Expert Economists Author Letter Clarifying Relevant Product Market Definition for Aetna/Humana Merger Challenge

Last week's big news was that the Department of Justice and a number of states have challenged Aetna's proposed merger with Humana. As in any merger challenge, the way that the relevant product and geographic markets are defined is crucial to the court's determination of whether the merger should be enjoined. According to the DOJ's (and other states') complaint, this merger would combine one of the two largest insurers of Medicare Advantage (Humana) with the fourth largest (Aetna). This, the complaint alleges, would further concentrate 364 county Medicare Advantage markets that are already highly concentrated among a small number of firms. Aetna's principal defense is that insurer share of Medicare Advantage ("MA") is of no antitrust relevance given that consumers have the option of enrolling in traditional Medicare ("TM"). Therefore, says Aetna, TM and MA plans are not separate product markets and the merged entity should be evaluated for its effects in a larger Medicare market combining MA and TM. Given the significance of this issue, 20 prominent health economists have analyzed the relevant market definition in a July 8, 2016 letter [full text also included below] to the Florida Attorney General, who has joined the DOJ in this merger challenge. The economists' letter concludes that "MA is not in the same relevant market as TM and, therefore, that the merger will cause a serious increase in concentration that raises a competitive concern." It will be interesting to see how the issue of market definition plays out in the litigation.

The full text of the letter follows:

July 8, 2016

Attorney General Pam Bondi
Office of Attorney General
State of Florida
The Capitol PL-01
Tallahassee, FL 32399-1050

Re: Pending Merger of Aetna with Humana: Erroneous Market Definition

Dear Attorney General Bondi:

I. Summary

We, the undersigned, submit to you this letter in our capacity as economists with expertise in the subjects of antitrust, competition policy, and health economics. We are concerned that the Florida Office of Insurance Regulation (OIR)'s recent decision to approve the Aetna-Humana merger is based on an erroneous belief that Medicare Advantage (MA) is in the same relevant product market as traditional fee-for-service Medicare (TM). Based on the commercial realities of the market and on scientific evidence from economic research, we believe that the MA is not in the same relevant market as TM and, therefore, that the merger will cause a serious increase in concentration that raises a competitive concern. Below we sketch out the rationale for our position.[1]

II. Analysis

The OIR's finding is stated in the Consent Order:

> *the OFFICE finds that Medicare Advantage, the private market product, competes directly with Traditional Medicare. Accordingly, when considering the impact of the acquisition, the private market is only a portion of the Medicare market. When analyzed as the combination of the public and private markets, the Medicare market on a statewide basis is not*

> *highly concentrated, and the impact of the proposed acquisition affects the concentration by only a minimal amount (Florida OIR Consent Order, 2016, p. 5).*

This finding is pivotal because the OFFICE also finds empirically that the MA market is already highly concentrated in most counties and MSAs and that the merger causes most of the moderately concentrated counties and MSA to become highly concentrated. Further, the increase in concentration is more pronounced in the more populous areas (Florida OIR Report, 2016, pp. 12, 15). Therefore, concluding that the merger would not affect competition requires the finding that MA is in the same relevant market as TM. As a result, the overall decision of the OFFICE is that:

> *the OFFICE finds that the proposed acquisition is not likely to be hazardous or prejudicial to the insureds of the insurer or the public and that the acquisition would not substantially lessen competition in this state or tend to create a monopoly therein (Florida OIR Consent Order, 2015, p. 9).*

To the contrary, we believe that the nature of the products and economic research leads to the conclusion that MA is not in the same relevant market as TM and, therefore, that the merger raises competitive concerns.

A. MA is Substantially Different than Traditional Fee-for-Service Medicare

Most MA plans are HMOs. In 2015, 64 percent of MA beneficiaries were in HMOs. In return for reduced choice of providers and utilization review, the Medicare beneficiary enrolled in an HMO obtains more complete coverage. Over the long term, MA plans have been steadily increasing in share, attracting 31 percent of Medicare beneficiaries by 2015 (Jacobson, Damico, Neuman and Gold, 2015, fig. 2|Newhouse and

McGuire, 2014). Traditional fee-for-service Medicare is a very different type of plan than MA plans. It has no panels and no serious utilization review. Indeed, fee-for-service Medicare is the only surviving large-scale example of traditional indemnity insurance in the U.S.

TM provides unrestricted choice of provider, but it exposes the beneficiary to the risk of high out-of-pocket responsibilities. In 2013-14, 16 percent of Medicare beneficiaries faced out-of-pocket responsibilities that exceeded 20 percent of their annual income (Schoen, *et. al*. 2016, p. 14). Purchase of a private Medicare supplemental policy ("Medigap" coverage) reduces the risk of high out-of-pocket responsibilities, but a high cost. MA insurance, on the other hand, leads to less risk of high out-of-pocket responsibilities. In MA plans, the average out-of-pocket maximum was $5,014 per year per beneficiary in 2015 (Jacobson, Damico, Neuman and Gold, 2015, fig. 9). In addition, most (87 percent) MA plans cover pharamaceuticals, where TM does not (Medicare Advantage 2016). TM enrollees can obtain drug coverage through Medicare Part D, at an additional expense.

