STATE OF RHODE ISLAND
OFFICE OF THE HEALTH INSURANCE COMMISSIONER

In Re:	Neighborhood Health Plan of Rhode Island	)	
	Rates Filed for 2026 Individual Market Plans	)	OHIC-RH-2025-2

OHIC Post-Hearing Memorandum

Introduction

The Office of the Health Insurance Commissioner ("Office" or "OHIC") hereby files its Post-Hearing Memorandum ("Memorandum") in the above captioned matter in support of OHIC's recommendations for modifications to the rates requested by Neighborhood Health Plan of Rhode Island ("Neighborhood" or "NHPRI") for their CY 2026 Individual Market plans. The Memorandum will discuss the law applicable to this proceeding, identify the issues in dispute and analyze the evidence and the law relevant to the disputed issues.

On May 19, 2025, Neighborhood filed its health insurance rate request in the Individual Market for calendar year 2026 ("Rate Request" or "Rate Filing") requesting a weighted average premium increase of 21.2% for its 2026 plans in the Individual Market.

For the reasons set forth below, the Office submits to the Health Insurance Commissioner for the State of Rhode Island (the "Commissioner") that Neighborhood has failed to prove that its Rate Request is consistent with the proper conduct of its business and with the interest of the public. Instead, the evidence supports a finding that a lower weighted average premium increase is more consistent with the proper conduct of Neighborhood's business and the best interest of the public. If OHIC's recommendations are adopted OHIC estimates this will result in an

approximate 4.6% reduction from the Rate Filing's proposed weighted average premium increase to a weighted average premium increase of approximately 15.60%.[1] See Brown TR II at 3-5. The Office notes that, because it does not have access to Neighborhood's pricing models, the ultimate percentage rate increase resulting from the adoption of one or more of the Office's recommendations will likely vary somewhat from OHIC's estimates contained herein.[2] Moreover, while not making a recommendation in favor of or against, OHIC is providing the Commissioner with information relevant to Neighborhood's requested 6% contribution to reserves if the Commissioner in his discretion determines a modification to be appropriate. Table 1 below contains a summary of the approximate rate impacts of the Office's various recommendations for alternative assumptions and the two topics the Office is presenting information on for the Commissioner's discretion.

[1] In the context of this administrative hearing matter, the weighted average rate increase (also alternatively referred to as the "weighted average premium increase" or the "overall average-rate increase") the parties refer to and that the Rate Filing reflects, refers to the Calibrated Plan Adjusted Index Rate (CPAIR) average increase. Brown TR I at 187. The CPAIR reflects the average base rate across all plans prior to the adjustments for age. The weighted average is calculated using the most recent membership enrollment by plan offering. Ultimately, each individual market enrollee's rate is equal to the CPAIR for the plan offering they are enrolled in multiplied by the enrollee's age factor or age adjustment factor (the age factors are federally prescribed). OHIC Exhibit 1 at 6.

[2] At the Hearing, Ms. Brown noted that some of OHIC's recommendations of alternative assumptions could result in somewhat different impacts to Neighborhood's proposed 21.2% rate increase when run through Neighborhood's internal rate development model. See e.g., Brown TR I at 5-6, 185, 263; Brown TR II at 4 and 6. An example of this can be found in Ms. Robb's testimony stating, *"so overall when we evaluated all of OHIC's recommended utilization changes, including pharmacy, which we'll discuss later, our pricing model showed a reduction of 2.3% to the rate increase compared to OHIC's estimate of 1.7%."* Robb TR I at 45. This fact is neither surprising to, nor contested by OHIC, given that OHIC does not have access to Milliman's pricing model and must instead provide the Commissioner with its educated approximation of the impact each of its recommendations will have on the rate request. See Brown TR II at 6.

Travel

Neighborhood filed its Rate Request on May 19, 2025 ("Rate Request" or "Rate Filing"). Neighborhood Exhibits 1 and 2, OHIC Exhibits 2, 4-8. The Rate Filing requested a weighted average CPAIR rate of $375.05, which represents a weighted average premium increase of 21.2% for 2026 plans in the Individual Market.[3] Neighborhood Exhibit 1; Neighborhood Exhibit 2 at Rate Template Tab V; OHIC Exhibit 5, Rate Template Tab V.

The primary drivers of the 21.2% weighted average premium increase set forth in the Rate Filing were identified by Neighborhood as: the *"anticipated changes in enrollment in 2026 due to enhanced premium tax credits ending,*[4] *increasing medical costs on paid claims for our members resulting in an approximate 9.0% medical/prescription drug annual trend assumption. Components of this trend also include increases in unit costs of medical services due to inflation, increased medical utilization, increases in specialty drug expenses, technology advances in medicine, equipment and drugs, changes in network provider contracts, and other factors."* Neighborhood Exhibit 1 at 69 (Consumer Narrative Justification). OHIC identified the major drivers of Neighborhood's proposed rate change as *"the most significant drivers are the medical cost trend at 2.3%, pharmacy trend at 4.5%, risk adjustment at 2.0%, and the increase in the contribution to reserve at 4.2%."* OHIC Exhibit 1 at 9; Rate Template at Tab V at OHIC Exhibit 5; See also Brown TR I at 189-190.

[3] For Calendar Year 2025, the weighted average CPAIR PMPM was $309.54. Neighborhood Exhibit 2, Rate Template Tab V; OHIC Exhibit 5, Rate Template Tab V.

[4] Specifically, Neighborhood had just over 36 thousand members in March of 2025 and they are projecting to have just under 28 thousand members for 2026 as a result of the expiration of the EPTCs. Robb TR I at 100; Brown TR I at 188.

Insurers, including Neighborhood, were also required to file an alternative rate filing for Calendar Year 2026 rates that assumed the Enhanced Premium Tax Credits (EPTC), set to expire at the end of 2025, instead continue intact through 2026. Robb TR I at 20.[5] Because the federal government has chosen not to extend the EPTCs, this alternative rate filing is not the subject of this rate hearing. Nonetheless, it remains informative as to the sizeable impact the expiration of the EPTCs will have on health insurance rates beginning in 2026.[6]

Neighborhood indicated they *"expect to see the largest impact in the market due to the EPTCs [expiring], because Neighborhood has the largest portion of members on the exchange receiving the EPTCs . . . at the time of filing, membership was 33 thousand members, and of those, 88 percent receive EPTCs. . . as of today, that is up to 92 percent received EPTCs,"* and highlighted *"the members staying are sicker than average and the healthier ones are leaving. And so that's why we expect morbidity increase in the market."* Robb TR I at 22-23. This alternative rate filing demonstrates that, had the EPTCs remained intact through the end of 2026, Neighborhood would have instead sought a rate increase of 16.3%, a difference of 5%. Robb TR

[5] References herein to TR I and TR II refer to the transcripts of the first and second day, respectively, of the Public Rate Hearing. OHIC notes that the electronically assigned page numbers of the electronic files of these documents are one page ahead of the transcript's page numbers.

In a few sections of the transcripts, testimony has not been transcribed correctly. In most instances the error is immaterial. However, on occasion the error may be material. For example, at page 19-20 of Brown TR II Ms. Brown's testimony is transcribed as *"I do think it is appropriate to blend PMPM trends and utilization trends."* OHIC represents this is transcribed in error, as is apparent from the context of that particular line and Ms. Brown's overall testimony. OHIC represents that Ms. Brown responded in the negative. OHIC asks that the Commissioner be aware of this fact as he is considering and weighing the evidence.

[6] See also Robb TR I at 20-24. More detail about the anticipated impact to Rhode Islanders because of the expiration of the EPTCs, including a projected loss of around 11,300 HSRI individual market enrollments between 2024 and 2027, can be found in the report *Coverage at Risk: State Actions to Keep Rhode Islanders Covered (Key findings and recommendations of the Marketplace Coverage Affordability Work Group)*. AG Exhibit 14.

I at 24; Brown TR I at 186; see also Robb TR I at 25-26 (attributing approximately 5.6% of its rate request to the EPTCs ending). The Neighborhood Alternative Rate Filing can be found at OHIC Exhibits 9 and 11-15.[7]

The Office has established standards and procedures relating to ex parte communications to ensure compliance with the requirements of Arnold v. Lebel, 941 A2d 813 (R.I. 2007) and with the requirements of R.I. Gen. Laws § 42-35-9(g). On or about May 19, 2025, the Office circulated a memorandum among OHIC staff and other relevant parties setting forth these standards and procedures.

The Commissioner assumed jurisdiction over the Rate Request, in accordance with R.I. Gen. Law § 42-62-13.

The proceedings have been conducted as an administrative hearing in accordance with the Rhode Island Administrative Procedures Act. R.I. Gen. Laws Title 42, Chapter 35.

The Commissioner scheduled the public rate hearing, as required by R.I. Gen. Law § 42-62-13, for July 15, 2025, and July 16, 2025 (the "Public Rate Hearing"). Appearances were

[7] For example, the expiration of the EPTCs at the federal level caused Neighborhood to include "*a morbidity adjustment equal to 1.015 to claims in the projection period; of this, 1.8% is attributable to the anticipated loss of enrollment as a result of the expiration of the EPTCs and -0.2% is due to anticipated market shifts between 2024 and 2025."* OHIC 1C at 21. *"The morbidity adjustment reflects expected changes in the morbidity of Neighborhood's population covered in CY 2024 versus that which is expected to be covered in CY 2026, primarily due to the anticipated expiration of the enhanced premium tax credits that were first enacted under the American Rescue Plan Act and later extended via the Inflation Reduction Act."* OHIC Exhibit 1C at 5. *"In the development of this assumption, they considered the overall reduction in enrollment levels, change in enrollment mix, the average morbidity of different cohorts of the population (healthier versus riskier members), and the difference in lapse rate of healthier versus riskier members. . . Based on my review, the morbidity adjustment being utilized by NHPRI is not unreasonable and is within the range of morbidity change assumptions I have observed being used for 2026 by other carriers in the industry. For example, the KFF-Peterson Health System Tracker recently released a summary of Marketplace premiums and the impacts due to the expiration of the EPTCs. They found that 'among the insurers that publicly quantified the impact of the expiration of the premium tax credits, the projected increases on top of expected annual premium increases range from about 1% to 7%.'"* OHIC 1C at 21-22.

entered on behalf of Neighborhood by Robert D. Fine Esq. of Chase Ruttenberg and Freedman and Mary Eldridge, Esq., General Counsel for Neighborhood, and on behalf of the R.I. Office of the Attorney General ("OAG" or "AG") by Jordan Broadbent, Esq., Special Assistant Attorney General. TR I at 3. The undersigned counsel entered her appearance on behalf of the Office. TR I at 3. The parties stipulated on the record at the Public Rate Hearing that the Commissioner, assisted by his legal advisor Raymond A. Marcaccio, Esq., has jurisdiction to hear this matter of the Rate Request. TR I at 4.

Public notice of the Rate Request and the Public Rate Hearing thereon was published in *The Providence Journal*, a newspaper of general circulation, in accordance with R.I. Gen. Laws § 42-62-13. Neighborhood Exhibit 4; TR I at 4.

The Parties filed their respective Pre-Hearing Submissions on July 3, 2025. The Pre-Hearing Submission of the Office included an Actuarial Analysis (alternatively referred to as the pre-filed testimony or Actuarial Report) of its actuarial expert Corryn Brown, marked as OHIC Confidential Exhibit 1 and OHIC Exhibit 1C (redacted version of OHIC Exhibit 1). The Pre-Hearing Submission of the OAG included a Consumer and Economic Report prepared by its health economist expert Christopher Whaley, AG Exhibit 1.

OHIC's Actuarial Analysis, prepared by Corryn Brown, FSA, MAAA, identified five aspects of the Rate Filing where on behalf of OHIC she recommended, in her professional actuarial opinion, equally reasonable or more reasonable alternative assumptions, methods or strategies that could be employed in developing components of Neighborhood's Rate Filing.

These five areas of dispute were: (1) Neighborhood's Pharmacy Rebate Assumption; (2) Neighborhood's Utilization Trend Assumptions; (3) Neighborhood's Overall Pharmacy Trend

Assumptions; (4) Neighborhood's 2026 Projected Risk Transfer Amount; and (5) Neighborhood's 2026 Projected Reinsurance PMPM. OHIC Exhibit 1C.

In addition to these five areas of dispute, Ms. Brown's report also provided information for the Commissioner's consideration on the question of the Contribution to Reserves factor included in the Rate Filing. OHIC Exhibit 1C at 26-28. Also, at the Public Rate Hearing Ms. Brown provided the Commissioner with information about the estimated impact to the Rate Request if Neighborhood were to be ordered to update their CY 2024 base period experience with claims runout through May 2025, not just through March 2025. Finally, during the Public Rate Hearing and in Neighborhood Exhibits 12 and 13 entered in evidence post-hearing, issues arose around the general topic of how, whether, and to what extent the Rate Filing had (or should have) accounted for Neighborhood's estimated cost of complying with OHIC Regulation 230-RICR-20-30-4 (see OHIC Exhibit 41), as amended effective March 20, 2025, which established increased primary care provider ("PCP") spending targets as a percentage of total medical expenses ("TME") through 2028, with intermediary targets set by Neighborhood for 2025 and 2026 at 5% and 6%, respectively ("PCP Regulatory Targets").

Following a series of pre-hearing conference calls with the Commissioner and the Commissioner's outside legal advisor, Raymond A. Marcaccio, Esq., an administrative hearing was held on the Rate Request before the Commissioner on July 15-16 of 2025 (the "Public Rate Hearing").

At this Public Rate Hearing Neighborhood presented actuary Michelle Robb, FSA, MAAA, consulting actuary for Neighborhood (TR I at 16-120 and 166-171)[8] and Elizabeth McClaine, Vice President of Commercial Products (TR I at 123-166), for testimony; the Office presented consulting actuary Corryn Brown, FSA, MAAA for testimony (TR I at 171-268, TR II at 3-56); and the OAG presented health economist Christopher Whaley for testimony (TR II at 57-127). No other witnesses testified at the Public Rate Hearing.

Michelle Robb and Corryn Brown, the actuarial experts who testified at the administrative hearing, are both experts in the field of actuarial science, as stipulated to by the Parties on the record at the Public Rate Hearing. TR I at 8. As stipulated to by the Parties on the record at the Public Rate Hearing, Christopher Whaley is a health care economist and testified in that capacity at the Public Rate Hearing. TR I at 8. All Parties had the opportunity to question all three witnesses at the Public Rate Hearing. Testimony of these witnesses concluded on the afternoon of July 16, 2025. TR I at 127.

At the Public Rate Hearing, the parties' proposed exhibits were admitted into the record as full exhibits, specifically: Neighborhood Exhibits 1 through 11; AG Exhibits 1 through 62; and OHIC Exhibits 1 (inclusive of OHIC Exhibits 1A, 1B and 1C), 2, 4-9 and 11-60; TR I at 4-6. Post-hearing, Neighborhood Exhibits 12-13 were admitted into the record as full exhibits.

[8] Ms. Robb is employed by the actuarial firm, Milliman, Inc. ("Milliman"). Milliman is a consultant to Neighborhood and Ms. Robb, as consulting actuary to Neighborhood, prepared and signed the Rate Filing. Ms. Robb explained that Milliman and Neighborhood worked collaboratively on the development of the Rate Request and that even though she is the signing actuary, Neighborhood ultimately provides final approval of the Rate Request and submits the request to OHIC. In this process, Neighborhood provides Milliman with its base data as well as Neighborhood's assumptions. Milliman takes this information and adds assumptions developed through Milliman's own modeling and then considers all this information and essentially integrates it into the Rate Request. See Robb TR I at 18-19.

Of these exhibits, OHIC Exhibits 1, 20-25, 28, 33-34, 37 and 46-47 (the "Confidential OHIC Exhibits") and the unredacted versions of Neighborhood Exhibits 5-10 and 12-13 (the "Confidential Neighborhood Exhibits") were identified as containing confidential information and it was determined on the record at the Public Rate Hearing, as well as pursuant to the *Stipulated Order Regarding Confidential Exhibits* issued by the Commissioner on July 29, 2025, that these exhibits contain confidential and proprietary business information of Neighborhood not for public disclosure in accordance with R.I. Gen. Laws §38-2-2(4)(B) and therefore would be designated as confidential exhibits, sealed, and excluded from the public record. TR I at 4-7; 121-124.

Notice and an opportunity for in-person public comment regarding the Rate Request was made available on the record at the Public Rate Hearing on July 15 and 16, 2025. Neighborhood Exhibits 4 and 11; TR I at 3, 5, 8 and 11-12. No individuals provided in-person public comment on either July 15 or July 16, 2025. TR I at 270 and TR II at 1-2. Notice and an opportunity for written public comment regarding the Rate Request was made available to the public, with notice that written public comment would be received by the Office by email, mail, and hand-delivery through 5 pm on July 24, 2025. Neighborhood Exhibit 4 and 11; TR I at 8. Written public comment received by the Office through 5 pm on July 24, 2025, relating to the Rate Request is attached hereto as Appendix A.[9]

Subsequent to the hearing, a stipulation entitled *Stipulation of the Parties Regarding (1) CPI-U 12-Month Percentage Change Through June 2025, (2) the 2024 Final Risk Adjustment Transfer Payment, and (3) State Budget $30M Assessment* and dated August 6, 2025 ("August 6,

[9] Where appropriate, the Office redacted personal information.

2025 Stipulation") was entered into evidence in full in the administrative record of the above-captioned matter. The August 6, 2025, Stipulation provided that on July 15, 2025, the U.S. Bureau of Labor Statistics released its Consumer Price Index for all Urban Consumers figures inclusive of the June 2025 data. The CPI-U (less food and energy) ("CPI-U") 12-month percent change through June 2025 is 2.9%. The August 6, 2025, Stipulation also provided that on July 23, 2025, the Centers for Medicate & Medicaid Services (CMS) issued the revised *Summary Report on Individual and Small Group Market Risk Adjustment Transfers for the 2024 Benefit Year*, indicating that Neighborhood is entitled to a risk adjustment transfer payment for calendar year 2024 in the individual market in the amount of $16,801,610.75. This $16,801,610.75 final risk adjustment payment figure for Neighborhood in the individual market for the 2024 benefit mirrors the estimated final risk adjustment payment figure for the 2024 benefit year developed by OHIC using the RATEE files included as OHIC Confidential Exhibit 21. Finally, the August 6, 2025, Stipulation set forth that R.I. Gen. Laws 42-7.4-3(c), passed into law on or about June 20, 2025, provides for a $30M deposit into the general revenue fund for calendar year 2026. See OHIC Ex.43, Article 10, at p. 23. "*The funding contribution is comprised of premium dollars across all commercial health insurers in Rhode Island. Based on its estimated proportional number of its contribution enrollees, Neighborhood has estimated that compliance with this new assessment will increase Neighborhood's rate request in the individual market for 2026 will translate into an additional $4.00 to the premium."* Appendix B.

The Office now submits this post-hearing memorandum and accompanying proposed findings of fact and conclusions of law, in support of its recommendation that Neighborhood's Rate Request be modified downwards as set forth herein.

Jurisdiction

The Commissioner has jurisdiction over the Rate Request pursuant to R.I. Gen. Laws §§ 42-14.5-3(e), 42-14-5(d), 42-62-13.

The Commissioner assumed jurisdiction over the Rate Request, in accordance with R.I. Gen. Laws § 42-62-13 and the parties stipulated that the Commissioner, assisted by his legal advisor Raymond A. Marcaccio, Esq., has jurisdiction to hear this matter of the Rate Request. TR I at 6.

