STATE OF CONNECTICUT

INSURANCE DEPARTMENT

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In the Matter of)
)
THE PROPOSED RATE INCREASE)
APPLICATION OF)
CONNECTICARE BENEFITS, INC.,)
) June 14, 2017
Applicant.)

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PUBLIC HEARING

Held Before:

JARED T. KOSKY, Hearing Officer

PAUL LOMBARDO

KRISTIN CAMPANELLI

Reporter: Bethany A. Carrier, RMR, CRR, LSR #071

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(The hearing commenced: 1:01 p.m.)

HEARING OFFICER KOSKY: Good afternoon everyone. I'd like to call this public hearing to order. Can you 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.

At the outset, again, I just want to remind everybody that the Department is validating parking tickets for anyone who parked in the Morgan Street Garage, which is the garage on the other side of Market Street. So if you haven't already done so, please talk to the people in the lobby out front and they'll be happy to help you.

And I want to take a moment at the start of this proceeding to explain how this works. Many of you may be familiar with hearings held by the legislature to consider proposed legislation, or agencies in your town or city

to consider municipal affairs, but may not be with this type of administrative hearing.

An administrative hearing such as this is a regulatory proceeding in which a party, in this instance ConnectiCare, ConnectiCare Benefits, Inc., is required to provide 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 comment, the amount of time for each statement restricted out of respect for everyone here. Second, there will be a half-hour period of public comment toward the end of this proceeding for others who may wish to comment. And third, written comment may continue to be submitted up until the close of business of July 1, 2017.

Unlike a legislative hearing, there may be times when we may need to call a recess. I'd like to remind all attendees that I expect everyone to conduct themselves in an orderly and respectful matter. Any conduct determined to be disorderly or interfering with this proceeding will be dealt with under the appropriate legal authority.

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

As a reminder for the media in attendance, because the rate filing is under active review by the Insurance Department, staff members of the Department are not available for public comment. Communication representatives for the insurance company are here to address media questions, and any interviews with members of the public must be conducted outside of the hearing room.

For the record, this hearing is being

held pursuant to Sections 38a-8 and 38a-481 of the Connecticut General Statutes and will be conducted in accordance with the Insurance Department's Rules of Practice in Connecticut Uniform Administrative Procedure Act. ConnectiCare Benefits, Inc., will be referred to as "ConnectiCare" or the "Applicant." And for the record, Docket Number LH 17-71 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 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 in application filing, the application dated May

1, 2017, by ConnectiCare concerning premium rates for its individual on Exchange Plans is excessive, inadequate, or unfairly discriminatory pursuant to Connecticut General Statutes, Section 38a-481.

The proceeding was commenced on May 1, 2017, when the Applicant filed with the Connecticut Insurance Department, which I'll refer to as the "Department," a rate application regarding the Applicant's individual rates for on Exchange plans. While there is no statutory requirement that a rate hearing be held, on May 30, 2017, Commissioner Wade ordered that a public hearing be held on June 14, 2017, to consider the commissioner granting approval of the proposed application.

As a result of the open enrollment beginning on November 1, 2017, the federal government exchanges, including the Connecticut Exchange, have required the 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 was submitted to the Office of the Secretary of State. In addition, this notice was posted on the Insurance Department's Internet website. This notice indicated 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 of practice of the Connecticut Insurance Department, ConnectiCare has been designated as a party to this proceedings. Without being designated as a party -- as an official party to this proceeding, the Connecticut Insurance Department staff will have the right to ask questions of the witnesses to this hearing.

Joining me are Paul Lombardo, Life & Health actuary, and Attorney Kristin Campanelli, Legal Division counsel.

At this time would counsel for the Applicant please identify themselves. I'll ask you later to identify your witnesses.

MR. BABBITT: Certainly. Good afternoon, Hearing Officer Kosky. I'm Bradford Babbitt from Robinson & Cole on behalf of ConnectiCare Benefits.

HEARING OFFICER KOSKY: Thank you, Attorney Babbitt. And for the record, I do wish to note that Deputy Commissioner Timothy Curry is in attendance today.

At this point, I'd like to enter into a record a stipulated list of exhibits. The list identifies seven 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. on Monday, June 12, 2017. Subsequent written comment received will be added to the record following the hearing. A copy of the exhibit list is available to members of the audience today.

On June 12, 2017, a prehearing conference call was held to expedite today's hearing by way of discussing exhibits, witnesses, and hearing procedures.

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 this proceeding to orally comment on the application. In this regard, there are two sign-up sheets available for persons interested in presenting oral comments; one for public officials, and one for persons other than public officials. And so we can better gauge our time, Ms. Medina, can you indicate how many people have signed up?

MS. MEDINA: We have two.

HEARING OFFICER KOSKY: So each person will have three minutes to comment. And we'll begin with public officials who wish to speak, followed by members of the general public. This is a comment period only. No questions should be directed to the Applicant or to the Department. The Applicant will then provide a presentation of the application. The 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 make a statement or be heard in the first half hour

will have the opportunity to orally comment on the application.

The public may also present written comments through the close of business, again, on July 1, 2017, by mail or delivery to the Department, or by submitting such comments online to the Department website.

Again, public comment portion of this hearing will commence with comments from public officials, then comments of other interested persons. I would ask that anyone interested in participating in this portion of the hearing to comply with the following guidelines:

First, each individual must identify himself or herself for the record, including any organization that he or she represents. And if you could please just spell your name for the benefit of our court reporter as well.

Second, each individual must address all comments to me, and all comments must relate specifically to the rate application that's the subject of today's hearing. And again, each individual must reasonably limit his or

her comments to three minutes.

For the public's benefit, we are providing a stopwatch so that you may organize your comments to fit within the time allotted. The clock is simply meant to help you better plan your statements and to provide the opportunity for everyone who wishes to be heard. So please don't feel rushed by the clock, it's just to help you organize your thoughts.

I will now begin with the public comment. And if I could just have the sign-up sheet. Senator Hwang.

MR. HWANG: Thank you very much. I'm State Senator Tony Hwang. I represent the 28th Senate District in the Connecticut General Assembly. I want to first thank the members of this review committee for your work. Your work is greatly appreciated. And I also want to take a moment to compliment the hard challenges that your company, ConnectiCare, has to endure in this very challenging and unpredictable healthcare market.

But I will speak and offer that I object

and request the Department to deny this rate increase. And the rationale is I would ask for you to deny pending further dialogue, further review, and further analysis of the impact of this rate increase on the general public and also some of the rationale behind it.

I think the frustration is, as I appeared before you virtually the same time last year, is the fact that we are not affording the general public an opportunity to fully understand the complexities and the challenges of healthcare costs in its totality. And so there are a number of offers that I would make in that regard; and that is perhaps the next public hearing be held in the Connecticut General Assembly at the Legislative Office Building, where it is a much more readily accessible location, and at a time that is more conducive for the residents that are impacted by these rate proposals.

The fact that you are holding this in the middle of a summer day, in the middle of a working hour, is a denial of opportunities

for the residents that are impacted by these rate increases to be here to offer their viewpoints.

So I have offered and submitted to the Department public testimonies that have been emailed to me that I will share with the Department. And I will deliver more down the road, because unfortunately the process is broken. The transparency aspect is suspect because of the fact that we're doing this and so few people can come and voice their frustrations, their fears, and ultimately their inability to afford some of the most critical elements, which is health insurance for themselves and their loved ones.

There's a problem here. And this process -- and I appreciate your hard work -- is not representative of getting this information out and having the people's voice be heard.

I think what we also want to add -- and I'd be remiss if I didn't add the fact that it feels like deja vu all over again when I come appearing before your review committee -- is the fact that we pretty much

have done this every year, that for the past year we've had a cumulative increase of over 100 percent plus of health insurance rate increases. Those are put-upon people that have no choice. They feel that it's a rigged system. They feel that they have no choice. And the fact that they're unable to come here is one of the biggest frustrations that we have in this whole process.

So I appreciate the opportunity. I hope that I'm able to speak in representing the people in the 28th District, but also in the emails that I've gotten throughout the state, that we need to create a far, far better, more predictable healthcare delivery and healthcare cost system. We need to create a system that's sustainable. And we need to create a system that's transparent and democratic.

If nothing else, the 100 percent rate increase that we've had to endure as a consumer in the general public is really a culmination where the Affordable Care Act has become anything but affordable.

So thank you very much and I appreciate

the opportunity to speak.

HEARING OFFICER KOSKY: Thank you, Senator Hwang. Thank you for your time.

So I understand the second person who signed up wants to wait until the second portion of the public comment period. So at this point, we are going to move on to the Applicant's presentation.

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 your witnesses.

MR. BABBITT: I'd be happy to. Thank you. At the far end of the table I'm joined by Roberta Wachtelhausen, who is senior vice president and chief sales and marketing officer for ConnectiCare. To her left, Neil Kelsey, chief actuary of ConnectiCare. And to my immediate right, Mary van der Heijde, principal and consulting actuary of Milliman, located in Denver, Colorado.

