STATE OF CONNECTICUT
INSURANCE DEPARTMENT

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In the Matter of:

THE PROPOSED RATE INCREASE APPLICATION OF CONNECTICARE BENEFITS, INC.

Docket No. LH 17-71

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ORDER

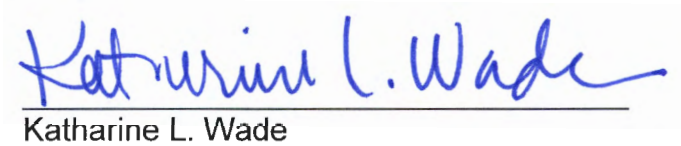
I, Katharine L. Wade, Insurance Commissioner of the State of Connecticut, having read the record in the above captioned matter, do hereby adopt the findings and recommendations of Jared Kosky, Hearing Officer, which are contained in the attached Proposed Final Decision, and issue the following orders,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

1. The rate application filed by ConnectiCare Benefits, Inc. ("ConnectiCare"), to be effective January 1, 2018, for its individual on exchange plans are excessive and are hereby disapproved in accordance with General Statutes § 38a-481.
2. ConnectiCare is authorized to submit revised rates for review and they shall thereafter be approved if I, the Insurance Commissioner, find them to be consistent with the recommendations as set forth in the Proposed Final Decision issued by Jared Kosky, Hearing Officer, on September 7, 2016. ConnectiCare will recalculate its rates using the following recommended rate assumptions for rates effective January 1, 2018, and submit a revised rate filing to the Insurance Department for review no later than September 12,

2017, to enable such time for review and adequate notice to be issued to policyholders.

- Reduce the risk adjustment charge from $11.45 PMPM to $3.00 PMPM;
- Gross up the Health Insurer fee of $9.49 PMPM to account for the lack of federal tax deductibility. This equates to $14.60 PMPM; and
- Reduce the lack of CSR funding adjustment from an increase of 34.1% to the silver on-exchange-only plans to an increase of 16.7%.

Dated at Hartford, Connecticut, this 7th day of September, 2017.



Katharine L. Wade
Insurance Commissioner

STATE OF CONNECTICUT
INSURANCE DEPARTMENT

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In the Matter of:

THE PROPOSED RATE INCREASE APPLICATION OF CONNECTICARE BENEFITS, INC.

Docket No. LH 17-71

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PROPOSED FINAL DECISION

I. INTRODUCTON

On May 1, 2017, ConnectiCare Benefits, Inc. ("ConnectiCare" or "Applicant"), filed a rate application regarding the Applicant's individual rates for on exchange plans ("Application") with the Connecticut Insurance Department ("Department") pursuant to General Statutes § 38a-481. The Application was later amended on May 15, 2017. Although there is no statutory requirement that a rate hearing be held, on May 30, 2017, Insurance Commissioner Katharine L. Wade ("Commissioner") issued a notice of public hearing ordering that a public hearing be held on June 14, 2017 concerning the Application.

A copy of the Notice of Public Hearing was submitted to the Office of the Secretary of the State on May 30, 2017, 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 May 30, 2017, the Commissioner appointed the undersigned to serve as Hearing Officer in the proceeding.

On June 14, 2017, a public hearing on the Application was held before the undersigned (the "Hearing"). The following individuals testified at the Hearing on behalf of the Applicant: Roberta Wachtelhausen, Senior Vice President and Chief Sales and Marketing Officer, ConnectiCare; Neil Kelsey, Chief Actuary, ConnectiCare; Mary van der Heidje, Principal and Consulting Actuary, Milliman. Bradford S. Babbitt, Esq., of Robinson & Cole 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. At the Hearing, the undersigned represented that the Department would continue to accept written comment on the Application until the close of business July 1, 2017. One public official and one member of the general public provided oral comment during the two public comment sessions at the Hearing. These individuals were Senator Tony Hwang and Marc Block. 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 there were 18 filings of written communication 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 ConnectiCare's Application. Opposition was mainly premised on the proposed rate increases being unaffordable to

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

consumers. There were also numerous comments critical of health insurers and health insurance rates in general.

At the conclusion of the hearing, ConnectiCare was directed to submit supplemental information no later than the close of business of July 5, 2017. ConnectiCare timely submitted the supplemental information on June 30, 2017, and the record was closed on that date.

