Department of Managed Healthcare

State of California

Application for an Award of Advocacy and Witness Fees

Entity Name: Consumers Union of United States, Inc.
Date Submitted: 11/6/2017 3:18:40 PM
Submitted By: Dena Mendelsohn
Application version: Original App

1. For which proceeding are you seeking compensation?

   Proposed merger of Anthem and Cigna

2. What is the amount requested?

   $13,087.50

3. Proceeding Contribution:

   Provide a description of the ways in which your involvement made a substantial contribution to the proceeding as defined in California Code of Regulations, Title 28, Section 1010(b)(14), supported by specific citations to the record, your testimony, cross-examination, arguments, briefs, letters, motions, discovery, or any other appropriate evidence.

Consumers Union of the United states, Inc., submits this request for reasonable advocacy fees for our substantial contribution to the decision of the Department of Managed Health Care (DMHC) regarding Anthem's acquisition of Cigna. Consumers Union substantially contributed to DMHC's review of the proposed merger in a variety of ways. On March 4, 2016, Dena Mendelsohn, Staff Attorney at Consumers Union, provided an oral statement to the Department during which she voiced major concerns held by Consumers Union regarding the proposed merger of these two major health plans. For example: - That market consolidation helps carriers, not consumers; - That increased market power may mean worse insurance products for consumers; - The historic and ongoing quality shortcomings at both Anthem and Cigna, which could become worse following a merger; - The potential for deteriorating provider networks following a merger; - The likelihood of reduced responsiveness to push back by DMHC in the rate review process. In addition to articulating the concerns of Consumers Union in person, Ms. Mendelsohn provided the Department with a detailed written testimony dated March 9, 2016. This statement included a substantial collection of background information, derived from a literature review and extensive review and analysis of public records and reports, highlighting a pattern of troubling quality issues by both health plans. Additionally, in our written testimony, Consumers Union detailed for the Department five recommended Undertakings, designed to protect consumer interests in the event that the Department approved the merger. They centered around: 1. Ensuring merged company did not move forward with premium rate increases in any market segment that CDI or DMHC deems unjustified or that could contain inaccurate or incomplete information. 2.Securing specific and enforceable assurances that Anthem-Cigna would reinvest a meaningful portion of profits in quality improvement and cost containment initiatives and provide clear explanations and documentation of those investments, dollar breakdowns, estimated savings, and descriptions of how each of them directly benefits policyholders. 3.Improving consumer satisfaction scores to at-or-above average for all three categories: Getting care, Satisfaction with physicians, and Satisfaction with health plan services. Similarly, we sought specific and enforceable commitments to raising its CAHPS scores to meet or exceed average ratings. 4.Making available to consumers, policyholders and non-policyholders, an accurate provider directory that is easily accessible. 5.Requiring dedicated, increased staffing in California and anywhere else trouble spots in the company may arise and affect California consumers Consumers Union stayed engaged and informed as the review process for this proposed merger progressed. As new

information became available in the months following our original recommendation, we, along with allied advocacy groups, evaluated whether additional undertakings would be necessary and appropriate. Having identified instances where consumers would be protected by additional undertakings, Consumers Union and colleagues presented those recommendations to the Department, both in writing and in a scheduled meeting. Our suggestions were as follows: 1. An increased investment to cover the uninsured and underinsured. 2. Funding for a consumer assistance program. We believe Consumers Union played an important role in the Department's hesitation to approve the merger in California. Although the merger did not ultimately come to fruition, a long-delayed approval in this state no doubt was a factor in Anthem dropping this merger attempt.

4. Please attach your time and billing record in the "Add Attachment" box below. In the time and billing record, include the hourly rate of compensation for each witness or advocate and a justification for each hourly rate, which may include copies of or citations to previously approved hourly rate; and each witness or advocate's resume or curriculum vitae. The time and billing record should show the date and exact amount of time spent on each specific task in thirty (30) minute increments, as defined in California Code of Regulations, Title 22, Section 1010(d)(3).

Document Name	Date Uploaded	Uploaded By	
Consumers Union Time and Billing Record	11/6/2017 1:33:04 PM	Dena Mendelsohn	View
Mendelsohn resume	11/6/2017 1:40:38 PM	Dena Mendelsohn	View
Imholz resume	11/6/2017 1:43:05 PM	Dena Mendelsohn	View
Joint letter dated Jan. 20 2017	11/6/2017 1:45:40 PM	Dena Mendelsohn	View
Consumers Union written comments on proposed merger	11/6/2017 1:46:31 PM	Dena Mendelsohn	View

5. Clear and concise statement of participants interest in the proceeding which explains why participation is needed to represent the interests of consumers

Mergers of health plans, especially large ones such as Anthem and Cigna, pose a threat of increased premiums and diminished choice for consumers. They also threaten to reduce the incentive to improve quality and innovation. Because this is a complicated and nuanced issue on which Consumers Union has expertise, both nationally and in California, our mission dictates that we advocate for consumers in order to balance out the robust panel of attorneys representing the plans

6. The information contained in the Petition to Participate remains true and correct to the best of the knowledge of the person verifying the information.

Yes

I am authorized to certify this document on behalf of the applicant. By entering my name below, I certify under penalty of perjury under the laws of the State of California that the foregoing statements within all documents filed electronically are true and correct and that this declaration was executed at San Francisco (City), CA (State), on November 06, 2017 .

