COMMISSIONER JONES: Good afternoon and welcome to the California Department of Insurance. My name is Dave Jones, and I have the privilege of serving as California’s Insurance Commissioner, and I wish to welcome you to this hearing on the proposed acquisition of Cigna Corporation by Anthem.

As I said a moment ago I have the privilege of serving as an Insurance Commissioner and leading the California Department of Insurance, which regulates California’s insurance industry where insurers collect $259 billion in premiums annually. We’re the largest insurance market in the United States, and I’m very appreciative of the assistance I get in that regulatory role from the very able and talented staff of the California Department of Insurance.

Today we’re in our office in San Francisco, and the subject of today’s hearing is a proposed merger between Anthem, the nation’s second largest health insurer, and Cigna, the nation’s fifth largest health insurer. The merger of these two companies would make the proposed merger transaction has been valued at $54.2 billion when it was announced in July of last year. I am holding this public hearing, because there will be a digital recording of this proceeding as well to give her a chance and the public and those that are watching as well, we try to keep the interruptions to a minimum. This proceeding is being transcribed by a court reporter. I’ve already told her that she should throw a flag if I go too fast or any witness goes too fast. We’ll be taking some breaks throughout the proceeding as well to give her a chance and the witnesses a chance to rest.

We have a court reporter, who is recording the proceedings, and there’s a little bit of background noise coming from a cell phone. So that’s probably a good moment for me to remind folks to, please, check their cell phones and turn them off and you’re happy to take any calls that you might need to take out in the hallway, and we just ask that out of respect for the public and those that are watching as well, we try to keep the interruptions to a minimum.

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There are restroom facilities along the corridor on this floor. There’s a drinking fountain and that’s about all we have to offer you. We are the government, after all. And so, again, we’re most appreciative.

Judging by the attendance here in this hearing room, this is obviously a matter of great public interest. We’re also streaming this live on the internet through our Department of Insurance Website and there will be a digital recording of this proceeding that will be available for folks going forward.

The proposed merger transaction has been valued at $54.2 billion when it was announced in July of last year. I am holding this public hearing, because
it's very important to me to hear from the public about
the potential impacts of this proposed merger on
customers, businesses, and California's insurance
market.

We're joined today by executives and counsel
from Anthem and Cigna, who will testify about the
proposed merger, and be available to answer questions,
and I'm most appreciative -- and we will have a chance
to have them introduce themselves in a moment, but I am
most appreciative of their participation in today's
hearing.

We'll also hear from academics, medical
provider organizations, consumer organizations and
members of the public, who will be afforded an
opportunity to testify directly about the proposed
merger.

The merger of Cigna Corporation with Anthem,
Incorporated would result in a change of control of
Cigna Health and Life Insurance Company, a
Connecticut-domiciled insurer licensed to do business in
the State of California and regulated by the California
Department of Insurance.

Cigna Health and Life Insurance Company wrote
approximately $899 million in premiums in California
alone in 2014 with over 480,000 covered lives in

commercial products in California.

In 2014, Cigna had total revenues nationwide
of roughly $34.9 billion. Anthem has approximately 4
million covered lives in California's commercial market
and government programs. Anthem's total nationwide
revenue in 2014 was $73.9 billion. Anthem's already the
largest health insurer in California's individual market
and the second largest behind Kaiser in California's
commercial insurance market. Anthem is also the largest
player in California's ASO or Administrative Services
Organization market with Cigna as a second largest
player in California's ASO, or Administrative Services
Organization market.

A major part of both companies' businesses is
the provision of administrative services and medical
provider networks to self-insured employers.

Anthem reports 2.25 million covered lives in
self-insured plans it administers, and Cigna reports
approximately 1.63 million covered lives in self-insured
plans it administers, which totals almost 3.9 million in
the self-insured market with these two companies
combined.

This administrative services market or ASO
market is how millions of Californians and their
families with employer-based coverage get their health
coverage.

So, in addition to the overlapping geographic
area in which Anthem and Cigna do business in the
individual and large group health insurance markets, the
self-insured market will be impacted as well.

So I look forward to hearing from all the
witnesses and the public today, but, in particular, I am
interested in hearing testimony about the following
issues, and let me offer these by way of guidance to the
witnesses.

One. The impact of the proposed merger on
competition in the California health insurance
marketplace for each segment market and for each
geographic region throughout California.

Two. The implications for consumers of
increased concentration in the California health
insurance marketplace.

Three. The impact of the proposed merger on
consumer premiums and out-of-pocket health care costs.

Four. The impact of the proposed merger on
medical provider and medical facility network
contracting and prices.

Five. The impact of the proposed merger on
medical provider network design, including the ability
of consumers currently covered by each respective

Six. The efficiencies, if any, expected from
the proposed merger and their implications for the cost
and the quality of care delivered to consumers in
California.

And seven. Any anticipated divestitures that
will result from the merger and the implications of
those divestitures if they occur for consumers in
California.

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those divestitures if they occur for consumers in
California.

It will tell you in light of the academic
studies, some of which we will hear about today, which
demonstrate that consumers have not benefitted from
prior health insurance mergers, I have some significant
skepticism about the benefits of the merger. But, I
will reserve judgment until I've had a chance to hear
from the companies from stakeholders and from witnesses,
including importantly, the public.

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witnesses and the public today, but, in particular, I am
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skepticism about the benefits of the merger. But, I
will reserve judgment until I've had a chance to hear
from the companies from stakeholders and from witnesses,
including importantly, the public.
1. I do not plan to come to a conclusion today about the proposed merger. In addition to the testimony that we will take today and the written comments that have already been provided to the department, I welcome and invite the public, especially those that were unable to join us in San Francisco today, to submit their written comments to the California Department of Insurance by Friday, 5 o’clock on April 1st. That’s this Friday, 5 o’clock. You can e-mail your comments to me care of Kayte. That’s K-A-Y-T-E dot Fisher, F-I-S-H-E-R, at insurance dot CA dot GOV. And she truly appreciates my handing out her e-mail address to the entire population of California. But, we are prepared to receive, and indeed want to receive, as many comments as possible from the public stakeholders and anyone interested in this matter. It’s critically important. It’s a tremendously important potential transaction and one in which the public ought to be heard, so I will carefully consider, both, the testimony we receive today and all comments submitted.

2. Once I have reviewed all the materials compiled by department staff and submitted by the insurers, interested stakeholders and the general public, I will make a decision about whether this merger will benefit Californians.

3. So, that in a nutshell is the nature of the proceeding and the kinds of testimony I hope we receive and how we plan to proceed. We do have an agenda that we’ve provided and we’ve divided the afternoon up into essentially five different segments. First, we’ll have an opportunity to hear directly from Cigna and Anthem and their representatives, and next, we’ll have an opportunity to receive some expert testimony, including testimony from a research institute at the University of California Berkeley, but also, testimony from the Department of Insurance with regard to claims handling practices of the two companies. Next, we’ll have a chance to hear from the provider community, and we have testimony from the California Medical Association, American Medical Association and the Physical Therapy Association.

4. I will also make a recommendation to the Department of Justice, and the Federal Trade Commission, both, of which have authority to disapprove or approve the merger. I will also be making a recommendation to other insurance commissioners or insurance superintendents with approval authority over this specific merger.

5. So, with that, what I would like to do now is move to our first panel, which is a panel composed of representatives by Cigna and Anthem. I would ask if you could -- we have three people that we had identified as testifying. There may be others. But, I would ask if it would be possible if there are three people that are going to be testify, if you could keep your testimony to, say, less than ten minutes each. That would afford some time for questions and then allow us to move through the next panels.

6. I’ll ask each of you that plans to testify to please, identify yourselves and if there are -- maybe some time for questions and then allow us to move on to the next segment will be consumer organizations. I hear we have a number of California and National consumer organizations that will be testifying, and then finally, we’ll open it up to public testimony from any member of the public who wishes to testify about the merger.

7. Our goal is to accomplish that by 5 o’clock. We’ll have to take some breaks, most importantly, for testimony from any member of the public who wishes to testify about the merger. Our goal is to accomplish that by 5 o’clock. We’ll have to take some breaks, most importantly, for testimony from any member of the public who wishes to testify about the merger.

8. I will also be making a recommendation to the California Medical Association, American Medical Association and the Physical Therapy Association.
1. Commissioner.

2. COMMISSIONER JONES: Very good.

3. JAY WAGNER:

4. MR. WAGNER: As I said, my name is Jay Wagner, vice president and counsel of Anthem, Inc. I would like to thank the Commissioner and staff for inviting us to this hearing.

5. Today, I would like to provide an overview of this highly complementary nature of proposed Anthem-Cigna accommodation to discuss the limited competitive impact of the transaction on insurance in California and to describe the value that would result for individual consumers, employers, providers, and our health care system.

6. A quick overview of the merger. We are very excited about the merger with Cigna, and the positive impact we expect the combined company to have on the health care system.

7. Anthem-Cigna accommodation to discuss the limited competitive nature of proposed transaction involve a change of control of a California domestic insurance company. Nor does the transaction affect any insurance company or HMO of either Anthem or subsidiaries. To be clear, these mergers do not involve

8. ...the separate corporate existence of the parent Cigna will cease and Anthem will continue as a surviving corporation, and the ultimate parent of the Cigna subsidiaries. To be clear, these mergers do not involve

9. merging any insurance company or HMO of either Anthem or Cigna. Simply the parent companies. Nor does the transaction involve a change of control of a California domestic insurance company.

10. Under Anthem, the day-to-day ordinary course of business with the Cigna entities will continue in the same manners as prior to the closing. The goal of this transaction is to provide a better product to stakeholders in our ever-changing, increasingly competitive health care industry.

11. I’ll talk a little bit about the complementary nature of the combination. This merger is about bringing together complementary capabilities of Anthem and Cigna to increase accessibility, improve affordability, and enhance health care quality.

12. The combined company will engage in the innovative and collaborative use of health care data to improve continuity of care while containing rising health care costs, improving predictability, and more efficiently, delivering services.

13. The combined Anthem-Cigna will make possible data driven, evidence based medical protocols, that enable providers to improve patient care and safety and deliver services more efficiently. By providing a holistic view of our members across the health care system, providers can more quickly evaluate the effectiveness of their own treatment protocols and identify factors that impact patient outcomes, both, positively and negatively. This helps providers do more what they do best, deliver care to patients and increase the overall health and wellness of our patients here in California. This is something we can only do more effectively and deliver more quickly for California’s consumers if Anthem and Cigna do it together.

14. Anthem and Cigna are committed to aligning incentives to encourage smarter, collaborative decision making that fosters healthier outcomes in a better patient experience. This focus has allowed us to give more care provided under value-based umbrella, which will only grow as a result of a proposed transaction, having a more immediate impact on our ability to bring down the total cost of care while improving quality.

15. In California from San Diego to the Oregon border Anthem has 19 accountable care organizations with some of the largest providers -- provider groups. Anthem’s first in the nation partnership with seven of the top leading hospitals in the Los Angeles and Orange County area has enabled us to launch Vivity, an integrated health system, that moves away from traditional fee for service and toward a structure that financial rewards activities that keep patients healthy, positively and negatively. This helps providers do more what they do best, deliver care to patients and increase the overall health and wellness of our patients here in California. This is something we can only do more effectively and deliver more quickly for California’s consumers if Anthem and Cigna do it together.

16. I’ll mention -- I’ll mention something about the consolidation nationally the five largest insurers to three, but to characterize the industry as only having five major players is not necessarily correct. The marketplace in California is competitive and dynamic. The top competitors in California are a diverse group of insurers from Kaiser, the leading commercial health plan in California, to Blue Shield of California, Aetna, United Health, Health Net, Sharp Health Plan, Sutter Health Plan, and Molina, among others.

17. In fact, a total of 12 health insurance companies or plans offer products on Covered California, the state based individual exchange. Health insurance is not one size fits all. Consumers now have and will continue to have a broad choice in obtaining affordable healthcare.

18. In 2015, the number of health insurers increased by 26 percent across the country, and nearly 60 percent of U.S. counties experience the addition of at least one insurer. Entry is easier than it has been
in recent memory.

In 2014, alone, at least 30 new companies began competing to provide insurance company in the U.S. In 2015, another other 70 were introduced.

That's more than 100 new entrances in two years. In addition -- in addition, hospitals and providers are increasingly offering their own plans. A recent PWC study found that approximately half of all U.S. health systems have applied or intend to apply for insurance license. Start ups are also making head way.

For example, Oscar, a 2014 New York base start up has expanded beyond New York and New Jersey into Texas and here in California.

In January of 2016 Oscar reported 125,000 members, more than three times its January 2015 enrollment across these four states.

We understand that Oscar plans to enroll 1 million customers within five years and operate in up to 30 markets.

When we look at each of Anthem and Cigna's shares of membership in commercial health insurance and health plan services overall, and in each of the fully insured individual, small group and large group lines of insurance in California, it is clear that the transaction will not have an adverse impact on health plan services overall, and in each of the fully shares of membership in commercial health insurance and large group lines of insurance in California.

Moreover, this segment is highly competitive. It is characterized by large employer customers who are extremely sophisticated buyers with entire teams dedicated to finding the best deals for their companies, and they commonly use consultants to ensure they receive the most competitive advantage.

Value of Anthem and Cigna combination to consumers. Anthem has served California for decades through its Blue Cross of California, Blue Cross Life and Health Insurance Company, and CareMore Health Plan subsidiaries.

The combination of Anthem and Cigna will bring together the complementary platforms of both companies in a way that will uniquely benefit consumers. Anthem brings an extensive network of providers, leading care coordination programs and Medicare advantage and Medicaid, 24/7 access to licensed providers via TeleHealth and more than 75 years of experience in commercial insurance.

Cigna brings its own distinct strengths, including consumer centric technology, highly regarded wellness program, substantial expertise in the international market and leading specialty capabilities like dental, vision, behavioral, life and disability coverage.

As health care evolves, consumers are demanding more information from a variety of trusted resources in order to make more informed decisions. We know that consumers want more transparency when it comes to their expected cost and quality of health care provided by their doctors and hospitals, and we have seen that making this information available to consumers and providers leads to better health outcomes and cost savings to the health care system. For example, Anthem and Cigna partnered with third party transparency vendors like Castlight Health and Health Care Blue Book to make sure the consumers have clear line sight into the price variation -- variations that exist often with the same geography or network. To encourage greater costs and quality competition among providers and to help consumers make better informed decisions about where to seek health care services, we implemented a reference based pricing system.

Leaders Inter-Study, the merger will result in just a nominal increase in share of 1.94 percent across the fully insured group enrollment data shows that the merger will result in an increase in share of California fully insured share would increase by less than three percent. In that loan, MSA, the Santa Maria, Santa Barbara MSA, the increase would only be 3.5 percent.

The only segment where there is any real overlap in California would be the self-insured or administrative services only business. ASO customers are typically large employers who pay for employees' medical claims directly and simply use an insurer or third-party administrator for administrative services, including to arrange for a provider network, negotiate reimbursement rates and process claims.

ASO customers bear all the risks and costs in insuring their employees, themselves. As a result, the sale of these administrative services is not insurance as regulated by the department, but rather regulated under ARISA.

Looking at yet another data source, HealthCareBlueBook study found that approximately half of all U.S. health systems have applied or intend to apply for insurance license. Start ups are also making head way.

