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. LH 16-45

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ORDER

I, Katharine L. Wade, Insurance Commissioner of the State of Connecticut, having read the record in the above captioned matter, do hereby adopt the findings and recommendations of Jared Kosky, 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, 2017, for its individual on and off exchange plans are excessive and are hereby disapproved in accordance with General Statutes § 38a-481.
2. Anthem is authorized to submit revised rates for review and they shall be approved if I, the Insurance Commissioner, find them to be consistent with the recommendations as set forth in the Proposed Final Decision issued by Jared Kosky, Hearing Officer, on September 2, 2016. Anthem will recalculate its rates using the following recommended rate assumptions for rates effective January 1, 2017 and submit a revised rate filing to the Insurance Department

no later than September 7, 2016 to enable adequate notice to be issued to policyholders.

- Reducing the annual trend from 9.6% to 9.1%.
- Reduce the pricing correction from 18.7% to 15.0%.
- Remove the Grace Period adjustment of 0.72%.
- Change the risk adjust receipt from $31.21 pmpm to $40.59 pmpm.

Dated at Hartford, Connecticut, this 2nd day of September, 2016.

Katharine L. Wade
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. LH 16-45

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PROPOSED FINAL DECISION

I. INTRODUCTON

On June 1, 2016, Anthem Health Plans, Inc. d/b/a Anthem Blue Cross and Blue Shield ("Anthem" or "Applicant"), filed a rate application regarding the Applicant's individual rates for on and off exchange plans ("Application") with the Connecticut Insurance Department ("Department") pursuant to General Statutes § 38a-481. Although there is no statutory requirement that a rate hearing be held, on June 6, 2016, Insurance Commissioner Katharine L. Wade ("Commissioner") issued a notice of public hearing ordering that a public hearing be held on August 3, 2016 concerning the Application.

A copy of the Notice of Public Hearing was filed with the Office of the Secretary of the State on June 6, 2016, and was published on the Department's Internet website (the "Notice"). The Notice indicated that the Application was available for public inspection at the Department, and that the Department was accepting written statements concerning the Application. In accordance with § 38a-8-48 of the Regulations of Connecticut State Agencies, the Applicant was designated as a party to the proceeding.

On June 28, 2016, the Commissioner appointed the undersigned to serve as Hearing Officer in the proceeding.

On August 3, 2016, a public hearing on the Application was held before the undersigned (the "Hearing"). The following individuals testified at the Hearing on behalf of the Applicant: James Augur, Regional Vice President – Sales, Anthem; Tu Nguyen, Director of Actuarial Services, Anthem. Michael G. Durham, Esq., of Donahue, Durham & Noonan, P.C., and John M. Russo, Esq., of Anthem Blue Cross and Blue Shield, represented the Applicant.

The following Department staff participated in the Hearing: Paul Lombardo, ASA, MAAA, Life and Health Actuary and Kristin Campanelli, Esq., Legal Division counsel.

Pursuant to the Notice, the public was given an opportunity to speak at the Hearing and to submit written comments on the Application with respect to the issues to be considered by the Commissioner no later than the close of business August 3, 2016. The deadline for submission of written comment was extended at the Hearing to the close of business August 10, 2016. Fourteen members of the public and two public officials provided oral comment during the two public comment sessions at the Hearing. Senator Joseph Crisco and Senator Tony Hwang provided oral comments at the Hearing. Members of the public who provided oral comment were Lynne Ide, Universal Health Care Foundation of Connecticut; Gaye Hyre, policy holder; Douglas Wade, Wade's Dairy; Matt McDermott, CONECT; Angela DeMello, CONECT and The Strategies Group; Mark Russo, insurance agent; Tom Swan, Connecticut Citizen Action Group; Linda Yannone, United Church of Christ; Mary Levine, individual; Ken Schaefer, individual; Stephanie Schaefer, individual; Kimberly Cossuto, nurse; Marc Sandy Block,

individual; and Mary Jennings, insurance broker. Public comment by persons who are not parties "shall be given the same weight as legal argument."[1]