HEARING OFFICER KOSKY: Thank you, Attorney Babbitt. And would the court

reporter please swear in the Applicant's witnesses.

ROBERTA WACHTELHAUSEN, NEIL KELSY and MARY van der HEIJDE, being first duly sworn by Bethany A. Carrier, a notary public within and for the state of Connecticut, were examined, and testified on their oaths as follows:

HEARING OFFICER KOSKY: Mr. Babbitt, please proceed with the Applicant's presentation of its application.

MR. BABBITT: Thank you very much. We're going to start with an opening statement by Roberta Wachtelhausen.

MS. WACHTELHAUSEN: Good afternoon, Hearing Officer Kosky, Mr. Lombardo, officials of the Connecticut Insurance Department, and members of the public. I'm Roberta Wachtelhausen, senior vice president and chief sales and marketing officer for ConnectiCare.

It's my pleasure to appear before you on behalf of ConnectiCare Benefits, Inc., to

provide additional information about our rate request for 2018, and to respond to your questions about our application.

First and foremost, I'd like to say that ConnectiCare is extremely proud to be Connecticut's local health plan. We live and work in the same communities as our members, and we strive every day to live up to our neighbors' expectations and earn their trust. We're committed to providing the highest quality health insurance to Connecticut residents. This has been our sole focus since we were founded by a group of physicians 36 years ago.

ConnectiCare's commitment to serving Connecticut residents can be measured in three ways: First, more small businesses have chosen ConnectiCare as their health insurer than any other carrier. Small business owners have put their trust in us, and we view serving them as a privilege. Second, we're consistently one of the market leaders in serving Connecticut's retirees with Medicare Advantage Plans.

Third, most importantly and most

relevant to today's discussion, we have been chosen by more people purchasing individual health insurance plans than any other carrier in Connecticut.

ConnectiCare is the market leader in this segment. We have the highest enrollment in Access Health CT, the state's marketplace for Connecticut residents who need a place to secure health insurance for themselves and their families.

Our commitment to Connecticut's residents and the success that we've earned demonstrates the trust that employers and our members have placed in us. And we take that responsibility very seriously. We're here today to discuss the rates and insurance premiums we filed to offer through Access Health CT.

The Affordable Care Act has provided a crucial safety net to individuals and families purchasing coverage on their own. We see the value that access to healthcare coverage has provided to families here in Connecticut. At the same time, since the program began, some things have changed.

Insurers have left the market and the state co-op became insolvent. The federal government failed to fund the promised risk corridor payments that ConnectiCare and other carriers depended upon. These payments were intended to offset the costs of newly insured individuals with pent-up demand for care. The Connecticut insurance market was especially destabilized by the federal risk adjustment program, which was intended to level the playing field for carriers who attracted a sicker and more costly population. Our experience of sicker and more costly population has still required our company to pay out approximately $100 million to our competitors under this program for the past three years.

We've worked hard with the Department, Access Health CT, and other policymakers to help navigate these challenges so we can continue to be the health plan choice on which we know so many of our Connecticut residents depend. However, the uncertainty around this market continues to grow as members of Congress contemplate fundamental

changes to the ACA.

As we all know, insurance is about predicting and managing risk. To do that successfully, the rules for 2018 and beyond need to be known. Right now, they're uncertain. We don't know with certainty who will be covered, what benefits will be required, what subsidies and other financial support will be available to our customers, and what regulatory requirements must be fulfilled. We are essentially blindfolded.

In addition, the individual mandate that allowed us to predict how many people would be covered is not being actively enforced and will potentially not be part of the architecture going forward. Also, there's fundamental uncertainty around cost-sharing reduction payments that defray costs for low-income individuals. That's the coverage side.

On the cost side, hospital consolidations have made costs higher and have not achieved promised efficiencies and quality improvements. Pharmaceutical companies are pricing new drugs for which

there is no competition at eye-popping prices with no justification or relationship to the cost of the drug or its research and development.

Despite the uncertainty and accelerating costs, we are submitting products and rates to you that reflect what is needed to offer individual health plans in our community.

We are one of only two plans to remain in the exchange. We see firsthand a value that the Affordable Care Act has brought to our members, our friends and neighbors here in the state. More people now have access to health insurance. Financial assistance has been available to provide a helping hand to make premiums more affordable for many. Preventative care is available at no out-of-pocket costs to encourage early treatment of disease and health maintenance. And people with pre-existing conditions know that coverage is available to them.

In summary, ConnectiCare has been Connecticut's local health plan for the past 36 years. We continue to be committed to the people of our state and recognize the value

the ACA has brought to our friends and neighbors. However, our company has been challenged by flawed federal programs, unmet commitments of the ACA, and the acceleration of the cost and use of care. Further, the uncertainty created by the current political and regulatory environment, coupled with the underlying increasing cost of care, require the rates as filed to ensure we can sustain our business and continue to offer high quality health insurance to the residents of Connecticut.

Our actuarial team works diligently to develop and file premium rates that are both sufficient and reasonable. That's why my colleague, Neil Kelsey and his team, are here and what they have done in preparing our application for the department.

Neil is now going to provide you with a brief overview of his team's work and the reasons that support our rate request. Thank you.

MR. KELSEY: Thank you, Roberta. Good afternoon, Hearing Officer Kosky, Mr. Lombardo, officials of the Connecticut

Insurance Department, and members of the public. I am Neil Kelsey, chief actuary for ConnectiCare. I am a Fellow of the Society of Actuaries and a member of the American Academy of Actuaries. I have over 30 years' experience in health insurance actuarial work. I have satisfied the annual continuing education requirements of the Academy; therefore, I am qualified to work as an actuary in the health industry, specifically for ConnectiCare.

The application before you today was prepared by actuaries and analysts at ConnectiCare under my direction. I am familiar with the analysis, assumptions, and projections that went into the application. I have reviewed the work performed to create the application. I have approved that work, and I endorse the conclusions contained in the application. After these brief remarks, I would be happy to answer your questions about the application.

The issue before the Department today is whether the rates that we have requested are adequate or excessive. In preparing the

application, my staff and I have complied with Actuarial Standard of Practice, ASOP No. 8, updated March, 2014, entitled, Regulatory Filings For Health Benefits, Accident and Health Insurance and Entities Providing Health Benefits.

This standard of practice defines adequate rates and excessive rates in the way that is consistent with, but more detailed, than those adopted by the commissioner under Section 38a-481. ASOP No. 8 defines the rate as adequate if it is sufficient to pay claims, administrative expenses, taxes and regulatory fees, and have a reasonable contingency for profit margin. A rate is excessive if it exceeds what is required to pay those costs.

Our application meets all of the standards in ASOP No. 8 and, therefore, meets the requirements of Section 38a-481.

I would like to speak first about the components that comprise our requested rate increase for 2018. I would then like to address a number of factors that we expect to remain unchanged in the future, but that

could significantly affect our rates if they were to change.

The first factor contributing to the requested rate increase is experience. Our 2017 rates were based on actual experience from 2015 projected forward based on internal analysis, supplemented with national studies, assumptions from multiple actuarial firms, health surveys, and several other sources. We followed a similar approach when developing our 2018 rates, starting with actual experience from 2016. Our actual experience during 2016, and during the first portion of 2017 has been higher than projected.

Next, we anticipate the medical costs will continue to trend higher in 2018. Contract discussions with doctors, hospitals, and other providers have revealed that, similar to prior years, providers expect to increase their charges for their services in 2018.

Additionally, a large share of total medical costs is driven by pharmacy services. Specialty drugs, in particular, which are

used to treat some of the most challenging medical conditions, are increasingly expensive and their prescribing rates are on the rise. Currently, specialty drug costs represents over 45 percent of total pharmacy spending and are expected to grow to 50 percent by 2020. Our rates must be sufficient to account for these increasing costs. Medical trend is contributing 9.1 percent towards the proposed increase to our rates, which is in the range of externally developed industry norms.

The next factor affecting our proposed 2018 rates is change to public policy mandates under the Affordable Care Act, or ACA. As with all health insurance carriers, we are required to adapt to various public policy-driven changes that have an impact on our pricing.

There are three such items impacting our proposed 2018 rates. First, there is the health insurer fee. This is a fee imposed by the ACA on all health insurers. This fee was subject to a temporary moratorium in 2017, but that moratorium expires at the end of

this year. Accordingly, ConnectiCare and other health insurers will be obligated to pay the health insurer fee in 2018. We expect that this fee will increase our rates by 2.1 percent.

Then there is the Federal Risk Adjustment Program. This program transfers funds between health insurers within the same market with the overarching goal of redistributing funds to those plans with enrolled individuals with relatively higher healthcare costs compared to the market average. Our rates must account for these payments.

