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Commissioner Sevigny
Insurance Commissioner State of New Hampshire
Chair for the Health Insurance and Managed Care (B) Committee
444 North Capitol Street, NW
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December 7, 2015

Chairman Sevigny:

Please find the enclosed supplement to my November 17, 2015 white paper discussing the health insurance mergers of Anthem and Cigna and Aetna and Humana. I would like to thank Commissioner Sevigny and Health Insurance and Managed Care (B) Committee for granting me an opportunity to speak on November 20, 2015. During my presentation and subsequent conversations with a number of Commissioners and staff, I was asked questions regarding the mergers of Anthem-Cigna and Aetna-Humana. This supplement addresses two separate issues raised during those conversations: (1) the post-merger(s) market concentration; and (2) independent Insurance Commissioner investigations in each state, and the need for a National Association of Insurance Commissioners to create a task force or working group.

Sincerely,

David A. Balto

Cc: Vice Chairman Mike Kreidler
Commissioner Andy Tobin
Commissioner Marguerite Salazar
Commissioner Katharine L. Wade
Commissioner Mike Rothman
Commissioner Laura N. Cali
Commissioner Teresa D. Miller
Commissioner Angela Weyne
Commissioner Todd E. Kiser
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Commissioner Tom Glause

Supplement to Health Insurance Mergers: The Vital Role of State Insurance Commissioners in Investigating Anthem-Cigna and Aetna-Humana

The pending mergers of Anthem-Cigna and Aetna-Humana are significant in nature combining four of the nation's five national insurers. These companies' footprints are significant, spanning not only the entirety of the United States, but also a range of insurance products. Post-mergers, 90 million Americans would receive insurance from either Anthem or Aetna.[1] In fact, the size and scope of these two mergers has even led presidential candidates to question the competitive nature of these transactions.[2]

In my initial November 17, 2015 white paper, I primarily focused on merger competition analysis under the Model Insurance Holding Company Systems Regulatory Act ("Model Act")[3] and standard antitrust analysis used by the federal and state enforcement agencies. As part of my analysis, I provided information on the mergers between Anthem-Cigna and Aetna-Humana and offered two conclusions: (1) each Insurance Commissioner should review the mergers, and (2) the National Association of Insurance Commissioners ("NAIC") should form a working group or task force on the mergers to assist the states. Based on questions raised subsequent to my November 20, 2015 presentation, I offer this supplement to my white paper addressing the issues of post-mergers market concentration and the need for independent investigations by individual state Commissioners as well as the creation of a NAIC task force or working group.

I. Post-Mergers Market Concentration

As was previously discussed in our white paper, the vast majority of health insurance markets are highly concentrated. According to the non-partisan Kaiser Family Foundation, on average, a state only has three insurers with a greater than five percent market share of the individual, commercial health insurance market with the largest insurer controlling a dominant 55 percent of the market.[4] The combinations of national insurers Anthem-Cigna and Aetna-Humana would further exacerbate concentration within the majority of health insurance markets. Moreover, studies from the American Hospital Association, American Medical Association, Kaiser Family Foundation, and Heritage Foundation all indicate, that post-mergers, newly formed Anthem and Aetna will exceed anticompetitive thresholds for concentration or market share in nearly half of

[1] Margaret Patrick, *Aetna Announces Its Acquisition of Humana*, MARKET REALIST (July 8, 2015), http://goo.gl/C6aJ1p.
[2] *See* Sam Frizell, *Hillary Clinton Targets Health Insurer Mega Mergers*, TIME.COM (Oct. 21, 2015), http://goo.gl/y2yjRS; *see also* Shannon Muchmore, *GOP candidates touch on Medicare plan changes during debate*, MODERN HEALTHCARE (Oct. 28, 2015), http://goo.gl/X3lKZ4 (Noting that presidential candidate Carly Fiorina "mentioned recent pharmaceutical and health insurance company mergers, saying big government favors the big and powerful, while crushing small businesses").
[3] MODEL INS. HOLDING CO. SYS. REGULATORY ACT § 440-1 (Nat'l Ass'n of Ins. Comm'rs 2015) [hereinafter "Model Act"].
[4] *Individual Insurance Market Competition*, KAISER FAMILY FOUNDATION (2015), http://goo.gl/tVRmL3; *see also 2014 Supplement Health Care Exhibit Report*, NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS (2015), *available at* http://goo.gl/BDf0qs (discussing market shares of insurers in the individual market for every state).

the states.[5] We incorporated this data into a map demonstrating where the mergers would have presumptively anticompetitive overlaps.[6]

The data used in our white paper is corroborated by a recent analysis done by Health Affairs that relied on data from the NAIC.[7] The Health Affairs piece analyzes both current trends in concentrations and then examines each state's market concentration post-mergers for different insurance products including commercial insurance, commercial administrative-services only ("ASO"), Medicare Advantage, and Managed Medicaid.[8] The analysis mirrors other cited data, finding that the majority of insurance markets are already highly concentrated, and that the mergers would increase concentration for different insurance products above presumptively anticompetitive levels in nearly half of the states.[9]

While an increase in market concentration is not conclusive of anticompetitive harm,[10] under the Model Act high market shares and increased levels of concentration are *prima facie* evidence a merger violates the "Competitive Standard."[11] The analysis offered from numerous sources offers significant evidence that the Anthem-Cigna and Aetna-Humana mergers could be deemed anticompetitive in a number of states.

