STATE OF CONNECTICUT

INSURANCE DEPARTMENT

UnitedHealthcare Insurance Company 2016 Individual Exchange Rate Filing

Finding of Facts

1. This filing is for rates intended to be used for individual health benefit plans sold on the health insurance exchange in Connecticut for the 2016 plan year.

2. The average proposed rate increase is 11.4%, with a range of 6.2% to 20.9%.

3. UHC refined the medical plan price relativities to reflect the most recent pricing methodology and pricing models. The methodology is based on UnitedHealthcare nationwide experience data, which contains utilization frequencies and unit costs by service category, in addition to claim distributions and adjustment factors for a large number of plan design variables. Benefit design parameters such as deductibles, coinsurance, copays, out-of-pocket maximums, etc. were input for each plan. The expected paid-to-allowed relativities and expected utilization differences due to differences in cost sharing for each plan are then used to develop the plan factors for each benefit plan. All benefit plans are priced consistently with each other, with the rates differing only by the estimated value of the benefits and the expected utilization differences due to differences in cost sharing. The utilization differences do not reflect differences due to health status.

4. No individual experience exists under UnitedHealthcare Insurance Company in the state of Connecticut for the experience period is January 1, 2014 to December 31, 2014.

5. As UnitedHealthcare Insurance Company does not have credible experience for individual medical guarantee issue products, they relied on the guarantee issue claims experience and rate development of their affiliated small group carriers to develop their previously approved individual rates for the 2015 plan year. The 2016 individual rates are subsequently developed from those previous approved individual projections for the 2015 plan year.

6. We have included a total annual trend assumption of 6.9% applicable from the 2015 to the 2016 plan year. The total trend assumption has been broken out into 3.8% for cost and 3.0% for utilization (1.038*1.03=1.069%, approximately). The total annual trend assumption is based on an affiliated small group carrier's annual trend assumptions.

7. Because the data we are using for the credibility rate manual are for small group business, we need to adjust for the estimated morbidity differential between the individual and small group markets. UnitedHealthcare has participated in a multi-

state study done by a large actuarial consulting firm to help estimate the average expected morbidity in the individual market relative to the average expected morbidity for the small group market. Our analysis of the information provided indicates that in states that did not allow transitional relief, we would anticipate that the average morbidity in the individual market in 2016 will be about 1% higher than the average morbidity in the small group market. This results in a 3.8% reduction in morbidity from 2015 to 2016.

8. An adjustment was made to account for a narrower network applicable to our individual plans.

9. Adjustments were made to reflect the benefit variations between the 2015 individual portfolio and our proposed 2016 individual product.

10. We anticipate our individual exchange business to have both a different age/gender composition and a different geographic composition compared to that of the affiliated small group business. Therefore, an adjustment was made to account for these differences.

11. In order to comply with the states requirement for the standard silver plan to be the lowest priced silver plan we took a weighted average of the standard silver plan and not standard silver plan to determine the plan factors for the Silver plans.

12. We believe that the affiliated small group experience used for developing the manual rates for this product to be fully credible. A specific credibility formula was not used for this determination, but rather professional actuarial judgment. As ASOP 25, section 3.4 states: “Professional Judgment - The actuary should use professional judgment when selecting, developing, or using a credibility procedure. The use of credibility procedures is not always a precise mathematical process.”

13. The paid-to-allowed ratios were developed using the proprietary UnitedHealthcare pricing model. This model uses UnitedHealthcare nationwide experience data which is fully credible. Claim data is projected to the pricing period based on national projections of utilization and unit costs. These projections are done at the service category level (inpatient, outpatient, etc.). Benefit design parameters such as deductibles, copays, and coinsurance rates are applied to the claim distributions of the matching service category. Cost-sharing is applied, and the values of each service category are summed to determine an overall benefit value, or paid-to-allowed ratio. In order to preserve consistency, the same claim experience and projection assumptions are applied to all plan relativity calculations.

14. We are offering a variety of plans at different metal levels and using a provider network that we anticipate to be similar in size to our competitors. In 2016 we anticipate the business we will write will be at the market level risk, therefore, we

are assuming zero risk adjustment transfers in our 2016 rate development. HHS Notice of Benefit and Payment Parameters for 2016 specifies a risk adjustment user fee of $1.75 per member per year, or approximately $0.15 PMPM.

15. Reinsurance recoveries are expected to be about 6.2% of incurred claims, as calculated below. The total incurred claims were calculated using an affiliated carrier's individual market nationwide experience for 2013 trended to the 2016 benefit period. Reinsurance recoveries were then calculated using the 2016 reinsurance parameters, as published in the HHS Notice of Benefit and Payment Parameters for 2016. The reinsurance parameters include a $90,000 attachment point, 50% coinsurance, and a $250,000 reinsurance cap.