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1. program in partnership with CalPERS.
2. In coordination with CalPERS we took on the
3. problem of significant price variation across California
4. providers for knee and hip replacement surgeries by
5. utilizing reference based-pricing and educating and
6. incentivizing consumers and providers through price
7. transparency CalPERS experienced a 20 percent increase
8. in patients who chose more affordable, high quality
9. providers for these procedures.
10. Anthem also brings its live health online
11. product that provides consumers access to providers from
12. home and during the weekends and evenings, which enables
13. engagement of a wider audience, including rural
14. populations.
15. Moreover, Anthem has just introduced online
16. visits with psychologists and therapists through this
17. product, which will also serve to benefit Cigna members
18. in the futures.
19. Lastly, we have partnered with America’s
20. health insurance plans to launch a new initiative to
21. identify solutions to improve the accuracy and
22. efficiency of provider data reporting. The objective of
23. this pilot is to improve consumers’ access to care and
24. provide information needed to make the most informed
25. decisions about their medical care.

1. As to efficiencies, currently Anthem has
2. identified cumulative, annual pre-text, run rate
3. synergies and efficiencies of over 2 billion.
4. There will be efficiencies derived from
5. medical network synergies and efficiencies, likely
6. substantial synergies and efficiencies from
7. complementary selling, pharmacy synergies and
8. efficiencies operating expense synergies and
9. efficiencies and other likely synergies and
10. efficiencies.
11. Medical and network synergies and efficiencies
12. that will result in cost savings include building upon
13. the best of Anthem and Cigna’s existing provider
14. relationship to obtain the best cost, quality and access
15. for our members.
16. Using the increased scope of the combined
17. company leading to better products and offerings,
18. including data analytics across the two platforms to
19. engage providers in more meaningful ways to reduce cost
20. and expanding value-based reimbursement and
21. provider-collaboration programs more quickly to further
22. lower medical costs and advance important public policy
23. goals.
24. Fully insured customers will benefit from
25. lower medical costs. The affordable care acts medical

1. loss ratio, the very purpose of which is to create a
2. regulatory structure that helps to ensure that such
3. savings are passed through to customers will ensure that
4. fully insured customers will benefit.
5. For large group customers, Anthem must spend
6. 85 percent of premium dollars on medical services.
7. For small group or individual customers,
8. Anthem must spend 80 percent on medical services. All
9. other administrative costs must be paid for within the
10. remaining 15 to 20 percent of revenue. ASO customers
11. will also recognize savings as a result of combination.
12. As previously mentioned, ASO customers bear
13. the cost of the employee’s medical care; and therefore,
14. will benefit directly from the cost of care savings
15. resulting from the combination.
16. The California Senate Committee on Health
17. issued its health care market consolidations paper this
18. month, which concludes that, “Healthcare economists
19. indicate that the market power of certain health care
20. providers is a major driver of price increases in health
21. care spending. A study on the impact of health care
22. provider market power on premiums for products available
23. in 2014 through covered California conducted by
24. researchers at the University of California Berkeley
25. found that the concentration of medical groups and

1. hospitals had an impact on premium rates in California's
2. 19 health insurer rating regions."
3. At the same time the researchers found that
4. "The concentration of health plans did not have an
5. impact on premiums."
6. Other studies included that insurer
7. consolidation can actually have downward pressure on
8. health care costs.
9. A 2011 health affairs article a 2015 paper
10. published by the journal of health economics showed that
11. more concentrated health plan markets can counteract the
12. price increase affects of concentrated hospital markets.
13. The health affairs article stated that a more
14. concentrated health insurer landscape brought down
15. prices by 12 percent.
16. In addition a 2015 Moody's analysis concluded
17. that health insured conduct consolidation will put
18. downward pressure on drug prices.
19. In closing, I would like to thank Commissioner
20. and the Department of Insurance for providing us with
21. the opportunity to speak today on behalf of the merger,
22. which as I've briefly detailed, would bring together two
23. highly complementary organizations that would provide
24. substantial benefits to consumers.
25. Finally, I believe it is also worth repeating
that at its core the proposed Anthem-Cigna combination represents a significant step forward on a path to a 21st century health care system that reflects a shared vision of greater value for consumers, increased access and choice, greater affordability and better outcomes achieved through innovation and collaboration. Thank you.

COMMISSIONER JONES: Thank you, Mr. Wagner.

THOMAS RICHARDS: Good afternoon.

MR. RICHARDS: Thank you, Commission Jones and the Department of Insurance, for the opportunity to speak at today’s hearing.

My name is Thomas Richards, and I’m the global lead for strategy and business development at Cigna. Today, I would like to do three things.

First, provide an overview of Cigna and Cigna’s current operations in California; second, briefly describe the effective of the proposed transaction on Cigna’s operations in California; and finally, explain why we are excited by the opportunities that this transaction presents -- presents for the combined company and for consumers.

First of all, the overview of Cigna in our California’s operations. Cigna is a holding company whose wholly-owned subsidiaries provide health services to individuals and groups around the globe. Cigna seeks to deliver affordable and personalized products and services to customers through employer-based, government sponsored and individual coverage arrangements. Increasingly, Cigna collaborates with health care providers to transition from volume-based fee for service arrangements towards a more value-based system designed to increase quality of care, lower costs and improve health outcomes.

As to California, Cigna’s operations include:

1. four health care service plans licensed by the Department of Managed Healthcare, and Cigna has filed a notice of material modification filing with the DMHC in connection with the proposed indirect change of control of these health care service plans.
2. Cigna does not have any domestic insurance companies here in California; however, several of Cigna’s insurance companies that are domiciled in other states are licensed as foreign insurers in California.
3. As explained by Jay Wagner, Cigna does not have a meaningful share of the total membership in California and any of the fully insured small or large group lines of insurance, nor do we operate Medicare advantage or Medicaid plans in California.
4. With respect to administrative services only business offered by insurers, Cigna falls behind other national insurers, such as, United Health Group and Aetna.
5. In addition, there is a broad range of competitors for the self-insured customer segment beyond traditional insurers, such as, third-party administrators, which are not required to report their enrollment; and as a result any publicly available self-insured market share data is likely to be incomplete.
6. As I noted previously, Cigna has filed a notice of material modification filing with the department of managed health care in connection with the proposed indirect change of control of its health care service plans. The proposed transaction will not result in a change of control over the California domestic insurance company.
7. As I mentioned earlier, Cigna does not have any domestic insurance company in California. The separate corporate existence and status of Cigna’s subsidiaries will remain unchanged.
8. As described by Jay Wagner, Anthem has no plans to make material changes in the operations of any of Cigna’s California licensees at closing.
9. Finally, on to the value of the Anthem-Cigna combination to consumers. As I mentioned at the onset, Cigna is excited about the opportunities that this transaction presents for the combined company and for our consumers.
10. Both companies’ commitments to ensure consumers have expanded access to high quality, affordable health coverage is the foundation of the proposed transaction and will remain the top priority of the combined company.
11. The primary benefits of this transaction are that it will ensure consumers have access to the highest quality, most effective care available, help keep quality health coverage as affordable as possible, improve consumer choice with respect to products and services and increase consumer access to an enhanced network of hospitals, physicians and other health care providers.
12. With respect to the affect of the proposed transaction on Cigna’s operations in California, the proposed transaction with Anthem will result in an indirect change of control of all of Cigna’s subsidiaries.

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In addition, there is a broad range of competitors for the self-insured customer segment beyond traditional insurers, such as, third-party administrators, which are not required to report their enrollment; and as a result any publicly available self-insured market share data is likely to be incomplete.
professionals. With respect to health care quality, consumers will benefit from higher quality care as a result of the combined company's ability to utilize complementary capabilities of Anthem and Cigna, such as, value-based care, care coordination, management programs and investments in customer service infrastructure, technology and customer-centered tools, such as, mobile apps, cost and quality transparency tools. These innovative technologies improve data capabilities and programs promote high-quality care and better customer outcomes. With respect to affordability, consumers will benefit from lower costs through the combined companies' greater act to address costs through efficiency means and common administrative, IT and business functions, as well as addressing rising medical costs and drug costs. The health care marketplace has for sometime been slowly moving to value-based care with its focus on outcomes. By combining the capabilities of Anthem and Cigna, the combined company will be able to speed along the adoption of the changes necessary to partner with providers and help them to transition to a value-based system.

Value-based care is a critical element in a long-term sustainability of health care affordability for consumers. With respect to choice, consumers will benefit from having a broader portfolio of products and services, including more value-based products and services to choose from. The proposed merger will accelerate the combined companies' ability to better compete and increase its capacity to test innovative programs with providers driving more value and quality to the system. And, finally, with respect to access, consumers will benefit from greater access through the combined capabilities that will create a premier network of hospitals, physicians and health care professionals that will also include virtual nurse and physician interaction and on site wellness clinics. Together, Anthem and Cigna will have the resources and capabilities necessary to exceed consumer expectations and accelerate transformation of the broader health care system. In closing, I would like to thank Commissioner Jones and the Department of Insurance for providing us the opportunity to speak in support of the merger. Cigna believes that the combination will have a positive impact on the health care industry generally and will result in cost savings and increased overall options in efficiencies for its policyholders specifically. Thank you.

COMMISSIONER JONES: Thank you very much. Thank you, both. I have a few questions before we turn to the next panel. First, the business plan of the merged companies. Both of you either today or in prior testimony by Mr. Wagner to the Department of Managed Healthcare in California. We hope, as I mentioned during my testifying, in the move from volume to value-based services and reimbursement rates.

Anthem has said that Cigna will not have any change after closing in their plans respective services and reimbursement rates. Do I have that correct?

MR. WAGNER: That's correct.

COMMISSIONER JONES: So that statement was made with regard to the DMHC-regulated entities. What about with regard to the non-domiciles insurance companies. Both of you either today or in prior testimony, in the move from volume to value-based services and reimbursement rates.

Anthem says that the Cigna-DMHC-regulated entities. What about with regard to the non-domiciles insurance entities that are transacting insurance under Cigna's terms of not changing provider networks, respective services and reimbursement rates?

Anthem has said and Cigna has said that Cigna will not tend to change over time, but we do not expect any changes in its plans, respective services provider, networks and reimbursement rates.

MR. RICHARDS: Yeah, absolutely. Those things tend to change over time, but we do not expect any changes at closing.

COMMISSIONER JONES: So after closing, what happens? How long will the Cigna-DMHC-regulated entities and the insurance entities that are foreign insurance entities not domiciled, but transacting business in California, how long will they continue to operate as separate, corporate entities?

MR. WAGNER: They will continue to operate as separate, corporate entities. So Cigna will continue to separate, corporate entities. It will continue to operate and exist with their products in the State of California. We hope, as I mentioned during my testimony, in the move from volume to value-based contracting, we hope to improve, both, the Cigna products and the Anthem products by, you know, building on the best of our provider relationships that each respective company has.

COMMISSIONER JONES: So let's talk about that specifically then since you mentioned the provider...
networks. So will Cigna -- the Cigna entities continue to develop provider networks separate from network development efforts of the Anthem entities?

MR. WAGNER: That's correct.

COMMISSIONER JONES: And how long will that continue?

MR. WAGNER: For the foreseeable future as long as they continue to offer their products, which there are no plans to stop offering any such products.

COMMISSIONER JONES: So that was my next question was whether the Cigna entities would continue to offer the same products that each of them is currently offering?

MR. WAGNER: That's correct.

COMMISSIONER JONES: And will the Anthem entities continue to offer the same products that they're currently offering?

MR. WAGNER: That is correct.

COMMISSIONER JONES: And is it anticipated at some point that might change?

MR. WAGNER: It is not anticipated at this point. I think I can say that to the extent that we identify in the future certain products that are better suited to the marketplace, you know, perhaps those -- those particular products in the specialty area,

perhaps, are used more often than not.

So in adding vision currently Cigna doesn't have, you know, vision coverage in addition to their medical products, so -- but perhaps in the future, you know, Cigna may develop their own vision products, which will be an additional tagalong to their major medical products. I mean, that's one of those.

COMMISSIONER JONES: Other than the specialty products, though, is there any planning underway at either, Anthem or Cigna to change the products currently offered by the entities under either of the two parent companies?

MR. WAGNER: There is not.

COMMISSIONER JONES: Okay. And is there any planning to indicate that when in the future there might be some sort of change in the products offered other than the specialty products?

MR. WAGNER: No, I don't believe so.

COMMISSIONER JONES: And the same answer with regard to Cigna?

MR. RICHARDS: Yeah, absolutely. We're still in very early stages of planning for the integration. Obviously, we're still operating very much as independent companies and very much starting the planning of the integration.

MR. RICHARDS: It is not anticipated at this time.

COMMISSIONER JONES: But no plans have been developed to change product offerings of any of the Cigna entities?

MR. RICHARDS: That's correct.

COMMISSIONER JONES: So Cigna currently, I believe, leases some of its medical provider networks to other insurers, and in so doing provides a means for new market entrance or smaller health insurers in California to compete in the market.

Is that correct?

MR. RICHARDS: That's correct.

COMMISSIONER JONES: And after the merger will Cigna continue to lease its networks to these other insurers?

MR. WAGNER: Yes, our plans will be to continue to do that.

COMMISSIONER JONES: How long?

MR. WAGNER: We don't have any plans to stop doing that. So.

COMMISSIONER JONES: What's the duration of those contracts currently?

MR. WAGNER: To be honest, the duration of the contracts with the provider networks or with --

COMMISSIONER JONES: With regard to the leasing of Cigna networks to other health insurers or

HMOs, what's the duration of the contracts between Cigna and the other health insurers and the HMOs?

MR. RICHARDS: Off the top of my head, I don't know the length of the contracts. I would presume they vary much by duration. They tend to be a lot of third-party administrators, although there are some insurers and HMOs, as you mentioned, but there tend to be third-party administrators, and again, there would be a variety of lengths of contracts, and they typically renew.

COMMISSIONER JONES: I don't want to force you to weigh in. Could you provide me separately with a written answer that tells me what the duration is, the minimum acts, the average duration of these contracts?

MR. RICHARDS: We can certainly provide some guidance around that.

COMMISSIONER JONES: I appreciate that.

Now, in both your testimonies and in prior testimony, and also, in an Anthem presentation titled "the compelling combination," which is I believe at Exhibit 10 of the binders that have been provided to you, there is a slide 14, which has title "Identifiable and achievable synergies." This references the $2 billion in synergies that Mr. Swedish, the CEO of the Anthem holding company, has alluded to and you,

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The marketplace. An example of really again providing new capabilities to duly eligible for both Medicaid and Medicare. So, it's both companies to develop new programs that would Cigna is particularly strong and using capabilities from that are inherent in Anthem's best and class Medicaid savings at all. It's about taking Medicaid capabilities growing through all the population, it's not about cost savings? 

As customers and clients. can provide synergies, and again, enhancements to our integration, we'll continue to look for areas where we categories. Again, as we continue to plan for the here? 

Mr. Richards: Not necessarily. For instance, growing through all the population, it's not about cost savings at all. It's about taking Medicaid capabilities that are inherent in Anthem's best and class Medicaid capabilities and Medicare advantage capabilities that Cigna is particularly strong and using capabilities from both companies to develop new programs that would address the most vulnerable population, people who are duly eligible for both Medicaid and Medicare. So, it's an example of really again providing new capabilities to the marketplace.

