Comments of
Consumer Watchdog
on the

Anthem Blue Cross Life & Health Insurance Company
Plan to Raise Rates by 9.6%
for 7,000 Small Businesses and Organizations in California

Consumer Watchdog Review of Anthem Filing #HA0-2013-0013
With actuarial analysis prepared by AIS Risk Consultants
April 1, 2013
Executive Summary

Over the past eight years, Anthem Blue Cross Life and Health Insurance Company ("Anthem") has reported more than $2.1 billion in net income from its health insurance business in California. In seven of these eight years, Anthem had a return on net worth of more than 20%. These high profits have been earned by overcharging individual policyholders, small businesses and large businesses alike, largely because California law currently has no provision to require insurance companies to charge reasonable rates.

On January 16, 2013, Anthem Blue Cross filed a rate increase plan for small group policies to raise rates on 7,000 small businesses and organizations in California that provide coverage for over 45,000 employees. Anthem’s plan, which takes effect today, April 1, 2013, marks the third rate hike by the company in less than a year and raises its policyholders’ rate by an average of 9.6% for the year, with some small businesses facing a 23% rate hike as a result of the filing.

Consumer Watchdog, a nonpartisan, nonprofit organization has been awarded a state grant to provide an independent assessment of the health insurance rate filings. Working with the actuarial firm AIS Risk Consultants, we have determined that Anthem’s hike is excessive and unreasonable. In fact, if the company used reasonable projections and standards, it would be lowering rates for the thousands of businesses and tens of thousands of employees who will face the April 1 increase.

According to our actuarial analysis, Anthem should be lowering rates for the quarter by about -4.5%1, which, after incorporating the company’s two previous hikes amounts to a net annual rate reduction of -0.5%. Instead, beginning today Anthem will charge California’s small businesses covered by the affected plans approximately $17 million more than is reasonable.

As the attached actuarial memo explains in more detail, we find two fundamental flaws in Anthem’s rationale that leads them to overcharge its customers:

1. Anthem’s selected core medical loss trend of 10.9% is about 50% higher than is reasonable.
2. Anthem’s selected underwriting profit factor of 6.6% (4.3% after-tax), which results in a 25% return on equity, is more than double the reasonable profit.

We also note that Anthem’s payments to affiliates of approximately $1 billion annually may include a hidden profit transfer to Anthem’s parent company, adjusting for which would require a lower rate still. We have not, however, adjusted our analysis to incorporate any possible excess created by these transfers. A more detailed review of Anthem’s

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1 After incorporating the company’s two previous hikes, the quarterly rate increase at issue amounts to a net impact of reducing the rates for small business customers by 0.5%.
management contracts and agreements could indicate an even bigger rate decrease. Similarly, we find that Anthem overstated its projected tax liability compared with what they have paid in past. We have not included, however, the rate impact of adjusting Anthem’s anticipated tax rate downward, though that, too, would indicate still lower rates.

**Loss Trend and Underwriting Profit**

As the actuarial memo details, the nearly $17 million difference between what Anthem should be charging small businesses and their employees and what it will charge results from Anthem’s use of excessive loss trends and underwriting profits.

In this rate plan, Anthem tells regulators and the insurance companies’ customers that the primary driver of future claims payments is increasing use of medical services by policyholders and increasing medical costs. Notably, however, Anthem’s parent company, WellPoint, tells Wall Street and its investors that usage is essentially flat.

What Anthem is telling investors is much more believable, especially in light of its SEC filings that include data showing that core cost trends are approximately 7.0% and other national research indicating trends of between 6.9% and 7.5%. We have used a 7% core cost trend as the basis of determining a reasonable rate for Anthem.

Anthem also includes an excessive “underwriting profit.” This is the amount over and above medical and administrative costs charged to policyholders. In Anthem’s case, the company will charge policyholders about $270 per employee per year to fund its pre-tax profits. In addition to the underwriting profit, Anthem can expect to earn significant investment gains from investing the premiums charged along with its substantial surplus.

Anthem suggests that about $95 of this underwriting profit factor will be used to pay taxes, though historical experience indicates Anthem’s tax liability will lower, leaving Anthem with a higher after-tax profit. This 6.6% before-tax underwriting profit, when set against the background of Anthem’s large investments and surplus, provides the company an excessive after-tax return on equity of about 25%. In our review, we have used a 2% after-tax underwriting profit, which yields an approximate return on equity of more than 10%, to calculate the reasonable rate that Anthem should be allowed to charge.

We conclude that Anthem’s plan to increase rates on small businesses and organizations in California by 9.6% is excessive. If California law required health insurance companies to charge reasonable and non-excessive rates, we believe that instead of the impending rate hike, 7,000 Anthem businesses and their 45,000 employees would be getting some much needed rate relief.

We provide this analysis of Anthem’s most recent plan to raise rates on small businesses with the hope that members of the public and customers of Anthem will better understand the choices the company has made in setting its rates in California and, importantly, what rate customers would be charged if Anthem were required to charge reasonable rates.

Consumer Watchdog
Santa Monica, California
Date: April 1, 2013

To: Consumer Watchdog

From: Allan I. Schwartz, FCAS, ASA, MAAA

Re: Review of Anthem Blue Cross Life and Health Insurance Company
Small Group Health Insurance Rate Filing Dated January 16, 2013
SERFF Tracking #: AWLP-128798003 State Tracking #: HAO-2013-0013

We have reviewed the above captioned filing, as well as the additional information submitted by the Anthem Blue Cross Life and Health Insurance Company ("Anthem").

Anthem proposes an average rate change for an “Overall % Indicated Change” of +5.2% and an “Overall % Rate Impact” of +9.6%. The range of rate impacts varies from a minimum of +0.47% to a maximum of +23.08%. The “Written Premium Change for this Program” requested by Anthem is $16,099,711. The average premium increase per policyholder is $2,312.

Our analysis shows that instead of an “Overall % Indicated Change” of +5.2%, an appropriate change would be for a decrease of –4.5%. Two reasons why the rate change proposed by Anthem is inflated and unreasonable are Anthem’s use of:

- Excessive medical loss trend factors averaging +12.9% a year

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1 This analysis was provided to assist Consumer Watchdog (CWD) in its evaluation of the Anthem filing, including submitting this document to the California Department of Insurance (CDI). It should not be relied upon for any other purpose or by any other entities. If this analysis is provided to any other entity the following conditions apply: (i) it should only be done after obtaining the written consent of AIS, (ii) the entire analysis should be supplied and (iii) that entity should be informed that AIS is available under appropriate circumstances to discuss the analysis.

2 I am qualified to provide this analysis. During the last several years I have been involved in the review of health insurance rate filings in seven jurisdictions.

