

July 20, 2016

Commissioner Ralph T. Hudgens
Office of the Insurance and Safety Fire Commissioner
Two Martin Luther King, Jr. Drive
West Tower, Suite 704
Atlanta, GA, 30334

Re: Public Hearing for Aetna- Humana Merger

Dear Commissioner Hudgens:

Georgians for a Healthy Future (GHF) is a state-wide consumer health advocacy organization and is writing on behalf of the undersigned organizations in regard to the proposed Aetna-Humana merger. Despite insurers' claim that the mergers will give them greater ability to negotiate lower prices, improve quality and efficiencies, history and research have shown these benefits are not passed on to consumers. Further, the scope and size of the proposed Aetna-Humana merger and the impact it would have on competition raise concerns about affordability, choice and access to care for millions of health care consumers in Georgia. Therefore, extreme caution should be taken in reviewing whether the merger should be approved at all.

The Georgia Office of Insurance and Safety Fire Commissioner (DOI) has the power to impose measures to protect consumers and hold insurers accountable for the positive effects they claim are only attainable through consolidation. If, at the end of the comment and review period, the DOI has a high degree of certainty that the merger does contain net benefits for consumers, the DOI should write into the consent order enforceable conditions to ensure consumers realize these benefits.

We commend the Georgia DOI for allowing consumer voices to be heard through the public commenting process. Our vision is that all Georgians will have access to the quality, affordable health care they need to live healthy lives. Ensuring that consumers tangibly benefit from the proposed Aetna-Humana merger and are protected from harm is our priority position. Georgians for a Healthy Future and the undersigned at the end of this letter offer the following comments on the proposed merger:

Mergers increase costs, not savings, for consumers

Greater insurer consolidation will likely lead to higher premiums for Georgians. While insurers argue that the mergers will give them greater ability to negotiate lower prices with hospitals, providers, and drug makers to decrease costs, analyses of previous mergers show that any such cost savings were not shared with consumers. In fact, to date insurers have offered no evidence

that any health insurance merger savings achieved through lower negotiated payments with providers are passed on to consumers. However, there is a large body of evidence that shows mergers increase health coverage costs for consumers.

Analyses of previous mergers found that:

- Premiums went up in 139 separate geographic markets after Aetna acquired Prudential in 1999ⁱ
- Small group premiums increased by 13.7 percent in markets a year after the Sierra-United merger in 2008ⁱⁱ

More recently, several economic studies have found that mergers and other consolidation activity do not result in savings for consumers. One study found a direct relationship between concentrated insurance markets and greater premium increases in large employer plansⁱⁱⁱ. Another study researched the potential impact of the Aetna-Humana merger on the Medicare Advantage market. The study found that:

- Aetna's annual premiums are \$155 lower and Humana's premiums are \$43 lower in counties where they compete head-to-head than premiums in counties where only one of the companies offers plans
- The average premium of the second lowest silver plan sold on the Marketplace would increase by \$335 in Georgia

The findings of this study^{iv} are of particular importance for Georgians who are enrolled in Medicare Advantage and Marketplace plans because Aetna and Humana currently compete in the Medicare Advantage market in 96 Georgia counties^v. In addition, Humana recently proposed a 65 percent increase to the average rate of plans sold on the Georgia Marketplace in 2017^{vi}. If Humana is allowed to merge with Aetna, decreased competition would likely result in even less incentive for the insurer to set reasonable rates in the future.

This underscores the importance of preserving competition in Georgia markets to safeguard consumers from higher costs. In its review, the DOI should consider asking Aetna and Humana to explicitly answer the following questions:

- How will the merger affect premium prices for individual insurance (both on the Marketplace and outside of it), small group insurance, large group insurance, and/or Medicare Advantage in Georgia?
- What portion, if any, of the projected savings from the merger can the companies prove can be reasonably expected in Georgia? Will the companies commit to a specified reduction in premiums, out-of-pocket costs, or increased benefits based on those estimated savings? If so, for how long would that commitment endure?

Plans are increasingly limiting access to providers

Mergers may also worsen current market conditions that limit consumer choice. Current market trends are already shifting more towards plans that offer limited out-of-network benefits, and restrict access to providers through narrower networks. Insurers have offered a variety of plan types that consumers could choose from based upon their health needs and willingness to pay for more benefits. Two common ones are platinum tiered plans sold on the marketplace and Preferred Provider Organization (PPO) plans. Platinum plans cover generous benefits at a higher premium and feature lower out-of-pocket costs (deductibles, co-pays, etc). Platinum plans are appealing to consumers who have chronic conditions or high annual health care costs or who value the security of a more comprehensive plan. Preferred Provider Organization plans provide consumers with the choice to get care from in-network or out-of-network providers. An individual pays less for care from an in-network provider and more if care is received from an out-of-network provider. In Georgia, all insurers have stopped offering platinum plans^{vii} and the number of PPO plans have been greatly reduced^{viii}. Further, Humana will reduce its Marketplace footprint, limiting plans to just the Atlanta, Columbus, Macon and Savannah areas in 2017^{ix}.

