Case Brief: Highlights from the District Court Decision Blocking the Aetna-Humana Merger

The United States District Court for the District of Columbia recently issued its decision in the Department of Justice's challenge to the proposed merger between Aetna and Humana, two of the largest health insurance companies in the nation. The complaint filed in July 2016 alleged that the merger violated Section 7 of the Clayton Act. DOJ argued that the merger would substantially lessen competition in two markets: (1) the Medicare Advantage market in 364 counties, and (2) the ACA Exchange market in 17 counties. The decision, issued on January 23, 2017, concluded that the merger would indeed illegally constrain competition and blocked the $37 billion deal.

In this post, we break down the key issues from the 156-page decision and discuss significance of the case.

I. ACA EXCHANGE MARKETS &amp|AETNA'S EXIT

The most alarming aspect of the case involved Aetna's decision to leave several ACA exchanges. The case focused on the merger's effect on 17 of these exchange markets located in Florida, Georgia, and Missouri. Shortly before DOJ filed its complaint in this case, Aetna announced it would not offer plans on any of these exchanges after 2016. The parties bitterly disputed why Aetna decided to leave these markets. Aetna argued that it withdrew because ACA exchanges were unprofitable. The government argued Aetna withdrew to evade judicial review.

The Court concluded that Aetna left ACA exchanges for two reasons: to improve its position in litigation, and to make good on threats made to the Obama administration. Timing of the exits, as well as internal documents and e-mails form Aetna executives proved key to this finding.

Aetna sought to improve its position in litigation by stifling competition on the 17 exchanges at issue in the case. By withdrawing, Aetna could argue that the merger would not diminish competition in the ACA markets because there was no longer any strong competition in those markets. The government countered this tactic by asking the Court to focus on ACA exchange competition prior to Aetna's exit. The Court decided to characterize Aetna as a participant in the ACA markets, rather than an outsider, given its history in the markets and potential to reenter. This characterization allowed the court to consider facts about competition on the exchanges both before and after Aetna's exit.

In evaluating competitive impact on the ACA exchanges, the Court chose to focus on Aetna's likelihood of reentering the 17 exchanges. The more likely Aetna is to reenter an ACA exchange market, the more harmful the merger is to the market. Aetna's reason for exiting the exchanges speaks to the likelihood that Aetna would reenter. If Aetna pulled out for valid business reasons, it would be unlikely to reenter. But if Aetna exited to evade judicial review of the merger or to punish the Obama administration, then the withdrawal says nothing about whether Aetna would reenter after litigation concludes.

Documents showed that during DOJ's initial investigation of the merger before filing its complaint, Aetna "tried to leverage its participation in the exchanges for favorable treatment from DOJ regarding the proposed merger."[1] In a deposition and in a meeting with then US Secretary of Health and Human Services Sylvia Burwell, Aetna threatened to pull out of the exchanges if DOJ blocked the merger. Aetna also

offered to expand its presence in the exchanges if the merger passed DOJ review. This evidence helped convince the Court that Aetna pulled out of the exchanges not to maximize profits, but instead make good on its prior threats.[2]

After DOJ filed its complaint, Aetna made the final decision to pull from the 17 exchanges. Aetna did not conduct a business analysis of the exchanges in these locations prior to the decision to withdraw. The Court took notice of Aetna's attempts to conceal the paper trail of their decision to pull from the exchanges. Later analysis of these exchanges actually showed that Aetna received substantial profits from operating in the Florida exchanges. The Georgia and Missouri exchanges, however, were unprofitable.

Turning to the key question to the antitrust analysis, the Court concluded that Aetna was likely to reenter the exchange markets in Florida, where the exchanges were profitable, but not in Georgia or Missouri. The Court thus concluded that that the merger would cause substantial anticompetitive effects in the ACA exchanges in Florida.

II. MEDICARE ADVANTAGE MARKETS

1. Does Medicare Advantage Compete with Traditional Medicare?

The second part of the case focused on Medicare Advantage markets, and the ubiquitous dispute in healthcare antitrust cases about market definition. The parties here agreed on the geographic market, but disagreed about the proper product market. The government argued for a limited product market that included only Medicare Advantage plans. The insurers fought for a product market that included both Medicare Advantage and traditional Medicare plans.

To resolve disputes about product markets, courts typically

use the “hypothetical monopolist” test. The test examines whether one product can be substituted for another, such that consumers could switch to between the products if the price of one product increases. If a hypothetical monopolist could profitably impose a “small but significant non-transitory increase in price” (SSNIP), then the product market has been properly defined. Here, that boiled down to whether Medicare Advantage plans compete with traditional Medicare plans.

Courts examine two types of evidence when applying the hypothetical monopolist test: practical indicia (evidence of industry practice and consumer practice) and expert testimony from economists. The practical indicia here showed that by and large, the insurers treated the markets for Medicare Advantage and traditional Medicare plans as distinct. The insurers struggled to produce any documents showing the companies discussing competition between the two types of plans. And importantly, insurers did not consider the pricing of one of the two types of plans when setting the price of the other. Data also showed that seniors rarely switch between Medicare Advantage plans and traditional Medicare, demonstrating that consumers do not typically treat the plans as interchangeable substitutes.

The government’s main expert witness, Dr. Aviv Nevo, relied on this switching data in his analysis of the hypothetical monopolist test to determine whether a market for Medicare Advantage plans existed outside of traditional Medicare. Dr. Nevo concluded first, that under the test, a hypothetical monopolist of all the Medicare Advantage plans could increase profits by imposing a SSNIP of about five to ten percent on at least one of Humana or Aetna’s plans in 364 counties. He also concluded that a hypothetical monopolist of all the Medicare Advantage who was permitted to raise prices on all Medicare Advantage plans in a single county would impose a SSNIP on at least one Humana or Aetna plan. This meant that the government’s proffered Medicare Advantage product market

passed the hypothetical monopolist test.

