STATE OF CONNECTICUT
INSURANCE DEPARTMENT

In the Matter of:	
THE PROPOSED RATE INCREASE APPLICATION OF ANTHEM HEALTH PLANS, INC. D/B/A ANTHEM BLUE CROSS AND BLUE SHIELD	Docket No. LH 17-70 June 14, 2017

PUBLIC HEARING

Held Before:

Jared T. Kosky, Hearing Officer

Paul Lombardo

Kristin Campanelli

Reporter: Robin Balletto, RMR, LSR #230

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Present:

John M. Russo, Anthem
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. . . The following is the transcript of the Public Hearing in the Matter of the proposed rate increase application of Anthem Health Plans, Inc., d/b/a Anthem Blue Cross and Blue Shield, held before Jared Kosky, Hearing Officer, Paul Lombardo and Kristin Campanelli, at the Insurance Department, 153 Market Street, Hartford, Connecticut, on June 14, 2017, commencing at 9:00 a.m.

HEARING OFFICER KOSKY: Good morning. I would 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.

At the outset I just want to remind everyone that the Department is validating parking tickets to anyone who parked in the Morgan Street garage. That's the garage on the other side of the building on the other side of Market Street. If you haven't already done so, the Department staff stationed at the doors that you entered will help you with that.

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

An administrative hearing such as this

is a regulatory proceeding in which a party, in this instance Anthem Health Plans, Inc. doing business as Anthem Blue Cross and Blue Shield is required to present documentation and arguments regarding their application. Ultimately Commissioner Wade will decide this matter based on a recommendation that I will prepare.

This is not a court proceeding, but it does operate under a system of rules with the presentation of evidence and witnesses who testify under oath. We will have three potential opportunities for public comment at this hearing. First in a couple of minutes there will be a half an hour devoted to public comment with the amount of time for each statement restricted out of respect for the time of everyone here; second, there will be a half-hour period of public comment toward the end of this proceeding for those who wish to make comments; and third, written comment may continue to be submitted up until the close of business of July 1, 2017. Unlike a legislative hearing, there may be times when we need to call a recess.

I would 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 outside the doors of this hearing room, no signs of demonstrations are permitted, and anyone not conforming to these restrictions will be required to leave the proceeding.

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

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

Anthem Health Plans, Inc. doing business as Anthem Blue Cross and Blue Shield will be referred to as Anthem or the Applicant. For the record, Docket Number LH17-70 has been assigned to this matter by the Insurance Department. Connecticut Statute governing this rate application, Connecticut General Statute section 38a-481 provides its rates shall not be excessive, inadequate or unfairly discriminatory. In addition, Section 38a-8 to 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 May 1, 2017 by Anthem concerning premium rates for its individual on and off-exchange plans are excessive, inadequate, or unfairly discriminatory pursuant to Connecticut General Statute Section 38a-481.

This proceeding was commenced on May 1,

2017 when the Applicant filed with the Connecticut Insurance Department, which I will refer to as the Department, a rate application regarding the applicant's individuals rates for on- and off-exchange plans.

While there is no statutory requirement that a rate hearing be held, on May 30, 2017 Commissioner Wade ordered that a public hearing be held on June 14, 2017, to consider the Commissioner granting approval for the proposed application.

As a result of the open enrollment beginning on November 1, 2017, the Federal Government and exchanges, including the Connecticut Exchange, have required that rate filings must be submitted with ample time for them to process the information. Thus, the Connecticut Insurance Department must hold the hearings at this time to comply with those strict deadlines.

A copy of the notice for this public hearing was submitted to the Office of the Secretary of State. In addition, this notice was posted on the Insurance Department's internet website. This notice indicated that the application was available for public inspection at

the Insurance Department and electronically on the Insurance Department's website, and that the Department was accepting written statements concerning the application.

In accordance with the Rules of Practice with 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 at this hearing.

Joining me are Paul Lombardo, Life and Health Actuary, and Attorney Kristin Campanelli, Legal Division Counsel.

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

MR. DURHAM: Good morning, Hearing Officer Kosky. Attorney Mike Durham from Donahue, Durham & Noonan in Guilford on behalf of the Applicant, Anthem Health Plans, Inc.

HEARING OFFICER KOSKY: Thank you, Mr. Durham. For the record I do wish to note that Commissioner Katharine Wade and Deputy Commissioner Timothy Curry are in attendance

today.

At this point I would like to enter into the record a stipulated list of exhibits. The list identifies eight documents which have been stipulated to as full exhibits by the parties to this proceeding. These exhibits include a copy of the rate filing application, and all written public comment received through 9:00 a.m. Monday, June 12, 2017. Subsequent rate and public comments received will be added to the record following this hearing. A copy of the exhibit list will be available to members of the audience today.

On June 12, 2017, a prehearing conference call was held to expedite today's hearing by way of discussing the exhibits, witnesses, and hearing procedures. The first item of business is public comment. Members of the public who have signed up to speak will have the first half hour of this proceeding to orally comment on this 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, and just so

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

MS. MEDINA: We have seven people that have signed in for the general public, and no one for public officials.

HEARING OFFICER KOSKY: Thank you. Again, each person will have three minutes to comment, and we'll begin with any public officials, although there aren't any today. 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 their application. The Insurance Department staff will then be given an opportunity to examine the witnesses. After the examinations have been concluded anyone from the public who did not have an opportunity to speak may make a statement or be heard in the second part of public comment. The public may also present written comments through the close of business of July 1, 2017, by mail or delivery to the Department or by submitting such written comments on line through the Department website.

Again, the public comments portion of

this proceeding will begin with all interested parties. I would ask that anyone interested in proceeding in this portion of the hearing comply with the following guidelines. First, each individual must identify himself or herself for the record, including any organization that he or she represents, and when you do approach, you can just please spell your name for the benefit of our court reporter here today. Second, each individual must address all comments to me. All comments must relate specifically to the rate application that is the subject of today's hearing, and each individual must reasonably limit his or her comments to three minutes. For the public benefit, we are providing a stop watch so that you may organize your comments to fit within the time allotted. The clock is simply meant to help you better plan your statements, and to provide time and opportunity for everyone who wishes to be heard, so please don't feel rushed by the clock.

We will now begin with the first public comment period, and if I can please have the sign-up sheet. We're going to start with Brenda Shipley. Good morning.

MS. SHIPLEY: Good morning. It's B-R-E-N-D-A, S-H-I-P-L-E-Y. Thank you for the opportunity to provide consumer comment regarding Anthem's requested premium rate increase. I'm enrolled in Anthem's Silver PPO Standard Pathway X Plan offered through the AccessHealth Marketplace. I am self-employed, over 50, and have a preexisting condition. I ask that the CID reject Anthem's requested rate increase.

Anthem's average rate increase of 33.8 percent would raise my premium costs from 7,500 to over $10,000 a year for single coverage. Anthem's rate increase of 52.2 percent would raise my premium cost to $11,500 a year. If the annual deductible of $4,000 remains constant, that's an outlay of 14,000 to $16,000 for the privilege of walking around with an ID card in my wallet. The cost of maintaining Anthem's health insurance is second only to the cost of my mortgage payment, and takes a huge disproportionate bite out of my household budget.

Anthem is actively sabotaging AccessHealth by making health insurance unaffordable, and therefore, inaccessible for people that don't work for large employers. If

Connecticut and CID are financially astute about rating gamesmanship, they must reject this rate increase. If Connecticut and CID support the premise of access and affordability, they must reject this rate increase. If Connecticut and CID recognize the toll of the uninsured on the healthcare system and population health, they must reject this rate increase. If Connecticut and CID understand the effect of the uninsured on economic growth, they must reject this rate increase. If Connecticut and CID have a moral compass for principled action, they must reject this rate increase.

It is especially vital that Connecticut through its Insurance Department push back on premium increases this year. Anthem is taking advantage of the people in congress to pray on its marketplace enrollees here in Connecticut.

AccessHealth enrollees are already terrified of the prospects of paying five times higher premiums, losing income based subsidies and being denied access to insurance either outright or indirectly through absorbent premium prices for preexisting conditions. The GOP insists that folks with preexisting conditions don't have to

worry if they have no breaks in coverage, which is why this year in particular Anthem's over-the-top rate request feels like extortion.

Anthem is raising its rates knowing full well if enrollees with preexisting conditions don't continue coverage, they may not be able to get health insurance at all for many years to come.

Anthem would not need premium increases of this magnitude if it didn't go hog wild on executive pay. At the same time health insurance companies are eliminating sick people from their rosters by pricing them out of coverage, they are awarding $30 million annual comp packages to their CEOs and other staff members. If Congress passes the GOP plan, health insurance companies will get more than $70 million a year in givebacks on executive pay compounding this disconnect.

Health insurance premiums in Connecticut are already some of the highest in the country. Anthem's premium rate increase would hit consumer pocketbooks at the very time property taxes are anticipated to increase because of our state's budget crisis, and at the very time job and wage growth in the state remains stagnant. Health

insurance premium increases may very well lead to increased exodus to more affordable states, and our state's political leaders and bureaucrats have utterly failed at economic development while simultaneously failing to rein in unsustainable promises of luxury health care coverage made in backroom deals for state employee unions.

HEARING OFFICER KOSKY: Ms. Shipley, just to save time for everybody, we have a three-minute time limit. You can finish up. I just want to save time for everybody.

