March 23, 2016

Insurance Commissioner Dave Jones
c/o Kayte Fisher, Attorney III
California Department of Insurance
300 Capitol Mall, Suite 1600
Sacramento, CA 95814

Sent via email to Kayte.Fisher@insurance.ca.gov

Re: Proposed merger of Cigna Corporation into Anthem, Inc.

Dear Commissioner Jones,

Consumers Union, the public policy and advocacy division of nonprofit Consumer Reports, offers this testimony on the proposed acquisition of Cigna Corporation ("Cigna") by Anthem, Inc. ("Anthem"). From its founding, Consumers Union has striven for a marketplace of safe, effective, reliable, and fairly priced products and services; access to affordable, high quality health care and coverage have always been deeply embedded in that mission. The advantages for health plans that merge are clear, but the advantages for consumers are not. In fact, we anticipate that a more consolidated insurance marketplace will lead to higher costs for consumers, with potentially lower quality products. While consumers around the nation await the outcome of the U.S. Department of Justice's investigation of this proposed merger, Californians also rely on our state regulators to take action as may be necessary to ensure that the sum of the merging plans is better than what consumers get when the plans stand alone.

In particular, we draw attention to: (1) the dominant, collective status of these insurers in California, (2) the fact that market consolidation is far more likely to benefit the carriers than the consumers, and (3) that increased market power may mean worse insurance products for consumers. We discuss these three aspects more fully below, as well as provide recommended steps to make the planned merger, in the event it goes forward, safer and more beneficial for consumers and the California insurance market.

I. Current state of the health insurance market in California

If this merger is approved, the combined insurance plan would cover *53 million* covered lives nationally, making Anthem the largest insurance company by membership and far ahead of United Healthcare's estimated 46 million members.[1] In California, a merged Anthem-Cigna would have about 8 million

[1] Bob Herman, *Anthem Acquiring Cigna in Largest-Ever Health Insurance Deal: $54.2B*, MODERN HEALTHCARE (July 24, 2015), http://www.modernhealthcare.com/article/20150724/NEWS/150729899.

members, slightly more than the currently largest health plan, Kaiser, with 7.8 million.[2] While the colossal size of this merged plan is of concern, the potential impact on the California market as a whole warrants closer attention. Even before a merger, Anthem is well entrenched, with a 46% share of the individual market in 2013.[3] In the same year, the largest three insurers in California dominated 84% of the individual, small group, and large group markets combined.[4] Broken out, the largest three insurers claimed 75% share of the small group market[5] and 74% of the large group market.[6]

II. Market consolidation helps carriers, not consumers

a. The fallacy of consolidation as an antidote to consolidation

Some interests assert that the merger of health plans is a necessary response to increased concentration in provider markets. That reasoning is faulty, especially for plans such as Anthem and Cigna, which together would enjoy a considerable market share, as described above. Rather, we agree with the American Antitrust Institute in its statement that, "Consolidation motivated largely by the quest for greater bargaining power between various participants in the supply chain is a losing proposition for competition and consumers."[7] Commonly known as the "Sumo Wrestler theory"-- with the two health sector giants, insurers and providers, exerting pressure on each other-- "experience suggests that a showdown between [them] may well result in a handshake rather than honest competition."[8] Although it might seem plausible that stronger market power will strengthen health plans' negotiating position with providers, it is also likely that having a high concentration of health insurers, as in other consolidated industries, will result in higher prices for consumers. This theory is borne out by experience. As explained by a health economist at USC's Schaeffer School for Health Policy and Economics, "when insurers merge, there's almost always an increase in premiums."[9] In addition to higher prices, we also predict decreased quality, less choice, and reduced innovation.

[2] Dan Diamond, *What the Anthem-Cigna Mega-Merger Could Mean for California*, CALIFORNIA HEALTHLINE (September 9, 2015), http://californiahealthline.org/news/what-the-anthem-cigna-mega-merger-could-mean-for-california.
[3] U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-15-101R, PRIVATE HEALTH INSURANCE: CONCENTRATION OF ENROLLEES AMONG INDIVIDUAL, SMALL GROUP, AND LARGE GROUP INSURERS FROM 2010 THROUGH 2013, at 19 (2014). Available at http://www.gao.gov/assets/670/667245.pdf.
[4] *Id*. at 13.
[5] *Id*. at 15.
[6] *Id*. at 17.
[7] Letter from the American Antitrust Institute to Assistant Attorney General William J. Baer of the U.S. Department of Justice, at 3 (January 11, 2016). Available at http://www.antitrustinstitute.org/sites/default/files/Health%20Insurance%20Ltr_1.11.16.pdf.
[8] Thomas Greaney, New Health Care Symposium: *Dubious Health Care Merger Justifications—The Sumo Wrestler and 'Government Made Me Do It' Defenses*, HEALTH AFFAIRS BLOG (Feb. 24, 2016), http://healthaffairs.org/blog/2016/02/24/dubious-health-care-merger-justifications-the-sumo-wrestler-and-government-made-me-do-it-defenses/.
[9] David Lazarus (quoting Erin Trish, a researcher at USC's Schaeffer School for Health Policy and Economics), *As Health Insurers Merge, Consumers' Premiums are Likely to Rise*, L.A. TIMES (July 10, 2015), http://www.latimes.com/business/la-fi-lazarus-20150710-column.html.

