STATE OF CONNECTICUT

INSURANCE DEPARTMENT

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In the Matter of:

THE PROPOSED RATE INCREASE APPLICATION OF ANTHEM BLUE CROSS AND BLUE SHIELD

Docket No. LH14-155

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ORDER

I, Thomas B. Leonardi, Insurance Commissioner of the State of Connecticut, having attended the entire hearing in the above captioned matter, do hereby adopt the findings and recommendations of Paul Lombardo, Hearing Officer, which are contained in the attached Proposed Final Decision, and issue the following orders, TO WIT:

1. The rate application filed by Anthem Blue Cross and Blue Shield ("Anthem") to be effective January 1, 2015 for individual on and off Exchange health insurance products are excessive and are disapproved in accordance with Conn. Gen. Stat. §38a-481.

2. Anthem is authorized to submit revised rates for review and they shall be approved if the Commissioner finds them to be consistent with the recommendations as set forth in the Proposed Final Decision issued by Paul Lombardo, Hearing Officer, on July 22, 2014. The recommended rates are deemed to be actuarially sound, and are adequate, not

excessive and not unfairly discriminatory in accordance with Conn. Gen. Stat.§38a-481. Anthem will recalculate the rates using the recommended rate assumptions with an effective date of January 1, 2015 and submit a revised rate filing to the Insurance Department no later than August 31, 2014 to enable adequate notice to be issued to policyholders.

Assumption	Current	Revised
Age/Gender Avg. Claim Factor (Future)	1.1439	1.1182
Annualized Trend	8.42%	7.67%
Grace Period	1.0038	1.0000
Net Reinsurance Recoveries	-$32.60	-$72.40

Dated at Hartford, Connecticut, this 25th day of July, 2014.

Thomas B. Leonardi
Insurance Commissioner

STATE OF CONNECTICUT

INSURANCE DEPARTMENT

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In the Matter of:

THE PROPOSED RATE INCREASE APPLICATION OF ANTHEM BLUE CROSS AND BLUE SHIELD

Docket No. LH14-155

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PROPOSED FINAL DECISION

I. INTRODUCTON

On May 30, 2014, Anthem Blue Cross and Blue Shield ("Anthem" or "Applicant"), filed a rate increase application regarding individual health insurance policies ("Application") with the Connecticut Insurance Department ("Department") pursuant to Conn. Gen. Stat. §38a-481. Although there is no statutory requirement that a rate hearing be held, on June 11, 2014, Insurance Commissioner Thomas B. Leonardi ("Commissioner") issued a notice of public hearing. The Commissioner ordered that a public hearing be held on June 27, 2014 concerning the application for approval of the proposed rate increases for individual health insurance products.

A copy of the notice for the public hearing was filed with the Office of the Secretary of State on June 23, 2014 and was published on the Department's Internet website. The notice indicated that the Application was available for public inspection at the Department, and that the Department was accepting written statements concerning

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the Application. In accordance with Conn. Agencies Regs. §38a-8-48, the Applicant was designated as a party to this proceeding.

On June 11, 2014, the Commissioner appointed the undersigned to serve as Hearing Officer in this proceeding.

On June 19, 2014, the Office of the Attorney General Office timely filed a Petition to Intervene on behalf of the Healthcare Advocate ("OHA"). The Petition was timely served by electronic mail to the Applicant and the Commissioner.

Petitioner OHA asserted her interests in intervening was to represent consumers and ensure that consumer concerns were heard and considered and to ensure a fair and complete adjudication of the rate approval process.

The Applicant did not object to the Petition to Intervene but did raise objections to scope of intervention and sought to limit the OHA's participation to representing and facilitating consumer concerns.

The OHA submitted a Petition that was deficient in both form and substance pursuant to Conn. General Statutes §4-177a or Conn. Agencies Regs. §38a-8-48(c). The OHA Petition failed to cite any statutory or regulatory basis upon which it sought intervenor status. The Petition failed to seek intervenor status pursuant to Conn. Agencies Regs. Sections 38a-8-48 and 38a-8-49 or Conn. General Statutes §4-177a which establish the standards for being designated as an intervenor in an administrative proceeding. Rather, it asserted the right of the OHA to intervene based primarily on a letter issued by the Commissioner on August 1, 2011 ("Letter") in which the Commissioner provides the OHA has a right to request a hearing for rate increases of 15% or more. The referenced Letter, however, merely confers a right to request a

hearing; it does not grant legal status as an intervenor nor does it establish the scope of the participation if the intervenor status is granted. In fact, as the OHA Petition itself indicated, the Letter specifically requires that any hearing called will be conducted in accordance with the Uniform Administrative Procedure Act (Chapter 54 of the General Statutes) which sets forth in Conn. Gen. Stat.§4-177a(b) the procedural requirements for seeking and obtaining intervenor status. The Petition further asserted the right of the OHA to intervene based upon a Superior Court grant of intervenor status to the OHA in an unrelated judicial matter which bore no resemblance to the captioned proceeding and claimed that based on its statutory responsibilities, which were incorrectly referenced and cited, the OHA should be granted intervenor status to facilitate public comment and to ensure fair and complete adjudication of the rate approval process as it related to the Anthem application.

The Petitioner did not present facts demonstrating her proposed intervention would advance the interests of justice and not impair the orderly conduct of the proceedings. The OHA pled no facts demonstrating that the Commissioner was incapable of discharging his statutory obligation to review rates and determine whether the Application should be approved nor did the OHA claim to possess any particular actuarial expertise which would benefit an actuarially based rate review or enable her to ensure fair and complete adjudication of the rate approval process. Neither did the OHA plead facts demonstrating that consumers lack the ability to communicate concerns relating to rate review and proposed rate increases directly to the Insurance Department as part of the normal course of business. The Insurance Department posts all health insurance rate filings and related communications on its website. A public

comment period is provided during which the public may comment on the rate filing directly to the Insurance Department. Prior to the date the Commissioner called for the captioned proceeding, approximately 140 comments had been received from the public relating to the Application demonstrating that the public was clearly able to make their views known to the Insurance Department relating to the Anthem Application. In addition, the ability of consumers to voice their concerns was well provided for in the proceeding. The Public Notice issued by the Commissioner on June 11, 2014 clearly stated that "The hearing will include a period devoted exclusively to public comment" and also provided for written comment to be submitted.

