

Winter 2019

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Recommended Citation

Jacqueline C. Lien, *Bad Behavior: Health Insurance Mega-Mergers*, 15 HASTINGS BUS L.J. 129 (2019).
Available at: https://repository.uchastings.edu/hastings_business_law_journal/vol15/iss1/4

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Bad Behavior: Health Insurance Mega-Mergers

*Jacqueline C. Lien**

INTRODUCTION

2015 marked the beginning of a long battle for two major health insurance companies. On July 3, 2015, health insurance giant and third largest health insurance company by revenue, Aetna, announced that it entered into an agreement to acquire the fifth largest health insurance company, Humana, for \$37 billion.¹ Following a similar timeline, on July 24, 2015, second largest, Anthem, negotiated an even bigger merger with Cigna, the fourth largest, for \$54.2 billion.² Officials from all four companies lauded the benefits of the mergers, stating that the synergies between the respective companies would result in enhanced health care access, quality, and affordability for consumers, as well as transform the market to a more “consumer-focused marketplace.”³ However, many, including the Department of Justice, expressed concerns about the potential impact the proposed mega-mergers would have on competition in the health insurance industry. On July 21, 2016, the Department of Justice launched a suit to block Aetna’s acquisition of Humana, as well as Anthem’s acquisition of Cigna, citing concerns that the mergers would harm competition by reducing the number of large, national health insurers from five to three.⁴

In the midst of it all, Aetna’s CEO, Mark Bertolini, wrote to the Department of Justice threatening that if the Department failed to approve

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1. Press Release, Aetna, Inc., Aetna to Acquire Humana for \$37 Billion, Combines Entity to Drive Consumer-Focused, High-Value Health Care, (July 3, 2015).

2. Ankur Banerjee & Ransdell Pierson, *Anthem to buy Cigna, creating biggest U.S. Health Insurer*, REUTERS (July 24, 2015), <http://www.reuters.com/article/us-cigna-m-a-anthem-idUSKCN0PY12B20150724> [<https://perma.cc/SK7L-F29V>].

3. *Supra* note 2; *see also* Aetna to acquire Humana, combined entity to drive consumer-focused, high-value health care, ANTHEM (Aug. 24, 2015), <https://news.aetna.com/2015/08/aetna-to-acquire-humana/> [<https://perma.cc/NMX7-GMHZ>].

4. Press Release, Department of Justice, Justice Department and State Attorneys General Sue to Block Anthem’s Acquisition of Cigna, Aetna’s Acquisition of Humana (July 21, 2016).

of the merger, Aetna would pull out of the Obamacare exchanges.⁵ The Department persisted and five months later, Aetna followed through with its threat withdrawing from markets in seventeen counties in Florida, Georgia, and Missouri.⁶ Taking Aetna's lead, Humana announced that starting in 2018, they would no longer offer health insurance plans in the state marketplace exchanges.⁷ A few months later, Anthem followed suit stating that it would need to "assess the long-term viability of [its] exchange footprint."⁸

In an attempt to win over the new administration, Anthem stated its support for the American Health Care Act and financially backed a number of political support groups that have some influence over the proposed merger. During their pursuit, Anthem remained relentless, even when faced with several obstacles—both internally and judicially. Their efforts to merge with Cigna were not only aggressive but politically transparent. Although both the mergers eventually failed,⁹ the tactics Aetna and Anthem used to pursue their acquisitions raised significant concerns about their market power. Anthem and Aetna's behavior in their pursuit of their respective mergers demonstrates that these health insurance companies have become so big and powerful that they are willing to openly threaten a federal agency that was currently investigating them for anticompetitive behavior. The time has come for the federal government to take bold steps to maintain some level of competition and fairness in the marketplace to protect consumers.

This note analyzes the role of political gaming as it relates to mergers and acquisitions of major health insurance companies and how it can negatively impact consumers. More specifically, this note focuses on the deceptive tactics that Aetna and Anthem displayed in their pursuit of their respective acquisitions. Additionally, this note explains why the Federal Trade Commission and the Department of Justice must investigate these

5. Scott Hensley, *Aetna CEO To Justice Department: Block Our Deal and We'll Drop Out of Obamacare*, NAT'L. PUB. RADIO (Aug 17, 2016), <http://www.npr.org/sections/health-shots/2016/08/17/490202346/aetna-ceo-to-justice-department-block-our-deal-and-well-drop-out-of-exchanges> [https://perma.cc/NXH3-CDW2].

6. *United States v. Aetna Inc.*, 2017 U.S. Dist. LEXIS 8409, 1992 (D.D.C. Jan. 23, 2017).

7. Reed Abelson, *Humana Plans to Pull Out of Obamacare's Insurance Exchanges*, N.Y. TIMES (Feb. 14, 2017), https://www.nytimes.com/2017/02/14/health/humana-plans-to-pull-out-of-obamacares-insurance-exchanges.html?_r=0 [https://perma.cc/6HW4-NJKL].

8. Shelby Livingston, *Anthem Warns of ACA Exchange Retreat In 2018*, MODERN HEALTHCARE (Nov. 2, 2016), <http://www.modernhealthcare.com/article/20161102/NEWS/161109978> [https://perma.cc/YJU2-5UMV].

9. Ana Mulero, *Anthem terminates Cigna merger*, Healthcare Dive (May 12, 2017), <http://www.healthcaredive.com/news/breaking-anthem-terminates-cigna-merger/442637/> [https://perma.cc/4WPM-M2HY]; see also, Rebecca Hersher, *Aetna And Humana Call Off Merger After Court Decision*, NAT'L. PUB. RADIO (Feb. 14, 2017), <http://www.npr.org/sections/thetwo-way/2017/02/14/515167491/aetna-and-humana-call-off-merger-after-court-decision> [https://perma.cc/N26S-SKZR].

tactics in order to protect competition, prevent further market consolidation, and ensure protection against big corporate insurance. Further, this note explains how transitioning to a single payer system may resolve the issues that stem from the proposed mega-mergers.

First, this note provides background information on the Aetna and Anthem mergers. Then, Part I examines the negative impacts of health insurance mega-mergers. Part II discusses the McCarran-Ferguson Act and whether Aetna and Anthem are exempt from all federal regulation, including federal antitrust regulation. Part III analyzes three separate bodies of federal antitrust regulation: the Clayton Act, The Sherman Act, and the Federal Trade Commission Act. Because the courts already reviewed the mergers as a whole, Part III addresses whether the tactics that Aetna and Anthem employed during their merger attempts violated those laws, rather than whether the mergers themselves did. Finally, Part IV argues that shifting from our current health insurance model to a single payer system or hybrid system would drastically decrease the health insurance companies' ability to use their political power to their advantage.

BACKGROUND

AETNA-HUMANA

In mid-2015, Aetna negotiated a merger with Humana for \$37 billion.¹⁰ In anticipation of potential litigation, Aetna CEO Mark Bertolini issued a letter to the Department of Justice¹¹ outlining Aetna's intent to withdraw its participation in the exchanges if the Department of Justice continued the suit to enjoin the merger with Humana.¹² Aetna claimed that the company was losing money from operating on the exchanges.¹³ The company also claimed that the costs of litigation would be too much of a financial burden for Aetna to bear.¹⁴ Thus, the merger would need to succeed, otherwise they could no longer continue to turn a profit while still participating in the exchanges.¹⁵ Many, including the court, considered the letter to be a threat to the Department of Justice.¹⁶ The court itself said,

10. Chad Bray & Reed Abelson, *Aetna Agrees to Acquire Humana for \$37 Billion in Cash and Stock*, N.Y. TIMES DEALBOOK (July 3, 2015), <https://www.nytimes.com/2015/07/04/business/dealbook/aetna-agrees-to-acquire-humana-for-37-billion-in-cash-and-stock.html> [https://perma.cc/5EEE-52UP].

11. *Supra*, note 6.

12. Letter from Mark Bertolini, CEO, Aetna Inc., to Dep't. of Justice (July 5, 2016) (accessed at big.assets.huffingtonpost.com/AetnaDOJletter.pdf).

