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STATE OF CONNECTICUT  
INSURANCE DEPARTMENT

- - - - - x  
In the Matter of  
|  
CONNECTICARE INSURANCE COMPANY |  
| July 27, 2015  
- - - - - x

PUBLIC HEARING

Held Before:

KRISTIN CAMPANELLI, ESQ., Hearing Officer  
MARY ELLEN BREAUULT, Director of Life and Health  
PAUL LOMBARDO, Actuary, Life and Health  
(Panel)

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2       For the State:

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          JOHN RUSSO, ESQ.

**PREMARKED EXHIBITS**

1  
2 (Whereupon, Insurance Department  
3 Exhibit 1, Public Comments submitted  
4 to the Insurance Department prior to  
5 9am Friday, July 24, 2015, was marked  
6 for identification.)

7 (Whereupon, Insurance Department  
8 Exhibit 2, Rate filing submitted via  
9 SERFF by ConnectiCare Insurance  
10 Company, Inc., to Connecticut  
11 Insurance Department, including  
12 actuarial memorandum, dated April 30,  
13 2015, all correspondence related  
14 thereto, and one page executive  
15 summary, was marked for  
16 identification.)

17 (Whereupon, Insurance Department  
18 Exhibit 3, Notice of Public Hearing  
19 ordered by Katharine L. Wade,  
20 Commissioner, Connecticut Insurance  
21 Department, dated July 6, 2015, was  
22 marked for identification.)

23 (Whereupon, Insurance Department  
24 Exhibit 4, Email to Theodore Bromley,  
25 Esq., Office of the Connecticut

1 Secretary of the State and Taffy  
2 Womack, Office of the Connecticut  
3 Secretary of the State with Notice of  
4 Public Hearing and cover letter  
5 provided as enclosure, from Kristin  
6 Campanelli, Connecticut Insurance  
7 Department, both dated July 7, 2015,  
8 was marked for identification.)  
9 (Whereupon, Insurance Department  
10 Exhibit 5, Order by Katharine L. Wade,  
11 Commissioner, Connecticut Insurance  
12 Department, naming Kristin Campanelli  
13 as hearing officer, dated July 7,  
14 2005, was marked for identification.)  
15 (Whereupon, Insurance Department  
16 Exhibit 6, Email to Kristin  
17 Campanelli, Esq. Connecticut Insurance  
18 Department, dated July 17, 2015 with  
19 Notice of Appearance for Bradford  
20 Babbitt, Esq., Robinson and Cole, LLP,  
21 was marked for identification.)  
22 (Whereupon, Insurance Department  
23 Exhibit 7, ConnectiCare Insurance  
24 Company List of Witnesses, submitted  
25 by Bradford Babbitt, Esq., Robinson

1 and Cole, LLP, received July 22, 2015, was  
2 marked for identification.)

3  
4 . . . The following is the  
5 transcript of the Public Hearing in the Matter  
6 of CONNECTICARE INSURANCE COMPANY, held before  
7 Kristin Campanelli, Hearing Officer, at the  
8 Insurance Department, 153 Market Street,  
9 Hartford, Connecticut, on July 27, 2015,  
10 commencing at 9:00 a.m. . . .

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1 (Hearing commenced: 9:00 a.m.)

2  
3 HEARING OFFICER: Good morning.

4 I'd like to call this public hearing to  
5 order. Please make sure that all cell  
6 phones and other electronic devices  
7 have been shut off. On behalf of the  
8 Connecticut Insurance Department, I  
9 would like to welcome you to this  
10 hearing. I am Kristin Campanelli and  
11 have been appointed by Commissioner  
12 Wade to preside at today's hearing.

13 I want to take a moment at the  
14 state of this proceeding to explain the  
15 way the hearing works. Many of you may  
16 be familiar with the hearings held by  
17 the legislature to consider proposed  
18 legislation or agencies in your town or  
19 city to consider town affairs, but may  
20 not be familiar with this type of  
21 administrative hearing. An  
22 administrative hearing such as this is  
23 a regulatory proceeding in which a  
24 party, in this instance ConnectiCare  
25 Insurance Company, Inc. is required to

1 present documentation and arguments  
2 regarding their application.  
3 Ultimately, Commissioner Wade will  
4 decide this matter based on a  
5 recommendation that I will prepare.  
6 This is not a court proceedings, but it  
7 does operate under a system of rules  
8 with the presentation of evidence, and  
9 witnesses who testify under oath. We  
10 will have three potential opportunities  
11 for public comment at this hearing.

12 First, in a couple of minutes,  
13 there will be a half an hour devoted to  
14 public comment, with the amount of time  
15 for each statement restricted out of  
16 respect for the time of everyone here.

17 Second, if time allows, there  
18 will be a period of public comment at  
19 the end of the proceeding for those who  
20 wish to make comments.

21 And third, written comment may be  
22 submitted up until 4 o'clock. Unlike a  
23 legislative hearing, there will be  
24 times when we need to call a recess.

25 For the record, this hearing is

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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 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 15-94 has been assigned to this matter by the Insurance Department.

The Connecticut Statute governing this rate application, Connecticut General Statutes 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 of the powers specifically granted, and all powers that are reasonably necessary to protect the public interest in accordance with the duties

1 imposed by the Connecticut insurance  
2 statutes.

3 This public hearing is being held  
4 to consider whether the premium rate  
5 increase application filing  
6 ("Application") dated April 30, 2015 by  
7 ConnectiCare Insurance Company, Inc.  
8 concerning premium rates for its  
9 individual off exchange plans  
10 ("Products") are excessive, inadequate  
11 or unfairly discriminatory pursuant to  
12 Connecticut General Statutes 38a-481.

13 This proceeding was commenced on  
14 April 30, 2015 when the Applicant filed  
15 with the Connecticut Insurance  
16 Department - to be referred to as the  
17 "Department" - a rate application  
18 regarding the Applicant's individual  
19 rates for off exchange plans. While  
20 there is no statutory requirement that  
21 a rate hearing be held, on July 6,  
22 2015, Commissioner Wade ordered that a  
23 public hearing be held on July 27, 2015  
24 to consider the Commissioner granting  
25 approval of the proposed application.

1 This hearing was ordered in partnership  
2 with the Healthcare Advocate  
3 ("Advocate") pursuant to the terms of  
4 an agreement between the Commissioner  
5 and the Advocate, dated May 14, 2015,  
6 which permits the Advocate to request  
7 up to four hearings per year for rate  
8 increase requests of 10% or more.

9 A copy of the notice for this  
10 public hearing was filed with the  
11 Office of the Secretary of State. In  
12 addition, this notice was posted on the  
13 Insurance Department's Internet  
14 website. This notice indicated that  
15 the Application was available for  
16 public inspection at the Insurance  
17 Department and electronically on the  
18 Insurance Department website and that  
19 the Department was accepting written  
20 statements concerning the  
21 Application.

22 In accordance with the Rules of  
23 Practice of the Connecticut Insurance  
24 Department, ConnectiCare has been  
25 designated as a party to this

1 proceeding.

2 Without being designated as an  
3 official party to this proceeding, the  
4 Connecticut Insurance Department staff  
5 will have the right to ask questions of  
6 the witnesses to this hearing. Joining  
7 me are Paul Lombardo, Life and Health  
8 Actuary, and Mary Ellen Breault,  
9 Director of the Life and Health  
10 division.

11 At this time, I would like  
12 counsel for the Applicant to identify  
13 themselves.

14 MR. BABBITT: Good morning. I'm  
15 Bradford Babbitt, counsel at Robinson  
16 and Cole on behalf of ConnectiCare.

17 HEARING OFFICER: At this point, I  
18 would like to enter into the record a  
19 stipulated list of exhibits. The list  
20 identifies seven documents, which have  
21 been stipulated to as full exhibits by  
22 the parties to this proceeding. These  
23 exhibits include a copy of the rate  
24 filing application and all written  
25 public comment received through 4 p.m.

1           yesterday. Written public comment  
2           received today will be added to the  
3           record following the hearing. A copy  
4           of the list is available to members of  
5           the audience today.

6                     At a pre-hearing conference to  
7           expedite today's hearing, was held on  
8           July 23, 2015. At that pre-hearing  
9           conference, the exhibits, witnesses and  
10          hearing procedures were discussed.

11                    The first item of business is  
12          public comment. Members of the public  
13          who have signed up to speak will have  
14          the first half hour of this proceeding  
15          to orally comment on the Application.  
16          In this regard, there are two sign-up  
17          sheets available for persons interested  
18          in presenting oral comments at this  
19          hearing: One for public officials and  
20          one for persons other than public  
21          officials. So we can gauge our timing,  
22          I am asking that Ms. Medina indicate  
23          for the record the number of people who  
24          have signed up to speak.

25                    MS. MEDINA: We have five people.

1 HEARING OFFICER: Excellent.  
2 Thank you. Each person will have three  
3 minutes to comment and we will  
4 alternate between the general public  
5 and any public officials who may also  
6 want to speak. This is a comment  
7 period only and no questions should be  
8 directed to the Applicant or the  
9 Department.

10 The Applicant will then provide a  
11 presentation of the Application.  
12 Insurance Department staff will be  
13 given an opportunity to examine the  
14 witnesses. After the examinations have  
15 been concluded, anyone from the public  
16 who did not have an opportunity to be  
17 heard in the first half hour, or who  
18 wishes to make a statement will have  
19 the opportunity to orally comment on  
20 the Application.

21 The public may also present  
22 written comments no later than 4 p.m.  
23 today, either to Ms. Medina during the  
24 course of today's hearing or at the  
25 Department's reception desk.

1                   The public comment portion of  
2                   this hearing will commence with  
3                   comments from public officials and then  
4                   alternate with comments of other  
5                   interested persons. I would ask that  
6                   anyone interested in participating in  
7                   this portion of the hearing comply with  
8                   the following guidelines:

9                   (1) each individual must identify  
10                  himself or herself for the record  
11                  including any organization that he or  
12                  she represents;

13                  (2) each individual must address  
14                  all comments to me;

15                  (3) all comments must relate  
16                  specifically to the rate application  
17                  that is the subject of today's hearing;  
18                  and each individual must reasonably  
19                  limit his or her comments to three  
20                  minutes.

**PUBLIC COMMENT PERIOD**

1  
2  
3 We'll now begin the public comment  
4 period. We're going to begin with  
5 public officials. The first person on  
6 the list is Vicky Beltry.

7 MS. BELTRY: I just want to say  
8 "good morning" and thank the Insurance  
9 Department for holding the hearing. I  
10 don't really want to bring a lot of  
11 substance forward because I know this  
12 department has a lot of questions  
13 you're going to ask and I know there's  
14 some commentators behind me that will  
15 probably bring up some more substantive  
16 comments, but I just wanted to get up  
17 here to thank everybody participating  
18 in the process who is willing to be  
19 here and have an open and transparent  
20 hearing so the public can learn how  
21 rates are set and the public can learn  
22 about the process and learn about the  
23 drivers of healthcare costs.

