POLICY & ACTION FROM CONSUMER REPORTS

August 25, 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 California Physicians' Service (dba Blue Shield of California) Rate Filing, SERFF number BCCA-130112529.

Dear Contract Manager:

Consumers Union, the policy and advocacy division of Consumer Reports, writes to provide you with comments on California Physicians' Service (dba Blue Shield of California) Rate Filing, SERFF number BCCA-130112529.

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. Blue Shield's proposal to increase its contribution to an already substantial surplus is unjustified and unreasonable.

II. Blue Shield's rate filing is inconsistent with that of a non-profit committed to its mission to ensure all Californians have access to high-quality health care at an affordable price.

III. Blue Shield's filing includes unsubstantiated statements to justify its proposed rate increases.

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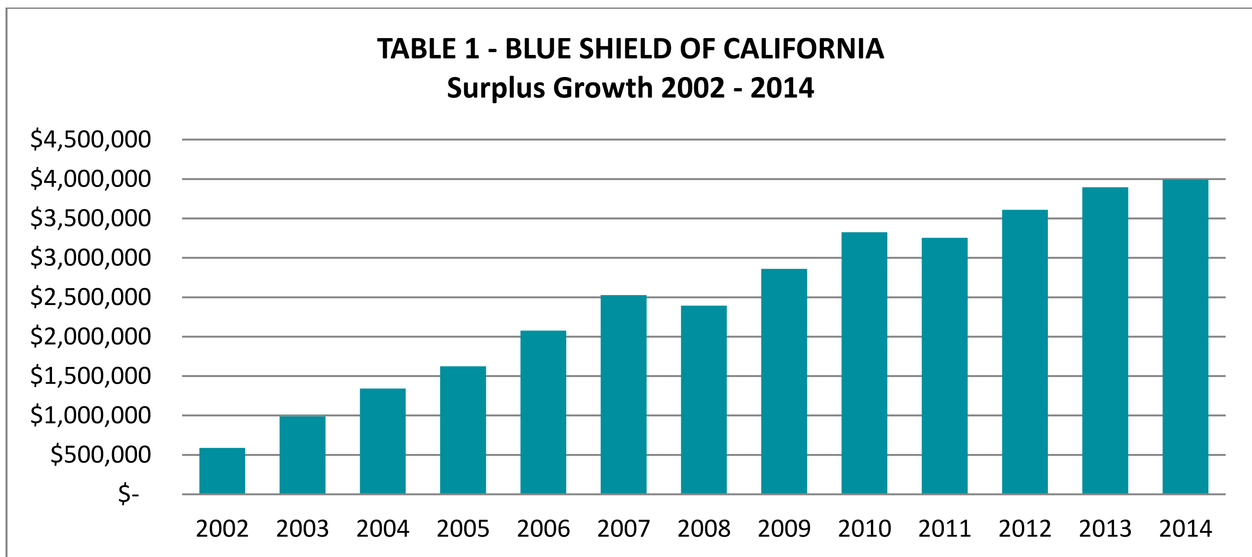
I. Blue Shield's proposal to increase its contribution to an already substantial surplus is unjustified and unreasonable.

Among the rate review requirements set by the Affordable Care Act, carriers must submit information on their capital, surplus, and reserve needs.[1] This information serves as a critical tool for regulators to discourage excessive surplus by rejecting proposed increases that are unjustified on the basis of needs for additional capital, surplus and reserves, in light of the carrier's anticipated MLR and other factors. Although DMHC cannot instruct Blue Shield how to use premiums, the Department can reject Blue Shield's proposal to collect excessive premiums in the first place.

According to Blue Shield's recent quarterly filing, the carrier holds nearly $4 billion in surplus, continuing its trend of annual surplus growth shown in Table 1, below.



Contributing to surplus in any year is neither a given nor a necessity for a non-profit carrier with a robust surplus, such as Blue Shield. Especially in light of tangible net equity over 12-times in excess of that which is required by the state, it is questionable why the carrier needs to grow its surplus at all. In contrast, for the 2015 plan year, Kaiser—another California non-profit carrier with substantial tangible net equity—intentionally drew from its surplus.[2] The results were far from catastrophic. Indeed, Kaiser's surplus remained sizeable for the 2016 plan year and the carrier only proposes to increase its own surplus by a modest 0.3% in the 2016 plan year.[3] Blue Shield should reduce its proposed rate increase and instead defray health care and administrative cost[4] increases in 2016 with its sizeable surplus.

[1] CMS's determination of Effective Rate Review Programs, 45 CFR 154.301.

[2] "The target margin in the 2015 rate filing was (4.8%)". Kaiser Foundation Health Plan, Inc. Actuarial Memorandum at 5.

[3] Kaiser Foundation Health Plan, Inc. Amended Actuarial Memorandum, Exhibit E-1, 30 July 2015 at 6.

[4] Blue Shield projects an increase in percent of premium dollars used for administrative costs from 7.8% to 9.28%. Milliman client Report for Blue Shield of California, Inc., 27 July 2015, at 7.

We strongly urge the DMHC to question Blue Shield on its proposed increase to an already robust surplus. For the 2015 plan year—when Blue Shield proposed increasing its contribution by 0.8% to 1.95%—DMHC's outside actuary requested an explanation of the rationale behind increasing contributions to surplus. The Final PDF Pipeline[5] of Blue Shield rate review documents show the response received was the same as what was originally in the carrier's filing; in other words, Blue Shield was non-responsive.[6] A similar non-response this year should deem the rate proposal unjustified.

II. Blue Shield's rate filing is inconsistent with that of a non-profit committed to its mission to ensure all Californians have access to high-quality health care at an affordable price.

