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Healthcare Mergers and Acquisitions in an Era of Consolidation: A Review and a Call for Agency Collaboration in Antitrust Enforcement

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Healthcare Mergers and Acquisitions in an Era of Consolidation: A Review and a Call for Agency Collaboration in Antitrust Enforcement

Abstract

Healthcare companies are consolidating at an alarming rate. From hospitals, to providers’ offices, to insurance companies, there are increasingly fewer consumer choices and more monopolies, which calls for heightened antitrust enforcement. Interestingly, antitrust enforcement authority in the healthcare industry is shared between the Federal Trade Commission (FTC), which presides over hospital and provider mergers, and the Department of Justice (DOJ), which presides over health insurance mergers. Although the FTC has challenged many hospital and provider mergers, the DOJ has only challenged six health insurance mergers. Furthermore, last year, the DOJ ultimately approved all health insurance mergers. In 2017, in United States v. Anthem, Inc. and United States v. Aetna, Inc., the DOJ pursued and obtained injunctions against two health insurance mergers, thereby signaling a shift in antitrust enforcement.

This Comment presents a historical overview of healthcare mergers, specifically examining health insurance merger case law. In addition, this Comment analyzes the recent Anthem and Aetna mergers and suggests why the courts made the unprecedented decision to enjoin those mergers. This Comment also assesses the future of health insurance mergers and asks whether we have reached the end of large health insurance company mergers. Finally, this Comment concludes by calling for the FTC and the DOJ to forge an effective and collaborative relationship, whereby the agencies collectively examine the antitrust concerns of healthcare mergers and discuss how these mergers will affect the industry as a whole.
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I. INTRODUCTION

"If you don’t think healthcare is about power, you haven’t been paying attention."¹ This statement originally referred to the importance of empowering patients, but it perfectly explains the current power struggle between healthcare entities and the motivation behind the trend toward consolidation.² In response, the government occasionally challenges healthcare mergers, but its approach is uncoordinated.³

The Federal Trade Commission (FTC) and the Department of Justice (DOJ), collectively the “Agencies,” are responsible for enforcing the federal antitrust laws.⁴ Despite their shared responsibility and jurisdiction over antitrust cases, in practice, the Agencies focus on different players in the healthcare industry.⁵ Whereas the FTC primarily focuses on challenging hospital and provider mergers, the DOJ focuses on challenging health insurance company mergers.⁶ Dividing and conquering is an effective strategy in certain circumstances, but this division may cause more harm than good when it comes to antitrust enforcement in the healthcare arena, leading to unpredictable challenges of mergers and an approach that does not consider how mergers affect all areas of the industry.⁷

Instituting a timely and unified effort among the Agencies is imperative.⁸ Currently, there are five major health insurance companies that dominate the

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¹ In this new era, we must share power with patients, Dr. Berwick urges, GOLD FOUND. (Nov. 8, 2017), http://www.gold-foundation.org/newsroom/news/new-era-must-share-power-patients-dr-berwick-urges/ (quoting Dr. Berwick, a former administrator for the Center for Medicare and Medicaid Services).


⁶ See O’Hara, supra note 5 and accompanying text.

⁷ See infra Part V. As one expert noted, the division between the FTC and DOJ is “extremely unfortunate.” Pear, supra note 5. In 2011, the FTC and DOJ announced an effort to develop one consistent policy, but that has yet to materialize. See id.

⁸ See infra Part V.
industry (Anthem, Cigna, Aetna, Humana, and UnitedHealthcare), known as the “Big Five.”9 If the recently proposed Aetna–Humana and Anthem–Cigna mergers were both permitted, the Big Five would have become the “Big Three,” and the revenue of each of the Big Three insurance companies would be nearly “twice the revenue of the next largest [health] insurer.”10 These cases represented a monumental shift in the industry; for the first time in history, the DOJ successfully blocked a health insurance merger.11 In comparison, the FTC has successfully challenged dozens of hospital and provider mergers.12

The Aetna–Humana and Anthem–Cigna mergers are not anomalies; the healthcare industry is consolidating at an alarming rate, largely because of the Affordable Care Act (ACA).13 While some argue that this was the goal of the ACA all along, one thing is certain: excessive consolidation hurts consumers, even if, as the healthcare industry argues, it is necessary.14 Now, courts are

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9. See Attorney General Loretta E. Lynch Delivers Remarks a Press Conference Announcing the Justice Department’s Actions to Block Aetna’s Acquisition of Humana and Anthem’s Acquisition of Cigna, U.S. Dep’t Just. (July 21, 2016), https://www.justice.gov/opa/speech/attorney-general-loretta-e-lynch-delivers-remarks-press-conference-announcing-justice. In the press release, Lynch stated that the mergers would, “leave much of the multi-trillion dollar health industry in the hands of three mammoth insurance companies, drastically constricting competition in a number of key markets that tens of millions of Americans rely on to receive health care.” Id.


11. See infra Part V.


‘Irony is wasted on the stupid.’ This quote, attributed to Oscar Wilde, seems fitting in light of the Obama administration’s . . . campaign to block two blockbuster mergers between the health insurers Aetna and Humana and Anthem and Cigna . . . The administration is rightly worried that this will lead to higher health care costs through reduced competition, yet it ignores the fact that its signature law, the Affordable Care Act, was specifically designed to foment such consolidation.

Id.
left to decide how few industry players is too few and at what point judges should draw the line and say “enough.” Unfortunately, antitrust law is complicated and far from an exact science, and there is no litmus test for when a judge will enjoin a proposed merger. Making matters worse, there are few administrative agency guidelines directing the process, and antitrust enforcement in the healthcare industry is split between the Agencies. Thus, uncertainty abounds, and judges’ decisions can seem arbitrary.

The recent Aetna–Humana and Anthem–Cigna decisions offer the perfect opportunity for the Agencies to begin a new collaborative working relationship amongst themselves and with others in the healthcare industry. Furthermore, the Agencies must make an effort to promote an open dialogue with all industry players, including hospitals, providers, and insurance companies, to foster certainty in whether mergers may be consummated. Perhaps more importantly, open dialogue will serve to prevent litigation, which wastes billions of healthcare dollars on court costs, attorney’s fees, termination fees, and damages.

This Comment suggests that the FTC and DOJ should work together and with industry players in examining future antitrust cases in the healthcare sector such that each decision is weighed in context, bearing in mind how it will

17. See O’Hara, supra note 5. The FTC has challenged dozens of hospital and provider mergers, but the DOJ has challenged only six health insurance mergers. See Hospitals: The Changing Landscape is Good for Patients & Health Care, supra note 12. The FTC scrutinizes Accountable Care Organizations (ACOs) most heavily. Id. Regarding ACOs, the Chairman of the FTC stated, “We’re not going to roll over and play dead and allow a lot of health-care consolidation.” Id. ACOs are “groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high quality care to their Medicare patients.” Accountable Care Organizations (ACO), CTR. FOR MEDICARE & MEDICAID SERV., https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ACO/ (last modified May 12, 2017, 8:19 AM). ACOs present antitrust problems because of group collaboration and because “[t]he Supreme Court long ago prohibited competing providers from jointly contracting to provide their services, except in specified circumstances.” Peer, supra note 5.
19. See infra Part V.
20. See infra Part V.
21. See infra Part V.
affect the rest of the industry, and avoiding litigation at all costs. Part II gives the background on the law underlying mergers and acquisitions under the Clayton Act and the Hart-Scott-Rodino Antitrust Improvements Act of 1976 (HSR Act). Part III examines the four health insurance mergers that were challenged prior to the Aetna–Humana and Anthem–Cigna cases. These mergers are similar in that they were all ultimately approved by the DOJ, but their settlement deals are unique. Part III also discusses the effectiveness of the divestiture requirements in the four cases. Part IV details the results of the Aetna–Humana and Anthem–Cigna cases. Part V analyzes the impact of these recent mergers, the industry response to the consolidation, how these decisions will impact future health insurance mergers, and how the Agencies can improve the antitrust landscape in healthcare. Finally, Part VI calls for the FTC and DOJ to join forces in reviewing and challenging future mergers in the healthcare industry.

II. BACKGROUND INFORMATION

A. Background on Antitrust Law in the Healthcare Industry

Antitrust law—the body of law governing marketplace competition and overseeing markets—has important implications in healthcare, particularly with mergers and acquisitions. This Comment will specifically focus on horizontal mergers, which occur when two or more companies operating in the same industry combine.
In general, markets are regulated by Section 7 of the Clayton Act, which allows the government to enjoin potential mergers before they occur, because they may eliminate market competition. The Clayton Act states, in relevant part:

no person subject to the jurisdiction of the Federal Trade Commission shall acquire the whole or any part of the assets of another person engaged also in commerce or in any activity affecting commerce, where in any line of commerce or in any activity affecting commerce in any section of the country, the effect of such acquisition may be substantially to lessen competition, or to tend to create a monopoly.

In addition, Section 7 of the Clayton Act prohibits planned mergers that "may . . . substantially . . . lessen competition, or . . . tend to create a monopoly." The use of the word "may" here is significant and indicates that a plaintiff challenging the merger need only show that the proposed merger will create a probability of harm; a showing of actual harm is not required. In determining the potential for harm, the government must first identify the relevant product and geographic markets. Defining these markets helps


33. Id.

34. Id.; see Stephens, supra note 30.

35. Plaintiff's Pretrial Brief at 9, United States v. Aetna, Inc., 240 F. Supp. 3d 1 (D.D.C. 2017) (No. 1:16-cv-01494-JDB) (quoting Brown Shoe Co. v. United States, 370 U.S. 294, 323 (1962) that Section 7 is concerned with "probabilities, not certainties"). Similarly, *Hospital Corporation of America v. FTC* notes that "[a]ll that is necessary is that the merger create an appreciable danger of such consequences in the future." 807 F.2d 1381, 1389 (7th Cir. 1986).

36. See U.S. DEP’T OF JUSTICE & FED. TRADE COMM’N, HORIZONTAL MERGER GUIDELINES (2010), http://www.justice.gov/atr/public/guidelines/hmg-2010.pdf [hereinafter 2010 MERGER GUIDELINES]. Defining the relevant markets (including product and geographic markets) and the market share is a key issue in horizontal merger cases. See id. at 7–20. Typically, defining the markets is a threshold burden that must occur before alleging presumptions or bringing forth evidentiary burdens. See id. at 3. "A merger enhances market power if it is likely to encourage one or more firms to raise
determine whether the proposed merger will increase competition in a way that will allow the defendant to raise prices or lower quality without substantially affecting market share.\textsuperscript{37} Even if the resulting merger leads to a high market share, however, the merger may still be permitted if other factors—including lower prices, the defendant's commitment not to use market share in harmful ways, and cost savings that would be passed on to consumers—weigh against a Section 7 violation.\textsuperscript{38}

Although defining the relevant market is critically important, Section 7 lacks instructions for doing so.\textsuperscript{39} In basic terms, the relevant market is the "area of effective competition" where the proposed merged businesses operate.\textsuperscript{40} In defining the relevant market, the plaintiff must define the product markets, which emphasizes the potential for goods or services to be substituted, and define the geographic market, which analyzes whether substitutions can be made in a certain geographic area.\textsuperscript{41} Defining both these markets is highly fact-specific, and economists are often consulted to introduce detailed economic and market data.\textsuperscript{42}

