Karen Weldin Stewart, CIR-ML
Commissioner

Delaware Department of Insurance

Public Comments Regarding Proposed 2017 Marketplace Health Insurance Rate Increases

Delaware Department of Insurance | July 2016

Please note: The DOI accepted comments from the public between June 1 and July 15, 2016, regarding the proposed health insurance rate increases for plans to be sold through the Health Insurance Marketplace in 2017. The comments received have been compiled below, and have not been corrected for accuracy, spelling or any other reason. In some instances, certain portions of a comment have been redacted because it contained sensitive and personal information. The comments received by email have been reformatted for easy reading; the comments received in writing are at the bottom of the list and are in their original format.

Commissioner Stewart will take all submitted comments in to consideration as she proceeds with the rate approval/denial process. Final, approved rates will be released in October 2016, once the Centers for Medicare & Medicaid Service have reviewed and approved the final rates.

Comment #1:

I am not in favor of raising the rates. I have emailed several Senators and Representatives concerning this issue when Highmark and Bayhealth were in negations.

I am writing to you because I will be out of the area for the public hearings. I have started investigating this issue because of the high profile negotiations between Highmark and Bayhealth.

In my research I found a document of health care costs for one procedure within all 50 states. This document breaks down these costs by state. The procedure is an echocardiogram….and the information I was able to obtain is from 2014.

The price range for this procedure within Delaware is according to this document is from $500.00 to 2456.00 in 2014. Bayhealth was the highest cost for Dover and Milford.

Bayhealth Kent General Dover DE $2,456.00

Bayhealth Milford Memorial Hospital MILFORD DE $2,456.0

Christiana Hospital (includes Wilmington Hosp) Wilmington DE $2,158.50

Saint Francis Hospital Wilmington DE $1,563.00

Beebe Medical Center Lewes DE $1,548.00

Nanticoke Memorial Hospital Seaford DE $1,078.00

MOBILE DIAGNOSTIC SERVICES, INC. HOCKESSIN DE $500.00

Here is a link to where I was able to obtain this information.

http://www.splashlightsolutions.com/wp-content/uploads/2015/02/93306-Echocardiogram.xls.pdf

I have also attached it in this email.

There is quite amazed to see such a large disparity on charges for a particular procedure and you will find this the case not only with this procedure but others as well.

The problem is that there is no baseline for these procedures as I see it and providers can essentially charge whatever they like. Now I am sure they will say they service more uninsured…..need to keep funding to replace equipment….need to have funding for expansion and growth…etc… etc.

If they are taking in taxpayer dollars for state employee healthcare….there needs to be a little sunshine put on this healthcare system.

I think it could be mandated that health care service providers should enter their CPT Codes and costs of those procedures into a State Database. Health care doctors would have access to this database and would be required to select the best cost when referring a patient for a procedure (Because after all…..the same test is being performed so there should not be a reduction in quality of health care). By mandating that doctors must refer patients to a lower cost alternative within say …a certain radius….that in itself may give Health service providers like Bayhealth pause at their pricing and they may think about lowering their pricing.

In effect…a centralized database and the added mandate of making doctors responsible for referring patients to these lower cost alternatives provides the "competition" that is needed in a "monopoly market structure" to drive down the costs of healthcare. A centralized database is a tool that could be used to drive down the costs and get them at a baseline.

I believe…..using a database like the one I mentioned above will drive down costs and insures such as Highmark would more than make up what their increase costs would be as well…based on the savings from healthcare competitive pricing.

If current large providers…seek to circumvent the competitive system by buying up these smaller service providers….then it is up to the legislature to write legislation to prevent monopolies within the healthcare system.

We always hear about the costs of healthcare going up…..what are you (the insurers) doing to bring the costs of healthcare down? Negotiations I don't believe have been very fruitful if you are continually asking for increases. Perhaps the Insurers could create this database and attempt to control the costs of healthcare within Delaware? If a system like this was put in place back in 2014….do you think Bayhealth back in 2014 would be charging 2456.00 for an echocardiogram, when doctors would be mandated to send patients to the lower costing facilities for the same procedure? I think they would have to lower their pricing structure to be competitive.

Thank you for your time.

Steve

Comment #2:

Dear Sirs,

I'm 53, do not work, have relatively high level of savings and investments I live on. I should have health insurance but the approx. $425 quote per month I received for a silver plan with a high deductible is too expensive. No subsidy was available. I'm not willing to throw thousands of dollars down the drain and get little back. I'll pay out of pocket if I need healthcare and gamble that my costs will be far lower even with the penalty I'll pay. I paid over $4k in the surtax this year to help fund the ACA so I did pay into the system but will not pay more.

I appreciate the goal of ObamaCare, but healthcare costs are too expensive and you should tackle this huge problem. Ration care, use more NP's and PA's, limit malpractice damages, nationalize drug companies, educate dying patient's families on the cost of care. Solutions must exist! The rich get richer and the sick stay poor.

Best Regards,
Rob McGinty

Comment #3:

Hello,

I'm writing to implore the insurance commission, the commissioner and everyone involved to not only prevent any premium increase this year, but to roll back the increases from 2015.

I am a partner in a small business of 4 people. We do not qualify for a group rate, and I earn too much to qualify for assistance.

I am currently barely able to afford insurance in our state.

I pay $330 per month to Highmark BCBS, for the privilege of having a $3400 deductible which I will never meet. At the end of last year, Highmark decided they would no longer be covering a hormone therapy treatment which costs me $4500 per year. As of the start of this year, my prescriptions for anti-depressants are also no longer covered, costing $268 per year, with the added bonus of driving me further in to a depressed state.

I am paying $3960 per year in premiums for no reason whatsoever.

Any rate increase will make the ACA non-coverage penalty *significantly less-expensive* than having insurance.

Please, do not increase insurance premiums. Please find a way to bring competitive insurers to the state. Please do the right thing for the people of Delaware.

--

Matt

Comment #4:

Dear Commissioner Stewart,

As a holder of an individual health care plan through Highmark here in Delaware, I am both very worried and very angry at the proposed rate increases and the proposed decrease in plan options.

Between Year 1 and Year 2, my insurance increased enough that my family and I had to downgrade our policy. Between Year 2 and Year 3 our policy rate increased 22%. Now, there is a possible increase of anywhere from 24.2% to 35.8%. (Average 32.5%)

My family and I are lucky enough to not qualify for subsidies. Never the less, with fewer choices and potential annual increases of as high as 35%, there will soon come a point where we will no longer be able to afford health Insurance. Our insurance will double every three years. What assurance do we have that Highmark won't ask for the same increase every year?

According to documents from the state website, only 22,586 will be affected so it may be politically expedient to let Highmark have what they want, each year they ask, since that isn't enough to sway an election and many of the individuals are subsidized, but that doesn't make it acceptable.

