DEPARTMENT OF Managed Health Care

State of California

Application for an Award of Advocacy and Witness Fees

Entity Name: Health Access of California
Date Submitted: 2/7/2018 11:41:16 AM
Submitted By: Tam Ma
Application version: Original App

1. For which proceeding are you seeking compensation?

Proposed merger of Anthem and Cigna

2. What is the amount requested?

$9,643.00

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.

Health Access California submits this request for reasonable advocacy fees for our substantial contribution to the Department of Managed Health Care's (DMHC) review of Anthem's proposed acquisition of Cigna. Health Access substantially contributed to DMHC's review of the proposed merger as follows: On March 4, 2016, Tam Ma, Health Access' Legal and Policy Director, provided oral testimony at the Department's public meeting where she highlighted concerns about Anthem's track record in abiding by consumer protections as well as the impact the merger would have on consumers. Health Access also submitted extensive written comments on March 9, 2016, which outlined how insurer consolidation affects on-going implementation of the Affordable Care Act, detailed research about mergers leading to higher prices for consumers, and how health care costs continue to be a major concern for consumers. We also raised concerns about how the Anthem-Cigna merger would increase concentration and limit competition in California's commercial market, and Anthem's history of repeated unreasonable rate increases in the individual and small group markets. We also provided detailed information about Anthem's failure to abide by consumer protections and provided a number of recommendations for questions and undertakings that should be imposed should the merger be approved. We followed up with a letter, written jointly with Consumers Union, on January 30, 2017 recommending additional undertakings to cover the uninsured and underinsured and provide support for consumer assistance programs. We applaud the DMHC for not approving this merger, which eventually fell apart after a federal court determined it would violate antitrust laws. The information Health Access provided to the DMHC helped the Department to critically evaluate how the merger would affect consumers and withhold its approval.

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 Comment Letter	2/7/2018 11:27:00 AM	Tam Ma	View
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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 when nonprofit health organizations such as hospitals, HMOs, and insurance companies have sought to restructure or change from nonprofit to for-profit status. Here, two managed care plans licensed by DMHC have filed applications for material modification of their Knox-Keene licenses to facilitate the acquisition of Cigna by Anthem. Health Access has experience and expertise in the laws and regulations affecting managed care. Our participation is necessary to ensure that consumers, particularly enrollees of Anthem and Cigna, are represented in this proposed transaction. In addition, our participation will help the Department determine the applicable law affecting this transaction and understand the impact this transaction may have on consumers and on the health system on which we all rely upon. We believe our participation will provide informed insight and ensure that the interests of health care consumers are represented and considered.

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 February 07, 2018 .

Enter Name: Tam Ma

HEALTH ACCESS CALIFORNIA

March 9, 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: Anthem-Cigna Merger

Dear Director Rouillard:

Health Access California, the statewide health care consumer advocacy coalition working for quality and affordable health care for all Californians, offers the following comments on health insurer consolidation and Anthem's proposed acquisition of Cigna. 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 Anthem and Cigna 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. The combination of Anthem and Cigna will create the nation's largest health insurer, a behemoth with 53 million plan members. Anthem, one of California's largest health plans, has had a troubling track record in California's Medi-Cal and 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 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. Anthem

and Cigna claim this merger furthers their "joint mission of enhancing value, choice and access to high quality, efficient care to consumers."[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] For example, 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]

Anthem has not provided evidence that merger will result in lower costs and better value. Anthem and Cigna also claim their merger will allow the "combined companies" to "operate more efficiently to reduce operational costs… helping to create more affordable health care for consumers"[6] Joseph Swedish, President & CEO of Anthem, touts the companies' investment in "initiatives that focus on improving the value of health care for consumers" and says "[t]he combined reach of Anthem and Cigna would go even further by providing these kinds of programs."[7] As researchers have noted, there is no evidence that larger insurers are more likely to implement value-based payment agreements and care management programs.[8] Anthem and Cigna, the second- and fifth-largest insurers by revenue, are already humungous, scaled entities and it is unclear how they will get any more scale economies from getting even bigger. Finally, we question what incentive an even larger, more dominant insurer would have to invest in such changes, and if they do, whether the savings and benefits will be passed on to consumers.