In spite of the statutory and regulatory deficiencies, there being no objection from the Applicant and in recognition that this hearing was not being held pursuant to any statutory requirement, but rather upon the discretion of the Commissioner and in the public interest, the OHA was granted intervenor status subject to specified limitations. The specific limitations imposed upon the Intervenor were:

1. The Office of Healthcare Advocate was granted intervenor status to:
    a. provide information to the Insurance Department related to the problems and concerns of consumers relevant to the specific Application at issue;
    b. make recommendations to the Department relevant to the specific Application at issue.
    c. facilitate public comment directly related to the Application
2. The Office of Healthcare Advocate was permitted to introduce evidence, examine and cross examine witnesses within the above scope limitations.

On June 25, 2014, the Applicant filed objections to two proposed exhibits the Intervenor submitted to be introduced into the record and to one of the Intervenor's proposed witnesses, Philip J. Bieluch ("Bieluch"). The objections relating to the exhibits were denied on June 26, 2014; decision on the witness objection was reserved to enable the undersigned to weigh the qualifications of the witness and the testimony offered by the witness.

On June 27, 2014, the public hearing on the Application was held before the undersigned. The following individuals testified at the public hearing on behalf of the Applicant: James Augur, Regional Vice-President Sales, Anthem Blue Cross and Blue Shield and Michael Bears, Regional Vice President and Actuary III. Michael G. Durham of Donahue, Durham & Noonan, P.C. and John M. Russo, Esq., of Anthem Blue Cross and Blue Shield of Connecticut represented the Applicant.

The following Department staff participated in the public hearing: Beth Cook, Counsel; and James Perras, Counsel.

Victoria L. Veltri, Esq. Office of Healthcare Advocate; Charles Hulin, Esq., Office of the Attorney General; Robert Clark, Esq., Office of the Attorney General; Thomas P. Ryan, Esq., Office of the Attorney General represented the OHA. Richard M Cozart, an Anthem individual policyholder who purchased his policy through Access Health CT testified as a witness for the OHA. Philip J. Bieluch, FSA, MAAA, FCA, an Anthem individual policyholder who purchased his policy through Access Health CT, was offered and testified as an expert health rate making/review actuarial witness.

Pursuant to the published hearing notice, the public was given an opportunity to speak at the hearing or to submit written comments on the Application with respect to

the issues to be considered by the Commissioner. Apart from the parties involved in the hearing, the Insurance Commissioner, Deputy Insurance Commissioner, the Insurance Department Director of the Life and Health Division and 48 people attended the hearing. Thirty four of the 48 were media (12), lobbyists (2), cornpetitors (10), law firms/medical societies (5), or state or federal government support staff (5). Of the 14 public attendees, 12 people were affiliated with five different special interest/advocacy groups with one of the groups having eight attendees; the unaffiliated general public was represented by one couple speaking about Anthem service problems on behalf of their son.

Six members of the public provided oral comments relating to service issues, provider contracting, and provider reimbursement as concerns causing them to raise objections to the proposed rates during the initial public comment portion of the hearing; no public official testified. Three of the six members of the public who testified orally provided written comments to the Department that were entered into the record; one additional public comment related to physician reimbursement and network adequacy concerns was received from a medical society which did not orally testify. No public comment was offered during a second oral public comment period.

Anthem was ordered to submit supplemental information and the record of the hearing was left open until 4 p.m. on July 3, 2014. Anthem timely submitted the supplemental information on July 3, 2014 and the record was closed.

All materials submitted in this proceeding, including copies of the public comment, a written transcript of the hearing, and a link to the recorded broadcast of the

hearing have been posted to the Insurance Department website at http://www.ct.gov/cid/cwp/view.asp?Q=547184&A=4059

II. FINDINGS OF FACT

After reviewing the exhibits entered into the record of this proceeding, the testimony of the witnesses, and utilizing the experience, technical competence and specialized knowledge of the Department, the undersigned makes the following findings of fact:

1. On May 30, 2014, Anthem electronically filed a rate application requesting the following increases/decreases effective 1/1/2015:

	% Change
Anthem HMO Catastrophic Pathway X Enhanced 6600/0%	-4.80%
Anthem HMO Bronze Pathway X Enhanced 0% for HSA	7.41%
Anthem HMO Bronze Pathway X Enhanced 5750/0%	16.29%
Anthem HMO Gold Pathway X Enhanced 1500/0%	17.38%
Anthem PPO Bronze Standard Pathway X 5000/40%	4.39%
Anthem PPO Bronze Standard Pathway X 0% for HSA	n/a
Anthem PPO Silver Standard Pathway X 2600	13.77%
Anthem PPO Silver Pathway X 3200/0%	13.47%
Anthem PPO Gold Standard Pathway X 1000	14.29%
Anthem Blue Cross Blue Shield HMO Multi State Plan	n/a
Anthem Blue Cross Blue Shield PPO Multi State Plan	n/a
Anthem HMO Catastrophic BlueCare 6600/0%	-3.40%
Anthem HMO BlueCare 0% for HSA	9.46%

Anthem HMO BlueCare 0% for HSA	8.88%
Anthem HMO BlueCare 5500/0%	15.99%
Anthem HMO BlueCare 6000/0%	6.96%
Anthem HMO BlueCare 0% for HSA	11.46%
Anthem HMO BlueCare 3000/0%	16.56%
Anthem HMO BlueCare 1500/0%	15.22%
Anthem PPO Century Preferred 20% for HSA	n/a
Anthem HMO BlueCare 3500/0%	10.66%
Anthem PPO Century Preferred 2750/20%	n/a
Anthem PPO Century Preferred 2500/20%	n/a
Anthem HMO Pathway X Enhanced 1850/0%	n/a

