CITIZEN POWER

Public Policy Research Education and Advocacy

July 1, 2015

James Laverty, Actuary
Insurance Department, Insurance Product Regulation
1345 Strawberry Square
Harrisburg, PA 17120

Re: ACA Related Filings for Proposed Rate Increases

Dear Mr. Laverty,

Enclosed for filing with the Pennsylvania Insurance Department on behalf of Citizen Power, Inc. are its Comments regarding the Proposed Rate Increases of Highmark Inc. (HGHM-130061378) for the Individual ACA Product Portfolio in the Western Pennsylvania Regions, Highmark Inc. (HGHM-130064391) for the Small Group ACA Product Portfolio in the Western Pennsylvania Regions, and HM Health Insurance Company (HGHM-130061791) for the Individual ACA Product Portfolio in Central and Western Pennsylvania Regions.

Sincerely,

/s/ Theodore S. Robinson
Theodore Robinson
Counsel for Citizen Power

Enclosures

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COMMENTS OF CITIZEN POWER, INC.

I. Introduction

Citizen Power provides these comments to the Pennsylvania Insurance Department ("PID") and the Centers for Medicare and Medicaid Services ("CMS") in response to the Proposed Rate Increases of Highmark Inc. (HGHM-130061378) for the Individual ACA Product Portfolio in the Western Pennsylvania Regions, Highmark Inc. (HGHM-130064391) for the Small Group ACA Product Portfolio in the Western Pennsylvania Regions, and HM Health Insurance Company (HGHM-130061791) for the Individual ACA Product Portfolio in Central and Western Pennsylvania Regions. All three of these product portfolios request rate increases of over 10%, are seeking certification as Qualified Health Plans ("QHPs") in order to be eligible to be placed on the 2016 Exchange, and are requesting increases that will impact consumers in Western Pennsylvania. These comments are being submitted in response to the invitations to submit comments found on the PID's ACA Related Filings webpage and the Center for Consumer Information and Insurance Oversight's Rate Review Data webpage.[1]

As a preliminary matter, Citizen Power will be addressing their comments regarding the two separate review processes applicable to these requested rate increases. The first review process is found at 45 CFR Part 154 and applies to all non-grandfathered individual and small group market rate changes that are subject to review under the standards stated in 45 CFR 154.200. The second review process is the Exchange's certification of QHPs under the standards of 45 CFR Part 155, Subpart K and is limited to determining whether a health plan should be allowed to participate on the Exchange. The 45 CFR Part 155, Subpart K Certification Process

[1]http://www.portal.state.pa.us/portal/server.pt/community/industry_activity/9276/aca-related_filings/1864901 and http://www.cms.gov/CCIIO/Resources/Data-Resources/ratereview.html.

addresses proposed rates both through the requirement under 45 CFR 155.1020(a) that a QHP issuer submit a rate justification for proposed rate increases as well as the obligation under 45 CFR 155.1000(c)(2) that the Exchange make an affirmative determination that making a health plan available to participate on the Exchange is in the interest of the qualified individuals and qualified employers. It should be noted that 45 CFR 155.1020(b) requires that the Exchange consider the recommendations provided to the Exchange from the State under section 2794(b)(1)(B) of the Public Health Service Act as a factor in determining whether to certify a QHP.

II. 45 CFR Part 154 Review Process

Pennsylvania has been determined to have an Effective Rate Review Program under 45 CFR 154.210(b). CMS will accept the determination of the PID regarding whether a rate increase is acceptable as long as the PID provides to CMS a final determination of whether a rate increase is unreasonable using the factors found in 45 CFR 154.301(a)(3).

The rate review process begins with a health insurance issuer submitting to CMS and the PID a Rate Filing Justification for any product subject to a rate increase.[2] The Rate Filing Justification is composed of three parts: Part I - the Unified Rate Review Template, Part II - a written description justifying the rate increase, and Part III - rate filing documentation which includes an actuarial memorandum that contains the reasoning and assumptions supporting the data contained in the unified rate review template. The Rate Filing Justification, along with public comments regarding the rate filing, are what the PID uses to determine whether a rate increase is justified.

[2] 45 CFR 154.215(a).

