|  |  |
| --- | --- |
|  | 3407 S. Jefferson  St. Louis, MO 63118  314.556.7379  cara@moconsumers.org  moconsumers.org |

September 25, 2017

**Comments on Individual Market (On-Exchange) Rate Filings of Healthy Alliance Life Insurance Company, HIOS Issuer ID #32753, Effective Date Jan. 1, 2018**

**I. Introduction**

Healthy Alliance Life Insurance Company (“HAL”) has made an application to the Missouri Department of Insurance to increase its rates on average by 41.7% for the 2018 year. At the individual plan level, rate increases will range from 29.7% to 46.7%. This change will have an effect on approximately 116,000 people in Missouri.

We urge the Department to exercise its authority under Mo. Rev. Stat. § 376.465.10(4) and deem HAL’s rates unreasonable absent further justification. HAL inappropriately redacted or entirely omitted several fundamental assumptions from its filing, thus impeding the public’s ability to provide meaningful comments and the Department’s ability to critically analyze the proposed rate increases. Moreover, HAL did not clearly explain how the assumptions it made regarding the elements of the rate filing will result in a 41.7% average increase. We are particularly concerned that HAL’s proposed rate increases fail to account for certain regulatory changes set forth in the revised Market Stabilization Rule that Anthem (under whose trade name HAL operates) and other issuers projected would reduce costs in 2018.

**II. Principal Reasons for the Rate Increase**

In Parts II and III of its rate filing—the Written Description Justifying the Rate Increase and the Actuarial Memorandum, respectively—HAL identified a number of factors behind its proposed rate increase. Despite highlighting the importance of these factors, HAL’s explanations of why they contribute to a 41.7% average rate increase are lacking.

1. Medical Trend

In its Written Description, HAL stated that the key driver of its rate increase was the increase in the cost of benefits for its insurance product­—specifically, increased prices in hospitals, physicians, and pharmacies—and an increase in utilization. This description is unhelpful for at least three reasons. First, it merely states the obvious: that overall trend consists of unit cost trend plus utilization trend. Second, the description neither explains nor discloses any of the underlying data on which HAL has calculated trend. Third, it implies that HAL is a passive price-taker, powerless to use its bargaining power with providers to drive down the prices it pays them. Although HAL wrote that it is committed to working to explore and apply new ways to reduce costs, the filing does not elaborate on if/how these efforts are effective and the extent to which they are reflected in its rate calculation

In fact, we learn from the Actuarial Memorandum that HAL is assuming a trend of 13.3%. That is over three times higher than the 4.3% countrywide trend Milliman calculated for 2017 in its Milliman Medical Index.[[1]](#footnote-1) This is the lowest trend has been in the 16 years Milliman has been publishing its Index, reflecting a long-term decline in medical trend from roughly 10% in the early 2000s to less than 5% today.[[2]](#footnote-2) In comparison, HAL’s 13.3% trend assumption appears to be unrealistically high. Of course there will be market-specific differences that HAL presumably took into account in calculating trend, but HAL should update its filing to elaborate on what those differences are so that consumers and officials can better understand the company’s trend calculations and their impact on its overall rate increases for 2018.

1. Changes in Morbidity

In its Actuarial Memorandum, HAL stated that it expects that “market deterioration will accelerate in 2018 due to increased selective entry and exit as members make health care decisions in the guaranteed issue, community rated ACA marketplace.”[[3]](#footnote-3) HAL offered no support for this claim, however. Most glaringly, HAL failed to address the impact of a number of recent regulatory changes, many of which were adopted for purposes of improving the health and stability of the individual market risk pool at the behest of the insurance industry. We discuss these changes in further detail below. In light of their absence from HAL’s Actuarial Memorandum, we encourage the Department to look critically upon HAL’s unsupported assumption that average market-wide morbidity will increase from 2017 to 2018 and to demand further explanation.

1. Funding of Cost-Sharing Reduction Subsidies

HAL stated that their calculations are based on the assumption that it will not receive cost-sharing reductions in 2018. Certainly there is lots of uncertainty in this area, but HAL has provided no information to show how or to what extent this assumption has affected their price calculations. Moreover, even though HAL has claimed that it assumed that no cost-sharing reduction payments will be made to issuers in 2018, it has redacted the relevant information from Exhibit C and F, under Part III of the Actuarial Memorandum. The Department must demand a fuller and more transparent explanation of these changes.

