Senate Health Committee Oversight Hearing
Health Care Market Consolidations: Impacts on Cost, Quality, and Access
March 16, 2016

Thank you for inviting me today. My remarks will provide:

- a brief overview of the DMHC;
- our role regarding health plan mergers and acquisitions;
- our role regarding nonprofit health plan restructuring;
- how we monitor negotiated undertakings; and
- the status of health plan mergers the DMHC is currently reviewing.

I. Background

The Department of Managed Health Care licenses and regulates 122 health care service plans that provide health care services to more than 25 million Californians.

We regulate the vast majority of commercial plans and products in the large group, small group and individual markets, including all of the plans that participate in Covered California, California's Health Benefit Exchange.

We regulate 17 of the 22 managed care plans that provide Medi-Cal services to California's Medi-Cal beneficiaries. (2/3)

The DMHC is first and foremost a consumer protection agency. Our mission is to protect consumers' health care rights and ensure a stable health care delivery system.

To accomplish our mission, the DMHC derives its authority from the Knox-Keene Health Care Service Plan Act of 1975.

- The DMHC requires full-service health plans to have contracts with hospitals, physicians, and ancillary health care providers for the full range of covered health care services.

- Health plans must provide timely health care services to their enrollees.

- Health plans must meet strict financial solvency requirements to ensure they can pay providers for the services delivered to plan enrollees.

- Health plans must also have systems in place that allow consumers to file grievances and appeal denials of care.

- The DMHC Help Center is available to assist consumers when they have problems accessing care. Whether they have been denied care, have an urgent need for care, have a question or complaint about their coverage, or simply don't understand how their coverage works, the Help Center can answer their questions and help them resolve their problems.

- Our role is to ensure plans fulfill their obligations to enrollees.

II. The DMHC's Role With Respect to Review of Health Plan Mergers and Acquisitions

Health plans that wish to consolidate must first obtain approval from the DMHC.

Our primary focus when reviewing mergers is to ensure health plans comply with the strong consumer protections and financial solvency requirements of the Knox-Keene Act.

The DMHC's review of mergers between health plans focuses many factors, including:

- Organizational and administrative changes such as changes to grievance and appeals processes, utilization management, and clinical decision making;

- Health delivery system changes such as changes to provider networks;

- Any product or subscriber contract changes that could impact enrollees, including changes to subscriber documents (EOCs); and

- Financial changes, including impact to tangible net equity, working capital, operations and claims payment, organization structure pre and post-transaction to understand who will hold control, as well as the financing of the transaction and the impact to the plan's financial stability.

III. DMHC's Role With Respect to Nonprofit Health Plan Restructuring

In addition to all of the issues the DMHC must consider in its review of any health plan merger, if a merger involves a *nonprofit* health plan that is converting or restucturing to a for-profit health plan, the DMHC must review the transaction under the requirements set forth in Article 11 of the Knox-Keene Act.

Article 11 applies when two factors are present: (1) the plan must be a nonprofit corporation that has assets subject to a charitable trust obligation, and, (2) if the nonprofit plan has such assets, the plan must be restructuring, or selling a substantial portion of its assets to a for-profit entity.

None of the four mergers the DMHC has to review have involved converting a nonprofit health care service plan to a for-profit entity, so Article 11 does not apply.

In the case of Blue Shield, a nonprofit health plan that purchased Care 1st, a for-profit health plan, Blue Shield converted Care1st to nonprofit status after the merger was approved.

During the review, the DMHC looked at Blue Shield's articles of incorporation, its bylaws and history, as well as the law regarding nonprofit mutual benefit corporations and determined that Blue Shield does not have assets subject to a charitable trust.

Therefore, even though Blue Shield is a nonprofit entity, Article 11 did not apply.

IV. Monitoring and Enforcement of Compliance with Negotiated Undertakings

The DMHC can require health plans to commit to making certain improvements in their health delivery system as part of the DMHC's approval process.

