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. LH09-51

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ORDER

I, Thomas R. Sullivan, Insurance Commissioner of the State of Connecticut, having read the record in the above captioned matter, do hereby adopt the findings and recommendations of Mary Ellen Breault, 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 October 1, 2009 for BlueCare, Century Preferred, Lumenos, Tonik, Traditional Fee For Service Products (SP-200, DP-30, C-90, E-94/96) and the Closed Book (Value, Kaiser, Conversion) 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 Mary Ellen Breault, Hearing Officer, on August 4, 2009. 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-48. The recommended rate are as follows:

	%Increase
BlueCare (HMO)	16.6%
Century Preferred (PPO and HSA)	16.5%
Lumenos (CDHP)	19.9%
Tonik (PPO)	13.0%
Traditional (FFS): SP-200, DP-30, C-90, E-94/96	20.0%
Closed HMO: Value, Kaiser, Conversion	20.0%

3. Any revised rates which may be submitted consistent with the above will be effective no earlier than January 1, 2010.

4. Anthem will recalculate the rates using the recommended rate increases with an effective date of January 1, 2010 and submit a revised rate filing to the Insurance Department no later than August 31, 2009 to enable adequate notice to be issued to policyholders.

Dated at Hartford, Connecticut, this 6th day of August, 2009.

Thomas R. Sullivan
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. LH09-51

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PROPOSED FINAL DECISION

I. INTRODUCTON

On June 9, 2009, 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 July 8, 2009, Insurance Commissioner Thomas R. Sullivan ("Commissioner") issued a notice of public hearing. The Commissioner ordered that a public hearing be held on July 20, 2009 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 July 8, 2009 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 July 15, 2009, the Commissioner appointed the undersigned to serve as Hearing Officer in this proceeding.

On July 13, 2009, the Office of the Healthcare Advocate ("OHA") timely filed a Petition to Intervene. The Petition was timely served by electronic mail to the Applicant and the Commissioner. On July 14, 2009, the Attorney General ("AG") submitted a Petition to Intervene that was not timely filed, and service was not made on the Applicant. The AG requested a waiver of the five day notice period pursuant to Conn. Agencies Regs. §38a-8-48(d), that is virtually identical to Conn. Gen. Stat. §4-177a(c), and provides that the five-day requirement may be waived at any time the Commissioner or presiding officer on a showing of good cause.

Petitioners asserted their interests in intervening were to represent consumers and ensure that consumer concerns were heard and considered. In addition, the OHA claimed that his intervention was necessary to ensure a fair and complete adjudication of the rate approval process.

The Applicant did not object to either Petition to Intervene.

Both the OHA and the AG submitted Petitions that were deficient in both form and substance pursuant to Conn. Agencies Regs. §38a-8-48(c). The Petitioners did not present facts demonstrating their 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 determine whether the Application should be approved. The ability of

consumers to voice their concerns was well provided for in the proceeding. The Public Notice issued by the Commissioner on July 8, 2009 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 and the AG were granted intervenor status subject to specified limitations. The specific limitations imposed upon the Intervenors were:

1. The subject matter of the intervention was limited to the issue of consumer concerns regarding the impact of the proposed rate increases if the increases are granted.
2. Neither Petitioner had discovery rights other than to inspect the public comments on file.
3. The Intervenors had the right to introduce documentary evidence and witnesses related to the consumer concerns they represent. In the interest of the orderly conduct of the hearing and in recognition of the right of the public to comment directly during the public comment period, as well as in writing, the Intervenors were limited to one witness each and were admonished to be succinct and to maintain a relevancy to the rate application.

4. The Intervenors had the right to cross examine the Applicant's witness limited to issues of consumer concern regarding the impact of the proposed rate increase.

