STATE OF CONNECTICUT

INSURANCE DEPARTMENT

ConnectiCare Benefits , Inc. Individual Exchange 2015

Finding of Facts

Original Filing

1. This filing is applicable to all eligible individual exchange members with rate effective dates in 2015.

2. The 2015 ACA fees are as follows:

   - Patient Centered Outcomes Research Fee: This charge of $2 per covered life applies to policies issued or renewed between 10/1/2012 and 9/30/13, and then is expected to be subject to adjustment for projected increases in National Health Expenditures per year for the years 2014-2019. ConnectiCare has included $0.17 pmpm to cover this cost.
   - Transitional Reinsurance Program: Recent guidance has put the cost of this program at $44 per capita for 2015 and has been converted to a $3.67 pmpm cost.
   - Health Insurer Fee: ConnectiCare has included a pmpm cost of $10.76 to cover this fee. In 2015, the health insurance industry will be assessed $11.3 billion based on market share. Calculations were done at the parent company level to estimate this fee which is not tax deductible. The tax effect is included in this pmpm.
   - Risk Adjustment Program: ConnectiCare has included $0.08 pmpm to cover this cost, as finalized in the 2015 Notice of Benefit and Payment Parameters.

3. The starting rates for this Individual Exchange product have been developed as follows. The projected claim costs for this Policy form, Individual Exchange, were based on the existing non-grandfathered individual risk pool of ConnectiCare Insurance Company, Inc.(CICI) for the incurred period January 2013 through December 2013, paid through March 2014. Appropriate completion factors were then applied and the claims were trended for 24 months. Adjustments were then made for the anticipated morbidity of the 2015 Individual market population relative to that of the experience period. Further adjustments were made to reflect the additional EHB benefits, including Pediatric Vision and Dental, as well as the favorable impact anticipated from the Federal Reinsurance program. Non-FFS costs and the impact of Health Care Reform were included. The projected claims were also normalized for average age, benefit and area factors to develop proposed base rate.

4. The inception of the CBI operations was January 1, 2014. Since this is a new operation, along with months' of claims lags, this rate filing is actually not based on CBI's own experience but rather, the more complete and mature experience of the off-Exchange individual book of business of CICI, including all non-grandfathered claims experience and with appropriate adjustments to reflect the expected Exchange experience. For this reason, this year's experience of CBI is not included in this rate filing.

5. Below is CY 2013 claims experience from ConnectiCare, Inc. & Affiliates which ties to the pricing build-up for this rate filing:

Category	Incurred Claims
Inpatient	$3,848,555.38
Outpatient	$5,076,865.94
Physician	$6,603,690.52
Rx	$1,860,943.16
Total	$17,390,055.00

Experience period membership is 90,739

Category	Claims PMPM
Inpatient	$42.41
Outpatient	$55.95
Physician	$72.78
Rx	$20.51
Total	$191.65

6. Unit Cost ($) Trend

Service	10/2011	10/2012	10/2013	10/2012 Trend	10/2013 Trend
Inpatient	3,593	3,865	3,943	7.6%	2.0%
Outpatient	561	604	648	7.7%	7.4%
Professional	107	107	106	0.4%	-1.5%
Subtotal Medical	207	216	219	4.1%	1.5%
Retail Rx	92	92	91	0.3%	-1.2%
Total	166	172	174	3.8%	1.3%

7. Utilization/1,000 Trend

Service	10/2011	10/2012	10/2013	10/2012 Trend	10/2013 Trend
Inpatient	271.2	278.6	283.5	2.7%	1.7%
Outpatient	1,932.8	1,978.8	2,006.0	2.4%	1.4%
Professional	15,956.9	16,466.2	16,937.1	3.2%	2.9%
Subtotal Medical	18,160.9	18,723.6	19,226.6	3.1%	2.7%

