

**In the matter of the proposed acquisition of  
Health Net, Inc. by Centene Corporation  
APP-2015-00889**

**Documents Introduced at Hearing,  
January 22, 2015,  
and documents submitted after hearing**

**January 29, 2016**

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FORM A

STATEMENT REGARDING THE ACQUISITION OF CONTROL OF  
**HEALTH NET LIFE INSURANCE COMPANY**  
(the "Domestic Insurer")

by

**CENTENE CORPORATION,  
CHOPIN MERGER SUB I, INC.,**

and

**CHOPIN MERGER SUB II, INC.**

(each an "Applicant" and, collectively, the "Applicants")

Filed with the California Department of Insurance

Dated: July 31, 2015

Name, Title, Address, Telephone Number and Email Address of Individuals to Whom Notices  
and Correspondence Concerning this Form A Statement Should be Addressed:

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This Form A Statement (this "Form A") seeks the approval of the Commissioner of Insurance of the State of California (the "Commissioner") pursuant to the requirements of California Insurance Code § 1215.2 for the acquisition of control of the Domestic Insurer by the Applicants.

This Form A contains confidential and/or proprietary information, and strategies that are not otherwise available to the public, that, if disclosed, could cause substantial injury to the competitive position of the Applicants. Accordingly, the Applicants request confidential treatment, pursuant to California Insurance Code section 12919, California Government Code sections 6254 and 6255, and California Civil Code section 1798.24, for Exhibit CE-1, Exhibit CE-2, and Exhibit CE-3, which comprise the confidential supplement to this Form A.

In particular, the biographical affidavits labeled as Exhibit CE-1 are submitted to the Commissioner in confidence and contain information that is not otherwise available to the public and should be afforded confidential treatment. The biographical affidavits are provided with the express understanding that the confidentiality of such biographical affidavits will be safeguarded and the executive officers and directors of the Applicants will be protected from any and all unwarranted invasions of personal privacy pursuant to all applicable provisions of law, including but not limited to, California Government Code section 6254 and California Civil Code section 1798.24.



## ITEM I. AGREEMENT OF MERGER

### The Domestic Insurer

This Form A relates to a proposed acquisition of control (the "Proposed Acquisition of Control") of the Domestic Insurer, Health Net Life Insurance Company, a California domiciled stock life and health insurance company. The main administrative office of the Domestic Insurer is located at 21281 Burbank Boulevard, B3, Woodland Hills, California 91367. The Domestic Insurer's NAIC number is 66141. The Domestic Insurer's Federal Identification Number is 73-0654885.

The Domestic Insurer is a direct wholly owned subsidiary of Health Net of California, Inc., a California corporation, which, in turn, is a direct wholly owned subsidiary of Health Net, Inc., a publicly traded Delaware Corporation ("Health Net").

### Method of Acquisition

#### Merger Agreement

On July 2, 2015, Centene Corporation, a publicly traded Delaware corporation ("Centene"), Chopin Merger Sub I, Inc., a Delaware corporation and a direct wholly owned subsidiary of Centene ("Merger Sub I"), Chopin Merger Sub II, Inc., a Delaware corporation and a direct wholly owned subsidiary of Centene ("Merger Sub II") and together with Merger Sub I, "Merger Subs", and Health Net, entered into an Agreement and Plan of Merger, a copy of which (including Exhibit B (Form of Second Merger Agreement)), is attached hereto as Exhibit A and incorporated herein by reference (the "Merger Agreement").

The Merger Agreement provides that, subject to the terms and conditions set forth therein, Merger Sub I will merge with and into Health Net (the "Merger"), with Health Net continuing as the surviving corporation in the Merger (the "Surviving Corporation"). Upon the consummation of the Merger, Health Net will be a wholly owned subsidiary of Centene. If Health Net's counsel provides a legal opinion regarding certain aspects of the tax treatment of the transaction, then immediately following the completion of the Merger, Health Net (as the surviving corporation in the Merger) will merge (the "Second Merger") with and into Merger Sub II, with Merger Sub II continuing as the surviving corporation in the Second Merger (the "Final Surviving Corporation") as a wholly owned subsidiary of Centene. Immediately following consummation of the Second Merger, Merger Sub II will be renamed Health Net, Inc. Following the consummation of the Merger (and if effected, the Second Merger), Centene will directly own 100% of the issued and outstanding shares of capital stock of Health Net, and will thereby indirectly own 100% of the issued and outstanding shares of capital stock of the Domestic Insurer. For the avoidance of doubt, regardless of whether the Second Merger occurs, Centene will acquire all of the outstanding equity securities of Health Net in the Merger.

At the effective time of the Merger, each share of Health Net common stock, par value \$0.001 per share, that is issued and outstanding immediately prior to the effective time of the Merger (excluding shares held by Health Net in treasury, any shares held, directly or indirectly, by Centene, by Merger Sub I or by Merger Sub II and any shares that are outstanding

immediately prior to the effective time of the Merger and that are held by any person who is entitled to demand and properly demands appraisal of such shares pursuant to Delaware law) will be converted into the right to receive the merger consideration (the "Merger Consideration"), which will consist of \$28.25 in cash and 0.622 of a share of Centene common stock, par value \$0.001 per share. The Merger Consideration will be paid in connection with the Merger and there will be no additional consideration paid if the Second Merger occurs.

At the effective time of the Merger, (i) each outstanding stock option to purchase shares of Health Net common stock will be converted into a right to receive cash and shares of Centene's common stock (net of the option exercise price); (ii) each of Health Net's vested performance share awards and vested restricted stock units will be converted into rights to receive the Merger Consideration in respect of the shares of Health Net common stock subject to the awards and units; and (iii) each unvested performance share award and each unvested restricted stock unit of Health Net will be converted into rights to receive shares of Centene's common stock, subject to the same criteria, provided that any performance vesting goal will be deemed satisfied at target.

The transaction is valued at approximately \$6.8 billion in cash and stock, based on stock prices as of July 1, 2015 and including the assumption of approximately \$500 million in debt from Health Net. Following consummation of the Proposed Acquisition of Control, existing stockholders of Centene will own approximately 71% of the combined company and existing stockholders of Health Net will own approximately 29% of the combined company based on stock prices and outstanding shares of Centene common stock and Health Net common stock as of July 1, 2015.

Each of Centene, Merger Subs, and Health Net has made customary representations and warranties in the Merger Agreement. The Merger Agreement also contains customary covenants and agreements, including covenants regarding the conduct of Health Net's and Centene's respective businesses prior to the closing of the Mergers and efforts of the parties to cause the Merger to be completed.

The completion of the Merger is subject to the satisfaction or waiver of customary closing conditions, including but not limited to: (i) approval of the Merger Agreement by Health Net's stockholders, (ii) approval of the issuance of Centene's common stock forming part of the Merger Consideration by Centene's stockholders, (iii) approval for listing of such Centene common stock on the New York Stock Exchange (the "NYSE"), (iv) there being no law or order prohibiting consummation of the Merger or the issuance of the shares of Centene's common stock forming part of the Merger Consideration, and there being no governmental proceeding pending that seeks to impose a burdensome condition on Health Net or Centene, (v) expiration or termination of any waiting period under the Hart-Scott-Rodino Antitrust Improvements Act of 1976, as amended, (vi) the effectiveness of a registration statement on Form S-4 with respect to the Centene common stock to be issued as part of the Merger Consideration, (vii) subject to specified materiality standards, the accuracy of the representations and warranties of the other party, (viii) compliance by the other party in all material respects with its covenants, and (ix) specified governmental filings and consents having been made or obtained. The completion of the Merger is not conditioned on receipt of financing by Centene.

The foregoing summary of the terms of the Merger Agreement is qualified in its entirety by the terms and conditions of the Merger Agreement.

#### Voting Agreements

Simultaneously with the execution of the Merger Agreement, on July 2, 2015, Centene entered into a voting agreement with Jay M. Gellert, President and Chief Executive Officer of Health Net, and Health Net entered into a voting agreement with Michael F. Neidorff, President and Chief Executive Officer of Centene, pursuant to which each has agreed to vote their respective shares in favor of the transactions contemplated by the Merger Agreement. A copy of each such voting agreement is attached hereto as Exhibit B-1 and Exhibit B-2 and is incorporated herein by reference.

### **ITEM II. IDENTITY AND BACKGROUND OF THE APPLICANTS**

#### **(a) Name and Business Address**

The name and current business address of each Applicant seeking to acquire control over the Domestic Insurer is as follows:

Centene Corporation  
7700 Forsyth Blvd.,  
St Louis, Missouri 63105

Chopin Merger Sub I, Inc.  
7700 Forsyth Blvd.,  
St Louis, Missouri 63105

Chopin Merger Sub II, Inc.  
7700 Forsyth Blvd.,  
St Louis, Missouri 63105

#### **(b) Entity Applicants' Business Operations**

##### Centene

Founded as a single health plan in 1984, Centene is a diversified, multi-national healthcare enterprise that provides programs and services to government sponsored healthcare programs, focusing on under-insured and uninsured individuals. Centene operates in two segments, namely managed care and specialty services. Centene's managed care segment provides health plan coverage to individuals through government subsidized programs, including Medicaid, the State Children's Health Insurance Program (CHIP), Long Term Care (LTC), Foster Care, dual-eligible individuals (Duals) and the Supplemental Security Income Program, also known as the Aged, Blind or Disabled Program, or collectively ABD. Beginning in 2014, Centene's managed care segment also provides health plan coverage to individuals covered through federally-facilitated and state-based Health Insurance Marketplaces (HIM). Centene's specialty services segment consists of its specialty companies offering diversified healthcare services and products to state programs, correctional facilities, healthcare organizations,

employer groups and other commercial organizations, as well as to its own subsidiaries. Following the consummation of the Merger (or if effected, the Second Merger), Centene will be the ultimate parent of the Domestic Insurer.

Centene's managed care membership totaled 4.6 million as of June 30, 2015. For the six months ended June 30, 2015, Centene's premium and service revenues and net income were approximately \$9.9 billion and \$152 million, respectively, and its total cash flow from operations was \$395 million. For the year ended December 31, 2014, Centene's premium and service revenues and net income were approximately \$15.7 billion and \$271 million, respectively, and its total cash flow from operations was \$1.2 billion.

Centene's initial health plan commenced operations in Wisconsin in 1984. Centene was organized in Wisconsin in 1993 as a holding company for its initial health plan and reincorporated in Delaware in 2001. Centene's stock is publicly traded on the NYSE under the ticker symbol "CNC." As of the date of this Form A, no filings made with the U.S. Securities Exchange Commission show a person holding 10% or more of the voting securities of Centene.

#### Merger Sub I

Merger Sub I is a corporation incorporated in Delaware on June 26, 2015 and is a direct wholly owned subsidiary of Centene. Merger Sub I was formed as an acquisition vehicle for the purpose of effecting the Merger. Merger Sub I has not conducted any activities other than those incidental to its formation and the matters contemplated by the Merger Agreement, including financing matters and the preparation of applicable regulatory filings in connection with the Merger.

#### Merger Sub II

Merger Sub II is a corporation incorporated in Delaware on June 26, 2015 and is a direct wholly owned subsidiary of Centene. Merger Sub II was formed as an acquisition vehicle for the purpose of effecting the Second Merger. Merger Sub II has not conducted any activities other than those incidental to its formation and the matters contemplated by the Merger Agreement, including financing matters and the preparation of applicable regulatory filings in connection with the Second Merger.

#### (c) Organizational Chart

Attached to this Form A as Exhibit C-1 and Exhibit C-2 are two charts presenting the identities and interrelationships among the Applicants and all affiliates of the Applicants before and after the Proposed Acquisition of Control. Such charts indicate the percentage of each class of voting securities of each such person, which is owned or controlled by the Applicants or by any other such person, and the type of organization and the jurisdiction of domicile of each person specified therein. No court proceedings involving a reorganization or liquidation are pending with respect to any person listed on the chart.

### ITEM III. IDENTITY AND BACKGROUND OF INDIVIDUALS ASSOCIATED WITH THE APPLICANTS

#### (a) Name and Business Addresses

Lists setting forth the names and business addresses of the directors and executive officers of Centene, Merger Sub I and Merger Sub II are attached hereto as Exhibit D-1, Exhibit D-2 and Exhibit D-3, respectively.

Centene and Health Net have agreed that immediately following the completion of the Merger, the Board of Directors of Centene will include one director to be designated by the Board of Directors of Health Net from those directors serving on the Health Net Board as of July 2, 2015, who qualifies as an "independent" director as defined by Section 303A.02 of the NYSE Listed Company Manual and is reasonably acceptable to the Nominating and Corporate Governance Committee of Centene.

It is anticipated that Michael F. Neidorff will continue to serve as Chairman of the Board of Directors of Centene and as Centene's President and Chief Executive Officer. It is also anticipated that certain members of Health Net's senior management team may continue in senior positions of Centene after the Merger (or if effected, the Second Merger).

The individuals who are the directors and officers of Merger Sub I immediately prior to the effective time of the Merger will, from and after such effective time, be the directors and officers of the Surviving Corporation, until the earlier of their death, resignation or removal or until their respective successors are duly elected and qualified, as the case may be.

If the Second Merger is effected, the individuals who are the directors and officers of Merger Sub II immediately prior to the effective time of the Second Merger will, from and after such effective time, be the directors and officers of the Final Surviving Corporation, without change until their successors have been duly elected and qualified in accordance with the certificate of incorporation and by-laws of the Final Surviving Corporation or until the earlier of their death, resignation or removal.

#### (b) Present Activity

California "Individual Affidavits" (the "Biographical Affidavits") for the individuals listed in Exhibit D-1 through Exhibit D-3 are labeled as Exhibit CE-1 to the confidential supplement to this Form A. The present principal business activity, occupation or employment, including position and office held and the name, principal business and address of any corporation or other organization in which such employment is carried on, for the individuals named in Exhibit D-1 through Exhibit D-3 are stated in the Biographical Affidavits.

Fingerprint cards and related forms will be submitted for the individuals listed in Exhibit D-1 through Exhibit D-3 as part of the Form A process.

(c) Employment History

The material occupations, positions, offices or employment during the last five years, including the starting and ending dates of each and the name, principal business and address of any business corporation or other organization in which each such occupation, position, office or employment was carried on, for the individuals named in Exhibit D-1 through Exhibit D-3 are included in the Biographical Affidavits. Except as may be set forth in the Biographical Affidavits, no such occupation, position, office or employment listed in the Biographical Affidavits required licensing by, or registration with, any Federal, state or municipal governmental agency.

(d) Criminal Proceedings

Except as may be set forth in the Biographical Affidavits, to the best knowledge, information and belief of the Applicants, no individual listed in Exhibit D-1 through Exhibit D-3 has ever been convicted in a criminal proceeding (excluding minor traffic violations) during the last ten years.

## ITEM IV. NATURE, SOURCE AND AMOUNT OF CONSIDERATION

(a) Consideration

The transaction is valued at approximately \$6.8 billion in cash and stock, based on stock prices as of July 1, 2015, and including the assumption of approximately \$500 million in debt from Health Net. The cash component of such total amount is equal to approximately \$2.3 billion.

Centene has obtained a commitment letter from certain lenders providing commitments for a new revolving credit facility of up to \$1 billion and, in the event Centene is unable to issue senior unsecured notes yielding up to \$2.67 billion on or prior to the closing date of the Proposed Acquisition of Control, a senior bridge facility of up to \$2.67 billion to consummate the Merger and the other transactions contemplated by the Merger Agreement (the "Commitment Letter"). A copy of the Commitment Letter is labeled as Exhibit CE-2 to the confidential supplement to this Form A. The financing contemplated by the Commitment Letter is referred to as the "Financing" in this Form A.

The Financing is subject to customary conditions and will be unsecured. In particular, no assets or stock of Health Net or of any person controlled by Health Net will be pledged or otherwise offered as security for the Financing. The Financing commitments will terminate on the date that is the earlier of (a) consummation of the Merger, (b) the termination of the Merger Agreement and (c) one business day after the Outside Date (as defined in the Merger Agreement).

(b) Criteria Used in Determining Consideration

The basis and terms of the Merger Agreement, including the nature and amount of consideration, were determined through arms' length negotiations among the representatives of the Applicants, on the one hand, and the representatives of Health Net, on the other hand, and

their respective legal and other advisors. Following substantial due diligence by the Applicants, the amount and type of consideration was determined by taking into account the consideration paid in other recent acquisitions of similar types of businesses, as well as the financial position and results of operations of the entities to be acquired, including the past and present business operations, historical and potential earnings, financial condition and prospects, assets and liabilities and such other factors and information as the Applicants considered relevant under the circumstances.

(c) **Identity of Lender of Loan**

Confidential treatment of the identity of the lenders named in the Commitment Letter is being sought.

(d) **Insurance Business and Assets of the Offeree**

No part of the Merger Consideration is to consist of the insurance business and assets of Health Net or of any person controlled by Health Net.

**ITEM V. FUTURE PLANS OF THE INSURER**

The Applicants have no present plans or proposals to cause the Domestic Insurer to declare an extraordinary dividend, liquidate the Domestic Insurer, sell any of the Domestic Insurer's assets (other than in ordinary course), or to merge the Domestic Insurer with any person or persons or to make any other material change in the Domestic Insurer's corporate structure, business operations or management. Following the consummation of the Proposed Acquisition of Control, the Domestic Insurer will continue to maintain its separate corporate existence.

Centene's current intention is to continue the business of the Domestic Insurer without any material modifications to the Domestic Insurer's existing plan of operation. For a description of the Proposed Acquisition of Control, see Item I of this Form A.

Financial projections for the years 2015, 2016, 2017, 2018 and 2019 for the Domestic Insurer are labeled as Exhibit CE-3 to the confidential supplement to this Form A. The financial projections reflect Centene's current intention to continue the business of the Domestic Insurer in accordance with the Domestic Insurer's existing plan of operation without material modification.

No changes are planned to be made after consummation of the Proposed Acquisition of Control with respect to the personnel comprising the board of directors and executive officers of the Domestic Insurer.

**ITEM VI. VOTING SECURITIES TO BE ACQUIRED**

The Domestic Insurer has 5 shares authorized all of which are issued and outstanding. All issued and outstanding shares of the Domestic Insurer are owned by Health Net of California, Inc., which, in turn, is a wholly owned subsidiary of Health Net. As a result of the consummation of the Proposed Acquisition of Control, Centene will become the ultimate controlling person of the Domestic Insurer by acquiring 100% of the outstanding voting securities of the Surviving Corporation or the Final Surviving Corporation, as applicable.

Except as set forth above, none of the Applicants, their affiliates or, to the knowledge of the Applicants, the individuals listed in Exhibit D-1 through Exhibit D-3, has any plans or proposals to acquire any voting securities issued by the Domestic Insurer or any of its controlling persons.

The fairness of the terms of the Proposed Acquisition of Control was arrived at through negotiation between the parties to the Merger Agreement.

#### **ITEM VII. OWNERSHIP OF VOTING SECURITIES**

None of the Applicants, their affiliates or, to the knowledge of the Applicants, the individuals listed in Exhibit D-1 through Exhibit D-3, currently beneficially owns any voting securities issued by the Domestic Insurer or any of its controlling persons. Except for rights to acquire voting securities of Health Net provided for or referenced in the Merger Agreement, none of the Applicants, their affiliates or, to the knowledge of the Applicants, the individuals listed in Exhibit D-1 through Exhibit D-3, has any other right to acquire beneficial ownership of any voting security issued by the Domestic Insurer or any of its controlling persons.

#### **ITEM VIII. CONTRACTS, AGREEMENTS OR UNDERSTANDINGS WITH RESPECT TO VOTING SECURITIES OF THE INSURER**

Other than the transactions described in the Merger Agreement or herein, neither the Applicants, their affiliates nor, to the knowledge of the Applicants, the individuals listed in Exhibit D-1 through Exhibit D-3, are involved in any contracts, arrangements or understandings with respect to any voting security of the Domestic Insurer or any of its controlling persons.

#### **ITEM IX. RECENT PURCHASES OF VOTING SECURITIES**

During the last twelve calendar months preceding the filing of this Form A, none of the Applicants, their affiliates or, to the knowledge of the Applicants, the individuals listed in Exhibit D-1 through Exhibit D-3, has purchased any voting securities of the Domestic Insurer or any of its controlling persons.

#### **ITEM X. RECENT RECOMMENDATIONS TO PURCHASE**

None of the Applicants, their affiliates or, to the knowledge of the Applicants, the individuals listed in Exhibit D-1 through Exhibit D-3, or no one based upon interviews or at the suggestion of the Applicants or, to the knowledge of the Applicants, any individual listed in Exhibit D-1 through Exhibit D-3, has made any recommendations to acquire any voting securities of the Domestic Insurer or any of its controlling persons during the twelve calendar months preceding the filing of this Form A.

#### **ITEM XI. AGREEMENTS WITH BROKER-DEALERS**

None of the Applicants, their affiliates or, to the knowledge of the Applicants, the individuals listed in Exhibit D-1 through Exhibit D-3, is party to any agreement, contract or understanding made with any broker-dealer as to solicitation of voting securities of the Domestic Insurer or its controlling persons for tender.



## ITEM XII. FINANCIAL STATEMENTS AND EXHIBITS

(a) – (b)

The following is a list of the exhibits and financial statements<sup>1</sup> to this Form A:

Exhibit	Description
A	Merger Agreement
B-1	Voting Agreement (Gellert)
B-2	Voting Agreement (Neidorff)
C-1	Organizational Chart of the Applicants Before the Proposed Acquisition of Control
C-2	Organizational Chart of the Applicants After the Proposed Acquisition of Control
D-1	List of Directors and Executive Officers of Centene
D-2	List of Directors and Executive Officers of Merger Sub I
D-3	List of Directors and Executive Officers of Merger Sub II
E-1	Financial Statement of Centene for the Quarter Ended June 30, 2015
E-2	Financial Statement of Centene for the Quarter Ended March 31, 2015
E-3	Audited Financial Statement of Centene for the Year Ended December 31, 2014
E-4	Audited Financial Statement of Centene for the Year Ended December 31, 2013
E-5	Audited Financial Statement of Centene for the Year Ended December 31, 2012
E-6	Audited Financial Statement of Centene for the Year Ended December 31, 2011
E-7	Audited Financial Statement of Centene for the Year Ended December 31, 2010
F-1	Annual Report of Centene for the Year Ended December 31, 2014
F-2	Annual Report of Centene for the Year Ended December 31, 2013

<sup>1</sup> As newly formed acquisition vehicles, the Merger Subs do not have historical audited financial statements. Therefore, financial statements for the Merger Subs are omitted from this Form A.

The following is a list of the exhibits that comprise the **CONFIDENTIAL**  
**SUPPLEMENT**<sup>2</sup> to this Form A:

Exhibit	Description
CE-1	Biographical Affidavits
CE-2	Commitment Letter
CE-3	Five-Year Financial Projections for the Domestic Insurer

<sup>2</sup> Confidential treatment is requested by the Applicants for this Form A in its entirety. The exhibits contained in the confidential supplement to this Form A comprise exhibits for which the Applicants are seeking additional protections beyond those contained in California Government Code § 6254.

ITEM XIII. SIGNATURE AND CERTIFICATION

State of Missouri                    )  
   )ss  
 County of St. Louis                )

Keith H. Williamson, first being duly sworn, deposes and says that he is the Executive Vice President, Secretary and General Counsel of Centene Corporation, the person preparing and filing the attached papers; that he has read the same and knows the contents thereof and that the contents are true of his own knowledge.

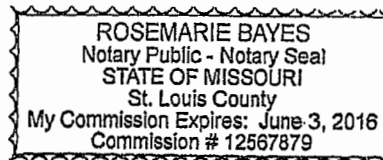
CENTENE CORPORATION

By: *Keith H. Williamson*  
 Name: Keith H. Williamson  
 Title: Executive Vice President,  
        Secretary and General Counsel

Subscribed and sworn to before me this \_\_\_\_ day of July, 2015.

*Rosemarie Bayes* (Notarial Seal)  
 Notary Public in and for said County  
 and State

My commission expires *June 3, 2016*



## ITEM XIII. SIGNATURE AND CERTIFICATION

State of Missouri                    )  
   )ss  
 County of St. Louis                )

Keith H. Williamson, first being duly sworn, deposes and says that he is the Secretary of Chopin Merger Sub I, Inc., the person preparing and filing the attached papers; that he has read the same and knows the contents thereof and that the contents are true of his own knowledge.

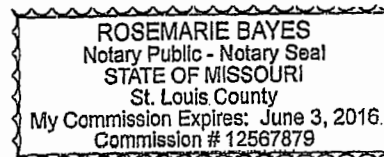
CHOPIN MERGER SUB I, INC.

By: *Keith H. Williamson*  
 Name: Keith H. Williamson  
 Title: Secretary

Subscribed and sworn to before me this \_\_\_\_ day of July, 2015.

*Rosemarie Bayes* (Notarial Seal)  
 Notary Public in and for said County  
 and State

My commission expires *June 3, 2016*



ITEM XIII. SIGNATURE AND CERTIFICATION

State of Missouri                    )  
   )ss  
 County of St. Louis                )

Keith H. Williamson, first being duly sworn, deposes and says that he is the Secretary of Chopin Merger Sub II, Inc., the person preparing and filing the attached papers; that he has read the same and knows the contents thereof and that the contents are true of his own knowledge.

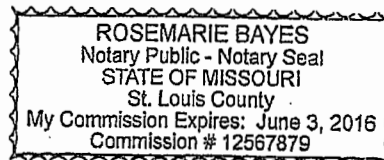
CHOPIN MERGER SUB II, INC.

By: *Keith H. Williamson*  
 Name: Keith H. Williamson  
 Title: Secretary

Subscribed and sworn to before me this \_\_\_\_ day of July, 2015.

*Rosemarie Bayes* (Notarial Seal)  
 Notary Public in and for said County  
 and State

My commission expires *June 3, 2016*



**BEFORE THE COMMISSIONER OF INSURANCE  
OF THE STATE OF CALIFORNIA**

**IN THE MATTER OF:**

The Proposed Acquisition of Control of:

HEALTH NET LIFE INSURANCE  
COMPANY, a California stock life and health  
insurance company

subsidiary of

HEALTH NET, INC., a Delaware corporation

BY

CENTENE CORPORATION, a Delaware  
corporation

AND

CHOPIN MERGER SUB I, INC. and CHOPIN  
MERGER SUB II, INC., each a Delaware  
corporation

File No. APP-2015-00889

**Written Testimony of Keith Harvey Williamson on behalf of Centene Corporation**

**I. Witness Identification**

1. My name is Keith Harvey Williamson. My business address is 7700 Forsyth Boulevard, St. Louis, Missouri 63105.

2. I am Executive Vice President, Secretary and General Counsel of Centene Corporation, a publicly traded Delaware corporation ("Centene").

3. In my capacity as holder of the position set forth in Paragraph 2, I am responsible for the oversight of the legal functions of Centene and its subsidiaries. I have held this position since November 2012 and previously held the position of Senior Vice President, Secretary and General Counsel with Centene with functionally similar responsibilities. Prior to joining Centene, I was employed by Pitney Bowes Inc. and Pitney Bowes Credit Corporation. I am a 1974 graduate of Brown University (B.A. Economics), a 1978 graduate of Harvard's Business and Law Schools (J.D./M.B.A.) and a 1986 graduate of New York University School of Law (LL.M.). I am admitted to practice law in the District of Columbia, the State of Missouri and the State of New York.

4. I have been authorized by Centene to provide this Testimony (as defined in Paragraph 5) on its behalf and in support of the Proposed Acquisition of Control (as defined in Paragraph 5).

## **II. Involvement with the Merger; Procedural Matters**

5. I submit this written testimony (this "Testimony") to the Department of Insurance for the State of California ("CDI") on behalf, and in support, of Centene, which, together with Chopin Merger Sub I, Inc. ("Merger Sub I") and, if certain conditions are met, Chopin Merger Sub II, Inc. ("Merger Sub II") and together with Centene and Merger Sub I, the "Applicants"), each a Delaware corporation and a wholly owned subsidiary of Centene, seeks to indirectly acquire control of Health Net Life Insurance Company, a California domestic stock life and health insurance company ("HNLIC") (the "Proposed Acquisition of Control"), via a merger (the "Merger") of Health Net, Inc., a publicly traded Delaware corporation ("Health Net"), with Merger Sub I and, if certain conditions are met, Merger Sub II.

6. In connection with the Proposed Acquisition of Control, I have reviewed and am familiar with the Form A Statement and the exhibits attached thereto filed by the Applicants with CDI on July 31, 2015 and the supplemental filings and submissions made by the Applicants to CDI in connection with such Form A Statement since its filing (collectively, the "Form A"). The facts set forth in the Form A are true to the best of my knowledge, information and belief.

7. I have been and continue to be actively involved in the Merger.

8. As required by Section 1215.2(a) of the California Insurance Code, the Applicants sent a copy of the initial filing of the Form A to HNLIC on July 31, 2015 via overnight courier.

9. As required by Section 1215.2(f)(1) of the California Insurance Code, on January 8, 2016, the Applicants provided HNLIC with an electronic copy of the third amended notice of public hearing on the Proposed Acquisition of Control issued by CDI on January 8, 2016.

10. In this Testimony, I will provide (a) an overview of the regulatory clearances and approvals required by the Merger (Paragraphs 11-14) and (b) support that clearly demonstrates that the Proposed Acquisition of Control satisfies the statutory standards set forth in Section 1215.2(d) of the California Insurance Code (Paragraphs 15-44).

## **III. Regulatory Approvals Required for the Merger**

11. To complete the Merger, Centene and Health Net must obtain approvals or consents from, or make filings with, a number of United States federal, state and foreign antitrust, health care and insurance regulators and other regulatory authorities. Paragraphs 12 to 14 contain a description of the material United States federal, state and foreign approvals.

12. On July 17, 2015, each of Centene and Health Net filed a Notification and Report Form under the Hart-Scott-Rodino Antitrust Improvements Act of 1976, as amended (the "HSR Act"), with the U.S. Department of Justice (the "DOJ") and the U.S. Federal Trade Commission (the "FTC"), which filings started the initial 30-day waiting period required by the HSR Act. On August 11, 2015, early termination of the waiting period under the HSR Act was granted by the FTC and DOJ.

13. The Merger requires approval (or non-objection, grant of exemption or, in certain circumstances, alternative resolution, as the case may be) from (i) state insurance regulators in the States of Arizona, California and Oregon for the "change of control" of Health Net's U.S. domiciled insurance company subsidiaries, (ii) the Department of Managed Health Care of the State of California with respect to the change of control for Health Net's Knox-Keene licensed health care service plan subsidiaries, (iii) the Health Care Cost Containment System of the State of Arizona with respect to a "change in ownership" for Health Net's Medicaid Acute Care Health Plan in the State of Arizona, (iv) the Department of Banking



and Insurance of the State of New Jersey with respect to the "material modification" to Health Net's subsidiary licensed as an "organized delivery system" in the State of New Jersey and (v) the Insurance Department of the State of Texas with respect to the change of control of Health Net's subsidiary licensed as a third party administrator in Texas. In addition, the Merger requires receipt of a response letter from the Department of Insurance of the State of Missouri confirming that the Merger falls below the threshold requirements for filing a Form E (pre-acquisition notification form regarding the potential competitive impact of a proposed merger) in Missouri, as well as a grant of (public company) exemption from approval requirements for a change of control of Health Net's Cayman Islands domiciled insurance company subsidiaries from the Cayman Islands Monetary Authority. To obtain these approvals, Centene, or the applicable Health Net subsidiary, as the case may be, has filed acquisition of control and material modification or similar statements, notices or applications, as required by the insurance and health care laws and regulations of each applicable state or jurisdiction.

14. To date, approvals have been received from the state insurance regulators in Arizona and Oregon for the "change of control" applications filed in those jurisdictions, though I note that the state insurance regulator in Oregon issued an approval conditioned on receipt of approval of the Proposed Acquisition of Control by the Commissioner of Insurance for the State of California (the "Commissioner"). Additionally, approvals have been received from the Health Care Cost Containment System of the State of Arizona and the Department of Banking and Insurance of the State of New Jersey with respect to the filings made with these regulators, as referenced in Paragraph 13 above, and the deemer period with respect to the filing made to the Insurance Department of the State of Texas has expired. Further, exemptions from the Department of Insurance of the State of Missouri and the Cayman Islands Monetary Authority referenced in Paragraph 13 above have been obtained. With the exception of the approval sought at this hearing, the sole approval which is still pending is the approval of the Department of Managed Health Care of the State of California.

#### IV. Statutory Standards

15. Pursuant to the laws of the State of California, the Commissioner may disapprove an acquisition of control if he finds that such acquisition of control is likely to result in one or more of five (5) adverse results, as set forth in Section 1215.2(d)(1)-(5) of the California Insurance Code. In the following Paragraphs, I will demonstrate how the Merger, and consequently the Proposed Acquisition of Control, will not result in any such adverse results, and therefore, should be approved by the Commissioner.

##### Licensure

The Commissioner may disapprove the transaction if the commissioner finds any of the following:

- (1) After the change of control the domestic insurer referred to in subdivision (a) could not satisfy the requirements for the issuance of a license to write the line or lines of insurance for which it is presently licensed. §1215.2(d)(1) Calif. Ins. Code

16. Pursuant to Section 1215.2(d)(1) of the California Insurance Code, the Commissioner may disapprove an acquisition of control if, following such acquisition, a domestic insurer would not be able to satisfy the requirements for the issuance of a license to write the business for which it is presently licensed. Under Section 717 of the California Insurance Code, the Commissioner evaluates applicants for licensure on the following factors: (a) capital and surplus; (b) lawfulness and quality of investments; (c) financial stability; (d) reinsurance arrangements; (e) competency, character, and integrity of management;



(f) ownership and control of issued and outstanding shares in the case of a capital stock insurer; (g) whether claims under policies are promptly and fairly adjusted and are promptly and fully paid in accordance with law and the terms of policies; (h) fairness and honesty of methods of doing business; (i) method by which said applicant was promoted if any of its promoters remain as stockholders or in management; and (j) hazard to policyholders or creditors.

17. With respect to subsections (a) through (c) of Section 717 of the California Insurance Code, the Merger will have no effect upon the capital of HNLIC. The financed portion of the Merger consideration will be serviced from cash flows generated from the combined enterprise resulting from the Merger. The repayment of the debt will not be dependent on earnings from HNLIC. No capital of HNLIC will be used or pledged in connection with the financing of the Merger. In addition, Centene is committed to maintaining a level of capitalization at HNLIC necessary to support its existing business plan.

18. With respect to subsection (d) of Section 717 of the California Insurance Code, Centene has no plans for HNLIC with respect to reinsurance arrangements.

19. With respect to subsection (e) of Section 717 of the California Insurance Code, the competency, character, and integrity of the management of HNLIC has been firmly established through its historical and current business operations and conduct. With respect to Centene, its executive officers are and directors all well respected and experienced in the healthcare industry. It is evident that such individuals possess the competence, experience, integrity and industry knowledge necessary to manage the combined company following the Merger based on (i) the successful growth and operation of Centene, (ii) their backgrounds and biographies which are available in publicly filed SEC documents, and (iii) the biographical information submitted by such individuals on a confidential basis to CDI as part of the Form A.

20. With respect to subsection (f) of Section 717 of the California Insurance Code, Centene's corporate profile and business operations are well documented in the Form A. The company has an established track record in the insurance and healthcare industries as the owner of regulated entities.

21. With respect to subsection (g) of Section 717 of the California Insurance Code, the plans described in Paragraphs 73 through 75 of Kenneth Rone Baldwin's written testimony with respect to the claims functions of HNLIC are prudent and sensible.

22. With respect to subsections (h), (i) and (j), support for licensure with regard to these areas is evident from the Form A.

23. Based on the above, there is no cause to believe that the Proposed Acquisition of Control would inhibit HNLIC's ability to continue to satisfy the requirements for licensure set forth under Section 717 of the California Insurance Code.

#### Competition

The Commissioner may disapprove the transaction if the commissioner finds any of the following:

- (2) The purchases, exchanges, mergers, or other acquisitions of control would substantially lessen competition in insurance in this state or create a monopoly therein. §1215.2(d)(2) Calif. Ins. Code

24. Pursuant to Section 1215.2(d)(2) of the California Insurance Code, the Commissioner may disapprove an acquisition of control if, following such acquisition, there would be a substantial lessening of competition in insurance in California or a monopoly created in California.

25. As described in Paragraphs 51-55 of the written testimony of Kenneth Rone Baldwin, the consummation of the Merger will not have any adverse effect upon competition in California, as Centene and HNLIC largely offer different products and operate in different geographical areas of California. The only line of business in which both Centene and Health Net write business in California is Medi-Cal, and I note that HNLIC itself has no Medi-Cal. As stated in the written testimony of Kenneth Rone Baldwin, and as set forth in the "Form E" analysis submitted to CDI by Centene as part of the Form A, there is no geographic overlap by county between the Centene and Health Net Medi-Cal products in California, which means that the companies do not compete with each other in any service area. Consequently, the Merger would not have the result of lessening competition in insurance in California, as the combination would not reduce either the number of competitors in the California insurance market or the products being offered.

26. Rather, the Merger is likely to have a beneficial effect on the ability of HNLIC to effectively compete in the California insurance market. As stated in Paragraph 53 of the written testimony of Kenneth Rone Baldwin, Health Net's strength in the California marketplace has been focused historically in Southern California. The Merger will result in a combined company which will have the size and resources to potentially expand its offerings similar to those historically limited to Southern California to other regions of California.

27. The Merger is also anticipated to positively contribute to the overall needs of California's healthcare system as articulated in Paragraph 54 of the written testimony of Kenneth Rone Baldwin.

28. The competitive effects of the Merger are analyzed in greater detail in the written testimony provided by Centene's expert witnesses, Drs. Lawrence Wu and Paul Wong, in this proceeding.

29. Accordingly, following the Merger, there will not be a substantial lessening of competition in insurance in California or a monopoly created in California.

#### Financial Stability and Policyholder Interests

The Commissioner may disapprove the transaction if the commissioner finds any of the following:

- (3) The financial condition of an acquiring person might jeopardize the financial stability of the insurer, or prejudice the interests of its policyholders. § 1215.2(d)(3) Calif. Ins. Code

30. Pursuant to Section 1215.2(d)(3) of the California Insurance Code, the Commissioner may disapprove an acquisition of control if the financial condition of any acquiring party in such acquisition of control is such as might jeopardize the financial stability of the domestic insurer or prejudice the interests of such domestic insurer's policyholders.

31. The financial condition of Centene will in no way jeopardize the financial stability of HNLIC. Indeed, Centene presents an extremely robust financial profile as evidenced by Centene's financial statements provided as exhibits to the Form A. Following the Merger, HNLIC will be within a combined

group that is expected to generate increased cash flow that would otherwise not be available on a standalone basis.

32. Pro forma financial projections for the combined company are contained in Centene and Health Net's joint proxy statement (Form S-4) filed with the U.S. Securities and Exchange Commission in connection with the Merger. These pro forma financials were also shared with CDI as part of the Form A review process. The pro forma financials project a financially strong and stable combined company.

33. There is also evidence that the financial strength of Centene will enhance HNLIC's financial stability in California's competitive marketplace, thereby protecting and enhancing the interests of its policyholders. For example, Centene is committed to maintaining a level of capitalization at HNLIC necessary to support its existing business plan.

34. In addition, the pro forma financial projections for HNLIC provided confidentially to CDI as part of the Form A review process reflect significant growth that would be more difficult to achieve on a standalone basis.

35. Accordingly, Centene's financial condition will not jeopardize the financial stability of HNLIC or prejudice the interests of HNLIC's policyholders.

#### Plans for the Domestic Insurer

The Commissioner may disapprove the transaction if the commissioner finds any of the following:

- (4) The plans or proposals which the acquiring person has to liquidate the insurer, to sell its assets, or to merge it with any person, or to make any other major change in its business or corporate structure or management, are not fair and reasonable to policyholders. §1215.2(d)(4) Calif. Ins. Code

36. Pursuant to Section 1215.2(d)(4) of the California Insurance Code, the Commissioner may disapprove an acquisition of control if the plans or proposals of an acquiring party in such acquisition of control are unfair and unreasonable to the policyholders of a domestic insurer.

37. As documented in the Form A, Centene has no plans or proposals to cause HNLIC to declare an extraordinary dividend, liquidate HNLIC, sell any of HNLIC's assets (other than in the ordinary course of business), or to merge HNLIC with any person or persons or to make any other material change in HNLIC's corporate structure, business operations or management. Following the consummation of the Proposed Acquisition of Control, HNLIC will continue to maintain its separate corporate existence.

38. As reflected in the written testimony of Kenneth Rone Baldwin, in the same manner in which Centene operates in all of its other states -- more than 20 -- Centene has no plans to make any material changes to HNLIC, its organizational structure, its governance, its management, its local headquarters, or any other function or process that would adversely impact California consumers or providers.

39. Centene is supportive of the current operations and management of HNLIC, and intends to cause current management to continue to pursue the business plan that it has already developed, but soon to be backed by the financial and other resources of Centene. For example, HNLIC currently outsources various administrative and claims functions because it does not have the scale to provide those services

internally. Centene will evaluate the potential to in-source those functions over time to the benefit of consumers and providers.

40. Accordingly, there are no current plans or proposals for HNLIC that would be unfair and unreasonable to the policyholders of HNLIC.

#### Competence and Integrity of Control Persons

The Commissioner may disapprove the transaction if the commissioner finds any of the following:

- (5) The competence, experience, and integrity of those persons who would control the operation of the insurer indicate that it would not be in the interest of policyholders or the public to permit them to do so. §1215.2(d)(5) Calif. Ins. Code

41. Section 1215.2(d)(5) of the California Insurance Code provides that the Commissioner may disapprove an acquisition of control if the competence, experience and integrity of the resulting control persons in such acquisition would not be in the interest of the policyholders of a domestic insurer or the public.

42. Paragraphs 26 through 28 of the written testimony of Kenneth Rone Baldwin provide and reference support for the competence, experience and integrity of the executive officers and directors of the Applicants.

43. As demonstrated by Centene's controlled growth over the past 30 years into more than 20 states, Centene's business model, commitment to local management, financial strength, and fair dealings with regulators, consumers, and providers are in fact in the best interest of policyholders and the public.

44. Accordingly, as demonstrated above, there should be no concern as to the competence, experience and integrity of the persons who would control the operations of HNLIC.

#### **VIII. Conclusion**

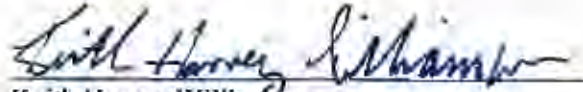
45. I would like to thank the Commissioner and the Staff of CDI for their attention to, and their diligence in reviewing, the Form A. Based on this Testimony, the Form A and the written testimonies of Kenneth Rone Baldwin, Steven Sell, and Drs. Lawrence Wu and Paul Wong submitted to CDI in this proceeding, it is Centene's position that the Proposed Acquisition of Control satisfies all of the applicable standards of review for approval under Section 1215.2(d) of the California Insurance Code and that the Commissioner has a sufficient and robust record for the issuance of an approval order with respect to the Proposed Acquisition of Control as set forth in the Form A.

46. In conclusion, for the foregoing reasons, Centene respectfully requests that the Commissioner approve the Proposed Acquisition of Control.

\* \* \* \* \*



Keith Harvey Williamson deposes and says that he is the Executive Vice President, Secretary and General Counsel of Centene Corporation, that he has read the foregoing written testimony and knows the contents thereof and that the same are true of his own knowledge.

  
Keith Harvey Williamson

**BEFORE THE COMMISSIONER OF INSURANCE  
OF THE STATE OF CALIFORNIA**

**IN THE MATTER OF:**

The Proposed Acquisition of Control of:

HEALTH NET LIFE INSURANCE  
COMPANY, a California stock life and health  
insurance company

subsidiary of

HEALTH NET, INC., a Delaware corporation

BY

CENTENE CORPORATION, a Delaware  
corporation

AND

CHOPIN MERGER SUB I, INC. and CHOPIN  
MERGER SUB II, INC., each a Delaware  
corporation

File No. APP-2015-00889

**Written Testimony of Kenneth Rone Baldwin on behalf of Centene Corporation**

**I. Witness Identification**

1. My name is Kenneth Rone Baldwin. My business address is 7700 Forsyth Boulevard, Clayton, Missouri 63105.

2. I am an Executive Vice President for the Insurance Group at Centene Corporation, a publicly traded Delaware corporation ("Centene").

3. I have held this position since 2012. I additionally hold several positions with certain of Centene's subsidiaries, including as Chairman and Director of NovaSys Health Inc., as President and Director of Celtic Group, Inc., and as President of Celtic Insurance Company. Prior to my joining Centene, I was employed by Optiwind, Guardian Life Insurance Company and Genworth Financial Inc. I am a 1980 graduate of Amherst College (BA) and a 1982 graduate of Harvard Business School (MBA).

4. I have been authorized by Centene to provide this Testimony (as defined in Paragraph 5) on its behalf and in support of the Proposed Acquisition of Control (as defined in Paragraph 5).

## II. Involvement with the Merger; Procedural Matters

5. I submit this written testimony (this "Testimony") to the Department of Insurance for the State of California ("CDI") on behalf, and in support, of Centene, which, together with certain of its subsidiaries (each of which is individually identified in Paragraph 16, collectively with Centene, the "Applicants") seeks to indirectly acquire control of Health Net Life Insurance Company, a California domestic stock life and health insurance company ("HNLIC") (the "Proposed Acquisition of Control"), via a merger of Health Net, Inc., a publicly traded Delaware corporation ("Health Net"), with Chopin Merger Sub I, Inc. ("Merger Sub I") and, if certain conditions are met, Chopin Merger Sub II, Inc. ("Merger Sub II"), each a Delaware corporation and a wholly owned subsidiary of Centene.

6. I have been and continue to be actively involved in the Merger (as defined in Paragraph 30).

7. In connection with the Proposed Acquisition of Control, I have reviewed and am familiar with (a) the Form A Statement and the exhibits attached thereto filed by the Applicants with CDI on July 31, 2015, and (b) the supplemental filings and submissions made by the Applicants to CDI in connection with such Form A Statement since its filing (collectively, the "Form A"). The facts set forth in the Form A are true to the best of my knowledge, information and belief.

## III. Benefits of the Merger for Health Net and California Consumers

8. Although this topic is addressed in detail in the written testimony of Steven Sell, I would like to preface this Testimony with a brief explanation of why the Merger is good for Health Net and California consumers.

9. **The Merger makes Health Net a stronger competitor:** Health Net is much smaller than many of the national competitors. To effectively compete in the post-Affordable Care Act health insurance market, Health Net needed to find a solution for its scale issue. By combining, Centene and Health Net have more opportunities to ensure quality of care for members and manage health care and administrative costs. Through the combination, California consumers will have the benefit of a stronger insurer to effectively compete with Anthem, United, Aetna, Kaiser and Blue Shield, with or without any mergers involving these dominant insurers and plans that might occur in the future.

10. **Centene follows a local approach which means that HNLIC will remain a California insurer:** Both Centene and HNLIC agree that healthcare is best viewed as a local service. This is demonstrated by Centene's approach in each of the 20 states in which it has health plans. In each state, a strong Chief Executive Officer/President leads a local management team and is responsible for that Health Plan's performance. If an interaction touches a member, provider, regulator or community advocate, it is handled by and is the responsibility of the local management team.

11. This same approach will be taken in California, where HNLIC will continue to be a California domiciled insurer with operational direction by a local management team. Health Net, although it will be merged into a subsidiary of Centene, will continue to be named Health Net, Inc. HNLIC will also not change its name. Centene has no plans to redomesticate or relocate HNLIC's headquarters outside of California, and is willing to commit, for so long as it maintains a majority of voting power of HNLIC, that it will not apply to transfer the state of domicile of HNLIC outside of California if, immediately following the redomestication: (a) HNLIC would be commercially domiciled in California pursuant to Section 1215.14(a) of the California Insurance Code; or (b) a plurality of covered lives of all types of coverage in all jurisdictions from all regulated entities that are subsidiaries of Health Net (or any successor) reside in California.

12. **This Merger will help ensure jobs stay in California:** Health Net, including HNLIC, had a competitive disadvantage compared to other plans in California as a result of its lack of scale. To counterbalance that competitive disadvantage, Health Net has for the last several years outsourced certain service functions and positions. Furthermore, in November 2014, Health Net signed an agreement with Cognizant Healthcare Services, LLC (the "BPaaS Agreement") to outsource on a going forward basis the bulk of Health Net's "back office" operations, which would have involved the re-badging (and potential subsequent off-shoring) of a significant portion of Health Net's more than 6,400 California employees. This BPaaS Agreement was put on hold as a result of the proposed merger with Centene. If the Merger is completed, it will result not only in the termination of the BPaaS Agreement (and, therefore, avoiding the outsourcing of employees), but may also result in the future in-sourcing of certain service functions and positions which are currently being outsourced by Health Net, as Centene's business model is to in-source as much as possible.

13. According to data provided by Health Net, the current total workforce for Health Net and its subsidiaries nationwide is 8,480, with 6,424 in California, including full-time, part-time, and individuals on leave of absence. Centene will not make any material reduction in this workforce or the overall number of employees in California as a result of the Merger. Centene anticipates that there will be elimination of certain positions at the corporate level (e.g. certain senior management and duplicative corporate roles), but not at the member or provider servicing level, as a result of the Merger.

14. **Centene has no competitive overlap with HNLIC:** As Centene has a small presence in California limited to providing Medi-Cal services, the combination does not reduce the number of competitors in the California commercial insurance market.

15. **Centene is committed to HNLIC's future growth in the commercial market in California:** Centene is committed to ensuring that HNLIC has the resources it needs to remain a financially strong insurer in California and is able to continue to grow. All acquisition costs will be booked at the holding company level and, consequently, will not have any impact at the HNLIC level and will not result in the depletion of any resources in California. Centene is committed to maintaining a level of capitalization at HNLIC necessary to support its existing business plan, which includes HNLIC's continued growth in the commercial market in California.

#### **IV. Overview of the Applicants**

16. The Applicants in this proceeding are Centene, Merger Sub I and Merger Sub II.

17. The Applicants propose to acquire control of HNLIC pursuant to, and subject to the terms of, an Agreement and Plan of Merger dated as of July 2, 2015 (the "Merger Agreement") by and among the Applicants and Health Net.

18. An executed copy of the Merger Agreement was provided to CDI as an exhibit to the Form A. Organizational charts setting forth the corporate structure of the Applicants prior to, and resultant of, the Merger were also included as exhibits to the Form A.

#### **Centene**

19. Centene is a publicly traded Delaware corporation listed on the New York Stock Exchange. As a Fortune 500 company and a leading multinational healthcare enterprise, Centene offers a comprehensive portfolio of innovative solutions within Medicaid, Medicare and the Health Insurance Marketplace. Centene also contracts with healthcare and commercial organizations to provide specialty services that help people attain better health and quality of life. Founded in Wisconsin in 1984, Centene has remained



deeply committed for over 30 years to a corporate mission of transforming the health of the community, one person at a time, and delivering results for its stakeholders: state governments, members, healthcare providers, uninsured individuals and families, and other healthcare and commercial organizations.

20. Centene works with state agencies, regulators and others to create quality solutions that address the distinct needs of health care consumers. Centene has the resources to provide customized solutions to its state partners through extensive experience in the Medicaid industry and uninsured market, as well as through specialty health solutions.

21. Centene operates in 23 states and principally in two market segments, managed care and specialty services. Centene is a national leader in managed health care serving 4.8 million members with a large network of physicians and hospitals. Centene's managed care segment has focused on government sponsored programs for lower income, uninsured and underinsured individuals. In California, Centene serves approximately 184,000 members in the Medi-Cal program through its subsidiary, California Health & Wellness Plan, which is a Knox-Keene licensed entity.

22. For the past two years, Centene's managed care segment has also provided coverage to individuals through federally facilitated and state-based exchanges under the Affordable Care Act. In 2015, Centene offered multiple plan choices in 12 states, covering approximately 156,000 exchange members.

23. Centene's other business segment, its specialty services business, offers diversified healthcare services and products to state programs, correctional facilities, healthcare organizations, employer groups, and other commercial organizations, as well as to its own health plan subsidiaries. Centene's specialty health solutions include pharmacy benefits, dental and vision benefits, behavioral health, and health and wellness programs.

#### Merger Sub I

24. Merger Sub I is a corporation incorporated in Delaware on June 26, 2015 and is a direct wholly owned subsidiary of Centene. Merger Sub I was formed as an acquisition subsidiary for the purpose of effecting the Merger. Merger Sub I has not conducted any activities other than those incidental to its formation and the matters contemplated by the Merger Agreement, including financing matters and the preparation of applicable regulatory filings in connection with the Merger.

#### Merger Sub II

25. Merger Sub II is a corporation incorporated in Delaware on June 26, 2015 and is a direct wholly owned subsidiary of Centene. Merger Sub II was formed as an acquisition subsidiary for the purpose of effecting the Second Merger (as defined in Paragraph 31). Merger Sub II has not conducted any activities other than those incidental to its formation and the matters contemplated by the Merger Agreement, including financing matters and the preparation of applicable regulatory filings in connection with the Second Merger.

### **V. Executive Officers and Directors of the Applicants**

26. The current executive officers and directors of Centene are all well respected and experienced in the healthcare industry. It is evident that such individuals possess the competence, experience, integrity and industry knowledge necessary to manage the combined company following the Merger based on (i) the successful growth and operation of Centene as described above, (ii) their backgrounds and biographies

which are available in publicly filed SEC documents, and (iii) the biographical information submitted by such individuals on a confidential basis to CDI as part of the Form A.

27. Pursuant to the terms of the Merger Agreement, the Board of Directors of Health Net will designate a director from those directors serving on the Board of Directors of Health Net as of July 2, 2015, who qualifies as an "independent" director as defined by Section 303A.02 of the NYSE Listed Company Manual and is reasonably acceptable to the Nominating and Corporate Governance Committee of the Board of Directors of Centene, to join the Board of Directors of Centene. While such individual has yet to be identified, given that such individual will have already been serving as a director of Health Net prior to his or her joining the Board of Directors of Centene, such individual will have had experience with Health Net and its subsidiaries, including HNLIC, and accordingly will be well qualified to take on this role. In addition, it is also anticipated that certain members of Health Net's senior management team will continue in senior positions at Centene following the Merger.

28. As described above, Merger Sub I and Merger Sub II are acquisition subsidiaries formed by Centene for purposes of implementing the Merger. The individuals who serve as the directors and officers of Merger Sub I and Merger Sub II are identical and are executive officers of Centene. As stated above, these individuals have the competence, experience, integrity and industry knowledge necessary to serve in their roles. The individuals who comprise the directors and officers of Merger Sub I immediately prior to the effective time of the Merger will, from and after such effective time, be the directors and officers of the surviving corporation, following the merger of Merger Sub I with and into Health Net, until the earlier of their death, resignation or removal or until their respective successors are duly elected and qualified, as the case may be. Additionally, if the Second Merger (as defined in Paragraph 31) is effected, the individuals who are the directors and officers of Merger Sub II immediately prior to the effective time of the Second Merger will, from and after such effective time, be the directors and officers of the surviving corporation, without change until their successors have been duly elected and qualified in accordance with the certificate of incorporation and by-laws of the surviving corporation or until the earlier of their death, resignation or removal.

## **VI. Structure of the Merger**

### Overview

29. Under the terms of the Merger Agreement, the Merger would be realized through a potential two-step process.

30. First, subject to the terms and conditions set forth in the Merger Agreement, Merger Sub I will merge with and into Health Net (the "Merger"), with Health Net continuing as the surviving corporation in the Merger. Upon the consummation of the Merger, Health Net will be a wholly owned subsidiary of Centene.

31. Second, and only if Health Net's counsel provides a legal opinion regarding certain aspects of the tax treatment of the transaction, immediately following the completion of the Merger, Health Net (as the surviving corporation in the Merger) will merge (the "Second Merger") with and into Merger Sub II, with Merger Sub II continuing as the surviving corporation in the Second Merger as a wholly owned subsidiary of Centene. Immediately following consummation of the Second Merger, Merger Sub II will be renamed Health Net, Inc..

32. The Second Merger will only be implemented if certain criteria are met and is designed to qualify as a "reorganization" under U.S. federal income tax law. If a merger qualifies as a "reorganization," then the target company's shareholders will generally owe tax on any cash received in the merger, but can

receive acquiring company stock on a tax-free basis. In addition, neither the target company nor the acquiring company will owe any U.S. federal income tax as a result of a reorganization. There are many technical substantive requirements for a merger to qualify as a "reorganization" for U.S. federal income tax purposes, and it is often not known whether a merger will qualify as a reorganization until the day the merger occurs. Centene and Health Net's respective tax advisors structured the proposed transaction as a two-step merger in order to protect the companies from the significant corporate tax that would be owed if the second step in the two-step merger process does not occur.

33. Following the consummation of the Merger (and if effected, the Second Merger), Centene will directly own 100% of the issued and outstanding shares of capital stock of Health Net, and will thereby indirectly own 100% of the issued and outstanding shares of capital stock of HNLIC. For the avoidance of doubt, regardless of whether the Second Merger occurs, Centene will acquire all of the outstanding equity securities of Health Net in the Merger.

34. In consideration, at the effective time of the Merger, each share of Health Net common stock, par value \$0.001 per share, that is issued and outstanding immediately prior to the effective time of the Merger (excluding shares held by Health Net in treasury, any shares held, directly or indirectly, by the Applicants and any shares that are outstanding immediately prior to the effective time of the Merger and that are held by any person who is entitled to demand and properly demands appraisal of such shares pursuant to Delaware law) will be converted into the right to receive the merger consideration (the "Merger Consideration"), which will consist of \$28.25 in cash and 0.622 of a share of Centene common stock, par value \$0.001 per share. The Merger Consideration will be paid in connection with the Merger and there will be no additional consideration paid if the Second Merger occurs.

35. At the effective time of the Merger, (i) each outstanding stock option to purchase shares of Health Net common stock will be converted into a right to receive cash and shares of Centene's common stock (net of the option exercise price), (ii) each of Health Net's vested performance share awards and vested restricted stock units will be converted into rights to receive the Merger Consideration in respect of the shares of Health Net common stock subject to the awards and units, and (iii) each unvested performance share award and each unvested restricted stock unit of Health Net will be converted into rights to receive shares of Centene's common stock, subject to the same criteria, provided that any performance vesting goal will be deemed satisfied at target.

36. Following consummation of the Merger, existing stockholders of Centene will own approximately 71% of the combined company and existing stockholders of Health Net will own approximately 29% of the combined company based on stock prices and outstanding shares of Centene common stock and Health Net common stock as of July 1, 2015.

#### Conditions to Close the Merger

37. The completion of the Merger is subject to the satisfaction or waiver of customary closing conditions, including but not limited to the conditions listed as follows (along with the current status of each such condition):

- (i) approval of the Merger Agreement by Health Net's stockholders was obtained on October 23, 2015;
- (ii) approval of the issuance of Centene's common stock forming part of the Merger Consideration by Centene's stockholders was obtained on October 23, 2015;



- (iii) approval of listing of such Centene common stock on the NYSE was requested by Centene on October 28, 2015;
- (iv) there being no law or order prohibiting consummation of the Merger or the issuance of the shares of Centene's common stock forming part of the Merger Consideration, and there being no governmental proceeding pending that seeks to impose a burdensome condition on Health Net or Centene, will be satisfied as of the closing date;
- (v) expiration or termination of any waiting period under the Hart-Scott Rodino Antitrust Improvements Act of 1976, as amended, was satisfied on August 11, 2015;
- (vi) the effectiveness of a registration statement on Form S-4 with respect to the Centene common stock to be issued as part of the Merger Consideration was satisfied on September 21, 2015;
- (vii) subject to specified materiality standards, the accuracy of the representations and warranties of the other party will be satisfied as of the closing date;
- (viii) compliance by the other party in all material respects with its covenants will be satisfied as of the closing date; and
- (ix) specified governmental filings and consents having been made and obtained, as will be discussed in the written testimony of Keith H. Williamson.

## **VII. Merger Consideration and Related Financing**

38. The Merger is valued at approximately \$6.8 billion in cash and stock, based on stock prices as of July 1, 2015, and including the assumption of approximately \$500 million in debt from Health Net. The cash component of such total amount is equal to approximately \$2.3 billion.

39. The basis and terms of the Merger Agreement, including the nature and amount of consideration, were determined through arms' length negotiations among the representatives of Centene, on the one hand, and the representatives of Health Net, on the other hand, and their respective legal and other advisors. Following substantial due diligence by Centene, the amount and type of consideration were determined by taking into account the consideration paid in other recent acquisitions of similar types of businesses, as well as the financial position and results of operations of the entities to be acquired, including the past and present business operations, historical and potential earnings, financial condition and prospects, assets and liabilities and such other factors and information as Centene considered relevant under the circumstances.

40. Centene expects to issue approximately \$2.3 billion of long term fixed-rate debt securities to partially fund the Merger (the "Debt Securities"). The details of the Debt Securities will not be known until close to time of issuance, which is anticipated to be shortly before the closing of the Merger. However, note 6 to the unaudited pro forma condensed combined financial statements on page 195 of the Form S-4 calculates interest expense associated with the Debt Securities based on the assumption of maturity tranches between seven and 10 years and an estimated weighted average annual interest rate of 5.44%.

41. Centene has obtained a commitment letter from certain lenders providing commitments for a new revolving credit facility of up to \$1 billion and, in the event Centene is unable to issue the Debt Securities on or prior to the closing date of the Merger, a senior bridge facility of up to \$2.67 billion to consummate the Merger and the other transactions contemplated by the Merger Agreement (the "Commitment").

Letter”). The financing contemplated by the Commitment Letter is referred to as the “Financing” herein and in the Form A.

42. The Financing is subject to customary conditions and will be unsecured. In particular, no assets or stock of Health Net or of any person controlled by Health Net, including HNLIC, will be pledged or otherwise offered as security for the Financing. The Financing commitments will terminate on the date that is the earlier of (a) consummation of the Merger, (b) the termination of the Merger Agreement, and (c) one business day after the Outside Date (as defined in the Merger Agreement). The completion of the Merger is not conditioned on receipt of financing by Centene.

43. Centene intends to service its new debt resulting from the Financing from cash flows generated from the combined enterprise resulting from the Merger. The repayment of the debt will not be dependent on earnings from HNLIC. The new debt will not impact network providers or policyholders of HNLIC. The most significant driver of insurance premiums in every state is the cost of the underlying health care. Centene utilizes its expertise to keep the cost of health care as low as reasonably possible. HNLIC will continue to set actuarially sound rates based on its historical practices and methodologies, taking into account the underlying medical costs of its members, and will not include any costs resulting from debt service obligations under the Financing, other acquisition costs, or executive compensation related to consummation of the Merger in any such rates.

### **VIII. Executive Compensation**

44. The Merger in and of itself will not trigger entitlement to any special bonuses or payouts to Health Net’s or HNLIC’s executive officers. Certain executive officers have 2013 stock-based awards that vest in the normal course on March 7, 2016. If the Merger closes prior to March 7, 2016, the vesting of those awards would accelerate upon close due to the change of control.

45. Health Net executives that are severed as a result of the Merger (e.g. terminated for other than good cause) would be entitled to severance benefits under their employment agreements. The severance benefits vary by executive but include a lump sum payment equal to a multiple of base salary (generally either 1x or 2x), or, in the case of Health Net’s Chief Executive Officer, \$6 million. In addition, stock-based awards held by severed executive officers will have accelerated vesting upon severance.

46. Non-severed executives with Health Net stock or stock options will be treated like shareholders and receive the Merger consideration (less, in the case of stock options, the exercise price and withholding taxes). All other Health Net stock units held by executive officers will be substituted with Centene stock units, and will remain subject to time-based vesting (any performance vesting criteria will be deemed met at target level).

47. Information regarding executive compensation was provided in additional detail in supplemental responses to the Form A as well as contained in Centene and Health Net’s joint proxy statement (Form S-4) filed with the U.S. Securities and Exchange Commission in connection with the Merger.

48. HNLIC and its resources will in no way be impacted by executive compensation payable by reason of the Merger, including any enhancements that may result from severance benefits payable due to termination of employment under certain circumstances following the Merger.

### **IX. Synergies Anticipated from the Merger**

49. The combined company is estimated to achieve approximately \$150 million of annual cost synergies by the second year following the closing of the Merger with 50% achieved after one year

following closing. The synergy estimates provided are expected from, among others, efficiencies in core general and administrative matters and integration of a range of specialty services. Additional synergies may be achieved over time from leveraging capabilities in IT systems and process management. Any synergies achieved will benefit the combined company as a whole.

50. There exists extremely limited overlap in the respective businesses of Centene and Health Net. As a result, post-Merger, Centene intends to maintain the business and infrastructure of HNLIC intact. Consumers will benefit from the continuation of HNLIC's business plan and lack of disruption in its service to the members. In addition, the combination of Health Net and Centene businesses will bring greater scale to the surviving company thus better positioning the surviving company to more effectively compete in California. Cost saving opportunities from the Merger are anticipated to include administrative cost savings which may result in lower administrative expenses for HNLIC on a fully allocated basis. However, the magnitude and timing for those savings are not known. Centene and HNLIC intend to manage HNLIC so that administrative costs are efficient and can better support premium rates that continue to be competitive, including keeping HNLIC's administrative cost ratio at or below the level currently contemplated in HNLIC's business plan.

## **X. Competition in the Insurance Markets of California**

51. The immediate result of the Merger will not have an adverse effect upon competition for any line of insurance business in the State of California. The only line of business in which both Centene and Health Net write business in California is Medi-Cal. HNLIC has no Medi-Cal business. As set forth in the "Form E" analysis submitted to CDI by the Applicants as a supplement to the Form A, and as confirmed by expert testimony filed in this proceeding, there is no geographic overlap by county between the Centene and Health Net Medi-Cal products in California, which means that the companies do not compete with each other in any service area.

52. Health Net is smaller than many of its national competitors in the California market. To effectively compete in the post-Affordable Care Act health insurance market, Health Net needed to find a partner. By combining, Centene and Health Net have more opportunities to implement quality initiatives and manage health care and administrative costs. Through the combination, California consumers will have the benefit of a stronger insurer to effectively compete with Anthem, United, Aetna, Kaiser and Blue Shield, with or without any mergers involving these dominant insurers and plans that might occur in the future.

53. In addition, as Centene's presence in California is limited to providing Medi-Cal services, the combination does not reduce the number of competitors in the California commercial insurance market. Health Net's strength in the California marketplace has been primarily in Southern California. The new combined company will have the size and resources to potentially expand its offerings similar to those historically focused in Southern California to other regions of California.

54. The Merger is anticipated to positively contribute to the overall needs of California's healthcare system by, among other things, (1) maintaining and enhancing Health Net's strong commercial business in California; (2) bringing greater scale to the combined companies, thus better positioning them to more effectively compete in the evolving healthcare sector; (3) creating a stronger insurer dedicated to servicing lower and moderate income consumers; and (4) providing for increased resources to invest in future organic and acquisition growth opportunities in comparison to HNLIC on a standalone basis. In addition, HNLIC would be within a combined group that is expected to generate increased cash flow that would otherwise not be available on a standalone basis. Moreover, enhancing the IT expertise of HNLIC will also improve the ability to meet the overall needs of California's healthcare system.



55. The competitive effects of the Merger are analyzed in greater detail in the written testimony provided by Centene's expert witnesses, Drs. Lawrence Wu and Paul Wong, in this proceeding.

## **XI. Post-Merger Matters**

### **A. Business Operations and Insurance Markets**

#### **1. Business Plan**

56. Centene has no plans or proposals to cause HNLIC to declare an extraordinary dividend, liquidate HNLIC, sell any of HNLIC's assets (other than in the ordinary course of business), or to merge HNLIC with any person or persons or to make any other material change in HNLIC's corporate structure, business operations or management. Following the consummation of the Proposed Acquisition of Control, HNLIC will continue to maintain its separate corporate existence.

57. As documented in Centene's Form A, Centene's intends to continue the business of HNLIC without any material change to its existing plan of operation or its product offerings.

58. Centene's commitment extends to the commercial market in California. Health Net has been one of the leading commercial plans in California with 7% overall fully insured market share. Centene intends to maintain and support Health Net's current business plan with respect to the commercial products, which has a goal of continued growth. There are no changes contemplated for the Health Net commercial products as a result of the Merger. CDI has been provided detailed information on HNLIC's plans for continued growth in individual, small group and large group products on a confidential basis.

59. Centene's interest and commitment in offering commercial coverages is evidenced by the fact that Centene provides commercial coverage for individuals in the health insurance marketplaces in 13 states out of the 20 states in which Centene is currently operating health plans in 2016.

#### **2. Premium Rates in California's Commercial Insurance Market**

60. Independent of the Merger, HNLIC made a California rate filing that included rate increases for certain products in December 2015. Centene has no plans to increase the premium rates on any commercial products of HNLIC currently offered in any market in California other than as may be necessary over time to implement HNLIC's existing business plan.

61. Following the Merger, HNLIC will not increase the premium payable by its policyholders in California as a result of (a) costs associated with the close of the Merger, including the consideration to be paid by Centene and the financing of such consideration, or (b) any and all executive compensation to be paid to executive officers of Health Net in connection with the Merger.

62. Centene is committed to continuing HNLIC's history of working closely and in a cooperative manner with CDI on rate filings to ensure that its pricing is actuarially sound and is reflective of market conditions. HNLIC will continue to make adjustments in the products that it offers and the service areas in which it offers them in order to respond to market demands and to ensure that its pricing is actuarially sound in order for it to remain financially viable.

#### **3. Provider Networks in California**

63. The Merger is not anticipated to impact the number or scope of networks associated with HNLIC's various health products. HNLIC will continue to evolve its networks as is necessary both to

remain competitive in the California market and respond to changes in the provider communities, but any such evolution will not be a result of the Merger. As Centene has only Medi-Cal business in California there is no overlap of networks for commercial products and minimal overlap for Medi-Cal. Accordingly, no significant provider re-contracting effort will be necessary.

#### 4. Other States

64. Centene believes that the Merger will allow the combined company to use its expertise to establish similar health care products in other states by drawing on Health Net's experience without detracting from any California services or resources.

65. Health Net subsidiaries currently participate in the small group or large group markets in Arizona, Oregon and Washington, in addition to California, and Centene intends to maintain that market participation going forward. Centene is assessing the potential to use the experience and expertise of Health Net's management to offer certain government related group commercial products similar to those of HNLIC in selective other states and is evaluating which states to target and the timing for that expansion. While this would expand the geographical scope of these products, this geographical expansion will not impair HNLIC or its California consumers and will likely be limited in scope. The financing for the expansion of Centene's commercial business outside California will be funded through the corporate resources of Centene as well as the resources of the local entity to be involved in the expansion. The operation of Health Net in California would not be impacted by Centene's potential expansion into the commercial health insurance marketplace in other states.

#### B. Health Net Employees

66. As stated in Paragraph 13, according to data provided by Health Net, the current total workforce for Health Net and its subsidiaries nationwide is 8,480, with 6,424 in California, including full-time, part-time, and individuals on leave of absence. Centene will not make any material reduction in this workforce or the overall number of employees in California as a result of the Merger. Centene anticipates that there will be elimination of certain positions at the corporate level (e.g. certain senior management and duplicative corporate roles), but not at the member or provider servicing level to occur as a result of the Merger.

67. As stated in Paragraph 12, Health Net, including HNLIC, had a competitive disadvantage compared to other plans in California as a result of its lack of scale in comparison to such other plans. To counterbalance that competitive disadvantage, Health Net has for the last several years outsourced certain service functions and positions. Furthermore, in November 2014, Health Net signed the BPaaS Agreement to outsource on a going forward basis the bulk of Health Net's "back office" operations, which would have involved the re-badging (and potential subsequent off-shoring) of a significant portion of Health Net's more than 6,400 California employees. If the Merger is completed, it will result not only in the termination of the BPaaS Agreement (and, therefore, avoiding the outsourcing of employees), but may also result in the future in-sourcing of certain service functions and positions which are currently being outsourced by Health Net, as Centene's business model is to in-source as much as possible.

68. Headcount and staffing are continuously analyzed at Health Net and Centene, and will continue to be analyzed as combined operations after the Merger, and additions or reductions might be required at some point in the future based on then-current market conditions, service levels, number of insureds in relevant market segments, and other relevant factors. Any such future changes will not, however, be made as a result of the Merger.

#### C. Corporate Governance



69. Both Centene and HNLIC approach corporate governance from a local perspective. The companies believe that healthcare is best viewed as a local service. This is demonstrated by Centene's approach in each of the 20 states in which it has health plans. In each state, a strong Chief Executive Officer/President leads a local management team who is responsible for that health plan's performance. If an interaction involves direct contact with a member, provider, regulator or community advocate, Centene's approach is to have that interaction handled by the local management team.

70. Centene has been successful in maintaining the local nature of the services it provides in each jurisdiction in which it operates. For example, Centene has no centrally branded healthcare service provider or insurer across the nation. Rather, Centene's insurance companies and healthcare service providers remain branded locally in each state to emphasize the local nature of the services. In California, Centene will be keeping "Health Net" as a brand name, which will avoid confusion for Health Net members.

71. This same approach will be taken in California, where HNLIC will continue to be a California domiciled insurer with operational direction by a California-based Chief Executive Officer/President and senior executive team providing functions in key operational areas. Health Net, although it will become a subsidiary of Centene, will continue to be named Health Net, Inc. HNLIC will also not change its name. Centene has no plans to redomesticate or relocate HNLIC's headquarters outside of California, and is willing to commit, for so long as it maintains a majority of voting power of HNLIC, that it will not apply to transfer the state of domicile of HNLIC outside of California if, immediately following the redomestication: (a) HNLIC would be commercially domiciled in California pursuant to Section 1215.14(a) of the California Insurance Code; or (b) a plurality of covered lives of all types of coverage in all jurisdictions from all regulated entities that are subsidiaries of Health Net (or any successor) reside in California.

72. With regard to the ultimate parent holding company, Centene will replace Health Net as a result of the Merger. In the process, Health Net will become a wholly owned subsidiary of Centene and will be delisted from the New York Stock Exchange and cease to be a publicly traded company. Following the Merger, certain policies and procedures implemented by Centene, a publicly traded company listed on the New York Stock Exchange, and uniformly applied to its subsidiaries, such as Centene's Business Ethics and Conduct Policy, will be applied to HNLIC in its capacity as a subsidiary of Centene. Because Health Net, Inc. is currently listed on the New York Stock Exchange and is therefore subject to the same rules as Centene with respect to such listed status, the policies and procedures implemented by Centene and applied to HNLIC will be materially the same as are currently in place for HNLIC.

#### D. Claims Functions

73. Centene will not make material changes to HNLIC's claims handling and policy administration systems or functions for calendar year 2016, although over time Centene may seek to improve such systems by integrating Centene's IT expertise in California as described in the next paragraph.

74. Cognizant Technology Solutions ("CTS") provides certain claims-related activities for all lines of HNLIC's business on Health Net's systems. This arrangement has been in place for a number of years and is separate from the BPaaS Agreement. The BPaaS Agreement would have expanded upon the services historically provided by CTS to Health Net and its subsidiaries. Centene has reviewed the CTS arrangement and has determined that because CTS is trained and has experience with the Health Net systems utilized for processing claims for HNLIC's insureds, no material changes will be made for at least calendar year 2016 with respect thereto. Centene expects that the CTS arrangement will continue to be reviewed each year to determine whether material changes are warranted and in the best interest of HNLIC and its customers. If it is determined that a material change is warranted after calendar year 2016,

Centene does not anticipate using a different vendor. Rather, any such material change would likely involve Centene's insourcing the labor for claims processing with the goal of using U.S. domestic staff employed by the combined entity.

75. Any changes implemented will factor in the need for any system transition to avoid disruption to members or providers. In any event, Centene will, and will cause HNLIC to continue to, comply with all applicable California laws with respect to processing of claims of California insureds.

E. Underwriting

76. Centene will maintain HNLIC's underwriting function for large group coverage in California.

F. Customer Service Functions

77. Centene will not make any material changes to HNLIC's customer service systems or functions for calendar year 2016, although over time Centene may seek to improve such systems by integrating Centene's IT expertise in California as described in the next paragraph.

78. Certain vendors provide certain customer service functions for HNLIC's business on Health Net's systems. These arrangements have been in place for a number of years. Centene reviewed these arrangements and determined that because the vendors are trained and have experience with the Health Net systems utilized for customer service for HNLIC's insureds, no material changes are planned for at least calendar year 2016 with respect thereto. Centene expects that these arrangements will continue to be reviewed each year to determine whether material changes are warranted and in the best interest of HNLIC and its customers. If a material change is determined to be warranted after 2016, Centene does not anticipate using a different vendor. Rather, any such material change would likely involve Centene's insourcing the labor for customer service with the goal of using U.S. domestic staff employed by the combined entity.

79. Any changes implemented will factor in the need for any system transition to avoid disruption to members or providers. In any event, Centene will, and will cause HNLIC to continue to, comply with all applicable California laws with respect to customer service operations and systems impacting California insureds.

G. IT Systems and Vendor Contracts

80. Centene will continue to use the core third-party vendors currently used by HNLIC, but will seek ways to integrate the insurer's IT systems over time with Centene's efficient and effective IT systems. Centene understands that any such integration must be implemented with the least possible disruption to insureds and service providers, and Centene commits to taking the time and allocating the resources necessary to help ensure that any transition to HNLIC's IT infrastructure is as seamless as is reasonably possible.

81. Centene has a proven track record of seamlessly providing corporate standards across multiple regional areas while maintaining and promoting its local presence. From an IT perspective, Centene deploys an enterprise Management Information System for all of our health plans, with support from over 980 IT professionals.

82. Centene currently operates in 23 states and has, over many years, completed acquisitions and implementation of new insurance programs that required integration of IT systems and the transition of members and providers to Centene's IT systems. Centene has a proven track record of not only

understanding IT systems, but understanding how to integrate and improve disparate systems in a manner that avoids disruption to both insureds and service providers. Centene commits to bringing this same expertise and experience to bear in California.

83. As Centene's IT expertise is integrated with HNLIC over the coming years, more people should have easier access to the information and systems necessary to more quickly, efficiently, and cost-effectively access the relevant information and services necessary for effective healthcare. By using enhanced IT expertise for data management, document storage, and claims handling facilitation, HNLIC also hopes to be able to drive down the cost of insurance overall, which would also accrue to the benefit of consumers.

## **XII. Conclusion**

84. I would like to thank the Commissioner and the Staff of CDI for their attention to, and their diligence in reviewing, the Form A. Based on this Testimony, the Form A and the written testimonies of Keith Harvey Williamson, Stevan Sell, and Drs. Lawrence Wu and Paul Wong submitted to CDI in this proceeding, it is Centene's position that the Proposed Acquisition of Control satisfies all of the applicable standards of review for approval under Section 1215.2(d) of the California Insurance Code and that the Commissioner has a sufficient and robust record for the issuance of an approval order with respect to the Proposed Acquisition of Control as set forth in the Form A.

85. In conclusion, for the foregoing reasons, Centene respectfully requests that the California Commissioner of Insurance approve the Proposed Acquisition of Control.

\* \* \* \* \*

Kenneth Rone Baldwin deposes and says that he is the Executive Vice President for the Insurance Group at Centene Corporation, that he has read the foregoing written testimony and knows the contents thereof and that the same are true of his own knowledge.



Kenneth Rone Baldwin

**Holdings:** The Court of Appeals, Maze, J., held that:

(1) original action concerned interpretation and enforcement of contract required trial court, and Court of Appeals to employ a de novo standard of review;

(2) managed care contract and relevant Medicaid regulations unambiguously required provider to pay disputed claims relating to school-based medical services performed by local public health departments;

(3) services provided by registered nurses were included within managed care contract; and

(4) potential provision of medical care to ineligible children did not relieve provider of its aforementioned contractual duties.

Affirmed.

West Headnotes (8)

(1) **Health**  
**De novo review**

Medicaid managed care provider's action against Commonwealth, in which provider sought declaratory and injunctive relief against Finance and Administration Cabinet's (FAC) interpretation of managed care contract to require provider to pay disputed claims relating to school-based medical services performed by local public health department registered nurses, was an original action concerning the interpretation and enforcement of the terms of a contract, which required trial court, and Court of Appeals on appeal from trial court, to employ a de novo standard of review rather than one affording FAC's decision deference, pursuant to specific provision of Model Procurement Code recognizing the right of individuals or entities to bring actions against Commonwealth for breach of contracts or for enforcement of contracts or for both. [Ky. Rev. Stat. Ann. § 45A.245\(1\)](#).

462 S.W.3d 723  
Court of Appeals of Kentucky.

Kentucky Spirit Health Plan, Inc.,  
Appellant/Cross-Appellee  
v.  
Commonwealth of Kentucky, Finance and  
Administration Cabinet; Lori Flannery, in Her  
Official Capacity as Secretary of the Finance and  
Administration Cabinet; Commonwealth of  
Kentucky, **Cabinet for Health and Family Services**;  
Audrey Haynes, in Her Official Capacity as  
Secretary of the Cabinet for Health and Family  
Services; and Commonwealth of Kentucky,  
Department of Medicaid Services,  
Appellees/Cross-Appellants

Commonwealth of Kentucky, Finance and  
Administration Cabinet; Lori Flannery, in Her  
Official Capacity as Secretary of the Finance and  
Administration Cabinet; Commonwealth of  
Kentucky, **Cabinet for Health and Family Services**;  
Audrey Haynes, in Her Official Capacity as  
Secretary of the Cabinet for Health and Family  
Services; and Commonwealth of Kentucky,  
Department of Medicaid Services,  
Appellees/Cross-Appellants

and  
Commonwealth of Kentucky, Finance and  
Administration Cabinet; Lori Flannery, in Her  
Official Capacity as Secretary of the Finance and  
Administration Cabinet; Commonwealth of  
Kentucky, **Cabinet for Health and Family Services**;  
Audrey Haynes, in Her Official Capacity as  
Secretary of the Cabinet for Health and Family  
Services; Commonwealth of Kentucky,  
Department of Medicaid Services; and Lawrence  
Kissner, in His Official Capacity as Commissioner  
of the Department of Medicaid Services,  
Appellees/Cross-Appellants  
v.  
Kentucky Spirit Health Plan, Inc.,  
Appellant/Cross-Appellee

RENDERED: MAY 15, 2015; 10:00 A.M.

NO. 2013-CA-001003-MR  
2013-CA-001081-MR

Synopsis

**Background:** Medicaid managed care provider brought action against Commonwealth, seeking declaratory and injunctive relief against Finance and Administration Cabinet's (FAC) interpretation of parties' managed care contract to require provider to pay disputed claims including those relating to school-based medical services performed by local public health department registered nurses. The Circuit Court, Franklin County, Phillip J. Shepherd, J., entered summary judgment in favor of Commonwealth. Provider appealed and Commonwealth cross-appealed.




[Cases that cite this headnote](#)

[2]

### **Contracts**

 [Application to Contracts in General](#)

### **Contracts**

 [Language of Instrument](#)

Where a contract's terms are plain, a court must assign them their ordinary meaning and enforce the contract as written.

[Cases that cite this headnote](#)

[3]

### **Evidence**


 [Grounds for admission of extrinsic evidence](#)

If no ambiguity exists in the contract, a court may not resort to extrinsic or parol evidence concerning the parties' intentions.

[Cases that cite this headnote](#)

[4]

### **Contracts**

 [Existence of ambiguity](#)

In making initial determination of whether an ambiguity exists in the Contract, the court asks whether the contract provisions in question were susceptible to inconsistent interpretations.

[Cases that cite this headnote](#)

[5]

### **Health**

 [Benefits and Services Covered](#)

Managed care contract, in conjunction with relevant Medicaid regulations, unambiguously required Medicaid managed care provider to pay disputed claims relating to school-based medical services performed by local public health

departments; the contract, tracking very similar language to that of relevant regulations, stated, "School-Based Services provided by public health departments are included in Contractor coverage." 907 Ky. Admin. Regs. 1:715, 11:034, 17:020.

[Cases that cite this headnote](#)

[6]

### **Appeal and Error**

 [Reasons for Decision](#)

An appellate court may affirm a lower court for any reason supported by the record.

[Cases that cite this headnote](#)

[7]

### **Health**

 [Benefits and Services Covered](#)

Services provided by local public health department registered nurses were included within managed care contract under which Medicaid managed care provider was required to pay for school-based medical services; controlling Medicaid regulations and the managed care contract simply did not require a doctor's order for every routine service provided within a school, be it an immunization or the dispensing of over-the-counter medicine.

[Cases that cite this headnote](#)

[8]

### **Health**

 [Benefits and Services Covered](#)

Potential provision of health care to children who were not Medicaid eligible did not justify limitation of managed care contract to relieve Medicaid managed care provider of its obligation to pay for school-based medical services performed by local public health department registered nurses; Medicaid regulations and other mechanisms provided

sufficient safeguards against violations of Medicaid guidelines. 907 Ky. Admin. Regs. 1:005, 1:360, 11:034.

Cases that cite this headnote

**\*725** APPEAL FROM FRANKLIN CIRCUIT COURT, HONORABLE PHILLIP J. SHEPHERD, JUDGE, ACTION NO. 13-CI-86.

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BEFORE: [COMBS](#), [JONES](#), AND MAZE, JUDGES.

### OPINION

[MAZE](#), JUDGE:

Kentucky Spirit Health Plan, Inc., (hereinafter “Kentucky Spirit”) appeals from a decision of the Franklin Circuit Court granting summary judgment in favor of **\*726** the numerous appellees in this case (collectively “the Commonwealth”). Specifically, Kentucky Spirit argues that the circuit court erroneously interpreted the terms of its Medicaid Managed Care Contract (hereinafter “the Contract”) with the Commonwealth, pursuant to which Kentucky Spirit provided various Medicaid-eligible services. The Commonwealth appeals the circuit court’s use of a non-deferential standard of review in addressing the decision of the Finance and Administration Cabinet’s (FAC) Secretary.

We conclude that the Contract required Kentucky Spirit to cover the contested services, though we do so for reasons other than those in the circuit court’s order. Hence, we affirm summary judgment for the Commonwealth. We further affirm the circuit court’s chosen standard of review.

### Background

The underlying facts of this case are neither disputed nor complex. Beginning in November 2011, Kentucky Spirit, a Missouri-based corporation and Managed Care Organization (MCO), facilitated Kentucky’s Medicaid program pursuant to the Contract<sup>1</sup> as well as various state and federal Medicaid statutes and regulations.<sup>2</sup> One of the many services Kentucky Spirit was charged with providing was “preventative health services.” Prior to 2011, approved medical professionals in the 104 subject Kentucky counties performed these and other services and billed the Department of Medicaid Services (DMS) directly as part of a “fee-for-service” system. Under this system, DMS also reimbursed local health departments for eligible services performed by healthcare professionals employed with local health departments, including school-based clinics staffed by registered nurses.

Under the new “managed care” scheme adopted in 2011, Kentucky Spirit became one of three providers of Medicaid with which the Commonwealth contracted to provide services to eligible Kentuckians. For these services, and in the place of the past fee-for-service arrangement, the Commonwealth paid Kentucky Spirit a monthly fee based upon the number of enrolled members. In 2012, after reviewing claims it had received from the Commonwealth, Kentucky Spirit determined that claims for services performed by health department registered nurses and licensed practical nurses at school clinics were “outside the scope of the Contract and therefore not eligible for payment....” Kentucky Spirit contended that the costs of these services were the responsibility of the Education Cabinet.

Pursuant to the Contract, Kentucky Spirit filed a reimbursement dispute with the Cabinet for Health and Family Services (CHFS) and later appealed to the FAC. The CHFS Secretary determined that the Contract required Kentucky Spirit to pay the disputed claims. However, she agreed with Kentucky Spirit that services provided by licensed practical nurses were not compensable under the Contract. The FAC Secretary



affirmed CHFS's decision.

**\*727** On January 25, 2013, Kentucky Spirit filed suit in Franklin Circuit Court seeking declaratory and injunctive relief against the decision of the FAC Secretary pursuant to [KRS 3 45A.245](#). Kentucky Spirit sought and received expedited handling of its action. The circuit court held oral arguments on the merits of the case; and after both parties filed motions for summary judgment and fully briefed the issue, the circuit court entered an Opinion and Order.

In its decision, the circuit court agreed with the Commonwealth that Kentucky Spirit was obligated under the Contract to provide the same level of coverage previously provided under the fee-for-service arrangement. The court further held that Kentucky Spirit could not disregard what the court deemed was a "longstanding interpretation of Medicaid eligibility" for school-based medical services performed by local public health departments. Employing the doctrines of contemporaneous construction and comity, as well as the legislative intent behind Kentucky's Medicaid-related statutes, the circuit court granted the Commonwealth's motion for summary judgment and denied Kentucky Spirit's motion for the same. Kentucky Spirit now appeals from the circuit court's decision; and the Commonwealth cross-appeals on the sole basis of the circuit court's chosen standard of review.

### Standard of Review

<sup>[1]</sup>While it is rare for this Court to address and dispose of a contested issue while merely stating the appropriate standard of review, the unique facts and arguments in this case prove it to be possible. On cross-appeal, the Commonwealth argues that the circuit court erred in failing to show appropriate deference to the FAC Secretary's ruling. More specifically, it contends that the circuit court was required, but failed, to conduct judicial review of the decision of the FAC Secretary "under the auspices of [KRS 13B.150](#) and the standards of common administrative law." Furthermore, the Commonwealth urges that we must do the same. We have observed this argument, or some variation of it, in several recent cases involving the Commonwealth; and we once again disagree.

We decline to apply KRS 13B. Above all, we cite to the fact that the parties agreed in Section 40.9 of the Contract that disputes between them would be resolved pursuant to KRS 45A, not KRS 13B. The Commonwealth is bound

by this provision and may not now choose another remedy.

In further support of a proposed deferential standard of review, the Commonwealth cites to [KRS 45A.280](#), part of Kentucky's Model Procurement Code, which states,

[t]he decision of any official, board, agent, or other person appointed by the Commonwealth concerning any controversy arising under, or in connection with, the solicitation or award of a contract, shall be entitled to a presumption of correctness and shall not be disturbed unless the decision was procured by fraud or the findings of fact by such official, board, agent or other person do not support the decision.

Kentucky Spirit's action sought declaratory and injunctive relief concerning the terms of its contract with the Commonwealth. In effect, Kentucky Spirit sought enforcement of the Contract. Hence, we conclude that the more specific and more applicable provision of the Model Procurement Code is [KRS 45A.245\(1\)](#). It states, in pertinent part,

**\*728** Any person, firm or corporation, having a lawfully authorized written contract with the Commonwealth at the time of or after June 21, 1974, may bring an action against the Commonwealth on the contract, including but not limited to actions either for breach of contracts or for enforcement of contracts or for both. Any such action shall be brought in the Franklin Circuit Court and shall be tried by the court sitting without a jury.

Applying the language of [KRS 45A.245\(1\)](#), Kentucky Spirit's action in the circuit court was an original action concerning the interpretation and enforcement of the terms of a contract. Thus, the circuit court was correct to apply a *de novo* standard of review; and we shall do the same. See *Hazard Coal Corp. v. Knight*, 325 S.W.3d 290, 298 (Ky. 2010), quoting *First Commonwealth Bank of Prestonburg v. West*, 55 S.W.3d 829, 835 (Ky. App. 2000).

### Analysis

[2] [3] [4] [5] The remaining issues in this case concern the interpretation of a contract. Thus, we must remember the well-established rule that, where a contract's terms are plain, a court must assign them their ordinary meaning and enforce the contract as written. See *Bryan v. Massey-Ferguson, Inc.*, 413 S.W.2d 891, 893 (Ky. 1966). If no ambiguity exists, a court may not resort to extrinsic or parol evidence concerning the parties' intentions. *Frear v. P.T.A. Industries, Inc.*, 103 S.W.3d 99, 106 (Ky. 2003), citing *Teague v. Reid*, 340 S.W.2d 235 (Ky. 1960). We must first determine whether an ambiguity existed in the Contract, as this will dictate the course of our analysis. In doing so, we ask whether the contract provisions in question were "susceptible to inconsistent interpretations." *Frear*, 103 S.W.3d at 106 n. 12, citing *Transport Ins. Co. v. Ford*, 886 S.W.2d 901, 905 (Ky. App. 1994). More specifically, we must determine if those provisions in the Contract concerning Kentucky Spirit's alleged obligation to provide coverage for school-based health services performed by local health department registered nurses were subject to more than one reasonable interpretation. We answer that question in the negative.

