March 18, 2010

The Honorable Steve Poizner
Insurance Commissioner
State of California
300 Capitol Mall, 17th Floor
Sacramento, CA 95814

Re: Anthem Blue Cross Rate Increase is Fraudulent and Must Be Rejected

Dear Commissioner Poizner,

According to congressional investigators, internal documents from Anthem Blue Cross's parent company WellPoint, Inc. show that the company intentionally padded the massive rate increases Blue Cross seeks to impose on hundreds of thousands of Californians. E-mails by its executives casually call for a higher percentage increase than was necessary, for the purpose of allowing the company to make a subsequent reduction in its rate in the event that you objected, or retain a higher profit if you did not. Submitting inflated data in order to win approval of a still exorbitant increase is not only a cynical attempt to mislead you and the public, it is a violation of California's insurance laws. Blue Cross's rate increases should be rejected outright for that reason alone.

WellPoint's duplicity reinforces our view, as we explain in this letter, that you have both the authority and the evidence to stop Blue Cross from increasing its premiums, and that your investigation should be conducted with full public scrutiny and participation, rather than behind closed doors. Your Department has indicated that it will not make public the data and justification provided by Blue Cross regarding its rate increase. These filings are clearly public records, and in conjunction with this letter we are serving you with a Public Records Act request.

It is a testament to the power of your office that your demand for a rate freeze resulted in Blue Cross not only temporarily suspending increases by Anthem Blue Cross Life & Health Insurance Company, which is regulated by the Department of Insurance, but also for customers of Anthem Blue Cross of California, which is regulated by the Department of Managed Health Care ("DMHC"). Now you must use the full measure of your authority under state insurance laws to protect California consumers and the state's struggling economy. The Blue Cross rate increases threaten to undermine the public health and safety as well as the state's economic recovery as Californians increasingly lose their insurance coverage. The revelations in Congress that Blue Cross deliberately padded its premium increases come at a time when families are struggling to pay their bills and provide further proof that its rates are set to maximize profit, rather than cover medical costs.

1. WellPoint Intentionally Submitted An Excessive Rate Increase

According to a memorandum prepared by the Subcommittee on Oversight and Investigations of the House Energy and Commerce Committee, internal company documents

provided to the committee by WellPoint, Inc. show that WellPoint padded its rate increase by five percentage points to counteract anticipated concessions to you concerning the size of its premium increases. The memorandum, dated February 24, 2010, states:

> On October 24, 2009, Mr. Shane, [a WellPoint actuary], e-mailed Mr. Sassi, the head of WellPoint's individual market division, that WellPoint executives needed to "reach agreement on a filing strategy quickly – specifically in the area of do we file with a cushion allowed for negotiations/margin expansion, or do we file at a lower level that maintains margin, but does not allow for negotiation."
> …
> It appears that WellPoint elected to file with "a cushion." In an October 21, 2009, presentation to the WellPoint Board of Directors, Mr. Sassi identified the "Key Assumptions" in the pricing for the individual market in 2010. This slide differentiated the "2010 Rate Ask" from the "2010 Plan Rate Increase." According to the slide, WellPoint's "Rate Ask" would be 25% to 26%, while the "Rate Increase" the company assumed in its "2010 Plan" was just 20.4%.
> …
> On October 14, 2009, David Shea, WellPoint's Vice President for Individual Pricing, transmitted a document entitled "Individual Rate Approvals and Risks" to Rajeev Bal, the President of the Individual Business Segment. This document stated that WellPoint "[a]ssumes two month approval delay and lowering rate increase 5%."[1]

(Memorandum to Members of the Subcommittee on Oversight and Investigations from Committee on Energy and Commerce Majority Staff, *Re: Questions Raised by Internal WellPoint Documents*, February 24, 2010, pages 2-3.)

You should not permit yourself and your office to become a pawn in WellPoint's game. You already ordered the "two-month delay" that WellPoint predicted. Under these circumstances, the public will not accept the kind of "split the baby" regulatory response that WellPoint clearly expected, in which they "concede" to some limited reduction that you "order," at least absent full public scrutiny of WellPoint's original filing and all subsequent documentation submitted to you pursuant to your investigation.

That the company has presented false actuarial data in support of a rate increase greater than necessary is grounds enough to reject Blue Cross's rate increases outright. (See Insurance Code §§ 10291.5 and 10293; California Administrative Code Title 10, § 2222.12.) Indeed, given the severe impact that the proposed increases will have on the public health and safety, you have the authority to suspend the company's right to do business in California for up to one year (Insurance Code § 704) or even seize control of the company (Insurance Code § 1011.)

[1] Memorandum to Members of the Subcommittee on Oversight and Investigations from Committee on Energy and Commerce Majority Staff, *Re: Questions Raised by Internal WellPoint Documents*, February 24, 2010, page 2-3 (emphasis added).