Notice of the Public Rate Hearing and an opportunity for public comment regarding the Rate Request was provided to the public, in accordance with R.I. Gen. Law § 42-62-13, together with notice that written public comment would be received by the Office by email, mail and hand-delivery through 5 pm on July 24, 2025. Neighborhood Exhibit 4. TR I at 6-7.

The Rate Request proceeding has been conducted in accordance with the provisions of the Administrative Procedures Act, R.I. Gen. Laws §§ 42-35-1 *et seq*.

Generally Applicable Law

The Rate Request is governed by Rhode Island laws and regulations relating to health insurance rates.

Neighborhood Health Plan of Rhode Island is a domestic insurance company subject to the Commissioner's jurisdiction.

Rhode Island law requires the Commissioner *"hold a public hearing in any instance where the applicant covers ten thousand (10,000) or more enrolled individuals in the individual market, and the rates proposed in the filing for the annual rate increase for products offered in the individual market produce an overall average-rate increase of ten percent (10%) or more."* R.I. Gen. Law § 42-62-13(b).

As set forth in Tab I of the Rate Filing, as of March 31, 2025, Neighborhood had an enrollment of 36,167 members in its Individual Market plans. Neighborhood Exhibit 2.

Neighborhood's proposed Rate Request for a 21.2% weighted average premium increase constituted a proposed *"overall average-rate increase of ten percent (10%) or more"* pursuant to R.I. Gen. Law § 42-62-13(b).

Rhode Island Law provides that at any hearing held pursuant to R.I. Gen. Law § 42-62-13, *"the applicant shall be required to establish that the rates proposed to be charged are consistent with the proper conduct of its business and with the interest of the public."* R.I. Gen. Law § 42-62-13(a). Consequently, Neighborhood must establish that its proposed rates are *"consistent with the proper conduct of its business and with the interest of the public."* R.I. Gen. Laws §§ 42-62-13(a).

Pursuant to R.I. Gen. Law § 42-62-13(f), the holding and conducting of any public hearing in connection with the proposed rates of a nonprofit Hospital Service Corporation or a Nonprofit Medical Service Corporation, *"shall be held in accordance with the provisions of chapter 35 of title 42,"* i.e., the Rhode Island Administrative Procedures Act.

In 2004 the Rhode Island General Assembly created the Office of the Health Insurance Commissioner, and directed the Commissioner to discharge the powers and duties of the Office for the following purposes: (1) to guard the solvency of health insurers; (2) to protect the interests of consumers; (3) to encourage fair treatment of health care providers; (4) to encourage policies and developments that improve the quality and efficiency of health care service delivery and outcomes; and (5) to view the health care system as a comprehensive entity, directing insurers towards policies that advance the welfare of the public through overall efficiency, improved health care quality, and appropriate access. R.I. Gen. Laws § 42-14.5-2.

The Commissioner is authorized to approve, disapprove, or modify the rates proposed by Neighborhood pursuant to R.I. Gen. Law § 42-62-13. The authority to modify rates includes the authority to modify any of the components or factors used to develop rates, if warranted by the evidence (or lack of evidence) in the record. The law does not constrain the Commissioner to review the Rate Request only from the perspective of mathematical and actuarial accuracy. Hospital Service Corporation of Rhode Island v. West, 308 A2d 489, 495 (RI 1973). Rather, the Legislature has directed the Commissioner to review rates based on considerations of affordability, health system improvement, and the interests of the public, provided there is a factual and analytical record to support the Commissioner's decisions and judgment. R.I. Gen. Laws §§ 42-14.5-1.1 and 42-14.5-2.

Neighborhood bears the burden of proving, by a preponderance of the evidence, that its Rate Request is consistent with the proper conduct of its business and with the interest of the public. Blue Cross & Blue Shield of R.I. v. McConaghy, PC No. 04-6806, 2005 WL 1633707 (R.I. Super. 2005); R.I. Gen. Law § 42-62-13(a). Consequently, to the extent the Commissioner determines, based on a review of all the evidence before him, that an alternative methodology or assumption is equally reasonable or more reasonable to a methodology or assumption proposed by Neighborhood, the Commissioner may adopt either methodology or assumption.

Issues in Dispute

The Office identified four aspects of the Rate Filing where more reasonable alternative assumptions, methodology or strategies should be or could be employed in the development of Neighborhood's rates and a fifth aspect where an equally reasonable alternative assumption, methodology or strategy could be employed, specifically: (1) Neighborhood should revise its Pharmacy Rebate Assumption; (2) Neighborhood should revise its Utilization Trend

Assumptions; (3) Neighborhood should revise its Overall Pharmacy Trend Assumptions (Brown TR I at 245-246); (4) Neighborhood should revise its 2026 Projected Risk Transfer Amount (Brown TR I at 253-254); and (5) Neighborhood should revise its 2026 Projected Reinsurance PMPM (Brown TR I at 257-258). OHIC Exhibit 1; Brown TR I at 262-266. Regarding Neighborhood's Pharmacy Rebate Assumption OHIC is recommending an equally reasonable alternative assumption. Brown TR I at 182-183.

In addition to the above alternative recommendations, OHIC provides an analysis and/or commentary in this memorandum on several other points, including:

(a) Potential arguments from Neighborhood that it should be allowed to update its CY 2024 base period experience with claims runout through May 2025, rather than through March 2025 as well as update the trend developments and other assumptions in the Rate Filing utilizing data with updated claims run out.

(b) Dr. Whaley's commentary and/or recommendations on a variety of topics.

(c) The PCP Regulatory Targets.

(d) Neighborhood's financial metrics and an appropriate Contribution to Reserves factor.

(e) The AG's likely recommendation that Neighborhood be denied any rate increase.

Neighborhood's CY 2024 Base Period Experience.

In developing its proposed Rate Request for 2026 rates, Neighborhood utilized its CY 2024 claims experience, including claims paid through March 2025 and an estimate of the completion of the 2024 claims incurred in 2024 but that had not yet been paid out. OHIC Exhibit 1 at 4-5; Robb TR I at 26; Brown TR I at 175-176.

While reviewing the Rate Filing, Ms. Brown requested Neighborhood provide an updated CY 2024 base period experience using claims paid through May 2025, in other words, to include two additional moths of run-out. Neighborhood submitted this response after Ms. Brown had completed her written Actuarial Analysis. OHIC Exhibit 1C at 5; Brown TR II at 7. This response can be found at OHIC Exhibit 48 and Neighborhood Exhibit 8.

Ms. Brown testified that, having reviewed OHIC Exhibit 48 she estimated that including the additional two months of claims run out in Neighborhood's CY 2024 base period experience (using claims paid through May 2025) would increase Neighborhood's CY 2024 allowed claims figure by approximately 0.9% and their incurred or paid claims by approximately 1.2%. Brown TR 176-177. "*My estimate of the impact [to the Rate Request] is an increase to rates of 0.8 percent."* Brown TR I at 177. Ms. Brown added that her 0.8% estimate is "*reflective of an increase to the base period experience in isolation"* and that that Neighborhood and their consulting actuaries (Milliman) might calculate a slightly different figure with the benefit of their internal rate models. Brown TR I at 177.

Ms. Brown agreed that the CY 2024 base period experience with the additional claims run out through May of 2025 *"would be more accurate."* However, she pointedly did not agree with the proposition that it is appropriate to recalculate the Rate Filing's CY 2024 base period experience with May run-out simply because that data is more complete than the data submitted with the filing, responding *"I think this data through March is appropriate to use for pricing, because pricing is a point in time estimate."* Brown TR II at 8-9. She further explained that the reason she requested the May run-out data from Neighborhood was because *"historically in Rhode Island there has been interest in seeing what additional May run-out shows for multiple carriers, and I think this consistency is appropriate."* Brown TR II at 9.

Neighborhood's testimony on the topic of updating its CY 2024 base period experience with additional claims run out through May of 2025 was limited and unclear as to what, if any, position was being taken. OHIC submits that Ms. Robb did not provide testimony that it would be actuarially more appropriate or more reasonable for Neighborhood to update its CY 2024 base period experience with additional claims run out through May of 2025, with the exception of some general references in her testimony to preferring to use actual, known claims in place of educated guesses (Robb TR I at 76). Instead, the only basis upon which Ms. Robb testified that it would be appropriate for Neighborhood to update its CY 2024 base period experience with additional claims run out through May of 2025 was to ensure consistent treatment across carriers – stating, *"[w]e also had observed in the other carriers hearing that there were questions asked regarding – including May run-out and we would believe that it would be most appropriate to use the same run out period across all carriers in the market."* Robb TR I at 28.

Because Neighborhood failed to clearly address, much less provide evidence in support of updating their CY 2024 base period experience in their pre-hearing filings, exhibits, the witnesses they called or cross-examined testimony elicited, or in evidence submitted post-hearing, the evidence in the record on this point is made up of Ms. Brown's testimony (summarized above) and the data contained in OHIC Exhibit 48 and Neighborhood Exhibit 8. Neither Ms. Brown's testimony nor OHIC Exhibit 48 and Neighborhood Exhibit 8 provide clear support for updating the CY 2024 base period experience.

While OHIC offered the Commissioner observations on the topic, OHIC is not making a recommendation on the Rate Filing's CY 2024 base period experience estimate using claims run out through March 2025.

To the extent Neighborhood makes an argument in its post-hearing memorandum that the Commissioner should order it to update its CY 2024 base period experience with claims run out through May of 2025, based on the evidence in the record Neighborhood has not carried its burden of proof in establishing that it is actuarially more reasonable for Neighborhood to update its CY 2024 base period experience with claims run out through May of 2025. Nonetheless, it would be within the Commissioner's discretion to determine, perhaps on a theory of consistency across carriers, that it is appropriate for Neighborhood to update its CY 2024 base period experience with claims run out through May of 2025.

OHIC notes that Neighborhood appeared to suggest adjusting the Rate Filing's trend analysis and other assumptions using the claims run out through May 2025, in some sections of Ms. Robb's testimony as well in cross examining Ms. Brown. For example, Ms. Robb testified that when Neighborhood calculated its rate request utilizing OHIC's proposed alternative assumptions *"and also utilizing a longer run out period we calculated a 2.7 percent decrease to the rate, which compares to the 4.6 percent calculated by OHIC."* Robb TR I at 26; see also Robb TR I at 27-28[10]; Robb TR I at 67.[11] This line of argument was also implied in the context of the following question posed to Ms. Brown on cross examination – *"would you agree, if the May run-out is impactful to base claims, that it would be appropriate to also include May run-*

[10] Ms. Robb testified *"if we included May run-out, that would increase our rate by 1.5 percent. So the 2024 allowed claims themselves increased by .9 percent due to the additional run-out, but then there is a little bit of addition, because that is really the basis of the rate increase, and so the downstream impacts within the filing are also impacted. Really the main one is the benefit relativity factor, since we calibrate those to our experience. As the experience goes up, those kind of tend to go up, too, especially in this case."*

[11] Ms. Robb testified "*However, we wanted to note that if we incorporate May run-out and reduce trend, as stated elsewhere in the filing, since we used those same assumptions in our reinsurance estimate, they would also impact our estimate, and that would increase the rate impact 0.1 percent."*

out consistently across the development of the entire filing, including development of trend and reinsurance assumptions?" TR II at 9.

Ms. Brown's response to this question --*"I think it is appropriate to have all of your data on an apples to apples basis and use the same information"* **--** should not be misconstrued by Neighborhood as support for the argument of revising the trend analysis in the Rate Filing with updated CY 2024 claims experience in the context of this Public Rate Hearing. This is because updating a base period experience is a straightforward exercise as compared to updating a trend. In the context of developing trends, while the trend data could be updated, selecting the final assumption typically involves a lot of actuarial judgment and analyzing. Presently, in the context of this rate review and rate hearing process, there is neither sufficient time nor an available forum pursuant to which the outcome of any such updates to trend data run through a certain methodology could be properly subjected to expert actuarial analysis, judgement, and recommendations. Instead, Ms. Brown's response can be understood as recommending against even updating the Rate Filing's base period experience with more recent claims data run out. In other words, Ms. Brown was conveying her opinion that it is more appropriate and more consistent to develop all the components of a rate filing using data available as of a singular point in time, i.e., *"having all of your data on an apples to apples basis and use the same information*", which in this case would necessitate using the base period experience with claims run out only through March 2025.

For the reasons set forth above, to the extent Neighborhood may advocate in its post hearing memorandum that the Commissioner should also allow or require an adjustment to Neighborhood's trend analysis and other assumptions included in its Rate Filing using the more recent claims run out through May 2025, OHIC strongly opposes any such recommendation on

the grounds that it would undermine the rate review process. If Neighborhood proffers this argument, based on all the evidence in the record and the reasonable conclusions that can be drawn from that evidence, Neighborhood has failed to carry its burden of proof.

Neighborhood Should Revise its Pharmacy Rebate Assumption.

The Rate Filing includes an assumption that Neighborhood's pharmacy rebates will decrease in 2026 relative to CY 2024. See Robb TR I at 29; Brown TR I at 180. More specifically, Neighborhood is assuming its 2025 and 2026 rebates as a percentage of allowed claims will decrease relative to 2024 levels, explaining that they have assumed rebates will trend lower than total pharmacy allowed cost will trend because they do not expect all incremental spend to be on pharmaceuticals that are subject to rebates. OHIC Confidential Exhibit 1 at 6; Brown TR I at 179, 181.

To assess this assumption, Ms. Brown requested and obtained from Neighborhood its historical and projected rebates as a percentage of pharmacy specific allowed claims dating back to CY 2021. Brown TR I at 179; See OHIC Confidential Exhibits 33 (Response 2-7.3) and 34 (Tab 2-7.4). Ms. Brown took this information and plotted it on Chart 1 of OHIC Confidential Exhibit 1. This Chart 1 clearly shows actual pharmacy rebates as a percent of pharmacy allowed claims have been *"consistently increasing"* from 2021 through 2024, followed by Neighborhood's projections that beginning in 2024 this trend will reverse itself and achieve a level in 2026 that is lower that it experienced in 2023. Chart 1, OHIC Confidential Exhibit 1 at 6; Brown TR I at 180

Ms. Brown offered testimony that while *"it's reasonable that you would not assume that all incremental spend in pharmacy is – as costs go up, . . . going to be subject to rebates, . .. it's*

also reasonable to assume that going forward, a similar percentage of the claims will be subject to rebates as seen in the base period . . . especially noting a consistent increase in rebates that they have seen over the historical period." Brown TR I at 181; see also Brown TR II at 11-12. Ms. Brown explained that, hypothetically she could have recommended a projection that Neighborhood's pharmacy rebates would continue to trend upwards consistent Neighborhood's historical trend – *"I think that's a pretty common way to project rebates, is to assume that they trend at the same rate they have in the past."* Brown TR II at 12. She explained further that because of some of the factors that Neighborhood noted relative to why they did not expect their pharmacy rebates to continue to trend upwards as they have been doing, *"I have chosen a more conservative assumption of holding it flat from 2024."* Brown TR II at 12. In other words, OHIC's recommend alternative pharmacy rebate assumption -- that Neighborhood should assume its 2026 pharmacy rebates as a percentage of allowed pharmacy claims will be consistent with the level observed in 2024 instead of instead of decreasing to levels lower than 2023 – takes into account the same factors that Neighborhood cited in support of its trend. OHIC Confidential Exhibit 1 at 6.

Ms. Robb's explanation of her disagreement with OHIC's recommended alternative assumption for 2026,[12] consisted essentially of three points. First, she stated that Neighborhood's 2025 and 2026 projections were based on their *"kind of monitor[ing] what's going on in the markets"* and that they had noted that several products are expected to lose or have reduced pharmacy rebates starting at the beginning of 2024 and continuing into 2026, some

[12] Because of the confidential nature of these pharmacy rebates as a percentage of allowed claims figures, for the specific percentage figures OHIC refers the Commissioner to OHIC Confidential Exhibit 1 at 6 and OHIC Confidential Exhibits 33 and 34.

examples being insulins, some autoimmune and GLP-1 products. Robb TR I at 28-29. OHIC observes that this first observation is not in conflict with OHIC's recommended alternative assumption and is even supportive of it.

Second, Ms. Robb testified that, separate from this monitoring, *"but really we looked at the projected rebates based on the guarantees that were provided by CVS, who is our PBM, and so we saw that without those contractual guarantees, . . . basically the allowed pharmacy costs were growing faster, and the rebates weren't keeping up . . ."* Robb TR I at 29. Neighborhood Confidential Exhibit 9.[13] Ms. Brown countered this argument by stating that, even after considering the additional information regarding Neighborhood's contractual guarantees as presented in Neighborhood Confidential Exhibit 9, she still believed her recommended alternative pharmacy rebate assumption was an actuarially equally reasonable assumption.[14] She essentially explained that keeping the pharmacy rebate assumption flat, as opposed to projecting a continued upwards trajectory consistent with the historical data, from 2024 was consistent with the assertion from the PBM that Neighborhood's contractual guarantees are going up at a rate lower than the rate by which their projected allowed pharmacy claims are increasing. See Brown TR I at 183.

Third, and likely most critical to Neighborhood's assessment, "*we also reviewed our emerging 2025 experience, so our quarter 1, 2025 experience,"* and *"looking at rebates as a*

[13] Neighborhood Confidential Exhibit 9 was produced after Ms. Brown's written Actuarial Analysis was completed and filed in this matter.

[14] Ms. Brown did note that, prior to considering Neighborhood Confidential Exhibit 9, she would have testified that her recommended assumption was more reasonable than Neighborhood's, but that after considering this additional information she believes that her alternative recommended pharmacy rebate assumption is equally reasonable to the assumption employed by Neighborhood in the Rate Filing. Brown TR I at 182-183.

percent of allowed, were lower. . . than what we saw even in 2024," Robb TR I at 29, indicating that this fact was a major driver of Neighborhood's assumption. See Brown TR I at 183. The tremendous weight Neighborhood placed on its emerging and incomplete 2025 experience in the context of developing multiple assumptions included in the Rate Filing that veered dramatically from historic trends became a major theme and topic of dispute throughout this rate hearing process. In the context of the topic of the pharmacy rebate assumption, Ms. Brown testified that *"while pharmacy claims [as opposed to medical claims] do complete quickly, pharmacy rebates do take a few months to kind of fully flush out and finalize, and in some cases even up to six months . . . so the information is not complete."* Brown TR I at 183.

Taken as a whole, Ms. Brown's recommendation to assume a pharmacy rebate consistent with what was observed in 2024, as opposed to assuming a higher 2026 pharmacy rebate based on observed historical trends, is consistent with all three of the reasons Neighborhood cited in support of their proposed assumption, including allocating some weight to the emerging experience. See Brown TR I at 183. Ms. Brown testified that in her professional opinion her alternative recommended pharmacy rebate assumption is equally reasonable to Neighborhood's. Brown TR I at 183, 264-265.

Neighborhood failed to carry its burden of proof by a preponderance of the evidence to establish that its' methodology and reasoning in selecting its pharmacy rebate assumption was more reasonable than OHIC's recommendation to utilize a pharmacy rebate assumption consistent with what was observed in 2024.[15] Neighborhood has therefore also failed to establish

[15] OHIC refers the Commissioner OHIC Confidential Exhibit 1 at 6 for OHIC's specific recommended assumption percentage.

that its selected pharmacy rebate assumption is both consistent with the proper conduct of Neighborhood's business and is in the public interest.

OHIC recommends the Commissioner direct Neighborhood to assume that their 2026 pharmacy rebates as a percentage of allowed claims will remain constant relative to the level it observed in 2024. OHIC estimates that adopting the OHIC recommended alternative pharmacy rebate assumption will result in an estimated net reduction of 1.0% in the proposed premium rates. Brown TR I at 184; OHIC Confidential Exhibit 1 at 6. Neighborhood calculated that adopting OHIC's recommended pharmacy rebate assumption would result in a 0.5% reduction to rates. Robb TR I at 30.