Enter Name: Dena Mendelsohn

Consumers Union Time and Billing Record for Award of Advocacy and Witness Fees
Acquisition of Cigna by Anthem

BETSY IMHOLZ, Special Projects Director -- RATE: $425/hour*			
Date	Description	Time spent in hours (30 min increments)	Amount
2/12/2016	Background research on Cigna compliance audit, fines	0.5	$ 212.50
2/19/2016	Anthem financial/dividends research	0.5	$ 212.50
2/26/2016	Phone meeting with national and state-based consumer groups re merger	1	$ 425.00
2/26/2016	Edits to draft testimony	2	$ 850.00
3/3/2016	Edits to oral testimony	1	$ 425.00
3/8/2016	Review and edits to final written testimony	1.5	$ 637.50
	TOTAL	**6.5**	**$ 2,762.50**

DENA MENDELSOHN, Senior Staff Attorney -- RATE $350/hour*			
Date	Description	Time spent in hours (30 min increments)	Amount
2/17/2016	Background research on Anthem and Cigna (compliance information with DMHC)	1	$ 350.00
2/18/2016	Background research on Anthem and Cigna (compliance information with DMHC)	1.5	$ 525.00
2/19/2016	Background research on Anthem and Cigna (compliance information with DMHC)	2	$ 700.00
2/23/2016	Background research on Anthem and Cigna (compliance information with DMHC)	1	$ 350.00
2/24/2016	Draft written testimony for DMHC hearing	4	$ 1,400.00
2/25/2016	Phone meeting with national and state-based consumer groups re merger	1	$ 350.00
2/25/2016	Draft written testimony for DMHC hearing	5	$ 1,750.00
2/29/2016	Phone meeting with national and state-based consumer groups re merger	1	$ 350.00
3/3/2016	Email correspondence with Health Access re Anthem routine medical survey	0.5	$ 175.00
3/4/2016	Meeting with Health Access to coordinate testimony	0.5	$ 175.00
3/4/2016	Attended DMHC hearing re proposed merger of Anthem and Cigna, presented oral testimony on the impact to consumers.	2	$ 700.00
3/5/2016	Commute to and from the DMHC hearing	4	$ 1,400.00
3/21/2016	Meeting with California advocacy groups to discuss DMHC hearing, areas that require follow-up from consumer advocates, streamlining communications with DMHC	0.5	$ 175.00
11/30/2016	Preparation meeting to discuss conditions around potential undertakings, if merger is approved. Meeting held with CU, Health Access, and WCLP.	0.5	$ 175.00
12/1/2016	Meeting with DMHC (Mary Watanabe and Gabriel Ravel), attended by CU, HA, and WCLP	0.5	$ 175.00
12/21/2016	Draft joint letter to DMHC re updated request for undertakings on Anthem	1.5	$ 525.00
12/22/2016	Draft joint letter to DMHC re updated request for undertakings on Anthem	0.5	$ 175.00
1/12/2017	Meeting with Health Access to discuss updated undertakings request	0.5	$ 175.00
1/19/2017	Correspondence with Health Access to follow-up with issues discussed, research for undertakings request.	0.5	$ 175.00
1/20/2017	Revisions to undertakings request letter	0.5	$ 175.00
1/26/2017	Final review/edits of joint letter, with Health Access, regarding additional recommended undertakings. Letter submitted 1/30/2017.	1	$ 350.00
	TOTAL	**29.5**	**$ 10,325.00**

TOTAL HOURS	**36**
TOTAL AWARD REQUESTED	**$ 13,087.50**

* Hourly billable rate is based on the hourly rate set by the Public Utilities Commission of the State of California, and used calculating other recent CPP awards.

Dena B. Mendelsohn, JD MPH
Senior Staff Attorney
Consumers Union, 1535 Mission Street, San Francisco, CA 94103
415-431-6747 x7613 • 415-431-0906 Fax • dena.mendelsohn@consumer.org

PROFESSIONAL EXPERIENCE

Consumer Reports

Senior Staff Attorney (2017-Present)
Staff Attorney (2015-2017)
Health Policy Analyst (2014-2015)

- Advocating for affordable, quality healthcare for consumers nationwide, focusing on health insurance, federal health reform, and insurer accountability.
- Research and analyze federal and state healthcare policy regarding premium rates, health insurer practices, and insurer mergers.
- Review rate filing justifications filed in California, submit comments to DMHC, and create consumer engagement opportunities around rate review. Consult with advocates nationwide on specific rate filing justifications filed outside California.
- Author reports and blogs on health insurance, health insurance rates, and health information technology.
- Crafting of written comments and oral testimony for state and federal regulators in response to state and federal rulemaking, as well as for hearings on proposed health insurance mergers.
- Cultivating a consortium of experts and advocates on health insurance rate setting by convening regular conference calls and providing detailed briefs in easily accessible formats.
- Contribute to a national campaign working on ending "surprise medical bills."
- Appointed to serve on a national committee addressing health IT and patient safety.

Independent Consultant (2013-2014)

Provided executive services to small businesses.

- Copywriting, copy editing, strategic thinking, and project management.
- Rehabilitation, improvement, and in some cases wholesale replacement of Excel workbooks.
- Legal research and writing.

Pacific Business Group on Health

Policy Analyst (2011-2013)

Balance priorities with aggressive timelines, working with stakeholders and experts nationwide to improve the quality, safety, efficiency, and patient-reported outcomes of health care.

- Comment letters on federal regulations related to health IT, Affordable Care Organizations, and Medicare data release.
- Policy analyst support to national representatives on four federally-funded committees.
- Ad hoc assignments related to employer wellness programming.
- Special assignments for the Executive director: creation of policy PowerPoint presentations, membership newsletter, Affordable Care Act (ACA) press releases.
- Proposed and drafted strategic communications including press releases and newsletter.
- Internal project management.

Hammond Law Group

Law Firm Manager (2010 – 2011)

Strategic planning and independent project management with the goal of increasing efficiency, cost effectiveness, and client satisfaction.

- Researched and implemented hardcopy and automated document management system.
- Recruited through interviews and hiring one legal secretary and one attorney.
- Managed client billing and offsite bookkeeper service.
- Optimized billable opportunities.

State of Missouri Office of Administration, Division of Budget and Planning

Budget and Planning Analyst II (2008-2010)

Individually tasked with educating the Governor on all pending legislation related to three major statewide departments as well as managing their budgets totally approximately $800 million.

- Represented the Governor's budgeting office in diverse settings with various stakeholders.
- Developed recommendations for the Governor's Office including drug court funding, responses to an influx in the prison population, and budget shortfalls for public attorneys.
- Engaged in the challenging work of budget cuts during a national economic crisis.

O'Gorman & Sandroni, P.C.

