State: Connecticut **Filing Company:** HealthyCT
TOI/Sub-TOI: H16I Individual Health - Major Medical/H16I.005A Individual - Preferred Provider (PPO)
Product Name: CTIND-HCT050713
Project Name/Number: Individual Mkt/

Correspondence Summary

Objection Letters and Response Letters

Objection Letters

Status	Created By	Created On	Date Submitted
Requesting Additional Information	Paul Lombardo	05/21/2013	05/21/2013

Response Letters

Responded By	Created On	Date Submitted
Bob Carey	06/05/2013	06/05/2013

Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Supporting Document	Actuarial Memorandum	Bob Carey	07/16/2013	07/16/2013
Supporting Document	Actuarial Memorandum and Certifications	Bob Carey	07/16/2013	07/16/2013
Supporting Document	Unified Rate Review Template	Bob Carey	07/16/2013	07/16/2013

Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
Rate revisions	Note To Reviewer	Bob Carey	07/16/2013	07/16/2013
Response to May 21 CID request for information	Note To Reviewer	Bob Carey	06/05/2013	06/05/2013

State:	*Connecticut*	***Filing Company:***	*HealthyCT*
TOI/Sub-TOI:	*H16I Individual Health - Major Medical/H16I.005A Individual - Preferred Provider (PPO)*		
Product Name:	*CTIND-HCT050713*		
Project Name/Number:	*Individual Mkt/*		

Objection Letter

Objection Letter Status	Requesting Additional Information
Objection Letter Date	05/21/2013
Submitted Date	05/21/2013
Respond By Date	06/04/2013

Dear Bob Carey,

Introduction:

Please review the attached questions/comments in support of this rate filing.

Conclusion:

Sincerely,
Paul Lombardo

CID Questions/Comments – HealthyCT 2014 Individual Rate Filing

May 21, 2013

1. Provide premium rates in a .pdf file format.
2. As HealthyCT, Inc. is a non-profit, explain the 1.00% profit/risk load.
3. State of CT premium tax is 1.75% by statute, explain the premium tax of 1.50% outlined in the filing.
4. If 2012 Milliman HCG was used as a starting point for the development of rates, why wasn't the appropriate unit cost and utilization data by category entered in Section II of the Unified Rate Review Template?
5. Why is the transitional reinsurance premium, net of recoveries and the stop-loss reinsurance premium, net of recoveries included in the description of the retention component?
6. Describe in more detail the stop-loss reinsurance premium and its purpose.
7. In light of the special assessment discussed at the May 16, 2013 Access Health CT board meeting, does HealthyCT plan on revising this rate filing to account for an exchange user fee?
8. Explain in more detail the quality improvement expenses.
9. The index rate in the Unified Rate Review Template is entered as $638.88, yet the index rate in Table 3 of the HealthyCT state actuarial memorandum is $264.77, explain.
10. When calculating the ACA reinsurance recoveries, the projected PMPM incurred claims before risk adjuster and recoveries is multiplied by 14.0%, explain the development of this percentage.
11. In Part III Actuarial Memorandum, the AV Pricing Values section on page 14 discusses the plan factors and that they reflect differences in the provider reimbursement rates and the degree of healthcare management expected between the various plans. Explain why provider reimbursement rates and healthcare management would vary by plan.
12. Explain in more detail the mental health parity issue described in Addendum B of the HealthyCT state actuarial memorandum.

State:	*Connecticut*	**Filing Company:**	*HealthyCT*
TOI/Sub-TOI:	*H16I Individual Health - Major Medical/H16I.005A Individual - Preferred Provider (PPO)*		
Product Name:	*CTIND-HCT050713*		
Project Name/Number:	*Individual Mkt/*		

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	06/05/2013
Submitted Date	06/05/2013

Dear Paul Lombardo,

Introduction:

Response 1

Comments:

Response to May 21 CID request for information.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Conclusion:

Sincerely,
Bob Carey

Amendment Letter

Submitted Date: 07/16/2013

Comments:

Revised rates and updated information.

Changed Items:

No Form Schedule Items Changed.

No Rate Schedule Items Changed.