2. The average proposed rate increase is 12.5%. Factors that affect the proposed rate increase for all plans include:

   - Anticipated changes in the market-wide morbidity of the covered population in the projection period
   - Changing trends in medical costs and utilization and other cost of care impacts
   - Changes in benefit design
   - Anticipated changes due to network contracting
   - Anticipated changes in payments from and contributions to the Federal Transitional Reinsurance Program
   - Changes in taxes, fees, and other non-benefit expenses

3. Although rates are based on the same single risk pool of experience, proposed rate increases vary by plan from -4.8% to 17.4%. Factors that affect the variation in the proposed rate increase by plan include:

   - Changes in benefit design that vary by plan

- Changes in the adjustment factor for Catastrophic eligibility
- Changes in Non-Benefit Expenses that are applied on a PMPM basis
- Changes in the underlying area rating factors

4. Description of How the Base Rate is Developed:

   The methodology used to develop the rates this year is consistent with the methodology that was used last year. A description of the methodology used to determine the base rate is as follows:

   - Historical Individual experience is not considered representative of the future market; therefore, the manual rates are developed based on Small Group experience.
   - The experience data is normalized to reflect anticipated changes in age/gender, area/network and benefit plan from the experience period to the projection period based on expected distribution of membership.
   - The projected claims cost is calculated by adjusting the normalized claims for the impact of benefit changes such as population morbidity, trend factors, etc. Adjustment is not based on the health status of the member.
   - The projection period is January 1, 2015 - December 31, 2015.
   - Adjustments for risk adjustment and reinsurance are applied to the projected claims cost.
   - Non-benefit expenses, profit, and risk are applied to the projected claims cost to determine the required projection period premium.
   - The projection period premium is adjusted by the average rating factors in the projection period to determine the base rate.
   - The base rate represents an average benefit plan and area for an age 21 member in Connecticut.

5. Source and Appropriateness of Experience Data Used

   - Historical Individual experience is not considered representative of the 2015 market environment due to ACA requirements of guarantee issue, EHB, minimum actuarial value constraints, and other mandate changes. Historical Small Group experience is more reflective of the 2015 population since Small Group business is already guarantee issue with no medical underwriting, and

benefit designs are closer to the 2015 ACA requirements. Therefore, Anthem is using Small Group experience to develop manual rates.

- The source data underlying the development of the manual rate consists of claims for Small Group business, incurred during the period January 1, 2013 – December 31, 2013. Completion factors are then calculated to reflect additional months of run-out after December 31, 2013 and are adjusted to reflect actual experience through March 31, 2014. Anthem expects a large portion of the Grandfathered policyholders to migrate to ACA-compliant policies prior to and during the projection period.

- In developing rates effective January 1, 2015, only limited 2014 experience is available. This experience is not deemed credible for purposes of rate development.

6. Adjustments made to the Data

Changes in Demographics

- The source data was normalized to reflect anticipated changes in age/gender, area, network, and benefit plan from the experience period to the projection period. The purpose of these factors is to adjust current experience to be reflective of expected claim experience in the projection period.

Changes in Benefits

- Claims are adjusted for 100% coverage of benefits for specific over the counter drugs obtained with a prescription from a physician.

- The claims are adjusted for differences in the Rx formulary and the impact of moving drugs into different tiers in the projection period relative to what is reflected in the base experience data.

Changes in the Morbidity of the Population Insured

- Higher morbidity expected from individual-level purchasing decisions in 2015: Anthem assumes that the morbidity of the smallest groups, sizes 2 – 5 members, relative to the total small group population are a reasonable approximation for the health status of the individual market. Relative morbidity by group size is based on health status determined from internal risk score data.

- Higher morbidity of the uninsured compared to the insured population: This adjustment is based on a CDC study on the health status and life styles of both currently insured and uninsured populations. This adjustment also considers the expected number of previously uninsured individuals expected to move into the Individual market in 2015.

- Pent-up demand: As previously uninsured individuals obtain insurance in 2015, Anthem expects them to have some pent-up demand for health care services. An

adjustment is needed to account for this additional utilization of health care services in year one. Previously uninsured individuals are assumed to utilize more health care services due to pent-up demand. Currently insured members are assumed to have no pent-up demand for health care services in year one.

7. Anthem's goal is to price to the average risk of the 2015 ACA market. Since Anthem-specific 2013 experience was used as a starting point, they adjusted this experience to be more consistent with the overall 2013 market in Connecticut. Wakely Consulting collected demographic and risk information from carriers, and calculated Anthem's relative risk to the market for 2013. We have adjusted our starting experience using the results of that survey.

8. The annual pricing trend used in the development of the rates is 8.4%. The trend is developed by normalizing historical benefit expense for changes in the underlying population and known cost drivers, and the result is projected forward using regression analysis. The trend includes a volatility provision in accordance with Actuarial Standards of Practice. The claims are trended 24 months from the midpoint of the experience period, which is July 1, 2013, to the midpoint of the projection period, which is July 1, 2015.

9. Projected trends include the estimated cost during 2014 and 2015 of the pharmaceutical Sovaldi and other high-cost drugs for treating Hepatitis C. These cost estimates were based on claims experience for Connecticut Individual business, together with CDC recommendations and Industry and Enterprise data. This drug will impact few members but an extremely high cost. The trend projection includes an increase of 54 basis points for the 2014 trend and 123 basis points for the 2015 trend.

