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 15-96

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ORDER

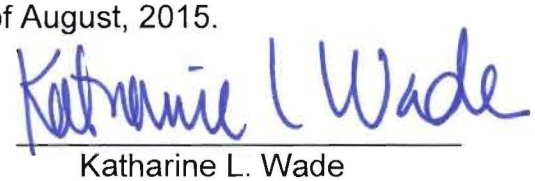
I, Katharine L. Wade, Insurance Commissioner of the State of Connecticut, having read the record in the above captioned matter, do hereby adopt the findings and recommendations of Kristin Campanelli, Hearing Officer, which are contained in the attached Proposed Final Decision, and issue the following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

1. The rates filed by Anthem Blue Cross and Blue Shield to be effective January 1, 2016 are excessive and the rate Application increases are disapproved in accordance with Conn. Gen. Stat. §38a-481.
2. The recommended rate revisions determined in the actuarial analysis presented in the hearing officer's decision are actuarially sound, and are adequate, not excessive and not unfairly discriminatory in accordance with Conn. Gen. Stat.§38a-481.
3. The following changes to the rating assumptions for rates effective January 1, 2016 are accepted:
    - Reducing the annual trend from 7.6% to 7.0%

- Remove the Grace Period adjustment of 0.24%
- Remove the Seasonality adjustment of 0.68%
- Reduce the cost of removing the age limit on the infertility mandate from $2.00 pmpm to $0.25 pmpm

4. Anthem will recalculate the rates using the recommended revised rating assumptions with an effective date of January 1, 2016 and submit a revised rate filing to the Department no later than September 3, 2015.

Dated at Hartford, Connecticut, this 27th day of August, 2015.



Katharine L. Wade
Insurance Commissioner

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In the Matter of:

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

Docket No. LH 15-96

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PROPOSED FINAL DECISION

I. INTRODUCTON

On April 30, 2015, 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 both on and off exchange plans ("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 6, 2015, Insurance Commissioner Katharine L. Wade ("Commissioner") issued a notice of public hearing. The Commissioner ordered that a public hearing be held on July 27, 2015 concerning the Application.

A copy of the notice for the public hearing was filed with the Office of the Secretary of State on July 7, 2015 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 the Application. In accordance with Conn. Agencies Regs. §38a-8-48, the Applicant was designated as a party to this proceeding.

On July 7, 2015, the Commissioner appointed the undersigned to serve as Hearing Officer in this proceeding.

On July 27, 2015, the public hearing on the Application was held before the undersigned. The following individuals testified at the public hearing on behalf of the Applicant: James Augur, Regional Vice President-Sales and John Bryson, Director of Actuarial Services. Michael G. Durham, Esq., 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, ASA, MAAA, Life and Health Actuary and Mary Ellen Breault, ASA, MAAA.

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 no later than the close of business July 27, 2015. Public comment by persons who are not parties "shall be given the same weight as legal argument." Conn. Agencies Regs. §38a-8-51(b). Three members of the public provided oral comment during the two public comment sessions at the hearing. Members of the public who provided oral public comment were Lynne Ide, Universal Health Care Foundation of Connecticut; Elizabeth Keenan, CONECT; and Angela DeMello, CONECT.

As of the close of the record for public comment at the close of business July 27, 2015, there were 112 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 overall objection to Anthem's application. Some of the comment letters and oral comments included some detailed description of the hardship of Anthem's rates on the consumers who made the comments. There were also comments critical of health insurers generally in relation to recent federal health reform, and critical of the Department's handling of prior rate filings and the captioned rate application.

Anthem was directed to submit supplemental information no later than July 31, 2015. Anthem timely submitted the supplemental information on July 31, 2015 and the record was closed as of July 31, 2015.

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. Anthem testified that this Application is a filing made by Anthem Health Plans, Inc., doing business as Anthem Blue Cross and Blue Shield and is applicable only to Connecticut based business, products offered in Connecticut, and based on Connecticut statutory requirements.
2. The filing included an Actuarial Certification by John Bryson, ASA, MAAA, Actuarial Director.