16. The projected reinsurance recoveries net of reinsurance premium are therefore $27.52 PMPM.

17. The 8.81% administrative expense load includes commissions, quality improvements, and SG&A.

    - Commissions: We anticipate an average commission rate of approximately 2.20% for 2016.

    - Quality Improvements: We included 0.20% for quality improvements based on an affiliated carrier's individual market data.

    - SG&A: Our general and administrative expense assumption is based on PMPM estimates provided by UnitedHealthcare's finance department for the 2016 calendar year. For this product in the state of Connecticut, this amount equates to approximately 6.41% of premium for 2016.

18. Our projected profit margin for the 2016 rating period is approximately 2.03% of premium.

Premium	$557.07	100.00%
Claims	-$482.02	-86.53%
Premium Tax	-$9.75	-1.75%
Reinsurance Fees	-$2.25	-0.40%
Reinsurance Recoveries	$29.77	5.34%
Risk Adjustment User Fees	-$0.15	-0.03%
Risk Adjustment Transfers	$0.00	0.00%
Net Insurer Fees	-$10.95	-1.97%
Exchange Fee	-$9.19	-1.65%
PCORI Fee	-$0.17	-0.03%
Commissions	-$12.26	-2.20%
SG&A	-$35.72	-6.16%
Quality Improvements	-$1.11	-0.20%
Pre-Tax Income	$23.27	4.18%

Income Tax	-$11.98	-2.15%
After-Tax Income	**$11.30**	**2.03%**

19. Taxes and fees are expected to be 7.55% and include premium tax, insurer fees, exchange fees, PCORI fees, and federal income tax.

    - Premium Tax: The premium tax rate is 1.75% for the state of Connecticut.

    - Exchange Fees: Exchange fees for the Connecticut state partnership exchange are 1.65%. We anticipate nearly our entire premium to come from exchange enrollees.

    - Insurer Fees: Each insurance carrier's assessment of insurer fees will be based on earned health insurance premium in the prior year, with certain exclusions. UnitedHealthcare (parent company of UnitedHealthcare Insurance Company) estimates that 1.965% of its 2016 premium will be allocated for insurer fees.

    - PCORI Fees: This product will be offered for the 2016 plan year, with a PCORI fee of $2.08 per member per year, or approximately $0.17 PMPM. For this product in the state of Connecticut, this equates to approximately 0.03% of premium.

    - Federal Income Tax: Federal income tax is projected to be 2.15% of premium and is calculated as 35% * (Pre-Tax Income + Insurer Fees), since insurer fees are not tax deductible.

20. The projected loss ratio using the federally prescribed MLR methodology for calendar year 2016 is 88.52%.

Claims	$482.02	86.53%
Reinsurance Recoveries	-$29.77	-5.34%
Risk Adjustment Transfers	$0.00	0.00%
Quality Improvement	$1.11	0.20%
Total MLR Claims	**$453.36**	**81.38%**
Premium	$557.07	100.00%
Net Insurer Fee	-$10.95	-1.97%
Premium Tax	-$9.75	-1.75%
Reinsurance Fees	-$2.25	-0.40%
Risk Adjustment User Fee	-$0.15	-0.03%
Exchange Fee	-$9.19	-1.65%
PCORI Fee	-$0.17	-0.03%
Income Tax	-$11.98	-2.15%
Total MLR Premium	**$512.64**	**92.02%**
Federal Medical Loss Ratio	**88.44%**	

21. Historical Experience – Oxford Health Insurance, Inc.

Calendar Year	Earned Premium	Incurred Claims	Loss Ratio	Members
2006	40,016,330	32,846,755	82.08%	11,311
2007	59,299,782	50,015,524	84.34%	16,874
2008	90,872,234	80,416,662	88.49%	24,930
2009	132,123,613	108,668,640	82.25%	34,497
2010	170,269,654	131,630,094	77.31%	39,153
2011	226,971,715	178,743,814	78.75%	46,907
2012	185,911,049	138,818,744	74.67%	34,313
2013	158,444,308	123,826,251	78.15%	27,483
2014	157,203,219	118,768,427	75.55%	25,015
Total	1,221,111,903	963,734,911	78.92%	

22. Historical Experience – Oxford Health Plans (CT).

Calendar Year	Earned Premium	Incurred Claims	Loss Ratio	Members
2006	172,668,631	133,537,070	77.34%	41,226
2007	140,808,596	106,500,513	75.63%	30,379
2008	117,134,291	88,005,717	75.13%	23,169
2009	93,813,871	79,041,509	84.25%	17,748
2010	85,940,456	69,936,868	81.38%	14,803
2011	148,278,725	115,912,983	78.17%	26,229
2012	131,911,570	102,653,481	77.82%	21,830
2013	100,195,516	75,422,304	75.28%	14,990
2014	41,409,794	35,233,006	85.06%	6,149
Total	1,032,161,451	806,233,452	78.11%	

