STATE OF CONNECTICUT

INSURANCE DEPARTMENT

ConnectiCare Inc. HMO Individual Off Exchange 2016

Finding of Facts

1. The starting rates for this Individual Direct product have been developed as follows. The experience for this Policy form(Individual Direct) was based on the existing non-grandfathered Individual risk pool of Connecticare, Inc.(CCI), using the incurred period January 2014 through December 2014, paid thru May 2015. Appropriate completion factors were then applied and the claims were trended at an annual trend of 7.86% for 24 months. Non-FFS costs and the impact of Health Care Reform are included. The projected claims were also normalized for average Age, Benefit and Area factors to develop proposed base rate.

2. Since CCI has only one product plan and low membership, its experience is not credible to use for pricing purposes. The source data used for the projected claims in the Unified Rate Review Template (URRT) is the 2014 claims experience from ConnectiCare Insurance Company Inc. (CICI), an affiliated company. Both CCI and CICI have been providing coverage to individuals in Connecticut, while CICI has materially more product plans as well as members, and its experience is deemed sufficient and appropriate to use for this submission. No rebate is expected for the premium of the experience period.

3. The morbidity of this block of business in 2016 is expected to be 8.8% better than the morbidity of the experience period individual market. A corresponding adjustment was made to the credibility manual.

4. A revised Manual base rate level for new business and renewals with rate effective in 2016. We proposing a base rate change of + 9.5% to the previously filed and approved Manual rate level for January 2015 rate effective dates.

5. ConnectiCare has made benefit changes within our product portfolio. Please see Exhibit 2 and Table 2 for the list of plan(s) to be offered to new and renewing individuals with rate effective dates on or after January 01, 2016. No current plans in our product portfolio will be discontinued.

6. The following is the most recent (non-grandfathered) historical experience:

Calendar Year	Earned Premium	Incurred Claims	Loss Ratio	Members
2010	90,110	58,277	64.7%	35
2011	468,052	434,709	92.9%	165
2012	680,386	838,926	123.3%	235

2013	860,187	1,409,105	163.8%	275
2014	589,111	1,084,978	184.2%	163
Total	2,687,847	3,825,995	142.3%	

7. Unit Cost ($) Trend

Service	YE 2012	YE 2013	YE 2014	YE 2013 Trend	YE 2014 Trend
Inpatient	4,180	5,085	4,598	21.7%	-9.6%
Outpatient	631	713	825	13.1%	15.7%
Professional	95	98	99	2.7%	0.5%
Subtotal Medical	185	206	210	11.2%	2.0%
Retail Rx	59	64	87	9.6%	34.6%
Total	148	164	170	10.2%	3.9%

8. Utilization/1,000 Trend

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

9. Allowed PMPM ($)

Service	YE 2012	YE 2013	YE 2014	YE 2013 Trend	YE 2014 Trend
Inpatient	60.13	72.33	77.74	20.3%	7.5%
Outpatient	82.20	92.35	127.73	12.3%	38.3%
Professional	123.52	123.24	150.31	-0.2%	22.0%
Subtotal Medical	265.85	287.91	355.79	8.3%	23.6%
Retail Rx	34.34	38.17	70.38	11.2%	84.4%
Total	300.19	326.09	426.17	8.6%	30.7%

10. Net PMPM ($)

Service	YE 2012	YE 2013	YE 2014	YE 2013 Trend	YE 2014 Trend
Inpatient	56.47	68.00	72.14	20.4%	6.1%
Outpatient	64.18	71.33	97.83	11.2%	37.1%
Professional	84.91	83.20	101.65	-2.0%	22.2%
Subtotal Medical	205.55	222.53	271.61	8.3%	22.1%

Retail Rx	18.19	22.53	51.40	23.9%	128.1%
Total	223.74	245.07	323.01	9.5%	31.8%

11. Projected Pricing Trends

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

12. The resulting annual trend is 7.86%. Claims data from the insured book of business of ConnectiCare Inc. & Affiliates was extracted and year to year trends were derived based on claims by benefit category.

13. ConnectiCare evaluates its trend using a ground-up historical review where utilization and allowed unit cost information is analyzed over a three to five year period of time. This information is then used with information from their Network Operation team (contracting department) to develop the prospective trend. It is important to note that historical utilization is understated because historical buy-downs drive up member cost-share and reduce utilization (historical utilization would have been higher if buy-downs didn't happen).

14. No new benefit mandates or requirements due to change in law are included. Benefits comply with provisions of the Affordable Care Act, including Essential Health Benefits.

