



STATE OF CONNECTICUT

INSURANCE DEPARTMENT

HealthyCT, Inc. Individual 2016 Rate Filing

Finding of Facts

1. HealthyCT (HCT) is a Consumer Operated and Oriented Plan (CO-OP) established pursuant to Section 1322 of the Patient Protection and Affordable Care Act (ACA). Its first policy was written effective January 1, 2014.
2. HealthyCT's individual experience for 2014 is as follows: Earned Premium of \$12,851,259; Incurred Claims of \$13,049,433; Medical Loss Ratio of 101.54%.
3. The 2016 proposed average rate change is 3.43%. Consists of the following:

Medical and Pharmacy Trend Change Factor	1.052
Administrative Expense Change Factor	1.010
Contribution to Surplus Change Factor	0.995
Transitional Federal Program Factor	1.095
Morbidity Change Factor	0.902
Demographic Change Factor	1.003
Benefit Change Factor	0.987

4. We based the 2015 to 2016 annual trend rates on Milliman's 2015 *Health Cost Guidelines*TM (HCGs), adjusted based on information provided by Healthy CT, as described below. This section presents the trend rates and describes their development.

We started with nationwide average annual trend rates that represent reasonable estimates of trend based on values observed in proprietary data used by Milliman in developing the HCGs. Table 2 displays the starting ranges of Milliman annual trend rates, which are described in the subsections following the table. We adjusted these trend rates to reflect programs and contracting arrangements that HealthyCT has implemented or will implement that would affect these starting trend rates.

Below are Milliman 2016 secular trend factor guidelines

<u>Component</u>	<u>Unit Cost Trend</u>	<u>Utilization Trend</u>	<u>Total Trend</u>
Inpatient Facility	3% to 8%	-1% to 3%	2% to 10%
Outpatient Facility	4% to 10%	0% to 4%	4% to 12%
Professional	4% to 7%	0% to 3%	4% to 9%
Rx	9.5% to 12.2%	0.5% to 3.2%	10.0% to 15.4%
Total			4% to 11%

The unit cost trends represent, by service category, the expected annual rate of growth in billed charges from 2015 to 2016. This unit cost is driven by factors such as provider price increases and substitution of older technologies and prescription drugs for newer, more expensive ones.

The utilization trends represent, by service category, the expected annual rate of growth in utilization of medical services and prescription drugs from 2015 to 2016. Utilization trend can be driven by factors such as changes in medical practice patterns toward regular use of services, or expansion of the availability of medical care.

5. As indicated earlier, the annual trend rates represent the results of Milliman's research and represent changes in the utilization of services and in billed charges. Several adjustments were made to the trend rates to reflect contracting arrangements and other programs that HealthyCT is implementing. The adjustments are:
 - Most of HealthyCT's Inpatient and Outpatient facility contracts are based on discounts from billed charges. Based on HealthyCT's experience and assessment of the marketplace, chargemasters (i.e. billed charges) are increasing at a slower rate than they have in the past. We are assuming a 3% increase in billed charges for 2016 over 2015. Accompanying this is more aggressive contracting terms and more performance based contracting with hospitals. Based on HealthyCT's progress toward implementing these changes, we have reduced the unit cost trend by 1.5%, bring the total to 3.4% for hospital inpatient and hospital outpatient.

- HealthyCT utilizes Medicare-based professional contracting, resulting in unit cost increases that are more comparable to changes in Medicare fee schedule changes than to billed charges. We assumed an annual unit cost trend rate of 2.5% for professional services.
- HealthyCT's use of performance-based contracting with various hospital systems and their professional groups was considered when setting the utilization trend rates for hospital and professional services near the midpoint of the Miliman range.
- HealthyCT's PBM, Catamaran, has provided projections of its total pharmacy trends for 2016 (combination of number of scripts, mix of scripts by tier and cost per script). Based on discussions between HealthyCT management and Mililman, we selected the high end of the range of the projection as the starting point for 2016 pharmacy trends. All of the trend is being shown in the unit cost column. Catamaran has entered into an agreement with several CO-Ops under which the contractual terms (e.g. discounts from average wholesale price (AWP)) will improve once total lives under contract exceed certain thresholds. Based on actual CO-OP membership in 2015, HealthyCT expects these thresholds to be hit by 2016. Recognizing this contracting change as well as Catamaran's projections for 2016, 9.0% was used as the total pharmacy trend rate.
- Other benefits include ambulance, DME, private duty nursing, home health care, and prosthetics. We assumed that increase in utilization of such services would be comparable to the utilization increase in professional services and that the unit costs would increase at a lower amount than billed charges due to some fixed fee contracts. The result is 1.5% utilization increase and 3.0% unit cost trend.

