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POLICY & ACTION FROM CONSUMER REPORTS

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Division of Premium Rate Review
Department of Managed Health Care
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Via email to: Wayne.Thomas@dmhc.ca.go

Re: Consumers Union's comments on Blue Cross of California (dba Anthem Blue Cross) Rate Filing, SERFF Tracking Number AWLP-130652521

Dear Chief Actuary Thomas:

Consumers Union, the policy and advocacy division of Consumer Reports, writes to provide you with comments on the Blue Cross of California (dba Anthem Blue Cross) Rate Filing, SERFF tracking Number AWLP-130652521, for the individual market. In addition to the review in the attached memorandum by our consulting actuary, Allan I. Schwartz, Consumers Union draws DMHC's attention to the following:

I. The rates proposed by Anthem—the second highest proposed in the California individual market—would further perpetrate rate instability and propel consumers towards excessive rate increases in the future.

II. This rate filing is characterized by unjustified assertions, such as those regarding medical trend projections as well as cost containment and quality improvement expenditures.

III. Anthem seeks to increase its administrative expenses and profit margin in a year where they propose vastly steeper rate increases than in recent years.

IV. Unique characteristics about Anthem and its products exist, demanding added scrutiny by the DMHC.

Californians must have a better understanding of the rate filings and the eventual DMHC decision. We therefore provide suggestions where the Department can give consumers a better understanding of the review process, and why their costs are going up.

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I. Anthem's proposed large rate increase perpetrates rate instability and propels consumers towards excessive rate increases in the future

Plan Year	Anthem Proposed Increase	Statewide Average Proposal
2014	7.2% (finalized)	N/A
2015	5.8%	4.2%
2016	5.7%	4.0%
2017	17.2%	12.1%

Anthem is no stranger to claims that its business practices are counter to the interest of consumers. In 2010, the House of Representatives Subcommittee on Oversight and Investigations of the Committee on Energy and Commerce convened specifically to address outsized rate increases by Anthem. That year, Anthem notified nearly 700,000 policyholders of rate increases of as much as 39%.[1] At the time, the proposed rate increase was called a "national problem," and it ignited the flames that launched the Affordable Care Act (ACA). Past behavior does not necessarily equate with future misconduct, but patterns of behavior are worthy of consideration. In this case, rate increases proposed by Anthem consistently outpace the California marketplace, as shown at right. Despite that, Anthem is one of the largest plans in California, with arguably outsized muscle in negotiations with providers and drug companies. This must put regulators on alert. What is clear, for Anthem policyholders, is the only thing they can count on, like death and taxes, is that their health plan rates will continuously and steeply rise.

Regions Where Anthem is the Highest Cost Product	
Region	Anthem Product
3 – Greater Sacramento	Anthem HMO[1]
4 – San Francisco County	Anthem EPO
5 – Contra Costa County	Anthem EPO
6 – Alameda County	Anthem EPO
9 – Santa Cruz, San Benito, Monterey	Anthem PPO
12 – Central Coast	Anthem PPO
15 – Los Angeles County, partial	Anthem EPO
16 – Los Angeles County, partial	Anthem EPO
17 – Inland Empire	Anthem EPO
18 – Orange County	Anthem EPO
19 – San Diego County	Anthem EPO

Year after year of outsized rate increases compound, and all but normalize, huge rate hikes. Consumers will never be desensitized to the sting of large rate increases, but it does make the outcome seem inevitable. It also sets a foundation for Anthem products to be excessively costly for consumers into the future. Proof of that theory is already available: as shown in the table at left, Anthem's proposed 2017 health plan products are the highest cost of all products being offered in the same category (Silver) in 11 of 19 regions in the state. Even more troubling, eight of those products are EPOs, which historically attract consumers with the promise of the flexibility of a PPO product at a lower price point. However, the devil is in the details. When it comes to EPOs, consumers pay the price for freedom of choice with the reality

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[1] *Premium Increases by Anthem Blue Cross in the Individual Health Insurance Market,* Before the Subcommittee on Oversight and Investigations of the House of Representatives Committee on Energy and Commerce, , Serial No. 111-97, February 24 2010. Available at https://www.gpo.gov/fdsys/pkg/CHRG-111hhrg76009/html/CHRG-111hhrg76009.htm.

that they may be free to choose, but their options will be extremely limited. Ultimately for consumers, what this means is expensive products with no option of going out-of-network with any amount of insurance coverage. Anthem's practice of pushing the envelope and raising premiums as far as it can without having regulators throw a flag on the field means that excessive insurance rates are all but guaranteed now and in the future.

II. This rate filing is characterized by unjustified claims, such as medical trend projections as well as cost containment and quality improvement expenditures

The rates proposed by Anthem are based on unjustified medical trend projections

In its rate filing justification (RFJ), Anthem projects an annual pricing trend of 9.55%, citing changes in "contracting, cost of care initiatives, workdays, costs associated with Hepatitis C … and expected introduction of generic drugs." This far-outstrips the much more moderate medical trend projection of 5.6%, from the national health expenditure projection for 2017-2019,[2] as well as the 6.5% projection from PricewaterhouseCoopers LLP.[3] Notably, the overall medical trend projected by Anthem is by far the highest of, and in contradiction to, those offered by other health plans selling in the same California market, as shown below.

Type of Trend in Rate Filings	Anthem Blue Cross	Health Net	Kaiser
Overall medical trend	**9.55%**	**5.90%**	**2.20%**
Inpatient Hospital cost	3.10%	6.10%	1.70%
Inpatient Hospital Utilization	4.70%	1.50%	N/A
Outpatient Hospital cost	3.10%	6.00%	N/A
Outpatient Hospital Utilization	4.70%	1.50%	N/A
Professional Cost	3.10%	5.50%	N/A
Professional Utilization	4.70%	1.50%	N/A
Prescription Drug Cost	8.30%	11.00%	6.00%
Prescription Drug Utilization	8.70%	0%	N/A

Finally, not only is Anthem sparing with hard data to support its trend projections but also, according to its outside consulting actuary, the medical trend factor was derived using "a sophisticated medical trend model." [4] It is easy to shield flawed assumptions, double counting, inappropriate weighting, and other mistaken rating data from public view by using a proprietary tool that relies on algorithms whose components are not disclosed. ***The Department, therefore, should demand access to both the data and the medical trend algorithm model to analyze***

[2] National Health Expenditure Projections 2015-2025, CTR. FOR MEDICARE AND MEDICAID SERVICES (Last updated: July 14, 2016), https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsProjected.html.

[3] PRICEWATERHOUSECOOPERS LLP, *Medical Cost Trend: Behind the Numbers 2017*, at 2 (June 2016).