**III. Market Stabilization Rule**

The U.S. Department of Health and Human Services (HHS) proposed the Market Stabilization Rule in an effort to “improve the risk pool and promote stability in the individual insurance market.[[4]](#footnote-4) The rule made changes to a number of requirements, including Guaranteed Availability of Coverage, Open Enrollment Periods, Special Enrollment Periods, Levels of Coverage, Network Adequacy, and Essential Community Providers. HAL has reflected only two of these changes within Part III of its Actuarial Memorandum. Its failure to address the remainder casts doubt on the validity of their morbidity assumptions.

1. Guaranteed Availability of Coverage (45 C.F.R. § 147.104)

Guaranteed availability of coverage requires each health insurance issuer that offers coverage in the individual or group market in a state to accept every individual and employer that applies for coverage.[[5]](#footnote-5) Previously, HHS interpreted this requirement to prohibit issuers from applying new enrollment premiums towards past-due premiums owed from previous coverage unless an individual sought to renew prior coverage with the same issuer in the same product. It also prohibited issuers from refusing to effectuate coverage based on the enrollee’s previous history of failing to pay their coverage premiums.[[6]](#footnote-6) Issuers objected to this interpretation, however, citing unfair gaming and adverse selection by consumers. They contended that individuals were purposefully declining to make premium payments near the end of a benefit year knowing they could sign up for new coverage during the next open enrollment period.[[7]](#footnote-7) HHS directly addressed these concerns in the Market Stabilization Rule, providing a new interpretation of guaranteed availability of coverage. Under this new interpretation, before effectuating new coverage issuers are allowed to attribute premiums paid for new coverage towards past-due premiums owed to them for coverage from the prior year from the same issuer.[[8]](#footnote-8) In support of this change, HHS cited a study showing that 21% of consumers enrolled in individual market plans stopped making their premium payments in 2015; 87% of these consumers then repurchased plans in 2016, with nearly half repurchasing the same plan in which they were previously enrolled.[[9]](#footnote-9)

Issuers, including Anthem and others seeking to participate in the Missouri individual and/or small group market in 2018, supported this reinterpretation in comments to HHS.[[10]](#footnote-10) Indeed, Anthem specifically observed that the stricter rules around eligibility for consumers who haven’t paid premiums “will help mitigate potential misuse and ‘gaming’ of the [system].”[[11]](#footnote-11) Cigna more broadly acknowledged that HHS’s proposed rule would “increas[e] the incentives for individuals to maintain enrollment in health coverage and decreas[e] incentives for individuals to enroll only after they require medical services.”[[12]](#footnote-12)

By the insurance industry’s own logic, HHS’s new interpretation should encourage individuals to maintain more continuous coverage and thus improve the 2018 risk pool. This, in turn, should put downward pressure on rates. This shared opinion should be reflected in HAL’s 2018 rate justifications. Instead, however, HAL baldly stated in its rate filing that more people will selectively lapse their coverage in 2018 than any year prior, resulting in “growing market volatility” and “deterioration.”[[13]](#footnote-13) This unsubstantiated claim must be heavily scrutinized in light of HHS’s reinterpretation of the Guaranteed Availability of Coverage requirements, among other changes announced in the Market Stabilization Rule we discuss below. Furthermore, HAL “assume[d] that all members who lapse coverage will change carriers and Anthem will not receive payment for the missing month of premium.”[[14]](#footnote-14) This assumption appears overly conservative in light of the statistics HHS cited in the Market Stabilization Rule and HAL provided no support or justification for how it reached this conclusion. Absent further clarification from HAL regarding if and how it took the new interpretation into account, the Department should deem HAL’s proposed rate increases unjustified and thus unreasonable.

1. Open Enrollment Periods (45 C.F.R. § 155.410)

HHS has shortened the open enrollment period for the 2018 plan year from 90 days to 45 days, with the new open enrollment period beginning on November 1, 2017 and ending on December 15, 2017.[[15]](#footnote-15) HHS adopted this change to improve the morbidity of the risk pool, “by reducing opportunities for adverse selection by those who learn they will need medical services in late December and January[] and [by] encourag[ing] healthier individuals who might have previously enrolled in partial year coverage after December 15th to instead enroll in coverage for the full year.”[[16]](#footnote-16)

