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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 Health Net of California Rate Filing, SERFF Tracking Number HNLH-130549406.

Dear Chief Actuary Thomas:

Consumers Union, the policy and advocacy division of Consumer Reports, writes to draw your attention to some areas of concern in the rate filing of Health Net of California, SERFF Tracking Number HNLH-130549406. In your review of this rate filing, we urge the Department to press the plan to submit adequate and complete information to justify its claims.

I. Health Net's contractual obligation to DMHC, "Undertaking 13," is a unique circumstance requiring heightened review of this rate filing.

II. This rate filing is characterized by numerous factors that were not adequately supported.

III. Health Net fails to justify why various expenses will rapidly escalate in the 2017 plan year.

IV. Health net fails to supply sufficient cost containment and quality improvement programming information, or support for various factors used in the rate calculation.

It should also be considered that Health Net's business in California has been profitable. During 2014 and 2015, Health Net had underwriting profits of 8.6% and 1.4% respectively.[1,2] That is an average actual profit of 5.0%, which was higher than the average expected profit of 2.8%.

[1] California Supplemental Rate Review Template, "Actual-to-Expected 2014" and "Actual-to-Expected 2015" sheets.
[2] In addition to underwriting profits, insurance companies earn profits from investment returns.

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I. Health Net's contractual obligation to DMHC, "Undertaking 13," is a unique circumstance requiring heightened review of this rate filing

To gain approval of its merger with Centene Corp., Health Net agreed to contractual obligations, known as "undertakings," with the Department of Managed Health Care (as well as parallel agreements with the California Department of Insurance). Undertaking 13[3] states:

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

Given that the 9.4% average proposed rate increase is substantially larger than in previous years, we urge the Department to investigate whether Health Net truly did make "every effort to keep premium rate increases to a minimum." The 2017 plan year is undeniably characterized by larger increases than average, but that does not mean a rate filing such as this should not be rigorously reviewed. The vast majority of consumers do not have 9.4% more income in 2017, so every fraction of a percent increase must be evaluated.

II. This rate filing is characterized by numerous factors that were not adequately supported

The rates proposed by Health Net are based on numerous assumptions lacking adequate support. Those assumptions undergird the medical trend projection as well as numerous factors in going from the "Experience Incurred Claims" to the "Projected Incurred Claims."[4]

<u>The filing lacks justification for its medical trend projection.</u>

The 5.9% overall medical trend used by Health Net falls in line with the projection of 5.6% from the national health expenditure projection for 2017,[5] and the 6.5% projection from PricewaterhouseCoopers LLP. Yet, the filing raises questions that should be resolved before any proposed rates are finalized:

1. In asserting an 11.0% prescription drug cost trend, Health Net in its filing says "we use 11.0% in rating which is 1% lower than internal forecast on pharmacy trends."[6] However, that "internal forecast" does not appear to be included with the rate filing. Neither are we aware of external forecasts of 12% increase in pharmaceutical drug

[3] The California Department of Insurance (CDI) extracted a similar undertaking, Undertaking 20(b).
[4] Health Net Filing, Actuarial memorandum and Certification, Projection Factors.
[5] 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.
[6] Rate filing justification for Health Net of California, SERFF HNLH-130549406, at 8.

costs. To the contrary, Express Scripts gives an overall prescription drug trend forecast for 2016 of 6.8% and for 2017 of 7.3%, for an average of 7.0%.[7]

2. As part of its prescription drug trend, Health Net uses a projected specialty Rx trend from 2015 to 2106 of 29% and from 2016 to 2017 of 19%.[8] That is a total trend in the two years from 2015 to 2017 of 54%. While there is a general acknowledgement that costs are increasing for specialty drugs, the trend used by Health Net is extremely large and was not justified.

3. Health Net projects drug utilization will remain the same in 2017, with a 0% prescription drug utilization trend. Although we prefer to see a flat or negative trend like this, a trend at exactly zero seems odd; it also appears inconsistent with Health Net's assertion that it liberalized its guideline for Hepatitis C treatment.[9] Furthermore, several other sources, such as a report from PricewaterhouseCoopers LLP, suggest that since the early 2000s the utilization trend has declined.[10]

Finally, in certifying the Health Net filing for the plan, Milliman included a list of factors[11] on which the medical trend is based, most of which are not laid out in the Health Net filing.[12] Many of these factors are to be expected, but several others raise questions.

1. *Cost for new technologies*: Health Net should be required to demonstrate that these new technologies are actually related to medical claims, rather than an administrative expense. We recommend that this fraction of the medical trend calculation be broken out for the reviewers.