Private Practicing Attorney (2005 – 2006)

- Practice primarily estate law and general litigation.
- Conceptualized and developed firm website, marketing materials.

EDUCATION

Washington University School of Law: J.D: May 2005

Honors and Activities:

Merit tuition scholarship award
Dean's List
CALI Award for highest grade in Biomedical Ethics writing seminar course
Excellence Award in Oral Advocacy
Credited for contribution in two legal treatises

Saint Louis University School of Public Health: MPH-Health Policy: May, 2008

Honors and Activities

Passed comprehensive exams with great distinction
Alpha Delta Chapter of Delta Omega – The Honorary Public Health Society
The Health Policy Outstanding Student Award recipient
Vice President, Graduate Students in Health Policy and Advocacy
Alpha Epsilon Lambda (AEL) Honor Society, based on academics (gpa 3.97), leadership, recommendations

Emory University, Atlanta, Georgia: B.A. (Magna Cum Laude): May 2002

Joint major in English/Writing

Honors and Activities: Dean's list, Leader of the Year award

PROFESSIONAL MEMBERSHIP

Missouri State Bar, licensed member in good standing (inactive)

Elizabeth Imholz, JD
Director of Special Projects
Consumers Union, 1535 Mission Street, San Francisco, CA 94103
415-431-6747 x125 • 415-431-0906 Fax • BImholz@consumer.org

EXPERIENCE

Oct. 2006-present **Special Projects Director, Consumers Union of U.S., Inc.**
Serves as liaison on health policy work between CU's Advocacy and Editorial Divisions. Provides strategic advice on, develops and leads consumer engagement-oriented health projects. Manages multiple projects including California Safe Patient Network, Community Health Assets Project, and Consumer Voices in Health IT.

Jan. 1999-Sept. 2006 **Director, Consumers Union of U.S., Inc., West Coast Office**
Developed and supervised implementation of policy agenda for regional office of national nonprofit; specialty focus on health policy and community engagement; provided leadership among consumer and other nonprofit groups across the country; developed and oversaw annual budget of $2.1 million; led fundraising that resulted in $10 million in foundation grants and other outside funds; supervised staff of 16; engaged in and supervised lobbying, media work, and development of reports and studies.

Dec. 1994-Dec. 1998 **Senior Attorney/Policy Analyst, Consumers Union of U.S., Inc., West Coast Office**
Directed office's health team, focusing on access, quality and affordability of health care. Included extensive project development, media work, hearing testimony, advocacy before government agencies, trainings, lobbying and coordination of consumer group allies. Developed and managed highly successful project on enlisting local residents and their schools to assume leadership role in reaching out to families to enroll their children in government-sponsored health insurance.

Nov. 1991 to Dec. 1997 **Director, Higher Education and Training Access Project, National Consumer Law Center**
Established national network of public interest groups and consumers involved in advocacy on behalf of low-income students on higher education and job training funding issues. Drafted proposals for reauthorization of federal Higher Education Act, the principal legislation dealing with federal involvement in postsecondary education, including for consumer representation in negotiated rulemaking. Secured consumer participants in subsequent negotiated rulemaking proceedings. From 1991 through 1994, the project operated under aegis of Legal Services for New York City and South Brooklyn Legal Services.

June 1993 to Dec. 1994 **Special Consultant, California Council for Private Postsecondary and Vocational Education**
Acted as liaison between state agency that licenses proprietary trade schools and federal and other state agencies. Trained agency staff on student loan and other legal issues.

Sept. 1990 to Nov. 1991 **Consumer Law Coordinator, Legal Services for New York City**
Organized and chaired consumer law task force for attorneys serving low-income consumers. Conducted training for citywide Legal Services staff and pro bono private attorneys. Served as consumer law resource for neighborhood programs. Lobbied state and federal agencies and legislatures for consumer law reform. Testified before committees of U.S. Senate and House of Representatives concerning fraudulent practices within proprietary trade school industry.

Oct. 1984 to Nov. 1991 **Director, Consumer and Employment Unit, South Brooklyn Legal Services**
Supervised consumer and employment law unit of attorneys, paralegals, and law students. Initiated national vocational school watch project consisting of federal and state legislative and administrative advocacy; class action litigation; community education and engagement; and substantial media coverage. Engaged and coordinated services of pro bono counsel. Notable decisions: Minino v. Perales, 79 N.Y. 2d 883 (1992); U.S. v. Grundhoefer, et al., 916 F. 2d 788 (2d Cir. 1990); Figueroa v. Market Training Institute, et al., 562 A.D. 2d 175 (2d Dept. 1990).

Sept. 1980 to Sept. 1984 **Staff Attorney, South Brooklyn Legal Services**
Handled consumer, employment, and government benefits (Social Security Disability, public

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assistance, and unemployment benefits) cases before federal and state courts and administrative tribunals. Notable decisions: Robinson v. Secty of Health and Human Services, 733 F. 2d 255 (2d Cir. 1984); Dartmouth Plan, Inc. v. Valle, 117 Misc. 2d 534 (Sup. Ct. Kings Co. 1983).

Jan. 1979 to Jan. 1980 **Research Assistant, Professor Arthur Kinoy, Rutgers School of Law**
Researched and wrote memoranda on constitutional and civil rights issues. Helped compile materials for Professor Kinoy's book, Rights on Trial (1983).

Summers, 1978 and 1979 **Law Clerk, Reproductive Freedom Project, American Civil Liberties Union Foundation**
Researched and wrote briefs, legal memoranda, motions, and affidavits for federal litigation on reproductive rights.

May 1976 to Sept. 1977 **Legislative Assistant, Office of the City Council President**
Assisted in development of Ombudsman Office to handle citizen complaints against New York City agencies. Wrote reports for New York City Charter Revision Commission. Analyzed contracts presented for approval by Board of Estimate and ordinances introduced before City Council.

EDUCATION

June 1980 **Rutgers University School of Law**, Newark, New Jersey
Juris Doctorate
Clinical Experience: Women's Rights Litigation Clinic (1978)
Urban Legal Clinic (1980)
Honors: Articles Editor, *Women's Rights Law Reporter,* (1979-1980)
G.A. Moore Prize for distinguished work in equal employment opportunity law.