It is generally understood that not-for-profit corporations, such as Blue Shield, are mission-driven institutions that benefit the communities they serve. As a California not-for-profit corporation, Blue Shield has stated that "[p]hilosophically, being a not-for-profit means we're guided by our mission to ensure all Californians have access to high-quality health care at an affordable price."[7] The carrier's rhetoric, however, tells a different story than the picture painted by its skeletal rate filing and recent revocation of its tax-exempt status.[8]

<u>The proposed contribution to surplus would explicitly violate Blue Shield's "2% Pledge".</u>

In 2011, Blue Shield instituted its *2% Pledge*, to "set rates and manage performance such that [it] earn[s] no more than 2% in profits."[9] Consumers Union is alarmed that for the 2016 plan year, Blue Shield proposes to *increase* its contribution to surplus from 1.95%—just a hair under the 2% Pledge—to 2.09%[10], a clear breach of the pledge altogether. As we previously commented regarding its prior surplus

[5] The Final PDF Pipeline is posted on DMHC's premium rate review filings web page for Blue Shield's individual rate filing for the 2015 plan year, available at http://wpso.dmhc.ca.gov/ratereview/Detail.aspx?lrh=oS8THuk9968%24 (accessed August 24, 2015).

[6] See *Letter from Lewis & Ellis, Inc. to Michael Cole*, 24 September 2014, available in the <u>Final PDF Pipeline</u> and the Excel document <u>09-24-2014 CommentLetterResponse</u>, both available at http://wpso.dmhc.ca.gov/ratereview/Detail.aspx?lrh=oS8THuk9968%24.

[7] Blue Shield of California website, *What Does Being a Non-Profit Mean to Us?* Accessed August 28, 2014, available at https://www.blueshieldca.com/employer/knowledge-center/features/perspectives/not-for-profit.sp (accessed August 25, 2015).

[8] California Physicians' Service dba Blue Shield of California Annual Financial Reporting Form submitted to DMHC for the year ending December 31, 2014, Overflow (1) worksheet.

[9] Blue Shield of California website, Our Pledge to Keep Healthcare Affordable, available at https://www.blueshieldca.com/bsca/about-blue-shield/health-reform/our-involvement/healthcare-quality-value/our-pledge.sp. (Accessed August 25, 2015.)

[10] Blue Shield Actuarial Memorandum at p.7. Additionally, Blue Shield's description of the increase to surplus to 2.09% as only a small. 0.1%, increase over 2015 suggests either a purposefully misleading miscalculation—2.09% is not a 0.1% increase from 1.95%—or it that Blue Shield actually contributed more towards their surplus in 2015 than planned. Or both. In reality, the proposal to increase their contribution to surplus to 2.09% represents a 7%

growth trend, Blue Shield "stands out for its relentless surplus growth despite changes under the ACA and its own '2% Pledge' to limit profit-taking, declared in 2011."[11] The current proposal begs the questions:

- How does Blue Shield justify the increased contribution to surplus when its tangible net equity is already markedly more than what is required or necessary?
- Why would an organization that has pledged to return to consumers all contributions to surplus in excess of 2% propose to do so in the first place unless they plan to disregard the pledge?
- How is the 2% contribution to revenue calculated and how is the refund "to customers or the community" determined?

Given that the 2% Pledge is at the discretion of Blue Shield's board of directors[12] and that in its rate filing Blue Shield failed to mention the pledge in the same prominence it has in previous rate filing justifications[13], there is reason to question whether Blue Shield is turning away from its pledge altogether. This does not comport with an organization following its mission to "ensure all Californians have access to high-quality health care at an affordable price."[14]

Failure to meet the 80% MLR floor in the 2014 plan year indicates Blue Shield's use of premium dollars disregards the needs of its enrollees.

The ACA includes MLR rebates as a factor in rate review, and that requirement is included as part of California's rate review process. [15, 16] As with surplus, DMHC cannot make demands on Blue Shield regarding its MLR. However, it can look at the carrier's historical and projected loss ratios when determining whether the proposed rate changes for 2016 are reasonable and justified.

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increase over what was proposed for 2015, which was already arguably too much, and a blatant violation of Blue Shield's own 2% Pledge.

[11] Mendelsohn, Dena, *How Much is Too Much: Nonprofit Insurer Surplus After the ACA*, June 2015, at p.4. Available at http://consumersunion.org/research/how-much-is-too-much-nonprofit-insurer-surplus-after-the-aca.

[12] "In any year in which Blue Shield earns more than 2%, we will return the difference to our customers and the community, with approval from our board of directors." Blue Shield of California's 2% Pledge webpage, available at https://www.blueshieldca.com/bsca/about-blue-shield/health-reform/our-involvement/healthcare-quality-value/our-pledge.sp (accessed August 10, 2015).

[13] For the 2015 plan year, Blue Shield discussed the 2% Pledge in the context of its contribution to surplus. For the 2016 plan year, the carrier describes the 2% Pledge within the sub-section on its transitional reinsurance program, far from the section of the filing that details its projected contribution to surplus.

[14] Blue Shield of California *Mission & Values* web page, available at https://www.blueshieldca.com/bsca/about-blue-shield/corporate/values.sp, (accessed August 11, 2015).

[15] 45 CFR 154.215(e)(2).

[16] "A plan shall submit any other information required under PPACA." California Health and Safety Code Section 1385.03(e)

According to a recent report to DMHC, Blue Shield will return $62 million in MLR rebates to consumers this summer, for the 2014 plan year on the individual market.[17] Based on the MLR calculation set by the ACA, Blue Shield spent only 76.8% of each premium dollar on health care claims, 3.2% less than the minimum set to protect policyholders. The amount spent on health care may actually be even less, because the ACA calculation credits carriers for their contribution to the federal "risk corridor" program as a medical expense. Were that excluded from the calculation, Blue Shield will have spent only 72% of each premium dollar on health care.[18] A non-profit carrier with a mission "to ensure all Californians have access to high-quality health care at an affordable price" should not have trouble meeting the MLR minimum. And yet Blue Shield owed significant MLR rebates to its enrollees.