3. Mr. Bryson testified that the filing 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 April 30, 2015, Anthem electronically filed a rate application requesting the following increases effective 1/1/2016:

	% Change
Catastrophic HMO Pathway X Enhanced	7.04%
Bronze HMO Pathway X Enhanced for HSA	11.08%
Bronze HMO Pathway X Enhanced	4.72%
Gold HMO Pathway X Enhanced	4.60%
Anthem HMO Catastrophic BlueCare 6850/0%	7.02%
Anthem Bronze HMO BlueCare 6000/12000/0% for HSA	9.38%
Anthem Bronze HMO BlueCare 6000/0%	5.09%
Anthem Bronze HMO BlueCare 6550/13100/0% for HSA	n/a
Anthem Silver HMO BlueCare 3500/7000/0% for HSA	4.93%
Anthem Silver HMO BlueCare 3500/0%	5.46%
Anthem Silver HMO BlueCare Tiered 3000/3850/0%	n/a
Anthem Gold HMO BlueCare 1500/0%	4.60%
Anthem Gold HMO Pathway X Enhanced 1850/0%	4.14%
Anthem Gold HMO BlueCare Tiered 2000/3500/0%	n/a
Bronze PPO Standard Pathway X	10.05%
Bronze PPO Standard Pathway X for HSA	3.64%

Silver PPO Standard Pathway X	5.50%
Silver PPO Pathway X	6.83%
Gold PPO Standard Pathway X	9.18%
Anthem Bronze PPO Century Preferred 5700/11400/20% for HSA	11.10%
Anthem Bronze PPO Century Preferred 6850/0%	n/a
Anthem Silver PPO Century Preferred 2750/20%	7.57%
Anthem Silver PPO Century Preferred 2500/20%	7.59%
Anthem Silver PPO Century Preferred 3000/6000/20% for HSA	n/a
Anthem Silver PPO Century Preferred 3500/7000/10%	n/a
Anthem Silver PPO Century Preferred Tiered 2850/4000/0%	n/a
Anthem Gold PPO Century Preferred 1500/3000/20% for HSA	n/a
Anthem Gold PPO Century Preferred 1750/0%	n/a
Anthem Gold PPO Century Preferred Tiered 1750/3250/0%	n/a
Gold HMO Pathway X Enhanced, a Multi-State Plan	4.14%
Silver PPO Pathway X, a Multi-State Plan	6.82%

5. On June 26, 2015, Anthem electronically filed a revised rate application requesting the following increases effective 1/1/2016:

	% Change
Catastrophic HMO Pathway X Enhanced	4.94%
Bronze HMO Pathway X Enhanced for HSA	8.95%
Bronze HMO Pathway X Enhanced	2.73%
Gold HMO Pathway X Enhanced	2.62%

Anthem HMO Catastrophic BlueCare 6850/0%	4.93%
Anthem Bronze HMO BlueCare 6000/12000/0% for HSA	7.28%
Anthem Bronze HMO BlueCare 6000/0%	3.08%
Anthem Bronze HMO BlueCare 6550/13100/0% for HSA	n/a
Anthem Silver HMO BlueCare 3500/7000/0% for HSA	2.93%
Anthem Silver HMO BlueCare 3500/0%	3.45%
Anthem Silver HMO BlueCare Tiered 3000/3850/0%	n/a
Anthem Gold HMO BlueCare 1500/0%	2.62%
Anthem Gold HMO Pathway X Enhanced 1850/0%	2.17%
Anthem Gold HMO BlueCare Tiered 2000/3500/0%	n/a
Bronze PPO Standard Pathway X	7.94%
Bronze PPO Standard Pathway X for HSA	1.66%
Silver PPO Standard Pathway X	3.50%
Silver PPO Pathway X	4.80%
Gold PPO Standard Pathway X	7.12%
Anthem Bronze PPO Century Preferred 5700/11400/20% for HSA	8.95%
Anthem Bronze PPO Century Preferred 6850/0%	n/a
Anthem Silver PPO Century Preferred 2750/20%	5.52%
Anthem Silver PPO Century Preferred 2500/20%	5.53%
Anthem Silver PPO Century Preferred 3000/6000/20% for HSA	n/a
Anthem Silver PPO Century Preferred 3500/7000/10%	n/a
Anthem Silver PPO Century Preferred Tiered 2850/4000/0%	n/a
Anthem Gold PPO Century Preferred 1500/3000/20% for HSA	n/a

Anthem Gold PPO Century Preferred 1750/0%	n/a
Anthem Gold PPO Century Preferred Tiered 1750/3250/0%	n/a
Gold HMO Pathway X Enhanced, a Multi-State Plan	2.17%
Silver PPO Pathway X, a Multi-State Plan	4.78%