The resulting 2016 annual trend rates used in the development of the HealthyCT 2016 rates are as follows:

<u>Component</u>	<u>Unit Cost Trend</u>	<u>Utilization Trend</u>	<u>Total Trend</u>
Inpatient Facility	3.4%	-0.0%	3.4%
Outpatient Facility	3.4%	2.0%	5.5%
Professional	2.5%	1.5%	4.0%
Rx	9.0%	0.0%	9.0%

Other	3.0%	1.5%	4.5%
Total			5.22%

6. Rather than apply an adjustment to the medical trend rates to separately account for cost sharing leveraging, the impact of the deductible and other cost sharing features on paid claims is directly modeled by using allowed claim levels (2015 values trended to 2016) in claim probability distributions and projection models that are used to develop the expected cost of plans that will be offered in 2016.
7. Medical technology trend is not broken out separately in our trend projections. This can be thought of as a component of the cost and utilization trends described above.
8. The annual trend rates described above apply to allowed charges. The effect of any benefit buy-downs is not applicable to the trend rates computed above.
9. No new benefit mandates have been identified for 2016. Therefore, no adjustment for new benefit mandates was needed.
10. Below are the components of retention that are assumed in the rate filing, along with the corresponding values used in the 2015 rate development and are displayed as a percentage of total gross premium:

Component	2016	2015
General Administrative Expenses	7.6%	6.0%
Quality Improvement Expenses	2.3%	1.2%
Commissions	1.3%	3.1%
Marketplace Administrative Fee	1.6%	1.4%
Comparative Effectiveness Research Fee	0.0%	0.1%
Health Insurer Fee	0.4%	0.1%
Risk Adjustment Administrative Fee	0.0%	0.0%
Premium Tax	1.8%	1.5%
<u>Provision for Profit and Contingencies</u>	<u>0.5%</u>	<u>1.8%</u>
Total	15.5%	15.1%

The transitional reinsurance fee is being treated as a reduction to the transitional reinsurance recoveries per Part I URRT Instructions and is not included in the table above.

HealthyCT commenced operations in 2014. The Statement of Revenue and Expenses for all of HealthyCT's business (individual, small group and large group combined) shows net premium of \$21,783,922, claims adjustment expenses of \$5,896,430 and general administrative expenses of \$13,370,853. The total, \$19,267,283, represents 88% of net premium. This ratio is higher than the

expense levels assumed in the pricing because HealthyCT is still in a start-up mode and is growing membership. Many of its expenses are fixed costs that, once spread over a larger and more stable membership basis, will produce actual expense ratios that are consistent with the pricing expense assumptions.

HealthyCT's adjusted 2016 operating budget was the foundation for establishing the 2016 administrative expense load. Working with HealthyCT's CFO, we assessed the expenses that are expected to be incurred during 2016 and allocated them among administrative expenses, quality improvement expenses and taxes and fees. We then converted the expenses into PMPM costs and percent of premium costs. Assuming membership targets across all markets are met in 2016, 100% of expenses will be covered in 2016.

11. HealthyCT's 2014 statutory annual statement shows total capital and surplus of \$58.2 million and authorized control level RBC of \$2.062 million, which produces an RBC ratio of 2,823%; this ratio is so high because HealthyCT had modest membership in 2014 but has received all of its federal solvency loan funds. Having been established as a CO-OP under the ACA, HealthyCT has been approved for federal solvency loans totaling \$107.0 million. Funds can be drawn against this amount to enable HealthyCT to satisfy the regulatory capital requirements of the state of Connecticut. During the initial years of operation, HealthyCT will need to build its capital levels to a point where it can ultimately become self-sufficient and end reliance on federal support. Through December 31, 2014, HealthyCT has drawn down all \$107.0 million of the solvency loan.

12. Under federal rules, the Medical Loss Ratio (MLR) is defined as:

MLR =

$$\frac{\text{Claims} + \text{Quality Improvement} \pm (\text{Transitional Reins.}, \text{Risk adj.}, \text{Risk corridors})}{\text{Premiums} - (\text{Premium taxes and Regulatory fees})}$$

A credibility adjustment may also be made depending on the size of the insured population. For individual and small group policies (tested separately), the MLR must be at least 80%.

