From:	Stephani Becker
To:	DOI.HealthRateReview
Cc:	Stralka, KC; stephanie altman; Jodi Helsel; Anusha; NIsrael@aidschicago.org; creadling@gmail.com
Subject:	[External] Comments on 2025 Proposed Rates in the Individual Market
Date:	Friday, July 26, 2024 9:11:30 AM
Attachments:	Comments on 2025 Proposed Rates - Submitted to DOI July 26.pdf

Dear Director Gillespie,

Thank you for the opportunity to comment on the proposed rates in the 2025 Illinois Health Insurance Marketplace posted on the Illinois Department of Insurance website. We appreciate the Department of Insurance's (DOI) efforts in reviewing the rates, providing transparency and education to the public, and enforcing the obligations of health insurers in Illinois to their customers.

We commend the Illinois General Assembly and DOI on the passage of landmark legislation to expand the authority of the DOI to review and approve rates as well as to provide public transparency on rates including the underlying reasons for rate changes (215 Ill. Comp. Stat. 5/355). We are excited to participate in the process to build our understanding of the rates and rate review process as well as to provide a perspective on behalf of our clients who need to access affordable coverage, choose the best coverage for them, and know how to use that coverage to access quality care.

Our chief interest in being able to view the proposed rates is not only to see what issuers are participating on the 2025 Marketplace and how premiums will increase or decrease next year, but also to understand the rationale and justification - including the cost drivers and changes in the population and the healthcare delivery system - that cause the rates to change from year to year. As this is our first year participating in the process, we would like to share feedback on the overall quality of the information provided on the rate filing website, so that we can utilize this year as a starting point to build on in the future. For our comments this year, we have consulted with Ibis Actuarial Consulting, LLC to help inform our understanding of the process and the rate filings.

Please see our comments (attached) and do not hesitate to contact us with any questions.

Sincerely,

Stephani Becker, Shriver Center on Poverty Law

Jodi Helsel, Committee to Protect Health Care

Anusha Thotakura, Citizen Action Illinois

Nadeen Israel, AIDS Foundation Chicago

Cate Readling, The People's Lobby

Stephani Becker

Associate Director of Healthcare Justice

pronouns: she, hers

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July 26, 2024

Ann Gillespie
Acting Director, Illinois Department of Insurance
122 S. Michigan Ave, 19th Floor
Chicago, IL 60603

RE: Proposed 2025 Rates and Rate Summaries in the Individual Market

Dear Director Gillespie:

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With an average premium increase in Illinois of 4.9% across carriers, Illinois appears to have a lower average increase in the individual market than most other states with early filings posted on public websites[1]. Of course, it is difficult to determine the impact on individual consumers as the enhanced premium tax credits utilized by 355,916[2] Illinois Marketplace enrollees protect the majority of consumers from the full effect of premium increases. If Congress does not vote to preserve these tax credits, the rate increase will be a larger affordability challenge for Illinois consumers in 2026. We appreciate the NAIC's recent letter in support of the continuation of the enhanced premium tax credit. It remains crucial for Illinois regulators to scrutinize the rate requests especially next year as DOI institutes its prior approval authority.

We will first present our key takeaways on the available 2025 rate information on individual market plans and then comment on the information presented by the insurers, what is missing, and what could be added next year.

[1] We looked at Indiana, District of Columbia, Maryland, Minnesota, Massachusetts, Rhode Island, Oregon, Connecticut, Washington, Vermont and Maine
[2] Source: Center for Medicare and Medicaid Services, 2024 Marketplace Open Enrollment Period Public Use Files, https://www.cms.gov/files/zip/2024-oep-state-level-public-use-file.zip, accessed July 19, 2024.

2025 Proposed Rate Information

We were pleased to be able for the first time to review the proposed rate filings and summaries so early in the process. It was helpful that DOI provided a table with all the proposed increases/decreases by carrier and a link to the filings. The DOI Company Bulletin from May 14, 2024, advised carriers to complete the new "Plan Year 2025 Public Rate Filing Summary" template. We have summarized the quantitative information included in the public rate filing summaries in **Table 1** below, that we believe will be helpful for the public to understand the landscape of the Illinois Individual Market.

TABLE 1: Information From the Illinois Public Rate Filing Summaries in the Individual Market