CMS is required to post the entirety of Part II on the CMS website along with redacted versions of Part I and Part III and a description of how the public can post comments regarding proposed rate increases.[3] Similarly, all states with an Effective Rate Review Program (such as Pennsylvania) "must provide, for the rate increases it reviews, access from its Web site to at least the information contained in Parts I, II, and III of the Rate Filing Justification that CMS makes available on its Web site (or provide CMS's Web address for such information) and have a mechanism for receiving public comments on those proposed rate increases."[4] It is clear that the intent of the regulations is to give the public the ability to intelligently comment on proposed rate increases by allowing them access to the public information contained in the Rate Filing Justification.

However, the Rate Filing Justification information available to the public for the 2016 Highmark Health Insurance Company ("HM Health Insurance Company") individual products 70194PA019, 70194PA016, 70194PA046, 70194PA018, 70194PA017, 70194PA013, 70194PA015, 70194PA014, and 70194PA047; the 2016 Highmark Inc. ("Highmark") small group products 33709PA048 and 33709PA064; and the 2016 Highmark individual products 33709PA040, 33709PA042, 33709PA038, 33709PA039, 33709PA059, and 33709PA060 was incomplete.[5] Specifically, the Part I United Rate Review Template was not available on either the CMS or PID website, the Part II written description did not meet the standards outlined in the *2016 Unified Rate Review Instructions*, and the Part III rate filing documentation was unnecessarily redacted. Citizen Power avers that without a complete set of information regarding

[3] 45 CFR 154.215(h).
[4] 45 CFR 154.301(b).
[5] These products correspond to the PID tracking numbers HGHM-130061378, HGHM-130064391, and HGHM-130061791. It is difficult to match products from the CMS website to the PID website due to the absence of consistent taxonomy.

the proposed rate increases, the ability to provide meaningful commentary regarding any specific proposed rate increases is limited.

First of all, the United Rate Review Templates for 2016 products are not available on the CMS website. There is a Public Use File (PUF) of single risk pool compliant Preliminary Justification Part I Submissions available at http://www.cms.gov/CCIIO/Resources/Data-Resources/ratereview.html. However, this information is only available for the 2014 and 2015 rate filings, which is of very limited usefulness to members of the public commenting on the proposed 2016 rate increases. Furthermore, the information is in two very large Excel files with thousands of rows and dozens of columns, which makes it difficult to navigate without having more than a passing familiarity with Excel. From a consumer standpoint, it would be easier to access the information if it was either provided in a searchable database or if the actual Part I submission was directly provided as a PDF file.

Second, the summaries provided by Highmark and HM Health Insurance Company did not adequately cover the components outlined by CMS in their *2016 Unified Rate Review Instructions* ("Instructions").[6] The purpose of Part II is "to provide context for the quantitative information provided in Part I."[7] However, without Part I being provided by CMS, it is difficult for the summary to accomplish this goal. Even ignoring the fact that Part II is supposed to be a companion piece to Part I, the summaries themselves have a scarcity of useful information. The Instructions state that the summary should address the scope and range of the rate increase, the financial experience of the product, the changes in medical service costs, the changes in benefits, and the administrative costs and anticipated profits. Although the summaries did address many of these aspects of the proposed rate increase, they did not do so with the specificity required by

[6] Centers for Medicare & Medicaid Services, *2016 Unified Rate Review Instructions, Rate Filing Justification: Parts I, II, and III*, pg. 47, current as of 2/21/15.
[7] Id.

the Instructions. For example, although all three product portfolios stated the range of the increase for the products in their summaries, they did not go further and "explain any variation in the increase among affected individuals." Similarly, the summaries are supposed to "describe any changes in benefits and explain how benefit changes affect the rate increase." Highmark's small group market product simply stated in their written description that "some plan designs required benefit changes to remain within the ACA law's metal level requirements of platinum, gold, silver, and bronze." The written descriptions did not provide "historical summary-level information on historical premium revenue, claims expenses, and profit." The "main drivers of changes in administrative costs" were also not identified. In summary, the written descriptions provided by Highmark and HM Health Insurance Company do not comply with what are required by CMS. Citizen Power recommends that CMS and the PID review all written descriptions to make sure they are in compliance with the guidelines provided in the *2016 Unified Rate Review Instructions*.