b. The dubious promise of shared savings with consumers

The announcement of a proposed merger—including a merger of health plans—is frequently padded with promises of cost savings to be passed along to consumers. Indeed, the announcement of this proposed merger was coupled with promises that the merger would "deliver meaningful value to consumers and shareholders through…enhanced affordability and cost of care management capabilities."[10] The public was also assured that this merger would "help address our health system's challenges and provide supplemental insurance protection, and health care security to consumers."[11] However, consumers have reason to doubt assurances that this proposed merger would afford efficiencies for the benefit of consumers. Research reveals a dearth of economic studies or other evidence substantiating those kinds of assurances to be borne out in practice. As explained by one leading healthcare antitrust scholar regarding such health plan mergers, even if a more powerful health insurer can force lower reimbursement rates to providers, there is "little incentive [for an insurer] to pass along the savings to its policyholders."[12] It may be that plans do achieve savings by combining some aspects of their operations and launching new programs. But evidence suggests that savings from these programs will be limited to "small pockets of inefficiency."[13] Beyond that, the savings of "more affordable" products could be attributable to lesser quality, reductions in customer service, or excessively narrow provider networks. Consumers need assurances that any cost savings will not be achieved via reductions in the availability or quality of services. Finally, claimed efficiencies through vague "synergies" are often illusory; improvements in quality or service can generally be achieved just as well without merging.

c. The unfounded linkage between consolidation and innovation

Consumers and regulators should be wary of assurances, such as the one by the President and CEO of Anthem, that the proposed merger will "deliver meaningful value to consumers" through "superior innovation".[14] As one leading expert testified before the Senate Committee on the Judiciary, "there is no research showing that larger insurers are likelier to innovate."[15] In a recently released paper, that expert

[10] Statement of Joseph Swedish, President and Chief Executive Officer of Anthem (July 24, 2015) (press release available at http://betterhealthcaretogether.com/content/uploads/2015/10/Better-Healthcare-Together_Press-Release.pdf).

[11] Statement of David M. Cordani, President and Chief Executive Officer of Cigna (July 24, 2015) (press release available at http://betterhealthcaretogether.com/content/uploads/2015/10/Better-Healthcare-Together_Press-Release.pdf).

[12] Thomas Greaney, *Examining Implications of Health Insurance Mergers*, HEALTH AFFAIRS BLOG (July 16, 2015), http://healthaffairs.org/blog/2015/07/16/examining-implications-of-health-insurance-mergers/.

[13] Amy Nordrum (quoting Mark Pauly, an expert in the economics of healthcare at the Wharton School of the University of Pennsylvania), *Aetna-Humana Merger: Major Insurers Seek Programs to Improve Care and Reduce Costs*, INTERNATIONAL BUSINESS TIMES (November 23, 2015), http://www.ibtimes.com/aetna-humana-merger-major-insurers-seek-programs-improve-care-reduce-costs-2192875.

[14] Statement of Joseph Swedish, President and Chief Executive Officer of Anthem (July 24, 2015) (press release available at http://betterhealthcaretogether.com/content/uploads/2015/10/Better-Healthcare-Together_Press-Release.pdf)

[15] Testimony of Leemore Dafny, PhD., *Health Insurance Industry Consolidation: What Do We Know From the Past, Is It Relevant in Light of the ACA, and What Should We Ask?*, before the Subcommittee on Antitrust, Competition

expanded on her statement, finding that "there is no evidence of greater product innovation in more concentrated insurance markets," and in fact noting to the contrary that, "insurers in more concentrated markets are less motivated to innovate because it isn't necessary to retain customers."[16] Indeed, it is unclear here how innovation would improve post-merger. Despite questions from consumer groups along those lines, we have yet to hear an adequate explanation from the carriers of why innovation is inextricably linked with their consolidation. It is not even apparent what health plans mean when they say "innovation." If *innovation* in this context means selective contracting, or network management as suggested by some scholars[17], this is not exactly a breakthrough that justifies a major shift in the composition of the insurance market. We support innovation that makes high quality products more affordable, improves health outcomes, or makes significant inroads in reducing racial and ethnic disparities. Health plans must be held accountable for assurances such as these so that they are not merely empty or self-interested promises.