13. *Id.*

14. *Id.*

15. *Id.*

16. *Supra* note 6, at 211; *see also* Hensley, *supra* note 5; *see also* Zachary Tracer, *Aetna Threatened to Quit Obamacare If Deal Blocked by U.S.*, BLOOMBERG (Aug 17, 2016); *see also*

“Aetna . . . was willing to threaten to limit its participation in the exchanges” and later addressed their withdrawal from 17 counties as Aetna following through with their threat.¹⁷ An excerpt from the letter follows below:

Our analysis to date makes clear that if the deal were challenged and/or blocked we would need to take immediate actions to mitigate public exchange and ACA small group losses. Specifically, if the DOJ sues to enjoin the transaction, we will immediately take action to reduce our 2017 exchange footprint. We currently plan, as part of our strategy following the acquisition, to expand from 15 states in 2016 to 20 states in 2017. However, if we are in the midst of litigation over the Humana transaction, given the risks described above, we will not be able to expand to the five additional states. In addition, we would also withdraw from at least five additional states where generating a market return would take too long for us to justify, given the costs associated with a potential breakup of the transaction. In other words, instead of expanding to 20 states next year, we would reduce our presence to no more than 10 states. We also would not be in a position to provide assistance to failing cooperative exchanges as we did in Iowa recently.¹⁸

After some consideration, the Department of Justice promptly launched an antitrust case against Aetna in response to the proposed merger, despite Aetna’s threat to pull out of the exchanges.¹⁹ Shortly after, Aetna followed through with their threats, announcing that it would not offer plans on the exchanges in 2017 in eleven of the fifteen states where they had participated in 2016.²⁰

ANTHEM–CIGNA

On February 8, 2017, the District Court determined that the proposed merger between Anthem and Cigna would substantially lessen competition and result in higher premiums and fewer choices in the large employer group market.²¹ During the court proceedings, discovery revealed tensions between the two health insurance giants.²² This included a letter that

Jonathan Cohn & Jeffrey Young, *Aetna CEO Threatened Obamacare Pullout If Feds Opposed Humana Merger*, HUFFINGTON POST (Aug. 17, 2016).

17. *Supra* note 6, at 211.

18. *Infra* note 35.

19. Dep’t. of Justice, *Justice Department and State Attorneys General Sue to Block Anthem’s Acquisition of Cigna, Aetna’s Acquisition of Humana*, (July 21, 2016); *see also supra* note 6.

20. *Supra* note 6, at 207.

21. *Supra* note 6, at 218.

22. Jimmy Hoover, *Transcripts In Anthem-Cigna Trial Show Merger Tension*, LAW360 (Nov. 29, 2016), <https://www.law360.com/health/articles/866682/transcripts-in-anthem-cigna-trial-show-merger->

Anthem CEO Joseph Swedish sent to Cigna CEO David Cordani, in which Swedish called the implementation of the integration “unacceptable.”²³ Discovery also revealed communications from an Anthem employee’s email indicating that Anthem established an Anthem-only team to proceed with the integration efforts “without Cigna’s knowledge or support” for a number of merger issues.²⁴ DOJ attorney Scott Fitzgerald also highlighted a letter from the chairman of Cigna’s board of directors, which accused Anthem of “taking actions that erode[d], rather than maximize[d], the value to be achieved from the transaction.”²⁵ Shortly after the District Court’s ruling, Cigna announced that had exercised its right to terminate the proposed merger with Anthem, stating that they believed that “the transaction cannot and will not achieve regulatory approval and that terminating the agreement is in the best interest of Cigna’s shareholders.”²⁶ Cigna promptly filed a lawsuit against Anthem in the Delaware Chancery Court to effect the termination and to seek \$13 billion in damages in addition to the \$1.85 billion breakup fee as stipulated in the merger agreement.²⁷

Under the agreement, both Anthem and Cigna have the right to terminate the agreement if the merger is not consummated by January 31, 2017, subject to extension to April 30, 2017.²⁸ Shortly after the Delaware Chancery Court filing, Anthem released a statement claiming that “Cigna’s lawsuit and purported termination is the next step in Cigna’s campaign to sabotage the merger and to try to deflect attention from its repeated willful breaches of the Merger Agreement in support of such effort.”²⁹ Anthem then filed a suit against Cigna seeking a temporary restraining order to enjoin Cigna from terminating the merger Agreement.³⁰ Despite the District Court’s ruling, the tensions between Anthem and Cigna, and the Chancery Court case, Anthem maintained that it believed that there was sufficient time and “a viable path forward” to complete the merger, which would eventually benefit millions of Americans by saving them more than

tension?nl_pk=f8dd95dc-32ce-4f4c-aeb3adfabadb396e&utm_source=newsletter&utm_medium=email
&utm_campaign=health [https://perma.cc/RUQ8-RGEP].

23. *Id.*

24. *Id.*

25. *Id.*

26. Cigna Corporation, *Cigna Terminates Merger Agreement With Anthem*, (Feb. 14 2017), <https://www.cigna.com/newsroom/news-releases/2017/cigna-terminates-merger-agreement-with-anthem> [https://perma.cc/L4K9-AX3M].

27. *Id.*

28. Merger Agreement, Anthem, Inc., Form 8-K, Item 1.01 (July 27, 2015).

29. Anthem, Inc., *Anthem Files Suit Against Cigna Seeking a Temporary Restraining Order to Enjoin Cigna from Terminating the Merger Agreement, Specific Performance Compelling Cigna to Comply with the Merger Agreement and Damages*, Press Release (Feb. 15, 2017).

30. *Id.*

\$2 billion in medical costs.³¹

Moreover, President Trump recently nominated Makan Delrahim to the Department of Justice to serve as an Assistant Attorney General in the Antitrust Division.³² Delrahim is an attorney who previously represented Anthem during his time in private practice and even went on to lobby Congress on behalf of Anthem on antitrust related issues regarding their merger with Cigna.³³ Delrahim's appointment could have resulted in a favorable outcome for Anthem. Court documents showed that Anthem was confident that the merger was still viable under a new DOJ.³⁴ Anthem publically endorsed the American Health Care Act, which is proposed to replace the Affordable Care Act.³⁵ Anthem even went as far as to donate \$460,000 to groups supporting the election campaigns of certain governors and state attorneys general.³⁶ These included the Republican Governors Association and the Democratic Governors Association.³⁷ In many states, governors appoint the insurance commissioners, who are responsible for reviewing proposed mergers like the Anthem–Cigna merger.³⁸ Anthem's political transparency and unwavering legal pursuit demonstrated the lengths that they were willing to go to successfully acquire Cigna.

I. THE NEGATIVE IMPACTS OF HEALTH INSURANCE MEGA–MERGERS

Large health insurance companies like Aetna and Anthem have long lauded the benefits of mergers like the ones they proposed. Aetna claimed that the merger would allow them to offer “a broad choice of affordable, consumer-centric health care products, [help] to constrain cost growth,

31. *Id.*

32. Melissa Lipman, *Trump Names Makan Delrahim As DOJ Antitrust Chief*, LAW360 (Mar. 27, 2017), <https://www.law360.com/articles/902548/trump-names-makan-delrahim-as-doj-antitrust-chief>.

33. Shelby Livingston, *Could Trump's Top DOJ Antitrust Pick Help Seal the Anthem-Cigna Deal?*, MODERN HEALTHCARE (Mar. 28, 2017), <http://www.modernhealthcare.com/article/20170328/NEWS/170329919> [https://perma.cc/79Z4-E2NB].

34. Shelby Livingston, *Anthem sees Trump's DOJ as its Wingman*, MODERN HEALTHCARE (Feb. 25, 2017), <http://www.modernhealthcare.com/article/20170225/MAGAZINE/302259918> [https://perma.cc/BD32-5JRF].

35. Virgil Dickson, *Anthem Backs GOP'S Obamacare Replacement*, MODERN HEALTHCARE (Mar. 10, 2017), <http://www.modernhealthcare.com/article/20170310/NEWS/170319992> [https://perma.cc/W458-XVLE].

36. David Sirota, *Anthem-Cigna Deal: Seeking Merger Approval, Anthem Makes Major Donations to State Political Groups*, INT'L. BUS. TIMES (Aug. 18, 2016), <http://www.ibtimes.com/political-capital/anthem-cigna-deal-seeking-merger-approval-anthem-makes-major-donations-state> [https://perma.cc/89AC-MQA2].