10. Normalized Unit Cost Data on a Paid Basis:

	2010	2011	2012	2013
Inpatient	$3,229.39	$3,369.11	$3,559.74	$3,734.39
Outpatient	$587.61	$655.43	$731.71	$808.52
Professional	$149.43	$154.82	$154.78	$157.44
Pharmacy	$73.00	$80.64	$86.48	$93.02

11. Normalized Utilization Data (per thousand members):

	2010	2011	2012	2013
Inpatient	24.9	23.5	23.5	23.2
Outpatient	135.0	136.5	136.8	138.9
Professional	891.7	875.9	881.6	892.5
Pharmacy	1,037.1	1,063.3	1,063.9	1,089.9

12. Paid PMPM:

	2010	2011	2012	2013
Inpatient	$80.28	$79.02	$83.79	$86.60
Outpatient	$79.34	$89.49	$100.07	$112.31
Professional	$133.25	$135.61	$136.45	$140.51
Pharmacy	$75.70	$85.75	$92.01	$101.38
Total	$368.58	$389.87	$412.32	$440.81

13. Paid Trend:

	2011/ 2010	2012/ 2011	2013/ 2012
Inpatient	-1.6%	6.0%	3.4%
Outpatient	12.8%	11.8%	12.2%
Professional	1.8%	0.6%	3.0%
Pharmacy	13.3%	7.3%	10.2%
Total	5.8%	5.8%	6.9%

14. Anthem's Estimated Paid trend in 2014 and 2015:

	2014/ 2013	2015/ 2014
Inpatient	4.5%	4.5%
Outpatient	8.5%	8.0%
Professional	3.2%	3.3%
Pharmacy	17.1%	21.3%
Total	8.0%	9.2%

15. Experience in the individual market (for illustrative purposes only):

CY	Earned Premium	Incurred Claims	Loss Ratio
2010	$204,923,165	$154,502,368	75.40%
2011	$196,371,650	$167,891,893	85.50%
2012	$188,970,213	$174,831,196	92.52%
2013	$187,458,882	$170,499,455	90.95%
Total	$777,723,910	$667,724,912	85.86%

16. Other Cost of Care Impacts:

- Induced Demand Due to Cost Share Reductions: Individuals below 250% Federal Poverty Level who enroll in silver plans On-Exchange will be eligible for

cost share reductions. As a result, the base period experience is adjusted to account for the higher anticipated utilization levels by a factor of 1.0133.

- Adjustment to align Anthem claims experience with benchmark plans established for Connecticut.

- Grace Period: The base period experience is adjusted upward to account for some incidence of enrollees not paying premiums due during the first month of the 90-day grace period when the QHP is liable for paying claims. Anthem is assuming a 15% rate of premium non-payment on one-twelfth of the annual premium due for 60% of the Individual population (those eligible for Advance Payments of a Premium Tax Credit). The amount of premium at risk is only on the portion that Anthem does not receive via direct subsidy, estimated to be about 50%. These assumptions result in an upward adjustment to the base rate of 0.375% (0.15 x 0.60 x 50% x 1/12 = 0.00375).

- Utilization or cost-per-service change: anticipated changes are reflected in the morbidity changes and trend.

- Change in Medical Management: medical management savings not already included in the claims experience and trend and is estimated at a factor of 0.9878.

17. Other Claim Adjustments:

    - Rx Rebates: The projected claims cost is adjusted to reflect anticipated Rx rebates. These projections take into account the most up-to-date information regarding anticipated rebate contracts, drug prices, anticipated price inflation, and upcoming patent expirations and is estimated at $7.60 per member per month (pmpm).

    - The cost of adding benefits for pediatric dental and vision are included and estimated at $3.45 pmpm.

18. The Risk Adjustment program transfers funds from lower risk plans to higher risk plans in the Non-Grandfathered Individual and Small Group market. The HHS operated Risk Adjustment program is supported by a user fee of $0.08 pmpm.

19. Anthem is assuming the risk for the plans in this filing are no better or worse than other plans in the market, resulting in no estimated risk transfer value.

20. The transitional reinsurance risk mitigation program collects funds from all insurance issuers and TPAs and redistributes them to high cost claimants in the Non-Grandfathered Individual market. The reinsurance contribution is equal to the national per capita reinsurance contribution rate and for 2015 it is $3.67 pmpm.

21. The reinsurance payment is developed using projected paid claims, claim probability distribution, and reinsurance payment guidelines. The claim probability distribution observes claims between $70K and $250K using a claim probability distribution that reflects the anticipated claim cost distribution of the 2015 Individual market. The coinsurance rate is 50%. Expected paid claims are calculated for an assumed average On-Exchange plan design. Reinsurance payments are allocated proportionally by plan premiums to all plans in the risk pool. CMS has announced an intention to modify the reinsurance program for 2015 by adjusting the attachment point and coinsurance rate. However, we do not expect this to change our projection of the total reinsurance payment, because the total funding available for the reinsurance program is not proposed to change. Anthems expected receipt from the reinsurance program is $36.35 pmpm.

22. Administrative Expense contains both acquisition costs associated with the production of new business through non-broker distribution channels (direct, telesales, etc) as well as maintenance costs associated with ongoing costs for the administration of the business. Acquisition costs are projected using historical cost per member sold amounts applied to future sales estimates. Maintenance costs are projected for 2015 based on 2013 actual expenses, with adjustments for expected changes in business operations including the elimination of underwriting offset by new expenses for risk management, regulatory compliance and premium reconciliation and balancing. Anthem included $46.83 pmpm for administrative expenses.

23. Taxes and Fees:

- Patient-Centered Outcomes Research Institute (PCORI) Fee: The PCORI fee is a federally-mandated fee designed to help fund the Patient-Centered Outcomes Research Trust Fund. For plan years ending before October 1, 2014, the fee is $2 per member per year. Thereafter, for every plan year ending before October 1, 2019, the fee will increase by the percentage increase in National Healthcare Expenditures.

- ACA Insurer Fee: The health insurance industry will be assessed a permanent fee, based on market share of net premium, which is not tax deductible. The tax impact of non-deductibility is captured in this fee.

- Exchange Fee: The Exchange User Fee applies to Exchange business only, but the cost is spread across all Individual plans. The expected charge is estimated at 1.35% of Total Individual Premium. The resulting percentage is applied evenly to all plans in the risk pool, both On and Off Exchange.

- Premium taxes, federal income taxes and state income taxes are also included in the retention items.

24. Profit is reflected on a post-tax basis as a percent that does not vary by product or plan. The profit percentage does not include any assumed risk corridor payments or receipts and is 3.25% of premium.