Issuer	Expected Number of People Affected	Market Share	Written Premium *	Average Rate Change	Maximum Rate Change	Minimum Rate Change	Expected Medical Loss Ratio	Expected Annual Medical Trend	Expected Administrative Cost Ratio
Blue Cross Blue Shield of Illinois	201,422	53.08%	$1,845,761,332	4.30%	16.30%	-12.20%	90.50%	5.70%	5.50%
Celtic Insurance Company	55,424	14.61%	$363,121,492	1.70%	2.96%	-2.28%	82.80%	1.69%	21.00%
Aetna Health Inc.	37,399	9.86%	$169,008,231	7.69%	19.29%	4.55%	79.30%	7.20%	14.10%
Health Alliance Medical Plans, Inc.	33,753	8.90%	$377,997,362	9.90%	19.56%	2.69%	85.78%	9.80%	11.22%
UnitedHealthcare of Illinois, Inc.**	21,968	5.79%	$151,447,159	1.46%	5.38%	-2.35%	85.60%	8.00%	10.50%
Oscar Health Plan, Inc. ***	7,303	1.92%	$42,609,457	11.70%	17.40%	3.40%	?	?	?
Cigna HealthCare of Illinois, Inc	6,931	1.83%	$44,252,350	6.40%	10.60%	3.40%	83.20%	5.80%	10.50%
Molina Healthcare of Illinois, Inc.	6,352	1.67%	$41,457,322	1.60%	3.80%	-2.20%	85.00%	6.70%	17.80%
Aetna Life Insurance Company	4,490	1.18%	$30,867,473	2.24%	12.67%	-1.98%	88.60%	6.80%	14.00%
Quartz Health Benefit Plans Corporation	3,190	0.84%	$34,244,154	9.91%	15.28%	4.15%	88.00%	6.30%	8.00%
MercyCare HMO, Inc.	1,223	0.32%	$12,461,221	5.37%	6.54%	3.31%	92.90%	3.40%	6.20%
TOTAL	379,455	100%	$3,113,227,553	4.86%	19.56%	-12.20%	87.93%		9.11%
	Numerical Average of Rate Changes****:			5.66%					

* Premium is not included in the Summary. The premiums shown here are taken from the Company Rate Information table on page 4 or 5 of each filing. For Blue Cross Blue Shield, it appears that the entries for "Written Premium Change for this Program" and Written Premium for this Program" were reversed in SERFF. We used the entry labeled "Written Premium Change for this Program."

** The "Expected Number of People Affected" reported by UnitedHealthcare in the Summary is the same as the "Number of Policy Holders Affected" shown in the Company Rate Information table on page 5 of their filing, so it may not include covered family members.

*** Oscar has not provided a Summary. The information shown is taken from he Company Rate Information table on page 4 of the filing, except the Expected Number of People Affected, which is from the Rate Increase Justification (page 71 of the filing).

**** The percentage shown on the Total line is the average rate change weighted by premium and therefore represents the percentage by which total premium in the state will change. The numerical average shown below the weighted average is simply the unweighted average of the rate changes for all issuers.

Ibis Actuarial Consulting, LLC reviewed the publicly available information and provided the following high-level observations:

- Written premiums in the individual market in Illinois total $3.1 billion.
- Blue Cross Blue Shield of Illinois has the largest market share, with 53% of the market, when measured by enrollees and 59%, when measured by written premium. BCBS reports a low administrative cost ratio of 5.5% compared to its competitors (although as we mention later, it is unclear whether carriers utilized the same definition of this metric).
- The average rate change for issuers in the individual market varies from a low of 1.46% to a high of 11.7%. The average rate change for the market is 4.9%.
- For several issuers, there is a wide range of rate changes. For example, Blue Cross Blue Shield of Illinois reported a 4.3% average rate change, ranging from a rate decrease of 12.2% to a maximum rate increase of 16.3%.
- Issuers have reported a wide range of expected annual medical trend - from 1.7% to 9.8%.
- There was a range of expected Medical Loss Ratios (MLRs), between 79.30% (Aetna Health Inc.) and 92.90% (MercyCare HMO, Inc.). One issuer, Oscar Health Plan, did not provide an unredacted version of its MLR.

Ibis also looked at information included in the rate tables. However, without knowing the metal tier of each plan and whether each plan is on or off the exchange, they found it difficult to draw any meaningful conclusions. Here are some of their observations:

- Aetna Life Insurance Company consistently has the highest rates in the rating areas where they offer plans.
- Health Alliance Medical Plans, Inc. has one low outlier plan in rating areas where they offer plans.
- Blue Cross Blue Shield of IL offers the most plans and usually has the widest range of rates within a rating area. They seem to have inconsistent relativities between rating areas, suggesting that geographic factors may not be the only differential between rating areas. It would be helpful for DOI to inquire of BCBS what other factors are responsible for the difference between areas. For each other issuer, the premium differential between rating areas were the same for each plan, suggesting that the geographic factor was the only differentiator between rating areas.
- Quartz Health offers plans in only rating area 5 and has many plans with a very wide range of rates.
- Ibis analyzed the rates of each plan in different rating areas and determined that four of the issuers had plans with premiums that were at least 50% higher than the rates for the same plans in the rating area with the lowest premiums. Rating practices appear to vary significantly by issuer. Some states regulate the maximum differential for policy reasons because for example the state is concerned about unaffordable rates for unsubsidized consumers in the rural areas. A common maximum differential is 40%, but that may vary by state and may be determined by the DOI's analysis of differences in the cost of care by rating area.
- To improve the usefulness of available data, it may be a good idea for DOI to add a summary of the plans and the metal tiers to the public summary. The URRT includes metal tiers and an "On Exchange/Off Exchange Indicator." Therefore, a public release of the URRT at the beginning of the public comment period would solve this issue.