3 Anthem Filing, Rate Information Page

4 Ibid.

5 Ibid.

6 $16,099,711 (Written Premium Change) / 6,965 (Number of Policyholders Affected); Ibid.

7 Another possible concern is the large amount of affiliate transactions for Anthem, which could result in inflated costs being included in the rate calculation. We have not made any numerical adjustment to the rate calculation for this item, which is discussed later in this memo.
• Excessive underwriting profit factors that can be expected to result in an after-tax return on surplus of more than 20%.

Our analysis is based upon the use of a core medical loss trend of 7.0%\(^9\) and a 2% after-tax underwriting profit. Using these values, along with the other ratemaking components used by Anthem, we derived an “Overall % Indicated Change” of -4.5% and an “Overall % Rate Impact” of -0.5%\(^{11,12}\).

A more detailed discussion of issues with the Anthem filing follows.

1. **Excessive Medical Loss Trend Factors**

Anthem’s selected medical loss trends are unsupported and result in excessive rates. A summary of those values is shown in the following table.

<table>
<thead>
<tr>
<th>Plan Family</th>
<th>Core Trend</th>
<th>Leveraging</th>
<th>Pricing Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Solution</td>
<td>13.0%</td>
<td>3.1%</td>
<td>16.5%</td>
</tr>
<tr>
<td>Elements</td>
<td>11.2%</td>
<td>1.5%</td>
<td>12.9%</td>
</tr>
<tr>
<td>GenRx</td>
<td>10.2%</td>
<td>1.7%</td>
<td>12.1%</td>
</tr>
<tr>
<td>Hosp BeneFits</td>
<td>10.1%</td>
<td>1.4%</td>
<td>11.6%</td>
</tr>
<tr>
<td>Total</td>
<td>10.9%</td>
<td>1.8%</td>
<td>12.9%</td>
</tr>
</tbody>
</table>

Source: Anthem Filing, Attachment 8

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\(^8\) Anthem Filing, Attachment 9(a), Line (12), Total Column

\(^9\) This is consistent with the historical experience of Anthem, where after-tax returns of more than 20% were common. This is discussed later in this memo.

\(^10\) The core medical trend is before taking into account the impact of leveraging. Anthem used a 1.8% annual value for this, which we have accepted for the purpose of this analysis.

\(^11\) These values are derived in Schedule AIS-1.

\(^12\) This analysis is based upon the information currently available. We may submit further comments, or modify our analysis, if additional relevant information becomes available. Furthermore, a lack of comment on particular aspects of the filing should not be taken to mean that we agree with those procedures.
The basis given by Anthem for its selected trends includes the following:13

Medical Trend Analysis: Medical Trends must be estimated to project medical costs from the Experience Period to the Rating Period. Anthem relies most heavily on what ActMod refers to as the “Corporate” approach to establishing basic Medical Trend estimates. Anthem also, however, considers what we call the “Product-Specific” approach to establishing Medical Trend estimates. Specifically, Anthem used the following approach to develop the Medical Trend estimates:

(1) Anthem obtained “Core Trends” from a corporate team with the responsibility of evaluating data for various benefit plans and/or product categories based on corporate and possibly industry and/or macro-economic health care data. The Anthem corporate team responsible for developing these “Core Trends” is referred to as the “Health care management, Actuarial, Underwriting, and Sales” team, or “HAUS”. For this Rate Filing, HAUS based its medical trend recommendations on the overall experience of those products impacted by the Rate Filing. For prior rate filings filed by Anthem with the CDI and reviewed by ActMod (“ActMod’s Prior Reviews”), HAUS based its medical trend recommendations on the overall experience of all small group products regulated by both the CDI and the Department of Managed Health Care.

(2) Anthem also prepared an analysis of Product-Specific Experience Trends for the 12-month period ending August 2012.

Anthem claimed to rely for the most part on the “corporate” trends.14 However, the Anthem filing did not include the underlying data, analysis and calculations underlying those trends.

Anthem is part of the WellPoint Corporation. We therefore looked into information available regarding the WellPoint loss trend experience. The 2012 WellPoint, Inc. 10-K makes that following statement regarding trend, “While our cost of care trend varies by geographic

13 Anthem Filing, Actuarial Modeling Report, Page 5

14 “Anthem relied much more heavily on the Corporate approach for this Rate Filing’s trend Analysis”; Anthem Filing, Actuarial Modeling Report, Page 6
A 7% medical loss trend is also consistent with other sources of information. PwC has stated, “PwC’s Health Research Institute projects medical cost trend will remain flat at 7.5 percent in 2013.”\textsuperscript{16,17} Milliman has stated, “The annual Milliman Medical Index (MMI) measures the total cost of healthcare for a typical family of four covered by a preferred provide plan (PPO). The 2012 MMI is cost of $20,728, an increase of $1,335, or 6.9% over 2011.”\textsuperscript{18,19}

These various sources of information indicate that a 7% annual core medical loss trend is reasonable, and that the 10.9% value used by Anthem is excessive and unreasonable.

Anthem provided a split of its medical trend into Use of Services and Price Inflation, as shown in the following table.

<table>
<thead>
<tr>
<th>Category</th>
<th>Proj. PMPM Trend by Category</th>
<th>Amount of Projected Trend, by Aggregate Benefit Category, Attributable to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Inpatient</td>
<td>8.8%</td>
<td>5.9% 2.9%</td>
</tr>
<tr>
<td>Hospital Outpatient (including ER)</td>
<td>9.5%</td>
<td>4.9% 4.6%</td>
</tr>
<tr>
<td>Physician/other professional services</td>
<td>7.1%</td>
<td>4.2% 2.9%</td>
</tr>
<tr>
<td>Prescription Drug</td>
<td>25.9%</td>
<td>6.4% 19.5%</td>
</tr>
<tr>
<td>Laboratory, Radiology &amp; Ancillary</td>
<td>9.9%</td>
<td>7.0% 2.9%</td>
</tr>
<tr>
<td>(Other than inpatient)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>10.9%</td>
<td>5.7% 5.2%</td>
</tr>
</tbody>
</table>

Source: Anthem subsequent submission, Exhibit 14(a)

\textsuperscript{15} WellPoint, Inc. 2012 10-K, page 53; Schedule AIS-2

\textsuperscript{16} Schedule AIS-3

\textsuperscript{17} PwC projections of medical trend from 2010 to 2012 were overstated by about 1% to 2% a year. If this pattern continues, then the 7.5% value would also be too high.

\textsuperscript{18} Schedule AIS-4

\textsuperscript{19} The MMI Index changes have been trending downward, from 7.6% for 2008/2007 to a low value of 6.9% for 2012/2011.
As can be seen, Anthem assigns a higher trend to “use of services” than to “price inflation”. However, Wellpoint claims just the opposite, that unit cost is driving the trend with very little impact from use of services, as shown by the following statements.