6. Based on this revised rate filing, the average proposed rate increase is 4.7%. Factors that affect the proposed rate increase for all plans include:
   - Lower claims cost in the experience: Anthem has included emerging 2014 ACA experience in the rate development.
   - Medical Trend: The underlying claim costs are expected to increase year over year due to inflation, advancing medical technology and techniques, and increased utilization and cost-shifting.
   - Morbidity: There are anticipated changes in the market-wide morbidity of the covered population in the projection period.
   - Benefit modifications and plan design changes.
   - Anticipated changes due to network contracting.
   - Changes in taxes, fees, and non-benefit expenses. These include changes in payments from and contributions to the Federal Transitional Reinsurance Program.

7. Although rates are based on the same experience, proposed rate changes vary by plan from 1.7% to 9.0%. Factors that affect the variation in the proposed rate changes by plan include:

- Changes in benefit design that vary by plan
- Updated measurement of relative benefits between plans
- Changes in the adjustment factor for Catastrophic eligibility
- Changes in Non-Benefit Expenses that are applied on a PMPM basis

8. Experience Period Premium and Claims

   Experience shown in Worksheet 1, Section I of the Unified Rate Review Template is for Connecticut Individual non-grandfathered, single risk pool compliant policies. The information shown is for the identified legal entity only.

   Claims experience in Worksheet 1, Section I of the Unified Rate Review Template reflects dates of service from January 1, 2014 through December 31, 2014. Claims shown are paid through May 31, 2015.

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

   Allowed and incurred claims are 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 claims paid for a particular month after one month of run out, two months, etc. Claim backlog files are reviewed on a monthly basis and are accounted for in the historical completion factor estimates.

Allowed and incurred claims shown in Worksheet 1, Section I of the Unified Rate Review Template are $336,701,558 and $255,550,265, respectively. These amounts differ from those shown in Exhibit B: Claims Experience for Rate Developments due to the Unified Rate Review Template taking Non-ACA plans and Rx Rebates into account.

The estimated Non-Grandfathered gross earned premium for Connecticut Individual is $286,373,832, where earned premium is the pro-rata share of premium owed to Anthem due to subscribers actively purchasing insurance coverage during the experience period.

The preliminary MLR Rebate estimate is $0, which is consistent with the December 31, 2014 Anthem general ledger estimate allocated to the Non-Grandfathered portion of Individual. Note that this is an estimate and will not be final until 7/31/2015.

9. Projection Factors

Changes in Demographics

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

- Area/Network: The area claims factors are developed based on an analysis of individual allowed claims by network, mapped to the prescribed 2016 rating areas using the subscriber's 5-digit zip code.
- Benefit Plan: The experience period claims are normalized to an average 2016 plan using benefit relativities. The benefit relativities include the value of cost shares and anticipated changes in utilization due to the difference in average cost requirements.

Changes in Benefits

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

Changes in the Morbidity of the Population Insured

- Individuals no longer qualifying for Medicaid
- Higher morbidity of the uninsured compared to the insured population: This adjustment is based on a CDC study on the health status and life styles of both currently insured and uninsured populations. This adjustment also considers the expected number of previously uninsured individuals expected to move into the Individual market in 2016.
- Individuals losing employer coverage.
- Individuals converting from Anthem Non-ACA policies
- Individuals electing to drop coverage

The movement assumptions above are based on market research and assumptions on the retention and sales rates. The morbidity impacts of population movement are based on health status determined from internal risk score data.

Pent-up demand adjustment: As previously uninsured individuals obtained insurance in 2014, Anthem expected them to have some pent-up demand for health care services in year one. This pent-up demand impact is captured in our 2014 experience and Anthem does not expect this additional utilization to continue in 2016. Therefore, an adjustment has been made to back-out the additional utilization in 2014 that was attributed to pent-up demand.

Our goal is to price to the average risk of the 2016 ACA market. Since Anthem-specific experience was used as a starting point, we adjusted this experience to be more consistent with the overall market in Connecticut. Wakely Consulting collected demographic and risk information from carriers, and calculated Anthem's relative risk to the market for 2014. We have adjusted our starting experience using the results of that survey.