II. Insurance Commissioner Investigations and the Role of the NAIC

As was noted in the white paper, we recommend that the Insurance Commissioner from each state wherein Anthem and Aetna must make a filing before consummating the merger – whether a Form A or a Form E – should investigate the merger to the fullest extent afforded by state statute. Where there is statutory discretion to hold a public hearing and conduct independent review of these mergers, we believe that the each Insurance Commissioner should fully utilize these powers. Public hearings and investigations will allow consumer, providers, and third parties to offer opinions and voice concerns. It will provide a public record and transparency so

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[5] Gretchen Jacobsen, Anthony Damico, & Tricia Neuman, *Data Note: Medicare Advantage Enrollment, by Firm, 2015*, KAISER FAMILY FOUNDATION (July 14, 2015), http://goo.gl/g1rJ0Z; *see also* Market Share and Enrollment of Largest Three Insurers- Individual Market, 2013, KAISER FAMILY FOUNDATION (2015), *available at* http://goo.gl/T4jgL7; *see also Effects on Competition of Proposed Health Insurer Mergers: Hearing before Comm. on the Judiciary Subcomm. on Regulatory Reform, Commercial and Antitrust Law*, 114th Cong. 5-8 (Sept. 29, 2015) (testimony of Edmund F. Haislmaier, Heritage Foundation), *available at* http://goo.gl/9E2Dkm; *see also Effects on Competition of Proposed Health Insurer Mergers: Hearing before Comm. on the Judiciary Subcomm. on Regulatory Reform, Commercial and Antitrust Law*, 114th Cong. 3 (Sept. 29, 2015) (testimony of Tom Nickels, Vice President, Am. Hospital Assoc.); *see also* Press Release, Am. Med. Assoc., AMA Releases Analyses on Potential Anthem-Cigna and Aetna-Humana Mergers (Sept. 8, 2015), *available at* http://goo.gl/3TZoJn.

[6] *See* white paper's Appendix B: Overlaps from Anthem-Cigna and Aetna-Humana Mergers.

[7] Douglas Hervey, David Muhlestein, and Austin Bordelon, *How Might Proposed Payer Mergers Impact State Insurance Markets?*, HEALTH AFFS. BLOG (Dec. 1, 2015), http://goo.gl/uadcAZ (Attached to this supplement as Appendix A).

[8] *Id.*

[9] *Id.*

[10] According to recent antitrust decisions in federal court, high market concentration can establish a *prima facie* case that a merger is anticompetitive. *See St. Alphonsus Med. Ctr. v. St. Luke's Health Sys.*, 778 F.3d 775, 788 (9th Cir. 2015) (stating that "the extremely high [Herfindahl-Hirschman Index] on its own establishes the *prima facie* case."); *see also ProMedica Health Sys., Inc. v. FTC*, 749 F.3d 559, (6th Cir. 2014) (finding that the "Commission was entitled to put significant weight upon the market-concentration data standing alone.").

[11] Model Act at § 3.1 (D).

that the competitive and consumer issues can be fully analyzed. As documented in our submission, numerous states have fully utilized these powers in analyzing past mergers, such as Pennsylvania's careful scrutiny of the Highmark – Independent Blue Cross acquisition. Moreover, these reviews by Insurance Commissioners can often lead to extensive remedies requiring the merging health insurers take certain actions to restore competition post-merger.[12]

Currently, we are aware that certain states have already begun to take action with both Florida and Arkansas holding hearings in December 2015.[13] We commend individual Insurance Commissioners for reviewing the mergers, and we recommend that other Insurance Commissioners conduct similar investigations.

In the white paper, we also recommended that the NAIC form a task force or working group to investigate these two health insurance mergers, and potentially other health insurance mergers in the future. There is precedent for forming such a task force or working group – the NAIC group established in the 1990's to analyze and investigate the Blue Cross conversions. After making this suggestion, we received questions from numerous Commissioners and staff about the role that such a task force or working group would play and why it would be necessary when there was an already pre-established state working group and individual state investigations.

While there may be individual investigations and smaller working groups, these entities do not have the same capacity and resources as the NAIC. A task force or working group on health insurance mergers could offer analysis and create tools to assist individual states. For example, the NAIC could establish model discovery request in health insurance merger cases. Given the importance of the Anthem-Cigna and Aetna-Humana mergers as well as potential future health insurance mergers, there is critical role for the NAIC to play.

I thank the NAIC and Commissioner Sevigny for accepting this supplemental submission. We would be more than happy to answer any questions regarding these mergers or the health insurance merger review process.

[12] As was detailed in our white paper Appendix A, we offered a list of past matters in which an Insurance Commissioner had reviewed a health insurance mergers and required remedies prior to approval. Attached to this supplement is Appendix B. Appendix B expands upon this topic offering analysis from five separate Insurance Commissioner decisions.

[13] Naseem S. Miller, *Office of Insurance Regulation holding public hearings on proposed mergers of insurance giants*, ORLANDO SENTINEL (Dec. 1, 2015 11:35 AM), http://goo.gl/lFWZwD; Arkansas Insurance Department, Notice of Public Hearing (Nov. 6, 2015), http://goo.gl/PiFWcK.

How Might Proposed Payer Mergers Impact State Insurance Markets?

Douglas Hervey, David Muhlestein, and Austin Bordelon

December 1, 2015

With recent news of the proposed Aetna/Humana, Anthem/Cigna, and Centene/Health Net mergers, a number of stakeholders have raised questions about consolidation's impact on the competitiveness of health care markets. For these proposed deals, we estimated the degree of payer consolidation post-merger across the 50 states and the District of Columbia.

If the mergers are finalized, Georgia, Connecticut, and Colorado could potentially experience 40 percent or higher increases in commercial insurance concentration (Table 1). Kansas, Alaska, Iowa, and Ohio could experience 60 percent or higher increases in Medicare Advantage concentration (Table 3). The mergers are not expected to heavily affect Medicaid managed care markets. We also recognize and discuss below how concentrated markets may still experience healthy consumer-benefiting competition from established and new entrants.

Understanding payer concentration trends and potential future scenarios will inform policy and decision makers as they discuss the implications of consolidation and competition within the United States health care system.

The National Landscape

Several factors are driving the Aetna, Anthem, and Centene merger announcements. First, they appear to be diversifying their product mix to create synergies and mitigate risk by expanding their offerings across market segments and experimenting with new distribution channels in public and private exchanges.

Second, by achieving greater scale, they can potentially reduce administrative costs, strengthen their negotiating ability with local providers, and pursue value-based payment arrangements. Enhanced scale could potentially create opportunities for the payers to offer more competitive products and pass along savings to the consumers through their market pricing. Third, the mergers can further enhance their ability to engage with and market to consumers over the long run.

