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Director John M. Huff
Mary S. Erickson, Hearing Officer
Department of Insurance, Financial Institutions & Professional Registration
Truman State Office Building
Room 530
P.O. Box 690
Jefferson City, MO 65102

Re: Supplemental Comment Concerning Aetna's Proposed Acquisition of Humana

Dear Director Huff and Ms. Erickson:

We provide this letter in supplement to our May 9, 2016 comments to address the issue of competition in the Medicare Advantage market. At the May 16, 2016 hearing before the Department of Insurance, Financial Institutions & Professional Registration ("Department"), Aetna's expert witness, Jonathan Orszag, provided testimony on his conclusion that the Department should consider both Medicare Advantage and traditional Medicare as a single product market in its evaluation of the competitive implications of the Aetna/Humana merger. The following provides additional information and clarifies our position, which is the same shared with the Department of Insurance, Financial Institutions & Professional Registration, that Medicare Advantage is its own separate and distinct market for the purposes of merger evaluation.

We make the following points:

- Under antitrust law and the Horizontal Merger Guidelines relevant market determination is a matter of price constraint. Only those products that constrain each other's prices are included in the relevant market. Traditional Medicare does not constrain the pricing of Medicare Advantage and thus is not in the same market.
- Extensive Department of Justice investigations, enforcement actions, and careful econometric studies demonstrate that Medicare Advantage is a separate relevant product market.
- A relevant market for merger analysis is defined to include the smallest set of products such that a "hypothetical monopolist" of that set of products could profitably raise price. Enrollees in MA strongly prefer another MA plan when their MA plan is terminated,

indicating a strong preference for MA and suggesting all MA plans collectively could raise price profitably. This is true even if some enrollees elect to switch to traditional Medicare in the wake of such a price increase. In essence, traditional Medicare does not act as a sufficient constraint on Medicare Advantage to be included in the market definition for the purposes of evaluating this transaction.

- The Department should not rely on Florida's decision in making its determination that the merger will substantially lessen competition.

Medicare Advantage and Traditional Medicare are Different Markets

The facts simply do not support Aetna's arguments that Medicare Advantage ("MA") and Traditional Medicare ("TM") are in the same product market. The key question in any relevant product market analysis is whether different products constrain each other's pricing. Only those products which constrain are included in the same relevant market.[1]

This issue has been comprehensively studied by the DOJ in several health insurance mergers and each time they have concluded that Medicare Advantage is a distinct market from traditional Medicare "[d]ue in large part to the lower out-of-pocket costs and richer benefits that many Medicare Advantage plans offer seniors over traditional Medicare."[2] In particular:

> An issue in the 2007 merger of health insurers United and Sierra was the extent to which the terms of Medicare Advantage (MA) plans the merged firm could profitably offer to seniors were constrained by the Medicare alternative. DOJ economists examined cross-market panel data on enrollment by seniors in the different types of health insurance plans. Consistent with the hypothesis that insurance provided by MA plans constitutes a relevant product market, the econometric analysis found that, after controlling for other relevant variables, an increase in the number of MA plan competitors in a geographic market generated higher enrollment in these products. This indicated that increased MA plan competition resulted in more favorable plan terms, in both price and quality dimensions. [Economic Analysis Group ("EAG")] staff also looked at the competitive impact of different sized firms in the market. EAG's cross-market empirical work found that a competitor's impact in the marketplace increases substantially with firm size.[3]

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[1] Dennis W. Carlton, Market Definition: Use and Abuse, *available at* https://www.justice.gov/atr/market-definition-use-and-abuse.

[2] Competitive Impact Statement, *United States v. UnitedHealth Group Inc. and Sierra Health Services, Inc.*, No. 08-cv-322 (D.D.C. Feb. 25, 2008), *available at* www.justice.gov/atr/case/us-v-unitedhealth-group-inc-and-sierrahealth-services-inc; *see also*, Competitive Impact Statement, *United States v. Humana Inc. and Arcadian Management Services, Inc*., No. 12-cv-00464 (D.D.C. March 27, 2012), *available at* https://www.justice.gov/atr/case-document/file/499056/download.

[3] Economic Evidence in Merger Analysis, Organization for Economic Co-operation and Development (Feb. 9, 2011), *available at* https://www.ftc.gov/sites/default/files/attachments/us-submissions-oecd-and-other-international-competition-fora/1102economicevidencemerger.pdf; *see also* Abe Dunn, *Does Competition Among Medicare*

This makes sense; MA is a TM alternative provided by private insurers that receive per-beneficiary payments from the government. These private insurers market MA to TM-eligible individuals based on the advantages offered over TM that the DOJ cites in its reasoning as to why MA is a separate product market. The pricing of TM does not constrain pricing by MA plans.