Other Adjustments

- For members active less than 12 months of the experience period, claims were adjusted using company specific seasonality and maturation factors. The impact of this analysis is reflected in the "Seasonality" adjustment factor of 1.0068.
- Induced Demand Due to Cost Share Reductions: Individuals below 250% Federal Poverty Level who enroll in silver plans On-Exchange will be eligible for

cost share reductions. The base period experience has higher anticipated utilization built-in as CSR plans were made available in 2014. As a result, the 2016 utilization impact is calculated based on the projected change in silver plans On-Exchange membership. Anthem used the HHS-promulgated factors for the Induced Demand Utilization factors.

- Grace Period: The base period experience may be adjusted upward to account for some incidence of enrollees not paying premiums due during the first month of the 90-day grace period when the QHP is liable for paying claims. Based on 2014 experience this adjustment is 1.0024.
- Change in Medical Management: medical management savings not already included in the claims experience and trend.
- Change in Provider Contracts: anticipated changes in provider contracts are reflected in the plan level adjustments and the region rating factors.
- The cost of pediatric dental and vision benefits are included.
- Rx Rebates: The projected claims cost is adjusted to reflect anticipated Rx rebates. These projections take into account the most up-to-date information regarding anticipated rebate contracts, drug prices, anticipated price inflation, and upcoming patent expirations.

Trend Factors (cost/utilization)

- The annual pricing trend used in the development of the rates is 7.6%. The 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. 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. Small Group benefit expense was used as the basis for the Individual trend development because there is not enough historical Individual ACA data to develop a credible trend analysis. The trend includes a volatility provision in accordance with Actuarial Standards of Practice. The claims are trended 23.6 months from the midpoint of the experience period, which is July 12, 2014, to the midpoint of the projection period, which is July 1, 2016. The mid-point of the experience period is shifted later than July 1, 2014 due to staggered open enrollment in 2014.

- Projected trends include the estimated cost of the pharmaceutical Sovaldi and other high-cost drugs for treating Hepatitis C. These cost estimates were based on claims experience, together with CDC recommendations, Industry and Anthem Inc. data.

10. Normalized Unit Cost Data on a Paid Basis:

	2011	2012	2013	2014
Inpatient	$3,369.11	$33559.74	$3,800.97	$3,887.58
Outpatient	$655.43	$731.71	$807.64	$841.22
Professional	$154.82	$154.78	$157.70	$163.02
Pharmacy	$80.64	$86.48	$92.84	$106.20

11. Normalized Utilization Data (per thousand members):

	2011	2012	2013	2014
Inpatient	23.5	23.5	22.0	22.6
Outpatient	136.5	136.8	136.7	137.4
Professional	875.9	881.6	874.2	897.5
Pharmacy	1,063.3	1,063.9	1,090.6	1,063.9

12. Paid PMPM:

	2011	2012	2013	2014
Inpatient	$79.02	$83.79	$83.80	$87.68
Outpatient	$89.49	$100.07	$110.38	$115.55
Professional	$135.61	$136.45	$137.86	$146.32
Pharmacy	$86.75	$92.01	$101.25	$112.99
Total	$368.58	$389.87	$412.32	$440.81

13. Paid Trend:

	2012/ 2011	2013/ 2012	2014/ 2013
Inpatient	6.0%	0.0%	4.6%
Outpatient	11.8%	10.3%	4.7%
Professional	0.6%	1.0%	6.1%
Pharmacy	7.3%	10.0%	11.6%
Total	5.8%	5.1%	6.7%

14. Anthem's Estimated Paid trend in 2015 and 2016:

	2015/ 2014	2016/ 2015
Inpatient	4.5%	4.5%
Outpatient	8.5%	8.0%
Professional	1.7%	2.6%
Pharmacy	16.4%	13.6%
Total	7.5%	7.2%

15. Experience in the individual market (2011-2013 Pre-ACA, 2014 ACA):

CY	Earned Premium	Incurred Claims	Loss Ratio
2011	$198,752,863	$168,082,111	84.57%
2012	$191,566,985	$174,932,659	91.32%
2013	$190,227,979	$169,573,536	89.14%
2014	$302,880,809	$209,948,826	69.32%
Total	$883,428,635	$722,537,132	81.79%

16. Risk Adjustment and Reinsurance

- Experience Period Risk Adjustment and Reinsurance: Wakely Consulting collected demographic and risk information from carriers, and calculated Anthem's relative risk to the market for 2014. Experience period risk adjustment transfers were based on the results of that survey. Experience period reinsurance recoveries were based on expected recoveries as of December 31, 2014, plus PPIA that was recognized through March 2015.

