POLICY & ACTION FROM CONSUMER REPORTS

September 1, 2015

Via email to: Wayne.Thomas@dmhc.ca.go

Contract Manager
Division of Premium Rate Review
Department of Managed Health Care
980 9th Street, Suite 500
Sacramento, CA 95814-2725

Re: Consumers Union's comments on Blue Cross of California (dba Anthem Blue Cross) Rate Filing, SERFF Tracking Number AWLP-130080574

Dear Contract Manager:

Consumers Union, the policy and advocacy division of Consumer Reports, writes to provide you with comments on Blue Cross of California (dba Anthem Blue Cross) Rate Filing, SERFF tracking Number AWLP-130080574.

In addition to the review enclosed in the attached memorandum by our consulting actuary, Allan I. Schwartz, Consumers Union draws DMHC's attention to the following when deciding whether this rate request is unreasonable:

I. Anthem Blue Cross's filing includes numerous factors that were not adequately supported to justify its claims that costs will increase in 2015.
II. Anthem Blue Cross intends to significantly increase administrative expenses and raise the dollar value for profits while dramatically cutting quality improvement expenses.

I. Anthem Blue Cross's filing includes numerous factors that were not adequately supported to justify its claims that costs will increase in 2015.

Anthem Blue Cross uses exaggerated medical and pharmaceutical trends.

Since the enactment of the Affordable Care Act (ACA), medical costs have grown at a slower rate than in the prior decade. Experts estimate that, despite a slight uptick predicted in 2016, the general slowing of medical cost increases will continue. In contrast to Anthem Blue Cross's projected medical trend of 6.45%, a recent *Health Affairs* article projected national health expenditure projection of 5.3%.[1] This downward pressure is attributed to: increased cost-sharing for patients; a shift away from traditional

[1] Sean P. Keehan, Gigi A Cuckler, Andrea M. Sisko, Andrew J. Madison, Sheila D. Smith, Devin A. Stone, John A. Poisal, Christian J. Wolfe and Joseph M. Lizonitz National Health Expenditure Projections, 2014-24: Spending Growth Faster than Recent Trends, *Health Affairs,* no. 8 (2015) at 1407.

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institutional care to telehealth, retail clinics, and community-based care; and new payment methodologies. Yet Anthem Blue Cross's actuarial memorandum fails to reflect increased value for providers or consumers.

Experts agree that the 2016 risk pool will be healthier than in previous years because the least healthy consumers, who most need health insurance and are the most costly to insure, already enrolled in 2014 and 2015. For example, a New England Journal of Medicine analysis of the Massachusetts enrollment experience reviewed enrollees' age, diagnosis of chronic illness and monthly health spending to determine the impact of the individual mandate. The researchers found that the early enrollees were four years older, 50% more likely to be chronically ill and had 45% higher health care costs than those who joined later.[2] Similar findings about the improved risk in the individual marketplace are outlined in research published by the Society of Actuaries.[3] Consumers Union believes that California will likewise experience an improvement in the individual market in 2016 as healthier and younger Californians enroll into coverage.

The most notably skewed component of Anthem Blue Cross's medical trend is its pharmaceutical trend, which is projected at 17.8% for the 2016 plan year, comprised of a projected 9.4% increase in use and 7.6% increase in cost.[4] Express Scripts recently reported that Exchange plan costs were 36% lower per member per month in the first quarter of 2015 than they were in the first quarter of 2014.[5] Express Scripts also found that the number of new Exchange plan enrollees who used at least one prescription drug in 2015 declined by 18% compared to Q1 2014; that new Exchange enrollees in Q1 2015 had 34% fewer adjusted specialty pharmacy claims than did enrollees in Q1 2014; and that new enrollees in 2015 were four years younger than were 2014 enrollees.[6] None of these cost reductions are reflected in Anthem Blue Cross's actuarial memorandum. Furthermore, we note that the cost of such specialty drugs as Sovaldi were factored into rates that were finalized for 2015. The fact that the pharmaceutical trend Anthem Blue Cross uses is far in excess of that of its market competitors[7]–and that Anthem projects a steep increase in pharmaceutical use in stark contrast with competitors–makes its projection especially suspect.

Given how far Anthem Blue Cross diverges from numerous independent resources and its market competitors, we strongly urge DMHC to closely review the carrier's medical and pharmaceutical trend.

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[2] The Importance of the Individual Mandate – Evidence from Massachusetts, http://www.nejm.org/doi/pdf/10.1056/NEJMp1013067.

[3] Society of Actuaries report Cost of the Future Newly Insured Under the Affordable Care Act, March 2013, available at http://cdn-files.soa.org/web/research-cost-aca-report.pdf.

[4] Anthem Blue Cross California Rate Filing Form at p.7.

[5] Express Scripts Press Release: Express Scripts Provides First Look at 2015 Public Exchange Pharmacy Trends, 7 July 2015.

[6] *Id.*

[7] For the 2016 plan year, other carriers' pharmaceutical trend projections are as follow. Blue Shield of California: 11.2% (0.7% use, 10.5% cost), Kaiser: 9.1% (1.0% use 8.1% cost), Health Net: 10.0% (0% utilization, 10% cost).

Anthem Blue Cross fails to account for cost savings due to the decrease in uncompensated care in the market.

As the number of insured Californians rises, the number of medical services likely to go unpaid by patients without insurance or who cannot afford to pay their portion of the cost is expected to decrease. As in prior years, Anthem Blue Cross does not account for this shift in their 2016 rates.

The Kaiser Family Foundation recently reported, "After two rounds of open enrollment under the Affordable Care Act, 68 percent of Californians who were uninsured prior to the first open enrollment period now report that they have health insurance … This share is up from 58 percent after the first open enrollment period in the spring of 2014."[8] This translates to approximately 4.2 million previously uninsured adult Californians now with coverage.[9] Overall, the rate of uninsurance was reduced by approximately two-thirds in the first two enrollment periods.[10] As in 2015, it continues to be likely that as more Californians gain and retain insurance, fewer will require charity care. In turn, the reduction in charity care obligations on the hospital should reduce the cost of insurance as the need to shift the cost of caring for the uninsured onto the insured diminishes. It is reasonable to predict that some health care providers will accept lower fees because of the reduction in bad debt.

Thirty-four percent of previously uninsured Californians are now covered by Medi-Cal, up from 25 percent in 2015.[11] According to a report by Fitch ratings, "Relative to the early muted influence of insurance expansion on volume growth, expansion of state Medicaid programs had an immediate and dramatic influence on payor mix. In expansion states, hospitals are experiencing strong growth in Medicaid patient volumes and a drop in uninsured patient volumes. Based on only one-quarter of experience under insurance expansion, it is difficult to determine the longer term effect of the payor mix shift, but these early results show the industry could experience a meaningful and durable reduction in the financial headwind created by uncompensated care."[12] Additional recent literature echoes the Fitch report in 2015, stating "Hospitals [in states that expanded Medicaid] reported a more significant drop in unpaid bills and more patients with Medicaid."[13]

When questioned about its failure to account for reduction of uncompensated care as a factor in its rates for the 2015 plan year,[14] Anthem Blue Cross assumed that the reduction in uncompensated care would be due to Medicaid expansion; it completely disregards the uninsured and underinsured population that would gain insurance through the public and private marketplaces. Based on that assumption, Anthem Blue Cross claimed there would actually be cost shifting borne by private insurance

[8] Bianca DiJulio et. al., *California's Previously Uninsured After the ACA's Second Open Enrollment*, Kaiser Family Foundation website available at http://kff.org/health-reform/report/californias-previously-uninsured-after-the-acas-second-open-enrollment-period/ (accessed August 12, 2015).