25. The expected medical loss ratio at the proposed rate level is 79.29%. The expected health care reform adjusted medical loss ratio at the proposed rate level is 85.32%. This reflects quality improvement expense, reduction to Rx incurred claims, federal and state taxes, premium taxes and licensing and regulatory fees.

26. The Actuarial Value (AV) Metal Values included in Worksheet 2 of the Unified Rate Review Template are based on the AV Calculator. To the extent a component of the benefit design was not accommodated by an available input within the AV Calculator, the benefit characteristic was adjusted to be actuarially equivalent to an available input within the AV Calculator for purposes of utilizing the AV Calculator as the basis for the AV Metal Values. Benefits for Plans that are not compatible with the parameters of the AV Calculator have been separately identified and documented in the Unique Plan Design Supporting Documentation and Justification that supports the Plan & Benefits Template.

27. Membership projections are developed using a population movement model plus adjustments for sales expectations. This model projects the membership in the projection period by taking into account:

    - Uninsured to Individual as a result of guaranteed issue, subsidized coverage, and individual mandate
    - Small Group to Individual as a result of guaranteed issue and rate disruptions due to the transition to Modified Community Rating
    - High Risk Pools to Individual as a result of guaranteed issue
    - Individual and Uninsured to Medicaid as a result of expanded Medicaid eligibility

28. The RBC Ratio for Anthem Health Plans, Inc. is 545.16% as of 12/31/2013.

29. Current capital and surplus for Anthem Health Plans, Inc. is $320,293,467 as shown on page 5, line 49 of the 2013 Annual Statement.

30. The impact due to the adjustment for catastrophic plans was an addition of 39 basis points to the rates.

31. Retention as a percentage of premium increased from 12.63% in 2014 to 13.65% in 2015, while expenses on a pmpm basis increased from $33.84 in 2014 to $36.35 in 2015.

32. Normalized 2013 claims experience and membership is captured by county. The counties with smaller membership are combined with neighboring larger counties

with similar pmpm's. This resulted in 3 areas within the state. The area factors are created based on the pmpm cost of the area to the average for the state. This resulted in minor changes in area factors from 2014 to 2015.

33. Metal slope, as used here, refers to the cost relationships between bronze and silver, silver and gold – bronze, silver, and gold being the standardized product groupings that ACA brought into being, "metallic tiers" as they are often referred to. Regulations state that prices can vary across those metallic tiers based on core features of the product themselves – copays, coinsurance, deductibles and the like – and also based on the economic impact those cost shares have on consumer behavior, or benefit richness. However, insurers cannot vary prices across metallic tiers in anticipation of the morbidity of likely purchasers.

34. A review of claims experience from 2013 and prior showed that the economic impact of member cost sharing was stronger than reflected in 2014 rates. As deductibles increased, customers were more selective in their use of services, even after using risk scores to remove the impact of morbidity as regulations require. Risk scores are numeric metrics that reflect the health of a customer. Given this, our 2015 rate application includes a slight movement to rotate our metal slope, to lower bronze rates slightly, where stronger economic incentives exist, and to tilt the slope slightly higher on the gold products. Doing so puts rates in better alignment with emerging experience under benefit richness variations. This change also aligns us more closely to market rates.

35. The 2014 Rate Development looked at both Individual Experience and Small Group experience in the development of the rates. Using Small Group data, which had lower level adjustments, produced a claims pmpm that was 2.3% less than the claims pmpm based on Individual claims experience. This year, we did not repeat this process. However, based on the DOI request, we replicated last year's process with similar findings, using small group data yields a lower rate. Adjusting the Individual experience for removal of underwriting, higher level of benefits in ACA products, the impact of uninsured members and high risk pool members enrolling, and the cost and utilization patterns in the current Individual market lead to greater adjustments to the experience period to account for the changes. Using the Small Group experience that is much closer to the expected makeup of the rate period experience allows for a lower magnitude of assumptions in the claims buildup.

36. The total morbidity adjustment of 0.9886 is comprised of the following:

- -4.69% based on a Risk Adjustment Simulation study released just recently of how the 2013 risk profiles for each Connecticut insurer compares to the Connecticut market overall. This study was facilitated by Wakely Consulting and involves health insurers across the State of Connecticut. Each health insurer received this study to guide their 2015 rates up or down in accordance with the results.

- 1.74% due to higher morbidity expected from individual-level purchasing decisions in 2015.

- 1.58% due to higher morbidity of the uninsured compared to the insured population

- 0.36% due to expected pent up demand from previously uninsured members

37. The Induced Utilization factors for the CSR variant plans between 100% and 200% are 12%, as supplied by CMS. We use those factors in the calculation of the Induced Demand factor that we use to adjust our experience data in the rates tab. The induced demand factor is not calculated at a plan level, but at the market level. We take the on exchange silver membership divided by the total individual experience, multiplied by the assumed percentage of silver members that fall into the 100% - 200% FPL category, multiplied by the induced utilization to come up with the total claims impact. The assumed percentage of members in the 100 - 200% FPL category comes from state specific assumptions based on our initial 2014 enrollment information, which were then adjusted down a bit to account for the possibility of more non-subsidized silver members joining closer to the sign-up deadline.

38. The Department requested Anthem provide the premium impact of reducing the reinsurance attachment point from $70,000 to $45,000 and separately increasing the coinsurance rate from 50% to (60%, 70% and 80%). Below is Anthem's response:

- Anthem approaches this question from a prudent actuarial perspective. The expected total payout of $6.0 billion dollars was used in the development of our expected recoveries. We do not see any indication that additional funds will be available above the $6.0 billion figure and any such determination is not likely to become evident until months later in 2015. HHS changed the parameters to $45K, 80%, $250K, for 2014 based on their expectation that these updated parameters align with paying out the entire $10B allotted for 2014. In addition, the entire $10B will be paid, as long as the coinsurance % does not exceed 100%. This allows for 2014 payouts of 25% more than the current 2014 HHS parameters. The 2014 ACA Individual enrollment is lower than originally expected, but 2014 rules make ACA an attractive choice for those members most likely to exceed the reinsurance threshold. These include members that were previously denied Individual coverage or could not afford coverage due to underwriting, former high risk pool members, and those that benefit from the elimination of underwriting and the compression of age as rating factors.

