Department of Managed Health Care

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Consumer Participation Program

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Award Application Details: Health Access of California

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Application Version: Original App

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Please review and approve this Application for an Award and Witness Fees if applicable.

Approvals & Comments | DMHC Attachments | Send Email

Entity Name:	**Health Access of California**
Submitted By:	Tam Ma
Date Submitted:	8/19/2016 12:20:36 PM
Status:	Pending
Date of Decision:	
DMHC Comment:	(8000 characters remaining)
Updated By:	
Updated Date:	

Save

Decisions & Comment History *(Hide Details...)*

There are currently no decisions or comment history.

Award Application *(Hide Details...)*

Printer Format

1. For which proceeding are you seeking compensation?

   Proposed merger of Aetna and Humana

2. What is the amount requested?

   $15,147.50

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.

(8000 characters remaining)

Health Access California submits this request for reasonable advocacy fees for our substantial contribution to the decision of the Department of Managed Health Care (DMHC) regarding Aetna's acquisition of Humana. Health Access substantially contributed to DMHC's review of the proposed merger by providing oral testimony at the DMHC's public meeting on January 4, 2016. We also submitted extensive written comments on January 11, 2016 about how the proposed merger would impact consumers and proposed a number of questions to ask and undertakings to consider should the material modification be approved. Many of the concerns we raised, and suggestions we made, are reflected in DMHC's decision and undertakings. For example, Health Access raised significant concerns regarding Aetna's history of pursuing unreasonable rate increases, both at DMHC and CDI. DMHC ended up requiring Aetna to submit itself to increased oversight in the DMHC rate review program. We provided extensive information about Aetna's track record on consumer protection issues and quality ratings. The Undertakings require them to improve their quality ratings as measured by the Office of the Patient Advocate and NCQA. Health Access also requested that Aetna maintain key functions in California, including medical decision making and enrollee grievance and appeals. These requirements are included in the undertakings.

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	
Health Access time tracker	8/19/2016 12:10:36 PM	Tam Ma	View
Biographies and billing classifications	8/19/2016 12:10:59 PM	Tam Ma	View
Written comments on Aetna-Humana merger	8/19/2016 12:11:32 PM	Tam Ma	View

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

As the statewide health care consumer advocacy coalition, Health Access has had a longstanding commitment to protecting consumer interests and ensuring health plans comply with the consumer protections provided by the Knox-Keene Act. We have been active in raising consumer concerns in health industry transactions, including health plan mergers. Health Access has experience and expertise in the laws and regulations affecting managed care. Our participation is necessary to ensure that consumers, particularly Aetna enrollees, are represented in this transaction. Our oral and written comments provides the Department with information regarding how health plan mergers affect competition and premiums. We also provide analysis of how health plan mergers should be reviewed in the context of California's implementation of the Affordable Care Act and detail Aetna's extensive track record of not abiding by basic consumer protections. We believe our participation provides informed insight and ensures that the interests of health care consumers are represented and considered during the Department's review of this transaction.

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 Sacramento (City), CA (State), on August 19, 2016 .

Enter Name: Tam M. Ma

Account Info at Time of Submission (Hide Details...)

Account Information

Organization Legal Name:	**Health Access of California**
Organization Fictitious Name:	
Account Type:	Organization
Email Address:	tma@health-access.org
Organization Phone Number:	(916) 497 - 0923 ext. 201

Physical Address

Physical Address:	1127 - 11th Street
Suite:	234
City:	Sacramento
State:	CA
Zip/Postal Code:	95814

Organization Information

Organization Name:	Health Access California
Is this a nonprofit organization?:	Yes
Under what Statute is your Organization Incorporated?:	Nonprofit Public Benefit Corporation Law for public and charitable purposes
Organization's Size:	$125,000.00
Organization's Structure:	501 c 4
Description of the Organization's General Purposes:	HEALTH ACCESS CALIFORNIA is the statewide health care consumer advocacy coalition, advocating for the goal of quality, affordable health care for all Californians.