- Projected Risk Adjustments: The Risk Adjustment program transfers funds from lower risk plans to higher risk plans in the Non-Grandfathered Individual and Small Group market. The HHS operated Risk Adjustment program is supported by a user fee, as shown in Exhibit F: Risk Adjustment and Reinsurance - Contributions and Payments. Anthem is assuming a risk transfer payment of ($0.43)
- Projected ACA Reinsurance Recoveries Net of Reinsurance Premium: The transitional reinsurance risk mitigation program collects funds from all insurance issuers and TPAs and redistributes them to high cost claimants in the Non-Grandfathered Individual market. The reinsurance contribution is equal to the national per capita reinsurance contribution rate. The reinsurance payment is developed using actual 2014 reinsurance experience, projected paid claims, claim probability distribution, and reinsurance payment guidelines. The claim probability distribution observes claims between $90,000 and $250,000 using a claim probability distribution that reflects the anticipated claim cost distribution of the 2016 Individual market. The coinsurance rate is 50%. Expected paid claims are calculated for an assumed average On-Exchange plan design. Reinsurance payments are allocated proportionally by plan premiums to all plans in the risk pool.

17. Administrative Expense contains both acquisition costs associated with the production of new business through non-broker distribution channels (direct, telesales, etc) as well as maintenance costs associated with ongoing costs for the administration of the business. Acquisition costs are projected using historical cost

per member sold amounts applied to future sales estimates. Maintenance costs are projected for 2016 based on 2014 actual expenses, with adjustments for expected changes in business operations including new expenses for risk management, regulatory compliance and prerniurn reconciliation and balancing.

18. The miscellaneous items represent DOI fees and assessments, including the assessment from the State of Connecticut to cover the cost of the Vaccine Immunization Program which provides immunizations for all Connecticut residents.

19. The quality improvement expense represents Anthern's dedication to providing the highest standard of customer care and consistently seeking to improve health care quality, outcomes and value in a cost efficient manner. The QI Expense assumptions are based on historical amounts related to the following initiatives: Improve Health Outcomes, Activities to Prevent Hospital Readmissions, Improve Patient Safety and Reduce Medical Errors, Wellness and Health Promotion Activities, HIT Expenses for Health Care Quality Improvements, and ICD-10.

20. Selling Expense represents broker commissions and bonuses associated with the broker distribution channel using historical and projected commission levels. Commissions will be paid both On-Exchange and Off-Exchange.

21. Taxes and Fees:

- Patient-Centered Outcomes Research Institute (PCORI) Fee: The PCORI fee is a federally-mandated fee designed to help fund the Patient-Centered Outcomes Research Trust Fund. For plan years ending on or after October 1, 2014, and before October 1, 2015, the fee is $2.08 per member per year. Thereafter, for every plan year ending before October 1, 2019, the fee will increase by the percentage increase in National Healthcare Expenditures.
- ACA Insurer Fee: The health insurance industry will be assessed a permanent fee, based on market share of net premium, which is not tax deductible. The tax impact of non-deductibility is captured in this fee.
- Exchange Fee: The Exchange User Fee applies to Exchange business only, but the cost is spread across all Individual plans. The expected charge is estimated at 1.65% of Total Individual Premium. The resulting fee/percentage is applied evenly to all plans in the risk pool, both On and Off Exchange.
- Premium taxes, federal income taxes, and state income taxes are also included in the retention items.

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

23. The projected Federal MLR for the products in this filing is estimated in Exhibit M: Federal MLR Estimated Calculation. Please note that this calculation is purely an estimate and not meant to be a true measure for Federal or State MLR rebate

purposes. 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. Also note that the projected Federal MLR presented here does not capture all adjustments, including but not limited to: three-year averaging, credibility, dual option, and deductible. Anthem's projected MLR is expected to meet or exceed the minimum MLR standards at the market level after including all adjustments.