The projected 2016 MLR, under the federal definition above is 90.17% (before applying a credibility adjustment), which is greater than the required minimum. This is calculated as:

$$90.17\% = \frac{\$335.69 \text{ Claims} + \$8.76 \text{ OI} - \$15.40 \text{ Trans. Reinsurance Receipts}}{\$381.83 \text{ Premiums} - (\$16.91 \text{ Premium Taxes and Regulatory Fees})}$$

13. Under federal rules implementing the ACA (published in the Federal Register February 27, 2013, Vol. 78, No. 39, pp. 13406-13442), insurance issuers in the

individual market must follow a prescribed set of guidelines in setting premiums. The basic approach is to develop a “market-wide index rate,” which is applicable to all plans the issuer sells in the individual market. To that index rate, multiplicative adjustment factors are applied to calculate an individual member’s premium. Those adjustment factors are:

- Plan selection factor (due to actuarial value and cost sharing design, provider network, delivery system, and utilization management practices, benefits in addition to EHBs, administrative costs, and characteristics of catastrophic plans)
- Age factor
- Geographic area factor
- Tobacco use factor

For the products in this rate filing, no tobacco use factor has been applied.

14. Although HealthyCT’s 2014 individual claim experience may be considered credible based on CMS standards for Medicare Advantage, we determined that no credibility should be placed on that experience for purposes of setting the 2016 rates. We identified the following specific factors among those that would suggest that 2014 experience should be assigned limited credibility:

- Partial year experience by many of the members, resulting from membership ramping up during 2014
- Pent up demand in the 2014 experience that will wane and is expected to disappear by 2016
- Systems not being fully implemented by early in the year, resulting in some delays in claim payments, focus shifted from care management and coordination toward getting claims paid, and other start-up "bugs" that make 2014 an atypical year
- Significant shift in the composition of membership between 2014 and 2016 due to significant membership growth since 2014, including a different mix of members by metal level, demographic composition, etc.
- COB issues with respect to members that appear to be Medicare eligible. HealthyCT is just now evaluating the COB recoveries it may receive from these members, the result of which would be a reduction in the cost of claims for 2014. At this time, we do not know the order of magnitude of the possible reduction.

Based on these factors, we assigned no credibility to the 2014 experience.

15. Because no credibility was assigned to the actual claim experience for these products the Milliman *Health Cost Guidelines*TM (HCG) cost and utilization information was used in the development of these rates. Considerations for premium rate development include:

- Benefit plan designs for existing 2015 products modified for 2016 as well as new products being offered in 2016, including the standard plans

required to be offered on Access Health CT by all carriers who participate on the Exchange;

- Anticipated medical trend, both utilization and cost of services;
- Anticipated morbidity levels relative to the HCGs that are expected in the small group single risk pool in 2016;
- Applicable taxes and fees, including those that are applicable in 2016 under the ACA; and
- Anticipated contributions to and benefit payments from the Federal Transitional Reinsurance Program.

16. The HCGs have been developed as a result of Milliman's continuing research into commercial health care costs. First developed in 1954, the HCGs have been updated and expanded annually since that time. The HCGs are continually monitored as we use them in measuring the experience or evaluating the rates of our clients, and as we compare them to other data sources. The detailed claims and enrollment data underlying the guidelines represent over 54 million commercially insured lives.
17. All adjustments and assumptions used in the HCGs stem from national claims and enrollment data by age, gender, and type of benefit. The primary use for these HCGs is to determine relative differences in expected claim costs between product types, benefit plans, medical management initiatives, negotiated provider reimbursement arrangements, age, gender, and area of the country. In particular, we adjusted these estimates to be on a Connecticut-specific unit cost and utilization basis.
18. Claim costs for proposed plans were developed using the HCGs, establishing a relative cost of the benefits for each plan being offered on and off the Exchange in 2016. Following the steps described below, we developed the market-wide index rate and the plan-level adjustments that were used to produce the 2016 HealthyCT individual insurance rates.

Step 1: Start with 2015 individual index rate.

The starting point for the 2016 pricing was the 2015 allowed claims pmpm for all plans that will be offered in 2016. We developed a weighted average 2015 index rate using the expected distribution of enrollment by plan for 2016 applied to the allowed claim cost pmpm for each plan.