As of the close of the record for public comment, on August 10, 2016, there were over 250 written communications containing public comment, some from persons who also provided oral comment. All of the written comments were in opposition to the Application. The major theme in the opposition letters and oral comments was for the reduction of the requested rate increases, if not an overall objection to Anthem's Application. Opposition was premised on the proposed rate increases being unaffordable to consumers as well as Anthem's profits, net income and its executives' salaries not justifying rate increases. Some of the written and oral comments included detailed descriptions of the hardship to consumers under Anthem's existing rates and requested rate increases. There were also numerous comments critical of health insurers and health insurance rates in general.

At the conclusion of the hearing, Anthem was directed to submit supplemental information no later than the close of business August 8, 2016. Anthem timely submitted the supplemental information on August 8, 2016 and the record was closed on August 10, 2016.

II. FINDINGS OF FACT

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

1. The Application is a filing made by Anthem Health Plans, Inc., doing business as Anthem Blue Cross and Blue Shield based on Connecticut statutory requirements

[1]Regs., Conn. State Agencies § 38a-8-51 (b)

and is applicable only to on and off exchange individual health insurance products offered in Connecticut.

2. The Application included an Actuarial Certification by Tu Nguyen, FSA, MAAA, Director & Actuary III, which certified that the Application was compliant with state filing guidelines, actuarial standards, including specifically Actuarial Standards of Practice No. 8, Regulatory Filings for Health Plan Entities ("ASOP 8"), and that data quality was reconciled to financial statements.
3. On June 1, 2016, Anthem electronically filed the Application requesting the following increases effective January 1, 2017:

	% Change
Catastrophic HMO Pathway X Enhanced	31.3%
Bronze HMO Pathway X Enhanced	20.9%
Bronze HMO Pathway X Enhanced for HSA	28.3%
Gold HMO Pathway X Enhanced	17.8%
Anthem HMO Catastrophic BlueCare 7150/0%	39.3%
Anthem Bronze HMO BlueCare 6200/12400/0% for HSA	35.0%
Anthem Silver HMO BlueCare 3850/0%	16.5%
Anthem Silver HMO BlueCare 3500/7000/0% for HSA	27.0%
Anthem Silver HMO BlueCare Tiered 3550/6400/0%	28.3%
Anthem Gold HMO BlueCare 1500/0%	24.4%
Anthem Gold HMO BlueCare Tiered 1650/3300/0%	n/a
Bronze PPO Standard Pathway X	18.9%
Bronze PPO Standard Pathway X for HSA	33.5%
Silver PPO Pathway X	20.9%
Silver PPO Standard Pathway X	23.2%

Silver Core PPO Pathway X 5300	n/a
Gold PPO Standard Pathway X	35.9%
Anthem Bronze PPO Century Preferred 5700/11400/20% for HSA	39.4%
Anthem Bronze PPO Century Preferred 7150/0%	39.8%
Anthem Silver PPO Century Preferred 2750	22.5%
Anthem Silver PPO Century Preferred 3000/6000 for HSA	29.8%
Anthem Gold PPO Century Preferred 1500/4500 for HSA	23.5%
Anthem Gold PPO Century Preferred 1900/0%	33.4%
Gold HMO Pathway X Enhanced, a Multi-State Plan	27.3%
Silver PPO Pathway X, a Multi-State Plan	21.5%

4. Anthem identified in its Application factors that affect the proposed rate increase for all plans include:

   - Emerging experience different than projected.
   - Trend: This includes the impact of inflation, provider contracting changes, and increased utilization of services.
   - Morbidity: There are anticipated changes in the market-wide morbidity of the covered population in the projection period.
   - Benefit modifications, including changes made to comply with updated Actuarial Value ("AV") requirements.
   - Changes in taxes, fees, and some non-benefit expenses, including the one-year suspension of the Health Insurer Tax for 2017.
   - Discontinuance of the Federal Transitional Reinsurance Program, which impacts both payments from and contributions to the program.

