



## POLICY & ACTION FROM CONSUMER REPORTS

April 25, 2016

Insurance Commissioner Dave Jones  
c/o Kayte Fisher, Attorney III  
California Department of Insurance  
300 Capitol Mall, Suite 1600  
Sacramento, CA 95814

Sent via email to [mergercomments@insurance.ca.gov](mailto:mergercomments@insurance.ca.gov)

Re: Proposed merger of Humana, Inc. into Aetna, Inc.

Dear Commissioner Jones,

Consumers Union, the public policy and advocacy division of nonprofit Consumer Reports, offers this testimony on the proposed acquisition of Humana, Inc. (“Humana”) by Aetna, Inc. (“Aetna”). Consumers Union was founded on the principle that all consumers should have access to a marketplace that is safe, effective, reliable, and fairly priced; implicitly included in that is a core belief that all consumers should have access to affordable, high quality healthcare and health coverage. This proposed merger is one of a string of major proposed health plans mergers over the past year. Our message throughout the review process is consistent: *the merger needs to do more than just provide advantages for the merging health plans; it needs to provide clear advantages for consumers.*

As we explore in more detail below, we strongly believe that: (1) market consolidation will likely give the merging carriers more market power, but that does not help consumers, (2) increased market power may mean worse insurance products for consumers, and (3) increased market power is likely to lead to higher premiums. The proposed merger of these two national insurance giants is receiving rigorous attention by anti-trust enforcement authorities, both federally and within the states. We thank the Insurance Commissioner for endeavoring to protect the public interest by holding this hearing and, in the course of doing so, making important information available for the regulators and anti-trust authorities.

### **Current state of the health insurance market in California**

If finalized, this merger would combine the third- and fourth-largest insurers nationwide by revenue,<sup>i</sup> creating a merged corporation with operating revenue of \$115 billion and 33 million health plan enrollees.<sup>ii</sup> It would fold Humana—which has traditionally focused on the Medicare market—into a much more diversified insurance portfolio with about two-thirds commercial medical membership (22.9

million) and the other third split between Medicare Advantage (4.4 million), Medicaid (2.4 million) and other members (3.8 million).<sup>iii</sup> According to one analysis, the merger could reduce Medicare market competitiveness in eight California counties.<sup>iv</sup>

## **Market consolidation helps carriers, not consumers**

### *The dubious promise of shared savings with consumers*

Health plans seeking to merge frequently justify their proposal with the promise of cost savings to be passed along to consumers. However, research on the subject reveals a dearth of evidence supporting those assurances. It is, therefore, with skepticism that we approach the statement of Aetna's Executive Vice President and CFO, who claimed: "The complementary nature of our two companies provides us with a significant synergy opportunity, furthering Aetna's efforts to increase its operating efficiency. ... These cost efficiencies will support our efforts to drive costs out of the system and offer more affordable products."<sup>v</sup> Aetna claims the savings could be significant; on July 3, 2015, Aetna projected a synergy potential of \$1.25 billion in 2018.<sup>vi</sup> However, as the Commissioner aptly noted when he questioned the CEO of Anthem in a hearing on March 29<sup>th</sup>, 2016, it is profoundly unclear what the plans mean when they say "synergy" and whether and how any savings will trickle down to consumers.

To regulators during hearings and public meetings, and in the media, health plan executives routinely predict robust savings from the efficiencies to be had by merging. Generally, one may translate this to mean savings achieved by eliminating redundancies. However, as a Carnegie Mellon economist and former FTC official is reported to have questioned, given the current size of the plans before merging, "It's not clear to me, do they get any more scale economies from getting bigger?"<sup>vii</sup> It is far more likely that claimed efficiencies through vague "synergies" are illusory and that improvements in quality or service can generally be achieved just as well without merging. Further, evidence suggests that savings from combining some aspects of the plans' operations, and launching new programs, will be limited to "small pockets of inefficiency."<sup>viii</sup> Beyond that, the savings of "more affordable" products could be attributable to lesser quality, reductions in customer service, or excessively narrow provider networks. We anticipate that the upside of the predicted \$1.25 billion in synergies is more likely to go to increased profits than to reduced premiums or improved service.

