NEW YORK STATE
DEPARTMENT OF FINANCIAL SERVICES

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PUBLIC HEARING IN RE:
APPLICATION BY ANTHEM, INC. FOR APPROVAL OF
ACQUISITION OF CONTROL OF CIGNA LIFE INSURANCE
COMPANY OF NEW YORK

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One State Street
New York, New York

September 8, 2016
10:00 A.M.

Reported By
Stefanie Krut

A P P E A R A N C E S:

DFS PANEL PRESENT:
MARIA VULLO, Superintendent

SCOTT FISCHER, Executive Deputy Superintendent for Insurance

TROY OECHSNER, Deputy Superintendent for Health Insurance

JAMES REGALBUTO, Deputy Superintendent for Life Insurance

SPEAKERS:
JAY WAGNER - Anthem
TOM RICHARDS - Cigna
LARRY SCHREIBER - Empire CEO
LEV GINSBURG - Business Council of New York State, Inc.
BRAD WASSER - Law Offices of David Balto
DR. MALCOLM REID - President of the Medical Society of the State of New York
BOB COHEN - Citizen Action of New York
AMANDA DUNKER - Health Care for All New York
HEIDI SIEGRIED - New Yorkers for Accessible Health Coverage
ERIN NEVINS - Nevins Insurance Agency
HENRY ALLEN - American Medical Association
MARK HANNAY - Healthcare for All New Yorkers
CHUCK BELL - Consumers Union

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MR. FISCHER: Good morning. I am Scott Fischer, the Executive Deputy Superintendent for Insurance, and I am going to call this public hearing to order. The public hearing is a public hearing on the proposed transaction between Anthem, Inc. and Cigna Corporation, and we have a full schedule so I am going to introduce the Superintendent of Financial Services, Maria Vullo.

SUPERINTENDENT VULLO: We need to figure out how to to use these mics. Good morning, everybody. As Mr. Fischer said, I am Maria Vullo, the Superintendent of Financial Services for the State of New York, and this public hearing, as Mr. Fischer noted, has been scheduled. It was scheduled pursuant to notice given on August 5th, 2016 to consider the application by Anthem to acquire Cigna, and it is a hearing pursuant to New York Insurance Law Section 1506.

In addition to Mr. Fischer, I am joined by Deputy Superintendent For Health Insurance, Troy Oechsner, as well as Deputy Superintendent for Life Insurance, James Regalbuto. And Mr. Regalbuto has the distinction of keeping us on

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time, and so he may need to urge witnesses, as we go along, to conclude.

On September 2, 2015 Anthem, Inc. filed with the Department an application for acquisition of control of Cigna Life Insurance Company of New York. Anthem is the ultimate parent of Empire Health Choice Assurance and Empire Health Choice HMO, both independent licensees of the Blue Cross and Blue Shield Association. The Cigna Corporation is the ultimate parent of Cigna Life Insurance Company of New York, a New York domestic insurer, as well as Connecticut General Life Insurance Company and Cigna Health and Life Insurance Company, both foreign insurers licensed to conduct business in the State of New York.

Section 1506-B of the New York Insurance Law provides that the superintendent, that's me, shall disapprove an acquisition if I determine, and I quote, "that such action is reasonably necessary to protect the interests of the people of this state. Only certain factors may be considered in making that determination, including the financial condition of the acquiring person and the insurer, the source of the funds or

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assets for the acquisition, whether the acquisition is likely to be hazardous or prejudicial to the insurers, policyholders or shareholders, and whether the effect of the acquisition may be substantially to lessen competition in any line of commerce in insurance or tend to create a monopoly therein."

In a letter dated August 13, 2016, the Department set forth our concerns about the proposed merger and we noticed this public hearing. While the Department has indicated certain concerns, we have not made any final decision on this application.

The purpose of this hearing is to provide the parties and the public the opportunity comment on this proposed acquisition so that the Department has full public input on the potential implications for New York State, as well as the impact on the availability, affordability and quality of health insurance in New York.

The parties and the public have been offered the opportunity to testify at this hearing and to submit any written comments of whatever length that we can review, and we received

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numerous requests to be heard, as well as some written comments. Witnesses, everyone who has requested to be heard will be heard today. They will present their testimony. The Department may ask questions. We will be the only persons permitted to ask questions at this hearing.

We will accept written submissions within five days after this hearing. Five business days, thank you. The record will be closed on September 15, 2016, after which the matter will be fully submitted to the Department's determination. Based on those present here today, it appears we will have the opportunity to hear from the parties themselves, from consumers, from providers and provider groups. So we have a full panoply of people wishing to be heard.

As described in the hearing notice, individuals or groups will have five minutes for their comments, and Anthem and Cigna, who are the parties who are presenting this acquisition, will each have 10 minutes to describe the transaction. And as I said, even after the close of this hearing, for five business days anyone is permitted to submit additional written

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submissions. So to the extent the timing of today's hearing is viewed as being insufficient, please feel free to submit any written comments after this hearing, even to comment on what we have heard today.

So given that this is Anthem's application, I think it's appropriate for Anthem to be the first witnesses to be heard today, and we would ask them to come forward, and Anthem has 10 minutes to present its oral testimony. Thank you. Just give us your name and... thank you.

MR. WAGNER: I am Jay Wagner, Vice President and Counsel of Anthem, Inc. Thank you, Superintendent Vullo, for the opportunity to speak at today's hearing. I will also be joined by Tom Richards from Cigna. He is the local lead of strategy and business development for Cigna. And I also will be joined by Larry Schreiber. Larry is the President of Anthem's New York operation operating as Empire Blue Cross and Blue Shield.

Today we would like to provide an overview of the highly complimentary nature of the proposed Anthem/Cigna combination, discuss the limited competitive impact of the transaction on

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insurance in New York, and describe the value that would result for individual consumers, employers, providers in our healthcare system.

This merger is about bringing together complimentary capabilities of Anthem and Cigna to increase accessibility, improve affordability and enhance healthcare quality. The combined company will engage in the innovative and collaborative use of healthcare data to improve continuity of care, while containing rising healthcare costs, improving predictability, and more efficiently delivering services. The combined Anthem/Cigna will make possible data driven, evidence-based medical protocols that enable providers to improve patient health and safety and provide care more effectively.

By providing wholistic view of our members across the healthcare system, providers can more quickly evaluate the effectiveness of their own treatment protocols and identify factors that impact patient outcomes, both positively and negatively. This helps providers do more of what they do best; deliver care to patients and increase the overall health and wellness of our

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patients here in New York. This is something we can only do more effectively and deliver more quickly in New York if Anthem/Cigna can do it together.

Anthem and Cigna are committed to aligning incentives to encourage smarter collaborative decision making that fosters healthier outcomes and a better patient experience. This focus has allowed us to get more care provided under the value-based umbrella, which will only grow as a result of the proposed transaction, having a more immediate impact on our ability to bring down the total cost of care while improving quality.

The health insurance marketplace is competitive and dynamic. Entry is easier than it has been in recent memory. In 2014 alone at least 30 new companies began competing to provide insurance coverage in the US. In 2015 another 70 companies were introduced. That's over 100 new entrants in just two years. In addition, hospitals and providers are increasingly offering their own plans. A recent Price Waterhouse study found that approximately half of all US health

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systems have applied or intend to apply for insurance licenses. Startups are also making headway. For example, Oscar, a 2014 New York based startup, has expanded beyond New York into other markets. From 2015 to 2016 Oscar has tripled its membership and plans to grow by more than one million customers and begin small group sales within the next five years.

When we look at each of Anthem's and Cigna's shares membership in commercial health insurance and health plan services overall and in each of the fully insured individual, small group and large group lines of insurance in New York, it is clear that the transaction will not have an adverse impact on competition. According to data provided by Health Leaders Inner Study, the merger would result in just a nominal increase in share of 3.3 percent across the fully insured segment in New York. Direct written premium data shows that the combined company would have a less than 18 percent share in the comprehensive large group line of insurance in New York. Furthermore, in all but one of New York Metropolitan's statistical areas, the combined company's fully insured share

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would increase by 1.5 percent or less. In that loan MSA, the New York City MSA, the increase would only be 5.3 percent and the combined share would be less than 12 percent.

The only segment where there is more than a diminutus overlap in New York would be in the self insured or administrative services only business. ASO customer are typically large employers who pay employees' medical claims directly and simply use an insurer or non insurer, such as a third-party administrator or consultant for administrative services. This business is highly competitive and is characterized by large employer customers who are extremely sophisticated buyers with entire teams dedicated to finding the best deals for their companies, and they commonly use consultants to insure that they receive the most competitive coverage.

It is also noteworthy that Anthem's New York ASO business is somewhat skewed by the fact that two customers, New York City and New York State, with a combined two million members account for a sizeable percentage of Anthem's total self insured business in the state. Thus, the depth of

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Anthem's ASO presence in New York is more limited than it otherwise would be.

The combination of Anthem and Cigna will bring together the complimentary platforms of both companies in a way that will uniquely benefit consumers. Anthem brings an extensive network of providers, leading care coordination programs in Medicare and Medicaid, 24/7 access to licensed provdiers via TeleHealth, and more than 80 years experience in commercial insurance.

Cigna brings its own distinctive strengths, including consumer centric technology platforms, highly regarded wellness programs, substantial expertise in the international market, and leading capabilities like dental, vision, behavioral and life and disability coverage.

As healthcare evolves, consumers are demanding more information from a variety of trusted resources in order to make more informed decisions. We know that consumers want more transparency when it comes to their expected cost and quality of health care provided by their doctors and hospitals, and we have seen that making this information available to consumers and

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providers leads to better outcomes and cost savings to the healthcare system. For example, Anthem is partnering with third-party transparency vendors like Castlight Health and Healthcare Blue Book to make sure that consumers have clear line of sight in the price variations that exist, often times within the same geography or network.

To encourage greater cost and quality of competition among providers and to help consumers make better informed decisions about where to seek health care services, we implemented a reference based pricing program in partnership with CPERS, the California Public Employee Retiree System. In coordination with CPERS, we took on the problem of significant price variation across California providers for knee and hip replacements by utilizing reference based pricing. By educating and incentivizing consumers and providers through price transparency, CPERS' experienced a 20 percent increase in patients who chose more affordable high quality providers for these procedures.