Step 2: Project HealthyCT enrollment by market, exchange status and product
HealthyCT's expected 2016 individual enrollment on and off the exchange by product was developed based on a combination of elements. The basis for the total enrollment was HealthyCT's enrollment to date in 2015, with projected growth to 2016. HealthyCT's penetration rate in the market was determined based on market research by its marketing team, conversations with brokers and informed judgment. We relied on the 2016 distribution of membership by plan as developed by HealthyCT.

Step 3: Claim cost projection (relative cost of claims by benefit plan)

The basis used to develop the plan relativity for the 2016 products is the 2014 HCGs. All adjustments and assumptions used in the HCGs stem from national claims and enrollment data by age, gender, and type of benefit. The primary use for these HCGs is to determine relative differences in expected claim costs among product types, benefit plans, medical management initiatives, negotiated provider reimbursement arrangements, age, gender, and area of the country. In particular, we adjusted these estimates to be on a Connecticut-specific unit cost and utilization basis. The claim cost relativities by plan assumed the same morbidity of the single risk pool for all plans, adjusted only for cost sharing differences and differences in utilization resulting from cost sharing differences.

Step 4: Adjustment for changes in morbidity

The 2014 Index Rate for the individual single risk pool assumed that the morbidity would be 8.6% higher than that underlying the Health Cost Guidelines, which was the foundation for the starting cost in the 2014 pricing. The 2015 individual rates included a reduction of 4.5% to remove part of this morbidity load. For the 2016 rates, we adjusted the morbidity downward to remove the remaining pent up demand that was originally included in the 2014 rates and that was not removed in the 2015 rates. In addition, the morbidity was further reduced by 6.0% to reflect several specific initiatives that HealthyCT is implementing and that will be fully operational by 2016. These initiatives described by HealthyCT include the following:

- Aggressive fraud, waste and abuse programs, using an outside vendor that indicated savings of 2-3% of claims.
- Implementation of a telemedicine program, which should reduce inappropriate use of emergency room and urgent care visits, and which may replace some routine office visits. One study shows net savings of \$4.25 pmpm; another study done by an independent vendor for a large employer that had implemented such a program showed even greater savings.
- An E-consult program for select specialties is expected to reduce the time between a primary care visit and specialty visit, reduce the number of additional tests, and improve coordination and communication between the PCP and specialists, along with greater member engagement.
- Radiology management, especially of complex testing is anticipated to produce savings in two areas. One is identification of inappropriate imaging that will be reduce the number of tests. Another is working with a vendor that creates steerage to lower cost providers of imaging services.
- ACO and PCMH contracting is ramping up and is expected to be fully operational in 2016. Cost improvement estimates are based on HealthyCT's estimates based on other programs operating in Connecticut, along with input from Milliman related to ACO/PCHM programs around the country.

- Select contracting with some out of area facilities is expected to reduce the cost of out of network claims. HealthyCT has found several providers just outside of Connecticut's borders that treat several HealthyCT members. HealthyCT is entering into direct contracting relationships with these facilities and providers to obtain more favorable reimbursement arrangements that exist under the current out of area fee arrangements.
- HealthyCT is implementing a specialty drug nurse program to monitor and manage compliance and interactions with complex, expensive specialty drugs. HealthyCT will initially approve only a limited number of doses of these expensive drugs, closely monitoring patient compliance and any adverse reactions to the drugs. By doing so, HealthyCT will reduce the number of expensive doses of these medicines that are wasted when full 30 day fills are initially prescribed.
- HealthyCT is also implementing a customized formulary with its PBM vendor. Included will be more aggressive pre-authorization for certain medicines.

The expected morbidity for the catastrophic plan was adjusted from 100% of the overall individual market average morbidity to 80%. This adjustment reflects the different shape of the claim cost curve for younger persons compared to the total individual market, along with anecdotal information about actual catastrophic plan experience from a plan in another market along with Connecticut marketplace relativities.

Step 5: Changes in benefits

HealthyCT is making benefit plan changes effective 2016 based on business decisions and on new Actuarial Value Calculator testing. The following are a list of the benefit changes:

1. Adjustments to reflect the 2016 deductible and out of pocket limits for certain plans
2. Adjustments to continue to meet metal level requirements using the new Actuarial Value calculator
3. Addition of a routine adult vision benefit to all plans.

The effect of these benefit changes is negligible when measured as a percent of the 2016 average rate. However, on a plan by plan basis, the premium rate adjustment varies more significantly for some plans.

