DEPARTMENT OF Managed Healthcare

State of California

Application for an Award of Advocacy and Witness Fees

Entity Name:	Consumers Union of United States, Inc.
Date Submitted:	11/6/2017 3:41:21 PM
Submitted By:	Dena Mendelsohn
Application version:	Original App

1. For which proceeding are you seeking compensation?

   Anthem individual market rate filing

2. What is the amount requested?

   $12,300.00

3. Proceeding Contribution:

   Provide a description of the ways in which your involvement made a substantial contribution to the proceeding as defined in California Code of Regulations, Title 28, Section 1010(b)(14), supported by specific citations to the record, your testimony, cross-examination, arguments, briefs, letters, motions, discovery, or any other appropriate evidence.

   Dena Mendelsohn, Senior Attorney for Consumers Union, reviewed many of the rate filing justifications posted on the DMHC rate review website for 2018, with an eye towards identifying any filing that required more in-depth analysis. The size of the rate increase proposed by Blue Cross of California (dba Anthem Blue Cross) compelled us to fully review their filing and to submit detailed comments urging the Department to press further on components of the Anthem filing that we believed could lead to consumers being overcharged. In our comment letter, dated September 7, 2017, we informed DMHC where Anthem failed to provide sufficient information to justify the basis of its rate increase, and identified information gaps DMHC should seek to resolve before the end of the rate review period. Our comments called attention to: 1. Unusually high medical trend projections, particularly in terms of prescription drugs, without supporting data to prove that projection or explanation of what they are doing to respond to that trend. 2. Failure to explain quality improvement or cost containment efforts. 3. Factors such as its grace period surcharge, which were not adequately supported, and Anthem's actuarial certification that relied on limited information in certifying the filing. By participating in the California rate review process this past summer, Consumers Union assisted the Department in identifying problematic areas of Anthem's rate filing, and urged the Department to push back against a particularly large and unfair rate increase. In a summary DMHC provided after rate review was complete, the Department noted that "During the course of our review trend and area factors were modified that resulted in the average rate increase being lower than originally filed." We believe the issues we raised--comparisons of Anthem's projections and trend factors to those of its competition, questions of why Anthem's projections were so much higher than its competitors', and our request that the Department demand additional documentation from the company--played a role in this outcome reducing the original rate request. Thus, we believe our analysis and arguments made a substantial contribution to the outcome which DMHC estimates saved California consumers roughly $21 million.

4. Please attach your time and billing record in the "Add Attachment" box below. In the time and billing record, include the hourly rate of compensation for each witness or advocate and a justification for each hourly rate, which may include copies of or citations to previously approved hourly rate; and each witness or advocate's resume or curriculum

vitae. The time and billing record should show the date and exact amount of time spent on each specific task in thirty (30) minute increments, as defined in California Code of Regulations, Title 22, Section 1010(d)(3).

Document Name	Date Uploaded	Uploaded By	
Consumers Union Time and Billing Record - Anthem 2018 individual plan	11/6/2017 3:38:22 PM	Dena Mendelsohn	View
Imholz resume	11/6/2017 3:38:46 PM	Dena Mendelsohn	View
Mendelsohn resume	11/6/2017 3:39:00 PM	Dena Mendelsohn	View
Consumers Union comments on Anthem rate filing	11/6/2017 3:39:34 PM	Dena Mendelsohn	View
LA Times article citing Consumers Union contribution	11/6/2017 3:40:09 PM	Dena Mendelsohn	View

5. Clear and concise statement of participants interest in the proceeding which explains why participation is needed to represent the interests of consumers