Retail Rx	10,144.9	10,167.7	10,255.3	0.2%	0.9%
Total	28,305.8	28,891.3	29,481.9	2.1%	2.0%

8. Allowed PMPM ($)

Service	10/2011	10/2012	10/2013	10/2012 Trend	10/2013 Trend
Inpatient	81.21	89.74	93.13	10.5%	3.8%
Outpatient	90.29	99.54	108.33	10.2%	8.8%
Professional	141.86	147.04	148.96	3.7%	1.3%
Subtotal Medical	313.36	336.32	350.42	7.3%	4.2%
Retail Rx	77.80	78.24	77.94	0.6%	-0.4%
Total	391.16	414.56	428.35	6.0%	3.3%

9. Net PMPM ($)

Service	10/2011	10/2012	10/2013	10/2012 Trend	10/2013 Trend
Inpatient	73.64	82.12	85.57	11.5%	4.2%
Outpatient	75.98	83.27	89.82	9.6%	7.9%
Professional	111.11	113.86	113.86	2.5%	0.0%
Subtotal Medical	260.73	279.25	289.25	7.1%	3.6%
Retail Rx	55.84	57.70	58.51	3.3%	1.4%
Total	316.57	336.95	347.75	6.4%	3.2%

10. Annual trend assumed from experience period to rating period is 3.84%.

11. Retention charge used in rate filing is 25.6%. This is comprised of 12.3% for administrative expenses, 3.9% for commissions, 1.75% for premium tax, 0.70% for federal income tax, 4.3% for ACA fees, 1.35% for exchange administration and 1.30% for AFIT margin.

12. The expected medical loss ratio for this filing is 74.4%. For federal rebate purposes, the following adjustments are made to revenue:

Premium Taxes:	$5.86 (1.75% of revenue)
FIT:	$2.34 (35% * Margin)
ACA Fees:	$14.68
Exchange Admin:	$4.52 (1.35% of revenue)
Adjusted Revenue:	$307.27
Federal MLR:	248.97/307.27 = 81.03%

An additional credibility adjustment factor, based on 67,783 combined projected life years and an average deductible less than $2,500, of 0.35%. This yields a credibility adjusted federal MLR of 81.38%.

13. The capital and surplus, as of March 31, 2014 is $7,585,481.

14. The Department received two public comments, they are documented below:

- Here we go again. Any and all excuses to increase rates excessively. Really, 11.8%. What happen to the modest increases of 3% to 4%. These rates far surpass any other increases. The State Department of Insurance is useless in when it comes to rate increases. The insurance companies know this very well and get those excessive rate increases at our expense. They always have an excuse no matter the laws, need or how much cost to the members. The insurance companies ALL MAKE HUGE PROFITS no matter what!!!! When is the insurance going to stand up for the people who pay thier saleries and reject these absurd rate increases. How serious is this platform of public comment taken???? Is it to apease us people that get r?ped by the insurance companies??? We all know that 11.8% is excessive, period. Now do something about it like DENY thier request!!!

From the Office of the Healthcare Advocate (Victoria Veltri, JD, LLM State Healthcare Advocate)

- ConnectiCare has recently supplemented its application in response to the request made by your office such that the parameters of the application have become clearer. Nevertheless, I have continuing concerns in a number of areas, many of which were explored relative to the Anthem proposal during the hearing. My questions and concerns are as follows:
  1. The rate filing is only for on-exchange products. Is there a filing for off – exchange products that has not yet been posted?
  2. The ConnectiCare correspondence signals that its aggregate filing is for a 12.8% increase. However, the Executive Summary on the CID website indicates that the aggregate increase is 11.8%. It is difficult to find within the filing what accounts for this change. (Appendix A on page 393 of the correspondence document states that the aggregate rate increase is 11.8% and first page of the "Post-Submission Request Processed on 6/23/14"—page 225 of the correspondence—states that the aggregate rate increase is 12.8%.)
  3. The actuarial memorandum refers to unit cost trend adjustments for the impact of negotiated provider discounts. However, there is no other information that provides support for the actual adjustment for provider discounts, what those discounts are and how those discounts impact access and utilization.
  4. The memorandum indicates that because the baseline population included a medically underwritten population that costs had to be adjusted for lack

of underwriting. As in the Anthem filing, one would assume that the risk of the already medically underwritten population had been accounted for, so it would be important to know how many previously medically underwritten individuals are now enrolled in ConnectiCare's individual exchange plans.