B. FTC and DOJ Review Process of Proposed Mergers

The FTC is the federal agency that is responsible for initially reviewing proposed mergers and, if appropriate, forwarding them to the FTC and DOJ's Antitrust Division for subsequent and additional review, as dictated by the HSR Act.\textsuperscript{43} The HSR Act is a three-part law that gives federal agencies the

\begin{flushleft}
\textsuperscript{38} See \textit{id} at *71--*72. Although courts have supported and adopted this two-part method of first defining the relevant market and subsequently analyzing additional factors, some economists disagree, arguing that it is imprecise and imperfect. See Thomas A. Piraino, \textit{A New Approach to the Antitrust Analysis of Mergers}, 83 B.U. L. REV. 785, 791--92 (2003). "[N]either the courts nor the agencies have developed standards for determining, first, what mitigating factors should be deemed particularly relevant, and second, the priority or weight that should be afforded such factors." \textit{id}.
\textsuperscript{39} See Edwards, \textit{supra} note 37, at *4.
\textsuperscript{40} Gregory J. Werden, \textit{Antitrust Needs the Relevant Market}, in \textit{FORDHAM COMPETITION LAW INST., INT'L ANTITRUST LAW & POLICY} 238 (Barry E. Hawk ed. 2013). In defining the "area of effective competition," the government considers the market where the seller conducts business and the buyer "can practically turn for supplies." \textit{id}.
\textsuperscript{41} See \textit{id} at 238--41.
\textsuperscript{42} See \textit{id} at 254.
\textsuperscript{43} See Debona P. Majoras, \textit{Reforms to the Merger Review Process}, \textit{FED. TRADE. COMMISSION
power to review proposed mergers and acquisitions.\textsuperscript{44} Prior to merging, companies with sufficient income, as defined by Title II of the statute, must properly file papers with the FTC and DOJ as part of the “[p]remerger notification and waiting period” requirements.\textsuperscript{45} Within thirty days of being notified, the FTC and DOJ must either (1) ask for more information on mergers or acquisitions that may present antitrust issues by filing a “Second Request,” or (2) permit the merger to go forward.\textsuperscript{46} If the FTC and DOJ file a Second Request for more information, the Agencies have thirty days after receiving additional information as part of the Second Request to review the new information and to decide whether to allow the proposed merger to proceed.\textsuperscript{47}

If the government decides there are antitrust concerns, the government can challenge the merger by filing a preliminary injunction in the “United States district court for the judicial district within which the respondent resides or carries on business.”\textsuperscript{48} Alternatively, the government can work with the parties to mitigate antitrust concerns and foster more competition in the market by negotiating a settlement in the form of a consent decree or a “fix-it-first” solution that permits the merger by forcing modifications seeking to maintain competition.\textsuperscript{49} Because mergers can cause substantial harm to consumers, the government often steps in and challenges large mergers.\textsuperscript{50}

\textsuperscript{44} E. Thomas Sullivan & Jeffrey L. Harrison, Understanding Antitrust and its Economic Implications 335 (5th ed. 2009).


\textsuperscript{49} Antitrust Division Policy Guide to Merger Remedies, U.S. DEP’T JUST. 21–23 (June 2011), https://www.justice.gov/sites/default/files/atr/legacy/2011/06/17/272350.pdf. The DOJ often considers “fix-it-first” proposals from the merging parties that they believe would maintain competition. Id. If the DOJ is satisfied that the “fix-it-first” remedy successfully eliminates the antitrust concerns, it will not file a case challenging the merger. Id.

\textsuperscript{50} See, e.g., infra Parts III and IV.
C. Current Horizontal Merger Guidelines

In 1968, the FTC and DOJ first promulgated a set of guidelines for horizontal mergers, which have since been revised multiple times.51 The most recent set of merger guidelines was issued in 2010, eighteen years after the last guidelines were issued in 1992.52 The new set of guidelines focuses on how to create appropriate remedies to proposed mergers.53 Among other principles, the guidelines address the structural remedies (such as divestitures) and conduct remedies, which limit companies’ anticompetitive behavior.54 Whether the government prefers a structural remedy, conduct remedy, or both is a fact-specific inquiry that depends on the circumstances.55

The current merger guidelines differ from the 1992 guidelines in several important ways.56 One major difference is the high degree of emphasis placed on the types of evidence that the FTC and DOJ will use in evaluating whether to allow a merger.57 In addition, the new guidelines discourage a rigid analysis of mergers and instead promote a more flexible and multifaceted approach.58 Although the guidelines are not binding law, experts believe that they will aid courts in evaluating proposed horizontal mergers challenged by the government.59 Unfortunately, these revised guidelines were unavailable to judges presiding over the four health insurance mergers that were challenged before Aetna and Anthem.60

51. See Salop & Culley, supra note 31, at 3; 2010 MERGER GUIDELINES, supra note 36, at 1 n.1.
52. 2010 MERGER GUIDELINES, supra note 36, at 1 n.1.
53. See id. at 1.
56. Bradley C. Weber, DOJ and FTC Issue New Horizontal Merger Guidelines, 7 ABA HEALTH RESOURCE 1 (2010), http://www.americanbar.org/newsletter/publications/aba_health_esource_home/weber.html (noting that “[t]he primary goal of the new Guidelines is to provide the public with a better understanding of how the Agencies identify and challenge competitively harmful mergers, while avoiding unnecessary interference with mergers that are not likely to have any anticompetitive impact on the marketplace”).
57. See id. Evidence includes “increased prices, diminished access to products or services, and decreased product innovation.” Id.
58. See id. Unlike the 1992 Guidelines, the revised guidelines do not follow a single methodology or a five-step analytic process. Id.
59. See id. Furthermore, the new guidelines reflect recent case law, particularly in hospital merger cases. See id.

The health insurance industry has experienced a boom of horizontal mergers since the 1990s.61 Between 1993 and 2009, the DOJ investigated thirty-four proposed mergers of health insurers, the majority of which were approved.62 In particular, there was an abundance of consolidations among health insurers between 1995 and 2006.63 Some of the most investigated consolidations were between “Aetna and Prudential; United and PacifiCare; Anthem and WellPoint; United and Oxford; United and MetraHealth; and HIP and GHI.”64 However, most proposed mergers were investigated and allowed to proceed; only four were actually challenged by the DOJ or state governments—all alleging violations of Section 7 of the Clayton Act—and all four were ultimately permitted with certain modifications.65


In Aetna, the United States Attorney General and the Texas Attorney General sought a permanent injunction to thwart the $1 billion dollar acquisition of The Prudential Insurance Company of America (Prudential) by Aetna Inc. (Aetna), alleging that the proposed merger violated Section 7 of the Clayton Act.66 At the time, Aetna was the largest health insurer in the country, insuring

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63. See Antitrust Enforcement, supra note 61, at 5; Fundakowski, supra note 62, at 1545–46.

64. Antitrust Enforcement, supra note 61, at 5.

65. Id.; see Fundakowski, supra note 62, at 1525 (noting that many more mergers were investigated by the DOJ, although they were never challenged in court).

over 15 million people in all 50 states.\textsuperscript{67} Prudential was the ninth largest insurer in the United States with almost 5 million members in 28 states.\textsuperscript{68}

In particular, the DOJ and the State of Texas were concerned about the health insurance markets in Houston and Dallas, where Aetna and Prudential were market competitors.\textsuperscript{69} The government alleged that the merger would give Aetna sixty-three percent of the market in Houston and forty-two percent of the market in Dallas.\textsuperscript{70} The government further argued that “Aetna’s acquisition of Prudential will eliminate the direct competition between them and will give Aetna the ability to increase prices paid for these products or to reduce their quality in Houston and Dallas.”\textsuperscript{71} The U.S. District Court for the Northern District of Texas permitted the merger with the condition that Aetna divest its interests in the Houston operations of NYLCare Health Plans of the Gulf Coast, Inc. and the Dallas operations of NYLCare Health Plans of the Southwest, Inc., consisting of, among other assets, approximately two hundred sixty thousand (260,000) and one hundred sixty-seven thousand (167,000) commercially–insured HMO and HMO-based POS enrollees, respectively.\textsuperscript{72}

The merger caused premiums to rise by seven percent, reduced physician earnings by three percent, and increased nurse’s earnings by approximately half a percent due to the substitution of nurses for physicians.\textsuperscript{73}

\begin{footnotesize}
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\item \textsuperscript{67} Id. at 1. Aetna reported over $14 billion dollars in revenues in 1998. Id. at 3.
\item \textsuperscript{68} Id. at 1. Prudential reported about $7.5 billion in revenues in 1998. Id. at 3.
\item \textsuperscript{69} See id. at 2.
\item \textsuperscript{70} Id. at 7.
\item \textsuperscript{71} Id. at 2.
\item \textsuperscript{73} Leemore Dafny, Mark Duggan & Subramaniam Ramanarayan, \textit{Paying a Premium on Your Premium? Consolidation in the US Health Insurance Industry}, 102 AM. ECON. REV. 1161, 1184 (2012).
\end{itemize}
\end{footnotesize}
B. United States v. UnitedHealth Group, Inc. and PacifiCare Health System (2006)

In United States v. UnitedHealth Group, Inc., the AntiTrust Division of the DOJ brought suit to permanently enjoin the proposed $8.15 billion acquisition of PacifiCare Health System, Inc. (PacifiCare) by UnitedHealth Group, Inc. (United) for violation of Section 7 of the Clayton Act. At the time, United was one of the largest health insurers in the United States, with over 55 million members. PacifiCare, the competitor that United sought to acquire, had over “[13] million . . . members in Arizona, California, Colorado, Nevada, Oklahoma, Oregon, Texas, and Washington.” Prior to the merger, individuals wishing to purchase small-group health insurance in Tucson had only three or four choices: “United, PacifiCare, and one or two other[s],” with PacifiCare being the lowest-priced option. It is therefore unsurprising that the government alleged in its complaint that “United’s acquisition of PacifiCare will eliminate direct competition between them, and may permit United to increase prices and reduce the quality of commercial health insurance plans to small-group employers in Tucson.” Furthermore, United’s acquisition of PacifiCare would make United and Blue Shield of California—another large insurance company—direct competitors, allowing both coordinated and unilateral competition, with each company having “access to highly sensitive competitive information about the other company.” This would, in turn, allow United and Blue Shield of California to increase insurance prices while


76. PacifiCare Complaint, supra note 74 at 1. PacifiCare was, on its own, fairly large; in 1996, PacifiCare purchased FHP International Corporation, which was its main Medicare revival. See Laurence Zuckerman, PacifiCare Will Buy FHP; Its Health Care Rival, N.Y. TIMES (Aug. 6, 1998), http://www.nytimes.com/1996/08/06/business/pacifiCare-will-buy-fhp-its-health-care-rival.html.


78. PacifiCare Complaint, supra note 74, at 2.

79. PacifiCare Competitive Impact Statement, supra note 77, at 9. Coordinated competition may occur when there are few competitors in the market. See Lessening of Competition Through Coordinated Interaction, U.S. DEP’T JUST., https://www.justice.gov/atr/21-lessening-competition-through-
decreasing provider reimbursement.\textsuperscript{80} Despite these concerns, the United States District Court for the District of Columbia denied the government’s request for injunction and allowed the merger to go through, with the stipulation that United divest its Tucson Commercial Insurance Contracts and Boulder Contract.\textsuperscript{81}

C. \textit{United States v. UnitedHealth Group, Inc. and Sierra Health Services, Inc.} (2008)

In \textit{United States v. UnitedHealth Group, Inc. and Sierra Health Services, Inc.}, the United States Attorney General brought suit to enjoin United’s $2.6 billion acquisition of Sierra Health Services, Inc. (Sierra).\textsuperscript{82} The government stressed that the proposed merger would create a significant monopoly in the Medicare Advantage market, estimating that the merger would give United ninety-four percent of the Medicare Advantage market in the Las Vegas area, totaling $840 million.\textsuperscript{83} The government further argued that this merger would cause senior citizens, who otherwise benefited from a competitive Medicare Advantage market that effectively decreased costs and increased quality, to suffer.\textsuperscript{84} The court allowed the merger, but it required United to divest its entire interest in Medicare Advantage in the Las Vegas area, which Humana ultimately acquired.\textsuperscript{85} In addition, United entered into a settlement

\textsuperscript{80} See PacifiCare Competitive Impact Statement, \textit{supra} note 77, at 9–10.

\textsuperscript{81} \textit{UnitedHealth Group, Inc.}, 2006 U.S. Dist. LEXIS 45938, at *7–*8 (using the term “Divestiture Assets” to mean “Tucson Commercial Insurance Contracts and the Boulder Contract”).

\textsuperscript{82} Complaint at 1, 4, United States v. UnitedHealth Group Inc., No. 08-322, 2008 U.S. Dist. LEXIS 83599 (D.D.C. Sept. 24, 2008) (No. 1:08-cv-00322-ESH) [hereinafter Sierra Complaint].

\textsuperscript{83} See \textit{id.} at 2, 6.