As part of the public rate filing summary template, issuers are required to provide a "Company Justification for Rate Change." As illustrated by **Table 2**, the level of detail provided by issuers in this template varies significantly by issuer and may not be as detailed as the Part II of the filing. For next year, we recommend that DOI should issue detailed instructions for completing the Company Justification for Rate Change with standardized categories to help consumers understand the drivers of rate change for the market as a whole and highlight any variation across issuers. Adding the quantitative impact of each driver of the rate change to the template may also help consumers to contextualize the information.

TABLE 2: Company Justification for Rate Change, as noted in the in the carriers' Public Rate Filing Summary

Drivers of Rate Increase	AHI	ALIC	BCBS	Celtic	Cigna	HAMP	Mercy	Molina	Oscar	QHBP	UHC
Change in Experience Data								X			X
Medical & Drug Trend	X	X	X	X	X	X	X	X		X	X
Change in Morbidity	X	X		X	X	X		X			
Change in ACA Environment	X	X			X						
Change in Plan Design	X	X			X	X					X
Change in Admin Expense, Taxes, Fees and Profit	X	X		X	X	X	X	X			X
Change in Company Business Plan	X	X									
Projected Population Mix	X	X									
Geographic Rating Factors	X	X						X			
Federal Risk Adjustment				X	X	X	X				
Other – Model Update	X	X									

We found it helpful to compare the company justifications for rate change in one chart. Unfortunately, it's difficult to make a valid comparison between the issuers due to the uneven level of detail provided. For example, in the separate Part II document, BCBS included information that was not included in the Company Justification section of the Public Rate Filing Summary. Further, in the BCBS actuarial memorandum, the company redacts all of the reasons for rate changes only providing a general statement related to medical and drug trend in their Part II. Therefore, we have not included other reasons for their rate changes as the issuer does not provide them publicly.

Below is a list of rate change explanations from each carrier (as included in the public rate filing summary):

Aetna Health Inc. (AHI)

• Inclusion of Aetna experience in the Individual market in the rating process. Previously, this block was completely manually rated now the block is solely priced with its own experience.
• Underlying medical and prescription drug trend.
• Projected changes in the morbidity of the insured population.
• Changes to the ACA environment, including changes to account for Medicaid redeterminations and the Unwinding Special Enrollment Period (SEP).
• Changes in plan designs to comply with metal level and standard plan design requirements.
• Changes in administrative expenses, profit & risk load and ACA-related fees and taxes.
• Changes related to Aetna's business initiatives.
• Evaluation of actuarial value (AV) and cost sharing factors using an updated model.
• Changes to Aetna's projected population mix.
• Changes in anticipated unit cost variations by geographic rating area.

Aetna Life Insurance Company (ALIC)

• Updated manual experience from a more closely associated segment of business.

• Underlying medical and prescription drug trend.
• Projected changes in the morbidity of the insured population.
• Changes to the ACA environment, including changes to account for Medicaid redeterminations, and the Unwinding Special Enrollment Period (SEP).
• Changes in plan designs to comply with metal level and standard plan design requirements.
• Changes in administrative expenses, profit & risk load and ACA-related fees and taxes.
• Changes related to Aetna's business initiatives.
• Evaluation of actuarial value (AV) and cost sharing factors using an updated model.
• Changes to Aetna's projected population mix.
• Changes in anticipated unit cost variations by geographic rating area.

Blue Cross Blue Shield of Illinois (BCBS)

The proposed rates reflect expected change in year over year medical service and prescription drug costs, which includes changes in reimbursement rates to providers, changes in expected utilization of services, the mix and intensity of services, and the introduction of new procedures and technologies.

The Affordable Care Act expects health plans in the individual market to spend at least 80% of each premium dollar they collect to pay for medical care and activities that improve health care quality for members. These rates assume BCBSIL will once again exceed the 80% threshold.

Celtic Insurance Company (Celtic)

We expect unit costs to increase for 2025. Further, we have updated underlying experience for the single risk pool, expected administrative expense, and assumptions for federal risk adjustment. These factors, as well as changes to the assumed morbidity of the single risk pool and medical trend, result in a premium rate increase.

Cigna HealthCare of Illinois, Inc (Cigna)

The following factors are the main drivers of the proposed rate change:
• Medical inflation and unit cost changes of medical services year over year: The underlying claim costs are expected to increase from 2023 to 2025, which is reflective of anticipated changes in the prices of medical services, the frequency with which consumers utilize services, as well as any changes in network contracts or provider payment mechanisms. The recent increase in Consumer Price Index (CPI) inflation is adding additional inflationary pressure for network contracts and provider payment mechanisms.
• The non-grandfathered individual market has continued to evolve since the inception of the Patient Protection and Affordable Care Act (PPACA), such as the introduction of the guaranteed issue requirement, the elimination of the individual mandate tax penalty, modified community rating, subsidies, the risk adjustment program, the external competitive landscape, transitional policy allowances, anticipated changes to regulations regarding Short Term Medical and Association Health Plans, and many other provisions. After consideration for expected risk adjustment transfers, the single risk pool experience for Cigna HealthCare of IL in Illinois was more adverse than assumed in the current rates. As a result, Cigna HealthCare of IL's best estimate of the average market-wide morbidity of the covered population has increased compared to 2024.
• Increased Expense Margin: Reflects decreased efficiencies and scale achieved by Cigna HealthCare of IL relative to 2024.
• Plan design changes and benefit modifications: Changes have been made to plans regarding the mandated restricted actuarial values for metal tiers that are resulting in an increase in expected cost share and therefore an increase to premium. All plan designs conform to actuarial value and essential health benefit requirements.