III. Increased market power may mean worse insurance products for consumers

Consumers are justified in questioning whether newly merged plans—with increased market power and less competition—will offer lower quality insurance products than in the past. Health carriers are more than a financial conduit between consumers and providers; the plans also have a direct relationship with consumers, such as by coordinating care and providing supplemental information or programs. It is, therefore, necessary to consider not only whether and how health plan market consolidation will affect prices for consumers, but also how decreased competition may alter the actual product.

a. The risk of quality going from bad to worse

The records for both Anthem and Cigna are replete with shortcomings, raising concern that the newly merged plans may adopt each other's perhaps less costly but worse practices, rather than adopt each other's best practices.

- In 2012, the California Department of Insurance (CDI) brought legal action against Cigna, (and Health Net), in response to Independent Medical Review (IMR) requests by Cigna policyholders who were—inappropriately, in the determination of CDI—denied coverage for Autism therapy.[18] The CDI and Cigna reached an agreement[19] obligating Cigna to cover behavioral therapy for

Policy, and Consumer Rights of the Senate Committee on the Judiciary, 114th Cong. 3 (2015) . Available at http://www.judiciary.senate.gov/imo/media/doc/09-22-15%20Dafny%20Testimony%20Updated.pdf.

[16] Leemore Dafny and Christopher Ody, *New Health Care Symposium: No Evidence That Insurance Market Consolidation Leads to Greater Innovation*, HEALTH AFFAIRS BLOG, (February 24, 2016), http://healthaffairs.org/blog/2016/02/24/no-evidence-that-insurance-market-consolidation-leads-to-greater-innovation/.

[17] *Id.*

[18] Press Release, California Department of Insurance, Insurance Commissioner Dave Jones Announces Agreements with Major Health Insurers to Provide Autism Coverage (February 27, 2012)(available at http://www.insurance.ca.gov/0400-news/0100-press-releases/2012/release017-12.cfm).

[19] *In the Matter of Connecticut General Life Insurance Company,* Before the Insurance Commissioner of the State of California, File No. UPA-2011-xxxxx, Stipulation and Waiver signed February 27, 2012. Available at http://www20.insurance.ca.gov/ePubAcc/Graphics/169853.pdf.

autism for the period of time leading up to enactment of SB 946, which requires health care service plan contracts and health insurance policies to provide coverage for behavioral health treatment for autism or other development disorders.

- In 2013, Anthem had the highest rate of IMR requests among health plans operating in California with 400,000 or more enrollees. Among all the health plans in the state, of any size, Anthem had the third-highest rate of IMRs.
- In 2013, Cigna was middle of the pack for IMR requests among plans with fewer than 400,000 enrollees. However, Cigna's rate of consumer complaints increased by 15% in 2014, causing the health plan to become the third-highest rate of IMR requests among plans with 400,000 or fewer members.[20]
- In 2014, Cigna and Anthem both had a higher rate of IMR requests than in 2013. In 2014, Anthem continued to have the highest rate of IMR requests among health plans operating in California with 400,000 or more enrollees. Nearly half of decisions involving Anthem that went through the IMR process for experimental/investigational care were overturned by DMHC[21], and about 60% of IMRs for medical necessity or Emergency Department reimbursement were either overturned by DMHC or reversed by the plan.[22] In 2014, Anthem also had the highest rate of IMR requests for all plans.
- In 2014, Anthem had:
    - The highest rate of complaints regarding access issues among plans with 400,000 or more enrollees, and the second highest rate of complaints for all DMHC-regulated plans.
    - The second highest rate of complaints to DMHC regarding claims and financial of all the plans with 400,000 or more enrollees.
    - The second highest rate of complaints to DMHC related to enrollment of all plans, as well as for the sub-category of plans with 400,000 or more enrollees, nearly tied with the plan that had the highest rate of complaints for this category.
    - The most complaints to DMHC regarding the "attitude" or service of the health plan among plans with 400,000 or more enrollees, and the second-most complaints for the same category among all plans.
- In 2014, Cigna had the third highest rate of consumer complaints regarding attitude/service among plans with fewer than 400,000 members.