May 1976 **Columbia University**, New York, New York
Bachelor of Arts, Political Science and Urban Studies
Honors: *Magna Cum Laude*
Columbia University Scholarship (1973-1976)
Phi Beta Kappa

BAR MEMBERSHIPS

- New York State (1981)
- Federal District Court, Southern and Eastern Districts of N.Y. (1981)
- Federal Court of Appeals, Second Circuit (1989)

PROFESSIONAL AWARDS, HONORS, MEMBERSHIPS

- National Consumer Law Center, Vern Countryman Consumer Law Award (1996): For "outstanding efforts to strengthen and affirm the rights of low-income Americans through the practice of consumer law."
- Association of the Bar of the City of New York, Legal Services Award (1991): For "outstanding work in providing civil legal assistance to the poor in New York City and equal access to justice."
- California Department of Managed Health Care, Advisory Committee on Managed Care, Gubernatorial Appointee (2000-2005).
- U.C.L. A. California Health Information Survey, Advisory Board Member.
- Insure the Uninsured Project Award (2009): For "Thoughtful Leadership on Value Purchasing and Quality Improvement."

PUBLICATIONS

- *Caveat Venditor*, a New York consumer law manual, with Stephen Newman, Professor of Law at New York Law School (1994).
- "Jobs, Education, Employment and Training," *Clearinghouse Review*, January 1994 co-author on advocacy opportunities.

ConsumersUnion®
POLICY & ACTION FROM CONSUMER REPORTS

January 30, 2017

Shelley Rouillard
Director, Department of Managed Health Care
980 9th Street, Suite 500
Sacramento, CA 95814-2725

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

Dear Director Rouillard:

Last spring, Consumers Union and Health Access submitted written comments on the Anthem-Cigna merger and provided public comments at the Department of Managed Health Care's public meeting. We raised strong concerns about how this merger would affect competition in California, as well as Anthem's history of failing to abide by basic consumer protections under the Knox-Keene Act. We continue to reiterate our strong objection to this merger and for the need for a contractual commitment from Anthem to do better by way of its customers.

Currently, Anthem Blue Cross and Cigna hold a substantial share of the California health insurance market, including on the individual marketplace as well as the small and employer-based marketplace. Cigna is also a leading carrier of ASOs. As the US Department of Justice recently stated, "Where Anthem has higher market shares, it is less responsive to customers and providers" and "Where Anthem has lower market shares, it seeks different ways to compete."[1] Without repeating the testimony of our organizations during the public hearing, and in follow-up written comments, we note that Anthem has historically struggled to meet consumers' expectations and regulators' standards. Between 2015 and 2016 alone the number of enforcement actions against Anthem by DMHC skyrocketed—from 87 to 195—and Anthem paid $2,498,500 in fines.[2] In addition, the Department issued a finding that Anthem had failed to correct known deficiencies in its provider directory, despite substantial notice and a looming state law that would require accuracy. Since last spring, the Department has completed a number of additional enforcement actions against Anthem for grievance systems failures and other serious problems and Anthem's provider directories continue to be inaccurate.

Anticipated changes to the healthcare system and in consumer protections on the federal level will likely impact millions of Californians. These changes would leave consumers more vulnerable and in need of support than we anticipated when this proposed merger was first announced. We, therefore, urge a redoubled effort by the department to ensure that an acquisition of Cigna by Anthem not only does not harm consumers, but actually benefits them. To make that more likely, we suggest the imposition of additional undertakings, should the merger be approved at all.

Despite the documented shortcomings in Anthem's treatment of consumers, if anticipated changes to the health insurance landscape are realized, an insurance carrier such as Anthem, with its resources and infrastructure, may be the source of a lifeline of sorts for consumers. Therefore, in addition to the

[1] U.S., et. al. v. Anthem, Inc. and Cigna Corp., Plaintiffs' Opening Statement Phase II, (Public, Redacted Version), available at https://www.justice.gov/atr/case-document/file/920046/download.
[2] Enforcement Action details via the Department of Managed Health Care (DMHC) Dashboard, last accessed January 20, 2017, available at http://wpso.dmhc.ca.gov/dashboard/EnforcementActions.aspx.

undertakings urged by our organizations in 2016, we also request that, if the merger does go forward, DMHC secure the following assurances from Anthem-Cigna as a condition for any approval:

1. Investments to cover the uninsured and underinsured. Based on the precedent set by both the United-Pacificare merger in 2006 and the Anthem-Wellpoint merger in 2004, we believe an undertaking of $1.08 billion is justified.[3] That would be used to expand insurance coverage for low-income Californians who are not qualified for Medi-Cal and cannot afford private insurance premiums.
2. Funding for a consumer assistance program. We support the Health Consumer Alliance's request for resources for consumer assistance programs and defer to their letter, sent separately to DMHC, for more information.

We thank the Department for reviewing this proposed merger with the utmost scrutiny and, if approval is granted, for protecting consumers to the fullest extent possible by achieving substantial and measurable undertakings. Please let us know if you have any questions about our position or the contents of this letter.

Sincerely,

Dena Mendelsohn
Staff Attorney
Consumers Union

Tam M. Ma
Legal and Policy Director
Health Access California

[3] At the time of both mergers, the plans were required to contribute approximately 2% of the cost of the transaction towards investments in programs to serve the underserved. Our recommendation of $1.08 billion is therefore based on 2% of the transaction cost of $54 billion of this merger is completed.

Statement of Dena Mendelsohn
Staff Attorney
Consumers Union

to the

Department of Managed Health Care

on the

Proposed Acquisition of Cigna Corporation by Anthem, Inc.