\textsuperscript{84} See \textit{id.} at 7.

agreement with the state of Nevada prohibiting United from passing to consumers the costs of the merger and requiring United to donate 15 million dollars to Nevada charities.86

In theory, this merger should have led to increased efficiencies with the potential to pass these savings on to consumers through decreased premiums.87 However, despite these safeguards, and especially due to the agreement preventing United from increasing premiums to pay for the merger, the United–Sierra merger led to more than a thirteen percent increase in insurance premiums for small-group plans in Nevada, suggesting that the insurer used its market power to exploit consumers.88

D. United States v. Humana Inc. and Arcadian Management Services, Inc.

In United States v. Humana Inc. and Arcadian Management Services, Inc., the DOJ challenged the proposed $150 million merger between Humana Inc. (Humana) and Arcadian Management Services, Inc. (Arcadian) on grounds that it would significantly decrease the head-to-head competition in the Medicare Advantage market “in forty-five counties and parishes in Arizona, Arkansas, Louisiana, Oklahoma, and Texas.”89 Prior to the merger, Humana and Arcadian comprised between 40 and 100 percent of the relevant market, totaling over $700 million in annual business.90

The government alleged that if the two companies merged, senior citizens

90. Humana Complaint, supra note 89, at 2.
taking advantage of the Medicare Advantage market—which provides significantly more coverage than Medicare alone—would experience increased prices and decreased quality as a result of Humana and Arcadian’s lost incentive to compete with each other.91 Once again, the DOJ approved the merger, but the court required Humana to divest its assets in Medicare Advantage in the relevant market to an insurer capable of inducing competition.92 In addition, the court required that the buyer of the Medicare Advantage plans offer similar rates and benefits to plan subscribers.93

E. Effects of These Mergers on Competition and Effectiveness of the Divestiture Requirements

The four above-mentioned cases substantially mirror each other in the claims brought and relief granted.94 All four cases were brought by the Antitrust Division of the DOJ alleging violations of Section 7 of the Clayton Act, and all were approved with the requirement that the companies divest certain assets.95 These divestitures were the DOJ’s compromise with insurance companies and its solution to safeguard competition in the health insurance market.96

According to research regarding the Humana–Arcadian merger, the required divestiture was unsuccessful in preserving competition.97 By 2015—

91. Id. at 2-3.
93. Id.

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three years after the merger—Medicare Advantage plans were discontinued in more than half of the counties in the relevant markets, and only two of the fifteen divested plans (a mere thirteen percent) are currently available to subscribers.\textsuperscript{98} Furthermore, the majority of plan premiums increased by an average of forty-four percent.\textsuperscript{99} Despite the required divestiture, this merger appears to have resulted in just what the DOJ feared—a lack of competition, which ultimately harmed consumers.\textsuperscript{100}

IV. RECENTLY PROPOSED MERGERS

A. Aetna–Humana Merger

In a $37 billion deal, Aetna announced on July 2, 2015 that it would acquire Humana.\textsuperscript{101} Fearing a monopoly, the DOJ, along with Delaware, Florida, Georgia, Illinois, Iowa, Ohio, Pennsylvania, Virginia, and the District of Columbia (collectively, the “government”) sued on July 21, 2016 to enjoin the merger, alleging that Aetna and Humana violated Section 7 of the Clayton Act.\textsuperscript{102}

Among the government’s chief complaints was the assertion that the merger “would lead to higher health-insurance prices, reduced benefits, less innovation, and worse service for over a million Americans” in the relevant product markets—Medicare Advantage plans and commercial health insurance plans offered on public exchanges.\textsuperscript{103} According to the government, the merger would be presumptively unlawful because it would produce heavy concentration in the Medicare Advantage market in 364 counties in 21 states.\textsuperscript{104}

\textsuperscript{98} See \textit{id.}
\textsuperscript{99} \textit{Id.} This premium increase primarily affected senior citizens. \textit{Id.}
\textsuperscript{100} See \textit{id.} The negative effects of this merger may make future health insurance mergers difficult. \textit{See id.}
\textsuperscript{101} \textit{Aetna to Acquire Humana for $37 Billion, Combined Entity to Drive Consumer-Focused, High-Value Health Care, Aetna (July 3, 2015), }https://news.aetna.com/news-releases/aetna-to-acquire-humana-for-37-billion-combined-entity-to-drive-consumer-focused-high-value-health-care/\textit{.}
\textsuperscript{102} \textit{Complaint at 2–6, United States v. Aetna Inc., }240 F. Supp. 3d \textit{1 (D.D.C. 2017) (No. 1:16-cv-01494) [hereinafter Aetna Complaint]. Additionally, the government argued, as required by the Clayton Act, that the merger “may . . . substantially . . . lessen competition.” Aetna Inc., }240 F. Supp. 3d \textit{at 8.}
\textsuperscript{103} \textit{Aetna Complaint, supra note 102, at 2;} \textit{Aetna Inc., }240 F. Supp. 3d \textit{at 10.}
\textsuperscript{104} See \textit{Aetna Complaint, supra note 102, at 5, 12.} Market concentration is often measured using the Herfindahl-Hirschman Index (HHI). \textit{Id.} at 12. A market is “highly concentrated,” allowing for enhanced market power, if the market has an HHI above 2,500 or if the merger would “involve an
Additionally, heavy competition would arise in health insurance plans on the public exchanges in seventeen counties in three states. Aetna disagreed, arguing for a more expansive relevant product market for Medicare that included the government-administered Original Medicare (Parts A and B) and Medicare Advantage (Part C). Under Aetna’s product market definition, the proposed merger would not be presumptively unlawful. In addition, Aetna argued that there was no competition in health insurance plans offered on public exchanges because Aetna withdrew from the seventeen identified complaint counties in 2017.

The court was unpersuaded by both of Aetna’s arguments and accepted the government’s definition of the relevant product market. Regarding the Medicare market, the court concluded that the correct product market was Medicare Advantage because, although Original Medicare and Medicare Advantage are interchangeable, the data shows that Medicare Advantage pro-

increase in the HHI of more than 200 points.” 2010 MERGER GUIDELINES, supra note 36, § 5.3; Aetna Inc., 240 F. Supp. 3d at 42; see also FTC v. H.J. Heinz Co., 246 F.3d 708, 716 (D.C. Cir. 2001) (measuring market concentration using HHI). These thresholds indicate when a merger is likely “presumptively unlawful.” See Aetna Complaint, supra note 102, at 12; 2010 MERGER GUIDELINES, supra note 36, § 5.3. To rebut the presumption, the defendant must make a persuasive “showing that the merger is unlikely to enhance market power.” 2010 MERGER GUIDELINES, supra note 36, § 5.3.

105. Aetna Inc., 240 F. Supp. 3d at 8. The three states were Florida, Georgia, and Missouri. Id. at 17.

106. See id. at 8. Original Medicare covers hospital stays through Part A and general medical care, including doctor’s visits and medically necessary services, through Part B. Your Medicare Coverage Choices, MEDICARE.GOV, https://www.medicare.gov/sign-up-change-plans/decide-how-to-get-medicare/your-medicare-coverage-choices.html#collapse-3134 (last visited Jan. 21, 2018). Medicare Advantage, also known as “Part C,” includes Medicare Parts A and B, but is offered by private insurance companies and generally provides more coverage. Id.

107. Aetna Inc., 240 F. Supp. 3d at 8. Further supporting this argument was the fact that Aetna and Humana were direct competitors. Id. at 10.

108. Id. at 9. Aetna argued that this was a business decision and denied the government’s allegation that it was to improve its litigation position. Id. at 80. The court later rejected Aetna’s argument. See infra note 115 and accompanying text.

109. Aetna Inc., 240 F. Supp. 3d at 9. The court explained that [t]o determine whether a group of products could be an antitrust market, the hypothetical monopolist test asks whether a hypothetical monopolist of all the products within a proposed market would likely impose a “small but significant and non-transitory increase in price” (SSNIP)—typically of five or ten percent—on at least one product in the market, including one sold by the merging firms.

Id. at 20 (quoting 2010 MERGER GUIDELINES, supra note 36, §§ 4.1.1, 4.1.2).

110. See id. at 19–23. “Switching data” shows that Medicare Advantage subscribers rarely switch to Original Medicare. See id. at 27–28. A study by the Kaiser Family Foundation found that seventy-
 providers compete only within the Medicare Advantage market instead of competing with Original Medicare.111 This potential for a strong market share would create the danger that Aetna could raise the price of its Medicare Advantage plans without losing many subscribers to Original Medicare.112 Similarly, the court sided with the government in allowing the public exchanges to be a relevant product market because Aetna decided not to compete in the seventeen identified counties in preparation for litigation “in an effort to evade judicial review of the merger.”113

The government further established its prima facie case by arguing that the merger was presumptively invalid because it would “lead to undue concentration in the market” for individual Medicare Advantage plans in all 364 complaint counties.”114 In further support of its claim, evidence showed “that the merger would substantially lessen competition” by eliminating “head-to-head competition between [Aetna and its] close competitors.”115 Of particular concern to the court were the increasing similarities between Aetna and Humana, both geographically and philosophically.116 Overall, the court concluded that the head-to-head competition between Aetna and Humana benefits consumers by expanding networks, lowering costs, and motivating quality improvements.117 Government regulation and new competitor entry, which

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\eight percent of Medicare Advantage subscribers kept their plans from 2013 to 2014. Id. at 27. Another study found that eighty-nine percent of seniors who involuntarily switched to Original Medicare later switched back to Medicare Advantage. Id.

111. Id. at 23–24. In an internal email in March 2015, Aetna’s CEO named Humana as Aetna’s “most formidable competitor” in the Medicare Advantage market. Id. at 44. In another email sent in 2015 to Aetna’s general managers, UnitedHealth, Cigna, and Humana were labeled as Aetna’s “true competition.” Id. at 25. Humana’s executives sent similar communications reflecting a focus on competition only with other Medicare Advantage providers. Id. at 25–26.

112. Id. at 46–47. The evidence showed that few senior citizens are on the fence about Medicare Advantage and Original Medicare. See id.

113. Id. at 9.

114. Id. at 42. The merger would yield an estimated HHI of more than 5,000 in 75% of the counties and an HHI increase of over 1,000 points in more than 70% of the counties. Id. at 42–43.

115. Id. at 43. The court explained that Aetna, as “the fourth largest Medicare Advantage insurer in the” United States, which expanded into 640 new counties in just 3 years, is a “particularly aggressive” competitor in the Medicare Advantage market and is on a “collision course” with Humana. Id.

116. Id. at 44. Evidence of Aetna and Humana’s similarities include a “shared outlook on the future of healthcare” and Aetna’s executive’s statement that Aetna “compete[s] with [Humana] everywhere” and that Humana is the company’s “most formidable competitor.” Id.

117. See id. at 45. Economically, the merger was estimated to yield $500 million per year in anticompetitive harm to consumers and taxpayers. Id. at 46.

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Aetna and Humana argued saved the merger from being presumptively invalid, were deemed insufficient preventative remedies that were unlikely to mitigate the harmful effects produced by the merger.\textsuperscript{118} Furthermore, the court concluded that the proposed divestiture of certain Medicare Advantage assets to Molina Healthcare would not “restore [the] competition” eliminated by the merger.\textsuperscript{119} Thus, the court enjoined the merger for the Medicare Advantage markets.\textsuperscript{120}

Regarding health insurance plans on public exchanges, the court found that the proposed merger would “substantially lessen competition” in public exchange markets.\textsuperscript{121} Of particular concern was the court’s conclusion that Aetna withdrew from the seventeen complaint counties to evade judicial review of the proposed merger.\textsuperscript{122}

In a final effort to save the merger, Aetna and Humana “defend[ed] the

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118. See id. at 47–59. Aetna defended on the ground that government regulation by CMS and new entry into the Medicare Advantage market by competitors effectively rebutted the presumption of anticompetitive harm. Id. at 47. The court, however, disagreed. See id. at 47. Regarding government regulation, the court explained that CMS lacked the ability to prevent Aetna and Cigna from increasing prices or reducing quality. See id. at 49–50. Furthermore, regarding the potential for new competitors to enter the Medicare Advantage market, “the [c]ourt conclude[d] that new entry will not be ‘timely, likely, and sufficient’ enough to counteract the anticompetitive effects of the merger.” Id. at 52. From 2012 to 2016, new competitors entered the market in only thirteen percent of the complaint counties. Id. at 54. Even worse, no new competitors entered the market in more than fifty percent of the complaint counties. See id. The court concluded that the barriers to entry were sufficiently high that it was unlikely that new competitors would enter the market after the merger. Id. at 57. Even if new competitors did in fact enter the market, the entry would not make up for the “competitive void” caused by the merger. Id. at 58.