[9] *Id.*

[10] *Id.*

[11] *Id.*

[12] Fitch Ratings, *For-Profit Hospitals Potentially Benefit from Early ACA*, 30 June 2014, available at https://www.fitchratings.com/gws/en/fitchwire/fitchwirearRMHMSle/For-Profit-Hospitals-Potentially?pr_id=837194.

[13] Modern Healthcare, 22 December 2014, at 4.

[14] Letter to Anthem Blue Cross from L & E Actuaries & Consultants at p.2, 24 September 2014, available in the *PDF Pipeline for SERFF Tracking Number* AWLP-129656693, generated 6 October 2014.

consumers due to Medicaid underpayment.[15] To support this argument, they cite a 2011 study out of Ohio.[16] Even though Medi-Cal reimburses at a lower rate than private insurance, clearly, any reimbursement is more than care that is uncompensated altogether.

Anthem Blue Cross fails to adequately adjust its morbidity factor to back-out pent-up demand.

In its rate filing justification, Anthem Blue Cross states:

> As previously uninsured individuals obtained insurance in 2014, Anthem Blue Cross expected them to have some pent-up demand for health care services in year one. This pent-up demand impact is captured in our 2014 experience and Anthem Blue Cross does not expect this additional utilization to continue in 2016. Therefore, an adjustment has been made to back-out the additional utilization in 2014 that was attributed to pent-up demand.[17]

As Anthem Blue Cross itself acknowledges, the pent-up demand of new entrants in the 2014 market will be depleted in the 2016 plan year. The absence of pent-up demand should cause a sizeable adjustment to the carrier's morbidity calculation. This rate filing fails to quantify the extent to which the carrier's morbidity factor was adjusted to acknowledge the elimination of pent-up demand. The fact that the morbidity change value is 0.9939[18]—or a 0.61% reduction—means the adjustment for pent-up demand could only have a very minor downward effect on proposed rates if any at all. We therefore urge DMHC to demand additional detail from the carrier on the extent to which pent-up demand was backed-out of proposed rates for 2016 and how that adjustment factored into the morbidity change variable altogether.

Anthem Blue Cross relies on a potentially flawed consultant report to project market adjusted index rate for 2016.

Anthem Blue Cross's stated goal is "to price to the average risk of the 2016 ACA market."[19] To do so, it relied on demographic and risk information in a report produced by Wakely Consulting.[20] Incidentally, all four major California carriers, (Anthem Blue Cross, Blue Shield of California, Kaiser, and Health Net), used an external consulting firm's report when calculating for risk adjustment. We believe they used the same report produced by Wakely Consulting.

Notably, although Health Net based its risk adjustment and reinsurance information on the Wakely study, the carrier voluntarily decreased its projection after gaining access to Covered California's EDGE Server data.[21] Using the EDGE Server data, Health Net reduced its proposed rates by 3.2%.[22] This

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[15] *09-24-2014 CommentLetterResponse*, worksheet "Q2", posted on the Anthem Blue Cross Premium Rate Review Filing webpage maintained by DMHC, available at http://wpso.dmhc.ca.gov/ratereview/Detail.aspx?lrh=oS8THuk9968%24 (accessed August 25, 2015).

[16] *Id.*

[17] Anthem Blue Cross Actuarial Memorandum at p.42.

[18] Anthem Blue Cross Actuarial Memorandum Exhibit A.

[19] *Id*.

[20] Anthem Blue Cross Actuarial Memorandum at p.42.

[21] Health Net Actuarial Memorandum at p.2.

[22] *Id.*

adjustment clearly indicates, at the least, varying opinions about the reliability of the Wakely report to the California market. The Wakely study is confidential, making it impossible to evaluate its accuracy. However, based on statements made during an earnings call, it is apparent Anthem also had misgivings, stating "We had concerns, though, regarding the Wakely data, because we knew a number of competitors had not reported their data."[23]

Without information to the contrary, there is reason to question and probe the methodology and procedures on which Anthem Blue Cross based its projections for the 2016 ACA market, as Health Net's recent adjustment would suggest. We therefore urge DMHC to require that Anthem Blue Cross justify the risk adjustment and reinsurance numbers it included in this rate filing justification, or to make appropriate adjustments in the vein of Health Net. At the least, DMHC should have access to the report so their actuaries can evaluate the accuracy of the information. We also urge DMHC to simulate risk adjustment using the EDGE Server data and to recommend that each of the carriers adjust their risk adjustment projections where appropriate.

Anthem Blue Cross fails to adequately justify the regional rating factors used for 2016 rates

Anthem Blue Cross clearly details the area rating factors used to set rates for 2016 alongside the area rating factors it used for 2015.[24] However, it fails to justify the rating factors at all—except to say they reflect "both recent experience and any changes to the 2016 provider network"[25]. It also neglects to explain the steep discrepancy between rating factor increases in Northern California versus Southern California.[26] This discrepancy is shown in Table 1, attached. Although we understand that greater provider consolidation in Northern California explains underlying rate differences between the northern and southern parts of the state, already reflected in rates, here we raise the question of why the percentage of increases for 2016 is so disparate. This pattern—of rate *increases* being steeper in the northern rating regions compared to the southern rating regions—holds true for the Anthem products. Adequately justifying proposed rate increases does not stop at unsubstantiated statements about anticipated expenses. We urge DMHC to investigate the extent to which provider consolidation is impacting these regions.

Although the accuracy of medical trend projections rests on actuarial finesse, changes in contractual agreements with providers are specific, known elements. At least to the extent that contractual provider payments are concerned, Anthem Blue Cross knows the cost component of its provider expenses in 2016. Since the carrier has access to this highly-relevant data, so too should its regulator charged with evaluating the reasonableness of rate requests built on this data. Even with confidentially to shield its provider contracts from public review, DMHC should have access in order to verify the justifications used by Anthem.

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[23] Anthem Inc. Earnings Call, July 29, 2015, Edited Transcript – page 12; http://ir.antheminc.com/phoenix.zhtml?c=130104&p=irol-calendar

[24] Exhibit K of the [24] Anthem Blue Cross Actuarial Memorandum.

[25] Anthem Blue Cross Actuarial Memorandum at p.39.

[26] There are two outlier regions: in northern California, the rating factor for Region 4 (San Francisco) will decrease by 7.4%, and in southern California, the rating factor for Region 17 (Riverside, etc.) will increase by 6.2%.

II. Anthem Blue Cross intends to increase administrative expenses and raise profits while cutting quality improvement expenses.

A comparison of the non-benefit expenses and margin for profit and contingencies proposed for 2016 compared to 2015 paints a troubling picture: that of a corporation intending to increase its spending on itself while decreasing spending on quality improvement for consumers. The comparison is shown in the table below.

Non-Benefit Expenses and Margin for Profit & Contingencies in 2015 Versus 2016			
	Proposed for 2015 Plan Year	Proposed for 2016 Plan Year	Difference in planned expenses
Administrative Costs	$24.52	$31.19	27%
Margin for profit and contingencies	$7.65	$8.35	9%
Quality Improvement Expense	$4.34	$3.20	**-26%**

Anthem Blue Cross's proposed substantial increase in administrative expense is unjustified.

As shown in the table above, Anthem Blue Cross intends to increase its administrative expenses by 27% in 2016 over its proposal for 2015. Rather than explaining *why* the administrative costs will expand exponentially, the carrier simply defines what an administrative cost is: "both acquisition costs associated with the production of new business through non-broker distribution channels (direct, telesales) as well as maintenance costs associated with ongoing costs for the administration of the business."[27] Far from an adequate justification, this explanation raises questions. Primary among them—given Anthem Blue Cross's dominant market position and the fact that the ACA individual mandate combined with Covered California's efforts to increase enrollment provides much of the marketing for each of the carriers on the Marketplace—why does Anthem need to substantially increase its expenditures to get and maintain business in 2016?