These commitments, called undertakings, are also used to ensure mergers benefit California consumers.

Undertakings are enforceable commitments agreed to by the plans. Some undertakings require the plan to submit post-merger information.

The DMHC uses a tracking system to monitor plans to ensure they keep the commitments they have made in the merger process.

DMHC staff review each plan filing carefully to ensure the plan is meeting its commitments.

The DMHC may also conduct on-site audits to determine whether the plan is complying with the undertakings.

The department also follows up on those undertakings during regularly scheduled financial exams and medical surveys.

For example, in the case of the 2005 PacifiCare-UnitedHealth merger, the DMHC reviewed plan compliance with financial undertakings during two subsequent financial examinations.

V. Mergers Currently Under Review

The DMHC is currently reviewing three mergers between for-profit health plans[1].

These mergers include:

[1] Enrollment numbers are from the Office of Plan Licensing December 9, 2015 presentation, Mergers and Acquisitions, to the FSSB.

- Centene's acquisition of Health Net, Inc. is a $6.8 billion transaction.
    - Health Net has approximately 4.2 million enrollees including 1.28 million commercial enrollees, 1.65 million Medi-Cal enrollees, and 1.39 million enrollees in a specialized behavioral health plan.
    - Centene enrollment consists of 169,000 Medi-Cal members.[2]
    - The DMHC held a public meeting about this merger on December 7, 2015.
- Aetna's acquisition of Humana is a $37 billion transaction.
    - In CA, Aetna has 1.4 million enrollees including 382,000 commercial plan enrollees, 118,000 specialized dental plan enrollees, and 886,000 enrollees in a specialized mental health and employee assistance plan.[3] (EAP)
    - Humana enrollment includes 65,000 Medicare Advantage members.
    - The public meeting was held January 4, 2016.
- Anthem's acquisition of Cigna is valued at $54.2 billion.
    - Anthem's Blue Cross commercial and Medi-Cal enrollment includes 3 million members in CA and a small number of specialized dental plan enrollees[4].
    - Cigna's enrollment includes 182,00 commercial enrollees and over half a million members in 3 specialized health plans[5]. (dental, Medicare Part D)

[2] Centene's California Health and Wellness Plan.

[3] Aetna's specialized mental health and EAP is Health and Human Resource Center.

[4] 22,000 enrollees in Golden West.

- The public meeting regarding this acquisition was held on March 4, 2016.

The DMHC has held public meetings on each of these transactions to solicit comments from interested parties for our consideration as we review the transactions.

During these public meetings, representatives from consumer groups and provider organizations urged the DMHC to consider these health plans' performance regarding access to care as part of our approval process.

Consumer group representatives have urged the DMHC to ensure plans improve their quality of care and patient satisfaction, as well as their performance in the areas of accurate provider directories, timely resolution of grievances and requests for independent medical review, and meeting enrollees' language access needs, as conditions of the DMHC's approval.

Noting their concern about the potential effect of these mergers on premium rates, consumer group representatives also recommended the DMHC obtain greater detail on any premium rate increases proposed by the plans.

Provider group representatives have raised concerns that mergers would increase plan buying power, and that this could result in decreased provider payments.

Provider groups are concerned that decreased provider payments also would cause provider networks to shrink and affect the quality of patient care.

As previously discussed, the DMHC reviews mergers for organizational, financial, health delivery system, and product changes, and the DMHC will consider all public comments as it conducts this review.

[5] 165,000 enrollees in Cigna Behavioral Health, 200,000 enrollees in Cigna Dental, and 164,000 Medicare Part D enrollees in HealthSpring Life & Health Insurance Company.

VI. Conclusion

The DMHC protects the health care rights of over 25 million enrollees.

We take this responsibility very seriously.

Our focus with each merger is to ensure compliance with the strong consumer protections and financial solvency requirements of the Knox-Keene Act, as well as compliance with any negotiated undertakings.

Thank you again for inviting me to explain the DMHC's review process and I'm happy to answer any questions.