119. Id. at 73 (alteration in original). Although Molina has considerable experience in the Medicaid market, the court concluded that its lack of experience in the Medicare Advantage market made it unlikely that the insurer would be a substantial competitor in the Medicare Advantage market. See id. The government also called the divestiture agreement a “fire sale” and presented evidence that Molina felt unprepared to enter the Medicare Advantage market, which was previously unchartered territory for them. Id. at 72; see Kevin McCoy, Aetna, Humana Assess Merger Options After Court Setback, USA TODAY (Jan. 24, 2017, 4:22 PM), http://www.usatoday.com/story/money/2017/01/24/aetna-humana-assess-merger-options-after-court-setback/96985398/. Molina would have had to start offering insurance in 364 counties with no prior experience whatsoever with Medicare Advantage. McCoy, supra.


121. Id. at 74–75.

122. See id. at 74. Evidence supporting this assertion came from timely emails Aetna sent that treat the seventeen complaint counties as separate from other counties where Aetna considered withdrawing. See id. at 82–83. Although fourteen of the seventeen counties were unprofitable for Aetna—meaning Aetna would be unlikely to re-enter these markets purely for economic reasons—three of the counties in Florida were profitable, and the court concluded that Aetna would likely re-enter the market at a later time if the merger were permitted. See id. at 89–90.
merger on the ground that it [would] create [significant] efficiencies” that could lower costs incurred by consumers.123 Although Aetna and Humana claimed that the merger would yield “$2.8 billion in annual efficiencies” after 2020, the government’s expert found that the merger would yield only $73.2 million in efficiencies.124 The court was unpersuaded by Aetna’s and Humana’s efficiencies argument.125 It reasoned that only fifty percent of cost savings are typically passed to consumers in the health insurance industry.126 Furthermore, the evidence demonstrated that “a consumer in one of the challenged markets [would not] choose the merger over continued competition.”127 The cost ramifications of the failed Aetna–Humana merger are significant.128 Because the merger did not succeed, Aetna will have to pay Humana a staggering $1 billion (the reverse termination or “break-up fee”).129

B. Anthem–Cigna Merger

On July 24, 2015, just three weeks after Aetna and Humana announced their proposed merger, Anthem, Inc. announced that it would acquire Cigna Corporation for $48 billion, bringing Anthem’s total number of subscribers to approximately 53 million and total revenue to approximately $115 billion.130

123. Id. at 94. “Although the Supreme Court has never recognized the ‘efficiencies’ defense in a Section 7 case, the [D.C. Circuit] as well as the Horizontal Merger Guidelines recognize that, in some instances, efficiencies resulting from the merger may be considered in rebutting the government’s prima facie case.” Id. (alteration in original) (quoting FTC v. Sysco Corp., 113 F. Supp. 3d 1, 81 (D.D.C. 2015)).

124. Id. at 95.

125. See id.

126. See id.

127. Id. at 98.


129. Id. A “breakup fee,” also called a “termination fee,” is a protective device used in mergers and acquisitions that forces the seller (i.e. the target company) to pay a pre-determined fee to the buyer if the seller is responsible for the merger failing to close. See Pritheesh Bajpai, Break-Up Fees: Failed M&A Can Cost A Lot (SPLS. HAL), INVESTOPEDIA (May 12, 2016, 1:17 PM), http://www.investopedia.com/articles/investing/051216/breakup-fees-failed-ma-can-cost-lot-splash.asp. A buyer may also be forced to pay the seller if the deal does not obtain the requisite antitrust approval in what is called a “reverse termination” or “reverse break-up” fee. See Dale Collins, Antitrust Reverse Termination Fees—2015 Update, SHERMAN & STERLING: ANTITRUST UNPACKED ANTITRUST L. BLOG, http://www.shearmananantitrust.com/?itemid=35 (last visited Jan. 21, 2018).

130. David McLaughlin, Andrew M. Harris & Zachary Tracer, Anthem, Aetna Sued by U.S. Seeking to Block Insurer Mergers, GARP (July 21, 2016), http://www.garp.org/#!/risk-intelligence/all/all/a1Z
If the merger had succeeded, it would have been the largest health insurance merger in history; Anthem was already the nation’s largest health insurer, and Cigna was a close second. In their announcement, Anthem and Cigna stated that the combined entity would be able to “offer a comprehensive range of high quality, high value products and services to the full spectrum of customers—individuals, employers and State and Federal governments.”

In July 2016, the DOJ and “the States of California, Colorado, Connecticut, Georgia, Iowa, Maine, Maryland, New Hampshire, New York, . . . Tennessee, . . . Virginia, and the District of Columbia” (collectively, the “plaintiffs”) challenged the merger. Among the plaintiffs’ chief complaints was that the merger would “substantially lessen competition, harming millions of American consumers, as well as doctors and hospitals.” In addition, the plaintiffs alleged that this merger could lead to significant market concentration in health insurance plans sold to large national employers. When the merger was announced, Anthem and Cigna were direct competitors, and the plaintiffs alleged that the competition between them had been an important driving factor in motivating both companies to improve. Although Anthem was already a dominant insurer in each of the fourteen states in which it operated, the DOJ alleged that it had a poor reputation. In contrast, Cigna had a favorable reputation with consumers because it offered innovative wellness

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131. See Anthem Complaint, supra note 10, at 3; Anthem Inc., 236 F. Supp. 3d 178–79.


133. Anthem Complaint, supra note 10, at 2.

134. Id. at 3.

135. *Anthem Inc.*, 236 F. Supp. 3d at 178–79. The relevant market was “national accounts,” which are defined as “customers with more than 5000 employees, usually spread over at least two states.”

136. See Anthem Complaint, supra note 10, at 19 (noting that “Cigna has been particularly effective in using its innovative wellness programs to compete with Anthem. For example, in September 2015, an Anthem sales account executive noted that Cigna was offering a large municipal account in New Hampshire up to $70,000 in wellness dollars, compared to Anthem’s $6,000. In response, his boss replied, ‘What? That’s absurd. What are their current admin rates?’ Around that same time, Anthem learned that Cigna was competing hard for a bid in California by selling its care management and wellness programs. An Anthem executive complained to the broker handling the bid, asking: ‘Does [the client] realize we are going to own Cigna in about a year anyways?’” (alteration in original)).

137. See id. at 4 (noting that “Anthem has also earned a reputation in many markets for having poor customer service, being slow to innovate, and being difficult to work with for doctors and hospitals. The president of Anthem’s Indiana business conceded, ‘There are some customers, some prospects who loathe us.’”).

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programs and superior customer service, and it lowered the costs of healthcare by working with providers and hospitals.\textsuperscript{138} According to the DOJ, Cigna was projected to double in size in less than a decade if it remained independent from Anthem.\textsuperscript{139}

In arguing that the merger would benefit consumers, Anthem stated that the merger would result in significant efficiencies amounting to approximately $2.4 billion in cost savings annually, most of which would come from lower reimbursement rates to physicians and hospitals.\textsuperscript{140} These savings, Anthem argued, would result in decreased healthcare costs for the employers comprising Anthem’s customer base for commercial health insurance.\textsuperscript{141}

Following the Aetna court’s lead, the court in Anthem enjoined the merger on the grounds that it was presumptively unlawful under the Horizontal Merger Guidelines and would lead to increased costs, decreased consumer choice, and would reduce “incentives for insurer innovation.”\textsuperscript{142} Agreeing with the plaintiffs, the court concluded that the relevant market was the “national accounts” insurance market for large group employers with 5,000 or more employees in fourteen Anthem states where Anthem and Cigna most vigorously competed.\textsuperscript{143} Anthem argued that new insurers would enter the market and restore competition, but the court disagreed given the challenges insurers face when entering a new market.\textsuperscript{144}

Anthem further defended the merger on the grounds that it would create efficiencies, such as allowing Anthem to offer Cigna’s quality products at Anthem’s low prices.\textsuperscript{145} Cost savings are important, but their value to consumers

\begin{itemize}
\item \textsuperscript{138} Id.
\item \textsuperscript{139} Id.
\item \textsuperscript{143} \textit{Anthem Inc.}, 236 F. Supp. 3d at 179. The court found that the plaintiffs’ analysis was “‘economically significant’ and corresponding to ‘commercial realities.’” \textit{Id.} at 255. Like the Aetna decision, the Anthem decision was also very lengthy and well-supported. \textit{See id.} at 178–259. The court found that only four providers in fourteen states would cause too great a harm on competition. \textit{See id.} at 178–89. Furthermore, competition in commercial insurance for large groups (companies with more than 100 employees) would also suffer. \textit{Id.} at 179. The court also acknowledged the possibility of a downstream effect on other insurance markets. \textit{Id.}
\item \textsuperscript{144} \textit{See id.} at 180.
\item \textsuperscript{145} \textit{See id.} at 181.
\end{itemize}
depends on whether they are actually passed on instead of held internally as profits.\textsuperscript{146} Furthermore, the court found that these projected efficiencies were neither merger-specific nor verifiable.\textsuperscript{147} The efficiencies were not merger-specific because Cigna subscribers could gain the benefits of Anthem’s plan simply by selecting Anthem insurance instead.\textsuperscript{148} In addition, the merger was not necessary for current Anthem subscribers to gain the benefits of Cigna’s products because Anthem could offer the same products.\textsuperscript{149} Furthermore, the court was unpersuaded by the cost savings because realizing them would take time and they merely redistributed wealth from providers to Anthem and, by extension, subscribers.\textsuperscript{150} The court characterized Anthem’s behavior as asking the [c]ourt to go beyond what any court has done before: to bless this merger because customers may end up paying less to healthcare providers for the services that the providers deliver even though the same customers are also likely to end up paying more for what the defendants sell.\textsuperscript{151}

Ultimately, the court concluded that there was too much potential for a concentrated market that would harm consumers.\textsuperscript{152} Making matters worse for Anthem, Cigna took some unexpected actions, during the course of the trial, that appeared to undermine what would have been the common goal of the parties to receive a governmental approval of the merger.\textsuperscript{153} The court recognized the apparent conflict in its decision as “the elephant in the courtroom,” though Anthem characterized it as “a mere

\textsuperscript{146} See id. at 18182. The court stated that there was no evidence that the merger would help hospitals and providers provide better care at a lower cost. See id. at 182. Moreover, Anthem’s own documents reveal that the firm has considered a number of ways to capture the network savings for itself and not pass them through to the customers as it insisted in court that it would. Id.

\textsuperscript{147} Id. at 181.

\textsuperscript{148} See id.

\textsuperscript{149} Id.

\textsuperscript{150} See id. at 182.

\textsuperscript{151} Id. The court also rejected Anthem’s cost-savings argument, stating that the savings “are not merger-specific, they are not verifiable, and it is questionable whether they are ‘efficiencies’ at all.” Id. at 181. The court argued that because consumers could simply purchase Anthem insurance to enjoy the lower rate, the merger was therefore unnecessary to achieve cost-savings. Id.

\textsuperscript{152} See id. at 179–80.