[20] *See* CALIFORNIA DEPARTMENT OF MANAGED HEALTH CARE, INDEPENDENT MEDICAL REVIEW SUMMARY REPORT (2013), https://www.dmhc.ca.gov/Portals/0/FileAComplaint/DMHCDecisionsAndReports/AnnualComplaintAndIMRDecisions/2013.pdf(showing that Cigna had 0.85 IMRs per 10,000). *See also* CALIFORNIA DEPARTMENT OF MANAGED HEALTH CARE, INDEPENDENT MEDICAL REVIEW SUMMARY REPORT (2014) [hereinafter *2014 Annual DMHC Report*], https://www.dmhc.ca.gov/Portals/0/FileAComplaint/DMHCDecisionsAndReports/AnnualComplaintAndIMRDecisions/2014.pdf (showing that Cigna had 1.01 IMRs per 10,000).
[21] *2014 Annual DMHC Report.*
[22] *2014 Annual DMHC Report.*

- In 2014, DMHC conducted a non-routine survey of Anthem Blue Cross provider networks and directories for the individual market and took enforcement action against the plan. [23] Fining the plan $250,000, the Department in its press release stated that Anthem would be required to "improve the accuracy of their provider directories and reimburse enrollees who may have been negatively impacted by inaccuracies in provider directories."[24]
- The California Office of the Patient Advocate (OPA) found, in its Health Care Quality Report Cards 2015-2016 Edition, based on surveys of HMO and PPO policyholders that:[25]
    - Anthem Blue Cross PPO was rated *Poor* (one star out of four) for the product overall[26] and that its HMO was rated *Poor* for *Getting care easily*.[27]
    - Cigna PPO was rated *Poor* for *Getting care easily* and *PPO helps members get answers*[28] and its HMO was rated *Poor* for both *Getting care easily* and for *Heart care*.[29]
- Out of 507 ranked private plans, the NCQA ranked Anthem Blue Cross HMO/POS #317, Anthem Blue Cross PPO #329, and Anthem Blue Cross Life and Health Insurance #330.[30]
- In the NCQA scoring, the Anthem Blue Cross HMO/POS product earned a below-average score for *customer satisfaction*, earning only 2 out of 5 for *getting care* and the lowest score possible, a 1 out of 5, for how consumers rated satisfaction with the product's specialists.[31] Also troubling, the HMO/POS product received low scores for well-child visits and access to pediatricians. In fact, the product earned only a single star when consumers were asked whether children age 15 months got the recommended up to six well-child visits since birth.[32]
- Failure to adequately ensure consumer privacy and data security
    - In 2013, Anthem (at the time called Wellpoint), the parent firm of Anthem Blue Cross Blue Shield in Virginia and Empire BlueCross BlueShield in New York, agreed to settle a

[23] Press Release, Department of Managed Health Care, DMHC Fines Blue Shield and Anthem for Inaccurate Provider Directories (November 3, 2015) (available at http://www.dmhc.ca.gov/portals/0/abouttheDMHC/newsroom/2015/pr110315.pdf).
[24] *Id*.
[25] The OPA patient ratings are based on Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey results. This survey queries HMO and PPO members on the care and services they received by their health plan.
[26] *Anthem Blue Cross PPO 2015-16 Edition*, State of California Office of the Patient Advocate. Available at http://reportcard.opa.ca.gov/rc/profile.aspx?EntityType=PPO&Entity=BLUE_CROSS_PPO.
[27] *Anthem Blue Cross HMO 2015-16 Edition*, State of California Office of the Patient Advocate. Available at http://reportcard.opa.ca.gov/rc/profile.aspx?EntityType=HMO&Entity=BLUE_CROSS.
[28] *Cigna HMO 2015-16 Edition*, State of California Office of the Patient Advocate. Available at http://reportcard.opa.ca.gov/rc/profile.aspx?EntityType=PPO&Entity=CIGNA_PPO.
[29] *Cigna HMO 2015-16 Edition*, State of California Office of the Patient Advocate. Available at http://reportcard.opa.ca.gov/rc/profile.aspx?EntityType=HMO&Entity=CIGNA.
[30] *NCQA Health Insurance Plan Rankings 2014-2015 – Summary Report (Private)*. Available at http://healthplanrankings.ncqa.org/2014/.
[31] *NCQA Health Insurance Plan Rankings 2014-2015 – Detail Report (Private)*, Plan Name: Anthem Blue Cross. Available at http://healthplanrankings.ncqa.org/2014/HprPlandetails.aspx?id=121.
[32] *Id.*

claim of potential HIPAA violations by paying a $1.7 million fine. According to HHS, "more than the health records of more than 600,000 individuals were found to be vulnerable to Internet breach" and that Wellpoint had inadequate technical safeguards against such a breach.[33]

