



# STATE OF CONNECTICUT

## INSURANCE DEPARTMENT

### ConnectiCare Benefits , Inc. Individual Exchange 2016

#### Finding of Facts

1. This submission is for products to be marketed through the Access Health CT Exchange for individual policies effective January 1, 2016.
2. ConnectiCare Benefits, Inc. (CBI) has been in this market since January 1, 2014 and is proposing a rate increase of 0.7% for the existing plans to be renewed in January of 2016.
3. This increase represents a weighted average of the rate changes for all existing plans, ranging from a -5.1% to 5.4%.
4. These rate changes reflect medical inflation and utilization trends, as well as changes including but not limited to member cost sharing, changes in benefit design (cost sharing levels) to ensure that plans comply with the Actuarial Value requirements, fees and the Federal reinsurance program.
5. Rate changes vary by plan primarily due to the following reasons:
  - Changes in cost sharing levels to ensure that plans comply with the HHS Actuarial Value metallic requirements.
  - Fixed dollar features in certain plans, such as deductibles, copayments, and out-of-pocket maximum, lead to leveraging effects when the underlying cost structure increases with trend. For example, with a plan containing a given fixed copay for a primary care visit, if underlying costs of PCP visits increase by 6%, then the net costs to the carrier are greater.
6. The average morbidity of the single risk pool for Connecticut is anticipated to be different from that in the 2014 experience period for the following reasons:
  - Experience in the early part of 2014 was dampened as it took time for new enrollees to understand their benefits and seek access to care. We are projecting more normal experience in the 2016 year since by then most individuals would have been insured for at least two years.

- A portion of the population newly enrolled in 2014 was previously uninsurable due to medical conditions. With the movement to a guaranteed issue market in 2014, these individuals joined the risk pool and had higher levels of utilization as they sought care for their conditions. This was a one-time impact which is not expected to continue into the projection period, as these individuals have now been engaged in care delivery.
  - The population purchasing in the individual market is younger in 2015 than in 2014. We are projecting a slightly younger population in 2016 than in the experience period, and the anticipated morbidity level has been adjusted for the projected population.
7. These effects are expected to impact the risk pool in different directions. Overall, the average morbidity of the single risk pool for Connecticut is anticipated to be favorable to that in the experience period as the individuals enrolled in the insurance pool stabilize.
  8. Claims costs are expected to increase for anticipated medical/prescription drug inflation and increased medical/prescription drug utilization.
  9. There are no changes in benefits covered.
  10. Certain plans in the individual Exchange offering have some benefit adjustments in order to meet the metal level based on the Actuarial Value Calculation, 2016 version. The benefit adjustments include changes in deductible or maximum out-of-pocket amounts, member cost shares, etc.
  11. Changes in administrative expenses on per member per month basis are based on the projected expense levels, included in the premium build-up accordingly.
  12. There are no material changes in provider networks and contracts. The anticipated changes are reflected in the unit cost trend assumptions.
  13. Federal transitional reinsurance program contributions and benefit limits have changed from last year. Specifically, the reinsurance contribution has changed from an estimated \$44 PMPY to \$27 PMPY. Further, the claims threshold upon which reinsurance recoveries are triggered has increased from the assumed \$45,000 to \$90,000; and the reinsurance cost share percentage paid by the program decreased from 70% to 50%. The combined effect of an increase threshold and a decreased program cost share results in a material decrease in transitional reinsurance recoveries. Therefore, there is a corresponding increase in the individual premium rates. Changes in the benefit levels of the reinsurance recoveries will only impact the individual market, while the changes in the reinsurance contribution levels will impact both the individual and small group markets.

