Attorney General William Tong

and

Healthcare Advocate Ted Doolittle

Comments Submitted to the Insurance Department regarding

Proposed Health Insurance Rate Filings for the 2022 Individual and Small Group Markets

Annual health insurance price increases can wreak havoc on family budgets, but to say that the current proposed increases come at a difficult time is truly an understatement. Many consumers are struggling with the impacts of COVID-19: they have lost jobs; they can't pay their rent and unemployment support is tapering. Small employers are likewise facing intense economic hardships as they struggle to regain a footing in the market. Meanwhile, carriers in comparable states such as Oregon are seeking 2022 rate increases under 2 percent, while small group plans in Rhode Island are seeking rate increases less than half those being sought here. It is for these reasons and others that it is extremely important for the Insurance Department to apply the highest level of scrutiny to the alleged drivers of proposed health insurance price increases and question their merit with a detailed review.

Health insurers have requested significant rate increases on and off exchange. The largest increases are focused on plans typically purchased by small employers with up to 50 employees—who are not required to offer insurance but do so because it attracts good workers and is the right thing to do. Among proposed rate increases in small group plans, all but one of the requests exceeds 10% and the highest request is a 15.8% increase by Oxford Health Insurance. These proposed increases follow a year during which many were surprised by the suppression of overall medical utilization due to COVID-19. Not only were elective outpatient procedures curtailed tremendously, but costly emergency department visits were significantly depressed, as were in-person office visits. Telehealth and behavioral health services picked up some of the slack, but did not offset the significant cost savings that were derived from the historic declines in overall utilization. The current rate increases for 2022 are based on rates from 2021 that do not fully account for the drop in healthcare spending in 2020. Although consumer rebates are anticipated pursuant to the Affordable Care Act, rebating for the COVID-19 period is unlikely to fully offset the large revenue gains enjoyed by the health plans. Consequently, we urge the Insurance Department to closely analyze historic medical loss ratio

data. In particular the Department must examine data from 2020, to ensure that the 2021 rates, upon which the proposed increases are built, are not overvalued themselves. If left unchecked, approving the proposed rates for 2022 will only compound the problem.

Many of the plans submitting requests this year specifically cite costs related to COVID-19 as a basis for increasing prices. These costs include federally mandated coverage for testing, vaccination and treatment. But because federal reimbursement was also available to health providers in some cases, the Department must apply strict scrutiny to these claims and require evidence to support them. The health plans have also advanced the assumption that the declines in utilization associated with patients delaying care and the temporary closure of medical services have resulted in pent-up demand now that the economy has reopened. However, the prevalence of the Delta variant and upticks in infection rates are a possible check against this outsized demand projection. Once again, these assumptions, normalizing modifiers, and experience demand a detailed review, and the burden must be on the insurers to provide evidence in support of their projections.

As they have in prior years, the petitioning health insurers have cited the increasing costs of medical services as another driver of rate increases. This is a continuing theme. It bears considering that health plans, which negotiate in-network rates with large health systems and directly set the terms of smaller provider contracts, are in the best position to drive down the cost of medical services. Nevertheless, these costs have continued to significantly exceed other inflationary markers in our economy and general wage increases. Regulators must apply scrutiny to the health plans' efforts to minimize these increases and find out why the plans' negotiation efforts are failing to stem the tide of runaway medical inflation.

Consumers – in the present case 222,700 employees of small businesses and individuals seeking to protect their families from high medical costs – rely almost exclusively on the Insurance Department's oversight of this ever-increasing portion of household budgets.

It is for these reasons that we ask the Insurance Department to ensure the following:

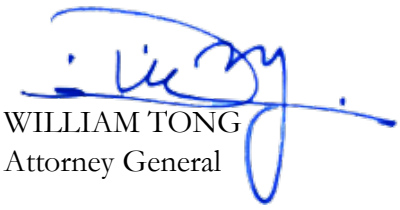
- All actuarial assumptions are supported by evidence;
- Sums withdrawn from the risk-based capital reserves of each of the relevant insurers, as reported to the Securities and Exchange Commission for 2020, were not excessive and that the uses of any such withdrawn funds be disclosed;
- All normalizing adjustments be fully justified in both a quantitative and qualitative sense; and
- Any risk adjustment assumptions be supported by specific evidence in the record.

While it is understandable that health plans and the actuaries who evaluate their filings might feel somewhat uncertain about the projections offered to predict future utilization rates and costs, the Department's authority to scrutinize rates makes it imperative every year that any increases reflect the lowest possible reasonable rates. However, this responsibility is especially grave during this time of pandemic. Families and small businesses are facing uneven prospects as they struggle to get back on their feet again.

We offer these general concerns and the attached specific queries regarding the Oxford small group and Anthem on and off exchange filings.

Thank you for considering the strong consumer imperative to curtail these unaffordable requests.