5. Although rates are based on the same experience, proposed rate changes vary by plan from 16.5% to 39.8%. The Application identified factors that affect the variation in the proposed rate changes by plan include:
   - Changes in benefit design that vary by plan.
   - Updates in benefit relativity factors among plans.
   - Updated adjustment factors for catastrophic plans.
   - Changes in some non-benefit expenses.
   - Changes in the claim cost relativity by area.
6. Experience Period Premium and Claims:

   The experience period premium and claims reported in Worksheet 1, Section I of the Unified Rate Review Template ("URRT"), in the Application, are for the non-grandfathered, single risk pool compliant policies of the identified legal entity in the Individual market.

   The experience reported in Worksheet 1, Section I of the URRT reflect the incurred claims from January 1, 2015 through December 31, 2015 based on claims paid through March 31, 2016.

   Per the Application, the earned premium prior to medical loss ratio ("MLR") rebate is $298,699,430. The earned premium reflects the pro-rata share of premium based on policy coverage dates, and includes expected risk adjustments for the experience period.

   The preliminary MLR rebate estimate is $0, which is consistent with Anthem's December 31, 2015 general ledger estimate allocated to the non-grandfathered portion of Individual business. This is an estimated amount and was not final until

July 31, 2016. Using this MLR estimate, the net earned premium is $298,699,430 for Anthem as reported in cell F14 of Worksheet 1, Section I of the URRT.

The allowed claims were determined by subtracting non-covered benefits, provider discounts, and coordination of benefits amounts from the billed amount.

Allowed and incurred claims were completed using the chain ladder method, an industry standard, by using historic paid vs. incurred claims patterns. The method calculates historic completion percentages, representing the percent of cumulative claims paid of the ultimate incurred amounts for each lag month. Claim backlog files were reviewed on a monthly basis and were accounted for in the historical completion factor estimates.

Allowed and incurred claims reported in Worksheet 1, Section I of the URRT were $351,107,881 and $279,876,943, respectively. Exhibit B of the Application provides claims detail.

7. Projection Factors:

Changes in the Morbidity of the Population Insured

- In the Application, adjustments were made to account for the differences between the average morbidity of the experience period population and that of the anticipated population in the projection period.
- In the Application, the projected population consists of expected retention of existing policies and new sales. The new sales include the previously uninsured population and previously insured populations from other carriers or coverage. The morbidity impacts of population movement were based on the experience period risk score data and estimated risk scores of the projected population. Exhibit E of the Application shows the morbidity factor.

Changes in Demographics (normalization)

- In the Application, the experience period claims were normalized to reflect anticipated changes in age/gender, area, network, and benefit plan in the projection period. Exhibit D of the Application provides detail of each normalization factor below:
    - Age/Gender: The assumed claim cost was applied by age and gender to the experience period membership distribution and the projection period membership distribution.
    - Area/Network: The area claims factors were developed based on an analysis of allowed claims by network, mapped to the prescribed rating areas using the subscriber's 5-digit zip code.
    - Benefit Plan: The experience period claims were normalized to reflect the average benefit level in the projection period using benefit relativities. The benefit relativities include the value of cost shares and anticipated changes in utilization due to the difference in average cost share requirements.

Changes in Benefits

- Essential Health Benefit ("EHB") Changes: In the Application, adjustments were made to reflect the 2017 requirement to provide separate but equal visit limits for rehabilitative and habilitative therapies per the U.S. Department of Health and Human Services ("HHS") Notice of Benefit and Payment Parameters.

Other Adjustments made in the Application

- Change in Medical Management: This adjustment reflects the medical management costs not already included in the Applicant's claims experience and trend.

