STATE OF CONNECTICUT
INSURANCE DEPARTMENT

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In the Matter of	)	
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ANTHEM BLUE CROSS AND BLUE SHIELD	)	
	)	July 27, 2015
Applicant.	)	

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PUBLIC HEARING

Held Before:

KRISTIN CAMPANELLI, Hearing Officer

PAUL LOMBARDO, Life & Health Division

MARY ELLEN BREAULT, Life & Health Division

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

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By: MICHAEL G. DURHAM. ESQ.
JOHN RUSSO, ESQ.

. . . The following is the transcript of the Public Hearing in the Matter of Anthem Blue Cross and Blue Shield, held before Kristin Campanelli, Hearing Officer, at the Insurance Department, 153 Market Street, Hartford, Connecticut, on July 27, 2015, commencing at 1:00 p.m. . .

(The hearing commenced at 1:00 pm.)

(Exhibit 1: Received in evidence.)
(Exhibit 2: Received in evidence.)
(Exhibit 3: Received in evidence.)
(Exhibit 4: Received in evidence.)
(Exhibit 5: Received in evidence.)
(Exhibit 6: Received in evidence.)
(Exhibit 7: Received in evidence.)
(Exhibit 8: Received in evidence.)

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

On behalf of the Connecticut

Insurance Department, I would like to welcome you to this hearing. I'm Kristin Campanelli, and I've been appointed by Commissioner Wade to preside at today's public hearing.

I want to take a moment at the start of this proceeding to explain the way this hearing will work. Many of you may be familiar with the hearings held by the legislature to consider proposed legislation, or agencies in your town to consider city or town affairs, but you may not be familiar with this type of administrative hearing.

An administrative hearing such as this is a regulatory proceeding in which a party, in this instance Anthem Blue Cross and Blue Shield, is required to present documentation and arguments regarding their application. Ultimately, Commissioner Wade will decide this matter based on a recommendation that I will prepare. This is not a court proceeding, but it does operate under a system of rules with the presentation of evidence and witnesses who

testify under oath.

We will have three potential opportunities for public comment at this hearing. First, in a couple of minutes, there will be a half an hour devoted to public comment with the amount of time for each statement restricted out of respect for the time of everyone here.

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

And third, written comment may be submitted up until 4:00 today.

Unlike a legislative hearing, there may be times when we need to call a recess.

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

Anthem Blue Cross and Blue Shield

will be referred as "Anthem" or "the applicant."

For the record, Docket Number LH 15-96 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 imposed by the Connecticut insurance statutes.

This public hearing is being held to consider whether the premium rate increase application filing, dated April 30th, 2015, by Anthem Blue Cross and Blue Shield concerning premium rates for its individual plans, both on and off exchange, are excessive, inadequate or unfairly

discriminatory pursuant to Connecticut General Statutes 38a-481. This will be the only subject at today's rate hearing.

This proceeding was commenced on April 30th, 2015, when the applicant filed with the Connecticut Insurance Department, to be referred to as "the department," a rate application regarding the applicant's individual rates for both on and off exchange plans.

While there's no statutory requirement that a rate hearing be held, on July 6th, 2015, Commissioner Wade ordered that a public hearing be held on July 27th, 2015, to consider granting approval of the proposed application.

This hearing was ordered in partnership with Healthcare Advocate pursuant to the terms of an agreement between the commissioner and advocate dated May 14, 2015, which permits the advocate to request up to four hearings per year for rate increase requests of 10 percent or more.

A copy of the notice for this

public hearing was filed with the office of Secretary of State. In addition, this notice was posted on the insurance department's Internet website. This notice indicated that the application was available for public inspection at the insurance department, and electronically on the insurance department website; and that the department was accepting written statements concerning the application.

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

Joining me are Paul Lombardo, Life and Health Actuary, and Mary Ellen Breault, Director of the Division of Life and Health.

At this time I'd like the counsel for the applicant to identify themselves.

MR. DURHAM: Good afternoon,

Hearing Officer Campanelli. I'm Attorney Mike Durham from Donahue, Durham & Nooonan, and I'll be representing Anthem today.

HEARING OFFICER: At this point I would like to enter into the record the stipulated list of exhibits. The list identifies eight documents which have been stipulated to as full exhibits by the parties to this proceeding.

These exhibits include a copy of the rate filing application and all written public comment received through 4:00 p.m. Friday. Written public comment received today will be added to the record following the hearing. A copy of the list is available to members of the audience today.

At a prehearing conference to expedite today's hearing held on July 23rd, 2015, we discussed the exhibits, witnesses, and hearing procedures for today. The first item of business today is public comment.

Members of the public who have signed up to speak will have the first half hour of this proceeding to orally comment

on the application that is the subject of today's hearing. In this regard, there are two sign-up sheets available for persons interested in presenting oral comments at this hearing: one for public officials, and one for persons other than public officials.

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

MS. MEDINA: Three.

HEARING OFFICER: Each person will have three minutes to comment, and we will alternate between the general public and any public officials who may also want to speak. This is a comment period only and no questions should be directed to the applicant or the department.

The applicant will then provide a presentation of the application. Insurance department staff will be given an opportunity to examine the witnesses. After the examinations have been concluded, anyone from the public who did not have an

opportunity to be heard in the first half hour, or wishes to make statement, will have the opportunity to orally comment on the application. The public may also present written -- excuse me, present written comments no later than 4:00 p.m. today either to Ms. Medina during the course of today's hearing, or at the department's reception desk.

