

September 7, 2016

Wayne Thomas, Chief Actuary, Division of Premium Rate Review
Division of Premium Rate Review
Department of Managed Health Care
980 9th Street, Suite 500
Sacramento, CA 95814-2725

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

Re: Consumers Union's comments on Blue Cross of California (dba "Anthem Blue Cross") SERFF Tr Num AWLP-131113535, Implementation 01/01/2018

Dear Chief Actuary Thomas:

Consumers Union, the policy arm of nonprofit Consumer Reports, writes to provide you with comments on the Anthem Blue Cross of California (dba Anthem Blue Cross) Rate Filing, SERFF tracking number AWLP-131113535, for the individual market. In this year of unprecedented uncertainties, we appreciate Covered California's efforts to maintain Anthem's presence for 108,000 Californians.¹ Although the carrier will retreat from sixteen out of nineteen of the insurance regions, the three regions in which they remain represent nearly half of their 2017 enrollees.² Their continued presence in the Marketplace is of course welcomed. At the same time, it is important that this rate filing undergo careful scrutiny. In particular, we write to the Department of Managed Health Care (DMHC) to call attention to the following areas of concern:

- 1) The medical trend projections are high and suggest that Anthem enrollees will increase their use of healthcare, particularly prescription drugs, at a far greater rate than enrollees with other carriers, without supporting data to prove that projection or explanation of what they are doing to respond to that trend.
- 2) The language used to explain quality improvement efforts duplicates that used for the 2017 plan year, which DMHC found to be inadequate that year, and is silent on cost containment efforts.
- 3) The filing includes factors that were not adequately supported, such as grace period surcharge, and the certifying actuary relied on that limited information in certifying the filing.

¹ Covered California, *Covered California's Individual Market in 2018: Competition and Choice*, (August 1, 2017). Available at https://www.coveredca.com/news/PDFs/CoveredCA_Consumer_Choice_2018.pdf.

² According to Covered California, the 16 counties from which Anthem will withdraw serves approximately 153,000 consumers and the three counties where Anthem will remain serves approximately 108,000 consumers. Covered California, *Covered California's Individual Market in 2018: Competition and Choice*, (August 1, 2017).

- 1) The medical trend projections suggest that its enrollees will increase their use of healthcare, particularly prescription drugs, at a far greater rate than other carriers, without supporting data to prove that out or explanation of what they are doing to respond to that trend.**

In its rate filing justification (RFJ), Anthem projects an annual overall medical trend of 13.2%. This far out-strips the national 5.7% private health insurance spending growth projected by CMS,³ as well as the 6.5% projection from PricewaterhouseCoopers LLP.⁴ Notably, the overall medical trend projected by Anthem is by far the highest of those offered by other health plans also selling in the California individual market and 4.2% higher than that of Blue Shield of California, which is expected to take on many of Anthem’s enrollees. Not only that, but the carrier also projects the largest utilization trends for all but one sub-category of its medical trend calculation. Something unique may be happening with the Anthem member pool, but the reader of the Anthem filing cannot know what that is, because the filing lacks sufficient data to support its assertions.

In the table below, the information in the Anthem rate filing is compared to details from the other major carriers selling through Covered California. This side-by-side comparison, along with a comparison to the prior year’s filing, highlights the fact that:

- Anthem projects its 2018 enrollees will use significantly more healthcare than they did in 2017.
- Anthem projects the increase in its members’ use of healthcare will surpass the increase experienced by all the other major carriers selling on the state Marketplace for 2018.
- Anthem projects an extraordinary increase in its enrollees’ use of prescription drugs at *four-or-more times* the rate of enrollees at other carriers.