This merger will not cause existing premiums or rates to increase or benefits to

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decrease. Rather, Anthem anticipates a positive effect on premiums due to the cost savings it expects and realizes as a result of the merger. Medical and network synergies and efficiencies that will result in cost savings include optimizing the best of Anthem's and Cigna's existing provider relationships to obtain the best cost, quality and access for our consumers; the increased scope of the combined company leading to better products and offerings, including data analytics across the two platforms to engage providers in more meaningful ways to reduce costs; and expanding value-based reimbursement and provider collaboration programs more quickly to further lower medical costs and advance important public policy goals.

I would like to thank the Superintendent and staff of the Department of Financial Services for providing us the opportunity to speak on behalf of the merger, and thank you for your time. And I think I will be followed, perhaps, by Mr. Richards briefly.

SUPERINTENDENT VULLO: Mr. Wagner, if I could just ask one question, and I appreciate

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your comments, particularly your comment that it will not cause premium increases. I would like you, if you could, to just specify in the individual market, on and off the exchange, any impacts of this merger. I mean, you talked generally about a 3.3 percent increase in share, but, you know, we at the Department are obviously focused on the entire insurance market, but we do have a great interest in choice and affordability on the New York exchange, as well as the individual market in general, and if you may just comment on that, I would appreciate it.

MR. WAGNER: Yes. Anthem has been committed to the individual products, both before the exchange and after the advent of exchange, and invested significant funds, over 500 million dollars, in developing strategy to approach the products for the exchange markets. We have rolled out individual exchange products, as well as off-exchange products, in all 14 of our markets and are dedicated to those marketplaces.

Cigna has not played as fully in the exchange market. For instance, they are not in New York on an individual market, either on

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exchange, not marketing on exchange or off exchange. We would anticipate one of the benefits of this transaction would enable us to expand individual products both on and off exchange into geographies that are outside of our current blue branded products, including western New York.

SUPERINTENDENT VULLO: Thank you.

MR. WAGNER: Thank you.

MR. RICHARDS: Good morning. My name is Thomas Richards, and I am the global lead for strategy and business development for Cigna Corporation. Thank you, Superintendent Vullo, for the opportunity to speak at today's hearing. Today I would like to do two things; first, provide an overview of Cigna and Cigna's current operations in New York, and, second, explain why we are excited about the opportunities that this transaction presents for the combined company and for our customers.

Cigna is a holding company that, through its subsidiaries and affiliates, provides global health services to individuals and groups. Cigna seeks to deliver affordable and personalized products and services to customers through

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employer-based, government sponsored and individual coverage arrangements. Cigna increasingly collaborates with healthcare providers to transition from volume-based fee-for-service arrangements toward a more value-based system designed to increase quality of care, lower costs and improve health outcomes. In fact, we were the first payer to commit to CMS's goal of 50/90 by the end of 2018, and we are on track to meet that goal.

We have 156 collaborative accountable care arrangements with a number here in New York. Since 2014 those collaborative accountable care arrangements have reduced total medical spending by $131 million and improve quality on average by two percent. And we believe that the merger with Anthem will allow us to accelerate our progress in this critical area.

As to New York, Cigna's operations in New York include our New York domiciled subsidiary, which you obviously mentioned, Superintendent, Cigna Life Insurance Company of New York, which provides disability, group, life and accident insurance to New Yorkers. Health

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insurance is provided to New Yorkers principally through Cigna Health and Life Insurance Company, which is a Connecticut based insurance company.

Cigna is excited about the opportunity that this transaction presents for the combined company and consumers. Both companies' commitment to ensuring consumers have expanded access to high quality affordable health coverage is the foundation of the proposed transaction and will remain the top priority of the combined company.

The primary benefits of this transaction are, one, ensure consumers have access to the highest quality most effective care available; two, help keep quality health coverage as affordable as possible; three, improve consumer choice with respect to products and services; and, four, increase consumer access to enhanced network of hospitals, physicians and healthcare professionals.

With respect to healthcare quality, consumers will benefit from higher quality care as a result of the combined company's ability to utilize complimentary capabilities of Anthem and Cigna, such as valued-based care, shared

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coordination and management programs, and investments in customer service infrastructure, technology and customer centric tools, such as mobile apps and cost and quality transparency tools. These innovative technologies improve data capabilities and programs to promote high quality care and better customer outcomes.

With respect to affordability, consumers will benefit from lower costs through the combined company's greater access and greater ability to adjust cost through efficiency gains in common administrator, IT and business functions, as well as addressing rising costs and medical costs and drug costs. The healthcare marketplace has for sometime been slowly moving to value-based care with its focus on patient outcomes, but by combining the capabilities of Anthem and Cigna, the combined company will be able to speed the adoption of the changes necessary to transition to a value-based system. Value-based care is a critical element in the long-term sustainability of making healthcare affordable for consumers.

With respect to choice, consumers will benefit from having a broader portfolio of product

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and services, including more value-based options to choose from. The proposed merger will accelerate the combined company's ability to better compete and increase its capacity to test innovative programs with providers, driving more value and quality into the system.

With respect to access, consumers will benefit from the greater access to the combined capabilities that will create an enhanced network of hospitals, physicians and healthcare professionals. It will also include virtual physician and nurse interaction and onsite wellness plans. Together, Anthem and Cigna will have the resources and capabilities necessary to exceed consumer expectations and accelerate the transformation of the broader healthcare system.

In closing, I would like to thank the Superintendent and the New York State Department of Financial Services for providing us the opportunity to speak in support of the proposed transaction. Cigna believes that the combination will have a positive impact on the healthcare industrial generally and will result in cost savings and increased overall options and

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efficiencies for our New York policyholders specifically. Thank you.

SUPERINTENDENT VULLO: Thank you, Mr. Richards. One question. We appreciate your focus and Cigna's focus on value-based care and your comments that you believe that the merger will help speed that process, you know, for a broader market. Can you give us a little bit more detail why you think the merger will further the goals and the speed towards value-based services?

MR. RICHARDS: Yes, absolutely. Well, there is obviously a very emerging markets and both companies have different capabilities, so they're bringing the best of our capabilities together that will certainly help us. In addition, if you look at the businesses we are in and the geographies we're in, we are very different businesses. So for instance, Anthem, as Jay mentioned, had a jong history of individual and small group coverage. They have Medicaid coverage. Cigna, on the other hand, doesn't offer Medicaid, with the exception of a couple of rules and some arrangements in a small number of counties in two states. We don't provide small

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group. We have a fairly new presence in individual, and obviously that doesn't include New York. And as we partner with a provider, being able to partner with them across their entire patient panel, actually provides advantages to providers. So I think in combining the companies, we will be able to serve all of the patients, all of those provider's patients and be able to do so again at a value-based arrangement. So we think it adds a lot of value to the providers. Thank you.

SUPERINTENDENT VULLO: Thank you.

MR. FISCHER: Actually, I have one question.

MR. RICHARDS: Sure, absolutely.

MR. FISCHER: Sir, is it possible for you -- you mentioned that the combined company would have an ability to decrease drug costs. Is there something that you can recognize, maybe some proprietary information -- is there something you can talk about, something specific that the combined company will be able to do in dealing with drug costs that they can't do or the insurers right now aren't able to do?

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MR. RICHARDS: I think there are some similarities to the prior question, again, capabilities and even our approach to pharma is quite different between the companies. So one of the things we would certainly look to do would be to kind of combine the best of both. But the other thing we know is that in pharma particularly, there is advantages to having more volume. The discounts that you get from, for instance, pharmaceutical manufacturers can be based on volume, and so I think that would be one way that we would be able to provide those savings, get those savings from the pharmaceutical companies and pass that on through customers and to clients. Thank you.

SUPERINTENDENT VULLO: Thank you.

MR. FISCHER: Thank you.

MR. SCHREIBER: Thank you, Superintendent, for the opportunity to speak in today's hearing. I am Larry Schreiber. I am the President of Empire Blue Cross and Blue Shield here in New York and Anthem New York Health Plan. Empire has been serving New Yorkers for over 80 years. Whether as a not-for-profit, a for-profit

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or a subsidiary of a national plan, Empire has remained committed to providing access to affordable healthcare for all New Yorkers. With over 4,600 employees in offices located throughout our New York service area and paying nearly two billion in state taxes and assessments, Empire is committed to remaining a vibrant part of New York's economic fabric and healthcare continuum.

Through its long-standing partnership with the State of New York, Empire has been uniquely asked to be an innovator of both healthcare financing and delivery. For example, at the request of the state, Empire has provided coverage to our most vulnerable populations, such as the individual market or the AIDS population in the 1980s, providing affordable coverage for low income children as a precursor to the Child Health Plus program or providing a comprehensive policy for the Medicare disabled population. Empire's commitment to vulnerable populations continues today through its re-entry into the Medicaid managed care market, effective -- oh, excuse me, and effective January 1 broad re-entry into New York's small group marketplace.

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In its unique position as a cornerstone of New York's healthcare system, Empire also collaborated with the state to enact insurance reforms, which ultimately became national models, including guaranteed issue in 1992, individual market reform in 1996, and independent external review of claims in 1997. Through the Empire foundation, Anthem continues its service to the communities in New York. In 2015 the foundation pledged over 2.7 million dollars to innovative programs aimed at improving the health of New Yorkers and communities we serve.

Today the New York marketplace is dynamic and highly competitive. Both healthcare delivery and financing are in a transformational period. Consumers now have and will continue to have broad choice in obtaining affordable healthcare program coverage. The top competitors in New York are a diverse group of insurers, including United Health, Excellis, Emblem, Health Now, Aetna, CBPHP, MBP and IHA, just to name a few. And multiple TPAs are available for self-funded accounts throughout New York.