On July 20, 2009, the public hearing on the Application was held before the undersigned. The following individuals testified at the public hearing on behalf of the Applicant: George Siriotis, Regional Vice-President Individual Sales, Anthem Blue Cross and Blue Shield and Jennie Casady, Associate Actuary Individual Markets, the WellPoint Companies. 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: Paul Lombardo, Life and Health Actuary; N. Beth Cook, Counsel; and Timothy Lyons, Counsel.

Victoria L. Veltri, General Counsel, represented the OHA. Jennifer Bass, an Anthem policyholder, testified as a witness for the OHA.

Richard Blumenthal, Attorney General and Thomas P. Ryan, Assistant Attorney General represented the Office of the AG. Ralph D'Agosta, an Anthem policyholder, testified as a witness on behalf of the AG.

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. There was a misunderstanding regarding the sign up sheet for speakers. All members of the public that entered the hearing room signed the posted sheet for those who wished to speak. Five members of

the public provided oral comments during the public comment portion of the hearing. Thirty members of the public provided written comments to the Department that were entered into the record.

Anthem was ordered to submit supplemental information and the record of the hearing was left open until 4 p.m. on July 21, 2009. Anthem timely submitted the supplemental information on July 21, 2009 and the record was closed. On July 27, 2009, the OHA submitted a motion to reopen the record to enable the Intervenors to file comment on the supplemental submission. The Applicant filed an objection to the motion and the motion to reopen was denied.

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 June 9, 2009, Anthem electronically filed a rate application requesting the following increases and resulting proposed base premium per member per month (PMPM) to be effective 10/1/2009:

	%Increase	Proposed PMPM
BlueCare (HMO)	22.7%	$ 473.34
Century Preferred (PPO and HSA)	21.9%	$ 372.25
Lumenos (CDHP)	27.7%	$ 296.92
Tonik (PPO)	21.9%	$ 262.81

Traditional (FFS): SP-200, DP-30, C-90, E-94/96	30.0%	$1,353.20
Closed HMO: Value, Kaiser, Conversion	30.0%	$ 512.46

2. Anthem filed a previous rate increase for these plans on September 5, 2008 and the Department approved the following rate changes effective 1/1/09:

BlueCare (HMO)	14.7%
Century Preferred (PPO and HSA)	13.4%
Lumenos (CDHP)	-4.0%
Tonik (PPO)	15.1%
Traditional (FFS): SP-200, DP-30, C-90, E-94/96	6.9%
Closed HMO: Value, Kaiser, Conversion	20.0%

3. Anthem testified it was experiencing deteriorating experience across all product lines.

4. The loss ratios by product are as follows:

	Actual 12 Mo. LR 4/08-3/09	Assumed LR in Pricing
BlueCare (HMO)	80.1%	83.8%
Century Preferred (PPO and HSA)	81.3%	79.9%
Lumenos (CDHP)	67.6%	74.5%
Tonik (PPO)	70.8%	71.4%
Traditional (FFS): SP-200, DP-30, C-90, E-94/96	109.7%	94.6%
Closed HMO: Value, Kaiser, Conversion	158.7%	92.1%

5. No changes were proposed to the existing age/gender factors or the HSA aggregate family deductible factors.

6. The retention is based on the following assumptions:

- Administrative expenses are $26.15 PMPM for products with Rx coverage and $24.84 PMPM for products without Rx coverage.
- Operating margin is $28.76 PMPM.
- Premium tax is 1.75% of premium.
- Commissions are a percentage of premium and vary by product. On average the total commission is 4% of premium.

7. The retention as a percentage of premium varies by product due to the fixed PMPM expenses for administrative expense and operating margin.
8. Commissions range from 2.8% to 6%. No commissions are included on the traditional fee for service products or closed blocks.
9. Anthem testified their rates were in compliance with the 1.75% premium tax.
10. The $26.15 flat component of the administrative expense includes employee compensation, employee benefits, overhead, disease management and care coordination programs, and consumer education and outreach.
11. The operating margin is composed of a profit charge and a risk charge. The risk charge covers adverse selection and claim volatility on plans with lower persistency. The operating margin is set at 7.5% of the overall premium for the individual block, but varies by product to be more equitable. Anthem testified it could not identify the values of the risk or the profit components. The 7.5% is consistent with past rate filing applications.
12. Anthem testified that the additional fees included in the Application, such as paper billing fee and a late charge, are not being implemented at this time. Anthem

testified that if it decides to implement these fees at a future date, it would seek Department approval prior to such action.