For Consumers Union, obtaining affordable, high quality healthcare for all Americans has been a banner issue from our inception in 1936. Consumers Union works solely for the consumer interest, accepting no commercial contributions. Since the founding of the West Coast Office in San Francisco in 1975, Consumers Union has been dedicated to representing the interests of diverse California consumers of health plan products in the commercial market. We protect and advocate for those interests in multiple forums including the California legislature, administrative agencies, the courts, and the marketplace generally. One area of special focus for Consumers Union's West Coast office both federally and at the state level has been health plan and insurer rates. The West Coast Office is Consumers Union's "rate review hub." We supported SB 1163 and, after it was enacted, wrote regulatory guidance comments on it to both the Department of Insurance and DMHC. In 2010, Consumers Union undertook an intensive rate review project, funded by the Robert Wood Johnson Foundation, which trained advocates around the nation and created materials still used today including an advocates' toolkit and paper on nonprofit insurer surplus, published How Much is Too Much (updated in 2015). In 2011, we began a three- year contract with DMHC on rate review under which we undertook numerous reviews in California, submitted detailed comments on several, and worked to build alliances with consumer group allies and to educate the public about health insurance ratemaking. Additionally, over 2014-2015, Consumers Union authored an array of materials to consumer advocates in the rate review process, including a Timeline of the rate review schedule nationwide, a primer on specialty drug costs, a FAQ, and a PowerPoint presentation that explains the rate review process and how advocates/consumers can be involved. Finally, over 2014-2016, funded under a contract from DMHC, (and one contract extension for 2016), Consumers Union reviewed California health plan rate filings, submitted extensive comments on five rate filings, educated the public via blogs and social media, and engaged over 5,200 Californians in a rate review-related petition to DMHC in 2015.

6. The information contained in the Petition to Participate remains true and correct to the best of the knowledge of the person verifying the information.

Yes

I am authorized to certify this document on behalf of the applicant. By entering my name below, I certify under penalty of perjury under the laws of the State of California that the foregoing statements within all documents filed electronically are true and correct and that this declaration was executed at San Francisco (City), CA (State), on November 06, 2017 .

Enter Name: Dena Mendelsohn

Consumers Union Time and Billing Record for Award of Advocacy and Witness Fees
Health Insurance Rate Review - Anthem Blue Cross Individual Product for 2018 Plan Year

BETSY IMHOLZ, Special Projects Director -- RATE: $425/hour*				
Date	Description	Time spent in hours (in 30 min increments)		Amount
8/31/2017	Review and inset comments/edits on draft letter	1.5	$	637.50
9/5/2017	Review final letter	0.5	$	212.50
9/1/2017	Review Anthem comment letter, provide feedback, additional information	1	$	425.00
	TOTAL	**3**	**$**	**1,275.00**

DENA MENDELSOHN, Senior Staff Attorney -- RATE $350/hour*				
Date	Description	Time spent in hours (in 30 min increments)		Amount
8/1/2017	Review Covered California rate book, research on medical trends-review of national landscape, initial ground work for review of rate filings recently posted, planning conversation with BI.	5	$	1,750.00
8/25/2017	Initial review of Anthem Blue Cross initial pipeline	2	$	700.00
8/25/2017	Research and review literature regarding projected medical trends for 2018, compile medical trend data from 2018 CC filings	2	$	700.00
8/25/2017	Meeting with BI to discuss findings from initial review of filings	1	$	350.00
8/28/2017	Additional review of Anthem initial pipeline document. Start of drafting comment letter.	5	$	1,750.00
8/29/2017	Drafting - Anthem comments	6.5	$	2,275.00
8/30/2017	Drafting - Anthem comments	4	$	1,400.00
9/1/2017	Editing and revision of Anthem comments, fact check and citations check	4	$	1,400.00
9/6/2017	Phone call with outside actuary, to receive feedback, discuss issues raised, and confirm actuarial details of the filing.	0.5	$	175.00
9/6/2017	Final proofing, revisions, and submission of CU and actuary's comments on Anthem rate filing	1.5	$	525.00
	TOTAL	**31.5**	**$**	**11,025.00**

TOTAL HOURS		**34.5**
TOTAL AWARD REQUESTED	**$**	**12,300.00**

* Hourly billable rate is based on the hourly rate set by the Public Utilities Commission of the State of California, and used calculating other recent CPP awards.

Elizabeth Imholz, JD
Director of Special Projects
Consumers Union, 1535 Mission Street, San Francisco, CA 94103
415-431-6747 x125 • 415-431-0906 Fax • BImholz@consumer.org

EXPERIENCE

Oct. 2006-present **Special Projects Director, Consumers Union of U.S., Inc.**
Serves as liaison on health policy work between CU's Advocacy and Editorial Divisions. Provides strategic advice on, develops and leads consumer engagement-oriented health projects. Manages multiple projects including California Safe Patient Network, Community Health Assets Project, and Consumer Voices in Health IT.