The insurers' countered with their economist expert, Jonathan Orszag, who criticized the technical inputs and assumptions built in to Dr. Nevo's economic model. But Dr. Nevo effectively rebutted this critique by re-running his analysis using estimates derived from Orszag's own model. Even using Orszag's numbers, the government's Medicare Advantage product market passed the hypothetical monopolist test. This proved more than enough to convince the Court that the product market should only include Medicare Advantage.

2. Will the merger lead to presumptively unlawful anticompetitive effects?

With the product market issue resolved, the Court turned to the merger's effect on competition in Medicare Advantage market. The insurers did not dispute that the proposed merger would vastly increase market concentration in every county at issue in the case. The government expert easily convinced the Court that the merger would surpass the Herfindahl–Hirschmann Index ("HHI"), the metric courts use to determine whether a merger is presumptively anticompetitive. Courts consider a HHI over 2,500 "highly concentrated."[3] If a merger causes a market's HHI to increase by 200 or more, the merger is "presumed to enhance market power."[4] Here the Court found "in more than 75% of the counties, the post-merger HHI would be greater than 5,000, and in more than 70% of the counties, the merger would cause an HHI increase of more than 1,000 points."[5] Thus, the Court granted the government the presumption that the merger was anticompetitive, shifting the burden to the insurers to show that other factors would mitigate the competitive harm.

The Court also seemed impressed by the additional evidence the government put forth about the nature of competition between Aetna and Humana. The Court characterized Aetna as a "particularly aggressive Medicare Advantage competitor" who

has “aggressively expanded,” putting it on “a collision course with Humana.”[6] The government showed how Aetna and Humana’s head-to-head competition has recently intensified. The companies geographic overlap increased from 79 counties in 2011, to 675 counties in 2016. The companies share the business strategy of growing value-based payment contracts and building broader provider networks. The experts also persuaded the Court that this strong prior competition between the two companies would make the deal particularly harmful to the Medicare Advantage markets.[7][8]

3. The Insurers’ Defenses

The insurers raised three defenses regarding the Medicare Advantage markets: (1) government regulation of Medicare Advantage protects competition|(2) new companies enter the market|and (3) the insurers’ divestitures to Molina Healthcare would create competition. The Court rejected all three.

Government Regulation: The insurers argued that CMS regulation of Medicare Advantage plans prevents competitive harm. The Court disagreed, finding that CMS lacks the tools needed to constrain plans from increasing plan costs or reducing quality. The insurer’s focused on CMS’s ability to reject an insurer’s bid if the insurer significantly increases cost sharing or limits benefits in a plan. The Court found that while this might prevent immediate harms, it would not prevent a “slow erosion of plan quality or increase in premiums resulting from lessened competition over time.”[9] In emphasizing the long term dangers of the merger, the Court again cited the level of concentration created by the proposed merger shown through the HHI scores.

Entry: The Court also found that entry by other insurers into the market would not sufficiently protect competition. This conclusion relied primarily on the expert analysis from Dr. Novo, who found that only 13.3% of the counties at issue would see a new insurer enter per year. Even Orszag’s favorable

analysis for the defendants left only a 25.5% chance that new entrants would make up for lost competition from the merger. This data left the Court unconvinced that entry by new competitors would make up for lost competition.

Molina Divestiture: Aetna and Humana's third attempt at a defense focused on a divestiture deal in the works with Molina Healthcare.[10] The Court had serious doubts about Molina's ability to compete on equal footing with Aetna-Humana. Molina's ability to build adequate provider networks particularly concerned the Court. Ultimately, the insurers did not persuade the Court that Molina could expand on its expertise in Medicaid to build value-based Medicare Advantage networks which would compete on equal footing with Aetna and Humana post-merger. The "extremely low" purchase price Molina paid also caused skepticism about the company's potential for success in in the Medicare Advantage market.

III. EFFICIENCIES

The last hope for the insurers rested in convincing the Court that the merger created efficiencies to offset the harmful competitive effects in the Medicare Advantage and Florida ACA exchange markets. The insurers faced an uphill battle, as the Court had cited the high concentration figures throughout earlier parts of the decision.

In assessing efficiencies, the Court questioned whether the insurers would pass on savings to consumers by reducing premiums or out-of-pocket costs. Even the insurers' expert admitted that insurers keep most savings generated by efficiencies. The Court also felt troubled by the insurers' inability to show that consumers in the particular Medicare Advantage and ACA markets at issue would receive any potential savings. Ultimately, the insurers failed to convince the Court that that the merger's potential efficiencies would

outweigh competitive harms created by the deal.

CONCLUSION

This decision is certainly a win for those in favor of preventing further market concentration in the health insurance market, but there is still significant action ahead. We will be waiting to find out whether Aetna and Humana appeal the decision to the U.S. Court of Appeals for the District of Columbia. The decision in the Anthem-Cigna merger trial is expected any day now. By almost all accounts, Anthem and Cigna faced a tougher antitrust hurdles than Aetna and Humana. If the Anthem-Cigna deal is also blocked, the two decisions draw a very strong line in the sand protecting competition in health insurance markets.

[1] *United States v. Aetna et al.*, No. 16-1494, Slip. Op. at 125 (D.D.C. Jan. 23, 2016).

[2] *Id.* at 127.

[3] *Id.* at 58.

[4] *Id.* at 59.

[5] *Id.*

[6] *Id.* at 60-61.

[7] *Id.* at 60.

[8] *Id.* at 64-65.

[9] *Id.* at 75.

[10] Note, the Court analyzed the impact of the divestiture despite the government's argument that the deal remained

contingent on approval by CMS, insurance regulators, and Molina itself.