State: *Connecticut* ***Filing Company:*** *HealthyCT*
TOI/Sub-TOI: *H16G Group Health - Major Medical/H16G.003A Small Group Only - PPO*
Product Name: *CTSG-HCT050713*
Project Name/Number: *Small Group Rates and Forms/*

Filing at a Glance

Company:	HealthyCT
Product Name:	CTSG-HCT050713
State:	Connecticut
TOI:	H16G Group Health - Major Medical
Sub-TOI:	H16G.003A Small Group Only - PPO
Filing Type:	Rate
Date Submitted:	05/08/2013
SERFF Tr Num:	HTCT-129017896
SERFF Status:	Assigned
State Tr Num:	201396342
State Status:	
Co Tr Num:	CTSG-HCT050713
Implementation Date Requested:	01/01/2014
Author(s):	Priya Jayarangan, Bob Carey
Reviewer(s):	Paul Lombardo (primary)
Disposition Date:	
Disposition Status:	
Implementation Date:	

State: *Connecticut* ***Filing Company:*** *HealthyCT*
TOI/Sub-TOI: *H16G Group Health - Major Medical/H16G.003A Small Group Only - PPO*
Product Name: *CTSG-HCT050713*
Project Name/Number: *Small Group Rates and Forms/*

General Information

Project Name: Small Group Rates and Forms
Project Number:
Requested Filing Mode: Review & Approval
Explanation for Combination/Other:
Submission Type: New Submission
Group Market Type: Employer
Filing Status Changed: 05/09/2013
State Status Changed:
Created By: Bob Carey
Corresponding Filing Tracking Number:

Status of Filing in Domicile: Not Filed
Date Approved in Domicile:
Domicile Status Comments:
Market Type: Group
Group Market Size: Small
Overall Rate Impact:

Deemer Date:
Submitted By: Bob Carey

PPACA: Non-Grandfathered Immed Mkt Reforms

PPACA Notes: null

Exchange Intentions:

Includes rates for small group plans sold on the exchange and off the exchange, as well as small group plans sold exclusively off the exchange.

Filing Description:
Small group rate filing for off- and on-Exchange

Company and Contact

Filing Contact Information

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203-949-1602 [Phone]

Filing Company Information

HealthyCT
35 Thorpe Avenue
Wallingford, CT 06492
(203) 949-1602 ext. [Phone]

CoCode: 15046
Group Code:
Group Name:
FEIN Number: 45-3366866

State of Domicile: Connecticut
Company Type:
State ID Number:

Filing Fees

Fee Required? No
Retaliatory? No
Fee Explanation:

SERFF Tracking #:	*HTCT-129017896*	***State Tracking #:***	*201396342*	***Company Tracking #:***	*CTSG-HCT050713*

State:	*Connecticut*	***Filing Company:***	*HealthyCT*
TOI/Sub-TOI:	*H16G Group Health - Major Medical/H16G.003A Small Group Only - PPO*		
Product Name:	*CTSG-HCT050713*		
Project Name/Number:	*Small Group Rates and Forms/*		

Rate Information

Rate data applies to filing.

Filing Method:

Rate Change Type: Neutral

Overall Percentage of Last Rate Revision: %

Effective Date of Last Rate Revision:

Filing Method of Last Filing:

Company Rate Information

Company Name:	Company Rate Change:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	# of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where req'd):	Minimum % Change (where req'd):
HealthyCT	New Product	%	%				%	%

State: *Connecticut* ***Filing Company:*** *HealthyCT*
TOI/Sub-TOI: *H16G Group Health - Major Medical/H16G.003A Small Group Only - PPO*
Product Name: *CTSG-HCT050713*
Project Name/Number: *Small Group Rates and Forms/*

Rate Review Detail

COMPANY:

Company Name: HealthyCT
HHS Issuer Id: 91069
Product Names: Healthy Partner Preferred
Healthy Partner Max
Healthy Partner Essential
Healthy Partner Basic
Healthy Partner Preferred Pro
Healthy Partner Select Plus
Healthy Partner Select
Healthy Partner Basic Plus
Trend Factors:

FORMS:

New Policy Forms: CTSG-HCT050713
Affected Forms:
Other Affected Forms:

REQUESTED RATE CHANGE INFORMATION:

Change Period: Quarterly
Member Months: 0
Benefit Change: None
Percent Change Requested: Min: Max: Avg:

PRIOR RATE:

Total Earned Premium:
Total Incurred Claims:
Annual $: Min: Max: Avg:

REQUESTED RATE:

Projected Earned Premium: 107,439,925.00
Projected Incurred Claims: 85,702,600.00
Annual $: Min: 155.85 Max: 1,501.38 Avg: 445.63

SERFF Tracking #:	*HTCT-129017896*	***State Tracking #:***	*201396342*	***Company Tracking #:***	*CTSG-HCT050713*

State:	*Connecticut*	***Filing Company:***	*HealthyCT*
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Product Name:	*CTSG-HCT050713*		
Project Name/Number:	*Small Group Rates and Forms/*		

Supporting Document Schedules

Satisfied - Item:	Actuarial Memorandum
Comments:	
Attachment(s):	HealthyCT state memorandum - SG - 5-3-2013.pdf
Item Status:	
Status Date:	

Bypassed - Item:	Consumer Disclosure Form
Bypass Reason:	Required documentation not currently available.
Attachment(s):	
Item Status:	
Status Date:	

Satisfied - Item:	Actuarial Memorandum and Certifications
Comments:	
Attachment(s):	HealthyCT Part III memorandum - SG - 5-3-2013.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Unified Rate Review Template
Comments:	
Attachment(s):	SG URRT workbook 5-3-2013.xlsm
Item Status:	
Status Date:	

SERFF Tracking #:	*HTCT-129017896*	***State Tracking #:***	*201396342*	***Company Tracking #:***	*CTSG-HCT050713*

State:	*Connecticut*	***Filing Company:***	*HealthyCT*
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Product Name:	*CTSG-HCT050713*		
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Attachment SG URRT workbook 5-3-2013.xlsm is not a PDF document and cannot be reproduced here.

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May 3, 2013

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

Dear Mr. Lombardo:

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

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

List of HealthyCT Small Group Market Plan Offerings

Plan Name	Offered Through Access Health CT	Offered Outside Access Health CT
Healthy Partner Preferred	X	X
Healthy Partner Max	X	X
Healthy Partner Essential	X	X
Healthy Partner Basic	X	X
Healthy Partner Preferred Pro		X
Healthy Partner Select Plus		X
Healthy Partner Select		X
Healthy Partner Basic Plus		X

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

Sincerely,

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

ACTUARIAL CERTIFICATION

HealthyCT, Inc.
Small Group Rate Filing Effective January 1, 2014

I, Stephen P. Melek, a member of the American Academy of Actuaries, am associated with the firm of Milliman, which has been retained by HealthyCT, Inc. (HealthyCT) to render this opinion. I meet the Academy qualification standards for rendering the opinion and am familiar with the applicable Connecticut statutory and regulatory requirements regarding preparation of actuarial memoranda and actuarial certifications for small group rate filings. I meet the qualification standards of the American Academy of Actuaries to render the actuarial opinion contained herein.

Actuarial Certification

To the best of my knowledge, this rate filing is in compliance with the applicable laws and regulations of the State of Connecticut in effect as of May 3, 2013, and federal requirements under the Patient Protection and Affordable Care Act and its implementing regulations. The attached memorandum identifies cases where requirements of Connecticut state law or regulation or directives by the state exchange (Access Health CT) conflict with federal law or regulation. In my opinion, the premium rates described in my Actuarial Memorandum dated May 3, 2013 are not excessive, inadequate, or unfairly discriminatory.

_____

Stephen P. Melek, FSA, MAAA
Member, American Academy of Actuaries
May 3, 2013

ACTUARIAL MEMORANDUM

HealthyCT, Inc.
Small Group Rate Filing Effective January 1, 2014

I, Stephen P. Melek, a member of the American Academy of Actuaries, am associated with the firm of Milliman, which has been retained by HealthyCT, Inc. (HealthyCT) to prepare this memorandum. I meet the Academy qualification standards for rendering the opinion that accompanies this memorandum (dated May 3, 2013). I meet the qualification standards of the American Academy of Actuaries to render the actuarial opinion contained herein.

Please see the cover letter, filed with this memorandum, for an overview of the products included in this rate filing. Details on benefit design can be found in other templates submitted alongside this memorandum.

This memorandum has been constructed to provide the information requested by the Connecticut Insurance Department (CID) in Bulletin HC-81-2 (dated May 31, 2011).

A. Historical experience from inception to date

HealthyCT was established as a Consumer Operated and Oriented Plan (CO-OP) under the Patient Protection and Affordable Care Act (PL 111-148 and PL 111-152; hereafter, "ACA"), §1322. As a new entity, there is no historical experience available for the products in this rate filing.

B. Consistency of historical experience with financial statements

As noted in Section A of this memorandum, HealthyCT is a new carrier without historical experience. As a new carrier, HealthyCT has not yet filed its initial financial statements with CID.