[4] Actuarial Services & Financial Modeling ("ActMod") Report, Pages 6-7.

and verify the appropriateness and accuracy of the medical trend conclusion drawn from them.

Unjustified pharmaceutical trend

For years now, the health plans have cited breakthroughs in the treatment of Hepatitis C as the cornerstone of their defense of astronomical prescription drug cost projections. Anthem is back at it again, for the 2017 plan year, basing its high medical trend projection in part on "high-cost drugs for treating Hepatitis C." We agree that pharmaceutical costs, especially those of specialty drugs, pose a challenge to the promise of affordable healthcare. However, the line must be drawn when health plans such as Anthem continue to leverage headlines about high cost drugs in order to artificially inflate claims projections.

Anthem fails to acknowledge that the cost of treating Hepatitis C *will likely decrease* in 2017. As recently as June, 2016, a new Hepatitis C drug gained FDA approval. At a list price of $74,760 for a 12-week course of treatment, Epclusa has a lower sticker price than Sovaldi ($84,000) and Harvoni ($94,500) and may be even more successful at treating Hepatitis C in some patients.[5] In addition to these drugs, the market for Hepatitis C treatment is crowded with a few additional options offered by other pharmaceutical manufacturers. As a result, Gilead Sciences, Inc., a major Hepatitis C drug manufacturer, recently cut its product sales forecast for 2016 and reported its quarterly sales for its Hepatitis C drugs failed to meet expectations.[6]

The Chief Financial Officer & Executive Vice President of Gilead recently explained to analysts that Hepatitis C drug sales were:

> *"down 33% year over year, driven by lower revenues per patient as a result of increased rebates and discounts due primarily to payer mix and lower patient starts for Harvoni as the initial group of warehouse patients was treated in 2015."*[7]

While not as upfront about the predicted reduction in revenues as was Gilead's officer, responding to investor questions about Merck's ability to sustain high prices long-term given the increasing number of treatment options, an Executive President / President Global Human Health from Merck did not assert its intent, or ability, to do so; rather, his response was that

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[5] Caroline Chen, *Gilead's New Hepatitis C Drug Approved by FDA, Priced at $74,760,* BLOOMBERG, June 28, 2016. Available at http://www.bloomberg.com/news/articles/2016-06-28/gilead-wins-fda-approval-of-hepatitis-c-drug-for-all-genotypes.

[6] Bloomberg, *Gilead Shares Slide as Product Sales Forecast Revised Lower*, July 25, 2016. Available at http://www.bloomberg.com/news/articles/2016-07-25/gilead-lowers-2016-net-product-sales-forecast-shares-slide.

[7] John F. Milligan, Transcript of Gilead Sciences (GILD) On Q2 2016 Results – Earnings Call (July 25, 2016).

Merck would "continue to think about the right ways to do pricing and contracting."[8] Not exactly the voice of an organization likely to wring every last dollar from the plans, as Anthem would have us believe. Even a senior actuarial director at Cigna—Anthem's would-be merger partner—has stated that the Hepatitis C cost trend is declining.[9] The price of these drugs appears to be coming down, yet Anthem continues to use Hepatitis C treatment as a justification for high prescription drug trends.

Let us not forget that the sticker price of these specialty drugs is just that: a sticker price. And as anybody familiar with drug pricing will agree, health plans do not pay sticker price. What they do pay is generally aggressively negotiated down by pharmacy benefit managers ("PBM"),[10] such as Express Scripts; the final agreed-upon price is, infuriatingly, frequently shrouded from the public and regulators. That said, more competition in specialty drugs is likely to increase the ability of PBMs to get larger discounts.[11] And, as the Chief Actuary for Kaiser Foundation Health Plan has stated, better management and pricing should mediate the specialty drug trend in 2017.[12] Indeed, Kaiser is making good on its Chief Actuary's statement with a prescription drug trend of only 6.0%,[13] while **Anthem uses a 17.7**%[14,15] combined prescription drug trend. While we see that Anthem adjusted its experience claims data with a $5.92 decrease "to reflect anticipated Rx rebates,"[16] without actual tangible data about those rebates, both looking forward and accounting for historic savings, it is hard to gauge whether the adjustment here is accurate. Even the outside actuary hired to certify the Anthem rate filing lacked the data to truly certify that this reduction is adequate; rather, the outside actuary stated he accepted Anthem's $5.92 adjustment "without detailed review."[17] ***We urge DMHC to demand this detailed information in order to protect California consumers.***

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[8] Transcript of Q2 2016 Merck & Co Inc. Earnings Call (July 29 2016), http://s21.q4cdn.com/755037021/files/doc_financials/quarterly/2016/Q2/MRK-Transcript-2016-07-29T12_00.pdf.

[9] PRICEWATERHOUSECOOPERS LLP, *Medical Cost Trend: Behind the Numbers 2017*, at 12 (June 2016).

[10] Caroline Humer, *Express Scripts' Miller Says Hepatitis C Price War to Save Millions*, January 22, 2015. Available at http://www.reuters.com/article/us-express-scr-hepatitisc-idUSKBN0KV26X20150122.

[11] PRICEWATERHOUSECOOPERS LLP, *Medical Cost Trend: Behind the Numbers 2017*, June 2016, at p.11.

[12] Id. at 12

[13] Rate Filing Justification of Kaiser Foundation Health Plan, Inc. SERFF Tracking Number KHPI-130516678, at 3 (July 7, 2016). https://ratereview.healthcare.gov/files/438734_2017KFHPIndividualActuarialMemorandum.pdf

[14] Blue Cross of California d/b/a Anthem Blue Cross, *California Rate Filing Form*.

[15] The drug trend of 17.7% a year is composed of "Trend attributable to use of services" of +8.7% and "Trend attributable to price inflation" of +8.3%. (California Rate Filing Form – Item 19) 17.7% = (1.087 x 1.083 – 1) x 100%

[16] Actuarial Memorandum of Anthem Blue Cross (licensed by DMHC), completed by Michael Polakowski, FSA, MAAA, at p.5. https://ratereview.healthcare.gov/files/1520140_20160718CA27603IndActuarialMemorandumRedactedAM.pdf

[17] Report prepared by Actuarial Services & Financial Modeling, Inc. as Requested by Anthem Blue Cross regarding Individual Rates to be Filed with the California Department of Managed Health Care for Health Care Plans with an Effective Date of January 1, 2017. Report dated August 5, 2016.

