STATE OF CONNECTICUT
INSURANCE DEPARTMENT

In the Matter of:	Docket No. LH 16-46
CONNECTICARE INSURANCE COMPANY, INC.	

HEARING

Held Before:

JARED KOSKY, Hearing Officer
KRISTIN M. CAMPANELLI, ESQ., Legal Division Counsel
PAUL LOMBARDO, Life and Health Actuary
(Panel)

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By: BRADFORD S. BABBITT, ESQ.

. . . The following is the transcript of the Public Hearing in the Matter of: CONNECTICARE INSURANCE COMPANY, INC., which was held before Jared Kosky, Hearing Officer, at the Insurance Department, 153 Market Street, Hartford, Connecticut, on August 4, 2016, commencing at 9:01 a.m. . . .

(Hearing commenced: 9:01 a.m.)

HEARING OFFICER: Good morning. I'd like to call this public hearing to order. Please make sure that all cell phones and other electronic devices have been shut off.

On behalf of the Connecticut Insurance Department, I'd like to welcome you to this hearing. I'm Jared Kosky and I've been appointed by Commissioner Wade to preside at today's public hearing. I want to take a moment at the start of this proceeding to explain the way the hearing works.

Many of you may be familiar with the hearings held by the legislature to consider proposed legislation, for agencies in your town or city to consider town affairs, but may not be familiar with this type of administrative hearing.

An administrative hearing such as this is a regulatory proceeding in which a party, in this instance, ConnectiCare Insurance Company, Inc., is required to present documentation and arguments regarding their

application.

Ultimately, Commissioner Wade will decide this matter based on a recommendation that I will prepare. This is not a court proceeding, but it does operate under a system of rules with the presentation of evidence and witnesses, who testify under oath. We will have three potential opportunities for public comment at this hearing.

First, in a couple minutes, there will be a half hour devoted to public comments, with the amount of time of each statement restricted out of respect for the time of everyone here. Second, if time allows, there will be a period of public comment at the end of the proceeding for those who did not have an earlier chance to comment.

And third, written comment may be submitted up until 4:00 p.m. on Thursday, August 11, 2016. Unlike a legislative hearing, there may be times when we will need to call a recess.

I'd like to remind all attendees that I expect everyone to conduct themselves in an

orderly and respectful manner. Any conduct determined to be disorderly or interfering with this proceeding will be dealt with under the appropriate legal authority.

Pursuant to the rules of the Insurance Department, which are posted in the reception area and on the doors of this hearing room, no signs or demonstrations are permitted and anyone not conforming to these restrictions will be required to leave the proceeding.

For the record, the hearing is being held pursuant to to Sections 38a-8 and 38a-481 of the Connecticut General Statutes and will be conducted in accordance with the Insurance Department's rules, practice and the Connecticut Uniform Administrative Procedure Act.

ConnectiCare Insurance Company, Inc. will be referred to as "ConnectiCare," or the applicant. For the record, docket number LH 16-46 has been assigned to this matter by the Insurance Department. The Connecticut statute governing this rate application, Connecticut General Statute, Section 38a-481, provides that rates shall not be excessive,

inadequate or unfairly discriminatory.

In addition, Section 38a-8 of the Connecticut General Statutes provides that the insurance commissioner has all the powers specifically granted and all powers that are reasonably necessary to protect the public interest in accordance with the duties imposed by the Connecticut Insurance Statutes.

This public hearing is being held to consider whether the premium rate increase application filing, the application, dated June 1, 2016 by ConnectiCare, and subsequently revised on June 15, 2016, July 27, 2016 and August 3, 2016, concerning premium rates for its individual off exchange plans, the products, is excessive, inadequate or unfairly discriminatory, pursuant to Connecticut General Statutes, Section 38a-481.

This proceeding was commenced on June 1, 2016, when the applicant filed with the Connecticut Insurance Department, to be referred to as "the department," a rate application regarding the applicant's

individual rates for off exchange plans.

While there is no statutory requirement that a rate hearing be held, on June 6, 2016, Commissioner Wade ordered that a public hearing be held on August 4, 2016, to consider the commissioner granting approval of the proposed application.

As a result of the open enrollment beginning on November 1, 2016, the federal government and exchanges, including the Connecticut Exchange, have required that rate filings must be submitted with ample time for them to process the information. Thus, the Connecticut Insurance Department is holding hearings at this time to comply with those strict deadlines.

A copy of the notice for this public hearing is filed with the Office of Secretary of State. In addition, this notice was posted on the Insurance Department's Internet website. This notice indicated that the application was available for public inspection at the Insurance Department and electronically on the Insurance Department website. And that the department was

accepting written statements concerning the application.

In accordance with the rules and practice of the Connecticut Insurance Department, ConnectiCare has been designated as a party to this proceeding. Without being designated as an official party to this proceeding, the Connecticut Insurance Department staff will have the right to ask questions of witnesses to this hearing.

Joining me are Paul Lombardo, life and health actuary, and Attorney Kristin Campanelli, legal division counsel. At this time I would like counsel for the applicant to identify themselves.

MR. BABBITT: Good morning, Hearing Officer Kosky. My name is Bradford Babbitt from Robinson & Cole. I represent ConnectiCare today.

THE COURT: Thank you, Attorney Babbitt. At this point, I'd like to enter into the record the stipulated list of exhibits. This list identifies 12 documents, which have been stipulated to as full exhibits by the parties to this proceeding. These exhibits include a

copy of the rate filing application and all written public comment received through 9:00 a.m. Tuesday.

Written public comment received after this will be added to the record following the hearing. A copy of the list will be available to members of the audience today.

At a prehearing conference to expedite today's hearing held on August 1, 2016, the exhibits, witnesses and hearing procedures were discussed. The first item of business is public comment. Members of the public who have signed up to speak will have the first half hour of the proceeding to orally comment on the application.

In this regard, there are two sign-up sheets available for persons interested in presenting oral comments at this hearing. One for public officials and one for persons other than public officials.

So, we can gauge our timing, I'm asking Ms. Medina to indicate for the record the number of people who have signed up to speak so far.

MS. MEDINA: For general public, I have

five. And for public officials, I have none.

HEARING OFFICER: Okay, thank you. Each person will have three minutes to comment and we would begin with public officials, but seeing as there are none, we will move on to the general public. Again, this is a comment period only and no question should be directed to the applicant or to the department.

The applicant will then provide presentation of the application. Insurance Department staff will then be given an opportunity to examine the witnesses. After the examinations have been concluded, anyone from the public, who did not have an opportunity to be heard in the first half hour will have the opportunity to orally comment on the application.

The public may also present written comments today, either to Ms. Medina, during the course of today's hearing, or the department's reception desk. In addition, written comment may be submitted up until 4:00 p.m. again on Thursday, August 11, 2016. The public comment portion of this hearing

will commence with comments from, again, just the general public at this point.

I'd ask that anyone interested in participating in this portion of the hearing comply with the following guidelines: Each individual must identify himself or herself for the record, including any organization that he or she represents. And I would ask also when you come up if you can spell your last name for purposes of the transcript.

Each individual must address all comments to me. All the comments must relate specifically to the rate application that is the subject of today's hearing. And each individual must reasonably limit his or her comments to three minutes.

Before we move on, I just want to note for the record that Deputy Commissioner Tim Curry is in attendance today. I will now begin with the public comment period. And I also want to start by noting that the Insurance Department received a written comment from the Office of Healthcare Advocate, through the acting healthcare advocate, Demian Fontanello, who was unable

to attend today's hearing.

In addition, Senator Kevin Kelly submitted written comment and he was also unable to attend. These comments will be included with the other written public comments received.

So, now I'll begin the first public comment period. May I have the list, please? And if I mispronounce anybody's name, please correct me when you come up to the podium. We're going to begin with Lynne Ide.

MS. IDE: Good morning again.

HEARING OFFICER: Morning.

MS. IDE: You're going to be tired of me after these three hearings. My name is Lynne Ide, spell I-d-e, and I'm the director of program and policy at the Universal Healthcare Foundation of Connecticut.

We understand that these are three distinct hearings about three distinct rate requests. And I'm going to submit some written testimony to you that goes into much more detail. But in my three minutes, I'd like to pick up a little bit where I left off yesterday at the end of my testimony at the

Anthem hearing. Because one of the concerns that we have here is that these rate increases, and ConnectiCare's are very high, especially the off market individual rates, which are 39.8 and 29.8. Those are, you know, the range of the increases are very high.

And yesterday as we said, one of the big impediments to people using their insurance is the high cost of premiums, copays and deductibles. And even though many people have been covered since the ACA, we see the issue of affordability as being a big barrier. And in fact, you know, unaffordable health insurance is a more expensive version of being uninsured for some people. And you heard from people in their comments that they submitted online.

I'd like to jump to the issue of affordability, even though I'm aware that is something that statutorily you are not required to deal with. But I'd like to put it out there again, like I did yesterday, and say that I do think this state does need to deal with this. And I would hope that the

Insurance Department would be a partner with organizations like ours in moving forward in this direction.

And we need only to look to nearby Rhode Island for a prime example of a state where affordability standards are a formal element of rate review. In Rhode Island, the legislature created a standalone Office of the Health Insurance Commissioner in 2004, which was essentially a legislative mandate to address affordability.

In 2010, the commissioner, through a public process, generated a first version of affordability standards, which were later refined in 2015, after assessment and evaluation of the first set of standards. So, I'd like to put that into the record.

