STATE OF CONNECTICUT

INSURANCE DEPARTMENT

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In the Matter of:

THE PROPOSED RATE INCREASE APPLICATION OF AETNA LIFE INSURANCE COMPANY

Docket No. LH 16-44

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ORDER

I, Katharine L. Wade, Insurance Commissioner of the State of Connecticut, having read the record in the above captioned matter, do hereby adopt the findings and recommendations of Jared Kosky, Hearing Officer, which are contained in the attached Proposed Final Decision, and issue the following orders, TO WIT:

The rate application filed by Aetna Life Insurance Company, to be effective January 1, 2017, for its individual off exchange plans are reasonable in relationship to the benefits being offered as they are neither excessive, nor inadequate, nor unfairly discriminatory and are hereby approved in accordance with General Statutes § 38a-481.

Dated at Hartford, Connecticut, this 2nd day of September, 2016.

Katharine L. Wade

Katharine L. Wade
Insurance Commissioner

STATE OF CONNECTICUT

INSURANCE DEPARTMENT

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In the Matter of:

THE PROPOSED RATE INCREASE APPLICATION OF AETNA LIFE INSURANCE COMPANY

Docket No. LH 16-44

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PROPOSED FINAL DECISION

I. INTRODUCTON

On June 1, 2016, Aetna Life Insurance Company ("Aetna" or "Applicant"), filed a rate application regarding the Applicant's individual rates for off exchange plans ("Application") with the Connecticut Insurance Department ("Department") pursuant to General Statutes § 38a-481. Although there is no statutory requirement that a rate hearing be held, on June 6, 2016, and amended on July 22, 2016, Insurance Commissioner Katharine L. Wade ("Commissioner") issued a notice of public hearing ordering that a public hearing be held on August 4, 2016 concerning the Application.

A copy of the Notice of Public Hearing was filed with the Office of the Secretary of the State on June 6, 2016, and amended on July 22, 2016, and was published on the Department's Internet website (the "Notice"). The Notice indicated that the Application was available for public inspection at the Department, and that the Department was accepting written statements concerning the Application. In accordance with § 38a-8-48 of the Regulations of Connecticut State Agencies, the Applicant was designated as a party to the proceeding.

On June 28, 2016, the Commissioner appointed the undersigned to serve as Hearing Officer in the proceeding.

On August 4, 2016, a public hearing on the Application was held before the undersigned (the "Hearing"). The following individuals testified at the public hearing on behalf of the Applicant: Jason Cirino, Director of Small Group and Select Markets, Connecticut, Aetna; William J. Swacker, Actuarial Senior Director, Aetna. Julie L. Young, Esq., of Locke Lorde LLP, represented the Applicant.

The following Department staff participated in the Hearing: Paul Lombardo, ASA, MAAA, Life and Health Actuary and Kristin Campanelli, Esq., Legal Division counsel.

Pursuant to the Notice, the public was given an opportunity to speak at the Hearing and to submit written comments on the Application with respect to the issues to be considered by the Commissioner no later than the close of business August 4, 2016. The deadline for submission of written comment was extended at the Hearing to the close of business August 11, 2016. Three members of the public provided oral comment during the two public comment sessions at the Hearing. These members of the public were Lynne Ide, Universal Health Care Foundation of Connecticut; Sonya Huber, policy holder; and Dr. Elizabeth Keenan, CONECT. Public comment by persons who are not parties "shall be given the same weight as legal argument."[1]

As of the close of the record for public comment, on August 11, 2016, there were over 25 written communications containing public comment, some from persons who also provided oral comment. All of the written comments were in opposition to the Application. The major theme in the opposition letters and oral comments was for the reduction of the requested rate increases, if not an overall objection to Aetna's Application. Opposition was premised on the proposed rate increases being

[1]Regs., Conn. State Agencies § 38a-8-51 (b)

unaffordable to consumers as well as Aetna's profits, net income and its executives' salaries not justifying rate increases. Some of the written and oral comments included detailed descriptions of the hardship to consumers under Aetna's existing rates and requested rate increases. There were also numerous comments critical of health insurers and health insurance rates in general.

At the conclusion of the hearing, Aetna was directed to submit supplemental information no later than the close of business August 8, 2016. Aetna timely submitted the supplemental information on August 8, 2016 and the record was closed on August 11, 2016.