Neighborhood Should Revise its Utilization And Severity Trend Assumptions.

Neighborhood develops its utilization trend projection factors by performing linear and exponential regression analyses using their historical individual market data. Neighborhood does not use its small group data as it is not considered fully credible. Robb TR I at 35; Brown TR I at 201. They perform their analyses with regression results by five major service categories: inpatient, outpatient, professional, ancillary/other, and pharmacy. OHIC Exhibit 1C at 13; Robb TR I at 30; Brown TR I at 201-202; Brown TR II at 14. Neighborhood also develops an average of their exponential regression and linear regression trends, as depicted in OHIC Exhibit 34, but

Ms. Robb testified that while they "*look at the average*" they "*didn't necessarily use that as our point estimate."* Robb TR I at 72-73; see also Brown TR II at 14.[16,17]

For medical service categories the total trend is a composite of the developed cost and utilization trends. However, for the pharmacy category, Neighborhood first develops its pharmacy utilization trend and then develops its total pharmacy trend (inclusive of cost and utilization). After it has both these trends, it backs out the utilization trend from the overall

[16] OHIC notes that the apparent fact that Neighborhood developed and presented this average of the linear and exponential regression trends but then did not use this average trend figure any further in their utilization trend development was not apparent from the Rate Filing or from Neighborhood's responses to OHIC's requests for information, such as OHIC Exhibit 34. As a result, in conducting its analysis of the Rate Filing OHIC was under the impression that Neighborhood took this average trend figure and applied its actuarial adjustments to this figure. See e.g., Brown TR I at 201-202, 204.

[17] It is worth noting that for the most part Neighborhood's selected trends fell well outside the range of trends produced by their linear and exponential regressions. For example:

- Inpatient Utilization trend range for 2025 was 1.9% to 1.3%
  - Neighborhood selected 3.5%
- Outpatient Utilization trend range for 2025 was 2.7 to 9.4%
  - Neighborhood selected 0.2%
- Professional Utilization trend range for 2025 was -0.6 to 0.5%
  - Neighborhood selected 2.5%
- Professional Utilization trend range for 2026 was -1.1% to -2.3%
  - Neighborhood selected 2.1%
- Ancillary Utilization trend range for 2025 was 2.4% to 5.7%
  - Neighborhood selected 0.2%
- Rx Utilization trend range for 2025 was 2.5 to 2.9%
  - Neighborhood selected 6.9%
- Rx Utilization trend range for 2026 was 2.1 to 2.3%
  - Neighborhood selected 4.5%

pharmacy trend to estimate its pharmacy cost trend. Robb TR I at 46. *"[D]ue to this approach, the utilization and cost components of pharmacy trend are not impactful to final rates, as the combined effect of the two components will always equal the total pharmacy trend assumption NHPRI has selected."* OHIC Exhibit 1C at 13; see also Robb TR I at 48; Brown TR I at 191. While OHIC took issue with aspects of Neighborhood's pharmacy utilization trend development and proposes an alternative recommended pharmacy trend, as a practical matter, whether this alternative recommendation is adopted will not impact the rates.

COVID-Impacted Data Included without Adjustments

The number of months of data Neighborhood used in their regressions varied by service category:

- inpatient: 21 months. Neighborhood indicated it only used 21 months (January 2023 through September 2024) of data for this category because they had noted a significant shift in utilization at the start of 2023 which they assumed was due to the end of the public health emergency (PHE), Medicaid redeterminations, and the resulting membership shift associated with these two events.
- outpatient: 57 months.
- professional: 57 months.
- ancillary/other: 56 months. Neighborhood indicated it removed their data for May of 2024 due to "major outliers."
- pharmacy: 57 months.

The service categories that used 56 and 57 months relied on data from January 2020 through September 2024, including months that were materially impacted by COVID-19 (e.g.,

April 2020, May 2020). OHIC Exhibit 1C at 14; Robb TR I at 33 (confirming Neighborhood had observed a COVID-impacted spike in utilization over Spring of 2020).

Neighborhood's use of 56-57 months of data in its utilization trend development raises serious concerns – *"I think that using the months with COVID impact is not necessary or necessarily appropriate at this point. We have enough post COVID data that you can use data without COVID impacts."* Brown TR I at 206-206. Equally concerning is the fact that Neighborhood is incorporating COVID months into the regression analysis but not adjusting the data or their regression analysis for known COVID impacts. Brown TR I at 203.

Ms. Robb acknowledged that the 2020 through 2022 data occurred during COVID and therefore had some limitations. Nonetheless, she appeared to explain that Neighborhood believed it was still appropriate to include so much of this COVID-impacted data in their trend development because their other data, the *"2023 and 2024 data reflected the end of the public health emergency and Medicaid redetermination, so you know, because there are so many people being enrolled with Neighborhood during that time period, coming off of Medicaid, we felt that time period also had its own limitation, so we kind of considered everything."* Robb TR I at 33-35; see also Robb TR I at 42. Ms. Robb went on to somewhat inconsistently explain that Neighborhood elected to only use 2023 and 2024 data for its inpatient utilization trend development to better control for COVID-19 impacts to their data, Robb TR I at 33,[18] and that they also excluded May of 2024 from their Ancillary trend development to account for it being an outlier month. Brown TR 1 at 203.

[18] Ms. Robb also confirmed that in developing their medical utilization trends there was no adjustment made to either the data being used in the trend development or trend that is ultimately being selected to account for COVID-19 impacts. Robb TR I at 81.

Ms. Brown testified that it did not make sense for Neighborhood to claim that the COVID-19 impacts were essentially neutralized, and vice versa, by the Medicaid enrollment impacts because *"two major impacts in the health insurance market do not necessarily offset each other."* Brown TR I at 208. And as further pointed out by Ms. Brown, Neighborhood made COVID-19 utilization adjustments when they developed their prior historical trends but now, when they are developing their trends of 2026, they are no longer making COVID-19 adjustments. Brown TR I at 207. Importantly, OHIC Exhibit 34, Tab 2-3.1 documents that historically Neighborhood identified and quantified a COVID Utilization Impact to its PMPM data in developing its Inpatient trends (for 2021 and 2022); Outpatient trends (for 2021 and 2022); and Professional trends (for 2021)). Moreover, this Tab indicates that Neighborhood did not make any adjustments to their utilization trends in 2023 or 2024 attributable to Medicaid redeterminations *"which I think speaks to the fact that Neighborhood feels COVID utilization impact is larger than the [Medicaid redetermination] impact"* Brown TR I at 207; Brown TR II at 19; OHIC Exhibit 34, Tab 2-3.1. Ms. Brown added that *"Neighborhood's population is changing significantly, because of some of these Medicaid redeterminations, and as I have noted, Neighborhood said they did not adjust for any differences in age, morbidity or benefit differences when developing their trend, so I think that if they felt like that was a meaningful component, that is something that they should be adjusting for."* Brown TR II at 19. Ms. Brown emphasized the importance of "*not including data that has that COVID impact in it . . . [because] I think the COVID data skews these trend results quite a bit."* Brown TR I at 208.

<u>Emerging Experience Adjustment Concerns</u>

Neighborhood then applied actuarial judgement to adjust all their utilization trends to account for their emerging experience in the first quarter of 2025. More specifically, Neighborhood calculated an emerging experience trend by reviewing their allowed claims PMPM trend between Q1 2024 and Q1 2025 for each major service category and then accounted for this emerging experience by developing a "blended" utilization trend, giving some weight to a trend figure Neighborhood selected (based on implicit actuarial judgement) from within or from one end of the range of possible trends between the regression analyses (i.e., selecting the linear regression line, the exponential regression line, the average of these two lines, or some other intermediary figure) and some weight to the emerging experience PMPM trends. Brown TR II at 14. As noted above, the weights applied to emerging experience varied by major service category. Brown TR I at 202.

OHIC identified several concerns regarding Neighborhood's emerging experience trends and its incorporation into their utilization trend development.

One, Neighborhood's emerging experience adjustment was developed using PMPM trends -- the PMPM comparison between these Q1 2024 and Q1 2025 included the impact of both cost and utilization changes. Brown TR II at 15. Neighborhood could have, but did not, separate out utilization and cost changes in this data to develop its emerging experience trends. OHIC Exhibit 1C; Robb TR I at 39 and 69; Brown TR I at 202. Ms. Brown commented *"I would say it is not actuarial standards of practice or best practice to combine utilization and cost trend -- utilization and PMPM trends in one calculation. I think you either look at a total trend or you look at cost and utilization separately, so the combining of these PMPM trends with utilization trends seems unreasonable to me."* Brown TR I at 205, 218-219; see also Brown TR II at 14 (*"Those were PMPM trends, not utilization trends. They blended those with their calculated [utilization] regression trend number. That was listed in all the exhibits as the blended trend."*);

OHIC Exhibit 1C at 15. Neighborhood attempted to minimize OHIC's concerns with their approach of considering and incorporating adjustments for PMPM trends in the context of utilization trend development by claiming *"we didn't separate out specifically utilization and cost, but we don't expect that cost trend to be material . . . because its only three months of data."* Robb TR I at 69-70; see also Robb TR I at 87 (conceding that Neighborhood did not explicitly calculate the charge increases between Q1 2024 and Q1 2025). On cross examination Ms. Robb admitted that Neighborhood's medical and pharmacy cost trends, as depicted on OHIC Confidential Exhibit 34, did project increasing cost trends in 2025 in multiple service categories. Robb TR I at 70; 87-88; see also Brown TR II at 20 (noting Neighborhood has included cost trends that are likely higher than 2-5% in these emerging experience PMPM trends).

Two, Neighborhood's emerging experience data for Q1 2025 constituted decidedly incomplete claims data, particularly with regard to medical claims, because it contained limited claims run out. Brown TR I at 204-205 ("*2025 data is shown run-out through March of 2025, so no run-out, meaning it's heavily dependent on the completion factors that would be applied here"*); Brown TR II at 14 (*"the emerging experience was developed based on Q-1 2025, [with] zero run-out estimated completion versus Q-1 2024 with a full year of run-out"*); see also Robb TR I at 77.

Three, Neighborhood compared its incomplete Q1 2025 data against its complete Q1 2024 data to develop its emerging experience trend. Robb TR I at 75-77. Neighborhood could have instead compared its incomplete Q1 2025 data with limited run-out against its Q1 2024 data captured as of the same point in time in 2024 with the same amount of limited run out to develop its emerging experience trend. Robb TR I at 75-76.

Four, by Neighborhood's own admission, its emerging 2025 medical experience is not very credible. Robb TR I at 76-78; Robb TR I at 38 *("we do agree there are limitations to using emerging experience"*).[19]

Five, the weight that Neighborhood assigned the emerging experience in each utilization service category varied – 5% weight in Inpatient, Outpatient and Professional, 15% weight in Ancillary, and 25% weight in Pharmacy. When asked how the weights had been determined, Neighborhood responded that it "*is really just a – that is actuarial judgment. . . . [i]t's not a precise analysis . . . so basically we go as low as we can, but to acknowledge it."* Robb TR I at 77 (also noting *"I could argue that maybe three percent or ten percent. I mean five percent is a judgement call, to be fair . . ."*). Ms. Brown countered that *"the weight that they provide . . . while I agree there is some actual judgment that needs to be included to understand sort of how much weight to give these, you know, they seem to vary by category without a super clear reason why."* Brown TR I at 205.

Other Adjustments

For the outpatient, professional, and pharmacy service categories, additional adjustments were made. For the outpatient service category, Neighborhood stated that historically inpatient and outpatient trends move in opposite directions, so they made an adjustment for this in the development of the outpatient trend to reflect the assumption that there is downward pressure on outpatient trends when inpatients trends go up and vice versa. OHIC 1C at 14. It bears noting that adjustment was also developed in reliance on a PMPM trend, specifically relying on the total

[19] Ms. Robb suggested Neighborhood accounted for these limitations and credibility issues by giving the emerging experience trends "*very low weight in our projection."* Robb TR I at 38.

facility PMPM trend from 2023 to 2024. OHIC 1C at 14; Brown TR II at 14-15. In the development of the professional trends, an additional increase of "2-4%" initially appeared to have been included to reflect expected increases in utilization due to enriched benefits for primary care services, which NHPRI is introducing in a good faith effort to meet its PCP Regulatory Targets. OHIC Exhibit 1C at 14. While this adjustment was noted, there was no indication in the rate filing or in discovery of how the adjustment was actually built into what was called the selected trend. Brown TR II at 15. Additional support for this adjustment was provided post-hearing wherein Neighborhood explained the development of this 2-4% adjustment and that it accounts for the expected realization and impact of PCP as a portion of professional claims. Neighborhood Exhibit 13. For pharmacy services, an additional adjustment was made to reflect the expected increase in utilization due to regulatory changes in the maximum cost sharing for specialty drugs. OHIC Exhibit 1C at 14. Again, *"there was no indication as to how [this adjustment was] actually built into what was called the selected trend. In all cases, the selected trend was a hard coded number that varied from the calculated number, so I tried to review the calculated number into that build up, but then the selected trend varied from that, and I assume there was some actuarial judgment, but it was hard . . . to fully review the hard coded number."* Brown TR II at 15.

Overall, Neighborhood's final selected utilization trends were ultimately based largely on actuarial judgement and vary substantially from the trends that were calculated using just their historical claims data. See OHIC 1C at 14. Of note, Ms. Brown testified that *"generally actuarial best practices would recommend that your trend be supportable, and I believe that the wording is something along the lines of an actuary -- another actuary should be able to pick up your -- any methodology that you have and easily follow it to your final number, and I don't*

believe that is the case here." Brown TR II at 18. Ms. Brown also pointed out on cross examination that Neighborhood's aggregate trend assumption of nine percent was *"on the high end of the same ranges."* Brown TR II at 18.

Recommended Alternative Methodologies for Utilization Trend Development

For each of the service categories, OHIC developed an alternative recommended utilization trend assumption using a methodology that honored the regression analysis method that Neighborhood chose. TR Brown I at 219-220. This methodology reflects some of the nuances in Neighborhood's data, such as the change in inpatient utilization that they observed, while also maintaining more consistency across the service categories and limiting the impact of COVID-19 on the trends. The methodology also removes the blending of PMPM emerging experience with utilization trends because, while it may be important to consider emerging experience, (a) blending PMPM trends with utilization trends is not actuarially appropriate; (b) effectively giving incomplete emerging experience more weight than complete historical experience is not appropriate; and (c) Neighborhood did not produce sufficiently complete emerging experience data adjusted to remove the cost component to make it possible to consider and possibly include an actuarially reasonable adjustment for emerging experience. Brown TR II at 20-21.[20] It is important to recognize that OHIC's proposed methodology of *"using trends that*

[20] See also Brown TR II at 33-34 ("*My buildup of alternative assumptions was trying to rely on the information I had from Neighborhood. Neighborhood provided emerging trends that were PMPM trends. They did not provide any information on emerging cost versus utilization trends. Therefore, I didn't have any data that I could incorporate into my trend development that was not, in my opinion, inappropriate to use, because it didn't have cost trend backed out of it. So I have only tried to replicate the method with the information I had, the emerging experience that they provided should be given zero weight, because you cannot mix PMPM trends and utilization trends.").*

are based on more recent months would put more weight on the more recent experience," consistent with Neighborhood's desire to reflect emerging trends. Brown TR II at 36. OHIC relied on the calculated trend (an average of the exponential and linear regressions performed on a specified number of months, consistent with NHPRI's utilization trend analysis) for the final trend selection (except where the calculated trend was negative and except in the case of the professional utilization trend). Finally, in developing each of the following alternative recommended trends, OHIC projected the trend through 2025 and assumed the increase in 2025 relative to 2024 would occur for two years. OHIC Exhibit 1C at 15; Brown TR I at 219-220.

Recommended Alternative Methodology for Inpatient Utilization Trend Development

Having confirmed Neighborhood's observation that utilization patterns changed meaningfully in 2023, OHIC similarly relied on the same 21 months of data (January 2023 through September 2024) utilized by Neighborhood for calculating of the inpatient service category trend. OHIC Exhibit 1C at 15; Brown TR I at 208, 221. Additionally, in the trend exhibit provided by Neighborhood (OHIC Exhibit 34, Tab 2-3.1) they show that 2022 inpatient utilization required an adjustment for COVID-19. Consequently, by using experience starting in 2023 the impact of COVID-19 on the resulting trend estimate is also lessened. OHIC Exhibit 1C at 15.

The resulting calculated inpatient utilization trend (the average of exponential and linear trends) was -0.3%. Because *"a utilization trend that's negative doesn't seem totally appropriate, so . . . I made an actuarial adjustment to make that zero percent."* Brown TR I at 222.

Ms. Brown's methodology differed from Neighborhood's in the following respects: (a) there was no blending with emerging PMPM experience; (b) instead of developing separate

trends for 2025 and 2026, one trend was developed for 2025 that could be applied to 2025 and 2026; and (c) a negative inpatient utilization trend was adjusted to a 0.0 trend.[21]

Ms. Brown's selected and recommended annual inpatient utilization trend of 0.0% compares to Neighborhood's selected trends of 3.8% for Year 1 and -0.4% for Year 2 (resulting in Neighborhood's average annual inpatient utilization trend of 1.7%). OHIC Exhibit 1C at 15, 17; Brown TR I at 208-209.

Recommended Alternative Methodology for Outpatient Utilization Trend Development

Neighborhood noted that it has observed that often inpatient and outpatient trends are inversely related due to shifts in services from inpatient settings to outpatient settings and vice versa. Indeed, Neighborhood made an adjustment to account for this general observation. To honor Neighborhood's reasonable stated interest in being able to observe and consider any such shifts, Ms. Brown calculated the outpatient utilization trend using the same 21 months of data (January 2023 through September 2024) that she (and Neighborhood) used to calculate the inpatient utilization trend. "*I believe by using the same time period for outpatient as for the inpatient calculations the relationship between these categories should be adequately reflected in the trends*." OHIC Exhibit 1C at 15; see Brown TR I at 221. An additional reason for relying only on the 21 months of data from January 2023 through September 2024 for the outpatient

[21] OHIC Notes that outside of discovery Neighborhood produced Neighborhood Exhibit 6, that appeared to reflect an updated version of their original inpatient regression analysis with additional months of data and run out, and which was entered in evidence. However, Neighborhood did not offer any testimony regarding this Exhibit. Therefore, it is unclear what if any relevance Neighborhood may be seeking to attribute to this exhibit. Ms. Brown had several questions about the exhibit and testified it was concerning in that it was adding in extra months with very limited run out that could be impactful to the trend. A more detailed discussion of this exhibit can be found at Brown TR I at 209-211.

service category is that *"in the trend exhibit provided by NHPRI [OHIC Exhibit 34, Tab 2-3.1] they show that 2022 outpatient utilization required an adjustment for COVID-19 therefore, like with inpatient, by using experience starting in 2023 the impact of COVID-19 on the resulting trend estimate is lessened.*" OHIC Exhibit 1C at 15; Brown TR I at 223 (*"I didn't want the 2022 COVID-19 impact to skew my results*").

The resulting calculated outpatient utilization trend (the average of exponential and linear trends) was 1.5%. No adjustment was made in consideration of the inpatient utilization trend because the 1.5% trend figure as compared to the original -0.3% inpatient utilization trend represented an appropriate relative trend relationship. See Brown TR I at 223.

Ms. Brown's methodology differed from Neighborhood's in the following respects: (a) 21 months of data were used in place of the 57 used by Neighborhood to be consistent with the 21 months of data used in the inpatient trend development and to control for COVID-19 impacts to trend; (b) there was no blending with emerging PMPM experience; (c) instead of developing separate trends for 2025 and 2026, one trend was developed for 2025 that could be applied to 2025 and 2026; and (d) no adjustment was necessary and therefore none was made in consideration of the 1.5% outpatient utilization trend as compared to the original -0.3% inpatient utilization trend.