Mr. Wagner: It -- it represents from -- at that time the sort of the broad categories of synergies that we thought might be able to develop as a result of the transaction. Each of those has certain elements to it. Leveraging Cigna specialty capabilities across Anthem could include, you know, perhaps the increase ability to use stop loss in different areas, which would expand product offerings for -- for current Anthem products, for instance. Network efficiencies and medical management within that we believe that there is a certain -- one of our main goals is to drive from volume to value, value-based contracting and that crossed both platforms. We intend to develop the efficiencies from that as well.

Commissioner Jones: Any others not listed here? 

Mr. Richards: I think those are the major categories. Again, as we continue to plan for the integration, we'll continue to look for areas where we can provide synergies, and again, enhancements to our customers and clients.

Commissioner Jones: Maybe just by way of definition, am I to understand that a synergy means cost savings?

Mr. Richards: Not necessarily. For instance, growing through all the population, it's not about cost savings at all. It's about taking Medicaid capabilities that are inherent in Anthem's best and class Medicaid capabilities and Medicare advantage capabilities that Cigna is particularly strong and using capabilities from both companies to develop new programs that would address the most vulnerable population, people who are duly eligible for both Medicaid and Medicare. So, it's an example of really again providing new capabilities to the marketplace.
the 2 billion, and we have some sense of where we might be able to obtain the synergies from within those categories, but to the extent that certain information is not exchangeable between the companies, there are a lot of assumptions stacked behind those. So, I would appreciate whatever level of specificity you give me. I have to say I'm a little concerned when you say that it's best estimate assumptions, guidance because you were very clear in your testimony, both of you, and Mr. Swedish has been that there is going to be $2 billion in savings.

MR. WAGNER: Right.

MR. RICHARDS: We do have confidence there, again, it shows the early nature of planning. Some of them may turn out to be more efficiencies than we expect and others may turn out to be less.

On an overall basis we have a high degree of confidence. Obviously, it's within each category there is more planning that needs to be done to drive a creditors within a category. COMMISSIONER JONES: I would like to see that allocation. Then on the next page of that slide deck, there's a slide titled "Value creation for both sets of shareholders," which has a graphic demonstration of shareholders, which has a graphic demonstration of there's a slide titled "Value creation for both sets of allocation. Then on the next page of that slide deck, there's a roll-up figure for that $3 per share based on the total number of shares that will exist after the merger, do you?

MR. WAGNER: No, I do not.

COMMISSIONER JONES: Can you provide me with that?

MR. WAGNER: I'm not sure I understand the question.

COMMISSIONER JONES: Well, you are saying there will be an additional $3 per share available to shareholders, and I'm curious what that represents in aggregate value. So, I'm assuming there is some finite number of shares that will be outstanding after the merger, assuming you don't issue additional shares right away, and so I'm -- I guess the question is: What's the --

the adjusted earnings per share, or rather, the adjustment of earnings per share that is anticipated to occur between 2015 and 2018 as a result of the merger. Is that what this deck slide is supposed to be telling us? I'll ask it a different way, because there is a pause. What is this supposed to tell us?

MR. WAGNER: What it's supposed to tell us is in 2018 what we're telling shareholders is that we will reach $17 in EPS within the combined companies. COMMISSIONER JONES: EPS stands for? MR. WAGNER: Earnings per share.

COMMISSIONER JONES: So it will be an additional $17.

MR. WAGNER: So, given the projections of Anthem and Cigna independently, we believe that there will be incremental value generating $17 of EPS in 2018. MR. RICHARDS: A total... (Inaudible.) COURT REPORTER: I'm sorry. I can't hear you. MR. RICHARDS: The estimate is the $17 and total earnings per share, not in incremental. COMMISSIONER JONES: So, what's the incremental increase that the slide is asserting will accrue as a result of the merger?

MR. WAGNER: I did not create the slide, but presumably it's $3.

COMMISSIONER JONES: And is it your understanding that the additional $3 in earnings per share will come from the $2 billion in cost savings annually by year two of the merger?

MR. WAGNER: That would be one component of it. It would be expanded business growth in the business and relative earnings associated with the growth.

COMMISSIONER JONES: I appreciate it very much. Getting back to one of the synergies that you identified in the prior slide, one of those is network efficiencies in medical management. Can you share with us what is intended by network efficiencies in medical management specifically?

MR. WAGNER: There are few different elements of that, and I'll let -- I'll let Tom speak to that as well. It encompasses, you know, both the combining the efforts both Anthem and Cigna have been out there in the marketplace primarily in the form of volume-to-value arrangements. In the case of Anthem approximately over $50 billion of our reimbursements is now tied to the value of quality. Cigna has experienced an uptick in their quality based payments, but also in the our direct programs and whether that's disease management programs, chronic condition programs, including new initiatives that we've undertaken that show specific value returns.

In the instance of Anthem, enhanced personal health care is a program that we ruled out with primary health care physicians, which allows primary care

MR. WAGNER: Okay. We can make that calculation.

COMMISSIONER JONES: I appreciate it very much. Getting back to one of the synergies that you identified in the prior slide, one of those is network efficiencies in medical management. Can you share with us what is intended by network efficiencies in medical management specifically?

MR. WAGNER: There are few different elements of that, and I'll let -- I'll let Tom speak to that as well. It encompasses, you know, both the combining the efforts both Anthem and Cigna have been out there in the marketplace primarily in the form of volume-to-value arrangements. In the case of Anthem approximately over $50 billion of our reimbursements is now tied to the value of quality. Cigna has experienced an uptick in their quality based payments, but also in the our direct programs and whether that's disease management programs, chronic condition programs, including new initiatives that we've undertaken that show specific value returns.

In the instance of Anthem, enhanced personal health care is a program that we ruled out with primary health care physicians, which allows primary care
physicians to share in the upside of a more holistic approach to patient care.

In the instance of Cigna you have collaborative accountability care programs, they ruled out, which has more to do with continuity of care. In both cases there is outcome consumer centric, technology solutions that each company is using that we think we can improve upon and engage consumers as well data analytic providers that will bring down the cost of care. There is a lot of that.

MR. RICHARDS: Let me just add.

COMMISSIONER JONES: Please.

MR. RICHARDS: To Mr. Wagner's comments.

Cigna is very committed to 5098, which is a goal HSS sent out early last year, and --

COMMISSIONER JONES: For Medicare advantage.

Pardon me. Right.

MR. RICHARDS: Well the HHS goal was actually for all of Medicare. Our goal is for all of -- all of Cigna's population. So certainly including Medicare Advantage across our population to have at least 90 percent of our -- of our arrangements in some sort of payment value to -- to the delivery system and 50 percent -- at least 50 percent to be alternative payment mechanisms, and again, we truly believe in the combined company will truly believe that moving the delivery system to rewarding providers for doing the right thing for improving health, for making sure the care is provided at the right level, both enough, but not over treatment, and at the right service is going to deliver both higher quality care and more efficient care and more importantly, or as importantly, better health to the population.

COMMISSIONER JONES: So, with regard to what you, both, have said regarding value-based approaches, is that an exhaustive list of the value-based approaches that the companies are contemplating?

MR. RICHARDS: No. It's a space that's, you know, rapidly evolving. I don't know that anyone has unlocked the exact secret codes. There is a lot of experimentation going on. The experimentation in the ability to partner varies very much by geography and by provider group. For instance, there is a lot of experimentation going on in California, and one of the advantages for having the companies combined is we truly believe we'll be able to take the best capabilities from both organizations and to deliver those to our provider partners.

COMMISSIONER JONES: So, with regard to the current value-based approaches and the ones that are anticipated. I understand you can't totally see the future, but the ones you currently are anticipating, can you get me a list of those? Because it's a term that's used quite a bit in the testimony of officials from both companies. There is some variability in how each company is currently engaged in these approaches, and I would be interested in a list of what these value-based approaches are from each company currently, and then what they anticipated the merged company will be pursuing in terms of these approaches.

MR. WAGNER: Yeah, I think we can put that together. The way to think of this is many respects is you had asked about sort of is than an exhaustive list or what does this represent? And I think there is a spectrum of shared risks that providers are willing to engage in. I talked about the Vivity example where we have joined with seven health systems to provide products in the L.A. area. So that's, you know, that's sort of the, you know, all the way through to an equity arrangement with provider sharing both upside and downside risk to arrangements with some amount of upside risk where the providers can see the benefit of delivering high quality health care to patients and reducing the overall cost of health care to the system, as well as improvement quality as well as the consumer satisfaction of those interactions.

COMMISSIONER JONES: Mr. Wagner, you said current Anthem has $50 billion in reimbursements tied to value-based contracts. What percentage of your overall annual reimbursements does that represent?

MR. WAGNER: 53 percent maybe.

COMMISSIONER JONES: And that's nationwide.

MR. WAGNER: Yes.

COMMISSIONER JONES: And with regard to Cigna, what percentage of your overall national medical reimbursements do your current value-base approaches represent?

MR. RICHARDS: I don't know the number off the top of my head, but we can get that number to you.

COMMISSIONER JONES: I'm interested in the dollar figure, the percentage and then the total annual medical reimbursement figure for each company. If I could have those three figures for each company, that would be greatly appreciated.

MR. RICHARDS: Sure.

COMMISSIONER JONES: Thank you.

Specifically, in the Cigna health care filing with DMHC, there is a reference to an indemnity managed care product, and I'm curious about that, and I'm wondering if Mr. Richards can shed any light on what an
1. indemnity managed care product is. It's included in
2. Exhibit 11 in the binder in front of you. It's a part
3. of the Cigna health care notice of modification filing.
4. It says that CHCC also subcontracts with affiliates
5. Connecticut General Life Insurance Company and Cigna
6. Health and Life Insurance Company in connection with its
7. indemnity based manage care product called Flex Care.
8. MR. RICHARDS: That refers to our point of
9. service plan which, as you mentioned, is often branded
10. Flex Care.
11. COMMISSIONER JONES: So can you elaborate a
12. little more on how that plan actually works, functions?
13. MR. RICHARDS: From a provider standpoint we
14. have a network in California, and actually, a national
15. network. Customers can choose at the point of care
16. whether they want to stay in network and provide -- and
17. receive both the network discounts and the higher
18. reimbursement rate or if they want to go outside. So, it's somewhat similar to a PPO, which you would be maybe
19. a little more familiar to Californians or to others
20. around the U.S., but it provides a little bit more of a
21. managed care structure to a then PPO. So, for instance, it would typically have a primary care physician plan, which PPOs do not necessarily have, and the reason we did that was because we believe that a primary care
22. physician or having a primary care physician helps to
23. guide the patient to get the right care from the right
24. specialists.
25. COMMISSIONER JONES: Question, Mr. Wagner.
26. Both Anthem and Cigna have said that they are currently
27. pursuing and have as a goal currently to pursue an
28. expansion in value based approaches. Why is a merger
29. necessary then to accomplish value-based approaches to
30. health care?
31. MR. WAGNER: Well, we see -- I mean, the
32. transaction in many respects we believe is
33. transformative because of the complementary nature of
34. the companies. Because we are approaching it in different ways, we think that we can accelerate the
35. approach to value-based care using best practices of both companies in a way that we haven't been able to do, quite frankly, on our own.
36. COMMISSIONER JONES: So you are doing it
37. currently and you have told your investors and
38. shareholders you are committed to doing it, and that it's been successful, but you still need to merge in order to make it successful.
39. MR. RICHARDS: To accelerate it and to provide
40. it over a wider sloth of our partner's patient panels.
41. So if you look at the companies, we're
42. actually complementary in California and really around
43. the country. Cigna has a very small percentage of
44. individual based.
45. We're not, for instance, in covered California
46. and, obviously, Anthem has a very strong individual
47. footprint in the 14 states in which they have a blue
48. license. Cigna doesn't really market small group
49. insurance. We tend to have more larger employers, self
50. funded and a lot of specialty programs. So behavior
51. programs. And so as we're successful in partnering with
52. on the delivery system with physicians and hospitals and are able to work with them and experiment with them to provide value-based programs that truly work that do improve the population, our hypothesis is among others, they are going to do want to do that with not only segments of the patient population, but they want to do that across, again, their entire patient population. So that's one reason why it's helpful.
53. Again, the other is I would say the companies have very different just capabilities, not just geographic and product differences, but capabilities and combining those capabilities. We think we are really going to be a better partner and much more adaptive at accelerating this transition.
54. COMMISSIONER JONES: So let's go back to
55. network efficiencies for a moment. So with regard to
56. that particular synergies you have described the
57. component of that that's related to value-based care,
58. but, after the merger will the Cigna and Aetna entities continue to have separate and distinct provider networks?
59. MR. WAGNER: They will to the extent they're
60. associated with the products. What we hope is that providers will adopt the best practices and value-based contracting that will benefit both Cigna and Anthem products in the future.
61. What we're really trying to accomplish is accelerating the adoption of these value-based approaches to increase the quality, to increase the accessibility, and certainly the affordability of the products. So, the networks, themselves, are not definition of is it an Anthem network or a Cigna network not quite as important as the relationships with the providers we hope will move in the same direction to value-based contracting.
62. COMMISSIONER JONES: So if they do so move, then the networks are no longer be distinct of each entity, they'll be merged in some way?
63. MR. WAGNER: There certainly will be overlap
64. of the networks amongst the providers.
COMMISSIONER JONES: But, if they embrace the value-based approach, which you are encouraging them or maybe requiring them to embrace, will that then result in the sensation of separate and distinct networks for the Cigna entities and for the Anthem entities?

MR. WAGNER: No, I don't think so.

COMMISSIONER JONES: And then you mentioned that there might -- that there would continue to be overlap in the medical provider networks of the entities then?

MR. WAGNER: Well, just as there are today, there are many providers that both companies contract with. So that's why common and overlap.

COMMISSIONER JONES: What I'm struggling with is I understand the point about value based, but it's hard to imagine that ultimately the networks for each entity won't be combined in some way, or reduced in size.

Am I mistaken?

MR. WAGNER: I think so to the extent that -- I mean, we're talking about different products in large part. What happens in California as far as you know, Anthem being involved in Medicare, Medicaid, small group, individual, etcetera, all those are different network arrangements with providers whereas the Cigna products in the State of California are associated with more the large groups.

COMMISSIONER JONES: But, didn't you just say that you're trying to move all the entities under the merger to a value-based approach that's uniform across the merged entity? You won't have these differences in approach --

MR. WAGNER: Not necessarily uniform across the entities, but something to the value-based approaches for the providers; that's correct.

COMMISSIONER JONES: And so those approaches will still differ based on the nature of the product or the market that that product is being sold into?

MR. WAGNER: Yes. Yes.

COMMISSIONER JONES: Now, you have also both said as a result of the merger, that the combined entities will have a premier network of hospitals and networks. Don't you already have that?

MR. WAGNER: Speaking -- you know, we've have a great network obviously. Ours is very broad based network in the State of California, as well as our other states where we have commercial products.

I think what we intended by the term that -- the use of that term is that we anticipate that, again, bringing the best of the companies to bear will ensure that we get the highest quality providers that each company is using.

COMMISSIONER JONES: Is any change anticipated in the number of providers that will be contracted with the merged entity versus the number of providers that currently contracted with each entity?

MR. WAGNER: We would anticipate that it will expand.

COMMISSIONER JONES: So you will be adding providers?

MR. WAGNER: That's correct.

COMMISSIONER JONES: Any particular providers?

MR. RICHARDS: Particularly to Cigna. Anthem tends to have more providers in the rural areas, so this potentially would allow us to expand some of the customers that we are able to service more completely.