C. Trend

As described below in Section J of this memorandum, we based our rate development on Milliman's 2012 *Health Cost Guidelines*™ (HCGs). Because the underlying data are on a 2012 basis and this rate filing is for calendar year 2014, we applied trend factors to adjust the claim cost projections to 2014. This section describes the trend rates we used.

We used annual trend rates that represent reasonable estimates of trend based on values observed in proprietary data used by Milliman in developing the HCGs. Table 1 displays these annual trend rates, which are described in the subsections following the table.

Table 1 – Trend assumptions

Component	Unit Cost Trend (Annual)	Utilization Trend (Annual)	Total (Annual)
Inpatient facility	7.0%	0.0%	7.0%
Outpatient facility	7.5%	2.0%	9.7%
Professional	6.0%	1.5%	7.6%
Prescription drugs	5.8%	2.3%	8.1%
Other	6.0%	1.5%	7.6%
All Benefits			**7.5%**

We intend to trend the initial index rate quarterly, at an annual rate of 7.5%, as shown below in Table 4. The Rates Table Template attached to this filing includes four worksheets, one for each quarter; the effective date and expiration date on each tab refer to the date when a group first enrolls. Rates for any particular member would be valid for a 12-month period. For example, if a group enrolls February 1, 2014, its members would receive the Q1 rates and those rates would remain constant until January 31, 2015. If a group enrolls May 1, 2014, its members would receive the Q2 rates and those rates would remain constant until April 30, 2015.

UNIT COST TREND

The unit cost trends in the first column of Table 1 represent, by service category, the expected annual rate of growth in costs from 2012 to 2014. This is driven by factors such as provider price increases and substitution of older technologies and prescription drugs for newer, more expensive ones.

UTILIZATION TREND

The utilization trends in the second column of Table 1 represent, by service category, the expected annual rate of growth in utilization of medical services and prescription drugs from 2012 to 2014. Utilization trend can be driven by factors such as changes in medical practice patterns toward greater use of services, or expansion of the availability of medical care.

IMPACT OF COST SHARING LEVERAGE ON TREND

Rather than apply an adjustment to the medical trend rates to separately account for cost sharing leveraging, the impact of the deductible on paid claims is directly modeled by using allowed claim levels (trended to 2014 at the rates in Table 1) in claim probability distributions, also trended to 2014 levels.

MEDICAL TECHNOLOGY TREND

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.

BENEFIT BUY-DOWN ANALYSIS AND IMPACT ON TREND

Because HealthyCT is a new carrier, there have been no benefit buy-downs in the past. To the extent that members select less rich benefit designs, the impact of this on trend is akin to the “impact of cost sharing leverage on trend,” described above.

D. Cost of new benefit mandates

All state and federal benefit mandates are included in the proposed rates. Because this is in initial rate filing for new products, without historical experience, impact of new mandates from the experience period to the rating period cannot be separately identified.

E. Impact of federal health reform law

Bulletin HC-81-2 requests that carriers provide “a list of each component of the health care reform bill that impacted premium and the actual impact used in pricing for each component.” The following are aspects of the premium development that are affected by the ACA. Because HealthyCT is a new carrier, there was not a specific “impact used in pricing” to adjust prior experience to a 2014 basis. Rather, premiums were developed incorporating all aspects of the ACA.

- HealthyCT is a CO-OP, which came into existence only as a result of the ACA.
- The set of benefits offered in the plans in this rate filing matches the benefits offered by the Essential Health Benefit (EHB) benchmark selected by the state of Connecticut.

- The ACA restricts carriers' ability to vary premiums to a few specific factors: age, geographic area, and family composition. (Tobacco use is also permitted as a rating variable under the ACA, but it is prohibited by state law; accordingly, HealthyCT's rates do not vary by tobacco use.) Section J below explains in detail how premiums were developed in accordance with the ACA.
- The ACA provides for three premium stabilization mechanisms: risk adjustment, reinsurance, and risk corridors. These mechanisms have a material impact on HealthyCT's premium development, as described below in Section J, and expense loads, outlined in Section F.

F. Retention

These are new products, so a comparison cannot be provided to prior retention factors. Table 2 below shows the components of retention that are assumed in this rate filing. Note that these are shown as a percentage of total gross premium. The federal MLR rules allow for certain adjustments to claims and premium, so the percentages shown in this table are not necessarily indicative of how they would be treated for federal MLR purposes. See Section I below for more details.

Table 2 – Retention components

Component	Percent of Premium
General administrative expenses	8.53%
Quality improvement expenses	1.80%
Commissions	5.00%
Stop-loss reinsurance premium, net of recoveries	0.95%
Transitional reinsurance premium	1.18%
Exchange administrative fee	0.00%
Comparative effectiveness research fee	0.04%
Health insurer fee (ACA §9010, as amended)	0.00%
Risk adjustment administrative fee	0.02%
Investment income on reserves	0.00%
Premium tax	1.50%
Dental admin	0.22%
Provision for profit and contingencies	1.00%
Total	**20.23%**

As a new carrier with no written premium in 2013, HealthyCT does not anticipate any assessment for exchange fees (according to the draft "Application for Participation" released by the exchange April 23, 2013) or ACA §9010 health insurer fees in 2014. We reserve the right to submit updated premium rates if the exchange releases a non-zero assessment or fee for HealthyCT's business.

G. Claim lag triangles

Because these are new products, there is no historical experience available for which claim lag triangles can be provided.

H. Capital and surplus

HealthyCT is a new entity and has yet to offer insurance coverage or file an annual statement.

Having been established as a CO-OP under the ACA, HealthyCT has access to a federal solvency loan of $58.5 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. During 2014, HealthyCT intends to draw against its available solvency loan as needed to ensure that its capital position exceeds 200% of its authorized control level. CMS, which also regulates CO-OPs, expects CO-OPs to utilize the solvency loan to attain a capital level of 500% of the authorized control level on an ongoing basis.

I. Demonstration of compliance with federal MLR rules

Under federal rules, MLR is defined as:

$$MLR = \frac{Claims + Quality\ Improvement\ Expenses\ \pm (Transitional\ reinsurance, risk\ adjustment, risk\ corridors)}{Premiums - (Premium\ taxes\ and\ regulatory\ fees)}$$

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

The projected MLR, under the federal definition above, is 84.0% (before applying a credibility adjustment), which is greater than the required minimum. This is calculated as:

$$84.0\% = \frac{\$348.87\ claims + \$8.00\ QI + \$5.25\ transitional\ reinsurance\ premiums + \$6.60\ risk\ adjuster\ payments)}{\$445.63\ Premiums - \$6.93\ Premium\ taxes\ and\ regulatory\ fees}$$

J. Detailed explanation as to how the proposed rates were developed

This section has been provided to describe to CID the methodology employed to develop the initial rates for these new products.

BACKGROUND

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 small group 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 in the issuer sells in the small group 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, consistent with state law.

This section of the memorandum describes the process we followed to develop the index rate for HealthyCT's small group products and the plan-specific adjustment factors.

DATA

Because HealthyCT has no prior small group product claim experience, there is no actual claim experience available for these products, and so the Milliman *Health Cost Guidelines*™ (HCG) cost and utilization information was used in the development of these rates. Considerations for premium rate development include:

- Proposed benefit plan designs for new products;

- Anticipated medical trend, both utilization and cost of services;
- Anticipated changes in the average morbidity of HealthyCT's market given underwriting, rating, and benefit requirements effective January 1, 2014, under the ACA;
- Applicable taxes and fees, including those that are applicable in 2014 under the ACA; and
- Anticipated contributions to the Federal Transitional Reinsurance Program.

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.

The HCGs provide a flexible but consistent basis for the determination of claim costs for a wide variety of health benefit plans. These rating structures are used to anticipate future claim levels, evaluate past experience and establish interrelationships between different health coverages.

The HCGs are a cooperative effort of all Milliman health actuaries and represent a combination of their experience, research and judgment. An extensive amount of data is used in developing these guidelines, including published and unpublished data. In most instances, cost assumptions are based upon our evaluation of several data sources and, hence, are not specifically attributable to a single source. Since these guidelines are a proprietary document of Milliman, they are only available for release to specific clients that lease these guidelines and to Milliman consulting health actuaries.

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.

The HCGs include detailed claim cost and utilization assumptions, which are readily available in a format consistent with the benefit categories in Section II of the URRT based on a detailed claims mapping algorithm. The claim cost basis from the HCGs was allocated directly to the following categories:

- Inpatient Hospital
- Outpatient Hospital
- Professional
- Other Medical
- Prescription Drug

Claim costs for proposed plans were developed using the HCGs. Additional adjustments were made to reflect anticipated changes in the average morbidity of the underlying experience given underwriting, rating, and benefit requirements effective January 1, 2014, under ACA. We followed the steps below to adjust the HCG claim experience to be on an appropriate basis for premiums for HealthyCT and to calculate the market-wide index rate and the plan-level adjustments.

STEP 1: PROJECT TOTAL CONNECTICUT MARKET MEMBERS AND HEALTH STATUS BY POPULATION COHORT

We expect significant shifts in the insured population when Access Health CT begins to operate in 2014 and ACA rules take effect mandating that all individuals obtain coverage and requiring insurers to accept all applicants. We projected Connecticut statewide population demographics and health status to help determine HealthyCT's share of the market.