What does this mean for the broader health care community? If approved, these mergers may bring a noticeable shift in health insurer market concentrations. However, national trends do not tell the full story. Health care markets are not created equal, and payer consolidation and its pace of change differs market to market.

Measures Of Concentration

For this analysis, we measure market concentration using the Herfindahl-Hirschman Index (HHI). The HHI is a commonly accepted measure of market concentration. It is calculated by squaring the market share of each firm competing in a market, and then summing the resulting numbers. A market with a single firm (i.e., a monopoly) would have a HHI of 1, while a perfectly competitive market would have a HHI approaching zero. Markets with higher HHI values are more concentrated and may be less competitive. Markets in which the HHI is below 0.15 are generally considered unconcentrated, from 0.15 and 0.25 to be moderately concentrated and in excess of 0.25 to be highly concentrated.

Market concentration can be a useful indicator for determining a market's competitive dynamics. As noted above, market concentration findings do not perfectly reflect competitive dynamics, and are best used in conjunction with other evidence of competitive forces. For example, there may be cases when a larger market is concentrated among two or three payers, and the competitive dynamics are healthy.

Our data comes from statutory insurance data filings made to the National Association of Insurance Commissioners (NAIC) and provided by Mark Farrah Associates.

Payer Concentration

Figure 1 displays current commercial insurance concentration. Figure 2 illustrates the post-merger increase in HHI of commercial insurance concentration at the state level, with higher HHIs indicating more concentrated markets. Figure 3 shows payer market concentration increases post-merger across the states for commercial administrative-services only (ASO) plans. Commercial ASO group health self-insurance programs involve large employers that assume responsibility for the cost of their employees' health care, generally purchasing only administrative services from an insurer. Figures 4and 5 highlight increases in Medicare Advantage and Managed Medicaid concentration across states (See Note 1).

Impact On Commercial Market

Figure 1 below reveals that commercial payer markets are generally concentrated and relatively few payers are competing in many markets. Figure 2 highlights how Georgia, Connecticut, Colorado, Virginia, and New Hampshire are likely to experience the greatest increase in commercial insurance concentration. Each of these markets is poised to increase 30 percent or more in commercial insurance concentration due to the combined market footprint the mergers create. Each of those state markets currently has a HHI above .15.

Impact On ASO Market

As shown in Figure 3 below, Georgia, Florida, Connecticut, Colorado, and California are poised to increase the most in commercial ASO concentration post-mergers (Table 2). The Anthem/Cigna deal most affects the commercial ASO market changes highlighted below. Cigna is a major market force among employers, and a combined merger will strengthen Anthem's foothold within the growing ASO market. As a way to reduce employer costs and improve care quality, Anthem and Cigna are likely exploring synergistic ways to enhance wellness programs, form accountable-care networks, and engage in direct provider contracting. If the mergers successfully drive down costs as planned, Anthem's CEO has stated that some savings will accrue to consumers.

Impact On Medicare Advantage

As demonstrated in Figure 4 below, Medicare Advantage concentration is likely to increase significantly in select states if the Department of Justice (DOJ) approves the

mergers. Kansas, Alaska, Iowa, Ohio, and Missouri are all likely expected to experience 50 percent or higher growth in concentration post-merger.

The Aetna and Humana deal is largely driving the increased market concentration within Medicare Advantage. Humana's Medicare enrollment has grown substantially in recent years and totals 3.2 million. Aetna's current membership equals 1.26 million. Combined, the merged company would displace current market leader UnitedHealth as the program's market leader.

Aetna and Humana believe the deal will help them lower consumer prices by exacting price reductions from hospitals and doctors. Both companies argue that lower overhead costs enhance their ability to conform to the Affordable Care Act requirement (i.e., Medical Loss Ratio) that a higher percentage of premium revenue is spent on medical benefits rather than administrative costs. Furthermore, the payers believe they could invest more in benefit packages that enhance their Medicare star quality ratings. The central question is whether the mergers will reduce prices to consumers without materially harming competition and creating prohibitive barriers to entry in select locations.

Impact On Medicaid Managed Care

The Aetna, Anthem, and Centene mergers are not expected to heavily affect the Medicaid managed care markets in states across the country. Among the 50 states, Kentucky is likely to see the only double-digit (18 percent) increase in Medicaid managed care concentration.

That said, both Aetna's and Humana's CEOs have said the proposed deal will strengthen their Medicaid businesses. Aetna's and Humana's government business—Medicare, Medicaid, and Tricare—will be headquartered in Louisville and is projected to account for 56 percent of the combined companies' projected 2015 operating revenue of about $115 billion.

The Centene/Health Net acquisition will further enable Centene to position itself as a market leader within the Managed Medicaid market while it diversifies its core business across other product lines. For example, the Health Net acquisition should deliver about 1.7 million Medicaid members to Centene's portfolio and enable it to capitalize on future state Medicaid expansion. But the acquisition will have a negligible effect on Medicaid managed care concentration. As Table 4 shows below, Medicaid managed care markets are currently not nearly as concentrated as commercial and Medicare Advantage markets. Current competition within Medicaid managed care dilutes the merger's impact in most markets. Centene and Health Net primarily operate in different states as well.

Possible Outcomes Of Merger Reviews

The DOJ and Federal Trade Commission (FTC) will closely scrutinize these acquisitions because of their potential for wide-reaching impact. The outcomes of this exacting review are difficult to predict and there is little precedent for health insurance mergers or acquisitions of this magnitude. It is important to note that each proposed merger will be evaluated independently.

Regulatory agencies will seek to understand whether aggregated purchasing power and altered competitive dynamics are in violation of antitrust laws and harmful to consumers. In addition to review by federal agencies, state insurance commissioners and attorneys general will also review impacts of these acquisitions for their respective markets and have a chance to weigh-in on the final deal. Based on our analysis, we have identified several possible outcomes for the finalization of these acquisitions, including several issues that are likely to influence their ultimate configuration.