MS. SHIPLEY: Okay. Then I will say this. If CID approves Anthem's rate hikes, people no longer able to afford health insurance for themselves will be asked to pay some of the highest taxes in the country so that CID employees and retirees continue to feast on generous helpings of Anthem health coverage at a minuscule fraction of the cost or at no cost. All tax payers should question this disparity, this double standard, this hypocrisy between health insurance costs for CID and other state employees, and health insurance costs for enrollees in the state's health insurance marketplace. Thank you.

HEARING OFFICER KOSKY: Manfred Mohring.

Correct me if I got that wrong.

MR. MOHRING: No, you got it right.

HEARING OFFICER KOSKY: If you can spell your name for the record.

MR. MOHRING: I'm also a card carrying member of the Anthem Medicare Supplement Plan, as I'm retired, so they tell me, although I got three other little jobs just to scrape by and make my house payments, insurance and such. I'm a U.S. citizen, and I immigrated in 1956 from Germany at a pretty well paying job in the computer industry, but with myself working and my wife taking care of family and household and children, I did not have a very large retirement savings. Now, people said, well, you should have saved more for your retirement. How can you when you have three kids, college, bringing them up, probably have about $70,000 savings, but that added to Social Security, which by the way has not increased for three years. It increased last year $12, and Medicare ate that up. Well, I definitely need to reject these increases. It really would be a financial burden. I'm just getting by now, and I work for Milford Adult Education, I work for St. Gabriel's Church in Milford also, of which I

am also a CONECT member of the Milford Adult Education. I mean, of the St. Gabriel's Church in Milford.

Well, anyway, I've talked to lots of people who are in my position, and they thought they would be retired. I'm age 75. They thought -- you know, I thought I would be retired, laying low, visiting relatives, taking care of my grandchildren, but it's not happening, that's a severe increase. That's really bad.

My son lives with us, he's got a part-time job at Southern Connecticut State University, he's developed a few medical problems, and he's on Medicare. He's really terrified with the things Trump is doing, and now with this rate increase. I mean, medical expenses is getting not affordable by people. He went to -- he started interpreting in Germany as an exchange program with Southern Connecticut State University. He got sick there. He went to the doctor, and he said, my finances are wiped out, you know, they told him, you're covered by us, universal healthcare, but you've got to pay your prescriptions. So he went, he got a prescription, he went to buy it, they usually costs him 60, $70,

he paid $12 for them. Compared to other countries, it's horrible.

HEARING OFFICER KOSKY: Just so there's time for everybody, if you can finish up. We have a three-minute time limit, just so there's time for everybody.

MR. MOHRING: These rate increases will sort of return us before Obamacare. Now, my daughter had Crohn's disease before Obamacare, and she had to resign one job and finish her nursing training, and then she tried to get another coverage before Obamacare, you know, things were horrible. She had to pay something like 7, $800 for Crohn's disease. She had to take loans to stay alive. I hate -- this is a little personal. When we visited her she was down to 90 pounds under this type of expensive system, and I have to reject this, I had to, and I felt a -- I thought I could say this, I felt a bulge in her back, and as soon as Obamacare passed she did not have a preexisting conditions anymore, she got new coverage, it saved her life, I have to thank Obama for that.

HEARING OFFICER KOSKY: Thank you, sir.

MR. MOHRING: That's about it.

HEARING OFFICER KOSKY: I appreciate it. Thank you very much, sir.

MR. MOHRING: And I hope Anthem Blue Cross does stay in the state. They're a very good plan, and I've had many positive experience, but you need to cut that back a little bit.

HEARING OFFICER KOSKY: Thank you, sir. Jennifer Lovett.

MS. LOVETT: Hi. Good morning. My name is Jennifer Lovett. I'm the president and CEO of Crystal Financial Services out of South Windsor. I'm also the presidential board member of Health Agents for America. Through the past year, I mean, we worked literally for no money. I actually was working for cookies to make sure my clients were taken care of. My agency has in excess of 10,000 members, many of them through the AccessHealth, and we still continue to service them throughout this year. I know you guys think I'm here to beat you up on commissions, that's not why I'm here. I watched these people go up as far as 48 percent last year. This year they're looking at another 33 percent. Within two years that's 81 percent for those of you that can do math. These people cannot afford it. I have a

lot of people that don't qualify for subsidies. They're the ones that are getting hit the hardest. There's 3 percent of our population here in Connecticut that have qualified for the subsidies, the other percentage does not, and they're the ones that are taking the brunt of these increases, so I'm begging you, please help these people. We get the calls, not you. Thank you.

HEARING OFFICER KOSKY: Thank you. Stephen Hunt.

MR. HUNT: How are you doing? S-T-E-P-H-E-N, H-U-N-T. Like Crystal I also work as an independent insurance agent, so I've been sort of neck deep in this whole thing since it started. I'm going to take a little bit of a different tact from some of other people and point out the fact that we have two remaining carriers in this state, two, ConnectiCare and Anthem. Both of them requested increases of, what, 20 to 40 percent? Both of them requested increases last years of 20 to 40 percent. The year before that it was, oh, yeah, 20 to 40 percent. The bottom line, we'll have a marketplace with no market if you don't allow the carriers to turn a profit. As she pointed out, they stopped paying us this year.

By a show of hands how many people on the Commission could work with no pay at all for a year? Okay, my suggestion, yes, keep the rate increases reasonable, keep them under control, but people have alluded to some things that don't get mentioned a lot. It's the cost of the actual care, not the insurance. The insurance is paralleling what it insures. If you're not going to reduce the actual cost of the prescription, or the test. My wife had an MRI not that long ago, and the gross price was $3,000 reduced to $2,000 by the insurance. Come on, $2,000 for one test, and then we wonder why the premium is high.

We hear about death spirals. Folks, we're already in the death spiral. We're well into the death spiral. The people mentioning preexisting conditions will stay, because even at $10,000 a year, if their $20,000 worth of medications are covered, the insurance carrier is still losing money, but it's the healthy guy that isn't going to do it.

So what I suggest you do is take a look at what reasonable increase is necessary to allow the carriers to turn a reasonable, if limited profit. It would be nice if guys like us could

actually get paid, because we won't be able to enroll people forever indefinitely without being able to earn a living, we'll have to go out and find another job somewhere.

Anthem just dropped out of Ohio. Aetna just dropped out of, what was it, Iowa and Virginia. Okay, one by one these carriers are dropping out. Don't think that they're going to go under, they're not. They're still going to make money on Medicare, they're still going to make money on group healthcare, they're still going to make money on dental. They're just going to drop a losing product line if we don't let them make money.

Insurance is supposed to be the spreading of risk, not the spreading of cost. You buy house insurance in case your house catches on fire, not after your house has caught on fire, and in Connecticut where we mandate coverage for everything under the sun, my personal favorite is sex changes. You can light your house on fire because you don't like the way it's designed, and then you expect somebody else to pay for the rebuild.

If we continue down this path, what

we're going to have is guaranteed access to a marketplace with no product to sell, and when you have no product at all to buy, it's not going to make any difference whether the rate is affordable, unaffordable, pre X's covered, not covered, there's just not going to be anything to buy.

So what I encourage you to do is take a reasonable look at it. Remember, people, ACA limits the profits insurance companies can make. They cannot have more than an 80 percent loss ratio. They cannot be gouging you. Best they could do if everybody worked for free, if nobody was paid, if there was no whatever, and your premium is a thousand dollars a month, it would be $800 a month, they somehow magically did it for nothing. So look at it, be reasonable, do your jobs as a Commission, and hopefully we as a state can get by this. Thank you.

HEARING OFFICER KOSKY: Thank you, sir. Arleen Block.

MS. BLOCK: Good morning. A-R-L-E-E-N, B-L-O-C-K. I'm here to represent my older son who has been working for eight years with two local nonprofit organizations. He's been engaged in

increasingly higher levels of training, be given increasing responsibilities, promotions, excellent evaluations, yet wage increases are barely measurable. His salary still hovers just above the minimum wage. Along with many of his colleagues he works for an hourly wage with limitations on the number of hours he can work. They are capped at 29 hours, and as we all know benefits are required beyond 29 hours.

I am proud to have raised a young man with ethics, he cares about people, and he works hard. He is intelligent and thoughtful, he's careful with the money he earns. It all goes to healthcare, which is his major expense, considering along food, transportation, to get to work, and shelter.

With annual increases of more than 33 percent affording even the affordable healthcare provided by Anthem would be highly burdensome. I'll just stop to say that my son is thrilled that he has insurance, and that Anthem does help pay for his healthcare, which he needs, however, the cost is just prohibitive. We were concerned to find out, first of all, that this hearing is once again being held at a time when my son is working,

he works seven days a week, as he is unable to take time from work to travel to Hartford. He's not alone, his coworkers, my neighbors, our friends, our colleagues, all face the same dilemma. This is particularly difficult on short notice and at a location distant for many people in Southern Connecticut. Thus, I'm here to speak for him.

The high cost of healthcare is an expectation for my husband and myself with the baby boomer generation. Little did we expect that after years of schooling, careers, and hard work we would have to worry about healthcare costs for our children. With salary increases as close to nonexistent for most middle class wage earners, how does an insurance company with hefty profits have the indecency to ask for an average of 33 percent increase in premiums. I just don't understand this.

I am woefully aware of the increase in the cost of medical care, and prescription medications, however, as consumers we are caught between a rock and a hard place as we are told that the cost of prescriptions is high because the insurance companies are working with middlemen who

force them to raise their prices. Questioning excessive costs for a medical procedure or a hospital stay we are told that we have to -- that they have to charge these rates based on appropriate codes for each service or treatment which are set by these insurance companies. As I said, consumers are in the middle. The dollar figures are staggering. A recent routine ambulatory surgical procedure that I had cost $22,000 before the physicians' fees.