Jan. 1999-Sept. 2006 **Director, Consumers Union of U.S., Inc., West Coast Office**
Developed and supervised implementation of policy agenda for regional office of national nonprofit; specialty focus on health policy and community engagement; provided leadership among consumer and other nonprofit groups across the country; developed and oversaw annual budget of $2.1 million; led fundraising that resulted in $10 million in foundation grants and other outside funds; supervised staff of 16; engaged in and supervised lobbying, media work, and development of reports and studies.

Dec. 1994-Dec. 1998 **Senior Attorney/Policy Analyst, Consumers Union of U.S., Inc., West Coast Office**
Directed office's health team, focusing on access, quality and affordability of health care. Included extensive project development, media work, hearing testimony, advocacy before government agencies, trainings, lobbying and coordination of consumer group allies. Developed and managed highly successful project on enlisting local residents and their schools to assume leadership role in reaching out to families to enroll their children in government-sponsored health insurance.

Nov. 1991 to Dec. 1997 **Director, Higher Education and Training Access Project, National Consumer Law Center**
Established national network of public interest groups and consumers involved in advocacy on behalf of low-income students on higher education and job training funding issues. Drafted proposals for reauthorization of federal Higher Education Act, the principal legislation dealing with federal involvement in postsecondary education, including for consumer representation in negotiated rulemaking. Secured consumer participants in subsequent negotiated rulemaking proceedings. From 1991 through 1994, the project operated under aegis of Legal Services for New York City and South Brooklyn Legal Services.

June 1993 to Dec. 1994 **Special Consultant, California Council for Private Postsecondary and Vocational Education**
Acted as liaison between state agency that licenses proprietary trade schools and federal and other state agencies. Trained agency staff on student loan and other legal issues.

Sept. 1990 to Nov. 1991 **Consumer Law Coordinator, Legal Services for New York City**
Organized and chaired consumer law task force for attorneys serving low-income consumers. Conducted training for citywide Legal Services staff and pro bono private attorneys. Served as consumer law resource for neighborhood programs. Lobbied state and federal agencies and legislatures for consumer law reform. Testified before committees of U.S. Senate and House of Representatives concerning fraudulent practices within proprietary trade school industry.

Oct. 1984 to Nov. 1991 **Director, Consumer and Employment Unit, South Brooklyn Legal Services**
Supervised consumer and employment law unit of attorneys, paralegals, and law students. Initiated national vocational school watch project consisting of federal and state legislative and administrative advocacy; class action litigation; community education and engagement; and substantial media coverage. Engaged and coordinated services of pro bono counsel. Notable decisions: Minino v. Perales, 79 N.Y. 2d 883 (1992); U.S. v. Grundhoefer, et al., 916 F. 2d 788 (2d Cir. 1990); Figueroa v. Market Training Institute, et al., 562 A.D. 2d 175 (2d Dept. 1990).

Sept. 1980 to Sept. 1984 **Staff Attorney, South Brooklyn Legal Services**
Handled consumer, employment, and government benefits (Social Security Disability, public

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assistance, and unemployment benefits) cases before federal and state courts and administrative tribunals. Notable decisions: Robinson v. Secty of Health and Human Services, 733 F. 2d 255 (2d Cir. 1984); Dartmouth Plan, Inc. v. Valle, 117 Misc. 2d 534 (Sup. Ct. Kings Co. 1983).

Jan. 1979 to Jan. 1980 **Research Assistant, Professor Arthur Kinoy, Rutgers School of Law**
Researched and wrote memoranda on constitutional and civil rights issues. Helped compile materials for Professor Kinoy's book, Rights on Trial (1983).

Summers, 1978 and 1979 **Law Clerk, Reproductive Freedom Project, American Civil Liberties Union Foundation**
Researched and wrote briefs, legal memoranda, motions, and affidavits for federal litigation on reproductive rights.

May 1976 to Sept. 1977 **Legislative Assistant, Office of the City Council President**
Assisted in development of Ombudsman Office to handle citizen complaints against New York City agencies. Wrote reports for New York City Charter Revision Commission. Analyzed contracts presented for approval by Board of Estimate and ordinances introduced before City Council.