Upon completing their review, these regulators will have an opportunity to file suit (DOJ remedy) or issue a complaint (FTC remedy) on the combining organizations or their practices. It is possible that regulators would allow these deals to go forward, unencumbered, as proposed. This could be based on the idea that increased consolidation will actually benefit consumers due to the power of larger insurers to push down provider prices. However, such high-profile consolidations and significant revisions to local competition are likely to trigger some degree of regulatory action.

Another possible outcome is that the regulatory agencies block these acquisitions entirely. The FTC has been willing to intervene in several notable health care provider mergers and acquisitions (i.e., St Luke's and Saltzar Medical) over the past few years which could have reduced competition or resulted in concentrated market power.
A final possible outcome could be that the agencies allow the acquisitions to proceed but with conditions of divestiture in markets or lines of business where the merger is deemed to be anti-competitive or establish dominant market power. Several recent health insurance acquisitions have resulted in similar deals with the DOJ. For instance, Humana's acquisition of Arcadian Management Services Inc. was only approved after agreeing to divest Medicare Advantage plans in five states andWellPoint Inc.'s acquisition of Amerigroup Corp. addressed concerns by divesting Amerigroup's Managed Medicaid business in Virginia. We view this third outcome as the most likely. For this reason, a major priority of the regulators' analysis will be the consumer impact of insurance carrier market concentration, pre- and post-acquisition, across lines of business and geographic markets. Input from third parties who stand to be affected by

these mergers, such as states,employers, and health care providers, will also be indicative of areas for possible regulator involvement.

Implications Of Proposed Mergers

If we assume the mergers are approved in some form, we see several broad implications for the health care community arising from the proposed mergers.

One key consideration is whether payers will pressure providers to bear greater risk within value-based payment arrangements in an attempt to improve the delivery of care. The more beneficiaries a payer has, the more leverage it can have. Will larger payers use that leverage to simply garner price concessions from providers or will they use the leverage to encourage more value-based payment arrangements?

Payer consolidation could also spark further consolidation. For example, regional and local payers may also respond with competitive moves of their own. Providers may also counter with their own mergers and acquisitions in affected markets as they feel heightened urgency to preserve their negotiating strength and generate scale.

Another consideration is the effect mergers will have on the competitiveness of the health insurance exchange marketplaces. If post-merger scale creates operational efficiencies and the combined entities drop prices in select markets, it could affect other payers' ability to compete. For example, the mergers could compound market entry efforts for non-profit co-ops and for-profit new entrants such as Oscar and ZoomPlus in select markets. At the same time, the recent emergence and situational successes of these new entrants may indicate that markets are, in fact, more competitive than any market concentration data may otherwise indicate.

All of these factors will determine the effect this enhanced payer market power will have on the health care community: whether heightened market power benefits consumers by lowering product costs and increasing coverage value. Either way, the emergence of a "big three" will motivate policymakers to reevaluate industry oversight. As noted above, the merger discussions have already prompted a stewof antitrust issues.

While debate will continue regarding the degree to which competition among health care payers may affect the cost of services, a more basic question is whether competition will exist among markets. Recognizing that market concentration is just one type of competitive measurement yardstick, we find that most health care payer markets will be highly concentrated. Whether these proposed mergers occur, though, and how they may ultimately affect the end consumer, remain to be seen.