<u>Blue Shield sought to keep its rate filing justification from public view.</u>

This year, Blue Shield made an unprecedented request of DMHC for confidential treatment of its rate filing justification, [19] notwithstanding that California's rate review law does not permit such confidentiality.[20] Citing Title 28, Sections 1007(a)(1) and (a)(2), but ignoring the underlying relevant statute, Blue Shield argued that the information in the rate filing justification is (1) proprietary or of a confidential business nature, (2) has been confidentially maintained by the business entity, and (3) the release of which would be damaging or prejudicial to the business concern,[21] <u>and</u> that "the public inspection of such information is not necessary for the purposes of the law under which the information was filed." Given that other carriers neither requested nor received trade secret protection for their rate filings, it is difficult to conclude that publicly disclosing Blue Shield's information would be either damaging or prejudicial. To contend that the public has no legitimate purpose for seeing the information contradicts the plain language, the very purpose and context of California's strong, public rate statute.[22]

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[17] Medical Loss Ratio report on DMHC website. Note that this is larger than the amount originally predicted in the actual rate filing: $53.5 million. Blue Shield Actuarial Memorandum at p.2.

[18] Johnson, Michael, *Blue Shield devoted just 72% of premiums to costs*, 6 August 2015, blog post available at http://makeitrightblueshield.org/blog/2015/8/6/blue-shield-devoted-just-72-of-2014-premiums-to-medical-costs (accessed August 20, 2015).

[19] Letter to the Department of Managed Health Care, Licensing Division File Clerk, dated 5 June 2015, signed by Kim Morimoto Esq.

[20] California Health and Safety Code §1385.03.

[21] The regulation also permits confidentiality if "the information is such that the private and/or public interest is served in withholding the information," which is certainly not the case when the conversation is around withholding rate filing justifications from the public during the rate review process.

[22] As Consumers Union has long argued, the trade secret exemption is designed to protect businesses from having key business and manufacturing details revealed to competitors for fear they will be stolen, not to protect actuarial calculations.[22] It has no place in the rate review process. For more on this, see Mendelsohn, Dena, *Health Insurance Rate Setting: Time to Raise the Bar and Lift the Veil of Secrecy*, Health Affairs Blog, 24 December 2014, available at http://healthaffairs.org/blog/2014/12/24/health-insurance-rate-setting-time-to-raise-the-bar-and-lift-the-veil-of-secrecy.

III. Blue Shield's filing includes unsubstantiated statements to justify its proposed rate increases.

Blue Shield relies on a flawed report to project reinsurance and risk adjustment payments in the 2016 plan year.

Blue Shield based its projected risk adjustment on "results from a statewide study conducted by an external consulting firm" that "collected diagnosis data from all of the major insurance companies in California and simulated the risk adjustment transfer."[23] Incidentally, all four major California carriers used an external consulting firm's report when calculating for risk adjustment. We believe the external consulting firm is the Wakely Consulting Group.

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.[24] Using the EDGE Server data, Health Net reduced its proposed rates by 3.2%.[25] This adjustment clearly indicates, at the least, varying opinions about the reliability of the Wakely report. The Wakely study is confidential, making it impossible to evaluate its accuracy.

A side-by-side comparison of Blue Shield's 2014 projected reinsurance and risk adjustment recoveries versus the actual 2014 recoveries announced by HHS, shown in the table below, clearly demonstrates shortcomings in the projections used by Blue Shield. That the same consultant was relied upon by Blue Shield to project risk adjustment recoveries is being used for the 2016 plan year should be a red flag for reviewers.

Comparison of Blue Shield Projected to Actual 2014 Reinsurance and Risk Adjustment Recoveries

Program	Blue Shield projected paid claims[26]	CMS reported paid claims[27]	% Blue Shield understatement
Net reinsurance recovery	$347,498,223	$363,050,264.53	4%
Net risk adjustment recovery	$113,364,005	$135,212,707.60	19%

Without information to the contrary, there is reason to question and probe the methodology and procedures on which Blue Shield based its reinsurance and risk adjustment projections for the 2016 plan year, as Blue Shield's history and Health Net's recent adjustment would suggest. We urge DMHC to require that Blue Shield 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.

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[23] Blue Shield Actuarial Memorandum at p.6.

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

[25] *Id.*

[26] Blue Shield Actuarial Memorandum at 2.

[27] *Summary Report on Transitional Reinsurance Payments and Permanent Risk Adjustment Transfers for the 2014 Benefit Year*, 30 June 2015, *infra*.

Blue Shield uses exaggerated medical and pharmaceutical trends.

Since the enactment of the 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 Blue Shield's projected medical trend of 6.5%, a recent *Health Affairs* article projected national health expenditure projection of 5.3%.[28] This downward pressure is attributed to: increased cost-sharing for patients; a shift away from traditional institutional care to telehealth, retail clinics, and community-based care; and new payment methodologies. Yet Blue Shield's actuarial memorandum fails to reflect this stabilizing trend 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.[29] Similar findings about the improved risk in the individual marketplace are outlined in research published by the Society of Actuaries.[30] 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 Blue Shield's medical trend is its pharmaceutical trend, which is projected at 11.2% for the 2016 plan year, broken out as 0.7% increase in use of services ("utilization") and 10.5% price inflation (cost).[31] 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.[32] 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.[33] None of these cost reductions are reflected in Blue Shield's actuarial memorandum. Furthermore, we note that the high cost of such specialty drugs as Sovaldi was factored into rates that were finalized for 2015. Given that the cost of this

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[28] 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.

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

[30] 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.

[31] Blue Shield California Rate Filing Form at 7.

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

[33] *Id.*

and similar drugs has not changed in the past year—yet price inflation is by far the largest component of the pharmaceutical trend used by Blue Shield—it is unclear how the carrier justifies its pharmaceutical trend for 2016.

Accordingly, we urge DMHC to closely review the medical and pharmaceutical trend used by Blue Shield, and to demand adequate justification—including validated claims data, such as that gathered by Covered California—to support its trend over and above what is documented by the literature.

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

California state law requires health insurance carriers to 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."[34]

In its filing, Blue Shield projects a decrease of per member per month (PMPM) expenditure for activities that improve health care quality and expenditures related to health information technology from $3.42 in 2015[35] to $2.56 in 2016.[36] That is the full extent of information they provide. It neither provides details on cost containment and quality improvement efforts nor estimates of costs or savings. Given the number of consumer complaints we understand were filed with DMHC and findings against Blue Shield by DMHC in 2015 alone, for example, inaccurate provider directories, quality improvement and consumer cost containment should be a priority for the carrier.

