STATE OF CONNECTICUT

INSURANCE DEPARTMENT

In the Matter of:	:	
THE PROPOSED RATE INCREASE APPLICATION OF ANTHEM BLUE CROSS AND BLUE SHIELD	:	Docket No. LH 10-159

ORDER

I, Barbara C. Spear, Acting Insurance Commissioner of the State of Connecticut, having read the record in the above captioned matter and having attended the hearing, do hereby adopt the findings and recommendations of Mark R. Franklin, Hearing Officer, which are contained in the attached Proposed Final Decision, and issue the following orders, TO WIT:

1. The rate application medical and prescription drug premium rate increase application regarding Grandfathered Individual Direct Pay Plan Options ("Application") filed November 1, 2010 by Anthem Health Plans, Inc., d/b/a Anthem Blue Cross and Blue Shield ("Anthem") to be effective January 1, 2011 is excessive and is disapproved in accordance with Conn. Gen. Stat. §38a-481.

2. The current medical and prescription drug premium rates in use for the Grandfathered Individual Direct Pay Plan Options are found to be actuarially sound, and are adequate, not excessive and not unfairly discriminatory in accordance with Conn. Gen. Stat. §38a-481.

Dated at Hartford, Connecticut, this 3rd day of December, 2010.

Barbara C. Spear
Acting Insurance Commissioner

STATE OF CONNECTICUT

INSURANCE DEPARTMENT

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In the Matter of:

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

Docket No. LH 10-159

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PROPOSED FINAL DECISION

I. INTRODUCTON

On November 1, 2010, Anthem Health Plans, Inc. d/b/a Anthem Blue Cross and Blue Shield ("Anthem" or "Applicant"), filed a medical and prescription drug premium rate increase application regarding Grandfathered Individual Direct Pay Plan Options ("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 November 3, 2010, former Insurance Commissioner Thomas R. Sullivan ("Commissioner Sullivan") issued a notice of public hearing. Commissioner Sullivan ordered that a public hearing be held on November 17, 2010 concerning the Application.

A copy of the notice for the public hearing was filed with the Office of the Secretary of State on November 3, 2010 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 November 3, 2010, the Commissioner appointed the undersigned to serve as Hearing Officer in this proceeding.

Three separate petitions requesting to be designated as intervenors in the captioned case were timely filed in the captioned matter pursuant to Conn. Agencies Regs. §§38a-8-48 and 38a-8-49. Specifically, (1) the State of Connecticut Office of Healthcare Advocate ("OHA") filed a petition to intervene on November 5, 2010 ("OHA Petition"); (2) the Honorable Richard Blumenthal, Attorney General of the State of Connecticut ("AG"), filed a petition to intervene on November 8, 2010 ("AG Petition"); and (3) the Connecticut State Medical Society ("CSMS"), a professional association located in Connecticut, filed a petition to intervene on November 8, 2010 ("CSMS Petition"). (The OHA Petition, AG Petition and CSMS Petition are collectively the "Petitions," and OHA, AG and CSMS are collectively "Petitioners.")

The OHA Petition and AG Petition were granted, and the CSMS Petition was denied for the reasons and subject to the limitations described below.

First, The OHA Petition asserted the OHA has assisted 252 Anthem consumers so far in 2010 and 575 Anthem consumers in 2009 with problems selecting plans, affording plans or denials of coverage. The petition was found to be in the interests of justice based on the statutory provisions that OHA may "provide information to . . . agencies . . . regarding problems and concerns of health insurance consumers and make recommendations for resolving those problems and concerns," Conn. Gen. Stat.

§38a-1041(b)(3); "facilitate public comment on . . . policies, including policies and actions of health insurers," Conn. Gen. Sat. §38a-1041(b)(6); and "take any other actions necessary to fulfill the purpose of sections 38a-1040 to 38a-1050, inclusive." Pursuant to Conn. Agencies Regs. §38a-8-48(e), the role of OHA was limited to (1) providing information to the Insurance Department related to the problems and concerns of consumers relevant to the Application; (2) making recommendations to the Department relevant to the specific Application at issue; and (3) in facilitating public comment related to the Application.

Second, in the AG Petition, Attorney General Richard Blumenthal ("AG Blumenthal") indicated that his office represents the public interest in numerous state administrative proceedings, and has regular contact with consumers who have problems with their health insurance, including consumers who have had complaints about past increases. In addition, the AG Petition indicated the AG has received complaints about the rate increase at issue in this proceeding, asserted that the Application failed to provide evidence that adequately delineates the costs that are the basis of the request and that it will impose hardship on insured citizens and small businesses that are not eligible for group insurance. Because of the AG's role and because the AG petition dealt with certain issues addressed by the Application, the AG Petition was determined to be in the interests of justice, and the petition was granted. Pursuant to Conn. Agencies Regs. §38a-8-48(e), the role of the AG was limited to: 1) the concerns of insured business and small businesses not eligible for group insurance that are relevant to the Application; (2) claim costs and claim cost trends that are

relevant to the Application; and (3) representation of, or serving as co-counsel with, the OHA related to the scope of the OHA intervenor status.