As a non-smoker in New Castle County, I ask you to please hold Highmark to a singe digit increase.

Andrew Edmonds
Wilmington, DE 19806

Comment #5:

I am fuming over the continual rising costs of the Affordable Health Care Act. I totally agreed with the purpose of its creation " To combat rising health care costs and to provide affordable health insurance to all Americans" In 2015 I paid over $6,000.00 in premiums, that was over $800.00 a month for the best coverage plan. I take no medications and the one visit to my doctors for my annual visit I had to pay the $126.75 for lab work, as "preventative lab work is not covered. Todays's paper said Highmark Delaware is asking for a 32.5% to cover rising costs.
The increase is to offset those who are eligible for tax credits and the rising cost of medical providers and prescriptions. Instead of continually asking for increases from the average american why not do the right thing and keep costs down on the coverage end. We eventually need to address all the benefits and tax breaks on the lower end before more and more people end in lower income. I think going forward I will do without health insurance and risk the penalties.

Please do something and let me know how I can help.

Eleanor Mazzio

(302) 290-9729

Comment #6:

Good Evening,

My name is Amanda Longacre. I am a 26 year old healthy female. My insurance rates increased last under a better health insurance plan that I once had with Highmark.

I had to move from a $1500.00 deductible plan with Highmark that cost about $293.00 to a HSA with a $6,300 deductible that is now the same price as the better plan I was on.

Why should my rate increase? Now if something does happen I will be in so much medical debt that it will cause hardship. I work for a bankruptcy attorney and it is very sad when people come in with so much medical debt that they need to file bankruptcy to be able to afford to live.

This increase will affect many people, myself and the clients I work for included. People are not going to be able to afford this. Please do not increase the rates this high. It will not work, and in fact will create more problems then the proposed plan is providing for with the rate increase.

How do you expect young families, older men and women to be able to live when most of their money is now going to medical expenses. This should not be a hardship. Health should be affordable so that people can enjoy their life.

Please consider a rate that is affordable and not at a ridiculous 32.5 percent.

Amanda Longacre, MSW

Comment #7:

I was made aware that all the insurance companies want to increase their rates. They are going to increase in the health market at astronomical levels. This needs to be blocked. Its funny that Highmark is coming out with a new pay scale for providers. They are even excluding providers in small practices. But after decrease payments they are going to increase rates by 35%. The whole point of the Health market is to provide insurance to people who can not get it themselves. This will only increase the people who do not purchase it. These plans are often high deductible already. So for instance Aetna my charge $800 a month for a bronze plan. Before they pay anything, patients will have to hit their deductible of $13,000. So not they will have to pay $1100 and still have this high deductible. Protect the public please

Thank you
Darren Franczyk

Comment #8:

June 3, 2016

Karen Weldin Stewart Insurance Commissioner

Delaware Department of Insurance

841 Silver lake Blvd.

Dover, DE 19904

In re: "Highmark is asking for a 32.5% increase in the individual market, while Aetna, Inc. requests 25.0% and Aetna Life 23.9%."

Dear Commissioner Weldin Stewart,

Please keep health insurance rates low. These health companies need to understand that the majority of folks like myself have not received cost of living raises and are no longer middle-class. We have dropped to poverty levels and bear the burden of Delaware's economic decline. We can barely maintain our homes, the school systems have failed our children who are unable to provide for themselves, many living at home and many who did not go to college. Where are we to get the money to pay for this increase? I am a full time state employee who has done more with less and now at a tipping point. I can't afford to retire but I can't afford to continue working for the state in constant decline. They should tell you where they propose to get the $$$ and who can afford the increase. It's not me, my community and many of my co-workers.

This is a direct assault on the affordability and accessibility of health care for ordinary citizens not the 1%ers who can afford this increase. I am greatly concerned about not only myself but other DE citizens. The cost of healthcare for me and my family is barely manageable as it is now. An increase would most definitely be a financial hardship and possibly prevent me from maintaining healthcare coverage.

As Insurance Commissioner you have the authority to stop this practice. I am asking that you deny Highmark's and Aetna, Inc.'s request to increase in the individual market at the public hearing is on June 21, 2016 and request they do the belt tightening from within their organizations that decided to break away from BCBS and changed systems to be more costly.

Thank you,

Sincerely

Nina DeVoe

3014 N. Heald St.

Wilmington, DE 19802

Nina.devoe@state.de.us

All the Best,

Nina DeVoe

Community Relations Officer

302 577-5289

Comment #9:

Karen Weldon Stewart,

I am writing to you ref the proposed increase in the health care coverage.

My personal rates increased from $1,368.00 per month to $ 1,736.00 per month in 2016, $ 368.70 added difference @ 27% increase, $ 4,424.40

With this proposed increase of 32.5%, my rates will go from $ 1,736.00 to approx. $ 2,300.00 an additional $ 564.00 per month or $ 6,768.00 total yearly increase !

In 2 years' time my rates will have increased 68% from 2015 levels, of $ 1368.00 to $ 2,300.00 or a total of $ 1,000.00 per month …$ 12,000.00 increase in 2 years !

How is a small business to survive? No other business I know of gets this amount of approved increase, and with only 2 major players in the market we are forced to pay these amounts,

I can move my business to Maryland and insure at approx. 60% of what we pay in Delaware, maybe that's an option ?

Please do not allow these large yearly increases to keep on !

Thanking you in advance,

Daniel P. Burris, Sr.

President

PHB, Inc.

(302) 378-9693 (office)

(302) 378-2087 (fax)

Comment #10:

I cannot attend these meetings but am incredulous that these companies have the balls to ask for a rate increase. Since I no longer qualify for help from the Healthcare.gov website, my insurance premiums have gone through the roof to the point that I can't afford it. How can it be okay for someone to have to choose between paying their mortgage and paying for healthcare? Especially healthcare that is completely useless. Deny, deny, deny claims. This goes to your $6800 deductible - these are the responses I get from **Highmark BC/BS**. In a period of 3 years I paid that company over $14,000 in premiums and they paid a total of less than $600 for my healthcare. Can someone please tell me what is right about that? No one is listening to these screams from middle class America about this industry's rape of our bank accounts. These companies should absolutely NOT be given rate increases.

eh

Comment #11:

To: DE Department of Insurance

From: Dr. Theresa del Tufo

Date: June 15, 2016

RE: PROPOSED HEALTH INSURANCE PREMIUM RATE INCREASE IN DELAWARE: 2017

As a Delaware resident, I am concerned and alarmed by Highmark Blue Cross Blue Shield of DE's request for a premium rate increase of 32.5%, and Aetna's, request of 25.0% in the individual market. Was the increase of 22.4% for Highmark and 16.9% for Aetna last year not enough to sustain these companies' profits? I urge the Insurance Commissioner to reject any rate increase. Outlined below are my concerns:

MAJOR CONCERN: Relates to the availability and affordability of private health insurance

1. Private health insurance market: 94%=Highmark Blue Cross Blue Shield of DE; 6% Aetna

§ Is this a virtual monopoly? It appears that DE health insurance system is dominated by a single entity.