Finally, the increase in utilization projected by Anthem is also troubling. First, its projection is **more than double** that of the next highest projection—**8.7% versus 3.9**%. We urge DMHC to carefully probe the basis for Anthem's expectation that its policyholders will have such a steep uptick in prescription drug use, especially in light of Gilead's Chief Financial Officer & Executive Vice President's prediction of "lower patient starts for Harvoni as the initial group of warehouse patients was treated in 2015."[18] A 2015 class action lawsuit filed against Anthem, claimed that the plan "repeatedly ignor[ed] treating physicians' recommendations" and prevented policyholders from accessing this high-cost treatment at all.[19] In 2017, does Anthem contemplate making specialty drugs such as Hepatitis C treatment more accessible to policyholders, thereby releasing pent-up demand the plan actually created itself? If so, has Anthem properly credited the drop in healthcare utilization as policyholders are cured of the disease? Any answers, of course, are mere speculation at this point, given the dearth of supporting information in the Anthem filing. ***We therefore urge DMHC to demand Anthem bolster its medical trend projections with real and substantive information justifying its assertions.***

Unjustified health care provider cost trends

As discussed earlier, in all but five (out of 19) regions in 2017, Anthem will offer EPO products rather than PPO Products. For consumers electing to purchase an EPO, rate increases may be steep. As the State of California Office of the Patient Advocate (OPA) explains, "EPOs often have smaller provider networks and other plan features that are designed to keep your costs affordable."[20] It is therefore striking that rate increases associated with Anthem's EPO product are nearly universally in the double-digits and exceed the statewide average in fourteen of the nineteen regions. Also, Anthem projects a 3.1% increase in professional costs while its closest

2017 Proposed Rate Increases Anthem EPO Versus Statewide Average			
Region	Statewide average change	Anthem EPO average change	Anthem EPO range
1	12.10%	10.50%	5.9 – 14.8%
2	12.50%	27.90%	22.7 – 33%
3	13.40%	19.50%	14.8 – 24.4%
4	14.80%	16.70%	12 – 21.6%
5	13.60%	22.60%	17.9 – 27.8%
6	12.30%	23.70%	18.6 – 28.5%
7	9.20%	8.40%	4.2 – 12.9%
8	11.70%	20.00%	15.3 – 24.9%
9	28.60%	31.00%	25.9 – 36.4%
15	16.40%	27.00%	21.9 – 32.3%
16	13.90%	26.30%	20.7 – 30.1%
17	10.10%	18.20%	13.4 – 22.9%
18	14.40%	21.70%	17.3 – 27.4%
19	10.00%	25.80%	21.1 – 31.5%

[18] John F. Milligan, Transcript of Gilead Sciences (GILD) On Q2 2016 Results – Earnings Call (July 25, 2016).

[19] Shima Andre v. Blue Cross of Cal. dba Anthem Blue Cross, No. BC 582063 (Cal. Super. Ct. filed May 15, 2015).

[20] State of California Office of the Patient Advocate, "What is an EPO" web page, available at http://www.opa.ca.gov/Pages/WhatIsanEPO.aspx (accessed July 26, 2016).

competitor, Blue Shield, is offering PPOs in every region, along with a mix of HMO products in some regions, and its professional costs trend is a comparatively low 1.7%.[21] Clearly, Anthem is not harnessing this product conversion from PPO to EPO as an opportunity to identify savings negotiated for consumers.

A consumer's choice of saving money by opting for a narrower network health product is a trade-off some consumers may prefer. However, when that deal only comes with the stick and no carrot, it is not a trade-off, it's just a rip-off. ***We therefore urge DMHC to require Anthem to explain to the regulator and consumers: why is a product defined by limited choice so much more expensive and who is reaping the savings?***

Unjustified Utilization Trends

In its California Rate Filing Form, Anthem projects a 4.7% uptick in the use of inpatient hospital, outpatient hospital, professional, and other medical care. As is the pattern in its rate filing, Anthem's utilization trends do not come supported by solid evidence. Given that this projection contradicts that of industry experts—for example, a very recent report by PricewaterhouseCoopers LLP explains that since the early 2000s the utilization trend has declined[22]—Anthem must be called-upon to substantiate its claim.

This past year, the plans, including Anthem, noisily protested to Covered California, as well as to the federal government, that consumers that enrolled during special enrollment periods (SEP) were not just disproportionally higher cost than those enrolling during open enrollment, but also unpredictably costly. The plans alleged that these consumers were such a substantial share of their business that they needed Covered California to provide protection from the threat of consumers enrolling in plans during the special enrollment period. The plans submitted to Covered California a national study from Oliver Wyman[23] to support their assertions. However, the plans refused to produce—at least for the work group convened by Covered California—data to allow the study to be independently validated, calling into question the veracity of the study. There is also no way to know any detail about the underlying data, including how it was selected, how extensive the claimed surprise costliness of SEP claims was, and whether it specifically applied to Anthem's California experience. Furthermore, because the study was national—including markets in other states that permitted grandfathered plans—the author's conclusions are based on wholly different risk profiles than that of the California market, making the results of the study murky and potentially irrelevant. It therefore stands to question

[21] Rate Filing Justification of California Physicians' Service dba Blue Shield of California, SERFF Tracking Number BCCA-130655115, (2016), at 3.
[22] PRICEWATERHOUSECOOPERS LLP, *Medical Cost Trend: Behind the Numbers 2017*, June 2016, at 4.
[23] OLIVER WYMAN, *Special Enrollment Periods and the Non-Group, ACA-Complaint Market*, (February 24, 2016).

how Anthem may have folded their unsubstantiated concerns about special enrollment period enrollees into its rate calculation, specifically within the utilization trends.

The RFJ submitted by Anthem does not indicate how its medical trend is adjusted to account for special enrollment period enrollees, but given its vociferous role at Covered California in seeking additional documentation from those applying due to SEP triggers in order to slow down such enrollments, we strongly urge DMHC to demand detailed documentation from Anthem about the trend it used to account for the SEP population, and to break out and document the full experience for SEP enrollees in 2016. Further, we believe the additional documentation now required for SEP enrollment will likely reduce the number of SEP enrollees in 2017. Therefore, DMHC should require Anthem to explain how the reduction of allegedly costly SEP enrollees in 2017 was factored into Anthem's medical trend, both in utilization and cost level of underlying care.

Insufficient cost containment and quality improvement programming information

In addition to the questions raised in other sections of these comments, Consumers Union urges DMHC to seek more transparency from Anthem regarding its cost containment initiatives and quality improvement programming.

California's rate review law, nearly unique among the states, requires health plans and insurers such as Anthem to specify and estimate their quality improvement and cost containment efforts. Health and Safety Code §1385.03(c)(3) requires plans 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."[24] The purpose of this provision is to improve Californians' health as well as to bend the cost curve in order to make coverage affordable. Health plans in general—and Anthem in particular as one of the largest carriers in California—have the ability and the responsibility to serve as resources and partners with their members in seeking and obtaining the highest quality, most appropriate healthcare when needed. And yet, over the past two years, Consumers Union has noted universal shortcomings in the information supplied by the plans in their rate filings.