The statewide market projections are based on the estimated population at the end of 2013, stratified by current insurance status, poverty status (income relative to FPL), health status, and family size. The Current Population Survey (CPS) from the U.S. Census provides state-level data for each of these strata. We adjusted the raw CPS data after reviewing the following additional data sources:

- Carriers' annual statutory financial filings provided to the NAIC. The filings contain reliable sizes of the individual and fully insured group markets.
- The Medicaid Statistical Information System (MSIS) (available through the Department of Health and Human Services), which provides reliable data on Medicaid enrollment in Connecticut.

We trended the entire population from 2011 to 2014 based on projected population growth rates. We then estimated the proportion of the population that will purchase coverage on the SHOP Exchange (i.e., "take up" rates). We anticipate that most of HealthyCT's small group sales, as well as sales in the small group market more generally, will continue to be through traditional distribution channels (brokers) rather than through the SHOP.

We also applied employer-sponsored insurance transition rates and individual/uninsured exchange take-up rates to estimate the population counts in each market (stratified by income-to-poverty ratio, health status, and family size).

For HealthyCT's products, the result is a 2014 statewide population projection by cohort (i.e., age, gender, income, and exchange status). Finally, we applied a smoothing algorithm to compensate for potential credibility issues.

STEP 2: PROJECT HEALTHYCT ENROLLMENT BY MARKET, EXCHANGE STATUS, AND PRODUCT

We projected HealthyCT's expected 2014 small group product enrollment on the exchange based on our estimate of the statewide population and HealthyCT's likely share of the total based on our assumed price relativity and appeal. We estimated the sales mix for the various plan options sold by HealthyCT. We also assumed that all 2014 members are enrolled for the entire year.

STEP 3: CLAIM COST PROJECTION

The basis used to develop rates for these new products is the 2012 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 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.

STEP 4: ADJUSTMENT FOR CHANGES IN MORBIDITY

The data in the HCGs are for a large group population. We believe this is a more appropriate basis for the development of future small group premium rates than current small group claim levels because large group experience includes a breadth of covered benefits consistent with those in the EHBs, and the impact of selection or medical underwriting present in the current small group market is mitigated by using non-underwritten large group experience. The HCGs are based on the 2012 large group population. We project that the 2014 small group market population will have a different population profile than the current large group market and therefore made specific adjustments to the claim cost projections to capture this change. Based on the population projection as outlined in Step 1 above, we adjusted the large group claims to represent our estimate of the market average demographics of the 2014 small group market.

We projected statewide risk scores by inferring the health status of the projected insured population by cohort using the self-reported health status field in the CPS data. We inferred a reasonable relative health status factor for each self-reported health status category based on the proportion of members within each self-reported health status category as well as risk scores generated for a large population dataset using the Milliman Advanced Risk Adjuster (MARA). We adjusted these inferred relative health status factors for age/gender claim cost factors from the HCGs to produce final statewide average risk scores for each population cohort. We estimate that the morbidity level of the 2014 small group market will be similar to the current large group market.

STEP 5: CHANGES IN BENEFITS

The underlying utilization and charge levels assumed in the 2012 HCG baseline data are typical of a comprehensive major medical plan with a $500 deductible, 80% coinsurance, and a $2,000 out-of-pocket-maximum. Adjustments were then made to reflect changes in utilization levels associated with different covered benefits (benefit limits and cost sharing). These adjustments have been created by studying the historical impact of different contractual limitations and cost sharing on utilization experience by the covered population.

STEP 6: CHANGES IN DEMOGRAPHICS

We expect significant shifts in the insured population when Access Health CT opens in 2014. We projected Connecticut statewide population demographics and health status to help determine HealthyCT's share of the market. Because we are using the HCGs as the basis of these premiums, we adjusted those data to be on a basis consistent with our projections of the demographics in 2014. Please see Step 1 above for more details on these projections.

STEP 7: ESTIMATE IMPACT OF RISK ADJUSTMENT

HealthyCT recognizes that to operate within a single risk pool, issuers are required to make a market-wide adjustment to the pooled market level index rate to account for federal risk adjustment and reinsurance payments. Therefore, HealthyCT must allocate anticipated risk adjustment revenue or payments proportionately across all plans in the risk pool based on plan premiums by applying the risk adjustment transfer as a constant multiplicative factor across all plans. We have developed an estimate of the risk adjustment payment for all of HealthyCT's plans in this risk pool. On- and off-exchange small group products are part of the same risk pool.

Since differences between HealthyCT's 2014 expected population mix and the market level risk will be accounted for through risk adjustment transfer payments, the impact of those transfer payments must be adjusted for in the index rates. Essentially, the index rates are priced at a market average risk profile, and the extent to which HealthyCT's actual block of business differs from the market will be accounted for through these transfers rather than in the form of higher or lower premium. Therefore, to ensure the appropriateness of HealthyCT's allocation of the risk adjustment transfers across the entire portfolio of plans in the risk pool, we developed premiums at the market level risk score, as opposed to developing them at HealthyCT's expected morbidity level. The difference between the market average risk pool and HealthyCT's expected morbidity is our estimate of what the transfer payments will be. This approach ensures that the impact is allocated proportionately based on plan premiums for all plans within a risk pool.

The following section outlines our approach for estimating the impact of risk adjustment for these products.

Project Statewide Risk Scores for Use in the Risk Adjustment Transfer Payment

We projected statewide risk scores (to estimate HealthyCT's risk adjustment transfer payment) by inferring the health status of the projected insured population by cohort using the self-reported health status field in the CPS data. We inferred a reasonable relative health status factor for each self-reported health status category based on the proportion of members within each self-reported health status category as well as risk scores generated for a large population dataset using MARA. We adjusted these inferred relative health status factors for age/gender claim cost factors from the HCGs to produce final statewide average risk scores for each population cohort.

Project HealthyCT's Risk Scores for Use in the Risk Adjustment Transfer Payment

We projected HealthyCT's risk scores (to estimate HealthyCT's risk adjustment transfer payment) by adjusting the statewide average risk scores by cohort for expected selection and coding intensity

differences between HealthyCT and the overall Connecticut market. Selection refers to the health status difference between a given carrier and the overall market due to member plan selection. Coding intensity refers to a differing frequency and accuracy with which diagnosis codes are captured in claims data impacting the calculated risk score of the population. We did not model the impact of selection between the metal plans (even though we expect it to occur) since carriers are not allowed to rate for selection between the metal tiers.

Estimate 2014 Statewide Average Claims for the Risk Adjustment Transfer Payments

In the CMS risk adjuster transfer formula, the average premium in the state is the basis for calculating transfer payments. We estimated statewide claim costs (to estimate the statewide premium in HealthyCT's risk adjustment transfer payment) by applying steps 1-6 above to estimate the PMPM claim costs for platinum, gold, silver, and bronze plans that would be sold throughout the state. HealthyCT is not selling platinum products, but we did assume some percentage of take-up of platinum plans in the marketplace as a whole.

Estimate HealthyCT's Risk Adjustment Transfer Payment

We estimated HealthyCT's risk adjustment transfer payment using the CMS formula, which includes the statewide average premium, induced demand factor, geographical cost factor, HealthyCT's risk score by plan, the plan's actuarial value, and allowable rating factors. The key determinant of whether HealthyCT receives or makes a transfer payment is how HealthyCT's risk score (normalized across all carriers) compares to the product of the actuarial value and allowable rating factors (normalized across all carriers).

We estimated the statewide average premium by adding HealthyCT's expenses to the statewide average claim costs described above. Next, we normalized HealthyCT's risk score to the statewide average risk score and removed the portion of HealthyCT's risk score that can be accounted for through age rating factors, leaving an "uncompensated risk" factor. We then multiplied the "uncompensated risk" factor by the state average premium PMPM to estimate the net risk adjustment PMPM received or paid by HealthyCT.

STEP 8: ESTIMATE IMPACT OF TRANSITIONAL REINSURANCE

Small group plans are not eligible to have any expenses reimbursed by the transitional reinsurance program. However, small group issuers must pay into the program at a rate of $5.25 PMPM. We have included this assessment in our premiums.

STEP 9: CALCULATE INDEX RATE AND PLAN-SPECIFIC ADJUSTMENTS

After estimating claim costs for all products (steps 1-6) and expected payments under the risk adjuster program (step 7) and transitional reinsurance program (step 8), we applied the retention loads discussed in Section F 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, net of risk adjuster	$355.47
B. Transitional reinsurance expense, net of recoveries	$5.25
C. Other administrative expenses	$80.45
D. Provision for profit and contingencies	$4.46
E. Total required premium (= A + B + C + D)	$445.63
F. Average of allowable rating factors (age, plan type)	1.6093
G. Index rate (= E/F)	**$276.91**

The administrative expenses and provision for profit and contingencies shown in Table 3 ($80.45 and $4.46) are the result of applying the retention percentages shown in Section F above.

