STATE OF CONNECTICUT
INSURANCE DEPARTMENT

In the Matter of:	Docket No. LH 16-45
ANTHEM BLUE CROSS AND BLUE SHIELD	August 3, 2016
Applicant.	

PUBLIC HEARING

Held Before:

JARED KOSKY, Hearing Officer

PAUL LOMBARDO, Life & Health Division

KRISTIN M. CAMPANELLI, Counsel
Connecticut Insurance Department

Reporter: Kristine A. Paradis, LSR #338

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. . . The following is the transcript of the Public Hearing in the Matter of Anthem Blue Cross and Blue Shield, Docket Number LH 16-45, which was held before Jared Kosky, Hearing Officer, at the State of Connecticut Insurance Department, 153 Market Street, Hartford, Connecticut, on August 3, 2016, commencing at 9:03 a.m.

(Hearing commenced: 9:03 a.m.)

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

On behalf of the Connecticut Insurance Department, I would like to welcome you to this hearing. I'm Jared Kosky and I've been appointed by Commissioner Wade to preside at today's public hearing.

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

An administrative hearing such as this is a regulatory proceeding in which a party, in this instance Anthem Blue

Cross and Blue Shield, is required to present documentation and arguments regarding their application. Ultimately, Commissioner Wade will decide this matter based upon a recommendation that I will prepare. This is not a court proceeding, but it does operate under a system of rules with the presentation of evidence and witnesses who testify under oath.

We will have three potential opportunities for public comment at this hearing. First, in a couple minutes, there will be 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 p.m. on Wednesday, August 10, 2016.

Unlike a legislative hearing, there

may be times when we need to call a recess.

I'd like to remind all attendees that I expect everyone to conduct themselves in an orderly and respectful manner. Any conduct determined to be disorderly or interfering with this proceeding will be dealt with under the appropriate legal authority.

Pursuant to the rules of the insurance department which are posted in the reception area and on the doors of this hearing room, no signs or demonstrations are permitted, and anyone not conforming to these restrictions will be required to leave the proceeding. For the record, 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 Rules of Practice and the Connecticut Uniform Administrative Procedure Act.

Anthem Blue Cross and Blue Shield

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

For the record, Docket Number LH 16-45 has been assigned to this matter by the insurance department.

The Connecticut statute governing this rate application, Connecticut General Statute Section 38a-481, provides that rates shall not be excessive, inadequate, or unfairly discriminatory.

In addition, Section 38a-8 of the Connecticut General Statutes provides that the insurance commissioner has all 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 -- "the application" -- dated June 1, 2016 by Anthem concerning premium rates for its individual on and off exchange plans --

"the products" -- is excessive, inadequate, or unfairly discriminatory pursuant to Connecticut General Statute Section 38a-481.

This proceeding was commenced on June 1, 2016 when the applicant filed with the Connecticut Insurance Department -- to be referred to as "the department" -- a rate application regarding the applicant's individual rates for on and off exchange plans.

While there's no statutory requirement that a rate hearing be held, on June 6, 2016 Commissioner Wade ordered that a public hearing be held on August 3, 2016 to consider the Commissioner granting approval of the proposed application.

As a result of the open enrollment beginning on November 1, 2016, the federal government and exchanges, including the Connecticut exchange, have required that rate filings must be submitted with ample time for them to process the information. And thus, the

Connecticut Insurance Department is holding hearings at this time to comply with those strict deadlines.

A copy of the notice for this public hearing was filed with the office of the 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 Attorney Kristin Campanelli, legal division counsel.

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

MR. DURHAM: Good morning, Mr. Kosky, and good morning to all the members of the department that are here. I'm Attorney Durham, Michael Durham from Donahue, Durham & Noonan, and I'm here representing the applicant, Anthem Health Plans, Inc. With me today also at Anthem's table is Attorney John Russo, who is the senior associate general counsel for Anthem, and also James Augur, the regional vice president of sales, and Mr. Tu Nguyen, who's the director of actuarial services for Connecticut.

HEARING OFFICER: Thank you, Mr. Durham.

At this point I'd like to enter into the record the stipulated list of exhibits. The list identifies 11 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 comment received through 9:00 a.m. yesterday. Written public comment received after this 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 August 1, 2016, the exhibits, witnesses, and hearing procedures were discussed. The first item of business is public comment.

Members of the public who have signed up to speak will have the first hour of this proceeding to orally comment on the application. In this regard, there are two sign-up sheets available for persons interested in presenting oral comments 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: There's still people signing in at the moment.

HEARING OFFICER: Okay. Roughly what do we have so far?

MS. MEDINA: So far we have 11 and we have two for public officials.

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

Each person will have three minutes to comment, and we will begin with any public officials who wish to speak, followed by members of the general public. This is a comment period only and no questions should be directed to the applicant or to the department.

The applicant will then provide a presentation of the application. Insurance department staff will then be given an opportunity to examine the witnesses. After the examinations have

been concluded, anyone from the public who did not have an opportunity to be heard in the first hour, or who wishes to make a statement, will have the opportunity to orally comment on the application.

The public may also present written comments today either to Ms. Medina during the course of today's hearing or at the department's reception desk. In addition, written comment may be submitted up until 4:00 p.m. on Wednesday, August 10, 2016.

The public comment portion of this hearing will commence with comments from public officials and then 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 as the subject of today's hearing. And each individual must reasonably limit his or her comments to three minutes.

I do wish to note for the record that Commissioner Katharine Wade and Deputy Commissioner Tim Curry are here in attendance.

We will now begin with the public comment period. I want to start by noting that the insurance department received written comment from the Office of the Health Care Advocate through acting health care advocate Demian Fontanella who was unable to attend today's hearing. In addition, Senator Kelly submitted written comment and he was also unable to attend today's hearing. These comments will be included with other written public comments received.

So, we're now going to begin with the public comment period. Ms. Medina, can I just get a copy of the sign-up

sheet?

MS. MEDINA: One second.

HEARING OFFICER: Sure.

(Pause.)

Again, we're going to start with the public officials. First, Senator Crisco.

SENATOR JOSEPH CRISCO: Good morning. Now, my name is Senator Joe Crisco. I'm senate chair of the Insurance and Real Estate Committee.

HEARING OFFICER: Hold on. Senator Crisco, hold on one second. I think your mic may not be on.

SENATOR JOSEPH CRISCO: Not on?

HEARING OFFICER: We'll start your time again.

SENATOR JOSEPH CRISCO: How's that?

MS. CAMPANELLI: Now it's on.

SENATOR JOSEPH CRISCO: All right. My name is Senator Joe Crisco of the 17th Senatorial District and chair of the Insurance and Real Estate Committee.

I want to thank you for this opportunity to comment on the request

from the various insurance companies. Let me state that the Insurance and Real Estate Committee has two primary objectives. Number one, we work very diligently to retain our reputation as the number one insurance state in the country. And at the same time, we work very diligently to protect the consumer or the policyholder or to assist them in any way we could.

Case in point in regards to our commitment to the industry, which we're very appreciative of, is that a couple of years ago we adopted legislation that created a captive insurance market for Connecticut companies which never existed before. I believe that this really fulfilled our reputation as number one insurance state in the country.

We also, obviously, work very diligently to protect the consumer and the policyholder. A good example of that is that Connecticut has become the number one state in the nation -- maybe

the world -- on early diagnosis of breast cancer when dense tissue is involved.

We have passed legislation for coverage and early diagnosis. In fact, this year we also adopted legislation entitled tomosynthesis, which gives a better chance of identifying breast cancer in women. And that was basically the work of Republican leader Themis Klarides whom we worked with.

I've come to oppose any increase in the request. And I base my comment on net income of the various companies. We're talking today about Anthem, who in 2015 experienced $2.5 billion of net income.

I realize the department uses various criteria to evaluate the request, but I think it's time that we consider the net income of the various companies who make these requests. So, I'm asking the department to deny any rate increase whatsoever. Thank you.

HEARING OFFICER: Thank you,

Senator.

Next, Senator Hwang.

SENATOR TONY HWANG: Thank you. And good morning. My name is Tony Hwang, state senator for the 28th district.

I also come to voice my opposition to these proposed rate increases, but I come from a context of feedback from so many of our constituents that are unable to be here at 9:00 o'clock in the morning in the middle of summer to be able to voice their thoughts and concern. And I certainly want to be able to reflect their voice.

Saying that, I understand that the Affordable Care Act, along with our current access exchange has very noble intentions, to be able to provide care and access to all the people in our community. But unfortunately the plan is flawed and the execution is simply not working as we've seen by the incredibly high rate increases that are being asked year after year. If nothing

else, the Affordable Care Act is absolutely unaffordable.

And what we've seen and what I've heard from the community -- and I wanted to articulate that -- is the fact that the middle class, the small businesses, the people that are outside of the access exchange policy programs are truly the individuals footing the burden, the financial burden of these. If you're looking at Anthem's 26.8 along with a lot of other rate increases that they're looking at, and you're looking at ConnectiCare's 39.8 percent increase outside of the exchange, it really sends a loud and clear message that something is not working.

No matter how well-intentioned, no matter how well philosophically, analytically it is purported to work, the system is not working. And we have to recognize that.

The last thing I would offer to you is this: If there's nothing else that we do moving forward, we have to

understand you have to operate this business, this access to health care based upon three principles. You have to be able to afford a sense of predictability. The consumer has been on a roller coaster ride of up and down and rate increases without any sense of predictability.