Step 6: Changes in demographics

The demographics assumed for 2016 differ from the demographics used in the 2015 pricing; they reflect HealthyCT's actual 2015 distribution of business as the foundation. The assumed population is younger than that used in the 2015 pricing.

Step 7: Estimate impact of transitional reinsurance

In CY2016, we assumed that individual membership sold through and outside the Marketplace will be assessed \$2.25 PMPM in reinsurance contributions.

Reinsurance recoveries were estimated at the plan level. The Milliman Health Cost Guidelines, combined with the projected allowed charges by plan, were used to estimate a claims probability distribution for an average marketplace risk population for each plan. The out-of-pocket maximum was added to the attachment point to estimate the carrier's paid claims obligation in excess of \$90,000, consistent with the methodology discussed in the 2016 Benefit and Payment Parameters. Similarly, the out-of-pocket maximum was added to the reinsurance cap to estimate the carrier's paid claims obligations in excess of \$250,000. A coinsurance rate of 50% was applied to the difference to estimate the expected annual reinsurance recovery. This amount was divided by 12 to obtain an expected monthly reinsurance recovery of \$15.40 PMPM.

We computed the transitional reinsurance recoveries using a claims probability distribution that is representative of the assumed 2016 morbidity level of the individual risk pool in Connecticut.

Step 8: Calculate 2016 index rate and plan-specific adjustments

After estimating claim costs for all products (steps 1-6) and expected cost under the transitional reinsurance program (step 7), we applied the retention loads discussed in Section G of this memorandum. This results in an aggregate PMPM required premium. We then project the average of all allowable rating factors (age and plan type). The ratio of required premium to average allowable rating factor is the index rate, as shown in Table 3.

Table 3 – Development of required premium

A. Expected claims	\$335.69
B. Transitional reinsurance expense, net of recoveries	-\$13.15
C. Other administrative expenses	\$57.37
D. Provision for profit and contingencies	\$1.91
E. Total required premium (A+B+C+D)	\$381.83
F. Average of allowable rating factors (age, plan type)	1.395
G. Index rate (E/F)	\$273.78

The administrative expenses and provision for profit and contingencies shown in Table 3 (\$57.37 and \$1.91) are the result of applying the retention percentages shown in Section G above.

The average allowable rating factor (1.395) shown in Table 3 is the result of the following formula:

The sum of (age factor for person i X plan type factor for person i)

Total Projected Enrollment

The age factors are shown in Addendum A, and are the ones required by the federal regulations. The plan factors are shown below in Table 4. These plan factors are entirely due to relative differences in actuarial value and cost sharing structure for each plan. There are no differences between the plans attributable to the factors listed in 45 CFR §156.80(d)(2)(ii-iv).

The impact of each plan's actuarial value and cost sharing includes the expected impact of each plan's cost-sharing amounts on the member's utilization of services, excluding expected differences in the morbidity of the members assumed to select the plan. We used the HCGs to estimate the value of cost sharing and relative utilization of services for each plan. Our pricing models assume the same demographic and risk characteristics for each plan priced, thereby excluding expected differences in the morbidity of members assumed to select the plan. (Under the single risk pool requirements of 45 CFR §156.80, differences in health status may not be used to make plan-level adjustments to the market-wide index rate.)

In summary, the following rating factors are used to adjust the market-wide index rate of \$273.78:

Table 4 – Rating factors

<u>Plan</u>	
Gold Preferred Standard PPO	1.174
Silver Enhanced Standard PPO	1.055
Bronze Basic Standard PPO	0.717
Gold Preferred PPO 1	1.131
Silver Enhanced PPO 2	0.933
Bronze Basic HSA 1	0.699
Silver Enhanced PPO 1	0.892
Basic Catastrophic PPO	0.539
Gold Preferred PPO 2	1.047
Silver Enhanced PPO 3	0.868
Silver Enhanced PPO 4	0.890
Silver Enhanced PPO 5	0.878
Silver Enhanced PPO 6	0.826
Silver Enhanced HSA 1	0.862
Silver Enhanced HSA 2	0.851
Silver Enhanced HSA 4	0.860
Bronze Basic HSA 3	0.707
Bronze Basic Standard HSA	0.719
CO-Options, Preferred Gold PPO,Multi-State Plan	1.101
CO-Options, Preferred Gold+ PPO,Multi-State Plan	1.105
CO-Options, Enhanced Silver PPO 1,Multi-State Plan	1.101
CO-Options, Enhanced Silver +PPO 1,Multi-State Plan	1.105

