MEHRI & SKALET PLLC

1250 CONNECTICUT AVENUE NW, SUITE 300 • WASHINGTON, DC 20036
TEL 202.822.5100 • FAX 202.822.4997 • WWW.FINDJUSTICE.COM

CYRUS MEHRI (DC, CT)
STEVEN A. SKALET (DC, MD)
JAY ANGOFF (DC, MO, NJ)
CRAIG L. BRISKIN (DC, NY, MA)
ELLEN EARDLEY (IL, DC)
RICHARD E. CONDIT (DC)
JOANNA WASIK (DC, NY)
CHRISTINE MONAHAN (DC)

OF COUNSEL
U.W. CLEMON (AL)
N. JEREMI DURU (DC, MD)
KARLA A. GILBRIDE (DC, CA, NY)
MICHAEL D. LIEDER (DC)
BRETT WATSON (DC, MD)

January 4, 2018

Jacqueline K. Cunningham
Commissioner of Insurance
Bureau of Insurance
P.O. Box 1157
Richmond, Virginia 23218-1157

Dear Madame Commissioner:

I am writing on behalf of Charlottesville for Reasonable Health Insurance ("CRHI") regarding the rates Optima Health Plan has filed for the individual market for 2018. CRHI is a community group with approximately 700 members in the Charlottesville area who are severely impacted by these rates.

CRHI appreciates the Bureau's efforts to ensure that all Virginians have the opportunity to buy health insurance on the Exchange in 2018, and we congratulate the Bureau on the success of those efforts. We are also aware of the difficulties the current Administration in Washington has caused for both the Bureau and for carriers, and we appreciate Optima's participation in the Charlottesville market notwithstanding those difficulties. Nevertheless, we believe that both the average rate level increase Optima has filed for 2018--81.8%--and the rating area factor it has filed for the Charlottesville area--a 57.9% increase on top of that 81.8%--are excessive. This letter explains the bases for that belief.

I. Optima's 1.579 rating area factor rating area for the Charlottesville region is excessive

In Attachment A to its 2018 individual market rate filing, which was prepared by Margaret Chance, an actuary in Milliman's Chicago office, Optima sets forth the rating area factors it is using for individual business in the four rating areas in which it is participating, as well as an out-of-area factor. Those factors vary from 1.000 in Hampton Roads to 1.579 in Charlottesville. Optima provides no data supporting these different factors, nor does it provide a narrative explaining them.

Optima's failure to provide any support for its selected area factors is reason enough for the Bureau to reject factors exceeding 1.000. In addition, however, substantial empirical data demonstrate that Optima's assumed 1.579 rating area factor for Charlottesville is unreasonable. Specifically:

A. Optima has admitted that its 1.579 factor for Charlottesville is based at least in part on the morbidity of its Charlottesville insureds, which violates federal law

We acknowledge the difficulty of distinguishing between increased costs that result from aggressive provider practice patterns in a region, which insurers are permitted to include in their area factors, and increased costs that result from the health status of a carrier's insureds in a region, which insurers are not permitted to include in their area factors. Nevertheless, HHS's guidance on this point is unambiguous,[1] and Optima's failure to comply with it is equally unambiguous. Notably, Optima executives acknowledged when CFHI met with them on December 14 that Optima's Charlottesville factor was based on the health status of its Charlottesville insureds: its Incoming President stated that utilization includes both "the relative health of the population that's buying" and "the usage of that population that is occurring based on health status." Even construing that language in the light most favorable to Optima, that is an admission that its Charlottesville factor is based at least in part on the health status of its enrollees.

B. All other carriers proposed rating area factors of 1.07 or less for the Charlottesville area.

Specifically:

* Aetna uses 0.897 in its small group filing.

* Anthem uses 0.9323 in its small group filing.

* Healthkeepers uses 0.9638 in its individual filing, and 0.9450 in its small group filing.

* Piedmont uses 1.000 in its individual and small group filings.

* UnitedHealthcare of the Mid Atlantic uses 1.07 in its small group filing.