### *The unfounded linkage of consolidation and innovation*

According to a press release issued by Aetna, the combination of the two plans "[b]uilds on each company's respective efforts to provide innovative, technology-driven products, services and solutions to build healthier populations, promote higher quality health care at lower cost, and offer greater transparency and convenience for consumers."<sup>ix</sup> The plans are consistently complimentary of each other's technology and cite that as a basis on which each plan will improve post-merger. However, the overwhelming majority of major corporations these days rely on technology to drive their business and merger does not appear to be a necessary ingredient for technology development.

As one leading expert testified before the Senate Committee on the Judiciary, “there is no research showing that larger insurers are likelier to innovate.”<sup>x</sup> In a recently released report, that expert expanded on her statement, reporting “there is no evidence of greater product innovation in more concentrated insurance markets,” in fact noting to the contrary the plausible reasoning that “insurers in more concentrated markets are less motivated to innovate because it isn’t necessary to retain customers.”<sup>xi</sup> In this case, after its proposed merger, Aetna projects an enhanced geographic profile in 16 states.<sup>xii</sup> Despite questions from consumer groups about why a merger is necessary to improve innovation, we have yet to hear an adequate explanation.

### **Increased market power may mean worse insurance products for consumers**

Consumers are justified in being concerned that newly merged health plans—with increased market power and less competition—will offer lower-quality insurance products than in the past. Health plans are more than a financial conduit between consumers and providers; they have a direct relationship with consumers, such as by coordinating care and providing supplemental information or programming. Humana has a relatively favorable track record but Aetna does not. It is therefore necessary to consider not only how health plan market consolidation will affect the prices consumers are paying, but also how decreased competition may alter the quality of the products they are purchasing.

#### *The risk of deteriorating health coverage quality*

In addition to the specter of increased health insurance premiums and other out-of-pocket costs under a more consolidated health plan marketplace, Consumers Union is also concerned that greater market power will dampen incentives for the newly merged plan to provide high-quality health insurance coverage, care and customer service to its members. Concurrently, we question whether the net effect of a company with Aetna’s record combining with a plan such as Humana—with higher quality scores according to CMS<sup>xiii</sup>—will be negative for consumers.

Aetna’s quality ratings, complaints record, and surveys by regulators give reason to be concerned:

- According to a recently issued report by the California Office of the Patient Advocate (“OPA”), Aetna PPO policyholders rated the plan the lowest score possible when asked whether they got accurate information on plan costs and claims payment during 2013 and 2014, when they contacted their plan.<sup>xiv</sup> Aetna HMO policyholders awarded the lowest score possible to the plan for the relative ease at which they could get doctor appointments, tests, and treatment during the 2014 plan year. Thus, both information and access to care were deemed problematic.
- Drilling down to specific medical care ratings, according to the California Office of the Patient Advocate, Aetna’s PPO earned only two stars or below in eight of the ten measures, three of which garnered the plan a single star.<sup>xv</sup> At least one of those receiving a single star is for diabetes, the seventh leading cause of death in the United States<sup>xvi</sup> and an increasingly prevalent condition that disproportionately affects communities of color.<sup>xvii</sup> Another single-star condition

affects only women and is the highest volume of all hospitalizations: maternity care.<sup>xviii</sup> The HMO fared even worse than the PPO, on nearly every measure, with all medical care ratings falling to two-stars or fewer.<sup>xix</sup>