§ Monopoly encourages profit making and limits healthy competition.

§ Highmark/BCBS is apparently structured as a non-profit ? What does this mean in terms of tax burden for the company? How does it benefit the state/citizens of Delaware?

2. Subsidies and increase in health insurance premium rates

§ The Insurance Commissioner has the authority to approve requested rate increases above 10%. Is this true? The average approved rate increase for 2016 for Highmark's "individual market" is 22.4% compared with 12.7% for the "small group market." For Aetna, it is 16.9% for the individual market, compared with -0.5% for small group market.

§ Why did the Insurance Commissioner approve such a significant increase in premiums in 2016?

§ Highmark received $175 million in corporate subsidy from the General Assembly when it entered the Delaware Health Marketplace. Why was this done?

3. I would like to know what the DE Department of Insurance has done for the citizens of Delaware in the area of private health insurance affordability and accessibility for ordinary Delawareans.

Thank you for the opportunity to comment and raise these critical issues and questions.

Dr. Theresa "Tes" del Tufo
Del Tufo Consulting, LLC
"Empowering Minds"
Dover and Rehoboth Beach, Delaware
302-674-8059 (work)

302-228-5232 (cell)

Comment # 12:

To whom it may concern,

I recently sent this letter to President Obama, Hillary Clinton and Bernie Sanders.

It is time I spoke up about the outrageous health insurance situation. Simply put, I will no longer be able to afford it next year and we barely afforded it this year. I have just learned that out of the only two Health Insurance companies left in my state (DE) since the ACA, Aetna plans to raise rates (again) by 32%.

Here's a breakdown:

We are a family of 3: Father, 57yo; Mother, 51yo; Son, 12yo.

We are college graduates and used to consider ourselves to be upper middle class

I have my own business; my husband has a full-time job as of 2 years ago (previously self-employed)

His job offers health insurance for the employee, not the family, and only pays half

He opted for a higher pay instead of the health insurance plan because in the end, even if he selected the insurance we still have to get a policy for myself and our son.

Here's the problem. Even though he could have insurance under a employer plan, I still have to use his salary when applying for Health Insurance for myself and our son, which means we earn too much to qualify for a reasonable rate...leading to the bigger problem - we earn too much to get into the Marketplace, but too little to afford full price.

Our coverage for the same comprehensive Aetna health plan looks like this:

2014: $586/mo; $7032/year

2015: $1009.93/mo; $12,119.16/year

2016: $1240.29/mo; 14,883.48/year

2017: potentially $1,637.19/mo; $19,646.19/year with the proposed increase

This is what a small business person who has to pay 100% of their health insurance is dealing with. $4,763 increase? Where is that going to come from?

And Why?

Why am I forced to pay for pediatric dental coverage in our current plan, yet there are no dentists in network. So in the end, I pay twice for his 2 annual checkups. Sneaky.

Why, at age 51, am I forced to be covered for pregnancy and prenatal care? How much is THAT adding to my premium?

Why can’t health insurance be modular? Why can’t I change it as I need it as my lifestyle changes? Why can’t I get covered for my lifestyle habits (like chiropractic care)? Why can’t I get covered for services I ACTUALLY use (like adult dental care)?

Is anybody really taking this on? This kind of continued increase is unsustainable. Incomes do not increase at the same rate. Eventually, NO ONE will be able to afford health insurance. We’re headed for a health insurance collapse, very much like the housing collapse. Is that what it will take to get this under control?

Rebecca Del Fabbro

Comment #13:

Attached please find my original statement submitted at the public hearing in Wilmington on 6/20/2017 on proposed 2017 rates.

After listening to the Highmark representatives’ presentation, I have new concerns that I have set forth below this original statement.

06/20/2016

Delaware Department of Insurance,

I am a healthy 57 year old single woman and I am writing to you to express my concern about my health care premium with Highmark Blue Cross of Delaware through the Affordable Care Act marketplace in Delaware.

I retired in 2011 and live off of investment income. I got an underwritten policy from BCBSDE for $361.00/month for 2011, 2012 and 9 months in 2013.

In **Oct 2013** my underwritten policy was eliminated because it was not a Guaranteed Issue plan and I was forced to join the ACA. I enrolled in the gold Shared Cost Blue PPO 1500 with a premium of **$365.00/month.** This plan was similar in benefits to my previous plan, but the deductible increased to $1500.00.

In **2014** my gold Shared Cost Blue PPO 1500 plan premium increased to **$754.00/month, an 106% increase.**

In **2015** my gold Shared Cost Blue PPO 1500 plan premium increased to **$819.74/month, an 9% increase** . I was not eligible for the entire subsidy.

In **2016** my gold Shared Cost Blue PPO 1500 plan premium increased to **$1040.15/month, a 27% increase**

I opted for a lesser policy, Shared Cost Blue EPO 3000 in the lower silver tier with a monthly premium of **885.96/month, an 8% increase** ,a deductible increase to $3000 and a restriction to use only in network providers. I may not be eligible for the subsidy.

I have faithfully prepared for a reasonably comfortable retirement. I did all I was supposed to do. I own my home and have no debt.

To date my premiums **would have increased 185%** had I not opted for a lesser plan in 2016.

My actual realized increase is 143% with less coverage every year.

Helping those who were previously denied affordable health insurance is important to me and I am happy to subsidize this effort.

However, there is a limit to my magnanimous generosity I am now highly concerned about future cost increases to myself and others in my situation.

Regards,

Elaine Field

110 Carlie Road

Wilmington DE 19803

302-562-3876

Additional post hearing comments:

It was explained to us by Highmark's actuarial director that the Individual policy plans hold a greater cost and risk to Highmark than the Employer based group plans. This was one of the reasons for the inequities in the rate requests.

I cannot speak to the laws that govern the ACA, but this certainly does not properly represent the spirit of the ACA where ALL policyholders, both Individual and employer based group plans, would shoulder the additional costs of those Americans in need.

The insurance company seems to have found a way to revert back to the pre-2013 risk based analysis method whereby the high risk group (previously the guaranteed issue plans and currently the Individual plan holder) faces a 37.5% average increase, and the low risk group (previously underwritten policy holders and employer based group plans and currently just the employer based group plan holders) face a mere 2.7% average increase.

In addition, Highmark is analyzing each policy type for risk and asking for tailored premium increases at that level as well.

Does this type of analysis follow the law of the Affordable Care Act? I suspect it does not nor should it.

Comment #14:

To Whom It May Concern:

In accordance with the press release in the Cape Gazette of June 17, 2016, the following is being submitted as Public Comment on Highmark Blue Cross Blue Shield's 2017 health insurance premium increase request.