MR. WAGNER: A little bit early in our integration to get specific on that, but I think that would be the case, although, again, we tend to contract with a lot of hospitals already. I think it might be more relevant to the position than the other health care selling health insurance in California?

MR. WAGNER: Particularly to Cigna. Anthem will continue after the merger add additional physician group contracts?

MR. RICHARDS: Yeah. Yes. Physician would agree with you.

COMMISSIONER JONES: So will the merged entity ensure that we get the highest quality providers that each company will be adding those?

MR. WAGNER: I think so. As Tom has spoken, I think from the Cigna perspective, that is certainly anticipated.

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MR. RICHARDS: From a network standpoint that would be.

MR. WAGNER: Not as a result of the transaction. The providers are in or out.

COMMISSIONER JONES: Will it be resolved by then, networks moving in and out, themselves?

MR. RICHARDS: Correct.

COMMISSIONER JONES: All right. Let me turn now to a particular market segment, and that’s the administrative services organization or ASO segment. I want to draw your attention in particular to a pie chart that is one which was constructed by the California Health Care Foundation, and I believe it’s at Exhibit 8 in the binder.

MR. HINZE: 72.

COMMISSIONER JONES: I’m told it’s on page 72.

So if you look at the pie chart of the six pies that are on this slide, the one that is at the lower right, which represents the ASO market, do you have that? You may have something different than what I have. Oh, no. You’ve got it. Right there.

Okay. Do you see what I’m talking about?

MR. RICHARDS: Yes.

COMMISSIONER JONES: It’s a yes from both gentlemen?

MR. WAGNER: Yes.

COMMISSIONER JONES: That indicates that there are roughly 6.4 million lives in California covered in the ASO market. That pie graph also indicates that Anthem Blue Cross has 37 percent of that market, and Cigna has 24 percent, and so taken together, the two companies would have 61 percent of the ASO market.

Won’t that represent the combined having more than half of the overall ASO market?

MR. WAGNER: Just looking at the pie chart, it does. I’m not sure about the sources of the figures. I think our figures might have been a little different from that, but more broadly if you look at the ASO it’s large employers, who tend to be very sophisticated who work with consultants who are in turn also sophisticated, and it’s a very competitive marketplace. So certainly the provider or the carriers or insurance companies are on this page on this pie chart participate in that market, but in addition, you have third-party administrators that participate in the ASO market, and again, there are lots of them, and you have provider based plans that are increasingly entering the market as well so. It’s a very sophisticated marketplace and a very competitive marketplace.

COMMISSIONER JONES: But, your nearest competitor would only have 13 percent of the market?

MR. RICHARDS: Commissioner, with all due respect, I can’t respond to the numbers. They’re a little bit inconsistent from what I would have expected, and beyond that, they are incomplete because of the fact that you have TPAs and others that are not publicly reporting their memberships.

COMMISSIONER JONES: So, you mentioned that in your testimony the TPAs are not required to report.

But, you have some of that information for areas where you subsidiaries of your respective companies serve as a TPA, correct?

MR. RICHARDS: So where we serve as a TPA, those would be in these numbers here. As you mentioned earlier, in your questioning, we also do provide network and health care services to competitors to other TPAs.

COMMISSIONER JONES: So, can each of you provide me with what you believe to be are the most accurate numbers with regard to the entirety of the ASO market?

MR. WAGNER: So the ASO market is particularly problematic for just that reason that Tom stated to the extent that TPAs are involved in the western states of over 800 TPAs operating. 19 or 20 of the leading TPAs are actually based here out of California. In addition, I have the lower right, which represents the ASO market, do you have that? You may have something different than what I have. Oh, no. You’ve got it. Right there.

Okay. Do you see what I’m talking about?

MR. RICHARDS: Yes.

COMMISSIONER JONES: It’s a yes from both gentlemen?

MR. WAGNER: Yes.

COMMISSIONER JONES: That indicates that there are roughly 6.4 million lives in California covered in the ASO market. That pie graph also indicates that Anthem Blue Cross has 37 percent of that market, and Cigna has 24 percent, and so taken together, the two companies would have 61 percent of the ASO market.

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MR. RICHARDS: Yes.

COMMISSIONER JONES: It’s a yes from both gentlemen?
That's why we don't really know the total market is for
ASO. We know what our customers are for sure.

COMMISSIONER JONES: So I would like to ask
each of you to provide me with your company's best
estimates of the overall market in this area based on
whatever information you have available, because if
you're disputing the -- which I believe you are -- the
completeness of the information provided here, I would
like to know what your best estimate is of the overall
market and your share of that overall market.

MR. WAGNER: Okay.

COMMISSIONER JONES: Would that be agreeable
to you also, Mr. Wagner?

MR. WAGNER: Yes, to the best we can estimate.

COMMISSIONER JONES: I understand. I mean,
but the assertion you're both making is that we
shouldn't worry about the ASO market. I have evidence
in front of me that makes me very concerned about the
ASO market. You're questioning the sufficiency of that
evidence, so I would like whatever you have got.

MR. WAGNER: Yes, certainly. That's talking
about the numbers, but as Tom indicated, the ASO market
is particularly unique in that these are very large
sophisticated employers losing an account or gaining an
account can switch these shares around fairly
dramatically on awards and losses.

Additionally, you know, large brokers
typically facilitate these procurements. Large brokers
themselves offer products in the form of private
exchanges, etcetera. Private exchanges are growing from
the 3 million members, you know, a year ago, to as many
as 40 million members in 2018. So we're seeing a lot of
shifts, but the competitors are there, and in the
California marketplace the group wants to make a big
shift of membership, they have numerous options
including United, Aetna, Kaiser, Health Net, local
regional players, including Sutter. Blue Shields is
also a large one.

COMMISSIONER JONES: But, certainly both
companies must have some estimate of what the share is
of all of those players in the market.

MR. WAGNER: As I said, we'll give our best
estimate we can. Yes.

COMMISSIONER JONES: Thank you.

Let me turn now to one of the other asserted
benefits of the merger, which is affordability. This
question is for Mr. Wagner.

Does the combined entity and its Anthem and
Cigna subsidiaries anticipate that after the merger
rates in any of the market segments these entities are
selling will go down for the products that these
entities are selling?

MR. WAGNER: That's always potential. I mean,
what we're -- you know, the aim obviously is to
increase. We want to bend the cost. So that's bending
it against an increase in medical costs, or keeping
that -- keeping it flat, or actually, reducing. It
depends on the marketplace and underlying costs.

Premiums, and premium increases are, you know, generally
97 percent of premium increases are associated with the
underlying medical costs. So, trying to bend that cost
curve and control those costs is absolutely essential in
keeping premiums down and keeping them down.

COMMISSIONER JONES: Are there any specific
products sold by any of the entities that will survive
after the merger that are selling in California for
which it's anticipated that the premium will go down in
price?

MR. WAGNER: I can't say that we've had that
degree of detail and prognostication into the ability to
bring the down in any one particular market segment or
not.

COMMISSIONER JONES: Not one?

MR. WAGNER: That's always potential. I mean,

MR. WAGNER: There are always going to be
sophisticated employers losing an account or gaining an
account can switch these shares around fairly
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COMMISSIONER JONES: So, can you provide any
evidence, or that -- keeping it flat, or actually, reducing.
It does obviously bend the cost curve. We would assume
that that would benefit across all product categories.
So, to the extent it does, it will differ from product
to product.

COMMISSIONER JONES: So, can you provide any
enforceable commitment that at least prices for all of
these products sold by all of the entities after the
merger will not increase?

MR. WAGNER: No, I would not -- I would say
that, again, with the underlying medical costs
comprising 90 percent of the premium increases, we don't
have a large amount of control over -- over trying to
get them flat or decreasing. That's why we're trying to
influence a true value based contract to the best of our
ability.

COMMISSIONER JONES: Is there any products
sold by any of the entities that will survive after the
merger that is selling health insurance in the State of
California for which you can provide an enforceable
guarantee a cost will not go up? Any product?

MR. WAGNER: No, I can't commit to that.

MR. RICHARDS: We would need a, you know,
guaranteed commitment from our provider partners in
order to do that. I don't know that we have those in
terms of multi-year guarantees in the system to be able
do that this morning.
Again, what we're trying to do with value-based care is really change the dynamic going forward so that we are taking efficiencies out of the system while reducing unnecessary medical costs, reducing drug spend, increasing drug costs and services that are needed for things like product conditions, so we can actually improve the health of participants, but it is not easy. This transition to value-based care, while both companies are very committed to it, and I would say most of the delivery system partners that we deal with are committed to it. It's not easy and it's going to take all of us together sometime to figure out a better mouse trap to improve care, improve health and enforce affordability.

I would suspect that the delivery system partners we have would similarly struggle to provide a guarantee that they're going to reduce their rates for the next several years, which, again, as Jay just said, compose about 97 percent of the increases as we're dealing with. It's really got to be a partnership of the payors and the delivery system working together to find a better way to take unnecessary costs out of the system and put back in unnecessary costs that are going to improve the health of Californians.

COMMISSIONER JONES: So none of you can provide any assurance, that any of the health insurance products sold by any of the entities that will continue selling after the merger will not increase in price, but at the same time, you're both very confident that there's going to be 2 billion in savings. So am I to understand from that, that none of that savings will go to the benefit of consumers in either maintaining or reducing the price of insurance that they're paying for from any of the merged entities?

MR. WAGNER: Correct. No, we cannot give you any assurance, that any of the synergies. I would like you also provide me, please, with an allocation of the $2 billion between policyholders and shareholders of the company.

MR. WAGNER: If we can split that out.

COMMISSIONER JONES: I appreciate that --

MR. WAGNER: -- and supply that.

COMMISSIONER JONES: And finally, in the past, Anthem has implemented rate increases that the Department of Insurance's actuaries determined to be excessive or unreasonable.

Department of Insurance's actuaries determined to be excessive or unreasonable.

Can you, Mr. Wagner, provide me with an enforceable guarantee that where either the Department of Managed Health Care or the Department of Insurance determines that a rate increase is excessive or unreasonable under our statutory rate review process that the merged entities will refrain from imposing that rate increase going forward?

MR. WAGNER: No, I cannot provide that guarantee. The rate review process is very transparent and robust. We hope that to the extent that there are any considered unreasonable, that that's very limited circumstance, and we believe that's becoming more so as we proceed.

COMMISSIONER JONES: Why don't we take a break at this time.
It's now 2:30, and what I would like to propose we do is to take a ten-minute break and then reconvene at 2:40 and we'll move to the next panel.

Gentlemen, thank you very, very much. I appreciate it. I would like to ask you if you could, as we did when we briefed you about the hearing, if you could remain for the duration of the hearing in the event that there are other questions that occur as a result of other panels or the public testimony. I do appreciate your attendance today and your participation in the hearing.

Thank you very much.

MR. WAGNER: Thank you, Commissioner.

COMMISSIONER JONES: So we'll take a ten-minute break.

(Whereupon, a break was taken from 2:27 p.m. to 2:42 p.m.)

COMMISSIONER JONES: We'll now resume the public hearing and our next panel will be a presentation by Professor Brent Fulton, who is with University of California, Berkeley who will be making a presentation based on an analysis that's been done with regard to the impacts on competition of the proposed merger. Before we get to that, though, I do want to note that we had anticipated in this panel also to have a presentation from the California Department of Insurance with regard to information related to the company's market conduct examinations of the Anthem and Cigna companies that are under the jurisdiction of the Department of Insurance, and in particular, information about the results of those market conduct exams over the last three or four years as it relates to compliance of any of the companies with the insurance codes requirements for claims handling. We're going to forgo that in the interest of time, but we will make available, both, on our Website to the public and to the companies a written summation of those results, and we do want to provide the companies an opportunity to respond to that if they see fit to do so, because they'll be seeing this -- they'll have seen the market conduct reports and exams previously, but they won't see this compilation of the information until we present it to them, and we'll make it available to the public as well if the public wishes to comment on it.

I'll talk off line with the companies as to how much time they'll need to respond to it. I want to give them as much time as they need to respond to it, but we'll forgo having testimony about that in the interest of time.

So, with that commercial, let me turn the

floor over to Dr. Fulton.

Welcome.

BRENT FULTON

DR. FULTON: Thank you.

Well, good afternoon, Commissioner Jones, and Deputy Commissioner Rocco and other members of your staff. Thank you for inviting us to testify today.

As you know, the Department of Insurance requested the Nicholas C. Petris Center on health care markets and consumer welfare, which is located in the school of public health at U.C. Berkeley.

requested the Nicholas C. Petris Center on health care markets and consumer welfare, which is located in the school of public health at the University of California, Berkeley to provide testimony on Anthem's proposed acquisition of Cigna.

My name is Brent Fulton. I'm the associate director of the Petris Center, and I'm an assistant adjunct professor of health economics and policy in the school of public health at U.C. Berkeley. This testimony is co-authored by two other individuals who are here with me in the audience, including Richard Scheffler, who is both director of the Petris Center, and a distinct professor of health, economics and public policy in the school of public health and the gold man on Anthem’s proposed acquisition of Cigna on health insurer market concentration for major health insurance primarily managed care, Try Care beneficiaries all within California. However, we are not taking a position on whether the proposed acquisition should be approved, nor the conditions thereof by state and Federal agencies with that authority. Therefore, our goal is to provide independent evidence and analysis to aid those agencies within that decision authority.

The following ten points are a summary of our testimony and main findings. We have submitted our full testimony, which includes a summary to the California Department of Insurance, and in particular, independent evidence and analysis to aid those agencies in their determination of whether the proposed acquisition should be approved, nor the conditions thereof by state and Federal agencies with that authority. Therefore, our goal is to provide independent evidence and analysis to aid those agencies within that decision authority.

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Point Number 1. Anthem is a publicly traded health benefits company headquartered in Indianapolis, Indiana with approximately 53,000 employees and 39 million medical members in the United States. Its 2015 revenue was 79.2 billion with net income of $2.6 billion. Anthem's principal interest is health insurance in managed care and it is an independent licensee of the Blue Cross, Blue Shield Association. Under that license trade name it has affiliates in 14 states, including Anthem Blue Cross, and related subsidiary in California. Formally, Anthem used the name Wild Point in some states, including California, and they changed its corporate name to Anthem in December 2013.

Point Number 2. Cigna Corporation is a publicly traded health services organization headquartered in Bloomfield, Connecticut with approximately 39,000 employees, and 15 million medical members in the United States. Its 2013 revenue was $2.6 billion. Cigna's principal business is health insurance and managed care. It operates the following subsidiaries in California: Care of California and Cigna Dental Health of California. Cigna Health Care of California Cigna Behavioral Health

Care of California and Cigna Dental Health of California.

Point Number 3. Anthem and Cigna are two of the largest five health insurers in the United States. On July 23, 2015, Anthem filed its intention to acquire Cigna via Anthem merger sub-corp, a directly wholly owned subsidiary of Anthem.

For this testimony we have the following four objectives. First, we briefly summarize the published evidence of the impact of health insurance mergers and market concentration on health insurance premiums. Second, we will describe our enrollment data and our methods to estimate market concentration. Third, we will present Anthem's and Cigna's enrollment in shares in California by line of business and product. This is done for descriptive purposes because the state is not a single market in an economic or antitrust sense. Fourth, we will provide empirical evidence on how the proposed Anthem-Cigna merger will affect health insurance market concentration at the county level, the geographical level of which most competition occurs. Within California with respect to insurers selling health insurance as well with respect to insurers buying health care services from hospitals, physician organizations and other providers. Points Number 5 through 10 summarize these findings in our results from those four objectives.