Organization's Governing Body

1.	**Director**	Aaron	Fox
2.	**Director**	Art	Pulaski
3.	**Director**	Betsy	Imholz
4.	**Director**	Cary	Sanders
5.	**Director**	Christina	Livingston
6.	**Director**	Emily	Rusch
7.	**Director**	Henry	Lacayo
8.	**Director**	Horace	Williams
9.	**Director**	Joan	Pirkle Smith
10.	**Director**	Jon	Youngdahl
11.	**Director**	Joshua	Pechthalt
12.	**Director**	Kathy Ko	Chin
13.	**Director**	Lori	Easterling
14.	**Director**	Nancy	Brasmer
15.	**Director**	Paul	Knepprath
16.	**Director**	Reshma	Shamasundra
17.	**Director**	Rick	Schlosser
18.	**Director**	Roma	Guy
19.	**Director**	Sonya	Young
20.	**Director**	Stewart	Ferry
21.	**Director**	Ted	Lempert
22.	**Director**	Thomas	Saenz

23.	**Director**	Vanessa	Aramayo	
24.	**Director**	Willie	Pelote	

Organization's Officers

1.	**Executive Director**	Anthony	Wright	

Contact Info at Time of Submission *(Hide Details...)*

First Name:	Tam
Last Name:	Ma
Email Address:	tma@health-access.org
Telephone Number:	(916) 497 - 0923 ext. 201
Status:	Active

- Jose Tapia
- Silvia Flores
- Tam Ma
- Rick Pavich
- Robin Avant

Tam Ma, Policy Counsel				
Date	**Work Performed**	**Time Spent**	**Hourly Rate**	**Total**
12/1/2015	Discussion with Health Access board re: mergers and strategy	1	$255	$255.00
12/3/2015	DMHC Consumer Advocates Meeting: discussion re: merger	0.5	$255	$127.50
12/18/2015	Internal meeting re: strategy for public meeting & written comments about Aetna merger	1	$255	$255
12/18/2015	Review Cattaneo & Stroud research on market impact of merger	0.5	$255	$127.50
12/29/2015	Research CA enrollment @ DMHC, CDI	1	$255	$255
1/2/2016	Review Aetna enforcement actions, routine medical survey, complaint & IMR data, quality ratings	4.5	$255	$1,147.50
1/3/2016	Research Covered CA SHOP program; Aetna departure from individual market; unreasonable rate increases @ DMHC and CDI.	3.5	$255	$892.50
1/3/2016	Prepare testimony for public meeting	3	$255	$765.00
1/4/2016	Internal emails re: testimony for public meeting	0.5	$255	$127.50
1/4/2016	Emails with consumer advocates re: hearing and written comments	0.5	$255	$127.50
1/4/2016	Attend and testify at public meeting	1.5	$255	$382.50
1/5/2016	Emails with consumer advocates discussing written comments	1	$255	$255.00
1/5/2016	Emails with Consumers Union re: Aetna enforcement actions	0.5	$255	$127.50
1/7/2016	Internal emails re: Aetna commercial business	0.5	$255	$127.50
1/7/2016	Internal discussion re: proposed conditions	0.5	$255	$127.50
1/7/2016	Work on comment letter	1.5	$255	$382.50
1/8/2016	Email with Consumers Union re: comment letters	0.5	$255	$127.50
1/8/2016	Addt'l research on prior Aetna merger, positions on transparency efforts	1	$255	$255.00
1/9/2016	Work on comment letter	4	$255	$1,020.00
1/10/2016	Work on comment letter	2.5	$255	$637.50
1/11/2016	Internal emails re: comment letter	1	$255	$255.00
1/11/2016	Finalize and submit comment letter	1.5	$255	$382.50
	TOTAL	**32**	**$255**	**$8,160**

Aetna Acquisition of Humana

Anthony Wright, Executive Director

Date	Work Performed	Time Spent	Hourly Rate	Total
12/1/2015	Discussion with Health Access board re: mergers and strategy	1	$355	$355.00
12/3/2015	DMHC Consumer Advocates Meeting: discussion re: merger	0.5	$355	$177.50
12/18/2015	Internal meeting re: strategy for public meeting & written comments about Aetna merger	1	$355	$355.00
12/1/2015	Discussion with Health Access board re: mergers and strategy	1	$355	$355.00
1/3/2016	Call around to coalition members	1	$355	$355.00
1/3/2016	Review testimony for public meeting and overall tone and strategy	1	$355	$355.00
1/4/2016	Emails with consumer advocates re: heairng and written comments	0.5	$355	$177.50
1/4/2016	Attend public meeting	1.5	$355	$532.50
1/5/2016	Emails with advocate in Connecticut re: Aetna concerns	0.5	$355	$177.50
1/7/2016	Internal discussion re: proposed conditions	0.5	$355	$177.50
1/10/2016	Review comment letter	1	$355	$355.00
1/11/2016	Provide and finalize comment letter	1	$355	$355.00
	TOTAL	**10.5**		**$3,727.50**