5. There's an accounting for $13.25 PMPM for commissions. It is not clear what if any component of that number represents an increase.
6. The morbidity adjustment is 19.8%, but the components of the morbidity adjustment are not broken out separately.
7. The capitation payment for behavioral health, $9.41 PMPM, is denoted, but it is unclear what portion of the behavioral health expense is administrative and what portion is for medical costs.
8. In the Paid to Allowed Ratio section of the memorandum, ConnectiCare states that the URRT reflects ConnectiCare's "best estimate of the impact of cost sharing, using historical cost sharing impacts from the business underwritten by ConnectiCare Insurance Company, Inc." Exchange plans clearly have various levels of cost sharing associated with those plans. The application does not make clear how specific cost-sharing components of the plans impact the rate or how ConnectiCare derived these "cost sharing impact" figures.
9. With respect to reinsurance, ConnectiCare's filing does not allow for potential coinsurance adjustments as requested in the Anthem hearing, i.e. 60%, 70% or 80% co-insurance rates with a $45,000 attachment point.
10. ConnectiCare includes an administrative load of 16.35%, but the composition of that administrative load is not clear. The filing refers to Plan Adjusted Index Rates using modifiers, including "The plan's provider network, delivery system characteristics and Utilization management practices." There is no explanation for these descriptors or individual attributions of these components to the index rate.
11. The annual 10.7% trend is not adequately explained in the answer to CID's Question 6. While there are allusions to differences between the Exchange and ConnectiCare's networks, it's unclear how a narrower network is factored into Exhibit 2 of the filing.
12. The answer to CID's Question 8 does not account for alternative reinsurance arrangements – see #8 above.
13. It doesn't appear that an answer was provided to Question 10.
14. The answer to Question 11 appears to need more explication.
15. Impacts to autism coverage limits, allowed by Bulletin HC-96, and referenced on page 392 of the application, are not quantified of the premium.

I appreciate your office's consideration of these concerns and questions as it reviews ConnectiCare's rate filing.

Revision to Original Filing (Submitted 7/27/14)

The following changes have been made to previously submitted Individual Exchange CBI Rate Filing

- Lowered experience period to projection period trend. Our trend factors reflect revised estimates of emerging utilization patterns and updated unit costs from our network provider partnerships (Annual trend revised from 3.84% to 3.26%).

- Increased expected Reinsurance Recoveries for Federal Reinsurance Program (Increased from $24.51 pmpm to $30.11 pmpm).

- Reduced the impact of Maternity coverage from 2.50% to 1.25% based on the distribution of enrolled members in child bearing ages.

- Lowered the Commissions component of our retention from $13.25 pmpm to $11.50 pmpm to reflect less broker involvement in generating Exchange membership.

- Revised select benefit relativities. HSA plan relativities were adjusted based on additional analysis of utilization patterns for these HSA plans (Bronze Standard HSA changed from 0.5500 to 0.5107 and the Bronze Select HSA changed from 0.4848 to .4505).

- Revised select Area Factors to reflect updated unit costs from our network provider partnerships (Fairfield changed from 1.1107 to 1.0985; Hartford changed from 0.9174 to 0.8926; Middlesex changed from 0.9800 to 0.9702; New Haven changed from 1.0270 to 1.0054).

- Revised the Adjust to Federal Demographic Curve factor to reflect continued growth of membership on the Exchange so as to reflect the differences between the 2014 Exchange membership and the experience period membership by age (changed from 0.6185 to 0.6080).