Issuers applauded this change.[[17]](#footnote-17) In its comments on the proposed rule, Anthem stated that it believed a shorter enrollment period “will improve the risk pool.”[[18]](#footnote-18) Centene agreed that the change “will promote a stable risk pool.”[[19]](#footnote-19) Cigna elaborated that, “[s]hortening open enrollment to end on December 15th ensures everyone’s coverage is effective the first day of the plan year which complements the underlying goal of full year continuous coverage and risk pool stability.”[[20]](#footnote-20) The BlueCross BlueShield Association likewise stated that shortening the open enrollment period was “critical” “to encourage that consumers maintain coverage for a full year.”[[21]](#footnote-21)

Despite this consensus view among issuers, it is not apparent that HAL took this change into consideration in its proposed rate increase. While it may have been one of the assumptions HAL has relied on when formulating its Morbidity Factor, it never stated as much in its Actuarial Memorandum. And because HAL completely redacted its morbidity calculation, it is impossible to ascertain whether the shortened enrollment period was considered. Absent further clarification from HAL regarding if and how it took this change into account, the Department should deem HAL’s proposed rate increases unjustified and thus unreasonable.

1. Special Enrollment Periods (45 C.F.R. § 155.420)

Special enrollment periods ensure that people who lose health insurance during the year—due to the non-voluntary loss of minimum essential coverage provided through an employer or other qualifying events such as marriage or birth or adoption of a child—have the opportunity to enroll in new coverage or make changes to their existing coverage.[[22]](#footnote-22) Issuers have raised concerns, however, that allowing previously uninsured individuals to enroll in coverage via a special enrollment period can increase the risk of adverse selection, negatively impact the risk pool, and contribute to market instability by leading issuers to leave the market.[[23]](#footnote-23) Issuers have also specifically criticized HHS’s decision to allow consumers to self-attest to their eligibility for most special enrollment periods, with trade groups arguing that “without verification, a significant number of people will only purchase coverage when they need it, driving up cost for everyone.”[[24]](#footnote-24)

In response to these concerns, HHS amended the regulations governing special enrollment periods in the Market Stabilization Rule.[[25]](#footnote-25) Effective June 2017, any individual attempting to enroll using a special enrollment period must undergo pre-enrollment verification of their eligibility.[[26]](#footnote-26) In addition, HHS limited the extent to which individuals can obtain more comprehensive coverage during a special enrollment period[[27]](#footnote-27) and allowed insurers to reject applicants who lost minimum essential coverage because they failed to make premium payments unless the applicants also pay the past-due premiums.[[28]](#footnote-28) HHS also adopted a number of other new restrictions.[[29]](#footnote-29) HHS’s Office of the Actuary estimated that these changes would reduce premiums by 1.5%.[[30]](#footnote-30)

Unsurprisingly, issuers strongly supported the new restrictions on special enrollment periods.[[31]](#footnote-31) In encouraging HHS to adopt these changes, Anthem expressed its concern “that the ability to utilize SEPs inappropriately [] is driving up premiums and placing the market on an unsustainable path.”[[32]](#footnote-32) Similarly, Cigna noted that the changes “will aid in improving the risk pool and market stability and encourage continuous coverage.”[[33]](#footnote-33) It later reiterated that “[t]he goal of verifying the eligibility for a special enrollment period is based on preventing adverse selection.”[[34]](#footnote-34) The BlueCross BlueShield Association likewise pointed to the higher claims costs of consumers who rely on special enrollment periods in voicing support for the changes.[[35]](#footnote-35)

Although these changes were highly supported by Anthem and others, HAL did not specify whether it considered these changes in calculating its rates for 2018. Because the restrictions on special enrollment periods will make it far more difficult for individuals to game the system by waiting until they get sick to purchase coverage, rather than during open enrollment, HAL’s claim that the market will be more volatile due to individuals selectively lapsing cover in 2018 warrants skepticism. Absent further clarification from HAL reconciling its unsupported assumptions with these established changes, the Department should deem HAL’s proposed rate increases unjustified and thus unreasonable.

1. Levels of Coverage (Actuarial Value) (45 C.F.R. § 156.140(c))

Under the Affordable Care Act, issuers of non-grandfathered individual and small group health insurance plans must ensure that the plans adhere to certain levels of coverage, defined by the plan’s actuarial value.[[36]](#footnote-36) A bronze plan is required to have an actuarial value of 60%, a silver plan is to have an actuarial value of 70%, a gold plan is to have an actuarial value of 80%, and a platinum plan is to have an actuarial value of 90%.[[37]](#footnote-37) To ensure that issuers meet these benchmarks, HHS created an actuarial value calculator that estimates a plan’s average spending by a wide range of consumers in a standard population.[[38]](#footnote-38) Because the calculator’s results are necessarily approximations, HHS has allowed *de minimis* variation of +/ – 2 percentage points in the actuarial valuations used to determine a plan’s level of coverage.[[39]](#footnote-39) Under the Market Stabilization Rule, HHS adopted a new *de minimis* range of – 4/+2 for the 2018 plan year.[[40]](#footnote-40) Thus, for example, a silver plan could have an actuarial value anywhere between 66 and 72%. According to HHS, this expanded *de minimis* range will allow flexibility for issuers that will improve the health and competitiveness of the market.[[41]](#footnote-41)