These organizations provide

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administrative and claims processing services that do not need to be located in New York to compete here. TPAs can create their own networks of providers in New York and they can rent provider networks from other organizations. Moreover, many hospital systems in New York are taking on insurance risk or simply becoming licensed insurers, such as North Well and its Care Connect Health Plan subsidiary, or Health First and its partnership with prestigious providers throughout New York. Others like Montefiore, NYU Langone and Mount Sinai are considering entering into the marketplace. And the New York City Health and Hospitals Corporation already operates a Medicare HMO and is, quote, "taking steps towards becoming an integrated delivery system," end quote.

The bottom line is that in a highly regulated environment, the New York insurance marketplace is more competitive and efficient than at any time in its history. Recent health plan mergers are only now beginning to catch up to the accelerated pace of provider consolidations which have included both hospital mergers and vertical acquisitions of physician practices.

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While some of these consolidations have improved efficiencies, a number of others have resulted in increased healthcare costs for consumers. Further, recent studies have found that the market power of healthcare providers is a major driver of price increases and healthcare spending, while at the same time the researchers found that the concentration of health plans did not have an impact on premiums. We're seeing the same dynamic play out in New York.

The merger will also enable the combined company to speed the transition to value-based reimbursement models. Anthem has been a leader investing in delivery system innovation in New York through, for example, our QHIP program, quality insight hospital incentive program, and our enhanced personal healthcare program, or EPHC, which financially reward hospitals and physicians for quality, member satisfaction and innovation.

The combined company will accelerate the transition to value-based care, which will have a more immediate impact on our ability to increase quality, patient satisfaction and lower

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overall costs. Another benefit of the merger will be increased availability of services to populations across the State of New York. Anthem will be able to expand Cigna's presence and compete more vigorously across the western part of the state.

Finally, at its core, the proposed Anthem/Cigna combination represents a significant step forward on the path to a 21st century healthcare system that reflects our shared vision for a greater value for New York consumers, increased access in choice, greater affordability and better health outcomes achieved through innovation and multistate over collaborations. Thank you very much. Any questions, Superintendent?

SUPERINTENDENT VULLO: Yes. Mr. Schreiber, thank you for your comments, and we certainly appreciate in particular the comments about the commitment to New York. You know, through the Governor's leadership we certainly believe that New York has a vibrant healthcare marketplace and our New Yorkers are provided with choice and, you know, affordability in healthcare

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across the state and certainly compared to other states across the country. While we are always looking to improve, we are quite proud of, again, through the Governor's leadership of what we have been able to do here in New York to provide universal healthcare coverage to all New Yorkers. And choice is important to us, and obviously that's why, you know, a combination could create the scenario of there not being as much choice.

You said that you believe the combination will actually result in some cost savings and further choice across the counties in New York. I wonder if you would comment on whether this lower cost that you think the merger will provide will be passed onto consumers.

MR. SCHREIBER: Absolutely. And I am so glad you asked that question because, as you think about the insurance market, there are the fully insured markets, which are regulated by prior rate approval and the individual and small group market, as well as MLR controls. So if we run our business at too much of a profit, two things can happen; A, the regulators can step in and mitigate our price increase in a future year;

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or, B, based on the medical loss ratio requirements in the affordable care act we would have to actually refund that excess profit to consumers.

In the individual and small group market, I believe the medical loss ratio is about 82 percent, if I am correct. In the large group space there's really two categories of consumers, if you will, or clients; fully insured and self-funded clients. On the fully insured side there is also a medical loss ratio threshold at 85 percent, so any excess profit would, again, go back to the clients, or the consumers in that case. On the other side of the coin, within the self-funded marketplace, all we do is collect an administrative fee to provide claim services, member services and so forth. So in that space, any additional savings that we have at the provider level through any contract synergies or payment evasion strategies that we may implement would be accrued directly to the client, the self-funded employer as those expenses are being incurred by their members.

So I believe there are ample controls

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in place, both in terms of the funding mechanisms that are available to the employers, and the MLR prior rate approval that consumers enjoy to ensure that excess profits do not result from this transaction.

SUPERINTENDENT VULLO: Okay.

MR. OECHSNER: So, you know, the base, as I understand what you are saying, the basic mechanism to ensure that there's not excess profits is the medical loss ratio minimum in place. Are there other ways that you think that these cost savings, other than the MLR protection, will get passed onto consumers? That's one part of the question. And, B, you know, rather than just the legal backstop, if you will, but in addition, one of the things I know we're concerned about is that we have a, you know, a fairly robust insured market. You guys together make a big piece of the self-funded market.

Will this -- does this signal a march towards more self-funded business and move away from the commercial market? And maybe you can talk about that as all.

MR. SCHREIBER: So the first part was

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additional mechanisms to ensure excess profitability doesn't sit with me, it goes back to consumers, which I would say out of the gate, I'd repeat what I said before, I think there's ample controls in place, but I would also add to that and say it is our desire to be competitive in this marketplace. And you have created a dynamic and competitive market. In large part in the insured markets, people buy based on product, service and price, in large part based on price. I have got to put forward a competitive price into the fully insured market in order to maintain and potentially grow my business.

What we saw as we now reenter the small group market, the space that we really hadn't been in for about half a decade, we see the move to ASL, and from my perspective we are moving with that market but we want to be in the risk space. You know, that's where we feel we can connect most closely with the consumers, add greater value for consumers. If I wasn't committed to the fully insured marketplace -- and for the record I have been the President of Empire for about eight and a half months now. I was running an Anthem property

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in Wisconsin before this. So I am kind of ramping up on the market, but one of the first things I realized is that we need to commit to the fully insured marketplace, hence, the reason we are launching into small group strategy. You know, we want to be in that space -- if I could slow the move to self-funded, I would because if I'm making one or two percent on fully insured premiums, it's better than making one or two percent on just an admin fee. And at the same time it's that margin that gives me the ability to reinvest in consumers and some of the payment innovation programs we are talking about.

So both from a practical perspective and from a consumer perspective, we are looking to maintain or even potentially grow the fully insured space.

And the second part of the question was with regards to the new ASO, correct? You know, New York is different in its construct in terms of Cigna than in other states. This is a national transaction that's spanning many states. In New York Cigna is primarily 100 plus primarily self-funded ASO business. You know, that

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membership will directly benefit from the transaction by clearing best in class contracts and best in class in the nation from each of the organizations. But it's -- you know, I am part of a larger transaction. There's other markets where Cigna plays more robustly in the individual and the small group markets and those plan presidents will have the benefit of serving that additional membership. For New York it's just a different construct than in some of the other states.

SUPERINTENDENT VULLO: Thank you.

MR. SCHREIBER: Thank you.

MR. REGALBUTO: So we can move on. Lev Ginsburg from the New York Council of New York State. You have five minutes and I will -- thanks.

MR. GINSBURG: Good morning. And I want to thank the Superintendent for the opportunity to speak. My name is Lev Ginsburg. I am the Director of Government Affairs for the Business Council of New York State. We are the state's leading business organization, representing nearly 2,400 members, employing more than a million New Yorkers; businesses large and

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small, insurers and the insured, all across the state of New York. On behalf of the Business Council's members, I wish to submit these comments into the record as part of the Department's consideration of Anthem, Inc.'s acquisition of Cigna Life Insurance Company of New York.

Year after year we survey our members and they report that the cost of healthcare is one of the leading costs or the leading cost driver in their businesses. This has only been exacerbated by changes brought on by the implementation of the ACA, or Affordable Care Act. Since Anthem's proposed merger with Cigna would result in substantial efficiencies and other savings that will directly benefit premium payers and result in greater access to affordable healthcare, we view it as quite favorable to employers across the state.

Respectfully, I found that your letter in August regarding this proposed acquisition a bit troubling. It showed an inconsistent philosophy within the Department regarding the cost of healthcare in the state. The letter stated that competition in the health insurance

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industry is needed so that providers, ie hospitals, doctors, etcetera, can negotiate with various insurers to maximize their income. Our concerns, frankly, are twofold. First, increasing the income of healthcare providers is not part of the mission of the Department of Financial Services. And, second, this statement simply misses the point that focusing such much on provider payments will most certainly lead to increased healthcare premiums, which is, in fact, the primary issue to which DFS should be particularly sensitive.

The analysis seemed to ignore the reality of healthcare provider mergers and acquisitions in the state. Last year alone there were 940 healthcare service transactions in New York, up from about 480 in 2010. This increase is at an unprecedented pace in New York; one which is likely to only accelerate. Numerous recent studies show that such mergers create upward pressure on healthcare costs. Today the Department is concerned with the cost implications of a perceived diminished competition among insurers. We ask that in your consideration of

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the merger, you strongly consider the very real diminished competition among healthcare providers.

As I mentioned, over the last five years New York has experienced an unprecedented consolidation of hospital systems and provider groups. The acquisitions have not only been among hospital systems and competing medical practices, but also vertical integration of hospital systems with downstream medical providers. While we are hopeful that these consolidations hold the potential to improve efficiencies and eliminate the need for the millions of dollars of taxpayer funded subsidiaries, they also have the very real potential of driving up healthcare costs as several systems already today enjoy a near monopolistic market share in their regions of operation.

As to provider compensation, health insurance competition in New York will remain robust, with plenty of competitors continuing to offer, and entering, each of the product and geographic markets in the state. In every area where Anthem and Cigna currently compete, healthcare providers will continue to have choices

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regarding their participation with different health plans and will be able to contract with any or all of those insurers, including Medicare and Medicaid. The bottom line is that Anthem will have to continue to offer quality products with adequate networks in order to compete, thus ensuring adequate compensation to providers.

In considering this need to ensure competition, it's well worth mentioning that Anthem will continue to compete across the state with many fully insured competitors, such as United Health, Aetna, CDPHP, Emblem, Fidelis, Health Now, MVP Healthcare and many others who happen not to be Business Council members. In fact, there are actually more competitors in the commercial market today than there were in 2004 and 2005 when the state approved both the United/Oxford merger and the HIP/GHI merger. This merger has less of a marketplace impact than either of those aforementioned and would not result in any significant impact in any particular area of the state.