However, the market risk is not known until over 24 months after the rates are developed. This means that the rates for any given year cannot be developed to include the specific provision to cover the related payments. We can only estimate the impact on our 2018 rates.

Prior-year transfers, adjusted for anticipated changes in the overall risk pool, and ConnectiCare's position relative to the overall risk pool, are used to inform the

assumption for future years. Our best estimate at this time is that risk adjustment payments imposed on ConnectiCare will require an increase of 2.8 percent to our rates.

The actual payment amounts for 2016 will be announced on June 30th of this year. It is imperative that we be permitted to adjust our application once we have learned of the scope of the actual 2016 payment amounts, as those will be an informative benchmark when projecting transfer payments for 2018.

Finally, there's the perceived change in the enforcement of the individual mandate and anticipated changes to the risk pool. The ACA requires individuals to maintain insurance coverage and imposes a tax on those who do not. Without such a requirement, fewer individuals, typically younger and healthier, can be expected to participate in the insurance pool. This lack of participation in turn increases the cost of insuring the remaining individuals in the risk pool.

Through the early part of 2017, a changing political climate has created

uncertainty about whether the mandate for individuals who participate in the insurance pool will be enforced and whether or not they will be taxed if they choose not to participate.

If the perception is that individuals are not required to participate in the risk pool, or that the tax will not be enforced for those choosing not to participate, more individuals may opt out of the risk pool, increasing the costs of insuring the individual market.

We have assumed in our rate development that individuals will still be required to participate in the risk pool in 2018. But we have also assumed that there is at least a perception that the requirement will not be enforced, which will leave some individuals to leave the market, particularly the younger and the healthier. In fact, we have already seen evidence of this aging, as the average age of our risk pool increased three-quarters of the year from 2016 to 2017. This factor has increased our rates by 2.4 percent.

The changes that we expect to see in

utilization, unit cost, and public policy mandates all contribute to the proposed increase in our rates for 2018. There is also a series of factors that, while we expect to remain unchanged in the future, would affect our proposed rates substantially if they did change.

For example, we have based our rates on our expectation that the cost-share reduction subsidies will continue to be funded and that the advanced premium tax credits will continue to be available to individuals purchasing insurance through Access Health CT. These payments and credits help make insurance more affordable for low-income individuals when they purchase their plans through the state exchange. As well, the CSR subsidies compensate insurers for the shortfall in funds resulting from the reduction in payments required from the members.

If either the CSR subsidies or the tax credits or both were to be eliminated or changed substantially, there would be significant operational and member changes,

which would require an increase in carriers' rates across the market.

Our application is premised on our expectation that both the cost-sharing reduction subsidy and the advanced premium tax credit will continue in effect. And as a result, we have not included any provision for changes to these programs in our requested rate increase. Any changes to CSR funding or premium tax credits would require an increase over the rates included in our application.

We appreciate the Commissioner's understanding of the impact of changes to these subsidies and the Department's willingness to allow an adjustment to rates, should the funding of these important subsidies be discontinued or changed.

Similarly, we have based our rates on the expectation that there will be no significant changes in carrier participation in Access Health CT and no changes to regulation or benefit mandates. Were either of these elements to change, our rates would need to be revised to reflect these changes.

Our application is therefore premised on our expectation that neither element will change in the coming year.

Our proposed 2018 rates also include a provision to cover the administrative cost of our business, including required revisions to broker compensation, member-service support, care-management programs, provider relations, and technology platforms which enable us to provide services to our members and providers.

ASOP No. 8 requires that our rates must be sufficient to cover the cost of doing business in the individual market. The component of our rates related to administrative expenses is also increasing. A greater proportion of ConnectiCare's business is shifting to individual products, which cost more to service.

Further, the component for sales costs has increased due to a requirement that broker commissions be paid on exchange at a level same or similar to the non-Exchange channel.

The application includes a pretax

operating margin, which is the same percentage that has been approved by the commissioner since 2015. Furthermore, any margin that we earn is not paid to shareholders, as ConnectiCare has no shareholders; rather, we reinvest in the company to support growth, innovation, and services to our members and providers.

The minimum medical loss ratio under the Affordable Care Act is set at 80 percent. ConnectiCare Benefits, Inc.'s, medical loss ratio has exceeded that standard. In 2016 our MLR was 92 percent and we did not achieve our targeted operating margin.

Our projected federal MLR for 2018 is 85 percent. The fact that ConnectiCare Benefits expects to exceed the minimum threshold by a significant amount establishes that the proposed rates in the application are reasonable and not excessive.

In developing our rate application, we have also relied on the industrywide expertise of our professionals at Milliman. Mary van der Heijde, sitting with us today, and her colleagues provided us insight into

industry experience across the country and also verified the quality of our assumptions and our projections.

I will now let Mary briefly share with you her qualifications, the role that her team served in our development of the application, and how the application fits into her industry experience.

MS. van der HEIJDE: Great. Thank you, Neil.

Good afternoon Hearing Officer Kosky, Mr. Lombardo, officials of the Connecticut Insurance Department, and members of the public. I am Mary van der Heijde, a principal and consulting actuary with Milliman based in Denver, Colorado. I'm a Fellow of the Society of Actuaries and a member of the American Academy of Actuaries, and have more than 15 years of experience providing actuarial services to the commercial health insurance industry, particularly those offering ACA products across the United States.

Since the implementation of the ACA, I have advised plans offering ACA products in

more than 40 states. I work closely with ACA experts across the country, with many state insurance departments, and with leaders in federal government agencies responsible for developing and implementing the ACA. I have been involved as a volunteer in leadership positions within the Society of Actuaries since 2008, including being the leader of the Society's annual advanced training sessions for other actuaries on the ACA.

I have presented frequently on the topic, both here and internationally. And pricing the rating in the commercial market is my primary area of expertise.

Beginning in 2015, ConnectiCare engaged Milliman to support them as they navigated the ACA environment. Again this year, ConnectiCare engaged me and my team to review the premium-rate methodology, assumptions and rates and to provide additional support prior to the submission of ConnectiCare Benefit, Inc.'s, application.

Neil and his team are experts on ConnectiCare's business and the Connecticut marketplace. My national knowledge and

experience has helped provide a broader context for evaluating ConnectiCare's application.

Debate about provisions to the ACA on the national level has been robust, to say the least, over the last six months. It's fair to say that the discussion around possible changes to the ACA has created substantial uncertainty about the future of the regulatory framework and requirement. Even without any changes having been formally adopted yet, ambiguity about the future at the national level is having an impact at the state level.

One example is the individual mandate requirement and the concern that it will not be rigorously enforced in the future. We believe that the continued debate and potential changes surrounding the essential aspects of the ACA is a critical influence when it comes to how insurers in every state are approaching their strategies for participating and pricing in the individual healthcare market for 2018.

The market in Connecticut includes

challenging dynamics, particularly in terms of fewer players in the market, such that any remaining carriers' exit have a significant impact on the market risk. A market exit could shift the mix of who remains covered, which impacts both the overall risk pool itself, as well as how risk adjustment manifests for all remaining carriers.

As Neil noted, the focus of the Commissioner's review of the application is to determine whether the proposed rates are adequate or excessive. To be adequate, the rates must provide for payment of claim, administrative expenses, taxes, and regulatory fees, and have reasonable contingency or profit margins.

My team and I have reviewed the application and all accompanying filing department documents. Our participation provided an independent assessment of the accuracy and validity of both the approach that ConnectiCare used to develop these rates, as well as the rates themselves.

We have confirmed that the proposed premium rates were developed in an

actuarially sound matter and that they satisfy ASOP No. 8 as being adequate and nonexcessive.

Based on my expertise as an actuary and my experience 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 ASOP No. 8.

MR. KELSEY: Thank you, Mary. We are now happy to answer any questions that the Department has concerning our application.

HEARING OFFICER KOSKY: Thank you. At this point we're going to take a five-minute recess at this point. And when we return, we will begin with the examination of the witnesses by the Department. It's going to be a firm five minutes, so don't stray too far. Thank you.

(Recess: 1:39 p.m. to 1:43 p.m.)

HEARING OFFICER KOSKY: We're back on the record in the matter of proposed rate increase application of ConnectiCare. We'll

now begin the cross-examination of the witnesses by the Department staff.

Mr. Lombardo, please proceed.

MR. LOMBARDO: Thank you. I ask that whoever seems to be the most appropriate party answer the question, understanding that in some cases it may be more than one person. Thank you.

If we turn to the Exhibit 1 in the rate filing, the buildup -- rate buildup, the next series of questions is going to come off of that.

If you could explain in more detail what is meant by "population morbidity" and the development of the factor of .57 percent for that adjustment in the pricing.

MR. KELSEY: Sure. So what we reflected in population morbidity is the change in the population as we expect from the 2016 baseline, because, as you know, the rate development begins with actual claim experience from 2016. We know something about how that experience has changed, or is expected to change in 2017, in terms of underlying change in the mix of people

insured.