- Induced Demand Due to Cost Share Reductions: Individuals who fall below 250% of the Federal Poverty Level and enroll in On-Exchange silver plans will be eligible for cost share reductions. The percentage of enrollment in the Cost Share Reduction ("CSR") Plans in the experience period was compared to that of the projection period to adjust for the different induced demand level due to CSR between the two periods.
- Grace Period: The claims experience was adjusted to account for incidences of enrollees not paying premiums due during the first month of the 90-day grace period when the Qualified Health Plan ("QHP") is liable for paying claims.
- Rx Rebates: The projected claims cost was adjusted to reflect anticipated Rx rebates. These projections took into account the most up-to-date information regarding anticipated rebate contracts, drug prices, anticipated price inflation, and upcoming patent expirations.
- Projected cost of pediatric dental and vision benefits were included on all plans. The "Silver Core PPO Pathway X 5300" plan (HIOS ID: 86545CT1330010) also includes the projected cost of offering adult vision benefits.
- Benefits in excess of the EHBs in the projection period were included. Exhibit F of the Application provides details of additional non-EHB benefits.

Trend Factors (cost/utilization)

- In the Application, the annual pricing trend used in the development of the rates is 9.6%. Consistent with prior Individual ACA[2] Rate Filings, the Individual pricing trend was developed by normalizing historical Small Group benefit expense for changes in the underlying population and known cost drivers, which were then

[2]Patient Protection and Affordable Care Act, 42, U.S.C. 18001, et seq. (2010).

projected forward to develop the pricing trend, recognizing recent emerging unfavorable trend experience. Examples of such changes include contracting, cost of care initiatives, workdays, costs associated with Hepatitis C, compound drugs, average wholesale price, and expected introduction of generic drugs. The trend includes a volatility provision in accordance with Actuarial Standards of Practice. For projection, the experience period claims were trended 24.1 months from the midpoint of the experience period, which is June 28, 2015, to the midpoint of the projection period, which is July 1, 2017.

- Projected trends included the estimated cost of the pharmaceutical Harvoni and other high-cost drugs for treating Hepatitis C. These cost estimates were based on Connecticut Individual claims experience, together with Centers for Disease Control and Prevention ("CDC") recommendations, Industry and Anthem data.

8. The following are illustrations provided by Anthem in its Application:

a. Anthem's Normalized Unit Cost Data on a Paid Basis:

	2012	2013	2014	2015
Inpatient	$3,869.21	$3,899.81	$3,638.84	$3,854.59
Outpatient	$787.84	$853.68	$772.01	$811.14
Professional	$124.24	$128.71	$122.76	$131.56
Pharmacy	$49.00	$53.64	$74.74	$106.31

b. Anthem's Normalized Utilization Data (per thousand members):

	2012	2013	2014	2015	Total
Inpatient	16.1	14.2	27.7	30.3	1.633.3
Outpatient	116.6	120.7	161.1	179.3	1,667.2
Professional	803.5	814.7	849.4	908.4	1,922.5
Pharmacy	697.0	717.6	884.3	1,084.4	2,202.4

c. Anthem's Paid Per Member Per Month ("PMPM"):

	2012	2013	2014	2015
Inpatient	$62.23	$55.31	$100.76	$116.91
Outpatient	$91.88	$103.04	$124.38	$145.44
Professional	$99.83	$104.86	$104.27	$119.51
Pharmacy	$34.15	$38.49	$66.09	$115.27
Total	$288.10	$301.70	$395.50	$497.14

d. Anthem's Paid Trend:

	2013/ 2012	2014/ 2013	2015/ 2014
Inpatient	-11.1%	82.2%	16.0%
Outpatient	12.1%	20.7%	16.9%
Professional	5.0%	-0.6%	14.6%
Pharmacy	12.7%	71.7%	74.4%
Total	4.7%	31.1%	25.7%

e. Anthem's Estimated Paid trend in 2016 and 2017:

	2016/ 2015	2017/ 2016
Inpatient	5.0%	7.7%
Outpatient	7.0%	10.9%
Professional	3.7%	3.8%
Pharmacy	31.9%	13.6%
Total	11.5%	9.4%

f. Anthem's experience in the individual market (2011-2014 Pre-ACA and ACA, 2015 ACA Only):

CY	Earned Premium ($)	Incurred Claims ($)	Loss Ratio
2011	$198,752,863	$168,082,111	84.57%
2012	$191,566,985	$174,926,541	91.31%
2013	$190,222,381	$169,556,744	89.14%
2014	$300,110,343	$210,652,468	70.19%
2015	$298,697,147	$247,479,697	82.85%
Total	$1,179,349,719	$970,697,561	82.31%