If Aetna and Humana consolidate, consumers may find that they have even less access to needed providers or out-of-network benefits required to cover their care because the consolidated companies would have more leverage over providers in their negotiations on provider networks and reimbursement rates. In its review, the DOI should consider asking Aetna and Humana to explicitly answer the following questions:

- Will the proposed company commit to continued participation in the federally facilitated Marketplace in Georgia if the merger is approved? If so, for how long would that commitment endure?
- How might the merger impact the types and number of plans offered in the various markets?

The problem of network adequacy

Another pivotal concern about insurance companies getting bigger is their ability to create more narrow and restrictive provider networks. Narrow networks in theory offer limited provider choice in exchange for lower premiums. They are defined as 25 percent or less of all providers in participating rating areas within a state that participate in the network^x. Tiered networks rank providers based on cost and quality. Big insurance companies can use their market power to exclude providers from their network or place a provider in a higher cost-sharing tier and consequentially reduce the number of patients who will seek care from that provider.

Narrow networks are becoming more common in Georgia: Georgia has the highest percent of narrow networks among all states with 83 percent of marketplace plans defined as narrow^{xi}. Narrow and tiered networks may be advantageous, especially for price conscious consumers, but only if they provide meaningful access to care. To ensure true network adequacy is achieved, meaningful access standards must be defined and enforced.

Georgia's current network adequacy standards are based in part upon the previous National Association of Insurance Commissioners (NAIC) model act dating back to 1996. Georgia's current standards do not specify clear, quantitative requirements, which leaves consumers with no guaranteed benchmark for services and enforceable rights. To assist states in developing new standards or bringing their existing standards up to date, the NAIC updated its network adequacy model act in November 2015^{xii}. The model act creates a framework that states can tailor to accommodate certain variations in insurance markets and regulatory authority among states and enact into law if they choose. To date, there has been state legislative interest in reviewing the recent NAIC model act to inform future revisions to Georgia's network adequacy standards but no new policies have been set.

As provider networks narrow and the number of insurance companies shrink, the need to assess and monitor the adequacy of these networks has increased. In its review, the DOI should consider asking Aetna and Humana to explicitly answer the following questions:

- How might the merger impact access to health care providers?
- How might the merger impact access to in-network providers that have not generally had strong negotiating power with insurers?

Policy recommendations to protect consumers

Mergers, once approved, cannot be reversed. Ensuring that consumers experience real benefits from the merger and are protected from harm should be the main points of consideration in the Aetna-Humana merger review. Should the merger be approved, there are a menu of approaches, or remedies, that the DOI may consider in its decision to give consumers assurance of benefits and protections.

While the U.S. Department of Justice (DOJ) has traditionally relied on divestitures as a remedy to restore competition in markets, there is little evidence that this method is effective. Divestitures occur when a company sells off assets such as operational business units, and/or policyholder contracts to another insurance company that is capable of restoring pre-merger market competition^{xiii}. Divestitures in Georgia markets could be difficult to execute because the market shares of the merging companies are significant in the individual, small group, large group and Medicare Advantage markets. Selling off assets in these markets means selling a large number of contracts of policyholders to another insurer. In the next open enrollment period, a divested enrollee may return to the previous insurer, which would negate the intent of restoring competition in the market. Also, insurers that purchase the divested enrollee contracts will have to adequately replace the competitive provider and hospital networks of the merging insurer. Lastly, divestitures do not prevent insurers from raising premiums. Key questions to the DOI may consider in its assessment of divestitures as a potential remedy are:

- If divestitures are sought as a remedy, how will consumers be protected in the divestiture process? Will consumers in active course of treatment be permitted to see their same providers? How will consumers be notified about the divestiture process?

- Will consumers have to leave their current plans? Will consumers be able to come back into those divested plans if they choose, and if so, how does this ensure that the merged company does not have too much power in the market after the merger?

Divestitures may address some competition issues resulting from mergers, but relying on this one remedy will not fully address consumer concerns. Additional remedies are needed to mitigate some of the cost, network adequacy, and consumer protection issues in Georgia markets. Several other states have approved mergers with remedies and their approaches offer promising policies for Georgia to consider in its review of the proposed Aetna-Humana merger.

Suggested remedies

Premium stability

Current market regulations do not protect consumers from unreasonable premium increases. While the Medical Loss Ratio (MLR) is a good tool to ensure insurers are efficient in their spending of premiums on medical services and quality improvements, it does not cap prices and premium increases. Rate review is a tool that can help protect consumers from unjustified increases in health insurance rates. It enables state insurance departments to review proposed rate increases charged by health insurance companies that sell plans in the state. Rate review requires insurers to openly explain how they determine the amount they charge for rates, on which health insurance premiums are based. Often, insurers also must justify proposed increases to these rates, documenting why an increase is both necessary and appropriate^{xiv}. Absent a more robust rate review process, the decreased competition resulting from the insurance merger would provide less incentive for insurers to set reasonable rates in the future. If the Aetna-Humana merger is approved, a stronger rate review process would be needed to help ensure any future premium increases are justified. Approaches that have been utilized in other states when approving mergers include insurer commitment to:

