STATE OF CONNECTICUT
INSURANCE DEPARTMENT

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In the Matter of:

THE PROPOSED RATE INCREASE APPLICATION OF ANTHEM HEALTH PLANS, INC. D/B/A ANTHEM BLUE CROSS AND BLUE SHIELD

Docket No. LH 17-70

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ORDER

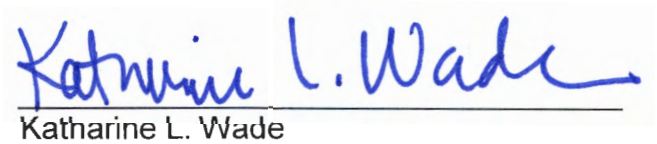
I, Katharine L. Wade, Insurance Commissioner of the State of Connecticut, having read the record in the above captioned matter, do hereby adopt the findings and recommendations of Jared Kosky, Hearing Officer, which are contained in the attached Proposed Final Decision, and issue the following orders, TO WIT:

1. The rate application filed by Anthem Health Plans, Inc. d/b/a Anthem Blue Cross and Blue Shield ("Anthem"), to be effective January 1, 2018, 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 thereafter 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 7, 2017. Anthem will recalculate its rates using the following recommended rate assumptions for rates effective January 1, 2018, and submit a revised rate filing to the Insurance Department for review no later than September 12,

2017, to enable such time for review and adequate notice to be issued to policyholders.

- Reducing the annual trend from 13.4% to 12.0%;
- Remove the Grace Period adjustment of 0.26%;
- Change the risk adjust receipt from $37.08 to $38.93; and
- Reduce the morbidity adjustment from 1.0998 to 1.0613.

Dated at Hartford, Connecticut, this 7th day of September, 2017.



Katharine L. Wade
Insurance Commissioner

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PROPOSED FINAL DECISION

I. INTRODUCTON

On May 1, 2017, 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 May 30, 2017, Insurance Commissioner Katharine L. Wade ("Commissioner") issued a notice of public hearing ordering that a public hearing be held on June 14, 2017 concerning the Application.

A copy of the Notice of Public Hearing was submitted to the Office of the Secretary of the State on May 30, 2017, 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 May 30, 2017, the Commissioner appointed the undersigned to serve as Hearing Officer in the proceeding.

On June 14, 2017, 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. At the Hearing, the undersigned represented that the Department would continue to accept written comment on the Application until the close of business of July 1, 2017. Nine members of the public provided oral comment during the two public comment sessions at the Hearing. Those who provided oral comment were Brenda Shipley, Manfred Mohring, Jennifer Lovet of Health Agents for America, Stephen Hunt, Arleen Block, Garry Malone, Marc Block, Angela DeMello of CONECT and The Strategies Group, and Tom McCormack. Public comment by persons who are not parties to the Hearing "shall be given the same weight as legal argument."[1]

As of the close of the record for public comment there were 50 filings of written communication containing public comment, some from persons who also provided oral comment. All of the written comments were in opposition to the Application. The major

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

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 mainly premised on the proposed rate increases being unaffordable to consumers. 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 of July 5, 2017. Anthem timely submitted the supplemental information on July 5, 2017 and the record was closed on that date.

Thereafter, on August 23, 2017, the Department requested that Anthem submit by August 30, 2017, a supplemental filing to consider the non-funding of Cost Share Reduction ("CSR") payments by the Federal Government and the rate impact, if any, to its already filed premium rates by applying that impact only to Silver On-Exchange plans. Anthem timely submitted this supplemental filing on August 30, 2017.

II. FINDINGS OF FACT

A. 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. 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 and is applicable only to on and off exchange individual health insurance products offered in Connecticut.
2. The Application requested an average increase of 33.8% on the Applicant's individual rates for on and off exchange plans to be effective January 1, 2018.