9. Risk Adjustment and Reinsurance:

- Experience period risk adjustments were estimated based on available 2015 information, including a Wakely market study, Center for Medicare and Medicaid Services' ("CMS") preliminary 2015 risk adjustment transfers and additional analysis of the market risk. Wakely Consulting collected demographic and risk information from carriers in the state and market, and calculated Anthem's relative risk to the market.
- Projection period risk adjustments were estimated based on the HHS payment transfer formula. The Wakely study and CMS preliminary 2015 risk adjustment transfers were used to develop the assumptions for the market level risk scores and Anthem's relative risk to the market. Any projected changes in population movements and demographics that may affect risk adjustments were also considered.

- The projected risk adjustment PMPMs reported in the URRT were net of risk adjustment fees, and on a paid claim basis. The projected amount applied to the development of Market Adjusted Index Rate was on an allowed claim basis.
- Experience period reinsurance recoveries were estimated by applying the 2015 federal reinsurance parameters[3] to member level incurred claims of the experience period.
- Beginning in 2017, the Federal reinsurance program will no longer be in effect. The projected reinsurance amount will be $0.

10. In the Application, administrative Expenses are expected to be consistent with historical levels and were developed utilizing the same methodology as previous filings. Maintenance costs were projected for 2017 based on 2015 actual expenses with adjustments made for expected changes in business operations.
11. Quality Improvement initiatives include programs such as Improve Health Outcomes, Activities to Prevent Hospital Readmissions, Improve Patient Safety and Reduce Medical Errors, Wellness and Health Promotion Activities, and Health Information Technology Expenses for Health Care Quality Improvements. In the Application, the expense assumptions are based on historical expense levels adjusted for cost inflation and anticipated changes in the programs.
12. In the Application, selling Expense represents projected broker commissions and bonuses associated with the broker distribution channel. Commissions will be paid for Off-Exchange plans but will not be paid for On-Exchange plans. Commissions will be paid only for members enrolling during the Open Enrollment period.

[3]HHS Notice: Notice of Benefit and Payment Parameters for 2016 (February 27, 2015). https://www.federalregister.gov/articles/2015/02/27/2015-03751/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2016.

13. Specialty Expenses were projected administrative expenses for dental and vision coverage.

14. In the Application, the miscellaneous items represent Connecticut Insurance Department fees and assessments, including the assessment from the State of Connecticut to cover the cost of the Vaccine Immunization Program and the Department of Public Health ("DPH") assessment.

15. 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.
- ACA Insurer Fee: The health insurance industry is 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. For 2017, this fee is 0% due to a one-year suspension by the federal government.
- Exchange User Fee: The Exchange User Fee applies to Exchange business only, but the cost is spread across all plans in the market. The expected charge is estimated at 1.65% of the premium. The resulting fee/percentage was applied by Anthem evenly to all plans in the risk pool, both On and Off Exchange.
- Premium taxes, federal income taxes, and state income taxes were also included.

16. Profit & risk margin was reflected on a post-tax basis as a percentage of premium.

17. Exhibit I of the Application shows the projected Federal MLR for the products in the Application. The calculation is an estimate and was not meant to be a true measure for Federal or State MLR rebate purposes. The products in this filing represent only

a subset of Anthem's Individual business. The MLR for Anthem's entire book of Individual business will be compared to the minimum Federal benchmark for purposes of determining regulation-related premium refunds. The projected Federal MLR presented in the Application does not capture all adjustments, including but not limited to: three-year averaging, credibility, dual option, and deductible. Anthem expects the projected MLR to meet or exceed the minimum MLR standards at the market level after including all adjustments.

18. The single risk pool for the Application is established according to the requirements in 45 CFR § 156.80.[4] It reflects all covered lives for every non-grandfathered product/plan combination sold in the Connecticut Individual market by Anthem.