My primary consideration on behalf of the Business Council members is how any given

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policy or transaction will affect the cost of healthcare for employers. We believe that the primary goal of this transaction is to enhance the ability to operate more efficiently, improve quality of services and control healthcare costs. In fact, there are studies that have found that the concentration of health plans did not have an impact on premiums. Other studies have concluded that insurer consolidation can actually have downward pressure on premiums and healthcare costs. A 2011 Health Affairs article and a 2015 paper published in the Journal of Health Economics showed that more concentrated health plan markets can counteract the price increasing effects of concentrated hospital markets. The Health Affairs article stated that a more concentrated health insurer landscape brought prices down by upwards of 12 percent.

I worry that the aforementioned letter made it seem that the Department is starting and ending much of the deliberation on this merger with the assumption that any increase in the carrier's market share will have a negative impact on the value-based payment model being promoted by

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the state. There is no evidence to support such an assumption and the logic is flawed in several ways. While the verdict --

MR. REGALBUTO: Thank you, Mr. Ginsburg. Your time is expired.

MR. GINSBURG: Oh, my time is expired. I will submit the rest of it.

SUPERINTENDENT VULLO: Thank you, Mr. Ginsburg. We appreciate your comments and we will take them into full consideration. You mentioned some issues about competition and I just state, you know, obviously the issue of affordability and access to healthcare is integral to the Department of Financial Services' mission and it's in that context that we are holding this public hearing and receiving comments from everyone. There is obviously, you know, a debate as to whether mergers, which, you know, from a numerical standpoint, reduce competition and have the impact of increasing or reducing premiums, and that's something that we are going to consider.

Since it's your view, I think, that this merger will not impact that issue, can you tell us why you think that the cost savings and

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efficiencies of the proposed merger will actually benefit consumers in the price and affordability of healthcare in New York?

MR. GINSBURG: Well, a couple of things. So first thing I would say is the market share -- and granted I don't work for either company and the numbers are things I read -- but the market share seems to be concentrated where there's real competition between the two companies in the self-insured zone, which we just heard about a little while ago. And so I don't have any concerns on that end because, frankly, that's an issue area that is subject to ARISA rather than the Department's oversight. So when it comes to that kind of stuff, I mean, I would leave it to the federal government to have consideration.

So when we talked about the smaller groups, if you will, who are paying insurance rather than those that are paying for third-party administration, I think that, you know, we can see across the board in every state when in the healthcare arena value-based, etcetera, that the more efficiencies that we can provide, the lower the premiums can be. The bigger the groups,

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typically the lower the premiums can be, based on purchases of things in bulk, based on the ability to contract with doctors and hospital systems, etcetera.

It's sort of the complete opposite of what I read in that letter which was that there was concern that providers were not going to get adequate payment. And the idea was if there's less folks on that side to negotiate with that they're going to get a worse deal. Well, I mean the converse of that logic also seems to be the case. You know, if there were better leverage on one side versus the other then prices would go up. So, you know, my thinking is that if leverage is better on the part of the negotiating on behalf of the consumer, on behalf of the premium prayer, that premium effect would have to go down.

SUPERINTENDENT VULLO: Then the impact would be on the providers is what you're saying.

MR. GINSBURG: Well, I mean --

SUPERINTENDENT VULLO: The providers might disagree with you.

MR. GINSBURG: Well, they might, but with that being said, you know, everybody is free

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to negotiate with everybody else. And the need for a robust, you know, for robust insurance product, you know, for networks to be robust is still there, so there is an incentive on all sides. So creating new efficiencies on the side of the insurance companies doesn't harm anyone in as much as anyone who is paying premium or seeking healthcare. Frankly, it puts pressure on the other side for lower prices so a more competitive arrangement.

SUPERINTENDENT VULLO: That may be, but, again, maybe we should have a separate discussion about this, would be, you know, the concept of freedom to negotiate requires that there be a sufficient number of people negotiating because otherwise it would just, you know, general philosophy of non ballistic behavior, which I am not suggesting this is, is that that takes away the freedom to negotiate. Right? So to the extent that would be -- and maybe it's appropriate in this context, I don't know, but if there is a reduction in the number of people at the table to negotiate with, then you're kind of strapped, and whether that be the consumers in terms of the cost

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of the premium or whether it be the providers in what they're going to get and what consequences that might have as to the providers' decisions as to what they do with their practices or hospital or what have you. So this is a very complex issue and we are looking at all of the issues, but it's not just simple one way or the other.
MR. GINSBURG: And I hear what you are saying, and I don't disagree with what you are saying as part of the negotiation, but I think as other speakers have mentioned today and as you folks certainly know because you are the regulators, there are more insurers in the market today than there were over the last, you know, decade, two decades or three decades when there were other lifetime mergers. I think there is zero risk whatsoever compared to any of the times in the last 10 or 20 years, you know, when mergers have been discussed prior. Not only that, I think it was mentioned, I may not have heard it or maybe I did, you know, there are hospital systems getting into the insurance game and there are players now that didn't exist even five years ago. So I think that your worries or the concerns that

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might be there are somewhat unfounded just given the number of folks that have entered the market, the number of companies that have entered the marketplace across the state.

SUPERINTENDENT VULLO: Thank you.

MR. GINSBURG: Thank you.

MR. REGALBUTO: So the next speaker will be Brad Wasser from the Law Offices of David Balto, and we understand that you are representing a consortium of consumer groups. So you will have five minutes.

MR. WASSER: Hi. My name is Brad Wasser. Superintendent, thank you very much for the opportunity to speak. As the gentleman just said, I'm representing a consortium of consumer groups. The testimony or the comments are going to reflect my own comments, but they are supported by a number of national being consumer and public interest groups who collectively submitted a letter to the Department back in March of this year.

And so again, my name is Brad Wasser. I am a public interest and a trust attorney with the Law Offices of David Balto. And, you know,

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our firm has represented consumer groups, health plans, unions, employers. We have testified before Congress and many state legislators, as well as the National Association of Insurance Commissioners and other department of insurance on healthcare competition, and, you know, this merger and the Aetna/Humana merger as well.

And I know, in representing consumer and healthcare providers firsthand, that highly concentrated health term markets and especially health insurance markets can result in escalating healthcare costs for the average consumer, decreased innovation, decreased quality and consumer satisfaction, and less consumer choice.

So, you know, I would implore you all in considering recommendations for the merger to ask yourself the following questions: One, will the proposed merger harm New Yorkers, and secondly, can this harm be fixed through remedies? Now, the Anthem and Cigna merger is happening during a critical time for our healthcare system. Workers' contributions to premiums have greatly outpaced the wage gross since 2000, and consumers are frequently putting off care due to costs.

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This increase in consolidation threatens to undue the progress made by the Affordable Care Act. And we belive thousands of New York consumers and hundreds of businesses will be harmed by this merger because the combined Anthem and Cigna company would result in concentration levels beyond antitrust thresholds in multiple metropolitan statistical areas and have over a 30 percent market share of New York's ASO markets, as we have heard discussions about previously this morning.

And as you're well aware, the State Attorney General is joining the Department of Justice in suing to enjoin the merger in part based on significant concerns over the impact of the merger in New York State. But focusing solely on market shares, however, can understate the competitive problems in New York and other markets. Market shares are just an initial threshold for looking at the potential competitive effects of the merger. So, for example, even at lower concentration levels, there are, you know, there's potential monopsony concerns, which is buying power as opposed to selling power, and

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monopsony concerns can exist at lower market shares than monopoly concerns. And ultimately when insurance companies possess monopsony power, they have the ability to dictate, for example, provider reimbursement and through the press for provider reimbursement consumers lose and quality of care goes down.

Additionally, the merger will harm New Yorkers' pocketbooks. Numerous studies show that premium increases as concentration increases. So, for example, studies looking at the past insurance mergers of Aetna/Prudential, United/Sierra, Humana/Arcadian, they all demonstrate the substantial increases in premiums, despite remedies.

And this is particularly concerning in New York where consumers already pay high health insurance costs and premiums are still climbing. I believe in 2016 New Yorkers on average saw an average seven percent premium increase for individual insurance, and there was an announcement last month by this Department that it would reduce your quest to 2017 rates.

Given my limited time, I am going to

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skip to just talking about profit efficiencies by the insurers. The efficiencies claim to result from the merger won't benefit New Yorkers because there's evidence that shows the efficiencies are not passed onto consumers, excuse me, there is no evidence to show the efficiencies are passed down to consumers. And I believe the Department of Justice in its recent complaint has stated that the proposed merger would not, excuse me, the proposed merger, quote, "the proposed merger would be unlikely to generate verified merger specific efficiencies sufficient to reverse or outweight the anticompetitive effects that are likely to occur." A similar statement was made by California Insurance Commissioner David Jones. You know, and our recommendation of course would be to block the merger, but in the event that the Department feels that it would be unfeasible to do so, we have five recommendations for potential remedies, and we have provided those in our written submissions so I will, for sake of time, not go through those at this time.

SUPERINTENDENT VULLO: I was going to ask you that question. So I would actually

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appreciate -- because, you know, we will make -- the Department will make an independent determination of this, but we are also mindful that this is a bigger issue, right? It's a nationwide thing. It may happen, and the merger can go through. It can go through in various different ways, depending on other actors. But do you have any suggestions as to any safeguards for New York that we might consider in connection with our analysis of this?

MR. WASSER: Sure. So I think our recommendations are more general in nature as to, you know, we would obviously leave it up to the parties about how the specific safeguards would be implemented, but I will just tell you quickly our five recommendations that we had provided in a written submission also.

So first that the Department of Financial Services should require any cost savings resulting from the mergers to be passed along to consumers in the form of lower premiums. Secondly is that the Department should require the merged companies to continue their current level of participation in the New York State marketplace.

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Thirdly, the merged companies should be prohibited from reducing plan benefits and options.

Fourthly, the Department should ensure that the merged company still offers the differentiated insurance products currently offered independently by the two companies. And finally, that the Department should require the merged company maintain access to adequate provider networks and that the networks options are preserved and strengthened.

SUPERINTENDENT VULLO: Thank you.

MR. WASSER: Thank you for your time.

MR. REGALBUTO: So the next speaker will be Dr. Malcolm Reid, the President of the Medical Society of the State of New York.