37. *Id.*

38. *Id.*

improve health outcomes, and promote wellness.”³⁹ Aetna also claimed that the merger would provide them with the “enhanced ability to work with providers and create value-based payment agreements” that would result in better care to the consumers.⁴⁰ Anthem CEO Joseph Swedish issued similar sentiments in a press release announcing the merger with Cigna.⁴¹

However, health insurance markets in the United States are already highly concentrated. In a study done by the American Medical Association (AMA), researchers found that seventy-two percent of the healthcare markets surveyed were highly concentrated according to the Herfindal-Hirschman Index (HHI).⁴² Mergers within markets that are already highly concentrated are presumptively illegal and raise significant antitrust concerns, including risks of increased prices and reductions in the number of services available.⁴³ Furthermore, while health insurance companies may suggest that concentration is not enough to bar mergers because rival insurers can enter into markets, “years of DOJ enforcement actions have shown that entry barriers into health insurer markets are substantial.”⁴⁴ This section will highlight some of the negative impacts of health insurance mega-mergers. If left unchecked, companies like Aetna and Anthem who already have such a substantial share of the market could use their political lobbying power to eliminate competition and make these impacts a reality to the detriment of the consumers.

39. Aetna, Inc., *Aetna to Acquire Humana for \$37 Billion, Combined Entity to Drive Consumer-Focused, High-Value Health Care*, Press Release (July 3, 2015), <http://www.businesswire.com/news/home/20150702005935/en/Aetna-Acquire-Humana-37-Billion-Combined-Entity#.VZYpMeTD9OI> [<https://perma.cc/9TD2-J7J8>].

40. *Id.*

41. Anthem, Inc., *Anthem Announces Definitive Agreement to Acquire Cigna Corporation*, BUS. WIRE (July 24, 2015), <http://www.businesswire.com/news/home/20150724005167/en/Anthem-Announces-Definitive-Agreement-Acquire-Cigna-Corporation> [<https://perma.cc/NR62-ARVP>].

42. See David W. Emmons & Jose R. Guardado, *Competition In Health Insurance: A Comprehensive Study of U.S. Markets*, AM. MED. ASSOC. (2014). The Herfindal-Hirschman Index (HHI) is used to measure market concentration. “The HHI is calculated by squaring the market share of each firm competing in the market and summing the resulting numbers.” The HHI factors in the relative size distribution of the firms in a market. The HHI is frequently used by the DOJ and FTC. <https://www.justice.gov/atr/herfindahl-hirschman-index>, [<https://perma.cc/9QLJ-2M29>].

43. Department of Justice and Federal Trade Commission, *Horizontal Merger Guidelines* at § 5.3 (Aug. 19, 2010).

44. David Balto & James Kovacs, *Health Insurance Merger Frenzy: Why DOJ Must Just say ‘No’*, LAW360 (Aug. 17, 2015), <https://www.law360.com/articles/683500/health-insurance-merger-frenzy-why-doj-must-just-say-no>; see, e.g., Complaint, *United States v. Aetna Inc. and Prudential Insurance Co. of Am.*, No. 3-99CV 1398-H (N.D. Tex. June 21, 1999) (finding that it was unlikely that new insurers would enter and compete with the newly formed Aetna/Prudential in Houston and Dallas “because of the costs and difficulties of doing so”).

A. INCREASED NEGOTIATION POWER

The idea is simple enough: when health insurance companies merge, they leverage their combined market power and resources when negotiating with health care providers, leading to cost savings and improved quality. While large health insurance companies claim that mergers amongst themselves allow them to gain more leverage to negotiate with providers at the benefit of the consumer, Thomas Greaney's Sumo Wrestler theory suggests otherwise. His theory suggests that when two dominant entities like a large-scale health care provider and a national health insurance company come together to negotiate, what is likely to result is a "handshake rather than an honest negotiation."⁴⁵ That is, instead of using their market power to negotiate a deal to benefit consumers, the two entities are more likely to negotiate a deal that benefits themselves. Precedent supports Greaney's theory. In *West Penn Allegheny v. UPMC and Highmark*, the dominant insurer in the Pittsburgh area, Highmark, reached an agreement with the largest health system, University of Pittsburgh Medical Center (UPMC).⁴⁶ The agreement protected the insurer against competition and harmed the health system's only hospital rival, West Penn.⁴⁷ Even more notable, executives of Partners HealthCare, the dominant hospital system in Massachusetts, and Blue Cross Blue Shield of Massachusetts, a dominant insurer, negotiated an agreement that would make insurance more expensive statewide.⁴⁸ The agreement stipulated that Blue Cross would increase insurance payments to Partners' doctors and hospitals.⁴⁹ In return, Partners would push other insurers to pay more for services rendered.⁵⁰ This agreement, known as a most favored nations provision, would ensure that all major insurers would face millions in cost increases by forcing them to pay more to compete with Blue Cross.⁵¹ To avoid potential antitrust violations, Partners and Blue Cross effectuated the agreement with a literal handshake, being sure not to leave a paper trail.⁵² Agreements like these ultimately hurt the consumers. Even when the dominant player is successful in bargaining with providers, it has little

45. Thomas Greaney, *New Health Care Symposium: Dubious Health Care Merger Justifications – The Sumo Wrestler and “Government Made Me Do It” Defenses*, HEALTH AFFAIRS BLOG (Feb. 24, 2016), <http://healthaffairs.org/blog/2016/02/24/dubious-health-care-merger-justifications-the-sumo-wrestler-and-government-made-me-do-it-defenses/> [http://perma.cc/49M3-HXXX].

46. *Id.*; see also *Highmark Inc. v. Allcare Health Mgmt. Sys.*, 134 S. Ct. 1744 (2014).

47. Greaney, *supra* note 45.

48. Scott Allen & Marcella Bombardieri, et al., *A Handshake That Made Healthcare History*, BOSTON GLOBE (Dec. 28, 2008), <https://www.bostonglobe.com/specials/2008/12/28/handshake-that-made-healthcare-history/QiWbywqb8oJJsA3IZ11o1H/story.html> [https://perma.cc/YT3N-LYQS].

49. *Id.*

50. *Id.*

51. *Id.*

52. *Id.*

incentive to pass the savings on to its policy holders.⁵³ Further, even if the negotiations lowered rates for consumers, it would likely “lead to a reduction in the quantity or degradation in the quality of physician services.”⁵⁴

Former policy director of the Bureau of Competition at the Federal Trade Commission, David Balto, suggested that the mergers would lead to an increase in monopsony power.⁵⁵ Monopsony power is “the power to reduce reimbursement for health care providers.”⁵⁶ Monopsony power gives health insurers a bigger bargaining chip against health care providers in terms of controlling the market in their favor (i.e., more restricted networks, contrived shortages of medical care,⁵⁷ etc.). While health insurers contend that increased monopsony power will lead to lower prices for consumers, the reality is that health insurance providers like Anthem, Aetna, Cigna, and Humana already have huge negotiating power. Balto suggests that rather than lowering premiums, the post-merger monopsony power will result in reduced “availability and affordability of health insurance for millions of consumers.”⁵⁸ Further, reducing reimbursement for health care providers can harm several provider markets and lead to shortages of health care providers and less service for patients.⁵⁹ According to the American Association of Family Practitioners, increased monopsony power will likely lead to more restricted networks, which “would only be exacerbated if a single insurer held greater influence over any potential market, state, or region—potentially separating patients from their physicians and community hospitals.”⁶⁰ Thus, the potential benefit of increased negotiation power as a result of a mega-merger is unlikely to confer to the consumers.

Increased negotiation power is not limited to negotiations with providers. As demonstrated by the health insurance mega-mergers, larger companies will likely have more political lobbying power. Because of their substantial share of the market and their negotiation power, both

53. Greaney, *supra* note 45; *see also* Leemore Dafny, Mark Duggan & Subramaniam Ramanarayanan, *Paying a Premium on your Premium? Consolidation in the U.S. Health Insurance Industry*, <http://www.bu.edu/sph/files/2010/10/Dafny-Duggan-Ramanarayanan.pdf>.