These advantages, including lower out-of-pocket costs, richer benefits, and one-stop shopping for full coverage under one plan, have made MA very successful.[4] MA is an important and growing market in Missouri and authorities should preserve a competitive marketplace. MA enrollment has steadily grown since 2004, despite reductions in payments to plans enacted by the Affordable Care Act of 2010 (ACA).[5] Enrollment over this time has tripled from 5.3 million to 17.6 million,[6] attracting 28% of Medicare beneficiaries.[7] And in Missouri specifically MA enrollment has increased 9 percent from 2013 to 2014 and 8 percent from 2014 to 2015 with over 100,000 new enrollees having entered the Missouri MA market in the last 5 years.[8]

A recent 2015 study by Anna Sinaiko and Richard Zeckhauser investigated beneficiary responses to the elimination of an MA plan and found that enrollees selected another MA plan rather than accepting the program default of enrollment under TM.[9] Another study by the same authors found ongoing and increasing enrollment in MA plans despite significant cuts in benefits following reforms under the Affordable Care Act suggesting distinct consumer preferences for the package of benefits and managed care format of MA plans.[10]

In addition, the Department's expert Jonathan Gruber listed a number of factors that show that MA and TM are in different markets. These factors include that (1) products and

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Advantage Plans Matter?: An Empirical Analysis of the Effects of Local Competition in a Regulated Environment, EAG Discussion Paper (July 2009), available at https://www.justice.gov/sites/default/files/atr/legacy/2009/07/27/248399.pdf (DOJ study finds when competition increases in the MA market, so does the number of enrollees served and product proliferation. This suggest that the existence of TM does not adequately motivate private MA companies to compete with TM).

[4] *See generally*, American Hospital Association, Letter to Hon. William Baer, DOJ, and Hon. Sylvia Burwell, HHS regarding a detailed analysis of the Aetna/Humana merger (September 1, 2015), available at http://www.aha.org/advocacy-issues/letter/2015/150901-let-hatton-burwell-baer.pdf.

[5] Gretchen Jacobson, Giselle Casillas, Anthony Damico, Tricia Neuman, and Marsha Gold, Medicare Advantage 2016 Spotlight: Enrollment Market Update, KAISER FAMILY FOUNDATION (May 11, 2016), *available at* http://kff.org/medicare/issue-brief/medicare-advantage-2016-spotlight-enrollment-market-update/.

[6] *Id.*

[7] Joseph P. Newhouse and Thomas G. McGuire, "How Successful is Medicare Advantage?" *Milbank Quarterly* Vo. 92, No. 2 (June 2014) pp. 351-394, at 352.

[8] Missouri Hospital Association, Comments to Mary S. Erickson, Hearing Officer, Dept. of Ins. (May 13, 2016), *available at* http://insurance.mo.gov/documents/mo-hospital-assn.pdf.

[9] Anna D. Sinaiko & Richard Zeckhauser, *Persistent Preferences and Status Quo Bias Versus Default Power: The Choices of Terminated Medicare Advantage Clients* (Working Paper, Harvard University, 2015).

[10] Anna D. Sinaiko & Richard Zeckhauser, *Medicare Advantage – What Explains Its Robust Health?*, Am J Manag Care. 2015;21(11):804-806, *available at* http://www.hks.harvard.edu/fs/rzeckhau/Medicare%20Advantage.pdf.

beneficiaries of MA plans are significantly different than TM plans, (2) higher reimbursement of MA plans is not fully passed on to consumers, (3) restriction of a third market participant had significant effects on MA, and (4) differences in MA market structure have disproportionate effects. The details of these factors can be found in his report.

A recent study by the Center for American Progress confirms that TM does not constrain MA pricing. It evaluated competition throughout the country in MA. It found that where Aetna and Humana compete head to head — as in Missouri — premiums are lower.[11] In particular, competition between Aetna and Humana lowers Aetna's annual premiums by up to $302, and lowers Humana's annual premiums by $43.[12] This shows direct evidence of price discipline between Aetna and Humana, despite the presence of TM in these markets.

Price constraint is the critical issue. To analogize with coffee there are many forms of coffee. But no one would suggest that the price of instant coffee constrains the ability of Starbuck's to raise prices.