In ruling for the Commonwealth, the circuit court never expressly held these provisions to be ambiguous; however, it employed several rules of contractual construction. Kentucky Spirit argues the circuit court was not permitted to do so because the terms of the Contract were unambiguous. Kentucky Spirit first points out that while the Contract required that it provide preventative health services "pursuant to 907 KAR<sup>4</sup> 1:360[.]" that regulation does not provide for *where* these services are to be performed. We are not convinced the location of the services is relevant given other terms in the Contract and the controlling regulations; however, even following Kentucky Spirit's guidance into other areas of Kentucky's Medicaid-related regulations, its argument fails.

Kentucky Spirit cites 907 KAR 1:715 Section 1(30)<sup>5</sup> as dictating where preventative health services can be performed. \*729 It contends that the regulation establishes that a school-based medical service is covered by Medicaid only if it is an "early and periodic screening, diagnosis, and treatment" provided under a student's individualized education program. 907 KAR 11:034 Section 1(3). Kentucky Spirit's reading is too restrictive.

We observe nothing in the regulations Kentucky Spirit cites, or in those to which the parties are bound under the

Contract, that indicates the preventative health services in question were excluded from coverage. The Contract specifically and unambiguously states that Kentucky Spirit is required to provide services pursuant to 907 KAR 1:360, which specifically includes a "pediatric service" performed by the Department of Public Health among its "Covered Services." 907 KAR 1:360 Section 3(6). The same regulation does not list the services in question in its "Services Limitations" provision. Furthermore, we see no inconsistency between the services to which 907 KAR 1:715 Section 1(30) and 907 KAR 11:034 refer and those at issue in this case.

Kentucky Spirit also cites to 907 KAR 17:020 Section 2(3)(e), which it quotes as saying "[a]n MCO shall not be responsible for the provision or costs of ... a school-based health service" except those early and periodic screening, diagnostic, and treatment services specified in a child's individualized education program. As is often the case, the devil is in the ellipses.

Regulation 907 KAR 17:020 Section 2(3)(e) states, in its entirety, "An MCO shall not be responsible for the provision or costs of the following: ... (e) Except as established in Section 6 of this administration regulation, a school-based health service[.]" Section 6 of the same regulation states, in pertinent part, "(4) A school-based health service provided by a local health department shall be covered by an MCO." Section 32.8 of the Contract itself, tracking very similar language to that of the regulations, states, "School-Based Services provided by public health departments are included in Contractor coverage." This language is subject to only one reasonable interpretation.

The broader basis for the circuit court's resort to various rules of contractual construction was that prior to 2011, local health departments performed, and were reimbursed under Medicaid for, the services Kentucky Spirit now contends it is not required to cover. This fact is important because the Contract expressly stated: "The Contractor shall cover all services for its Members at the appropriate level, in the appropriate setting and as necessary to meet Members' needs to the extent services are currently provided." At oral argument, Kentucky Spirit argued that the circuit court's emphasis on what it called "prior practice" was misplaced. We disagree. The language above lies perfectly within the four corners of the Contract—Appendix I, to be exact. More importantly, this language is also subject to only one interpretation.

[6] Based on the aforementioned provisions within the Contract, we agree with Kentucky Spirit that the document is unambiguous. The four corners of the

Contract, in conjunction with relevant regulations, unambiguously required Kentucky Spirit to provide coverage for school-based services performed by local health departments. While our conclusion may indicate that the circuit court unnecessarily resorted to rules of contractual construction, this is of little consequence because the result is the same. “[I]t is well-settled that an appellate court may affirm a lower court for any reason supported by the record.” *McCloud v. Commonwealth*, 286 S.W.3d 780, 786 n. 19 (Ky. 2009), citing \*730 *Kentucky Farm Bureau Mut. Ins. Co. v. Gray*, 814 S.W.2d 928, 930 (Ky. App. 1991); see also *Emberton v. GMRI, Inc.*, 299 S.W.3d 565, 576 (Ky. 2009). We invoke this provision and affirm the circuit court’s order in its entirety.

<sup>[7]</sup>Having held that the services at issue are Kentucky Spirit’s responsibility to cover, we must also resolve the question of who may perform those services. Kentucky Spirit contends that it was not obligated to cover services provided by unsupervised health department registered nurses. It cites a provision in the State Plan which states,

Nursing Services: Services must be medically necessary. The services may be provided in accordance with an Individualized Education Program or an Individual Family Service Plan. Nursing services must be those services that are in a written plan of care based on a physician, physician assistant or nurse practitioner’s written order.

Based upon this, Kentucky Spirit argues the circuit court impermissibly expanded the scope of registered nurses’ practice under the Contract and Medicaid regulations. We disagree.

The provision in the State Plan to which Kentucky Spirit cites refers to nursing care for specialized services benefitting children with identifiable and serious health conditions. If Kentucky Spirit had quoted the full paragraph regarding “Nursing Services,” it would have continued as follows:

The plan of care must be developed by a licensed registered nurse. Services include but are not limited to: assessments including referrals based on results, [bladder catheterizations](#), suctioning, medication administration and management including observation

for adverse reactions, response or lack of response to medication, informing the student about their medications, oxygen administration via [tracheostomy](#) and ventilator care, enteral feedings, emergency interventions, individual health counseling and instructions, and other treatments ordered by the physician and outlined in the plan of care.

By contrast, this case concerns largely routine pediatric services provided by health department nurses, not the specialized services to which the above portion of the State Plan clearly refers. Furthermore, nothing in this or any other regulation we observe states that licensed registered nurses cannot provide the services which are the subject of this case.

In sum, Kentucky Spirit reads the controlling regulations and documents in this case as requiring a doctor’s order for every routine service provided within a school—be it an immunization or the dispensing of over-the-counter medicine. We do not read such an extreme limitation to apply to the services in question. Instead, we agree with the circuit court that Kentucky Spirit was responsible for the eligible services of local health department nurses performed in schools.

<sup>[8]</sup>Finally, we address a more tangential argument of Kentucky Spirit’s. At oral argument and in its briefs, Kentucky Spirit voiced a concern regarding services being provided to children who are not Medicaid eligible. Kentucky Spirit seeks our reversal of the circuit court’s decision based on this concern; however, we do not agree that the Contract, or past practice, permits such violations of federal and state Medicaid guidelines.

As we have stated, the Contract expressly required services to be provided consistent with [907 KAR 1:360](#) Section 2(a), which expressly requires Departments of Public Health to “comply with the terms and conditions” of state and federal Medicaid statutes and regulations, including those regarding “nonduplication of payments.” [907 KAR 1:360](#) Section \*731 2(a), referencing [907 KAR 1:005](#). Regulation [907 KAR 11:034](#) Section 1(5), to which Kentucky Spirit so fervently directs us in support of its argument, defines “Recipient” as “a Medicaid eligible child....” These are but a few examples within both Kentucky’s Medicaid regulations and the Contract which act to alleviate, in this Court’s mind, any concern surrounding the “free service” issue Kentucky Spirit raises. Sufficient safeguards exist against any such

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violation of Medicaid guidelines. Furthermore, we strain to grasp how such a concern informs our decision on the services at issue in this case.

Kentucky Spirit has alleged in this case. Therefore, the decision of the Franklin Circuit Court is affirmed.

### **Conclusion**

This case involves preventative health services provided to eligible children by health department medical professionals within schools. There is no basis in the Contract, State Plan, or relevant regulations for the coverage limitations, geographic or otherwise, that

ALL CONCUR.

### **All Citations**

462 S.W.3d 723

### **Footnotes**

- <sup>1</sup> In 2013, Kentucky Spirit announced its intention to withdraw from its duties under the Contract. Litigation ensued, and in an unpublished opinion rendered on February 6, 2015, this Court affirmed the Franklin Circuit Court's conclusion that this constituted breach of the Contract. See [Kentucky Spirit Health Plan, Inc. v. Finance and Administration Cabinet, 2015 WL 510852 \(Ky. App. 2015\)\(2013–CA–001050–MR and 2013–CA–001201–MR\)](#).
- <sup>2</sup> One such authority is the "Kentucky State Plan Under Title XIX of the Social Security Act Medical Assistance Program" (hereinafter referred to as the "State Plan").
- <sup>3</sup> Kentucky Revised Statutes.
- <sup>4</sup> Kentucky Administrative Regulations.
- <sup>5</sup> This specific provision defines a "School-based health services," as referenced in the regulation, as medically-necessary health services:
  - (a) Provided for in 907 KAR 1:034 [since re-codified as [907 KAR 11:034](#)]; and
  - (b) Specified in an individualized education program for a child determined to be eligible under the provisions of the Individuals with Disabilities Education Act, 20 U.S.C. Chapter 33, and 707 KAR Chapter 1.

2015 WL 510852

Only the Westlaw citation is currently available.

Unpublished opinion. See KY ST  
RCP Rule 76.28(4) before citing.

NOT TO BE PUBLISHED  
Court of Appeals of Kentucky.

Kentucky Spirit Health Plan,  
Inc., Appellant/Cross-Appellee  
v.

Commonwealth of Kentucky, Finance and  
Administration Cabinet; Lori Flanery, in her Official  
Capacity as Secretary of Finance and Administrative  
Cabinet; Commonwealth of Kentucky, [Cabinet for  
Health and Family Services](#); Audrey Haynes, in  
her Official Capacity as Secretary of the Cabinet  
for Health and Family Services; Commonwealth  
of Kentucky, Department of Medicaid Services;  
and Lawrence Kissner, in his Official Capacity  
as Commissioner of the Department of  
Madicaid Services, Appellees/Cross-Appellants

NO. 2013-CA-001050-MR  
AND NO. 2013-CA-001201-MR

|  
RENDERED: FEBRUARY 6, 2015; 10:00 A.M.

|  
MODIFIED: AUGUST 7, 2015

APPEAL AND CROSS-APPEAL FROM FRANKLIN  
CIRCUIT COURT, HONORABLE THOMAS D.  
WINGATE, JUDGE, ACTION NOS. 12-CI-01373 AND 13-  
CI-00458

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Louisville, Kentucky

BEFORE: [CAPERTON](#),<sup>1</sup> [JONES](#), AND [KRAMER](#),  
JUDGES.

#### OPINION

[JONES](#), JUDGE:

\*1 This appeal and cross-appeal arise out of a declaratory judgment decision rendered by the Franklin Circuit Court. Therein, the circuit court determined that Kentucky Spirit Health Plan, Inc. (Kentucky Spirit) did not have a contractual right to terminate its Medicaid Managed Care Contract (Contract) with the Commonwealth of Kentucky, Finance and Administration Cabinet (Commonwealth) prior to the expiration of the initial three-year contractual term. The circuit court also determined that early termination of the Contract by Kentucky Spirit would constitute a breach triggering the liquidated damages provision.

On appeal, Kentucky Spirit argues that the circuit court incorrectly interpreted the Contract. The Commonwealth has also filed a cross-appeal asserting that it should not be limited to seeking only liquidated damages for Kentucky Spirit's unauthorized early termination. For the reasons more fully explained below, we affirm the circuit court's decision relating to the interpretation of the termination provision and applicability of the liquidated damages provision. However, we decline to address the issues presented by the Commonwealth's cross-appeal because those issues have not yet been fully addressed by the circuit court as part of any action by the Commonwealth seeking damages.

#### I. BACKGROUND

##### A. The Medicaid Program & Kentucky

“In 1965 Congress authorized the Medicaid program by adding Title XIX to the Social Security Act; the program was established ‘for the purpose of providing federal financial assistance to States that choose to reimburse certain costs of medical treatment for needy persons.’ ” [Connecticut Dept. of Income Maintenance v. Heckler](#), 471 U.S. 524, 528–29, 105 S.Ct. 2210, 2213, 85 L.Ed.2d 577 (1985) (quoting [Harris v. McRae](#), 448 U.S. 297, 301, 100 S.Ct. 2671, 2680, 65 L.Ed.2d 784 (1980)). To be eligible for financial assistance under the program, states must develop plans for providing medical assistance to their residents and have those plans approved by the Secretary of the Department of Health and



Human Services.<sup>2</sup> *Id.* In general, however, “the program was designed to provide the states with a degree of flexibility in designing plans that meet their individual needs.” *Addis v. Whitburn*, 153 F.3d 836, 840 (7th Cir. 1998).

Pursuant to regulations enacted by the Department of Health and Human Services, payment for Medicaid services must be made “directly by the State to the individual or entities that furnish the services.” 42 Code of Federal Regulations (CFR) § 430.0. States, however, have discretion whether to pay for care directly on a claim-by-claim basis (a fee-for-service system) or to contract with an organization that the state pays based on a monthly, fixed-fee basis per enrollee (a managed care system).<sup>3</sup> See *Appalachian Regional Healthcare, Inc. v. Coventry Health and Life Ins. Co.*, 714 F.3d 424, 426 (6th Cir. 2013).

\*2 In its inception, the Kentucky Medicaid program compensated providers under a fee-for-services system. *Id.* In March 2011, the Kentucky General Assembly authorized transitioning from a fee-for-service system to a managed care system.<sup>4</sup> In April 2011, the Commonwealth issued a request for bid proposals (RFPs) from managed care providers interested in contracting with the Commonwealth to administer Medicaid benefits to its residents.

### B. Kentucky Spirit

On May 25, 2011, Kentucky Spirit submitted its response to the RFP. In June 2011, the Commonwealth awarded Kentucky Spirit and two other managed care providers contracts. After a period of negotiation, on July 6, 2011, Kentucky Spirit and the Commonwealth entered into a Medicaid Managed Care Contract (the Contract). Under the terms of the Contract, Kentucky Spirit agreed to administer Medicaid benefits to eligible Kentuckians in exchange for monthly “capitation payments”<sup>5</sup> from the Commonwealth. The Contract called for an initial three-year term (7/6/2011–7/5/2014) with the option to renew the Contract for four additional one-year terms (Renewal Term 1: 7/6/2014 to 7/5/2015; Renewal Term 2: 7/6/2015 to 7/5/2016; Renewal Term 3: 7/6/2016 to 7/5/2017; Final Renewal Term 7/6/2015–7/5/2016).

On October 17, 2012, Kentucky Spirit tendered notice of its intent to terminate the Contract effective at midnight on July 5, 2013, twelve months before the expiration of the Contract's

initial term. Kentucky Spirit tendered its notice of intent to terminate pursuant to Section 39.13 of the Contract. That section provides:

The Contractor may terminate this Contract with notice given in accordance with the requirements of **Section 40.13**[<sup>6</sup>] at least six (6) months but not more than twelve (12) months prior to the end of the initial term of this Contract or any renewal terms.

The Commonwealth responded that the Contract did not permit Kentucky Spirit to terminate prior to the end of the initial three-year term. The Commonwealth maintained that Section 39.13 permits Kentucky Spirit to terminate the Contract *only* upon expiration of the initial contract term or any of the first three renewal terms.

On October 22, 2012, Kentucky Spirit filed a complaint in Franklin Circuit Court seeking a declaration that Section 39.13 afforded it the right to terminate the Contract prior to the conclusion of the initial term. Thereafter, Kentucky Spirit and the Commonwealth filed cross-motions for summary judgment arguing that the plain language of the Contract supported their respective interpretations.

The parties' motions also addressed whether the Contract's liquidated damages provision, Section 39.11, was at issue in the event Kentucky Spirit's early termination was deemed to be a breach of the Contract. Kentucky Spirit maintained that the liquidated damages provision was the only method by which the parties had agreed to assess damages in the event of a breach and, therefore, was controlling. The Commonwealth argued that if Kentucky Spirit terminated the Contract under Section 39.13, it would be liable for liquidated damages equal to 10% of the Capitation Payment for each month up to the end of the initial contract term, which the Commonwealth claimed bore “relation to the actual damage sustained.” In the alternative, the Commonwealth argued that the liquidated damages provision should not apply because the Commonwealth's damages could be ascertained and, therefore, it was entitled to actual damages.

\*3 The circuit court ultimately ruled against Kentucky Spirit on the termination issue finding that the Contract did not permit termination by Kentucky Spirit before expiration of the initial term. In so doing, the circuit court first examined Section 39.13 and determined that it was unambiguous. The

circuit court concluded that the only reasonable interpretation of Section 39.13 is that it required Kentucky Spirit to give notice to the Commonwealth in the event that it did not intend to renew the Contract after the fixed, initial three year term. The circuit court specifically rejected Kentucky Spirit's argument that Section 39.13 could be interpreted to allow termination before the end of the initial term. The circuit court rationalized that when Section 39.13 is examined in relation to the entire Contract it becomes clear that "the parties contemplated a transition period to phase out Kentucky Spirit and transition patients to another managed care provider." The circuit court also based its conclusion on the RFP and [200 Kentucky Administrative Regulations \(KAR\) 5:312](#).<sup>7</sup> In conclusion, the circuit court held:

The only reasonable interpretation ... is to conclude that Section 39.13 is a notice provision, with the earliest possible termination date being the final date of the initial term of three years, July 5, 2014. Based on the plain meaning of the Contract's terms and an examination of the Contract as a whole, Kentucky Spirit does not have a right to terminate the Contract one year early under Section 39.13.

The circuit court then held that if Kentucky Spirit ceased performing its contractual duties prior to the end of the initial term, it would be in breach of the Contract, which would allow the Commonwealth to terminate the Contract due to Kentucky Spirit's default entitling the Commonwealth to liquidated damages under Section 39.11.

This appeal followed.

## II. STANDARD OF REVIEW

"Questions concerning the construction and interpretation of contractual terms are legal in nature as are questions regarding the existence of an ambiguity." [Richey v. Perry Arnold, Inc.](#), 391 S.W.3d 705, 709–10 (Ky. 2012). Accordingly, our review of the trial court's decision is *de novo*, meaning we afford no deference to the trial court's decision. See [Spot-A-Pot, Inc. v. State Resources Corp.](#), 278 S.W.3d 158, 161 (Ky. App. 2009).

## III. ANALYSIS

### A. Guiding Principles in the Interpretation of Written Contracts

"Under Kentucky law, an enforceable contract must contain definite and certain terms setting forth promises of performance to be rendered by each party." [Kovacs v. Freeman](#), 957 S.W.2d 251, 254 (Ky. 1997). Contracts can be oral or written.<sup>8</sup> When parties undertake to reduce their agreement to a written document, we presume that the words they chose express their intent. See [Siler v. White Star Coal Co.](#), 226 S.W. 102, 104 (Ky. 1920) ("The law presumes that the parties understood the import of their contract, and that they had the intention which its terms manifest.").

\*4 "The cardinal rule in the interpretation of contracts is to ascertain the intention of the parties and to give effect to that intention." [Jones v. Riddell](#), 5 S.W.2d 1077, 1078 (Ky. 1928). In the case of a written contract, we first look to the parties' written agreement to ascertain their intent. [Muncey Coal Mining Co. v. Muncey](#), 268 S.W. 293, 294 (Ky. 1925) ("Intention is to be gathered from the words employed in the contract and not from any unexpressed mental intention which the parties may have entertained but which they did not express.").

In so doing, we attempt to divine intent from the scope of the entire agreement, not by relying simply on individual terms or phrases examined in isolation. See [Martin Oil & Gas Co. v. Fyffe](#), 65 S.W.2d 686, 687–88 (Ky. 1933) (holding that courts must "look to the entire instrument and deduce the intention of the parties from the language employed."); [City of Louisa v. Newland](#), 705 S.W.2d 916, 919 (Ky. 1986) (recognizing that a contract "must be construed as a whole, giving effect to all parts and every word in it if possible."). Moreover, "words used in contracts are not given legal or technical meaning; rather, they are defined by the contract itself, or, absent that, by the usage of the average man and as they would be read and understood by him." [Neighborhood Investments, LLC v. Kentucky Farm Bureau Mut. Ins. Co.](#), 430 S.W.3d 248, 251 (Ky. App. 2014).

After examining the contractual language as a whole, we must next decide whether the contract is ambiguous. An ambiguous contract is one that is susceptible to "more than one different, reasonable interpretation." [Central Bank & Trust Co. v.](#)

*Kincaid*, 617 S.W.2d 32, 33 (Ky. 1981); see also *Transport Insurance Co. v. Ford*, 886 S.W.2d 901, 905 (Ky. App. 1994) (stating “[t]o determine that an ambiguity exists, the court must first determine that the contract provision is susceptible to inconsistent interpretations.”). Determining whether the contract is ambiguous is a pivotal point in the process of contract interpretation. The outcome of this decision will dictate how the remainder of our interpretive analysis will proceed, specifically whether we can rely on parol evidence to ascertain the parties’ intent. *Frear v. P.T.A. Industries, Inc.*, 103 S.W.3d 99, 107 (Ky. 2003).

“When no ambiguity exists in the contract, we look only as far as the four corners of the document to determine that intent.” *Abney v. Nationwide Mut. Ins. Co.*, 215 S.W.3d 699, 703 (Ky. 2006). We cannot use parol evidence to arrive at an interpretation that differs from the unambiguous terms used by the parties in their contract. *Hoheimer v. Hoheimer*, 30 S.W.3d 176, 178 (Ky. 2000).

If the contract is ambiguous, however, we must look outside the four corners of the agreement to determine which interpretation is most consistent with the parties’ intent at the time they entered into the agreement. While nothing can be added to or taken from a written contract by parol evidence, it is the rule that ambiguities may be explained by parol evidence. *Stubblefield v. Farmer*, 291 Ky. 795, 165 S.W.2d 556, 557 (1942). Accordingly, when the contract at issue is ambiguous, we examine “the situation of the parties and the conditions under which the contract was written” to determine the parties’ intent. *Frear*, 103 S.W.3d at 106.

However, we cannot consult parol evidence to make the initial determination of whether the contract is ambiguous. Moreover, we are mindful that “an otherwise unambiguous contract does not become ambiguous when a party asserts—especially post hoc, and after detrimental reliance by another party—that the terms of the agreement fail to state what it intended.” *Id.* at 107.

\*5 Finally, because the Contract at issue involves the Commonwealth as a party, we are also mindful that “the rule in construing contracts to which the government is a party is to resolve all ambiguities, presumptions and implications in its favor. Where the public interest is affected, an interpretation is preferred which favors the public.” *Codell Const. Co. v. Commonwealth*, 566 S.W.2d 161, 164 (Ky. App. 1977).

## B. Is the Contract Ambiguous?

With these guiding principles in mind, we now turn to the dispute at hand. Our ultimate goal is to discern the intended effect of Section 39.13. To reach that goal, we must first determine whether Section 39.13 is subject to more than one reasonable interpretation. While both parties maintain that the provision is unambiguous, they ascribe different meanings to it.

Section 39.13 states in full as follows:

### 39.13 Termination by Contractor

The Contractor may terminate this Contract with notice given in accordance with the requirements of Section 40.13 at least six months [January 5, 2014] but not more than twelve months prior [July 5, 2013] to the end of the initial term [July 5, 2014] of this Contract or any renewal terms.

Kentucky Spirit maintains that the unambiguous language of Section 39.13 is susceptible to only one reasonable interpretation: Kentucky Spirit had the right to terminate the Contract within a specified time before expiration of its initial term. Kentucky Spirit asserts that the circuit court erred in holding instead that Section 39.13 was a provision permitting Kentucky Spirit to provide notice of nonrenewal. Kentucky Spirit focuses its argument on the word “termination” in this provision. Citing the dictionary definition, it argues that the word “terminate” means “to end formally and definitely (as a pact agreement, or contract).” Under its interpretation, Kentucky Spirit believes that it had the right to terminate all its obligations under the Contract prior to a conclusion of the initial term so long as it provided the notice required by Section 40.13 (registered mail to the Office of Procurement Services, Finance and Administration Cabinet) at least six months but not more than twelve months prior to the end of the initial term of the Contract or any renewal terms.

The Commonwealth maintains that Section 39.13 must be examined in light of the other contractual provisions. It argues that when Section 39.13 is considered in light of the entire Contract, the only logical and reasonable interpretation is Section 39.13 refers to when notice is to be given by Kentucky Spirit that it will not continue beyond the required three-year term in Section 8.1 or any renewal term, rather than when Kentucky Spirit may terminate its performance under the Contract. Thus, according to the Commonwealth, Kentucky Spirit has no right to terminate its performance before the

initial term or any renewal terms end and no right to terminate its performance one year early on July 5, 2013.

The Commonwealth asserts that Kentucky Spirit's proffered interpretation is inconsistent with the Contract as a whole because it would afford the Commonwealth no right to advance notice of the termination and thus no transition or "wind down" period; ignores the totality of the RFP, the applicable administrative regulations, and the Contract as a whole; and undermines the paramount public interest.

**\*6** In resolving the parties' dispute, we will not examine Section 39.13 in isolation. We must consider Section 39.13 in light of the Contract as a whole.<sup>9</sup> Only then can we determine how the provision was intended to operate in the context of the greater Contract.

We begin with Section 8 of the Contract. It sets forth the initial contract term. Section 8.1 provides that "[t]he initial term of the contract shall be for a period of three (3) years from the Execution Date of the contract." The Contract was executed on July 6, 2011. Therefore, the initial term was set to run from July 6, 2011, to July 5, 2014. Section 8 further provides that the parties could renew the initial contract term for four additional, one-year terms. It goes on to require that "[t]he Department shall use its best efforts to commence negotiations with the Contractor for the next term of the agreement, within one hundred and eighty days (180) prior to the expiration of the current term [January 5, 2014] and propose rates at least one hundred and eighty days prior to expiration of the current term, unless the Department elects to terminate the Agreement hereunder." If the parties are not able to agree on the renewal terms prior to June 30, 2014, Section 8 requires the Contractor to "continue to provide services to Department for up to six (6) months after the end of the term [January 5, 2015], or until such time as any applicable 1915(b) waiver(s) expire, whichever is less." The Contract states that payment for these extended services shall be the same as the prior year adjusted up by 3% per annum.

Kentucky Spirit argues that it is clear under Section 8.1 that the Contract did not automatically renew. As such, it maintains that it is illogical to construe the term "terminate" in Section 39.13 as meaning notification of an intent not to renew. The main problem with Kentucky Spirit's argument in this regard is that while the renewal terms are not automatic, the Commonwealth is required under the Contract to take affirmative, automatic steps toward negotiating for renewal terms. Section 8 placed an affirmative obligation on the

Commonwealth to begin the negotiations for the first renewal term no later than January 6, 2014. Likewise, Section 8.1 is clear that the Contract did not expire immediately upon completion of the initial term. It provided a mechanism for continuation of the contract term for up to six months after expiration of the initial term, even if the parties were unable to agree on the renewal terms.

The next set of relevant provisions is contained in Section 39 of the Contract. Sections 39.8 and 39.9 deal with the Commonwealth's right to terminate for convenience (Section 39.8) and default (Section 39.9). Section 39.10 governs obligations upon termination. Read together these three sections lay out a comprehensive scheme whereby the Commonwealth may terminate the Contract subject to certain notice provisions and continuation obligations by Kentucky Spirit. For example, Section 39.8 of the Contract (termination for convenience) permits the Commonwealth to terminate the Contract for convenience. However, under this contractual provision, Kentucky Spirit "shall have a transition period of not less than three (3) nor more than (6) months to transition services, during which the terms and conditions of this Contract shall continue to apply." Likewise, Section 39.10 (obligations upon termination) states that the "contractor may be requested to continue in place for two additional months." Further, this section contains several continuing obligations beyond the "final notice of termination" emphasizing that Kentucky Spirit's obligation to perform cannot be ended immediately.

**\*7** Having reviewed the Contract and all the incorporated documents (none of which reference a termination right for the contractor), we are convinced that the circuit court appropriately interpreted the Contract. We agree that the only logical interpretation of the disputed provision is a notification provision allowing Kentucky Spirit to notify the Commonwealth of its intent not to renew after the initial three-year terms or any subsequent renewal periods. This would effectively relieve the Commonwealth of its obligation to propose renewal terms and allow it to focus on securing another contractor. Moreover, we believe that it is important to consider how Section 39.13 would function in a renewal year term, under Kentucky Spirit's interpretation. As stated above, under Section 8.1 the Contract may be renewed at the end of the initial term for four additional one-year periods. To follow Kentucky Spirit's reasoning that it can terminate early under Section 39.13, during a renewal period, Kentucky Spirit could terminate six to twelve months into a one-year renewal period. Thus, under Kentucky Spirit's interpretation,



it could renew the Contract at the end of the initial term, but then immediately terminate the Contract the same day simply because such termination would fall within this twelve-month period. This result would be absurd and render the renewal term completely illusory.

Additionally, having reviewed the entire Contract we believe that an overriding concern behind all its provisions was avoidance of any interruption of member benefits. To this end, the Contract specifies throughout the exact time periods the Commonwealth must provide notice of its intent to terminate and when such notice becomes effective. And, even where the Commonwealth has a right of immediate termination under the Contract, that right arises only after the Commonwealth has provided notice of a breach to Kentucky Spirit and provided it with an opportunity to cure. In the event Kentucky Spirit did not cure a material breach of the Contract, the Commonwealth could not only immediately terminate the Contract, it also had the right under the Contract to “directly operate the contractor's network, using the existing contractor's administrative organization to ensure delivery of care to members through the contractor's network until cure by the contractor of the breach ... or until the successful transition of those members to fee for service Medicaid providers at the expense of the contractor.”

Applying Section 39.13, according to Kentucky Spirit's interpretation, would provide it with a right of immediate termination at any time after the two years. While Kentucky Spirit gave advance notice in this case, its interpretation of the provision would not have required it to advance notice. Furthermore, under Kentucky Spirit's interpretation it is not required to adhere to any transition period or to continue to provide services to members until the members could be transitioned to other providers. Such an interpretation is entirely inconsistent with the other portions of the Contract, which clearly contemplate an orderly and extended transition period with some prior notification by the terminating party.

In sum, having reviewed the entire Contract, we agree with the circuit court's conclusion that Section 39.13 is unambiguously a notice of non-renewal provision. We do not believe that the provision, when read in light of the Contract as a whole, can reasonably be interpreted to provide Kentucky Spirit with the right to terminate its obligations prior to the end of the initial three-year term.

### C. Liquidated Damages

Section 39.11 of the Contract entitled “Liquidated Damages” provides as follows:

The Contractor acknowledges and agrees that in the event this Contract is terminated prior to the end of the term, except at the convenience of the Commonwealth under Section 39.8 or for lack of funding under Section 30.17, the Department will incur substantial inconvenience and additional expenses and costs which are difficult or impossible to accurately estimate. The Contractor shall pay to the Department liquidated damages equal to ten percent (10%) of the Contractor's Capitation Payment. Such payment is to be made no later than thirty (30) days following the date of the notice of termination. Finance and the Contractor agree that the sum set forth herein as liquidated damages is a reasonable pre-estimate of the probable loss which will be incurred by the Department in the event this Contract is terminated prior to the end of the Contract term.

\*8 The circuit court stated at the beginning of its opinion that one of the questions before it for resolution involved the damages in the event of early termination. It noted that Commonwealth sought a declaration that “if Kentucky Spirit in fact terminates its performance under the Contract prior to July 5, 2014, that it will be obligated to remit to the Commonwealth in accordance with Section 39.11 of the Contract liquidated damages [in addition to] compensating the Commonwealth by way of compensatory and special damages as well as attorney's fees.” Finding that Kentucky Spirit had not yet ceased performance under the Contract, the circuit court held only that “if Kentucky Spirit were to cease performing its contractual duties before the end of the initial term, Kentucky Spirit would be breaching the Contract” providing the Commonwealth the “right to terminate the Contract due to Contractor default” and “triggering the liquidated damages provision.” The circuit court did not address whether the Commonwealth would be entitled to



any additional damages or limited to liquidated damages. Moreover, as the circuit court determined that no breach had yet occurred, it did not undertake a damages calculation.

We find no error in the circuit court's determination that this provision is applicable in the event of premature termination of the Contract term. The provision unambiguously states that if the Contract is terminated for any reason other than for convenience of the Commonwealth under Section 39.8 or for lack of funding 39.17, Kentucky Spirit will be liable for liquidated damages. As there had been no termination at the time the circuit court rendered its decision, it did not address the other issues raised by the parties regarding the enforceability of this provision as an appropriate measure of

damages or its applicability in the face of an unauthorized termination by Kentucky Spirit. Just as those issues were not properly before the circuit court when it rendered its opinion, they are not properly before us as part of this appeal. Accordingly, we leave those issues to be resolved by the circuit court at the appropriate time.

ALL CONCUR.

All Citations

Not Reported in S.W.3d, 2015 WL 510852

## Footnotes

- 1 Judge Caperton concurred in this opinion prior to Judge Debra Lambert being sworn in on January 5, 2015, as Judge of Division 1, Third Appellate District. Release of this opinion was delayed by administrative handling.
- 2 In general, Medicaid benefits are available for "low-income persons who are age 65 or over, blind, disabled, or members of families with dependent children or qualified pregnant women or children." [42 CFR § 430.0](#).
- 3 In examining Kentucky's transition to managed care, the Sixth Circuit Court of Appeals provided an excellent description of a managed care system versus fee-for-service system:  
The theory of managed care is relatively simple. Rather than pay providers directly every time a Medicaid beneficiary receives care, the state instead contracts with managed-care organizations (MCOs) and pays them a flat "capitation rate" each month to provide, within certain limits, all of the care a beneficiary needs. The state pays the same amount regardless of whether the beneficiary receives healthcare services or not. So the MCO bears the risk that the costs of care may exceed the capitation payment. But on the other side, it stands to profit if beneficiaries use fewer services. In exchange for receiving a capitation payment, an MCO is responsible for three principal tasks: enrolling Medicaid beneficiaries as members; forming a contracted network of healthcare providers to care for its members; and paying providers for their services. An MCO then directs its members to in-network providers, with whom the MCO has negotiated discounted rates. When members go out-of-network, they receive only limited benefits and may pay more for services.  
[Appalachian Regional Healthcare, Inc.](#), 714 F.3d at 426.
- 4 Initially, Kentucky was scheduled to begin transitioning to managed care on October 1, 2011; this was subsequently changed to November 1, 2011.
- 5 The Contract defines a "capitation payment" as "the amount(s) to be paid monthly to the Contractor by the Commonwealth for Members enrolled based on such factors as the Member's aid category, age, gender, and service."
- 6 Section 40.13 provides the method by which notices are to be delivered and the addresses where they are to be directed.
- 7 Pursuant to Section 39.14, the Contract includes:  
1. The Medicaid Managed Care agreement; 2. The Appendices to this agreement; 3. The Request for Proposal and all attachments and addendums thereto, including Section 40—Terms and Conditions of a Contract with the Commonwealth of Kentucky, where applicable; 4. General Conditions contained in [200 KAR 5:021](#) and Office of Procurement Services' FAP1 10–10–00; 5. Any clarifications concerning the Contractor's proposal in response to the RFP; 6. The Contractor's proposal in response to the RFP. Provided however, by submitting materials in response to the RFP the Contractor has not fulfilled any obligation under this Contract to submit plans, programs, policies, procedures. Forms or documents etc. to the Department for approval as required by this Contract.
- 8 Under Kentucky's Statute of Frauds, however, contracts requiring certain types of performance must be in writing. See [Kentucky Revised Statutes \(KRS\) 371.010](#). Contracts that cannot be performed within a year fall with the Statute of Frauds. [KRS 371.010\(7\)](#); [Sawyer v. Mills](#), 295 S.W.3d 79 (Ky. 2009).
- 9 While we have examined the entire Contract, including those documents it incorporates by reference, we have limited our discussion to those provisions that we find most illuminating with respect to the purpose/intent of the disputed provision,

Section 39.13. Where we do not discuss a section, the reader can assume that we found the omitted section of no material impact with respect to our ultimate decision.

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**BEFORE THE COMMISSIONER OF INSURANCE  
OF THE STATE OF CALIFORNIA**

IN THE MATTER OF:

### The Proposed Acquisition of Control of:

HEALTH NET LIFE INSURANCE  
COMPANY, a California domestic stock  
insurer and indirect subsidiary of

HEALTH NET, INC., a Delaware corporation

BY

CENTENE CORPORATION, a Delaware corporation

AND

CHOPIN MERGER SUB I, INC. and  
CHOPIN MERGER SUB II, INC., each a  
Delaware corporation

) File No. APP-2015-00889

) **WRITTEN TESTIMONY OF STEVEN**  
 ) **SELL ON BEHALF OF HEALTH NET**  
 ) **LIFE INSURANCE COMPANY AND**  
 ) **HEALTH NET, INC.**

## I. Witness Identification

1. My name is Steven Sell. My business address is 21650 Oxnard Street, Woodland Hills, California 91367.

2. I am the President of Health Net Life Insurance Company, Inc., a California domestic stock insurer (“HNLIC”), Health Net of California, a California health care service plan licensed under the Knox-Keene Health Care Service Plan Act of 1975, as amended (“Health Net California”), and the Western Region for Health Net, Inc., a publicly traded Delaware corporation (“Health Net”).

3. I have held the foregoing positions since 2008 and have been employed by Health Net in various capacities for the past 18 years. Additionally, I am responsible for the Commercial Business, Medicare Business and Marketing and Products in California, Arizona and Oregon. I am a 1989 graduate of Swarthmore College and a 1997 graduate of Stanford Business School.

4. HNLIC is a direct wholly-owned subsidiary of Health Net California, which, in turn, is a direct wholly-owned subsidiary of Health Net.

5. I have been authorized by each of HNLIC and Health Net to provide this Testimony (as defined in Paragraph 6 hereof) on their behalf and in support of the Proposed Acquisition of Control (as defined in Paragraph 6 hereof).

## **II. Involvement with the Merger; Procedural Matters**

6. I submit this written testimony (this "Testimony") to the Department of Insurance for the State of California (the "Department") on behalf of HNLIC and Health Net, and in support of Centene Corporation, a publicly traded Delaware corporation ("Centene"). Centene, together with certain of its subsidiaries (each of which is individually identified below, collectively with Centene, the "Applicants"), seeks to indirectly acquire control of HNLIC (the "Proposed Acquisition of Control"), via a merger (the "Merger") of Health Net with Chopin Merger Sub I, Inc. ("Merger Sub I") and, if certain conditions are met, Chopin Merger Sub II, Inc. ("Merger Sub II"), each of which is a Delaware corporation and a wholly-owned subsidiary of Centene.

7. I have been and continue to be actively involved in the Merger.

8. In connection with the Proposed Acquisition of Control, I have reviewed and am familiar with (a) the Form A Statement and the exhibits attached thereto filed by the Applicants with the Department on July 31, 2015, and (b) the supplemental filings and submissions made by the Applicants with the Department in connection with such Form A Statement since its filing (collectively, the "Form A").

## **III. Overview of HNLIC**

9. HNLIC is a California domestic stock insurance company that has been licensed by the Department to transact life and disability insurance since September 8, 1998 (California Company ID # 3173-2).

10. HNLIC offers commercial and Medicare coverages in addition to dental, vision, behavioral health and life insurance products.

11. In that regard, HNLIC offers PPO and EPO products in the commercial individual and small and large group markets. Such products are typically included as part of a suite of products made available to small and large groups by HNLIC and Health Net's other subsidiaries, from which group members may choose.

## **IV. The Merger**

12. The Applicants propose to acquire control of HNLIC pursuant to, and subject to the terms of, an Agreement and Plan of Merger dated as of July 2, 2015 (the "Merger Agreement") by and among the Applicants and Health Net. An executed copy of the Merger Agreement was provided to the Department as an exhibit to the Form A.

## V. Centene as a Merger Partner

13. Health Net is smaller than many of the national competitors in the California market. Health Net believes that based upon scale (*i.e.*, its size relative to the national competitors), there were certain competitive disadvantages in maintaining Health Net as an independent company absent a solution to address the scale issue.

14. In order to address the scale issue and attempt to more effectively compete, Health Net explored several options over the past several years. Those options included discussions with other strategic partners. With respect to strategic alternatives, no viable option materialized until the opportunity with Centene. This was described in Centene's and Health Net's SEC Form 424(b)(3) dated September 21, 2015 (the "SEC Form"), a copy of which was provided to the Department as part of the Form A.

15. To address the scale issues, in November 2014, Health Net signed an agreement with Cognizant Healthcare Services, LLC ("Cognizant") (the "Business Process as a Service" or "BPaaS Agreement"), to become effective following satisfaction of certain conditions, to further outsource certain back office administrative and claims related activities. The BPaaS Agreement would have involved the re-badging (and potential subsequent off-shoring) of a significant portion of Health Net's more than 6,400 California employees.

16. Subsequently, and prior to the implementation of the BPaaS Agreement, Centene informed Health Net that it was interested in pursuing a potential merger with Health Net. After due diligence and arm's-length negotiations, Health Net's Board of Directors unanimously voted in favor of (a) entering into the Merger Agreement and (b) suspending implementation of the BPaaS Agreement.

17. After due consideration, the Board concluded that the Merger (a) was in Health Net's best interests, (b) would bring greater scale to the benefit of the surviving corporation including HNLIC, and (c) would result in California consumers having the benefit of Health Net being a stronger insurer and better positioned to effectively compete in the evolving health insurance sector with the likes of Blue Shield, Anthem, UnitedHealthcare, Aetna and Kaiser. Health Net and HNLIC have gained familiarity with Centene's service offerings and believe that Centene can strengthen Health Net's position to effectively compete in the California health insurance sector because of the resources, capabilities and customized solutions Centene has developed as a result of its extensive experience in the Medicaid industry. In addition, Health Net can benefit from Centene's array of specialty health solutions and medical management tools to supplement existing Health Net solutions, as well as implement Centene technology solutions and expertise for service enhancements that provide easier access for consumers and providers to the information and systems necessary to seamlessly provide healthcare coverage. Health Net believes that, as compared to other strategic alternatives, as well as outsourcing via the BPaaS Agreement, the proposed Merger presents the best opportunity to allow Health Net to grow and develop its product offerings to California consumers.

18. Moreover, because no overlap exists between Centene's and Health Net's respective businesses, and because of the number of large incumbent insurers, local competitors and entrants alike, HNLIC believes that the Merger will create a concentration of attention and



improvement in performance, but will not have an adverse effect upon competition for any line of insurance business in the State of California. On August 11, 2015, after conducting an investigation, the Federal Trade Commission and U.S. Department of Justice granted early termination of the waiting period under the Hart Scott Rodino Antitrust Improvements Act of 1976, as amended.

19. The only common line of business for both Centene and Health Net write business in California is Medi-Cal. HNLIC, however, has no Medi-Cal business and no subsidiary of Centene is regulated by the Department. As set forth in the "Form E" analysis submitted to the Department by the Applicants as a supplement to the Form A, there is no geographic overlap by county between the Centene and Health Net Medi-Cal products in California, which means that the companies do not compete with each other in any service area.

## **VI. California Insurance Markets**

20. From the perspective of policyholders and California consumers, Health Net and HNLIC believe that the Merger will: (a) strengthen Health Net's existing business lines; (b) maintain its commitment to the California-based model of health care; and (c) enhance competition in California.

- (a) HNLIC and Health Net believe that the Merger will strengthen their existing businesses. Centene is an ideal strategic partner for Health Net and HNLIC as Centene maintains a robust nationwide government focused business, but a relatively small footprint in California. The Merger (i) provides the benefit of economies of scale and allows the combined entity to be more competitive and (ii) allows the "new" Health Net to be a stronger competitor in California.
- (b) Health Net will retain its strong commitment to California, including, in particular, to the commercial business in California. Centene has informed Health Net of its local approach pertaining to Health Net's operations and that it intends to keep Health Net and HNLIC headquartered in California. In that regard, Centene has informed Health Net that it intends to continue the business of HNLIC without any material modification to its existing plan of operation, its product offerings or its management.
- (c) HNLIC and Health Net believe that the Merger will enhance competition in California. The Centene and Health Net combination will bring together complementary products, without limiting any competitive options in the market. Because no overlap exists between Centene's and Health Net's respective businesses, the transaction will not result in market concentration. Through the combined entities, HNLIC will continue to provide affordable health care options for California consumers.

*See also* Appendix 1 (Confidential Supplement).

21. Health Net will also remain committed to the quality of care provided to its members. The National Committee for Quality Assurance ("NCQA"), an independent third party non-profit

organization dedicated to improving health care quality, administers a rating system pertaining to the delivery of quality customer service. Health Net will maintain NCQA accreditation for all products currently subject to such accreditation and will re-submit to the accreditation process with NCQA for off-exchange PPO products, for which Health Net had discontinued its participation independent of, and prior to, the Merger Agreement being signed. The re-submission process would be initiated promptly following the consummation of the Merger for the next NCQA accreditation cycle. Prior to re-accreditation, Health Net will undertake to maintain the quality reporting metrics under the Healthcare Effectiveness Data and Information Set (“HEDIS”) and the Consumer Assessment of Healthcare Providers and Systems (“CAHPS”) associated with NCQA accreditation.


22. Demonstrating its commitment to quality, Health Net will continue its efforts agreed upon with the Department. On December 18, 2015, the Department adopted its Field Claims Examination Report of HNLIC for the claims review period ending July 31, 2012. HNLIC understands the importance of policyholder satisfaction and strives to meet policyholders’ expectations and handle claims in accordance with applicable law and its procedures. HNLIC worked closely with the Department during the claims review process and diligently addressed the examiners’ concerns. In that regard, HNLIC took remedial action to respond to and correct any deficiencies, implemented training sessions for claims employees regarding specific issues raised by the Department, issued employee claims alerts for issues requiring immediate attention, conducted self-audits and made additional payments to claimants as the Department requested. Health Net continues to monitor these areas and address any identified issues.

## **VII. Conclusion**

23. In conclusion, for the foregoing reasons set forth in this Testimony and in the Form A, HNLIC and Health Net believe that the Merger is in their best interests and HNLIC and Health Net respectfully request that the Department approve the Form A in respect of the Proposed Acquisition of Control.

\* \* \* \* \*

Steven Sell deposes and says that he is the President of Health Net Life Insurance Company, that he has read the foregoing written testimony and knows the contents thereof and that the same are true of his own knowledge.

  
Steven Sell

January 15, 2016

**APPENDIX 1**

**CONFIDENTIAL SUPPLEMENT TO THE WRITTEN  
TESTIMONY OF STEVEN SELL**

*[redacted]*

**Centene Corporation**

**November 10, 2015  
5:00 PM EST**

Scott Seidel: Okay, good afternoon. I'm Scott Seidel, Managed Care and Health Care Facilities analyst with Credit Suisse. We're very pleased to have our next presentation from Centene. Here from the Company we have the Senior Vice President of Investor Relations and Finance, Ed Kroll. So, with that, I'll turn it over to Ed.

Ed Kroll: Thank you, Scott, and good luck on your career here at Credit Suisse. I'm sure you'll do a great job, as you always have. And thanks to Credit Suisse for having us again here.

We've got some Safe Harbor statements and would strongly encourage you all to read all of the — in our publicly filed documents, those with the SEC and otherwise — all the risk factors and how estimates can change and all those types of things — very important disclosures.

Centene is a St. Louis-based company that's been in a very nice growth trajectory for the eight and a half years that I've had the pleasure of working here. And we've moved up nicely in the Fortune 500. Our guidance calls for us to do a little over \$21 billion in revenue this year. We're now in 23 states. We just entered Oregon through an acquisition that closed in September.

We've got 4.8 million members focused on lower income, uninsured, under-insured populations that get government-sponsored coverage, mostly Medicaid but we've also done — we've entered nicely into the exchanges. We're in 11 states with exchanges, and we also do some prison health care for five states.

So it's been a very nice growth trajectory for us, and we've been delivering on our financial guidance. You can see here the initial numbers that we put out for last year and where we wound up on the EPS initially guided to \$1.75 to \$1.90 and wound up at \$2.23.

So — so far this year, it's been another good year for us. We've actually raised our guidance four times this year, so in a very strong position from a growth standpoint and delivering on the financial results. Here's our full-year 2015 guidance. Again, just over \$21 billion on the revenue, \$2.84 to \$2.90 on the EPS. As you see, we pay a fairly high tax rate, 48% to 50%.

And if you look back over — or rolling over a five-year period, our growth rates are at the top of our industry. Compounded annual growth rate from 2010 to 2015, we've grown our top line 38%; 26% at the EPS line; and the stock price appreciation 37%, and that's for full years 2009 to 2014, just on the stock price.



And just to give you a picture and how we drive this growth, in 2008 we were in eight states. You see them listed across the top of this chart, and we provided 70 solutions, 70 different types of contract that we were operating on behalf of those eight states. And you can see the various types of Medicaid contracts, the 10-F, the age, blind, disabled. We also have specialty companies so the pharmacy benefit management, or PBM, we do that internally. We have a specialty pharmacy subsidiary, behavioral health, and so on.

So those support services for the health plans, we try to do as much of that with Centene subsidiaries as possible. And now here we are, seven years later, and you can see this has almost turned into an eye test here. We're now in 23 states. So that's one way we grow, by entering new states, which we've done quite a bit of, as you can see. But also adding different types of solutions, different types of services that we provide for different types of populations for our state customers, so now we're doing foster care and long-term care, a lot more high acuity. We've gotten into dual eligibles through the five demonstration projects in our states.

So — getting more states across the top adds to the growth and then filling in more of the dots and adding vertically more lines, more different types of solutions that we can provide for our states, now it's up to 237 for those 23 states. So just every empty box on this chart is an opportunity for us to do additional business with our existing states and, of course, we hope to continue to add geographically by expanding into additional states.

The cash flow dynamics of our business, very strong, and I think you could say that generally for any well-run managed care company. The cash flow dynamics are strong. The operating cash flow, we get paid, at least in our business, at the beginning of the month, and there tends to be a lag with the claims that we pay out associated, or they get matched up with that revenue. And it's even better when you're growing, when you're in a growth mode like we are, as those checks coming in the door get bigger from our government customers.

And we also, at Centene, have, through those specialty companies I mentioned, part of our cash flow is unregulated, and therefore available to the parent, Centene Corp., for general corporate purposes right away. Whereas, in our health plans, which are regulated, we have to essentially get permission from the states to dividend any excess capital upstream to the parent.

And we've done that, too, but we just — first of all, we like the specialty companies because they provide a more seamless health delivery and coordinate much better with the other in-house entities, the other specialty companies, or our own health plans. So a more holistic approach, if you will, but also from a cash flow standpoint, this gives us the opportunity to have a greater amount of free cash sooner.

So that was and is Centene, and now we are acquiring another company, Health Net, and this we announced back in July, and Health Net, of course, is a publicly traded company based in California. And we think that this transaction will only enhance our growth trajectory. It's going to put us into a couple of new businesses that I'll get into here in a moment.

It will make us bigger, so there will be greater scale. On a pro forma basis for 2015, the combined company would be doing \$37 billion, and adjusted EBITDA for 2015 of \$1.5 billion.

So what does Health Net have that's complementary for Centene and how do they make us a better growth company than we already are? Well, first of all, combining the two will make for the largest Medicaid — managed Medicaid vendor in the country. They have a leading position in California, Medicaid, the largest Medicaid program in the country. So we'll be the biggest player nationwide in Medicaid with the addition of Health Net.

They also, and this is probably the most interesting part, the most helpful to us, is the Medicare Advantage business that they have. Just under 300,000 Medicare Advantage lives, and they've generally been focused on lower income people, lower income seniors, people over 65, which is what we have always done — government-sponsored health care for lower income people. And they've — over 65% of Medicare-eligible people in the US are at 400% of federal poverty or below.

So there are a lot of them for us to focus on as a combined company. And I think, very importantly, they have achieved very high quality scores for their Medicare Advantage business. There's a star rating system, five is the maximum, and their company average is just above four. They have just under 80% of all of their Medicare Advantage members are in plans that have at least four stars, and that's important because — well, quality, in general, is becoming more and more important in health care. And in this case CMS reimburses a 5% bonus for four stars or higher, so you get extra revenue. And also the ability to market oneself to seniors with the high-quality ranking, I think, is certainly a differentiator.

So we intend to take their Medicare Advantage platform and import it into our states — the 23 states that we operate in. We'll do it as we always do things — methodically, carefully, probably four to six states to start. The first year would be, most likely, 2017, so focus on the integration of the two companies during 2016. Do all the analysis and filings and be up and running in four to six Centene markets in 2017.

And we get to use the four-star ratings in those new markets, so we'll be getting the revenue bonus and, again, that sales advantage of being able to hold one's plan out as a top-quality plan. So that's a big key for us.

And the Medicare population is growing, we all know that, and so it's under-penetrated by managed care, just as Medicaid is, so you have not only that but a growing pie as the baby boom continues to retire into — or move — not necessarily retiring but moving into Medicare eligibility.

So we think this will add a significant new growth leg and allow us to sustain superior growth for a longer period of time than if we didn't have a Medicare Advantage plan. We felt this was the best way for us to enter this business rather than building something from scratch, we're doing it in a transaction that's accretive to earnings in the first 12 months after we close.

We are on track to close early in 2016, and it will add 10% accretion to our GAAP earnings and 20% to adjusted earnings. And the difference between the two being the amortization on this transaction that we'll be booking. So if you ignore that noncash deal amortization, it's 20% accretive in the first year after close.

Like us, they've got — they're in some dual demonstration projects. I think, certainly, the biggest one is California. And they've also got some other interesting businesses. Again, government-sponsored. They have a tri-care contract for health care for military dependents and certain active duty personnel, retirees, and then they've got some very interesting contracts with the Veterans' Administration that could really prove to be a solution to the problems that that agency is having.

And then, finally, I mentioned the specialty companies that Centene has. We'll have the opportunity to integrate them throughout the existing health care book of business and create that holistic approach and, hopefully, some better returns than what they've been able to achieve by outsourcing those services.

The key terms of the transaction, it's stock and cash, \$28.25 in cash, 0.622 shares of Centene will be exchanged for each share of Health Net. And we've already got the financing lined up for the cash portion. We haven't issued — we plan to issue notes and use — redo our bank line and use part of the — tap part of the bank line, about \$350 million and a senior notes offering of around \$2.3 billion, \$2.4 billion.

Pro forma, the debt-to-total cap of Centene, post the transaction, will be in the low 40% area, and that will move, based on where the share price is, how much the cash portion is as a percentage of the total, the value of the equity we issue, of course.

We got the — in terms of the timeline to close, as I mentioned, we feel we're on track for an early 2016 close. We got the Hart-Scott-Rodino, the early termination of that was only in three weeks. So that was, at the federal level, the key approval, if you will. And then we've got several of the states involved that have either waived or already approved the transaction and, basically, it's down to California, Arizona, and Oregon at this point. So we feel like we're on track.

And, importantly, there are two other transactions out there in our industry — Aetna-Humana and Anthem-Cigna. And those companies have the two, and the two have overlap in products and in markets, whereas, we with Health Net, even though we share four states in common, we have, virtually, no overlap in those four states geographically, very little by product. So — thus the early termination of the Hart-Scott-Rodino and our confidence that we'll stay on our early 2016 closing target date.

And, of course, we got the shareholder approval, most importantly, last month — late last month, with 99% of Centene shares voted voting to approve the deal.

I mentioned that it's accretive, and one way that we get to that accretion is through cost synergies, cost savings. And it's \$75 million in year one post-close, and then up to \$150 million in year two. So an incremental \$75 million on top of that initial \$75 million to get you a \$150 million run rate in the second year.

And we feel like these are very realistic numbers given the size of the combined company and some of the numbers that the other — that are being talked about at the other two transactions.

Just some numbers for you on what our combined map will look like. So over 6 million — if you look at where we are on a pro forma basis at September 30, the most recently reported quarter for both of us, just over 6 million Medicaid lives, 3 million specialty and government, a little over 1 million in commercial and exchanges, 280,000 on the Medicare Advantage, and then the dual is around 50,000 combined. So almost 11 million members between the two of us.

If the other two transactions close, again, there's some more issues on the antitrust front for them, but if they both close, we'll be the fourth-largest managed care company after United, Anthem, and Aetna. And, arguably, the fastest-growing given the dynamics I talked about here with continued robust growth on the Medicaid side and the addition of the Medicare Advantage to the Centene platform.

The combined pie shows you how the Medicare — it would be, roughly, 8% of the total and, hopefully, we'll grow that, over time. And Medicaid will keep growing because of the robust pipeline there.

I think I've mentioned all of these — the growth opportunities, the leading Medicaid position, expanding their Medicare Advantage success into our states. Targeted exchange — both of us have focused on the low income subsidized populations getting coverage through exchanges that were created by the ACA, and we'll continue to grow that business. I mentioned the VA as a future opportunity, leveraging our specialty companies, integrating them into Health Net's book.

And they have a commercial business in California that I think is complementary to the government business they're doing. It's value-oriented, and we intend to keep that in place but not necessarily grow it outside of California.

The number of people getting coverage through government-sponsored health care continues to grow. You see these numbers here. The Medicare, 50 million to just over 60 million by the end of this decade, going to 72 million; and the Medicaid, 72 million, 91 million, 93 million, by 2024. So we're in the growth part of the managed care industry with our focus.

So we're going from a growth company focused on Medicaid to one that's adding a Medicare Advantage along with some other capabilities. We'll have better scale and we think the financial profile of the combined company at the current valuation of the stock is compelling.

So I'll leave it there. I guess we have a little time before —

Scott Seidel:

We have less than a minute, so — maybe if we have a quick one out there. If not, we'll just take it over to the breakout session for Q&A. Is there a quick one out there? No, all right, why don't we break it there, and we'll just take it over to the breakout session for Q&A.

Ed Kroll:

Thank you, Scott.

**Forward Looking Statements**

This material may contain certain forward-looking statements with respect to the financial condition, results of operations and business of Centene, Health Net and the combined businesses of Centene and Health Net and certain plans and objectives of Centene and Health Net with respect thereto, including the expected benefits of the proposed merger. These forward-looking statements can be identified by the fact that they do not relate only to historical or current facts. Forward-looking statements often use words such as “anticipate”, “target”, “expect”, “estimate”, “intend”, “plan”, “goal”, “believe”, “hope”, “aim”, “continue”, “will”, “may”, “would”, “could” or “should” or other words of similar meaning or the negative thereof. There are several factors which could cause actual plans and results to differ materially from those expressed or implied in forward-looking statements. Such factors include, but are not limited to, the expected closing date of the transaction; the possibility that the expected synergies and value creation from the proposed merger will not be realized, or will not be realized within the expected time period; the risk that the businesses will not be integrated successfully; disruption from the merger making it more difficult to maintain business and operational relationships; the risk that unexpected costs will be incurred; changes in economic conditions or political conditions; changes in federal or state laws or regulations, including the Patient Protection and Affordable Care Act and the Health Care Education Affordability Reconciliation Act and any regulations enacted thereunder; provider and state contract changes; the outcome of pending legal or regulatory proceedings; reduction in provider payments by governmental payors; the expiration or termination of Centene’s or Health Net’s Medicare or Medicaid managed care contracts with federal or state governments; tax matters; the possibility that the merger does not close, including, but not limited to, due to the failure to satisfy the closing conditions; the risk that financing for the transaction may not be available on favorable terms; and risks and uncertainties discussed in the reports that Centene and Health Net have filed with the Securities and Exchange Commission (the “SEC”). These forward-looking statements reflect Centene’s and Health Net’s current views with respect to future events and are based on numerous assumptions and assessments made by Centene and Health Net in light of their experience and perception of historical trends, current conditions, business strategies, operating environments, future developments and other factors they believe appropriate. By their nature, forward-looking statements involve known and unknown risks and uncertainties because they relate to events and depend on circumstances that will occur in the future. The factors described in the context of such forward-looking statements in this announcement could cause Centene’s and Health Net’s plans with respect to the proposed merger, actual results, performance or achievements, industry results and developments to differ materially from those expressed in or implied by such forward-looking statements. Although it is believed that the expectations reflected in such forward-looking statements are reasonable, no assurance can be given that such expectations will prove to have been correct and persons reading this announcement are therefore cautioned not to place undue reliance on these forward-looking statements which speak only as of the date of this announcement. Neither Centene nor Health Net assumes any obligation to update the information contained in this announcement (whether as a result of new information, future events or otherwise), except as required by applicable law. These risks, as well as other risks associated with the merger, are more fully discussed in the joint proxy statement/prospectus, as it may be amended, that is included in the Registration Statement on Form S-4 that has been filed with the SEC on September 21, 2015 in connection with the merger. A further list and description of risks and uncertainties can be found in Centene’s Annual Report on Form 10-K for the fiscal year ended December 31, 2014 and in its reports on Form 10-Q and Form 8-K as well as in Health Net’s Annual Report on Form 10-K for the fiscal year ended December 31, 2014 and in its reports on Form 10-Q and Form 8-K.



**Additional Information and Where to Find It**

The proposed merger transaction involving Centene and Health Net was approved by the respective stockholders of Centene and Health Net. In connection with the proposed merger, Centene prepared a registration statement on Form S-4 that included a joint proxy statement/prospectus for the stockholders of Centene and Health Net filed with the SEC on September 21, 2015. The registration statement has been declared effective by the SEC. Each of Centene and Health Net have mailed the definitive joint proxy statement/prospectus to their respective stockholders and, at the appropriate time, will file other documents regarding the merger with the SEC. Centene and Health Net urge investors and stockholders to read the definitive joint proxy statement/prospectus, as well as other documents filed with the SEC, because they will contain important information. Investors and security holders may receive the registration statement containing the joint proxy statement/prospectus and other documents free of charge at the SEC's web site, <http://www.sec.gov>. These documents can also be obtained free of charge from Centene upon written request to the Investor Relations Department, Centene Plaza 7700 Forsyth Blvd. St. Louis, MO 63105, (314) 725-4477 or from Centene's website, <http://www.centene.com/investors/>, or from Health Net upon written request to the Investor Relations Department, Health Net, Inc. 21650 Oxnard Street Woodland Hills, CA 91367, (800) 291-6911, or from Health Net's website, [www.healthnet.com/InvestorRelations](http://www.healthnet.com/InvestorRelations).

## **LAWRENCE WU**

### **President**

Dr. Wu's expertise is in the economics of antitrust and intellectual property. He has testified in US district courts and in a variety of regulatory proceedings. Prior to joining NERA, he was a staff economist in the Bureau of Economics of the Federal Trade Commission (FTC). From 2011 to 2015, he was a Visiting Scholar at the Stanford Institute for Economic Policy Research (SIEPR) at Stanford University.

In the area of antitrust, Dr. Wu has evaluated the competitive effects of numerous mergers and acquisitions. These include proposed and consummated transactions. He also has been retained as an economic expert to testify on issues related to antitrust class certification, liability, and damages. He has testified on issues related to price fixing, as well as market definition and market power in antitrust litigations involving allegations of exclusive contracting, price discrimination, and anticompetitive exclusionary conduct. Dr. Wu has analyzed these and other competitive issues in a variety of retail, manufacturing, and service industries, but he is particularly well known for his work in the area of health care, which includes health insurance, hospital services, physician services, and a variety of medical devices and technologies.

With respect to intellectual property economics, Dr. Wu has testified on reasonable royalties, and he has written and consulted on issues involving patent pools.

Dr. Wu has edited three books on the economics of antitrust, including a book on the use of econometrics in antitrust analysis. His publications, which have appeared in *Antitrust*, *The Antitrust Bulletin*, *Antitrust Chronicle*, *Antitrust Report*, *The Antitrust Source*, *European Competition Law Review*, *Journal of Business Venturing*, and *Medical Care*, include articles on merger analysis, market share-based merger screens, empirical methods in merger analysis, patent pools, and the multiple dimensions of market power. He also is frequently invited to speak at conferences and seminars.

Dr. Wu earned his PhD from the University of Chicago Graduate School of Business and his BA from Stanford University.

## Education

**University of Chicago, Graduate School of Business**

Ph.D. (Economics) 1992

**Stanford University**

B.A., Economics, 1986

## Professional Experience

**NERA Economic Consulting**

1996- President (current position, since 2013)

**Stanford University, Stanford Institute of Economic Policy Research**

2011-2015 Visiting Scholar

**Federal Trade Commission, Bureau of Economics, Division of Antitrust**

1992-1996 Economist

**New York University, Robert F. Wagner Graduate School of Public Service**

Spring 1997 Adjunct Assistant Professor of Public Health Administration

**University of Chicago, Department of Economics**

Fall 1991 Lecturer

**American Hospital Association, Division of Economic Analysis**

1990-1991 Research Analyst

**Federal Reserve Bank of New York, Banking Studies Department**

1986-1987 Research Assistant

## Honors and Professional Activities

Section of Antitrust Law, American Bar Association:

Member, Publications Advisory Group, 2009-2011

Member, Competitiveness Task Force, 2007-2008

Vice Chair, Economics Committee, 2003-2006

Member, Exemptions and Immunities Task Force, 2003-2004

Member, American Economic Association

Member, American Health Lawyers Association

Member, Western Economic Association

Member, Section of Antitrust Law, American Bar Association

Member, The Antitrust and Unfair Competition Law Section, State Bar of California

Federal Trade Commission Award for Meritorious Service, March 1996

Great American Cookie Company Grant and Fellowship, International Franchise Association Educational Foundation, 1990

University of Chicago Fellowship, 1987-1989

## Expert Reports and Testimony

Deposition testimony and expert report on behalf of Eaton Corporation in *Mark S. Wallach, et al. v. Eaton Corporation, et al.*, United States District Court, District of Delaware, Civil Action No. 10-260-SLR and *In re Class 8 Transmission Indirect Purchaser Antitrust Litigation*, United States District Court, District of Delaware, Civil Action No. 11-cv-00009. Report: May 22, 2015. Deposition: June 17-18, 2015.

Deposition testimony and expert report on behalf of MAG Aerospace Industries, Inc. in *MAG Aerospace Industries, Inc. v. B/E Aerospace, Inc.*, United States District Court, Central District of California, Western Division (Case No. CV-13-06089-JFW). Reports: October 9, 2014 and December 5, 2014. Deposition: December 2, 2014.

Deposition testimony and expert report on behalf of Koninklijke Philips N.V. and Philips Electronics North America Corporation in *In Re: Cathode Ray Tube (CRT) Antitrust Litigation*, United States District Court, Northern District of California, San Francisco Division (Master File No. CV-07-5944-SC, MDL No. 1917). Reports: April 15, 2014, August 5, 2014, September 23, 2014, and November 6, 2014. Depositions: July 11, 2014, September 12, 2014.

Declaration on behalf of Philips Electronics North America Corporation in *The State of California, et al. & The City and County of San Francisco v. Chunghwa Picture Tubes, LTD., et al.*, Superior Court for the State of California for the County of San Francisco, Unlimited Jurisdiction (Case No. CGC-11-515786). Declaration: October 29, 2013.

Trial and deposition testimony, expert report, and declaration on behalf of the defendants in *In re: Vitamin C Antitrust Litigation*, United States District Court for the Eastern District of New York (Case No. 06-MD-1738 (BMC) (JO)). Report: June 29, 2012. Deposition: August 1, 2012. Declaration: October 12, 2012. Trial: March 11, 2013.

Deposition testimony and expert reports on behalf of the defendants in *Stanislaus Food Products Company v. USS-POSCO Industries, et al.*, United States District Court for the Eastern District of California (Case No. CV F 09-0560 LJO BAM). Reports: October 24, 2012 and November 9, 2012. Deposition: December 7, 2012.

Expert report on behalf of Ortho-Clinical Diagnostics, Inc. in *In re: Blood Reagents Antitrust Litigation*, United States District Court for the Eastern District of Pennsylvania (MDL Docket No. 09-2081). Report: October 26, 2012.

Deposition testimony and expert report on behalf of Martek Biosciences Corp. in *BNLfood Investment SARL v. Martek Biosciences Corp.*, United States District Court for the District of Maryland, Northern Division (Case No. 1:11-CV-00446-WDQ). Report: June 15, 2012. Deposition: July 30, 2012.

Deposition testimony and expert reports on behalf of American Society of Heating, Refrigerating and Air-Conditioning Engineers Inc. in *Thermal Design, Inc. v. American Society of Heating, Refrigerating and Air-Conditioning Engineers Inc.*, United States District Court in the Eastern District of Wisconsin, Milwaukee Division (Case No. 07-C-0765:WEC). Reports: June 1, 2012 and July 9, 2012. Deposition: July 9, 2012.

Expert report on behalf of Fujifilm North America Corporation in *Retail Imaging Management Group LLC v. Fujifilm North America Corporation*, United States District Court for the District of Oregon, Portland Division (Case No. 3:11-cv-01242-SI). Report: March 27, 2012.

Trial and deposition testimony and expert reports on behalf of the patent holder in *Jan K. Voda, M.D., v. Medtronic Inc., and Medtronic Vascular, Inc.*, United States District Court for the Western District of Oklahoma (Case No. 5-09-CV-00095-L). Reports: September 2, 2011, September 15, 2011, and February 10, 2012. Deposition: October 12, 2011. Trial: January 23, 2012.

Deposition testimony on behalf of the defendants in *United States Federal Trade Commission v. Laboratory Corporation of America, et al.*, United States District Court for the Central District of California, Southern Division (Case No. SACV-10-1873-AG (MLGx)). Deposition: January 24, 2011.

Declaration on behalf of LabWest, Inc. and Laboratory Corporation of America in *In re: Westcliff Medical Laboratories, Inc. and Biolabs, Inc.*, (Case No. 8:10-bk-16743-RK, jointly administered with 8:10-bk-16746-RK) and *LabWest, Inc. and Laboratory Corporation of America v. Federal Trade Commission*, United States Bankruptcy Court, Central District of California, Santa Ana Division. Declaration: November 16, 2010.

Expert report prepared for mediation on behalf of Fairmont Hotels & Resorts (U.S.) Inc. in *Mark Apana, et al., v. Fairmont Hotels & Resorts (U.S.) Inc., dba Fairmont Kea Lani Hotel & Resort*, United States District Court for the District of Hawaii, (Civil No. 1:08-cv-00528-JMS-LEK). Report: September 13, 2010.

Expert report on behalf of St. James Healthcare in *Jesse A. Cole, M.D., v. St. James Healthcare and Sisters of Charity of Leavenworth Health System, Inc.*, Montana Second Judicial District



Court, Silver Bow County (Cause No. DV-07-44). Reports: August 2, 2010 and September 13, 2010.

Deposition testimony and expert reports on behalf of Allied Exhaust Systems, Inc. in *Gorlick Distribution Centers, LLC v. Car Sound Exhaust System, Inc. and Allied Exhaust Systems, Inc.*, United States District Court for the Western District of Washington at Seattle (Case No. C07-1076 RAJ). Reports: April 12, 2010 and May 19, 2010. Deposition: May 12, 2010.

Deposition testimony and expert report on behalf of a defendant in *John Karamanos, Advanced Microtherm, Inc.; HVAC Sales, Inc., v. Norman Wright Mechanical Equipment Corporation, et al.*, United States District Court for the Northern District of California, San Jose Division (Case No. C04-02266 JW). Report: February 5, 2010. Deposition: March 24, 2010.

Expert report on behalf of the defendant physicians in *Mark G. Wood, M.D. v. Archbold Medical Center, Inc., John D. Archbold Memorial Hospital, Inc., et al.*, United States District Court for the Middle District of Georgia, Valdosta Division (Case No. 7:07-cv-109). Report: July 28, 2009.

Oral testimony at an Informal Fact Finding Conference on behalf of Inova Health System in connection with Virginia Department of Health Certificate of Public Need Request No. Va-7622. Testimony: May 12, 2009.

Deposition and trial testimony and declarations on behalf of Johnson & Johnson and Cordis Corporation in *Boston Scientific Corporation, Boston Scientific Scimed, Inc., Scimed Life Systems, Inc., and Schneider (Europe) GmbH v. Johnson & Johnson and Cordis Corporation and Cordis Corporation v. Boston Scientific Corporation, Boston Scientific Scimed, Inc., Scimed Life Systems, Inc., and Schneider (Europe) GmbH*, United States District Court for the Northern District of California, San Francisco Division (Case No. 02-0790 SI). Declarations: May 9, 2008 and September 22, 2008. Deposition: June 5, 2008. Evidentiary Hearing: February 2, 2009.

Testimony and affidavit on behalf of Delta Dental Plan of Massachusetts in *Concerning Fees that Dental Services of Massachusetts d/b/a Delta Dental Plan of Massachusetts Pays Participating Dentists and the Method Used to Determine Such Fees Pursuant to M.G.L. c. 176E, Section 4*, Commonwealth of Massachusetts, Office of Consumer Affairs and Business Regulation, Division of Insurance (Docket No. G2008-10). Testimony: December 18, 2008. Affidavit: March 5, 2009.

Deposition testimony on behalf of The Hospice of the Florida Suncoast, Inc. in *Hospice of Palm Coast, Inc. vs. Agency for Health Care Administration and The Hospice of the Florida Suncoast, Inc.*, State of Florida, Division of Administrative Hearings (DOAH Case No. 06-1272 CON). Depositions: December 2, 2008 and March 12, 2009.

Deposition testimony and expert report on behalf of United Healthcare of Ohio, Inc. in connection with class certification in *Academy of Medicine of Cincinnati, et al. v. Aetna Health, Inc., et al.*, Court of Common Pleas, Hamilton County, Ohio (Case No. A0204947). Report: September 29, 2008. Deposition: November 20, 2008.

Declarations on behalf of Inova Health System in connection with Virginia Department of Health Certificate of Public Need Request No. Va-7529 by Inova Health Care Services on behalf of Inova Fairfax Hospital. Declarations: August 1, 2008 and September 9, 2008.

Declaration on behalf of the defendants in *Hawai'i Children's Blood and Cancer Group v. Hawai'i Pacific Health; Kapi'olani Medical Specialists; Kapi'olani Medical Center For Women and Children*, United States District Court for the District of Hawai'i (Civil No. CV03-00708). Declaration: July 14, 2008.

Declaration and expert report on behalf of the defendants in *Kelley Woodruff, M.D. and Hawai'i Children's Blood and Cancer Group v. Hawai'i Pacific Health, et al.*, Circuit Court of the First Circuit, State of Hawaii, (Civil No. 02-1-0090-01 (BIA)). Declaration: February 14, 2008. Expert Report: February 22, 2008.

Deposition testimony on behalf of St. Joseph's Hospital in connection with *St. Joseph's Hospital, Inc., d/b/a St. Joseph's Hospital v. Agency for Health Care Administration, et al.*, State of Florida, Division of Administrative Hearings (Case No. 05-2754). Deposition: September 25, 2007.

Declarations on behalf of the defendants in *The City of New York v. Group Health Incorporated, HIP Foundation, Inc., and Health Insurance Plan of Greater New York*, United States District Court for the Southern District of New York (Case No. 06 Civ. 13122 (KMK) (RME)). Declarations: March 6, 2007, November 9, 2007, and February 18, 2010.

Deposition testimony and report on behalf of the plaintiff in *American Medical Response Inc. v. City of Stockton*, United States District Court in and for the Eastern District of California (Civil Action No. 2:05-CV-01316 DFL-EFB). Report: November 2, 2006. Deposition: January 19, 2007.

Expert report on behalf of the defendant in connection with *San Diego Physicians Medical Group, Inc. v. Sharp Community Medical Group Inc.*, Superior Court of the State of California for the County of San Diego Central (Case No. GIC 862275). Report: April 14, 2006.

Deposition testimony and report on behalf of PCI Holding Corporation in connection with *Chemed Corporation v. PCI Holding Corporation, et al., v. Vitas Healthcare Corp.*, Superior Court of the Commonwealth of Massachusetts (Civil Action No. 04-2354-BLS2). Report: November 30, 2005. Deposition: June 30, 2006.

Testimony before the Provider Reimbursement Review Board, Centers for Medicare and Medicaid Services, on behalf of St. David's Healthcare System in *St. David's Healthcare System v. Blue Cross Blue Shield Association/Trailblazer Health Enterprises, LLC*, Exception to Related Organization Principle (PRRB Case No. 95-0315G). Testimony: September 29, 2005.

Deposition testimony and reports on behalf of the defendants in connection with *East Portland Imaging Center, P.C., and Body Imaging, P.C., v. Providence Health System-Oregon, Providence Health Plan, Portland Medical Imaging, LLP, Radiology Specialists of the Northwest, P.C., Center for Medical Imaging, LLP and Advanced Medical Imaging, LLC*, United

States District Court for the District of Oregon (Case No. 05-CV-465-KI). Reports: June 1, 2005 and November 1, 2005. Deposition: November 22, 2005.

Expert report on behalf of Regence Blue Shield of Idaho, Inc. in connection with *Government Employees Medical Plan and Mutual Insurance Associates, Inc. v. Regence Blue Shield of Idaho, Inc. and Blue Cross of Idaho Health Services, Inc.*, United States District Court for the District of Idaho (Case No. CIV 04-284-E-BLW). Report: May 16, 2005.

Expert reports on behalf of the defendant in connection with *George Yardley Co. and Yardley-Zaretsky, Inc. v. Johnson Controls, Inc., et al.* (American Arbitration Association, Case No. 72 110 01086 02 HLT). Reports: October 4, 2004 and December 1, 2004.

Expert report on behalf of Business Venture Investments No. 790 (PTY) Limited and Afrox Healthcare Limited in connection with the proposed acquisition of an ownership interest in Afrox Healthcare Limited. Report was submitted to the Competition Tribunal of South Africa in connection with Case No. 76/LM/DEC 03. Report: July 1, 2004.

Expert report on behalf of Nestlé in connection with Nestlé's proposed acquisition of Chocolates Garoto, S.A. Report was submitted to Brazil's competition authority, CADE (Conselho Administrativo de Defesa Econômica), in connection with the agency's review of the proposed transaction. Report: December 3, 2003.

Deposition testimony and expert report on behalf of the defendants in connection with *EasCare, LLC v. Cape Cod Healthcare, Inc. and Cape Cod Medical Enterprises, Inc. d/b/a Cape Cod Ambulance and Medical Services Ambulance*, United States District Court for the District of Massachusetts (Civil Action No. 02-11460-RWZ). Report: July 25, 2003. Deposition: September 11-12, 2003.

Deposition and trial testimony on behalf of Naples Community Hospital in connection with *Collier HMA, Inc.'s Certificate of Need Application (CON #9551)*, State of Florida, Division of Administrative Hearings. Deposition: February 11, 2003. Trial testimony: March 18, 2003.

Deposition and trial testimony on behalf of LifePath, Inc. in connection with *LifePath, Inc. v. Agency for Health Care Administration and Hernando-Pasco Hospice, Inc.*, Case Nos. 00-3203 *et seq.*, State of Florida, Division of Administrative Hearings. Deposition: June 29, 2002. Trial testimony: August 7, 2002.

Deposition testimony and expert report on behalf of three defendants (suppliers of biotin) in connection with *In re: Vitamins Antitrust Litigation*, United States District Court for the District of Columbia (M.D.L. Docket No. 1285). Report: June 28, 2002. Deposition: August 26, 2002.

Deposition and trial testimony and expert reports on behalf of the merging parties in the matter of *Federal Trade Commission v. Swedish Match North America, Inc. and National Tobacco Company, L.P.*, United States District Court for the District of Columbia (No. 1:00-CV-001501 TFH). Reports: July 28, 2000 and August 15, 2000. Deposition: August 16, 2000. Trial testimony: September 7-8, 2000.

Expert report on behalf of Aetna U.S. Healthcare in connection with Aetna U.S. Healthcare's proposed acquisition of Prudential Health Care Plan, Inc. before the Department of Insurance of the State of Georgia. Report: May 19, 1999.

Oral testimony and expert report on behalf of Aetna U.S. Healthcare in connection with Aetna U.S. Healthcare's proposed acquisition of Prudential Health Care Plan, Inc. before the Department of Banking and Insurance and the Department of Health and Senior Services of the State of New Jersey. Testimony: April 9, 1999.

Deposition and trial testimony and expert report on behalf of the Federal Trade Commission in the matter of *Federal Trade Commission and State of Missouri v. Tenet Healthcare Corporation and Poplar Bluff Physician's Group, Inc.*, United States District Court for the Eastern District of Missouri (No. 4:98-CV-709 CDP). Report: May 20, 1998. Deposition: June 2, 3, and 5, 1998. Trial: June 23 and 26, 1998.

Deposition testimony and expert report on behalf of the defendants in connection with *William G. Marshall, Jr., M.D., v. Edward Planz, M.D. and Southeastern Cardiovascular Associates, P.C.*, United States District Court for the Middle District of Alabama (No. CV-97-T-793-S). Report: March 16, 1998. Deposition: May 22, 1998.

Deposition and trial testimony on behalf of the Federal Trade Commission *in the Matter of International Association of Conference Interpreters*. Docket Number 9270, Federal Trade Commission administrative proceeding. Deposition: January 4, 5, and 6, 1996. Trial testimony: January 16-19, 1996.

## **Statements and Testimony at Government Hearings and Workshops**

Statement on "Direct Evidence of Competitive Effects." Prepared for the Federal Trade Commission and the Department of Justice Horizontal Merger Guidelines Workshop, Stanford, CA, January 14, 2010.

Statement on the Analysis of Entry in Health Insurance Markets. Prepared for the Federal Trade Commission and the Department of Justice Hearings on Health Care and Competition Law and Policy, Washington, D.C., April 24, 2003.

Statement on the Analysis of Competitive Effects in Health Insurance Markets. Prepared for the Federal Trade Commission and the Department of Justice Hearings on Health Care and Competition Law and Policy, Washington, D.C., April 23, 2003.

Statement on the Analysis of Hospital Post-Merger Conduct. Prepared for the Federal Trade Commission and the Department of Justice Hearings on Health Care and Competition Law and Policy, Washington, D.C., April 23, 2003.

Statement before the Federal Trade Commission on Health Insurance: Payor/Provider Issues. Prepared for the Federal Trade Commission Workshop on Health Care and Competition Law and Policy, Washington, D.C., September 9, 2002.

## Books and Monographs

Michele Floyd and Lawrence Wu, *The Revolution in the Law and Economics of Antitrust Class Certification* (LexisNexis, Inc., 2015).

*Econometrics: Legal, Practical and Technical Issues, Second Edition*, ed. Lawrence Wu and Charles Biggio (American Bar Association Section of Antitrust Law, 2014).

*Economics of Antitrust: Complex Issues in a Dynamic Economy*, ed. Lawrence Wu (White Plains, NY: NERA Economic Consulting, 2007).

*Economics of Antitrust: New Issues, Questions, and Insights*, ed. Lawrence Wu (White Plains, NY: NERA Economic Consulting, 2004).

## Publications

Nadia Soboleva and Lawrence Wu, "Standard Setting: Should there be a Level Playing Field for all FRAND Commitments?" *Competition Policy International Antitrust Chronicle*, Vol. 10, No. 1, Autumn 2013.

Gregory K. Leonard and Lawrence Wu, "Merger Assessment and Frontier of Economic Analyses (4): Empirical Methods in Antitrust Merger Review," *Kokusai Shoji Houmu* (International Business Law and Practice) Vol. 40, No.3, 2012, pp. 391-401.

Gregory K. Leonard and Lawrence Wu, "Merger Assessment and Frontier of Economic Analyses (5): Empirical Methods in Antitrust Merger Review," *Kokusai Shoji Houmu* (International Business Law and Practice) Vol. 40, No.4, 2012, pp. 557-564.

Gregory K. Leonard and Lawrence Wu, "Merger Assessment and Frontier of Economic Analyses (6): Empirical Methods in Antitrust Merger Review," *Kokusai Shoji Houmu* (International Business Law and Practice) Vol. 40, No.5, 2012, pp. 731-739.

Corey Roush and Lawrence Wu, "Market Definition and Implications for Merger Review," *Law 360*, July 11, 2011.

Elizabeth M. Bailey, Gregory K. Leonard, and Lawrence Wu, "Unilateral Competitive Effects of Mergers Between Firms with High Profit Margins" *Antitrust*, Vol. 25, No. 1, Fall 2010.

Elizabeth M. Bailey, Gregory K. Leonard, G. Steven Olley, and Lawrence Wu, "Merger Screens: Market Share-Based Approaches Versus 'Upward Pricing Pressure'," *The Antitrust Source*, February 2010.

Gregory K. Leonard and Lawrence Wu, "Revising the Merger Guidelines: Second Request Screens and the Agencies' Empirical Approach to Competitive Effects," *Antitrust Chronicle*, Vol. 12, No. 1, Winter 2009.



Gregory K. Leonard and Lawrence Wu, "Assessing the Competitive Effects of a Merger: Empirical Analysis of Price Differences Across Markets and Natural Experiments," *Antitrust*, Vol. 22, No. 1, Fall 2007, pp. 96-101.

Paul Hofer, Mark Williams, and Lawrence Wu, "The Economics of Market Definition Analysis in Theory and in Practice," *The Asia Pacific Antitrust Review 2007*, Global Competition Review, May 2007, pp. 10-13.

Christian Dippon, Gregory Leonard, and Lawrence Wu, "Application of Empirical Methods in Merger Analysis," a chapter in a Japan Fair Trade Commission Competition Policy Research Center report titled *Merger Investigation and Economic Analysis*, November 2005, pp. 108-155.

Alan J. Daskin and Lawrence Wu, "Observations on the Multiple Dimensions of Market Power," *Antitrust*, Vol. 19, No. 3, Summer 2005, pp. 53-58. (Also see Chapter 11 in *Economics of Antitrust: Complex Issues in a Dynamic Economy*, ed. Lawrence Wu (White Plains, NY: NERA Economic Consulting, 2007), pp. 137-153.)

Lawrence Wu and Thomas R. McCarthy, "Essential Issues in the Competitive Analysis of Patent Pools," in *Economic Approaches to Intellectual Property Policy, Litigation, and Management*, ed. Gregory K. Leonard and Lauren J. Stiroh (White Plains, NY: NERA Economic Consulting, 2005), pp. 233-249.

Robert Skitol and Lawrence Wu, "A Transatlantic Swim through Patent Pools: Keeping Antitrust Sharks at Bay," in *On the Merits: Current Issues in Competition Law and Policy, Liber Amicorum Peter Plompen*, ed. Paul Lugard and Leigh Hancher (Antwerpen-Oxford: Intersentia, 2005), pp. 103-116.

Paul Hofer, Patrick Smith, and Lawrence Wu, "Quantitative Techniques in Competition Policy Analysis," *The Asia Pacific Antitrust & Trade Review 2005*, Global Competition Review, April 2005, pp. 13-16.

Lawrence Wu and Rika Mortimer, "Competition and Innovation in Health Care Markets and their Implications for Antitrust Enforcement," *Antitrust Health Care Chronicle*, Vol. 18, No. 4, Winter 2005, p. 3, 12-16.

Paul Hofer, Mark Williams, and Lawrence Wu, "Principles of Competition Policy Economics," *The Asia Pacific Antitrust Review 2004*, Global Competition Review, April 2004, pp. 4-7.

Lawrence Wu, "Two Methods of Determining Elasticities of Demand and Their Use in Merger Simulation," in *Economics of Antitrust: New Issues, Questions, and Insights*, ed. Lawrence Wu (White Plains, NY: NERA Economic Consulting, 2004), pp. 21-33. (Previously published in *Antitrust Insights*, NERA Economic Consulting, January/February 2003.)

Lawrence Wu, Paul Hofer, and Mark Williams, "The Increasing Use of Empirical Methods in European Merger Enforcement: Lessons from the Past and a Look Ahead," in *Economics of Antitrust: New Issues, Questions, and Insights*, ed. Lawrence Wu (White Plains, NY: NERA Economic Consulting, 2004), pp. 71-83. (Originally prepared for the UCLA Law First Annual

Institute on U.S. and E.U. Antitrust Aspects of Mergers and Acquisitions, Los Angeles, California, February 28, 2004.)

Lawrence Wu, “The Economic Analysis of Mergers After *Daubert*,” *The Economics Committee Newsletter*, American Bar Association Section of Antitrust Law, Economics Committee, Vol. 1, No. 1, Spring, 2001, p. 16-20.

Robert E. Bloch, Scott P. Perlman, and Lawrence Wu, “A New and Uncertain Future for Managed Care Mergers: An Antitrust Analysis of the Aetna/Prudential Merger,” *Antitrust Report*, October 1999, pp. 37-61.

Thomas R. McCarthy, Scott J. Thomas, and Lawrence Wu, “Efficiencies Analysis in Hospital Mergers,” in *Antitrust and Healthcare Insights into Analysis and Enforcement*, American Bar Association, 1999, pp. 119-149. (A similar version appeared in the *Antitrust Health Care Chronicle*, Vol. 13, No. 1, Winter 1999, pp. 2-11.)

Lawrence Wu, “The Pricing of a Brand Name Product: Franchising in the Motel Services Industry,” *Journal of Business Venturing*, Vol. 14, No. 1, January 1999, pp. 87-102.

Lawrence Wu, “The Evidence Is In: A Review of the Market Definition Debate in Hospital Merger Cases,” *Antitrust Report*, November 1998, pp. 23-41.

Simon Baker and Lawrence Wu, “Applying the Market Definition Guidelines of the European Commission,” *European Competition Law Review*, Vol. 19, No. 5, June 1998, pp. 273-280.

Lawrence Wu and De-Min Wu, “Measuring the Degree of Interindustry Competition in U.S. v. Continental Can,” *The Antitrust Bulletin*, Vol. XLII, No. 1, Spring 1997, pp. 51-84.

David Dranove, William D. White, and Lawrence Wu, “Segmentation in Local Hospital Markets,” *Medical Care*, Vol. 31, No. 1, January, 1993, pp. 52-64.

## Other Professional Reports and Articles

Lawrence Wu, James Mellsop, Stephen King, Kristin Terris, and Will Taylor, “Levelling the Playing Field: The Role of the Internet and Mobile Computing in Improving the Efficiency and Competitiveness of Australian Small Business,” November 17, 2014.

Elizabeth M. Bailey, Gregory K. Leonard, and Lawrence Wu, “Comments on the 2010 Proposed Horizontal Merger Guidelines,” a comment prepared in response to the FTC and DOJ’s Request for Views on Proposed Horizontal Merger Guidelines, June 3, 2010.

Gregory K. Leonard and Lawrence Wu, “Revising the Merger Guidelines: Second Request Screens and the Agencies’ Empirical Approach to Competitive Effects,” a comment prepared in response to the FTC and DOJ’s Notice of Public Workshop(s) and Request for Comments in connection with the FTC and DOJ’s Horizontal Merger Guidelines Review Project, November 9, 2009.

Paul Lugard, John Taladay, and Lawrence Wu, “Comments on Draft EC Guidelines on the Assessment of Non-Horizontal Mergers Under the Council Regulation on the Control of Undertakings Between Undertakings,” on behalf of the International Chamber of Commerce, Commission on Competition. Submitted to the European Commission, May 13, 2007 (at [http://ec.europa.eu/comm/competition/mergers/legislation/files\\_non\\_horizontal\\_consultation/icc.pdf](http://ec.europa.eu/comm/competition/mergers/legislation/files_non_horizontal_consultation/icc.pdf)).

Paul Lugard, Lawrence Wu, Ilene Gotts, John Taladay, Eileen Reed, and Doris Hildebrand, “Comments on the Church Report and its Implications for Non-Horizontal Merger Guidelines,” a report to the European Commission on behalf of the International Chamber of Commerce, September 13, 2006 (at <http://www.iccwbo.org/uploadedFiles/ICC/policy/competition/Statements/CommentsChurchReport13Sept06.pdf>).

Lawrence Wu, “Innovation in the Coronary Stent Industry: A Note on the Competitive Importance of Products in the R&D Pipeline,” prepared for the 2005 Antitrust in Healthcare Conference sponsored by the American Bar Association Antitrust Law and Health Law Sections and the American Health Lawyers Association, Washington, DC, May 2005.

Lawrence Wu and Rika Mortimer, “Competition Policy Challenges in Innovative Health Care Markets,” prepared for the 6th Annual Conference on Emerging Issues in Healthcare Law sponsored by the American Bar Association Health Law Section, Lake Buena Vista, Florida, February 2005.

Lawrence Wu, “Economic Aspects of an Analysis of Hospital Post-Merger Pricing and Conduct,” prepared for the 2003 Antitrust in Healthcare Conference sponsored by the American Bar Association Antitrust Law and Health Law Sections and the American Health Lawyers Association, Washington, DC, May 15-16, 2003.

Lawrence Wu, “Using Surveys to Evaluate the Effect of Non-Infringing Alternatives on Patent Infringement Damages,” a NERA Brief prepared for and presented at NERA’s Intellectual Property Seminar Series, Washington, DC, October 28, 1998, and New York, New York, June 3, 1998.

## **Invited Presentations**

### **A. Invited Presentations in the Economics of Antitrust and Competition Policy and Merger Analysis**

#### **Topics in Antitrust Litigation and Competition Policy**

“Retreat from Trinko? Revisiting Refusals to Deal.” Participant on a panel discussion at the 62<sup>nd</sup> Annual Spring Meeting of the American Bar Association Section of Antitrust Law, Washington, DC, March 28, 2014.

“What Does Comcast Portend for Economic Evidence Concerning Impact, Both on Class Certification and on the Merits?” Panel discussion at the Antitrust Law & Economics Institute for Judges, co-sponsored by the American Bar Association Section of Antitrust Law and George Mason University School of Law Judicial Education Program, Arlington, Virginia, October 8, 2013.

