib/news/regional/s_608270.html; Balto, David, personal interview (May 23, 2016).

9. Lerner, Arthur N., "Mergers: Antitrust Issues for Hospitals and Health Plans," Paper prepared for the American Health Lawyers Association Annual Meeting (June 2008). https://www.crowell.com/documents/Mergers_Antitrust-Issues-for-Hospitals-and-Health-Plans_Lerner.pdf.
10. Commissioner of Securities and Insurance and Montana State *Conversion of Blue Cross Blue Shield of Montana, Inc., and Alliance with Health Care Service Corporation: Amended Stipulation Between the CSI and Applicants* (June 2013) http://csimt.gov/wp-content/uploads/INS-2012-238-ASBCSI.pdf; Nelson, Caterina, "United Health Group, Inc. and Pacificare Health Systems, Inc: Summary," Member Briefing for the American Health Lawyers Association (January 2006); Nevada v. Unitedhealth Group, Stipulated Final Judgement (D. Nev, 2008). http://ag.nv.gov/uploadedFiles/agnvgov/Content/About/Consumer_Protection/UnitedStipulatedFinalJudgment20081008.pdf.
11. Commissioner of Insurance, State of Georgia, *Acquisition of Domestic Insurers Blue Cross Blue Shield of Georgia, Inc., Blue Cross Blue Shield Healthcare Plan of Georgia, Inc., and Greater Georgia Life Insurance Company by Anthem, Inc: Amended Order* (July 2004) and Frick, David R., "Letter of Commitment—Georgia Rural Health Care Initiative" (November 2004); Nelson, Op. Cit.
12. Florida Office of Insurance Regulation, *Application for the Indirect Acquisition of Humana Health Insurance Company of Florida, Inc. by Aetna, Inc.: Consent Order*, (February 2016). http://www.floir.com/siteDocuments/AetnaHumanaAcquisition185926-16-CO.pdf.
13. "Undertakings to the California Department of Insurance" (November 2004). http://www.sec.gov/Archives/edgar/data/1156039/000119312504192658/dex992.htm and "Undertakings Provided as Part of Blue Cross of California Notice of Material Modification Regarding Proposed Change in Control of Ultimate Parent Company" (November 2004), https://www.dmhc.ca.gov/portals/0/AbouttheDMHC/ArchivedDocuments/072304/BCCunder112404.pdf; Insurance Commissioner of the State of California, *Change of Control of the Health Net Life Insurance Company Due to the Indirect Acquisition by Centene, Inc: Stipulation and Undertakings* (March 2016). http://www.insurance.ca.gov/0400-news/0100-press-releases/2016/upload/nr028UndertakingsHealthNetCenteneMerger.pdf; California Department of Managed Health Care, "Exhibit A: Undertakings" (October 2015), http://www.dmhc.ca.gov/Portals/0/AbouttheDMHC/NewsRoom/2015/pr100815.pdf.
14. The Healthcare Effectiveness Data and Information Set (HEDIS) measures health plan performance across five domains—effectiveness of care, access to/availability of care, experience of care (based on the Consumer Assessment of Healthcare Providers and Systems, or CAHPS), utilization and relative resource use, and plan descriptive information. A plan's Total HEDIS Score is a composite score derived from plan performance on specified HEDIS measures appropriate to the plan's enrollee population (e.g., commercial, Medicare or Medicaid) and is one component of the plan's total accreditation score from the National Committee for Quality Assurance (NCQA).
15. Insurance Commissioner of the State of California (Centene), Op. Cit.
16. Ibid.; California Department of Managed Health Care, Op. Cit.; Division of Insurance, State of Colorado, *Findings of Fact, Conclusions of Law and Final Order Approving Application Re: UnitedHealth Group Acquisition of Pacificare Health Systems, http://www.hmo-info.com/page/frontpage/CO_DOI_Final%20Order[1].pdf%20(00255377).PDF.*
17. California Department of Managed Health Care, Op. Cit.
18. Ibid.
19. Ibid.
20. Ibid.; Insurance Commissioner of the State of California (Centene), *Op. Cit.;* Commissioner of Insurance, State of Georgia, *Op. Cit.;* "UnitedHealth-PacifiCare Deal Approved, With Conditions," *American Medical News*, January 16, 2006, http://www.amednews.com/article/20060116/business/301169993/6/.
21. See, e.g., NY Academy of Medicine Health Policy Symposium, "Blue Cross Conversions: Consumer