Supporting Document Schedule Item Changes

Satisfied - Item:	Actuarial Memorandum
Comments:	
Attachment(s):	Revised individual market state memorandum 7-15-2013.pdf
Previous Version	
Satisfied - Item:	*Actuarial Memorandum*
Comments:	
Attachment(s):	*HealthyCT state memorandum - individual - 5-3-2013.pdf*

Satisfied - Item:	Actuarial Memorandum and Certifications
Comments:	
Attachment(s):	Ind Part III memorandum revised 7-15-2013.pdf
Previous Version	
Satisfied - Item:	*Actuarial Memorandum and Certifications*
Comments:	
Attachment(s):	*HealthyCT Part III memorandum - Individual - 5-3-2013.pdf*

Satisfied - Item:	Unified Rate Review Template
Comments:	
Attachment(s):	Individual URRT 7-15-2013.pdf Individual URRT 7-15-2013.xlsm
Previous Version	
Satisfied - Item:	*Unified Rate Review Template*
Comments:	
Attachment(s):	*Individual URRT workbook 5-3-2013.xlsm*

State:	*Connecticut*	***Filing Company:***	*HealthyCT*
TOI/Sub-TOI:	*H16I Individual Health - Major Medical/H16I.005A Individual - Preferred Provider (PPO)*		
Product Name:	*CTIND-HCT050713*		
Project Name/Number:	*Individual Mkt/*		

Note To Reviewer

Created By:

Bob Carey on 07/16/2013 08:46 AM

Last Edited By:

Bob Carey

Submitted On:

07/16/2013 08:46 AM

Subject:

Rate revisions

Comments:

Mr. Lombardo,

HealthyCT is submitting revised rates for individual market coverage effective January 1, 2014. Please do not hesitate to contact me if you have any questions or need additional information.

Sincerely,

Bob Carey
Consultant
HealthyCT

1400 Wewatta Street
Suite 300
Denver, CO 80202-5549
USA

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Fax +1 303 299 9018

milliman.com

July 15, 2013

Mr. Paul Lombardo, ASA, MAAA
Life & Health Division
Connecticut Insurance Department
153 Market Street
Hartford, CT 06103

Dear Mr. Lombardo:

Enclosed for your review and approval is a revised rate filing for HealthyCT's individual health insurance products, to be issued starting January 1, 2014. HealthyCT is a Consumer Operated and Oriented Plan (CO-OP) established pursuant to Section 1322 of the Patient Protection and Affordable Care Act (ACA). This is the first rate filing for HealthyCT's individual products. Milliman has been retained by HealthyCT to develop premiums and prepare this rate filing.

HealthyCT intends to offer coverage both inside and outside Access Health CT (Connecticut's health insurance exchange). The following products are included in this rate filing:

List of HealthyCT Individual Market Plan Offerings		
Product Name	**Offered Through Access Health CT**	**Offered Outside Access Health CT**
Healthy Partner Preferred	X	X
Healthy Partner Max	X	X
Healthy Partner Essential	X	X
Healthy Partner Min	X	X
Healthy Partner Preferred Pro		X
Healthy Partner Select Plus		X
Healthy Partner Select		X
Healthy Partner Basic Plus	X	X

Summaries of these benefits, prepared by HealthyCT, are included elsewhere in this filing.

Sincerely,

Stephen P. Melek, FSA, MAAA
Principal and Consulting Actuary

State:	*Connecticut*	***Filing Company:***	*HealthyCT*
TOI/Sub-TOI:	*H16I Individual Health - Major Medical/H16I.005A Individual - Preferred Provider (PPO)*		
Product Name:	*CTIND-HCT050713*		
Project Name/Number:	*Individual Mkt/*		

Note To Reviewer

Created By:

Bob Carey on 06/05/2013 01:13 PM

Last Edited By:

Bob Carey

Submitted On:

06/05/2013 01:13 PM

Subject:

Response to May 21 CID request for information

Comments:

Attached responses to May 21 CID request for information.

