STATE OF CONNECTICUT

INSURANCE DEPARTMENT

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In the Matter of:

THE PROPOSED RATE INCREASE APPLICATION OF CONNECTICARE INSURANCE COMPANY, INC. Docket No. LH 15-94

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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 Kristin Campanelli, Hearing Officer, which are contained in the attached Proposed Final Decision, and issue the following orders, TO WIT:

1. The rates filed by ConnectiCare Insurance Company, Inc. to be effective January 1, 2016 are excessive and the rate Application increases are disapproved in accordance with Conn. Gen. Stat. §38a-481.
2. The recommended rate revisions determined in the actuarial analysis presented in the hearing officer's decision are actuarially sound, and are adequate, not excessive and not unfairly discriminatory in accordance with Conn. Gen. Stat.§38a-481.
3. The following changes to the rating assumptions for rates effective January 1, 2016 are accepted:

- Change annualized trend from the proposed 8.83% to the recommended 8.00%
- Reduce the cost of removing the age limit on the infertility mandate from $1.14 pmpm to $0.25 pmpm

4. ConnectiCare Insurance Company, Inc. will recalculate the rates using the recommended revised trend assumption with an effective date of January 1, 2016 and submit a revised rate filing to the Department no later than September 3, 2015.

Dated at Hartford, Connecticut, this 27th day of August, 2015.

Katharine L. Wade
Insurance Commissioner

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In the Matter of:

THE PROPOSED RATE INCREASE APPLICATION OF CONNECTICARE INSURANCE CO. INC.

Docket No. LH 15-94

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PROPOSED FINAL DECISION

I. INTRODUCTON

On April 30, 2015, Connecticare Insurance Company Inc. ("Connecticare" 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 Conn. Gen. Stat. §38a-481. Although there is no statutory requirement that a rate hearing be held, on July 6, 2015, Insurance Commissioner Katharine L. Wade ("Commissioner") issued a notice of public hearing. The Commissioner ordered that a public hearing be held on July 27, 2015, concerning the Application.

A copy of the notice for the public hearing was filed with the Office of the Secretary of State on July 7, 2015 and was published on the Department's Internet website. 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 Conn. Agencies Regs. §38a-8-48, the Applicant was designated as a party to this proceeding.

On July 7, 2015, the Commissioner appointed the undersigned to serve as Hearing Officer in this proceeding.

On July 27, 2015, the public hearing on the Application was held before the undersigned. The following individuals testified at the public hearing on behalf of the Applicant: Michelle Zettergren, Senior Vice President-Sales and Marketing; Neil Kelsey, Chief Actuary; Mary Van Der Heidje, Principal of Milliman. Bradford Babbitt, Esq., of Robinson & Cole LLP represented the Applicant.

The following Department staff participated in the public hearing: Paul Lombardo, Life and Health Actuary, ASA, MAAA and Mary Ellen Breault, ASA, MAAA.

Pursuant to the published hearing notice, the public was given an opportunity to speak at the hearing or 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 July 27, 2015. Public comment by persons who are not parties "shall be given the same weight as legal argument." Conn. Agencies Regs. §38a-8-51(b). Four members of the public and one public official provided oral comment during the two public comment sessions at the hearing. Vicky Veltri, Healthcare Advocate provided oral comments at the hearing. Members of the public who provided oral public comment were Lynne Ide, Universal Health Care Foundation of Connecticut; Elizabeth Keenan, CONECT; Angela DeMello, CONECT; and Cheryl Silber, policy holder.

As of the close of the record for public comment at the close of business July 27, 2015, there were 94 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 overall objection to ConnectiCare application. Some of the comment letters and oral comments included some detailed description of the hardship of ConnectiCare rates on the consumers who made the comments. There were also comments critical of health insurers generally in relation to recent federal health reform, and critical of the Department's handling of rate filings and the captioned rate application.

ConnectiCare was directed to submit supplemental information no later than July 31, 2015. ConnectiCare timely submitted the supplemental information on July 31, 2015 and the record was closed as of July 31, 2015.