3. 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.
4. On May 1, 2017, Anthem electronically filed the Application requesting the following increases effective January 1, 2018:

	% Change
Catastrophic HMO Pathway X Enhanced	18.9%
Bronze HMO Pathway X Enhanced	27.1%
Bronze HMO Pathway X Enhanced for HSA	23.2%
Gold HMO Pathway X Enhanced 2500	48.9%
Anthem HMO Catastrophic BlueCare 7350/0%	21.9%
Anthem Bronze HMO BlueCare 6200/12400/40% for HSA	21.2%
Anthem Bronze HMO BlueCare 6750/13500/40%	31.5%
Anthem Silver HMO BlueCare 3500/7000/10% for HSA	48.9%
Anthem Silver HMO BlueCare Tiered 4350/6350/0%/20%	52.2%
Anthem Gold HMO BlueCare 1500/4500/10%	50.3%
Bronze PPO Standard Pathway X	31.8%
Bronze PPO Standard Pathway X for HSA	26.3%
Silver Core PPO Pathway X	22.6%
Silver PPO Standard Pathway X	23.1%
Gold PPO Standard Pathway X	50.8%
Anthem Silver EPO Century Preferred 2800/8400/20%	47.1%

5. Anthem identified in its Application factors that affect the proposed rate increase for all plans which include the following:
    - 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 reinstatement of the Health Insurer Tax in 2018.
6. Although rates are based on the same claims experience, the rate changes vary by plan from 18.9% to 52.2%. 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 that are applied on a per-member per-month ("PMPM") basis.
7. Additionally, the U.S. Department of Health and Human Services ("HHS") Notice of Benefit and Payment Parameters for 2018 Final Rule amends provisions related to age rating for children for plan or policy years beginning on or after January 1, 2018. The Application stated that while the change to the Federal default standard age curve is revenue neutral in total, rate increases for policies may be affected.

8. 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, 2016 through December 31, 2016 based on claims paid through February 28, 2017.

Per the Application, the earned premium prior to medical loss ratio ("MLR") rebate is $278,326,397. The earned premium reflects the pro-rata share of premium based on policy coverage dates.

The preliminary MLR rebate estimate is $0, which is consistent with Anthem's December 31, 2016 general ledger estimate allocated to the non-grandfathered portion of Individual business. Using this MLR estimate, the net earned premium is $278,326,397 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 versus 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 by Anthem in its historical completion factor estimates.

Allowed and incurred claims reported in Worksheet 1, Section I of the URRT were $382,905,916 and $309,295,764, respectively. Exhibit B of the Application provides claims detail.

9. The Application stated that Anthem reconciles its internal source systems monthly to ensure consistency with reported financials. It further noted that the products contained in the Application were only a part of the total business reported on the financial statements and that there were timing differences and certain definitional differences in the statutory statements compared to emerging experience utilized in the Application.

10. Projection Factors:

Changes in the Morbidity of the Population Insured

- The morbidity adjustment in Exhibit E of the Application reflects the market deterioration in morbidity. Anthem assumes morbidity relative to the market remains the same between 2016 and 2018. Anthem assumes that relative morbidity shifts between carriers would be largely offset by risk adjustment transfer payments.
- The Application states that based on Anthem's individual experience it has seen an increase in lapse rate for the 2017 individual segment. Per the Application, below are lapse rates for the first four months of 2015, 2016 and 2017:

	Jan	Feb	Mar	April
2015	10.3%	9.3%	3.6%	3.7%
2016	9.9%	4.0%	2.3%	3.0%
2017	15.6%	4.5%	2.8%	3.7%

- Anthem expects that this selective lapse and market deterioration will accelerate in 2018 due to increased selective entry and exit as members make health care spending decisions in the guaranteed issue, community rated Affordable Care Act ("ACA")[2] marketplace. The Application states that while not isolated individually in Anthem's modeling, increasing market volatility, a weak individual mandate, and the need for significant rate increases should compound to drive to higher selective market contraction.
- Exhibit W of the Application provides data that was used in Anthem's modeling with an increase in lapse assumption of 15% resulting in the market morbidity impact of 1.0998. Anthem assumes that members with Advance Premium Tax Credit and Cost Share Reduction subsidies as well as high risk members are less likely to drop coverage and that healthy members are more likely to drop coverage.

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.

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

- 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 HHS Notice of Benefit and Payment Parameters.
- Network Adjustments: In the Application, adjustments were made to account for the member cost sharing change for Out-of-Network benefits between the experience period and the projection period for some plans.

Other Adjustments

- Change in Medical Management: In the Application, this adjustment reflects the medical management costs not already included in Anthem'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 are currently eligible for cost share reductions. The percentage of enrollment in the CSR Plans in the experience period was compared by Anthem 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. Per the Application, 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 " plan (HIOS ID: 86545CT1330010) also included 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 13.4%. The trend was developed by normalizing historical benefit expense for changes in the underlying population and known cost drivers, which were then projected forward to develop the pricing trend. Examples of such changes include contracting, cost of care initiatives, workdays, average wholesale price, and expected introduction of generic drugs. The trend was developed by normalizing historical Individual benefit expense for changes in the underlying population and known cost drivers, which was then projected forward to develop the pricing trend. For projection, the experience period claims were trended 24.1

months from the midpoint of the experience period, which is June 29, 2016, to the midpoint of the projection period, which is July 1, 2018. Exhibit E of the Application has details.