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

Each individual must identify himself or herself for the record, including any organizations that he or she represents. Each individual must address all comments to me. All comments must relate specifically to the rate application that is the subject of today's hearing. And each individual must reasonably limit

his or her comments to three minutes.

At this point we'll commence public comment period.

All right. First person I have signed up for comment is Lynne Ide at the Universal Healthcare Foundation of Connecticut.

MS. LYNNE IDE: Good afternoon. I'm here today on behalf of Universal Healthcare Foundation of Connecticut. I'm Lynne Ide, director of program and policy. This is my third time speaking to this panel today. And I know these are all separate administrative processes, but I'm going to do -- punt on going over my comments that I've given to you in two different ways about our feeling about the inadequacy of the public hearing process as it regards public engagement, and my suggestions that we might be able to work with the commissioner, along with other stakeholders, to figure out a better process outside of the administrative hearing process for the public to comment will stand.

And I know that you're going to be hearing from other people today, and I just want to note that the 4.7 percent average may be misleading to the public as it masks a double-digit request of 11.1 percent for one plan offered by Anthem. In short, we think the rate increases that Anthem is proposing deserve careful scrutiny.

The foundation, in its written comments that was submitted to you -- that were submitted to you refer to the independent Wakely Consulting Group's input that was given to you, and we concur that there were at least four points that they raised that are worth careful consideration. And I anticipate that that will be discussed when Mr. Lombardo gets into discussion with Anthem.

We also, in our testimony, raised points raised by Kevin Counihan, CEO of the Health Insurance Marketplace at CMS's Center for Consumer Information and Insurance Oversight. And I did talk about those issues that were raised in his letter

that was sent to the commissioner earlier this month.

In closing, I'd like to leave you with the three Anthem policyholder comments that were posted on the CID website.

"I object to Anthem's less than transparent filing and excessive rate increase proposal. In the letter that was mailed to subscribers, it states that the rate change request was an average increase of 6.7 percent. Well, that is incorrect, since for my plan the rate increase was 9.18 percent, and I had to read the fine print to find it.

"What Anthem should have stated was that the 6.7 percent was an average rate increase, and they should have identified the 9.1 percent increase applicable to my plan.

"This lack of transparency makes me question everything else that was submitted, especially since it does not require one to be an actuary to state the rate increase accurately."

Second comment: "A rate increase

of 6.7 percent is well in excess of the rate of inflation, well ahead of wage growth, and is not accompanied by any improvement in service for the customers."

And on that point, I'd like to say that at the foundation, the most customers that we have heard complaints from in the past several years have been Anthem customers by far.

And the final point is: "Now the rate is going up, I have no source of action. There is nothing I can do but urge you not to let this increase happen."

So in closing, I urge you to put the policyholder first in your decision regarding Anthem's rate increase request. Something has got to give, and it shouldn't always be hard-working people's wallets. Thank you very much.

HEARING OFFICER: Thank you very much.

Next we have Elizabeth Keenan and Angela DeMello.

MS. ANGELA DeMELLO: Good afternoon. And my name is still Angela

DeMello, and I'm one of the three chairs of Healthcare Team for CONECT. Ms. Keenan is one of the chairs who will also be speaking today.

CONECT is Congregations Organized for a New Connecticut, and we are a multi-faith, multi-issue, nonpartisan organization of about 15,000 people from 27 congregations in Fairfield and New Haven counties.

Before we comment on Anthem's health plan request for an average increase of 4.7 percent on its individual plans marketed through Access Health Connecticut, I would like to thank, as did my colleagues earlier today, Insurance Commissioner Katherine Wade and State Healthcare Advocate Victoria Veltri for their agreement that they reached that allows such hearings to happen. Thank you.

MS. ELIZABETH KEENAN: I'm Elizabeth Keenan. And now to turn our attention to Anthem's proposal.

Our comments are based on Anthem's initial proposal, which it sought

an overall average rate increase of 6.7 percent, and now the revised proposal submitted more recently in which it lowered the average increase to 4.7 percent.

We appreciate and applaud Anthem for revising its original filing. Since we do not know what changes Anthem made in its revised filing, however, we acknowledge that our comments may not be as applicable to the current proposal as they would have been to the original. We trust that Mr. Lombardo and the department, which is aware of the details of both proposals, will judge fairly the relevancy of our remarks.

Similar to Ms. Ide, we are basing our comments on the work of the Wakely Consulting Group. We ask you to take note that according to Wakely, Anthem provided clear and concise exhibits to support its request; however, the company's overall documentation lacked justification for many of its assumptions that it made to support the request. Therefore, Wakely stated that it was difficult to assess the reasonability of this request.

For example, Wakely noted that Anthem, in its original proposal, assumed an annual paid claims trend of 7.6 percent. It's exhibit with historical trend information, however, does not appear to support this assumption. Wakely recommended that Anthem provide further justification for this trend assumption.

It should also explain why it included a volatility factor in its calculation, especially given the company's overall strong financial position, and the fact that it already included a reasonable profit margin in its rate.

Other areas that Wakely suggested needed further justification are Anthem's morbidity assumptions, its calculations related to pent-up demand, and its addition of .24 percent to its rates to account for those members who do not pay their monthly premium, but who continue to generate claims expenses.