- In a Routine Medical Survey of Aetna Health of California, Inc., a wholly-owned subsidiary of Aetna, conducted in 2012, the Department of Managed Health Care (DMHC) identified three deficiencies: (1) quality management<sup>xx</sup>, (2) grievances and appeals<sup>xxi</sup>, and (3) utilization management<sup>xxii</sup>. A year later, the Plan had yet to correct any of the cited deficiencies. DMHC granted Aetna another 14-16 months, after which DMHC would conduct a Follow-Up Review and issue a report.<sup>xxiii</sup> Three years after the original report, Aetna still had not completely resolved its deficiencies: the plan continued to fail to address its website's inadequate grievance information.<sup>xxiv</sup> Although the Plan provided to DMHC details of how the website would be improved, DMHC found that "the proposed changes to the Plan's website and grievance form have not been implemented."<sup>xxv</sup> Further, DMHC noted that "[n]either the public nor the enrollee website allow the enrollee to preview the grievance before submission" and that "the process for an enrollee to submit an online grievance through either the public or the member log-in web portals is not easily accessible."<sup>xxvi</sup> Aetna claims the shortcomings in its website are resolved at this point. Yet, questions remain about why such an important repair, which is seemingly relatively easily, took so long to address.
- In 2013, approximately two out of every three consumers who complained to DMHC regarding Aetna's coverage determination for medically necessary or emergency room care, via the Independent Medical Review (IMR) process, received a judgment in their favor. Of the cases reviewed for medical necessity, nearly-half (43.8%) were overturned by IMR, while another 18.8% were reversed by the Plan.<sup>xxvii</sup> Of the Emergency Room (ER) reimbursements that underwent independent review, another two-thirds were reversed, with 45.8% overturned and another 20.8% reversed by the Plan.<sup>xxviii</sup> DMHC's 2013 Independent Medical Review Results report shows that there were 1.17 independent medical reviews requested for every 10,000 Aetna members—this ratio is in the highest quartile by frequency for all full service plans regulated by DMHC and is the third highest ratio for full service plans regulated by DMHC with over 400,000 enrollees.<sup>xxix</sup> For perspective, Aetna's 1.17/10,000 is more than four-times the rate of LA Care Health Plan, which has a rate of 0.28 per 10,000 members.<sup>xxx</sup>
- In 2014, DMHC fined Aetna \$200,000 for its failure to process claims and provider disputes in a timely manner.<sup>xxxi</sup> The plan was also subject to **sixty-five additional enforcement actions** between 2010 to 2015, totaling over a half-million dollars in fines. The majority of these enforcement actions related to Aetna's handling of patient grievances and improper conduct related to independent medical review.<sup>xxxii</sup>
- For both 2013 and 2014, the most common complaints filed with DMHC against Aetna were related to benefits and coverage, raising questions about the overall quality of its products.<sup>xxxiii</sup>

We urge that in the event this merger is approved, the approval be conditioned on enforceable obligations that raise the bar for quality and customer service for Aetna and to ensure that Humana's favorable track record does not dissolve. This may include more consumer-friendly benefits and

coverage design,<sup>xxxiv</sup> and enhanced grievance processes, including resolving its remaining deficiency and making it easier for policyholders to understand the availability of and make use of the grievance process.

#### *The potential for deteriorating provider networks*

Health plans continuously adjust their networks, partly in an effort to negotiate more favorable rates with providers and also to contain the cost of care. Carefully tailored networks can be a valid option for lowering costs and attaining higher value in the health care system. However, “sufficient consumer protections must be in place to realize these benefits without unduly limiting consumer choice or decreasing healthcare value.”<sup>xxxv</sup> Among other factors to be considered, there must be sufficient numbers and types of providers in the marketplace to ensure consumers can access high quality affordable care when needed. The risk of two major plans merging and using their newly-increased clout to shrink networks could threaten this consumer access to care. We therefore strongly urge that, in the event this merger is approved, the approval be conditioned on enforceable commitments by the newly merged plan as to both network adequacy and provider directory accuracy, and that the Department closely monitor the plan networks to ensure compliance.

#### *The impact of out-of-touch management of California-based health plans*

If this merger is approved, Aetna will headquarter its Medicare, Medicaid, and TRICARE products, along with a number of corporate positions, in Louisville, KY, where Humana was founded and is currently based.<sup>xxxvi</sup> We expect the rest of Aetna will continue to operate out of Connecticut, with other subsidiaries based in California.<sup>xxxvii</sup>

Aetna’s truculence in responding to deficiencies and findings of unreasonable rate requests paint a picture of a corporation that is already poorly responsive to California regulators. The legal requirements in this state are robust, with extensive consumer protections and a unique regulatory framework of having two regulators as well as an active purchaser Exchange. It is unlikely that the newly formed corporation will undergo a culture transformation and become more sensitive to our state-specific rules and regulations once its market power increases. We therefore urge DMHC to oblige Aetna-Humana to install “local management” in California, comprised of high-level executives and regulatory specialists with prior experiences of considerable depth in California insurance regulations and operations—the California subsidiaries must be run by California-based management. Not only should management be local, but customer service operations should be conducted within the state, and the newly merged Plan should prioritize practices that truly put consumers first.