I also would like to, in my last like 30 seconds, remind you all that one in four adults with non-group coverage went without some needed healthcare, because they could not afford the cost. I'm submitting that graphic today, along with my testimony. I'm adding in 50-plus more petition signatures that we received in the past 24 hours from

people addressed to Commissioner Wade about these rate increases.

And I'm also submitting into the record testimony from a woman named Ann Hagman (phonetic), who is a disgruntled former ConnectiCare customer. And she couldn't be here today, but she asked me to submit her testimony. I urge you to read it, because she's very distressed about the lack of choice that she's going to have on the exchange and the marketplace moving forward, because she will no way ever go back to ConnectiCare. Thank you very much.

HEARING OFFICER: Thank you, Ms. Ide. Alison Bliss.

MS. BLISS: Hi. My name is Alison Bliss and I am a former ConnectiCare customer.

HEARING OFFICER: If you could just spell your last name?

MS. BLISS: B-l-i-s-s.

HEARING OFFICER: Thank you.

MS. BLISS: I received my letter about the potential rate increase in June. I proceeded to call ConnectiCare that day and drop my insurance completely as of that day.

I will not have insurance from a company who I feel is trying to price gouge their customers. I'd rather go without insurance and get fined by the Government, then have a rate increase of 30 percent.

I'm an independent person, who has to buy my insurance on my own, because I'm a real estate agent. I don't have a choice to get it through my company. I pay it completely on my own. According to the Government, I don't qualify for any subsidies or anything like that, I make too much money, but if you look at my bank account, and supporting my children and myself, and all the bills I have, the rate increase would kill me, like cripple me financially. There is no way I could do it and pay everything I need to pay.

So, in lieu of dropping them in January or not going with the insurance again in November, I said, You know what, I'm just going to do it now. I'm not going to give them another penny based on their request for this increase.

So, that's pretty much a person that has

ConnectiCare and will never have ConnectiCare again. Thank you.

HEARING OFFICER: Thank you, Ms. Bliss. Elizabeth Keenan.

DR. KEENAN: Good morning.

HEARING OFFICER: Good morning.

DR. KEENAN: My name is Dr. Elizabeth Keenan, K-e-e-n-a-n. I am a co-chair of the healthcare team for CONECT, Congregations Organized for a New Connecticut, which is a multi-faith, multi-issue, non-partisan organization. We represent 15,000 people from 28 religious congregations and civic organizations in Fairfield and New Haven Counties.

We are here to comment today on ConnectiCare's request for an average 24.3 percentage increase on its individual off exchange plans for 2017. These plans cover a total of 37,142 lives.

As we noted in our testimony yesterday with Anthem health plans, the Connecticut Insurance Department is required, as you mentioned by state statute, to evaluate the rate increases on three aspects: Excessive,

inadequate or unfairly discriminatory terms. And we note that the state statute is silent on affordability.

So, in your minds, we encourage the department to be free to take into account whether any proposed rate increase can be justified in terms of its affordability to think broadly in those terms. And to to us, affordability can be defined as any increase equal to or less than projected increases in healthcare costs for the year in question as determined by the Office of the Actuary, Center for Medicare and Medicare Services.

So, ConnectiCare, in its filing, claims that a significant factor affecting its 2017 rate request was the discontinuation of the federal government's transition reinsurance program for the individual market. So, under this program, started when the ACA began in 2014, insurers were provided with the funds to offset what was expected to be higher claims from newly insured persons, that is persons prior to the introduction of the ACA who had no health insurance and who were expected to need more medical services.

This program, however, was always meant to be a temporary measure and not a permanent feature of the ACA. Insurers knew this from the beginning. So, for them to now raise the ending of this program to justify in part the rate increase for 2017, we believe is nothing more than opportunism at its worst. We urge the department to reject this argument in its final ruling.

There is also a great deal of incomplete, missing or inconsistent actuarial data in the application, data that's essential for the department to carry out their own analysis of the request. Much of that detail is cited by the department in your follow-up questions to the insurer, including information on claims experience and per member per month cost.

What we also want to note that the demise of HealthyCT is bringing 40,000 healthier lives into the market, which we think is another reason for ConnectiCare to not be granted this request. Thank you.

HEARING OFFICER: Thank you, Dr. Keenan. Anne Watkins?

MS. WATKINS: Good morning. I'm Anne, Watkins, W-a-t-k-i-n-s. I'm also a member of CONECT, a resident of New Haven, a parent and a small business owner. I actually am an organizational and leadership development consultant.

When our family was changing insurance plans a number of years ago, we noticed that rates were startlingly lower in states like Minnesota. Instead of embarking on a move, we decided upon ConnectiCare as our insurer. For that privilege, we pay more than $11,000 annually, more than $900 per month for a family of four, with a generous $10,000 deductible.

As a small business owner, this inhibits the growth of my business. ConnectiCare is currently proposing a rate increase of 29.8 percent, or in our case, around $3,000 annually. At this point, I feel a bit like a pawn in these healthcare executives' game of chess.

They propose a ridiculous increase. We come and speak before you and we can all acknowledge that the proposed increase is too

high. Perhaps, an increase is only 10 percent or a thousand dollars for my family.

When I do leadership development work sometimes I share a story, some research that was done maybe in 2007, about cookies and executives. When you put a plate of cookies at a table, executive directors of organizations, CEOs, will always take more, always. If you put the plate out, the people who are at the lower level of the organization take fewer. If there is an extra, it goes to the CEO.

The system we have is broken. Insurance executives are lining their pockets with expenses of the regular people, like me and my family, who are trying to make their way in Connecticut.

According to *Bloomberg,* Michael Wise, the CEO of ConnectiCare makes $1.1 million annually in salary and bonuses, with a $10 million option benefit. Hands off that plate of cookies. Perhaps, we should rethink that move to Minnesota after all.

HEARING OFFICER: Thank you,

Ms. Watkins. Richard Duenas. And I know I have that wrong.

DR. DUENAS: It's Duenas.

HEARING OFFICER: Duenas, thank you.

DR. DUENAS: My name is Dr. Richard Duenas. I am the president of the Connecticut Chiropractic Association. On behalf of the CCA, and chiropractic physicians throughout this state, I'm here to address the proposed insurance rates increases for Aetna and ConnectiCare and share our concerns about policies established by these companies that reduce the full scope of chiropractic services to the patients and practice, as allowed by law, thus compromising patient rights to select their chiropractic physician for their general primary specialty healthcare needs.

We submitted a letter yesterday addressing these issues, but I would like to cover a few points. Aetna and ConnectiCare have stated they are in compliance with the Patient Protection of Affordable Care Act, for exchange and non-exchange plans in their executive summaries, we disagree.

The Patient Protection and Affordable Care act, the ACA, section 2706 specifically prohibits discrimination against providers, healthcare provider. Also, Section 38-591 of the Connecticut Statutes, specifically required these plans to follow the state mandates and also the Affordable Care Act.

There are two state mandates which specifically require, one for group insurance, one for individual health plans, require insurance companies to cover chiropractic services to the same extent as they provide for medical services. In our experience, this has not been carried through for the past 15, 16 years.

We note that all plans limit -- impose limits on chiropractic services, chiropractic physical treatment services, when no such limits are imposed upon the medical profession. Most, if all -- if not all plans also ascribe chiropractic physicians as specialists. This causes higher copayments for patients. Copayments could typically range from 40 to $60. And the reimbursement from the insurance company may be $50. As a

result, the patient is paying the full fee. The insurance company is bearing no burden.

There is ample evidence that shows a chiropractic physicians save considerable money in the healthcare -- in healthcare costs and it's very effective in healthcare.

For instance, a study in Chicago, actually Illinois. Illinois' BlueCross BlueShield demonstrated that chiropractic physicians utilized for primary care demonstrate a 60 percent decrease in in-hospital admissions, 59 percent decrease in hospital days, 62 percentage decrease in outpatient surgery procedures, 85 decrease in pharmaceutical costs.

With results like this, you would think that these insurance companies would raise chiropractic a little bit more fully. We've been trying to discuss these issues with the insurance industry, but we have been un -- have not been able to get much ground work.

It's therefore our position that no insurance rates be raised until insurance companies change their policies to be in compliance with the federal and state laws,

and that they sit down with the healthcare provider, medical, chiropractic, naturopathic, the nursing profession, in order to discuss these issues to get everything nice and square. Thank you.

HEARING OFFICER: Thank you, doctor.

And now I'd like counsel for the applicant to identify the individuals who are present and available to testify and we'll have those individuals sworn in.

Mr. Babbitt, would you please start the introductions of the applicant witnesses?

MR. BABBITT: I'd be happy to. Thank you. Sitting to my right at the end the table is Eric Galvin, chief financial officer of ConnectiCare. To his left is Neil Kelsey, chief actuary for ConnectiCare. And immediately to my right is Mary van der Heijde, principal and consulting actuary with Milliman.

HEARING OFFICER: Thank you, Mr. Babbitt. Would the court reporter please swear in the applicant witnesses?

ERIC GALVIN, called as a witness by the

Department, being first duly sworn by the Court Reporter, was examined and testified, on his oath, as follows:

NEIL KELSEY, called as a witness by the Department, being first duly sworn by the Court Reporter, was examined and testified, on his oath, as follows:

MARY van der HEIJDE, called as a witness by the Department, being first duly sworn by the Court Reporter, was examined and testified, on her oath, as follows:

HEARING OFFICER: Thank you. Mr. Babbitt, please proceed with the presentation of the application.