Not unexpectedly, issuers supported the expanded *de minimis* range.[[42]](#footnote-42) According to Anthem, “the ability to offer a range of [plan] designs that appeal to consumers with different demographic profiles and health care needs is particularly important in the individual market,” and the “additional allowed [actuarial value] variation could protect or increase enrollment by making certain attractive plan designs more accessible to consumers.”[[43]](#footnote-43) Centene added that “[t]he flexibility allowed by creating greater variance within a metal tier will help issuers maintain their current plans year over year, while minimizing disruption by avoiding discontinuance notifications.”[[44]](#footnote-44)

HAL has utilized this change to add an additional silver plan this year, keeping all other plans at their prior actuarial value. Although it is commendable to at least add one plan, HAL has not provided details on how this adjustment will affect the overall cost of the plan. Furthermore, HAL could have taken further advantage of this rule change to implement plans at other metal levels with an adjusted actuarial value to create savings across the board.

**IV. Conclusion**

HAL has not adequately explained in its Actuarial Memorandum why a 41.7% average rate increase is justified. The Department should insist that HAL elaborate on the assumptions it made, without unnecessary redactions, and account for the impact of the various changes in the Market Stabilization Rule that should put a downward pressure on rates. If HAL is unable to adequately respond to these concerns, the Department should deem HAL’s proposed rate increase unreasonable.