Gold Preferred HSA 1	0.981
Silver Enhanced HSA 6	0.851
Silver Enhanced HSA 7	0.842
Tobacco Rating Factor	1.0000
<u>Geographic Area</u>	<u>Value</u>
Fairfield County	1.077
Hartford County	0.941
Litchfield County	0.911
Middlesex County	1.021
New Haven County	1.001
New London County	1.041
Tolland County	0.926
Windham County	0.951
Standard Federal Age Factors	

19. The Department received four public comments, summarized below:

- Wakely Consulting Group
Comments regarding HealthyCT 2016 Individual Filing June 5, 2015

Background

Access Health CT (AHCT) retained Wakely Consulting Group, Inc. (Wakely) to perform an independent review of the initial 2016 rate filings for carriers expected to participate on the Exchange in 2016. The following comments are being submitted by Wakely on behalf of AHCT.

The comments below reflect Wakely's review of the initial rate filings and may not apply to subsequent re-filings of rates. In order to meet the timeline for public comments, Wakely did not have sufficient time to contact each carrier to discuss comments and questions regarding the filings. Wakely's assessment of the filing could change if additional clarifications are provided by the carrier. It is also important to note that two qualified actuaries following applicable Actuarial Standards of Practice, each using reasonable methods and assumptions, can reach different but reasonable results.

Comments on HealthyCT Individual Rate Filing

Following are the comments and observations resulting from Wakely's review.

Rate Change Summary

HealthyCT (HCT) is proposing an aggregate rate increase of 13.99%, though there are large variances in rate increases at the plan level, ranging from 0.7% to 22.3%. HCT reported 23,491 member months in 2014 and is projecting 281,814 member months in 2016.

Overall Assessment of Filing

In general, HCT's filing was well organized, easy to follow, and contained appropriate justification. However, Wakely did notice that nearly all of the assumptions employed had the effect of keeping rates low. In particular –

- 90% credibility was applied to a manual rate which was substantially lower than the experience rate
- Trend assumptions were at the low end of reasonable ranges
- Levels of target profit were reduced from 2015
- Administrative expense assumptions are very low

HCT mentions in the memorandum that they need to meet enrollment goals to cover administrative expenses in 2016. It will be important to monitor both HCT's 2014 claim expenses and 2015 emerging enrollment. Now that several more months of runout have materialized on HCT's 2014 experience, it would be advisable to see whether claims came in better or worse than what was estimated in mid-February. It will also be important to assess HCT's risk adjustment results upon release.

Additional follow-ups and conclusions can be found at the end of this document.

Key Components of the Filing

Rate Change: HCT is proposing an aggregate rate increase of 13.99%. As illustrated in the actuarial memorandum, the drivers of the rate increase are –

- o Medical trend valued at 5.2%
- o Changes in federal reinsurance parameters valued at 7.7%
- o Demographic adjustments valued at 4.7%

Base Rate (Manual): The memorandum indicates that Milliman's 2014 Health Cost Guidelines (HCGs) were used as the basis for 2016 pricing. The memorandum also indicates that the 2015 index rate was the starting point to estimate 2016 claim costs. This leads us to believe that the base period data was not updated and instead, adjustments were applied to the 2015 index rate to calculate the 2016 index rate.

- o Morbidity – The memorandum indicates that the 8.6% morbidity that had been included in the 2014 pricing to reflect pent-up demand (reduction of 4.5% for 2015) was completely removed for 2016 pricing.

- o Demographics – In Part II of the memorandum, where a written justification of the rate increase is provided, 4.7% of the rate increase is attributable to recovery of the shortfall in revenue due to prescribed age rating restrictions.