24 So, again, thank you. And we  
25 look forward to hearing from you.

1 HEARING OFFICER: Great. Thank  
2 you. Next on the comment list will be  
3 Elizabeth Keenan from CONC.

4 MS. KEENAN: Good morning. My  
5 name's Elizabeth Keenan. I am one of  
6 three chairs of the healthcare team for  
7 CONC, which is Congregations Organized  
8 for a New Connecticut, a multi-phased,  
9 multi-issue nonpartisan organization of  
10 15,000 people representing 27  
11 congregations in Fairfield and New  
12 Haven Counties.

13 Before we comment on  
14 ConnectiCare's request for an average  
15 increase of 9.8 percent on its  
16 individual plans that are marketed  
17 outside Access Health Connecticut. We  
18 want to first commend the Insurance  
19 Commissioner, Katharine Wade, and the  
20 State Healthcare Advocate, Victoria  
21 Beltry for the agreement they recently  
22 made that allows such hearings as this  
23 one today to be held.

24 MS. DEMELLO: Good morning. I'm  
25 Angela DeMello, one of the other

1 co-chairs of CONC.

2 And now turning to the  
3 ConnectiCare request. We noted two  
4 favorable trends that insurance has  
5 been making. Why ConnectiCare along  
6 with other insurers did experience over  
7 the past year an increase of claims  
8 from people who prior to the enactment  
9 of the Affordable Care Act, could not  
10 obtain coverage due to pre-existing  
11 condition. The company said it  
12 believed this phenomenon was a one-time  
13 event only and unlikely to repeat  
14 itself in the year ahead. That was not  
15 a factor in calculating rates in 2016.  
16 ConnectiCare also noted that persons  
17 buying insurance in the individual  
18 market in 2015, were generally younger  
19 than those doing so in 2014.

20 It also projected a slightly  
21 younger population for 2016. Both of  
22 these factors should help stabilize the  
23 insurance risk pool, which would seem  
24 to indicate less of a need for a large  
25 rate increase.

1           To counter these popular trends,  
2           however, ConnectiCare stated it needed  
3           higher rates to deal with what is  
4           claimed was an 8.98 percent increase in  
5           trend. That reflected both increased  
6           medical inflation and an increased  
7           demand for medical services. This 8.98  
8           trend factor seems to us high when  
9           compared to that calculated by other  
10          insurers.

11          ConnectiCare also does not seem  
12          to offer enough data in its application  
13          to justify this higher than average  
14          trend factor, as well as many of the  
15          other assumptions it used to justify  
16          its rate increases.

17          Accordingly, we recommend that  
18          the department reject this request and  
19          ask ConnectiCare to submit its proposal  
20          either asking for a lower increase or  
21          providing additional data that better  
22          supports its assumption.

23          Thank you again for the  
24          opportunity to address to you directly  
25          on this matter. We look forward to

1           working with you in the future to  
2           ensure that both the rates that  
3           insurers seek are adequate for the  
4           benefit offered and that at the same  
5           time, the needs of the consumers for  
6           reportability are met. Thank you.

7           HEARING OFFICER: Thank you. Next  
8           for public comment is Lynne Ide.

9           MS. IDE: Good morning. I'm here  
10          today on behalf of Universal Healthcare  
11          Foundation of Connecticut. My name is  
12          Lynne Ide. I'm the Director of Program  
13          and Policy.

14          I'm here today to register our  
15          opposition to ConnectiCare's proposed  
16          rate increase for individual plans as  
17          well as raise concerns regarding the  
18          flawed rate hike hearing process.

19          The Foundation does not believe that  
20          the current rate hike hearing process  
21          is truly open and accessible to the  
22          people who are going to be directly  
23          impacted by the actions of ConnectiCare  
24          and the deliberation of the Connecticut  
25          Insurance Department.

1                   Most of the 34,000 Connecticut  
2                   individual policy holders are unable to  
3                   take time off from work and/or travel  
4                   to downtown Hartford for a midsummer  
5                   weekday hearing. In short, this  
6                   process is decidedly not consumer  
7                   friendly. That is evidenced by who is  
8                   sitting here in the room today. I urge  
9                   the Commissioner to work with advocates  
10                  and other key stakeholders to design  
11                  and implement a more inclusive consumer  
12                  input process. I understand that this  
13                  is an administrative hearing, but that  
14                  should not preclude a true public  
15                  hearing. It is good that insurers must  
16                  notify policyholders of proposed rate  
17                  increases and a small percentage of  
18                  those policyholders weigh in via the  
19                  online platform, but that is no  
20                  substitute for meaningful engagement of  
21                  consumers. This process must be fixed.  
22                  Other experts will weigh in today on  
23                  the actuarial underpinning and rationale  
24                  for the proposed average 9.8 percent  
25                  increase of ConnectiCare's rates.

1           The foundation would like to make  
2           a few points. In its rate filing,  
3           ConnectiCare acknowledges that 2016  
4           will bring two favorable trends and  
5           those were covered by the previous  
6           speakers so I'm not going to go into  
7           those details but my written comments  
8           talk about that in a little more  
9           detail.

10           I also want to raise that Kevin  
11           Counihan, CEO of the Health Insurance  
12           Marketplace at CMS' Center for Consumer  
13           Information Insurance Oversight, sent a  
14           letter to the Commissioner on July  
15           21st, which bolsters some of the  
16           arguments that were made by the  
17           previous speakers and are made in my  
18           testimony.

19           Finally, Counihan's letter states  
20           that CMS remains committed to the risk  
21           quarter program and that CMS  
22           anticipates that risk quarter  
23           collections will be sufficient to pay  
24           for all risk quarter payments.  
25           Counihan urged the Commissioner to take

1           these payments into account before  
2           decisions are made on the final rates.

3           In closing, I'd like to leave you  
4           with three ConnectiCare policyholder  
5           comments that were posted on the CID  
6           website.

7           As an has type policyholder, we  
8           bear the cost of healthcare cost  
9           increases first. Basically, these  
10          increases, such as those proposed do  
11          not translate to the customer in truly  
12          greater coverage.

13          Also, the ACA was designed with  
14          provisions to drive down healthcare  
15          costs. An increase of this magnitude  
16          based on the primary argument that  
17          healthcare costs are increasing seems  
18          to run contradictory to this intent.

19          Finally, this proposed rate  
20          increase is much larger than inflation  
21          rate. Nowhere are there cost of living  
22          increases of this magnitude.

23          The second comment: If I can get  
24          a pay increase to sustain me with this  
25          insurance premium, then okay. Maybe

1           you should talk to my employer. Let me  
2           know how that works out.

3                     And finally, seems like all I do  
4           is waste my hard earned money paying  
5           for a plan I cannot use to my high  
6           deductible.

7                     I urge you to put the  
8           policyholder first in your decision  
9           regarding ConnectiCare's rate increase.  
10          Something has got to give and it  
11          shouldn't always be hardworking  
12          people's wallets. Thank you.

13                    HEARING OFFICER: Thank you. Next  
14          for public comment, I have Cheryl  
15          Silber.

16                    MS. SILBER: Thank you. I'm  
17          learning a lot this morning. I want to  
18          thank you for having the hearing and I  
19          thank Medicare for sending me the  
20          e-mail announcing that the hearing was  
21          taking place.

22                    My husband is actually a  
23          ConnectiCare policyholder. I'm already  
24          on Medicare, and I can tell you right  
25          now with this projected increase, I'm

1           paying less than half of what he's  
2           going to be paying.

3                        So my comment to the Commissioner  
4           is that when you increase the base rate  
5           by almost ten percent, the age factor  
6           at 64 or 63, actually this year was 2.9  
7           and next year it's three. So it's a  
8           factor of three, which translates quite  
9           a bit more. He'll be paying almost  
10          \$814 for one person premium membership.

11                      So I would just like you to  
12          consider that. Thank you.

13                      HEARING OFFICER: Thank you. That  
14          concludes the public comment lists.  
15          Thank you all for presenting your  
16          comments.

17                      I'd now like counsel for the  
18          Applicant to identify the individuals  
19          who are present and available to  
20          testify and we'll have those  
21          individuals sworn in by the court  
22          reporter.

23                      MR. BABBITT: Certainly. First we  
24          have Michelle Zettergren, Senior Vice  
25          President for ConnectiCare. Also, Neil

1 Kelsey, Chief Actuary from  
2 ConnectiCare. And Mary van der Heidje,  
3 Actuary from Milliman.

4 HEARING OFFICER: Thank you.

5 THE COURT REPORTER: Should I  
6 swear them in one at a time?

7 HEARING OFFICER: All together.

8 THE COURT REPORTER: Please raise  
9 your right hands.

10 Michelle Zettergren, Neil Kelsey,  
11 Mary van der Heidje, called as  
12 witnesses by the Department, being  
13 first duly sworn by the Notary Public,  
14 was examined and testified, on her  
15 oath, as follows:

16  
17 **APPLICANT PRESENTATIONS**

18  
19 HEARING OFFICER: Mr. Babbitt,  
20 please proceed with the Applicant's  
21 presentation.

22 MR. BABBITT: Certainly.

23 MS. ZETTERGREN: Good morning  
24 Hearing Officer Campanelli, and  
25 officials of the Connecticut Insurance

1 Department, and members of the public.  
2 My name is Michelle Zettergren. I'm  
3 here on behalf of ConnectiCare  
4 Insurance Company, Inc. one of the  
5 family of ConnectiCare Companies. I  
6 serve a as Senior Vice President, Chief  
7 Sales and Marketing Officer.

8 Here at the table with me this  
9 morning are Neil Kelsey, ConnectiCare's  
10 Chief Actuary. Mary van der Heijde,  
11 Principal and Consulting Actuary from  
12 the Actuarial firm Milliman. And Brad  
13 Babbitt partner with Robinson & Cole.  
14 ConnectiCare is here this morning at  
15 the request of the Connecticut  
16 Insurance Department to explain the  
17 reasons for our request for a  
18 9.6 percent rate increase for our  
19 individual office change plans. We  
20 welcome this opportunity to review with  
21 you the facts behind our request for a  
22 rate increase and to answer any  
23 questions that you may have.  
24 I would like to begin by saying that we  
25 are doing everything possible to

1 control costs. We see the impact rate  
2 increases have on our members. We hear  
3 what our members and Connecticut  
4 residents are saying. We want all of  
5 you to know that we take our  
6 responsibility to control costs very  
7 seriously.

8 ConnectiCare is proud to be  
9 Connecticut's local company. We have  
10 been in business in Connecticut since  
11 1981. We do not have any shareholders.  
12 Our offices and employees are located  
13 in Farmington and in Bridgeport,  
14 Connecticut. All of the member  
15 services that we provide such as call  
16 center services, medical case  
17 management, disease management  
18 programs, claim processing, and  
19 community outreach are provided out of  
20 our offices here in Connecticut.  
21 ConnectiCare is proud to report that in  
22 the last few years thanks to our  
23 members and to our physician and  
24 hospital partners, we have been able to  
25 grow to have the largest membership in

1 Connecticut's individual small group  
2 and Medicare markets. We were humbled  
3 and grateful that so many members have  
4 put their trust in us. We strive every  
5 day to do the best we can to make it  
6 easy for our members to get the care  
7 that they need.