Efforts to Protect the Public's Interests," Silas, J., E. Hamburger, C.W.F. Bell, and M.V. Hunter, 74, No. 2, 1997; and Consumers Union, "Selling Out?: How to Protect Charitable Health Dollars and Services," Oct. 1998.

22. *Los Angeles Times,* "Non-Profit Blue Shield Accused of Backing Out of $140 Million Charity Pledge," November 17, 2015, http://www.latimes.com/business/la-fi-blue-shield-charity-20151117-story.html.
23. Johnson, Peter, "Blue Cross Reopens Great Falls Center," *Great Falls Tribune,* June 5, 2014, http://www.greatfallstribune.com/story/news/local/2014/06/04/blue-cross-reopens-great-falls-center/9993875/.
24. Dafny, Leemore, personal interview, May 11 2016.
25. Kwoka, John E., "Does Merger Control Work? A Retrospective on U.S. Enforcement Actions and Merger Outcomes," *Antitrust Law Journal,* 78 (3), 2013, 619-650; Kwoka, John E. and Diana L. Moss, "Behavioral Merger Remedies: Evaluation and Implications for Antitrust Enforcement," *Antitrust Bulletin*, Vol. 57, No. 4, (2012), http://www.antitrustinstitute.org/sites/default/files/AAI_wp_behavioral%20remedies_final.pdf.
26. Kwoka, John E., "Declaration," (Sept. 8, 2014) http://www.antitrustinstitute.org/content/aai-urges-massachusetts-court-reject-conduct-remedy-anticompetitive-hospital-merger.
27. Wright, Anthony and Tam Ma, personal interview (April 14, 2016).
28. Ibid.
29. Angoff, Jay, personal interview (April 14, 2016).

## About this Report and Acknowledgements

Author Karen Davenport used case studies and expert interviews to craft this analysis. Prior mergers examined for this report are listed in Table 2. The following individuals generously contributed to this research through interviews, providing background materials or answering questions:

| | |
|---|---|
| Jay Angoff | Former MO regulator |
| David Balto | Antitrust expert, former DOJ official |
| Amy Bogner | FL regulator |
| Suzanne Curry | Health Care for All, Massachusetts |
| Leemore Dafny | Economist, former FTC official |
| Demien Fontanella | CT Office of the Healthcare Advocate |
| Christina Goe | MT regulator |
| Tam Ma | Health Access California |
| Dena Mendelsohn | Consumers Union |
| Margaret Witten | GA regulator |
| Robert Wake | ME regulator |
| Anthony Wright | Health Access California |

Thanks to Consumers Union colleagues Lynn Quincy, Betsy Imholtz and George Slover who reviewed the report.

ALTARUM
HEALTHCARE VALUE HUB

**ABOUT THIS SERIES**
The Healthcare Value Hub takes a careful look at the evidence and consults with experts in order to clarify for advocates, media and policymakers the important cost drivers and the promising policy solutions. Hub Research Briefs, Easy Explainers, infographics and other products are available at our website. Note: This publication was produced when the Healthcare Value Hub was affiliated with Consumer Reports. As of July 1, 2017, the Hub is part of Altarum Institute.

**Contact the Hub:** 2000 M Street, NW, Suite 400, Washington, DC 20036
(202) 828-5100 | www.HealthcareValueHub.org | @HealthValueHub

Support provided by the Robert Wood Johnson Foundation