EDUCATION

June 1980 **Rutgers University School of Law**, Newark, New Jersey
Juris Doctorate
Clinical Experience: Women's Rights Litigation Clinic (1978)
Urban Legal Clinic (1980)
Honors: Articles Editor, *Women's Rights Law Reporter,* (1979-1980)
G.A. Moore Prize for distinguished work in equal employment opportunity law.

May 1976 **Columbia University**, New York, New York
Bachelor of Arts, Political Science and Urban Studies
Honors: *Magna Cum Laude*
Columbia University Scholarship (1973-1976)
Phi Beta Kappa

BAR MEMBERSHIPS

- New York State (1981)
- Federal District Court, Southern and Eastern Districts of N.Y. (1981)
- Federal Court of Appeals, Second Circuit (1989)

PROFESSIONAL AWARDS, HONORS, MEMBERSHIPS

- National Consumer Law Center, Vern Countryman Consumer Law Award (1996): For "outstanding efforts to strengthen and affirm the rights of low-income Americans through the practice of consumer law."
- Association of the Bar of the City of New York, Legal Services Award (1991): For "outstanding work in providing civil legal assistance to the poor in New York City and equal access to justice."
- California Department of Managed Health Care, Advisory Committee on Managed Care, Gubernatorial Appointee (2000-2005).
- U.C.L. A. California Health Information Survey, Advisory Board Member.
- Insure the Uninsured Project Award (2009): For "Thoughtful Leadership on Value Purchasing and Quality Improvement."

PUBLICATIONS

- *Caveat Venditor*, a New York consumer law manual, with Stephen Newman, Professor of Law at New York Law School (1994).
- "Jobs, Education, Employment and Training," *Clearinghouse Review*, January 1994 co-author on advocacy opportunities.

Dena B. Mendelsohn, JD MPH
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PROFESSIONAL EXPERIENCE

Consumer Reports

Senior Staff Attorney (2017-Present)
Staff Attorney (2015-2017)
Health Policy Analyst (2014-2015)

- Advocating for affordable, quality healthcare for consumers nationwide, focusing on health insurance, federal health reform, and insurer accountability.
- Research and analyze federal and state healthcare policy regarding premium rates, health insurer practices, and insurer mergers.
- Review rate filing justifications filed in California, submit comments to DMHC, and create consumer engagement opportunities around rate review. Consult with advocates nationwide on specific rate filing justifications filed outside California.
- Author reports and blogs on health insurance, health insurance rates, and health information technology.
- Crafting of written comments and oral testimony for state and federal regulators in response to state and federal rulemaking, as well as for hearings on proposed health insurance mergers.
- Cultivating a consortium of experts and advocates on health insurance rate setting by convening regular conference calls and providing detailed briefs in easily accessible formats.
- Contribute to a national campaign working on ending "surprise medical bills."
- Appointed to serve on a national committee addressing health IT and patient safety.

Independent Consultant (2013-2014)

Provided executive services to small businesses.

- Copywriting, copy editing, strategic thinking, and project management.
- Rehabilitation, improvement, and in some cases wholesale replacement of Excel workbooks.
- Legal research and writing.

Pacific Business Group on Health

Policy Analyst (2011-2013)

Balance priorities with aggressive timelines, working with stakeholders and experts nationwide to improve the quality, safety, efficiency, and patient-reported outcomes of health care.

- Comment letters on federal regulations related to health IT, Affordable Care Organizations, and Medicare data release.
- Policy analyst support to national representatives on four federally-funded committees.
- Ad hoc assignments related to employer wellness programming.
- Special assignments for the Executive director: creation of policy PowerPoint presentations, membership newsletter, Affordable Care Act (ACA) press releases.
- Proposed and drafted strategic communications including press releases and newsletter.
- Internal project management.

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POLICY & ACTION FROM CONSUMER REPORTS

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.