- In Spring 2015, waiting four months after they discovered it, Anthem finally disclosed a data breach affecting as many as 80 million past and current policyholders.[34, 35] Through a cyberattack on its IT system, hackers may have gained access to policyholders' names, birthdays, Social Security numbers, health care ID numbers, home addresses, email addresses, employment information, and income data.[36] Anthem estimated that the breach occurred over the course of several weeks in December 2014. Experts said Anthem was a likely target for hackers because "they have been slower to adopt measures" to protect consumers and are "generally less secure than financial service companies who have the same type of customer data."[37]

- On September 3, 2014, DMHC issued a Preliminary Report to Anthem Blue Cross, in which the Plan was cited for seven deficiencies (shown below). In its 2015 Final Routine Survey[38], the Department found that Anthem had not corrected *any* of the noted deficiencies. Those were[39]:
  - Grievances and appeals: (1) failure to maintain a grievance system that consistently ensures any written or oral expression of dissatisfaction; (2) impermissible processing of standard grievances pertaining to coverage disputes, disputed health care services involving medical necessity, and experimental or investigational treatment through its exempt grievance process; (3) impermissible processing of standard grievances that are not resolved by the close of the next business day through its exempt grievance process; (4) failure to maintain a grievance system that consistently ensures adequate consideration of enrollee grievances and rectification where appropriate.
  - Grievances and appeals (behavioral health only): their grievance system does not consistently ensure compliance with all acknowledged letter requirements.

[33] *Anthem, Empire Parent Firm Settles HIPAA Charges for $1.7 Million Fine*, INSURANCE & FINANCIAL ADVISOR (July 18, 2013), http://ifawebnews.com/2013/07/18/anthem-empire-parent-firm-settles-hipaa-charges-for-1-7-million-fine/.
[34] Reed Abelson and Matthew Goldstein, *Anthem Hacking Points to Security Vulnerability of Health Care Industry*, N.Y. TIMES: BUSINESS DAY (February 5, 2015), http://www.nytimes.com/2015/02/06/business/experts-suspect-lax-security-left-anthem-vulnerable-to-hackers.html?_r=0.
[35] ANTHEM, https://www.anthemfacts.com/ (last updated August 25, 2015)
[36] Reed Abelson and Matthew Goldstein, *Anthem Hacking Points to Security Vulnerability of Health Care Industry*, N.Y. TIMES: BUSINESS DAY (February 5, 2015), http://www.nytimes.com/2015/02/06/business/experts-suspect-lax-security-left-anthem-vulnerable-to-hackers.html?_r=0.
[37] *Id*.
[38] *Final Report Routine Survey of Blue Cross of California*, DEPARTMENT OF MANAGED HEALTH CARE HELP CENTER DIVISION OF PLAN SURVEYS (April 3, 2015). Available at http://dmhc.ca.gov/desktopmodules/dmhc/medsurveys/surveys/303_r_full%20service-behavioral%20health_040315.pdf.
[39] *Id.*

  - Utilization management: for decisions to deny, delay, or modify health care service requests by providers based in whole or in part on medical necessity, the plan does not consistently include in its written response: a clear and concise explanation or the reasons for the decision, a description of the criteria or guidelines used, and the clinical reasons for the decision.

- In 2015, DMHC fined Anthem more than $1.5 million for the plan's failure to pay for an important screening for pregnant women when the only provider able to conduct that screening was out-of-network.[40]
- In 2015, the Missouri Department of Insurance fined Cigna subsidiaries $140,800 for "using unapproved forms, incorrectly denying chiropractic claims, charging copayments of more than 50 percent and failing to send an explanation of benefits to members."[41]
- In 2016, CMS issued an enforcement action prohibiting Cigna from enrolling new Medicare beneficiaries in a number of regions and from marketing activities to Medicare beneficiaries. In its enforcement notice, CMS stated that Cigna "substantially failed to comply with CMS requirements" and that Cigna's failures were "widespread and systemic. Violations resulted in enrollees experiencing delays or denials in receiving medical services and prescription drugs, and increased out of pocket costs for medical services and prescription drugs."[42]

Despite historical underperformance of these plans and significant customer service and quality problems, Anthem instead recently announced a 4% increase in shareholder dividends.[43] Yet, in its rate filing justification for the 2016 plan year, Anthem projected increased administrative expenses and profits alongside *decreases in quality improvement expenses* compared to what was projected for the year prior.[44] While for-profit corporations have an obligation to their shareholders, they do not need to increase dividends rather than reinvest those profits in improving their products. It is illogical to suppose that with even less competition Anthem would elect to spend its profits to improve its product rather than its bottom line and the pockets of its investors.