24. The Anthem Index Rate for Individual business in Connecticut is based on total combined claims costs for providing essential health benefits within the single risk pool of non-grandfathered Individual plans in Connecticut. The Index Rate is adjusted on a market-wide basis for the state based on the total expected market-wide payments and charges under the risk adjustment and reinsurance programs and Exchange user fees. The premium rates for all Anthem non-grandfathered plans in the Individual market use the applicable market-wide adjusted index rate, subject only to the permitted plan-level adjustments. This demonstrates that the Single Risk Pool for Anthem Individual business is established according to the requirements in 45 CFR part 156, §156.80(d).

25. The experience period index rate represents the average allowed claims PMPM of essential health benefits for Anthem's Individual Non-Grandfathered Business.

26. The projection period index rate represents the average allowed claims PMPM of essential health benefits for Anthem's Individual Non-Grandfathered Business. The projection period index rate was developed as shown in Exhibit A: Market Adjusted

Index Rate Development by adjusting the projected incurred claims PMPM as described in Section 7: Projection Factors of this memorandum. Covered benefits in excess of essential health benefits that are included in the projection period allowed claims (cell V32 of Worksheet 1, Section II of the Unified Rate Review Template) are elective abortion. No benefits in excess of the essential health benefits are included.

27. The Market Adjusted Index rate is calculated as the Index Rate adjusted for all allowable market wide modifiers defined in the market rating rules.

28. The Plan Adjusted Index Rate is calculated as the Market Adjusted Index Rate adjusted for all allowable plan level modifiers defined in the market rating rules. This development is presented in Exhibit N: Plan Adjusted Index Rate and Consumer Adjusted Premium Rates. Plan level modifiers are as follows:

- 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 EHBs: This multiplicative factor adjusts for additional benefits that are not EHBs.
- Adjustments for Administrative Cost: This is an additive adjustment that includes all the Selling Expense, Administration and Retention Items shown in Exhibit G:

Non-Benefit Expenses and Profit & Risk, with the exception of the Exchange User Fee since it is already included in the Market Adjusted Index Rate.

- Catastrophic Factor: This adjustment assumes a healthier than average population will select the catastrophic plan. The catastrophic adjustment factor is only applied to catastrophic plans, as shown in Exhibit N: Plan Adjusted Index Rate and Consumer Adjusted Premium Rates.

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

30. Membership projections in Worksheet 2 of the Unified Rate Review Template are developed using a population movement model plus adjustments for sales expectations. This model projects the membership in the projection period by taking into account:

- Uninsured to Individual as a result of guaranteed issue, subsidized coverage, and individual mandate.

- Small Group to Individual as a result of guaranteed issue and Small Group insuring decisions.
- High Risk Pools to Individual as a result of guaranteed issue.
- Individual and Uninsured to Medicaid as a result of expanded Medicaid eligibility

31. The 2016 Individual plan portfolio contains four new 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 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.

32. The RBC Ratio for Anthem Health Plans, Inc. is 551.11% as of 12/31/2014.

33. Current capital and surplus for Anthem Health Plans, Inc. is $311,734,534 as shown on page 5, line 49 of the 2014 Annual Statement.

34. The claims were normalized for age/gender, area/network, plan, and risk. The results show the following:

- Previously Insured - Normalized Claims PMPM $564.94
- Previously Uninsured - Normalized Claims PMPM $586.63
- Previously Uninsured Morbidity Load 1.038

The 1.052 morbidity load used in the filing is based off of an earlier study and is slightly greater than the load calculated using normalized claims experience for 2014.

35. The attached file "Anthem 2014 Individual Risk Adjustor" shows data from Wakely Consulting received in February 2015. This data was used for our estimate of the risk adjustment that Anthem expected to receive for the 2014 year. An expected receivable of $19,884,164 was used in the development of the 2016 Individual rates. Based on 2014 Individual membership this represents a -$37.72 PMPM. The HHS final risk adjustment payment due Anthem was $13,893,513 which represents a -$26.36 PMPM. Based on these final results, the development of the 2016 rates contains an excess reduction of $11.36 PMPM to the base claims.

36. The attached file "Anthem 2014 Individual MLR Calc Preliminary" shows the calculation of the preliminary 2014 Individual MLR calculation. We want to point out that the 2014 calculation is a three year average; and Anthem's 2014 portfolio included ACA business that was the basis for the filing, plus it included a non-

grandfathered block of business that was discontinued 01/01/2015.

I would also like to submit Anthem's loss ratio for Individual business based on claims over premium for calendar year 2014 using internal financial reports. The restated loss ratio which includes all adjustments through June 2015 is 70.4%.