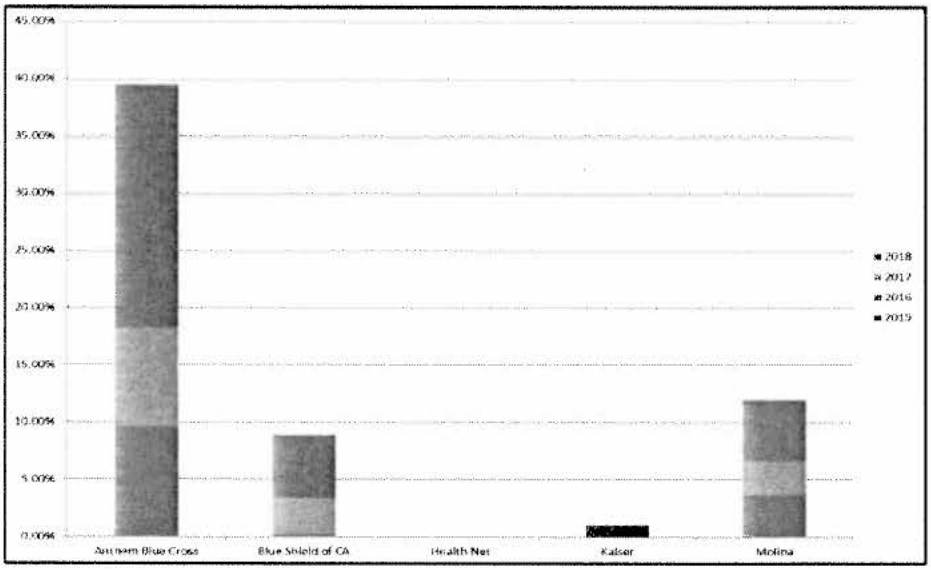
Type of Trend	Anthem Blue Cross	Health Net	Blue Shield of California	Molina	Oscar
Overall medical trend	13.20%	**6.20%**	**9.00%**	**6.80%**	**3.30%**
Hospital inpatient	**9.90%**	**5.60%**	11.40%	**2.90%**	**1.00%**
Inpatient Hospital cost	3.40%	4.70%	4.00%	1.90%	1.00%
Inpatient Hospital Utilization	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.

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[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.

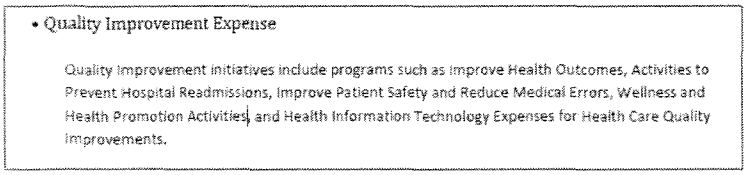
- Whether any of Anthem's quality improvement or cost containment initiatives are designed to address prescription drug utilization trends.
- What data Anthem has on how much the carriers receive back from pharmaceutical manufacturers in rebates, including whether and how those rebates are factored into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

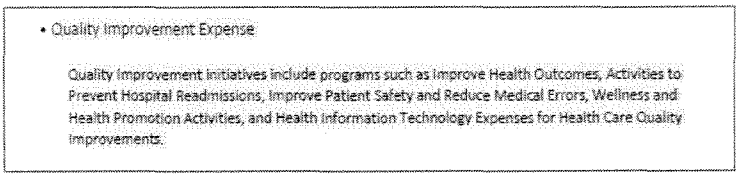
California's rate review law, nearly unique among the states, requires health plans and insurers such as Anthem to specify and estimate their quality improvement and cost containment efforts. Health and Safety Code §1385.03(c)(3) requires plans to detail "significant new health care cost containment 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.

Source: Anthem 2017 Rate 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.

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

Dena B. Mendelsohn
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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.

Anthem eases up on 2018 health insurance premium hikes after pressure from California

The Anthem logo at the company's corporate headquarters in Indianapolis. Anthem cut two planned premium increases after California regulators challenged its estimates of drug expenses. (Darron Cummings / AP)

By **Chad Terhune**

OCTOBER 12, 2017, 5:45 PM

Insurance giant Anthem Blue Cross agreed to reduce two planned premium increases for 2018 after California regulators questioned the company's rationale for raising rates by as much as it had initially proposed.

The scaled-back rate hikes, in the individual and small-employer markets, will reduce premiums by $114 million, state officials said.

