General questions for all carriers:

Reasonableness of efforts to control medical trend

1. 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?

2. Medical loss estimates obviously bear directly on proposed premium rates. 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?

3. 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).

4. Have you removed any provider from any of your networks primarily for reasons of cost 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.

5. Regarding the medical trend rates embedded in your proposed rates and your efforts to control these medical trend rates, please describe how you work with providers to control these trends and achieve lower premiums and lower medical costs.

    a. For instance, when you negotiate network rates with the largest five in-network healthcare providers in the state (measured by dollars allowed by you, *i.e.*, dollars paid by you and your members for care), do you share with the providers projections of the impact negotiated in-network prices have on the premium rates you must charge consumers, employers and any other premium-paying entities? That is to say, do you use estimates of how proposed provider pricing impacts your medical trend projections during negotiations with large providers, and if so, how do you use these estimates?

b. Again with specific respect to your negotiations with the five largest healthcare providers, what use do you make of consumer cost metrics such as the total estimated cost of healthcare (premium plus all forms of patient responsibility)?

c. What portion of your proposed medical trends are due to price increases at the five largest in-network providers?

6. Does your enterprise engage in any medical cost control collaborative efforts with other health care payers, such as but not limited to CMS's Healthcare Fraud Prevention Partnership? If so, which efforts does your enterprise participate in, and how do you track any savings or costs avoided? If yes, please quantify results for the past five years.

7. What percentage of your total fully-insured revenue is invested in program integrity? Please quantify the trend in program integrity investment over the past five years. What is your enterprise's most recent return on investment for program integrity? Do you have a view on whether or not the ACA's medical loss ratio requirements changed your enterprise's level of program integrity investment, and if so, can this effect be quantified? For instance, can you quantify your enterprise's program integrity investment for each of the last two complete fiscal years before the medical loss ratio regulations took effect on January 1, 2011, compared to each of the first two complete fiscal years after the rules went into effect, and for your most recent fiscal year? (Should we address this under a separate heading for Reasonableness of Program Integrity Expenses? Since this falls under the administrative expense section of the rate build up, but impacts utilization, unit costs, etc., I could see it going either way)

8. When you estimate the annual medical trend rates for your self-funded customers, do you use the same medical trend numbers you use for calculating fully insured rates for comparable groups? If yes, please indicate, then skip the lettered subsections below and move to the next numbered question.

a. Please describe the differences in the medical trend metric(s) used on the self-funded vs. fully insured sides.

b. Please quantify the differences in the medical trend numbers you used for the two segments over the past five years.

c. If you have experienced any differences in the extent of reliance on HDHPs in the fully-insured vs. self-funded segments over the past five years, please quantify.

d. Regarding the five largest medical providers in the state by claim dollar volume allowed by you, do you have different price structures for your comparable self-funded vs. fully insured groups? If no, move on to subsection (e.) below. If yes,

taking into account the five largest claim types or CPT codes by allowed dollar volume for each of the five providers, is the allowed price for one segment (self-funded vs. fully insured) consistently below the other? If no, move on to subsection (e.) below. If yes, to what do you attribute this consistent price difference between demographically comparable self-funded and fully insured groups?

e. Measured by dollar value of total allowed claims, is the rate of investment in program integrity efforts different on the fully-insured side vs. the self-funded side? If so, please provide comparative information for the last five years, and explain why the levels of investment differ for the two segments.

f. Please quantify the recent trends over the past five years that your enterprise is seeing in the self-funded category vs. the fully-insured category in terms of gross and net revenues, lives covered, and any other pertinent metrics the enterprise uses to track the relative sizes of the two segments in Connecticut.

Reasonableness of premiums in relation to patient responsibility assumptions

1. If you have experienced over the past five years any increase in the marketplace penetration of high-deductible health plans (using the IRS definition of HDHP), please quantify. Does your enterprise have a policy or strategy of promoting or recommending the HDHP approach to your clients, and if so, is the ability to titrate your proposed premium rates by changing HDHP levels (or other patient responsibility) one of the advantages of this policy? Is your company's strategy or policy regarding HDHPs, or experience with market penetration rates, different on the self-funded vs. fully-insured side? If so, please describe.