DR. REID: Good morning. I am Dr. Malcolm Reid. I am the President of the Medical Society of the State of New York, and I am also Chair of the Department of Physical Medicine and Rehab at Mount Sinai, St. Luke's Mount Sinai West. On behalf of the over 20,000 MSNY members, thank you for the opportunity to shore our concerns regarding Anthem's takeover of Cigna.

The recent litigation announced by the

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US Department of Justice to block this and the proposed Aetna/Humana merger validated the very serious concerns held by many physicians and patient advocates who, like the DOJ, believe the possibility of four of the five largest health insurance companies in the country merging are unprecedented in their scale and in their scope.

We thank the Superintendent for her recent written comments that this proposed merger would let the insurers limit New Yorkers' access to healthcare because providers would be forced to either not participant with a dominant insurer or to cut hours of services in order to accommodate a deal they would have to accept.

We agree the merger could have serious adverse implications for patient care delivery. And B, we have been warned for years of the consequences of growing insurer market concentration. Many physicians already feel powerless to negotiate with existing insurance bigamists and believe that this merger will exacerbate an already extremely difficult practice environment.

Our own recent survey showed

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significant numbers of physicians being dropped by insurer networks, questioning whether these insurers even have adequate networks, and 83 percent of physicians responded to a recent MSNY survey indicating that they spent time -- increased time spending or obtaining authorizations from health insurers for needed patient care which has increased in the last three years and nearly 60 percent of respondents indicated that it had increased significantly.

Many physicians feel they have no choice but to become employees of large systems, which can cause disruptions to the existing physician/patient relationships. Multiple reports prepared by the AMA, referenced in my written testimony, notes that this proposed merger would substantially increase the market power of the combined entity in downstate New York and most particularly in Long Island and raise significant competitive concerns.

The Superintendent's own letter about this proposal noted that it would increase Anthem's market share across commercial products to 31 percent statewide, for which Anthem would

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command over 50 percent of the self-insured market. She noted that the biggest impact would be right here in New York City where Anthem would control nearly 70 percent of the commercial, self-insured market in the Bronx and Staten Island and 63 percent in Queens and Brooklyn. Like the Superintendent, we are concerned that the contracting health insurance market and diminishing competition will reduce patient choice of care providers and enable insurers to expand already extensive administrative hassles that make it difficult for patients to get the care and medications they need.

One need only look to the behavior of other companies operating in the New York City area that are permitted to purchase competitors over the last decade and have in the last few years drastically reduced their physician networks and reduced the patient care. It is also worth noting, according to a recent DFS report, Empire currently has a mixed record with regards to addressing the care and needs of their insureds, including having both the work overall consumer complaint ratio among HMO products offered in New

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York State and the work overall prompt payment complaint ratio among HMO products offered in New York State.

As a result of these factors, many physicians have expressed concerns, strong concerns that this proposed merger will make these existing problems even worse. 83 percent of the respondents of the MSNY survey indicated that the Empire/Cigna merger would very or somewhat likely lead to a narrower physician network and 79 percent reported that they will be very or somewhat likely be pressured not to engage in aggressive patient advocacy. With less competition, there will be less incentive for Empire and the remaining health insurers to have comprehensive physician network and to fix these excessive prior authorization hassles.

Again, we appreciate that the DOJ, the DFS and the New York Attorney General have recognized these concerns and urged that this proposed merger be rejected on the grounds that it would harm patient access to needed care. Thank you, folks, for your attention in this matter.

SUPERINTENDENT VULLO: Thank you,

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Dr. Reid. I would like to ask you a similar question I asked the previous witness, which is, as you have recognized, this is -- part of our determination is part of the broader national issue because we don't have any, you know, say beyond New York State. So were this to go forward, were this merger to go forward, do you have any recommendations for safeguards that we as DFS might be able to implement to protect the interests that you are concerned about?

DR. REID: I think it's clearly the narrowing of the networks is a particular problem. The fact that issues really look -- have a connection with a doctor and then they're not able to see that doctor. These are serious concerns that are there. Clearly if this merger were to go through, we would like to work with you very closely to safeguard any adverse effects. Thank you, Superintendent.

SUPERINTENDENT VULLO: Thank you, Doctor.

DR. REID: You're welcome.

MR. REGALBUTO: So the next speaker will be Bob Cohen from Citizen Action of New York.

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You will have five minutes. Thanks.

MR. COHEN: Good morning, Superintendent Vullo and other members of the Insurance Department. I would also like to echo the thanks from the consumer community as well as others for holding this important hearing. We know it's discretionary on your part. We think the issue is incredibly important and needs to be publically aired.

I am with Citizen Action of New York. It's a membership organization that has thousands of members throughout New York State. In seven different locations, we have chapters. We have affiliates throughout New York. We are dedicated to social, racial, economic, environmental depth, and healthcare is one of our focuses, and we are also a steering committee member of Healthcare for All New York.

So I will do my best, given the time, not to duplicate too much what other consumer advocates either have said or will say.

SUPERINTENDENT VULLO: Appreciate that.

MR. COHEN: So we share what has been

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said previously, and what we said in the letter previously to you, that the -- or the Coalition of Consumer Groups that was Mr. Wasser represents, that Anthem and Cigna's merger will have an extremely significant impact on consumers. It's already been talked about the share of the overall health insurance market that these two companies would have if combined. I won't repeat that because I know you know that information.

So I will skip to -- and also, I think it's important to mention, although you already know it, that there's so many -- and it's been said before, there are so many different products that these two companies would, you know, encompass and we think it's really important, as we are particularly interested in the individual and small group market, and that's why my emphasis in my comments will be on those particular markets.

We, for the record, do believe that the Department should reject the merger. We think -- for a number of reasons that I will layout in a moment. There's actually two focuses that I would like to talk about -- actually, three. One is the

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impact on consumer costs and consumer premiums, the second would be service issues, and the third, I guess it would be under service issues but I would like to talk briefly about the customer service records of Anthem in particular.

So as others have said already but I would like to reiterate, it is clear from the available studies covering a number of markets, including public health insurance, large group and Medicare Advantage that multiple insureds in the market is correlated with lower premiums. I don't think there's, as far as I know, any dispute about that fact, and some of the studies have already been referred to by the previous speaker, by Mr. Wasser.

But I think -- I'm not sure if he did mention that, but it's also important to note that premium increases are not limited to the merging insurers. Rival insurers, according to the studies, raise premiums as well. At least the studies find where the merging firms had what they call substantial overlap. I have two minutes left?

MR. REGALBUTO: Yes.

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MR. COHEN: Okay. Well, for reasons of time, I am going to skip and go very quickly. We share concerns about service and provider, you know, provider options. For reasons of time, I think I will defer to my colleague Heidi Siegfried, who I believe is going to go talk about that, and it was also mentioned by the Medicare Society. And we also share the concern that the Superintendent raised in her letter about the impact on New York's delivery system and reform efforts.

I think that my particular contribution in the time that I have, the couple of minutes I have, is to just say that in preparation for hearing I looked at the Department's own file in its rate proceeding for Empire, and it certainly confirmed the views of consumers that what was just said about Empire's service record -- I will just read a couple of comments consumers made to -- and I only was able to get through, the last couple of days, 45 of the 91 pages. I am sure there was a lot more, and I was not selective. I pretty much mentioned every consumer comment that is substantive on service. Consumers said that

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none of the specialists that the consumer's primary care doctor recommended accepted the plan; the consumers said that the company's networks are, quote, poor and customer service was, quote, a joke. The customer said that his or her family had spent hours working with Empire to, quote, rectify errors in charges and coverage, and the consumer said that Empire was the worst from, presumably from a customer service standpoint of the four companies he/she had enrolled in since 2003. And finally, my favorite were, I guess it would be the opposite, the customer claimed that the company, quote, repeatedly denies claims erroneously, forcing the customer to spend large amounts of time contacting the company to rectify the mistakes. That's a quote. And the consumer pressed the opinion, which I guess -- I don't know for sure, but I would certainly be sympathetic to, that because of the company's practice of improperly denying claims and resisting the resolution of consumer complaints, many consumers give up and pay for claims themselves that should have been covered by the company.

And I have to just say anecdotally,

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when we had Empire, my wife and I, we had the same experience; they deny everything and then you just have to call them up, and they will usually back down if you are an advocate, but they seem to have a policy of first -- I guess I would call it presumptive denial.

MR. REGALBUTO: Thank you, Mr. Cohen.

MR. COHEN: And I would just say in terms of remedies, most of what I have said has already been covered, but I would like to add that we think that the Department should monitor the customer service records if, in the event, if you choose, which we hope you don't, to approve the merger. Thank you.

SUPERINTENDENT VULLO: Thank you, Mr. Cohen. And I was actually going to say with respect to those issues, obviously the Department has powers that we've, you know, exercised when necessary, and of course will do so whenever we find any information that's impacting consumers. I want to just ask you a question on the premium issue, you know, because reference has been made to the medical loss ratio, and obviously this Department has prior approval authority in the

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individual and small group market. So why is that not a sufficient check on premium increases?

MR. COHEN: Well, I would say first of all, I believe what was said previously by Mr. Schreiber, the Empire representative, he did say and as you know, there is a remedy under the law that consumers can pay back, excuse me, that DFS can order a payback, but we have always, as a consumer coalition, viewed that as an inadequate remedy. Consumers can't wait forever, you know, a a year for their money. They need the money. So I would say, you know, just saying -- and also, I am philosophically opposed to the notion that gee, I should be allowed to violate the law and then I'll wait for the regulator to catch me at it. I mean, that's not sufficient philosophically.

And the other thing I wanted to say, and it's in my written testimony and it's also in the testimony of Healthcare for All New York, about Empire and our rate proceeding, which is Empire consistently not met its MLRS. So this is not a theoretical concern on our part. They just don't have a good record in paying claims adequately.

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SUPERINTENDENT VULLO: Thank you. Appreciate it.

MR. COHEN: Thanks.

MR. REGALBUTO: The next speaker will be Amanda Dunker, Healthcare for All New York.