There are also assumptions related to seasonality, federal reinsurance, risk adjustment, essential

health benefits, and other factors, all of which require, in Wakely's opinion, further data to justify them.

Therefore, in conclusion, unless some gaps identified by Wakely were addressed in the revised filing, we respectfully suggest that the department reject the company's request and ask it to resubmit its proposal with further details. Thank you.

HEARING OFFICER: Thank you very much.

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

MR. DURHAM: Yes. With me today on behalf of Anthem are James Augur, who is regional vice president of sales, and Mr. John Bryson, who is the director of actuarial services for Connecticut.

HEARING OFFICER: Thank you. Would the court reporter please swear in the applicant's witnesses.

JAMES AUGUR and JOHN BRYSON, called as witnesses by the Applicant, being first duly sworn by the Notary Public, was examined, and testified on their oaths as follows:

HEARING OFFICER: Thank you. Mr. Durham, please proceed with the applicant's presentation of the application.

MR. DURHAM: Thank you.

MR. AUGER: Good afternoon, Hearing Officer -- can you hear me? Yes.

Good afternoon, Hearing Officer Campanelli, members of the Department of Insurance, the Healthcare Office -- Office of the Healthcare Advocate, and members of the public.

Thank you for the opportunity to be here. My name is Jim Augur. I am here on behalf of the applicant, Anthem Health Plans. As Attorney Durham said, I served as Anthem's regional vice president of sales, and I am one of over 1,400 Anthem associates based in Wallingford,

Connecticut, who work daily to meet the needs of our members.

As Attorney Durham also said, joining me here is John Bryson, director of actuarial services for Anthem Blue Cross and Blue Shield in Connecticut.

Anthem has a long-standing and deep commitment to Connecticut and its residents. Anthem, the largest health insurer in the state, has served Connecticut residents for more than 75 years. Our mission is simple: To help our members maintain and improve their health while providing our members with coverage for the cost of healthcare services, and working together with key stakeholders across the state to address the underlying drivers of healthcare costs.

Anthem, like all health carriers, is required to have rates that are adequate and not excessive or unfairly discriminatory. And we take that obligation very seriously.

Anthem's proposed 2016 rates for our individual products on and off exchange

reflect on average a 4.7 percent increase over our 2015 rates. In developing our 2016 rates, we use our experience from the individual Affordable Care Act, or ACA compliant products we -- these compliant products that we offer during 2014.

This was the first time that Anthem was able to use ACA product experience in the development of our individual rates. Our proposed rates reflect the combination of the following key drivers: Medical trend related to increases, changes in pharmacy costs based on rising drug prices, utilization of these high-cost drugs, such as those used to treat hepatitis C and brand of generic conversions; and third, scheduled reductions in the funds available under the federal reinsurance program created under the ACA.

Other factors impacting the proposed rates included expected morbidity changes, and the calibration of the health of our base experience to the Connecticut market average. You will hear more about

these factors that impact Anthem's rate development during the technical actuarial discussion that will take place through the department's questioning.

While building premium rates is an important part of what we do, in my brief remarks I would like to focus on the part of Anthem's mission I referenced previously that you won't hear about during the technical rate discussions; specifically, Anthem's mission to help our members maintain and improve their health.

I could spend a lot of time today describing the comprehensive portfolio of products and programs Anthem offers to improve the health of those we serve. Instead, I will simply summarize them succinctly by placing them in the context of three core commitments: A commitment to help our members during their time of healthcare need; a commitment to empowering our members to become informed healthcare consumers and active participants in their own healthcare; a commitment to empowering our participating physicians and other

providers to provide care that is proactive, that is coordinated, and built around the individual needs of their patients and consistent with nationally recognized guidelines.

Through these commitments, our goals are aligned with those of the people we serve. We want to be there for them when they need us most, enabling them to access care, navigate the healthcare system, and manage their health, as well as their healthcare costs.

I appreciate the opportunity to speak with you about Anthem's proposed individual on and off exchange filed rates that would go into effect January 1st, 2016. I hope that the information I've presented will be of assistance to the department as it reviews Anthem's rate application. John and I are now welcome -- we welcome any questions from the Department of Insurance. Thank you.

HEARING OFFICER: Thank you.

MR. BRYSON: Can I go on record?

HEARING OFFICER: Sure.

MR. BRYSON: I am John Bryson, the actuarial pricing director for Anthem Blue Cross Blue Shield Connecticut. I am an Associate with the Society of Actuaries and a member of the American Academy of Actuaries.

HEARING OFFICER: Thank you. We'll now begin the examination of the witnesses by department staff.

Mr. Lombardo.

MR. LOMBARDO: Thank you. I ask that whoever seems to be the most appropriate party answer the question, understanding that in some cases it may be more than one person. It may be James Augur or John Bryson. So whoever -- and both of you can chime in with your responses as well.

DIRECT EXAMINATION

BY MR. LOMBARDO:

Q Just for a point of clarification, on April 30th, the original filing submission for Anthem had an average rate increase of 6.7 percent with a range of

3.6 percent to 11.1 percent. On June 26th, Anthem submitted a revised rate filing which generated an average increase of 4.7 percent with a range of 1.7 percent to 8.95 percent.

Anthem, can you confirm that?

A I confirm that.

Q Thank you.

Can you explain briefly what paid-to-allowed is, and the reason for the change from the 2015 pricing to the 2016 pricing? In that paid-to-allowed factor it went from .774 in 2015, to .799 in 2016.

