Anthem Blue Cross

[redacted]

April 25, 2011

VIA U.S. MAIL AND E-MAIL

Gary L. Baldwin
Assistant Chief Counsel, Division of Licensing
Department of Managed Health Care
980 9th Street, Suite 500
Sacramento, CA 95814

Re: Department Correspondence dated April 7, 2010

Dear Mr. Baldwin:

Blue Cross of California dba Anthem Blue Cross (the "Plan" or "BCC") submits the following in response to the Department's correspondence dated April 7, 2011 regarding the Plan's December 29, 2010 individual rate filing, as well as products offered by Anthem Blue Cross Life and Health Insurance Company, an insurer licensed and regulated by the California Department of Insurance.

Background

On December 29, 2010, the Plan submitted a rate filing for a closed portion of the Plan's individual block of business. The filing proposed a 14.6% average increase for the Plan's grandfathered and non-grandfathered individual plan contracts that are no longer available for sale. The rate changes were to be implemented beginning on April 1, 2011.

On January 20, 2011, the Plan had a teleconference with the Department and its retained actuary , Oliver Wyman. During the teleconference, the Department and Oliver Wyman requested specific information pertaining to the Plan's rate filing. This information was formally submitted to the Department on January 25, 2011.

A second teleconference with the Plan, the Department and Oliver Wyman occurred on January 31, 2011. The purpose of the call was to discuss the information previously submitted by the Plan and answer any additional questions the Department or Oliver Wyman had with respect to the Plan's filing.

The Plan also submitted revised rate sheets on February 2, 2011.

The Plan received the Department's notice that the individual rate filing was closed on February 9, 2011. Prior to receiving the notice of closing, the Plan received no notice that the information submitted by the Plan was insufficient or that any questions remained. In fact, on March 3, 2011, the

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Department stated publicly that the rate increase was reviewed by an independent actuary to ensure compliance with law, and that the actuary found the increase "was not unreasonable or unjustified."

On April 7, 2011, the Plan received the Department's letter that is the subject matter of this response. The Plan has not made any changes to its rates subject to Filing No. 20102521 since the Department closed the filing and the Plan has concluded that the information in this letter does not constitute an amendment to its Plan license application under Section 1352 of the Knox-Keene Act and therefore we are providing the requested information to you directly, rather than filing through the Department's web portal.

General Comments

The Department's letter contains some general comments regarding certain products offered by the Plan and by Anthem Blue Cross Life and Health Insurance Company. The Plan is concerned that some of these comments are susceptible to being misconstrued and believes they must be clarified.

One comment suggests that the PPO Share 500, 1000 and 5000-R products are regulated by both DMHC and CDI. This is not correct. The PPO Share 500, 1000 and 5000-R plans issued by BCC under the Knox-Keene Act are regulated exclusively by the DMHC. Likewise, the PPO Share 500, 1000 and 5000-R policies issued by Anthem Blue Cross Life and Health Insurance Company under the California Insurance Code are regulated exclusively by the CDI. The comment appears to suggest that if they are essentially identical in benefit structures that they should then be priced the same. The products offered by these two companies in 2011 are not identical in benefit structure. More importantly, the DMHC regulated entity and CDI regulated entity do not have the same claim experience or cost trends, have different historical and projected loss ratios, and must comply with different statutory and regulatory requirements enforced by different regulators. Consequently, they must be treated differently.

Specific Responses

For convenience, the Department's question is set forth in bold and the Plan's response follows immediately thereafter.