Overall, our medical cost trend is driven by unit cost. Inpatient hospital trend was in the mid-to-high single digit range and was primarily related to increases in the average cost per admission. While provider rate increases are a primary driver of unit cost trends, we continually negotiate with hospitals to manage these cost trends. We remain committed to optimizing our reimbursement rates and strategies to help address the cost pressures faced by employers and consumers. Both inpatient admission counts per thousand members and inpatient day counts per thousand members were only slightly higher than the prior year. The average length of stay was relatively the same as the prior year. In addition to our recontracting efforts, a number of clinical management initiatives are in place to help mitigate the inpatient trend. Focused review efforts continue in key areas, including inpatient behavioral health stays and spinal surgery cases, among others. Additionally, we continue to refine our programs related to readmission management, focused utilization management at high cost facilities and post-discharge follow-up care.  

It is unclear why Anthem’s positions on medical loss trends are so different than the public statements of the corporation to which it belongs, especially since the filing claims that the medical loss trends are based upon “the Corporate approach”.

It is also worth noting that Wellpoint, as a corporate entity, has a philosophy of adding a provision for adverse deviation into its loss projections and that over the last several years, the loss trends used have turned out to be excessive. The extent to which the Wellpoint loss projections have turned out to be excessive / favorable (amounts shown are in millions), split between the issues of trend factors and completion factors is shown in the following table, along with an explanation as provided by WellPoint.

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20 WellPoint, Inc. 2012 10-K, page 53; Schedule AIS-2, emphasis supplied

21 “Liabilities for both claims incurred but not reported and reported but not yet processed through our systems are determined in aggregate, employing actuarial methods that are commonly used by health insurance actuaries and meet Actuarial Standards of Practice. Actuarial Standards of Practice require that the claim liabilities be appropriate under moderately adverse circumstances.” “The years ended December 31, 2012 and 2011 reflect a lower level of targeted reserve for adverse deviation and a resultant lower level of prior years’ redundancies than the year ended December 31, 2010.” WellPoint, Inc. 2012 10-K, pages 61-62; Schedule AIS-2

22 WellPoint, Inc. 2012 10-K, page 127; Schedule AIS-2, emphasis supplied
The favorable development recognized in 2012 resulted primarily from trend factors in late 2011 developing more favorably than originally expected as well as a smaller but significant contribution from completion factor development. The favorable development recognized in 2011 was driven by trend factors in late 2010 developing more favorably than originally expected. This impact was partially offset by completion factors developing unfavorably due to slight increases in payment cycle times. The favorable development recognized in 2010 was driven by trend factors in late 2009 developing more favorably than originally expected. In addition, a minor but steady improvement in payment cycle times impacted completion factor development and contributed to the favorability.

In summary, Anthem’s 10.9% annual medical core trend is excessive and unreasonable.

A 7% annual medical core trend as used in our analysis is reasonable and appropriate.

2. **Excessive Underwriting Profit Factors**

The Anthem filing is based upon an overall before-tax underwriting profit factor as a percent of premium of 6.6%. The after-tax underwriting profit factor as a percent of premium was 4.3%. The implied tax-rate of 35.4% is higher than the actual historical tax rates for

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21 \( \left( \frac{14.42 + 7.90}{337.52} \right) = 6.6\% \), Anthem filing, Attachment 9(a), Lines (26), (27), (29)

24 \( \frac{14.42}{337.52} = 4.3\% \); *Ibid.*

Anthem. During 2011 and 2012, federal income taxes as a percent of net income for Anthem were 25.7% and 29.1%, respectively.27,28

A 4.3% after-tax underwriting profit as a percent of premium is equivalent to an after-tax return on surplus of more than 20%, which is consistent with the very high level of profit historically earned by Anthem.

During the last five years Anthem has had a premium to net worth ratio in the range of 4 to 5. Using a mid-range value of 4.5, a 4.3% after-tax underwriting profit as a percent of premium is equivalent to a 19.4% after-tax underwriting profit as a percent of net worth.29 Furthermore, in addition to underwriting profits, Anthem earned investment income. During 2011 and 2012, net investment gains as a percent of net worth were 8.6% and 8.8%, respectively.30 Combining the underwriting profit and investment gain, gives a projected after-tax return on net worth of about 25%.

In summary, Anthem’s 4.3% after-tax underwriting profit as a percent of premium is excessive and unreasonable.

A 2% after-tax underwriting profit as a percent of premium as used in our analysis provides an at least adequate overall profit, and is reasonable and appropriate.

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26 The Anthem filing states the Federal Income Taxes are 32.85% of Profit. *Ibid.* However, that is different than the percent derived directly from the values shown for after-tax profit and federal income taxes in the filing. The difference is related to how profit is defined for various calculations in the filing.

27 Anthem 2012 Annual Statement, Statement of Revenues and Expenses, Line (31) / Line (30)

28 The Actuarial Modeling Report, which contained the rate calculation included with the Anthem filing, relied on the tax rate provided by Anthem without performing its own analysis. “ActMod accepted the estimated Federal Income Tax rate provided by the Reliance Actuary without detailed review.” Anthem Filing, Actuarial Modeling Report, Page 12; There were numerous places in the Anthem filing where that procedure (of using values without verification) was followed. “For certain items (e.g. establishment of Retention Factors, Geographic Area, Age Factors, and the detailed source data upon which many of the assumptions in the Rate Filing are based), ActMod did not conduct a detailed review and relied on the information provided by the qualified Anthem actuary identified in Attachment 2 (the “Reliance Actuary”).” Anthem Filing, Actuarial Modeling Report, Page 4

29 19.4% = 4.3% X 4.5

30 Anthem 2012 Annual Statement, Statement of Revenues and Expenses, Line (27) / Line (33); these values are before taxes. The after-tax values, using the overall tax rates for Anthem in those years would be 6.4% and 6.2%, respectively.
3. **Anthem Has A Very High Level Of Historical Profits**

Anthem has earned a very high level of profits on a historical basis, as shown in the following table.