“The Proper Role of Economic Experts.” Panel discussion at the Antitrust Law & Economics Institute for Judges, sponsored by the American Bar Association Section of Antitrust Law and George Mason University School of Law Judicial Education Program, Arlington, Virginia, October 9, 2012.

“The Law of Pricing, Including Resale Price Maintenance in California after *Leegin*.” Panel discussion at the 21st Annual Golden State Antitrust and Unfair Competition Law Institute, sponsored by the State Bar of California Antitrust and Unfair Competition Section, San Francisco, California, October 27, 2011.

“Trying a Case Involving Mixed Vertical and Horizontal Restraints: The Legal, Economic and Practical Considerations.” Panel discussion at a teleconference sponsored by the American Bar Association, Antitrust Section, Unilateral Conduct Committee, Trial Practice Committee, and Health Care and Pharmaceuticals Committee, October, 20, 2011.

“Use and Misuse of Competitive Intelligence.” Panel discussion at the Reed Smith Pharmaceutical, Medical Device and Life Sciences Antitrust Seminar, Philadelphia, Pennsylvania, December 2, 2009.

“True Grit: Weighing the Risks & Developing the Strategies for Private Litigation.” Participant on a panel discussion at the Second Annual Chicago Forum on International Antitrust Issues, Northwestern University School of Law, Chicago, Illinois, June 9, 2011.

“Mock Trial.” Expert witness in a mock trial on the competitive impact of a resale price maintenance agreement at the 56th Annual Spring Meeting of the American Bar Association Section of Antitrust Law, Washington, DC, March 27, 2008.

“Trial Preparation: Not Just for Outside Counsel.” Speech presented at the 54th Annual Spring Meeting of the American Bar Association Section of Antitrust Law, Washington, DC, March 29, 2006.

“The Ninth Circuit’s Recent Decision in *Dagher v. Saudi Refining Inc.*” Participant on a panel discussion on joint ventures sponsored by the American Bar Association, Antitrust Section, Sherman Act Section 1 and Section 2 Committees, Washington, DC, October 26, 2004.

“An Economic Perspective on Business Practices with ‘Billion Dollar’ Price Tags.” Speech presented at the Antitrust Law Committee Forum, “Antitrust and Distribution: How to Avoid the Billion Dollar Judgment,” at the Spring Meeting of the American Bar Association Section of Business Law, Seattle, Washington, April 3, 2004.

“The Sixth Circuit’s Recent Decision in *Conwood Co., L.P. et al. v. United States Tobacco Co., et al.*” Participant on a panel discussion sponsored by the American Bar Association, Antitrust Section, Sherman Act Section 2 Committee, July 17, 2002.

“The Role of Economics in a Bid-Rigging Investigation.” Speech presented at the Antitrust Seminar, National Association of Attorneys General, Baltimore, Maryland, October 12, 1995.

### **Merger Analysis**

“Merger Analysis from an Economist’s Perspective.” Speaker on a webcast titled “Perspectives on Innovation, Information Exchange, and Antitrust in a Global Context,” sponsored by The Knowledge Group, LLC, August 28, 2012.

“Let’s Make a Deal: Roundtable on EU and US Merger Developments.” Participant on a panel discussion sponsored by The New York State Bar Association Antitrust Law Section and The State Bar of California Antitrust & Unfair Competition Law Section, Los Angeles, California, July 20, 2011.

“The Federal Trade Commission’s Challenge to Laboratory Corporation of America’s Acquisition of Westcliff Medical Laboratories.” Participant on a panel discussion sponsored by the American Bar Association, Antitrust Section, Health Care and Pharmaceuticals Committee and Mergers & Acquisitions Committee, Washington, DC, June 8, 2011.

“The Increasing Use of Empirical Methods in European Merger Enforcement: Lessons from the Past and a Look Ahead.” Speech presented at the UCLA Law First Annual Institute on U.S. and E.U. Antitrust Aspects of Mergers and Acquisitions, Los Angeles, California, February 28, 2004.

“Getting a Fix on *FTC v. Libbey, Inc., et al.*” Speech presented at a seminar sponsored by the Antitrust Committee of the Boston Bar Association, March 8, 2002.

### **Health Care Economics, Competition Policy, and Merger Analysis**

“Antitrust Counseling for Hospital and Physician Affiliations in an Age of FTC Dominance.” Speaker at a Bloomberg BNA webinar, July 14, 2015.

“Assessing Market Power and Harm to Competition in Evolving Health Care Markets.” Panel discussion at the 2014 Antitrust in Health Care conference, co-sponsored by the American Bar Association Antitrust Law and Health Law Sections and the American Health Lawyers Association, Washington, DC, May 14, 2014.

“Can Competition and Innovation Cure the Concerns over Health Care Spending?” Presentation for the Chicago Economics Society Distinguished Alumni Speaker Series, San Francisco, California, October 11, 2013.

“Understanding Competition in Health Care Markets: How is Health Care Different from Other Industries.” Panel discussion sponsored by the American Bar Association, Section of Antitrust Law, Health Care and Pharmaceuticals Committee, Washington, DC, February 15, 2012.

“Challenges in Assessing the Competitive Effects of ACOs.” Presentation at the 2011 Fall Forum, sponsored by the American Bar Association, Antitrust Section, Washington, DC, November 17, 2011.

“Current Issues in Healthcare Antitrust.” Panel discussion at the 20th Annual Golden State Antitrust and Unfair Competition Law Institute, sponsored by the State Bar of California Antitrust and Unfair Competition Section, San Francisco, California, October 21, 2010.

“Mergers and Acquisitions Among Healthcare Providers in 2010: Are There New Rules for the Game?” Panel discussion at the 2010 Antitrust in Healthcare conference, co-sponsored by the American Bar Association Antitrust Law and Health Law Sections and the American Health Lawyers Association, Washington, DC, May 25, 2010.

“Hospital Mergers, Acquisitions, and Joint Ventures—Antitrust Considerations.” Panel discussion at the Washington State Society of Healthcare Attorneys Annual Spring Hospital & Health Law Seminar, Seattle, Washington, April 30, 2010.

“Why Don’t Health Insurance Markets Work Like Other Markets? Or Do They?” Panel discussion on the economics of health reform at an American Health Lawyers Association teleconference, co-sponsored by the Antitrust and Payors, Plans, and Managed Care Practice Groups and the Healthcare Reform Educational Task Force, April 27, 2010.

“Current Antitrust Issues in Healthcare: A New Dose of Competition or the Same Old Prescription?” Panel discussion at the New York State Bar Association Annual Meeting, Antitrust Section, New York, New York, January 28, 2010.

“Assessing Market Power in Healthcare Markets: Developments in Private Litigation and Government Enforcement.” Speech presented at the 2008 Annual Meeting of the American Health Lawyers Association before the Antitrust Practice Group, San Francisco, California, June 30, 2008.

“Fundamentals of Health Care Antitrust Economics.” Faculty presenter on the program, which was sponsored by the American Bar Association, Section of Antitrust Law, Economics and Health Care and Pharmaceuticals Committees, Washington, DC, November 8, 2007.

“Hot Topics in Healthcare Antitrust: Market Definition.” Speech presented at the 2005 Antitrust in Healthcare conference, co-sponsored by the American Bar Association Antitrust Law and Health Law Sections and the American Health Lawyers Association, Washington, DC, May 12, 2005.

“Protecting Competition or Protecting Competitors? Antitrust Issues for Plans and Providers.” Speech presented at the 2005 Law Conference on Health Insurance Plans: Bridging the Gap between Providers and Insurers, co-sponsored by America’s Health Insurance Plans and the American Health Lawyers Association, Colorado Springs, Colorado, May 3-4, 2005.

“Is Competition the Answer: Did DOJ and FTC Get it Right, or Does Regulation Still Serve its Purpose in Healthcare?” Participant on a panel discussion at the 6th Annual Conference on



Emerging Issues in Healthcare Law sponsored by the American Bar Association Health Law Section, Lake Buena Vista, Florida, February 24, 2005.

“Forces Shaping the Next Era in Health Care and their Economic Impact on Hospitals.” Invited keynote speaker at the Mercer Human Resource Consulting and Marsh USA, Inc. Fifth Annual Hospital Management Seminar, Portland, Oregon, October 4, 2004.

“Antitrust and Health Care: Assessing Issues for California and the United States.” Invited speaker at a conference sponsored by the Nicholas C. Petris Center on Health Care Markets and Consumer Welfare at the University of California, Berkeley, California, April 30 – May 1, 2004.

“Rx/OTC Switches and Prescription Drug Reimportation: Consequences for Consumers.” Speech presented at the New York State Bar Association Annual Meeting, Food, Drug and Cosmetic Law Section, New York, New York, January 29, 2004.

“Forces Shaping the Next Big Idea in Health Care.” Speech presented at the Marsh Healthcare Forum, Colorado Springs, Colorado, September 9, 2003.

“Economic Perspectives on Retrospective Reviews of Healthcare Mergers.” Speech presented at the Antitrust in Healthcare Conference sponsored by the American Bar Association Antitrust Law and Health Law Sections and the American Health Lawyers Association, Washington, D.C., May 15-16, 2003.

“The Brave New World for Managed Care Mergers: The *Aetna/Prudential* Merger.” Speech presented at the 11th Annual Managed Care Law Conference, co-sponsored by the American Association of Health Plans and the American Bar Association, Kiawah Island, South Carolina, May 1, 2000.

“The Analysis of Product Market Definition and Entry in the *Aetna/Prudential* Transaction.” Speech presented at a health care antitrust conference sponsored by the American Health Lawyers Association, Arlington, Virginia, February 17-18, 2000.

“The New Challenge for Mergers of Health Plans: What Does the *Aetna/Prudential* Decree Portend?” Speech presented at the Fifth Annual Health Care Antitrust Forum, Chicago, Illinois, October 22, 1999.

“Vertical Integration in Health Care.” Speech presented at the 47<sup>th</sup> Annual Spring Meeting of the American Bar Association Section of Antitrust Law, Washington, DC, April 14, 1999.

“Hospital Price Inflation: Will it Continue to Fall?” Speech presented at a conference presented by J&H Marsh & McLennan, Inc., St. Louis, Missouri, February 25, 1999.

“An Introduction to the Economics of Hospital Merger Analysis.” Speech presented at a health care antitrust conference sponsored by the Federal Trade Commission, the Missouri Attorney General, St. Louis University School of Law and the American Bar Association Antitrust Section, St. Louis, Missouri, November 14, 1997.

“Hospital Merger Efficiencies: Passing on the Cost Savings to Consumers.” Speech presented at a health care antitrust conference sponsored by the Federal Trade Commission, Denver, Colorado, October 25, 1996.

## **B. Invited Presentations in the Economics of Intellectual Property and Patent Damages**

“Patent Pools Face New Antitrust Threats,” Panel discussion at the Antitrust and Intellectual Property Conference co-sponsored by the American Bar Association Sections of Antitrust Law and Intellectual Property Law and Stanford University, Stanford Law School, Stanford, California, October 10, 2013.

“Paper Tiger or Hidden Dragon: The Law, Economics and Business of Patent Infringement Damages in an Era of Innovation & Global Competition.” Panel discussion at the National Asian Pacific American Bar Association (NAPABA) Annual Convention, Los Angeles, California, November 19, 2010.

“Patent Licensing and Competition Policy: Implications of *Quanta Computer* and Patent Trolls.” Remarks presented at the 57th Annual Spring Meeting of the American Bar Association Section of Antitrust Law, Washington, DC, March 26, 2009.

“Mock Trial on Patent Damages.” Expert witness in a mock trial on reasonable royalty damages at an intellectual property seminar for Chinese judges sponsored by Stanford Law School, Stanford Program in Law, Science & Technology, August 16, 2007.

“Patent Pools and Standard Setting – an Economic Perspective.” Speech presented before the Antitrust Law Section of the Minnesota State Bar Association, Minneapolis, Minnesota, October 25, 2005.

“Standard Setting, Market Power, and IP Value.” Speech presented before the Antitrust Section of the Los Angeles County Bar Association, Los Angeles, California, December 14, 2004.

## **Selected Merger Experience**

*Zillow, Inc. and Trulia, Inc.*: presentations and reports to the Federal Trade Commission in connection with a proposed transaction that combined two online real estate advertising platforms, 2014-2015.

*Stryker Corporation and Mako Surgical Corporation*: consulting on the competitive implications of a proposed acquisition involving technology for robot-assisted orthopedic surgery, 2013.

*Express Scripts, Inc. and Medco Health Solutions*: consulting on the competitive implications of a proposed acquisition involving pharmacy benefit management (PBM) services, 2011-2012.

*Laboratory Corporation of America and Westcliff Medical Laboratories, Inc.:* presentations to the Federal Trade Commission in connection with a transaction involving companies that provide clinical laboratory services to physicians in Southern California, 2010-2011.

*McKesson Corporation and US Oncology:* analyses submitted to the Federal Trade Commission in connection with a proposed acquisition involving competition in physician practice management services and the distribution of oncology drugs to physician practices, 2010.

*Thoratec Corporation and HeartWare International, Inc.:* presentations and reports to the Federal Trade Commission in connection with a proposed transaction that would have combined two manufacturers of mechanical circulatory support devices used to treat patients with advanced heart failure, 2009.

*Datascope Corporation and Getinge AB:* consulting on the competitive implications of a proposed acquisition involving companies that make and sell surgical grafts, 2008.

*Inova Health System and Prince William Hospital:* presentations to the Federal Trade Commission in connection with a proposed merger of two hospitals, 2008.

*Cal Dive International, Inc., Helix Energy Solutions Group, Inc., and Horizon Offshore, Inc.:* presentation to the Department of Justice in connection with an acquisition involving certain diving and offshore pipelay assets, 2007.

*The City of New York v. Group Health Incorporated, HIP Foundation, Inc., and Health Insurance Plan of Greater New York,* United States District Court for the Southern District of New York (Case No. 06 Civ. 13122 (KMK) (RME)): declarations on behalf of the merging parties in connection with an acquisition involving two health insurance plans, 2007.

*Proctor & Gamble (P&G):* reports and presentations to the Federal Trade Commission in connection with an acquisition involving over-the-counter heartburn products, 2006.

*Fresenius Medical Care and Renal Care Group:* reports and presentations to the Federal Trade Commission in connection with an acquisition of a national chain of kidney dialysis treatment centers in the US, 2005-2006.

*Evanston Northwestern Healthcare Corporation and Highland Park Hospital:* reports and presentations to the Federal Trade Commission in connection with a retrospective analysis of the competitive effects of a merger of two hospitals in the Chicago area, 2002-2004.

*General Electric Company and Instrumentarium Corporation:* reports and presentations to the Department of Justice and European Commission on behalf of a third party in connection with a proposed acquisition involving patient monitoring devices, 2003.

*Libbey, Inc. and Anchor Hocking Glass Company:* report and presentations to the Federal Trade Commission in connection with a proposed acquisition in the glass beverageware industry, 2001-2002.

*Cytoc Corporation and Digene Corporation:* presentations to the Federal Trade Commission in connection with a proposed acquisition involving the sale of diagnostic test kits for the human papillomavirus (HPV), 2002.

*Philips Medical Systems and Agilent Technologies, Inc.:* report and presentations to the Department of Justice in connection with the proposed acquisition of Agilent's Healthcare Solutions Group by Philips Medical Systems. Both companies manufactured and sold cardiac ultrasound machines, 2000-2001.

*Tyco International Ltd. and Pulmonetic Systems, Inc.:* report and presentations to the Federal Trade Commission in connection with a proposed acquisition involving home care respiratory ventilators, 2001.

*Federal Trade Commission v. Swedish Match North America, Inc. and National Tobacco Company, L.P.,* United States District Court for the District of Columbia (No. 1:00-CV-001501 TFH): deposition and trial testimony and expert reports on behalf of the merging parties in connection with an acquisition involving smokeless tobacco products, 2000.

*Aetna U.S. Healthcare and Prudential Health Care Plan, Inc.:* reports and presentations to the Department of Justice and to various state insurance departments in connection with a proposed acquisition in the health insurance industry, 1998-1999.

*Newell Rubbermaid, Inc. and Regal Ware, Inc.:* report to the Federal Trade Commission in connection with a proposed acquisition in the cookware industry, 1999.

*Federal Trade Commission and State of Missouri v. Tenet Healthcare Corporation and Poplar Bluff Physician's Group, Inc.,* United States District Court for the Eastern District of Missouri (No. 4:98-CV-709 CDP): deposition and trial testimony and expert report on behalf of the Federal Trade Commission in connection with a proposed merger of two hospitals, 1998.

*Arrow International, Inc. and C.R. Bard:* presentation to the Federal Trade Commission in connection with the acquisition of C.R. Bard's cardiac assist unit. Both companies manufactured and sold intra-aortic balloon pumps and catheters, 1998.

*Pacificare Health Systems, Inc. and FHP International Corporation:* presentations to the Federal Trade Commission in connection with an acquisition in the health insurance industry. Both firms offered Medicare managed care plans to seniors, 1996-1997.

*Vail Resorts, Inc. and Ralston Resorts, Inc.:* report and presentation to the Department of Justice in connection with an acquisition of ski resorts in Colorado, 1996.

## **Selected Litigation Consulting Experience**

*In re: DRAM Antitrust Litigation:* retained by counsel for Nanya Technology Corporation and Nanya Technology Corp. USA to assess issues related to antitrust liability in connection with a nationwide class action suit brought by purchasers of DRAM (dynamic random access memory)

chips and modules, in the United States District Court for the Northern District of California, 2006.

*In re: Cotton Yarn Antitrust Litigation:* retained by counsel for Parkdale America, LLC and Parkdale Mills, Inc. to estimate antitrust damages to a class of direct purchasers of cotton yarn in the United States, in the United States District Court for the Middle District of North Carolina, Greensboro Division, 2004-2005.

*In re: Managed Care Litigation:* retained by counsel for the defendants to assess issues related to antitrust liability in connection with a nationwide class action suit brought by physicians and medical societies against ten commercial health insurance plans, in the United States District Court for the Southern District of Florida, Miami Division, 2003-2005.

*In the Matter of Certain Recordable Compact Discs and Rewritable Compact Discs:* retained by counsel for Philips Electronics N.V. and U.S. Philips Corporation to assess the competitive issues surrounding the CD-R and CD-RW patent pools and allegations of patent misuse and injury to competition, in the US International Trade Commission, 2002-2003.

## **Selected Industry Experience**

### Consumer Goods and Services

Bakeware/Ovenware  
Chocolate Candies  
Compact Discs  
Cookware  
Glass Beverageware  
Mattresses  
Mobile Phones and Wireless Products and Services  
Ski Resorts  
Smokeless Tobacco (loose leaf chewing tobacco)

### Health Care Services

Ambulance Services  
Dialysis Services  
Health Insurance (e.g., HMOs and other managed care products)  
Hospice and Palliative Care  
Hospital Beds  
Hospital Services  
Laboratory Tests and Services  
Methadone Maintenance Treatment  
Over-the-Counter Drugs  
Pharmacy Benefit Management (PBM) Services  
Physician Practice Management Services  
Physician Services (e.g., cardiovascular surgery, nephrology, obstetrics, orthopedic, radiology)  
Specialty Drug Distribution (oncology)  
Specialty Pharmacy Services

## Vitamins

### Medical Devices

Blood Testing Instruments and Supplies  
Cardiac Catheters and Stent Delivery Systems  
Cardiac Medical Devices (e.g., Intra-Aortic Balloon Pumps and Catheters)  
Cardiac Ultrasound Machines  
Clinical Diagnostic Tests (cervical cancer screening)  
Coronary Stent and Balloon Angioplasty Catheters  
Diagnostic Imaging Equipment  
Mechanical Circulatory Support Devices (e.g. ventricular assist devices used to treat patients with advanced heart failure)  
Microfiltration Products  
Orthopedic Products  
Patient Monitoring Equipment and Anesthesia Machines  
Respiratory Ventilators  
Sleep Therapy Devices  
Surgical Grafts and Stent Grafts Used to Repair Damaged Blood Vessels  
Urinary Catheters

### Software and Technology

CRT (cathode ray tubes)  
DRAM (dynamic random access memory)  
Internet Search and Online Advertising  
Online Postage and Shipping  
Online Real Estate Advertising Platforms  
Software Solutions (time and billing solutions sold to law firms; time solutions sold to hospitals and health care providers)  
SRAM (static random access memory)

### Other Products and Services

ARA and DHA Amino Acids made for use in Infant Formula  
Aircraft Vacuum Toilets  
Automotive Parts Distribution (exhaust systems)  
Carton Sealing Tape  
Cotton Yarn  
Decorative Laminate Products (e.g., countertops)  
Ferrous Scrap  
Fertilizer  
Heating, Ventilation, and Air Conditioning (products and contracting)  
Insulation Systems used in Roofs and Walls of Metal Buildings (standards and building codes)  
Lamps and Lighting  
Media Research  
Oil Pipelay Services  
Outdoor Advertising



Photo Minilab Services

Postage Meters

Printers and Printing Supplies (e.g., wide format printers)

Tin-mill Products used to make Tin Cans

Truck transmissions (Class 8)

**Paul Wong**

Consultant

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**PAUL WONG  
CONSULTANT**

Dr. Wong is part of NERA's Healthcare and Antitrust practices. In his work at NERA, Dr. Wong has consulted on a variety of hospital and health insurance mergers, including mergers involving notable hospital systems in California, Florida, Wisconsin, and Michigan. Dr. Wong has also consulted on a number of antitrust litigations in healthcare industries, including hospitals, multispecialty physician groups, medical devices, and medical supply distribution.

Prior to joining NERA, Dr. Wong received a Ph.D. and M.A. in Economics from Stanford University, and a B.A. in Business Economics from University of California, Los Angeles (UCLA). Professionally, Dr. Wong has experience in healthcare services research and healthcare analytics from his prior work at Palo Alto Medical Foundation Research Institute, and experience as an investment manager from his prior work at Brandes Investment Partners.

Dr. Wong has also done academic research on a variety of healthcare industries. Most notably, Dr. Wong has written multiple papers analyzing competition and regulation in the US health insurance industry. In addition, Dr. Wong has researched the impact of patient-centered primary care on patients' medical costs, and he has researched how competition impacts patenting and innovation in agricultural biotechnology. Dr. Wong has presented his research for a number of different organizations, including the US Department of Justice and the American Society of Health Economists.

## Education

**Stanford University**

Department of Economics  
Ph.D., Economics, 2015

**Stanford University**

Department of Economics  
M.A., Economics, 2015

**University of California, Los Angeles**

Department of Economics  
B.A. (summa cum laude), Business Economics, 2008

## Professional Experience

2015- **NERA Economic Consulting**  
Consultant

2012-2015 **Stanford University**  
Teaching Assistant

2003-2015 **Palo Alto Medical Foundation (Sutter Health), Research Institute**  
Research Assistant

2008-2010 **Brandes Investment Partners**  
Research Associate

## Honors and Recognition

Stanford University First Year Ph.D. in Economics Fellowship, 2010

Professor Harry Simons Endowed Undergraduate Economics Scholarship,  
UCLA, 2008

Howard J. and Mitzi W. Green Economics Scholarship, UCLA, 2007

Phi Beta Kappa, Eta Chapter of California, UCLA

National Society of Collegiate Scholars, UCLA

ALD/PES Honor Society, UCLA

## Working Papers

“Entry and Long-Run Market Structure in Nongroup Health Insurance”

“Studying State-Level Variation in Nongroup Health Insurance Regulation: Insurers’ Incentives to Screen Consumers”

“Competition and Innovation: Evidence from Patents and Field Trials for Genetically Modified Crops,” with Petra Moser

“Associations Between Features of Patient-Centered Primary Care and Patients' Use of Ambulatory Care” with Ming Tai-Seale and Laura Panattoni

## Invited Presentations

2015      Job Market Seminar Series: US Department of Justice; US Congressional Budget Office; Deloitte, Los Angeles; Seattle University, Department of Economics

2014      American Society of Health Economists, Biennial Conference

### **Exhibit 3**

#### **Materials Relied Upon**

We have relied upon all documents and citations referenced in the report and exhibits, in addition to the following:

#### **Interviews:**

- Interview with Jeff Schwaneke, Senior Vice President, Corporate Controller and CAO at Centene, and Mark Eggert, Senior Vice President, Contractual and Regulatory Affairs, on December 22, 2015.
- Interview with Jesse Hunter, Executive Vice President, Chief Business Development Officer at Centene, on December 23, 2015.
- Interview with Cynthia Brinkley, Executive Vice President, International Operations and Business Integration at Centene, on December 23, 2015.
- Interview with Greg Buchert, California Health and Wellness Plan President and CEO, on December 23, 2015 and follow-up correspondence on December 29, 2015.
- Interview with Health Net employees Steven Sell, President of Health Net Life Insurance Company, Health Net of California, and the Western Region for Health Net, Inc.; Douglas Schur, Vice President & Deputy General Counsel; Kathleen Waters, Senior Vice President, General Counsel and Secretary; Patricia Clarey, Chief State Health Programs & Regulatory Relations Officer; Eric Hause, Vice President, Strategy & Business Development, Commercial; and Susan Hill, Vice President, Strategy and Business Planning, Government Programs, on December 23, 2015.

#### **Documents Received From Counsel:**

- Centene and Health Net, SEC Form 424(b)(3), September 21, 2015.
- Centene Corporation, Hart-Scott-Rodino Filing, FTC Form C4, 16 CFR Part 803, July 17, 2015.
- Confidential Health Net Data.

#### **Publicly Available Data:**

- California Health and Benefit Exchange, 2014 Covered California Data, 2014 Product Prices for all Health Insurance Companies.
- California Health and Benefit Exchange, 2015 Covered California Data, 2015 Product Prices for all Health Insurance Companies.

- California Health and Benefit Exchange, 2016 Covered California Data, 2016 Product Prices for all Health Insurance Companies.
- California Health and Benefit Exchange, 2015 Covered California Data, 2015 Active Member Profiles, June 2015.
- California Department of Health Care Services, Medi-Cal Managed Care Enrollment Reports, November 2015.
- State of California, Department of Health Care Services, Medical Certified Eligibles, Summary Pivot Table by County, Most Recent 24 Months, December 2015.
- California Department of Managed Health Care, Enrollment Summary Report - 2014.
- California Department of Insurance, Health Insurance Covered Lives Report, December 31, 2014.
- Centers for Medicare & Medicaid Services, Medicare Advantage/Part D Contract and Enrollment Data, Monthly Enrollment by Contract/Plan/State/County, December 2015.
- Centers for Medicare & Medicaid Services, State County Penetration Data for Medicare Advantage, December 2015.
- Kaiser Family Foundation, State Health Facts on Health Costs & Budgets, <http://kff.org/state-category/health-costs-budgets/>, accessed on January 13, 2016.

**Publicly Available Documents:**

- Centene Corporation, 10-Q for period ending September 30, 2015.
- Centene Corporation, 10-K for period ending December 31, 2014.
- Health Net, Inc., 10-Q for period ending September 30, 2015.
- Dafny, L., Duggan, M., & Ramanarayanan, S. 2012. Paying a Premium on Your Premium? Consolidation in the US Health Insurance Industry. *American Economic Review*, 102(2): 1161–1185.
- Wholey, D., Feldman, R., Christianson, J., & Engberg, J. 1996. Scale and scope economies among health maintenance organizations. *Journal of Health Economics*, 15(6): 657-684.
- Wu, V. 2009. Managed care's price bargaining with hospitals. *Journal of Health Economics*, 28(1): 350-360.



- California Department of Health Care Services, Medi-Cal Managed Care Program Fact Sheet, November 2014.

**BEFORE THE COMMISSIONER OF INSURANCE  
OF THE STATE OF CALIFORNIA**

IN THE MATTER OF:

### The Proposed Acquisition of Control of:

HEALTH NET LIFE INSURANCE  
COMPANY, a California domestic stock  
insurer and indirect subsidiary of

HEALTH NET, INC., a Delaware corporation

BY

CENTENE CORPORATION, a Delaware corporation

AND

CHOPIN MERGER SUB I, INC. and  
CHOPIN MERGER SUB II, INC., each a  
Delaware corporation

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) File No. APP-2015-00889  
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) **WRITTEN TESTIMONY OF DR.**  
) **LAWRENCE WU AND DR. PAUL**  
) **WONG ON BEHALF OF HEALTH**  
) **NET LIFE INSURANCE COMPANY**  
) **AND HEALTH NET, INC.**

## I. INTRODUCTION

### A. Qualifications and Experience of Lawrence Wu

1. I, Lawrence Wu, am an economist at and President of NERA Economic Consulting. NERA is a global firm of experts dedicated to applying economic, finance, and quantitative principles to complex business and legal issues. I received my B.A. from Stanford University and my Ph.D. from the University of Chicago, Graduate School of Business. Prior to joining NERA, I was a staff economist in the Bureau of Economics at the Federal Trade Commission (FTC). From 2011 to 2015, I was a Visiting Scholar at the Stanford Institute for Economic Policy Research at Stanford University.

2. I have many years of experience analyzing competition issues in the healthcare field. I have been asked to assess the competitive effects of hospital mergers and health plan mergers and alleged exclusionary conduct by health plans and hospitals. I also have been asked to testify on issues related to hospital reimbursement. I have provided written and oral expert testimony on numerous occasions, including testimony in U.S. district courts; presentations before the FTC and the Antitrust Division of the U.S. Department of Justice (DOJ); and reports and/or oral testimony in connection with reviews by various state Departments of Insurance regarding a proposed acquisition of a health insurance company. My research has appeared in *Antitrust*, *The Antitrust Bulletin*, *The Antitrust Chronicle*, *The Antitrust Source*, *Antitrust Report*, *European Competition Law Review*, *Journal of Business Venturing*, and *Medical Care*. I have edited three books that have been published on the economics of antitrust, including a book on the use of econometrics in antitrust analysis. I also am a co-author of a book on antitrust class certification. My publications, prior testimony, and selected consulting assignments are listed in my curriculum vitae, which is appended to this report as Exhibit 1.

## **B. Qualifications and Experience of Paul Wong**

3. I, Paul Wong, am an economist and Consultant at NERA Economic Consulting. I received my B.A. in Business Economics from the University of California, Los Angeles and my M.A. and Ph.D. in Economics from Stanford University. I have prior professional experience working as a health services researcher and healthcare analyst at the Palo Alto Medical Foundation Research Institute and as an investment manager at Brandes Investment Partners.

4. I have consulted on a variety of hospital and health insurance mergers, including mergers involving notable hospital systems in California, Florida, Wisconsin, and Michigan, and I have consulted on a number of antitrust litigations in healthcare industries, including hospitals, multispecialty physician groups, medical devices, and medical supply distribution. I have also done academic research on a variety of healthcare industries. I have written multiple papers analyzing competition and regulation in the U.S. health insurance industry, and I have presented my research for a number of different organizations, including the U.S. Department of Justice and the American Society of Health Economists. My credentials, professional experience, and research are listed in my curriculum vitae, which is appended to this report as Exhibit 2.

## C. Nature and Scope of the Assignment

5. Centene Corporation (“Centene”) has proposed to acquire control of Health Net, Inc. (“Health Net”). Centene operates one subsidiary in California – California Health and Wellness. Health Net operates two full-service health care service plan subsidiaries in California – Health Net of California, Inc. and Health Net Community Solutions, Inc. – and one health insurance company subsidiary – Health Net Life Insurance Company (“HNLIC”).

6. Centene provides health insurance coverage to 4.8 million people in 23 states, the large majority of whom are Medicaid subscribers.<sup>1</sup> In California, Centene focuses on Medi-Cal (California’s Medicaid program), offering Medi-Cal Managed Care products in 19 counties. Centene’s operations in California are relatively new, having begun in 2013 when the company submitted bids for newly established Medi-Cal Managed Care programs (the “Regional” and the “Imperial” programs). Centene’s senior management see the company’s entry into Medi-Cal as potentially an important step toward building a lasting presence in California.<sup>2</sup>

7. Centene’s entry into Medi-Cal Managed Care has been a success for both consumers and the company. For consumers, Centene’s entry has helped to bring managed care services to counties that did not previously have a Medi-Cal Managed Care program. For Centene, its entry enabled it to cultivate a managed care coverage network in areas where this has proven difficult for other insurance carriers.<sup>3</sup> Furthermore, Centene’s success in California mirrors its success in building Medicaid managed care programs around the country. Centene is known as a national, high-quality Medicaid managed care operator, and Centene has grown its Health Insurance Exchange operations quite successfully since 2014.<sup>4</sup>

8. Health Net provides and administers health benefits to over 6 million people in a variety of products, including commercial insurance, Medicare, and Medicaid, as well as

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<sup>1</sup> Centene Corporation, 10-Q for period ending September 30, 2015, p. 20.

<sup>2</sup> Interviews with senior management of Centene.

<sup>3</sup> Based on our interviews, we understand that (a) no other insurance carriers were willing to enter *de novo* into the new Medi-Cal Managed Care programs in 2013 (Anthem and Molina each had a pre-existing presence in the Regional and Imperial counties, respectively) and (b) other parties expressed doubts whether Centene could build a viable coverage network in rural counties. [Interviews with senior management of Centene.] We believe that both are evidence of the difficulty facing Centene at the time of its entry and the subsequent success the company has demonstrated.

<sup>4</sup> The breadth in Centene’s Medicaid operations and the growth of Centene’s Health Insurance Exchange business are explained in more detail in Section III.

programs with the U.S. Department of Defense and the U.S. Department of Veterans Affairs.<sup>5</sup> In California, Health Net, including all of its subsidiaries, insures over 2.9 million people.<sup>6</sup> In this hearing, Health Net's insurance products sold by HNLIC are the only products subject to the jurisdiction of the California Insurance Commissioner. As of December 2014, HNLIC's commercial insurance products covered 163,036 people in California, which only accounts for approximately 6 percent of Health Net's total California membership.<sup>7</sup> In the analysis that follows, we will discuss HNLIC's insurance business as well as Health Net's overall insurance business, including its commercial insurance and Medi-Cal Managed Care products, but not including its federal contract business.

9. With respect to commercial insurance in California, Health Net's three subsidiaries – combined – insure 236,768 members through individual insurance products, 243,053 members through small group insurance products, and 443,191 members through large group insurance products.<sup>8</sup> Of these totals, HNLIC accounts for 57,683 members through its individual products, 81,154 members through its small group products, and 24,199 members through its large group products.<sup>9</sup> None of Health Net's subsidiaries sell administrative services only ("ASO") insurance products. In the last few years, Health Net's individual products – including those sold by HNLIC – have been popular and growing, particularly in Southern California where they have sold well among low-income and Latino populations.<sup>10</sup> Health Net's large group products – including those sold by HNLIC – have experienced slight declines recently, but the company continues to retain large, notable customers, including the University of California, Boeing, and Walmart.<sup>11</sup>

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<sup>5</sup> Health Net, Inc., 10-Q for period ending September 30, 2015, pp. 39 and 49.

<sup>6</sup> *Ibid.*

<sup>7</sup> HNLIC's enrollment is quoted as of December 31, 2014, which is the most recently available enrollment from the California Department of Insurance. Enrollment counts are shown in more detail in Section IV.

<sup>8</sup> Enrollment includes all of Health Net's subsidiaries and is quoted as of December 31, 2014.

<sup>9</sup> HNLIC's enrollment is quoted as of December 31, 2014.

<sup>10</sup> For example, Health Net accounts for 25 percent of Covered California (California's Health Insurance Exchange) enrollees who are between 138 percent and 150 percent of the federal poverty line, and Health Net accounts for 27 percent of Covered California enrollees who are Latino. The Covered California data are not reported separately for HNLIC and Health Net's other subsidiaries. [California Health and Benefit Exchange, 2015 Covered California Data, 2015 Active Member Profiles, June 2015, sheet "QHP".]

<sup>11</sup> Interviews with senior management of Health Net.

10. Health Net and its subsidiaries also administer Medi-Cal Managed Care programs in 12 counties. In total, Health Net and its subsidiaries cover approximately 18 percent (including CalViva members administered by Health Net) of the state's Medi-Cal Managed Care enrollees.<sup>12</sup> Health Net's Medi-Cal operations are concentrated in Southern California and the Central Valley; it did not have existing Medi-Cal operations in rural parts of California, and it did *not* bid to provide coverage in the counties where Centene entered in 2013. Health Net has also overseen important Medi-Cal programs, including a Medicare-Medicaid Dual-Eligible pilot program in Los Angeles and San Diego.

11. The purpose of this testimony is to address the following questions and issues:

- What is the economic framework within which to assess the competitive effects of consolidation in health insurance markets in California?
- What is the rationale for the proposed transaction and the potential benefit to consumers?
- What is the competitive overlap, if any, between the two companies in California?
- What is the competitive effect of the proposed transaction?
- Does the proposed transaction substantially lessen competition in health insurance in California or create a monopoly therein?

#### **D. Information Relied Upon**

12. Our opinions expressed in this testimony are based on our combined professional training and experience, as well as our review of (a) materials that were previously provided to California regulators, which include data and documents produced by Centene and Health Net, (b) publicly available data and information, and (c) interviews with senior management of Centene and Health Net. A complete list of the materials and information that we have relied upon to prepare this report is attached as Exhibit 3.

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<sup>12</sup> Though not branded as "Health Net" plans, Health Net administers Medi-Cal Managed Care plans in three counties on behalf of CalViva Health and some members in two counties on behalf of Molina Healthcare. Total Medi-Cal enrollment for Health Net and its subsidiaries includes 1,482,308 Health Net enrollees, 335,810 CalViva Health enrollees, and approximately 12,400 Molina Healthcare beneficiaries.



13. In addition, our opinions expressed in this testimony may be supplemented or updated to reflect any subsequent production of documents, testimony, or additional information provided to us. We also intend to review any additional information or report(s) that may be submitted by Centene, Health Net, California regulators, various experts, or any interested members of the public, and submit additional reports of our own, if appropriate.

## **II. THE ECONOMIC FRAMEWORK WITHIN WHICH TO ASSESS THE COMPETITIVE EFFECTS OF CONSOLIDATION IN HEALTH INSURANCE MARKETS**

14. Mergers and consolidation have the potential to create both procompetitive and anticompetitive effects. Procompetitive effects can result from a number of factors, including the ability of mergers and consolidation to create economies of scale or to combine complementary assets of the merging parties. However, there is the potential for anticompetitive effects due, principally, to the elimination of competition between the two merging parties in the same market. In evaluating the proposed acquisition, we will weigh the likelihood of realizing procompetitive effects against the risk of any anticompetitive effects. In doing this calculus, our focus will be on the effect of the proposed acquisition on consumers. Our approach is centered on answering the following economic question: Is consumer welfare likely to increase or decrease because of the acquisition? Consumer welfare is likely to decrease if the acquisition will result in higher prices, suppress output, or discourage innovation. But consumer welfare is likely to increase if the acquisition results in the opposite, lowering prices, increasing output, or encouraging innovation.

15. In addition, in assessing the competitive impact of the proposed acquisition, we appreciate that the overall dynamic of competition could change in the future as a result of consolidation by other health insurance carriers in California. Our approach, however, does not depend on whether there is (or is not) consolidation by other carriers. This is because, if the proposed acquisition is procompetitive *on its own*, consumers will benefit and their welfare will be enhanced if the proposed acquisition is allowed to proceed, whether or not there is consolidation by other carriers.

16. Our approach is consistent with the economic literature on the effects of mergers and consolidation in health insurance markets. Indeed, the literature acknowledges that both procompetitive and anticompetitive effects are possible. On one hand, mergers and consolidation of close, significantly overlapping health insurance carriers can create market power and decrease consumer welfare through higher prices, lower output, or lower quality. For example, one study found that the anticompetitive effects of mergers are most likely when the merging carriers have *significant competitive overlap in a local area*.<sup>13</sup> On the other hand, the literature also indicates that allowing health insurance carriers to gain additional enrollment can create procompetitive effects, including economies of scale and lower healthcare costs.<sup>14</sup>

17. The general conclusions in the literature, however, should be adapted to the marketplace for health insurance in California. This marketplace is somewhat unique compared to the United States at large. California has several significant health insurance carriers and a regulatory framework governing health insurance and managed healthcare that are unlike those present in many other states. Furthermore, the competitive healthcare marketplace in California has generally achieved good outcomes for California consumers in the past, including lower healthcare spending per capita compared with many other states.<sup>15</sup>

18. In the following sections, we will assess the competitive effects of Centene's proposed acquisition of Health Net. First, we will summarize the rationale for the acquisition and the possible procompetitive effects. We will place an emphasis on the benefits to consumers that we believe are most likely to be realized or that are more specific to California. Second, we will review the competitive overlap between Centene and Health Net. We place an emphasis on identifying the products and geographic areas in which the two companies directly compete, if any. Finally, we will weigh both considerations and assess the overall competitive effect of the proposed acquisition. Our conclusion is that the procompetitive benefits to consumers are cognizable and that the anticompetitive effects are minimal.

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<sup>13</sup> See Dafny et al. (2012).

<sup>14</sup> See, for example, Wholey et al. (1996) and Wu (2009).

<sup>15</sup> California ranks in the top ten (rank one being the lowest) in healthcare spending per capita. California also ranks better than both the national average and the median state in its average individual insurance premiums and its health insurance market concentration for individual, small group, and large group insurance. [Kaiser Family Foundation, State Health Facts on Health Costs & Budgets, <http://kff.org/state-category/health-costs-budgets/>, accessed on January 13, 2016.]

### III. THE RATIONALE FOR THE PROPOSED TRANSACTION AND THE POTENTIAL BENEFIT TO CONSUMERS

19. There is a strong procompetitive rationale for Centene's proposed acquisition of Health Net. If benefits from the acquisition are realized, the combined companies are likely to be a more efficient and more effective competitor in California and elsewhere, which ultimately will benefit consumers in the form of lower prices and/or better health benefits.

20. For Centene, the acquisition provides the company with (a) better scale and scope, possibly facilitating lower pricing; (b) the ability to participate more fully in California's Medi-Cal Managed Care program, giving the company more legitimacy as a quality, nationwide Medicaid operator;<sup>16</sup> (c) the ability to enter both commercial insurance and Medicare in California with sufficient scale and expertise, thereby increasing competition in California and elsewhere; and (d) the ability to share in Health Net's expertise in administering commercial products in California and capitated managed care plans.<sup>17</sup>

21. For Health Net, the acquisition provides the company with (a) better scale and the opportunity to improve its infrastructure, most notably by allowing it to avoid continuing a significant outsourcing initiative;<sup>18</sup> (b) expertise and programs that complement its own, including Centene's award-winning Medicaid programs and success in growing Health Insurance Exchange businesses; and (c) a *willing* partner that will enable Health Net to compete more vigorously across all of Health Net's lines of business.

22. Although some of the procompetitive benefits are likely to accrue broadly across Centene and Health Net and across many states, a number of the anticipated benefits are *specific to California* and are likely to promote competition and enhance consumer welfare in the state.

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<sup>16</sup> Centene's senior management explained to us that building more operations in California has been one of the Centene's goals for a number of years. Moreover, expanding operations in California – the largest Medicaid program in the country – would enhance Centene's credibility both within the state and nationwide. [Interviews with senior management of Centene.]

<sup>17</sup> The companies' prospectus summarizes much of the rationale for the transaction. [Centene and Health Net, SEC Form 424(b)(3), September 21, 2015.]

23. First, Centene and Health Net's operations in California are geographically distinct but complementary, and their combined California footprint has the potential to serve as a strong foundation for continued competition statewide in multiple lines of business. Exhibit 4A shows the counties in which Centene and Health Net have Medi-Cal operations. Centene's Medi-Cal operations in California are primarily in rural counties in Central and Northern California, whereas Health Net's Medi-Cal operations are focused on Southern California and the Central Valley. Combined, Centene and Health Net will have a more complete and comprehensive coverage network for Medi-Cal Managed Care programs. This will enhance the ability of the combined companies to compete in Medi-Cal Managed Care in the future. Moreover, as Exhibits 4B through 4D show, the existing commercial health insurance operations for Health Net's subsidiaries – including HNLIC – are focused primarily on Southern California and the more urban areas in the state, and there is potential for the combined companies to leverage their Medi-Cal provider networks to expand their commercial health insurance operations.<sup>19</sup> Indeed, this is the approach that Centene has taken in other states to expand its presence in individual commercial health insurance. For example, over the past few years, Centene leveraged its existing Medicaid provider networks and infrastructure to build successful Health Insurance Exchange operations in 13 states.<sup>20</sup> Health Net – including HNLIC – has used a similar strategy of leveraging its existing provider networks and infrastructure to successfully grow its Health Insurance Exchange operations in Southern California.<sup>21</sup> The proposed acquisition generates more of these same opportunities in California. By combining Centene and Health Net's complementary Medi-Cal networks and infrastructure, the combined company will have stronger networks that it can leverage to expand Health Net's existing commercial health insurance business in California.

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<sup>18</sup> The prospectus explains the outsourcing initiative that Health Net began prior to the proposed acquisition. As a consequence of the acquisition, the services that would have been outsourced will, instead, continue to be provided by Health Net. [Centene and Health Net, SEC Form 424(b)(3), September 21, 2015.]

<sup>19</sup> Having a broad Medi-Cal coverage network in place would make it easier to offer new commercial products in the future, as the combined companies would likely have more existing relationships with local providers, more recognition among consumers, and better understanding of local market dynamics.

<sup>20</sup> Centene's senior management cite the company's Medicaid operations that were established and fully-scaled as having been integral to the company's efforts to build new Health Insurance Exchange operations. By having Medicaid operations in-place in a given state, Centene has familiarity with local providers and market dynamics, and its products are more recognized among consumers. [Interviews with senior management of Centene.]

<sup>21</sup> Interviews with senior management of Health Net.

24. Second, Centene and Health Net complement one another in terms of their expertise and focus on serving the Medicaid population. From a national perspective, both Centene and Health Net have successful Medicaid programs, and Medicaid has been an important line of business for both companies. Centene has developed award-winning Medicaid programs around the country, and it can bring the best aspects of these programs to California to help supplement those that Health Net already offers.<sup>22</sup> Centene's products have, furthermore, been locally focused, innovative, and popular despite their short history in California.<sup>23</sup> Centene's acquisition of Health Net is likely to help promote long-term innovation and quality in Medicaid programs in California by combining the extensive Medicaid expertise of the two companies.

25. In addition, both Centene and Health Net have growing, successful Health Insurance Exchange businesses. Exhibit 5A shows Centene's growth in Health Insurance Exchange enrollment and price positioning around the country since 2014. Centene's growth has been considerable, and it is one of the lowest priced plans in many of its rating regions.<sup>24</sup> Exhibit 5B shows Health Net's growth in Covered California (California's Health Insurance Exchange) enrollment and price positioning over the same time period.<sup>25</sup> Health Net has been very popular in Southern California and has been consistently among the lowest priced plans in its rating regions. Centene's acquisition of Health Net would bring together two companies with similar approaches toward their Health Insurance Exchange businesses and two companies that

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<sup>22</sup> An example of Centene's award-winning Medicaid programs is "Smart Start for Baby" (a perinatal and NICU management program that emphasizes early identification and stratification of pregnant members, and education and Care Management interventions). Centene also offers "CentAccount" (a healthy rewards account program that encourages healthy behaviors through valued financial incentives). Moreover, Centene has begun innovative programs in California, including a "TeleHealth" program, non-emergency transportation programs, and other community-based programs (such as holding "Anti-Bullying" events at local schools). [Interviews with senior management of Centene.]

<sup>23</sup> For example, to illustrate Centene's local focus, the company has contributed over \$2.1 million to California communities and community-based organizations, and it has five offices in California and many local employees, including specific liaisons for the 19 public health departments in each of the counties in which it operates. [Interviews with senior management of Centene.] To illustrate Centene's popularity, Centene has enrolled 51 percent of Medi-Cal Managed Care enrollees in aggregate in the counties it entered. [California Department of Health Care Services, Medi-Cal Managed Care Enrollment Reports, November 2015.]

<sup>24</sup> Centene's total enrollment from Health Insurance Exchanges grew from 74,500 to 155,600 (109 percent) from 2014 to 2015. In 2015, Centene was the lowest or second lowest priced plan in 60 percent of its rating regions. In 2016, Centene will be the lowest or second lowest priced plan in 67 percent of its rating regions. See Exhibit 5A.

<sup>25</sup> The Covered California data are not reported separately for HNLIC and Health Net's other subsidiaries.

have been low-price leaders in their separate respective markets – Centene’s Health Insurance Exchange business outside California and Health Net’s Health Insurance Exchange business in California.<sup>26</sup> Thus, the acquisition is likely to help strengthen and grow Centene and Health Net’s combined Health Insurance Exchange operations in California, promoting competition with other insurance carriers in the individual insurance market.

26. Third, Centene’s acquisition of Health Net provides Health Net with the scale and infrastructure it needs to continue to operate efficiently in California and elsewhere. To become more efficient, Health Net engaged Cognizant, a business and technology services firm, to outsource nearly all of its IT, claims processing, and call-center services. This outsourcing arrangement also called for Cognizant to take-on nearly one-third of Health Net’s workforce.<sup>27</sup> The proposed acquisition would allow Health Net to withdraw from this outsourcing arrangement with Cognizant, keeping its operations in-house. Doing so will ensure better continuity and ultimately better efficiency in Health Net’s existing operations. Moreover, the proposed acquisition allows Health Net’s existing operations in California and elsewhere to benefit from Centene’s national scale. These benefits include more cost effective joint purchasing and access to important services provided by Centene’s specialty companies.<sup>28</sup> Together, the various improvements in scale and infrastructure are projected to save the two companies approximately \$150 million per year.<sup>29</sup>

27. Fourth, Centene’s acquisition of Health Net allows Centene to gain additional opportunities in business lines outside of Medicaid, including commercial insurance and

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<sup>26</sup> Senior management of both companies have expressed their interest in building Health Insurance Exchange operations that leverage their Medicaid infrastructure and that offer affordable, “value-oriented” health insurance products. [Interviews with senior management of Centene. Interviews with senior management of Health Net.]

<sup>27</sup> The history and timing concerning Health Net’s outsourcing plans are spelled out in detail in the companies’ prospectus. [Centene and Health Net, SEC Form 424(b)(3), September 21, 2015.] Details concerning the outsourcing agreement are described in the companies’ Hart-Scott-Rodino filing. This filing has been provided to the California Department of Insurance for review. [Centene Corporation, Hart-Scott-Rodino Filing, FTC Form C4, 16 CFR Part 803, July 17, 2015.]

<sup>28</sup> Centene operates a number of specialty companies in California, including US Script, a pharmacy benefits management company; AcariaHealth, a specialty pharmacy management company; Cenpatico, a behavioral health and specialty rehabilitation therapies company; and Nurtur, a life and health management company.

<sup>29</sup> The companies’ Hart-Scott-Rodino filing provides detail concerning the projected efficiencies arising from the acquisition. This filing has been provided to the California Department of Insurance for review. The companies expect to reach cost savings of \$150 million per year by the second year following the proposed acquisition. [Centene Corporation, Hart-Scott-Rodino Filing, FTC Form C4, 16 CFR Part 803, July 17, 2015.]

Medicare. Centene has an interest in growing these other business lines, and more opportunities in California would only further facilitate Centene's likelihood of entering similar markets outside of California.<sup>30</sup> Entry by Centene into additional commercial insurance markets in other states can only be procompetitive and an important source of consumer benefit, even if the benefits accrue predominantly to consumers outside California.

#### **IV. THERE IS NO COMPETITIVE OVERLAP BETWEEN CENTENE AND HEALTH NET IN CALIFORNIA**

28. We have reviewed the California operations of Centene and Health Net to independently assess the competitive overlap between the two companies. There is no competitive overlap between Centene and Health Net. Given the absence of competitive overlap, Centene's proposed acquisition of Health Net is unlikely to create any anticompetitive effects, and it is unlikely to substantially lessen competition in health insurance in California or create a monopoly therein.

##### **A. There is No Overlap in Medi-Cal Coverage**

29. Both Health Net and Centene offer Medi-Cal Managed Care coverage in California. Health Net, across all of its subsidiaries, has approximately 1.8 million Medi-Cal members; Centene has 184,193 Medi-Cal members (see Exhibit 6A).<sup>31</sup> Health Net and Centene account for approximately 18 percent and approximately 2 percent of California's Medi-Cal Managed Care members, respectively.<sup>32</sup> There is no competitive overlap between the two companies, however, for the following reasons.

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<sup>30</sup> See Centene and Health Net, SEC Form 424(b)(3), September 21, 2015.

<sup>31</sup> HNLIC does not provide Medi-Cal benefits. The data from the California Department of Health Care Services do not differentiate between Health Net of California and Health Net Community Solutions. Health Net enrollment includes CalViva Health and a portion of Molina Healthcare members in San Bernardino and Riverside counties. As shown in Exhibit 6A, total Health Net enrollment includes 1,482,308 Health Net enrollees, 335,810 CalViva Health enrollees, and approximately 12,400 Molina Healthcare beneficiaries.

<sup>32</sup> Note also that Health Net and Centene account for approximately 14 percent and approximately 1 percent of California's Medi-Cal eligible individuals, respectively.

30. First, the two companies do not overlap geographically. As shown in Exhibit 4A, Health Net operates principally in Southern California and the Central Valley, whereas Centene operates principally in rural counties in Central and Northern California. The two companies do not compete to provide coverage to the same Medi-Cal enrollees, and they have not done so in the past.

31. Second, the two companies have not bid against one another to win Medi-Cal Managed Care contracts in California. In 2013, Centene entered Medi-Cal Managed Care by bidding to serve Medi-Cal Managed Care programs in 19 counties (the Regional and Imperial Medi-Cal Managed Care programs). Health Net *did not* submit a bid for any of these 19 counties. Thus, Centene did not compete with Health Net in any of the counties it entered. Moreover, since Centene's entry in 2013, it *has not* bid on Medi-Cal Managed Care programs in any county for which Health Net is currently an incumbent. Based on this bidding history, it is clear that the two companies have not competed with one another over multiple years. Because the proposed acquisition does not combine two companies that compete against each other, the transaction is unlikely to lead to a reduction in competition and bidding for Medi-Cal Managed Care contracts.

## **B. There is No Overlap in Individual and Small Group Commercial Health Coverage**

32. Health Net, across all its subsidiaries, has 236,768 individual members and 243,053 small group members in California (see Exhibit 6B and 6C).<sup>33</sup> HNLIC accounts for 57,683 individual members and 81,154 small group members in California – only 24 and 33 percent of Health Net's overall individual and small group members in California, respectively. Centene does not have any individual or small group members in California. There is no competitive overlap between Centene and Health Net in both the individual and small group commercial health insurance markets in California. Thus, the proposed acquisition does not eliminate or reduce competition in these lines of business.

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<sup>33</sup> Health Net, across all its subsidiaries, accounts for approximately 11 percent and approximately 12 percent of California's individual and small group members, respectively.



### **C. There is No Overlap in Large Group Commercial Health Coverage**

33. Health Net, across all its subsidiaries, has 443,191 large group members in California (see Exhibit 6D).<sup>34</sup> HNLIC accounts for 24,199 large group members – only 5 percent of Health Net’s overall large group members in California. Centene does not have any large group members in California. There is no competitive overlap between Centene and Health Net in the large group commercial health insurance market in California. Thus, the proposed acquisition does not eliminate or reduce competition in this line of business.

### **D. There is No Overlap in ASO Coverage**

34. Neither Health Net nor Centene have any ASO members in California (see Exhibit 6E). There is no competitive overlap between Centene and Health Net in ASO commercial health insurance in California. Thus, the proposed acquisition does not eliminate or reduce competition in this line of business.

### **E. There is No Overlap in Medicare Coverage**

35. Health Net has 166,013 Medicare Advantage members and 22,124 Dual-Eligible Medicare-Medicaid members in California (see Exhibit 6F).<sup>35</sup> Health Net’s overall 188,137 Medicare members account for approximately 4 percent of California’s Medicare members with privately sponsored coverage and approximately 3 percent of California’s Medicare-eligible individuals. Centene does not have any Medicare members in California. There is no competitive overlap between Centene and Health Net in the provision of Medicare health insurance in California. Thus, the proposed acquisition does not eliminate or reduce competition in this line of business.

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<sup>34</sup> Health Net, across all its subsidiaries, accounts for approximately 5 percent of California’s large group members.

<sup>35</sup> The data from the Centers of Medicare and Medicaid Services do not differentiate between Health Net’s different subsidiaries.

## V. THE COMPETITIVE EFFECT OF THE PROPOSED TRANSACTION

36. There are many large health insurance carriers that compete in California, and in each line of business, there is considerable competition.

- In Medi-Cal, there are three carriers with over one million lives: L.A. Care, Health Net, and Inland Empire Health Plan. These carriers compete against other carriers that specialize in Medi-Cal (Molina Healthcare, Centene, and numerous other community-sponsored plans, including CalOptima) and carriers that also have a significant presence in the commercial health insurance market (Anthem Blue Cross and Kaiser Permanente) (see Exhibit 6A).
- In commercial health insurance (individual, small group, large group, and ASO), the large carriers competing in California include Kaiser Permanente, Anthem Blue Cross, Blue Shield of California, UnitedHealthcare, Cigna, Aetna, and Health Net (where HNLIC is one of Health Net's three subsidiaries that serve California). Each of these carriers has approximately one million or more members combined across all the different categories of commercial health insurance products (see Exhibits 6B through 6E).
- In Medicare, the carriers include all of the previously referenced commercial insurance carriers. In addition, this market is served by Humana, large pharmacy companies (CVS Health, Rite Aid, and Express Scripts), and numerous other Medicare-focused plans, including Scan Health Plan and Wellcare Health Plans (see Exhibit 6F).

37. As noted above, there is virtually no competitive overlap between Centene and Health Net's three subsidiaries in California. Accordingly, the proposed transaction will not have an anticompetitive effect. Still, we understand that the California Department of Insurance has specifically requested an assessment of the potential effect of the proposed transaction if (a) Centene were to acquire Health Net *and* (b) the two companies (or one of their subsidiaries) were

to then exit one or more of their lines of business in California. To our knowledge, the companies have expressed *no intent* to exit any line of business in California. Moreover, as we discuss below, Health Net and Centene are very unlikely to exit any line of business in California. However, in the hypothetical situation in which Centene and Health Net were to exit a line of business in California, it is unlikely that consumers will be negatively affected. In the sections that follow, we discuss our reasoning in each line of business.

#### **A. Medi-Cal**

38. Although both Centene and Health Net operate in Medi-Cal, there is no competitive overlap in any geography. Thus, there is little risk that the proposed acquisition would lead to a reduction in competition. Moreover, as we discussed above, there are certain procompetitive effects from the acquisition, including the potential for growth and an improvement in the quality of the companies' combined Medi-Cal operations. Overall, in weighing these factors, we believe that the acquisition would be a net benefit to Medi-Cal enrollees in California and have a positive effect on competition in Medi-Cal Managed Care.

39. Given their experience and expertise in Medi-Cal, Centene and Health Net are unlikely to exit this line of business. As we discussed above, Medicaid managed care programs are a core part of both companies' operations. Centene is a nationally known Medicaid operator but is not well known in California. Health Net has one of the largest, most successful Medi-Cal Managed Care programs in California. Furthermore, both companies view California as an important Medicaid population and an essential source of future Medi-Cal business. If anything, the proposed acquisition provides the combined company with the ability to offer even better coverage to consumers and the ability to compete even more effectively than the two have in the past as separate companies in separate geographies.

40. If, hypothetically, Health Net and Centene were to exit Medi-Cal, there are a large number of existing competitors and ready entrants. County- and community-sponsored plans are popular and they present an important source of competition in the Medi-Cal marketplace. Moreover, commercial insurance carriers either (a) already compete in Medi-Cal Managed Care or (b) have the infrastructure and provider networks in place in the state to rapidly enter the Medi-Cal Managed Care marketplace were Centene and Health Net to exit and leave a void.

Given the presence of these many competitors and potential entrants, any exit by Health Net and Centene – however unlikely – would do little to diminish competition in Medi-Cal in the future.

## **B. Individual and Small Group Commercial Health Insurance**

41. Health Net – including its HNLIC subsidiary – currently has large and successful operations in both individual and small group commercial health insurance in California. Exhibits 6B and 6C show that Health Net has a significant share of enrollment in individual and small group insurance statewide, and Exhibit 5B shows Health Net’s popularity in Southern California. There is no competitive overlap between Health Net and Centene in either individual or small group commercial health insurance, and there is little risk that the proposed acquisition would lead to a reduction in competition in either line of business.

42. Given the success Health Net has had and the existing popularity of its products, it is very unlikely Centene and Health Net – if combined – would exit either individual or small group insurance. The combined company has an incentive to continue Health Net’s success and promote the combined company’s growth. Assuming Centene and Health Net do continue to have success, they will not have incentive to take a currently functioning and successful business and exit their operations – such action would defy basic logic and business sense. Furthermore, combining with Centene would only *improve* Health Net’s incentive to stay and grow these lines of business because Centene has (a) expressed interest in growing its commercial insurance business, (b) demonstrated recent success growing its individual insurance businesses in other states, and (c) complementary infrastructure in place to facilitate growth in Health Net’s commercial insurance business, all of which we discussed in Section III. These are all factors that would facilitate continuing Health Net’s operations and continuing competition in individual and small group insurance.

43. Moreover, it is the case that Centene and Health Net’s incentives to grow or shrink their operations are aligned with their competitive importance in the marketplace. When a business is large, successful, and growing, this – almost by definition – implies that the business is likely to be an important competitor and play a central role in the marketplace. When a business is small, struggling, and weak, this – again, almost by definition – implies that the business is likely to be insignificant to competition and play a more peripheral role in the

marketplace. Hence, if conditions are ripe for exit from a line of business in the future, it must necessarily be the case that the operations in question are *no longer* able to significantly impact competition. This conclusion follows from basic economic principles.

44. Looking forward, it is unlikely that Centene and Health Net will exit the California individual or small group health insurance markets. The two companies have every incentive to grow – not shrink – their operations. Nonetheless, were Centene and Health Net’s operations to decline in the future, their exit from individual or small group insurance would naturally come only at a point where they no longer played an important competitive role. Thus, in the unlikely scenario in which Centene acquires Health Net and then the two companies exit individual or small group insurance in the future, the competitive effect of any hypothetical exit of the combined firm in this line of business would be minimal.

### **C. Large Group Commercial Health Insurance**

45. Health Net – including HNLIC – has large group health insurance operations in California.<sup>36</sup> Compared to the other large commercial insurers in California, Health Net’s large group insurance operations are relatively small. Exhibit 6D shows Health Net’s share of enrollment in large group insurance statewide. There is no competitive overlap between Health Net and Centene in large group commercial health insurance, and there is little risk that the proposed acquisition would lead to a reduction in competition in this line of business.

46. As with individual and small group insurance, it is very unlikely that Centene and Health Net would exit large group insurance. Health Net continues to have a number of large, loyal customers, including the University of California, Boeing, Walmart, and other large municipal organizations.<sup>37</sup> The companies have every incentive to continue this line of business, and the proposed acquisition would not change this incentive. If anything, the broader benefits from the acquisition are likely to improve the combined companies’ large group insurance operations, encouraging them to remain in this line of business.

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<sup>36</sup> Neither Health Net nor Centene compete in ASO insurance. The acquisition will have no competitive impact on ASO insurance markets.

<sup>37</sup> Interviews with senior management of Health Net.

47. If Health Net's large group operations were, hypothetically, to decline substantially in the future, exit might become a more likely option. However, the competitive effect of this hypothetical exit would be minimal. Economic principles suggest that Health Net's exit would, in theory, only occur if and when the company has already lost a significant fraction of its large group enrollment and after its operations had already declined significantly. By definition, the company – at that point – would not be a strong or effective competitor. Thus, in the unlikely scenario in which Centene acquires Health Net and then the two companies exit large group insurance in the future, the competitive effect of such an exit is likely to be minimal, if any.

48. In addition, the market for large group insurance has more national reach, which alters the competitive dynamics in large group insurance relative to other lines of business. The presence of other health insurance carriers in this line of business further mitigates the risk to competition if the combined firm were to exit large group insurance. For example, Aetna and UnitedHealthcare are two national carriers that would help ensure that consumers of large group insurance products would continue to benefit from competition if Centene and Health Net were, hypothetically, to exit large group insurance. An exit by the two companies would do nothing to impede competition from these other national insurance carriers.

49. Moreover, many purchasers of large group insurance have multiple options that will enable them to reduce or minimize the impact of any hypothetical exit by Centene and Health Net. Primarily, this is because many large group insurance customers are sizeable, multisite (possibly multistate) employers that purchase insurance from multiple insurance carriers, possibly with a mix of insured (i.e., large group) and self-insured (i.e., ASO) products. Even if, hypothetically, the combined company were to stop providing large group health insurance in California, national health insurance carriers outside California would continue to serve the large employers. It is also even less likely that a large employer who self-insures would be harmed by a hypothetical exit by Centene and Health Net, as any hypothetical exit by the combined company in large group insurance would not diminish the ASO options that are available.

## **D. Medicare**

50. Centene does not have any Medicare operations in California, and there is no competitive overlap between the two companies. Thus, the proposed acquisition is not likely to lead to any anticompetitive effect in Medicare in California. Moreover, it is possible some of the procompetitive benefits from the acquisition would spill over and help Health Net's Medicare operations.<sup>38</sup>

51. Centene has expressed an interest in growing its Medicare business, and Medicare is an important part of Health Net's operations and it has demonstrated its commitment to Medicare across a spectrum of Medicare products.<sup>39</sup> For these reasons, Centene and Health Net are very unlikely to exit Medicare. If anything, the proposed transaction gives the combined company the ability to be stronger and more efficient overall.

52. As with Medi-Cal, there are a large number of existing competitors in Medicare in California. The Medicare market is served by many commercial insurance carriers and multiple Medicare-focused plans, including pharmacy companies and companies specializing in private Medicare coverage. These many insurance carriers present an important and robust source of competition in the marketplace. Given the presence of many competitors, any exit by Health Net and Centene – however unlikely – would do little to diminish competition in Medicare in California in the future.

## **VI. CONCLUSIONS**

53. We have been asked to evaluate the competitive impact in California of Centene's proposed acquisition of Health Net. Our approach considered the likely procompetitive effects of the acquisition, as well as the competitive overlap between the merging parties. The proposed

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<sup>38</sup> As we explained in Section III, having scaled operations in other lines of business would make it easier to offer new products in the future, as the combined companies would have more existing relationships with providers and more recognition among consumers.

<sup>39</sup> Centene's interest in Medicare is expressed in the companies' prospectus. [Centene and Health Net, SEC Form 424(b)(3), September 21, 2015.] For example, Health Net has many Medicare Advantage members, including many Special Needs members. Also, for example, Health Net oversees a large Medicare-Medicaid Dual-Eligible pilot program in Los Angeles and San Diego.

transaction is likely to benefit consumers in California by (a) combining the complementary geographic footprint of Centene and Health Net's operations, (b) combining Centene and Health Net's strengths as low-price leaders in their separate respective markets, (c) creating the opportunity to realize economies of scale and scope, particularly in commercial health insurance markets, and (d) enhancing Centene's ability to enter other markets in the future. At the same time, there is minimal risk of anticompetitive effects from the acquisition because there is no competitive overlap between the two companies. As such, the proposed acquisition will not substantially lessen competition in health insurance in California or create a monopoly therein.

54. In weighing these criteria, we believe the proposed acquisition will be a benefit to consumers in California across all of Centene and Health Net's existing lines of business, including Medi-Cal Managed Care, individual insurance, small group insurance, large group insurance, and Medicare. Moreover, with the efficiencies that will be possible by combining the two companies, the combined company will inject even more competition into the various insurance markets that it will serve in California, which can only benefit consumers.

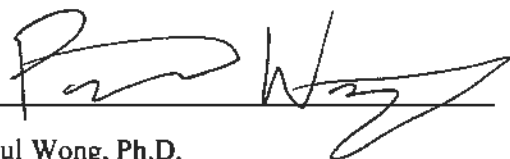
Dated: January 15, 2016, San Francisco, California.

Lawrence Wu, Ph.D. deposes and says that he is an economist at and President of NERA Economic Consulting, that he has read the foregoing written testimony and knows the contents thereof and that the same are true of his own knowledge.



Lawrence Wu, Ph.D.

Paul Wong, Ph.D. deposes and says that he is an economist and Consultant at NERA Economic Consulting, that he has read the foregoing written testimony and knows the contents thereof and that the same are true of his own knowledge.



Paul Wong, Ph.D.



### **Exhibit 3**

#### **Materials Relied Upon**

We have relied upon all documents and citations referenced in the report and exhibits, in addition to the following:

#### **Interviews:**

- Interview with Jeff Schwaneke, Senior Vice President, Corporate Controller and CAO at Centene, and Mark Eggert, Senior Vice President, Contractual and Regulatory Affairs, on December 22, 2015.
- Interview with Jesse Hunter, Executive Vice President, Chief Business Development Officer at Centene, on December 23, 2015.
- Interview with Cynthia Brinkley, Executive Vice President, International Operations and Business Integration at Centene, on December 23, 2015.
- Interview with Greg Buchert, California Health and Wellness Plan President and CEO, on December 23, 2015 and follow-up correspondence on December 29, 2015.
- Interview with Health Net employees Steven Sell, President of Health Net Life Insurance Company, Health Net of California, and the Western Region for Health Net, Inc.; Douglas Schur, Vice President & Deputy General Counsel; Kathleen Waters, Senior Vice President, General Counsel and Secretary; Patricia Clarey, Chief State Health Programs & Regulatory Relations Officer; Eric Hause, Vice President, Strategy & Business Development, Commercial; and Susan Hill, Vice President, Strategy and Business Planning, Government Programs, on December 23, 2015.

#### **Documents Received From Counsel:**

- Centene and Health Net, SEC Form 424(b)(3), September 21, 2015.
- Centene Corporation, Hart-Scott-Rodino Filing, FTC Form C4, 16 CFR Part 803, July 17, 2015.
- Confidential Health Net Data.

#### **Publicly Available Data:**

- California Health and Benefit Exchange, 2014 Covered California Data, 2014 Product Prices for all Health Insurance Companies.
- California Health and Benefit Exchange, 2015 Covered California Data, 2015 Product Prices for all Health Insurance Companies.

- California Health and Benefit Exchange, 2016 Covered California Data, 2016 Product Prices for all Health Insurance Companies.
- California Health and Benefit Exchange, 2015 Covered California Data, 2015 Active Member Profiles, June 2015.
- California Department of Health Care Services, Medi-Cal Managed Care Enrollment Reports, November 2015.
- State of California, Department of Health Care Services, Medical Certified Eligibles, Summary Pivot Table by County, Most Recent 24 Months, December 2015.
- California Department of Managed Health Care, Enrollment Summary Report - 2014.
- California Department of Insurance, Health Insurance Covered Lives Report, December 31, 2014.
- Centers for Medicare & Medicaid Services, Medicare Advantage/Part D Contract and Enrollment Data, Monthly Enrollment by Contract/Plan/State/County, December 2015.
- Centers for Medicare & Medicaid Services, State County Penetration Data for Medicare Advantage, December 2015.
- Kaiser Family Foundation, State Health Facts on Health Costs & Budgets, <http://kff.org/state-category/health-costs-budgets/>, accessed on January 13, 2016.

**Publicly Available Documents:**

- Centene Corporation, 10-Q for period ending September 30, 2015.
- Centene Corporation, 10-K for period ending December 31, 2014.
- Health Net, Inc., 10-Q for period ending September 30, 2015.
- Dafny, L., Duggan, M., & Ramanarayanan, S. 2012. Paying a Premium on Your Premium? Consolidation in the US Health Insurance Industry. *American Economic Review*, 102(2): 1161–1185.
- Wholey, D., Feldman, R., Christianson, J., & Engberg, J. 1996. Scale and scope economies among health maintenance organizations. *Journal of Health Economics*, 15(6): 657-684.
- Wu, V. 2009. Managed care's price bargaining with hospitals. *Journal of Health Economics*, 28(1): 350-360.

- California Department of Health Care Services, Medi-Cal Managed Care Program Fact Sheet, November 2014.

**Exhibit 4A**  
**Medi-Cal Managed Care Operations for Centene and Health Net<sup>1</sup>**  
**2015**



Note:<sup>1</sup> Health Net operations report those by all Health Net companies combined, including Health Net Life Insurance Company, Health Net of California, Inc., and Health Net Community Solutions, Inc., where applicable.

Source: California Department of Health Care Services, Medi-Cal Managed Care Enrollment Reports, November 2015.

**Exhibit 4B**  
**Covered California (Health Insurance Exchange) Operations for Health Net<sup>1</sup>**  
**2015**



Note: <sup>1</sup> Health Net operations report those by all Health Net companies combined, including Health Net Life Insurance Company, Health Net of California, Inc., and Health Net Community Solutions, Inc., where applicable.

Source: California Health and Benefit Exchange, 2015 Covered California Data, 2015 Active Member Profiles, June 2015, sheet "Product By Region".

**Exhibit 4C**  
**Small Group Insurance Operations for Health Net<sup>1</sup>**  
**2015**



Note: <sup>1</sup>Health Net operations report those by all Health Net companies combined, including Health Net Life Insurance Company, Health Net of California, Inc., and Health Net Community Solutions, Inc., where applicable.

Source: Confidential Health Net Data.



**Exhibit 4D**  
**Large Group Insurance Operations for Health Net<sup>1</sup>**  
**2015**



Note: <sup>1</sup>Health Net operations report those by all Health Net companies combined, including Health Net Life Insurance Company, Health Net of California, Inc., and Health Net Community Solutions, Inc., where applicable.

Source: Confidential Health Net Data.

**Exhibit 5A**  
**Centene's Health Insurance Exchange Operations**  
**Total Enrollment and Price Position**  
**Individual Insurance**

**2014 - 2016**

<b>State</b>	<b>Share of Centene's Rating Regions in which it is the Lowest or Second Lowest Priced Issuer</b>		
	<b>2014</b>	<b>2015</b>	<b>2016</b>
<b>(1)</b>	<b>(2)</b>	<b>(3)</b>	<b>(4)</b>
	<b>------(Percent)-----</b>		
Arkansas	0.0 %	100.0 %	85.7 %
Florida	33.3	33.3	66.7
Georgia	66.7	100.0	100.0
Illinois	-	0.0	100.0
Indiana	33.3	70.0	25.0
Massachusetts	0.0	14.3	0.0
Mississippi	100.0	66.7	100.0
Ohio	25.0	85.7	100.0
Texas	42.9	37.5	87.5
Washington	100.0	100.0	100.0
Wisconsin	-	0.0	50.0
<b>Totals:</b>	<b>46.2 %</b>	<b>60.0 %</b>	<b>66.7 %</b>
<b>Total Enrollment:<sup>1</sup></b>	<b>74,500</b>	<b>155,600</b>	

Notes: <sup>1</sup> Enrollment figures are from Centene's 10-Q filing and are reported as of December 31, 2014 and September 30, 2015.

Pricing data for Oregon was unavailable.

Centene will also begin offering individual health insurance coverage in New Hampshire in 2016.

Sources: Pricing data are from a collection of publicly available sources, including www.Healthcare.gov, Massachusetts Health Connector, and Washington Health Benefit Exchange.

Centene Corporation 10-Q for period ending September 30, 2015, p. 20.



**Exhibit 5B**  
**Health Net's Covered California (Health Insurance Exchange) Operations<sup>1</sup>**  
**Total Enrollment and Price Position**  
**Individual Insurance**  
**2014 - 2016**

<b>Rating Region<sup>2</sup></b>	<b>Rating Regions in which Health Net is the Lowest or Second Lowest Priced Issuer<sup>3</sup></b>		
	<b>2014</b>	<b>2015</b>	<b>2016</b>
<b>(1)</b>	<b>(2)</b>	<b>(3)</b>	<b>(4)</b>
Region 15 (Los Angeles)	X	X	X
Region 16 (Los Angeles)	X	X	X
Region 17 (Inland Empire)	X	X	X
Region 18 (Orange)	X	X	X
Region 19 (San Diego)	X	X	X
<b>Totals:</b>	<b>5</b>	<b>5</b>	<b>5</b>
<b>Total Enrollment:<sup>4</sup></b>	<b>237,000</b>	<b>267,000</b>	

Notes: <sup>1</sup> Health Net operations and enrollment reported by all Health Net companies combined, including Health Net Life Insurance Company, Health Net of California, Inc., and Health Net Community Solutions, Inc., where applicable.

<sup>2</sup> Only rating regions in which Health Net had at least 1,000 members in 2015 are displayed.

<sup>3</sup> Based on data produced by the California Health and Benefit Exchange. An "X" denotes that Health Net's Silver Plan sold to a 40 year-old individual is the lowest or second lowest priced Silver Plan available in the rating region.

<sup>4</sup> Enrollment figures are from Health Net's 10-K and 10-Q filings and are reported as of December 31, 2014 and September 30, 2015.

Sources: California Health and Benefit Exchange, 2014-2016 Covered California Data, 2014-2016 Product Prices for all Health Insurance Companies.

Health Net, Inc., 10-Q for period ending September 30, 2015, p. 49.

Health Net, Inc., 10-K for period ending December 31, 2014, p. 76.

**Exhibit 6A**  
**California Insurance Enrollment and Shares**  
**By Carrier**  
**Medi-Cal**

Carrier (1)	Medi-Cal <sup>1</sup>		
	Enrolled (2)	Share of Medi-Cal Managed Care (3)	Share of Medi-Cal Eligible <sup>2</sup> (4)
	----- (Count) -----	----- (Percent) -----	
L.A. CARE	1,832,424	18.1 %	14.3 %
<b>HEALTH NET<sup>3</sup></b>	<b>1,482,308</b>	<b>14.6</b>	<b>11.5</b>
INLAND EMPIRE HEALTH PLAN	1,094,746	10.8	8.5
CALOPTIMA	783,079	7.7	6.1
ANTHEM BLUE CROSS	752,869	7.4	5.9
PARTNERSHIP HEALTH PLAN OF CA	563,434	5.6	4.4
MOLINA HEALTHCARE <sup>4</sup>	450,456	4.4	3.5
CENTRAL CALIFORNIA ALLIANCE FOR HEALTH	340,762	3.4	2.7
<b>CALVIVA HEALTH<sup>5</sup></b>	<b>335,810</b>	<b>3.3</b>	<b>2.6</b>
HEALTH PLAN OF SAN JOAQUIN	320,389	3.2	2.5
COMMUNITY HEALTH GROUP	264,639	2.6	2.1
ALAMEDA ALLIANCE FOR HEALTH	257,285	2.5	2.0
SANTA CLARA FAMILY HEALTH	255,119	2.5	2.0
KERN FAMILY HEALTH	218,750	2.2	1.7
GOLD COAST HEALTH PLAN	202,217	2.0	1.6
<b>CA HEALTH &amp; WELLNESS (CENTENE)</b>	<b>184,193</b>	<b>1.8</b>	<b>1.4</b>
CENCAL	173,370	1.7	1.3
CONTRA COSTA HEALTH PLAN	172,568	1.7	1.3
SAN FRANCISCO HEALTH PLAN	131,392	1.3	1.0
KAISER PERMANENTE	131,179	1.3	1.0
HEALTH PLAN OF SAN MATEO	113,202	1.1	0.9
CARE 1ST HEALTH PLAN	71,831	0.7	0.6
Other Carriers <sup>6</sup>	853	0.0	0.0
<b>Totals:</b>	<b>10,132,875</b>	<b>100 %</b>	<b>78.8 %</b>
<b>Total Medi-Cal Eligible:</b>	<b>12,858,756</b>		

Notes: <sup>1</sup> Medi-Cal enrollment as of November 2015.

<sup>2</sup> Total Medi-Cal eligible based on latest available (August 2015) Medi-Cal Certified Eligibles from California Department of Health Care Services.

<sup>3</sup> Health Net operations and enrollment reported by all Health Net companies combined, including Health Net Life Insurance Company, Health Net of California, Inc., and Health Net Community Solutions, Inc., where applicable.

<sup>4</sup> Health Net is a subcontractor to Molina Healthcare (the direct contractor) in San Bernardino and Riverside counties and manages approximately 12,400 beneficiaries as of November 2015.

<sup>5</sup> CalViva Health's Medi-Cal Managed Care programs are administered by Health Net.

<sup>6</sup> Other Carriers include all carriers with a share of Medi-Cal Managed care enrollees less than 0.5%.

Source: California Department of Health Care Services, Medi-Cal Managed Care Enrollment Reports, November 2015.

State of California, Department of Health Care Services, Medical Certified Eligibles, Summary Pivot Table by County, Most Recent 24 Months, December 2015.

**Exhibit 6B**  
**California Insurance Enrollment and Shares**  
**By Carrier**  
**Individual Insurance**

Carrier (1)	Individual Insurance <sup>1</sup>			
	DMHC <sup>2</sup> (2)	CDI <sup>3</sup> (3)	Total (4)	Share (5)
	------(Count)-----			--(Percent)--
ANTHEM BLUE CROSS	564,197	164,341	728,538	33.4 %
BLUE SHIELD OF CALIFORNIA	503,901	55,629	559,530	25.6
KAISER PERMANENTE	504,730	0	504,730	23.1
<b>HEALTH NET</b>	<b>179,085</b>	<b>57,683</b>	<b>236,768</b>	<b>10.8</b>
CIGNA	2	64,180	64,182	2.9
TIME INS. CO.	0	39,290	39,290	1.8
CHINESE COMMUNITY HEALTH PLAN	12,795	0	12,795	0.6
SHARP HEALTH PLAN	11,781	0	11,781	0.5
Other Carriers <sup>4</sup>	12,151	13,169	25,320	1.2
<b>Totals:</b>	<b>1,788,642</b>	<b>394,292</b>	<b>2,182,934</b>	<b>100 %</b>

Notes: <sup>1</sup> Represents most recent available data through December 31, 2014.

<sup>2</sup> Represents data from the California Department of Managed Health Care. Includes Individual, PPO Individual, and POS Individual.

<sup>3</sup> Represents data from the California Department of Insurance. Includes PPO, POS, EPO, FFS, HDHP, and Other.

<sup>4</sup> Other Carriers include all carriers with a share of individual insurance less than 0.5%.

Source: California Department of Managed Health Care, Enrollment Summary Report - 2014.

California Department of Insurance, Health Insurance Covered Lives Report, December 31, 2014.

**Exhibit 6C**  
**California Insurance Enrollment and Shares**  
**By Carrier**  
**Small Group Insurance**

Carrier	Small Group Insurance <sup>1</sup>			
	DMHC <sup>2</sup>	CDI <sup>3</sup>	Total	Share
(1)	(2)	(3)	(4)	(5)
	------(Count)-----			--(Percent)--
KAISER PERMANENTE	665,076	843	665,919	31.5 %
ANTHEM BLUE CROSS	380,780	116,470	497,250	23.5
BLUE SHIELD OF CALIFORNIA	187,851	224,813	412,664	19.5
<b>HEALTH NET</b>	<b>161,899</b>	<b>81,154</b>	<b>243,053</b>	<b>11.5</b>
AETNA	144,721	111	144,832	6.9
UNITEDHEALTHCARE	34,583	45,974	80,557	3.8
WESTERN HEALTH ADVANTAGE	28,004	0	28,004	1.3
SHARP HEALTH PLAN	12,254	0	12,254	0.6
Other Carriers <sup>4</sup>	10,786	17,336	28,122	1.3
<b>Totals:</b>	<b>1,625,954</b>	<b>486,701</b>	<b>2,112,655</b>	<b>100 %</b>

Notes: <sup>1</sup> Represents most recent available data through December 31, 2014.

<sup>2</sup> Represents data from the California Department of Managed Health Care. Includes Small Group Commercial, PPO Small Group, and POS Small Group.

<sup>3</sup> Represents data from the California Department of Insurance. Includes PPO, POS, EPO, FFS, HDHP, and Other.

<sup>4</sup> Other Carriers include all carriers with a share of small group insurance less than 0.5%.

Source: California Department of Managed Health Care, Enrollment Summary Report - 2014.

California Department of Insurance, Health Insurance Covered Lives Report, December 31, 2014.

**Exhibit 6D**  
**California Insurance Enrollment and Shares**  
**By Carrier**  
**Large Group Insurance**

Carrier	Large Group Insurance <sup>1</sup>			
	DMHC <sup>2</sup>	CDI <sup>3</sup>	Total	Share
(1)	(2)	(3)	(4)	(5)
	------(Count)-----			--(Percent)--
KAISER PERMANENTE	4,629,161	3,882	4,633,043	47.7 %
BLUE SHIELD OF CALIFORNIA	1,452,918	15,823	1,468,741	15.1
ANTHEM BLUE CROSS	1,235,966	135,419	1,371,385	14.1
UNITEDHEALTHCARE	398,140	133,576	531,716	5.5
AETNA	259,385	218,723	478,108	4.9
<b>HEALTH NET</b>	<b>418,992</b>	<b>24,199</b>	<b>443,191</b>	<b>4.6</b>
CIGNA	189,893	244,182	434,075	4.5
WESTERN HEALTH ADVANTAGE	77,159	0	77,159	0.8
SHARP HEALTH PLAN	61,173	0	61,173	0.6
EPIC HEALTH PLAN	44,348	0	44,348	0.5
Other Carriers <sup>4</sup>	105,699	54,691	160,390	1.7
<b>Totals:</b>	<b>8,872,834</b>	<b>830,495</b>	<b>9,703,329</b>	<b>100 %</b>

Notes: <sup>1</sup> Represents most recent available data through December 31, 2014.

<sup>2</sup> Represents data from the California Department of Managed Health Care. Includes Large Group Commercial, PPO Large Group, and POS Large Group.

<sup>3</sup> Represents data from the California Department of Insurance. Includes PPO, POS, EPO, FFS, HDHP, and Other.

<sup>4</sup> Other Carriers include all carriers with a share of large group insurance less than 0.5%.

Source: California Department of Managed Health Care, Enrollment Summary Report - 2014.

California Department of Insurance, Health Insurance Covered Lives Report, December 31, 2014.

**Exhibit 6E**  
**California Insurance Enrollment and Shares**  
**By Carrier**  
**ASO Insurance**

Carrier	ASO Insurance <sup>1</sup>			
	DMHC <sup>2</sup>	CDI <sup>3</sup>	Total	Share
(1)	(2)	(3)	(4)	(5)
	------(Count)-----			--(Percent)--
ANTHEM BLUE CROSS	224,232	2,137,565	2,361,797	37.0 %
CIGNA	0	1,557,973	1,557,973	24.4
UNITEDHEALTHCARE	0	842,104	842,104	13.2
BLUE SHIELD OF CALIFORNIA	803,160	0	803,160	12.6
AETNA	0	664,255	664,255	10.4
KAISER PERMANENTE	0	141,044	141,044	2.2
Other Carriers <sup>4</sup>	4,248	11,729	15,977	0.3
<b>Totals:</b>	<b>1,031,640</b>	<b>5,354,670</b>	<b>6,386,310</b>	<b>100 %</b>

Notes: <sup>1</sup> Represents most recent available data through December 31, 2014.

<sup>2</sup> Represents data from the California Department of Managed Health Care.

<sup>3</sup> Represents data from the California Department of Insurance.

<sup>4</sup> Other Carriers include all carriers with a share of ASO insurance less than 0.5%.

Source: California Department of Managed Health Care, Enrollment Summary Report - 2014.

California Department of Insurance, Health Insurance Covered Lives Report,  
December 31, 2014.

**Exhibit 6F**  
**California Insurance Enrollment and Shares**  
**By Carrier**  
**Medicare**

Carrier	Medicare <sup>1</sup>				Share of Medicare Plans	Share of Medicare Eligible <sup>4</sup>
	Medicare Advantage <sup>2</sup>	Prescription Drug Plans	Dual and Other <sup>3</sup>	Total		
	(2)	(3)	(4)	(5)	(6)	(7)
	------(Count)-----				------(Percent)-----	
KAISER PERMANENTE	1,037,408	0	963	1,038,371	23.6 %	18.2 %
UNITEDHEALTH GROUP	341,595	441,915	0	783,510	17.8	13.8
CVS HEALTH	0	521,845	0	521,845	11.8	9.2
HUMANA	65,707	418,539	0	484,246	11.0	8.5
BLUE SHIELD OF CALIFORNIA	164,326	90,348	8,427	263,101	6.0	4.6
ANTHEM BLUE CROSS	76,980	130,033	8,976	215,989	4.9	3.8
<b>HEALTH NET<sup>5</sup></b>	<b>166,013</b>	<b>0</b>	<b>22,124</b>	<b>188,137</b>	<b>4.3</b>	<b>3.3</b>
SCAN HEALTH PLAN	160,607	0	0	160,607	3.6	2.8
RITE AID	0	155,776	0	155,776	3.5	2.7
AETNA	24,603	91,538	0	116,141	2.6	2.0
WELLCARE HEALTH PLANS	32,219	55,606	0	87,825	2.0	1.5
EXPRESS SCRIPTS	0	72,134	0	72,134	1.6	1.3
GRANITE CREEK FLEXCAP	0	61,648	0	61,648	1.4	1.1
AHMC CENTRAL HEALTH	29,384	0	0	29,384	0.7	0.5
CIGNA	29	28,276	0	28,305	0.6	0.5
INLAND EMPIRE HEALTH PLAN	932	0	22,034	22,966	0.5	0.4
INTERVALLEY HEALTH PLAN	21,828	0	0	21,828	0.5	0.4
Other Carriers <sup>6</sup>	61,839	30,216	61,779	153,834	3.5	2.7
<b>Total:</b>	<b>2,183,470</b>	<b>2,097,874</b>	<b>124,303</b>	<b>4,405,647</b>	<b>100 %</b>	<b>77.4 %</b>
<b>Total Medicare Eligible:</b>	<b>5,694,859</b>					

Notes: <sup>1</sup> Medicare enrollment as reported in December 2015.

<sup>2</sup> Medicare Advantage includes Special Needs Plans.

<sup>3</sup> Dual and Other includes Dual-Eligible, Health Care Prepayment, and Medical Savings Account plans.

<sup>4</sup> Total Medicare eligible based on reported Medicare eligible for California.

<sup>5</sup> Health Net operations and enrollment reported by all Health Net companies combined, including Health Net Life Insurance Company, Health Net of California, Inc., and Health Net Community Solutions, Inc., where applicable.

<sup>6</sup> Other Carriers include all carriers with a share of Medicare plans less than 0.5%.

Source: Centers for Medicare & Medicaid Services, Medicare Advantage/Part D Contract and Enrollment Data, Monthly Enrollment by Contract/Plan/State/County, December 2015.

Centers for Medicare & Medicaid Services, State County Penetration Data for Medicare Advantage, December 2015.