\textsuperscript{153} See id. at 183.
‘rift between the CEOs,'”154 Cigna’s executives argued against Anthem’s projected network savings, cross-examined Anthem’s expert, and refused to sign Anthem’s Findings of Fact and Conclusions of Law on the basis that they “reflect[ed] Anthem’s perspective” and some of the findings were “inconsistent with the testimony of Cigna witnesses.”155 Cigna’s decision to undermine Anthem’s position at trial may have contributed to the merger’s failure, a fate Anthem attempted to prevent when, subsequent to the trial court’s decision, it filed and received from the Delaware Chancery Court a temporary restraining order barring Cigna from abandoning the deal.156

Anthem quickly appealed the merger to the D.C. Circuit Court of Appeals, primarily arguing that the district court failed to give proper weight to the billions of dollars of efficiencies that would result from the merger.157 Anthem argued that these efficiencies constituted a valid defense (the “efficiencies defense”) that would offset any anticompetitive harm caused by the merger.158 Despite Anthem’s efforts, the D.C. Circuit affirmed, in a 2-1 decision, the district court’s decision and concluded that Anthem failed to show that the projected efficiencies would offset the anticompetitive effects, stating that “Anthem failed to show the kind of ‘extraordinary efficiencies’ that would be needed to constrain likely price increases in this highly concentrated market, and to mitigate the threatened loss of innovation.”159

Anthem argued that the efficiencies were indeed merger-specific, meaning that they could not be achieved without the merger, because the merger would “allow Anthem to create a ‘new product’ that is ‘unavailable on the

154.  Id.
155.  Id.  Cigna’s CEO even characterized Anthem’s cost savings calculation as “narrow-minded” and “incomplete.”  Id. at 244.
157.  United States v. Anthem, Inc., 885 F.3d 345, 348–49 (D.C. Cir. 2017).  Anthem argued that, “so long as at least one-third of the $2.4 billion of savings are likely to be achieved, the merger is procompetitive.”  Id. at 364.  The court ultimately declared that this argument “rings hollow,” thereby rejecting a “dollar-for-dollar comparison” of the merger’s benefits against potential harm.  Id.
158.  Zaret, supra note 142.  This defense—that evidence of verifiable, merger-specific efficiencies can rebut a presumption that a merger is unlawful—has been deemed valid by “[s]everal circuit courts, including the D.C. Circuit.”  Id.
159.  Anthem Inc., 885 F.3d at 364.  The court also held that “[p]ossible economies cannot be used as a defense to illegality.  Congress was aware that some mergers which lessen competition may also result in economies but it struck the balance in favor of protecting competition.”  Id. at 353 (quoting FTC v. Procter & Gamble Co., 386 U.S. 568, 580 (1967)) (alteration in original).
market today,” featuring Anthem’s lower rates and Cigna’s customer-centric programs. The court rejected this argument on the grounds that even if the merger created a new product, developing it could take an extended period of time, and rather than merge, Anthem should merely innovate to offer Cigna-like products. Finally, the court found that Anthem’s argument that Anthem could renegotiate Cigna’s contracts with providers to achieve lower rates was not verifiable or likely to occur, because obtaining lower rates would not necessarily mean that Anthem would be able to negotiate rates as favorable as current Anthem rates.

Despite the majority opinion, Judge Brett Kavanaugh issued a strong dissent, stating “that the merger would not substantially lessen competition.” Instead, Judge Kavanaugh argued that the merger would benefit large employers by saving them $1.7 to $3.3 billion in the form of lower rates—money which could be spent on employees’ salaries. Judge Kavanaugh further argued that the majority did not adequately consider the benefit that the merger would create in the upstream product market by being able to negotiate lower rates with hospitals and providers.

Anthem appealed the decision to the Supreme Court, arguing that the D.C. Circuit relied on outdated merger precedents that must be changed to reflect modern economic principles and consumer benefit. The most recent Supreme Court decision that explored the issue of efficiencies in merger cases was F.T.C. v. Procter & Gamble Co. In that case, the Supreme Court declined

160. Id. at 357.
161. Id. at 357–58.
162. See id. at 360 (concluding that “the assumption that it will in every instance lead to the Anthem rate is farfetched”). The majority held that “[i]f merging companies could defeat a Clayton Act challenge merely by offering expert testimony of fantastical cost savings, Section 7 would be dead letter.” Id. at 364.
163. Id. at 373 (Kavanaugh, J., dissenting).
164. See id. at 372–75. Judge Kavanaugh argued that insurers “act as purchasing agents” for employers, and when insurers gain more market power, they are able to negotiate better prices for their employer customers. Id. at 372.
165. Id. at 373.
166. See Anthem, Inc. v. United States, 137 S. Ct. 2250 (2017); Eric Kroh, Anthem Appeals 548 Cigna Merger Case to Supreme Court, LAW360 (May 5, 2017, 11:32 AM), https://www.law360.com/articles/920964/anthem-appeals-548-cigna-merger-case-to-supreme-court. Anthem stated: “Given that many lower courts have felt bound by an interpretation of this Court’s precedent that is inconsistent with modern economics, guidance is sorely needed from this Court to ensure that mergers are analyzed in a way that will protect consumers, including consumers of healthcare.” Kroh, supra.
to recognize an efficiencies defense, but Justice Harlan, in a concurring opinion, argued that efficiencies should be allowed as a defense to a Section 7 violation.\textsuperscript{167} Ultimately, the Supreme Court declined to hear the \textit{Anthem} case.\textsuperscript{168} However, the issue of whether the "efficiencies defense" can be used to rebut a Section 7 violation will likely return, as there is a significant need to ensure that mergers are evaluated in a way that protects consumers.\textsuperscript{169} As a result of the failed merger, Anthem will owe Cigna $1.85 billion in reverse termination fees.\textsuperscript{170}

V. ANALYSIS

A. Industry Response

The failed Aetna–Humana and Anthem–Cigna mergers come as a surprise to some experts, particularly those who confidently projected that these deals would close.\textsuperscript{171} One expert from a leading healthcare-centric investment bank predicted that the Aetna–Humana deal had an eighty percent chance of closing.\textsuperscript{172} Experts’ confidence in these deals was not entirely misguided, given that these health insurance mergers were the first in history to be blocked by the court.\textsuperscript{173} Thus, the courts diverged from precedent and appeared to “draw a . . . line in the sand,” potentially ending mergers of large

\begin{thebibliography}{99}
\bibitem{168} \textit{Anthem, Inc.}, 137 S. Ct. 2250.
\bibitem{169} \textit{See} Petition for Writ of Certiorari at 11–20, \textit{Anthem Inc.}, 137 S. Ct. 2250 (No. 16-1342).
\bibitem{171} \textit{See} Caroline Humer & Diane Bartz, \textit{Justice Dept. Has Concerns over Aetna-Humana Deal: Source}, Reuters (July 7, 2016, 10:35 AM), http://www.reuters.com/article/us-humana-m-a-aetna-idUSKCN0ZN21V. The basis for this estimate was the constructive communication between Aetna, Humana, and the DOJ, and the plan for divestiture to ensure that the deal went through. \textit{See id.} Another expert believed the deal would be approved as long as Aetna and Humana divested “Medicare Advantage assets in eight to [twelve] states.” \textit{See} Boris Ladwig, \textit{Attorney: Humana and Aetna Likely to Get Merger Approval, Insider Louisville} (July 19, 2016, 6:00 AM), http://insiderlouisville.com/business/big-business/health-care-lawyer-humana-merger-likely-to-happen/.
\bibitem{172} \textit{See} Humer & Bartz, \textit{ supra} note 171.
\end{thebibliography}
health insurance companies that offer national coverage to their customers.174

Unsurprisingly, other players in the healthcare industry, including physicians, medical societies, and hospital associations, strongly opposed both the Aetna–Humana and Anthem–Cigna mergers.175 One state medical society noted that “the mergers will result in higher premiums, less patient time with physicians, lower reimbursement and reductions in staff.”176 The American Hospital Association wrote two separate letters to the DOJ, one opposing each merger.177 In a Senate hearing, the American Consumer Union, American Hospitals Association, and two law professors testified in opposition to the mergers.178 The House of Representatives’ Judiciary Committee also held a similar hearing on the topic, in which several speakers expressed concern over the merger.179 The American Medical Association (AMA) has been the most vocal lobbyist against these deals.180 The AMA’s president stated, “Elderly patients were the big winners today... Aetna’s strategy to eliminate head-to-head competition with rival Humana posed a clear and present threat to the

174. See Gale, supra note 15.
179. See Healthy Competition? An Examination of the Proposed Health Insurance Mergers and the Consequent Impact on Competition: Hearing Before the House of Representatives, 114th Cong. (2015) [hereinafter Healthy Competition Hearing]. At this hearing, the American Medical Association, American Hospital Association, Heritage Foundation, and a law professor provided testimony opposing the mergers. See id.
180. See McLaughlin, Tracer & Harris, supra note 128.
quality, accessibility and affordability of health care for millions of seniors."\(^{181}\) The AMA similarly opposed the Anthem merger.\(^{182}\) The strong opposition from the AMA and others is not surprising given the group’s interest in protecting physician reimbursement rates and earnings.\(^{183}\)

**B. The Aetna and Anthem Decisions in Context**

Weighing the *Aetna* and *Anthem* decisions without considering the rest of the healthcare industry does not provide the whole picture.\(^{184}\) Insurance companies are often criticized for their profit-centric business goals, but their ability to make a profit, and even to survive, depends on the balance of power between all industry players, including pharmaceutical and medical device companies, hospitals, and providers’ offices—all of which are profit-centric entities.\(^{185}\) The bargaining power that insurance companies can exert over doctors and hospitals is an important consideration in maintaining a balance of power, but equally important is the power that other groups have over insurers.\(^{186}\) If any collective entity possesses too much bargaining power, it can effectively dictate prices in the industry as a whole or within the smaller service, geographic, or specialty segments over which it has influence.\(^{187}\)

\(^{181}\) *Id.*


The termination of the Anthem-Cigna merger is a clear victory to preserve competition in the health insurance industry. To the detriment of patients, there is already far too little competition among insurers. Networks are already too narrow, and premiums are already too high. Competition, not consolidation, is the right prescription for health insurance markets.

\(^{183}\) Tom Rogan, *The American Medical Association is a Special-interest Lobby, Not a Patient Ally*, WASH. EXAMINER (June 27, 2017, 9:55 AM), http://www.washingtonexaminer.com/the-american-medical-association-is-a-special-interest-lobby-not-a-patient-ally/article/2627185 (asserting that the AMA is “a lobbying group with specific, vested interests. Namely, the pursuit of maximized doctor earnings, interests, and protections under law”).

\(^{184}\) *See infra* notes 224–34 and accompanying text.


\(^{186}\) *See id.*

The ACA continues to force heavy consolidation across all groups in the healthcare industry. From 2010 to 2015, there were 554 hospital mergers. In 2015 alone, there were 112 hospital mergers, up eighteen percent from 2014. There has also been significant consolidation in the pharmaceutical industry. In 2014, there were 1,299 total mergers in the healthcare industry, valued at $387 billion—$213 billion of which came from 188 transactions between pharmaceutical companies. The ACA forced healthcare groups to consolidate by demanding lower prices on the public exchange. In addition, the ACA added a significant amount of costs and paperwork for insurers and providers, thereby encouraging consolidation to shrink administrative costs. When pharmaceutical companies, hospital groups, and physician medical groups obtain stronger bargaining power, they have the power to dictate prices for their goods and services, which inevitably harms consumers by increasing health insurance premiums. In response, and to regain bargaining power,
insurers often merge, thereby perpetuating consolidation in the healthcare industry.\textsuperscript{196} Thus, while regulating health insurance mergers is important, the FTC and DOJ must also keep the consolidation of all groups in check by enforcing antitrust laws fairly and equitably across the entire healthcare industry.\textsuperscript{197}

C. Was This the Right Decision?

The biggest concern with these mergers was that they would substantially reduce or almost entirely eliminate competition, allowing the insurance companies to fill their pockets at the expense of consumers.\textsuperscript{198} Like in past cases, both Aetna and Anthem defended the mergers on the grounds that the consolidation would lead to increased efficiencies, thereby lowering costs.\textsuperscript{199} However, even if the Aetna and Anthem mergers would have resulted in consumer

\begin{flushleft}
\textsuperscript{196} See Frakt, supra note 187. Whereas hospital consolidation leads to significant price increases, insurer consolidation typically only leads to modest price increases. \textit{Id.}
\textsuperscript{197} See \textit{id.} Mergers tend to have a trickle-down effect, and changes in one segment of the industry can significantly affect the industry as a whole. See \textit{id.} Of note, hospital mergers are challenged by the FTC whereas insurance company mergers are challenged by the DOJ. See Pear, supra note 5. Thus, to have a coordinated effect on the healthcare industry, these two agencies must work together to set common goals. See \textit{id.}
\textsuperscript{198} See Frakt, supra note 187. In its Complaint, the government argued that the Anthem–Humana merger would allow the insurance company to profit at the expense of providers and hospitals, and would result in higher prices and reduced quality. Aetna Complaint, \textit{supra} note 10, at 4–5. Similarly, the government argued that the Aetna–Humana merger would allow the company to profit at the expense of senior citizens relying on Medicare Advantage. Aetna Complaint, \textit{supra} note 102, at 3.
\textsuperscript{199} \textit{Examining Consolidation in the Health Insurance Industry and Its Impact on Consumers, supra} note 178. During the Hearing, Aetna’s Chief Executive Officer claimed that the merger with Humana would allow the merged entity to provide better care to more consumers at a lower cost. See \textit{id.} at 8–9 (statement of Mark T. Bertolini, Chairman and Chief Executive Officer, Aetna, Inc.) Similarly, Anthem’s Chief Executive Officer claimed that the deal with Cigna would lower costs, and that one hundred percent of the cost savings from the care management programs would be passed to large insurers that self-insure. See \textit{id.} at 9–10 (statement of Joseph Swedish, President and Chief Executive Officer, Anthem, Inc.).
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cost savings, data from prior health insurance mergers suggests that cost savings do not automatically translate to increased competition.\textsuperscript{200} In prior mergers, even when healthcare provider reimbursements decreased, the savings were not necessarily passed to consumers.\textsuperscript{201} Instead, prices increased after prior mergers, leading to the consumer savings argument being labeled an "economic fallacy."\textsuperscript{202}