Base Rate (Experience): In 2014, HCT reported insuring 23,491 member months with an allowed PMPM of \$767.35. Referring to the 2016 URRT, the following adjustments were made to bring costs into the projected period –

- o Morbidity – The URRT contains a morbidity adjustment factor of .80. It's not clear by reading the actuarial memorandum how this adjustment is developed. In a prior year memorandum, pent-up-demand in 2014 was estimated at 8.6% of 2014 claim costs. The current memorandum discusses removing that assumption but it is unclear how the .80 is developed.
- o Other – The URRT contains an “other” adjustment factor of 1.05 for most service categories (except “Other Medical”, which is at 1.101). Exhibit 5 in the memorandum discusses changes between 2014 and 2016 caused by demographics and other adjustments due to 2014 being HealthyCT's first year of operations but doesn't discuss their valuation and how they relate to what is in the URRT.
- o Trend – The change in premium rates from 2015 to 2016 due to trend is 5.2%. The annual trend rates are based on Milliman's HCGs and are then adjusted to reflect projected changes to provider contracting terms and changes to care management and other programs. In our opinion, the 5.2% trend rate is on the low end of reasonable. In particular, the facility unit cost trends of 3.4% are on the ambitious end of what we feel is realistically attainable based on other carrier experience.

Credibility: With 23,941 member months, 10% credibility has been assigned to the experience and 90% to the manual. Typically, a much higher level of credibility would be assigned to a block of business with this many member months. As is indicated in the actuarial memorandum, the CMS threshold for full credibility is 24,000 member months. The reviewer notes that the CMS threshold applies to Medicare and may not be appropriate for ACA business. However, HCT does not supply a formula utilized for the development of their credibility assumptions but does offer reasons why a low level of credibility was utilized, including partial year experience for many members, claim payment system issues, pent-up demand, and a change in enrollment mix.

Federal Reinsurance: The federal transitional reinsurance assumption for the individual market was estimated assuming that HCT will recover 50% of incurred claims between \$90,000 and \$250,000 per member. In 2015, the coinsurance amount was assumed to be 70% with a \$45,000 attachment point. Rate development also incorporated the reduced assessment from \$3.67 to \$2.25 PMPM. We find the 7.7% increase as a result of changes in reinsurance assumptions to be reasonable.

Risk Adjustment: HCT is not reporting a risk adjustment receivable or payable in 2014 nor are they projecting any in 2016. They note that there is inadequate information to assess whether a risk adjustment payable or receivable would apply to 2014 due to incomplete risk scores for HCT and no formal marketplace information. On Exhibit 9 of the memorandum, it is noted that the overall impact of the projected net risk adjustment transfers is a premium increase of \$0.15 PMPM. This doesn't seem to take into account the \$0.08 PMPM fee in 2015. The change in risk adjustment is not mentioned in table 2.3 where anticipated non-benefit expense changes are displayed.

Administrative Expense: The administrative expenses assumed in the rate development remain low and are estimated to be 9.0% of premium in 2016. In 2014, HCT reports having administrative expense of 88% of total net premium for its individual, small group, and large group blocks of businesses combined. HCT anticipates that membership growth in its individual, small group, and large group markets due to competitively priced plans will provide the scale required to support the low administrative costs. HCT also reports that if its membership targets for all lines of business are met, it will be able to cover its 2016 administrative expenses. HCT does report a large increase in enrollment in 2015 but it isn't clear if the increase is enough to bring down average expenses or how many of the expenses are fixed versus variable.

Profit / Margin: Profit assumptions are reduced from 1.0% to 0.5%. HCT justifies doing so due to strong RBC and to maintain competitive rates.

Changes to the Paid to Allowed Factor: On Worksheet 1 of the URRT, HCT reports a paid to allowed factor of .797, while in the 2015 filing the paid to allowed factor was .702. Contributing to this change is a much higher proportion of plans at the Silver and Gold level in 2016 than had been projected for 2015.

Changes in Plan Level Factors: While the rate change is reported to 13.99%, the variations in premium rate changes across plans varied significantly from 0.7% to 22.3%. For example, the Catastrophic plan has a 22.3% increase while the two CO-Options Enhanced Silver PPO plans only has a 0.7% increase.

Age Calibration: The age calibration factor changed from 1.361 (average age of 43) in 2015 to 1.772 (average age of 50) in 2016.

Geographic Calibration: HCT notes that the relativities between its geographic factors are unchanged from 2015. While this appears to be the case, the values of the factors have changed. The geographic calibration factor is 1.0. Wakely does not have enough information to verify the reasonableness of the geographic adjustment.

