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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 California Physicians' Services (dba Blue Shield of California) Rate Filing, SERFF Tracking Number BCCA-130655115

Dear Chief Actuary Thomas:

Consumers Union, the policy and advocacy division of Consumer Reports, writes to provide you with comments on the California Physicians' Services (dba Blue Shield of California) Rate Filing, SERFF Tracking Number BCCA-130655115, 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. Unique characteristics about Blue Shield and its products exist, demanding added scrutiny by the DMHC.

II. The rate increase proposed by Blue Shield—the highest proposed in the California individual market—perpetrates rate instability and propels consumers towards excessive rate increases in the future.

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

IV. Blue Shield seeks to increase its administrative expenses in a year where they also propose vastly steeper rate increases than in recent years.

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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.

I. Unique characteristics about Blue Shield and its products exist, demanding added scrutiny by DMHC

Upon review of the rate filing presented by Blue Shield of California, we conclude that this filing is unjustified and unreasonable, all the more so in light of prior commitments made by the plan to DMHC as well as taking into consideration its nonprofit status. For this filing in particular, we urge DMHC to evaluate Blue Shield's assertions in light of unique facts about the plan. Specifically: Blue Shield's corporate status as a nonprofit organization and contractual agreements with the Department, known as "undertakings," that impose special obligations on the plan.

Blue Shield is a nonprofit that sets rates like a for-profit

Nonprofit corporations, such as Blue Shield, are mission-driven institutions that benefit the communities they serve. As a California nonprofit 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."[1] However, it is hard to reconcile what we know about nonprofits, and what Blue Shield itself says on its website, with the highest rate increase proposed this year and the largest rate increase proposed since the start of Covered California. Nobody would describe an average rate increase of 19.4%, all the way up to 24.9%, as "affordable."

We urge DMHC to review this plan with particular attention to how Blue Shield functions as a nonprofit organization with a stated mission of offering affordable health coverage. It is our finding that the plan failed to offer sufficient details and justifications to explain its rate calculation. And, rather than taking steps to bend the cost curve, Blue Shield uses the cost of healthcare to mask the fact that it is serving itself an extra slice of the pie. For these reasons, **we urge DMHC to give this filing the utmost scrutiny.**

[1] *What Does Being a Non-Profit Mean to Us?*, BLUE SHIELD OF CALIFORNIA, https://www.blueshieldca.com/employer/knowledge-center/features/perspectives/not-for-profit.sp (last accessed August 23, 2016).

This Rate Filing May Signal a Breach of *Undertaking 15*

To gain approval of its acquisition of for-profit insurer Care1st, Blue Shield agreed to contractual obligations known as "undertakings." Undertaking 15 states:

> *…Blue Shield will make every effort to keep premium rate increases to a minimum. For any Blue Shield premium rate increase deemed unreasonable or unjustified by the Department, Blue Shield agrees to meet and confer with the Department and make a good faith attempt to resolve any differences regarding the premium rate increase.*[2]

Yet, this rate filing evinces no effort by Blue Shield to "keep premium rate increases to a minimum." The average rate increase Blue Shield proposes for 2017 is larger than the rate increases proposed by **all the other plans** offered on the Marketplace, as shown below. In fact, it is:

- Larger than the increase proposed by Blue Shield's largest competitor, Anthem;
- More than three-times larger than the increase proposed by the third-largest statewide insurer, Kaiser;
- More-than double the increase proposed by the fourth largest plan.

Proposed rate increase filed with DMHC, >50,000 members		
Health Plan	# Members	Proposed increase
Molina Healthcare of California	75,272	5.7%
Health Net of California, Inc.	191,067	9.4%
Kaiser Foundation Health Plan, Inc.	467,303	5.7%
Anthem Blue Cross	577,716	17.2%
Blue Shield of California	**554,259**	**19.4%**

As if to put a fine point on Blue Shield's flagrant disregard of *Undertaking 15*, the plan fails to adequately justify the factors it uses to support its rate increase. As discussed throughout these comments, the rate filing justification (RFJ) submitted by Blue Shield is a hollow compendium of excuses, rather than a careful recounting of factual underpinnings. Both the rate review process and the contractual obligation attached to the acquisition of Care1st exist to protect consumers from potentially predatory health plan behavior. Any rate increase of the severity of what is proposed here surely alerts the Department to the need for the closest scrutiny. The fact that nearly no justification is provided, that the actuarial certification was delayed for reasons unknown to us, and that the actuarial certification relies on the veracity of Blue Shield's own, often inconsistent assertions,[3] sounds an undeniable alarm. **We therefore urge the**

[2] Department of Managed Health Care agreement with Blue Shield, *Exhibit A*, http://www.dmhc.ca.gov/Portals/0/AbouttheDMHC/NewsRoom/2015/pr100815.pdf (October 8, 2015) [hereinafter Undertakings].

[3] Milliman, Inc., Blue Shield of California Individual Non-Grandfathered DMHC-Regulated Plans 1/1/2017 Rate Filing Certification, at 3: "Blue Shield staff performed the majority of the analysis and I reviewed the work product."

Department to deem this rate filing unreasonable and unjustified, and to compel Blue Shield to come to the table and propose a lower, justified rate increase that will leave its members financially secure, while still ensuring Blue Shield's solvency. With a 19.4% rate increase on the table, the Department must give the closest attention to protecting Californians this year and in the ensuing years.

Consumers must not pay for expenses to which Blue Shield is contractually obligated

Several of the undertakings to which Blue Shield agreed in exchange for acquiring Care1st require sizeable expenses. For example, Undertaking 21 requires annual contributions of $2 million for a period of five years, as well as $50 million to "strengthen the health care delivery system."[4] Given that these undertakings are intended to protect consumers, it would be a farce if the cost of these programs were paid for with premium dollars. We have no way to tell whether Blue Shield has folded those expenditures into its rate request given the limited information available. **We strongly urge that the Department secure an explanation from Blue Shield on how the cost of meeting its contractual obligations with the Department will be paid for without financing by its policyholders' rates for 2017. We also urge DMHC to ensure that these expenditures are not included in the MLR calculation in a way that would skew the ratio in the plan's favor.**

II. The rate increase proposed by Blue Shield—the highest proposed in the California individual market—perpetrates rate instability and propels consumers towards excessive rate increases in the future

Historically, rate increases proposed by Blue Shield consistently outpace the California marketplace, as shown at right. This, despite the fact that Blue Shield is well-positioned to leverage its status as one of the largest health plans in California in negotiations with providers and pharmaceutical companies. For Blue Shield policyholders, it seems the only thing they can count on, like death and taxes, is that their health plan rates will continuously and steeply rise.