Health Alliance Medical Plans, Inc. (HAMP)

Medical and Rx unit cost inflation, changes in utilization of medical services and prescription drug usage, projected changes in morbidity, projected risk adjustment program transfer, changes in administrative costs, and plan design changes.

MercyCare HMO, Inc. (Mercy)
Rate changes reflect changes in medical and pharmacy benefit cost, both price changes and changes in utilization. They also reflect the cost of CMS risk adjustment transfer payments borne by the plan, along with changes in expenses, including Exchange user fees and administrative expenses.

Molina Healthcare of Illinois, Inc. (Molina)
This rate change is driven by changes to underlying experience period claims, expectations of risk pool acuity, provider unit cost assumptions, taxes and fees and administrative costs.

Oscar Health Plan, Inc. (Oscar) – Not Provided[3]

Quartz Health Benefit Plans Corporation (QHBP)
This justification is intended to comply with the requirements of Section 2794 of the Public Health Service Act as added by Section 1003 of the Patient Protection and Affordable Care Act. This justification may not be appropriate for purposes or scopes beyond those described above and, therefore, should not be used for other purposes.

Scope and Range of Rate Increase
Quartz Health Benefit Plans Corporation (Quartz) is requesting an average rate increase of 8.80%. Quartz members would receive premium increases ranging from 4.15% - 15.28%, depending on their plan selection. As of March 2024, there are 2,968 individuals on HMO Product One and 222 individuals on HMO Product Two that will be impacted by this increase. Additionally, premium rates may change for individual contracts by an amount outside of the filed rates due to changes occurring at the contract level. These contract level changes may include changes in various characteristics, such as age, benefit plan, and tobacco user status.

Financial Experience of the Products
For the experience period, these products had a loss ratio of 89.0%. The proposed rate increase is needed to maintain a target projected loss ratio of 88.0%. Please note that this MLR calculation is purely an estimate and not meant to be a true measure for purpose of calculating the Federal or State MLR rebates. The products contained in this filing represent only a subset of Quartz's Individual business.

Changes in Medical Service Costs
The requested rate increase is impacted by both medical and pharmacy trends increasing due to utilization and service cost changes.

Utilization Changes
A portion of the rate increase is due to the changes in claim costs associated with utilization increases from the number of services, severity of services and change in mix of services.

Service Cost Changes
A portion of the rate increase is due to the changes in the plan claim costs due to increased reimbursement payments to healthcare providers. Changes in Benefits Quartz has added optional dental benefits and has

[3] Oscar's "Rate Filing Justification" document included some but not all of the information that is required to be provided in the Public Rate Filing Summary.

made some minor cost sharing changes to current plan designs to maintain compliance within the federally mandated benefit ranges.

Administrative Costs and Anticipated Margins
Administrative Costs as a percentage of premium is not contributing to the requested rate increase.

UnitedHealthcare of Illinois, Inc. (UHC)
The proposed rate change is 1.46% and will affect 21,968 individuals. The rate changes vary between -2.35% to 5.38%. Given that the rate changes are based on the same single risk pool, the rate changes vary by plan due to plan design changes. The primary factors that affect the rate change are:
• Change in experience used in the 2025 premium rate development relative to the 2024 rate development.
• Changes in unit cost per service and utilization of services.
• Changes in benefits including those made to comply with the requirements of the Affordable Care Act.
• Changes in non-benefit expenses such as administrative costs, taxes, and fees.

Key Takeaways on Information Posted

We were pleased to see much more information this year than we have seen for Illinois on RateReview.HealthCare.gov. For example, last year over half of the IL carriers did not post a consumer justification for their rate changes on HealthCare.gov. We were disappointed that the information provided by the issuers and posted on the DOI website this year was in some instances incomplete, not standardized across carriers and heavily redacted. The intent of the rate review law was to have a plain language summary describing the reason for the rate increases/decreases available to compare across carriers. However, the information posted was not easy to compare. For future years, we recommend looking at how other states post their rate filings; for example please see the Narrative Summaries posted here for New York.

Our actuarial consultants' opinion was that many of the redactions in other parts of the filings were not only unnecessary but that some of the incomplete and inaccurate nature of the information posted is detrimental to the ability of the public to engage in the process and may effectively undermine the intent of posting the information publicly and providing an opportunity for public comment within 30 days of posting. Without complete and accurate information, it is difficult to get an understanding of the rates/rate changes and develop informed comments.

We appreciate the Department's cooperation in posting corrected information and extending the comment period to accommodate these changes. We urge the Department to require the issuers to provide unredacted filings, summaries and justifications wherever possible especially if the same information is provided to the public by the issuer in other jurisdictions.

After reviewing the rate filings and summaries posted by the Department, we have the following questions and comments on the information provided and missing, the rates, the process, and the Department's next steps.