Thereafter, on August 23, 2017, the Department requested that ConnectiCare submit by August 30, 2017, a supplemental filing to consider the non-funding of Cost Share Reduction ("CSR") payments by the Federal Government and the rate impact, if any, to its already filed premium rates by applying that impact only to Silver On-Exchange plans. ConnectiCare timely submitted this supplemental filing on August 30, 2017.

II. FINDINGS OF FACT

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

1. The Application is a filing made by ConnectiCare Benefits, Inc. based on Connecticut statutory requirements and is applicable only to on exchange individual health insurance products offered in Connecticut.
2. The Application requested an average increase of 15.2%, later amended and increased to 17.5%, on the Applicant's individual rates for on exchange plans to be effective January 1, 2018.
3. The Application included an Actuarial Certification by Neil S. Kelsey, F.S.A., M.A.A.A., Vice President and Chief Actuary, which certified that the Application was compliant with state filing guidelines, actuarial standards, including specifically

Actuarial Standards of Practice No. 8, Regulatory Filings for Health Plan Entities ("ASOP 8"), and that data quality was reconciled to financial statements.

4. The following are illustrations provided by ConnectiCare in its Application:

   a. ConnectiCare's most recent historical experience:

Calendar Year	Earned Premium	Incurred Claims	Loss Ratio	Members
2014	147,779,712	129,396,399	87.6%	21,184
2015	200,158,084	187,374,856	93.6%	36,519
2016	277,154,188	284,549,608	102.7%	50,891
Total	625,091,984	601,320,863	96.2%	

   b. ConnectiCare's Unit Cost ($) Trend:

Service	YE 2014	YE 2015	YE 2016	YE 2015 Trend	YE 2016 Trend
Inpatient	3,767	3,806	4,123	1.0%	8.3%
Outpatient	663	716	784	8.0%	9.05%
Professional	87	93	99	7.4%	6.0%
Subtotal Medical	213	220	236	3.6%	7.2%
Retail Rx	67	85	85	27.2%	0.2%
Total	161	168	176	4.5%	5.1%

   c. ConnectiCare's Utilization/1,000 Trend:

Service	YE 2014	YE 2015	YE 2016	YE 2015 Trend	YE 2016 Trend
Inpatient	354.5	320.2	331.9	-9.7%	3.7%

Outpatient	2,656.8	2,327.2	2,344.7	-12.4%	0.8%
Professional	19,503.3	18,085.8	18,702.0	-7.3%	3.4%
Subtotal Medical	22,514.6	20,733.2	21,378.7	-7.9%	3.1%
Retail Rx	12,534.9	13,225.5	14,107.1	5.5%	6.7%
Total	35,049.5	33,958.6	35,458.8	-3.1%	4.5%

d. ConnectiCare's Allowed Per Member Per Month ("PMPM") ($):

Service	YE 2014	YE 2015	YE 2016	YE 2015 Trend	YE 2016 Trend
Inpatient	111.27	101.54	114.04	-8.7%	12.3%
Outpatient	146.81	138.89	153.21	-5.4%	10.3%
Professional	140.85	140.24	153.72	-0.4%	9.6%
Subtotal Medical	398.93	380.68	420.96	-4.6%	10.6%
Retail Rx	70.00	93.94	100.42	34.2%	6.9%
Total	468.93	474.61	521.38	1.2%	9.9%

e. ConnectiCare's Net PMPM ($):

Service	YE 2014	YE 2015	YE 2016	YE 2015 Trend	YE 2016 Trend
Inpatient	103.19	93.92	106.51	-9.0%	13.4%
Outpatient	130.91	120.01	133.68	-8.3%	11.4%
Professional	119.59	113.37	124.89	-5.2%	10.2%
Subtotal Medical	353.69	327.29	365.08	-7.5%	11.5%
Retail Rx	59.32	84.53	89.95	42.5%	6.4%

Total	413.01	411.82	455.03	-0.3%	10.5%

f. ConnectiCare's Projected Pricing Trends:

Category	Utilization Per 1,000	Gross Unit Cost	Gross PMPM	Pricing Trend
Inpatient	1.1%	6.5%	7.6%	7.6%
Outpatient	2.7%	7.0%	10.0%	10.0%
Physician	3.0%	2.3%	5.4%	5.4%
Rx	7.1%	10.0%	17.8%	17.8%

Pricing trend assumed is 9.62%.

