Office of the Healthcare Advocate
STATE OF CONNECTICUT

August 2, 2016

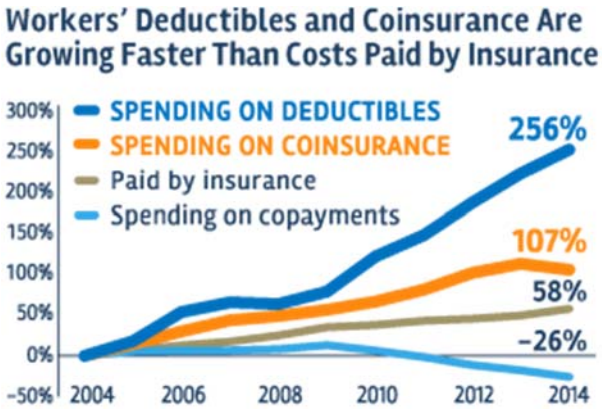
Mr. Lombardo,

I appreciate the opportunity to provide comments about the requested premium rate increases for the 2017 plans, and was pleased to see the depth and focus of the questions you posed to the insurers in the Correspondence posted on the Department's website. These concerns are echoed by many consumers and consumer advocates, myself included. As you know, the mission of the Office of the Healthcare Advocate (OHA) is to promote consumer rights and education, and to advocate for consumers engaged in Connecticut's healthcare system, with specific emphasis on their ability to effectively obtain and utilize health insurance coverage and services. Of particular relevance, OHA is mandated to "provide information… regarding problems and concerns of health insurance consumers and make recommendations for resolving those problems and concerns."[i]

Today, I am compelled to comment on the proposed premium rate increases before you, especially in light of the significant challenges that consumers in the state of Connecticut face as the cost of obtaining and using health insurance coverage continues to climb. The inherent complexities of our nation's healthcare system, and the impact of rising healthcare costs on premiums and consumer cost sharing, are well known, immutable factors in this calculation, and the inevitable role that these, and many other factors, play in insurer's development of plan designs and the associated premiums, cannot be understated. Also fundamental to this discussion is your mandate as you consider these rate filings to ensure that each insurer's plan and rate designs will not compromise the fiscal solvency of the organization.

However, fundamental to the promise of the ACA, and to the goal of improving overall member and population health through early intervention and prevention, is an analysis of consumers' ability to actually use the plans they purchase to achieve these goals. Merely having health insurance is not a guarantee that consumers will be able to use it as intended. Instead, the combination of high premiums and high member cost sharing serves to disincentivize consumer's effective utilization of the healthcare system, leading to persistent insurer estimates of elevated utilization costs, decreasing the likelihood of cost effective early intervention for highly manageable conditions and diseases, and increasing the risk of much higher cost, acute and crisis disease management.[ii] Indeed, trends shifting the cost of care to consumers have outpaced medical expenditures of insurers. A recent Kaiser Family Foundation analysis showed that between 2004 and 2014, consumer cost sharing

increased 77%, while insurers' payments for medical services only increased 58%.[iii] When we consider the specific impact of co-insurance and deductibles on consumers, the difference is even more stark.



I applaud the independent initiatives that insurers are taking to promote improved population health, and acknowledge the innovative pilot programs that have been developed. However, while these efforts hold promise for the future, they do very little to counter the increasing cost trends and drivers and the adverse impact on consumers in the short term. As integral partners in our system of healthcare, insurers can and should contribute towards the realization of the long term goals of the ACA by promoting effective consumer utilization of healthcare, and the increasing costs associated with utilizing health services may serve as a crucial barrier to this aim. Early identification and intervention has been repeatedly shown to increase treatment efficacy, decrease downstream costs and, most importantly, improve consumer outcomes and health.