So how we -- how we develop that calculation was we looked at the average risk score of our total book of business in 2016, and then looked at the average risk score for those members who were with us in 2016 that stayed with us in 2017. And that population was about .6 percent higher in terms of a risk score. So we're using that as a proxy for what we expect the underlying risk profile of the business to change from point 16 to point 17.

MR. LOMBARDO: Okay. As you noted in your comments, Healthy CT is no longer part of the market in 2017. They were one of the carriers that participated on the exchange.

Do you have a sense of how many members -- ex-members of Healthy CT that were on the exchange are now with CBI for 2017?

MR. KELSEY: I don't have a sense of the exact number, but I can tell you how our overall block changed from 2016 to 2017.

At the end of 2016, we had 49,158 members; of those, 38,265 stayed with us. Okay. So those are the ones that we

evaluated the morbidity impact off of. That means 10,893 left, presumably went to a competitor or to a different market, some of them might have gotten a job and gotten into a small group, et cetera.

We also had migration from our individual direct business, what we call "solo," of 49,095 members. New to ConnectiCare were 23,246 members. Some of those would have come from Healthy CT. So it's a subset of that number that came from Healthy CT.

MR. LOMBARDO: Okay.

MR. KELSEY: And that left us with just around 67,000 members in January of this year.

MR. LOMBARDO: For CBI?

MR. KELSEY: Just for CBI, yes.

MR. LOMBARDO: So you identified the morbidity -- population morbidity adjustment that supports the experience in 2016. But you don't know as of right now what the potential risk scores are of the new 23,000 that joined CBI as of 1/1/2017?

MR. KELSEY: Correct.

MR. LOMBARDO: Okay. So has there been any -- so there is no adjustment for that group in this population morbidity adjustment?

MR. KELSEY: Correct. We have been -- given the limited claim data that we have, basically four months of valid claim data, meaning complete through April, we have limited insight into the 23,000 new members. Now we are reaching out to them, we are starting to get claims on them, and we're starting to get a picture of what their risk profile is. But sitting here at the time of the application, it's premature.

MR. LOMBARDO: Would you be able to provide the Department with the first four months of claims PMPM? I'm assuming you have year-to-date experience.

MR. KELSEY: Yes.

MR. LOMBARDO: Through April?

MR. KELSEY: Yes.

MR. LOMBARDO: If you can provide that based upon the existing 38,000 that you had as of 1/1 -- 12/31/2016, and a separate claim PMPM for the additional 23,000 or so. And it

does not have to be split out between Healthy CT and non-Healthy CT. At this point it really doesn't matter. You just have 23,000 new in.

MR. KELSEY: Sure. We can provide that.

MR. LOMBARDO: Okay. Second question I have is: The next adjustment on the rate buildup is an underwriting mix change. Can you explain what that means and how you developed it? It certainly appears to be a reduction in premium.

MR. KELSEY: Right. So that -- that's also commonly referred to as "normalization." So what we did there was we took our 2016 experience and effectively normalized it to take out the change in benefits, change in distribution by area, as our business shifts from county to county, and an underlying change in demographics, meaning the aging of the population, the distribution, male and female, et cetera.

So that's a reduction in this rate or in this component of the rate. But it ties to -- and you have to look at them in totality. Because down at the bottom of the

development, under the calibration section, there are the projected benefit area in demographic changes. So those two factors working in conjunction.

MR. LOMBARDO: Okay. So could you explain those adjustments? Was there a positive or a negative impact to premium, based upon the adjustments under the calibration?

MR. KELSEY: It --

MR. LOMBARDO: From the prior rates to the expectation for 2018.

MR. KELSEY: It would be a slight increase to the rates through the projection.

MR. LOMBARDO: Okay. Do you have it split out between area and age?

MR. KELSEY: Yes. Yes.

MR. LOMBARDO: Okay.

MR. KELSEY: And the primary driver of that was a change in demographics.

MR. LOMBARDO: A change in demographics. Okay.

And, again, that does not account for the new 23,000 members that you have as of

January 1st, 2017?

MR. KELSEY: That accounts for where -- yes, it does, in terms of what plan design they were in in 2017, and what area they're in, and what age and gender they are. Because what we started with was a 2016 experience, and now we're projecting it to 2018.

MR. LOMBARDO: Okay. Thank you.

You have approximately $12.54 PMPM for the individual mandate impact. I'm assuming that that is the 2.4 percent adjustment --

MR. KELSEY: Correct.

MR. LOMBARDO: -- that you identified in your opening statement?

MR. KELSEY: Yes.

MR. LOMBARDO: You mentioned that the -- you believe that it is the younger population that is leaving as a result of this perception that the individual mandate, it's not being enforced. And I think you mentioned there was support for that in the fact that your average age from 2016, to at least the first quarter of 2017, increased by three-quarters of the year --

MR. KELSEY: Yes.

MR. LOMBARDO: -- is what you said? I'm assuming that that increase of three-quarters of a year was included the 23,000 new members?

MR. KELSEY: Yes.

MR. LOMBARDO: So you really don't know if it was the younger population that would be leaving; because you really need to do an analysis of your membership as of 2016 to what you lost, because it's conceivable that the reason why your average age is increased is because the new 23,000 members have a slightly higher age than your existing population. And it's not necessarily supportive of you losing younger folks out of the market; because we're talking about not leaving ConnectiCare, we're talking about leaving the individual market?

MR. KELSEY: Leaving the individual market. Right. Right.

MR. LOMBARDO: Right. So do you have anything specific that supports the fact that it would be the younger, less-costly population that is actually leaving the

marketplace?

MR. KELSEY: We don't have anything with us today that would demonstrate that. You know, we are a large proportion of the market, especially on the exchange in Connecticut. So we do believe that what we're seeing in our average age is indicative of what's happening in the market.

MR. LOMBARDO: Okay. So the average age, even though you've increased your membership by 23,000, you're -- what I'm getting at is that the average increase in the age wasn't related to the fact that you picked up 23,000 members?

MR. KELSEY: It was indicative that the book of business before those 23,000, and after, and then also including the members that left us, it's taking all of that into account. So it's total population, our population in '16, versus total population in '17.

MR. LOMBARDO: Okay. The last question is that obviously it's an age-rated product now. So you would anticipate -- and you don't have a lot of new membership into the

market. Would you agree with that? Not to ConnectiCare CBI, but into the individual market. We're four years in now, and so this will be the fifth year. We wouldn't anticipate a huge flux of people that were not insured in 2016 to all of a sudden be insured in 2018?

MR. KELSEY: Yes. I don't anticipate that. And specifically on the exchange, the overall Access Health CT membership stayed fairly flat from 2016 to 2017.

MR. LOMBARDO: Right. So you would expect a normal increase in your average age of your block of business from one year to the next?

MR. KELSEY: Would you elaborate?

MR. LOMBARDO: Well, if your membership is constant, so you don't have a lot of turnover in your membership -- and I'm 50 years' old -- which I'm not, by the way -- but if I'm 50 years old in 2016, I'm going to be 51 in 2017. If all of the other members of CBI are 50 years old in 2016, they're going to be to 51 in 2017. So you would see a natural progression.

If you have a dropoff of members and an increase in members of normal turnover, you might have your average age change. But if the membership count stays approximately the same and you think most people that are in it today in 2016 will be in it in 2018, then you would anticipate that your average age would increase? Or am I not --

MR. KELSEY: But you do have some -- you do have people who are older who are aging out of the market.

MR. LOMBARDO: Correct.

MR. KELSEY: And you do have newborns coming into the market.

MR. LOMBARDO: Yes.

MR. KELSEY: So it's not as easy as saying everybody increases their ages one year.

MR. LOMBARDO: Understood.

MS. van der HEIJDE: That's exactly right. So you would expect for it to be relatively static, actually, if it were a static population, despite the fact that a 50-year-old would become 51, some people would become eligible for Medicare and some

would have babies. So the whole block would essentially churn and tread water at the same spot.

So seeing an average drift over time strikes me as a real change, as opposed to just the aging that you would see over time.

MR. LOMBARDO: Okay. So maybe what you could do is provide the average age of your group as of 12/31 and your average age of the just the 23,000 members that came in --

MR. KELSEY: Okay.

MR. LOMBARDO: -- just to prove the stabilization of the average age. And if -- obviously, if we see the 23,000 members is approximately equivalent to your average age of your group on 12/31/16, then that absolutely plays out.

If, for whatever reason, your average age of the new 23,000 that you picked up is proportionately higher, that might be a reason for the average age increase. So we're just trying to establish or confirm where it's coming from.

MS. van der HEIJDE: It might be

worthwhile to add too, in terms of the development of the individual mandate factor, it's not just looking at the aging, and that's the entirety of the individual mandate. There really are three important pieces that are connected there, of course. There's the guaranteed issue that's part of this program, where everyone who would like coverage is eligible to purchase coverage. There's affordability, of course, which is making sure that everyone is able to afford it. And then there's the individual mandate which says everyone is responsible for having insurance coverage.