14. Source and Appropriateness of Experience Data Used: The source data used in the projected claims is based on the experience from CBI, which has been providing coverage to individuals on the Exchange in Connecticut. No rebate is expected for the premium of the experience period.
15. Baseline experience data from calendar year 2014 was projected to 2016, reflecting expected utilization and unit cost trends associated with the individual Exchange membership. These unit cost trends include the impact of negotiated provider discounts. When new Exchange members, most of whom were uninsured by private health coverage carriers previously, join the book of business, their costs of care increase as the months go by even after seasonality adjustments. For it takes time to adapt to their new health care systems, it is expected that this pattern of gradual increases would continue into 2016 as more new members join in after the experience period. As a result of this analysis, the morbidity of the individual Exchange market in 2016 is expected to be 1.5% greater than the morbidity of the experience period.
16. CBI has sufficient membership in 2014 and its claims experience is considered to be fully credible.
17. The rate level developed reflects an assumption that the morbidity level and demographic composition of CBI's population will be consistent with the morbidity level and demographic composition of the overall individual market. Therefore, the anticipated risk adjustment payments are expected to be minimal, and were not factored into the rate development. A negative \$0.15 PMPM is included to represent the cost of the program administration.
18. Reinsurance recoveries in the Individual market, which are projected at 50% of an individual's annual incurred claims between \$90,000 and \$250,000, per the final 2016 Notice of Benefit and Plan Parameters, were valued per the continuance tables from Milliman's Health Cost Guidelines as well as the continuance tables developed internally. Projected recoveries were reduced by the cost of the Reinsurance Program, which has been established for 2016 at \$2.25 PMPM or \$27 PMPY.
19. The anticipated loss ratio for Federal MLR Rebate purposes is 85.2%.
20. The Index Rate for the Projection Period is equal to the Total Allowed Claims PMPM developed in Worksheet 1 Section II, reduced by 1.15%\* to adjust total allowed costs to allowed costs related to EHB. The Index Rate represents projected Allowed Claims in 2016. It reflects anticipated claim levels in 2016 with respect to trend, benefit and demographic differences for the single risk pool. Covered benefits related to routine adult vision care and elective abortion services are in excess of EHB, which are included in Allowed Claims but excluded from the Index Rate.

21. Plan level rates are developed from the Index Rate using the following modifiers allowed per 45 CFR 156.80(d)(2):

- The actuarial value and cost-sharing design of the plan
- The plan's provider network, delivery system characteristics and utilization management practices
- Administrative costs

22. Two factors are used in the calibration of the rate to be applied uniformly to all plans: age curve calibration and geographic factors. CBI membership age distribution and rating area distribution are used to derive these factors, along with the federal age factors and the geographic rating area factors.

23. Plan factors were developed using a standard plan relativity calculator developed by ConnectiCare. The calculator reflects differences in costs and utilization under various plan designs.

24. Two 2015 plans will be terminated in 2016, and their HIOS plan ID's are 76962CT0010018 and 76962CT0010009.

25. The 2016 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 \$27 per capita for 2016 and has been converted to a \$2.25 pmpm cost.
- Health Insurer Fee: ConnectiCare has included a pmpm cost of \$13.47 to cover this fee. 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 \$0.15 pmpm to cover this cost, as finalized in the 2015 Notice of Benefit and Payment Parameters.

26. Below is CY 2014 claims experience from ConnectiCare Benefits, Inc. which ties to the pricing build-up for this rate filing:

2014 Earned Premium = \$148,484,017  
2014 Incurred Claims = \$128,764,003  
2014 LR = 86.72%

Based on 302,547 member months for calendar year 2014

27. Unit Cost (\$)

<u>Service</u>	<u>2014</u>
Inpatient	3,792
Outpatient	664
<u>Professional</u>	<u>86</u>
Subtotal Medical	212
<u>Retail Rx</u>	<u>71</u>
Total	164

28. Utilization/1,000

<u>Service</u>	<u>2014</u>
Inpatient	366.9
Outpatient	2,725.5
<u>Professional</u>	<u>20,115.2</u>
Subtotal Medical	23,207.6
<u>Retail Rx</u>	<u>11,943.0</u>
Total	35,150.6

29. Allowed PMPM (\$)

<u>Service</u>	<u>2014</u>
Inpatient	115.92
Outpatient	150.72
<u>Professional</u>	<u>144.08</u>
Subtotal Medical	410.72
<u>Retail Rx</u>	<u>70.48</u>
Total	481.20

30. Net PMPM (\$)

<u>Service</u>	<u>2014</u>
Inpatient	105.73
Outpatient	132.35
<u>Professional</u>	<u>120.20</u>
Subtotal Medical	358.28
<u>Retail Rx</u>	<u>59.19</u>
Total	417.47

31. Annual trend assumed from experience period to rating period is 8.52%.

<u>Category</u>	<u>Utilization</u>	<u>Unit Cost</u>	<u>Leveraging</u>	<u>Pricing Trend</u>
Inpatient	1.50%	4.80%	0.50%	6.90%
Outpatient	4.00%	3.80%	1.50%	9.50%
Physician	4.90%	1.20%	0.70%	7.00%
Pharmacy	1.00%	8.70%	2.20%	12.20%
Total	3.30%	4.00%	1.10%	8.52%

32. Retention charge used in rate filing is 21.09%. This is comprised of 10.24% for administrative expenses, 7.24% for taxes and fees and 3.11% for AFIT margin.