- The table below shows our recoveries at different attachment points and coinsurance levels as requested. The table also shows an estimated amount of the total dollars that would be available for reinsurance payments under these parameters.

$70K, $250K

Coins Level	Reinsurance PMPM	Fed Reins Total (billions)
50%	$36.35	$6.0
60%	$43.62	$7.2
70%	$50.88	$8.4
80%	$58.15	$9.6

$45K, $250K

Coins Level	Reinsurance PMPM	Fed Reins Total (billions)
50%	$54.40	$9.0
60%	$65.27	$10.8
70%	$76.15	$12.6
80%	$87.03	$14.4

39. Below is Anthem's actuarial justification for changing the future population age/gender average claim factor from 1.0924 in the 2013 filing to 1.1439 in this filing:

- Our age/gender rating period membership distributions were based on revised state-and mbu-specific MPACT modeling used to project the expected 2015 market distributions. Summary highlights discussing changes to assumptions relative to last year's MPACT modeling that help explain the older expected distribution for the CT individual market:
    - Reduced uninsured uptake assumption relative to previous MPACT model due to "prohibition of auto-enrollment, and significant licensing requirements that may create capacity constraints" and "exclusion of smoking premium from subsidy, penalty salience, etc." Since the uninsured population has a high density of young adults, this assumption adjustment skews the age distribution towards higher ages.
    - Higher assumed lapse rates for the Individual market; impact of shock rate assumed to be higher than previously expected. Since lapse rates are generally higher at the younger ages, this adjustment should also reduce the proportion of younger ages expected in 2015.

40. The Department requested that Anthem identify the value of the network adjustment and provide actuarial justification to support this adjustment. Below is Anthem's response:

    - Historically the Anthem HMO and PPO networks have had slight differences in contractual arrangements with the hospitals and physicians. That difference remains for 2015 and is included in the rate development. In addition Anthem has created an additional network for members enrolling through the Individual Exchange. Additional discounts were agreed to with many of our hospitals and providers to help lower the cost for members enrolling with Anthem through the Individual Exchange

41. Anthem made a change to their trend development process to base the trends on a paid basis versus an allowed basis. The additional trend exhibit identified on an allowed basis shows consistent unit cost data on the allowed and paid versions for the 2015 trend exhibits. The historic allowed amounts in the 2015 filing will not match the historic allowed amounts in the 2014 filing due to the change in Anthem's trend development. Previously Anthem used large group and small group data to develop our rating trends. With the change to base the trends on paid data we were also able to develop small group and large group trends independently. (This was in response to a question raised about the consistency of the trend data from year-to-year).

42. The trends used to develop the 2015 rates expected the 2014 spend for Hep C drugs to be $1.9M and the 2015 drug spend to be 5.2M. The claims paid for this population in 2014 to date is $940,000 through June 22, 2014. This leads to our concerns that the trend submitted as part of this filing may not be sufficient to cover the costs for these new drugs. (This was in response to a question raised concerning the impact of Hepatitis C on trend).

43. The annual pricing trend used in the development of the rates is 8.4%. The trend is developed by normalizing historical benefit expense for changes in the underlying population and known cost drivers, and the result is projected forward using regression analysis. The trend includes a volatility provision of 75 basis points in accordance with Actuarial Standards of Practice. The claims are trended 24 months from the midpoint of the experience period, which is July 1, 2013, to the midpoint of the projection period, which is July 1, 2015.

44. The formulary used for all Individual products was adjusted to account for adding the HIV drug Atripla plus some behavioral health drugs, and a few other small changes. Also all generics that were in tier 2 and moved back to tier 1. The impact of these changes was an increase of 66 basis points to the rates.

III. DISCUSSION

The first issue to dispose of is the decision which was reserved to following his hearing appearance on whether the witness Bieluch was to be considered an expert witness and his testimony accorded the weight normally provided to testimony provided by an expert. The undersigned finds that based on the record established at the hearing, for the purpose of being considered an expert witness in health insurance rate making or reviewing, Bieluch does not qualify as an expert in health insurance rate making or reviewing by current knowledge, skill, experience, training, education and the testimony provided did not assist the undersigned in understanding the evidence or in determining a fact in issue.

The Intervenor submitted a curriculum vitae which provided only high level, non-descriptive statements relating to Bieluch's individual health insurance experience and qualifications. The Intervenor was directed to provide additional information clarifying and expanding upon the stated qualifications, but was unable to comply claiming that Bieluch refused to produce the additional experience and qualifications because (1) he perceived to do so would violate his Professional Code of Conduct and (2) the Hearing Officer could not compel him under law to produce the requested information. As a point of reference, Sec. 7-2 of the Connecticut Code of Evidence provides "A witness qualifies as an expert by knowledge, skill, experience, training, education...if the testimony will assist the trier of fact in understanding the evidence or in determining a fact in issue". The commentary to the above referenced section provides that "Crucial to this inquiry is a determination that the scientific, technical or specialized knowledge

upon which the expert's testimony is based goes beyond the common knowledge and comprehension."

Since January 2014, Bieluch has been the managing member of a firm devoted to insurance company financial analysis, reinsurance analysis, merger & acquisition advisory, health insurance and private placement advisory; his only other stated health insurance experience is stated as occurring during the period of October 2002 to April 2012 during which Bieluch indicates he consulted on health insurance rate filings but citing Precept 9 of the Code of Professional Conduct will not disclose any information regarding his activities other than to indicate he reviewed health insurance rates for law firms and provided expert testimony at a rate hearing for the Connecticut Attorney General. Bieluch's Society of Actuaries ("SOA") page and two (2) Linkedin pages (Philip B. and Philip Bieluch) reflect his primary area of practice to be life insurance although the SOA page also indicates a specialization in Health Insurance – Commercial, but lists no experience in such field. Bieluch's Linkedin pages, which provide detailed experience and project experience, do not include health insurance as a stated skill, but rather something Bieluch "knows about" and the Linkedin pages are inconsistent with his submitted curriculum vitae and his SOA page. Neither includes any mention that during the period of October 2002 to April 2012, Bieluch consulted on health insurance rate filings.