**Anthem Blue Cross Life and Health Insurance Company**

<table>
<thead>
<tr>
<th>Year</th>
<th>Net Income</th>
<th>Ending Surplus</th>
<th>Income / Surplus</th>
</tr>
</thead>
<tbody>
<tr>
<td>2005</td>
<td>$287.6</td>
<td>$667.1</td>
<td>43.1%</td>
</tr>
<tr>
<td>2006</td>
<td>$329.6</td>
<td>$767.2</td>
<td>43.0%</td>
</tr>
<tr>
<td>2007</td>
<td>$380.9</td>
<td>$898.8</td>
<td>42.4%</td>
</tr>
<tr>
<td>2008</td>
<td>$194.5</td>
<td>$760.1</td>
<td>25.6%</td>
</tr>
<tr>
<td>2009</td>
<td>$170.5</td>
<td>$813.8</td>
<td>21.0%</td>
</tr>
<tr>
<td>2010</td>
<td>$205.9</td>
<td>$973.8</td>
<td>21.1%</td>
</tr>
<tr>
<td>2011</td>
<td>$203.5</td>
<td>$1,145.4</td>
<td>17.8%</td>
</tr>
<tr>
<td>2012</td>
<td>$342.4</td>
<td>$1,361.0</td>
<td>25.2%</td>
</tr>
<tr>
<td>Combined</td>
<td>$2,115.0</td>
<td>$7,387.3</td>
<td>28.6%</td>
</tr>
</tbody>
</table>

Source: Anthem Annual Statements, Five Year Historical Data

From 2005 to 2012, Anthem earned net income, on an after-tax basis, of more than $2 billion. In seven of these eight years, Anthem had a return on net worth of more than 20%, ranging from a minimum of 18% to a maximum of 43%, with an average annual value of 29%.

The high level of profits has allowed Anthem to pay significant shareholder dividends. From 2007 to 2012, Anthem paid shareholder dividends of almost $900 million, which was about 60% of the net income during that time period.
Anthem Blue Cross Life and Health Insurance Company

Shareholder Dividends Paid
(Amounts in Millions)

<table>
<thead>
<tr>
<th>Year</th>
<th>Stockholder Dividends</th>
<th>Net Income</th>
<th>Dividends / Income</th>
</tr>
</thead>
<tbody>
<tr>
<td>2007</td>
<td>$238</td>
<td>$381</td>
<td>63%</td>
</tr>
<tr>
<td>2008</td>
<td>$325</td>
<td>$195</td>
<td>167%</td>
</tr>
<tr>
<td>2009</td>
<td>$130</td>
<td>$171</td>
<td>76%</td>
</tr>
<tr>
<td>2010</td>
<td>$0</td>
<td>$206</td>
<td>0%</td>
</tr>
<tr>
<td>2011</td>
<td>$0</td>
<td>$204</td>
<td>0%</td>
</tr>
<tr>
<td>2012</td>
<td>$192</td>
<td>$342</td>
<td>56%</td>
</tr>
<tr>
<td>Combined</td>
<td>$885</td>
<td>$1,498</td>
<td>59%</td>
</tr>
</tbody>
</table>

Source: Anthem Annual Statements, Statement of Revenue and Expenses

The high level of profit earned by Anthem has allowed the actual surplus to be many times larger than the required minimum surplus\(^3\), as shown in the following table.

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\(^3\) The authorized control level risk based capital (ACL RBC) values are calculated by Anthem and shown in its Annual Statement filed with CDI. The ratio of the actual surplus to the ACL RBC is the RBC %.
Anthem Blue Cross Life and Health Insurance Company

Risk Based Capital Percent
(Amounts in Millions)

<table>
<thead>
<tr>
<th>Year</th>
<th>Ending Surplus</th>
<th>ACL RBC</th>
<th>RBC %</th>
</tr>
</thead>
<tbody>
<tr>
<td>2005</td>
<td>$667.1</td>
<td>$79.6</td>
<td>838%</td>
</tr>
<tr>
<td>2006</td>
<td>$767.2</td>
<td>$94.1</td>
<td>815%</td>
</tr>
<tr>
<td>2007</td>
<td>$898.8</td>
<td>$109.4</td>
<td>822%</td>
</tr>
<tr>
<td>2008</td>
<td>$760.1</td>
<td>$126.8</td>
<td>600%</td>
</tr>
<tr>
<td>2009</td>
<td>$813.8</td>
<td>$143.4</td>
<td>568%</td>
</tr>
<tr>
<td>2010</td>
<td>$973.8</td>
<td>$172.7</td>
<td>564%</td>
</tr>
<tr>
<td>2011</td>
<td>$1,145.4</td>
<td>$198.5</td>
<td>577%</td>
</tr>
<tr>
<td>2012</td>
<td>$1,361.0</td>
<td>$183.8</td>
<td>740%</td>
</tr>
<tr>
<td>Average</td>
<td>$923.4</td>
<td>$138.5</td>
<td>667%</td>
</tr>
</tbody>
</table>

Source: Anthem Annual Statements, Five Year Historical Data

The 740% RBC% for Anthem at the end of 2012 can be considered to be above a typical level, indicating a high amount of surplus. That high level of surplus has been achieved despite Anthem paying almost $900 million in stockholder dividends from 2007 to 2012. That high level of surplus is a result of the very large profits earned by Anthem.

4. **Affiliate Transactions**

   During the five years from 2008 to 2012, Anthem paid affiliates almost $5 billion for management agreements and service contracts, as shown in the following table.
Anthem Blue Cross Life and Health Insurance Company

Management Agreements and Service Contracts With Affiliates
(Amounts in Millions)

<table>
<thead>
<tr>
<th>Year</th>
<th>Affiliate</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008</td>
<td>$918.9</td>
</tr>
<tr>
<td>2009</td>
<td>$950.8</td>
</tr>
<tr>
<td>2010</td>
<td>$1,021.1</td>
</tr>
<tr>
<td>2011</td>
<td>$1,036.3</td>
</tr>
<tr>
<td>2012</td>
<td>$1,027.5</td>
</tr>
<tr>
<td></td>
<td>$4,954.7</td>
</tr>
</tbody>
</table>

Source: Anthem Annual Statements, Schedule Y - Part 2
Summary of Insurer's Transactions with Any Affiliates

It is unclear whether the payments by Anthem to affiliated companies for management agreements and service contracts is at a fair price and / or if those payments may include a hidden transfer of profit from Anthem to affiliates. As those affiliate payments could impact the level of expenses included in the rate calculation, inflated values for those affiliate payments could result in an excessive and unreasonable rate level.

Please feel free to contact me if there is anything you would care to discuss.