Plan Year	Blue Shield Proposed Increase	Statewide Average Proposal
2014	13%	N/A
2015	6.0%	4.2%
2016	4.6%	4.0%
2017	19.4%	12.1%

[4] Undertakings, *supra*.

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 Blue Shield products to be excessively costly for consumers into the future. Proof of that theory is already here: as shown in the table at right, Blue Shield's proposed 2017 health plan products are the highest cost of all products being offered in same category (Silver) in over a quarter of the regions in the state, second only to Anthem. Blue Shield is a nonprofit organization—despite losing its tax-exempt status—that claims to work in service of its community. Yet, its actions speak louder than its words, and annual large rate increases mean that excessive insurance rates are all but guaranteed now and in the future.

Regions where Blue Shield is the highest cost Silver product	
Region	Blue Shield Product
Region 1 – Northern counties	Blue Shield HMO
Region 2 – North Bay Area	Blue Shield HMO
Region 7 – Santa Clara County	Blue Shield PPO
Region 13 – Eastern counties	Blue Shield PPO
Region 14 – Kern County	Blue Shield HMO

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

<u>This rate filing is characterized by inconsistencies that muddy the waters for rate review and transparency</u>

Health insurance companies and plans are required to annually submit rate filing justifications. What must be included in these filings is well-defined under both federal and California law, and the timeline in which the data are due is neither a surprise nor a secret. The plans, including Blue Shield, have ample time to compile, verify, and validate the data they produce for regulatory and public review.[5] It is therefore, at best, careless that Blue Shield would submit a rate filing that manages to be both absent of critical details and also pockmarked with inconsistencies and likely errors.

This filing is replete with inconsistencies. For example, the C*ompany Rate Information* table would have reviewers believe that the proposed rate increases range from 11.1% to 24.9%. Especially if you are a consumer at the upper end of that range, this proposed increase is troubling. It could be worse, though: the *State Specific* section of Blue Shield's coversheet, actually shows a range of 11.1% to 96.7%. Suddenly, 24.9% does not look so bad. Of course, there is no reason to believe one statement is accurate as opposed to the other. And this is only

[5] Indeed, in the past HHS has adjusted its timeline in order to make the deadlines more palatable for carriers.

on the boilerplate sections of the RFJ. Once we get further into the rate filing, and its attendant Excel worksheets, we find more inconsistencies.

Inconsistencies are also found within documents composed by the actuarial firm contracted by Blue Shield to conduct an independent analysis of the filing. In its independent certification, Milliman references an expense of $3.13 PMPM in two sections of its rate filing: as part of Blue Shield's administrative expense load referred to as "Medical Management,"[6] and as a Quality Improvement expenditure factored into the Federal MLR calculation.[7] While it is possible that Blue Shield projects the exact same expense for two separate and unconnected expenditures, it is unlikely, especially because Blue Shield only includes the figure once and only as an administrative expense. Milliman claims to have relied on Blue Shield's analysis, and it is unclear why they interpreted "medical management" to be the same as "quality improvement."[8]

In addition to failing to provide substantive information, but including inconsistent and confusing information, Blue Shield also makes use of terms that are not self-explanatory and which lack actual explanation. For example, there is no explanation of the term "medical management," which it appears Blue Shield's own independent actuary may have failed to fully understand. Similarly, acronyms such as "CoHC" leave the reader assuming a certain definition to fill a gap that should not exist. Again, this ambiguous language makes it impossible to fully analyze the filing.

While these inconsistencies, information gaps, and confusing language do little to shed light on why consumers' rates may skyrocket, together they comprise a theme of careless disregard that signals the need for especially rigorous review.

<u>The rates proposed by Blue Shield are based on unjustified medical trend projections</u>

In its RFJ, Blue Shield projects an annual pricing trend of 7.8%[9] for 2017 but does not explain the basis of its projection. Instead, Blue Shield leaves reviewers to assume the plans' statements are accurate; it's as if they're saying to the regulator and the public, "Trust me."

[6] Milliman, Inc., Blue Shield of California Individual Non-Grandfathered DMHC-Regulated Plans 1/1/2017 Rate Filing Certification, at 7.
[7] *Id*. at 10.
[8] It should also be noted that the term "medical management" lacks definition and may itself actually be a reason for Milliman's confusion.
[9] The actual trend used by Blue Shield is unclear in the filing because the plan uses varying trend values throughout its filing. The independent actuarial certification submitted by Milliman shows an annual trend value of 8.5%, based upon a cost trend of 4.5% and a utilization trend of 3.9% (1.085 = 1.045 X 1.039, within rounding). Those are the same values shown in the URRT (Unified Rate Review Template spreadsheet, "Wksh 1 – Market Experience" sheet). The Blue Shield Actuarial Memorandum shows trends for 2016 and 2017 of 9.2% and 7.8%, which averages to 8.5%.