#### **Increased market power likely means higher premiums**

*Undue consolidation by plans and providers alike is a losing proposition for consumers.*

Consumers Union rejects the notion that health plan mergers are either a necessary or appropriate response to increased concentration in provider markets. We believe that reasoning is flawed, especially with regards to the third- and fourth- largest plans in the country. Rather, we agree with the American Antitrust Institute in its statement that, “Consolidation motivated largely by the quest for greater bargaining power between various participants in the supply chain is a losing proposition for competition and consumers.”<sup>xxxviii</sup> Termed the “Sumo Wrestler theory”—with the two health sector giants, insurers and providers, supposedly exerting countervailing pressure on each other— “experience suggests that a showdown between [them] may well result in a handshake rather than honest competition.”<sup>xxxix</sup> And as explained by this leading health care antitrust scholar, in the case that a powerful health plan does manage to reduce its costs by squeezing providers on fees, rates, and/or charges, there is “little incentive [for the health plan] to pass along the savings to its policyholders.”<sup>xl</sup> Further, such a squeeze on providers, imposed through market power leverage, could have the side effect of forcing the providers to cut corners on service quality.

Regardless of whether stronger negotiating leverage against providers will lower a health insurer’s own costs, having a high concentration of health insurers, as in other concentrated industries, is likely to result in higher prices for consumers. This theory is borne out by experience. As explained by a health economist at USC’s Schaeffer School for Health Policy and Economics, “When insurers merge, there’s almost always an increase in premiums.”<sup>xli</sup> In an oft-cited example particularly prescient given the plan involved, when Aetna and Prudential merged in 1999, premiums rose by seven percent.<sup>xlii</sup> While this example precedes the ACA and its significant impact on the insurer landscape, we believe the outcome is still telling.

*A larger, more powerful carrier may be less responsive to rate review*

Aetna’s pattern and practice of disregarding regulators’ findings against the plan’s rate proposals, and its general opposition to rate review and transparency, is troubling, especially in a scenario where the plan is even larger and more powerful, where its aggressive pricing would have a wider impact.

Aetna has a notably poor track record when it comes to rate setting in California. Over a four year period, the California Department of Insurance (CDI) deemed three proposed small group rate increases as unreasonable. These unreasonable rate increases were all in the double-digits<sup>xliii</sup>, well in excess of inflation, and affected over 100,000 small business group members at an additional many millions of dollars in premiums paid by Californians. According to a report issued by the California Health Care Foundation, among Aetna’s products overall, Aetna increased individual health insurance premiums for some of its CDI products at a rate higher than the median in 2011, 2012, 2013.<sup>xliiv</sup>

Within its Knox-Keene products, in fewer than three years, DMHC deemed four Aetna rate requests unreasonable, unsubstantiated, and unjustified. In fact, in 2015, “[t]wo thirds of the Department’s unreasonable premium rate findings have been for Aetna rate increases.”<sup>xlv</sup> DMHC described Aetna’s pattern of unreasonable increases as “price gouging in today’s market.”<sup>xlvi</sup> Each request impacted over 75,000 members, for a total of in excess of 300,000 affected consumers. Upon finding the most recent rate request by Aetna unjustified, DMHC noted that the Plan “failed to provide the DMHC with timely

and adequate documentation that would justify the rate increase.”<sup>xlvii</sup> Despite the Department’s objections, Aetna proceeded with each of its unreasonable rate increases, at an added cost to consumers estimated by DMHC to total \$39 million in 2015 alone<sup>xlviii</sup>.

Not only has Aetna flaunted its power to give itself unreasonable rate increases, it also has a history of opposing price transparency in the large group market, as demonstrated by its opposition to SB 546 (Leno) enacted in 2015. The plan’s opposition to this bill—which aims to keep large group rate increases in line with rates for large purchasers and active purchasers, and with rates in the individual and small employer markets—makes clear Aetna’s unwillingness to align its rates with either regulators or large group purchasers.

With increased market power from a merger, it seems highly unlikely that the larger company would improve its responsiveness to regulators, or its sensitivity to consumer rate burdens. While other plans have come to the table with regulators to find a common ground on rate increases, Aetna has time and again demonstrated itself to be antagonistic to compromise on rate setting. In making your recommendation to antitrust authorities, we urge the Commission to consider Aetna’s extreme history of recalcitrance and the low odds that a rate review undertaking would be effective in protecting consumers from unjustified rate increases by an even more powerful Aetna.

#### *Existing requirements on profits and administrative expenditures cannot adequately protect consumers*

We urge the Commissioner to be skeptical of any argument from the plans that government regulations such as the medical loss ratio (MLR) will protect consumers from unfairly priced insurance or health plan products. Although the Affordable Care Act established the MLR to cap the *percentage* of each premium dollar that can go towards administrative costs or profits, it is an imperfect instrument for keeping rates in check.