I would just like to quote Anthem from their justification for a nearly 34 percent premium increase. I'm just reading from the website. As a Connecticut based company that has done business here for over 75 years, we care about our customers and the community. We share the concerns raised by our members over the rising cost of healthcare services and the corresponding impact they have on premiums, particularly in this challenging economy. We are dedicated to working with our members to find health coverage plans that are the most appropriate, beneficial, and affordable for their needs. We are also committed to driving quality in the healthcare system overall, improving the lives of not only the

members we serve, but also the health communities across Connecticut.

I implore you to reconsider. Think about the faces of each of the people being impacted by your excessive demands. Aren't there other alternatives? Thank you.

HEARING OFFICER KOSKY: Thank you. Garry Malone.

MR. MALONE: Good morning. G-A-R-R-Y, Malone, M-A-L-O-N-E. I'm here to express my concern over these rate hikes. I would like the Commission to reject this rate hike. I don't know of anybody in this room here that's gotten a 33 percent raise at their jobs. I've been working all my life, I'm 58 years old, I have a preexisting condition. Some small business owners in this state, they're on their spouse's insurance where you can own a business, but you have to be on your wife's policy at her job, or you have to be on your husband's policy at his job. A lot of small business owners don't have insurance. I'm self-insured myself. It's like a choking effect with this. The higher the rates go, the smaller the pool.

Now, on my way here this morning I

decided to come here at last minute when I saw this happening, told my boss I've got to go, I've got to leave, I've got to come here, because it's important. Again, the higher the rate, the smaller the pool.

Now, on my way in here this morning I took a drive through Hartford, and believe me, there's people in the housing around Hartford that don't even own cars. There's a lot of people I can see that can't afford insurance. To me if you were to lower the rates, more people would come on board. I don't see why somebody that's not working at 16 or 18 years old can't pay some type of insurance premium. You know, they want people to be on their parents' policy until 25, 26 years old. Why can't they start at a lower rate? Their younger, maybe have a reduced rate. The more people that pay in, the lower the rates will be for everybody. You just can't have -- insurance shouldn't be for the elite. Health insurance should not be for the elite. Again, the bigger the pool, the better it's going to be.

At these rates, you have to have a six-figure job to continue a normal life and be a good responsible consumer and buy goods. You

know, you shouldn't have to get rid of your cable, turn your air conditioners off. I've been working since I've been 16 years old, again, I'm 58. I am a blue collar worker, that's why I'm dressed like I am here to come here and work, and to explain the situation.

Yes, there is a problem with the medicines, the costs of healthcare. It's not all on the insurers. There's some that are ridiculous. The price overruns, the gouging on the medicines, I think we can all agree on that there's a lot of things going wrong with the health insurance system, it's a national problem, but it has an effect right down to your local communities. All of us want to be healthy. I might have to reduce my -- I go to the gym. I might have to just cancel my gym application because I won't be able to afford to go. I go to the gym a lot. Is that something I'm going to have to dump now also? I can't afford to go to the gym to stay healthy? It doesn't make any sense. You know, not everybody makes six figures, and even if you make upwards five figures it's still not enough to continue a normal lifestyle. We don't all want 82-inch TVs, and Cadillacs and

brand new cars. We just want to have a normal life, and these type of rate increases, it's always somebody, the power company, utilities, everything is going up, but our wages don't go up at this capacity, at this rate, there's just no way. I haven't had a 1 percent raise in the last ten years, never mind 33 percent. I do have a preexisting condition, so this stuff is important to myself, I want to continue to be a part of the workforce, I don't want to sit back and watch TV and collect some Social Security, or Medicare. I want to continue to work, because that's what I've done since I've been a kid, work, and that's all I'm asking to do, and have healthcare should I get sick. A lot of us don't choose to get sick, it just happens.

So I would like the board to reject this rate increase, and to take a little bit of time to think about everybody around here, even the little guy, because again, if the rates were lower, more people would do it. You have to have insurance when you get your license, but you don't have to have health insurance? It doesn't make any sense. Sixteen years old you get your driver's license, you've got to be insured, yet health insurance,

which is critical to the nation, you know, anybody can get sick. You have a child with diabetes, some people are sick before they're five years old, cancer, it strikes anybody, leucemia, so we have to look at the big picture, and raising the rates so only the elite can have insurance, we're going to have a mess. Like one of the other gentlemen said, we're in a death spiral. As this continues, the rich get richer, and they have to turn a blind eye to -- really, it's a problem. So I want to thank you for your ear, thank you very much, and I hope we can get to the bottom of this problem, please. Thank you.

HEARING OFFICER KOSKY: Thank you, sir. Marc Block.

MR. BLOCK: My name is Marc, M-A-R-C, Block, B-L-O-C-K. I want to thank you all for allowing me the opportunity to speak. I also wanted to thank Anthem for a number of reasons. First of all, I'm insured by Anthem at my employer, and thank you for allowing me to remain in good health. I also want to thank Anthem for being one of the providers under the Affordable Care Act, and I appreciate the fact that you're taking care of people in the community that have

not been able to get insurance through their employer. Third, I want to thank Anthem for providing insurance to my son pursuant to the ACA. My son works two and three jobs for a nonprofit, and he works from 5:00 in the morning to 9:00 at night, instead of 9:00 to 5:00, and he directs programs that involve promoting health and fitness in children and adults, so he has to be healthy, and I, again, thank Anthem for their contribution to enabling him to be healthy, so I want to start out with that thanks to Anthem.

My message today is simple. We need to keep the premiums affordable as previous speakers have said so we can service our towns and the people who have needs. The rates that are between 20 and over 50 percent averaging at 33 percent are excessive and are really unacceptable. A second message though that I would like to get across is, is there something that the public, patients, and providers can do to try and lower the rates, and a number of the speakers before me have gotten into this.

I assume that the insurance companies are doing something to try and lower the costs of medical care. As we heard, some of the procedures

are somewhat staggering in the costs that they are commanding. Is there some kind of a group that gets together and says, if we did this, care would go down and rates would go down. I think that would be something that would be a very useful thing. Along this line, I would ask, one of the factors that were cited for increased rate hikes is the health insurance tax factor. Presumably someone will explain what that is. I would appreciate knowing what that is, because I didn't follow that in the Anthem description, but I think there are other things that could be -- I think there are things that could be done about looking for preferred suppliers who is providing medications at a more reasonable cost, what are the different costs for getting the same operation at different hospitals, and things of that nature, that if the patients knew about it, could result in a lower care cost and a more efficient healthcare system.

Basically I follow the adage that I should be for myself, but not just for myself. I applaud success, innovation, and reward people for providing services that are needed, and I think that's all part of being good citizens, as you put

in your handbook.

I also want to point out that I am a volunteer in the CONECT organization, but I'm here representing other people who can't be, and not representing them.

I would also like to suggest that maybe some of these meetings could be held at a more convenient time and place, maybe along the 95 corridor where all the major cities are from New London, Stamford and Greenwich, that might make it a little easier for people to attend who might have something to add to this discussion, so again, I thank you for your time.

Just one other thing. Given the fact that ACA and the current state of healthcare is in flux, if this meeting could be suspended instead of adjourned so that when more information comes down from Washington this discussion could be continued, I think that would be a helpful addition. So I thank you all for your time, and I appreciate, again, Anthem and the things that you do in our state. Thank you.

HEARING OFFICER KOSKY: Thank you, Mr. Block. That's going to conclude our first period of public comment. Ms. Medina, I want to

give you the sign-up sheet so people can sign up for the second period.

We're now going begin the period of the applicant's presentation. I would now like counsel for the applicant to identify the individuals who are present and available to testify, and we will have those individuals sworn in.

MR. DURHAM: Thank you, Hearing Officer Kosky. I should say, first off, that also with me as counsel is Attorney John Russo. He's senior associate general counsel for Anthem, and his appearance is in the record, it's Exhibit 6. Mine, as you know, is Exhibit 5.

Anthem will provide testimony from two witnesses today in further support of the actuarial soundness of their application for 2018 rates on the individual market both on and off the exchange. First, Anthem's first witness will be James Augur, who is the regional vice president of sales. After Mr. Augur testifies, Anthem's director of actuarial services for Connecticut, Tu Nguyen, will testify in response to the Department's questions through Mr. Lombardo.

HEARING OFFICER KOSKY: Thank you,

Mr. Durham. Can the court reporter please swear in the Applicant's witnesses.

James Augur and Tu Nguyen, Witnesses, having been first duly sworn by Robin Balletto, RMR, a Notary Public in and for the State of Connecticut, testifies as follows:

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

MR. DURHAM: Yes. The first witness will be Mr. Augur.

MR. AUGUR: Good morning, Hearing Officer Kosky, members of the Department of Insurance, and members of the public. Thank you for the opportunity to be here today. My name, again, is Jim Augur, and I'm here on behalf of the Applicant Anthem Health Plans. I serve as Anthem's regional vice president of sales, and as Mr. Durham said, joining me is Tu Nguyen, Anthem's director of actuarial services here in Connecticut.

Let me start by saying that we appreciate that the Connecticut Insurance

Department's essential task of evaluating rate applications is more complex this year as it is charged in an uncertain environment with ensuring that the rates requested meet the statutory criteria that they be adequate and not excessive or unfairly discriminatory.

A stable insurance market is dependent on products that create value for consumers through the broad spreading of risk and a known set of conditions upon which rates can be developed.