1. Chris Girod et al., *2017 Milliman Medical Index*, Milliman Research Report 3 (May 2017), http://www.milliman.com/uploadedFiles/insight/Periodicals/mmi/2017-milliman-medical-index.pdf. [↑](#footnote-ref-1)
2. *Id*. at 4. [↑](#footnote-ref-2)
3. HAL, Actuarial Mem. 5 (2017). [↑](#footnote-ref-3)
4. Patient Protection and Affordable Care Act; Market Stabilization, 82 Fed. Reg. 10,980, 10,981 (proposed Feb. 17, 2017) (hereinafter “Market Stabilization Proposed Rule”). [↑](#footnote-ref-4)
5. 42 U.S.C. § 300gg-1(a). [↑](#footnote-ref-5)
6. Market Stabilization Proposed Rule, 82 Fed. Reg. at 10,983. [↑](#footnote-ref-6)
7. *Id*. (citing Patient Protection and Affordable Care Act; Health Insurance Market Rules; Rate Review, 78 Fed. Reg. 13,406, 13,416 (Feb. 27, 2013)). [↑](#footnote-ref-7)
8. Patient Protection and Affordable Care Act; Market Stabilization, 82 Fed. Reg. 18,346 18,377 (April 18, 2017) (hereinafter “Market Stabilization Final Rule”). [↑](#footnote-ref-8)
9. *Id.* (citing 2016 OEP; Reflection on enrollment, Center for U.S. Health System Reform, McKinsey & Company, May 2016, available at *http://healthcare.mckinsey.com/2016-oep-consumer-survey-findings*). [↑](#footnote-ref-9)
10. *See, e.g.*, Aetna, Comment Letter on Market Stabilization Proposed Rule 2, 7 (March 6, 2017), https://www.regulations.gov/document?D=CMS-2017-0021-1143; Anthem, Comment Letter on Market Stabilization Proposed Rule 9 (March 7, 2017), https://www.regulations.gov/document?D=CMS-2017-0021-3083; BlueCross Blue Shield Ass’n, Comment Letter on Market Stabilization Proposed Rule 1, 3 (March 7, 2017), https://www.regulations.gov/document?D=CMS-2017-0021-3144; Centene, Comment Letter on Market Stabilization Proposed Rule 1 (March 7, 2017), https://www.regulations.gov/document?D=CMS-2017-0021-1716; Cigna, Comment Letter on Market Stabilization Proposed Rule 3 (March 7, 2017), https://www.regulations.gov/document?D=CMS-2017-0021-3237. [↑](#footnote-ref-10)
11. Anthem, *supra* note 10 at 9. [↑](#footnote-ref-11)
12. Cigna, *supra* note 10 at 1. [↑](#footnote-ref-12)
13. HAL, Actuarial Mem. 5 (2017). [↑](#footnote-ref-13)
14. *Id.* at 6. [↑](#footnote-ref-14)
15. Market Stabilization Final Rule, 82 Fed. Reg. at 18,354. [↑](#footnote-ref-15)
16. *Id*. at 18,346. [↑](#footnote-ref-16)
17. *See* Aetna, *supra* note 10 at 1; Anthem, *supra* note 10 at 3; Blue Cross Blue Shield Ass’n, *supra* note 10 at 5; Centene, *supra* note 10 at 2; Cigna, *supra* note 10 at 2. [↑](#footnote-ref-17)
18. Anthem, *supra* note 10 at 3. [↑](#footnote-ref-18)
19. Centene, *supra* note 10 at 2. [↑](#footnote-ref-19)
20. Cigna, *supra* note 10 at 2. [↑](#footnote-ref-20)
21. BlueCross BlueShield, *supra* note 10 at 5. [↑](#footnote-ref-21)
22. *See* 45 C.F.R. § 155.420 (2017); Market Stabilization Final Rule, 82 Fed. Reg. at 18,355. [↑](#footnote-ref-22)
23. *See, e.g.*, Julie Appleby, *UnitedHealth Warns of Marketplace Exit*, Kaiser Health News (Nov. 20, 2015), <http://khn.org/news/unitedhealth-warns-of-marketplace-exit-start-of-a-trend-or-push-for-white-houseaction/>; Phil Galewitz, *UnitedHealthcare to Exit All but “Handful” of Obamacare Markets in 2017*, Kaiser Health News, April 19, 2016, http://khn.org/news/unitedhealthcare-to-exit-all-but-handful-of-obamacare-marketsin-2017/. [↑](#footnote-ref-23)
24. Matthew Eyles & Justine Handelman, *Appropriate Use of Special Enrollment Periods Is Key to Exchange Stability, Affordability for Consumers: Misused Special Enrollment Periods Impact All Consumers through Higher Cost* (February, 2016), https://www.ahip.org/wp-content/uploads/2016/03/AHIP-BCBSA-SEP-Analysis-Feb16.pdf. [↑](#footnote-ref-24)
25. Market Stabilization Final Rule, 82 Fed. Reg. at 18,346, 18,355-56. [↑](#footnote-ref-25)
26. *Id*. at 18,358. [↑](#footnote-ref-26)
27. *Id*. at 18,358-59. [↑](#footnote-ref-27)
28. *Id*. at 18,362-63. [↑](#footnote-ref-28)
29. *Id*. at 18,358-65. [↑](#footnote-ref-29)
30. *Id.* at 18,378. [↑](#footnote-ref-30)
31. Aetna, *supra* note 10 at 1, 5; Anthem, *supra* note 10 at 2, 4; BlueCross Blue Shield, *supra* note 10 at 1-3; Centene, *supra* note 10 at 3; Cigna, *supra* note 10 at 2-3. [↑](#footnote-ref-31)
32. Anthem, *supra* note 10 at 2 [↑](#footnote-ref-32)
33. *Id.* at 2. [↑](#footnote-ref-33)
34. *Id.* at 3. [↑](#footnote-ref-34)
35. BlueCross Blue Shield, *supra* note 10 at 1-3. [↑](#footnote-ref-35)
36. 42 U.S.C. § 18022(d). [↑](#footnote-ref-36)
37. *Id.* [↑](#footnote-ref-37)
38. Market Stabilization Proposed Rule, 82 Fed. Reg. at 10,989. [↑](#footnote-ref-38)
39. *Id.* [↑](#footnote-ref-39)
40. Market Stabilization Final Rule, 82 Fed. Reg. at 18,369-71; 45 C.F.R. § 156.140(c). [↑](#footnote-ref-40)
41. Market Stabilization Final Rule, 82 Fed. Reg. at 18,369. [↑](#footnote-ref-41)
42. Aetna, *supra* note 10 at 1, 6; Anthem, *supra* note 10 at 10, 4; BlueCross Blue Shield, *supra* note 10 at 3; Centene, *supra* note 10 at 3-4; Cigna, *supra* note 10 at 3. [↑](#footnote-ref-42)
43. Anthem, *supra* note 10 at 11. [↑](#footnote-ref-43)
44. Centene, *supra* note 10 at 3. [↑](#footnote-ref-44)