Figure 1

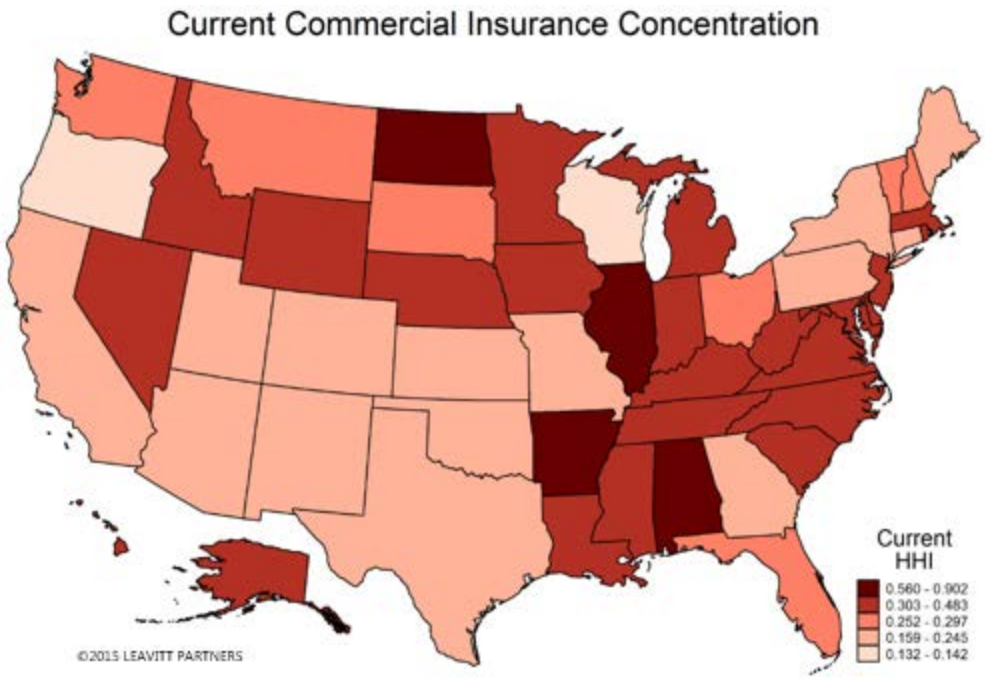

Figure 2

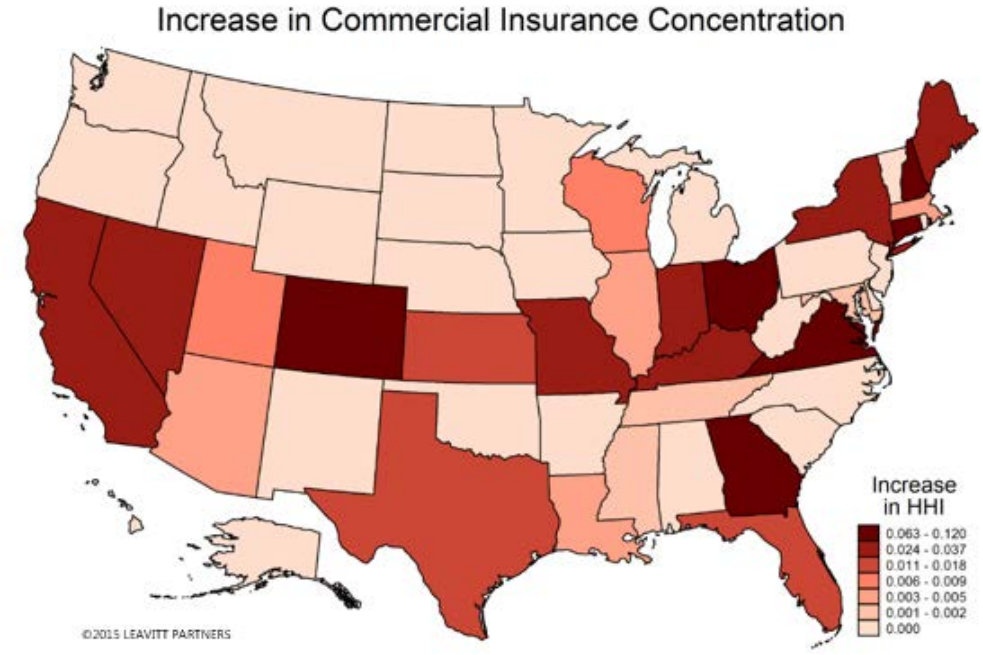

Figure 3

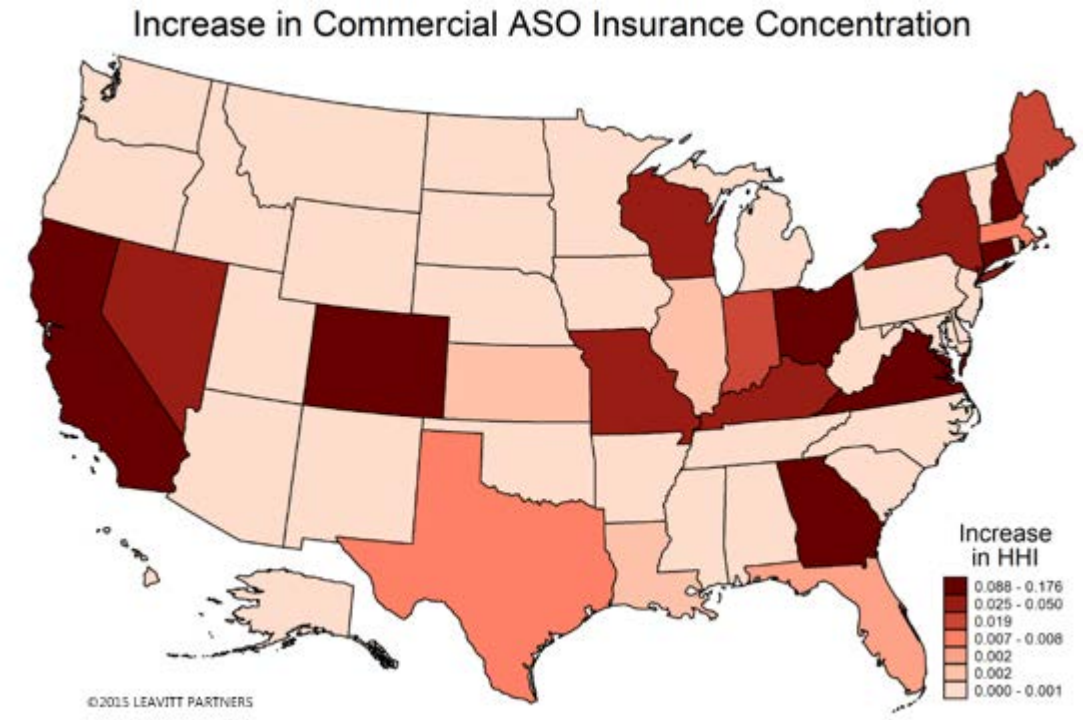

Figure 4

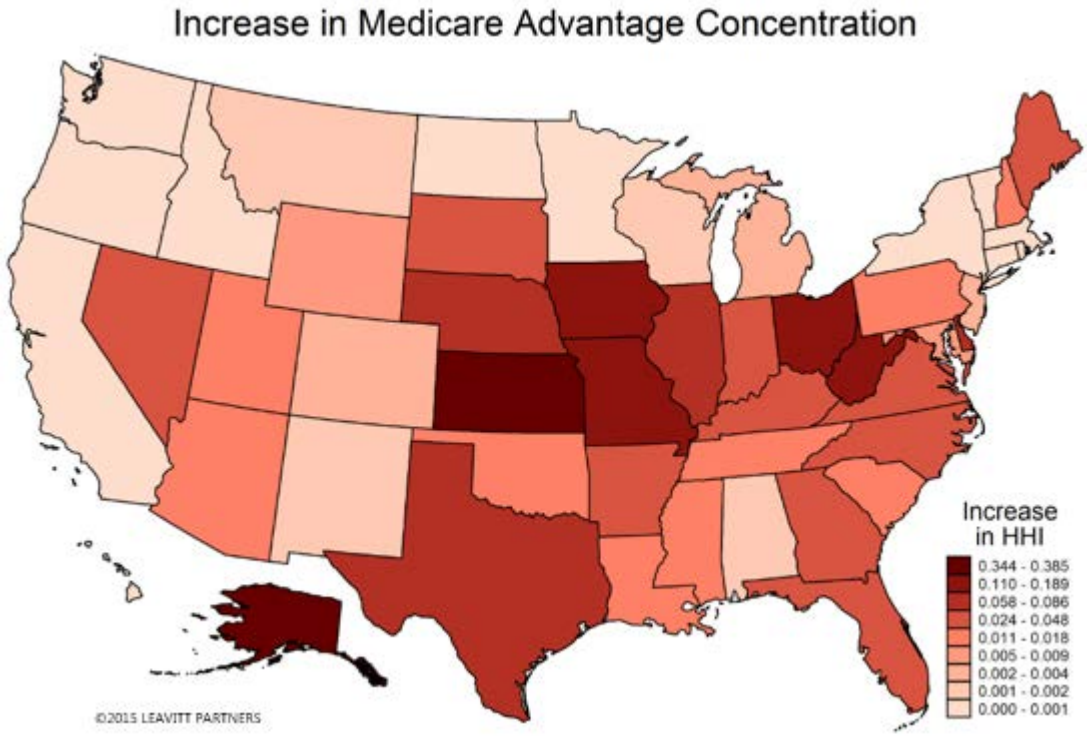

Figure 5

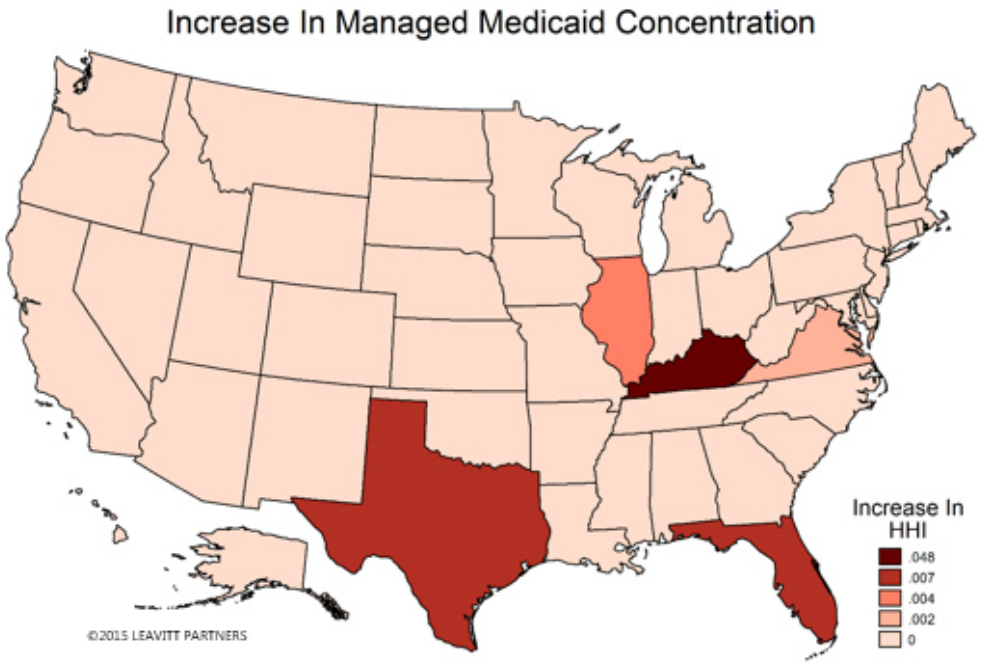

Table 1

Table 1: Increase in Commercial Insurance Concentration			
States with Largest Change	HHI Pre-Merger	HHI Post-Merger	Increase
Georgia	.22	.35	52%
Connecticut	.21	.31	44%
Colorado	.16	.23	42%
Virginia	.32	.43	34%
New Hampshire	.30	.39	30%

Table 2

Table 2: Increase in Commercial ASO Insurance Concentration			
States with Largest Change	HHI Pre-Merger	HHI Post-Merger	Increase
Georgia	.31	.46	48%
Florida	.37	.55	47%
Connecticut	.25	.36	47%
Colorado	.21	.29	43%
California	.28	.39	39%

Table 3

Table 3: Increase in Medicare Advantage Concentration			
States with Largest Change	HHI Pre-Merger	HHI Post-Merger	Increase
Kansas	.40	.78	98%
Alaska	.39	.73	89%
Iowa	.28	.47	68%
Ohio	.17	.28	64%
Missouri	.26	.39	53%

Table 4

Table 4: Increase in Managed Medicaid Concentration			
States with Largest Change	HHI Pre-Merger	HHI Post-Merger	Increase
Kentucky	.27	.32	18%
Texas	.11	.12	6%
Florida	.17	.18	4%
Illinois	.15	.15	3%
Virginia	.25	.25	1%

Note 1

Data in our analysis is based on each company's market share as of Q4 2014.

TAGS: CONCENTRATED MARKETS, INSURERS, MERGERS, STATES

Appendix B: Comparison of State Insurance Mergers

The following provides a detailed analysis of five separate Insurance Commission decisions. The table outlines different requirements the Insurance Commissioner had for the parties in order for them receive approval in the state and consummate the merger.

Requirement	**UnitedHealth-Sierra Health Insurance** **Nevada Insurance Commissioner 2008**	**Anthem- Blue Cross of California** **California Insurance Commissioner 2004**	**UnitedHealth-PacifiCare of Colorado** **Colorado Insurance Commissioner 2005**	**UnitedHealth-PacifiCare Life and Health of California** **California Insurance Commissioner 2005**	**UnitedHealth-PacifiCare of California** **California Insurance Commissioner 2005**
Continued Role in the market place	HPN must continue serving the same Nevada marketplace using the same market place approach (P. 26).[1]	BCC will continue its historic role in serving the California marketplace, and its same marketplace approach with regard to Medi-Cal Health Families Program, Access for Infants and Moths, and California Major Risk Medical	N/A	Practices and methodologies for indemnity/PPO, self-directed health plans, and Medicare Supplement products will not vary post-merger from PLHIC's pre-merger practices and	PCC will continue its historic role in serving the California marketplace, and will continue its same marketplace approach. (P. 12).

[1] Page numbers are those found in the Insurance Commissioner's decision in each matter.