If permitted, the resulting increase in market shares would likely have given Aetna and Anthem increased bargaining power, which groups feared would allow them to control reimbursement rates.\textsuperscript{203} Anti-merger activists argued that giving any one entity too much bargaining power could have detrimental consequences, especially in an industry with very little competition already.\textsuperscript{204} The American Hospital Association reported that the Anthem–Cigna merger would reduce competition in 817 metropolitan statistical areas.\textsuperscript{205} Similarly, the Aetna and Humana deal would mean that in 180 counties, at least 75 percent of Medicare Advantage subscribers would have only


\textsuperscript{201} See \textit{Healthy Competition Hearing}, supra note 179, at 3 (statement of Andrew W. Gurman, President of the AMA); see also Guardado, Emmons & Kane, supra note 88, at 23 (explaining that premiums increased when UnitedHealth Group merged with Sierra Health Services).


\textsuperscript{203} See \textit{id.} at 10. One expert stated before the case went to trial that the Aetna–Humana merger would mean that the insurer could use "blunt force trauma" to dictate reimbursement rates. Bonnie Ladwig, \textit{Attorney: Humana and Aetna Likely to Get Merger Approval}, \textit{Insider Louisville} (July 19, 2016, 6:00 AM), http://insiderlouisville.com/business/big-business/health-care-lawyer-humana-merger-likely-to-happen/.


\textsuperscript{205} \textit{Letter from American Hospital Association to William Baer, Assistant Attorney General}, supra note 177, at 3. The American Hospital Association represented almost "5,000 member hospitals, health systems and health care organizations, and 43,000 individual members" in its letter to the DOJ. \textit{id.} at 1.
one choice of insurer.\textsuperscript{206}

According to the DOJ, the \textit{Aetna} decision was a victory for consumers, and particularly for Medicare subscribers.\textsuperscript{207} Although not an argument cited by the court, the fact that this involved Medicare Advantage patients, who are senior citizens, is important.\textsuperscript{208} Compared to their younger counterparts, older individuals are generally considered more vulnerable, therefore requiring more protection.\textsuperscript{209} After the court blocked the Aetna merger, the AMA announced its support of the decision, stating that it “preserves the benefits of health insurer competition for a vulnerable population of seniors.”\textsuperscript{210}

Additional consequences of health insurer mergers in general include the potential for harm to providers and hospitals in the form of lower reimbursement rates.\textsuperscript{211} Lowering reimbursement rates could force doctors to leave insurance networks, thereby reducing consumer choice and potentially affecting


\textsuperscript{207} Eric Kroh, \textit{DOJ Wins Bid To Block $37B Aetna-Humana Merger}, LAW 360 (Jan. 23, 2017, 11:59 AM), https://www.law360.com/articles/879134/doj-wins-bid-to-block-37b-aetna-humana-merger. After the decision, Deputy Assistant Attorney General Brent Snyder stated, Today’s decision is a victory for American consumers—especially seniors and working families and individuals . . . . Competition spurs health insurers to offer higher quality and more affordable health insurance to seniors who choose Medicare Advantage plans and to low-income families and individuals who purchase insurance from public exchanges . . . . Aetna attempted to buy a formidable rival, Humana, instead of competing independently to win customers. Millions of consumers have benefited from competition between Aetna and Humana, and will continue to benefit because of today’s decision to block this merger.


\textsuperscript{209} See id. One reason senior citizens are vulnerable is that many have small retirement accounts that barely cover expenses. See Diane Rowland & Barbara Lyons, \textit{Medicare, Medicaid, and the Elderly Poor}, 18 HEALTH CARE FINANCING REV., no. 2, Winter 1996, at 61, https://www.ssa.gov/history/pdf/RowlandandLyons.pdf.

\textsuperscript{210} Gurman, supra note 208. This decision was also important because, for the first time, a judge deemed Medicare Advantage a separate product market. See United States v. Aetna, 240 F. Supp. 3d 1, 23 (D.D.C. 2017).

\textsuperscript{211} See \textit{Healthy Competition Hearing}, supra note 179, at 4 (statement of Andrew W. Gurman, President of the AMA); see generally Asaka S. Moriya, William B. Vogt & Martin Gaynor, \textit{Hospital Prices and Market Structure in the Hospital and Insurance Industries}, 5 HEALTH ECON., POL’Y & L. 459 (2010) (analyzing the impact of health insurer consolidation on hospital prices and market consolidation).
quality of care. Alternatively, low reimbursement rates could impair quality of care by forcing physicians to forego purchasing new equipment or spend less time with patients.

Preserving competition is also important to protecting patients. Patients often depend on physicians to advocate on their behalf when their insurer denies coverage for a medication or treatment. For example, when insurance companies deny coverage for treatments, many physicians advocate for their patients by pushing back against insurers’ decisions. Physicians also advocate for their patients when insurers deny coverage for a more expensive drug and instead force a patient to fail a cheaper alternative medication before they will pay for the more expensive medication that the patient’s doctor originally prescribed. When physicians lack sufficient bargaining


213. See Healthy Competition Hearing, supra note 179, at 5–6 (statement of Andrew W. Gurman, President of the AMA).

214. See Paul von Ebers, Mega Health Insurance Mergers: Is Bigger Really Better?, HEALTH AFF. (Jan. 22, 2016), http://healthaffairs.org/blog/2016/01/22/mega-health-insurance-mergers-is-bigger-really-better/; see also Healthy Competition Hearing, supra note 179, at 4 (statement of Andrew W. Gurman, President of the AMA) (stating that “lack of competition . . . exerts adverse pressure on the ability of physicians to advocate for their patients”).


217. See Charles & Molinari, supra note 216. This practice of forcing patients to fail other medications before the insurer will pay for the more expensive medication is called “fail first” or “step therapy.” Id. Oftentimes, the cheaper alternative therapy that the patient must first fail is not even FDA approved for the patient’s condition. See id. (noting that insurers often require patients to fail off-label therapies before they will approve the more expensive, on-label therapy). In addition to being potentially harmful to patients and certainly frustrating for physicians, there are legitimate costs associated with fail-first practices. See id. Although insurance companies gain in the short-term by saving money on expensive therapies by forcing patients into cheaper alternatives, when patients are denied the care they need, the cost of healthcare rises—a phenomenon that is all too familiar to millions of Americans. See Charles, supra note 215. Additionally, healthcare providers’ offices spend thirty-one billion dollars per year on administrative costs pertaining to insurance companies. Id. Furthermore, doctors spend, on average, three weeks per year dealing with insurance companies. Id.
power to effectively advocate against insurers on behalf of their patients, patients—and by extension, society as a whole—lose.\textsuperscript{218}

These concerns demonstrate the need for the FTC and DOJ to carefully monitor all mergers in the healthcare industry to maintain an effective balance of power between all industry players, but it does not mean that all health insurer mergers should be enjoined simply because they will lead to an increased market share.\textsuperscript{219} In fact, assuming the cost savings are actually passed on to consumers, an insurer gaining increased market share can help consumers if there are resulting efficiencies or if hospitals and provider groups have too much bargaining power and the merger simply restores a proper balance.\textsuperscript{220}

Ultimately, healthcare mergers must be effectively regulated in a way that does not harm consumers in the process.\textsuperscript{221} Although the Aetna and Anthem decisions may have prevented consumer harm, consumers did not come out unscathed.\textsuperscript{222} The break-up fees in the Aetna–Humana and Anthem–Cigna cases alone totaled almost $3 billion.\textsuperscript{223} On top of the billion dollar break-up fee, Aetna also issued “$13 billion in bonds to fund the merger,” which it must

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\textsuperscript{218} See Charles, supra note 215.
\textsuperscript{220} See id (Kavanaugh, J., dissenting). Merging companies should demonstrate “substantial evidence (i.e., documents and data) that the merger is necessary to achieve the claimed efficiencies and that the efficiencies are likely to occur.” Jeff Spigel, Norm Armstrong & John Carroll, Aetna/Cigna Decision Latest Example of Skepticism About Whether Mergers Can Benefit Consumers, BLOOMBERG BNA (May 23, 2017), https://www.bna.com/aetna-cigna-decision-latest-n73014451369/.
\textsuperscript{221} See infra notes 222–30 and accompanying text.
\textsuperscript{223} See id. These fees are not unusually large. See David Shne, Antitrust Termination Fees: Rational or Emotional?, PAUL HASTINGS (Sept. 2015), https://www.paulhastings.com/docs/default-source/PDFs/stay-current-antitrust-termination-fees.pdf. In the recent AT&T-T-Mobile failed merger, AT&T paid T-Mobile $6 billion. Id. at 1. Verizon agreed to pay Vodafone $10 billion in termination fees, the largest contracted termination fee in history, but fortunately for Verizon, the deal succeeded and Verizon did not have to pay. See David Benoit, Verizon Wireless Deal Comes with Biggest Breakup Fee Too, WALL ST. J. (Sept. 3, 2013, 12:46 PM), http://blogs.wsj.com/moneybeat/2013/09/03/verizon-wireless-deal-comes-with-biggest-breakup-fee-too/. Some experts suggest that reverse termination fees should be limited. See Jacqueline Bell, Crisis Sparks New Focus on Reverse Breakup Fees, LAW360 (Oct. 14, 2009, 3:52 PM), https://www.law360.com/articles/124648/crisis-sparks-new-focus-on-reverse-breakup-fees. In the past, termination fees were limited to three percent, but recently, these fees have exceeded seven percent of the total deal amount. Id.
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buy back at a loss of more than $304 million. In addition, Aetna is estimated to have spent more than $400 million on “transaction and integrated-relation costs,” bringing “the total cost of the Humana deal to more than $1.8 billion.”

Cigna also filed a claim against Anthem for $13 billion in damages—in addition to the $1.85 billion break-up fee—in the Delaware Chancery Court, and Anthem countersued. Furthermore, there are shareholder derivative suits on all sides. At the end of the day, this enormous amount of money was spent on a cause that left all four insurers (Anthem, Cigna, Aetna, and Humana) with wasted large capital expenditures and/or enormous financial penalties; the healthcare dollars that were lost could have been better spent on causes such as insurer innovations or other advancements in medicine and healthcare. Making matters worse, these losses could affect American consumers, as the companies could pass these costs on to their members, in the form of higher premiums, and/or to hospitals and providers in the form of decreased reimbursement rates. The DOJ technically “won” the lawsuit, but the truth is that everyone lost in some way, especially consumers.

224. See Hiltzik, supra note 222.
225. Id.
228. See supra notes 223–27 and accompanying text.
230. See id.
D. Why Were Divestitures Not an Option?