Merger will increase concentration and limit competition in California's commercial market. HMO enrollment is already highly concentrated in every segment of California's commercial market, and this merger will further strengthen Anthem's market position. The state's four largest plans—Kaiser, Anthem, Blue Shield, and Health Net—control 93 percent of the individual, 88 percent of the small group, and 82 percent of the large group markets.[9] Anthem holds 19 percent of the commercial market overall, and 33 percent of the individual, 24 percent of the small group, and 14 percent of the large group markets.[10] If this merger goes through, Anthem is likely to surpass Kaiser as the state's largest health plan.

Large, small, and rural counties across the state will see less competition and higher prices as a result of this merger. According to an analysis by Cattaneo and Stroud, a merger between Anthem and Cigna is likely to reduce competition in 31 counties, including Alameda, Butte, Contra Costa, El Dorado, Fresno, Glenn, Kern, Kings, Los Angeles, Marin, Merced, Orange, Placer, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, San Joaquin, San Luis Obispo, San Mateo, Santa Barbara, Santa Clara, Santa Cruz, Solano, Sonoma, Stanislaus, Sutter, Tulare, Ventura and Yolo.[11] Allowing Anthem to increase its market concentration significantly undermines the public interest in ensuring the state has competitive, robust health insurance markets.

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. Many 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.[12] Enrollment in DMHC's licensed health plans increased 28 percent in the first full year of ACA implementation.[13] In 2014, 2.2 million Californians obtained coverage through the individual market, representing a 47 percent increase over the previous year.[14] Group coverage continues to be the main source of commercial health insurance, providing coverage for 11.8 million Californians in 2014.[15] 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.[16]

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.

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.

Anthem has repeatedly pursued unreasonable rate increases. Anthem's history of imposing unreasonable rate increases on individuals and small business purchasers must be scrutinized because it undermines consumers' financial stability, particularly those who live paycheck to paycheck. In the recent years, the California Department of Insurance (CDI) has found a number of Anthem's rate increases to be unreasonable. Some examples include:

- In April 2015, CDI found Anthem failed to justify the average 8.7 percent premium increase it imposed on consumers with individual grandfathered health insurance policies, affecting 170,000 people. Anthem refused to lower the rate increase, which would have saved California consumers approximately $33.6 million.[22]
- In 2014, CDI found Anthem's 9.8 percent average rate increase on small employers, which affected 120,000 consumers, was excessive and unreasonable. Anthem adjusted its rate increase to 8 percent, which CDI continued to find unreasonable. In this instance, consumers would have saved $33 million had Anthem revised its rate increase to the 2.1 percent requested by CDI.[23]
- In 2013, CDI found Anthem's 10.5 percent average rate increase for small group products to be unreasonable. This increase impacted nearly 250,000 consumers. Consumers would have saved $38 million had Anthem not pursued this unreasonable rate increase.[24]
- In 2012, Anthem proceeded with a 6.5 percent increase deemed to be unreasonable, affecting 284,000 over the course of 2012.[25]

Individuals and small businesses have had to pay more for health coverage because Anthem has repeatedly imposed rate increases that have been found to be unreasonable and unjustified. As a result, we have absolutely no confidence that Anthem would act any differently than it has in the past, nor do we expect Anthem to pass along the benefits of any cost savings or efficiencies to consumers. Finally, a company with even larger market share has little incentive to act reasonably when it comes to price increases, especially when consumers and purchasers face fewer choices if this and other mergers are allowed to go through.

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. Anthem 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.

Anthem 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, Anthem opposed SB 546 (Leno), Chapter 801, Statutes of 2015, legislation that establishes new rate review requirements for the large group market.[26] 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, Anthem 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 Anthem's track record in California's commercial market, which we find to be distressing. The deficiencies found in Anthem's routine and non-routine medical surveys, extensive history of enforcement actions, poor quality ratings, high rate of Independent Medical Review requests and complaints, and history of proceeding with unreasonable rate increases 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 Anthem is allowed to get bigger. We urge DMHC to scrutinize how Anthem 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 (2015), Anthem was found to have seven major deficiencies that have not been corrected.[27] The deficiencies center on Anthem's grievances and appeals, utilization management, and language assistance processes.