As we are all aware, there are uncertainties that are impacting Anthem's on- and off-exchange individual rate application for 2018. This includes uncertainty about the Federal Government's decision to continue to fund the cost sharing reduction subsidy.

CSR funding is vitally important because it is one of those conditions that helps to promote a more balanced risk pool. Anthem's current filing assumes full funding of the CSR. If the CSR funding is not confirmed, Anthem will need to adjust and refile its pricing to ensure its rates remain adequate as required by the law in light of the changes in the risk pool that are

likely to occur. Even if the funding of the CSR subsidies is confirmed for all of 2018, we have continued to experience increased benefit costs for the individual ACA compliant products, and this reality is reflected in our rate application.

In addition to the usual increases in provider costs and utilization that we see across all insurance markets, we are forecasting that the individual market will continue to shrink, and that those individuals with the greater healthcare needs will be the most likely ones to purchase and retain their coverage thereby accelerating the trend of increased morbidity that this market has seen. This dynamic is driven by a guaranteed issue market with rating constraints and an individual mandate penalty that continues to be far less than the cost of coverage for most individuals. Further, non-benefit expense costs are continuing in 2008 in this rate increase. Absent a change in federal law the ACA's health insurance tax will return in 2018. Premiums must be set to cover this fee, but we can and we will remove those costs in the event that the federal policymakers repeal the tax or extend the current moratorium through 2018. Even with these

overarching uncertainties Anthem is here today to present our 2018 on- and off-exchange individual market rate application.

Anthem is seeking a 33.8 percent average rate increase for its individual market plans which represents about 35,000 policyholders. In short, planning and pricing for ACA compliant health plans has become increasingly difficult due to the shrinking number of participants in the individual market and the corresponding increase in the population's morbidity as well as the uncertainty around the marketplace features, such as the fundings for CSRs that I mentioned.

As noted, Anthem, like all health insurers is required to have rates that are adequate, that are not excessive, or unfairly discriminatory. We take that obligation seriously. Offering products at adequate rates it's critical to ensure market stability and to meet our obligations to our members.

I hope that the information that is presented during this hearing is of assistance to the Department as it reviews Anthem's rate application.

We now welcome any questions the

Department of Insurance might have. Thank you.

HEARING OFFICER KOSKY: Thank you, sir. At this point we're just going to take a five-minute recess. When we return we will begin with the examination of the witnesses by the Department.

(Recess: 9:50 a.m. to 9:57 a.m.)

HEARING OFFICER KOSKY: All right. We're back on the record in the matter of the proposed rate increase application of Anthem. We will start with the examination of the witnesses by the Department. Mr. Lombardo, will you please proceed.

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

We'll start right off the bat. There's factors that affect the rate changes for all plans. I'm going to go through each one of them that you've identified in the filing, and ask you to explain the factor in more detail, and provide on average the effect that that has had on the rate request that you've put forth in the rate filing.

The first one identified is emerging experience is different than what you had projected, so if you can provide a further explanation of what is meant by that, and provide an average impact on the rate increase that you're asking for.

MR. NGUYEN: Definitely. I'm happy to respond to your questions. So for the first driver of the rate increase is the price in collection that we were talking about years to date based on the data we estimate that the medical loss ratios is higher than what we expected of price. The target MOR is setting at 82 percent. We estimate that by year-end the MOR will be roughly 90 percent.

MR. LOMBARDO: So let me just make sure for my sake and everyone else's sake, you had projected -- you're using 2016 experience, and you're taking that experience and you're projecting it forward to 2018, and what you've identified is, is that what you've previously projected for experience to 2017 is not coming in at what you anticipated. Your target for 2017 was 82 percent. What you're estimating your loss ratio will be by the end of 2017 is 90 percent.

MR. NGUYEN: That's correct.

MR. LOMBARDO: Okay. Given the fact that we're not at the end of 2017 yet, can you provide the Department with an estimate year to date of where you thought you would be at this time using 2017 experience and what you had assumed? So the 82 percent was for the entire benefit year of 2017. You're estimating 90 percent for the entire year. Provide us with what you expected based on year-to-date experience.

MR. NGUYEN: We can definitely provide that. Just to give you an example of, in 2016, because right now we already have the data for 2016. But last year at the time we did the rate filings I believe it was running around 89, and then by the time that we had the hearing it went up to 92. By year-end we have the MOR went to 100 percent. So as similar patterns we would expect for 2017 we definitely can provide the data.

MR. LOMBARDO: Right. But you also received rate action for 2017. We would anticipate that that would mitigate some of the 2016 experience, correct?

MR. NGUYEN: That's correct. Without some of the approval rate actions that we had.

MR. LOMBARDO: Right.

MR. NGUYEN: It would be even worse than what we requested, right.

MR. LOMBARDO: Correct. We'll just ask you for what you experienced based upon what was approved for rates for 2017, and what you've already experienced this year, and what you would have expected to experience to this date.

MR. NGUYEN: Yes.

HEARING OFFICER KOSKY: Mr. Nguyen, if you could either speak up or talk a little closer to the mike so the court reporter can pick your voice up. Thank you.

MR. LOMBARDO: The second item is trend. This includes the impact of inflation, provider contracting changes, and increased utilization of services.

If you can provide a little bit more detail as to what trend is and the impact that it's having on the rate increase request.

MR. NGUYEN: Definitely. Trend is basically the increase on cost of care from one year to the next. Within that increase there are utilization increase as well as the unit cost increase. One additional item would be a mix of

services, like, for example, every year you have new services coming in, new technologies. The increase in trend also accounts for that as well.

MR. LOMBARDO: Okay. And approximately what percentage of the rate increase is attributable to the trend factor?

MR. NGUYEN: It's roughly 12 percent.

MR. LOMBARDO: Okay. So between the first two, the emerging experience, what I gathered is, is it's about 8 percent impact on the rate request, and the trend is approximately 12 percent?

MR. NGUYEN: That's correct.

MR. LOMBARDO: So for the first two it's approximately 20 percent of the request that you're asking for.

MR. NGUYEN: That's correct.

MR. LOMBARDO: The third identified is morbidity. There are anticipated changes in the market-wide morbidity of the covered population and the projection period. Can you describe that in more detail, and again, approximately what percentage of the increase?

MR. NGUYEN: That's account for roughly 9 percent.

MR. LOMBARDO: Okay. And if you can provide more detail as to what you mean by the change in morbidity, changes in the market-wide morbidity that's generating this 9 percent.

MR. NGUYEN: Definitely. So when you have a high rate increase that is going up, in this case Anthem requests a 33.8 percent, and the penalties has basically remained at a flat level, so members have to make a decision of if they're going to buy coverage or paying the penalties. Normally in that situation you would have healthy members drop coverage, and then the ones that needs healthcare would buy coverage, and that's where the morbidity factors would get worse and the claims would increase. So in that case Anthem estimates the impact will be roughly 9 percent.

MR. LOMBARDO: Do you have a basis for your estimate of 9 percent? Where do you come up with the 9 percent?

MR. NGUYEN: We did. Actually, we did provide an exhibit in the rate filings, that is Exhibit W. What we did in that exhibit was we provide the cost of care by different members' categories, where healthy members, what are the cost of care for those, and high risk members,

what are the cost of care for those, and then we did our modeling assuming that the ones that are receiving subsidies are most likely going to stay in the risk pool. The ones that do not receive the subsidies, those are the ones who are more likely going to drop out. Particularly the one, the healthy members, those are the ones that more likely would drop out, and when we did the modeling, that was the assumption that we did. We assumed roughly 15 percent of the members would drop coverage.

MR. LOMBARDO: You would assume that 50 percent of those low cost members would drop out?

MR. NGUYEN: That's correct. Fifteen percent.

MR. LOMBARDO: Fifteen percent.

MR. NGUYEN: Yes.

MR. LOMBARDO: We'll get into the Exhibit W a little bit later on in more detail.

MR. NGUYEN: Okay.

MR. LOMBARDO: Thank you. The fourth item on the list, so by my calculations, the first three are the reason for the bulk of the increase that you're asking for, it's about 29 percent now, fairly close to the 33.8 that you're asking for on

average.

Another identifier is benefit modifications including changes made to comply with updated AV requirements. Can you explain that and provide any impact that's related to the increase.

MR. NGUYEN: Definitely. So every year we have to comply with the metal level, such as like gold, silver, and bronze, so every year we have an update to the actuarial calculator. So if the benefits are falling out of the metal level, we have to make sure that we change the benefits, that it meets the requirement. We also make additional benefit changes, like, for example, we have services that cost depending on where the members goes. So what we have the benefit changes, what we call the site of service, where we would have a design that incent the members to go to a low cost and high quality kind of providers, so we make those changes. On average the impact is roughly 2.1 percent.

MR. LOMBARDO: So the impact on the rate increase request at this point is approximately 2 percent or so?

MR. NGUYEN: Right. 2.1 percent

reduction to the rates.

MR. LOMBARDO: 2.1 percent reduction.

MR. NGUYEN: Right.

MR. LOMBARDO: Okay. So we're back to about 27 percent now for the first four, and then the last identified here is changes in taxes, fees, and some non-benefit expenses, including the restatement of the health insurer tax in 2018. So if you can describe all of that in a little bit more detail, and specifically the HIT being reintroduced in 2018, and what impact that has on the rate increase request.

MR. NGUYEN: Definitely. So in 2017 the insurer fees went away, and then in 2018 it's coming back, the reinstatement of that fees is worth 3.8 percent.

MR. LOMBARDO: Okay. There was other identified in the changes, taxes, and fees and non-benefits. Was that the primary driver?