But, with a proposed 19.4% rate increase on the table, their assertions must be verified, especially in light of the recent finding by DMHC that "Blue Shield's medical cost projections for the 2014 Plan Year proved to be substantially greater than its actual costs."[10]

The 7.8% trend used by Blue Shield outstrips the much more moderate medical trend projection of 5.6% from the national health expenditure projection for 2017,[11] as well as the 6.5% projection from PricewaterhouseCoopers LLP. The trend factors adopted by Blue Shield are considerably greater than those of outside analysts, and also contradict those proposed by two other plans in the same market. Health Net adjusted its morbidity projection *downward* based on the expectation that newcomers to the market in 2016 will be 15% healthier than in 2015, and newcomers to the market in 2017 will be still another 15% healthier than 2016.[12] Kaiser uses a dramatically lower average medical (non-pharmacy) cost trend of 1.7%.[13] Blue Shield, in stark contrast to both of these other QHPs, alleges that utilization of hospital services, physician services and prescription drug coverage will increase, but provides no data to support its claim.[14]

In addition, Blue Shield's prescription drug cost trend projections are far steeper than those of the other major plans in this market, as shown below. Pharmaceutical expenses are one factor among several that contribute to the medical trend, but it may also be the most rapidly rising and the factor most open to exploitation by a plan, such as Blue Shield, searching for a Trojan horse with which to usher in excessively priced insurance rates.

Type of Trend	Anthem	Blue Shield	Health Net	Kaiser
Overall medical trend	**9.55%**	**7.80%**	**5.90%**	**2.20%**
Prescription Drug Cost	8.30%	**11.50%**	11.00%	6.00%
Prescription Drug Utilization	8.70%	3.90%	0%	N/A

For years now, the health plans have cited outsized increases in prescription drug costs. Some of their assertions are justified. Blockbuster drugs are savings lives and breaking the bank. However, the line must be drawn when health plans such as Blue Shield continue to leverage headlines about high cost drugs in order to artificially inflate claims projections.

The rate filing submitted by Blue Shield goes one step beyond making unsupported claims to justify its medical trend projections—Blue Shield fails to justify its trends *at all*. When Blue Shield claims that prescription drug costs will be over 11% more expensive in 2017, it does so without providing any evidence to support its claim. It must be required to provide supporting

[10] Department of Managed Health Care, *Memorandum of the Director*, dated October 5, 2015.
[11] 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.
[12] Rate filing justification for Health Net of California, SERFF HNLH-130549406, at 5.
[13] Rate filing justification for Kaiser Foundation Health Plan, Inc., SERFF KHPI-130516678, at 4.
[14] Rate filing justification for California Physicians' Services (dba Blue Shield of California), SERFF BCCA-130655115, at 11.

evidence that substantiates its claim. Further, the claim that prescription drugs will get exponentially more expensive each year becomes especially questionable in light of recent information to the contrary from other sources. DMHC must closely scrutinize the evidence on the expected trend in prescription drug pricing for the coming year, and not allow health plans to build worst case scenarios five years out into their rate requests.

There is strong evidence, for example, that the cost of some of the specialty drugs that have served as bulwarks for rate increases in the past are slowing, as is their utilization (the latter of which Blue Shield appears to acknowledge). One clear example of a high cost specialty drug that is unlikely to continue to put upward pressure on insurance rates is the medication used for treating Hepatitis C. 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.[15] 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.[16] 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."[17]

Merck Executive Vice President, President Global Human Health was circumspect in his response to investor questions about Merck's ability to sustain high prices, stating that Merck would "continue to think about the right ways to do pricing and contracting."[18] This is not exactly the voice of an organization expecting to be able to extract the highest prices from the plans. Even a senior actuarial director at Cigna, another major national health plan, stated that the Hepatitis C cost trend is declining.[19] Conveniently left out of Blue Shield's medical trend projections is any acknowledgement that the price of Hepatitis C treatment, and perhaps of other high cost drugs, is likely to go down in 2017.

Let us not forget that the sticker price of these specialty drugs is just that: a sticker price. And as is well known and settled about drug pricing, health plans do not pay sticker price. What they do pay is generally aggressively negotiated down by pharmacy benefit managers ("PBM"), such

[15] Caroline Chen, *Gilead's New Hepatitis C Drug Approved by FDA, Priced at $74,760*, BLOOMBERG (June 28, 2016), http://www.bloomberg.com/news/articles/2016-06-28/gilead-wins-fda-approval-of-hepatitis-c-drug-for-all-genotypes.
[16] Caroline Chen, *Gilead Shares Slide as Product Sales Forecast Revised Lower*, BLOOMBERG (July 25, 2016), http://www.bloomberg.com/news/articles/2016-07-25/gilead-lowers-2016-net-product-sales-forecast-shares-slide.
[17] John F. Milligan, Transcript of Gilead Sciences (GILD) On Q2 2016 Results – Earnings Call (July 25, 2016).
[18] 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.
[19] PRICEWATERHOUSECOOPERS LLP, *Medical Cost Trend: Behind the Numbers 2017*, at 12 (June 2016).

as Express Scripts[20]; 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.[21] And, as the Chief Actuary for Kaiser Foundation Health Plan has stated, better management and pricing should mediate the specialty drug trend in 2017.[22] Indeed, Kaiser is making good on its Chief Actuary's statement with a prescription drug trend of only 6.0%,[23] while **Blue Shield uses a 15.2%**[24] combined prescription drug trend. Even Anthem—Blue Shield's primary competitor, non-integrated plan in California and a plan on which Consumers Union has also commented—adjusted its experience claims data with a $5.92 *decrease* "to reflect anticipated Rx rebates."[25] Blue Shield, on the other hand, fails to acknowledge the existence of rebates or discounts *at all*.

We therefore urge DMHC to demand that Blue Shield substantiate and justify the factors it uses to support its proposed rate increase. The lack of any level of granularity must not be permitted, especially in light of its exorbitant rate request and its contractual commitment to DMHC to minimize rate increases.