1. **In light of the differences in rate increases between CDI and DMHC products as detailed above, explain how the rate increase is not "unreasonable," as that term is used in Health and Safety Code section 1385.11(f) and as that term is defined in 45 CFR 154.205 (as proposed on December 31, 2010), including how the rate increase is not unfairly discriminatory.**

Anthem Response

The Knox Keene Service Plan Act of 1975 ("Knox Keene Act") is set forth in Division 2, Chapter 2.2 of the Health and Safety Code. The rate review provisions, including Health and Safety Code section 1385.11, were added to the Knox Keene Act through SB 1163 (Chapter 661, Statutes 2010) effective

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January 1, 2011. The provisions of the Knox Keene Act, including the rate review provisions, are limited in application to health care service plans and health care service plan contracts licensed and regulated by the Department. (Health and Safety Code §§ 1343(a); 1345(f), 1345(g)) SB 1163 is consistent with this regulatory scheme in setting forth certain rate review requirements that are applicable only to health care health care service plan contracts, which require a health care service plan only to file information pertaining to health care service plan contracts – not insurance policies. (Health and Safety Code § 1385.02 and § 1385.03)

SB 1163 added nearly identical provisions to the Insurance Code by adding Article 4.5 to Chapter 1 of part 2 of Division 2 of the Insurance Code. These provisions are only applicable to insurers and insurance policies regulated by the Department of Insurance. (Insurance Code section 10181.2) In other words, an insurer is not required to file information pertaining to health care service plan contracts as part of a rate filing for insurance policies.

By adding separate rate review requirements to both the Knox Keene Act and the Insurance Code, the Legislature has maintained the dual regulatory schemes under the Knox Keene Act and Insurance Code based on whether an entity is a "health care service plan" or an "insurer." These terms are specific and unique to the Knox Keene Act and the Insurance Code, respectively. (See Health and Safety Code § 1345 and Insurance Code §§ 23, 106) The Knox Keene Act is applicable only to health care service plans, and the Insurance Code is applicable only to insurers. By excluding insurers from being subject to the Knox Keene Act and excluding health care service plans from being subject to the Insurance Code, the Legislature unambiguously established a separate and unique regulatory scheme for health care service plans and insurers. (See *People v. Gardeley* (1997) 14 Cal.4th 605,621 [59 Cal.Rptr.2d 356, 366] when the Legislature uses a term or phrase in one place but excludes it from another, it must be assumed the Legislature intended the exclusion and it should not be implied where the Legislature excluded it)

Treating health care service plans and insurers separately is necessary in order to comply with the federal government's implementation of PPACA. As part of the implementation of PPACA, the federal government considered and rejected the proposal to combine the experience of separate legal entities for purposes of determining compliance with the medical loss ratio requirements under PPACA. This means that products offered by two separate legal entities must be considered and evaluated separately and independently for purposes of compliance with PPACA. This result is consistent with the California regulatory scheme wherein health care service plans and insurers are subject to separate and distinct regulatory schemes, including substantially different financial and reporting requirements.

SB 1163 was enacted to implement the rate review requirements of PPACA. On health care service plan contracts for which a rate increase is requested, SB 1163 requires a health care service plan to submit data specific to the health care service plan contracts subject to the filing. For example, total earned premiums and total incurred claims for each plan contract form must be submitted. (Health and Safety Code § 1385.03(11) and (12)) Importantly, this does not include information pertaining to insurance policies offered by other legal entities, affiliated or not, because SB 1163 only requires information pertaining to insurance policies to be submitted in connection with rate increases sought

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for insurance policies. (See Insurance Code § 10181.3) Treating health care service plan contracts separately and independently from insurance policies is consistent with the dual regulatory scheme created by the Legislature and the fundamental fact that the DMHC does not regulate insurers. Here, Anthem submitted the data required by SB 1163 and other data requested by the Department that related to the health care service plan contracts subject to the filing. To require information or consider information pertaining to insurance policies offered by Anthem Blue Cross Life and Health Insurance Company or other CDI regulated insurers would not only be inconsistent with the express and plain language of SB 1163, but would also be contrary to the federal government's express consideration and rejection of combining the experience of separate legal entities for purposes of determining compliance with PPACA. In addition, due to the variance in demographics, claim experience and medical cost trend among the different entities, such information is not considered relevant for the Plan's rate setting purposes.