15. Retention from most recent statutory blank is 97.5%; retention charge used in rate filing is 21.99%.

16. The expected medical loss ratio for this filing is 82.2%. The federal MLR for rebate purposes is 89.6%. The federal MLR calculation components are Total Projected Benefit Expenses divided by (Total Rate – ACA Fees – Premium Tax – Exchange Administration – FIT). This calculation is prior to any credibility adjustment factor.

17. ConnectiCare has included the following health care reform impacts in this filing:

    - Patient Centered Outcomes Research Fee: this charge of $2 per covered life applies to policies issued or renewed between 10/1/2012 and 9/30/2013, and then is expected to be subject to adjustment for projected increases in National Health Expenditures per year for the years 2014-2019. We have included $0.17 pmpm to cover this cost.

- Transitional Reinsurance Program: Recent guidance has put the cost of this program at $27 per capita. We have included a pmpm cost of $2.25 to cover this cost.
- Health Insurer Fee: Included a pmpm cost of $19.76 to cover this cost.
- Risk Adjustment Program: Include a pmpm cost of $0.15.

18. The rate level developed reflects an assumption that the morbidity level and demographic composition of CCI's population will be consistent with the morbidity level and demographic composition of the overall individual market. Therefore, the anticipated risk adjustment payments are expected to be minimal, and were not factored into the rate development. A negative $0.15 PMPM is included to represent the cost of the program administration.

19. The capital and surplus, as of December 31, 2014, is $115,628,900.

20. Federal transitional reinsurance program contributions and benefit limits have changed from last year. Specifically, the reinsurance contribution has changed from an estimated $44 PMPY to $27 PMPY. Further, the claims threshold upon which reinsurance recoveries are triggered has increased from the assumed $45,000 to $90,000; and the reinsurance cost share percentage paid by the program decreased from 70% to 50%. The combined effect of an increase threshold and a decreased program cost share results in a material decrease in transitional reinsurance recoveries. Therefore, there is a corresponding increase in the individual premium rates.

21. There are no material changes in provider networks and contracts. The anticipated changes are reflected in the unit cost trend assumptions.

22. The Department received 116 public comments, they are briefly summarized below:

    - Why should there be a rate increase when you have so many more members enrolling due to ACA and sharing more cost/ risk?. I am an internist and run a small practice in Colchester. With the rate hike do I as a physician see some of the corresponding increase in my reimbursements? I would like to know how much of this increase is going towards CEO salaries/ bonuses. There is no justification in rate hikes. We are containing costs tremendously and this should reflect in the premiums.
    - 15 new board members, dividends and profits being the major focus. I understand a company needs to make money but the rates are ridiculous. As they cut benefits, raise deductibles, limit prescriptions and whine about the drug and medical monopolies costs are not addressed. Every step of out medical system creates a profit for doctors, hospitals and insurance companies. What I would like to know are how many of the decision makers in the CT Health Insurance Department have worked for the health insurance

companies. How many of the CT Health Insurance decision makers leave and work for the health insurance industry?

- I'd rather just go without insurance again than pay any more money.
- The cost of health insurance for individuals is already way too high. If the rate increase is in fact due to the matters asserted in the email from my provider, then perhaps the commission should start looking at the cost of Pharma. Prescription drug costs are outrageous. At the least, the commission should require the health insurers to provide detailed information about their accounting practices, costs and expenses.
- I am disappointed in the decision if it happens. My husband is a contractor and it is costly to have health insurance and to raise us would be unfair. I like Connecticare and it has been good to me so far. I would be disappointed if this change was to happen. Please try in everyway to fight for the consumer.
- We're already going broke paying for this. I can't pay any more.

Department Summary

The actual incurred medical loss ratios have steadily been increasing from 2010 to the present with an overall loss ratio of 142.3%. The most recent data available produces an incurred loss ratio of 184.2% for calendar year 2014, which is above the 80% loss ratio for MLR rebate purposes identified in PPACA.

Upon analyzing the trend information contained within the rate filing, the Department determined that the overall trend of 7.86% is appropriate based on recent trend experience identified in the filing.

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.

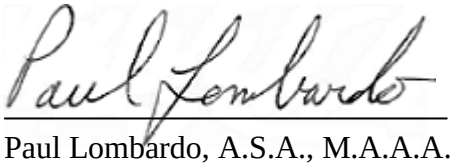
Since the assumptions for the attachment point and coinsurance level have changed from 2015 to 2016, this resulted in an increase to premiums.

Department Disposition

Based upon the finding of fact, and the summary information described above, the 5.1% rate increase is approved as submitted.

The approved rates are reasonable in relationship to the benefits being provided, and are neither excessive, inadequate nor unfairly discriminatory.

Dated August 27, 2015.



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