In the first three years after the MLR was enacted, Aetna was required to issue over \$60 million in rebates nationwide.<sup>xlix</sup> Because of how this safeguard works, millions of consumers had been gouged for a year before they received their rebate. The lack of MLR rebates from Aetna in California over the past three years does not necessarily mean consumers have not been overcharged. First, Aetna’s presence in California is predominantly in the administrative services only (ASO) market, which is not subject to the MLR rule. Second, we will not see the plan’s MLR report for 2015—when the Plan imposed three unreasonable rate increases—until this coming summer. Californians therefore still have reason to be wary, especially if Aetna widens its presence in California by entering the individual market, as recently suggested by Aetna’s CEO.<sup>1</sup>

Finally, many experts believe that by requiring the plans to spend between 80 and 85 percent of net premiums on medical services and quality improvements, the MLR created a framework in which the plans can increase the size of the pie—by failing to pursue cost containment initiatives while at the same time setting high premiums—and thereby also super-size the size of its own “administrative” slice.

## **Recommended steps to protect the interest of consumers should the merger be approved**

If this proposed merger is ultimately approved, consumers would need assurances that the newly combined Aetna-Humana corporation will lift up consumer interests and improve their lot—on access, affordability, and quality—rather than leaving consumers carrying the weight of this deal and its resulting enrichments to Aetna. In the event this merger is to be approved, Consumers Union urges consideration of conditioning approval on the following commitments, among others:

- Health insurance rates: The merged company should agree to not move forward with rate increases, in any market segment, that the regulators deem unjustified or that contain inaccurate or incomplete information. Given the high risk that the bigger and more powerful merged company will have higher premiums, it should agree to providing even greater detail, publicly available, to aid the regulators in especially close rate review for at least several years after the merger. Moreover, it should agree that proposed rate increases will be quantified based on either Aetna or Humana rates for the 2016 plan year (depending on which offered the product in 2016). Aetna-Humana must not be permitted to finalize proposed premium rate increases deemed unreasonable or unjustified by the Department, and instead should confer with regulators until a reasonable and justified rate is set. This should apply to all lines of business subject to rate review at the time the rate is filed.
- Quality improvement and cost containment initiatives: Existing state law requires that each plan's rate filing include "any cost containment and quality improvement efforts since the last filing for the same category of health benefits plan. To the extent possible, the plan shall describe any significant new health care cost containment and quality improvement efforts and provide an estimate of potential savings together with an estimated cost or savings for the projection period."<sup>li</sup> That requirement is often honored more in the breach than in the observance. Aetna-Humana should be required not only to reinvest profits in quality improvement and cost containment initiatives, but also to provide clear explanations and documentation of those investments, dollar breakdowns, estimated savings, and descriptions of how each directly benefits policyholders.
- Improved quality and consumer satisfaction ratings: Achieving above-average quality ratings as measured by NCQA, Covered California, the Right Care Initiative, the Office of Patient Advocate Quality Report Card, and the Medi-Cal Managed Care Health Care Options Consumer Guide, by no later than the performance measurement period ending December 31, 2019, with an effective enforcement or penalty mechanism..
- Improved provider directory: Making available to consumers, both policyholders and non-policyholders, an accurate provider directory that is easily accessible and regularly updated is essential. Provider directory inaccuracies are a serious problem, and one that is likely to be exacerbated by a merged company combining IT systems and networks.
- Maintaining presence in the commercial market at least commensurate with Aetna's current participation: The aim of this suggested undertaking is to ensure that the merged insurer



continues to provide at least the same availability and choices for consumers, both in the number and variety of insurance products offered.

- Adequate, dedicated staffing in California: We urge that high-level staff for the newly merged company—Medical Director, Customer Service, and Legal Compliance personnel—be located in California and include individuals with a depth of expertise regarding our state, in order to be responsive to the regulatory and consumer protection environment in California.
- Dedicated staffing for transition issues: Whether due to network shifts, information technology glitches or other operational issues, mergers inevitably have bumps in the road which will affect the newly merged Aetna-Humana and its customers. Consumers Union recommends that the newly merged plan be required to have dedicated, increased staffing—in California and anywhere else trouble spots in the company may arise and be rectified—such as personnel to craft provider directories, provide customer service, and to ensure that protected health information is continuously secured through the transition and thereafter.