54. Leemore Dafny, Mark Duggan, & Subramaniam Ramanarayanan, *Paying a Premium on Your Premium? Consolidation in the US Health Insurance Industry*, 102 AM. ECON. REV. 1161, 1183 (2012).

55. David Balto & James Kovacs, *Health Insurance Merger Frenzy: Why DOJ Must Just say ‘No’*, LAW360 (Aug. 17, 2015), <https://www.law360.com/articles/683500/health-insurance-merger-frenzy-why-doj-must-just-say-no> [https://perma.cc/TM5U-MP8M].

56. *Id.*

57. Laurie J. Bates & Rexford E. Santerre, *Do health insurers possess monopsony power in the hospital services industry?*, 8 INTL. J. OF HEALTH CARE FINANCE AND ECON. 1, 2 (2008).

58. Balto & Kovacs, *supra* note 55, citing Letter from Reid Blackwelder, Board Chair, AAFP, to Chairwoman Edith Ramirez, FTC (June 4, 2015), available at <http://goo.gl/vk4IHM>.

59. *Id.*

60. *Id.*

Aetna and Humana were emboldened to attempt to negotiate with the federal government. Additionally, because of the financial resources they have, both companies were able to throw their support behind key political players that would be able to make political decisions to benefit their companies. Although these health insurance companies claim that increased negotiation power is beneficial to the consumers, it is more than likely that the companies will use it for their own financial gain to the detriment of the consumers.

B. COST INCREASE OF HEALTH CARE PREMIUMS

While there is evidence that suggests that larger insurers have the ability to pay providers less,⁶¹ research has shown that health insurance mergers often result in premium increases for consumers.⁶² In a study done on the effect of health insurance mergers on policy premiums, researchers found that exchange premiums are responsive to competition.⁶³ The study found that when insurance markets become more concentrated, premiums are highly likely to increase, rather than decrease like the health insurance companies claim.⁶⁴

Another study conducted by the American Medical Association (AMA) found that physicians who practice in areas with low competition tended to charge more for office visits than physicians who practiced in areas with high competition.⁶⁵ This further demonstrates that decreased competition negatively impacts consumers by increasing costs. Without an increase in quality or any other reasonable justification, concentration alone should not determine the price of health care.

C. QUALITY IMPROVEMENT ON POLICIES UNLIKELY

Decreased competition also negatively impacts consumers by reducing the incentive to improve the quality of care. The AMA suggested that if the mergers were successful, the health insurance companies would feel less pressure to offer broader networks to compete for members or respond

61. Glenn A. Melnick, Yu-Chu Shen, & Vivian Yaling Wu, *The Increased Concentration Of Health Plan Markets Can Benefit Consumers Through Lower Hospital Prices*, 30 HEALTH AFFAIRS, 1728, 1728–33 (2011).

62. Leemore S. Dafny, *The Risks of Health Insurance Company Mergers*, HARV. BUS. REV. (Sep. 24, 2015), <https://hbr.org/2015/09/the-risks-of-health-insurance-company-mergers> [<https://perma.cc/J5XT-3QWE>].

63. Leemore S. Dafny, Jonathan Gruber, & Christopher Ody, *More Insurers Lower Premiums*, AM. J. OF HEALTH ECON. (2015), 53–78, available at http://www.mitpressjournals.org/doi/pdf/10.1162/AJHE_a_00003.

64. *Id.*; see also Dafny, *supra* note 62; Leemore Dafny, “Health Insurance Industry Consolidation: What Do We Know From the Past, Is It Relevant in Light of the ACA, and What Should We Ask?” *Testimony before the Senate Committee on the Judiciary*, Sept. 22, 2015, at 10.

65. *Infra* note 78.

to the access needs of patients.⁶⁶ Thus, patients would likely find themselves forced to go to out-of-network providers to receive care,⁶⁷ which shifts the costs from the insurer to the seemingly insured—resulting in a cost savings for the insurance companies.

Some research has shown that competition can affect the quality of health plans. In a study done in 2003 on consumer surplus relating to the Medicare HMO program, researchers found that “all other facts being equal, the more rivals in a geographic area, the greater the availability of prescription drug benefits.”⁶⁸ Thus, health insurance companies like Aetna, Humana, Anthem, and Cigna should not be allowed to merge because they will not feel obligated to improve quality, which is a key component in maintaining competition.

D. INCREASED INNOVATION UNLIKELY

Innovation is essential to fostering competition in the marketplace. The American Hospital Association (AHA) contends that mega-mergers are likely to result in decreased innovation.⁶⁹ The AMA mirrored that sentiment finding that contrary to the health insurers’ claims that the mergers will enable them to innovate patient care, “large insurers are *not* more likely to implement the innovative payment and care management programs that benefit employers and individual patients.”⁷⁰ In fact, “concerted delivery system reform efforts have tended to emerge from other sources, such as provider systems . . . and non-national payers,” not commercial health insurers.⁷¹ Since innovation is a key component in keeping the marketplace competitive, health insurance mega-mergers could pose a major threat to competition in the health insurance industry. Although large health insurance companies laud the benefits of mega-mergers, the mergers can have negative impacts on consumers to the benefit of the companies, including higher costs and decreased quality of

66. *Id.*

67. *Id.*

68. Dafney, *supra* note 62, citing Robert Town & Su Liu, *The Welfare Impact of Medicare HMOs*, 34 RAND J. OF ECON. (2003) 4. This study was done prior to the enactment of Medicare Part D, which funded drug benefits for nearly all Medicare enrollees.

69. Amicus Curiae Brief of American Hospital Association, No. 17-5024, <https://assets.documentcloud.org/documents/3519060/American-Hospital-Association.pdf>.

70. American Medical Association, *The Anthem-CIGNA and Aetna-Humana Mergers: Putting Profits Ahead of Patients*, 3, <https://www.ama-assn.org/sites/default/files/media-browser/Insurance-Merger-Myth-Reality.pdf>.

71. American Medical Association, *The Anthem-CIGNA and Aetna-Humana Mergers: Putting Profits Ahead of Patients*, <https://www.ama-assn.org/sites/default/files/media-browser/Insurance-Merger-Myth-Reality.pdf> citing Dafny, “Health Insurance Industry Consolidation: What Do We Know From the Past, Is It Relevant in Light of the ACA, and What Should We Ask?” Testimony before the Senate Committee on the Judiciary, Sept. 22, 2015, at 6.

premiums. Mega-mergers such as Anthem-Cigna and Aetna-Humana have to potential to threaten competition and harm the consumers, which is why the government must intervene in order to protect competition in the health insurance market.

II. THE REGULATION OF INSURANCE— THE MCCARRAN-FERGUSON ACT

Despite the health insurance industry being one of the largest and most lucrative industries in the United States, the McCarran-Ferguson Act might allow health insurance companies to try to avoid federal antitrust enforcement. Left unregulated, health insurance companies have the potential to grow so large that they can harm the market and consumers. This should not be the case and was not the case in the Anthem-Cigna and Aetna-Humana mergers, as discussed below.

Congress passed the McCarran-Ferguson Act in 1945 in response to the 1944 Supreme Court ruling in *United States v. South-Eastern Underwriters Association*, in which the Court determined that the federal government had the authority to regulate insurance companies under the Commerce Clause, which included antitrust regulation.⁷² The Act provides that “the business of insurance, and every person engaged therein, shall be subject to the law of the several States which relate to the regulation or taxation of such business.”⁷³ The McCarran-Ferguson Act stipulates that federal antitrust regulations (i.e., the Sherman Act, the Clayton Act, and the Federal Trade Commission Act, etc.) shall apply to the business of insurance “to the extent that such business is not regulated by State Law.”⁷⁴ Under the Act, the antitrust exemption pertains to activities that “(1) constitute the “business of insurance,” (2) are “regulated by State law,” and (3) do not constitute an agreement or act to “boycott, coerce, or intimidate.”⁷⁵

Turning to the first element, the business of insurance is not all-encompassing and does not include all activities of insurance companies.⁷⁶ While mergers are not considered the “business of insurance,”⁷⁷ this note

72. *United States v. South-Eastern Underwriters Association*, 322 U.S. 533, 546.