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**Current Faculty Position**

1981– Present      Distinguished Professor of Health Economics and Public Policy,  
joint tenured appointments in School of Public Health and Goldman  
School of Public Policy, University of California, Berkeley

1999 – Present      Endowed Chair, Attorney General of the State of California

**Current Academic Administrative Positions**

2012–present      Co-Director, The Berkeley Forum for Improving California's Healthcare  
Delivery System, University of California, Berkeley, School of Public Health

2005–present      Director, The Global Center for Health and Economic Policy Research,  
University of California, Berkeley, School of Public Health

1999–present      Director, The Nicholas C. Petris Center on Health Care Markets and  
Consumer Welfare, University of California, Berkeley, School of Public Health

**Current Affiliated Faculty Positions**



Haas School of Business, University of California, Berkeley

School of Social Welfare, University of California, Berkeley

Institute of Industrial Relations, University of California, Berkeley

Institute for Health Policy Studies, School of Medicine, University of California, San Francisco

Institute for Health and Aging, School of Nursing, University of California, San Francisco

### **Previous Faculty Positions**

2013            Visiting Professor, Economics Department, Carlos III University of Madrid, Spain

2012 – 2013   Visiting Professor, School of Public Health, Pontificia Universidad Catolica de Chile, Santiago, Chile

1996–1997    Visiting Professor, University of Barcelona and University of Pompeu Fabra, Barcelona, Spain

1989           Visiting Professor and Scholar, London School of Economics and Political Science and London School of Hygiene and Tropical Medicine

1981–1988    Associate Professor, Department of Social and Administrative Health Sciences, School of Public Health, University of California, Berkeley

1978–1981    Professor (tenured), Department of Economics, George Washington University

1974–1975 Visiting Assistant Professor, Department of Economics and Institute of Policy Sciences and Public Affairs, Duke University

1971–1976 Associate Professor (tenured), Department of Economics, University of North Carolina, Chapel Hill

### **Education**

PhD, Economics, New York University, 1971

MA, Economics, Brooklyn College, 1967

BS, Economics, Hofstra University, 1965

### **Awards**

2015 - School of Public Health Committee on Teaching Excellence Award

2015 - Gold Medal from Charles University in Prague, Czech Republic for his continued support of international scientific and educational collaboration

2013 – Chair of Excellence in Economics, Carlos III University of Madrid, Spain

2012 – Fulbright Scholar, Pontificia Universidad Catolica de Chile, Santiago, Chile

2009 – Investigator Award in Health Policy Research, "ADHD Medication in America: Society, Schools, and Public Policy," Robert Wood Johnson Foundation

2007 – Silver Medal of the Charles University, Prague

2004 – Carl A. Taube Award, honoring distinguished contributions to the field of mental health services research, American Public Health Association's Mental Health Section

1996 – Fellow of the Association for Health Services Research

1971 – PhD Awarded with Honors

1970 – Pre-doctoral Dissertation Fellowship, National Science Foundation

### **Award Positions**

2013 Chair of Excellence, Carlos III University of Madrid, Madrid, Spain  
2012 –2013 Fulbright Scholar, Pontificia Catolica University of Chile, Santiago, Chile  
2003 Scholar in Residence, World Bank  
2003 President, International Health Economists Association (iHEA) 4<sup>th</sup> World Congress  
2000 –2006 Senior Scientist, National Institute of Mental Health NIH  
1999 –Present Distinguished Professor of Health Economics and Public Policy – Attorney General Endowed Chair, State of California  
1999 Resident, Bellagio Study and Conference Center, Rockefeller Foundation, Bellagio, Italy  
1993 Fulbright Scholar, Charles University, Prague, Czech Republic  
1976 –1978 Scholar in Residence, Institute of Medicine, National Academy of Sciences, Washington, DC

### **Teaching**

Health Economics and Public Policy  
Global Health Economics and Policy  
The Global Health Workforce

### **University Service**

2014 - present University Committee on Faculty Welfare - Health Care Task Force  
  
2012 Faculty Chair (elected), School of Public Health, University of California, Berkeley

2008–present      Executive Committee, Robert Wood Johnson Scholars in Health Policy

2008–present      Executive Committee, PhD Program Health Services and Policy Analysis, University of California, Berkeley

2008-2011          Committee Member, Undergraduate Admissions, School of Public Health, University of California, Berkeley

2008–present      Associate Director, California Medicaid Research Institute (CaMRI) Steering Committee, University of California, San Francisco

2008–present      Committee Member, Joint-Medical Program, University of California, Berkeley

2009–present      Faculty Advisory, Global Health Leadership Program, University of California, Berkeley

### **Editorial Boards**

*Human Resources for Health Journal, World Health Organization- Editorial Board Member and Reviewer*

*Journal of Health Economics- Reviewer*

*Journal of Mental Health Policy and Economics- Reviewer*

*Health Services Research- Editorial Board Member and Reviewer*

*Journal of Mental Health Policy and Economics- Reviewer*

*Health Affairs- Reviewer*

*Archives of General Psychiatry- Reviewer*

*Inquiry- Reviewer*

*Mental Health Services Research- Reviewer***Other Professional Affiliations & Services to Educational and Government Agencies**

2014 - Present	Global Workforce for the World Bank
2010 – Present	Consultant to the OECD on Pay for Performance
2010 – Present	Consultant to the World Bank on Pay for Performance in Health
2007 – Present	Advisor to the World Health Organization, February
2003	Program Chair, International Health Economists Association (iHEA)
4 <sup>th</sup> World Congress	
2002	Panel Chair, Mental Health Funding Committee, Mental Health & Public Policy Symposium: Coping with Mental Illness and Crafting Public Policy
2001–2005	iHEA Kenneth J. Arrow Committee Member
2001–2002	Member, Committee on Incorporating Research into Psychiatric Residency Training, Institute of Medicine - National Academy of Sciences
2000 – Present	Chair, Subcommittee of the Attorney General's Charity Task Force on Health Care Services
2000 – Present	Depression in Primary Care National Advisory Committee Member/ RWJF Member, Robert Wood Johnson Depression in Primary Care: Linking Clinical and System Strategies Program

**Publications****BOOKS**

14. Scheffler, R.M., Chereches, R., (Editors) Mental Health Systems in Central European Countries: Moving Forward on Improving Service Delivery, Access, and Financing (Forthcoming 2017)

13. Scheffler, R.M. (Editor) World Scientific Handbook of Global Health Economics and Public Policy Volume 3: (3-volume set). 1: The Economics of Health and Health Systems; 2: Health Determinants and Outcomes; 3: Health Systems Characteristics and Performance. World Scientific Series in Global Health Economics and Public Policy. (January 3, 2016)

12. Scheffler, R.M., (Lead Editor) Human Resources for Health Labor Market Toolkit. World Bank. (Forthcoming 2016)

11. Scheffler, R.M. (Editor) World Scientific Handbook of Global Health Economics and Public Policy (3-volume set). Volume 2: The Economics of Social Capital and Health. (World Scientific, 2014)
10. Scheffler, R.M. (Editor) World Scientific Handbook of Global Health Economics and Public Policy. Volume 1: Accountability and Responsibility in Health Care. World Scientific Series in Global Health Economics and Public Policy. (World Scientific, 2012)
9. Scheffler, R.M., Hinshaw, S.P. The ADHD Explosion: Myths, Medication, Money, and Today's Push for Performance. (March 2014, Oxford University Press)
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7. Scheffler, R.M. Is There a Doctor in the House? Market Signals and Tomorrow's Supply of Doctors. Stanford, California: Stanford University Press, 2008.
6. Scheffler, R.M., M. Potůček, eds. Mental Health Care Reform in the Czech and Slovak Republics, 1989 to the Present. Prague, Czech Republic: Charles University Press, 2008.
5. Preker, A.S., R.M. Scheffler, and M. Bassett, eds. Private Health Insurance in Development: Friend not Foe. Washington, D.C.: The World Bank, 2006.
4. Waitzman, N. J., R.M. Scheffler, and P.S. Romano. The Cost of Birth Defects: Estimates of the Value of Prevention. Lantham, Md.: University Press of America, 1996.
3. Scheffler, R.M., and N. Andrews, eds. Cancer Care and Cost: DRGs and Beyond. Ann Arbor, Mich.: Health Administration Press, 1989.
2. Advances in Health Economics and Health Services Research (formerly Research in Health Economics), with L. F. Rossiter, vols. 1–15, Greenwich, Conn.: JAI Press, 1979, 1981–1984, 1986–1993, 1995.
1. Scheffler, R. M., G. Ruby, N. Weisfeld, and J. Goldberg. A Manpower Policy for Primary Health Care. Washington, D.C.: National Academy Press, 1978.

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199. Tulenko, K., Scheffler, R., Estimating health workforce needs, deficits, and costs for the Global Strategy on Human Resources for Health (2016-2030). World Health Organization. (Forthcoming 2016)
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197. Bruckner, T., Liu, J., Scheffler, R.M., Demands Based and Needs Based Forecast for Healthcare Workers. (Chapter 2) Human Resources for Health Labor Market Toolkit. World Bank. (Forthcoming 2016)
196. Scheffler, R.M., A Labor Market Framework for Human Resources for Health in Low- and Middle- Income Countries (Chapter 1). Human Resources for Health Labor Market Toolkit. World Bank. (Forthcoming, 2016)
195. Friedman, J., Scheffler, R.M., World Scientific Handbook Chapter (Volume 3): Pay for Performance in Health Systems Around the Globe. World Scientific Publishing. (January, 2016)
194. Kessell, E., Scheffler, R., Shortell, S., Avoiding Spending While Meeting Patients’ Wishes: A Model of Community-Based Palliative Care Uptake in California from 2014-2022. Journal of Palliative Medicine. (November, 2015)
193. Scheffler, R.M. Kessell, E., Brandt, M., Covered California: The Impact of Provider and Health Plan Market Power on Premiums. Journal of Health Politics, Policy, and Law (October 2015).
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161. Scheffler, R.M., T.A. Bruckner, G. Shen, J. Yoon, D. Chisholm, J. Morris, B.D. Fulton, M.R. Dal Poz, S. Saxena. Human Resources for Mental Health: Workforce Shortages in low- and middle-income countries. World Health Organization: Geneva, Switzerland (February 2011).

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158. Ronconi, L., Brown, T.T., and R.M. Scheffler. "Social Capital and Self-Rated Health in Argentina." Health Economics (December 2010).
157. Bruckner, T.A., R.M. Scheffler, G. Shen, J. Yoon, D. Chisholm, J. Morris, B.D. Fulton, M.R. Dal Poz, S. Saxena. "The Mental Health Workforce Gap in Low and Middle Income Countries: A Needs-Based Approach." The Bulletin of the World Health Organization (November 2010).
156. Borowitz, M., R.M. Scheffler, and B.D. Fulton. Value for Money in Health Spending (Chapter Four). Organisation for Economic Co-operation and Development 9:15 (October 2010): 105-122.
155. Lang, H.C., R.M. Scheffler, and T.W. Hu. "The Discrepancy in Attention Deficit Hyperactivity Disorder (ADHD) Medications Diffusion: 1994–2003—A Global Pharmaceutical Data Analysis." Health Policy 97:1 (September 2010): 71-78.
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20. Scheffler, R.M. "The Employment, Utilization, and Earnings of Physician Extenders." Social Science and Medicine 11 (1977): 785–791.
19. Scheffler, R.M. "The Industry of Employment and Primary Work Activity of PhD Economists: A Multiple Logit Analysis." Atlantic Economic Journal 5.3 (1977): 32–41.
18. Scheffler, R.M., and J. Kushman. "A Production Function for Dental Services: Estimation and Economic Implications." Southern Economic Journal 44.1 (1977): 25–35.
17. Scheffler, R.M., and L. Paringer. "The Nation's Health Today." Current History 72.427 (1977): 193–195, 229–230.

16. Scheffler, R.M. "Reply to Professors Raymond and Sesnowitz." Industrial Relations 15.3 (1976): 359.
15. Kushman, J., and R.M. Scheffler. "Family Power Structure and Family Labor Supply." Social Science Quarterly 56.2 (1975): 239–251.
14. Lipscomb, J., and R.M. Scheffler. "Impact of Expanded-Duty Assistants on Cost and Productivity in Dental Care Delivery." Health Services Research 10.1 (1975): 14–35.
13. Scheffler, R.M. "Further Consideration on the Economics of Group Practice: The Management Input." Journal of Human Resources 10.2 (1975): 258–263.
12. Scheffler, R.M. "Physician Assistants: Is There a Return to Training?" Industrial Relations 14.1 (1975): 78–89.
11. Scheffler, R.M. "The Pricing Behavior of Medical Groups." Milbank Quarterly 53.2 (1975): 225–240.
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9. Scheffler, R.M., and J. Lipscomb. "Reply to Martin K. Chen." Inquiry 12.4 (1975): 359.
8. Scheffler, R.M. "The Market for Paraprofessionals: The Physician Assistant." Quarterly Review of Economics and Business 14.3 (1974): 47–60.
7. Scheffler, R.M. "Productivity and Economies of Scale in Medical Practice." Health, Manpower, and Productivity. J. Rafferty (ed.). Lexington, Mass.: Lexington Books, 1974.
6. Scheffler, R.M., and G. Iden. "The Effect of Disability on Labor Supply." Industrial and Labor Relations Review 28.1 (1974): 122–132.
5. Scheffler, R.M., and J. Lipscomb. "Alternative Estimations of Population Health Status: An Empirical Example." Inquiry 11.3 (1974): 220–228.

4. Scheffler, R.M., and J. Lipscomb. "Consumption and Investment Benefits of Disease Programs." Growth and Change 5 (1974): 8–16.
3. Scheffler, R.M, and O.D. Stinson. "Characteristics of Physicians' Assistants: A Focus on Specialty." Medical Care 12.12 (1974): 1019–1030.
2. Scheffler, R.M. "The Regional Distribution of Physicians and Specialists." Review of Regional Studies 2.2 (1972): 63–80.
1. Scheffler, R.M. "The Relationship between Medical Education and the Statewide Per Capita Distribution of Physicians." Journal of Medical Education 46 (1971): 995–998.

### **Grants and Contracts**

Title: Accountable Care Organizations: Cost and Quality

Funded by: CA Attorney General

Role: PI

September 1, 2013 – August 31, 2015

Title: Pay for Performance in Health Care Delivery Systems: A Global Perspective

Funded by: U.S. Fulbright Scholar Program

Role: PI

October 1, 2012 – January 31, 2013

Title: Pay for Performance in Health Care Delivery Systems: A Global Perspective

Funded by: Carlos III University of Madrid

Role: PI

February 1, 2013 – July 31, 2013

Title: Impact of State Rate Review Regulation on Health Insurance Premiums

Funded by: Robert Wood Johnson Foundation

Role: PI

April 1, 2012 – March 31, 2014

Title: Berkeley Forum on Improving California's Healthcare Delivery System

Funded by: Various Gifts

Role: Co-PI

January 1, 2012-December 31, 2012

Title: Research Training: Socio-Economics of Mental Health Delivery System in Southeastern Europe

Funded by: National Institutes of Health, Fogarty International Center

Role: PI

August 1, 2011 – July 31, 2016

Title: Investigator Award in Health Policy Research

Funded by: Robert Wood Johnson Foundation

Role: PI

Dates: March 1, 2009 – February 29, 2014

Title: HRH in Africa: A New Look at the Crisis

Funded by: The World Bank

Role: Editor

Dates: March 6, 2009 – February 1, 2013

## **Curriculum Vitae**

**Brent D. Fulton, Ph.D., MBA**  
50 University Hall, MC7360  
School of Public Health  
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January 4, 2016

### **A. Employment**

#### Current Positions

2011 to present     Assistant Adjunct Professor of Health Economics and Policy, Division of Health Policy and Management, School of Public Health, University of California, Berkeley

2011 to present     Associate Director, Nicholas C. Petris Center on Health Care Markets and Consumer Welfare, and Global Center for Health Economics and Policy Research, School of Public Health, University of California, Berkeley

#### Previous Positions

2009-2014     Assistant Research Economist, Nicholas C. Petris Center on Health Care Markets and Consumer Welfare, and Global Center for Health Economics and Policy Research, School of Public Health, University of California, Berkeley

2006-2009     Health Services Researcher, Nicholas C. Petris Center on Health Care Markets and Consumer Welfare, and Global Center for Health Economics and Policy Research, School of Public Health, University of California, Berkeley

2001-2006     Graduate Student Research Fellow, RAND Corporation

1999-2001     Business Consultant, independent and as an employee (multiple businesses)

1997-1998     Senior Consultant, Ernst & Young LLP

1992-1997     Project Manager/Engineer, U.S. Air Force

## **B. Education**

Ph.D., Public Policy Analysis (health economics focus), Pardee RAND Graduate School, 2006

MBA, Strategy and Finance, Anderson School at UCLA, 1997

B.S., Engineering Mechanics, U.S. Air Force Academy, 1992

## **C. Teaching**

2012 to present	Public Health W200E: Health Policy and Management (Instructor, online class)
2013 to present	Public Health 126: Health Economics and Public Policy (Instructor/Co-Instructor)
2010, 2012	Public Health 126: Health Economics and Public Policy (Lecturer Appointment to co-teach course)
2009, 2011	Public Health 126: Health Economics and Public Policy (guest lecturer for five classes)

## **D. Awards**

School of Public Health Award for Teaching Excellence (Springs 2014, 2015)

## **E. Peer-Reviewed Publications**

Research areas: health workforce, health insurance, mental health services, California's healthcare market, accountable care organizations, Affordable Care Act, payment reform, and cost analysis

### **Published or In Press**

21. **Fulton BD**, Hollingshead A, Karaca-Mandic P, Scheffler RM. Republican states bolstered their health insurance rate review programs using incentives from the Affordable Care Act. *Inquiry* 52; 2015: 1-10.
20. Karaca-Mandic P, **Fulton BD**, Hollingshead A, Scheffler RM. States with stronger health insurance rate review authority experienced lower premiums in the individual market in 2010-13. *Health Affairs* 34(8); 2015: 1358-1367.

19. **Fulton BD**, Pegany V, Keolanui B, Scheffler RM. California accountable care organizations: number, characteristics and state regulation. *Journal of Health Politics, Policy and Law*, 2015 (published online June 29).
18. Kessell ER, Pegany V, Keolanui B, **Fulton BD**, Scheffler RM, Shortell SM. Review of Medicare, Medicaid and commercial quality of care measures: considerations for assessing accountable care organizations. *Journal of Health Politics, Policy and Law*, 2015 (published online June 29).
17. **Fulton BD**, Scheffler RM, Hinshaw SP. State variation in increased ADHD prevalence: links to NCLB school accountability and state medication laws. *Psychiatric Services* 66(10); 2015: 1074-1082.
16. **Fulton BD**, Scheffler RM, Keolanui B, Shortell SM. Forecasts and drivers of health expenditure growth in California. *California Journal of Politics & Policy* 7(2); 2015: 1-14.
15. **Fulton BD**, Galarraga O, Dow WH. Informing public policy toward binational health insurance: empirical evidence from California. *Salud Pública de México* 55(4); 2013: S468-S476.
14. Scheffler RM, **Fulton BD**. Needs-based estimates for the health workforce. In Soucat AS, Scheffler RM (eds.), *The Labor Market for Health Workers in Africa: A New Look at the Crisis*, Washington, D.C.: The World Bank, 2013. (Reviewed by peer reviewers internal and external to The World Bank.)
13. Bruckner TA, Hodgson A, Mahoney CB, **Fulton B**, Levine P, Scheffler RM. Health care supply and county-level variation in attention-deficit hyperactivity disorder prescription medications. *Pharmacoepidemiology and Drug Safety* 21(4); 2012: 442–449.
12. Kapur K, Karaca-Mandic P, Gates SM, **Fulton BD**. Do small group health insurance regulations influence small business size? *Journal of Risk and Insurance* 79(1); 2012: 231-259.
11. **Fulton BD**, Dow WH. Is California different? State-specific risk adjustment needs under health reform. *California Journal of Politics & Policy* 3(4); 2011.
10. Hinshaw SP, Scheffler RM, **Fulton BD**, et al. International variation in treatment procedures for attention-deficit/hyperactivity disorder: social context and recent trends. *Psychiatric Services* 62(5); 2011: 459-464.
9. Bruckner TA, Scheffler RM, Shen G, Yoon J, Chisholm D, Morris J, **Fulton BD**, Dal Poz MR, Saxena S. The mental health workforce gap in low- and middle-income countries: a needs-based approach. *Bulletin of the World Health Organization* 89; 2011: 184-194.

8. Scheffler RM, Bruckner TA, **Fulton BD**, Yoon J, Shen G, Chisholm D, Morris J, Dal Poz MR, Saxena S. Human resources for mental health: workforce shortages in low- and middle-income countries. *Human Resources for Health Observer* # 8. Geneva: World Health Organization, 2011.
7. **Fulton BD**, Scheffler RM, Sparkes SP, Auh EY, Vujicic M, Soucat A. Health workforce skill mix and task shifting in low-income countries: a review of recent evidence. *Human Resources in Health* 9(1); 2011.
6. Dow WH, **Fulton BD**, Baicker K. Reinsurance for high health costs: benefits, limitations, and alternatives. *Forum for Health Economics & Policy* 13(2); 2010.
5. Scheffler RM, Mahoney CB, **Fulton BD**, Dal Poz MR, Preker AS. Estimates of health care professional shortages in Sub-Saharan Africa by 2015. *Health Affairs* 28; 2009: w849-w862.
4. **Fulton BD**, Scheffer RM, Hinshaw SP, Levine P, Stone S, Brown TT, Modrek S. National variation of ADHD diagnostic prevalence and medication use: health care providers and education policies. *Psychiatric Services*, 60(8); 2009:1075-1083.
3. Finlayson TL, Brown TT, **Fulton BD**, Jahedi S. Adult oral health status in California, 1995-2006: demographic factors associated with tooth loss due to disease,” *Journal of the California Dental Association*, 37(8); 2009: 561-570.
2. Brown TT, Finlayson TL, **Fulton BD**, Jahedi S. The demand for dental care and financial barriers in accessing needed care among adults in California. *Journal of the California Dental Association*, 37(8); 2009: 539-547.
1. Scheffler RM, Brown TT, **Fulton BD**, Hinshaw SP, Levine P, Stone S. Positive association between ADHD medication use and academic achievement during elementary school. *Pediatrics* 123(5); 2009: 1273-1279.

### **Working Papers**

Fulton BD, Ivey SL, Rodriquez HP, Shortell SM. Impact of the California Right Care Initiative’s University of Best Practices on inpatient hospitalization rates for heart attacks and strokes in San Diego County (working paper).

Fulton BD, Karaca-Mandic P, Tsan-Yao H, Scheffler RM. Association between State Health Insurance Rate Review and Health Insurance Premiums in the Individual Market, 2002-2013 (working paper).

Galarraga O, Sosa-Rubi SG, Rosales-Martinez Y, Alarid-Escudero F, **Fulton BD**, Dow WH. Informing Public Policy Toward Binational Health Insurance: Empirical Evidence from Mexico (working paper).



## F. Publications and Reports (not peer-reviewed)

13. Spetz J, Tellez M, **Fulton BD**. Global human resources for health. In Scheffler RM (editor). *World Scientific Handbook of Global Health Economics and Public Policy*. Singapore: World Scientific, 2016.
12. Hollingshead A, King J, **Fulton BD**, Rushakoff J, Scheffler RM. *State Actions to Promote and Restrain Commercial Accountable Care Organizations*. Berkeley, CA: Nicholas C. Petris Center on Health Care Markets and Consumer Welfare, School of Public Health, University of California, in partnership with Milbank Memorial Fund, 2015.
11. Shortell SM, Scheffler RM, **Fulton BD**, Kessell ER. *Accountable Care Organizations in California: Promise & Performance*. Berkeley, CA: Berkeley Forum for Improving California's Healthcare Delivery System, School of Public Health, University of California, Berkeley, 2015.
10. **Fulton BD**, Kessell ER, Keolanui B, Pegany V, Shortell SM, Scheffler RM. *Drivers of Health Expenditure Growth in California: Forecasts and Progress on Delivery System Integration*. Berkeley, CA: Berkeley Forum for Improving California's Healthcare Delivery System, School of Public Health, University of California, Berkeley, 2014.
9. Bowers LG, Scheffler RM, Shortell SM, **Fulton BD**. The Berkeley Forum – A roadmap for improving healthcare in California. *California Journal of Politics and Policy* 6(2); 2014: 207-224.
8. Bowers LG, Scheffler RM, Shortell SM, **Fulton BD**. Introduction: six comments on the Forum. *California Journal of Politics and Policy* 6(2); 2014: 225-226.
7. Scheffler RM, Bowers LG, **Fulton BD**, Connors C, Shortell SM, Morrison I. A new vision for California's healthcare system: integrated care with aligned financial incentives. *California Journal of Politics and Policy* 6(2); 2014: 249-334.
6. California Health Benefits Review Program. *Analysis of Assembly Bill 460: Health Care Coverage: Infertility*. Report to the California State Legislature. Oakland, CA: California Health Benefits Review Program, 2013. (**Fulton BD**, cost lead).
5. **Fulton BD**, Scheffler RM. *Health Insurance Premium Rate Review: Case Studies to Inform California*. Berkeley, CA: California Program on Access to Care, 2012.
4. Borowitz M, Scheffler RM, **Fulton BD**. Improving value for money in health by paying for performance. *OECD Health Policy Studies: Value for Money in Health Spending*; Paris: Organisation for Economic Co-operation and Development 2010.
3. **Fulton BD**. Is America ready for the economic impact of Alzheimer's? in Shriver M, Alzheimer's Association, Geiger AT, Morgan O, Meyer K, Skelton K (eds.), *The Shriver*

*Report: A Woman's Nation Takes on Alzheimer's.* Chicago, IL: Alzheimer's Association, 2010.

2. **Fulton BD**, Scheffler RM. Health care professional shortages and skill-mix options using community health workers: new estimates for 2015. In Moore JM, Dal Poz MR, Perfilieva G, Jaccard-Ruedin H, Doan BDH (eds.). *The Performance of a National Health Workforce*. Paris: Centre de Sociologie et de Demographie Medicales, 2010.
1. Wasserman J, Asch S, Bamezai A, Wynn B, Ringel J, **Fulton B**, Newberry S, Washington G. *Financing the Health Services 'Safety Net' in Los Angeles County*, Woodland Hills, Calif: California Endowment, 2004.

## G. Conference, Symposia and Public Policy Presentations

Scheffler RM, **Fulton BD**, Hollingshead A, Karaca-Mandic P. "Is Rate Review the Answer to Lower Health Insurance Premiums?" Webinar. AcademyHealth and Robert Wood Johnson Foundation's Changes in Health Care Financing and Organization, November 2015.

**Fulton BD**. "Impact Analysis of California Right Care Initiative's University of Best Practices on Hospitalization Rates for Acute Myocardial Infarctions and Strokes in San Diego County." California Right Care Initiative Annual Summit. University of California, Berkeley, November 2015.

**Fulton BD**, Karaca-Mandic P, Hollingshead A, Scheffler RM. "Association between Health Insurance Premiums and State Health Insurance Rate Review in the Individual Market, 2001-2012." Poster Presentation, AcademyHealth Annual Research Meeting, June 2014.

Karaca-Mandic P, **Fulton BD**, Hollingshead A, Scheffler RM. "Rate Review Authority and Premiums in the Individual Market: Entering into the Affordable Care Act Era." Panel Presentation by Karaca-Mandic, American Society of Health Economics (ASHEcon) Biennial Meeting, June 2014.

**Fulton BD**. "California Accountable Care Organizations: Number, Characteristics and State Regulation" with Vishaal Pegany. Accountable Care Organization Workshop. Nicholas C. Petris Center on Health Care Markets and Consumer Welfare. University of California, Berkeley, April 2014.

Shortell SM, **Fulton BD**. "Implementing Health Care Reform in California Lecture Series: A New Vision for California's Healthcare System: Integrated Care with Aligned Financial Incentives," University of California, Berkeley, April 2013.

**Fulton BD**, Connors C. "Berkeley Forum's Vision for California's Healthcare System and Palliative Care Presentation to California HealthCare Foundation Palliative Care Action Community," San Francisco, CA, April 2013.

Shortell SM, Scheffler RM, Bowers LG, **Fulton BD**. “Berkeley Forum for Improving California’s Healthcare Delivery System presentation to Let’s Get Healthy California Task Forces,” Webinar, February 2013.

Shortell SM, Scheffler RM, **Fulton BD**. “Berkeley Forum Collaboration with California’s State Innovation Model,” Sacramento, CA, February 2013.

**Fulton BD**. “Provider Pay for Performance in Global Health: Selected Country Case Studies,” with Richard Scheffler. 7<sup>th</sup> National Pay for Performance Summit, Los Angeles, California, March 2012.

**Fulton BD**. “Framework to Evaluate Policies to Increase Primary Health Workforce Capacity,” California Health Workforce Development Council, Sacramento, California, April 2011.

**Fulton BD**. “Estimates of Sub-Saharan Africa Health Care Professional Shortages in 2015: What Can Be Done at What Cost,” 18th Annual Global Health Education Consortium Conference & 7th Annual Western Regional International Health Conference: Transcending Global Health Barriers: Education & Action, University of Washington, April 2009.

**Fulton BD**. “U.S./Mexico Bi-National Health Insurance,” The Nicholas C. Petris Center Symposium: Health Insurance Reform, University of California, Berkeley, April 2009.

**Fulton BD**. “Financing Binational Health Insurance” Foro Binacional Salud Para Los Migrantes: Propuestas Hacia La Atención Integral (Binational Forum Health for Migrants: Proposals Towards Comprehensive Care), Mexico City, June 2008.

**Fulton BD**. “Linkages Between Health Workforce Mix and Health Outcomes” Panel Discussant, Berkeley Global Health Workforce Conference: From Evidence-Based Research to Policy, University of California, Berkeley, April 2008.

**Fulton BD**. “Reinsurance and Risk Adjustment Programs,” The Nicholas C. Petris Center Symposium: California Health Reform - Progress and Prognosis, University of California, Berkeley, April 2008.

**Fulton BD**. “Implications of Using Reinsurance Programs to Stabilize the Individual Market” California’s Proposed Health Care Reform: The Legal and Economic Implications, University of California, Berkeley, November 2007.

**Fulton BD**. “The Market for ADHD Mediations in California and Globally,” with Richard Scheffler, The Nicholas C. Petris Center Symposium: Implementing Health Reforms in California, University of California, Berkeley, May 2007.

## H. Research Support

Sandler-Bowes support for UCSF Center for Next Generation Precision Diagnosis, July 1, 2015 to June 30, 2017. Role: investigator.

Commonwealth Fund. “Impact of Healthcare Market Consolidation on Health Insurance Premiums: Evidence from the Affordable Care Act’s Health Insurance Marketplaces.” January 1, 2016 to December 31, 2017. Role: investigator and helped write proposal.

California Right Care Initiative. July 1, 2015 to December 31, 2016. Role: investigator.

Centers for Disease Control and Prevention. Natural Experiments of the Impact of Population-Targeted Health Policies to Prevent Diabetes and its Complications (RFA-DP-15-001). “State Innovation Model Initiative Impacts on Diabetes Prevention and Management.” October 1, 2015 to September 30, 2020. Role: investigator and helped write proposal.

Office of the Attorney General, State of California. “Accountable Care Organizations and California Healthcare Markets.” September 1, 2013 to August 31, 2015. Role: investigator and helped write proposal.

Berkeley Forum for Improving California’s Healthcare System. January 1, 2012 to December 31, 2014. Funded by various gifts. Role: investigator and helped write research plan.

Robert Wood Johnson Foundation. “Impact of State Rate Review on Health Insurance Premiums.” April 1, 2012 to September 30, 2014. Grant #69906. Role: investigator and helped write proposal.

Robert Wood Johnson Foundation Investigator Award in Health Policy Research. “ADHD Medication in America: Society, Schools, and Public Policy.” February 2009 to February 2014. Grant #65881. Role: investigator and helped write proposal.

Ambulatory Surgery Center Association. “Medicare Cost Savings Tied to Ambulatory Surgery Centers.” October 1, 2012 to January 31, 2013. Role: investigator and helped write proposal.

California Program on Access to Care, School of Public Health, University of California, Berkeley. “Health Insurance Premium Rate Review: Case Studies to Inform California.” February 2011 to April 2012. Role: investigator and helped write proposal.

Programa de Investigacion en Migracion y Salud (PIMSA), a program administered by Health Initiative of the Americas and California Program on Access to Care, both at University of California, Berkeley. November 2008 to August 2009. Role: investigator and helped write proposal.

California Program on Access to Care, University of California, Berkeley. “Technical Assistance for California Governor’s Office: Reinsurance Modeling.” 2008. Role: investigator and helped write proposal.

California Endowment via UCSF Global Health Sciences. “Binational Health Insurance between the U.S. and Mexico.” 2008. Role: investigator and helped write proposal.

## **I. University Service**

- |                         |  |
|-------------------------|--|
| July 2013 to present    | Faculty Task Force, California Health Benefits Review Program, University of California Office of the President  |
| May 2012 to present     | Admissions Committee, On-Campus/Online Professional Master of Public Health Degree Program, School of Public Health  |
| January 2012 to present | Undergraduate Management Committee, School of Public Health  |
| July 2011 to present    | Associate Director, Nicholas C. Petris Center on Health Care Markets and Consumer Welfare, and Global Center for Health Economics and Policy Research, School of Public Health, University of California, Berkeley |

## **J. Professional Service**

Consultant, The World Bank: “Provider Pay for Performance Programs in Health: Key Factors and Selected Country Case Studies,” 2011, with Richard Scheffler and Cheryl Cashin.

Academic Coordinator and a course faculty member: “Human Resources in Health Labor Markets Course” held at the University of California, Berkeley for one week in August 2010. Course attended by 25 professionals and students from 10 countries. Led the effort to design the curriculum with the course faculty, who were from the University of California-Berkeley, University of California-San Francisco, The World Bank, and World Health Organization.

## **K. Public Service**

Advisor, University Research Corporation (USAID contractor), on developing the request for proposal “Task Shifting for Improvement of Maternal, Newborn and Child Health Services” (RFA #: MNCH2012-001), 2011.

**Testimony Regarding  
Centene Corporation's Proposed Acquisition of Health Net, Inc.**

by

Richard M. Scheffler and Brent D. Fulton<sup>1</sup>

at the

California Department of Insurance

January 22, 2016

## **A. Background of Experts**

### **A.1. Richard M. Scheffler, Ph.D.**

Richard M. Scheffler is Distinguished Professor of Health Economics and Public Policy at the School of Public Health and the Goldman School of Public Policy at the University of California, Berkeley. He also holds the Chair in Healthcare Markets & Consumer Welfare endowed by the Office of the Attorney General for the State of California. Professor Scheffler is the founding director of The Nicholas C. Petris Center on Health Care Markets and Consumer Welfare.

Professor Scheffler has published 200 papers and edited and written twelve books. He has recently completed a longitudinal study and survey of health insurance rate review regulations in all 50 states funded by the Robert Wood Johnson Foundation. Professor Scheffler has also completed a study entitled *Covered California: The Impact of Provider and Health Plan Market Power on Premiums*. He is Co-Chair of the Berkeley Forum for Improving California's Healthcare Delivery System and the lead author of the Berkeley Forum Report "A New Vision for California's Healthcare System: Integrated Care with Aligned Financial Incentives" published in the *California Journal of Politics and Policy*, 2014.

Dr. Scheffler recently testified at the Federal Trade Commission and Department of Justice Meeting: Examining Healthcare Competition in Washington D.C. (February 25, 2015).<sup>2</sup>

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<sup>1</sup> We'd like to thank for Daniel Arnold, a doctoral student in economics at the University of California, for assistance with the analysis in this testimony.

<sup>2</sup> <https://www.ftc.gov/news-events/audio-video/video/examining-health-care-competition-workshop-day-1-part-3>

## **A.2. Brent D. Fulton, Ph.D., MBA**

Brent D. Fulton is an Assistant Adjunct Professor of Health Economics and Public Policy, and Associate Director of the Nicholas C. Petris Center on Health Care Markets and Consumer Welfare, School of Public Health, University of California, Berkeley. Professor Fulton has published over 20 articles in the areas of health insurance, healthcare services and health policy. He recently co-authored articles on how states changed their health insurance rate review authority since the passage of the Affordable Care Act (ACA) (Fulton et al., *Inquiry*, 2015) and how those changes were associated with health insurance premiums in the individual market (Karaca-Mandic et al., *Health Affairs*, 2015). His doctorate is in public policy analysis from Pardee RAND Graduate School and his MBA is from the University of California, Los Angeles.

## **B. The Petris Center**

On June 23, 1999, the Office of the Attorney General for California provided an endowment to Professor Scheffler for the creation of the Nicholas C. Petris Center on Health Care Markets and Consumer Welfare (<http://petris.org/>) at the University of California, Berkeley. The center was named after former California Senator Nicholas Petris, who advocated strongly on behalf of California consumers for affordable, accessible, and quality health care. The Center uses a collaborative strategy to work with students, staff, faculty, and outside experts to analyze health economics and policy topics in California and nationally. The broad research focuses of the Center are: consumer protection, affordability and access to health care – especially for low and middle-income individuals, the role of information in consumer choice, and regulation and competition within health care markets. Recent research topics include healthcare market concentration, the ACA Marketplaces, Accountable Care Organizations, and health insurance rate review.

## C. Overview of Centene Corporation and Health Net, Inc.

This section provides an overview of Centene Corporation and Health Net, Inc., based on these corporations' recent Form 10-Q and 10-K filings with the U.S. Securities and Exchange Commission (SEC).<sup>3</sup>

### C.1. Centene Corporation

Centene Corporation is a publicly traded managed care organization and healthcare specialty services company headquartered in St. Louis, Missouri, with 13,400 employees. It originated in Wisconsin in 1984. Currently, its managed care segment focuses on government subsidized programs, such as Medicaid, Children's Health Insurance Program, Medicare-Medicaid dual eligibles, Supplemental Security Income Program (also known as the Aged, Blind or Disabled Program), and the ACA's Health Insurance Marketplaces. As of September 30, 2015, it had 4.8 million members in 23 states, representing a 24% increase in membership from the previous year. Its largest membership is in Texas (976,500), Florida (486,500) and Georgia (406,700), and it had 183,900 members in California. In the United States overall, most of Centene's members are in Medicaid, totaling 3.5 million. In 2013, Centene formed a subsidiary in California called California Health and Wellness, which serves Medi-Cal beneficiaries under Medi-Cal's Managed Care Rural Expansion program.

Centene's specialty services segment provides healthcare services and products to various customers, including state programs, correctional facilities and employer groups. Centene's California subsidiaries include AcariaHealth Pharmacy #13, AcariaHealth Pharmacy #14, AcariaHealth Pharmacy, Inc., which are specialty pharmacy benefit management companies, and Cenpatco Behavioral Health, LLC, which manages benefits for vulnerable populations specializing in behavioral health, school-based services, specialty therapy and rehabilitation, and community re-entry.

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<sup>3</sup> 10-Q filings for the period ending September 30, 2015 and 10-K filings for the period ending December 31, 2014. Centene Corporation's SEC filings are available at <http://www.centene.com/investors/sec-filings/> and Health Net, Inc.'s are available at <http://investor.health.net/phoenix.zhtml?c=70296&p=irol-irhome>.



Between 2010 and 2014, the company's revenues increased from \$4.4 billion to \$16.6 billion, with net earnings increasing from \$95 million to \$271 million. This growth was largely due to expanding operations into more states and through acquisitions. In 2014, the managed care segment and the specialty services segment respectively accounted for 89% and 11% of its total external premium and services revenues.

### **C.1. Health Net, Inc.**

Health Net, Inc. is a publicly traded managed care organization headquartered in Woodland Hills, California, with 7,922 employees. Its current operations are the result of a 1997 merger between Health Systems International and Foundation Health Corporation; in 2000 it changed its name to Health Net. Currently, it operates under two segments, Western Region Operations and Government Contracts, and serves 6.1 million members across many lines of business, such as the individual and group markets, Medicare Advantage and Medicare Part D, Medicaid, and Medicare-Medicaid dual eligibles. The Western Region Operations segment provides managed care services and health insurance to commercial, Medicare and Medicaid enrollees, and also operates behavioral health and pharmaceutical services subsidiaries. This segment primarily operates in Arizona, California, Oregon and Washington and had 3.3 million members as of September 30, 2015. Of this total, 2.9 million of these members are in California, including 1,777,000 Medi-Cal members, 953,000 commercial members (in the individual, small group, and large group markets), 168,000 Medicare Advantage members, and 24,000 dual eligibles. The Government Contracts segment includes managed care contracts with the U.S. Department of Defense under the TRICARE program.

Between 2010 and 2014, the company's revenues increased from \$13.1 billion to \$14.0 billion, with net earnings decreasing from \$204 million to \$146 million. During this period, premiums from health plans services modestly increased between 2010 and 2013—from \$9.5 billion to \$10.4 billion—but then sharply increased by 29% to \$13.4 billion in 2014, because of the ACA's insurance expansion through Health Insurance Marketplaces and Medicaid. During this period, revenue from government contracts decreased from \$3.3 billion to \$0.6 billion.

## **D. Roadmap**

In this testimony, we plan to discuss the following three points. First, we will briefly summarize the published evidence of the impact of health insurance mergers and market concentration on health insurance premiums. Second, we will provide empirical evidence on how the proposed Centene-Health Net merger will affect health insurance market concentration with respect to purchasers of insurance as well as with respect to hospitals, physician groups and other providers of healthcare services. Third, we will provide empirical evidence on how health insurance market concentration would change in Covered California's rating areas if Health Net were to exit that market. We examine this potential scenario, because of Centene's stronger focus in the Medicaid line of business.

## **E. Impact of Health Insurer Concentration**

Today, the five largest insurers in the U.S. include UnitedHealth Care, Anthem, Cigna, Aetna, and Humana, but soon, these five insurers may merge into three (Armstrong & Kishan, 2015). In July 2015, Anthem announced its intentions to acquire Cigna for \$54 billion, and Aetna announced its intentions to acquire Humana for \$37 billion. Also in July 2015, Centene announced plans to acquire Health Net for \$7 billion. These mergers require the approval of the U.S. Department of Justice as well the Commissioners of Insurance in states impacted by these mergers.

Two recent studies found that higher health insurer concentration was associated with lower hospital prices, but they did not analyze the impact on premiums (Melnick, Shen, & Wu, 2011; Moriya, Vogt, & Gaynor, 2010). However, even if insurers are able to negotiate lower provider reimbursement rates, there is substantial evidence that those cost savings might not be passed on to employers and consumers in the form of lower health insurance premiums (Balto, 2015; Dafny, 2015; Gaynor, Ho, & Town, 2015; Guardado, Emmons, & Kane, 2013). A pre-ACA study examined firms' profitability (i.e., profitability of employers buying insurance) and found that more concentrated health insurer markets led to higher premiums for more profitable firms, providing evidence of insurers exercising their market power (Dafny, 2010). A

second pre-ACA study used the impact of the 1999 Aetna and Prudential Healthcare insurance merger to estimate that health insurer consolidation during 1998 to 2006 led to a 7% real increase in large group health insurance premiums (Dafny, Duggan, & Ramanarayanan, 2012).

There have been fewer studies since the passage of the ACA, particularly those that have analyzed ACA Health Insurance Marketplaces. One study estimated that the second-lowest-price silver premium in the federally facilitated Marketplaces would have been 5.4% lower had UnitedHealthcare decided to participate in these markets during the first open enrollment in 2014 (Dafny, Gruber, & Ody, 2015).

## **F. Impact of Centene-Health Net Merger on Market Concentration**

In this section, we provide empirical evidence on how the proposed Centene-Health Net merger will affect health insurance market concentration with respect to purchasers of insurance as well as with respect to hospitals, physician groups and other providers of healthcare services. On the one hand, when an insurer sells its health insurance policies to purchasers, such as individuals and employers, its market power stems from its market share within a particular line of business. However, as a buyer of hospital and physician organization services, an insurer's market power from those transactions stem from its full book of business, including the individual, small group, large group (as an insurer or as administrative services only), Medicare Advantage, and Medicaid managed care.

Health Net and Centene operate in separate lines of business in the counties where they both operate. As such, HHIs by product line, which affects purchasers of insurance, will not increase from the two companies merging.

With respect to hospitals, physician groups and other providers of health care services, an insurer's market power comes from its full book of business. When computing HHIs from insurers' full books of business enrollment, HHIs will increase post-merger in counties where Health Net and Centene overlap. Health Net insures over 2.9 million people in California. Health Net's enrollees are spread out across all 58 California counties in commercial, Medicare Advantage, and Medi-Cal plans. Centene's California enrollment includes 183,900 Medi-Cal

enrollees located in 19 California counties.<sup>4</sup> As such, there are 19 counties in California in which both Health Net and Centene are currently operating. The HHIs calculated from insurers' full books of business in these 19 counties are discussed next.

We started by measuring health insurer market concentration (as of July 1, 2015) in the 19 counties where Health Net and Centene overlap. We used the well-known Herfindahl-Hirschman Index (HHI) as our measure of market concentration. HHI has been used frequently as a measure of market concentration in merger cases brought by the U.S. Department of Justice (DOJ) and Federal Trade Commission (FTC). The Horizontal Merger Guidelines, authored by the DOJ and FTC, categorize markets by HHI as: unconcentrated (below 1,500), moderately concentrated (between 1,500 and 2,500), and highly concentrated (above 2,500) (U.S. Department of Justice and the Federal Trade Commission, 2010).

We used insurer county-level enrollment shares as the market share for the HHIs presented in Exhibit 1 (see Section J: Appendix).<sup>5</sup> These enrollment shares account for enrollment across all lines of business.<sup>6</sup> The HHIs for the 19 counties we examine range from 1,600 to 3,496 with 14 of the counties at HHIs above the Horizontal Mergers Guidelines' highly concentrated market threshold of 2,500. Given the level of the HHIs in Exhibit 1, Health Net and Centene overlap in markets that are highly concentrated. Future consolidation in markets that are already highly concentrated is generally concerning.

Exhibit 1 also presents post-merger HHIs in the 19 counties where Health Net and Centene overlap. Post-merger HHIs were calculated similarly to the current HHIs, except that Health Net and Centene enrollments were combined in order to create Health Net-Centene county-level market shares as opposed to using separate shares for the two companies. The point increases between current HHIs and post-merger HHIs range from 6 to 77 across counties. The largest point increase occurs in Nevada County, where HHI increases by 3% from 2,613 to 2,690.

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<sup>4</sup> Alpine, Amador, Butte, Calaveras, Colusa, El Dorado, Glenn, Imperial, Inyo, Mariposa, Mono, Nevada, Placer, Plumas, Sierra, Sutter, Tehama, Tuolumne

<sup>5</sup> County-level enrollment shares were computed from the enrollment data in Decision Resources Group's Managed Care Surveyor (formerly HealthLeaders-Interstudy).  
<https://decisionresourcesgroup.com/report/?id=1730>

<sup>6</sup> Includes Medicare Advantage, Medi-Cal, commercial, individual, and TRICARE enrollment.

There are a few limitations to our analysis that should be pointed out. First, using counties to define geographic markets has been common in research studies, but whether or not counties are the proper geographic market definition has been the subject of much debate (Baker, 2007; Frech, Langenfeld, & McCluer, 2004; Gaynor, Kleiner, & Vogt, 2013). Because we lack patient-level data, it was not possible to define each insurer market using the Elzinga-Hogarty and Critical Loss Analysis methods that rely on patient flows.

In sum, we consider the HHI point increases from a Health Net-Centene merger to be modest at best. However, as Health Net and Centene overlap in rural counties that are already highly concentrated, any increases in market concentration are potentially concerning to the competitive nature between insurers and providers.<sup>7</sup> The impact could be greater if Centene's county market shares grow significantly post-acquisition.

## **G. Analysis of Health Net Exiting Covered California**

Covered California is the ACA Marketplace for California. Participating health insurers can offer individual and SHOP coverage through the Marketplace. As of June 2015, total Covered California enrollment is 1.3 million. Of these 1.3 million, 221,140 (16.9%) are enrolled in a Health Net plan, making Health Net the 4<sup>th</sup> largest insurer (by enrollment) in Covered California. In 2015, Health Net offered coverage in 13 of the 19 geographic rating areas of Covered California.<sup>8</sup> In 2016, Health Net will begin offering coverage in rating areas 1, 3, and 11. Exhibit 2 lists Health Net's enrollment by rating area. The majority of Health Net's Covered California enrollment is in Southern California.

In this section, we analyze the scenario of Health Net exiting Covered California. As of September 2015, Centene's total U.S. enrollment is 4.8 million. Of these 4.8 million enrollees, 3.5 million are enrolled in a Medicaid plan, making Medicaid Centene's primary line of business. Given this, it is possible that Health Net's 1.8 million Medi-Cal enrollees are the part of Health Net's California enrollment that are of most interest to Centene. This section is about posing the question: what would be the impact of Centene focusing on Medi-Cal and deciding to have

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<sup>7</sup> We do not have data on provider concentration in these 19 counties.

<sup>8</sup> See Section J: Appendix, Exhibit 3 for a map of the geographic rating areas.

Health Net exit California's commercial insurance market. We address this question in the context of Covered California.

Again, we compute HHI measures of market concentration. First, we compute HHIs at the rating area-level as opposed to the county-level. As such, we use rating area enrollment shares for our HHI calculations. Second, the rating area enrollment shares are specific to Covered California enrollment; no enrollment from other lines of business is included.

Exhibit 2 (see Section J: Appendix) presents the results of our calculations. Current HHIs and post-Health Net HHIs are computed. Current HHIs use insurer rating area-level market shares as of June 2015. Post-Health Net HHIs remove Health Net from the set of insurers. We assume the other insurers participating in a rating area will pick up Health Net's enrollment in proportion to their current enrollment shares in the rating area.

We find that a Health Net exit from Covered California would increase health insurer HHIs between 43 and 1,202 points over Covered California's 19 rating areas. Notably, the increases are significantly larger in Southern California rating areas (two Los Angeles rating areas (15 & 16), Inland Empire, Orange County, San Diego) than the rest of the state. The mean HHI point increase for the Southern California rating areas is 731 points, while the mean HHI point increase for the other rating areas in which Health Net currently participates is 86 points. In fact, in three Southern California rating areas (Los Angeles (16), Inland Empire, San Diego) health insurer HHIs would cross over the Horizontal Merger Guidelines highly concentrated market threshold of 2,500 should Health Net exit Covered California.

In sum, we find a Health Net exit from Covered California may have a measureable and significant impact on the competitiveness of the Southern California rating areas, but would have little to no impact on the rest of the rating areas in Covered California.

## H. Summary

As health insurance markets become more concentrated, the evidence suggests that health insurance premiums increase. Centene Corporation and Health Net, Inc. managed care operations overlap in 19 California counties; however, they are in distinct lines of business. In those 19 counties, Centene manages Medi-Cal lives and Health Net manages commercial lives. Therefore, market concentration would not increase with respect to purchasers in particular lines of business, such as Covered California, the individual market, and the employer-sponsored market.

But more importantly, with respect to purchasing health care services, such as from physicians and hospitals, the merger will modestly increase insurer market concentration in these 19 California counties. A merged entity may be able to negotiate lower rates from physician organizations and hospitals; however, the evidence suggests those cost savings might not be passed on to purchasers of insurance.

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## J. Appendix

**Exhibit 1:** Pre- and post-merger Herfindahl-Hirschman Indices (HHI) for the counties in which both Health Net and Centene operate

County	Population Estimate <sup>9</sup> (as of 1/1/15)	HHI (as of 7/1/15)	Post-merger HHI	HHI Point Increase	HHI Percent Increase
Alpine	1,121	2,975	3,016	42	1.4%
Amador	36,312	2,684	2,689	6	0.2%
Butte	224,323	3,431	3,451	20	0.6%
Calaveras	45,668	2,113	2,158	45	2.1%
Colusa	21,715	3,209	3,238	30	0.9%
El Dorado	184,917	1,600	1,665	65	4.0%
Glenn	28,728	2,801	2,828	27	1.0%
Imperial	183,429	2,611	2,632	21	0.8%
Inyo	18,574	2,609	2,622	13	0.5%
Mariposa	17,791	2,512	2,518	6	0.2%
Mono	14,695	3,403	3,413	11	0.3%
Nevada	98,193	2,613	2,690	77	3.0%
Placer	369,454	2,120	2,141	21	1.0%
Plumas	19,560	2,555	2,574	18	0.7%
Sierra	3,105	2,881	2,902	21	0.7%
Sutter	95,948	3,496	3,517	21	0.6%
Tehama	64,323	3,147	3,171	25	0.8%
Tuolumne	54,337	2,591	2,619	28	1.1%
Yuba	74,076	3,186	3,201	15	0.5%

Notes: The HHIs were computed using county-level enrollment shares. Enrollment includes employer-sponsored insurance (fully-insured and self-insured), Medicare Advantage, Medicaid managed care, ACA Marketplace coverage (individual and SHOP), and Tricare. Enrollment data comes from Decision Resources Group's Managed Market Surveyor (formerly HealthLeaders-Interstudy).<sup>10</sup>

<sup>9</sup> California Department of Finance. <http://www.dof.ca.gov/research/demographic/reports/estimates/e-1/view.php>

<sup>10</sup> <https://decisionresourcesgroup.com/report/?id=1730>

**Exhibit 2: Market Concentration Impact of Health Net Exiting Covered California**  
(as of June 2015)

*Enrollment Source:* Covered California. June 2015 Profile.

Available at <http://hbex.coveredca.com/data-research/>.

Rating Area (number-name)	Health Net Enrollees	Health Net Market Share	Current Health Plan HHI	Health Plan HHI if Health Net exits	HHI point increase from Health Net exit	HHI percentage increase from Health Net exit
2 – North Bay Counties	340	0.7%	3,488	3,537	49	1%
4 – San Francisco	460	1.3%	2,666	2,735	69	3%
5 – Contra Costa County	230	0.6%	4,664	4,720	56	1%
7 – Santa Clara County	870	1.5%	3,734	3,846	112	3%
8 – San Mateo County	350	1.4%	3,627	3,729	102	3%
9 – Monterey Coast	350	1.2%	5,233	5,359	126	2%
10 – San Joaquin Valley	220	0.4%	5,403	5,446	43	1%
14 – Kern County	270	1.6%	3,947	4,074	127	3%
15 – Los Angeles County, partial	57,430	36.5%	2,834	3,723	890	31%
16 – Los Angeles County, partial	65,000	32.9%	2,277	2,653	376	17%
17 – Inland Empire	32,230	27.7%	2,297	2,927	630	27%
18 – Orange County	33,850	26.6%	2,938	4,140	1,202	41%
19 – San Diego County	29,540	24.5%	2,132	2,688	555	26%
Statewide	221,140	16.9%				

Notes: Enrollment is exclusively Covered California enrollment. The market shares presented above for Health Net (and those of other insurers used for the HHI calculations) are based on Covered California specific market shares in a rating area. The HHIs based on the scenario of Health Net exiting assume Health Net's rating area enrollment is absorbed by the other insurers participating in the rating area in proportion to current enrollment shares in the rating area. For example, if current enrollment shares in a rating area are as followed: Health Net 25%, Blue Shield 25%, and Anthem 50%, then Anthem would pick up two times the enrollment that Blue Shield picks up such that post-Health Net market shares are Blue Shield 33.3% and Anthem 66.7%.

### Exhibit 3: Covered California's 19 Rating Areas (Pricing Regions)

Source: Covered California. Health Insurance Companies and Plan Rates for 2015. July 31, 2014. Available at <https://www.coveredca.com/PDFs/CC-health-plans-booklet-2015.pdf>.



**TESTIMONY OF LEEMORE S. DAFNY, Ph.D**

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**Before the**

**Senate Committee on the Judiciary**

**Subcommittee on Antitrust, Competition Policy, and Consumer Rights**

**On**

**“Health Insurance Industry Consolidation:  
What Do We Know From the Past, Is It Relevant in Light of the ACA, and  
What Should We Ask?”**

**September 22, 2015**

## Summary

Nearly two-thirds of the U.S. population under age 65 is enrolled in a private, comprehensive health insurance plan.<sup>1</sup> The private health insurance industry is also playing an increasingly important role in supplying coverage to enrollees in public insurance programs. The public interest in a competitive, robust marketplace has never been greater. Not only are private insurance premiums (\$16,834 for the average family) and out of pocket spending (\$800 per person)<sup>2</sup> high and projected to grow, but the individual health insurance mandate now requires those without public coverage to purchase private policies. Federal subsidies for the purchase of private insurance through the health insurance marketplaces are projected to total \$32 billion in 2015, and \$84 billion by 2020.<sup>3</sup> Given these stakes, there is a substantial public benefit to critically evaluating any significant changes in industry market structure.

There are two primary and complementary ways to assess the impact of consolidation: backward-looking (what has happened in the past?) and forward-looking (what is different, if anything, and how might those differences alter predictions based on the past?). This testimony addresses both. First, I review economic studies on the impact of insurance consolidation on premiums and other outcomes of potential interest to consumers. These studies suggest that consolidation leads to premium increases. This is true notwithstanding the growing body of research that finds insurers with larger local market shares pay lower rates to healthcare providers, particularly hospitals.<sup>4</sup> As I discuss below, lower provider rates can, under certain circumstances, also harm consumers directly. The evidence on the link between insurance market concentration and health plan quality is sparse, but at least one study suggests benefit generosity declines with fewer competitors.<sup>5</sup>

In sum, economic research demonstrates that insurance industry consolidation in the past has not tended to improve the lot of consumers. Any individual proposed merger may have different

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<sup>1</sup> National Center for Health Statistics, "Early Release of Selected Estimates Based on Data From the National Health Interview Survey, 2014," Table 1.2b, *available at* <http://www.cdc.gov/nchs/data/nhis/earlyrelease/earlyrelease201506.pdf>.

<sup>2</sup> Kaiser Family Foundation and Health Research & Educational Trust, *2014 Survey of Employer Health Benefits*, *available at* <http://kff.org/health-costs/report/2014-employer-health-benefits-survey>; Health Cost Institute, *2013 Health Care Cost and Utilization Report*, *available at* <http://www.healthcostinstitute.org/2013-health-care-cost-and-utilization-report>.

<sup>3</sup> Congressional Budget Office, *Insurance Coverage Provisions of the Affordable Care Act—CBO's March 2015 Baseline*, March 2015, *available at* <https://www.cbo.gov/sites/default/files/cbofiles/attachments/43900-2015-03-ACAtables.pdf>.

<sup>4</sup> I discuss the evidence on this point below.

<sup>5</sup> Robert Town and Su Liu, "The Welfare Impact of Medicare HMOs," *RAND Journal of Economics* (2003): 719-736.

effects and should be evaluated on its own potential merits, however these merits should be assessed with the context provided by this academic, refereed body of literature.<sup>6</sup>

Proponents of continued industry consolidation have introduced two primary arguments for why the existing research is not prescriptive in the post-ACA era. The first is that the Medical Loss Ratio (MLR) regulation<sup>7</sup> prevents merging insurers from reaping profits that might otherwise be possible as a result of a post-merger increase in market power. Essentially, this amounts to a claim that the MLR regulation provides a substitute for competition. There are a number of reasons to doubt this supposition. Chief among them: the MLR regulation does not pertain to the majority of privately-insured Americans, who are enrolled in self-insured plans (which are exempt from the regulation)<sup>8</sup>; it does not adequately address non-price competition; it is likely “gameable”; and the legislated minima may be below prevailing MLRs in certain markets and have no impact at all.

The second argument is subtle, and embraced to a greater extent by economists than industry: insurers with larger local market share have stronger incentive to invest in changing the healthcare delivery system through payment innovations because they can reap more of the rewards from their local investments. At the same time, providers can spread their costs of collaborating on these innovations across more lives. Although this argument has merit, there is also an important countervailing effect of size. An insurer with stronger market power has less of an incentive to invest in new products as it “replaces itself” in the market, i.e. there is less potential to “steal business” from rivals. In addition, there is no research showing that larger insurers are likelier to innovate.

In sum, I see no reason the evidence from the past should be discounted when evaluating current and future consolidation. I would also caution that consolidation that occurs now is unlikely to be undone if it later proves anticompetitive. History also suggests that vigorous competition by new entrants is unlikely to arise and offset such effects.

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<sup>6</sup> As the Horizontal Merger Guidelines state, merger analysis “is a fact-specific process.” U.S. Department of Justice and Federal Trade Commission, *Horizontal Merger Guidelines*, 2010, available at <http://www.ftc.gov/os/2010/08/100819hmg.pdf>.

<sup>7</sup> The ACA requires health insurers to maintain an MLR, defined as the proportion of premium revenues spent on clinical services and quality improvement, above 80% for fully-insured individual and small group plans and 85% for fully-insured large group plans. An insurer falling short of these minima must provide rebates to policyholders such that the MLR meets the prescribed level. See, e.g., Center for Consumer Information & Insurance Oversight, “Medical Loss Ratio: Getting Your Money’s Worth on Health Insurance,” Dec. 2, 2011, available at <https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/mlrfinalrule.html>.

<sup>8</sup> Approximately 54% of privately insured Americans are exempt from MLR requirements. (This figure is derived as the product of the share of privately insured Americans with employer-sponsored coverage—88 percent—and the share of covered workers enrolled a plan that is completely or partially self-funded—61 percent.) Kaiser Family Foundation and Health Research & Educational Trust, *2014 Survey of Employer Health Benefits*, available at <http://kff.org/health-costs/report/2014-employer-health-benefits-survey>. Kaiser Family Foundation, “Health Insurance Coverage of the Total Population,” 2015, accessed Sep. 9, 2015, <http://kff.org/other/state-indicator/total-population>.

My testimony concludes with a call for sunshine. It is unlikely that consolidation is “inherently bad” or “inherently good”; we need research that reveals how to protect against harms and unlock benefits. Current and historical data on various aspects of commercial health insurance (e.g., enrollment and costs) at a disaggregated level (e.g., by specific health plan, customer segment, and sub-state geographic market, such as the MSA) would enable research that would help us to understand whether and where consolidation is harmful or beneficial, and for whom. While such transparency is rare in many private industries, it is common where there is a strong public interest and substantial public regulation, both of which characterize this vital sector.

## **1. Concentration in the Health Insurance Industry Is High and Growing**

### *1.1 Private Health Insurance Plans*

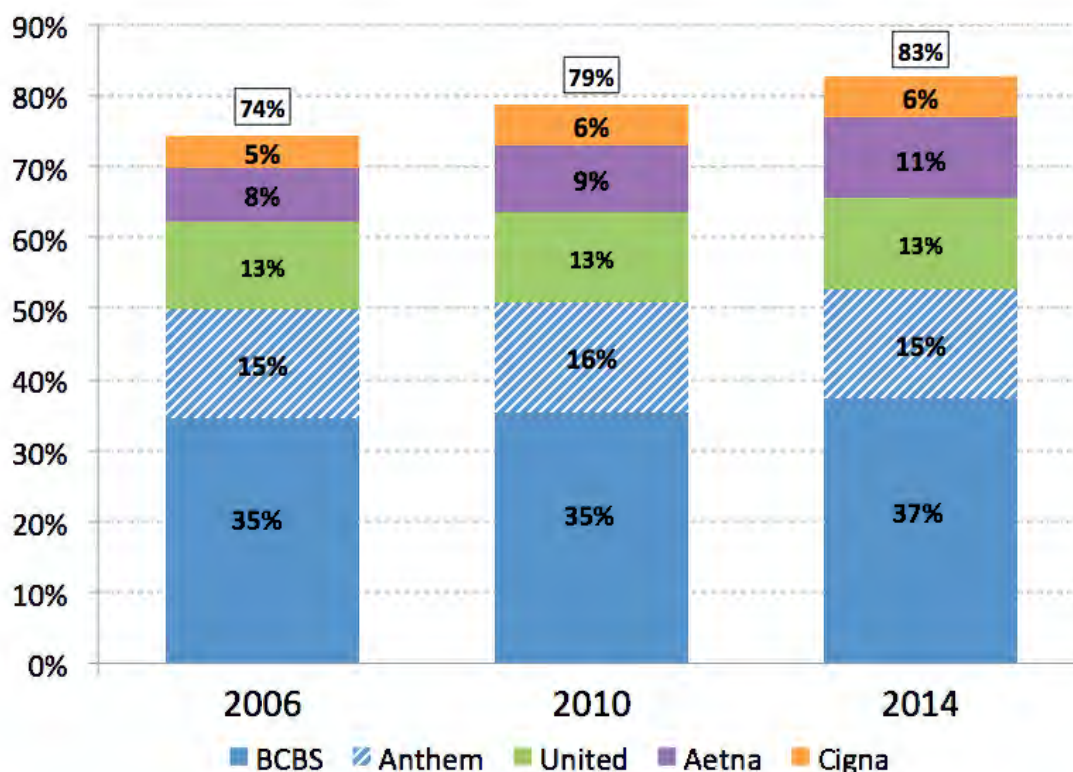
Roughly 175 million Americans under age 65 purchased private insurance through their employers or via the individual insurance market in 2013, the most recent year for which data are available.<sup>9</sup> The industry has expanded since the introduction of the health insurance marketplaces in 2014.

Figure 1 contains my rough estimates of the national market share of the four largest insurers over the period 2006–2014. For most customers – national multisite employers being the primary exception – insurance markets are local, but these share estimates provide context for the changing landscape. In the figure, all 36 Blue Cross and Blue Shield (BCBS) companies are grouped together. With a few exceptions, BCBS affiliates have exclusive, non-overlapping market territories, and hence do not compete with one another. Shares for Anthem, Inc., the for-profit insurer (previously known as Wellpoint) that today operates BCBS plans in 14 states, are denoted separately.

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<sup>9</sup> Per the U.S. Census Bureau’s 2013 Current Population Survey (CPS) Annual Social and Economic (ASEC) Supplement, Table HI01, available at [https://www.census.gov/hhes/www/cpstables/032014/health/h01R\\_000.htm](https://www.census.gov/hhes/www/cpstables/032014/health/h01R_000.htm).



**Figure 1. Estimated National Market Shares of 4 Largest Insurers, 2002–2014<sup>10</sup>**

The national four-firm concentration ratio (the sum of the leading four firms in terms of market share) for the sale of private insurance increased significantly between 2006 and 2014, from 74 to 83 percent. As a point of comparison, the four-firm concentration ratio for airlines is 62 percent.<sup>11</sup> BCBS affiliates collectively account for over half of privately-insured lives today, a position they have held throughout this period (following growth during the first half of the 2000s, not pictured). The figure also reflects some of the more significant mergers among non-BCBS insurers in recent history, including the acquisition of Coventry by Aetna (in 2013).

<sup>10</sup> Figure 1 is constructed using the number of privately-insured lives reported in each insurer's annual reports. Consistency over time and across insurers in terms of products included is not assured. BCBS share (exclusive of Anthem) is estimated using enrollments reported by BCBS for 2010 and 2014, and extrapolating back to 2006 by applying the growth rate in BCBS enrollments from data supplied by the National Association of Insurance Commissioners (NAIC), and corrected for states not reporting or underreporting BCBS enrollment. The BCBS association reports total enrollment of 100 million in 2010 and 106 million in 2014 and may include non-comprehensive insurance. Unfortunately, NAIC reflects only fully-insured plans outside of California, whereas Figure 1 includes both full and self-insurance for all states. Anthem operates BCBS affiliates in CO, CT, KY, ME, NH, NV, OH, VA, IN, GA, MI, WA, CA, and NY. National market size in each year is the number of privately-insured lives, as estimated from the Current Population Survey. Current Population Survey, "Total people with private health insurance," 2002–2013, available at <http://www.census.gov/cps/data/cpstablescreator.html>.

<sup>11</sup> U.S. Department of Transportation Bureau of Transportation Statistics, "Airline Domestic Market Share July 2014–June 2015," available at <http://www.transtats.bts.gov/>.

Figure 1 does not necessarily reflect the degree of concentration in insurance markets that are relevant to most consumers. Commercial health plans are generally offered and priced differently for each customer segment (e.g., individual, small group, large group-fully insured, large group-self-insured – and perhaps others) in different geographic areas. These areas are generally smaller than the state (e.g., metropolitan and/or micropolitan statistical areas or ratings areas as defined for the state health insurance marketplaces).<sup>12</sup> There are many health plans with a significant local, but not a national, presence – Kaiser, Intermountain, and Geisinger among them. The degree of competition in any product and geographic market depends on the relevant market participants (current and potential), and on the characteristics of the plans they offer (or might offer).

The American Medical Association publishes an annual report containing commercial insurance market shares for the top 2 insurers, as well as corresponding market Herfindahl index (HHI), in 388 metropolitan statistical areas (MSAs). These reports show that concentration is generally higher within local markets than in the nation as a whole: the median population-weighted *two-firm* concentration ratio for 2012 is 0.65. Concentration within MSAs also appears<sup>13</sup> to be increasing over time. The median HHI increased from 1,716 in 2001 to 2,973 in 2012, well in excess of the threshold for “highly concentrated” (2,500) per the *Horizontal Merger Guidelines* issued jointly by the Department of Justice and the Federal Trade Commission.<sup>14</sup>

### 1.2 Medicare Advantage

There are nearly 22 million Medicare beneficiaries enrolled in Medicare Advantage plans of various kinds.

Figure 2 presents the market shares of the four leading providers of Medicare Advantage plans in from 2007 to 2015. Again, these shares are provided for context and may not reflect market structure at the local level at which Medicare beneficiaries make plan selections. The four-firm concentration ratio increased markedly between 2011 and 2015, rising from 48 to 61 percent. The Medicare Advantage market has experienced significantly more turbulence than the private insurance sector, owing to myriad changes in regulations and reimbursement rules.<sup>15</sup> The

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<sup>12</sup> For example, plans offered on the Health Insurance Marketplaces are priced at the rating area level. Rating areas are defined as one or more counties and are generally smaller than MSAs. See, e.g., Kaiser Family Foundation, “Medicare Advantage,” Jun. 29, 2015, accessed Sep. 9, 2015, <http://kff.org/medicare/fact-sheet/medicare-advantage>. CMS Center for Consumer Information and Consumer Oversight, “Market Rating Reforms,” May 28, 2014, accessed Sep. 9, 2015, <https://www.cms.gov/ccio/programs-and-initiatives/health-insurance-market-reforms/state-gra.html>.

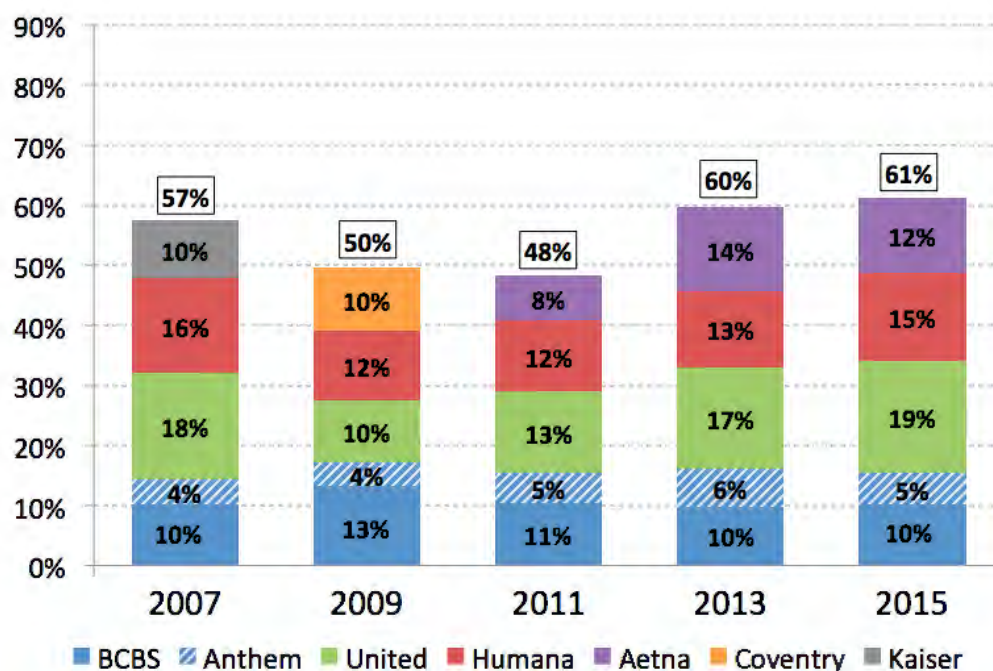
<sup>13</sup> The AMA reports are not strictly comparable over time due to changes in the number of MSAs included, and the inclusion of self-insured lives. The figures for 2012 include self-insured lives.

<sup>14</sup> U.S. Department of Justice and Federal Trade Commission, *Horizontal Merger Guidelines*, 2010, available at <http://www.ftc.gov/os/2010/08/100819hmg.pdf>.

<sup>15</sup> Total enrollment in Medicare Advantage has increased significantly over this period, from 9.3 million in 2007 to 22 million in 2015. Duggan, Starc and Vabson (2014) show that reimbursement is strongly linked to entry. They

national market leaders for Medicare Advantage are a bit different from those in the private insurance market (in Figure 1), although they are the same as the market leaders in the fully-insured segment of private insurance.<sup>16</sup>

**Figure 2. Medicare Advantage 4-firm Concentration Ratio, 2007–2015<sup>17</sup>**



Most of the research on insurance consolidation utilizes data from private insurance plans, hence my testimony focuses on this set of customers. Although Medicare Advantage and other health insurance products such as Medicaid Managed Care plans are clearly different – e.g., they face different regulatory requirements, and different challenges with regard to assembling provider networks and negotiating competitive provider rates – the insights from private insurance markets are clearly relevant in light of the similarities in the “production process” for insurance, as evidenced by the significant overlap in the suppliers across the different market types.

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estimate that for every dollar of additional reimbursement from the Medicare program, 20 cents is passed through to enrollees in the form of better coverage. Mark Duggan, Amanda Starc, and Boris Vabson, “Who Benefits When the Government Pays More? Pass-through in the Medicare Advantage Program,” No. w19989, National Bureau of Economic Research, 2014.

<sup>16</sup> In 2013, these are United (14 percent), Anthem (11 percent), Aetna (7 percent) and Humana (4 percent). Source: 2013 CCHIO MLR data, available at <https://www.cms.gov/CCIIO/Resources/Data-Resources/mlr.html>.

<sup>17</sup> Source: Centers for Medicare and Medicaid Services, Medicare Advantage Enrollment Data, 2007–2015, available at <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDENrolData/index.html>.

### 1.3 Drivers of Industry Consolidation

Industry consolidation arises from two sources: structural (i.e., entry, exit, and mergers), and non-structural (i.e., growth or decline of incumbent firms). There is little research on the relative contribution of each to rising concentration.<sup>18</sup> Most of the structural change has been driven by mergers, and the most significant non-structural development appears to be the growth in the market shares of the various BCBS affiliates.<sup>19</sup>

Insurance mergers over the past 20 years can be characterized by four phenomena: (1) attempts by regional insurers to gain broader service areas; (2) attempts by national insurers to obtain a presence in virtually all geographies; (3) acquisitions of local HMOs and provider-sponsored plans by incumbents; (4) consolidation of for-profit BCBS affiliates (into Anthem). Reported motivations include a desire to achieve economies of scale in administration, sales, and marketing; to achieve economies of scale (more lives) and scope (more product lines) with respect to pioneering novel care management and shared savings programs; to strengthen the insurer's negotiating position vis a vis providers (who are themselves growing more concentrated); and to diversify across revenue sources (e.g., government and non-government-insured lives). It is possible that the most recent merger wave is a "contagion" ignited by the announcement of some large acquisitions; to the extent that an insurer is contemplating a merger, learning of other suitors is a motivator to act quickly.

Some have posited that recent or proposed insurance mergers are the result of the Affordable Care Act (ACA). However, the figures above reveal consolidation was well underway before the ACA was passed. It is worth noting that, to the extent such consolidation is anticompetitive, it is at cross-purposes with the Act. As Professor Thomas Greaney recently observed in testimony before the House Subcommittee on Regulatory Reform, Commercial and Antitrust Law, the ACA "does not regulate prices for commercial health insurance or prices in the hospital, physician, pharmaceutical, or medical device markets. Instead the law relies on (1) competitive bargaining *between* payers and providers and (2) rivalry *within* each sector to drive price and quality to levels that best serve the public."<sup>20</sup>

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<sup>18</sup> Scanlon et al. (2005) find that non-structural fluctuations in enrollment accounted for more than one-third of the change in MSA-level HHI between 1998 and 2002. Scanlon, Chernew, Swaminatham, and Lee, "Competition in Health Insurance Markets: Limitations of Current Measures for Policy Analysis," *Medical Care Research and Review*, Vol. 63 No. 6, (Supplement to December 2006) 37S-55S. The insurer HHI data pertain only to HMOs.

<sup>19</sup> This growth precedes the period depicted in Figure 1. Per Ginsburg (2005), "the relative position of the Blues strengthened with the loosening of managed care because of the diminishing importance of HMOs, which were generally a weak point for the Blues. Blue plans' ability to negotiate lower rates with providers on the basis of their large market share became more important." Paul Ginsburg, "Competition in Health Care: Its Evolution Over the Past Decade," *Health Affairs* 24.6 (2005): 1512–1522.

<sup>20</sup> Thomas L. Greaney, "The State of Competition in the Health Care Marketplace: The Patient Protection and Affordable Care Act's Impact on Competition," United States House of Representatives Committee on the

In fact, the Act *promotes* competition in the insurance industry in several ways, including via regulatory reforms (e.g., product standardization and plan certification, which reduce the hurdle to entry posed by the need to establish a credible reputation) and via the health insurance marketplaces (which reduce marketing and sales costs, thereby raising the likelihood of entry). The Health Insurance Marketplaces were explicitly designed to facilitate competition among insurers. The notion that the ACA's MLR regulations, which place a floor on the share of premiums devoted to medical spending and quality improvement activities, provoke consolidation is inconsistent with profit-maximizing behavior. To the extent that scale reduces administrative costs, insurers would have benefited from such reductions in the absence of the regulation.

Even if the ACA *inadvertently* provoked consolidation – perhaps because of a surge of investor interest in growing private insurance markets, and the thirst for higher company valuations – the question before the committee today is whether this phenomenon is likely to be beneficial to consumers. To answer it, I begin by summarizing the empirical evidence on the effects of insurance consolidation.

## 2. What have we learned from the past?

*2.1 If past is prologue, insurance consolidation will tend to lead to lower payments to healthcare providers, but those lower payments will not be passed on to consumers. On the contrary, consumers can expect higher insurance premiums.*

### 2.1.1 Effects of consolidation on healthcare provider prices and health plan quality

Several health economists have studied the correlation between insurance market structure, typically measured by insurer HHI at the MSA level, and hospital prices.<sup>21</sup> Using different data sources and time periods, these studies generally find hospital prices are lower in areas with higher insurance HHIs (typically measured at the MSA level). This relationship also holds when

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Judiciary, Subcommittee on Regulatory Reform, Commercial and Antitrust Law, Sep. 10, 2015, available at <http://judiciary.house.gov/cache/files/0a0e88c8-0519-4a47-8fa8-4c2233c760c3/greaney-testimony.pdf>.

<sup>21</sup> Glenn A. Melnick et al., "The Increased Concentration of Health Plan Markets Can Benefit Consumers through Lower Hospital Prices," *Health Affairs*, 30, no. 9 (2011): 1728–1733; Asako S. Moriya, William B. Vogt, and Martin Gaynor, "Hospital Prices and Market Structure in the Hospital and Insurance Industries," *Health Economics, Policy and Law* 5.04 (2010): 459–479.; and Erin E. Trish, and Bradley J. Herring, "How do Health Insurer Market Concentration and Bargaining Power with Hospitals Affect Health Insurance Premiums?" *Journal of Health Economics*, 42 (2015): 104–114. All three rely on estimates of insurer HHI calculated from InterStudy data. Melnick et al. find that hospital prices in 2001–2004 are lower in MSAs with higher insurer HHI, provided the insurer HHI exceeds 3,200. Moriya et al. find that increases in MSA-level insurer HHI between 2001 and 2003 are associated with decreases in hospital prices. Trish and Herring use more recent data (from 2006–2011) and find that hospital prices are lower among more concentrated insurance markets.

researchers study *changes* over time, i.e., areas experiencing faster growth in insurer HHI exhibit slower growth in hospital prices.

Lower prices for healthcare services will only benefit consumers if – and only if – they are ultimately passed through to consumers in the form of lower insurance premiums (and/or out-of-pocket charges); I discuss the lack of evidence for this pass-through below. However, it is worth noting that even if price reductions are in fact realized *and* passed through, if they are achieved as a result of monopsonization of healthcare service markets then consumers may experience an offsetting harm. Monopsony is the mirror image of monopoly; lower input prices are achieved by reducing the quantity or quality of services below the level that is socially optimal.<sup>22</sup>

There are a handful of studies that directly study monopsony. One study (of which I am a coauthor) finds such evidence in the wake of the Aetna and Prudential merger of 1999.<sup>23</sup> Post-acquisition, the combined entity covered 21 million lives. In the three-year period following the merger, we found relative reduction in healthcare employment and wages in those geographic areas where the two parties had more substantial pre-merger overlap. The implication is that the exercise of market power vis-a-vis healthcare providers reduced price *and* output – the hallmark of monopsony. Indeed, the DOJ had required Aetna and Prudential to divest health plans in two Texas markets before closing precisely because of concerns over post-merger monopsony power. This remedy proved effective: we found no evidence of monopsony in these markets following the merger.<sup>24</sup>

Whether monopsony is likely in the face of consolidation depends on the provider market in question. The textbook monopsony scenario described above pertains when there is a large buyer and fragmented suppliers, as is the case for physicians in some specialties within a given geographic area negotiating with dominant insurers. However, in settings where both sides possess market power and they bargain over prices, an increase in buyer power can reduce price without reducing output (or, equivalently, without leading to a deterioration in quality). Indeed, two other studies of monopsony focus on hospitals – an industry that is concentrated in many

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<sup>22</sup> The way in which a monopsonistic insurance sector would achieve lower reimbursement rates is by setting a low market reimbursement rate, one which is beneath the value that some consumers place on those services. That is, there will be excess demand by consumers for services at this rate, and the monopsonist does not allow price to rise to expand output and equilibrate demand and supply.

<sup>23</sup> Leemore Dafny, Mark Duggan, and Subramaniam Ramanarayanan, “Paying a Premium on Your Premium? Consolidation in the US Health Insurance Industry,” *American Economic Review*, 2012, 102(2): 1161–1185.

<sup>24</sup> The formal complaint alleged the merger “would enable Aetna to exercise monopsony power against physicians, allowing Aetna to depress physicians’ reimbursement rates in Houston and Dallas, likely leading to a reduction in quantity or degradation in quality of physicians’ services”. U.S. vs. Aetna Inc. (ND TX, 21 June 1999)



areas – and they find areas with higher insurer HHI have higher, not lower, hospital utilization.<sup>25,26</sup>

In sum, there is some empirical evidence that consumers may be harmed as a result of lower payments to healthcare *personnel*, however more research is needed on this subject.

There is very little published research on the link between consolidation and plan quality. The most relevant study to date pertains to the Medicare Advantage market. The study found that the availability of prescription drug benefits (before the enactment of Part D) was higher in areas with more rivals, all else equal.<sup>27</sup> There is a vast literature in other healthcare settings – e.g., hospitals – showing that quality does not improve when markets become more consolidated.<sup>28</sup> Although quality is often more difficult to evaluate than price, the competitive mechanisms linking diminished competition to higher prices operate similarly with respect to lower quality.

### 2.1.2 Insurance Premiums

There are a number of studies documenting lower insurance premiums in areas with more insurers, including on the state health insurance marketplaces,<sup>29</sup> the large group market (self- and fully-insured combined),<sup>30</sup> and Medicare Advantage.<sup>31</sup> A recent study suggests premiums for employer-sponsored fully-insured plans are increasing more quickly in areas where insurance market concentration is rising, controlling for other area characteristics such as the hospital market concentration.<sup>32</sup>

Arguably the most relevant research in light of the recent proposed mergers are two studies of consummated mergers. Both found that structural changes in market concentration led to higher insurance premiums. The first is the previously-mentioned study of the Aetna-Prudential merger

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<sup>25</sup> Feldman and Wholey (2001) present evidence that prices are lower, but hospital utilization (a measure of quantity) is higher in markets with less competitive insurance markets. Similarly, McKellar et al. (2014) find in more concentrated insurer markets, health care prices are lower, utilization is higher, but overall spending is lower.

<sup>26</sup> It is worth noting that many health policy experts believe some types of health care services are overutilized.

Where true, a quantity reduction arising from the exercise of monopsony power might be viewed as beneficial.

However, this paternalistic approach to consumption is not ordinarily adopted by antitrust enforcers.

<sup>27</sup> Robert Town and Su Liu, "The Welfare Impact of Medicare HMOs," *RAND Journal of Economics* (2003): 719-736.

<sup>28</sup> See, for example, Gaynor, M. and R. Town (2012), "The Impact of Hospital Consolidation," available at <http://www.rwjf.org/en/library/research/2012/06/the-impact-of-hospital-consolidation.html>

<sup>29</sup> Steven Sheingold et al., ASPE Issue Brief, "Competition and Choice in the Health Insurance Marketplaces, 2014-2015: Impact on Premiums," U.S. Dept. of Health and Human Services, July 27, 2015, available at <http://aspe.hhs.gov/basic-report/competition-and-choice-health-insurance-marketplaces-2014-2015-impact-premiums>.

<sup>30</sup> Leemore Dafny, Mark Duggan, and Subramaniam Ramanarayanan. *Paying a Premium on Your Premium? Consolidation in the US Health Insurance Industry*. No. w15434. National Bureau of Economic Research, 2009.

<sup>31</sup> Zirui Song, Mary Beth Landrum, and Michael E. Chernew, "Competitive Bidding in Medicare: Who Benefits From Competition?" *The American Journal of Managed Care* 18.9 (2012): 546.

<sup>32</sup> Trish and Herring (2015). *Ibid.*

of 1999. Using detailed data on health insurance plans sponsored by large, mostly multi-site employers representing roughly 10 million lives, my coauthors and I found that premiums increased significantly more in areas with greater pre-merger overlap. Importantly, we were able to control for changes over time in the average premium for any given employer, so that these changes reflect relative differences across markets for the same firm. Moreover, premium increases were observed not just for the merging firms but for their rivals (in areas where the merging firms had substantial overlap). Thus, even though this particular merger was linked to lower healthcare personnel wages and employment, the cost savings were not passed on to consumers.

We used the estimate from the above paper to predict the impact of all (structural and non-structural) consolidation over the period 1998-2006. We estimate that large group premiums in 2007 were 7 percent (roughly \$200 per person) higher than they would have been had local market concentration remained at its initial level. Although this is a small figure relative to the aggregate premium increase during the same period, it is large compared to typical operating margins of insurers – implying substantial consolidation-induced growth in profits.

A second study, Guardado et al. (2013), examined the effect of the 2008 merger between Sierra Health Services and United on small group premiums in two Nevada markets. As compared to control cities in the South and West, small group premiums in these markets increased by 13.7 percent the year following the merger.<sup>33</sup>

*2.2 There are substantial barriers to entry in the private health insurance industry, and consolidation-induced premium increases have not generally been offset by competition from new entrants.*

Over the past few decades, the private health insurance industry has seen relatively little entry by new firms. Barriers to entry include: (1) building networks of local providers and negotiating competitive reimbursement rates;<sup>34</sup> (2) establishing a credible reputation with area employers and consumers; (3) developing relationships with brokers, who serve as intermediaries for most purchasers; (4) achieving economies of scale in information technology, disease management, utilization review, and customer-service related functions. “Entry” into a given geographic market has tended to occur via acquisition. To wit, the most likely potential entrants in a market are incumbents in other product and/or geographic markets.<sup>35</sup> In light of the impediments to de

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<sup>33</sup> Jose R. Guardado, David W. Emmons, and Carol K. Kane, “The Price Effects of a Large Merger of Health Insurers: A Case Study of UnitedHealth-Sierra” *Health Management, Policy and Innovation*, 2013: 16–35.

<sup>34</sup> This is a particularly salient barrier due to the “chicken and egg problem” of insurer-provider negotiations. Providers are generally willing to offer the most competitive rates to insurers with a large market share, however to gain market share an insurer needs to offer low premiums (and to do so sustainably, must have competitive provider rates).

<sup>35</sup> For example, recent entry in the private individual insurance market – sparked by the introduction of the Health Insurance Marketplaces and the individual mandate to carry insurance – has largely consisted of firms offering



novo entry, consolidation even in non-overlapping markets reduces the number of potential entrants who might attempt to overcome price-increasing (or quality-reducing) consolidation in markets where they do not currently operate.

### **3. How relevant is what we have learned in light of changes arising from the Affordable Care Act?**

#### *3.1. Applicability of merger retrospectives*

A reasonable question to ask is whether the previously described retrospective analyses (of the Aetna-Prudential and United-Sierra mergers) are informative in light of the significant recent changes in the healthcare sector. The early evidence suggests that competition has its salutary effects on health insurance market even in the post-ACA world. One study (which I coauthored) finds that premiums on the individual exchanges in 2014 were more than 5 percent higher as a result of the decision by a large national insurer not to participate in federally-facilitated exchanges in that year.<sup>36</sup> Another study estimates that having an additional insurer in a given ratings area results in premium savings of nearly \$500 per individual.<sup>37</sup>

#### *3.2 The Medical Loss Ratio (MLR) regulations do not protect consumers from adverse consequences which may arise as a result of consolidation.*

The ACA enacted sweeping regulatory changes on the commercial insurance industry, including minimum product standards, a requirement that insurers take all comers (“guaranteed issue”), a ban on medical underwriting, and limits on age-based pricing. However, the provision that is most relevant to the subject of insurer consolidation and its consequences concerns Medical Loss Ratios (MLRs). As of 2011, insurers must devote at least 85 (80) percent of premium revenues – net of taxes and licensing fees – to medical claims and quality improvement for their large group (small group/individual) fully-insured lives. Insurers failing to satisfy these requirements in any given state and market segment must refund the amount of the shortfall to their enrollees in the relevant segment.

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Medicaid plans in those states. There are a number of new not-for-profit co-operatives as well, however entry of these organizations was subsidized by the federal government and many are not believed to be financially viable.

<sup>36</sup> Leemore Dafny, Jonathan Gruber, and Christopher Ody, “More Insurers, Lower Premiums: Evidence from Initial Pricing on the Health Exchanges,” *American Journal of Health Economics*, Winter 2015: 53–81.

<sup>37</sup> Michael J. Dickstein, et al., “The Impact of Market Size and Composition on Health Insurance Premiums: Evidence from the First Year of the Affordable Care Act,” *American Economic Review*, 105.5 (2015): 120–25.

Some have argued<sup>38</sup> that these regulations mitigate concerns over potential anticompetitive consequences of consolidation in this sector. I do not find this argument convincing for at least five reasons.

First, more than half of privately-insured enrollees are in self-insured plans, and the minimum MLR regulations do not pertain to these plans.

Second, consumers are concerned with “value” for their health insurance dollar, and the minimum MLR restriction does not substitute for competition to provide value. Suppose there are two insurers competing in a given market segment, and both satisfy the MLR requirement for that segment. These insurers likely compete for enrollees on dimensions other than the share of spending devoted to medical claims and quality improvement activities, for example their product design, provider networks, customer service, and chronic disease management programs. Eliminating the competition (or potential competition) from this market via a merger relaxes or eliminates competition on these dimensions. Why expend effort in, say, developing shared savings programs to improve quality of care and reduce spending when you can still pocket the same margin per insured life?<sup>39</sup> In short, the MLR regulation attempts to cap industry profits, but it does not protect consumers from post-merger harm due to the loss of competition on a variety of relevant dimensions.

Third, for the MLR regulations to impact the usual analysis of consolidation effects, they must “bind”: the statutory floors must be higher than we would otherwise see. For example, if insurers in a given market segment and state generally have MLRs above 90 percent, merging insurers benefiting from an increase in market power might still profitably raise profits and premiums by 5 percent. Although there are no published analyses of the MLR data that pinpoint where the regulations currently bind, a recent study by the non-profit Commonwealth Fund reports the following national MLRs for 2013: 85.9% (individual); 83.6% (small group); 88.6% (large group). These data suggest there may be substantial room for profitable merger-related price increases in the individual market in particular, notwithstanding the minimum MLR requirement.

In addition, because the MLR is calculated at the state and market level, it is conceivable that mergers can enable insurers to offset low MLRs in one geographic area or sub-segment with high MLRs in another. For example, consider an insurer offering plans in a (hypothetical) competitive, urban individual exchange ratings area, where MLRs tend to be on the high side (e.g., 90 percent). This insurer could be an attractive target for another insurer who offers plans

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<sup>38</sup> See, e.g., CNBC, “Aetna, Humana CEOs Talk Antitrust Concerns,” Jul. 6, 2015, *available at* <http://video.cnbc.com/gallery/?video=3000394309>.

<sup>39</sup> Reductions in the value of insurance provided may reduce the total volume of insurance purchased, and hence provide some constraint on the reduction in value that a profit-maximizing monopolist insurer would impose. However, the demand for health insurance is relatively inelastic, and particularly so in light of the new insurance mandates.

in less-competitive rural markets. Post-merger, the insurer might be able to lower MLRs in these markets and use the “excess” spending in the target’s market to offset these new profits.

Fourth, it may be possible to legally “game” the MLR regulation by effectively labeling profits as medical costs. For example, insurers often have ownership stakes in healthcare facilities and provider organizations. Such insurers could adjust internal transfer payments to these groups to ensure MLR minima are satisfied. Similarly, many insurers engage in quality improvement efforts. It would seem possible to create a separate quality improvement arm and to charge the insurance arm fees that offset profits in excess of the MLR minima. Although these possibilities are speculative, the main point is that regulation is an imperfect substitute for competition in terms of keeping premiums low for consumers.

Fifth, the minimum MLR regulation could be repealed. If we permit transactions that would otherwise be deemed anticompetitive under the belief that the MLR regulation acts as a check on post-merger margin increases, where are we left if a more consolidated insurance industry successfully argues for its repeal? As is well known to the Subcommittee, it is an order of magnitude more difficult to dissolve a consummated merger that proves anticompetitive than to prevent the transaction in the first instance.

*3.3. Reforms to the healthcare delivery system may give rise to new efficiencies from consolidation, but at present these efficiencies are speculative.*

The recent shift toward paying for value – rather than volume – of healthcare services will require significant changes in how insurers pay providers and how providers deliver and organize care. Some insurers have suggested that mergers will enhance their ability to develop and implement new value-based payment agreements.<sup>40</sup>

This claim embeds at least three possible sources of merger efficiencies (1) there are local economies of scale in implementation of value-based agreements; (2) there are non-local economies of scale in implementation of value-based agreements; (3) some insurers have a unique ability to implement such programs and others cannot replicate or access it without a merger.