## Conclusion

In conclusion, the California commercial health insurance marketplace has been relatively competitive and stable to date. We believe this has worked to consumers' advantage. Consolidation in that marketplace—from this and other pending mergers—is worrisome both for marketplace stability and for pricing and quality and access for consumers. Consumers Union appreciates the Department of Insurance holding a hearing on this proposal and its openness to input. If the merger ultimately goes forward, Consumers Union urges the regulators to consider appropriate actions, including the actions described above, to help ensure that the merger does not harm consumers or insurance markets in California.

Sincerely,



Dena B. Mendelsohn  
Staff Attorney  
Consumers Union

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<sup>i</sup> Wall Street Journal, Justice Department Delays Ruling on Aetna-Humana Merger, 18 Sept 2015. Available at <http://www.wsj.com/articles/justice-department-delays-ruling-on-aetna-humana-merger-1442615133>.

<sup>ii</sup> Modern Healthcare, *Intensified Price Competition Driving Aetna-Humana Deal*, 7 July 2015. Available at <http://www.modernhealthcare.com/article/20150707/NEWS/150709936>.

<sup>iii</sup> Table adapted from Slide 23 of the Aetna presentation to shareholders, (July 3, 2015).

<sup>iv</sup> Those counties are Fresno, Kern, Los Angeles, Orange, Riverside, San Bernardino, San Diego, and Ventura. Cattaneo & Stroud, Inc., *Effect of Proposed California HMO Acquisitions*, presentation to the Financial Standards Solvency Board Meeting, 9 September 2015, slide 13.

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<sup>v</sup> BusinessWire, *Aetna to Acquire Humana for \$37 Billion, Combined Entity to Drive Consumer-Focused, High-Value Health Care*, 3 July 2015. Available at <http://www.businesswire.com/news/home/20150702005935/en/Aetna-Acquire-Humana-37-Billion-Combined-Entity>.

<sup>vi</sup> Aetna press release: *Aetna to acquire Humana, combined entity to drive consumer-focused, high-value health care*. Available at <https://news.aetna.com/2015/08/aetna-to-acquire-humana/>.

<sup>vii</sup> FORBES, *Aetna Buys Humana for \$37 Billion, But Deal Doesn't Add Up*, 3 July 2015. Available at <http://www.forbes.com/sites/dandiamond/2015/07/03/aetna-buys-humana-for-34-billion-but-deal-doesnt-add-up/#d8a63b87b326>.

<sup>viii</sup> Mark Pauly, an expert in the economics of healthcare at the Wharton School of the University of Pennsylvania. Available at <http://www.ibtimes.com/aetna-humana-merger-major-insurers-look-for-programs-improve-care-reduce-costs-2192875>.

<sup>ix</sup> Aetna press release: *Aetna to acquire Humana, combined entity to drive consumer-focused, high-value health care*. Available at <https://news.aetna.com/2015/08/aetna-to-acquire-humana/>.

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

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

<sup>xii</sup> Aetna presentation to shareholders, slide 17, (July 3, 2015).

<sup>xiii</sup> CMS awarded four stars (out of five) for Humana's Medicare HMO product in California for each of its measurement categories: overall, health plan, and drug plan. [www.medicare.gov](http://www.medicare.gov).

<sup>xiv</sup> State of California Office of the Patient Advocate, PPO Quality Ratings Summary 2015-2016 Edition. Available at <http://reportcard.opa.ca.gov/rc/pporating.aspx>.

<sup>xv</sup> The Aetna PPO earned two stars for *PPO Provides Recommended Care, Asthma and Lung Disease Care, Checking for Cancer, Treating Adults*, and *Treating Children*. The plan earned a single star for *Diabetes Care, Heart Care*, and *Maternity Care*.

<sup>xvi</sup> Centers for Disease Control and Prevention. National diabetes fact sheet: national estimates and general information on diabetes and prediabetes in the United States, 2011. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2011. Available at <http://www.familydocs.org/f/CDC%20Diabetes%20fact%20sheet-2011.pdf>.

<sup>xvii</sup> *Id.*

<sup>xviii</sup> Agency for Healthcare Research and Quality, *Statistical Brief #148: Most Frequent Conditions in U.S. Hospitals, 2010*, January 2013. Available at <http://www.hcup-us.ahrq.gov/reports/statbriefs/sb148.pdf>.