II. FINDINGS OF FACT

After reviewing the exhibits entered into the Hearing record, the testimony of witnesses, and utilizing the experience, technical competence and specialized knowledge of the Department, the undersigned makes the following findings of fact:

1. The purpose of Aetna's Application is to provide details of the premium rate development and resulting monthly premium rates for 2017 plans that will be offered to Individuals off-Exchange in the State of Connecticut for effective dates of January 1, 2017 through December 31, 2017.
2. The development of the rates reflects the impact of the market forces and rating requirements associated with the Affordable Care Act ("ACA")[2] and applicable regulation.
3. Aetna's new plans are in compliance with the benefit plan requirements of the ACA. Additionally, these plans conform to the federal metallic tiers of coverage, defined as Bronze, Silver, Gold, and Platinum. All plans within a tier have achieved an actuarial value consistent with the thresholds established for each

[2]Patient Protection and Affordable Care Act, 42 U.S.C. 18001 et seq. (2010).

tier – 60%, 70%, 80%, and 90%, respectively – within the allowable range of deviation of two percentage points.

4. Aetna's plans will be marketed through brokers and general agents, as well as potentially via direct mail, telemarketing, and the Internet. Aetna will verify applicant eligibility for these plans based on standard underwriting guidelines available under the ACA, such as geographic limitations. Any written policy is guaranteed renewable as required under § 2703 of the Public Health Service Act.
5. Revised rates for these products reflect the following:
    - Impact of medical claim trend (including changes in provider unit costs and increased utilization of medical cost services) and pharmacy trend;
    - Revisions to Aetna's assumptions about market-wide population morbidity and the projected population distribution;
    - Elimination of the ACA Reinsurance program;
    - Revisions to administrative expense projections;
    - Modifications in cost sharing to ensure that plans comply with Actuarial Value ("AV") requirements; and
    - Updates to Aetna's pricing models used to determine the impact of cost sharing designs.
6. Rate changes differ by plan for the following reasons:
    - Modification to cost sharing differs by plan in order to maintain compliance with AV and other regulatory requirements.
    - Aetna's internal pricing models were updated to reflect more current information on claim expectations associated with different benefit

designs. These changes impact Aetna's estimates of the relative costs of the plan designs that it will offer.

7. In its Application, Aetna's weighted average increase across plans based on current ACA-compliant membership, inclusive of benefit and cost sharing changes, is 27.9%. The minimum increase is 25.8% and the maximum increase is 31.5%.
8. Experience period premiums are date-of-service premiums from Aetna's actuarial experience databases for Individual business in Connecticut. Its internal projections indicate that no medical loss ratio ("MLR") rebate is expected to be paid in 2016 (for 2015 experience) for the Individual MLR Pool in Connecticut. As such, no adjustment was made to premiums to account for expected rebates.
9. Allowed claims come directly from the claim records for hospital and physician services. For markets with capitated services, the capitation rate in the Application was used for incurred claims; allowed claims are then the same as the incurred claims.
10. In the Application, total incurred claims were developed by estimating the incurred but not paid ("IBNP") reserves using aggregate block of business paid claims. Paid claims were adjusted using the IBNP completion factors. More specifically, historical claim payment patterns were used to predict the ultimate incurred claims for each date-of-service month. The IBNP was estimated using actuarial principles and assumptions which consider historical claim submission and adjudication patterns, unit cost and utilization trends, claim inventory levels, changes in membership and product mix, seasonality, and other relevant factors including a review of large claims. This same process was used to develop IBNP estimates for allowed claims.

11. In addition to the fee-for-service and capitation payments discussed above, some of Aetna's provider contracts include provisions under which it shares claim cost differences with the provider relative to a pre-determined target amount. These adjustments serve to increase Aetna's claims cost when results are favorable to the target and decrease its claims costs when results are unfavorable. Aetna adjusted both allowed and incurred claims by its current estimate of the impact of provider risk sharing provisions.

12. The experience period data in the Application includes claims for single risk pool policies in-force in 2015. The projected change in the morbidity of the population is based on an internal analysis of the 2015 members' standard silver plan liability risk score, normalized for age and gender. This analysis divided Aetna's market into cohorts of new members and members renewing from a 2014 ACA plan. Aetna then modeled renewals and new market entrants for 2016 and 2017 from information sources, such as 2014 Centers for Medicare and Medicaid Services ("CMS") Risk Adjustment Reports and Wakely 2015 Risk Adjustment reports, as well as its internal analysis of special enrollment period members. The projected normalized average risk was developed from the market model, and compared to the average 2015 normalized scores.