Type of Trend	Anthem Blue Cross	Health Net	Blue Shield of California	Molina	Oscar
Overall medical trend	13.20%	6.20%	9.00%	6.80%	3.30%
Hospital inpatient	9.90%	5.60%	11.40%	2.90%	1.00%
Inpatient Hospital cost	3.40%	4.70%	4.00%	1.90%	1.00%
Inpatient Hospital Utilization	6.20%	0.90%	7.10%	1.00%	0.00%
Hospital outpatient (including ER)	9.90%	5.40%	4.80%	4.90%	2.80%
Outpatient Hospital cost	3.40%	4.50%	4.20%	2.40%	1.30%
Outpatient Hospital Utilization	6.20%	0.90%	0.60%	2.50%	1.50%
Physician/other professional services	9.90%	4.90%	5.20%	3.60%	1.50%
Professional Cost	3.40%	4.00%	1.40%	0.60%	0.00%
Professional Utilization	6.20%	0.90%	3.80%	3.00%	1.50%
Prescription Drug	30.00%	15.00%	16.40%	10.60%	9.90%
Prescription Drug Cost	7.20%	15.00%	10.30%	5.00%	8.50%
Prescription Drug Utilization	21.20%	0.00%	5.50%	5.30%	1.30%

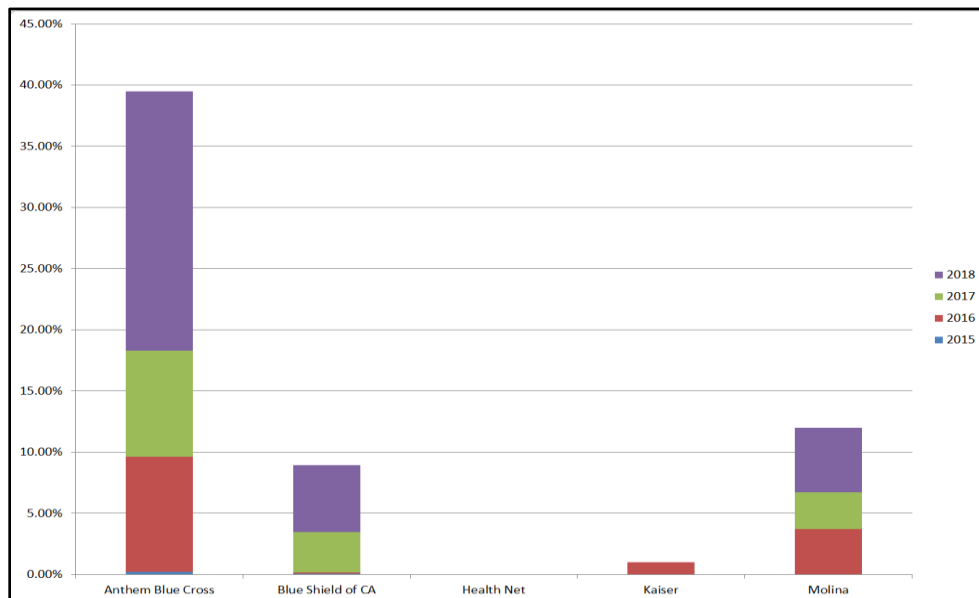
Unnecessary and unsafe prescription drug use is an area of enormous concern for Consumers Union and policymakers. Evidence shows that the inappropriate use of antibiotics has increased the

³ The Office of the Actuary in the Centers for Medicare & Medicaid Services, *NHE Projections 2016-2025*, available at <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsProjected.html>.

⁴ PricewaterhouseCoopers, *Medical Cost Trend: Behind the Numbers 2018*, (June 2017).

prevalence of antibiotic-resistant bacteria.⁵ Concurrently, opioid addiction—which often starts with unnecessary or inappropriate prescriptions—has risen to crisis point across the country.⁶ It therefore bears questioning why Anthem’s enrollees will increase their utilization of prescription drugs in 2018, and why to such an extent. We also question which prescription drugs Anthem anticipates will increase in use the most, and what the carrier is doing to ensure that consumers are taking the right prescriptions, at the right time, for the right duration. Although prescribing and treatment plans are rightly the role of providers in partnership with their patients, we believe there is a role for carriers to avoid harm and optimize outcomes, especially when that carrier anticipates explosive growth in prescription drug use by its enrollees.

Furthermore, we note that over a four year span, Anthem’s prescription drug utilization trend has consistently outstripped that of the other carriers (shown below).⁷ The enrollee population among the carriers is not static—it is subject to change as consumers are encouraged to “shop around” during open enrollment, and as they switch between a Covered California product, Medi-Cal, and employer-based coverage. We therefore encourage the Department to inspect this extreme trend pattern that appears to be unique to Anthem, and to confirm that these large utilization trends, which build on each other year after year, are justified with solid data.