13. The annual trend factors by product that were used to develop the rates are as follows:

BlueCare (HMO)	19.9%
Century Preferred (PPO and HSA)	15.1%
Lumenos (CDHP)	16.5%
Tonik (PPO)	15.1%
Traditional (FFS): SP-200, DP-30, C-90, E-94/96	15.3%
Closed HMO: Value, Kaiser, Conversion	20.5%

14. Trend includes anticipated changes in costs, utilization, savings initiatives, deductible leveraging, aging and emerging experience.
15. The experience period used for the rate development is the 12 month period from 4/1/2008 through 3/31/2009.
16. Projected experience was based on incurred claims in the experience period that were paid through 4/30/2009.
17. Anthem testified to having a high level of confidence with using only one month of paid claims beyond the incurral period.
18. The rating period is the 12 month period from 10/1/2009 through 9/30/2010.
19. The projected trend factor was applied from the midpoint of the experience period to the midpoint of the proposed rating period.

20. Annual trend for medical services ranged from 16.21% to 21.8% depending on the services covered. The annual trend for prescription drugs ranged from 14.2% to 15.7%.

21. Claim cost trend includes the expected change in Anthem's reimbursements to providers.

22. Anthem testified that utilization management programs and the expected cost savings from those programs are included in the trend calculations.

23. Deductible leveraging occurs when the cost of services increase, but the policy deductible does not change, resulting in Anthem paying a higher percentage of total claims compared to past policy periods.

24. Anthem testified that it added an explicit margin for added risk into the claim cost trend for the Blue Care product since it is the only carrier offering in Connecticut an HMO product with maternity coverage at the $1500 deductible level.

25. An adjustment of .5% was included in trend to account for the aging of the policyholders.

26. Anthem testified that rates are on an attained age basis with five year age brackets. Every five years an individual will enter the next age bracket and be subject to higher premium rates due to the change in age factor.

27. Rebates are credited for prescription drug coverage. The credit is 3.3% of prescription drug claims. The full amount of the rebate is not passed on to the policyholder.

28. Mental health and substance abuse, lab and embedded vision services are capitated, so the actual fees are included in the premium rate. Immunization and pharmacy dispensing fees are also fixed amounts added to the premium rate.
29. Capitated costs are not included in the claims data.
30. Anthem testified that only Connecticut specific experience has been included in the rate filing.
31. Rates are adjusted for the wearing off of underwriting as the policy duration ages.
32. Anthem is proposing to change the Lumenos HSA deductible relativities as a result of worse claims experience at the lower deductibles when compared to the higher deductibles.
33. Anthem is proposing to change the Century Preferred deductible relativities as a result of worse claims experience at the lower deductibles when compared to the higher deductibles.
34. Anthem testified that is experiencing increased costs in hospital care due to increased utilization, new services and technology, high cost implantable devices and drugs, diagnostic imaging and cost shifting as a result of underfunded government programs.
35. Anthem testified that 40% of diagnostic imaging is medically unnecessary or does not contribute to improved patient care.
36. Anthem testified that it estimates that the cost of unnecessary procedures ranges from $2 to over $16 billion.
37. Anthem testified regarding a seasonality effect on the high deductible plans. Anthem testified that the 69.8% loss ratio calculated by the Department's actuary for

the first four months of 2009 for Tonik and Century Preferred experience combined reflects that in the early duration of the policy period, policyholders have not all met the deductible. The higher pricing loss ratio reflects that in the later duration of the policy period, claims are expected to increase as policyholders meet the deductible and many of the plans pay 100% of claims once the deductible is met. Anthem testified that the twelve month loss ratio ending December 2008 reflects this claim pattern.