1. **Incomplete or Missing Information:** Some of the material posted appeared to be incomplete or missing. We informed the Department informally about the incomplete or missing information and requested it be corrected and published publicly, with an extended period to allow for amended comments. We greatly appreciate DOI's cooperation and timely response to our requests. A couple of follow up notes:

- Under the updated Admin Code Section 2026.50 "Submission of Rate Filing Justification", each health insurance issuer must complete and submit Part II of the Rate Filing Justification that is marked for public access in SERFF regardless of any increase, decrease, or continuation of rates. It initially appeared that only Aetna Health and Blue Cross Blue Shield's filings contained Part II. However, DOI has since clarified for us via email that every company substantively included a Part II justification. For some companies, the only Part II justification that they submitted was the "Plan Year 2025 Public Rate Filing Summary" template. Other companies used their own formatting, and they also may have labeled it "Consumer Justification" instead of specifically identifying it as "Part II". The discrepancy in how each company provided their rate change justification narratives made it difficult to compare information across carriers.

- The regulation also specifies certain information that must be included in the Part II document:[4]
    1. Explanation of the most significant factors causing the rate increase, including a brief description of the relevant claims and non-claims expense increases reported in the rate increase summary;[5]
    2. Brief description of the overall experience of the policy, including historical and projected claim and administrative expenses, loss ratios, number of historical and projected covered lives, and assumed medical trends. In addition to general medical trends and other trend information the issuer deems relevant for the justification, the description of assumed medical trends must address the impact of hospital and generic, brand, and specialty drug cost trends on the proposed premium rates; and
    3. Notification of the public comment period described in Section 355(e) of the Code.

    For the two Part II documents that were posted, we note the following:

        - **Blue Cross Blue Shield of Illinois:** The average rate change for Blue Cross Blue Shield of Illinois is a relatively modest 4.3% and the information provided in Part II is not inconsistent with that. However, the maximum rate change for this issuer is 16.3%. The Part II document does differentiate between HMO products, with an average rate change of 1.6%, and PPO products, with an average rate change of 5.1%, but otherwise does nothing to explain the larger increases or the reasons behind such a large range of rate increases. Much of the information in the document is general and not quantified. For example, it states that the proposed rates reflect expected change in the cost of medical services and prescription drugs but does not say how much costs are expected to increase. Regarding the required elements listed above, it is deficient in the following areas:
            - While it does state 2023 claims experience and states that the 2025 rates are "expected to achieve the loss ratio assumed in the rate development," there is no description of experience with respect to administrative expenses (other than a statement that "these rates assume BCBSIL will once again exceed the 80% [MLR] threshold").
            - There is no mention of assumed medical trends, general medical trends, or the impact of hospital and generic, brand, and specialty drug cost trends.
            - There is no mention of the number of historical and projected

[4] Ill. Admin. Code tit. 50 § 2026.50(3).
[5] Ill. Admin. Code tit. 50 § 2026.50(e).

covered lives.
- There is no notification of the public comment period described in Section 355(e) of the Code.

- **Aetna Health Inc.:** Aetna Health's average rate change is 7.69% with a maximum of 19.29%. The Part II document does state that health costs are expected to increase 7.2%, which is fairly close to the average rate change. It also states that rate changes can vary greatly by individual and states some of the reasons for this, but in a confusing way. It says, "The exact rate change depends on where the plan the individual has selected and where the individual is located, as well as tobacco status." It is not at all clear what "where the plan the individual has selected" means. It was possibly intended to say "what plan the individual has selected." The document further states, "Under the ACA, at least 75% of the premiums collected by a health plan should be used to pay for the medical costs of the members of that health plan. This is referred to as the Minimum Loss Ratio (MLR)." This is inaccurate as the actual standard is 80%, not 75%. Regarding the required elements listed above, it is deficient in the following areas:
  - While it does state that "non-claim expenses have been updated to reflect most recent administrative expense, profit, and taxes/fees" there is no discussion of past experience with respect to these items,
  - There is no mention of the historical number of covered lives.
  - There is no notification of the public comment period described in Section 355(e) of the Code

For at least one issuer (Quartz Health Benefit Plans Corporation), the initial PDF did not appear to capture the full Company Justification for Rate Change in the Illinois Public Rate Filing Summary. DOI has corrected this on the website and indicated that this issue was due to an error in converting from Excel to PDF format. We note in our recommendations below that posting the files in Excel format would avoid this issue in the future.