13. The experience data in the Application includes experience for Single Risk Pool products that cover all essential health benefits ("EHB"). The projection factors reflect the impact of any changes in 2017 State Benchmark EHBs and any new state mandated benefits. Specific to Connecticut, Aetna did not identify any material Benchmark changes. However, Aetna adjusted claims by 0.4% to account for the following revisions to existing state mandates as of January 1, 2016 or later:

- The removal of the age cap associated with the Infertility mandate;
- Elimination of dollar limits and associated cost-sharing for Early Intervention Services; and
- Expansion of services covered under mental or nervous conditions.

14. The change in projected utilization due to changes in benefits was also considered by Aetna. As cost sharing decreases (measured by increasing AV), utilization increases. This pattern is reflected in the factors that are built into the federal risk adjustment mechanism that started in 2014. The federal risk adjustment program factors and other proprietary models were considered by Aetna in the development of the utilization change. The average cost sharing in the experience period was compared with the average cost sharing in the projection period. From the average cost sharing change, an expected utilization change was derived.
15. Experience data in the Application was normalized by Aetna for projected shifts in the age/gender and area mix using internally-developed factors. Section B of the Application, Index Rate Development, includes exhibits detailing this normalization process for both items.
16. The 'Other' adjustment in the Application also includes the projected impact of any changes in network composition and/or provider contracting.
17. In the Application, medical trend factors were based on local trend and network experience excluding catastrophic claims, with national trend results used for reasonability testing. Allowed medical trend includes known and anticipated changes in provider contract rates, severity and medical technology impacts, and

expected changes in utilization. The impact of benefit leveraging was accounted for with projected paid trend.

18. In the Application, pharmacy trends were also based on local market commercial group trend analysis, with national expectations as a benchmark. Pharmacy trend considers the impact of formulary changes, patent expirations, new drugs, other general market share shifts, and overall utilization trend.

19. The source data for Aetna's manual rate is the experience incurred from January 1, 2015 through December 31, 2015 and paid through March 2016 in the Connecticut Small Group market. Aetna considered the Small Group market experience an appropriate source for the manual rate due to similarities in covered benefits and market dynamics in the post-2014 ACA Individual market.

20. In the Application, the Small Group experience used as the basis for the manual rate was adjusted in a similar manner as the base period Individual experience for changes in population risk morbidity, benefits, and demographic and area normalizations. The data was further adjusted for projected changes in network, provider contract rates, and unit cost and utilization trend, as discussed in Section B of the Application, Index Rate Development as well as the Supplemental Actuarial Memo in the Application.

21. The manual experience included capitation for the same services that are expected to be capitated for the products in the Application in 2017. Aetna adjusted the manual experience for known or anticipated changes in capitation contracts and projected changes in demographics where capitation rates vary based on demographics.

22. The CMS Medicare full credibility standard is 24,000 member months.[3] Based on Aetna's experience, as stated in its Application, the Medicare population has significantly higher utilization – in the realm of 10 times of the Commercial population. Thus, Aetna assumed a full credibility standard of 240,000 member months and calculated its credibility based upon the partial credibility calculation: (86,222 ACA Individual experience MMs / 240,000)^0.5 = 59.9%).

23. Reinsurance recoveries in the experience period incurred claims were calculated by Aetna by assuming 50% recovery of paid claim amounts less U.S. Department of Health and Human Services ("HHS") cost-sharing payments between $45,000 and $250,000. Plan information is known by Aetna on paid claims and thus, recoveries were listed in the appropriate HIOS ID on Worksheet II of the Application. Reinsurance recoveries were reduced by the $3.67 reinsurance contribution assessed on Aetna in 2015.

24. Risk Adjustment transfer is accrued at the issuer and market level. The transfer was allocated by Aetna to the member-level by applying the HHS risk transfer calculation to each member relative to the imputed market average, such that members with higher resulting relative transfers scores may have a receivable and members with lower resulting scores may have a payable, regardless of the net market risk transfer result. The resulting member transfers were summed to the HIOS plan level and adjusted for 2015 Risk Adjustment fees of $0.08 Per Member Per Month ("PMPM") in Worksheet 2 of the Application.