A The paid-to-allowed is the relationship of the actual amount paid for a claim versus the allowed component before member cost shares. The change from '15 to '16 was driven mainly by a change in the -- the distribution of members by product.

We had a -- an increase in our lower-cost products, the Bronze -- mainly the Bronze products in several areas due to a change in the movement from embedded deductibles to nonembedded deductibles. That, along with the -- we introduced ten new plans and closed three and renewed 21.

The renewing plans projected higher paid-to-allowed ratios compared to 2015, and the new plans have an average paid-to-allowed of .776, while

the closed plans only had a 675.

So mainly it was just the change in the membership distribution by plan that drove that paid-to-allowed increase.

Q Thank you.

For the record, could you explain what the difference between embedded deductible and an unembedded deductible is?

A The embedded deductible applies on a family contract, and when a member is required to meet the family deductible before coverage takes place. On the nonembedded, the member is required to hit the single deductible and at that point coverage takes place.

Q Thank you.

Can you explain in a little bit more detail -- there's three items here: Changes in benefit design that vary by plan, updated measurement of relative benefit between plans, and the changes in the adjustment factor for the catastrophic eligibility.

A Well, the relative benefits between plans, Anthem's benefit relativity model was updated to more accurately measure the cost impact of benefit differences between plans. And this is something that occurs continually as we're always looking to improve our rating tools that we're using. The average impact

of those was a 3.1 percent reduction to the benefit relativities overall.

The change in the catastrophic eligibility, we had revised our analysis of the catastrophic adjustment factor for 2016. We viewed the risk adjustment for catastrophic plans across 11 Anthem states to improve the credibility of our sample. One of the issues of the catastrophic plans, there's not a lot of enrollment, so the credibility of those on a state-by-state basis is -- doesn't produce a significant pool.

And we developed the catastrophic adjustment factor that would achieve the same percentage operating gain as the medical plans. And this resulted in an adjustment factor of .8267 from the standard ACA pool.

The corresponding 2000 factor had been .7532, which was estimated based on early catastrophic and raw risk scores across several Connecticut states.

Q Thank you.

Can you explain in a little more detail changes due to network contracting that are affecting price?

A Contracts with our network providers are established for a 12-month period often with multiple years' extensions. Anticipated changes in upcoming

provider network contract arrangements, which will be negotiated between the filing date and the end of the rate period, are considered in our development. The expected results of those negotiations, coupled with existing contractual arrangements, are compared to the contractual arrangements in place, and for the experience period to determine the impact for the rate period.

Q Do you have a measurement of that impact? And if you don't have it with you, could you provide that to the department?

A Yes, I do not have that with me.

Q Thank you.

The reinsurance recoveries and the difference between the reinsurance recoveries in 2015 and the reinsurance recoveries in 2016, you alluded to -- I believe Jim alluded to the fact that there were changes from 2015 to 2016.

Can you explain for the record what those are and how it impacted pricing?

A Yes. In 2015, the reinsurance was based on a $45,000 attachment point and 70 percent of co-insurance up to $250 -- $250,000 maximum.

The 2016 plan defined by HHS is that it will be a $90,000 attachment point with 50 percent

co-insurance up to $250,000. And that change is a significant reduction in the amount of funds that will be returned to Anthem due to this program in 2016.

Q Do you have an estimate of what that is, what the difference is between the 2015 reinsurance assumptions and the 2016 reinsurance assumptions on pricing?

A The numbers used for -- I'm not exact here, but the numbers used in 2015, I believe, was a $78 PMPM fund that we expected, and I think that adjusted for the payment that was needed to be made I think ended about $74 PMPM.

The 2016 number is right around -- well, I'm sorry, it was 72.40 based on 2015. And the reinsurance recoveries for 2016 are 34.85.

Q Thank you.

Rate filing states that pent-up demand utilization was backed out when projecting to 2016. Please provide more detail, including the value of the pent-up demand that was removed.

So if you can explain what pent-up demand is and why it was removed and what the value of that factor is.

A Pent-up demand is an increase in utilization that you expect when members who previously have had no

insurance now become enrolled in an insurance program.

In a study that was done across some of the Anthem states, it was determined back in -- for 2014, that that impact was worth 6.1 percent for the members who were joining the uninsured ranks.

The numbers used in 2014 adjusted that because of the late enrollment, and 75 -- or 85 percent of that was used, and a factor of 1.052 was used in -- for 2014.

Based on our numbers that we had, the numbers were roughly 20 percent of the uninsured members enrolled in 2014. And using that percent, we would have taken 20 percent of the 1.052 factor, and that created 1.0116 factor that would have been used in 2014.

And to back that out, it's simply a factor of .9886 is used to remove that 1.0116 from the experience used in developing the 2016 rates.

Q Okay. So just to summarize, because there was a lot of numbers that flew back and forth, regular enrollment, the pent-up demand was estimated to be 6.1 percent. Because of the late enrollment, you took 85 percent of the 6.1 percent, and then you estimated that 20 percent of your claims were going to be coming from the previously uninsured; therefore, you ended up with

a pricing factor for pent-up demand in 2014 pricing of 1.6 percent?

A That's 1.16 percent.

Q 1.16 percent. And that in order to back that out, you took the .9 --

A .9886.

Q Yup. And that removes the pent-up demand that you had in 2014 pricing.