19. The experience period Index Rate is equal to the allowed claims PMPM for the essential health benefits of Anthem's non-grandfathered business in the Individual market. The Index Rate reported in Worksheet 1, Section I, cell G17 of the URRT is $558.00, rounded to the nearest whole dollar as instructed. No benefits in excess of the EHBs have been included in this amount.

20. The projection period Index Rate is equal to projected allowed claims PMPM for the EHBs of Anthem's non-grandfathered business in the Individual market. It reflects the anticipated claim level of the projection period including impact from trend, benefit and demographics as described in Section 6 of the Actuarial Memorandum in the Application. The projected index rate is reported in Worksheet 1, Section III, cell V44 of the URRT and is also shown in Exhibit C of the Application. No benefits in EHBs are included in this amount.

[4] 45 CFR 156 – Health Insurance Issuer Standards Under the Affordable Care Act, Including Standards Related to Exchanges, General Provisions, Single Risk Pool.

21. The Market Adjusted Index rate is calculated as the Index Rate adjusted for all allowable market-wide modifiers defined in the market rating rules.[5]

22. In the Application, the Plan Adjusted Index Rate was calculated as the Market Adjusted Index Rate adjusted for all allowable plan level modifiers defined in the market rating rules. Exhibit J of the Application shows the development. The plan level modifiers are described below:

- AV and Cost Sharing Adjustments: This is a multiplicative factor that adjusts for the projected paid/allowed ratio of each plan, based on the AV metal value with an adjustment for utilization differences due to differences in cost sharing.
- Provider Network Adjustments: This is a multiplicative factor that adjusts for differences in projected claims cost due to different network discounts.
- Adjustments for Benefits in Addition to the EHBs: This multiplicative factor adjusts for additional non-EHB benefits shown in Exhibit F of the Application.
- Catastrophic Plan Adjustment: This adjustment reflects the projected costs of the population eligible for catastrophic plans. The catastrophic adjustment factor is applied to catastrophic plans only; all other plans have an adjustment factor of 1.0.
- Adjustments for Distribution and Administrative Cost: This is an additive adjustment that includes all the selling expense, administration and retention Items shown in Exhibit H of the Application, with the exception of the Exchange user fee. The Exchange user fee is included in the Market Adjusted Index Rate at the market level.

[5]See 45 CFR § 154.

23. In the Application, the age factors are based on the Default Federal Standard Age Curve. The age calibration adjustment was calculated as the member weighted average of the age factors, using the projected membership distribution by age, with an adjustment for the maximum of 3 child dependents under age 21. Under this methodology, the approximate average age rounded to the nearest whole number for the risk pool is 48.

24. The AV Metal Values reported in Worksheet 2, Section I of the URRT 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. When applicable, benefits for plans that are not compatible with the parameters of the AV Calculator were separately identified and documented in the Unique Plan Design Supporting Documentation and Justification that supports the Plan & Benefits Template in the Application.

25. The Applicant's 2017 Individual plan portfolio contains two plans with tiered in-network benefits. These plans have up to three networks of provider care and different cost share provisions for each network:

- The Tier 1 network is a subset of preferred in-network providers; members have the lowest cost share amounts when utilizing this preferred network.
- The Tier 2 network is comprised of the remaining in-network providers and has higher cost share amounts compared to the Tier 1 network.

- For tiered Preferred Provider Organization ("PPO") plans, the Tier 3 network is comprised of the out-of-network providers and has the highest cost share amounts.

Additional cost of care savings are expected from increased utilization of Tier 1 providers. These savings are used to reduce the tiered plan rate compared to a non-tiered plan with similar cost share provisions.

26. The Risked Based Capital ("RBC") Ratio for Anthem is 572.85% as of December 31, 2015, as identified in Anthem's 2015 Annual Statement filed with the Department.

27. Current capital and surplus for Anthem is $284,114,721 as shown on page 5, line 49 of Anthem's 2015 Annual Statement filed with the Department.