2. Proper Application of the 70% Medical Loss Ratio Requirement

The California Insurance Code gives the Insurance Commissioner explicit authority to "withdraw approval . . . [of a] policy if after consideration of all relevant factors . . . the benefits provided under the policy are *unreasonable in relation to the premium charged*." Cal. Ins. Code § 10293 (emphasis added). State regulations currently in effect specify that one factor to be considered in determining whether benefits are reasonable in relation to the premium charged is whether the medical benefits provided under a policy account for at least 70% or more of the premiums collected. Cal. Admin. Code tit. 10, § 2222.12. This calculation is to be based on *an analysis of actual loss experience*. *Id.* (emphasis added).

Citing skyrocketing premiums and other out-of-pocket costs borne by individual policyholders, the Department of Insurance promulgated the 70% medical loss ratio requirement in December of 2006 to "increase[] the efficiency of the market for individual hospital, medical or surgical insurance."[2] Furthermore,

> the legislative mandate of a reasonable relationship between premium charged and benefits received requires that the loss ratio requirement be raised in order . . . that these consumers obtain fair value for their hospital, medical or surgical insurance dollars.[3]

Section 2222.12 (a) makes clear that the commissioner may consider any other relevant factors when determining whether to withdraw approval of a policy.

The Medical Loss Ratio Must Consist of Health Care Costs, Not Disguised Profits and Overhead

In order to accurately apply the 70% medical loss ratio (MLR) adopted in section 2222.12 and determine whether the health care benefits under a policy are reasonable in relation to the premium charged as required by statute, *only* true medical costs should be tabulated as policy "benefits." Your audit must require Blue Cross to document, under penalty of perjury, every dollar the company claims to have spent on medical benefits. The company cannot be allowed to pad its numbers by including undisclosed administrative or overhead costs, profits or dividends to its parent company as part of medical expenditures.

Section 2222.12 also requires that whether the commissioner should withdraw approval of a rate increase

> shall be determined by *an analysis of actual loss experience, giving due consideration to all factors relevant to the determination of how the past loss experience may be used to reasonably indicate the average loss experience which should develop*. (Emphasis added.)

[2] California Department of Insurance, Notice of Proposed Action and Notice of Public Hearing, Individual Disability Policy Loss Ratio Regulations, RH-06092236, July 21, 2006, page 4.
[3] *Id*.

Insurance companies regularly overstate their expected losses to regulators in order to justify higher rates. For example, in the property and casualty rate-setting process, companies routinely argue for loss development and loss trends that are most advantageous to the company, which results in an overstatement of their expected losses. (See, e.g., *In re the Rate Applications of Allied Property and Casualty Insurance Company, and AMCO Insurance Company*, Decision Denying Consumer Watchdog's Petition for Hearing, PA-2009-00007, Nov. 23, 2009, at 4:21-22 ["The Department agrees with the Petitioner [Consumer Watchdog] that the 8-point loss trend selected by the Applicants is inappropriate in this case"].)

In fact, internal emails obtained by the House subcommittee on oversight and investigations suggest that WellPoint manipulated its medical loss ratio by over-reporting expected claims. One factor that affects medical spending, and therefore the medical loss ratio, is the proportion of older and sicker consumers enrolled in a particular coverage plan. If a company overestimates the number of healthy people—who are relatively inexpensive to insure—who chose to a leave a particular coverage plan, then the estimated spending on medical care for the remaining sicker population will be overstated. According to the House subcommittee, in one email WellPoint executives acknowledge that they are manipulating such changes in the risk pool, known as "adverse selection," in order to create the appearance of a higher medical loss ratio:

> David Shea, the Vice President for Individual Pricing, proposed for health plans regulated by the California Department of Insurance to "add 1.0% to margin for adverse selection to ultimately keep MLR flat." In the same e-mail, Mr. Shea also proposed for health plans regulated by the California Department of Managed Care to "[a]dd 2.0% to projected claims for adverse selection to lower the margin to flat."[4]

By proposing to "keep [the medical loss ratio] flat" by inflating projected claims, Blue Cross expected to attract less scrutiny from you regarding their rates.

Medical Loss Ratio – Per policy form

Section 2222.12 makes clear that each of an insurer's "policy forms"–i.e. each type of policy, such as a PPO Share $2500 or a PPO Share $5000 policy–must meet the 70% medical loss ratio requirement. If any policy form does not meet the 70% medical loss ratio requirement, you have the authority to retroactively withdraw approval of that policy form. Blue Cross must demonstrate that each policy form is operating efficiently as required by the regulation. If your review is not thorough enough, Blue Cross could get away with gouging consumers through selective exorbitant increases while keeping the company's overall medical loss ratio above the 70% requirement.

[4] *See* Memorandum to Members of the Subcommittee on Oversight and Investigations from Committee on Energy and Commerce Majority Staff, *Re: Questions Raised by Internal WellPoint Documents*, February 24, 2010, page 7.