The average allowable rating factor (1.6093) shown in Table 3 is the result of the following formula:

$$\overline{\mathrm{ARF}} = \frac{\sum_{i=1}^{n}[\mathrm{age}_i * \mathrm{plan}_i]}{n}$$

Where:

$$\overline{\mathrm{ARF}} = \text{Average allowable rating factor}$$

$$\mathrm{age}_i = \text{Age factor for person i}$$

$$\mathrm{plan}_i = \text{Plan type factor for person i}$$

$$\mathrm{n} = \text{Total projected enrollment}$$

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 differences in actuarial value and cost sharing structure compared to the reference plan (Healthy Partner Basic was selected as the reference plan, with a 1.0000 factor). 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 $276.91:

Table 4 – Rating factors	
Factor	**Value**
Trend factor: Plan effective dates 1/1/2014 – 3/31/2014	1.0000
Trend factor: Plan effective dates 4/1/2014 – 6/30/2014	1.0182
Trend factor: Plan effective dates 7/1/2014 – 9/30/2014	1.0368
Trend factor: Plan effective dates 10/1/2014 – 12/31/2014	1.0557
Plan design factor: Healthy Partner Preferred	1.5352

Table 4 – Rating factors (continued)	
Plan design factor: Healthy Partner Max	1.3474
Plan design factor: Healthy Partner Essential	1.1906
Plan design factor: Healthy Partner Basic	1.0000
Plan design factor: Healthy Partner Preferred Pro	1.5544
Plan design factor: Healthy Partner Select Plus	1.2741
Plan design factor: Healthy Partner Select	1.1689
Plan design factor: Healthy Partner Basic Plus	1.0131
Tobacco rating factor	1.0000
Rating area 1: Fairfield County	1.101
Rating area 2: Hartford County	0.916
Rating area 3: Litchfield County	0.901
Rating area 4: Middlesex County	0.993
Rating area 5: New Haven County	1.000
Rating area 6: New London County	1.071
Rating area 7: Tolland County	0.886
Rating area 8: Windham County	1.000
Age	See Addendum A

Addendum A: Age factors

Under 45 CFR §147.102, all carriers in each state must use a standardized set of age factors. There is a federal default which is to be used in states (such as Connecticut) that do not set their own factors. The following are the age factors that will be used as multiplicative adjustments to the market-wide index rate.

Table A.1 – Age Factors

Age	Factor	Age	Factor
0-20	0.635	43	1.357
21	1.000	44	1.397
22	1.000	45	1.444
23	1.000	46	1.500
24	1.000	47	1.563
25	1.004	48	1.635
26	1.024	49	1.706
27	1.048	50	1.786
28	1.087	51	1.865
29	1.119	52	1.952
30	1.135	53	2.040
31	1.159	54	2.135
32	1.183	55	2.230
33	1.198	56	2.333
34	1.214	57	2.437
35	1.222	58	2.548
36	1.230	59	2.603
37	1.238	60	2.714
38	1.246	61	2.810
39	1.262	62	2.873
40	1.278	63	2.952
41	1.302	64+	3.000
42	1.325		

Addendum B: Provisions which differ between state and federal requirements

ACTUARIAL VALUE CERTIFICATION FOR STANDARD EXCHANGE PLANS

Under federal rules (45 CFR §156.135), the actuarial value calculator provided by HHS is how actuarial value is defined for all plans, unless the cost sharing features are "not compatible" with the calculator. In that case, it is permitted to either adjust the inputs to the calculator such that they can be fit into it, or adjust the calculator's output to account for features that cannot be measured by the calculator. For three of the plan designs being mandated by Access Health CT, the AV calculator does not yield an acceptable actuarial value within the de minimis variation of the required coverage levels, permitted by 45 CFR §156.140(c).

Access Health CT engaged Gorman Actuarial to make adjustments outside the calculator due to the presence of separate medical and prescription drug deductibles, citing "counterintuitive results" from the calculator (even though separate drug deductibles can easily be accommodated by the calculator). In a telephone conference on April 17, 2013, Access Health CT instructed all carriers that they should rely on Gorman's certification of the actuarial values. We have relied upon the certification provided by Gorman Actuarial, to affirm that these benefit designs comply with applicable state and federal law.

MENTAL HEALTH PARITY

Section 1301 of the ACA gives state exchanges (in this case, Access Health CT) the authority to certify health plans as qualified health plans (QHPs). Access Health CT is requiring that in order to participate in the state exchange and be certified as a QHP, issuers must offer a set of prescribed benefit designs (one gold, one silver, and two bronzes). We believe that the required benefit designs for the two bronze products are inconsistent with the requirements of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) and its implementing regulations (hereafter, "the IFR," published in the Federal Register on February 2, 2010, pages 5410-5451) due to the presence of copayments on behavioral health outpatient in-network services where substantially all medical/surgical in-network outpatient services are not subject to copayments.

HealthyCT, Inc.
Small Group Comprehensive Medical Business
Rate Filing Justification
Part III - Actuarial Memorandum and Certification

I. General Information

Company Identifying Information

Company Legal Name:	HealthyCT, Inc.
State:	Connecticut
HIOS Issuer ID:	91069
Market:	Small group
Effective Date:	January 1, 2014

Company Contact Information

Primary Contact Name:	Bob Carey
Primary Contact Telephone Number:	617-470-3614
Primary Contact Email-Address:	r.l.carey@comcast.net

II. Proposed Rate Increase(s)

This submission is for new products available for sale January 1, 2014. HealthyCT, Inc. (HealthyCT) is a new entrant to this market, and therefore there are currently no policies, certificates, or covered lives. Because these are new products, there are no proposed rate increases as there were no prior products against which to compare these rates.

Because no prior claim experience was available for this product, the Milliman *Health Cost Guidelines* cost and utilization information was used in the development of these rates. Considerations for premium rate development include:

- Proposed benefit plan designs for new products;
- Anticipated medical trend, both utilization and cost of services;
- Anticipated changes in the average morbidity of HealthyCT's market given underwriting, rating, and benefit requirements effective January 1, 2014, under the Patient Protection and Affordable Care Act (ACA);
- Applicable taxes and fees, including those that are applicable in 2014 under the ACA; and
- Anticipated contributions to the Federal Transitional Reinsurance Program.

Each of these factors is discussed in more detail later in this memorandum.

III. Experience Period Premium and Claims

Claims Paid Through Date

HealthyCT is a new carrier in the small group market, and as such does not have any prior claim experience. Therefore, no claim experience is provided in Worksheet 1, Section I of the Unified Rate Review Template (URRT) for the experience period.

Premiums (net of MLR Rebate) in Experience Period

HealthyCT is a new carrier in the small group market, and as such has not collected any prior premiums in this market. Therefore, no experience period premium information is provided in Worksheet 1, Section I of the Unified Rate Review Template (URRT) for the experience period.

Allowed and Incurred Claims Incurred During the Experience Period

HealthyCT is a new carrier in the small group market, and as such does not have any prior claim experience. Therefore, no claim experience is provided in Worksheet 1, Section I of the Unified Rate Review Template (URRT) for the experience period. Premiums were developed using a credibility manual rating approach.

IV. Benefit Categories

HealthyCT is a new carrier, and as such does not have any prior claim experience in the small group market. Therefore, no claim experience is provided in Worksheet 1, Section I of the Unified Rate Review Template (URRT) for the experience period.

Because no prior claim experience was available for this product, the Milliman *Health Cost Guidelines* (HCGs) cost and utilization information was used in the development of these rates.

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.

The HCGs provide a flexible but consistent basis for the determination of claim costs for a wide variety of health benefit plans. These rating structures are used to anticipate future claim levels, evaluate past experience and establish interrelationships between different health coverages.

The HCGs are a cooperative effort of all Milliman health actuaries and represent a combination of their experience, research and judgment. An extensive amount of data is used in developing these guidelines, including published and unpublished data. In most instances, cost assumptions are based upon our evaluation of several data sources and, hence, are not specifically attributable to a single source. Since these guidelines are a proprietary document of Milliman, they are only available for release to specific clients that lease these guidelines and to Milliman consulting health actuaries.

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.

The HCGs include detailed claim cost and utilization assumptions, which are readily available in a format consistent with the benefit categories in Section II of the URRT based on a detailed claims mapping algorithm. The claim cost basis from the HCGs was allocated directly to the following categories:

- Inpatient Hospital
- Outpatient Hospital
- Professional
- Other Medical
- Capitation (*which was not applicable in this context*)
- Prescription Drug

V. Projection Factors

HealthyCT is a new carrier, and as such does not have any prior claim experience. Therefore, as mentioned previously we used the Milliman *Health Cost Guidelines* with adjustments as the basis for these rates. This section describes the projection factors we used with the HCGs to develop the credibility manual rates for the projection period.

Projections and Adjustments Made to the Data

Because the process for projecting and adjusting the data used to estimate the claim costs for these products involved a number of steps that are interrelated, the entire process is described here and will be used for reference throughout this document.

Claim costs for proposed plans were developed using the Milliman HCGs, with adjustments to reflect the relative value of HealthyCT's small group experience compared to the Milliman HCGs. Additional adjustments were made to reflect

anticipated changes in the average morbidity of the underlying experience given underwriting, rating, and benefit requirements effective January 1, 2014, under ACA.