[40] Letter of Agreement between DMHC and Anthem Blue Cross, Enforcement Action 11- 371 (May 8, 2015). Available from http://wpso.dmhc.ca.gov/enfactions/docs/2294/1432760550987.pdf. The Department leveraged a $1.5 million administrative penalty against the insurer for failing to cover alpha fetal protein (AFP) testing at in-network rates.

[41] Missouri Department of Insurance, Missouri Department of Insurance Fines Health Insurer Cigna for Violations, (August 13, 2015) (available at http://insurance.mo.gov/news/2015/Missouri_Department_of_Insurance_fines_health_insurer_Cigna_for_violations).

[42] Letter from Department of Health & Human Services to Cigna-HealthSpring President Herb Fritch, at 2 (January 21, 2016). Available at https://www.cms.gov/Medicare/Compliance-and-Audits/Part-C-and-Part-D-Compliance-and-Audits/Downloads/Cigna_Sanction_01_21_16.pdf.

[43] *Anthem Declares First Quarter 2016 Dividend of $0.65 Per Share*, BUSINESSWIRE (18 February 18, 2016), http://www.businesswire.com/news/home/20160218006619/en/Anthem-Declares-Quarter-2016-Dividend-0.65-Share.

[44] Consumers Union comments on Blue Cross of California (dba Anthem Blue Cross) Rate Filing, SERFF Tracking Number AWLP-130080574, at 6 (September 1, 2015).

Therefore, as a condition for any approval of this merger, we urge the regulators to obtain contractual obligations that raise the bar for quality for both plans. This may include an enhanced grievance process so policyholders can have issues resolved before escalating to the Independent Medical Review stage, improved customer service, and a detailed plan and launch schedule to improve data security.

b. The potential for deteriorating provider networks

Health plans are continuously adjusting their networks, partly in an effort to negotiate more favorable rates with providers and contain the cost of care. Although network narrowing has become a hot button topic, a recent report from the Robert Wood Johnson Foundation found that "[m]ore than 95 percent of regionally ranked hospitals were in-network with at least one Affordable Care Act marketplace plan in both 2015 and 2016."[45] Through careful tailoring, the California health insurance market shows regionally ranked hospitals included in 12 out of Covered California's 12 regions, an increase of 10% in 2016 over 2015.[46] We worry whether a merged mega-plan like the one proposed here will disrupt the current balance on the networks in California. For example, in Missouri, there was an outcry among consumers when the network for the Anthem BlueCross BlueShield plans, sold on the federal marketplace, did not include BJC HealthCare and its 13 hospitals, including Barnes-Jewish Hospital, an internationally recognized academic medical center, and its children's hospital.[47]

Carefully tailored networks can be a valid option for lowering costs and attaining higher value in the health care system. However, "sufficient consumer protections must be in place to realize these benefits without unduly limiting consumer choice or decreasing healthcare value."[48] Among other factors to be considered, there must be sufficient numbers and types of providers in the marketplace to ensure consumers can access high quality affordable care when needed. Yet, the risk of two major plans merging and using their clout—and reduced competition-- to shrink networks is concerning in terms of whether consumers will be able to access care. We, therefore, strongly urge California regulators, in the event this merger is approved, to closely monitor the plan networks, and to hinge any merger approval on undertakings related to both network adequacy and provider directory accuracy.

c. A larger carrier may be less responsive to rate review

Although our California regulatory scheme successfully compelled health plans in California to reduce proposed rate increases by about $349 million over three years,[49] the fact remains that California is a *file and use* state, and a health plan that is disinclined to work with regulators is not required to do so. In

[45] *Most Regionally Ranked Hospitals Stay In-Network with Marketplace Plans, But Participation Declines*, Robert Wood Johnson Foundation, at 1 (February 23, 2016). Available at http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2016/rwjf426368.
[46] *Id*. at 4.
[47] Jay Hancock, *Consumer Groups Criticize Anthem's Narrow Network in Missouri's Obamacare Marketplace*, KAISER HEALTH NEWS (September 26, 2013), http://khn.org/news/narrow-insurance-network-missouri-exchange-marketplace/.
[48] *Addressing Consolidation in the Healthcare Industry*, CONSUMERS UNION HEALTH CARE VALUE HUB, Research Brief No. 10, at 7 (January 2016), http://www.healthcarevaluehub.org/files/2614/5452/4976/Addressing_Consolidation_in_Healthcare.pdf.
[49] See *California Health Insurance Rate Review*, CALPIRG, at 7 (April 17, 2014), http://www.calpirg.org/reports/cap/california-health-insurance-rate-review.