8 As we see in here every day, the  
9 health insurance industry is in the  
10 midst of extraordinary and complex  
11 change. The federal Affordable Care  
12 Act has allowed more people to get  
13 coverage, and in many cases financial  
14 assistance to make the premiums more  
15 affordable. More people now have  
16 access to the benefits of preventative  
17 care services at no cost to them.  
18 These changes are all positives for our  
19 state and for our country. But all of  
20 these good changes do come with a cost.  
21 At a very high level, ConnectiCare's  
22 expenses fall into two categories.  
23 Medical cost for the care and  
24 prescription drugs our members receive  
25 and administrative costs for doing

1 business including expenses related to  
2 complying with the requirements of the  
3 Affordable Care Act.

4 My colleagues are going to talk  
5 more about what is driving these  
6 expenses. I want to assure the  
7 Insurance Department, the people in  
8 this room, our members and all the  
9 residents of Connecticut that  
10 ConnectiCare is doing everything it can  
11 reasonably do to address and control  
12 the rising cost of healthcare in this  
13 state. For example, ConnectiCare is  
14 actively partnering in new ways with a  
15 number of physician groups and  
16 hospitals throughout the state to  
17 provide high quality health services  
18 with improved patient outcomes at lower  
19 costs to ConnectiCare members. These  
20 new partnerships with providers are  
21 working. ConnectiCare members who are  
22 patients of these doctors participating  
23 in ConnectiCare's new partnerships  
24 actually saw their primary care doctors  
25 10 percent more often, were admitted to

1 the hospital 9 percent less often, and  
2 went to the emergency room 6 percent  
3 less often in 2014. We are encouraged  
4 by these results and we know that they  
5 are having a direct impact on  
6 controlling costs.

7 As I said a moment ago,  
8 Connecticut's feels and hears the  
9 impact that rate increases have on our  
10 members and the citizens of  
11 Connecticut. We do not make a request  
12 for a rate increase lightly. We make  
13 the request for solid business reasons,  
14 which have been set forth in detail in  
15 our rate filing and which have been  
16 confirmed by Milliman.

17 My colleague, ConnectiCare's  
18 Chief Actuary, Neil Kelsey, will now  
19 provide a brief overview of the reason  
20 underlying ConnectiCare's request for a  
21 rate increase.

22 MR. KELSEY: Good morning, Hearing  
23 Officer Campanelli, officials of the  
24 Connecticut Insurance Department and  
25 members of the public. My name is Neil

1 Kelsey. I'm here as Chief Actuary on  
2 behalf of ConnectiCare Insurance  
3 Company, Incorporated and ConnectiCare  
4 Company. I am a fellow of the Society  
5 of Actuaries and a member of the  
6 American Academy of Actuaries. I have  
7 over 30 years experience in health  
8 insurance actuarial work. I have  
9 satisfied the annual continuing  
10 education requirements of the Academy;  
11 therefore, I am qualified to perform  
12 actuarial work in the health industry,  
13 specifically for ConnectiCare.

14 The rate filing which is the  
15 subject of today's public hearing was  
16 prepared and completed by a team of  
17 actuaries on my staff at ConnectiCare.  
18 I have reviewed their work, and I am  
19 familiar with their assumptions, and  
20 with their numbers, and I have approved  
21 and agreed with their conclusions.  
22 I am here to explain in detail the  
23 reasons underlying ConnectiCare's  
24 request for a 9.6 percent rate increase  
25 in our individual health exchange

1 plans.

2 Briefly, there are six key  
3 drivers of this increase. First is  
4 baseline experience. When building  
5 rates for a future year, we begin with  
6 the underlying known costs in an  
7 earlier period called the experience  
8 period. Our 2016 rate submission is  
9 based on the 2014 experience of our  
10 individual health exchange membership  
11 in Connecticut.

12 Second is medical trend. Medical  
13 trend is projected future costs for  
14 services. Each year, the cost of  
15 medical services changes. Our members  
16 use of medical services also changes.  
17 To the extent that individuals are  
18 using different healthcare services  
19 from the ones they used in the past and  
20 to the extent that the cost of that  
21 care are different from the cost in the  
22 past, the amount of premium we charge  
23 changes, as well.

24 Third, specialty drugs. The  
25 introduction and use of so-called

1 specialty drugs is a key driver of our  
2 medical trend. For example, the class  
3 of specialty drugs that cure Hepatitis  
4 C, Salvadi, Harvoni and Viekira Pak  
5 became available to the public in early  
6 2014 and the use of those drugs has  
7 skyrocketed. Specialty drugs are  
8 usually very expensive. Salvadi and  
9 Harvoni alone each carry a price tag of  
10 up to \$100,000 per course of treatment.

11 As we look ahead to 2016, we know  
12 the drug cost will be affected by the  
13 introduction in late 2015 of a class of  
14 specialty drugs known as PCSK9. These  
15 are injectable drugs that dramatically  
16 reduce cholesterol levels. We expect  
17 that the PCSK9 speciality drugs will  
18 cost between \$7,000 and \$12,000  
19 annually for each person taking that.  
20 And that person must take these drugs  
21 for life.

22 Next, are the acts of the Federal  
23 Reinsurance Program. The Affordable  
24 Care Act created a temporary Federal  
25 Reinsurance Program to protect

1 consumers from large rate increases in  
2 the newly created guaranteed issued  
3 market.

4 Initially, the Federal  
5 Reinsurance Program reimbursed insurers  
6 for 20 percent of their claimed  
7 policies. The federal program,  
8 however, phases out over three years  
9 until it is eliminated completely in  
10 2017.

11 The Federal Reinsurance Program  
12 progressively reimburses insurers less  
13 each year starting in 2015. With less  
14 reimbursement from the Federal  
15 Reinsurance Program, insurer's costs go  
16 up. As those costs go up, rates go up.

17 The next item is changes in the  
18 overall health status in the  
19 marketplace. As Michelle stated  
20 earlier, the Affordable Care Act opened  
21 health insurance markets in 2014 to  
22 individuals who previously were not  
23 eligible for or who could not afford  
24 health insurance. Many of those  
25 individuals had health conditions that

1           made their care very expensive. As  
2           they became insured and received  
3           medical services the overall cost of  
4           healthcare increased because the demand  
5           for healthcare services increased.  
6           And dental insurance. There is a  
7           concept known -- (microphone went out.)  
8           Sorry.

9                     In dental insurance, there is a  
10           concept known as you waited in life.  
11           When someone who has had not dental  
12           treatment first comes in for a teeth  
13           cleaning, let's say, he or she often  
14           needs other more expensive dental  
15           treatment like fillings or bridgework.  
16           As a result, the first year of the  
17           dental insurance typically sees a  
18           sliding cost. After that cost  
19           stabilized or even decreased. The  
20           phenomena is similar to if you waited  
21           in life for dental insurance also  
22           occurs in health insurance.

23                     The first year, there's an  
24           increase in costs because of an  
25           increase in the utilization of medical

1 services. The following years, costs  
2 stabilize or even decrease because of  
3 the decrease in the utilization of  
4 medical services.

5 What all this background  
6 discussion means is that when we  
7 establish rates for 2016, we projected  
8 that some of the costs of care in 2014  
9 would not repeat in the future because  
10 previously uninsured individuals had  
11 now been insured for over two years and  
12 we expected that these individuals  
13 would have received care for previously  
14 existing and previously untreated  
15 medical conditions in the earlier  
16 years.

17 Finally, there's a category of  
18 other factors. Other factors in this  
19 category include increases in  
20 administrative expenses and fees  
21 associated with compliance of the  
22 federal regulatory requirements of the  
23 Affordable Care Act and with state  
24 regulatory requirements like those  
25 associated with the National Health

1 Insurance Exchange.

2 The Affordable Care Act  
3 effectively caps a profit margin for  
4 health insurers as it requires a health  
5 insurer to rebate dollars to consumers  
6 if that health insurer's medical cost  
7 ratio is below 80 percent. The  
8 expected medical loss ratio in  
9 Connecticut in the 2016 rate filing is  
10 well above 80 percent. Thus, our  
11 profit margin is less than the profit  
12 margin allowed under the Affordable  
13 Care Act.

14 Of course, we want to keep  
15 ConnectiCare's premium rates as low as  
16 possible so that our customers can  
17 afford our products, and so that we can  
18 remain competitive and an industry  
19 leader in Connecticut. We have to  
20 balance our desire to be competitive  
21 with our obligations to keep  
22 ConnectiCare financially solid so that  
23 we can continue to fulfill our mission  
24 to make it easy for our members to see  
25 get the care that they need.

1           When ConnectiCare's actuaries calculate  
2           the prices of our products, we follow a  
3           painstaking process within strict  
4           actuarial standards. We must take into  
5           account a number of objective factors  
6           such as the cost of medical services,  
7           the overall health of the marketplace,  
8           administrative expenses associated with  
9           providing a broad spectrum of benefits,  
10          compliance with federal, state and  
11          state laws and regulations and services  
12          to our members. But in the end, our  
13          actuarial numbers are predictive of an  
14          uncertain future. If our actuarial  
15          predictions turn out to be too low, the  
16          company will experience losses. If our  
17          actuarial predictions turn out to be  
18          too high, the company is not allowed to  
19          pocket the overcharge, instead  
20          ConnectiCare is required by the  
21          Affordable Care Act to rebate that  
22          overcharge as a refund to our  
23          customers.

24                    If our actuarial predictions are  
25                    just right, that is if the turn out to

1 be within the profit margin allowed by  
2 the Affordable Care Act, any profit we  
3 realize is not paid to shareholders.  
4 Rather, it is reinvested to better the  
5 products, the tools and the services  
6 that we provide to our customers.  
7 Because threading this actuarial needle  
8 and we're doing too high rates and too  
9 low rates, it is too difficult and so  
10 critically important to ConnectiCare  
11 and to ConnectiCare's customers, we  
12 have called upon the expertise of the  
13 outside professionals at Milliman to  
14 review and evaluate the reasonableness  
15 of our work.

16 Milliman, as you know, is one of  
17 the world's largest and most respected  
18 providers of actuarial related products  
19 and services. Sitting beside me today  
20 is Mary van der Heijde, Principal and  
21 Consulting Actuary at Milliman. Mary  
22 is a fellow of the Society of Actuaries  
23 and a member of the American Academy of  
24 Actuaries. She has over a decade of  
25 underwriting and actuarial experience

1 specific to pressing individual  
2 improved health insurance products.

3 I will now let Mary provide more  
4 details of her professional background  
5 and experience as well as explain  
6 briefly her role here today. Mary?

7 MS. VAN DER HEIDJE: Great. Thank  
8 you, Neil.

9 Good morning, Hearing Officer  
10 Campanelli, officers of Connecticut  
11 Insurance Department and members of the  
12 public. My name is Mary van der Heidje  
13 and I'm a principal with Milliman.  
14 First I would like to say a few words  
15 about Milliman. Milliman is the  
16 leading provider of actuarial support  
17 and services. We have more actuaries  
18 that focus on health issues than does  
19 any other firm in the world. Milliman  
20 as a whole, currently works on  
21 commercial pricing across the country.  
22 My own office in Denver works on  
23 commercial pricing in over 2,000  
24 states.