Anthem Blue Cross's proposed rate increases will boost its already robust earnings.

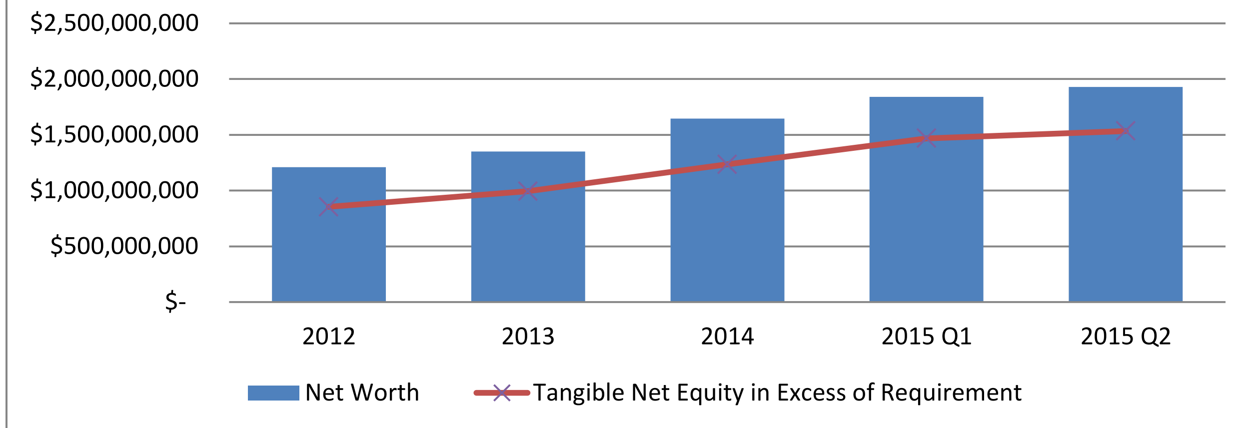
The financial reports that Anthem Blue Cross submits to DMHC show that the carrier has enjoyed profitable returns in the dawn of the ACA.[28] As shown in the table below, Anthem's net worth has grown well into the second quarter of 2015, as has its tangible net equity in excess of that which is required by DMHC.[29] In the second quarter of 2015, Anthem Blue Cross held $1,534,476,000 tangible net equity *in excess* of that which is required by DMHC. Maintaining its current margin for profit and contingencies as a percent of premium results in a larger number of actual dollars going towards profits and contingencies, since the size of its own "pie" is also increased. This is particularly trouble with tangible net equity at 492% of what is required by DMHC.[30]

[27] Anthem Blue Cross Actuarial Memorandum at 45.

[28] Available via DMHC's *HMO/Health Plan's Financial Statement Search* website, available at http://wpso.dmhc.ca.gov/fe/search/#top.

[29] As required in the Knox-Keene Health Care Service Plan Act of 1975, as amended, §1374.64, referring to the *Plan Tangible Net Equity Requirement* in 28 CCR §1300.76.

[30] 4.92 = $1.925 billion (tangible net equity) / $391 million (required tangible net equity).



Anthem Blue Cross's explanation for its proposed increase in profits is limited to the statement that "margins for contingencies are necessary to cover the uncertainties in pricing assumptions."[31] However, the margin for contingencies is not intended to offset shortcomings in pricing assumptions, it is meant to protect against the risk of unforeseen contingencies. Price setting is not an unforeseen contingency it is an actuarial exercise. Furthermore, the federal "3 R" programs are designed to address uncertainties in the initial years of the ACA and, for the most part, these programs have served the purpose for which they were designed. We therefore strongly urge DMHC to inquire of Anthem Blue Cross how this factor of the proposed rate increase is anything other than an attempt to increase profits for this for-profit carrier and its shareholders at the expense of its consumer base.

<u>The projected quality improvement expenditures leave questions about how this expense is calculated and how it will benefit policyholders.</u>

By state law, health insurance carriers must detail "significant new health care cost containment and quality improvement efforts and provide an estimate of potential savings together with an estimated cost or savings for the projection period."[32] In its filing, Anthem Blue Cross projects a decrease in per member per month (PMPM) expenditure for activities that improve health care quality and expenditures related to health information technology from $4.34 in 2015 to $3.20 in 2016.[33, 34] The information provided on quality improvement expenses is very limited:

> The QI Expense assumptions are based on historical amounts related to the following initiatives: Improve Health Outcomes, Activities to Prevent Hospital Readmissions, Improve Patient Safety

[31] Anthem Blue Cross Actuarial Memorandum at 36.

[32] Health and Safety Code Section 1385.03(c)(3).

[33] Anthem Blue Cross Actuarial Memorandum for 2015 Plan Year, Exhibit G.

[34] *Id.*

and Reduce Medical Errors, Wellness and Health Promotion Activities, HIT Expenses for Health Care Quality Improvements, and ICD-10.[35]

Certainly, this description includes valid quality improvement initiatives. Reductions in hospital admissions, improved patient safety, and the like are worthy goals.[36] The problem here is that without details about the initiatives and the related costs, it is difficult to see this report as anything other than a laundry list of quality improvement catch-phrases.

Given that consumers have filed complaints against Anthem Blue Cross with DMHC and the department's finding of multiple deficiencies in a Non-Routine Survey of the carrier's online provider directory,[37] fixing inaccurate provider directories, quality improvement, and consumer cost containment should be a priority for the carrier. The fact that quality improvement expenditures are projected to decrease while administrative expenses and profits increase makes this proposed reduction in spending all the more questionable. Consumers Union therefore urges DMHC to require that Anthem Blue Cross satisfy its obligation to better detail its quality improvement and cost containment initiatives and projected savings. For the carrier to do otherwise would be unreasonable.

Conclusion

We strongly encourage DMHC to demand additional information that fully justifies Anthem Blue Cross's rate request. If Anthem Blue Cross is unable to do so, given the financial burden of escalating costs on California families and in light of Anthem Blue Cross's continuously strong profits, Consumers Union urges DMHC to find the requested rates unreasonable and not justified.