But since the 2016 pricing is based upon your actual experience in 2014, did you do an actual development of the demand for the uninsured? Because that's really what you should -- because you're using actual, you're not using the theoretical anymore.

If you use the actual demand, the built-up demand for the uninsured, we would like you to calculate that value. Do you understand what I'm asking?

A Yes. Our number was based on the actual. It actually wasn't based on claims, it was based on the number of members. And it was the number of uninsured members as a percent of the total enrolled members that was used to adjust that.

But yes, I understand what you're saying. I do not have that with me.

Q Okay. Just to be clear, what we'd be asking

for is for you to evaluate the difference between the claim values in 2014 for your uninsured versus your previously insured. Okay? And you obviously have to -- this is strictly due to pent-up demand. We're not asking you to affect morbidity differences between the two, because you can't price for morbidity differences between the two.

What we're asking for is the actual difference in the claim values for the previously uninsured versus the insured in 2014, and that would give a better indicator of what the actual pent-up demand was in 2014. And if you truly want to back that out for 2016, because you don't anticipate that continuing -- and I think we're all in agreement with that -- I'd like to see the analysis done that way, rather than just take the theoretical number out, the 1.116.

A Okay. Yes. And the assumption is that would need to be normalized.

Q Yes. Absolutely. Correct. Thank you.

The next question relates to the CCIIO report that came out on June 30th with regard to risk adjustment and reinsurance. And this is specifically the risk adjustment piece of that.

The report from CCIIO states as an estimate

for Anthem, that Anthem received a payment of -- or will be receiving a payment of close to 14 million dollars in receipt for risk adjustment. We estimated that, based upon your 2014 experience that you submitted in the rate filing, to be about $26 per member per month that you received in payment. That's based on the experience that you submitted and the membership costs that you submitted, and we just took a straight 14 million over your membership and came up with the $26 PMPM.

In your filing you don't have an estimate for receiving a payment in 2016. I believe you have basically the cost of the risk adjustment program in your pricing. Can you explain why, if you had a payment received in 2014, why you wouldn't expect a payment to be received in 2016?

A The calculation that's used is the payment in 2000 -- for 2014 was reduced -- removed from the claims expense for 2014. So that was pricing to the market where we're adjusting our experience back to the market.

So by adjusting it in that format and reducing it out of the 2014 claims expense that we were using to project forward, it would already be implied that it's -- that an adjustment will be made for 2016.

Q Okay. So that -- and again, I'm just trying to make sure I understand and we all understand. The morbidity adjustment of .9294 accounts for what you just suggested?

A That's correct.

Q Okay. Would you be able to do a -- provide an exhibit that indicates that the .9294 equates to the $26 PMPM that you received in a payment for 2014, or something that indicates that they're equivalent? What you just stated was that you took out from the claims the risk adjustment that you received and you did that by the morbidity adjustment. I need to quantify the morbidity adjustment, because risk adjustment is in a PMPM -- is on a PMPM basis. So I need a way to compute and make sure that the .9294 is comparable to the payment you received in 2014, and that you are accounting for that in your 2016 pricing.

So however way you want to put that exhibit together to explain it, that's what we're looking for.

A Okay. Wakely Consulting had provided estimates of what that risk adjuster payment would be throughout the year.

Q Okay.

A And the risk adjuster payment, based on that Wakely study, was 19.9 million. And the adjustment to

get to the .9294 is based on removing 19.9 million dollars out of the 2014 claims experience.

Q Okay. So you're actually taking out more than what you received in a payment for 2014?

A Right. The amount that we received wasn't known at the time of the filing of 6/26. Wasn't known until June 30th.

Q Okay. Thank you. If you could just provide that summary of what you just stated to the department, that would be helpful.

There's a number of adjustments from your Exhibit D that I'll just ask for further explanation. There's an Rx adjustment of 1.0007, there's a medical management adjustment of .02 percent, there's an induced demand for CSR of .997, there's a grace period adjustment of .24 percent. So if you can talk about these adjustments and the bases for these adjustments and how they were developed would be appreciated by the department.

A Okay. Starting with the Rx adjustment. The original development of the Rx pricing is a select formulary in 2014. And that select formulary had less Rx scripts available than the national. And over time, we have added new -- or additional scripts to that select formulary. So the value of the select formulary

has lost a little of the rate impact it had in the beginning. And the adjustment to adjust that select Rx formulary to the cost associated with the current drugs associated -- or listed on that formulary was valued at .7 -- .07 percent, which is in saying that the Rx adjustment is -- the select formulary is a little richer this year than it was in the prior year.

Q And that's for the state of Connecticut membership in the individual market?

A Yes. The medical management, this is a slight adjustment for the autism spectrum disorder that we were required to adjust in 2015. And since we were going off of 2014 experience, this adjustment was needed to account for the additional cost related to the change in the autism spectrum disorder beginning in 2015.

The induced demand calculation is a factor based on 2016 projected membership is equal to 1.0203. And the induced demand factor inherent in the 2014 experience was 1.0234. So with the induced demand reduced in 2016, the adjustment factor of .9970 was to move -- reduce that induced demand factor out of the 2014 experience for 2016.

And the grace period is based upon a 2014 Connecticut ACA experience. 9.28 percent of the total

on and off individual population did not pay their last month's premium, and 9.11 percent of their total premiums were not paid.