Grievances and appeals: Five out of the seven major deficiencies found in the Routine Medical Survey are due to Anthem's poor handling of grievances.[28] Consumers often have a hard time navigating the complicated health care system, and they need help getting the care they need. Plans must have effective grievance systems that quickly resolve individual problems and identify systemic issues that need attention. In Anthem's most recent Routine Medical Survey, DMHC found that consumer complaints were not adequately investigated or resolved because Anthem misclassified them as inquiries instead of grievances or did not properly document calls, making it impossible to know if a patient was calling with a question or a complaint. When a consumer called about multiple issues, Anthem would address some, but not all of them. DMHC also found Anthem did not always do its due diligence when reviewing complaints.[29] As a result, critical facts or solutions were overlooked, leaving consumers without needed medications or stuck with bills they should not have to pay.

Patients lose out on significant consumer protections when their complaints are not handled properly. Problems are not resolved within 30 days, and patients do not know the reasons why the plan made a particular decision about their care. Care delayed is care denied. The right to timely access to medically necessary care is at the core of the Knox-Keene Act;

failure to resolve grievances promptly means consumers go without the care they need. Finally, consumers have no way of knowing they have the right to ask for an Independent Medical Review or to ask DMHC to review their complaint. Although Anthem has taken steps to address these deficiencies, they have not been corrected. We ask DMHC to not approve this merger until Anthem corrects these problems.

Utilization Management: Anthem's utilization management practices were also found to be deficient. DMHC found Anthem routinely failed to adequately explain why it denied, delayed, or modified treatment requested by providers.[30] While there are substantial problems with standard denials and delegated provider group denials, the deficiencies are particularly egregious when it comes to denials of behavioral health treatment, where 87% of the files reviewed did not have denial letters that clearly and concisely explain the reason for the denial. Anthem also told adults diagnosed with autism that Applied Behavioral Analysis Therapy was not medically necessary for them, but didn't provide the criteria or guideline used to make the decision.[31] As a result, patients have no way of knowing if decisions about medical necessity are made using sound clinical judgment.

Language assistance: Anthem has also failed to assess the language needs of its current enrollees. Knox-Keene regulations require plans to update their assessment of enrollee language needs and enrollee demographic profile at least once every three years. According to the Routine Medical Survey, Anthem did its initial comprehensive assessment of the language needs of its enrollees in 2009, but has not completed the reassessment.[32] As a result, some patients are unable to communicate with their providers. This issue is particularly important because 40% of Medi-Cal[33] and subsidy-eligible Covered California consumers[34] speak a language other than English. That Anthem is not complying with language access requirements is a critical indicator that it is not providing quality care to all Californians.

Non-Routine Survey - Provider Directories: Anthem has also had notoriously inaccurate provider directories, making it difficult for consumers to know their options for care and avoid going to out-of-network doctors. After receiving numerous complaints from consumers, the DMHC conducted a non-routine survey of Anthem's provider directory for its individual market provider networks. The survey uncovered frustrating facts: 12.5 percent of the physicians were not at the location listed in the provider directory and, that of those who were at the location listed, 12.8 percent were not willing to accept patients enrolled in Anthem's Covered California products, despite being listed as doing so.[35] Anthem was subsequently fined $250,000 for these inaccuracies in its provider directory.[36]

Anthem's provider directory for its Medi-Cal plan is also riddled with inaccuracies. Last year, the California State Auditor audited Medi-Cal managed care provider directories, including Anthem's provider directory for Fresno County, which was found to have the highest rate of inaccurate provider information of three plans that were reviewed. 23.4 percent of Anthem's provider information was found to be inaccurate, whereas another plan only had a 3.1 percent error rate because it actively reached out to its providers multiple times a year.[37]

Network Adequacy and Timely Access to Care: The problems with Anthem's provider directories raise serious questions about whether Anthem actually has adequate networks. We are awaiting public release of the timely access reports required by SB 964 (Hernandez), Chapter 573, Statutes of 2014 to see if Anthem and other plans are complying with timely access requirements. In the meantime, we request the DMHC to scrutinize Anthem's timely access fillings to determine whether it has adequate networks for all its plan products, and whether it has met its obligations to provide its enrollees with timely access to care.