25. Aetna expected its 2015 Connecticut Individual membership to be in a payer position of about 2% when 2015 CMS Risk Adjustment results were to be

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[3]https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/ClaimsCredibilityGuidelines.pdf.

published in June 2016. This analysis by Aetna is based upon 2014 CMS Risk Adjustment and Wakely 2015 Risk Adjustment reports. Given the expected deterioration to population risk identified by Aetna in Section 5A of its Application, it anticipated this will raise the Risk Adjustment position to level with the Connecticut Individual Market. Thus, Aetna's projected 2017 Risk Adjustment consists solely of the 2017 user fee of $0.13 PMPM.

26. In the Application, the prospective general and administrative expenses were based on historical corporate Individual market expense levels, current-year projections, and projected changes in expenses, inflation, and Aetna's membership for 2017. The commission expense factor covers anticipated sales and marketing expenses. Those may include, without limitation, purchase of television, internet and other advertising; payments of commissions and other incentive compensation to an internal sales force; and payment of commissions to external brokers. The exact amounts and distribution among the categories of sales and marketing expenses will depend on a variety of factors including competitive conditions, business strategy, consumer behaviors, and legal and regulatory requirements.

27. Federal taxes on Aetna include Federal income taxes as well as ACA taxes and fees based on the Notice of Benefit and Payment Parameters for 2017. The Risk Adjustment user fee, as mentioned in Section 9 of the Application, was applied to the projected risk adjustment transfer and was therefore excluded from the taxes and fees shown under non-benefit expenses. State premium taxes were estimated on most current known levels and included any known assessments. The profit and risk component is consistent with the target used in pricing Aetna's 2016 plans.

28. The expected 2017 MLR for the Application, as defined by the ACA and before any credibility adjustment, is 85.7%, as shown in the Financial exhibit of Section A of the Application. Per Aetna, this calculation is an estimate only, as it does not account for potential MLR rebates, credibility adjustments, nor Risk Adjustment program results.

29. Aetna's index rate reflects the projected mix of business by plan. The AV pricing values for each plan were based on Aetna's internal company modeling of plan cost-sharing designs, the plan's provider network, delivery system characteristics, and utilization management practices, as well as the impacts (as applicable) of benefits in addition to EHBs and catastrophic eligibility criteria, and the distribution and administrative costs applicable to the plan/product. Rates do not differ for any characteristic other than those allowable under the regulations as described in 45 CFR § 156.80 (d) (2).[4]

[4]45 CFR 156 – Health Insurance Issuer Standards Under the Affordable Care Act, Including Standards Related to Exchanges, General Provisions, Single Risk Pool.

30. The following are illustrations provided by Aetna in its Application:

a. Connecticut small group experience for Aetna, pre and post ACA:

CY	Earned Premium ($)	Incurred Claims ($)	Loss Ratio	Members
2007	20,567,835	17,301,597	84.1%	5,092
2008	32,814,369	27,385,221	83.5%	8,338
2009	61,914,560	49,730,102	80.3%	16,219
2010	110,713,752	90,891,861	82.1%	27,976
2011	118,081,224	95,980,807	81.3%	27,585
2012	160,289,638	133,561,183	83.3%	36,169
2013	173,246,289	139,345,453	80.4%	36,402
2014	180,511,228	146,137,062	81.0%	36,754
2015	208,121,062	169,166,391	81.3%	38,809
Total	$1,066,259,957	$869,499,677	81.5%	

b. Connecticut individual ACA experience for Aetna:

CY	Earned Premium ($)	Incurred Claims ($)	Loss Ratio	Members
2014	23,134,124	23,604,789	102.0%	4,621
2015	34,608,789	29,905,091	86.4%	7,185
Total	$57,742,913	$53,509,880	92.7%	

c. Unit Cost and Unit Cost Trend (Small Group)

Category	CY 2014	CY 2015	Trend
Inpatient Services	$4,081	$4,261	4.4%
Outpatient Services	$1,435	$1,519	5.8%
Physician Services	$208	$209	0.6%
Other Services	$209	$225	7.9%
Pharmacy	$104	$111	6.1%
Total			4.3%

d. Utilization (per 1,000 members) and Utilization Trend (Small Group)

Category	CY 2014	CY 2015	Trend
Inpatient Services	262.5	261.3	-7.6%
Outpatient Services	600.7	624.0	3.9%
Physician Services	7,758.8	8,153.3	5.1%
Other Services	4,617.7	4,594.8	-0.5%
Pharmacy	10,029.5	10,974.2	9.4%
Total			3.8%

e. Normalized Allowed Claims PMPM (Small Group)