38. Anthem testified that the average hospital length of stay has increased since mid-2008.

39. Exhibit 7 of the rate filing details reserve data, but does not provide this data for each product separately. Anthem combined certain products due to the lack of fully credible data for some products.

40. Attachment A of the rate filing details actual loss ratio and trend data, but does not provide this data for each product separately.

41. Anthem filed supplemental documents to provide the loss ratio and trend data by product with claims paid through June 2009.

42. The rolling twelve month claim cost trends for the Blue Care and Century Preferred products have increased fairly steadily from mid-2008 to 2009. For the period ending April 2009, the revised values are 18.5% for Blue Care and 22.4% for Century Preferred.

43. The actual rolling twelve-month trend factors by product provided in the revised Attachment A with paid claims through June 2009 are as follows:

	Actual	Pricing

BlueCare (HMO)	18.5%	19.9%
Century Preferred (PPO and HSA)	22.4%	15.1%
Lumenos (CDHP)	23.9%	16.5%
Tonik (PPO)	15.0%	15.1%
Traditional (FFS): (Excluding CHCBP)	32.2%	15.3%
Closed HMO: Value, Kaiser, Conversion	-9.5%	20.5%

44. The original Attachment A combined certain products since the experience was not fully credible. The actual rolling twelve-month trend factors by product provided in the original Attachment A with paid claims through April 2009 are as follows:

	Actual
BlueCare (HMO) and Closed HMO	18.8%
Century Preferred (PPO and HSA) and Tonik	16.3%
Lumenos (CDHP)	25.5%
Traditional (FFS) and CHCBP	13.6%

45. The twelve-month loss ratios ending in April 2009 by product provided in the revised Attachment A with paid claims through June 2009 are as follows:

	Actual
BlueCare (HMO)	80.5%
Century Preferred (PPO and HSA)	80.7%
Lumenos (CDHP)	66.1%
Tonik (PPO)	69.6%
Traditional (FFS): SP-200, DP-30, C-90, E-94/96	99.3%
Closed HMO: Value, Kaiser, Conversion	156.4%

46. The number of monthly members by product are as follows:

	April 2009	Jan. 2008
BlueCare (HMO)	14,709	20,871
Century Preferred (PPO and HSA)	19,227	24,482
Lumenos (CDHP)	14,360	5,656
Tonik (PPO)	6,975	3,436
Traditional (FFS): SP-200, DP-30, C-90, E-94/96	131	196
Closed HMO: Value, Kaiser, Conversion	134	178
TOTAL	55,536	54,819

47. Anthem testified that it does not track reasons for disenrollment.

48. Anthem testified that membership had decreased, but new members continue to enroll.

49. Anthem has historically revised premium rates on January 1.

50. Anthem testified that it filed for an effective date of October 1, 2009 to avoid a larger rate increase expected if delayed to January 1, 2010.

51. Anthem provides a minimum of 30-45 days notice to policyholders prior to the implementation of a rate increase.

52. Anthem testified that customer service representatives will be available to assist members who cannot afford the new rates with options for other alternatives.

53. Anthem testified that it does not provide a one year rate guarantee.

54. Some brokers told applicants that the rates were valid for a one year period.

55. Anthem's communication to some brokers simply stated that rates are effective January – December 2009.

56. Anthem testified that it does not track members on the basis of percentage of deductible met during the policy period.

57. Anthem did not know if there were plans to credit the members contributions towards any deductible during the calendar year to a new policy should the member decide to move to a lower cost plan due to the October increase.

58. Anthem testified it does not project membership mixes between product portfolios.

59. Anthem testified it did not account for shock lapse.

III. DISCUSSION

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.

Lacking any other statutory definitions in Conn. Gen. Stat. §38a-38a-481, we therefore use the definitions in Conn. Gen. Stat. §38a-665, and the reasonableness elements espoused in that statute as well as Conn. Agencies Reg. §38a-474-3, and along with standard actuarial principles 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. 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.