II. FINDINGS OF FACT

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. On April 30, 2015, ConnectiCare electronically filed a rate application ("Application") requesting an increase of 10.1%, later reduced to 9.8% on the Applicant's individual rates for off exchange plans to be effective January 1, 2016.
2. ConnectiCare testified that this Application is a filing made by ConnectiCare Insurance Company Inc. and is applicable only to Connecticut based business, products offered in Connecticut, and based on Connecticut statutory requirements.

3. The filing included an Actuarial Certification by Shumei R. Kuo, FSA, MAAA, Director of Actuarial Services.
4. At the public hearing, Neil Kelsey testified that the filing 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.
5. The following is the most recent historical experience:

Calendar Year	Earned Premium	Incurred Claims	Loss Ratio	Members
2010	1,308,245	646,095	49.4%	396
2011	8,410,245	4,864,060	57.8%	2,594
2012	15,244,772	10,353,405	67.9%	4,613
2013	25,109,377	17,465,822	69.6%	7,527
2014	86,587,530	80,121,284	92.5%	20,380
Total	136,660,170	113,450,666	83.0%	

Unit Cost ($) Trend

Service	YE 2012	YE 2013	YE 2014	YE 2013 Trend	YE 2014 Trend
Inpatient	4,180	5,085	4,598	21.7%	-9.6%
Outpatient	631	713	825	13.1%	15.7%
Professional	95	98	99	2.7%	0.5%
Subtotal Medical	185	206	210	11.2%	2.0%

Retail Rx	59	64	87	9.6%	34.6%
Total	148	164	170	10.2%	3.9%

6. Utilization/1,000 Trend

Service	YE 2012	YE 2013	YE 2014	YE 2013 Trend	YE 2014 Trend
Inpatient	172.6	170.7	202.9	-1.1%	18.9%
Outpatient	1,563.8	1,553.4	1,857.0	-0.7%	19.5%
Professional	15,522.9	15,079.2	18,291.3	-2.9%	21.3%
Subtotal Medical	17,259.4	16,803.3	20,351.2	-2.6%	21.1%
Retail Rx	7,005.4	7,105.0	9,730.0	1.4%	36.9%
Total	24,264.7	23,908.3	30,081.2	-1.5%	25.8%

7. Allowed PMPM ($)

Service	YE 2012	YE 2013	YE 2014	YE 2013 Trend	YE 2014 Trend
Inpatient	60.13	72.33	77.74	20.3%	7.5%
Outpatient	82.20	92.35	127.73	12.3%	38.3%
Professional	123.52	123.24	150.31	-0.2%	22.0%
Subtotal Medical	265.85	287.91	355.79	8.3%	23.6%

Retail Rx	34.34	38.17	70.38	11.2%	84.4%
Total	300.19	326.09	426.17	8.6%	30.7%

8. Net PMPM ($)

Service	YE 2012	YE 2013	YE 2014	YE 2013 Trend	YE 2014 Trend
Inpatient	56.47	68.00	72.14	20.4%	6.1%
Outpatient	64.18	71.33	97.83	11.2%	37.1%
Professional	84.91	83.20	101.65	-2.0%	22.2%
Subtotal Medical	205.55	222.53	271.61	8.3%	22.1%
Retail Rx	18.19	22.53	51.40	23.9%	128.1%
Total	223.74	245.07	323.01	9.5%	31.8%

Below is first quarter 2014 compared to first quarter 2015

9. Unit Cost ($) Trend

Service	2014Q1	2015Q1	2015Q1 Trend
Inpatient	5,110	5,449	6.6%
Outpatient	798	785	-1.7%
Professional	97	100	2.8%
Subtotal Medical	209	211	1.1%
Retail Rx	73	84	15.1%

Total	148	164	2.9%

10. Utilization/1,000 Trend

Service	2014Q1	2015Q1	2015Q1 Trend
Inpatient	172.9	164.8	-4.6%
Outpatient	1,668.3	1,685.0	1.0%
Professional	16,379.9	16,435.4	0.3%
Subtotal Medical	18,221.1	18,285.3	0.4%
Retail Rx	8,901.7	9,060.2	1.8%
Total	27,122.8	27,345.4	0.8%