The 32.5% premium increase requested for 2017 for the individual coverage market is excessive, as illustrated by the following specific case (also see attachment for further details).

Name of Insured: Louellen Braithwaite, 2221 Kings Drive, Lewes, DE 19958.

Insurance Carrier: Highmark Delaware

2013 Actual Rate Increase (from prior year): 1.22%
2014 Actual Rate Increase: 5.0%
2015 Actual Rate Increase: 23.6%
2016 Actual Rate Increase: 55.4%
2017 Highmark's Requested Rate Increase: **32.5% !!!!**

The last couple of years have been spiraling out of control. It is unrealistic to expect individuals' budgets to continue to absorb such increases.
Thank you for your consideration.
Gavin Braithwaite
2221 Kings Drive
Lewes, DE 19958
(302) 645-1539

Public Comment on Highmark Blue Cross Blue Shield's 2017 health insurance premium increase request.

HIGHMARK PREMIUMS FOR LOUELLEN BRAITHWAITE

YEAR	MONTHLY PREMIUM	% INCREASE FROM PRIOR YEAR
2013	$245.00	1.2%
2014	$257.25	5.0%
2015	$317.99	23.6%
2016	$494.06	55.4%
2017 **(requested)**	**$654.62!!!**	**32.5%**

COMMENTS:

1. Insured in individual market. Does not qualify for group coverage.

2. 2015: turned 55 years old.

3. 2015/16: was made to move to an ACA-compliant policy. (Similar high-deductible policies both before and after switch to ACA).

4. The last couple of years have been spiraling out of control. It is unrealistic to expect individuals' budgets to continue to absorb such increases.

06/21/16

Prepared by: Gavin Braithwaite

2221 Kings Drive

Lewes, DE 19958

Email: sparkyncleo@verizon.net

Comment #15:

Karen Weldon Stewart,

I am writing to you ref the proposed increase in the health care coverage.

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Thanking you in advance,

Daniel P. Burris, Sr.

President

PHB, Inc.

(302) 378-9693 (office)

(302) 378-2087 (fax)

Comment #16:

To whom it may concern,

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And Why?

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Why can’t health insurance be modular? Why can’t I change it as I need it as my lifestyle changes? Why can’t I get covered for my lifestyle habits (like chiropractic care)? Why can’t I get covered for services I ACTUALLY use (like adult dental care)?

Is anybody really taking this on? This kind of continued increase is unsustainable. Incomes do not increase at the same rate. Eventually, NO ONE will be able to afford health insurance. We’re headed for a health insurance collapse, very much like the housing collapse. Is that what it will take to get this under control?

Rebecca Del Fabbro

Comment #17:

Dear Karen Weldin Stewart,

Thank you for encouraging the community to write and discuss proposed heath care rates for 2017. My husband is self-employed and we purchase health care for our family of three each year for the past 11 years.

When we returned to Delaware in 2012 we paid $592 a month for quality health coverage that included a reasonable deductible and co-pays. In subsequent years that plan premium rose steadily until the rates for 2016 made it unaffordable at over $1200 a month. After comparing numbers and adjusting our budget we chose a plan with a $6800 family deductible and currently pay $907.29 a month. This rate combined with the deductible is over $17,600 a year in out-of-pocket spending alone for our family.

If rates rise again as significantly as Highmark requests, my husband and I are faced with not being able to get quality coverage. This is devastating to the middle-class. I please ask that your office considers the impacts on individuals, families, and children.

Sadly, after many attempted and failed treatments for tendonitis in his elbow, my husband had surgery through the Rothman Institute. His care was wonderful and after a six-week recovery we expect him to be able to use his right arm again. As expected we went through all the necessary channels for authorization of the surgery and were instructed on how much we had to pay to meet the deductible and prepaid for the surgery. Once the surgery was complete we received a denial of coverage from Highmark. According to them we owe over $12,000 to the surgeon, lab, and surgical center. None of which would then apply to our deductible. The billing department at Rothman is continuing to aid us in trying to understand why the coverage was denied. The Explanation of Benefits explains that this type of surgery is not covered under our plan.

As a consumer it is sickening to question if I had continued with the plan I had and paid the $1200 a month would my husband's surgery then have been covered. Why were we told what our bill would be and paid it only to be told it was denied?

The future of our healthcare is unknown for my family. Please think of people like us who work hard to provide for our families. Thank you.

Sincerely,

Frank & Katherine Collins

Comments from Aetna and Highmark BCBS from Public Information Sessions

1. Comment from Aetna:

2017 Delaware IVL/SG Rate Hearings

Good evening (morning). I am here today on behalf of Aetna to discuss our recently submitted 2017 Affordable Care Act rate filings.

Aetna has filed 2017 premium rates for both the Individual and Small Group markets in the state of Delaware. Aetna will be participating both On and Off the Exchange Marketplace for both Individual and Small Group. We will begin our presentation by discussing our Individual rate filings, followed by our Small Group rate filings. Aetna files its HMO products under Aetna Health, Inc., and its PPO products under Aetna Life Insurance Company.

Individual

Aetna is filing rates for Individual plans in Delaware, both on and off the Exchange Marketplace. This filing proposes to raise premium rates on average by approximately 25.0% for Aetna Health, Inc. and 23.9% for Aetna Life Insurance Company.

The rates will apply to policies that start or renew from January 2017 through December 2017. Approximately 1,500 members for Aetna Health, Inc., and 2,100 members for Aetna Life Insurance Company, as of January 2016, are enrolled in plans to which the new rates will apply. In 2017, we will offer a total of 12 plans under Aetna Health, Inc., in Delaware: 1 Gold, 3 Silver, and 2 Bronze plans for both on exchange and off exchange. We will also offer 12 plans under Aetna Life Insurance Company: 1 Gold, 3 Silver, and 2 Bronze plans for both on exchange and off exchange. In 2016, we are offering 8 plans under Aetna Health, Inc.: 1 Gold, 1 Silver, and 2 Bronze plans for both on exchange and off exchange. We are also offering 8 plans under Aetna Life Insurance Company: 1 Gold, 1 Silver, and 2 Bronze plans for both on exchange and off exchange. Delaware members currently enrolled in 2016 plans will be mapped to the closest 2017 plan upon renewal. However, members also have the ability to change to another Aetna plan or move to a competitor.

Each of the plans we offer falls into one of the metallic tiers, as designated by the Department of Health and Human Services (HHS) as part of the Affordable Care Act. Each year, HHS provides carriers an Actuarial Value Calculator, and the carriers are required to calculate an Actuarial Value for each plan to be offered. Actuarial Value, or “AV”, measures the proportion of total medical costs paid by the plan. A plan with a higher AV indicates the plan will cover a higher proportion of medical costs, with less responsibility falling on the member. Plans are then assigned metal tiers based on their calculated AV. Platinum plans have the highest AV, ranging from 88% to 92%. Gold plans range from 78 to 82%, Silver plans range from 68 to 72%, and Bronze plans range from 58 to 62%.