[1] HHS, 2018 Unified Rate Review Instructions at 11, https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/Unified-Rate-Review-URR-Reporting-Requirements-for-Single-Risk-Pool-Plans-OMB-0938-1141-Final-2018-URR-Instructions-Parts-I-II-and-III-.PDF ("Geographic factors should only reflect differences in the cost of delivery (which can include both unit cost and provider practice pattern differences). Geographic factors may not reflect differences in morbidity by region.")

* UnitedHealthcare of the River Valley uses 0.943 in its small group filing.[2]

Optima has failed to explain why its factor for Charlottesville departs so dramatically from those used by all other carriers.

C. Optima uses a 0.937 rating area factor for Charlottesville in its small group filing.

Using a different rating area factor for small group business than for individual business does not appear to be supported by Milliman's own Health Care Cost Guidelines which Optima reportedly relied on, since those guidelines provide data for Commercial Insurance as a whole. In addition, Optima has acknowledge that the amount it pays providers is the same for its individual market insureds and small group insureds, and it has not suggested that provider practice patterns differ depending on whether the patient has individual or small group insurance. D difference of 68.5% ([1.579-.937]/.937) between Optima's small group area factor for Charlottesville and its individual market area factor for Charlottesville therefore would seem to have no rational basis.

D. In its initial rate filing Optima used a 1.262 factor for Charlottesville.

The 1.579 Optima now seeks to justify means that, all else equal, it is now raising Charlottesville rates by more than double what it originally proposed to raise them by. Optima has provided neither data nor a narrative explanation supporting such an increase.

Notably, a differential of 1.579 is essentially unprecedented: fewer than 1% of the rating regions in the national HHS database exceed the lowest-rated region in the state to that extent. Moreover, Charlottesville has none of the characteristics of a region in which a credible case for a substantially higher-than-average area factor could even arguably be made. To the contrary, the presence of two hospitals within five miles of each other, and the ability of Charlottesville residents to access care in the Richmond area or even Northern Virginia if necessary, indicate that actual and potential competition should result in Charlottesville costs being near or even below average, assuming such competition is not artificially restrained. In short, there is no rational basis for Charlottesville, VA having the highest health insurance rates in the entire country, as Optima has assumed.

E. Optima's parent company's ownership of Martha Jefferson Hospital should enable it to drive down costs in Charlottesville

Optima has appropriately noted that it can keep costs down in the Hampton Roads market because it is owned by the Sentara hospital chain.[3] The same situation exists in the

[2] 2018 Premium Rate Presentations (July 25, 2017), http://www.scc.virginia.gov/boi/co/acafilinginfo/files/ratePres2018.pdf.

[3] *See* In re: Presentation of Premium Rates in Connection with Health Insurance Coverage Issued in the Individual and Small Group Markets, Transcript of Proceedings at 76 (July 25, 2017), http://www.scc.virginia.gov/boi/co/acafilinginfo/files/1750trans.pdf (hereinafter "Rate Presentations Transcript").

Charlottesville area: Martha Jefferson Hospital is owned by Sentara, and thus Optima should be able to obtain favorable terms from the Sentara network in Charlottesville just as it has obtained favorable terms from the Sentara network in Hampton Roads. In addition, as the only carrier on the Exchange Optima has at least some leverage not only with Martha Jefferson but with UVA hospital, since the only way either hospital can access Exchange insureds in the Charlottesville region is by dealing with Optima. One would therefore reasonably expect Optima to negotiate stringently with UVA hospital, and to play it off against its own Martha Jefferson Hospital, in an effort to obtain the most favorable rates for its insureds. Instead, however, the 1.579 area factor Optima is using for Charlottesville raises the possibility that Sentara/Optima is using its market power not to enable its insureds to benefit from lower provider rates, but rather to enable the Sentara provider network to maintain higher rates.

In addition, because of Optima's provider ownership we are concerned that it may be more interested in propping up provider rates in general than in driving them down: when we sought an explanation for its 1.579 Charlottesville factor Optima's Incoming President stated that "If we start hammering a partner in this market, it will hurt our ability to develop a deeper relationship." Such a statement does not indicate that Optima views the interests of its insureds as paramount. Further, it may well be inconsistent with the legal duties a non-profit insurer owes to its insureds.