Medical Association in its annual analysis of competition in health insurance markets. Point Number 7. In California there are 32.6 million enrollees with major health insurance. Primarily, furnished via managed care in the health leaders interstudy a decision resources group company. Health leaders interstudy primarily collects enrollment data by surveying health insurance, and when necessary, supplemented survey-based data with secondary sources, such as, insurer websites, state websites, and health insurer filings to the National Association of Insurance Commissioners. This data has been used in peer review studies on health insurer concentration and is also used by the American Medical Association in its annual analysis of competition in health insurance markets. Point Number 8. Although the entire state is not a single market in an economic or antitrust sense, we report Anthem and Cigna state enrollment for descriptive purposes. Of California's 32.6 million enrollees Anthem has 6 million enrollees with a market share of 8 -- 18.5 percent. Its share is highest for employer-sponsored market as well as the individual market outside of covered California. Within these markets, its share is for -- is 46.2 percent for PPOs; 37.0 percent for POS or point of service plans, and is 37.0 percent for POS or point of service plans, and is 37.0 percent for POS or point of service plans, and is 37.0 percent for POS or point of service plans, and is 37.0 percent for POS or point of service plans.
those lines of business when the product market includes a collection of PPOs, EPOs, point of service plans and HMO products.

So for this collection of products in these lines of business, we found that 18 of California’s 58 counties warrant the highest concern and scrutiny under the federal horizontal merger guidelines, and this is a combination of these counties post merger insurer Herfindahl-Hirschman Index being greater than 200 and the change in the HHI being greater than 200 as a result of the merger. This is detailed in table A-1 in the appendix. This highest concern in scrutiny is also warranted in these lines of business in 41 counties when the product market only includes PPOs, EPOs and point of service products. This is detailed in table A-2 in the appendix. The highest concern in scrutiny is also awarded in these lines of business in 46 counties when the product market only includes PPOs and EPOs, and again, this information is detailed in table A-3 in the appendix.

Now, turning to analyzing insurers as buyers of health care services from hospitals, physician organizations and other providers, then the product market includes all lines of business to cross all products.

1. In this situation, the highest concern and scrutiny is warranted in four counties. However, the post merger HHI for the median county is still considered to be highly concentrated with an HHI of 2,732. You can see table A-4 in the appendix for more detail. The summary statistics for A-1 through A-4 in the appendix are included in A in table 2 of the testimony. It summarizes the key summary statistics of those tables in the appendix.

1. Although certain counties warrant the highest concern and scrutiny for particular product definitions, the federal horizontal merger guidelines thresholds do not represent a rigid test to identify competitively benign from anti-competitive mergers. Instead, they provide a way to identify mergers when it is important to examine other competitive factors that may influence the potentially harmful impact of increased competition, such as, the ease of entry, the significant merger specific efficiencies and the presence of powerful buyers.

My last point, Point Number 10. In summary, our results provide an important initial barometer that shows where additional scrutiny may be warranted to employ more sensitive models with more robust data to better understand the proposed mergers impact on competition.

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market as defined by all these products, but look more
at a granular level at the competition that occurs or is
lost with regard to a particular narrower set of
products. For example in this case, just the PPO and
EPO products. Is that a fair -- is that a fair
characterization of the rationale behind the analysis?
DR. FULTON: Yes: that is a fair
characterization that the product market the information
that you would need to define it in very granular
detail, we didn't have, and so we thought it was
important to do this analysis showing what we think is a
fair representation of what the product markets might
look like, and we think, our table A-3, which is the PPO
and EPO market by itself is -- is the narrowest market
that we analyzed, and the reason we did that you
referred to what is the substitutability of let's say
PPOs if prices were to go up with the PPOs and the EPOs,
would people transfer over to point of service plans or
HMOs? So there was a study in 2002 by Jean Abraham,
William Vogue and Martin Gaynor. This was published in
September 2002 by the National Bureau of Economic
Research as a working paper and it found relatively low
cross price elasticities and so to describe what I mean
by that, if the price of a PPO product meaning the
insurance premium being the price, if it went up by ten
percent, the demand for HMO products somewhat a
substitute would only go up by about one to two percent.
COMMISSIONER JONES: So it's fair to say that
in lay person's language, that there is not a lot of
movement between the products even -- even if pricing
one product goes up.
DR. FULTON: That's correct. These cross
prices elasticities are fairly low.
COMMISSIONER JONES: And from a regulatory
standpoint, we, at the Department of Insurance, and our
colleagues, the Department of Health Care, do look at
each of these markets separately. We also look at them
together, but I think it's most helpful that you have
done the analysis, if you will look -- defining the
market as including all these products, but then also
providing more, if you will, products specific analysis
because I think that is consistent with how many people
operate in the real world. Some people in families want
a PPO and EPO product. Others are more comfortable with
HMO maybe a little bit of a movement between, but I
think the study you referred to indicates that there is,
as you said, in economic terms not a lot of
cross-elasticity between the various product types.
Now, I want to drill a little deeper though
and that is even if the market is defined as including
as populous as Orange County, Los Angeles County, San Francisco County, San Diego County, just about every county you can imagine. So, I also note that with regard to your more granular analysis where the definition of the market, if you will, is looking at particular products that there is also a number of counties that fall into the moderate category as well, and I'm wondering if you could just quickly confirm what that number is for each of those additional definitions of the market, if you will.

DR. FULTON: Sure. I'm going to refer to table 2 in the testimony. It's found on page 19, and so the tables is laid out with a four scenarios of lines of business and the products that are included, and they respectively refer to tables A-1, A-2, A-3 and 84. And so, as I noted in the testimony, if the product market is defined as PPOs, EPOs, point of service plans and HMOs, within the employer-sponsored market and the individual market outside of covered California, then the highest scrutiny is for 18 counties and moderate scrutiny is for 31 and the lowest scrutiny is for nine.

If I switched to the second scenario by dropping HMOs out of the first scenario, the number of counties increase warrant the highest scrutiny increase is 41, 14, with moderate scrutiny, and three warrant the lowest scrutiny, and then if we isolate PPOs and EPOs within the employer-sponsored market and the products that are included, and they are generally available. It's not an exhibit currently, but we will make it available on our website. I'm wondering if you are generally familiar with her work, her research and I hope you will be able to stay with us a considerable in making our decision.

DR. FULTON: Yes, I am.

COMMISSIONER JONES: So one of the points she makes in her testimony to the United States Senate is that -- I want to quote it -- "If past is prolog contrary, consumers can expect higher insurance premiums."

DR. FULTON: Table A-3.

COMMISSIONER JONES: A-3, also includes... the testimony of Professor Lemore Daphney, who is the president of the California Medical Association, and the general counsel and senior vice president of the California Medical Association, and also, a representative from the American Medical Association, Mr. Henry Allen.

Herman Smith research professor in health services at the Cal Ex School of Management. She had occasion to testify before the Senate Committee on the judiciary subcommittee on antitrust, competition policy consumer rights on September 22nd, 2015, and that testimony is, I believe, an exhibit. If it's not, we'll make it generally available. It's an exhibit currently, but we will make it available on our website. I'm wondering if you generally familiar with her work, her research and her analysis.

DR. FULTON: That's correct there is no guarantee.

COMMISSIONER JONES: Okay. Thank you. I don't have any questions. I really appreciate the thoroughness, once again, of the Petris Center's research and her analysis.

DR. FULTON: Thank you as well.

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Mr. Commissioner, for the opportunity to provide our perspective on the proposed merger. CMA and AMA have long been concerned with the consolidation of the insurance marketplace and the impact it has on physicians and their patients.

Mr. Commissioner, I want to get your cards to the reporter, and we’ll need you to turn your microphone on.

Mr. Silva, And thank you again.

We’re concerned that this proposed merger will impact patients in the terms of health care access, quality and affordability, and for those reasons we urge that the proposed merger will.

Mr. Commissioner Jones, I was able to hear you through earlier, but thank you and, at the close we want to get your cards to the reporter and we’ll need them.

Mr. Silva, Is my microphone on? There we go.

My name is Francisco Silva. I’m the general counsel for the AMA. And thank you again.

Cigna is convinced that an Anthem and Cigna merger would result in less competitive pressure on all enrollees to respond to patient’s access needs. Enrollees’ access to providers would significantly reduce economic pressure on the combined company to reduce costs.

21.0

Cigna is convinced that an Anthem and Cigna merger would result in less competitive pressure on all enrollees to respond to patient’s access needs. Enrollees’ access to providers would significantly reduce economic pressure on the combined company to reduce costs.

Mr. Commissioner Jones, I was able to hear you through earlier, but thank you and, at the close we want to get your cards to the reporter and we’ll need them.

Mr. Silva, And thank you again.

We’re concerned that this proposed merger will impact patients in the terms of health care access, quality and affordability, and for those reasons we urge that the proposed merger will.

Mr. Commissioner Jones, I was able to hear you through earlier, but thank you and, at the close we want to get your cards to the reporter and we’ll need them.

Mr. Silva, Is my microphone on? There we go.

My name is Francisco Silva. I’m the general counsel for the AMA. And thank you again.
MR. ALLEN: Thank you, Commissioner Jones. My name is Henry Allen. I'm an advocacy attorney at the American Medical Association working on antitrust matters in health care and in the insurance markets. I am here today speaking on behalf of the AMA and our physician and student members. The AMA has analyzed the likely competitive affects of the proposed Anthem merger with Cigna, both, in the sell side market for the sale of health insurance, and in the buy side market where health insurers purchase physician services.

We have concluded that this merger will likely impair affordability and quality in the sell side market for health insurance. On the buy side, the merger will deprive physicians of the ability to negotiate competitive health insurer contract terms. The result will be detrimental to consumers, and here, Commissioner Jones, let me repeat what Professor Daphney, now Harvard has -- she's moving to Harvard this fall.

COMMISSIONER JONES: We won't hold that against her.

MR. ALLEN: But she says that you have quoted, "If past is prolonged insurance consolidation will tend to lead to lower payments to health care providers, but those lower payments will not be passed on to consumers.

Unfortunately, many highly populated markets for commercial health insurance in California are highly concentrated, and this proposed merger would make matters much worse.

The AMA has analyzed data from health leaders and we ask that Anthem's application to merge with Cigna be denied. Competition is likely to be greatest when there are many sellers, none of which have any significant market share.

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 insurers brand recognition. The blues brand possessed
incumbent insurers with significant business. Hence,
providers usually offer the best discount to
achieved by obtaining discounts from providers.

However, providers usually offer the best discount to
incumbent insurers with significant business. Hence,
incumbent insurers have a durable cost advantage. The
second most significant barrier is the incumbent
insurers brand recognition. The blues brand possessed
by Anthem is the most powerful. This was well

demonstrated in the 2008 hearings before the
Pennsylvania Insurance Department on the competition
ramifications of the proposed merger between high
marketing and independent Blue Cross in Pennsylvania.
A report commissioned by the Pennsylvania
Insurance Department included that the strength of the
blue brand made it unlikely that any competitor would be
able to step into the market and replace a loss in
competition caused by the merger.

Recent developments only highlight the barrier
to entry problem. 12 of the 23 nonprofit insurance
corporations, which were intended to inject competition
into health insurance markets have failed. The quick
death of these co-ops illustrate that even with heavy
federal subsidies, health insurance is a tough business
to enter. One of the most important implications of the
barriers to entry that persist with the advent of the
marketplaces is the need to preserve the potential
competition that would be lost if an incumbent insurer
is acquired. Thus, when one of the two largest
commercial insurers in the state, Anthem, acquires the
sixth largest, Cigna, the highly concentrated geographic
markets where Anthem faces little competition are
deprieved of one of their most likely entrance, Cigna.

is inconsequential because new firms could easily enter
the market and compete on a scale sufficient to restrain
any post-merger exercise of market power. There is no
credible evidence to support such a story.

AMA market analysis shows that competition
lost in the merger is likely to be permanent and
acquired health insurance market power would be durable.

In the numerous highly populated MSAs where the merger
would be anti-competitive, the market shares, ranking of
market leaders and number of competitors have been
little changed from 2010 through 2013, the most recent
time frame for which we have data. This is because
barriers to entry in health insurance prevent new
entrance from restoring competitive prices. Perhaps a greatest obstacle is the so called
chicken and egg problem of health insurer market entry. Health insurer entrance need to attract

Anthem has had a long history of not hesitating to
oppose to greater efficiencies or lower health care
costs. These studies are discussed in the materials we
are submitting on Friday. Given the research findings
there can be little doubt that an Anthem-Cigna merger
would produce the higher premiums predicted by the
market concentrations and their merger-induced increase.
Anthem has had a long history of not hesitating to
increased premiums to levels that the California
Department of Insurance has found unjustified.
Plan quality. The competitive mechanisms

linking diminished competition to higher prices operates
in these markets, it is prima facia and competitive in

The foreclosure of its future market role
serves to lessen competition. Professor Daphney
expressed concern about this loss of potential
competition in her Senate testimony. Quote.

Consolidation even in nonoverlapping markets reduces
the number of potential entrance who might attempt to
overcome price fixing or quality reducing consolidation
and markets where they do not currently operate."