A beneficiary could piece together a plan of TM+Part D+Supplemental Insurance to approximate the breadth of coverage of MA plans. However, that pieced-together plan would be much more expensive in both premiums and out-of-pocket expenses than MA. A recent study of Miami-Dade County data showed that the average pieced-together plan would have monthly premiums of $318 v. $88 for MA. Average monthly out-of-pocket expenditures would be $409 v. $182 (Sinaiko, Afendulis and Frank 2013, pp. 206-207).

Further, MA utilization control for hospitals appears to be quite strict and effective. A recent study found that when MA beneficiaries had to switch to fee-for-service Medicare, their hospital utilization and costs rose substantially (Duggan, Gruber and Vabson 2015). This shows that MA utilization review had a large impact. In summary, there are large functional and financial differences between MA and TM.

B. MA Beneficiaries Differ from those in Traditional Fee-for-Service Medicare

Economic research shows that Medicare MA beneficiaries differ from those in TM in important respects. MA beneficiaries are healthier than those in TM. One way to see this is to compare the past health care expenditures of beneficiaries who switch from TM to MA to those who remain in TM. Various studies in recent years have found expenditures to have ranged from 20 to 45 percent lower among switchers than the average in the TM population (See Gruber, 2016, p. 7) for more discussion on this point). Further, the small percentage (3 percent) of beneficiaries who switch in the opposite direction (from MA to TM) are sicker than those who remain (Brown *et. al.* 2014, pp. 3356, 3357). Further, MA beneficiaries are more accepting of restrictions on provider choice in order to reduce costs than TM beneficiaries are (Hu 2005, pp. 1, 3).

C. Switching from MA to Traditional Fee-for-Service Medicare is Rare

Consumer behavior shows that beneficiaries view MA plans as quite different from traditional fee-for-service Medicare. MA enrollees who were involuntarily terminated because their plan left the market overwhelmingly (95 percent) sought another MA plan (Sinaiko and Zeckhauser 2015, p. 12). Voluntary switching from MA to TM is quite rare, only 3 percent per year nationally (Brown *et. al.* 2014, p. 3357). The corresponding figure for Miami-Dade County is similar at 5 percent (Sinaiko, Afendulis and Frank 2013, p. 209). These facts alone cast serious doubt on whether MA and TM are in the same product market.

D. The Growth of MA at the Expense of Traditional Fee-for-Service Medicare is Irrelevant

Over time, MA plans have grown at the expense of traditional fee-for-service Medicare. But, that does not imply that they compete closely enough to be considered to be in the same market. The MA growth represents a slow shift to a new organizational form and incentive system that is favored by a (slowly) growing number of Medicare beneficiaries. As indicated above, switching between TM and MA is very low. For a historical analogue, consider the slow grow of automobile sales at the expense of horse-drawn carriages in the early 20th Century. The availability of horses did not constrain the pricing of automobiles.

E. MA Pricing is Driven by Concentration in MA

Another approach to market definition is to see if MA pricing and other behavior responds to concentration among MA plans. Recent research indicates that this is the case: where there are fewer MA insurers, premiums are higher. This demonstrates that traditional Medicare is not a serious constraint on MA pricing. If TM were in the same market as MA there should be little relation of MA premiums to the number of MA insurers – traditional Medicare would already act as a competitive constraint on MA pricing, so it wouldn’t matter how many MA plans are in the market. That is not what the research shows.

A recent study of competition in the MA market at the county level finds evidence of market power, stemming from market concentration of MA plans (Song, Landrum and Chernew 2013). MA plans are able to and do charge higher premiums where there is higher concentration among MA plans.[2] Another county-level study shows that integrated MA/hospital plans charge higher quality-adjusted premiums than MA plans that are not integrated (Frakt, Pizer and Feldman 2013). These results would be impossible if TM competed closely with MA plans.

This research relates directly to the bottom line issue with the merger. Higher concentration in MA markets leads to higher MA prices , in spite of the presence of TM.

III. Conclusion

In sum, economic research suggests that Medicare Advantage insurance, is a separate relevant product market. Evidence shows that traditional fee-for-service Medicare does not much constrain Medicare Advantage price and decisions. Empirical research by the OIR shows that the merger would cause large increases in concentration in many local markets that are already highly concentrated. We urge you to consider this when weighing the evidence on the competitive consequences of allowing this merger.

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[1] For a fuller discussion of some of these issues and also for a discussion of additional factors suggesting that MA is a separate market see Gruber (2016). For an excellent discussion of the effects of past insurance mergers see Dafny (2015). For a general discussion of competitive concerns and market definitions relevant to this merger and also to the proposed Anthem-Cigna merger, see Frech (2016).

[2] See also, (Spiro, Calsyn and O'Toole, 2016). They conclude that when Humana offers a MA plan in the same county as Aetna, Aetna's premium is lower than in counties where Humana does not offer a plan.