Conclusions

Wakely recommends that the following issues be addressed:

- Based on heavy reliance on a manual rate, aggressive assumptions, and the need to achieve enrollment goals to cover expenses, Wakely recommends HCT do sensitivity testing on various claim and enrollment scenarios and the impact on RBC of those scenarios.
- As was the case last year, we are unable to determine if the manual rate is developed by refreshing base period data or if assumptions that went into the development of the 2015 rates were adjusted to reflect 2016 projections. Standard actuarial practice is to update the base data at least annually when revising analyses. Given 90% credibility is being applied to the manual rate to a sizable block of business, more transparency into the development of the manual rate is warranted. A step-by-step development from the base data to the index rate, in which each adjustment is quantified and explained, should be provided.
- There are inconsistencies between the adjustment values contained in Worksheet 1 of URRT to adjust the experience data into the projection period and what is outlined in the memorandum. The adjustments in the URRT should be bridged to the verbiage in the memorandum.
- A value of 4.7% of the rate increase is attributable to the difference between the true cost of care by age and gender and what the prescribed rating curve allows. HCT should provide additional support for this adjustment.
- HCT should clarify how the rate change was affected by the change in risk adjustment fee. HCT should also report risk adjustment results for 2014 when they are released and confirm that they believe 2016 rates will be adequate given this additional information.
- More justification should be furnished as to how the credibility value of 10% was derived. It is our opinion that instead of deviating from the generally accepted practice of using a credibility formula, the items that caused HCT not to use much of its 2014 base experience could have instead been quantified and adjusted to the projection period.
- As was previously mentioned, HCT's administrative expenses seem very low, particularly for a new company, even if initial expenses are spread over three years. In order to validate the reasonability of the general admin assumption, further support of the assumption, including estimates of claims administration, marketing, employee costs, and other administrative expenses, and projected membership for all lines of business would need to be requested, as these items were not provided by HCT. Without this additional information, the reasonability of the general administrative expenses incorporated in the 2016 rate development could not be verified.
- There is sizable variation in the 2015 to 2016 premium rate changes at the plan level. More detail should be provided to explain rate changes for plans with rate changes to deviate from the average, including the impact of any plan design changes.

- HCT should indicate if they used the federal assumptions for induced demand. If not, they should provide these assumptions.

All comments may not apply to subsequent re-filings of the rates. Wakely appreciates the opportunity to provide public comment to CID regarding the rate filings.

- No rate increase that is that BIG, are they mismanaged?

Department Summary

Since 2014 is the first year that HealthyCT is writing health insurance business in the individual market in Connecticut, there is not credible actual experience to develop a number of pricing assumptions necessary to generate 2016 premium rates. The reliance on Milliman Inc. actuarial models is an acceptable approach, as much of the data supporting the models is from health insurance experience across the country with adjustments made for Connecticut specific cost and utilization.

This filing reflects rates that incorporate all the new rating requirements of PPACA 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 5.22% annual trend assumption used in the rate filing and believes that based upon the information provided by HealthyCT and the average trend the rest of the Connecticut market is experiencing, relying on Connecticut specific experience this assumption is inadequate and should be increased to 7.5%.

HealthyCT is introducing morbidity saving programs for 2016 that have been projected to reduce morbidity by 6%, based on the information and descriptions provided, the Department is reducing that morbidity savings from 6% to 4%.

The Department reviewed the June 30, 2015 CCIIO Reinsurance and Risk Adjustment report for Connecticut. Based on this report HealthyCT is required to make a risk adjustment payment of \$569,431.67 for the individual market. The Department believes HealthyCT's significant growth in 2015 creates enough uncertainty that only the net risk adjustment of -\$0.15 pmpm, representing the cost of the program, is appropriate for 2016.

Based upon the federal MLR for this filing of 90.17% the Department believes that the proposed pricing supports the federally required 80% loss ratio for individual 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.

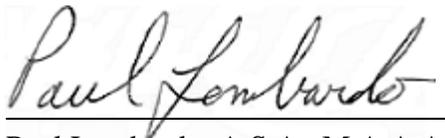
Since the assumptions for the attachment point and coinsurance level have changed from 2015 to 2016, this resulted in an increase to premiums.

Department Disposition

Based upon the finding of fact, and the summary information described above, the proposed revised average rate increase of 3.43%, with a range from -13.6% to 10.3% is found to be inadequate and is disapproved as submitted. The approved average increase is 7.2% with a range from -10.5% to 14.3%.

The approved rates, described above, are reasonable in relationship to the benefits being offered, they are also, neither excessive, inadequate nor unfairly discriminatory.

Dated August 27, 2015.

A handwritten signature in cursive script that reads "Paul Lombardo". The signature is written in black ink on a white background.

Paul Lombardo, A.S.A., M.A.A.A.
Insurance Actuary