MEMORANDUM

To: Paul Lombardo, Actuary, Life and Health Division
Connecticut Insurance Department

From: Bob Carey, Consultant
HealthyCT

Re: Response to questions from Connecticut Insurance Department

Date: June 5, 2013

Attached please find responses to the questions raised in your memo of May 21, 2013 regarding HealthyCT's individual market rate filing. HealthyCT is currently revising its initial rate filing to address the issues raised in your memo and to correct other issues that we have identified subsequent to our initial submission on April 30, 2013.

We plan to submit a revised rate filing shortly. We appreciate your attention to our filing and look forward to your review. If you have any questions or need additional information, please do not hesitate to contact me at 617-470-3614 or via email at r.l.carey@comcast.net, or Ken Lalime, CEO of HealthyCT, at 203-949-1602 x 1011.

Responses to CID questions and comments on HealthyCT 2014 individual rate filing (May 21, 2013)

1. Provide premium rates in a .pdf file format.

We are currently revising our rate filing and will submit premium rates in a .pdf file format with our revised rate filing.

2. As HealthyCT, Inc. is a non-profit, explain the 1.00% profit/risk load.

The "profit/risk load" could alternatively be labeled as "contribution to capital/surplus." The purpose of this line is to enable HealthyCT to:

(a) Repay its loan obligations to the Centers for Medicare and Medicaid Services (CMS) when they are due under HealthyCT's loan agreements; and
(b) Accumulate surplus (line 33 on the "Liabilities, Capital and Surplus" section of the NAIC Annual Statement) in order to meet solvency requirements.

A not-for-profit entity does not have shareholders to whom profits can be distributed, and profit-making is not the objective of the entity. Nonetheless, not-for-profit entities do not break even every single year of operations. In fact, as a health insurer, HealthyCT cannot break even every year. Doing so would result in HealthyCT being unable to meet Connecticut's solvency requirements. HealthyCT also would have no sources of cash with which to repay its start-up and solvency loans to CMS.

We note that from an accounting perspective, repayments of loans are a financing matter. Loan repayments are not expenses, and they do not reduce profit. (This is similar to shareholder dividends in the case of a for-profit company.) For this reason, and because no repayments to CMS are due in 2014, "loan repayment" would not be an appropriate item to list in components of retention.

3. State of CT premium tax is 1.75% by statute, explain the premium tax of 1.50% outlined in the filing.

The 1.50% CT premium tax used for purposes of our rate development relative to the 1.75% statutory rate is a function of the fact that HealthyCT expects to take advantage of a variety of tax credits available to businesses subject to premium tax. We expect that tax credits will reduce our effective premium tax rate by at least 25 basis points.

A critical element of our business model includes a conscious effort to employ Connecticut residents, as well as select business partners based in Connecticut to help build and operate our organization. Being a start-up Connecticut-based business, we expect to utilize such credits as small business job creation credits, electronic data processing equipment credits, and new job creation credits to name a few of the many tax saving opportunities available in the tax code. Therefore, by operating our business in this fashion, we have incorporated the benefits of that approach into our premium tax strategy in order minimize our tax liability.

4. **If 2012 Milliman HCG was used as a starting point for the development of rates, why wasn't the appropriate unit cost and utilization data by category entered in Section II of the Unified Rate Review Template?**

   Use of the *Health Cost Guidelines*™ in the rate filing accords with Actuarial Standard of Practice No. 8, Section 3.2.6. This states that for new plans and in the absence of sufficient data, appropriate models should be used. The *Health Cost Guidelines*, however, are not HealthyCT's own experience. It is our understanding that the purpose of Section II of the URRT is to provide actual experience, which does not exist for a new carrier like HealthyCT.