Despite reports of the negative fiscal impact of the ACA, and all of the factors identified in the rate filings to justify the requested increases, health insurers generally have benefitted. Over the last five years, insurers' stock prices have increased, in some instances quite dramatically. Anthem experienced a 130% increase since 2011. Aetna's stock increased 628% since 2009 and Cigna, in that same timeframe, had a 1,113% increase in stock value.[iv] This is not demonstrative of an industry that is struggling to remain solvent.

What does present a challenge, not only to the insurance industry, but all participants in our healthcare system, is the rapidly increasing cost to consumers receiving care. Insurers base premiums and cost sharing on a myriad of factors, but utilization costs are chief among them. While the actual cost of services is one key element over which insurers have minimal influence, incentivizing consumers to access and use the healthcare system at the earliest possible stage can significantly reduce those utilization costs. However the increasing unaffordability of plans disincentivizes consumers from seeking healthcare services at this early, lower cost, stage. A Kaiser Family Foundation study last year found that 42% of consumers reported having a difficult time affording healthcare services, much higher than housing, utilities or food. [v] This barrier becomes even more significantly pronounced as income declines.

While I know that your analysis of each of the requested rate filings will be fair, thorough and impartial, I would like to take this opportunity to encourage you to exercise your authority to make a meaningful impact on Connecticut's healthcare system. As stated in the Department's FAQ on the

rate review process, you must assess whether the rates are excessive, inadequate, or unfairly discriminatory. Specifically, it states that excessive rates are those that are unreasonably high in relation to the benefits provided and the underlying risks. I would suggest that the consumers' ability to actually access the benefits is a fundamental element of consideration in this analysis, and that affordability, with premiums and cost sharing, hampers this access. More relevant, the underlying risk estimates assume unmet need, but the affordability issues discussed here perpetuate that need, creating a cycle of inadequate access, especially for those with lower income, and chilling the innovation that is so fundamental to reforming our system of healthcare delivery and payment. Accordingly, I respectfully request that you consider all of these elements as you evaluate these requested premiums, and limit the increases to promote greater affordability.

In addition to my general comments above, I have included specific comments and questions concerning each of the rate filings below. Thank you for your time and consideration as you undertake this important task.

Best regards,

Demian Fontanella
Acting Healthcare Advocate

[i] C.G.S. 38a-1041(a)(3)

[ii] Gould, E. (2013, May 8). Increased health care cost sharing works as intended: It burdens patients who need care the most. Retrieved July 26, 2016, from http://www.epi.org/publication/bp358-increased-health-care-cost-sharing-works/

[iii] Claxton, G., Levitt, L., & Long, M. (2016, April 12). Payments for cost sharing increasing rapidly over time. Retrieved July 27, 2016, from http://www.healthsystemtracker.org/insight/payments-for-cost-sharing-increasing-rapidly-over-time/

[iv] Potter, W. (2016, March 01). No. Obamacare isn't killing the insurance industry. Retrieved July 27, 2016, from https://www.healthinsurance.org/blog/2016/03/01/no-obamacare-isnt-killing-the-insurance-industry/

[v] DiJulio, B. (2015, October). Kaiser Health Tracking Poll: October 2015. Retrieved July 27, 2016, from http://kff.org/health-costs/poll-finding/kaiser-health-tracking-poll-october-2015/