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

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

	2014	2015	2016
Inpatient	$3,563.50	$3,881.84	$4,162.64
Outpatient	$771.23	$820.68	$854.81
Professional	$123.24	$132.60	$135.36
Pharmacy	$74.75	$106.29	$119.55

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

	2014	2015	2016
Inpatient	31.5	31.7	32.0
Outpatient	180.9	186.5	188.4
Professional	949.1	940.6	950.0
Pharmacy	1,055.7	1,039.2	1,049.6

c. Anthem's Paid PMPM:

	2014	2015	2016
Inpatient	$112.13	$123.04	$133.26
Outpatient	$139.48	$153.09	$161.05
Professional	$116.97	$124.72	$128.59
Pharmacy	$78.91	$110.46	$125.48
Total	$447.49	$511.31	$548.38

d. Anthem's Paid Trend:

	2015/ 2014	2016/ 2015
Inpatient	9.7%	8.3%
Outpatient	9.8%	5.2%
Professional	6.6%	3.1%
Pharmacy	40.0%	13.6%
Total	14.3%	7.2%

e. Anthem's Estimated Paid trend in 2017 and 2018:

	2017/ 2016	2018/ 2017
Inpatient	14.5%	19.7%
Outpatient	4.9%	5.1%
Professional	2.8%	3.0%
Pharmacy	24.7%	27.0%
Total	11.3%	13.9%

f. Anthem's experience in the individual market (2012-2014 Pre-ACA and ACA, 2015-2016 ACA Only):

CY	Earned Premium	Incurred Claims	Loss Ratio
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	$303,520,256	$249,297,279	82.14%

2016	$301,903,451	$302,902,905	100.33%
Total	$1,287,323,416	$1,107,335,938	86.02%

12. Risk Adjustment:

- In the Application, experience period risk adjustments were estimated on available 2016 independent consultant's market study. Per the Application, the Center for Medicare and Medicaid Service ("CMS") preliminary risk transfers, provided in Exhibit G of the Application, were not used due to data issues including inconsistent cutoff dates from various carriers, differences in supplemental data, member month anomaly and known issues not yet fixed with the EDGE server by various carriers.
- In its Application, Anthem assumes that the risk adjustment transfer payment for 2018 is the same as 2016 with adjustments for provision adverse deviation due to uncertainties of risk adjustment estimates including the potential of HealthyCT not paying the risk adjustment payment for calendar year 2016. This assumption implies that Anthem's morbidity deteriorates at the same rate as the market due to unstable market conditions. Per the Application, an independent consultant's study was used to develop the assumptions for the Anthem's relative risk to the market. Further detail can be found in Exhibit G of the Application.
- The projected risk adjustment PMPMs reported in the URRT were net of risk adjustment fees, and are on a paid claim basis. The projected amount applied to the development of Market Adjusted Index Rate was on an allowed claim basis.

13. In the Application, Administrative Expenses were expected to be consistent with historical levels and were developed utilizing the same methodology as previous filings. Maintenance costs were projected for 2018 based on 2016 actual expenses with adjustments made for expected changes in business operations.

14. In the Application, 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. Per the Application, the expense assumptions were based on historical expense level adjusted for cost inflation and anticipated changes in the programs.
15. In the Application, Selling Expense represents projected broker commissions and bonuses associated with the broker distribution channel. Commissions are to be paid at a rate of $5.00 PMPM for On-Exchange plans and $15.00 PMPM for Off-Exchange plans. Commissions will be paid only for members enrolling during the Open Enrollment period.
16. In the Application, Specialty Expenses were projected administrative expenses for dental and vision coverage.
17. In the Application, the miscellaneous items represent Department fees and assessments, including the assessment from the State of Connecticut to cover the cost of the Vaccine Immunization Program and the Connecticut Department of Public Health ("DPH") assessment.
18. 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. The insurer fees are to be reinstated in 2018.

- 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 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.

19. In the Application, profit and risk margin was reflected on a post-tax basis as a percentage of premium.

20. Exhibit I of the Application shows the projected Federal MLR for the products in the Application. Per 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 the Application 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.