5. **Why is the transitional reinsurance premium, net of recoveries and the stop-loss reinsurance premium, net of recoveries included in the description of the retention component?**

   Every dollar of premium revenue either becomes a dollar of paid claims or a dollar of retention. Net cost of reinsurance (whether through the ACA's transitional reinsurance program or purchased stop-loss coverage) is not a paid claim, and is therefore a component of retention. This is a commonly accepted characterization of net reinsurance expense. For example, consider the following Connecticut state laws (emphasis added):
   (a) Connecticut General Statutes, 700c §38a-478l(b)(2)(A): "'State medical loss ratio' means the ratio of incurred claims to earned premiums for the prior calendar year for managed care plans issued in the state. **Claims shall be limited to medical expenses for services and supplies provided to enrollees and shall not include expenses for stop loss coverage, reinsurance**, enrollee educational programs or other cost containment programs or features."
   (b) Connecticut General Statutes, 700c §38a-513f(a)(1): "'Claims paid' means the amounts paid for the covered employees of an employer by an insurer, health care center, hospital service corporation, medical service corporation or other entity as specified in subsection (b) of this section for medical services and supplies and for prescriptions filled, **but does not include expenses for stop-loss coverage, reinsurance,** enrollee educational programs or other cost containment programs or features, administrative costs or profit."

6. **Describe in more detail the stop-loss reinsurance premium and its purpose.**

   HealthyCT is still in the process of obtaining stop-loss reinsurance coverage. The stop-loss reinsurance premium shown in the rate filing is $14.67 on a PMPM basis. This was estimated by using Milliman's claim probability distributions (part of the *Health Cost Guidelines*) to project the cost of claims that will exceed the stop-loss level. Milliman then assumed a 75% loss ratio for the reinsurer to arrive at the estimated reinsurance premium. This loss ratio implies reinsured claims of $11 PMPM. The claim probability distributions imply that the PMPM claim costs in excess of a $300,000 annual attachment point (with 100% coinsurance) would be approximately $11. Again, note that these are estimates, HealthyCT has engaged representation to acquire stop-loss coverage. Currently, their representative is actively soliciting quotes from reinsurance carriers in this market; The actual selected attachment point and coinsurance level could vary, and rates available in the marketplace may vary from Milliman's estimates.

   The purpose of stop-loss reinsurance is to protect HealthyCT (and, by extension, its members and its financers [taxpayers]) from the impact of catastrophic claims. This is particularly important for a start-up entity like HealthyCT, which does not yet have the capital levels to absorb such claims. The

federal transitional reinsurance program is very different than traditional stop-loss reinsurance. Stop-loss reinsurance protects against catastrophic claims. The federal transitional reinsurance program provides reimbursement for 80% of claims between $60,000 and $250,000 per year. This program still leaves HealthyCT with significant exposure to large claims, since individuals can and do have significantly higher claim levels in a year.

7. **In light of the special assessment discussed at the May 16, 2013 Access Health CT board meeting, does HealthyCT plan on revising this rate filing to account for an exchange user fee?**

   Yes, HealthyCT intends to revise its rate filing to account for the special assessment announced subsequent to the filing date.

8. **Explain in more detail the quality improvement expenses.**

   The quality improvement expenses are a reflection of the Quality Improvement / Utilization Management Program that has been approved by HealthyCT's Board of Directors, and will be the basis by which we operate our medical management function. We have uploaded a copy of the program to SERFF.

9. **The index rate in the Unified Rate Review Template is entered as $638.88, yet the index rate in Table 3 of the HealthyCT state actuarial memorandum is $264.77, explain.**

   The federal rate review rules (published in the Federal Register on February 27, 2013, Vol. 78, No. 39, pp. 13406-13442) define index rate as a base rate to which adjustments are applied to account for differences in age, plan selection, tobacco use, and area. This index rate is "to be based on the total combined EHB claims experience of all enrollees in all non-grandfathered plans in the risk pool." This is the $264.77 shown in the state actuarial memorandum. Premiums for individual members, shown on the Rates Table Template, result from multiplying that base rate by the age, area, and plan factors shown in Table 4 of the state actuarial memorandum.