<sup>xix</sup> The Aetna HMO earned two stars for *HMO Provides Recommended Care, Checking for Cancer, Chlamydia Screening, Diabetes Care, Behavioral and Mental Health Care, Treating Adults*, and *Treatment Children*. The plan earned a single star for *Asthma and Lung Disease Care, Heart Care*, and *Maternity Care*.

<sup>xx</sup> Quality management as defined as "The Plan does not consistently ensure that the quality of care provided is being reviewed, that problems are being identified, that effective action is taken to improve care where deficiencies are identified, and that follow-up is planned where indicated."

<sup>xxi</sup> The grievances and appeals deficiency is described as "The Plan's Internet Web site does not contain adequate grievance information that meets statutory requirements."

<sup>xxii</sup> The utilization management deficiency is described as "The Plan does not consistently apply criteria or guidelines that are consistent with statutory and regulatory requirements, and clinical principles and processes, in its determination of whether to approve, modify, or deny requests by providers for speech therapy services."

<sup>xxiii</sup> DMHC Final Report Routine Medical Survey of Aetna Health of California, Inc., 25 October 2013 (issued to plan) 4 November 2013 (issued to public file).

<sup>xxiv</sup> DMHC Routine Survey Follow-up Report of Aetna Health of California, Inc., 11 August 2015, at 2. Available at <http://www.dmhc.ca.gov/desktopmodules/dmhc/medsurveys/surveys/176fsfu082115.pdf>.

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<sup>xxv</sup> *Id.* at 8.

<sup>xxvi</sup> *Id.*

<sup>xxvii</sup> California Department of Managed Health Care 2013 Independent Medical review Summary Report. Available at

<http://www.dmhc.ca.gov/Portals/0/FileAComplaint/DMHCDecisionsAndReports/AnnualComplaintAndIMRDecisions/2013.pdf>.

<sup>xxviii</sup> *Id.* The breakdown is 11.1% were overturned by IMR and 55.6% were reversed by the plan. California Department of Managed Health Care 2013 Independent Medical review Summary Report.

<sup>xxix</sup> California Department of Managed Health Care 2013 Independent Medical review Summary Report. Available at

<http://www.dmhc.ca.gov/Portals/0/FileAComplaint/DMHCDecisionsAndReports/AnnualComplaintAndIMRDecisions/2013.pdf>.

<sup>xxx</sup> *Id.* LA Care Health Plan has the lowest sum total IMR per 10,000 enrollees of the plans in California with in excess of 400,000 enrollees. Kaiser Permanente, with the second lowest ratio, has 0.47 IMR per 10,000 enrollees, less than half that of Aetna.

<sup>xxxi</sup> The Department of Managed Health Care, *2014 Annual Report*, at 14. Available at

<http://dmhc.ca.gov/Portals/0/FileAComplaint/DMHCDecisionsAndReports/AnnualComplaintAndIMRDecisions/2014.pdf>.

<sup>xxxii</sup> Data exported from the DMHC Web Portal: Search Enforcement Actions, available at

<http://wpso.dmhc.ca.gov/enfactions/actionSearch.aspx>.

<sup>xxxiii</sup> In 2014, over-half of consumer complaints of Aetna were related to benefits and coverage, according to the Department of Managed Health Care, *2014 Annual Report*, “2014 Complaint Results by Category and Health Plan.” In 2013, complaints related to benefits and coverage was the most frequent complaint against the Plan. DMHC “2013 Independent Medical Review Summary Report Overview.”

<sup>xxxiv</sup> In 2014, over-half of consumer complaints of Aetna were related to benefits and coverage, according to the Department of Managed Health Care, *2014 Annual Report*, “2014 Complaint Results by Category and Health Plan.” In 2013, complaints related to benefits and coverage was the most frequent complaint against the Plan. DMHC *2013 Independent Medical Review Summary Report Overview*.

<sup>xxxv</sup> *Addressing Consolidation in the Healthcare Industry*, CONSUMERS UNION HEALTH CARE VALUE HUB, Research Brief No. 10, at 7 (January 2016),

[http://www.healthcarevaluehub.org/files/2614/5452/4976/Addressing\\_Consolidation\\_in\\_Healthcare.pdf](http://www.healthcarevaluehub.org/files/2614/5452/4976/Addressing_Consolidation_in_Healthcare.pdf).