2. **Redacted Material:**

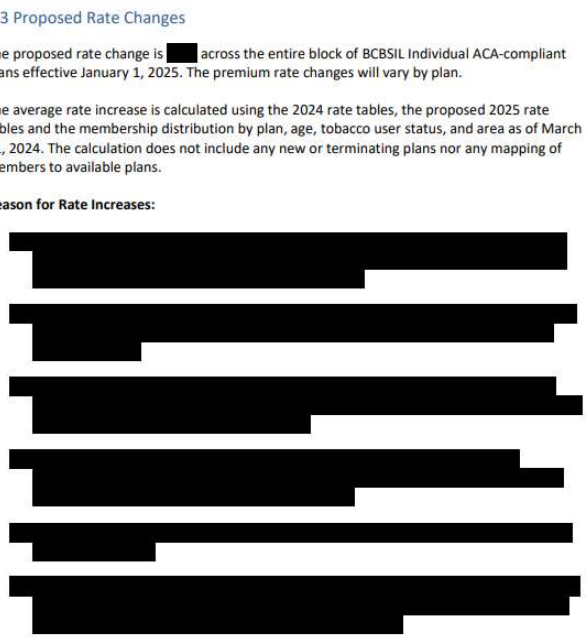
The information released to the public by DOI from some of the issuers continues, as in past years, to be substantially redacted. As mentioned above, the lack of information impedes the public's ability to understand the issuers' justifications, especially when the information in the "Consumer Justification" section of the Public Rate Filing Summaries is not standardized. We see a wide variation in what information is made public from carrier to carrier although every issuer redacts some information. Therefore, it appears, but is impossible to know, if each issuer is making a different decision on whether the redacted information containing the reasons for rate changes is considered a trade secret. This lends credence to our opinion that the trade secret exception is being used arbitrarily or too broadly by some issuers and that, to be consistent with DOI's transparency goals, the intent of the transparency provisions of the ACA, and ensure a level playing field among issuers, DOI should require fewer redactions and provide detailed guidance for the information that must be made public across issuers.

Actuarial Memorandums for Aetna Health and Aetna Life are almost entirely redacted. Section 2026.50(c)(3)(C) of the new Illinois rate review regulation states that information that is shown elsewhere in the filing cannot be redacted in the Actuarial Memorandum. However, we noted several places where such information was redacted. For example, for Aetna Health and Aetna Life, the average, maximum, and minimum rate change are redacted in the Actuarial Memorandum even though they are disclosed in the Company Rate Information table on page 5 of each filing, as well as in the new Public Rate Filing Summary exhibit. Such redaction unnecessarily inhibits the public's ability to read and digest this extremely complicated information and thereby discourages participation in the public comment process.

The Part II summary must contain specific minimum contents including explanation of the most significant factors causing the rate increase, to be made public, so the Department has specified it is not eligible for redaction and must be made public on SERFF. *See* proposed 50 Ill. Adm. Code 2026.50(c)(2) and (e). However, the Part II justifications were completed by only two issuers, with two very different formats and level of detail.

The rate regulation rule allows redaction if disclosure of the information would cause competitive harm to the health insurance issuer. In Illinois, Blue Cross Blue Shield's (BCBS) 2025 actuarial memos posted on DOI's website are almost completely redacted and the public cannot see the proposed rate change, nor the reason for the rate increase (see BCBS IL 2025 Actuarial Memo, page 4 of 31- depicted in **Image 1**); in comparison, the same type of Actuarial Memo for the HCSC products in Montana is far more transparent (See BCBS MT 2024 Actuarial Memo, page 4 depicted in **Image 2**). We recognize that trade secret laws are different in every state. However, if the same type of information is made public and not redacted in another state by the same company, it seems reasonable that the issuer at least be required to explain why it is considered harmful to competition in Illinois but not in another market. The lack of a standard for what information may be redacted by an issuer has allowed insurers to redact nearly entire actuarial memos, leaving interested parties without recourse outside of FOIA, which would not be timely enough to inform this public comment period unless it is significantly extended.

Image 1: BCBS IL 2025 Actuarial Memo, page 4



4.3 Proposed Rate Changes

The proposed rate change is [redacted] across the entire block of BCBSIL Individual ACA-compliant plans effective January 1, 2025. The premium rate changes will vary by plan.

The average rate increase is calculated using the 2024 rate tables, the proposed 2025 rate tables and the membership distribution by plan, age, tobacco user status, and area as of March 31, 2024. The calculation does not include any new or terminating plans nor any mapping of members to available plans.

Reason for Rate Increases:

[redacted]

Image 2: BCBS MT 2024 Actuarial Memo, page 4

4.3 Proposed Rate Changes

The proposed rate change is 4.9% across the entire block of BCBSMT Individual ACA-compliant plans effective January 1, 2024. The premium rate changes will vary by plan.

The average rate increase is calculated using the 2023 rate tables, the proposed 2024 rate tables and the membership distribution by plan, age, tobacco user status, and area as of March 31, 2023. The calculation does not include any new or terminating plans nor any mapping of members to available plans.

Reason for Rate Increases:

- Base Period Experience reflects the impact of restating 2023 pricing due to additional experience availability and a better understanding of how assumptions unfolded. The base experience has runout through March 31, 2023.
- Pricing Trend and Leveraging represents the expected increase in claims costs resulting from changes in utilization and unit cost as well as the impact of fixed member cost sharing amounts. Trend calculations include an estimation of COVID-19 impacts in the experience period and the projection period.
- Provider Networks and Cost Sharing represents the expected change in claims costs resulting from adjustments to our contracted networks and service providers, as well as those resulting from plan provision changes.
- Market Risk reflects the impact of the change in morbidity of the market wide population, including projected impacts associated with resumed Medicaid redeterminations following the end of the Public Health Emergency as well as broader access to premium tax credits and cost sharing subsidies for family members of individuals with employer-sponsored coverage. This also includes changes in risk adjustment payment assumptions (i.e., BCBSMT's share of the population risk relative to the market).
- Reinsurance represents the change in expected payments under the Montana State Reinsurance program.
- Drug Rebates reflects the impact on rates of anticipated changes to rebates received from drug manufacturers.
- Other reflects changes to expected 2024 retention, including an update to our estimate of core administrative expenses, not discussed above compared to those for the 2023 rates. Additional information can be found in Section 4.4.4.