2. *Adverse selection*: In its certification, Milliman asserts that the medical trend includes as a factor the influence of adverse selection "due to the new requirements of guaranteed issue, no pre-existing condition limitations, and modified community rating that prohibits rate variation by other than age, family composition, geographic area, and tobacco use status."[13] This is a familiar contention but one more suitably applied to filings in the first years of the ACA, not for the 2017 plan year. To assert that it still applies would be unjustified, particularly given that 2017 rates are built upon 2015 claims, and 2015 claims are from a period where the new requirements of the ACA were already in place.

3. *Change in overall risk level*: Milliman's statement that the medical trend could be raised by "the migration of new enrollees in an environment that is more likely to

[7] Express Scripts 2015 Drug Trend Report, March 2016, page 41.
[8] California Supplemental Rate Review Template, "Specialty Rx Trends" sheet.
[9] Rate filing justification for Health Net of California, SERFF HNLH-130549406, at 6.
[10] PRICEWATERHOUSECOOPERS LLP, *Medical Cost Trend: Behind the Numbers 2017*, June 2016, at 4.
[11] Milliman, Inc., Health Net of California Individual HMO Policy Filing, at 6.
[12] This in itself is interesting, given that Milliman actuary explicitly stated that his review was entirely based on materials supplied by Health Net. Milliman, *supra*, at 1. "While I reviewed the information for reasonableness, I did not audit the underlying data for correctness."
[13] *Id*.

attract less healthy individuals than healthier ones"[14] raises the question of where these "less healthy individuals" are migrating from and why they are more likely to select Health Net than another plan.

We urge DMHC to question whether the above three factors were included in developing the medical trend used by the plan, and to require that Health Net justify any that were.

The filing lacks sufficient justification for its projected incurred claims.

The rate filing by Health Net includes numerous factors in going from the "Experience Incurred Claims" to the "Projected Incurred Claims".[15] Many of those factors were not reasonably supported. While we will not address each of those items, a brief discussion of three of those items follows.

1. *Release of Pent-Up Demand*: The explanation provided for this was "We believe that Pent-up demand has been fully realized, therefore the factor is 1.0." However, since there was pent-up demand in the historical period (2015), but not pent-up demand for the rate period (2017), then the release of pent-up demand should be a relative decrease in costs, or a factor lower than 1.0.
2. *Adjustment for Emerging 2016 Jan-May Claims*: The filing asserts the following about this: "The URRT instructions state that the base experience period should be calendar year 2015, however emerging 2016 experience (rolling 12 months ending May 2016) is coming in approximately 4.6% higher than CY2015. We assume that 75% of this worsening experience will be mitigated by risk adjustment, therefore we adjust claims by a factor of 1.012 = 1 + (25% x 4.6%)." There are several concerns regarding this. First, the "emerging 2016 experience" along with the comparison to 2015 was not provided,[16] so there is no way to verify the accuracy of the statements provided. Second, insurance companies generally, including Health Net, indicate that medical costs go up over time, so it is not surprising that 2016 costs are higher than those in 2015. Third, this issue should be taken care of in the trend factor, so that there appears to be an overlap or double-counting of the higher costs in 2016.
3. *Claims Adjustment: Hepatitis C*: The filing states "Claims have been adjusted for the impact of new drugs for Hepatitis C, Sovaldi and Olysio. These drugs were introduced in 2014. In 2015, we liberalized the guidelines for allowing the prescriptions. As such, we expect 2017 to be higher than the 2015 experience trended forward to 2017 by $1 PMPM."[17] There are two main concerns regarding this. First, given the very high specialty Rx trend (54% increase from 2015 to 2017)

[14] *Id*.
[15] Rate filing justification for Health Net of California, SERFF HNLH-130549406, Actuarial Memorandum and Certification, Projection Factors.
[16] The California Supplemental Rate Review Template has a sheet "Monthly Claims – Experience" which gives information through for 2015, but no data for 2016.
[17] Rate filing justification for Health Net of California, SERFF HNLH-130549406, at 6.

used by Health Net there would not appear to be a need to add in a further cost increase. Second, if these new guidelines were in place in 2015, it is already reflected in the base experience and therefore does not need to be added in again, which would be an overlap or double-counting.

The Department of Managed Health Care should request that Health Net 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 Health Net to DMHC should be made public, so that policyholders can evaluate the basis for any rate increase that is allowed.

III. Health Net fails to justify why various expenses will rapidly escalate in the 2017 plan year

For 2017, Health Net projects that its administrative expenses will increase to $43.69 PMPM from the $34.10 PMPM projected for the 2016 plan year. This equates to 10.6% of each premium dollar for 2017, a 14% increase in the fraction of premium dollars put towards administrative expenses from the 9.3% for 2016.[18] Health Net fails to justify why its administrative expense will rise at a pace outstripping CPI growth,[19] and there is no information to suggest a need for administrative expenses to become a larger fraction of premium. Given that this increase could cost consumers around $12.3 million[20] in a year where proposed rate increases are at record levels, we urge DMHC to question this assertion.