2. Do you track for your own internal purposes the total estimated cost of healthcare (premiums from all sources plus all forms of patient responsibility) to your members? If so, please provide the trends you have seen over the past five years in total patient estimated cost of care, if possible providing the figures for the 25^{th} percentile, the median, the 75^{th} percentile, and the 95^{th} percentile, for families and individuals. Also if so, did you use these (or similar) total estimated cost of care metrics in determining your proposed rates for this year and over the past five years (and if yes please describe how you used such metrics)? Also if so, is there a difference in the total estimated cost of care in the self-funded vs. fully-insured segments over the past five years?

Anthem

1. Discuss whether and to what extent the shorter enrollment period for 2018, stricter application of special enrollments and any specific changes in individual mandate enforcement were factored into your calculation of accelerating lapse rates and/or selective market contraction.

2. Explain how elimination of CSR payments would be expected to impact the $11.45 PMPM CSR receivable projection in Exhibit F – e.g., is it dollar-for-dollar? Also, please provide details of your contingency plan if CSR payments end during the 2018 plan year. In doing so, please specifically address how consumers will be protected, including continuity of care planning.

3. To the extent not addressed in general questions above, what are you doing to put downward pressure on trend, including provider costs?

    a. How do you attempt to influence unit costs identified in Exhibit Q and how do you measure the success of those efforts to mitigate unreasonable trend increases?
    b. Quantify any impacts of value-based provider agreements.

4. Provide a breakdown by medical expense category of billings by in-network vs. out-of-network. Please use whatever medical expense categories (*e.g.*, medical, drug, *etc.*) that you commonly use for your own purposes.

5. Provide a further breakdown by category of the reductions to billings to arrive at allowed claims based on: (a) non-covered benefits, (b) provider discounts, (c) coordination of benefits and (d) any other category. For each category, provide a comparison with prior experience periods, and comment as to the reasonableness of any trends in reductions due to non-covered benefits, provider discounts, *etc.*

6. Provide a further breakdown by category of reductions to allowed claims to arrive at paid claims by: (a) deductible, (b) copayment, (c) coinsurance and (d) any other category. For each category, provide a comparison with prior experience periods and comment as to the reasonableness of any trends in reductions due to deductibles, coinsurance, *etc.*

7. On what do you base your assumption that Healthy CT will not pay a risk adjustment payment for 2016? How does that assumption factor into the risk adjustment calculation in Exhibit G?

8. To the extent not already addressed, provide measurements of impacts on claims incurred/allowed/paid, utilization, morbidity and trend relative to $6.50 PMPM QI

expenses in Exhibit H – *i.e.*, provide an analysis of the reasonableness and effectiveness of QI initiatives.

9. Explain the how structure of broker fees, including difference between on exchange and off exchange plans, may impact enrollment projections.

10. Discuss how the PMPM Exchange User Fee is affected by Anthem's inclusion of off-exchange and on-exchange rates as part of the same filing.

11. In further support of your utilization and trend forecasts, provide an analysis, with supporting data, as to how increases in patient responsibility impact utilization of various service. To the extent possible, address the following in your analysis:

    a. Identify rates of member utilization of services by acuity level (i.e., ED, Urgent Care, primary care, etc.) across metal tiers over the available experience periods

    b. Discuss any differences among metal tier levels as to rates of member utilization of services by acuity level. Specifically, identify any correlations between each metal tier level and higher or lower use of certain services or settings. For Silver metal level plans, also identify any correlations between CSR plans and non-CSR plans and higher or lower use of certain services or settings within CSR plans vs. non-CSR plans.

    c. Discuss any differences over time, within the same metal tier level, as to rates of member utilization of services by acuity level. Specifically, identify any correlations between changes in cost sharing within a particular metal tier level and higher or lower use of certain services or settings over time.

    d. For each year of experience, identify by metal tier level any under-utilization of services by (i) members with diagnoses of chronic conditions, (ii) members with diagnoses of serious conditions requiring long-term follow up or (iii) services not provided but for which prior authorization was obtained by the member/provider. For each category of under-utilization, provide analysis and supporting data regarding additional services/costs associated with a delay of care (i.e. waiting until the illness becomes too acute for routine management and going to the ED, or not beginning medication or other regimen for treatment).