Ms. Brown's selected and recommended annual outpatient utilization trend of 1.5% compares to Neighborhood's selected trends of 0.2% for Year 1 and 4.1% for Year 2 (resulting in Neighborhood's average annual outpatient utilization trend of 2.0%). OHIC Exhibit 1C at 16-17; Brown TR I at 224.

<u>Recommended Alternative Methodology for Professional Utilization Trend Development</u>

Ms. Brown noted that in the trend exhibit provided by Neighborhood at OHIC Exhibit 34, Tab 2-3.1, Neighborhood shows that its 2021 professional utilization trend required an adjustment for COVID-19 but its 2022 professional utilization trend did not. Consequently, Ms. Brown *"used experience starting in 2022 to lessen the impact of COVID-19 on trends but rely on as much recent historical data as possible."* OHIC Exhibit 1C at 15; Brown TR I at 224. Specifically, Ms. Brown utilized 33 months of data from January 2022 through September 2024. She testified that 33 months of data is considered a reasonable amount of data for an actuary to use to develop utilization trends and even observed that, similar to how Neighborhood developed its inpatient utilization trend, 24 months of data or even less than 24 months of data can be used for utilization trends. Brown TR I at 224.

The resulting calculated professional utilization trend (the average of exponential and linear trends) was negative. *"[T]rying to be consistent with all service categories, [and because] I don't think a negative utilization trend is necessarily appropriate . . . I made the adjustment to a zero percent trend." Brown TR I at 225. OHIC Exhibit 1C at 16.*

Ms. Brown also indicated that she wanted to honor Neighborhood's testimony that it was their intention to implement policies aimed at increasing PCP utilization as a component of their efforts to ensure compliance with Neighborhood's PCP Regulatory Targets set forth in 230-RICR-20-30-4.10(B). See OHIC Exhibit 41. Consequently, she then adjusted the 0.0% professional utilization trend upwards to 0.3%. Ms. Brown testified that this upwards adjustment was not intended to represent the low end of what she understood to be Neighborhood's adjustment to reflect anticipated increased utilization towards compliance with the PCP Regulatory Targets. Brown TR II at 45-46.

OHIC respectfully submits that Neighborhood's trend development spreadsheets, narratives provided in discovery, and testimony at the Public Rate Hearing were not sufficiently clear in their attempts to explain exactly how Neighborhood had incorporated a portion of the cost their compliance with the PCP Regulatory Targets into their professional utilization trend. Ms. Brown understood Neighborhood's evidence on this point to be that they expected their primary care services to increase annually by 2-4% (or a quarter of the 11.6% annual increase that they believe is necessary to increase primary care spend as a percent of total medical expenditures by 1.0%) as a result of policy initiatives they were implementing.[22] Therefore, Ms. Brown added 0.3% to the professional trend to reflect this adjustment and account for primary care services being approximately 9.4% of total professional services. OHIC Exhibit 1C at 16; Brown TR I at 225.

However, after considering the additional information on this topic provided by Neighborhood at the Public Rate Hearing as well as in Neighborhood Exhibit 13, submitted post-hearing, OHIC now observes that it would be actuarially reasonable to allow for a 2% upward adjustment to the annual professional utilization trend to account for Neighborhood's projected 2024 to 2026 PCP Util/1000 change of 28.3%.[23] As noted elsewhere, the Rate Request included approximately $300,000 of Neighborhood's total $2.1 million estimated increased claims cost in 2026 necessary to comply with the PCP Regulatory Targets. It remains unclear to OHIC whether Neighborhood intends in its post-hearing papers to request the Commissioner ensure the approximate $2.1 million total cost of compliance is accounted for in Neighborhood's approved

[22] Neighborhood appeared to concede this fact at McClaine TR II at 55.

[23] It is OHIC's understanding that this 4% adjustment to the projected 2026 professional |utilization trend will account for approximately $287,065 of Neighborhood's estimated $2.1 million total cost of compliance with the PCP Regulatory Targets.

rates for 2026. It also remains unclear whether the Commissioner, regardless of Neighborhood's request, will reasonably determine that ensuring the full cost of compliance is accounted for in Neighborhood's 2026 plan year rates is in the proper conduct of Neighborhood's business and in the interest of the public. Consequently, OHIC makes two alternative recommendations regarding the proposed professional utilization trend. If a determination is made that, consistent with the Rate Filing, it is appropriate to include only approximately $300,000 of the PCP Regulatory Target compliance cost, it is OHIC recommendation that this can and should be achieved through a 2% upward adjustment to the annual professional utilization trend (resulting in a recommended 2% annual professional utilization trend assumption). However, if a determination is made that it is in the proper conduct of Neighborhood's business and in the interest of the public for Neighborhood's approved rates to account for the approximate $2.1 million total increased costs of compliance, then OHIC recommends that, given the nature of the evidence in the record, the Commissioner allow for no upward adjustment to the annual professional utilization trend to account for compliance with the PCP Regulatory Targets (leaving the professional utilization trend at 0.0%) and instead include up to the full cost of compliance as a contribution to Neighborhood's reserves.[24]

Ms. Brown's methodology differed from Neighborhood's in the following respects: (a) 33 months of data were used in place of the 57 used by Neighborhood to control for COVID-19 impacts to trend; (b) there was no blending with emerging PMPM experience; (c) instead of developing separate trends for 2025 and 2026, one trend was developed for 2025 that could be

[24] Neighborhood Exhibit 13 represents that a 4% CTR, resulting in a 3.1% increase in average premiums, would be necessary to account for the full cost of compliance, assuming no adjustment to professional utilization trend attributable to the PCP Regulatory Targets. Neighborhood Exhibit 13 at 1-2.

applied to 2025 and 2026; (d) adjusted the resulting negative trend to a 0.0% trend using actuarial judgement and (e) to adjust for Neighborhood's estimated increased utilization to anticipated with efforts to comply with the PCP Regulatory Targets with either a 0% or a 2% adjustment was made.

Ms. Brown's selected and recommended annual professional utilization trend of either 0% or 2% compares to Neighborhood's selected trends of 2.5% for Year 1 and 2.1% for Year 2 (resulting in Neighborhood's average annual professional utilization trend of 2.2%).

Recommended Alternative Methodology for Ancillary/Other Utilization Trend Development

The Ancillary/Other service category is an extremely small category with limited data and, as a result, many carriers simply apply their professional utilization trends to the ancillary category. Because this category reflects such a small amount of data it can be very volatile. Brown TR I at 227.

For consistency with the development of the professional trend estimate as well as to respect nuances in Neighborhood's data reflecting that May of 2024 was an outlier, Ms. Brown utilized 32 months of data (January 2022 through September 2024, excluding May 2024 consistent with Neighborhood regressions) for the calculation of the ancillary/other medical trend. The resulting alternative estimated ancillary/other utilization trend (the average of exponential and linear trends) using Ms. Brown's methodology was 7.1%. OHIC Exhibit 1C at 16.

Ms. Brown's methodology differed from Neighborhood's in the following respects: (a) 32 months of data were used in place of the 56 used by Neighborhood for consistency with professional trend and to respect Neighborhood's actuarial judgement to remove May 2024 data; (b) there was no blending with emerging PMPM experience; and (c) instead of developing

separate trends for 2025 and 2026, one trend was developed for 2025 that could be applied to 2025 and 2026.

Ms. Brown's selected and recommended annual professional utilization trend of 7.1% compares to Neighborhood's selected trends of 0.2% for Year 1 and 3.8% for Year 2 (resulting in Neighborhood's average annual professional utilization trend of 1.9%). OHIC Exhibit 1C at 16, 17.

Recommended Alternative Methodology for Pharmacy Utilization Trend Development

For consistency with the development of the professional and ancillary/other trends; to limit the potential impact of COVID-19 on the results (while acknowledging COVID is not as impactful on pharmacy as it is on other service categories); and to acknowledge that pharmacy trends change more rapidly than other trends, Ms. Brown utilized 33 months of data (January 2022 through September 2024) as compared to Neighborhood's 57 months to calculate the pharmacy utilization trend. OHIC Exhibit 1C at 16; Brown TR I at 228.

Ms. Brown also sought to honor Neighborhood's indication in their rate development that an adjustment of 2-4% is necessary to reflect an expected increase in utilization due to the specialty cost sharing maximum effective 1/1/2025 by applying an upward adjustment of 2% in the calculation of the pharmacy utilization trends. She selected the low end of this 2-4% range because, based on her interpretation of how Neighborhood had developed its rates, it appeared to Ms. Brown that Neighborhood had applied a 1.6% adjustment. Brown TR I at 228-229.

Ms. Brown's resulting alternative projected pharmacy utilization trend was 4.4%, as compared to Neighborhood's selected trends of 6.9% for Year 1 and 4.5% for Year 2 (resulting in Neighborhood's average annual pharmacy utilization trend of 5.3%). OHIC Exhibit 1C at 16-17; Brown TR I at 230.

OHIC Independent Trend Analysis for Reasonability and Neighborhood Exhibit 5

Ms. Brown also testified regarding her independent utilization trend development analysis that she performed on Neighborhood's data analyzing rolling 6-month and rolling 12-month trends, for the purpose of using it as *"a way for me to look at the data and develop a version of trends where I can say, okay, looking at the overall trends, looking at trends I developed; is what Neighborhood is doing or any alternative assumptions I'm coming to, reasonable."* Brown TR I at 192. Ms. Brown emphasized that her *"development of the rolling trends was really a reasonability check and not used in the actual development of my . . . alternative assumptions."* Brown TR I at 197-198.

Ms. Brown looked at both rolling six-month and rolling 12-month trends because *"rolling six month trends might indicate more recent emerging experience, which, as we note, is important to reflect on and understand. Rolling 12 months are going to give a more historical view of the data. It's typical to kind of analyze, looking at a few different time periods, to kind of fully understand the picture. Rolling 12 month claims or trends are going to be less volatile, but six month trends are going to show more emerging new patterns."* Brown TR I at 194. Her analysis looked at all the medical service claims categories aggregated because *"it can be helpful to look at the total medical trend, because it reflects sort of the full picture view. It will account for shifts amongst service categories, so you are kind of looking, again, at across the board, with what is the trend for your entire block.*" Brown TR I at 200. The methodology and results of this independent utilization trend development analysis are described in more detail at OHIC Exhibit 1C, pages 10-13. Having completed this analysis as a reasonability check, Ms. Brown observed that her rolling 6-month and rolling 12-month results as depicted in Tables 7 and 8 of her

Actuarial Analysis produced lower overall trends as compared to the pricing trends utilized by Neighborhood. OHIC Exhibit 1C at 13.

It should perhaps be noted that Neighborhood appears to have performed some sort of updated replication of Ms. Brown's rolling 6-month and rolling 12-month analysis that included an additional month of claims run out (through May 2025 vs through April 2025) in Neighborhood Exhibit 5 that was produced outside of discovery and entered in evidence. Brown TR I at 196-197. Neighborhood, however, did not provide or elicit any testimony relating to its Neighborhood Exhibit 5 so its purpose and relevance in the context of the Public Rate Hearing from Neighborhood's perspective is unclear. Ms. Brown commented that Neighborhood Exhibit 5 appeared to be illustrating trend lines running all the way through March of 2025 --*"so they are showing the trends all the way through March of 2025. I think that is . . . really still very early and very incomplete . . . the completion factor is a really be component to how that PMPM would be developed . . . so I would focus on still the December 2024 row as sort of my guideline."* Brown TR I at 198.

Ms. Brown testified that, having had an opportunity to review and consider the information presented in Neighborhood Exhibit 5, this information did not change her opinion as to any of the alternative utilization trends she is recommending to the Commissioner. Brown TR I at 199.

Dr. Whaley's Testimony related to Medical Utilization

Before leaving the topic of Neighborhood's Medical Utilization Trends, OHIC notes that Dr. Whaley provided extensive written and oral testimony on the topic of GLP-1

pharmaceuticals.[25] See AG Exhibit 1 at 4-6; Whaley TR II at 78-81. Dr. Whaley's points on the topic of GLP-1s can be summarized as: (a) a component of Neighborhood's increased premium trend projections are attributable to its coverage of GLP-1 pharmaceuticals; (b) that *"while initially costly, increased use of GLP-1s may lead to longer-term reductions in overall spending"* such as on reduced hospitalizations and medical costs and may ultimately reduce spending and thus premiums; (c) *"[i]f increased GLP-1 use for diabetes patients leads to reductions in overall spending, expanded coverage may actually reduce spending, and thus premiums";* (d) *"[t]hese offsets may not have yet occurred, given that the majority of the increased spending on GLP-1s for diabetes care among the NHPRI population occurs since 2024";* (e) Dr. Whaley thinks that an offset may occur in Neighborhood's 2026 experience that has not already been baked into their historical experience because *"I believe most of the increase in spending for [Neighborhood's] GLPs happened in the 2024 period";* and therefore (f) the Commissioner should somehow consider these medical cost offsets that may not have been fully reflected in the Rate Filing. AG Exhibit 1 at 4-6; Whaley TR II at 79-81, 96.

There are numerous shortcomings to Dr. Whaley's analysis, conclusions and recommendation. First, Dr. Whaley's hypothesis that there may be unaccounted for medical cost offsets in 2026 is based on his belief that *"most of the increase in spending for GLPs happened in the 2024 period."* However, the evidence in the record does not contain evidence of a marked increase in utilization of GLP-1s in 2024. Dr. Whaley's assumption on this point is likely taken

[25] Indeed, several of the OAG's exhibits related to the topic of insurance coverage of GLP-1s. AG Exhibits 18-26.

from the figures in OHIC Confidential Exhibit 28.[26] What Dr. Whaley did not clarify and/or did not understand is that OHIC Confidential Exhibit 28 reflects membership months and overall spending. It does not bear evidence of a dramatic increase in GLP-1 utilization among Neighborhood's membership in 2024 because the figures therein are not separated into cost and utilization factors. Also, given general testimony in evidence regarding relatively recent GLP-1 drug shortages and price spikes, not to mention Neighborhood's approximate 50% increase in membership over 2024, guessing at utilization trends from the data in OHIC Confidential Exhibit 28 would be unwise. OHIC not suggesting that there has not been increased utilization of GLP-1s over time. However, Dr. Whaley's theory is based on the premise that there was a decided surge in this utilization in Neighborhood's population specifically in 2024. It is that fact, either the truth of it or the magnitude of it, that OHIC submits is not established in the evidence.

Second, given that there is no evidence in the record, at least none that the AG has identified, of a marked increase in GLP-1 utilization in 2024 as compared to 2023, it is at least equally and likely more reasonable to assume that the medical cost offsets from GLP-1 coverage, to the extent they have begun to be realized, have already been baked into Neighborhood's historical medical trends. See Whaley TR II at 80. Dr. Whaley appeared to acknowledge this when he testified *"I guess what to note is I mean there is suggested evidence that maybe those offsets are projected to occur through the estimates of both reduced inpatient PMPM to both the Neighborhood and the OHIC actuarial review."* Whaley TR II at 80.

[26] OHIC Confidential Exhibit 28 is data that Neighborhood provided in response to a request for information from the Attorney General. As Dr. Whaley indicated in his earlier testimony and as is apparent from a review of the exhibits entered in evidence, The OAG and Dr. Whaley had ample opportunity to request information from Neighborhood during discovery and could have requested information about historical GLP-1 utilization experience if it were material to the Dr. Whaley's review and recommendations.

Third, and perhaps most concerning is that when asked if he could have quantified for the Commissioner's consideration these unaccounted-for 2026 offsets that he had testified to, Dr. Whaley responded *"I believe I would be able to. I have not quantified it in my report, but that is something with, say, access to claims data, and say, looking at adherence measures can certainly be done."* Whaley TR II at 97.

We are left with a vague recommendation from Dr. Whaley that is unsupported by the evidence, that the Commissioner consider that Neighborhood's GLP-1 coverage may lead to an unquantified amount of medical cost offsets that may occur in 2026 and that may not have already been baked into Neighborhoods historical claims data.

OHIC submits that, based on the credible evidence in the record, it is not reasonable to recommend an adjustment to the medical utilization trends based on Dr. Whaley's written and verbal testimony on the topic of GLP-1s.

Summary of Recommended Utilization Trend Alternative Assumptions, in Total

With regard to each of her recommended alternative utilization trend assumptions Ms. Brown testified that in her professional actuarial opinion her *"assumptions are more reasonable [than Neighborhood's] in all cases, with the exception of professional, because . . . I would want to further understand [the PCP adjustment] calculation. . ."* Brown TR I at 231. Ms. Brown added she nonetheless believed her recommended professional trend was a reasonable trend. Brown TR I at 232.

On the specific topic of an adjustment to Neighborhood's professional utilization trend to account for anticipated increased PCP utilization as a component of policy initiatives Neighborhood is undertaking towards compliance with its PCP Regulatory Targets, on the one

hand OHIC agrees it is appropriate to make an adjustment to account for this and upon further consideration of all the evidence, including Neighborhood Exhibit 13 admitted in evidence post-hearing, OHIC represents that an approximate 2% upwards adjustment to the 0.0% annual professional utilization trend would appropriate to account for this factor in place of OHIC's originally proposed 0.3% upward adjustment. On the other hand, OHIC notes that Neighborhood Exhibits 10, 12 and 13, taken together in relevant parts, indicate Neighborhood only incorporated approximately $300,000 of its projected approximate $2.1M cost to comply with its PCP Regulatory Targets into the professional utilization trend component of the Rate Request and indicate an additional percentage increase in CTR or premium that would be needed to cover its projected $2.1M compliance costs assuming no actuarial adjustment to the professional utilization trend component.

OHIC submits that the questions around whether, to what extent, and where the estimated cost of compliance with the 2025 and 2026 PCP Regulatory Targets should be incorporated into the Rate Filing are all within the discretion of the Commissioner, particularly given that Neighborhood affirmatively decided to exclude approximately $1.8M of this cost in the Rate Request (see below discussion on the issue of CTR).

Neighborhood failed to carry its burden of proof by a preponderance of the evidence to establish that its methodology and reasoning in selecting each of its utilization trend lines was more reasonable than OHIC's and Ms. Brown's recommended alternative methodologies and resulting utilization trends. In particular, Neighborhood has failed to establish that it was reasonable to develop its trends on COVID-impacted data without adjusting for this COVID impact and has also failed to establish that it was reasonable to blend emerging PMPM data with utilization trends. Neighborhood has therefore also failed to establish that its selected utilization

trend lines are both consistent with the proper conduct of Neighborhood's business and is in the public interest.

With the caveat noted below, OHIC recommends that it is actuarially more reasonable for Neighborhood to revise its utilization assumptions to be based on the alternative methodologies recommended by Ms. Brown at the Public Rate Hearing. Brown TR I at 231, 265. By directing Neighborhood to adopt these alternative methodologies, OHIC estimates Neighborhood's annual utilization trend assumptions would change from 1.7% to 0.0% for inpatient; from 2.0% to 1.5% for outpatient; from either (a) 2.2% to 2% for professional or (b) 2.2% to 0% for professional; from 1.9% to 7.1% for ancillary/other medical; and from 5.3% to 4.4% for pharmacy.

Because OHIC has updated the recommendation it proffered at the Public Rate Hearing and is now providing two alternative professional utilization trend recommendations (see below paragraph), OHIC is unable to provide the Commissioner with an estimate of the impact of the above changes to utilization trends on premium rates. (OHIC previously included a recommendation to revise the professional utilization trend from Neighborhood's 2.2% to 0.3%. When that recommendation was included with its other recommended changes to utilization trends, OHIC estimated these changes would result in a net reduction of 1.7%[27] to Neighborhood's proposed premium rates. OHIC Exhibit 1C at 16-17; Brown TR 1 at 230).