March 9, 2016

Consumers Union, the public policy and advocacy arm of nonprofit Consumer Reports, offers this testimony on the proposed acquisition of Cigna Corporation ("Cigna") by Anthem, Inc. ("Anthem"). From its founding, Consumer Reports has striven for a marketplace of safe, effective, reliable, and fairly priced products—this mission extends deeply into the health care sector. The advantages for health plans that merge are clear, but the advantage for consumers are not. Instead, we anticipate a less competitive insurance marketplace, with the potential for lower quality products at higher costs for consumers. While consumers around the nation await the outcome of the U.S. Department of Justice's investigation of this proposed merger, Californians also rely on state regulators to take action as may be necessary to protect consumer interests in our state. We, therefore, ask you to ensure that if Anthem and Cigna merge, consumers are not harmed, and the sum of the two plans is better than what consumers get when the plans stand alone.

We urge the Department of Managed Health Care ("DMHC") to review this proposed merger in light of: (1) the dominant, collective status of these insurers in California, (2) the fact that market consolidation is far more likely to benefit the carriers than the consumers, and (3) that increased market power may mean worse insurance products for consumers. We discuss these three aspects more fully below, as well as provide recommended steps to make the planned merger, in the event it goes forward, safer and more beneficial for consumers and the California insurance market.

I. Current state of the health insurance market in California

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

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

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

II. Market consolidation helps carriers, not consumers

a. The fallacy of consolidation as an antidote to consolidation

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

b. The dubious promise of shared savings with consumers

The announcement of a proposed merger—including a merger of health plans—is frequently padded with promises of cost-savings to be passed along to consumers. Indeed, the announcement of this

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[2] Dan Diamond, *What the Anthem-Cigna Mega-Merger Could Mean for California*, CALIFORNIA HEALTHLINE (September 9, 2015), http://californiahealthline.org/news/what-the-anthem-cigna-mega-merger-could-mean-for-california.

[3] U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-15-101R, PRIVATE HEALTH INSURANCE: CONCENTRATION OF ENROLLEES AMONG INDIVIDUAL, SMALL GROUP, AND LARGE GROUP INSURERS FROM 2010 THROUGH 2013, at 19 (2014). Available at http://www.gao.gov/assets/670/667245.pdf.

[4] *Id.* at 13.

[5] *Id.* at 15.

[6] *Id.* at 17.

[7] Letter from the American Antitrust Institute to Assistant Attorney General William J. Baer of the U.S. Department of Justice, at 3 (January 11, 2016). Available at http://www.antitrustinstitute.org/sites/default/files/Health%20Insurance%20Ltr_1.11.16.pdf.

[8] David Lazarus (quoting Erin Tirsh, a researcher at USC's Schaeffer School for Health Policy and Economics), *As Health Insurers Merge, Consumers' Premiums are Likely to Rise*, L.A. TIMES (July 10, 2015), http://www.latimes.com/business/la-fi-lazarus-20150710-column.html.

proposed merger was coupled with promises that the merger would "deliver meaningful value to consumers and shareholders through...enhanced affordability and cost of care management capabilities."[9] The public was also assured that this merger would "help address our health system's challenges and provide supplemental insurance protection, and health care security to consumers."[10] However, consumers have reason to doubt assurances that this proposed merger would afford efficiencies for the benefit of consumers. Research on the subject reveals a dearth of economic studies or other evidence substantiating those kinds of assurances to be borne out in practice. As explained by one leading healthcare antitrust scholar regarding such health plan mergers, even if a more powerful health plan can force reimbursement rates lower, there is "little incentive [for an insurer] to pass along the savings to its policyholders."[11] It may be that plans do achieve savings from combining some aspects of their operations and launching new programs. But evidence suggests that savings from these programs will be limited to "small pockets of inefficiency."[12] Beyond that, the savings of "more affordable" products could be attributable to lesser quality, reductions in customer service, or excessively narrow provider networks. Consumers need assurances that any cost savings will not be achieved via reductions in the availability or quality of services. Finally, claimed efficiencies through vague "synergies" are often illusory; improvements in quality or service can generally be achieved just as well without merging.

c. The unfounded linkage of consolidation and innovation

Consumers and regulators should be wary of assurances, such as the one by the President and CEO of Anthem, that the proposed merger will "deliver meaningful value to consumers" through "superior innovation".[13] As one leading expert testified before the Senate Committee on the Judiciary, "there is no research showing that larger insurers are likelier to innovate."[14] In a recently released report, that expert expanded on her statement, reporting "there is no evidence of greater product innovation in more concentrated insurance markets," in fact noting to the contrary the plausible reasoning that

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

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

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

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

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

[14] *"Health Insurance Industry Consolidation: What Do We Know From the Past, Is It Relevant in Light of the ACA, and What Should We Ask?," Before the Subcomm. on Antitrust, Competition Policy, and Consumer Rights of the S. Comm. on the Judiciary*, 114th Cong. 3 (2015) (testimony of Leemore S. Dafny, PhD.). Available at http://www.judiciary.senate.gov/imo/media/doc/09-22-15%20Dafny%20Testimony%20Updated.pdf.

"insurers in more concentrated markets are less motivated to innovate because it isn't necessary to retain customers."[15] Indeed, it is unclear how innovation would improve post-merger. Despite questions from consumer groups along those lines, we have yet to hear an adequate explanation from the carriers of why innovation is inextricably linked with consolidation. It is not even apparent what health plans mean when they say "innovation." If *innovation* in this context means selective contracting, or network management, as suggested by some scholars[16], this is not exactly a breakthrough that justifies a major shift in the composition of the insurance market. We support innovation that makes high quality products more affordable, improves health outcomes, and makes significant inroads in reducing racial and ethnic disparities. Health plans must be held accountable for assurances such as these so that they are not merely empty or self-interested promises.

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

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

a. The risk of quality going from bad to worse

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

- In 2012, the California Department of Insurance (CDI) brought legal action against Cigna, (and Health Net), in response to IMR requests by Cigna policyholders who were—inappropriately, in the determination of CDI—denied coverage for Autism therapy.[17] The CDI and Cigna reached an agreement[18] obligating Cigna to cover behavioral therapy for autism for the period of time leading up to enactment of SB 946, which requires health care service plan contracts and health

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

[16] *Id.*

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

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

insurance policies to provide coverage for behavioral health treatment for autism or other development disorders.