Number two, we have to truly understand how a program works to afford a sustainability program. There has to be a truly organic manageable program combined with predictability that the consumer can understand, and not have these hearings at 9:00 o'clock in the morning, again, in the summer, where people who are working and trying to make a living can't come and have their voice be heard.

And I think the third, first and foremost, is transparency. The idea that we're having this and the difficulty for people to get information about this is remarkable.

So, let's remember that as we move

forward, predictability, sustainability, and transparency above all. It's something that we sorely have been lacking in this whole process.

So, I appreciate the opportunity to speak. Thank you for the clock.

HEARING OFFICER: Thank you, Senator.

SENATOR TONY HWANG: Thank you.

HEARING OFFICER: We'll now begin public comment from members of the general public. Excuse me if I get anybody's name wrong. If I do, please correct me when you come on up. We're going to begin with Lynne Ide.

(Off-the-record discussion.)

HEARING OFFICER: Sure. And when you do come up and identify yourself, if you can please, for the record, spell your last name. Thank you.

MS. LYNNE IDE: As long as it doesn't count against my three minutes.

MS. CAMPANELLI: I won't start

the --

MS. LYNNE IDE: I have a short last name, though. Lynne Ide spelled I-d-e. And I'm the director of program and policy at the Universal Health Care Foundation of Connecticut.

I have written testimony that I'll submit to you that goes into a little bit more detail on the points that we're going to make here today, but in my three minutes I want to just talk a little more off the cuff about what our concerns are.

We understand that the insurance department uses -- focuses on actuarial analysis when they're looking at these rate requests. And we understand, based on pushback that we got from you last year when we testified, that the department is required to ensure the fiscal solvency of the insurers via their rates. But we have a question about how much fiscal solvency is involved in issues such as was said by the legislators before me when you're

asking for 39 percent rate increases, 28 percent rate increases, double-digit rate increases almost uniformly across the board.

We know that the department has shown a willingness to reduce rates, and they actually have done that. But unaffordable health insurance is more -- is a more-expensive version of being uninsured because, in fact, if your insurance with your copays, deductibles, cost sharing, whatever is so high, you're not going to use it even if you could afford to buy it.

So, there are a few points we'd like you to consider. Health care costs just keep rising. In July 2016 the Kaiser Health Tracking Poll showed that 38 percent of registered voters said that health care costs are a top issue for them. The trends and high deductible plans and increased cost sharing are causing deferral of care which contributes to higher health cost down the road and closing the door to

needed care for many. One in four adults with non-group coverage went without some needed health care because they could not afford the cost.

And I'm going to share this with you. Dwindling choice in the marketplace puts people in an even harder position. In the exchange and the individual market they're going to have two choices; in the small group market, one choice. What is that?

We come to the conclusion that affordability must become part of the department's charge. We know that you say you're not statutorily required to do that. Then why are you asking for consumers to weigh in? You've got over 500 comments from people saying that they can't afford these rate increases, but you can't do anything about that.

So, what we think you need are the tools to do that. And we are going to be working to statutorily require that in the future you be considering affordability to the consumers.

We have hundreds of petition signatures to hand in to you today. You should read them. They are comments from the people who signed the petitions. And I'll end it at that. Thank you.

HEARING OFFICER: Thank you.

MS. LYNNE IDE: May I approach you to --

HEARING OFFICER: You can -- Ms. Medina by the door, you can give it to her.

MS. LYNNE IDE: Okay. Thanks.

HEARING OFFICER: Next up, Gay Hyre.

MS. GAY HYRE: Well done.

HEARING OFFICER: Thank you.

MS. GAY HYRE: Thank you. My name is Gay Hyre. That's H-y-r-e. I would like to submit my written testimony, and I am going to diverge from this because of what several other people have said before me.

I want to speak to you to oppose the rate hikes of Anthem Blue Cross and

Blue Shield. I got a letter saying that my premiums were going to go up 26.8 percent set to begin January 1st. Oh, by the way, for the record, I am representing myself as a citizen and as a patient.

And one of the things that I want to make pellucidly clear is that at the end of all of this is a person and a patient. And every last one of us at some point in our lives is going to be a patient. We're not consumers; we're not customers. We are people and we are patients. That's the bottom line.

Now, regarding that, I'm on a fixed income because I'm a cancer survivor and my husband is disabled. He is on Medicare because he's 65. I'm younger than he is. There's a seven-year gap between us.

The original idea of the ACA and, therefore, Access Health Connecticut was that health care insurance costs should total no more than 9.6 percent of your modified adjusted gross income. Given

the copays and the deductibles, many expenses in medicine for normal people wind up not being accrued to your deductible.

You think it will be, but the deductible keeps moving away from you because this test doesn't go to the deductible; that medication doesn't go to the deductible. This medication that you've had for years that's on the $5 copay all of a sudden is in the $35 tier.

This is untenable. It is absolutely ridiculous. And the fact that self-reporting six people in management at Anthem have a total compensation package of $59.1 million last year, do they really need an extra 200 bucks a month from me? I don't think so. And I don't think they need to take it out of any other patient's hide. Thank you very much.

HEARING OFFICER: Thank you.

Next up, Douglas Wade.

MR. DOUGLAS WADE: Good morning.

My name is Douglas Wade. I am a fourth-generation owner of Wade's Dairy in Bridgeport, Connecticut.

I'm 62 years old. I grew up in the family business. I remember my dad was very proud of the fact that we had health insurance for all our employees. And back in that day it was a free benefit.

And I remember the copays starting and, you know, prescription copays. And I've seen year after year the past ten years, our employees dropping out of our health care program because they couldn't afford it.

When the Affordable Care Act came in, we would offer the group health care plan because the subsidies were terrific for our employees. But we recently have been growing and we hit that 50 employee threshold.

And so now I had to go back on a group health care plan. And I absorbed the extra cost of that for my employees. And it was about $3,000 a month. But we

have fewer employees on it now because they're finding it unaffordable.

And come January, I can't absorb another rate increase like this. And I know my employees, even those that can afford and deem it necessary to have insurance, they can't use it, you know, other than going for an annual physical, all right, because the deductibles run a high deductible plan. They're just totally unaffordable.

We're currently on the Anthem access health shop platform, and everyone is on a high deductible. We pay the major portion of the employee's premiums, but, again, they really can't afford to use them.

My understanding was the ACA, the Affordable Care Act, by virtue of its name, was designed to be affordable to consumer, individuals, and businesses. All of us. Sadly, that does not seem to be the case.

In addition to the complex set of regulations and penalties, we are

continuously faced with escalating health insurance premiums. This 28 percent is just off the charts and unacceptable. And we need a truly affordable health care plan. Thank you.

HEARING OFFICER: Thank you.

Matt McDermott.

MR. MATT McDERMOTT: Good morning. My name is Matt McDermott, M-c capital D-e-r-m-o-t-t. I'm the lead organizer of CONECT, Congregations Organized for a New Connecticut, which is a grassroots organization made up of 25 congregations in New Haven and Fairfield counties of Connecticut, multi-ethnic, multi-racial interfaith organization working on issues of common concern to the member congregations.

We were part of working with Senator Crisco and others in the legislature back in 2011 that led to a compromised deal at that time with Commissioner Leonardi to lead to these public hearings taking place in the first place, so we're glad to have this

opportunity to testify. We're glad that we're here now the third summer in a row. It seems to be we're setting a good precedent of having public participation in this process.

I would echo Senator Hwang's comments that 9:00 a.m. during the weekday in Hartford is hardly an accessible time for most of the public to be here. So, that continues to be a concern.

We're very concerned about this proposed rate increase by Anthem and the general trend of the other companies that will be heard tomorrow, that these are excessively high rate increase requests. They will drive, as Mr. Wade said, many employers and many individuals to drop coverage altogether. And we worry that that heads us toward a market failure here in Connecticut.

When folks -- as Lynne Ide said, you're not technically expected to consider affordability, but when the inaffordability of these products is

raised to such a level that people drop out of the market altogether, then the market you're attempting to regulate as a department is beginning to fail. And that will fail both companies and consumers in the long run.

We think that -- I'll just briefly summarize a few points that -- I have written testimony that's been prepared by CONECT health care team. We know that one issue that's been raised in this request is the phasing out of the Affordable Care Act's risk pool. That's happening this year and will not be there present to be reinsurance for companies in 2017.

That has always been designed as a phased-out program in the Affordable Care Act. Insurance companies have known that from the start. To use that as an opportunistic -- opportunity to or opportunistic moment to raise rates, exorbitant rates, exorbitant amounts is purely that, opportunism by the companies.

We're concerned that the department has asked, we understand, 14 follow-up questions. There's a lot of missing data and actuarial assumptions in the proposed filing by Anthem. One question we have is why the group rate trend of 9.6 percent has been the basis of the filing as opposed to what we consider the more relevant individual trend.

And lastly, something that's happened since the filing -- and I'll finish very quickly -- is the department's ruling that HealthyCT must go out of business. This will move 40,000 customers into the market that Anthem will be competing for. HealthyCT was ruled out of business because of a $13 million risk pool payment precisely because their clientele was deemed healthier and less risky.

So, we urge the department to consider those 40,000 new customers that will potentially become Anthem customers in how they assess the proposal going forward. Thank you.

HEARING OFFICER: Thank you.

Angela DeMello.

MS. ANGELA DeMELLO: Thank you everyone and good morning. My last name DeMello, D-e-m-e-l-l-o. Angela DeMello.