Beth Capell, Policy Advocate

Date	Work Performed	Time Spent	Hourly Rate	Total
12/1/2015	Discussion with Health Access board re: mergers and strategy	1	$425	$425.00
12/18/2015	Internal meeting re: strategy for public meeting & written comments about Aetna merger	1	$425	$425.00
1/7/2016	Internal emails re: Aetna commercial business	0.5	$425	$212.50
1/7/2016	Internal discussion re: proposed conditions	0.5	$425	$212.50
1/11/2016	Internal emails re: comment letter	1	$425	$425.00
1/11/2016	Review and edit comment letter	1.5	$425	$637.50
1/7/2016	Internal discussion re: proposed conditions	0.5	$425	$212.50
	TOTAL	**6**		**$2,550.00**

HEALTH ACCESS
California's Health Consumer Advocacy Coalition

BETH CAPELL, PH.D., *Capell & Assoc.* has been the principal and owner of Capell & Assoc.since its founding in 1995. She has thirty-eight years of experience in Sacramento, working in the Legislature, various Administrations, and with various interest groups.

Beth Capell provides policy analysis, legislative advocacy, and other strategic input to Health Access and to other consumer, labor and public interest organizations on health care issues.

Health Access California sponsored the package of legislation known as the HMO Patient Bill of Rights from 1995 to its enactment in 1999. Health Access Foundation led a collaborative of consumer groups that monitored initial implementation of the more than 20 pieces of legislation enacted between 1995 and 2000 intended to protect consumers from HMOs. Health Access Foundation has continued to work on implementation and ongoing monitoring of the law with respect to consumer protections against HMOs. Beth Capell has been an architect and active advocate throughout the two decades of these efforts.

Beth Capell has worked on issues including prescription drugs, universal access, hospital overcharging, balance billing by physicians, nursing home regulations, hospital standards, health insurance regulation, and other health care issues.

Prior to establishing Capell & Assoc. Beth Capell represented the California Nurses Association from 1986 to 1995, first as the legislative advocate and later as the Director of Government Relations for the association. From 1983 to 1986, Ms. Capell worked at the California Manufacturers Association, working on job training and human resource issues, including health insurance. From 1977 to 1983, Ms. Capell worked in various positions in the Legislature, the Administration, and other efforts.

Ms. Capell has Ph.D. in political science from the University of California, Berkeley, and continues to publish articles and present papers on political science, specifically interest groups, legislatures, and the impact of legislative term limits.

Billing classification: Experts: 13+ years of experience. $425/hour.

ANTHONY WRIGHT serves as Executive Director for Health Access California, the statewide health care consumer advocacy coalition, working on behalf of the insured and uninsured, made up of over 200 organizations representing seniors, children, working families, people with disabilities, immigrants, people of faith, labor, and communities of color.

Under Wright's leadership since 2002, Health Access has been a leader in efforts to fight health care budget cuts, to expand both employer-based coverage and public insurance programs, to advance consumer protections, and to address the causes of medical debt. For example, his work on hospital overcharging and abusive billing and collections practices led to both to legislative action and hospital guidelines on the issue. Recently, he served as co-chair and campaign manager for the No on 78/Yes on 79 initiative effort, facing the prescription drug industry and the most expensive ballot campaign in the nation's history.

Wright's background is as a consumer advocate and community organizer, and he has been widely quoted in local and national media on a range of issues. He served as Program Director for New Jersey Citizen Action. As coordinator of New Jersey's health care consumer coalition, he ran successful campaigns to win HMO patient protections, defeat for-profit takeovers of nonprofit hospitals and Blue Cross Blue Shield, pass a law to govern hospital conversions and acquisitions, and expand coverage for low- and moderate-income children and parents.