MR. NGUYEN: That's correct. When you do the math, I believe you do the additions.

MR. LOMBARDO: Yes.

MR. NGUYEN: In actuarial terms normally we do multiplication, so that's why when you add it up it does not match to the 33.8 percent.

MR. LOMBARDO: Okay. Can you describe in a little bit more detail what the health insurer tax is.

MR. NGUYEN: Definitely. The insurer fees, that is the federal tax that the carrier has to pay. I believe it's funding some kind of healthcare cost, I couldn't remember for that, but the fees, the intent of that fees is the carrier has to pay, and then that's going to funding some kind of healthcare cost. I don't remember that now.

MR. LOMBARDO: If you could just provide that in your response that we'll ask at the end what it funds.

MR. NGUYEN: Will do.

MR. LOMBARDO: Thank you. Under number six in the rate filing, under projection factors, we're going to ask you to provide the Department with a comparison of average claim PMPMs for members who have left the individual market to members who have remained in the market. So your assumption that 15 percent of your existing population will leave, and you're assuming their PMPM would be the lower PMPMs. We would like to see what actually occurred for Anthem from 2014 to

2015, from 2015 to 2016. So we're going to want to know what people -- now you're suggesting that they're leaving the individual market all together. You're not suggesting that they're just leaving the exchange; is that correct?

MR. NGUYEN: That's correct. Some of the members may switch carriers, but the assumptions that we have is the predominance that we have here is not members switching carriers. We would see the market, the healthy members would drop coverage because of the high rate increase.

MR. LOMBARDO: So it's dropping out of the individual market all together?

MR. NGUYEN: That's correct.

MR. LOMBARDO: So I guess my question is, is that how would you know from 2014 to 2015 and from 2015 to 2016 people who have left completely the individual market? I would understand that you would know who is leaving Anthem from year to year, but how do you know they're actually leaving the market?

MR. NGUYEN: The only things that we can know for sure is the information we do the simulation weekly where they collect the market data, and they did a simulation, so that is the

only available information that we can draw conclusions from.

MR. LOMBARDO: Could you, and I understand you're getting collective market data, but you still don't know who is actually leaving the market?

MR. NGUYEN: That's correct.

MR. LOMBARDO: The assumption you're making is that it's the healthy people that are leaving the market?

MR. NGUYEN: That's correct.

MR. LOMBARDO: Under your assumption.

MR. NGUYEN: Right.

MR. LOMBARDO: But you don't have any data that indicates that the healthy people are leaving the market, correct? Other than this idea that Wakely provides, you know, total market analysis, but do they provide the PMPM of the people who are actually leaving the market in this analysis.

MR. NGUYEN: No, they do not.

MR. LOMBARDO: So could we at least see the PMPM of the people that are leaving Anthem?

MR. NGUYEN: Yes.

MR. LOMBARDO: And not just the

exchange, because obviously you offer products off of the exchange. So this isn't an exchange on and off exchange, because they would be staying in your same risk pool.

MR. NGUYEN: That's correct.

MR. LOMBARDO: Thank you. Within the projection factors there is actual lapse results that you've identified for 2015, 2016, and 2017, at least for the first four months of the calendar year. Again, is this lapse data related to Anthem specifically, so these are people who have left Anthem, lapsed to Anthem, or lapsed out of coverage completely?

MR. NGUYEN: This is the lapse from Anthem experience. We don't know if they switched carriers or they dropped coverage completely.

MR. LOMBARDO: Okay. Now, you've identified that there's some extreme lapsation occurring in 2017. I would argue that it's very, very similar to the lapsation you saw in the first four months if you combine the numbers of 2015. Just to read them in, in 2015 you had approximately 10 percent in January, 9 percent in February, three and a half in March, and three and a half in April. You've seen 15 in January, four

and a half, two, almost three, and three and a half. So if we total those up, it's approximately the same as in 2015, and you're identifying that some of this is a result of the lapsation that you're having to increase your rates. How is this any different than in 2015, and did you recognize that you had to increase rates from 2015 to 2016 for that reason?

MR. NGUYEN: Right. The 2015, the rate increase was a lot lower, I believe. In 2017, that's when we had the high rate increase, and then that accelerated in 2017 -- I mean 2018.

MR. LOMBARDO: So they left in 2015 for a different reason other than the rate increases?

MR. NGUYEN: That's correct.

MR. LOMBARDO: That's your premise. Do you have any idea of why they would have left at this approximately the same level that they're leaving in 2017 in 2015?

MR. NGUYEN: Well, even though you look at the data they are very similar, but if you add them up, there are definitely an increase in lap rates.

MR. LOMBARDO: Thanks. Identified in the paragraph below it says, Increased selective

entry and exit. Can you explain what's meant by increased selective entry and exit?

MR. NGUYEN: So a drop in coverage is the same thing as you buying coverage. Like, for example, when you are healthy you don't have coverage, however, if you know that you have a condition, you definitely would consider, so you selectively would consider coverage if you didn't have it before. The same thing as you have current coverage. If you know you're not going to need health care, and the rate increases are going up so much, and the members themselves have to make a decision economically do they want to buy coverage and keep the coverage, or do they want to drop coverage and pay the penalties, since the penalties are so low compared to the coverage that they have to buy, that's where the selective entry or lapses occur.

MR. LOMBARDO: Thank you. You've explained a weak individual mandate. Can you explain what -- you've identified that as one of the reasons as well. Can you identify what is meant by a weak individual mandate.

MR. NGUYEN: Well, that's what I meant is the premiums are going up so high, and the

penalty remain flat, and that's when the members have to make economically does this make sense for them to keep coverage or drop coverage.

MR. LOMBARDO: Okay. But again, you're assuming that it's the healthier people with the lower PMPM cost structure that are leaving as a result of the low penalty as premiums are increasing, but you don't have data to support that other than a model?

MR. NGUYEN: We only have our data, but we don't have the market's data.

MR. LOMBARDO: Thank you. Can you explain in a little bit more detail why you're assuming that 15 percent of the low claim PMPM people are exiting? How did you come up with the 15 percent in your modeling.

MR. NGUYEN: The 15 percent was based on the data that we provide to the Department year to date, and then we anticipate in 2018, because the premium rates increase are so high, so we do anticipate that going to accelerate in 2018.

MR. LOMBARDO: So I'm just trying to understand, you're using the 15 percent based upon your own lapses, but this is 15 percent leaving the market.

MR. NGUYEN: That's correct.

MR. LOMBARDO: Those are two different things. So you're using the 15 percent lapsing that you're experiencing as a proxy for people leaving the market?

MR. NGUYEN: That's correct.

MR. LOMBARDO: What we're going to ask you to do is run your model assuming that 10 percent of the people lapse and 5 percent of the people lapse, and what that would result, and how that would impact your morbidity adjustment that you filed with the Department.

Within the projection number 6 in the filing you have a bullet, Changes in benefits. Explain the network adjustment and specifically the change in member cost sharing for out-of-network benefits from the experience period to the projection period. You've identified that as well.

MR. NGUYEN: Definitely. So the way that we make adjustments to that is, since we use 2016 data, what we did was we calculate what is the average network and areas impacts for that, and then years to date we have 2017, and then we try to forecast that into 2018, based on that

forecast of membership mix we come up with the average factor for area network. The comparison between those two is the impact to our rates application.

MR. LOMBARDO: Okay. Can you provide for the record what the difference was and the impact that it has?

MR. NGUYEN: Definitely. So for the areas of impact is roughly --

MR. LOMBARDO: If you can just identify the exhibit you're referencing.

MR. NGUYEN: Exhibit D. For areas the impact is .18 percent. For network it's .64 percent.

HEARING OFFICER KOSKY: And just for the public, when the witnesses are referring to Exhibit W, Exhibit D, which they've done, these are exhibits that are contained within the filing that is available for the public to see on our website. Thank you.

MR. LOMBARDO: So in this instance, the idea here is, is that you're anticipating more cost?

MR. NGUYEN: That's correct.

MR. LOMBARDO: From the population that

you're expecting to have in 2018 versus 2016 for the two items that you discussed?

MR. NGUYEN: That's correct.

MR. LOMBARDO: Thank you. Again under other adjustments within that Category 6 in the rate filing.

MR. NGUYEN: There was additional adjustment. The two additional adjustment is age and gender and benefit.

MR. LOMBARDO: Understood. But there's other adjustments under number 6. It's actually a bullet below the normalization.

I would appreciate next time if you number the pages of the rate filing. It would help to reference in the future.

MR. NGUYEN: Definitely.

MR. LOMBARDO: Thanks. It's where you describe change in medical management, induced demand due to CSR and so forth.

MR. NGUYEN: Right. There are additional adjustments that we made, for example, grace periods.

MR. LOMBARDO: Right. I'll get to the questions. I don't need to have an explanation for all of them. If you can explain in more

detail what is meant by medical management.

MR. NGUYEN: Definitely. So medical management, what we do is try to contain the costs. So we do, like, for example, inpatient authorizations. We did some ER cost managements trying to, making sure that members appropriately utilize ER.

MR. LOMBARDO: Okay. How does that compare to a category in your expenses that is stated as quality improvement?

MR. NGUYEN: The quality improvement is more like HEDIS where we have to do reporting to comply with HEDIS and all of that. So the quality is more making sure that members utilize high quality cost of health care.