MR. BABBITT: Thank you very much. We're going to start with a statement by Eric Galvin, chief financial officer of ConnectiCare. Eric?

MR. GALVIN: Good morning, Hearing Officer Kosky, officials of the Connecticut Insurance Department and members of the public, my name is a Eric Galvin. I am the

chief financial officer for ConnectiCare.

My colleagues and I are here this morning to give you a comprehensive rationale for the proposed 2017 rate submitted by ConnectiCare Insurance Company, Inc. for its off-exchange individual health insurance products.

Also testifying with me today are Neil Kelsey, ConnectiCare's chief actuary, and Mary van der Heijde, principal and consulting actuary with the firm of Milliman.

On behalf of ConnectiCare, I respectfully urge the department to approve our proposed rates for 2017. We fully understand that you take seriously your legal responsibility to determine whether our rates are excessive, unfairly discriminatory or inadequate. Our responsibility, which we take exceedingly seriously is to provide you with a full picture to evaluate our request.

For the reasons detailed in our filing in which I might -- which I will summarize in my opening statement, we believe that our rate request satisfies the legal standard for approval, because it is necessary in order

for us to continue to offer this product.

For 35 years, ConnectiCare has had a single-minded focus on providing the highest quality health insurance products and services to the residents of Connecticut. We are the only health insurer focused exclusively on serving the people of ConnectiCare.

Our mission has been and remains to make it easy for our members to get the care they need. We are seeking constantly new and innovative ways to accomplish this mission. We are deeply honored to be the market leader in health insurance for individuals both on and off the exchange, as well as in the small group market in Connecticut.

We are committed to remaining the high-quality plan of choice for people in Connecticut, which is why this rate filing is so important. We cannot continue to provide the quality plans and services that have allowed ConnectiCare to become a market leader in our state with premium rates that are insufficient to pay for the cost of care for our beneficiaries, related expenses and

provide reasonable ability for ConnectiCare to sustain the volatility of the individual insurance market.

Our off exchange individual product, which we call SOLO has been battered in recent years by historic levels of healthcare utilization in a federal risk adjustment program under the Affordable Care Act that has caused us to pay tens of millions of dollars to our largest competitors.

As my colleague, Neil Kelsey, and I have described in our prefiled written testimony, ConnectiCare members in our SOLO product line are utilizing health services at a rate far in excess of anything we could have predicted or in which we have seen during our careers in healthcare.

Before the implementation of the Affordable Care Act, many national studies predicted that utilization and costs of medical services would spike in the early years of ACA, as previously uninsured individuals use healthcare services for issues that had not been previously addressed. This phenomenon is often referred

to as pent-up demand.

These studies concluded that the market would stabilize after absorbing the pent-up demand from the previously uninsured population. We have seen this spike in the use in corresponding cost of medical services, but rather than stabilize, that cost has continued to skyrocket and we see no end to that higher level of spending.

For example, in-patient admissions for cancer in the first quarter of 2016, were twice that experienced in the same period last year. The number of newborn ICU cases has doubled this year. And the severity of those cases often measured by the length of stay in the NICU has increased as well, eight days in 2015, and 25 days in 2016, year-to-date.

Services for acute kidney failure and progression to end-stage renal disease increased as well. And primary and specialists' visits have increased by more than 17 percent with a frequency of radiology and imaging services increasing by 40 percent.

We have initiated a comprehensive effort to more deeply analyze these costs. The historic increase in healthcare utilization has been difficult to reflect in our rates accurately because of the timeline under which we are now required to establish those rates.

We are required to finalize our 2015 rates in May of 2014; and our 2016 rates, in May of 2015. Because this sharp increase in utilization in 2015 could not be predicted when ConnectiCare applied in May of 2014.

And because that continued escalation persisted after we submitted our 2016 rates in May of 2015, both our rates for 2015 and 2016 for the SOLO product were inadequate to cover the costs of the healthcare services obtained by our members. We simply cannot sustain a situation where we have premium rates that do not accurately reflect the rising cost of caring for our members.

The inadequate premium as a result of these unprecedented levels of healthcare utilization has been exacerbated by a federal risk adjustment program. We believe that

program, as implemented, is flawed and works to the detriment of companies, such as ConnectiCare.

Today's rate hearing is not a proper forum to voice our detailed concerns with the substance of the risk adjustment program. However, I will note our concerns with the program's failure to account for partial year enrollments, which causes insurers to not receive risk adjustment credit for sick members just because they enrolled during, rather than at the beginning of the year. As well as the program's emphasis on the benefit richness of plans an insurer sells, rather than the actual medical cost of the plan's members.

In its current form, risk adjustment has required ConnectiCare to pay its competitors $11 million for the 2014 benefit year, $26 million for the 2015 benefit year, and an estimated 35 to $40 million for the 2016 benefit year, notwithstanding our losses.

This turns the entire concept of risk adjustment on its head. The original goal of the system was to protect plans from the

risks associated with providing coverage to disproportionally sick populations, which was expected to cluster in higher benefit richness plans. Our experience shows a high concentration of sick people in less benefit rich plans, yet we have been required to pay approximately $100 million in the past three years to bolster the earnings of other insurers.

Beyond the referenced systemic flaws of the program, implementing risk adjustment has been complicated by the same timing issues I described prior.

As with claim cost data, developing rates for our SOLO product for '15 and '16, ConnectiCare was required to use assumptions, rather than actual data, regarding average market risk of the market as of the spring of 2014 for our 2015 rates and the spring of 2015, for our 2016 rates. The risk adjustment program dictates that premiums must be set at a claim level representing the average market risk.

Because this critical information is not known until six months after premiums take

effect, carriers must instead use their actuarial best estimates to complete pricing. It is very challenging for ConnectiCare to estimate average market risk of the entire market, because the average largely represents the experience of our competitors.

True average market risk for Connecticut was not known until June 30, 2015, 18 months after the first Affordable Care Act individual plans took effect. Now that we have the actual average market risk data, our rates for 2017 accurately reflect that data.

The end result of the factors discussed in my testimony, namely the healthcare utilization far in excess of anything predicted by national experts and the difficulty in accurately predicting average market risk for purposes of pricing the risk adjustment payment have caused ConnectiCare to experience significant losses in its SOLO product line.

In 2014, we lost $7 million on this product. Those losses grew to $30.8 million in 2015, and are estimated at $60.2 million for 2016. We simply cannot afford to

continue to offer this product at premium rates that result in financial losses to the company, because those losses will eventually undermine our financial strength and harm our members.

It is for these reasons that we respectfully urge the department to approve the rates as submitted in our filings. We appreciate this opportunity and are happy to answer any questions you may have.

MR. BABBITT: Thank you. I'm now going to ask Mary van der Heidje, principal and consulting actuary with Milliman, to make an opening statement as well. Mary?

MS. VAN DER HEIDJE: Great, thank you. And thank you, Eric. Good morning, Hearing Officer Kosky, officials of the Connecticut Insurance Department and members of the public, I am Mary van der Heidje, a principal and consulting actuary based in Denver, Colorado. I have more than 15 years' experience providing actuarial services to the commercial health insurance industry, particularly those offering ACA products across the United States.

Last Friday, ConnectiCare submitted written testimony from me in support of the application filed by ConnectiCare Insurance Company before you today. I adopt that testimony. I will offer just a few remarks before I help ConnectiCare respond to any questions you may have about the application.

As Eric noted, the focus of the commissioner's review of the application is to determine if the proposed rates are adequate or excessive. To be adequate, rates must support a long-term solvency of the insurer, here ConnectiCare.

Recent experience across the country as well as here in Connecticut demonstrates that solvency of health plans in the ACA market is a critical issue and concern for state regulators. Many health plans, large and small across the country, have stopped offering the ACA products due to insolvency or the losses and strains directly related to ACA business.

More plans have opted to end participation in the ACA. I hope the marketplace for consumers requires that

insurers be able to remain solvent, to stay in business and to pay claims.

Therefore, one of the commissioner's responsibilities is to ensure that the insurers premium rates are adequate. The ACA protects consumers from excessive premium rates, through rebates of premiums exceeding the minimum medical loss ratio of 80 percent in the individual and small group markets.

If an insurer's actuarial premium predictions are too high, then the company spends less on medical services than 80 cents out of every dollar of premium retained for these products, then the health insurance company is not allowed to keep that excess amount, rather the health insurance company is required, by the ACA rebate to pay excess premium as a refund to its customers.

However, no similar protection exists with respect to inadequate rates, which increases the importance of the commissioner ensuring in this proceeding that ConnectiCare's rates are adequate.

I was engaged by ConnectiCare to review the premium rates and to provide additional

support prior to the submission of the application. I have reviewed ConnectiCare's application and have confirmed that its proposed premium rates were developed in an actuarially sound manner. And that the proposed premium rates satisfying the Actuarial Standard of Practice, or ASOP, number 8, as being adequate and not excessive.

Based on my experience as an actuary, in my appearance in the healthcare industry, it is my opinion that premium rates lower than those requested by ConnectiCare in its application would not be adequate and would fail to satisfy based on.

MR. BABBITT: Thank you, Mary. A couple of questions, Attorney Kosky. I'm going to start with Mary, if I can.

Ms. van der Heijde, you prepared written testimony for submission of this docket; is that right?

MS. VAN DER HEIDJE: Yes.

MR. BABBITT: And to your knowledge, that written testimony was submitted, in fact, to the department in the docket?