Enclosures
# Anthem Blue Cross Life and Health Insurance Company

Anthem Blue Cross Life and Health Insurance Company  
**Experience Period:** 9/1/2011 - 8/31/2012; Pd thru 10/31/12  
**Rating Period:** Apr, May, Jun 2013

<table>
<thead>
<tr>
<th>STEP</th>
<th>Description of Rate Development Steps</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1)</td>
<td>Incurred Claims</td>
<td>$113,353,465</td>
</tr>
<tr>
<td>(2)</td>
<td>Pooled Claims</td>
<td>$16,825,272</td>
</tr>
<tr>
<td>(3)</td>
<td>Incurred Claims w/ Pool Charge</td>
<td>$113,353,465</td>
</tr>
<tr>
<td>(4)</td>
<td>Rx Rebates (-$5.15 PMPM)</td>
<td>$(1,421,636)</td>
</tr>
<tr>
<td>(5)</td>
<td>Med Mgmt Reclass ($3.22 PMPM)</td>
<td>$1,667,457</td>
</tr>
<tr>
<td>(6)</td>
<td>Inc’d Claims (w/ Rx rebates, Med Mgmt Reclass)</td>
<td>$113,599,285</td>
</tr>
<tr>
<td>(7)</td>
<td>Premium Earned</td>
<td>$154,924,328</td>
</tr>
<tr>
<td>(8)</td>
<td>Loss Ratio (Incl Rx Rebates &amp; Med Mgmt Exp.)</td>
<td>73.3%</td>
</tr>
<tr>
<td>(9)</td>
<td>Member Months (Experience Period)</td>
<td>518,084</td>
</tr>
<tr>
<td>(10)</td>
<td>Prem PMPM at current rate tables (Jan 2013)</td>
<td>$320.85</td>
</tr>
</tbody>
</table>

### TREND ADJUSTMENTS

| (11) | Trend Months | 20.09 |
| (12) | Annual Medical Trend Factor | 8.9% |

### ONE-TIME BENEFIT ADJUSTMENTS

| (13) | Benefit Mix (Plan Replacements) | 0.4% |
| (14) | Benefit Change Adjustments ("New Impacts") | (0.7%) |
| (15) | Benefit Change Adjustments ("Residual Impacts") | (2.5%) |

### INCURRED CLAIMS (RATING PERIOD)

| Calculated Step | Proj’d Incurred Claim (Excl. Rx Rebates, Med Mgmt) PMPM | $251.72 |
| (16) | Proj’d Rx Rebates PMPM | $(2.80) |
| (17) | Proj’d Medical Mgmt Reclass PMPM | $3.22 |
| (18) | Proj’d Incurred Claim PMPM (All in) | $244.95 |
| (19) | Member Months (Aug 2012 for Most Recent) | 45,235 |

### RETENTION (RATING PERIOD)

| (20) | Selling Expenses (8.66% of Premium) | $26.53 |
| (21) | Admin Expenses (PMPM) | $14.26 |
| (22) | Reinsurance Fee Contribution (PMPM) | $1.69 |
| (23) | ACA Insurer Fee | $1.58 |
| (24) | Comp Eff Research Fee (PMPM) | $0.17 |
| (25) | Premium Taxes (2.35% of Premium) | $7.20 |
| (26) | After-Tax Profit & Contingencies (PMPM) | $6.13 |
| (27) | Federal Income Taxes (32.85% of Profit) | $3.77 |

### FILED RATING FACTORS

| (28) | Indicated 2Q13 Rate Change (Quarter) | -4.5% |
| (29) | Filed Premium PMPM | $306.27 |

### RATING PERIOD MLRS

| (30) | GAAP-defined MLR | 80.0% |
| (31) | ACA-defined MLR | 83.1% |

### RATE CHANGES

| (32) | 3Q12 Rate Change (Quarter) | 0.0% |
| (33) | 4Q12 Rate Change (Quarter) | 1.9% |
| (34) | 1Q13 Rate Change (Quarter) | 2.3% |
| (35) | 2Q13 Renewal Rate Change (Annual) | -0.5% |
UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549
FORM 10-K
(Mark One)

☒ ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934
For the fiscal year ended December 31, 2012

☐ TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934
For the transition period from to

Commission file number 001-16751

WELLPOINT, INC.
(Exact name of registrant as specified in its charter)

Indiana
(State or other jurisdiction of incorporation or organization)

120 Monument Circle
Indianapolis, Indiana
(Address of principal executive offices)

35-2145715
(I.R.S. Employer Identification No.)

46204
(Zip Code)

Registrant’s telephone number, including area code: (317) 488-6000

Title of each class

Common Stock, Par Value $0.01

Name of each exchange on which registered

New York Stock Exchange

Indicate by check mark if the Registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. Yes ☒ No ☐

Indicate by check mark if the Registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Exchange Act. Yes ☐ No ☒

Indicate by check mark whether the Registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. Yes ☒ No ☐

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T (§232.405) during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes ☒ No ☐

Indicate by check mark whether disclosure of delinquent filers pursuant to Item 405 of Regulation S-K (§229.405) is not contained herein, and will not be contained, to the best of Registrant’s knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K. ☒

Indicate by check mark whether the Registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer or a smaller reporting company. See definitions of “large accelerated filer”, “accelerated filer”, and “smaller reporting company” in Rule 12b-2 of the Exchange Act.

Large accelerated filer ☒ Accelerated filer ☐
Non-accelerated filer ☐ (Do not check if a smaller reporting company)
Smaller reporting company ☐

Indicate by check mark whether the Registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act). Yes ☐ No ☒

The aggregate market value of the voting and non-voting common equity held by non-affiliates of the Registrant (assuming solely for the purposes of this calculation that all Directors and executive officers of the Registrant are “affiliates”) as of June 29, 2012 was approximately $20,656,154,130.

As of February 8, 2013, 304,035,158 shares of the Registrant’s Common Stock were outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

Part III of this Annual Report on Form 10-K incorporates by reference information from the Registrant’s Definitive Proxy Statement for the Annual Meeting of Shareholders to be held May 15, 2013.

Schedule AIS-2, Page 1 of 5
Other Membership & Customers (in thousands)

Our Other products are often ancillary to our health business, and can therefore be impacted by corresponding changes in our medical membership.

Behavioral health membership increased 1,172, or 4.9%, primarily due to new sales to several major accounts in our National Accounts business, increased Medicare Advantage and State-Sponsored medical membership and a change in methodology of how we report certain portions of the behavioral health membership.

Life and disability membership decreased 189, or 3.6%, primarily due to lapses in our National Accounts business. Life and disability products are generally offered as a part of Commercial medical fully-insured membership sales.

Dental membership increased 39, or 1.0%, primarily due to new sales resulting from the introduction of new product offerings and, to a lesser extent, our acquisition of a dental benefits plan in December 2011.

Dental administration membership decreased 110, or 2.6%, primarily due to the termination of a contract in the North Carolina market.

Vision membership increased 275, or 7.8%, primarily due to strong sales and market penetration of our Blue View vision product within the Local Group markets and embedding of vision benefits in certain of our Consumer products, partially offset by lapses.

Medicare Advantage Part D membership increased 141, or 32.5%, primarily due to new membership associated with the increase in our Medicare Advantage medical membership, including additional Medicare Advantage medical membership resulting from our acquisition of CareMore.

