OFFICE OF THE ATTORNEY GENERAL
CONNECTICUT

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By Email

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

Re: *2025 Health Insurance Rate Request Filings*

Dear Commissioner Mais:

I am writing to comment on the proposed 2025 rate increases submitted to the Connecticut Insurance Department by individual and small group insurers Anthem Blue Cross and Blue Shield, ConnectiCare and United/Oxford. These insurers are once again requesting rate increases that exceed other inflationary and general economic growth measures.

It is hard to comprehend why managed care companies fail to bring premiums and their underlying cost drivers in line with other products and services that consumers purchase. At the heart of these increases, as has been the case over the past decade, are unit cost and utilization trend. The former of these two measures, unit cost trend or the actual cost of covered care and services, has been widely recognized as the primary driver for premium increases in Connecticut and other states.

The unit cost driver is highly affected by the rates that these plans negotiate with hospital systems and other providers. Prior to the mid-1990s, Connecticut had in place a statutory formula for hospital charges that was repealed in large part because it was assumed that the burgeoning managed care industry would tenaciously negotiate rates that reflected a fair market price. Clearly that assumption has not borne out. Instead, we are informed each year of unit costs that far outstrip inflation as a forgone conclusion, without any explanation for why the costs cannot be curtailed through negotiation.

Unit Cost Trend

Insurers that manage care do so by controlling the two main components of trend. Much focus is brought to bear on the ways in which they control utilization. Unfortunately, it is often overlooked that when insurers go to the bargaining table with healthcare providers, they are acting on behalf of the individuals and employers who purchase insurance and are uniquely positioned to

leverage their marketshare to drive down costs. There are no other entities that are responsible for this critical role, not the Connecticut Insurance Department nor any other governmental agencies. In this role, insurers have consistently allowed increases in medical costs that far exceed other inflationary measures year over year. We as consumers have become resigned to the notion that medical cost inflation will always exceed these other inflationary measures. This is not a healthy outlook because these costs will ultimately prove to be unsustainable. Historically, insurers have cost-shifted these increases to consumers through direct rate increases and by offering higher deductible plans, instead of challenging the runaway unit cost problem directly through hard negotiations with providers. Thus, the overall cost of care continues to skyrocket. In the case of the individual and small group markets we are looking at here, individual consumers and small employers shoulder the burden of these ever-rising costs. It is long overdue for insurers to explain why they have been unable to rein in medical costs through their negotiations with medical providers, most importantly institutions which provide inpatient and outpatient hospital care.

Hospital Based Services

Over the last 10 years we have seen tremendous growth in the costs of inpatient and outpatient hospital care. During that time frame, hospitals have converted and built new so-called provider-based offices through which they charge separate professional and facility fees for typical office-based services. Insurers' solution to this problem has often been to treat these office-based services as outpatient services and thus shift the burden to consumers to pay high deductibles that would not typically be applicable to regular office services. This is a form over substance approach. It is unclear why insurers have not tried to push back against this practice. State lawmakers have attempted to curtail facility fees and make them more transparent. Nevertheless, insurers have neglected to negotiate single reasonable rates for these office-based services under circumstances where the health system is both the owner of the office and the employer of its professionals, which negates the need for separate fees.

Drug Costs

Health insurers often subcontract the role of managing and negotiating pharmacy costs to pharmacy benefit managers (PBMs). This subcontracting shifts responsibility to separate entities to shoulder these important roles. It is unclear whether health insurers have exercised meaningful oversight over PBM functions. It is noteworthy that the insurers who have filed rate increase requests generally have not disclosed the names of their PBMs or the types of auditing that they employed to ensure proper management of benefits and measures to negotiate lower costs of covered medications. In essence, through a process of subcontracting, health insurers are able to remove scrutiny by the Insurance Department of the policy's pharmacy benefit, a substantial component of the overall healthcare benefit. During last year's rate hearing insurers were asked whether they return pharmacy rebates directly to patients at the pharmacy. The answer to that

question was that pharmacy rebates are held by the insurer and used to offset premium increases. It remains unclear, because there is no transparency over the rebating process, how much, if any, of these rebates act as a credit against other claimed costs and trends in the construction of the overall rate. It is also unclear what portion of a pharmacy rebate is retained by the PBM. This needs to change through full disclosure in the rate filing of the terms of the PBM agreement and a detailed accounting of all rebates received by the PBM and insurer, as well as their application following receipt.

Double Counting

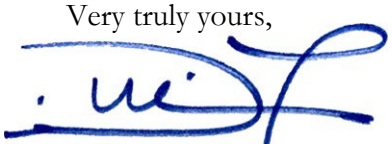
I remain concerned, as I expressed last year, that the overlap between trend and other cost factors such as morbidity and age and gender present the potential for double counting. Because trend is a projection on all increases in utilization, which at least partially includes utilization changes connected 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.