MS. VAN DER HEIDJE: Yes.

MR. BABBITT: And was the written testimony true and accurate to the best of your knowledge at the time you prepared it?

MS. VAN DER HEIDJE: Yes, it was.

MR. BABBITT: And does it remain true and accurate today?

MS. VAN DER HEIDJE: Yes.

MR. BABBITT: Do you adopt that written testimony as your testimony in this matter?

MS. VAN DER HEIDJE: Yes, I do.

MR. BABBITT: Mr. Kelsey, I have similar questions for you. Did you prepare written testimony for submission in this docket?

MR. KELSEY: I did.

MR. BABBITT: And to your knowledge, was that written testimony submitted to the department in the docket?

MR. KELSEY: Yes.

MR. BABBITT: Was the written testimony true and accurate to the best of your knowledge at the time it was written?

MR. KELSEY: Yes.

MR. BABBITT: And is it -- does it remain true and accurate today?

MR. KELSEY: Yes.

MR. BABBITT: Do you adopt that testimony as your testimony in this matter?

MR. KELSEY: I do.

MR. BABBITT: Finally, Mr. Galvin, did you prepare written testimony for submission in this docket?

MR. GALVIN: I did.

MR. BABBITT: And to your knowledge, was that written testimony submitted to the department in the docket?

MR. GALVIN: Yes.

MR. BABBITT: And was the written testimony that you provided true and accurate at the time that you prepared it?

MR. GALVIN: Yes.

MR. BABBITT: And does it remain true and accurate today?

MR. GALVIN: Yes.

MR. BABBITT: And you adopt that testimony as your testimony in this matter?

MR. GALVIN: I do.

MR. BABBITT: Excellent. Attorney Kosky, we're ready for questions from the department.

HEARING OFFICER: Thank you, Attorney Babbitt.

MR. BABBITT: Thank you.

HEARING OFFICER: We'll now begin with cross examination of witnesses by the department staff. Mr. Lombardo, please proceed.

MR. LOMBARDO: Thank you, Hearing Officer Kosky. I'd like to ask of whoever seems to be the most appropriate party to answer questions, understanding that some cases it may be more than one person. Just anyone can respond of the three that were sworn in.

Just for the record, I need -- as Hearing Officer Kosky identified, there were amendments made to the rate filing on June 15th, July 27th and August 3rd. I'd like someone to read in for the record the changes, the requested -- revised requested rate increases, the magnitude of the ranges and the reason, in a summary format, the reason for those changes.

MR. KELSEY: Okay. Mr. Lombardo, I'd be happy to address that. As you mentioned on

June 1st of this year, I -- we submitted our initial application, which include a 23. -- 24.3 percent average rate increase. On June 15, 2016, we revised that filing and submitted an average rate increase of 29.8 percent.

There were two primary changes in that resubmission. The first being that in our original submission we had only claims paid through February of this year incurred in 2015. And we took that opportunity in that two-week period to look at claims paid through May. So, the additional three months have gone out on the 2015 year. And they'll look at the yearly indications for 2016. It indicated the 2016 claims continued to emerge higher than we had anticipated when we did our original rate bill. And they show few signs of mitigating.

As a result, we increased our morbidity assumption by five percent to six and a half percent. The second change we made was we modified our plan slopes to more precisely reflect the impact of trend leveraging at the plan design level. By that I mean that plans

with higher deductibles experience greater leveraging than plans with lower deductibles. And that we factored into our plan slopes.

Subsequent to that, the department asked us a question regarding risk adjustment. And that question came because on June 30th of this year, after our first and second submissions, we received final notification from CMS regarding the amount ConnectiCare owed into the risk adjustment program on behalf of the 2015 benefit year.

That amount ended up being $55.40 pmpm, which was higher than we had built into our rate assumption for 2017. Given that new knowledge from CMS and now another data point, which was consistent with the 2014 data point for this line of business, we decided to increase our risk adjustment amount from $24 to $55.40. Again, that led us from a 29.8 percent to a 37 and a half percent rate increase.

Finally, on August 3rd, we submitted our final rate application or modification to the application requesting a 42.7 percent average rate increase. The only assumption we

changed there was again in reference to risk adjustment. And what we did there was, the CMS Guidelines, or the actual answer for 2015 was based on a market average premium in 2015.

The way this program works is it's a percentage of applied to a market average premium. Based on our analysis of the competitive landscape in Connecticut and the refilings that everybody has submitted, we anticipate that the average market level premium in 2017 will be significantly higher, in the magnitude of 25 to 30 percent higher in 2017, than it was when the $55 pmpm amount was calculated by CMS. Therefore, we increased, we felt it prudent to increase our assumption for risk adjustment from the $55 to just under $77 pmpm.

MR. LOMBARDO: Thank you. So, just so that everyone is very clear, the rate application that the department has in front them is an average request, premium request of 42.7 percent, from the original 24-plus percent that was requested on June 1st.

I have a lot of questions pertaining to

the risk adjustment for prior years and what transpired over the last couple of weeks in your application, but I'm going to hold that off until the end. I have a series of other questions that I think we should get through fairly quickly with quick responses and maybe some follow-up.

What we will have -- any additional data that we request from ConnectiCare, we'd like to receive that, even though the record for public comment will be held open until next Thursday, we'd like to receive any additional information we request by Monday, August 8th. And we -- the information that we're asking for, we think should be readily available to ConnectiCare. And if there are any issues in responding to it in that time frame, once the hearing is over, we can communicate, but the response should come through SERFF as it relates to any questions that are being asked at the rate hearing.

Okay. The dollar 38 that you identify as pmpm cost for tomosynthesis, can you elaborate on that, briefly describe the development of it and provide a general

explanation for how you derived the dollar 38 per member per month?

MR. KELSEY: Okay. I'll start with an overall description and then give you a couple of more facts. The dollar 38 pmpm for tomosynthesis, for those of you who don't know, that is a new technique. It's 3D imaging for mammography. And this is a new mandate in the state of Connecticut, which will take effect in 2017.

Our estimate was derived based on our claim experience, as well as incident rates per public information, as we searched for the utilization assumptions.

The unit cost was based on Medicare rate tables in terms of what they reimbursed for tomosynthesis, as well as in the evaluation of the historical contractual discounts for such services. So, a few more details around that. It is essentially a projection of utilization times unit cost, is much of our analysis is.

On tomosynthesis, we projected based on our experience, because obviously we don't have experience directly related to

tomosynthesis. So, we had experience related to mammograms. And in consultation with our chief medical officers and other medical professionals at ConnectiCare, we came up with looking at that data an average utilization of 5,869 services per year, with an average unit cost of $110 per service. If you multiply those two numbers and divide by approximately 500,000 member months, you get to the dollar 38.

MR. LOMBARDO: Thank you. Can you go through the same type of explanation for the 24 cents per member per month cost in the rate filing for infertility and specialized formula?

MR. KELSEY: Yes. The infertility cost in specialized formula was in our 2016 rates. That was a mandate that was put in for 2016, actually, very late in the year, last year, as you will recall. We built 21 cents pmpm into our 2016 rates for that.

It's necessary to build a factor for that in again, because it's not in that experience, it's not in our 2015 starting point. We trended the 21 cents pmpm and an

average trend of 10 percent and that came out. That's how we derived at the 24 cents.

MR. LOMBARDO: Okay. So, just for everyone's information, once tomosynthesis, and the infertility and specialized formula are built into your experience, there will not be any explicit need for a pmpm load onto your premiums going forward?

MR. KELSEY: That's correct. Once it comes through our experience, in those cases, infertility, which took effect in 2016 will be in our experience. When we do our 2018 rates, we won't have to be that -- add a factor in for that. Tomosynthesis, being new in 2017, we will need to make an adjustment in our 2018 rates for that. And then by 2019, it should be in our experience.

MR. LOMBARDO: Okay, thank you. There is a 30 cents per member per month cost for other identified in the rate filing. Can you elaborate on that and the development of the 30 cents?

MR. KELSEY: Sure. This was a change we made not related to a State mandate, but it was related to a benefit change that

ConnectiCare implemented. We have a list of pharmaceuticals, a list of drugs, that people can access at little or no cost. We call it our value drug list.

We decided, as we approach 2017, to add -- expand that list and include additional drugs in that list. So, the 30 cents is a representation or evaluation of the value of us, in effect, waiving the copay and paying the full cost of those drugs. So, we looked at our 2015 experience, we determined how much was covered by copays and we trended that to 2017. And that would then be the additional costs of enhancing that list.

MR. LOMBARDO: Okay. So, it's primarily the waiving of the copay for additional drugs?

MR. KELSEY: Yes.

MR. LOMBARDO: Okay, thank you. We can turn to Appendix A, within the rate filing. That is, for everyone's information, the breakdown of the rate increase request into certain categories.

There is an identified 4.4 percent claim

experience update. Can you briefly describe what that is, why there is a need for it and how it was developed?

MR. KELSEY: Just bear with me for a moment while I find that in my notes --

MR. LOMBARDO: Sure, absolutely. I'll still be here.

MR. KELSEY: Okay. Do you have the page? Thank you. So, one of the first components we looked at when we set our rates, obviously, is how our claims have changed since we set our last rates, okay. So, the 4.4 percent rate increase, as you said, attributed to the claims experience updated is the value of comparing 2015 claims to what the 2016 rate filing would have projected, okay.