Overall, based on the limited information provided in the Anthem rate filing, we request that in its rate review communications with the carrier, the Department ask the following questions and require that answers be substantiated with data as well as narrative.

- Why Anthem anticipates its enrollees will have a substantially higher medical and prescription drug utilization rate in 2018 than in 2017.
- Why Anthem’s enrollees have sizeable prescription drug utilization trends year after year.

⁵ Consumer Reports, *Protect Yourself From the Overuse of Antibiotics*, (July 28, 2017). Available at <https://www.consumerreports.org/overuse-of-antibiotics/protect-yourself-from-overuse-of-antibiotics>.

⁶ Consumer Reports, *Some Doctors Still Prescribe Too Many Opioids, CDC Finds*, (July 6, 2017). Available at <https://www.consumerreports.org/opioids/some-doctors-still-prescribe-too-many-opioids-cdc-finds>.

⁷ This graph shows the cumulative total of each year of utilization trends. In reality, the total of these trends would be far greater, exceeding 40%. As each percentage is layered on top to the earlier percentage, the final result would be larger than the result of simple addition.

- Whether any of Anthem’s quality improvement or cost containment initiatives are designed to address prescription drug utilization trends.
- What data Anthem has on how much the carriers receive back from pharmaceutical manufacturers in rebates, including whether and how those rebates are factored into cost sharing.⁸

2) The language used to explain quality improvement efforts duplicates that used for the 2017 plan year, which DMHC found to be inadequate that year, and is silent on cost containment efforts.

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

California’s rate review law, nearly unique among the states, requires health plans and insurers such as Anthem to specify and estimate their quality improvement and cost containment efforts. Health and Safety Code §1385.03(c)(3) requires plans to detail “significant new health care cost containment and quality improvement efforts and provide an estimate of potential savings together with an estimated cost or savings for the projection period.”⁹ The purpose of this provision is to improve Californians’ health as well as to bend the cost curve in order to make coverage affordable. Health plans in general—and Anthem in particular, as one of the largest carriers in California—have the ability and the responsibility to serve as resources and partners with their members in seeking and obtaining the highest quality, most appropriate healthcare when needed. And yet, over the past three years, Consumers Union has noted universal shortcomings in the information supplied by the plans about quality improvement and cost containment in their rate filings.

During the 2017 rate review period, Consumers Union and allied California health advocates pressed for 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). When Anthem failed to provide sufficient information, an actuarial firm acting on behalf of DMHC demanded it of them;¹⁰ when that response was found insufficient, Anthem was compelled to expand on its answer.¹¹ In preparing its rate filing for 2018, Anthem knew the information required of them. Yet, aside from projecting a quality improvement expense of \$7.49PMPM, Anthem here submits no information on how it is addressing quality. In fact, it submitted the exact same language that the Department found lacking just one year prior, (as shown below with the 2018 filing highlighted), and the term “cost containment” never appears in the filing.

• Quality Improvement Expense

Quality Improvement initiatives include programs such as Improve Health Outcomes, Activities to Prevent Hospital Readmissions, Improve Patient Safety and Reduce Medical Errors, Wellness and Health Promotion Activities, and Health Information Technology Expenses for Health Care Quality Improvements.

• Quality Improvement Expense

Quality Improvement initiatives include programs such as Improve Health Outcomes, Activities to Prevent Hospital Readmissions, Improve Patient Safety and Reduce Medical Errors, Wellness and Health Promotion Activities, and Health Information Technology Expenses for Health Care Quality Improvements.

Source: Anthem 2017 Rate Filing

Source: Anthem 2018 Rate Filing

⁸ On page 5 of the Anthem Blue Cross *Actuarial Memorandum*, and *Exhibit F* of the Anthem filing, the carrier accounts for rebates in the cost of prescription drugs but fails to include supporting data.

⁹ California Health and Safety Code Section 1385.03(c)(3).

¹⁰ NovaRest Actuarial Consulting, Memorandum Subject: Anthem Blue Cross Individual 2017 Rate Filing, (September 6, 2016).

¹¹ NovaRest Actuarial Consulting, Memorandum Subject: Anthem Blue Cross Individual 2017 Rate Filing, (September 15, 2016).