23. Allowed Unit Cost and Unit Cost Trend

Service	CY 2012	CY 2013	CY 2014	2013/ 2012	2014/ 2013
Inpatient	$3,322	$3,421	$3,617	3.0%	5.7%
Outpatient	$216	$203	$218	-5.7%	7.2%
Ancillary/Other	$91	$118	$124	28.9%	5.7%
Professional	$97	$103	$104	6.2%	0.9%
Retail Pharmacy	$98	$104	$110	6.1%	5.4%
Total	$139	$146	$153	5.0%	4.1%

24. Utilization/1,000 and Utilization Trend

Service	CY 2012	CY 2013	CY 2014	2013/ 2012	2014/ 2013
Inpatient	290.4	287.1	295.2	-1.1%	2.8%
Outpatient	5,550.4	6,203.0	6,172.3	11.8%	-0.5%
Ancillary/Other	4,302.6	3,609.2	4,423.9	-16.1%	22.6%
Professional	16,977.4	17,284.1	17,886.6	1.8%	3.5%
Retail Pharmacy	10,014.9	10,261.7	10,062.7	2.5%	-1.9%
Total	37,135.7	37,645.1	38,840.7	1.4%	3.2%

25. Allowed PMPM and Allowed PMPM Trend

Service	CY 2012	CY 2013	CY 2014	2013/ 2012	2014/ 2013
Inpatient	$80.39	$81.85	$88.98	1.8%	8.7%
Outpatient	$99.69	$105.11	$112.14	5.4%	6.7%
Ancillary/Other	$32.70	$35.36	$45.81	8.1%	29.6%
Professional	$137.02	$148.17	$154.75	8.1%	4.4%
Retail Pharmacy	$81.86	$88.96	$91.92	8.7%	3.3%
Total	$431.66	$459.45	$493.60	6.4%	7.4%

26. Net PMPM and Net PMPM Trend

Service	CY 2012	CY 2013	CY 2014	2013/ 2012	2014/ 2013
Inpatient	$73.54	$74.75	$81.66	1.6%	9.2%
Outpatient	$80.97	$86.10	$91.08	6.3%	5.8%
Ancillary/Other	$30.60	$33.03	$42.92	7.9%	30.0%
Professional	$106.39	$114.05	$119.53	7.2%	4.8%
Retail Pharmacy	$61.02	$67.74	$71.02	11.0%	4.8%
Total	$352.52	$375.66	$406.20	6.6%	8.1%

27. Implied benefit leverage is 0.9% for medical and 1.7% for pharmacy.

28. The impact of new medical trend technology is not isolated in the baseline pricing trend development or, apart from mandated benefit changes noted elsewhere, presumed to have an explicit increasing/decreasing impact in rate projection period trends.

29. Estimated impact of benefit buy-downs is -1.0% for medical and -0.3% for pharmacy.

30. Trend used for pricing is 6.9%.

31. No impact of mandates and federal health reform on projected claims expense in 2016.

32. The capital and surplus as of 12/31/14 for United HealthCare Insurance Company was not provided.

33. The Department received nine public comments, a summary of those comments are below:

    - The rates doubled last year 2015 and these insurance companies should not be able to rip off and move rates up another 18% in 2016 as health insurance is becoming impossible to afford.

    - Wakely Consulting Group
      Comments regarding UnitedHealthcare Insurance Company Individual Market Rate Filing June 5, 2015

      Background

      Access Health CT 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.

      Summary of Proposed Rate Changes

      The overall proposed rate increase is 12.4% with plan specific rate changes varying by plan from 7.1% to 22.0%.

      Overall Assessment of the Filing

      Based on our review of the filing, we believe that the filing lacks adequate detail for us to be able to follow all of the carrier's calculations. For some assumptions, inadequate support was provided making it difficult to assess reasonability with regards to carrier's circumstances. We assessed reasonability based on whether the assumptions were within industry norms.

Assessment of Key Components of the Rate Filing

Following are the comments and observations resulting from Wakely's review of United Healthcare Insurance Company's (United) Individual filing of 2016 exchange rates.

Base period / credibility:
- The single risk pool was defined correctly.
- The carrier should explain why it is appropriate to use small group experience to rate individual policies beyond the fact that small group is guaranteed issue.
- It is unclear what time period of data was used by the carrier to develop the manual rate.

Adjustments to experience:
- We understand that adjustments were made to small group experience to reflect individual market characteristics such as morbidity, demographics, and benefit differences. The carrier should also discuss network differences, among any other additional differences not already described in the memo.
- The carrier should describe the methodology used to adjust the small group experience for demographics and area mix. What demographic factors were used and do those factors reflect gender mix?
- The carrier should explain what (if any) induced demand factors were used.