- In 2013, Anthem had the highest rate of Independent Medical Review (IMR) requests among health plans operating in California with 400,000 or more enrollees. Among all the health plans in the state, of any size, Anthem had the third-highest rate of IMRs.
- In 2013, Cigna was middle of the pack for IMR requests among plans with fewer than 400,000 enrollees. However, Cigna's rate of consumer complaints increased by 15% in 2014, causing the health plan to become the third highest rate of IMR requests.[19]
- Like Cigna, Anthem had a higher rate of IMR requests in 2014 than in 2013. In 2014, Anthem continued to have the highest rate of IMR requests among health plans operating in California with 400,000 or more enrollees. Nearly half of decisions involving Anthem that went through the IMR process for experimental/investigational care were overturned by DMHC[20] and about 60% of IMRs for medical necessity or ER reimbursement were either overturned by DMHC or reversed by the plan.[21] In 2014, Anthem also had the highest rate of IMR requests for all plans.
- In 2014, Anthem had:
    - The highest rate of complaints regarding access issues among plans with 400,000 or more enrollees and the second highest rate of complaints for all DMHC-regulated plans.
    - The second highest rate of complaints to DMHC regarding claims and financial of all the plans with 400,000 or more enrollees.
    - The second highest rate of complaints to DMHC related to enrollment of all plans, as well as for the sub-category of plans with 400,000 or more enrollees, nearly tied with the plan that had the highest rate of complaints for this category.
    - The most complaints to DMHC regarding the "attitude" or service of the health plan among plans with 400,000 or more enrollees, and the second-most complaints for the same category among all plans (second only to the Chinese Community Health Plan).
- In 2014, Cigna had the third highest rate of consumer complaints regarding attitude/service among plans with fewer than 400,000 members.

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

[20] *2014 Annual DMHC Report.*

[21] *2014 Annual DMHC Report.*

- In 2014, DMHC conducted a non-routine survey of Anthem Blue Cross provider networks and directories for the individual market and took enforcement action against the plan.[22] Fining the plan $250,000, the Department in its press release stated that Anthem would be required to "improve the accuracy of their provider directories and reimburse enrollees who may have been negatively impacted by inaccuracies in provider directories."[23]
- The California Office of the Patient Advocate (OPA) found, in its Health Care Quality Report Cards 2015-2016 Edition, based on surveys of HMO and PPO policyholders:[24]
    - Anthem Blue Cross PPO was rated *Poor* (one star out of four) for the product overall[25] and that its HMO was rated *Poor* for *Getting care easily*.[26]
    - Cigna PPO was rated *Poor* for *Getting care easily* and *PPO helps members get answers*[27] and its HMO was rated *Poor* for both *Getting care easily* and for *Heart care*.[28]
- Out of 507 ranked private plans, the NCQA ranked Anthem Blue Cross HMO/POS #317, Anthem Blue Cross PPO #329, and Anthem Blue Cross Life and Health Insurance #330.[29]
- In the NCQA scoring, the Anthem Blue Cross HMO/POS product earned a below-average score for *customer satisfaction*, earning only 2 out of 5 for *getting care* and the lowest score possible, a 1 out of 5, for how consumers rated satisfaction with the product's specialists.[30] Also troubling, the HMO/POS product received low scores for well-child visits and access to pediatricians. In fact, the product earned only a single star when consumers were asked whether children age 15 months got the recommended up to six well-child visits since birth.[31]
- Failure to adequately ensure consumer privacy and data security
    - In 2013, Anthem (at the time called Wellpoint), the parent firm of Anthem Blue Cross Blue Shield in Virginia and Empire BlueCross BlueShield in New York, agreed to settle a

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[22] Press Release, Department of Managed Health Care, DMHC Fines Blue Shield and Anthem for Inaccurate Provider Directories (November 3, 2015) (available at http://www.dmhc.ca.gov/portals/0/abouttheDMHC/newsroom/2015/pr110315.pdf).

[23] *Id.*

[24] The OPA patient ratings are based on Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey results. This survey queries HMO and PPO members on the care and services they received by their health plan.

[25] *Anthem Blue Cross PPO 2015-16 Edition*, State of California Office of the Patient Advocate. Available at http://reportcard.opa.ca.gov/rc/profile.aspx?EntityType=PPO&Entity=BLUE_CROSS_PPO.

[26] *Anthem Blue Cross HMO 2015-16 Edition*, State of California Office of the Patient Advocate. Available at http://reportcard.opa.ca.gov/rc/profile.aspx?EntityType=HMO&Entity=BLUE_CROSS.

[27] *Cigna HMO 2015-16 Edition*, State of California Office of the Patient Advocate. Available at http://reportcard.opa.ca.gov/rc/profile.aspx?EntityType=PPO&Entity=CIGNA_PPO.

[28] *Cigna HMO 2015-16 Edition*, State of California Office of the Patient Advocate. Available at http://reportcard.opa.ca.gov/rc/profile.aspx?EntityType=HMO&Entity=CIGNA.

[29] *NCQA Health Insurance Plan Rankings 2014-2015 – Summary Report (Private)*. Available at http://healthplanrankings.ncqa.org/2014/.

[30] *NCQA Health Insurance Plan Rankings 2014-2015 – Detail Report (Private)*, Plan Name: Anthem Blue Cross. Available at http://healthplanrankings.ncqa.org/2014/HprPlandetails.aspx?id=121.