F. Optima's response to the Bureau's December 22, 2017 letter asking it to justify its area factor for Charlottesville contains no such justification

On December 22, 2017, the Bureau sent a letter to Optima giving it the opportunity to justify what the Bureau called the "dramatic difference" between Optima's individual market rates in Charlottesville and both its small group rates in Charlottesville and its individual market rates in the rest of the state. The letter also pointed out that Optima's incoming CEO had been quoted in the C-VILLE Weekly as saying that "the morbidity of the people buying in this marketplace [i.e., Charlottesville] is higher than other parts of the state," and noted that HHS does not permit insurers to consider the morbidity of its insureds in an area in determining the rating factor for that area.

On December 27 Optima's Regulatory Compliance Manager responded to the Bureau with a half-page letter providing no substantive justification for its Charlottesville rates whatever. The letter also did not deny that Optima's incoming CEO had been quoted accurately.

Optima's failure to provide any justification for its 1.579 Charlottesville area factor when the Bureau specifically gave it the opportunity to provide such justification may be the best evidence that such justification does not exist.

II. Optima's average 81.8% rate level increase is excessive

Optima has filed for an average 81.8% rate level increase for all its insureds,[4] before the application of area rating factors. That 81.8% increase alone produces excessive rates because Optima's assumed statewide morbidity, trend, and profit are all unreasonably high.

A. Morbidity

Optima's rate filing for the individual market, which was prepared by Margaret Chance, an actuary in Milliman's Chicago office, includes a factor of 25% for "additional morbidity" in calculating the overall rate level.[5] It thus assumes that the health status of its insureds will be 25% worse than it was in 2016. The filing provides no numerical support for this assumption; it justifies this 25% factor, which has a huge impact on the rate, based only on what it says is "a growing uncertainty in the marketplace" and on "a review of published studies and preliminary 2018 rate filings across various markets."[6] The filing neither discloses nor describes any such studies nor explains how they support a 25% morbidity factor, nor does it disclose the rate filings it is relying on, what states they are from, or how they support a 25% morbidity factor. Moreover, notwithstanding any uncertainty in the marketplace, data from the just-concluded open enrollment period indicate that individual market enrollment for 2018 has been essentially the same as last year, and has been particularly robust in Virginia: of the 39 states using the federal Exchange, for 2018 Virginia has enrolled more people than all but five, including many with substantially larger populations than Virginia.[7]

If enrollment for 2018 had fallen dramatically then a significant factor for increased morbidity would at least arguably be defensible, since those who drop coverage are likely to be the healthiest individuals, for whom health insurance is less of a necessity than it is for people with health conditions. Enrollment has not fallen materially, however, so such a factor is not defensible. To be sure, Congress has eliminated the individual mandate penalty, but the elimination of the penalty, which became law on December 22, 2017, and is not effective until 2019, had no effect on 2018 enrollment. Further, the industry has generally argued that the penalty was too weak to have any meaningful effect.[8]

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[4] Part II Actuarial Memorandum, Optima Health Plan Individual Rate Filing Effective Jan. 1, 2018, at 2 (Sept. 15, 2018) (hereinafter "Optima Actuarial Memorandum").

[5] *Id*. at 6.

[6] *Id*.

[7] *See* "Hey Trump, repeal THIS: 11.6M QHPs confirmed, likely 12.0M when the dust settles," http://acasignups.net/17/12/28/multiple-updates-hey-trump-repeal-116m-qhps-confirmed-likely-120m-when-dust-settles; New York Times, "Obamacare Sign-ups at High Levels Despite Trump Saying It's 'Imploding'," https://www.nytimes.com/2017/12/21/us/politics/health-obama-care-affordable-care-act.html?_r=0 (Dec. 21, 2017).

[8] *See, e.g.*, Lewis Krauskopf, Healthcare Individual Mandate Too Weak to Matter, Aetna CEO Says, INS. J. (Jan. 19, 2012), https://www.insurancejournal.com/news/national/2012/01/19/231693.htm.