Department Summary

Since this filing reflects rates for the newly developed CT insurance exchange and incorporates all the new rating requirements of PPACA effective 1/1/2014, the Department used criteria spelled out in the latest HHS rate regulations as a template for review along with previously issued CT Insurance Department Bulletins that discuss the requirements for rate filings.

The Department reviewed the original 3.84% annual trend assumption used in the rate filing and believed that based upon past experience that this assumption was excessive.

We believe that the revised annual trend of 3.26%, submitted on 7/27, is more appropriate and is approved as the annual trend factor.

Based upon the federal MLR for this filing of 80.8% and the allowed credibility adjustment, the Department believes that the proposed pricing supports the required 80% loss ratio for individual business.

ConnectiCare Benefits Inc. is using ConnectiCare Insurance Company Inc. 2013 individual experience as an experience base for the development of 2015 rates for this rate filing. Since this baseline data is representative of a medically underwritten population, the effects of underwriting on medical costs were removed. In addition, adding members who are currently uninsured or currently in the state High Risk Pool, as well as members currently insured in the group market, is expected to have an adverse effect on morbidity in the Exchange population relative to the adjusted baseline data. This resulted in a morbidity adjustment of 19.8%. Based upon this information the Department believes that the estimated increase in morbidity of 19.8% appears to be reasonable for the anticipated difference between the base period experience and the rating period.

The Department has reviewed the request by ConnectiCare Benefits Inc., to adjust the benefit relativities for their two HSA plans. There was not enough actuarial justification provided to the Department to support the change in the benefit relativities. In addition, the Department does not believe that a utilization adjustment in benefit relativities is allowed. The benefit relativities should be based upon the actuarial value of the plan and the cost-sharing design per the federal regulation. The Department views these as objective benefit relativities that will vary by metal plan and within a set of metal plans the objective actuarial difference in cost sharing.

In Federal Register/Vol. 79, No. 101/Tuesday, May 27, 2014 / Rules and Regulations it states the following, “Specifically, in the proposed 2016 Payment Notice, we intend to propose to lower the 2015 attachment point from $70,000 to $45,000. We may also propose to modify the target 2015 coinsurance rate based on estimates of roll-over of funding from 2014 and estimates of collections of payments for 2015”.

In addition, 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.

Based upon the information described in the last two paragraphs, the Department is requiring that all individual carriers use a $45,000 attachment point in their 2015 pricing as well as a coinsurance level of 70%. 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.

ConnectiCare Benefits Inc. submitted this rate filing assuming an attachment point of $45,000 with a coinsurance level of 50%. As described above, the Department is requiring that the pricing support 70% coinsurance for 2015, rather than the 50%. This has an impact of lowering rates by 4.5%. This is generated from averaging all the individual carrier's adjustments that were submitted for the change in coinsurance from 50% to 70%, that are participating in the exchange, and not necessarily the specific adjustment provided by ConnectiCare Benefits Inc. in correspondence. The final pmpm impact approved by the Department is reinsurance recoveries of $39.50 pmpm.

Department Disposition

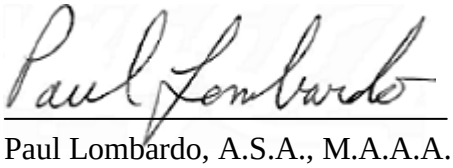
Based upon the finding of fact, and the summary information described above, the original proposed average rate increase of 12.8% and the revised proposed average increase of 6.2% are disapproved as submitted.

The approved base rate change is an increase of 2.1% versus the original requested 11.8% and the revised 5.3% increase and the approved average premium rate change of 3.1% versus the requested average premium rate increase of 12.8% and the revised average increase of 6.2%.

Please recalculate and submit the rates and any appropriate exhibits reflecting the revised assumptions.

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

Dated July 29, 2014.



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