Argument (1) implies that an insurer must have sufficient scale in a local market area to warrant the investment in changing practice patterns; if not, much of their investment in doing so will “spill over” and benefit rivals. Indeed, a recent study suggests the much-vaunted BCBS-MA Alternative Quality Contract for commercially-insured lives had a significant impact on

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<sup>40</sup> For example, see Aetna’s press release announcing the acquisition of Humana: “The combination will provide Aetna with an enhanced ability to work with providers and create value-based payment agreements that result in better care to consumers, and spread cutting-edge clinical practices and quality care.” Aetna, “Aetna to Acquire Humana for \$37 Billion, Combined Entity to Drive Consumer-Focused, High-Value Health Care,” Jul. 3, 2015, available at <https://news.aetna.com/news-releases/aetna-to-acquire-humana-for-37-billion-combined-entity-to-drive-consumer-focused-high-value-health-care/>.

traditional fee-for-service Medicare enrollees.<sup>41</sup> BCBS-MA does not share in any savings generated for this population. At the same time, a provider can spread its fixed costs of collaborating with a given insurer across more lives the larger is that insurer. Although these are economically appealing arguments, at the moment they are theoretical. There is no evidence that larger insurers are more likely to implement innovative payment and care management programs. In addition, there is a countervailing force offsetting this heightened incentive to invest in payment and delivery system reform: more dominant insurers in a given insurance market are less concerned with ceding market share.

Argument (2) implies that scale across markets may be helpful in implementing value-based agreements. This might be true, for example, because of the ability to work with national employers to develop such programs. However, there is an opposing force that may also operate. Implementing new payment or care management models across disparate markets can introduce complexity and costs into national systems that are poorly designed for exceptions. For example, in early pilots of bundled payment programs, claims have been pulled for individual patients one-by-one out of claims payment processes. These costs are prohibitive and might lead to less, not more, innovation by payers with a cross-market presence. This reality may explain why concerted delivery system reform efforts have tended to emerge from other sources, such as provider systems (sometimes vertically integrated with insurers) and non-national payers like Massachusetts Blue Cross and Blue Shield.

Argument 3 is a standard claim of merger proponents and subject to all the usual forms of skepticism. Efficiencies must be merger-specific and verifiable if they are to be credited against potential harm arising from diminished competition, and there is still the question of whether benefits will be passed through to consumers in light of that diminished competition. Moreover, any short term gain from avoiding development costs for value-based programs may be offset by a reduction in long-term benefits arising from competition among insurers to develop better versions of these programs.

#### **4. Next steps: How to assess proposed and potential consolidation going forward?**

The Horizontal Merger Guidelines issued jointly by the FTC and DOJ explain how the DOJ will evaluate whether a proposed merger violates Section 7 of the Clayton Act. Some likely analyses include: (1) seeking detailed information on how costs will be trimmed *as a result* of any given transaction, and confirming they cannot be achieved in their absence or through means that are less likely to diminish competition; (2) soliciting input from state regulators and other informed stakeholders to gain an understanding of what mergers have proven beneficial in the past and the

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<sup>41</sup> J. Michael McWilliams, Bruce E. Landon, and Michael E. Chernew, "Changes in Health Care Spending and Quality for Medicare Beneficiaries Associated with a Commercial ACO Contract," *JAMA*, 310.8 (2013): 829–836.

characteristics of these mergers; (3) seeking data on MLRs at a granular level, so as to assess the relationship between prior or proposed mergers and MLRs; (4) seeking information from CMS on how Medicare Advantage (MA) is impacted by market structure (both in and outside of MA); (5) evaluating the impact of mergers on prospective entry, and the role of prospective entrants in disciplining premium growth historically; (6) considering the implications of cross-market overlap on insurance competition. This is but a short list of potential analyses.

As the Subcommittee knows, ascertaining whether a transaction violates competition law is a different matter from ascertaining whether it is in the public interest. For example, a merger that is likely to lead to price increases without offsetting benefits may not violate Section 7 if it cannot be shown that the merger lessens competition in a relevant market. Different stakeholders might also place different weights on the potential losses and gains for various affected parties. Given the significance of the insurance sector to our wallets and to the functioning of our healthcare system, the public deserves better data with which to evaluate these transactions as well as the industry more generally. As a start, I would explore avenues for requiring detailed reporting on insurance enrollment, plan design, premiums, and medical loss ratios at a fine unit of geography (e.g., zip code) and for every possible customer segment. This reporting must include self-insured plans (and specifically, the insurance administration charges associated with such plans), as more than half of the privately-insured are enrolled in these types of plans. With these data in hand, policymakers and regulators will be able to monitor market developments and to intervene, if necessary, based on better and more timely information. And researchers such as myself will, in the future, be able to provide much stronger guidance regarding the likely effects of consolidation.

## Paying a Premium on Your Premium? Consolidation in the US Health Insurance Industry<sup>†</sup>

By LEEMORE DAFNY, MARK DUGGAN, AND SUBRAMANIAM RAMANARAYANAN\*

Although the majority of health-care spending in the United States is funneled through the private health insurance industry, few researchers have examined whether the industry itself is contributing to rising health insurance premiums. This possibility has become ever more salient as consolidations continue in this highly concentrated sector. In 2001, the American Medical Association (AMA) reported nearly half of the 40 largest Metropolitan Statistical Areas (MSAs) were “highly concentrated,” as defined by the *Horizontal Merger Guidelines* issued in 1997 by the US Department of Justice and the Federal Trade Commission. In 2008, the AMA expanded its annual report to include 314 geographic areas (mainly MSAs), 94 percent of which were found to be highly concentrated.<sup>1</sup> During this seven-year period, the average, inflation-adjusted premium for employer-sponsored family coverage rose 48 percent (to \$12,680 in 2008)<sup>2</sup> while real median household income *declined* by 2 percent to \$50,303 (DeNavas-Walt, Proctor, and Smith 2009).

Prior studies point to the potential for insurer consolidation to raise premiums (e.g., Robinson 2004; Wholey, Feldman, and Christianson 1995; and

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<sup>1</sup> “Competition in Health Insurance: A Comprehensive Study of US Markets,” American Medical Association, 2001 and 2008. These figures are based on the reported levels of the Herfindahl-Hirschman Index (HHI) for HMOs and PPOs combined. Estimates are not strictly comparable over time due to changes in methodology and sample selection. For example, self-insured HMOs are generally included in 2001 but excluded in 2008. The *Horizontal Merger Guidelines* issued in 1992 and updated in 1997 define markets with HHI > 1,800 as “highly concentrated.” A recent update adjusted this threshold to 2,500 (DOJ 2010), and as a result the share of markets in 2008 that would be highly concentrated is somewhat lower at 70 percent.

<sup>2</sup> The corresponding increase for single coverage was 44 percent (Kaiser Family Foundation/Health Research and Educational Trust *Employer Health Benefits Annual Survey 2009*). Premiums include both employer and employee contributions, and are adjusted to 2008 dollars by the authors using the CPI-U.

Dafny 2010)); however, none attempts to quantify this effect.<sup>3</sup> From a theoretical standpoint, the effect of concentration on insurance premiums is ambiguous. On one hand, increases in market concentration may allow health insurers to raise their mark-ups, leading to higher premiums. On the other hand, increases in market concentration may strengthen insurers' bargaining positions vis-à-vis health-care providers, leading to reduced negotiated reimbursements and lower premiums. In addition, there are many potential sources of efficiency gains from consolidation, including economies of scale in investments in information technologies (IT) investing and disease management programs. Such efficiency gains would reduce optimal premiums.<sup>4</sup> The net effect on insurance premiums is ultimately an empirical question.

There are two key challenges to empirically estimating such a link: (i) adequate data and (ii) plausibly exogenous variation in market concentration. Regarding the first issue, comprehensive data on a large sample of health plans are extremely difficult to obtain because contracts are customized for each buyer across many dimensions, renegotiated annually, and considered highly confidential. In addition, premiums vary based on the demographics, health risks, and expenditure history of the insured population. Thus, it is difficult to calculate a standardized premium to enable comparisons across employers and/or markets. With respect to the second challenge, highly concentrated markets (or markets that are becoming more concentrated) are likely to differ from other markets in unobservable ways, making it difficult to separately identify the effect of concentration from other factors.

We address these challenges as follows. First, we utilize detailed longitudinal data on the health plans offered by a sample of more than 800 employers in 139 distinct geographic markets in the United States. The data span the nine years between 1998 and 2006 and represent approximately 10 million active employees and their dependents in each year. Rather than attempting to standardize premiums across different employee populations, products, and plan designs, we focus on the *growth rate* of health insurance premiums for the same employer in a specific geographic market over time and examine how this relates to the local market structure of health insurers. Focusing on growth alleviates concerns about time-invariant unobservable differences in the risk profiles of employee groups and the characteristics of plans they utilize that may be correlated with premium *levels*. We also control for the influence of time-varying measures such as employee demographics, the types of plans utilized (HMO, PPO, etc.), and the generosity of benefit design.

After documenting trends in the level and growth of concentration (as measured by the Herfindahl-Hirschman index (HHI), which is the sum of squared market shares) in 139 distinct geographic markets, we estimate OLS models of the relationship between premium growth and concentration levels. We do not find evidence

<sup>3</sup>Robinson (2004) shows that state-level insurance markets are dominated by a small number of firms and observes that insurer profits increased rapidly over 2000–2003. Wholey, Feldman, and Christianson (1995) report that premiums per HMO member are negatively related to the number of competitors facing the HMO in question, controlling for a host of HMO and market characteristics such as per capita income, Blue Cross affiliation and HMO ownership status. Last, Dafny (2010) finds health insurers engage in “direct” price discrimination, charging higher premiums to firms with deeper pockets, as measured by operating profits. This evidence of price discrimination implies insurers possess and exercise market power in some local markets but does not yield an estimate of the contribution of imperfect competition in this market to premium growth.

<sup>4</sup>Of course, rent transfers from providers to insurers are not true efficiency gains, although they may reduce premiums.



that premiums are rising more quickly in markets that are becoming more concentrated. While these estimates are useful for descriptive purposes, they are unlikely to provide causal estimates of the impact of market structure on premiums. Differences in HHI across markets—or even changes in HHI within markets—are likely to be driven by many factors that are not exogenous to premiums. These include differences (or changes) in consumer preferences and constraints, product offerings and pricing strategies, and the market conduct of hospitals, physicians, and other health-care providers. For example, consider a market with a struggling local economy. In such a market, consumers may flock to low-priced carriers, bringing about an increase in local market concentration and a simultaneous reduction in average premium growth (relative to other markets). This pattern does not imply consolidations in such a market would reduce premium growth, *ceteris paribus*.

In order to address the endogeneity challenge and obtain a credible estimate of the impact of concentration on premium growth, we exploit sharp and heterogeneous increases in local market concentration generated by the 1999 merger of two industry giants, Aetna and Prudential Healthcare. Both were national firms, active in most local insurance markets, and thus the merger had widespread impact. However, the premerger market shares of the two firms varied significantly across specific geographic markets, resulting in very different shocks to post-merger concentration. For example, in our sample the premerger market shares of Aetna and Prudential in Jacksonville, Florida were 19 and 24 percent, respectively, versus just 11 and 1 percent, respectively, in Las Vegas, Nevada. Holding all else equal, this implies an increase in post-merger HHI of 892 points in Jacksonville, but only 21 points in Las Vegas. Focusing on the years immediately surrounding this merger, we examine the relationship between premium growth and HHI changes using these predicted changes as instruments for actual changes and controlling as fully as possible for changes in the characteristics of health plans (such as benefit design).

The point estimates indicate that rising concentration in local health insurance markets accounts for a nontrivial share of premium growth in recent years. Specifically, our instrumental variables estimates imply that the mean increase in local market HHI between 1998 and 2006 (inclusive) raised premiums by roughly 7 percent from their 1998 baseline, all else equal. Given private health insurance expenditures of \$490 billion in our base year 1998, *if* this result is generalizable, then the “premium on premiums” by 2007 is on the order of \$34 billion per year, or about \$200 per person with employer-sponsored health insurance.<sup>5</sup>

Although our focus is on the exercise of market power by insurers in the *output* market, consolidation may also have important effects on *input* prices. Using data on earnings and employment of health-care personnel, we exploit the differential impact across geographic markets of the Aetna-Prudential merger to examine whether there is a causal link between concentration and these outcomes. Our analysis suggests that the growth in insurer bargaining power following this merger reduced earnings and employment growth of physicians and raised earnings and employment growth

<sup>5</sup> Source: National Health Expenditure Data provided by the Center for Medicare and Medicaid Services; available online at <http://www.cms.hhs.gov/NationalHealthExpendData/>. The vast majority of this spending is due to employer-sponsored plans; only 9 percent of the nonelderly privately insured have policies that are not employment based (DeNavas-Walt, Proctor, and Smith 2009). Additionally, this figure understates the size of the private health insurance industry as it excludes expenditures by Medicaid and Medicare managed care plans.



of nurses. This pattern of results is consistent with postmerger substitution of nurses for physicians, and the exercise of monopsony power vis-à-vis physicians.

The paper is organized as follows. Section I describes the data in detail. We examine the association between local market concentration and premium growth in Section II. In Section III we investigate whether a causal relationship exists between these two variables using the variation across geographic markets in the merger-induced increase in insurer concentration. Section IV contains our analyses of the relationship between concentration and health-care employment and earnings. Section V concludes.

## I. Data

Our primary source is the Large Employer Health Insurance Dataset (LEHID). LEHID contains information on all of the health plans offered by a large sample of employers between 1998 and 2006, inclusive. It is an unbalanced panel gathered and maintained by a leading benefits consulting firm. The data are proprietary, and employers included in the dataset have some past or present affiliation with the firm. Online Appendix 1, which contains additional details of the data not presented here, illustrates that LEHID plans are on average very similar to the plans offered by a representative sample of large employers nationwide.

The original unit of observation is the health plan–year. A health plan is defined as a unique combination of employer, market, insurance type, insurance carrier, and plan type (e.g., Company X’s Chicago-area fully insured Aetna HMO). There are 813 unique employers, 139 geographic markets, two insurance types (self- and fully insured), 357 insurance carriers<sup>6</sup> and four plan types (HMO, POS, PPO, Indemnity) represented in the data.<sup>7</sup> Most employers in LEHID are large, multisite, publicly traded firms, such as those appearing on the *Fortune 1000* list. The leading industries represented include manufacturing (110 employers), finance (101), and consumer products (73), although nonprofit and government sectors are also represented (43 in the “government/education” category). Geographic *markets* are defined by the data source using three-digit zip codes. According to the data provider, the 139 markets reflect the geographic boundaries typically used by insurance carriers when quoting prices. Large metropolitan areas are separate markets, and nonmetropolitan areas are lumped together within state boundaries (e.g., “New Mexico—Albuquerque” and “New Mexico—except Albuquerque”).<sup>8</sup>

The sample includes both *fully insured* and *self-insured* plans. As these terms suggest, the former is “traditional” insurance in which the insured pays the carrier to bear the risk of realized health-care outlays. Many large employers choose to self-insure, outsourcing benefits management, provider contracting, and/or claims

<sup>6</sup>Many of these carriers are third-party administrators, who “rent” provider networks and process claims for self-insured employers.

<sup>7</sup>HMO and POS plans control utilization through primary care physicians (“gatekeepers”). HMOs cover only in-network providers, while POS and PPO plans provide some coverage for out-of-network providers. Indemnity plans have no gatekeepers or network restrictions.

<sup>8</sup>There is only one market that crosses state boundaries, “Massachusetts—Southern and Rhode Island.” A few rural areas of the United States are excluded. A map of the markets is available in Dafny (2010).

administration but paying the realized costs of care. The percent of LEHID enrollees in self-insured plans increased from 55 to 80 percent during the study period.

In addition to the elements that jointly define a plan, our dataset includes the following variables: *premium*, *demographic factor*, *plan design factor*, and *number of enrollees*. *Premium* is expressed as an average amount per enrollee (i.e., a covered employee); it therefore increases with the average family size of enrollees in a given plan. Premium combines employer and employee contributions, and for self-insured plans it is a projection of expected costs per enrollee (including estimated administrative fees paid to an insurance carrier, as well as premiums for stop-loss insurance, if any). Because the forecasts are used for budgeting and to establish employee premium contributions, they are carefully developed and vetted. Employers often hire outside actuaries and benefits experts (such as our source) to assist in formulating accurate projections.

*Demographic factor* is a measure that reflects family size, age, and gender composition of enrollees in a given plan. All of these characteristics are important determinants of average expected costs per enrollee in a plan. *Plan design factor* captures the generosity of benefits within a particular carrier–plan type, with an emphasis on the levels of coinsurance, copayments, and deductibles. Both factors are calculated by the source, and the proprietary formulae were not disclosed to us. Higher values of either factor are associated with higher premiums.

The LEHID also records the *number of enrollees* in each plan. This figure includes only employees of the relevant firm; dependents are accounted for by the demographic factor described above. The total number of enrollees in all LEHID plans averages 4.7 million per year. Given an average family size of more than two, this implies that more than ten million US residents are part of the sample in a typical year, representing approximately 7 percent of those with employer-sponsored insurance (ESI) during this period, and a much larger share of those insured through large firms.

We supplement the LEHID data with time-varying measures of local economic conditions (the unemployment rate, as reported by the Bureau of Labor Statistics), a measure of health-care utilization (Medicare costs per capita, as reported by the Centers for Medicare and Medicaid services), and the concentration of the hospital industry (HHI as calculated by the authors using the *Annual Surveys of Hospitals* administered by the American Hospital Association).<sup>9</sup> As the first two measures are reported at the county-year level, and LEHID markets are defined by three-digit zip codes, we make use of a mapping between zip codes and counties and, where necessary, use population data to calculate weighted average values for each LEHID market and year.

We perform most analyses using data aggregated to the employer-market-year level. Table 1 presents descriptive statistics for this unit of observation for 1998, 2002, and 2006, which represent the initial, middle, and final years of the sample respectively. Because our primary outcome is *growth* in health insurance premiums (in order to avoid cross-sectional identification of the coefficients of interest),

<sup>9</sup>To calculate HHI for each geographic market and year, we use data on the number of beds for all general hospitals located in the set of three-digit zip codes that define the market, assigning hospitals with the same “system ID” to a common owner.

TABLE 1—DESCRIPTIVE STATISTICS (*Unit of Observation: Employer-Market-Year*)

	1998	2002	2006
Premium (\$)	4,104.47 (1,047.76)	5,624.70 (1,280.61)	7,832.46 (1,807.98)
Number of enrollees	399.86 (1,465.47)	370.42 (1,397.66)	361.47 (1,245.86)
Demographic factor	2.35 (0.47)	2.29 (0.41)	1.84 (0.38)
Plan design	1.05 (0.06)	1.05 (0.06)	0.98 (0.07)
Plan type			
HMO	29.4%	30.6%	25.4%
Indemnity	22.4%	7.2%	2.8%
POS	28.1%	16.8%	14.1%
PPO	20.0%	45.4%	57.6%
Percent fully insured	33.0%	24.2%	14.4%
Observations	10,033	14,851	11,497

*Notes:* All statistics are unweighted. The unit of observation is an employer-market-year combination. Demographic factor reflects age, gender, and family size for enrollees. Plan design measures the generosity of benefits. Both are constructed by the data source and exact formulae are not available. Premiums are in nominal dollars. Standard deviations are in parentheses.

aggregating the data to the employer-market-year level enables us to use a much larger proportion of the data. With the health plan-level data, growth in premium is undefined when an employer terminates a particular plan. Analogously, new plans can enter the analysis only after multiple observations are available. Changes to plan offerings are quite common in our data (24 percent of plans in year  $t$  whose firm-markets are still present in year  $t + 1$  no longer exist). Moreover, changes in market concentration may affect the insurance carriers and plan types chosen by employers, so we do not want a priori to eliminate this substitution from our sample.<sup>10</sup> Given this aggregation, both fully and self-insured plans must be included together in the analysis sample to ensure the set of employees represented over time is stable (but for hiring, attrition, and changes in employees' decisions to take up employer-sponsored insurance).

## II. Is Premium Growth Correlated with Local Market Concentration?

In this section, we examine the relationship between the growth in health insurance premiums and local market concentration. We begin by describing the distribution of market-level HHI and how this has changed over time. Next, we estimate OLS regressions relating premium growth at the employer-market level to the corresponding market HHI. We include market fixed effects in our models, so that we identify the coefficient of interest using changes in *within-market* HHI. The richness

<sup>10</sup>This occurs very frequently in the LEHID. For example, consider employer-market pairs that are present in both 1999 and 2002. More than half of the plans offered by these firms in 1999 are no longer present in 2002, either because the employer switched to different carriers or because it changed the type of plan with the same carrier.

of the data also permits us to control for important time-varying differences (such as the percent of enrollees in HMOs and the magnitude of copayments). Although interesting as a descriptive exercise, this analysis is unlikely to yield unbiased estimates of the causal impact of changes in market structure on premium growth, as changes in market structure are unlikely to be exogenous.

### *A. Market Structure of Large Group Insurance Markets, 1998–2006*

During our nine-year study period, the average market-level HHI (estimated using our sample and scaled from 0 to 10,000) increased from 2,286 to 2,984.<sup>11</sup> Using the categorization from the *Horizontal Merger Guidelines* issued in 1997, the fraction of markets falling into the top “highly concentrated” category (HHI > 1,800) rose from 68 to 99 percent. The median four-firm concentration ratio increased from 79 to 90 percent. Thus, our data support the conclusions of well-publicized reports issued by the American Medical Association and the General Accounting Office: local health insurance markets are concentrated and becoming more so over time.<sup>12</sup>

Figure 1 presents histograms of the market-level changes in HHI, separately for 1998–2002, 2002–2006, and 1998–2006. The larger increases tended to occur during the second half of the study period, but sizable increases are present in the first half as well. Between 1998 and 2002, 53 percent of markets experienced increases in HHI of 100 points or more, and 25 percent saw increases of 500 or more points. The corresponding figures for 2002 to 2006 are 78 and 53 percent, respectively. The Merger Guidelines provide a helpful frame of reference for interpreting these changes. According to the Guidelines, mergers resulting in an increase of 100 or more points when HHI already exceeds 1,800 are “presumed ... likely to create or enhance market power or facilitate its exercise.” There is wide variation in the magnitude of changes in HHI across markets, notwithstanding the fact that most are positive.

The reasons for these changes in HHI can be subdivided into “structural” (related to entry, exit, and consolidation) and “nonstructural” sources. Using data on fully insured HMOs only, Scanlon, Chernew, Swaminathan, and Lee (2006) report that 61 to 65 percent of the variation in HHI between 1998 and 2002 is attributable to structural changes. These changes are also important in our sample: the mean number of carriers per market declined from 18.9 in 1998 to 9.6 in 2006.<sup>13</sup> Of course, neither source of HHI change can be presumed exogenous to other determinants of premium growth. Consumer preferences simultaneously determine market shares and premium growth, and exit and consolidation of carriers may be impacted by expectations of premium growth.

<sup>11</sup> To gauge the impact of this change on concentration, consider the following two examples. A market with five insurers, four of which have a market share of 23.75 percent, would have an HHI of 2,281. A market with four insurers, three of which each have a market share of 31.33 percent, would have an HHI of 2,981.

<sup>12</sup> AMA *ibid*; GAO (2009a).

<sup>13</sup> As the data on HHI suggest, many of these carriers are quite small. This is due to the presence of many small self-insured plan administrators, particularly in the earlier part of the study period. Some of these administrators may not be active participants in a given market, i.e., they “rent networks” from other carriers so as to offer a particular client a consistent plan across all geographies.

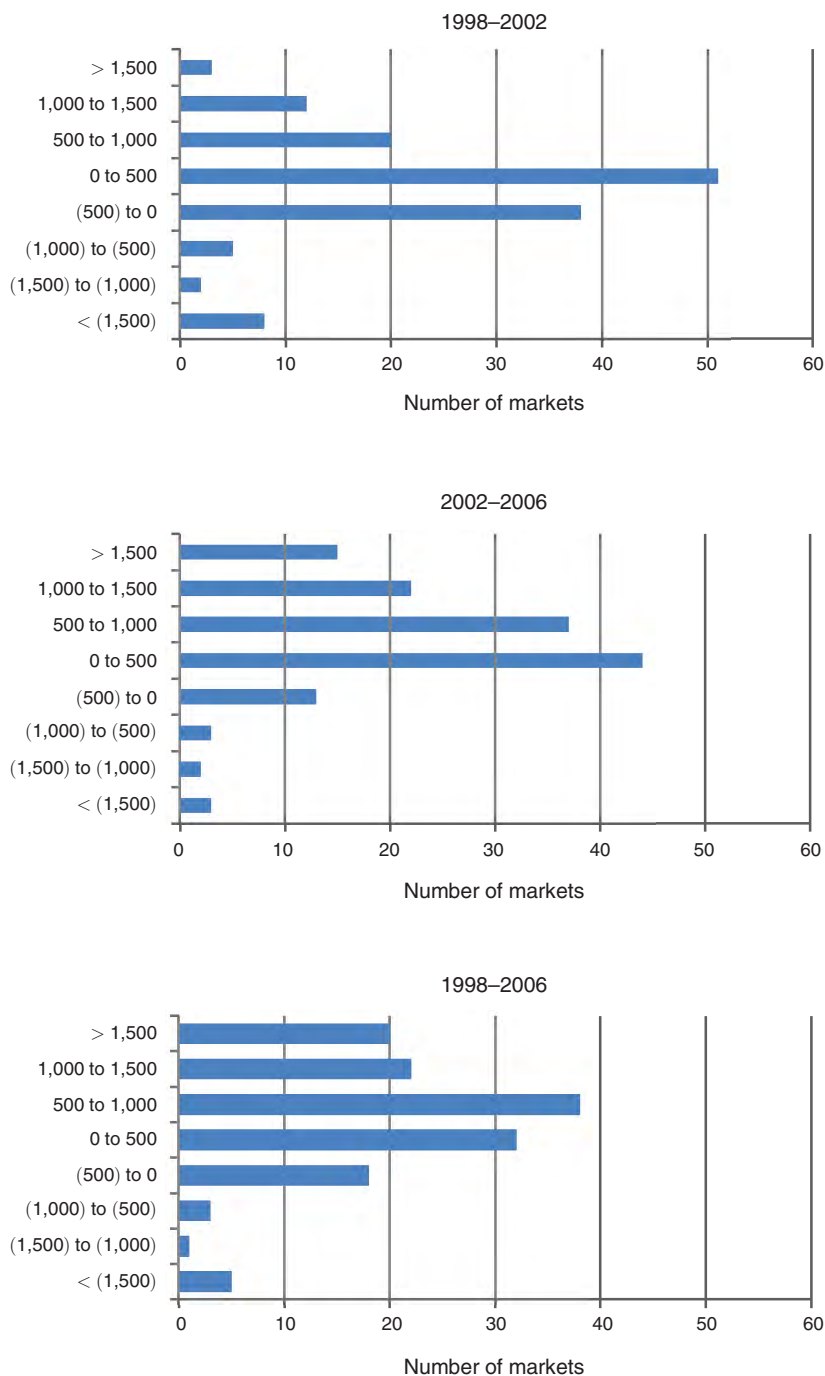


FIGURE 1. CHANGE IN LOCAL MARKET HERFINDAHL

Note: HHI is scaled from 0 to 10,000.

### B. OLS Estimates of the Relationship between Market Structure and Premiums

To explore the relationship between premium growth and market concentration, we begin by estimating equations of the following form:

$$(1) \Delta \ln(\text{premium})_{emt} = \alpha + \beta \text{HHI}_{mt-1} + \phi X_{mt-1} + \rho \Delta C_{emt} + \tau_t + \lambda_m \\ [+ \varsigma_e][+ \omega \Delta \text{plan type shares}_{emt} + \vartheta \Delta \text{plan design}_{emt}] \\ + \varepsilon_{emt}.$$

In this specification, we model premium growth between year  $t - 1$  and year  $t$  for a given employer  $e$  in market  $m$  as a function of lagged market characteristics (including HHI),<sup>14</sup> contemporaneous changes in observable characteristics of the insured population (such as demographics), and year and market fixed effects. Market characteristics are lagged by one year because premiums are set prospectively, i.e., premiums for 2006 are determined in 2005. In addition to HHI, the market-year covariates (denoted by  $X_{mt-1}$ ) include the unemployment rate (to capture local economic conditions), the log of per-capita Medicare costs (to capture trends in health-care utilization), and the general, acute-care hospital HHI (to capture concentration in the provider market, which could independently lead to premium increases). Note these characteristics are included in level form (rather than first differences) to allow for a delayed response to changes in market structure or in local economic conditions.<sup>15</sup>

In contrast, we anticipate concurrent premium responses to changes in characteristics measured at the employer-market-year level ( $\Delta C_{emt}$ ), specifically demographic factors and the percentage of enrollees in self-insured plans. The year fixed effects capture average national changes in premium growth, and the market fixed effects capture differences in average growth rates across markets. Finally, we also estimate specifications including the terms in brackets: employer fixed effects, changes in the share of enrollees in each plan type, and changes in the average generosity of these plans.<sup>16</sup>

Results are presented in columns 1 through 3 of Table 2. There is no significant association between concentration levels and premium growth, and the estimates change little upon inclusion of additional controls.<sup>17</sup> Of course, causality can be inferred from this model only if within-market variation in insurer concentration is uncorrelated with other unobserved determinants of premiums, and if variation in premium growth does not induce variation in concentration. As previously noted,

<sup>14</sup> From a theoretical standpoint, HHI is a valid measure of competition if firms compete à la Cournot. While the Cournot model does not accurately describe the health insurance market, we follow the lead of most prior studies in the related literature, as well as the Horizontal Merger Guidelines, in adopting the HHI as a measure of competition.

<sup>15</sup> Given the inclusion of market fixed effects in equation (1), the coefficients on market-year covariates (including HHI) are identified by within-market changes in these variables.

<sup>16</sup> Note that employer fixed effects will substantially affect the coefficient on HHI only if employers with high or low growth in premiums are systematically located in markets that have high or low levels of HHI.

<sup>17</sup> The estimates are similarly small in magnitude and statistically insignificant if we use the change in HHI in place of the level of HHI as the key explanatory variable. For the most part, the coefficient estimates on the market-level control variables are statistically insignificant. The coefficient estimates on the employer-market controls are highly significant and generally have the expected signs. For example, a shift from 100 percent enrollment in POS plans (the omitted category) to 100 percent enrollment in HMO plans is associated with a 5 percent decline in premiums.

TABLE 2—EFFECT OF CONSOLIDATION ON PREMIUMS (OLS MODELS)  
(Study Period: 1998–2006)

	Dependent variable = annual change in ln(premiums)		
	(1)	(2)	(3)
Lagged HHI	0.002 (0.010)	−0.004 (0.009)	−0.005 (0.009)
Market-year controls			
Lagged ln(Medicare costs per cap)	−0.015 (0.016)	−0.020 (0.016)	−0.019 (0.016)
Lagged unemployment rate	0.118 (0.098)	0.147 (0.090)	0.158* (0.092)
Lagged hospital HHI	0.008 (0.016)	−0.003 (0.015)	0.001 (0.015)
<i>Employer-market controls</i>			
Δ Demographic factor	0.303*** (0.004)	0.314*** (0.004)	0.311*** (0.004)
Δ Fraction of self-insured employees	0.028*** (0.005)	0.032*** (0.005)	0.024*** (0.004)
Δ Plan design			0.349*** (0.022)
Δ Fraction in indemnity plans			0.085*** (0.006)
Δ Fraction in HMO plans			−0.052*** (0.006)
Δ Fraction in PPO plans			0.002 (0.003)
Employer FE	No	Yes	Yes
Observations	66,906	66,906	66,906

Notes: The unit of observation is the employer-market-year. All specifications include market and year fixed effects. HHI is scaled from 0 to 1. Standard errors are clustered by market.

\*\*\*Significant at the 1 percent level.

\*\*Significant at the 5 percent level.

\*Significant at the 10 percent level.

there are good reasons to doubt the validity of these assumptions. Hence, in the section that follows we pursue an instrumental variables approach.

### III. Do Increases in Local Market Concentration Cause Increases in Premiums?

In this section, we estimate the causal effect of changes in market concentration on premium growth by exploiting shocks to local market concentration produced by mergers and acquisitions (M&A).<sup>18</sup> Because M&A activity in local or regional markets may itself be motivated by expected trends in premium growth, we considered only large, nonlocal mergers as candidates for this analysis. We also ruled out mergers with insufficient pre or post periods (e.g., Aetna and NYLCare in 1998, the

<sup>18</sup> Our approach is similar in spirit to that of Hastings and Gilbert (2005), who use an acquisition of a West Coast refinery as a source of exogenous variation in the degree of vertical integration across retail gasoline markets in 13 West Coast metropolitan areas. They find that nonintegrated rival stations face higher costs, controlling for several time-varying station characteristics.



first year for which we have data), few overlapping markets, or very small shares in our sample for one of the merging parties (e.g., United Healthcare and MAMSI).

Only one merger remained: the Aetna-Prudential merger of 1999. Postmerger, the new firm (known as “Aetna”) was widely reported to be the nation’s largest insurer, covering 21 million individuals.<sup>19</sup> As we describe in detail below, there was substantial overlap in the local market participation of Aetna and Prudential prior to the merger, generating the potential for sizable postmerger changes in market concentration. Online Appendix 2 provides additional discussion of the circumstances surrounding the merger. Importantly, there is no *ex ante* evidence that Aetna targeted Prudential because of expectations about premium growth or changes in insurer concentration in affected markets.

Our analysis is subdivided into four sections. First, we estimate the impact of the merger on market concentration (the “first stage” analysis). In so doing, we document the range of premerger market shares for Aetna and Prudential as well as the degree of premerger overlap. Second, we perform a reduced-form analysis, in which we examine the impact of the merger on premium growth. Third, we combine these analyses to produce our estimate of the causal impact of concentration on premiums. Last, we investigate the plausibility of alternative explanations for our findings. In particular, we estimate specifications to tease out the reaction of Aetna’s *rivals*, as these responses are informative vis-à-vis the market dynamics.

#### A. The Effect of the Aetna-Prudential Merger on Market Concentration

Immediately prior to the merger in 1999, Aetna and Prudential were the third and fifth largest insurers in our sample in terms of the number of enrollees. All 139 markets included plans offered by both firms. There was significant variation across markets, however, in the premerger shares of each firm. We hypothesize that markets served by both firms experienced increases in market concentration immediately following the merger, and that these increases varied by the premerger shares of the two merging firms. Specifically, for every market we calculate the “simulated change in HHI” ( $\text{sim } \Delta HHI_m$ ) as the merger-induced *change* in market  $m$ ’s HHI that would have occurred from 1999 to 2000 absent any other changes, i.e.,

$$\begin{aligned} (2) \quad \text{sim } \Delta HHI_m &= [\text{Aetna 1999 share}_m + \text{Pru 1999 share}_m]^2 \\ &\quad - [(\text{Aetna 1999 share}_m)^2 + (\text{Pru 1999 share}_m)^2] \\ &= 2 \times \text{Aetna 1999 share}_m \times \text{Pru 1999 share}_m. \end{aligned}$$

For example, if Aetna and Prudential had market shares of 10 percent each in 1999,  $\text{sim } \Delta HHI_m$  (scaled by 10,000 as discussed above) would equal 200.

Figure 2 provides detail on the actual distribution of  $\text{sim } \Delta HHI_m$  in the 139 LEHID markets. There is significant variation in this measure, with 46 largely unaffected markets ( $\text{sim } \Delta HHI_m < 10$ ) and 42 highly affected markets ( $\text{sim } \Delta HHI_m \geq 100$ ).

<sup>19</sup> Sanders, “Will the Aetna-Prudential Merger Hurt the Patient?” *TIME*, June 22, 1999.



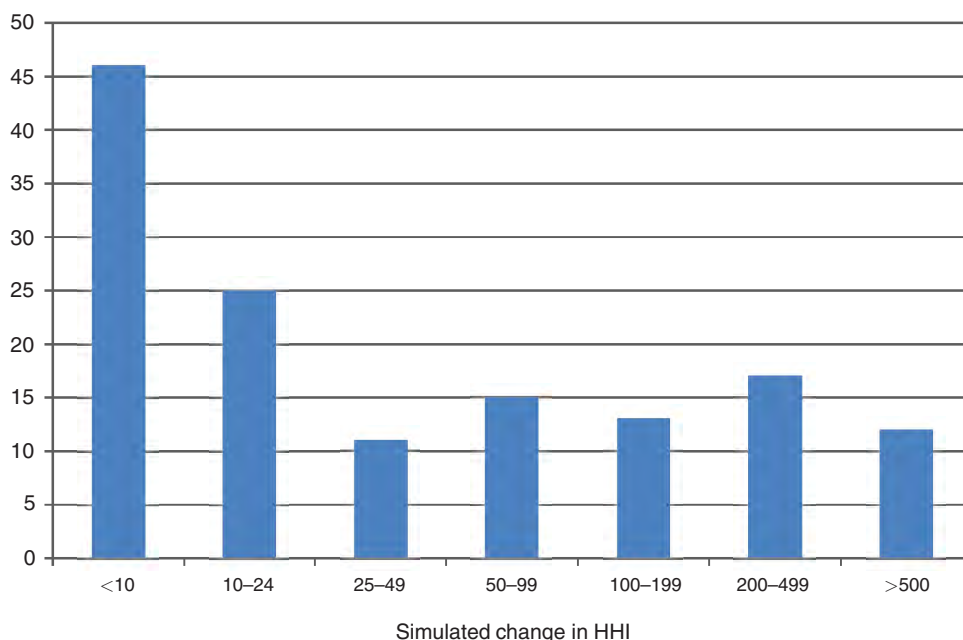


FIGURE 2. DISTRIBUTION OF SIMULATED CHANGE IN HHI RESULTING FROM AETNA-PRUDENTIAL MERGER

Notes:  $N = 139$ .  $HHI$  is scaled from 0 to 10,000.

One state in particular stands out for its high levels of  $\text{sim } \Delta HHI_m$ : Texas. Five of the six markets in Texas have  $\text{sim } \Delta HHI_m$  greater than 500. The high degree of overlap in Texas provoked action by the Department of Justice. To address the concerns raised by the Department, Aetna agreed to divest the Texas-based HMO businesses it had acquired from NYLCare in 1998.<sup>20</sup> We therefore examine whether the consent decree in Texas successfully neutralized the effect of the merger in these markets; to the extent it did, markets in Texas can serve as a “placebo” group for the natural experiment we study.

We propose to use  $\text{sim } \Delta HHI_m \times \text{post}_t$  as an instrument for HHI in equation (1), where  $\text{post}$  is an indicator variable for the postmerger years in the sample. To evaluate this instrument, we estimate the following equation using market-year data, initially excluding observations from Texas:

$$(3) \quad HHI_{mt} = \alpha + \lambda_m + \tau_t + \beta \text{sim } \Delta HHI_m \times \tau_t + \varepsilon_{mt}.$$

<sup>20</sup> DOJ alleged that after the merger, Aetna would have a market share for fully insured HMOs of 63 percent in Houston, and 42 percent in Dallas. DOJ stated that “The required divestitures . . . will preserve competition and protect consumers from higher prices” and “deny Aetna the ability to unduly depress physician reimbursement rates.” See <http://www.justice.gov/opa/pr/1999/June/263at.htm>. Although the allegations pertained to Houston and Dallas, because Aetna divested all NYLCare plans in Texas, the consent decree affected the entire state. Source: “Blue Cross and Blue Shield of Texas to Purchase NYLCare Texas Operations,” Aetna press release, 9/14/1999, [http://www.aetna.com/news/1999/pr\\_19990914.htm](http://www.aetna.com/news/1999/pr_19990914.htm).

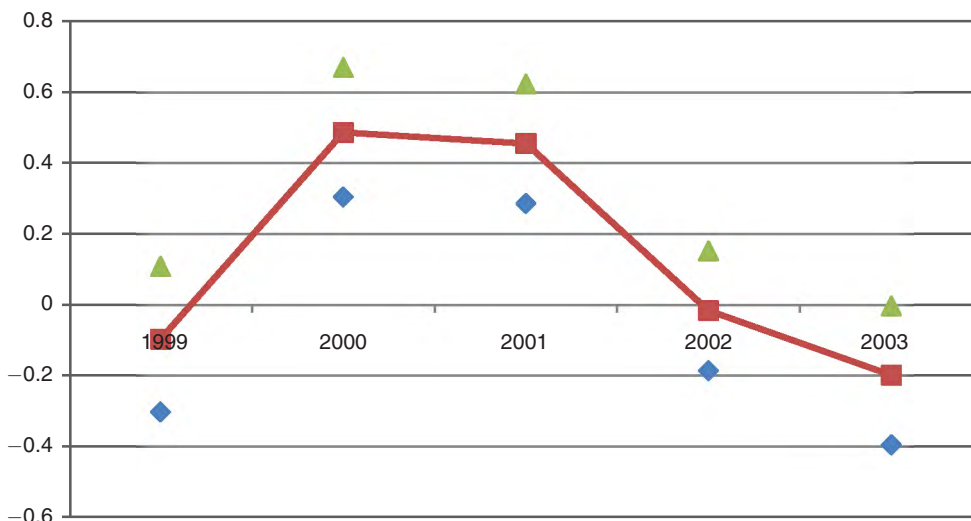


FIGURE 3. ESTIMATED COEFFICIENTS AND 95 PERCENT CONFIDENCE INTERVALS FROM REGRESSION OF HHI ON SIMULATED CHANGE IN HHI

Note: Coefficients and standard errors are reported in column 1 of Table 3.

The vectors denoted by  $\lambda_m$  and  $\tau_t$  represent a full set of market and year fixed effects, respectively. By interacting  $\text{sim } \Delta HHI_m$  with separate indicators for each year (except 1998, the omitted category), this model investigates the possibility that trends in market concentration may have been different prior to the merger in markets differentially impacted by the merger. The estimated coefficients will also help to determine the appropriate study period for our analysis. In this and all specifications including  $\text{sim } HHI_m$ , we use a scale of 0 to 1 for this measure.

Figure 3 graphs the coefficient estimates on the yearly interactions with  $\text{sim } \Delta HHI_m$ , together with the 95 percent confidence intervals. The sample includes data from 1998 to 2003. Estimates are presented in numerical form in column 1 of Table 3. Relative to the omitted interaction term,  $\text{sim } \Delta HHI_m \times (\text{year} = 1998)$ , only the interactions with indicators for 2000 and 2001 are statistically significant. At  $-0.10$ , the coefficient estimate for  $\beta$  in 1999 is small and (insignificantly) negative, whereas estimates for  $\beta$  in 2000 and 2001 are large (0.49 and 0.46, respectively) and significant at the 5 percent level. The timing is consistent with expectations: the merger was effectively cleared in July 1999, when the Department of Justice submitted its Proposed Final Judgment. The coefficients in 2000 and 2001 are significantly smaller than 1, implying that employers to some extent substituted away from Aetna and Prudential in the wake of the merger. In addition, there is likely attenuation bias due to measurement error, as we have only a sample (rather than a census) of insurance contracts.

The coefficient estimates of  $\beta$  in 2002 and 2003 are both noisy and negative indicating that the merger-induced shocks to local concentration dissipated quickly.<sup>21</sup> In

<sup>21</sup> This finding is consistent with reports from industry experts. According to a 2004 *Health Affairs* article by Robinson, “[G]ossip speculates [Aetna] would be lucky to still have 30,000 of the 5 million it acquired from Prudential.”

TABLE 3—EFFECT OF THE AETNA-PRUDENTIAL MERGER ON MARKET CONCENTRATION  
(Dependent Variable = HHI)

	1998–2003 (1)	1998–2001 (2)	1998–2001 (3)	1998–2001 (4)
<i>Sim Δ HHI</i> × (year = 1999)	−0.097 (0.180)			
<i>Sim Δ HHI</i> × (year = 2000)	0.487** (0.204)			
<i>Sim Δ HHI</i> × (year = 2001)	0.455** (0.194)			
<i>Sim Δ HHI</i> × (year = 2002)	−0.017 (0.205)			
<i>Sim Δ HHI</i> × (year = 2003)	−0.199 (0.248)			
<i>Sim Δ HHI</i> × (year ≥ 2000)		0.520*** (0.166)	0.512*** (0.165)	0.520*** (0.166)
<i>Sim Δ HHI</i> × (year ≥ 2000) × (Texas == 1)			−0.646*** (0.224)	−1.262*** (0.291)
<i>Texas</i> × (year ≥ 2000)				0.052 (0.037)
Texas included?	No	No	Yes	Yes
Observations	798	532	556	556
<i>R</i> <sup>2</sup>	0.677	0.674	0.677	0.678

Notes: The unit of observation is the market-year. All specifications include market and year fixed effects. HHI is scaled from 0 to 1. Standard errors are clustered by market.

\*\*\*Significant at the 1 percent level.

\*\*Significant at the 5 percent level.

\*Significant at the 10 percent level.

order to use the merger as an instrument for market concentration, we must therefore focus our analyses on the early years of our sample: 1998–2001 for the first-stage model, and 1998–2002 for the second stage (because HHI impacts premiums with a lag). However, in Section IIIB below, we discuss reduced-form analyses of the longer-term impact of changes in simulated HHI on health insurance premiums by extending the study period out to 2006.

Next, we use data from 1998 through 2001 to estimate a more parsimonious model that replaces the individual year interactions with a single “post” indicator that takes a value of one during 2000 and 2001:

$$\begin{aligned}
 (4) \text{ } HHI_{mt} = & \alpha + \lambda_m + \tau_t + \beta_0 \text{sim} \Delta HHI_m \times \text{post}_t \\
 & + [\beta_1 \text{sim} \Delta HHI_m \times \text{post}_t \times \text{Texas}_m] + [\psi \text{post}_t \times \text{Texas}_m] \\
 & + \varepsilon_{mt}.
 \end{aligned}$$

After estimating the baseline model (which excludes the terms in brackets), we add the six Texas markets to the sample and include a triple-interaction,

$\text{sim } \Delta HHI_m \times \text{post}_t \times \text{Texas}_m$ , to explore whether the post-merger impact of  $\text{sim } \Delta HHI$  differs in these markets. We then add the term  $\text{post}_t \times \text{Texas}_m$  to control for average changes in Texas as compared to other states during the post period, although it may be difficult to separately identify the coefficient on the two Texas interactions because there are only six Texas markets and two post years.

The results are displayed in column 2 of Table 3. As anticipated, the coefficient on  $\text{sim } \Delta HHI_m \times \text{post}_t$  is statistically significant: 0.52, with a standard error of 0.17. The results in columns 3 and 4 show that the federal government achieved its objective of neutralizing the merger's effect on market concentration in Texas markets. The triple-interaction term for Texas markets is negative and statistically significant in both specifications and fully offsets the impact of the merger. In both models, we cannot reject the hypothesis that the sum of the relevant double- and triple-interaction terms equals zero. Observations from Texas are therefore suitable for the placebo test (or falsification exercise) previously noted. If premium growth has a similar relationship with  $\text{sim } \Delta HHI$  in Texas as in other parts of the United States, then changes in insurer concentration may not be driving the observed relationship.

#### B. The Effect of the Aetna-Prudential Merger on Health Insurance Premiums

To investigate the effect of merger-induced increases in local market concentration on plan premiums, we estimate models of the following form:<sup>22</sup>

$$\begin{aligned} (5) \Delta \ln(\text{premium})_{emt} = & \alpha + \kappa_0 \text{sim } \Delta HHI_m \times \text{post}_t + \phi X_{mt-1} + \rho \Delta C_{emt} \\ & + \tau_t + \lambda_m [+ \varsigma_e] [+ \omega \Delta \text{plan type shares}_{emt} \\ & + \vartheta \Delta \text{plan design}_{emt}] \\ & [+ \kappa_1 \text{sim } \Delta HHI_m \times \text{post}_t \times \text{Texas}_m] \\ & [+ \gamma \text{post}_t \times \text{Texas}_m] + \varepsilon_{emt}. \end{aligned}$$

In light of the results from the preceding section, we focus on the period between 1998 and 2002 (i.e., annual premium growth from 1998–1999, 1999–2000, 2000–2001, and 2001–2002). Note that in this model  $\text{post}_t$  takes a value of one for the 2000–2001 and 2001–2002 changes, and is otherwise equal to zero.<sup>23</sup> As in the OLS regressions presented in Section II, we begin with a parsimonious specification that controls for lagged market covariates and changes in employer-market characteristics, as well as fixed differences across years and markets in average premium growth (captured respectively by year and market fixed effects, denoted  $\tau_t$  and  $\lambda_m$ ).

The results are reported in column 1 of Table 4. The estimated coefficient on  $\text{sim } \Delta HHI_m \times \text{post}_t$  is positive and statistically significant. Given the mean

<sup>22</sup> In a companion set of specifications (results available upon request), we define the outcome variable to be  $\ln(\text{premium})$  (rather than the change in this measure) and include market time trends. The results are similar to those presented in this section.

<sup>23</sup> Recall the last year of the merger-induced HHI increase was 2001, and premiums for 2002 are set in 2001.

TABLE 4—MERGER EFFECTS ON PREMIUMS  
(Study Period: 1998–2002)

	Dependent variable = annual change in ln(premiums)					
	(1)	(2)	(3)	(4)	(5)	(6)
<i>Sim</i> $\Delta HHI \times (\text{year} \geq 2001)$	0.177*** (0.056)	0.202*** (0.048)	0.186*** (0.050)		0.193*** (0.049)	0.188*** (0.049)
<i>Sim</i> $\Delta HHI \times (\text{year} = 2000)$				0.011 (0.061)		
<i>Sim</i> $\Delta HHI \times (\text{year} = 2001)$				0.181** (0.071)		
<i>Sim</i> $\Delta HHI \times (\text{year} = 2002)$				0.200*** (0.067)		
<i>Sim</i> $\Delta HHI \times (\text{year} \geq 2001)$ $\times (\text{Texas} = 1)$					−0.238*** (0.069)	−0.056 (0.191)
$(\text{Year} \geq 2001) \times (\text{Texas} = 1)$						0.016 (0.017)
<i>Market-year controls</i>						
Lagged ln(Medicare costs per cap)	−0.029 (0.034)	−0.047 (0.036)	−0.039 (0.036)	−0.040 (0.036)	−0.046 (0.033)	−0.048 (0.033)
Lagged unemployment rate	0.479*** (0.174)	0.579*** (0.161)	0.567*** (0.155)	0.570*** (0.155)	0.575*** (0.152)	0.535*** (0.152)
Lagged hospital HHI	0.003 (0.022)	−0.004 (0.021)	0.003 (0.020)	0.003 (0.020)	−0.010 (0.020)	−0.008 (0.020)
<i>Employer-market controls</i>						
$\Delta$ Demographic factor	0.304*** (0.006)	0.328*** (0.005)	0.323*** (0.006)	0.323*** (0.006)	0.324*** (0.005)	0.324*** (0.005)
$\Delta$ Fraction of self-insured employees	0.048*** (0.007)	0.054*** (0.007)	0.019*** (0.006)	0.019*** (0.006)	0.017*** (0.006)	0.017*** (0.006)
$\Delta$ Plan design			0.223*** (0.040)	0.223*** (0.040)	0.210*** (0.040)	0.211*** (0.040)
$\Delta$ Fraction in indemnity plans			0.089*** (0.008)	0.089*** (0.008)	0.091*** (0.008)	0.091*** (0.008)
$\Delta$ Fraction in HMO plans			−0.081*** (0.009)	−0.081*** (0.009)	−0.084*** (0.009)	−0.084*** (0.009)
$\Delta$ Fraction in PPO plans			0.000 (0.006)	0.000 (0.006)	−0.001 (0.006)	−0.001 (0.006)
Employer FE	No	Yes	Yes	Yes	Yes	Yes
Texas observations included?	No	No	No	No	Yes	Yes
Observations	28,645	28,645	28,645	28,645	30,493	30,493

Notes: The unit of observation is the employer-market-year. All specifications include market and year fixed effects. HHI is scaled from 0 to 1. Standard errors are clustered by market.

\*\*\*Significant at the 1 percent level.

\*\*Significant at the 5 percent level.

\*Significant at the 10 percent level.

*sim*  $\Delta HHI_m$  of 0.014 (across all 139 geographic markets), the point estimate of 0.177 implies that, in a typical market, the merger induced an average premium increase of approximately 0.25 percent in both 2001 and 2002, and thus a total increase of approximately 0.50 percent. The point estimate changes little upon inclusion of employer fixed effects (column 2), and as expected the standard errors decrease. Adding controls for changes in the generosity of plans (column 3) also has little impact on the estimate.

Next, we study the pattern of premium growth over time by replacing the term  $\text{sim } \Delta \text{HHI}_m \times \text{post}_t$  with  $\text{sim } \Delta \text{HHI}_m \times \tau_t$  (interactions with individual year dummies, with 1998 as the omitted year). The results, in column 4, provide two key insights. First, there is no evidence of a “pretrend” in premium growth; that is, the estimated reaction to the merger is not due to a premerger trend in markets with large overlapping Aetna and Prudential market shares. Second, the effect of the merger on premium growth is very similar in both “post” years.

This finding strongly suggests that the impact of the merger is appropriately modeled, i.e., that concentration affects the growth rate rather than the level of premiums.<sup>24</sup> If the sample is extended to 2006, we find the coefficients remain of similar magnitude for two more years, and then fall down close to zero.<sup>25</sup> The fact that the coefficient estimates remain positive and do not become negative suggests some amount of hysteresis: consolidation results in a higher rate of premium growth, and even when circumstances change (in this case, the effect of the merger on concentration eventually disappeared) premiums remain elevated.<sup>26</sup>

Columns 5 and 6 of Table 4 present the results of the falsification test enabled by the divestiture requirement in Texas. To execute this test, we add Texas observations to the sample and estimate the full model (as in column 3) with the addition of a triple interaction term,  $\text{sim } \Delta \text{HHI}_m \times \text{post}_t \times \text{Texas}_m$ .<sup>27</sup> The estimated coefficient on this term is highly significant and negative ( $-0.24$ ) and almost perfectly offsets the main effect of  $\text{sim } \Delta \text{HHI}_m$  in this specification ( $0.19$ ). Although the result is not robust to including a separate term for  $\text{post}_t \times \text{Texas}_m$  (column 6), this is not surprising given there are only six markets in Texas and just two post years. On net, the results suggest that the market power effect of the merger in Texas was indeed neutralized by the DOJ’s actions.<sup>28</sup>

### C. IV Estimates

Table 5 presents the first-stage, reduced-form, and second-stage models corresponding to our IV estimate; the reduced-form model is repeated from column 3 of Table 4. At 0.39, the estimated effect of lagged HHI on premium growth is positive, statistically significant, and roughly twice as large as the reduced-form estimate. This is anticipated given the first-stage coefficient of 0.48 reported in column 1.<sup>29</sup>

Because our estimates suggest that changes in HHI affect the growth *rate* (rather than just the level) of premiums, to estimate the average effect of consolidation over the entire study period, we must consider the timing of consolidation between 1998

<sup>24</sup> An alternative explanation is that an increase in concentration does raise the level (rather than the growth rate) of premiums, but it takes multiple years to reach the new level.

<sup>25</sup> To be precise, the coefficients on interactions of the simulated change in HHI with indicators for 2003 and 2004 are 0.293 and 0.203 respectively, and are both significant with  $p < 0.01$ .

<sup>26</sup> As noted earlier, the results of the first stage necessitate a study period ending in 2002. However, the results just described suggest the estimates will be conservative.

<sup>27</sup> Note a second-order interaction (i.e.,  $\text{post}_t \times \text{Texas}_m$ ) is arguably not necessary in this model as market fixed effects already control for differences in average annual growth rates across markets.

<sup>28</sup> As an additional extension of the reduced-form analysis, we examined whether the impact of the merger was greater in markets with higher initial levels of concentration. Unfortunately, coefficient estimates on  $\text{sim } \Delta \text{HHI}_m \times \text{post}_t \times \text{initial HHI}_m$  (and variants thereof) were very imprecise.

<sup>29</sup> Note this first-stage coefficient differs slightly from the coefficient obtained using market-year data, as the unit of observation is the employer-market-year.

TABLE 5—THE IMPACT OF HHI ON PREMIUMS  
(Study Period: 1998–2002)

	Dep var = lagged HHI	Dep var = annual change in ln(premium)		
	First-stage estimates	Reduced-form estimates	IV estimates	OLS estimates
$Sim \Delta HHI \times (year \geq 2001)$	0.475*** (0.014)	0.186*** (0.050)		
Lagged HHI			0.391*** (0.130)	0.015 (0.018)
<i>Market-year controls</i>				
Lagged ln(medicare costs per cap)	0.034** (0.014)	−0.039 (0.036)	−0.052 (0.037)	−0.018 (0.034)
Lagged unemployment rate	0.204*** (0.048)	0.567*** (0.155)	0.488*** (0.163)	0.474*** (0.162)
Lagged hospital HHI	−0.060*** (0.007)	0.003 (0.020)	0.026 (0.022)	0.006 (0.020)
<i>Employer-market controls</i>				
$\Delta$ Demographic factor	0.004*** (0.001)	0.323*** (0.006)	0.321*** (0.004)	0.323*** (0.003)
$\Delta$ Fraction of self-insured employees	0.000 (0.001)	0.019*** (0.006)	0.019*** (0.004)	0.019*** (0.004)
$\Delta$ Plan design	0.019* (0.010)	0.223*** (0.040)	0.216*** (0.028)	0.222*** (0.027)
$\Delta$ Fraction in indemnity plans	0.001 (0.002)	0.089*** (0.008)	0.089*** (0.005)	0.089*** (0.005)
$\Delta$ Fraction in HMO plans	−0.003 (0.002)	−0.081*** (0.009)	−0.080*** (0.006)	−0.081*** (0.006)
$\Delta$ Fraction in PPO plans	0.001 (0.002)	0.000 (0.006)	0.000 (0.005)	0.001 (0.005)
Observations	28,645	28,645	28,645	28,645

Notes: The unit of observation is the employer-market-year. All specifications include employer, market, and year fixed effects. HHI is scaled from 0 to 1. Standard errors are clustered by market.

\*\*\*Significant at the 1 percent level.

\*\*Significant at the 5 percent level.

\*Significant at the 10 percent level.

and 2006. As previously noted, the average increase in HHI across all markets was 698 points during this period. If this increase were evenly distributed over time, the effect of consolidation on premiums during our study period would be approximately 13 percent. However, consolidations tended to occur later in the study period, yielding a cumulative estimated effect of approximately 7 percent.<sup>30</sup>

For the sake of comparison, we also present coefficient estimates obtained using OLS models, in which lagged HHI is the predictor of interest. As noted before, OLS estimates are likely to be downward biased, understating the actual impact of changes in market concentration on premiums. Indeed, the coefficient from the OLS model (presented in column 4) is near zero (and imprecisely estimated).

<sup>30</sup>Details of our calculation are available in online Appendix 3. If one assumes that an increase in concentration between  $t$  and  $t + 1$  affects premium growth for only two years (i.e., until  $t + 3$ , rather than indefinitely), then the implied increase in premiums caused by the increase in HHI between 1998 and 2006 is somewhat lower at 5 percent.



Hausman specification tests reject the null assumption of consistency for this model ( $p < 0.01$ ), underscoring the need for instrumental variables estimation.

Collectively, the results presented in this section show that consolidation does result in a “premium on premiums.” We arrive at this conclusion by exploiting arguably exogenous increases in local market concentration caused by the nationwide merger between two large insurance firms, Aetna and Prudential. Two key results indicate our conclusions are not driven by unobserved factors correlated with the pre-merger market shares of Aetna and Prudential. First, there is no evidence that concentration *or* premiums in markets with higher *sim*  $\Delta HHI$  were trending differently before the merger took effect. Second, we find no response in Texas, where the merger was effectively blocked by the Department of Justice. These tests support the use of *sim*  $\Delta HHI_m$  as an instrument for *lagged*  $HHI_m$ . In online Appendix 4, we examine the impact of consolidation on health plan characteristics other than price, such as *plan design* and the share of employees enrolled in HMOs.<sup>31</sup>

#### D. Alternative Explanations

The findings summarized above are consistent with the exercise of market power in the wake of consolidation. However, the pattern of results is also consistent with alternative explanations, in particular a “mistake” in Aetna’s postmerger pricing strategy, and/or increases in insurance quality (and therefore price). In this section, we discuss the evidence with regard to these alternative hypotheses.

Our results show that prices increase *on average* in markets with higher *sim*  $\Delta HHI_m$ . If this price increase is primarily due to actions by Aetna, then Aetna’s subsequent loss of market share would suggest the price increase was unsuccessful, i.e., they were not able to exercise market power following the merger. On the other hand, if competitors followed suit by increasing their prices as well, that would suggest that Aetna’s action softened competition marketwide, implying the presence (and exercise) of market power.

To investigate whether Aetna’s competitors increased their premiums in response to the merger, we estimate a set of specifications analogous to those in Table 4 for the 61 percent of employer-markets that were *not served* by either Aetna or Prudential at the time of the merger in 1999. Our point estimates for the coefficient of particular interest ( $\kappa_0$  from equation (5)) are similar to the estimates for the full sample, as shown in online Appendix 5. This implies that insurers not directly involved in the merger responded to the merger-induced change in concentration by raising their premiums, which supports the market-power explanation for our findings.

Importantly, when we restrict the sample to employer-markets that *were served* (either partially or fully) by Aetna or Prudential at the time of the merger, our estimates for  $\kappa_0$  are approximately twice as large. This suggests that the merged entity increased its premiums more than its competitors in markets where Aetna and Prudential had significant overlap, which is consistent with the merged entity

<sup>31</sup> Among other results, we find that employers reduced the generosity of *plan design*. This is consistent with efforts by employers to reduce the burden of higher insurance premiums through so-called “benefit buybacks.” We emphasize that our premium results *do* control for changes in plan design. We find a somewhat counterintuitive shift away from HMOs; however, we discuss plausible explanations for this pattern in online Appendix 4.



exercising price leadership and its oligopolistic rivals following. Last, it is notable that premiums remained elevated in high-*sim*  $\Delta HHI$  markets through at least 2006, notwithstanding Aetna's loss of market share by 2002. This hysteresis in market price is again consistent with a new oligopolistic pricing equilibrium facilitated by Aetna's original exercise of market power.

The second alternative explanation, that Aetna raised quality and competitors followed its lead, is less amenable to exploration using our data. Conceptually, there are at least two reasons to question this hypothesis. First, quality is "lumpy" (e.g., enhancing consumer access to claims) and far more difficult to calibrate across different markets than price. Second, quality changes take time to implement and to communicate to the marketplace, and the impact of the merger on price occurs within the first year. These points notwithstanding, quality remains an important omitted factor in our analysis.

#### IV. Evaluating the Effects of Insurer Consolidation on Providers

Thus far, we have examined the impact of market structure in the insurance industry on downstream buyers, specifically of group plans. However, the degree of competition in the insurance industry will also potentially affect upstream suppliers, such as health-care providers, pharmaceutical firms, and medical device manufacturers. To the extent that suppliers have few outside options, a lack of vigorous competition among insurers may lead to monopsonistic practices. Capps (2010) reviews the theoretical and practical implications of monopsony in the context of health insurance mergers.<sup>32</sup>

Concern about insurers' monopsonistic practices has emanated not only from provider organizations such as the American Medical Association and the American Hospital Association but also from state and federal regulatory authorities. In fact, the DOJ's formal complaint regarding the Aetna-Prudential merger alleged that the merger "would enable Aetna to exercise monopsony power against physicians, allowing Aetna to depress physicians' reimbursement rates in Houston and Dallas, likely leading to a reduction in quantity or degradation in quality of physicians' services."<sup>33</sup>

In this section, we consider the possibility that consolidation facilitates the exercise of monopsony power by estimating the relationship between our instrument for HHI (*sim*  $\Delta HHI_m$ ) and both the employment (or "quantity") and average compensation (or "price") of health-care personnel (such as physicians and nurses). As in the premium analysis, if variation in the impact of the merger on different geographic localities can be assumed orthogonal to other determinants of employment and compensation *growth*, our results can be interpreted as causal estimates of the impact of consolidation on these outcomes.

To execute this analysis, we supplemented the LEHID data with the Occupational Employment Statistics (OES) survey on income and employment in

<sup>32</sup> A number of recent studies examine the effect of insurer bargaining power on hospital prices, including Feldman and Wholey (2001), Sorensen (2003), Moriya, Vogt, and Gaynor (2010), and Ho (2009).

<sup>33</sup> See Complaint, *United States vs. Aetna Inc.* (ND TX, 21 June 1999). More recently, the DOJ required a similar divestiture before approving a 2005 merger between United Health Group Inc. and Pacificare Health Systems Inc. Both divestitures were driven by concerns about the effect on physician services in specific markets (see Complaint, *United States vs. UnitedHealth Group Inc. and Pacificare Health Systems Inc.*, Dec 20, 2005).

health care–related occupations. We restrict our attention to the 43 occupation categories that are classified under the Standard Occupational Classification (SOC) system as “Healthcare Practitioner and Technical Occupations.” These include dentists, registered nurses, anesthesiologists, surgeons, and pharmacy technicians. To facilitate a comparison of impacts on physicians versus nurses, we pool together the eight occupation categories pertaining to physicians and the two for nurses.<sup>34</sup> Nurses are by far the largest group, accounting for 56 percent of personnel in our sample; pharmacists are second (4.3 percent), and physicians are a close third (4.2 percent). Additional details, including descriptive statistics for our sample, are available in online Appendix 6.

The unit of observation for the OES data (as well as our analysis) is the occupation-MSA-year and the variables of interest are the mean annual wage and estimated employment. Using a crosswalk that matches LEHID markets to MSAs, we merge this data with our measures of insurer concentration (including our instrument). We estimate parsimonious specifications using the change in log average earnings or employment between 1999 and 2002 as the dependent variable, and  $\text{sim} \Delta HHI$  as the main predictor:

$$\begin{aligned} (6) \quad \Delta \ln y_{os,99-02} = & \alpha + \gamma \text{sim} \Delta HHI_s + \omega \text{Physician}_o \times \text{sim} \Delta HHI_s \\ & + \vartheta \text{Nurse}_o \times \text{sim} \Delta HHI_s \\ & + \varsigma \text{Physician}_o + \theta \text{Nurse}_o + v \Delta \text{Hospital} HHI_s \\ & + [\Delta \ln y_{os,97-98} + \mathbf{s}_o] + \varepsilon_{os}. \end{aligned}$$

The subscripts  $o$  and  $s$  denote occupation and MSA, respectively. Our baseline specification includes indicators for the physician and nurse occupation categories as well as interactions between these indicators and  $\text{sim} \Delta HHI_s$ . The indicators capture differences in earnings and employment growth for each category (relative to other health-care occupations), while the interactions reflect the differential impact of insurer consolidation on earnings and employment in these categories. In all specifications, we control for the change in hospital concentration in each market. As specification checks, we progressively add each of the terms in brackets. The first term,  $\Delta \ln y_{os,97-98}$ , represents the change in earnings or employment between 1997 and 1998 and serves as a control for preexisting trends in earnings (or employment) growth. The second term represents a full set of fixed effects for the 35 occupation categories. We necessarily restrict the sample to occupation-markets present in both 1999 and 2002, and we weight each observation by the average estimated employment in that occupation-market. Standard errors are robust and clustered by MSA.

<sup>34</sup> The categories pooled under “Physicians” are Dentists, Family and General Practitioners, General Internists, Obstetricians and Gynecologists, General Pediatricians, Psychiatrists, Podiatrists, and Surgeons. Some of the individual physician categories have low estimates for employment and are present in only a handful of markets during our study period. The “Nurses” category includes Registered Nurses (RNs) and Licensed Vocational Nurses (LVNs).

TABLE 6—EFFECT OF THE AETNA-PRUDENTIAL MERGER ON HEALTH-CARE PROVIDER EARNINGS AND EMPLOYMENT

	Dep var = $\Delta \log$ (average income) from 99–02; mean = 0.121			Dep var = $\Delta \log$ (employment) from 99–02; mean = 0.191		
<i>Simulated <math>\Delta HHI</math></i>	0.111 (0.180)	0.078 (0.215)	0.091 (0.204)	–2.372*** (0.809)	–2.723*** (0.941)	–2.437** (0.978)
Physician indicator	0.193*** (0.034)	0.184*** (0.035)	NA	0.523*** (0.170)	0.497*** (0.167)	NA
<i>Physician <math>\times</math> simulated <math>\Delta HHI</math></i>	–2.007** (0.833)	–2.180*** (0.801)	–2.195*** (0.811)	–2.507 (7.934)	–2.582 (8.441)	–2.858 (8.439)
Nurse indicator	–0.013** (0.006)	–0.015** (0.006)	NA	–0.154*** (0.025)	–0.160*** (0.027)	NA
<i>Nurse <math>\times</math> simulated <math>\Delta HHI</math></i>	0.440** (0.221)	0.471* (0.257)	0.457* (0.254)	1.707** (0.845)	2.012* (1.071)	1.738* (1.032)
$\Delta$ Hospital HHI, 1999–2002	0.023 (0.029)	0.021 (0.031)	0.024 (0.032)	–0.024 (0.254)	–0.027 (0.247)	–0.067 (0.235)
Trend in dep var, 1997–1998	No	Yes	Yes	No	Yes	Yes
Occupation fixed effects	No	No	Yes	No	No	Yes
Observations	2,110	1,631	1,631	2,110	1,631	1,631

Notes: Unit of observation is the occupation-market-year. All physician occupations are combined into one category. Specifications are restricted to occupation-markets present in both 1999 and 2002. Simulated HHI is scaled from 0 to 1. Sample does not include observations from Texas. All specifications are weighted by average estimated employment in each occupation-market. Standard errors are clustered by market.

\*\*\*Significant at the 1 percent level.

\*\*Significant at the 5 percent level.

\*Significant at the 10 percent level.

The results are presented in Table 6. Columns 1 through 3 pertain to models using the change in log average earnings from 1999–2002 as the dependent variable, while columns 4–6 use the change in log employment as the dependent variable. The coefficient estimate on *sim  $\Delta HHI_s$*  in columns 1 through 3 is positive but imprecisely estimated, implying no significant impact of the merger on average earnings across all health-care occupations. The coefficient on the physician indicator in columns 1 and 2 demonstrates that physicians experienced an increase of around 21 percent in average nominal earnings between 1999 and 2002 (relative to nonnursing health-care personnel). However, the coefficient estimate on *Physician<sub>o</sub>  $\times$  sim  $\Delta HHI_s$*  is negative and significant in all models, revealing that earnings growth for physicians was lower in markets affected by the merger. Given the average value of 0.014 for *sim  $\Delta HHI_s$* , the point estimate implies that the merger restrained growth in physician earnings by approximately 3 percent in a typical market. The coefficient on the nurse indicator reveals that nurses experienced a small decrease in relative earnings over the same time period. However, the interaction term for nurses is positive and statistically significant, implying this decrease was offset at least in part in markets where Aetna and Prudential had premerger overlap (by approximately 0.6 percent in the typical market).

Columns 4 through 6 present estimates from specifications examining the impact of the merger on employment. The coefficients are again similar across all models. Relative to other health-care occupations, employment of physicians increased, while that of nurses decreased, during the study period. The point estimate on *sim  $\Delta HHI_s$*  is negative and significant: in a typical market, the merger led to a drop in health care–related employment of 2.7 percent. The interaction between the physician indicator

and  $\text{sim}\Delta HHI_s$  is negative but noisily estimated, whereas the interaction between the nurse indicator and  $\text{sim}\Delta HHI_s$  is large, positive, and marginally significant. The relative increase in nurse employment in geographic markets differentially affected by the merger suggests there was some substitution toward nurses in these markets. This explanation is buttressed by the earnings regressions, which found the merger depressed growth in physicians' earnings while modestly boosting nurses' earnings.<sup>35</sup>

To summarize, we find that increases in market concentration predicted to occur in the wake of the Aetna-Prudential merger resulted in pronounced declines in health care–related employment. These declines were smaller for nurses than for other occupations on average (including physicians), and nurses also enjoyed wage increases relative to other occupations (and physicians in particular).<sup>36</sup> The evidence suggests that market power facilitates the substitution of nurses for physicians. The results are also consistent with the exercise of monopsony power by insurers vis-à-vis physicians, as their relative earnings and employment growth declined most in markets with the largest predicted merger impact. Paired with the findings of the previous section, we conclude that in markets where Aetna and Prudential had substantial premerger overlap, insurers were able to exercise market power simultaneously in input *and* output markets postmerger. Thus, the premium increases documented in the previous section likely understate the increase in insurer profits due to consolidation.

## V. Discussion and Conclusions

The scope of the private health insurance industry is difficult to overstate. More than 170 million nonelderly Americans are privately insured, and this figure does not include the millions of publicly insured individuals whose coverage is outsourced to private insurers. The recent health insurance reform legislation will further expand the reach of this industry, with the Congressional Budget Office projecting an increase of 16 million in the number with private primary insurance by 2019 (CBO 2010). In addition, the annual growth in employer-sponsored health insurance premiums has exceeded the annual growth in earnings by a factor of seven during the last several years (Romer and Duggan 2010).<sup>37</sup> In this study, we investigate whether and to what extent increasing consolidation in the US health insurance industry is responsible for this rapid growth in premiums.

We arrive at four main conclusions. First, most Americans live in markets served by a small number of insurers, and most markets are becoming more concentrated over time. We estimate that the fraction of local markets falling under the “highly

<sup>35</sup> As a robustness check, we estimated all models using 1999–2001 as the study period, as the BLS changed its methodology for constructing mean wages in 2002 (see online Appendix 6). Our findings are qualitatively similar.

<sup>36</sup> We also estimated specifications subdividing the nurse category into two large subgroups (Registered Nurses—RNs and Licensed Vocational Nurses—LVNs). We find that only RNs earned higher relative raises in markets where the merger had most impact. LVNs enjoyed significant relative employment gains, whereas the employment gains for RNs were not statistically significant (although they are of similar magnitude). On the whole, the results are consistent with outward shifts of demand for both nursing types, with a less-elastic short-run supply curve for RNs. The results from these specifications are presented in online Appendix 6. We thank an anonymous referee for this suggestion.

<sup>37</sup> Data from the BLS “Employer Costs for Employee Compensation” survey indicate that workers' real average hourly wage and salary income increased by 0.7 percent annually from 2000 to 2009. During that same period, the growth rate in ESI premiums was substantially higher at 5.1 percent per year (Romer and Duggan 2010).

concentrated” category (per the DOJ’s Horizontal Merger Guidelines) increased from 68 to 99 percent between 1998 and 2006. Second, premiums are *not* rising more quickly in markets experiencing the greatest increases in concentration, even controlling for a rich set of observable plan characteristics.

Third, when we account for the fact that changes in concentration are not orthogonal to other determinants of premium growth, we find that increases in concentration do raise premiums. Our instrumental variables estimates, which exploit plausibly exogenous shocks to local market structure generated by the 1999 merger of Aetna and Prudential, imply that the average market-level changes in HHI between 1998 and 2006 resulted in a premium increase of approximately 7 percentage points by 2007, *ceteris paribus*. Given our sample includes both fully and self-insured plans, and insurers have less control over pricing of the latter, it is plausible that consolidation is associated with an even larger impact on fully insured plans, which are dominant in the individual and small group markets.

Fourth, we find evidence that consolidation reduces the employment of health-care workers and may facilitate the substitution of nurses for physicians. Using data from the Occupational Employment Statistics survey between 1999 and 2002, we find the Aetna-Prudential merger reduced physician earnings in a typical market by 3 percent and raised nurse earnings by 0.6 percent. The magnitude of this effect was higher (lower) in markets where the premerger shares of the two companies overlapped more (less). Thus, the results imply that insurers exercised monopsonistic power against physicians in some markets during the period 1998–2002.

Our findings indicate that Americans are indeed paying a premium on their health insurance premiums as a result of recent increases in market concentration of the health insurance industry. However, consolidation explains only a fraction of the steep increase in premiums in recent years. While 7 percent is large in absolute terms (it translates into approximately \$34 billion in extra annual premiums), and large relative to operating margins of insurers, it is only one-eighth of the increase in average, inflation-adjusted premiums observed in our sample during the same 1998 to 2006 time period.<sup>38</sup>

We caution that our analysis relies on a single merger whose substantial effects on market concentration persisted for just two years. However, it is among the largest mergers to date in the health insurance industry, and one with differential impacts across 139 geographic markets in the United States (implying 139 small experiments). Additional research that utilizes other plausibly exogenous sources of variation in market structure would be valuable to assessing conduct in this important industry. We also emphasize that our sample consists primarily of large, multisite firms, and the results may not be generalizable to all market segments, including the small group and individual markets.<sup>39</sup> Finally, there has also been a great deal of consolidation across (as opposed to within) markets, the effects of which are not reflected in our estimates.

<sup>38</sup> As shown in Table 1, average premiums in our sample increased from \$4,104 in 1998 to \$7,832 in 2006. Adjusting these both to 2007 dollars yields an increase in average, inflation-adjusted premiums of 54 percent. The \$34 billion figure is based on an estimated \$490 billion in total private insurance premiums in the United States as of 1998 (CMS 2011). The aggregate effect of consolidation on profits should be larger as the “premium on premiums” does not incorporate reductions in provider payments obtained through the exercise of monopsony power.

<sup>39</sup> High and increasing concentration has also been documented in the individual/small group market (GAO 2009b).



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Jan. 15, 2016

The Honorable Dave Jones  
Insurance Commissioner  
California Department of Insurance  
300 Capitol Mall, 17th Floor  
Sacramento, CA, 95814

Re: Proposed Acquisition of Health Net Life Insurance Company by Centene Corporation, File No. APP-2015-00889

Dear Commissioner Jones,

Consumer Watchdog, a nonpartisan, nonprofit public interest group, urges the California Department of Insurance (CDI) to use its full authority to impose comprehensive requirements to protect consumers before allowing the merger between Centene and Health Net to move forward.

The Affordable Care Act was meant to give more people to access to healthcare, and millions of Californians are newly insured. Yet many low- and middle-income families continue to struggle to pay the costs of a policy, let alone use their new health coverage. Increasing premiums, shrinking physician networks, ruinous out-of-network charges and soaring deductibles have become the hidden premium hike that an increasing number of consumers simply can't afford. A Kaiser Family Foundation/New York Times survey released January 5<sup>th</sup> showed that one in five working-age Americans ran into serious financial difficulties trying to pay medical bills despite being insured.<sup>1</sup>

Research on insurance consolidation has confirmed these results. Northwestern University Professor Leemore Dafny, who testified at a U.S. Senate hearing in September about insurance industry consolidation, noted that in her 2012 consolidation study<sup>2</sup> of the 1998 Aetna and Prudential Healthcare merger that top executives cut jobs and wages as well as reduced payments to healthcare providers to cut costs. Dafny wrote, "Americans are indeed paying a premium on their health insurance premiums as a result of recent increases in market concentration of the health insurance industry."

At a related U.S. House of Representatives hearing on the same subject, Jaime King, a law professor at the University of California, said there was an almost immediate 7 percent hike in premiums after the Aetna-Prudential merger. She added that despite promises of Aetna at the time, the quality of care did not increase.<sup>3</sup>

<sup>1</sup> <http://kff.org/health-costs/report/the-burden-of-medical-debt-results-from-the-kaiser-family-foundationnew-york-times-medical-bills-survey/>

<sup>2</sup> [http://www.kellogg.northwestern.edu/faculty/dafny/personal/documents/publications/ms\\_2010\\_0837\\_0804.pdf](http://www.kellogg.northwestern.edu/faculty/dafny/personal/documents/publications/ms_2010_0837_0804.pdf)

<sup>3</sup> <http://ctmirror.org/2015/09/29/aetna-anthem-merger-plans-under-scrutiny-again-by-congress/>



In order to safeguard against making California's health insurance market even worse for consumers post-merger, CDI should use its statutory powers<sup>4</sup> to require the best protections for policyholders. Insurance Code Section 1215.18 gives the Insurance Commissioner the ability to deny a transaction if he finds any of the following:

- (1) After the change of control the domestic insurer referred to in subdivision (a) could not satisfy the requirements for the issuance of a license to write the line or lines of insurance for which it is presently licensed;
- (2) The purchases, exchanges, mergers, or other acquisitions of control would substantially lessen competition in insurance in this state or create a monopoly therein;
- (3) The financial condition of an acquiring person might jeopardize the financial stability of the insurer, or prejudice the interests of its policyholders;
- (4) The plans or proposals which the acquiring person has to liquidate the insurer, to sell its assets, or to merge it with any person, or to make any other major change in its business or corporate structure or management, are not fair and reasonable to policyholders;
- (5) The competence, experience, and integrity of those persons who would control the operation of the insurer indicate that it would not be in the interest of policyholders or the public to permit them to do so.

### ***Merger Undertakings***

#### **1. Enhanced Rate Review**

Under Insurance Code 1215.2 (d)(4), the Insurance Commissioner has the authority to deny a merger transaction if the plans or proposals "are not fair and reasonable to policyholders."

Health Net's past rate filings with the Department of Insurance and Department of Managed Health Care have not always been fair or reasonable.

In 2013, Consumer Watchdog, CalPIRG and Department of Insurance actuaries determined that Health Net's proposed individual PPO rates for Covered California were unreasonable.<sup>5</sup> The company ultimately agreed to amend its proposal and reduced rates,<sup>6</sup> however Health Net did not have to accept the Department and consumer advocates' findings.

In 2014, a proposed rate hike by Health Net for individual policyholders regulated by the DMHC was also found to be unjustified by Consumers Union.<sup>7</sup> Their analysis found that Health Net's pricing and network design suggested manipulation of the market to reduce Health Net's risk by discouraging sicker enrollees. The analysis also found that Health Net had failed to reflect, and thus did not pass on

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<sup>4</sup> Insurance Code Section 1215-1215.18

<sup>5</sup> <http://www.consumerwatchdog.org/blog/healthnets-exchange-rate-unreasonable>

<sup>6</sup> [https://interactive.web.insurance.ca.gov/apex/f?p=102:9:8204134511014::NO::P9\\_RATE\\_FILINGS\\_ID%2CP9\\_COMPANY\\_NAME%2CP9\\_REFER\\_PAGE\\_NUM:7607%2C%5CHealth+Net+Life+Insurance+Company%5C%2C4&cs=13866C17A08C0AFF5E149A02EF3FC6E9D](https://interactive.web.insurance.ca.gov/apex/f?p=102:9:8204134511014::NO::P9_RATE_FILINGS_ID%2CP9_COMPANY_NAME%2CP9_REFER_PAGE_NUM:7607%2C%5CHealth+Net+Life+Insurance+Company%5C%2C4&cs=13866C17A08C0AFF5E149A02EF3FC6E9D)

<sup>7</sup> [https://consumersunion.org/wp-content/uploads/2014/09/CU\\_Health\\_Net\\_comments\\_0914.pdf](https://consumersunion.org/wp-content/uploads/2014/09/CU_Health_Net_comments_0914.pdf)

to consumers, anticipated cost savings in its rates. Significantly, Health Net did not consistently account for the cost savings achieved by narrowing its networks.

As we've seen with other health insurance companies, such as Aetna<sup>8</sup> and Anthem<sup>9</sup>, insurance companies repeatedly ignore findings of excessive and unjustified rate proposals, leading to outrageous premium hikes for consumers. Since 2012, Californians have paid at least \$385 million in unreasonable premium hikes.

The proposed merger comes with, according to Centene CEO Michael Neidorff, plans to cut \$150 million in "costs" from Health Net through "synergies."<sup>10</sup> Such "savings" are often achieved through reductions in benefits, such as narrowing networks. Merged insurers may also obtain savings by applying pressure on providers, with a larger entity's market power, to lower costs. Unless the Department of Insurance has binding authority over rates, there is no reason to believe – or even for the Department to know if – these cost savings will be passed on to consumers.

To ensure that the terms of the merger are "fair and reasonable," as statute dictates, the Department must require enhanced rate review as part of any approval. Rate review can ensure: details of any cuts are made public, any cost savings are passed on to consumers, and premiums are not used to finance any part of the deal. The merged company must also agree not to impose unreasonable rates and that premiums, co-payments and other rates will not increase more than the rate of inflation following the merger for a period of five years.

## 2. 'No Material Change' in Health Net Plans

Under Insurance Code 1215.2 (d)(2), the Insurance Commissioner may also deny a transaction if it "would substantially lessen competition."

Just four health insurance companies, Anthem Blue Cross, Blue Shield, Kaiser and Health Net control 83 % of California's private insurance market. Health Net's 6% share, while small, provides a measure of critical competition and greater choice for consumers.<sup>11</sup>

In California, Health Net's 1.4 million Medi-Cal enrollees are undoubtedly a primary reason for Centene's interest in a merger. Centene cannot be allowed to abandon the private market in California. There is precedent for Centene leaving an insurance market.<sup>12</sup> In 2012, Centene abruptly cancelled a year-long Medicaid contract short in Kentucky, citing a lack of full disclosure about how ill patients were, resulting in chaos for its 125,000 enrollees.

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<sup>8</sup> <http://www.bizjournals.com/sacramento/news/2015/10/16/insurance-commissioner-slams-aetnas-small-business.html>

<sup>9</sup> <http://www.latimes.com/business/la-fi-jones-anthem-rates-20141023-story.html>

<sup>10</sup> <http://www.prnewswire.com/news-releases/centene-to-combine-with-health-net-in-transaction-valued-at-approximately-68-billion-300108184.html>

<sup>11</sup> <http://www.chcf.org/publications/2015/02/data-viz-health-plans>

<sup>12</sup> <http://insiderlouisville.com/business/media-centene-pulls-out-of-kentucky-medicare-managed-care-deal/>

In recent years, Health Net has withdrawn both its on- and off-exchange PPO plans, causing consternation and confusion for consumers. If Health Net's plans in California were canceled, seven of Covered California's 19 regions would lose a low cost option, five regions would have just one HMO option for consumers to consider and one region would have only PPO plans. Any further Health Net plan cancellations, considering its place in the market, would be a major blow to competition in California.

At a Department of Managed Health Care (DMHC) public hearing in December on the proposed merger, a representative for Centene pledged that there would be no "material change" to any of Health Net's plans. The company will undoubtedly make the same promise at the CDI hearing on the 22<sup>nd</sup>. The Commissioner must hold the company to that promise.

As a condition of the merger, the merged company must agree not to withdraw from the private market in favor of the lucrative Medi-Cal business, and CDI should require the company to maintain Health Net's individual and small group products on the same basis as prior to the merger.

### 3. Bar "Upstreaming" of California Premiums to Centene

Insurance Code 1215.2 (d)(3), also gives the Insurance Commissioner the ability to deny a transaction if the financial condition of an acquiring person might "prejudice the interests of its policyholders."

CDI should be vigilant when it comes to executive compensation related to the merger and any "upstream" funds sent from California to the parent company post-merger. Past insurers have used these financial avenues to drain money from the state.

In the 2004 merger of Anthem and WellPoint, WellPoint executives wanted to walk away with \$600 million from the deal. Then-Insurance Commissioner John Garamendi blocked that attempt, citing Insurance Code section 1215.2(d)(3) and (4) as the legal standard by which he could review a potential purchase of a California insurance company.

Garamendi eventually approved the merger only after Anthem agreed to concessions, including reduced executive compensation tied to the merger, and donations of \$265 million into California state health programs. As part of the concessions, Anthem also had to restrict the practice of selecting healthy populations while excluding people who are more likely to get ill or incur medical expenses, and had to agree that Blue Cross Life & Health customers would not pay for the merger through any higher rates.<sup>13</sup>

Even with a reduced compensation package, it was reported that WellPoint CEO Leonard Schaeffer and other executives received \$265 million, and Anthem CEO Larry Glasscock was rewarded with a \$42.5 million bonus for closing the deal.<sup>14</sup>

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<sup>13</sup> <http://www.sandiegouniontribune.com/news/2004/nov/10/california-insurance-commissioner-oks-anthem/>

<sup>14</sup> <http://www.publicintegrity.org/2015/08/24/17890/merger-health-insurers-usually-leads-big-payday-executives>

Since the merger, Anthem has also transferred more than \$5.4 billion in dividends to its corporate parent as of December 2014, according to its annual income reports, while raising rates on individual policyholders in California with increases of up to 39%.<sup>15</sup>

California policyholders should not bear such a price if Centene and Health Net are allowed to merge. CDI should prohibit Centene from removing reserves from California to pay for severance and retention packages for executives in connection with the merger and require it to explain any “upstream” amounts sent out of state post merger.

#### 4. Improve Quality of Care

The Insurance Commissioner may also deny the transaction under Insurance Code Section 1215.2 (d)(5), if “the competence, experience, and integrity of those persons who would control the operation of the insurer indicate that it would not be in the interest of policyholders or the public to permit them to do so.”

Health Net’s integrity in its treatment of policyholders has been in question in California for years. Accusations about Health Net’s record include privacy breaches,<sup>16</sup> failing to respond adequately to policyholder complaints,<sup>17</sup> denial of “medically necessary” services<sup>18</sup> and narrow doctor and hospital (“provider”) networks.<sup>19</sup> It has scored poorly in the rankings of the Office of the Patient Advocate’s HMO quality report card<sup>20</sup> and the National Committee for Quality Assurance<sup>21</sup> related to timely care and customer satisfaction.

Consumer Watchdog is currently involved in litigation on behalf of Health Net consumers because the insurer failed to provide customers accurate information about which providers were participating in their networks.<sup>22</sup>

CDI should not reward this behavior. Centene should have to promise to resolve these issues and litigation to benefit consumers. It should be required to have adequate provider networks for all of its health plans and pledge to approve medically necessary services.

Centene must be also required to improve any star rating for Health Net on the 2014 Office of Patient Advocate Quality Report Card that is below two stars with a rating of at least three stars by end of 2017. It must also improve Health Net’s ranking in the NCQA to the top 1/3 of all plans ranked in California by the end of 2017.

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<sup>15</sup> <http://articles.latimes.com/2010/feb/23/business/la-fi-anthem-cash23-2010feb23>

<sup>16</sup> <https://www.dmhc.ca.gov/Portals/0/AbouttheDMHC/NewsRoom/PressReleases/2011/pr031411.pdf>

<sup>17</sup> <http://www.dmhc.ca.gov/desktopmodules/dmhc/medsurveys/surveys/300fs022414.pdf>

<sup>18</sup> <http://articles.latimes.com/2012/sep/13/business/la-fi-medical-denials-case-20120913>

<sup>19</sup> <http://articles.latimes.com/2013/sep/14/business/la-fi-insure-doctor-networks-20130915>

<sup>20</sup> <http://reportcard.opa.ca.gov/rc/hmorating.aspx>

<sup>21</sup> <http://blog.ncqa.org/top-health-insurance-plans-california/>

<sup>22</sup> <http://www.consumerwatchdog.org/newsrelease/health-net-sued-%E2%80%98bait-switch%E2%80%99-doctor-and-hospital-networks-consumer-pays-12000-out-pocke>

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Insurance Commissioner Dave Jones  
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Consumer Watchdog urges that any undertakings include provisions requiring the commitments to be tracked, measured, and enforced. CDI needs to make sure that all requirements are written down and not just agreed to in negotiation. As DMHC's most recent experience shows when Blue Shield refused to donate millions of dollars to a charitable organization despite its earlier promises to DMHC makes all too clear that without explicit guarantees, health insurers are likely to ignore any concessions.<sup>23</sup> Make sure they don't.

Centene and Health Net claim that the merger will increase competition, improve care and benefit consumers. Historically, healthcare mergers generally lead to the opposite: fewer choices, inadequate physician networks and higher premiums. The result of increasing consolidation and lack of competition will lead to a healthcare crisis in California if regulators don't protect consumers with meaningful and stringent safeguards.

If Centene and Health Net do not agree to the above-proposed undertakings, which are reasonable and protect consumers, the Commissioner should use his statutory powers and stop the proposed merger.

Sincerely,



Eddie Barrera  
Consumer Advocate

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<sup>23</sup> <http://www.latimes.com/business/la-fi-blue-shield-charity-20151117-story.html>



POLICY & ACTION FROM CONSUMER REPORTS

January 14, 2016

Jennifer Chambers  
California Department of Insurance  
45 Fremont Street, 24th Floor,  
San Francisco, CA 94105

Re: Summary of intended testimony regarding the proposed acquisition of Health Net Life Insurance Company by Centene Corporation.

Dear Ms. Chambers,

The attached letter, originally submitted to the California Department of Managed Health Care (DMHC), is intended to summarize our intended testimony at the upcoming hearing of the California Department of Insurance on the proposed acquisition of Health Net Life Insurance Company by Centene Corporation.

In addition to this summary, we intend to testify at the hearing, scheduled for January 22, 2016, and to submit written testimony to CDI.

Sincerely,

A handwritten signature in blue ink that reads "Dena B. Mendelsohn".