Unsubstantiated Utilization Trend Based on Changes in Duration

In its RFJ, Blue Shield justifies a 1.7% increase to its utilization trend with the assertion that "members who joined during [the] special enrollment period were observed to utilize services at a much higher rate than those who joined during open enrollment period."[26] This 1.7% number seems very exact, but it is unknown to us what is based upon. If finalized, this fraction of the increase proposal alone will cost enrollees about $25 million.[27]

This past year, Blue Shield vocally protested to Covered California that consumers that enrolled during special enrollment periods (SEPs) were not just disproportionally higher cost than those enrolling during open enrollment, but also that they were unpredictably costly. The allegation by plans that SEP enrollees are more costly than those who enroll during open enrollment is neither new nor controversial. The challenge is in the claim that these SEP enrollees should be treated as a separate member group and will shift the medical trend of the overall group from prior years' projections. Instead, Consumers Union firmly believes that Blue Shield should have

[20] 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.
[21] *Id.* at 10.
[22] *Id.* at 12.
[23] Rate filing justification of Kaiser Foundation Health Plan, Inc. SERFF Tr Num KHPI-130516678.
[24] CALIFORNIA PHYSICIANS' SERVICE D/B/A BLUE SHIELD OF CALIFORNIA, *California Rate Filing Form*.
[25] Actuarial Memorandum from Michael Polakowski (FSA, MAAA) to Anthem Blue Cross (licensed by DMHC), at 5 (July 14, 2016) [hereinafter Blue Cross Actuarial Memorandum].
[26] *Blue Shield Filing*, *supra* note 12, at 3.
[27] Calculated based on 1.7% of the projected overall dollar increase of $281 million divided by 19.4% (the overall percent increase).

anticipated the number of SEP enrollees and their costs and that it makes no sense to add an additional surcharge—here, in the form of a utilization trend bump—when the risks of these members should be well-known to the plans, especially plans such as Blue Shield with its access to robust member data.

This past year, Blue Shield and other plans argued to Covered California that members who enroll during SEPs are such a substantial share of business that the plans need Covered California to provide protection from "suspicious" SEP enrollments. The plans submitted to Covered California a national study from Oliver Wyman[28] to support their assertions. However, the plans refused to produce data—at least for the work group convened by Covered California—to allow the study to be independently validated. With no way to independently validate the study's conclusions, and no way to know how the data was collected, the accuracy and relevance of the entire study is questionable. There is also no way to know any detail about the underlying data, including how they were selected, how extensive the claimed surprise costliness of SEP claims was, and whether it specifically applied to Blue Shield's experience. Furthermore, because the study was national—including markets in other states that permitted grandfathered plans to continue and thus had weakened risk profiles in their Exchanges—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 irrelevant even if it could be validated. Blue Shield did not supply sufficient proof that SEP enrollment is a real problem and that those SEP enrollees shift costs in any measurable way. Yet, Blue Shield is making similar claims in this rate filing, without supporting evidence, to DMHC. Blue Shield must be called to account for these blanket assertions by providing comprehensive supporting evidence.

While consumer advocates, Blue Shield, and Covered California may disagree about whether SEP enrollment is a problem, they do agree that a more rigorous certification process will lead to lower SEP enrollment. At a Covered California Board Meeting in February, 2016, the Chief Actuary for Covered California stated that "the California big four health plans [of which Blue Shield is one] believe that having documentation requirements would reduce SEP enrollment."[29] Covered California, in fact, modified its SEP enrollment procedure in 2016, including adding a random sampling process with a new documentation requirement. In addition, in response to experts' assertion that SEPs are actually underutilized,[30] Covered California will increase marketing for SEP enrollment by Californians who experience legitimate SEP triggers. The combination of these two approaches by Covered California is likely to strengthen the enrollee pool by enlarging and diversifying the entire risk pool, a fact Blue Shield disregards when it asserts in its filing that this "influx of new members through special enrollment" in 2017 will increase the utilization trend. The plans succeeded in requiring greater validation of enrollment for purportedly higher cost enrollees, and Covered California is taking

[28] OLIVER WYMAN, *Special Enrollment Periods and the Non-Group, ACA-Compliant Market*, (February 24, 2016).
[29] Statement of John Bertko, Minutes of Board Meeting Feb. 18, 2016, p. 14 accessed Aug. 30, 2016, http://board.coveredca.com/meetings/2016/4-07/HBEX%20Board%20Meeting%20February%202016.pdf.
[30] Laurel Lucia, *How Do We Make Special Enrollment Periods Work?*, Health Affairs Health Policy Lab, (February 16, 2016). Available at http://healthaffairs.org/blog/2016/02/16/how-do-we-make-special-enrollment-periods-work/.

steps to strengthen the enrollee pool, so why isn't this reflected in the rate filing? Blue Shield cannot have it both ways. Instead of applying an upward trend factor, it may be more appropriate to apply a reduction to this factor.

Blue Shield must not continue to capitalize at consumers' expense on its unsubstantiated allegations about special enrollment period enrollees. **We therefore urge DMHC to press Blue Shield to justify its assertions with specific, comprehensive and unfiltered data.**

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 demand more transparency from Blue Shield regarding its cost containment initiatives and quality improvement programming. Healthcare and prescription drugs in our country cost more than they should. It is estimated that about a third of health care spending is wasted on things that do not make us healthier.[31] Far too often, insurers simply pass those costs along to policyholders in the form of higher premiums.

California's rate review law, nearly unique among the states, requires health plans and insurers such as Blue Shield 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." 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 Blue Shield 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, including Blue Shield, 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 increase 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). With a virtual answer key available to it on what cost containment and quality improvement measures it will pursue—those

[31] 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%.

required by its QHP contract with Covered California—the most we see from Blue Shield is a statement that a "key component" of its trend factor is "CoHC strategies and initiatives that are expected to produce incremental cost savings" followed by a complete absence of details, including what "CoHC" stands for.[32] The cost and quality of healthcare are major consumer concerns, yet Blue Shield 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 quality reporting required by Covered California in its QHP certification process. *It is therefore especially troublesome that Blue Shield is shortchanging DMHC in its filing; it must not be permitted to get away with it.* As DMHC knows, transparency is a foundational element of the rate review process. **For Blue Shield to fail to provide this information to DMHC—information that is clearly required and already available in writing—screams for enforcement by DMHC.**

IV. Blue Shield seeks to increase its administrative expenses in a year where they also propose vastly steeper rate increases than in recent years

Blue Shield PMPM administrative expense load			
Category	2015	2016	2017
Total	$ 29.31	$ 37.21	$ 38.71
Admin % of Premium	**7.80%**	**9.28%**	**10.60%**

Blue Shield asserts that its administrative expenses will increase to $38.71 PMPM. This equates to 10.6% of each premium dollar. In just two short years, Blue Shield's administrative expense projections have grown from 7.8% of premiums to 10.6%. As is their habit, Blue Shield fails to justify why it anticipates larger administrative expenses in the coming plan year. Viewing these numbers as percentages of premiums, rather than flat dollar amounts reveals that expenses are not just growing over time, but also taking up a larger proportion of premium dollars. When percentages are used, like slices in a pie, enlarging one slice means at least one of the other slices becomes smaller. With the medical loss ratio (MLR), the other two slices are contributions to surplus and costs associated with members' care.