73. 15 U.S.C. §§ 1011-1015, 1012(a) (1988).

74. § 1012(b).

75. 15 U.S.C. § 1012(b); *see also* 15 U.S.C. § 1013; *see also* Michael Cowie, *Health Insurance and Federal Antitrust Law: An Analysis of Recent Congressional Action*, THE ANTITRUST SOURCE (Dec 2009) at 1.

76. Michael Cowie, *Health Insurance and Federal Antitrust Law: An Analysis of Recent Congressional Action*, THE ANTITRUST SOURCE (Dec 2009), 2.

77. Robert Cyran, *The Regulatory Hurdles to Health Insurance Mergers*, N.Y. TIMES DEALBOOK (July 24, 2015) <https://www.nytimes.com/2015/07/25/business/dealbook/the-regulatory-hurdles-to->

focuses on Aetna and Anthem’s conduct in their pursuit of the mergers. Courts have typically interpreted the second criterion, regulation by State law, for McCarran-Ferguson exemption broadly. However, because the federal government has already established through the Affordable Care Act that the health insurance exchanges will be largely left to the individual States for regulation, both Aetna and Anthem satisfy this criterion. Thus, this analysis focuses on the first and third elements in each of the Aetna and Anthem cases.

Finally, turning to the last criterion for antitrust exemption, an entity is exempt from federal antitrust liability if its conduct does not constitute an agreement or act to boycott, coerce, or intimidate. By definition, a boycott is a refusal to deal with another in unrelated transactions in order to achieve terms desired in targeted transaction.⁷⁸ In *St. Paul Fire & Marine Insurance Co. v. Barry*, the Court concluded that the term “boycott” included “concerted refusals to deal with parties who were not competitors.”⁷⁹

AETNA

In order to determine what activities constitute the business of insurance under the parameters of the McCarran–Ferguson Act, courts must consider (1) whether the conduct has the effect of transferring or spreading a policyholder’s risk, (2) whether the conduct is an integral part of the policy relationship between the insurer and the insured, and (3) whether the practice is limited to entities within the insurance industry.⁸⁰ Here the conduct in question is Aetna’s withdrawal from the marketplace exchanges as a response to the DOJ’s suit to enjoin the merger with Humana.

In this case, because Aetna is a health insurance provider, their conduct has the effect of transferring or spreading the policyholder’s risk. In other words, when policyholders contracted with Aetna for insurance, the policyholders’ risk was spread throughout the other Aetna policyholders in their risk pool. Aetna’s withdrawal affected the coverage of their consumers that had policies through the marketplace exchanges by transferring the risk back to the individual policyholders. Moreover, their conduct is an integral part of the policy relationship between the insurer and the insured because withdrawing from the exchanges directly affected

health-insurance-mergers.html [https://perma.cc/2CUA-MN5W].

78. *Hartford Fire Ins. Co. v. Cal.*, 509 U.S. 764, 769 (1993).

79. Alan M. Anderson, *Insurance and Antitrust Law: The McCarran-Ferguson Act and Beyond* 25 WM. & MARY L. REV. 81 at 104 (1983), <http://scholarship.law.wm.edu/wmlr/vol25/iss1/3>; citing *St. Paul Fire & Marine Ins. Co. v. Barry*, 438 U.S. 531 (1978).

80. *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119, 129 (1982).

Aetna's consumers. Aetna policyholders in those particular markets were left without insurance and had to seek different coverage as a result of the withdrawal. Aetna effectively ended their relationship with those policyholders. Lastly, Aetna's conduct is limited to entities within the insurance industry because the marketplace exchanges were established for private health insurance companies. Therefore, Aetna's conduct satisfies the first prong for McCarran-Ferguson exemption and should constitute the "business of insurance."

Turning to the third prong for McCarran-Ferguson exemption, Aetna withdrew from the federally established health insurance exchanges in an attempt to influence the Department of Justice to relent in its action against Aetna. In fact, the court concluded that Aetna's reasoning for withdrawing was to improve its litigation position.⁸¹ In this case, a court could consider Aetna's refusal to participate in the health insurance exchanges a boycott against the federal government in order to achieve their desired transaction—a successful merger with Humana. Moreover, Aetna's conduct, including their letter to the Department of Justice, may be characterized as coercion or intimidation.

Although Aetna's conduct constitutes the "business of insurance" and is regulated by state law, Aetna may not be able to escape federal antitrust liability because their withdrawal may be considered a boycott. Further, a court could consider their withdrawal, in conjunction with their letter to the DOJ, an attempt to coerce and intimidate the government to change its position on the merger.

ANTHEM

In contrast to Aetna, Anthem has yet to take any affirmative action, rendering the McCarran-Ferguson Act inapplicable. Anthem's political lobbying, although transparent, does not violate antitrust laws. However, it raises concerns about the ability of major health insurance companies to utilize their market power to influence politics to their advantage. Anthem's behavior shows that the health insurance companies, particularly the biggest players in the industry (i.e., Anthem, Aetna, Humana, and Cigna) have grown so large that they are emboldened to challenge the federal government and destabilize insurance markets for their own business gain.

Although the McCarran-Ferguson Act allows health insurers to try to avoid federal antitrust enforcement, it is not always the case. Health insurers cannot always escape enforcement, as was the case in both the Aetna and Anthem mergers. Without any federal regulation, particularly

81. *Supra* note 6, at 192–93.

antitrust regulation, health insurance companies have the ability to grow so large that they can completely control the marketplace. However, antitrust laws like the Clayton Act, Sherman Act, and Federal Trade Commission Act can help combat the problem, as discussed below.

III. ANTITRUST REGULATION

The Department of Justice and the Federal Trade Commission are tasked with protecting competition in the marketplace through the enforcement of antitrust laws such as the Clayton Act, Sherman Act, and Federal Trade Commission Act. These pieces of legislation allow the DOJ and FTC to punish anticompetitive behavior to prevent further consolidation of the marketplace and protect consumers. This section discusses whether Aetna and Anthem's merger conduct, specifically the tactics they used, violated antitrust laws.

A. THE CLAYTON ACT

The Clayton Act Section 7 prohibits mergers and acquisitions that “may . . . substantially . . . lessen competition or tend to create a monopoly.”⁸² The Department of Justice and the Federal Trade Commission typically enforce Section 7, although state attorneys general and private parties can also enforce Section 7, pursuant to Section 4 or 16 of the Clayton Act.⁸³ Typically, when a merger is under review, the court will analyze whether the challenge is appropriate under Section 7. A merger is subject to challenge if it is “likely to encourage one or more firms to raise price, reduce output, diminish innovation, or otherwise harm consumers.”⁸⁴ Hart–Scott Rodino filings often triggers Section 7 review.⁸⁵ Under the Hart Scott Rodino Act, parties who want to acquire another entity must file a detailed report to the Federal Trade Commission and the Department of Justice prior to completing the merger or transferring any securities or assets if the combined assets of the two companies would exceed a 323 million dollar threshold.⁸⁶ Here, both Aetna and Anthem's respective 37 billion dollar and 52.4 billion dollar attempted mergers well exceeded the 323 million dollar threshold.

In order to determine if a merger violates Section 7, courts will typically conduct a rule of reason analysis. Courts will analyze and define the relevant markets, the companies' market share, and if the merger will

82. 15 U.S.C. § 18.

83. 15 U.S.C. § 15(a), 26.

84. U.S. Dep't of Justice & Fed. Trade Comm'n, Horizontal Merger Guidelines (2010), *available at* <https://www.ftc.gov/sites/default/files/attachments/merger-review/100819hmg.pdf>.

85. 15 U.S.C. § 18a.

86. 15 U.S.C. § 18a (updated as of Feb. 27, 2017).

result in a highly concentrated market.⁸⁷ The Department of Justice brought suits against Aetna and Anthem for their attempted mergers and eventually prevailed.⁸⁸ The court in both cases found that the Aetna and Anthem mergers would substantially lessen competition based on findings of market share and concentration.⁸⁹ Because Section 7 was already addressed in detail by the courts,⁹⁰ this note will not go into further detail regarding the mergers as they relate to the Clayton Act. Rather, this note will discuss the tactics that Aetna and Anthem employed to ensure the success of their respective mergers and why those tactics should raise concerns for the government and consumers.

