



OFFICE OF THE ATTORNEY GENERAL  
CONNECTICUT

WILLIAM TONG  
ATTORNEY GENERAL

August 15, 2023

**By Email**

Andrew N. Mais  
Commissioner  
Connecticut Insurance Department  
153 Market Street, 7<sup>th</sup> Floor  
Hartford, Connecticut 06103

Re: *2024 Health Insurance Rate Request Filings*

Dear Commissioner Mais:

Once again, we find ourselves in the unfortunate position of reacting to double-digit rate increases sought by the nine health insurers offering individual and small group plans.

Collectively, these plans cover over 188,000 Connecticut lives, with significant impact to those families and our small business community. Although the Department's rate review authority does not reach the large and self-insured plans covering the majority of Connecticut residents enrolled in commercial health insurance, the Department's actions in this segment impact the incentive structure and negotiation dynamics broadly between insurers and healthcare providers. Simply put, the decisions made here will impact the cost of healthcare in Connecticut for us all.

The proposed average individual rate request for the plan year starting January 1, 2024 is a 12.4 percent increase, compared to 20.4 percent in plan year 2023. Increases requested range from 9.8 percent to 17.5 percent. The proposed average small group rate request is a 14.8 percent increase, compared to 14.8 percent in 2023 and ranges from 7.5 percent to 23.0 percent.

Pursuant to Connecticut law, in order for these rates to be approved, the Connecticut Insurance Department must determine that these requested rates are not "excessive, inadequate, or unfairly discriminatory." *Conn. Gen. Stat. sec. 38a-481(b)* The burden of proof falls on the insurers to justify their rates—to provide transparent, factually-supported actuarial analysis. In at least the case of Cigna's 14.9 percent increase in the small group market, Anthem's 9.8 percent increase in the individual group and 14.9 percent increase in the small group market, and ConnectiCare's 17.5 percent increase in the individual market, the insurers have failed to meet that burden and **their requests must be rejected**. Should any increase or modification be granted, the burden is on these companies to immediately amend their submissions with factually-supported evidence before the Department takes any further action.

165 Capitol Avenue  
Hartford, Connecticut 06106

*An Affirmative Action/Equal Opportunity Employer*

Between 2016 and 2022, rates sought by insurers and approved by the Connecticut Insurance Department far outstripped consumer inflationary trends. The average rate increases requested by ConnectiCare and Anthem for individual on exchange plans between 2016 and 2022 were 6.7 percent and 16 percent respectively. The average approved rates for those plans during that timeframe were 7.9 percent and 9.73 percent respectively. By contrast, the average Consumer Price Index (“CPI”) for the same years as published by the Bureau of Labor Statistics was 2.8 percent, which includes the historically high annual CPI rate of 6.2 percent in 2022. These inflated costs are excessive and unjustified and unaffordable for too many Connecticut families, individuals, and businesses. When viewed through a historic lens, it seems equally clear that these rate increases are unsustainable and are a likely cause of the flight that is occurring from the fully insured market.

### **Trend**

Trend is the rate at which insurers project that health care costs will increase. It consists of two components: unit cost and utilization. This is the basic underpinning of all rates. An inflated, unsupported, excessive trend will yield an inflated, unsupported, excessive rate request. Our comments thus focus predominantly on the unsupported trend in each application.

#### *The Rate Review Process Disincentivizes Negotiations to Lower the Costs of Medical Services*

Cigna, Anthem, and ConnectiCare all submit rate requests based on trends well in excess of nationally-supported data. Approval of high trend is a self-fulfilling prophecy: such approval reflects an expectation that providers will increase their charges in excess of inflation (even medical inflation) and providers do increase their charges because they expect the Insurance Department to approve rates that reflect such increases. If instead, the Department were to consistently approve rates that do not reflect higher reimbursement rates being charged by providers, insurers would be incentivized to negotiate lower reimbursement rates. Insurers have a great deal of leverage in negotiating with hospitals and other providers, but rather than use that leverage to aggressively drive down healthcare costs, they act as little more than pass-through mechanisms for ever-increasing provider fees. This makes economic sense for the insurers—higher healthcare spending (unit cost) justifies higher premiums and thus higher revenue to insurers, even when percentage-based profit margins remain static year over year. While the Insurance Commissioner does not oversee the negotiations of these contracts, the Commissioner’s approval of rates which incorporate higher unit costs disincentivize effective negotiations designed to reduce the cost of care.