Wright also worked at the Center for Media Education in Washington, DC, *The Nation* magazine in New York, and in Vice President Gore's office in the White House. Born and raised in the Bronx, Wright graduated from Amherst College magna cum laude in both English and Sociology.

Billing classification: Experts: 13+ years of experience. $355/hour.

Tam M. Ma is Policy Counsel at Health Access California, where she represents health care consumers in the Legislature and before administrative and regulatory entities. Tam has over thirteen years' experience crafting state public policy. She started her career as a California Senate Fellow and was previously senior staff to Senators Mark Leno and Sheila Kuehl, where she advised the Senators on policy and state budget issues relating to health and human services, consumer protection, housing, judiciary, and women's issues.

Tam has crafted and worked for passage of legislation to protect consumers from unfair out-of-pocket costs, increase transparency in health care premiums, streamline state public benefits programs, help people living with HIV/AIDS to transition between new forms of health coverage under the Affordable Care Act, enhance consumer awareness of toxic flame retardant chemicals in home furnishings, strengthen the rights of low-income tenants, and increase protections for survivors of domestic violence, sexual assault, and human trafficking.

Tam was honored by the California Partnership to End Domestic Violence and the California Coalition Against Sexual Assault for her work to strengthen protections for survivors of these crimes. Tam advocated for the rights of low-income tenants when she was a trial attorney with Legal Services of Northern California's Sargent Shriver Civil Counsel Act project.

Tam sits on the board of the Women's Foundation of California and has served as a trainer and mentor for the foundation's award-winning Women's Policy Institute since its inception in 2003. She also serves on the board of the Asian/Pacific Bar Association of Sacramento and is Past President of My Sister's House, a domestic violence shelter serving women throughout the Central Valley. Tam received her B.A. (2002) and J.D. (2011) from the University of California, Berkeley, and has served as a lecturer at the law school.

Billing classification: Attorney: 3-4 years of experience. $255/hour.

HEALTH ACCESS
CALIFORNIA

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CA Black Women's Health Project

Jon Youngdahl
SEIU State Council

Anthony Wright
Executive Director

January 11, 2016

Shelley Rouillard
Director, Department of Managed Health Care
980 9th Street, Suite 500
Sacramento, California 95814-2725
Via e-mail to: publiccomments@dmhc.ca.gov

RE: Aetna-Humana Merger

Dear Director Rouillard:

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 Aetna's proposed acquisition of Humana. As a consumer protection agency, the Department of Managed Health Care (DMHC) 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, and insurers seeking to merge have the burden of showing that consumers will benefit from consolidation. As the DMHC evaluates each individual merger, it must 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.

We urge you to deny the Applications for Material Modification submitted by Aetna and Humana unless the companies 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. Aetna has had a troubling track record in California's commercial market, one that reflects a lack of respect for California law as well as basic consumer protections. As detailed herein, this proposed merger would have a substantial impact on consumers, other purchasers, and our health system as a whole. 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, including Aetna-Prudential, 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 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. At DMHC's January 7, 2016 public meeting, executives from Aetna and Humana claimed that this merger would result in savings and that "consumers will see lower overall costs, and those savings will improve consumers' experience."[1] 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.[2] In fact, Aetna's acquisition of Prudential in 1999 resulted in premiums increasing by seven percent.[3] 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.[4] 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.[5]

Aetna has not provided evidence that merger will result in lower costs and better value. Aetna also says the merger will give them "an enhanced ability to work with providers and create value-based payment agreements that result in better care to customers and spread cutting-edge clinical practices and quality care."[6] As researchers have noted, there is no evidence that larger insurers are more likely to implement value-based payment agreements and care management programs.[7] Aetna and Humana are already humungous, scaled entities and it is unclear how they will get any more scale economies from getting even bigger. If Aetna 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. We posed these questions to Aetna and Humana executives at DMHC's public meeting and they did not address them, further reinforcing our skepticism about whether this merger will bring any benefit to consumers.