All right. Let’s turn to the likely
anti-competitive events. First, price increases. So
what will be the likely health insurer price and quality
affects of this merger if it is approved? A growing
body of peer review literature suggests that health
insurer consolidation leads to price increases, as
| 1 | similarly with respect to lower plan quality. Insurers  |
| 2 | are already creating very narrow and restricted networks  |
| 3 | that force patients to go out of network to access care.  |
| 4 | A 2015 study by the University of Pennsylvania  |
| 5 | researchers shows that 76 percent of health plans sold  |
| 6 | in California through covered California have  |
| 7 | significantly limited networks. A California medical  |
| 8 | association survey conducted about a month ago asked  |
| 9 | questions -- asked physicians questions concerning  |
| 10 | network adequacy and the likely affects of the  |
| 11 | Anthem-Cigna merger. 989 physicians completed the  |
| 12 | lengthy CMA survey. It’s unusually large number in  |
| 13 | history of CMA surveys.  |
| 14 | I think, Francisco, you said it was like a  |
| 15 | third.  |
| 16 | MR. SILVA: Top three.  |
| 17 | MR. ALLEN: It's the top three. Of  |
| 18 | respondents to the CMA survey who contracted with  |
| 19 | Anthem, 32 percent, that's one in three, said that they  |
| 20 | had difficulty finding available in network physicians  |
| 21 | who accepted new patients for referrals. 26 percent of  |
| 22 | respondents who are contracted with Cigna reported  |
| 23 | similar experiences. Comments included, quote, "No  |
| 24 | patients report being able to obtain timely appointments  |
| 25 | with primary care providers."  |

| 1 | Moreover, 53 percent of California physicians  |
| 2 | survey respondents who were contracted with Anthem  |
| 3 | encountered formulary limitation which, quote,  |
| 4 | "presented a patient's optimal treatment." Close quote.  |
| 5 | 42 percent of respondents contract the Cigna-similar  |
| 6 | experiences.  |
| 7 | An Anthem-Cigna merger threatens to reduce  |
| 8 | access to care. 82 percent of physician practice  |
| 9 | decision makers responding to CMA survey believe that  |
| 10 | the Anthem-Cigna merger would vary or somewhat likely  |
| 11 | lead to narrower physician networks, which will in turn  |
| 12 | reduce patient access to care.  |
| 13 | Your department clearly takes the issue of  |
| 14 | network adequacy and transparency very seriously given  |
| 15 | its actions over the last several years on provider  |
| 16 | networks. You played a prominent role on the NAIC work  |
| 17 | group that revised NAIC standard -- that revised the  |
| 18 | NAIC network adequacy model bill. However, the CDI no  |
| 19 | doubt appreciates the network adequacy requirement  |
| 20 | standards are no panacea for the weaker provider  |
| 21 | networks likely to result in the Anthem-Cigna merger.  |
| 22 | Generally speaking, the network’s focus on  |
| 23 | notions of whether enough providers and facilities are  |
| 24 | included in the network, they address adequacy as a  |
| 25 | floor and not as a prescription for optimal physician  |

| 1 | and provider availability.  |
| 2 | While regulation of provider networks and  |
| 3 | network products is a critical component of ensuring  |
| 4 | patient access to care, market competition and  |
| 5 | associated consumer pressures to maintain or improve the  |
| 6 | quality of products, including provider networks is  |
| 7 | essential.  |
| 8 | Without competition among health insurers to  |
| 9 | offer comprehensive networks in accurate and accessible  |
| 10 | provider directors, patients will be choosing among  |
| 11 | limited, low quality products without the ability to  |
| 12 | lower their fee.  |
| 13 | I’ll talk a little about monopsony. Consumers  |
| 14 | also do best when there is a competitive market for  |
| 15 | purchasing physician services. This was the well  |
| 16 | documented conclusion reached in the 2008 hearings  |
| 17 | before the Pennsylvania Insurance Department on the  |
| 18 | competition ramifications of the proposed merger between  |
| 19 | high marketing and independent Blue Cross.  |
| 20 | Based on an extensive record of nearly 50,000  |
| 21 | pages of expert and other commentary, the Pennsylvania  |
| 22 | Insurance Department was prepared to find the proposed  |
| 23 | merger to be anti-competitive in large part because it  |
| 24 | would have granted the merged health insurer undue  |
| 25 | leverage over physicians and other health care  |

27 (Pages 102 to 105)

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monopsony power through coordinated interaction by
health insurance companies.
Health insurance companies have a strong
incentive to follow a price leader when it comes to
payment rate to physician payment rates.
Fortunately, the antitrust division as the
Department of Justice has recognized that health insurer
mergers can enhance or entrench monopsony power that's
harmful to consumers. It has successfully challenged
affects in the purchase of physician services.
In a third merger matter involving Blue Cross,
Blue Shield of Michigan in 2010, the health insurers
abandoned their merger plan when the DOJ complained that
the merger, quote, "would have given Blue Cross Michigan
the ability to control physician payment rates in a
manner that could harm the quality of health care
delivered to consumers." Close quote.
DOJ's monopsony challenges properly reflect
the agency's conclusions that it is a mistake to assume
that a health insurer's negotiating leverage acquired
through a merger is a good thing for consumers.
We heard this representation being made today
that there will be two sumo wrestlers facing off and
that somehow consumers will benefit to offset provider
power we -- if you allow this merger. But, on the
contrary, consumers can expect higher insurance
premiums. That is because health insurer monopsonists
typically are all for monopolists. Facing little, if
any, competition they lack the incentive to pass along
cost savings to consumers.
Results of the CMA survey on the monopsony
issue. The CMA survey explored the monopsony issue. We
begin with a principal -- we begin with a principal that
a loss of competition in the buy side market for the
purchase of physician services occurs when the merging
health insurers hold contract with a significant number
of physicians who are financially dependent on
contracting with the merged health plans. This is
precisely the case in a merger of Anthem with Cigna.
71 percent of physician respondents to the CMA survey
felt they had to contract with Anthem in order to have a
financial viable practice and 47 percent felt that way
with respect to Cigna. 66 percent and 45 percent of
practice decision makers who are contracted with Anthem
and Cigna respectively reported that contracts were take
it or leave it offers.
While these percentages are indicative of
monopsony power, the merger promises to make matters
worse. 83 percent of responding physicians said that
the merger of Anthem and Cigna would make the process of
contract negotiations even less favorable for
physicians.
Physicians responding to the CMA survey also
declare that the very large percentages -- excuse me -- also
identified by very large percentages a number of
anti-competitive effects likely to occur in the event of
an Anthem-Cigna merger. An astonishing 89 percent of
physician decision maker said there would be a reduction
in the quality and quantity of the services that
physicians are able to offer their patients as a result
of the merger. 82 percent reported that they will be
very or somewhat likely pressured not to engage in
aggressive patient advocacy as a result of the merger.
The extent of the merged entity's monopsony power and
how it may injure consumers is revealed in physician
responses to the question of whether there would be any
consequences in not continuing to contract with the
merged firm. 31 percent of the respondents said they
would need to cut investments and practice
infrastructure. 40 percent would need to cut or reduce
staff salaries. 43 percent would have to spend less
time with patients and 27 percent would need to cut
quality initiatives for patients services. Such
reduction in service levels and quality of care would
cause immediate harm to consumers. In the long run, it
is imperative to consider whether monopsony power
enhanced in the merger would harm consumers by driving
physicians from the market.
Health Insurance payments that are below
competitive levels may reduce patient care and access by
motivating physicians to retire early or seek
opportunities outside of medicine that are more
rewarding financially or otherwise. This is a serious
core concern. Recent projections by the health resources and
services administration suggest a significant shortage
of primary care physicians in the United States.
According to the CMA survey if Anthem-Cigna were to
merge and physicians did not continue to have a contract
with the merged health plan, significant numbers of
physicians would be driven from the market. 13 percent
would retire from active practice. 15 percent would
need to close their practice. And eight percent would
move their practice to a more competitive reimbursement
market.
In conclusion, it is critical for CDI to
reject the proposed merger so that consumers and
physicians have adequate competitive alternatives.
Unless the application is rejected, the merged entity would likely be able to raise premiums, reduce planned quality, and lower payment rates for physicians to a degree that would reduce the quality or quantity of services that physicians offer to patients.

Thank you very much.

COMMISSIONER JONES: Thank you, Mr. Allen, and thank you, Mr. Silva. I really appreciate the thoroughness of the analysis and the testimony and appreciate your providing to us, both, the AMA analysis of the Metropolitan statistical areas with regard to the application of the FTC and DOJ guidelines to California MSAs and the impact on competition associated with this merger. It's very consistent with the expert testimony that we received earlier, which did a county-by-county analysis and also, appreciate the provision of the survey results as it relates to the views of California physicians with regard to this merger as well. So we will very carefully consider all that.

I don't have any questions at this time, but, again, really appreciate your participation in the hearing, your testimony, and thank you, Mr. Allen, for journeying all the way here to participate in the hearing.

MR. ALLEN: Thank you, Commissioner.

We are at 4 o'clock now. So, what I want to ask is that -- and we do have written testimony from everybody, which we will look at very carefully. I want to ask if those that are testifying going forward would attempt to keep their remarks to between 5 to 7 minutes, because we do want to afford the public that has not had a chance to testify so far an opportunity to testify, and let me see by a show of hands in the room how many folks are members of the general public that have not already had an organizational representative or some entity either testified or about to testify?

Anybody else here who wishes to testify who is not already been or represented in some capacity?

Well, that makes it a little easier.

There may be some in the overflow room. We'll provide an opportunity, and I will stay as long as necessary to hear each and every person that does wish to testify, and our very able IT staff will stay as well, and we'll see whether all of you stay.

But in any event, why don't we turn to the California Physical Therapy Association.

Welcome.

TAMEKA ISLAND

MS. ISLAND: Thank you, Commissioner.

Good afternoon, I am Tameka Island with the California Physical Therapy Association, and again, thank you Commissioner Jones and CDI staff for the opportunity to offer testimony on the proposed Anthem-Cigna merger today.

The California Physical Therapy Association is the third largest physical association in the world, and as a chapter of the American Physical Therapy Association which represents more than 93,000 physical therapists and physical therapists assistants nationwide, I offer public comment regarding the proposed Anthem-Cigna acquisition currently under consideration by the California Department of Insurance. CPTA has a number of concerns with the proposed merger. The primary concern being the potential risk of reduced competition and a decrease in consumer choice. Reduced competition often results in an increase in consumer health care costs because of a lack of viable options available to the public.

The merger of Anthem and Cigna will bring the private health insurance market from five large players to three. This will actually improve efficiencies and reduce cost for consumers down the line in, quote, Cigna’s spokesman Matt Asencio stated. CPTA finds

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COMMISSIONER JONES: Thank you.

Let me check in with the court reporter. We do have our next panel, which has on it representatives of various estate and national consumer organizations and I want to see how the reporter is doing before we launch into that panel.

COURT REPORTER: Break please.

COMMISSIONER JONES: Okay. We'll take a ten-minute break, and we will resume at five to the hour. It's actually an eight-minute break, and so, with that we are going to recess until five minutes to 4 o'clock.

Thank you.

(Whereupon, a break was taken from 3:45 p.m. to 3:56 p.m.)

COMMISSIONER JONES: So we'll resume the hearing at this point. We're going to begin with testimony from the California Physical Therapy Association. We had a little bit of a miscue earlier. When I called the medical providers, I thought all the medical providers had come forward, but there was a misunderstanding to that, and so we're delighted to have the California Physical Therapy Association here to provide additional testimony from a provider perspective then we will move smartly to the consumer organizations.
Mr. Asencio’s statement problematic based upon Anthem’s
past inability to offer enrollee access to medically
necessary care and past failures to satisfy the state’s
ongoing concern with regard to increased denials for
justified care, as well as failing to provide enrollees
and providers with clinical evidence based guidelines to
support the large volumes of denials.

Recently the DMHC issued an accusation and
cease and desist order against Anthem on November 18,
2013. Based upon Anthem’s unjustified denial of
enrollee coverage request for speech therapy and
occupational from 2010 to 2013. Under that order,
Anthem had to revise its clinical guidelines for speech
therapy and occupational therapy and had to notify its
providers and enrollees of the provision while also
reimbursing portions of paid premium back to enrollees.

This accusation clearly demonstrates Anthem’s inability
to manage specialty care and its adverse impact on
access to necessary health care services.

Anthem has similarly demonstrated difficulty
in managing its proposed contract to partner with
OrthoNet for utilization management of physical therapy
and occupational therapy services. Despite Anthem
applying for approval of this agreement in July 2015,
the DMHC issued an order postponing notice of material
modification on August 2015. This order still remains
in effect and Anthem has failed to cure its deficiencies
with the department.

Further, in a recent correspondence to Anthem,
the DMHC referred Anthem to DMHC’s enforcement unit for
investigation and possible disciplinary action for the
aforementioned deficiencies. These issues confirm that
Anthem is unequipped under its current structure to
manage access to necessary health care services and has
failed to demonstrate for nearly a year that it can
manage health care benefits. These documented
deficiencies are currently in 2015, 2016, and ongoing.

Similarly, Cigna currently utilizes a benefit administrator, American Specialty Health, to manage its
utilization review, provide a network for claims for
physical therapy and occupational therapy services.

During the past year, in which ASH, American
Specialty Health, has been utilized in California,
consumers have reported many of the same issues noted
above with Anthem. The primary grievance being delays
in treatment in authorization generally 50 percent
longer than the clinical guidelines stipulate.

Beginning in 2016, Cigna began using ASH in
all states where it provides product lines. Since that
time, the delays in the authorization process has
doubled. Information from other states, including
Connecticut, Nevada, New York and Vermont notes delays
of up to 14 days in prior authorization requests.

Delaying the approval for skilled physical
therapy will not only increase health care cost, but
most importantly, delays to initiate treatment
jeopardizes negatively impact the patient’s recovery and
overall well-being. The potential affects to the
consumer could be catastrophic.

In closing, Anthem’s subpar management of its
utilization process and reduced access to medical
necessary health care services will likely expand with
merging with Cigna’s large network of enrollees and
providers.

Under current circumstances CPTA urges the CDI
to reject Anthem’s proposal to acquire Cigna and please
protect consumer choice in the great State of
California.

Thank you.

And CPTA will provide written comment as well.

COMMISSIONER JONES: Thank you very much. I
greatly appreciate your attendance and thoughtful
necessity of the testimony.

Is there more? Excellent. And you will be adding some additional

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between Cigna and Anthem.

disaster.

programs to combine forces seems like a recipe for

comply with requests made by California Department of

OrthoNet program to California as they have failed to

in a manner beneficial to the consumers, and in fact,

Anthem has been temporarily barred from bringing their

in the end extends overall cost to the consumer. For

or the defined planned benefits which disrupts care and

in the end extends overall cost to the consumer. For

any patient referred to physical therapy without

regard -- without going through the review process

regardless of what the physician requests.

Other issues being experienced in California

and other states where Anthem and Cigna operate their

networks include retroactive denials or not

authorization when an authorization actually exists,

denying dates of service when an authorization for those

services is on file, increased administrative burdens

related to the number of calls required to reprocess

claims and delays improving post-operative patients thus

extending their recovery time at patient's expense.

Customers who purchase insurance from Anthem and Cigna

are unaware that a third party not involved in their

care has an ability to deny their services. This is a
total lack of transparency to the consumer.

I feel that we are dealing with two companies

that have failed to administer their specialty networks

in a manner beneficial to the consumers, and in fact,

Anthem has been temporarily barred from bringing their

OrthoNet program to California as they have failed to

comply with requests made by California Department of

Managed Health Care. Allowing two dysfunctional

programs to combine forces seems like a recipe for
disaster.