The primary concern raised by the Intervenors and members of the public were that the applied for increases would not be affordable for each individual wishing to purchase Anthem individual health insurance. 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 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. Based on information provided in the Application and presented orally or in writing, the actuarial analysis indicated that Anthem's adverse claims experience is increasing for the overall block. The overall trend factors have also increased significantly for the overall block. In reviewing products individually, some products are not fully credible. Tonik and Lumenos were introduced in 2007 and therefore do not have the same level of credibility found in the Blue Care and Century Preferred products.

Based on the data provided by product, the actuarial analysis deems that the actuarial methodology used was consistent with ASOP 8 and was applied consistently across all products. The starting per member per month values are deemed to be reasonable and actuarially sound in relation to the benefits provided and the underlying risks.

The actuarial review of the retention indicates that the assumptions are reasonable with the exception of the operating margin. The operating margin is composed of a risk charge and a profit charge, but Anthem could not identify the values of the two components. The operating margin used in the rate filing is $28.76 PMPM

and is calculated as 7.5% of overall premium. Anthem testified that there has been a significant loss in membership that is causing anti-selection. Although overall membership has not declined, the data provided shows a shift in membership from the Blue Care and Century Preferred plans to Lumenos and Tonik. Since a portion of the risk charge is captured in other assumptions including trend for each product and no specific evidence was provided in support of the need for this level of margin, an operating margin of 5% is deemed to be a reasonable value to capture both the risk charge and profit charge.

Anthem applies an adjustment for the wearing off of underwriting. No specific evidence was provided to support this adjustment, and any increase in claims on this basis is captured in the actual claims experience.

The trend used in the pricing was lower than the actual trend for the twelve months ending April 2009 for all products except the Blue Care and Closed HMO products. Attachment A in the rate Application that provides loss ratios and trend values with paid claims through April 2009, combined the HMO blocks. The actual trend for the twelve month period ending April 2009 is 18.8%, while the trend used in pricing is 19.9% for Blue Care and 20.5% for the closed block. Anthem provided a revised Attachment A with paid claims through June 2009 that provides loss ratios and trend values by product. The actual trend for Blue Care for the twelve months ending April 2009 based on claims through June 2009 is 18.5%. The actual trend for the closed block is negative and cannot be viewed as credible with only 134 members. Based on the evidence provided, the trend used for pricing for the HMO products is

viewed as unreasonable. Using the actual trend of 18.5% for Blue Care is viewed to be a reasonable assumption with no further adjustment.

Anthem stated that the trend factors used for projection included a .5% adjustment for aging. The actuarial analysis provides that this factor is redundant since the premium rates are calculated on an attained age basis. The age factors that Anthem applies to the base premium already reflect that higher claims are expected as an individual ages. Reasonable trend assumptions for the Century Preferred, Lumenos and Tonik are those used in the rate filing less the .5% aging adjustment.

The Closed HMO and the Traditional products do not have credible experience with only 134 and 131 members as of April 2009, respectively. The Application indicated the need for 119.8% rate increase for the Closed HMO product and 40.5% rate increase for the Traditional products. Anthem requested a 30% rate increase for both products. The previously approved rate Application for the January 1, 2009 effective increases indicated the required rate increase for the Closed HMO product was 77.3%, yet Anthem only requested 20%. Although this increase may not result in a self-supported adequate rate, the lower increase was not deemed to be inadequate since the data was not credible and the resulting rate would not adversely impact the adequacy of the rates for the entire individual block of business and continued use would not impact the solvency of the company. For the Traditional products, Anthem requested 6.9% that was the increase needed based on the actuarial analysis. A review of the overall experience of the individual block indicates there would not be any significant adverse financial impact if the rate increases on these small closed blocks was limited to 20%.