Trend:
- Annual trend of 6.9% with 3.8% for unit cost and 3.0% for utilization trend was used for rate development. The trends were based on small group experience and appear to be within a reasonable range based on industry standards.
- The carrier should explain why it is appropriate to use small group trends to project individual experience.

Morbidity: The carrier stated that a study from a large actuarial consulting firm was used to develop morbidity of the individual relative to the small group market. No additional information was provided that could be used to judge the reasonability of this assumption.

Reinsurance: The reinsurance parameters used were $90k to $250k with 50% coinsurance. The impact of reinsurance was 6.2% of paid claims.

Risk adjustment: The carrier adjusted its small group experience to the estimated individual market average morbidity level, and thus assumed no risk adjustment transfers. We believe this is a reasonable approach.

Administration:

- The overall administrative load of 8.75% is within industry norms. The carrier provided sufficient break down of this cost. In 2015, the admin load was 7.9%. The carrier should provide justification for the increase in administrative cost.
- The carrier should support the commission assumption of 2.2% and note what portion of the business is old through brokers and what the commission levels are.

Profit margin: The profit margin assumed was 2.03% which is within industry norms. The projected medical loss ratio (MLR) was above 80%.

Taxes and fees: The Patient-Centered Outcomes Research Institute (PCORI), insurer fees, premium tax rates, reinsurance, and risk adjustment fees used were consistent with those in the 2015 filing.

Plan factors:

- The carrier noted that the plan level adjustments do not include morbidity differences, consistent with federal requirements.
- The carrier should explain if any adjustments were made for induced demand and what factors were used, if any.
- The carrier indicated that it calculated and is applying a weighted average plan factor for its two Silver level plans to comply with AHCT's requirement that the standard Silver plan be the lowest cost Silver plan offered by the carrier. It is unclear that pricing these the same unless actuarially justified is an appropriate approach. The carrier should indicate how this is compliant with federal rating regulations as well as the spirit of the AHCT requirement.
- Rate changes by plan were reported to range from 7.1% to 22.0%. The carrier should explain the reason for this variation by plan, splitting out the impact of any plan design changes. The carrier should specifically explain the 22.0% increase in the standard silver rate since it is significantly higher than the rate increases for the other plans included in the filing.
- The carrier indicated that refinements were made to the model used for developing plan factors. The carrier should provide details on what refinements were made and how the refinements impacted the factor for each plan differently.
- The carrier must explain why plan factors on page 2 of the actuarial memorandum do not correspond to the actuarial value and cost sharing adjustment column on page 7.

Geographic factors: The carrier updated the area factors relative to 2015 factors. Explanation should be provided for why the area factors were updated and indicate the impact to consumers. The carrier should indicate whether consideration was given to smoothing these changes to limit consumer impact.

Tobacco factors: Similar to 2015, the carrier is not charging a load for tobacco users.

Other considerations:
- The federal age factors used were accurate
- The federal guidelines for developing the various index rates were followed

Conclusion

Without the additional documentation described above, we are unable to identify any specific issues related to the carrier's rate development. Should additional documentation be provided, we would be happy to provide further comments given the opportunity.

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.

Department Summary

Since this filing reflects rates for the newly developed CT insurance exchange and incorporates all the new rating requirements of PPACA effective 1/1/2014, with some modifications due to federal regulations that impact future year's premiums, 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 6.9% annual trend assumption used in the rate filing and believes that this assumption is appropriate.

Based upon the federal MLR for this filing of 88.44% before the impact of the credibility adjustment, the Department believes that the proposed pricing supports the required 80% loss ratio for small group business.

UHC decided to use 2013 experience from the small group affiliates and trend this experience to the rating period rather than using 2014 small group affiliate experience and trend to the rating period. The Department reviewed the small group affiliates rate filings and the 2014 experience that was used from them as a basis for this rate filing. The 2014 experience was better than the 2013 experience and was recognized in the affiliates rate filings as an experience adjustment. Based upon this updated experience the Department is requiring that an additional experience adjustment of -5% be implemented, which has the effect of reducing expected claims by 5.0%.

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.

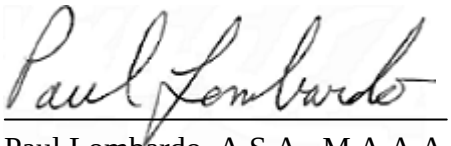
Since the assumptions for the attachment point and coinsurance level have changed from 2015 to 2016, this resulted in an increase to premiums.

Department Disposition

Based upon the finding of fact, and the summary information described above, the revised average rate increase of 11.4% is disapproved as submitted. Based on the additional 5% reduction in morbidity, described above, the revised average rate increase is 5.5%.

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.



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