25 Milliman, generally, and I,

1 specifically, have significant  
2 experience with commercial pricing  
3 including both development and review  
4 of rates. Milliman and I support Neil  
5 and his team at ConnectiCare with their  
6 rate development and their filing works  
7 by reviewing their analyses and by  
8 providing an outside parties' opinion  
9 on their work. Specifically, my team  
10 and I have reviewed ConnectiCare's 2016  
11 individual and small group pricing and  
12 rate documents and all the accompanying  
13 filing department documents. This  
14 review provided additional assurance  
15 into the accuracy and to the validity  
16 of the approach that ConnectiCare used  
17 and of the results that ConnectiCare  
18 calculated.

19 We also furnished an independent  
20 viewpoint as to the appropriateness of  
21 the rates. So while we know Michelle  
22 and our colleagues are experts on  
23 character assistance, as well as broad  
24 professional knowledge by additional  
25 expertise and useful commentary on

1           ConnectiCare's filing as well as on the  
2           National Health Insurance Market.

3                     It is my opinion that  
4           ConnectiCare is very thorough in that  
5           process. It is not unreasonable given  
6           the specifications and requirements  
7           imposed by the Affordable Care Act.

8                     MR. KELSEY: Thank you, Mary. On  
9           behalf of ConnectiCare, I thank the  
10          Connecticut Insurance Department for  
11          this opportunity to make a brief  
12          opening statements.

13                    We are ready now to respond to  
14          questions from the Insurance Department  
15          of the specifics of our findings.

16                    HEARING OFFICER: Okay. Thank you  
17          very much.

18

19    **DIRECT EXAMINATION**

20

21                    HEARING OFFICER: We'll now be  
22          doing examination of the witnesses by  
23          the Department staff.

24          Mr. Lombardo, please proceed.

25                    MR. LOMBARDO: Thank you. I'm

1 Paul Lombardo, Staff Actuary in the  
2 Life and Health division. I'd ask that  
3 whoever seems to be the most  
4 appropriate party of the witnesses to  
5 please answer the questions,  
6 understanding that in some cases, it  
7 may be more than one person.

8 Just for a point of clarification for  
9 everyone that's here, ConnectiCare has  
10 three companies that do business in the  
11 State of Connecticut in the individual  
12 market. ConnectiCare Insurance  
13 Company, which is the party to this  
14 rate hearing today; ConnectiCare  
15 Benefits, Inc., which is their exchange  
16 carrier; and ConnectiCare, Inc., which  
17 is their HMO but does off exchange  
18 business.

19 By requirement, federal  
20 requirement, each of those risk pools  
21 must remain separate for pricing  
22 purposes. So this will only be related  
23 to ConnectiCare Insurance Company  
24 individual business, which is strictly  
25 off exchange today.

1                   A point of clarification in Mr.  
2                   Kelsey's testimony. Neil, I think you  
3                   mentioned that in 2014, a reimbursement  
4                   from the feds on the reinsurance  
5                   program was 20 percent. I believe you  
6                   meant to say 80 percent.

7                   MR. KELSEY: Yes. Thanks for  
8                   asking for the clarification on that.  
9                   What I meant was that while the  
10                  coinsurance percentage of rate was  
11                  80 percent within the threshold between  
12                  \$45,000 and \$450,000 in -- it actually  
13                  turned out to be 100 percent because of  
14                  excess funding nationally that  
15                  Connecticut benefitted from but that  
16                  represented 20 percent of our claim  
17                  costs.

18                  So I wasn't referring to the  
19                  coinsurance percentage, I was referring  
20                  to the percentage of our cost that  
21                  we'll be reimbursed at.

22                  MR. LOMBARDO: Thank you for the  
23                  clarification.

24                  Reinsurance in 2015, for everyone  
25                  that is here, scheduled to be the same

1 criteria, 45,000 and 250,000 in between  
2 those thresholds and reimbursed to the  
3 carriers at 50 percent coinsurance.  
4 Based upon the federal estimate of a  
5 carryover dollar amount, we anticipate  
6 that that coinsurance level of  
7 50 percent for 2015 will be higher, but  
8 we do not believe it will meet the  
9 100 percent coinsurance value and then,  
10 therefore, roll over any additional  
11 money into 2016.

12 For 2016, the attachment points  
13 change to 90,000 to 250. So it moves  
14 from 45,000 to 90,000. So as carriers  
15 we're getting reimbursed between 45 and  
16 90 at a coinsurance level in 2014 and  
17 2015, they will start to be reimbursed  
18 at a coinsurance level of 50 percent  
19 beginning at \$90,000. So there is an  
20 impact to premium rates for all  
21 carriers in the individual market in  
22 Connecticut and across the country if  
23 that attachment point goes past the  
24 points that are applicable to everyone  
25 in the individual market across the

1 country.

2 The first question that I have  
3 for ConnectiCare: Based upon the unit  
4 costs and utilization data in your  
5 trend exhibit, please explain the  
6 development of the revised 8.83 percent  
7 trend. And then I will talk briefly  
8 about the change that ConnectiCare made  
9 in their final once they respond to it  
10 the trend calculation.

11 MS. VAN DER HEIDJE: Sure. Let me  
12 start answering the question and I'll  
13 pass over to Neil for more specific  
14 context here.

15 The issue of medical trend is a  
16 very important one when studying rates.  
17 It's a factor that is important and  
18 it's challenging as Mr. Lombardo  
19 mentioned is a key factor in our  
20 interface, as well. So the comments  
21 were touching on medical trends, as  
22 well.

23 So I want to take a minute and  
24 focus on how medical trends are set  
25 generally and then how we set them here

1 specifically. As we know, there are  
2 multiple things that cause the cost to  
3 increase over time. So different  
4 components and inflation. And the way  
5 we generally break those down, you  
6 know, I'll give you two different  
7 parts.

8 So one part is generally referred  
9 to as utilization trend and another  
10 part is unit cost trend. So I'd like  
11 to touch on both of those briefly  
12 together that won't be in the total  
13 medical terms.

14 Utilization trends especially,  
15 how these services -- of what kind are  
16 used. And if we look at the services,  
17 you know, today or we look at the  
18 services in their experience period,  
19 the number tends to increase over by a  
20 small amount over time. This could be  
21 because an increased access of care, it  
22 could be for new technologies. It's  
23 really an evolution in the way that  
24 services are used in our country and  
25 around the world.

1                   So the utilization trend tends  
2                   not to be flat, it tends to have a  
3                   small increase in there. Unit cost  
4                   trend is essentially, given these  
5                   services, how much is the cost per  
6                   service changed over time. So the unit  
7                   cost trend needs to look at things like  
8                   what kind of arrangements do you have  
9                   with providers and what mix of services  
10                  are being used?

11                  Neil touched on some of the  
12                  things that are causing prescription  
13                  drug unit costs to start to be higher.  
14                  Those utilizations are very pricey, so  
15                  they're projecting at a cost higher, as  
16                  well.

17                  So when looking at the trend,  
18                  it's a trickier question and just how  
19                  much higher should medical costs  
20                  projection be one year over the next  
21                  year. As you'll see as we go through  
22                  this, there's really quite lot of  
23                  components and I'm sure that Mr.  
24                  Lombardo and others will touch on  
25                  those, as well. But those are the key

1 components, as well.

2 Within those, we also plan to  
3 bring down claim costs in  
4 communication, hospital costs  
5 separately from outpatient hospital  
6 separately from professional and for  
7 drugs to give a very rigorous look at  
8 how the cost and how the utilization  
9 changes for each of those. So that's  
10 the kind of a context about the process  
11 that we use. We look at the data,  
12 split it by those categories and do a  
13 significant amount of -- do you want to  
14 share a little bit more about the  
15 specific values?

16 MR. KELSEY: Sure. Yes, at  
17 ConnectiCare, we review historical and  
18 experienced data. We typically go back  
19 three years and we review unit costs  
20 for utilization by high level cost  
21 category; in-patient and outpatient,  
22 physician and pharmacy unit cost. We  
23 also factor in negotiations and  
24 contracts that we have with our  
25 providers so changes in those over

1 time.

2 In addition to our own data, we  
3 were constantly monitoring industry  
4 towards, as you know, there's various  
5 -- Milliman and others to get their  
6 view of emerging trends.

7 For inpatient in 2015, just a  
8 couple of facts: Year-to-date, we're  
9 experiencing an increase in the NICU  
10 and nursery utilization is sturdy, so  
11 that's one of the contributors to our  
12 inpatient trends.

13 And on the outpatient, while  
14 we're seeing reduced utilization of  
15 outpatient surgery and radiology type  
16 services, we are seeing more increases  
17 in the -- in both the costs and the  
18 utilization of emergency room and  
19 ambulatory surgery. So those are both  
20 contributing to our trends.

21 And physician, most of the trends  
22 there is driven by two things, one  
23 being unit cost increases. Second  
24 being more intensive services, what  
25 they call MENSA services. The

1 utilization overall is that the people  
2 are going in for more severe and  
3 therefore, more costly type of  
4 services.

5 One of the biggest drivers, as I  
6 mentioned in my opening statements, is  
7 pharmacy. And again, similar to  
8 physician, while utilization of  
9 pharmacy overall for members remain  
10 flat, the unit cost in the mix of drugs  
11 have changed dramatically. 60 percent  
12 in the increase in unit cost came from  
13 the Hepatitis C from specialty drugs  
14 primarily in Hepatitis C from 2014  
15 going into 2015.

16 Other drivers include  
17 historically pharmacy trends were  
18 mitigated somewhat as drugs such as  
19 Lipitor in the past came off of a brand  
20 name drug and transitioned into a  
21 generic drug, that is a cheaper  
22 alternative, just doesn't have the  
23 brand name. So we had some savings  
24 from that. There's less and less of  
25 those generic versions going on now.

1           There's a raised trend in generic  
2           versions. So that's going to increase  
3           the trends.

4                     I mentioned Hepatitis C, very low  
5           utilization on that, but extremely high  
6           costs. As Michelle said in her opening  
7           statement, it's a good thing that it  
8           cures people with Hepatitis C, but it  
9           does have a cost and the cost is high  
10          going through our trends.

11                    The PCSK9, as I mentioned in my  
12          opening statement, actually, just last  
13          night or Friday, I got an e-mail  
14          yesterday, the first of those  
15          Praluent, I'm not a pharmacist so I'm  
16          probably butchering the name, but that  
17          was approved. We knew it was coming  
18          sometime late this year. That was  
19          actually just approved and will be  
20          available to retail on Wednesday of  
21          this week. Wholesale cost of that drug  
22          is expected to be \$14,000. Slightly  
23          higher than what I said in my opening  
24          statement.