Although divesting assets allowed the previous four mergers to proceed, divesting assets was not an option in Aetna and Anthem.231 One explanation for this is that Aetna and Anthem are different from the previous four mergers in several important ways.232 First, unlike the previous four cases, the Aetna–Humana and Anthem–Cigna mergers were announced within three weeks of each other in what seemed like a storm of events—known as the “merger frenzy.”233 The government blamed Humana for effectively starting a bidding war, stating in the Complaint:

In a two-month period, Anthem made several bids for Cigna; Cigna made two bids for Humana; UnitedHealthcare made bids for Aetna and Cigna; and Aetna made a bid for Humana, which after only weeks of negotiation resulted in an agreement on July 2, 2015. Just a few weeks later, on July 23, 2015, Anthem agreed to acquire Cigna for $54 billion.234

Following the simultaneous nature of these proposed acquisitions, the DOJ filed lawsuits seeking to enjoin the Anthem–Cigna and Aetna–Humana acquisitions on exactly the same day.235

Making matters worse, as one Anthem executive explained, the health insurance industry is already “very consolidated,” and is “really down to a big

231. See McLaughlin, Harris & Tracer, supra note 130. In analyzing whether the proposed modifications, including a proposed divestiture by Anthem, would be adequate, Bill Baer, the DOJ official who brought the Aetna and Anthem lawsuits, explained, “The standard we apply is: Will the status quo be preserved? Will consumers after a divestiture benefit from the same degree of competition that exists today?” Id. “We have zero confidence that the proposals that have been made to us come close to meeting that standard.” Id.

232. See infra notes 233–39 and accompanying text.


234. Anthem Complaint, supra note 10, at 7.

235. See id. at 1; Aetna Complaint, supra note 102, at 1.
five and then, it gets much . . . smaller in terms of players that are available after that."\textsuperscript{236} In addition, consolidations in the health insurance industry are fundamentally different from other mergers; unlike many other goods and services, healthcare is essential to life and thus demands greater protection.\textsuperscript{237} Thus, the DOJ’s decision to aggressively challenge both mergers, and the industry response, seem almost inevitable.\textsuperscript{238} Furthermore, the Aetna decision concluded that divesting assets to Molina would be inadequate given Molina’s current and historical non-presence in the Medicaid market.\textsuperscript{239}

E. What Does This Mean for the Future of Health Insurance Mergers?

1. Effect of the Judicial Decisions on the Healthcare Industry

Competition in the healthcare marketplace is arguably only “weakly competitive.”\textsuperscript{240} According to a 2015 study by the AMA, “there has been a near total collapse of competition” in the health insurance industry.\textsuperscript{261} Seventy percent of metropolitan statistical areas (MSAs) are highly concentrated, and in thirty-eight percent of MSAs, a single health insurance company has at least fifty percent of the market share.\textsuperscript{242} Lack of competition in Medicare markets

\textsuperscript{236} Anthem Complaint, supra note 10, at 4.
\textsuperscript{237} See McLaughlin, Harris & Tracer, supra note 130. Attorney General Loretta Lynch stated, “Health insurance can mean the difference between life and death. If the big five were to become the big three, not only would the bank accounts of American people suffer, but the American people themselves.” Id.
\textsuperscript{238} See Mathews & Weaver, supra note 206.
\textsuperscript{239} United States v. Aetna, Inc., 240 F. Supp. 3d 1, 73–74 (D.D.C. 2017). Molina’s primary focus is on Medicaid. Id. at 73. When it was founded in 1980, Molina was a health clinic for Medicaid patients. Id. at 60–61. In 1994, Molina expanded its scope to offer health insurance, primarily in the form of Medicaid plans. Id. at 61. Over the past few years, Molina tried to expand into the Medicare Advantage market across eight states but it failed, eventually cancelling its Medicare Advantage plans in all eight states except New Mexico. Id. at 62. Molina commented that “the plans were losing money because the ‘benefits, network and formulary’ for pharmacy benefits were ‘average to below average’ as compared to competitors.” Id.
\textsuperscript{241} See Healthy Competition Hearing, supra note 179, at 3 (statement of Andrew W. Gurman, President of the AMA).

\textsuperscript{242} Id. The term “MSA” is defined by the U.S. Census Bureau as encompassing both micro and metro areas, Metropolitan and Micropolitan, U.S. Census Bureau, https://www.census.gov/programs-surveys/metro-micro/about.html (last visited Jan. 21, 2018). “An MSA must include at least one city with 50,000 or more inhabitants, or a Census Bureau-defined urbanized area, and a total metropolitan population of 100,000 people . . . .” David J. Barron, Reclaiming Home Rule, 116 HARV. L.
is even more concerning. According to another 2015 study, ninety-seven percent of Medicare Advantage markets are highly concentrated.

Despite these statistics, smaller insurers will likely continue to merge, or at least attempt to. On November 17, 2016, while Aetna and Anthem were at trial, WellCare Health Plans revealed its plan to merge with Universal American to improve its position in the Medicare Advantage market, the very same market that was at the forefront of the Aetna case. In another merger, Kaiser Permanent acquired Seattle-based Group Health in a deal that was approved by state and federal regulators on February 1, 2017. However, the Aetna and Anthem decisions will likely have a chilling effect on future mergers, both in healthcare and beyond. Given Aetna and Anthem, large mergers of health insurance companies could be a thing of the past.

Anthem’s failed Supreme Court petition effectively ended the Anthem–Cigna merger. Although Aetna is considering appealing the decision, the merger is unlikely to succeed, especially after the fate of Anthem. In both cases, the district court’s opinions were particularly lengthy and involved an
extensive discussion of the background relating to all aspects of the case.\textsuperscript{252} Even given the fact that the district court broke with precedent, Aetna’s success is unlikely.\textsuperscript{253}

However, if history is any indication, the change in administration could help Aetna on appeal.\textsuperscript{254} In 1999, towards the end of President Clinton’s Administration, the DOJ won an antitrust lawsuit against Microsoft.\textsuperscript{255} In 2001, though, after George W. Bush assumed office, a federal judge reversed the breakup order and the DOJ abandoned its quest to block the Microsoft deal.\textsuperscript{256} The DOJ and Microsoft later reached a settlement that allowed the merger to proceed.\textsuperscript{257} Thus, United States v. Microsoft Corporation provides strong precedential support for Aetna if the insurer chooses to appeal.\textsuperscript{258}

Alternatively, both Aetna and Humana may have the option to purchase other, smaller insurance companies that do not rise to the level triggering a challenge by the DOJ.\textsuperscript{259} Future deals will likely center around the Medicaid


\textsuperscript{257} See id.; Abelson, supra note 254.

\textsuperscript{258} See Abelson, supra note 254.

\textsuperscript{259} Gale, supra note 15. Aetna and Humana have enough cash to purchase smaller competitors, which would still allow them to increase their market presence, although to a smaller extent than would have been possible had the larger mergers been permitted. See id.; McLaughlin, Tracer & Harris, supra note 128. Potential target companies include Molina, Centene Corp., and WellCare. Gale, supra note 15.
market.\textsuperscript{260} However, shareholder derivate suits, reverse termination fees, and claims for excessive damages could significantly deter future mergers of large health insurance companies.\textsuperscript{261}

2. Effect of the Change in Administration

Significantly, the Aetna–Humana decision involved the DOJ under the Obama Administration.\textsuperscript{262} Although the Aetna–Humana decision was released just three days after President Trump’s inauguration, and the Anthem–Cigna decision was released shortly thereafter, both trials occurred completely under the Obama DOJ.\textsuperscript{263} Now, under the new Trump Administration, the results could be different.\textsuperscript{264}

Although the fate of the Aetna–Humana and Anthem–Cigna mergers may seem unexpected, perhaps there were clues of their certain doom all along.\textsuperscript{265} Under the Bush Administration, hundreds of health insurance companies successfully merged, which led to a dearth of competition in the market.\textsuperscript{266} Even when Obama was just a presidential candidate, he openly criticized President Bush’s treatment of antitrust cases and made it clear that, under an Obama

\textsuperscript{260} See McLaughlin, Tracer & Harris, \textit{supra} note 128. The Medicaid market is a likely target, given the government’s increasingly common practice of contracting out Medicaid plans to private insurers. \textit{See id.} This practice is expected to continue and maybe even increase under President Trump. \textit{See id.}


\textsuperscript{263} Id.


\textsuperscript{265} See infra notes 266–88 and accompanying text.

\textsuperscript{266} See David Balto, \textit{President Obama’s Antitrust Enforcement}, HILL (Oct. 27, 2016, 1:40 PM), http://thehill.com/blogs/congress-blog/judicial/303065-president-obamas-antitrust-enforcement. In eight years, the DOJ was successfully challenged only one merger. \textit{See id.}
Administration, mergers would be evaluated with intense scrutiny.\textsuperscript{267} Furthermore, he expressed concern over the rise in mergers in the healthcare industry, and particularly in the health insurance industry.\textsuperscript{268}

Despite an originally strong stance against mergers, mergers generally thrived under the Obama Administration, particularly in Obama’s first term.\textsuperscript{269} In Obama’s eight years, only two health insurance mergers were reported to the FTC or DOJ—between Aetna and Humana, and between Anthem and Cigna—and both were challenged by the DOJ in the final years of the Obama Administration.\textsuperscript{270} In what seemed like a final effort to crack down on mergers before the change in administration, the DOJ’s uncharacteristic decision to vehemently oppose these mergers and reject any potential remedies is arguably unexpected, even given Obama’s anti-merger statement as a candidate.\textsuperscript{271}

Now, under a Trump Administration, the status quo in antitrust lawsuits

\textsuperscript{267} See Jacqueline Bell, \textit{Obama To Take Aggressive Stance on Antitrust}, LAW360 (Oct. 31, 2008, 12:00 AM), https://www.law360.com/articles/75182/obama-to-take-aggressive-stance-on-antitrust. During the 2008 election, Obama stated, “As president, I will direct my administration to reinvigorate antitrust enforcement. I will step up review of merger activity and take effective action to stop or restructure those mergers that are likely to harm consumer welfare, while quickly clearing those that do not.” \textit{Id.} Obama also made it clear that mergers would be more closely examined than they were under the Bush Administration. \textit{See id.}

\textsuperscript{268} See Statement of Senator Barack Obama for the American Antitrust Institute, ANTITRUST INST., http://www.antitrustinstitute.org/files/aai-%20Presidential%20campaign%20-%20Obama%209-07_092720071759.pdf (last visited Jan. 21, 2018) [hereinafter Obama Statement]. In support of his opposition of mergers, Obama referenced the 400 healthcare mergers in the previous ten years and an AMA report claiming that ninety-five percent of insurance markets are highly concentrated. \textit{Id.}

\textsuperscript{269} See David Goldman, \textit{Obama’s Not as Tough on Mergers as You Might Think}, CNN MONEY (Apr. 8, 2016, 10:11 AM), http://money.cnn.com/2016/04/08/news/obama-mergers-antitrust/index.html. As of April 2016, the FTC and DOJ, under Obama, had challenged 150 mergers, compared to 129 under Bush and 292 under Clinton. \textit{Id.} Only sixty-nine of the 150 challenged mergers actually went to trial under Obama, compared to fifty-nine under Bush and 103 under Clinton. \textit{See id.} As explained by one law professor, “[t]here is this big difference between the rhetoric at the top and the day-in, day-out practice in the trenches of antitrust . . . . Even though there may be some vaguely more pro-enforcement mind-set, a lot of mergers have been approved over the last eight years.” Appelbaum, \textit{supra} note 264. Critics of Obama’s antitrust policies cite to \textit{United States v. U.S. Airways Group, Inc.}, 38 F. Supp. 3d 69 (D.D.C. 2014), in which the government allowed the airlines to merge and become the world’s largest airline. See Jad Mouawad & Christopher Drew, \textit{Justice Dept. Clears Merger of 2 Airliners}, N.Y. TIMES (Nov. 12, 2013, 11:19 AM), https://dealbook.nytimes.com/2013/11/12/us-s-said-to-be-near-settling-american-us-airways-merger-lawsuit/?mcubz=0.

\textsuperscript{270} See \textit{United States v. Aetna}, 240 F. Supp. 3d 1, 1 (D.D.C. 2017); Anthem Complaint, \textit{supra} note 10, at 1.