Anthem

1) What differences in enrollment are anticipated between 2015 experience and 2017 projections? Worksheets indicate an 8% anticipated increase in total member months from experience to projected, with largest concentration in Silver Exchange plans. How are the following factors accounted for?
    a. HCT leaving the market and HUSKY A parents and caretakers are entering the market;
    b. Lack of broker commissions for marketplace plans;
2) Given the $13.4M 2015 risk adjustment payment due from Healthy CT (HCT), and the $50M owed to Anthem, it is reasonable to posit that the HCT members who will be purchasing QHPs from other insurers had lower utilization costs, and represent lower risk. How is this addressed in the filing?
3) How is the 2015 utilization, which is the basis for 2017 projections, impacted by the $50M risk adjustment payment owed to Anthem?
4) Discuss why increased utilization is expected to continue – also how is induced demand due to CSR not duplicative of this analysis? (Exhibit E)
5) Discuss the provider contracting changes and detail impacts (Section 3)
6) Discuss the benefit modifications required to comply with updated AV requirements (re: habilitative and rehabilitative visit limits) based on utilization and cost of services (Exhibit E)
7) Detail the impact of the reinsurance program termination.
8) How specifically is the metal tier distribution of plan enrollment estimated?
9) What additional administrative expenses are represented by vision and dental Specialty Expenses?
10) Discuss how the historical experience in loss ratios (Exhibit S) has impacted projections in utilization and costs, if at all, given:
    a. no ACA experience prior to 2014
    b. no non-ACA experience in 2015
    c. overall low loss ratios in 2014
11) What specific evidence has been provided to affirm compliance with the Mental Health and Addiction Equity Act (MHPAEA)? Please post detailed comparison documents showing how mental health and substance use benefits are substantially similar to medical/surgical benefits, which calculations were used to evaluate parity, and any discrepancies.
12) Detail any state mandated benefits, and demonstrate that the pmpm for any new mandates (for example, tomosynthesis) have not been incorporated into premiums.

Connecticare

1) Explain further the statement "historical utilization is understated because historical buy-downs drive-up member cost-share and reduce utilization". Also, explain the degree that the "understatement" of historical utilization has impacted the projected utilization for the 2017 period, particularly in light of the apparent minimal increase in utilization during the 2015 experience period (HC-81-15 Exhibit 2). Also detail why utilization projections should not be lower despite substantial 1Q16 increases in utilization in a few sub-categories;
2) Describe the plan benefit changes that are anticipated to yield a 7.3% decrease in premiums (Appendix A) – despite statement in Actuarial Memorandum of no material changes in benefits;
3) Explain the 20% decline in enrollment (member months) reported in the URRT in Section IV, and how are those differences affected by:
    a. HCT leaving the Exchange/market
    b. HUSKY A parents and caretakers are entering the market
4) What specific evidence has been provided to affirm compliance with the Mental Health and Addiction Equity Act (MHPAEA)? Please post detailed comparison documents showing how mental health and substance use benefits are substantially similar to medical/surgical benefits, which calculations were used to evaluate parity, and any discrepancies.
5) Detail any state mandated benefits, and demonstrate that the pmpm for any new mandates (for example, tomosynthesis) have not been incorporated into premiums.

Aetna

1) Explain the factual basis for the proposed Effective Date Factor increase based on later effective dates. Which experience data supports the underlying premise that utilization of these members will equate to that of members enrolled for the full plan year.
2) Discuss the benefit modifications required to comply with new mandates (re: infertility, based on utilization and cost of services (+ 0.1% each);
3) Detail any state mandated benefits, and demonstrate that the pmpm for any new mandates (for example, tomosynthesis) have not been incorporated into premiums;
4) Explain the premise that the -0.5% inpatient hospitalization utilization is unsustainable and provide justification for the +0.5% projection in utilization without reference to the national inpatient utilization trend approaching 2.0% – remaining cognizant of Aetna's statement in the filing that "unit cost and utilization trends should not be viewed in isolation nor should they be compared to other external data sources or views of market-based price and utilization changes."
5) Explain why Aetna expects to be at market average for purposes of 2017 risk adjustment, compared to significant receiver position in 2016;
6) Explain 6.73% increase in G&A (Operating Expenses) pmpm
7) Explain 3.52% increase in commissions pmpm
8) Explain 4.28% and 1.4% *increases* in state and federal taxes, assessments and fees pmpm
9) What differences in enrollment are anticipated b/w 2015 experience and 2017 projections. Worksheets indicate significant decrease in total membership from experience to projected.
10) What specific evidence has been provided to affirm compliance with the Mental Health and Addiction Equity Act (MHPAEA)? Please post detailed comparison documents showing how mental health and substance use benefits are substantially similar to medical/surgical benefits, which calculations were used to evaluate parity, and any discrepancies.