MR. LOMBARDO: Thank you. If you can explain in a little bit more detail. It's stated in the filing that there's induced demand due to CSR when the experience period already includes the demand related to CSR. So if your base experience in 2016 already includes your estimates of what -- well, it's actual demand, and you know the demand based upon your CSR members, and for everyone here CSR is the cost sharing reduction, it's related to the silver plan, it's the three

plans above the standard silver plan that reduce cost sharing to individuals, and right now the carriers are being reimbursed for that expense from the federal government, and we'll get to the question about the CSR funding in a little bit, but if that's already in the experience, what adjustments -- why do you have to make any adjustments for 2018?

MR. NGUYEN: Right. So in 2016 when we use the data definitely already in the experience, however, you have to project going forward if the changes in the CSR population, if it's occurring or not. If it does, then we have to make adjustments to that.

MR. LOMBARDO: And that's what I thought it was, but in your adjustment, it's an adjustment of less than one, so to me you're assuming a slightly, and it's very, very marginal at best, it's like .99 and goes out to four decimal points, but you're assuming actually better population, slightly miniscule better population in 2018 from 2016. It seems inconsistent with what you've been explaining to us that you're expecting a sicker population in 2018 because of the folks who are lapsing. So maybe if you can explain in a little

bit more detail why that assumption doesn't mean that you're expecting a better population.

MR. NGUYEN: Definitely. Earlier I mentioned about in our modeling who we assume would drop coverage, or who would stay and have healthcare coverage. The members that we see for subsidies, those are the ones that are most likely going to remain because they have the subsidies, so that is one of the reasons why.

MR. LOMBARDO: So the CSR population isn't necessarily changing from 2016 to 2017 -- or 2018?

MR. NGUYEN: Definitely. One of the assumptions that we do, and as you can see in the attachment, it's very small.

MR. LOMBARDO: Yes.

MR. NGUYEN: We do have rate increases. For example, the standard silver plan, that is the most popular plan. We do have lower rate increases than the average.

MR. LOMBARDO: Okay. Thank you. Under the risk adjustment, I think it's number 10 identified in your rate filing, you've identified Healthy CT as having an impact on whether or not they pay the 2016 risk adjustment that you think

they might owe the pool, so we're going to ask you to explain how Healthy CT possibly not paying the 2016 risk adjustment has an impact on Anthem's risk adjustment estimate for 2018, because they're different benefit years. So I'm not quite sure why one would have something to do with the other.

MR. NGUYEN: The only things that we reflect is when we estimate 2016 risk adjustments, we factored that in as one of the -- that we assume that we would not get paid for 2016, and that's what we reflect in our rate filings.

MR. LOMBARDO: Right, but how does it roll into 2018 estimate of risk adjustment? I understand you may not get paid for the 2016 benefit year, but how does that impact the 2018 estimate of risk adjustment?

MR. NGUYEN: For the 2018 risk adjustment it definitely will not have an impact on '18. We just reflect whatever the estimates that we have in 2016.

MR. LOMBARDO: All right. So speaking of that, if we go to Exhibit G. In Exhibit G you were given a CMS preliminary number, I believe that was in March, the end of March of 2017, and I think that reflected nine months of 2016, and the

estimate you were given was $43.13 PMPM. It appears that your independent consultant has provided an estimate of approximately $40, and it looks like you used the $40 instead of the $43 from CMS as your basis to apply a deviation from. Can you explain why you're using the consultant's and not CMS's estimate?

MR. NGUYEN: So far what we did was we compare previous years. The CMS for the PM numbers, which is a final one, we do the same thing with the independent. The independent studies are closer to what the actual numbers that we receive in previous years, so that's what we did. The provision for adverse deviation right now is still in estimates, so it's still very volatile. So whenever we have uncertainties in our estimates, we also have it there a provision for adverse deviation.

MR. LOMBARDO: Thank you. That was my next question, so I appreciate you explaining that.

And just for the record, the Federal Government is going to be issuing their risk adjustment report I believe on June 30, 2017, so we'll have actual data to review as part of this

process when that comes in.

Under Category 11, non-benefit expenses and profit and risk, there's one explanation that inflation impacts the quality improvement expense. You gave a brief description of what is meant by quality improvement, but how does inflation impact that expense component?

MR. NGUYEN: Well, every years, because that expense includes the salary and expense and all that, staff are working on the quality improvement, so definitely there is inflation to that cost.

MR. LOMBARDO: Okay. I would expect your general expenses to have the salaries of the folks that work on things. You're suggesting that for quality improvement the salaries are separated out from your general expenses?

MR. NGUYEN: That's correct.

MR. LOMBARDO: Okay. Thank you for the explanation. It's identified in the filing, again, under that same section, that your on-exchange commissions, I believe they're $5 per member per month, and your off-exchange commissions are $15 per member per month. Can you explain why the significant difference in the

commission paid on exchange versus off exchange? Are you doing anything differently? Are there different services being provided both on or off?

MR. NGUYEN: For on exchange the brokers does not have to do as much work, and Jim can jump in if he would like to.

MR. LOMBARDO: Sure. Please.

MR. AUGUR: Sure. So in evaluating what the brokers do on behalf of the members, we did take into consideration the historical levels of how brokers are compensated. We did make the difficult decision in 2017 to not pay brokers on exchange business, and so we are changing to pay brokers in 2018, and we looked at it, tried to evaluate the work efforts involved, and made that adjustment.

MR. LOMBARDO: Okay. Just for the record, if you could provide us with the different levels of lack of intensity versus intensity, the different types of things that they do, just so that we have support for the difference in the commissions, we would appreciate it.

Under Category 25 in your rate filing, it talks about tiered network benefit plans. Can you explain in more detail what is meant by that,

and also the estimated utilization for Tier I, and the estimated cost savings that you're anticipating seeing for the tier network.

MR. NGUYEN: Definitely. So Anthem tiers the network into three different tiers. Depending on where you go, you will receive a different benefits level. So Tier I is where members can go to, have a high quality provider at low cost, and that's where the members would receive the richest benefits.

MR. LOMBARDO: I'm going to interrupt. When you say low cost, are you talking lower cost sharing?

MR. NGUYEN: No, when I talk -- the cost share, yes, the members would definitely receive richer benefits for low cost share for the members, but at the same time we do have the Tier I network where the providers providing those services also have lower costs.

MR. LOMBARDO: Okay. So it's perceived to be higher quality, lower cost, and also lower cost sharing to the individual if they utilize Tier I?

MR. NGUYEN: That's correct.

MR. LOMBARDO: Do you know what

assumption you're using for the people who do purchase the plans that have the tiered network, what percentage of those people are going to use Tier I?

MR. NGUYEN: I don't have it here. We can definitely provide that information to you.

MR. LOMBARDO: Yes, and if you can provide what utilization of Tier I versus Tier II versus Tier III, it would be appreciated.

MR. NGUYEN: Definitely.

MR. LOMBARDO: And do you have an idea of what it's saving versus if you just had your regular network?

MR. NGUYEN: The savings I would say roughly 4 to 7 percent.

MR. LOMBARDO: Four to 7 percent. And this is not the first year that you're offering the tiered network, or it is?

MR. NGUYEN: That's correct. We did have the tier network last year.

MR. LOMBARDO: Okay. Are you having any problems with people accessing the providers for Tier I? Because if everybody chose this product or this plan, and wanted to use the Tier I providers, have you had any issues with members

not being able to access Tier I providers?

MR. AUGUR: We have not had any customer service issues, but kind of the uptake in this product has been relatively low.

MR. LOMBARDO: Okay. That was the next question. Fairly low membership into it?

MR. AUGUR: Right.

MR. LOMBARDO: Thank you. It appears your retention charge in the filing is 18.8 percent?

MR. NGUYEN: That's correct.

MR. LOMBARDO: From your annual statement it appears that the retention expenses equate to approximately 14.1 percent.

MR. NGUYEN: That's correct.

MR. LOMBARDO: Can you explain the difference between the two?

MR. NGUYEN: Definitely. The one in our STAT filings are basically based on our actual experience. As you're well aware that we lost money in the individual markets. As a result of that, the retention for our STAT filing would be lower than what we have in our rate filings.

MR. LOMBARDO: Because it recognizes a loss?

MR. NGUYEN: Because in the STAT filings the retentions there, the calculation is the claim cost compared to the premiums. In this case because we lost money in individual markets, so that's why the loss ratio is much higher, so when you take one minus the loss ratio, the retention component in the STAT filings would be much lower than what we target in the filing.

MR. LOMBARDO: Right. So it recognizes an underwriting loss essentially?

MR. NGUYEN: That's correct.

MR. LOMBARDO: And that's what you're suggesting is the difference between the two?

MR. NGUYEN: That's correct.

MR. LOMBARDO: Okay. Thank you. If we can turn to Exhibit Q, the trend exhibit. Your trend pick in the filing is approximately 13.4 percent.

MR. NGUYEN: That's correct.

MR. LOMBARDO: If you can provide more detail around that pick. How did you come up with it? Because when I look at the data here on the trend exhibit, and I'll just -- I'll read it off to you, calendar year 2017 and calendar year 2018 are just estimate, so we're just going to stick

with calendar year 2014, '15, and '16 right now, because those are actual data points.

Your pay trend from 2014 to 2015 is approximately 14.3 percent, and from 2015 to 2016 approximately 7.2 percent, and when you combine the two-year average of 2014 to 2016, you come up with approximately 10.7 percent. So I'm not seeing the data that generates the level of trend pick that you chose. So if you can kind of walk me through the data here, and how you got to the 13.4 percent pick.