So that when we did our 2016 rates, we were looking at 2014 experience, trending forward two years. Inherent in that, underlying that is an assumption of what 2015 would look like. Now, we know with retrospect where 2015 came in in terms of total cost.

So, the 4.4 percent indicates that 2015

came in that much higher than we had projected when we built our 2016 rates. So, that is the valuation of that. Keep in mind here, we're talking about reasons for rate increases. So, that's why that's a valid number --

MR. LOMBARDO: Correct. The next on the list is the change in morbidity, 14.3 percent. You described an additional five percent or so that you added on in the June 15th amendment to the filing.

MR. KELSEY: Sure.

MR. LOMBARDO: Can you describe the -- what is change in morbidity, why the level of 14.3, and maybe explain a little bit more in detail how morbidity interacts with what you just talked about with increased claim experience and how morbidity interacts with the risk adjustment assumption that you are making?

MR. KELSEY: Right. Given the -- your questions in this area, if you can indulge me, I'd like to actually give a brief introduction to how all the components come together, if that would be helpful?

MR. LOMBARDO: Yes.

MR. KELSEY: Okay, all right. So, the morbidity, as you mentioned and other things, are key components of the request of rate increase. In particular, morbidity, the experience update, that we just talked about, risk adjustment and trend which I presume we will talk about later, are all components of the rate increase and all impact future projections in a similar way. It is critical, however, to understand the distinct and independent nature of each of these components and how we reflect each in our pricing, so as to avoid double counting, et cetera.

We start with the experience update, as we just discussed, which is a measurement of the difference between the experience used to develop 2016 and 2017 rates. 2015 claims experience was materially worse than the 2016 rate development would have anticipated. The 4.4 percent impact states that these 2015 claims were 4.4 percent higher than ConnectiCare would have anticipated when developing the 2016 rates.

This impact assumes that the market morbidity, as well as ConnectiCare's morbidity, is consistent between the two experience periods used to develop the 2016 and 2000 rates. This assumption ensures that the experience update component of the rate increase is independent of the morbidity adjustment.

Because we assume that the morbidity between the experience used to price 2016 and 2017 is the same, we next must remove the morbidity adjustment used in the 2016 pricing. If we did not remove -- which was a 7.1 percent morbidity adjustment -- the experience update would be 7.1 percent higher.

This occurs because ConnectiCare's morbidity has tracked that of the Connecticut individual market. Once we have established the appropriate baseline, we trend the experience to 2017, reflecting the projected changes in utilization and unit cost from 2015 to 2017.

Next, we are required to put ConnectiCare experience on the same basis as

market average risk. This is accomplished through the risk adjustment component of the rate increase. To the extent that ConnectiCare's population is sicker or healthier than the market average in 2017, it ultimately will be adjusted for by a risk adjustment transfer payment.

However, if the whole market changes, then the average for all carriers changes and it is not adjusted for by risk adjustment. Therefore, any change in the overall market average needs to be captured in the premium rates. In addition to trueing up the morbidity of the experience period and putting ConnectiCare's experience onto a market average morbidity basis, we also must project the morbidity level of 2017 versus 2015, which was the baseline experience period.

We estimate that the 2017 individual market will have a 6.5 percent higher risk in 2017 than in 2015. This estimate was developed based on the deteriorating claims experience ConnectiCare has seen between 2016 and 2017. 2016 experience will continue to

develop the claim experience incurred and paid within the first six months of the year in 2016 as materially higher than 2015.

ConnectiCare's re-forecast of the 2016 already shows claim levels 6.6 -- 6.5 percent higher than in our pricing assumptions. Details of the risk in utilization driving this suggests that the 6.5 percent is the best estimate, but there are indications that the final morbidity increase may actually be greater.

To date, ConnectiCare's experience in risk is tracked with what the individual market in Connecticut as a whole has experienced. One challenge in the ACA is the carriers must price to the market average risk and this risk is not known at the time of pricing.

Given that all of ConnectiCare's past experience has been tracked by the market and that we have no reason to believe that we have begun to attract members with a risk profile different than the market as a whole, we are forced to estimate that the risk increase seen between 2015 and 2016 for

ConnectiCare is actually a market-wide phenomenon. I don't know if you have anything else to add to that?

MS. VAN DER HEIDJE: Sure, yeah. I think -- thank you, yeah. To build on what Neil was just describing, morbidity and risk adjustment are very tightly interwoven. And so, when you're thinking about how you build into premiums or don't build into premiums, impact of your population health or the morbidity, it's very important to think about those two pieces.

I think as you walk through the steps of how it was built into morbidity, there's some portion to the extent if we see a higher morbidity profile in the population, is that the market changing or is that ConnectiCare changing? Is it our portion of the market or is it the whole market?

And I think that's the key question that we isolate and try to identify when determining how much to build in as morbidity versus how much we consider as part of risk adjustment. To unpack that a little bit more, so when you're thinking about risk

adjustment, what it essentially does is it normalizes within a market between the carriers in that market to the extent that there is a higher or lower risk profile of the population. So, that's the stated intent of the risk adjustment program.

So, if you had one carrier with a healthier measured population and one with a sicker measured population, then you'd essentially have an imbalance between the two. And the risk adjustment program's intent is to try to shift some of the funds from one to the other.

If you have the whole market increase or decrease, imagine all of the carriers shifting together, the risk adjustment actually would not normalize that difference out.

So, just to take an example, if you had some set percentage that increases -- let me pause for just a minute.

THE REPORTER: I'm sorry.

MS. VAN DER HEIDJE: Can everybody hear me?

HEARING OFFICER: Yeah. Apparently, the

air conditioner just really kicked on loud. So, we'll check to see if somebody turned it on. Why don't we take a quick five-minute recess at this point. It sounds like it's getting a little quieter.

MS. VAN DER HEIDJE: Oh, I think it's getting better.

HEARING OFFICER: We're going to take a five and we'll let it cool down a little bit.

MS. VAN DER HEIDJE: Thank you.

(Recess: 10:03 to 10:08.)

HEARING OFFICER: We're back on the record. This is a continuation of the rate hearing for ConnectiCare Insurance Company, Inc. We'll continue with examination by department staff. And Ms. van der Heijde, to the best of your ability, if you can kind of repeat the last 10 to 20 seconds of what you said before we had to take a recess. Thank you.

MS. VAN DER HEIDJE: Absolutely, no problem. So, like you said, let me back up maybe about a minute into the content that we

were discussing.

So, the morbidity and the risk adjustment really move together and to the extent that different carriers in a market have different risk profiles, the intent of the risk adjustment program is to help transfer risk between them.

However, if the whole market shifts at once, you can think of it like a market tide shifting up and down. If the tide of all the boats increases or decreases, then a transfer between them doesn't change the absolute level of premium or revenue or cost or anything, because everyone is fundamentally on the same new higher basis.

So, we'll talk a lot more about risk adjustment when we get to that portion of your questioning, but in terms of morbidity, our task is to identify the change in that tide, the extent to which the actual market has changed. And so that is not the change between carriers. That is actually the change in the aggregate of all carriers together.

What I wanted to add, too, is this has

been an issue, not just in this market, but in many other states in which we've filed rates or reviewed rates. In my experience, there's a lot of things that are causing unprecedented need for services and need for care and a higher level of morbidity in these markets across the country.

I wanted to point out a few things that are different here, too, that maybe could be contributing to some of the morbidity change. A change in the grandfathered policies, there is very few left, so that's been a change from policies that had been outside of the pool into the pool.

I think looking at who the population is that chooses to purchase as part of the pool. That can, of course, change. There's many different ways to adjust for that in terms of age and products and so forth. But the actual need for the people in that population is different.

And so, as you think through the market, and again we'll touch more on the risk adjustment between carriers, but the market itself really drives that morbidity portion.

So, I think as we're breaking down the impact on this year's rates, like Neil was saying, there's really two parts of it. So, Neil, do you want to maybe break down the 14.3 between the two years?

MR. KELSEY: Sure. So, with that background, the 14.3, again, is a change in rates from 2016 to 2017. So, you may recall that when we came before you a year ago with our 2016 rate, we had made an assumption that the accumulated neglect or the pent-up demand that Eric had mentioned was actually showing signs of mitigating, that we had seen a ramp up in 2014, as new members came into the market. But the signs through the first part of 2015 were that that was mitigating.

We therefore built a negative 7.1 percent adjustment to our 2016 rates. In effect, removing the impact of pent-up demand, saying that that was not going to continue into the future. In retrospect, what happened was, starting in late 2015, we saw a ramp up in a demand for services.

So, that assumption, in retrospect, of the 7.1 percent favorable adjustment did not

materialize, and in fact, is likely getting worse. So, part of the 14.3 is the removal of that 7.1 percent adjustment from a year ago.

The 2017 rates include a six and a half percent morbidity adjustment. And that is what we feel is the value of how the -- to Mary's analogy, all the tides are rising, all the boats, as we go through 2016 into 2017.

So, that reflects essentially our view of 2016 and how it's emerging and that that is now a new norm, if you will; that the market is getting sicker. And Eric cited in his opening statement, some examples of cancer, NICU, kidney, dialysis, kidney treatment; those are all morbidity issues. It's a reflection that the population that is in the market now is sicker than it was before.

So, the uptick in utilization is a trend issue, but the fact that we're seeing more and more cancer patients, people on dialysis, et cetera, that's a morbidity issue. So, we've tried to separate those two.

