



STATE OF CONNECTICUT

INSURANCE DEPARTMENT

Celtic Insurance Company Individual 2016 Off Exchange Rate Filing

Finding of Facts

1. This filing is a rate submission for the Celtic ACA-compliant individual major medical policy introduced to the Connecticut market in 2014.
2. This policy provides major medical benefits. There is one proposed plan design, which is at the prescribed Bronze plan tier, based on a 60.7% Actuarial Value as determined using the Actuarial Value (AV) Calculator. The plan design is unchanged from 2015.
3. This product will be sold through various marketing channels including brokers, telesales representatives, and through an online web portal. This product will not be offered on the exchange.
4. Rates are updated to be applicable to calendar year 2016, the requested rate change of 15.95% includes adjustments to reflect:
 - Updated market experience, including adjustments for pent-up demand
 - Underlying medical trend, including trend leveraging from the plan design
 - Changes in the contributions to and receipts from the transitional federal reinsurance program
 - Changes to ACA-related fees and taxes, including the health insurer fee
5. Celtic does not have credible experience for non-grandfathered or ACA individual policies in 2014. Consequently, rates for this product were developed from a manual rate established from the nationwide experience contained in the 2012 Truven Health Analytics MarketScan Commercial database (MarketScan).
6. Experience under the manual rates was adjusted to be reflective of anticipated Connecticut specific experience, and projected forward to account for medical inflation and morbidity differences expected in the rating period. Additional adjustments made to adjust to a 2016 expected allowed claim cost include adjustments for changes in provider discounts, benefit level changes, EHB covered services, and demographics. Paid claims were calculated as projected allowed claims multiplied by the estimated paid-to-allowed ratio for the proposed 2016 plan design. Finally, after making adjustments to reflect the impact of transitional reinsurance and risk transfer payments, the adjusted paid claims were converted to a premium base rate by adding the expected costs for ACA related fees/taxes, administrative expenses, and a load for profit/risk margin.

7. Rates were developed under the assumption that they would remain in effect for new sales for twelve months after the proposed effective date of 1/1/2016. The average annual premium per member is projected to be \$5,926. Please see Exhibit A for the proposed monthly rates by age and tobacco use. Premiums are developed for family coverage by adding up the rate of each covered family member, with no more than the three oldest covered children under age 21 being taken into account in computing the premium.
8. Rating factors for age, tobacco use, and geographic differences were as retained unchanged from the current rates. Below is a description of the development of the age, geography and tobacco use rate adjustments.
 - Age Factors – The age curve being applied in the proposed rates is based on the 3:1 age curve prescribed by HHS. The standard curve was fitted such that the resulting average rate when weighted by the projected membership was equal to the calculated average premium PMPM after applying the factors noted above to the index rate.
 - Geographic Factors – Premiums will vary by the 8 defined geographic rating areas. The geographic relativities were retained from the 2015 filing, and were originally developed from the MarketScan 2010 data. Relativities were developed such that the rating factors do not reflect expected morbidity differences. Average expected geographic claims costs PMPM from the data were adjusted for the risk adjustment factors for the membership underlying the experience in each geography.
 - Tobacco Use – A factor of 1.30 is being applied for those members who utilize tobacco. This factor is retained from prior filings and had originally been developed based on Celtic’s historical experience which demonstrates that tobacco users relative to non-tobacco users have approximately 30% higher claims after normalizing for age differences within the population. It is being assumed that approximately 11% of total enrolled adults will be tobacco users.
9. The date through which claims from the experience period of January 1, 2014 to December 31, 2014 were paid was January 31, 2015.
10. Given the limited Celtic 2014 base period enrollment, the projected experience is not considered credible and does not impact the final rates charged.
 - Medical underwriting is no longer applicable to the individual market, leading to an expectation of higher morbidity compared to pre-reform markets. 2014 experience may include both non-grandfathered experience, where some time has elapsed since medical underwriting, and coverage issued under the reformed individual market. Additionally, the experience is limited and not credible. Consequently, we assumed no change in morbidity in the projection of the Celtic 2014 experience. Compared to prior filings we no longer project

excess pent-up demand; reflecting that 2016 represents the third year of availability of guarantee-issue individual products.

- Consistent with the 2015 rate filing, mandated coverage for 2016 relative to the coverage available under the pre-reform policies included in the experience period is estimated to increase the expected allowed claims by approximately 6.3%. This adjustment had been developed based on a comparison of the coverage underlying Celtic's pre-ACA population relative to the Connecticut EHB benchmark plan. The most impactful newly mandated covered services which result in the estimated change include the following: pediatric dental (1.5%), habilitative services (0.5%), maternity (3.0%), home health care services (0.2%), emergency transportation (0.3%), skilled nursing facility (0.2%), chiropractic care (0.5%), and hearing aids (0.1%). Adjustments for each of these changing benefits were developed using a combination of an analysis of claims by service type from MarketScan as well as information available in other industry studies. As almost all Celtic exposure in 2014 relates to pre-ACA policies, this assumption was retained without modification.
- We assumed no change in demographics in the projection of Celtic 2014 experience.
- An adjustment was applied to the historical allowed costs to reflect a shift from the discount levels in calendar year 2014 to those expected in 2016. Claims submitted in 2014 were adjusted, as necessary, to reflect the expected allowed costs that would have been incurred if the 2016 network's discounts had been applied instead. The total network adjusted claims for the experience period were compared to the unadjusted claims for the experience period to develop the final adjustment to be applied. For Connecticut, this adjustment is equal to 0.952.
- No large claim pooling adjustment is applied for projecting base period experience.