33. The expected medical loss ratio for this filing is 78.91%. For federal rebate purposes, the credibility adjusted federal MLR is 81.38%.

34. The capital and surplus, as of December 31, 2014 is \$29,656,280.

35. The Department received 59 public comments, they are summarized below:

- Wakely Consulting Group  
Comments regarding ConnectiCare Benefits, Inc. Individual Market Rate Filing June 5, 2015

#### Background

Access Health CT (AHCT) retained Wakely Consulting Group, Inc. (Wakely) to perform an independent review of the initial 2016 rate filings for carriers expected to participate on the Exchange in 2016. The following comments are being submitted by Wakely on behalf of AHCT.

The comments below reflect Wakely's review of the initial rate filings and may not apply to subsequent re-filings of rates. In order to meet the timeline for public comments, Wakely did not have sufficient time to contact each carrier to discuss comments and questions regarding the filings. Wakely's assessment of the filing could change if additional clarifications are provided by the carrier. It is also important to note that two qualified actuaries following applicable Actuarial Standards of Practice, each using reasonable methods and assumptions, can reach different but reasonable results.

#### Summary of Proposed Rate Changes

The overall proposed rate increase is 2.0% with plan-specific rate changes varying from -3.8% to 6.8%.

## Overall Assessment of the Filing

Based on our review of the filing, we believe that the filing lacks adequate detail for us to be able to follow all of the carrier's calculations. Virtually no support was provided for any of the assumptions making it difficult to assess reasonability with regards to the carrier's circumstances. We assessed reasonability based on whether the assumptions were within industry norms.

## Assessment of Key Components of the Rate Filing

The following are comments and observations resulting from Wakely's review of the ConnectiCare Benefits, Inc. (CBI) individual filing of 2016 exchange rates.

### Base period / credibility

- o The single risk pool was defined correctly.
- o Exhibit 1 – Pricing Build-Up shows a “Total Medical/Rx - Net PMPM”. It is unclear whether this is on an allowed or paid basis and whether it includes incurred but not reported (IBNR). We believe it is an allowed PMPM because it closely matches the allowed per member per month (PMPM) on the Unified Rate Review Template (URRT) but we recommend that the carrier clarify and note whether IBNR is included. The carrier should also provide an estimate of the IBNR used and the methodology used to develop the IBNR.
- o The carrier should explain why HC-81-15 Exhibit 1's member months and paid PMPM does not match the URRT Worksheet 1.
- o The carrier did not document any credibility considerations but did note that the experience had 302,000 member months which is likely fully credible by most credibility standards.

### Adjustments to experience

- o Exhibit 1 – Pricing Build-up includes a non-fee for service (FFS) component. This number is inconsistent with the capitation PMPM provided in the URRT. The carrier should explain what the non-FFS component in Exhibit 1 is, how it was developed, and how it relates to the capitation in the URRT.
- o Based on the rate build up, it was unclear if and how the carrier followed the HHS instructions for rate development, which includes development of index rates, market-adjusted index rates, plan adjusted index rates, and then consumer adjusted index rates. The instructions are specific about what adjustment can and cannot be included in each of these index rates.

### Trend

- o The 2-year trend of 17.8% (8.5% annually) is within industry norms. However, the trend rate more than doubled when compared to the 2015 filing. The carrier should provide support for the trends used and the source data used to develop the trends.

#### Morbidity / Risk Adjustment

- o Section VI of the memorandum explains that the morbidity of the carrier's individual exchange market in 2016 is expected to be 1.5% greater than the morbidity of the experience period membership. We recommend that the carrier provide additional support for this assumption. It appears that the carrier is assuming that members who wait to purchase insurance by up to 2 years are sicker than those who purchased coverage earlier which seems counterintuitive. We think it is counterintuitive because those who wait to purchase until 2016 insurance presumably did not need it as badly as those who signed up in 2014.
- o The carrier estimates that it will pay 1.6% of the allowed claims in risk adjustment payments in 2014 (based on the URRT). The carrier should explain how this information was used in the development of 2016 rates.
- o Section IX of the memorandum states that the carrier's morbidity is expected to be the same as market average. In section VI it is explained that the carrier's morbidity will increase by 1.5% from 2014 to 2016. We recommend that the carrier confirm that the carrier is then assuming that the market average morbidity will also increase by 1.5% from 2014 to 2016 and comment on the reasonability of this assumption.