Merger may limit competition in California's Medicare Market. While our concerns about this proposed merger is focused on how it affects consumers in California's commercial market, where most of Aetna's California business is based, we also note that its acquisition of Humana affects the national Medicare marketplace and will result in less competition and fewer options for consumers.[8] According to an analysis by Cattaneo and Stroud, the Aetna-Humana merger is likely to reduce competition in the Medicare market in eight California counties, including Fresno, Kern, Los Angeles, Orange, Riverside, San Bernardino, San Diego and Ventura.[9]

INSURER CONSOLIDATION AMID ON-GOING IMPLEMENTATION OF THE AFFORDABLE CARE ACT

The ACA has transformed the health insurance market and increased enrollment. As the primary regulator of health care service plans in California, the DMHC protects consumers' health care rights and ensures a stable health care delivery system. It must also 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 care through private managed health plans. DMHC-licensed health plans provide care to more than 25 million Californians, representing 91% of the large-group market, 82% of the individual market and 77% of the small-group market.[10] Enrollment in DMHC's licensed health plans increased 28 percent in the first full year of ACA implementation.[11] In 2014, 2.2 million Californians obtained coverage through the individual market, representing a 47

percent increase over the previous year.[12] Group coverage continues to be the main source of commercial health insurance, providing coverage for 11.8 million Californians in 2014.[13] 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.[14]

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.

Aetna has opted-out of California's health reform programs. Aetna's stock valuation has tripled in the past five years, since the Affordable Care Act was signed into law.[15] Despite record profits, Aetna's business strategy has left California consumers and purchasers with fewer choices for coverage. In 2013, Aetna left the state's individual market and chose to not participate in Covered California,[16] even as implementation of the Affordable Care Act expanded the individual market business. Although Aetna maintained its group business in California, neither its health nor dental plans have been offered in the Covered California for Small Business program, which provides options for medical and dental coverage. That Aetna has not participated in any aspect of health reform implementation in California, coupled with the fact that this proposed merger will not give California consumers any new or additional options for coverage (and would actually decrease choices in the Medicare Advantage market), we question whether this merger is in the interest of consumers.

HEALTH CARE COSTS AND UNREASONABLE RATE INCREASES BURDEN CONSUMERS

Consumers with health coverage struggle to pay medical bills. 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.[17] Workers are also seeing reduced benefits and increased cost sharing.[18] Almost 90 percent of those who enrolled through Covered California for coverage in 2015 received premium assistance to make their health insurance more affordable.[19] 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.[20] 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.[21] 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.

Aetna has repeatedly pursued unreasonable rate increases. Aetna's egregious history of imposing unreasonable rate increases on small business purchasers should be scrutinized because this deplorable practice undermines consumers' financial stability, particularly those who live paycheck to paycheck. In the last three years, DMHC has found four of Aetna's rate increases to be unreasonable, unsubstantiated, and unjustified, calling it "price gouging in today's market."[22]

- In July 2015, DMHC found Aetna's 21 percent increase affecting 13,000 small group members to be unreasonable.
- In May 2015, DMHC found Aetna's 19.2 percent increase affecting 16,000 small group members to be unreasonable.
- In December 2014, DMHC found Aetna's 17.3 percent increase affecting 9,500 small group members to be unreasonable.
- In March 2013, DMHC found Aetna's 11.4 percent increase affecting 20,000 small group members to be unreasonable.

Aetna has also imposed rate increases on its small business customers that the California Department of Insurance (CDI) deemed to be unreasonable.

- In October 2015, CDI found Aetna's average 27.4 percent increase affecting 40,000 people to be excessive unreasonable. By imposing the unreasonable rate increase, Aetna cost small businesses a projected $5.5 million in excessive rates.[23]
- In December 2014, CDI found Aetna's average 10.7 percent increase affecting 64,000 individuals to be excessive and unreasonable.[24]
- In April 2012, CDI noted that Aetna had an average 30.3 percent increase over 24 months for small employers with Aetna's PPO health insurance policies.[25]

Small businesses have had to pay more for health coverage because Aetna has repeatedly imposed rate increases that have been found to be unreasonable and unjustified. As a result, we have absolutely no confidence that Aetna would act any differently than it has in the past, nor do we expect Aetna to pass along the benefits of any cost savings or efficiencies to consumers and other purchasers. It is also worth noting that the $1.35 million in savings Aetna expects to achieve in the first year of the merger[26] pales in comparison to the tens of millions of dollars they have gained by overcharging small business purchasers.