addition to benefiting from two insurance regulators that rigorously review rate filings,[50] Californians also have the advantage of a state-based marketplace that, through its active purchaser status, negotiates rates before they are even subjected to regulatory review. But the ability of Covered California to moderate rate increases has limitations. In 2015, for example, CDI announced that Anthem failed to justify its rate increase for consumers with individual grandfathered health insurance products and that the carrier refused to honor to a request by CDI to moderate the rate increase.[51] The merger of Anthem and Cigna, with its greatly expanded market share, threatens to further shift this delicate balance. Anthem recently filed with DMHC a proposed small group rate increase averaging 13.5% with a maximum of 24.9%, which would affect 39,000 members.[52] If Anthem increases its market share, and businesses on the small group market have fewer options, how will consumers absorb such a large increase, especially since it may tend to happen year after year?

Even in a relatively positive climate for rates in California, where the combination of rate review and an active purchaser marketplace may moderate rate increases, Anthem's performance in the process leaves room for improvement. For example, in its 2016 rate filing justification, Anthem indicated intent to increase its administrative expenses by 27% in 2016 over its proposal for 2015. However, rather than explaining *why* the administrative costs will expand exponentially, the carrier simply defined what is an administrative cost.[53] Additionally, of the Anthem plans regulated by DMHC and CDI between 2011 and 2016, nearly all had premium increases at or above the median.[54] Notably, two of its individual products that were regulated by CDI in 2013 had premium increases significantly above the median—19.4% and 25.6%—and affecting a total of 636,144 enrollees, even after dropping its rate increases from 24.6% and 28.1% respectively.[55]

Anthem has proven itself willing to go up against state regulators who do not approve its exorbitant rate increases. Anthem Blue Cross and Blue Shield of Maine went to court after the state, which has prior approval authority, refused to approve an average rate hike of 18.5 percent on its policyholders. The court found against Anthem on all its arguments, holding that the "Superintendent's balancing of consumer interests against Anthem's desire for profits was appropriate."[56] If this merger is approved, regulators may find themselves reviewing larger rate increases across the table from a large health plan

[50] For example, in 2014, Anthem Blue Cross initially requested 12-month rate increases averaging 15.2% for its small group business. After discussion with DMHC, Anthem Blue Cross lowered the average rate increase, saving consumers approximately $35 million. *2014 Annual DMHC Report*, *supra* note 22, at 13.

[51] Press Release, California Department of Insurance, Anthem Blue Cross Fails to Justify Rate Increase on Individual Grandfathered Health Insurance Policies (April 22, 2015) (available at http://www.insurance.ca.gov/0400-news/0100-press-releases/2015/release044-15.cfm).

[52] Blue Cross of California (dba Anthem Blue Cross) Rate Filing, SERFF Tracking Number AWLP-130344239 (submitted November 25, 2015). Available at http://wpso.dmhc.ca.gov/ratereview/Detail.aspx?lrh=M%2fo1fxhi6Wk%24.

[53] Consumers Union comments on Blue Cross of California (dba Anthem Blue Cross) Rate Filing, SERFF Tracking Number AWLP-130080574, at 6 (September 1, 2015).

[54] Katherine Wilson, *Individual Health Insurance Premium Growth in California*, CALIFORNIA HEALTH CARE FOUNDATION (November 2015), http://www.chcf.org/publications/2015/11/individual-premiums-growth-california.

[55] *Id*.

[56] *Summary of Key Points of Anthem health Plans of Maine, Inc. v. Superintendent of Insurance, Maine Attorney General, and Consumers for Affordable Health Care*, CONSUMERS FOR AFFORDABLE HEALTH CARE (2012), http://www.mainecahc.org/wp-content-cahc/uploads/Anthem_summary.pdf.

unwilling to negotiate. Consumers Union, therefore, urges the regulators to link any approval, if one is ultimately forthcoming, to an enforceable undertaking that obligates the newly formed plan to only go forward with rates that are reasonable and fully justified.

IV. Recommended steps to protect the interest of consumers should the merger be approved

For approval of this merger to be in the public interest, consumers would need assurances that the newly combined Anthem-Cigna corporation will be an improvement for consumers—on access, affordability, and quality—rather than leaving consumers carrying the weight of this deal. We, therefore, recommend that, if the merger does go forward, regulators secure the following assurances from Anthem-Cigna as a condition for any approval.