B. THE SHERMAN ACT

The Sherman Act also regulates competition and the behavior of competitors in any given market. Congress passed the Sherman Act in 1890.⁹¹ The Act generally prohibits anticompetitive business activities:⁹² Section 1 targets and prohibits specific means of anticompetitive conduct, whereas Section 2 focuses on results that are anticompetitive in nature.⁹³ Because Section 2 focuses on results, and the court already decided to enjoin both mergers, this note will not address Section 2. Rather, this section will address Section 1 as it relates to Aetna and Anthem's conduct.

Section 1 of the Sherman Act, "prohibits every contract, combination, or conspiracy in restraint of trade or commerce."⁹⁴ In order to determine whether an action violates Section 1 of the Sherman Act, courts will turn to the elements as follows: (1) a conspiracy or agreement, (2) which unreasonably restrains competition, (3) and which affects interstate commerce.⁹⁵ Anthem pulled out of the marketplace on their own volition. Because there was no agreement with Cigna, the Sherman Act does not apply in this case. Similarly, Aetna's conduct does not amount to a conspiracy or agreement with another entity either. Therefore, the Sherman Act is not applicable to both of the mergers discussed in this note.

C. THE FEDERAL TRADE COMMISSION ACT

The Federal Trade Commission Act (FTCA) was created with the sole

87. *Id.*

88. *Supra* note 6, and *United States v. Anthem, Inc.*, 2017 U.S. Dist. LEXIS 23613.

89. *Id.*

90. *Supra* note 6, and *United States v. Anthem, Inc.*, 2017 U.S. Dist. LEXIS 23613.

91. 15 USCA §§ 1-7.

92. *Id.*

93. *Wex Antitrust Overview*, CORNELL LAW SCHOOL, <https://www.law.cornell.edu/wex/antitrust> [<https://perma.cc/R4HQ-K3MS>].

94. 15 USCS § 1.

95. *Richter Concrete Corp. v. Hilltop Basic Resources, Inc.*, 547 F. Supp. 893, 917 (1981).

objective to “protect the process of competition for the benefit of consumers, making sure there are strong incentives for businesses to operate efficiently, keep prices down, and keep quality up.”⁹⁶ The FTCA established the Federal Trade Commission, which granted the FTC the power to prohibit and prevent anti-competitive practices.⁹⁷ Under the FTCA, “unfair methods of competition in or affecting commerce, and unfair or deceptive acts or practices in or affecting commerce” are prohibited.⁹⁸ The FTCA allows the Commission to “seek monetary redress and other relief for conduct injurious to consumers, prescribe rules defining with specificity acts or practices that are unfair or deceptive, and establishing requirements designed to prevent such acts or practices,” among other things.⁹⁹

To determine if a practice is unfair, courts will assess if the practice (1) causes or is likely to cause substantial injury to consumers, (2) cannot be reasonably avoided by consumers, and (3) is not outweighed by countervailing benefits to consumers or to competition. Courts may also take public policy, regulation, or judicial decisions into consideration in conjunction with all other evidence in making their determination.¹⁰⁰ An act or practice is considered deceptive where (1) a representation, omission, or practice misleads or is likely to mislead the consumer, (2) a consumer’s interpretation of the representation, omission, or practice is considered reasonable under the circumstances, and (3) the misleading representation, omission, or practice is material.¹⁰¹

This section assesses whether Aetna and Anthem’s conduct constituted unfair or deceptive activities under the Federal Trade Commission Act.

AETNA

Unfairness

To reiterate, a practice is unfair if it (1) causes or is likely to cause substantial injury to consumers, (2) cannot be reasonably avoided by consumers, and (3) is not outweighed by countervailing benefits to consumers or to competition.¹⁰²

Charles Gaba, founder of ACAsignups.net which extensively tracks

96. The Antitrust Laws, Fed. Trade Comm., ftc.gov (2016).

97. 15 USCS § 45 (1890).

98. 15 USCS § 45(a)(1).

99. *Federal Trade Commission Act*, FED. TRADE COMM. <https://www.ftc.gov/enforcement/statutes/federal-trade-commission-act> [<https://perma.cc/ZB4P-94SF>].

100. 15 USCS § 45(n).

101. *Southwest Sunsites, Inc. v. FTC*, 785 F2d 1431, 1436 (1986).

102. 15 USCS § 45(n).

ACA enrollment in detail, estimates that 600,000 Aetna policyholders will be affected by Aetna's withdrawal from the exchanges.¹⁰³ 600,000 previously insured Aetna policyholders will no longer have coverage, placing them at risk of having uncovered medical bills or being subject to a penalty fee per the Affordable Care Act's individual mandate.¹⁰⁴ Because Aetna's withdrawal left their policyholders either without coverage, having to find different coverage, or having to choose an alternative coverage option that they had not originally contracted for, a substantial number of their policyholders sustained a substantial injury. Further, while policyholders can arguably shop around for a different policy, Aetna policyholders must do so after the fact. Because the conduct was a unilateral decision on Aetna's part, its policyholders could not avoid losing coverage. Thus, Aetna's withdrawal satisfies the second element because consumers could not reasonably avoid the conduct. Finally, to determine that Aetna's practice was unfair, Aetna's withdrawal must not be outweighed by countervailing benefits to consumers or to competition. Here, Aetna stated that it withdrew from the exchanges due to financial reasons, despite the fact that they were actually profiting in those markets.¹⁰⁵ Aetna asserted that they, along with the other major payers have "experienced continued financial stress within their individual public exchange business" and that in order to provide affordable, high-quality health care options to consumers, they need to withdraw from the exchanges.¹⁰⁶ Although Aetna may benefit its consumers as a whole by increasing its financial solvency, withdrawing from the exchanges does not benefit the consumers injured by its conduct nor does it benefit competition. Therefore, Aetna's conduct constitutes an unfair practice under Section 5 because its withdrawal from the exchanges does not outweigh the countervailing benefits to consumers or competition.

Based on the analysis above, Aetna's withdrawal from the marketplace exchanges constitutes an unfair practice because its withdrawal caused substantial injury to consumers, could not be reasonably avoided by consumers, and was not outweighed by countervailing benefits to consumers or to competition. Given these assessments, it seems likely that the FTC could sustain a claim against Aetna for violation of the FTCA.

103. Charles Gaba, *OK, How Many People Will HAVE to Shop Around This Fall*, AFFORDABLE CARE ACT SIGNUPS (Aug. 17, 2016), <http://acassignups.net/16/08/29/update-x2-ok-how-many-people-will-have-shop-around-fall> [https://perma.cc/YUV7-RUBM].

104. 26 USCS § 5000A(b)(1).

105. Aetna, Inc., *Aetna to Narrow Individual Public Exchange Participation*, Press Release (Aug. 15, 2016), <https://news.aetna.com/news-releases/aetna-to-narrow-individual-public-exchange-participation/> [https://perma.cc/NY2A-XU46].

106. *Id.*

Deception

Under the FTCA, an act or practice is considered deceptive where (1) a representation, omission, or practice misleads or is likely to mislead the consumer, (2) a consumer's interpretation of the representation, omission, or practice is considered reasonable under the circumstances, and (3) the misleading representation, omission, or practice is material and is likely to cause injury to a reasonable relying consumer.¹⁰⁷

While Aetna claimed that they withdrew from the exchanges due to a loss of profits from their participation, the court found otherwise.¹⁰⁸ The court determined that Aetna threatened the Department of Justice and withdrew from the exchanges in order to improve the outcome of its merger litigation.¹⁰⁹ In fact, Aetna withdrew from exchanges in some states and counties that were actually profitable, indicating that the reasons provided in the letter and in subsequent press releases were misleading to the public.¹¹⁰

If evidence can be found that Aetna's policyholders in those markets were misled by Aetna's claim, relied on it, and sustained an injury, such as leaving their exchange plan for a more expensive private plan because they thought the exchanges were failing, then the FTC may be able to penalize Aetna for deceptive behavior. Otherwise, although Aetna's representation may be misleading, Aetna policyholders' loss of coverage cannot be traceable to their reliance on Aetna's representation that their withdrawal was for financial reasons. Rather their injury was caused by Aetna's unilateral decision to withdraw. Thus, although Aetna was deceptive in their motive to withdraw participation, the Section 5 deception practices assessment does not apply here, unless evidence can support otherwise.

