Consumers Union
Nonprofit Publisher of Consumer Reports

May 6, 2011

Edward G. Heidig
Interim Director
Department of Managed Health Care
980 Ninth Street
Sacramento, CA 95814

Re: **Blue Shield of California Rate Increase, Effective January 1, 2011**

Dear Mr. Heidig:

Consumers Union, nonprofit publisher of *Consumer Reports*, provides these comments to the Department of Managed Health Care (DMHC) regarding Blue Shield of California's ("Blue Shield") latest health plan rate increase. On April, 4, 2011, Blue Shield filed a report from Axene Health Partners, dated March 22, 2011, in support of Blue Shield's average increase of 17.6%, effective January 1, 2011, for 10 DMHC plans. According to the Axene report, this increase comes on top of Blue Shield's last increase averaging 25%.[1] The cumulative impact of these increases during the past 18 months is an average of 37.5%, according to DMHC.

The Axene report and the plain language description submitted with the report fail to show that the January 1 rate hike is reasonable. This increase will affect 70,833 Blue Shield members who have already endured a prior round of average increases up to 28.2%. Blue Shield is a financially strong, non-profit with a mission "to ensure all Californians have access to high-quality health care at an affordable price."[2] This mission and its nonprofit status obligate Blue Shield to fully justify these continuing double-digit rate hikes and to make its products as affordable as possible, especially for individual market customers who purchase coverage on their own.

The sparse documentation submitted to support this increase shows that Blue Shield has used numerous assumptions to calculate the increase that have not been backed up by data. Blue Shield has aggressively (no doubt conservatively, in its view) projected claims and expenses for the rating period, and has built in unnecessary profit margins. Moreover, the company's financial strength, when weighed against the hardship of this increase on consumers, dictates that the increase is per se unreasonable.

[1] Axene Health Partners, Review of 2011 Blue Shield of California DMHC Individual Rate Filing, p. 3, Revenue box. The report shall be referred to throughout this letter as the "Axene report."
[2] Blue Shield Mission and Values Statement at https://www.blueshieldca.com/bsc/aboutbsc/mission-values/index.jhtml.

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I. Blue Shield has submitted insufficient documentation to justify the rate increase

It is our understanding that the Axene report, the plain-language summary, and the tables showing monthly premiums, constitute Blue Shield's entire submission to justify the rate increase, at least as of April 26 when CU last requested all documents filed in support of the increase. The Axene report states that Axene actuaries reviewed Blue Shield's "2011 California DMHC Individual Rate Filing," but that rate filing has apparently not been given to DMHC and has not been posted on the DMHC website.

Axene also states that it "accessed a significant number of materials provided directly to us by BSC."[3] The report further states that Axene "assumed that the responses provided by BSC are complete and accurate."[4] DMHC should not work from these same assumptions, but should conduct its own review of the underlying rate filing and the other materials provided by Blue Shield to Axene. This rate increase poses too much of a hardship on thousands of consumers for DMHC to rely only on Axene's cursory report as justification.

II. Blue Shield has provided no support for its high trend assumptions and multiple adjustments used to develop the rate increase

The assumptions used to calculate this increase are wholly unsupported. Based on the limited information available in the Axene report, Blue Shield has used an experience period of April 2009 to March 2010, in which claims averaged $258.25 per member per month for all plans in total. Blue Shield then projects that claims for all of 2010 (including the 9 months beyond the experience period) will increase by 11.7% to $288.41. No claims data or other information is provided to support that projection. Blue Shield then assumes that claims will jump another 17.6% from $288.41 to $339.23 in 2011, for a total trend of 31.4% from the baseline claims. Again, the company provides no data to explain why claims will increase so dramatically from the experience period to 2011, nor from 2010 to 2011.

In addition to these extremely high claims projections, Blue Shield adds multiple "adjustments," including 4% for duration and 12.4% for selection, to bring the projected claims costs PMPM to $396.03. This results in a **53% increase** in claims from the baseline period to 2011 Blue Shield must explain why it projects that its costs will increase in the January-December 2011 rating period by 53% from the April 2009-March 2010 period. We know that medical costs are rising. But we have seen no data anywhere, from any source, indicating that they are rising at a rate of 53% in about one year's time.