The caveat to this recommendation is that, regarding the professional utilization trend assumption, OHIC submits it is equally reasonable and within the Commissioner's discretion to

[27] In her testimony, Ms. Brown noted that in reaching her cumulative -1.7% estimated impact on rates figure, she specifically did not assume that the change in the pharmacy utilization trend would impact rates at all. So, while she noted it in her written Actuarial Report as well as in her testimony, the impact to pharmacy utilization is merely reflective of how Neighborhood is calculating its trends. Brown TR I at 230-231.

adopt either of OHIC's two following alternative recommendations, or something else: (1) a 2% upward adjustment to the annual professional utilization trend to account for Neighborhood's projected 2024 to 2026 PCP Util/1000 change of 28.3% (resulting in a recommended 2% annual professional utilization trend assumption) in the event the Commissioner determines it is appropriate for the rate filing to be deficient for the balance of the total $2.1 million estimated increased claims costs through 2026 necessary to comply with the PCP Regulatory Targets; or (2) a 0% adjustment to the annual professional utilization trend line (i.e., leaving the professional utilization trend at 0.0%) in the event the Commissioner determines Neighborhood's rates should account for the total cost of compliance with the PCP Regulatory Targets and allows a CTR to account for same.

Neighborhood Should Revise its Overall Pharmacy Trend Assumptions for Specialty and Other Non-Specialty and Revise its 2025 GLP1/SGLT2 Trend Assumption.

To develop the overall pharmacy trend assumptions Neighborhood analyzed the annualized PMPM trend for pharmacy, gross of rebates, by three categories: GLP1/SGLT2, Specialty, and Other Non-Specialty. Neighborhood first calculated the observed annualized trend for each category from 2021 to 2024. Next, Neighborhood selected a final trend that varied from the observed calculated trends based on their actuarial judgement. In response to questions submitted to them by OHIC, Neighborhood stated their adjustments for actuarial judgement were based on (a) upward pressure from emerging 2025 trends (Robb TR I at 51-52), (b) expected increases in specialty utilization due to state mandated cost sharing maximums, and (c) the expectation that their GLP1/SGLT2 utilization will plateau in 2026. OHIC Exhibit 1C at 20; 28 Brown TR I at 239-240; see Robb TR I at 97.

Taken together, Neighborhood selected higher overall pharmacy trends for 2025 relative to actual observed annual trends developed from its 2021-2024 claims data for both the GLP1/SGLT2 category and the Other Non-Specialty category. OHIC Exhibit 1C at 20 (see also Table 12 therein).

The overall pharmacy trend assumption is the key rate development factor for pharmacy in the Rate Filing. While the Rate Filing template has separate cells for projected pharmacy unit costs and projected pharmacy utilization trends, developing the information for these tabs is largely an exercise. *"[T]he way the trends are developed by Neighborhood for pharmacy is they develop the total pharmacy trend. They develop the utilization trend and then back into the cost trend, so while this is a valid exercise, what really matters in pricing is the total pharmacy trend."* Brown TR I at 220;[28] see also Brown TR I at 239-240.

Regarding Neighborhood's assertion that it adjusted its overall pharmacy trend to account for upward pressure from emerging 2025 trends, Ms. Robb asserted that she believed it was appropriate to account for emerging first quarter 2025 pharmacy data in their calculations because this pharmacy data was virtually complete at the time of filing. Robb TR I at 51and 85. However, Ms. Robb went on to testify that Neighborhood had not explicitly included an adjustment to the overall pharmacy trend development to account for their emerging experience.[29] Instead, she noted that *"[i]implicitly, there's a little bit of consideration for emerging trend, looking at our selection, looking at our selection, based on the annualized trend, so mostly that is on the non-specialty, where you can see '22 to '24 had trends of minus 1.5 plus*

[28] Ms. Robb explained *"first we estimate the utilization trend and then we estimate the total PMPM trend. Once we have both of those pieces, we are able to just back into the cost trend"*. Robb TR I at 46.

[29] She said they instead *"used the emerging experience to separate out the utilization trend from the cost trend."* Robb TR I at 98.

6.0 and .5 and we ultimately selected 5.0. Although the annualized was 1.6, so that is where we gave a little bit of consideration to the fact that we're seeing larger trends emerging." Robb TR I at 97-98. In other words, Neighborhood claims that it implicitly adjusted its "Other Non-Specialty" trend upwards from its historical annualized trend of 1.6% to 5% to account for its emerging first quarter 2025 PMPM pharmacy experience.[30] Inexplicably though, Neighborhood did not include any actuarial adjustment, explicit or implicit, to its historical annualized trend of 7.5% in its "Specialty" category to account for the emerging experience it claimed it was seeing in that category as well.[31] Robb TR I at 98-99.

[30] OHIC would disagree with the characterization of this adjustment as only reflecting "*a little bit of consideration."*

[31] Transcript I at 98 contains the following cross-examination exchange with Ms. Robb:

> *Q. But you also, and correct me if I am wrong, but I believe you testified earlier that you were seeing some significant emerging experience in the specific category of specialty drugs; is that a fair understanding of your testimony?*
>
> *A. Yes, although, I didn't mean to imply that it was only specialty.*
>
> *Q. Okay, but with that caveat, when I look at the same trend development chart, it appears -- is it fair to say that the selected trend number is the annualized percentage that was selected for 2025?*
>
> *A. For a specialty?*
>
> *Q. For a specialty, yes.*
>
> *A. That is correct.*
>
> *Q. And so would it be fair to say that there hasn't been an adjustment for specialty drug to account for this emerging experience in your overall pharmacy trend development?*
>
> *A. That is correct.*
>
> *Q. And also, with regard to the specialty drug rate cap legislation, that is somewhat recently effective; is it also fair to say that there wasn't an adjustment to your specialty trend for that?*
>
> *A. For the overall, yes. For utilization there was an adjustment.*
>
> *Q. Okay, but for your overall, there was not?*
>
> *A. Correct.*

Neighborhood's testimony, responses in discovery, and production of Neighborhood Exhibit 7,[32] sought to justify their actuarial judgement adjustments to their overall pharmacy trend as necessary to account for the impact of the specialty co-payment cap legislation, particularly in their emerging experience. See Robb TR I at 97-99;[33] and Neighborhood Confidential Exhibit 7. However, a review of Tab 2-3.7A of OHIC Confidential Exhibit 34 shows that Neighborhood did not in fact make any actuarial adjustment to the "Specialty" category included in their overall pharmacy trend assumption and instead based their selected trend entirely on their historical experience. Brown TR I at 242. To put it more simply, Neighborhood did not in fact adjust its "Specialty" category trend component to adjust for the specialty co-payment cap legislation. When questioned about this inconsistency, Ms. Robb's response was that Neighborhood took the state mandated specialty co-payment maximum cap legislation into account in developing their pharmacy utilization trends for specialty drugs but did not do so in the context of their overall pharmacy trend. Robb TR I at 98-99. This testimony failed to satisfactorily explain the inconsistency, *"because what matters is the total [overall pharmacy] trend, based on how they are calculating the trend."* Brown TR I at 240-241; see Brown TR I at 192; 203-204 ("*the utilization trend for pharmacy is not as impactful, because of the total pharmacy trend is what is meaningful in the rate development"*). While in theory it may be actuarially appropriate for Neighborhood to have developed an adjustment to account for the impact of the specialty drug co-payment cap legislation on the Specialty drug component of its

[32] Neighborhood Exhibit 7 is a Table titled "Pharmacy Impact on Specialty Copayment Cap" that seeks to set forth a trend comparison of increased Pharmacy PMPM between January to June 2024 and January to June 2025. Neighborhood did not address this Exhibit in their testimony at the Public Rate Hearing.

[33] Indicating that Neighborhood observed significant emerging experience, i.e., from 1st quarter 2025, in the specific category of specialty drugs on account of recent specialty drug state mandated cost sharing maximum cap legislation and that this fact influenced their adjustments based on actuarial judgement.

overall pharmacy utilization trend, "*Neighborhood did not adjust for that in their total pharmacy trend, so it's hard for [OHIC] to know what that adjustment would be, because they did not build in an adjustment for it."* Brown TR II at 25

On the specific topic of Neighborhood Confidential Exhibit 7 which sought to depict the impact of the specialty drug copayment cap as seen in emerging 2025 pharmacy, Ms. Brown did grant that she thought it was informative of pharmacy trends (noting that unlike medical trends, pharmacy trend needs less run-out to be complete). However, she again noted that Neighborhood had not included any adjustment on account of this data to their specialty trend and that she did not find the information on this exhibit to be *"enough for me to apply any adjustment, myself, using that,"* Brown TR I at 242, and indicated that, even thought it might be actuarially reasonable to make an adjustment for that information, *"I am not sure how to quantify a number to increase the trends for that."* Brown TR I at 246.

Having noted the shortcomings and inconsistencies with Neighborhood's development of its overall pharmacy trend[34], OHIC recommends an alternative methodology for developing Neighborhood's Overall Pharmacy Trend Assumption that places more weight on recent (albeit not "emerging") experience and less on vague actuarial judgment adjustments. Ms. Brown testified that in her professional opinion this alternative proposed assumption is equally or more reasonable that the assumption employed by Neighborhood. Brown TR I at 245-246.[35]

[34] Neighborhood's testimony on the topic of its overall pharmacy trend development was at times confusing because of the manner in which it was folded into their discussion about pharmacy utilization trend development, and it was at times difficult to determine which trend they were referring to.

[35] OHIC notes that at pages 245-246 of TR I Ms. Brown testified that her alternative assumption for overall pharmacy was more reasonable than Neighborhoods. At pages 265-266 of TR I Ms. Brown testified that her alternative assumption for overall pharmacy trend was equally reasonable to Neighborhoods and based on the context of that statement it is reasonable to conclude that her arguable

First, OHIC recommends that Neighborhood develop its average annualize PMPM trend rate using more recent claims data to develop their trends. Specifically, three years of claims data from 2022 through 2024 (in place of the four years utilized by Neighborhood), and then utilize that PMPM trend rate developed using this more recent time period rather than Neighborhood's approach of selecting a trend based largely on actuarial judgement. *"Using trends that are based on more recent months would put more weight on the more recent experience."* Brown TR II at 36. The result would be a lower pharmacy trend overall (although some components of these trend results were slightly higher than what Neighborhood selected, Brown TR I at 243). OHIC Exhibit 1C at 20. Neighborhood said it selected its January 2021 through December of 2024 claims period for developing its pharmacy trend *"in order to in order to incorporate as much relevant data as we could. Pharmacy trends tend to evolve more rapidly compared to medical trends due to new launches and generic availability, in particular, so we felt that excluding 2020 was appropriate, given that a shorter amount of time is then a little bit more reliable for pharmacy compared to medical."* Robb TR I at 46-47. As Ms. Brown noted, this statement is supportive of the component of OHIC's alternative recommendation to develop the overall pharmacy trend utilizing data from the shorter and overall more recent time frame of 2022 through 2024. Brown TRI I at 243.

Second, OHIC recommends adopting Neighborhood's lower assumed trend assumption of 39.6% for 2026 specifically in the GLP1/SGLT2 category on account of Neighborhoods assertion that it expects GLP1/SGLT2 utilization to plateau in 2025. Ms. Brown explained,

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slight change in opinion was influenced by the specialty drug copayment cap information in Neighborhood Confidential Exhibit 7 which she indicated was informative but, because Neighborhood did not make an adjustment for that information she did not know how to quantify it and incorporate it into her recommendation. Brown TR I at 265-266.

"[f]or 2026 trends, I tried to be consistent with theirs, so using the same trend for both '25 and '26, when it comes to specialty and other non-specialty, I do think that their commentary on GLP-1s plateauing in 2026 is reasonable. Generally speaking, when a high cost drug enters the market you see an uptick in usage, due to some pent up demand and then that will eventually plateau as the pent up demand decreases, and then the utilization sort of ends up in your experience, so I selected the same trend as Neighborhood." Brown TR I at 243-244; see also Brown TR II at 25. While Ms. Robb seemed to take issue with Ms. Brown's recommendation that Neighborhood continue to utilize its lower 2026 trend figure for GLP1/SGLT2 claiming doing so might create consistency issues, Robb TR I at 51-52, her reasoning falls flat in light of the fact that Neighborhood itself "inconsistently" made this adjustment only to its 2026 trend figure to account for Neighborhood's expectation that utilization of GLP1/SGLT2 would decrease to that level in 2026.

At one point during a discussion on pharmacy trend, Ms. Robb expressed a concern that OHIC's overall pharmacy trend recommendation and its pharmacy utilization trend recommendation may may be duplicative of each other since they were considered separately, perhaps suggesting a risk that Ms. Brown was double counting in her estimates. Robb TR I at 52. Ms. Brown put those concerns to rest stating that when she estimated the impact on the rate request, both for her recommendation on the topic of pharmacy utilization trend and in her recommendation of overall pharmacy utilization trend she did not assume any change to rates on account of any changes to the pharmacy utilization trend assumption and was instead focused on the overall pharmacy trend. Brown TR I at 230, 244-245; see also Brown TR II at 23-24.

OHIC's methodology and resulting alternative calculations and recommended overall pharmacy trends can be found at OHIC Exhibit 1C at 20, including Tables 12 and 13 therein.

Neighborhood has failed to carry its burden of proof, by a preponderance of the evidence, to support that its proposed overall pharmacy trend assumption for 2026 of 14.0%, that is arrived at by relying heavily on the inconsistent application of implicit actuarial judgement, is more reasonable than OHIC's recommended alternative assumption of a 12.1% for 2026. Neighborhood has therefore failed to establish that its proposed overall pharmacy trend assumption for 2026 of 14.0% is consistent with the proper conduct of Neighborhood's business and is in the public interest.

OHIC submits, based on all the credible evidence introduced on this matter, that it is more reasonable for Neighborhood to revise its overall pharmacy trend assumptions for Specialty and Other Non-Specialty to be set equal to the observed annualized trends for those categories when using experience from 2022 through 2024, and revising the 2025 trend assumption for GLP1/SGLT2 to be based on the same experience (leaving Neighborhood's 2026 trend assumption for GLP1/SGLT2 intact). OHIC's proposed alternative assumption is supported by the evidence in the record and consistent with the proper conduct of Neighborhood's business, and in the public interest.

If Neighborhood were to revise its overall pharmacy trend assumptions for Specialty and Other Non-Specialty to be set equal to the observed annualized trends for those categories when using experience from 2022 through 2024, and revise the 2025 trend assumption for GLP1/SGLT2 to be based on the same experience, this would be estimated to decrease the proposed rates by approximately 1.3%. Brown TR I at 246, 263; OHIC Exhibit 1C at 20. Neighborhood estimated that adopting OHIC's overall pharmacy trend assumptions would result in a decrease to the proposed rates of 1.9%.

Before leaving this topic, OHIC notes that Dr. Whaley recommended the Commissioner *"consider the increased use and availability of biosimilars as a dampening impact on . . . spending on specialty medications."* Whaley TR II at 97. In support of this vague recommendation Dr. Whaley offered that in the context of biologic "*brand"* drugs, which make up a subset of specialty drugs, the market has seen increases in the availability of biosimilar drugs, *"essentially generic options,"* as evidenced by Neighborhood's increased spending on biosimilar drugs. Whaley TR II at 81; OHIC Confidential Exhibit 28. Consequently, Dr. Whaley reasoned *"so I think both the downward pressure on prices that is likely to and almost certain to occur as more biologics or biosimilar become available as well as potential options to increase use of biosimilars, could be both areas that would lead to reductions in overall rates."* Whaley TR II at 81.

While OHIC does not quibble with Dr. Whaley's general observations in this area, both he and the OAG failed to assert, much less establish, that these savings from member's switching from more expensive branded biologics to less expensive biosimilars are not already acknowledged, incorporated into and accounted for in Neighborhood's development of its specialty drug trend. Indeed, the evidence in the record indicates the opposite. Neighborhood's Part III Actuarial Memorandum, page 3, states that *"[w]hile the availability of new biosimilars in 2024 and 2025 may support slowing of trend, there are limited biosimilars to be released in 2026."* Neighborhood Exhibit 1 at 21. Also, OHIC Confidential Exhibit 28, produced by Neighborhood, indicates the material slowing of overall cost increases in specified specialty drug categories when member switch to newly available biosimilars is already baked into Neighborhood's historical claims experience.

When questioned more than once on cross examination whether he was *"aware of any biosimilars that may be coming onto the market in 2026,"* Dr. Whaley repeatedly deflected and failed to respond to the question, Whaley TR II at 125, implicitly acknowledging he was not aware of any unaccounted-for biosimilar market entrants that might specifically impact 2026 specialty drug costs.

We are left with a vague recommendation from Dr. Whaley that is unsupported by the evidence, that the Commissioner consider that Neighborhood's GLP-1 coverage may lead to other unquantified medical cost offsets that may occur in 2026 and that may not already been baked into Neighborhoods historical claims data.

Dr. Whaley's recommendation on behalf of the Attorney General that the Commissioner should consider the increased use and availability of biosimilars as an unaccounted-for dampening impact on Neighborhood's proposed overall specialty drug trend projection is not supported by the credible evidence in the record and reasonable inferences to be drawn from that evidence.

Neighborhood Should Assume A Risk Adjustment Transfer Payment Of $43.50 PMPM Rather Than $45.30 PMPM.

The Risk Adjustment program is a program implemented under the Affordable Care Act and administered by CMS. The program is designed to compensate carriers that insure higher-than-average risk of the market. And for carriers that insure lower-than-average risk for the market, they need to pay into the pool to fund the payments to those higher-than-average carriers. There are only two carriers in the Rhode Island Individual Market and Neighborhood has historically been a payor of risk adjustment payment in the market.

While a component of the Risk Adjustment program is the high-cost risk pool, Neighborhood did not assume any high-cost risk pool receipts in the development of their projected 2026 Risk Adjustment payment because Neighborhood typically does not have any high-cost risk pool receipts from the program. Neighborhood Exhibit 1 at 53 (page 9 of Part III Actuarial Memorandum); OHIC Exhibit 1C at 22; Brown TR I at 250.

Neighborhood is projecting a $45.30 PMPM payment for risk adjustment in 2026 and a $2.00 PMPM charge for the high-cost risk pool; the net effect of these components is an estimated $47.30 PMPM payable. OHIC Exhibit 1C at 22; Brown TR I at 250.

To determine Neighborhood's risk adjustment transfer payments for CY 2026, Neighborhood first made a projection of its final risk adjustment transfer payment for CY 2024. Neighborhood Exhibit 1 at 53 (page 9 of Part III Actuarial Memorandum). At the time they made this projection, the final risk adjustment payment notices for 2024 had not yet been issued. See Robb TR I at 57. Consequently, Neighborhood's assumption was arrived at by developing its best estimate for its final risk adjustment transfer payment for CY 2024, and then projecting that result forward based on assumed changes to the statewide average premium between 2024 and 2026, applying adjustments to the statewide plan liability risk score (PLRS) to account for morbidity changes between 2024 and 2026, and assuming the mix by demographics and metal level do not change meaningfully between 2024 and 2026. OHIC Exhibit 1C at 22; see also Robb TR I at 57-58; Brown TR I at 250.

This projection was done at the plan level for Neighborhood. Statewide average premium trend was assumed to be 7.6% from 2024 to 2025 (based on actual approved rate increases and weighted on projected member months), and 15.0% from 2025 to 2026 (based on NHPRI's estimate). The assumed statewide morbidity change reflects NHPRI's best estimate based on

different changes by carrier due to the on and off exchange distributions for each carrier and market share. OHIC Exhibit 1C at 22-23; see also Robb TR I at 57-58; Brown TR I at 250-251.