[31] *Id.*

claim of potential HIPAA violations by paying a $1.7 million fine. According to HHS, "more than the health records of more than 600,000 individuals were found to be vulnerable to Internet breach" and that Wellpoint had inadequate technical safeguards against such a breach.[32]

- In Spring 2015, after waiting four months after they discovered it, Anthem disclosed a data breach affecting as many as 80 million past and current policyholders.[33, 34] Through a cyberattack on its IT system, hackers may have gained access to policyholders' names, birthdays, Social Security numbers, health care ID numbers, home addresses, email addresses, employment information, and income data.[35] Anthem estimated that the breach occurred over the course of several weeks in December 2014. Experts said Anthem was a likely target for hackers because "they have been slower to adopt measures" to protect consumers and are "generally less secure than financial service companies who have the same type of customer data."[36]

- On September 3, 2014, DMHC issued a Preliminary Report to Anthem Blue Cross, in which the Plan was cited for seven deficiencies (shown below). In its 2015 Final Routine Survey[37], the Department found that Anthem had not corrected *any* of the noted deficiencies. Those were[38]:
  - Grievances and appeals: (1) failure to maintain a grievance system that consistently ensures any written or oral expression of dissatisfaction; (2) impermissible processing of standard grievances pertaining to coverage disputes, disputed health care services involving medical necessity, and experimental or investigational treatment through its exempt grievance process; (3) impermissible processing of standard grievances that are not resolved by the close of the next business day through its exempt grievance process; (4) failure to maintain a grievance system that consistently ensures adequate consideration of enrollee grievances and rectification where appropriate.
  - Grievances and appeals (behavioral health only): their grievance system does not consistently ensure compliance with all acknowledged letter requirements.

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[32] *Anthem, Empire Parent Firm Settles HIPAA Charges for $1.7 Million Fine*, INSURANCE & FINANCIAL ADVISOR (July 18, 2013), http://ifawebnews.com/2013/07/18/anthem-empire-parent-firm-settles-hipaa-charges-for-1-7-million-fine/.

[33] Reed Abelson and Matthew Goldstein, *Anthem Hacking Points to Security Vulnerability of Health Care Industry*, N.Y. TIMES: BUSINESS DAY (February 5, 2015), http://www.nytimes.com/2015/02/06/business/experts-suspect-lax-security-left-anthem-vulnerable-to-hackers.html?_r=0.

[34] ANTHEM, https://www.anthemfacts.com/ (last updated August 25, 2015)

[35] Reed Abelson and Matthew Goldstein, *Anthem Hacking Points to Security Vulnerability of Health Care Industry*, N.Y. TIMES: BUSINESS DAY (February 5, 2015), http://www.nytimes.com/2015/02/06/business/experts-suspect-lax-security-left-anthem-vulnerable-to-hackers.html?_r=0.

[36] *Id.*

[37] *Final Report Routine Survey of Blue Cross of California*, DEPARTMENT OF MANAGED HEALTH CARE HELP CENTER DIVISION OF PLAN SURVEYS (April 3, 2015). Available at http://dmhc.ca.gov/desktopmodules/dmhc/medsurveys/surveys/303_r_full%20service-behavioral%20health_040315.pdf.

[38] *Id.*

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

- In 2015, DMHC fined Anthem more than $1.5 million for the Plan's failure to pay for an important screening for pregnant women when the only provider able to conduct that screening was out-of-network.[39]
- In 2015, the Missouri Department of Insurance fined Cigna subsidiaries $140,800 for "using unapproved forms, incorrectly denying chiropractic claims, charging copayments of more than 50 percent and failing to send an explanation of benefits to members."[40]
- In 2016, CMS issued an enforcement action prohibiting Cigna from enrolling new Medicare beneficiaries and from marketing activities to Medicare beneficiaries. In its enforcement notice, CMS stated that Cigna "substantially failed to comply with CMS requirements" and that Cigna's failures were "widespread and systemic. Violations resulted in enrollees experiencing delays or denials in receiving medical services and prescription drugs, and increased out of pocket costs for medical services and prescription drugs."[41]

Despite historical underperformance of these plans and room for quality improvement, Anthem instead recently announced a 4% increase in shareholder dividends.[42] Yet, in its rate filing justification for the 2016 plan year, Anthem projected increased administrative expenses and profits alongside *decreases in quality improvement expenses* compared to what was projected for the year prior.[43] While for-profit corporations have an obligation to their shareholders, they do not need to increase dividends rather than reinvest those profits in improving their products. It is illogical to suppose that with even less competition Anthem would elect to spend its profits to improve its product rather than its bottom line and the pockets of its investors.

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

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

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

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

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

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

b. The potential for deteriorating provider networks

Health plans are continuously adjusting their networks, partly in an effort to negotiate more favorable rates with providers and contain the cost of care. Although network narrowing has become a hot button topic, a recent report from the Robert Wood Johnson Foundation found that "[m]ore than 95 percent of regionally ranked hospitals were in-network with at least one Affordable Care Act marketplace plan in both 2015 and 2016."[44] Through careful tailoring, the California health insurance market is at a comfortable point in terms of network size: regionally ranked hospitals are included in 11 out of California's 12 regions, an increase of 10% in 2016 over 2015.[45] We therefore worry whether a merged plan like the one proposed here will alter networks in California out of the current comfort zone. For example, in Missouri, there was an outcry among consumers when the network for the Anthem BlueCross BlueShield plans, sold on the federal marketplace, did not include BJC HealthCare and its 13 hospitals, including Barnes-Jewish Hospital, an internationally recognized academic medical center, and its children's hospital.[46]

Carefully tailored networks can be a valid option for lowering costs and attaining higher value in the health care system. However, "sufficient consumer protections must be in place to realize these benefits without unduly limiting consumer choice or decreasing healthcare value."[47] Among other factors to be considered, there must be sufficient numbers and types of providers in the marketplace to ensure consumers can access high quality affordable care when needed. Yet, the risk of two major plans merging and using their clout to shrink networks is concerning in terms of whether consumers will be able to access care. We therefore strongly urge the Department, in the event this merger is approved, to closely monitor the plan networks, and to hinge any merger approval on undertakings related to both network adequacy and provider directory accuracy.

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[44] *Most Regionally Ranked Hospitals Stay In-Network with Marketplace Plans, But Participation Declines*, Robert Wood Johnson Foundation, at 1 (February 23, 2016). Available at http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2016/rwjf426368.

[45] *Id.* at 4.

[46] Jay Hancock, *Consumer Groups Criticize Anthem's Narrow Network in Missouri's Obamacare Marketplace*, KAISER HEALTH NEWS (September 26, 2013), http://khn.org/news/narrow-insurance-network-missouri-exchange-marketplace/.