25                    Again, those drugs are very good.

1           They're injectable drugs. They're for  
2           people that can't get -- can't control  
3           their cholesterol either for genetic  
4           reasons or they've been statin  
5           resistant, but they do come with a  
6           price tag. It's a lot more expensive  
7           to take a drug at \$14,000 a year than  
8           it was to take \$5 generic for your  
9           cholesterol treatment in the past.  
10          The other item that Mary touched upon  
11          was leveraging. We look at the unit  
12          costs of utilization. Those are the  
13          overall increases in our medical costs.  
14          What happens is when somebody has a  
15          deductible or has a co-payment, the  
16          trend affects them more than it would  
17          just on our costs.

18                 And the way that happens is if  
19                 you go to -- if you go to a store and  
20                 you have a \$50 gift card or something  
21                 and you buy an item for \$100. You pay  
22                 out-of-pocket \$50. If next year, you  
23                 have that same \$50 card, gift card, and  
24                 that -- the cost of that service went  
25                 up by 5 percent. So it went from \$100

1 to \$105. You actually end up paying  
2 out-of-pocket \$55. So that 5 percent  
3 trend drove a 10 percent trend or  
4 increase in your out-of-pocket.

5 That's the concept of leveraging.  
6 To the extent we have comparables, it's  
7 a testimony from one year to the next  
8 there's a multiple database on trends.

9 MS. VAN DER HEIDJE: And to build  
10 on -- to build on what Neil was saying,  
11 as well, the initial filing had 8.98  
12 percent trends and changed it too  
13 slightly to 8.83 percent with the  
14 recent database that he popped through  
15 that were available.

16 Milliman has nationwide trend  
17 data for over 60 years, which take a  
18 very large body of data, and measures  
19 trends and predicts these as those  
20 detailed categories and utilization as  
21 well as with the planned design  
22 specific leveraging.

23 When we reviewed the trends  
24 earlier this year when they were being  
25 filed, they all look very reasonable

1 with the range of the Milliman health  
2 cost guidelines.

3 MR. KELSEY: Thank you. We -- I'm  
4 sorry, were interested in what changed  
5 from our first filing to our revised?  
6 You asked about the -- suggested mine  
7 being .98 or something.

8 MR. LOMBARDO: I'll get to the  
9 change. What I was more specifically  
10 asking for is based upon the trend  
11 development table that you're showing  
12 in your rate filing, how did you get to  
13 the 8.83 percent? You provided a lot  
14 of detail on what the drivers were, but  
15 I'm looking specifically on how you  
16 took the data that was on that table  
17 and got to the 8.83 percent. I will  
18 talk about the change in the rate  
19 filing as a followup question.

20 MR. KELSEY: Okay. So the data in  
21 the table is there for historical  
22 reasons. And let me just pull that up.  
23 So the table you are referring to, bear  
24 with me while I find it in the filing  
25 here.

1 MR. LOMBARDO: It's Exhibit 2.

2 MR. KELSEY: Thank you.

3 So what Exhibit 2 does is shows  
4 historical -- going back to 2012, it  
5 shows historical utilization and unit  
6 costs, which are the primary  
7 contributors to our overall the trend  
8 numbers. And basically that's  
9 utilization actual cost changes driving  
10 the -- a lot of changes.

11 One thing I would point out is  
12 that the experience here which was for  
13 this book of business as you mentioned  
14 that the ConnectiCare individual office  
15 share, office change business. We saw  
16 really a seismic shift in the  
17 underlying population and in the  
18 underlying costs in 2014.

19 So you see here the annual 2014  
20 over 2013 trends are extremely high.  
21 That was a reflection of the fact that  
22 prior to 20 -- prior to the ACA, prior  
23 to January 1st of 2014, insurance  
24 carriers like us were able to  
25 underwrite individuals in the

1 individual market. We could use their  
2 rate history or their medical history  
3 at the time they applied for a plan to  
4 set the rates for that plan.

5 When ACA opened this up to a  
6 guaranteed issue market without medical  
7 underwriting, you had an influx of  
8 people that had, as I mentioned in my  
9 opening statement, had accumulated a  
10 lot. It was really a different book of  
11 business. So you're seeing that in the  
12 trends from 2014 back, you know, over  
13 2013.

14 So for that reason, while this  
15 information is required to be submitted  
16 as part of the file, it's not really  
17 used in setting the trends. It's more  
18 a historical perspective.

19 MR. LOMBARDO: So to summarize and  
20 I'd like to get a confirmation, 2014  
21 was a dramatic change in your unit  
22 costs of your utilization of services  
23 more so on the utilization side from  
24 2013 on ACA to 2014 ACA, but because as  
25 you state in your rate filing that you

1 don't anticipate that to continue, that  
2 is a phenomenon that will wear off over  
3 time.

4 Just for the record, the overall  
5 allowed trend from 2013 to 2014 was  
6 almost 31 percent combined unit costs  
7 and utilization. You're not using that  
8 value because you don't anticipate in  
9 2016 to see the same level of cost  
10 structure and utilization of services  
11 other than what you've identified in  
12 your testimony.

13 MR. KELSEY: Correct.

14 MR. LOMBARDO: Thank you.

15 Just to confirm and verify that this  
16 data that's in here, the experience and  
17 the trend data is strictly for  
18 ConnectiCare Insurance Company off  
19 exchange individual market.

20 MR. KELSEY: Yes.

21 MR. LOMBARDO: Thank you.

22 Just for the record, ConnectiCare did  
23 revise their rate filing June 26 of  
24 2015 and made a minor change to the  
25 trend from 8.98 percent to

1           8.83 percent. And a reduction in the  
2           average rate increase request went from  
3           10.1 percent down to 9.8 percent on  
4           average and the range is slightly  
5           dropped, as well. Just to confirm  
6           that --

7           MR. KELSEY: Yes.

8           MR. LOMBARDO: -- for  
9           ConnectiCare? Thank you.  
10          Appendix A, I'll give you a second to  
11          pull that up. As part of the  
12          department requirements in Bulletin  
13          HC81-15, the carriers are required to  
14          file an Appendix A, which clearly  
15          identifies the impacts to the rates  
16          from one year to the next. And this  
17          should provide a summary explanation of  
18          the rate adjustments that the carrier  
19          is asking for. So I just want to go  
20          through this once you get it, Neil.

21          MR. KELSEY: Okay.

22          MR. LOMBARDO: So the first item  
23          is trend. We talked about that. We  
24          don't need to discuss that any further.  
25          There's a base period adjustment of

1 1.1 percent, a positive 1.1 percent.

2 Can you explain what that is?

3 MR. KELSEY: Yes. If you wouldn't  
4 mind, I'd actually like to approach  
5 this a slightly different way. Okay?

6 MR. LOMBARDO: Let me know, and  
7 then I'll let you know if it's okay.

8 MR. KELSEY: Because what these  
9 adjustments are is a crosswalk and an  
10 explanation of the rate increase and on  
11 purely a member per month basis and  
12 they're mathematically accurate as you  
13 look at the different filings from 2015  
14 to 2016.

15 What I'd rather do which is just  
16 how I looked at this when I reviewed at  
17 the work. Remember, I said that I  
18 agreed with the conclusions of the  
19 Board. I'd like to tell what the main  
20 drivers are. And it speaks to these  
21 points in a slightly different way.  
22 And it speaks to them in terms of the  
23 percentage rate increase.

24 MR. LOMBARDO: As long as you can  
25 tie into where these fit into your

1 explanation, I'm okay with that.

2 MR. KELSEY: Okay.

3 So the key drivers and I'll come back

4 and kind of crosswalk this for you.

5 Okay? One of the big drivers is

6 trends. Okay. That's on average about

7 8.8 percent. And that's an increase in

8 the rates. That, as we've talked about

9 earlier, the change of the use and the

10 services and the unit cost of those

11 services.

12 The next change is the change in

13 Federal Reinsurance Program. As you

14 mentioned, and as did I, that program

15 is phasing out over a three-year

16 period. And I can give you more

17 details on this, but that actually

18 causes about an 8.7 percent upward

19 pressure on our rates.

20 And then there's baseline

21 experience. And what that is is

22 essentially when we set our 2015 rates,

23 we were looking at 2013 experience

24 trended to 2015. That experience has

25 evolved and as we filed incomplete data

1           because we were filing 6 to 9 months in  
2           advance of the rate increase.

3                       So now in retrospect, the period  
4           between 2013 to 2015 has evolved  
5           differently than we thought at the  
6           time. Okay.

7                       So that, coupled with changes in  
8           trends and changes in emerging items,  
9           causes our baseline, our starting point  
10          now to be different than it was a few  
11          years ago. So the baseline for the  
12          2016 rates is 2014 experience trending  
13          forwards. So there are baseline  
14          affects there. That -- the fact that  
15          it's only about 3.6 percent increases.  
16          So those are the three factors that  
17          increase our rates. Again, 3.6 for  
18          center baseline, 8.8 for trend and 8.7  
19          for that phaseout for the Federal  
20          Reinsurance Program, second year of a  
21          three-year phase out.

22                      Benefits, which allowed us to  
23          lower our rates and I have more details  
24          on these if you'd look. One is the  
25          removal of the accumulated neglect.

1           What I talked about in the opening  
2           statement, a one-time added cost in  
3           2014, which is now my baseline period  
4           that I don't expect to replicate itself  
5           in 2016.

6                        So I have removed almost six  
7           percent from the rates because of that.  
8           And then there is a requirement that  
9           under ACA, there are two risk pools, if  
10          you will. One is the individual  
11          market. One is a small group market.  
12          ConnectiCare has two companies working  
13          in or offering products in the  
14          individual market. They have the  
15          Connecticut Benefits, Inc., which is  
16          operating on the exchange and.  
17          ConnectiCare Insurance Company, the  
18          subject of this hearing, which is  
19          operating out of the direct off  
20          exchange products.

21                       What we did there was we tried to  
22          combine the experience or reflect the  
23          fact that we have to price to a single  
24          risk pool across those two companies.  
25          I can't just price for the ConnectiCare

1 Insurance Company experience or the  
2 exchange experience separately because  
3 those are going to be blended in the  
4 final analysis. So that actually  
5 allowed me to lower the rates on the  
6 rate increase on ConnectiCare Insurance  
7 Company by one-and-a-half points.

8 MR. LOMBARDO: Can we go back to  
9 that point?

10 MR. KELSEY: Sure.

11 MR. LOMBARDO: Because my  
12 understanding that the risk pools  
13 needed to be separate for each legal  
14 entity so your risk adjustment for  
15 ConnectiCare Insurance Company is  
16 separate from ConnectiCare Benefits,  
17 Inc.

18 MR. KELSEY: It is, yes.

19 MR. LOMBARDO: So when you say  
20 merged and blended, what does that  
21 mean? For what purpose?

22 MR. KELSEY: To, in effect,  
23 neutralize the impact of the gross  
24 adjustment across the two companies.

25 MR. LOMBARDO: So you're doing

1           that internally?