11. Allowed PMPM ($)

Service	2014Q1	2015Q1	2015Q1 Trend
Inpatient	74.67	74.89	0.3%
Outpatient	111.02	110.05	-0.9%
Professional	132.65	136.55	2.9%
Subtotal Medical	318.34	321.49	1.0%
Retail Rx	54.02	63.13	16.9%
Total	372.36	384.62	3.3%

12. Net PMPM ($)

Service	2014Q1	2015Q1	2015Q1 Trend
Inpatient	69.88	68.98	-1.3%
Outpatient	78.32	72.80	-7.1%
Professional	79.60	77.88	-2.2%
Subtotal Medical	227.80	219.66	-3.6%
Retail Rx	32.71	40.69	24.4%
Total	260.52	260.35	-0.1%

13. Summary of Trend Assumptions

Category	Utilization Per 1,000	Gross Unit Cost	Gross PMPM	Leveraging Impact	Pricing Trend
Inpatient	0.4%	6.5%	7.0%	0.5%	7.5%
Outpatient	1.7%	5.8%	7.6%	1.5%	9.2%
Physician	4.7%	2.0%	6.8%	0.7%	7.5%
Rx	1.0%	8.8%	9.9%	2.2%	12.3%

Pricing trend assumed is 8.83%.

14. ConnectiCare uses the following process to set forward looking trends:

- Historic experience: We review our historic experience for unit cost and utilization by high level cost category (inpatient, outpatient, physician and pharmacy).
- CICI specific factors: We estimate unit cost based on expected or actual contract changes and we estimate the impact of CICI specific actions taken to mitigate trends.
- Industry comparison: We compare to industry guidance on forward looking trends.
- Leveraging: We adjust for the impact of plan design leveraging (ie. deductibles or copays being held flat rather than trending with medical cost).

15. No new benefit mandates or requirements due to change in law are included. Benefits comply with provisions of the Affordable Care Act, including Essential Health Benefits.
16. Retention from most recent statutory blank is 17.7%; retention charge used in rate filing is 22.6%.
17. The expected medical loss ratio for this filing is 77.4%. The anticipated loss ratio for Federal MLR Rebate purposes is 84.7%.
18. The 2016 ACA fees are as follows:
    - Patient Centered Outcomes Research Fee: this charge of $2 per covered life applies to policies issued or renewed between 10/1/2012 and 9/30/2013, and then is expected to be subject to adjustment for projected increases in National Health Expenditures per year for the years 2014-2019. They have included $0.17 pmpm to cover this cost.

- Transitional Reinsurance Program: Recent guidance has put the cost of this program at $27 per capita for 2016 and has been converted to a $2.25 pmpm cost.
- Health Insurer Fee: Included a pmpm cost of $12.07 to cover this cost.
- Administrative cost of the Risk Adjustment Program is $0.15 pmpm.

19. The capital and surplus, as of December 31, 2014, is $68,448,043.
20. The starting rates for this individual direct product have been developed as follows. The experience for this policy form (individual direct), was based on the existing non-grandfathered individual risk pool of ConnectiCare Insurance Company , Inc. (CICI), using the incurred period January 2014 through December 2014, paid thru May 2015. Appropriate completion factors were then applied and the claims were trended at an annual trend of 8.83% for 24 months.
21. ConnectiCare is requesting a 9.6% increase to the base rate. Along with pricing factor changes, the average rate increase request is 9.8%. This represents a weighted average of the rate changes for all existing plans, ranging from 5.6% to 14.3%.

III. DISCUSSION

Conn. Gen. Stat. §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. While these terms are not defined in Conn. Gen. Stat §38a-481, the Legislature has given us guidance as to their meanings through other statutes dealing with rate filings. Conn.

Gen. Stat. §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.

Conn. Agencies Reg. §38a-474-3, which governs rate filings for Medicare Supplement products provides in relevant part:

> The commissioner shall not approve a rate for a Medicare supplement policy that is excessive, inadequate, unreasonable in relation the benefits provided or unfairly discriminatory.