Medicare Part D standalone membership decreased 147, or 18.1%, primarily due to lapses in Low Income Subsidy, or LIS, membership in 2011. LIS is a Medicare Part D program that provides additional premium and cost-sharing assistance to qualifying Medicare beneficiaries with low incomes and/or limited resources.

Cost of Care

The following discussion summarizes our aggregate underlying cost of care trends for the year ended December 31, 2012 for our Local Group fully-insured business only.

Our cost of care trends are calculated by comparing the year-over-year change in average per member per month claim costs, including member co-payments and deductibles. While our cost of care trend varies by geographic location, based on underlying medical cost trends, we estimate that our aggregate cost of care trend was near the low end of 7.0% plus or minus 50 basis points for the full year of 2012.

Overall, our medical cost trend is driven by unit cost. Inpatient hospital trend was in the mid-to-high single digit range and was primarily related to increases in the average cost per admission. While provider rate increases are a primary driver of unit cost trends, we continually negotiate with hospitals to manage these cost trends. We remain committed to optimizing our reimbursement rates and strategies to help address the cost pressures faced by employers and consumers. Both inpatient admission counts per thousand members and inpatient day counts per thousand members were only slightly higher than the prior year. The average length of stay was relatively the same as the prior year. In addition to our recontracting efforts, a number of clinical management initiatives are in place to help mitigate the inpatient trend. Focused review efforts continue in key areas, including inpatient behavioral health stays and spinal surgery cases, among others. Additionally, we continue to refine our programs related to readmission management, focused utilization management at high cost facilities and post-discharge follow-up care.
December 31, 2012; and (2) claims reported to us and processed through our systems but not yet paid, which approximated 4.5%, or $276.6, of the total medical claims payable as of December 31, 2012. The level of claims payable processed through our systems but not yet paid may fluctuate from one period to the next, from 1% to 3% of our total medical claims liability, due to timing of when claim payments are made.

Liabilities for both claims incurred but not reported and reported but not yet processed through our systems are determined in aggregate, employing actuarial methods that are commonly used by health insurance actuaries and meet Actuarial Standards of Practice. Actuarial Standards of Practice require that the claim liabilities be appropriate under moderately adverse circumstances. We determine the amount of the liability for incurred but not paid claims by following a detailed actuarial process that entails using both historical claim payment patterns as well as emerging medical cost trends to project our best estimate of claim liabilities. Under this process, historical paid claims data is formatted into “claim triangles,” which compare claim incurred dates to the dates of claim payments. This information is analyzed to create “completion factors” that represent the average percentage of total incurred claims that have been paid through a given date after being incurred. Completion factors are applied to claims paid through the period end date to estimate the ultimate claim expense incurred for the period. Actuarial estimates of incurred but not paid claim liabilities are then determined by subtracting the actual paid claims from the estimate of the ultimate incurred claims.

For the most recent incurred months (typically the most recent two months), the percentage of claims paid for claims incurred in those months is generally low. This makes the completion factor methodology less reliable for such months. Therefore, incurred claims for recent months are not projected from historical completion and payment patterns; rather they are projected by estimating the claims expense for those months based on recent claims expense levels and health care trend levels, or “trend factors.”

Because the reserve methodology is based upon historical information, it must be adjusted for known or suspected operational and environmental changes. These adjustments are made by our actuaries based on their knowledge and their estimate of emerging impacts to benefit costs and payment speed. Circumstances to be considered in developing our best estimate of reserves include changes in utilization levels, unit costs, mix of business, benefit plan designs, provider reimbursement levels, processing system conversions and changes, claim inventory levels, claim processing patterns, claim submission patterns and operational changes resulting from business combinations. A comparison of prior period liabilities to re-estimated claim liabilities based on subsequent claims development is also considered in making the liability determination. In our comparison of prior year, the methods and assumptions are not changed as reserves are recalculated; rather the availability of additional paid claims information drives our changes in the re-estimate of the unpaid claim liability. To the extent appropriate, changes in such development are recorded as a change to current period benefit expense.

We regularly review and set assumptions regarding cost trends and utilization when initially establishing claim liabilities. We continually monitor and adjust the claims liability and benefit expense based on subsequent paid claims activity. If it is determined that our assumptions regarding cost trends and utilization are significantly different than actual results, our income statement and financial position could be impacted in future periods. Adjustments of prior year estimates may result in additional benefit expense or a reduction of benefit expense in the period an adjustment is made. Further, due to the considerable variability of health care costs, adjustments to claim liabilities occur each period and are sometimes significant as compared to the net income recorded in that period. Prior period development is recognized immediately upon the actuary’s judgment that a portion of the prior period liability is no longer needed or that an additional liability should have been accrued. That determination is made when sufficient information is available to ascertain that the re-estimate of the liability is reasonable.

While there are many factors that are used as a part of the estimation of our medical claims payable liability, the two key assumptions having the most significant impact on our incurred but not paid claims liability as of December 31, 2012 were the completion and trend factors. As discussed above, these two key assumptions can be influenced by other operational variables including system changes, provider submission patterns and business combinations.
There is variation in the reasonable choice of completion factors by duration for durations of three months through twelve months where the completion factors have the most significant impact. As previously discussed, completion factors tend to be less reliable for the most recent months and therefore are not specifically utilized for months one and two. In our analysis for the claim liabilities at December 31, 2012, the variability in months three to five was estimated to be between 40 and 90 basis points, while months six through twelve have much lower variability ranging from 0 to 30 basis points.

The difference in completion factor assumptions, assuming moderately adverse experience, results in variability of 2%, or approximately $143.0, in the December 31, 2012 incurred but not paid claims liability, depending on the completion factors chosen. It is important to note that the completion factor methodology inherently assumes that historical completion rates will be reflective of the current period. However, it is possible that the actual completion rates for the current period will develop differently from historical patterns and therefore could fall outside the possible variations described herein.

The other major assumption used in the establishment of the December 31, 2012 incurred but not paid claim liability was the trend factors. In our analysis for the period ended December 31, 2012, there was a 300 basis point differential in the high and low trend factors assuming moderately adverse experience. This range of trend factors would imply variability of 4%, or approximately $276.0, in the incurred but not paid claims liability, depending upon the trend factors used. Because historical trend factors are often not representative of current claim trends, the trend experience for the most recent six to nine months, plus knowledge of recent events likely affecting current trends, have been taken into consideration in establishing the incurred but not paid claims liability at December 31, 2012.