I wear several hats. And in addition to being co-chair of CONECT, the organization that Matt McDermott just spoke for, I'm also a small business owner in Stratford.

Our agency is The Strategies Group, and we provide health insurance on several different platforms: for individuals, for small and large employers, as well as Medicare recipients. Our agency has been in the industry for 25-plus years and we have experienced many changes and challenges to our health care landscape.

Affordable Care Act, ACA, has definitely brought many positive changes, the biggest of which, in my opinion, has been the elimination of pre-existing conditions. It has also been heartwarming that so many of my

clients and their families have been able to see doctors for the first time in many years, or even ever. Subsidies and advanced premium tax credits have made that possible.

However, and sadly, the majority of my clients have not experienced this opportunity. They supposedly make too much money. And most of them are now paying much higher premiums than they were before.

Affordable Care Act, while make insurance more accessible, is now definitely not affordable to the consumer. I do understand that the definition of "affordable" is based in actuarial projections of the solvency of the insurance carriers rather than the affordability to the consumer.

While that may be the letter of the law, I'm appealing to you, the insurance department, to take into consideration the spirit and the intent of the law. Many of our individuals and small business clients are opting to pay

penalty rather than pay insurance premiums.

Their rationale is simple: Do we pay premiums or do we put food on our tables or pay the mortgage or . . . For many small businesses it is a choice between paying insurance premium or paying payroll. A Hobson's choice? What would you do?

The plan to pay the penalty may be a big challenge; however, I do not perceive that as the main challenge. The bigger, more insidious challenge is that without insurance, hospitals and providers are, by law, able to collect the full cost for services provided. That is -- there is no insurance company at that point to negotiate claims.

I have always understood it to be the insurance department's job to encourage, manage, and regulate a competitive insurance market in the state. That is where the actuarial metrics of excessive, inadequate, and discriminatory come from, which is

intended to keep insurance companies solvent, reasonably profitable, and to not overcharge certain segments of the state's population unfairly while undercharging others.

HEARING OFFICER: Ms. DeMello, another 30 seconds or so --

MS. ANGELA DeMELLO: Okay. No problem.

HEARING OFFICER: -- to wrap up. Thank you.

MS. ANGELA DeMELLO: Okay. I will skip the rest of mine and come to the end.

I make no apology for preaching to the choir. I realize that you as the insurance department are probably feeling the same challenges. However, laws were made by people like you and I sitting across the table from one another and making decisions that would improve the lives of our communities and fellow beings. Again, thank you for your time and consideration.

HEARING OFFICER: Thank you.

Mark Russo.

MR. MARK RUSSO: Good morning. My name is Mark Russo, Main Street Insurance. I'm a licensed agent with the State of Connecticut for health insurance. Last name is R-u-s-s-o.

I come here in a multitude of platforms here: as a consumer, a patient, and a broker. I do not agree with the rate increase; it seems excessive.

I don't have the actuarial skills, you know, to determine those rates, but I do think they are excessive. And how everyone else kind of seems, they're way overboard.

I also wanted to mention that, you know, they do have a no-commission level on the exchange policy. And I do think that hurts the consumer. It will basically cut out the broker.

And we as brokers do provide invaluable service. We help the clients pick policies; we go through their prescriptions, their drugs, you know, to

make sure that they have the best policy for them. And to cut the broker out of that I think definitely hurts the consumer.

And with a limited number of companies -- there still are a multitude of plans; last year there were 37 plans. This year, I'm not sure how many there will actually be. But there still is a huge difference from one plan to the other. And based on the customer's medications that they take, the doctors that they go to, you know, the medical services that they need, it makes a very big difference.

We've helped thousands of people sign into plans. And I think without our assistance, it will definitely hurt the consumer and they will not be as satisfied with the policy in the long run. That's it.

HEARING OFFICER: Thank you.

Tim Swan.

MR. TOM SWAN: Tom.

HEARING OFFICER: I'm sorry, Tom

Swan.

MR. TOM SWAN: Good morning. My name is Tom Swan and I'm the executive director of the Connecticut Citizen Action Group. Swan is spelled S-w-a-n. Tom is spelled T-o-m.

With that I want to thank you all for the hearing this morning. I've had nothing but a professional experience over the years with particularly Paul in terms of dealing with things.

But unfortunately I'm going to say I find this whole thing to be a farce. I think that the proposed rate increase is nothing but a ruse to try to make the insurance commissioner look somewhat ethical at a time anything that you do is clouded by the unethical behavior of the insurance commissioner.

Anthem is proposing to take over a company which she worked for 20 years, where she -- her husband owns stock options, where she continues to be the lead regulator across the country in terms of trying to push that merger

through acting de facto as a continued lobbyist on behalf of the company. Anything that you do short of a 10 percent rate reduction will be viewed through the prism of what the public perceives is a corrupt insurance department.

That is not fair to the professionals that work there on an ongoing basis and the civil servants. But unfortunately, that is the fact.

When somebody says that they can sell their stock options because they have no business before them --

HEARING OFFICER: Mr. Swan, this is a rate hearing. I would ask that you keep your comments --

MR. TOM SWAN: I believe that this --

HEARING OFFICER: -- to this rate hearing.

MR. TOM SWAN: I believe that this is business before the insurance department. I believe that the sale is related to it and how that would impact

the value of the Commissioner's stock. She's acting in an unethical manner. It --

HEARING OFFICER: Again, Mr. Swan --

MR. TOM SWAN: The department has --

HEARING OFFICER: -- this is a rate hearing for Anthem Blue Cross and Blue Shield. I would ask that all comments be related to the application --

MR. TOM SWAN: And I'm -- what I'm doing is I'm --

HEARING OFFICER: -- or a rate increase. Thank you.

MR. TOM SWAN: -- explaining why the proposed rate increase we take to be a farce and that this whole activity to be a farce is because Anthem, its stock since 2011 has increased over 130 percent. And that's with stock by max -- they didn't need this money. They are fully flush by the criteria that you use to make sure that they're economically viable. They do not need

this money.

This is a sham. And unfortunately everything the department does will be viewed through that manner as long as Katharine Wade remains the insurance commissioner. Thank you.

HEARING OFFICER: Thank you, Mr. Swan.

Linda -- I'm sorry, I can't read the last name.

MS. LINDA YANNONE: Linda Yannone.

HEARING OFFICER: Thank you.

MS. LINDA YANNONE: I am here representing myself as a patient and a human being on the planet. I am a lay leader in the United Church of Christ, the Congregational Church, and I have worked for five years as an advocate for social justice around health care reform with the United Church of Christ health care ministry team. So, I come and give -- I'm giving my statement on that.

Yannone, Y-a-n-n-o-n-e. I live in Sherman, Connecticut for 35 years and I work as a farmer. So, I'm here to

address this rate hike because it is completely unjust and it is a moral issue to me as a leader in the church. I see many families struggling, not being able to pay their bills and do things, just regular basic necessities.

And for the first time, because of the Affordable Care Act, I was able to have health care. You don't -- you can't afford it when you're working as a farmer and you weren't even able to have health care.

I currently work as a substitute teacher. I have no access to affording and neither does my husband. So, I'm speaking for myself primarily and the struggles to pay and to stay not sinking, losing everything.

The United Church of Christ calls us to speak out against injustice. And people making that much money is unjust to me and it's an -- it's absolutely unacceptable, when I'm as one individual living on $9,000 a year and then they're asking for rate hikes of this method and

there's millions and millions of dollars to sustain a system like this when all these people are struggling and having hard time.

Now, not only that, I worked as a navigator and an assister for Connecticut and for New York state. So, I saw hundreds of people signing up for health care and how it was unaffordable.

So, I want to give you that message from myself, Linda Yannone, and the United Church of Christ. We don't go for this at all. And it will be -- and we stand that this is wrong. It should be lowered. Everybody should be able to be healthy and live a good life that we can generate income and taxes and be healthy, not just make a few people rich. It's very -- it's sick and it's wrong.

HEARING OFFICER: Thank you, Ms. Yannone.

A Mary -- and I'm sorry, I can't read the last name on the sign-up sheet from CCAC. Is Mary here?

MS. LINDA YANNONE: Mary Levine.

HEARING OFFICER: Mary Levine. Sorry.

MS. MARY LEVINE: My name is Mary Levine. I actually didn't know I was going to speak today, so I hope you would bear with me.

I am -- I guess I would describe myself as a health care advocate. I worked as a volunteer for Access Health CT, and I worked with health care brokers and also assisters and navigators to set up enrollment fairs throughout the state. And I did this with very, very limited resources, just the help of some friends like Linda Yannone.

We had very, very successful enrollment fairs. I think Access Health CT had some professionals that also did enrollment fairs. But like -- as I said, we did it alone with limited resources.

I did this in the name of the United Church of Christ health care

ministry team. And so in that context, I saw many, many people who had not had health care for 20 years, 30 years. Some of the people were qualified for the Medicaid reimbursement and others were qualified for the subsidy.

I saw people come -- I'm thinking of a woman who was 50 years old. She started to fill out the application and asked me what she should put down for her address because she lived in her car. She was 50 years old. This was the first time she was able to have health care.

I imagine that living in a car might be detrimental to your health. But she was -- she was somebody that had a bright outlook on life and this was really a gift to her.

Other people -- as I said, they came from different economic backgrounds. Most of them could not afford health care without the Affordable Care Act. Raising the hikes on health insurance will knock these

people off of the gains that they've made.