There is thus little reason to believe that morbidity will be substantially worse in 2018 than it was in 2016. Moreover, it can reasonably be argued that morbidity should improve in 2018. Not only are those with health conditions likely to have signed up for insurance when they first had the opportunity to do so, but they are likely to have gotten their high initial needs taken care of when they first enrolled. Thus, they are likely not to have as high costs in the future as they did when they first obtained coverage.[9]

In short, Optima has no demonstrated that a 25% morbidity factor is justified, and substantial evidence indicates that it is not justified.

B. Trend

The Optima rate filing assumes a trend factor of 8.1%. As with its morbidity assumption, Optima has failed to produce any evidence justifying such a trend, and substantial evidence--in this case including the generally accepted analyses of Milliman actuaries not retained by Optima--indicate that trend should be lower than 8.1%.

First, the Optima rate filing includes no claims experience to justify an 8.1% trend; it says only that it "was developed based on a combination of OHP small group experience, the Milliman HCGs, and general industry knowledge regarding recent trends in medical inflation."[10] The Bureau should not accept such a vague, unsupported explanation. Rather, it should require the actuary to set forth both Optima's actual small group experience and the specific Milliman HCG provisions she is relying on to project trend. It should also require her to explain what constitutes "general industry knowledge" regarding trend, and how she used such knowledge in calculating trend.

Second, the evidence that does exist indicates that an 8.1% trend is excessive. The best evidence may be Milliman's own Milliman Medical Index ("MMI"), which has been calculating the annual increase in healthcare costs for each of the last 15 years. According to the MMI, medical trend has been steadily decreasing, and hit new lows of 4.7% in 2016 and 4.3% in 2017.[11] The Milliman actuary preparing the Optima filing has submitted no data supporting her assumption that trend in Virginia is almost double the trend that Milliman itself has found to exist nationally.

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[9] *See* John Bertko, What to Expect for 2015 ACA Premiums: An Actuary Opens the Black Box, at 2 (NIHCM Foundation May 2014); *see also* UCLA Center for Health Policy Research, Increased Service Use Following Medicaid Expansion Is Mostly Temporary: Evidence from California's Low Income Health Program, at 3 (Oct. 2014) ("Pent-up demand for care appears to decline rapidly after the first year of enrollment and becomes comparable to the demand of those with previous comprehensive coverage.")

[10] Optima Actuarial Memorandum at 8.

[11] 2017 Milliman Medical Index, http://www.milliman.com/insight/Periodicals/mmi/2017-Milliman-Medical-Index/.

C. Profit

Optima has included an 8.0% underwriting profit factor in its rate filing.[12] That is unjustifiable for three reasons.

First, Optima assumed a profit factor of 5.5% in its 2017 rate filing. Its 2018 rate filing provides no explanation, and no numerical justification, for assuming a profit factor that is 45% higher ([8.0 - 5.5]/5.5 = .45) than it was the year before. Second, for its small group business Optima assumed a profit factor of 5.7%, and it has told the Bureau that it "made a business decision to reduce our profit margin by .7%" in the small group market.[13] By making a business decision to increase its projected profit on its individual market business while reducing its projected profit on its small group business, Optima is effectively requiring its individual policyholders to subsidize its small group policyholders. The Bureau may wish to consider whether such a strategy could reasonably be considered unfair discrimination.

Second, Optima seeks to justify its 8% profit assumption based on "anticipated uncertainty of the 2018 market."[14] However, Optima already used the "uncertainty" argument as its rationale for including a 25% morbidity factor; to also use it as the rationale for an additional profit factor constitutes double-counting. Moreover, as explained above, based on the latest data from the just-concluded open-enrollment period, uncertainty in the marketplace has not materially reduced enrollment in Virginia.