<sup>xxxvi</sup> BusinessWire, *Aetna to Acquire Humana for \$37 Billion, Combined Entity to Drive Consumer-Focused, High-Value Health Care*, 3 July 2015. Available at

<http://www.businesswire.com/news/home/20150702005935/en/Aetna-Acquire-Humana-37-Billion-Combined-Entity>.

<sup>xxxvii</sup> Although Aetna has a local presence in California, those Aetna entities are wholly owned subsidiaries of the larger Aetna corporation, which is based in Hartford, Connecticut.

<sup>xxxviii</sup> Letter from the American Antitrust Institute to Assistant Attorney General William J. Baer of the U.S. Department of Justice, at 3 (January 11, 2016). Available at

[http://www.antitrustinstitute.org/sites/default/files/Health%20Insurance%20Ltr\\_1.11.16.pdf](http://www.antitrustinstitute.org/sites/default/files/Health%20Insurance%20Ltr_1.11.16.pdf).

<sup>xxxix</sup> Thomas Greaney, *New Health Care Symposium: Dubious Health Care Merger Justifications—The Sumo Wrestler and ‘Government Made Me Do It’ Defenses*, HEALTH AFFAIRS BLOG (Feb. 24, 2016),

<http://healthaffairs.org/blog/2016/02/24/dubious-health-care-merger-justifications-the-sumo-wrestler-and-government-made-me-do-it-defenses>.

<sup>xl</sup> Thomas Greaney, *Examining Implications of Health Insurance Mergers*, Health Affairs, 16 July 2015. Available at

<http://healthaffairs.org/blog/2015/07/16/examining-implications-of-health-insurance-mergers>.

<sup>xli</sup> Erin Trish, researcher at USC’s Schaeffer School for Health Policy and Economics, as quoted by David Lazarus, *As Health Insurers Merge, Consumers’ Premiums are Likely to Rise*, 10 July 2015. Available at

<http://www.latimes.com/business/la-fi-lazarus-20150710-column.html>.

<sup>xlii</sup> Leemore Dafny, Mark Duggan and Subramaniam Ramanarayanan, *Paying a Premium on your Premium? Consolidation in the U.S. Health Insurance Industry*, NBER Working Paper No. 15434, Issued October 2009.

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<sup>xliii</sup> In October, 2015, CDI determined unreasonable a proposed average increase of 27.4%. (California Department of Insurance Press Release, October 2016.) In December, 2014, CDI determined unreasonable a proposed average increase of 10.7%. (California Department of Insurance Press Release, December 18, 2014.) In April 2012, CDI found unreasonable a proposal to increase rates at an average 30.3% over 24-months. (California Department of Insurance Press Release, April 5, 2012.)

<sup>xliv</sup> California HealthCare Foundation, Individual Health Insurance Premium Growth in California, available at <http://www.chcf.org/publications/2015/11/individual-premiums-growth-california>. In the same timeframe, Aetna increased premiums at a rate below average for three of its smaller products.

<sup>xlv</sup> DMHC Press Release, 16 July 2015, available at <https://www.dmhc.ca.gov/Portals/0/AbouttheDMHC/NewsRoom/2015/pr071615.pdf>.

<sup>xlvi</sup> *Id.*

<sup>xlvii</sup> *Id.*

<sup>xlviii</sup> DMHC estimated the inflated cost of Aetna's January 1, 2015, rate increase (AETN-129577528) was \$24 million. DMHC estimated the inflated cost of Aetna's April 1, 2015, rate increase (AETN-129884062) was \$11 million. DMHC estimated the inflated cost of Aetna's July 1, 2015, rate increase (AETN-130035569) was \$4 million.

<sup>xlix</sup> The DCcenter for Consumer Information & Insurance Oversight, *Medical Loss Ratio Data and System Resources*, Reporting Years 2012-2014. Available at <https://www.cms.gov/CCIIO/Resources/Data-Resources/mlr.html>.

<sup>1</sup> California Healthline, *Aetna CEO Backs Obamacare Exchanges, Talks of Joining Covered California*, (February 29, 2016). Available at <http://californiahealthline.org/news/aetna-ceo-backs-obamacare-exchanges-talks-of-joining-covered-california/>.

<sup>ii</sup> California Health and Safety Code Section 1385.03(c)(3).