So, it's not just about raising a dollar amount, it's not just about whatever criteria you can check off, it's about real people. It's about their lives.

The Affordable Care Act, I think the rationale for it is to include as many people as possible. When you include as many people as possible and give them access into this market, you enable them to get preventative care.

Once they have preventative care, the illnesses, many of the illnesses that they develop -- like colon cancer because they didn't have regular screenings -- cost the economy millions and millions of dollars. So, we're all part of one system, you know.

HEARING OFFICER: Ms. Levine, another 30 seconds.

MS. MARY LEVINE: Yeah.

HEARING OFFICER: Thank you.

MS. MARY LEVINE: So, we're all

part of one system. And creating something that's going to destroy the basic rationale of the health -- of the Affordable Care Act to include everyone and thereby have economic gain for everyone, including, you know, people who work in the insurance industry, really makes absolutely no sense.

I think businesses always look towards the short-term goal in a lot of sense, a lot of areas, but I think you really need to look at the long-term goals of the Affordable Care Act and the total picture. Thank you.

HEARING OFFICER: Thank you.

Ken Schaefer.

MR. KEN SCHAEFER: Thank you for hearing my concern. My name is Ken Schaefer, S-c-h-a-e-f-e-r from Newtown, Connecticut.

I am one of the 56,000 Connecticites who are on individual policies. Anthem has requested a 26.8 percent average increase for individual policies. These 56,000

individuals are paying the highest rates because they don't have a group plan and they are using their taxable dollars for typically the lowest amount of coverage.

Instead of asking for an increase in rates, I'm asking for a decrease in rates. These individuals include people like myself and my wife who are unemployed.

We do not qualify for a subsidy because they keep -- they look at investments or dividends, whatever you have. But yet we're unemployed. I am seeking employment and have been for the last nine months.

We currently pay $1,796 a month for insurance. We have a $2,750 individual network deductible and a $6,500 out-of-network deductible. Why would you have the highest increases -- 26.8 percent -- on people with the highest premiums with the least likely ability to pay these things?

I heard about this hearing yesterday. It was announced today on

the news. I heard about it because I contacted my congressperson and asked them what was going on. So, this is something that wasn't well-publicized.

And I do have documentation to submit for these rates, if you need it. Thank you very much for your time.

HEARING OFFICER: Thank you, Mr. Schaefer.

Stephanie Schaefer.

MS. STEPHANIE SCHAEFER: Good morning. My name is Stephanie Schaefer. That's S-c-h-a-e-f-e-r. And I'm also from Newtown, Connecticut. Thank you for hearing me this morning. I appreciate it.

I am 60 years old and I'm retired; I'm not employed. And basically we're trying to keep our budget intact and everything working. We do have Anthem.

Recently I was denied orthotics. And I've had two physicians tell me that I needed them. They wouldn't even pay anything on them.

I've also met my individual

deductible and now you all are telling us that we're going to have rate increases that seem unprecedently (sic) high and it just does not seem fair. And in the long term, we're looking at trying to make our money last throughout our lives. We don't want to wind up on our children's doorsteps some day saying please take care of us.

So, we need these -- all these increases to -- they're outlandishly high and they're unreasonable. So, we -- I really oppose any increase at all. Thank you so much.

HEARING OFFICER: Thank you.

Kimberly Cossuto.

MS. KIMBERLY COSSUTO: Good morning. My name is Kimberly Cossuto. Last name is spelled C-o-s-s-u-t-o. And I'm an infusion nurse. I do home infusion. So, I'm here on behalf of myself as well as my patients.

I'd briefly like to explain what I do. I infuse medications intravenously, moreso immunoglobulin, which is a

protein produced mainly by plasma cells that is used by the immune system to identify and neutralize pathogens such as bacteria and viruses. It's used for many neurological diseases such as chronic demyelinating polyneuropathy or CIDP, as well as MS.

I have many patients suffering physical effects that prevent them from holding down a job on a daily basis and have been affected by the rate increase from a few years ago and that will be affected by the increase if it passes. One particular patient who's 48 years old and suffers from CIDP has been on IVIG for ten years up until two weeks ago when his doctor told him that if his nerves improved on an EMG test, then he would also be reapproved.

His nerves came back fine, but his insurance company denied him. And the doctor said that if only the drug cost three or $400, then it would be approved. But this particular drug costs $16,000 a month. The patient was

denied.

I have another patient who is on Medicaid and pays nothing for her IVIG, yet the patient who is barely holding on to his own company pays a high deductible and has met his deductible is being denied and couldn't come here today because he can't get off the couch because he's too dizzy. And all because he hasn't had his IVIG in two weeks.

Then there's myself. I pay $8,000 a year for health coverage. And I'm not on IVIG. Before the increases I remember paying $6,500 a year and I thought that was fairly decent.

But if you increase the -- if you increase the rate by 26.8 percent, you're going to put all the small businesses either out of commission or barely holding on. My patient wouldn't stand a chance. And the sad part is he has two kids. And unless he gets the medication, he's not going to be able to take care of those kids and -- or see them in the future.

The doctor said to this patient, Let's revisit this in three months. But in three months both the patient and I know that there's not anything that they can do to recoup that time lost by not getting the IVIG. So, I'd like to thank Anthem for the further decline of my patient.

He is not the only one. There are many people struggling on a daily basis, both physically and financially. They come in all types: mothers, fathers, sisters, brothers. They all suffer, some more than others.

With this rate increase, some of those -- maybe even your own family members or friends -- may not be able to afford the medication that they need to survive or have a quality of life worth living, which ultimately could lead them to claim disability earlier in life than originally planned. And now the State or -- and/or our taxes pays for them. But if they had the medication without delay or interruption, then none of this

would happen or it would potentially delay that by a few years.

So, when people are cutting pills in half, not getting a well visit that they should be getting, skipping meals to pay for meds, something has to be done. Not a rate increase, but a decrease.

So, thank you for listening and I ask you to put yourself in my patient's shoes when you're making this decision, and as well as keeping him in your prayers because apparently that's all he has left right now.

HEARING OFFICER: Thank you.

MS. KIMBERLY COSSUTO: Thank you.

HEARING OFFICER: Marc Sandy Block.

MR. MARC SANDY BLOCK: Yes. Thank you. Hard act to follow.

My name is Marc Sandy Block, B-l-o-c-k. I'm from Weston, Connecticut. And I'm here today for my son who cannot be here today because he is working.

He works several jobs seven days a

week. He is one of the nicest, hardest working young men you'll ever know. He's repeatedly recognized by his employers and coworkers for his contributions to his job. He works with young children and he instructs others to teach your children in a lot of different areas at a number of different nonprofits.

Like other young people -- and old people who work at minimum wage, minimum hourly wage or a bit above that -- a major hike in premiums will take a substantial bite out of his compensation. Coupled to the changes in copays and deductibles and effects on medications due to different policy changes of the insurers, excessively ratcheted premiums is plain hard and hard to justify.

For the purposes of disclosure, I am with a congregation that is a member of CONECT. I will leave questions about statistics and data to CONECT and the papers that they have provided to the

hearing officer.

In effect, I would just like to thank you for the opportunity to sort of put a face on some of the patients as we've heard before and some of the people that are under the Affordable Care Act so that when you're thinking about excessive rates, you will, of course, include the implicit consideration of affordability and impact on those who are insured. So, I thank you.

HEARING OFFICER: Thank you, sir.

That's going to end the first part of our public comment for this hearing. I think at this point we're going to take a quick ten-minute recess. When we come back, we are going to begin with presentation of the applicant's application followed by examination by the department. Thank you.

(Recess taken: 10:01 a.m. to 10:13 a.m.)

HEARING OFFICER: We're now back on

the record. This is the continuation of the rate hearing for Anthem Blue Cross and Blue Shield. I'd now like counsel for the applicant to again identify the individuals who are present and available to testify and we'll have those individuals sworn in.

Mr. Durham, would you please start the introduction with the applicant witnesses?

MR. DURHAM: Yes, Mr. Kosky. On behalf of Anthem, Mr. Auger, who's the regional vice president of sales who will give an opening statement.

Following his opening statement, Anthem's director of actuarial services, Mr. Nguyen will testify in support of the application and the actuarial soundness of the application through responding to the department's questions, most notably those by Mr. Lombardo.

HEARING OFFICER: Thank you. Would the Court Reporter please swear in the applicant witnesses.

JAMES AUGUR and TU NGUYEN, called as witnesses by the Applicant, being first duly sworn by the Notary Public, were examined, and testified on their oaths as follows:

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

MR. DURHAM: Mr. Auger, would you please provide your opening testimony.

MR. AUGUR: Thank you.

Good morning Hearing Officer Kosky, members of the Department of Insurance, legislators, and members of the public. Thank you for the opportunity to be here today.

My name is Jim Augur and I am here on behalf of the applicant, Anthem Health Plans, Inc. I serve as Anthem's regional vice president of sales, and I am one of 1,400 employees based in Wallingford who work daily to meet the needs of our members. Joining me here this afternoon as Mr. Durham said is Tu

Nguyen, our director of actuarial services at Anthem Blue Cross and Blue Shield in Connecticut.

Anthem has a longstanding and deep commitment to Connecticut and its residents. Anthem has served Connecticut residents for nearly 80 years. Our mission is simple: To be a valued health care partner to our members, helping them meet their individual health goals and access to the right care at the right time while addressing the underlying drivers of avoidable health care costs. For instance, developing programs designed to help our members with chronic conditions improve their health, or reducing the health complications that lead to emergency room and hospital admissions. We're working thoughtfully with key stakeholders across the state who share these common goals.