#### Reinsurance

- o The federal transitional reinsurance assumption for the individual market was estimated assuming that CBI will recover 50% of incurred claims between \$90,000 and \$250,000 per member.
- o Section IX of the memo notes that the reinsurance estimate was developed using the Milliman Health Cost Guidelines as well as the continuance tables developed internally. The carrier should provide what data source was used in the development of the internal continuance tables and if its own 2014 individual market experience was used.
- o The reinsurance recoveries of \$39.33 (7.9% of the allowed claim PMPM of \$499.02, shown on Exhibit 1) is not unreasonable relative to what we have experienced in other nationwide 2016 rate filings. However, it is unreasonable when compared to the carrier's own 2014 reinsurance recoveries noted in the URRT of \$10,407,616.80, which is only 7% of the allowed claims (\$148,321,066). Since the reinsurance protections decline significantly from 2014 to 2016, the reinsurance recoveries should also decline. It is possible that this discrepancy is an artifact of how the allowed claims are being stated in Exhibit 1 compared to the URRT. If so, the carrier should explain how the allowed PMPM of \$558 (\$148,321,066/492,000 member months) in section IV of the URRT reconciles to the allowed PMPMs shown in Exhibit 1 Rate Build-Up.

#### Risk Adjustment / Reinsurance Fees

- o From Exhibit 1, it is unclear whether the risk adjustment fees and reinsurance fees were applied as market level adjustments. The exhibit gives

the appearance that these were plan level adjustments. We recommend that the carrier confirm that the fees were market level adjustments and not plan level adjustments.

#### Administration

- o The administrative costs shown on Exhibit 1 increased significantly in 2016 relative to 2015. The carrier should provide support for why they increased. The carrier should also support the non-benefit expenses provided on Exhibit 3.
- o Commissions in 2016 shown on Exhibit 1 are the same on a PMPM basis as what was assumed in 2015. Since commissions are typically calculated as a percent of premiums and the premiums increased, the carrier should confirm that the PMPM commissions are accurate.

#### Profit Margin

- o After Federal Income Tax (AFIT) margin % shown on Exhibit 1 increased in 2016 relative to 2015. We recommend that the carrier explain this increase. Additionally, the AFIT margin referenced in the memo does not match what is shown on Exhibit 1.
- o The projected MLR was above 80%, the minimum federal loss ratio standard.

#### Taxes and Fees

- o FIT % shown on Exhibit 1 increased in 2016 relative to 2015 and is now identical to the premium tax %. We recommend that the carrier explain this increase and confirm that the percentage noted on the exhibit are accurate.
- o The PCORI, reinsurance, and risk adjustment fees used are accurate.
- o Exchange fees are 1.35% of premiums.

#### Plan Factors

- o Exhibit 1 shows a benefit, area, and demographic normalization. The carrier should explain what these factors are, how they were developed, and apply them at the appropriate step in the rate development consistent with the federal instructions.
- o An explanation is needed for how the 'adjust to federal demographic curve' factor shown on Exhibit 1 was developed.
- o The actuarial memo mentions that utilization differences under various plan designs were included in the plan factors. It is unclear whether the carrier used the federal induced demand factors or their own internal factors. It is also unclear whether these factors were normalized to appropriately account for differences in induced demand between the experience and the projection periods as required by the CMS instructions.
- o There are variations in rate changes from 2015 to 2016 within a particular metal level. The carrier should provide the impact of plan design changes and provide an explanation to justify changes above and beyond those explained by design changes.

- o The carrier should provide support for the catastrophic adjustment.
- o The carrier noted that the plan level adjustments do not include morbidity differences, consistent with federal requirements.

#### Geographic Factors

- o The carrier should confirm that the area factors do not include morbidity. The actuary is required to certify this. The carrier did not change the 2016 area factors relative to 2015 area factors.

#### Tobacco Factors

- o No adjustments were made for tobacco.