See Note 12, “Medical Claims Payable,” to our audited consolidated financial statements as of and for the year ended December 31, 2012 included in this Form 10-K, for a reconciliation of the beginning and ending balance for medical claims payable for the years ended December 31, 2012, 2011 and 2010. Components of the total incurred claims for each year include amounts accrued for current year estimated claims expense as well as adjustments to prior year estimated accruals. In Note 12, “Medical Claims Payable,” the line labeled “Net incurred medical claims: Prior years redundancies” accounts for those adjustments made to prior year estimates. The impact of any reduction of “Net incurred medical claims: Prior years redundancies” may be offset as we establish the estimate of “Net incurred medical claims: Current year.” Our reserving practice is to consistently recognize the actuarial best estimate of our ultimate liability for our claims. When we recognize a release of the redundancy, we disclose the amount that is not in the ordinary course of business, if material. Further, while we believe we have consistently applied our methodology in determining our best estimate for unpaid claims liability at each reporting date, starting in 2010 we began using a lower level of targeted margin for adverse deviation, which resulted in a benefit to 2010 income before taxes of $67.7.

The ratio of current year medical claims paid as a percent of current year net medical claims incurred was 89.1% for 2012, 88.8% for 2011 and 89.6% for 2010. The increase in 2012 reflects acceleration in processing claims that occurred in 2012 due to higher levels of automatic claims adjudication and faster claims payment. The decline in 2011 reflects the impact of processing a claims inventory backlog that accumulated at the end of 2010.

We calculate the percentage of prior years’ redundancies in the current period as a percent of prior years’ net incurred claims payable less prior years’ redundancies in the current period in order to demonstrate the development of the prior years’ reserves. This metric was 10.4% for the year ended December 31, 2012. This metric was 4.5% for the year ended December 31, 2011 and 15.3% for the year ended December 31, 2010. The years ended December 31, 2012 and 2011 reflect a lower level of targeted reserve for adverse deviation and a resultant lower level of prior years’ redundancies than the year ended December 31, 2010.

We calculate the percentage of prior years’ redundancies in the current period as a percent of prior years’ net incurred medical claims to indicate the percentage of redundancy included in the preceding year calculation of current year net incurred medical claims. We believe this calculation measure indicates the reasonableness of
12. Medical Claims Payable (continued)

established year end liability. Negative amounts reported for incurred medical claims related to prior years result from claims being settled for amounts less than originally estimated. The prior year redundancy of $513.6 shown above for the year ended December 31, 2012 represents an estimate based on paid claim activity from January 1, 2012 to December 31, 2012. Medical claim liabilities are usually described as having a “short tail,” which means that they are generally paid within twelve months of the member receiving service from the provider. Accordingly, the majority of the $513.6 redundancy relates to claims incurred in calendar year 2011.

The following table provides a summary of the two key assumptions having the most significant impact on our incurred but not paid liability estimates for the years ended December 31, 2012, 2011 and 2010, which are the completion and trend factors. These two key assumptions can be influenced by utilization levels, unit costs, mix of business, benefit plan designs, provider reimbursement levels, processing system conversions and changes, claim inventory levels, claim processing patterns, claim submission patterns and operational changes resulting from business combinations.

<table>
<thead>
<tr>
<th></th>
<th>(Favorable) Unfavorable Developments</th>
<th>2012</th>
<th>2011</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assumed trend factors</td>
<td></td>
<td>$ (394.4)</td>
<td>$ (264.8)</td>
<td>$ (534.9)</td>
</tr>
<tr>
<td>Assumed completion factors</td>
<td></td>
<td>(119.2)</td>
<td>55.1</td>
<td>(183.1)</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>$ (513.6)</td>
<td>$ (209.7)</td>
<td>$ (718.0)</td>
</tr>
</tbody>
</table>

The favorable development recognized in 2012 resulted primarily from trend factors in late 2011 developing more favorably than originally expected as well as a smaller but significant contribution from completion factor development. The favorable development recognized in 2011 was driven by trend factors in late 2010 developing more favorably than originally expected. This impact was partially offset by completion factors developing unfavorably due to slight increases in payment cycle times. The favorable development recognized in 2010 was driven by trend factors in late 2009 developing more favorably than originally expected. In addition, a minor but steady improvement in payment cycle times impacted completion factor development and contributed to the favorability.

Due to changes within our Company and industry during 2010, we re-evaluated our actuarial processes and resulting levels of reserves. As discussed in Note 2, “Basis of Presentation and Significant Accounting Policies,” Actuarial Standards of Practice require that claims liabilities be appropriate under moderately adverse circumstances. To satisfy these requirements, our reserving process has historically involved recognizing the inherent volatility in actual future claim payments compared to the current estimate for the related liability by recording a provision for adverse deviation. This additional reserve establishes a sufficient level of conservatism in the liability estimate that is similar from period to period. There are a number of factors that can require a higher or lower level of additional reserve, such as changes in technology that provide faster access to claims data or change the speed of adjudication and settlement of claims, or overall variability in claim payment patterns and claim inventory levels. Given that in the more recent periods we experienced higher levels of automatic claims adjudication and faster claims payment leading to lower and more consistent claims inventory levels, we determined that using a lower level of targeted reserve for adverse deviation provides a similar level of confidence that the established reserves are appropriate in the current environment. This change in estimate resulted in a benefit to 2010 income before income tax expense and diluted earnings per share of $67.7 and $0.11, respectively. We continued to use this lower level of targeted reserve for adverse deviation in 2011 and 2012.
Medical Cost Trend: 
Behind the Numbers 2013

May 2012
Health Research Institute

pwc
Medical cost trend in 2013 will surprise the industry with another year of historically low growth. The continued slowdown is the result of a sluggish economy, medical plans with greater cost sharing, and new care models that reward value over volume.

PwC’s Health Research Institute projects medical cost trend will remain flat at 7.5 percent in 2013.

Employers and insurers will want to capitalize on the recent slowdown, while doctors, hospitals, and pharmaceutical companies need to retool their business models to succeed in the new environment.
Medical cost trend in 2013 will surprise the industry with another year of historically low growth. The continued slowdown is the result of a sluggish economy, medical plans with greater cost sharing, and new care models that reward value over volume.
Healthcare spending growth in the United States has slowed considerably over the past three years. And despite expectations that the trend would bounce back up in 2012, it did not. In fact, we see no major change on the horizon for 2013.

Medical cost trend measures spending growth on health services and products—a critical factor in calculating insurance premiums for employers and consumers. For 2013 PwC’s Health Research Institute projects a medical cost trend of 7.5%. Perhaps most notably, the historically large gap between healthcare growth and overall inflation has closed slightly.

As a result, the United States finds itself at a crossroads with respect to medical inflation. History suggests that the current slowdown is merely a dip mirroring broader economic trends and that medical cost growth will return to “normal” when the rest of the economy recovers fully. Looking even further out, if the Affordable Care Act is fully implemented, tens of millions of newly-insured Americans receiving care for the first time in years could cause a spike in spending in 2014 and beyond.