So as those three pieces fit together, and as we've all now seen the individual mandate impact that 2.4 percent that you mentioned, it was more of a global exercise of thinking through how those components fit together too, as opposed to just this is a key factor, but as opposed to ASOP.

MR. LOMBARDO: So speaking of the model you used, you had to assume a certain number of less costly people leaving the market. Do you remember what percentage you had?

MR. KELSEY: Yes. So to walk you through the methodology we used, we started with breaking our 2016 experience into cohorts by metal level: bronze-, silver-, gold-age cohort, broadbands, and health risk of the population: low, medium, high, and very high. Within each of those cohorts, we assumed that a certain number would exit. And we projected that forward to 2017 and looked at the change in risk profile.

So we assumed that a greater number would exit in higher-metal plans, the gold and platinum plans, at younger ages. And that was primarily 25 to 40, at that age. And the healthier, the low, and the moderately risky individuals from 2016.

So overall we're projecting that the market would shrink by about 9 percent and that most of the loss would be in the 27 to 40-year-old category; that that category itself or that cohort would drop by about 14 percent.

MR. LOMBARDO: Okay. Could you -- go ahead.

MR. KELSEY: Just take it one step

further. From a medical cost, what that does is increase our overall medical cost by about 4 percent. Okay? To turn that into a premium impact -- and this gets into normalization, one of your earlier questions -- as a result of that, now our population is now older if younger people leave. So we will get a lift in the premium, or the revenue per member, as the population ages. So that allows us to take that 4 percent medical cost, that increment, and decrease it by 1.3 percent.

So we ended up with an overall increase of 2.7 by that medical, and that translated into 2.4 overall rate.

MR. LOMBARDO: Thank you. Could you run that with -- instead of 9 percent, could you run it at 5 percent of the market leaving?

MR. KELSEY: Sure.

MR. LOMBARDO: And you can keep the same 14 percent of the population being at the younger ages. But just if you have the whole market leaving by 5 percent and provide that result.

MR. KELSEY: Sure.

MR. LOMBARDO: And the result I'm assuming would be less than the 2.4 percent rate impact. I would envision it would be fairly close to about half that, but that's just an educated guess.

MR. KELSEY: Right. Yes. And we can run that through.

MR. LOMBARDO: Okay. Thank you. There's a line in your rate buildup that says 2017 mandates not in experience. If you can provide an explanation of which ones are not included and what the prices for each of them are. We know what the total is.

MR. KELSEY: Sure. The one that -- there's only one that we reflected, and that was the tomosynthesis, the cost of the 3D breast imaging. So that the total of 1.52 is based on that. And it's the standard calculation of utilization times unit cost divided by member cost.

MR. LOMBARDO: Okay. Thank you. The next question is the risk adjustment. And it's 11.45 per member per month; but as you stated in your opening remarks, it's approximately 2.8 percent of premium.

If you can provide -- was that from the consultant, that estimate? Was that from your consultant that provided that? And if so, do you know -- I know CMS came out with estimates at the end of March of 2017. If you could provide what CMS estimated for CBI as well.

MR. KELSEY: Sure. So on the risk adjustment, there were two components to that. I'll dismiss with the smaller one first. And this was -- as you know, we filed a rate revision subsequent to our initial filing two weeks later. And what we learned in that interim period was from an external consultant that did a national survey: as part of the risk adjustment formula in 2018, the proposal from the ACA notice of benefit plan parameters is that they're going to institute a high-cost pool in 2018. And basically provide a level of reinsurance for individual claims above a million dollars.

The national -- that's going to be spread nationally across all carriers, the cost of that program. So it's not going to cost taxpayers or anybody else money; it's

going to be funded by the insurance carriers, similar to the risk adjustment and spread back to those who would benefit from it.

We're expecting the impact of that to be .34 percent of premium. So that's in the $11 and change that I have it here for risk adjustment because it's part of that program.

MR. LOMBARDO: Right.

MR. KELSEY: The remaining piece was informed -- let me answer two questions. Or the first question yes, it was based on information we got from Wakely Consulting.

Since the inception of the ACA, Wakely Consulting Group has been performing market-level simulations across the country to help carriers identify and project what their risk is relative to market. Because, as you know, we know what our own experience is. We don't know what the market experience is. So by all carriers submitting that experience to Wakely and then them coming back and doing the analysis, they can tell us how our risk profile stacks up and compares to the market and, therefore, project for us an estimate of what the transfer payment

would be.

The CMS numbers that came out were based on ED server data, which ultimately gets to what the final formula that will be released on June 30th, what those results would be. Their interim assessment was very close to the Wakely Consulting Group, within a million dollars overall on a $30 million number across all ConnectiCare companies. So it was very close to them.

So how we projected --

MR. LOMBARDO: Well, let me go back to that. So approximately $11 or so is what Wakely is estimating that you're going to have to pay per member per month, aside from the cost of the reinsurance?

MR. KELSEY: No. The $11 -- 9.84 of that is what we're projecting to have to pay prehigh-risk pool. And that is based on a projection. And what we did for that is we looked at the Wakely results by metal level from 2016, the transfer payment, PMPM by metal level. We removed any plans that we no longer have in the market -- because there was a couple that changed -- and we projected

membership at the metal level into 2018.

So if you look at it at a metal level, we're assuming the same number from Wakely, but we're projecting membership based on the new distribution. And that comes back to the 9.84. So we used the Wakely to inform our projection.

MR. LOMBARDO: And how close is that to what CMS gave you for what you will be paying in -- what you think you'll be paying for CBI in 2016?

MR. KELSEY: In 2016, we expect to pay about a dollar PMPM.

MR. LOMBARDO: Okay. So you're expecting to pay about a dollar PMPM, but you're projecting that you're going to be paying in 2018 approximately $10 per member per month?

MR. KELSEY: Correct. And that's based on a granular projection.

MR. LOMBARDO: Yes.

MR. KELSEY: Now, there are two other components of that projection that are noteworthy. One is we did reflect the average market premium increase from 2016 to

2017; that was about 24 percent in the Connecticut market, because the transfer of payment is based on average market premium. So we took the 2016, inflated it 24 percent for that.

And then there was one change that we think is material to the risk adjustment formula in 2018, and that's the fact that CMS is going to reflect administrative costs as a negative component of that transfer payment through the premium. That's a 14 percent decrement. So those two factors are in there as well.

MR. LOMBARDO: Okay. Did you build in some level of estimate of your 23,000 members you picked up in 2017? I know this is for 2018, but did you account for the potential risk score for the 23,000 that are now on your books that are new?

MR. KELSEY: Since we don't have any insight into that, we couldn't. But we did project what plan designs we think they're going to land in.

MR. LOMBARDO: All right. Thank you. It appears from the 2016 CBI Supplemental

Healthcare Exhibit Part 1 that's within the filing, that the retention identified in the rate filing is 13.9 percent. The retention charge used in pricing is approximately 21.9 percent. So if you could explain for the record the difference between those two numbers.

MR. KELSEY: Sure. Two primary contributors: One is that the individual business is becoming a bigger proportion of the ConnectiCare's overall book of business. And I touched on this in my opening statement.

Individual business is more expensive to administered. So that factors into the administrative costs that gets loaded into our 2018 rates, as opposed to the 2016 supplemental healthcare exhibit.

The other component of that would be the broker commissions that was also touched upon. In 20 -- in 2016, we were paying less on the exchange and we had a bigger component in the rates for the direct market. Going forward into 2018, the requirement now is that we pay commissions on same or similar

basis, on and off exchange. So we had moved our exchange assumption to the same level that's in our direct market.

MR. LOMBARDO: Okay. And can you give an estimate on a percent basis what that is?

MR. KELSEY: I can tell you it went from -- I think it was around $7 PMPM in the 2017 rates. It's now $14.13. So double the sales.

MR. LOMBARDO: Doubled. And that is a requirement from the healthcare exchange that they be equivalent?

MR. KELSEY: Yes. And in working with the commissioner.

MR. LOMBARDO: Okay. Thank you. There's a 10 percent load for tobacco use that you're introducing into the filing. If you could provide a little bit more detail as to the development of the 10 percent and if you are still going to plan on using tobacco in your rating going forward.

MR. KELSEY: We are -- I'm happy to provide that, if you'd like. We are -- for 2018, however, we have decided not to use tobacco in our rating. So the -- everybody

will get the rates that are called the "nonsmoker" or "nontobacco" use rates in our filing.

MR. LOMBARDO: Okay.

MR. KELSEY: But if you still want the 10 percent, I can --

MR. LOMBARDO: No, I don't need that. Thanks.

As you mentioned in your opening statements -- and it is in the filing -- the filing states that as premiums rise and certain carriers exit the market, CBI anticipates further adverse impact to the pool. I would understand as premiums rise, you anticipate, you know, the penalty that people have to pay isn't commensurate with the premium.