Service	CY 2014	CY 2015	Trend
Inpatient Services	$80.31	$82.35	2.5%
Outpatient Services	$64.64	$70.10	8.4%
Physician Services	$121.04	$126.33	4.4%
Other Services	$72.31	$76.60	5.9%
Pharmacy	$71.63	$82.18	14.7%
Total	$409.93	$437.56	6.7%

f. Projected medical and Rx trends:

Service	Unit Cost Increase	Severity Adjustment	Utilization Change	Allowed Trend	Leveraging	Paid Annual Trend
Inpatient Services	5.9%	1.0%	0.5%	7.5%	1.5%	9.1%
Outpatient Services	5.9%	0.5%	3.8%	10.5%	1.5%	12.2%
Physician Services	1.8%	0.0%	4.1%	6.0%	1.5%	7.6%
Total Medical	4.5%	0.4%	3.2%	8.3%	1.5%	9.9%
Pharmacy	8.0%	0.0%	4.5%	12.9%	2.7%	15.9%
Total Medical/Rx				9.1%	1.7%	11.0%

31. Aetna's development of projected claim trend is a multi-step process that begins with its historical analysis from its Application. Consideration was given by Aetna to expected changes in network design and provider contracts, as well as new healthcare developments and technology. Pharmacy trends were developed utilizing formulary changes, new drugs in the pipeline, and patent expirations.

32. In its Application, Aetna's CT Small Group trend results are shown as a proxy due to its belief of the reduced credibility of the CT Individual ACA block. As these components are based on actual provider billing and Aetna claim payment practices, they are subject to fluctuations for several reasons including: changes in provider billing practices, changes in Aetna claim payment practices, and changes in the mix of services and procedures delivered by the medical profession.

33. Included in Section A of the Application is a summary of actual allowed trend results for calendar year 2015 versus calendar year 2014, as well as the details of the projected trends used in the Application. Projected trends utilize historical trend results as a starting point. They were then adjusted for a variety of considerations, such as:

- Historical anomalies, such as extreme winter weather or a severe flu season;
- Credibility of a Market versus regional and national indicators/results;
- Anticipated changes in provider contracts and network changes;
- The introduction and use of new technology;
- Economic conditions;
- Formulary changes;
- Patent expirations;
- New pipeline drugs;
- Other general market share shifts; and
- The influence of these & other factors on member utilization.

34. Specific to the differences between Aetna's actual 2015 trend and its projected 2017 trend, Aetna noted the following in its Application:

- Managing inpatient hospital use is an integral part of containing overall healthcare costs. As a situation allows, members are encouraged to instead access care in outpatient settings. However, while the -0.5% Inpatient utilization is encouraging, Aetna does not view it as sustainable, and have used a +0.5% Inpatient utilization expectation for projected trend. In comparison, national Inpatient utilization is approaching 2.0%.
- Pharmacy costs and trends are driven by Specialty drugs, which in one year rose from 35% to 45% of total Pharmacy claims while only accounting for less than 2% of total prescriptions. Given that few brand medications are projected to lose patent security in the near future, Aetna's unit cost trend for 2017 reflects this increasing Specialty impact with a leveling-off of brand-to-generic conversion.
- Specific to Pharmacy utilization, this figure continues to be high for CT Small Group, although it is reflecting a reduction since the third quarter 2016 rate filing. National average pharmacy utilization is only 2%. In recognition of the reduced utilization since the previous filing, Aetna has chosen a projected utilization of 4.5%, which is lower than the 2015 figure of 9.4% but still above the national average.

35. Aetna identified three changes to existing mandates since the end of the experience period that have a material impact to expected claims:
    - The removal of the age cap associated with the Infertility mandate: +0.1%, approved in its 2016 filing.
    - Elimination of dollar limits and associated cost-sharing for Early Intervention Services: +0.1%.

- Expansion of services covered under mental or nervous conditions: +0.1%.

36. The Applicant's benefit plan provisions include:

    - Elimination of cost sharing for preventive care.
    - Elimination of lifetime benefit maximums.
    - Elimination of annual dollar maximums for essential benefits.
    - Expansion of dependent age eligibility for children to age 26.
    - Waiver of pre-existing limitations for children under age 19.
    - Addition of the Women's Health mandate effective August 1, 2012.
    - Inclusion of taxes and fees beginning with premiums paid January 1, 2014 and later.
    - The inclusion of EHBs in plans effective January 1, 2014.
    - The suspension of the Health Insurance Fee ("HIF") for calendar year 2017.