   In the URRT instructions, on the other hand, "index rate" is defined as follows (Part I Unified Rate Review Template Instructions, April 29, 2013, p. 15):

   > *As noted in Section I, the index rate represents the average allowed claims PMPM for essential health benefits. This legal entity-specific rate for the projection period should not reflect any adjustments for payments and charges under the risk adjustment and reinsurance programs or for Exchange user fees. It is simply projected allowed claims PMPM for essential health benefits.*

   The term "index rate" therefore has been given two different meanings. In the rate filing itself (which is used to compute actual premiums), it is the base rate to which the multiplicative adjustments are applied, and it is based on *paid* claims and *must* account for the impact of the federal reinsurance and risk adjustment programs (45 USC §156.80(d)(1)). In the URRT, the "index rate" is a projection of *allowed* costs and *may not* account for the impact of the federal reinsurance and risk adjustment programs.

   We understand that it is confusing to have the same term mean two very different things in different parts of the filing. Nonetheless, this is what the federal rules and instructions require.

10. When calculating the ACA reinsurance recoveries, the projected PMPM incurred claims before risk adjuster and recoveries is multiplied by 14.0%, explain the development of this percentage.

The 14.0% cited in the URRT Part III memorandum is equal to the following:

$$14.0\% = \frac{\$64.11\ reinsurance\ recoveries}{\$458.29\ claims\ before\ risk\ adjustment}$$

Additional detail on the numerator and denominator:

(a) The $64.11 in projected reinsurance recoveries is calculated using Milliman's claim probability distributions from the *Health Cost Guidelines*. The federal transitional reinsurance program provides for recovery of 80% of each member's paid costs between $60,000 and $250,000 per year. Claim probability distributions show the likelihood of a member having various claim levels in a 12-month period. We applied these probabilities to estimate the total costs that would fall in this range in 2014, and multiplied by 80%.

(b) The $458.29 in claims before risk adjustment can be found in cell V34 of Worksheet 1 of the URRT. Development of this amount is described in the state actuarial memorandum, section J.

11. In Part III Actuarial Memorandum, the AV Pricing Values section on page 14 discusses the plan factors and that they reflect differences in the provider reimbursement rates and the degree of healthcare management expected between the various plans. Explain why provider reimbursement rates and healthcare management would vary by plan.

Under the federal rate review rules (45 USC §156.80(d)(2)), degree of healthcare management and provider reimbursement rates are permitted plan-level adjustments to the index rate (specifically, they are "provider network, delivery system characteristics, and utilization management practices"). The following are examples of reasons that these attributes *could* vary from one plan to another:

(a) A carrier might offer narrow network and expanded network plans. In the narrow network plans, more of the utilization would be with providers with which the carrier has negotiated more favorable reimbursement rates (and hence were selected for inclusion in the preferred network).

(b) A carrier might offer plans with different rules for access to specialists. For example, one plan might allow open access, while another follows a "gatekeeper" model that requires PCP approval for specialty care. This would be a difference in healthcare management.

However, HealthyCT's plans do not actually vary by either of these attributes (as shown on Page 15 of the URRT Part III memorandum).

12. Explain in more detail the mental health parity issue described in Addendum B of the HealthyCT state actuarial memorandum.

The interim final rules (IFR) to the Mental Health Parity and Addiction Equity Act (MHPAEA) lay out specific mathematical tests that must be conducted to determine the permissibility of cost sharing for behavioral health services. The full text of the IFR can be found here, and page references below are to the Federal Register page numbers in the document: http://www.gpo.gov/fdsys/pkg/FR-2010-02-02/pdf/2010-2167.pdf

Among the things that <u>cannot</u> be done to confirm that a plan complies with the requirements of MHPAEA:

- Designing a benefit that seems fair or generous or conservative
- Using a dictionary definition of “parity”
- Making assumptions about which plan designs are likely or unlikely to be selected by persons with behavioral health needs

The IFR’s standard for what constitutes “parity” is that member financial requirements and quantitative treatment limits for mental health and substance use disorder benefits must not be “more restrictive than the predominant financial requirement or treatment limitation applied to substantially all medical/surgical benefits in the same classification” (p. 5413). Several of the words in this quote have specific meanings defined in the rules:

- “Substantially all” means at least two-thirds (p. 5414)
- “Predominant” means more than 50% (p. 5414)
- “Classification” refers to the division of medical/surgical services into (p. 5413):
    - In-network inpatient services
    - Out-of-network inpatient services
    - In-network outpatient services
    - Out-of-network outpatient services
    - Emergency services (in- and out-of-network combined)
    - Prescription drugs
- Additionally, a compliance safe harbor released July 1, 2010, allows the two outpatient classes to be divided into sub-classes for office visits versus all other outpatient services (http://www.dol.gov/ebsa/faqs/faq-mhpaea.html).