Consumer Watchdog has good reason to be concerned. In 2004, prior to the promulgation of the current section 2222.12, Blue Cross's individual policy medical loss ratio was an abysmal 51%, while its aggregate medical loss ratio for both the individual and group markets was 68%, according to data provided by the Department.[5] This was significantly below the current legal minimum. Furthermore, the documents recently obtained by the House Subcommittee on oversight and investigations suggest that WellPoint is aware that its current medical loss ratio is below the 70% requirement. A WellPoint document obtained by the subcommittee states:

> Lack of attention to risk management, decreased ability to use pre-existing claim denials and rescind policies, and maternity policies have led to first year loss ratios climbing from less than 50% five years ago to over 65% today.[6]

3. Possible Manipulation of Surplus & Dividends

A thorough accounting of every dollar held in surplus by Blue Cross Life & Health ("BC L&H"), as well as money transferred to its California sister company regulated by the Department of Managed Health Care ("DMHC"), Blue Cross of California ("BCC"), and all "dividends" paid to its parent company WellPoint, is necessary to ensure that Blue Cross Life & Health is not cooking its books to create the appearance that it is meeting the 70% medical loss ratio requirement.

Just since 2007, according to financial information reported to the Department, Blue Cross Life & Health has transferred $757.6 million in dividends to WellPoint. The company had an additional $755 million on hand at the end of 2008 in the form of "surplus." That surplus alone is enough money to provide health coverage to more than 50,000 California families for an entire year.

	BCC Dividends to WellPoint[7]	BC L&H Dividends to WellPoint	BCC Excess Tangible Net Equity[8]	BC L&H Surplus[9]	BCC Management Agreements & Service Contracts With Affiliates[10]	BCC Total Affiliate Company Distributions[11]
2003	$300 million	Not available	$986.4 million	N/A	$2.1 billion	$2.4 billion
2004	$350 million	$165 million[12]	$1.35 billion	$550.7 million	$2.7 billion	$3.1 billion
2005	$518 million	$195 million[13]	$1.6 billion	$657.8 million	$2.9 billion	$3.4 billion
2006	$538 million	$207.2 million[14]	$1.7 billion	$757.1 million	$2 billion	$2.6 billion
2007	$949.8 million	$238.1 million[15]	$1.5 billion	$887.4 million	$2.2 billion	$3.2 billion
2008	$575 million	$325 million[16]	$856.1 million	$755.1 million	Not available[17]	Not available[18]
2009	$525 million	$194.5 million[19]	$1.03 billion	Not available	Not available	Not available
2010	Not available	Not available	Not available	Not available	Not available	Not available

[5] California Department of Insurance, Health Insurance in California: Where Do Your Premium Dollars Go?, December 1, 2005.

[6] *See* Memorandum to Members of the Subcommittee on Oversight and Investigations from Committee on Energy and Commerce Majority Staff, *Re: Questions Raised by Internal WellPoint Documents*, February 24, 2010, page 6.

Similarly, the DMHC-regulated Blue Cross of California has transferred $2 billion to WellPoint since 2007 and reports more than $1 billion in excess reserves ("tangible net equity") on hand. In addition, between 2003 and 2007, the DMHC-regulated company paid between $2 billion and $3 billion *each year* to affiliated companies in the form of "service contracts." For example, in 2007, the last year that the data was made publicly available, Blue Cross of California paid Blue Cross Life & Health $606.8 million, Professional Claim Services, Inc. $1.2 billion, and Comprehensive Integrated Marketing Services, Inc. $10.8 million.[20]

In 2007 Consumer Watchdog complained to regulators that Blue Cross may be laundering profits and dividends in violation of a 2004 merger agreement (see below) and urged that those "service contract" transfers to sister companies be scrutinized. Beginning in 2008, the DMHC-regulated Blue Cross of California stopped providing service contract information in its financial filings, claiming that the information is now "proprietary." This crucial data must be obtained and considered to determine whether Blue Cross has collected premiums in excess of what is permitted by law.

4. The 2004 Anthem/WellPoint Merger Agreement

In 2004, WellPoint, Inc., parent of Blue Cross, requested that California regulators approve a merger with Indiana-based Anthem, Inc. At that time, the key issue in the public debate surrounding the merger was whether Blue Cross enrollees would pay for the approximately $4 billion in merger financing costs as well as up to $600 million in severance, retention bonuses and stock options awarded to Anthem, WellPoint and Blue Cross executives. Consumer Watchdog and consumers feared that Californians would ultimately pay for these costs through either increased rates or reductions in coverage.