#### Other Observations

- o The memorandum does not explain what is included in the 'Other' projection factor of the URRT Worksheet 1 as required by the federal instructions.
- o The memorandum does not explain what methodology was used to develop the cost sharing reduction subsidy estimates included in Worksheet 2 of the URRT. The explanation is required by the CMS instructions.
- o The federal age factors used were accurate.
- o The carrier provided two rate increases. The base rate increased by 6.8% and the average premiums increased by 2.0%. The carrier should explain why the two are different.

#### Conclusion

Without the additional documentation described above, we are unable to opine on the reasonability of the proposed rate changes. Should additional documentation be provided, we would be happy to provide further comments given the opportunity.

All comments may not apply to subsequent re-filings of the rates. Wakely appreciates the opportunity to provide public comment to CID regarding the rate filings.

- I am hoping the rates will not increase, as I am struggling to pay the amount I pay now. I just got onto the Connecticare Plan this year, and I very much urge you to please not increase my rate. Thank you so much and hope you will consider not raising the rates.
- Thank you for the opportunity to offer a comment on this rate filing by Connecticare. Given the rate my wife and I pay to insure ourselves increased 250%, yes 250%, with the implementation of Obamacare we stand absolutely against another 10% increase in our health coverage. This would increase our annual payment for healthcare by more than \$1000 in 2016, which is absolutely absurd for two healthy people who don't smoke, don't drink,

exercise daily and work hard to make sure we DON'T use healthcare services. The only time we have seen the doctor in the past 10 years is for annual checkups. Yet we pay almost \$11,000 a year in health insurance premiums. Is this fair? The health system in this country is a travesty and is nothing more than a tax to redistribute income. If the commission deems it necessary to increase the rates yet again, I ask that a list of those for whom my wife and I are paying insurance costs be sent to me so I can claim them as dependents on my income taxes.

- Many other public comments requested that the Department disapprove the rate increase request.

### 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 8.52% annual trend assumption used in the rate filing and believes that based upon the experience data submitted this assumption is excessive and should be reduced to 8.0%.

The Department reviewed the June 30, 2015 CCIIO Reinsurance and Risk Adjustment report for Connecticut. Based on this report CBI, Inc. paid out \$6,289,036.98 in risk adjustment payments for the individual market. The Department believes the net risk adjustment of -0.15, representing the cost of the program, is appropriate for 2016.

Based upon the federal MLR for this filing of 81.38% the Department believes that the proposed pricing supports the federally required 80% loss ratio for small group business.

The Department reviewed the 1.5% morbidity load assumed in the rate filing. This load reflects that the anticipated morbidity of the Exchange population is worse than that of the single risk pool. The Department does not believe that this is an appropriate adjustment as the experience of CBI, from 2014, is used in the rate development for 2016 and already incorporates any morbidity differences between on and off exchange inherent in the experience. For these reasons, the Department is removing the 1.5% morbidity load.

In the 2015 pricing the Connecticut Insurance Department required that all individual carriers in the non-grandfathered market in Connecticut use a \$45,000 attachment point (per HHS guidance), a \$250,000 reinsurance cap, and a 70 percent coinsurance rate. The coinsurance rate assumption was based upon the following:

- The federal government has allowed states to decide whether or not to allow existing non-grandfathered, non-ACA compliant plans (grand-mothered plans for ease of explanation) to continue to renew until sometime in 2016. These grand-mothered plans are considered transitional plans and carriers will not have access to the temporary reinsurance program for these plans. A number of states have elected to allow these transitional plans while Connecticut has not. All Connecticut individual plans, as of 1/1/2015 and beyond, will be considered fully ACA compliant plans eligible for the temporary reinsurance program.
- As a result, the Department believes that there will be excess funds available in 2015 since all transitional individual plans will not have access to the reinsurance program and were originally expected to be fully ACA compliant by 2015 when the funding parameters were originally set.

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

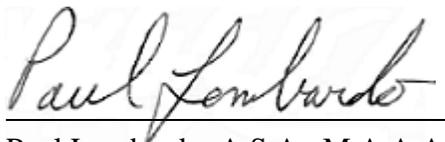
#### Department Disposition

Based upon the finding of fact, and the summary information described above, the original proposed average rate increase of 2.0% and the revised proposed average increase of 0.7% are disapproved as submitted.

The approved base rate change is an increase of 3.3% versus the original requested 6.8% and the revised 5.4% increase and the approved average premium rate decrease of -1.3% versus the requested average premium rate increase of 2.0% and the revised average increase of 0.7%.

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

Dated August 27, 2015.



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