Third, the information contained in Part III was extensively redacted to the point that it is impossible for the public to provide meaningful commentary regarding large sections of the submission. In addition, many of the sections of the rate filing documentation refer back to Part I, which was not provided to the public. The guidelines used by HHS are contained at 45 CFR 5.65 and allow for the withholding of trade secrets, commercial information, and financial information that is obtained from a person and is privileged or confidential. Some of the information that one would assume that is in the unredacted version could arguably be comprised of confidential financial records. However, the fact that the Part I information is provided in detail (albeit for prior years) casts doubt regarding the necessity of redacting any information provided in Part III. If better financial information was provided, it would have been possible to

comment on trend and projected expenses. Even if this limited amount of information was properly redacted, there is information that is not provided that should be included in the Actuarial Memorandum because it is not confidential information. One example would be that the Actuarial Memorandum does not list the products that are being offered at each metal level along with cost sharing information. Citizen Power recommends that CMS examine each rate filing to determine whether the information redacted meets the standards under 45 CFR 5.65.

III. 45 CFR Part 155, Subpart K Certification Process

The 45 CFR Part 155, Subpart K Certification Process requires that any proposed rate increases are accompanied by a rate justification, that this rate justification is considered by CMS in the certification process, and that the Exchange makes an affirmative determination that allowing the plan to participate on the Exchange is in the interest of the qualified individuals and qualified employers.[8] The rate filing justification required by 45 CFR 155.1020(a) is not necessarily limited to the same information provided by the QHP issuer under the 45 CFR 154 review process. An Exchange has the flexibility to request more in-depth information regarding the QHP issuer's justification for a requested rate increase. This justification must be posted "prominently" on both the QHP issuer's website as well as the website operated by the Exchange.[9]

It is unclear whether either the PID or CMS requested additional information under 45 CFR 155.1020(a) to conduct the 45 CFR 155.1020(b) review. If additional information was required it should have been posted to both the QHP issuer's and CMS's website. In addition, the Rate Filing Justification, if submitted as part of 45 CFR 155.1020(a), should have been posted on

[8] 45 CFR 155.1020(a), 45 CFR 155.1020(b), and 45 CFR 155.1000(c)(2).
[9] 45 CFR 155.1020(a).

both the QHP issuer's and CMS's websites. As noted above, a complete record of the Rate Filing Justification was not available on the websites of the QHP issuer, CMS, or the PID.

Many commenters to the proposed regulations at 45 CFR 155.1020 expressed support for enhanced public notification of rate increase justifications. In response, it was noted that "nothing in this final rule would preclude an Exchange from separately posting an issuer's justification or otherwise informing consumers about rate increase justifications, as suggested by commenters."[10] The proposed rate increases by Highmark and the HM Health Insurance Company are significant and will impact current customers in Western Pennsylvania. Citizen Power recommends that the PID or CMS alert current customers of Highmark and HM Health Insurance Company through the mail of all Exchange rate increases above 10%, providing a one page notice of the rate increase along with information regarding shopping on the Exchange, the Rate Filing Justification Part II summary, and the website location of Part I and Part III. Although consumers will be alerted to the rate increases through mailings from the QHP, we believe that customers are already inundated with required notices from the QHP and therefore may overlook a notice regarding rate increases. In our opinion, a notice that comes directly from a governmental agency is more likely to be noticed and read by a consumer.

There is an additional requirement, found at 45 CFR 155.1000(c)(2), that the Exchange must determine whether it would be in the interest of qualified individuals and qualified employers if a particular plan is allowed to participate in the Exchange. Although this requirement can potentially encompass a wide range of concerns regarding a plan, including the quality of care plan members are receiving or the similarity between plans potentially available on the Exchange, one part of this interest standard must be whether the proposed premiums are in the interest of qualified individuals and employers. Therefore, plans must be analyzed to

[10] 77 Fed. Reg. 18,407 (March 27, 2012).

determine whether their inclusion in the Exchange is a benefit for qualified individuals from a macro perspective. It is conceivable that a plan's proposed rates are justifiable from an actuarial standpoint, but offering that plan into the Exchange would not be in the interest of qualified individuals and qualified employers because of the impact including that plan would have on the Exchange marketplace.

As an example, during the 2014 coverage year, many of the Exchange's geographic rating areas in Western Pennsylvania had two very similar Highmark Community Blue plans available in the Silver category. Since the amount of subsidy that an individual receives from the government under the ACA is based upon the second least expensive policy available in the Silver category, the existence of two inexpensive policies had a major impact on Pennsylvania's subsidies. It could be argued that the existence of the second Community Blue plan was not in the interest of consumers under 45 CFR 155.1000(c)(2) because of the negative impact on subsidies as explained in the next several paragraphs; and it should not have been certified by the Exchange.