37. Anthem has contracts with all hospitals and most physicians in the state of Connecticut. Some contracts are renewed annually while others are multi-year contracts with annual adjustments. A portion of the increase in network contracting is known due to contract agreements already in place. A portion of the increase is estimated based on contracts yet to be finalized from the point of the filing to the end of the rate period. The estimate is determined by using expected final negotiated amounts combined with the amounts in place for existing agreements. The historic and projected increases are as follows:

    2013 3.1%

    2014 2.5%

    2015 3.4%

    2016 3.8%

38. The 2014 data indicated that 9.28% of members failed to pay their last month of premium. Based on data through June 2015 7% of the members have failed to pay their final month of premium and have not re-enrolled during the 90 day grace period. We expect the number of members not paying their last month's premium to increase toward the end of the year when members typically change carriers and enroll with those other carriers without a lapse in coverage. The experience period

used for the rate development is the 12-month period from January 1 2014 through December 31, 2014.

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 ASOP 8 issued by the Actuarial Standards Board of the American Academy of Actuaries.

A primary concern raised by members of the public is that the applied for increases would not be affordable for the renewing policyholders. 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, 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 Affordable Care Act (ACA)[1] effective 1/1/2014, the Department used criteria spelled out in the latest HHS rate regulations as a template for review along with previously issued CT Insurance Department Bulletins that discuss the requirements for rate filings.

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

The normalized paid trend for the last three years has been 5.8%, 5.1% and 6.7%. Anthem estimates that 2015 and 2016 trend is 7.5% and 7.2% respectively. A significant impact to 2015 and 2016 trend is the affect of the pharmaceutical Sovaldi and other high-cost drugs for treating Hepatitis C. Anthem also included a load in the trend for volatility. The undersigned is recommending that the assumed trend in the rate filing of 7.6% be reduced by .6% to account for the removal of the volatility factor as well as historical paid trend information provided. As a result, the recommended annualized trend is 7.0%.

The grace period adjustment of .375% was removed from the 2013 and 2014 rate filings as the Department did not believe this adjustment was necessary. The undersigned recommends that the .24% grace period adjustment be removed from this 2015 rate filing in the same manner it was in 2013 and 2014.

The seasonality adjustment of .68% represents members active less than 12 months of the experience period. The undersigned does not believe this adjustment is necessary for 2016 rating as the ACA will have been in place for a full two years and recommends that the .68% seasonality adjustment be removed from this 2015 rate filing.

Anthem estimated the cost of removing the age limit of 40 from the Infertility Mandate as $2.00 pmpm. The undersigned recommends that this estimate be reduced to $0.25 pmpm. The basis for this recommendation is the 2014 Connecticut Mandated Health Insurance Benefits Review for the 2015 Legislative session which analyzed all current mandates and updated the pmpm cost analysis performed in the 2010 mandate report. The 2014 report estimated that the current infertility mandate with the age 40

limit is estimated to be $1.06 pmpm for 2016 in Connecticut. Based on this $1.06 pmpm, the Department believes that the above age 40 population will have significantly less utilization of this mandate than the 40 and under population leading to the recommended $0.25 pmpm.

IV. CONCLUSION AND RECOMMENDATION

Based on the foregoing and the record of the July 27, 2015 public hearing, the undersigned concludes that the rates filed by Anthem to be effective January 1, 2016 are excessive and recommends that the Insurance Commissioner disapprove the rate Application increases in accordance with Conn. Gen. Stat. §38a-481. The undersigned concludes that the recommended rate revisions determined in the actuarial analysis presented in the discussion section are actuarially sound, and are adequate, not excessive and not unfairly discriminatory in accordance with Conn. Gen. Stat.§38a-481. The undersigned recommends that the Commissioner accept the following changes to the rating assumptions for rates effective January 1, 2016:

- Reducing the annual trend from 7.6% to 7.0%
- Remove the Grace Period adjustment of 0.24%
- Remove the Seasonality adjustment of 0.68%
- Reduce the cost of removing theage limit on the infertility mandate from $2.00 pmpm to $0.25 pmpm

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, 2016 and submit a revised rate filing to the Department no later than September 3, 2015.

Dated at Hartford, Connecticut, this 27th day of August, 2015

Kristin Campanelli
Hearing Officer