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[7] Annual Financial Reporting Form, Anthem Blue Cross, December 31, 2008, "CashFlow" tab [*hereinafter ABCC Financial*].
[8] *ABCC Financial*, TNE(1), line 21.
[9] Annual Statement, Anthem Blue Cross Life & Health, Annual Statement For the Year Ended December 31, 2008, p. 22 [*hereinafter ABC L&H Financial*].
[10] *ABCC Financial*, Schedule K.
[11] *Id*.
[12] California Department of Insurance, Report of Examination of the Blue Cross Life and Health Insurance Company as of December 31, 2006, page 2.
[13] *Id*.
[14] *ABC L&H Financial*, 2007, page 19.10.
[15] *Id*.
[16] *Id*.
[17] As of 2008, this information is not available. The *ABC Financial* states on Schedule K: "Proprietary information not available on website."
[18] *Id*.
[19] Based on 2008 projections. Anthem Blue Cross Life and Health Insurance Company, Annual Statement For the Year Ended December 31, 2009, page 19.11.
[20] Annual Financial Reporting Form, Anthem Blue Cross, December 31, 2007, Schedule K.

As a result of overwhelming public concern, the Department of Insurance and the Department of Managed Health Care entered into agreements ("undertakings") with WellPoint, Inc. addressing various financial and health care access concerns. In the merger undertakings, WellPoint made specific commitments regarding its post-merger financial activity, including:

- That premiums of Blue Cross subscribers would not increase as a result of the merger (Undertaking #1).

- That Anthem would cover all costs, including executive severance and retention payments resulting from the merger, and that no costs of the merger would be charged, directly or indirectly, to Blue Cross and its policyholders (Undertaking #3).

In 2007 testimony before the DMHC, Consumer Watchdog presented clear evidence that the terms of the agreement were violated by excessive dividend payments and service contract payments to WellPoint-affiliated companies. DMHC director Cindy Ehnes said such behavior "reflects a viewpoint of California being [WellPoint's] own ATM machine, while, at the same time, Californians are struggling to get health insurance for their families."[21] Yet the DMHC declined to take enforcement action that could have included refunding overpayments to Blue Cross of California and its policyholders. (See Consumer Watchdog's 2007 testimony at http://www.consumerwatchdog.org/resources/FTCRcomments.pdf.)

A renewed investigation of Consumer Watchdog's charges would be an appropriate function of your investigation. Any violation would be reason to bar the current increases.

5. WellPoint's Conduct Demands a Transparent Public Investigation

Blue Cross's most recent excuse for the rate increase—that healthier people are dropping coverage due to the recession—is contradicted by the data that WellPoint reported to the National Association of Insurance Commissioners.[22] As Representatives Waxman and Stupak recently wrote in a letter to the company, enrollment in Blue Cross increased from "583,967 individual policyholders at the end of 2008 to 627,082 individual policyholders at the end of the third quarter of 2009."[23]

Previously, Anthem Blue Cross told policyholders that its 39% rate increases were purely a result of increasing medical costs, even though consumer inflation had flat-lined and wages continue to sink. At the same time, WellPoint was telling investors that despite its continuing overall loss of customers, its profits and dividends would remain the same as this year's. E-mails

[21] Lisa Girion, "WellPoint dividend is questioned; State officials say Blue Cross' $950-million payout to its parent may have violated a deal with regulators," Los Angeles Times, May 26, 2007.
[22] Jeffrey Young, "Waxman takes insurance company to task over proposed premium hikes," The Hill, February 18, 2010.
[23] *Id*.

obtained pursuant to a Congressional hearing show that WellPoint's real intent was to raise the profit margin on individual policies in California from 5% to 7%.[24]

The delay that you have secured in the Blue Cross rate increases provides a much-needed temporary respite for Californians struggling to stay above water in our horrible economy. However, the depth of public anger and mistrust in connection with the increases, and the latest revelation of impropriety, demands that your investigation of Blue Cross be conducted through a transparent process that includes public participation, starting with the release of the original filings and all actuarial data provided to the Department for your review.

Your investigation should also include a minimum of four public hearings in different geographic areas of the state.

In light of the latest revelations, a closed-door investigation is not a viable approach, not that it ever was. A suspicious public is rightly angry that an insurance company assumed it could overprice policies and quietly negotiate away any public scrutiny. If you continue to choose not to make public the information that Blue Cross provides to you, any conclusion you might reach to permit any portion of the rate increase from taking effect will be met with public outrage. Moreover, you will inevitably share the blame for pricing health insurance out of reach for tens of thousands more families, even if you succeed in modifying the increases. Complete transparency and robust use of your department's powers will help to restore public trust, enhance the Department's reputation, and speed development of better public policy.

Sincerely,

Harvey Rosenfield

Jerry Flanagan

Judy Dugan

[24] Download the emails form the House Energy and Commerce Committee website at: http://energycommerce.house.gov/documents/20100224/E-mail.from.Barry.Shane.to.Cindy.Miller.October.7.2009.pdf