MR. NGUYEN: Definitely. So what we did was we base on individual experience 2014. When you compare the population in 2014 that you have a new population coming in that do not know how to use, or are not used to buying coverage and all that, so comparing 2014 to '15, there's a lot of noise there. So last year what we did was we based on small group's experience and derived a trend of that.

In 2017, or in our current rates application, what we did was we compared 2016 to 2015. 2015, that's when we have two stable years where we can develop trend of the individual experience, and that's what we did, and then based

on '16 to '15, we forecast, because now we do have years to date 2017, we incorporate that into our trend projection, and then we project into 2018, and that's how we come up with the 13.4 percent.

MR. LOMBARDO: So maybe what would be helpful to better understand that is, if you can take year to date 2017 data and compare it to year to date 2016 data, and compare that to year to date 2015 data, so that we have two years that are more recent than 2014 and 2016, and I asked for something similar on year to date claim PMPMs before. What is your year-to-date experience for 2017? Is it through April?

MR. NGUYEN: Right now we have through April, yes.

MR. LOMBARDO: So what I'm asking for is, is through the first four months of 2017 to provide -- first four months of 2016, first four months of 2015 to provide this exhibit, Exhibit Q.

MR. NGUYEN: Will do.

MR. LOMBARDO: Okay. Thank you. If we can go to Exhibit W. Okay. The first question I have is, is I'm looking at data. What benefit year does this data --

MR. NGUYEN: I believe this is 2016.

MR. LOMBARDO: So this would be for calendar year 2016 data.

MR. NGUYEN: That's correct.

MR. LOMBARDO: Could you provide this same report for 2014 and 2015 calendar year?

MR. NGUYEN: We can definitely do that. Yes, sir.

MR. LOMBARDO: Okay. And as you described before, this Exhibit W is what you're using as a basis for the morbidity adjustment that when the people that leave, you're anticipating that 15 percent of the low claim PMPM people are leaving, which generates the need for almost a 10 percent load for --

MR. NGUYEN: That's correct.

MR. LOMBARDO: And I just have some general questions. Can you maybe describe in more detail, it doesn't matter who answers this, the types of cost savings programs, both utilization management and on the provider cost side that you've implemented, and maybe describe any savings that you're seeing or estimated savings you're seeing that -- you've identified that you're doing the best you can to hold expenses down, if you can describe some of those programs that you're using,

and some of the savings that you're seeing, some things that maybe aren't working and some things that are working.

MR. AUGUR: The first savings opportunity, we talk about collaborating with our providers, and one of the focal points for us has been working with our primary care physicians on a program in which we call Enhanced Personal Healthcare. It is simply trying to move from a pay-for-service to a pay-for-value, and we've contracted with our primary care physicians differently. They are incented to manage folks with chronic care, to reach out, to engage them more in the healthcare system, to identify folks early with disease states, and again, to effectively manage them.

Through this program primary care physicians had extended their hours of operation to avoid things like emergency room utilization, which I'll come back to in a second to talk about another program. We have now about 85 percent of our primary care physicians in this program. Again, it's a program that incents providers to change the way they practice medicine.

We did realize when we introduced this

program a couple of years ago that the opportunity to just simply declare a different state of delivering healthcare was not enough. So we've empowered providers with good data on what our members are experiencing, whether it's pharmacy data, whether it's realtime hospitalizations, and we've also put resources within the provider community to help them practice care a little differently. It's been a popular program. We have seen compliance with preventative care schedules increase, we've seen emergency room utilization decrease. So the program has shown some positive results.

Relative to another program, we introduced a Tele Health program to allow our members access to providers to avoid high cost emergency room costs, and we have seen that the volume has begun to increase in Tele Health services as the general public has become more aware of this as an alternative to expensive emergency room coverage, and those are just a couple of the programs that we've introduced in the more recent period to help members manage their cost of healthcare services.

MR. LOMBARDO: Now, I would anticipate

in some of those programs you've identified that you've seen some positive results. Are you taking those positive results and applying them to your forecasted trend for 2018?

MR. NGUYEN: We do. We do incorporate that.

MR. LOMBARDO: Okay. Can you give us a sense and provide that to us of estimates? It doesn't have to be program by program, but some of the things that you've identified, identify that in your response, and generally how you're applying that to your forecast, because I think what I'm hearing is, is that without those programs, the pick would be higher than 13.4 percent.

MR. NGUYEN: That's correct, and the program that Jim identified not just for this population it's for all Anthem populations.

MR. LOMBARDO: That's great, but we're most --

MR. NGUYEN: That's correct.

MR. LOMBARDO: Specifically about the population of the rate filing is for, so we would want to see that as well.

To the extent there's a shorter open

enrollment period this year for individual market for 2018, there's going to be reportedly stricter special enrollment for 2018 as well. Did you factor any of that into your pricing?

MR. NGUYEN: We did. We did estimate that, and the impacts of that are very small, I would say less than 1 percent of premiums.

MR. LOMBARDO: Less than 1 percent?

MR. NGUYEN: That's correct.

MR. LOMBARDO: If you can get us what, and where specifically that is in the filing, that would be appreciated where it's contained.

MR. NGUYEN: Yes, definitely.

MR. LOMBARDO: The other question I have before I get off of trend is, is historically you've built in 50 basis points or half a percent for volatility in your trend, did you do the same thing this year?

MR. NGUYEN: We did. According to the Actuarial Standard of Practice Number 8, Section 3.4.10, the actuaries should consider when they're doing a projection in their rates development, should consider a provision for adverse deviation, and that's what we did in filings.

MR. LOMBARDO: Thank you. Do you have a

sense of, and it's similar to the tiered network concept, but do you have a sense of what percentage of your membership is using in network versus out of network.

MR. NGUYEN: I don't have it here, but we can definitely provide that.

MR. LOMBARDO: That would be great. Do you have a ballpark of --

MR. AUGUR: It's very high.

MR. LOMBARDO: So that the network, in network versus out of network seems to be working?

MR. AUGUR: Yes.

MR. NGUYEN: That's correct.

MR. LOMBARDO: So if you could get that to us, that would be great. Quality improvement you identified some of the things. Do you have an idea of what the impact is on claims from the quality improvement programs?

MR. NGUYEN: I don't have it here.

MR. LOMBARDO: You can provide that to us, and again, without those quality improvement programs I would anticipate that the premiums would be higher, so if you can just provide us with what that -- I'm assuming it has a positive impact on claim costs, and when I say positive,

reduces claim costs. Okay. That would be great. I have nothing further.

HEARING OFFICER KOSKY: Thank you, Mr. Lombardo. Mr. Durham, do you wish to redirect your witnesses?

MR. DURHAM: No.

HEARING OFFICER KOSKY: We're going to press on to the second portion of public comment, and again, this second portion of public comment is for those who did not have an opportunity to speak during the first period of time. Again, I would ask that anyone participating in this portion of the hearing to again comply with the following guidelines. Each individual must identify himself or herself for the record, including any organization that he or she represents. Each individual must address all comments to me. All comments must relate specifically to this rate application of the insured that is under review by the Department, and again, each individual must reasonably limit his or her time to three minutes, and can I have the sign-up sheet, please? Angela Demello.

MS. DEMELLO: Good morning, everyone.

HEARING OFFICER KOSKY: Still morning.

MS. DEMELLO: I'm grateful for that. Angela Demello, A-N-G-E-L-A, D-E-M-E-L-L-O. I'm a resident of Stratford, Connecticut, health insurance broker and a small business owner for about 25 years. The name of our agency is The Strategies Group. I'm also a leader with CONECT Congregations Organized for a New Connecticut. I serve on their strategy team, and I'm a co-chair on their healthcare plan. Thank you for the opportunity to speak at this hearing.

This hearing represents the fourth year in a row that the Department of Insurance has held rate increase hearings, and while this is a good and important step to what's transparency and public confidence in the process, it also means that for four years in a row insurance companies have asked for increases of 10 percent, or likely 20 percent or more, or greater in Connecticut. We know, however, that family incomes have not been increasing anywhere near this rate, if at all.

This year due to the volatile debate in Washington there is a great deal of uncertainty about the future of the Affordable Care Act and Medicaid. This uncertainty means that a hearing this early in summer is particularly difficult for

companies and consumers to give accurate projections and make informed comments and questions.

We urge the Department to consider a recess in hearings after today rather than adjourn them, and to resume them in late summer or early fall so that companies can give the public and the Department of Insurance the most accurate data and that more of the public can participate in the process where the implications are more clear.

Lastly, as CONECT and others have noted in previous years, we urge the Department to hold future hearings at more convenient times and locations for public participation. Evening sessions at community locations would be more conducive for public participation. We realize this may not be easy for your staff or for the companies themselves, but we believe that this should not be the primary consideration. Due to the early date and time and location of this hearing this year it seems ostensibly that we could have the lowest public participation of the last four years. I'm sure this could be easily remedied if the Department prioritized evening hearings, and on a more personal note I would like

to add my endorsement of Ms. Lovett here and Mr. Hunt here. I'm an insurance advisor, and it is really impossible to work for nothing. We continue to support our AccessHealth clients and clients of the exchange. In fact, AccessHealth is gracious to send us clients, but it's difficult to do it without an income.

I thank you for the opportunity to speak today, and I look forward to hearing some really positive changes. Thank you.

HEARING OFFICER KOSKY: Thank you, ma'am. Tom McCormick. I can't quite read it. If you can please correct me when you come up.

MR. MCCORMICK: Good day. Tom McCormick of West Hartford. I would like to thank the chair for his obvious intelligence and great knowledge of the details of the brief. I would hope someday if you wish a change of hats, you might get yourself out to the Utility Commission where I'm not always seeing such fine displays.