In April, 2016, Consumers Union, along with CALPIRG, the California Pan-Ethnic Health Network, and Health Access wrote to urge the Department of Managed Health Care to maintain its vigilance over plans' adherence to Health and Safety Code §1385.03(c)(3), the requirement that plans submit information on cost containment initiatives and quality improvement programming as part of their rate filing justifications (RFJs). As we noted in that letter, the cost and quality of healthcare are major consumer concerns. Yet, aside from projecting a quality

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

improvement expense that is 115% more than the value used just one year prior,[25] Anthem here submits no information on how it is addressing these issues.

This year, of all years, the expectation that the plans satisfy §1385.03(c)(3) to the fullest should pose a trivial burden, if any, given the wide breadth of reporting required by Covered California in its QHP certification process. It is therefore especially perplexing that Anthem is claiming dramatically escalated expenditures while it shortchanges DMHC in its filing and expects to get away with it. ***As DMHC knows, transparency is a foundational element of the rate review process. For Anthem to refuse to provide this information to DMHC—information that is clearly required and already available in writing—screams for enforcement from DMHC regulatory officers.***

III. Anthem seeks to increase its administrative expenses and profit margin in a year where they propose vastly steeper rate increases than in recent years

The profit margin anticipated by Anthem in the 2017 plan year is unjustified and unreasonable. Similarly, its anticipated loss ratio is unreasonable in light of the already robust ratio of tangible net equity to required tangible net equity.

For the 2017 plan year, Anthem projects that 2.27% of expenses will go towards its profit and risk margin (post-tax, net of those federal income taxes which are deductible from the MLR denominator).[26] Although on first glance this profit margin may appear unremarkable, a 2.27% profit and risk margin actually exceeds those projected in the past by nearly 10%. The projection for 2016 was 2.07%[27] and, in that year, Anthem profited so handsomely that it was able to disburse larger shareholder dividends than in the preceding years.[28] Furthermore, as a cost PMPM, the percent increase was much larger, a 26% increase from $8.25 in the prior filing to $10.52 in the current filing. Given the steep increase in rates for consumers, DMHC should ask why Anthem needs even more profits for this year. Is it for larger shareholder dividends? Or perhaps capital to support merger battles and payouts?

The fact that Anthem estimates a federal MLR of 87.24% in 2017 and did not trigger a MLR rebate for its 2016 product is likely to be a defense point for Anthem. However, that Anthem

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[25] Rate Filing Justification of Blue Cross of California dba Anthem Blue Cross, SERFF Tracking Number AWLP-130080574, Exhibit G – Non-Benefit Expenses and Profit & Risk.

[26] Anthem Blue Cross rate filing justification, Exhibit H - Non-Benefit Expenses and Profit & Risk. http://wpso.dmhc.ca.gov/ratereview/Detail.aspx?lrh=XbZWkzRmrkA%24

[27] Rate Filing Justification of Blue Cross of California dba Anthem Blue Cross, SERFF Tracking Number AWLP-130080574, (2015), at 59.

[28] *Anthem Declares First Quarter 2016 Dividend of $0.65 Per Share*, BUSINESSWIRE (18 February 18, 2016), http://www.businesswire.com/news/home/20160218006619/en/Anthem-Declares-Quarter-2016-Dividend-0.65-Share.

did not take advantage of consumers as much as it could have in the absence of the MLR is not a valid rationalization. Further, the MLR does not, standing alone, guarantee the protection of consumer interests or serve as an effective constraint on insurer premiums or profits. To wit, even with seemingly modest profits combined with record shareholder dividends, Anthem boasts a tangible net equity (TNE) over four times that which is required by the state and also far in excess of that which is required by the Blue Cross Blue Shield Association.[29,30] Two-and-a-quarter percent profit may not seem large, but as a total dollar amount, the underwiring profit (after-tax) to be charged by Anthem to policyholders is about $75 million. While the after-tax profit is the amount retained by Anthem, the actual charge to policyholders is before tax, which is about $115 million. When added to a piggybank already bursting at the seams while consumers and taxpayers foot the bill, the implications are far from reasonable.

Additionally, for the 2017 plan year, Anthem proposes increasing its administrative expenses to the highest per member per month expenditure yet over the past three years, without so much as a hint about why this year will be the most expensive. Once again, just because costs tend to go up year after year does not necessarily mean that costs *must* go up year after year. It should not be a given; Anthem should be compelled to justify why they intend to spend more on administrative functions.

IV. DMHC should consider unique facts about Anthem and its 2017 products in its review

We urge DMHC to evaluate whether the rates proposed by Anthem are reasonable and justified in light of unique facts about the plan. Namely, its large-scale conversion of PPO products into EPO products, and a costly acquisition attempt that may cost billions of dollars, even if the actual merger fails to come to fruition.

The toll on consumers of the PPO to EPO conversion must be considered in addition to the rate increases in general

The conversion of fourteen PPO products into EPO products should be given utmost scrutiny because the health plan products that Anthem proposes to sell in 2017 may be widely different from what it offered in 2016. In particular, we urge the Department to leverage its provider licensing division to compare and contrast the provider network for the 2016 PPO products

[29] According to the Quarterly Statement as of March 31, 2016, filed with the Department of Managed Health Care (DMHC) by Blue Cross of California (dba Anthem Blue Cross), Anthem holds $1.8 billion in tangible net equity in contrast to a much lower required tangible net equity of $400 million.

[30] BCBS companies to hold at least 375% of RBC-ACL to avoid triggering more active monitoring by the Association.

against the 2017 EPO product networks. It will be meaningful for consumers to know what fraction of the network will stay the same—especially if their preferred providers are no longer included—and how much more limited their provider choice will be in 2017 if they remain Anthem policyholders. We also encourage the Department to question Anthem on when its network will be finalized, whether the 2017 network will be publicly available in time for open enrollment, and what they are doing to ensure that the plan meets timely access requirements.

Making sure the $1.8 billion "break-up fee" is not paid by consumers

As part of the rate review process, we urge the Department of Managed Health Care to ensure that the costs of health plan mergers—whether they are finalized or not – do not result in elevated rates or premiums for consumers.

During the merger review process, Consumers Union voiced our concerns that these proposed mergers, if consummated, would result in higher rates. With the recent lawsuit filed by the U.S. Department of Justice (DOJ), the likelihood that these mergers will be finalized is becoming less likely. However, in agreeing to merge, Anthem and Cigna contractually bound each other to pay substantial buyouts if the deal fell through, with the payer and payee varying depending on the basis for a failure to merge. In this case, Anthem may be required to pay Cigna $1.85 billion if their defense against DOJ litigation fails.[31] **It is essential that these costs are not passed on to consumers.** One way to ensure they are not is by rigorously reviewing the rate filings submitted by these plans and ensuring that these high break-up costs are not part of the equation, overtly or covertly.