Sincerely,

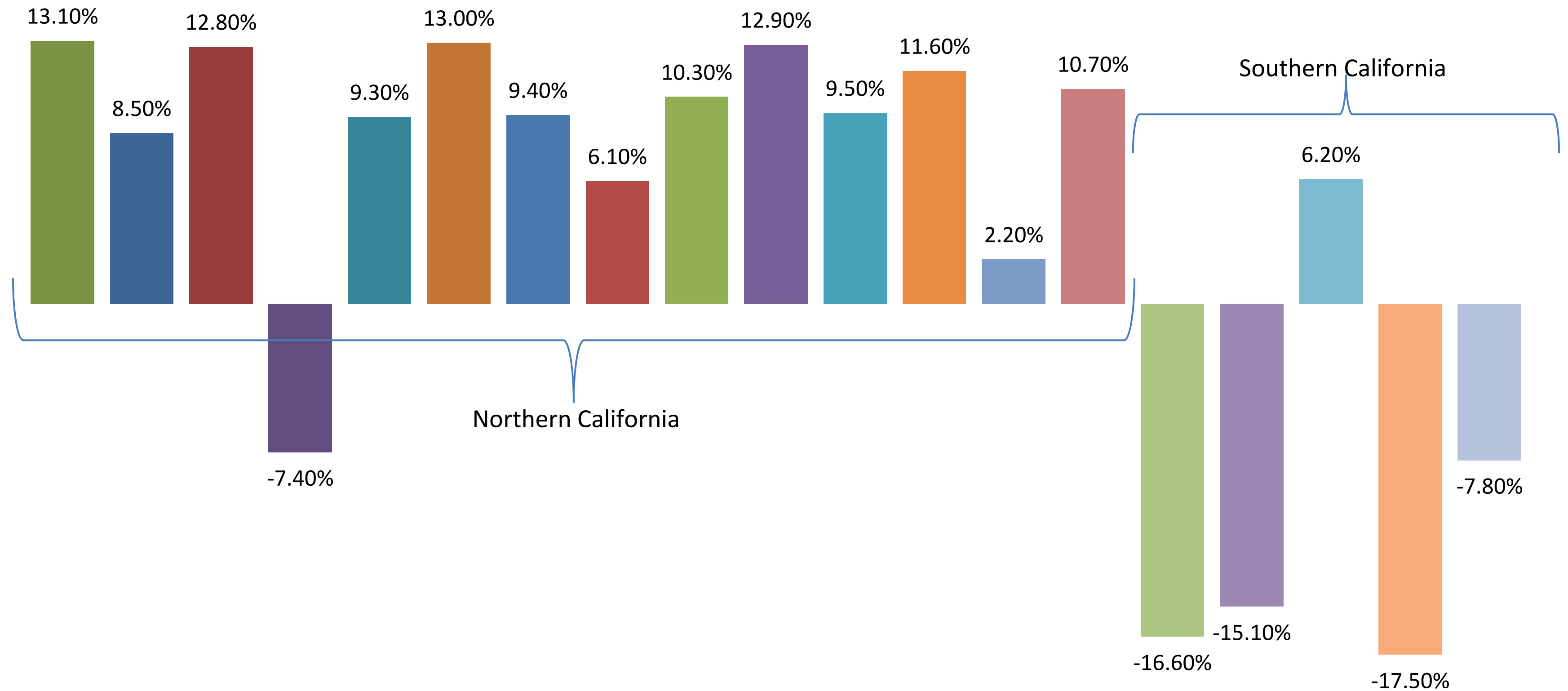
Dena B. Mendelsohn, JD, MPH
Staff Attorney
Consumers Union

[35] Anthem Blue Cross Actuarial Memorandum for 2016 Plan Year at p.46.

[36] We question including the ICD-10 as a quality improvement activity. This undertaking may have quality benefits, but is an administrative requirement and has been in progress for several years.

[37] DMHC *Final Report of the Non-Routine Survey*, 7 November 2014, available at http://www.dmhc.ca.gov/desktopmodules/dmhc/medsurveys/surveys/303fsnr111814.pdf (last accessed August 26, 2015).

Table 1



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Date: September 1, 2015

To: Consumers Union

From: Allan I. Schwartz, FCAS, ASA, MAAA

Re: Review of Blue Cross of California (dba Anthem Blue Cross)
DMHC Individual On and Off Exchange Rate Filing Dated July 8, 2015
HOrg02I Individual Health Organizations - Health Maintenance (HMO)
HOrg02I.005A Individual - Preferred Provider (PPO)
SERFF Tracking #: AWLP- 130080574

As you requested, we have reviewed the above captioned filing submitted by Blue Cross of California ("Anthem") to the Department of Managed Health Care (DMHC).[1,2,3] Anthem is requesting a rate increase of 5.7% with an effective January 1, 2016.[4,5] The total annual premium increase being requested is about $118.9 million.[6] The average annual premium increase per policy holder is about $241.[7]

In evaluating the rate proposal by Anthem, two overall issues can be considered.

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[1] This analysis was provided to assist Consumers Union (CU) in its evaluation of the Anthem filing, including submitting this document to the California Department of Managed Health Care (DMHC). It should not be relied upon for any other purpose or by any other entities. If this analysis is provided to any other entity the following conditions apply: (i) it should only be done after obtaining the written consent of AIS, (ii) the entire analysis should be supplied and (iii) that entity should be informed that AIS is available under appropriate circumstances to discuss the analysis.

[2] This analysis is based upon the information currently available. The analysis and conclusions may change if additional relevant information becomes available. Furthermore, my lack of comment on particular aspects of the filing should not be taken to mean that I agree with those procedures.

[3] The rate filing documents from the DMHC we relied upon consisted five PDF files and six EXCEL files. These were available at: http://wpso.dmhc.ca.gov/ratereview/Detail.aspx?lrh=FoY7rpCgnjI%24

[4] Anthem filing, Filing at a Glance Section and Rate Information Page

[5] 5.7% is the average rate increase. The Rate Information section of the Anthem filing gives a range of rate changes from a minimum of -13.4% to a maximum of 17.1%. *Ibid.* The filing did not adequately explain the basis for this 30% range (17.1% + 13.4%) in rate changes.

[6] Anthem filing, Rate Information Page

[7] $118,861,186 (Written Premium Change) / 492,593 (Number of Policyholders Affected); Anthem filing, Rate Information Page

First, according to the filing materials submitted by Anthem to DMHC, the actual experience for California Individual Market business during 2014 was much better than expected.[8] According to Anthem the actual to expected experience for 2014 was as follows:

- Actual Medical Benefits were 82% of expected, or 18% lower than expected
- Actual Administrative Expenses were 98% of expected, or 2% lower than expected
- Actual Profit was 263% of expected, or 163% higher than expected
- Actual Taxes & Fees were 83% of expected, or 17% lower than expected
- Actual ACA Reinsurance Recoveries were 202% of expected, or 102% higher than expected

Second, according to the financial reports filed by Anthem, its Tangible Net Equity as of June 30, 2015 of $1.925 billion exceeds the Required Tangible Net Equity of $391 million by $1.534 billion.[9,10] Put another way, the actual Tangible Net Equity for Anthem is equal to 492% of the Required Net Equity.[11] Anthem could use some of the excess Tangible Net Equity to offset in part or in whole its requested rate increase. As previously discussed, the rate proposal by Anthem is for an increase of around $119 million. This is only about 8% of the Tangible Net Equity Excess reported by Anthem. Furthermore, the Tangible Net Equity of Anthem would be much higher except that during the eight years from 2007 to 2014, Anthem paid over $4 billion in stockholder dividends.

Our analysis shows that the proposed rate increase is likely inflated and unreasonable for various reasons including Anthem's use of an excessive Annual Medical/Rx Trend Rate of

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[8] DMHC website, Anthem filing, SRRT Excel file, sheet "Actual-to-Expected" showing values for "Actual-to-Expected Analysis for 1/1/2014 to 12/31/2014"

[9] Anthem Blue Cross June 30, 2015 financial statement filed with DMHC

[10] The Total Net Equity for Anthem at June 30, 2015 was $1.930 billion. The total net equity reflects $5 million in "Unsecured Receivables from officers, directors and affiliates; Intangibles" that is not included in the Tangible Net Equity

[11] 4.92 = $1.925 billion / $391 million

+6.45% a year, an Excessive ACA Insurer Fee Provision of 3.81% and an unreasonable increase in Administrative Expenses of 27%.[12]

Other concerns with the Anthem filing include:

- Cost Containment Issues
- Lack of Support and Documentation of Ratemaking Factors
- Failure to Account for Reduction in Uncompensated / Charity Care
- Historically High Profits for Anthem

A more detailed discussion of issues with the Anthem filing follows.

1. **Excessive Annual Medical/Rx Trend Rate**

The Anthem filing is based upon an Annual Medical/Rx Trend Rate of +6.45% a year, which includes a prescription drug trend of 17.8% a year.[13,14] The filing was essentially devoid of any basis for those values. The filing contained two general vague descriptions related to the trend.