We followed the steps below, to adjust the Milliman *Health Cost Guidelines* claim experience to be on an appropriate basis for premiums for HealthyCT.

Step 1: Project Total Connecticut Market Members and Health Status by Population Cohort

We expect significant shifts in the insured population when the health insurance Exchange opens in 2014. We projected Connecticut statewide population demographics and health status to help determine HealthyCT's share of the market.

The statewide market projections are based on the estimated population at the end of 2013, stratified by current insurance status, poverty status (income relative to FPL), health status, and family size. The Current Population Survey (CPS) from the U.S. Census provides state-level data for each of these strata. We adjusted the raw CPS data after reviewing the following additional data sources:

- Carriers' annual statutory financial filings provided to the NAIC. The filings contain reliable sizes of the individual and fully insured group markets.

- The Medicaid Statistical Information System (MSIS) (available through the Department of Health and Human Services), which provides reliable data on Medicaid enrollment in Connecticut.

We trended the entire population from 2011 to 2014 based on projected population growth rates. We then estimated the proportion of the population that will purchase coverage on the individual and SHOP Exchanges (i.e., "take up" rates). The Exchange take-up rate assumptions are primarily driven by a person's current insurance status (i.e., insured or uninsured) and the federal subsidy available (if any) if the member enrolls in an individual Exchange plan.

We then applied employer-sponsored insurance transition rates, small group, and individual / uninsured Exchange take-up rates to estimate the population counts in each market (stratified by income-to-poverty ratio, health status, and family size).

For HealthyCT's products, the result is a 2014 statewide population projection by cohort (i.e., age, gender, income, and Exchange status). Finally, we applied a smoothing algorithm to compensate for potential credibility issues.

Step 2: Project HealthyCT Enrollment by Market, Exchange Status, and Product

We projected HealthyCT's expected 2014 small group product enrollment on and off the exchange based on our estimate of the statewide population and HealthyCT's likely share of the total based on our assumed price relativity and appeal. We

estimated the members that would select each of HealthyCT's benefit plans based on the expected appeal of the plan options. We also assumed that all 2014 members are enrolled for the entire year.

Step 3: Claim Cost Projection

The basis used to develop rates for these new products is the 2012 Milliman *Health Cost Guidelines*. 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.

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.

Step 4: Adjustment for Changes in Morbidity

The data in the *Guidelines* is for a large group population. We believe this is a more appropriate basis for the development of future small group premium rates than current small group claim levels because large group experience includes a breadth of covered benefits consistent with those in the Essential Health Benefits (EHBs), and the impact of selection or medical underwriting present in the current small group market is mitigated by using non-underwritten large group experience. The *Guidelines* are based on the 2012 large group population. We project that the 2014 small group market population will have a similar population profile as the current large group market.

Changes in the Morbidity of the Population Insured

We anticipate little change in the average morbidity of this market in 2014 due to ACA provisions effective in January 2014. Please see Step 4 in the "Projections and Adjustments Made to the Data" section above for a description of the development of the adjustment factor.

The projection factor of "Pop'l risk Morbidity" shown in Worksheet 1, Section II reflects the impact of the shift in mix over time. This projection factor was calculated based on our projection from the current credibility manual experience to the 2014

small group market morbidity. Note that this factor does not include the impact of changes in demographics.

Changes in Benefits

The underlying utilization and charge levels assumed in the 2012 Milliman *Health Cost Guidelines* baseline data are typical of a comprehensive major medical plan with a $500 deductible, 80% coinsurance, and a $2,000 out of pocket maximum. Adjustments were then made to reflect changes in utilization levels associated with different covered benefits (benefit limits and cost sharing). These adjustments have been created by studying the historical impact of different contractual limitations and cost sharing on utilization experience by the covered population.

The adjustments we used to develop utilization rates consistent with these products are as follows:

- Starting with large group experience enables us to capture the impact of removal of underwriting and pre-existing condition exclusions in the current small group market, post 2014.
- Adjusted for the difference between the current large group and future (2014) small group market average risk status. This analysis involved a study of morbidity levels and relied on CPS data. The analysis is described in Step 4 of the following section.
- Adjusted for differences in benefit designs (e.g., metallic levels).
- Adjusted for changes from mandated benefits (e.g., EHBs)

Changes in Demographics

We expect minimal shifts in the insured small group population when the health insurance Exchange opens in 2014. We projected Connecticut statewide population demographics and health status to help determine HealthyCT's share of the market. Because we are using the HCGs as the basis of these premiums, we adjusted those data to be on a basis consistent with our projections of the demographics in 2014. Please see Step 1 in the "Projections and Adjustments Made to the Data" section above for more details for these adjustments.

Other Adjustments

Because we are using the HCGs as the basis for these premiums, there are additional adjustments necessary to put the claim experience on a consistent basis with these products. Please see Steps 1-4 in the "Projections and Adjustments Made to the Data" section for more details surrounding additional adjustments we made.

Annualized Trend Factors

The utilization and cost trend factors shown in Worksheet 1, Section II are reflective of an aggregate allowed cost trend of 7.5%. This aggregate value was developed based on the Milliman *Health Cost Guidelines* and general industry knowledge regarding recent trends in medical inflation.

Separate factors for utilization and cost were developed based on relative values from the Milliman *Health Cost Guidelines*. Factors were developed such that the aggregate value is 7.5%.

These trend assumptions are based on the utilization and cost per service trends developed from claims data for the *Guidelines*. We have reviewed these trend assumptions and believe they are reasonable for this purpose. The trend assumptions above do not include the impact of changes in demographics, benefit design, or morbidity since those are captured elsewhere in the development of the index rate.

VI. Credibility Manual Rate Development

HealthyCT is a new carrier in the small group market, and as such does not have any prior claim experience. Therefore, as mentioned previously we used the Milliman *Health Cost Guidelines* with adjustments as the basis for these rates.

Source and Appropriateness of Experience Data Used

The base experience for the proposed plans was composed of claim costs developed using the Milliman *Health Cost Guidelines*, chosen to reflect the demographic and unit cost differences specific to Connecticut, as well as HealthyCT's plan benefit designs. Additional adjustments were considered to reflect anticipated changes in the average morbidity of the underlying experience given underwriting, rating, and benefit requirements effective January 1, 2014, under ACA. The *Health Cost Guidelines* are described in sections "IV Benefit Categories" and "Projections and Adjustments Made to the Data" above.

Adjustments Made to the Data

Adjustments made to the *Health Cost Guidelines* to create estimated claim costs for these products are described in detail in section "Projections and Adjustments Made to the Data" above.

Inclusion of Capitation Payments

The HCGs are based on nationwide claim experience, which include a complete picture for incurred and allowed dollars. These data include relevant capitation payments as part of the underlying claim experience.

Portion of Cost Payable by HHS's Fund on Behalf of Insureds

Cost sharing subsidies are not available in the small group market.

VII. Credibility of Experience

HealthyCT is a new carrier in the small group market, and as such does not have any prior claim experience. Therefore, as mentioned previously we used the Milliman *Health Cost Guidelines* with adjustments as the basis for the Credibility Manual rates and have given them 100% credibility weight.

VIII. Paid to Allowed Ratio

The Paid to Allowed ratio shown in Worksheet 1, Section II of the URRT was developed as our best estimate of the impact on cost sharing. We developed allowed claim costs, and used the Milliman HCGs to develop the expected portion of claims that are covered by the plan versus the member to develop the paid to allowed ratio. The paid to allowed ratio was developed as follows:

$$\frac{Weighted\ Average\ Paid\ Claim\ PMPM\ estimate}{Weighted\ Average\ Allowed\ Claim\ PMPM\ Estimate}$$

IX. Risk Adjustment and Reinsurance

Projected Risk Adjustments PMPM

HealthyCT recognizes that to operate within a single risk pool, issuers are required to make a market-wide adjustment to the pooled market level index rate to account for federal risk adjustment payments. Therefore, HealthyCT must allocate anticipated risk adjustment revenue proportionately across all plans in the risk pool based on plan premiums by applying the risk adjustment transfer as a constant multiplicative factor across all plans. We have developed an estimate of the risk adjustment revenue for all of HealthyCT's plans in this risk pool.

Since differences between HealthyCT's 2014 expected population mix and the market level risk will be accounted for through risk adjustment transfer payments, the impact of those transfer payments must not be included in the index rates. Essentially, the index rates are priced at a market average risk profile, and the

extent to which HealthyCT's actual block of business differs from the market will be accounted for through these transfers rather than in the form of higher or lower premium. Therefore, to ensure the appropriateness of HealthyCT's allocation of the risk adjustment transfers across the entire portfolio of plans in the risk pool, we developed premiums at the market level risk score, as opposed to developing them at HealthyCT's expected morbidity level. The difference between the market average risk pool and HealthyCT's expected morbidity is our estimate of what the transfer payments will be. This approach ensures that the impact is allocated proportionately based on plan premiums for all plans within a risk pool.

The following section outlines our approach for estimating the impact of risk adjustment for these products.