2           MR. KELSEY: Right.

3           MR. LOMBARDO: That is -- that is  
4           an internal business, I'm not going to  
5           say that you're managing, but for  
6           purposes of pricing and purposes of the  
7           risk adjustment and the MLR rebate, all  
8           those calculations are separate and  
9           distinct for each company?

10          MR. KELSEY: Yes. So that's an  
11          internal price cut, yes. And it's not  
12          dissimilar from if we only had one  
13          company operating both on and off, we  
14          would be combining these.

15          MR. LOMBARDO: Yes.

16          MR. KELSEY: And then the last  
17          item is changes in retention and for  
18          that we were able to lower our rates  
19          9.6 or 7 percent. And those were  
20          changes in administrative costs. One  
21          of the things, I think it was Michelle  
22          that pointed it out, was that we had  
23          had a lot of growth in this segment,  
24          which on a per member per month basis,  
25          drives our admin load down. So that

1 drives a lot of that. So when you  
2 combine all those things, you get to a  
3 9.6 or 7 percent increase.

4 MR. LOMBARDO: Okay.

5 MR. KELSEY: So to kind of  
6 crosswalk to the -- to the -- remember,  
7 from what they said that -- although  
8 the numbers are slightly different when  
9 you do it this way, you can see the  
10 Federal Reinsurance adjustment, it's  
11 out there specifically. The retention  
12 adjustment and the ACA adjustment does  
13 kind of combine to get to the retention  
14 adjustment that I just mentioned. And  
15 the other things are either trend or  
16 base period adjustments.

17 MR. LOMBARDO: Okay. Thank you  
18 for that explanation.

19 My next question relates to a  
20 morbidity adjustment that you had  
21 included in your original 2014 pricing.  
22 It was to account for the difference in  
23 population morbidity from the new group  
24 that was coming on in 2014. And you  
25 included it also in your 2015 pricing

1 because you did not have ACA experience  
2 for 2015, as well. And that was an  
3 estimate of 19.8 percent adjustment.  
4 In your rate development exhibit, you  
5 identified a morbidity adjustment of  
6 negative 8.8 percent in 2016. Can you  
7 explain a little bit more about what  
8 that is and the development of the  
9 8.8 percent?

10 MS. VAN DER HEIDJE: Sure. And if  
11 you don't mind, I think I can take a  
12 minute and clarify the 19.8 to 8.8  
13 reduction, what all that is so you know  
14 exactly what those are. But there are  
15 so many numbers flying around here that  
16 I wasn't sure that it made sense how  
17 this all fits together.

18 So essentially, as Neil mentioned  
19 in the post ACA premium development  
20 process, we very clearly have not  
21 allowed and should not and would not  
22 include morbidity in the premiums. Now  
23 what do I mean by that?  
24 So if you have two carriers, and let's  
25 say that one attracts a sicker

1 population and one attracts a healthier  
2 population, the risk adjustment  
3 provision, which is a federal  
4 provision, we can talk more about it if  
5 you want. The risk adjustment  
6 provision essentially transfers risks  
7 between carriers. And the way it does  
8 that is by setting up a pool that  
9 always balances out to zero because  
10 money that goes in is money that comes  
11 out where a carrier that might have  
12 healthier than average populations and  
13 pay into the pool and carriers with  
14 sicker than average might receive money  
15 out.

16 Now, why is that? How does that  
17 work and how does that fit together?  
18 Essentially what that would do is if  
19 you're a carrier that is a healthier  
20 than average population, you would not  
21 want or should not be in a position of  
22 having better margins on your work just  
23 because you had a healthier population.  
24 And on the flip side, if you're a  
25 carrier that happens to attract a

1           sicker population, it would not be fair  
2           if your premiums were inadequate  
3           because you attracted a sicker  
4           population.

5                        So what happens with this risk  
6           assessment pooling is that it takes a  
7           step back at the end of the year after  
8           the 2014 or 2015 or 2016 years were  
9           done, looks at that year and says, what  
10          was the market average risk, not just  
11          for us but for everybody in the market,  
12          pools it and says, this is the average  
13          risk and to the extent to which you are  
14          higher or lower average is where you  
15          either contribute into or receive from  
16          this pool.

17                       So why does this matter? The  
18          reason this matters is if we're looking  
19          at 2014 experience and we see a sicker  
20          than average or a healthier than  
21          average population, we need to  
22          specifically think about how we pull  
23          that out of our premium so that we  
24          don't accidentally double count what  
25          the risk assessments are.

1                   So, for example, we had a  
2                   healthier than average population and  
3                   we charged the average market average  
4                   -- I should say we charged our  
5                   experience is level, then you would do  
6                   the pricing comparative because of this  
7                   risk adjustment mechanism.

8                   So those are what the 19.8 and  
9                   the 8.8 are essentially trying to do is  
10                  run up the tide of the premiums so  
11                  that's what we think is the tide of the  
12                  markets so that we are pricing at a  
13                  level that is accurate after we get the  
14                  risk adjustment payment or transfer  
15                  payment.

16                  So if we just take the experience  
17                  and let it roll, that's going to be  
18                  incorrect. Because what we need to do  
19                  is take the experience, think about our  
20                  health status versus the market  
21                  consciously adjust for that and so  
22                  forth.

23                  And so while we were looking at  
24                  2014, we used very different experience  
25                  to set the rates than when we looked at

1           2016. In 2016, we had actual 2014  
2           experience to use. In 2014, we  
3           obviously would not have had 2014  
4           experience to use, yet, we would have  
5           had to use the pre-ACA business and so  
6           we have to think through what  
7           adjustment is the most appropriate to  
8           prove our opinions to what we think if  
9           the market average risk in each of  
10          those two-cases. So I think the  
11          difference in the experience is really  
12          the driver here.

13                 So Neil, do you want to describe  
14                 more about those two adjustments?

15                 MR. KELSEY: Okay. Thank you.  
16                 The 19.8 percent was taking a block of  
17                 business as I said earlier that was  
18                 medically underwritten in 2014 and  
19                 projecting that for a lot of new  
20                 entrants coming into the market. So it  
21                 was really the seismic shift in the  
22                 underlying population.

23                 That was an estimate that -- and  
24                 we didn't have any hard data and we  
25                 relied on industry sources, including

1           Milliman, to come up with that  
2           19.8 projection. The Society of  
3           Actuaries and some other consulting  
4           firms also published data that allowed  
5           us to triangulate in on that number.  
6           If you think of that 19 to 28 percent,  
7           think of it in two pieces. One is the  
8           population is -- that came to us in  
9           2014 was less healthy, meaning they  
10          required more services, more care than  
11          the population that was in the  
12          experience of 2013.

13                 Secondly, there was accumulated  
14          neglect. Okay. So they -- for the  
15          first couple of years we expected that  
16          that population as they learned out to  
17          use their insurance, and they started  
18          to manage their prior condition to get  
19          things taken care of that they hadn't  
20          seen a doctor for when they were  
21          uninsured, that would all contribute to  
22          higher morbidity or higher average  
23          costs in the first year or two of the  
24          program.

25                         Now with benefit of hindsight,

1 and we're now building up off of the  
2 2014 experience, which has that  
3 accumulated rate, we're able to remove  
4 that. So the morbidity adjustment that  
5 you're seeing reflects the removal of  
6 that without accumulating over time.  
7 And essentially how we did that was we  
8 compared our paid claims per member per  
9 month in 2014 between ACA compliant  
10 members, members that had already moved  
11 to ACA compliant plans and not ACA  
12 compliant plan numbers because we had  
13 both 2014 as the business had shifted  
14 again.

15 Those plans, we normalize it per  
16 area, demographics and plan design and  
17 those plans, the ACA plans had a  
18 normalized cost of about 8 percent  
19 higher than what we expected in the  
20 non-ACA plans. So that was the  
21 adjustment we were able to pull out.

22 So going forward, those pieces of  
23 any morbidity adjustment, I think this  
24 is the last time we'll see those.

25 MR. LOMBARDO: Okay. Thank you

1 for that explanation.

2 The next question we have is:  
3 You mentioned value drugs and global  
4 maternity within the pricing in a  
5 couple of areas. Can you briefly  
6 describe what value drugs are and  
7 global maternity and identify -- I  
8 think there were some changes made from  
9 4/30 rate filing to the 8/26 rate  
10 filing.

11 MR. KELSEY: Yes. So these were a  
12 couple of minor changes we made. Value  
13 drugs, we have a certain list of value  
14 drugs with a relatively low co-pay. In  
15 the past, on certain times, we applied  
16 that co-pay towards their deductible  
17 and going forward, we're going to  
18 change the plan design so that we are  
19 no longer applying that co-pay towards  
20 their deductible. So a slight nuance  
21 in plan design.

22 Based on 2014 experience, we felt  
23 that that would increase the cost by 27  
24 cents EMPM. I don't expect it to be as  
25 significant in 2016, so I billed 40

1           cents per member per month into the  
2           rate file.

3                   One other thing I'll point out is  
4           that in the initial rate package and we  
5           mentioned this in response to your  
6           objection letter, we had the numbers  
7           between individual and small group  
8           flip-flopped, so that bill was -- I  
9           think it was 26 cents. And then you  
10          have small group which was in our  
11          analysis.

12                   MR. LOMBARDO: Yes.

13                   MR. KELSEY: And global maternity  
14          we -- we went back. Again, that was a  
15          small change in benefit design. We  
16          re-looked at the experience and  
17          determined that the impact was subtle  
18          so we removed that adjust from our  
19          first filing.

20                   MR. LOMBARDO: Okay. Thank you.  
21          The federal MLR calculation, can you  
22          just briefly explain what your actual  
23          loss ratio was. We did a calculation  
24          at the Department. You're actual loss  
25          ratio, which just incurred claims over

1           earned premium for your 2014  
2           experience, which you provided was  
3           92.53 percent for this business in  
4           2014.

5                         Without risk adjustments, without  
6           reinsurance adjustments, without any  
7           adjustments, that's just your straight  
8           loss ratio. Can you explain what  
9           you're pricing for in a straight  
10          incurred claim over earned premium and  
11          what the federal MLR is for the 2016  
12          pricing? Thank you.

13                        MS. VAN DER HEIDJE: And while  
14          you're pulling the exact numbers here,  
15          what I think what's important to note  
16          is the two different types of loss  
17          ratios that can be calculated. And you  
18          all are well aware, there's a  
19          traditional loss ratio I'll call it, a  
20          more simple ratio, which is that on  
21          every dollar of premium how much is  
22          spent on that complaint? So, for  
23          example, you've got an 80 percent loss  
24          ratio and \$100 opinion, that would say  
25          that \$80 is being spent on medical

1 claims and 20 percent is being spent on  
2 administrative expenses. So when we're  
3 going over and thinking about these MLR  
4 calculations, there's that way which is  
5 how we candidly always thought about  
6 that prior to the new definition that  
7 came out in 2011.

8 And then there's the medical loss  
9 ratio and a more formal MLR  
10 requirement, which I think is the one  
11 that you're referring to here, which is  
12 -- and includes quite a few more  
13 things.