5. In the Application, ConnectiCare stated that it continues to experience increasing costs for healthcare services, and its rates must be adjusted to account for those rising costs. The Applicant identified three key drivers of the increased medical costs: 1) higher unit costs; 2) increased utilization; and 3) increased pharmacy spending led by specialty drug costs. Further in the Application, ConnectiCare stated that with respect to unit costs, it knows from contract discussions that doctors, hospitals and other providers will seek to charge more for their services in 2018. In addition, it expects the population to continue to seek services at an increased rate, consistent with the higher utilization noted in its illustrations above.
6. ConnectiCare stated in its Application that a large share of total medical cost is driven by pharmacy services. Specialty drugs in particular, which are used to treat some of the most challenging medical conditions, are increasingly expensive, and their prescribing rates are accelerating. Per the Application, currently specialty drug

costs represent over 40% of total pharmacy spending and are expected to grow to 50% by 2020.

7. In the Application, the mandated benefits were separately identified in the rate development. Exhibit 1 of the Application provides the price build-up. Per the Application, benefits comply with provisions of the Affordable Care Act ("ACA")[2], including Essential Health Benefits ("EHB").
8. Retention from the most recent statutory blank is 13.8%. The retention charge used in the Application is 17.2%.
9. ConnectiCare's expected medical loss ratio ("MLR") for the Application is 82.8%. Per the Application, the anticipated loss ratio for Federal MLR Rebate purposes is 85.2%.
10. The 2018 ACA fees are as follows:
    - Patient Centered Outcomes Research Fee: $0.20 PMPM
    - Transitional Reinsurance Program: N/A
    - Health Insurer Fee: $14.60 PMPM
    - Administrative cost of the Risk Adjustment Program is $0.14 PMPM.
11. Pursuant to its 2016 Annual Statement, ConnectiCare's capital and surplus, as of December 31, 2016, was $27,245,548.
12. Per the Application, the starting rates for the Individual Exchange product have been developed by ConnectiCare as follows:
    a. The projected claim costs for the Policy form, Individual Exchange, were based on the existing non-grandfathered Individual risk pool of ConnectiCare for the

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

incurred period January 2016 through December 2016, paid through February 2017.

b. Appropriate completion factors were then applied and the claims were trended at an average annual trend of 9.62% for 24 months.

c. Non-Fee For Service costs and the impact of Health Care Reform were included.

d. The projected claims were also normalized for average Age, Benefit and Area factors to develop the proposed base rate.

B. At the conclusion of the Hearing, ConnectiCare was asked to provide additional information in response to specific questions posed by the Department during the Hearing. Based upon that information, the undersigned makes the following additional findings of fact:

1. The following are illustrations provided by ConnectiCare in response to the Department's requests:

   a. ConnectiCare's Average Age of Exchange business:

	Average Age	Count
2016 Exchange Block at YE	44.4	49,158
2016 Renewing Members	45.0	38,264
2017 New Members	41.5	23,246
Migrators	42.6	5,768
2017 Exchange Block	43.6	67,278

   b. ConnectiCare's 2017 YTD claims PMPM of the various cohorts:

	Distribution	**Total PMPM**
Stayer	55%	$440.58
New Member	28%	$367.43
Migrated	8%	$255.24
Others*	10%	$449.95
Total	100%	$406.89

   * Members termed prior to May 2017

2. The Applicant provided the below table showing the April YTD claims PMPM for each of the past three years. These are claim incurred through April of each year, paid through May, 2017. These claims are on an incurred basis – they include completion factors. Per the Applicant, 2017 YTD claims reflect the significant growth and churn in Exchange membership, and may not be indicative of full year 2017 experience.

Period	Completed Claims	Member Months	PMPM
201501 - 201504	57,044,887	148,966	$382.94
201601 - 201604	87,911,478	205,099	$428.63
201701 - 201704	117,545,800	267,440	$439.52

3. Per the Applicant, in 2016, 2.9% of claims were out of network, representing 5.4% of total paid claims. Year to date in 2017, 1.9% of claims are out of network, representing 3.3% of total paid claims.
4. Per the Applicant, the modeling performed during the initial rate development yielded a 2.4% rate impact under the assumption that there was a perception that the individual mandate would be enforced less strictly than in the past. The modeling was performed at the age cohort and risk cohort level – assuming a greater proportion of younger and healthier lives would exit the market. The initial modeling projected that 9% of the existing membership would exit the market. Per the Applicant, if the assumptions in the model were modified such that it projected 5% of the membership would exit, the rate impact would be 1.3% rather than 2.4%.
5. ConnectiCare indicates that it has been notified by the Centers for Medicare and Medicaid Services ("CMS") that it will be assessed a Transfer Payment of $1,673,116 for the 2016 benefit year.