Project Statewide Risk Scores for Use in the Risk Adjustment Transfer Payment

We projected statewide risk scores (to estimate HealthyCT's risk adjustment transfer payment) by inferring the health status of the projected insured population by cohort using the self-reported health status field in the CPS data. We inferred a reasonable relative health status factor for each self-reported health status category based on the proportion of members within each self-reported health status category as well as risk scores generated for a large population dataset using the Milliman Advanced Risk Adjuster (MARA). We adjusted these inferred relative health status factors for age / gender claim cost factors from Milliman's *Health Cost Guidelines* to produce final statewide average risk scores for each population cohort.

Project HealthyCT*'s Risk Scores for Use in the Risk Adjustment Transfer Payment*

We projected HealthyCT's risk scores (to estimate HealthyCT's risk adjustment transfer payment) by adjusting the statewide average risk scores by cohort for expected selection and coding intensity differences between HealthyCT and the overall Connecticut market. Selection refers to the health status difference between a given carrier and the overall market due to member plan selection. Coding intensity refers to a differing frequency and accuracy with which diagnosis codes are captured in claims data impacting the calculated risk score of the population. We did not model the impact of selection between the metal plans (even though we expect it to occur) since carriers are not allowed to rate for selection between the metal tiers.

Estimate 2014 Statewide Average Claims for the Risk Adjustment Transfer Payments

We estimated HealthyCT's risk adjustment transfer payment using the CMS formula, which includes the statewide average premium, induced demand factor,

geographical cost factor, HealthyCT's risk score by plan, the plan's actuarial value, and allowable rating factors. The key determinant of whether HealthyCT receives or makes a transfer payment is how HealthyCT's risk score (normalized across all carriers) compares to the product of the actuarial value and allowable rating factors (normalized across all carriers).

We estimated the statewide average premium by adding HealthyCT's expenses to the statewide average claim costs described above. Next, we normalized HealthyCT's risk score to the statewide average risk score and removed the portion of HealthyCT's risk score that can be accounted for through age rating factors, leaving an "uncompensated risk" factor. We then multiplied the "uncompensated risk" factor by the state average premium PMPM to estimate the net risk adjustment PMPM received by HealthyCT.

Estimate HealthyCT's Risk Adjustment Transfer Payment

We estimated HealthyCT's risk adjustment transfer payment using the CMS formula, which includes the statewide average premium, induced demand factor, geographical cost factor, HealthyCT's risk score by plan, the plan's actuarial value, and allowable rating factors. The key determinant of whether HealthyCT receives or makes a transfer payment is how HealthyCT's risk score (normalized across all carriers) compares to the product of the actuarial value and allowable rating factors (normalized across all carriers).

We estimated the statewide average premium by adding HealthyCT's expenses to the statewide average claim costs described above. Next, we normalized HealthyCT's risk score to the statewide average risk score and removed the portion of HealthyCT's risk score that can be accounted for through age rating factors, leaving an "uncompensated risk" factor. We then multiplied the "uncompensated risk" factor by the state average premium PMPM to estimate the net risk adjustment PMPM received (or paid) by HealthyCT.

Projected ACA Reinsurance Recoveries Net of Reinsurance

Carriers pay contributions for the ACA reinsurance program, estimated to be $5.25 PMPM in 2014. Consistent with the Part III Actuarial Memorandum instructions, which state that this line item must be reported net of reinsurance contributions, we have included this payment on Worksheet 1, Section II of the URRT.

We estimated additional costs due to the Federal transitional reinsurance program. Differences exist between the markets since only the individual market is subsidy-eligible. We assumed both markets on and off the Exchange will pay $5.25 PMPM in reinsurance contributions.

X. Non-Benefit Expenses and Profit & Risk

Administrative Expense Load

Administrative expenses were developed on a PMPM basis using on HealthyCT's 2013 business plan, with adjustments for anticipated changes in 2014, including general expense inflation. The value entered in Worksheet 1, Section III of the URRT illustrates this value as a percent of the index rate.

Profit & Risk Load

Profit and Risk Load target values were determined as an aggregate value for the single-risk pool based on company targets and consideration for federal MLR requirements. The value entered in Worksheet 1, Section III of the URRT illustrates this value as a percent of the index rate.

Taxes and Fees

Table 2 provides a breakdown of projected taxes and fees illustrated in Worksheet 1, Section III of the URRT.

Table 2
Projected Taxes and Fees

Item	% of Premium	PMPM	% of Index Rate
Premium Tax	1.50%	$6.68	1.31%
Health Insurer Fee	0.00%	$0.00	0.00%
Comparative Effectiveness Research	0.04%	$0.17	0.03%
Risk Adjustment Admin Fee	0.02%	$0.08	0.02%
Exchange User Fee	0.00%	$0.00	0.00%
Transitional Reinsurance Premium	1.18%	$5.25	1.03%
Total	2.73%	$12.18	2.39%

We believe the exchange fee/assessment will be $0 for HealthyCT since the assessment as currently described is based on 2013 market share (according to the draft "Application for Participation" released by the exchange April 23, 2013). As a new entity, HealthyCT had no business in 2013. We reserve the right to submit updated premium rates if the exchange releases a non-zero assessment or fee for HealthyCT's business.

XI. Projected Loss Ratio

The projected loss ratio based on the federally prescribed MLR methodology is 84.0%. The numerator of the projected MLR contains projected claim costs and quality improvement expenses, net of receipts from the risk adjuster, reinsurance, and risk corridors programs. The denominator consists of total premiums, net of premium taxes and regulatory fees. A credibility adjustment is then applied to account for the size of HealthyCT's enrollment. The following demonstrates our projection of HealthyCT's MLR, using the federal definition but not including any credibility adjustment (which could only increase the MLR):

$$84.0\% = \frac{\$348.87\ claims + \$8.00\ QI + \$5.25\ transitional\ reinsurance\ premiums + \$6.60\ risk\ adjuster\ payments}{\$445.63\ Premiums - \$6.93\ Premium\ taxes\ and\ regulatory\ fees}$$

XII. Index Rate

As previously discussed, HealthyCT is a new carrier and as such does not have prior claim experience to use to develop an experience period index rate. We used a credibility manual approach, in which the base claims did not include cost for items which are not EHBs, and therefore did not need to be adjusted for the removal of non-EHBs.

The projected index rate includes the projected claim level for the projection period, including all adjustments for trend, benefit and demographic differences. It reflects the experience for all of the products we are developing since they are within a single risk pool. The projected index rate shown in Worksheet 1, Section II of the URRT was developed as follows:

Projected Allowed Claims PMPM x % of Allowed Claims Attributable to EHB

Projected allowed claims are those after credibility adjustments, but before any adjustment for risk adjuster or reinsurance payments and/or recoveries.

Development of Plan Level Rates

Plan level rates are developed based on the following approach:

Adjusted Index Rate =
- Index Rate
- +/- Risk Adjustment Payment
- +/- Reinsurance Recoveries net of Fees
- + User Exchange Fees

Plan Level Rate =

Adjusted Index Rate
x Plan actuarial value and cost sharing value factor
x Administrative costs, excluding user exchange fees

Note that the plan actuarial value and cost sharing factors as presented in this memorandum already include any differences due to plan provider network, delivery system characteristics, and utilization management practices.

XIII. AV Metal Levels

The AV Metal Values included in Worksheet 2, Section I of the URRT were developed based on the CMS Actuarial Value calculator.

We did not employ an alternate methodology to develop the AV Metal Values.

XIV. AV Pricing Values

The fixed reference plan selected for purposes of developing AV Pricing Values is Healthy Partner Basic.

Plan factors were derived based on the actuarial value of these products and the age/gender mix of the standard *Guidelines* population. The plan factors reflect differences in the provider reimbursement rates and degree of healthcare management expected between the various HealthyCT plans. The plan factors below do not incorporate differences in morbidity; overall morbidity is reflected in other rating factors and the index rate. Plan factors are presented in the table below:

Product	Rate Factor	URRT AV Pricing Value
Healthy Partner Preferred	1.5352	1.170
Healthy Partner Max	1.3474	1.033
Healthy Partner Essential	1.1906	0.896
Healthy Partner Basic	1.0000	0.766
Healthy Partner Preferred Pro	1.5544	1.181
Healthy Partner Select Plus	1.2741	0.970
Healthy Partner Select	1.1689	0.890
Healthy Partner Basic Plus	1.0131	0.749

Attachment A provides a summary of the AV pricing values by plan, as illustrated in Worksheet 2, Section I, and the portion of the value that is attributable to each of the allowable modifiers to the index rate, as described in 45 CFR Part 156, §156.80(d)(2).

Plan	AV Pricing Value	Adjust 1 AV/Cost Share	Adjust 2 Network	Adjust 3 Other Benefits	Adjust 4 Admin Expense	Total
Healthy Partner Preferred	1.170	100%	0%	0%	0%	100%
Healthy Partner Max	1.033	100%	0%	0%	0%	100%
Healthy Partner Essential	0.896	100%	0%	0%	0%	100%
Healthy Partner Basic	0.766	100%	0%	0%	0%	100%
Healthy Partner Preferred Pro	1.181	100%	0%	0%	0%	100%
Healthy Partner Select Plus	0.970	100%	0%	0%	0%	100%
Healthy Partner Select	0.890	100%	0%	0%	0%	100%
Healthy Partner Basic Plus	0.749	100%	0%	0%	0%	100%

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 Milliman *Health Cost Guidelines* 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.