21. The single risk pool for the Application is established according to the requirements in 45 CFR § 156.80.[3] It reflects all covered lives for every non-grandfathered product/plan combination sold in the Connecticut Individual market by Anthem.

22. Per the Application, the experience period Index Rate is equal to the allowed claims PMPM for the essential health benefits of Anthem's non-grandfathered business in

[3]45 CFR pt. 156 – Health Insurance Issuer Standards Under the Affordable Care Act, Including Standards Related to Exchanges, General Provisions, Single Risk Pool.

the Individual market. The Index Rate reported in Worksheet 1, Section I, cell G17 of the URRT is $616.77. No benefits in excess of the EHBs are included in this amount.

23. Per the Application, 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 excess of the EHBs are included in this amount.

24. In the Application, the Market Adjusted Index rate was calculated as the Index Rate adjusted for all allowable market-wide modifiers defined in the market rating rules.[4] The two market-wide adjustments - risk adjustment and Exchange user fee adjustment - were described in the Actuarial Memorandum in the Application.

25. 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.

[4]See 45 CFR pt. 154 – Health Insurance Issuer Rate Increases: Disclosure and Review Requirements.

- 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.

26. In the Application, the age factors were 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 49.
27. In the Application, the geographic factors were developed from historical claims experience. The geographic calibration adjustment was calculated as the member weighted average of the geographic factors, using the projected membership distribution by area.
28. In the Application, the AV Pricing Values for each plan were reported in Worksheet 2, Section I of the URRT. The AV Pricing Value represents the cumulative effect of adjustments made to move from the Market Adjusted Index Rate to the Plan

Adjusted Index Rate. Per the Application, consistent with final Market Rules, utilization adjustments were made to account for member behavior variations based upon cost-share variations of the benefit design and not the health status of the member.

29. The Applicant's 2018 Individual plan portfolio contains one plan 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.

Per the Application, 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.

30. The Risk Based Capital ("RBC") Ratio for Anthem is 396.07% as of December 31, 2016, as identified in Anthem's 2016 Annual Statement filed with the Department.

31. Current capital and surplus for Anthem is $232,222,134 as shown on page 5, line 49 of Anthem's 2016 Annual Statement filed with the Department.

32. In the Application, the proposed retention charge in the rate development is 18.8%. 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, 2016 Annual Statement for Anthem has a retention amount of 14.1%. This amount was calculated from the Analysis of Operations by Lines of Business exhibit on page 7 of Anthem's Annual Statement: 1 – [line 17, column 2 $825,603,699 / line 7, column 2 $961,505,587] = 14.1%.

33. Number 16-82 of the 2016 Public Acts requires health insurance coverage for mammograms provided by breast tomosynthesis. Anthem considers this coverage as a new mandate for 2017. Per the Application, the expected cost of this coverage has been included as an adjustment with a $0.21 PMPM impact.

B. At the conclusion of the Hearing, Anthem was asked to provide additional information in response to specific questions posed by the Department during the Hearing. Based upon that information, the undersigned makes the following additional findings of fact:

1. In its supplemental filing with the Department, Anthem's 2017 projected year-end loss ratio is 90.8% which is a pure loss ratio rather than a HHS loss ratio used for the rebate calculation, which would be higher than 90.8%. Anthem derived this by taking the difference between the April year-to-date loss ratio and the year-end loss ratio for 2015 and 2016. The average of these two differences was then added to the April 2017 year-to-date loss ratio to project the 2017 year-end loss ratio. Below is an illustration provided by Anthem of this calculation:

    (A) April 2015 Year to Date Loss Ratio 68.3%
    (B) 2015 Year End Loss Ratio 80.4%
    (C) Difference = (B) - (A) 12.1%

    (D) April 2016 Year to Date Loss Ratio 88.2%
    (E) 2016 Year End Loss Ratio 97.3%
    (F) Difference = (E) - (F) 9.1%

(G) April 2017 Year to Date Loss Ratio 80.3%
(H) Average of differences for 2015 & 2016 = [(C) + (F)] / 2 10.6%
(I) **2017 Year End Projected Loss Ratio = (G) + (H) 90.8%**