Enforcement Actions: Since DMHC began its regulatory work over 15 years ago, it has filed 2,595 enforcement actions against health plans for violating state laws and regulations.[38] Anthem has racked up a whopping 1004 enforcement actions, 39 percent of the statewide total. In comparison, Blue Shield and Kaiser have had 359 and 288 enforcement actions, respectively.[39] Last year, Anthem was fined $1.5 million for not arranging for a prenatal test that is only available through an out-of-network provider. As a result, 27,000 consumers were billed for more than the in-network cost-sharing.[40] In 2013, Anthem was ordered to cease and desist from denying their members access to medically necessary speech and occupational therapy.[41]

DMHC must require Anthem to correct all outstanding deficiencies and fully implement Corrective Action Plans before it is allowed to complete its acquisition of Cigna.

Quality Ratings: Anthem must be required to improve any substandard quality ratings and bring them to above-average:

Office of the Patient Advocate: According to the Office of the Patient Advocate, Anthem's HMO products receive a "good" (3 out of 4 stars) rating. Patients, however, give Anthem a "poor" (1 out of 4 stars) rating for "getting care easily." Anthem's medical care ratings range from "fair" (2 out of 4 stars) to "good" (3 out of 4 stars). It should be required to improve in the topics where it has less than a "good" rating, including: asthma and lung disease care, heart care, maternity care, and behavioral and mental health care.[42]

Anthem's PPO products receive a "good" (3 out of 4 stars) rating. However, Anthem customers rated their care and services poorly (1 out of 4 stars) and feel Anthem only does a "fair" (2 out of 4 stars) job when it comes to customer service and giving accurate information on plan costs and claims payment. Anthem's PPO medical care ratings range from "fair" (2 out of 4 stars) to "good" (3 out of 4 stars), with far more topics being rated "fair": asthma and lung disease care, chlamydia screening, heart care, maternity care, behavioral and mental health care, and getting the right care for adults. [43]Anthem should be required to improve its ratings in areas where it has less than a "good" rating.

Covered California: Both Anthem's HMO and PPO products received 2 out of 4 stars in Covered California's quality ratings, meaning it scored between the 25th and 50th percent of all plans.[44] Anthem should be required to raise its ratings to at least three out of four stars.

Medi-Cal: The National Committee on Quality Assurance (NCQA) gives Anthem's Medi-Cal plan (Blue Cross of California Partnership Plan) a rating of 2.5 out of 5.0.[45] Within this score, Anthem has a 1.0 rating for customer satisfaction, 2.5 for treatment, and 3.0 for

prevention. Anthem should be required to improve its ratings, especially in customer satisfaction. Anthem has recently begun serving an additional eighteen counties through California's rural managed care expansion program, which are not included in NCQA's quality ratings.

Consumer Complaints and Independent Medical Review (IMR): Among large plans, Anthem had the highest rate of Independent Medical Reviews (IMR) requests filed in 2014[46] It had 2.06 IMRs per 10,000, which is a high rate, especially when compared to Blue Shield's 1.80 IMRs per 10,000 and Kaiser's 0.43 IMRs per 10,000.[47] 33.5 percent of Anthem's Experimental/Investigational IMRs and 28.8% of Medical Necessity IMRs were overturned by the DMHC. The Department should ensure Anthem has appropriate policies and procedures in place to ensure it does not inappropriately refused to cover needed medical services.

Anthem has also had a high rate of consumer complaints compared to other large plans. In 2014, it had 5.24 complaints per 10,000 enrollees, compared to the average rate of 3.53 complaints per 10,000 enrollees for large full service plans.[48] Anthem also had higher than average complaints for access issues, benefits/coverage, claims/financial, enrollment, and attitude/service of health plan.[49] The source of these complaints must be reduced if Anthem is to get bigger.

Patient Privacy: In February 2015, 80 million past and current Anthem customers learned their personal information, including social security numbers, was stolen by hackers. A number of authorities, including the U.S. Department of Health and Human Services and National Association of Insurance Commissioners have launched investigations into Anthem's data security practices in light of the massive data breach. DMHC should consult with these entities and see if Anthem has been found to be negligent in handling patient data.