Although the medical loss ratio (MLR) requirements provide some protection for consumers from unfair prices, they are only a minimum and do not ensure that consumers are protected from being overcharged. The MLR requirements only require insurers to pay a certain percentage of their premium income for claims and quality improvement expenses. Insurers with sufficient market power can simply raise their premiums, allowing them to pay a larger medical claims amount, but also enabling them to capture greater profits because they are able to retain the same percentage of a higher level of premium revenue. If the mergers fail, these insurers may try to capitalize on this loophole to cover the substantial costs of the break-up fees. We believe the proposed 17.2% rate increase by Anthem could enable the carrier to manipulate the MLR. It is imperative that the Department of Managed Health Care ensures that any break-up fee paid by Anthem to Cigna is not incorporated into consumer costs.

[31] See Form 8-K, submitted to the United States Securities and Exchange Commission, dated July 27, 2015. Available at https://www.sec.gov/Archives/edgar/data/701221/000095012315007700/d97261d8k.htm.

V. Key factors DMHC should highlight in the rate filing to give consumers a better understanding of the DMHC decision

Californians need a clear understanding of the decision reached on the Anthem rate request. They will want, and deserve, to know the basis for any increase allowed; whether it has been negotiated down; what is and is not part of the equation. We, therefore, provide below suggestions for how the Department can give consumers a better understanding of the decision reached and what the state has done to protect their interest in reasonable rates.

Consumers Union previously asked DMHC to post a plain language summary of the rate decision for each carrier, along with the Department's rationale—which DMHC did in 2015 for 2016 rates. The key factors we believe DMHC should highlight—for Anthem and all carriers—remain the same:

- Basic features of the rate filing (requested average rate change, approved average rate change, 2016 estimated monthly premium for silver plan 40-year old in a specific region);
- The rating factors used by the carrier that were reviewed and verified by DMHC;
- How the finalized rate will impact the carrier's profit or surplus accumulation in 2016;
- Cost containment and quality improvement efforts undertaken by the carrier and estimated savings;
- Itemization of reduction(s) or modifications from the original filing, if any;
- The resulting range of rates; and
- DMHC's final rate filing decision.

An easily understandable, particularized summary aids public understanding of the dollars families are required to spend from their core budgets for health insurance. Coupling rigorous rate review with accessible information on the process and its outcomes will provide a strong framework for protecting consumers' rights, building public confidence in California's rate review system, and enabling consumers to make the right health coverage choices for their families.

We thank DMHC for providing the requested information to a certain degree in 2015 but think the Department can do even better in 2016. We encourage the Department to highlight this overview prominently on its web site, rather than simply with the rest of the rate filing. Information that is helpful to the public, and which explains the Department's work, should be promoted.

In addition to the aforementioned, we urge DMHC to provide as much information as possible to consumers about what the conversion from EPO to PPO products may mean to them. This includes:

- A lay-person friendly explanation of what is an EPO, and how EPOs differ from PPOs;

- Data on the difference between network size and composition of the EPOs Anthem will offer in contrast to the network size of the Anthem PPO product in 2016. This information may be reassuring to the public if the changes are modest, or critical to the public if they will affect what product is right for the consumer.

Conclusion

We strongly urge DMHC to demand additional documentation from Anthem to fully justify its exorbitant proposed rate increase. If Anthem is unable to provide sufficient information, given the financial burden of escalating costs on California families and in light of Anthem's strong financial footing, Consumers Union strongly urges DMHC to find the requested rates unreasonable and not justified.

Sincerely,

Dena B. Mendelsohn
Staff Attorney
Consumers Union

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Date: August 26, 2016

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 14, 2016
HOrg02I Individual Health Organizations - Health Maintenance (HMO)
HOrg02I.005A Individual - Preferred Provider (PPO)
SERFF Tracking #: AWLP-130652521

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 17.2% with an effective January 1, 2017.[4,5] The total annual premium increase being requested is about $454.6 million.[6] The average annual premium increase per policyholder is about $1,165.[7]

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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, our lack of comment on particular aspects of the filing should not be taken to mean that we agree with those data, analyses, or assumptions.

[3] The rate filing documents from the DMHC we relied upon consisted five PDF files and four EXCEL files. These were available at: http://wpso.dmhc.ca.gov/ratereview/Detail.aspx?lrh=XbZWkzRmrkA%24. The prior filing submitted by Anthem for rates effective January 1, 2016 had five PDF files and six EXCEL files. One of the EXCEL files available in connection with the prior filing that was not available in connection with the current filing was the "SRRT", which included various information, including but not limited to sheets titled "Monthly Claim – Experience" and "Actual-to-Expected".

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

[5] 17.2% is the average rate increase. The Rate Information section of the Anthem filing gives a range of rate changes from a minimum of -2.1% to a maximum of 27.8%. *Ibid.* The filing did not adequately explain the basis for this 30% range in rate changes.

[6] Anthem filing, Rate Information Page

[7] $454,562,882 (Written Premium Change) / 390,097 (Number of Policyholders Affected); Anthem filing, Rate Information Page

In evaluating the rate proposal by Anthem, three overall issues should be considered.

First, according to the financial reports filed by Anthem, its Tangible Net Equity as of June 30, 2016 of $2.138 billion exceeded the Required Tangible Net Equity of $448 million by $1.690 billion.[8,9] Put another way, the actual Tangible Net Equity for Anthem is equal to 477% of the Required Net Equity.[10] 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 $455 million. This is about 27% of the Tangible Net Equity Excess reported by Anthem. Furthermore, the Tangible Net Equity of Anthem would be much higher except that during the nine years from 2007 to 2015, Anthem paid about $4.3 billion in stockholder dividends, or an average of almost $500 million a year in stockholder dividends.

Second, the excessive equity for Anthem has been fueled by enormous profits which have increased over time. During 2014 and 2015, the net income (after-tax) for Anthem on an annual basis was $426 million and $502 million, respectively. During the first six months of 2016, the net income (after-tax) was $356 million. The annual return on equity for these three periods was 26%, 28% and 33%, respectively.[11]

Third, the filing lacked important data that would be useful in the review of the filing, such as a comparison of the actual experience for California Individual Market business during 2015 to what was expected. The absence of significant amounts of relevant information from the Anthem filing is inconsistent with reasonable regulatory and actuarial standards, impedes the review of the filing, and is a hindrance to public disclosure and transparency.

Our analysis shows that the proposed rate increase is inflated and unreasonable for various reasons including Anthem's use of an excessive overall Annual Medical Trend Rate of +9.55% a year, including an annual Prescription Drug Trend of 17.7%.