XV. Membership Projections

Membership projections, as illustrated in Worksheet 2, Section IV of the URRT were developed by applying an assumed market penetration for HealthyCT to the total market size estimated as described above in Section V.

Membership projections, as illustrated in Worksheet 2, Section IV of the URRT were developed based primarily on U.S. Census data and Milliman internal research. The Current Population Survey (CPS) from the U.S. Census for the year 2012 was used to develop initial market size estimates. These market sizes were trended forward to 2014 at a population trend rate of 0.25%.

We estimate a Connecticut uninsured population of 229,000 at the end of 2013. We estimate that this uninsured population will decrease to 117,000 in 2014 due to the individual mandate and expansion of Medicaid. We estimate 255,000 members in the small group market at the end of 2013, decreasing to 230,000 in 2014, with approximately 1,000 of them purchasing coverage on the SHOP Exchange. Some members of small group plans in 2013 are expected to transition to have individual coverage in 2014.

We assume a market penetration of 2.5% of the off exchange market. We expect only small enrollment on the exchange.

XVI. Terminated Products

HealthyCT is a new entrant to the market, and so does not have any current products. Therefore, no products will be terminated.

XVII. Plan Type

The applicable plan type for each plan has been noted in Worksheet 2, Section I of the URRT.

XVIII. Warning Alerts

The following provides additional information regarding differences between the sum of the plan level experience and projections in Worksheet 2, Sections III and IV of the URRT and the total experience and projected amounts found on Worksheet 1 of the URRT:

There is a warning in cell A82 of Worksheet 2. This warning is attributable to the fact that the workbook will not validate if zeroes are entered in R28 and S28 of Worksheet 1. Because there is no capitation in this plan, zero would be the appropriate values for those cells. To allow the worksheet to validate, we have instead entered 1 in those cells, which causes a difference of approximately $17 between B82 and F82 on Worksheet 2.

XIX. Reliance

In preparing the Part I Unified Rate Review Template (URRT) and Part III Actuarial Memorandum, I have relied on information provided to me by the management of HealthyCT, Inc. In particular, information has been provided by the following employees and contractors of HealthyCT:

- Ken Lalime, Chief Executive Officer
- Bob Carey, Consultant to HealthyCT

- Maryann Gaynor, Senior Vice President Clinical Operations
- Alex Hutchinson, Consultant to HealthyCT, and
- Christopher Masi, Chief Financial Officer.

This information includes provider discounts, utilization management initiatives, market information, financial information, benefit design guidance, and compliance requirements.

I also relied on an actuarial certification prepared by Bela Gorman, FSA, MAAA, certifying the actuarial values of the Healthy Partner Preferred plan and the Healthy Partner Max plan.

To the extent that this information is incomplete or inaccurate, the contents of the URRT and Actuarial Memorandum may be materially affected.

XX. Actuarial Certification

I, Stephen P. Melek, am a member of the American Academy of Actuaries and I meet the Qualification Standards of the American Academy of Actuaries to render the actuarial opinion contained herein. This filing is prepared on behalf of HealthyCT, Inc. (the "Company").

I am affiliated with Milliman, Inc. ("Milliman"), an independent actuarial consulting firm that is not affiliated with, nor a subsidiary, nor in any way owned or controlled by a health plan, health insurer, or a trade association of health plans or insurers.

I hereby certify that the projected index rate is, to the best of my knowledge and understanding:

- In compliance with all applicable State and Federal Statutes[1] and Regulations (45 CFR 156.80(d)(1)),
- Developed in compliance with the applicable Actuarial Standards of Practice
- Reasonable in relation to the benefits provided and the population anticipated to be covered
- Neither excessive nor deficient

I certify that the index rate and only the allowable modifiers as described in 45 CFR 156.80(d)(1) and 45 CFR 156.80(d)(2) were used to generate plan specific premium rates. The allowable modifiers used to generate plan specific premium rates were based on the following:

[1] I believe that the two prescribed bronze products required in order to offer products on the exchange are inconsistent with the requirements of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) and its implementing regulations (hereafter, "the IFR," published in the Federal Register on February 2, 2010, pages 5410-5451) due to the presence of copayments on behavioral health outpatient in-network services.

- The actuarial value and cost-sharing design of the plan.
- The plan's provider network, delivery system characteristics, and utilization management practices.
- The benefits provided under the plan that are in addition to the Essential Health Benefits. These estimated benefits were pooled with similar benefits within the single risk pool and the claims experience from those benefits was utilized to determine rate variations.
- Administrative costs, excluding Exchange user fees.

I certify that the percent of total premium that represents Essential Health Benefits included in Worksheet 2, Sections III and IV were calculated in accordance with Actuarial Standards of Practice.

I certify that the benefits included in HealthyCT's plans are substantially equivalent to the Essential Health Benefits (EHBs) in the State of Connecticut benchmark plans.

I certify that the AV Calculator was used to determine the AV Metal Values shown in Worksheet 2 of the Part I Unified Rate Review Template for all plans except those specified in the certifications attached to this memorandum. The AV Metal Values included in Worksheet 2 of the Part I Unified Rate Review Template were based on the Federal AV Calculator.

For the Healthy Partner Preferred Pro plan, the benefit design includes a copay for outpatient surgery. The AV calculator does not permit a copay to be entered for outpatient surgery. A certification is attached describing the adjustment that was made to the AV calculator inputs.

For the Healthy Partner Max and the Healthy Partner Preferred plans, the AV calculator was not used without adjustment. These plan designs, which have been mandated by the state exchange, have been certified to comply with the requirements of 45 CFR §156.135(b) by Bela Gorman, FSA, MAAA, of Gorman Actuarial. That certification is attached, per the instructions provided by personnel at Access Health CT during a teleconference on April 17, 2013. I was not involved in creating this certification.

The Part I Unified Rate Review Template (URRT) does not demonstrate the process used to develop proposed premium rates. It is representative of information required by Federal regulation to be provided in support of the review of rate increases, for certification of qualified health plans for Federally Facilitated Exchanges and for certification that the index rate is developed in accordance with Federal regulation and used consistently and only adjusted by the allowable modifiers.

Signed: 

_____

Stephen P. Melek, FSA, MAAA
Member, American Academy of Actuaries

Dated: May 3, 2013

Actuarial Value Calculator: Certification of Actuarial Judgment Deviation

I, Stephen P. Melek, am a member of the American Academy of Actuaries and I meet the Qualification Standards of the American Academy of Actuaries to render the actuarial opinion contained herein.

I certify that the Actuarial Value (AV) Calculator was used to determine the AV Metal Values shown in Worksheet 2 of the Part I Unified Rate Review Template for all plans except those specified in this certification, and except for the plans specified in the attached certification by Bela Gorman, FSA, MAAA. The AV Metal Values included in Worksheet 2 of the Part I Unified Rate Review Template were based on the Federal AV Calculator.

For the following categories, it was necessary to employ actuarial judgment in completing the AV Calculator inputs, as the categories in the AV Calculator did not provide for as much specificity as did the plan's benefit variables. The values input into the AV Calculator, for these categories, were developed in accordance with generally accepted actuarial principles and methodologies.

- For outpatient surgery, the Healthy Partner Preferred Pro benefit design includes a copay. There is no mechanism to input a copay into this line in the AV calculator. Accordingly, I have assumed an approximate allowed charge per service of $4,500, consistent with data from Milliman's *Health Cost Guidelines*™. The $75 copay is therefore approximately equivalent to a coinsurance rate of 98.33%. I have entered this amount as coinsurance in the line "OP Facility (e.g., ASC)" to approximate the impact of the $75 copay. Attached is a copy of the AV calculator, showing the result.

For the following plan design features, it was necessary to make appropriate adjustments to the AV identified by the calculator as they deviated substantially from the parameters of the AV calculator. Only in-network cost-sharing features were considered in these adjustments.

- No adjustments were made to the calculator output.

Signed: 

Stephen P. Melek, FSA, MAAA
Member, American Academy of Actuaries

Dated: May 3, 2013

AV Calculator
HCT Gold

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Gold

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$750.00			
Coinsurance (%, Insurer's Cost Share)			80.00%			
OOP Maximum ($)			$5,000.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☐ All	☐ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$150.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$250.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$15.00	☑	☑		
Specialist Visit	☐	☐		$25.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☐	☐		$15.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☐		$75.00	☑	☑		
Rehabilitative Speech Therapy	☐	☐		$25.00	☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☐	☐		$25.00	☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☐		$75.00	☑	☑		
X-rays and Diagnostic Imaging	☑	☐		$25.00	☑	☑		
Skilled Nursing Facility	☑	☐		$250.00	☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	98.33%		☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☐			☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$10.00	☑	☑		
Preferred Brand Drugs	☐	☐		$25.00	☑	☑		
Non-Preferred Brand Drugs	☑	☐		$50.00	☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☐		$100.00	☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	81.2%
Metal Tier:	Gold

GORMAN ACTUARIAL, LLC

Memo

To: Connecticut Health Insurance Exchange – Grant Porter

From: Gorman Actuarial – Bela Gorman, Don Gorman, Jenn Smagula

Date: March 28, 2013

Re: Connecticut Standard Plan Design AV Certification

This memo summarizes the final actuarial values (AV) calculated using the HHS Actuarial Value Calculator (AVC)[1] with modifications made to account for separate medical and pharmacy deductibles. A separate document describes the methodologies used to derive the pharmacy deductible adjustments[2]. Adjustments to the Silver, Silver Cost Sharing Reduction (CSR) 0.73 and Gold standard plan designs were necessary due to their use of non-integrated deductibles. Adjusted AVs were calculated for various combinations of cost sharing elements, including medical deductible, pharmacy deductible, maximum out-of pocket maximum, drug copays and coinsurance, inpatient copays, etc. After reviewing the adjusted AVs, the Connecticut Health Insurance Exchange selected the final plan design attributes for their standard plans. A summary of the final plan designs are provided in Appendix A. In addition, each of the standard plan designs has an outpatient surgery copay. Since the AVC cannot handle member cost sharing in this form, the copay amounts have been translated into a coinsurance amount, as allowed for in section 45 CFR 156.135(b)(2)[3].