Now the members portion, total premium minus the APTC portion percentage was 28 percent. Thus the adjustment we're making to our base rates is .24 percent, which is the .00928 times .00911 times 28 percent. And that is to cover premium that is expected lost due to the regulations dealing with members not paying their premium in final month.

Q Are you continuing to see that in 2015? And if you don't have the answer, you can get back to the department.

A Yes. It's, I think, more of a year-end phenomena than a middle of the year. But I can certainly check to see if it is occurring routinely through the year as well.

Q Okay. Thank you.

Next question is from Exhibit A. There's a .68 percent seasonality factor that's applied to the claims. If you could describe what that is and the development of it.

A The seasonality adjustment is -- as members -- it's trying to get the 2014 claims experience correct to project it into 2016. The

seasonality adjustment deals with the members coming on in 2014 throughout the year, especially with the extended open enrollment period.

The calculation is to -- and when members come on in the latter -- later in the year, the impact of deductible impacts differently than it does in the beginning of the year. And the seasonality adjustment was to correct and align those members to imply that this would be aligned for a calendar-year period, and then that would more correctly align it with the expenses that a 2014 member would have in 2016.

Q So what would be the difference between open enrollment in 2016 and open enrollment in 2014 to cause that not to be the same or to cause it to be different or to be the same in 2016?

For example, the open enrollment was extended beyond January 31st in 2014. Open enrollment in 2016 is only through January 31st. So based upon that, I wouldn't be seeing the same effect that you're seeing in 2014 in 2016, especially when everyone has been fully ACA compliant in Connecticut on an individual policy since the end of 2014, or really 1/1/2015.

So explain why that phenomenon still occurs in 2016.

A Well, the design is that in 2014, as the

members would have enrolled later in the year through the open enrollment period, they would have not met their deductible as a member who would have started earlier in the year. So the seasonality adjustment was to adjust those members to a period -- a level where they would have aligned with their deductible more starting for a full year. And that will occur in 2016 as they renew for the full-year period.

And then the open enrollment, as you said, is supposed to go through January 31st. So that will, for the most part, make those members have full years of coverage.

Q So because of the open enrollment issues in 2014 and the differences versus 2016, that's what this adjustment is recommended for?

A Yes.

Q Thank you.

Are there any non-EHB benefits embedded in the starting paid claim PMPM and start the rate development process.

A There are not.

Q Pediatric dental and pediatric vision are EHB benefits. There's a separate development of those in Exhibit 8 that's outside of the base claims experience for 2014.

Why did you need to make a separate adjustment outside of that? Why weren't they in the base experience period claims?

A The pediatric dental and pediatric vision benefits are adjusted on a separate claim processing system, and they do not meet the same adjustments for our morbidity, medical Rx trend, and other normalization adjustments; so therefore, we -- we have them separated. They're not in the starting medical claims expense, and then we add them in the process to develop the overall claims expense.

Q Okay. So just to be clear, the pediatric dental and pediatric vision were benefits that were offered by Anthem in 2014. And for purposes of the rate development, because certain adjustments don't apply to them, you separated those claims outside of the original paid claims for 2014?

A That is correct.

Q Okay. Thank you. About halfway done, so we're getting there.

The exchange fee -- the question is, is that the exchange fee was included in the market adjusted index rate development, as well as in Exhibit G in the nonbenefit expenses and the profit and risk adjustment. Explain why it needs to be in those calculations.

A In Exhibit A, the market adjusted index rate development shows the development of the market adjusted index rate. By definition, the market adjusted index rate equals the index rate, plus the reinsurance, plus the risk adjuster fee, plus the risk adjuster net transfer, plus the exchange fee, divided by the paid-to-allowed ratio. Therefore, the exchange fee is shown in the exhibit on a PMPM basis to complete the development of the market adjusted index rate.

In Exhibit G, nonbenefit expenses and profit and risk shows all nonbenefit components of the premium rate, including expenses applied as a PMPM and as a percentage. In this exhibit the exchange fee is shown as a 1.65 percent of premium.

Then in Exhibit N, the plan adjusted index rate and consumer adjusted premium rates showed a developmental plan adjusted index rate, includes an annual adjustment -- or includes an adjustment for administrative costs and includes all the selling expenses, administrative retentions shown in Item G, nonbenefit expenses and profit and risk, with the exception of the user exchange fee, since it is already included in the market adjusted index rate development.

So it allows us to comply with our interpretation of what needs to be included in the

market adjusted index rate, and then -- but to show it as part of the retention, but then make sure it doesn't get double-counted into the rate development.

Q Okay. That was my question. I wanted to make sure it wasn't being double-counted.

Explain in Exhibit G what is meant by specialty expenses.

A Specialty expenses are the expenses associated with the pediatric dental and pediatric vision programs, since they are run on -- by a separate company on a separate -- or a separate division on separate platforms. The charges for those two are defined outside of our normal GNA expense.

Q Okay. Thank you.

Medicaid is changing, and we're getting Medicaid population in the exchange this year, additional Medicaid population. And it is alluded to in your pricing that you recognize the fact that Medicaid, and the impact of that, you don't specifically spike out what you did in pricing to price for Medicaid.

We'll ask you, A, do you understand the Medicaid population? Are you pricing -- did you price adjust for that? And if you did, what was the factor and what was the basis for the adjustment?

A The -- we did not specifically price for the Medicaid membership. Hold on a second. I think I had it back here.