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. Aetna has also shown that rate review does not prevent health insurers from raising premiums beyond what regulators deem to be reasonable. Finally, California rate review for large group health plans has not been implemented.

Aetna 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, Aetna opposed SB 546 (Leno), Chapter 801, Statutes of 2015, legislation that establishes new rate review requirements for the large group market.[27] 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 individual and small employer markets where rate review has already been implemented. In opposing SB 546, Aetna 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.

ON-GOING VIOLATIONS OF CONSUMER RIGHTS MUST BE RECTIFIED

DMHC's oversight and enforcement activity provides an abundance of information about Aetna's track record in California's commercial market, which we find to be distressing. The deficiencies found in Aetna's routine medical survey, extensive history of enforcement actions, poor quality ratings, high rate of being overturned in Independent Medical Review (IMR), and history of proceeding with unreasonable rate increase pose significant concerns about the quality and value of services provided to its existing enrollees. As consumer advocates, we are deeply concerned these problems will become more acute if Aetna is allowed to get bigger. We urge DMHC to scrutinize how Aetna will remedy its existing deficiencies and rate setting practices and ensure that enrollees have access to adequate networks, timely access to care, high quality health care, effective grievance procedures, language access, and reduced health disparities.

Routine Medical Survey: In DMHC's most recent routine medical survey (2013), Aetna was found to have three major deficiencies in the plan's quality management, grievances and appeals, and utilization management processes.[28] In a recent follow-up survey, Aetna still has not corrected one of the deficiencies, nearly three years after it was brought to their attention.[29] The uncorrected deficiency pertains to DMHC's finding that Aetna's website makes it difficult for patients to submit a grievance and does not provide important information about the California HMO grievance process, a critical consumer protection.[30] As a result, Aetna consumers do not know the timeframes for acknowledgement and resolution of an appeal, procedures pertaining to expedited appeals, or information about the Department's grievance process. It is appalling that Aetna has repeatedly failed to do something as basic as posting information about consumer rights on its website, in spite of multiple corrective action plans.[31] We question whether Aetna should be allowed to get bigger if it cannot do something as simple as update its website. DMHC should require Aetna to immediately comply with statutory requirements regarding grievance information and not wait until the next routine medical survey to determine if this deficiency has been corrected.

Enforcement actions: Aetna has been the subject of over 100 enforcement actions by DMHC. Aetna's poor handling of patient grievances has been the subject of most of DMHC's enforcement actions, for which it has accumulated 46 fines since 2011. The fines encompass 128 violations of Knox-Keene Act statutes and regulations regarding grievance systems and the handling of grievances.[32] In addition, Aetna has accumulated over $100,000 in fines in the last year alone, twice for prolonging the independent medical review process by not cooperating with the Department[33]; and seven times for poor

handling of consumer grievances, a recurring theme. In 2014, Aetna was fined $200,000 for failing to process claims and provider disputes in a timely manner.[34]

Quality ratings: Aetna has 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, patients give Aetna a good rating (3 out of 4 stars) overall and for helping members get answers.[35] Patients give Aetna a poor rating (1 out of 4 stars) for not helping them get the care they needed when they needed it.[36] In addition, Aetna's clinical performance ratings range from poor to fair for all eleven health conditions measured.[37]

Consumer Complaints and Independent Medical Review (IMR): In recent years, Aetna has had a high number of consumer complaints compared to most other large HMOs, especially as it pertains to benefit and coverage issues. In 2014, Aetna received 1.09 complaints per 10,000 enrollees for benefits and coverage issues, the third highest rate amongst plans with more than 400,000 enrollees.[38] Benefits and coverage issues was the highest source of Aetna's complaints in 2013.[39] The source of these complaints must be reduced if Aetna is to get bigger.

While Aetna's rate of being overturned by IMR was relatively low in 2014, it was high in 2013, when 43.8% of medical necessity IMRs, 45.8% of ER reimbursement IMRs, and 33.3% of Experimental/Investigational IMRs were overturned.[40] The Department should ensure Aetna has appropriate policies and procedures in place to ensure patients get the care they need.