The expense provisions for both commissions and broker bonus also significantly increased for 2017 compared to 2016. A summary of the expense changes for these three items is shown in the following table.

Expense Load PMPM[21]			
Expense Category	**2016**	**2017**	**Change**
Administrative	$34.10	$43.69	28.1%
Commissions	$8.61	$9.73	13.0%
Broker Bonus	$0.00	$1.94	NA
Total – PMPM	$42.71	$55.36	29.6%
Total - Percent of Premium	11.7%	13.4%	14.5%

[18] 14% = (10.6% / 9.3% – 1) X 100%

[19] 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).

[20] $$12.3 million = Projected earned premium of $946.4 million x (10.6% - 9.3%). (See Health Net filing, "Requested Rate Change Information" Section.

[21] Source: A1295-California Rate Filing Form (#24).pdf

The proposed expenses also do not appear to take into account the savings anticipated from the merger with Centene. In its "2016 Investor Day" presentation on June 17, 2016 Centene discussed the following:[22]

- *"Realization of SG&A synergy opportunities tied to core operational enhancements and improvements using Centene model"*
- *SG&A cost reductions of 30% for claims, 10% for call center, 20% for Provider Data Management and 10% for Enrollment & Billing*
- *Savings in Year 1 of $75 million, split as 40% Core G&A Efficiencies and 60% for Medical Costs*
- *Cognizant Savings in Year 2 of $150 Million for Core G&A Efficiencies, Specialty Company Integration, Medical Costs and Technology Platform*

Health Net has not explained how these projected savings in both SG&A and Medical Costs have been considered in its rate filing.

IV. Health Net neglects to supply sufficient 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 Health Net 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.[23] 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 Health Net 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 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 Health Net, in their rate filings.

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[22] http://www.centene.com/investors/document-library/presentations/; slides 54, 55 and 61.

[23] 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%.

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). This year, the plans had a virtual answer key available to them on what cost containment and quality improvement measures they will pursue: those required by its QHP contract with Covered California. Yet, Health Net only says the following on the topic.

- "Starting in 2016 we have committed to reducing our health care costs through several cost containment initiatives. We valued these initiatives at $0.95 PMPM for the Payment Integrity program and $1.80 for the OON payment program. The full realization of these 2016 initiatives reduces costs by $2.75,"[24] and
- An estimate of 0.7% of revenue, or $2.92 PMPM, will be spent on quality improvement.[25]

This is far from submitting sufficient details on which a reviewer could determine how the plan will tackle cost containment and also improve its quality. Not only does it lack relevant facts, but the cost containment figures may also be misplaced; these debits seem more like administrative expenditures. For example, will the savings from the OON payment program contain costs for consumers or just for Health Net? The cost and quality of healthcare are major consumer concerns, yet Health Net submits very little 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. We therefore urge DMHC to pursue this information from Health Net, and make any new information publicly available.

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

Health Net's proposed 2017 products are the highest cost of all Silver products offered in four regions in the state.[26] Most 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, when it comes to EPOs, consumers pay the price for freedom of choice with the reality that they may be free to choose, but their options will be substantially more limited. For consumers, what this means is expensive products with no option of going out-of-network with any amount of insurance coverage. The EPO model also lacks the care coordination that is integral to HMO

[24] Rate filing justification for Health Net of California, SERFF HNLH-130549406, at 5.
[25] Rate filing justification for Health Net of California, SERFF HNLH-130549406, at 12.
[26] Those regions are Regions 4, 8, 10, and 11.

products. We recommend that DMHC press Health Net to supply sufficient justification for the expense of these products. That information should be posted publicly and paired with details to assist consumers in determining whether a Health Net plan is right for them. In addition, we urge DMHC to provide as much information as possible to consumers about each of the different product types offered, and to work with Covered California to ensure that enrollees have the necessary information to make the right purchasing decision for them and their families.

In addition to learning more about the type of products offered by Health Net in 2017, HMO versus EPO, Californians need a clear understanding of the decision reached on this and all 2017 plan year rate requests. 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 all the 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 appreciate that DMHC provided 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 place it with the rest of the rate

filing. Information that is directed to the public on this important topic, and which explains the Department's work, should be promoted.

Conclusion

In a rate review climate overheating with substantial rate increases, a proposed rate increase that is slightly cooler than the others—but still much higher than in years past—should not be exempt from rigorous review. In reviewing the filing submitted by Health Net, we were struck by questions listed above. We strongly urge DMHC to demand additional documentation from Health Net—as it will for the plans with larger proposed increases—to ensure that all increases are reasonable and justified.

Sincerely,

Dena B. Mendelsohn
Staff Attorney
Consumers Union