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[8] Anthem Blue Cross June 30, 2016 financial statement filed with DMHC

[9] The Total Net Equity for Anthem at June 30, 2016 was $2.179 billion. The total net equity reflects $41 million in "Unsecured Receivables from officers, directors and affiliates; Intangibles" that is not included in the Tangible Net Equity

[10] 4.77 = $2.138 billion / $448 million

[11] These values are calculated as a percent of the end of period equity. If the average equity or beginning of the period equity were used, which are acceptable procedures, the figures would be higher.

Other concerns with the Anthem filing include:

- Administrative Expenses
- Cost Containment Issues
- Profit Provision
- Lack of Support and Documentation of Ratemaking Factors
- Historically High Profits for Anthem

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

1. **Excessive Overall Annual Medical and Rx Trend Rate**

The Anthem filing is based upon an Overall Annual Medical Trend Rate of +9.55% a year, which includes a prescription drug trend of 17.7% a year.[12,13] The filing was essentially devoid of any basis for those values. The filing contained two general vague descriptions related to the trend.

One vague description was given by the outside consulting actuary retained by Anthem, which stated:[14]

> (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. Specifically, Anthem used the following approach to develop the Annual Medical Trend estimates:

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

[13] The drug trend of 17.7% a year is composed of "Trend attributable to use of services" of +8.7% and "Trend attributable to price inflation" of +8.3%. (California Rate Filing Form – Item 19) 17.7% = (1.087 X 1.083 – 1) X 100%

[14] Actuarial Services & Financial Modeling ("ActMod") Report, Pages 6 - 7

> (1) Anthem obtained Medical, Pharmacy, and Capitation "Trend Driver" factors for Calendar Years 2016 and 2017 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.
>
> (4) Since the ACA-compliant Individual health care plans do not have sufficient history for trend analysis, the corporate team responsible for the trend analysis used California small groups as the basis for its analysis.
>
> …
>
> (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 2016 and 2017 Calendar Years. This resulted in a single annual trend factor of 9.5% 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 9.55% was derived and has very little, if any, probative value.[15]

Another vague description was included in the actuarial memorandum in the Anthem filing, which stated:[16]

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[15] As discussed elsewhere, DMHC should 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. This would include the medical trend factors, as well as the "Integrated Financial Trend Model".

[16] Anthem Filing, Actuarial Memorandum, Item 6. Projection Factors, Trend Factors (cost/utilization)

- The annual pricing trend used in the development of the rates is 9.55%. 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. For projection, the experience period claims are trended 24 months from the midpoint of the experience period, which is July 2, 2015, to the midpoint of the projection period, which is July 1, 2017. Exhibit E has details.

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

This again does not provide any information regarding how the specific numerical value of 9.55% was obtained. Furthermore, Exhibit E: Projection Period Adjustments, does not contain any additional relevant information about how the value of 9.55% was derived, but instead simply lists the value as 9.55% without any support or analysis.

Since Anthem did not provide the basis for the numerical value of the annual 9.55% 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

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[17] ActMod Report, Page 6

[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." "We calculate the percentage of prior years' redundancies in the current year as a percent of prior years' net incurred claims payable less prior years' redundancies in the current year in order to demonstrate the development of the prior years' reserves. This metric was 15.1% for the year ended December 31, 2015, 9.7% for the year ended December 31, 2014 and 10.8% for the year ended December 31, 2013. The year ended December 31, 2015 metric reflects a slightly higher level of conservatism compared to the targeted prior year reserve for adverse deviation and a resultant higher level of prior years' redundancies than the years ended December 31, 2014 and 2013." Anthem, Inc. 2015 10-K, pages 62-63

loss trends, as well as the completion factors, used have turned out to be excessive. The Anthem loss projections have turned out to be excessive (i.e., favorable[19]) by more than $500 million a year, each and every year from 2013 to 2015. The values for these loss results, which are favorable to Anthem, split between the issues of trend factors and completion factors is shown in the following table (amounts shown are in millions), along with an explanation as provided by Anthem.

	Favorable Developments by Changes in Key Assumptions		
	2015	2014	2013
Assumed trend factors	$ (467.9)	$ (399.5)	$ (428.4)
Assumed completion factors	$ (332.3)	$ (142.4)	$ (170.7)
Total	$ (800.2)	$ (541.9)	$ (599.1)

> The favorable development recognized in 2015 and 2014 resulted primarily from ***trend factors in late 2014 and late 2013, respectively, developing more favorably than originally expected*** as well as a smaller but significant contribution from completion factor development. The favorable development recognized in 2013 was driven by ***trend factors in late 2012 developing more favorably than originally expected***.[20]

The annual medical cost trend of 9.55% proposed in this filing is almost 50% higher than the 6.45% used by Anthem in its prior filing.[21] That difference in trend increases the indicated rate by about 5.9%.[22] The Anthem filing is completely devoid of any reasonable basis for the 9.55% trend.

In fact, various sources show that the 9.55% annual medical trend used by Anthem is completely unreasonable and unsupported. That includes Anthem's own public statements about medical cost trends.

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[19] Anthem uses the word favorable to describe the excessive loss projections it made related to the trend factors and completion factors. See excerpt from Anthem, Inc. 2015 10-K.

[20] Anthem, Inc. 2015 10-K, page 123, emphasis supplied

[21] (9.55% / 6.45% - 1) X 100% = 48%

[22] 5.9% = ((1.0955 / 1.0645) ^ 2 – 1) X 100%), the filing uses two years of trend

Anthem has stated "While our cost of care trend varies by geographic location, based on underlying medical cost trends, we estimate that our aggregate cost of care trend was in the lower half of the 6.5% to 7.5% range for the full year of 2015. We anticipate that medical cost trends will be in the range of 7.0% to 7.5% in 2016."[23] Anthem reaffirmed that trend projection recently stating "In terms of trend on the local group side, that's actually going very well, and we reaffirmed the 7% to 7.5% outlook for that and feel very comfortable with that given the results for the first half of the year."[24]

Other sources of information regarding trends are:

- The 4.7% increase for 2016 in the Milliman Medical Index (MMI) is the lowest increase ever calculated by Milliman.[25]
- "PwC's Health Research Institute (HRI) projects the medical cost trend to be the same as the prior year – a 6.5% growth rate for 2017."[26]
- Altarum Institute found "Health spending growth is estimated at 5.1% for the first 5 months of 2016, with no discernable trend"[27,28]
- The annual trends used in the Kaiser and Health Net filings are 2.2% and 5.9%, respectively.

Both actuarial reports for Anthem reference specialty drugs for the treatment of Hepatitis C as part of the basis for the large drug trends. However, various sources indicate that future costs for these drugs will moderate, or even decrease going forward.