Cigna's uncorrected deficiencies: In a 2015 Routine Medical Survey of Cigna Behavioral Health Plan, DMHC found the plan to have six major deficiencies that have not been corrected.[50] A 2015 Routine Medical Survey of Cigna Dental Health of California found four major deficiencies that have not been corrected.[51] For both plans, the uncorrected deficiencies relate to quality management, grievances and appeals, and utilization management. These deficiencies must be corrected before Cigna can merge with Anthem.

Cigna's quality ratings: According to the Office of the Patient Advocate's HMO report card, patients rate Cigna poorly (one star) for "getting care easily" and think it does a fair job (two stars) of "helping members get answers."[52] Cigna also has below average ratings for health care measures such as asthma and lung disease care, heart care, behavioral and mental health care. Anthem must commit to improving the quality of care that Cigna patients receive.

ENSURING QUALITY AND ACCESS FOR MEDI-CAL CONSUMERS

Anthem is a Medi-Cal managed care contractor and is responsible for 750,000 lives in the Medi-Cal program.[53] Anthem is also one of the plans participating in the managed care rural expansion program, which was implemented less than two years ago. As previously

discussed, Anthem has been found to have significant problems with maintaining accurate provider directories and has earned low quality ratings for its Medi-Cal plans. It is also not meeting language access requirements, which affects 40 percent of Medi-Cal beneficiaries.

The Department of Health Care Services (DHCS), as part of its monitoring and oversight activities, validates plan encounter data[54] and evaluates the performance[55] of the Medi-Cal managed care plans it contracts with. DMHC should consult with DHCS to identify areas where Anthem needs improvement and require Anthem to address these issues as part of the undertakings, should the merger be approved.

ENFORCEABLE UNDERTAKINGS NEEDED TO ENSURE CONSUMER PROTECTION

Anthem should not be allowed to make empty promises to California's health care consumers. Its track record gives us deep concerns about how the merger will affect its existing and future enrollees. Anthem has not shown how its promises of affordability, efficiency, and value will be realized and shared with consumers, and why a merger is necessary to accomplish these goals. Its longstanding failure to abide by minimal consumer protections raises makes us skeptical that an even larger company would be accountable to California regulators and consumers. If Anthem's acquisition of Cigna 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.

Clear and enforceable undertakings to protect consumers. DMHC has found Anthem 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. Anthem's existing enrollees must have access to the quality care they are entitled to under the Knox-Keene Act.

- Immediately correct deficiencies and implement corrective action plans. Anthem should be required to immediately correct outstanding deficiencies found in its Routine and Non-Routine Medical Surveys and maintain compliance with all Knox-Keene requirements over a sustained period. Anthem should also fully implement any corrective action plans from DMHC and DHCS. Cigna must also correct outstanding deficiencies for its behavioral health and dental health plans.
- Improve service, care, and quality. DMHC should require Anthem to meet specific benchmarks in improving access to care and customer service for its patients. Anthem 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. This includes quality ratings for Cigna's plans.
- Reduce source of IMRs and consumer complaints. Anthem 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 Anthem be accountable to California consumers and regulators? It should be required to be responsive to the California market and California law by maintaining 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. Anthem 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 Anthem 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 fact that health insurer mergers lead to higher costs for consumers, coupled with Anthem's history of imposing unreasonable rate increases, give us great pause that it will provide consumers with a quality, affordable product.[56] DMHC should require 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, Anthem must 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: Anthem should be required to reinvest profits earned from the California market in California.
- Increasing transparency: Anthem and Cigna should be required to provide full transparency for the pricing of premiums, compensation for senior management and the board of directors, and costs associated with the merger. Such costs must be detailed in rate filings and information provided for large group purchasers for at least the next ten years.
- Support for safety-net providers: Safety-net clinics have played a critical role in providing care for the Medi-Cal population. 54 percent (over 1.3 million) of new Medi-Cal managed care members are assigned to safety-net clinics.[57] Anthem should invest in the safety-net by contracting with safety-net clinics and investing in the safety-net infrastructure.
- Improve access to care in rural and underserved communities: Anthem should be required to invest in improving access to care in rural and underserved communities for 25 years and support efforts to provide comprehensive health coverage for the remaining uninsured, including the undocumented.
- Improve the health system as a whole: In order to address other potential impacts of the merger and these insurers' practices, Anthem 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 Anthem and Cigna 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
Assemblymember Jim Wood, Chair, Assembly Health Committee