Connecticut has been nationally recognized for the success of its exchange program. This program offers

choice and access to health insurance for many who did not have such access just a few short years ago.

While we have seen stories in the news about states that have chosen -- that have not chosen to establish and operate a state-based exchange program and other states that are abandoning their exchanges due to unsustainable costs, Connecticut has remained committed to a locally operated exchange, Access Health Connecticut, and with a board comprised of people who live and work in Connecticut to meet the needs of Connecticut residents.

Likewise, while other carriers have become insolvent or have decided to leave the exchanges due to financial losses, Anthem remains committed to its leadership role in the exchange and working together with the state of Connecticut and Access Health Connecticut to ensure that the exchange remains a viable marketplace with financially sound carriers for years to

come.

That leads us to the Department of Insurance review of our rate application today. Anthem, like all carriers, is required to have rates that are adequate and not excessive or unfairly discriminatory.

We take that obligation very seriously. Offering products at adequate rates is critical to ensure market stability and to meet our obligation to our members.

In developing our 2017 rates, we relied on our experience from the currently offered 2015 exchange products which are compliant with the various coverage mandates and benefit levels of the Affordable Care Act, also known as the ACA. Anthem's proposed 2017 rates for individual products on and off the exchange reflect, on average, a 26.8 percent increase over our 2016 rates.

Under the ACA, there are some minimum medical loss ratio requirement

to ensure that carriers are not charging excessive rates. Carriers with excessive rates not complying with the minimum medical loss ratio requirement must refund these excess amounts to their customers.

Anthem produced a medical loss ratio within the requirements of the ACA in 2014 and 2015 and expects to comply with this requirement again in 2016. As a result, we have never paid a rebate to our customers.

Our proposed rates reflect the combination of the following key drivers: One, a correction for our 2016 rates which we now know from our year-over-year data are not adequate.

Two, increases in medical trend.

Three, changes in pharmacy costs based on rising drug prices, utilization for high-cost drugs such as those used to treat hepatitis C, and brand-to-generic conversions which are not unique to Connecticut.

And, four, the scheduled

elimination of the funds available under the federal reinsurance program created under the ACA which impacts all insurers that are participating in the individual market.

Other factors impacting the proposed rates include expected morbidity changes and the calibration of the health of our base experience to the Connecticut market average. You'll hear more about the factors that impact Anthem's rate development during the highly technical actuarial discussion that will take place through the department's questioning.

Working together to ensure the continued stability of the Connecticut exchange needs to be a priority for all stakeholders. One of the key determinants of that stability, as well as the continued presence of multiple carriers on the exchange, will be the adequacy of the 2017 rates for the individual market.

Anthem understands how the rising

cost of health care impacts working families and individuals in our state. And as I mentioned, Anthem has worked hard to develop strategies and programs to identify and address these cost drivers. Unfortunately, as the ACA and the Connecticut exchange move out of their infancy, health care costs have been higher than expected, impacting the financial solvency of some carriers, while causing others to exit the exchange.

Anthem believes that our rate increase addresses these conditions responsibly for our members. Though higher than we would like, the 2017 rate is actuarially sound and adequate under the law, and it will enable Anthem to maintain its commitment to the individual market.

While building premium rates is an important part of what we do, in my brief remarks I would like to emphasize the part of Anthem's mission I referenced previously that you won't

hear about during the technical rate discussions. Specifically, Anthem's mission is to be a valued health care partner by helping members maintain and improve their health.

I can spend a lot of time here today describing the comprehensive portfolio of products and programs Anthem offers to improve the health of those we serve; instead, I will summarize them succinctly by placing them in the context of three core commitments: One, a commitment to help our members during their time of health care need; two, a commitment to empowering our members to become informed health care consumers and active participants in their own health; and, three, a commitment to empowering our participating physicians and other providers to provide care that is proactive, coordinated, and built around the individual needs of their patients and consistent with nationally recognized care 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 health care system, and manage their health as well as their health care costs.

I appreciate the opportunity to speak about Anthem's proposed individual on- and off-exchange filed rates that would go into effect January 1, 2017. I hope that the information I've presented will be of assistance to the department as it reviews Anthem's rate application.

We now welcome any questions the Department of Insurance might have.

HEARING OFFICER: Thank you. Just a moment, Mr. Augur.

Could the recording device that's been put on Anthem's table please be removed? The audio in the room should be sufficient to record any of the proceedings. Thank you.

Go ahead, Mr. Durham.

MR. DURHAM: With that, Mr. Kosky,

the direct testimony is completed on behalf of Anthem. Mr. Augur has made that -- given that testimony in support of the application and the other filings. Mr. Nguyen, as well as Mr. Auger are now available to respond to the department's questions.

HEARING OFFICER: Thank you, Mr. Durham. We'll now begin with the cross-examination (sic) of witnesses by the department staff.

Mr. Lombardo, please proceed.

MR. LOMBARDO: Thank you, Hearing Officer. 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.

First line of questioning will be related to the trend that's assumed in the rate filing.

DIRECT EXAMINATION

BY MR. LOMBARDO:

Q For the record, could you identify the

trend that you're proposing in the rate filing?

A Yes. Good morning. Happy to respond to that.

The proposed trend that we use in the development of the rate filings is 9.6 percent.

Q Thank you.

The explanation for the trend that's being used in the rate filing is based on small group experience with some adjustments. Can you go into a little bit more detail as to why you're using small group trend data rather than the individual trend data, as well as what the trend would be if you were to use solely individual trend data?

A Definitely. We use small group's data to arrive at the pricing trend because we do believe that the data for small groups is a lot more credible than if we use individual data.

Prior to ACA it was medically underwritten. So, that population is basically not a good representation.

Again, in 2014 we have new uninsured population coming in. There is a ramp-up demand for individual experience. And then in 2015 that's when we would have more credible data.

However, when you compare 2015 to 2014, there's a lot of those in there. So, that is one of the reason why we propose to use small groups, which is the same methodology that we used last year to build the pricing trend.

So, we start out with small groups pricing trend and then we're adjusting for hepatitis C. And in additions to that, for years-to-date we do see high trend years-to-date. It's at 13.8 percent. So, we make some additional adjustments to reflect the high years-to-date trend.

Q And what would the trend have been proposed if you had just used straight individual data?

A Yes. If we use individual experience to arrive at the pricing trend, we would use a 10.9 percent instead of the 9.6.

Q Okay. You mentioned two adjustments to the small group. So, just for the record, since you identified it within the individual filing and that small group trend is a basis for your individual trend, I'm going to use some information from your small group rate filing that you submitted to the department.

The small group rate filing is proposing trend of 8.3 percent. So, the difference between the 8.3 percent and the 9.6 percent are adjustments that you've identified. One question I have is why wouldn't hepatitis C impact both small group and individual in the same way, therefore, you wouldn't need an additional adjustment for hep C when you're moving from small group to individual to set the trend?

A Definitely. For individual we do see high utilization of hepatitis C. The population for individual definitely are different than small groups. So, that is the reason why we make an adjustment for that.

Q Okay. If we could see the incidence level between small group and individual, that would be appreciated. As the -- Mr. Hearing Officer had identified, the record will be kept open until next Wednesday at 4:00 o'clock. So, you'll have an opportunity to submit that information.

And we'll ask you to submit that information via SERFF, the electronic rate form filing system that we have set up. And any correspondence that you submit to us will become

part of the record and will be on our website as correspondence as well.

A We can definitely provide that.

Q Okay. The second question I have is with regard to hepatitis C. Wouldn't hepatitis C have been in your 2015 experience, and the impact of hepatitis C?

It appears that you're taking additional steps to increase the impact of hep C beyond 2015, where it might already be included in the actual experience in 2015. Can you comment on that, please?

A Yes. For 2015 there were some -- what we continue to see, high hepatitis C utilization through early of 2016.

Q Okay. And, again, if you can provide the difference between 2015 utilization and the 2016 utilization that you're seeing right now, we would appreciate that as well.

A Definitely.

Q Thank you.

Can you explain in a little bit more detail the area factor changes that you're proposing, what the changes are and the basis for those changes?

A Definitely. So, when we come up with the area factors, what we did was we looked at 2015 experience. And then that's how we come up with 2015 kind of relativity called area factors.

However, we also have contract changes for 2016 and 2017. So, what we did was we make an adjustments for anticipated contract negotiations. And that's -- becomes the final area of factors that we propose in the filings.

Q Okay. So, just so that we understand exactly what occurred, you did a claim analysis by county rating area?

A That's correct.

Q You came out with claim area factors that I'm seeing in your response to our questions. And the reason why there's a difference between the claim area factors and the final area factors is related to the projected contract changes from 2015 to 2016 and 2017?

A That's correct.

Q Okay. Thank you.

I want to go back to the trend question. There is an identifier of a volatility adjustment in your trend. It appears that it's half a percent or 50 basis points that you build in for

volatility for trend. Can you explain what that is and the reason why you include it?

A Definitely. So, under ACA, we are required to use a full years of data. And then we have to trend that into the rating periods. And that trending periods is over a two-years period. It's longer than what normally that we have to trend.

So, for that reason there's a lot of uncertainties on the trend. So, that was one of the reason why we have a .5 percent added to the trend, for the uncertainties.