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CONFIDENTIAL TREATMENT AND TRADE SECRET PROTECTION REQUESTED PURSUANT BUT NOT LIMITED TO: 5 U.S.C. §§ 552(b)(4) and (b)(6), 45 C.F.R. §§ 5.31(d) and (f), the Trade Secrets Act (18 U.S.C. § 1905), §30-14-402 and §33-22-158, MCA, and applicable affidavits in support of BCBSMT's request for confidentiality and trade secret protection.

The US Department of Health and Human Services asserted in the preamble to a 2019 federal regulation that provider rate pricing factors and the rates insurers pay to health providers are NOT trade secrets, and their disclosure does not implicate federal FOIA exemptions, like competitive harm, nor First Amendment protections. *See* Price Transparency Requirements for Hospitals to Make Standard Charges Public, 84 Fed. Reg. 65524, 65544 (November 27, 2019). We acknowledge that DOI, in response to our comments to the rules filed last year, disagreed with our interpretation that the Federal Transparency Act requires issuers to include provider reimbursement in the context of rate filing. DOI agreed that the Federal Transparency Act requires insurers to publicly post the negotiated provider rates on the internet but in DOI's opinion, this requirement does not apply in the context of rate filings and therefore provider reimbursement information if being used to justify a rate change can be redacted under the Illinois Trade Secrets Act. Unfortunately, we don't know if provider reimbursement increases, or any other factor is being used to justify the rates due to the redactions.

Every other unredacted section of the BCBSIL filing was general and unquantifiable. For example: it states that the proposed rates reflect expected change in the cost of medical services and prescription drugs, but does not say how much costs are expected to increase (p.286); there is no mention of assumed medical trends, general medical trends, or the impact of hospital and generic, brand, and specialty drug cost trends; there is no mention of the number of historical and projected covered lives. We can only assume that the redacted "reasons for rate increases" are more specific and quantifiable if the insurer is contending that they are all a trade secret. We encourage DOI to rigorously review the redacted reasons to ensure that they meet the definition of a trade secret under Illinois law and again contend that federal Transparency Law controls even this in context.

According to DOI, the Health Premium Rate Review Program is designed to evaluate premium rate increases proposed by health care plans marketing in Illinois, protect consumers from unreasonable rate increases and educate consumers on the medical and administrative costs driving such increases.[6] It is impossible for the public to be educated on medical and administrative costs when the justifications for those costs are hidden. We suggest that clear guidance and enforcement regarding what information can be redacted may help Illinois achieve its transparency goals.

Suggestions to Improve Information Posted for 2026 Rates

The following, in consultation with Ibis Actuarial Consulting, LLC summarizes our observations, questions, and recommendations related to the information that is currently publicly available. We recognize that this is a new process in Illinois and that improvements to the transparency of rate filing information will continue to evolve.

- **Clarification of the List of Documents to be Included in the Filing Posted on DOI's Website.** It is not clear which of the files that were provided in Excel format in SERFF were intended to be available for public access during the comment period. The annual Bulletin indicated that the filings would be posted on DOI's website. Including in the Bulletin a list of all files that are intended to be available for review during the comment period, would make it easy for DOI to determine if the information posted was complete. Specifically, is it DOI's intention to include the URRT, which includes a lot of details that would provide context for the rates and rate changes, as part of the publicly available information posted on DOI's website before the comment period?

[6] https://idoi.illinois.gov/consumers/consumerinsurance/health/premium-rate-review.html

- **Accessible Format for Posted Documents.** Requiring all files that are intended to be available during the comment period to be submitted in SERFF in a PDF format would ensure they would be uploaded using the PDF pipeline function in SERFF, which can only combine PDF files. However, all Excel files should be posted directly to DOI's website in Excel format so the user can more easily access, compile, and analyze the data. For example, to be able to compile the results of the Public Rate Filing Summary, for each carrier, Ibis started with the large pdf file, extracted the portions of the pdf file that were the Public Rate Filing Summary, and then converted it to Excel before we could summarize the results. Had the Public Rate Filing Summary files been provided in Excel format on the DOI website, we would have simply downloaded each file and then compiled them.

- **Incomplete or Inaccurate Information.** As mentioned above, in some cases, the information posted on DOI's website initially appeared to be incomplete or inaccurate. Without complete and accurate information during the 30-day comment period, it is difficult to get an understanding of the rates/rate changes and develop informed comments. We appreciate that DOI extended the comment period this year to address some of the missing information. In the future, will there be consequences to carriers if they provide incomplete or inaccurate information? Could DOI perform a "completeness" review before posting the filings?