    All provisions related to benefit & healthcare services are fully incorporated into Aetna's 2015 claim experience.

37. The proposed retention portion of the projected premium is 20.5%, while the retention from Aetna's December 31, 2015 annual financial statement is 18.9%.

38. Aetna expects the loss ratio for these products to be 76.6%, calculated in the traditional manner.[5] The expected 2016 MLR for the Application, as defined by the ACA and before any credibility adjustment is 84.5%. Below is a table submitted by Aetna in its Application detailing its calculation to demonstrate compliance with the Federal MLR Rebate:[6]

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[5]Incurred Claims ÷ Earned Premium

[6]CID Notice: Health Insurance Rate Filing Submission Guidelines (March 7, 2016). http://www.ct.gov/cid/lib/cid/LH-HealthInsuranceRateFilingSubmissionGuidelines.pdf.

	Premium	Claims
Earned Premium	100.0%	
Expected Medical Benefits ("MBR")		79.5%
Premium Reductions:		
Federal & State Taxes + Licensing & Regulatory Fees	6.4%	
Claim Adjustments:		
Quality Improvement Expenses		0.76%
Net Numerator MBR		80.3%
Net Denominator (Premium)	93.6%	
Resulting Federal MLR	85.7%	

39. The age factors in the Application are based on the HHS Default Standard Age curve.

40. Connecticut permits tobacco use to be a rating factor for Off-Exchange plans, using the Federal market rules definitions. Premium rates for tobacco users age 21 and over were increased in the Application by 10% from the corresponding non-tobacco premium rate.

41. Aetna's additional comments for Section 3 of the Application, which addresses the components of the rate increase, are as follows:

- The Experience adjustment of +3.2% reflects a -0.3% true-up to the 2015 claim PMPM baseline as well as a +3.4% trend correction. The trend correction was calculated as the current projected paid trend of 11.0% versus the approved 2016 paid trend of 7.3%.

- The Morbidity Change was detailed in Section B of the Application.
- The Risk Adjustment change reflects the change in expected position versus the Market Average for 2017 versus 2016. For 2017, Aetna expects to be at the Market Average, whereas the 2016 rate structure assumed a significant receiver position.
- The Reinsurance change reflects the termination of the 3-year ACA Reinsurance program.
- The Expense change is driven primarily by the suspension of the HIF for calendar year 2017.

42. The premium for each billable member was calculated by Aetna as: (Calibrated Plan Adjusted Index Rate x Age Factor x Area Factor x Tobacco Factor).

43. As of December 31, 2015, the capital and surplus held by Aetna was approximately $3.7 billion. This amount was disclosed in page 4, line 55 of Aetna's statutory financial statement dated December 31, 2015 filed with the Department. Aetna issues commercial and Medicare Advantage coverage for multiple business segments, including to large employer, small employer, and individual purchasers.

III. DISCUSSION

General Statutes § 38a-481 provides that individual health insurance rates must be filed with the commissioner. The commissioner may disapprove such rates if the rates are found to be excessive, inadequate or unfairly discriminatory.[7] These terms

[7]See General Statues § 38a-481 (b), and Regs. Conn. State Agencies § 38a-481-7 (e).

are not defined in § 38a-481 but are defined by § 38a-481-1 of the Regulations of Connecticut Agencies which provides in part:

> As used in Sections 38a-481-1 to 38a-481-9, inclusive, of the Regulations of Connecticut State Agencies, unless the context otherwise requires: ... (3) "Excessive rate" means the rate is unreasonably high for the insurance provided .... (6) "Inadequate rate" means a rate that is unreasonably low for the insurance provided, and continued use of it would endanger solvency of the insurer .... (11) "Unfairly discriminatory" means rating practices that reflect differences based on age, disability, race, ethnicity, gender, sexual orientation or health status that are not actuarially justified or otherwise prohibited by law.