#### *Applicants’ Trend Projections Are Excessive Relative to Independent Projections*

Milliman, the large actuarial firm on which insurers themselves heavily rely, publishes the Milliman Medical Index which calculates both the actual medical trend in recent years and estimates the trend for the current year. In its 2023 index published in May of this year, Milliman reports that

the annual health care trend since 2021 has been 4.8 percent, and it projects that the trend for 2023 will be 5.6 percent. Meanwhile, the Connecticut Cost Growth Benchmark for plan year 2024 is 2.9 percent and the State Employee Health Plan, managed by Anthem, reported a medical trend of 3.7 percent for the period of April 2022 to March 2023.

How do Cigna, Anthem, and ConnectiCare's trends compare?

- **Cigna Small Group:** In its small group rate filing, Cigna inexplicably uses two different trends—8.3 percent and 7.4 percent in different parts of their application. Cigna provides no data to support either trend, and the data they do provide is questionable at best. For example, Cigna assumes identical trends for inpatient hospital charges, for outpatient hospital charges, for doctors and other professional charges, and for charges for other medical services, although the change in cost and utilization of those four components inherently varies. Cigna also says that it bases its unit cost trend assumption on Connecticut data, but its utilization trend assumption on national data. **Cigna does not explain this divergence, nor does it disclose any underlying data, whether Connecticut-specific or countrywide. Its entire application is built on these opaque, unsupported assumptions that defy basic logic and must be rejected.**
- **Anthem Individual and Small Group:** Anthem assumes a trend of 9.5 percent for individual and 10 percent for small group annually, which it applies for two years, resulting in a 19.96 and 21.42 percent trend, respectively, for the relevant 24.4 month period from January 2, 2023 to January 15, 2025. Anthem never shows how it arrives at the 9.5 and 10 percent trend it assumes. To the contrary, it says only that it is “normalizing historical benefit expense changes in the underlying population and known cost drivers, which are then projected forward to develop the pricing trend.”

Anthem neither specifies the cost drivers it refers to or shows any projections regarding those cost drivers. Anthem states, in the text of its Actuarial Memoranda, that its Projection Period Adjustments Exhibit has the details but that exhibit has no such details. It simply asserts the trend and states that the “Explanation of factors above is provided in the Actuarial Memorandum.” The Actuarial Memorandum then tells the reader to go back to the Projection Period Adjustments Exhibit. These circular references do little to demystify the bases of Anthem's assumptions, which appear to deviate significantly from the carrier's experience administering the State Employee plan.

Exhibit Q later provides some data, but undermines rather than supports Anthem's assumptions. There, Anthem shows that they use a baseline year of 2020, which was the first and worst year of the pandemic when many fewer people than average sought healthcare resulting in a decrease in healthcare costs for the first time in memory followed by a spike

due to pent up demand. The 9.5 and 10 percent trends that Anthem assumes in its rate filings is thus doubly overstated: it uses the pandemic-caused aberrationally low-cost 2020 as the starting point, and it uses the aberrationally high years of 2021 and 2022 to compare. And, even if we were to accept the flawed proposition that 2020 trend is a legitimate starting point, and 2021 and 2022 are legitimate end points, Exhibit Q still fails to justify a 9.5 or 10 percent trend because it never discloses the weights Anthem gives for each of the components of these healthcare costs—inpatient, outpatient, professional, and pharmacy. Without knowing the weights Anthem gives to each of these, it is impossible to evaluate whether those weights are reasonable. **Connecticut deserves better than this shoddy, circular logic, and the Insurance Department should reject this trend as unjustified absent any supporting evidence.**

