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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

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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 merger²⁶ 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 Department³³, 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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- ²¹ *Id.*
- ²² DMHC Press Release, July 16, 2015, available at: <https://www.dmhc.ca.gov/Portals/0/AbouttheDMHC/NewsRoom/2015/pr071615.pdf>.
- ²³ California Department of Insurance Press Release, October 2016, available at: <http://www.insurance.ca.gov/0400-news/0100-press-releases/2015/release099-15.cfm>
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- ²⁶ See *Supra* note 1.

²⁷ Senate Floor Analysis of SB 546 (Leno), Chapter 801, Statutes of 2015, September 10, 2015.

²⁸ *Final Report Routine Medical Survey of Aetna Health of California, Inc.*, Department of Managed Health Care, November 4, 2013. Available at:

<http://dmhc.ca.gov/desktopmodules/dmhc/medsurveys/surveys/176fs110413.pdf>

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³² See DMHC's Enforcement Action Database, available at:

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³³ DMHC Enforcement Matter Number: 14-331 (October 28, 2015), available at:

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³⁴ DMHC Enforcement Matter 13-361 (December 8, 2014). Available at:

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³⁵ *HMO Quality Report Card: Aetna Health of California, Inc. 2015-16 Edition*, Office of the Patient Advocate. Available at: <http://reportcard.opa.ca.gov/rc/profile.aspx?EntityType=HMO&Entity=AETNA>

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