The first vague description included in the filing was given by the outside consulting actuary retained by Anthem, which stated:[15]

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[12] Anthem Filing, Exhibit D - Projection Period Adjustments and Exhibit G - Non-Benefit Expenses and Margin for Profit & Contingencies

[13] Anthem Filing, Exhibit D - Projection Period Adjustments and California Rate Filing Form – Item 18

[14] The drug trend of 17.8% a year is composed of “Trend attributable to use of services” of +9.4% and “Trend attributable to price inflation” of +7.6%. (California Rate Filing Form – Item 19) 17.8% = (1.094 X 1.076 – 1) X 100%

[15] Anthem Filing, Actuarial Services & Financial Modeling (“ActMod”) Report, Pages 7 - 8

(a) Annual Medical Trend Factor: Anthem relied on what ActMod refers to as the "Corporate" approach to establish Annual Medical Trend estimates by calendar year. The Corporate approach contrasts with what we call the "Product-Specific" approach to establishing Annual Medical Trend estimates. Specifically, Anthem used the following approach to develop the Annual Medical Trend estimates:

(1) Anthem obtained Medical, Pharmacy, and Capitation "Trend Driver" factors for Calendar Years 2015 and 2016 from a corporate team with the responsibility of evaluating data for various benefit plans and/or product categories based on corporate and possibly industry and/or macro-economic health care data.

(2) The Anthem corporate team developed and applied a sophisticated medical trend model referred to as the Integrated Financial Trend Model (the "IFT" Model).

(3) The "Trend Drivers" specifically considered by the IFT Model included such items as: Provider Network Changes, Provider Contracting Changes, Medical Management Changes, Seasonality, Brand versus Generic Drug Changes, Seasonal Flu Changes, and the recent introduction of the new pharmacy treatments for Hepatitis C such as Sovaldi.

…

(c) Single Annual Trend Factor: Anthem next developed a single annual trend factor for the composite of Medical, Pharmacy, and Capitation benefits by combining the trends for the 2015 and 2016 Calendar Years. This resulted in a single annual trend factor of 6.45% that was used for each of the products impacted by this Rate Filing.

That "description" essentially says nothing about how the specific value for the annual trend of 6.45% was derived and has very little, if any, probative value.

The second vague description included in the filing was given by an actuary employed by Anthem, which stated:[16]

[16] Anthem Filing, Actuarial Memorandum, Item 7. Projection Factors, Trend Factors (cost/utilization)

- The annual pricing trend used in the development of the rates is 6.45%. The trend is developed by normalizing historical benefit expense for changes in the underlying population and known cost drivers, which are then projected forward to develop the pricing trend. Examples of such changes include contracting, cost of care initiatives, workdays, costs associated with Hepatitis C, compound drugs, average wholesale price, and expected introduction of generic drugs. The claims are trended 23.7 months from the member-weighted midpoint of the experience period, which is July 10, 2014, to the midpoint of the projection period, which is July 1, 2016. Additional information can be found in Exhibit D: Projection Period Adjustments.

- Projected trends include the estimated cost of the pharmaceutical Sovaldi and other high-cost drugs for treating Hepatitis C. These cost estimates were based on claims experience for California Individual business, together with CDC recommendations, Industry and total Anthem data.

This again does not provide any information regarding how the specific numerical value of 6.45% was obtained. Furthermore, Exhibit D: Projection Period Adjustments, does not contain any additional relevant information about how the value of 6.45% was derived, but instead simply lists the value as 6.45% without any support or analysis.

Since Anthem did not provide the basis for the numerical value of the annual 6.45% trend it used, we looked at other sources of information, a discussion of which follows.

Anthem claimed to rely on a "'Corporate' approach to establish Annual Medical Trend estimates".[17] It is worth noting that Anthem, as a corporate entity, has a philosophy of adding a provision for adverse deviation into its loss projections[18] and that over the last several years, the loss trends used have turned out to be excessive. The extent to which the Anthem loss projections have turned out to be excessive / favorable (amounts shown are in millions), split

[17] Anthem Filing, ActMod Report, Page 7

[18] "Liabilities for both claims incurred but not reported and reported but not yet processed through our systems are determined in aggregate, employing actuarial methods that are commonly used by health insurance actuaries and meet Actuarial Standards of Practice. Actuarial Standards of Practice require that the claim liabilities be appropriate under moderately adverse circumstances." "The year ended December 31, 2014 metric reflects a slightly higher level of accuracy compared to the targeted prior year reserve for adverse deviation and a resultant lower level of prior years' redundancies than the years ended December 31, 2013 and 2012." Anthem, Inc. 2014 10-K, pages 62-63

between the issues of trend factors and completion factors is shown in the following table, along with an explanation as provided by Anthem.[19]

	Favorable Developments by Changes in Key Assumptions		
	2014	2013	2012
Assumed trend factors	$ (399.5)	$ (428.4)	$ (394.4)
Assumed completion factors	$ (142.4)	$ (170.7)	$ (119.2)
Total	$ (541.9)	$ (599.1)	$ (513.6)

> The favorable development recognized in 2014 and 2013 resulted primarily from ***trend factors in late 2013 and late 2012, respectively, developing more favorably than originally expected*** as well as a smaller but significant contribution from completion factor development. The favorable development recognized in 2012 was driven by ***trend factors in late 2011 developing more favorably than originally expected***.

Altarum Institute has reported "Health care prices in June 2015 were 1.1% higher than in June 2014, the third consecutive month at that rate. The June 2015 12-month moving average held at 1.4%, the same as the May level. Year-over-year hospital prices rose 0.7% in June, equal to the May rate. Physician and clinical services prices fell 1.2%, a tenth lower than May and the steepest drop seen in Altarum Institute's data series extending back to 1990. Other non-durable medical products prices fell 1.6%. Prescription drug prices rose 4.8%, down from 5.3% in May."[20]

The medical trend used by Anthem is more than twice as much as the 3.0% annual trend used by Kaiser. The Kaiser filing for rates effective January 1, 2016 states "The Plan has projected an overall Medical Trend of 3.0%."[21]

Both actuarial reports for Anthem reference specialty drugs (e.g., Sovaldi) as part of the basis for the large drug trends. However, the actuarial firm Milliman has discussed various issues in forecasting specialty drug trends and found that, "Although producing accurate forecasts is inherently difficult, we found that, in the past, PBM [Pharmacy Benefit Managers]

[19] Anthem, Inc. 2014 10-K, page 123, emphasis supplied

[20] Price Brief, August 13, 2015; http://altarum.org/our-work/cshs-health-sector-economic-indicators-briefs

[21] Kaiser Foundation Health Plan, Inc. filing, SERFF Tracking #: KHPI-130043097; Exhibit E-1, Page 6

forecasts were systematically overstated – sometimes by as much as nine percentage points for near term forecasts."[22]

Although both actuarial reports reference specialty drugs as an issue causing high drug trends, the information submitted by Anthem to DMHC stated "Projected specialty Rx trends are not an explicit part of the pricing trend development, and we do not have the specialty Rx trend information."[23] Hence, there appears to be a discrepancy between what the two actuaries stated compared to what is included in the Anthem documents submitted to DMHC.