MR. LOMBARDO: Okay, thank you. Just a

quick question on morbidity and reinsurance and how they interact -- not reinsurance, risk adjustment, because I will get to the risk adjustment later.

Normally, when a carrier assumes more significant morbidity, it's assuming a sicker population for themselves and therefore you would anticipate a dampening effect of any type of payment in risk adjustment. What I think you're suggesting is is that the entire market is moving six and a half percent higher. I can tell you in looking at all of the other rate filings, there's not a carrier out there right now that we have a rate filing in front of us in the individual market that has a six and a half percent morbidity adjustment built into their 2017 pricing.

So, I'd like you to provide a little bit more detail on how you think it's the entire Connecticut individual market when we're not -- it's not being suggested in other individual filings.

MS. VAN DER HEIDJE: Sure. I think to your first point, that is what we're saying,

that it's not that we think that the ConnectiCare cohort is going to have a 6.5 higher risk. In that case, if the market were static and ConnectiCare's risk profile increased, you would actually see ConnectiCare getting closer to the market, which would look like a reduction in risk adjustment.

MR. LOMBARDO: That's right.

MS. VAN DER HEIDJE: In fact, we're saying the opposite, which is compared to where the ConnectiCare population, health population, morbidity level is that the tide is going up. And so, I think in general, how do you back into, how do you infer, how do you calculate how much you see in your experience is ConnectiCare versus the market? And that's where the information that came out on June 30th about the 2015 plan year is quite helpful, because that allows us to line up assumptions about risk adjustment and cost and put those pieces on a level basis to see how much of that is captured by risk adjustment versus how much of it is, perhaps, beyond what is included in risk adjustment,

which would infer back to the rising tide issue, that if risk adjustment hasn't captured it, then it's an overall cost structure issue instead. So, is there anything you'd like to add to that, Neil?

MR. KELSEY: I think you summarized that quite well. The only thing I would add is that I can't speak to how others have built their rate filings, but I can tell you how we have tried to parse this out.

MR. LOMBARDO: Thank you. There is a 5.6 percent impact due to the transitional reinsurance program going away as of 12/31/2016. Can you go into a little bit more detail and elaborate on how that was developed, the 5.6 percent?

MS. VAN DER HEIDJE: Sure. While you're gathering the specifics here, so, essentially, the transitional reinsurance program is a program that's around just for the first three years, 2014, '15 and '16, and it is phased out starting in 2017.

So, when thinking about how the 5.6 percent rate increase is calculated really, it's that we're no longer pulling out

cost that would have been refunded back through this program. So, the lack of an adjustment has an impact, the lack of the removal.

So, essentially, going through the provisions for 2015, '16, '17, those have changed downward, and in 2017, they're now gone. So, this program in 2016 would have paid for 50 percent of claims for high claimants between 90 and 250,000. And so, essentially, in last year's rates, we've gone through and estimated what's the portion, looking at experience, you can now calculate what's the portion looking back to 2015 with different parameters then and had pooled that out. So, like I said, it's the absence of that adjustment that's actually producing the increase.

MR. LOMBARDO: Do you know what the per member per month built in to the 2016 rates was for the reinsurance program?

MR. KELSEY: I can find that for you, if you give me a minute?

MR. LOMBARDO: Yep.

MR. KELSEY: You want that from our

final filing, right?

MR. LOMBARDO: Yes.

MR. KELSEY: Okay. So, last year, we had built in $23.53 as a detriment or a savings from that program.

MR. LOMBARDO: Right. Do you know as a percentage of your rate that was?

MR. KELSEY: It works out to about the 5.6 percent.

MR. LOMBARDO: Oh, okay. So, that's essentially, you built in in 2016 --

MR. KELSEY: Right.

MR. LOMBARDO: -- approximately a savings of about 22, $23 per member per month?

MR. KELSEY: Right.

MR. LOMBARDO: And we won't know the actual results of 2016 reinsurance and the savings to you until sometime next year in 2017, correct?

MR. KELSEY: Yes, yep. Yes. Until June 30th of next year.

MR. LOMBARDO: Okay, thank you.

MR. KELSEY: So, yeah, just to tack onto what Mary said, I think it's important to

note, as I mentioned before, when we established our 2017 rates, we're trying to establish a rate that's adequate and not excessive, okay. The demonstration of the increase or the change in that, is a mathematical demonstration of how the rates change from one year to the next.

Said another way, in our 2017 rate build, there is no reinsurance program. There is no savings projected, okay. So, we are now calculating the difference of 2016, where there was a program. So, that's the 5.6 --

MR. LOMBARDO: Correct, okay. Thank you. Can you provide some support and explanation around the 0.3 percent impact from direct and brokered administrative expenses that's identified in Appendix A?

MR. KELSEY: Sure. So, there's a couple of components to our admin. The direct admin is fairly consistent with 20 -- with what we had built into the 2016 pricing. If you look back at our assumptions, they were $33.70 was in our 2016 pricing. We're projecting $33.28. And that has to do really with our

projected administrative cost levels and of our direct expenses combined with membership and growth, you know, across all of our business lines.

The sales component of our expenses actually increased about 80 cents. In the 2016 rates, we had $13.25. We're now projecting $14.13. So, the combination of a decrease in the direct and a slight increase in the sales component lead us to the 0.3 percent.

The sales expense is really consistent with what we paid out in 2015 on a per member per month basis and what we expect to pay out in 2016. So, that's how we come up with those numbers.

MR. LOMBARDO: All right, thank you. The rate changes that are proposed vary by plan pretty significantly; there is a wide range by plan. Can you explain why that is and in more detail the development of those benefit relativity factors that were revised?

MR. KELSEY: Sure. So, the plan relativities, there were really two things that there were -- two primary changes made

to our plan designs. I'll put them under the -- the bucket of related to the actuarial value calculator, which changed from 2016 to 2017. So, certain benefit plans had to change just to continue to comply with medal level requirements of ACA.

And then the other significant change that we made to our rates was how we interact the pharmaceutical deductible with the medical deductible. Many of our plan designs in the past had separate deductibles for medical services and pharmacy. We decided, going into 2017, to combine the deductibles across all services. So, now your pharmacy cost will go towards one deductible, as opposed to having a separate deductible for pharmacy.

MR. LOMBARDO: Yep.

MR. KELSEY: The combination of those is what you see by the variation by plan or by plan design. The first thing we did, just mechanically, was the combination of the deductible. And that then triggered other things that had to be changed, copays, deductibles, maximum out of pockets in order

to satisfy the ACA actuarial value calculations.

MR. LOMBARDO: Okay, thank you, okay. Now, I'm going to get to the risk adjustment and the variations in your risk adjustment assumptions in the -- from the proposal of June 1st to the final amendment on August 3rd and some questions around that, as it relates to the risk adjustments.

And I want to first start off by identifying something that Eric mentioned in his testimony regarding 2014 and 2015 data. Last year, ConnectiCare submitted a 2016 rate filing with no adjustment for risk adjustment built in for 2016. That was prior to the release of the 2014 report. There was a rate hearing held subsequent to June 30th. It was identified that ConnectiCare paid $44 per member per month in that CCIIO report that was issued on June 30, 2015. The department asked specifically why ConnectiCare would not want to update or adjust their risk adjustment for pricing for 2016 to the tune of the $44 per member per month.

If you can re-explain why that

assumption was done, because I think you'd be in a slightly different situation for your 2016 rates, if you had to assume the $44 per member per month that was known during the rate filing process last year. So, I'd like you to re-explain that.

MR. KELSEY: Sure, sure.

MR. LOMBARDO: Thank you.

MR. KELSEY: So, I agree we would be in a significantly different position in our 2016 rates --

MR. LOMBARDO: Yeah.

MR. KELSEY: -- had we built the risk adjustment into the 2016 rates, we'd be in a much different position financially. However, that doesn't change the required rate for 2017.

MR. LOMBARDO: Understood. But, Mr. Galvin brought up the idea of past rate deficiencies as a need for additional rate increases this year. And this is part of past rate deficiencies, is ConnectiCare's inaction on a $44 per member per month risk adjustment that was known and the risk was available and ConnectiCare chose not to

incorporate that into their 2016 rates.

MR. KELSEY: Right.

MR. LOMBARDO: So, that's why I'm bringing it up.

MR. KELSEY: Sure. Yeah, I'd be happy to --

MR. LOMBARDO: Yeah. So, if you can provide a little bit more explanation of why that was not incorporated into the rates, since the department gave ConnectiCare the opportunity to do that last year.

MR. KELSEY: Right. So, when we were setting our 2016 rates, which started in the first, second quarter of the 2014 or 2015, and you're correct, the department did give us an opportunity to review this in June, July time frame, once we had the first year, the CMS numbers known.

The fact of the matter was a couple of things. One, 2014 was the first year of risk adjustment. And there was a lot of movement in and out of the marketplace in 2014. Not all -- not all the members came into the ACA market in January, right. You had members who had been a July renewal, that didn't come

in until July of 2014. So, there was a lot of differences between the 2014 marketplace and what we were projecting in 2016.

Secondly, in 2015, we experienced significant churn in our population between 2014 and 2015. More churn than I would have expected in terms of about 45 percent of our members were brand new to us in 2015. We had almost 16 percent turnover of people leaving us and then a whole bunch more people coming in.

So, with a -- really a growing population, and the fact that 45 percent of -- almost half of that population was brand new to us and we didn't have any insight at all into their risk scores or how they would perform, their morbidity level, we didn't feel comfortable making an assumption around that.