Please explain in a little bit more detail if certain carriers exit, how that's going to adversely affect the pool.

MS. van der HEIJDE: Yes. So I think, as you've seen in this market and in markets around the country, it's very challenging right now with all the different pressures in terms of cost and all of these issues. So

this has been a common situation that there are carriers exiting markets and members with those carriers need to identify what they're going to do. Are they going to pick a different carrier? Are they going to exit the market? What are those people going to do?

So we've seen -- I think consistent with how we thought about it here, we've seen in a lot of different states quite a bit of movement when you have a significant market exit. So breaking it down into maybe pieces that seem most salient here. You tend to get a change in the mix of business in the market, the mix of age and gender. We get a change in the mix of what products people purchase. Because if you're used to a particular product and that product isn't there -- it's not automatic -- that the best option for those members is to shift to the exact same thing with another carrier. So you end up getting a change as members make the best choice for them and their families as they move and make their decision.

If you come to the position that you're

the only carrier in a state -- so if you have two carriers, you lose one -- it's interesting to think about risk adjustment because it actually is meaningless at that point because you would be sharing risk with yourself. Right? You'd be the only carrier that's in that market. That's an important consideration as well.

Said differently: you essentially would be pricing for the market average risk; rather than using your estimate of your claims, adjusting for risk adjustment to lend market average, you now become the market average. So that's important.

MR. LOMBARDO: Right. And I think that was the impetus for my question. Because I wouldn't -- I mean, unfortunately it's basically ConnectiCare and Anthem in our individual market. So by stating that if a carrier exited the market, you would become the market and, therefore, you would become the average risk in the market and, therefore, the -- I think you noted, Neil -- about $30 million that you had to pay into the risk adjustment process would kind of go

away at that point.

MS. van der HEIJDE: It would, but it would also be -- yeah, the market would shift as well. So the reason -- if you're paying in versus if you're getting money out is there's a difference between your portion of the market and the overall market.

So if Carrier A pays in, Carrier B receives out, and Carrier B leaves, Carrier A no longer pays in because they are the market. But Carrier A would also have a proportion of Carrier B, and the market pool would shift.

So I would say that there's really two pieces that are important for us to break this down here: What is the risk adjustment transfer? Which, like you mentioned, that would be the piece you wouldn't transfer anything. I think even the bigger question that's built on that one would be: What happens to the market average? Because that's the tide at which you should be setting your premiums.

And so if the act of market exit itself impacts who's in the market pool, I think

that would be a specific driver that would make premiums that are calculated under one basis not line up with a different basis.

MR. LOMBARDO: Yes. And I also think the premise that the risk adjustment is working exactly the way it's supposed to work proper would lead to that conclusion. I'm not quite sure that the risk adjustment mechanism, all the parts are working correctly.

So I do agree in theory with your statement, but I'm not quite sure in practice it would work out that way. If you look at the claims data that is publicly available -- you know, one carrier receiving lots of money and the other carrier paying in -- there's not a big difference between the claim PMPMs that we're seeing.

So I do recognize in theory you're right, but I think in practice it may not work out that way. So --

MR. KELSEY: Just to follow up on that a little bit. When you look at 2016, which is the experience we're using to set our rates, while there were two competitors on the

exchange, us and Anthem, there was also Healthy CT; and in the individual market overall, which is what risk adjustment looks at, it's both on and off combined. You had some other carriers like Golden Rule and Aetna. So those carriers have already left the market.

We didn't know that at the time we did our rate filing. We did -- we have gone back, we've looked at that since we had that two-year window. We looked at what -- how that might affect us, and we concluded that there was no impact on it. They didn't have a huge market share. But we did try to analyze that piece of that.

If a competitor -- remaining competitor leaves the market, it doesn't mean we're going to take all their business either, because some of those people will find other recourse; maybe they'll go uninsured, maybe they can -- you know, maybe they were on an individual plan and now they can go on their spouse's group plan, for example. So there are other dynamics involved.

Just one nuance. There would still be

two companies left. Right? There would be ConnectiCare Benefits on the exchange, which is the subject of this file, and ConnectiCare on the direct business. So we would still have a risk adjustment and some mechanism between those two.

MR. LOMBARDO: Right. Correct. In 2016 and 2015, the claims PMPM remained fairly stable, with a significant increase in claims PMPM in 2016. And obviously you're seeing some increase in -- continued increase in 2017. I believe that's what was stated.

Why do you believe that it's going to continue to increase at such a significant rate into 2018?

MR. KELSEY: Are you talking about the trend assumptions in terms of --

MR. LOMBARDO: Yes. Yes, the claims PMPM and the trend.

MR. KELSEY: Okay. So what we feel now in retrospect happened between 2014 and 2015 -- first of all, in every year there's been significant churn. If you go back to '15 and 2016 to open enrollment, the market was churning in an over 50 percent, 60

percent rate. So it was -- even though the PMPMs were stable from '14 to '15, it was a different population.

Second point would be in the first open enrollment period, people got insurance. And this is specifically on the exchange. Many of those people were uninsured prior to that. This was the first time they had insurance. They may not have fully understood what they bought or how they utilized the benefits, how to actually access the insurance that they had. So there was a learning curve as people became familiar with their benefits and what they're paying a premium for.

So I think the experience, as it went from '14 to '15, was fairly steady on the exchange, and started to ramp up in '16 as people became more familiar with what is it about the pool? How do I find a doctor? And actually started to engage the system.

What we're projecting going forward in terms of medical trend, an overall 9 percent -- 9.6 percent annual increase in medical trend. I wouldn't categorize that as high, based on recent history. I would

categorize that as more of a normal increase. That includes that the one abnormal piece of it is the impact of specialty drugs, not only from the unit cost perspective, but the utilization on those drugs continues to rise. And that's part of that 9.6 percent.

But we have tested our assumptions against industry norms. And for the most part, with the exception of the utilization of specialty drugs, we're right within the midpoint, just above the midpoint of those ranges. Some buckets a little bit lower. But on average, we're right in the middle.

The one piece, as I noted, was specialty utilization, where we're an outlier with respect to industry norms. And that's based on our actual experience.

MR. LOMBARDO: You when say "outlier," more significant utilization?

MR. KELSEY: Yes.

MS. van der HEIJDE: That's right.

MR. LOMBARDO: You mentioned the 9.62 percent trend assumption. This is just a point of clarification. You identified the rate impact for trend in our opening

statements as 9.1 percent due to trend. What's the difference between the 9.1 and the 9.62?

MR. KELSEY: The 9.6 is the impact on medical costs; it included pharmacy. The 9.1 is how that translates into premium.

MR. LOMBARDO: Okay. Great. And the last piece of that is in the rate justification page of your filing that was submitted, it identifies an increase as a result of that of 10-and-a-half percent. So can you explain the difference between the 10-and-a-half, the 9.1, and the 9.62?

MR. KELSEY: Sure. And if you refer to Exhibit A, which is part -- or Appendix A, which is part of the rate filing, in the rate justification, rather than having nine categories, we tried to group it to tell the story of what was driving the cost.

So under the medical cost inflation, I included the medical trend of 9.1 percent, plus the morbidity changes from 2016 to 2017. So those components add up to the 10-and-a-half.

MR. LOMBARDO: Okay. All right. Thank

you for that explanation.

You mentioned in your opening statement that experience has -- is a portion of the rate increase request. I don't believe you gave an approximate percentage.

MR. KELSEY: Okay. Let me go back to my opening statement and pull that.

MR. LOMBARDO: Okay. Yeah. I think it was mentioned that 2016 is coming in higher than projected, and the first quarter of 2017 is coming in higher than projected. But you didn't --

MR. KELSEY: Yes. That was the 1.4 percent.

MR. LOMBARDO: 1.4 percent.

MS. van der HEIJDE: The 1.4, that includes that change in morbidity of .6 as well as the claim experience of .8. Together it's 1.4.

MR. LOMBARDO: Okay. So the claims experience was .8?

MS. van der HEIJDE: Is .8.

MR. LOMBARDO: And the morbidity adjustment.

MS. van der HEIJDE: And then the change

in morbidity is .6, exactly, for 1.4.

MR. LOMBARDO: All right. Good. As part of that, can you provide -- I think I may have asked this before, but I just want to reiterate the first four months' claims PMPM for 2017, I think that was already asked originally. But if you could do that for 2016 as well as 2015.

MR. KELSEY: 2015 as well.

MR. LOMBARDO: Yes. If you could add 2015 in there as well, I would appreciate it.

MR. KELSEY: Just to make sure, you're looking for year-to-date April, claim PMPM, total business?

MR. LOMBARDO: Yes.

MR. KELSEY: 2015, 2016, 2017?

MR. LOMBARDO: Yep. And then if you could provide the trend exhibit with the same four months of experience for the same three years.