		Insurance Program, individual and small group market. (P. 5-6).		methodologies. (P. 2).	
Compliance Reports	HPN must file an Annual Compliance Report, detailing compliance with the requirements set forth in the Commitment Letter (HPN must prove it has not changed practices and methodologies post acquisition). (P. 27).	For a period of 3 years following the merger closing, BCC shall file annual reports demonstrating compliance with the Undertaking and what it believes to be the benefits of the Merger. (P. 12).	United must file an annual report certifying, among other things, that no debt financing factors or merger costs have been included as part of any premium rates. (P. 1).	PLHIC shall file annually a report demonstrating compliance with each of the Undertakings. (P. 14).	PCC shall file a report annually with DMHC demonstrating compliance with the Undertakings. (P. 10).
Premium Stability	Premiums paid by HPN individual or small groups shall not increase (fee stability). (P. 29).	N/A	Merger costs will not be passed onto Colorado consumers in the form of higher premiums. (P. 1).	UnitedHealth and PLHIC undertake that premiums payable by PLHIC policyholders will not increase as a result of the Merger. (P. 1).	Represents and warrant that premiums payable by PCC enrollees will not increase as a result of Merger costs. (P. 6).
Underserved markets/small and individual markets	Must participate in the "Reinsurance Program" to attract and enable competition and product choice in the Nevada market. (P. 29-30). HPN must maintain its efforts to provide services to	N/A	N/A	PLHIC will maintain its current level of efforts in offering and renewing individual and small group medical products. (P. 8-9).	PCC will maintain support for commercial HMO product development with emphasis on products appealing to small groups and individuals (P. 15).

	underserved communities including Medicare and Medicaid markets, and to offer and renew individual and small group products. (P. 27).				
Claim platforms	Practices and methodologies with respect to adjudicating and paying commercial and Medicare claims after the acquisition shall not vary from pre-Acquisition practices. (P. 30-31	N/A	N/A	N/A	N/A
Medicare Business	Must offer substantially the same Medicare products and benefit designs during the Acquisition period. (P. 31).	N/A	N/A	N/A	N/a
Payments related to change in control	All payments relating to the change in control (severance payment, retention bonus payments) shall be the sole responsibility of Applicant. (P. 31).	All of the change in control severance payments and retention bonus payments payable by reason of the merger will be the sole payment responsibility of Anthem. (P. 1).	N/A	UnitedHealth has paid for all executive change in control severance payments and retention bonus payments by reason of the Merger, and is solely the	All of the executive compensation by reason of the Merger, including change in control payments... will be the sole responsibility of UnitedHealth. (P. 2).

				responsibility of United.	
Dividends/distributions	During the Acquisition Period, neither HPN nor PacifiCare of Nevada, shall declare or pay dividends, or similar distributions of cash or property in respect to its capital stock. (P. 32).	BCC will not declare or pay dividends, make other distributions of cash or property, or in any other way upstream any funds or property to Anthem or any of its affiliates. (P. 2).	N/A	PLHIC will not declare or pay dividends, make other distributions of cash or property, or in any other way upstream any funds or property to its corporate parents. (P. 6).	PCC will not declare or pay dividends, make other distributions of cash or property, or in any way upstream any funds or property to UnitedHealth. (P. 2).
Indebtedness or obligations	During the Acquisition period, HPN shall not co-sign or guarantee any loans, permit any portion of loans obtained by Applicant to be assumed by HPN, borrow any funds for purpose of making a Parent Company Distribution. (P. 33).	BCC will not take any of the following actions without the Department's prior approval: co-sign or assume any current or future loans entered into by Anthem or its Affiliates. (P. 4).	N/A	PLHIC will not take any of the following actions: co-sign or guarantee any portion of any current or future loans entered into by United or its affiliates, permit a portion of loans obtained by United to be assumed by PLHIC. (P. 7).	PCC will not take any of the following actions: co-sign or guarantee any portion of any current or future loans by United, or permit any portion of loans obtained by UnitedHealth or any of its affiliates to be assumed by PCC. (P. 5).
Health plan offering stability	During the Acquisition Period, HPN shall renew and not terminate any health benefit plan	BCC shall renew, and shall not terminate, any group or individual health	N/A	PLHIC will maintain its current level of efforts in offering	PCC will renew and note terminate any group or individual commercial health

	for any commercial insured and shall not terminate any health benefit plan before the end of its contract term. (P. 33-34).	care service plan contract prior to the expiration of its term unless otherwise permitted under the Knox-Keene Act. (P. 5, 11).		and renewing individual and small group Medical Products. (P. 8).	care benefit contract. (P. 11-12).
Retention of local operation	During the Acquisition Period, Applicant shall ensure that such affiliates maintain, at a minimum, the following organizational and administrative functions in Nevada for HPN's commercial	BCC will maintain its organization and administrative capacity, and will maintain a number of administrative processes, e.g., prior authorization, enrollee grievance, Independent Medical Review, provider dispute resolution. (P. 6-7).	United has no current plans to reduce any material respect or intention to change the executive and operational presence of PacifiCare in CO. for the foreseeable future. (P. 8).	N/A	PCC will maintain its organizational and administrative capacity, and unless the Department otherwise grants prior approval, this administrative capacity includes clinical decision-making and medical policy development, prior authorization, enrollee grievance system, independent medical review. (P. 8).
Local record retention	During the Acquisition period, all parties shall not remove, or require, permit, or cause the removal of HPN's books and records. (P. 34).	BCC agrees that it shall not remove, require the removal, permit, or cause the removal of BCC's books and records. (P. 7).	N/A	PLHIC agrees that it shall not remove, or require, permit, or cause the removal of PLHIC's books	PCC agrees that it shall not remove, require, permit, or cause the removal of PCC's books and records. (P. 9).