OHIC is recommending a relatively simple revised methodology for projecting Neighborhood's 2026 risk adjustment figure. The primary difference is that OHIC is recommending that Neighborhood use the updated the final 2024 risk adjustment results released by CMS in place of Neighborhood's estimate of the final 2024 risk adjustment results. The final 2024 risk adjustment results correspond with OHIC's estimates of these results using the RATEE files which are incorporated into Ms. Brown's Actuarial Analysis.[36] OHIC Exhibit 1C; August 6, 2025, Stipulation at Appendix B.

Using the final risk adjustment results for CY 2024 will constitute more accurate information as compared to the data used by Neighborhood in their risk adjustment estimate for CY 2024. OHIC determined that this update leads to a small decrease of approximately $0.50 PMPM in the estimated 2024 risk adjustment payment from $42.94 PMPM developed by Neighborhood to $42.41 PMPM generated by the final risk adjustment results and the May 2025 RATEE files. Brown TR I at 252; see also OHIC Exhibit 1C at 23.

"Projecting this [2024 final risk adjustment payment] forward, [to] 2026, the impact is slightly larger than the 50 cents PMPM and that is mainly due to the way Neighborhood is projecting a difference in enrollment by plan, relative to 2024, so while the impact on '24 is rather

[36] In her Actuarial Analysis, Ms. Brown was able to accurately predict the final 2024 risk adjustment results in the Individual Market via the May 2025 RATEE files sent to them by CMS. See OHIC Confidential Exhibit 22. The RATEE files, which were not available to Neighborhood when it developed its risk adjustment payment, effectively reflect the final results for the risk adjustment program and enabled OHIC to accurately estimate final 2024 risk adjustment payments and receivables in the Rhode Island Individual Market in advance of CMS releasing its final summary report of risk adjustment transfers for CY 2024. See OHIC Exhibit 1C at 23; Brown TR I at 251-252.

small, the impact on 2026 is slightly magnified . . . [and results in] my estimated transfer of 43.50[PMPM]." Brown TR I at 252; see also OHIC Exhibit 1C at 23 (Table 15 therein depicts an abbreviated version of Ms. Brown's calculations).

Ms. Brown testified that in her professional opinion, "*it is important that they use the updated [final 2024 risk adjustment] data."* She also noted that she reached her recommended alternative assumption of Neighborhood's CY 2026 risk adjustment transfer payment – the $43.50 PMPM figure – by replicating how Neighborhood calculated the figure in the Rate Filing, using *"[a]ll of their assumptions regarding premium, morbidity changes, et cetera, just updating the 2024 information and making no other changes in the assumptions."* Brown TR I at 253.

Ms. Brown stated that if Neighborhood is directed to use her calculated 2026 projected risk adjustment payment of $43.50 PMPM in place of the $45.30 PMPM Neighborhood included in the Rate Filing, she estimated this change would result in an average reduction to the proposed rates of approximately 0.4%. Brown TR I at 253-254, 267.

Ms. Brown testified that in her professional actuarial opinion it was more reasonable for Neighborhood to update its development of its assumption for CY 2026 utilizing the final risk adjustment transfer results that were recently published by CMS than to continue to utilize its estimate of the 2024 figures.

Neighborhood agreed that it was appropriate to incorporate the final 2024 risk adjustment transfer results into its development of its projected 2026 risk adjustment transfer payment, acknowledging that risk adjustment updates have been required of carriers historically in the context of rate review. See Robb TR I at 59. However, Ms. Robb testified that when Neighborhood followed OHIC's recommended methodology and only updated the final 2024 risk adjustment results (and made no changes to the statewide average premium) they calculated

a $44.16 PMPM as compared to OHIC's $43.50 PMPM and the Rate Filing's $45.30 PMPM. Robb TR I at 60. OHIC has been unable to account for this discrepancy. Ms. Robb added that, with the benefit of its rate model, Neighborhood estimated that using its $44.16 PMPM figure will similarly reduce the overall rate increase by approximately 0.4%. Robb TR I at 60.

Ms. Robb testified further that Neighborhood thought it should also be allowed to adjust its methodology to update its 2026 projected statewide average premium figure within its risk adjustment methodology because the preliminary rate increases are presently known and relevant to this calculation. Robb TR I at 59-60 *("Since preliminary rate increases are known at this point, we would also be on that update -- the same transfer factors consistent with OHIC's recommendation. We believe that only partially representing the most recently available information would not be an actuarially sound approach."*).

Ms. Robb testified that when Neighborhood incorporated both the updated final 2024 risk adjustment results (as recommended by OHIC) and the *"initially filed rate increases, our 2025 to 2026 assumption changes from 15 percent to 24 percent, which then increases our projected transfer payment to $47.49 PMPM, which is higher than the [$45.30 PMPM] that we initially filed."* Robb TR I at 60. Ms. Robb estimated that including a projected risk transfer payment of $47.49 PMPM for 2026 would produce a 0.4% increase to the Rate Request.

Ms. Brown addressed Neighborhood's apparent proposal/request, raised for the first time at the Public Rate Hearing, that they be allowed to also adjust the premium assumption that is incorporated into their development of their projected risk adjustment transfer figure using information about statewide premium averages that is presently publicly available. Ms. Brown suggested that while in theory "*that would be an appropriate adjustment to make,"* or to want to

make, she had concerns about this proposal from a practical and procedural standpoint in the context of the Public Rate Hearing and rate filings in general. See Brown TR I at 253 and 266.

OHIC recommends against allowing Neighborhood to also adjust its premium assumption based on information contained in its competitor's rate filing. Even though that information may now be public, it is not in evidence in this matter. OHIC respectfully submits that that once you start allowing one carrier to adjust their rate filing based on information gleaned from a competitor's rate filing, regardless of how relevant that information may be, a regulator will soon find themselves descending a slippery slope.

Based on the evidence introduced on this matter, reasonable inferences that can be drawn from that evidence, and Neighborhood' burden of proof, Neighborhood has failed to establish by a preponderance of the evidence that it is more reasonable for Neighborhood to project its 2026 risk adjustment figure using an estimate of the final 2024 rate adjustment figures as opposed to using the final 2024 risk adjustment transfer figures recently issued by CMS (which mirror the figures contained in the RATEE files at OHIC Confidential Exhibit 21).

OHIC's proposed alternative methodology on the topic of calculating the Risk Adjustment receivable for 2026 is supported by the evidence in the record and consistent with the proper conduct of Neighborhood' business, and in the public interest.

If the Commissioner adopts OHIC's recommendations regarding the calculation of the Risk Adjustment receivable for 2026 and instructs Neighborhood to use OHIC's estimated $43.50 PMPM figure, this would lead to an estimated 0.4% decrease in premium. In the alternative, if the Commissioner adopts OHIC's recommendations regarding the calculation of the Risk Adjustment receivable for 2026 and instructs Neighborhood to use Neighborhood's calculated $44.16 PMPM

figure, Neighborhood calculated this would similarly lead to an estimated 0.4% decrease in premium. Robb TR I at 60.

Neighborhood Should Revise Its Projected Reinsurance PMPM To Assume A Reinsurance Reimbursement PMPM Of $19.56 PMPM Rather $18.00 PMPM

The 1332 Waiver Reinsurance Program is a state-developed program to reimburse carriers for a certain subset of Individual Market incurred claims on a per member per year basis that fall between an attachment point and a cap amount. The program reimburses carriers for some percentage of claims between those levels on a per member per year basis. The carriers take these reimbursements into consideration in the context of their rate development as an offset to claims costs and this ultimately produces lower premium rates. The parameters change annually. Neighborhood assumed the 2026 reinsurance parameters will be equal to a $30,000 attachment point, 33.08% coinsurance rate, and $60,000 reinsurance cap. Actual reimbursements, however, are limited to the total funds generated and consequently carriers bear the risk if program funding comes in lower than anticipated. Robb TR I at 61; See Neighborhood Exhibit 1 at 26 (page 8 of Part III Actuarial Memorandum); OHIC Exhibit 1C at 25. OHIC is not challenging Neighborhoods projected program parameters for 2026.

The Rate Filing indicates Neighborhood is expecting to receive reinsurance reimbursements from the state reinsurance program equal to approximately $18.00 PMPM. Neighborhood blended three calculations from three separate sources of data in the development of this reinsurance reimbursement. First, they used their 2024 member level incurred claims data and they projected that claims data forward to 2026. To trend forward to 2026, Neighborhood applied an annual allowed trend assumption, consistent with pricing assumptions, and made

adjustments for changes due to morbidity and induced utilization. Then they applied their reinsurance parameters at the member level to estimate a payment by member. In other words, for this last step Neighborhood went member by member to see if the member had claims over $30,000 and, if they did, then they did the math to estimate what their expected reinsurance reimbursement would be under their projected 2026 1332 Waiver Reimbursement Program parameters. Brown TR I at 255; OHIC Exhibit 1C at 25. Second, Neighborhood used their 2023 member level claims data, projecting the claims data forward to 2026 using a similar methodology, again applying their anticipated 2026 reinsurance parameters to estimate reinsurance recoveries. Third, Neighborhood used Milliman's Commercial Health Cost Guidelines ("HCGs") data, adjusted to Neighborhood's projected 2026 incurred claims experience. Neighborhood Exhibit 1 at 26 (page 8 of Part III Actuarial Memorandum); OHIC Exhibit 1C at 25; Robb TR I at 61-63.

Neighborhood then calculated its final $18.00 PMPM projected reinsurance receivable as a weighted average of these three figures, which Neighborhood developed by applying 25% weight to each to the Neighborhood claims experience data sets and 50% weight to the Milliman HCGs. OHIC Exhibit 1C at 25; Brown TR I at 255; Robb TR I at 63-64; see also Neighborhood Exhibit 1 at 26 (page 8 of Part III Actuarial Memorandum). Ms. Robb testified that this methodology is consistent with the methodology Neighborhood has used in previous years to estimate its projected reinsurance PMPM. Robb TR I at 63.

On behalf of OHIC, Ms. Brown developed her own analysis to estimate Neighborhood's reinsurance assumption. She indicated that she *"made a couple of adjustments, but again, tried to honor the methodology shown by Neighborhood to the extent I could*." Brown TR I at 256. First, in projecting Neighborhood's claims forward from 2024 to 2026 and from 2023 to 2026,

she applied the same adjustments that Neighborhood had applied to these projections (i.e., the allowed trend adjustments, morbidity and induced demand changes) but then she *"also included adjustments to reflect demographic changes, plan design changes, [and] other changes that are in the index rate, and I also applied the leveraging impact for claims and the benefit changes, so specifically, these claims are incurred, not allowed, so I think it's important to note that the leveraging impact would be applicable. So I think that making these additional adjustments would make sure that the projected claims costs are kind of apples to apples, with the actual claims cost in the pricing."* Brown TR I at 256; Brown TR II at 27-28; See OHIC Exhibit 1C at 26 (*"[g]iven these assumptions were all incorporated into NHPRI's projected claim costs for 2026, it is appropriate to also incorporate them into the projected reinsurance reimbursement to ensure that the claim cost levels being assumed in both cases are consistent."*). OHIC submits that Neighborhood did not present any testimony or other evidence indicating a disagreement with Ms. Brown's inclusion of her additional stated adjustments to project the 2023 and 2024 data sets forward.

Next, Ms. Brown's final calculation to project Neighborhood's 2026 reinsurance PMPM was weighted 50% each to the Neighborhood 2023 and 2024 claims datasets and 0% to the Milliman HCG data. OHIC Exhibit 1C at 26; Brown TR I at 256. (Ms. Robb testified that she disagreed with this aspect of OHIC's alternative recommendation on the theory that Neighborhood's data alone was not sufficiently credible).[37]

Having considered Ms. Robb's testimony in support of Neighborhood's methodology to project its reinsurance PMPM, Ms. Brown testified that she would still recommend assigning the

[37] Neighborhood's explanation for why it used the three data sets (inclusive of the external HCG data) instead of relying only on its own data can be found at Robb TR I at 63-67.

Milliman HGC data a 0% weight. Ms. Brown explained her reasoning for this opinion, stating *"[t]he NHPRI claims experience is considered fully credible, and the credibility of this calculation is further increased by the use of multiple years of data. When possible, I believe it is best to rely on the company's own data for projection purposes."* OHIC Exhibit 1C at 26; see also Brown TR I at 257 (*"I recognize what Ms. Robb said about the fact that at the member level the data is not as credible, and to her dart board example, you would need more data to be more exact. I think that is why I find it extremely reasonable for them to include the 2023 data. They included an additional year of their own experience to support their calculation."*).

Ms. Brown concluded her testimony on the topic of reinsurance assumptions by stating that, in her professional actuarial opinion, her recommended alternative methodology and her estimate of Neighborhood's projected 2026 reinsurance figure was more reasonable than the methodology used by and the $18.00 PMPM figure produced by Neighborhood *"because it is more reasonable to rely on their own experience."* Brown TR I at 259; 266. On cross examination, when asked whether Neighborhood's specific numbers of reinsurance-eligible members from 2023 and 2024 constituted a sufficiently credible membership amount, Ms. Brown reiterated her position that Neighborhoods 2024 and 2023 was sufficiently credible. She then elaborated that carriers relying solely on their own data is a very common methodology that is employed in reinsurance projections, noting *"and I think Neighborhood is increasing that credibility by using two [years of data], so I would say actuarially speaking people consider that methodology to be credible."* Brown TR II at 28-29. Ms. Brown added that, *"I don't think that the fact that they've historically missed the mark [in projecting their reinsurance payments] means including another methodology that under-projects their estimate, inherently makes . . . their projection better or more likely to be accurate."* Brown TR II at 30-31.

When incorporating Ms. Brown's additional adjustments into the development of Neighborhood's reinsurance assumption and giving full weight to the Neighborhood experience, the projected reinsurance reimbursement PMPM increases from $18.00 to $19.56 PMPM. This change is estimated by OHIC to result in an average reduction to the proposed rates of approximately 0.3%. Brown TR I at 257; OHIC Exhibit 1C at 26. Ms. Robb testified that, utilizing OHIC's recommended methodology, she also estimated a reduction to the proposed rates of approximately 0.3%. Robb TR I at 67.

Based on the evidence introduced on this topic, reasonable inferences that can be drawn from that evidence, and Neighborhood' burden of proof, Neighborhood has failed to establish that its methodology incorporating Milliman's HGC data is more reasonable than OHIC's recommended alternative methodology for projecting Neighborhood's 2026 reinsurance reimbursement.

OHIC's proposed alternative methodology on the topic of developing a projected 2026 reinsurance reimbursement that includes additional adjustments and excludes Milliman's HGC data is supported by the evidence in the record as a more reasonable actuarial assumption and is also consistent with the proper conduct of Neighborhood' business, and in the public interest.

If the Commissioner adopts OHIC's recommendations for projecting its 2026 reinsurance reimbursement, this will result in an assumed reinsurance reimbursement PMPM of $19.56 rather than $18.00 PMPM, and the proposed premium rates would be estimated to decrease by approximately 0.3%.

Neighborhood's Requested Administrative Charge

Ms. Brown observed from her review of the Rate Filing that Neighborhood's administrative charge estimate for 2026 is approximately 0.8% higher than had been assumed for 2025 on a PMPM basis, increasing from $65.69 PMPM to $66.25 PMPM. OHIC Exhibit 1C at 26. OHIC represents, for the Commissioner's information, that this percent increase is within the maximum of the average of the most recent three months of CPI-Urban: Less Food 12-Month Percentage Change figures. Brown TR I at 260.

Neighborhood's Requested 6% Contribution to Reserves

The Commissioner has a statutory responsibility to balance his obligation to promote the affordability of health insurance with his obligation to ensure the financial solvency of health insurance carriers. R.I.G.L. §42-14.5-2. This balancing obligation is particularly at the center of the question that arises each year during the rate review process of whether and how much of a contribution to reserves ("CTR") should be allowed to be incorporated as part of a carrier's proposed rates.

Reserves are important to a carrier's financial stability. Neighborhood Exhibit 1 at 67. Neighborhood described its need for reserves stating, *"for an adverse event, a catastrophic event as well . . .we're actually required to have a certain level of reserves on hand in the event that we have to pay out claims, and there's an unforeseen circumstance that would drive [our] reserves back down."* Robb TR I at 129. If a carrier does not have adequate reserves, it can ultimately lead to claims not being paid for consumers.

Neighborhood included a CTR amount equal to 6.0% of premium in its rates. This reflects an increase of 3.0% relative to the final CTR included in Neighborhood's 2025 pricing.

Brown TR I at 258. Neighborhood indicated that 1% of this 3.0% increase is due to *"current market volatility as it relates to significant enrollment shifts and membership mix"* and the other 2% is to *"strengthen the overall financial health of the company."* OHIC Exhibit 1C at 28; Brown TR I at 261-262; OHIC Exhibit 18 at 11-12; Robb TR I at 27 (*"the increasing contribution to reserve . . . because there is so much uncertainty in the market, particularly related to the EPTCs, but also high trends and other regulatory impacts"*). Neighborhood was unable to specifically quantify the development of these specific values but it indicated that financial solvency and reserves are a top priority so they can continue to offer affordable coverage during what they are calling this *"era of uncertainty."* OHIC Exhibit 1C at 28; OHIC Exhibit 31 at 10; Brown TR I at 261-262.

Ms. Brown reviewed some of Neighborhood's financial metrics for 2022 through 2024 to provide the Commissioner with some context for Neighborhood's requested CTR and provided a table in her Actuarial Analysis at page 26 that summarized key metrics. Ms. Brown noted that as of the end of 2024, Neighborhood had a risk-based capital (RBC) ratio of 213.5% and a SAPOR (Surplus as a Percent of Revenue) of 6.7%. OHIC Exhibit 1C at 27; Brown TR I at 261; see also OHIC Exhibits 39-40.

When asked her opinion on Neighborhood's CTR request in the context of their financial metrics, Ms. Brown responded *"I am not, again, an expert, but I would note that the levels shown, the RBC of 213 is -- does raise some concerns."* Brown TR I at 262.

Dr. Whaley, the OAG's expert health economist, testified that he reviewed OHIC Exhibits 39 and 40, Neighborhood's 2024 Annual Statement Key Pages and Neighborhoods 2025 Q1 Quarterly Report, respectively, and indicated simply that these two documents *"indicate relative financial stability"* and *"I believe they also indicate that cash on hand is*

increasing relative to the prior period, especially in the first quarter of 2025, and so overall, I believe that they indicate, as I said earlier, relative financial stability." Whaley TR II at 71. Taken in context, Dr. Whaley appeared to be offering testimony on the isolated, and not terribly relevant, point that Neighborhood's 2025 Q1 cash-on-hand financial metric relative to its 2024 annual cash-on-hand metric had remained relatively stable and had even possibly increased. Disappointingly, Dr. Whaley appeared not to have reviewed any earlier annual reports, nor did he provide any testimony relative to Neighborhood's RBC or SAPOR levels or relative to whether Neighborhood's financial metrics were at a level that would be considered adequate or appropriate for an insurance carrier with Neighborhood's book of business.