- Contribute funding that would provide more resources for the state's rate review process and regulatory agencies to:
 - Improve consumer interfaces and education: Develop a consumer-friendly page on the DOI website that includes documents filed by insurers for rate review, rate review guide or booklet to provide consumers with a plain language explanation of the filing process, and a guide to understand the rate filings and public comment process
- Implement rate increases that are deemed reasonable by state regulators. In the event an insurer implements an unreasonable rate, regulators would set appropriate conditions for future rate filing
- Not pass any merger associated costs onto enrollees, including any and all executive compensation, pay-outs, bonuses, interest on loans one company may use to purchase another, legal fees, etc.
- Pass cost savings associated with merger efficiencies on to consumers in the form of lower premiums and cost sharing

Network adequacy

Network adequacy serves as an important link between having health insurance and accessing health care services. Provider networks must be adequate to ensure consumers enrolled in the plan have meaningful access to all covered benefits. The risk of big insurers merging and continuing to reduce network sizes and plan options is concerning in terms of whether consumers, and especially rural consumers, will have access to the care they need. If state regulators approve the mergers, they should consider requiring insurers to take the following steps to ensure access and consumer choice are improved:

- Publish and maintain printed and online provider directories in compliance with provisions in SB 302^{xv}. Agree to concrete penalties when inaccuracies are identified
- Submit provider networks to DOI for review for compliance with state or DOI-specific standards, and resolve existing network problems prior to merger approval
- Build more robust provider networks that include specialties and services for the medically underserved (e.g. essential community providers, substance use recovery and treatment services, mental health providers, pediatricians, etc.) in the state
- Continue participation on the Marketplace and expand offerings into counties not currently served
- Offer the same plans both on and off the Marketplace

Value-based coverage

Insurers claim that mergers will enable them to offer more value-based insurance design (VBID) options. These have the potential to improve health and lower health care costs but they must be driven by high-value care at the best prices. Improving the quality of care in plans is critical to ensuring consumers experience value in their coverage. One way to measure the realization of this benefit is to closely monitor plan quality ratings. The National Committee for Quality Assurance (NCQA) rates health insurance plans based on customer satisfaction and clinical measures. For 2015-2016, Aetna and Humana received “average performance” ratings for commercial plans in Georgia^{xvi}. To enhance quality for enrollees, and make certain that plans improve based on a measureable metric, state regulators should consider requiring insurers to improve any substandard and/or average quality ratings by a set time.

Consumer assistance

The health insurance market is rapidly changing and consumers report difficulty navigating the market. Millions of Georgians impacted by the proposed merger will need help understanding their rights and responsibilities regarding their insurance plans. Consumer Assistance Programs (CAPs) and ombudsman offices provide one-on-one services to help consumers understand and use their health insurance. Georgia had a CAP operated by the DOI until 2013^{xvii}. The Georgia CAP was instrumental in building capacity and expertise to assist consumers and strengthen regulatory oversight and would be invaluable in Georgia if proposed mergers occur. Regulators and policymakers will also need to increase their capacity to closely monitor post-merger market activities. Through interactions with consumers, these CAPs are able to collect and analyze

valuable data on the trends and issue areas in the health insurance market at the ground level, all of which can be reported back to the DOI and policymakers.

Consumer assistance programs provide a direct benefit for consumers and regulators. If the merger is approved, regulators should consider requiring insurers to make community investments in consumer assistance. These contributions should be sufficient to establish a grant program to support non-profit organizations and/or public-private partnerships in providing direct consumer assistance to seniors and individuals enrolled in Medicare Advantage, Marketplace and other plans that are subject to regulatory oversight by the DOI. The non-profit organizations who seek grant funding will serve the following functions:

- Assist consumers with enrollment in coverage and help them understand plan quality, networks, and other critical factors when choosing a plan
- Educate consumers about their rights and responsibilities regarding their health insurance plans, how to file, and navigate grievance processes
- Track consumer complaints in real-time and share with the DOI to strengthen oversight
- Annually compile collected data and submit to DOI for review

Accountability and Enforcement

Insurers should be accountable to consumers and regulators. Close monitoring and oversight are needed to ensure insurers comply with all merger approval conditions. Regulators should consider requiring insurers to commit to the following if the merger is approved:

- Provide the DOI with annual reports detailing the realization of estimated merger efficiencies, savings, how savings are passed on to consumers, and any cost containment and quality improvement efforts undertaken. Reports should be publicly available through the DOI website
- Meaningful penalties and sanctions by the DOI for non-compliance with merger approval conditions

Conclusion

Georgians for a Healthy Future and the undersigned organizations are strongly concerned about the impact of the proposed Aetna-Humana merger on price, access, and quality of care for consumers in Georgia. We recommend that Georgia's DOI carefully consider whether or not to approve the merger and which remedies best address the expected concerns of and effects on consumers. Thank you for your high level of scrutiny for these issues and prioritizing the interests of consumers in this process.

If you have additional questions or comments we would be happy to address them. Please contact Meredith Gonsahn, Health Policy Analyst at mgonsahn@healthyfuturega.org or 404-567-5016 ext 6.

Respectfully submitted,

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