MS. DUNKER: So actually, I think I am a perfect height for my microphone. So I am here testifying on behalf of Healthcare for All New York, which is a consumer coalition. We have over 170 members all across the state. So we are really statewide. And our mission is securing quality affordable healthcare for everyone in New York State.

You've heard before, we are testifying against the merger. So our bottom line recommendation is that this be rejected but it be found to be not in the public interest. And so the first reason is that we do think that it will reduce competition. And in our written testimony we have included the analysis that shows that. And, you know, the analysis does show that it's worked for the ASO market, that people talked about that earlier today. And it's worse in some parts of the state, and including New York City.

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But we do feel like it also is going to hurt consumers overall, even though it's worse in those specific areas.

So, you know, given that it reduces competition, we feel that, you know, reducing competition hurts consumers by leading to higher costs and reduced services. That is a basic economic premise, and yes, health insurance markets are very complex, but research of past mergers has suggested that that does hold true for the health insurance market. And, you know, I think Bob and others have cited that research, and of course it's in our written testimony. But we have seen premiums go up for people, and either a lot of factors writing premiums are up in New York State. So we don't want to feel like we've added another factor that's going to drive premiums up even more.

And when we talk about reduced services, our main concern is network adequacy. Networks are getting smaller and smaller everywhere in the insurance markets, and we have heard testimony that this will allow them to provide more robust networks, but there is just no

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incentive for them to do that. Competition incentivizes people to provide better service to people by giving a lot of options. Taking away competition gives the network incentive to improve their numbers. I think a lot of the cost efficiencies they are talking are going to come from reducing the numbers, and that is a big problem for consumers. Consumers obviously care a lot about premiums, but not being able to access a doctor because the networks are so narrow is a huge issue for consumers. And we hear about it every day.

So, you know, we don't want the merger to go through. We are hoping it doesn't go through. But we share the recommendations that people have made about what the remedies may be if the merger does go through, and so I will just go through this quickly. So we first hope that any cost savings -- we have heard that this will lead to cost savings. We hope that those cost savings will be documented for the Department and that the new company, you know, the newly merged company will be able to show that those cost savings have accrued to customers.

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Second, we think that the merged company could be required to continue its current level of participation in the New York State marketplace and including geographically to not withdraw from any parts of the state.

Third, we think the merged companies could be prohibited from reducing plan benefits and health options. Four, we think that they could be required, for at least a few years, to continue offering the differentiated products that they currently offer by the two separate companies.

And then last, you know, the merged companies should be required to maintain adequate provider networks and also strengthen the networks, including and especially in underserved areas. And just on a final note, we don't think the health insurance market in New York State is competitive right now. It's not as bad as other states, but that's kind of a low bar. And when you look at other very consolidated industries, you know, it's common for the government to ask for a minimum level of service and a minimum level of coverage. So, you know, for example, things

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that want to merge or expand, you know, they have to prove that they are investing in long (inaudible).

So, you know, given that context and given that the health insurance market is fairly concentrated already, we don't really feel like our conditions are unreasonable, and we think that they would be the most fair thing to do for New York State. Thank you.

SUPERINTENDENT VULLO: Thank you, Ms. Dunker.

MR. REGALBUTO: So the next speaker will be -- so we will go to Heidi Siegfried, New Yorkers for Accessible Healthcare Coverage. You will have five minutes. Thanks.

MS. SIEGFRIED: So I am Heidi Siegfried, and I am the Project Director of New Yorkers for Accessible Health Coverage, which is a coalition that's existed for more than 20 years of groups that serve people with serious illness and disability. So this includes -- some of the groups that serve and represent people with chronic illnesses, like cancer, cystic fibrosis, diabetes, eating disorders, kidney disease, mental

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illness, lupus and multiple sclerosis, and it's very important to these patients and consumers that they have access to affordable and comprehensive health coverage to maintain their well-being.

So we also represent people with serious diseases and disability and their healthcare work coalition, and so we join in their recommendations and their testimony.

Of course we think that the Anthem/Cigna merger is likely to increase premiums and cost sharing and also reduce access to healthcare. Previous mergers have produced these results and we know that regulator's attempts to tag consumers through conditions not really fared well. So we just, in general, oppose the merger and urge the Department to reject it.

I think probably the thing that we're most concerned about, of course we are concerned about premiums increases and increases in cost sharing, but also in the quality of the networks. And I think -- you know, I think I agree with quite a lot that the President of MSNY had to say because I run a monthly roundtable for our members

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and we usually have speakers with different topics, but it continues to come up at every monthly roundtable that people are not getting the access to their providers that they need and that networks are narrowing and narrowing and it continues to be raised, you know, even though we try to address it.

So what we find is that people who have serious illness and disability try to find a product that includes their providers with whom they have a relationship that's important. That's what's important to them, not value-based payment, quality measures are -- well, we are going to be looking a little bit more at quality measures and what consumers think of quality measures. But they really want to have access to their provider, and they cannot find any network that contains their provider. And network providers try to join the network and they accept the payment and they are refused. And this is like a common thing.

And we also have psychologists that participate in our coalition, and they say, you know, mental health is really a very weak area for network adequacy. So some of the people in our

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coalition, they say well, maybe what I should do is move to California where I can get access to my providers here in New York by buying a product there. So I think that our concern about, you know, this constant refrain that they are going to have better and more quality networks is not something that has been borne out lately and we are concerned that it will get worse.

We think that it just continues to become a problem and so that's why, if we were to -- if the merger were to go through, the recommendation that would be most important to our members would be that they regularly monitor the customer service and subsidiaries and make sure that adequate provider networks are maintained and strengthened, especially -- well, not just enroll another serve network area but also in New York, New York City right here, people are not able to access their providers.

SUPERINTENDENT VULLO: Thank you very much.

MR. REGALBUTO: So the next speaker will be Erin Nevins from Nevins Insurance Agency.

MS. NEVINS: So I would first like to

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thank the Department for inviting me here to this hearing or having an open hearing that I can come and speak. My name is Erin Nevins, and I am the President and owner of an insurance agency in upstate New York in the Latham, Capital District area, and I have been in the insurance industry for 17 years, 10 years of which I have owned my own insurance agency.

And so one of the reasons why I felt it important to come today is I actually have a very unique perspective in the marketplace. So I have a perspective of talking to businesses as well as individuals because we work with chambers of commerces that have sole proprietors and husband and wife joint ventures, businesses, individuals, even at times, because of our participation with the New York State exchange, we are also able to assist people on the exchange that have subsidy coming back to them.

So we are basically entrenched in every aspect of this whole insurance cycle and so we sit with these clients, we hear their daily issues, we work with them on their daily issues. We speak with the carriers on a daily basis. We talk about

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the doctors on a daily basis. We talk about the pharmaceuticals on a daily basis. So we are in the center of this circle of all the stakeholders, and what has become apparent is that the doctor groups, which I don't blame them, I'm sure that they want to negotiate a higher reimbursement rate, the pendulum seems to be swinging more towards their direction of power, which has created a large network in whole in our region that we serve.

So most of my clients are in the upstate and out west portion of the state. Most of my clients are not in New York City. And it seems that most of the comments today are kind of circle around the New York City Metropolitan area, but we service a very rural upstate network region. We have multiple carriers there. I don't feel that this acquisition and merger would create a problem because we already have a number of carriers in our region, four to five major players in the upstate market.

As a matter of fact, Empire Blue Cross has not even been a major player in our region because they have not been participating in the

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small group market as of the last four or five years. Cigna itself is not even a player in the upstate market. We have no business with them, nor do they write insurance in the upstate market.

So for us, this acquisition within the State of New York, specifically within the rest of the geographical area, not just the city, would actually increase competition amongst carriers. One of the issues at hand is the power to negotiate reimbursements with providers. Some of the smaller regional carriers do not have everything, all the tools in the toolbox to be able to combat that, and subsequently as the Affordable Care Act rolled on and the exchange rolled out, tons of clients, specifically in the mid-Hudson area, have lost access to their providers specifically because of that. The reimbursement levels for the individual products are less than the small group marketplace, and because of that the doctors do -- have decided to kind of band together and not accept the insurers.

So there needs to be a balance between the carriers as well the doctor groups, and changing the distribution of insurance doesn't

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help in actually speaking to the cost of care. So there needs to be a joint venture between everybody, and this merger would allow more negotiating power between the providers and the insurers to come up with a good practice to incorporate as many people in the state as possible. So I appreciate the opportunity to speak, and thank you.

SUPERINTENDENT VULLO: Thank you. And you do have a unique perspective, not only geographically, but also from where you sit in the market, I think. I want to follow up on what you are saying about the provider side because I think what I heard you say is that you have seen, and this merger hasn't gone through yet, but you have seen sort of the reduction in reimbursement rates which have caused providers to not participate and I guess that narrows the networks, which is what some of the consumer groups -- so I get that part but --

MS. NEVINS: Partly, yes. But with the Affordable Care Act comes the MLR. And so the carriers cannot charge more than a certain amount for their product. So they can't negotiate

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anymore than they already have and they are already getting prior approval from DFS whether or not their rates are justified based on cost of care. So how much more can they negotiate at the point where the providers have consolidated. Now they are saying well, we are not going to accept insurance. I have so many members that cannot access doctors because they won't take the insurance. So as they're not accepting the insurance, these members have nowhere to go for their care expect upstate Albany, which is quite a drive for them, or downstate.

SUPERINTENDENT VULLO: So I am trying to understand the why. I mean, and I appreciate that Empire/Anthem is actually, you know, increasing itself. This is without a merger happening. It's a small group market. So that is providing, you know, additional competition in the small group market. But as I understand it, part of potential savings from the proposed merger is savings from the sort of cost of care. So why would that not --

MS. NEVINS: Not so much actual cost of care. There is a number of things that go into

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it more than just the cost of true care. Pharmaceutical.

SUPERINTENDENT VULLO: Of course.

MS. NEVINS: So merging together and having more buying power to reduce the cost of prescription drugs, which contributes to probably 30, 40 percent of the premium itself, that ability to lower premiums in and of itself from this merger would be a positive.

SUPERINTENDENT VULLO: Right. But I am focused on sort of the provider issue, which is the sort of lesser reimbursement causes providers not to accept insurance, and if some of the cost savings from the merger is from provider contracts, why won't that result in the same type of behavior of providers not accepting the insurance and therefore making that situation even worse?