Another issue to consider is the California Integrated Data Exchange (Cal INDEX) jointly "founded through $80 million in seed funding from Blue Shield of California and Anthem Blue Cross".[24] The stated goals of Cal INDEX include:[25]

- Improve the quality of care by providing clinicians with a unified statewide source of integrated patient information
- Provide patients with a seamless transition between health plans or across various healthcare professionals and hospitals
- Improve efficiency and reduce the cost of healthcare
- Encourage healthcare technology innovation
- Improve public health by providing de-identified data for medical research

Recently the CEO of Cal INDEX stated "This future requires payers and providers to share data if they are to share risk appropriately. That's where Cal INDEX – leveraging the integration of payer and provider data – will help power these new value-based arrangements. Integrating data and making it available at the point of care will help prevent unnecessary or

[22] "Understanding Specialty Drug Forecasts", Milliman, February 2015; www.phrma.org/sites/default/files/pdf/milliman-specialty-drug-forecasts.pdf

[23] DMHC website, Anthem filing, SRRT Excel file, sheet "Specialty Rx Trends"

[24] https://www.blueshieldca.com/bsca/about-blue-shield/newsroom/calindex-launch-080514.sp

[25] *Ibid*.

duplicative care – no need to order another expensive test if the patient had the same one on their last visit – while giving doctors, nurses and other providers a more complete picture of the patient's health. That's a much brighter future for patients and our economy, and that's why we at Cal INDEX are excited to enable the adoption of value based care."[26]

Anthem has touted the benefits of Cal INDEX stating "In California, Anthem Blue Cross is a founding member of Cal INDEX, a new statewide health information exchange. Through Cal INDEX, participating doctors, nurses and hospitals across systems and offices can access patients' health records so they can provide better, more cost-effective care. When a consumer receives services from a participating doctor or hospital, their health record is updated so other Cal INDEX participants can see a more complete view of their patient's health history. This not only helps avoid duplicative procedures and potential drug interactions, but also makes health information available in emergency situations so care can be delivered more effectively."[27]

These items should lower the cost of providing healthcare – both medical costs and administrative expenses. The filing has not shown how this has been taken into account, either by lowering trend factors or otherwise adjusting downward the projected costs.

All of this information demonstrates that the overall annual cost trend of +6.45% a year, as well as the prescription drug trend of 17.8% a year, used by Anthem are both excessive and unsupported.

2. Excessive ACA Insurer Fee Provision

Anthem uses a provision of 3.51% of premium for the ACA Insurer Fee.[28] The filing did not provide documentation for this value. This is another place where Anthem simply selected a figure without any basis or support.

There are, however, various projections that have been made regarding the ACA Insurer Fee. The actuarial firm Milliman, which is often relied upon by health insurance companies, has projected the ACA Insurer Fee to have a premium impact of 1.9% in 2016.[29]

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[26] CEO Blog, May 13, 2015; https://www.calindex.org/leveraging-data-value-based-care/

[27] Anthem Inc. 2014 Annual Report, page 5

[28] Exhibit G - Non-Benefit Expenses and Margin for Profit & Contingencies

Other projections have arrived at similar values. For example, a June 2011 letter to Senator Jon Kyl from the Joint Committee on Taxation stated: "We estimate that repealing the health insurance industry fee would reduce the premium prices of plans offered by covered entities by 2.0 to 2.5 percent."

In summary, Anthem has not provided support for the impact of the ACA Insurer Fee used in the filing. That provision, as contained in the filing, is excessive and will result in inflated rates being charged to California policyholders.

3. Administrative Expenses

The amount included for administrative expenses increased by 27% from $24.52 PMPM in the prior filing to $31.19 in the current filing. No explanation was given for this huge increase in administrative expenses. Given the growth in business for Anthem such that fixed expenses could be spread out over a larger base, along with the start-up costs associated with the ACA being in the past, it would be reasonable to believe that the administrative expenses PMPM could be flat or decreasing as opposed to the considerable increase proposed by Anthem.

The filing only contained vague general comments regarding this stating: "Administrative Expense contains both acquisition costs associated with the production of new business through non-broker distribution channels (direct, telesales) as well as maintenance costs associated with ongoing costs for the administration of the business. Acquisition costs are projected using historical cost per member sold amounts applied to future sales estimates. Maintenance costs are projected for 2016 based on 2014 actual expenses with adjustments made for expected changes in business operations."[30]

This very large increase in administrative expenses, which is unsupported and unjustified, constitutes about 25% of the overall rate change being requested by Anthem.

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[29] ACA Health Insurer Fee – Estimated Impact on the U.S. Health Insurance Industry, April 2013; http://us.milliman.com/insight/healthreform/ACA-health-insurer-fee-Estimated-impact-on-the-U_S_-health-insurance-industry/

[30] Anthem Filing, Actuarial Memorandum, Item 12 Non-Benefit Expenses and Margin for Profit and Contingencies, Administrative Expense

4. Cost Containment Issues

Given the inflated cost trend proposed by Anthem, a possible issue is whether Anthem is taking reasonable steps to control health care costs.

The applicable statute requires Anthem to include specific information on cost containment issues:[31]

> (c) A health care service plan subject to subdivision (a) shall also disclose the following aggregate data for all rate filings submitted under this section in the individual and small group health plan markets: …
>
> (3) Any cost containment and quality improvement efforts since the plan's last rate filing for the same category of health benefit plan. To the extent possible, the plan shall describe any significant new health care cost containment and quality improvement efforts and provide an estimate of potential savings together with an estimated cost or savings for the projection period.

Despite this requirement, the Anthem filing did not contain relevant useful information on the issue of cost containment.[32] The filing includes a value for Quality Improvement Expense of $3.20 PMPM.[33] This is a decrease of -26% below the value of $4.34 from the prior filing.[34] No discussion or explanation was provided as to why the amount being spent for Quality Improvement was decreasing, or the adverse impact this would have on policyholders.

This is a critical issue for not just Anthem, but also other insurance companies, as well as health care providers. It has been estimated that about 30% of health care expenditures are

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[31] California Health and Safety Code Section 1385.03(c)(3)

[32] The filing simply contains some vague general statements about Anthem's "dedication" to contain costs. See Actuarial Memorandum, Item 12. Non-Benefit Expenses and Margin for Profit and Contingencies – Quality Improvement Expense

[33] Exhibit G - Non-Benefit Expenses and Margin for Profit & Contingencies

[34] AWLP-129656693, Exhibit G - Non-Benefit Expenses and Profit & Risk

wasted.[35] With rising costs making health care a significant financial burden for many people, DMHC can encourage all insurance companies to strengthen efforts to contain costs by cutting waste and focusing on prevention and other proven strategies that keep patients healthier.

Given this situation, Anthem should explain why it is decreasing the amount being spent for Quality Improvement.

5. Anthem Filing Included Numerous Factors That Were Not Adequately Supported

The "Market Adjusted Index Rate Development" in the Anthem filing[36] included numerous factors for which adequate support was not provided. We previously discussed the medical trend factor[37] and showed that the annual value of 6.45% included in the Anthem filing was excessive. A complete list of the factors used by Anthem in deriving the "Projected Paid Claim Cost" from the "Starting Paid Claims PMPM" follows:

Starting Paid Claims PMPM	$ 264.89
Factor for	
Seasonality	1.0083
Market-Level Adjustment	1.0616
Normalization Factor	1.0799
Rx Adjustments	1.0034
Morbidity Changes	0.9939

[35] Institute of Medicine, *Best Care at Lower Cost: The Path to Continuously Learning Health Care in America* (2012), available at http://iom.edu/Reports/2012/Best-Care-at-Lower-Cost-The-Path-to-Continuously-Learning-Health-Care-in-America.aspx -- "Current waste diverts resources; the committee estimates $750 billion in unnecessary health spending in 2009 alone." Compared to the 2009 Health Care Expenditures of $2.5 trillion, this is 30%.

[36] Anthem filing, Exhibit A

[37] *Ibid.*, Line (9)

Trend Factor	1.1314
Other Cost of Care Impacts	1.0038
Cumulative	1.3092
Projected Paid Claim Cost	$ 346.79

While the "Market Adjusted Index Rate Development" Exhibit in the Anthem filing refers to other portions of the Anthem filing for those items, a review of those shows that numerical values were simply listed without supporting documentation and calculations. This lack of support for the values included in the filing is consistent with the fact that the "independent" actuarial report included with the Anthem filing for the most part simply accepted the values provided by Anthem without actually reviewing and checking those calculations.[38]

Out of the total increase of 30.9% for the Projected Paid Claim Cost compared to the Starting Paid Claims PMPM, 29.7% is attributable to the three components of the Market-Level Adjustment, Normalization Factor and Trend Factor. We have already explained why the trend factor is excessive and unsupported. We will discuss these other two components and also the Morbidity Changes.