I request that you do not approve the merger

between Cigna and Anthem.
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<th>Page 123</th>
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<tbody>
<tr>
<td>1. written testimony from you, and we're certainly eager to receive additional written testimony if you so wish to provide it, but with that, let me turn the floor over to Mr. Balto, and thank you for journeying all the way here to California, and we're most interested in hearing your testimony. Welcome.</td>
<td>16:10:22</td>
<td>16:10:27</td>
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<tr>
<td>2. DAVID BALTO: Thank you so much, Commissioner.</td>
<td>16:10:42</td>
<td>16:10:40</td>
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<tr>
<td>3. I'm David Balto, and I'm a consumer advocate and former policy director of the Federal Trade Commission. I have testified in the past before the Pennsylvania, Nevada Insurance --</td>
<td>16:11:02</td>
<td>16:11:09</td>
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<tr>
<td>4. COMMISSIONER JONES: Make sure it's green, Mr. Balto: Right. I've testified in the past for the Pennsylvania and Nevada Insurance Commissioners before Congress on four occasions on health insurance competition and our coalition has already submitted comments in seven states and we applaud you for your leadership in putting a spotlight on the competitive affects of the merger. Our written testimony documents the reasons why this merger should simply be rejected. I want to focus today and sort of transition between the earlier panel and this panel on three major points, the impact on competition and consumers, the efficiencies and the remedies.</td>
<td>16:11:15</td>
<td>16:11:20</td>
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<td>5. On competition and consumers, the market share data that Mr. Fulton has presented, it's much worse than you think it is. The data suggests that other states competitive concerns, the efficiencies which have never lead to the approval of an anti-competitive merger even in history don't meet the legal requirements and can't outweigh the harms, and there is no way to effectively remedy this merger. I want to explain an important thing when we're looking at competitive affects. We have heard a lot about market shares, but market shares are just an initial threshold of looking at the competitive affects of the merger, and I trust laws and based on the slide rule -- for those of you sitting in the audience sitting next to a millennial, please explain what a slide rule is. It's rather it's an initial screening mechanism. There are many other aspects of mergers that raise competitive concerns. The ultimate question, Commissioner, is whether or not a merger will lead to market power. That's the ability to raise price or engage in reduced services. You already know Anthem has market power. It has the ability to raise price. It engages in practices that are clearly anti consumers. That's what my colleagues on the panel have documented. You don't need to go and carefully assess whether or not the market share increase is this number or that number. You already know they have market power. Acquiring Cigna will make things worse, but the law, Commissioner, is also clear that market share, its concerns our even greater where there are other factors, such as, difficulty of entry and a trend to consolidation. The law's crystal clear that of that and both of those factors are met in California. So even at the lower concentration levels, you will have substantial competitive concerns. I want to make a quick point about monopsony, an excellent presentation by Mr. Allen here. Monopsony concerns exist at lower market shares than a monopoly concern. So, on the monopsony side, even if the market shares are relatively low, there can be concerns. If you are the doctor, the obstetrician in Riverside and all of a sudden Aetna, which only has 20 percent market shares, significantly lowers your reimbursement rate, you can't make that up by picking up a bunch of Medicaid patients or running down and trying to get patients from San Diego. That's what the Department of Justice has found, that it's even lower levels of concentration, there are concerns on the monopsony side. That's what they decided if found in The United Pacific Care merger. You should not leave this panel without understanding that the concerns of consumers are coincident with the concerns of providers. This is what Congressman Campbell said. The insurance companies economic incentive is to spend as little as possible on medical care, and if there is not sufficient competition among insurers, that a physician can turn to for another offer, the doctor no alternative, no choice, but to lower the quality of care ordered by the insurance company. Ultimately when insurance companies possess monopsony power, consumers loss. The quality of care goes down. Now, you figured out already that the stake of this meal is whether or not there are efficiencies that outweigh the competitive harm. Three important concepts to keep in mind. The courts have never approved an anti-competitive merger based on efficiencies. Secondly, as you assess these claims of their aspirations, remember who you are talking about. I have never in -- we do this in every state. We're involved in every state looking at these mergers, but in no state does Anthem have such a poor record as in the state.</td>
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<td>6. Mr. Balto, and thank you for journeying all the way here to California, and we're most interested in hearing your testimony. Welcome.</td>
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<td>7. The ultimate question, Commissioner, is whether or not a merger will lead to market power. That's the ability to raise price or engage in reduced services. You already know Anthem has market power. It has the ability to raise price. It engages in practices that are clearly anti consumers. That's what my colleagues on the panel have documented. You don't need to go and carefully assess whether or not the market share increase is this number or that number. You already know they have market power. Acquiring Cigna will make things worse, but the law, Commissioner, is also clear that market share, its concerns our even greater where there are other factors, such as, difficulty of entry and a trend to consolidation. The law's crystal clear that of that and both of those factors are met in California. So even at the lower concentration levels, you will have substantial competitive concerns. I want to make a quick point about monopsony, an excellent presentation by Mr. Allen here. Monopsony concerns exist at lower market shares than a monopoly concern. So, on the monopsony side, even if the market shares are relatively low, there can be concerns. If you are the doctor, the obstetrician in Riverside and all of a sudden Aetna, which only has 20 percent market shares, significantly lowers your reimbursement rate, you can't make that up by picking up a bunch of Medicaid patients or running down and trying to get patients from San Diego. That's what the Department of Justice has found, that it's even lower levels of concentration, there are concerns on the monopsony side. That's what they decided if found in The United Pacific Care merger. You should not leave this panel without understanding that the concerns of consumers are coincident with the concerns of providers. This is what Congressman Campbell said. The insurance companies economic incentive is to spend as little as possible on medical care, and if there is not sufficient competition among insurers, that a physician can turn to for another offer, the doctor no alternative, no choice, but to lower the quality of care ordered by the insurance company. Ultimately when insurance companies possess monopsony power, consumers loss. The quality of care goes down. Now, you figured out already that the stake of this meal is whether or not there are efficiencies that outweigh the competitive harm. Three important concepts to keep in mind. The courts have never approved an anti-competitive merger based on efficiencies. Secondly, as you assess these claims of their aspirations, remember who you are talking about. I have never in -- we do this in every state. We're involved in every state looking at these mergers, but in no state does Anthem have such a poor record as in the state.</td>
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California. It's intense. It's carefully documented in the filings by Health Access and Consumers Union. Allowing them to permit this merger -- permitting this merger on efficiencies is like letting Jessie James run the bank.

All you are going to have is the consumers will lose. Ultimately, the key question, though, is the effect of consumers. You asked precisely the right question. How much of that 2 billion is going to result in lower premiums to consumers? You asked. But the key issue in mergers is efficiencies is whether or not the efficiencies are merger specific. Do you need a merger to go and achieve those efficiencies?

Now, what these two companies have basically told you is we do this good, they do this good and if we combine, we both can do this good. This is like Google and Samsung coming up to the Justice Department and saying we need to merge our smart phone businesses because we don't know how to go and manage our legal expenses good enough, but if we merge them, we'll be able to reduce the cost of legal services, which by the way, as a lawyer would be something very harmful. You don't need a merger to do that. The purpose -- the reason we have a capitalist system is that consumers benefit most when competitors have to roll up their sleeves and


develop a better mouse trap and if one of these firms has a better mouse trap than the other firm, then they should compete against each other and come up with a better mouse trap. The crucible, the engine to the benefits that they seek is that divestitures would work? And one more thing to keep in mind. A merger forever. There is no divorce for us to do this unless we have so many covered lies, unless we have so much clout, so much of this or that. They haven't told you that story. They haven't documented that story to you, and besides, listen carefully to their testimony.

What they talked about at the end of the day was providers doing something because they were larger. The crucible, the engine to the benefits that they seek are what providers will do. Those are efficiencies that come from providers. Those are efficiencies by having providers work more effectively together. That's not efficiencies from the insurance companies, and as you pointed out, they're not really merging their two networks. Those networks will be separate.

If there is one case that the Commission needs to read is the FTC case against the St. Lukes Hospital merger. If you read it, it will sound a lot like today's hearing.

This was a case where a dominant hospital wanted to acquire a physician practice 60 miles away, and they said, oh, we have got this really fantastic computer system and the doctors in this distant town will be able to use this really fantastic computer system, and they will be able to integrate our care better because doctors and physicians will be able to work better together and things like that, and the Ninth circuit was explicit. They said the Clayton Act does not excuse mergers that lessen competition simply because they can improve the businesses' operations. If you want to improve your operations, that's what the capitalist system is based on. Do it by yourself. You don't need a merger to do that. That's why their efficiencies don't count.

But, finally, if they count, they have to exceed the competitive harm, and as your expert has documented, you have a prima facia violation of your statute and the antitrust statute. They have a substantial burden to overcome to demonstrate that.

Let's turn to the issue of remedy. Now, anybody who thinks the Justice department can get remedy correct only has to find an airplane and ask themselves, really, did those divestitures in the United's, Continental and American, U.S. Air, did they really...
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<td>1 coverage through Medi-Cal or subsidized coverage through Covered California are limited English proficient. The fact that Anthem is not complying with language access requirements is a critical indicator that it may not be providing quality care to all of its enrollees. Anthem has also had notoriously inaccurate provider directories. making it difficult for consumers to know which doctors are in network and which doctors are actually accepting new patients.</td>
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I am going to focus my remarks on some of the challenges that consumers have with Anthem starting with its grievance systems.

In Anthem's most routine -- most recent routine survey at the Department of Managed Health Care. Five out of the seven major decisions he found are rooted and it's poor handling of grievances. The DMHC found that consumer complaints were not adequately investigated or resolved because Anthem misclassified them as inquiries instead of grievances.

In addition, Anthem does not always do its due diligence when reviewing complaints. As a result, critical facts or solutions were overlooked leaving consumers without needed medications or stuck with bills that they should not have to pay.

Anthem has also failed to provide its consumers with language assistance as it is obliged to do under the law. Anthem has not assessed the needs of its current enrollees. As a result some patients are unable to communicate with their providers. These issues are particularly important in California because 40 percent of consumers who receive

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Anthem and Cigna is likely to reduce competition in 31 counties, and others -- as others have mentioned this merger also has a significant impact on the ASO market. According to a study in the Health Affairs Journal California is one of five states that will see the biggest increase in ASO market concentration, which is projected to increase by 39 percent. The anti-competitive affects of this merger coupled with Anthem’s poor track record makes it really highly likely that quality will continue to go down while prices will continue to go up. That is why we have asked regulators to impose strong, enforceable conditions to ensure that consumers will actually benefit in the form of lower premiums, lower out-of-pocket costs, higher quality care, and reduced health disparities.

In closing we respectfully ask you to include your very able executive director, Mr. Anthony Wright, and we’re delighted to have both of you here and we thank you for holding this hearing and for your testimony and your verbal testimony as well.

We thank you for your comments, and I also have a question for Anthem.

And may I ask it at this time?

COMMISSIONER JONES: No. What I think I would like to do is get through all the testimony, and then if you have a question, I understand that Miss Imholz may have a question, and then we can pose that question at that time.

Great.

MS. MA: Thank you.

COMMISSIONER JONES: Wonderful. Thank you, Miss Ma, and I also want to note that you’re joined by your very able executive director, Mr. Anthony Wright, and we’re delighted to have both of you here and we really appreciate the thoroughness of your written testimony and your verbal testimony as well.

Thank you.

Next I would like to go to the executive director Consumer Watchdog, Miss Carmen Balber.

Welcome.

CARMEN BALBER

MS. BALBER: Thank you.

And as Insurance Commissioner Jones said, my name is Carmen Balber with Consumer Watchdog. We’ve spoken about this a lot today about the size and reach, but if this merger is approved, Anthem will leapfrog Kaiser in California, if you look at the entire market to become the largest insurer in the state. It will leapfrog United Health Care in the nation to become the largest insurance company in the nation and make no mistake that $115 billion in annual revenue that Anthem anticipates is what they’re touting to Wall Street investors. That’s what they’re focused on in this circumstance.

If Anthem and Cigna merge here in California, they’ll eliminate our fifth largest player. They create as many as said before a near monopoly in the large insurer market. We can argue about the numbers, but doubling Anthem’s market share and giving it over 50 percent of the market, whether it’s 60 or 70, will clearly give it market power and will harm nearly every metro area in California by increasing Anthem’s market share when we look at, both, the academic and the AMA studies.

What we don’t have is any proof from Anthem either today or in their previous statements of concrete benefits to consumers of this merger, and that’s why Consumer Watchdog believes this merger is where the Department of Insurance needs to draw a line in the sand. To say that California’s market is concentrated as it needs to be, and -- and reject the Anthem merger.

We’ve talked about the fact that consumers are already hurting on cost. Anthem imposed unjustified rate increases in California.

In January, a survey of all Americans found that 20 percent of consumers still can’t afford their medical costs even though they’re insured. Consumers are hurting on costs. Consumers are hurting on quality, and Health Access just listed a host of examples where Anthem is a key problem in that regard, and I think we’ll see some of the other troubling claims and service issues later.

Nothing Anthem said today has given us any indication of how Anthem or Cigna merged will make those benefits to consumers of this merger, and that’s why either today or in their previous statements of concrete benefits to consumers of this merger, and that’s why Consumer Watchdog believes this merger is where the Department of Insurance needs to draw a line in the sand. To say that California’s market is concentrated as it needs to be, and -- and reject the Anthem merger.

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The self-insured market if you trust the California health care foundation numbers, which we do, is about 20 percent of insured Californians, and giving Anthem 60 percent control of that market essentially gives them bullying power over approximately 6 million employees of large employers in California. Prices will inevitably go up for this group of employers, because they'll have less ability to shop around and eventually 2013, those unreasonable rate increases have amounted to $145 million in California. A merger which has extensive financing costs only increases the need of the company to upstream more money to the parent company, and I would imagine now coincidentally raise rates in California. Most of the rest what I was going to touch on was really has been said, the concentration in the market here in California. The fact that self-insured large employers will have so many fewer options. Maybe the important thing there to note is that most Californians get their insurance from their employer. The deal initially, and he rejected that deal for many reasons. One of those reasons was obscene executive compensation package that was rumored to be as high as $600 million, and because of the large amount of money that Anthem habitually upstreams out of California, California policyholder dollars to the parent company, He was concerned that even though the merged company said they wouldn't finance the merger on California policyholder's back, that all of that money that they are upstreaming out of the state would cover those costs anyway. He did eventually approve the merger. He set really strict at the time consumer protection conditions, say, okay, we'll approve this merger, but you have to abide by these guidelines. It was a reduced executive compensation package, although, it ended up being accepted nonetheless, restrictions on Anthem's underwriting practices. So trying to reign in some other black listing or sicker patients at the time which, of course, was still legal then. They had to donate hundreds of millions of dollars to state health programs and they agreed that California customers wouldn't pay for the merger through higher rates. Nevertheless, over the next decade, and we've looked at this through Anthem's 2014 annual report, Anthem in California has sent $5.4 billion in California to the parent company, and at the same time as all these billions of dollars were leaving the state, yearly California policyholders have experienced rate increase after rate increase usually in the double digits and often unjustified. We all remember the 39 percent rate increase that Anthem proposed that kick started the Affordable Care Act, which we are probably all glad in retrospect they tried to impose that rate increase, but generally they're not a good thing for consumers, and of course we have already mentioned the unjustified rate increases that both the Commissioner and the Director of the DMHC found to be unreasonable that Anthem put forward anyway. Just since 2013, those unreasonable rate increases have amounted to $145 million in California. A merger which has extensive financing costs only increases the need of the company to upstream more money to the parent company, and I would imagine now coincidentally raise rates in California. Most of the rest what I was going to touch on was really has been said, the concentration in the market here in California. The fact that self-insured large employers will have so many fewer options. Maybe the important thing there to note is that most Californians get their insurance from their employer. The proposed merger between Anthem and Cigna will result in likely increases in Anthem's market power, it amounts to 33.3 million Californians. That's 85 percent of the state. That is Los Angeles, San Diego, Orange County, Bay Area, Sacramento, basically everywhere but portions of the Central Valley and the counties north of here. So everyone in California will be impacted if this merger were to go through and everyone should be concerned. Because of all this we don't believe there are enough concessions in the world that you can dream up or that Anthem would agree to, to make this merger protect consumers, which is why we urge you to reject it. I appreciate your journeying from Santa Monica to attend the hearing, and thank you for the thoroughness of your testimony as well. Next we'll have an opportunity to hear from the Greenlining Institute. Welcome. ANTHONY GALACE MR. GALACE: Thank you so much, Commissioner Jones. My name is Anthony Galace. I'm the director of health policy at the Greenlining Institute, and we're a statewide, multi-ethnic policy organization committed to achieving racial and economic justice. Communities of color have experienced health and economic progress due to the Affordable Care Act; however barriers still exist and the proposed merger between Anthem and Cigna threatens to perpetuate systemic inequities, limited provider networks rising premiums, and substandard quality of care outline just a few of our concerns. I urge the Department of Insurance to reject this merger.
color, we are confident a robust partnership with Cigna are truly committed to serving communities of blatant health and wealth disparities. If Anthem and suffer from systemic barriers that have left such communities of color, then California will continue to this record is unacceptable.