The California Department of Managed Health Care challenged Anthem's estimates for future medical costs, in particular its prediction of a 30% jump in pharmacy expenses for the individual market — nearly double the estimates of two other big insurers and out of line with industry trends nationally.

As a result of the department's intervention, the nation's second-largest health insurer shaved 3 percentage points off its 2018 rate increase for individuals and families, still leaving a hike of 37.3%. That puts the company second — after Molina Healthcare — among the 11 insurers that sell in the Covered California exchange. Anthem also cut its rate hike on small businesses by more than half, to 2.5%.

The smaller premium hikes are expected to save individuals about $21 million and small-business customers an estimated $93 million.

California's two insurance regulators, the Department of Managed Health Care and an elected insurance commissioner, can pressure companies to reduce their rates, but neither has the authority to block rate hikes.

In a statement, Anthem said it works with regulators routinely "to revisit our assumptions and rates as more data becomes available.... We are pleased that the emerging data allowed us to provide some rate relief to California individuals and small businesses versus what was originally filed."

Regulators said that during their review of Anthem's small-group rates, the company updated its projection for medical spending, which resulted in a lower premium increase than originally proposed.

For the individual market, regulators at the managed care department dug deeper into Anthem's forecast for prescription drug use and spending. "This is a much higher pharmacy trend than we have seen with other carriers and we will need sufficient documentation to consider it reasonable," they wrote to Anthem.

In response to the state's questions, Anthem lowered its estimate of the rise in pharmacy costs by 7 percentage points, to 23%. That led, in part, to the reduced rate increase.

Like all California insurers, Anthem had been asked by state officials to submit two rate filings for the individual market. The lower set of rates assumed that the Trump administration would continue to pay so-called cost-sharing subsidies that help low-income consumers with out-of-pocket costs. The higher rate increases, which state officials adopted on Wednesday, assume President Donald Trump might make good on his threats to end those payments.

Anthem had sought a 35.4% increase under the lower-rate scenario and a 40.6% hike with a surcharge tacked on to reflect the possible loss of subsidies. That higher rate proposal was the one Anthem reduced by 3 percentage points.

The state's examination of Anthem echoed concerns raised by the advocacy group Consumers Union in a letter to regulators on Sept. 7. The group questioned why Anthem's projections were so much higher than its competitors' and asked the state to demand additional documentation from the company.

Dena Mendelsohn, a staff attorney for Consumers Union in San Francisco, said she welcomed any reduction of the rate increase. "We're glad to see the pharmacy trend was brought down during the rate review process. That is exactly why we need such a rigorous rate review process," she said.

However, the 37.3% average rate increase from Anthem still "poses a real concern for consumers," especially those who do not qualify for federal tax credits that help pay for premiums, Mendelsohn said.

Some of the follow-up information Anthem submitted to regulators about its drug costs is under seal. The insurer asserted it contained confidential trade secrets that are protected from disclosure under state law.

The Department of Managed Health Care said it was looking into whether that information can be released publicly.

Another insurer, L.A. Care Health Plan, also faced questions from the managed care department. In response, the health plan dropped its proposed rate increase in the individual market by nearly 9 percentage points, to 21.7%. That would generate savings of $9 million, according to the state.

L.A. Care told regulators it was able to lower its rates after getting new information about the amount of federal cost-sharing subsidies it receives.

Health Net, whose rates for some plans were reviewed by the California Department of Insurance rather than the managed care agency, cut a proposed premium increase of 23% for individual policies nearly in half, to 12.1%. That yielded an estimated savings of $15.1 million, according to the insurance department.

Overall, Molina Healthcare has the highest rate increase for 2018 among insurers selling on the Covered California exchange, at 44.7%. Valley Health Plan comes in lowest at 9.8%.

Blue Shield of California, the largest insurer in the state exchange by enrollment, fell in between at 22.8%. HMO giant Kaiser Permanente will charge 11.6% more, on average, next year. (Kaiser Health News, which produces California Healthline, is not affiliated with Kaiser Permanente.)

Terhune is a senior correspondent for Kaiser Health News, an editorially independent publication of the Kaiser Family Foundation.

UPDATES:

5:45 p.m.: This article has been updated with a comment from Anthem.

This article was originally published at 3:40 p.m.