In its rate filing, Blue Shield anticipates contributing 1.23% to surplus, stating "Please note that this represents a decrease of 0.9% from our 2016 target." Of course, Blue Shield's 2016 surplus target of 2.09%[33] was in clear violation of its 2% Pledge, as we discussed at length in our 2016 comments[34] and as the Department noted in its Memorandum and Order, issued October,

[32] Blue Shield Actuarial Memorandum, at 4. One may guess that "CoHC" stands for *Cost of Health Care*, but in a justification for a substantial rate increase like this, glaring gaps should not be resolved with assumptions.
[33] *Id.* at.7.
[34] Consumers Union's comments on California Physicians' Service (dba Blue Shield of California) Rate Filing, (August 25, 2015), http://consumersunion.org/wp-content/uploads/2015/09/Consumers-Union-comments-on-California-Physicians-Service-Rate-Filing-2016-Plan-Year.pdf.

2015.[35] Blue Shield's proposal to decrease its contribution to surplus in 2017 is not by choice—it was by Order of the Department.[36]

Blue Shield may intend to decrease the percentage contributed to surplus by increasing the percent paid to administrative services; if that is the case, we do not know if it is an even trade. Additionally, Blue Shield fails to justify why its administrative expense will rise at a pace outstripping CPI growth, and there is no information to suggest a need for administrative expenses to become a larger fraction of spending. By reducing its contribution to surplus and noting the slightly decreased percentage, Blue Shield may be using this rate filing to reframe its narrative in a more positive light. With a tangible net equity nearly seven-times[37] that which is required by the state, and much larger than that which is required by the Blue Cross and Blue Shield Association,[38] Blue Shield does not need to contribute even "just" 1.23% to surplus. Instead it could have elected to follow the lead of another California nonprofit, Kaiser Health Plan, which in 2015 priced its products with an expectation that the plan would draw from surplus. The results for Kaiser were far from catastrophic. Rather, the plan remains strong and will also offer the *lowest* cost Silver product in 6 regions in 2017, the benchmark Silver product in 6 regions, and—based on current rate proposals—will not offer the most expensive Silver in *any* region.

If the increase in the percentage of the premium dollars spent on administrative expenses is *not* drawn from the funds Blue Shield contributes to its surplus, then it logically follows that the reduction will come from the amount Blue Shield anticipates spending on consumers' healthcare. While that is permissible—so long as the plan meets the MLR minimum—given the very large increase requested this year, it is counter to its stated mission "to ensure all Californians have access to high-quality health care at an affordable price." Blue Shield should not simply aim for the minimum loss ratio floor. This is especially true in a year in which Blue Shield is the subject of a class action lawsuit for alleged miscalculations of its medical loss ratio resulting in $34 million in unpaid rebates to consumers.[39]

When MLR is calculated, contributions to surplus and administrative costs are counted together. Nothing prohibits Blue Shield from drawing some of its increased administrative expenses from surplus. **We urge the Department to ensure that Blue Shield does not increase its already robust surplus dollar amount in 2017 by overcharging consumers and obscuring its allocations.** It may be that the increase in administrative expenses projected here will be drawn

[35] Department of Managed Health Care, *Memorandum of the Director*, dated October 5, 2015. "[T]he Plan's target level of profit for the products will implicate the Plan's pledge not to keep any profits in excess of 2%."
[36] Department of Managed Health Care, *Order* issued to California Physicians' Service dba Blue Shield of California dated October 5, 2015.
[37] Calculation based on: CALIFORNIA PHYSICIANS' SERVICE D/B/A BLUE SHIELD OF CALIFORNIA, Quarterly Financial Reporting Form for Quarter Ending March 31, 2016, worksheet TNE (1).
[38] The BCBS Association sets a minimum of 375% of RBC-ACL for its members to avoid triggering more active monitoring by the association.
[39] Rebecca Morris and Becky Ebenkamp v. Blue Shield of California, No. BC 625804 (Cal. Super. Ct. filed July 1, 2016).

solely from the plan's contribution to its surplus. But it may also be that this is a shell game being played at California consumers' expense. We urge the Department to find out.

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

In 2015, Consumers Union reached out to DMHC to ask the Department to post a plain language summary of the rate decision for each carrier, along with the Department's rationale. We credit the Department for doing so in 2015, and urge it to continue. The key factors we believe DMHC should highlight remain the same this year:

- 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 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 would aid 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. This transparency is especially critical in the case of very large increases requested such as those sought by Blue Shield.

For the 2017 plan year, we further encourage the Department to make this overview more prominent on its site rather than folding it into the rest of the rate filing, and to strive to provide as much layperson-friendly detail as possible in order to give the media and consumers a full and complete picture of how health plan rates were evaluated and determined. Furthermore, information that is helpful to the public, and which explains the Department's work, should be readily seen and easily located.

Additionally, we encourage DMHC to highlight its efforts to protect consumers during a wave of health plan mergers this past year. In particular, consumers should be aware that DMHC achieved 25 contractual obligations from Blue Shield, including:

- Undertakings 7 and 8, which require the plan to improve its quality rating scores as rated by the Office of the Patient Advocate Quality Report Card and the Med-Cal managed Care Health Care Options Consumer Guide.
- Undertaking 9, which requires the plan to engage in programs designed to promote health literacy education.
- Undertaking 15, which requires the plan to "make every effort to keep premium rate increases to a minimum" and to actively and in good faith participate in the rate review process in California.
- Undertaking 21, which requires the plan to make contributions totaling $50 million to strengthen the health care delivery system, at least $14 million per year to the Blue Shield Foundation, and an additional $2 million annually for five years towards consumer programs.

