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PRESS RELEASE

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IN DMHC LETTER, CONSUMER GROUPS SEEK STRONG CONDITIONS ON MEGA MERGER OF AETNA-HUMANA

- *Aetna Has Pattern of Raising Rates Deemed "Unreasonable" by State Regulators; Assurances Sought Against Such Rate Hikes In Future*
- *Health Access Letter Submitted Today (Available Upon Request) Details Other Consumer Protection Commitments and Investments the DMHC (Department of Managed Health Care) Should Require of This Latest Mega-Merger*

SACRAMENTO, CA – On Monday afternoon, Health Access California submitted a 10-page comment letter to the Department of Managed Health Care (DMHC) raising significant concerns about the proposed merger of Aetna and Humana. In the letter, Health Access questions Aetna's track record in California, the merger's potential impact on California's patients and health care systems, and the assurance of proper oversight as insurance companies merge and become larger.

"State regulators should be skeptical of all these insurer mega-mergers, and at a minimum require strong concrete commitments to ensure these deals truly benefit California consumers and our health system. Given Aetna's track record, California should not approve the latest proposed merger between Aetna and Humana unless Aetna agrees to not proceed with unreasonable rate increases or violate other consumer protections," said Anthony Wright, executive director of Health Access California, the statewide health care consumer advocacy coalition. "California should make sure Aetna's problems don't get bigger as a result of the company growing larger."

In addition to focusing on Aetna's rate increases and poor consumer responsiveness, Health Access also outlined the lack of consumer benefit from industry consolidation; Aetna's refusal to participate in California's health reform efforts in Covered California and Medi-Cal, and their inability to address problems identified. In the letter, consumer advocates urge that state regulators and policymakers scrutinize this deal and others that are pending to impose conditions to ensure protections for individual policyholders and for California's health system as a whole.

The letter outlined the following conditions that the DMHC should impose:

- 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. 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: 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.

"As these insurers get bigger, Californians deserve assurances they will get better. While these mergers are in the interest of the insurers, there's little evidence that they actually benefit patients or our health system as a whole." said Tam Ma, policy counsel of Health Access California. "These insurance mega-mergers need to be heavily scrutinized by state regulators, to ensure these deals are in the best interest of patients and the public. Beyond the anti-trust and competition issues inherent in mega-mergers, regulators need to ensure that these deals actually benefit the health system on which we all rely," said Ma.

Additional hearings are planned for the next few weeks by the Department of Insurance and the Department of Managed Health Care, on this merger as well as the pending HealthNet-Centene and Anthem-Cigna mergers.