2. In its supplemental filing with the Department, Anthem stated that the 15% lapse assumption yields a morbidity impact of 1.0998. A 10% lapse assumption yields an impact of 1.0613 and a 5% lapse assumption yields an impact of 1.029.
3. In its supplemental filing with the Department, Anthem stated that the risk adjustment value from CMS on June 30, 2017 was $24,193,391 for Individual business. This results in a $38.93 PMPM.
4. In its supplemental filing with the Department, Anthem stated that the difference in commissions it had proposed in its Application is premised on several factors that demonstrate that the broker experience should be simpler and less time intensive On Exchange than it is Off Exchange. Anthem went on to state the following: First, Access Health Connecticut ("AHCT") is a single point of contact for all On Exchange business and has attempted to create a standard, streamlined, and simple interface with brokers. The broker experience has been simplified and improved by AHCT in a number of ways. AHCT created a "Broker Connect" portal specifically for certified producers that enables them to handle a number of tasks, ranging from submission of application information to managing appointments. "Broker Connect" was improved with the creation of a mobile app, available for both Apple and Android users. AHCT is assessing carriers 1.65% of premium to partially fund these initiatives. Second, the limited portfolio associated with AHCT creates an easier environment and this is improved further with the "standard plans" available via AHCT. Third, the heavily subsidized population has primarily chosen plans that are standard among participating carriers, and fourth, Anthem has made significant

additional investment in call center resources, which provide assistance to prospective members and brokers.

5. In its supplemental filing with the Department, Anthem stated that Tier 1 historical utilization is 71%, Tier 2 utilization is 24%, and Tier 3 utilization is 5%. Anthem's assumption for future use is 76% for Tier 1, 19% for Tier 2, and 5% for Tier 3.
6. In its supplemental filing with the Department, Anthem stated that the utilization of the medication for Hepatitis C was high for the first several months of 2016, came down in the second half of 2016 and remains at that level in 2017. This reduced utilization led to a 1.9% decrease in observed trend that Anthem does not expect to recur in future periods.
7. In its supplemental filing with the Department, Anthem stated that the 2017 YTD trend is also impacted by changes in metal mix. The paid trend information by metal level shows how the mix of membership by metal level has had an impact on the Paid PMPM due to the shift of the membership from Gold to Bronze. Using the cost differences by metal shown in the data provided, 2016 to 2017 shifts in metal mix has suppressed emerging 2017 trend by 5.5%. Per Anthem, since premiums vary by metal level, the impact of this shift should be restored to pricing trend.
8. In its supplemental filing with the Department, Anthem stated that including the two key factors with the 1.9% currently showing for 2017 implies 2017 is actually coming in at 9.5%.
9. In its supplemental filing with the Department, Anthem stated that the impact of special enrollment is minimal and no impact was assumed in its Application. Anthem modeled Special Enrollment Period ("SEP") enrollment enforcement by splitting Open Enrollment Period ("OEP") experience and looking at Under/Over age 45 and low, medium, and high risk. Anthem assumed 10-20% would not qualify for

SEP across all age and risk segments for SEP members due to enforcement of eligibility requirements. This assumption was based on the historical off exchange enforcement of qualifying events. For Connecticut this produces a 0.1% SEP credit.

10. In its supplemental filing with the Department, Anthem stated that 95% of the utilization was in network for each of 2015 and 2016.

11. In its supplemental filing with the Department, Anthem stated that the trend used for the rate filing would be 0.7% higher without the following member patient focused programs which were described by Anthem as follows:

Enhanced Personal Health Care: The focus is on creating incentives for Primary Care Physicians to provide member patient's comprehensive ongoing preventative care.

Specialty Rx Level of Care: The focus is to assist member patients who are prescribed injectable drugs to consider and utilize alternative and cost effective care settings including home, ambulatory infusion center, or a physician office.

Genetic Testing: The focus of the program is have providers consider obtaining a medical necessity review pre-service for genetic testing.

Specialty Rx Hemophilia Clinical Site of Care: The focus of the program is to assist member patients who are prescribed hemophilia agents that are covered under the medical benefit for self-administered specialty drugs to consider and utilize alternative and cost effective providers.

Cancer care quality program: The focus of the program is the provision of a provider portal that promotes evidence based, cost-effective oncology care by assisting the provider with a comprehensive treatment review tool to create a plan of care.