28. In the Application, the proposed retention charge in the rate development is 16.9%. This is comprised of both fixed and variable expenses and includes selling expense, administrative expense, federal fees, federal income tax, exchange fees and risk and net profit margin. The December 31, 2015 Annual Statement for Anthem has a retention amount of 22.4%. This amount is calculated from the Analysis of Operations by Lines of Business exhibit on page 7 of Anthem's 2015 Annual Statement: 1 – [line 17, column 2 $791,038,042 / line 7, column 2 $1,018,886,075] = 22.4%.

29. Connecticut Insurance Department Bulletin HC-102 (June 16, 2015) removed the age limit on hearing aid benefits. The expected cost of this change is an additional $0.34 claims PMPM during the 2017 rating period, which is not included in the 2015 experience period. The $0.34 PMPM represents 75% of the expected $0.45 impact of the October, 2015 benefit mandate that removed age limits on hearing aids, which was included in the approved 2016 benefit year Application of Anthem.

30. Connecticut Insurance Department Bulletin HC-114 (July 7, 2016) requires health insurance coverage for mammograms provided by breast tomosynthesis. Anthem considers this coverage as a new mandate for 2017. The expected cost of this coverage has been considered but no adjustment to the rates has been made to cover the expected increase in cost at this time.

31. Connecticut Insurance Department Bulletin HC-104 (August 13, 2015) removed the age limit on infertility benefits. The expected cost of this change is an additional $0.25 claims PMPM during the 2017 rating period, which is not included in the 2015 experience period. The $0.25 represents 100% of the expected impact of the January, 2016 benefit mandate that removed age limits on infertility benefits, which was included in the approved 2016 benefit year Application of Anthem.

III. DISCUSSION

General Statutes § 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.[6] These terms are not defined in § 38a-481 but are defined by § 38a-481-1 of the Regulations of Connecticut Agencies which provides in part:

> As used in Sections 38a-481-1 to 38a-481-9, inclusive, of the Regulations of Connecticut State Agencies, unless the context otherwise requires: ... (3) "Excessive rate" means the rate is unreasonably high for the insurance provided .... (6) "Inadequate rate" means a rate that is unreasonably low for the insurance provided, and continued use of it would endanger solvency of the insurer .... (11) "Unfairly discriminatory" means rating practices that reflect differences based on age, disability, race, ethnicity, gender, sexual orientation or health status that are not actuarially justified or otherwise prohibited by law.

[6]See General Statues § 38a-481 (b), and Regs. Conn. State Agencies § 38a-481-7 (e).

These definitions are consistent with those found for the same terms in another statute dealing with rate filings within the insurance statutes (Title 38a). General Statutes § 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.[7]

With the definitions noted above, along with actuarial standards of practice for health insurance, 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.

[7]General Statutes § 38a-665 (a).

- The actuarial review of the Application to determine if the rates are reasonable, i.e. not excessive, inadequate or unfairly discriminatory, must be in compliance with ASOP 8 issued by the Actuarial Standards Board of the American Academy of Actuaries.

A primary concern raised by numerous members of the public is that the applied for increases would not be affordable for the renewing policyholders. As one commenter noted, "unaffordable health insurance is a more – is a more-expensive version of being uninsured because, in fact, if your insurance with your copays, deductibles, cost sharing, whatever is so high, you're not going to use it even if you could afford to buy it."[8] Affordability, however, is relative to each person and subjective, and although of overall concern, is not a standard for rate review within the statute or actuarial standards of practice. Public officials and members of the general public also argued that Anthem's profits, net income and its executives' salaries cannot justify any such rate increases. Furthermore, a portion of comments suggested that Anthem was well aware that the federal government's transition reinsurance program for the individual market would be ending and that it is being opportunistic by using that event to justify the increases being requested.