Overall we did have a factor of 1.0005 for a higher morbidity of uninsured compared to the insured population expected for enrollment in 2016. And with that, we did not further adjust for Medicaid members potentially coming in.

Q Okay. So I just want to make sure I understand. Under Number 7 on projection factors within your actuarial memorandum you state, Changes in the morbidity of the population insured, and you state, Morbidity changes include the following: Individuals no longer qualifying for Medicaid.

So is what you're saying is you recognize it, but you're not pricing separately for it?

A That's correct.

Q And the 1.0005 adjustment is for the next component, which is the morbidity of the uninsured compared to the insured population?

A That's correct.

Q Do you have any spike-outs of any of the others that are within their individuals losing employer coverage, converting from Anthem non-ACA policies or electing to drop coverage, do you have any

specific pricing adjustments for those?

A We used a 1.0 factor for all of those. We looked at them and did not make any adjustments for 2016.

Q So the only one you made an adjustment for was the uninsured compared to the insured population of .05 percent?

A Yes.

Q Thank you.

This isn't a true MLR rebate calculation, but what we did was we took 2014 experience that you provided, just earned premium and incurred claims, and came up with a loss ratio of 69.61 percent based upon 2014 experience.

When you account for the reinsurance payment you received and the risk adjustment payment you received, that reduces the loss ratio -- and again, I know there's other adjustments to the MLR rebate -- but that reduces it down to 44 percent to account for the reinsurance adjust -- the payment you received for reinsurance and the payment you received for risk adjustment.

I know in the past you have identified that you don't anticipate paying a rebate. Given the CCIIO report with the risk adjustment and the reinsurance --

and I know the MLR rebate report is not out as of yet for 2014 -- are you anticipating paying a rebate for 2014?

A No, we are not. The -- I can share with you preliminarily the MLR is approximately 84.7 percent for 2014.

Q Okay. Would you be able to provide the department with a preliminary -- the calculation of that on a preliminary basis, understanding that it's not a final number --

A Yes.

Q -- and how you arrived at that? Thank you.

Could we turn our attention to the trend exhibit. It's Exhibit Q. The assumed trend that Anthem is using is 7.57 percent. Correct?

A Correct.

Q In the pricing. In looking at Exhibit Q, when I look at pay trend, and I'd read off for the record the last five years -- or the last three years of actual and then projected trend. So 2012 over 2011 was 5.8 percent; 2013 over 2012 was 5.1; 2014 over 2013 is 6.7; 2015 over 2014 is expected to be 7.5; and 2016 over 2015 is 7.2.

So based upon historical trend, pay trend that you've identified in Exhibit Q, how did you arrive

at the 7.57 percent that you are assuming in the pricing for 2016?

A It's certainly going from the experience period in 2014 to the rate period in 2015 -- '16; you have to cover two years.

So the -- looking at the '15 over '14, the 7.5; and the '16 over '15, the 7.2, the combination of those two, plus a provision for adverse deviation, was included to come up with the 7.57.

There was also two small adjustments made after we had developed a trend. They were both -- one was relating to a contracting change that we became aware of that was used to reduce the trend by .1 percent, and then another adjustment based on a program that we hope to implement in 2016 when we created another .1 percent reduction. And then we did have a half a point adjustment for adverse deviation.

And just to comment on the adverse deviation, we've already seen one of our assumptions be off by 6 million, referring to the risk adjuster impact that occurred. And that, I think, was he -- that risk adjuster factor was about 2.3 percent to the overall rate.

Q Okay. So you're saying adverse deviation, that's discussed as the volatility provision --

A Yes.

Q -- in there? Okay.

I don't want to harp on this, but the 7.5 and 7.2 are your estimates of trend, 2015 over 2014 and 2016 over 2015. Based upon the actual trend you had with actual data the last three years, it's 5.85, .16, .7. So how did you get to -- with those three years' of experience, how did you get to the -- you know, let's take out the volatility for a second -- but how did you get to the original fit for trend based upon those three years of actual?

A The trend is developed by looking at the historic and creating -- in a sense pulling out everything that can be defined that's driving trend, such as cost of care programs, such as contracting. On the Rx side, certainly the change in AWP brand to generic components moving. And then certainly the impact of especially drugs dealing with hepatitis C.

So the -- backing out the factors how the earlier known trends and replacing those with the estimates we have for those other items, the impact of cost of care programs, the provider contracting changes that are occurring, and the -- and specifically the drug as average wholesale prices continue to increase significantly, we're seeing less brand to generic

movement, and then hepatitis C is still expected to grow considerably in 2016 over where it is today.

So that the combination of that is put together that leads to that 7.5 and 7.2 projections.

Q Okay. Thank you. Two more questions. I promise.

Can you explain in a little bit more detail what the new tiered networks are, and if they were priced any differently from one another versus your regular network?

A Yes. The -- we introduced -- for 2016 we are introducing a few products that are -- we're calling tiered products. These are offered off exchange only. There's no on exchange tiered products. This is the first -- our really first attempt to move into this market.

And the design is that certain hospitals will be in Tier 1, and others, based on cost and quality in Tier 2, and also our enhanced personal healthcare involvement with the physicians has been showing improvements in cost of care along the lines of utilization and cost as well.