It is important to note that the regulatory requirements applicable to health care service plans are not the same as the regulatory requirements for insurers regulated by the CDI. For example, benefits that must be included in all health care plan service contracts by mandates and regulatory requirements are significantly more expansive than those included in insurance products offered by insurers (e.g., requirement that all plan contracts offer maternity coverage). Moreover, the CDI has imposed a regulatory requirement that insurers must meet the federal medical loss ratio requirements on a prospective basis rather than a retrospective basis under PPACA. DMHC has no such prospective requirement.

Most importantly, the experience of the DMHC regulated individual business is significantly different than the CDI regulated individual business. In terms of membership, Anthem's individual DMHC insured pool has been shrinking at a significant rate, contributing to higher utilization of medical services for the DMHC regulated business. Anthem's individual CDI business is not experiencing this type of adverse selection. Although both entities exceed the 80% medical loss ratio requirements, the DMHC block of business (including open, closed and HIPAA/GIP business) will have a loss ratio of approximately 88.5% after an average filed increase of 16%; whereas, the CDI block of business will have a loss ratio of approximately 84% and that is after the 9.1% average increase. The difference in loss ratios and associated size of rate increases is a direct result of the different performance and very different medical costs of the entities.

With respect to the reasonableness of the rate increases, the plan notes that SB 1163 does not contain a definition of "unreasonable rate increase" but instead incorporates the definition contained in PPACA. PPACA also does not include a definition but the proposed regulation issued by HHS sets forth factors that HHS will consider in determining if a rate increase is reasonable. 45 CFR 154.205 defines that a rate will be unreasonable if the rate increase is determined to be excessive, unjustified or unfairly discriminatory. A rate is excessive if the premium is unreasonably high in relation to the benefits provided under the coverage. The factors to determine if the premiums are high in relation to the benefits applied to this case support a finding of reasonableness. First, the loss ratio for the DMHC products is well over the 80% requirement imposed by PPACA and the rate increases are necessary to prevent continuing financial losses by the Plan. Second, the information supporting the proposed rate increases was submitted to and reviewed by the Department's retained actuaries, who found them not

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to be unreasonable or unjustified. The Department then closed the filing, which suggests that the Department concluded the assumptions were both supported by substantial evidence and reasonable.

The last factor regarding "unfairly discriminatory" is also inapplicable. Consistent with the federal government's requirement to treat entities alone for purposes of compliance with PPACA, the unfairly discriminatory factor must be evaluated at the entity level. Here, the rate increases will be applied uniformly to all DMHC members as specified in the rate filing. In other words, DMHC members of the same risk category will be treated the same. By the operation of different statutory and regulatory requirements, CDI insureds and DMHC members are required to be treated in accordance with the applicable provisions of the Knox Keene Act or the California Insurance Code that govern the product they have purchased. Accordingly, there is no unfair discrimination between these different groups of individuals.

2. **In light of the differences in rate increases between CDI and DMHC products as detailed above, explain how this rate increase is "justified" as that term is used in section 1385.11(f).**

Anthem Response

The term "justified" is not defined in SB 1163 even though it is used in Health and Safety Code §1385.11(f). As stated above, the DMHC block of business (including open, closed and HIPAA/GIP business) will have a loss ratio of approximately 88.5% after an average increase of 16%; whereas, the CDI block of business will have a loss ratio of approximately 84% after an average 9.1% increase. The higher loss ratio and medical cost trend for the DMHC block of business justifies the different rates and determines the size of the appropriate increase.

The rate review regulations issued by HHS include a factor for determining if a proposed rate increase is unjustified. (See 45 CFR 154.205(c)) This factor does not apply in this case. The information supporting the proposed rate increases was submitted to and reviewed by the Department and its actuaries. The Plan's actuary was made available to discuss the information and respond to questions from the Department. The Department has not informed the Plan that any information was incomplete or inadequate. Information pertaining to rates on CDI-regulated products does not affect the inapplicability of this factor.

3. **Please Prepare a comparison table identifying the benefit differences between the DMHC and CDI PPO Share 500, 1000 and 5000-R Products**

Anthem Response

The requested comparison table is attached as Exhibit A to this letter.