- Atkinson-Baker Court Reporters
- www.depo.com
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that they’re having on California policyholders. I find the testimony very compelling and disturbing. We support the concerns that have been raised. At the same time I just want to highlight a different perspective on concerns relating to the merger, and that specifically is the extent to which the companies are impacting communities in the form of their investments, and in particular, we find these companies are not doing a sufficient job in investing in vehicles and projects that help meet the state's affordable housing and community development needs. The needs in our state are tremendous. Our state is in the midst of a profound affordable housing crisis according to the California Housing Partnership Corporation. The state's shortfall of 1.5 million rental homes for extremely low income and very low income rent for households contribute substantially to California's 22 percent poverty rate, the highest poverty rate any state in the nation. We do believe that state affordable housing is directly connected to positive health outcomes as a large body of research confirms, and we have some of this in our written testimony. Both Mr. Wagner and Mr. Richards noted in their comments and commitment to improving health outcomes for their customers. This is an easy way to do that, with the billions in revenue and in investments that they have available, and perhaps this could be a form of the value-based approach to health care provision in the context of investments. We note that the Department of Insurance through the coin program provides the ready-made pathway for insurance companies to make safe and sound investments that also help address California's critical housing and other community development needs and that lead to improved health outcomes, but what are these companies doing relating to helping to meet that need, according to the department data available on its Website, neither company appears to have ever participated in the state coin CDFI credit program and this is going all the way back to 1997 when the program began. In the past, the companies have reported some high impact holding and/or coin qualified holdings, but to the extent to which Anthem or Cigna have made any such double bottom line investments since 2012, the last date for which date is available is unclear. We urge the Commissioner to consider the data made available through a recent data call before determining his recommendations on this merger.

Our primary question here is whether these companies will commit to substantially participate in the state coin CDFI tax credit program, and other programs so as to make safe and sound investments that will also contribute to the state's effort to meet critical affordable housing, job creation and other crucial needs. As noted earlier, Health Net Santine, which we estimate to have about one-fifth the premiums of Anthem-Cigna made $230 million jobs community investment commitment. Does Anthem and Cigna feel that they should do any less by California? In conclusion, we urge the companies to make a significant commitment to invest in health services in California, and to hire investment managers that have experience with and a deep understanding of the affordable housing and community development infrastructure in our state. In the absence of such substantial commitment, and in the absence of further undertakings that address the other concerns that have been raised during this hearing, we urge you to reject the merger.

Thank you. COMMISSIONER JONES: Thank you very much, Mr. Stein. Thanks for your leadership and your time.

Mr. Stein. Thanks for your leadership and your time. We urge the Commissioner to consider the data made available through a recent data call before determining his recommendations on this merger.  

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Today and your very thoughtful testimony. We look forward to getting a written testimony as well. Next we'll have a chance to hear from Betsy Imholz with Consumer Union. Welcome.

ELIZABETH IMHOLZ MS. IMHOLZ: Good afternoon. I'm Elizabeth Imholz, special projects director for Consumers Union, the policy and advocacy division of non-profit consumer reports. We're a national organization, also, advocating for consumers here in California for the past 40 years. Thank you for the opportunity to comment on this $54 billion transaction. This deal far exceeds the scale of the other pending and the concluded insurance mergers here in California, and as wholly different character, rather than enhance competition or keep a flagging insurer alive, this one would give a tightened, even greater market power. Experts for Department of Managed Health Care have been mentioned who analyze which the affects on the HMO market found that it would reduce competition in 31 California counties, and we have heard other compelling analysis on the antitrust implications from Professor Fulton and Mr. Balto.

Thank you.

Mr. Stein. Thanks for your leadership and your time.

We urge the Commissioner to consider the data made available through a recent data call before determining his recommendations on this merger.
Clearly, the proposed merger would benefit  

Anthem and Cigna, but it’s not apparent after a day of testimony here that it would benefit consumers in any way. I’ll try not to duplicate what’s been said already, because a lot has been said, but our concerns fall into three buckets. The first and foremost is the risk and likelihood of increased prices -- premium prices for consumers.

Evidence shows these mergers generally result in these increases as Professor Daphne has stated. Even if a bigger and more powerful Anthem squeezes out some inefficiencies, there is little incentive for  

Anthem to pass along the savings to policyholders. In fact, we have heard a reluctance to commit to that. In fact, Anthem’s history in California suggests that it would be unlikely to pass along these savings if the merger is approved.

We all know that in 2010, Anthem’s proposed average increased in the individual market of 25 percent up to 69 percent for other consumers was the lightning bolt that really sparked the enactment of the Affordable Care Act. Anthem clung to that proposed increase until an independent actuary hired by the California Department of Insurance found substantial mathematical errors there with an overstated medical trend, and of course the unlawful rescissions from 2008 to ’10, resulted in enforcement actions as well and $15 million or more in fines by California regulators. Commenting on some filings from last year, Consumers Union noted in filing some inflated medical trend and pharmaceutical trend information far in excess of its competitors, and we’ve already alluded to the Department’s own finding that some of the rates in the non-grandfathered -- the grandfathered -- sorry -- individual plans were unjustified, and yet Anthem refused to moderate those increases. So with this record, it seems to us unlikely that an even larger Anthem would have on its own accord pass along savings to consumers unless compelled to do so.

And earlier today we did hear about the $2 billion in expected synergies and increased earnings per share, but an unwillingness to commit to keeping premiums down.

The second category of concerns for Consumers Union is quality. The record is detailed in my written testimony, so I won’t throw a lot of numbers this late in the day. But, on the NCQA health plan ratings, I would just pull out a couple of nuggets. Cigna’s HMO scored two out of ten -- two out of five rather, for consumer satisfaction as did Anthem’s HMO. Especially problematic is Anthem’s Blue Cross of California partnership plan for Medi-Cal. It rated in the bottom quarter of all NCQA rank Medicaid plans nationally.

That’s 101 out of 136, and its customer satisfaction rating for California was the lowest possible score, one of a possible five, and in fact the majority of individual measures under that consumer satisfaction heading also got the same lowest score, one.

In both 2013 and 2014, Anthem enrollees in California made more requests for independent medical review of its decisions about care than any enrollees in any of the large plans, and in 2014, Anthem also has the highest rate of complaints to the Department of Managed Health Care regarding access out of all the large plans.

The third bucket of our concerns is about data security, which has not been brought up today. We think that consumer protection privacy protection is a major weakness for Anthem. Last year Anthem disclosed that in 2014 it experienced a breach affecting some 80 million policyholders. That’s the size of the entire population of Germany by the way. This affected not just Anthem’s policyholders and its plans across the country, but also 42 non-Anthem plans, with which Anthem was intertwined through business-associate agreements and experts have opined that Anthem was a likely target for hackers.

And today, potentially affecting the privacies of consumers and plans, which it has administrative service contracts related to the prior line of questioning today about ASOs.

In conclusion, antitrust experience in common

Also, potentially affecting the privacies of consumers and plans, which it has administrative service contracts related to the prior line of questioning today about ASOs.

In conclusion, antitrust experience in common sense suggest that an even larger Anthem will be less, not more motivated to innovate to improve quality and to pass along savings to consumers, since it will have fewer competitors for customers.

Consumers Union, thus, urges the state give the closest scrutiny to this transaction. As federal and state antitrust investigations continue, it may well be that this deal will be blocked. If it’s not, we insist that the state extract concrete, enforceable assurances that the marketplace will be improved by consumers. My written testimony includes many recommended undertakings. I’ll just put out three. The first is rate stabilization insuring that Anthem won’t
The testimony that's been provided either in writing, or verbally, at this hearing, and so I make that offer to both Anthem and Cigna, if they wish to provide something to me in writing to respond to the testimony that has been provided by the Department's experts, by the medical provider panel, the consumer panel, you're certainly invited to do so. Let me try to get a read on what a reasonable period of time might be to accomplish that, because I know that both Anthem and Cigna are eager to get decisions from various regulators, and I feel some urgency to make a decision.

So how much time would Anthem and Cigna need to take up that invitation?

MR. DANILSON: Well, we'll have to get back to you on that, Commissioner.

COMMISSIONER JONES: The public comment period is open until Friday. If you can accomplish it by Friday, that would be most appreciative. If you need additional time, I'm happy to entertain that as well. I recognize, though, that the point you made is one of not having had an opportunity to respond in full, and I want to give you that opportunity subject to some reasonable time in which to accomplish that. I notice that you have some very, very able and talented lawyers from highly regarded law firms in California, so I'm very confident of your ability to do that, and I welcome, I welcome your doing exactly that.

So, why don't we know now, I think, Miss Ma and Miss Imholz had a question.

 Pose questions to Anthem or Cigna. I'm happy to entertain that. Why don't you pose the questions to me and then we'll invite Anthem and Cigna's witnesses forward, and I can pose the question to them, and that will obviate, I think, the flurry of activity I notice in the hallway in the moment where counsel will be consulted and there might have been some concern, so let me see if that's agreeable to Anthem and Cigna. I trust that it is, since I'll be asking the questions.

MR. DANILSON: Jerald Danilson for White and Case. I think that is acceptable to Anthem and Cigna. Bear in mind, that neither parties had the opportunity to review these matters and the witnesses' statements prior to coming here today, so it's unlikely that any substantive information or commitment or conversation is likely to take place.

COMMISSIONER JONES: Great. Well, let me make a suggestion with regard to that. I think that's a fair point, and what I want to do is give the companies an opportunity to respond in writing if they so choose to the testimony that's been provided either in writing, or verbally, at this hearing, and so I make that offer to both Anthem and Cigna, if they wish to provide something to me in writing to respond to the testimony that has been provided by the Department's experts, by the medical provider panel, the consumer panel, you're certainly invited to do so. Let me try to get a read on what a reasonable period of time might be to accomplish that, because I know that both Anthem and Cigna are eager to get decisions from various regulators, and I feel some urgency to make a decision.

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16:58:38 1  COMMISSIONER JONES: Yes.  17:01:15
16:58:40 2  Mr. Wagner, you are still here?  17:01:15
16:58:44 3  There you are. You are hiding behind that --  17:01:17
16:58:46 4  you weren't hiding. I didn't see you with that picture  17:01:20
16:58:50 5  there.  17:01:22
16:58:53 6  Okay. Wonderful.  17:01:22
16:58:57 7  MR. LIVINGSTON: I don't need to tell you that  17:01:23
16:59:01 8  it's been a long, intense afternoon. Obviously it has.  17:01:25
16:59:04 9  What we would like to do is take those questions under  17:01:29
16:59:07 10  advisement, because some of those issues are not things  17:01:31
16:59:11 11  we came prepared to talk about and somewhat in the  17:01:34
16:59:17 12  interest of time in hearing from other people in the  17:01:37
16:59:20 13  public, we would propose to get back to you in writing  17:01:40
16:59:25 14  with respect to those questions.  17:01:45
16:59:25 15  COMMISSIONER JONES: Okay. I'm fine with  17:01:47
16:59:26 16  that. I just want to make sure that you got all of the  17:01:49
16:59:28 17  questions, but we've also got them transcribed as well  17:01:53
16:59:29 18  if need be. But, I think that would be fine. And I do,  17:01:58
16:59:32 19  as I said a moment ago, want to give both companies an  17:02:02
16:59:37 20  opportunity to respond to anything else that's been  17:02:05
16:59:39 21  provided by way of written or verbal testimony today.  17:02:07
16:59:40 22  Any further thought as to what amount of time  17:02:12
16:59:43 23  the companies would need to do so?  17:02:17
16:59:46 24  MR. LIVINGSTON: No. One thing that you did  17:02:19
16:59:49 25  mention was the summary of the market-conduct exams. We  17:02:25

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1  need to take a look at that and to see what would be  17:02:28
2  involved in responding to that.  17:02:31
3  With respect to the testimony of the  17:02:32
4  economist, we see no need to respond to that at this  17:02:38
5  point. So, we just need to figure out how long it will  17:02:44
6  take to get answers or responses or our reaction to  17:02:49
7  these three questions and to look at that market context  17:02:55
8  exam summary.  17:03:00
9  COMMISSIONER JONES: We'll endeavor to get the  17:03:01
10  summary to you no later than tomorrow, and let me set a  17:03:03
11  tentative deadline of two weeks. That will also afford  17:03:13
12  the opportunity to, if any additional comments come in  17:03:16
13  from other organizations between now and the 1st, you  17:03:19
14  will have an opportunity to respond to those, and if  17:03:23
15  there is some extenuating circumstance that makes that  17:03:27
16  deadline unattainable, I would encourage you to let me  17:03:32
17  know, and we can have a dial on that.  17:03:35
18  Great.  17:03:38
19  Then, I appreciate the consumers  17:03:39
20  organization's testimony. I appreciate the questions  17:03:43
21  they posed. I'm giving the companies an opportunity to  17:03:44
22  answer those questions in writing, as well as provide  17:03:48
23  any other written responses they would like to make.  17:03:51
24  We're setting a deadline of two weeks for that, but if  17:03:55
25  that becomes problematic, the companies should so

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communicate to me. So.

MR. DANILSON: Commissioner, can I ask -- I
apologize for interrupting. Is that two weeks from
today or are we saying two weeks from the date that the
record closes, which will be the 1st?

COMMISSIONER JONES: I was thinking two weeks from
today.

MR. DANILSON: Thank you.

COMMISSIONER JONES: I appreciate the
suggestion for clarification. That's a fair question.

MR. LIVINGSTON: Thank you, Mr. Commissioner.

COMMISSIONER JONES: Very good. I think what
we'll do now is see if any other members of the public,
who have not already had an opportunity to testify, wish
to testify, and let me see by a show of hands in the
room if there is anybody that falls into that category,
and I want to make sure that everyone has been permitted
from the overflow room to make their way to make this
room as far as we know.

MR. HINZE: We'll double check, Commissioner.

COMMISSIONER JONES: Hold tight for a moment.
We'll make sure that everyone in that room has had an
opportunity to join us today so choose.

If the answer to that is there is no one in
that room or there is no one in that room that wishes to

consider. Obviously, there is a great deal to consider
and I will do exactly that, and my plan is to make a
decision in a matter of weeks and then make a
recommendation to the Federal Department of Justice as
well as the Federal Trade Commission and any of my
insurance commissioner colleagues that have jurisdiction
over this transaction.

I want to thank my staff who did a fantastic
job in organizing and preparing the hearing. I've been
joined up here by Deputy Commissioner Janis Rocco, who
leads our health policy in reform, branch Mr. John
Finstin, our general counsel has escaped the box, and
now he's in the audience. But you can't miss him. He's
kind of tall. I want to thank both attorneys Hinze,

Trin Go Say for their tremendous work as well as our IT
staff and everyone else that was involved in the
hearing, and if there is no one else who wishes to
testify, we will now adjourn, and again, thank you very,
very much and I look forward to making a decision on
this tremendously important matter for California
consumers, California businesses and our health care
market.

Thank you very much.

(Proceedings concluded at 5:08 p.m.)

Dated: April 3, 2016

DEBRA L. ACEVEDO-RAMIREZ, hereby certify:
That I am a Certified Shorthand Reporter of the
State of California;
That in pursuance of my duties as such, I attended
the proceedings in the foregoing matter and reported
all of the proceedings and testimony taken therein;
That the foregoing is a full, true and correct
transcript of my shorthand notes so taken.

Dated: April 3, 2016

DEBRA L. ACEVEDO-RAMIREZ, RPR, CSR 7692
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