14 And so the way that that formula  
15 works is instead of just having claims  
16 over premium, at the end of that ratio,  
17 what portion of opinions belong to  
18 claims. It would be claims plus  
19 quality improvement or qualified IT  
20 expenses that are directly related to  
21 the medical claims, minus the impact of  
22 the three Rs, the risk assessment, the  
23 retention reinsurance and the four that  
24 we touched on. And the premium is  
25 less. Funny construct, but, of course,

1           it's one that we all use for that  
2           federal MLR. So I think as we're  
3           looking through these different  
4           numbers, there's a pure and traditional  
5           loss ratio and then there's this  
6           federal MLR which is (inaudible).

7           MR. KELSEY: All right.

8           So in our 2016 rate bill, the  
9           traditional project MLR as Mary called  
10          it is 77.4 percent. So that's the  
11          traditional projected and incurred  
12          claims over -- over premium for  
13          revenue.

14          The adjusted federal MLR for  
15          rebate purposes is at 84.7. And that's  
16          the one where for the individual  
17          business the threshold there is if that  
18          is below 80 percent carriers have to  
19          refund money to the consumers.  
20          Our loss ratio is almost five points  
21          higher than the required minimum.

22          MR. LOMBARDO: Thank you.

23          So if your pricing loss ratio is  
24          77.4 percent and your retention charge  
25          in your file is 22.6 percent, getting

1 back to one of the requirements that  
2 the Department has in the bulletin, we  
3 asked you to compare your retention  
4 charge in your statutory statement to  
5 the retention charge you're using in  
6 the rate filing.

7 The rate filing has a  
8 22.6 percent retention charge. The  
9 retention charge from your stat  
10 statement, which you provide an excerpt  
11 in the rate filing is 15.5 percent.  
12 So can you create and tie up loose ends  
13 on what the difference between the 15.5  
14 and the 22.6 is.

15 MR. KELSEY: Sure. We can get  
16 back to you with more information on  
17 that. The as 15.5 is from a statutory  
18 statement and there's all kinds of  
19 rules about how things get bucketed in  
20 that statement. Maybe we can try to go  
21 through in our demonstration for you  
22 how we got to that 15.5 percent.  
23 It's also historical and it's on a  
24 financial basis.

25 So as you have one-time events or

1 things happen during the year where  
2 you're making a payment or an expense  
3 or something that all gets into the  
4 historical statutory numbers. It  
5 doesn't affect our pricing going  
6 forward. The pricing is on a projected  
7 basis so there's always going to be  
8 some differentials between the two.

9 MR. LOMBARDO: Thank you.

10 Soto identified in June, June 30th,  
11 they came out with a reinsurance and  
12 risk adjustment report that identified  
13 -- and I'll identify it for the record,  
14 ConnectiCare Insurance Company and I  
15 understand these are estimates. I  
16 understand these are estimates. The  
17 reinsurance amount that ConnectiCare  
18 received was about \$13 million in 2014.  
19 The payout and the risk adjustment  
20 program for 2014 is almost \$11,000,000.  
21 That equated in your 2014 membership as  
22 a payout of about \$44 per member per  
23 month. Right now in the pricing, you  
24 don't have a payout value for risk  
25 adjustment in 2016. I think you just

1           have the expense of the program which  
2           is 15 cents per member per month in  
3           your pricing.

4                        So can you walk us through why  
5           you wouldn't? And I understand what  
6           I'm asking you, because this would  
7           increase your rates because you're  
8           making a payment into the risk  
9           adjustment program, but explain for the  
10          record and the Department why you  
11          wouldn't want to make an adjustment in  
12          2016 pricing for the potential for a  
13          repeat payment of that level for this  
14          business.

15                      MR. KELSEY: Sure. Just to  
16          clarify before we start, you mentioned  
17          in your prelude both risk adjustment  
18          and reinsurance. The question is just  
19          on risk adjustment?

20                      MR. LOMBARDO: Yes, the  
21          reinsurance amount was in the value  
22          that you've assumed in your pricing in  
23          2016 is consistent with our  
24          calculations that we made on a PMPM  
25          basis for the 50 percent insurance in

1 revised corridors, but there's a big  
2 discrepancy between the 2014 payment  
3 and 2016. So it's just risk  
4 adjustment.

5 MS. VAN DER HEIDJE: Sure.

6 MR. KELSEY: So Mary will give  
7 this. You can start.

8 MS. VAN DER HEIDJE: What I'm  
9 going do next I'm going to talk a  
10 little, let me give you a little bit of  
11 background on the risk adjustment and  
12 how it's built in. As I mentioned,  
13 when we're trying to estimate the  
14 morbidity factor and what you built  
15 into the premium level what you need to  
16 do is think of not just consider plain  
17 experience, but what we think the  
18 market average is and what we think the  
19 projected market average is.  
20 So it's a different question that we're  
21 trying to answer, which is, of course,  
22 what makes it all complicated as it  
23 fits together. And when we adjust our  
24 claim experience to bring it back up to  
25 the market average versus only project

1 the market average in 2014 and '13,  
2 those are essentially two different  
3 steps.

4 So, I think, when we're looking  
5 back on 2014 experience, we now know as  
6 you mentioned the June 30th report that  
7 the amount that shows what the  
8 estimated is, that would be March 10,  
9 the risk adjustment. We know about  
10 what we paid for 2014. We have a good  
11 estimate now at this point. If we took  
12 that value and rolled that forward,  
13 what we're essentially saying is two  
14 things. We think that our population  
15 is going to be the same difference from  
16 the average in 2016 as it was in 2014.  
17 And we're saying that we think the 2016  
18 population is going to be the same  
19 health stats.

20 So if either of those two things  
21 move and if we get changes or if the  
22 market ties or the market average  
23 changes, if either of those things  
24 change in the amount that we should  
25 build in for 2016, rates should change,

1 as well. And that's the factor that's  
2 driving us to not include our risk  
3 adjustment insurance rate higher.

4 Do you want to add more to that?

5 MR. KELSEY: Yes.

6 Say specifically to our decision  
7 and the three reasons why we did not  
8 include a negative impact to risk  
9 adjustment, which as you correctly  
10 pointed out would increase our rates.  
11 We didn't include the charge or credit  
12 for risk adjustments for the following  
13 reasons:

14 First, and most significantly or  
15 very significantly, our market share  
16 has grown in 2015. As our share grows,  
17 our results are going to drive the  
18 market. Okay, so in other words, as  
19 you become a bigger player, you become  
20 -- -- your experience or your morbidity  
21 level comes closer to the market  
22 average, okay. So that's step number  
23 one.

24 Probably the most significant  
25 thing is that we've experienced

1 significant membership churn in 2015.  
2 To date, in this company alone, the  
3 individual direct market, 45 percent of  
4 our members are brand new to us in  
5 2015. Some of those are new to the  
6 market but a good share of those came  
7 from our competitors in the prior year.  
8 So in 2014, their risk are with our  
9 competitors and not with us.

10 Overall, if I combine the  
11 exchange business in, almost 50 percent  
12 of our members are brand new. That's  
13 an unprecedented churn in this market  
14 and I fully expect that that type of  
15 churn in a very price sensitive market  
16 is going to continue year after year  
17 after year. It's going to take a long  
18 time to stabilize.

19 And then finally on the risk  
20 adjustment model itself, the actual  
21 model used to calculate the amounts of  
22 the transfers is new. This was the  
23 first time that it was in place. The  
24 model has already changing for next  
25 year. There remains a good deal of

1           variability in the results and that can  
2           affect your over year stability. So  
3           because of those three things, we  
4           decided not to make a charge to our  
5           rates.

6           MR. LOMBARDO: Thank you for the  
7           explanation. I promise I will wrap up  
8           very soon. Just a couple of more  
9           questions.

10           There are some major changes,  
11           significant differences on mobilization  
12           factors, demographic benefit in the  
13           area on your rate development page from  
14           1/15. If you can briefly explain those  
15           adjustments, what they are and why they  
16           changed? I think I understand in all  
17           the answers, but I'd like to hear it  
18           for the record.

19           MS. VAN DER HEIDJE: Sure. Why  
20           don't you get those values here  
21           (indicating Mr. Kelsey.)  
22           Essentially, there are elevations that  
23           Mr. Lombardo is mentioning here, is a  
24           balancing step that we take in the end  
25           that governed the dictated instructions

1 for the ACA pricing. And what we  
2 essentially were doing is going through  
3 and noting excessive claims and that's  
4 the problem we just had so far. What  
5 we need to do is make sure that is  
6 balanced within the required construct  
7 of the ACA.

8 So an example of that could be  
9 the age factor. The age rates can vary  
10 between 3 to 1 from the oldest to  
11 youngest adult. And, in fact, that's  
12 not up to us. That's not up to any of  
13 us in this room, it's governed by the  
14 law.

15 And so there's a specific set of  
16 factors that we all need to comply with  
17 that show what the variation would be,  
18 age over age.

19 When we look at our claim  
20 experience those are actually not how  
21 the claims vary by age. This is a  
22 place where the pricing at the very end  
23 differs from the underlying plan  
24 experience. The curve is steeper than  
25 3 to 1 if you were to look at the

1 actual plain.

2 So what we do is go through a  
3 balance for the population, here's the  
4 actual cost and at the end there is a  
5 normalization factor that needs to  
6 occur that basically formed the average  
7 into the rules that we're allowed to  
8 make for them. Now, there's that with  
9 gender, the rates are all how you  
10 impact 2014 once you're balancing all  
11 that out.

12 So the total amount of premium  
13 that's collected doesn't change the  
14 facts. It just takes it and you  
15 calculate the total premium and your  
16 normalize it to fit it into the  
17 required construct here.

18 As I mentioned, there's specific  
19 rules about how you're supposed to do  
20 this. This has to be done uniformly  
21 across plans. We couldn't go in and  
22 say we're going to just do it like this  
23 and just like that and have -- even if  
24 the average crafted and preserved, that  
25 would not be okay. So it's a global

1 adjustment factor that we make at the  
2 end.

3 So globalization tests that he's  
4 mentioning is how we've gone through  
5 and kind of balanced to make sure that  
6 the (inaudible) is correct and it's  
7 very -- it's mathematical nuts and  
8 bolts point of how it's all fitting  
9 together.

10 MR. KELSEY: I got it. I'm not  
11 technologically savvy, I guess. So the  
12 changes that were made and the key  
13 thing here is you have to kind of look  
14 at all these factors together. Okay?  
15 The demographic factors, those were put  
16 into the filing in two places. There's  
17 a demographic adjustment to the base  
18 experience and then a projection to the  
19 federal demographic curve, okay? The  
20 combination of those two factors even  
21 though they -- the factors themselves  
22 change in each of those cohorts or  
23 those buckets from 2015 to 2016 the net  
24 impact on rates is the first one  
25 divided by the second one. And if you

1 do that both of those come out to about  
2 1.56 or 1.58. So the communications of  
3 the population overall was very stable,  
4 slightly over.