Very truly yours,



WILLIAM TONG
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Questions for Carriers

before the

Connecticut Department of Insurance

Informational Hearing *re*

Health Insurance Premium Rate Requests for 2022

August 31, 2021

General Questions for Carriers

1. Please discuss the implicit and explicit margin in all assumptions used to develop the rates. This should include examples of any assumptions that have implicit or explicit margin.

2. Provide the calculation of the projected 2022 risk adjustment receivable in Excel, with working formulas and justify any adjustments made to the 2020 risk adjustment receivable.

3. Please provide quantitative and qualitative support for the impact on the 2022 rates of the 2020 claims reimbursed by the high-cost risk pool as well as the cost of the program. Please describe if this process is different than prior years rate development.

4. Provide the actual and expected traditional loss ratios (incurred claims / earned premium) for each of the past 5 years. For the expected loss ratio, this should represent the filed loss ratio.

5. Provide actual to expected analysis for the historical trends for the Company and show how the data was normalized.

6. What is your company's position on appropriate levels of surplus to protect consumers? What is the company's position on levels of surplus in excess of appropriate levels? Should this surplus be given back to consumers since they are the ones that contributed to the surplus by paying premiums?
7. How was affordability taken into consideration in the premium development?
8. We can see how much our premiums are going up, but how much are our out-of-pocket costs going up? (Remember, under high deductible plans, most families have to pay all of their non-routine healthcare costs on their own before the insurance even kicks in.)
9. Currently families who join a plan mid-year typically have to pay the full annual deductible, no matter how high; if the annual deductible were pro-rated for mid-year joiners, would there be any discernible impact on premium? Likewise, would there be more than a negligible impact on premium if families switching mid-year from one high-deductible plan to another (like after changing jobs) were given credit by the new plan for deductible amounts paid under the old plan?
10. Why can companies like GoodRx often negotiate better prices than the insurance companies? What new tools or policies does the insurance industry need to match the negotiating success of GoodRx?
11. Which specific healthcare providers (hospitals, drug manufacturers, and other medical providers) are contributing the most to the requested increases?
12. Which services or drugs are contributing the most to each plan's requested premium increase?

Projected Claims Payments From All Sources

1. Premiums are only part of the costs that Connecticut consumers pay for health insurance. Insurance carriers also rely on their customers to pay increasing deductibles, co-pays, co-insurance and other patient responsibility whenever consumers seek to use their health insurance. For 2022 for each proposed plan, please provide projections related to these all-in consumer costs per member per month (pmpm) for each of your plans. If possible, identify any increases or decreases in actual or average dollar amounts as well as percentages. In other words, in addition to the percentage increase in the premiums to be charged to plan members, please provide a percentage increase in cost sharing and total

out-of-pocket costs projected to be absorbed by plan members, vs. the percentage of the increase to be borne by non-OOP costs, *i.e.* by carrier-paid claims. Additionally, please provide total out-of-pocket costs (premium plus patient responsibility) for each plan for individuals at the 25th, 50th, 75th and 90th percentile.

2. For each plan, what percentage of your members (please provide information separately by individual and family coverage, or self plus one if your plan has it) are anticipated to pay OOP costs of: a) $1000-$2499; b: $2500-$5000; c) more than $5000?

3. For each plan, what percentage of your members (both by individual, family, or self plus one) are anticipated to hit the deductible maximum and the OOP maximum?

4. For each plan for 2022, how much do you anticipate paying in total medical claims in 2021, and how much do you anticipate consumers will incur in OOP costs? Please provide the same information for 2021, actual plus anticipated.

5. Focusing on anticipated consumer OOP costs, for each plan please identify the top five providers by dollar amounts of OOP payments anticipated to be incurred, and please give the amounts anticipated to be paid OOP to each of the top five provider recipients. If possible, please give from last year the list of the top five provider recipients of OOP payments, and the amounts either anticipated or actually paid to each of these top five providers.

6. Provide data and analysis with respect to the impact on enrollment and utilization due to changes in IRS rules regarding the use of HRA funds to pay for marketplace and off-exchange premiums?

Cost containment

Medical Trend (*i.e.*, the predicted increase in the cost of medical care)

7. Please provide data and analysis addressing the impact on utilization rates and overall trend as a result of members declining recommended and/or medically necessary services to avoid high cost sharing obligations? Describe what steps your company has taken to ensure that high cost sharing obligations are not preventing members from utilizing necessary services.

8. What specific techniques do you use to control your medical trend, both overall and with your largest three providers by dollar volume? How do you measure the success or failure

of these techniques, and can you quantify your enterprise's successes or failures in medical cost control over the past five years with these providers?

9. What portion of your proposed medical trends are due to price increases for 2022 at the five largest (by claims amount allowed) in-network providers? Provide more details regarding network contract changes that are driving increases in unit costs and overall trend.