Q And the point -- why .5 percent, I guess? Where was the development of the .5? Where did you come up or derive the .5 percent?

A So, what we did was we looked at historical how much trend with the up and down and that's how we arrive at the .5 percent.

Q Okay. Thank you.

If you can go over specifically the separate identifiable portions of the average rate increase that you're asking for, for the record.

A Definitely. There are four key components and then there are some miscellaneous (inaudible).

(Fixing microphone.)

The first one is the price and corrections.

THE COURT REPORTER: I'm sorry, could you just repeat -- "there are four key components and then there are some miscellaneous" --

THE WITNESS: Definitely.

There are four key components and then there are some miscellaneous line -- on the last one. The first one is the price and corrections. That is the pricing for the inadequate rates or rates for 2016 are not adequate level.

The second component is the health care trend.

The third one is the elimination of the research program.

The fourth component is the health insurance tax. That piece is going away in 2017. So, we reflect that in the rates.

And then the last piece is just like commissions and benefit changes, so on and so forth.

BY MR. LOMBARDO:

Q Okay. To get to the other portion that you identified, commissions, it's our understanding from the rate filing that for the exchange business, you will not be paying commissions; for off-exchange business you will be paying commissions. Is that correct?

A For off exchange we will pay commissions, but on exchange we will not pay commissions.

Q Okay. And that's obviously reflected in the rates for the on-exchange business will be lower than rates for off exchange by the commission percentage?

A That's correct.

Q Okay. Thank you.

The pricing correction of 18.7 percent. In your explanation we've asked you to provide some more detail in correspondence the department has sent to Anthem. It identifies a loss ratio year-to-date in 2016 of 89 percent and a pricing loss ratio for 2016 of 79.2 percent.

So, when I do a quick analysis of those two loss ratios, it generates about a 12 percent differential between the two loss ratios. You're

identifying almost 19 percent in the rate component build-up.

So, if you can explain -- I can understand the differential between the experience when you're sitting in a loss ratio of 89 and you priced for 79. But that only accounts for about 12 percent. So, can you explain the other almost 7 percent that's built in?

A Definitely. So, the years-to-date that we give was through May of 2016. Now we have June data. So, the years-to-date through June actually at 92.5 percent. We anticipate that year-by-year end the medical loss ratio would be a lot higher than the 92.5 percent.

Q Okay. Thank you.

Can you explain a little bit more how the reinsurance adjustment component of the rate increase, 6.8 percent, was derived at?

A So, what we did was we looked at 2015 data and then we trend those data to 2016. And then there is a threshold for 2016 that we apply to. So, that's how we arrive at a 6.8 percent.

Q Do you know what percentage of your 2016 premium was as it relates to the reinsurance program?

A If I recall correctly, it's around 14 percent.

Q Okay. I don't think it would have been that high. It would only have been about 20 to $25 per member per month on your premium for reinsurance that you had priced for in your 2016.

So, if you could get -- if you could provide to the department the actual per member per month that you built into the URRT --

A Yeah.

Q -- for 2016 pricing as a percentage. Fourteen seems a little high.

MR. LOMBARDO: And just for the general public's knowledge, the 2016 reinsurance was 50 percent coinsurance between 90,000 and $250,000. That program is going away 12/31/2016. So, all of the carriers do not have that reinsurance program available to them where the federal government would have reimbursed 50 percent of the claims in between those two thresholds.

So, yeah, if you can get the pricing, what you had priced for in 2016 for the --

MR. NGUYEN: Definitely.
MR. LOMBARDO: -- reinsurance program --
MR. NGUYEN: Definitely.
MR. LOMBARDO: -- I would appreciate that.

BY MR. LOMBARDO:

Q The filing states that the rate changes vary by plan as well as product. Can you go into a little bit more detail as to why they vary by, A, by product, and why they vary by plan?

A Definitely. There are four components that drive the variation of the rates. The first one is the benefit changes. It has an impact of a rate reduction up to 8.7 percent.

The second component is the relativity changes. Every years we do make an update to our relativity models, and that's at an impact of a 6.8 percent reduction to a 9.4 percent increase.

And then the last component that we made was the additional adjustments to induce utilization adjustments. That has an impact of 10.8 percent to 11.5 percent, using post-risk adjustment and reinsurance adjustment.

Q Okay. One of the questions that I had

was -- one of the questions --

MR. LOMBARDO: I think I'm going to wait a minute until we can figure out where that's (indicating) coming from. Thank you.

HEARING OFFICER: Why don't we take a quick five-minute recess and we'll figure out what's going on with the audio. Thank you.

(Recess taken: 10:39 a.m. to 10:41 a.m.)

HEARING OFFICER: All right. We're back on the record. Continuation of the rate hearing for Anthem Blue Cross and Blue Shield. We are going to continue with cross-examination (sic) by Mr. Lombardo.

MR. LOMBARDO: Thank you, Mr. Hearing Officer.

BY MR. LOMBARDO:

Q It appears that Anthem is estimating the more -- oh, excuse me. I want to go back to my previous question.

You had talked in your response with

regard to the induced utilization adjustments that you believe that you have the ability to make these and that they're allowable and that they're not related to rating on the health status of the population. Explain in a little bit more detail, because what it appears is, is if you're doing this by plan and you're creating induced utilization by plan, as a result of the experience within that plan, it would seem on a basic level that it would be directly related to the health status of the population that's purchasing that plan.

So, if you can describe why you think that's an allowable adjustment, we would appreciate it.

A Definitely. I'm glad to respond to that.

The intent of the risk adjustment is to making sure that carriers that have high risk, the health status, would receive money for insure those high risk. And then carriers with healthier risk would pay into the risk pool.

So, the intent of that is to adjust for the health status. So, we assume that the adjustments after we look at the MOR adjusting for

the risk adjustment and the reinsurance program is just making the adjustments for the induced utilization, not for the health status.

And what we did was -- because at the plan level we may not have enough experience. So, what we did was we grouped plan into a similar kind of design, and that's how we come up with the adjustment for the induced utilization.

Q Could you provide that information --

A Definitely.

Q -- and data?

One of the things that was brought up during our mini recess is even though the record will be held open until next Wednesday until 4:00 o'clock, the department would appreciate this additional information that we're asking for here to be provided as soon as you can provide it to us so we can continue our analysis on the filing.

A Will do. Will do.

Q So, we appreciate that.

Okay. It appears that Anthem is estimating that morbidity will improve from the experience period to the rating period by a factor of about 3 percent. Can you explain in detail why that is, especially in terms of the fact that it

appears that your experience is deteriorating in 2016? Why would you assume that morbidity would become better over that period of time?

A The deterioration in 2016, we do believe this is not unique to Anthem. It's pretty much consistently all carriers out there will see a similar kind of experience.

In term of coming up with the factors, because 2015 we do have high-risk populations. So, what we estimate is some of our members would lapse and go to other carriers and buy coverage from there. And then the market, because they are healthier compared to Anthem, we do anticipate some of that members will join Anthem and that will bring down the risk.

So, Anthem make an adjustment to lower the claim cost for that projection. And at the same time, what we did, because our population are getting healthier, so we also project from 2015 to 2017 that we going to receive lower risk strengths or payment for individual.

Q Okay. Thank you.

So, as a follow-up question, if morbidity -- if you see this deterioration on not just Anthem but other carriers, wouldn't you

expect that the average morbidity of the population would be going in the same direction, therefore, there really wouldn't be -- for risk adjustment purposes, there really wouldn't be a relative change in the morbidity if you're working off an average risk per concept?

A That's -- that's correct. But for Anthem, because we do anticipate that our members today has higher risk than the market average. So, once they lapse, versus the healthier population coming from the market or other carriers today, for Anthem specifics, it definitely -- it will impact the risk pool. But the market themselves, I totally agree.

Q Okay. I guess the question I have is: Why would you assume that you're going to be losing sicker people and gaining healthier people?

I'm asking that question because, you know, the same argument can be made by any other carrier that's out in the marketplace, that they're either going to gain sicker or lose sicker or gain healthier or lose healthier people. So, I'm trying to better understand the assumption of why you think you're going to lose sicker people and you're going to gain healthier people.

A Right. The projection, what we did was we assume X percent of the market membership will join us built on new members to us. And then some of the members that we have today, we assume that we lose some of that, X percent or so.

And then we calculate the average risk scores for 2017. We compare that to 2015. And that's how we arrived at the 3 percent claims reduction.

So, what we have here is a consistency of both a claims reduction that we have. At the same time, also the risk adjustments. Because if the population is getting healthier, we reduce the claims by 3 percent. But at the same time, if they are getting healthier and then we have to make an adjustment on the risk adjustments.

Q Yeah. Can you provide the department with your historical risk that has left you for 2014 and 2015 and 2016 and what you gained from a risk perspective --

A Definitely.

Q -- so that it can support what you're suggesting will happen --

A Definitely.

Q -- for 2017?

Thank you.

Can you explain the benefit modifications and the need to update for actuarial value requirements?

A Are you referring to the benefit changes?

Q Yes, general benefit modifications and any changes you had to make as a result of actuarial value requirements.

A Definitely. One of the changes that we did is because every years we have a new calculator come out and we have to comply with meta-level. So, they are then designed for -- I'm sorry, the meta-level, we have to make benefit changes to comply with that. So, that is one of the reason that we make benefit changes.

Q Okay. And those benefit changes can be up or down impacting the rates?

A That's correct. But on average it's a reduction.