In addition to informing the public about these undertakings, the Department should post publicly and regularly update information on whether and how these undertakings are being met and at what cost. At this time of instability in the insurance marketplace, consumers need a clear message about the specific ways in which DMHC is safeguarding the public interest.

Conclusion

We strongly encourage DMHC to demand additional information from Blue Shield to fully justify its exorbitant proposed rate increase, especially in light of its nonprofit status as well as its unique obligation, associated with Undertaking 15, to "make every effort to keep premium rate increases to a minimum … [and] meet and confer with the Department and make a good faith attempt to resolve any differences regarding the premium rate increase."[40] Given the financial burden of escalating costs on California families and in light of Blue Shield's strong financial footing, If Blue Shield is unwilling or unable to come to the table or provide sufficient information, DMHC must find the requested rates unreasonable and not justified. Additionally, we urge the Department to publicly notify consumers of this finding, and to work with Covered California to alert the public so they can make educated purchasing decisions.

Sincerely,

Dena B. Mendelsohn
Staff Attorney
Consumers Union

[40] Undertakings, *supra*.

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Date: August 31, 2016

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 July 15, 2016
HOrg02I Individual Health Organizations - Health Maintenance (HMO)
HOrg02I.005A Individual - Preferred Provider (PPO)
SERFF Tracking #: BCCA-130655115

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 19.4% with an effective date of January 1, 2017.[4,5,6] The filing indicates that total annual premium increase being requested is about $281 million[7],

[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, 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 seven EXCEL files. These were available at: http://wpso.dmhc.ca.gov/ratereview/Detail.aspx?lrh=0QtDat9Z%2fL8%24

[4] Blue Shield filing, General Information Section and Company Rate Information Page. (The Filing at a Glance Section gives an "Implementation Date Requested of 01/01/2016. That is clearly a typo.)

[5] One part of the filing gives a range of rate change from a minimum of a +11.1% increase to a +24.9% increase. *Ibid.* The filing did not adequately explain the basis for this 14% range in rate changes. However, another part of the filing shows the same minimum of +11.1%, but a much different maximum of 96.7%, Blue Shield filing, State Specific Section.

[6] The huge 19.4% proposed increase appears inconsistent with the statement that "Blue Shield will make every effort to keep premium rate increases to a minimum". ("Undertakings" document dated October 1, 2015 signed by Blue Shield, Cumulus and Care 1st; Undertaking 15) DMHC should require Blue Shield to explain how a 19.4% increase is consistent with keeping "premium rate increases to a minimum".

[7] *Ibid.*

with an average increase per policyholder of $645.[8] However, there is some uncertainty regarding the dollar impact of the rate change given various values in the filing. The Rate Review Detail Section gives a Prior Rate Total Earned Premium of $3.120 billion. Applying a 19.4% increase to that gives a dollar increase of $605.3 million. Based upon the value shown for Member Months of 6,651,110; that is an increase PMPM of $91, which is an annual increase per member of $1,092. Blue Shield should be required to explain, and reconcile, the discrepancy between various values shown in the filing. As discussed later, there is also a discrepancy between the medical cost trends shown in different places in the Blue Shield filing.

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

First, according to the financial reports filed by Blue Shield, its Tangible Net Equity as of June 30, 2016 of $2.731 billion exceeded the Required Net Equity of $432 million by $2.299 billion.[9,10,11] Put another way, the actual Tangible Net Equity for Blue Shield is equal to 632% of the Required Net Equity.[12] 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 $281 million. This is about 12% of the Tangible Net Equity Excess reported by Blue Shield.

Second, Blue Shield has earned profits on the individual line of business in both 2014 and 2015. Blue Shield's 2014 individual business medical loss ratio calculated in accordance with the ACA requirements was only 76.7% and a rebate of about $64 million was indicated.[13] 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

[8] $281,278,434 (written premium change) / 436,392 (number of policyholders affected for this program); *Ibid*.

[9] Blue Shield June 30, 2016 financial statement filed with DMHC

[10] The Total Net Equity for Blue Shield at June 30, 2016 was $4.145 billion. The total net equity reflects $1.415 billion in "Unsecured Receivables from officers, directors and affiliates; Intangibles" that is not included in the Tangible Net Equity

[11] As of June 30, 2015, the Total Net Equity and Tangible Net Equity for Blue Shield were $4.246 billion and $4.080 billion, respectively. Hence, while the Total Net Equity remained relatively constant from June 30, 2015 to June 30, 2106, the Tangible Net Equity dropped significantly. This is the result of the "Unsecured Receivables from officers, directors and affiliates; Intangibles" increasing from $167 million as of June 30, 2015 to $1.415 billion as of June 30, 2016. It is not clear why the unsecured receivables increased by about 750% during this period.

[12] 6.32 = $2.731 billion / $432 million

[13] 2014 Medical Loss Ratio report on DMHC website

2014 to 503,829 at the end of 2014.[14] During 2014 and 2015, Blue Shield had underwriting profits of 6.7% and 1.2% of premium, respectively.[15,16] As a dollar amount, those are underwriting profits of about $128 million in 2014 and about $31 million in 2015.[17]

Our analysis shows that the proposed rate increase is inflated and unreasonable for various reasons including Blue Shield's use of an excessive Overall Annual Medical Trend Rate, which is shown as +7.8% a year in a portion of the filing, but as 8.5% elsewhere in the filing.[18,19,20]

Other concerns with the Blue Shield filing include:

- Expense Increase
- Duration Factor
- Cost Containment Issues
- Lack of Documentation of Ratemaking Factors

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

[14] Blue Shield 2014 Annual statement filed with DMHC

[15] California Supplemental Rate Review Template, "Actual-to-Expected 2014" and "Actual-to-Expected 2015" sheets

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

[17] This is based upon premiums in 2014 and 2015 of $1.905 and $2.558 billion, respectively. California Supplemental Rate Review Template, "Monthly Claims - Experience" sheet

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

[19] 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 8.5%, based upon a cost trend of 4.5% and a utilization trend of 3.9%. (1.085 = 1.045 X 1.039, within rounding) Those are the same values shown in the URRT (Unified Rate Review Template spreadsheet, "Wksh 1 – Market Experience" sheet). The Blue Shield Actuarial Memorandum shows trends for 2016 and 2017 of 9.2% and 7.8%, which averages to 8.5%.