But across the healthcare landscape behaviors are beginning to change. Employers are pushing wellness programs with real enforcement muscle. Healthcare providers and drug makers are embracing the quest for value. And patients are becoming more cost-conscious medical consumers.

It is always dangerous to predict that medical cost trend could be approaching a more sustainable level. Yet if the structural forces in the industry take hold, the U.S. health system may be entering a “new normal.”
An in-depth discussion

PwC’s Health Research Institute projects medical cost trend will remain flat at 7.5 percent in 2013.
Executive summary

The focus on medical cost containment strategies is continuing, aided by the sluggish economy, reforms in the healthcare industry, and efforts by employers to hold down costs.

More than half of the employers surveyed by HRI are considering increasing employees’ share of health benefit cost and expanding health and wellness programs in 2013.

In estimating the medical cost trend growth for 2013, HRI relied on multiple sources including interviews with health plan actuaries and industry leaders, a review of available surveys and analyst reports, and PwC’s own 2012 Health and Well-Being Touchstone Survey of 1,400 employers from more than 30 industries. In this year’s report, we identified:

Four factors that will deflate medical cost trend in 2013:

- Medical supply and equipment costs abate under market pressure. Supplies can account for more than 40% of the cost of certain procedures. Recent hospital consolidation and physician employment are enabling administrators to move away from “physician preference” purchasing and negotiate for significant savings. In addition, insurers are pressuring hospitals to hold down these expenses.

- New methods to deliver primary care gain popularity. One of the slowest areas of cost growth has been in physician services, and this trend is expected to continue in 2013 as consumers choose alternatives to the traditional doctor’s office visit. Lower-cost options such as workplace and retail health clinics, telemedicine, and mobile health tools continue to gain market share because employers and consumers view them as cost effective and convenient.

- Price transparency exerts pressure. As comparative cost information becomes more readily available, purchasers such as employers and individual patients can shop for non-emergency services such as tests and elective procedures. Providers meanwhile are under pressure to justify prices. More than 30 states require some reporting of hospital charges and reimbursement rates. Congress is considering legislation that would prohibit cost confidentiality clauses in insurance and hospital contracting.

- The pharmaceutical patent cliff continues to foster the use of cost-saving generics. Many blockbuster drugs have recently gone off patent, which will have a major effect on lowering drug spending in 2013.

Two factors that will inflate medical cost trend in 2013:

- Uptick in utilization trend is expected in 2013. The recession of 2007–2009 contributed to a significant slowing in healthcare consumption, as many people who lost jobs or were afraid of losing employment delayed care. As the economy continues to strengthen, utilization is expected to rebound.

- Medical and technological advances accelerate growth of higher-cost care. Remarkable new discoveries and technological advances let many in society live much longer—but often at a significantly higher cost. New technologies, such as robotic surgery and positron emission tomography services, have grown rapidly, with 36% of hospitals performing robotic surgery in 2010.1 Several health plans reported an uptick in high-cost cases, many surpassing the million-dollar mark

What this means for your business

Employers and insurers will want to capitalize on the recent slowdown, while doctors, hospitals, and pharmaceutical companies will need to retool their business models to succeed in the new environment.

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Behind medical cost trend

Medical cost trend could be defined in several ways; for this report, it looks at the projected increase in costs of medical services assumed in setting health insurance premiums. Commercial insurers and large, self-insured businesses use medical cost trend to estimate what the same health plan would cost in the following year. Medical trend does not take into account benefit changes, which were reduced by 1% to 2% over the period reviewed.

PwC’s Health Research Institute (HRI) estimates the medical cost trend for 2013 will be 7.5%. HRI has also recalibrated its trend estimates down for the three previous years as the latest available information indicates medical costs have come in lower than expected. Taken together, Figure 1 shows the trend is estimated to be in the relatively low range of 7% to 7.5% for the entire period 2010–2013, raising the possibility that we have entered a “new normal.”

The net cost trend after accounting for changes in plan benefits, such as higher deductibles and cost sharing, is also in a narrow range of 5.5% to 6%.

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2 PwC estimates that the wedge between medical cost trend before health plan changes and the net trend after changes is typically 1.5% to 2%, as was estimated in 2010 and 2012, and is expected in 2013. The small adjustment in 2011 is the result of the enactment of the Affordable Care Act, which included new benefit requirements (e.g., removing lifetime limits), that offset other reductions. Some analysts also argue that low wage increases may have increased resistance to plan changes. By the end of 2013, HRI estimates that the typical relationship between medical trend before and after plan changes will return, yielding a medical trend of 5.5% after accounting for plan changes.

3 HRI’s changes in the 2011 and 2012 estimates were based on this year’s look back including interviews with officials from health plans. Unlike premiums, which are directly observed in the marketplace, the medical cost trend is based on estimates from health plans, large employers, and other analysts.
2012 Milliman Medical Index

Healthcare costs for American families in 2012 exceed $20,000 for the first time

Because of the way employer-sponsored health insurance is paid for, many families may not realize the cost of their healthcare for a single year is roughly equivalent to the cost of a basic mid-size sedan.
EXECUTIVE SUMMARY

The annual Milliman Medical Index (MMI) measures the total cost of healthcare for a typical family of four covered by a preferred provider plan (PPO). The 2012 MMI cost is $20,728, an increase of $1,335, or 6.9% over 2011. The rate of increase is not as high as in the past, but the total dollar increase was still a record. This is the first year the average cost of healthcare for the typical American family of four has surpassed $20,000.

Key considerations

Our family of four is insured by an employer-sponsored PPO plan, which includes certain out-of-pocket costs such as copays and deductibles. The plan’s premiums are paid jointly by the employer and by the employee via payroll deductions. Healthcare benefits are a substantial portion of the employee’s compensation.

Our family of four may be surprised to learn that their annual healthcare costs are nearing $21,000, because their own out-of-pocket costs, at an average of $3,470, are the portion of the cost of care most visible to them (see Figure 1). Some employees may also be acutely aware of the $5,114 in payroll deductions. This brings the employee’s total share to $8,584 (see Figure 9).

While the annual rate of increase fell below 7% for the first time in the 12 years tracked by the MMI, the total dollar amount of the increase overshadows any relief that consumers might derive from the slowing percentage increase.

As of the release date of this report, the nation is awaiting a U.S. Supreme Court decision on the future of the Patient Protection and Affordable Care Act (PPACA). To date, PPACA has had only a limited effect on total healthcare costs for the MMI’s illustrative family of four. With the MMI release in between the Supreme Court deliberations and its decision, we are left with more uncertainty about the future of healthcare costs than usual. As we examine the different components of the MMI, we offer considerations for the future both with and without reform (see page 7).