MR. KELSEY: Sure.

MR. LOMBARDO: Just so that we could see the relative impact that 2017 is having and make sure that it's consistent with what

you're projecting for 2018.

MR. KELSEY: Okay.

MR. LOMBARDO: And you may have already talked about this, but in the justification, it talks about other impacts to the rate increase, and it's approximately 4 and a half percent.

MR. KELSEY: Correct.

MR. LOMBARDO: So if you could provide what that "other" means in the development of the 4 and a half. I'm sure it has to do with some of the other things you identified, but if you could -- just to clarify that.

MR. KELSEY: Sure. So the impact of the administrative cost increases is part of that, as is a decrement for the fact that the federal age -- or what we are now required -- or have been required to use in our pricing, is changing in 2018. They're going to be giving us more revenue for children under 20. So that allows us to decrement the rate across -- we could spread that increase in that cohort across everybody else. So those two things net up to the 4 and a half.

MR. LOMBARDO: Okay. Thanks a lot. So

that is a decrement to your --

MR. KELSEY: The age curve.

MR. LOMBARDO: Without that, it would have actually been higher.

MR. KELSEY: 5.6.

MR. LOMBARDO: Okay. Thank you.

You mentioned in your opening statements that if the CSR funding goes away, that there would be some level of impact to the premiums. Do you have an estimate? A ballpark?

MR. KELSEY: Right now I could tell you the national studies have pointed to upwards 19 percent or higher.

MR. LOMBARDO: Okay. And would you assume that that would be specific to the standard silver plan? Or is that 19 percent would be spread over other metal --

MR. KELSEY: The national studies that I've seen, the 19 percent is specific to the standard silver.

MR. LOMBARDO: Standard silver plan. Okay. Thank you.

I have a few general questions. It doesn't matter who answers at this point.

Within medical trend, we obviously assume that ConnectiCare has utilization management programs, has cost reduction programs, network contracting, and so forth and so on, provider contracting that tries to achieve lower costs. Can you briefly describe some of those programs? And are you seeing some savings there? And has that been projected and applicable to the estimates for 2018 trend? Has it been included in that?

MR. KELSEY: The -- I can't speak to the actual programs themselves, but in our base experience, we've been doing utilization management and care management since inception. And every year we look at new programs.

In our experience, then, in what's 2016 and prior reflects the programs that were in place during those years. Those translate into our trend, because we're using experience reflecting those programs to come up with our trend factors. We're assuming, as we look to our trend into 2018, that we will achieve at least the same amount of savings that we have in the past through

those programs.

MR. LOMBARDO: Okay. I do know -- the reason why I ask is ConnectiCare has been actively developing some buildings across the state, some facilities across the state. And I think there is a firm out of Florida that you also contracted with as part of that. And I know that's fairly new for ConnectiCare. So I just wanted to make sure that that type of savings, if you could -- if it was included in the rate projections and the trend projections.

MR. KELSEY: Certainly. The clinics you're talking about are CliniSanitas -- and I don't know if you want to add anything -- but yes, we have reflected -- they're essentially a provider for us, albeit a rather unique setting and a different care model, care coordination model. But yes, the impact of that is in our rates.

MR. LOMBARDO: Okay. Thank you.

MS. WACHTELHAUSEN: I'll just -- I'll just comment on the retail centers in particular. I think, first of all, it's been a great experience for our members to go

there and get help to understand their plans and get some guidance. It's a natural extension of our brand; we want to be in the communities and helping members. And as Neil said, we're always looking for ways to improve our business, to recontract around specialty drugs, around all the big drivers of care. And as he said in his opening remarks, we're always looking for ways to reinvest in our business.

So this is a very tangible way where we're reinvesting in our business to extend our brand to help the residents of Connecticut.

MR. LOMBARDO: Thank you. Would a shorter open enrollment period in 2018 and some stricter special enrollment rules, were those considered in when you developed the 2018 rates?

MR. KELSEY: Yes. And in terms of the shorter open enrollment period, I still -- my belief in what is in the rates is that people will still sign up for coverage, they will just now have to sign up by December 15th instead of making that decision after the

holidays.

It's incumbent on the market, us, Access Health, everybody, to get that message out. But I don't think the shorter open enrollment period is going to exclude anybody. I think it's just going to get them insured by a deadline.

MR. LOMBARDO: Okay. And what about the stricter special enrollment rules?

MR. KELSEY: That is underlying our projection as well. We're aware of all those rules, and we assume they're going to take effect.

MR. LOMBARDO: Okay. Do you have an idea or a sense of what percentage of your total claims for CBI is in network versus out of network.

MR. KELSEY: I don't have that handy, but I could get that for you.

MR. LOMBARDO: Okay. Great. Yes. And the last question I have is: Quality improvement programs, do you have a sense of the impact on claims PMPM that that has had? I think you have approximately $4 worth of expense --

MR. KELSEY: Right.

MR. LOMBARDO: -- for quality improvement.

MR. KELSEY: Those are the costs of those quality improvement programs that we can include as a medical expense under the federal formula.

MR. LOMBARDO: Understood. But are you getting savings from those quality improvement programs? We're hoping that you are. Do you have a sense of what impact that's had on premium?

MR. KELSEY: I don't have that -- I don't have a study of that, per se. Part of that is because it's hard to prove what didn't happen. Right? So the best way to analyze that would be to have a control group where you didn't have those initiatives or management programs in place and a group where you did and look at the savings.

My view on that is it comes through experience. We believe that there's a value to that, both in terms of cost and quality of care. And that would come through the experience.

MR. LOMBARDO: Yes. I guess in general it was just a general question. Because obviously if you're spending money on it and it's not working, then the idea is, you know, why continue to spend money on it or expense for it in the filing if you're not going to have the savings? So that was more the rationale for the question.

MS. van der HEIJDE: I think -- well, it makes perfect sense. And I would draw a direct connection between the money that's invested and really the philosophy of CBI having quality coordination, and all those things, the money that you spend on that and the lower medical trend position.

So there's two parts of medical trend, as Neil touched on: there's the unit cost and then there's the utilization. And in terms of both keeping care and most appropriate location, and also making sure there's not unnecessary care being performed, that's not good for members, not good for costs, not good for any of us.

I would put the philosophy that I've seen in working with CBI compared to others

that we worked with, very much focused on quality and management and as a driver for keeping claims and trend and growth and utilization appropriate.

So I think like Neil is saying, because it's nothing new, because it's something that's been a philosophy going to the past, the prior claims experience includes a lower basis for having these programs in place, and the prior trend and the prior increase in cost has been flatter because of that as well. So it's in there, but it's in there implicitly rather than an explicit adjustment because it's not a new philosophy.

MR. LOMBARDO: Sure. Understood. Thank you. I don't have anything further.

HEARING OFFICER KOSKY: Thank you, Mr. Lombardo.

Attorney Babbitt, do you wish to redirect your witnesses?

MR. BABBITT: No, thank you.

HEARING OFFICER KOSKY: We're going to press on to the second public comment period. And again, this is for those who did not have an opportunity to speak the first time. I'd

ask anyone participating in this portion of the hearing to again comply with the following guidelines: Each individual must identify himself or herself for the record, including any organization that he or she represents. Each individual must address all comments to me. All comments must relate specifically to this rate application, which is under review by the Insurance Department. And again, each individual must reasonably limit his or her time to three minutes.

Marc Block.

MR. BLOCK: Thank you. I'm glad to see that the microphone is standing up on its own. It was embarrassing before.

My name is Marc Block, B-L-O-C-K. As my comments will reflect, I'm not in the healthcare industry. I am a member of CONECT, which is a group of religious organizations throughout the state that are trying to make an improved Connecticut. And I've been actively involved in the insurance questions for the last few years, not because of me, because -- thank you, I'm in a company plan -- but my son is not and he participates

in the ACA and exchange, and he is really straining at trying to make the premiums that he has at this point. He works at two and three jobs and he works very hard and he takes care of children, he teaches children and adults in a nonprofit organization -- several nonprofit organizations. And his health is very important because he has to work with children and in physical activities.

But I would like to thank you folks. I really appreciated the discussion of your mission statement and how you're working with the community, because it really -- it's very important to the rest of us that we have someone like you here providing insurance for those people that need it. So thank you.

I do have a couple of questions. First of all, I'm trying to figure out as a member of the public and someone related to the exchange, what can we do about the health insurance fee that was referenced earlier that seems to be adding a few percent to this mix here? I think someone said it was on a moratorium before and now it's coming back.

I would be interested in knowing why it's coming back, and if there's a way to keep it coming back for insurance companies in the exchange. That seems to be like a low-hanging fruit.

There also seems to be another piece of fruit here called the penalty or the tax or something that the tax kind of stays down here as the premiums keep increasing. And I keep getting confused by this, because as the premiums increase, more people are willing to take the penalty, which means that the premiums will increase. So I'm a little bit confused by that. And if there's something that might be done or should be done about the penalty that could sort of balance out this divergence.