MS. NEVINS: So what's happening is the providers are picking and choosing which level of contract they want to accept reimbursement for, and putting two companies together and spreading the risk over a much larger pool of people, between Anthem and Cigna, would allow them to be

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more competitive with their provider contributions.

SUPERINTENDENT VULLO: Okay.

MR. REGALBUTO: Thank you.

SUPERINTENDENT VULLO: Thank you.

MS. NEVINS: Thank you.

MR. REGALBUTO: The next speaker will be Henry Allen from the American Medical Association. You will have five minutes.

MR. ALLEN: Good morning, and thank you, Superintendent Vullo. My name is Henry Allen. I am an American Medical Association attorney, here today speaking on behalf of the AMA. The AMA has analyzed the likely competitive effects of the proposed Anthem merger with Cigna. We have concluded that this merger will likely impair affordability and quality in New York commercial health insurance markets.

Additionally, in the markets where health insurers purchase physician services, the merger will deprive physicians of the ability to negotiate competitive health insurer contract terms. The result will be detrimental to consumers. As Harvard Health Economist Leighmore

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Daphney has noted, quote, if past is prolonged, insurance consolidations will lead to lower payments to healthcare providers, but these lower payments will not be passed onto consumers. On the contrary, consumers can expect higher insurance premiums," closed quote.

For these reasons, we conclude that the proposed merger would substantially lessen competition and we respectfully ask that, pursuant to New York Insurance Law Section 1506-B, you disapprove Anthem's application to acquire Cigna.

The American Medical Association has analyzed commercial health insurance market data for markets within New York State, and we have determined, in accordance with the federal government's horizontal merger guidelines, that an Anthem acquisition of Cigna would, in several of the most populous MSAs, be either presumed likely to enhance market power or potentially raise significant competitive concerns.

We have further found that the merger would eliminate -- excuse me. We have further found that the merger would constitute a prima fascia violation of the competitive standard

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adopted by the National Association of Insurance Commissioner, the NAIC, in its 2015 bill. Under that standard the New York State commercial health insurance market is highly concentrated, meaning the share of the four largest insurers is 75 percent compared to domestic airlines, for example, which is actually just 62 percent.

Moreover, the merging insurers' shares exceed the NAIC permissible limits applicable to such highly concentrated markets. The anticompetitive market structural effects of this merger are likely to be permanent. An acquired health insurer market power would be durable because barriers to entry prevent new entrants from restoring competitive pricing.

So what would be the likely health insurance price and quality effects of this merger if it is improved? A growing body of peer reviewed literature suggests that health insurer consolidation leads to price increases as opposed to greater efficiency or lower healthcare costs. There can be little doubt that an Anthem/Cigna merger would produce the higher premiums predicted by the higher market concentrations and their

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merger induced increase.

The diminished competition leading to higher prices would also lower plan quality, as measured by, for example, the availability of prescription drug and other benefits, paying bills accurately and on time, and, we have heard, network adequacy.

Turning to the market for physician services, when Anthem seeks to contract with physicians, it must today compete with Cigna, a leader in value-based contracts. The merger would eliminate Cigna and therefore reduce any Anthem incentive to enter into value-based contracts. Indeed, Anthem tends to exploit Cigna's disappearance by applying in an exercise of monopsony power, Anthem's generally lower physician reimbursement rates to the Cigna membership it acquires.

Generally monopsony power acquired in a merger such as this allows the merged insurer to depress physician reimbursements to below competitive levels, ultimately harming consumers. Reimbursements at below competitive levels may force physicians to cut investments and practice

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infrastructure that are essential if physicians are to successfully transition to value-based payment. It may also require physicians to spend less time with patients in order to be practice expenses, to cutback on clinical staff, to reduce quality initiatives or to retire early.

The monopsony problem associated with this merger was a basis for the California Insurance Department, urging the Department of Justice to challenge the merger. The California DOI stated, quote, "Anthem's greater size and thus its increased bargaining power relative to providers post-merger may prompt it to reduce provider reimbursement rates to a point at which quality will inevitably be sacrificed. Indeed, Anthem representatives have stated that one purpose for the merger is to reduce payments to providers." Quote, "it is important to understand that consumers do not see any savings resulting from buyer power acquired in health insurer mergers. Studies have shown that premium increase post-merger -- that premiums increase post-merger, not decrease. This is because health insurer monopsonists typically also are monopolists.

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Facing little, if any, competition, they lack the incentive to pass along cost savings to consumers." I see my time has expired.

SUPERINTENDENT VULLO: Thank you, Mr. Allen. And, you know, we appreciate, obviously, the American Medical Association's input in this hearing. It sounds like you are a supporter of value-based care, which is a good thing for us to hear. I would like to ask you a similar question I asked some others. You know, does this -- it's not a dichotomy, but there are two in some ways countervailing forces here where you have the issue of provider reimbursement rates, which could be a potential cost savings that would get passed along to consumers, while at the same time if those reductions are so low, the providers are not going to participate in the networks and then that has the impact to the consumers of what their networks are.

So trying to balance those two things is obviously not an easy thing. Can you tell us, though again, if this merger were to go through, because, again, we don't control the whole piece of this issue of the merger, but, you know, in New

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York do you have any recommendations of, you know, safeguards that we might be able to implement in New York, you know, to maybe impact that balance somehow in a way that makes everybody happy? How about that?

MR. ALLEN: Okay. Well, what we think that competitive markets are the way to safeguard consumers --

SUPERINTENDENT VULLO: And I don't disagree.

MR. ALLEN: -- both in the markets in which insurers sell insurance and also in the markets in which they acquire provider services, that those markets should remain -- shouldn't be competitive and that regulation is a very poor substitute for a competitive marketplace. And, you know, one example would be we have heard testimony on MLRs. MLRs are just regulatory minimums of performance. It's never been represented in the enactment of the ACA as being some kind of standard that health insurers should aspire to. And so -- thank you.

SUPERINTENDENT VULLO: Thank you. Appreciate that. Thank you.

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MR. ALLEN: Thank you. Appreciate it.

MR. REGALBUTO: So the final scheduled speaker is Chuck Bell from Consumers Union. Is Mr. Bell here?

SPEAKER: He is on his way.

MR. REGALBUTO: Are there any members of the public that would like to be heard? Can you state your name when you get up there? And you will have five minutes.

MR. HANNAY: Sure. Good morning. My name is Mark Hannay. I am Director of Metro New York -- Healthcare for All New Yorkers, a consumer and labor coalition here in the city that does help the advocacy work. We have been around 20 years or more. And we will be submitting written testimony to you.

We are a member of the steering committee of healthcare for all New York. So we endorse that testimony and recommendations there. I am actually here just kind of off-the-cuff speaking a little bit as an Empire policyholder. In my experience with that, I have been covered by them for a year and a half now, since the collapse of Health Republic, which was my previous carrier.

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I guess I just want to say, my concern about this merger is sort of the increasing complexity for the consumer, the patient, the policyholder in trying to negotiate the infrastructure of a large insurance company.

It seems that Empire contracts out many of its different services, including pharmaceutical, specialty pharmaceutical, utilization review to different entities based on what kind of service you are looking for, and it sort of seems like when that sort of process happens, the responsibility to actually respond and solve a problem gets so diffuse that nobody takes responsibility and everybody is kind of pointing fingers at it's this entity's problem, it's that entity's problem, and it sort of leaves the patient and the policyholder in the lurch. So I am kind of concerned about that.

The other has been my experience in terms of some of the networks that they have, and it is a fairly narrow network relatively speaking, but in terms of some major medical procedures that I have had about six months ago, I kind of lined everything up so that all my providers and the major medical center that I was having the procedures done at and so forth was all in order. And as part of the procedure, the day before I was told go to the hospital and give them a blood sample so they have everything ready for you. So even though the hospital was in the network and all the providers, I found out on the spot that day that for some reason the in-house lab wasn't part of the plan. And I was like what's this all about, and they said well, here is a list, you can go someplace else that will take your coverage. But I was there on my lunch hour and I didn't have time to run around the city and try to find someplace else. I kind of lucked out in the sense that the cost was only $20, so I sort of ate that. But it was just kind of yet another concern of there's this kind of everything is so pigeonholed that I would encourage any insurer, and in this case should the merger go forward, that less pigeonholes please is kind of what I would kind of say in that regard.

And to the extent that the Department and your colleagues at the Department of Health, which I understand have a major responsibility

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around the provider network issues, and I know you're working with them to develop a process there and reach out to us advocates, and we are looking forward to engaging in that multistate coalition to solve this problem of network advocacy here in New York, but I would just kind of say those are some thoughts off the top of my head in my own experience as an Empire policyholder.

SUPERINTENDENT VULLO: Thank you. We appreciate those concerns, and yes, we work very closely with the Department of Health. Thank you.

MR. REGALBUTO: So now we will have Chuck Bell, Consumers Union. You will have five minutes.

MR. BELL: So I am Chuck Bell, Programs Director for Consumers Union. We are the nonprofit organization that publishes consumer reports, based in Yonkers, New York. I apologize for being late, and I know a lot of the points I would like to make have probably been made by other speakers. I have a 14 page statement I am submitting for your consideration.

We have joined with New York consumer

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groups and national groups like Consumer Federation of America, US Purge, Consumer Action, among others, expressing concern about the Anthem/Cigna merger. And we are not persuaded by arguments made by the management of these companies that will result in innovation and in synergy and cost savings for consumers.

And I would refer you to the letter sent by California Insurance Commissioner David Jones to the Department of Justice indicating that he was not persuaded by the testimony they received in California that innovation or synergies would result from the merger, and he felt that Anthem and Cigna had failed to make their case. According from their testimony in California, we also think the harmful impacts of the merger on competition and choice may be greater than the numbers suggested about market concentration provided by AMA and others because of issues related to Blue Cross/Blue Shield trademark licensing. These companies typically do not compete head to head in areas where they are likely to use the Blue Cross trademarks. And so some of the numbers from New York maybe make it

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look like our market is more competitive than it actually is.