One of the central tenets of the ACA is that healthcare policies in the Exchange should be affordable. In order to make premiums affordable, the ACA provides subsidies to consumers shopping in an Exchange in the form of premium credits, which are tax credits that can be used either in advance to defray premium costs or credited at the end of the year on the consumer's tax return. The value of these credits is the difference between what health insurance premiums cost and what the consumer should be able to afford. For example, if an individual could afford $200 a month to pay for insurance premiums and health care premiums cost $300 a month in the Exchange, s/he would receive a tax credit of $100 a month which s/he could either use towards their monthly premium or apply at the end of the year towards their tax return.

The ACA has very specific rules to determine what consumers should be able to afford in premiums. For those that live in households between 100 and 400% of the Federal Poverty Level (FPL), the ACA sets what a consumer should be able to afford on a formula that slides between 2% and 9.5% of income. The greater the income (as a percentage of the FPL) the greater the percentage the consumer is expected to pay toward their monthly premium. Consumers below 100% of the FPL are not eligible for premium credits because it was anticipated that they would be eligible for Medicaid. However, the Supreme Court made expanded Medicaid optional for the states, which has created a situation where low-income consumers may not qualify for Medicaid and are also not eligible for premium credits. Consumers in households with income greater than 400% of the FPL are also not eligible for premium credits. As an example, under the ACA the following are considered affordable premiums:

Chart 1: Affordable Premiums by Income

Household Size	Household Income	Household Income as a % of the FPL	Affordable Yearly Premium	Affordable Monthly Premium
1	$10,000	87%	N/a – below 100% threshold	N/a
1	$15,000	131%	2% of income	$25
1	$20,000	174%	5.1% of income	$85
1	$25,000	218%	6.9% of income	$144
1	$30,000	261%	8.4% of income	$210
1	$40,000	348%	9.5% of income	$317
1	$50,000	435%	N/a – over 400% threshold	N/a

The credit pays for the monthly cost of the insurance premium above the affordable monthly premium for a customer. However, they will not pay this difference for all insurance policies because some policies are more expensive than others. The ACA was not set up to make expensive insurance affordable, but was established to make regular insurance affordable. As mentioned earlier, in order to determine the quality of insurance in an Exchange, the ACA set up four different categories based upon the average amount of out-of-pocket costs that the consumer

should expect to pay for any claims: Platinum, Gold, Silver, and Bronze. The expected out-of-pocket costs for Platinum policies is 10%, for Gold is 20%, for Silver is 30%, and for Bronze is 40%. For example, a consumer who has a Gold plan will on average pay $20 in co-pays, co-insurance, and deductibles for every $100 in claims. In order to determine the premium credit, the benchmark used is the second cheapest monthly premium Silver plan available on the Exchange. For example, in Allegheny County, a sixty year old individual had the option to buy 13 different Silver plans on the Exchange for 2014, ranging in price from $347-$655 per month. The second least expensive of these plans set the benchmark and had a premium of $361 per month. Therefore, for the following income levels, a sixty year old individual would have received the following premium credit:

Chart 2: Monthly Premium Credit for a 60 Year Old Individual

Household Size	Household Income	Household Income as a % of the FPL	Affordable Yearly Premium	Affordable Monthly Premium	Monthly Premium Credit
1	$10,000	87%	N/a – below 100% threshold	N/a	N/a
1	$15,000	131%	2% of income	$25	$336
1	$20,000	174%	5.1% of income	$85	$276
1	$25,000	218%	6.9% of income	$144	$217
1	$30,000	261%	8.4% of income	$210	$151
1	$40,000	348%	9.5% of income	$317	$44
1	$50,000	435%	N/a – over 400%	N/a	N/a

The cost of the monthly premium for each plan changes depending upon the age of the individual. If the person mentioned above was thirty years old, the premiums for Silver plans would range from $145-$274 per month. The second least expensive of these plans sets the benchmark and has a premium of $151. The thirty year old would receive the following premium credit:

Chart 3: Monthly Premium Credit for a 30 Year Old Individual

Household Size	Household Income	Household Income as a % of the FPL	Affordable Yearly Premium	Affordable Monthly Premium	Monthly Premium Credit
1	$10,000	87%	N/a – below 100% threshold	N/a	N/a
1	$15,000	131%	2% of income	$25	$126
1	$20,000	174%	5.1% of income	$85	$66
1	$25,000	218%	6.9% of income	$144	$7
1	$30,000	261%	8.4% of income	$210	$0
1	$40,000	348%	9.5% of income	$317	$0
1	$50,000	435%	N/a – over 400%	N/a	N/a