Dena B. Mendelsohn, JD, MPH  
Staff Attorney  
Consumers Union

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Statement of Dena Mendelsohn  
Staff Attorney  
Consumers Union

to the

California Department of Managed Health Care

On

Proposed Merger of Centene Corporation and Health Net of California, Inc.

December 14, 2015

Consumers Union, the public policy and advocacy arm of nonprofit Consumer Reports, is pleased to offer comments on the proposed merger of Centene Corporation and Health Net of California. From our vantage point advocating for consumers on a number of health access, cost, and quality issues—including health insurance rate setting, network adequacy, and health insurance benefit design—we are keenly attuned to the burden of health care and coverage costs for Californians.

In our mission to work for a fair, just, and safe marketplace for all consumers, we have examined proposed mergers in health insurance and other markets to assess whether they threaten to impede the competitive nature of the marketplace, potentially reducing choice as well as affordability, quality, and the incentive to innovate. Given that the federal Department of Justice and the Federal Trade Commission both granted early termination of the waiting period under the Hart Scott Rodino Antitrust Improvements Act of 1976 (HSR Act), Californians now rely on state actors to protect consumer interests. We, therefore, turn to the Department of Managed Health Care (DMHC) to ensure that when plans such as Centene and Health Net merge, the sum of the two plans is better than what consumers get when the plans stand alone.

#### **I. Impact of the Centene-Health Net Merger on the California Health Insurance Market**

Some say that mergers like that proposed here are necessary responses to increased concentration in provider markets. Indeed, in our work on health insurance rate review, we witness a growing chasm between rate increases for northern California versus rate change in southern California<sup>1</sup>, due at least in

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<sup>1</sup> For the 2016 plan year, for example, Covered California reported that the “weighted average increase for Southern California consumers who stay in their current plan is ... 1.8 percent, while for consumers in Northern California it is 7 percent. Consumers in Southern California can save an average of nearly 10 percent by moving to a lower-cost plan in the same metal tier, while consumers in Northern California would potentially be able to limit their rate increase to an average of 1 percent if they did the same.” Covered California press release, 27 July 2015, available at <http://news.coveredca.com/2015/07/covered-california-holds-rate-increases-27.html>.

part to the consolidation of providers in northern California. However, we are not convinced that the antidote to provider consolidation is plan consolidation. Rather, if history is a guide, having a high concentration of health insurers, as in other industries, results in higher prices. For example, when Aetna and Prudential merged in 1999, premiums rose seven percentage points.<sup>2</sup> While this example precedes the ACA and its significant impact on the insurer landscape, we believe the outcome is still telling.

We also have reason to doubt assurances by Centene and Health Net, stating that the merger of these two companies would afford efficiencies for the benefit of consumers.<sup>3</sup> The announcement of a proposed merger of health plans is frequently padded with promises of cost-savings to be passed along to consumers. However, research on the subject reveals a dearth of economic studies or other evidence finding those assurances to be true. Rather, according a health economics expert, “Past mergers among insurance companies suggest that consumers seldom benefit. ‘When insurers merge, there’s almost always an increase in premiums’.”<sup>4</sup> While it is foreseeable that stronger market power will strengthen health plans’ negotiating position with providers, as a leading health antitrust scholar notes, there is “little incentive [for an insurer] to pass along the savings to its policyholders.”<sup>5</sup> Furthermore, we note that if price reductions are in fact realized and passed through, we seek assurances that cost savings will not be achieved via reductions in the quantity or quality of services.

The threat of increased insurance rates also stems from the possibility that Centene will opt to shrink or remove Health Net’s presence from the commercial market in California altogether. In 2015, Health Net offered products in all but three Covered California regions, capturing 18% of statewide enrollment in Covered California (subsidized and non-subsidized).<sup>6</sup> Health Net was also the third largest health plan of all full service commercial HMO enrollees, serving 8% of the California market.<sup>7</sup> Centene, on the other hand, has limited exposure in the commercial market, focusing most heavily in government contracting; it does not operate at all in California’s commercial market and appears to have entered the commercial market in other states only after the implementation of the ACA.<sup>8</sup> The possibility of a large player such

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<sup>2</sup> Leemore Dafny, Mark Duggan and Subramaniam Ramanarayanan, *Paying a Premium on your Premium? Consolidation in the U.S. Health Insurance Industry*, NBER Working Paper No. 15434, Issued October 2009.

<sup>3</sup> Testimony of Steve Sell, President and CEO of HealthNet of California and Rone Baldwin, Executive Vice President of Centene, DMHC public meeting conducted December 7, 2015.

<sup>4</sup> Erin Trish, researcher at USC’s Schaeffer School for Health Policy and Economics, as quoted by David Lazarus, *As Health Insurers Merge, Consumers’ Premiums are Likely to Rise*, 10 July 2015. Available at <http://www.latimes.com/business/la-fi-lazarus-20150710-column.html>.

<sup>5</sup> Thomas Greaney, *Examining Implications of Health Insurance Mergers*, Health Affairs, 16 July 2015. Available at <http://healthaffairs.org/blog/2015/07/16/examining-implications-of-health-insurance-mergers/>.

<sup>6</sup> Covered California, *Health Insurance Companies and Plan Rates for 2016 (preliminary rates)*, July 27, 2015 (updated Oct. 29, 2015), at p.31. Available at <https://www.coveredca.com/PDFs/7-27-CoveredCA-2016PlanRates-prelim.pdf>.

<sup>7</sup> Cattaneo & Stroud, Inc., *Before & After Results of the Proposed California HMO Acquisitions*, 24 August 2015 at pp.1-2.

<sup>8</sup> Avalere Health LLC, *New Market Entrants: Growth and Diversification in U.S. Health Insurance*, September 2015.



as Health Net exiting the market altogether is troubling because it would result in less competition, and potentially higher prices for consumers. At the DMHC public meeting, on December 7, both Centene and Health Net executives made assurances that Health Net's current Knox-Keene products would be maintained in the California marketplace. However, Centene has a history of backing out of a health insurance market abruptly: in 2013, Centene discontinued its Kentucky Medicaid product, Kentucky Spirit Health Plan, a year prior to the conclusion of its contract, leaving policyholders scrambling.<sup>9</sup> We therefore urge DMHC to get these assurances of continued presence in both the Medicaid and commercial markets in California in writing, in the form of a specific undertaking, if this merger is approved.

## II. Impact of Centene-Health Net Merger on Incentive to Improve Quality

In addition to the specter of the cost of health insurance increasing under a consolidated plan marketplace, Consumers Union is also concerned that greater market power will erode incentives for plans, including the newly merged company, to provide high quality health insurance coverage to its members.

Looking at what we know about current records for both Health Net and Centene gives us reason for concern.

- According to a recently issued report by the California Office of the Patient Advocate, Health Net HMO members on the commercial market conferred on Health Net a single star—the lowest score possible—for both categories of “*ease of access to care*” and “*members get answers to questions*.”<sup>10</sup>
- The National Committee for Quality Assurance (NCQA) reported that Health Net of California earned the lowest score possible for consumer satisfaction for its Medicaid Managed Care Organization in 2014-2015.<sup>11</sup>
- In a 2013 Routine Medical Survey conducted by DMHC, the Department identified five deficiencies.<sup>12</sup> Of those, a year later, Health Net failed to resolve one: “to demonstrate adequate

<sup>9</sup> Centene was recently found in breach of its contract with the state of Kentucky by the Court of Appeals and the case is pending calculation of damages by the Circuit Court. The Courier-Journal, *Kentucky Spirit Loses Appeal in Medicaid Suit*, available at <http://www.courier-journal.com/story/news/local/2015/02/06/kentucky-spirit-loses-appeal-medicare-suit/23000931/>.

<sup>10</sup> State of California Office of the Patient Advocate, Health Net of California, Inc. 2015-16 Edition Medical Care Ratings, available at [http://reportcard.opa.ca.gov/rc/profile.aspx?EntityType=HMO&Entity=HEALTH\\_NET](http://reportcard.opa.ca.gov/rc/profile.aspx?EntityType=HMO&Entity=HEALTH_NET).

<sup>11</sup> Kaiser Family Foundation Medicaid MCO Quality Rankings available at <http://kff.org/medicaid/state-indicator/medicaid-mco-quality-rankings/>. Centene is currently unranked because of its nominal share of the California market.

<sup>12</sup> The Department of Managed Health Care, *Final Report—Routine Medical Survey of Health Net of California, Inc. A Full Service Plan*, February 2014. Available at

consideration and rectification of enrollee grievances.” Indeed, it appears to have taken a full two years after the deficiency was originally identified for Health Net to correct this failure. Obviously, responsiveness to consumer grievances is a key measure for consumers, but it was not prioritized by Health Net.

- DMHC’s 2013 Independent Medical Review Results report shows that there were 1.13 independent medical reviews requested for every 10,000 Health Net members—a number that puts Health Net in the dubious position of one of the top in the state for members requesting outside review. For perspective, Health Net’s 1.13 is more than double the rate of Kaiser Permanente, which has a rate of 0.47 per 10,000 members. Of the cases reviewed for medical necessity, two-thirds were reversed either via judgment by the independent reviewer or by the plan.<sup>13</sup> Of the Emergency Room (ER) reimbursements that underwent independent review, another two-thirds were reversed, many of which by the plan itself.<sup>14</sup>
- DMHC fined Health Net in 2014 for its failure to properly secure of protected health information.<sup>15</sup>
- A visit to the Better Business Bureau Business Review website reveals a bevy of recent consumer complaints against Ambetter, Centene’s health insurance exchange product for the individual market. These complaints include lost documentation, unrecorded premium payments, inadequate provider network, and customer service hours that are limited to the standard work day (meaning that policyholders that work during the day may be unable to contact Centene during customer service hours). Complaints were spread among the states where Ambetter was offered in 2014 and 2015.

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<http://www.dmhc.ca.gov/desktopmodules/dmhc/medsurveys/surveys/300fs022414.pdf>. Those deficiencies were: (1) The plan failed to demonstrate adequate consideration and rectification of enrollee grievances; (2) The plan does not consistently and correctly display in all its written responses to grievances the Department’s telephone number, the CA Relay service’s telephone number, the Plan’s telephone number, and the Department’s Internet address in 12-point boldface type with the statement required by Section 1368.02(b); (3) The Plan does not consistently follow timeframes indicated in its Evidence of Coverage (EOC) for enrollees to file grievances; (4) Upon receipt of an urgent grievance, the Plan does not consistently, immediately inform the complainant of his/her right to contact the Department regarding the urgent grievance; (5) The Plan does not consistently provide the direct telephone number of the professional who made the denial decision in its commercial denial letters sent to requesting/treating providers.

<sup>13</sup> The breakdown is 28.8% were overturned by IMR and 37.0% were reversed by the plan. California Department of Managed Health Care 2013 Independent Medical review Summary Report. Available at <http://www.dmhc.ca.gov/Portals/0/FileAComplaint/DMHCDecisionsAndReports/AnnualComplaintAndIMRDecisions/2013.pdf>.

<sup>14</sup> The breakdown is 11.1% were overturned by IMR and 55.6% were reversed by the plan. California Department of Managed Health Care 2013 Independent Medical review Summary Report. Available at <http://www.dmhc.ca.gov/Portals/0/FileAComplaint/DMHCDecisionsAndReports/AnnualComplaintAndIMRDecisions/2013.pdf>.

<sup>15</sup> The Department of Managed Health Care, *2014 Annual Report*, at 14. Available at <http://dmhc.ca.gov/Portals/0/FileAComplaint/DMHCDecisionsAndReports/AnnualComplaintAndIMRDecisions/2014.pdf>.

Despite all this, Health Net's individual health insurance rate increases that were not subject to negotiations with Covered California exceeded the median increase in California in four out of the past five years.<sup>16</sup> The sole year in the period where they fell below was the year the market overall experienced the highest median rate increase by a significant margin.<sup>17</sup>

Outside California, Centene's subsidiary, Sunshine State Health Plan, a Medicaid Managed Care Organization (MCO), also earned a single star in some Florida counties where it operated. Further, Centene's subsidiaries operating Medicaid MCOs in Florida, Georgia, Indiana, Ohio, South Carolina, Texas, Washington, and Wisconsin each earned at or below average scores for consumer satisfaction.<sup>18</sup> Health plans are more than a financial conduit between consumers and providers; they also have a direct relationship with consumers, such as by coordinating care and providing resources. Clearly, consumers' experience with a merged Health Net-Centene entity must be improved.

Finally, in his testimony before the DMHC on December 7, 2015, Health Net President and CEO Steve Sell claimed the proposed merger of the two plans would enable Health Net to innovate and transform Health Net into a leader in the transformation of health care in the country.<sup>19</sup> However, as one leading expert recently testified before the Senate Committee on the Judiciary, "there is no research showing that larger insurers are likelier to innovate."<sup>20</sup> One innovation Mr. Sell frequently cited was value-based products. It is unclear, however, how innovation will improve post-merger. Further, there is no evidence that an insurance merger is required to carry out such initiatives. While we support the transition from volume-based care to patient-oriented value-based delivery, health plans must be held accountable for assurances such as these.

We urge DMHC to impose an undertaking on the merger that raises the bar for quality. This may include improved ease of enrollment,<sup>21</sup> more consumer-friendly benefits and coverage design,<sup>22</sup> and enhanced

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<sup>16</sup> We do note, however, that its rate increases for products sold on the state Exchange, which underwent negotiations with Covered California, came in more favorably than for many other plans.

<sup>17</sup> California Health Care Foundation, *Individual Health Insurance Premium Growth in California*, available at <http://www.chcf.org/publications/2015/11/individual-premiums-growth-california>.

<sup>18</sup> See <http://kff.org/medicaid/state-indicator/medicaid-mco-quality-rankings/> for notes and sources. Centene's subsidiary operating a Medicaid MCO in South Carolina, Absolute Total Care, achieved a score of four out of five and the subsidiaries in Illinois, Kansas, Louisiana, Massachusetts, Mississippi, and Missouri are not yet scored by NCQA.

<sup>19</sup> Testimony of Steve Sell, President and CEO of HealthNet of California, DMHC public meeting conducted December 7, 2015.

<sup>20</sup> Testimony of Leemore S. Dafny, PhD., Before the Senate Committee on the Judiciary Subcommittee on Antitrust, Competition Policy, and Consumer Rights on "Health Insurance Industry Consolidation: What Do We Know From the Past, Is It Relevant in Light of the ACA, and What Should We Ask?," 22 September 2015. Available at <http://www.judiciary.senate.gov/imo/media/doc/09-22-15%20Dafny%20Testimony%20Updated.pdf>.

<sup>21</sup> In 2014, the most frequent complaint by consumers was in Health Net's enrollment process. The Department of Managed Health Care, *2014 Annual Report*, "2014 Complaint Results by Category and Health Plan."

<sup>22</sup> In 2013, the most frequent complaint by consumers was in Health Net's benefits and coverage. The Department of Managed Health Care, *2013 Annual Report*, "2014 Complaint Results by Category and Health Plan." Available at

grievance processes so policyholders can have issues resolved before escalating to the Independent Medical Review stage.

### **III. Impact of Entry by an Out-of-State Corporation and Management of a California-based Health Plan**

While Health Net has a longstanding presence in California, Centene has operated on only a very limited basis here, for a relatively short period of time, and outside the commercial market. Given this, it is unlikely that Centene is familiar with the intricacies of California legal requirements, the state's extensive consumer protections, and the unique regulatory framework of having two regulators as well as an active purchaser Exchange. In the DMHC public meeting held December 7<sup>th</sup>, executives for both plans insisted that Centene would maintain local management in California. We urge DMHC to hold Centene to this promise and to require that "local management" be comprised of high level executives with prior experiences of considerable depth in California insurance regulations and operations. In addition, not only should management be local, but it should also prioritize practices that put consumers first.

### **IV. Recommended Undertakings**

If this merger is finalized, consumers need assurances that the newly combined Centene-Health Net corporation will lift up consumer interests and improve their lot—on access, affordability, and quality—rather than leaving consumers carrying the weight of this deal. Some undertakings we recommend for your consideration include, but are not limited to:

- Health insurance rates: The merged company should agree to not moving forward with rate increases in any market segment that DMHC deems unjustified or that contain inaccurate or incomplete information. California's rate filing law, with broad transparency and detailed information breakout requirements, is more extensive than in other states and quite different from the government contract environment to which Centene is accustomed. Given the risk that the bigger merged company may have higher premiums, it should agree to providing even greater detail, publicly available, to aid DMHC in especially close rate review for the first years after the merger. Moreover, it should agree that Covered California and DMHC may calculate any proposed increase rate based on Health Net rates for the 2016 plan year. Centene must not be permitted to finalize proposed premium rate increases deemed unreasonable or unjustified by the Department and instead 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.

- 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".<sup>23</sup> Unfortunately, that requirement is often honored more in the breach than the observance. In fact, in commenting on Health Net's rate filing justification for 2015, Consumers Union noted "[t]he Health Net filing lacks even minimal narrative on the subject and the data they provide is scant yet paints an unsettling picture."<sup>24</sup> Therefore, we urge assurances that Centene will reinvestment 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 directly benefits policyholders. As noted above, we recommend that any filing by Centene in the first years after the proposed merger refer back to the Health Net products for 2016 as its basis for comparison and build on or differentiate its quality/cost efforts from those of Health Net.
- Improving quality and consumer satisfaction ratings: Achieving above average quality ratings as measured by NCQA, Covered California, the Right Care Initiative, the Office of Patient Advocate Quality Report Card, and the Medi-Cal Managed Care Health Care Options Consumer Guide, by no later than the performance measurement period ending December 31, 2017.
- Improving provider directory: Making available to consumers, policyholders and non-policyholders, an accurate provider directory that is easily accessible and regularly updated. The issue of provider directory inaccuracies is a serious one and likely to be exacerbated by a merged company combining IT systems.
- Maintaining presence in the commercial market at least commensurate with Health Net's current participation: The aim of this suggested undertaking is to ensure that competition remains vigorous, on and off the state Exchange, both in the number and variety of insurance products offered.
- Adequate, dedicated staffing in California: We urge that high level staff for the newly merged company— Medical Director, Customer Service, and Legal Compliance personnel—be located in California and be comprised of individuals with a depth of expertise in our state in order to acclimate and immerse the newly merged company into the regulatory and consumer protection environment in California.
- 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

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<sup>23</sup> Health and Safety Code Section 1385.03(c)(3).

<sup>24</sup> Consumers Union comments on the Health Net rate filing justification, available at <http://wps0.dmhc.ca.gov/ratereview/Detail.aspx?lrh=k2flWv6xelQ%24>.

affects Health Net's and the newly merged company's customers. Consumers Union recommends that DMHC require dedicated, increased staffing—in California and anywhere else trouble spots in the company may arise and be rectified—such as personnel 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 competitive and relatively 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 pricing and access for consumers. We appreciate DMHC holding a public forum on this proposal and the Department's openness to input. Consumers Union intends to play an active role with the Department in urging your close scrutiny and imposition of undertakings for this deal for the protection of consumer interests.

Sincerely,



Dena B. Mendelsohn, JD, MPH  
Staff Attorney  
Consumers Union



CDIX242

# HEALTH ACCESS CALIFORNIA

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Organizations listed for  
identification purposes

January 15, 2016

## Summary of Intended Testimony Proposed Acquisition of Health Net Life Insurance Company by Centene Corporation

Tam M. Ma  
Policy Counsel, Health Access California

Health Access California intends to provide testimony regarding the following issues:

### I. HISTORY SHOWS CONSUMERS DO NOT BENEFIT FROM HEALTH INSURANCE INDUSTRY CONSOLIDATION

- Research shows prior mergers have led to higher costs.
- No evidence provided that proposed merger will lead to lower costs or better value.
- Insurer mergers must not undermine the state’s implementation of the Affordable Care Act (ACA).

### II. IMPACT OF PROPOSED MERGER ON CALIFORNIA’S COMMERCIAL MARKET

- The proposed merger raises concerns about how it will affect commercial and government purchasers such as Covered California, and their ability to maintain continuity of care, negotiate for value, and manage costs.
- Health Net’s continued participation in Covered California and Centene’s competency in new lines of business should merger go through.

### III. IMPACT OF PROPOSED MERGER ON CALIFORNIA CONSUMERS

- When an insurer with problems seeks to merge, California regulators should insist on commitments to ensure they get better as they get bigger—so their problems do not grow along with the company.
- Health care costs are a major concern for consumers and purchasers. Health Net’s history of unreasonable rate increases undermine consumers’ financial security and force consumers and purchasers to pay more for health care than justified.
- Premium dollars must not be used to finance costs of the merger.
- Health Net’s track record, as evidenced by quality ratings, independent medical review, complaint data, and other information.
- The newly merged company must be accountable to CA consumers and regulators by having a key legal, regulatory, and customer service staff based in California.

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[www.health-access.org](http://www.health-access.org)

January 12, 2016

Commissioner David Jones  
c/o Jennifer Chambers  
Senior Staff Counsel  
California Department of Insurance  
45 Fremont Street, 21<sup>st</sup> Floor  
San Francisco, CA 94105

Submitted Electronically via [chambersj@insurance.ca.gov](mailto:chambersj@insurance.ca.gov) &  
[tomashoffj@insurance.ca.gov](mailto:tomashoffj@insurance.ca.gov)

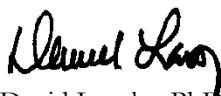
Dear Commissioner Jones:

As one of the nation's leading nonprofit business coalitions focused on healthcare, the Pacific Business Group on Health (PBGH) works to improve health care quality and accountability while moderating costs. PBGH supports a marketplace of competing health plans and provider organizations held accountable for quality management and improvement, affordability and transparency of cost and quality information for consumers and purchasers. Health Net plays an important role in helping to maintain a competitive marketplace and supporting performance accountability among California's diverse provider organizations and hospitals. We hope that CDI's continuing oversight of Health Net will support members' access to higher quality healthcare services on a cost-effective basis, and ensure measurable quality outcomes. The proposed partnership between Health Net, Inc. and Centene Corporation could help strengthen Health Net's presence in California and western states through administrative efficiencies and appropriate investments in infrastructure, continuing to leverage its local approach more broadly. .

PBGH and its members have had a long collaboration with Health Net, including support of the California Quality Collaborative, engagement in the California Healthcare Performance Information System Patient Assessment Survey and participation in the IHA Pay for Performance program. Health Net also supports transparency by responding to PBGH's annual eValue8 Health Plan RFI and encouraging its contracted hospitals to report patient safety information to the Leapfrog Group. Historically, Health Net has also participated in the joint purchasing program among our Negotiating Alliance members and in PacAdvantage.

Our history with Health Net makes us hopeful that the consolidated organization with Centene can be a positive player in the market. We hope that your regulatory review will support the evolution of a competitive marketplace in California that facilitates consumer choice of health plan options, while continuing to hold plans accountable for quality, access, transparency and affordability.

Sincerely,



David Lansky, PhD  
President & CEO





## Health Insurance Merger Frenzy: Why DOJ Must Just Say 'No'

Law360, New York (August 17, 2015, 5:59 PM ET) --

A vital national goal is controlling health care costs and improving the quality of health care. A simple but crucial principle of our economic system is that competition matters. Where there are more competitors, transparency and choice, consumers prosper through greater competition, lower prices, higher quality and more innovation. Where competition is less than robust, consumers suffer.

In health insurance, there is an unmistakable record, well-documented in years of congressional debate, economic studies and government enforcement actions — health insurance markets are highly concentrated and there is often a lack of transparency and choice. And, research has shown that when competing health insurers merge, consumers suffer through higher premiums.



David A. Balto

That is why two current deals — the mergers of [Aetna Inc.](#) and [Humana Inc.](#), and Anthem Inc. and [Cigna Corp.](#), reducing the total number of national health insurers from five to three — must be blocked by the [U.S. Department of Justice](#).<sup>[1]</sup> If these mergers are consummated, employers, unions and health care buying groups will have less choice, and consumers will have fewer options and face higher premiums. Moreover, health care providers — the heart of the health care delivery system — will be faced with reduced reimbursement potentially leading to a reduction in services rendered. As important, the remaining three insurance firms will dictate the terms of innovation vital to correcting the flaws in the health care system and moving to a less costly higher performance health care system. While the DOJ has stated that it will investigate the deals collectively,<sup>[2]</sup> the only real answer is to block both these mergers affecting nearly 100 million beneficiaries and the health care providers that serve them.

### The Mergers Will Further Consolidate Already Highly Concentrated Health Insurance Markets

Concentration is the core to competitive analysis. You do not need a Ph.D. in economics to understand that the greater the number of choices in a transparent market, the more consumer sovereignty will result in an optimal market outcome — low prices, high quality and innovation.

By any measure, health insurance markets in the United States are highly concentrated. According to the [American Medical Association](#), using the Horizontal Merger Guidelines' Herfindahl-Hirschman Index, more commonly known as HHI, 72 percent of health care markets are "highly concentrated" with an HHI above 2,500.<sup>[3]</sup> Mergers within such highly concentrated markets are presumptively illegal and "raise significant antitrust concerns," including higher prices and a lessening of services.<sup>[4]</sup> The mergers between these four insurance giants would create overlaps in a large number of geographic markets.

These mergers will clearly worsen a competitively unhealthy situation. Analysis by the [American Hospital Association](#) demonstrates that the Anthem and Cigna merger alone will reduce competition in 817 metropolitan statistical areas.<sup>[5]</sup> In fact, post-Anthem/Cigna transaction, 600 markets will have significant HHI increases in markets already exceeding the HHI threshold of 2,500.<sup>[6]</sup> Additionally, a combined Aetna and Humana would mean that 180 additional U.S. counties would have at least 75 percent of customers for Medicare Advantage plans in the hands of only one insurer.<sup>[7]</sup> With such highly concentrated markets, there is a heightened presumption that the parties will use their newfound market power to impose competitive advantages.

Concentration is not the sole issue in competitive analysis. The merging parties may suggest that concentration is irrelevant because rival insurers can prevent any competitive harm by entering into markets. They are wrong. Years of DOJ enforcement actions have shown that entry barriers into health insurer markets are substantial.[8] Health insurers have tremendous resources, yet the examples of successful entry into metropolitan areas is modest at best. That is why, a former acting assistant attorney general cautioned these arguments should be viewed “with skepticism and will almost never justify an otherwise anti-competitive merger.”[9]

## Substantial Concentration Harms Payors and Consumers

The substantial concentration in health insurance markets has been a poor prescription for competition. Health insurance markets have been characterized by rising premiums and reduced choice and quality, while profits have continued to rise. Indeed, rapidly increasing premiums was one of the reasons Congress imposed an effective cap on insurance profits through medical loss ratio (MLR) regulation.[10] The MLR regulation ensures that a large group insurer must spend at least 85 percent and a small group or individual insurer 80 percent of net premiums on medical services and quality improvements. However, the MLR does not act as a “price cap” as insurers still have the ability to make up “lost” profits by increasing premiums on consumers.[11]

Economic studies demonstrate the close and essential relationship between concentration and harm to consumers. For example, one study found direct evidence “linking private insurance premiums to the market power of insurers.”[12] Another study of health insurance premiums on 34 federally facilitated marketplaces found that adding one additional insurer would lower premiums by 5.4 percent, while adding every available insurer would lower rates by 11.1 percent.[13]

Eliminating competition through these mergers means that consumers will pay more.

## Divestitures Cannot Adequately Remedy the Competitive Problems

Often, the antitrust enforcement agencies have remedied anti-competitive mergers through cut and paste divestitures, requiring spinoffs of assets where there are competitive overlaps. Yet, increasingly, economic studies demonstrate limited divestitures are inadequate and the right course is simply to block the merger. An economic survey by Northeastern University professor John Kwoka demonstrates how divestitures often fail to fully restore competition.[14] That is a lesson the antitrust enforcers are beginning to learn. Recently, the [Federal Trade Commission](#) and the DOJ rejected substantial proposed divestitures in blocking the [Comcast-Time Warner Cable](#)[15] and Sysco-[US Foods](#) mergers.[16] They should do the same here.

In the past, the DOJ has relied exclusively on divestitures in health insurance merger matters. Of course, these deals are vastly more substantial than these earlier deals and the competitive overlaps are considerable. In the 2012 Humana/Arcadian transaction, for example, the DOJ noted problematic overlaps for the parties' Medicare Advantage businesses, requiring divestitures in 45 different counties throughout the United States.[17] Also in 2012, the DOJ required divestitures of Medicaid managed care plans in Northern Virginia in [Wellpoint's](#) acquisition of [Amerigroup](#). [18]

However, in each of those cases, the merger involved a large insurance plan combining with a relatively small, niche plan. In contrast, the mergers of Aetna and Humana and Anthem and Cigna involve the combination of some of the largest health insurers in the country affecting tens of millions of beneficiaries in highly concentrated markets throughout the United States.[19] A handful of targeted divestitures are unlikely to remedy the megacompetitive problems raised by these mergers.

Moreover, there is readily available evidence that narrowly targeted divestitures within insurance markets do not alleviate a transaction's overall competitive impact. In 1999, Aetna merged with Prudential, with the DOJ requiring Aetna to divest its health maintenance organization business in Texas.[20] Using the aftermath of that merger to estimate the impact of market concentration on premiums, the authors projected that the increase in market concentration over the period 1998-2006 “raised premiums by roughly seven percent from their 1998 baseline.”[21] The study's findings were made more impactful in that the evidence was collected from 139 separate geographic markets.[22] A more recent study, relying on data from the 2008 consummated merger involving [UnitedHealth](#) and Sierra Health Services in which the DOJ required divestitures of Medicare Advantage beneficiaries in Las Vegas,[23] found that post-merger commercial premiums in Nevada increased by 13.7 percent.[24] Taken together, these studies demonstrate that, regardless of utilizing the remedy of

divesting certain assets, health insurance consolidation allows large, dominant insurers to drive up the cost of premiums.

The simple lesson may be that the only sensible course is to block the transactions. That was the course taken by the Pennsylvania commissioner of insurance in 2010 when he blocked the merger of Pittsburgh-based Highmark and Philadelphia-based [Independence Blue Cross](#).<sup>[25]</sup> Because of that action, there is the potential for rivalry between the two firms.

## Unlikely Efficiencies

As is typical in all merger matters, the parties will rely on efficiencies to attempt to demonstrate pro-competitive benefits of the mergers. But, they face an incredible burden in invoking efficiencies as a defense to these insurance mergers. Under DOJ/FTC merger guidelines, efficiencies must be merger-specific, substantiated and cognizable.<sup>[26]</sup> The parties may make claims of improved service, but, as the Ninth Circuit recently instructed, “better service to patients” is a laudable goal “but the Clayton Act does not excuse mergers that lessen competition or create monopolies simply because the merged entity can improve its operations.”<sup>[27]</sup>

Aetna has already noted significant, \$1.25 billion, “synergy opportunit[ies]” that will improve “operating efficiency” between Aetna and Humana.<sup>[28]</sup> The firms claim a need to increase scale to lower reimbursement rates to health care providers, thus ensuring cost savings for the entire health care system and for consumers in the form of lower premiums.<sup>[29]</sup> The parties do not explain whether a merger is the only or best means to achieve those efficiencies, nor do they explain how these savings will be passed along to consumers.

There are substantial reasons to doubt those types of claims. While a strong market presence may enable health insurance companies to negotiate lower provider reimbursement, research demonstrates those savings are not passed along to consumers. As some academics have observed, “when insurers merge, there’s almost always an increase in premiums.”<sup>[30]</sup> The only way to assure lower insurance premiums is through competition.<sup>[31]</sup>

## Creating More Powerful Insurers Will Not Benefit Consumers

Along with increasing prices for consumers in the form of higher premiums, narrowing the market to just three dominant health insurers would also lead to an increase in monopsony power, or the power to reduce reimbursement for health care providers. This has been a concern in past DOJ health insurance mergers and certainly was a concern that animated the DOJ and [Federal Communications Commission](#) challenges to the Comcast/Time Warner Cable merger.<sup>[32]</sup> Merging to create a stronger buyer is only beneficial to the extent it leads to lower prices for consumers.

Rather than leading to lower premiums, the mergers and any attendant monopsony power will lead to reduced “availability and affordability of health insurance for millions of consumers.”<sup>[33]</sup> As the American Association of Family Practitioners cautions, this power will lead to more restricted networks — that trend “would only be exacerbated if a single insurer held greater influence over any potential market, state, or region — potentially separating patients from their physicians and community hospitals.”<sup>[34]</sup> Additionally, there are significant and increasing shortages of primary physicians and rural hospitals,<sup>[35]</sup> and giving insurers monopsony power will only exacerbate those trends.

The parties may try to dress up as David claiming the mergers are necessary to bargain with hospital Goliaths. The DOJ will clearly see through that masquerade. The health insurers are already very powerful and large and have substantial bargaining power against providers. The canard that hospitals have substantial bargaining power is belied by the facts — hospital costs are not increasing substantially.<sup>[36]</sup>

Moreover, the insurers would acquire monopsony power against all health care providers, not just hospitals, and reduced reimbursement would clearly harm numerous provider markets leading to greater shortages of health care providers, such as family practitioners and rural hospitals, and less service for patients.

Finally, permitting a merger to enable an insurer to secure greater bargaining power is at best a Faustian bargain — since it would also acquire monopoly power, it would have no need to pass on any decreased reimbursement in lower premiums to consumers.

The DOJ recognizes that simple truth. In the DOJ's complaint in UnitedHealth's 2005 acquisition of PacifiCare, the agency noted that the parties' increased buying power would allow it to lower rates to physicians. "Such lower rates would likely lead to a reduction in the quantity or degradation in the quality of physicians services." [37] The 2012 Aetna/Prudential study made a similar finding noting that post-merger, "insurers were able to exercise market power simultaneously in input and outputs markets." [38] Mergers between Aetna and Humana and Anthem and Cigna would further increase their ability to lower provider reimbursement rates. As previously noted, this monopsony power does not translate into lower premiums, but likely would lower physician reimbursement and could deteriorate health care quality.

## Conclusion

These mergers raise profound economic and public health concerns. Strong antitrust enforcement is vital to making these markets work.

As a former Antitrust Division head has explained:

The success of health care reform will depend as much upon healthy competitive markets as it will upon regulatory change. If health care reform is to produce more efficient systems, bring health care costs under control and provide higher-quality health care delivery, then we must vigorously combat anti-competitive mergers and conduct that harm consumers with responsible antitrust enforcement. [39]

The mergers between Aetna and Humana and Anthem and Cigna will not serve to lower costs or improve care. Instead, they will increase health insurance concentration in already concentrated markets leading to higher premiums, decreased quality of health care services, and less innovation. These mergers should be blocked.

—By David A. Balto and James Kovacs, Law Offices of David Balto

*David Balto is an antitrust attorney who frequently represents consumer groups and health care providers. He is a former policy director of the Bureau of Competition at the Federal Trade Commission, attorney-adviser to FTC Chairman Robert Pitofsky and antitrust lawyer at the U.S. Department of Justice.*

*James Kovacs is an associate at the Law Offices of David Balto.*

**DISCLOSURE: Balto is currently general counsel for the Independent Specialty Pharmacy Coalition, which is involved in health policy lobbying.**

*The opinions expressed are those of the author(s) and do not necessarily reflect the views of the firm, its clients, or Portfolio Media Inc., or any of its or their respective affiliates. This article is for general information purposes and is not intended to be and should not be taken as legal advice.*

[1] See Robert Cyran, The Regulatory Hurdles to Health Insurance Mergers, N.Y. Times (July 24, 2015), <http://goo.gl/ph89r1>.

[2] See Brent Kendall & Anne Wilde Matthews, DOJ Girds for Strict Review of Any Health-Insurance Mergers, Wall St. J. (June 28, 2015, 5:13 PM), <http://goo.gl/q1P3Ay>.

[3] See David W. Emmons & Jose R. Guardado, Competition In Health Insurance: A Comprehensive Study of U.S. Markets, Am. Med. Assoc. (2014).

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

[5] Letter from American Hospital Association, to William Baer, Assistant Attorney General, U.S. Dep't of Justice Antitrust Division (Aug. 5, 2015), available at <http://goo.gl/S3gZCt>.

[6] Id.

[7] Anna Wilde Mathews & Christopher Weaver, Health Mergers Could Cut Consumer Options, Wall St. J (June 21, 2015 10:55 PM), <http://goo.gl/zwY0ft>.

[8] See e.g. Complaint, United States v. Aetna Inc. and [Prudential Insurance Co. of Am.](#), No. 3-99CV 1398-H (N.D. Tex. June 21, 1999) (finding that it was unlikely that new insurers would enter and compete with the newly formed Aetna/Prudential in Houston and Dallas “because of the costs and difficulties of doing so”).

[9] Assistant Attorney General Christine Varney, Department of Justice Antitrust Div., [American Bar Association](#)/American Health Lawyers Association Antitrust Healthcare Conference (May 24, 2010), available at <http://goo.gl/rzPC0G>.

[10] See generally Michael J. McCue & Mark A. Hall, Insurers’ Responses to Regulation of Medical Loss Ratios, Commonwealth Fund (Dec. 2012), available at <http://goo.gl/xudcVH> (noting the purpose of Medical Loss Ratio as part of the Affordable Care Act was created to reduce insurance profits).

[11] See Reed Abelson, Bigger May Be Better for Health Insurers, but Doubts Remain for Consumers, N.Y. Times (Aug. 2, 2015), <http://goo.gl/QBHsNj>; see also Robert Pear, Obama Administration Urges States to Cut Health Insurers’ Request for Big Rate Increases, N.Y. Times (Aug. 3, 2015), <http://goo.gl/NIV2vq> (insurance plans are seeking 10 to 40 percent increases on health insurance premiums).

[12] Leemore Dafny, Are Health Insurances Markets Competitive?, 100 Am. Econ. Rev. 1399, 1403 (2010).

[13] See More Insurers, Lower Premiums? [Kellogg Insight](#) (July 7, 2014), <http://goo.gl/Dw4Qeq> (discussing research by Leemore Dafny, Jonathan Gruber and Christopher Ody).

[14] See generally John Kwoka, Mergers, Merger Control, and Remedies: A Retrospective Analysis of U.S Policy, MIT Press (2015).

[15] Press Release, DOJ, Comcast Corporation Abandons Proposed Acquisition of Time Warner Cable After Justice Department and Federal Communications Commissions Informed Parties of Concerns (Apr. 24, 2015), available at <http://goo.gl/msZq6f>.

[16] Press Release, FTC, Following Sysco’s Abandonment of Proposed Merger with US Foods, FTC Closes Case (July 1, 2015), <https://goo.gl/XfwPsW>.

[17] See Complaint, United States v. Humana Inc., No. 1:12-cv-00464 (D.D.C. March 27, 2012).

[18] Press Release, Dep’t of Justice, Amerigroup Corp.’s Divestiture of Its Virginia Operations Addresses Department of Justice’s Concerns with Wellpoint Inc.’s Proposed Acquisition of Amerigroup (Nov. 28, 2012), available at <http://goo.gl/5npDzs>.

[19] See Carolyn Johnson, Anthem announces it will buy Cigna to create new health insurance giant, Wash. Post (July 24, 2015), <http://goo.gl/3v4e4y> (noting the combination of Anthem and Cigna will create an entity with 53 million beneficiaries); see also Adam Smeltz, Aenta plan to buy Humana under review, Pittsburgh Post-Gazette (July 14, 2015 12:00 AM), <http://goo.gl/ioywBV> (the Aetna/Humana merger will involve 33 million covered lives).

[20] See Revised Final Judgement, United States v. Aetna Inc. and Prudential Insurance Co. of Am., No. 3-99CV 1398-H (N.D. Tex. Dec. 7, 1999).

[21] Leemore Dafny, Mark Duggan, & Subramaniam Ramanarayanan, Paying a Premium on Your Premium? Consolidation in the US Health Insurance Industry, 102 Am. Econ. Rev. 1161, 1163 (2012).

[22] Id. at 1164.

[23] Final Judgement, United States v. UnitedHealth Group Inc. and Sierra Health Servs. Inc., 1:08-CV-00322 (D.D.C. Sept. 24, 2008).

[24] José R. Guardado, David W. Emmons, & Carol K. Kane, The Price Effects of a Large Merger of Health



Insurers: A Case Study of UnitedHealth-Sierra, 1 Health Mgmt., Pol'y & Innovation 16, 21 (2013).

[25] See Highmark, Inc. v. Commonwealth of Pennsylvania, Insurance Department and Pennsylvania Insurance Commissioner Joel S. Ario, Civil Action No: 194 M.D. 2010 (Pa. Commw. Ct.).

[26] Horizontal Merger Guidelines, *supra* note 4 at § 10.

[27] St. Alphonsus Med. Ctr. v. St. Luke's Health Sys., 778 F.3d 775, 791-92 (9th Cir. 2015)

[28] Press Release, Aetna, Aetna to Acquire Humana for \$37 Billion, Combined Entity to Drive Consumer-Focused, High-Value Health Care (July 3, 2015), available at <https://goo.gl/dktKof>.

[29] See Thomas Greaney, Examining Implications of Health Insurance Mergers, Health Affs. (July 16, 2015), <http://goo.gl/ETT1DB>.

[30] David Lazarus, As Health insurers merge, consumers' premiums are likely to rise, L.A. Times (July 10, 2015 4:00 AM), <http://goo.gl/nF7HRS> (quoting Erin Trish, USC's Schaeffer Center for Health Policy and Economics).

[31] See More Insurers, Lower Premiums?, *supra* note 13 (finding that increasing the number of insurers in a market drives down price).

[32] Comcast Corporation Abandons Proposed Acquisition, *supra* note 15.

[33] Letter from Reid Blackwelder, Board Chair, AAFP, to Chairwoman Edith Ramirez, FTC (June 4, 2015), available at <http://goo.gl/vk4IHM>.

[34] *Id.*

[35] See generally Elizabeth Burrows, Ryung Suh, & Danielle Harmann, Health Care Workforce Distribution and Shortage Issues in Rural America, Nat'l Rural Health Assoc. (2012), available at <http://goo.gl/szNwKe>.

[36] Overall Growth in Spending on Health Care Down Sharply, American Hospital Assoc. (2014), available at <http://goo.gl/7NZhPN> (from 2012 to 2013, the change in hospital prices was only a 1.5 percent increase).

[37] Complaint. United States v. UnitedHealth Group Inc. and PacifiCare Health Sys. Inc., 1:05-cv-02436 (D.D.C. Dec. 20, 2005).

[38] Dafny et al., *supra* note 21 at 1183.

[39] Assistant Attorney General Sharis A. Pozen, DOJ Antitrust Division, Remarks at World Annual Leadership Summit on Mergers and Acquisitions in Health Care: Competition and Health Care: A Prescription for High-Quality, Affordable Care (Mar. 19, 2012), <http://goo.gl/aQkmZw>.



Member Driven. Patient Focused.

January 13, 2016

Commissioner Dave Jones  
State of California Department of Insurance  
45 Fremont Street, 24th Floor  
San Francisco, CA 94105

Dear Commissioner Jones:

On behalf of the Community Clinic Association of Los Angeles County (CCALAC), I am pleased to express our support for the emerging partnership between Health Net, Inc. and Centene Corporation.

Founded in 1994, CCALAC represents the interests of 58 community clinics and health centers that operate over 300 clinic sites across LA County. Our members provide comprehensive primary care services including medical, dental and mental health to over 1.4 million uninsured, underinsured, and low-income residents in the county.

CCALAC and our members have enjoyed a longstanding partnership with Health Net as one of LA County's two Medi-Cal managed care plans. Most recently, CCALAC and Health Net worked closely to successfully implement the Affordable Care Act (ACA) in LA County, including planning the successful transition of thousands of Low Income Health Program (LIHP) members into the Medi-Cal program. Our strong partnership has resulted in the successful initial enrollment of patients and other community members into Covered California, an effort that continues today. Other areas of partnership include improving oral health access and outcomes, enrolling communities into coverage, and expanding networks to improve parity in mental health services.

Health Net and Centene share a similar focus on serving low to moderate income populations through Medi-Cal in various parts of California. We are hopeful that the Centene partnership will enhance Health Net's ability to serve its members and work collaboratively effectively with partners. We expect that the partnership between these plans will result in improved access to care and coordination of resources, as well as strengthened data systems to support improved patient outcomes in LA County. CCALAC looks forward to working with Health Net and Centene to improve the systems of care that support our most vulnerable populations.

Sincerely,

A handwritten signature in blue ink, appearing to read "Louise McCarthy".

Louise McCarthy, MPP  
President & CEO



**Greater Sacramento  
Urban League**

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January 18, 2016

Commissioner Dave Jones  
State of California Department of Insurance  
45 Fremont Street, 24th Floor  
San Francisco, CA 94105

Dear Commissioner Jones:

On behalf of the Greater Sacramento Urban League, I intend to speak at the hearing on January 22, 2016 to express our support for the emerging partnership between Health Net, Inc. and Centene Corporation. My comments will focus on the strong presence and impact that both Centene (California Health and Wellness) and Health Net have within our community. I will particularly address in my brief testimony the following:

- Community presence and partnership in Sacramento
- Commitment to the concept that all health care is local
- Branding the local plan with a California name
- Delivering on its commitments

Given Centene's emphasis in the holistic concept of health and wellness and its purpose of transforming communities, one person at a time, it's no surprise that Centene has so closely aligned itself with the Greater Sacramento Urban League. The local health plan CEO has joined our Board and is actively supporting our programs to provide education, job training and job placement to underserved persons. Recently, Centene stepped up to cover expenses for testing so that students could go right to work.

For over 48 years, the Greater Sacramento Urban League has provided underserved youth and adults with opportunities to achieve economic self-reliance. With partners like Centene and Health Net, we can transform the lives of people in a real way.

Thank you for the opportunity to provide testimony at the upcoming hearing.

Sincerely,

Cassandra H. B. Jennings  
President and CEO

*Empowering Communities.  
Changing Lives.*

#### **Board of Directors**

**Cassandra H. B. Jennings**  
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California State University  
Sacramento

**Rannon Maddox**  
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**Erica Manuel**  
SMUD

**Yen Marshall**  
AT&T

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UC Davis

**Kent Stone**  
US Bank

**Todd Trotter**  
Kaiser Permanente

**Chalessa White**  
Intel

**Kenneth Maxey**  
Comcast





**From:** [John Wallace](#)  
**To:** [Chambers, Jennifer](#); [Tomashoff, Jon](#)  
**Cc:** [Amber Watson](#)  
**Subject:** Hearing Regarding the proposed acquisition of Health Net Life by Centene Corporation -- Jan 22, 2016  
**Date:** Thursday, January 14, 2016 1:45:18 PM  
**Attachments:** [Image002.png](#)

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Dear Ms. Chambers and Mr. Tomashoff,

On behalf of Heritage Provider Network, I plan to testify in person at the Department's Hearing on January 22 in support of the proposed merger of Health Net Life with Centene. Heritage supports this merger because we have worked extensively with Health Net over many years and they have been responsive to our providers and overall a responsible partner. We believe that the merger will make Health Net financially stronger to compete in the market. As there is no geographic overlap of market areas between Health Net and Centene, there will be no consolidation of health plans for our providers. Finally, Centene's commitment to continuing with local, knowledgeable management to run their combined business makes us supportive of this merger.

Please let me know if this is sufficient notice to deliver very brief oral testimony at the hearing or if you require my remarks in advance.

---

**John Wallace**  
Senior Vice President

HPN Brand

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01.15.16

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Via e-mail 01.15.16 [Jon.tomashoff@insurance.ca.gov](mailto:Jon.tomashoff@insurance.ca.gov)

**Comments Regarding Pending Mergers of: Centene-Health Net, Aetna-Humana, Anthem-Signa, Blue Shield-Care 1st Health Plan**

Dear Mr. Tomashoff:

This letter represents my personal views. I am a Disability Policy Consultant and the Associate Director and Adjunct Associate Professor at Harris Family [Center for Disability and Health Policy](#). I work as an advocate and as a contractor with a variety of health facilities, managed care plans, government projects and consulting firms. These projects include work with Rehabilitation Research and Training Centers: on Aging with a Disability, Managed Care and Disability, Health and Wellness and Disability, National Center of Physical Activity and Disability and the Rehabilitation Engineering Research Center on Accessible Medical Instrumentation, and the served on the [Access Board's](#) Medical Diagnostic Equipment Advisory Committee. I provide workshops on developing practical and actionable disability competencies in health care covering the demographics of disability populations (prevalence, causes, function versus diagnosis, employment rates, and health disparities) compliance with the Americans with Disabilities Act (attitudinal, communication, physical, medical equipment and programmatic access), care coordination and long term support services, and stakeholder engagement. More information is available at <http://www.jik.com>.

As the wave of proposed health plan consolidations is carefully reviewed for approval by California, I urge the California Department of Insurance to take advantage of this unique opportunity to strengthen and improve health care for people with disabilities and others with access and functional needs.

The documented gaps in network adequacy significantly impact **people with disabilities and others with access and functional needs** and contributes to

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**substandard and unequal treatment.** (The **bolded terms** are defined in the paragraphs that follow these recommendations.)

Health disparities linked to race, ethnicity, language and disability status are deeply imbedded in our healthcare system. The requirement for provider networks standards to address the inaccessible status quo among providers is a change that is very important to the disability community. The majority of people with disabilities and others with access and functional needs are covered under commercial plans and not as commonly believed covered under public insurance.

## Recommendations:

All merger approved health plans must:

1. Provide funds to carefully selected network provider sites, (primary care, specialty providers, FQHCs, clinics, and urgent care) to improve access to medical equipment through the purchase accessible examination equipment, communication devices and Video Remote Interpretation as well as mandating “effective use and disability competency” training for the recipients of this equipment regarding. Sites would be identified at strategic locations throughout the network service area to maximize access for members thus improving network adequacy. (See **Promising Practices** below)
2. The development of a statewide centralized database that captures accurate information regarding the **physical, communication and program access elements** for the purpose of creating a single portal that can be accessed by all plans members, member services, care coordinators and case managers. The database must be interoperable with any and all centralized data for provider directories.
3. The development of specific tools to evaluate the **physical, communication and program access elements** of hospitals.
4. Development of strategies to identify and integrate key disability **physical, communication and program access** elements into network capacity by:

Establishing a statewide taskforce consisting of representatives from key associations of providers, community clinics, medical groups and IPAs, hospitals, health plans, and representatives from disability access groups as well as DMHC, and DHCS). Anticipated outcomes would include but not be limited to:

- A. Develop and / or identify educational tools and materials explaining for disability access compliance requirements, history of disability access and the Americans with Disabilities Act requirements.

- B. Develop network adequacy definitions and standards that define and integrate physical and programmatic accessibility, including components and requirements for easily accessible statewide data base for health plans and beneficiaries to access.
- C. Recommend options for fundable incentives to support network providers, the health plan, and community providers to improve network capacity.
- D. Develop audit strategies to identify and address the physical communication and programmatic access gaps. This includes clear guidance and a recommended enforcement mechanism.
- E. Develop regulation that mandate accurate physical and programmatic accessibility information regarding each provider be integrated (through clear and specific information via with well explained legends of accessibility codes) into provider directories including web site versions of these directories. This information must be easily available to care coordinators and case managers.
- F. Develop standards for corrective action plan for providers with problematic access. (Even small providers can make some affordable changes such as installing grab bars, providing a ramp, adding Braille and raised lettering to elevator signage, rearranging display racks, adding directional signage. Larger providers and clinical groups can afford to make changes over time and should be held accountable to do so.)

## BACKGROUND AND PROBLEM:

### Network Capacity:

Achieving network adequacy remains a challenge for many health plans and managed care organizations (MCOs). Medicaid enrollment California

Current California law governing managed care plans /// amber has specific geographic distance and time requirements that must be met for a plan's provider network to be considered adequate. These regulations do not take into account physical and programmatic accessibility needs.

For example, there may be 15 gynecologists in a provider network who are within allowable distance and time requirements of a member who is a wheelchair user, but if few or none of these gynecologists have height-adjustable exam tables, lifts, or available trained personnel to assist with transfers, none of the providers can provide the member with an effective examination.

Existing time and distance standards do not take into account lengthy public transportation needs in dense urban areas such as Los Angeles, when public transportation is often the only viable form of transportation for many people with mobility, vision, and other disabilities, nor do the account for lengthy commute times of rural areas.

The MCO's data, presented in Los Angeles on 01.7.16 FSR training, from health plans with public projects using the **PARS** [(Attachment C, Physical-Accessibility Reviews Survey(PARs) which is approximately 1 hour part of the 6-7 hour the Facility Site Reviews (FSR) conducted by plans)] surveys continue to show a significant and widespread lack of accessible providers (Data). These findings are in sync with earlier research published by Mudrick, Nancy R.; Breslin, Mary Lou; Liang, Mengke; and Yee, Silvia, "Accessibility of Primary Health Care Settings for People with Disabilities" (2010). *School of Social Work*. These findings:

- Looked a combined data from 5 California plans address this gap with data on 2400 primary care provider facilities.
- Found 22 accessible weight scale was present in 3.6% and 23 a height adjustable examination tables were available in 8.4% of the sites
- Other high prevalence access barriers were in bathrooms & examination rooms.

### **People with disabilities and others with access and functional needs:**

The requirement that health plans must provide access to health care services for people with disabilities and others with access and functional needs including preventive care and needed health services see <https://www.dmhc.ca.gov/HealthCareinCalifornia/YourHealthCareRights/DisabilityAccess.aspx#.VpEvioldliot> continues to be problematic and not met for a large group of people.

The numbers of people who need an access related to communication, building, equipment and program and services are large across all lines of business and represent the vast majority of patients under Medi-Cal SPDs, Cal MediConnect and Medicare senior products. This large population includes: those with limited hearing, seeing, reading, or speaking abilities as well as those who use mobility devices such as wheelchairs, scooters, walkers, canes, crutches and those with limited ability to walk and use steps.

The invisibility of people with disabilities and others with access and functional needs is very common. These populations are typically under recognized and very under counted. & are far greater in numbers than those coded as seniors and people with disabilities (SPD) and aged, blind and disabled (ABD) ///



### **Substandard and unequal treatment:**

When people with disabilities and others with access and functional needs have to struggle to find access, some find the effort of pursuing care is just too exhausting, overwhelming and / or too degrading. This leads to postponing or avoiding care, resulting in a downward spiral of lack of care, delayed diagnosis, and worsening conditions leading to wider disparities, deteriorating health, that eventually requires more extensive and expensive health care and diminished opportunities for productive lives.

Substandard and unequal treatment put all at risk of missing critical signs of conditions needing attention and contribute to such disparities as poorer overall health and increase prevalence of diabetes, obesity, smoking, inactivity, stroke, heart disease and pain. This unequal treatment is commonly manifested when providers say “will just examine you from you wheelchair” (because a height adjustable table or transfer assistance is not provided), “will just skip that test because I know it is hard for you” (because they don’t know what referral could accommodate the individual) or “just guess your weight” (because there is no accessible scale for wheelchair users and those unable to step up) or “We can write notes back and forth” (because a ASL interpreter, Computer assisted real-time transcription, or an assistive listening system is not available).

### **Promising practices:**

An infusion of funds via grant programs for public programs has proven to be effective. These programs include projects initiated by L.A. Care, IEHP, Health Net, San Francisco Health Plan, and Molina, (past and current efforts) that provide funds to carefully selected network provider sites (primary care, specialty providers, FQHCs, clinics, and urgent care sites ) to improve access to medical equipment through the purchase accessible examination equipment, communication devices and Video Remote Interpretation as well as mandating “Effective use and disability competency” training for the recipients of this equipment. Sites are identified at strategic locations throughout the network service area to maximize access for members thus improving network adequacy. Site selections includes geo-coding and mapping of high volume providers and significant geographic gaps.

Formal outcome reports are not yet available, but funded project exit interviews reveal many positive observations and anecdotal stories regarding the effectiveness of these installations and improved patient care and safety as well as provide safety (especially focused on prevention of work place injuries).

### **Programmatic and communication access:**

When health plans only consider addressing the needs of people with physical disabilities, they leave out a large segment of people with disabilities and others with access and functional needs. These population segments include those with limitations

in seeing, hearing, speaking, reading, remembering, understanding, cognitive and intellectual abilities, as well as people with limited language proficiency. Without attention to these issues large numbers of people are prevented from receiving, understanding and using health information.

Practices need to identify, document, update and provide communication accommodations including:

- Sign language interpreters
- Oral interpretation
- Assistive listening devices
- Computer assisted real-time transcription
- Longer appointments - commonly needed when working with participants with intellectual, speech, or hearing disabilities
- Print materials in alternative formats:
  - Audio recording
  - Large print
  - Electronic text/CD/flash drive
  - Braille
- Telecommunication / Phone options to reach those with communication limitations:
  - Email
  - Text messaging
  - 711 relay services: TTY, Video, Voice carry over, Speech-to-speech?
- Accessible web site that include following WCAG Level 2.0 AA for development, maintaining and updating

Thank you for considering protecting the interests of people with disabilities and others with access and functional needs. And thank you for giving these issues your serious attention so that California's requirements for true access for these diverse and growing populations, do not remain empty promises, but becomes reality, and thank you for helping these health plans get better, and not just get bigger!

Sincerely,



June Isaacson Kailes  
Disability Policy Consultant

Copy: Shelley Rouillard, Director, Department of Managed Health Care



LOS ANGELES AREA  
CHAMBER OF COMMERCE

January 4, 2016

Honorable Dave Jones  
California Insurance Commissioner  
300 Capitol Mall, Suite 1700  
Sacramento, CA 95814-2724

Dear Commissioner Jones:

The Los Angeles Area Chamber of Commerce (The Chamber) is southern California's largest nonprofit business federation, representing over 1,600 businesses of every size across a variety of industries. I write to express our strong support for the emerging partnership between Health Net, Inc. and the Centene Corporation.

Health Net is a California-based company creating jobs as one of the largest employers in the City of Los Angeles, while delivering managed care services through employer-sponsored plans and government-sponsored managed care programs. Centene and Health Net share similar philosophies and together will enhance their ability to serve members and work collaboratively and effectively with providers and government partners. The proposed partnership will strengthen Health Net's presence in California by continuing to leverage a local approach, enhance members' access to higher quality healthcare services on a cost-effective basis, and ensure measurable quality outcomes.

Californians will have the benefit of a stronger health insurer to effectively compete in the marketplace, helping to ensure more consumer choice throughout the Golden State. The combined entity of Health Net and Centene will expand resources to more regions throughout the state, allowing for additional innovative solutions for value-based healthcare.

It is for these reasons and many more that the Chamber supports the Health Net and Centene partnership. If you have any questions, please contact Jessica Duboff, Vice-President of Public Policy at [jduboff@lachamber.com](mailto:jduboff@lachamber.com) or 213.580.7585. Thank you.

Sincerely,

A handwritten signature in cursive script that reads "Gary Toeppen".

Gary Toeppen  
President & CEO





January 5, 2016

The Honorable Dave Jones  
State of California Insurance Commissioner  
300 Capitol Mall, Suite 1700  
Sacramento, CA 95814

**Subject: Health Net, Inc. & Centene Corporation Partnership**

Dear Commissioner Jones,

The Valley Industry and Commerce Association (VICA) continues our strong support for the emerging partnership between Health Net, Inc. and the Centene Corporation.

Health Net, Inc. plays a vital role in the San Fernando Valley and across the state by delivering quality managed care services through employer-sponsored plans and government-sponsored managed care services. These services strengthen the health and economic vitality of the region by supporting local job growth in the healthcare industry. Centene and Health Net, Inc. share a similar philosophy, working tirelessly to enhance their ability to serve members and working effectively with providers and government partners.

The proposed partnership between the two groups will strengthen Health Net, Inc.'s presence in California by continuing to leverage a local approach, enhancing access to high quality healthcare services on a cost-effective basis and ensuring measurable quality outcomes.

Californians will have the benefit of a stronger health insurer to effectively compete in the marketplace, helping ensure more consumer choice through the state. The combined entity of Health Net, Inc. and Centene will strengthen resources to regions across the state, allowing more innovative solutions for value-based healthcare.

It is for these reasons and more that VICA supports the Health Net, Inc. and Centene partnership.

Sincerely,

A handwritten signature in black ink, appearing to read 'Kevin Tamaki'.

Kevin Tamaki  
Chair

A handwritten signature in black ink, appearing to read 'Stuart Waldman'.

Stuart Waldman  
President

cc: Jon Tomashoff, Senior Staff Counsel

**From:** [Tomashoff, Jon](#)  
**To:** [Chambers, Jennifer](#); [Hinze, Bruce](#)  
**Subject:** FW: Request to testify at the Centene / Health Net hearing  
**Date:** Thursday, January 21, 2016 10:53:01 AM  
**Importance:** High

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**From:** Sean Atha [mailto:satha@rcmg.com]  
**Sent:** Thursday, January 21, 2016 3:46 AM  
**To:** Tomashoff, Jon <Jon.Tomashoff@insurance.ca.gov>  
**Subject:** Request to testify at the Centene / Health Net hearing

River City Medical Group (RCMG) would like to testify in support of the Centene/Health Net merger.

RCMG is a local Sacramento based medical group that exclusively serves the Medi-Cal Managed Care population. RCMG has had a strong partnership with Health Net for over 20 years. I personally as an Anthem Blue Cross administrator have been part of a national Medicaid team working hard to compete against strong Medicaid programs funded by Centene. After careful discussion with leaders from both Health Net and Centene, I am comfortable about their combined future. I have been given commitments that indicate that Centene will be helping fund Medi-Cal specific innovations for California through Health Net's delegated IPA provider network. This new model for California has the potential of significantly improving the existing Health Net Medi-Cal program by assisting existing Medi-Cal focused IPA's to implement proven quality health programs from Centene's other non California operations. Further, RCMG has been given the understanding that the delegated IPA model will be utilized in the rural counties where Centene currently has a more limited fee-for-service direct network model.

Overall - RCMG has been given assurances that the existing California leadership will remain in leadership but will be able to integrate the Centene best practices into the California Health Net model.

--

**Sean Atha, MHA**

**SVP Business & Network Development**

River City Medical Group

Phone: 916.329.8336

Cell: 916.397.2564

Fax: 916.329.8337

7311 Greenhaven Drive, Suite 145, Sacramento, CA 95831

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*The Voice of Accountable Physician Groups*

December 14, 2015

Commissioner Dave Jones  
California Department of Insurance  
200 Capitol Mall, Suite 1700  
Sacramento, CA 95814

Re: Aetna – Humana, Anthem – CIGNA and Centene – Health Net Mergers

Dear Mr. Jones,

CAPG has previously written to Director Shelley Rouillard concerning the request for inclusion of specific undertakings that are within the authority of the DMHC under the Knox Keene Act. We understand that the California Department of Insurance has differing review authority than the DMHC. While CDI does not have the same level of authority, there is historical precedent of collaboration between CDI and DMHC with respect to the Anthem-Blue Cross and United-Pacificare mergers in the mid-2000s. CAPG believes that the further consolidation of the health insurer and plan marketplace will present both pitfalls and unprecedented opportunities for Californians. Your unique position with respect to these pending transactions affords you a tremendous opportunity to shape the direction of the California health care system toward a higher-performing, more accountable and transparent consumer-centric model.

These mergers will amass greater market power in but a few health plans, a consequence which experience has taught us does not produce lower premiums, or higher quality of care delivery, or better access to care for patients. These transactions can, however, deliver on the stated promises of greater efficiency and affordability if their closure is conditioned on executing undertakings that establish clear commitments to advancing California's delivery system through set benchmarks to improve the

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infrastructure for 21<sup>st</sup> century health care delivery. These undertakings, if required, will help build the kind of infrastructure that is needed to improve the larger healthcare ecosystem and produce higher quality, lower cost, with greater access. Without such undertakings, the merged entities will likely continue to perform as they are structured and legally required; that is, to generate maximum profits for the benefit of their shareholders, a mission that is not well aligned with the interests of California's consumers and providers.

**Require Compliance with Adopted Infrastructure Improvement Goals.** CAPG has urged the DMHC to adopt the health care system infrastructure improvement goals set forth in the Berkeley Forum report, which states the primary vision for a 21<sup>st</sup> Century California healthcare system as undertaking requirements in the remaining mergers:

*"...the Forum Vision calls for a rapid shift towards integrated systems that coordinate care for patients across conditions, providers, settings and time, along with risk-adjusted global budgets that encompass the vast majority of an individual's healthcare expenditures. Specifically, the Forum endorses two major goals for California to achieve by 2022: 1) Reducing the share of healthcare expenditures paid for via fee-for-service from the current 78% to 50%; and 2) Doubling, from 29% to 60%, the share of the state's population receiving care via fully- or highly-integrated care systems."*<sup>1</sup>

HHS Secretary Sylvia Burwell announced similar goals for the Medicare system in January, 2015.<sup>2</sup> California has endorsed these goals as part of its Cal Sim and Let's Get Healthy Task Force processes to establish a strategic plan for healthcare improvement and innovation in this state. At least three of the health plans involved in these pending mergers contributed to the Berkeley Forum Report – Anthem, Blue Shield and Health Net. Secretary Dooley participated in Berkeley Forum and has indicated she supports the goals it adopted. The following commitments are necessary:

- A commitment in accordance with Secretary Dooley's policy statement to increase value-based contracting in the California market, by annually increasing the transition from fee-for-service to value-based and risk-based contracting with providers under all lines of the plan's business, in all operational areas, where qualified providers exist.

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<sup>1</sup> A New Vision for California's Healthcare System. Berkeley Forum, February 2013. Web: <http://berkeleyhealthcareforum.berkeley.edu/wp-content/uploads/Berkeley-Healthcare-Forum-%E2%80%93-Executive-Summary.pdf>.

<sup>2</sup> <http://www.hhs.gov/about/news/2015/01/26/better-smarter-healthier-in-historic-announcement-hhs-sets-clear-goals-and-timeline-for-shifting-medicare-reimbursements-from-volume-to-value.html>.

- A commitment to increasing the health plan network population to integrated delivery system models, as outlined in the Forum report.
- Annual monitoring, through reports to the CDI, that document the plan's progress with providers toward this contracting benchmark. CAPG is informed that the Department of Public Health may already be monitoring this particular metric, but the Forum, the CHCF or the other organizations could be authorized to handle the monitoring in accordance with the Forum plan. The data sources and methodology are set forth in Appendix II to the Berkeley Forum Report.<sup>3</sup>
- Continued commitment by the plan to financially support California-based, value-based provider incentive programs, such as the IHA pay-for-performance system.
- Proof of the plan's efforts through demonstrated improvement by the plan's provider network on an annual basis with established performance and quality measures, such as MA 5-Star, IHA P4P, the DMHC TAR survey and other accepted standards.
- Failure to achieve substantial performance of these undertaking requirements should result in the issuance of corrective actions and/or cease and desist orders pursuant to the Department's enforcement authority under the Knox Keene Act.

**Require Faster, Common Platforms for Claims and Encounter Data Processing.** Health plan mergers should produce an improved health information exchange environment that ensures faster, more accurate claims and encounter reporting and processing. Such an infrastructure improvement is fundamental and necessary in order to create the efficiencies that translate to increased transparency for consumers such as automated, online deductible tracking. Too often, mergers produce greater complexity within the healthcare system. According to the Integrated Healthcare Association:

*"While encounter data have always been important, recent changes in the policy and market landscape heighten the importance of complete and timely data. Increasingly, market competitiveness depends on better data for risk adjustment, performance measurement and incentive programs, consumer cost-sharing, and transparency initiatives."*<sup>4</sup>

The ability of consumers to track their progress against deductibles in a timely and accurate manner, online, without resorting to a shoebox of receipts is but one of the capabilities required of the emerging health care system. The deductible tracking function (a deductible accumulator) is linked to the creation of a common clearinghouse

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<sup>3</sup> <http://berkeleyhealthcareforum.berkeley.edu/wp-content/uploads/Appendix-II.-California%E2%80%99s-Delivery-System-Integration-and-Payment-System-Methodology.pdf>.

<sup>4</sup> Integrated Healthcare Association Issue Brief: Encounter Data: Issues and Implications for California's Capitated, Delegated Market (Sept. 20, 2015)

of both claims and encounter data that would operate in near-real time to the provision of medical services to patients. Automated deductible tracking cannot be solved until encounter data reporting is also improved and automated.

- Each of the subsequent mergers should therefore produce funding to build and implement a standardized, all plan, all provider, encounter data clearing house, with a standardized portal for encounter data reporting across the industry, and a standard “deductible accumulator” so that enrollees can access information about their deductible limits as easily as checking their bank balance on a smart phone.
- It is far more efficient to build a common system or utility for use by all plans and providers in California than to require each plan to build and maintain their own individual legacy systems.
- The Department should expand the requirement first set forth in the Blue Shield-Care First undertakings to these three remaining mergers to fund a statewide, independent, third party utility that will accomplish these functions.
- Health Net and CAPG have previously collaborated on a concept for a faster system, based on a technological platform that is analogous to the financial services sector’s development of current ATM technology. This concept encourages all types of providers, but especially non-contracted providers, to submit claims and encounter data in near real-time to the delivery of service. The benefit of such a system would be that faster data reporting will drive quicker claims resolution, producing better analytical capability concerning the performance, cost and quality of providers. By driving near real-time claims resolution, a workable, online patient deductible accumulator technology also becomes feasible, improving the transparency of the health care system for consumers and patients.

Create a Funding Pool and Structure for an Online Multiplan Provider Directory. The Department of Managed Health Care has already required Blue Shield to pursue the development of an online provider directory and AHIP is piloting an eventual, national solution to this issue. We have urged the DMHC to impose this requirement on all remaining merger entities to broaden the funding sources for the solution and to drive collaboration throughout the industry.

SB 137 requires an immediate effort by the industry to comply with the July 1, 2016 deadline for health plans to go live with online provider directories. California providers will be hard-pressed to respond to each plan via their individual portals under this new statute, and they will be subject to significant payment withholds should they fail to comply. These inclusion of these financial penalties on providers were lobbied for by health plans involved in these mergers, and therefore, it is fair and appropriate for the Department to facilitate a solution for California providers in these undertakings.

D. Jones

December 14, 2015

Page 5 of 6

- **CAPG Provider Directory reporting portal pilot** CAPG has initiated a pilot that we expect to start-up in early December that will introduce a single online reporting portal for providers to enter and update their status information in compliance with SB 137 and Medicare Advantage standards. This portal would enable provider groups, individual physicians and facilities to input their data once and make it available to each provider's multiple contracted payers. Payers could then incorporate the data into their own online directory solutions, and eventually to an AHIP-sponsored uniform solution. We will test the pilot in December, and expect to have a sustainable model in place well prior to the July 1, 2016 implementation date for SB 137. We would be happy to brief the Department further on our pilot and we suggest that you consider allocating funding for this portal in one or more of the remaining mergers. As our pilot progresses, we ask the Department to consider the incorporation of our solution into the Multiplan provider directory requirement, and to require funding and collaboration from the merger plans.

**Concluding thoughts.** Many important initiatives have lagged for years due to the lack of identified funding sources. These mergers provide a unique opportunity to ensure progress toward the Berkeley Forum, CalSim and Let's Get Healthy Task Force goals, as well as many other desirable legislative concepts. Spreading the costs over four near-simultaneous merger transactions would lessen the financial impact to any single health plan and would create a funding pool that is substantial. The creation of this new infrastructure would benefit consumers, who would enjoy much greater ease of use in the California health care marketplace. In summary, we believe that the inclusion of the following goals and projects are worthwhile components of the undertakings:

- Demonstrable commitment to increased value-based payment to providers
- Demonstrable commitment to increased use and facilitation of integrated, coordinated care delivery systems in provider networks
- Funding and creation of a faster, common claims and encounter clearinghouse
- Funding an integrated, automated deductible accumulator technology
- Funding for online provider directory reporting technology

Thank you for the opportunity to provide our suggestions.

Sincerely,



Donald H. Crane  
President and CEO

CDIx267

D. Jones

December 14, 2015

Page **6** of **6**

CAPG

Attch. Letter of September 9, 2015 to DMHC Director Shelley Rouillard





*The Voice of Accountable Physician Groups*

September 9, 2015

Shelley Rouillard  
Director, Department of Managed Healthcare  
980 Ninth Street, Suite 900  
Sacramento, CA 95814-2725

Re: Anthem – CIGNA, Aetna – Humana, Blue Shield – Care First, and Centene – Health Net Mergers

Dear Shelley,

Thank you for inviting CAPG to offer suggestions to the potential undertakings that may apply to the pending mergers of Anthem-CIGNA, Aetna-Humana, Blue Shield-Care First and Centene-Health Net.

The scale of consolidation is unprecedented and carries real risks to consumers of decreased choice and higher premiums and to providers of decreased compensation for the care they deliver. In each of these mergers, health plans will argue that greater synergies will be created as result of the combination of these large plans, including increased geographic coverage for managed care across California, simplification of payer systems and contracting, increased provider networks resulting from the combination, etc. These synergies will only occur if the Department requires undertakings that will ensure a better infrastructure for enrollment and continuity of care delivery for California's covered population. The Department has previously used undertakings in the past Anthem and United Health Care mergers of the mid-2000s that incorporated health system infrastructure commitments.

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The promise of the Affordable Care Act was that more people would have access to affordable health coverage. While in the main that promise has been delivered in California, the available, affordable options have incorporated high deductibles and narrow provider networks. These narrow networks generally incorporate steep financial consequences for stepping out of the prescribed path of access to care. In most instances, the consequence is significantly higher coinsurance or copays. However, in some Covered California offerings, there is no coverage for out of network care.

It is frequently stated as an axiom that health consumers must become better shoppers for health care services. But how can a patient or their family gain the critical information to know that Doctor A is a provider on their particular health plan coverage? Physicians may agree to a contract for one line of service but not for another. Frequent terminations are increasingly the norm. Convolutioned coverage language places the risk on the member for a misstep.

CAPG is proposing two initiatives that enjoy wide support in the health industry and policy arena that will empower enrollees to determine which plans and providers deliver the best care at the price that they can afford. Restating from the goals of the Let's Get Healthy Task Force and the CalSim proposal, we urge you to consider the following priorities:

**All Payer Claims Database.** As we have seen in Colorado under the Center for Improving Value in Health Care (CIVHC) database, consumers can access a wide variety of cost, utilization and quality reports that are currently available on the website by county and zip code. The website is constantly improved as broader payer data and greater consumer utility functions are added. This empowers enrollees to determine which plans and providers deliver the best care at the price that they can afford. California is not that far away from implementing such a system. We already have comprehensive quality information on public websites, we have the ability to collect fee for service claims data. California needs a centralized, all plan, all provider, encounter data clearing house, and we will soon have the DHCS PACES encounter data reporting system that will span 26 health plans. PACES will provide a standardized portal for encounter data reporting across the industry. We will also need a standard "deductible accumulator" so that enrollees can access information about their deductible limits as easily as checking their bank balance on a smart phone (similar to the 2014 bill, SB 1176). The Department could require as undertakings in these four pending mergers the creation of a fund to build a statewide, independent, third party utility similar to that proposed under Senator Hernandez' SB 26.

- **Multiplan Provider Directory:** Fund a single, multi-plan provider directory project under an independent third party entity, or under the auspices of the Department of Managed Health Care, that provides an online portal for near-real time updating of provider status. A provider could log on and update his or her

status and information and the data would be accessible to each of that provider's contracted health plans. The portal could be accessed by the Department for filing compliance and review and the public for network transparency. This will empower enrollees by increasing their ease of access to providers and it will allow them to compare one plan's network against another so that they can make more informed decisions about their health care.

Spreading the costs over four near-simultaneous merger transactions would lessen the financial impact to any single health plan. Consumers would enjoy much greater ease of use in the California health care marketplace. In addition to the specific items above, we suggest that the undertakings include provisions requiring the commitments to be tracked, measured, and enforced.

Thank you for the opportunity to provide our suggestions. Should there be an opportunity for CAPG to participate in the drafting or review of the undertaking, we would ask to be included in that process.

Sincerely,

A handwritten signature in dark ink, appearing to read "Donald H. Crane", is positioned above the typed name.

Donald H. Crane  
President and CEO  
CAPG

CDIx271  
January 12, 2016

Jennifer Chambers  
Senior Staff Counsel  
Department of Insurance  
45 Fremont Street, 24<sup>th</sup> Floor  
San Francisco, CA 94105

Subject: Health Net Acquisition by Centene Corporation

Dear Ms. Chambers:

On behalf of the undersigned members of the California Health & Wellness Community Advisory Committee (CAC), thank you for the opportunity to express our support for the Health Net acquisition by Centene Corporation. As an advisory committee to California Health & Wellness, a Centene health plan, the CAC's purpose is to provide advice and recommendations to the health plan about the needs of the members served and provide recommendations about how the plan can best provide culturally and disability-responsive services to its members. The CAC represents community based organizations serving seniors, people with disabilities including those served by Regional Centers, working families, and other agencies providing medical and social support.

In its brief existence, California Health & Wellness stepped up and out into the community in ways not seen by other health plans. The plan leadership practices the principles in its purpose statement, "Transforming the health of community, one person at a time." They demonstrate this through their active involvement and presence with their members and organizations serving their members across their 800 mile expanse of coverage. Most importantly, not only are they present, but they listen to the concerns of these members and organizations and serve as a convener for them to share their thoughts. Centene and Health Net share a philosophy and goal of serving their members well. When the community based emphasis of Centene is coupled with the extensive membership of Health Net, it is a natural fit to provide higher quality and more community responsive services to the residents of California.

Californians will soon have the opportunity to benefit from a stronger health plan with expanded resources and an uncompromising commitment to meeting the needs of individuals served by the plan. We encourage your support of this partnership.

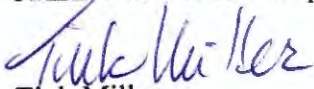
Sincerely,



Ana Acton  
Executive Director  
FREED Center for Independent Living



Ann Guerra  
Executive Director  
Nevada Sierra Regional IHSS Public Authority



Tink Miller  
Executive Director  
Placer Independent Resource Services



Diana Peacher  
Chief Executive Officer, Patient Navigator  
Cancer Resource Center of the Desert



Barry Smith  
Executive Director  
Disability Resource Agency for Independent Living

January 5, 2015

Dave Jones  
Insurance Commissioner  
Department of Insurance  
300 Capitol Mall, Suite 1700  
Sacramento, CA 95814

Dear Commissioner Jones,

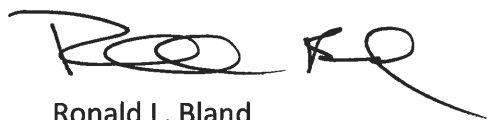
As a Northern California Group Benefits insurance broker serving the bay area specifically, I support the emerging partnership between Health Net, Inc. and the Centene Corporation.

I have been in the California health insurance industry for 30 years. Health Net, a California based company, is a solid partner with its managed care product offering focused on employer-sponsored plans, and government-sponsored managed care programs, offering a variety of healthcare options to fit California's diverse population. The partnership between Health Net and Centene is a natural fit, combining complementary services and service areas and leveraging expertise in innovative solutions.

Centene and Health Net share a philosophy and together will enhance their ability to serve members and work collaboratively and effectively with providers and government partners. The proposed partnership will strengthen Health Net's presence in California by continuing to leverage a local approach, enhance members' access to higher quality healthcare services on a cost-effective basis, and ensure measurable quality outcomes.

For these reasons and many more, I support and look forward to the emerging partnership between Health Net and Centene. I have faith that California insurance agents such as myself will continue to see great things as a result of Health Net and Centene's combination. Thank you.

Sincerely,



Ronald L. Bland  
Principal





January 8, 2016

Jennifer Chambers  
Senior Staff Counsel  
45 Fremont Street, 24th Floor  
San Francisco, CA 94105

Jon Tomashoff  
Senior Staff Counsel  
45 Fremont Street, 24th Floor  
San Francisco, CA 94105

**RE: Emerging Partnership between Health Net Inc. & Centene Corporation**

Dear Ms. Chambers and Mr. Tomashoff:

On behalf of AltaMed Health Services Corporation, I write to express our support for the emerging partnership between Health Net Inc. and Centene Corporation. As the largest Federally Qualified Health Center (FQHC) in the nation, delivering more than 1.2 million annual patient encounters through our 46 sites in Los Angeles and Orange Counties, AltaMed prides itself in the quality of its care delivered by its premier health care professionals. Similar to Health Net, we are also dedicated to help people be healthy, secure and comfortable with the heart of the community at the forefront of our operations. Centene's commitment to build healthier and stronger communities is also of high importance to AltaMed.

Currently, we proudly serve 56,143 Health Net members. This is a significant number of our total enrollees, making this a particularly important matter for us. We trust that Centene will continue committed to its mission, serving all of its members with the same or even greater level of service after integrating their planning efforts with Health Net. We acknowledge Centene for being consistent and an effective advocate for initiatives that improve the quality of life and health in our communities. Not only has Centene been a strong advocate for the benefit of the public, it has also contributed by providing substantial financial and leadership support to many community health organization helping families, especially children in need.

As a member of the California Primary Care Association (CPCA) and the California Association of Physician Groups (CAPG), we consider the recommendations made by these two associations worthy of application to ensure this emerging partnership results in exceptional care and healthier populations. By doing so, Californians will have the benefit of a stronger health insurer, helping to guarantee more consumer choice throughout the Golden State.

Centene and Health Net are both committed to providing access to patient-centered, high quality, and



cost effective health care for their members and they complement each other well. We are confident that together they will have the resources to better serve the growing Medi-Cal and Medicare populations.

It is for these reasons that AltaMed supports the Health Net and Centene partnership. Should you have any questions, please free to contact Dr. Marie Torres at (323) 889-7328 or by email at [mtorres@la.altamed.org](mailto:mtorres@la.altamed.org).

Respectfully,

A handwritten signature in blue ink, reading "Castulo de la Rocha".

Cástulo de la Rocha, J.D.

President and Chief Executive Officer

Cc: Mr. Jay Gellert, President & CEO, Health Net, Inc.  
Ms. Martha Santana-Chin, Vice President, Dual Eligible Health Services Management



January 4, 2016

Dave Jones  
Insurance Commissioner  
Department of Insurance  
300 Capitol Mall, Suite 1700  
Sacramento, CA 95814

Dear Dave,

As a Southern California Group Benefits insurance broker, I support the emerging partnership between Health Net, Inc. and the Centene Corporation.

I have been in the California health insurance industry for 30 years. Health Net, a California based company, is a solid partner with its managed care product offering focused on employer-sponsored plans, and government-sponsored managed care programs, offering a variety of healthcare options to fit California's diverse population. The partnership between Health Net and Centene is a natural fit, combining complementary services and service areas and leveraging expertise in innovative solutions.

Centene and Health Net share a philosophy and together will enhance their ability to serve members and work collaboratively and effectively with providers and government partners. The proposed partnership will strengthen Health Net's presence in California by continuing to leverage a local approach, enhance members' access to higher quality healthcare services on a cost-effective basis, and ensure measurable quality outcomes.

For these reasons and many more, I support and look forward to the emerging partnership between Health Net and Centene. I have faith that California insurance agents such as myself will continue to see great things as a result of Health Net and Centene's combination. Thank you.

Sincerely,

A handwritten signature in black ink, appearing to read 'Scott Buettner', is written over a horizontal line.

Scott Edward Buettner





January 14, 2016

Commissioner Dave Jones  
California Department of Insurance  
300 Capitol Mall, Suite 1700  
Sacramento, CA 95814

Commissioner Jones:

CalViva Health is a local Medi-Cal health plan serving residents in Fresno, Kings, and Madera counties serving more than 360,000 consumers. Governed by the Fresno-Kings-Madera Regional Health Authority, CalViva Health has a strong local presence with ongoing input from enrolled members, health care providers, and the community. Health Net has been a long-standing partner with Cal Viva in providing health care coverage to our Medi-Cal beneficiaries.

Health Net, much like Centene, is committed to serving low- to moderate-income populations in a cost-effective and quality manner. The proposed partnership will bring similar yet distinct assets from different markets together to enhance their ability to serve members and government partners across the state. Combining similar philosophies and bringing additional resources to the California market will result in stronger product lines to benefit consumers.

The combined Health Net-Centene entity, will also strengthen Health Net's presence in California by leveraging a local approach with national best practices to ensure affordable access to health care.

It is for these reasons and many more that Cal Viva supports the Health Net and Centene partnership. Thank you.

Sincerely,

Gregory Hund, Chief Executive Officer  
Cal-Viva Health  
Fresno-Kings-Madera Regional Health Authority

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Cancer Institute, Professor of Medicine, University  
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Eastchester Medical Associates, PC, Bronx, NY

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Adjunct Professor, Snelville, GA**Norma Gomez Parra, MD**

Medical Director, CentroMed, San Antonio, TX

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Jackson Memorial Hospital, University of Miami,  
Miller School of Medicine, Hialeah, FL**Abner Murray**Latino Medical Student Association  
MD/PhD Candidate, Steinmetz Laboratory,  
Department of Biomedical Engineering,  
Department of Molecular Biology and Microbiology,  
Molecular Virology Program  
Case Western Reserve University, Cleveland, OH**ADVISORY COUNCIL****Richard H. Carmona, MD, MPH, FACS**17<sup>th</sup> US Surgeon General (2002-2006)  
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**Ivelisse Estrada**Senior Vice President for Corporate and  
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President &amp; CEO, Griego Enterprises, Inc., Los Angeles, CA

**Yasmine Winkler**Senior VP Innovation and Productivity  
United HealthCare, Chicago, IL**Richard Zapanta, MD**

Orthopedic Surgeon, Monterey Park, CA



December 21, 2015

Jennifer Chambers  
Senior Staff Counsel  
Department of Insurance  
45 Fremont Street, 24<sup>th</sup> Floor  
San Francisco, CA 94105

The National Hispanic Medical Association (NHMA) is a non-profit association representing the interests of 50,000 licensed Hispanic physicians in the United States. The vision of the organization is to be the national leader to improve the health of Hispanic populations. Given the demographics of California, we are very active throughout the state. We strongly support the acquisition of Health Net by Centene Corporation.

We've enjoyed a rapidly developing relationship with Centene Corporation over the past few years. NHMA is impressed by the commitment and the long range vision of Centene of "improving the health of communities, one person at a time". We find this to be more than a catchy phrase. Centene serves large Hispanic populations across the country and their California-based plan, California Health and Wellness, has some counties where over 80% of their members are Hispanic. The company recognizes that in order to optimally serve their Hispanic members, they can benefit from developing physicians and other health care professionals through their NHMA relationship that look like, speak like and understand the culture of these members.

If Centene acquires Health Net, they will dramatically expand the number of Hispanic members they serve in California. Health Net has had a broad geographic presence across the state and we are confident that the Hispanic members will be very well served by the expanded presence of Centene and their emphasis on culturally sensitive, locally delivered services. We look forward to a long term relationship with the combined companies and know that the residents of California will benefit from our partnership.

As a physician who grew up and trained in California and as a leader from California where the largest number of our members practice, I urge you to approve this acquisition.

Sincerely,

Elena Rios, MD, MSPH  
President & CEO

**From:** [Chambers, Jennifer](#)  
**To:** [Withers, Dawn](#)  
**Subject:** FW: merger  
**Date:** Thursday, January 21, 2016 10:31:48 AM

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**From:** Jeanne Amato [mailto:myriadie@comcast.net]  
**Sent:** Wednesday, January 20, 2016 5:20 PM  
**To:** Chambers, Jennifer <Jennifer.Chambers@insurance.ca.gov>  
**Subject:** merger

Health Insurance companies are damaging to healthcare and our economic state. People are working nonproductively, not adding anything of real value, just haggling over getting providers payments. It's disgusting and stupid that Americans fall for it.

**From:** [Chambers, Jennifer](#)  
**To:** [Withers, Dawn](#)  
**Subject:** FW: Comments on the health care company mergers  
**Date:** Thursday, January 21, 2016 10:31:34 AM

---

**From:** Gracee Arthur [mailto:arthurgracee1@gmail.com]  
**Sent:** Wednesday, January 20, 2016 5:19 PM  
**To:** Chambers, Jennifer <Jennifer.Chambers@insurance.ca.gov>  
**Cc:** Dave Jones <insurancecommissionerdavejones@gmail.com>  
**Subject:** Comments on the health care company mergers

Jennifer:

I think these health companies merging is a terrible thing for the consumer aka the insured. The gangster insurance companies have been raising the rates without any restriction since the Affordable Care Act. Also since California removed the PPO's from the Insurance Commissioner's office and placed them with the insurance company friendly Managed Care department.

My rate has increased again this year, \$70 per month with Blue Shield.

If the insurance companies and the rates are not restrained and regulated by the Insurance Commissioner's office, we cannot allow these greedy companies to merge and further stick it to their insured.

Sincerely,  
Gracee Arthur

Gracee Arthur  
[arthurgracee1@gmail.com](mailto:arthurgracee1@gmail.com)

Estate Agent  
Sothebys Int'l Realty  
Malibu, Ca.  
CalBRE# 01118257  
Cell 310-804-0708

**From:** [Withers, Dawn](#)  
**To:** [Withers, Dawn](#)  
**Subject:** FW: Centene/HealthNet - Merger Philosophy & Opinion  
**Date:** Thursday, January 21, 2016 1:01:23 PM

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**From:** Hugh A. Calvin [<mailto:hugh.calvin2014@comcast.net>]  
**Sent:** Thursday, January 21, 2016 11:19 AM  
**To:** Chambers, Jennifer <[Jennifer.Chambers@insurance.ca.gov](mailto:Jennifer.Chambers@insurance.ca.gov)>  
**Subject:** Centene/HealthNet - Merger Philosophy & Opinion

Thank you for your efforts on behalf of the citizens of CA.

Finding an optimum balance between community- and self-interest is difficult work. Because for-profit corporations tend to be focused on their profit objective, they are willing to marshal resources, including lobbyists and information not available to the public, to make their case. The consumers, respectfully, have neither the ability nor the interest to compete with a company focused on achieving an objective. So it's easy for the legislative branch to hear the self-interest arguments of the corporation and difficult to find a coherent message from the community of individual citizens you represent.

As an individual, I feel that corporations have dominated the legislative agenda in Washington, DC, and Congress has represented individual-interest poorly, despite rhetoric to the contrary. I believe our national political system has been co-opted by corporations, and our state political system is vulnerable.

At the moment, I feel competition generally benefits the consumer and corporations have or are acquiring too much influence over government, so, independent of the merits of this merger, I'd encourage you to deny the corporations this merger request.

Hugh A. Calvin  
Santa Cruz, CA

**From:** [Chambers, Jennifer](#)  
**To:** [Withers, Dawn](#)  
**Subject:** FW: Merger  
**Date:** Thursday, January 21, 2016 10:32:09 AM

---

**From:** Moe Evans [mailto:2bemee88@gmail.com]  
**Sent:** Wednesday, January 20, 2016 5:59 PM  
**To:** Chambers, Jennifer <Jennifer.Chambers@insurance.ca.gov>  
**Subject:** Merger

Please stop any merger between Centene (?) and Health Net. Mergers are a nightmare for the public to say the least in so very many cases.

Elizabeth Evans.



**From:** [Chambers, Jennifer](#)  
**To:** [Withers, Dawn](#)  
**Subject:** FW: Insurance Merger  
**Date:** Thursday, January 21, 2016 10:34:54 AM

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**From:** Gary Germano [mailto:garywgermano@hotmail.com]  
**Sent:** Thursday, January 21, 2016 6:52 AM  
**To:** Chambers, Jennifer <Jennifer.Chambers@insurance.ca.gov>  
**Subject:** Insurance Merger

Dear Dave,

I believe that "mega-mergers" are almost exclusively bad for America. I cannot speak exactly for these two companies, because I do not know them like you do. But, here's the deal.

CVS bought out Longs Drugs.

What do I find?

Less selection, higher store prices overall, higher prices on their weekly sale flyer.

Now Walgreens, one of the highest price drug stores (IMO) wants to buy Rite Aid, the one left with the better prices and sales. (But not for long if this goes through.) LESS JOBS, LESS COMPETITION, **MONOPOLY**, and all of us pay for it! THIS MERGER NEEDS TO BE STOPPED. How can we do it?

When the Walgreens and CVS CEO's play golf on Wednesday, IT DOESN'T TAKE EINSTEIN TO CONNECT THE DOTS AND KNOW WHERE OUR PRICES ARE HEADING!

As always, I appreciate you asking for your constituents opinion and the good communications you always have with me.

Best regards,

Gary Germano

**From:** [Chambers, Jennifer](#)  
**To:** [Withers, Dawn](#)  
**Subject:** FW: Proposed merger of HealthNet and the other insurance carrier  
**Date:** Thursday, January 21, 2016 10:32:23 AM

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-----Original Message-----

From: Donald Goldmacher [<mailto:donald.goldmacher@gmail.com>]  
Sent: Wednesday, January 20, 2016 6:31 PM  
To: Chambers, Jennifer <[Jennifer.Chambers@insurance.ca.gov](mailto:Jennifer.Chambers@insurance.ca.gov)>  
Subject: Proposed merger of HealthNet and the other insurance carrier

As somebody who is insured by HealthNet along with Medicare, I am absolutely opposed to any mergers with another insurance company. What these mergers accomplish is getting more money to top management and shareholders. Those who are insured get less service, and find it more difficult to obtain help from the staff of these insurance companies. In the past, these types of mergers were illegal under federal antitrust laws, and the state of California should adhere to the antitrust laws. This merger would accomplish nothing positive for the actual insured subscribers.