[20] The excessive medical cost trends used by Blue Shield appear inconsistent with its statement "Blue Shield agrees that controlling health care costs is of the utmost importance". Undertakings, *Op. cit*. DMHC should require Blue Shield to provide documentation on what it is doing to control health care costs, and why that does not appear to be accomplishing the intended goal.

1. Excessive Annual Medical Trend Rate

The Blue Shield filing is based upon an Annual Medical Trend Rate of +7.8% (or 8.5%) a year, which includes a prescription drug trend of 15.2% a year.[21] The filing was essentially devoid of any basis for those values. 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."[22,23]

The Actuarial Memorandum stated: [24]

> Trend factors are derived from historical Blue Shield experience. The key components of the trend factor buildup are as follows:
> • effective days trend which is largely a leap year effect,
> • CoHC strategies and initiatives that are expected to produce incremental cost savings,
> • provider contracting changes,
> • and residual trends that reflect the unexplained variance from actual trend after accounting for demographics, duration, benefits, and seasonality changes.
> For 2016 and 2017 trends, we have assumed a blend of the lower residual trend derived from Large Group's historical experience consistent with prior pricing and the 2015 IFP residual trend. The 2016 residual trend was further adjusted to account for emerging experience. The table below

[21] Blue Shield Filing, California Rate Filing Form, Item 19; The values shown for prescription drugs for "Trend attributable to use of services" is 3.3% and for "Trend attributable to price inflation" is 11.5%; 15.2% = (1.033 X 1.115 – 1) X 100%. By contrast, the Milliman Report shows the same 8.5% annual trend each benefit category, including prescription drugs (Appendix C-3 - Development of Claim Cost Trends), and also on a total basis for all benefit categories combined. It is unclear why different parts of the Blue Shield filing show varying numerical values for trend factors.

[22] Page 4

[23] It is unclear how detailed of an analysis Milliman performed in evaluating the Blue Shield filing. The Milliman report stated "Blue Shield staff performed the majority of the analysis and I reviewed the work product." Milliman report, page 3

[24] Section V.g.

summarizes the trend assumptions separately for 2016 and 2017 (this reconciles to the overall trends shown in columns Land M of the URRT.

However, in neither place were any data, analyses or calculations provided.

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 significantly lower than 7.8% (or 8.5%).

These various sources of information regarding trends showed the following:

- 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.

The medical trend used by Blue Shield is more than three times as much as the 2.2% annual trend used by Kaiser. The Kaiser filing for rates effective January 1, 2017 states "The Plan has projected an overall Medical Trend of 2.2%."[29] Milliman, the actuarial firm that provided the Independent Actuarial Certification for both the Blue Shield and Kaiser filings, stated in relation to the 2.2% trend used in Kaiser filing that "I have reviewed the choice of

[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

[29] Kaiser Foundation Health Plan, Inc. filing, SERFF Tracking #: KHPI-130516678; Exhibit E-1, Page 6

assumptions in light of Kaiser and industry experience and found the assumptions to be reasonable. Appendix C-1 shows the projected aggregate trend. Part IV of Exhibit E-1 describes the choice of assumptions, including annual trends and experience period data."[30,31,32]

With respect to the huge prescription drug annual trend of 15.2% used by Blue Shield, insurance companies often attempt to justify that on the basis of the cost of specialty drugs for Hepatitis C and compound drugs.[33] However, a review of the facts shows that those items do not support the very high drug trends.

With respect to Hepatitis C drugs, Express Scripts has stated:[34,35]

> 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

[30] Milliman Report "Kaiser Foundation Health Plan, Inc. Individual Plan HMO 1/1/2017 Non-Grandfathered California On and Off Exchange Rates Actuarial Certification" dated July 26, 2016, Page 4

[31] The same actuary from Milliman, Ms. Susan E. Pantely, provided the independent actuarial certification for both the Blue Shield and Kaiser filings. It is unclear how Ms. Pantely could determine that both a 2.2% annual trend and an annual trend of 8.5% were both reasonable at the same time for projecting California medical costs.

[32] The trend used by Kaiser and found to be appropriate by Milliman split by medical component was 1.7% for everything other than prescription drugs and 6.0% for prescription drugs. Milliman Report / Kaiser, *Op. cit.,* – Appendix C-1

[33] Blue Shield showed projected specialty drug trends from 2015 to 2016 and 2016 to 2017 of 38.9% and 26.3%, respectively. (California Supplemental Rate Review Template, "Specialty Rx Trends" sheet) That is a total specialty drug trend from 2015 (experience period) to 2017 (rate period) of 75.4% (= (1.389 X 1.263 – 1) X 100%). With regard to those trends Blue Shield stated "Higher unit cost trend in 2016 due to uptick in Hep C costs due to relaxed criteria" and "Lower unit cost trend in 2017 due to expected lower Hep C costs in 2017 vs 2016". The specialty drug projected unit cost trend from 2016 to 2017 is 17.8%. It is hard to understand how Blue Shield can refer to that as a "lower" value.

[34] 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

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

> 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.[36]

Altarum Institute found:[37]

> 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 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.

With regard to compound drugs Express Scripts has stated "Payers effectively mitigated the dramatic increases in spending on compounded medications in 2014."[38] The projected annual trend in compound drugs from Express Scripts is a ***decrease*** of about -7% a year.[39]

All of this information demonstrates that the overall annual cost trend of +7.8% (or 8.5%) a year, as well as the prescription drug trend of 15.2% a year, used by Blue Shield are both excessive and unsupported.

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[36] *Ibid*., page 44

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

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

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

2. Expenses

The provision included in rates for expenses increased significantly from 2015 to 2016, by 7.5%, as shown in the following table.