6. The following are illustrations provided by ConnectiCare indicating its first four months of 2017 compared to its first four months of 2016:

a. ConnectiCare's Unit Cost ($) Trend:

Service	2016YTD	2017YTD	2017YTD Trend
Inpatient	4,256	4,461	4.8%
Outpatient	777	789	1.6%
Professional	96	94	-2.5%
Subtotal Medical	234	231	-1.3%
Retail Rx	83	86	3.6%
Total	177	174	-1.5%

b. ConnectiCare's Utilization/1,000 Trend:

Service	2016YTD	2017YTD	2017YTD Trend
Inpatient	324.7	317.9	-2.1%
Outpatient	2,264.4	2,288.8	1.1%
Professional	18,325.8	19,057.4	4.0%
Subtotal Medical	20,914.9	21,664.2	3.6%
Retail Rx	12,839.3	14,092.3	9.8%
Total	33,754.2	35,756.5	5.9%

c. ConnectiCare's Allowed PMPM ($):

Service	2016YTD	2017YTD	2017YTD Trend
Inpatient	115.14	118.18	2.6%

Outpatient	146.54	150.51	2.7%
Professional	146.80	148.91	1.4%
Subtotal Medical	408.48	417.61	2.2%
Retail Rx	89.31	101.54	13.7%
Total	497.79	519.15	4.3%

d. ConnectiCare's Net PMPM ($):

Service	2016YTD	2017YTD	2017YTD Trend
Inpatient	106.94	108.13	1.1%
Outpatient	125.81	124.27	-1.2%
Professional	117.59	118.14	0.5%
Subtotal Medical	350.33	350.53	0.1%
Retail Rx	78.34	88.95	13.5%
Total	428.67	439.48	2.5%

C. At the request of the Department, on August 30, 2017, ConnectiCare submitted a supplemental filing that contemplates the absence of CSR payments for 2018 and applies that impact only to Silver On-Exchange plans. ConnectiCare has determined the impact to the Silver On-Exchange plans in the absence of CSR payments for 2018 to be 34.1%.

In this supplemental filing, ConnectiCare stated that in the event that CSR payments were not funded, carriers, including ConnectiCare, would not collect enough in premium

to cover the benefits required to be offered. In its supplemental filing, ConnectiCare determined the impact of spreading the cost of the unfunded CSR payments across all Silver plans offered on-Exchange and evaluated the following two factors in developing the additional premium:

- The difference in the benefit richness relative to the base Silver plan; and
- What members would remain in the pool over which this cost would be spread.

ConnectiCare provided the table below that shows the development:

Plan Design	Dist	Relativity
Base Silver	32.2%	0.654
73% CSR	16.5%	0.677
87% CSR	26.5%	0.859
94% CSR	24.8%	0.896
(a)	Filed Pricing Relativity	0.654
(b)	Average 87-94 CSR	0.877
(b)/(a)	Net Silver CSR Adjustment	1.341

Per the supplemental filing, given a significant increase in Silver premiums on-Exchange, ConnectiCare expects that many members will have other, more cost effective alternatives:

- Due to their eligibility for Advanced Premium Tax Credits ("APTC"), Base Silver net premium for individuals and families below 400% FPL will not be impacted. However, the net premium for Bronze and Gold plans will be reduced due to a higher APTC, making those plans attractive.

- Certain members who are sensitive to premium will opt for Bronze plans.
- As the premium cost of Silver plans approach or exceed Gold premiums, certain members will find the richer Gold plans more attractive.
- Certain members will find more attractive options off-Exchange.

Per the supplemental filing, those members who otherwise would have purchased a Base Silver or 73% CSR plan on-Exchange are most likely to migrate away from the Silver on-Exchange pool. To the extent this pool shrinks, the resulting impact of covering the benefit cost of those in the 87% and 94% CSR plans will be spread over a smaller pool, thus increasing the required load.

ConnectiCare's Filed Pricing Relativity is the average Base Silver premium factor which was included in its May 24, 2017 filing with the Department, under the assumption that CSR payments would be fully funded. Further, ConnectiCare expects that all members otherwise enrolled in a Base Silver or 73% CSR plan will migrate away from the on-Exchange Silver pool. Per the supplemental filing, as a result, the average benefit cost on the on-Exchange Silver pool will be 0.877, which is 34.1% higher than the currently filed premium of 0.654.

ConnectiCare stated in the supplemental filing that it has validated its assumptions, methodology, and resulting impact with external actuarial firms, and took an additional approach using federal actuarial values and induced demand factors. This yielded a range of impacts of between 34.7% and 36.1%, which substantiated its impact of 34.1%.