Since the premium credit is based upon what the cost of insurance is for a consumer (based on the cost of the second cheapest Silver plan) minus what is affordable for a consumer (based on income), the available premium credit is highly dependent upon which policies are offered into the Exchange, and most specifically the premium of the second cheapest Silver plan. For the 2014 coverage year in Allegheny County, Highmark offered two similar "Community Blue" plans (Health Savings Blue PPO 2750 and Shared Cost Blue PPO 2650) into the Exchange at the Silver level at a much lower price than any other policy. These plans had limited access to UPMC facilities. For a sixty year old individual, the Community Blue plans had premiums of $347 and $361, while the eleven other plans ranged in cost from $501-$655. If Highmark had offered only one of the Community Blue plans into the Silver exchange, the benchmark plan premium would have increased from $361 to $501, resulting in higher monthly premium credits:

Chart 4: Monthly Premium Credit Increase for a 60 Year Old Individual if only One Community Blue Plan Offered into the Exchange

HH Size	Household Income	Household Income as a % of the FPL	Affordable Yearly Premium	Affordable Monthly Premium	Monthly Premium Credit	**Monthly Premium Credit Increase**
1	$10,000	87%	N/a – below 100% threshold	N/a	N/a	**N/a**
1	$15,000	131%	2% of income	$25	$476	**$140**
1	$20,000	174%	5.1% of income	$85	$416	**$140**
1	$25,000	218%	6.9% of income	$144	$357	**$140**
1	$30,000	261%	8.4% of income	$210	$291	**$140**
1	$40,000	348%	9.5% of income	$317	$184	**$140**
1	$50,000	435%	N/a – over 400% threshold	N/a	N/a	**N/a**

Similarly, for a thirty year old individual, if only one Community Blue plan had been offered into the Silver Exchange, the benchmark premium would have been $210 and there would be an increase in the monthly premium credits:

Chart 5: Monthly Premium Credit Increase for a 30 Year Old Individual if only One Community Blue Plan Offered into the Exchange

HH Size	Household Income	Household Income as a % of the FPL	Affordable Yearly Premium	Affordable Monthly Premium	Monthly Premium Credit	**Monthly Premium Credit Increase**
1	$10,000	87%	N/a – below 100% threshold	N/a	N/a	**N/a**
1	$15,000	131%	2% of income	$25	$185	**$59**
1	$20,000	174%	5.1% of income	$85	$125	**$59**
1	$25,000	218%	6.9% of income	$144	$66	**$59**
1	$30,000	261%	8.4% of income	$210	$0	**$0**
1	$40,000	348%	9.5% of income	$317	$0	**$0**
1	$50,000	435%	N/a – over 400% threshold	N/a	N/a	**N/a**

The impact of two Community Blue offerings in the Silver Exchange reduced the benchmark premium impacts to consumers whether they chose Community Blue or another product. For instance, these were the costs for a sixty year old individual to purchase the cheapest Silver Community Blue offering versus the cheapest Silver offering that includes UPMC facilities:

Chart 6: Differences in Premiums for Community Blue Product and Highmark Plan for a 60 Year Old Individual

HH Size	HH Income	Affordable Monthly Premium	With 2 Community Blue Plans - $361 Benchmark			With 1 Community Blue Plan – $501 Benchmark		
			Monthly Credit	Net Cost of $347 CB Plan	Net Cost of $501 Highmark Plan	Monthly Credit	Net Cost of $347 CB Plan	Net Cost of $501 Highmark Plan
1	$10,000	N/a	N/a	$347	$501	N/a	$347	$501
1	$15,000	$25	$336	$11	$165	$476	-$129	$25
1	$20,000	$85	$276	$71	$225	$416	-$69	$85
1	$25,000	$144	$217	$130	$284	$357	-$10	$144
1	$30,000	$210	$151	$196	$350	$291	$56	$210
1	$40,000	$317	$44	$303	$457	$184	$163	$317
1	$50,000	N/a	N/a	$347	$501	N/a	$347	$501

It should be noted that a negative net cost is not refunded to the consumer. However, the consumer can use a negative monthly balance to pay for supplemental insurance such as vision or dental.