Expense Load PMPM

Expense Category	2016	2017	Change
Administrative	$36.13	$38.71	7.1%
Broker Commission	$7.71	$8.04	4.3%
Medical Management	$2.56	$3.13	22.3%
Total	$46.40	$49.88	7.5%

Source: Current and Prior Blue Shield Filings, Actuarial Memorandum
Section VIII : Non-Benefit Expenses and Profit & Risk

This is significantly 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 Blue Shield[40] 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 expenses PMPM could be flat or decreasing as opposed to the significant increase proposed by Blue Shield.

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 2017."[41] We do not believe it is reasonable to assume that expenses PMPM will increase 7.5% from 2016 to 2017.

[40] The projected member months of 8,992,505 are 35% higher than the experience period member months of 6,651,110. (Unified Rate Review Template spreadsheet, "Wksh 1 – Market Experience" sheet)

[41] Actuarial Memorandum, page 6, Section VIIIa

The increase in these expenses as proposed by Blue Shield result in more than $30 million in additional premiums charged to California policyholders.[42]

3. Changes due to Duration

Blue Shield gave the following so-called "explanation" for the cost increase of 1.7% attributable to duration.[43]

> The following dynamics were observed from members enrolled during 2014 and 2015 plan years, and have contributed to higher per member per month claim cost.
> • A gradual ramp-up in utilization by members in the initial months of their coverage duration. This dynamic is associated with new members, and high volume of new members in 2014 resulted in a lower allowed PMPM in 2014 plan year than in 2015. To the extent that the volume of new sales relative to total membership is expected to decrease over time, we expect claim cost to be higher in 2016 and 2017 than in 2015.
> • In addition, members who joined during special enrollment period were observed to utilize services at a much higher rate than those who joined during open enrollment period. With influx of new members through special enrollment expected to continue in 2017, claim cost is also expected to increase.

That passage does not provide a reasonable basis for the provision included, and no data or support of any kind was provided for the specific numerical value of 1.7% selected.

The first bullet item seems to indicate that the large number of new members in 2014 resulted in a lower cost, and since the number of new members would be smaller in subsequent years that would increase costs. That simply does not make any sense. It is widely accepted that the new members entering in 2014 resulted in higher costs, not lower costs. Hence, the basis of the first item appears wrong. There also does not seem to be any logical connection between the premise that there will be a decrease in the number of new members in the 2016 to 2017 years; and the conclusion that this would somehow result in higher costs in 2017 than in 2015.

The second bullet item seems to be based on the assumptions that there will be a significant number of new members in special enrollment in 2017 and that those members in 2017 will have a higher cost. But Blue Shield has not provided any support that either of those

[42] ($49.88 –$46.40) X 8,992,505 = $31.3 million

[43] Actuarial Memorandum, Section V – Projection Factors

assumptions are accurate for California policyholders. Furthermore, to the extent that special enrollment increases costs, that cost increase is already reflected in the 2015 year base experience period. In addition, there is no evidence indicating that special enrollment period enrollees in 2017 will have a higher relative cost than those already included in the 2015 base year. Blue Shield, by adding in an extra provision for special enrollment costs that are already reflected in the historical experience, is double counting any impact that special enrollment might have.

The virtually complete absence of meaningful data and information regarding how the specific numerical value included the filing was derived makes it is difficult to analyze this item. The Department of Managed Health Care should request the underlying support and detailed calculations for this 1.7% increase in rates due to duration, which will cost policyholders about $25 million.[44] Furthermore, any information submitted to DMHC should be made public, so that policyholders can evaluate the basis for any rate increase that is allowed.

4. Cost Containment Issues

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:[45]

> (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.

[44] $25 million = $281 million (overall dollar increase) X 1.7% / 19.4% (overall percent increase)

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

Despite this requirement, the Blue Shield filing did not contain relevant useful information on the issue of cost containment. It is not clear how much is included in the filing for Quality Improvement Expense. The Milliman report gives a value of $3.13 PMPM, but also states "The Quality Improvement adjustment includes a small but unknown amount attributable to Health Information Technology".[46] The Blue Shield filing refers to this amount as "Medical Management".[47]

Whatever the exact value being spent by Blue Shield for Cost Containment and Quality Improvement, it is clearly not working given the huge rate increase of 19.4% being requested.

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.[48] 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.[49]

Given this situation, Blue Shield should explain why its Cost Containment programs do not appear to be accomplishing the intended goal.

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

The derivation of the January 1, 2017 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 7.8% (or 8.5%) included in the Blue Shield filing was excessive and unsupported. We have also previously discussed concerns regarding the

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

[47] The Milliman report refers to the $3.13 as both "Medical Management" (page 7) and "Quality Improvement" (page 10).

[48] 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%.

[49] 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 Blue Shield even more excessive.

basis and support for various expenses and the duration factor, both of which appear to result in excessive premiums being charged to policyholders.

The rate filing by Blue Shield gives the following as various projection factors impacting the rates: (i) population risk morbidity, (ii) demographics, (iii) seasonality, (iv) duration, (v) plan mix, (vi) pediatric benefits and (viii) trend factors.[50] However, no reasonable support was provided for any of the values used by Blue Shield.

The lack of data and support in the Blue Shield filing is inconsistent with accepted actuarial procedures. Actuarial Standard of Practice No. 41, *Actuarial Communications*, states in part:[51]

> 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 Blue Shield 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 thirteen items.[52]

While the numerical values used for some of these items were 1.000 or less, that could still represent an overcharge, since the appropriate value could be lower. For instance, the Morbidity Changes effective value of 1.00 ("No changes in the population risk is expected for 2017") used by Blue Shield (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.

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[50] Actuarial Memorandum, pages 3-4, Section V

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

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

[53] Blue Shield filing, Actuarial Memorandum; states "No changes in the population risk is expected for 2017. The risk profile embedded in the 2015 baseline experience period is expected to continue into 2017." No basis, support, data or information of any kind was provided for that assertion.

The Department of Managed Health Care should 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. Furthermore, any information submitted by Blue Shield to DMHC should be made public, so that policyholders can evaluate the basis for any rate increase that is allowed.

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.