Consumers Union urges DMHC to require that Blue Shield satisfy its obligation to better detail its quality improvement and cost containment initiatives. Blue Shield's response to questioning along this line was unsatisfactory in 2014, failing to detail its quality improvement initiatives and providing little insight with regards to cost containment. We encourage DMHC to continue to push for answers, especially if the initial responses are inadequate.

<u>Blue Shield fails to justify the rate increase associated with converting EPO plans to PPO plans in 2016.</u>

For the 2016 plan year, Blue Shield plans to widen the network of all its EPO plans, converting them to PPOs, in contrast to the 2015 plan year where the same carrier narrowed its networks in a move to contain costs. There is general consensus that narrow networks result in cost savings; it is therefore logical that widening networks will increase costs. The question, therefore, is not whether costs will go up in conjunction with expanding these networks, but rather by how much. Without adequate justification for the severity of the adjustments Blue Shield proposes, it is difficult to determine that its proposal is either reasonable or justified.

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

[35] Blue Shield Rate Filing Form Q20-24.

[36] Milliman Client Report for Blue Shield of California, Inc., 27 July 2015, Appendix C-1 at 11.

In a comparison of 2015 rates versus proposed 2016 rates, for each of the metal tiers, two discrepancies are apparent: (1) the extent to which widening networks will affect costs in Region 9, the Central Coast Region, and (2) the extent to which widening the networks in Regions 1, 2, 6, and 9[37] will increase costs for platinum plan holders versus the other metal plans in those regions. See Appendix for a chart showing these increases.

In our comparison of 2015 rates versus proposed 2016 rates, the difference between the rate increases in Rating Area 9 is striking. In contrast with the other regions that will see their EPOs converted to PPOs, premiums in Region 9 will increase by 20%-44%. This substantial rate increase is too large to be deemed reasonable without adequate justification. Given the absence of supporting information in the rate filing justification, we strongly urge DMHC to require Blue Shield submit additional materials to support this increase.

Additionally, based on our comparison of 2015 rates versus proposed 2016 rates, we found that the rate increase for all metal plans *except* the platinum plans ranged from single-digits to mid-teens. This range is in line with the 2015 plan rate filing justification, which projected a cost savings of 14.4% based on a narrowed network.[38] In contrast, the rate increase for platinum plans is approximately double that. Although platinum plans may be costlier to carriers than other plans, that fact alone is already built into the original rates from 2015—the platinum plan is always the most expensive plan. Blue Shield does not, however, justify why expanding the network will make platinum plans significantly costlier to the carrier compared to plans in the other metal tiers.

<u>Blue Shield fails to justify the substantial disparity among different rating regions.</u>

For all plans combined, the weighted average increase for Southern California consumers who stay in their current plan is 1.8%, while those in Northern California will experience a weighted average of 7% increase.[39] 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 Blue Shield products. Nowhere is this more apparent than in Region 9, the Central Coast, where rate increases proposed range from 20% to 44%. Notably, rate increases are also substantially larger in one part of Los Angeles—where proposed rate changes range from increases of 3%-23%—as opposed to another part of Los Angeles—where proposed rate changes will range from a decrease of 9% to an increase of 8%. The discrepancy between rate increases in two parts of a single metropolitan area is especially jarring.

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[37] Region 1 is Northern counties, Region 2 is North Bay counties, Region 6 is Alameda County, Region 9 is Central Coast.

[38] Blue Shield of California 2015 Individual Products Rate Filing Actuarial Memorandum.

[39] Covered California Press Release, 27 July 2015, available at http://www.coveredca.com/news/press-releases (accessed August 12, 2015).

While we understand that provider consolidation weakens carriers' negotiating position, Blue Shield neglects to include data to support the extent of the disparities in rate increases between the regions. In the case of northern California, providers have had a consolidated provider market for many years. Given that fact, the discrepancies between contracted rates between providers and carriers is logically already incorporated into the rates from prior years. Steeper rate increases in some regions and not others may be justifiable in a year in which providers gained negotiating power, but provider market power does not necessarily support costs rising exponentially in perpetuity. We, therefore, urge DMHC to question Blue Shield further on this before deeming the proposal *justified*.

<u>Blue Shield fails to adequately account for the lower cost of covering future enrollees.</u>

Although Blue Shield acknowledges that the new members in 2016 are likely to be healthier than prior members—using a population risk morbidity of (-1.0%) for individuals purchasing due to the individual mandate—the carrier may not have adequately accounted for the lower cost of covering future enrollees. Many market experts expect that the mix of customers enrolling in health coverage in 2015 and 2016 will be younger and healthier than those who signed up for 2014, bringing down costs. This 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."[40] The 1% downward adjustment is actually smaller than the downward adjustment Blue Shield used to set 2015 rates. However, evidence suggests that the change in enrollee health between 2015 and 2016 will be greater than the change in enrollee health for the preceding year. Based on that comparison, Blue Shield's downward adjustment should be larger for the 2016 plan year than for the 2015 plan year.

Additionally, we question the population risk morbidity Blue Shield associated with employer migration. In its actuarial memorandum, Blue Shield projects an increase in the overall morbidity of the employee population to the individual market. They do not, however, provide any supporting evidence to this theory. Even if it is the case that employers are opting to send their employees to Covered California for health insurance, Blue Shield does not provide data to show that those employees are any less healthy than individuals that otherwise purchase from the exchange.

Finally, we note that Blue Shield failed to adjust its projected utilization in recognition of the fact that pent-up demand, which was a consideration in the past, is unlikely to impact claims costs in 2016. Blue Shield's competitor Anthem Blue Cross did make this adjustment, stating:

> [P]ent-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."

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

For those who signed up in 2014 and 2015, pent-up demand has already been satisfied, and rates set for those plan years already took this risk into account. We therefore suggest Blue Shield should back-out the pent-up demand factor.

We therefore encourage DMHC to investigate how Blue Shield justifies its morbidity adjustment both overall and due to employer migration, and the extent to which it elected to back out upward adjustments in previous years that do not apply to the 2016 plan year.