				and records. (P. 9).	
Administrative services agreements/reimbursement under ASAs	If HPN decides to materially amend, change, terminate, or replace any administrative service agreement(s) with any of the parties involved, HPN must file the changes with the Commissioner. (P. 34-35).	Any proposed change to the reimbursement rates or method for reimbursement under BCC's administrative services agreements with WellPoint, Anthem, or any of their affiliates is changed, BCC must obtain prior approval from DMHC. (P. 7).	N/A	If PLHIC decides to amend, change, terminate or replaces its administrative services agreement(s) with PacifiCare, CDI must approve. (P. 9).	If there are any changes to an administrative service agreement to which PCC is a part with any PCC affiliate, PCC will file notice of the changes, and must obtain prior approval from the DMHC. (P. 9).T
Tax sharing agreements	After the closing date, if HPN decides to amend, change, terminate, or replace any tax sharing agreements, HPN shall file tax-sharing agreements with the Commissioner. (P. 36).	If BCC decides to change its tax sharing agreements, as previously filed with, and approved by, the Department, BCC will file any changes to those tax-sharing agreements with the Department. (P. 7).	N/A	If PHLIC decides to amend, change, terminate or replace its tax sharing agreements, PHLIC will file any changes to those tax sharing and must have prior approval by CDI. (P. 9).	If PCC desires to amend, change, terminate or replace its tax sharing agreements, as previously filed, PCC can only do so upon prior DMHC approval. (P. 9-10).
Administrative medical expense ratio	Medical Expense Ratio assumptions for commercial rate filings (e.g. the schedule of	The percentage of BCC's administrative costs to premium revenue	N/A	PLHIC represents that it will maintain its "Administrative	PCC's administrative expense ratio shall not exceed 10%,

	changes) shall not change during the Acquisition Period from those used previously. (P. 30). HPN's administrative expense Ratio for its commercial products will not materially exceed HPN's average Administrative Expense Ration for commercial products for the years 2003 through 2006. (P. 35-36).	will not exceed 13.31% that reflects the average of the annual percentage that BCC's administrative costs bear to its premium revenues for the years 2001-2003. (P. 7).		Expense Ratio" for its products for the prior three years. (P. 9-10).	measured on an annual basis, which reflects the average of the annual percentage over the years 2002-2004. (P. 10).
Management continuity/executive agreements	Certain current executives with Sierra who join the combined business shall continue to be located in Nevada. (P. 36-37).	BCC and Anthem will promptly provide the Department with copies of the written agreements of the executive officers of WellPoint and BCC. (P. 12).	The present executive officers and directors of PacifiCare will not change as a result of the merger.	N/A	N/A
Retention of employees	Applicant shall maintain at least seventy-five percent (75%) of HPN's current number of employees in the State of Nevada during the Acquisition Period. (P. 37).	N/A	United has no current plans to reduce the number of PacifiCare employees, and compensation will equal what employees received prior to	N/A	N/A

			the merger or to what similarly-situated United employees receive. (P. 8).		
Distribution channels	Applicant and HPN each work extensively with agents, brokers, and other distribution channel in Nevada. (P. 37-38).	N/A	N/A	N/A	N/A
Social responsibility	Applicant is expected to maintain, and build on, its and Sierra's community presence, including charitable giving and philanthropic and community endeavors, in Nevada. (P. 38).	BCC and Anthem undertake to implement the investment in a Healthy California Program. (P. 10). The WellPoint Foundation has agreed to commit $5 million in each of three years (for a total of $15 million) to its Insuring Healthy Futures initiative. (P. 10).	United Healthcare has agreed to contribute $7.5 million to improve access to care to rural and underserved Coloradans	See next column	United will contribute $50 million to benefit California health care consumers (Charitable Commitment). (P. 18). UnitedHealth, PCC and their affiliates agree to invest $200 million in CA's health care infrastructure (Investment Commitment). (P. 15-16).
Laboratory protocol	During the Acquisition Period, Applicant shall not implement the $50 sanction laboratory protocol, or any similar	N/A	N/A	N/A	N/A

	monetary out-of-network laboratory referral sanctions. (P. 38-39).				
Assumption of regulatory costs	N/A	BCC undertakes to promptly pay for the costs arising from activities of the Department in connection with the Undertakings. (P. 12).	N/A	PLHIC will pay for the costs of all reviews the CDI determines are necessary to confirm compliance with the Undertakings. (P. 9).	PCC shall promptly pay for the costs arising from the activities of the Department in determining the PCC's compliance with the Undertakings. (P. 11).
Provider reimbursements	There is not to be a change in the structure, composition, and reimbursements payable to the health care providers supporting HPN's provision of products and services. (P. 27).	There is not to be a change in the structure, composition and reimbursement payable to the health care providers supporting BCC's provision of products. (P. 6).	N/A	N/A	In the event there are reductions in the level of provider reimbursements, such reductions shall not be attributable to Merger costs. (P. 6). PCC is also required to maintain currently capitated PCC contracts with willing and capable physician groups, subject to mutual agreements on contract terms,

					including upon renewal. (P. 13).
Quality initiatives	N/A	BCC undertakes to implement the Patient Advocacy Improvement Program (PAI Program)... a comprehensive effort by BCC to bring demonstrable improvements to the quality of care delivered to BCC members. (P. 15).	N/A	See next column	United agrees to implement and/or maintain certain quality programs or reporting mechanisms, e.g., reporting quality of care results, improving PacifiCare's performance on all CCHRI scores. United will structure the PacifiCare P4P program so that eligible programs will receive an additional $13.76 million, and will promote HIT infrastructure. (P. 13).
Benefit design/premium calculation	HPN's practices and methodologies for determining commercial products and benefit designs and premiums cannot vary materially from pre-Acquisition status. (P. 28).	N/A	N/A	PHLIC's methodologies for determining premium rates and benefit designs must remain unchanged. (P. 2).	PCC's practices and methodologies for determining products and benefit designs and premium prices must remain unchanged. (P. 6).

Duration	2 years	Until terminated by agreement of BCC, Anthem, and the DMHC. (P. 13).	3 years	4 years	4 years
Specific physician-protection provisions	N/A	N/A	United and PacifiCare will convene a Colorado Physician Advisory Council which will meet regularly to discuss physician concerns. (P. 2). United and PacifiCare will appoint an ombudsman for the Colorado Medical Society to address physician concerns. (P. 2). For the duration of the Undertakings, United and PacifiCare must comply with specific physician-service metrics, e.g., deadlines within which to resolve physician complaints,	PLHIC shall maintain compliance with specific metrics, and shall report quarterly its performance against metrics relating to complaint resolution, appeals resolution, claims processing within 30 days, and auto-adjudication (P. 14-15).	N/A

			limitation on time periods within which to recoup overpayments. (P. 2-3).		