These definitions are consistent with those found for the same terms in another statute dealing with rate filings within the insurance statutes (Title 38a). General Statutes § 38a-665, which addresses rates pertaining to commercial risk insurance provides in relevant part:

> Rates shall not be excessive or inadequate, as herein defined, nor shall they be unfairly discriminatory. No rate shall be held to be excessive unless (1) such rate is unreasonably high for the insurance provided or (2) a reasonable degree of competition does not exist in the area with respect to the classification to which such rate is applicable. No rate shall be held inadequate unless (A) it is unreasonably low for the insurance provided, and (B) continued use of it would endanger solvency of the insurer, or unless (C) such rate is unreasonably low for the insurance provided and the use of such rate by the insurer using same has, or, if continued, will have the effect of destroying competition or creating a monopoly.[8]

With the definitions noted above, along with actuarial standards of practice for health insurance, the Department uses the following standards for the review of health insurance rate filings.

- The Department deems rates excessive if they are unreasonably high in relation to the benefits provided and the underlying risks.

[8]General Statutes § 38a-665 (a).

- Rates are deemed inadequate if they are unreasonably low in relation to the benefits provided and the underlying risks, and continued use of it would endanger the solvency of the insurer.
- Rates would be deemed unfairly discriminatory if the methodology to develop the rates is not actuarially sound and is not applied in a fairly consistent manner so that resulting rates were not reasonable in relation to the benefits and underlying risks.
- The actuarial review of the Application to determine if the rates are reasonable, i.e. not excessive, inadequate or unfairly discriminatory, must be in compliance with ASOP 8 issued by the Actuarial Standards Board of the American Academy of Actuaries.

A primary concern raised by numerous members of the public is that the applied for increases would not be affordable for the renewing policyholders. As one commenter noted, "unaffordable health insurance is a more expensive version of being uninsured."[9] Affordability, however, is relative to each person and subjective, and although of overall concern, is not a standard for rate review within the statute or actuarial standards of practice. Members of the general public also argued that Aetna's profits, net income and its executives' salaries cannot justify any such rate increases. Furthermore, a portion of comments suggested that Aetna was well aware that the federal government's transition reinsurance program for the individual market would be ending and that it is being opportunistic by using that event to justify the increases being requested.

As previously stated, under § 38a-481, the Department is required to evaluate any proposed rate increase based on whether, from an actuarial perspective, it is

[9]Hrg. Transcr. 14:2-4 (August 4, 2016).

excessive, inadequate or unfairly discriminatory. Without the affirmative act of the Connecticut General Assembly to amend or replace the statute and include either, or both, an affordability standard or insurer net income standard, they will remain issues the Department cannot consider in its health insurance rate filing reviews.

To determine if the rates filed by Aetna are reasonable in relation to the benefits provided, the Department's actuarial staff completed an actuarial analysis to review the experience, assumptions and projections used in the Application. Since this filing incorporates all the new rating requirements of the ACA, the Department used criteria set forth in the latest HHS rate regulations as a template for review along with previously issued Connecticut Insurance Department Notices[10] that discuss the requirements for rate filings.

The Department reviewed the 9.1% annual trend assumption used in Aetna's Application and believes that based upon the experience data submitted this assumption is appropriate. This results in a paid annual trend of 11.0%.

The Department reviewed the June 30, 2016 Center for Consumer Information and Insurance Oversight ("CCIIO") Reinsurance and Risk Adjustment report for Connecticut. Based on this report Aetna paid out $621,770.44 in risk adjustment payments for the individual market. This amounted to a payment of $7.21 pmpm. The Department believes the net risk adjustment of $0.00 in the Application is appropriate for 2017.

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[10]CID Notice: Filing Requirements for Individual and Small Employer Group Health Insurance Policies Subject to ACA (March 7, 2016). http://www.ct.gov/cid/lib/cid/LH-FilingRquirementSubjectToACA.pdf.
CID Notice: Health Insurance Rate Filing Submission Guidelines (March 7, 2016). http://www.ct.gov/cid/lib/cid/LH-HealthInsuranceRateFilingSubmissionGuidelines.pdf.

Based upon the federal MLR of 85.7%, before the impact credibility adjustment, the Department believes that the proposed pricing supports the federally required 80% loss ratio for individual business.

IV. CONCLUSION AND RECOMMENDATION

Based on the foregoing and the Hearing record, the undersigned recommends that the proposed average rate increase of 27.9%, with a range from 25.8% to 31.5%, be approved as submitted.

The approved rates, described above, are reasonable in relationship to the benefits being offered and they are neither excessive, nor inadequate, nor unfairly discriminatory pursuant to § 38a-481.

Dated at Hartford, Connecticut, this 2nd day of September, 2016.

Jared T. Kosky, Esq.
Hearing Officer