Since there is a new AV Calculator each year, we must re-assess metallic AVs. It is important to note that while a certain plan may fall into a metal tier in one calendar year, that same plan may fall out of a metal tier

the following year. If this occurs, then the plan's benefit design must be adjusted so that the new AV will fall within the previously stated ranges. As a result, some plans will change from year to year.

Why Do We Need to Increase Premiums? Medical costs are going up, and we are changing our rates to reflect this increase. We expect medical costs to go up 11.0% in 2017, excluding the effect of benefit changes referenced above. Medical costs go up mainly for the following reasons – providers raise their prices and members get more medical care.

Examples of increasing medical costs we have experienced over the last year include:

- The cost of Pharmacy scripts has increased 9%.
- The cost of Inpatient Facility visits has increased 6%.

What Else Affects Our Request to Increase Premiums? For Aetna Health, there were 11,470 member months in 2015, with revenues of $3.5 million and claims of $3.6 million, including the impacts of Risk Adjustment and Reinsurance. Claims experience for this market has been worse than anticipated. Part of the rate increase is needed to ensure that we can continue to offer coverage in this market.

As described earlier, medical costs are going up, and we are changing our rates to reflect this increase.

Also, the federal ACA Reinsurance Program has ended. The discontinuance of this program will increase premiums 5%.

Finally, retention has decreased primarily due to the 2017 suspension of the Health Insurer Fee.

Will Premiums for All Individuals Increase 25.0% for HMO and 23.9% for PPO? No, increases differ by plan. The exact rate change depends on what benefit plan the subscriber chooses, the ages of family members and whether they use tobacco. Rating by age is regulated by the ACA, and as each member's age increases their rates will increase based on the ACA Age Scale. Also, members who use tobacco will be charged rates 10% higher than those who do not, all else being the same. If tobacco usage changes for a member, rates would go up or down. Aetna has not changed its tobacco load from 10%.

Finally, individuals who purchase insurance through the Delaware Marketplace and qualify for advanced premium tax credits may see a different rate change, as the rate they pay depends upon the determination of the applicable government subsidy.

What is Aetna doing to keep premiums affordable?
Aetna strives to keep our products as affordable as possible and to address the underlying cost of health care. We are:

• Developing new agreements, arrangements, and partnerships with health care providers that base provider compensation on the quality of care.
• Creating medical management programs that address potential health issues for members earlier, improving health outcomes and reducing the need for high-cost health care services.
• Working to reduce the ability of out-of-network providers to collect unreasonably excessive payments for services they provide.

We are dedicated to increasing transparency within the health care system and helping members best utilize the plans that they have. Members can access Aetna Navigator, a secure member website, which allows them to research their specific plan benefits, health care providers in a given area, and in some locations, the cost of certain health care services. The Aetna Navigator streamlined mobile app is also available to allow members to take their health care on the go.

We will now discuss our Small Group rates for 2017.

Small Group

Aetna is filing rates for Small Group plans in Delaware, for both the SHOP Marketplace and off exchange. This filing proposes to increase premium rates on average by approximately 23.2% for Aetna Health and 18.6% for Aetna Life, based on current ACA-compliant membership. Combined with the approved rate decreases from 2016, the two-year aggregate rate increase is approximately 16.5% (or 8.0% annually on average) for Aetna Health and approximately 11.4% (or 5.5% annually on average) for Aetna Life.

The rates will apply to policies that start or renew from January 2017 through December 2017. Approximately 6,200 Aetna Health members and 500 Aetna Life members, as of January 2016, are enrolled in plans to which the new rates will apply. In 2017, we will offer a total of 4 plans under Aetna Health, Inc. in Delaware: 1 Platinum, 1 Gold, 1 Silver, and 1 Bronze plan. We will also offer 17 plans under Aetna Life Insurance Company: 1 Platinum, 6 Gold, 7 Silver, and 3 Bronze plans. In 2016, we are offering a total of 32 plans under Aetna Health, Inc.: 1 Platinum, 14 Gold, 13 Silver, and 4 Bronze plans. We are also offering 30 plans under Aetna Life Insurance Company: 1 Platinum, 13 Gold, 13 Silver, and 3 Bronze plans. Those Delaware members currently enrolled in 2016 plans will be mapped to the closest 2017 plan upon renewal. However, members also have the ability to change to another Aetna plan or move to a competitor.

Similar to Individual, each of the Small Group plans we offer fall into one of the metallic tiers as designated by HHS, as part of the Affordable Care Act. Plans are then assigned metal tiers based on their calculated AV. Platinum plans have the highest AV, followed by Gold, Silver, and Bronze plans.

As stated earlier, Small Group premium rates will increase 23.2% for Aetna Health and 18.6% for Aetna Life. These figures are averages. Rate changes differ by plan due to changes in cost sharing, and the exact rate change will depend on what benefit plan the member chooses. It will also depend on the number of family members covered and their ages. Rating by age is regulated by the ACA, and as each member's age increases their rates will increase based on the ACA Age Scale. In addition, the group's contract renewal date will have an impact on its rate increase. Small Group rates increase each quarter with trend.

Finally, changes in the premium that members pay will also depend on changes in employer contributions.

This concludes Aetna's presentation on 2017 Affordable Care Act rate filings. Thank you for your time.

2: Comment from Highmark BCBS at Public Information Session:

Remarks by Peg Eitl
Delaware 2017 Rates Public Information Sessions
June 20 and 21, 2016

- Good [afternoon/evening]. My name is Peg Eitl, and I am Regional Vice President of Sales for Highmark Blue Cross Blue Shield Delaware.

- I have been with Highmark and our predecessor company, Blue Cross Blue Shield of Delaware for about four years and I have more than 30 years of health care experience.

- Our company has a long history in the state of Delaware. We started in an office over a drugstore in downtown Wilmington, and have been serving Delawareans since 1935.

- We live and work right here in the communities we serve, and our commitment to Delawareans is something that we take very seriously.

- For more than 80 years, we have focused on offering high-quality, cost-effective products that meet the needs of Delawareans. As part of this commitment, in 2013 we applied for approval to participate on the individual and small group marketplaces, which were created as part of the Affordable Care Act. We received approval from the Delaware Department of Insurance and the Centers for Medicare and Medicaid Services to begin selling ACA products with an effective date of Jan. 1, 2014.

- At the end of the first open enrollment period, we had more than 16,500 members enrolled in our individual ACA plans. Currently, we have more than 32,000 members enrolled in our individual ACA products.