5 Area factors: The area  
6 normalization changed in the historical  
7 period. That was really because of a  
8 shift in business. We wrote a lot more  
9 business in Fairfield County in 2014.  
10 Almost double the amount, if not more,  
11 than cost of the share that we had in  
12 Fairfield County. That's a high cost  
13 area so that changed the demographics  
14 down there.

15 Benefit factors were up about  
16 9 percent. Reflection of the ACA and  
17 the required meta levels, some of the  
18 plans that were below primes are no  
19 longer available in the market. Also,  
20 people bought more silver than they  
21 have before. So they're buying higher  
22 benefit plans. So that's reflected in  
23 benefit factor.

24 MR. LOMBARDO: Great. Thanks. I  
25 just have one last question and then I

1 can summarize what additional  
2 information we'd be looking for and  
3 talk to the Hearing Officer about  
4 keeping the record open to get that  
5 information.

6 The last I have is: Is what we  
7 have on record is revised rate increase  
8 of an average of 9.8 and a range of 5.6  
9 to 14.3. Can you explain for the  
10 record why there's such a significant  
11 range around the average based upon the  
12 different benefit plan designs that you  
13 offer, why they're being affected  
14 differently?

15 MR. KELSEY: Sure. You said, 9.8.  
16 The revised number was 9.6.

17 MR. LOMBARDO: 9.6.

18 MR. KELSEY: 9.8 was the initial  
19 number. Let me just pull out a page  
20 here. The plan relativities changed  
21 significantly on a handful of plans  
22 which accounts for the range. The AV  
23 calculator, which is a federal  
24 calculator changed for the 2016 benefit  
25 year. So plans that had been at silver

1 level and as you know, you have to be  
2 within a very narrow range, plus or  
3 minus two percent on the calculator to  
4 pass to the calculator. With the  
5 changes in the calculator certain plan  
6 designs failed. Certain 2015 plans  
7 actually, you could no longer offer in  
8 2016.

9 So we had to change deductibles,  
10 maximum out-of-pockets primarily, made  
11 some co-payment changes or  
12 ex-co-payment changes to satisfy that  
13 AV calculator. Those were positive and  
14 negative. Mostly negative, but there  
15 were a couple of plans where we had to  
16 lower the deductible to continue to be  
17 the silver AV range.

18 We lowered the deductible from  
19 \$5,000 to \$4,500. Lowered the maximum  
20 out-of-pocket from 6,350 to \$5,000 and  
21 we no longer are subjecting laboratory  
22 services (inaudible).

23 All of those are benefits to the  
24 consumer through lower co-pays, but  
25 does increase the plan value by about

1 4.3 percent.

2 On the down -- on the negative  
3 side, I'll give you the largest one.  
4 The largest one under this rate filing  
5 would have been one of our has plan  
6 designs. That one just made it to the  
7 bronze level. It was a \$5,000  
8 deductible plan, we had to make it  
9 5,5350. And we had to add \$100 maximum  
10 out-of-pocket.

11 So again, those changes were  
12 necessitated by the AV calculator and  
13 that requirement. In that case it  
14 actually reduced the benefit and  
15 therefore we lose the money.

16 MR. LOMBARDO: Thank you for the  
17 clarification.

18 Just two things as a followup  
19 that I'd ask from ConnectiCare. One is  
20 that Neil, I think you mentioned that  
21 you'd be willing to give some  
22 additional information on the crosswalk  
23 between the statutory retention of  
24 15.5, I think. And what you assumed in  
25 pricing for your retention?

1 MR. KELSEY: Yes.

2 MR. LOMBARDO: You'll get some  
3 additional information. You also  
4 mentioned in your trend explanation  
5 that you had some updated 2015 data  
6 that you were using as a tool to  
7 estimate 2016 trend. If you can  
8 provide anything that you have more  
9 up-to-date information on that trend in  
10 2015, that would be beneficial and  
11 helpful to the Department.

12 MR. KELSEY: What we have right  
13 now in the exhibit that we showed you  
14 was calendar year numbers.

15 MR. LOMBARDO: Right.

16 MR. KELSEY: What we have is  
17 year-to-date and first quarter with two  
18 months run outs. So in through May.

19 MR. LOMBARDO: So if you have  
20 year-to-date for the first quarter of  
21 2014.

22 MR. KELSEY: Well, we can go over  
23 it again.

24 MR. LOMBARDO: Or first quarter of  
25 2015, that would be beneficial, as

1 well.

2 Hearing Officer, that's all I  
3 have.

4  
5 **SECOND PUBLIC COMMENT PERIOD**

6  
7 HEARING OFFICER: Okay, great.

8 At this time, we'll now go the second  
9 public comment portion of the hearing.

10 The public comment portion of the this

11 hearing commences with comments from

12 public officials and then continues

13 with comments of other interested

14 persons. I would ask that anyone

15 interested in participating in this

16 portion of the hearing comply with the

17 following guidelines: Each individual

18 must identify himself or herself for

19 the record including any organization

20 he or she represents. Each individual

21 must direct all comments to me. All

22 comments must relate specifically to

23 the rate application of the insured,

24 which is under review by the Insurance

25 Department and now pending before me.

1                   And finally, we'll not have the  
2                   same time constraints as earlier, but I  
3                   reserve the right to ask you to sum up.  
4                   Is there anybody else who would like to  
5                   present public comments at this time?  
6                   Okay. Seeing no one, would the  
7                   Applicant like the respond to any  
8                   public comments from earlier in the  
9                   general specifically?

10                   MR. BABBITT: No.

11  
12                   **CLOSING STATEMENTS**

13  
14                   HEARING OFFICER: The Applicant  
15                   will now have the opportunity to make a  
16                   brief closing statement, although it is  
17                   not required. I'm asking that any  
18                   opposing statements be limited to five  
19                   minutes.

20                   Mr. Babbitt, does the Applicant  
21                   wish to make a closing statement?

22                   MR. BABBITT: We do.

23                   HEARING OFFICER: Great.

24                   MR. BABBITT: Thank you.

25                   MS. ZETTERGREN: Thank you,

1           Hearing Officer Campanelli. Thank you  
2           officials of the Connecticut Insurance  
3           Department and members of the public.  
4           Medicare supports transparency in the  
5           marketplace and appreciate the  
6           opportunity today to share with you  
7           additional information on our  
8           individual office change rate filing.  
9           We hope the Insurance Department and  
10          all in attendance found the information  
11          we provided to be helpful and  
12          clarifying.

13                 As I mentioned in my opening  
14          remarks, we hear the impact rate  
15          increases have on our members. We want  
16          everyone present today to know that we  
17          take our responsibility to control  
18          costs very seriously. We pledge to  
19          continue to do everything reasonably  
20          possible to control the rising cost of  
21          healthcare and health insurance in this  
22          state.

23                 ConnectiCare was founded by a  
24          group of doctors in 1981 and we have  
25          been committed to the state ever since.

1 We are continually identifying and  
2 seeking new ways to improve the  
3 delivery of healthcare in our state.

4 Today, for example, we are  
5 collaborating with doctors in new ways  
6 to help them coordinate and manage  
7 their patient's care. These kinds of  
8 innovations help keep our members  
9 healthy and have a direct impact on  
10 controlling costs and improving the  
11 patient experience.

12 Connecticut is part of our name.  
13 And we are a leader in offering health  
14 insurance in this state. We have the  
15 largest membership in Connecticut's  
16 individual, small group and Medicare  
17 markets. We are honored that our net  
18 promoter score is the highest among  
19 health insurance carriers in  
20 Connecticut because that score is a  
21 measure of customer satisfaction. We  
22 are proud to be in the top 15 percent  
23 of health plans in the country as  
24 ranked by the National Committee for  
25 Quality Assurance.

1           As a leader, our goal has been  
2           and continues to be to partner with all  
3           constituents to bring about the changes  
4           needed to deliver high quality  
5           affordable healthcare to all of  
6           Connecticut's residents. We pledge to  
7           continue working hard to make it easy  
8           for our members to get the care that  
9           they need. Thank you.

10           HEARING OFFICER: Thank you.  
11           Are there any further questions from  
12           staff to the Insurance Department?

13           MR. LOMBARDO: No, I don't have  
14           any further questions.

15           HEARING OFFICER: Okay.

16           MR. LOMBARDO: Just that we  
17           request that the proceeding be closed  
18           as of the end of today except for the  
19           request for additional information from  
20           ConnectiCare; that is the crosswalk of  
21           the statutory statement expenses to a  
22           further explanation to the retention  
23           used as well as additional first  
24           quarter 2015 experience to use as a  
25           trend evaluation to the first quarter

1 of 2014. And that be submitted no  
2 later than July 31, 2015.

3 HEARING OFFICER: Great. In  
4 accordance with Section 38A8-40 of the  
5 Regulation to the Agency, I'm ordering  
6 the Applicant to submit the two  
7 documents listed by Mr. Lombardo by  
8 July 31, 2015. The record of this  
9 hearing will be held open until further  
10 written comment until the close of  
11 business today.

12 Today's hearing is adjourned.

13 Thank you.

14 (Whereupon, the hearing was adjourned at  
15 10:35 a.m.)

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CERTIFICATE

I hereby certify that the foregoing 100 pages are a complete and accurate computer-aided transcription of my original stenotype notes taken in the Public Hearing in the Matter of ConnectiCare Insurance Company, held before Kristin Campanelli, Hearing Officer, Insurance Department, 153 Market Street, Hartford, Connecticut, on July 27, 2015.

/s/ \_\_\_\_\_

Jolene Isdale, LSR 497

Licensed Shorthand Reporter

**I N D E X**

**WITNESSES:**     **Michelle Zettergren**  
                       **Neil Kelsey**  
                       **Mary van der Heidje**

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<b>LIST OF EXHIBITS</b>		
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1	Public Comments submitted to the Insurance Department prior to 9am Friday, July 24, 2015	3
2	Rate filing submitted via SERFF by ConnectiCare Insurance Company, Inc., to Connecticut Insurance Department, including actuarial memorandum, dated April 30, 2015, all correspondence related thereto, and one page executive summary	3
3	Notice of Public Hearing ordered by Katharine L. Wade, Commissioner, Connecticut Insurance Department, dated July 6, 2015	3
4	Email to Theodore Bromley, Esq., Office of the Connecticut Secretary of the State and Taffy Womack, Office of the Connecticut Secretary of the State with Notice of Public Hearing and cover letter provided as enclosure, from Kristin Campanelli, Connecticut Insurance Department, both dated July 7, 2015	3
5	Order by Katharine L. Wade, Commissioner, Connecticut Insurance Department, naming Kristin Campanelli as hearing officer, dated July 7, 2005	4

1	NO.		Page
2	6	Email to Kristin Campanelli, Esq. Connecticut Insurance Department, 3 dated July 17, 2015 with Notice of 4 Appearance for Bradford Babbitt, Esq., Robinson and Cole, LLP	4
5	7	ConnectiCare Insurance Company List Of Witnesses, submitted by Bradford 6 Babbitt, Esq., Robinson and Cole, LLP, received July 22, 2015	4
7			
8		<b>**REPORTER'S NOTE:</b> All exhibits retained by Hearing Officer Campanelli.	
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