We are very concerned about the current state of affordability of premium for consumers. The Commonwealth Fund reported that the share of family median income going to premiums has gone up from about 15 percent of median income for a family household in 2003 to 25 percent in 2013, so an increase of 10 percent of the consumer's household income.

So this merger is not occurring in a vacuum. As you know, premiums have been going up in New York State, is consuming a larger and larger share of family budgets, and affordability and accessibility really matters to consumers. And so we were so pleased that you scheduled this hearing and it actually came much quicker than we were expecting. I reached out extensively during the last two weeks of August to try to reach out to particularly players in the ASO market to try to bring them to the table to speak to you, and quite a number of them are concerned. I think a lot of the companies that are in self-insured -- workers within self-insured plans don't even

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realize they are in the ASO market, so it's a little bit of an education job that even has to be done to get people to understand how concentration in that market could effect the quality and cost of their coverage.

So I think there is a broader group of stakeholders that is really concerned about this proceeding, and certainly from the Consumers Union's perspective, we have tens of thousands of people who have e-mailed us in New York State. We have three and a half million subscribers throughout the country. And for them, they understand that concentration of ownership really does make a difference and hits them in the pocketbook. Perhaps the biggest example people understand is when you have duopoly or monopoly situation for cable and telecom communication providers that these highly concentrated companies tend to be price makers rather than prices takers, and they are not competing head to head to deliver better value or bend the cost for consumers.

And if we were expecting to see innovation and synergies and so forth, you would think we would have seen much more of it by this

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point because we have already had a phenomenal amount of consolidation in the market across the country. So for reasons that -- I also layout some concerns using DFS data about the poor performance of Empire Blue Cross and Cigna and some of the complaint rankings that have been compiled by the Department over the last five years, including on prompt pay issues, and for overall complaint rankings, Empire Health Choice Assurance finished and Empire Health Choice HMO either ninth or 10th out of 10 HMOs or PPOs in the last two years. So, you know, the last place or right next to last place. So we think that that record of marketplace conduct should be considered as you are considering the merger.

We do not think that imposing conditions on this merger or divestitures is likely to ameliorate or mitigate the market concentration that consumers already experience. We are concerned that consumers will see quite a sharp premium increase, an increase in cost on top of what they are already paying and can barely afford.

So therefore, we urge you to reject the

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merger in its entirety. If it moves forward for some reason, we do support a position of conditions along the lines of those proposed by Healthcare for All New York, and we stand together around those issues.

I just also want to thank you, the leadership of the Department of Financial Services, on this price medical field issue. We have now passed laws in three other states; Connecticut, Florida and now California, in the month of August to adopt the protection against surprise medical bills. So I want to thank DFS and Governor Cuomo for your leadership on that issue and helping to show that we can do a better job for consumers. And I'm pleased to say other states are following New York's lead on that issue. So thank you very much.

SUPERINTENDENT VULLO: Great. Thank you, Mr. Bell. We have a question for you.

MR. FISCHER: I am just trying to get my arms around it. The rise in healthcare premiums is, I think, we would all agree is a national issue, and that there hasn't necessarily been consolidation evenly across the US, perhaps.

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I could be wrong about that. But there are a lot of drivers to the increase in premium. There's increase consolidation among providers we have heard about, there's drug costs. Where is your sense that consolidation among health insurers fits into the rising premium amounts?

MR. BELL: Yeah. So actually, the point I am trying to make in my testimony is that actually consumers have their back at the wall. So at the margin, any additional increase in premiums is unhelpful. So I am not just making the case that consolidation is, you know, a sole force for this. I mean, obviously it's medical trend, it's a lot of different things. But so I think we are concerned that we've already -- I mean, consumers can experience loss of welfare basically because of higher administrative costs, higher returns to investors and less competition. And so in that light we think that because consumers can barely handle the level of increases that are coming down on an annual basis, it would be quite difficult if the premiums would increase on the range of seven to 14 percent, as suggested by the record of past mergers, that it can have

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that level of effect over what a consumer has to pay.

So we don't -- we think that the case that there is an economy of scale or that there's going to be some, you know, tremendous breakthroughs, you know, health IT systems or management of care, we think that is speculative, it's unproven, and the companies have really not put a lot of meat on the bones in terms of demonstrating why they should be granted this authority to merge and making even larger combination. And I know that you must examine the transactions before you right now, but also it's quite possible that we will see further consolidation in the New York metro are and upstate.

You know, 20 years ago Anthem tried to combine with Verizon Blue Cross/Blue Shield in New Jersey. These two companies in Connecticut are now going to have 60 percent of the market if the mergers goes through in Connecticut, and it wouldn't take the sale of maybe one or two more companies in New York State to have an extremely tight market where there will be very little

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choice in head to head competition for consumers.

So I think our concern is that consumers will take it as a result of marketplace effects from this consolidation, and also there is a negative impact on consumers from the political consolidation of power of these large insurers. When you have three large insurers nationwide that cover 132 million lives, those insurers have more political power, both in Washington and the state capitols to put lots of pressure on the rate review process, for example, that we really rely on here in New York. And so even that may also be an issue that's outside of your scope. It's an issue I have to worry about as a consumer and community advocate, and I think many people are concerned about democracy, and pluralistic political systems should be worried about that issue too.

SUPERINTENDENT VULLO: Mr. Bell, I wanted to follow up on that because on the issue of premiums, you know, which obviously is a concern of ours, you know, and your point that or your opinion that the merger could result in increased premiums to consumers. Why isn't the

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Department's prior approval authority sufficient, or maybe it is in your view, to address that issue, counterbalanced by at least the argument that this merger might actually reduce costs by, you know, provider maybe reimbursements or drug reimbursements or other efficiencies that could passed along to the consumer.

MR. BELL: Yeah, I don't feel like I am an expert in answering that question, but I guess one concern I would have is that rate review or prior approval is an activity that sort of follows what the marketplace brings you, in terms of the rate filings that are made by carriers. If you have fewer carriers are filing rate filings, there's less competition among rate filings, there's less -- and there's less diversity in the marketplace of different economic models that might be able to deliver better healthcare at better value or lower administrative costs. We'll have probably likely fewer nonprofit health insurers going forward. If more of them convert, the for-profit purposes where they have a fiduciary duty to deliver as much return to investors and executives as possible, and so that

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additional level of, you know, marketing and administration, profits and salaries comes also out of the consumers' welfare, we would argue.

SUPERINTENDENT VULLO: Okay. Thank you. Appreciate that. Oh, wait.

MR. OECHSNER: Hi, Chuck. One of the concerns we have mentioned is the increasing move to self-funded business, ASO business, and clearly, you know, when you put that in the mix here with these two companies, that's certainly one concern that we've had, but is that a concern that you share as consumers? And if so, why?

MR. BELL: Well, yes, we do. I am very concerned about that issue because I feel that for a consumer who is in a self-funded plan that there's less oversight and accountability for the way that that health coverage is delivered to the consumer. I am dealing with two significant complaints now involving very large amounts of money for surprise bills for consumers, very large amounts of money that received neurosurgery, and received a very small payments from their self-funded plans. So -- and then to go through the check, you know, the oversight structures at

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the federal level, the Department of Labor and elsewhere, I mean, first of all, you know, HR managers and others are barely even aware of -- they don't even know where to refer to. So we would much rather see people from sort of a public accountability point of view, we'd much rather see people in a fully insured health plan that's regulated by an active state regulator like the New York DFS.

So I think accountability is a big concern, and also, you know, one of the reasons people go in that direction, employers go in that direction, is because there is less regulation and less oversight. And we don't know as we're working, for example, to close the loopholes on surprise bills around the country, we don't know when those loopholes will be closed for people who are in the self-funded plans. And so that -- since that's half of the private sector workforce, that's a very large number of people in the country. So we are concerned about that, and we also recognize -- we talked to some city government as we were preparing for the hearings, they are concerned about how much they have to pay

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even if they aren't in a self-funded plan. They are concerned that their costs are going up as well. They see this market concentration as a possible problem. So we have to also be concerned about those employers and whether they're going to be able to bear what comes out of consolidation.

SUPERINTENDENT VULLO: Thank you, Mr. Bell.

MR. BELL: Thank you.

MR. REGALBUTO: So are there any other members of the public that would like to be heard before the Superintendent? Seeing none, I will turn it over for closing comments.

SUPERINTENDENT VULLO: Great. Thank you, and thank you, everyone, for being here and in particular for everyone who has provided us with testimony today. It was certainly illuminating and it came from, you know, different points of view and different stakeholders in the market, which is precisely why, you know, as a matter of transparency and otherwise we determined that it was appropriate to hold the public hearing. So we appreciate all the voices that we have heard.

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DFS in this matter will make an independent determination as to the merits of this proposed acquisition, and we will, you know, focus not only on the present New York State market but also what we might perceive as to the benefits or not of this proposed acquisition on the New York market in the future. Because we think that it's not only looking at it as it is today, but obviously with data and other information to inform us to be able to reliably predict what might happen in the future and also to the extent we might consider approval, any potential safeguards or other things that we might be able to do in New York.

But, again, we haven't made a determination. This is incredibly useful. I will repeat, we want a vibrant New York marketplace for health insurance for our consumers across the state in all geographic regions with a variety of products. We believe we have a vibrant marketplace. We are concerned that that marketplace could change, not simply from this, but overall, and that is our focus and that is our mandate, and I can assure everyone that we will

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consider this very, very carefully.

As I said in the beginning, we will take any additional written submissions within five business days of this hearing because we want to make sure that we have all the available public input in order for us to make a determination. So with that, again, appreciate everybody being here. We know you took time to be here and for the work that everybody put into this. And at this point I will close the public hearing. So thank you, again, and have a wonderful day.

(TIME NOTED: 11:55 A.M.)

CERTIFICATION

I, STEFANIE KRUT, a Notary Public in and for the State of New York, do hereby certify:

THAT the foregoing is a true and accurate transcript of my stenographic notes.

IN WITNESS WHEREOF, I have hereunto set my hand this 12th day of September, 2016.

STEFANIE KRUT