The rules require that each type of financial requirement be tested separately (p. 5413). Copays for mental health and substance use disorder benefits must be tested to ensure that they are no higher than the predominant copay applied to substantially all medical/surgical services in the same classification. Coinsurance must likewise be separately tested against medical/surgical coinsurance. They cannot be mixed, nor is it permitted to test for “cost sharing” or “financial requirements” as a whole.

To be very specific about the outpatient benefits in question (the in-network copay in the Exchange’s Bronze #1 plan), the only way it is permitted to have <u>any</u> copay on mental health and substance abuse outpatient services in this plan is if:

1. At least two-thirds of the population-wide allowed costs for outpatient medical/surgical services are subject to copays, AND
2. The mental health and substance use services copay is no higher than the Predominant level of copay for outpatient medical/surgical services

In this plan, the only medical/surgical outpatient services with copays are PCP office visits. It is highly unlikely that PCP office visits account for at least two-thirds (substantially all) of the allowed medical/surgical outpatient costs in an insured population, even when using the sub-classes. Therefore, it is not permitted to have any copay on mental health services. The compliance safe harbor is unlikely to help in this particular case.

We understand that having a copay may be more generous to members than other cost sharing arrangements. We also understand that it "seems fair" to have the behavioral health copay match the PCP copay. However, as stated at the outset of this response, neither of these are relevant considerations when determining compliance with the IFR. Plans have to follow the mathematical tests laid out in the IFR, and the potential penalties from offering noncompliant coverage are significant.

The Exchange's Bronze #2 plan design has a similar issue, since mental health and substance use disorder providers are also subject to the $30 copay for the first three visits (combined with PCP). It is virtually impossible to argue that at least two-thirds of outpatient costs (or even outpatient office visit costs) occur during the first three PCP visits per member per year; therefore, the IFR would not permit requiring members to pay a copay for any mental health and substance use disorder office visits. However, we recognize that the Exchange has decided not to require carriers to offer the Bronze #2 plan.

Our findings here are not unusual. When the IFR was first released and plans had to bring their benefit designs into compliance, it was not uncommon to see benefit designs where 100% of medical/surgical services were subject to *some* form of cost sharing, but because no *one* form of cost sharing applied to at least two-thirds of allowed healthcare costs in a classification, *all* cost sharing needed to be removed for mental health and substance use disorder services in that classification. We understand how counter-intuitive this result is, but this is what the regulations require.

State:	*Connecticut*	***Filing Company:***	*HealthyCT*
TOI/Sub-TOI:	*H16I Individual Health - Major Medical/H16I.005A Individual - Preferred Provider (PPO)*		
Product Name:	*CTIND-HCT050713*		
Project Name/Number:	*Individual Mkt/*		

Post Submission Update Request Processed On 07/23/2013

Status:	Allowed
Created By:	Bob Carey
Processed By:	Paul Lombardo
Comments:	

Company Rate Information:

Company Name:HealthyCT

Field Name	Requested Change	Prior Value
Product Names:	Healthy Partner Preferred Healthy Partner Max Healthy Partner Essential Healthy Partner Preferred Pro Healthy Partner Select Plus Healthy Partner Select Healthy Partner Basic Plus Healthy Partner Min	Healthy Partner Preferred Healthy Partner Max Healthy Partner Essential Healthy Partner Basic Healthy Partner Preferred Pro Healthy Partner Select Plus Healthy Partner Select Healthy Partner Basic Plus Healthy Partner Min
REQUESTED RATE:		
Projected Earned Premium:	54,859,473.000	69,603,032.000
Projected Incurred Claims:	44,153,484.000	59,187,566.000
Min:	111.010	141.670
Max:	1,079.950	1,364.090
Weighted Avg.:	271.100	427.350