- **ConnectiCare Individual:** ConnectiCare assumes an annual trend factor of 11.2 percent (23.8 percent over the two-year period)—the highest trend factor used by any carrier in its 2024 rate filing. ConnectiCare claims that it makes adequate adjustments for the aberrations experienced in 2020, 2021 and 2022 by using 2019 as a starting point, comparing it to 2022, when claims experience was still high due to pent-up demand. While ConnectiCare does make a reduction of 2.8 percent to adjust for pent up demand in 2022, this is almost entirely cancelled out by an increase of 2.1 percent for “Covid impact on projection period 2024” on top of its 11.2 trend assumption. This factor is not justified in the filing.

ConnectiCare also cites an increase in morbidity due to the Medicaid “unwinding” process whereby states are redetermining eligibility for Medicaid for the first time since the pandemic, which may result in a large group of people losing coverage and a subset of those people obtaining coverage through the health insurance exchange or other sources. ConnectiCare, without explanation, includes a factor of 1.006 for “adjustment to baseline morbidity (Medicaid Redetermination)” – assuming that Medicaid unwinding will result in sicker insureds entering ConnectiCare’s risk pool. Notably, ConnectiCare’s assumption is at odds with Anthem’s individual market filing which uses a 1.000 morbidity factor and thus has concluded that the addition of former Medicaid recipients to its insureds will not increase morbidity in its risk pool.

Finally, ConnectiCare increases its rate by an additional .8 percent, a provision for adverse events due to historic “changes in the marketplace” that have increased costs and that it anticipates will increase costs in the future. However, ConnectiCare does not provide any detail or rationale as to what specific changes it anticipates, nor does it cite any changes in the marketplace that result in a decrease in rates. Rather than allowing carriers to include a provision for unnamed adverse events that may become self-fulfilling prophecies, we would encourage the Department to approve rates that reflect an expectation that carriers will negotiate aggressively to reduce costs.

### **Double Counting?**

I am concerned that the overlap between trend and other cost factors such as morbidity, age and gender present the potential for double counting. Because trend is a projection on all increases in utilization, which at least partially includes utilization changes connected with increased morbidity, age factors, and gender factors, the plans should bear the burden of explaining their projections and why they are not subject to overlap with trend.

### **Pandemic Distortions**

All of these plans use experience data from the pandemic era which significantly skews any trend projections either because they utilize 2020 base year experience, which reflected substantially below normal utilization, and/or they use as the end point the immediate subsequent years which experienced higher utilization due to pent up demand. At this point, since the pandemic restrictions have been lifted and the states of emergency lapsed, those experience foundations for trend projections require a level of adjustment or normalization to fairly reflect what unit costs and utilization rates are likely to be in 2024.

I would also urge that the Department take a close look at the level of funds insurers hold in reserve and charge to insureds. We have long been told that reserves are necessary to guard against unforeseen and catastrophic events. Certainly the Covid-19 pandemic and related public health emergencies would qualify as catastrophic events. Health insurers, however, were not adversely affected by the pandemic. To the contrary, not only did COVID cause their costs to decrease, but the federal government provided robust subsidies for Covid-19 testing, treatment and other healthcare services, thus enabling health insurers to increase their surpluses during the pandemic.

### **Administrative Expenses**

As carriers gain more experience administering Affordable Care Act business, one would reasonably expect administrative expenses to be decreasing. That is not the case. Insurers have failed to explain how their administrative costs continue to rise. ConnectiCare has especially high administrative costs—\$93.40 per member per month (PMPM). This is the highest PMPM administrative cost of any Connecticut carrier. Cigna and Anthem each have administrative costs exceeding \$50 PMPM-- \$84.79 PMPM for Cigna, \$54.68 for Anthem individual, and \$63.10 for Anthem's small group plan.