Finally, the 8% profit factor Optima assumes is particularly unjustified, and particularly troubling, because Optima is a non-profit carrier. Non-profit organizations have legal duties that for-profit corporations do not have. Accordingly, CareFirst, the non-profit Blue plan serving northern Virginia, has included a 1.3% profit factor in its rates.[15] That 1.3% is in line with the profit factors that non-profit carriers in other states include in their rate filings. In fact, in some cases non-profit carriers assume a negative profit factor, since they anticipate earning sufficient investment income on their premiums and surplus combined to at least break even.

In short, an 8% underwriting profit factor for any carrier is difficult to justify, and there is certainly no justification for a non-profit carrier like Optima including such a factor.

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[12] Optima Actuarial Memorandum at 13.

[13] *See* Rate Presentations Transcript at 79.

[14] *Id*.

[15] *See* Actuarial Memorandum for CareFirst Blue Choice, Inc., Rate Filing # 2212, available at https://filingaccess.serff.com/sfa/search/filingSummary.xhtml?filingId=131172296. CareFirst characterizes its profit factor as a "contribution to reserves."

III. Additional policy issues

A. The effect of Anthem's withdrawal on Optima

Optima assumes that Anthem's withdrawal from the market will cause the health status of its insureds to deteriorate. It is possible, however, that rather than causing Optima's average health status to deteriorate, the addition of both Anthem's members and individuals previously insured by other carriers could improve the overall health status of Optima's risk pool (although the more Optima seeks to increase its rates, as pointed out above, the more the average health status of Optima's insureds is likely to deteriorate, whether they were previously insured by Optima or Anthem or anyone else).

In addition, and perhaps more important, regardless of the health status of its insureds, the more insureds Optima has the more leverage it has with providers to negotiate lower rates. And for purposes of negotiating with providers, less favorable health status can actually be an advantage rather than a weakness: the worse the health status of the group, the more procedures providers will be able to perform on that group, and thus the greater the potential of those providers to profit.

B. The death spiral issue

A premium increase of the magnitude of that which Optima is seeking to implement for Charlottesville residents--as much as 300% for some CRHI members--is not only devastating to policyholders paying that increase but may ultimately not be in the best interests of Optima. That is because such an increase is likely to result in a death spiral. Relatively healthy people will conclude that they are better off not buying insurance at all, and thus the only people left in the pool will be the highest-cost people, which will cause the average costs in the pool to increase to an even greater extent, thus forcing rates up even more. Looked at most cynically, this is not necessarily a bad outcome for Optima in the short run, since most of those costs for most of its policyholders will continue to be subsidized by taxpayers: as Optima raises its rates the subsidy increases, and thus the more money Optima receives from taxpayers. There may come a point, however, when there are simply too few people in Optima's individual market pool to support the pool.

IV. Requested relief

We respectfully ask the Bureau for two types of relief. First, and of most immediate importance to CRHI, we ask that the Bureau issue an order in the nature of a preliminary injunction that provisionally reduces Optima's rates to the extent called for in this letter, or in the alternative to another level found reasonable by the Bureau.

Second, we ask that the Bureau hold a hearing on Optima's 2018 rates to permanently determine both a reasonable overall rate level and a reasonable area factor for the Charlottesville region. We ask that the Bureau hear testimony from both Optima executives and the actuary who prepared its rate filing as to the basis for each assumption in the rate filing, and that it

require the actuary to produce any data she relied on and calculations she made that support those assumptions. We also ask that the Bureau hear testimony regarding the payment rates Optima has contracted for with both Martha Jefferson and UVA hospitals. As discussed above, we find it particularly troubling that in an area with two hospitals which reasonably should be expected to compete on price for many services, Optima has filed rates 57% higher than its statewide average. We ask that after carefully considering all the evidence the Department order Optima to reduce its rates to the extent the Bureau finds reasonable, and that it refer any matters beyond its jurisdiction to the Attorney General.

We appreciate your consideration of our views, and we would be happy to provide further information at any time. In addition, because the manner in which this matter is resolved will determine whether or not many of our members will be able to buy health insurance for 2018, may we ask for your response to this letter by January 15th?

Thank you again for your consideration.

Sincerely,

/s/

Jay Angoff

JA:cm
cc:
Bob Grissom
David Shea
Dennis Matheis