Network Adequacy and Timely Access to Care: DMHC should review Aetna's timely access reports, which are not yet publicly available, to determine whether Aetna has adequate networks for all its plan products and whether it has met its obligations to provide its enrollees with timely access to care.

ENFORCEABLE UNDERTAKINGS NEEDED TO ENSURE CONSUMER PROTECTION

Aetna and Humana should not be allowed to make empty promises to California's health care consumers. Although the two companies have little overlap in the California market, Aetna's track record gives us deep concerns about how the merger will affect its existing and future enrollees. Neither company has demonstrated how their promises of innovation, efficiency, and value will be realized and shared with consumers, and why a merger is necessary to accomplish these goals. Finally, this deal involves two large national companies headquartered elsewhere in the United States. Given Aetna's longstanding failure to abide by minimal consumer protections, we question how an even larger company would be accountable to California regulators and consumers. If Aetna's acquisition of Humana is supposed to be good for California, then clear and enforceable conditions must be in place to ensure transparency, accountability, consumer protection, and safeguard Californians' hard-earned premium dollars.

Questions about Aetna's commitment to serving California consumers.

- Why a merger? Why is an acquisition of Humana necessary for Aetna to serve Medicare customers and deliver better value to consumers? Why not build on its

existing line of business and offer Medicare patients with additional choices rather than supplanting an existing option?

- Commitment to getting better. As previously discussed, Aetna has provided lackluster service and care to its commercial enrollees. Is it in the public interest to allow Aetna to be acquired if there is no commitment to fix these problems?
- Individual group market. Aetna left the individual group market in 2013 and opted to not participate in Covered California. Does it have plans to offer products in the individual market again, or will it focus on the small and large group market?
- Small group market. Aetna has not participated in any of Covered California's programs, including Covered California for Small Business. If the small group market is a key segment of Aetna's commercial business, why has it not participated and provided small businesses with more options?

Clear and enforceable undertakings to protect consumers. DMHC has found Aetna to provide deficient services to its enrollees, and it must be required to improve care and services to its enrollees before it can get bigger. Aetna's existing enrollees must have access to the quality care they are entitled to under the Knox-Keene Act.

- Immediately correct deficiencies. Aetna should be required to immediately correct outstanding deficiencies found in its Routine and Follow-up Medical Surveys and maintain compliance with all Knox-Keene requirements over a sustained period.
- Improving service, care, and quality. DMHC should require Aetna to meet specific benchmarks in improving access to care and customer service for its patients. Aetna must be required to bring all its quality ratings up to above-average levels within 3 years, and submit plans on how it will accomplish this task.
- Reduce source of IMRs and consumer complaints. Aetna must be required to reduce the rate of IMRs filed and overturned by DMHC 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 larger Aetna be accountable to California consumers and regulators? Aetna 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.
- Plans for achieving efficiency and savings. Aetna and Humana 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 Aetna 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 Aetna's business has been based on rates charged to commercial customers in the small and large group markets. The fact that health insurer mergers lead to higher costs for consumers, coupled with Aetna's history of imposing unreasonable rate increases, give us great pause that Aetna will provide consumers with a quality, affordable product.[41] DMHC should include clear and enforceable undertakings requiring rate

filings and information provided for group purchasers demonstrate how efficiencies reduce rates for consumers and other purchasers. How will the efficiencies be sustained over time, and how will purchasers benefit? Finally, Aetna should be required to not pursue any rate increases deemed to be unreasonable by regulators, pursuant to the rate review program established by SB 1163 (Leno), Chap. 661, Statutes of 2010.

- Keeping premium dollars and profits in California: Aetna 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: Aetna and Humana 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.
- Improve the health system as a whole: In order to address other potential impacts of the merger and these insurers' practices, Aetna 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.

The proposed merger between Aetna and Humana has significant implications for California's commercial market, 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 or (916) 492-0973 x. 201 if we can be of assistance as you evaluate the Applications for Material Modification. Thank you for giving these issues your highest level of scrutiny and for protecting the interests of consumers in this process.

Sincerely,

Anthony Wright
Executive Director

Cc: Secretary Diana Dooley, California Health and Human Services Agency
Senator Ed Hernandez, Chair, Senate Health Committee
Assemblyman Rob Bonta, Chair, Assembly Health Committee

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