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[23] Anthem, Inc. 2015 10-K, page 55

[24] Edited Transcript, ANTM - Q2 2016 Anthem Inc. Earnings Call, Event Date/Time: July 27, 2016 / 12:30PM GMT, page 11, http://ir.antheminc.com/phoenix.zhtml?c=130104&p=irol-financial_information

[25] 2016 Milliman Medical Index, page 1, http://www.milliman.com/mmi/

[26] PwC Medical Cost Trend: Behind the Numbers 2017, June 2016, page 2, http://www.pwc.com/us/medicalcosttrends

[27] Altarum Institute describes itself as follows: "Altarum Institute is a nonprofit health systems research and consulting organization. Altarum integrates independent research and client-centered consulting to create comprehensive, systems-based solutions that improve health." http://altarum.org/about

[28] Altarum Institute Center for Sustainable Health Spending, Health Sector Trend Report, July 2016, page 1

Express Scripts has stated:[29,30]

> In the next three years, moderate increases in trend are likely for drugs to treat hepatitis C. Two new drugs were approved in July 2015. Daklinza™ (daclatasvir) was approved for use with Sovaldi® (sofosbuvir) to treat genotype 3 hepatitis C, and Technivie® (ombitasvir / paritaprevir / ritonavir) was approved to treat genotype 4 for patients without cirrhosis. In January 2016, the approval of Zepatier™ (elbasvir/grazoprevir) introduced another option for genotypes 1 and 4. Multiple regimens that treat more than one genotype are expected to be approved through 2018. As a result, more competition and more affordable pricing may increase utilization and help to alleviate costs.

Express Scripts projects that the future annual trend for Hepatitis C treatment will be around 9% a year, much lower than the previous very large increases that significantly impacted the overall prescription drug trends.[31]

Altarum Institute found:[32]

> Spending on prescription drugs grew by only 5.2% in May 2016, the slowest monthly rate since before the December 2013 introduction of breakthrough hepatitis C drugs.
>
> - Much of the slowdown in spending on prescription drugs can be attributed to slowing sales of the new hepatitis C drugs whose introduction pushed spending up beginning in 2014.
>
> - Company reports through Q2 2016 show that the decline in quarterly sales of hepatitis C drugs seen over the past year appears to be ending, as sales

[29] Express Scripts describes itself as follows: "Express Scripts is a prescription benefit plan provider that makes the use of prescription drugs safer and more affordable for our members. Express Scripts handles millions of prescriptions each year through home delivery from the Express Scripts Pharmacy." https://www.express-scripts.com/faq/index.html

[30] Express Scripts 2015 Drug Trend Report, March 2016, page 45

[31] *Ibid.*, page 44

[32] Altarum, *Op. cit.*, page 1

> level off (see chart). However, 2016 is still well behind 2015 in year-to-date sales. If the current rate persists through the end of the year, we will see $9.2 billion in sales for the year, compared to $13.5 billion in 2015.

The actuary employed by Anthem also identified compound drugs as a "cost driver". However, the reality is that while compound drugs may have applied upward pressure on drug trends previously, that is no longer the situation. Express Scripts has stated "Payers effectively mitigated the dramatic increases in spending on compounded medications in 2014."[33] The projected annual trend in compound drugs from Express Scripts is a ***decrease*** of about -7% a year.[34]

All of this information demonstrates that the overall annual cost trend of +9.55% a year, as well as the prescription drug trend of 17.7% a year, used by Anthem are both excessive and unsupported.

2. Administrative Expenses

The amount included for administrative costs increased by 2.4% from $31.19 PMPM in the prior filing to $31.93 in the current filing. This is somewhat higher than the annual rate of inflation as measured by the CPI, which was 1.5% in 2013, 1.6% in 2014, 0.1% in 2015 and 1.0% in 2016 (through July).

Furthermore, given the growth in business for Anthem[35] 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 increase proposed by Anthem.

In addition, Anthem has claimed elsewhere that it has been able to control its administrative expenses, as shown by the following statements:[36]

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[33] Express Scripts, *Op. cit.*, page 6

[34] Express Scripts, *Op. cit.*, page 41

[35] The total enrollees for Anthem in PPO Individual Plans were 529,002 as of 12/31/14, 549,771 as of 12/31/15 and 595,527 as of 6/30/16, based on the financial reports filed by Anthem with DMHC.

[36] Transcript, Anthem Inc. Earnings Call, *Op. cit.*, pages 4 and 7, http://ir.antheminc.com/phoenix.zhtml?c=130104&p=irol-financial_information

> Our SG&A expense ratio came in at a better than previously expected 14% in the second quarter of 2016, a decrease of 140 basis points from the prior year. This was driven by an intentional focus on administrative expense control, coupled with better-than-expected enrollment trends, as well as the changing mix of our membership towards the government business, which carries a lower than consolidated average SG&A ratio.
> …
> In terms of the G&A, I'd say the bulk of the G&A is sustainable. What we've really done is an outstanding job of fixed cost leveraging. We are increasing membership this year between 1 million and 1.2 million members and maintaining our cost structure relatively constant.
>
> We are growing. Our headcount increased in the second quarter but it increased at a far slower rate than our membership increased. Revenue's gone up about $2.5 billion for the change in guidance from the beginning of the year to today, yet the raw SG&A number is only going up very slightly. So, it really has as much to do with an excellent job of fixed cost leveraging.

The "fixed cost leveraging" refers to a situation where overhead costs such as administrative expenses are increasing at a slower rate than the number of covered members, and therefore these expenses PMPM should be decreasing. While Anthem has been telling its investors that this is taking place, it is telling DMHC the exact opposite. Anthem should be required to explain this discrepancy.

The filing fails to explain why its administrative costs are increasing faster than inflation, and also why its projection of increasing costs appears to be at odds with the statements made elsewhere by Anthem about cost control.

The filing only contained vague general comments regarding expenses 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 based on projected cost per member applied to future sales estimates. Maintenance costs are projected

for 2017 based on 2015 actual expenses with adjustments made for expected changes in business operations."[37]

This increase in administrative expenses, which is unsupported and unjustified, will cost Anthem policyholders in California over $5 million.

3. Cost Containment Issues

Given the very 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:[38]

> (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.[39]

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[37] Anthem Filing, Actuarial Memorandum, Item 11 Non-Benefit Expenses and Margin for Profit and Contingencies, Administrative Expense

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

[39] The filing simply contains a listing of "Quality Improvement initiatives" without providing any meaningful information or data regarding those. See Actuarial Memorandum, Item 11. Non-Benefit Expenses and Margin for Profit and Contingencies – Quality Improvement Expense

The filing includes a value for Quality Improvement Expense of $6.89 PMPM.[40] This is an *increase of 115%* above the value of $3.20 from the prior filing.[41] That represents a charge to policyholders of about $50 million for "quality improvement expense". This huge amount of funds allegedly being spent by Anthem appears to be inconsistent with the very high cost trends included in the filing.