- Health insurance rates: The merged company should agree to not moving forward with premium rate increases in any market segment that the regulator deems unjustified or that contain inaccurate or incomplete information. Given the risk that the bigger merged company could unreasonably increase premiums, it should agree to providing even greater detail, and making it publicly available, to aid the regulator in especially close rate review, for a number of years after the merger. And to begin with, it should agree that Covered California, DMHC, and CDI may calculate any proposed increase rate based on Anthem or Cigna rates for the 2016 plan year, whichever sold the original product in that year. No proposed rate increase should be permitted to be finalized if it has been deemed unreasonable or unjustified by the regulators; instead, the plan should confer with regulators until a reasonable and justified rate is set. This should apply to all lines of business subject to rate review at the time the rate is filed. While this would not replace the protections provided by effective competition, it would help alleviate some of the potential excesses.

- Quality improvement and cost containment initiatives: Existing state law requires that each plan's rate filing include "any cost containment and quality improvement efforts since the last filing for the same category of health benefits plan. To the extent possible, the plan shall describe any significant new health care cost containment and quality improvement efforts and provide an estimate of potential savings together with an estimated cost or savings for the projection period."[57] Unfortunately, that requirement is often honored more in the breach than the observance. In fact, in commenting on Anthem's rate filing justification for 2015, Consumers Union noted that the plan's actuarial memorandum "simply lists a generic assortment of quality improvement programs. … [I]t neither provides details on cost containment and quality improvement efforts nor estimates of costs or savings, as required."[58] The same was true in the following year, when Consumers Union's comment to DMHC was that, "The problem here is that without details about the initiatives and the related costs, it is difficult to see this report as

[57] CAL. HEALTH & SAFETY CODE § 1385.03(c)(3) (Deering 2016).
[58] Consumers Union comments on Blue Cross of California Rate Filing, SERFF Tracking Number AWLP-129656693, (August 27, 2014).

anything other than a laundry list of quality improvement catch-phrases."[59] We urge the regulators to secure specific and enforceable assurances that Anthem-Cigna will reinvest a meaningful portion of profits in quality improvement and cost containment initiatives and provide clear explanations and documentation of those investments, dollar breakdowns, estimated savings, and descriptions of how each of them directly benefits policyholders.

- Improving quality and consumer satisfaction ratings: Achieving above average quality ratings as measured by NCQA, Covered California, the Right Care Initiative, and the Office of Patient Advocate Quality Report Card, by no later than the performance measurement period ending December 31, 2017. For example, in addition to merely maintaining NCQA certification, any such undertaking should compel the combined plans to improve consumer satisfaction scores to at-or-above average for all three categories: *Getting care*, *Satisfaction with physicians*, and *Satisfaction with health plan services.* Similarly, we want to see specific and enforceable commitments to raising its CAHPS scores—for both commercial and Medi-Cal markets-- as reflected in the OPA Health Care Quality Report Cards, to meet or exceed average ratings.
- Improving its provider directory: Making available to consumers, policyholders and non-policyholders, an accurate provider directory that is easily accessible. The issue of provider directory inaccuracies is a serious one and likely to be exacerbated by a merged company combining IT systems and revising provider networks and products, all the while having less incentive to work to satisfy the needs and preferences of consumers.
- Dedicated staffing for transition issues: Whether due to network shifts, information technology glitches or other operational issues, mergers inevitably have bumps in the road which will disrupt the lives of the newly merged company's customers. Consumers Union recommends that the regulators require dedicated, increased staffing in California and anywhere else trouble spots in the company may arise and affect California consumers. For example, such relevant personnel may be needed to craft provider directories, provide customer service, and to ensure that protected health information is continuously secured through the transition and thereafter.

Conclusion

In conclusion, the California commercial health insurance marketplace has been relatively competitive and stable to date. We believe this has worked to consumers' advantage. Consolidation in that marketplace—from this and other pending mergers—is worrisome both for marketplace stability and for pricing and quality and access for consumers. Consumers Union appreciates the Department of Insurance holding a hearing on this proposal and its openness to input. The Justice Department, working with the California Attorney General, could determine that the merger should not go forward, and challenge it under the antitrust laws. Or, state regulators might decide under their own authority not to approve the merger. But if the merger ultimately goes forward, Consumers Union urges the regulators

[59] Consumers Union comments on Blue Cross of California Rate Filing, SERFF Tracking Number AWLP-130080574, (September 1, 2015).

to consider appropriate actions, including the actions described above, to ensure that the merger does not harm consumers or insurance markets in California.

Sincerely,

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