Lacking any other statutory definitions in Conn. Gen. Stat. §38a-38a-481, we therefore use the definitions in Conn. Gen. Stat. §38a-665, and the reasonableness elements espoused in that statute as well as Conn. Agencies Reg. §38a-474-3, and along with standard actuarial principles 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 rate 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 members of the public is that the applied for increases would not be affordable for the renewing policyholders. 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 standard actuarial principles.
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 Affordable Care Act (ACA)[1] effective 1/1/2014, the Department used criteria spelled out in the latest HHS rate regulations as a template for review along with previously issued CT Insurance Department Bulletins that discuss the requirements for rate filings.

The Department reviewed the 8.83% annual trend assumption used in the rate filing and believes that based upon the experience data submitted this assumption is excessive and should be reduced to 8.0%.

ConnectiCare estimated the cost of removing the age limit of 40 from the Infertility Mandate as $1.14 pmpm. The undersigned recommends that this estimate be reduced to $0.25 pmpm. The basis for this recommendation is the 2014 Connecticut Mandated Health Insurance Benefits Review for the 2015 Legislative session which analyzed all current mandates and updated the pmpm cost analysis performed in the 2010 mandate report. The 2014 report estimated that the current infertility mandate with

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

the age 40 limit is estimated to be $1.06 pmpm for 2016 in Connecticut. Based on this $1.06 pmpm, the Department believes that the above age 40 population will have significantly less utilization of this mandate than the 40 and under population leading to the recommended $0.25 pmpm.

The Department reviewed the June 30, 2015 CCIIO Reinsurance and Risk Adjustment report for Connecticut. Based on this report ConnectiCare Insurance Company, Inc. paid out $10,948,959.34 in risk adjustment payments for the individual market. The Department believes the net risk adjustment of -0.15, representing the cost of the program, is appropriate for 2016, since there has been significant churning of membership from 2014 to 2015.

Based upon the federal MLR for this filing of 84.7% the Department believes that the proposed pricing supports the federally required 80% loss ratio for small group business.

In the 2015 pricing the Connecticut Insurance Department required that all individual carriers in the non-grandfathered market in Connecticut use a $45,000 attachment point (per HHS guidance), a $250,000 reinsurance cap, and a 70 percent coinsurance rate. The coinsurance rate assumption was based upon the following:

- The federal government has allowed states to decide whether or not to allow existing non-grandfathered, non-ACA compliant plans (grand-mothered plans for ease of explanation) to continue to renew until sometime in 2016. These grand-mothered plans are considered transitional plans and carriers will not have access to the temporary reinsurance program for these plans. A number of states have elected to allow these transitional plans while Connecticut has not.

All Connecticut individual plans, as of 1/1/2015 and beyond, will be considered fully ACA compliant plans eligible for the temporary reinsurance program.

- As a result, the Department believes that there will be excess funds available in 2015 since all transitional individual plans will not have access to the reinsurance program and were originally expected to be fully ACA compliant by 2015 when the funding parameters were originally set.

Since the assumptions for the attachment point and coinsurance level have changed from 2015 to 2016, this resulted in an increase to premiums.

IV. CONCLUSION AND RECOMMENDATION

Based on the foregoing and the record of the July 27, 2015 public hearing, the undersigned concludes that the rates filed by ConnectiCare Insurance Company, Inc. to be effective January 1, 2016 are excessive and recommends that the Insurance Commissioner disapprove the rate Application increases in accordance with Conn. Gen. Stat. §38a-481. 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 Conn. Gen. Stat.§38a-481. The undersigned recommends that the Commissioner accept the following changes to the rating assumptions for rates effective January 1, 2016:

- Change annualized trend from the proposed 8.83% to the recommended 8.00%

- Reduce the cost of removing the age limit on the infertility mandate from $1.14 pmpm to $0.25 pmpm

The undersigned recommends that the Insurance Commissioner order ConnectiCare Insurance Company, Inc. to recalculate the rates using the recommended revised trend assumption with an effective date of January 1, 2016 and submit a revised rate filing to the Department no later than September 3, 2015.

Dated at Hartford, Connecticut, this 27th day of August, 2015

Kristin Campanelli
Hearing Officer