Table 1 shows the final adjusted AVs for each of the impacted standard plan designs.

Standard Plan Design	Adjusted Actuarial Value
Silver	71.97%
Silver CSR 0.73	73.81%
Gold	81.82%

Table 1 – Standard Plan Design Adjusted AVs

[1] http://cciio.cms.gov/resources/files/av-calculator-2-25-13.xlsm
[2] "Pharmacy Adjustment Methodology", March 2013; Access Health CT Pharmacy Adjustments.xlsx
[3] http://www.gpo.gov/fdsys/pkg/FR-2013-02-25/pdf/2013-04084.pdf

This section of this memo replicates the format of the responses requested to complete the "Unique Plan Design Supporting Documentation and Justification" document[4] required when a carrier submits a plan design for a Qualified Health Plan.

Reasons the plan design is unique (benefits that are not compatible with the parameters of the AV calculator and the materiality of those benefits):

Since the AVC does not support an outpatient surgery copay, the benefit plan is not compatible with the AVC. In addition, the AVC does not produce an accurate measure of a plan's generosity when there are separate medical and pharmacy deductibles.

Acceptable alternate method used per 156.135(b)(2) or 156.135(b)(3):

Per 45 CFR 156.135 (b)(2) the member cost sharing copay for outpatient surgery has been translated to a coinsurance amount. Per 45 CFR 156.135 (b)(3) adjustments have been made to the AVC output to modify the AVs using the methodology described in the methodology document titled "Pharmacy Adjustment Methodology", and the accompanying Excel file titled "Access Health CT Pharmacy Adjustments.xlsx".

Confirmation that only in-network cost sharing, including multitier networks, was considered:

Yes

Description of the standardized plan population data used:

The AVC was used to calculate baseline AVs, and these AVs were adjusted using the prescription drug continuance tables in the AVC. The population data used came from the AVC.

If the method described in 156.135(b)(2) was used, a description of how the benefits were modified to fit the parameters of the AV calculator:

A copay amount was translated into a coinsurance amount for the outpatient surgery benefit. This was done by assuming that the average outpatient surgery facility fee in 2014 is $1,500, and then translating the copay dollar amount into a percentage. For example, if the copay amount that a member pays is $500, then the coinsurance amount entered into the AVC for the "Outpatient Facility Fee (e.g., Ambulatory Surgery Center)"benefit is 66.67% (1- $500/$1500)[5]. A coinsurance charge was not entered for "Outpatient Surgery Physician/Surgical Services" because doing so would double count the impact of the outpatient surgery copay[6].

[4] http://www.serff.com/documents/plan_management_data_templates_help_instructions.zip, Chapter 13a

[5] This is the amount that the insurer pays.

[6] Based on discussions with CCIIO.

If the method described in 156.135(b)(3) was used, a description of the data and method used to develop the adjustments:

Please see the methodology described in the methodology document titled "Pharmacy Adjustment Methodology", and the accompanying Excel file titled "Access Health CT Pharmacy Adjustments.xlsx".

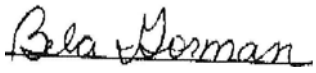
Certification Language:

The development of the actuarial value is based on one of the acceptable alternative methods outlined in 156.135(b)(2) or 156.135(b)(3) for those benefits that deviate substantially from the parameters of the AV Calculator and have a material impact on the AV.

The analysis was

(i) conducted by a member of the American Academy of Actuaries;

(ii) performed in accordance with generally accepted actuarial principles and methodologies;

Actuary signature: 

Actuary Printed Name: Bela Gorman, FSA MAAA

Date: March 28, 2013

Appendix A – Summary of Connecticut Standard Plan Designs

This is a summary of the benefit designs for the standard plan designs. It is included as an embedded PDF document. Double clicking on the image below will open the document in Adobe Acrobat.

Access Health CT - Members' Cost Sharing for Standard Plan Designs for Qualified Health Plans

	BRONZE, Option 1: HSA-eligible HDHP	BRONZE, Option 2: "Catastrophic"	SILVER	COST SHARING REDUCTION PLANS: SILVER - CSR-73	SILVER - CSR-87	SILVER - CSR-94	GOLD	PLATINUM
Acturial Value Final AV Calculator)	**61.6%**	**59.3%**	**72.0%**	**73.8%**	**87.8%**	**93.3%**	**81.8%**	**91.8%**
Deductible(s)								
Medical	$ 3,250	$ 6,250	3,000	2,500	500	-	1,000	-
Prescription Drugs			400	300	-		150	
Out-of-Pocket Maximum	$ 6,250	$ 6,250	$ 6,250	$ 5,200	$ 2,250	$ 2,000	$ 3,000	$ 2,000
Medical Benefits	***Subject to Deductible***	***Subject to Deductible***	***Subject to Medical Deductible***	***Subject to Medical Deductible***	***Subject to Medical Deductible***	***No Deductible***	***Subject to Medical Deductible***	***No Deductible***
Office Visits								
Preventive Care/Screening/Immunization	$ -		$ -	$ -	$	$ -	$	$ -
Primary Care Visit	30 ✓	30 ✓ *ded. waived for 3 primary care or mental health visits (or combination thereof)*	30	30	10	5	20	10
Specialist Visit	40% ✓	- ✓	45	45	30	15	45	30
Mental Health Visits	30 ✓	30 ✓	30	30	10	5	20	10
Habilitative and Rehabilitative Services (i.e. PT, OT, ST) *PT/OT/ST limited to a combined 40 visits For treatment of autism spectrum disorder, habilitative services are covered at parity and in accordance with state law*	40% ✓	- ✓	30	30	10	5	20	10
Laboratory Services	40% ✓	- ✓	30	30	10	5	20	10
X-Rays	40% ✓	- ✓	45	45	30	15	45	30
High-Tech Imaging (CT/PET Scans, MRIs) *Total annual copayments cannot exceed $375 for MRIs and CT scans, combined, or $400 for PET scans*	40% ✓	- ✓	75	75	75	50	75	75
Emergency Room Services	40% ✓	- ✓	150	150	100	75	150	100
Urgent Care	40% ✓	- ✓	75	75	50	50	75	50
Home Health Care *Per State law home health care cannot have a deductible exceeding $50--except for HSA-eligible HDHP*	0% ✓	25% *subject to a $50 deductible*	-	-	-	-	-	-
Inpatient Admission *Apply Copayment per Day (max days per admission specified)*	40% ✓	✓	500 ✓ *yes - max 4*	500 ✓ *yes - max. 2*	250 ✓ *yes - max. 2*	250 *yes - max 2*	500 ✓ *yes - max 2*	250 *yes - max 2*
Outpatient Surgery	40% ✓	- ✓	500 ✓	500 ✓	250 ✓	250	500 ✓	250
Skilled Nursing Facility *Apply Copayment per Day (max days per admission specified)*	40% ✓	- ✓	500 ✓ *yes - max 4*	500 ✓ *yes - max. 2*	250 ✓ *yes - max. 2*	250 *yes - max 2*	500 ✓ *yes - max 2*	250 *yes - max 2*
Prescription Drug Benefit	***Subject to Deductible***	***Subject to Deductible***	***Subject to Rx Deductible***	***Subject to Rx Deductible***	***No Rx Deductible***	***No Deductible***	***Subject to Rx Deductible***	***No Deductible***
Tier 1 (i.e. Generics)	$ 10 ✓	$ - ✓	$ 10 ✓	$ 10 ✓	$ 5 ✓	$ 5 ✓	$ 10 ✓	$ 5 ✓
Tier 2 (i.e. Preferred Brand Drugs)	40% ✓	- ✓	25 ✓	25 ✓	15 ✓	15 ✓	25 ✓	15 ✓
Tier 3 (i.e. Non-Preferred Brand Drugs)	40% ✓	- ✓	40 ✓	40 ✓	30 ✓	30 ✓	40 ✓	30 ✓
Specialty Tier (i.e. Speciality High-Cost Drugs)	40% ✓	- ✓	40% ✓	40 ✓	40 ✓	40 ✓	30% ✓	20% ✓