Conclusion

It is abundantly clear that insurers are perversely disincentivized from driving down unit costs through negotiation of lower rates. If the carriers in this regulated market can demonstrate trends and experience that justify higher expenditure, they benefit by receiving more renumeration for the identical profit margin each year. In other words, a hypothetical 4% profit margin slice of the entire premium pie is greater when premiums go up and the size of the entire pie increases. Thus, the system discourages insurers from expending the resources to scrutinize provider costs and negotiate favorable rates in order to drive down unit costs.

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. The lack of information about PBM arrangements makes these applications facially deficient. Moreover, the carriers make sweeping statements about their annual trend but do not provide the data to justify their assumptions. I encourage the Insurance Department to thoroughly scrutinize these applications and reduce any and all components of the requested increases that are not actuarily justified.

Very truly yours,



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APPENDIX A

Anthem – Individual on and off exchange

1. Anthem posts a 9.8% average annual trend but does not specifically state the component unit cost and utilization percentages that contribute to that average. Please state those component costs.

2. How much does Anthem or its PBM receive in drug rebates and how do rebates impact the premium?

3. Does Anthem apply all of its drug rebates to premium reduction?

4. Does Anthem use the state Cost Growth Benchmark in its contract negotiations with providers or in setting rates that are not subject to negotiation?

5. What efforts is Anthem making to drive down medical costs, especially in the high growth areas of inpatient and outpatient care?

6. Does Anthem's utilization trend projection overlap with age, gender and demographic adjustments, which presumably are cited for their impact on projected utilization?

7. What approaches has Anthem taken to challenge the expansion of office-based facility fees? Does Anthem typically pass on the additional facility costs to patients by characterizing the services as outpatient and applying high deductibles to claims?

8. What is the "NY HCRA" surcharge referenced in the actuarial memorandum and why would it affect rates in Connecticut?

9. Why has Anthem not provided a numeric projected MLR as have its competitors, instead stating the conclusion it is expected to meet or exceed minimum requirements?

10. How much greater is Anthems' capital surplus than state requirements and should it return some of that surplus to its Connecticut plans in order to lower premiums?

APPENDIX B

ConnectiCare – Individual On-Exchange

1. ConnectiCare posts a 10.3% average annual trend but does not specifically state the component unit cost and utilization percentages that contribute to that average. Please state those component costs.

2. ConnectiCare continues to adjust for Medicaid unwinding under the assumption that Medicaid members moving into the exchange market will raise costs. It is unclear why the unwinding which occurred in 2023 would continue to have an impact in 2025. Please explain the rationale behind the need to adjust for Medicaid unwinding in plan year 2025.

3. Does ConnectiCare use the state Cost Growth Benchmark in its contract negotiations with providers or in setting rates that are not subject to negotiation?

4. How much does ConnectiCare or its PBM receive in drug rebates and how do rebates impact the premium?

5. Does ConnectiCare apply all of its drug rebates to premium reduction?

6. ConnectiCare includes 2% premium increase for adverse events. These are unidentified future events speculated to have impact on expenditures. Please identify these anticipated adverse events and explain the reasoning behind the 2% increase.

7. What approaches has ConnectiCare taken to challenge the expansion of office-based facility fees? Does ConnectiCare typically pass on the additional facility costs to patients by characterizing the services as outpatient and applying high deductibles to claims?

8. Does ConnectiCare's utilization trend projection overlap with morbidity factors, demographic changes, and other adjustments, which presumably are cited for their impact on projected utilization?

9. What efforts is ConnectiCare making to drive down medical costs, especially in the high growth areas of inpatient and outpatient care? Last year we asked whether ConnectiCare does a line-item review of provider charges and negotiates based on each elemental component of the fee schedule. ConnectiCare responded that it does not. Why is line-item

review and negotiation not an appropriate method to ensure that specific items in the fee schedule bear a direct relationship to the actual cost of those items?

APPENDIX C

United/Oxford Small Group Off Exchange

1. United Oxford posts a 9.5% average annual trend but does not specifically state the component unit cost and utilization percentages that contribute to that average. Please state those component costs.

2. What approaches has United/Oxford taken to challenge the expansion of office-based facility fees. Does United/Oxford typically pass on the additional facility costs to patients by characterizing the services as outpatient and applying high deductibles to claims?

3. How much does United/Oxford or its PBM receive in drug rebates and how do rebates impact the premium?

4. Does United/Oxford apply all of its drug rebates to premium reduction?

5. Does United/Oxford use the state Cost Growth Benchmark in its contract negotiations with providers or in setting rates that are not subject to negotiation?

6. What efforts is United/Oxford making to drive down medical costs, especially in the high growth areas of inpatient and outpatient care? Does it negotiate with hospitals on a unit cost line-item basis? If not, why not?