Q Okay. Thank you.

Can you explain the impact of changes in the taxes, fees, and the non-benefit expenses that are proposed in the rate filing?

A I'm assume you're referring to the

2.9 percent reductions --

Q Yeah.

A -- in there?

Q That's correct.

A So, that health insurance tax carriers have to pay in 2014, '15, and '16. But in 2017, federal has made the decision not to have that tax. And that's worth 2.9 percent. So, Anthem reflect that into our rates as a 2.9 rate reduction.

Q So, just so that everyone is clear, if that tax resumes in 2018, then there will be a charge that will be reinstated in the rate --

A That's correct.

Q -- proposals for 2018?

A That's correct.

Q Okay. Thank you.

Can you discuss in a little bit more detail the anticipated changes in the average claim factors that you identified in the rate filing?

A I'm assuming you're referring to the 8.6 percent?

Q No, I'm looking at the age, gender, the area, the network, and the benefit plan changes.

You have experience period, future population, and normalization factors.

A Definitely.

Q Yeah.

A So, there are four adjustments that we did to our claim experience. The first one is the age and gender. The second one is the area factors. The third one is network. And the last one is the benefit plan. And, again, going over one of them, the rest of them, the calculation are very similar.

To come up with the adjustment for those, what we did was because we're using 2015 experience. So, what we did was using the membership that we have in 2015, coming up with the average age and gender. And then going to 2016, we already have information on 2016 and we're trying to forecast it to 2017 membership.

And what we did was we used those information to come up with the average age and gender. And the comparison of 2016 versus 2015 -- I mean, 2017 versus 2015. And that's how we come up with the adjustments for gender -- for age and gender. The rest of the factors -- areas, network, and benefits -- the calculation follow a

similar method.

Q Okay. Can you go into a little bit more detail on some of your products that have a different network aspect to it?

A Yes. So, for on exchange we do have a different network than off exchange.

Q Okay. Can you describe what the difference is in the networks in general terms?

A For on exchange we have a narrow network or less provider than off exchange. We also have a different contract.

Q Okay. And do you know what the relative rate impact is between the two networks?

A I don't have the details with me right now. I can definitely provide that as a follow-up.

Q Thank you.

Can you describe in more detail what Anthem is doing differently from the experience period to the rating period in regards to medical management?

A I'm glad to provide that.

There are four categories that Anthem do differently than 2015. For members that utilize a high ER, we would identify them for medical

management. Again, the medical management would reach out to them to seek case management, seek management solutions.

The second one is the -- the medical management, we started to review the inpatient and the outpatient hip replacement, knee replacement, so on and so forth.

The last one is the medical management where we have prior authorization of care administration of specialty drugs. Those are the three programs.

Q Thank you. It's assumed in your rate filing that there will be increased enrollment into your CSR plans. Can you describe in more detail what a CSR plan is? And then I have a follow-up question.

A Definitely. CSR is the cost-share reduction. That is our subsidies program that the federal would subsidize for members paying cost share. Those are the members, they have to buy Silver plan in order to qualify for that CSR.

So, what we have is an outreach application. We do have Silver plan going up less than the average. So, as a mix, we assume that we going to get more membership on Silver plan. And

as a result, we would have higher CSR population.

Q Okay. Based -- and I know there's a lot of questions around risk adjustment in the program, but based upon how I understand the risk adjustment program to work is it appears that the more CSR enrollees that you have, the more opportunity that you will have to receive a payment in the process when they calculate risk adjustments.

So, to counter the morbidity benefit that you're seeing and reducing the risk adjustment that you estimate that you're going to receive, wouldn't an increased enrollment in CSR go the other way to the point of potentially receiving more money than you normally would have had, assuming everything being equal?

A That's correct. And the increase in the CSR population actually also factored into our calculation of our estimate for the risk adjustment.

Q Okay. Was that calculated through the morbidity or through the risk adjustment calculation itself?

A It's both.

Q Okay. Thank you.

Can you talk in a little bit more detail about the grace period adjustment that you've included in the pricing, what it is and how you developed the 72 basis point adjustment?

A Definitely. The grace period adjustment is for members who lapse during the last month where they do not pay premiums. Even though they do not pay premiums, carriers are required to still cover them during the last month.

So, to come up with the estimates of that, first we would identify how many members would lapse due to premium payment.

The second component of the calculation is even though they lapse, they did pay premium previously. So, we have to estimate how much of the premiums that they did not pay versus the premiums that they pay. So, that is the second component that we estimate.

The last piece is even though they do not pay premiums, carriers still receive the advanced premium credits. So, Anthem have to estimate how much the members owe versus the credits or the subsidies on the premium side. So, Anthem incorporate that into the calculation as well.

Q Okay. So, that acts as an offset to your --

A That's correct.

Q -- calculation?

A That's correct.

Q Thank you.

Can you explain, briefly explain why you trend your actual experience slightly more than 24 months to your rating period experience? You have 24.1 months identified in the filing.

A Right. What we did was we making adjustments for members not -- was partially reflected in the years. So, that's why we use more than 24 months.

Q Okay. I can't imagine -- most all members have to be a 1/1 renewal date. So, this would just be people with partial years that come on that purchase Anthem --

A That's correct.

Q -- throughout the year possibly --

A Right.

Q -- through special enrollment periods?

A Right.

Q Is that correct?

A Right.

Q Can you get me the percentage of enrollment that you see throughout the year as a percentage of your total enrollment --

A Definitely.

Q -- through the SEP?

A Yes, we will do that.

Q Thank you.

Okay. I know you touched upon this before and there was some factors that led up to the development of this, but can you go into a little bit more detail -- so, in the 2015 -- excuse me, the 2016 CCIIO report that we just received on June 30th of this year for the 2015 benefit plan year with regard to risk adjustment, Anthem received approximately $25 million in the individual market. That, as it relates to your membership for 2015, is approximately about $40 to $41.

You price for the risk adjustment approximately net $31 per member per month. So, can you explain the difference between the 31 and the 40 and a half that you received?

A Definitely. When we submit the application, we didn't have the June 30th reports that you mentioned. So, what we did was we relied

pretty much on what the risk adjustment for 2014 and also as -- there was some assimilation we participate with weekly. So, we use those two information to arrive at the 2015 estimates.

So, the numbers that you refer earlier were based on the actual payments. It was $40.59 PMPM. The estimates that we have for 2015 was at $40.07 PMPM. What we did was we adjusting that $40.07 PMPM for the healthier population that we mention about earlier.

Q Uh-hum.

A Because if we see a healthier population, we lower the claims. At the same time we also project that the risk adjustment transfer that we receive in 2015, it would come down as well.

Q Okay. Thank you.

There's -- within the rate filing you identified tiered networks. Can you explain what -- I believe you have a couple of plans that are part of a tiered network. Can you explain what that tiered network is and the relative impact on pricing that a tiered network has?

A Definitely. So, what Anthem did was we tiered the benefits based on cost and quality.

So, T1, if a members go to T1, they would receive a greater benefit. And then if they go to Tier 2, they would receive a lower benefits than if they go to tier 1. Anthem tried to basically drive members to go to high-quality provider as well as low-cost provider.

Q Okay. There is a tier 3. Can you explain the tier 3 for your PPO product?

A For tier 3 those are the out-of-network benefits. So, that's the tier 3 that I'm assuming you're referring to.

Q Yes. So, for your tier 1 and tier 2 that you have, both in your PPO and your HMO products, do you know what percentage of your network is in tier 1 and what percentage of your network is in tier 2?

A I don't have the detail with me right now. I can definitely provide that as a follow-up.

Q Okay. I would appreciate that.

And do you know what the relative pricing impact of a tiered network product is versus a non-tiered network product?

A I don't have the detail with me either.

Q Okay. Thank you.

And the last comment I have, I'd like you to confirm that, for the record, that the tomosynthesis mandate did not add any additional cost to the pricing.

A That's correct.

MR. LOMBARDO: Okay. Thank you.

Mr. Hearing Officer, the insurance department has no additional questions at this time.

HEARING OFFICER: Thank you, Mr. Lombardo.

Mr. Durham, do you wish to examine your witnesses following the cross of Mr. Lombardo?

MR. DURHAM: No, Mr. Kosky, we don't have any other questions.

HEARING OFFICER: Okay. Thank you.

Ms. Medina, did we have any sign-ups for second round of public comment?

MS. MEDINA: I don't have any more -- oh, would you like to sign up?

(Pause.)

HEARING OFFICER: At this time I will now commence the second public

comment portion of this hearing. Again, the public comment portion of the hearing will commence with comments from public officials -- we don't have any. We have members of the general public.

Again, I'm going to go through some of the guidelines for you with regards to public comment, first being you must identify yourself for the record, including any organization that you represent. You 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 we don't have the same time constraints, but if you can reasonably limit your comments to the three minutes.

And so for the record, we have Mary Jennings. And if you can please just spell your last name for the record. Thank you.

MS. MARY JENNINGS: Yes. Thank you. My last name is spelled -- excuse

me -- J-e-n-n-i-n-g-s.

I want to disclose first that I am a broker and I do represent quite a few consumers in the state of Connecticut on Anthem plans. I have received phone calls from a number of my clients who are extremely concerned and confused by the proposed rate increase. The confusion relates to what they report to me to be very uneven servicing of their health plan through Anthem.