Blue Shield 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. Blue Shield does not account for this shift in their 2016 rates, as it failed to in 2015 as well.

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."[41] This translates to approximately 4.2 million previously uninsured adult Californians now with coverage.[42] Overall, the rate of uninsurance was reduced by approximately two-thirds in the first two enrollment periods.[43] As in 2015, it continues to be likely that as more Californians gain and retain insurance, fewer will require free care from hospitals. 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.[44] 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."[45] Additional recent literature echoes the Fitch

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[41] 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).

[42] *Id.*

[43] *Id.*

[44] *Id.*

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

report in 2015, stating "Hospitals [in states that expanded Medicaid] reported a more significant drop in unpaid bills and more patients with Medicaid."[46]

When questioned about its failure to account for a reduction in uncompensated care as a factor in its rates for the 2015 plan year,[47] Blue Shield responded that it did not project cost savings from a decrease in uncompensated care that would initially benefit providers, and that those providers may or may not pass on the relief to insurers when negotiating their contracts.[48] Additionally, Blue Shield claimed that unit cost trends for 2015 are based on already negotiated contracts.[49] Now entering the third year of the ACA, and with an increasingly insured statewide population, we urge DMHC to question whether Blue Shield is still unable to use the expected reduction in uncompensated care as a negotiation point to achieve lower provider rates, and if not why.

Conclusion

We strongly encourage DMHC to demand additional information that fully justifies Blue Shield's rate request. If Blue Shield is unable to do so—given the financial burden of escalating costs on California families and in light of Blue Shield's substantial surplus and large elective expenses in 2015—Consumers Union urges DMHC to find the requested rates unreasonable and not justified.

Sincerely,

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

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

[47] Letter to Blue Shield of California from L & E Actuaries & Consultants at p.2, 24 September 2014, available in the *PDF Pipeline for SERFF Tracking Number BCCA-129656912*, generated 7 October 2014.

[48] 09-24-2014 CommentLetterResponse, worksheet Q5, available at http://wpso.dmhc.ca.gov/ratereview/Detail.aspx?lrh=oS8THuk9968%24 (accessed August 14, 2015).

[49] *Id.*

APPENDIX 1: Proposed Rate Increases for Plans Converted from EPO to PPO

	Age: 25			Age: 40			Age: 60		
	2015	2016		2015	2016		2015	2016	
Rating Area 1 Northern counties	2015 - EPO	2016 - PPO	% Change	2015 - EPO	2016 - PPO	% Change	2015 - EPO	2016 - PPO	% Change
Bronze 60	$221.20	$246.70	12%	$281.56	$314.02	12%	$597.94	$666.86	12%
Bronze 60 HSA	$217.56	$248.87	14%	$276.94	$316.79	14%	$588.12	$672.74	14%
Gold 80	$315.32	$364.54	16%	$401.37	$464.03	16%	$852.37	$985.43	16%
Min. Coverage	$210.40	$229.42	9%	$267.82	$292.03	9%	$568.75	$620.15	9%
Platinum 90	$361.31	$464.75	29%	$459.92	$591.58	29%	$976.70	$1,256.29	29%
Silver 70	$267.78	$288.02	8%	$340.85	$366.62	8%	$723.85	$778.57	8%
Rating Area 2 North Bay counties	2015 - EPO	2016 - PPO		2015 - EPO	2016 - PPO		2015 - EPO	2016 - PPO	% Change
Bronze 60	$234.85	$266.78	14%	$298.94	$339.59	14%	$634.85	$721.15	14%
Bronze 60 HSA	$230.99	$269.13	17%	$294.03	$342.58	17%	$624.42	$727.51	17%
Gold 80	$334.78	$394.22	18%	$426.15	$501.81	18%	$904.98	$1,065.65	18%
Min. Coverage	$223.39	$248.09	11%	$284.35	$315.80	11%	$603.86	$670.64	11%
Platinum 90	$383.62	$502.58	31%	$488.31	$639.74	31%	$1,036.99	$1,358.57	31%
Silver 70 EPO	$284.30	$311.47	10%	$361.89	$396.47	10%	$768.53	$841.96	10%
Rating Area 6 Alameda County	2015 - EPO	2016 - PPO		2015 - EPO	2016 - PPO		2015 - EPO	2016 - PPO	% Change
Bronze 60	$220.52	$233.73	6%	$280.70	$297.51	6%	$596.10	$631.81	6%
Bronze 60 HSA	$216.89	$235.79	9%	$276.09	$300.13	9%	$586.30	$637.37	9%
Gold 80	$314.35	$345.38	10%	$400.14	$439.64	10%	$849.75	$933.63	10%
Min. Coverage	$209.75	$217.36	4%	$267.00	$276.68	4%	$567.00	$587.56	4%
Platinum 90	$360.20	$440.32	22%	$458.50	$560.48	22%	$973.69	$1,190.26	22%
Silver 70	$266.95	$272.88	2%	$339.80	$347.35	2%	$721.62	$737.65	2%
Rating Area 9 Central Coast	2015 - EPO	2016 - PPO		2015 - EPO	2016 - PPO		2015 - EPO	2016 - PPO	% Change
Bronze 60 EPO	$232.63	$290.03	25%	$296.12	$369.18	25%	$628.85	$784.00	25%
Bronze 60 HSA	$228.81	$292.58	28%	$291.26	$372.43	28%	$618.52	$790.90	28%
Gold 80 EPO	$331.62	$428.57	29%	$422.12	$545.54	29%	$896.44	$1,158.52	29%
Min. Coverage	$221.28	$269.71	22%	$281.67	$343.32	22%	$598.16	$729.08	22%
Platinum 90 EPO	$379.99	$546.38	44%	$483.70	$695.49	44%	$1,027.19	$1,476.96	44%
Silver 70 EPO	$281.62	$338.61	20%	$358.48	$431.02	20%	$761.27	$915.33	20%

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Date: August 25, 2015

To: Consumers Union

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

Re: Review of California Physicians' Service dba Blue Shield of California
DMHC Individual On and Off Exchange Rate Filing Dated June 5, 2015
HOrg02I Individual Health Organizations - Health Maintenance (HMO)
HOrg02I.005A Individual - Preferred Provider (PPO)
SERFF Tracking #: BCCA-130112529

As you requested, we have reviewed the above captioned filing submitted by California Physicians' Service ("Blue Shield") to the Department of Managed Health Care (DMHC).[1,2,3] Blue Shield is requesting a rate increase of 4.6% with an effective January 1, 2016.[4,5] The total annual premium increase being requested is about $220 million[6], with an average increase per policyholder of $624.[7]

In evaluating the rate proposal by Blue Shield, three overall characteristics of the company can be considered.