- Fifty percent of those members that enrolled during the first year were new to Highmark Delaware. We can't say for certain what, if any, coverage these members had before joining Highmark, but it is highly likely that many were either uninsured or underinsured. That resulted in this population seeking more medical care than we anticipated.

- Increased utilization is one of a number of factors, including the increasing cost of care, rising hospital costs, increasing specialty drug costs and the phasing out of government programs originally instituted to stabilize premiums that are driving rates higher.

- Our 2016 rates were determined using actual claims data to set the rates and are based on what it actually costs to insure this population.

- Up until 2016, we had to set the rates for our ACA products without the benefit of actual ACA claims data. As we talk with you today, we know how much it costs to pay the claims for this population covered by ACA benefit plans, and that is what we are using to set these rates. So as we discuss our rates for 2017, we are supported by more substantial data.

- I also want to briefly mention another part of our ACA experience. As you may know Highmark has filed suit to recover damages owed to us because the federal government has not honored its statutory and contractual obligations regarding the ACA.

- Since the ACA rollout Highmark has demonstrated its willingness to be a meaningful partner in the ACA and has agreed to participate in good faith, with the understanding that the federal government would honor its statutory, regulatory and contractual commitments regarding the premium-stabilization programs, including the temporary risk corridor program. This has not happened, and Highmark Delaware is owed more than $6 million. Thus far the federal government has paid less than $1 million of this total now past due. The Highmark companies overall are owed nearly $223 million and have been paid only approximately $27.3 million.
  Highmark's repeated efforts to resolve the federal government's failure to pay the full amount of CY 2014 risk corridors payments owed have been unsuccessful, necessitating Highmark's filing a lawsuit.

- I want to be clear that this litigation has nothing to do with rates. We are taking action to recover monies already owed to us by the federal government under the risk corridor program for the years 2014 – 2015. Our rate requests are by their very nature forward looking and apply to anticipated risks for 2017 for our ACA plans. Our objective is to ensure that Highmark's ACA business remains stable and financially viable for the benefit of all our customers. However, it is important to note that the federal government's failure to pay risk corridor payments owed to us has created additional challenges to our business as we strive to maintain a viable ACA marketplace in Delaware.

- You'll hear from Frank Haver, our Actuarial Director, in a moment, who will provide more details about the specifics of our request rate increases.

- But before I turn it over to Frank, I want assure you that at Highmark, we are working to transform the way health care is delivered, and to help keep rates down by reducing the growth of medical costs.

- We are implementing robust wellness and care management programs, to help keep people well, and prevent future health problems from arising.

- These programs help our members with chronic illnesses such as diabetes, asthma and heart disease better manage their conditions by ensuring that they receive preventive care, take their medications as directed, and incorporate exercise and proper nutrition into their daily lives.

- Highmark has also made hard decisions, such as seeking to reduce reimbursements to doctors and hospitals treating our ACA members as a way to help lower the costs of covering them.

- We are going to continue to work to enhance quality and lower cost, because we are committed to improving the health and wellness of Delawareans.

- Now, I'd like to turn it over to Frank Haver. Frank is Actuarial Director at Highmark.

3: Comment from Highmark BCBS at Public Information Session:

Remarks by Frank Haver
Delaware 2017 Rates Public Information Sessions
June 20 and 21, 2016

- Thank you Peg.

- As Peg said, I am an Actuarial Director at Highmark.

- My team develops the Individual ACA premium rates for Highmark.

- To do this, one of the key things that we look at is past claims experience.

- Specifically we focus on utilization trends (that's the number of services members are using, such as the number of times per year that they see their PCP) and service cost trends (that's the actual cost of each service, such as the cost of an Emergency Room visit).

- We then combine that historical knowledge with a comprehensive list of items for which the future may be different than the past (such as reflecting a new medical technology that is going to be hitting the market, or reflecting a new contract with a hospital).

- We take all of that information, and use it to develop premium rates that we call actuarially sound. This means that the rates cannot be excessive, inadequate or unfairly discriminatory.
- That means that they are not too high, but it also means that they aren't too low. It is the actuary's job to determine the right balance of predicted claim costs, to ensure the future solvency of our company so that we can continue to be here for our members when they need us.
- Across the country, many companies have filed significant rate increases for their 2017 ACA individual health insurance products to get the premiums in line with the actual cost of insuring the ACA population.
- Here in Delaware, we requested an average rate increase of 32.5 percent for our individual ACA products.
- The actual increase will vary by plan, and will range from 24.2 percent to 35.8 percent. There are approximately 32,000 members currently enrolled in our Individual ACA plans.
- We also offer small group ACA products for which we are requesting an average rate increase of 2.7 percent. The actual increases for these products will range from 0.4 percent to 6.4 percent. We have about 23,000 members enrolled in these products.
- The Small Group increase is favorably affected by having an established pool where the historical experience more closely aligns with future projections. Most of those employer groups have provided health coverage for some time, adding to that stability and enabling the pool to cover its costs.
- While many factors are driving up the cost to insure the Individual ACA population, many insurers are concluding that a key driver is higher-than-anticipated medical costs for newly insured ACA individuals.
- While we can't say for certain what coverage, if any, they had before enrolling in our ACA programs, it is highly likely that many were either uninsured or underinsured.
- As a result, the health needs of this population are driving greater utilization than anticipated.
- The good news is that people who have been without insurance for some time are finally getting the services they need to address their health.
- In addition to the higher-than-expected utilization by these new members, there continues to be extreme cases of adverse selection.
- For example, we saw several members in Delaware who incurred more than $100,000 in claims and then remain covered for only a few months of the year. Additionally, we have seen members purchase ACA coverage after open enrollment and incur this high level of claims expense.
- This behavior drives up the cost to insure the entire pool, as people use benefits and then discontinue paying for coverage once their health care needs have been temporarily met.
- Additionally, our data has found that, on average, people who purchased an Individual ACA plan utilized services more than those who purchased coverage through an employer.
- The underlying cost of health care is another factor that continues to drive up premiums.