### **Conclusion**

There appears to be a widespread lack of specific justifications for conclusions stated in actuarial memoranda in each of the filings. The carriers make sweeping statements about their

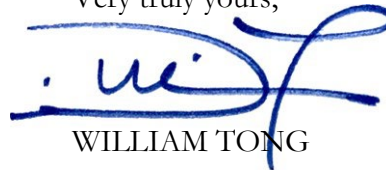
Andrew N. Mais, Commissioner  
August 15, 2023  
Page | 6

annual trend but do not provide the data to justify their assumptions. The Insurance Department can and must thoroughly scrutinize these applications and be a voice for consumers in a system that is making health insurance less accessible every year— as profit and executive compensation continues to rise and companies lobby hard to protect the status quo.

The Office of the Attorney General is exploring potential legislative reforms that would impose heightened scrutiny to any insurer applying trend data in excess of industry accepted or government-developed benchmarks. We look forward to working with the Connecticut Insurance Department and other stakeholders to ensure the highest level of transparency and professionalism in the applications you receive and evaluate each year.

I have set forth these specific questions, concerns and more with each filing in the attached four appendices. I ask that the Insurance Department use the full weight of its authority to demand better of these companies on behalf of Connecticut individuals, families and businesses.

Very truly yours,



WILLIAM TONG

*Appendix A*

**ConnectiCare (Individual)**

1. Why is ConnectiCare's trend is the highest of any of the carriers in the 2024 rate filings?
2. Why has ConnectiCare placed a reduction factor of 2.8 percent for COVID impact on baseline in 2022, and effectively negated that reduction by adding a 2.1 percent increase in 2024 for COVID impact?
3. Why does ConnectiCare's trend rate exceed the Milliman Medical Index ("MMI") rate by 5.56 percent (11.2 ConnectiCare versus 5.64 MMI)?
4. Please provide explanation and evidence for the projection of an increased morbidity due to Medicaid unwinding.
5. Why should ConnectiCare's Medicaid unwinding adjustment be higher than Anthem's?
6. Please explain ConnectiCare's projections for increased cost due to mandated breast and ovarian cancer screenings and mandated mental health examinations. Isn't it true that such screenings are often mandated as preventive services to reduce the need for expensive medical care through early discovery of conditions?
7. Why does ConnectiCare need a 0.8 percent adjustment for "provisions for adverse events" in addition to its trend projections? Isn't such a generalized adjustment purely speculative?
8. Why are ConnectiCare's PMPM administrative costs of \$93.40 so much higher than its competitors?

## *Appendix B*

### **Anthem (Small Group)**

1. Why does Anthem use 2020 as its base experience year without adjustment or acknowledgement that 2020 experienced extraordinarily low utilization due to pandemic shutdowns?
  - a. Doesn't the use of unmodified 2020 base experience and the high pent up demand years of 2021 and 2022 create a distorted delta between the base and subsequent experience years and thus an artificially high trend?
2. Please specify the precise documents in the filing that support the 10 percent annual trend Anthem projects. (Anthem employs a circular reference in its actuarial memorandum and exhibit, with each referencing the other as justification of a conclusion. Its Actuarial Memorandum references and exhibit F as justification of its trend conclusion and exhibit F refers back to the Actuarial Memorandum for explanation.)
3. Isn't it true that Exhibit Q, which does provide some data relating to trend, demonstrates the distorted effect of using 2020 as an experience baseline and subsequent years with higher-than-normal utilization due to pent up demand? (It reports an increase between 2020 and 2021 for outpatient utilization of 30.6 percent.)
4. Why does Anthem's trend exceed the Milliman Medical Index ("MMI") rate by 4.4 percent (10% Anthem versus 5.6 percent MMI)?
5. Why does Anthem's trend exceed the trend for the Anthem-managed State Employee plan?
6. Please explain why the 1 percent morbidity factor as well as increases related to anticipated changes in age/gender are not already included in the general forecast of utilization trend.
7. What are the "other benefit expenses" delineated as a factor in Anthem's premium build up?
  - a. Please provide specific details about the provider settlements referenced as an element of "other benefit expenses." What is the impact of those settlements on the projected premium?
  - b. Are the settlements related to the Connecticut insurance market, and, if not, shouldn't they be paid from the parent company's funds rather than via a premium hike?
8. How does Anthem's \$63.10 PMPM administrative expense compare to administrative expenses from prior years?
  - a. What are the elemental components of that administrative cost?
  - b. Why are the \$63.10 PMPM administrative costs for Anthem's small group policies 8.42% higher than the \$54.68 PMPM administrative charge Anthem includes in its individual rate? Why doesn't small group have a lower per capita administrative cost?