As previously stated, under § 38a-481, the Department is required to evaluate any proposed rate increase based on whether, from an actuarial perspective, it is excessive, inadequate or unfairly discriminatory. Without the affirmative act of the Connecticut General Assembly to amend or replace the statute and include either, or both, an affordability standard or insurer net income standard, they will remain issues the Department cannot consider in its health insurance rate filing reviews. As correctly stated by the same commenter at the Hearing, "[y]ou've got over 500 comments from

[8]Hrg. Transcr. 23:8-14 (August 3, 2016).

people saying that they can't afford these rate increases, but you can't do anything about that."[9]

To determine if the rates filed by Anthem are reasonable in relation to the benefits provided, the Department's actuarial staff completed an actuarial analysis to review the experience, assumptions and projections used in the Application. Since this filing incorporates all the new rating requirements of the ACA, the Department used criteria set forth in the latest HHS rate regulations as a template for review along with previously issued Connecticut Insurance Department Notices[10] that discuss the requirements for rate filings.

Anthem's normalized paid trend for the last three years, as identified in its Application, has been 4.7%, 31.1% and 25.7%. Anthem estimated in its Application that the 2016 and 2017 trend will be 11.5% and 9.4% respectively. Consistent with prior Individual ACA Rate Filings, the Individual pricing trend is developed by normalizing historical Small Group benefit expense for changes in the underlying population and known cost drivers, which are then projected forward to develop the pricing trend, recognizing recent emerging unfavorable trend experience. Examples of such changes include contracting, cost of care initiatives, workdays, costs associated with Hepatitis C, compound drugs, average wholesale price, and expected introduction of generic drugs. Anthem also included in its Application a load in the trend for volatility. The undersigned is recommending that the assumed trend in the rate filing of 9.6% be reduced by 0.5%

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[9]Id. 24:17-20.

[10]CID Notice: Filing Requirements for Individual and Small Employer Group Health Insurance Policies Subject to ACA (March 7, 2016). http://www.ct.gov/cid/lib/cid/LH-FilingRquirementSubjectToACA.pdf.
CID Notice: Health Insurance Rate Filing Submission Guidelines (March 7, 2016). http://www.ct.gov/cid/lib/cid/LH-HealthInsuranceRateFilingSubmissionGuidelines.pdf.

to account for the removal of the volatility factor as well as the historical paid trend information provided. As a result, the recommended annualized trend is 9.1%.

In its Application, Anthem assumed a pricing correction of 18.7%. Based on the updated experience provided by Anthem to the Department on August 8, 2016, the undersigned recommends that this pricing correction be reduced from 18.7% to 15.0%.

The grace period adjustment of 0.375% was removed from Anthem's prior 2013 and 2014 Applications as the Department did not believe this adjustment was necessary. The undersigned recommends that the 0.72% grace period adjustment be removed from this Application in the same manner.

Anthem assumed a net risk adjustment receipt of $31.21 pmpm in its Application. The Department reviewed the June 30, 2016 Center for Consumer Information and Insurance Oversight ("CCIIO") Reinsurance and Risk Adjustment report for Connecticut. Based on this report, Anthem received $25,538,509.66 in risk adjustment payments for the individual market. This amounted to a receipt of $40.59 pmpm. The undersigned recommends that the net risk adjustment receipt be changed from $31.21 pmpm to $40.59 pmpm.

IV. CONCLUSION AND RECOMMENDATION

Based on the foregoing and the Hearing record, the undersigned concludes that the rates filed by Anthem, to be effective January 1, 2017, are excessive pursuant to § 38a-481 and recommends that the Insurance Commissioner disapprove the rate increases requested in the Application. The undersigned recommends that the Commissioner accept the following changes to the rating assumptions for rates effective January 1, 2017:

- Reducing the annual trend from 9.6% to 9.1%.
- Reduce the pricing correction from 18.7% to 15.0%.

- Remove the Grace Period adjustment of 0.72%.
- Change the risk adjust receipt from $31.21 pmpm to $40.59 pmpm.

Accordingly, the undersigned recommends that the Insurance Commissioner order Anthem to recalculate the rates using the above recommended revised rating assumptions with an effective date of January 1, 2017, and submit a revised rate filing to the Department no later than September 7, 2016.

Dated at Hartford, Connecticut, this 2nd day of September, 2016.

Jared T. Kosky, Esq.
Hearing Officer