ConnectiCare

1. Discuss whether and to what extent the shorter enrollment period for 2018 and/or stricter application of special enrollments were factored into your calculations regarding enrollments/projected member months/lapses.

2. Provide evidentiary support for your calculation that a 2.4% or $12.54 PMPM increase is needed due to an Individual Mandate Impact.

3. Explain how elimination of CSR payments would be expected to impact rates? Provide additional supporting details regarding the impact of CSR payments during the experience period. Also, please provide details of your contingency plan if CSR payments end during the 2018 plan year. In doing so, please specifically address how consumers will be protected, including continuity of care planning.

    e. To the extent not addressed in general questions above, what are you doing to put downward pressure on trend, including provider costs? Also, more specifically, how do you attempt to influence unit costs identified in Exhibit 2 and how do you measure the success of those efforts to mitigate unreasonable trend increases? Quantify any impacts of value-based provider agreements.

4. Provide a breakdown by medical expense category of billings by in-network vs. out-of-network. Please use whatever medical expense categories (*e.g.*, medical, drug, *etc.*) that you commonly use for your own purposes.

5. Provide a further breakdown by category of the reductions to billings to arrive at allowed claims based on: (a) non-covered benefits, (b) provider discounts, (c) coordination of benefits and (d) any other category. For each category, provide a comparison with prior experience periods and comment as to the reasonableness of any trends in reductions due to non-covered benefits, provider discounts, *etc.*

6. Provide a further breakdown by category of reductions to allowed claims to arrive at paid/incurred claims by: (a) deductible, (b) copayment, (c) coinsurance and (d) any other category. For each category, provide a comparison with prior experience periods and comment as to the reasonableness of any trends in reductions due to deductibles, coinsurance, *etc.*

7. To the extent not already addressed, provide measurements of impacts on claims incurred/allowed/paid, utilization, morbidity and trend relative to $4.80 PMPM QI

expenses in Exhibit 1 – *i.e.*, provide an analysis of the reasonableness and effectiveness of QI initiatives.

8. Provide further justification for the $14.13 PMPM (2.7%) increase in sales costs.

9. Provide further explanation and justification for the "Misc. Admin" increase in the Price Build-up, that is in addition to the "Administration" line item.

10. In further support of your utilization and trend forecasts, provide an analysis, with supporting data, as to how increases in patient responsibility impact utilization of various service. To the extent possible, address the following in your analysis:

    a. Identify rates of member utilization of services by acuity level (i.e., ED, Urgent Care, primary care, etc.) across metal tiers over the available experience periods;

    b. Discuss any differences among metal tier levels as to rates of member utilization of services by acuity level. Specifically, identify any correlations between each metal tier level and higher or lower use of certain services or settings. For Silver metal level plans, also identify any correlations between CSR plans and non-CSR plans and higher or lower use of certain services or settings within CSR plans vs. non-CSR plans;

    c. Discuss any differences over time, within the same metal tier level, as to rates of member utilization of services by acuity level. Specifically, identify any correlations between changes in cost sharing within a particular metal tier level and higher or lower use of certain services or settings over time;

    d. For each year of experience, identify by metal tier level any under-utilization of services by (i) members with diagnoses of chronic conditions, (ii) members with diagnoses of serious conditions requiring long-term follow up or (iii) services not provided but for which prior authorization was obtained by the member/provider. For each category of under-utilization, provide analysis and supporting data regarding additional services/costs associated with a delay of care (i.e. waiting until the illness becomes too acute for routine management and going to the ED, or not beginning medication or other regimen for treatment).