Transparency is a foundational element of the rate review process. For Anthem to fail to provide information that is clearly required to DMHC—and instead file copy that was insufficient just one year prior—suggests that a firm response from DMHC regulatory officers is appropriate. This many years into the rate review process, there is no excuse for this shortcoming.

3) The filing includes factors that were not adequately supported, such as grace period surcharge, and the certifying actuary relied on that limited information in certifying the filing.

As in prior years, we are struck by the extent to which Anthem provided the minimum materials possible to substantiate its proposed rate increase, in some cases falling short. In addition to adopting inadequately supported medical and pharmaceutical trends, and failing to provide sufficient detail on quality improvement and cost containment efforts, the filing submitted by Anthem also lacks sufficient information and data to support other the values in its rate filing, such as its grace period surcharge.

As Anthem explains in its filing, its rates for 2018 are adjusted to “account for incidences of enrollees not paying premiums due during the first month of the 90-day grace period when the QHP is liable for paying claims.”¹² According to past filings, Anthem has adjusted rates to account for uncompensated grace period claims for the 2017 plan year,¹³ the 2016 plan year,¹⁴ and the 2015 plan year.¹⁵ The adjustment for 2018 is the largest of the past four years. As in other areas of the filing, and consistent with its assertions of grace period adjustment in prior years, Anthem provided insufficient information to support its assertion; there is also neither reference to nor justification for the fact that the grace period adjustment for 2018 exceeds that of each of the prior years, which suggests that the problem has gotten worse each year. We therefore encourage DMHC to inquire with the plan whether it has the data to support the extent to which consumers are failing to pay premiums for care they obtain during the grace period.

The lack of support for the values included in this filing is intensified by the fact that the independent actuarial report included with the Anthem filing, for the most part, simply accepted the values provided by Anthem, stating “ActMod did not conduct a detailed review and relied on the information provided by the qualified Anthem actuary identified in Attachment 2.”¹⁶ Although the lack of data and support in the Anthem filing is consistent with accepted actuarial procedures,¹⁷ that does not mean it is *best practice* for a certifying actuary. Something with such a large impact on consumers—including an average 35.4% rate increase—should receive the utmost scrutiny, which

¹² Anthem Blue Cross *Actuarial Memorandum* at p.5.

¹³ Anthem Blue Cross rate filing, Rates Effective January 1, 2017, Exhibit E -- application of a 1.0034 experience rate.

¹⁴ Anthem Blue Cross rate filing, Rates Effective January 1, 2016, Exhibit D -- application of a 1.0019 experience rate.

¹⁵ Anthem Blue Cross rate filing, Rates Effective January 1, 2015, Exhibit D -- application of a 1.0038 experience rate.

¹⁶ Report Prepared By Actuarial Services & Financial Modeling, Inc. As Requested By Anthem Blue Cross Regarding Individual Rates to be Filed with the California Department of Managed Health Care For Health Care Plans with an Effective Date of January 1, 2018, (July 17, 2017), at p.5.

¹⁷ See Actuarial Standards Board, Actuarial Standard of Practice No. 41, Actuarial Communications. Available at <http://www.actuarialstandardsboard.org/asops/actuarial-communications>. Specifically, Section 3.2 Actuarial Report, states: “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.”

is why an independent actuarial certification is part of the process. A certification that relies on information provided in the document under review as fact falls short.

Therefore, in addition to closely scrutinizing this filing, we press DMHC to emphasize to Anthem—and each of the other plans filing with the Department—that rate filings must be comprehensive, detailed, and substantially supported; and for future filings, all independent actuarial certifications be conducted without undue reliance on assertions made by the plans themselves.

Conclusion

We strongly urge DMHC to demand additional documentation from Anthem to fully justify its substantial proposed rate increase of 35.4% on average, the highest of all the carriers.¹⁸ If Anthem is unable to provide sufficient information, given the financial burden of escalating costs on California families and in light of Anthem's strong financial footing, Consumers Union urges DMHC to find the requested rates unreasonable and not justified.

Sincerely,



Dena B. Mendelsohn
Staff Attorney
Consumers Union

¹⁸ The 35.4% average proposed rate increase is for the Anthem filing that assumes CSR is paid. The alternate filing, if CSR is not paid, proposes a 40.6% rate increase and is only topped by that of Molina Healthcare of California's non-CSR filing, which proposes a 44.7% average annual rate increase.