- **Overly Redacted Actuarial Memorandums**. We appreciate that Illinois has a very healthy, competitive insurance market, which we do not want to jeopardize. However, many of the Actuarial Memorandums posted seem to redact far more information than necessary. The redacted Actuarial Memorandum for Health Alliance Medical Plans is an example of the level of redaction we would expect to see; a relatively small amount of information is redacted. At the other extreme, the Actuarial Memorandums for Aetna Health and Aetna Life are almost entirely redacted. The actuarial memoranda for the other issuers fall somewhere between these extremes.

    - Section 2026.50(c)(3)(C) of the new Illinois rate review regulation states that information that is shown elsewhere in the filing cannot be redacted in the Actuarial Memorandum. However, we noted several places where such information was redacted. For example, for Aetna Health and Aetna Life, the Actuarial Memorandum even though they are disclosed in the Company Rate Information table on page 5 of each filing, as well as in the new Illinois Summary exhibit.

    - The new rate regulation rule allows redaction if disclosure of the information would cause competitive harm to the health insurance issuer. However, the redacted Actuarial Memorandums posted appear to go well beyond this. In many cases, entire sections of the memorandum are redacted, as are entire tables. We believe that while some data in the tables may be appropriately redacted, the title, headings, and non-confidential items should be visible, although there may be exceptions if the structure of the table shows trade secret methodology.

    - For nearly all issuers, the company contact information and the name and affiliation of the certifying actuary are redacted. We believe that company contact information, the name and affiliation of the certifying actuary, and the proposed rate change should be public.

    - Could DOI provide guidance to carriers on the level of redaction expected by the Department to level the playing field among carriers? Here is an example taken from another state:

      State will not accept heavily redacted federal actuarial memorandums. When selecting items to redact, a carrier may not redact an entire section or table. For example, a column of data within a table may be redacted, but the table must remain in place. The title, headings, and non-confidential items must be visible, and only the confidential items may be redacted. Specifically, information that may not be redacted include:

- *Actuarial caveats related to the limitations of the guarantee of the proposed rates*
- *Company contact information*
- *Proposed rate change*
- *Reason for rate change*
- *General descriptions of actuarial methodology*
- *Information that is already public (e.g., information included in another public document or published on CCIIO's website).*

- **Identification of the Documents that Should be Publicly Available.** To encourage consistency among issuers, it may be prudent to explicitly identify the documents that are intended to be accessible to the public during the comment period.

- **Suggested Changes to the Public Rate Filing Summary for Individual and Small Group ACA-Compliant Plans.** The new Summary template provides information not publicly available in previous years, which is helpful. However, some additional information would make it even more useful:

    1. **Instructions:** We have been unable to find any instructions for this summary. If there are none, some items could be interpreted in different ways, making it misleading if used to compare issuers. For example, regarding the "Expected Administrative Cost Ratio," the URRT shows "Administrative Costs" in three components: "Administrative Expense," "Taxes and Fees," and "Profit & Risk Load." One issuer might use the total of the three components as the Expected Administrative Cost Ratio, while another might use only the "Administrative Expense" component. Also, issuers may or may not include Exchange User Fees, which are not included under Taxes and Fees in the URRT because they are included elsewhere as a market-wide adjustment. The wide range of entries for Expected Administrative Cost Ratio suggests that issuers may have, in fact, interpreted this in different ways. Another example of an item that may be open to different interpretations is the Expected Medical Loss Ratio, which may mean incurred claims divided by earned premiums or alternatively, the federally defined MLR used for refund purposes.

    2. **Current Enrollment:** While the Expected Number of People Affected is important information, adding the basis (such as the "as of date") for that information and the projected enrollment would provide context, as the issuer's projections may not be consistent with current enrollment.

    3. **Explanation of Rate Change Range:** For some issuers, there is a wide variation between the minimum and maximum rate changes. These may be due to variations by metal level, by plan within metal levels, or a change in area factors or network factors, or possibly other reasons. Requiring issuers to provide more granular information about rate changes for different types of policies (HMO/PPO, etc.), and by rating area, along with a narrative describing the major drivers of variations among plans and rating areas would provide valuable insight to the public.

    4. **Historical MLR:** Including the historical MLR for the prior three years would make it easy to compare with the expected MLR for the same period. Also, an indication of whether the company has had to pay refunds in the last three years would provide an important frame of reference. The actual MLR is publicly available information but having it in one place would

be useful for consumers evaluating the rate information.

5. **Identification of the Rating Area and Metal Tier of Each Plan:** Without knowing the metal tier and whether the plans are offered On or Off Exchange, it is difficult to analyze the rates and develop an informed opinion. The inclusion of an additional document with an indicator showing if the plan is offered On or Off Exchange along with the metal tier for each plan would make this information much more usable. Note that the URRT includes metal tiers and an On Exchange/Off Exchange Indicator. Therefore, a public release of the URRT at the beginning of the public comment period would solve this issue.

Thank you for the opportunity to provide comments on the proposed 2025 rates and for extending the comment period to allow for updated information to be posted. We look forward to continuing to work with the Department on the rate review process, including transparency measures, in the future.

Sincerely,

Stephani Becker, Shriver Center on Poverty Law
Jodi Helsel, Committee to Protect Health Care
Anusha Thotakura, Citizen Action Illinois
Nadeen Israel, AIDS Foundation Chicago
Cate Readling, The People's Lobby