The Commissioner requested additional detail from Neighborhood Health Plan, including *"a breakdown of revenue and underwriting performance by line of business for the last five years, 2020 through 2024, with a focus on commercial business compared to Medicaid, and specifically, I said I would like NHPRI to address financial performance in Medicaid, how this has influenced the company's financial performance over time as a whole and the company's ability to build reserves, and then secondly, I would like Neighborhood Health Plan of Rhode Island to address the future outlook for financial performance in the Medicaid line of business, in particular, for 2025 and 2026."* TR I at 134

In response to the Commissioner's request, Neighborhood produced Neighborhood Confidential Exhibit 10 which included a table indicating that Neighborhood's underwriting gains (i.e., effectively Neighborhood's CTRs) over the 2020 to 2024 five-year period were made up of approximately one-third from Medicaid gains and two-thirds from commercial market gains. This exhibit also contained Neighborhood's explanation for why, in its opinion, it's reasonable that these two very different products with different financial risk arrangements

would not contribute equally to reserve, nor follow reserve contributions consistent to membership or revenue. Neighborhood Confidential Exhibit 10.

Another factor that is potentially relevant to the Commissioner's determination of the appropriateness of Neighborhood's requested CTR can be found in the context of the discussion at the Public Rate Hearing on the questions of (a) how much additional money does Neighborhood project it will need to direct to primary care in 2025 and 2026 to comply with the Primary Care Regulatory Targets and (b) to what extent does the Rate Filing incorporate this figure? Neighborhood Confidential Exhibit 10, produced during the course of the Public Rate Hearing in response to questions posed by the Commissioner indicated for the first time in that it had calculated its cost of compliance at approximately $2.1M but that it had ultimately only incorporated approximately $300,000 of this cost into the Rate Filing.[38,39] Consequently Neighborhood appears to be contemplating a $1.8M risk in its rate request, Robb TR II at 165, and if its premiums are not sufficient in 2026 to cover this risk it will be paid out of reserves. Robb TR II at 169.

[38] Ms. Robb's testimony appeared to indicate that Neighborhood had initially accounted for this additional $2.1M in its development of its professional utilization trend but that it had ultimately "dampened" that trend downwards for a variety of factors (including balancing affordability and Medicaid increase). As a result, only approximately $300,000 of the estimated cost of compliance with the Primary Care Regulatory Targets was incorporated into Neighborhood's professional utilization trend. Robb TR I at 166-168.

[39] Ms. Brown confirmed that prior to being presented with Neighborhood Exhibit 10 at the Public Rate Hearing, she had not received any information from Neighborhood during the course of discovery or in the form of exhibits that clearly indicated that Neighborhood had quantified its estimated cost of compliance with the PCP Regulatory Targets and what those figures were, nor had she previously seen any information indicating that Neighborhood had decided to build only a small fraction of the estimated cost of its compliance with the PCP Regulatory Targets into the Rate Filing. Brown TR II at 46-48.

Post-hearing, Neighborhood Exhibit 12 was entered in evidence which provided the following response to the question – "What is the increase to the overall rate to meet the PCP spend target requirement?":

> ***NHPRI Response:*** *In 2026, the regulation requires Neighborhood to increase PCP expenditures by 0.5% in 2025 and 1.0% in 2026. Based on current PCP spend to total medical expense, we believe we need to increase to 6% PCP spend overall. To reach this target directly through fee schedule increases, the overall average premium would need to increase by approximately 3.1%. That would reflect the regulation is funded through an increase to CTR by an additional 4% (from proposed) and no assumption in trend for increased utilization. This assumes no other changes to proposed rates, as other variables will impact this amount.*

For the Commissioner's consideration, prior to this extended exploration of the topic of whether Neighborhood had adequately planned and accounted for the potential cost of compliance with the new regulatory PCP spend requirements, Ms. Brown estimated that a 3.0% CTR charge to fund reserves, consistent with 2025 pricing, would decrease Neighborhood's Rate Request by 3.6%. OHIC Exhibit 1C at 29.

Neither Ms. Brown nor Dr. Whaley made an alternative recommendation to the Commissioner in regards to Neighborhood's proposed contribution to reserves figure.

The evidence supports that a 6.0% contribution to reserves is not unreasonable. In the event the Commissioner determines it is appropriate for Neighborhood's rates to also account for the cost of complying with the PCP Regulatory Targets, a contribution to reserves in excess of the 6.0% would similarly not be unreasonable. However, the Commissioner must weigh the proper conduct of Neighborhood's business against the affordability concerns of Rhode Island health insurance consumers, all while recognizing that a fiscally stable Neighborhood with adequate reserves is also in the public interest.

OHIC submits that, based on the evidence in the record, it is within the Commissioner's discretion in the context of issuing a decision on the Rate Request to find that an alternative contribution to reserves figure is consistent with the proper conduct of Neighborhood's business, and in the public interest.

PCP Regulatory Targets and Dr. Whaley's Related Recommendation

As noted above, effective March 20, 2025, OHIC's amended OHIC Regulation 230-RICR-20-30-4 (see OHIC Exhibit 41), established increased PCP spending targets as a percentage of TME for Neighborhood of approximately 5% for 2025 and 6% for 2026, the PCP Regulatory Targets. During the Public Rate Hearing and in Neighborhood Exhibits 12 and 13 entered in evidence post-hearing, issues arose around the general topic of how, whether, and to what extent the Rate Filing had (or should have) accounted for its reasonably estimated costs of complying with the PCP Regulatory Targets. What is ultimately uncontroverted is that (1) Neighborhood's strategy to comply with the PCP Regulatory Targets is made up of two components – (a) assumed PCP utilization growth, to be achieved in the near term through cost share waivers for two PCP visits annually and marketing efforts and (b) unit cost increases aka reimbursement increases for primary care (Robb TR I at 106); (2) that Neighborhood's ability to increase PCP utilization is hampered due to long wait times and PCP shortages; and (3) that approximately $1.8 million worth of Neighborhood's estimated increased costs for 2025 and 2026 to comply with the PCP Regulatory Targets through CY 2026 were not accounted for in the Rate Request.

Dr. Whaley's testimony validated the anticipated long-term effectiveness in terms of affordability of the PCP Regulatory Targets -- one of OHIC's more recent data-driven policy initiatives to strengthen Rhode Island's primary care system via an amendment to OHIC's Affordability Standards. This regulatory amendment mandates a multi-year proportional increase in primary care funding by commercial payers in an effort to shift a greater percentage of the health care dollar over time towards more affordable primary care services. See OHIC Exhibit 41.

Dr. Whaley, when testifying generally about strategies that an insurer could adopt to reduce its claims spending and thereby control its premiums, identified policies such as OHIC's amended PCP Regulatory Target, stating "*I believe, the intent of the policy to require investments in primary care physicians . . . and studies have shown, substantial offsetting effects due to, as I mentioned earlier, maybe you are spending more on office visits and primary care visits, but if patients are more likely to get preventative care, then that could avoid future high cost hospitalizations. Patients are also more likely to adhere to medication, which again can reduce ER visits, hospitalizations, et cetera, and so I think it's important to look at not just one component individually, but actual consider how these components together can interact . . . and so as increase spending in primary care and increase access to primary care expands, then it's likely that we will start to see some of those offsetting effects."* Whaley TR II at 82-84; Whaley TR II at 82-83 (*"studies have shown substantial offsetting effects due to . . . spending more on . . . primary care visits*").

Dr. Whaley then opined that he thought it would be possible to see the medical cost offsets attributable to the PCP Regulatory Targets in plan year 2026 and recommended that the Commissioner consider his opinion on this when deciding on Neighborhood's Rate Request.

Whaley TR II at 83-84. OHIC submits that based on the evidence in the record and the reasonable conclusions that can be drawn from that evidence, including Dr. Whaley's testimony taken as a whole, it is highly unlikely that Neighborhood will experience meaningful medical cost offsets as early as CY 2026 because of increased PCP utilization. First, Neighborhood has not yet implemented policies to comply with the PCP Regulatory Targets. See Robb TR I at 106 (stating that Neighborhood intends to begin waiving cost share for two primary care visits in plan year 2026). Second, there is ample uncontested evidence in the record that Neighborhood foresees limitations to its ability to significantly increase PCP utilization by 2026 because of long wait times and shortages of PCPs, see e.g., Robb TR I at 118. Three, Neighborhood's two main proposed mechanisms to increase PCP utilization – waiving co-sharing and marketing – *"have relatively small impacts on spending or on use of services"* according to Dr. Whaley. Whaley TR II at 85; see Whaley TR II at 97-98.

Considering all the credible evidence introduced in the Public Rate Hearing regarding the amended PCP Regulatory Targets, it is reasonable to assume that, despite the up-front costs of these investments in primary care services and their upwards pressure on CY 2026 premiums, over time these amended regulations mandating appropriate financing of primary care will ensure a high performing health care system and will lead to more affordable health insurance. The PCP Regulatory Targets will further serve to strengthen the primary care workforce over time. However, based on the credible evidence in the record and reasonable conclusions that can be drawn from that evidence, it is not reasonable to project that material medical cost offsets will be realized in Plan Year 2026 because of the intermediary PCP Regulatory Targets being met.

OAG's "Consumer and Economic Report: Neighborhood Health Plan of Rhode Island" and Comments Of Dr. Christopher Whaley.

In recent history, in the context of Individual Market rate reviews and rate hearings, the Office of Attorney General has engaged the services of a consulting actuarial expert or firm to scrutinize the assumptions, projections and methodology employed in the rate filing at issue and to offer recommended alternative actuarial assumptions, projections and methodologies where deemed appropriate to components of the rate request that combine to result in the rate request's proposed annual rate increase. The OAG's consulting actuary would prepare a written analysis of his or her work as well as, in the context of any rate hearings, offer testimony in support of these alternative recommended assumptions, projections and/or methodologies which typically resulted in the OAG's consulting actuary recommending an overall lower rate increase that the actuary determined was still actuarially reasonable. See e.g., OHIC Exhibit 38 (OAG 2024 comment letter at page 15, noting that its *"expert team of actuaries reviewed the filings submitted by NHPRI and requested further information that would allow the actuaries to make industry-standard recommendations . . . . the actuaries were able to determine that several areas of the filing were either incorrect or unreasonable through actuarial observations . . . These observations allowed the actuaries to produce a reasonable range for increased rates, which even at the highest end is lower than NHPRI's requested rate increase."*). However, it has also been the Attorney General's general practice since at least 2020, to recommend that the Commissioner deny Neighborhood any rate increase regardless of the fact that the Attorney General's expert actuaries were recommending rate increases of between 0.3% to 9.8%, depending on the plan year at issue. See OHIC Exhibit 38.

Perhaps because the Attorney General became dissatisfied with the expert recommendations of his actuaries, in a break from past practice, this year the OAG engaged the services of Dr. Christopher Whaley, a health economist*, "to provide comments on Neighborhood Health Plan of Rhode Island's (NHPRI) proposed premium increases as a part of Rhode Island Office of the Health Insurance Commissioner's Rate Review process."* AG Exhibit 1 at 1. Dr. Whaley submitted a report he authored titled *Consumer and Economic Report: Neighborhood Health Plan of Rhode Island* and testified at the Public Rate Hearing on July 16, 2025.[40] Dr. Whaley made clear that he was not providing an opinion on whether the Rate Request was actuarially justified but was simply *"providing an opinion on some of the economic assumptions that contribute to the finding, as well as the impact on the proposed rate to Rhode Island consumers."* Whaley TR II at 89-90.

OHIC respectfully submits that a useful portion of Dr. Whaley's testimony and written report were his descriptions of the research, much of it his own research, that has evidenced the effectiveness of OHIC's rigorous rate review process and affordability standards, such as the hospital rate caps, in controlling health insurance premiums in Rhode Island relative to the nation and relative to other New England states. For example:

- *"[t]he [Rhode Island] rate review process has led to a relative reduction in insurance rate relative to other states."* Whaley TR II at 92.
- *"While provider consolidation is an important driver of health expenses, the rate review process and provider price cap policies in Rhode Island limits the inflationary impact of*

[40] While Dr. Whaley's resume indicates he is an accomplished academic in his field of study and a useful resource for ideas about and evaluations of potential policy initiatives, it was frequently challenging to understand the purpose of his commentary in the very specific context of this Public Rate Hearing.

provider consolidation, relative to other states . . . In large part due to this process, commercial insurance hospital prices in Rhode Island have decreased relative to prices in the rest of the country. From 106 percent of the national average (e.g., 6 percent higher) in 2012, Rhode Island hospital prices have decreased to 84 percent of the national average (e.g., 16 percent lower) in 2022." AG Exhibit 1 at 7; see Whaley TR II at 92.

- *"[T[he rate review and rate increase caps in Rhode Island place a constraint on future provider price growth that is unique to Rhode Island."* AG Exhibit 1 at 8.
- *"[T]he unique Rhode Island rate review process has limited both provider price and premium growth relative to other states."* AG Exhibit 1 at 8; See also Whaley TR II at 92.
- OHIC and its Commissioner have demonstrated a significant engagement in developing and adopting innovative data driven policy approaches to address issues like access and affordability. Whaley TR II at 105.

Dr. Whaley also noted or confirmed that:

- *"Rising spending is a national challenge, in which Rhode Island is not unique."* AG Exhibit 1 at 2 and Whaley TR II at 103-104.
- *"[R]esearch finds that Rhode Island has the fifth lowest commercial insurance hospital prices in the country."* AG Exhibit 1 at 8.
- Rhode Island has the 9th lowest average marketplace benchmark plan in the nation. Whaley TR II at 104-105.
- Between 2020 and 2025, apart from New Hampshire, Rhode Island has had the lowest average benchmark premium among New England states. Whaley TR II at 90-91; see also OHIC Exhibit 31.

- *"With an uninsurance rate of approximately 2 percent, Rhode Island has among the lowest share of uninsured individuals in the country*." AG Exhibit 1 at 2; see Whaley TR II at 102.

Dr. Whaley's comparative analysis and comments described above highlight and affirm (a) the degree to which fully insured commercial health insurance premiums in Rhode Island are affordable as compared to the rest of the nation and (b) the important policy work OHIC has done and continues to do in its ongoing efforts to improve access and affordability. It is particularly helpful to keep these facts in mind in the context of a year when several factors outside the control of OHIC are contributing to a significantly higher than usual rate request that will undoubtedly create financial challenges for many Rhode Islanders.

However, the primary purpose of Dr. Whaley's testimony in the Public Rate Hearing appears to have been to put the rate request in context for the Commissioner and to provide commentary on its potential economic impacts. See AG Exhibit 1. No one is contesting that a 21.2% rate increase is a significant premium increase request that will impact the household budgets of many of Neighborhood's members. This fact is self-evident and does not require the expertise of an economist to convey. And it glosses over the fact that the biggest adverse impact by far to the affordability of health insurance in 2026 for many lower-income Rhode Islanders, and the primary reason why both carriers in the Rhode Island Individual Market are predicting a significant drop in membership in 2026, is the expiration of the enhanced premium tax credits at the federal level. See e.g., McClaine TR I at 129-130

What could have been relevant testimony from a health economist for the Commissioner to consider in the context of this Public Rate Hearing would have been Dr. Whaley's *"opinion as to what the rate increase should be."* Unfortunately, Dr. Whaley was unable or unwilling to

offer an answer to this question despite it being posed to him more than once, initially deflecting and then indicating he was not offering an opinion on that question. Whaley TR II at 91; see also Whaley TR II at 101.[41] When asked if, given Rhode Island's current approximate 2% uninsured rate, he would agree that health insurance is currently affordable in Rhode Island, he again avoided answering the question directly. Whaley TR II at 126. OHIC submits that a health economist's thoughtful and credible analysis and opinion on the question of what would be an appropriate range of health insurance premium that would be considered relatively affordable for Neighborhood's members and contribute to a stable health insurance market (or a similar question) would have been perhaps the most relevant testimony that a health economist could offer for the Commissioner's consideration in the context of this Rate Hearing.

Similarly, assuming that the Attorney General will again recommend the Commissioner deny Neighborhood any rate increase, consistent with the AG's past recommendations and inconsistent with the past recommendations of the AG's actuarial experts, it would have been reasonable to expect the Attorney General to have his expert health economist provide detailed testimony, or even any testimony, on how exactly this could be a sustainable approach to rate

[41] The following exchange during cross examination of Dr. Whaley illustrates this point:

> *Q. And given that rate review requirement, would you agree that the Commissioner is charged with determining whether Neighborhood's proposed rates are consistent with the proper conduct of its business as well as with the interest of the public?*
>
> *A. I believe that the Commissioner is tasked with balancing the rate request as well as access to affordable insurance options for the Rhode Island public.*
>
> *Q. And is it fair to say as a health economist, although you've offered some general comments in three categories that you just mentioned, you don't have a specific range of what you think would be an appropriate -- either a specific percentage or a specific range of percentages that you would recommend to the Commissioner as being more appropriate or equally reasonable as what Neighborhood has proposed; is that correct?*
>
> *A. This is correct.*

Whaley TR II at 101.

review. No such testimony was presented by the Attorney General. Instead, when asked this question on cross examination, the following exchange with Dr. Whaley ensued:

> *Q. And are you suggesting in your report that Neighborhood should offer a product for less than its actual cost?*
>
> *A. My report, again, highlights issues (inaudible) with the underlying economic assumptions in the rate review process and impacts on Rhode Island consumers.*
>
> *Q. And do you agree that if Neighborhood is required to offer a product for less than its actual cost, that Neighborhood would be unable to pay providers; that wouldn't be a good business model, correct?*
>
> *A. If Neighborhood were -- I guess, presumably.*
>
> *Q. And if Neighborhood is unable to pay claims, that would lead to uncompensated care?*
>
> *A. I guess that is not quite clear.*
>
> *Q. Well, if nobody pays providers for the provision of healthcare services, that would be uncompensated to the provider, correct?*
>
> *A. If -- in the absence of other options, potentially, but presumably, there could be other options.*
>
> *Q. What other options would there be?*
>
> *A. There could be other insurers, for example.*
>
> *Q. But there's only one other carrier in Rhode Island whose rates are greater than Neighborhood's, correct?*
>
> *A. That is my understanding.*
>
> *Q. And if Neighborhood did not exist, the cost to that vulnerable population for health insurance would be greater, correct?*
>
> *A. I don't -- it depends. There is a lot of assumptions on how the market would work, and you know, it could go several ways.*

Whaley TR II at 94-95.

The Attorney General might argue that Dr. Whaley offered up policy initiatives that Rhode Island or Neighborhood could adopt to lower premium increases and that such potential policy initiative might justify advocacy for a 0% rate increase. Dr. Whaley's written report did indeed imply that Rhode Island could make modest additional headway in controlling premium growth by *"learn[ing] from the policy successes of other states."* AG Exhibit 1 at 2. His report went on to highlight *"the State of Vermont recently enacted legislation that aims to apply reference-based pricing with commercial prices limited to 200 percent of Medicare*" as an example that could be applied to Neighborhood to control premium increases. AG Exhibit 1 at 9-10; Whaley TR II at 106. However, between the effectiveness of OHIC's hospital rate caps in controlling facility cost increases (See AG Exhibit 12, the 5th slide, indicating Rhode Island hospital prices at approximately 200% of Medicaid; Whaley TR II at 108) and the vast majority of Neighborhood's provider reimbursement rates as a percentage of Medicaid (See Neighborhood Confidential Exhibit 10), as confirmed by Ms. McClaine, adopting a reference pricing model limited to 200 percent of Medicare prices would be unlikely to produce any savings for Neighborhood. McClaine TR I at 144.[42] While OHIC actively pursues data-driven policy initiatives to improve access, quality and affordability of healthcare, and welcomes the research and policy suggestions of healthcare economists, in the context of this Public Rate Hearing the Attorney General has not presented policy initiatives that would lower Neighborhood's projected 2026 claims experience.

[42] OHIC notes that Dr. Whaley did not necessarily agree with this conclusion. However, OHIC submits that his commentary on the topic failed to effectively rebut it. Whaley TR II at 109-111.