Additionally, as a retired physician, I can tell you that this does not benefit patients at all, and does not improve the quality of health care received by patients. Rather, it puts more money in the hands of shareholders and top management, which inevitably increases the cost of care for all of us.

Don Goldmacher, MD, retired



**From:** [Chambers, Jennifer](#)  
**To:** [Withers, Dawn](#)  
**Subject:** FW: Merger  
**Date:** Thursday, January 21, 2016 10:34:38 AM

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**From:** Gilbert Gonzalez [mailto:ggonzalez@williamoneil.com]  
**Sent:** Thursday, January 21, 2016 6:48 AM  
**To:** Chambers, Jennifer <Jennifer.Chambers@insurance.ca.gov>  
**Subject:** Merger

Dear Ms. Chambers,

I am opposed to the Centene / Healthnet merger I may not have a thorough understanding or all of the facts on this merger but what I do know is that these companies are already to big and all mergers do is eliminate competition and in the end the public consumers suffer.

Yours,

Gilbert Gonzalez

**From:** [Chambers, Jennifer](#)  
**To:** [Withers, Dawn](#)  
**Subject:** FW: Merger  
**Date:** Thursday, January 21, 2016 10:34:38 AM

---

**From:** Gilbert Gonzalez [mailto:ggonzalez@williamoneil.com]  
**Sent:** Thursday, January 21, 2016 6:48 AM  
**To:** Chambers, Jennifer <Jennifer.Chambers@insurance.ca.gov>  
**Subject:** Merger

Dear Ms. Chambers,

I am opposed to the Centene / Healthnet merger I may not have a thorough understanding or all of the facts on this merger but what I do know is that these companies are already to big and all mergers do is eliminate competition and in the end the public consumers suffer.

Yours,

Gilbert Gonzalez

**From:** [Chambers, Jennifer](#)  
**To:** [Withers, Dawn](#)  
**Subject:** FW: Insurance question  
**Date:** Thursday, January 21, 2016 10:34:11 AM

---

**From:** moneywhys@aol.com [mailto:moneywhys@aol.com]  
**Sent:** Thursday, January 21, 2016 1:08 AM  
**To:** Chambers, Jennifer <Jennifer.Chambers@insurance.ca.gov>  
**Subject:** Insurance question

It appears that California is working toward a "single insurer" system. Opposition to a "single payer" plan has been led by insurers. So why does the private sector want control over health insurance premiums while objecting to a public plan? Besides profit, why is less competition better for Californians than a mutual public plan?

Than you,  
Don Krouse  
Morongo Valley, CA

**From:** [Chambers, Jennifer](#)  
**To:** [Withers, Dawn](#)  
**Subject:** FW: Comments re: Proposed Merger of Centene and Healthnet  
**Date:** Thursday, January 21, 2016 10:33:45 AM

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-----Original Message-----

From: Thea Merrill [[mailto:thea\\_merrill@stanfordalumni.org](mailto:thea_merrill@stanfordalumni.org)]  
Sent: Wednesday, January 20, 2016 8:50 PM  
To: Chambers, Jennifer <[Jennifer.Chambers@insurance.ca.gov](mailto:Jennifer.Chambers@insurance.ca.gov)>  
Subject: Comments re: Proposed Merger of Centene and Healthnet

Dear Ms. Chambers and Insurance Commissioner Jones,

I am writing today as a consumer with a family of four, to comment on the proposed merger of Centene and Healthnet. As a consumer, I am concerned that this merger reduces the number of companies offering health insurance in California. These companies are already large, already have a disproportionate amount of leverage over consumers, and already face too little competition to provide a healthy market of choices for consumers.

Our family currently has a very good health plan through my husband's employer, so the chances are that we would not be personally affected by this merger. However, until and unless our country develops a single-payer system (which is what we'd really like to see), we think that anything that results in a decline in the number of choices for consumers is a bad thing, both in principle and in practice.

Thank you for taking these comments.

Thea Merrill, Ph.D.  
Los Altos, CA

**From:** [Chambers, Jennifer](#)  
**To:** [Withers, Dawn](#)  
**Subject:** merger of health insurers  
**Date:** Thursday, January 21, 2016 10:31:19 AM

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**From:** Barby Ulmer [mailto:odw@magiclink.net]  
**Sent:** Wednesday, January 20, 2016 5:09 PM  
**To:** Chambers, Jennifer <Jennifer.Chambers@insurance.ca.gov>  
**Subject:** merger of health insurers

Please disallow the merger. Experience has shown when there are mergers with less competition premiums increase. PLEASE don't let this happen.  
Sincerely, Vic and Barby Ulmer

408-379-4431  
[odw@magiclink.net](mailto:odw@magiclink.net)  
13004 Paseo Presada  
Saratoga, CA 95070

**From:** [Chambers, Jennifer](#)  
**To:** [Withers, Dawn](#)  
**Subject:** FW: Insurer merger  
**Date:** Thursday, January 21, 2016 10:33:56 AM

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**From:** rockynvang [mailto:rockynvang@aol.com]  
**Sent:** Wednesday, January 20, 2016 9:15 PM  
**To:** Chambers, Jennifer <Jennifer.Chambers@insurance.ca.gov>  
**Subject:** Insurer merger

Do any benefit changes after it is merged? Rocky Vang

From my Android phone on T-Mobile. The first nationwide 4G network.

**From:** [Chambers, Jennifer](#)  
**To:** [Withers, Dawn](#)  
**Subject:** FW: Proposed merger  
**Date:** Thursday, January 21, 2016 10:34:26 AM

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-----Original Message-----

From: Camille [<mailto:cczeleny@cox.net>]  
Sent: Thursday, January 21, 2016 6:04 AM  
To: Chambers, Jennifer <[Jennifer.Chambers@insurance.ca.gov](mailto:Jennifer.Chambers@insurance.ca.gov)>  
Subject: Proposed merger

Dear Ms. Chambers,

Please consider the impact this merger would have on price setting. As you are well aware the fewer number of competitors in a given field, the more likely their prices will rise, and the quality of services will diminish. Our health care is already the most expensive among the developed nations, and in most categories of care, not the best. My personal experience as a retired 60 year old for a major medical PPO policy, is my monthly premium has increased in two years from \$360. To \$750.00! ! !

Please do your part to increase the number of health insurance companies and thus support more competition in this critical segment of our quality of life.

Sincerely,

Camille Zeleny

Sent from my iPad



# Health Care LA, IPA

January 5, 2016

Dave Jones, Insurance Commissioner  
California Dept. of Insurance  
45 Fremont Street, 24th Floor  
San Francisco, CA 94105

Dear Commissioner Jones:

Health Care LA, IPA (HCLA) is a nonprofit 501c3 organization with a mission to support safety net Community Clinics and Federally Qualified Health Centers (FQHCs). HCLA is proud of our partnership with Health Net in California, which is built on a foundation of supporting and expanding access to quality comprehensive healthcare for underserved communities.

Health Net has a focus on serving low to moderate income populations as one of the largest Medicaid/Medi-Cal plans in California and Centene shares a similar focus through California Health and Wellness, its Medi-Cal plan serving rural counties in California. The partnership between the two companies is a natural fit, combining complementary services and service areas and leveraging expertise in innovative solutions for delivering community-based healthcare to the state's diverse Medi-Cal population. Over the years, HCLA has worked with Health Net on innovative approaches to population health management by creating shared-risk pool models with providers and hospital partners. We expect our close working relationship to continue under the combined Health Net/Centene entity.

HCLA remains committed in expanding access to quality comprehensive healthcare to underserved communities in our region through an organized, fully integrated healthcare delivery system. To this end, we look forward to continuously working with Health Net under the combined Health Net/Centene entity. Thank you.

Sincerely,

Health Care LA, IPA

IRIS WEIL, Executive Director





Jaime S. King, JD, PhD  
 Professor of Law  
 Associate Dean and Co-Director  
 UCSF/UC Hastings Consortium on Law,  
 Science and Health Policy

University of California Hastings College of the Law | 200 McAllister Street | San Francisco, CA 94102  
 phone 415.581.8834 | fax 415.565.4865 | [www.uchastings.edu](http://www.uchastings.edu) | [kingja@uchastings.edu](mailto:kingja@uchastings.edu)

January 22, 2016

Commissioner David Jones  
 State of California Department of Insurance  
 300 Capitol Mall, Suite 1700  
 Sacramento, CA 95814

Re: Proposed Acquisition of Health Net Life Insurance Company by Centene Corporation

Dear Commissioner Jones,

I very much appreciate the opportunity to write on the potential impact of the proposed acquisition of Health Net Life Insurance Company by Centene Corporation on consumers and competition in California. I am a professor of law at the University of California Hastings College of the Law and the Associate Dean and Co-Director of the UCSF/UC Hastings Consortium on Law, Science and Health Policy. I have written and taught in the field of health law and policy for the last seven years. I am also the Co-Founder and Executive Editor of The Source on Healthcare Price and Competition, a free and independent academic website devoted to issues of health care prices, costs, and markets. In September 2015, I testified before the U.S. House of Representatives Judiciary Committee's Subcommittee on Regulatory Reform, Commercial and Antitrust Law regarding the potential impact of the proposed mergers of Aetna and Humana and Anthem and Cigna on consumers and competition in the U.S. health care system. My brief letter aims to provide insight to the consumer risks associated with health insurance mergers and put the potential merger of Centene and Health Net into a broader national context.

## **Introduction**

The United States has experienced more than a 400 percent increase in total health care expenditures since 1990.<sup>1</sup> By 2014, health care expenditures exceeded \$3 trillion and represented 17.5 percent of our GDP. Private insurance premiums are at their highest levels in history (\$17,545 for the average family).<sup>2</sup> One of the reasons our health care costs so much is that we overpay for health care

<sup>1</sup> Center for Medicare and Medicaid Services, National Health Expenditures 2014, Aggregate and Per Capita Amounts available <https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nhe-fact-sheet.html>.

<sup>2</sup> Kaiser Family Foundation and Health Research & Educational Trust, "2015 Survey of Employer Health Benefits," available at <http://kff.org/health-costs/report/2015-employer-health-benefits-survey/>; Health Cost Institute, 2013 Health Care Cost and Utilization Report, available at <http://www.healthcostinstitute.org/2013-health-care-cost-and-utilization-report>.

goods and services, in part due to price increases caused by consolidation in health care markets. After decades of increased consolidation in provider and insurer markets resulting in ever-escalating health insurance premiums and health care expenditures, consumers have begun to demand more accountability for health care costs from their providers, insurers, and policymakers. Reform efforts, big and small, have started to shift the playing field for providers and insurers and new alliances are being formed with a wide array of potential risks and benefits for consumers. I offer some considerations and data regarding recent health insurance mergers to inform your analysis of the potential risks to consumers from the transaction at hand.

## **Key Concerns for Consumers**

The key risks for Californians associated with any health insurance merger are increased premiums and/or reductions in quality, competition, and innovation.

### ***Increased Premiums***

In terms of premiums, research has consistently found increased premiums in the wake of an insurance merger.<sup>3</sup> The research on past insurance mergers reveals that insurers can and do exercise newly acquired market power by raising premiums.<sup>4</sup> An examination of the 1999 Aetna and Prudential Health Care Insurance merger estimated that health insurance consolidation between 1998 and 2006 led to a 7 percent increase in large group health insurance premiums.<sup>5</sup> Further, analysis of the UnitedHealth Group and Sierra Health Services merger increased the post-merger premiums in the Nevada markets by 13.7 percent, suggesting that the merging parties exploited the market power gained from the merger.<sup>6</sup> When premiums go up, employers often pass the added costs through to employees in the form of reduced pay, higher cost sharing, or reduced benefits.<sup>7</sup> Furthermore, early data from the individual health care marketplaces also support the inverse notion that increased competition among insurers is associated with lower premiums in the post-ACA landscape.<sup>8</sup>

Some have argued that the Medical Loss Ratio (“MLR”) will prevent consolidated insurers from increasing premiums. But, the MLR depends on competition to function. In markets that lack adequate competition, the MLR is gameable. Because it limits administrative costs to a percentage of total premiums, in the absence of sufficient competition, insurers in have an incentive to grant higher provider reimbursement rates, increase premiums, and thereby increase the value of their allowed

<sup>3</sup> Leemore Dafny *et al.*, *Paying a Premium on Your Premium? Consolidation in the US Health Insurance Industry*, 102 AM. ECON. REV. 1161 (2012) (examination of the 1999 Aetna and Prudential Health Care Insurance merger estimating that health insurance consolidation between 1998 and 2006 led to a 7 percent increase in large group health insurance premiums). See also Jose R. Guardado *et al.*, *The Price Effects of a Large Merger of Health Insurers: A Case Study of UnitedHealth-Sierra*, 1 HEALTH MGMT., POL’Y & INNOVATION 16 (2013) (finding the UnitedHealth Group and Sierra Health Services merger increased the post-merger premiums in the Nevada markets by 13.7 percent, suggesting that the merging parties exploited the market power gained from the merger).

<sup>4</sup> Leemore Dafny, *Are Health Insurance Markets Competitive?*, 100 AM. ECON. REV. 1399 (2010).

<sup>5</sup> See *Paying a Premium on Your Premium? Consolidation in the US Health Insurance Industry*, *supra* note 4.

<sup>6</sup> Jose R. Guardado *et al.*, *The Price Effects of a Large Merger of Health Insurers: A Case Study of UnitedHealth-Sierra*, 1 HEALTH MANAGEMENT, POL’Y & INNOVATION 16 (2013).

<sup>7</sup> David W. Emmons & Jose R. Guardado, “Competition in Health Insurance: A Comprehensive Study of U.S. Markets,” AM. MED. ASS. 33 (2014).

<sup>8</sup> See *id.* at 13; Leemore Dafny *et al.*, *More Insurers Lower Premiums: Evidence From Initial Pricing in the Health Insurance Marketplaces*, AM. J. OF HEALTH ECON. 53 (Winter 2014) (finding that the addition of one insurer would lower premiums by 5.4 percent, while adding every available insurer would lower rates by 11.1 percent); Michael J. Dickstein, *et al.*, *The Impact of Market Size and Composition on Health Insurance Premiums: Evidence from the First Year of the Affordable Care Act*, 105.5 AM. ECON. REV. 120 (2015) (estimating that an additional insurer in, a given ratings area, results in savings of nearly \$500 per person).

administrative<sup>CDIx294</sup> percentage. Finally, the MLR does not apply to enrollees in self-insured plans, which make up over half of the private insurance market, leaving those consumers still at risk of premium increases.

### ***Reductions in Quality and Innovation***

Consumers may also be harmed by reductions in competition that hinder incentives to improve quality and innovate. Quality reduction in the insurance industry can take many forms: delayed or refused claims payment, poor responsiveness to customers, inadequate and poor quality provider networks, lack of access to claims information, and mishandling of appeals, to name a few. Examining whether the acquiring firm has a history of quality reduction following a merger or in markets in which it has considerable market share can be instructive.

### **Benefits from Market Leverage and Efficiencies:**

Merging insurers sometimes argue that the merger will benefit consumers because (1) any gains in market power obtained by the new insurance entity will counterbalance gains in market leverage by providers; and (2) the merger will result in significant post-merger efficiencies. While some evidence exists to support a claim that increasing health insurers' market power enhances their ability to negotiate lower prices from dominant provider organizations, those lower prices only benefit consumers if there is sufficient competition in the market to incentivize the insurer to pass the savings through to consumers in the form of lower premiums.<sup>9</sup> Unfortunately, no study has found that those savings have ever been passed on to consumers.<sup>10</sup> The more typical result is that physicians make less money, and consumers still overpay for health care following an insurance merger. History also provides several examples of dominant insurers and providers joining forces to disadvantage rivals and increase premiums and reimbursement rates.<sup>11</sup> In other words, as antitrust and health care scholar Professor Thomas Greaney posits in his "Sumo Wrestler Theory Fallacy," when dominant insurers and dominant providers face off, the result may be "a handshake rather than an honest wrestling match."<sup>12</sup>

Second, in looking at any efficiencies promised to accompany the merger, it is essential to determine whether the merger is *necessary* to achieve those efficiencies, or whether the firms could achieve those same objectives on their own. In recent healthcare antitrust cases, proving that the claimed procompetitive efficiencies are merger-specific has proven challenging.<sup>13</sup> I am confident that the California Department of Insurance will carefully analyze whether the proposed merger will enhance competition and is necessary to obtain Centene's claimed efficiencies.

### **Conclusion**

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<sup>9</sup> Erin Trish and Bradley J. Herring, *Health Insurer Market Concentration and Bargaining Power*, 42 J. Health Econ. 104 (2015).

<sup>10</sup> Leemore Dafny, "Health Insurance Industry Consolidation: What Do We Know From the Past, Is It Relevant In Light of the ACA, and What Should We Ask?" United States Senate Committee on the Judiciary, Subcommittee on Antitrust, Competition Policy, and Consumer Rights, Sept. 22, 2015 [hereinafter *Dafny Statement*] at 9, available at <http://www.judiciary.senate.gov/imo/media/doc/09-22-15%20Dafny%20Testimony%20Updated.pdf>.

<sup>11</sup> See, e.g., *West Penn Allegheny Health Sys., Inc. v. UPMC; Highmark, Inc.*, 627 F.3d 85 (3rd Cir. 2010) (In Allegheny County, PA, the dominant provider, the University of Pennsylvania Medical Center (UPMC), agreed to use its market power to prevent competitors of the dominant insurer, Highmark, from successfully entering or expanding in the Allegheny County market and, in exchange, Highmark agreed to use its position to strengthen UPMC and weaken its rivals); see also *Complaint, U.S. v. Blue Cross Blue Shield of Michigan*, 2:10-cv-15155 (E.D. Mich., 2010).

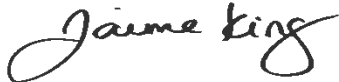
<sup>12</sup> Thomas L. Greaney, "The State of Competition in the Health Care Marketplace: The Patient Protection and Affordable Care Act's Impact on Competition," United States House of Representatives Committee on the Judiciary, Subcommittee on Regulatory Reform, Commercial and Antitrust Law, at 11, Sept. 10, 2015 [hereinafter *Greaney Statement*] available at [http://judiciary.house.gov/\\_cache/files/0a0e88c8-0519-4a47-8fa8-4c2233c760c3/greaney-testimony.pdf](http://judiciary.house.gov/_cache/files/0a0e88c8-0519-4a47-8fa8-4c2233c760c3/greaney-testimony.pdf).

<sup>13</sup> *St. Alphonsus Med. Ctr.-Nampa Inc. v. St. Luke's Health Sys., Ltd.*, 778 F.3d 775, 791 (9th Cir. 2015).

Overall, consumers bear the brunt of the impacts of consolidation in health care in multiple ways. When provider prices increase from consolidation in the provider market, insurance premiums follow.<sup>14</sup> When insurance markets consolidate, premiums also tend to increase.<sup>15</sup> When premiums go up, employers pass the cost through to employees in the form of reduced pay, higher cost sharing, or reduced benefits.<sup>16</sup> If past is not prologue, and merging insurance companies do pass through any beneficial price reductions obtained from providers, consumers can still be harmed by reductions in the quality and quantity of provider services.<sup>17</sup> Further, consolidation may compromise opportunities to increase and sustain competition. Given the significant increase in consolidation in the health insurance and provider markets, both in California and throughout the United States, government agencies and antitrust enforcers should carefully analyze the significant long-term risks of any further concentration to consumers.

Thank you for your efforts and diligence in doing so.

Warmest regards,

A handwritten signature in black ink that reads "Jaime King". The signature is written in a cursive, flowing style.

Jaime King, J.D., Ph.D.

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<sup>14</sup> See *Competition Policy in Health Care Markets*, *supra* note 13; Richard Scheffler, E.R. Kessler, and M. Brandt, *Covered California: The Impact of Provider and Health Plan Market Power on Premiums*, J. OF HEALTH POLITIC, POL'Y & L. (forthcoming 2015).

<sup>15</sup> Kate Ho & Robin S. Lee, *Insurer Competition in Health Care Markets*, NBER, Working Paper No. 19401 (Sept. 2013), available at <http://www.nber.org/papers/w19401>; See *Paying a Premium on Your Premium? Consolidation in the US Health Insurance Industry*, *supra* note 4.

<sup>16</sup> See *Competition Policy in Health Care Markets*, *supra* note 7, at 33.

<sup>17</sup> See Dafny Statement, *supra* note 5, at 10.

**From:** [Tam Ma](#)  
**To:** [Hinze, Bruce](#)  
**Subject:** Centene Data Breach  
**Date:** Wednesday, January 27, 2016 10:54:32 PM

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<http://www.californiahealthline.org/articles/2016/1/27/insurer-loses-hard-drives-with-personal-health-data-on-950k-people>

## Insurer Loses Hard Drives With Personal Health Data on 950K People

Wednesday, January 27, 2016

On Monday, health insurer Centene announced that it is missing six hard drives containing the personal and health information of nearly 950,000 individuals, *Reuters* reports (Shaji, *Reuters*, 1/25).

St. Louis-based Centene is working to complete a \$6.8 billion acquisition of Woodland Hills-based Health Net, which has about 2.9 million California enrollees (Rauber, "Bay Area BizTalk," *San Francisco Business Times*, 1/26).

### Details of Missing Hard Drives

The data breach affects patients who received laboratory services between 2009 and 2015. Data on the missing hard drives include:

- Addresses;
- Birth dates;
- Health information;
- Member identification numbers;
- Names; and
- Social Security numbers.

The company said the hard drives did not include information on customers':

- Finances; or
- Payments.

Centene President and CEO Michael Neidorff said the hard drives contained data that were part of a project using laboratory results to improve customers' health outcomes (*Reuters*, 1/25).

In a statement, Neidorff said, "While we don't believe this information has been used inappropriately, out of abundance of caution and in transparency, we are disclosing an ongoing search for the hard drives" (Conn, *Modern Healthcare*, 1/25).

The company is providing no-cost credit and health care monitoring to affected customers (*Reuters*, 1/25). It also said it is reviewing its policies for managing IT assets (*Modern Healthcare*, 1/25).

January 27, 2016

**Via Email and Hand Delivery**

Jennifer Chambers  
Senior Staff Counsel  
California Department of Insurance  
45 Fremont Street, 24th Floor  
San Francisco, CA 94105

Re: IDB 15-6405/APP-2015-00889  
Public Hearing on Form A Application of Centene Corporation to Acquire Control of Health Net,  
Inc.

Dear Jennifer:

As indicated at the hearing on January 22, 2016, enclosed are two originals of the sworn statement of Michael F. Neidorff for inclusion in the official records of this proceeding. Please let me know if you have any questions.

Sincerely,



Dan Brown  
Partner

cc: G. Margolis, California Department of Insurance (via email)  
J. Finston, California Department of Insurance (via email)  
J. Tomashoff, California Department of Insurance (via email)

**Statement of Michael F. Neidorff Read Into the Record at the Public Hearing Before  
the Insurance Commissioner of the State of California Regarding the Proposed  
Acquisition of Health Net Life Insurance Company by Centene Corporation Held  
on January 22, 2016**

1. We have here today a team of very capable Health Net and Centene executives who will be presenting and responding to your questions throughout this hearing.
2. I appreciate the opportunity to make these comments. This process is very important to all of us, and my executives are empowered to work with you and the DMHC to see this transaction through to completion. I wanted to make sure you knew how committed I am to making this transaction a success for Californians and also to share with you our approach to delivering health care.
3. I'd like to state up front that we are fully committed to maintaining and working to grow our commercial business in California. This includes, of course, when necessary, working with the State to alter the product design when competitive issues arise or when consumer demand dictates.
4. We share first and foremost a common concern for the individuals we serve. Our mission is to transform the health of the community one person at a time, and our members are at the heart of what we do. As it relates to Medicaid members who we have served for most of our history I have long believed that except for the Grace of the Lord, any of us could receive our healthcare through Medicaid. And we would expect to be treated with dignity and respect. This is exactly the way our recipients should expect to be treated, and it is the kind of care they receive. We focus on treating the whole person, improving their health status. We take very seriously the responsibility you as the State give us, and the trust our members have placed in us.
5. Incidentally, our approach is already in place in California. We are proud to serve California consumers through our local health plan: California Health and Wellness. Know that we will continue to put our members first, whether they are enrolled in commercial coverage, MediCal, the Marketplace, Medicare, ... all products.
6. It is Centene's practice that anything that touches a recipient, a provider, a contractor, a regulator is done locally. Our presidents and CEOs are charged with representing the best interest of their health plan in their State.
7. You will not find a health plan that carries a Centene name anywhere in the country. In Ohio we are Buckeye, in Florida we are Sunshine; in Texas we are Superior. Health Net is and will continue to be a California company.

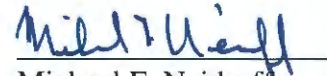
8. As I alluded to earlier we treat our members one person at a time. Equally important is the way we view our provider network. Providers are our product and we are committed to working with them to support and enhance through our systems their ability to treat our members or recipients. We also take very seriously the responsibility to ensure the quality of care our members receive. Part of our success is the strength that our provider network brings to us.
9. I know you have an interest in protecting and growing California jobs. This transaction involving Health Net will result in more jobs in California than if the transaction didn't take place. The current number of Health Net employees in California is approximately 6500 and in three years if our plans come to full fruition we estimate it will be 7000.
10. We believe in insourcing our work, not outsourcing it. Over 85% of our employees are located in the markets we serve. I remind you that our high speed transactions are consolidated at various centers in the U.S. By high speed transactions I mean claims, financials and systems development. Health Net will maintain the local financial support necessary to meet the State reported requirements. With our acquisition of Health Net, while not immediately, over the next several years, as Health Net's processes are transitioned to Centene's systems, we will be bringing back to the US the Health Net functions that are taking place in India and the Philippines. As appropriate, many of the currently outsourced positions will be brought to California.
11. Centene is a Fortune 186 company. Each of our local companies is supported by its significant resources. Centene brings a strong commitment to recipients of all lines of insurance, a strong balance sheet, and integrated systems from which consumers of healthcare will benefit. Our high speed claims and system transactions enable us to pay provider claims on average 8 days from the day we receive them. Our claims payment accuracy exceeds 98%.
12. Finally, Mr. Commissioner, we have always placed a great deal of value in ensuring that any recommendations we make are based on sound public policy. This transaction, in my opinion, is in the best interest of the State of California and consumers of all the insurance products we currently offer, and new ones that may be added. By sound public policy I mean we are committed to improving outcomes for our members; we are committed to providing products and services in the most efficient manner to the benefit of your tax payers; and we are committed to maintaining our local approach which grows jobs in your state. In other words, we are committed to the growth of Health Net. When we make a commitment, we live up to it. Our word is our bond. It is a matter of honor, integrity and credibility.



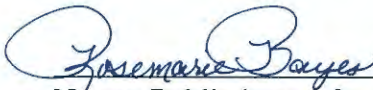
13. Thank you again for this opportunity to make these brief comments today. I appreciate your thoughtful consideration of our acquisition of Health Net, and we look forward to ensuring a smooth transition and commit to working effectively with you.

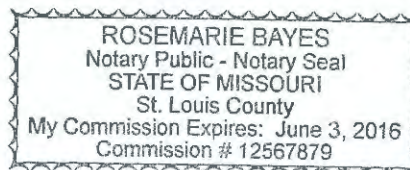
\* \* \* \* \*

Michael F. Neidorff says that he is the Chairman, President and Chief Executive Officer of Centene Corporation, that he has read the foregoing testimony and knows the contents thereof and that same are true of his own knowledge.

  
Michael F. Neidorff

Subscribed and sworn to before me this 25<sup>th</sup> day of January, 2016

 (Notarial Seal)  
Notary Public in and for said County  
and State



My commission expires June 3, 2016

**From:** [Jona Milo](#)  
**To:** [Chambers, Jennifer](#)  
**Subject:** Opposition to Centene swallowing up HealthNet  
**Date:** Friday, January 22, 2016 4:40:42 PM

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I am writing to oppose the merger of the subject healthcare providers. It's simple economics: the fewer providers, the less competition, and the more they can abuse the patients and their families. Prices will rise, customer service will suffer. Patients are helpless to fight for needed care.

Jona Milo  
Patient

Sent from my iPad

**From:** [Lorna](#)  
**To:** [Chambers, Jennifer](#)  
**Subject:** HealthNet Merger  
**Date:** Thursday, January 21, 2016 9:02:43 PM

---

Dear Insurance Commissioner:

There should be no more health insurance company mergers at this point in time. Too many people are not being served sufficiently. For example, larger companies are purchasing smaller ones, but NOT providing the quality services that smaller company had provided. For example, my doctor's office was bought out by a company. Service has been terrible since the change over. I still have a great doctor, but I have a difficult time getting in to see him. If he decides to leave his position & start over, then I will take my business with him. Additionally, a diagnostic lab bought out an excellent smaller lab; however, this larger lab cannot seem to keep nor process the needed lab work at all. There needs to be a quality review of ALL California insurance companies, providers, & service companies BEFORE any more changes should be allowed. Bigger is NOT better so far.

If you want the specifics about the examples I have provided, then I will provide them.

Frustratedly,  
Mrs. Lorna Ramos Farnum  
3305 Druid Ln.  
Orange County, CA 90720

**From:** [David Hoptman](#)  
**To:** [Chambers, Jennifer](#)  
**Subject:** Public Comment RE: Health Net/CENTENE Merger  
**Date:** Friday, January 29, 2016 2:10:33 AM

---

Thursday, 1/28/16

Hello Jennifer,

I would like to submit my public comment in hopes my voice will be heard by Commissioner Dave Jones and/or to whom it may concern.

I am EXTREMELY against allowing the Health Net/CENTENE merger for reasons primarily related to Health Net's violation of Basis#5 of the Insurance Code: The competence, experience and integrity of those persons who would control the operations insurers indicate that it would not be in the interest of the policy holders or the public to permit them to do so.

My name is David Hoptman, a former Health Net employee of 15 years who recently was wrongfully terminated seemingly due to unlawful retaliation after I filed complaints against Health Net to the DMHC, DHHS and the DFEH in regards to various violations allegedly made against me by Health Net.

I was subject to several false accusations allegedly made by Health Net as well as possible discrimination along with threats and retaliation over a 2-year period. I was then diagnosed 3 months later with an early stage of leukemia followed by alleged HIPAA violations where details of my health condition were somehow accessed and leaked to management. I attempted to file several complaints against those individuals responsible, and finally escalated to the executive level, but I have been continuously treated unfairly as investigators allegedly covered up important details in regards to said violations and refused to look into evidence I brought to them that supported my claims. It is my belief that the complaints I filed with the various health agencies as well as my persistence to seek resolution of my issues are what lead to alleged retaliation and the termination of my 15-year employment by Health Net due to an accusation against me based on circumstantial evidence.

These alleged HIPAA violations against me are only 1 example that demonstrates PRIVACY issues that Health Net has in addition to numerous compliance issues in regards to securing the PHI of Health Net members that I have been witness to on a regular basis in my 15-year tenure. Examples of these compliance issues are various associates who leave PHI sitting on printers and fax machines, leaving PHI unattended on desks and unlocked drawers that contain sensitive PHI. It is for these reasons, among others that I feel Health Net's competency and ability to keep member's private health information secure is questionable at best.

Furthermore, part of my job was working as a claim adjuster updating the deductibles and out of pocket maximums for members, primarily those who have accumulators that are combined with medical and pharmacy claims. These claims are adjudicated in separate systems which are supposed to be electronically updated in real time, but that is rarely the case. In fact, a great number of Health Net members in CA, AZ and OR, mainly exchange members of the Affordable Care Act (ACA) under Obamacare were loaded with a glitch where NONE of their claims data would carry over to the correct systems. Health Net's solution is a shady business practice to update these member's accumulators when exceeding their annual out of pocket maximum (OOPM) is to adjust various random medical claims, and putting the responsibility on members to seek reimbursement of the excess monies from each provider themselves. Needless to say, some members never end up seeing some reimbursements, and if they do, it's usually after going through a lot of "red tape." I recall helping one member recently who was waiting for nearly a \$2,000.00 reimbursement from 2012, and still had not received it. This clearly shows a lack of integrity on the part of Health Net that leaves a lot to be desired.

Lastly, in regards to how Health Net handles claims for Medicare members regulated by CMS, I have seen many cases of Health Net participating in double billing of vaccine injectable claims. In this process, seniors are sometimes forced to pay out of pocket, when the provider has already been paid by Health Net. The seniors file for reimbursement only to be have their claim(s) DENIED as a DUPLICATE, and once again putting the responsibility

on these poor seniors living on a fixed income to seek reimbursement from their medical group. It is no surprise that some never get reimbursed. Another issue I witnessed is Health Net sending out a mailing to seniors, that is not very clear, advising members that they can be reimbursed for any administration fees charged for vaccines. Since the letters do not give a clear explanation, members spend time sending in claims for the wrong thing, only to have the majority of the claims DENIED, leaving many of these seniors VERY frustrated and upset. Finally, in regards to Health Net's handling of Medicare claims, in order to remain in compliance, I have seen what appears to be altering received dates on a claim to remain in compliance, and sometimes even re-scanning a claim and deleting the other.

These are just some examples of why I feel Health Net does not have the competency, experience or integrity to be granted this merger. At the very least, I feel that a FULL AUDIT be conducted would surely uncover some of these examples I mentioned. Health Net has already had 2 sanctions within the past 5 years, and deserving of a 3rd, in my opinion.

I sincerely hope these details will be taken into consideration. I sent an email with a similar public comment to the DMHC, prior to their deadline, but inaccurately told it was sent too late, which it wasn't.

Thank you very much for you time in reviewing my public comment.

Best Regards,  
David Hoptman  
213-591-1368

**From:** [Win Carson](#)  
**To:** [Chambers, Jennifer](#)  
**Subject:** Proposed merger of Centene and HealthNet  
**Date:** Thursday, January 21, 2016 11:15:16 PM

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To Whom It May Concern:

I oppose the merger of two giant health insurers Centene and HealthNet. This creation of an even larger giant company creates even less competition in an already small field.

Sincerely,

Winfield Carson  
Poway

**From:** [Jerome Kahle](#)  
**To:** [Chambers, Jennifer](#)  
**Subject:** Health Net  
**Date:** Friday, January 22, 2016 7:34:55 AM

---

My only concern is competition in the healthcare insurance industry. I hope that this proposed merger will not create an unregulated monopoly.  
How will current members of Health Net be affected?  
Will their coverage be affected?

Thanks  
Jerome Kahle  
[jerrykahle@prodigy.net](mailto:jerrykahle@prodigy.net)  
Elk Grove

**From:** [Sherrill Futrell](#)  
**To:** [Chambers, Jennifer](#)  
**Subject:** No on Health Net merger  
**Date:** Monday, January 25, 2016 11:02:46 PM

---

Dear Dave,

I left Health Net years ago because of the disgustingly huge annual salary paid to its CEO and the lousy service I got from the company. How exactly would a MERGER be in the public interest? These endless mergers in the healthcare industry have strangled competition and only guaranteed fat salaries to upper-level bureaucrats who know nothing about healthcare. We need single-payer if you ask me.

Thanks and best wishes,

Sherrill Futrell  
151 Inner Cir  
Davis, CA 95618





CDIx308

# HEALTH ACCESS

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SEIU State Council

Anthony Wright  
Executive Director

Organizations listed for  
identification purposes

January 29, 2016

The Honorable Dave Jones  
Insurance Commissioner  
California Department of Insurance  
300 Capitol Mall, Suite 1700  
Sacramento, CA 95814

Via e-mail to: [jennifer.chambers@insurance.ca.gov](mailto:jennifer.chambers@insurance.ca.gov)  
and [jon.tomashoff@insurance.ca.gov](mailto:jon.tomashoff@insurance.ca.gov)

### RE: Proposed Acquisition of Health Net Life Insurance Company by Centene Corporation, File No. APP-2015-008889

Dear Commissioner Jones:

Health Access California, the state health care consumer advocacy coalition working for quality and affordable health care for all Californians, offers the following comments on health insurer consolidation and Centene's proposed acquisition of Health Net. As a regulator of insurance companies and a consumer protection agency, the California Department of Insurance (CDI) is tasked with protecting the public interest by ensuring California maintains a robust and competitive commercial health insurance market that delivers quality and affordable care. The stakes—for consumers and the health system as a whole—are high. As you evaluate each individual merger, you should keep an eye on the larger picture and evaluate the cumulative effects of these megamergers on patients and the health system we all rely on.

Centene, an out-of-state insurer with virtually no experience in the California market, wishes to acquire Health Net, a large California insurer with a lackluster track record of providing care for its policyholders. This merger would allow Centene to have a significant presence in California, gain entry into our commercial market and Covered California, and drastically increase its participation in the Medi-Cal program by nearly sevenfold. As detailed herein, this proposed merger would have a substantial impact on consumers, other purchasers, and our health system as a whole. We urge you to reject the Proposed Acquisition of Control unless they can show this merger not only does no harm to consumers, but that consumers will actually benefit in the form of lower premiums, lower out-of-pocket costs, higher quality care, and reduced health disparities over a sustained period. Should this merger be approved, it must be accompanied by strong, enforceable conditions to ensure consumers receive the benefits promised by company executives and existing problems are not exacerbated, as insurers get bigger.

### HISTORY SHOWS CONSUMERS DO NOT BENEFIT FROM HEALTH INSURANCE INDUSTRY CONSOLIDATION

**Prior mergers have led to higher costs.** We question whether this and other mergers leave consumers and government purchasers better off. When an insurer with problems seeks to

Capitol Headquarters: 1127 11<sup>th</sup> Street, Suite 243, Sacramento, CA 95814 PH: 916.497.0923 FAX: 916.497.0921

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Southern California: 121 West Lexington Drive, Suite 246, Glendale, CA 91203 PH: 818.480.3262 FAX: 818.480.6595

[www.health-access.org](http://www.health-access.org)

The Honorable Dave Jones

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merge, California regulators should insist on commitments to ensure they get better as they get bigger—so their problems do not grow along with the company. Executives from Centene and Health Net claim that consolidation would create a more competitive company, improve efficiency, and increase value for consumers. History and research show that insurer mergers have had the opposite effect. Consolidation in the private health insurance industry leads to premium increases, even as insurers with larger local market shares obtain lower prices from providers.<sup>1</sup> For example, Aetna’s acquisition of Prudential in 1999 resulted in premiums increasing by seven percent.<sup>2</sup> A study of the 2008 merger between UnitedHealthcare and Sierra Health in Nevada increased premiums in the small group market by nearly 14 percent, relative to a control group.<sup>3</sup> Researchers said the results of this merger “suggest that the merging parties exploited the market power gained from the merger.” Furthermore, there is no evidence that mergers lead to improved quality.<sup>4</sup>

**Centene and Health Net have not provided evidence that merging will lead to lower costs and better value.** Health Net has said that this merger will “enhance our focus on value-based solutions” and Centene has claimed there will be cost savings through “synergies.” As researchers have noted, there is no evidence that larger insurers are more likely to implement value-based payment agreements and care management programs.<sup>5</sup> Centene and Health Net are already large, scaled entities and it is unclear how they will get any more scale economies from getting even bigger. If Centene claims efficiencies will counteract any negative harm created by its increased market share, then it must provide specific and verifiable information about these purported outcomes. Finally, we question whether larger, more dominant insurers have much incentive to invest in such changes, and if they do, whether the savings and benefits will be passed on to consumers.

## **INSURER CONSOLIDATION AMID ON-GOING IMPLEMENTATION OF THE AFFORDABLE CARE ACT**

**The ACA has transformed the health insurance market and increased enrollment.** As a regulator of health insurance products, CDI protects consumers’ health care rights and ensures a stable insurance marketplace. The Department must ensure that insurer mergers do not undermine the state’s implementation of the Affordable Care Act (ACA). In addition to promoting competition in the insurance industry, the ACA has increased access to health coverage and cut the state’s rate of uninsured by half. Most of the newly covered, whether through Medi-Cal or Covered California, receive their coverage through managed care health plans. CDI-licensed health policies provide care to more than 1.7 million Californians, representing 18% of the individual market and 23% of the small-group market, 9% of the large-group market.<sup>6</sup> In 2014, 2.2 million Californians obtained coverage through the individual market, representing a 47 percent increase over the previous year.<sup>7</sup> Group coverage continues to be the main source of commercial health insurance, providing coverage for 11.8 million Californians in 2014.<sup>8</sup> California’s Medicaid program has also seen a rapid increase enrollment as a result of the ACA, and private plans play a significant role in providing coverage to Medi-Cal beneficiaries. As of early 2015, thirty percent of the nearly 9.4 million Medi-Cal beneficiaries enrolled in Medi-Cal managed care received their care through private plans.<sup>9</sup>

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While the Affordable Care Act sets up the standards and parameters for a robust market in health insurance, the success and sustainability of the ACA depends on a competitive market. For example, Covered California will not be able to negotiate as effectively for its patient population without a competitive number of plans in the market. If insurer mergers reduce the number of market players and make it less likely that new entrants will participate, then mergers will have a negative impact on the ability of purchasers such as Covered California to negotiate on cost and quality.

**Healthcare costs continue to burden consumers.** The Affordable Care Act has enabled millions of previously uninsured Americans to receive health coverage, improving their financial security and access to care by establishing new rules that provide better financial protection and more comprehensive benefits. Health care costs, however, continue to be a major concern for consumers and purchasers. Since 2002, health insurance premiums in California have increased by 202 percent, more than five times the 36 percent increase in the state's overall inflation rate.<sup>10</sup> Workers are also seeing reduced benefits and increased cost sharing.<sup>11</sup> Almost 90 percent of those who enrolled through Covered California for coverage in 2015 received premium assistance to make their health insurance more affordable.<sup>12</sup> According to a newly released Kaiser Family Foundation/New York Times survey, these increasing costs have resulted in one in five Americans *with health insurance* having problems paying their medical bills.<sup>13</sup> The survey also found that medical expenses limit the ability of patients and their families to meet other basic needs—such as paying for housing, food, or heat—or make it tough for them to pay other bills.<sup>14</sup> Against this backdrop, it is imperative that you critically evaluate how insurer mergers will impact the significant strides California has made in reducing our rate of uninsured and our ability to control health care costs. HealthNet is a significant player in the large employer market as well as Medi-Cal managed care and Covered California and if this acquisition is approved, Centene will take this market position as well.

**Existing law does not protect consumers from price gouging.** Insurers have claimed that government regulation such as medical loss ratio (MLR) requirements and rate review limits insurers' ability to raise premium prices. Although MLR requires insurers to spend between 80 and 85 percent of net premiums on medical services and quality improvements, it does not cap prices and insurers can still raise premiums to collect higher profits. In addition, rate review does not prevent health insurers from raising premiums beyond what regulators deem to be reasonable. We note that Health Net has opposed efforts to give California regulators the power to deny unreasonable rate increases.<sup>15</sup>

**Health Net has opposed measures to increase price transparency in the large group market.** Existing state and federal laws regarding rate review provides the public with critical information about rate setting in the individual and small group markets. However, the large group market has largely been left to grapple with dramatic rate increases on its own. Last year, Health Net opposed SB 546 (Leno), Chapter 801, Statutes of 2015, legislation that establishes new rate review requirements for the large group market.<sup>16</sup> This law, which took effect on January 1, 2016, encourages rate increases in the large group market to be more aligned with rates for large purchasers and active negotiators such as CalPERS and Covered California, and with the

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individual and small employer markets where rate review has already been implemented. In opposing SB 546, Health Net wanted to continue to not disclose any information or justification when it increases rates for its large group products and ensure that large group purchasers negotiate blind.

### **IMPACT OF MERGER ON CALIFORNIA'S COMMERCIAL AND MEDI-CAL MARKET**

This proposed merger also raises concerns about how it will affect commercial and government purchasers such as Covered California and Medi-Cal, and their ability to maintain continuity of care, negotiate for value, and manage costs.

**Covered California and the Commercial Market:** Health Net currently offers products in the individual, small, and large group markets, and has participated in Covered California since it began offering plans in 2014. Health Net currently offers products in 16 of Covered California's 19 regions and covers 18% of Covered California's enrollment statewide.<sup>17</sup> Health Net is also responsible for managing care for nearly a million commercial lives in California. If Centene were to acquire Health Net, it would take Health Net's place as one of the largest insurers in California, gain entry into our commercial market, and become a participant in Covered California for the first time. Given Centene's lack of experience in California's commercial market and limited experience in the commercial market elsewhere, we question whether its entry would merely be a byproduct of its merger with Health Net and wonder how Centene will develop competency in this new line of business. These changes also raise questions about how consumers would be affected if Centene were to withdraw from the commercial market and Covered California, particularly in the regions where few plan choices are available.

**Medicaid/Medi-Cal:** Nationally, Centene is the largest Medicaid managed care company, and it is relatively new to California's Medi-Cal program. The company's business has rapidly grown in recent years because of Medicaid expansion and its stock has increased by 448 percent since the ACA was passed.<sup>18</sup> Centene's Medicaid population increased by 32% between 2013 and 2014, and the company continues to expand into additional states.<sup>19</sup> California Health and Wellness, Centene's wholly owned subsidiary, was selected in 2013 to offer coverage as part of California's managed care expansion in rural counties. Data is not yet publicly available to evaluate Centene's performance in California, and you should ask them to submit this data early so you can consider it in your review of this merger.

While Centene has taken advantage of opportunities to expand its presence in the Medicaid market, it has also quickly exited when profits did not meet expectations. A few years ago, Centene abruptly pulled out of Kentucky's Medicaid program mid-contract, affecting care for its 125,000 patients.<sup>20</sup> Earlier this year, an appeals court found Centene in breach of contract and ordered them to pay damages to the state.<sup>21</sup> Centene's actions in Kentucky give us great pause here in California.

Health Net has had a large presence in the Medi-Cal program, where it serves nearly 1.4 million consumers, mostly in two-plan model counties.<sup>22</sup> Health Net's low quality ratings for its Medi-

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Cal products are troubling. The National Committee for Quality Assurance (NCQA) gives Health Net low ratings for customer satisfaction (1.0 out of 5.0), prevention (2.0 out of 5.0), and treatment (2.5 out of 5.0).<sup>23</sup>

Given these facts, we are unclear how Centene will add value to California's Medi-Cal program. Centene has not provided details on how it will serve a larger share of Medi-Cal beneficiaries, including how it will provide language access and culturally competent care, adequate networks with sufficient primary care and specialist providers equipped to treat conditions common to the Medi-Cal population in a timely manner. Since Centene has a lot of experience in the Medicaid program, what, if any, best practices would it apply in California, and how will it improve Health Net's dismal quality ratings? 54 percent (over 1.3 million) of new Medi-Cal managed care members are assigned to safety-net clinics.<sup>24</sup> Does Centene have plans to support the state's safety-net by contracting with safety-net clinics and investing in the safety-net infrastructure, which has played a critical role in providing care for the Medi-Cal population? How will Centene improve access to care in rural and underserved communities? Finally, given that Centene abruptly exited Kentucky's Medicaid program mid-contract, how do we know it would not do the same in California? It is important to note that much of Health Net and Centene's Medi-Cal business is in rural counties where they are one of two plan options, and withdrawing from the Medi-Cal market would have significant implications for our state's lowest income consumers.

### **ON-GOING VIOLATIONS OF CONSUMER RIGHTS MUST BE RECTIFIED**

We urge you to scrutinize how Centene will improve upon Health Net's track record, both in the commercial and Medi-Cal markets. Here, it is relevant to look at oversight and enforcement actions from all California regulators because problems that are present in one line of business are likely to manifest themselves across the company. The deficiencies found in Health Net's routine medical survey, extensive history of enforcement actions, poor quality ratings, and high rate of being overturned in Independent Medical Review (IMR) pose significant concerns about the quality and value of services provided to its existing customers. As consumer advocates, we are deeply concerned that these problems will become more acute if Centene, an out-of-state company that has virtually no experience in California's commercial market and little familiarity with California's consumer protections, is allowed to acquire Health Net. We urge you to scrutinize how Centene will improve upon Health Net's track record and ensure that policyholders have access to adequate networks, timely access to care, high quality health care, effective grievance procedures, language access, and health equity.

- **Routine Medical Survey:** In the Department of Managed Health Care's (DMHC) most recent routine medical survey (2014), Health Net was found to have five major deficiencies in the plan's grievances and appeals and utilization management processes.<sup>25</sup> While these deficiencies were eventually corrected, we want assurances that Centene will ensure there are no deficiencies in the future.
- **Enforcement actions:** In recent years, Health Net has been the subject of serious enforcement actions by both DMHC and CDI. Some of the more recent fines included six-

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figure penalties for terminating patients' COBRA coverage without informing them of their right to request a review from the DMHC (\$120K)<sup>26</sup>; losing 9 server drives, putting the personal information of 700K enrollees at risk (\$200K)<sup>27</sup>; failing to provide medically necessary speech therapy and occupational therapy services (\$300K)<sup>28</sup>; and not having an on-call representative available to address an urgent need for medical care (\$150K)<sup>29</sup>. Health Net has also been heavily fined for failing to pay claims (\$750K)<sup>30</sup> and for cancelling coverage after patients became ill (\$1M)<sup>31</sup>; a practice that is now outlawed by the Affordable Care Act.

In 2012, you initiated enforcement actions against Health Net and other insurers to make sure they meet their obligations to cover behavioral therapy for autism whenever medically necessary. Prior to the settlement you reached with Health Net, it had routinely violated the state's Mental Health Parity Act by denying treatment to children.<sup>32</sup>

- **Quality ratings:** Health Net's commercial plans have poor quality ratings in some key areas that are important to consumers. According to the Office of the Patient Advocate's HMO quality report card, Health Net has poor ratings for not helping patients to get the care they needed when they needed it and for not providing customer service and helping them get answers to questions.<sup>33</sup> Among the largest HMOs in the state, Health Net does the worse job of answering calls quickly by far, with only 25% of plan members saying that their calls are answered quickly.<sup>34</sup> While Health Net has average ratings for providing needed care, there are areas that need improvement. Health Net has poor to fair ratings for asthma and lung disease care, behavioral and mental health care, heart care, and maternity care.<sup>35</sup>

Covered California Quality Ratings, which were recently made available to consumers shopping in the current open enrollment period, show Health Net's HMO products earned a dismal 2 out of 5 stars in all its regions, placing Health Net in the 25 to 50 percent range as compared to plans in the western U.S. region. Ratings for Health Net's EPO and HCSP products are not yet available.<sup>36</sup> Health Net's Medi-Cal products also have low quality ratings from the NQCA for customer satisfaction, prevention, and treatment.<sup>37</sup>

- **Independent Medical Review:** DMHC data shows consumers prevailing against Health Net in IMR at a high rate. In 2014, Health Net had 1.17 IMRs filed per 10,000 enrollees, the third highest among insurers. IMR overturned Health Net one-third of the time for experimental/investigational and medical necessity IMRs.<sup>38</sup>
- **Complaint Data:** According to the Office of the Patient Advocate, regulators received 17 complaints per 10,000 enrollees in Health Net, in the median of the number of complaints as compared to other health plans.<sup>39</sup> The sources of Health Net's complaints should be reduced.
- **Network Adequacy and Timely Access to Care:** CDI should review Health Net and Centene's (California Health and Wellness') timely access reports, which are not yet publicly available, to determine whether they have adequate networks for all their products and whether they have met their obligations to provide policyholders with timely access to care.

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- **Language Assistance Program:** State law and the Department's Language Assistance Program regulations<sup>40</sup> require insurers to provide limited-English proficient and non-English speaking health consumers with meaningful access to interpreters when receiving their health care. Insurers are also required to translate vital documents and collect data on race, ethnicity, and language to address health inequities. We understand the Department is reviewing insurer compliance with these requirements for its biennial report to the Legislature, and we request you to look into whether Centene and Health Net are in compliance. Health Access regards compliance with language access requirements as a critical indicator of whether insurers are providing quality care to all Californians.
- **Privacy and Protection of Confidential Patient Information:** Just this week, the public learned that Centene has lost six hard drives containing the names, addresses, birth dates, Social Security numbers, and other confidential information for 950,000 patients.<sup>41</sup> We urge you to conduct a financial and market conduct examination of Centene, investigate the data breach, and determine what protections they have in place and what actions could have been taken to avoid data loss.

## **ENFORCEABLE UNDERTAKINGS NEEDED TO ENSURE CONSUMER PROTECTION**

Centene and Health Net's proclamation that that this merger will not affect competition because the two companies do not have any overlapping geographic markets does not alleviate all our concerns about how the merger will affect California's commercial and Medi-Cal market, and whether Centene's growth strategy is sustainable. The insurers have provided no information to demonstrate how their promises of increased competition, efficiency, and value will be realized and shared with consumers. Finally, if this deal goes through, it would make Health Net the latest of California-based insurers to end up being headquartered elsewhere, raising questions about how Centene would be accountable to California regulators and consumers. If Centene's acquisition of Health Net is supposed to be good for California, then clear and enforceable conditions must be in place to ensure transparency and accountability and protect Californians' hard-earned premium dollars.

### **Questions about Centene's commitment to serving California consumers.**

- Why a merger? Centene currently has a very small presence in California's Medi-Cal program. The proposed merger, whereby Centene acquires an existing California insurer, does not expand the number of plans participating in Medi-Cal managed care, Covered California, or the commercial market. Why has Centene chosen to increase its presence in the California market through an acquisition rather than as a new entrant? Why not provide California consumers with additional choices, rather than supplanting an existing option?
- Commitment to getting better. As discussed, Health Net has provided lackluster service and care to its commercial enrollees. Is it in the public interest to allow Health Net to be acquired if there is no commitment to fix these problems? In testimony, Centene executives extolled their "local model" and local control over operations but did not say how would they ensure better outcomes.

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- How big is too big? Centene has grown rapidly in recent years and most of its growth is attributed to new business opportunities created by Medicaid expansion. Is Centene's business model sustainable?
- Will existing problems get bigger? As previously discussed, Health Net has provided lackluster service and care to its 1.4 million Medi-Cal enrollees and 1 million commercial enrollees. Is it in the public interest to allow Health Net to be acquired if there is no commitment to fix these problems?
- How will consumers benefit? Centene and Health Net should be required to reveal how they will achieve efficiencies and savings, show how these efficiencies and savings will be shared with consumers, and commit to a plan for sharing these savings through lower premiums and cost-sharing. These commitments must be maintained over time, and not just in the near term. Does Centene have the demonstrated management capacity to manage the growth in a way that assures that consumers get the care they need when they need rather than simply delivering the profits shareholders want?

**Clear and enforceable commitments to protect consumers and further the public interest.**

Regulators have found Health Net to provide deficient services to its policyholders, and it must be required to improve care and services to its enrollees before it can get bigger. Health Net and Centene's existing policy must have access to the quality care they are entitled to under California law.

- Immediately correct deficiencies. Health Net should be required to immediately correct outstanding deficiencies identified by regulators and maintain compliance with all California laws and regulations over a sustained period.
- Improving service, care, and quality. CDI should require Centene and Health Net to meet specific benchmarks in improving access to care and customer service for its patients. They must be required to bring all its quality ratings up to above-average levels within 3 years, and submit plans on how this task will be accomplished.
- Reduce source of IMRs and consumer complaints. Centene and Health Net must be required to reduce the rate of IMRs filed and overturned by regulators and reduce the source of consumer complaints, a critical measure of how well a plan meets their members' needs and solves problems when they occur.
- Accountability to California regulators and consumers. How will a much larger Centene be accountable to California consumers and regulators? They should be required to be responsive to the California market and California law by having California-based medical director, legal counsel and regulatory compliance staff who are knowledgeable about California-specific consumer protections and other requirements we place on our health plans. In addition, consumer complaints and grievance staff should be based in California to ensure quick resolution of problems.



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- Plans for achieving efficiency and savings. Centene and Health Net should be required to reveal how they will achieve efficiencies and savings, show how these efficiencies and savings will be shared with consumers, and commit to a plan for sharing these savings through lower premiums and cost-sharing, improved quality, and reduced health disparities. These commitments must be maintained over time, and not just in the near term. Can Centene assure that consumers get the care they need when they need it rather than simply delivering the profits shareholders want?
- Ensuring and maintaining affordable Care for consumers and purchasers: The core of Health Net's business has been based on negotiated rates with Medi-Cal, Covered California, and rates charged to commercial customers, particularly in the large group market. As previously discussed, research has shown that health insurer mergers lead to higher costs for consumers.<sup>42</sup> How will efficiencies be achieved and savings passed on to consumers? There should clear and enforceable conditions that rate filings and information provided for large group purchasers demonstrate how efficiencies reduce rates for consumers and other purchasers. How will they be sustained over time, and how will purchasers benefit? Will Centene commit to not pursue any rate increases deemed to be unreasonable by regulators, pursuant to the rate review program established by SB 1163 (Leno), Chapter 661, Statutes of 2010?
- Keeping premium dollars and profits in California: Centene should be required to reinvest profits earned from the California market in California, instead of using Californians' hard-earned premium dollars to expand elsewhere.
- Increasing transparency: Centene and Health Net should be required to provide full transparency for the pricing of premiums, compensation for senior management and the board of directors, and costs associated with the merger. Such costs must be detailed in rate filings and information provided for large group purchasers for at least the next ten years.
- Support for safety-net providers: Safety-Net clinics have played a critical role in providing care for the Medi-Cal population. 54 percent (over 1.3 million) of new Medi-Cal managed care members are assigned to safety-net clinics.<sup>43</sup> Will Centene and Health Net increase investments in the safety-net by contracting with safety-net clinics and investing in the safety-net infrastructure?
- Improve the health system as a whole: In order to address other potential impacts of the merger and these insurers' practices, Centene should commit to key investments for the state's safety-net, the remaining uninsured, rural and other underserved populations. They should also support systems that help California's health care system to achieve the quadruple aim of better care, healthier populations, lower costs, and *health equity*, such as the development of health care cost and quality database. Support for these initiatives should supplement, not supplant, the aforementioned consumer protections that are required to ensure California's patients receive the purported benefits of this merger.

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- Invest in strategies that address the social determinants of health: At the Department's January 22, 2016 hearing, the California Reinvestment Coalition pointed out that neither Centene nor Health Net have participated in the Department's COIN program or other mechanisms that would ensure these companies' investments benefit California's low-to-moderate income and rural communities. We echo the California Reinvestment Coalition's recommendation that Centene be required, as a condition of this merger, to participate in COIN in a substantial way and engage in other investment strategies that address the needs of underserved communities.

The Affordable Care Act improves health by expanding access to health coverage and supporting reforms to the health care delivery system. While increasing access to health care and transforming the health care delivery system are important, insurers can improve population health and achieve health equity by supporting broader approaches that address social, economic, and environmental factors that influence health. For example, insurer investments can help low-income Californians to access quality and affordable housing in safe communities, which will in turn improve their health and the overall ability of families to make healthy choices.<sup>44</sup>

## **THE CALIFORNIA INSURANCE CODE SAFEGUARDS CONSUMERS AND THE PUBLIC INTEREST WHEN INSURERS SEEK TO MERGE**

State law allows the Insurance Commissioner to disapprove a merger if they find that it is likely to result in any of the five adverse outcomes delineated in Section 1215.2(d) of the Insurance Code.

- (1) After the change of control the domestic insurer referred to in subdivision (a) could not satisfy the requirements for the issuance of a license to write the line or lines of insurance for which it is presently licensed.*
- (2) The purchases, exchanges, mergers, or other acquisitions of control would substantially lessen competition in insurance in this state or create a monopoly therein.*
- (3) The financial condition of an acquiring person might jeopardize the financial stability of the insurer, or prejudice the interests of its policyholders.*
- (4) The plans or proposals which the acquiring person has to liquidate the insurer, to sell its assets, or to merge it with any person, or to make any other major change in its business or corporate structure or management, are not fair and reasonable to policyholders.*
- (5) The competence, experience, and integrity of those persons who would control the operation of the insurer indicate that it would not be in the interest of policyholders, or the public to permit them to do so.*

Centene and Health Net have not shown how this merger will benefit their policyholders or the public interest. While the range of testimony presented at the Department's January 22, 2016 hearing suggests that most of the adverse outcomes in Section 1215.2(d) will materialize if the merger goes through, we focus our attention on the outcomes described in Section 1215.2(d)(1) and (5).

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**After the change of control the domestic insurer referred to in subdivision (a) could not satisfy the requirements for the issuance of a license to write the line or lines of insurance for which it is presently licensed.<sup>45</sup>**

Centene cannot satisfy the requirements for the issuance of a license. Under Section 717 of the Insurance Code, the Insurance Commissioner can deny a license to an insurer if it is materially deficient when it comes to, among other things, its competency, character and integrity of management, and its fairness and honesty of methods of doing business.<sup>46</sup> As we have discussed, Health Net has fallen short in its statutory and contractual obligations to provide its policyholders with quality care and good customer service across all its plan products. Despite these problems, Centene stated at the Department's January 22, 2016 hearing that it would not make any material changes to the management and operations when Health Net becomes its California subsidiary. In addition, Centene has not made any enforceable commitments to rectify Health Net's ongoing violations of patient rights, raising strong concerns about its competency, character, and integrity of management. Centene's breach of its Medicaid contract with the State of Kentucky calls into question its fairness and honesty of methods of doing business. As a result, we do not believe Centene satisfies the requirements for the issuance of a license to provide health insurance policies.

**The competence, experience, and integrity of those persons who would control the operation of the insurer indicate that it would not be in the interest of policyholders, or the public to permit them to do so.<sup>47</sup>**

Centene and Health Net have not established that this transaction will further the interests of policyholders or the public. Centene has asserted that this merger will yield cost savings and efficiencies that will benefit consumers, but has failed to demonstrate how consumers will actually share in these gains. At the same time, Centene has not made any enforceable commitments to ensure that policyholders receive the quality of care and customer service they are entitled to. Centene has also not demonstrated it is competent serve California's commercial market, including Covered California, which it has never done before. Finally, neither Centene nor Health Net have committed to supporting the safety net or improving the health system as a whole. Therefore, this merger is not in the interest of policyholders or the public and it should be rejected unless there are clear and enforceable conditions in place to ensure the interests of policyholders and the public are protected.

### **INSURANCE COMPANIES MUST ACT IN THE PUBLIC INTEREST**

Insurance companies doing business in California are bound by the duties and obligations imposed by statute and by contract. The California Supreme Court has noted that insurance companies are also subject to additional duties and obligations as a matter of public policy. In *Egan vs. Mutual of Omaha*, the Supreme Court noted that as suppliers of a public service, insurance companies must take the public's interest seriously, placing it before their own interest in maximizing profits and limiting payouts:

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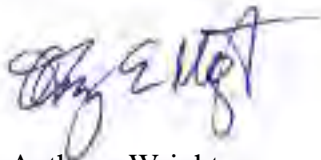
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The insurers' obligations are . . . rooted in their status as purveyors of a vital service labeled quasi-public in nature. Suppliers of services affected with a public interest must take the public's interest seriously, where necessary placing it before their interest in maximizing gains and limiting disbursements . . . (A)s a supplier of a public service . . . the obligations of insurers go beyond meeting reasonable expectations of coverage. The obligations of good faith and fair dealing encompass qualities of decency and humanity inherent in the responsibilities of a fiduciary. Insurers hold themselves out as fiduciaries, and with that the public's trust must go private responsibility consonant with that trust. *Egan v. Mutual of Omaha Insurance Co.* (1979) 24 Cal.3d 809, 820.

The proposed merger between Centene and Health Net has significant implications for California's commercial and Medi-Cal markets, and we are highly skeptical that it is in the best interest of California consumers or the health system as a whole. On behalf of California's health care consumers, we urge you to scrutinize this deal and make sure patients are not left with higher prices and unfulfilled promises.

Please contact Tam Ma, Health Access' Policy Counsel at [tma@health-access.org](mailto:tma@health-access.org) or (916) 492-0973 x. 201 if we can be of assistance as you evaluate this merger. Thank you for giving these issues your highest level of scrutiny and for protecting the interests of consumers in the process.

Sincerely,

A handwritten signature in blue ink, appearing to read "Anthony Wright", is positioned above the printed name.

Anthony Wright  
Executive Director

Cc: Senator Ed Hernandez, Chair, Senate Health Committee  
Assemblyman Rob Bonta, Chair, Assembly Health Committee

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<sup>1</sup> L. S. Dafny, *Evaluating the Impact of Health Insurance Industry Consolidation: Learning from Experience*, The Commonwealth Fund, November 2015. Available at: <http://www.commonwealthfund.org/publications/issue-briefs/2015/nov/evaluating-insurance-industry-consolidation>

<sup>2</sup> L. Dafny, M. Duggan, and S. Ramanarayanan, "Paying a Premium on Your Premium? Consolidation in the U.S. Health Insurance Industry," *American Economic Review*, April 2012 102(2):1161–85.

<sup>3</sup> J. R. Guardado, D. W. Emmons, and C. K. Kane, "The Price Effects of a Large Merger of Health Insurers: A Case Study of UnitedHealth-Sierra," *Health Management, Policy and Innovation*, June 2013 1(3):16–35.

<sup>4</sup> *Id.*

<sup>5</sup> See *Supra* note 2.

<sup>6</sup> Wilson, Katherine, *Enrollment in Individual Health Plans Up 47% in 2014*. Prepared for the California HealthCare Foundation, May 2015. Available online at: <http://www.chcf.org/articles/2015/05/enrollment-individual-up>

<sup>7</sup> *Id.*

<sup>8</sup> *Id.*

<sup>9</sup> *Medi-Cal Managed Care Plans and Safety-Net Clinics Under the ACA*, California Health Care Foundation, December 2015. Available at:

<http://www.chcf.org/~media/MEDIA%20LIBRARY%20Files/PDF/PDF%20M/PDF%20MediCalMgdCarePlansSafetyNet.pdf>

<sup>10</sup> *California Employer Health Benefits: Rising Costs, Shrinking Coverage*, California Health Care Foundation, April 2015.

Available at: <http://www.chcf.org/publications/2015/04/employer-health-benefits#ixzz3u9z4ZMrT>

<sup>11</sup> *Id.*

<sup>12</sup> *Health Insurance Companies and Plan Rates for 2016, Keeping the Individual Market in California Affordable*, Covered California, Updated October 29, 2015. Available at: <https://www.coveredca.com/PDFs/7-27-CoveredCA-2016PlanRates-prelim.pdf>

<sup>13</sup> *The Burden of Medical Debt: Results from the Kaiser Family Foundation/New York Times Medical Bills Survey*, Kaiser Family Foundation, January 2016. Available at: <https://kaiserfamilyfoundation.files.wordpress.com/2016/01/8806-the-burden-of-medical-debt-results-from-the-kaiser-family-foundation-new-york-times-medical-bills-survey.pdf>

<sup>14</sup> *Id.*

<sup>15</sup> Health Net opposed AB 52 (Feuer, 2011) and Proposition 45 (November 2014 ballot). See Senate Floor Analysis of AB 52 (Feuer), August 29, 2011, and Skelton, George, *Insurers' spending against Prop. 45 tips scale in its favor*, Los Angeles Times, October 15, 2014. Available at: <http://www.latimes.com/local/politics/la-me-cap-proposition45-20141016-column.html>

<sup>16</sup> Senate Floor Analysis of SB 546 (Leno), Chapter 801, Statutes of 2015, September 10, 2015.

<sup>17</sup> See *Supra*, note 10.

<sup>18</sup> Herman, Bob, *Centene's behemoth Medicaid business continues to swell*, Modern Healthcare, October 27, 2015. Available at: <http://www.modernhealthcare.com/article/20151027/NEWS/151029904>

<sup>19</sup> Herman, Bob, *Rising Medicaid enrollment boosts Centene's profit, revenue*, Modern Healthcare, October 28, 2014. Available at: <http://www.modernhealthcare.com/article/20141028/NEWS/310289961>

<sup>20</sup> Colston, Kenny, *Medicaid Operator Kentucky Spirit Plans to Break Contract, Beshear says He's Disappointed*, October 17, 2012. Available at: <http://wfp1.org/medicaid-operator-kentucky-spirit-plans-break-contract-beshear-says-hes-disappointed>

<sup>21</sup> The Associated Press, *Court rules Kentucky Spirit must pay the state damages*, February 6, 2015. Available at: <https://www.ksl.com/?sid=33379597>

<sup>22</sup> *Medi-Cal Managed Care Enrollment Report*, Department of Health Care Services, October 2015. Available at: [http://www.dhcs.ca.gov/dataandstats/reports/Documents/MMCD\\_Enrollment\\_Reports/MMCEnrollRptOct2015.pdf](http://www.dhcs.ca.gov/dataandstats/reports/Documents/MMCD_Enrollment_Reports/MMCEnrollRptOct2015.pdf)

<sup>23</sup> *NCQA Health Insurance Plan Ratings 2015-16 for Health Net of California (Medicaid)*. Available at: <http://healthinsuranceratings.ncqa.org/2015/HprPlanDetails.aspx?id=296>

<sup>24</sup> *Medi-Cal Managed Care Plans and the Safety Net Under the ACA*, California Health Care Foundation, December 2015. Available at:

<http://www.chcf.org/~media/MEDIA%20LIBRARY%20Files/PDF/PDF%20M/PDF%20MediCalMgdCarePlansSafetyNet.pdf>

<sup>25</sup> *Final Report Routine Medical Survey of Health Net of California*, Department of Managed Health Care, February 13, 2014. Available at: <http://dmhc.ca.gov/desktopmodules/dmhc/medsurveys/surveys/300fs022414.pdf>

<sup>26</sup> DMHC Enforcement Matter Number: 14-152 (March 16, 2015). Available at:

<http://wpso.dmhc.ca.gov/enfactions/docs/2273/1429554844522.pdf>

<sup>27</sup> DMHC Enforcement Matter 11-260 (December 22, 2014). Available at:

[wpso.dmhc.ca.gov/enfactions/docs/2214/1420496039748.pdf](http://wpso.dmhc.ca.gov/enfactions/docs/2214/1420496039748.pdf)

<sup>28</sup> Department of Managed Health Care Enforcement Matter No. 12-165 (November 20, 2014). Available at:

[wpso.dmhc.ca.gov/enfactions/docs/2041/1420496203478.pdf](http://wpso.dmhc.ca.gov/enfactions/docs/2041/1420496203478.pdf)

<sup>29</sup> Department of Managed Health Care Enforcement Matter No. 11-009 (March 25, 2011). Available at:

[wpso.dmhc.ca.gov/enfactions/docs/1362/1301333605540.pdf](http://wpso.dmhc.ca.gov/enfactions/docs/1362/1301333605540.pdf)

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<sup>30</sup> Department of Managed Health Care Enforcement Matter Numbers 10-002, 07-330, 09-424, and 10-204 (January 25, 2011). Available at: [wpso.dnhc.ca.gov/enfactions/docs/1335/1297789648054.pdf](http://wpso.dnhc.ca.gov/enfactions/docs/1335/1297789648054.pdf)

<sup>31</sup> Department of Managed Health Care Enforcement Matter No. 07-206 (November 16, 2007). Available at: [wpso.dnhc.ca.gov/enfactions/docs/752/1215016308591.pdf](http://wpso.dnhc.ca.gov/enfactions/docs/752/1215016308591.pdf) [wpso.dnhc.ca.gov/enfactions/docs/690/1218580267793.pdf](http://wpso.dnhc.ca.gov/enfactions/docs/690/1218580267793.pdf)

<sup>32</sup> California Department of Insurance Press Release, *Insurance Commissioner Dave Jones Announces Agreements with Major Health Insurers to Provide Autism Coverage*, February 27, 2012. Available at: <https://www.insurance.ca.gov/0400-news/0100-press-releases/2012/release017-12.cfm>

<sup>33</sup> *HMO Quality Report Card: Health Net of California, Inc. 2015-16 Edition*, Office of the Patient Advocate. Available at: [http://reportcard.opa.ca.gov/rc/profile.aspx?EntityType=HMO&Entity=HEALTH\\_NET](http://reportcard.opa.ca.gov/rc/profile.aspx?EntityType=HMO&Entity=HEALTH_NET)

<sup>34</sup> *Office of the Patient Advocate HMO Quality Ratings: HMO Helps Members Get Answers Summary, 2015-16 Edition*. Available at: [reportcard.opa.ca.gov/rc/HMOTopic.aspx?Category=HMOCAHPS&Topic=PlanService](http://reportcard.opa.ca.gov/rc/HMOTopic.aspx?Category=HMOCAHPS&Topic=PlanService)

<sup>35</sup> See *Supra* note 24.

<sup>36</sup> *Covered California Quality Rating System*, October 2015. Links to ratings by Covered California pricing regions available at: <http://hbex.coveredca.com/insurance-companies/ratings/>

<sup>37</sup> See *Supra* note 23.

<sup>38</sup> See *Supra* note 4.

<sup>39</sup> *Rate of Inquiries and Complaints About HMOs Received by DMHC*, Office of the Patient Advocate. Available at: [http://reportcard.opa.ca.gov/rc/hmo\\_member\\_inquiry.aspx](http://reportcard.opa.ca.gov/rc/hmo_member_inquiry.aspx)

<sup>40</sup> California Insurance Code Sections 10133.8 and 10133.9 and the Department of Insurance's regulations (Title 10, California Code of Regulations sections 2538.1-2538.8).

<sup>41</sup> Chris Rauber, Hard drives holding health data missing at medical insurer, *San Francisco Business Times*, January 27, 2016. Available at: <http://www.bizjournals.com/sanfrancisco/blog/2016/01/missing-hard-drives-health-data-centene.html>

<sup>42</sup> See *Supra* note 1.

<sup>43</sup> *Medi-Cal Managed Care Plans and the Safety Net Under the ACA*, California Health Care Foundation, December 2015. Available at:

<http://www.chcf.org/~media/MEDIA%20LIBRARY%20Files/PDF/PDF%20M/PDF%20MediCalMgdCarePlansSafetyNet.pdf>

<sup>44</sup> For an example of strategies to address housing and health, see: C Pollack, S Egerter, T Sadegh-Nobari, M Dekker, and P Braveman, *The Links Between Housing and Health*. Robert Wood Johnson Foundation, 2011. Available at: [http://www.rwjf.org/content/dam/farm/reports/issue\\_briefs/2011/rwjf70451](http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2011/rwjf70451)

<sup>45</sup> California Insurance Code Section 1215.2(d)(1).

<sup>46</sup> California Insurance Code Section 717.

<sup>47</sup> California Insurance Code Section 1215.2(d)(5).



# California Medical Association

*Physicians dedicated to the health of Californians*

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January 29, 2016

Dave Jones, Commissioner  
California Department of Insurance  
300 Capitol Mall, Suite 1700  
Sacramento, CA 95814

**Comments submitted via e-mail to:** [Jennifer.Chambers@insurance.ca.gov](mailto:Jennifer.Chambers@insurance.ca.gov)

Dear Commissioner Jones:

The California Medical Association (CMA) respectfully submits the following comments related to Centene's proposed acquisition of Health Net. CMA is a not-for-profit, professional association for California physicians with more than 42,000 members. CMA physician members practice medicine in all specialties and modes of practice throughout California. For more than 150 years, CMA has promoted the science and art of medicine, the care and well-being of patients, the protection of public health, and the betterment of the medical profession. CMA and its physician members are committed to the protection of the physicians' ability to exercise their medical judgment to provide quality and effective care for their patients.

The CMA has long been concerned with the consolidation of health plans and health insurers and the reduction of competition. Physicians across the country have serious concerns with the recent, rapid wave of proposed mergers and consolidation of health plans and health insurers.<sup>1</sup> A statement from the American Medical Association states that patients would be better served in health care system that promotes competition and choice.

The success of health care reform will depend as much upon its regulatory implementation as it will upon healthy, competitive health plan markets. In order to improve health care we must encourage competitive health markets that provide ample choice, high quality, and transparency. Accordingly, we urge the Department of Insurance (CDI) to review Centene's proposed acquisition of Health Net in the context of the national move by health plans to merge and the goal of health care reform to increase access, improve quality and lower costs. This is particularly important in this case because both Centene and Health Net are significant participants in the Medi-Cal managed care market, which is expected to accommodate substantial growth to facilitate health care access for millions of Californians.

Below, we outline our specific concerns with health plan consolidation and potential undertakings we urge the CDI to consider if it decides to approve the proposed merger.

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<sup>1</sup> Hereinafter the terms health plan and health insurer are used interchangeably in the context of discussing the merger and consolidation of companies that provide health insurance and health plan products.

## **Regulatory Oversight**

CMA appreciates CDI taking official notice of the United/Pacificare merger and its subsequent enforcement action. The CMA participated in the regulatory consideration of that merger and the regulatory oversight of that merger to address the subsequent shortcomings and problems. We urge the CDI to carefully review past mergers in an attempt to duplicate the effectiveness of past undertakings, and improve any shortcomings or specific concerns presented by Centene's proposed acquisition of Health Net. Based upon past experience, CMA recommends that a particular area of focus should be on strengthening the oversight and enforceability of any undertakings.

## **Limited Choice for Patients**

The health insurers should also be required to specifically demonstrate efficiencies and improvements in access to health care to justify their increase in market power. Studies demonstrate that health plan mergers do not result in lower costs to consumers.<sup>2</sup> That is, the promise to use their increased market power, or monopsony power, to negotiate lower reimbursement rates from providers does not materialize into lower premiums or lower deductibles. Instead, as further discussed below, past mergers demonstrate that more market power can result in limited patient choice of physicians in the form of narrow networks without sufficient physicians (including specialty care), reduced administrative capacity and resources to administer quality health care access to patients, and the loss of competition among health care plans that reduces their incentives to collaborate with health care providers.

While limited or tiered networks are currently being used by health plans to control health care costs, when a health plan increases its market power, we are concerned that it can be further incentivized, and less hindered by competition, to utilize restricted networks to limit patient access to medically necessary care and increase profits. This concern is compounded in the Medi-Cal managed care market, of which both Health Net and Centene are significant participants, by the low physician reimbursement rates that have already severely limited patient choice and access. Medicaid patients newly insured under the ACA's Medicaid expansion are struggling to get appointments or find doctors in the narrow Medi-Cal networks, and consequently seeking care in emergency rooms.<sup>3</sup> Commercial networks are similarly narrow and getting more constrained. A study by University of Pennsylvania researchers shows that 76 percent of health plans sold in California through Covered California have significantly limited networks.<sup>4</sup> Specifically: 38% were considered "x-small," meaning they included 10% or less of providers in the rating area; 38% were considered "small," meaning they included 10% to 25% or less of providers in the rating area; 19% were considered "medium," meaning they included 25% to 40% of providers in the rating area; and 6% were considered "large," meaning they included 40% to 60% of providers in the rating area. No provider networks offered through the California exchange were

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<sup>2</sup>Thomas Greaney, *Examining Implications of Health Insurance Mergers*, Health Affs. (July 16, 2015); Leemore Dafny et al., *Paying a Premium on Your Premium? Consolidation in the US Health Insurance Industry*, 102 Am. Econ. Rev. 1161 (2012); Jose Guardado, et al., *The Price Effects of a Larger Merger of Health Insurers: A Case Study of United-Sierra*, 1(3) Health Management, Policy and Innovation 1; Robert Pear, *Many Say High Deductibles Make Their Health Law Insurance All but Useless*, N.Y. Times (Nov. 14, 2015); David Lazarus, *As Health Insurers Merge, Consumer's Premiums Are Likely to Rise*, L.A. Times (July 10, 2015); Leemore Dafny, *Are Health Insurance Markets Competitive?*, 100 Am. Econ. Rev. 1399 (2010).

<sup>3</sup> Stephanie Armour, *U.S. Emergency-Room Visits Keep Climbing*, The Wall Street Journal, May 4, 2015; Sally C. Pipes, *A New Cost of Obamacare: Surging Emergency Room Usage*, New Pittsburgh Courier, July 26, 2015.

<sup>4</sup> Dan Polsky & Janet Weiner, *State Variations in Narrow Networks on the ACA Marketplaces*, Leonard Davis Inst. Of Health Econ. (Aug. 2015).



considered by researchers to be "x-large," meaning they included 60% or more of providers in the rating area. In fact, some health plans have no in-network doctors in key-specialties.<sup>5</sup>

### **Administrative Capacity and Resources**

The aftermath of past health plan mergers have also taught California physicians and their patients that post merger, it is imperative that the consolidated entity have the administrative capacity and resources in California to administer quality health care access to patients. We experienced this with the United/PacifiCare merger, where post merger the company did not have enough dedicated resources in California to administer claims, authorizations, or otherwise facilitate timely access to health care.<sup>6</sup>

### **Loss of Competition and Collaboration**

One driver behind health care reform and value based health care is to incentivize collaboration in health care markets in order to increase innovation and reduce costs. When examining recent mergers, industry experts have expressed concern that if insurers have too much market power then they have no reason to collaborate with health care providers.<sup>7</sup> California physicians have experienced this effect already in California markets where health insurers do not negotiate with solo and small group physicians but instead offer them take-it-or-leave contracts. While health insurers assert that their exercise of such market power results in lower provider reimbursement rates, such savings do not necessarily benefit the consumer because the savings are not passed down in cost savings to the patients, patients lose access to their physicians who are driven out of the network, and the opportunity to "collaborate" with physicians to provide innovative, quality health care is lost.

Unfortunately, CMA is experiencing this lack of collaboration with Centene's subsidiary, California Health and Wellness. CMA has a member only benefit where physicians may avail themselves of the expertise from CMA's Center for Economic Services (CES). This center is staffed by highly qualified practice management experts. The services provided by CMA's CES center range from coaching and education to direct intervention with payors or regulators. In instances where a physician or group of physicians is having a longstanding issue with a payor that hasn't been resolved utilizing the payor's internal dispute process, CES staff will reach out to high level contacts at the payor to try to resolve the dispute between the insurer and the provider. However, California Health & Wellness has been slow to resolve these types of issues and is resistant to allowing CMA to participate in the resolution of issues that have been escalated on physician behalves.

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<sup>5</sup> Stephen C. Dorner, et al., *Adequacy of Outpatient Specialty Care Access in Marketplace Plans Under the Affordable Care Act*, JAMA, October 27, 2015.

<sup>6</sup> The California Department of Insurance imposed penalties against United Healthcare of more than \$173 million dollars for 900,000 violations of the insurance code from 2005 to 2008. The administrative proceeding arose from problems that surfaced after United Healthcare's acquisition of PacifiCare in 2005, which had been heavily scrutinized by regulators. Shortly after the transaction, the CMA saw a spike in complaints from physicians about the way PacifiCare was processing claims and contracts. CMA forwarded dozens of physician complaints to the DOI and requested the insurance regulator investigate. After conducting its own market conduct investigation, the DOI filed an administrative proceeding against United Healthcare, charging PacifiCare with violations that included: (1) failing to give providers notice of their appeal rights and members notice of their right to an independent medical review; (2) failing to timely pay or correctly pay claims as well as interest on late-paid claims; (3) failing to acknowledge receipt of claims; (4) failing to timely respond to provider disputes; (5) illegally closing claims files; and (6) sending untimely collection notices for overpayment.

<sup>7</sup> Reed Abelson, *With Merging of Insurers, Questions for Patients About Costs and Innovation*, N.Y. Times (July 5, 2015).

CMA has worked to build collaborative relationships with most of the major payors in California, including Health Net and the Department of Health Care Services, administrator of Medi-Cal benefits, and as a result, CMA and the payors are very successful in resolving various types of issues. Other payors, as well as the State, see the value in working collaboratively with CMA because CMA has consistently demonstrated that our goal is to facilitate resolution of outstanding disputes when the payor's internal process fails and not to derail the payor's direction.

This lack of collaboration with providers from one of the smaller payors in California raises concerns with what collaboration will look like once Centene joins the ranks as one of the largest payors in California.

### **Undertakings**

With the aforementioned concerns in mind, CMA respectfully urges CDI to consider the following undertakings if it decides to approve Centene's proposed acquisition of Heath Net:

- *Organizational and administrative capacity.* CMA recommends that CDI require Centene/Health Net to demonstrate that it will maintain and improve their administrative capacity to process claims, authorizations and respond to consumer, provider and regulators complaints and issues. The undertakings, for instance, should address key functions that should be maintained in California in order to ensure that the merged company has the capacity to administer health care, including the prior authorization and referral system, grievance system, independent medical review process, provider dispute resolution mechanism, clinical decision making, and medical policy decision making. The CMA has long worked with Health Net and its provider relations staff to efficiently address physician and patient complaints. This process has resulted in successful resolution of complaints and provided patients timely access to their physicians' medical care. If the merger is approved, it is imperative that this capacity is not only maintained by Health Net in California but also further developed by Centene in California.
- *Network adequacy and stability.* On the front end, prior to approving a merger, the CDI should require the health insurers to demonstrate that their physician networks are robust and stable, and that their provider directories are accurate. If the CDI approves the merger, CMA urges that the undertakings delineate an on-going process financed by the merged companies for an assessment of the health insurer's network capacity and network directory accuracy. At the same time, CMA encourages CDI to prohibit health insurer practices that disrupt physician networks. Past mergers and the substantial use of narrow networks in Medi-Cal managed care and Covered California products have demonstrated that minor fluctuations in a provider network can have major ramifications on access for patients. A practice that disrupts physician networks and creates great confusion for both patients and physicians, which CMA respectfully urges CDI to consider prohibiting, is health insurer's practice of opting-in physicians to new network products without obtaining physicians' affirmative consent or the use of all products clauses that allow health plans to force physicians in and out of their networks without much, if any, collaboration with physicians. In addition, CMA urges CDI to require the health insurers to provide additional instructions necessary for patients to successfully locate and navigate the specific network in which he or she has subscribed. This may also help to ensure that any cost savings the plans see from narrow networks are not the result of patients being unable to get needed care. More information also needs to be available to patients so they can make informed decisions when selecting a plan.

- *Access to specialty care.* CMA urges the CDI to consider providing assurances and reporting requirements regarding Health Net's and Centene's network of contracted specialty providers in order to improve network access.
- *Financial commitments to improve infrastructure, including for physicians to participate in value based health care programs.* CMA urges the CDI to consider an undertaking requiring that Centene make a significant charitable contribution with a specific purpose of investing in providing the tools, financial capital, and know-how to individual physicians and physician groups so that they have the ability to participate in value based health care. Most physicians do not have the financial capital necessary to create and lead the integrated health care organizations that the federal health care reform legislation, commercial health plans and self-insured purchasers of health care services are seeking.<sup>8</sup> Instead, capital-rich health care systems are leading the development of such organizations even though studies consistently demonstrate that physician-led ACOs and value based programs create the greatest savings. CMA is uniquely positioned to provide guidance on this issue and would welcome an opportunity to discuss this further with the CDI.

Thank you for the opportunity to provide comments on Centene's proposed acquisition of Health Net. We look forward to continuing to participate in your consideration of this proposed merger and its potential impact on physicians, patients and the California health care market.

Sincerely,



Francisco J. Silva

General Counsel and Senior Vice-President  
Centers for Legal Affairs, Health Policy, & Economic Services

Attachments Enclosed

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<sup>8</sup> For additional background on this topic see Jeff Goldsmith, Ph.D., "The Future of Medical Practice: Creating Options for Practicing Physicians to Control Their Professional Destiny," available at [www.physiciansfoundation.org](http://www.physiciansfoundation.org).

## Paying a Premium on Your Premium? Consolidation in the US Health Insurance Industry<sup>†</sup>

By LEEMORE DAFNY, MARK DUGGAN, AND SUBRAMANIAM RAMANARAYANAN\*

Although the majority of health-care spending in the United States is funneled through the private health insurance industry, few researchers have examined whether the industry itself is contributing to rising health insurance premiums. This possibility has become ever more salient as consolidations continue in this highly concentrated sector. In 2001, the American Medical Association (AMA) reported nearly half of the 40 largest Metropolitan Statistical Areas (MSAs) were “highly concentrated,” as defined by the *Horizontal Merger Guidelines* issued in 1997 by the US Department of Justice and the Federal Trade Commission. In 2008, the AMA expanded its annual report to include 314 geographic areas (mainly MSAs), 94 percent of which were found to be highly concentrated.<sup>1</sup> During this seven-year period, the average, inflation-adjusted premium for employer-sponsored family coverage rose 48 percent (to \$12,680 in 2008)<sup>2</sup> while real median household income *declined* by 2 percent to \$50,303 (DeNavas-Walt, Proctor, and Smith 2009).

Prior studies point to the potential for insurer consolidation to raise premiums (e.g., Robinson 2004; Wholey, Feldman, and Christianson 1995; and

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<sup>†</sup> To view additional materials, visit the article page at <http://dx.doi.org/10.1257/aer.102.2.1161>.

<sup>1</sup> “Competition in Health Insurance: A Comprehensive Study of US Markets,” American Medical Association, 2001 and 2008. These figures are based on the reported levels of the Herfindahl-Hirschman Index (HHI) for HMOs and PPOs combined. Estimates are not strictly comparable over time due to changes in methodology and sample selection. For example, self-insured HMOs are generally included in 2001 but excluded in 2008. The *Horizontal Merger Guidelines* issued in 1992 and updated in 1997 define markets with HHI > 1,800 as “highly concentrated.” A recent update adjusted this threshold to 2,500 (DOJ 2010), and as a result the share of markets in 2008 that would be highly concentrated is somewhat lower at 70 percent.

<sup>2</sup> The corresponding increase for single coverage was 44 percent (Kaiser Family Foundation/Health Research and Educational Trust *Employer Health Benefits Annual Survey 2009*). Premiums include both employer and employee contributions, and are adjusted to 2008 dollars by the authors using the CPI-U.

Dafny 2010); however, none attempts to quantify this effect.<sup>3</sup> From a theoretical standpoint, the effect of concentration on insurance premiums is ambiguous. On one hand, increases in market concentration may allow health insurers to raise their mark-ups, leading to higher premiums. On the other hand, increases in market concentration may strengthen insurers' bargaining positions vis-à-vis health-care providers, leading to reduced negotiated reimbursements and lower premiums. In addition, there are many potential sources of efficiency gains from consolidation, including economies of scale in investments in information technologies (IT) investing and disease management programs. Such efficiency gains would reduce optimal premiums.<sup>4</sup> The net effect on insurance premiums is ultimately an empirical question.

There are two key challenges to empirically estimating such a link: (i) adequate data and (ii) plausibly exogenous variation in market concentration. Regarding the first issue, comprehensive data on a large sample of health plans are extremely difficult to obtain because contracts are customized for each buyer across many dimensions, renegotiated annually, and considered highly confidential. In addition, premiums vary based on the demographics, health risks, and expenditure history of the insured population. Thus, it is difficult to calculate a standardized premium to enable comparisons across employers and/or markets. With respect to the second challenge, highly concentrated markets (or markets that are becoming more concentrated) are likely to differ from other markets in unobservable ways, making it difficult to separately identify the effect of concentration from other factors.

We address these challenges as follows. First, we utilize detailed longitudinal data on the health plans offered by a sample of more than 800 employers in 139 distinct geographic markets in the United States. The data span the nine years between 1998 and 2006 and represent approximately 10 million active employees and their dependents in each year. Rather than attempting to standardize premiums across different employee populations, products, and plan designs, we focus on the *growth rate* of health insurance premiums for the same employer in a specific geographic market over time and examine how this relates to the local market structure of health insurers. Focusing on growth alleviates concerns about time-invariant unobservable differences in the risk profiles of employee groups and the characteristics of plans they utilize that may be correlated with premium *levels*. We also control for the influence of time-varying measures such as employee demographics, the types of plans utilized (HMO, PPO, etc.), and the generosity of benefit design.

After documenting trends in the level and growth of concentration (as measured by the Herfindahl-Hirschman index (HHI), which is the sum of squared market shares) in 139 distinct geographic markets, we estimate OLS models of the relationship between premium growth and concentration levels. We do not find evidence

<sup>3</sup>Robinson (2004) shows that state-level insurance markets are dominated by a small number of firms and observes that insurer profits increased rapidly over 2000–2003. Wholey, Feldman, and Christianson (1995) report that premiums per HMO member are negatively related to the number of competitors facing the HMO in question, controlling for a host of HMO and market characteristics such as per capita income, Blue Cross affiliation and HMO ownership status. Last, Dafny (2010) finds health insurers engage in “direct” price discrimination, charging higher premiums to firms with deeper pockets, as measured by operating profits. This evidence of price discrimination implies insurers possess and exercise market power in some local markets but does not yield an estimate of the contribution of imperfect competition in this market to premium growth.