9. How does the combined 6 percent profit percentage compare with margins from prior years and why is it higher than Anthem's competitors?
10. Isn't it true that the \$6,464,288 MLR rebate for the period ending December 31, 2022 suggests that Anthem's aggregate rates were too high in the years 2020, 2021 and 2022?
  - a. Have those excessive rates been offset in subsequent years or are they continuing to distort the base rate upon which the current rate increase is based?
11. Has Anthem considered using its capital surplus to lower rates in order to help consumers afford its products?

### *Appendix C*

#### **Anthem (Individual)**

1. Why does Anthem use 2020 as its base experience year without adjustment or acknowledgement that 2020 experienced extraordinarily low utilization due to pandemic shutdowns?
  - a. Doesn't the use of unmodified 2020 base experience and the high pent up demand years of 2021 and 2022 create a distorted delta between the base and subsequent experience years and thus an artificially high trend?
2. Why does Anthem's trend exceed the Milliman Medical Index ("MMI") rate by 3.9 percent (9.5 percent Anthem versus 5.6 MMI)?
3. Please explain why the 1 percent morbidity factor as well as increases related to anticipated changes in age/gender are not already included in the general forecast of utilization trend.
4. What are the "other benefit expenses" delineated as a factor in Anthem's premium build up?
  - a. Please provide specific details about the provider settlements referenced as an element of "other benefit expenses" and the impact of those settlements on the projected premium.
  - b. Are the settlements related to the Connecticut insurance market, and, if not, shouldn't they be paid from the parent company's funds rather than via a premium hike?
5. How was the risk adjustment payment for 2021 calculated and what is its impact on the current rate increase request?
6. How does Anthem's \$54.68 PMPM administrative expense compare to administrative expenses from prior years?
  - a. What are the elemental components of that administrative cost?
7. Has Anthem considered using its capital surplus to lower rates in order to help consumers afford its products?

### *Appendix D*

#### **Cigna (Small Group)**

1. Why are Cigna's trend projections inconsistent? In its Actuarial Memorandum it projects an all-in medical cost trend of 8.3 percent, but its appendix sets forth an annual trend of 7.4 percent.
2. Why are both the 8.3 percent and 7.4 percent trends higher than the Milliman Medical Index ("MMI") projected trend of 5.6 percent?
3. Why are the 1.8 percent morbidity adjustment and the 1.8 percent adjustment for aging not already included in the general forecast of utilization trend?
4. Please describe Cigna's "internal company affordability initiatives" and how Cigna has measured their cost effectiveness.
  - a. How did Cigna derive the 0.977 factor for these initiatives?
5. What are the large claims Cigna has referred to in its filing and why is it appropriate for them to have an impact on Cigna's rate base for this filing?
6. How did Cigna calculate its 11.9-million-dollar risk adjustment and what is its impact on the current rate request?
7. How does Cigna's \$84.79 PMPM administrative expense compare to administrative expenses from prior years?
  - a. What are the specific elemental components of that administrative cost?
8. Has Cigna considered using its capital surplus to lower rates in order to help consumers afford its products?
9. How does Covid 19 impact Cigna's trend?