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 wasted.[42] 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.[43]

Anthem should be required to: (i) actually provide the cost containment information required by the statute, and (ii) explain the discrepancy between the high cost trend it is using and the large amount proposed to be charged to policyholders for quality improvement.

4. **Profit Provision**

The provision included for the underwriting profit (after-tax) increased by 10% from 2.07% of premium in the prior filing to 2.27% in the current filing.[44] As a cost PMPM, the percent increase was much larger, a 26% increase from $8.35 in the prior filing to $10.52 in the current filing.

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[40] Exhibit H - Non-Benefit Expenses and Margin for Profit & Contingencies

[41] AWLP-130080574, Exhibit G - Non-Benefit Expenses and Profit & Risk

[42] 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%.

[43] Covered California has tried to address this issue in its contracting and certification process with the QHPs for 2017. To the extent this is successful, it should put downward pressure on costs, thereby making the medical trends and rates proposed by Anthem even more excessive.

[44] In addition to underwriting profit, insurance companies earn profits from investment returns.

As a total dollar amount, the underwriting profit (after-tax) proposed to be charged by Anthem to policyholders is about $75 million. While the after-tax profit is the amount retained by Anthem, the actual charge to policyholder is before tax, which is about $115 million.

Hence, about ¼ of the rate increase proposed by Anthem is to fund the underwriting profit charged to policyholders. While insurance companies should have the opportunity to earn a fair return, there should also be a balancing of the interests of policyholders with that of the insurance company. Given the very large rate increase being proposed by Anthem, it would be reasonable to moderate any provision for underwriting profit included in the rate calculation.

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

The "Market Adjusted Index Rate Development" in the Anthem filing[45] included numerous factors for which adequate support was not provided. We previously discussed the medical trend factor[46] and showed that the annual value of 9.55% 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	$ 339.49
Factor for	
Normalization Factor	0.9545
Benefit Changes	0.9991
Morbidity Changes	0.9900
Trend Factor	1.2001
Other Cost of Care Impacts	1.0034
Cumulative	1.1369

[45] Anthem filing, Exhibit C

[46] *Ibid.*, Line (6)

Projected Paid Claim Cost $ 385.95

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.[47]

The lack of data and support in the Anthem filing is inconsistent with accepted actuarial procedures. Actuarial Standard of Practice No. 41, *Actuarial Communications*, states in part:[48]

> 3.2 Actuarial Report
> …
> In the actuarial report, the actuary should state the actuarial findings, and identify the methods, procedures, assumptions, and data used by the actuary with sufficient clarity that another actuary qualified in the same practice area could make an objective appraisal of the reasonableness of the actuary's work as presented in the actuarial report.

The Anthem filing is totally lacking in sufficient information and data to support the values used in the rate calculation. This can be seen in part from the Objections by the actuary retained by DMHC, which requested data and information for eighteen items, several of which contained subparts.[49]

One example of an inadequately supported value is the cost increase of 0.34% for Other Cost of Care Impacts, which the filing describes as follows: "Grace Period: The claims experience has been adjusted to account for incidences of enrollees not paying premiums due

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[47] 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 6

[48] http://www.actuarialstandardsboard.org/standards-of-practice/#filter=.General

[49] July 27, 2016 Memorandum from NovaRest Actuarial Consulting

during the first month of the 90-day grace period when the QHP is liable for paying claims."[50] However, no data, information or support was provided for the specific value included in the rate calculation. If there really was an issue regarding this, surely Anthem would have data to support the value it was using. This is especially the situation given than Anthem emphasizes its data analytics[51] and also claims to already have data though the first six months of 2016.[52] Hence, Anthem should have several years of data dealing with this issue. The fact that Anthem declined to include any such data in its filing calls in question the reliability of the cost factor it included. While 0.34% may seem like a small number, it represents about $9 million extra charged by Anthem to policyholders.

Furthermore, a value less than 1.00 could still represent an overcharge, since the appropriate value could be lower. For instance, the Morbidity Changes value of 0.9900 used by Anthem (which is again a value that was not documented or supported in the filing[53]) could be too high (i.e., that it is does not sufficiently reflect expected improvements in morbidity) for several reasons. First, it is generally accepted that the morbidity of new insureds in 2016 and 2017 will be lower than in prior years. Second, the pent-up demand of new insureds will be substantially eliminated by 2017.

The Department of Managed Health Care should request that Anthem provide the underlying support and detailed calculations for the numerous factors and assumptions used in

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[50] Actuarial Memorandum, Section 6. Projection Factors, Other Adjustments

[51] Joe Swedish - Anthem, Inc. - Chairman, President & CEO, in response to the questions "Is there anything different about you heading into Q3 this year versus you heading into Q3 last year as far as what you're doing from a data analytics perspective? Anything there that gives you more confidence or visibility this year than what you had heading into the back half of last year?" stated "I certainly believe that we are always improving year over year, especially in this space given we've got more and more data. Certainly recognize that this is a company that's had a long-standing engagement in high-risk pools. We have a lot of data that has backed us up for a long period of time." Transcript, Anthem Inc. Earnings Call, *Op. cit.*, page 16

[52] John Gallina - Anthem, Inc. – CFO has stated "And the other comment that I'll just add to that, I think maybe will address here what would be different going into the third quarter, is 2016 we actually had more members come on board on January 1 than we did in 2015 or 2014. 2014 in particular, if you recall, we had a vast majority of members come onboard early second quarter. And in 2015 with the extension of the open enrollment period, a lot of members came on later in the first quarter. 2016, a lot more January 1. So, we actually do have a full six months of information this year, and we had not had that in prior years." Transcript, Anthem Inc. Earnings Call, *Op. cit.*, page 16

[53] Anthem filing, Exhibit E - Projection Period Adjustments; shows a "Total Morbidity Changes" factor of 0.9900 without any reference to how that value was calculated. The actuarial memorandum (page 4) was also devoid of any meaningful information regarding this factor.

the filing to derive the proposed rates. Furthermore, any information submitted by Anthem to DMHC should be made public, so that policyholders can evaluate the basis for any rate increase that is allowed.

6. 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.

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%
2015	$502	$1,801	27.9%
Combined	$4,163	$12,928	32.2%

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

From 2007 to 2015, Anthem earned net income, on an after-tax basis, of about $4.2 billion. In each of those nine 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 32%.

The high level of profits has allowed Anthem to pay significant shareholder dividends. From 2007 to 2015, Anthem paid shareholder dividends of about $4.3 billion, which was more than the net income during that time period.[54]

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%
2015	$300	$502	60%
Combined	$4,325	$4,163	104%

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

[54] 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.

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.