So a set of providers who are involved in the -- the PCPs who are in the enhanced personal healthcare, and then the set of Tier 1 hospitals become

the Tier 1. And basically the benefits are such that deductibles and co-insurance are different between Tier 1 service -- the services occurring at a Tier 1 provider versus a Tier 2 provider. And the impact of those -- of the costs associated with the providers in Tier 1 versus Tier 2 is used to adjust the rate, as well as the expected usage of Tier 1 versus Tier 2 by the member which will impact cost shares. And the combination of those two are used to develop the pricing for those tiered products.

It's certainly an attempt to try to lower cost and drive utilization in the proper way.

Q So just bear with me here. If I go to a Tier 1 provider, my cost share, my out-of-pocket expense would be less to go to a Tier 1 provider for the same service versus going to a Tier 2 provider?

A Yes.

Q Okay. If more people go into Tier 1 providers overall, is the expectation that your unit cost and utilization will be less than if they go to Tier 2?

A Yes.

Q Okay. So the cost sharing is lower to me, but the unit cost and utilization are lower to you.

So do you know the relative pricing impact,

assuming, let's say, two benefit plans were identical, what the pricing -- what you're expecting the pricing impact to be of this tiered network?

A The -- can you say -- make sure -- the part about benefits are the same.

Q If there's two plan designs that are exactly the same, the benefit designs are exactly the same and I don't purchase a tiered network plan, and Mary Ellen purchases a tiered network plan, but our benefits are exactly the same, the covered benefits are the same, and our cost sharing are the same, except that Mary Ellen's bought into the tier network approach, so she goes to Tier 1, her cost sharing is going to be less. What is the general pricing impact of this tiered network, everything else being equal?

A It ranges from -- on the individual component, I believe it ranges from 3 to 6 percent.

Q Okay. Thank you.

And presumably the Tier 1 will be a subset of your network? You won't have all the hospitals, you won't have all the providers in the Tier 1 network. Correct?

A That's correct.

Q That's the nature of it?

A Yes.

Q Okay. Thank you.

Last question. In looking at some of the other carriers' changes in their -- relative changes, not the magnitude of the rate changes, the Bronze plans for you are the outliers. They are the highest increase in the rate filing.

Do you know -- you mentioned -- you alluded to something about the Bronze plans earlier, John. If you could maybe explain why there is a wide range of differences in the rate change that you're requesting, and specifically why the Bronze plan seems to be increasing. That's the most significant one. So if you can provide an explanation for that.

A The key on the Bronze is the movement from the nonembedded to embedded deductible. We saw ranges of -- I think I recall basically 49 percent impacted by moving, and that was with change based on the amount of the deductible. That was the significant movement in Bronze. And it applies to our high deductible CDH plans, the HSA plans, which are mainly all Bronze-level plans.

So that was the key as to why Bronze went -- had a different rate than the other tiers.

Q Okay. Thank you.

MR. LOMBARDO: I'm all set.

(Witness excused.)

HEARING OFFICER: Thank you. At this time we will now commence with the second public comment portion of the hearing.

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

Each individual must identify himself or herself for the record, including any organization that he or she represents. Each individual must address all comments to me. All comments must relate specifically to the rate application of the insurers, which is under review by the insurance department and now pending before me. We will not have the same time constraints as earlier, but I reserve the right to ask you to sum up.

Would anyone like to make public

comment?

Okay. Seeing none, would the applicant like to respond to any public comments, either generally or specifically?

MR. DURHAM: No.

HEARING OFFICER: The applicant will now have the opportunity to make a brief closing statement, although it's not required.

I'm asking that any closing statements be limited to five minutes. Mr. Durham, does the applicant wish to make a closing statement?

MR. DURHAM: Yes, we do.

HEARING OFFICER: Go ahead.

MR. AUGER: Hearing Officer Campanelli and members of the Department of Insurance, I'd like to again thank you for the opportunity to be here. I hope that you found the answers to our questions and presentation helpful in your overall review of Anthem's rate application. Thank you.

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

MR. LOMBARDO: No. Not at this time. But we'd ask that the record of this proceeding be closed as of the end of today, except for items identified and requested by Anthem. And I'll quickly summarize those and ask that these be submitted no later than July 31st.

One of them was the pent-up demand calculation using your actual experience for 2014 and normalizing the data and identifying what the true pent-up demand was, the difference between the uninsured, previously uninsured, and the insured population.

The development of the 19.9 million dollars that you used in the pricing or the rationale for it, the basis for it, and not using the payment you actually received, which was about 14 million. And I understand the rate filing came in before then, but explain the mechanics of that 19.9 million.

The development of the 2014 MLR rebate. You said you had preliminary information on that. So if you could

provide that to the department as well. And I think that was it.

HEARING OFFICER: Thank you. In accordance with Section 38a-8-40 of the Regulations of the Connecticut State Agencies, I am ordering the applicant to submit documents previously referenced by Mr. Lombardo by July 31st, 2015.

The record of this hearing will be held open for further written comment until the close of business today. Today's hearing is adjourned. Thank you.

(The hearing concluded at 2:20 pm.)

CERTIFICATE

I, Bethany A. Carrier, a court reporter within and for the State of Connecticut, do hereby certify that the foregoing 58 pages are a complete and accurate computer-aided transcription of my original stenotype notes taken in the Public Hearing in the Matter of Anthem Blue Cross and Blue Shield, held before Kristin Campanelli, Hearing Officer, Insurance Department, 153 Market Street, Hartford, Connecticut, on July 27, 2015.

/s/_____

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

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Received in Evidence