ANTHEM

Anthem recently pulled out the exchanges in several states including Nevada, Maine, and Ohio and drastically reduced their presence in states like California and Georgia.¹¹¹ If evidence can be found that Anthem's

107. *Supra* note 101.

108. *United States v. Aetna Inc.*, 240 F. Supp. 3d 1, 74 (D.D.C. 2017).

109. *Id.* at 82.

110. *Id.* at 74; Aetna, *supra* note 105.

111. Tami Luhby, *Anthem exits more Obamacare markets*, CNN MONEY (Aug. 7, 2017), <http://money.cnn.com/2017/08/07/news/economy/anthem-obamacare/index.html> [<https://perma.cc/T8VG-DZK3>]; Pauline Bartolone, Anna Gorman; Chad Terhune, *Anthem's Retreat Leaves Californians With Fewer Choices, More Worries*, KAISER HEALTH NEWS (Aug. 2, 2017), <https://khn.org/news/anthems-retreat-leaves-californians-with-fewer-choices-more-worries/> [<https://perma.cc/46MC-9Y5Q>]; Dwyer Gunn, *Anthem Pulls Out of Nevada's ACA Exchanges Entirely*, PACIFIC STANDARD (Aug. 7, 2017), <https://psmag.com/news/anthem-pulls-out-of-nevada-aca-exchanges> [<https://perma.cc/JCM5->

withdrawals were motivated for the same reasons as Aetna's withdrawals (i.e., to effectuate their merger), then the FTCA may have a case against Anthem.

Anthem's political power moves, while manipulative, are not against antitrust laws. Despite Anthem's unwillingness to relent to court decisions to enjoin the merger with Cigna and its lack of political transparency, the current antitrust laws do not have the ability to control the kind of political influence large corporations like Anthem can assert. Although ultimately, antitrust laws served its purpose and protected consumers against the mergers, permissive lobbying allows for manipulation of the system, as is shown in this case.

Considering the analysis above, the Federal Trade Commission should investigate Aetna and potentially Anthem for their unfair conduct. In doing so, large health insurance companies like Aetna and Anthem will be deterred from using their market power and influence to harm the government and the consumers. Aetna's withdrawal from the exchanges has already had a significant impact on the marketplace exchanges in that it caused a ripple effect. Anthem, Humana, and Cigna followed Aetna's footsteps and released statements in which they said they were planning to pull out of the exchanges or they are at least assessing the option of doing so.¹¹² The current state of the health insurance exchanges could collapse if this behavior is left unchecked.

Even so, federal antitrust enforcement agencies like the FTC still cannot protect competition from the companies' political lobbying tactics, as is demonstrated with Anthem. This exposes a loophole for major health insurance companies to influence the federal government. Because of the vast resources these companies have—financial, political, or otherwise, the companies could drastically impact competition and like Anthem, become audacious enough to directly threaten the government. Lobbying allows big corporations like Aetna and Anthem to reach into their deep pockets and essentially turn their dollars into policy, which should not be the case in a modern, capitalist society.

Legislation reform can help tackle the health insurance companies abusing their power, both politically and in the market. Legislators should

RN43]; Leslie Small, *Anthem pulls out of Maine's ACA Exchange*, FIERCE HEALTHCARE (Sept. 28, 2017), <https://www.fiercehealthcare.com/aca/anthem-maine-exit-aca-exchange-no-bare-counties> [https://perma.cc/8L3R-W9JT]; Jordan Weissman, *A Major Insurer Just Pulled Out of Obamacare in Ohio—and It Basically Blamed Trump*, SLATE (June 6, 2017), http://www.slate.com/blogs/moneybox/2017/06/06/anthem_pulls_out_of_ohio_s_obamacare_exchanges_basically_blames_trump.html [https://perma.cc/Q6F7-ZAA3].

112. Baylee Pulliam, *Aetna's playing hardbal –now others are too*, BIZJOURNALS (Aug. 29, 2016), <https://www.bizjournals.com/louisville/news/2016/08/29/aetnas-playing-hardball-now-others-are-too.html> [https://perma.cc/N9J5-U484].

introduce stronger antitrust laws as a first line of defense, as well as stricter lobbying laws in order to deter companies from gaining too much power that they are able to manipulate the government. However, short of legislation reform, another way that the federal government can address this lobbying loophole altogether is to overhaul the whole system and transition to a single payer system, which is discussed in the following section.

IV. POTENTIAL SOLUTION: SINGLE PAYER SYSTEM

Aetna and Anthem were so intent on effectuating their mergers that both companies were willing to use any means necessary to ensure success. Although their attempts were ultimately unsuccessful, their conduct demonstrated that political lobbying can be a powerful and potentially dangerous tool for major health insurance companies to manipulate the executive branch and subvert existing judicial oversight. Our current capitalist health insurance system depends on competition. When major health insurance companies use their market power as political lobbying power to promote anticompetitive mergers and acquisitions, it doubly threatens competition. However, a single-payer system could all but eliminate the health insurance companies' ability to engage in conduct like that of Aetna and Anthem's as well as provide a major benefit to consumers—actual coverage.

Prior to the ACA, 32 out of 33 developed nations had universal health care, with the United States being the one exception.¹¹³ The implementation of the ACA changed that by introducing the individual mandate. Even with the individual mandate, eleven percent of U.S. adults remain uninsured.¹¹⁴ With the increasing complexities and political uncertainty surrounding the health care system in the United States, the once impossible single-payer system, now seems politically viable. A single-payer system is a system in which “the government—not the employer—collects the health insurance premiums of all Americans in the form of payroll or income taxes.”¹¹⁵ The money goes into a health security trust fund established by the federal government and then distributed to the states.¹¹⁶ Each state then pays health care providers directly (i.e., hospitals,

113. *List of Countries with Universal Healthcare* (Feb. 8, 2018), <https://truecostblog.com/2009/08/09/countries-with-universal-healthcare-by-date/#link1> [<https://perma.cc/JHY8-52NT>].

114. Stephanie Marken, *U.S. Uninsured Rate Remains at Historical Low of 11.0%*, GALLUP, (July 11, 2016) <http://www.gallup.com/poll/193556/uninsured-rate-remains-historical-low.aspx> [<https://perma.cc/QV2B-WJZZ>].

115. Jim McDermott, *Single-Payer Makes Cents*, 27 BILL RTS J. 11, 12 (1994).

116. *Id.*

physicians, etc.) for their services.¹¹⁷ Payments can be made in various ways: fee for service, bundled payment, episodic payment, capitated payment, payment for value, to name a few. In a single payer system the federal or state government can negotiate payments for services, or the government can contract with outside entities for the healthcare services like Canada does.¹¹⁸ In some instances, the single payer model has transformed into socialized medical care, where the government employs, establishes, and operates their own doctors and hospitals, similar to the system in the United Kingdom,¹¹⁹ but this need not be the case in the United States. The two do not go hand-in-hand.

Successful single payer models have shown that it is possible for a country to have inexpensive, reliable healthcare for all that does not bankrupt the economy.¹²⁰ For example, Thailand's healthcare system is notably one of the most successful implementations of a single-payer system to date. In 2000, Thailand was in a healthcare crisis.¹²¹ Roughly a quarter of Thailand's population was uninsured, and several of the insured had inadequate policies.¹²² An estimated twenty percent of the poorest Thai homes became impoverished as a result of out-of-pocket healthcare spending.¹²³ The following year, Thailand introduced "one of the most ambitious healthcare reforms ever undertaken in a developing country."¹²⁴ Ten years later, ninety eight percent of the population, about forty-eight million Thai people, had insurance.¹²⁵ Since the program's implementation, Thailand's mortality rates significantly dropped, and life expectancy has increased.¹²⁶ The program improved health outcomes for millions of Thai people at the cost of \$80 per person annually.¹²⁷ This is a stark contrast from the over \$10,000 spent per person in the United States.¹²⁸

117. *Id.*

118. Philip Kotler, *It's Time For a Single-Payer Healthcare System*, HUFFINGTON POST, (Mar. 25, 2017), http://www.huffingtonpost.com/entry/its-time-for-a-single-payer-healthcare-system_us_58d6470de4b0f633072b37f8 [https://perma.cc/FL25-227L].