The Code of Professional Conduct ("Code") Precept 9 provides "An Actuary shall not disclose to another party any Confidential Information unless authorized to do so by the Principal or required to do so by Law". The Code defines "Confidential Information" as "Information not in the public domain of which an Actuary becomes aware as a result of

providing Actuarial Services to a Principal. It includes information of a proprietary nature and information that is legally restricted from circulation". "Law" is defined in the Code as "Statutes, regulations, judicial decisions, and other statements having legally binding authority". The Intervenor took the position that the captioned administrative hearing did not meet the definition of "Law" as provided in the Code and therefore Bieluch was not required to provide additional detail relating to his health insurance experience. The Actuarial Standards of Practice No. 17 ("ASOP 17"), effective as a standard for all expert actuarial testimony provided on or after July 15, 2002 as adopted by the Actuarial Standards Board in March 2002 and as updated for deviation language effective May 1, 2011 defines an "Expert" as "one who is qualified by knowledge, skill, experience, training, or education to render an opinion or otherwise testify concerning the matter at hand. ASOP 17 defines "Testimony" as "communication presented in the capacity of an expert witness at trial, ***in hearing*** or arbitration, in deposition, or by declaration or affidavit. Such testimony may be oral or written, direct or responsive, formal or informal". (emphasis added)

Bieluch has demonstrated no current knowledge, skill, experience, training or education to render an opinion or otherwise testify as an actuarial health insurance rate making or review expert. His refusal to provide additional information in this legal proceeding relating to his claimed experience in this particular actuarial area, even when advised he could identify the claimed duties and experience without disclosing the client, appears to be an overly conservative and unreasonable interpretation of Precept 9 of the Code of Professional Conduct and inconsistent with ASOP 17.

I now turn to the primary matter. Conn. Gen. Stat. §38a-481 provides that individual health insurance rates must be filed with the Commissioner. The Commissioner may disapprove such rates if the rates are found to be excessive, inadequate or unfairly discriminatory. While these terms are not defined in Conn. Gen. Stat §38a-481, the Legislature has given us guidance as to their meanings through other statutes dealing with rate filings. Conn. Gen. Stat. §38a-665, which addresses rates pertaining to commercial risk insurance provides in relevant part:

> Rates shall not be excessive or inadequate, as herein defined, nor shall they be unfairly discriminatory. No rate shall be held to be excessive unless (1) such rate is unreasonably high for the insurance provided or (2) a reasonable degree of competition does not exist in the area with respect to the classification to which such rate is applicable. No rate shall be held inadequate unless (A) it is unreasonably low for the insurance provided, and (B) continued use of it would endanger solvency of the insurer, or unless (C) such rate is unreasonably low for the insurance provided and the use of such rate by the insurer using same has, or, if continued, will have the effect of destroying competition or creating a monopoly.

Conn. Agencies Reg. §38a-474-3, which governs rate filings for Medicare Supplement products provides in relevant part:

> The commissioner shall not approve a rate for a Medicare supplement policy that is excessive, inadequate, unreasonable in relation the benefits provided or unfairly discriminatory.

While Connecticut has not defined what an excessive rate increase is for individual health insurance, the federal government has done so when the Centers for Medicare and Medicaid ("CMS"), reviews a commercial health insurance rate increase if a state has not been deemed by CMS to have an effective rate review program. (Connecticut has been designated by CMS to have an effective rate review program and therefore retains rate review authority.) 45 CFR §154.205 provides that "the rate increase is an unreasonable rate increase if the increase is an excessive rate increase, an unjustified rate increase, or an unfairly discriminatory rate increase". This section further provides that the rate increase "is an excessive rate increase if the increase causes the premium charged for the health insurance coverage to be unreasonably high in relation to the benefits provided under the coverage". Determining whether the rate increase causes the premium charged to be unreasonably high in relationship to the benefits provided, CMS considers:

> (1) Whether the rate increase results in a projected medical loss ratio below the Federal medical loss ratio standard in the applicable market to which the rate increase applies, after accounting for any adjustments allowable under Federal law; (2) Whether one or more of the assumptions on which the rate increase is based is not supported by substantial evidence; and (3) Whether the choice of assumptions or combination of assumptions on which the rate increase is based is unreasonable.

CMS considers the rate increase to be an unjustified rate if the health insurance issuer provides data or documentation to CMS in connection with the increase that is

incomplete, inadequate or otherwise does not provide a basis upon which the reasonableness of an increase may be determined.

CMS finds that a rate increase is an unfairly discriminatory rate increase if the increase results in premium differences between insureds within similar risk categories that (1) Are not permissible under applicable State law; or (2) In the absence of an applicable State law, do not reasonably correspond to differences in expected costs.

Lacking any other statutory definitions in Conn. Gen. Stat. §38a-38a-481, we therefore look to the federal definitions in 45 CFR §154.205 which are consistent with the legislative rate review intent presented in Conn. Gen. Stat. §38a-665, the reasonableness elements espoused in that statute as well as Conn. Agencies Reg. §38a-474-3, and standard actuarial principles for health insurance, and the Department uses the following standards for the review of health insurance rate filings. The Department deems rates excessive if they are unreasonably high in relation to the benefits provided and the underlying risks. Rates are deemed inadequate if they are unreasonably low in relation to the benefits provided and the underlying risks, and continued use of it would endanger the solvency of the insurer. Rates would be deemed unfairly discriminatory if the methodology to develop the rates is not actuarially sound and is not applied in a fairly consistent manner so that resulting rates were not reasonable in relation to the benefits and underlying risks. The actuarial review of the rate Application to determine if the rates are reasonable, i.e. not excessive, inadequate or unfairly discriminatory, must be in compliance with Actuarial Standard of Practice No.