11. A trend rate used to project claims from the experience period to the rating period was developed based on a review of the Oliver Wyman Carrier Trend Report – January 2015. Given the limited enrollment in Celtic's individual book of business, it was assumed that industry level studies such as this would be most reliable for developing trend estimates.

12. In total, the weighted average reported medical trend being used for individual PPO products was 6.98%. The reported weighted prescription drug trend is 10.2%, significantly higher from 8.7% in 2014. Celtic is including an annual trend rate of 7.0% when projecting base period experience. Historical experience was then projected from the midpoint of the experience period, 7/1/2014, to the assumed midpoint of the rating period, 7/1/16, for a total of 24 months. The overall trend adjustment being applied to the 2014 historical claims is 1.145.

Credibility Manual Rate Development

13. MarketScan nationwide experience from 2012 was used as the basis for the manual rates which were developed. The experience was considered appropriate for use in the manual rate as it represents a fully credible dataset (based on over 300 million member months of experience), with the majority of the experience from non-underwritten coverage (consistent with the ACA individual market).
14. Adjustments made to the nationwide MarketScan experience to reflect appropriate Celtic-specific cost and utilization levels for Connecticut:
 - A morbidity adjustment of 0.978 is included to adjust for MarketScan differences between the observed nationwide morbidity and the morbidity of Connecticut. The factor included demographic adjustments. To estimate the true morbidity adjustment, the impact of the expected shift in the average mix by age and gender, equal to -0.2%, was removed. After removing the demographic change impacts, an adjustment equal to 0.980 was applied to the underlying Connecticut experience period allowed claims PMPM for population morbidity.
 - The only adjustment included for EHB benefits in the manual rate relates to the inclusion of habilitative services (0.5%) and pediatric dental benefits (1.5%), for a total estimated impact of 2.0%.
 - A utilization adjustment factor equal to 0.909 was applied to the nationwide experience to reflect the expected impact on utilization of the difference in cost sharing between the estimated experience period AV of 0.834 for the large group market and the projected actuarial value of 60.7% for the rating period plan design.
 - A geographic adjustment of 1.150 was applied to reflect the impact of differences in geographic claim costs between Connecticut and Nationwide enrollment.
 - An adjustment was applied to the projected costs in the manual rate to reflect a shift from the discount levels underlying the MarketScan experience in calendar year 2012 to the projected level of provider discounts projected to exist for Celtic in 2016. The adjustment is 1.125 and reflects this difference for provider pricing.
15. The projected Paid-to-Allowed ratio was developed by running the Bronze plan design through Oliver Wyman's proprietary pricing model, which was adjusted to reflect the projected level of allowed claims per person per year for Celtic's 2016 Connecticut enrollees. This analysis resulted in a projected Paid-to-Allowed ratio for the specific plan design of 64.7%.
16. No risk transfer payment is being projected. This based on the assumption that the morbidity and geographic distribution of Celtic's 2016 population will look similar to the individual market average overall.

17. A projected net reinsurance recovery equal to \$27.90 PMPM is being assumed in the development of the proposed rates. This adjustment is made at the market level.
18. Capitation payments were not considered, given that no capitation payments were made during the experience period nor are any expected to be made during the projected rating period.
19. Retention charge used in this filing is 24.5%: this includes 15% for administrative expenses, 1.75% for state premium tax; ACA Insurer Tax of 2.75%; \$0.18 pmpm for the Comparative Effectiveness Research Fee; \$0.15 pmpm for the Risk Adjustment Fee; and 5.0% of premium for pre-tax profit/contribution to surplus & risk margin.
20. Celtic anticipates that the HealthCare Reform defined medical loss ratio will be 80.4% for calendar year 2016, while the traditional pricing loss ratio is 75.5%.
21. Celtic Life's capital and surplus, as of 12/31/2014, was \$29,360,659.
22. One public comment was received, see below:
 - Highway robbery! Do not allow this increase!!! We need affordable insurance rates!!!

Department Summary

Since this filing reflects rates that incorporate 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.

Upon analyzing the trend information contained within the rate filing, the Department determined that the annual trend of 7.0% is appropriate based on the trend data provided in the filing.

Based upon the federal MLR for this filing of 80.4%, before the impact of credibility adjustment, the Department believes that the proposed pricing supports the federally required 80% loss ratio for individual business.

In the 2015 Final Benefit Payment Rule, published by the Department of Health and Human Services (HHS), it describes the HHS Notice of Benefit and Payment Parameters for 2016. It finalizes a 2016 uniform reinsurance contribution rate of \$27 annually per enrollee, and the following 2016 uniform reinsurance payment parameters – a \$90,000 attachment point, a \$250,000 reinsurance cap, and a 50 percent coinsurance rate.

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.

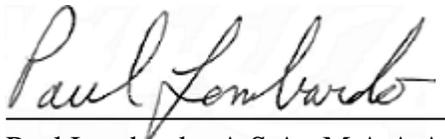
Since the assumptions for the attachment point and coinsurance level have changed from 2015 to 2016, this resulted in an increase to premiums of 14.7%, which is the majority of the 15.95% requested increase.

Department Disposition

Based upon the finding of fact, and the summary information described above, the rate increase of 15.95% is approved as submitted.

These rates are reasonable in relationship to the benefits being provided, and are 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