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[1] This analysis was provided to assist Consumers Union (CU) in its evaluation of the Blue Shield 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 eight PDF files and seven EXCEL files. These were available at: http://wpso.dmhc.ca.gov/ratereview/Detail.aspx?lrh= kMogolOcn98%24

[4] Blue Shield filing, Filing at a Glance Section and Company Rate Information Page

[5] The range of rate changes is from a minimum of a -9.5% decrease to a +43.8% increase. *Ibid.* Blue Shield has not explained why some policyholders would receive such extremely large rate increases.

[6] *Ibid.*

[7] $220,539,364 (written premium change) / 353,567 (number of policyholders affected for this program); *Ibid.*

First, according to the financial reports filed by Blue Shield, its Tangible Net Equity as of June 30, 2015 of $4.080 billion exceeds the Required Net Equity of $334 million by $3.746 billion.[8,9] Put another way, the actual Tangible Net Equity for Blue Shield is equal to 1,222% of the Required Net Equity.[10] Blue Shield 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 Blue Shield is for an increase of around $220 million. This is only about 6% of the Tangible Net Equity Excess reported by Blue Shield.

Second, Blue Shield's profitability for the individual line of business since the beginning of 2014 has been significant. Blue Shield's 2014 individual business medical loss ratio calculated in accordance with the ACA requirements was only 76.8% and a rebate of about $62 million was required.[11] Blue Shield achieved this low ratio and correspondingly high profits at the same time that its individual book of business increased significantly, from enrollment of 71,067 at the start of 2014 to 503,829 at the end of 2014.[12]

Third, Blue Shield appears to be spending policyholder funds on items that are not appropriately charged to policyholders. These unnecessary expenditures may be related to why Blue Shield is proposing a significant increase in its administrative expenses.[13]

Our analysis shows that the proposed rate increase is likely inflated and unreasonable for various reasons including Blue Shield's use of an excessive Overall Annual Medical Trend Rate of +6.5% a year.[14,15]

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[8] Blue Shield June 30, 2015 financial statement filed with DMHC

[9] The Total Net Equity for Blue Shield at June 30, 2015 was $4.246 billion. The total net equity reflects $167 million in "Unsecured Receivables from officers, directors and affiliates; Intangibles" that is not included in the Tangible Net Equity

[10] 12.22 = $4.080 billion / $334 million

[11] Medical Loss Ratio report on DMHC website

[12] Blue Shield 2014 Annual statement filed with DMHC

[13] Blue Shield is proposing a 28% increase in Medical Administrative Expenses PMPM from $28.28 in 2015 to $36.13 in 2016 (36.13 / 28.28 = 1.278); Blue Shield Filing, Milliman report, page 7

[14] Blue Shield Filing, California Rate Filing Form, Item 18

[15] There is some uncertainty regarding the actual trend used by Blue Shield, since various places in the Blue Shield filing show varying trend values. The Milliman report shows an annual trend value of 6.4%. The Blue Shield Actuarial Memorandum shows trends for 2015 and 2016 of 6.2% and 6.5%, which averages to 6.35%.

Other concerns with the Blue Shield filing include:

- Administrative Expenses
- Impact of Migration from Group to Individual Market
- Risk Transfer and Reinsurance
- Cost Containment Issues
- Lack of Documentation of Ratemaking Factors
- Failure to Account for Reduction in Uncompensated / Charity Care

A more detailed discussion of issues with the Blue Shield filing follows.

1. <u>Excessive Annual Medical Trend Rate</u>

The Blue Shield filing is based upon an Annual Medical Trend Rate of +6.5% a year, which includes a prescription drug trend of 11.3% a year.[16] The filing was essentially devoid of any basis for that value. The filing contained two general vague descriptions related to the trend.

The Milliman report stated "A summary of anticipated claim cost trends by service category is shown as Appendix C-3. I have reviewed the methodology and assumptions used in developing the proposed premium rates and found the methodology and assumptions to follow generally accepted actuarial practice."[17] The Actuarial Memorandum stated "Trend factors are derived from historical Blue Shield experience."[18] However, in neither place were any data, analyses or calculations provided.

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[16] Blue Shield Filing, California Rate Filing Form, Item 19; The values shown for prescription drugs for "Trend attributable to use of services" is 0.7% and for "Trend attributable to price inflation" is 10.5%; 11.3% = (1.007 X 1.105 – 1) X 100%. By contrast, the Milliman Report shows the same 6.4% annual trend for all benefit categories, including prescription drugs (Appendix C-3 - Development of Claim Cost Trends). It is unclear why different parts of the Blue Shield filing show varying numerical values for trend factors.

[17] Page 4

[18] Section 6i

Given this lack of information in the Blue Shield filing, we reviewed other sources of information regarding an appropriate trend factor. These sources are consistent with a medical loss trend lower than 6.5%.

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."[19]

The medical trend used by Blue Shield is more than twice as much as the 3.0% annual trend used by Kaiser. The Kaiser filing for rates effective January 1, 2015 states "The Plan has projected an overall Medical Trend of 3.0%."[20] Milliman, the actuarial firm that provided the Independent Actuarial Certification for both the Blue Shield and Kaiser filings, stated in relation to the 3.0% trend used in Kaiser filing that "I have reviewed the methodology and assumptions used in developing the proposed premium rates and found the methodology and assumptions to follow generally accepted actuarial practice."[21,22,23]

Blue Shield claims there are two main drivers of the proposed rate increase – those being Core Trend and the Transitional Reinsurance Program.[24] With regard to the Core Trend issue; Blue Shield states "Rates for Blue Shield are also impacted by the growth in high cost specialty drugs, led by expensive new drugs like Sovaldi. The proliferation of these high cost drugs, and continued increases in pricing for existing drugs, have a direct impact on rates to our members." However, 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,

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

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

[21] *Ibid.*, Milliman Report – Page 4

[22] The same actuary from Milliman, Ms. Susan E. Pantely, provided the independent actuarial certification for both the Blue Shield and Kaiser filings.