- While Peg talked about the many new initiatives that we are instituting at Highmark to transform the way health care is delivered and paid for, the underlying cost of providing services continues to go up, forcing health insurance companies to raise rates in order to cover the costs of the services.
- One of the most notable causes of escalating health care costs is the explosion in prescription and specialty drug prices.
- On average, a specialty drug costs about $8,000 per script and is becoming a larger proportion of overall pharmacy expenses.
    - According to a 2015 report from Express Scripts, spending on specialty medications increased by more than 20 percent last year.
        - This same study shows that specialty drugs now represent approximately 50 percent of the total spend on prescription medications for ACA business sold on the Exchanges.
    - Hepatitis C drugs have received a lot of attention because the average cost per year is over $70,000, but other examples include new drugs for Pulmonary Fibrosis which are also over $90,000 per year, and new drugs for certain cancers that cost over $100,000 per year.
- I will discuss other drivers of the increases in a moment, but the most important point that I would like to make today is that the rates that we are proposing reflect what it actually costs to administer these products, and pay the claims for these individuals.
- Our 2017 rates are set using actual claims data for the people that we cover in these ACA programs.
- Because our ACA plans were brand-new products, with prices set far in advance of the effective date, we had to set our 2014 and 2015 rates without the benefit of actual claims data or knowledge of what the membership base would look like. Last year, actual claims were available for some members, but only partial for others. For the 2017 rate development on the ACA products, over 80% of the membership used in the rate development had previous Highmark claims experience.
- That actual claims data from the ACA marketplace helps us to better understand the health needs of that population, as these enrollees are generally older and often managing multiple chronic conditions.
- We must price products to reflect the rising cost of providing care to these individuals and families so Highmark can continue to offer financially sustainable plans to all of our customers.
- When the marketplaces first launched, the government put in place programs to ease the transition to a marketplace where everyone can obtain health insurance, regardless of their medical conditions, including programs to stabilize premiums for consumers.
- These programs are being phased out, and are putting upward pressure on premiums.
- All of these factors plus changes in benefit designs and administrative costs come together to create the 32.5 percent rate increase request for our individual ACA products.
- The primary drivers of the proposed increase can be grouped into three categories,

    - First, the proposed rates are for one year into the future, so we need to account for increased utilization and rising health care costs. The annual claim trend is 10 percent. This is consistent with the actual trends that we are seeing for these members.

    - Second, the government reinsurance program that was put in place to ease the transition to the marketplace where everyone can obtain health insurance is completely phasing out in 2017. That is another 5.5 percent.

    - Third, the actual claim experience is significantly higher than what was projected in prior years. Accounting for the observed cost of the ACA population and aligning the premiums with that cost is another 10 percent. This does not try to recoup past losses. This component just helps get the premiums to adequate levels for 2017.
- These are the primary drivers of our rate increases. The American Academy of Actuaries also identified these three as primary drivers in their May 2016 Issue Brief.

- I also want to point out that consumers have many choices in ACA products, offered by Highmark and other health insurers in Delaware.

- Based on our modeling and the information made publicly available by the Department, our proposed 2017 rates will be competitive in the marketplace when compared to other insurers.

- We understand that a 32.5 percent rate increase is significant. But I want to reemphasize that these rates are what it actually costs to insure the ACA population and to administer these products.

- It is also important that the ACA contains specific consumer protections to insulate members from rates that are too high. The main protection is based on our Medical Loss Ratio, or MLR.

- MLR is the share of premium revenues that an insurer spends on patient care and quality improvement activities, as opposed to administrative expenses and profits.

- Insurers in the small group and individual markets must meet an MLR standard of 80 percent annually, or issue rebates to their members.

- With that said, we understand the challenges that these rate increases may present for our members in Delaware. I hope that I have helped you better understand the necessity of our proposed rates.

- These rates are necessary and actuarially sound, and will help ensure that Highmark Blue Cross Blue Shield Delaware can continue to provide high-quality health coverage for the residents of Delaware.

Karen and Philip Hamilton
31030 Starling Road
Ocean View, DE 19970

June 11, 2016

Delaware Department of Insurance
Attn: Health Rate Public Comments
841 Silver Lake Blvd.
Dover, DE 19904

Dear Sir/Madam:

We are writing to express our concerns about the proposed average 32.5 percent increase in premiums for 2017 Highmark Blue Cross Blue Shield health insurance market place plans for individuals. As you know, this comes on top of a 22 percent increase in these plans in 2016.

By way of background, we moved to Ocean View in Sussex County in early 2013 from a Maryland suburb of Washington, D.C. We are nearing retirement and are self-employed. Because we are not yet 65, and do not have employer-provided health insurance, we need individual health insurance. When we first moved to Delaware, we were able to get a Highmark Blue Cross/Blue Shield plan that covered both of us for $726 per month. It is important to note that in 2013, there were several (five or six) insurance companies offering policies, so there was some competition. We chose the BCBS plan because it was a good one with access to a national network of providers. It had a reasonable deductible of $1800 per person. We had this policy for all of 2013, and after reconsideration by the Delaware Insurance Commissioner, we were able to keep the policy for all of 2014.

Unfortunately, all non-Affordable Care Act (ACA) compliant plans were terminated in Delaware beginning in 2015, and we had no choice but to get an ACA plan beginning January 2015. We were shocked to find just two companies offering market place plans in Delaware – Aetna and Blue Cross. The problem with the Aetna plan was (and still is) that it had a limited network of Delaware –only providers at a cost similar to the BCBS plan that offers access to their national network. As you know, access to doctors, especially specialists, in southern Delaware is a problem. The first six primary care doctors that were referred to us by friends were not accepting new patients. In any event, the least expensive Bronze policy we could find was a BCBS policy with a deductible of $6300 per person, or $12,600 for the two of us that had a significantly increased monthly premium of $983.

For 2016, there are still just two providers for individual health insurance, and our premium increased 22 percent; we are now paying $1,223 per month. This means that we will need to pay out-of-pocket health care expenses (premium and deductible) of **over $27,000 this year**

before we receive a penny in benefits. That would be well over $30,000 in 2017 with the proposed premium increase!

We are fortunate to be in relatively good health and have income just a bit above the cut-off to qualify for a subsidy. However, the current monthly premium of $1223 plus out of pocket costs for health care to date averaging an additional $425 per month is untenable and unaffordable. If BCBS is granted anywhere close to a 32.5% increase in premiums for 2017, we will need to go without coverage or move back to Maryland. This year, I could have saved almost $500 per month for the same Bronze policy simply by moving back to Maryland. (This is particularly frustrating because due to the lack of physicians in our area, we go to Salisbury or Berlin, Maryland for most of our healthcare needs).

We realize that Delaware is a small state with relatively high per capita heath care costs. We also understand that the lack of competition (in fact a near monopoly) with just one viable insurance carrier causes a problem for the Department of Insurance to reign in premium increases. However, there will be no end to the absurd annual premium increases unless the Department of Insurance gets **creative with a proactive strategy to address the problem**.

So what to do? There are many possibilities, all of which require a change in mindset from sitting back and debating the next premium increase. First, there needs to be a recognition that the ACA is based on increasing the number of insured individuals and thereby spreading the underwriting risk for insurance companies. Because the number of market place individual policies in the state is relatively small (11,629 members for BCBS), basing the premiums on the experience with such a limited group goes against the fundamental purpose of the ACA. **Therefore, we strongly urge the Department of Insurance to limit premium increases to the average annual increase for health care costs statewide.**

We realize that protecting Delawareans from exorbitant health insurance premiums poses some risk to insurers pulling out of the state altogether. Therefore, our second recommendation is to **require a company that is licensed to provide health insurance in Delaware to provide policies for all citizens of the state – not just those covered by employer or group plans**. Similarly, a company should not be allowed to withdraw from the state's exchange for individual plans while still providing employer or group plans. Third, Delaware should **seek to establish a regional pact (an alignment with nearby states) to introduce more competition for a much larger pool of insured individuals**. Given the state's predicament, the Delaware Insurance Department should also seek permission to have some flexibility in policies so that individuals could **opt out of coverage for services they do not need or want.** For example, we do not need dental coverage for children and are not of child-bearing age, i.e. do not need maternity coverage. Why are we forced to pay for these services?