8 (ASOP 8) issued by the Actuarial Standards Board of the American Academy of Actuaries and with federal rate review requirements.

The primary concerns raised by the Intervenor and members of the public were that the applied for increases were not reasonable based upon Anthem's past unacceptable service performance; secondarily was the concern that the rates would not be affordable for each individual wishing to purchase Anthem individual health insurance. While it is reasonable to expect acceptable service delivery when paying for any product, service delivery failures are not factors used in rate review within the statute or standard actuarial principles. Nor is affordability which is relative to each person and subjective, and although of overall concern, is also not a standard for rate review within either the state or federal statutes or standard actuarial principles.

To determine if the rates filed by Anthem are reasonable in relation to the benefits provided, an actuarial analysis was conducted to review the experience, assumptions and projections used in the rate Application. This analysis was based on the written information provided in the Application, oral testimony by the Applicant provided at the rate hearing, and the additional submission of written information and materials requested to be provided as a follow-up to the June 27, 2014 hearing. It should be noted that while additional follow-up questions were considered, a determination was made to proceed with the record as provided as of July 3, 2014. To seek further information or clarification of the Applicant's submission would have been considered an ex parte communication without offering the Intervenor the opportunity to examine and seek additional information as well. To provide this type of examination would have required the reopening of the record and reconvening of the hearing; it was

determined that while some useful additional information might have been gathered that could have further refined the rate review, the additional cost and time associated with reopening the record and reconvening the proceeding would have significantly delayed the rate determination being finalized. This inability to ask multiple rounds of questions is a review limitation imposed by utilizing an administrative hearing process to review a rate filing rather than leaving it to the usual regulatory oversight process which provides for more flexibility, more deliberation, and less cost.

The normalized paid trend for the last three years has been 5.8%, 5.8% and 6.9%. Anthem estimates that 2014 and 2015 trend is 8.0% and 9.2% respectively. A significant impact to 2014 and 2015 trend is the affect of the pharmaceutical Sovaldi and other high-cost drugs for treating Hepatitis C. Anthem also included a 75 basis point load in the trend for volatility. The undersigned is recommending that the assumed trend in the rate filing of 8.42% be reduced by .75% to account for the removal of the volatility factor. As a result, the recommended annualized trend is 7.67%.

The average normalized age/gender claim factor Anthem assumed for the 2015 population is 1.1439. This is a significant change from the factor used in the development of the 2014 rates of 1.0924. Anthem stated that they revised this factor due to a reduced uninsured uptake assumption and higher assumed lapse rates for the individual market. Since Anthem has no actual experience on which to base the change in the age/gender average claim factor from the 2013 rate filing to this filing, the undersigned recommends that the proposed factor of 1.1439 and the factor used in last year's filing of 1.0924 be averaged, this results in an age/gender average claim factor of 1.1182.

The grace period adjustment of .375% was removed from the 2013 rate filing as the Department did not believe this adjustment was necessary. The undersigned recommends that the .375% grace period adjustment be removed from this 2014 rate filing in the same manner it was in 2013.

In Federal Register/Vol. 79, No. 101/Tuesday, May 27, 2014 / Rules and Regulations it states the following, "Specifically, in the proposed 2016 Payment Notice, we intend to propose to lower the 2015 attachment point from $70,000 to $45,000. We may also propose to modify the target 2015 coinsurance rate based on estimates of roll-over of funding from 2014 and estimates of collections of payments for 2015".

In addition, the federal government has allowed states to decide whether or not to allow existing non-grandfathered, non-ACA compliant plans (grand-mothered plans for ease of explanation) to continue to renew until sometime in 2016. These grand-mothered plans are considered transitional plans and carriers will not have access to the temporary reinsurance program for these plans. A number of states have elected to allow these transitional plans while Connecticut has not. All Connecticut individual plans, as of 1/1/2015 and beyond, will be considered fully ACA compliant plans, eligible for the temporary reinsurance program.

Based upon the information described in the last two paragraphs, the Department is requiring that all individual carriers use a $45,000 attachment point in their 2015 pricing as well as a coinsurance level of 70%. The Department believes that there will be excess funds available in 2015 since all transitional individual plans will not have access to the reinsurance program and were originally expected to be fully ACA compliant by 2015 when the funding parameters were originally set.

Anthem submitted this rate filing assuming an attachment point of $70,000 with a coinsurance level of 50%. As described above, the Department is requiring that the pricing support an attachment point of $45,000 and a coinsurance level of 70% for 2015, rather than the $70,000 and 50%. This has an impact of lowering the net reinsurance recoveries from -$32.60 to -$72.40. This is generated from Anthem's analysis submitted and referenced in item #38 of the above Findings of Fact.

IV. CONCLUSION AND RECOMMENDATION

Based on the foregoing and the record of the June 27, 2014 public hearing, the undersigned concludes that the rates filed by Anthem to be effective January 1, 2015 are excessive and recommends that the Insurance Commissioner disapprove the rate Application increases in accordance with Conn. Gen. Stat. §38a-481. The undersigned concludes that the recommended rate revisions determined in the actuarial analysis presented in the discussion section are actuarially sound, and are adequate, not excessive and not unfairly discriminatory in accordance with Conn. Gen. Stat.§38a-481. The undersigned recommends that the Commissioner accept the following changes to the rating assumptions for rates effective January 1, 2015:

Assumption	Current	Revised
Age/Gender Avg. Claim Factor (Future)	1.1439	1.1182
Annualized Trend	8.42%	7.67%
Grace Period	1.0038	1.0000
Net Reinsurance Recoveries	-$32.60	-$72.40

The undersigned recommends that the Insurance Commissioner order Anthem to recalculate the rates using the recommended revised rating assumptions with an effective date of January 1, 2015 and submit a revised rate filing to the Department no later than August 31, 2014

Dated at Hartford, Connecticut, this 22 day of July, 2014

Paul S. Lombardo
Hearing Officer