[23] The trend used by Kaiser and found to be appropriate by Milliman split by medical component was 2.5% for everything other than prescription drugs and 9.1% for prescription drugs. *Ibid.*, Milliman Report – Appendix C-1

[24] http://wpso.dmhc.ca.gov/ratereview/Detail.aspx?lrh= kMogolOcn98%24; File Name "2016 Part II Rate Justification DMHC"

PBM [Pharmacy Benefit Managers] forecasts were systematically overstated – sometimes by as much as nine percentage points for near term forecasts."[25]

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 Blue Shield Blue Cross".[26] The stated goals of Cal INDEX include:[27]

- 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 CalINDEX 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 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."[28]

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.

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

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

[27] *Ibid.*

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

All of this information demonstrates that the overall annual cost trend of +6.5% a year, as well as the prescription drug trend of 11.3% a year, used by Blue Shield are both excessive and unsupported.

2. Administrative Expenses

The provision included in rates for administrative expenses increased significantly from 2015 to 2016, by 27.0%, as shown in the following table.

Expense Category		2015		2016	Change
Medical Administrative PMPM	$	28.28	$	36.13	27.8%
Pediatric Administration PMPM	$	1.03	$	1.08	4.9%
Total General & Administrative PMPM	$	29.31	$	37.21	27.0%

Source: Milliman Report, page 7, item 16

A sufficient explanation was not provided by Blue Shield for this large increase. The filing only states "Administrative expense load assumptions were developed from Blue Shield historical expense costs, with appropriate trend adjustments to 2016."[29] We do not believe it is reasonable to assume that expenses PMPM will increase 27% from 2015 to 2016.

These expenses as a percent of premium increased from 7.80% for 2015 to 9.28% in 2016, which would increase the rates by about 1.5%.[30,31] We do not believe that this increase in administrative expenses was justified.

[29] Actuarial Memorandum, page 6, Section VIIIa

[30] Milliman Report, page 7, item 16

[31] The Blue Shield filing claims that the increase in administrative expenses results in a -1.6% decrease in rates. (Actuarial Memorandum, page 1, item II) No explanation was provided by Blue Shield as to why they believe a significant increase in the administrative expenses would have the impact of decreasing rates.

3. Impact of Migration from Group to Individual Market

Blue Shield claims that migration from the group market to the individual market will increase costs, stating "The migration from group coverage to the Individual market is expected to increase the overall morbidity of the insured population, as we have compared the relative health of our own members who have migrated from group coverage."[32] Blue Shield alleged this would have a 1.7% impact in 2015 and a 1.2% impact in 2016. However, Blue Shield did not provide any actual data or analysis to support its assertion.

Milliman examined the issue of the impact of migration from the group to individual market and stated "Based on our analyses of this limited information, along with Milliman data on morbidity differences that are due to underwriting change and case size from our 2014 Health Cost Guidelines™ and experience of the consultants conducting this analysis, we believe the difference in morbidity levels may be between 10% and 20% higher in the individual public exchange compared to the large group employer-sponsored insurance market."[33] Milliman further projected that based upon this difference in morbidity, the impact of migration from the group to individual market could ***reduce*** public exchange premiums from -3.3% to -11.7%.[34] These results by Milliman, who performed the actuarial certification for this filing, are the complete opposite of what was assumed by Blue Shield in its rate calculations.

Based upon the Milliman report, the migration from the group to individual market can be expected to result in lower premium rates as opposed to higher rates as was assumed by Blue Shield.

4. Risk Adjustment and Reinsurance

The Blue Shield filing reflects projected risk adjustment and reinsurance amounts PMPM of $21.92 and $22.10, respectively.[35] The filing was essentially devoid of support for these specific amounts.

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[32] Actuarial Memorandum, page 3, Section Va

[33] "Employer-sponsored health insurance migration to public health insurance exchanges: Potential effect on exchange premiums", Milliman, December 2014, http://us.milliman.com/insight/2015/Employer-sponsored-health-insurance-migration-to-public-health-insurance-exchanges-Potential-effect-on-exchange-premiums/

[34] *Ibid*.

[35] Actuarial Memorandum, page 6, Section VII - This reinsurance amount is gross of the fee of $2.25. On a net basis after the fee, the reinsurance amount is $19.86.

With regard to risk adjustment the filing states "Our risk adjustment projections are based on the results from a statewide study conducted by an external consulting firm."[36] The filing, however, does not identify the consulting firm, provide any details about this study or provide any numerical values from the study applicable to the market as a whole or Blue Shield specifically. The reliability of that study is called into question by the fact that for 2014, the actual risk adjustment payments to Blue Shield of $135 million[37] exceeded the amount projected by Blue Shield based upon that study of $113 million[38] by about 19%. A similar understatement of risk adjustment recoveries based upon that model for 2016 would result in an inflated rate indication.

On the issue of reinsurance the filing states "We estimated the percentage of claims that would be covered by the temporary reinsurance program based on 2014 experience."[39] The filing, however, does not explain how this estimate was made, provide any of the information used, or explain how that data was analyzed.

The virtual complete absence of meaningful data and information regarding how the specific numerical values in the filing were derived, makes it is difficult to analyze and evaluate the particular figures used for the projected risk adjustment and reinsurance amounts.