For the Market-Level Adjustment of 1.0616, Anthem's filing states "Adjustment based on Wakely survey to bring starting experience in-line with the market". However, no underlying data, analysis or calculations were provided to support the specific value used. Even if Anthem correctly applied the Wakely study, which is impossible to determine because of the lack of information in the filing, there are questions about the reliability of the Wakely study. As discussed in our comments on the California Physicians' Service (dba Blue Shield of California)

[38] Two of the many instances where the "independent" actuary relied on the values provided by Anthem follows: "For certain items (e.g. establishment of Retention Factors, Provider Network Factors, Geographic Area Factors, Age/Gender experience data, Benefit Plan Relativities, and the detailed source data upon which many of the assumptions in the Rate Filing are based), ActMod did not conduct a detailed review and relied on the information provided by the qualified Anthem actuary identified in Attachment 2 (the "Reliance Actuary")." ActMod report, page 4
"ActMod relied on the Reliance Actuary for the specific factors used for the normalization process (e.g. the age/gender factors, the provider network/area factors, and the benefit plan factors)." ActMod report, page 7

filing[39], the use of the Wakely study resulted in an inaccurate risk adjustment value. In fact, Anthem itself has raised concerns regarding the Wakely study, stating "We had concerns, though, regarding the Wakely data, because we knew a number of competitors had not reported their data."[40]

With respect to the Normalization Factor of 1.0799, that is based on the following three components: Age/Gender of 1.0228, Area/Network of 1.0120 and Benefit Plan of 1.0433.[41] For each component, Anthem gave a value for the Experience Period Population and another value for the Future Population. The normalization factor for each component is calculated as the Future Population value divided by the Experience Period value. However, Anthem did not provide support or documentation for the values of any of the components for either time period. So again, the actual numerical values used by Anthem cannot be verified.

With regard to the Morbidity Changes value of 0.9939, that is again a value that was not documented or supported in the Anthem filing.[42] However, the Morbidity Changes value of 0.9939 used by Anthem could be too high (i.e., that it is does not sufficiently reflect expected improvements in morbidity) for two reasons. First, it is generally accepted that the morbidity of new insureds in 2015 and 2016 will be lower than that in 2014. Second, the pent-up demand of new insureds from 2014 will be substantially eliminated by 2016.

This expected better health status of 2015 and 2016 enrollees compared to the early enrollees in 2014 is a generally recognized actuarial concept, as expressed by the American Academy of Actuaries: "In general, higher-cost individuals are more likely to enroll early during the open enrollment period and in the first year of the program. Lower-cost individuals are more likely to enroll later during the open enrollment period and perhaps in later years as the individual mandate penalty increases."[43]

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[39] SERFF Tracking #: BCCA-130112529 (AIS Comments dated August 25, 2015)

[40] ANTM - Q2 2015 Anthem Inc. Earnings Call, July 29, 2015, Edited Transcript – page 12; http://ir.antheminc.com/phoenix.zhtml?c=130104&p=irol-calendar

[41] Anthem filing, Exhibit C - Normalization Factors (1.0799 = 1.0228 * 1.0120 * 1.0433)

[42] Anthem filing, Exhibit D - Projection Period Adjustments; shows a "Total Morbidity Changes" factor of 0.9939 without any reference to how that value was calculated.

[43] "Drivers of 2015 Health Insurance Premium Changes," http://www.actuary.org/content/actuaries-shed-light-2015-health-insurance-premium-changes_

Milliman has stated the following with respect to morbidity in 2015 compared to 2014:[44]

> Many actuaries believe that the total morbidity of the 2015 individual market will improve relative to 2014 due to increasing participation in the market. …
>
> As these factors drive increased participation in the market in 2015, overall morbidity is generally expected to improve, which will help to mitigate rate increases.

Milliman has stated the following with respect to pent-up demand in 2015 compared to 2014:[45]

> Known as pent-up demand, this factor reflects the temporary increase in health-related expenditures as previously uninsured or underinsured individuals seek care that was delayed due to a prior lack of adequate coverage. Many believe that the impact of pent-up demand lasts a year or less. Thus, as the proportion of the 2015 population that was previously uninsured is expected to decrease—as many uninsured individuals will have obtained insurance in 2014 thanks to ACA—the impact of pent-up demand on claim costs is also expected to decrease relative to 2014. This should help to mitigate 2015 rate increases in the individual market.

Wakely consulting group has stated “there is general consensus that the remaining uninsured population who may take-up insurance in 2016 is generally healthier than the population of previously uninsured individuals who have already entered the market”.[46]

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[44] http://us.milliman.com/insight/2013/What-now-2015-individual-market-pricing-Morbidity-and-other-considerations/

[45] *Ibid*.

[46] Considerations for 2016 Health Insurance Rate Development, Filing and Review, March 2015, http://www.wakely.com/wp-content/uploads/2015/04/White-Paper-2016-Rate-Considerations.pdf

The Society of Actuaries studied the issue of pent-up demand for newly enrolled in 2014 and found it to exist.[47] The study stated "Pent-up demand has been studied for years, and there is a consensus that it exists and that it is transitory." For the 2016 period, the pent-up demand from new enrollees in 2014 can be expected to be significantly dissipated, which should provide for a relative reduction in costs for those newly insured in 2014. This should be adequately reflected in the rates implemented for 2016.

It would be appropriate for the Department of Managed Health Care to request that Anthem provide the underlying support and detailed calculations for the numerous factors and assumptions used in the filing to derive the proposed rates.

6. Failure to Account for Reduction in Uncompensated / Charity Care

Anthem does not appear to have adjusted its cost projections to reflect a reduction in uncompensated care and charity care (i.e., "bad debt") from the Affordable Care Act's expansion of coverage. The savings associated with these reductions could be substantial, and should be passed along to consumers in the form of lower rates.

Among the outcomes of this expansion has been a reduction in uncompensated hospital care for uninsured individuals. Since the uninsured often cannot pay for their own care out of pocket, the cost of providing needed care in emergency situations is frequently shifted onto the insured population and is reflected in the reimbursement rates insurers pay hospitals and other health care providers for various services. This is the so-called "bad debt" factor, and the anticipated reduction in bad debt should exert substantial downward pressure on hospital rates.

Anthem's filing is silent on this issue, and hence it is not possible to know what, if any, consideration Anthem gave to this issue in developing the rates it proposed to charge to California policyholders.

Actual experience shows that there have been substantial reductions in uncompensated / charity care. "Based on estimated coverage gains in 2014, ASPE estimates that hospital uncompensated care costs were $7.4 billion lower in 2014 than they would have been had coverage remained at its 2013 level, at $27.3 billion versus $34.7 billion (Table 1). This represents a 21 percent reduction in uncompensated care spending."[48] The savings in states that

[47] Indications of Pent-up Demand New ACA enrollee use of preference-sensitive services, April 2015, https://www.soa.org/research/research-projects/health/2015-pent-up-demand.pdf

[48] *Insurance Expansion, Hospital Uncompensated Care, And The Affordable Care Act*; March 23, 2015;

expanded Medicaid were higher than average, with a total savings of $5.0 billion and a 26% reduction in uncompensated care costs.[49]

Historically there has been a large amount of uncompensated medical care in California, which has been estimated at $2.4 billion for 2010.[50] As the uninsured population in California decreases as a result of the Affordable Care Act[51], the amount of uncompensated care will decrease, and that should result in a reduction in provider charges for commercial insurance coverage. Hence, as the uninsured population decreases in California, the amount of uncompensated care that is built into provider charges for commercial insurance coverage should decease, resulting in a lowering of those charges.