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.[3] These terms 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.

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.
- 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

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

be in compliance with ASOP 8 issued by the Actuarial Standards Board of the American Academy of Actuaries.

A primary concern raised year and again by members of the public in their written and oral comments is that rate increases are not affordable for renewing policyholders. Affordability, however, is relative to each person and subjective, and although it is of overall concern to the Department, is not a standard for rate review within the aforesaid statute, regulation or actuarial standards of practice that the Department must utilize in reviewing the rate requests.

To determine if the rates filed by ConnectiCare are reasonable in relation to the benefits provided, the Department 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 effective January 1, 2014, the Department used criteria set forth in the latest HHS rate regulations as a template for review along with previously issued Connecticut Insurance Department Bulletins[4] that discuss the requirements for rate filings.

The Department reviewed the 9.62% annual trend assumption used in the rate filing and believes that based upon the experience data submitted this assumption is appropriate.

ConnectiCare estimated the weakened individual mandate as an increase of 2.4%. Based upon the information provided, this estimate appears to be reasonable.

The Department reviewed the June 30, 2017 Center for Consumer Information and Insurance Oversight ("CCIIO") Reinsurance and Risk Adjustment report for Connecticut. Based on this report ConnectiCare paid out $1,673,116.38 in risk

[4]CID Bulletin HC-90-17: Filing Requirements For Individual and Small Employer Group Health Insurance Policies Subject to The Affordable Care Act (ACA) (March 2, 2017).
CID Bulletin HC-81-17: Health Insurance Rate Filing Submission Guidelines (March 2, 2017).

adjustment payments for the individual market which equates to approximately $2.75 PMPM. The Department believes the net risk adjustment payment of $11.45 PMPM, is excessive and should be reduced to $3.00 PMPM for 2018.

Based upon the federal MLR for this filing of 85.2%, the Department believes that the proposed pricing supports the federally required 80% loss ratio for individual business.

In its Application, ConnectiCare identified the 2018 ACA Health Insurer fee as $9.49 PMPM. This figure does not take into account that the Health Insurer fee is not federally tax deductible. Taking into account no tax deduction, the Health Insurer fee should be $14.60 PMPM which is calculated as follows: $9.49 ÷ (1 – 35%) = $14.60.

ConnecitCare's supplemental filing of August 30, 2017, requested a 34.1% rate increase for the silver on-exchange-only plans to account for the lack of CSR funding. While ConnectiCare provided a theoretical calculation of what the additional premium should be if the CSR is no longer funded, the undersigned believes that the calculation should be based on the actual CSR experience of the exchange carriers. The undersigned agrees with the membership movement out of the silver on-exchange plans if the CSR is not funded, as described by ConnectiCare in its supplemental filing. Taking into account the membership movement, the undersigned recommends that actual experience should be used and that the premium increase, for lack of CSR funding, be uniform for both exchange carriers (ConnectiCare and Anthem Health Plans, Inc. d/b/a Anthem Blue Cross and Blue Shield), resulting in an increase of 16.7%.

IV. CONCLUSION AND RECOMMENDATION

Based on the foregoing and the Hearing record, the undersigned concludes that the rates filed by ConnectiCare, to be effective January 1, 2018, are excessive

pursuant to § 38a-481 and recommends that the Insurance Commissioner disapprove the rate increases requested in the Application. The undersigned concludes that the recommended rate revisions determined in the actuarial analysis presented in the Discussion section are actuarially sound, and are adequate, not excessive and not unfairly discriminatory in accordance with § 38a-481. The undersigned recommends that the Commissioner request the Applicant make the following changes to the rating assumptions for rates effective January 1, 2018:

- Reduce the risk adjustment charge from $11.45 PMPM to $3.00 PMPM;
- Gross up the Health Insurer fee of $9.49 PMPM to account for the lack of federal tax deductibility. This equates to $14.60 PMPM; and
- Reduce the lack of CSR funding adjustment from an increase of 34.1% to the silver on-exchange-only plans to an increase of 16.7%.

Accordingly, the undersigned recommends that the Insurance Commissioner order ConnectiCare to recalculate the rates using the recommended revised rating assumptions with an effective date of January 1, 2018 and submit a revised rate filing to the Department for review no later than September 12, 2017.

Dated at Hartford, Connecticut, this 7th day of September, 2017.

Jared T. Kosky, Esq.
Hearing Officer