The SSNIP Test is the Preferred Test for Determining Product Markets

The agencies tasked with enforcing the antitrust laws "use the hypothetical monopolist test to identify a set of products that are reasonably interchangeable with a product sold by one of the merging firms."[13]

> Specifically, the test requires that a hypothetical profit-maximizing firm, not subject to price regulation, that was the only present and future seller of those products ("hypothetical monopolist") likely would impose at least a small but significant and non-transitory increase in price ("SSNIP") on at least one product in the market, including at least one product sold by one of the merging firms.[14]

What this means for example, is if a company can raise the price of their product by 5% and it results in customer defection to another product, then it is likely that both products are in the same market. However, if this does not result in an exodus from the market then the product market definition is likely correct. The SSNIP test has been successfully used in a number of cases to provide economic evidence of when consumers consider a certain product as a distinct market. Gruber's analysis is the traditional application of the SSNIP test -- it finds that a price increase in one segment of a market is not fully constrained by the existence of another segment of the market.

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[11] Topher Spiro, Maura Calsyn, & Meghan O'Toole, Bigger Is Not Better: Proposed Insurer Mergers Are Likely to Harm Consumers and Taxpayers, Center for American Progress (Jan. 21, 2015), https://www.americanprogress.org/issues/healthcare/report/2016/01/21/129099/bigger-is-not-better/.
[12] *Id.*
[13] 2010 Horizontal Merger Guidelines § 4.1.1.
[14] *Id.*

The SSNIP test is the traditional means of developing the economic evidence necessary to show a product market. While the diversion ratio analysis proposed by Aetna's expert, Jonathan Orszag, has been used in some instances, it has also been rejected by courts.[15] This makes sense. Diversion ratios show consumer choices without context. There may be a number of external factors that cause diversion from MA to TM, unrelated to a change in the relative price of the two products. For example, there may not be enough choices in the market for the enrollee to find a more attractive MA plan. This could be the case in Missouri, where Aetna, Humana and United make up 82% of the MA market.[16] A Commonwealth study has also found that there is little to no competition in 97% of the U.S. at the county level.[17] Prices could also already be so high that consumers are willing to accept imperfect substitutes. These customers may also have tried MA and realized it wasn't for them, or are switching from their MA plan based on bad experiences and would prefer not to have to deal with another MA provider. Therefore, Orszag's analysis is not relevant in determining a relevant market. Regardless of whether individuals switch between TM and MA that does not mean these products are price constraints on each other, which again is the relevant analysis for determining a relevant product market.

Missouri Should Not Follow the Florida Office of Insurance Regulations Finding

The Florida Office of Insurance Regulations recently found, in its approval of Aetna's acquisition of Humana that MA and TM were competitors in the same market. Missouri should not rely upon Florida's decision in making its determination. First, Florida's decision is not precedential in any respect, and differs from the findings of the federal government and other regulatory bodies that have examined such markets. Second, the Department analyzes health insurance mergers under applicable Missouri law. Florida's decision was based on dynamics specific to Florida law, which are not necessarily applicable to Missouri, and therefore should not be relied upon by the Department. Third, part of Florida's analysis is the examination of the future of Medicare. While mergers are often predictive exercises of how a market will act post-merger, guessing at what regulatory changes may take effect and the timing for such effect leads to very uncertain results. The market should be analyzed as it exists today, not how it may look at some unknown point in the future. And the current MA market substantially differs from the product offerings of TM.

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[15] *FTC v. CCC Holdings Inc*., 605 F. Supp. 2d 26, 70-71 (D.D.C. 2009) (finding the methodology of the diversion analysis flawed); *City of New York v. Group Health Inc*., 649 F. 3d 151, 156 (2d Cir. 2011) (diversion analysis rejected because it was based on the buyer's preferences).

[16] Gretchen Jacobson, Anthony Damico, and Tricia Neuman, Data Note: Medicare Advantage Enrollment, by Firm, 2015, KAISER FAMILY FOUNDATION (July 24, 2015), *available at* http://kff.org/medicare/issue-brief/data-note-medicare-advantage-enrollment-by-firm-2015/.

[17] New Report: Little or No Competition in Medicare Advantage Insurance Markets in 97% of U.S. Counties, Commonwealth (Aug. 25, 2015), *available at* http://www.commonwealthfund.org/publications/press-releases/2015/aug/little-competition-in-medicare-advantage.

Thank you for the opportunity to provide additional comments. Should you have any questions, please let us know.

Sincerely,

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