119. *Id.*

120. Amartya Sen, *Universal Health Care: The Affordable Dream*, HARV. PUB. HEALTH REV. (2015), <http://harvardpublichealthreview.org/universal-health-care-the-affordable-dream/> [https://perma.cc/N6FD-9HS2].

121. Sue George, *What Thailand Can Teach The World About Universal Healthcare*, THE GUARDIAN (May 24, 2016), <https://www.theguardian.com/health-revolution/2016/may/24/thailand-universal-healthcare-ucs-patients-government-political> [https://perma.cc/ZC56-43UT].

122. *Id.*

123. *Id.*

124. *Id.* citing the book *Millions Saved: New Cases of Proven Success in Global Health*.

125. *Id.*

126. Sen, *supra* note 120.

127. George, *supra* note 121.

128. Ricardo Alonso-Zaldivar, *\$10,345 per person: U.S. health care spending reaches new peak*, ASSOCIATED PRESS (July 13, 2016), <https://www.pbs.org/newshour/health/new-peak-us-health-care->

Single payer models can also be successful in developed countries as well. An example of a successful single payer system in the developed country is Taiwan. In 1995, Taiwan adopted a National Health Insurance (NHI) system.¹²⁹ Prior to its implementation, roughly fifty-seven percent of the Taiwanese population was insured by a number of health insurers.¹³⁰ Per Taiwan's NHI, every Taiwanese citizen has an identification card, and it includes a brief medical history.¹³¹ Each person must bring their card every time they utilize a medical service.¹³² The card allows hospitals to claim the charges, tracked by the cards, from the government.¹³³ This system enables rapid claims processing for healthcare providers.¹³⁴ Although the program is government-run, Taiwan relies on private healthcare providers for healthcare services. Thus, health care providers still compete for patients. Some of the strengths of Taiwan's NHI include good accessibility, comprehensive coverage, short waiting times, low cost, high coverage rate, and a nationwide research databank, which allows the government to conduct research to track public health outcomes.¹³⁵ However, some of the weaknesses of Taiwan's NHI include reduced quality of outpatient visits and a shortage of funding.¹³⁶ Because of the programs convenience and affordability, coupled with "a high level of health seeking behavior" in Taiwan, general practitioners often see above average numbers of patients each day.¹³⁷ This results in extremely short consultation times, typically no more than five minutes of physician time, which in turn leads to a decrease in quality because physicians are unable to spend quality time to assess the patient's needs.¹³⁸ Regardless, the NHI consistently receives satisfaction rates about seventy percent, and the Taiwanese have improved health outcomes.¹³⁹ Moreover, Taiwan's health care system costs about \$2,595 per capita and covers 99.9% of its population, which is considerably different from the United States for both metrics.¹⁴⁰

spen ding-10345-per-person [https://perma.cc/8QSC-LSNU].

129. Wai-Yin Wu, Azeem Majeed, & Ken Kuo, *An Overview of the Healthcare System in Taiwan*, 3 LONDON J. OF PRIMARY CARE 115, 115 (2010) <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3960712/pdf/LJPC-03-115.pdf>.

130. *Id.* at 116.

131. *Id.*

132. *Id.*

133. *Id.*

134. *Id.*

135. *Id.* at 117.

136. *Id.* at 118.

137. *Id.*

138. *Id.*

139. *Id.*

140. Tsung-Mei Cheng, *The Taiwan Health Care System*, THE COMMONWEALTH FUND <http://international.commonwealthfund.org/countries/taiwan/> [https://perma.cc/YD6Q-J4XK].

A pure single payer system would eliminate the political abuses and market manipulations outlined in this note. Without private health insurance companies, the government is solely accountable for the health insurance of its citizens. Consequentially, healthcare providers would be forced to improve costs and exceed quality measures in order to compete for better reimbursement rates from the government. However, a pure single payer system is difficult to accomplish, considering the highly polarized political environment in the United States currently. Some countries, such as Australia, France, Spain, and the United Kingdom have hybrid systems.¹⁴¹ These hybrids allow people the option of choosing a private health insurer if they do not want to opt into the government system, otherwise known as a public option. In this type of system, the private health insurers must compete with the government-run plans. A hybrid model may be the most viable option for the United States going forward, and health insurance companies would have to truly improve costs and quality to bolster competition, which would benefit the consumers. A hybrid model will also take away much of the political power and influence that major health insurance companies have, which will benefit and protect consumers from political gaming. While the single payer system is not without its flaws, there are relatively successful models in both developed and developing countries that can offer the United States some guidance. Further, it can look to the Medicare system, a semi-single payer system that already exists in the United States for individuals who are 65 and older, in which taxpayers pay for a large majority while private entities pay some parts.¹⁴² The U.S. government can use Medicare as a guide to expand the covered population. With several existing single payer models to look to, the United States should consider transitioning to a single payer system, or a hybrid form of it, to deter major health insurance companies from using their power to harm consumers.

Although there are several benefits and positive examples of single payer systems, there are some issues to consider. A main issue regarding single payer systems is solvency. In the Taiwanese model and the Medicare model, controlling the overall budget poses a problem for the government. The Taiwanese have had to cut into other government funds to pay for their citizens' healthcare, and funding for Medicare is predicted to run out in 2028.¹⁴³ Spending can often exceed what is collected from the

141. Kotler, *supra* note 118.

142. What is Single Payer Healthcare?, HEALTHCARE NOW, <https://www.healthcare-now.org/what-is-single-payer/> [<https://perma.cc/ZSC4-NBEP>].

143. Juliette Cubanski & Tricia Neuman, *The Facts on Medicare Spending and Financing*, KAISER FAMILY FOUNDATION (2016), <http://kff.org/medicare/issue-brief/the-facts-on-medicare-spending-and-financing/> [<https://perma.cc/2YQ2-JDKU>].

people by the government. This is an issue that has yet to be resolved. Solvency aside, the U.S. should still consider transitioning to a hybrid single payer and private insurer hybrid because the current private insurance model is becoming increasingly costly and burdensome to consumers and is likely going to continue to be so due to the rapid consolidation nature of the industry. Further, doing so would allow the government to reign in the health insurance companies' ability to use their market power and political influence against it because it would shift some control back to the government.

CONCLUSION

The goal of antitrust regulation should be to ensure the conditions of a free market and to protect competition in the marketplace.¹⁴⁴ With the health care industry transitioning to a highly capitalized and monetized environment, antitrust regulation is becoming increasingly important. Without safeguards in place, health insurance companies have the potential to destroy competition in the marketplace, which ultimately harms the consumers. While the Department of Justice and the Federal Trade Commission share the authority to sue to enjoin mega-mergers like the Aetna-Humana and Anthem-Cigna mergers and stop them from effectuating, the Federal Trade Commission has the authority to investigate and prohibit corporations from engaging in unfair or deceptive practices that are oftentimes used as means to succeed in their merger pursuits. The Federal Trade Commission should exercise their authority to protect the process of competition and to prevent large corporations from becoming bad actors just so they can succeed. These practices can lead to catastrophic consequences, as we are beginning to see with the marketplace exchanges.

Alternatively, those issues can be resolved if the government can move toward a single payer system or a hybrid system. While not entirely perfect, a single payer system would all but eliminate the negative behaviors discussed in this note. A hybrid system would be a viable option for the government to explore because it still allows for competition in the health insurance market, but it also allows the government to set the industry standard to reign in bad behavior.

Regardless, the health insurance industry is likely to continue to see changes and transform, whether it be from political forces or shifts in the market. The outcome of which is unknown. It is crucial that the U.S.

144. Jonathan Macey & Geoffrey Miller, *The McCarran-Ferguson Act of 1945: Reconceiving the Federal Role in Insurance Regulation*, 68 N.Y.U. L. REV. 13, 17 (1993).

government take steps in order to ensure the health of its citizens and continue to make strides to achieve healthcare for all and not allow big health insurance companies to use their market power as political power to coerce the government or harm competition or the consumers.