Actual experience for California under the ACA is already showing a large decrease in the uninsured population. The Commonwealth Fund has indicated that from July / September of 2013 to April / June 2014, the uninsured rate in California dropped by ½, from 22% to 11%.[52]

A report prepared for Covered California by Milliman discusses this issue, stating in part "The Affordable Care Act has the potential to reduce the costs for commercially funded health services by reducing the impact of 'cost shifting.' Providers currently argue that they are underpaid for Medicare and Medi-Cal patients, and not paid for uninsured patients. In order to cover their costs and achieve target total revenue, the only reimbursement rates that the providers can negotiate are for commercial members. If providers believe that their revenue for services provided to Medi-Cal and for currently uninsured patients will increase in 2014, they may be willing to accept lower reimbursement for commercial patients, or possibly just for Exchange patients."[53]

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http://aspe.hhs.gov/pdf-document/insurance-expansion-hospital-uncompensated-care-and-affordable-care-act

[49] *Ibid.*

[50] California Health Care Almanac, published by the California Health Care Foundation, January 2013

[51] The California HealthCare Foundation projects that the number of uninsured in California will drop from 5.6 million in 2013 to 3.1 million in 2019. As a percent of the insured population, that is a decrease from 19.4% in 2013 to 9.5% in 2019, or a reduction by more than ½. "Where Will Californians Get Insurance?" www.chcf.org/translation

[52] http://www.commonwealthfund.org/interactives-and-data/chart-cart/issue-brief/gaining-ground-americans-health-insurance-coverage-and-access-to-care/uninsured-rates-fell-sharply-in-california-and-texas

[53] Factors Affecting Individual Premium Rates in 2014 for California; March 28, 2013

The Anthem filing did not discuss how it took into account expected reductions in uncompensated care, how that should decrease provider charges for commercial insurance, and how that was reflected in the rate calculation.

The available evidence is clear that the ACA has resulted in an increase in Medicaid enrollment and a decrease in charity care. A Colorado Hospital Association study confirms this stating in part[54]:

- The Medicaid proportion of patient volume at hospitals in states that expanded Medicaid increased substantially in the first quarter of 2014. At the same time, the proportion of self-pay and overall charity care declined in expansion-state hospitals.
- Medicaid, self-pay and charity care showed no change outside normal variation for hospitals in non-expansion states in 2014.
- The increase in Medicaid volume, which occurred only in expansion states, is due to Medicaid expansion. The parallel decrease in self-pay and charity care shows that previously uninsured patients are now enrolled in Medicaid.

A reduction in uninsured patients along with a beneficial financial impact on uncompensated care is also discussed by the rating agency Fitch which has stated "Relative to the early muted influence of insurance expansion on volume growth, expansion of state Medicaid programs had an immediate and dramatic influence on payor mix. In expansion states, hospitals are experiencing strong growth in Medicaid patient volumes and a drop in uninsured patient volumes. Based on only one-quarter of experience under insurance expansion, it is difficult to determine the longer term effect of the payor mix shift, but these early results show the industry could experience a meaningful and durable reduction in the financial headwind created by uncompensated care."[55]

Anthem has acknowledged an increase in Medicaid business -- "Our government business segment had another strong quarter, adding 147,000 members, driven by strong organic

[54] Impact of Medicaid Expansion on Hospital Volumes, June 2014, http://www.cha.com/Documents/Press-Releases/CHA-Medicaid-Expansion-Study-June-2014.aspx

[55] https://www.fitchratings.com/gws/en/fitchwire/fitchwirearRMHMSle/For-Profit-Hospitals-Potentially?pr_id=837194

growth in Medicaid. Revenues in the quarter were $10.4 billion, up approximately 25.7% versus the prior-year quarter. Government business year-to-date membership growth has exceeded our expectation. We've grown by approximately 630,000 members, including 571,000 in Medicaid, 31,000 in our federal employee program, and 28,000 in Medicare."[56]

A decrease in the uninsured population is consistent with the very large increase in the number of people insured with Anthem in California during 2014 and continuing into 2015. The number of PPO Individual enrollees with Anthem increased from 75,965 at December 31, 2013 to 529,002 at December 31, 2014 to 594,537 at June 30, 2015.[57] The number of Medi-Cal enrollees with Anthem increased from 833,173 at December 31, 2013 to 1,076,635 at December 31, 2014 to 1,113,890 at June 30, 2015.[58]

The amount of cost savings from the reduction in bad debt can be expected to become more precise -- and to grow -- over time. However, it is abundantly clear that uncompensated care costs are already going down. Furthermore, it is reasonable to believe that some health care providers will accept lower fees because of the reduction in bad debt. This position is supported by Milliman, an actuarial firm commonly relied upon by health insurance companies, which stated that "some providers may be willing to accept lower rates than in the past, perhaps due to a reduction in uncompensated care for the uninsured."[59]

The pattern of reduced bad debt is already clear, and the impact of that can be expected to be even more important in the coming year. If insurance rates are not adjusted to reflect this reality, consumers will be paying premiums for unjustified costs. We believe the DMHC should carefully consider this issue before making a decision on Anthem's rate proposal.

7. **Historically High Profits For Anthem**

Anthem has consistently earned a very high level of profits on a historical basis over an extended period of time, as shown in the following table.

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[56] ANTM - Q2 2015 Anthem Inc. Earnings Call, July 29, 2015, Edited Transcript – page 3; http://ir.antheminc.com/phoenix.zhtml?c=130104&p=irol-calendar

[57] Anthem quarterly reports to DHMC; Report #4: Enrollment and Utilization Table

[58] *Ibid*.

[59] 2014 Milliman Medical Index, http://us.milliman.com/uploadedFiles/insight/Periodicals/mmi/pdfs/2014-mmi.pdf

Anthem Blue Cross

Historical Profitability
(Amounts in Millions)

Year	Net Income	Ending Surplus	Income / Surplus
2007	$717	$1,844	38.9%
2008	$286	$1,218	23.5%
2009	$450	$1,377	32.7%
2010	$414	$1,259	32.9%
2011	$508	$1,226	41.4%
2012	$407	$1,210	33.7%
2013	$453	$1,349	33.6%
2014	$426	$1,644	25.9%
Combined	$3,661	$11,127	32.9%

Source: Anthem Blue Cross
Consolidated Financial Statements and Supplementary Information
Prepared by Ernst & Young

From 2007 to 2014, Anthem earned net income, on an after-tax basis, of about $3.7 billion. In each of those eight years, Anthem had a return on net worth of more than 20%, ranging from a minimum of 24% to a maximum of 41%, with an average annual value of 33%.

The high level of profits has allowed Anthem to pay significant shareholder dividends. From 2007 to 2014, Anthem paid shareholder dividends of about $4.0 billion, which was more than the net income during that time period.[60]

[60] Anthem was able to pay more in shareholder dividends than its net income, by using a portion of its surplus to pay dividends, as shown by the decrease in surplus over time. Other items that can impact the amount available for the shareholder dividends include net unrealized capital gains / losses.

Anthem Blue Cross

Shareholder Dividends Paid
(Amounts in Millions)

Year	Stockholder Dividends	Net Income	Stockholder Dividends / Income
2007	$950	$717	132%
2008	$575	$286	201%
2009	$525	$450	117%
2010	$525	$414	127%
2011	$500	$508	99%
2012	$450	$407	110%
2013	$350	$453	77%
2014	$150	$426	35%
Combined	$4,025	$3,661	110%

Source: Anthem Blue Cross
Consolidated Financial Statements and Supplementary Information
Prepared by Ernst & Young

While the consistently very high amount of profits and shareholders dividends over time are not completely attributable to the business underlying this filing, that business did contribute to the overall results shown, and these historical data could indicate a tendency for Anthem to charge excessive rates.

I am a member of the American Academy of Actuaries and meet the requirements to provide this opinion, which is based upon generally accepted actuarial procedures.

Please feel free to contact me if there is anything you would care to discuss.