10. Does your enterprise track and reward success by identifiable teams or groups, and/or individuals within the enterprise, in cutting medical losses or moderating the rate of increase of medical losses? If so, how, and what financial results are you projecting for these efforts in 2022?

Program Integrity/Quality Improvement

11. How do you track the financial results of your program integrity and quality improvement efforts, and on an aggregated basis, how much do you project these efforts will contribute to keeping premium and all-in costs down for 2022, either in terms of actual recoveries, cost avoided, or both?

12. Regarding claims submitted to your plans, do you participate in the federal government's Healthcare Fraud Prevention Partnership administered by CMS's Center for Program Integrity? If so, please provide aggregated data on estimated amounts recovered or costs avoided for the past three most recently available years for your on-exchange plans. How about any other collaborative anti-fraud data sharing programs?

Administrative Expenses

13. What steps are you taking to lower administrative expenses?

14. Please describe your company's plans for providing premium relief to members as a result of lower medical losses due to from the COVID-19 pandemic

Cost Variation

15. Does your enterprise track cost outliers among your in-network providers? If so, please describe the techniques you use to identify cost outliers, what steps are taken when an outlier is identified, and any efforts to correlate cost outliers with quality or consumer outcomes and downstream/long-term cost avoidance (*e.g.*, provider with higher utilization of high cost procedures yields shorter recoveries, fewer follow ups and less need for medications).

16. Have you removed any provider from any of your networks primarily for reasons of cost and/or price over the past five years? If so, with reference to up to the five largest terminated providers (measured by the total cost of care paid by you and/or your members), please provide the total cost of care paid by you and/or your members to each such discontinued provider during each provider's last twelve months as an in-network provider.

Anthem Only

1. Please explain how the 7.7% utilization trend from 2019 to 2020 as shown in Exhibit Q of the Individual On/Off Exchange rate filing is consistent with the statement on page 5 of the Actuarial Memorandum for that rate filing that "Experience claims are adjusted for impact of COVID-19 due to lower levels of utilization related to the COVID-19 pandemic." Provide the quantitative impact on 2022 rates of removing this adjustment for "lower levels of utilization."

2. Please provide quantitative and qualitative support for the statement on page 5 of the Actuarial Memorandum for the Individual On/Off Exchange rate filing that "projected claims costs are adjusted to include the impact of COVID-19 including costs of vaccinations, testing, and treatment, and changes in practice patterns."

3. Please provide quantitative and qualitative support for the development of the costs estimates, found in the Individual On/Off Exchange rate filing, for Vaccines ($2.64), Testing ($0.80) and Treatment ($9.87). Further, describe whether these adjustments are the total for 2022 or in addition to the amounts included in the base period experience, trended forward.

4. Provide the complete development of the pricing trend, including all variables used to normalize historical benefit expenses in the Individual On/Off Exchange rate filing, in Excel with working formulas.

5. Please support the assumption that telemedicine utilization will not continue to increase into 2021 and 2022 as the access and awareness has increased along with the delta variant influencing consumer's behavior. This support should include a comparison of telemedicine utilization between 2020 and the first half of 2021.

6. Provide quantitative and qualitative support for the following assumptions in tab Q2 of the file Responses to CID IND Questions 07.26.2021:

a. Expected Uptake: Include comparison to the number of members that lapsed coverage from 2016 to 2019; and
b. Incoming RS Uninsureds to ACA: Include comparison to the RS of those members that lapsed coverage from 2016 to 2019.

7. Rx rebate adjustments – please provide additional information and data regarding existing rebate programs in order to support adjustment calculations

8. To what extent do you anticipate network tiering to impact the continued rapid growth of outpatient unit costs and overall trend reflected in Exhibit Q?

Oxford Only

1. Please remove the roundup formula in Exhibit 2 of the Small Group Off Exchange rate filing and use the resulting factor of 4.4% in the development of the rates.

2. Please provide a complete list of any other instances in the development of the rates found in the Small Group Off Exchange rate filing or other filings, where the company used the roundup formula.

3. Provide quantitative and qualitative support for the Covid Monthly Claims % Impact in Exhibit 7 of the Small Group Off Exchange rate filing.

4. Provide quantitative and qualitative support for the need to trend forward 25 months in Exhibit 2 of the Small Group Off Exchange rate filing.

5. Provide quantitative and qualitative support for trending to the midpoint of a quarter in Section 6 of the Actuarial Memorandum for the Small Group Off Exchange rate filing. Does the average group renew in the middle of a quarter?

6. Provide actual to expected analysis for the historical trends for the Company and show how the data was normalized.

7. Provide support for the Historic to Projected Adjustments in the trend analysis of the Small Group Off Exchange rate filing.

8. Provide support for the Projected Benefit Leveraging by Service Category in the Small Group Off Exchange rate filing.