4. **Explain how the Plan contract names, which no longer correspond to a deductible amount, are not misleading, confusing or deceptive. For example, the PPO Share 3500 product deductible was raised from $3,500 to $4,100, but the product name has not changed and is still based on a $3,500 deductible.**

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As a result of PPACA, the Plan was required to discontinue selling its then existing individual products on September 23, 2010 and began offering a new product portfolio that was compliant with PPACA. The benefit changes being referred to in this question are only applicable to products sold before September 23, 2010. In other words, the deductible is only changing on products that are no longer available for new sales and have not been available for new sales since September 23, 2010.

At the time the plan contracts were purchased, the deductible referenced in the contract name accurately reflected the deductible of the plan contract. Each plan contract contains a provision disclosing to the enrollees the terms of the plan contract, including the deductible is subject to change upon providing the requisite notice. Accordingly, enrollees had actual notice that the terms of the agreement, including the amount of their deductible, could change. Based on this express disclosure, the terms of the plan contract are changing as expressly permitted by the plan contracts.Due to the express disclosure allowing amendments and changes to the plan contracts, there is no basis for any claim that the enrollees were mislead, confused or deceived about changes that could occur in the future at the time of or after purchase. Although this change does not impact products being currently offered for sale, if the Department so directs, the Plan will file a name change for each closed product that has had a deductible change.

5. **Please specify and explain the effective date(s) of the rate increases and any benefit changes (e.g., eliminating the mid-calendar year deductible for the CDI products) for both the CDI and DMHC products referenced in the above table, including an actuarial justification for any differences between the CDI and DMHC products.**

Anthem Response

As specified in the Plan's filings, the plan contracts subject to the filing will begin receiving both the rate changes and benefit changes on May 1, 2011, and enrollees have been notified of those changes in accordance with SB 1163.

Insurance policies issued by Anthem Blue Cross Life and Health Insurance Company will receive rate changes beginning on July 1, 2011 and benefit changes on January 1, 2012.

As set forth above, the separate regulatory schemes applicable to health care service plans and insurers require that health care service contracts and insurance policies be treated differently. Different treatment is also consistent with sound actuarial practice and the requirements of PPACA. The historical and projected loss ratio for BCC and Anthem Blue Cross Life and Health Insurance Company are significantly different. For 2011, DMHC regulated individual business is projected to have a loss ratio of approximately 88.5% after a rate increase of 16% and benefit changes on May 1,

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2011. CDI regulated individual business is expected to have a loss ratio in 2011 of approximately 84% with a rate increase of 9.1% and no benefit changes. Because of different historical and projected loss ratios and trends, different rate increases between the legal entities are justified and required. Even with the filed rate increases, the DMHC regulated block will continue to have a higher loss ratio and the Plan may incur further losses on this business.

Conclusion

As stated above, the membership mix for DMHC regulated plans and CDI regulated policies are quite different and as such reflect very different medical cost. In addition, Anthem's Individual DMHC insured pool has been shrinking, contributing to higher utilization of medical services for the DMHC regulated business. As a result, premiums for DMHC products tend to be higher than for CDI products.

Anthem's Individual DMHC business has operated at a substantial loss in 2010 and will likely continue to operate at loss in 2011, even with the new rates in place. The rate increases in the Individual market are not unique to Anthem, but rather represent an economic reality faced throughout the entire industry and reflect the fact that health care costs continue to escalate faster than the growth of premiums.

Anthem is concerned with the current rate of health care cost growth in California and the premium increases that result; however, we believe premiums must be sustainable in order to ensure a stable health insurance market in California. We are committed to working with California's health care stakeholders when it comes to identifying solutions and to developing and deploying new approaches and best practices so that every Californian has access to high quality health care.

Regards,

[redacted]

cc: Maureen McKennan, Acting Deputy Director, Plan and Provider Relations (via e-mail)
Dennis Balmer, Deputy Director, Division of Financial Oversight (via e-mail)

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