[1] http://betterhealthcaretogether.com/consumers/
[2] L. S. Dafny, *Evaluating the Impact of Health Insurance Industry Consolidation: Learning from Experience*, The Commonwealth Fund, November 2015. Available at: http://www.commonwealthfund.org/publications/issue-briefs/2015/nov/evaluating-insurance-industry-consolidation
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ConsumersUnion®
POLICY & ACTION FROM CONSUMER REPORTS

HEALTH ACCESS

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.

Health Access California Time Records				
Anthem-Cigna				
Tam Ma, Legal and Policy Director				
Date	**Work Performed**	**Hours**	**Hourly Rate**	**Total**
2/22/2016	Research on impact of Anthem-Cigna merger on market concentration & competition & Covered CA for public meeting testimony & comment letter	0.5	$305	$152.50
2/24/2016	Research Anthem rate review & unreasonable rate increases; provider directory problems for public meeting testimony & comment letter	3	$305	$915.00
2/25/2016	Call with national consumer organizations re: Anthem-Cigna merger, common issues & state-specific concerns for testimony for public meeting & comment letter	1	$305	$305.00
2/29/2016	Call with CA advocates to prep for DMHC public meeting	1	$305	$305.00
3/1/2016	Research Anthem's CA enrollment, enforcement actions, routine medical survey, complaint & IMR data, quality ratings for public meeting testimony & comment letter	4	$305	$1,220.00
3/3/2016	Prepare testimony for public meeting	1.5	$305	$457.50
3/4/2016	Meet with consumer advocates re: testimony at public meeting	0.5	$305	$152.50
3/4/2016	DMHC public meeting: attend & provide public comment	1.5	$305	$457.50
3/8/2016	Work on comment letter	2	$305	$610.00
3/9/2016	Research Cigna routine medical surveys, quality ratings for comment letter	1	$305	$305.00
3/10/2016	Work on comment letter	4	$305	$1,220.00
3/11/2016	Finalize & submit comment letter to DMHC	2	$305	$610.00
3/21/2016	Meeting with consumer advocates re: follow-up work after DMHC public meeting	0.5	$305	$152.50
11/30/2016	Meeting with consumer advocates to prepare for meeting with DMHC re: undertakings	0.5	$305	$152.50
12/1/2016	Consumer advocates meeting with DMHC re: undertakings	0.5	$305	$152.50
12/21/2016	Work on joint letter to DMHC (1/30/17) re: undertakings	1	$305	$305.00
1/12/2017	Meet with Consumers Union re: undertakings	0.5	$305	$152.50

1/19/2017	Emails with Consumers Union re: undertakings & research	0.5	$305	$152.50
1/28/2017	Work on joint letter to DMHC (1/30/17) re: undertakings	1	$305	$305.00
	TOTAL	26.5	$305	$8,083

Anthony Wright, Executive Director

Date	Work Performed	Hours	Hourly Rate	Total
3/4/2016	Attend DMHC public meeting	1.5	$385	$532.50
3/4/2016	Review & edit Health Access testimony for DMHC public meeting	0.5	$385	$177.50
3/11/2016	Review & edit comment letter	1	$385	$355.00
1/30/2017	Review letter to DMHC re: undertakings	0.5	$385	$177.50
	TOTAL	2		$710.00

Beth Capell, Policy Advocate

Date	Work Performed	Hours	Hourly Rate	Total
3/4/2016	Review & edit Health Access testimony for DMHC public meeting	0.5	$425	$212.50
3/11/2016	Review & edit comment letter	1	$425	$425.00
1/30/2017	Review letter to DMHC re: undertakings	0.5	$425	$212.50
	TOTAL	2		$850.00
	OVERALL TOTAL			**$9,643.00**

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. $385/hour.

Tam M. Ma is Legal and Policy Director 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: 5-7 years of experience. $305/hour.