<sup>4</sup>Of course, rent transfers from providers to insurers are not true efficiency gains, although they may reduce premiums.

that premiums are rising more quickly in markets that are becoming more concentrated. While these estimates are useful for descriptive purposes, they are unlikely to provide causal estimates of the impact of market structure on premiums. Differences in HHI across markets—or even changes in HHI within markets—are likely to be driven by many factors that are not exogenous to premiums. These include differences (or changes) in consumer preferences and constraints, product offerings and pricing strategies, and the market conduct of hospitals, physicians, and other health-care providers. For example, consider a market with a struggling local economy. In such a market, consumers may flock to low-priced carriers, bringing about an increase in local market concentration and a simultaneous reduction in average premium growth (relative to other markets). This pattern does not imply consolidations in such a market would reduce premium growth, *ceteris paribus*.

In order to address the endogeneity challenge and obtain a credible estimate of the impact of concentration on premium growth, we exploit sharp and heterogeneous increases in local market concentration generated by the 1999 merger of two industry giants, Aetna and Prudential Healthcare. Both were national firms, active in most local insurance markets, and thus the merger had widespread impact. However, the premerger market shares of the two firms varied significantly across specific geographic markets, resulting in very different shocks to post-merger concentration. For example, in our sample the premerger market shares of Aetna and Prudential in Jacksonville, Florida were 19 and 24 percent, respectively, versus just 11 and 1 percent, respectively, in Las Vegas, Nevada. Holding all else equal, this implies an increase in post-merger HHI of 892 points in Jacksonville, but only 21 points in Las Vegas. Focusing on the years immediately surrounding this merger, we examine the relationship between premium growth and HHI changes using these predicted changes as instruments for actual changes and controlling as fully as possible for changes in the characteristics of health plans (such as benefit design).

The point estimates indicate that rising concentration in local health insurance markets accounts for a nontrivial share of premium growth in recent years. Specifically, our instrumental variables estimates imply that the mean increase in local market HHI between 1998 and 2006 (inclusive) raised premiums by roughly 7 percent from their 1998 baseline, all else equal. Given private health insurance expenditures of \$490 billion in our base year 1998, if this result is generalizable, then the “premium on premiums” by 2007 is on the order of \$34 billion per year, or about \$200 per person with employer-sponsored health insurance.<sup>5</sup>

Although our focus is on the exercise of market power by insurers in the *output* market, consolidation may also have important effects on *input* prices. Using data on earnings and employment of health-care personnel, we exploit the differential impact across geographic markets of the Aetna-Prudential merger to examine whether there is a causal link between concentration and these outcomes. Our analysis suggests that the growth in insurer bargaining power following this merger reduced earnings and employment growth of physicians and raised earnings and employment growth

<sup>5</sup> Source: National Health Expenditure Data provided by the Center for Medicare and Medicaid Services; available online at <http://www.cms.hhs.gov/NationalHealthExpendData/>. The vast majority of this spending is due to employer-sponsored plans; only 9 percent of the nonelderly privately insured have policies that are not employment based (DeNavas-Walt, Proctor, and Smith 2009). Additionally, this figure understates the size of the private health insurance industry as it excludes expenditures by Medicaid and Medicare managed care plans.

of nurses. This pattern of results is consistent with postmerger substitution of nurses for physicians, and the exercise of monopsony power vis-à-vis physicians.

The paper is organized as follows. Section I describes the data in detail. We examine the association between local market concentration and premium growth in Section II. In Section III we investigate whether a causal relationship exists between these two variables using the variation across geographic markets in the merger-induced increase in insurer concentration. Section IV contains our analyses of the relationship between concentration and health-care employment and earnings. Section V concludes.

## I. Data

Our primary source is the Large Employer Health Insurance Dataset (LEHID). LEHID contains information on all of the health plans offered by a large sample of employers between 1998 and 2006, inclusive. It is an unbalanced panel gathered and maintained by a leading benefits consulting firm. The data are proprietary, and employers included in the dataset have some past or present affiliation with the firm. Online Appendix 1, which contains additional details of the data not presented here, illustrates that LEHID plans are on average very similar to the plans offered by a representative sample of large employers nationwide.

The original unit of observation is the health plan–year. A health plan is defined as a unique combination of employer, market, insurance type, insurance carrier, and plan type (e.g., Company X’s Chicago-area fully insured Aetna HMO). There are 813 unique employers, 139 geographic markets, two insurance types (self- and fully insured), 357 insurance carriers<sup>6</sup> and four plan types (HMO, POS, PPO, Indemnity) represented in the data.<sup>7</sup> Most employers in LEHID are large, multisite, publicly traded firms, such as those appearing on the *Fortune 1000* list. The leading industries represented include manufacturing (110 employers), finance (101), and consumer products (73), although nonprofit and government sectors are also represented (43 in the “government/education” category). Geographic *markets* are defined by the data source using three-digit zip codes. According to the data provider, the 139 markets reflect the geographic boundaries typically used by insurance carriers when quoting prices. Large metropolitan areas are separate markets, and nonmetropolitan areas are lumped together within state boundaries (e.g., “New Mexico—Albuquerque” and “New Mexico—except Albuquerque”).<sup>8</sup>

The sample includes both *fully insured* and *self-insured* plans. As these terms suggest, the former is “traditional” insurance in which the insured pays the carrier to bear the risk of realized health-care outlays. Many large employers choose to self-insure, outsourcing benefits management, provider contracting, and/or claims

<sup>6</sup>Many of these carriers are third-party administrators, who “rent” provider networks and process claims for self-insured employers.

<sup>7</sup>HMO and POS plans control utilization through primary care physicians (“gatekeepers”). HMOs cover only in-network providers, while POS and PPO plans provide some coverage for out-of-network providers. Indemnity plans have no gatekeepers or network restrictions.

<sup>8</sup>There is only one market that crosses state boundaries, “Massachusetts—Southern and Rhode Island.” A few rural areas of the United States are excluded. A map of the markets is available in Dafny (2010).

administration but paying the realized costs of care. The percent of LEHID enrollees in self-insured plans increased from 55 to 80 percent during the study period.

In addition to the elements that jointly define a plan, our dataset includes the following variables: *premium*, *demographic factor*, *plan design factor*, and *number of enrollees*. *Premium* is expressed as an average amount per enrollee (i.e., a covered employee); it therefore increases with the average family size of enrollees in a given plan. Premium combines employer and employee contributions, and for self-insured plans it is a projection of expected costs per enrollee (including estimated administrative fees paid to an insurance carrier, as well as premiums for stop-loss insurance, if any). Because the forecasts are used for budgeting and to establish employee premium contributions, they are carefully developed and vetted. Employers often hire outside actuaries and benefits experts (such as our source) to assist in formulating accurate projections.

*Demographic factor* is a measure that reflects family size, age, and gender composition of enrollees in a given plan. All of these characteristics are important determinants of average expected costs per enrollee in a plan. *Plan design factor* captures the generosity of benefits within a particular carrier-plan type, with an emphasis on the levels of coinsurance, copayments, and deductibles. Both factors are calculated by the source, and the proprietary formulae were not disclosed to us. Higher values of either factor are associated with higher premiums.

The LEHID also records the *number of enrollees* in each plan. This figure includes only employees of the relevant firm; dependents are accounted for by the demographic factor described above. The total number of enrollees in all LEHID plans averages 4.7 million per year. Given an average family size of more than two, this implies that more than ten million US residents are part of the sample in a typical year, representing approximately 7 percent of those with employer-sponsored insurance (ESI) during this period, and a much larger share of those insured through large firms.

We supplement the LEHID data with time-varying measures of local economic conditions (the unemployment rate, as reported by the Bureau of Labor Statistics), a measure of health-care utilization (Medicare costs per capita, as reported by the Centers for Medicare and Medicaid services), and the concentration of the hospital industry (HHI as calculated by the authors using the *Annual Surveys of Hospitals* administered by the American Hospital Association).<sup>9</sup> As the first two measures are reported at the county-year level, and LEHID markets are defined by three-digit zip codes, we make use of a mapping between zip codes and counties and, where necessary, use population data to calculate weighted average values for each LEHID market and year.

We perform most analyses using data aggregated to the employer-market-year level. Table 1 presents descriptive statistics for this unit of observation for 1998, 2002, and 2006, which represent the initial, middle, and final years of the sample respectively. Because our primary outcome is *growth* in health insurance premiums (in order to avoid cross-sectional identification of the coefficients of interest),

<sup>9</sup>To calculate HHI for each geographic market and year, we use data on the number of beds for all general hospitals located in the set of three-digit zip codes that define the market, assigning hospitals with the same "system ID" to a common owner.



TABLE 1—DESCRIPTIVE STATISTICS (Unit of Observation: Employer-Market-Year)

	1998	2002	2006
Premium (\$)	4,104.47 (1,047.76)	5,624.70 (1,280.61)	7,832.46 (1,807.98)
Number of enrollees	399.86 (1,465.47)	370.42 (1,397.66)	361.47 (1,245.86)
Demographic factor	2.35 (0.47)	2.29 (0.41)	1.84 (0.38)
Plan design	1.05 (0.06)	1.05 (0.06)	0.98 (0.07)
Plan type			
HMO	29.4%	30.6%	25.4%
Indemnity	22.4%	7.2%	2.8%
POS	28.1%	16.8%	14.1%
PPO	20.0%	45.4%	57.6%
Percent fully insured	33.0%	24.2%	14.4%
Observations	10,033	14,851	11,497

Notes: All statistics are unweighted. The unit of observation is an employer-market-year combination. Demographic factor reflects age, gender, and family size for enrollees. Plan design measures the generosity of benefits. Both are constructed by the data source and exact formulae are not available. Premiums are in nominal dollars. Standard deviations are in parentheses.

aggregating the data to the employer-market-year level enables us to use a much larger proportion of the data. With the health plan-level data, growth in premium is undefined when an employer terminates a particular plan. Analogously, new plans can enter the analysis only after multiple observations are available. Changes to plan offerings are quite common in our data (24 percent of plans in year  $t$  whose firm-markets are still present in year  $t + 1$  no longer exist). Moreover, changes in market concentration may affect the insurance carriers and plan types chosen by employers, so we do not want a priori to eliminate this substitution from our sample.<sup>10</sup> Given this aggregation, both fully and self-insured plans must be included together in the analysis sample to ensure the set of employees represented over time is stable (but for hiring, attrition, and changes in employees' decisions to take up employer-sponsored insurance).

## II. Is Premium Growth Correlated with Local Market Concentration?

In this section, we examine the relationship between the growth in health insurance premiums and local market concentration. We begin by describing the distribution of market-level HHI and how this has changed over time. Next, we estimate OLS regressions relating premium growth at the employer-market level to the corresponding market HHI. We include market fixed effects in our models, so that we identify the coefficient of interest using changes in *within-market* HHI. The richness

<sup>10</sup>This occurs very frequently in the LEHID. For example, consider employer-market pairs that are present in both 1999 and 2002. More than half of the plans offered by these firms in 1999 are no longer present in 2002, either because the employer switched to different carriers or because it changed the type of plan with the same carrier.

of the data also permits us to control for important time-varying differences (such as the percent of enrollees in HMOs and the magnitude of copayments). Although interesting as a descriptive exercise, this analysis is unlikely to yield unbiased estimates of the causal impact of changes in market structure on premium growth, as changes in market structure are unlikely to be exogenous.

#### *A. Market Structure of Large Group Insurance Markets, 1998–2006*

During our nine-year study period, the average market-level HHI (estimated using our sample and scaled from 0 to 10,000) increased from 2,286 to 2,984.<sup>11</sup> Using the categorization from the *Horizontal Merger Guidelines* issued in 1997, the fraction of markets falling into the top “highly concentrated” category (HHI > 1,800) rose from 68 to 99 percent. The median four-firm concentration ratio increased from 79 to 90 percent. Thus, our data support the conclusions of well-publicized reports issued by the American Medical Association and the General Accounting Office: local health insurance markets are concentrated and becoming more so over time.<sup>12</sup>

Figure 1 presents histograms of the market-level changes in HHI, separately for 1998–2002, 2002–2006, and 1998–2006. The larger increases tended to occur during the second half of the study period, but sizable increases are present in the first half as well. Between 1998 and 2002, 53 percent of markets experienced increases in HHI of 100 points or more, and 25 percent saw increases of 500 or more points. The corresponding figures for 2002 to 2006 are 78 and 53 percent, respectively. The Merger Guidelines provide a helpful frame of reference for interpreting these changes. According to the Guidelines, mergers resulting in an increase of 100 or more points when HHI already exceeds 1,800 are “presumed ... likely to create or enhance market power or facilitate its exercise.” There is wide variation in the magnitude of changes in HHI across markets, notwithstanding the fact that most are positive.

The reasons for these changes in HHI can be subdivided into “structural” (related to entry, exit, and consolidation) and “nonstructural” sources. Using data on fully insured HMOs only, Scanlon, Chernew, Swaminathan, and Lee (2006) report that 61 to 65 percent of the variation in HHI between 1998 and 2002 is attributable to structural changes. These changes are also important in our sample: the mean number of carriers per market declined from 18.9 in 1998 to 9.6 in 2006.<sup>13</sup> Of course, neither source of HHI change can be presumed exogenous to other determinants of premium growth. Consumer preferences simultaneously determine market shares and premium growth, and exit and consolidation of carriers may be impacted by expectations of premium growth.

<sup>11</sup>To gauge the impact of this change on concentration, consider the following two examples. A market with five insurers, four of which have a market share of 23.75 percent, would have an HHI of 2,281. A market with four insurers, three of which each have a market share of 31.33 percent, would have an HHI of 2,981.

<sup>12</sup>AMA *ibid*; GAO (2009a).

<sup>13</sup>As the data on HHI suggest, many of these carriers are quite small. This is due to the presence of many small self-insured plan administrators, particularly in the earlier part of the study period. Some of these administrators may not be active participants in a given market, i.e., they “rent networks” from other carriers so as to offer a particular client a consistent plan across all geographies.

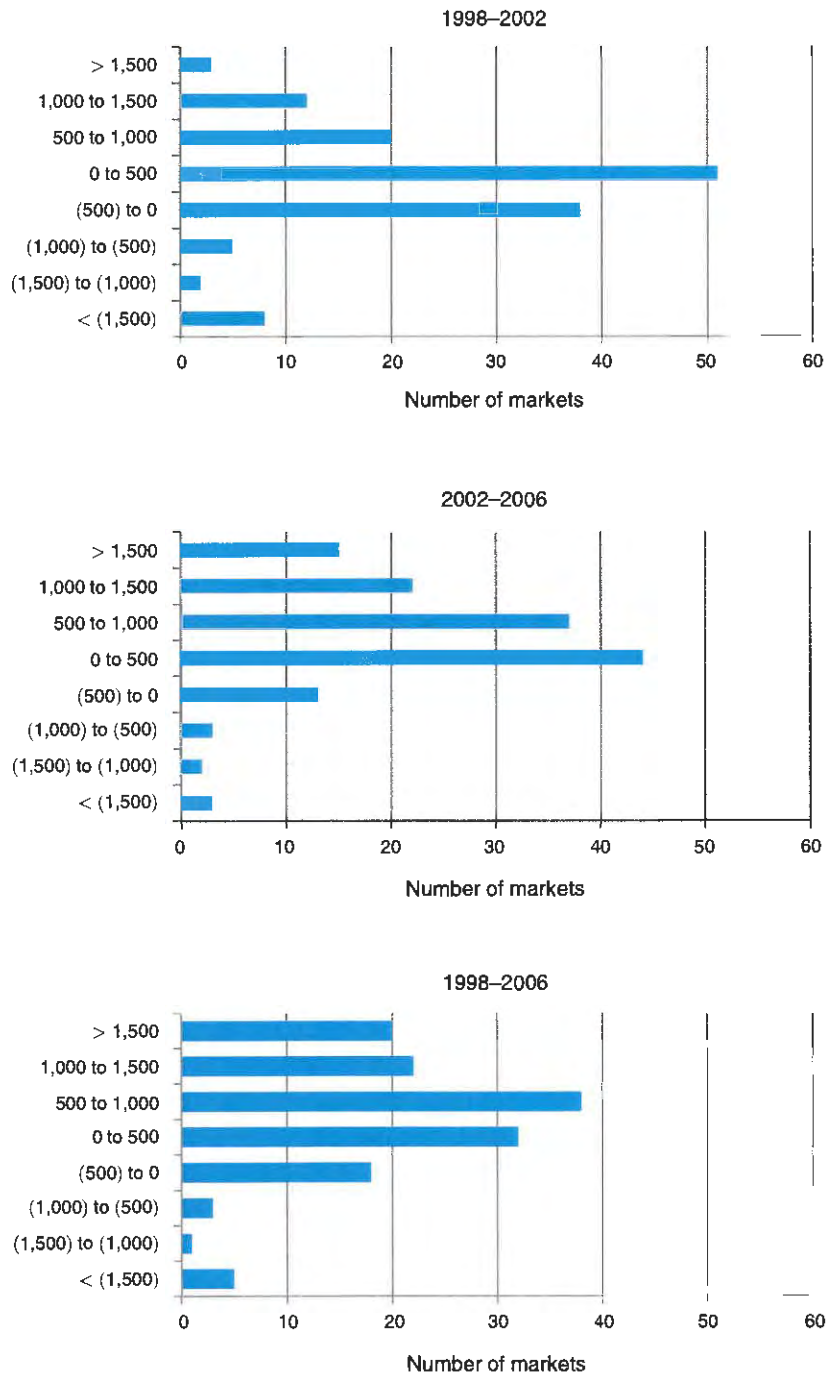


FIGURE 1. CHANGE IN LOCAL MARKET HERFINDAHL

Note: HHI is scaled from 0 to 10,000.

### B. OLS Estimates of the Relationship between Market Structure and Premiums

To explore the relationship between premium growth and market concentration, we begin by estimating equations of the following form:

$$(1) \Delta \ln(\text{premium})_{emt} = \alpha + \beta \text{HHI}_{mt-1} + \phi X_{mt-1} + \rho \Delta C_{emt} + \tau_t + \lambda_m \\ [+ \varsigma_e][+ \omega \Delta \text{plan type shares}_{emu} + \vartheta \Delta \text{plan design}_{emt}] \\ + \varepsilon_{emt}.$$

In this specification, we model premium growth between year  $t - 1$  and year  $t$  for a given employer  $e$  in market  $m$  as a function of lagged market characteristics (including HHI),<sup>14</sup> contemporaneous changes in observable characteristics of the insured population (such as demographics), and year and market fixed effects. Market characteristics are lagged by one year because premiums are set prospectively, i.e., premiums for 2006 are determined in 2005. In addition to HHI, the market-year covariates (denoted by  $X_{mt-1}$ ) include the unemployment rate (to capture local economic conditions), the log of per-capita Medicare costs (to capture trends in health-care utilization), and the general, acute-care hospital HHI (to capture concentration in the provider market, which could independently lead to premium increases). Note these characteristics are included in level form (rather than first differences) to allow for a delayed response to changes in market structure or in local economic conditions.<sup>15</sup>

In contrast, we anticipate concurrent premium responses to changes in characteristics measured at the employer-market-year level ( $\Delta C_{emt}$ ), specifically demographic factors and the percentage of enrollees in self-insured plans. The year fixed effects capture average national changes in premium growth, and the market fixed effects capture differences in average growth rates across markets. Finally, we also estimate specifications including the terms in brackets: employer fixed effects, changes in the share of enrollees in each plan type, and changes in the average generosity of these plans.<sup>16</sup>

Results are presented in columns 1 through 3 of Table 2. There is no significant association between concentration levels and premium growth, and the estimates change little upon inclusion of additional controls.<sup>17</sup> Of course, causality can be inferred from this model only if within-market variation in insurer concentration is uncorrelated with other unobserved determinants of premiums, and if variation in premium growth does not induce variation in concentration. As previously noted,

<sup>14</sup>From a theoretical standpoint, HHI is a valid measure of competition if firms compete à la Cournot. While the Cournot model does not accurately describe the health insurance market, we follow the lead of most prior studies in the related literature, as well as the Horizontal Merger Guidelines, in adopting the HHI as a measure of competition.

<sup>15</sup>Given the inclusion of market fixed effects in equation (1), the coefficients on market-year covariates (including HHI) are identified by within-market changes in these variables.

<sup>16</sup>Note that employer fixed effects will substantially affect the coefficient on HHI only if employers with high or low growth in premiums are systematically located in markets that have high or low levels of HHI.

<sup>17</sup>The estimates are similarly small in magnitude and statistically insignificant if we use the change in HHI in place of the level of HHI as the key explanatory variable. For the most part, the coefficient estimates on the market-level control variables are statistically insignificant. The coefficient estimates on the employer-market controls are highly significant and generally have the expected signs. For example, a shift from 100 percent enrollment in POS plans (the omitted category) to 100 percent enrollment in HMO plans is associated with a 5 percent decline in premiums.

TABLE 2—EFFECT OF CONSOLIDATION ON PREMIUMS (OLS MODELS)  
(Study Period: 1998–2006)

	Dependent variable = annual change in ln(premiums)		
	(1)	(2)	(3)
Lagged HHI	0.002 (0.010)	−0.004 (0.009)	−0.005 (0.009)
Market-year controls			
Lagged ln(Medicare costs per cap)	−0.015 (0.016)	−0.020 (0.016)	−0.019 (0.016)
Lagged unemployment rate	0.118 (0.098)	0.147 (0.090)	0.158* (0.092)
Lagged hospital HHI	0.008 (0.016)	−0.003 (0.015)	0.001 (0.015)
<i>Employer-market controls</i>			
Δ Demographic factor	0.303*** (0.004)	0.314*** (0.004)	0.311*** (0.004)
Δ Fraction of self-insured employees	0.028*** (0.005)	0.032*** (0.005)	0.024*** (0.004)
Δ Plan design			0.349*** (0.022)
Δ Fraction in indemnity plans			0.085*** (0.006)
Δ Fraction in HMO plans			−0.052*** (0.006)
Δ Fraction in PPO plans			0.002 (0.003)
Employer FE	No	Yes	Yes
Observations	66,906	66,906	66,906

Notes: The unit of observation is the employer-market-year. All specifications include market and year fixed effects. HHI is scaled from 0 to 1. Standard errors are clustered by market.

\*\*\* Significant at the 1 percent level.

\*\* Significant at the 5 percent level.

\* Significant at the 10 percent level.

there are good reasons to doubt the validity of these assumptions. Hence, in the section that follows we pursue an instrumental variables approach.

### III. Do Increases in Local Market Concentration Cause Increases in Premiums?

In this section, we estimate the causal effect of changes in market concentration on premium growth by exploiting shocks to local market concentration produced by mergers and acquisitions (M&A).<sup>18</sup> Because M&A activity in local or regional markets may itself be motivated by expected trends in premium growth, we considered only large, nonlocal mergers as candidates for this analysis. We also ruled out mergers with insufficient pre or post periods (e.g., Aetna and NYLCare in 1998, the

<sup>18</sup>Our approach is similar in spirit to that of Hastings and Gilbert (2005), who use an acquisition of a West Coast refinery as a source of exogenous variation in the degree of vertical integration across retail gasoline markets in 13 West Coast metropolitan areas. They find that nonintegrated rival stations face higher costs, controlling for several time-varying station characteristics.

first year for which we have data), few overlapping markets, or very small shares in our sample for one of the merging parties (e.g., United Healthcare and MAMSI).

Only one merger remained: the Aetna-Prudential merger of 1999. Postmerger, the new firm (known as “Aetna”) was widely reported to be the nation’s largest insurer, covering 21 million individuals.<sup>19</sup> As we describe in detail below, there was substantial overlap in the local market participation of Aetna and Prudential prior to the merger, generating the potential for sizable postmerger changes in market concentration. Online Appendix 2 provides additional discussion of the circumstances surrounding the merger. Importantly, there is no *ex ante* evidence that Aetna targeted Prudential because of expectations about premium growth or changes in insurer concentration in affected markets.

Our analysis is subdivided into four sections. First, we estimate the impact of the merger on market concentration (the “first stage” analysis). In so doing, we document the range of premerger market shares for Aetna and Prudential as well as the degree of premerger overlap. Second, we perform a reduced-form analysis, in which we examine the impact of the merger on premium growth. Third, we combine these analyses to produce our estimate of the causal impact of concentration on premiums. Last, we investigate the plausibility of alternative explanations for our findings. In particular, we estimate specifications to tease out the reaction of Aetna’s *rivals*, as these responses are informative *vis-à-vis* the market dynamics.

#### A. The Effect of the Aetna-Prudential Merger on Market Concentration

Immediately prior to the merger in 1999, Aetna and Prudential were the third and fifth largest insurers in our sample in terms of the number of enrollees. All 139 markets included plans offered by both firms. There was significant variation across markets, however, in the premerger shares of each firm. We hypothesize that markets served by both firms experienced increases in market concentration immediately following the merger, and that these increases varied by the premerger shares of the two merging firms. Specifically, for every market we calculate the “simulated change in HHI” ( $\text{sim } \Delta \text{HHI}_m$ ) as the merger-induced *change* in market  $m$ ’s HHI that would have occurred from 1999 to 2000 absent any other changes, i.e.,

$$\begin{aligned} (2) \quad \text{sim } \Delta \text{HHI}_m &= [\text{Aetna 1999 share}_m + \text{Pru 1999 share}_m]^2 \\ &\quad - [(\text{Aetna 1999 share}_m)^2 + (\text{Pru 1999 share}_m)^2] \\ &= 2 \times \text{Aetna 1999 share}_m \times \text{Pru 1999 share}_m. \end{aligned}$$

For example, if Aetna and Prudential had market shares of 10 percent each in 1999,  $\text{sim } \Delta \text{HHI}_m$  (scaled by 10,000 as discussed above) would equal 200.

Figure 2 provides detail on the actual distribution of  $\text{sim } \Delta \text{HHI}_m$  in the 139 LEHID markets. There is significant variation in this measure, with 46 largely unaffected markets ( $\text{sim } \Delta \text{HHI}_m < 10$ ) and 42 highly affected markets ( $\text{sim } \Delta \text{HHI}_m \geq 100$ ).

<sup>19</sup> Sanders, “Will the Aetna-Prudential Merger Hurt the Patient?” *TIME*, June 22, 1999.

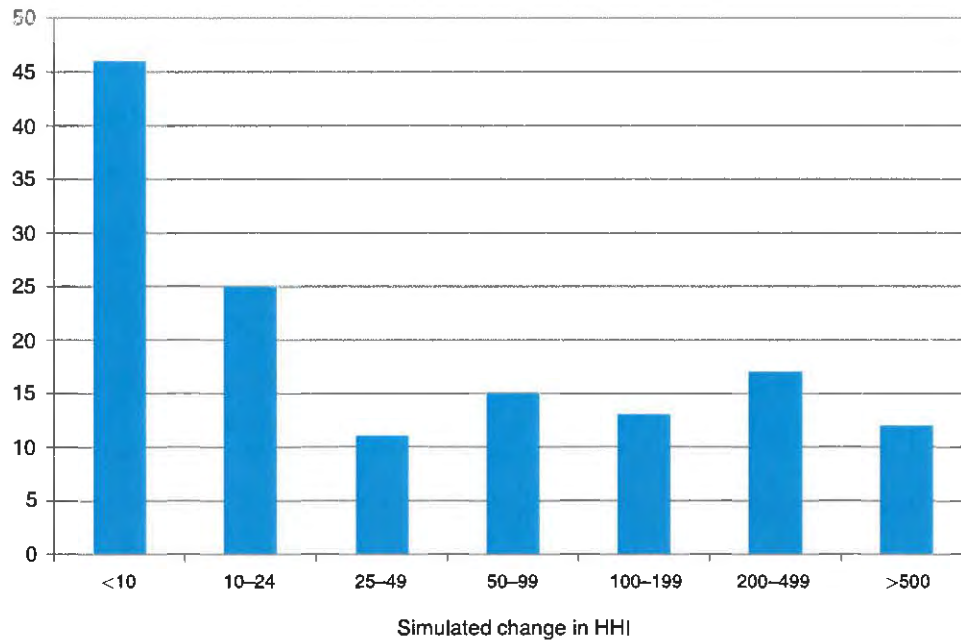


FIGURE 2. DISTRIBUTION OF SIMULATED CHANGE IN HHI RESULTING FROM AETNA-PRUDENTIAL MERGER

Notes:  $N = 139$ .  $HHI$  is scaled from 0 to 10,000.

One state in particular stands out for its high levels of  $\text{sim } \Delta HHI_m$ : Texas. Five of the six markets in Texas have  $\text{sim } \Delta HHI_m$  greater than 500. The high degree of overlap in Texas provoked action by the Department of Justice. To address the concerns raised by the Department, Aetna agreed to divest the Texas-based HMO businesses it had acquired from NYLCare in 1998.<sup>20</sup> We therefore examine whether the consent decree in Texas successfully neutralized the effect of the merger in these markets; to the extent it did, markets in Texas can serve as a “placebo” group for the natural experiment we study.

We propose to use  $\text{sim } \Delta HHI_m \times \text{post}_t$  as an instrument for  $HHI$  in equation (1), where  $\text{post}$  is an indicator variable for the postmerger years in the sample. To evaluate this instrument, we estimate the following equation using market-year data, initially excluding observations from Texas:

$$(3) \quad HHI_{mt} = \alpha + \lambda_m + \tau_t + \beta \text{sim } \Delta HHI_m \times \tau_t + \varepsilon_{mt}.$$

<sup>20</sup>DOJ alleged that after the merger, Aetna would have a market share for fully insured HMOs of 63 percent in Houston, and 42 percent in Dallas. DOJ stated that “The required divestitures... will preserve competition and protect consumers from higher prices” and “deny Aetna the ability to unduly depress physician reimbursement rates.” See <http://www.justice.gov/opa/pr/1999/June/263at.htm>. Although the allegations pertained to Houston and Dallas, because Aetna divested all NYLCare plans in Texas, the consent decree affected the entire state. Source: “Blue Cross and Blue Shield of Texas to Purchase NYLCare Texas Operations,” Aetna press release, 9/14/1999, [http://www.aetna.com/news/1999/pr\\_19990914.htm](http://www.aetna.com/news/1999/pr_19990914.htm).

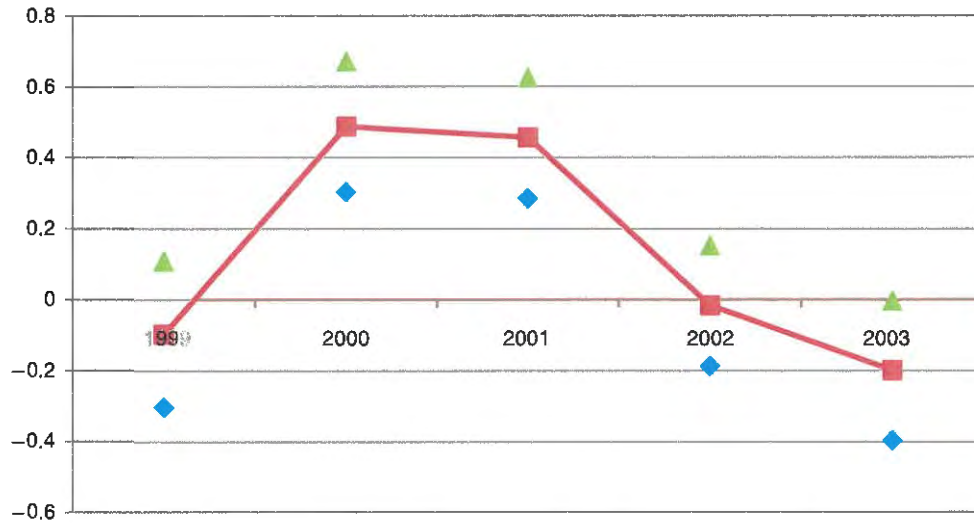


FIGURE 3. ESTIMATED COEFFICIENTS AND 95 PERCENT CONFIDENCE INTERVALS FROM REGRESSION OF HHI ON SIMULATED CHANGE IN HHI

Note: Coefficients and standard errors are reported in column 1 of Table 3.

The vectors denoted by  $\lambda_m$  and  $\tau_t$  represent a full set of market and year fixed effects, respectively. By interacting  $\text{sim} \Delta HHI_m$  with separate indicators for each year (except 1998, the omitted category), this model investigates the possibility that trends in market concentration may have been different prior to the merger in markets differentially impacted by the merger. The estimated coefficients will also help to determine the appropriate study period for our analysis. In this and all specifications including  $\text{sim} HHI_m$ , we use a scale of 0 to 1 for this measure.

Figure 3 graphs the coefficient estimates on the yearly interactions with  $\text{sim} \Delta HHI_m$ , together with the 95 percent confidence intervals. The sample includes data from 1998 to 2003. Estimates are presented in numerical form in column 1 of Table 3. Relative to the omitted interaction term,  $\text{sim} \Delta HHI_m \times (\text{year} = 1998)$ , only the interactions with indicators for 2000 and 2001 are statistically significant. At  $-0.10$ , the coefficient estimate for  $\beta$  in 1999 is small and (insignificantly) negative, whereas estimates for  $\beta$  in 2000 and 2001 are large (0.49 and 0.46, respectively) and significant at the 5 percent level. The timing is consistent with expectations: the merger was effectively cleared in July 1999, when the Department of Justice submitted its Proposed Final Judgment. The coefficients in 2000 and 2001 are significantly smaller than 1, implying that employers to some extent substituted away from Aetna and Prudential in the wake of the merger. In addition, there is likely attenuation bias due to measurement error, as we have only a sample (rather than a census) of insurance contracts.

The coefficient estimates of  $\beta$  in 2002 and 2003 are both noisy and negative indicating that the merger-induced shocks to local concentration dissipated quickly.<sup>21</sup> In

<sup>21</sup>This finding is consistent with reports from industry experts. According to a 2004 *Health Affairs* article by Robinson, "[G]ossip speculates [Aetna] would be lucky to still have 30,000 of the 5 million it acquired from Prudential."



TABLE 3—EFFECT OF THE AETNA-PRUDENTIAL MERGER ON MARKET CONCENTRATION  
(Dependent Variable = HHI)

	1998–2003 (1)	1998–2001 (2)	1998–2001 (3)	1998–2001 (4)
<i>Sim Δ HHI</i> × (year = 1999)	−0.097 (0.180)			
<i>Sim Δ HHI</i> × (year = 2000)	0.487** (0.204)			
<i>Sim Δ HHI</i> × (year = 2001)	0.455** (0.194)			
<i>Sim Δ HHI</i> × (year = 2002)	−0.017 (0.205)			
<i>Sim Δ HHI</i> × (year = 2003)	−0.199 (0.248)			
<i>Sim Δ HHI</i> × (year ≥ 2000)		0.520*** (0.166)	0.512*** (0.165)	0.520*** (0.166)
<i>Sim Δ HHI</i> × (year ≥ 2000) × (Texas = 1)			−0.646*** (0.224)	−1.262*** (0.291)
<i>Texas</i> × (year ≥ 2000)				0.052 (0.037)
Texas included?	No	No	Yes	Yes
Observations	798	532	556	556
<i>R</i> <sup>2</sup>	0.677	0.674	0.677	0.678

Notes: The unit of observation is the market-year. All specifications include market and year fixed effects. HHI is scaled from 0 to 1. Standard errors are clustered by market.

\*\*\*Significant at the 1 percent level.

\*\*Significant at the 5 percent level.

\*Significant at the 10 percent level.

order to use the merger as an instrument for market concentration, we must therefore focus our analyses on the early years of our sample: 1998–2001 for the first-stage model, and 1998–2002 for the second stage (because HHI impacts premiums with a lag). However, in Section IIIB below, we discuss reduced-form analyses of the longer-term impact of changes in simulated HHI on health insurance premiums by extending the study period out to 2006.

Next, we use data from 1998 through 2001 to estimate a more parsimonious model that replaces the individual year interactions with a single “post” indicator that takes a value of one during 2000 and 2001:

$$\begin{aligned}
 (4) \quad HHI_{mt} = & \alpha + \lambda_m + \tau_t + \beta_0 \text{sim} \Delta HHI_m \times \text{post}_t \\
 & + [\beta_1 \text{sim} \Delta HHI_m \times \text{post}_t \times \text{Texas}_m] + [\psi \text{post}_t \times \text{Texas}_m] \\
 & + \varepsilon_{mt}.
 \end{aligned}$$

After estimating the baseline model (which excludes the terms in brackets), we add the six Texas markets to the sample and include a triple-interaction,

$\text{sim} \Delta HHI_m \times \text{post}_t \times \text{Texas}_m$ , to explore whether the post-merger impact of  $\text{sim} \Delta HHI$  differs in these markets. We then add the term  $\text{post}_t \times \text{Texas}_m$  to control for average changes in Texas as compared to other states during the post period, although it may be difficult to separately identify the coefficient on the two Texas interactions because there are only six Texas markets and two post years.

The results are displayed in column 2 of Table 3. As anticipated, the coefficient on  $\text{sim} \Delta HHI_m \times \text{post}_t$  is statistically significant: 0.52, with a standard error of 0.17. The results in columns 3 and 4 show that the federal government achieved its objective of neutralizing the merger's effect on market concentration in Texas markets. The triple-interaction term for Texas markets is negative and statistically significant in both specifications and fully offsets the impact of the merger. In both models, we cannot reject the hypothesis that the sum of the relevant double- and triple-interaction terms equals zero. Observations from Texas are therefore suitable for the placebo test (or falsification exercise) previously noted. If premium growth has a similar relationship with  $\text{sim} \Delta HHI$  in Texas as in other parts of the United States, then changes in insurer concentration may not be driving the observed relationship.

### B. The Effect of the Aetna-Prudential Merger on Health Insurance Premiums

To investigate the effect of merger-induced increases in local market concentration on plan premiums, we estimate models of the following form:<sup>22</sup>

$$\begin{aligned} (5) \Delta \ln(\text{premium})_{emt} = & \alpha + \kappa_0 \text{sim} \Delta HHI_m \times \text{post}_t + \phi X_{mt-1} + \rho \Delta C_{emt} \\ & + \tau_t + \lambda_m [+ \varsigma_e] [+ \omega \Delta \text{plan type shares}_{emt} \\ & + \vartheta \Delta \text{plan design}_{emt}] \\ & [+ \kappa_1 \text{sim} \Delta HHI_m \times \text{post}_t \times \text{Texas}_m] \\ & [+ \gamma \text{post}_t \times \text{Texas}_m] + \varepsilon_{emt}. \end{aligned}$$

In light of the results from the preceding section, we focus on the period between 1998 and 2002 (i.e., annual premium growth from 1998–1999, 1999–2000, 2000–2001, and 2001–2002). Note that in this model  $\text{post}_t$  takes a value of one for the 2000–2001 and 2001–2002 changes, and is otherwise equal to zero.<sup>23</sup> As in the OLS regressions presented in Section II, we begin with a parsimonious specification that controls for lagged market covariates and changes in employer-market characteristics, as well as fixed differences across years and markets in average premium growth (captured respectively by year and market fixed effects, denoted  $\tau_t$  and  $\lambda_m$ ).

The results are reported in column 1 of Table 4. The estimated coefficient on  $\text{sim} \Delta HHI_m \times \text{post}_t$  is positive and statistically significant. Given the mean

<sup>22</sup>In a companion set of specifications (results available upon request), we define the outcome variable to be  $\ln(\text{premium})$  (rather than the change in this measure) and include market time trends. The results are similar to those presented in this section.

<sup>23</sup>Recall the last year of the merger-induced HHI increase was 2001, and premiums for 2002 are set in 2001.

TABLE 4—MERGER EFFECTS ON PREMIUMS  
(Study Period: 1998–2002)

	Dependent variable = annual change in ln(premiums)					
	(1)	(2)	(3)	(4)	(5)	(6)
<i>Sim</i> $\Delta HHI \times (\text{year} \geq 2001)$	0.177*** (0.056)	0.202*** (0.048)	0.186*** (0.050)		0.193*** (0.049)	0.188*** (0.049)
<i>Sim</i> $\Delta HHI \times (\text{year} = 2000)$				0.011 (0.061)		
<i>Sim</i> $\Delta HHI \times (\text{year} = 2001)$				0.181** (0.071)		
<i>Sim</i> $\Delta HHI \times (\text{year} = 2002)$				0.200*** (0.067)		
<i>Sim</i> $\Delta HHI \times (\text{year} \geq 2001)$ $\times (\text{Texas} = 1)$					-0.238*** (0.069)	-0.056 (0.191)
$(\text{Year} \geq 2001) \times (\text{Texas} = 1)$						0.016 (0.017)
<i>Market-year controls</i>						
Lagged ln(Medicare costs per cap)	-0.029 (0.034)	-0.047 (0.036)	-0.039 (0.036)	-0.040 (0.036)	-0.046 (0.033)	-0.048 (0.033)
Lagged unemployment rate	0.479*** (0.174)	0.579*** (0.161)	0.567*** (0.155)	0.570*** (0.155)	0.575*** (0.152)	0.535*** (0.152)
Lagged hospital HHI	0.003 (0.022)	-0.004 (0.021)	0.003 (0.020)	0.003 (0.020)	-0.010 (0.020)	-0.008 (0.020)
<i>Employer-market controls</i>						
$\Delta$ Demographic factor	0.304*** (0.006)	0.328*** (0.005)	0.323*** (0.006)	0.323*** (0.006)	0.324*** (0.005)	0.324*** (0.005)
$\Delta$ Fraction of self-insured employees	0.048*** (0.007)	0.054*** (0.007)	0.019*** (0.006)	0.019*** (0.006)	0.017*** (0.006)	0.017*** (0.006)
$\Delta$ Plan design			0.223*** (0.040)	0.223*** (0.040)	0.210*** (0.040)	0.211*** (0.040)
$\Delta$ Fraction in indemnity plans			0.089*** (0.008)	0.089*** (0.008)	0.091*** (0.008)	0.091*** (0.008)
$\Delta$ Fraction in HMO plans			-0.081*** (0.009)	-0.081*** (0.009)	-0.084*** (0.009)	-0.084*** (0.009)
$\Delta$ Fraction in PPO plans			0.000 (0.006)	0.000 (0.006)	-0.001 (0.006)	-0.001 (0.006)
Employer FE	No	Yes	Yes	Yes	Yes	Yes
Texas observations included?	No	No	No	No	Yes	Yes
Observations	28,645	28,645	28,645	28,645	30,493	30,493

Notes: The unit of observation is the employer-market-year. All specifications include market and year fixed effects. HHI is scaled from 0 to 1. Standard errors are clustered by market.

\*\*\*Significant at the 1 percent level.

\*\*Significant at the 5 percent level.

\*Significant at the 10 percent level.

$\text{sim} \Delta HHI_m$  of 0.014 (across all 139 geographic markets), the point estimate of 0.177 implies that, in a typical market, the merger induced an average premium increase of approximately 0.25 percent in both 2001 and 2002, and thus a total increase of approximately 0.50 percent. The point estimate changes little upon inclusion of employer fixed effects (column 2), and as expected the standard errors decrease. Adding controls for changes in the generosity of plans (column 3) also has little impact on the estimate.

Next, we study the pattern of premium growth over time by replacing the term  $\text{sim} \Delta \text{HHI}_m \times \text{post}_t$  with  $\text{sim} \Delta \text{HHI}_m \times \tau_t$  (interactions with individual year dummies, with 1998 as the omitted year). The results, in column 4, provide two key insights. First, there is no evidence of a “pretrend” in premium growth; that is, the estimated reaction to the merger is not due to a premerger trend in markets with large overlapping Aetna and Prudential market shares. Second, the effect of the merger on premium growth is very similar in both “post” years.

This finding strongly suggests that the impact of the merger is appropriately modeled, i.e., that concentration affects the growth rate rather than the level of premiums.<sup>24</sup> If the sample is extended to 2006, we find the coefficients remain of similar magnitude for two more years, and then fall down close to zero.<sup>25</sup> The fact that the coefficient estimates remain positive and do not become negative suggests some amount of hysteresis: consolidation results in a higher rate of premium growth, and even when circumstances change (in this case, the effect of the merger on concentration eventually disappeared) premiums remain elevated.<sup>26</sup>

Columns 5 and 6 of Table 4 present the results of the falsification test enabled by the divestiture requirement in Texas. To execute this test, we add Texas observations to the sample and estimate the full model (as in column 3) with the addition of a triple interaction term,  $\text{sim} \Delta \text{HHI}_m \times \text{post}_t \times \text{Texas}_m$ .<sup>27</sup> The estimated coefficient on this term is highly significant and negative (−0.24) and almost perfectly offsets the main effect of  $\text{sim} \Delta \text{HHI}_m$  in this specification (0.19). Although the result is not robust to including a separate term for  $\text{post}_t \times \text{Texas}_m$  (column 6), this is not surprising given there are only six markets in Texas and just two post years. On net, the results suggest that the market power effect of the merger in Texas was indeed neutralized by the DOJ’s actions.<sup>28</sup>

### C. IV Estimates

Table 5 presents the first-stage, reduced-form, and second-stage models corresponding to our IV estimate; the reduced-form model is repeated from column 3 of Table 4. At 0.39, the estimated effect of lagged HHI on premium growth is positive, statistically significant, and roughly twice as large as the reduced-form estimate. This is anticipated given the first-stage coefficient of 0.48 reported in column 1.<sup>29</sup>

Because our estimates suggest that changes in HHI affect the growth *rate* (rather than just the level) of premiums, to estimate the average effect of consolidation over the entire study period, we must consider the timing of consolidation between 1998

<sup>24</sup> An alternative explanation is that an increase in concentration does raise the level (rather than the growth rate) of premiums, but it takes multiple years to reach the new level.

<sup>25</sup> To be precise, the coefficients on interactions of the simulated change in HHI with indicators for 2003 and 2004 are 0.293 and 0.203 respectively, and are both significant with  $p < 0.01$ .

<sup>26</sup> As noted earlier, the results of the first stage necessitate a study period ending in 2002. However, the results just described suggest the estimates will be conservative.

<sup>27</sup> Note a second-order interaction (i.e.,  $\text{post}_t \times \text{Texas}_m$ ) is arguably not necessary in this model as market fixed effects already control for differences in average annual growth rates across markets.

<sup>28</sup> As an additional extension of the reduced-form analysis, we examined whether the impact of the merger was greater in markets with higher initial levels of concentration. Unfortunately, coefficient estimates on  $\text{sim} \Delta \text{HHI}_m \times \text{post}_t \times \text{initial HHI}_m$  (and variants thereof) were very imprecise.

<sup>29</sup> Note this first-stage coefficient differs slightly from the coefficient obtained using market-year data, as the unit of observation is the employer-market-year.

TABLE 5—THE IMPACT OF HHI ON PREMIUMS  
(Study Period: 1998–2002)

	Dep var = lagged HHI	Dep var = annual change in ln (premium)		
	First-stage estimates	Reduced-form estimates	IV estimates	OLS estimates
<i>Sim</i> $\Delta$ HHI $\times$ (year $\geq$ 2001)	0.475*** (0.014)	0.186*** (0.050)		
Lagged HHI			0.391*** (0.130)	0.015 (0.018)
<i>Market-year controls</i>				
Lagged ln(medicare costs per cap)	0.034** (0.014)	−0.039 (0.036)	−0.052 (0.037)	−0.018 (0.034)
Lagged unemployment rate	0.204*** (0.048)	0.567*** (0.155)	0.488*** (0.163)	0.474*** (0.162)
Lagged hospital HHI	−0.060*** (0.007)	0.003 (0.020)	0.026 (0.022)	0.006 (0.020)
<i>Employer-market controls</i>				
$\Delta$ Demographic factor	0.004*** (0.001)	0.323*** (0.006)	0.321*** (0.004)	0.323*** (0.003)
$\Delta$ Fraction of self-insured employees	0.000 (0.001)	0.019*** (0.006)	0.019*** (0.004)	0.019*** (0.004)
$\Delta$ Plan design	0.019* (0.010)	0.223*** (0.040)	0.216*** (0.028)	0.222*** (0.027)
$\Delta$ Fraction in indemnity plans	0.001 (0.002)	0.089*** (0.008)	0.089*** (0.005)	0.089*** (0.005)
$\Delta$ Fraction in HMO plans	−0.003 (0.002)	−0.081*** (0.009)	−0.080*** (0.006)	−0.081*** (0.006)
$\Delta$ Fraction in PPO plans	0.001 (0.002)	0.000 (0.006)	0.000 (0.005)	0.001 (0.005)
Observations	28,645	28,645	28,645	28,645

Notes: The unit of observation is the employer-market-year. All specifications include employer, market, and year fixed effects. HHI is scaled from 0 to 1. Standard errors are clustered by market.

\*\*\*Significant at the 1 percent level.

\*\*Significant at the 5 percent level.

\*Significant at the 10 percent level.

and 2006. As previously noted, the average increase in HHI across all markets was 698 points during this period. If this increase were evenly distributed over time, the effect of consolidation on premiums during our study period would be approximately 13 percent. However, consolidations tended to occur later in the study period, yielding a cumulative estimated effect of approximately 7 percent.<sup>30</sup>

For the sake of comparison, we also present coefficient estimates obtained using OLS models, in which lagged HHI is the predictor of interest. As noted before, OLS estimates are likely to be downward biased, understating the actual impact of changes in market concentration on premiums. Indeed, the coefficient from the OLS model (presented in column 4) is near zero (and imprecisely estimated).

<sup>30</sup>Details of our calculation are available in online Appendix 3. If one assumes that an increase in concentration between  $t$  and  $t + 1$  affects premium growth for only two years (i.e., until  $t + 3$ , rather than indefinitely), then the implied increase in premiums caused by the increase in HHI between 1998 and 2006 is somewhat lower at 5 percent.

Hausman specification tests reject the null assumption of consistency for this model ( $p < 0.01$ ), underscoring the need for instrumental variables estimation.

Collectively, the results presented in this section show that consolidation does result in a “premium on premiums.” We arrive at this conclusion by exploiting arguably exogenous increases in local market concentration caused by the nationwide merger between two large insurance firms, Aetna and Prudential. Two key results indicate our conclusions are not driven by unobserved factors correlated with the pre-merger market shares of Aetna and Prudential. First, there is no evidence that concentration *or* premiums in markets with higher *sim*  $\Delta HHI$  were trending differently before the merger took effect. Second, we find no response in Texas, where the merger was effectively blocked by the Department of Justice. These tests support the use of *sim*  $\Delta HHI_m$  as an instrument for *lagged*  $HHI_m$ . In online Appendix 4, we examine the impact of consolidation on health plan characteristics other than price, such as *plan design* and the share of employees enrolled in HMOs.<sup>31</sup>

#### D. Alternative Explanations

The findings summarized above are consistent with the exercise of market power in the wake of consolidation. However, the pattern of results is also consistent with alternative explanations, in particular a “mistake” in Aetna’s postmerger pricing strategy, and/or increases in insurance quality (and therefore price). In this section, we discuss the evidence with regard to these alternative hypotheses.

Our results show that prices increase *on average* in markets with higher *sim*  $\Delta HHI_m$ . If this price increase is primarily due to actions by Aetna, then Aetna’s subsequent loss of market share would suggest the price increase was unsuccessful, i.e., they were not able to exercise market power following the merger. On the other hand, if competitors followed suit by increasing their prices as well, that would suggest that Aetna’s action softened competition marketwide, implying the presence (and exercise) of market power.

To investigate whether Aetna’s competitors increased their premiums in response to the merger, we estimate a set of specifications analogous to those in Table 4 for the 61 percent of employer-markets that were *not served* by either Aetna or Prudential at the time of the merger in 1999. Our point estimates for the coefficient of particular interest ( $\kappa_0$  from equation (5)) are similar to the estimates for the full sample, as shown in online Appendix 5. This implies that insurers not directly involved in the merger responded to the merger-induced change in concentration by raising their premiums, which supports the market-power explanation for our findings.

Importantly, when we restrict the sample to employer-markets that *were served* (either partially or fully) by Aetna or Prudential at the time of the merger, our estimates for  $\kappa_0$  are approximately twice as large. This suggests that the merged entity increased its premiums more than its competitors in markets where Aetna and Prudential had significant overlap, which is consistent with the merged entity

<sup>31</sup> Among other results, we find that employers reduced the generosity of *plan design*. This is consistent with efforts by employers to reduce the burden of higher insurance premiums through so-called “benefit buybacks.” We emphasize that our premium results *do* control for changes in plan design. We find a somewhat counterintuitive shift *away* from HMOs; however, we discuss plausible explanations for this pattern in online Appendix 4.

exercising price leadership and its oligopolistic rivals following. Last, it is notable that premiums remained elevated in high-*sim*  $\Delta HHI$  markets through at least 2006, notwithstanding Aetna's loss of market share by 2002. This hysteresis in market price is again consistent with a new oligopolistic pricing equilibrium facilitated by Aetna's original exercise of market power.

The second alternative explanation, that Aetna raised quality and competitors followed its lead, is less amenable to exploration using our data. Conceptually, there are at least two reasons to question this hypothesis. First, quality is "lumpy" (e.g., enhancing consumer access to claims) and far more difficult to calibrate across different markets than price. Second, quality changes take time to implement and to communicate to the marketplace, and the impact of the merger on price occurs within the first year. These points notwithstanding, quality remains an important omitted factor in our analysis.

#### IV. Evaluating the Effects of Insurer Consolidation on Providers

Thus far, we have examined the impact of market structure in the insurance industry on downstream buyers, specifically of group plans. However, the degree of competition in the insurance industry will also potentially affect upstream suppliers, such as health-care providers, pharmaceutical firms, and medical device manufacturers. To the extent that suppliers have few outside options, a lack of vigorous competition among insurers may lead to monopsonistic practices. Capps (2010) reviews the theoretical and practical implications of monopsony in the context of health insurance mergers.<sup>32</sup>

Concern about insurers' monopsonistic practices has emanated not only from provider organizations such as the American Medical Association and the American Hospital Association but also from state and federal regulatory authorities. In fact, the DOJ's formal complaint regarding the Aetna-Prudential merger alleged that the merger "would enable Aetna to exercise monopsony power against physicians, allowing Aetna to depress physicians' reimbursement rates in Houston and Dallas, likely leading to a reduction in quantity or degradation in quality of physicians' services."<sup>33</sup>

In this section, we consider the possibility that consolidation facilitates the exercise of monopsony power by estimating the relationship between our instrument for HHI (*sim*  $\Delta HHI_m$ ) and both the employment (or "quantity") and average compensation (or "price") of health-care personnel (such as physicians and nurses). As in the premium analysis, if variation in the impact of the merger on different geographic localities can be assumed orthogonal to other determinants of employment and compensation *growth*, our results can be interpreted as causal estimates of the impact of consolidation on these outcomes.

To execute this analysis, we supplemented the LEHID data with the Occupational Employment Statistics (OES) survey on income and employment in

<sup>32</sup>A number of recent studies examine the effect of insurer bargaining power on hospital prices, including Feldman and Wholey (2001), Sorensen (2003), Moriya, Vogt, and Gaynor (2010), and Ho (2009).

<sup>33</sup>See Complaint, *United States vs. Aetna Inc.* (ND TX, 21 June 1999). More recently, the DOJ required a similar divestiture before approving a 2005 merger between United Health Group Inc. and Pacificare Health Systems Inc. Both divestitures were driven by concerns about the effect on physician services in specific markets (see Complaint, *United States vs. UnitedHealth Group Inc. and Pacificare Health Systems Inc.*, Dec 20, 2005).

health care–related occupations. We restrict our attention to the 43 occupation categories that are classified under the Standard Occupational Classification (SOC) system as “Healthcare Practitioner and Technical Occupations.” These include dentists, registered nurses, anesthesiologists, surgeons, and pharmacy technicians. To facilitate a comparison of impacts on physicians versus nurses, we pool together the eight occupation categories pertaining to physicians and the two for nurses.<sup>34</sup> Nurses are by far the largest group, accounting for 56 percent of personnel in our sample; pharmacists are second (4.3 percent), and physicians are a close third (4.2 percent). Additional details, including descriptive statistics for our sample, are available in online Appendix 6.

The unit of observation for the OES data (as well as our analysis) is the occupation-MSA-year and the variables of interest are the mean annual wage and estimated employment. Using a crosswalk that matches LEHID markets to MSAs, we merge this data with our measures of insurer concentration (including our instrument). We estimate parsimonious specifications using the change in log average earnings or employment between 1999 and 2002 as the dependent variable, and  $\text{sim} \Delta HHI$  as the main predictor:

$$\begin{aligned} (6) \quad \Delta \ln y_{os,99-02} = & \alpha + \gamma \text{sim} \Delta HHI_s + \omega \text{Physician}_o \times \text{sim} \Delta HHI_s \\ & + \vartheta \text{Nurse}_o \times \text{sim} \Delta HHI_s \\ & + \varsigma \text{Physician}_o + \theta \text{Nurse}_o + v \Delta \text{Hospital} HHI_s \\ & + [\Delta \ln y_{os,97-98} + \varsigma_o] + \varepsilon_{os}. \end{aligned}$$

The subscripts  $o$  and  $s$  denote occupation and MSA, respectively. Our baseline specification includes indicators for the physician and nurse occupation categories as well as interactions between these indicators and  $\text{sim} \Delta HHI_s$ . The indicators capture differences in earnings and employment growth for each category (relative to other health-care occupations), while the interactions reflect the differential impact of insurer consolidation on earnings and employment in these categories. In all specifications, we control for the change in hospital concentration in each market. As specification checks, we progressively add each of the terms in brackets. The first term,  $\Delta \ln y_{os,97-98}$ , represents the change in earnings or employment between 1997 and 1998 and serves as a control for preexisting trends in earnings (or employment) growth. The second term represents a full set of fixed effects for the 35 occupation categories. We necessarily restrict the sample to occupation-markets present in both 1999 and 2002, and we weight each observation by the average estimated employment in that occupation-market. Standard errors are robust and clustered by MSA.

<sup>34</sup>The categories pooled under “Physicians” are Dentists, Family and General Practitioners, General Internists, Obstetricians and Gynecologists, General Pediatricians, Psychiatrists, Podiatrists, and Surgeons. Some of the individual physician categories have low estimates for employment and are present in only a handful of markets during our study period. The “Nurses” category includes Registered Nurses (RNs) and Licensed Vocational Nurses (LVNs).



TABLE 6—EFFECT OF THE AETNA-PRUDENTIAL MERGER ON HEALTH-CARE PROVIDER EARNINGS AND EMPLOYMENT

	Dep var = $\Delta \log$ (average income) from 99–02; mean = 0.121			Dep var = $\Delta \log$ (employment) from 99–02; mean = 0.191		
<i>Simulated <math>\Delta HHI</math></i>	0.111 (0.180)	0.078 (0.215)	0.091 (0.204)	–2.372*** (0.809)	–2.723*** (0.941)	–2.437** (0.978)
Physician indicator	0.193*** (0.034)	0.184*** (0.035)	NA	0.523*** (0.170)	0.497*** (0.167)	NA
<i>Physician <math>\times</math> simulated <math>\Delta HHI</math></i>	–2.007** (0.833)	–2.180*** (0.801)	–2.195*** (0.811)	–2.507 (7.934)	–2.582 (8.441)	–2.858 (8.439)
Nurse indicator	–0.013** (0.006)	–0.015** (0.006)	NA	–0.154*** (0.025)	–0.160*** (0.027)	NA
<i>Nurse <math>\times</math> simulated <math>\Delta HHI</math></i>	0.440** (0.221)	0.471* (0.257)	0.457* (0.254)	1.707** (0.845)	2.012* (1.071)	1.738* (1.032)
$\Delta$ Hospital HHI, 1999–2002	0.023 (0.029)	0.021 (0.031)	0.024 (0.032)	–0.024 (0.254)	–0.027 (0.247)	–0.067 (0.235)
Trend in dep var, 1997–1998	No	Yes	Yes	No	Yes	Yes
Occupation fixed effects	No	No	Yes	No	No	Yes
Observations	2,110	1,631	1,631	2,110	1,631	1,631

Notes: Unit of observation is the occupation-market-year. All physician occupations are combined into one category. Specifications are restricted to occupation-markets present in both 1999 and 2002. Simulated HHI is scaled from 0 to 1. Sample does not include observations from Texas. All specifications are weighted by average estimated employment in each occupation-market. Standard errors are clustered by market.

\*\*\*Significant at the 1 percent level.

\*\*Significant at the 5 percent level.

\*Significant at the 10 percent level.

The results are presented in Table 6. Columns 1 through 3 pertain to models using the change in log average earnings from 1999–2002 as the dependent variable, while columns 4–6 use the change in log employment as the dependent variable. The coefficient estimate on *sim  $\Delta HHI$* <sub>*s*</sub> in columns 1 through 3 is positive but imprecisely estimated, implying no significant impact of the merger on average earnings across all health-care occupations. The coefficient on the physician indicator in columns 1 and 2 demonstrates that physicians experienced an increase of around 21 percent in average nominal earnings between 1999 and 2002 (relative to nonnursing health-care personnel). However, the coefficient estimate on *Physician<sub>o</sub>  $\times$  sim  $\Delta HHI$* <sub>*s*</sub> is negative and significant in all models, revealing that earnings growth for physicians was lower in markets affected by the merger. Given the average value of 0.014 for *sim  $\Delta HHI$* <sub>*s*</sub>, the point estimate implies that the merger restrained growth in physician earnings by approximately 3 percent in a typical market. The coefficient on the nurse indicator reveals that nurses experienced a small decrease in relative earnings over the same time period. However, the interaction term for nurses is positive and statistically significant, implying this decrease was offset at least in part in markets where Aetna and Prudential had premerger overlap (by approximately 0.6 percent in the typical market).

Columns 4 through 6 present estimates from specifications examining the impact of the merger on employment. The coefficients are again similar across all models. Relative to other health-care occupations, employment of physicians increased, while that of nurses decreased, during the study period. The point estimate on *sim  $\Delta HHI$* <sub>*s*</sub> is negative and significant: in a typical market, the merger led to a drop in health care–related employment of 2.7 percent. The interaction between the physician indicator

and  $\text{sim} \Delta HHI_s$  is negative but noisily estimated, whereas the interaction between the nurse indicator and  $\text{sim} \Delta HHI_s$  is large, positive, and marginally significant. The relative increase in nurse employment in geographic markets differentially affected by the merger suggests there was some substitution toward nurses in these markets. This explanation is buttressed by the earnings regressions, which found the merger depressed growth in physicians' earnings while modestly boosting nurses' earnings.<sup>35</sup>

To summarize, we find that increases in market concentration predicted to occur in the wake of the Aetna-Prudential merger resulted in pronounced declines in health care–related employment. These declines were smaller for nurses than for other occupations on average (including physicians), and nurses also enjoyed wage increases relative to other occupations (and physicians in particular).<sup>36</sup> The evidence suggests that market power facilitates the substitution of nurses for physicians. The results are also consistent with the exercise of monopsony power by insurers vis-à-vis physicians, as their relative earnings and employment growth declined most in markets with the largest predicted merger impact. Paired with the findings of the previous section, we conclude that in markets where Aetna and Prudential had substantial premerger overlap, insurers were able to exercise market power simultaneously in input and output markets postmerger. Thus, the premium increases documented in the previous section likely understate the increase in insurer profits due to consolidation.

## V. Discussion and Conclusions

The scope of the private health insurance industry is difficult to overstate. More than 170 million nonelderly Americans are privately insured, and this figure does not include the millions of publicly insured individuals whose coverage is outsourced to private insurers. The recent health insurance reform legislation will further expand the reach of this industry, with the Congressional Budget Office projecting an increase of 16 million in the number with private primary insurance by 2019 (CBO 2010). In addition, the annual growth in employer-sponsored health insurance premiums has exceeded the annual growth in earnings by a factor of seven during the last several years (Romer and Duggan 2010).<sup>37</sup> In this study, we investigate whether and to what extent increasing consolidation in the US health insurance industry is responsible for this rapid growth in premiums.

We arrive at four main conclusions. First, most Americans live in markets served by a small number of insurers, and most markets are becoming more concentrated over time. We estimate that the fraction of local markets falling under the “highly

<sup>35</sup> As a robustness check, we estimated all models using 1999–2001 as the study period, as the BLS changed its methodology for constructing mean wages in 2002 (see online Appendix 6). Our findings are qualitatively similar.

<sup>36</sup> We also estimated specifications subdividing the nurse category into two large subgroups (Registered Nurses—RNs and Licensed Vocational Nurses—LVNs). We find that only RNs earned higher relative raises in markets where the merger had most impact. LVNs enjoyed significant relative employment gains, whereas the employment gains for RNs were not statistically significant (although they are of similar magnitude). On the whole, the results are consistent with outward shifts of demand for both nursing types, with a less-elastic short-run supply curve for RNs. The results from these specifications are presented in online Appendix 6. We thank an anonymous referee for this suggestion.

<sup>37</sup> Data from the BLS “Employer Costs for Employee Compensation” survey indicate that workers’ real average hourly wage and salary income increased by 0.7 percent annually from 2000 to 2009. During that same period, the growth rate in ESI premiums was substantially higher at 5.1 percent per year (Romer and Duggan 2010).

concentrated” category (per the DOJ’s Horizontal Merger Guidelines) increased from 68 to 99 percent between 1998 and 2006. Second, premiums are *not* rising more quickly in markets experiencing the greatest increases in concentration, even controlling for a rich set of observable plan characteristics.

Third, when we account for the fact that changes in concentration are not orthogonal to other determinants of premium growth, we find that increases in concentration do raise premiums. Our instrumental variables estimates, which exploit plausibly exogenous shocks to local market structure generated by the 1999 merger of Aetna and Prudential, imply that the average market-level changes in HHI between 1998 and 2006 resulted in a premium increase of approximately 7 percentage points by 2007, *ceteris paribus*. Given our sample includes both fully and self-insured plans, and insurers have less control over pricing of the latter, it is plausible that consolidation is associated with an even larger impact on fully insured plans, which are dominant in the individual and small group markets.

Fourth, we find evidence that consolidation reduces the employment of health-care workers and may facilitate the substitution of nurses for physicians. Using data from the Occupational Employment Statistics survey between 1999 and 2002, we find the Aetna-Prudential merger reduced physician earnings in a typical market by 3 percent and raised nurse earnings by 0.6 percent. The magnitude of this effect was higher (lower) in markets where the premerger shares of the two companies overlapped more (less). Thus, the results imply that insurers exercised monopsonistic power against physicians in some markets during the period 1998–2002.

Our findings indicate that Americans are indeed paying a premium on their health insurance premiums as a result of recent increases in market concentration of the health insurance industry. However, consolidation explains only a fraction of the steep increase in premiums in recent years. While 7 percent is large in absolute terms (it translates into approximately \$34 billion in extra annual premiums), and large relative to operating margins of insurers, it is only one-eighth of the increase in average, inflation-adjusted premiums observed in our sample during the same 1998 to 2006 time period.<sup>38</sup>

We caution that our analysis relies on a single merger whose substantial effects on market concentration persisted for just two years. However, it is among the largest mergers to date in the health insurance industry, and one with differential impacts across 139 geographic markets in the United States (implying 139 small experiments). Additional research that utilizes other plausibly exogenous sources of variation in market structure would be valuable to assessing conduct in this important industry. We also emphasize that our sample consists primarily of large, multisite firms, and the results may not be generalizable to all market segments, including the small group and individual markets.<sup>39</sup> Finally, there has also been a great deal of consolidation across (as opposed to within) markets, the effects of which are not reflected in our estimates.

<sup>38</sup> As shown in Table 1, average premiums in our sample increased from \$4,104 in 1998 to \$7,832 in 2006. Adjusting these both to 2007 dollars yields an increase in average, inflation-adjusted premiums of 54 percent. The \$34 billion figure is based on an estimated \$490 billion in total private insurance premiums in the United States as of 1998 (CMS 2011). The aggregate effect of consolidation on profits should be larger as the “premium on premiums” does not incorporate reductions in provider payments obtained through the exercise of monopsony power.

<sup>39</sup> High and increasing concentration has also been documented in the individual/small group market (GAO 2009b).

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# Health Affairs Blog

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## Examining Implications Of Health Insurance Mergers

Thomas Greaney

July 16, 2015

COSTS AND SPENDING, HEALTH PROFESSIONALS, INSURANCE AND COVERAGE, POPULATION HEALTH



The flurry of [announced](#) <sup>[1]</sup> and [rumored](#) <sup>[2]</sup> mergers in the health insurance sector has focused attention on how the Antitrust Division of the Department of Justice (DOJ) might assess the combination of some (or all) of the big five players (in order of size by revenues: UnitedHealth, Anthem, Aetna, Humana, Cigna).

There is no question but that consolidations of this magnitude would raise considerable concern for the simple reason that cost control in health care depends on competitive markets at both the payor and provider levels. Incidentally, robust payor competition is not only [vital to the success of the Affordable Care Act](#) <sup>[3]</sup> (ACA), but also to voucher programs [proposed](#) <sup>[4]</sup> by conservatives.

## Lessons From Previous Mergers

Unfortunately, history does not provide much of guide as to how DOJ would assess any particular merger combination. This is because there are a number of distinct health insurance product markets that would need to be evaluated.

Because each market is local, antitrust analysis would also require an assessment of the competitive overlap in each region. DOJ, which [has been criticized](#) <sup>[5]</sup> for its inattention to health insurance consolidation, has challenged only four mergers of health insurance companies, in contrast to dozens of cases and investigations involving hospital mergers. The result: all were settled by consent decree where the insurers agreed to divest overlapping plans and secured the government's approval of the merger.

In 1999 DOJ settled a case challenging [Aetna's acquisition of Prudential Insurance](#) <sup>[6]</sup>, focusing on the Health Maintenance Organization (HMO) product market in the Dallas and Houston. In 2006 it challenged and settled the [UnitedHealth's acquisition](#) <sup>[7]</sup> of PacificCare Health Systems where the relevant product market alleged was the sale of insurance products to small group employers. In 2008, it focused on competitive effects in the Medicare Advantage market, settling its challenge to [UnitedHealth's acquisition of Sierra Health Services](#) <sup>[8]</sup> plans in Las Vegas. Finally DOJ's complaint involving [Humana's acquisition of Arcadian Management Services](#) <sup>[9]</sup> Medicare Advantage business in 2012, also settled by a consent decree, alleged competitive harm in 45 markets in five states.

Complicating the analysis even more is the possibility that the government might find a competitive harm resulting from a merger's effect on providers, that is, the enhanced market power of the merged firm might enable it to ["unduly reduce" payment to physicians](#), <sup>[10]</sup> a claim it advanced in the Aetna/Prudential and Humana/Arcadian mergers.

## Competition Concerns

Given antitrust law's focus on distinct local markets, the strategy behind some mergers may be to find a partner with minimal overlapping business, agree to divest in the markets with large combined market shares, and march off into the sunset. This result would not well serve competition for a number of reasons.

First, it's important to remember that both providers and payors are evolving as a result of health reform. Hopeful signs from a market competition standpoint include the willingness of insurers to enter new markets via the health insurance exchanges and to develop innovative integrated delivery systems, such as Accountable Care Organizations (ACOs)



in partnerships with hospitals and physicians. The lessons of oligopoly are pertinent here: consolidation that would pare the insurance sector down to less than a handful of players is likely to chill the enthusiasm for venturing into a neighbor's market or engaging in risky innovation. One need look no further than the airline industry for a cautionary tale.

Secondly, a likely defense posits that mega mergers will enable payors to counter the market power of dominant "must-have" hospitals and specialty physician practices. This argument, which I have called the "Sumo Wrestler theory," holds that only a large payor can effectively bargain down the prices demanded by large providers. Payors will then pass along the savings to their customers.

To be sure, there is [substantial evidence](#) <sup>[11]</sup> that a large share of health care cost increases is caused by dominant providers charging high prices. There are a number of reasons to be skeptical of the idea that consolidated insurers will bargain down prices with providers. There is no compelling economic [evidence](#) <sup>[12]</sup> that "bilateral" monopoly produces better results for consumers; and even if a dominant payor succeeds in bargaining successfully with providers it has little incentive to pass along the savings to its policyholders. Moreover, as experiences in Boston and Pittsburgh suggest, a showdown between the Sumo Wrestlers may result in a [handshake](#) <sup>[13]</sup> rather than a serious wrestling match.

History also teaches that mergers often tend to beget mergers. There is a risk that the consolidation in the insurance sector will prompt even more mergers among hospitals, among physician groups, and acquisitions of physician practices, as each sector asserts a need to "level the playing field." Mergers are not always driven by efficiency considerations; sometimes a merger "cascade" occurs simply because the other guy is doing it, [hubris, or even "empire-building"](#) <sup>[14]</sup>.

## Policy Concerns

A further concern relates to the influence that a highly concentrated insurance industry may wield in Congress, state legislatures, and regulatory agencies. With a large and growing portion of beneficiaries in Medicare and Medicaid served by private insurance companies, the laws and administrative regulations that govern plan bidding, appeals, and administration of health plans are increasingly important.

The ability to influence these rules are as significant to the bottom line as any aspect of insurers' business operations. Although antitrust law does not explicitly take into account accumulating influence over the regulatory process, it is a concern that should call for greater scrutiny of mergers from politicians who claim to support market-based policies in health care.



Whether antitrust enforcement will deter excessive concentration in the insurance industry is an open question. If it fails, regulation may be the only alternative: state insurance regulators and state legislatures may need to step in to curb or undo consolidation or strengthen regulatory controls on insurer pricing.

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July 24, 2015

# Insurance Mergers Will Reduce Competition and Choice

**For immediate release:**

July 24, 2015

**Statement attributed to:**

[Steven J. Stack, MD](#)

President, American Medical Association

"The American Medical Association believes patients are better served in a health care system that promotes competition and choice. We have long cautioned about the negative consequences of large health insurers pursuing merger strategies to assume dominant positions in local markets. Recently proposed mergers threaten to increase health insurer concentration, reduce competition and decrease choice.

"The AMA's own study shows that there has been a serious decline in competition among health insurers with nearly 3 out of 4 metropolitan areas rated as 'highly concentrated' according to federal guidelines used to assess market competition. In fact, 41 percent of metropolitan areas had a single health insurer with a commercial market share of 50 percent or more.

"Further AMA analysis shows that based on federal guidelines, the proposed Anthem-Cigna merger would be presumed to be anticompetitive in the commercial, combined (HMO+PPO+POS) markets in nine of the 14 states (NH, ME, IN, CT, VA, CO, GA, NV, KY) in which Anthem is licensed to provide coverage.

"The lack of a competitive health insurance market allows the few remaining companies to exploit their market power, dictate premium increases and pursue corporate policies that are contrary to patient interests. Health insurers have been unable to demonstrate that mergers create efficiency and lower health insurance premiums. An AMA study of the 2008 merger involving UnitedHealth Group and Sierra Health Services found that premiums increased after the merger by almost 14 percent relative to a control group.

"To give commercial health insurers virtually unlimited power to exert control over an issue as significant and sensitive as patient health care is bad for patients and not good for the nation's health care system. The U.S. Department of Justice has recognized that patient interests can be harmed when a big insurer has a stranglehold on a local market.

"Given the troubling trends in the health insurance market, the AMA believes federal and state regulators must take a hard look at proposed health insurer mergers. Antitrust laws that prohibit harmful mergers must be enforced and anticompetitive conduct by insurers must be stopped."

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**Editor's Note:** The findings on health insurer consolidation come from the 2014 edition of *AMA's Competition in Health Insurance: A Comprehensive Study of U.S. Markets*, which offers the largest and most complete picture of competition in health insurance markets for 388 metropolitan areas, as well as all 50 states and the District of Columbia. The study is based on 2012 data captured from commercial enrollment in fully and self-insured plans, and includes participation in consumer-driven health plans. Credentialed members of the media can obtain a free copy of the AMA study by contacting AMA Media & Editorial at: [media@ama-assn.org](mailto:media@ama-assn.org).

**Media Contact:**

Robert J. Mills

AMA Media & Editorial



## POLICY &amp; ACTION FROM CONSUMER REPORTS

January 29, 2016

Jennifer Chambers  
California Department of Insurance  
45 Fremont Street, 24th Floor,  
San Francisco, CA 94105

Re: Follow-up comments regarding the proposed acquisition of Health Net, Inc. by Centene Corporation.

To the Department of Insurance,

As advocates for consumers on a number of health access, cost, and quality issues—including health insurance premium rates, network adequacy, and health insurance benefit design—we are concerned with the potential impact on consumers if these two corporations are to merge with inadequate safeguards. For the reasons discussed in our written and oral testimony, Consumers Union urges the Department to closely scrutinize this deal and, if the department decides to approve it, to impose undertakings that effectively protect consumer interests.

Without repeating points we previously raised, we take the opportunity here to respond to some representations by the plans at the public hearing, held January 22, 2016. To wit, Centene's statements related to: (I) premium rate setting, (II) maintenance of local control, (III) commitment to quality improvement, and (IV) commitment to adequate data security practices.

I. A Commitment to be Better Than the Minimum: Premium Rate Setting

As Centene and Health Net executives are surely aware, California is a *file and use* rate review state. While the state rigorously reviews rate filing justifications, our regulators are not statutorily empowered to block an unjustified or unreasonable rate increase. However, between 2011 and 2014, California consumers saved \$349 million in excessive premium rates via the robust negotiating power wielded by our state regulators.<sup>1</sup> In order to save consumers from being overcharged, however, there must be health plans that are willing to come to the table. Unlike some other health plans, Health Net has historically worked with our regulators and Covered California to finalize acceptable premium rates. We are therefore troubled that Centene demurred from committing to the practice of only going forward with those rate increases determined by regulators to be reasonable and justified. Rather, Centene would only commit to "following the law" with regard to rate review. We believe that these plans should strive for more than following the law—that should be a given and the bare minimum. We

<sup>1</sup> CALPIRG Report: California Health Insurance Rate Review, 17 April 2014. Available at <http://www.calpirg.org/reports/cap/california-health-insurance-rate-review>.

therefore urge CDI to pursue a more robust commitment from Centene than to simply follow the law. We want assurances that a newly merged plan will improve consumers' financial wellbeing, or at least not diminish it, and that includes a commitment to continue Health Net's practice of working with the regulators to achieve acceptable premium rates.

## II. Maintaining Adequate Local Control

As we stated in our oral and written testimony, maintenance of meaningful local presence in California is important. For that reason, we welcome commitments by Centene to maintain a local presence here. However, although we are reassured to hear that customer-facing services will remain in California, we are not convinced that the "local presence" promised fully encompasses the areas needed. Specifically, responses offered by Centene during questioning acknowledged that outside of customer-facing services, certain staffing "efficiencies" will be adopted. Consumers Union remains concerned that some of the staffing efficiencies envisioned by Centene includes centralizing legal services and regulatory compliance teams out of state. We urge CDI to inspect these planned efficiencies with particular attention to the expertise required to adhere to the regulatory system and consumer protections unique to California. Given our state's unique regulatory framework, we urge CDI to pursue an undertaking that commits Centene to maintaining legal and regulatory staffing with in-state, California-specific expertise.

## III. Actual Achievement of Quality Improvement

During the public hearing, Centene stated a willingness to commit resources to improving Health Net's low quality ratings. Given the low scores earned by Health Net by several measures—as detailed in our testimony—we are pleased that Centene agreed to commit to this point. We urge the Department to memorialize this commitment as an enforceable undertaking.

We note, though, that a commitment to additional resources is not enough. In its 2016 rate filing justification for the individual market in California, Health Net projected expending just 0.7% of revenue, (or, \$2.68 PMPM), on quality improvement.<sup>2</sup> Additional resources seem appropriate but, while a good start, do not come as a major commitment. Quality improvement is more than a promise to spend— it includes results such as improved quality ratings scores of health plans based on outside validated measurements.

There are a number of valid and comprehensive measures of quality for health plans and providers. Importantly, these are measures not only of the quality of medical care but also of consumers' experience getting the care they need in dealing with their plans. In securing this commitment from Centene, we also urge CDI to tie quality improvement obligations to more than one indicator to ensure comprehensive improvement across the broad scope of products offered by the two plans. For example, we suggest a commitment to achieve above average ratings on the Office of Patient Advocate Quality Report Card as well as the National Committee for Quality Assurance (NCQA) consumer satisfaction

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<sup>2</sup> Health Net rate filing justification, submitted to the California Department of Managed Health Care on 31 July 2015 at p.120.

score for Medicaid Managed Care Organizations—both of which have conferred low scores on Health Net in the past—as well as on Covered California Quality Ratings. We further recommend that this undertaking require Centene-Health Net to report to the Department its action plans and progress on a regular basis, for example every six months; action plans that the Department deems inadequate to effectively improve quality must be improved upon until the Department is satisfied.

In addition to achieving certain quality scores, there are other ways to determine whether Centene-Health Net is providing a high quality product for its policyholders: average time it takes for policyholders to reach customer service, accuracy of the its provider directory, and both the number of independent medical reviews (IMRs) requested by policyholders and the rate of reversal of initial plan decisions. We recommend that CDI review the plans' track record with regard to these and other measurable variables and commit the plans to tangible improvements wherever possible.

#### IV. Data Security

The fact that there is always a risk of data breach of health plans' vast stores of data does not legitimize inadequately securing consumers' very personal health and financial information. When consumers' names, addresses, dates of birth, Social Security numbers, member identification numbers, and health information are lost to unknown parties, it is not enough to apologize and offer free credit and healthcare monitoring to those affected. The damage by then is already done. Yet, after a breach at this point, that seems to be consumers' only protection.

At the hearing on January 22, Health Net acknowledged a prior security lapse, which was the subject of a penalty by DMHC, and detailed its efforts to improve. In contrast, Centene was less forthcoming; it failed to acknowledge that the plan is actually currently missing six hard drives containing the personal and health information of nearly 950,000 individuals.<sup>3</sup> This significant omission to the department suggests a lack of appreciation for either the gravity of the situation or the importance of transparency with regulators, policyholders, and the general public.

If this merger is approved, Centene and Health Net will be tasked with combining two large data systems into one, perhaps leaving policyholders even more vulnerable to security lapses. We therefore urge the department to investigate the most recent data breach to determine the timeline when the hard drive loss was known versus when information was shared with the department, other regulators, and the general public. Additionally, both plans should be compelled to present to the department a clear strategy for safely and securely combining IT systems, as well as a strategy for the method, mode, and speed with which they will inform regulators and the public of any data breach. We believe notice must occur within days or weeks, not months, of any such breach.

#### **Conclusion**

We thank CDI for holding a public forum on this proposed acquisition, for your thorough process and examination, and the Department's inclusion of consumer advocates and the general public in the review process. It behooves the Department to closely scrutinize this proposed acquisition in order to ensure the availability of affordable, high quality health insurance in California. Thus, if this deal is

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<sup>3</sup> *Health Insurer Centene Missing Data Drives With Client Information*, Reuters, 25 January 2016. Available at <http://www.reuters.com/article/us-centene-privacy-harddrives-idUSKCN0V32RN>.

approved, Consumers Union urges you to impose undertakings that will effectively protect consumer interests.

Sincerely,



Dena B. Mendelsohn  
Staff Attorney  
Consumers Union

**BEFORE THE COMMISSIONER OF INSURANCE  
OF THE STATE OF CALIFORNIA**

IN THE MATTER OF:

### The Proposed Acquisition of Control of:

HEALTH NET LIFE INSURANCE  
COMPANY, a California domestic stock  
insurer and indirect subsidiary of

HEALTH NET, INC., a Delaware corporation

BY

**CENTENE CORPORATION**, a Delaware corporation

AND

CHOPIN MERGER SUB I, INC. and  
CHOPIN MERGER SUB II, INC., each a  
Delaware corporation

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) File No. APP-2015-00889  
)  
)  
)  
)  
) **SUPPLEMENTAL WRITTEN**  
) **TESTIMONY OF STEVEN**  
) **SELL ON BEHALF OF HEALTH NET**  
) **LIFE INSURANCE COMPANY AND**  
) **HEALTH NET, INC.**  
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1. My name is Steven Sell. My business address is 21650 Oxnard Street, Woodland Hills, California 91367.

2. I am the President of Health Net Life Insurance Company, Inc., a California domestic stock insurer (“HNLIC”), Health Net of California, Inc. (“HNCA”), a California health care service plan licensed under the Knox-Keene Health Care Service Plan Act of 1975, as amended (“Knox-Keene Act”) and the “Western Region” for Health Net, Inc., a Delaware corporation (“Health Net”).

3. On January 22, 2016, a hearing was held before the California Insurance Commissioner, Dave Jones (the “Commissioner”), with respect to the above-captioned matter (the “Hearing”).

4. At the Hearing, the Commissioner requested that business plans for Health Net and its Knox-Keene Act subsidiaries (*i.e.*, HNCA, Health Net Community Solutions (“HNCS”), and Managed Health Network (HNCA, HNCS and Managed Health Network, together, the “Knox-Keene Plans”)) be submitted to supplement the record.

5. A general over-view of Health Net's and the Knox-Keene Plans' respective operations is as follows:

6. **Health Net.** Health Net is a publically traded Delaware corporation. Through its operating subsidiaries, Health Net delivers managed health care services through health plans and government-sponsored managed care plans. Those subsidiaries provide and administer health benefits to approximately six million individuals across the country through group, individual, Medicare, Medicaid, dual eligible, U.S. Department of Defense, including TRICARE, and U.S. Department of Veterans Affairs programs. Through its subsidiaries, Health Net also offers behavioral health, substance abuse and employee assistance programs, and managed health care products related to prescription drugs.

7. **Investment Summary.** Consistent with the Commissioner's goals, Health Net, through its subsidiaries, maintains (i) a \$10 million investment in the California Organized Investment Network (COIN); (ii) no investments in thermal coal; and (iii) no investments in Iran or any Iranian related companies identified on the Commissioner's List of Companies Doing Business with the Iranian Petroleum/Natural Gas, Nuclear, and Military Sectors, dated as of October 17, 2014.

8. **HNCA.** HNCA is a California corporation and wholly-owned subsidiary of Health Net. HNCA is a Knox-Keene Act licensee operating commercial, Medicare and Medi-Cal lines of business throughout California. HNCA is a direct Medicare contractor with the Centers for Medicare & Medicaid Services ("CMS"). As of September 30, 2015, HNCA had a total membership of approximately 1,279,478, including 217,451 Covered California members, 553,144 other commercial members, 167,064 Medicare risk members, and 341,819 dental Medicaid members.

- a. HNCA files its annual audited and quarterly financial statements and other reports with the California Department of Managed Health Care ("DMHC") and as of September 30, 2015, HNCA had a total net worth of \$1,001,178,415 and tangible net equity of \$946,787,965, including excess tangible net equity of \$767,993,991. During the nine month period ended September 30, 2015, HNCA had revenue of \$5,748,497,141; total expenses of \$5,861,709,923, including \$5,088,911,272 of medical and hospital expenses and \$782,833,107 of administrative expenses; and \$(10,034,456) of income taxes, and earned a net loss of \$(113,212,782).

9. **HNCS.** HNCS is a California corporation and wholly-owned subsidiary of Health Net. HNCS is a licensed health care service plan operating Medi-Cal and Medicare lines of business in California. HNCS is a direct Medi-Cal contractor with the California Department of Health Care Services ("DHCS"). HNCS has direct contracts with DHCS in Los Angeles, San Diego, Sacramento, San Joaquin, Tulare, Kern and Stanislaus counties. In addition, HNCS is a Medi-Cal subcontractor for The Fresno-Kings-Madera Regional Health Authority, under the name of CalViva Health, which is a direct Medi-Cal contractor with the DHCS and is an indirect Medi-Cal contractor in Riverside and San Bernardino Counties through a subcontract with Molina Healthcare of California.



- a. As of September 30, 2015, HNCS had a total membership of approximately 1,800,934 including 1,441,976 Medi-Cal risk members, 321,946 Medi-Cal risk members subcontracted from CalViva, 13,198 Medi-Cal risk members subcontracted from Molina, and 23,814 Cal MediConnect (dual eligible) members.
- b. HNCS files its annual audited and quarterly financial statements and other reports with the DMHC and as of September 30, 2015, HNCS had a total net worth of \$518,257,594 and tangible net equity of \$488,257,594, including excess tangible net equity of \$358,805,626. During the nine month period ended September 30, 2015, HNCS had revenue of \$5,027,886,478; total expenses of \$ 4,672,179,979, including \$3,939,668,229 of medical and hospital expenses and \$461,210,521 of administrative expenses; and \$271,301,229 of income taxes; and earned net income of \$355,706,499.

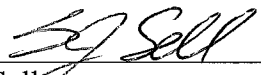
10. **Managed Health Network.** Managed Health Network is a California corporation and wholly-owned subsidiary of Managed Health Network, Inc., (“MHN”) a Delaware corporation, which, in turn, is a wholly-owned subsidiary of Health Net. Managed Health Network is a specialized Knox-Keene Act licensee operating a mental health and chemical dependency line of business.

- a. As of September 30, 2015, Managed Health Network had a total membership of approximately 985,886 large group commercial members.
- b. Managed Health Network files its annual audited and quarterly financial statements and other reports with the DMHC and as of September 30, 2015, Managed Health Network had a total net worth of \$6,623,624 and tangible net equity of \$6,623,589, including excess tangible net equity of \$5,933,936. During the nine month period ended September 30, 2015, Managed Health Network had revenue of \$12,317,895; total expenses of \$10,387,001, including \$6,826,282 of medical and hospital expenses, \$2,232,365 of administrative expenses, and \$1,328,354 of income taxes; and earned a net income of \$1,930,894.

11. Attached hereto as **Appendix 1** is a Confidential Supplement to this Supplemental Written Testimony containing a narrative business plan and pro forma financial projections for each of the Knox-Keene Plans, Health Net Health Plan of Oregon, Inc. and Health Net Access, Inc. With respect to Health Net’s business plan, attached hereto and incorporated herein by reference as **Appendix 2**, is a copy of Health Net’s Form 10-K for the fiscal year ended December 31, 2014. As Health Net is essentially a non-operating holding company, its financial results are, for the most part, comprised of the results of the operations of its subsidiaries, including HNLIC, HNCA, HNCS and Managed Health Network, for whom projections are included or were previously provided.

\* \* \* \* \*

Steven Sell, deposes and says that he is the President of Health Net Life Insurance Company and Health Net of California, Inc., that he has read the foregoing Supplemental Written Testimony and knows the contents thereof and that the same are true of his own knowledge.

By:   
Steven Sell

Dated: 1-27-16

## **APPENDIX 1 – BUSINESS PLANS**

*[redacted]*

**EXHIBIT A TO APPENDIX 1**

*[redacted]*

## **APPENDIX 2**

### **HEALTH NET'S FORM 10-K FOR THE FISCAL YEAR ENDED DECEMBER 31, 2014**

# UNITED STATES SECURITIES AND EXCHANGE COMMISSION

WASHINGTON, DC 20549

## FORM 10-K

(Mark One)

☒ ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934

For the fiscal year ended December 31, 2014

☐ TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934

For the transition period from \_\_\_\_\_ to \_\_\_\_\_  
Commission File Number: 1-12718

**HEALTH NET, INC.**

(Exact Name of Registrant as Specified in Its Charter)

Delaware

95-4288333

(State or Other Jurisdiction  
of Incorporation or Organization)

(I.R.S. Employer  
Identification No.)

21650 Oxnard Street, Woodland Hills, CA

91367

(Address of Principal Executive Offices)

(Zip Code)

Registrant's Telephone Number, Including Area Code: (818) 676-6000

Securities Registered Pursuant to Section 12(b) of the Act:

Title of each class

Name of each exchange on which registered

Common Stock, \$.001 par value

The New York Stock Exchange

Rights to Purchase Series A Junior Participating Preferred Stock

The New York Stock Exchange

**Securities Registered Pursuant to Section 12(g) of the Act: None**

Indicate by check mark whether the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. Yes ☒ No ☐

Indicate by check mark whether the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act. Yes ☐ No ☒

Indicate by check mark whether the registrant: (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. Yes ☒ No ☐

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T (§ 232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes ☒ No ☐

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K is not contained herein, and will not be contained, to the best of registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K. ☒

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, or a smaller reporting company. See the definitions of "large accelerated filer," "accelerated filer" and "smaller reporting company" in Rule 12b-2 of the Exchange Act. (Check one):

☒ Large accelerated filer      ☐ Accelerated filer      ☐ Non-accelerated filer      ☐ Smaller reporting company

(Do not check if a smaller reporting company)

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act). Yes ☐ No ☒

The aggregate market value of the voting stock held by non-affiliates of the registrant as of June 30, 2014 was \$3,265,069,381 (which represents 78,600,611 shares of Common Stock held by such non-affiliates multiplied by \$41.54, the closing sales price of such stock on the New York Stock Exchange on June 30, 2014).

The number of shares outstanding of the registrant's Common Stock as of February 23, 2015 was 76,903,375 (excluding 76,238,167 shares held as treasury stock).

### Documents Incorporated By Reference

Part III of this Form 10-K incorporates by reference certain information from the registrant's definitive proxy statement for its 2015 Annual Meeting of Stockholders to be filed with the Securities and Exchange Commission within 120 days after the close of the year ended December 31, 2014.