I speak in opposition to any rate hike, any increase, and the rate of return for these gentlemen sitting to the left of me. The insurance, the health insurance industry is a leech sucking the life blood out of the sick of

America. They provide no healthcare. They suck and suck as parasites.

The Affordable Care Act allows these guys over here to take up to 20 percent of every single premium dollar that goes into their building. I've talked to doctors about this at length, they give me different figures, but at least 20 percent of every single dollar that goes into their practice never reaches their personal pocket, nor the nurse's pocket, nor the PA's pocket. It never gets to the person providing the actual healthcare. These people are unproductive, they drain our economy.

Now, and I have to say, I'm a little built disturbed with the Commission in general. I've been before them. Totally worthless, worthless, worthless, even though I have to say the young lady I dealt with was very pleasant, personable, and if I wasn't married, I would ask her out on a date of course.

You said a few things, one issue popped right into my mind. You asked the gentleman about salaries. What do they make? Now, you can make no sound judgement concerning this case if you do not know every single penny that's spent by that

company. You need to look under every doormat. Now, I know what your salary is if I want, don't I? My employees, you, that work for me, work for her, him, we know what your salaries are. Do these people work for us, or do they work for themselves? What special interests are they working for? And if you don't know what they make, you can't make a sound judgment. And it's been obvious to me reading about this Commission, I don't know about you individuals, but let's just say in whole has been totally captured by the insurance industry. You are a regulatory body that has been infiltrated, that you have a Commissioner who is -- has herself firmly rooted in the insurance industry, could come into this building and make decisions about that industry is disgusting, and I would use a whole lot stronger language if it wasn't for this state policeman standing over there, and I am tempted even with him standing there. You know, the Generals from the Pentagon go to Boeing, Lockheed after their done, government consultants, people from Lockheed, Martin Marietta, whatever, they go to the White House back and forth round and round, that should not be going on in the state of

Connecticut regarding the insurance industry. I can only ask you to go up to the Governor's office, to go to the Legislature and announce your plan to cut rates, to cut rates, and to cut rates so these people are no longer in business. They do not deserve to be in business. What do we have, lawyers that used to work for the asbestos industry, the cancer industry, do we have accountants that work for that same firm that was doing, what, Enron's books, oh, I forgot, I forgot, they're not in business anymore.

HEARING OFFICER KOSKY: Mr. McCormick, please wrap up. We have a time limit.

MR. MCCORMICK: Sure. So then you get the basic message. Put these people out of business.

HEARING OFFICER KOSKY: Thank you, sir. Just a reminder everybody, this public comment portion was for those who did not have a chance to speak during the first public comment portion. We still are accepting written comments. Written comments will be open until July 1st of 2017, so if anybody wishes to make any comments specific to the Anthem rate application, again, you can submit written comments to the Department until July 1,

2017. You can either mail them, hand deliver them in, or you can use our internet website to do that. Thank you.

Mr. Durham, would you like to respond to any of the public comments, either specifically or generally, or your witnesses.

MR. DURHAM: No, not at this time.

HEARING OFFICER KOSKY: Mr. Durham -- Mr. Augur, go ahead.

MR. AUGUR: I would like to offer a closing.

HEARING OFFICER KOSKY: I was just going to get to that. At this point the Applicant can make their closing. For purposes of time constraints I'm asking that the closing be no more than five minutes. Thank you very much.

MR. AUGUR: Thank you, Hearing Officer Kosky. On behalf of everyone at Anthem in Connecticut I want to thank the Department for giving us the opportunity today to listen to all of the members of the public who took the time to come and voice their views. We also appreciate the opportunity to provide additional information in detail to support the approval of Anthem's 2018 rates for its individual business on and off the

exchange consistent with the statutory criteria, and this in response to Mr. Lombardo's questions.

Anthem is working to hold down the cost of insurance through, among other efforts, innovative value based partnerships with physicians, hospitals, and other providers, and by providing members with tools that allow them to make informed decisions about their health and their healthcare.

For the reasons noted in my opening comments, despite these concerted efforts the cost of healthcare services and the use of those services continues to outpace premium increases necessitating the file rate adjustments to ultimately foster long-term stability.

Continued increases in the covered populations' morbidity and uncertainties around conditions designed to promote a balanced risk pool create a healthcare climate that is extraordinarily challenging and places the stability of the Connecticut Exchange and the entire individual market at risk.

Though higher than Anthem would want, the individual rate developed for 2018 is actuarially sound and adequate under the law.

Respectfully, Anthem requests that its 2018 rate be approved as submitted and supported by its application. Thank you again.

HEARING OFFICER KOSKY: Thank you, sir. Are there any further questions from the Department?

MR. LOMBARDO: I do have one last one. You identified that you would have to refile your rates if the CSR funding goes away. I believe you identified what you anticipate approximately what that impact would have on the rates within your rate filing. For the record, can you identify what that potential rate impact would be if the CSR funding was not there?

MR. NGUYEN: I would say roughly 20 percent.

HEARING OFFICER KOSKY: Just hit your mike again, and please answer the question again.

MR. NGUYEN: I'm sorry. I would say the impact if the funding is not there for the CSR, the impact would be roughly 20 percent.

MR. LOMBARDO: And that would be 20 percent on the standard silver plan or 20 percent overall.

MR. NGUYEN: That would be the overall,

but that is a good question where the most impacts would be the standard silver plan or the silver plan on exchange.

HEARING OFFICER KOSKY: Any further questions for the Department?

MS. CAMPANELLI: No questions, but at this time I would like to request a five-minute recess.

HEARING OFFICER KOSKY: At this time we'll take a five-minute recess. I would ask everybody to stay where you are. It shouldn't take too long. We just need to go over some of the requests we made to the company, and make sure we have the information accurate.

(Recess: 11:04 a.m. to 11:10 a.m.)

HEARING OFFICER KOSKY: We're back on the record in the matter of the proposed rate increase of Anthem. Mr. Lombardo, please proceed.

MR. LOMBARDO: Thank you. For the record we're going to read in the requests that we have of Anthem that we believe we've asked throughout. If you have any questions about those requests, now is the time to ask.

We've asked you to provide your experience for the year to date on an MLR basis

for 2017, and the same period of time for 2016.

MR. DURHAM: And was that January through April, was that the time?

MR. LOMBARDO: I think during the course you identified that those are -- your year to date is through April of 2017. So it would be for the first four months of 2017, for the first four months of 2016, and it would be your earned premium and incurred claims for that period of time. That was in connection with your estimate that your loss ratio for 2017 would be approximately 90 percent versus you pricing 82 percent for it. So that was the basis for the question.

MR. NGUYEN: Right. The 90 percent was the year-end projection.

MR. LOMBARDO: Yes, for 2017, correct, and since you don't have that, we want to see what your first four months of 2017 is compared to what your first four months of 2016 is as well, what you expected for 2017 as well. Okay?

MR. NGUYEN: Definitely.

MR. LOMBARDO: Your morbidity adjustment of approximately 10 percent, you assumed 15 percent of the low claim PMPM people were -- would

be leaving the market. We've asked you to run that same model with 10 percent of that cohort, and 5 percent of that cohort.

Okay. We're going to be asking you to provide your risk adjustment for 2016 from the risk adjustment report that comes out from the Feds on June 30th of 2017. We've also asked you to provide supporting documentation for the difference in the commissions you assume between on and off exchange.

We've also asked for the historical utilization of your Tier I, Tier II and Tier III. I know you've only had it in place for one year, but what you've seen so far and what you're assuming for the 2018 benefit period.

As it relates to the trend, we've asked you to provide that Exhibit Q for the first four months of 2017, first four months of 2016, first four months of 2015.

We've asked for Exhibit W to be generated for calendar year 2014 as well as calendar year 2015, or benefit year 2014 and benefit year 2015.

You've identified the shorter enrollment period and the stricter application of special

enrollments was approximately less than 1 percent, but you were going to identify what that was and where it is in the filing.

You're also going to identify over your risk pool what percentage of your members use in network versus out of network, and that would be maybe for 2015 and 2016, if you have that data, at least for 2016.

And you were also going to provide the impact, the positive impact on claim costs for your quality improvement programs. That was the summary that we had that we believe we asked during the rate hearing process.

HEARING OFFICER KOSKY: Thank you, Mr. Lombardo. So in accordance with Section 38a-8-40 of the regulations of Connecticut state agencies I'm ordering the applicant to submit the items identified by Mr. Lombardo to the Department by July 5, 2017.

The record of this hearing will be held open for further written comment, as I explained earlier, which may be submitted to the Department until the close of business July 1, 2017. The record of this hearing will close July 5, 2017, with those additional documents due by that day,

and to remind everyone again, if you parked in the Morgan Street garage, we will validate for you at the lobby. Today's hearing is adjourned. Thank you.

(Hearing adjourned at 11:16 a.m.)

CERTIFICATE OF REPORTER

I Hereby certify that the foregoing 93 pages are a complete and accurate computer-aided transcription of my original stenotype notes taken in the Matter of: THE PROPOSED RATE INCREASE APPLICATION OF ANTHEM HEALTH PLANS, INC. D/B/A ANTHEM BLUE CROSS AND BLUE SHIELD, which was held before Jared T. Kosky, Hearing Officer, Paul Lombardo and Kristin Campanelli at the Insurance Department, 153 Market Street, Hartford, Connecticut, commencing at 9:00 a.m. on June 14, 2017.

Robin Balletto

Robin Balletto, RMR

Notary Public

My commission expires: October 31, 2018