Again, we support access to health insurance for all citizens, but unless changes are made to bring more choice and competition for insurance plans in Delaware, the system is going to fail. Middle class folks, gigers and others who are self-employed simply cannot afford it. Healthy individuals that you want to buy insurance will increasingly go without and pay the tax penalty. The result will be an even smaller pool of relatively unhealthy people and an ever-increasing spiral of premium increases. It is time to get the program under control in Delaware!

Sincerely,

Karen Rubin-Hamilton

Philip W. Hamilton

Please sign to lower heatcare!

PETITION TO REJECT PROPOSALS FOR HEALTH INSURANCE RATE INCREASE FOR 2017

RE: PROPOSED HEALTH INSURANCE PREMIUM RATE INCREASE IN DELAWARE: 2017

As Delaware residents, we are concerned and alarmed by Highmark Blue Cross Blue Shield of DE and Aetna's requests for premium rate increase of 32.5%, while Aetna, Inc. requests 25.0% in the individual market. We, the undersigned, feel that the rate increase of 22.4% for Highmark and the rate increase of 16.9% for Aetna for 2016 are enough to sustain both companies' profits for the next five years. We strongly urge the Insurance Commissioner **to reject** any rate increase for Highmark Blue Cross Blue Shield of DE and Aetna.

NAME	ADDRESS
Kitty Carver	307 Persimmon Cir. W. Dover DE. 19901
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Marie Lewis	4201 Westville Rd Wyoming, DE 19934
James M. Babel	788 Wagga Dr Dover, Del 19904
Esther Brown	707 River Rd Dover Del
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Donald W. Wesner	
Shirley Brogan	50 Lost Tree Ct.
Cecilia Gonzalez	735 Sorrell Circle Smyrna, De 19977
Annie Hodges	
Carla D'Blente	

Joseph E. [illegible] (signature)	Jeani Long
430 Kings Hwy.	4614-B Maine Dr.
BLDG 3 APT. 3006	Dover, DE 19901
Dover, DE, 19901	

PETITION TO REJECT PROPOSALS FOR HEALTH INSURANCE RATE INCREASE FOR 2017

RE: PROPOSED HEALTH INSURANCE PREMIUM RATE INCREASE IN DELAWARE: 2017

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[illegible]	118 Beech Drive, Dover, DE
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Juan Hines	51 Webbs Ln B4 Apt.
Charles A. Dupree	Charles A. Dupree general delivery
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Juanita Bynum	7087 N. West Street Dover, DE 19904
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Wallace Wright	101 Babb Dr 19901

Apt 1203

Gary Warren	1117 Houston Dr. - 19966
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Mary Ann Simmons	74 Fairmont Lane, Dover, DE. 19904
Terry Simmons	Same as above
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[illegible] Lyons	1145 Clayton Greenspring Rd Smyrna DE 19977
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Annie Lewis	40 Jacquita Ct Smyrna DE 19977
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[illegible]	37 Emerson Dr Dover DE
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Veronica Brenson	136 Maple Glen Dr. Dover 19904

Myriam Ramos	197 Cardinal Hill Rd Dover, 19904
Shirley Mayhew	114 Burning Tree Rd Dover
Betty J Smith	129 Delshire Dr Dover
Rosalie Phillips	97 Deer Path Lane Smyrna
LeRoy Phillips	" " " "
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Jacqueline S-Ruff	412 W. Carnastie Rd Dover DE 19904
Nejwa Whaley	310 David Hall Rd
Rose Barlow	115. S. New ST Dover DE

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State of Delaware
Delaware Commission for Women
Department of State

"Advocacy, Leadership & Resources"

POSITION STATEMENT: PROPOSED HEALTH INSURANCE

PREMIUM RATE INCREASE IN DELAWARE: 2017

DE COMMISSION FOR WOMEN

June 21, 2016

Position Statement: The Delaware Commission for Women (DCW) is committed to the development and sustainability of a robust and competitive health insurance markets in Delaware that guarantee universal health care to all Delaware residents. We are particularly concerned about healthcare disparities for Delaware women. Cost for care is a core factor in accessing and maintaining good health care. It is therefore incumbent on the government to expand access to quality and affordable health care to safeguard and ensure that families and individuals are able to purchase health insurance that is affordable, available and meets the needs and requirements of the citizens of Delaware. We strongly urge the Insurance Commissioner to reject any and all forms of rate increase in 2017. Outlined below are the fundamental reasons why we oppose any increase:

- **Lack of Availability and Affordability**
  - ✓ Currently, Highmark controls 94%, while Aetna has 6% of the private health insurance marketplace. Monopoly encourages profit making and limits healthy competition.
  - ✓ Highmark/BCBS is apparently structured as a non-profit? What does this mean in terms of tax burden for the company? How does it benefit the state/citizens of Delaware?
- **High Health Care Premium Increase in Delaware for 2016**
  - ✓ The average approved rate increase for 2016 for Highmark's individual market is **22.4%** compared with 12.7% for the small group market. For Aetna, it is **16.9%** for the individual market, compared with -0.5% for small group market.

- ✓ The Insurance Commissioner has the authority to approve requested rate increases above 10% through the rate review process the intent of which is to protect consumers from unreasonable rate increases, such as the massive rates that had just been approved.

- **Lack of Choice**
  - ✓ Affordable and accessible health care is a basic human right. How can we expand access to quality, affordable health care if the insurance rates are constantly increasing? What percentage of an individual or a family's income is spent on health care premiums? We request the Department of Insurance to actively research this key issue. It could provide the Insurance Commissioner with critical data in implementing a more systematic and fair process for the rate review of insurance companies' proposed health care increase.

Conclusion: The DE Commission for Women advocates and supports health care reforms that guarantee access to high-quality and affordable healthcare for all. The apparent lack of affordable and available health care for residents is a violation of their basic human rights. Double-digit increases over the past two years have the effect of forcing Delaware residents to spend thousands of dollars and/or substantially reduce or eliminate coverage. It is in direct opposition to the spirit of the law (Affordable Care Act) that guarantees protection against losing or being denied health insurance coverage and better access to primary and preventive services. We, the Commissioners of the DE Commission for Women, strongly urge the Insurance Commissioner **to reject** any and all forms of health care rate increase in 2017.