Applying the same analysis as above to a thirty year old individual yields the following:

Chart 7: Differences in Premiums for Community Blue Product and Highmark Plan for a 30 Year Old Individual

HH Size	HH Income	Affordable Monthly Premium	With 2 Community Blue Plans - $151 Benchmark			With 1 Community Blue Plan – $210Benchmark		
			Monthly Credit	Net Cost of $145 CB Plan	Net Cost of $210 Highmark Plan	Monthly Credit	Net Cost of $145 CB Plan	Net Cost of $210 Highmark Plan
1	$10,000	N/a	N/a	$145	$210	N/a	$145	$210
1	$15,000	$25	$126	$19	$84	$185	-$40	$25
1	$20,000	$85	$66	$79	$144	$125	$20	$85
1	$25,000	$144	$7	$138	$203	$66	$79	$144
1	$30,000	$210	$0	$145	$210	$0	$145	$210
1	$40,000	$317	$0	$145	$210	$0	$145	$210
1	$50,000	N/a	N/a	$145	$210	N/a	$145	$210

Based on the potential for subsidy impacts, the PID and the Exchange should examine the effect that allowing a specific plan to participate in the Exchange would have upon the premium

subsidies that are available to individuals through the Exchange. Citizen Power recommends that for every plan that would impact the premium subsidies in an Exchange, e.g. any plan whose introduction into an Exchange would alter which plan is the second least expensive silver plan, the State and the Exchange should estimate the total impact on community subsidies and weigh that against the benefit of that particular plan being offered into the Exchange. In determining this benefit, consideration should be given to alternative plans that are also available on the Exchange that an individual could choose, including plans at other metallic levels. In some cases, not certifying a particular plan would increase some individuals' subsidies to the point where similar gold plans would become as affordable as silver plans.

IV. Recommendations

Citizen Power appreciates the opportunity to comment on the Proposed Rate Increases of Highmark Inc. (HGHM-130061378) for the Individual ACA Product Portfolio in the Western Pennsylvania Regions, Highmark Inc. (HGHM-130064391) for the Small Group ACA Product Portfolio in the Western Pennsylvania Regions, and HM Health Insurance Company (HGHM-130061791) for the Individual ACA Product Portfolio in Central and Western Pennsylvania Regions.

Citizen Power has the following recommendations regarding the PID and CMS rate review process. Many of these recommendations are generally applicable to all Exchange products and are not limited to the submissions of Highmark and HM Health Insurance Company. Although, as described above, we believe that the information available to the general public regarding these rate increases was insufficient; we also believe that these submissions are typical of those available on CMS's and the PID websites. Therefore, even though our comments

are aimed at the Highmark and HM Health Insurance submissions, they can be generally applied to the 45 CFR Part 154 review and the 45 CFR Part 155, Subpart K Certification Process.

First, the CMS and PID should agree on a consistent terminology regarding the labeling of products. The use of a consistent tracking number for specific plans would make it easier for the public to locate all documents relating to that plan. Second, the information in Part I of the Rate Filing Justification should be current and a copy of the version submitted by the insurer or a searchable database should be made available to consumers. Third, although CMS does not edit the statements provided by issuers for Part II, they should review the provided statements to make sure they are compatible with the standards outline in the *Unified Rate Review Instructions*. Fourth, the CMS should actively analyze both the confidential and redacted versions of Part III of the Rate Filing Justification to determine whether HHS's Freedom of Information Act regulations at 45 CFR 5.65 are being properly applied. Fifth, some of the proposed rate increases are rather substantial. We believe that a mailed notice from a governmental agency for rate increases over 10% would better alert policyholders to potential rate increases. Sixth, an analysis of whether including a particular plan in the Exhchange is in the interest of qualified individuals is required under 45 CFR 155.1000(c)(2). Such analysis should be made public and posted on both the PID and CMS websites. Seventh, the PID should hold a stakeholder process concerning the yearly submittal of ACA related products. Finally, the CMS and PID should release the relevant records related to the 2016 Highmark Health Insurance Company ("HM Health Insurance Company") individual products 70194PA019, 70194PA016, 70194PA046, 70194PA018, 70194PA017, 70194PA013, 70194PA015, 70194PA014, and 70194PA047; the 2016 Highmark Inc. ("Highmark") small group products 33709PA048 and 33709PA064; and the 2016 Highmark individual products 33709PA040, 33709PA042,

33709PA038, 33709PA039, 33709PA059, and 33709PA060. The public should then have an additional two weeks to comment on these proposed rate increases.

Respectfully Submitted,

/s/ Theodore S. Robinson___
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