In then finally, I'd cite that the risk adjustment model itself used to make the transfers has a great deal of volatility in it. We've hinted or cited some of the concerns that we have on the risk adjustment model and other forums would allow us to go

into more detail on that.

But armed with those suspicions and those concerns and the fact that we didn't have a whole lot of insight into half of our membership, we chose not to build that into the 2016 rates.

MR. LOMBARDO: Okay, thank you for that explanation. Does ConnectiCare participate in the Wakely, annual Wakely study?

MR. KELSEY: Yes.

MR. LOMBARDO: Okay.

MR. KELSEY: And they actually do it three, four, five times a year. Yes.

MR. LOMBARDO: I also note for the record that CCIIO did come out with a nine-month analysis in March, a report and Connecticut had enough data --

HEARING OFFICER: You're losing power in yours.

MR. LOMBARDO: -- had enough data to support an analysis for the Connecticut market. Do you know what ConnectiCare received in March as an estimate of what 2015 would be on a per member per month basis?

MR. KELSEY: I don't, off the top of my

head, have the CCIIO number, but that's something we can provide to you.

MR. LOMBARDO: Okay.

MR. KELSEY: You know, we did get Wakely numbers --

MR. LOMBARDO: Yeah, I was going to ask you --

MR. KELSEY: -- about the same time frame.

MR. LOMBARDO: Yeah. So, what was the Wakely estimate on a per member per month basis for the payment that you presumably would have been paying for 2015 risk adjustment?

MR. KELSEY: Let me see if I brought that. While I'm looking for that, I know that the Wakely numbers, as you started, I think the first view of the year was around March. And then there's another one in July, and another one as the year progresses.

That was showing improvement as we went through 2015. So, it started out at a total dollar amount significantly higher than we ended up. It started out in the -- actually, it started, spiked up and then it came down.

So, it's dependent on the data from the other carriers and their projections.

I don't know if I have the transfer on a pmpm basis. It doesn't look like I have the various versions from Wakely. I have that back at the office.

MR. LOMBARDO: Yeah, if you could get that. Well, let me ask you this in general terms: Was the $50, I think it was $55, I believe, that was in the CCIIO report, was that significantly different than Wakely's estimate of what your payment would be for 2015?

MR. KELSEY: I believe it was lower than Wakely's estimate, but it ended up not being a very reliable predictor of what we actually paid.

MR. LOMBARDO: Okay.

MR. KELSEY: There were flaws in the data.

MR. LOMBARDO: Right.

MR. KELSEY: And CCIIO actually put that in their report.

MR. LOMBARDO: Right.

MR. KELSEY: That the data was -- had

certain inefficiencies. It was based on EDGE server data at the time.

MR. LOMBARDO: Yeah.

MR. KELSEY: Carriers were not under an obligation to have complete EDGE server data until after that report was submitted.

MR. LOMBARDO: Okay.

MR. KELSEY: So, there was a lot of concerns about that report.

MR. LOMBARDO: Okay.

MR. KELSEY: For us, it was a data point. It didn't -- we didn't take any action on it. We already accrued a number for year end. It was -- our accrual was supported by some of the information we were getting from Wakely. CCIIO was another data point.

MR. LOMBARDO: Okay.

MR. KELSEY: But it wasn't actionable.

MR. LOMBARDO: So, let's start with the initial June 1st and then the June 15th amendment. Included in the June 5 -- 1st and June 15th amendment, you had estimated the risk adjustment is $21.34 on a net basis pmpm, correct?

MR. KELSEY: It was in that neighborhood, 21 or $24.

MR. LOMBARDO: Okay. I looked them up. So, it's fairly accurate. It's right from the URRT that was submitted for both.

So, I guess the question has to be asked that if you knew you were a significant payor in 2014, you were getting some data points that were identifying that you were a significant payor in 2015. Can you kind of take us and walk us through why you only estimated $21 or so in your initial filing and an amendment 15 days later of only $21 per member per month? I would assume that you anticipated that that was sufficient to cover the risk adjustment for 2017.

MR. KELSEY: At the time -- at the time, we picked the $21, we were actually looking at about a 40 to $45 estimate for 2017. Again, not having full faith and having significant churn, et cetera, in the marketplace even in 2016, and not having the full emerging results that we're experiencing in 2016, our initial plan was to phase the risk adjustment impact in over a two-year

period.

As experience continues to deteriorate and losses continue to amount, we no longer felt that that rate would allow us to be adequate for what we needed in 2017. And that's the primary rationale for the increase.

MR. LOMBARDO: Okay. I would recommend in future rate filings that if you're planning on implementing something over time, you identify that in the rate filing.

MR. KELSEY: Okay.

MR. LOMBARDO: If you had assumed 45 to $50 per member per month and you knew that was approximately what you were going to try to get to, you should probably put -- probably should have put it in the rate filing, and identified it as an explanation of what you were doing. Because it does look, on the surface, to be that the $21 was sufficient for 2017. And now, not only is it not sufficient, but the $55 is insufficient, according to your August 3rd rate filing.

The August 3rd filing identifies, frankly, a unique feature that no other

carrier has described to the department and ConnectiCare hasn't described to the department in past rate filings. This idea of premium trend from -- in the marketplace. You've described it in somewhat detail, but I guess I have to ask both Neil and Mary, I'm a little confused as to where this comes from and the timing of it.

It was never identified as a build-in for this. We don't frankly have any other carriers that have structured their risk adjustment this way. Clearly, there's a solid data point of $55 per member per month from the CCIIO report.

So, kind of explain to me and the hearing officer what went into the assumption to get to the 55 and then why regarding this new feature with a premium trend has it not been built in to previous ConnectiCare filings?

MS. VAN DER HEIDJE: Sure. Perhaps, I'll go first and Neil, of course, feel free to fill in with other information. I think you pointed out a couple of important timing pieces that I think drive a lot of the story

of what happened walking between the different summary of the revisions that occurred here.

So, the first one, the 20 some-odd dollar, 21, 22 somewhere around there, value in June 15th, that was just right before that June 30th report. And so, I think at some level having a projection that it could be in the 40, $45 range, using information that you have so far is one thing. To get the June 30th report two weeks later that has a payable of that size is quite another.

And so I think that was part of the challenge. I think, Neil, I share your description of this, that you have a series of data points from which you have to make a really important projection. And prior to the June 30th report, we were missing a key data point, which is the June 30th number for 2015.

There's one important piece of timing. The other important piece of timing fits into what you mentioned about the market average premium. So, maybe if I can touch on that for a minute?

MR. LOMBARDO: Sure.

MS. VAN DER HEIDJE: Like you mentioned, with the risk adjustment program, the transfer isn't on a pure dollar basis. It's on a percentage of market premium basis. So, if we go through within a market, it must be budget neutral between all carriers, for example, within the individual market and the state of Connecticut. It must be budget neutral.

The way that that calculation works is each carrier essentially gets a transfer percentage, either a positive or a negative. To make that all budget neutral, the transfer percentages used the same market average premium. So, if one paid in X percent, one received back five percent, it would be X and Y percent of that market average premium, not X and Y percent of a ConnectiCare premium and another carrier and another carrier's own premium.

If you think about the stated intent of that from the risk adjustment regulation, it was to ensure the budget neutrality, because if we did have a transfer based on a

ConnectiCare premium rather than another, everyone's premium is a little different. And so, the transfers would be different and the whole thing doesn't add up appropriately to be budget neutral.

So, when we think back in terms of timing and we look at the market average premiums from '15, '16 and so forth, and had that guiding what we think the market average might be for '17, at the time of either of these first couple filings, didn't have full information of what the market average premium could look like.

Now, of course, ConnectiCare is a driver of the market average premium as part of the market, but there wasn't full transparency at the time of our initial filings of what the other carriers in the market might look like.

Seeing that ConnectiCare is by no means alone in this market and in many other markets across the country right now with double-digit increases, that changes our perception of the market average premium as well. So, even if you have the same percentage, if you think the market average

is going up and you have a payable of X percent, it's now X percent of a larger average number. So, kind of looking at the July 28th versus the August 3rd, looking at the $55 pmpm and how that's consistent with the higher value, that's from the average shifting.

MR. LOMBARDO: Okay, thank you. I did an analysis of 2014 average premium in the State of Connecticut, and a 2015 average premium for the individual market in Connecticut. The average earned premium in 2014 was approximately $460 per member per month. The average earned premium in 2015 in the individual market was approximately $435. So, there was about a five and a half to six percent decrease in the premium from 2014 to 2015.

Based upon the concept of what you just described, if the premium goes up, then your risk adjustment, everything being equal, should be going up. It was not the case when the premium dropped by five to six percent from 2014 to 2015. ConnectiCare's risk adjustment went from $44 to $55 per member

per month.

Other carriers had significant swings in per member per month. Some were receiving money. Some paid. Some paid before, were now receiving money. So, I do want, for the record, to comment on the fact that the risk adjustment process is a difficult one to evaluate. I think everyone that's doing this can agree, regulators, consultants and the carriers themselves.

But I do want to impress upon the fact that there's a significant number of assumptions that go into estimating the risk adjustment and driving it. And I'm not sure that we're completely there on describing what actually happens as a result of premium trend or things like that.

Because it -- as the data points become available in 2016 and beyond, but certainly the mechanism, and I understand, it's the way the premium for the market, but there's a lot of things that can change from 2015 to 2017 in the risk profile of a carrier that dramatically changes either the payment received or the payment made into the

program.