Along the lines of the penalty, is there any data on what expenses we are -- we, as a public, are incurring as a result of people going off insurance and running to the emergency room, which is a lot more expensive and it's a lot more cost in the end to us than having them go through their insurance carriers and through the normal, more

cost-effective channels?

Along that line, I guess one of the questions that I have is -- and I wanted to thank Mr. Lombardo for getting into this, I think he got into it -- am I correct that there's a risk adjustment and at the same time, as people are leaving the plan, those are the healthy people?

So what I heard was younger, healthy people are leaving, and then there's a risk adjustment that goes to other carriers who have more riskier, sicker people I guess. Is that what you -- I don't know if I'm supposed to ask any questions.

HEARING OFFICER KOSKY: Yeah, Mr. Block, this portion is just relegated to public comment.

MR. BLOCK: Okay. It's not clear to me that the up and the down are being balanced here; that as people are leaving and you're getting a more risky pool of insured, that that's not being addressed for in the risk adjustment. I think it was. I think I thought you said that it was with all of those 4.4 percent and 3.3 percent. The

numbers didn't work out for me. But I think that that -- if it wasn't addressed, I would think that it should be.

HEARING OFFICER KOSKY: And Mr. Block, although you are our one and only comment the second time, I'm giving you a little more time. In order for me to be consistent to everybody else, if you could just finish up your comments. Thank you. May we remind you we are accepting written comments.

MR. BLOCK: Yes. I'm just about done.

HEARING OFFICER KOSKY: Thank you.

MR. BLOCK: I have some wonderful written comments, but you guys kind of trumped me on most of them. But I, again, would like to just thank you all for the work that you do and for participating in the exchange. And to the extent that you can look for ways and programs, as Mr. Lombardo said, to reduce some of the costs, I would like to say that programs that you talked about, talked about the insurance company and the providers, and I guess my question would be: Is there anything that the public can do? Are there any things that education can

do for the patient so that they could take a more cost effective, efficient approach to some of these expenses? For example, looking for a less expensive pharmaceutical provider or going to the clinics or your -- the clinic that you talked about, rather than going to an alternative?

So again, if there are any programs that you can think of to reduce the cost, because it is a challenge for a lot of the people that don't have the kind of income that can support these kinds of increases.

And I also would like to say I second everything that Tony Hwang said about having a more convenient forum. Thank you.

HEARING OFFICER KOSKY: Thank you, sir.

Attorney Babbitt, at this time would you or your witnesses like to address any of the public comments, either specifically or generally?

MR. BABBITT: We appreciate the public comments. We don't have any specific comments on that, beyond our closing statement, at the appropriate moment.

HEARING OFFICER KOSKY: Yes. At this

time you'll have the opportunity to present a brief closing statement, although it's not required. I ask that any closing statement be no more than five minutes. You may proceed with the closing statement.

MR. BABBITT: Thank you.

MS. WACHTELHAUSEN: Hearing Officer Kosky, Mr. Lombardo, officials of the Connecticut Insurance Department, and members of the public, thank you for the opportunity to provide additional information about our rate request for 2018. We believe that the open exchange of information about these requests serves the interest of the Department, and ConnectiCare share in establishing adequate rates.

The best information available to us today leads us to believe that our requested rates will be adequate to pay claims and expenses and to maintain our business on the exchange, Access Health CT, through 2018. But none of us have perfect knowledge. Indeed, the risk adjustment payments for 2016 won't be announced for another two weeks, as we've discussed today.

The chance that these 2016 risk adjustment payments will exceed the estimates built into our rate request for 2018 highlights the importance that we be allowed to revise our rate request after the risk adjustment payments are established.

As noted, the major drivers of our rate increase are the increasing pharmaceutical costs, hospital consolidations, which allow hospitals and physicians to charge higher rates, and an aging population. As we've also noted, substantial uncertainty is impacting the exchange markets, both nationally and in Connecticut. Uncertainty surrounds the future of cost-sharing reduction payments nationally.

We hope that cost-sharing reduction payments will continue to be made in the future, and we've based our rate request on that expectation. Also, the number of insurers that will continue to participate on the exchange in Connecticut is uncertain.

We hope that Connecticut does not experience further attrition of the carriers participating on the exchange, and we based

our rate request on that expectation. These are only two examples of factors that could change in the near future, and that would require an increase in our rates for them to remain adequate.

Finally, let me reiterate that ConnectiCare remains committed to serving all of our members, including those purchasing plans through the exchange. We must have accurate rates to do so. The rates that we proposed for 2018 are reasonable and are not excessive; therefore, we respectfully request that our proposed rates be approved. Thank you.

MR. BABBITT: Thank you.

HEARING OFFICER KOSKY: Thank you. Any questions from the Department?

At this moment we are going to take a five-minute recess just to review those items that we're going to be asking ConnectiCare to provide to us and we will be putting those on the record. Again, we're going to go to a five-minute recess right now. Again, it's going to be a short five minutes, so don't stray too far.

(Recess: 2:47 p.m. to 2:50 p.m.)

HEARING OFFICER KOSKY: So we're back on the record in the matter of proposed rate increase application of ConnectiCare. Mr. Lombardo, please proceed.

MR. LOMBARDO: Yes. I'd just like to read in for the record our request. This will be your formal notification and it should summarize what we've asked for through the hearing, just to go through and make sure that we caught everything. And we would appreciate if we miss something, you identify it now rather than later.

Average age of your business as of 12/31/2016.

Average age of the new 23,000 members that came in in the first quarter of 2017.

Claims per member per month for the first four months of 2015, 2016 and 2017.

The trend exhibit that you provided, if you can send that in with, again, the first four months of 2015, 2016, and 2017 data.

The estimate of in- and out-of-network.

Running your mandate model with instead of 9 percent leaving the market, 5 percent leaving the market, all other assumptions being the same.

And then CMS is going to be sending a report out on the risk adjustment we believe on June 30th of 2017. If you could submit CBI's risk adjustment that's contained in that report to the Department.

We don't have anything else listed. Do you have anything, Neil?

MR. KELSEY: I had one. The -- you were looking for the year-to-date claim PMPM for the 38,000 members that stayed with us from 2016 to '17.

MR. LOMBARDO: Yes.

MR. KELSEY: As well as the new members.

MR. LOMBARDO: Yes. That's correct. So it's the average age.

MR. KELSEY: Right. Then you listed more -- other PMPMs, but those were total groups. So those were specific. You also want the 38,000 stayers versus --

MR. LOMBARDO: Yes. That's correct.

Thanks.

MR. KELSEY: Then I had a rough note on QI impact.

MR. LOMBARDO: Yes.

MR. KELSEY: Can you elaborate there?

MR. LOMBARDO: Yes. So you have an expense within your -- what you're allowed to use to offset on the federal MLR, you have a QI expense of, I think, a little over $4 PMPM. And if you have estimates of what those quality improvements impacts have had on claims. I think you mentioned that you didn't, but if you do, that's fine. If you don't, that's fine too.

MR. KELSEY: Yes. I'll go back and ask if there's anything even historical that I can pull up.

MR. LOMBARDO: Yes. I think that's it.

HEARING OFFICER KOSKY: All right. Okay. Thank you.

In accordance with Section 38a-8-40 of the regulations of Connecticut state agencies, I'm ordering the Applicant to submit the items identified by Mr. Lombardo to the Department by July 5th, 2017. The

record of this hearing will also be held open for further comment, which may be submitted to the Department, again, until the close of business of July 1st, 2017. The record of this hearing will close on July 5th, 2017, the deadline for which those items noted by Mr. Lombardo.

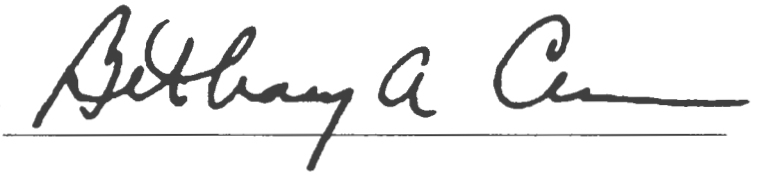
As a last reminder for anyone marked in the Morgan Street Garage, we'll validate that parking so you can go talk to the people out in the lobby; they'll help you. Today's hearing is adjourned. Thank you everyone.

MR. BABBITT: Thank you.

(The hearing concluded: 2:55 p.m.)

CERTIFICATE

I, Bethany A. Carrier, a court reporter within and for the State of Connecticut, do hereby certify that the foregoing 96 pages are a complete and accurate computer-aided transcription of my original stenotype notes taken in the Public Hearing in the Matter of the Proposed Rate Increase Application of ConnectiCare Benefits, Inc., held before Jared Kosky, Hearing Officer, Insurance Department, 153 Market Street, Hartford, Connecticut, on June 14, 2017.

/s/ 

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