We urge you to examine, and publicly disclose, a rolling claims history for at least the past five years for these plans so that DMHC and the public can assess whether Blue Shield's costs are indeed rising at such a rapid rate. This information is crucial to a determination of the actuarial soundness and reasonableness of the increase, and a "comparison of claims cost and rate of changes over time" is required under SB 1163.

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[3] Axene report, p. 1.
[4] Id.

Moreover, adding adjustments for deductible leveraging (which was apparently incorporated in the claims trend), duration, selection, demographics, and undefined "manual adjustments" creates a real danger that Blue Shield is inflating cost projections in calculating this increase. Adding such adjustments may be "double-counting" because the historical claims trends will already reflect the impact of these factors. Blue Shield must justify these adjustments and should bear the burden of proving that the underlying trend was calculated from historical trend data by first removing all trends associated with the impact of leveraging, duration, selection, and demographics. In addition, some of these adjustments, such as selection and demographics, could encompass the same impact. The selection factor used is the highest selection factor we have ever seen a carrier use, and we note that some states would not allow these adjustments at all.

Finally, the "Provision for Adverse Deviation" (PFAD) is unnecessary and unfair in light of the hardship this increase will impose. Ostensibly, Blue Shield has added the 1% PFAD adjustment to protect it in case actual claims are higher than anticipated claims. But Blue Shield has ample surplus to address any "adverse deviation." This adjustment is just a hidden profit margin.

DMHC should require Blue Shield to submit and release the past profit margins on these plans and its individual market as a whole. In addition, Blue Shield should show whether using these high assumptions and adjustments in the past had resulted in accurate predictions of costs. The dearth of back-up information for these trend assumptions and multiple adjustments alone should lead to a presumption that the request is "unreasonable."

III. The administrative expense and margin load is too high on some plans

According to the Axene report, Blue Shield builds in an administrative expense and margin load that ranges from 15.4% to 27.6% across the plans, with a composite load of 19%. This may bring Blue Shield within the federal 80% loss ratio requirement, but that does not mean the load is reasonable. Blue Shield should explain why some plans are getting the benefit of more efficient administration and others have very high expenses. Meeting the federal loss ratio minimum for the individual market segment is not conclusive of reasonableness, especially if some plans have much higher expense loads than others.

IV. Blue Shield's financial strength weighs against a finding of reasonableness

There is no reason why Blue Shield, a non-profit plan, should seek a profit margin of 3% from its most vulnerable customers. Such a profit margin may be reasonable according to Axene, but it is not in light of the hardship this increase poses on Blue Shield customers. Even more so, we see no reason why such a large increase is necessary given Blue Shield's financial strength. Blue Shield, for example, reported consolidated surplus of almost $3.5 billion at the end of 2010 and made net income of more than $314 million in 2010. DMHC should take these factors into consideration when evaluating the increase.

V. Blue Shield should be required to explain the drop in enrollment in its DMHC plans

The Axene report shows that Blue Shield's membership in these plans is projected to continue to drop from about 105,678 members between April 2009 and March 2010 to 53,473 members between January 2011 and December 2011.[5] During the same periods, enrollment in the plans filed with the California Department of Insurance (CDI) is projected to increase. Thus, this rate increase may push more than 17,300 people off Blue Shield's rolls and possibly into California's already-too-large uninsured population.[6] Blue Shield must be called upon to explain this drop in enrollment and whether these members are shifting to other plans (under CDI) with higher cost-sharing and skimpier benefits.

For the reasons stated above, and on behalf of tens of thousands of Californians who are struggling to afford these spiraling monthly premiums, we urge DMHC to insist that Blue Shield provide all back-up documentation for the Axene actuarial report and we urge that DMHC conduct a thorough review to determine whether this latest Blue Shield increase is unreasonable.

Sincerely,

Sondra Roberto
Staff Attorney
Consumers Union

cc: Janice Rocco, CDI

[5] See Table 1, Rate Development Process, Member Months, Axene report, p. 3.
[6] According to DMHC, 70,833 members are affected by the increase, and Blue Shield projects that enrollment will drop to 53,473, a loss of more than 17,300 people.