Due to a debacle on the part of Anthem when they launched their on-exchange plans, I, as a broker, have attempted to assist these folks the best I can. A large percentage of the people I do serve, English is not their first language, and therefore, as a generosity and to contribute my time to these consumers, I take on quite a bit in trying to resolve these issues. So, I would like to just share that comment with you.

It is -- the other piece of what I would like to talk about, because it's

not clear to me right now what's going on, is the network changes within Anthem. Because I do serve quite a few consumers in lower Fairfield County who either commute from New York, work, and vice versa, there has been massive confusion related to networks.

And I -- it's not clear to me that any of the consumers are particularly aware of the subtleties between the networks. And I would encourage the Commission, depending on how you decide on this rate increase discussion, to provide to the consumers very clear communication about the shift in the network.

As some of you may know or may not know, when these plans were launched by Anthem on the Connecticut exchange initially, there wasn't even a web access. I will -- given the fact my compensation now may be at risk for that, I would like to reach out to consumers as a courtesy to inform them that things have shifted. And if there

is a very clear simple English way to communicate that, that would be greatly appreciated.

And I guess I'm looking -- I don't know if I've run out of time. I have one further comment.

HEARING OFFICER: Another minute. You've got time.

MS. MARY JENNINGS: Another minute? Thank you.

So, I will disclose to the group that due to a very wobbly beginning with Anthem in the state of Connecticut, most of my books shifted year two to HealthyCT, year three to ConnectiCare. That is -- because I have had a seat in the public enrollment center in New Haven, Connecticut, I feel I have a particularly helpful view to help people view Anthem or versus the other carriers in the state.

So, just to wrap it up, I apologize I did get here late. I do appreciate the opportunity to speak at this time. Thank you.

HEARING OFFICER: Thank you. We do have a second sign-up, Kimberly Cossuto.

MS. KIMBERLY COSSUTO: Hi, I'm Kimberly Cossuto and I'm an infusion nurse again. Last name is C-o-s-s-u-t-o.

I just wanted to I guess ask the panel if you were aware that patients on certain medications, including tier 1 and tier 2 can't take certain meds due to fillers within the medications and are forced to take tier 3, which are out-of-network meds and further deepen their pockets. Do you have or -- do you or can you adjust for that? Or do you adjust for that? I guess this is a question for --

HEARING OFFICER: It's a comment period.

MS. KIMBERLY COSSUTO: Comment? Okay.

HEARING OFFICER: Yeah.

MS. KIMBERLY COSSUTO: So, I guess the comment is just that there's fillers in some of the medications that they're

forced to have out-of-network cost for the medications and it just further deepens their pockets. So, it's just another something that, you know, you should take into consideration. And that's it. Thanks.

HEARING OFFICER: Thank you.

We have two more additional comments and I am going to close the public comment period after these last two. Thank you.

MS. GAY HYRE: Thank you for letting me do a follow-up comment.

HEARING OFFICER: Go ahead.

MS. GAY HYRE: My name is Gay Hyre, H-y-r-e. I'm from West Haven, Connecticut and I am an Anthem policyholder.

One thing that I wanted to let you know about these increases in costs is that if you're on a fixed income -- or possibly even if you're not -- sometimes you have to take pre-tax funds out of a tax-deferred 401(k) account in order to cover these premiums. That money then

goes to the modified adjusted gross income bottom line, which then increases the amount of taxable income which you pay the taxes on, and it decreases the amount of subsidy that you get. So, every dollar that you take out of lifetime savings costs you four in order to cover these premiums.

You are now looking at the face -- the new face of poverty in the state of Connecticut. A lifetime of savings is going to be depleted in very short order. That is not conducive to the public goodwill. Thank you.

HEARING OFFICER: Thank you.

Mark Russo.

MR. MARK RUSSO: I'm going to limit my comments more to the on-exchange business. I just want to say that, you know, Access Health is a model built for a State exchange business, probably one of the best in the country from what I've heard and everything I've known. I think it's an excellent system and I'd love to see it stay that way.

And I think one of the things that -- you know, not providing commission to brokers anymore undermines that system. From what I understand, we probably do over 30 percent of the qualified health plans through brokers, and I think we provide a great service.

If the brokers are no longer commissioned, it makes it difficult for us to have any employees and brokers to do any of this. And I think what will end up is that the service will end up going to unlicensed assisters who legally are not even allowed to discuss or, you know, recommend plans and go through all that. That will actually hurt the consumer.

I think it will also create a toxic environment, you know, for other companies to look at coming into the State exchange. And I think, you know, if we lose one more company, we really don't have a marketplace anymore; we just have one company. And I think that would definitely be a disadvantage to

the consumers. You've already lost two of them this year, and I think, you know what, if we make it a more level thing where everyone is paying a certain amount, I think that would definitely help.

Consumers quite often don't understand the plans that they're getting into, and I see what happens when they deal with unlicensed, you know, assisters where they're not really getting any kind of good advice, even though they shouldn't be getting any. So, I just wanted to say that, you know what, that it definitely should have still the commission so that we can service our customers.

There's going to be thousands of HealthyCT customers that have to pick a new plan, and they're going to need some help. And to go into -- from what they were used to and going into another plan -- and they're either looking at ConnectiCare or Anthem now -- they can't just directly call Anthem because then

they can't really even shop the plan. So -- and if they just do it on their own or go through an unlicensed assister, you know, they may end up with a plan that's either not the best one suited for them or they don't understand it. And I'd really hate to see a lot more complaints coming into the department about this, you know, that you guys don't really need to handle. And I think we can circumvent that by having them go through a licensed broker. Thank you.

HEARING OFFICER: Thank you.

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

MR. DURHAM: Yes, Mr. Kosky. Mr. Auger is going to give a brief closing.

HEARING OFFICER: All right. Thank you.

MR. AUGUR: Thanks. Hearing Officer Kosky and members of the Department of Insurance, on behalf of

everyone at Anthem here in Connecticut, I want to thank the department for giving us the opportunity today to listen to all the members of the public who took the time to come and voice their views and to provide responses to Mr. Lombardo's questions seeking additional information in detail regarding the actuarial soundness of our application for approval of Anthem's 2017 rates for its individual business on and off the exchange.

As I mentioned in my opening statement, Anthem's mission is to continue to be a valued health care partner to our members by helping them to become informed and proactive health care consumers, to access quality care, to maintain and improve their health, and to manage their health care costs. In these ways our goals remain aligned with those of the people we serve.

It is particularly poignant to hear today the experiences of those folks who shared their struggles to gain access to

quality health care in our state. And hearing about those difficulties is a reminder that Anthem must carry on its commitment to working to ensure that our members' health care needs are met and that the underlying avoidable drivers of health care costs are addressed and innovative in responsible ways.

The truth is that the current health care climate is challenging and the stability of the Connecticut exchange as a multi-carrier marketplace for individual insurance needs to be a priority. It is undeniable that higher than expected health care costs have jeopardized the financial solvency of some insurers and have caused other insurers to leave the exchange altogether.

To be clear, at this time in this climate it is imperative that the adequacy of the 2017 rates for the individual market be ensured by the department. As I mentioned earlier, though higher than Anthem would want,

the individual rate development for 2017 is actuarially sound and adequate under the law, and it will enable Anthem to maintain its commitment to the individual market here in our state.

Respectfully, Anthem requests that its 2017 rate be approved as submitted and supported by its application. We thank you again.

HEARING OFFICER: Thank you, Mr. Augur, Mr. Durham.

Are there any further questions from the staff of the insurance department?

MS. CAMPANELLI: We don't have any further questions. But we would like to ask that the record to this proceeding be held open until Friday, August 4, 2016 (sic) for some documents mentioned earlier. The first one was the incidence between individual and small group for hepatitis C utilization.

The second was 2015 and 2016, the difference in utilization for hepatitis C.

Provide data for adjustment for induced utilization. Provide historical risk for Anthem 2014, 2015, and 2016 and what was gained from a risk perspective to predict 2017. The information on network tiering for on and off exchange, the percentage of enrollment through SEP, the network percentage in tier 1 and tier 2 and tiered network product versus non-tiered network products.

HEARING OFFICER: Thank you, Attorney. Thank you, Attorney Campanelli.

Does Anthem have all that information? Okay. So, in accordance with Section 38a-8-40 of Regulations of Connecticut State Agencies ordering the applicant to submit the documents that Attorney Campanelli has just read in for the record, I know we had talked about this being held open for public comment until next week, Wednesday, end of business day, August 10th. But along with what Mr. Lombardo said, if you can provide that information to us as soon

as possible, that would be great.

Mr. Durham?

MR. DURHAM: And just for the record, we certainly will get right on that and we'll keep the department up to date and provide that information, that documentation as soon as we can. If we run into any difficulties we'll contact you and explain what the issues are. But we'll get right on it. Thank you.

HEARING OFFICER: Thank you, Mr. Durham.

The record of this hearing will be held open for further written comment, again, until the close of business day on Wednesday, August 10, 2016.

Today's hearing is adjourned. Thank you.

(Hearing adjourned: 11:21 a.m.)

CERTIFICATE

I hereby certify that the foregoing 113 pages are a complete and accurate computer-aided transcription of my original stenotype notes taken of the Public Hearing in the matter of Anthem Blue Cross and Blue Shield, Docket Number LH 16-45, which was held before Jared Kosky, Hearing Officer, State of Connecticut Insurance Department, 153 Market Street, Hartford, Connecticut, on August 3, 2016.

/s/_____

Kristine A. Paradis, LSR 338
Licensed Shorthand Reporter

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