The actuarial analysis by the Department developed revised projected rates effective October 1, 2009 with the following changes to assumptions used in the rate Application:

- The base PMPM for Blue Care was trended at 18.5%.
- The base PMPM for Century Preferred, Lumenos and Tonik were reduced by .5% to remove the aging factor, resulting in trends of 14.6%, 16% and 14.6% respectively.
- The underwriting wear-off adjustment was reduced to 0%.
- The operating margin was recalculated on the basis of 5% of total premium compared to 7.5% of total premium.
- Since a change in assumptions would still provide a required increase in excess of that requested, the rates for the closed blocks were not recalculated with the cited adjustments.

The resulting rate increases deemed to be reasonable and actuarially sound as of October 1, 2009 are:

	%Increase
BlueCare (HMO)	12.5%
Century Preferred (PPO and HSA)	13.4%
Lumenos (CDHP)	16.7%
Tonik (PPO)	10.3%
Traditional (FFS): SP-200, DP-30, C-90, E-94/96	20.0%
Closed HMO: Value, Kaiser, Conversion	20.0%

Consumer concern was raised with the October 1, 2009 rather than a January 1, 2010 effective date. Although Anthem does not provide one year rate guarantees, the rates have historically changed on January 1. Through public comment, the Department was advised that some brokers indicated to members that the rates were valid for a one year period. Anthem's communications to brokers in some instances were not clear and stated the rates were effective from January to December. This presents an issue of misrepresentation to the members. Of additional concern with this change in effective date is the loss of credits toward meeting the deductible that would be lost should a member feel the need to switch to a lower cost plan. This adds additional financial burden to the policyholder that is near or may have already met the annual deductible by October 1.

Anthem stated that a delay in implementing a rate increase on October 1, 2009 would result in an even higher rate increase at a later date. The additional months of trend that would need to be projected would increase the rates from the October 1 levels.

As part of the actuarial analysis by the Department, the Anthem claims experience and the Department's revised assumptions were used to project rates to an effective date of January 1, 2010. The closed blocks were not recalculated. The resulting rate increases deemed to be reasonable and actuarially sound as of January 1, 2010 are:

	%Increase
BlueCare (HMO)	16.6%
Century Preferred (PPO and HSA)	16.5%

Lumenos (CDHP)	19.9%
Tonik (PPO)	13.0%
Traditional (FFS): SP-200, DP-30, C-90, E-94/96	20.0%
Closed HMO: Value, Kaiser, Conversion	20.0%

Although the resulting increases are higher than those recalculated by the Department based on an October 1, 2009 effective date, the resulting rate increases are lower than those requested in the rate Application.

IV. CONCLUSION AND RECOMMENDATION

Based on the foregoing and the record of the July 20, 2009 public hearing, the undersigned concludes that the rates filed by Anthem to be effective October 1, 2009 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. In light of the possible misrepresentations to members that rates were effective through December 2009 and the potential financial impact to members that would choose to elect a new plan and lose credit for claims previously credited to the deductible, the undersigned recommends delaying any rate increase to January 1, 2010. The undersigned concludes that a delay in the requested October 1, 2009 effective date to January 1, 2010 effective date will not result in rates that are significantly higher using

the revised assumptions presented in the discussion section. The undersigned recommends that the Commissioner accept the following rate increases to be effective January 1, 2010:

	%Increase
BlueCare (HMO)	16.6%
Century Preferred (PPO and HSA)	16.5%
Lumenos (CDHP)	19.9%
Tonik (PPO)	13.0%
Traditional (FFS): SP-200, DP-30, C-90, E-94/96	20.0%
Closed HMO: Value, Kaiser, Conversion	20.0%

The undersigned recommends that the Insurance Commissioner order Anthem to recalculate the rates using the recommended rate increases with an effective date of January 1, 2010 and submit a revised rate filing to the Department no later than August 31, 2009.

Dated at Hartford, Connecticut, this 4th day of August, 2009

Mary Ellen Breault
Hearing Officer