\textsuperscript{271} See Obama Statement, \textit{supra} note 268. Obama also wrote an article in the Journal of the AMA calling for more competition in the healthcare markets. See Barack Obama, \textit{United States Health Care Reform Progress to Date and Next Steps}, 316 JAMA 525, 529–30 (2016).
could change.\textsuperscript{272} Overall, experts believe that Trump’s Administration will revert to a more Bush-like attitude towards mergers, favoring more permissive rules over strict mandates.\textsuperscript{273} However, some experts remain skeptical of the Trump Administration making any meaningful changes to the status quo established by the Obama Administration.\textsuperscript{274} However, Trump opposed the proposed AT&T–Time Warner deal and has vowed to crack down on pharmaceutical drug pricing, suggesting that he might not be as permissive towards mergers as some might think.\textsuperscript{275} Moreover, in a recent meeting with major health insurers, President Trump stated, “Obamacare forced providers to limit the plan options they offered to patients and caused them to drive prices way up . . . Now a third of U.S. counties are down to one insurer, and the insurers are fleeing. You people know that better than anybody.”\textsuperscript{276}

Two of Trump’s executive orders are relevant to antitrust regulations in the health insurance industry and could assist the Agencies in working together: (1) the Executive Order on Enforcing the Regulatory Reform Agenda.\textsuperscript{277} and (2) the Executive Order Minimizing the Economic Burden of

\textsuperscript{272} See Appelbaum, supra note 264.


\textsuperscript{274} See Appelbaum, supra note 264.


\textsuperscript{277} Exec. Order No. 13777: Enforcing the Regulatory Reform Agenda, 82 Fed. Reg. 39, 12285
the Patient Protection and Affordable Care Act Pending Repeal.278 The Regulatory Reform Agenda calls for each federal agency to establish a Regulatory Reform Task Force to review regulations and suggest amendments and modifications.279 This Executive Order could aid in antitrust enforcement in the health insurance sector by amending current regulations and methods to involve a more cohesive effort between the DOJ and FTC.280 Similarly, the Executive Order Minimizing the Economic Burden of the Patient Protection and Affordable Care Act Pending Repeal could help by lessening the pressure on health insurance companies to decrease costs, which has directly motivated the mergers.281 Finally, if the ACA exchanges continue to exist, this Executive Order could motivate insurance companies to continue offering their plans on the exchange, thereby preserving competition.282

For health insurers, perhaps the strongest indicator of the future of mergers is the future of the ACA.283 The ACA is widely viewed as a major culprit driving the merger frenzy,284 and President Trump has issued an executive

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280. See id.
281. See Manning, supra note 13 (opining that a competitive marketplace would decrease health provider consolidation and drive efficiency, thus lowering costs for consumers).
284. See Abelson, supra note 233. Underlying the ACA is the necessity to provide “better care at
order to repeal the ACA. 285 The new Administration must find a balance between encouraging efficiencies in healthcare while not necessarily condemning the method industry players choose to achieve that goal. 286 As the ACA is repealed, some experts question whether the merger frenzy will continue, an assertion to which both Anthem and Aetna refuse to respond. 287 Overall, uncertainty abounds regarding the future of health insurance mergers after the Aetna and Anthem decisions. 288 Not only has the court just issued the first two injunctions blocking health insurance mergers, but there is also a new Administration with views on healthcare drastically different from the prior Administration’s views. 289

F.  Potential Solutions: A Call for Government Action

As a result of the failed Aetna and Anthem lawsuits and the repercussions resulting from the extensive litigation, the Agencies must modify their antitrust practices. 290 One potential solution is for the Agencies to work together and with other relevant agencies to resolve antitrust concerns. 291 Tradition-

lower prices.” Id. Faced with this challenge, healthcare companies are on guard to move. See id. Many healthcare companies, not just insurers, have made the decision to consolidate, effectively starting a domino-effect of “[m]ergers beget[ting] more mergers.” Id. One senator argued that “Obamacare is killing competition and that means lousy choices and awful premiums for American families.” Howell, supra note 282.


286. See Vaida, supra note 192 (citing experts who believe that “there is a contradiction in advocating for the policies that have driven provider consolidation but then condemning the mergers. Health care costs are rising at a historically low rate, and it is possible that policies that would reduce provider concentration could raise health care costs”). Many are “blaming high health care costs on the increased concentration of providers,” and thus “the consolidation of providers has become a convenient target for policy makers who want to be viewed as actively pursuing solutions” to increasing health care costs. Bruce C. Vladeck, Paradigm Lost: Provider Concentration and The Failure of Market Theory, 33 HEALTH AFFAIRS 1083, 1083 (June 2014), http://www.healthaffains.org/doi/pdf/10.1377/hlthaff.2014.0336. However, “many of the factors fueling increased provider concentration” are unavoidable. Id. Hence, there is a “contradiction between efforts to contain health care prices and the fact that aggressive policies aimed at reducing provider concentration might be ineffective.” Id.

287. See Livingston, supra note 283. Repealing Obamacare could allow for easier entry into the healthcare market, a task that the courts have acknowledged is anything but easy. See id.

288. See Livingston, supra note 283. The general uncertainty in the industry is compounded by the uncertainty as to how and when the ACA will be replaced. See id.

289. See supra notes 272–82 and accompanying text.

290. See infra notes 298–305 and accompanying text.

291. See infra notes 292–97 and accompanying text.
ally, the Agencies have divided their responsibilities in the healthcare industry, with the FTC tackling hospital and provider mergers and the DOJ tackling insurance company mergers.\textsuperscript{292} However, because healthcare is such an integrated industry between insurers, providers, and hospitals, and changes in one group can significantly affect other industry players, the Agencies must collaborate in their approach to deliver consistent, balanced, and predictable results.\textsuperscript{293} Although combining forces may be difficult given the delayed process and the fundamental differences between the Agencies, the Agencies could have quarterly briefing sessions in which they present proposed mergers on their respective sides and discuss the ramifications to other areas of the industry.\textsuperscript{294} The Agencies already work together in the “clearance process” to decide which agency will review the proposed merger, so including a discussion about proposed ramifications would not be difficult.\textsuperscript{295} The Agencies could also host more roundtable discussions similar to the one hosted on the topic of competition in hospital services.\textsuperscript{296} In addition, President Trump’s

\begin{itemize}
\item \textbf{292.} See O’Hara, supra note 5. This approach is not unique to healthcare. See, e.g., FTC and DOJ Announce New Clearance Procedures for Antitrust Matters, FED. TRADE COMM’N (Mar. 5, 2002), https://www.ftc.gov/news-events/press-releases/2002/03/ftc-and-doj-announce-new-clearance-procedures-antitrust-matters. In 2002, the FTC and DOJ decided to formally allocate primary areas of responsibility across antitrust matters, arguing that “[a]llocating industry sectors in a more rational manner will enable the Department to investigate more efficiently possible anticompetitive conduct affecting consumers and will provide greater certainty to the business community, all of which is good for consumers.” Id. The Agencies gave, as an example, the regulation of cars and trucks, which were once split between the FTC and DOJ. Id. This new approach made it so that the FTC would preside over cars and the DOJ would preside over trucks. Id. Although this method may allow for more efficient review of proposed mergers, the problem is that it leads to unequal and inconsistent enforcement of antitrust laws. See O’Hara, supra note 5. The FTC frequently challenges hospital and provider mergers, whereas the DOJ rarely does. See id. Although there are several explanations for this inequality, one reason is because different agencies preside over the different groups. See id.
\item \textbf{293.} See Frakt, supra note 187 (demonstrating the inverse correlation between the market power of hospitals and insurers).
\item \textbf{295.} See Egge & Cruise, supra note 294, at 3. The “clearance process” is when the FTC and DOJ review proposed mergers and allocate responsibility to one agency or the other. Id.
\end{itemize}
Executive Order Minimizing the Economic Burden of the Patient Protection and Affordable Care Act Pending Repeal provides the opportunity for the Agencies to work with the Department of Health and Human Services (HHS) to develop a concerted effort for resolving healthcare antitrust concerns.297

A second approach is for the Agencies to encourage Congress to adopt legislation limiting reverse termination fees.298 The purpose of reverse termination fees is to reduce uncertainty regarding damage amounts, compensate sellers with liquidated damages when deals do not close, and limit buyers’ liability.299 Thus, at the very least, sellers’ damages should be limited to reverse termination fees; additional damages, like those claimed by Cigna, should be statutorily barred.300

Third, given the immense costs of the Aetna and Anthem lawsuits, and the resulting harm to all involved, the Agencies must avoid litigation at all costs.301 One solution is for the Agencies to facilitate purposeful, open dialogue during the initial review process and fix-it-first discussions to help merging entities understand the basis for the Agencies’ concerns and discuss


298. See supra note 223.


300. See id. In Cigna’s lawsuit for damages against Anthem, Anthem will likely argue that the purpose of the reverse termination fee was to allocate antitrust risk, and therefore, Cigna is not entitled to additional damages. See id.

potential settlement options.302 One way to accomplish this is for the Agencies to publish detailed explanations of their findings and conclusions to inform the relevant parties and the public of how they arrived at their conclusion.303 These reports could help provide certainty to future mergers by revealing critical factors the Agencies consider and their analytical reasoning when reviewing proposed mergers.304 Alternatively, some experts argue that merging entities should be barred altogether from litigating fix-it-first proposed settlements in court.305 Judicial review of these settlements may be unconstitutional, as it “encroach[es] upon the executive branch’s congressionally delegated role in bringing and settling Clayton Act merger cases.”306 Ultimately, no matter the solution employed, the Agencies must promptly institute change to avoid further harm to consumers.307


303. See Gelfand & Calsyn, supra note 302, at 3–4. After reviewing bids for a cruise line in 2002, the FTC noted that “it [was] appropriate to provide an unusually detailed explanation for [its] decision” because the matters presented “important, albeit firmly settled, issues of merger policy;” the “issues were complex and the ultimate decision depended on a close analysis of industry-specific facts;” and “the transactions [had] been the subject of unusually extensive media coverage—some of it misinformed.”


304. See Gelfand & Calsyn, supra note 302, at 4.

305. See Horton, supra note 46, at 170.

306. Id.

Whether through choosing the path of least resistance, benign indifference, or aggressive overreaching, the results are the same. The courts increasingly are overstepping their statutory and constitutional boundaries in Clayton section 7 cases by allowing merger defendants to rewrite the government’s “case” through unilaterally proffered “fix-it-yourself” solutions over the government’s consistent objections. In so doing, the courts are wrongfully decreeing themselves as the governmental branch with statutory authority to present the “case” for adjudication, and usurping the government’s “settlement authority.”

Id. at 213.

307. See supra notes 222–30 and accompanying text.
VI. CONCLUSION

The Aetna–Humana and Anthem–Cigna decisions mark a drastic change from previous mergers in the healthcare industry, and they stand out as the only health insurance mergers ever to be successfully blocked by the DOJ.\textsuperscript{308} Because of these almost simultaneous decisions, mergers of large health insurance companies could effectively be over.\textsuperscript{309} Nevertheless, competition between health insurers is only one sector in the much larger healthcare industry that is significantly affected by other industry players—including pharmaceutical companies, hospitals, and provider groups.\textsuperscript{310} Successful and equitable antitrust monitoring requires a holistic, comprehensive, collaborative, and predictable approach.\textsuperscript{311} Thus, to successfully regulate antitrust in the healthcare industry, the antitrust divisions of the FTC and DOJ must promote equal antitrust enforcement in healthcare mergers; have regular meetings with each other and with HHS; facilitate open, honest, and transparent dialogue with merging entities; and avoid litigation at all costs.\textsuperscript{312} Furthermore, instituting statutory limits on reverse termination fees may prevent excessive fee windfalls causing consumer harm.\textsuperscript{313} Instituting change to protect consumers from antitrust litigation harm, particularly in healthcare, rests in the Agencies’ hands; will they unite to spark reform?

Anna Molinari*


\textsuperscript{309} See supra Part V. One solution for insurers may be to change their business model. See Alicia Gallegos, \textit{Megamerger Rulings May Chill Future Consolidations}, ONCOLOGY PRAC. (Feb. 27, 2017), http://www.mdedge.com/oncologypractice/article/132302/practice-management/megamerger-rulings-may-chill-future. In recent years, the prevailing business strategy has been for insurers to get as large as possible and then merge. See id. Now, with more antitrust scrutiny, insurers may have to modify their strategy and focus on value instead of volume. See id.

\textsuperscript{310} See supra Part V.

\textsuperscript{311} See supra Part V.

\textsuperscript{312} See supra Part V.

\textsuperscript{313} See supra note 223 and accompanying text.

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