5. <u>Cost Containment Issues</u>

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

The applicable statute requires Blue Shield to include specific information on cost containment issues:[40]

> (c) A health care service plan subject to subdivision (a) shall also disclose the following aggregate data for all rate filings submitted

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[36] *Ibid.*

[37] *Summary Report On Transitional Reinsurance Payments And Permanent Risk Adjustment Transfers For The 2014 Benefit Year*; June 30, 2015; https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/RI-RA-Report-Draft-6-30-15.pdf

[38] Actuarial Memorandum, page 2, Section IIIc

[39] *Ibid.*

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

> 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 Blue Shield filing did not contain relevant useful information on the issue of cost containment. The filing includes a value for Quality Improvement Expense of $2.56 PMPM.[41] This is a decrease of -25% below the value of $3.42 from the prior filing.[42] 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 Blue Shield, but also other insurance companies, as well as health care providers. It has been estimated that about 30% of health care expenditures are wasted.[43] 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. Various programs can be expected to control, and have reduced, health care costs.

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

[41] Milliman Report, Appendix C-1 - Projected Medical Loss Ratio - The derivation of this value was not provided.

[42] SERFF Tracking #: BCCA-129656912, Milliman Report, Appendix C-1 - Projected Medical Loss Ratio - The derivation of this value was not provided.

[43] 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%.

6. Blue Shield Filing Included Numerous Factors That Were Not Adequately Supported

The derivation of the January 1, 2016 Rates by Blue Shield was based upon numerous assumptions for which adequate support was not provided. We previously discussed the medical trend factor and showed that the annual value of 6.5% included in the Blue Shield filing was excessive and unsupported.

Blue Shield provided the following as the drivers of the rate increase.[44]

Updated Experience	0.7%
Core Trend	6.0%
Health Status	0.4%
Reinsurance	4.1%
Changes in Benefits	0.4%
Risk Adjustment	-5.2%
Other	0.0%
Administrative Expenses	-1.6%
Margin (before taxes)	0.0%
2016 Rate Increase	4.6%

It is unclear why updated experience would cause the rates to increase. The 2014 experience period underlying this filing was favorable for Blue Shield; and a Medical Loss Ratio Rebate from Blue Shield to policyholders of about $62 million was required based upon that experience.

An important consideration in projecting the experience for 2016 is that it is likely that the mix of customers enrolling for health coverage in 2016 will be younger and healthier than those who signed up for 2014. This expected difference in the health status between the early enrollees in 2014 compared to later enrollees 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.”[45] Furthermore, it is probable that the people with underlying health concerns that could drive pent-up demand likely obtained coverage in 2014 and had those problems addressed. Therefore, pent-up demand should be less

[44] Actuarial Memorandum, page 1, Section II

[45] “Drivers of 2015 Health Insurance Premium Changes,” http://www.actuary.org/content/actuaries-shed-light-2015-health-insurance-premium-changes

of an issue in 2016 than 2014.

Milliman has stated the following with respect to morbidity in 2015 compared to 2014:[46]

> 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:[47]

> 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".[48]

The Society of Actuaries studied the issue of pent-up demand for newly enrolled in 2014 and found it to exist.[49] The study stated "Pent-up demand has been studied for years, and there is

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

[47] *Ibid*.

[48] 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

[49] 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

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.

With regard to Administrative Expenses, we previously discussed the unsupported increase of 27% in overall administrative expenses included in the filing.

With regard to profit, it has already been pointed out that Blue Shield has about $3.7 billion of Tangible Net Equity Excess. Therefore, instead of increasing the profit provision included in its filing, Blue Shield could easily have kept its profit provision at the same level or even lowered that value. The filing states "The proposed rate increase reflects an expected contribution to surplus of 2.09% or $8.37 PMPM. Please note that this represents an increase of 0.1 % from 2015."[50,51] This is the second year in a row that Blue Shield increased the profit included in the rates charged to policyholders.[52] Blue Shield has more than sufficient Tangible Net Equity to operate with a 0% profit provision during 2015 and still be in a financially secure position.[53]

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

7. <u>Failure to Account for Reduction in Uncompensated / Charity Care</u>

Blue Shield 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.

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[50] Actuarial Memorandum, page 7, Section VIIIb

[51] Since Blue Shield admits that it is increasing the profit provision included in its rates, it is unclear why Blue Shield also claims this has a 0.0% impact on the proposed rates.

[52] The prior Blue Shield filing stated "Proposed pricing reflects an expected contribution to surplus of 1.95% or $7.35 PMPM. Please note that this represents an ***increase*** of 0.8% from 2014 and better aligns with our commitment to limit annual net income to 2% of revenue across the company." Blue Shield filing, SERFF Tracking #: BCCA-129656912, Actuarial Memorandum, Section 9b (emphasis added)

[53] Even without an explicit profit provision, Blue Shield can expect earnings from investment income, which would increase the Tangible Net Equity.

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.

Blue Shield's filing is silent on this issue, and hence it is not possible to know what, if any, consideration Blue Shield 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."[54] The savings in states that expanded Medicaid were higher than average, with a total savings of $5.0 billion and a 26% reduction in uncompensated care costs.[55]

Historically there has been a large amount of uncompensated medical care in California, which has been estimated at $2.4 billion for 2010.[56] As the uninsured population in California decreases as a result of the Affordable Care Act[57], 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.

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[54] *Insurance Expansion, Hospital Uncompensated Care, And The Affordable Care Act*; March 23, 2015; http://aspe.hhs.gov/pdf-document/insurance-expansion-hospital-uncompensated-care-and-affordable-care-act

[55] *Ibid*.

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

[57] 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

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%.[58]

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."[59]

The Blue Shield 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[60]:

- 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.

[58] 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

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

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

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.”[61]

A decrease in the uninsured population is consistent with the very large increase in the number of people insured with Blue Shield in California during 2014. The number of PPO Individual enrollees with Blue Shield increased from 71,067 at December 31, 2013 to 503,829 at December 31, 2014 to 587,646 at June 30, 2015.[62]

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.”[63]

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 Blue Shield’s rate proposal.

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.

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

[62] Blue Shield Annual and Quarterly reports to DHMC; Report #4: Enrollment and Utilization Table

[63] 2014 Milliman Medical Index, http://us.milliman.com/uploadedFiles/insight/Periodicals/mmi/pdfs/2014-mmi.pdf