[47] *Addressing Consolidation in the Healthcare Industry*, CONSUMERS UNION HEALTH CARE VALUE HUB, Research Brief No. 10, at 7 (January 2016), http://www.healthcarevaluehub.org/files/2614/5452/4976/Addressing_Consolidation_in_Healthcare.pdf.

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

Although regulators successfully compelled health plans in California to reduce proposed rate increases by about $349 million over three years,[48] the fact remains that California is a *file and use* state, and a health plan that is disinclined to work with regulators is not required to do so. In addition to benefiting from two insurance regulators that rigorously review rate filings,[49] Californians also have the advantage of a state-based marketplace that, through its active purchaser status, negotiates rates before they are even put through for regulatory review. But the ability of Covered California to moderate rate increases has limitations. In 2015, for example, CDI announced that Anthem failed to justify its rate increase for consumers with individual grandfathered health insurance products and that the Plan refused to honor to a request by CDI to moderate the rate increase.[50] The merger of Anthem and Cigna, with its greatly expanded market share, threatens to further shift this delicate balance. Anthem recently filed with DMHC a proposed small group rate increase averaging 13.5% with a maximum of 24.9%, which would affect 39,000 members.[51] If Anthem increases its market share, and businesses on the small group market have fewer options, how will consumers absorb such a large increase, especially since it may tend to happen year after year?

Even in a relatively positive climate for rates in California, where the combination of rate review and an active purchaser marketplace may moderate rate increases, Anthem's performance in the process leaves room for improvement. For example, in its 2016 rate filing justification, Anthem indicated intent to increase its administrative expenses by 27% in 2016 over its proposal for 2015. However, rather than explaining *why* the administrative costs will expand exponentially, the carrier simply defined what is an administrative cost.[52] Additionally, of the Anthem plans regulated by DMHC and CDI between 2011 and 2016, nearly all had premium increases at or above average.[53] Notably, two of its individual products that were regulated by CDI in 2013 had premium increases significantly above average—19.4% and 25.6%--and affecting a total of 636,144 enrollees, even after dropping its rate increases from 24.6% and 28.1% respectively.[54]

Anthem has proven itself willing to go up against state regulators who do not approve its exorbitant rate increases. Anthem Blue Cross and Blue Shield of Maine went to court after the state, which has prior

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[48] *California Health Insurance Rate Review*, CALPIRG, at 7 (April 17, 2014), http://www.calpirg.org/reports/cap/california-health-insurance-rate-review.

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

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

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

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

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

[54] *Id.*

approval authority, refused to approve an average rate hike of 18.5 percent on its policyholders. The court found against Anthem on all its arguments, holding that the "Superintendent's balancing of consumer interests against Anthem's desire for profits was appropriate."[55] If this merger is approved, regulators may find themselves reviewing larger rate increases across the table from a large health plan unwilling to negotiate. We therefore urge DMHC to link any approval, if one is ultimately forthcoming, to an enforceable undertaking that obligates the newly formed plan to only go forward with rates that are reasonable and fully justified.

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

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

- Health insurance rates: The merged company should agree to not moving forward with premium rate increases in any market segment that CDI or DMHC deem unjustified or that contain inaccurate or incomplete information. Given the risk that the bigger merged company could unreasonably increase premiums, it should agree to providing even greater detail, and making it publicly available, to aid DMHC and CDI in especially close rate review, for a number of years after the merger. And to begin with, it should agree that Covered California, DMHC, and CDI may calculate any proposed increase rate based on Anthem or Cigna rates for the 2016 plan year, whichever sold the original product in that year. No proposed rate increase should be permitted to be finalized if it has been deemed unreasonable or unjustified by the Department; instead, the plan should confer with regulators until a reasonable and justified rate is set. This should apply to all lines of business subject to rate review at the time the rate is filed. While this would not replace the protections provided by effective competition, it would help alleviate some of the potential excesses.
- Quality improvement and cost containment initiatives: Existing state law requires that each plan's rate filing include "any cost containment and quality improvement efforts since the last filing for the same category of health benefits plan. To the extent possible, the plan shall describe any significant new health care cost containment and quality improvement efforts and provide an estimate of potential savings together with an estimated cost or savings for the projection period."[56] Unfortunately, that requirement is often honored more in the breach than the observance. In fact, in commenting on Anthem's rate filing justification for 2015, Consumers Union noted that the plan's actuarial memorandum "simply lists a generic assortment of quality improvement programs. ... [I]t neither provides details on cost containment and quality

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

[56] CAL. HEALTH & SAFETY CODE § 1385.03(c)(3) (Deering 2016)

improvement efforts nor estimates of costs or savings, as required."[57] The same was true in the following year, when Consumers Union's comment to DMHC was that, "The problem here is that without details about the initiatives and the related costs, it is difficult to see this report as anything other than a laundry list of quality improvement catch-phrases."[58] We urge the Department to secure specific and enforceable assurances that Anthem-Cigna will reinvest a meaningful portion of profits in quality improvement and cost containment initiatives and provide clear explanations and documentation of those investments, dollar breakdowns, estimated savings, and descriptions of how each of them directly benefits policyholders.

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

Conclusion

In conclusion, the California commercial health insurance marketplace has been 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 for pricing and quality and access for consumers. We appreciate DMHC holding a public meeting on this

[57] Consumers Union comments on Blue Cross of California Rate Filing, SERFF Tracking Number AWLP-129656693, (August 27, 2014).
[58] Consumers Union comments on Blue Cross of California Rate Filing, SERFF Tracking Number AWLP-130080574, (September 1, 2015).

proposal and the Department's openness to input. The Justice Department, working with the California Attorney General, could determine that the merger should not go forward, and challenge it under the antitrust laws. Or the Department might decide under its own authority not to approve the merger. But if the merger ultimately goes forward, we would urge the Department to consider appropriate actions, including the actions we have described above, to ensure that the merger does not harm consumers or insurance markets in California.

Sincerely,

Dena B. Mendelsohn
Staff Attorney
Consumers Union