MR. KELSEY: So, yeah. And I would agree. There's a lot of uncertainty, which is why, for us, this is kind of an evolutionary process. And the reason we brought this up within the last week was we're continuing to look at risk adjustment and trying to figure out what it means. And what it means to us this year, next year, et cetera.

And there are -- there is so much complexity in it and there's so much differences of opinions. The part of what we're doing is talking to other people in the industry as well. And that's an ongoing process.

MR. LOMBARDO: Yes.

MR. KELSEY: So, it does evolve. In terms of the market average premium, I'm not sure what your data source was, but how we got our numbers, we -- since we do participate in the Wakely study, as you mentioned, according to them, according to their analysis, in 2015, the average market premium was $430 for the individual market,

very consistent with your 435. We actually have insight into 2016 from the first quarter study and that shows $440. So, not much of an increase there.

MR. LOMBARDO: Right.

MR. KELSEY: That was in a period of time, however, when the -- and this is the individual market, including direct and exchange.

MR. LOMBARDO: Yeah.

MR. KELSEY: Between '15 and '16, rate increases were modest, okay.

MR. LOMBARDO: Uh-hum.

MR. KELSEY: What exacerbates this issue now is the fact that we're not looking at anybody putting modest rate increases in front of you.

MR. LOMBARDO: Uh-hum.

MR. KELSEY: We're looking at significant rate increases. Our projection based on what's filed today, the market share is about a 26 percent change from 2016 to 2017 across the market.

MR. LOMBARDO: Okay, thanks. Hearing Officer Kosky, the insurance department has

no additional questions at this time.

HEARING OFFICER: Thank you, Mr. Lombardo.

Mr. Babbitt, do you wish to examine your witnesses?

MR. BABBITT: No. No, thank you. Not at this time. We do have a closing statement, when that's time.

HEARING OFFICER: Thank you.

MR. BABBITT: Thank you.

HEARING OFFICER: At this time, we'll now commence the second public comment portion of the hearing. Public comment portion of this hearing will commence with comments from public officials, and comments of other interested persons, who did not have an opportunity to speak earlier.

I've asked anyone interested in participating in the hearing to again comply with the following guidelines. Each individual must identify himself or herself for the record, including any organization he or she represents. Each individual must address all comments to me.

All comments must relate specifically to

the rate application of the insurers, which is under review by the Insurance Department and now pending before me. And each individual must reasonably limit his or her comments to three minutes.

Do we have a sign up sheet?

MS. MEDINA: Yes, we have one person.

HEARING OFFICER: Mary Jennings.

MS. JENNINGS: Good morning. My name is Mary Jennings and I'm an independent broker based in lower Fairfield County with several hundred ConnectiCare members.

As the churn has been mentioned, this is the year for ConnectiCare with my book of business, due to the fact that primarily all my members are on the exchange.

Since I was here yesterday making comments, I would like to recognize that ConnectiCare, from my point of view, does provide superior customer service within the state of Connecticut, as relative to Anthem and United.

But that being said, before I came today, I attempted to clarify whether I would be paid commission for next year. I got a

vague response, read the trade press, and it's not clear to me from what I've heard what the filing is. I'm assuming it may be no commission on the exchange plans.

So, I would like to say the following, about the customer experience of those consumers purchasing plans on the Connecticut exchange. They are truly the state's most vulnerable. They do not necessarily have computers. They often have English not as their first language. And they are presented with overburdened call centers, complex computer navigation and a lot of other information that only an expert truly can navigate, whether a provider list, a formulary. It typically takes me, when I sit with a new member to select the plan, even a healthy member, to do them service, it typically takes for an individual, about 20 to 25 minutes.

After that occurs, I would like to point out to the Department of Insurance, to keep this as a paying member, the brokers are often pulled into a very difficult verification process on the income. The

consumers who attempt to do it on their own often say, It's confusing, it's not resolved.

And in extreme cases, with autopay with ConnectiCare, all of a sudden 400 or $800 is zapped out of an account, because those tax credits have fallen off. Therefore, I urge the department to reconsider and not reduce by a penny, please, the proposed commission rate. If it does, there is a lot of -- and I have a tag going around, I personally witnessed what happens in an over-subscribed fair what happens when non-experts give this information. Even if they call a doctor's office, the doctor -- you have to go to a billing department to find out what network these various carriers are in.

HEARING OFFICER: Another 30 seconds, please.

MS. JENNINGS: Another 30 seconds, okay. I would like to just close with one statement. This is my experience: When people buy the wrong plan, don't get the expert advice they need, they say they have quote "bad insurance." They attempt their first time to go to the doctor or they get

the first bill, they simply drop out.

And I think this is a cycle that will continue, unless the brokers in the state of Connecticut are properly compensated for our work on the exchange. Thank you.

HEARING OFFICER: Thank you, Ms. Jennings.

Mr. Babbitt, would the applicant like to respond to any of the public comments either generally or specifically?

MR. BABBITT: No, thank you.

HEARING OFFICER: The applicant will now have an opportunity to make a brief closing statement, although, it is not required. I'm asking any closing statement be limited to five minutes. Mr. Babbitt, does the applicant wish to make a closing statement?

MR. BABBITT: We would, please.

HEARING OFFICER: All right, proceed.

MR. BABBITT: Mr. Galvin?

MR. GALVIN: Yes. In advance of my closing statement, I just wanted to comment on the risk adjustment scaling for purposes of the record. So, we have added the impact of the average market premium increases for

the reasons that we stated and Neil and Mary have all outlined.

What I would just point out is that our competitors would be very reluctant to do the same, because that would in effect lower their rates, given the fact that we are paying our competitors those amounts of money. So, I just wanted to comment as a more general matter.

In terms of closing, Hearing Officer Kosky, officials of the Connecticut Insurance Department and members of the public, I sincerely appreciate the opportunity to be here and explain our rate filing for the SOLO product.

We are deeply honored by the trust that our members place in us to serve as their health insurer and have for the past 35 years. We work hard every day to be worthy of that distinction.

Ultimately, our rate filing, which is the focus of today's hearing, is driven by our commitment to remain financially strong. We want to be able to continue to be the health plan of choice for Connecticut over

the next 35 years. As we have discussed in our filing and during this hearing, we are forced to add more than 18 percent of premium in the form of risk adjustment payments, to which we pay our competitors.

Further, the premiums have not been sufficient to cover the care of cost that our members are seeking. The difficulty in accurately predicting the average market risk for purposes of pricing risk adjustment and the healthcare utilization far in excess of anything predicted by national experts has caused ConnectiCare to experience losses, as I described.

We simply cannot afford to continue to offer this product at premium rates that result in financial losses to the company as those losses will eventually undermine our financial strength and harm our members.

It is for these reasons that we respectfully urge the department to approve the rates as submitted. Thank you.

MR. BABBITT: Thank you, Attorney Kosky.

HEARING OFFICER: Thank you. Are there any further questions from the staff of the

Insurance Department?

MR. LOMBARDO: No.

MS. CAMPANELLI: No.

(Pause.)

MR. BABBITT: Attorney Kosky, can we clarify before we conclude the hearing what information the department is seeking from us? I just --

MS. CAMPANELLI: We're going to do that right now.

HEARING OFFICER: Absolutely.

MR. BABBITT: Excellent. I thought that might be what we're doing. Thank you.

MR. LOMBARDO: Just to reiterate what we're looking for specifically, and I think you should be able to get this to us fairly quickly is the estimate, Wakely's estimate on a pmpm basis of what your risk adjustment payment would be for 2015 and the estimate from the March report from the feds that was CCIIO that was based on nine months.

I think that was the only additional information that we asked. And I think you can provide it to us by the end of business today. I don't think that should be a

problem. If it is, let me know right now.

MR. KELSEY: So, you want the risk adjustment transfer payment for the SOLO block?

MR. LOMBARDO: For this carrier that's subject to the rate hearing --

MR. KELSEY: Yes.

MR. LOMBARDO: -- for the individual market, the estimate that Wakely had given you.

MR. KELSEY: '15 and the CCIIO estimate?

MR. LOMBARDO: And the CCIIO estimate, yeah.

MR. BABBITT: Yes. That is possible by the end of business today.

MR. KELSEY: Yes.

MR. LOMBARDO: Okay, thank you.

HEARING OFFICER: So, again, for the record, no issue in supplying that information by the end of business day today?

MR. KELSEY: Correct.

HEARING OFFICER: Okay.

MR. KELSEY: And it will be uploaded through SERFF.

MR. LOMBARDO: Yes, okay. Thank you.

HEARING OFFICER: Therefore, in accordance with Section 38a-8-40 of the Regulations of Connecticut State Agencies, I'm ordering the applicant to submit the aforesaid documents by the end of business day today, August 4, 2016.

The record of this hearing will be held open for further written comment until the closing of business day, again, Thursday, August 11, 2016. Again, that's for written comment. Today's hearing is adjourned. Thank you.

(Hearing concluded: 10:55 a.m.)

CERTIFICATE

I hereby certify that the foregoing 99 pages are a complete and accurate computer-aided transcription of my original stenotype notes taken of the Public Hearing, in the Matter of: CONNECTICARE INSURANCE COMPANY, INC., which was held before Jared Kosky, Hearing Officer, at the Insurance Department, 153 Market Street, Hartford, Connecticut, on August 4, 2016, commencing at 9:01 a.m.

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Mary Falzarano Mayhew, LSR 477
Licensed Shorthand Reporter