To the extent Dr. Whaley sought to further contextualize the impact of Neighborhood's rate request on Rhode Islanders,[43] his analysis frequently appeared misleading or incomplete, which renders it of limited usefulness for the Commissioner. Much of his testimony related to national figures for household incomes and typical insurance premiums,[44] his sources for some figures were occasionally not terribly current, and he at times compared varying periods of time against each other.

One example can be found in his written testimony that states *"Since 2020, NHPRI insurance premiums have increased by 27%. Over this period, medical inflation has increased by 8.4%. Over the 2020 to 2023 period, median household wages in Rhode Island have increased by just 2.1%. NHPRI's insurance premium rates continue to substantially outpace wage growth."* In this one short passage he compares the increase in Neighborhood's premiums from 2020 through and including 2025 (a six-year period)[45] against a medical inflation increase of 8.4% which he writes took place "over this period." However, as Dr. Whaley admitted on cross examination, the 8.4% medical inflation increase did not occur "over this period." Instead, Dr. Whaley's source documents illustrate that his selected medical inflation figure of 8.4% occurred from January 2020 through January 2024, a four-year period. See Whaley TR II at 117-

[43] Dr. Whaley inexplicably did not attempt to contextualize the impact on Neighborhood's Rate Request on Neighborhood members specifically. Indeed, many parts of his testimony and written report indicate Dr. Whaley was unaware of many relevant factors related to Neighborhood's membership or its place in in the Rhode Island health insurance system. For example, he highlights that Neighborhood plans have deductibles of up to $7,050 (AG Exhibit 1 at 3) while seemingly ignoring the significant role that Cost Sharing Subsidies play towards ensuring affordability for Neighborhood members. See e.g., Brown TR I at 248-249; McClaine TR I at 142.

[44] See AG Exhibit 1 at 2-4. Also, on occasion Dr. Whaley cited self-insured household premiums figures rather that fully insured commercial premium figures. AG Exhibit 1 at 3 (footnote 5).

[45] On direct examination Dr. Whaley indicated this increase took place over 5 years, Whaley TR I at 77, but the chart at OHIC Exhibit 38 illustrates that his 27% figure is the total of six years of premium increases.

118; AG Exhibit 9. It is unclear why Dr. Whaley chose to highlight this 8.4% inflation figure through January 2024 in his report and testimony when the source he obtained this figure from sets forth medical inflation data through May of 2025 (which indicated an additional 4-5% increase). Whaley TR II at 117-119. OHIC Exhibit 54. Finally, the 2.1% wage growth figure he selected to use in this passage as a comparison to six years of premium increases[46], reflects only three years of growth from January 2020 through January 2023 (see Dr. Whaley's citation for this figure), During the same January 2020 to January 2023 period of Dr. Whaley's 2.1%, Neighborhood's average benchmark premium increased 8.4%. OHIC Exhibit 38. Certainly, it is more than likely that Neighborhood's health insurance premiums have outpaced wage growth in Rhode Island, but Dr. Whaley has, at best, presented the Commissioner with evidence that between January 2020 to January 2023[47] Neighborhood's premiums rose 8.4% as compared to a presumably slightly lower increase in medical inflation and a 2.1% increase in wages -- information of little relevance in the context of a rate hearing for the 2026 plan year. At worst, the inconsistencies and inaccuracies in this passage undermine the reliability of Dr. Whaley's report.

Another example of the unreliability and/or inapplicability of Dr. Whaley's testimony – can be found in this testimony that the impact of Neighborhood's rate request on a family of four in Rhode Island would be an increase of $4000, that *"these impacts would be quite a bit larger*

[46] In his verbal testimony, when asked how the 27% increase in insurance premiums compare to Rhode Island wages, Dr. Whaley inaccurately responded, "*Over this time period Rhode Island wages have increased by about 2.1 percent."* Dr. Whaley went on to give verbal testimony about inflation increases "*over this time period*" and his estimates of income growth more recently in Rhode Island but given other inaccuracies in his spoken and written words it is difficult to give the other specific figures or time frames he references in his testimony much weight.

[47] Years when the entire RI economy was impacted by the COVID-19 pandemic. Whaley TR II at 120.

for lower income households," and "*among a household at roughly 200 percent of the federal poverty line, with these rate increases, health insurance would be nearly 50 percent of their household budget.".* Whaley TR II at 66; Whaley TR II at 86;[48] See AG Exhibit 1 at 13.

First, Dr. Whaley's testimony ignores the fact that the vast majority of Neighborhood's membership is made up of individuals and, to the extent families are covered by Neighborhood, the children in those families qualify for Medicaid. McClaine TR I at 141-142. One assumes a health economist is well-aware that in Rhode Island children under the age of 19 living in households with income up to approximately 266 percent of the federal poverty level qualify for Medicaid. See McClaine TR I at 141-142. Based on this fact alone, Dr. Whaley's examples offered with the goal of help the Commissioner put the impact of Rate Request on families in context are off by 50%. See also Whaley TR II at 116.

Second, Dr. Whaley's testimony indicated that he came up with at least some of his healthcare expenses as a percentage of household income figures by adjusting the healthcare expense figure upwards to include not just insurance premium but also expenses for out-of-pocket costs and cost sharing, Whaley TR II at 113. While he made these upward adjustments to his healthcare expense figure in the calculations he presented to help put the Rate Request in context, Dr. Whaley admitted on cross examination that, in addition to not adjusting for the Medicaid eligibility of children in families covered by Neighborhood, he did not make downward adjustments to account for the impact of Cost Sharing Reductions, the approximate 15

[48] It is disappointing that Dr. Whaley chose to conclude his direct testimony by referring back to this four-thousand-dollar premium increase for a family of four in the context of Neighborhood's Rate Request, given that he had sat through Ms. McClaine's testimony the day before where she testified that, to the limited extent that Neighborhood's membership is made up of families, the children in those families are covered by Medicaid. McClaine TR I at 141-142; Whaley TR II at 115-116 (acknowledging hearing Ms. McClaine's testimony on these and other points).

percent of Rhode Islanders under 65 who qualify for Medicare due to disability, or the eligibility of lower income households for Advanced Premium Tax Credits.

Third, while agreeing that the year would be relevant to his figure comparisons, Dr. Whaley initially testified that he did not know the time frame for the source he used to establish his median Rhode Island income figure. Whaley TR II at 112. When given an opportunity to review his source for this figure – the Bureau of Labor Statistics – Dr. Whaley conceded that his Rhode Island household income figure represented 2023 income. Whaley TR II at 113-115. OHIC submits that many of Dr. Whaley's figures appear to represent comparisons of 2026 proposed insurance premiums (plus out of pocket costs and cost-sharing) to 2023 household income.

OHIC submits that much of the evidence presented by Dr. Whaley on the topic of how Neighborhood's requested rate increase may financially impact its members is neither sufficiently targeted (and thereby relevant) nor sufficiently reliable to be afforded any material weight.

If the Attorney General's Post-Hearing Memorandum Recommends No Rate Increase.

To date, in the context of this Public Rate Hearing, the Attorney General has failed to articulate or attempt to offer support for a recommendation the Commissioner should deny Neighborhood's Rate Request all together. Nonetheless, consistent with past practices (See OHIC Exhibit 38) OHIC assumes that in its post-hearing memorandum, the OAG will urge the Commissioner to disregard the expert actuarial opinions related to what would constitute a rate increase that is sufficient to cover Neighborhood's reasonably projected claims for the premium

year at issue and ensure Neighborhood's fiscal stability and outright deny Neighborhood any rate increase on the simplistic theory that this will benefit consumers. See OHIC Exhibits 38.

To the extent the OAG makes this argument or recommendation in its post hearing papers, OHIC would object to the Commissioner considering this recommendation on the ground that neither the OHIC nor Neighborhood were given adequate notice of such an extreme recommendation and therefore an opportunity to present witness testimony and examine witnesses on any such position/recommendation. OHIC respectfully submits that the state's top attorney should appreciate that in the context of an administrative hearing the parties to the hearing are entitled to reasonable notice of each other's positions regarding the Rate Filing so that the parties are able to examine them critically and provide the Commissioner with relevant evidence to enable him to make the most informed, evidence-based decision.

To the extent the OAG might point to Dr. Whaley's testimony as support for a recommendation that Neighborhood should be denied any rate increase, OHIC submits that Dr. Whaley's testimony is insufficient to support any such recommendation. This is because Dr. Whaley's testimony failed to realistically address how threatening the fiscal stability of one of Rhode Island's largest insurers or effectively driving that insurer out of the commercial market would be consistent with either the proper conduct of Neighborhood's business or with the overall interest of the public and Neighborhood's members in particular. Moreover, as noted above in more detail, Dr. Whaley repeatedly declined to offer an opinion on the question of what an appropriate rate increase would be, and he certainly did not make a zero percent rate increase recommendation.

A recommendation from the Attorney General of no rate increase for Neighborhood's 2026 rates could also be seen as duplicitous considering the Attorney General's recent press

release applauding the General Assembly's budget *"for putting over $40 million dollars more towards primary care [because it] will radically improve the health of our health care system."* OHIC Exhibit 42 (Attorney General Peter F. Neronha June 11, 2025 Press Release). What the press release fails to mention is that at least $30 million of the $40 million mentioned – which $30 million is to be used primarily towards increased Medicaid reimbursements to primary care providers -- are funded through an assessment on commercial health insurance plans and will raise annual commercial health insurance premiums by approximately $48 per member. OHIC Exhibit 43; August 6, 2025 Stipulation at Appendix B; House Budget Bill 5076Aaa at 355.[49]

Protecting the interests of consumers and considering and promoting affordability are always at the forefront of the Commissioner's and OHIC's actions and decisions. Moreover, the Office applauds the OAG's commitment to and advocacy on behalf of consumers. However, to the extent the OAG recommends that it is legally appropriate for the Commissioner to deny Neighborhood any rate increase for 2026, OHIC respectfully submits that based on the facts in evidence in this matter doing so would be in direct conflict with the Commissioner's statutory duty to guard the solvency of insurance companies as well as with the statutory rate review standard of evaluating proposed rates to ensure they are consistent with both the proper conduct of an insurer's business and with the interest of the public.

Accordingly, to the extent the OAG recommends a 0% rate increase, the Office recommends the Commissioner deny the Attorney General's request that Neighborhood be ordered to charge a markedly actuarially insufficient rate for its 2026 plans because this request

[49] H5076Aaa.pdf

is contrary to the proper conduct of Neighborhood's business as well as contrary to the public interest.

Public Comment

OHIC received six pieces of written public comment from individuals, elected officials and interested organizations relating to the Neighborhood Rate Request. See Appendix A. OHIC expresses its appreciation to each individual and organization that took the time to participate in this rate review process by sharing their views and insights regarding the rate review process, the Rate Request, and how the Rate Request impacts them individually and/or Rhode Island and Rhode Islanders more broadly.

Overall, these comments acknowledged the work OHIC does to keep health insurance premiums low, through its rate review process, the affordability standards, cost growth benchmark and broader policy initiatives to improve affordability, access and quality of care for consumers and in the public interest, all while balancing its statutory charge to also guard the solvency of health insurers. Some of the comments also noted the seismic impact of changes at the federal level – such as the expiration of the enhanced premium tax credits which HealthSourceRI has estimated will single-handedly result in as many as 30% of current enrollees through the exchange losing coverage.

Taken as a whole, these public comment letters also shared concerns about the magnitude of the proposed Rate Request(s) for 2026[50] and the impact sizeable leaps in premium could have

[50] A few commenters indicated that the proposed average rate requests' % increases in the individual market in RI are higher than RI's peer states that have publicly reported this information. While this observation is largely true, OHIC notes that Connecticut's posted 17.8% proposed average individual rate

on consumers (and the ripple effect on the health care system as a whole), such as leading some Rhode Islanders to forego insurance or purchase lower value plans and generally adding fiscal stress to many struggling Rhode Island households.

Summary of OHIC's Alternative Assumption Recommendations and Observations

Alternative Assumption #1: It is actuarially equally reasonable for Neighborhood to assume their 2026 pharmacy rebates as a percentage of allowed claims will remain constant relative to the level observed in 2024, instead of assuming a decrease in rebates as a percentage of allowed claims. Brown TR I at 182, 265. This change is estimated by OHIC to result in a 1.0% reduction to rates. With the benefit of its pricing models, Neighborhood estimated that the impact of this change will reduce the overall rate increase by approximately 0.5%. Robb TR I at 30.

Alternative Assumption #2: With the caveat noted below, it is actuarially more reasonable for Neighborhood to revise their utilization assumptions to be based on the alternative methodologies recommended by Ms. Brown at the Public Rate Hearing. Brown TR I at 231, 265. By directing Neighborhood to adopt these alternative methodologies, OHIC estimates Neighborhood's annual utilization trend assumptions would change from 1.7% to 0.0% for inpatient; from 2.0% to 1.5% for outpatient; from either (a) 2.2% to 2% for professional or (b) 2.2% to 0% for professional; from 1.9% to 7.1% for ancillary/other medical; and from 5.3% to 4.4% for pharmacy. Because OHIC has both updated the recommendation it proffered at the Public Rate Hearing and is now providing two

request did not include the impact of the expiration of the enhanced federal premium tax credits and that when you include the estimated impact of their expiration their posted proposed 17.8% figure is expected to increase to between 21.3% and 24.6%. See OHIC Exhibit 57.

alternative professional utilization trend recommendations (see below paragraph), OHIC is unable to provide the Commissioner with an estimate of the impact of the above utilization trend changes on premium rates. (OHIC previously recommended revising the professional utilization trend from Neighborhood's 2.2% to 0.3%. When that recommendation was included with its OHIC's other recommended changes to utilization trends, OHIC estimated these changes would result in a net reduction of 1.7% to Neighborhood's proposed premium rates and Neighborhood, with the benefit of its rate models, estimated this would produce an approximate 2.3% decrease in the proposed premium rate. Robb TR I at 45).

The caveat to this recommendation is that, regarding the professional utilization trend assumption, OHIC submits it is equally reasonable and within the Commissioner's discretion to adopt either of OHIC's two following alternative recommendations, or something else – (1) a 2% upward adjustment to the annual professional utilization trend to account for Neighborhood's projected 2024 to 2026 PCP Util/1000 change of 28.3% (resulting in a recommended 2% annual professional utilization trend assumption) in the event the Commissioner determines it is appropriate for the rate filing to be deficient for the balance of the total $2.1 million estimated increased claims costs through 2026 necessary to comply with the PCP Regulatory Targets; or (2) a 0% adjustment to the annual professional utilization trend line Targets (leaving the professional utilization trend at 0.0%) in the event the Commissioner determines Neighborhoods rates should account for up to the total cost of compliance with the PCP Regulatory Targets and allows a CTR to account for same.[51]

[51] Neighborhood Exhibit 13 represents that a 4% CTR, resulting in a 3.1% increase in average premiums, would be necessary to account for the full cost of compliance, assuming no adjustment to professional utilization trend attributable to the PCP Regulatory Targets. Neighborhood Exhibit 13 at 1-2.

Alternative Assumption #3: It is actuarially more reasonable for Neighborhood to revise its overall pharmacy trend assumptions for Specialty and Other Non-Specialty to be set equal to the observed annualized trends for those categories when using experience from 2022 through 2024, and revise Neighborhood's 2025 trend assumption for GLP1/SGLT2 to be based on the same experience (leaving Neighborhood's proposed 2026 trend assumption for GLP1/SGLT2 intact). Brown TR I at 245-246. This change is estimated by OHIC to result in an approximate 1.3% reduction to proposed premium rates. With the benefit of its pricing models, Neighborhood estimated that the impact of this change will reduce the overall rate increase by approximately 1.9%. Robb TR I at 53.

Alternative Assumption #4: It is actuarially more reasonable for Neighborhood to assume a risk adjustment payment of $43.50 PMPM utilizing OHIC's recommended methodology rather than $45.30 PMPM utilizing Neighborhood's methodology. OHIC estimates this would decrease the proposed rates by approximately 0.4%. Neighborhood indicated that when they updated their calculation with the 2024 final risk adjustment transfer payment factor (not making any changes to statewide average premium) consistent with OHIC's recommendation they calculated a $44.16 PMPM. Robb TR I at 60. Regardless, with the benefit of its rate model, Neighborhood similarly estimated that the impact of this change will reduce the overall rate increase by approximately 0.4%.

Alternative Assumption #5: It is a more reasonable actuarial assumption for Neighborhood to assume a reinsurance reimbursement PMPM of $19.56 rather than $18.00 PMPM. OHIC estimates that adopting this recommendation will decrease the proposed 2026 premium rates by approximately 0.3%. With the benefit of its rate model, Neighborhood similarly estimated that the impact of this change will reduce the overall rate increase by approximately 0.3%. Robb TR I at 67

OHIC Observation #1: OHIC does not make a recommendation on the question of updating the 2024 base period experience using claims paid through May of 2025. However, if Neighborhood was directed to do so, OHIC estimated it would result in an approximate 0.8% increase in the proposed premium request. OHIC noted its +0.8% estimate is reflective of an increase to the base period experience in isolation. While it is within the Commissioner's discretion to direct or allow Neighborhood to update its 2024 base period experience using claims paid through May of 2025, OHIC submits that Neighborhood failed to establish by a preponderance of the evidence that doing so would be consistent with the proper conduct of Neighborhood's business as well as the public interest.

To the extent Neighborhood argues the Commissioner should also direct adjustments to the Rate Filing's trend analysis and other assumptions using claims run out through May 2025 to ensure consistency within all components of the Rate Filing, OHIC strongly opposes this request because it will undermine the rate review process and submits that Neighborhood's interest in ensuring consistency within the Rate Filing would be better served by allowing no updates to the 2024 base period experience or other aspects of rate development using claims paid through May of 2025.

OHIC Observation #2: OHIC is not making a recommendation regarding Neighborhood's requested contribution to reserves. However, OHIC offers the observation that, based on all the evidence presented and reasonable inferences that can be drawn from that evidence -- including potential concerns the Commissioner may have around (a) whether the Rate Request adequately accounts for Neighborhood's reasonably estimated up-front costs to comply with the PCP Regulatory Targets and (b) the proportion of reserves that have historically been funded by Neighborhood's commercial products versus its Medicaid products, -- it remains squarely within the Commissioner's discretion to

modify Neighborhood's requested CTR figure to an amount the Commissioner determines consistent with the proper conduct of Neighborhood's business and in the public interest.

Table 1 below shows the approximate impact to Neighborhood's filed Rate Request based on changing certain assumptions. Please note that the changes in Table 1 below are not additive.

Table 1: Summary of Alternative Assumption for Consideration	
Description of Alternative Assumption	**Estimated Impact to 2026 Rates**
1. Revised Pharmacy Rebate Assumption	-1.0%
2. Revised Utilization Trend Assumptions	-1.7%
3. Revised Overall Pharmacy Trend Assumption	-1.3%
4. Revise 2026 Projected Risk Adjustment Transfer Amount	-0.4%
5. Revise 2026 Projected Reinsurance PMPM	-0.3%
Total	**-4.6%**

Conclusion

If the Commissioner accepts the recommendations of the Office as set forth above, Neighborhood should be directed to file a modified Rate Request consistent with the assumptions and conclusions herein.

Respectfully submitted,
Office of the Health Insurance Commissioner

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In re Neighborhood Health Plan of Rhode Island
Rates Filed for 2026 Individual Market Plans
Docket No. OHIC-RH-2025-2

CERTIFICATE OF SERVICE

I hereby certify that on this 7th day of August 2025, a copy of this OHIC's Post-Hearing Memorandum was sent by electronic mail to the following:

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APPENDIX A

(See attached for public comment submissions)

APPENDIX B

(See attached for August 6, 2025 Stipulation)