C. At the request of the Department, on August 30, 2017, Anthem submitted a supplemental filing that contemplates the absence of CSR payments for 2018 and applies that impact only to Silver On-Exchange plans. Anthem has determined the impact to the Silver On-Exchange plans in the absence of CSR payments for 2018 to be 16.7%. As stated in this supplemental filing, Anthem's analysis reflects the following market reactions to the higher On-Exchange Silver price point:

- Since the rates for the On- Exchange Silver plans will become more expensive, Anthem assumes that Silver On-Exchange members without Advance Premium Tax Credit ("APTC") will buy the less expensive Off-Exchange Silver plans.
- For a similar reason, Anthem also assumes that the On-Exchange members purchasing the 73% AV CSR option will migrate to On-Exchange Bronze plans, rather than Off-Exchange Silver plans, in order to still qualify for APTC.
- The Silver members on 87% and 94% AV CSR options will remain on Silver plans On-Exchange to receive a higher APTC and maintain their current benefits.
- Consistent with this logic, Anthem used YTD through June, 2017 actual premium and CSR estimates to develop the weighted average CSR receipt estimate as a percentage of premium for 87% and 94% CSR AV plans.
- The Silver Core PPO Pathway X plan's revised rate increase request is now 43.3%.
- The Silver PPO Standard Pathway X plan's revised rate increase request is now 43.9%.
- The average rate increase request is now 41%.

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.[5] 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.

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.

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

- 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 year and again by members of the public in their written and oral comments is that the rate increases would not be affordable for renewing policyholders. Affordability, however, is relative to each person and subjective, and although it is of overall concern to the Department, it is not a standard for rate review within the aforesaid statute, regulation or actuarial standards of practice that the Department must utilize in reviewing rate filings.

To determine if the rates filed by Anthem are reasonable in relation to the benefits provided, the Department 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 effective January 1, 2014, the Department used criteria spelled out in the latest HHS rate regulations as a template for review along with previously issued Connecticut Insurance Department Bulletins[6] that discuss the requirements for rate filings.

The normalized paid trend for the last two years has been 14.3% and 7.2%. Anthem estimates that 2017 and 2018 trend will be 11.3% and 13.9% respectively. The trend is developed by normalizing historical benefit expense for changes in the underlying population and known cost drivers, which are then projected forward to develop the pricing trend. Examples of such changes include contracting, cost of care initiatives, workdays, average wholesale price, and expected introduction of generic

[6]CID Bulletin HC-90-17: Filing Requirements For Individual and Small Employer Group Health Insurance Policies Subject to The Affordable Care Act (ACA) (March 2, 2017).
CID Bulletin HC-81-17: Health Insurance Rate Filing Submission Guidelines (March 2, 2017).

drugs. Anthem also included a load in the trend for volatility. The undersigned is recommending that the assumed trend in the rate filing of 13.4% be reduced to account for the removal of the volatility factor as well as historical paid trend information and trend for the first four months of 2017. As a result, the recommended annualized trend is 12.0%.

The grace period adjustment was removed from the 2013-2016 rate filings as the Department did not believe this adjustment was necessary. The undersigned recommends that the 0.26% grace period adjustment be removed from this rate filing in the same manner it was in 2013 through 2016.

Anthem assumed a net risk adjustment receipt of $37.08 PMPM. The Department reviewed the June 30, 2017 Center for Consumer Information and Insurance Oversight ("CCIIO") Reinsurance and Risk Adjustment report for Connecticut. Based on this report, Anthem received $24,193,391.03 in risk adjustment payments for the individual market. This amounted to a receipt of $38.93 PMPM. The undersigned recommends that net risk adjustment receipt be changed from $37.08 PMPM to $38.93 PMPM.

Anthem assumed a 15% lapse rate would occur in 2018, resulting in a morbidity adjustment of 1.0998. Based on the information provided, the undersigned believes a better reflection of lapses for 2018 is 10%, which results in an adjustment of 1.0613.

Anthem's supplemental filing of August 30, 2017 requested a 16.7% rate increase for the Silver On-Exchange-only plans to account for a lack of CSR funding. Based on the information provided in this supplemental filing, the undersigned believes this request of 16.7% is appropriate.

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, 2018, are excessive pursuant to § 38a-481 and recommends that the Insurance Commissioner disapprove the rate increases requested in the Application. 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 § 38a-481. The undersigned recommends that the Commissioner request the Applicant make the following changes to the rating assumptions for rates effective January 1, 2018:

- Reducing the annual trend from 13.4% to 12.0%;
- Remove the Grace Period adjustment of 0.26%;
- Change the risk adjust receipt from $37.08 to $38.93; and
- Reduce the morbidity adjustment from 1.0998 to 1.0613.

Accordingly, 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, 2018 and submit a revised rate filing to the Department for review no later than September 12, 2017.

Dated at Hartford, Connecticut, this 7th day of September, 2017.

Jared T. Kosky, Esq.
Hearing Officer