Third, in the *pro se* CSMS petition, there was a reference to media accounts regarding health insurance coverage and rates generally; physician reimbursement by health insurers; and Multi-District litigation regarding WellPoint. However, generalized issues regarding health coverage and rates and the Multi-District Litigation are irrelevant to the proceedings related to the specific requests in the Application. There was also an assertion in the CSMS petition related to the problems of physician members' practices as small businesses that will be impacted by the proposed rate increases. However, the CSMS petition identified no specific member small businesses that would be impacted. Because certain of the CSMS issues, specifically the impact on small business and medical costs were being addressed by the AG in his intervention and because the petition was a *pro se* petition while the AG had four attorney appearances on file, the CSMS petition was determined to not enhance the orderly conduct of the hearing. Subsequent to denial of the CSMS petition, two attorneys filed appearances on behalf of CSMS.

CSMS filed a Motion for Reconsideration dated November 16, 2010, the day before the hearing, which motion was denied.

On November 15, 2010, the AG filed a Motion for Continuance and for Hearing Officer to Request Additional Information, and the OHA filed a Request for Documents and Motion for Continuance. Such requests were denied because of the negative impact uncertainty as to rates would have on affected policyholders and the insurance

buying public and because the purpose of the hearing is to elicit information on the record.

On November 17, 2010 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: Jennie Keith Cassaday, FSA, MAAA, actuarial director, and Robert S. Ruiz-Moss, market segment lead. 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; Mary Ellen Breault, ASA, MAAA; N. Beth Cook, Esq., Counsel; and Timothy Lyons, Esq., Counsel.

Victoria L. Veltri, Esq., OHA General Counsel, represented the OHA, and Assistant Attorney General Richard Kehoe, Esq., ("AAG Kehoe") took over representation of OHA during the course of the hearing. Jennifer Bass, an Anthem individual product policyholder, testified as a witness for the OHA.

AG Blumenthal, AAG Kehoe, and Assistant Attorneys General Thomas P. Ryan, Esq., Arnold Menchel, Esq., and Richard M. Porter, Esq., represented the AG. Matthew C. Katz, CSMS executive vice president; Steven Wolfson, M.D., and Philip J. Bieluch, FSA, MAAA, FCA, testified as witnesses 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 no later than the close of business November 17, 2010. Public comment by persons who are not parties or intervenors

"shall be given the same weight as legal argument." Conn. Agencies Regs. §38a-8-51(b). Eight members of the public provided oral comments and four public officials provided oral comment during the two public comment sessions at the hearing. Public officials providing comments were State Senator Edith Prague, co-chair, Aging Committee and Labor and Public Employee Committee; State Senator Joseph Crisco, co-chair, Insurance and Real Estate Committee ("Sen. Crisco"); State Representative Steven Fontana, co-chair, Insurance and Real Estate Committee ("Rep. Fontana"); and Hartford City Councilman Larry Deutsch, MD ("Councilman Deutsch"). Members of the public who provided oral public comment were Layne Gakos, Connecticut State Medical Society; Jennifer Jaff, of Farmington; Sarah Littman, of Cos Cob; Brenda Shipley, of Branford; Bev Brakeman, Kevin Garlick, of Farmington; Lauren Santos, of Clinton; and Harvey Wooding of Redding.

As of the close of the record for public comment at the close of business November 17, there were 25 written communications containing public comment, some from persons who also provided oral comment and several signed by more than one person. Among the written public comments were communications from the following public officials: Governor-Elect Dan Malloy, Speaker of the House Christopher G. Donovan and Representative Elizabeth B. Ritter; as well as Sen. Crisco, Rep. Fontana and Councilman Deutsch. All but one 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, while 12 of the comment letters, and four of the oral comments, included some detailed description of the hardship of Anthem's rates on the consumers who made the comments. The sole letter that was neither in opposition nor

in favor asked the Commissioner to consider the possibility that Anthem could pull out of the Connecticut market if it is not sufficiently profitable. There were also comments critical of health insurers generally in the recent federal health reform debates, 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 November 29, 2009. Anthem timely submitted the supplemental information on November 19, 2010 and the record was closed as of November 19, 2010.

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 November 1, 2010, Anthem electronically filed a rate application ("Application") requesting an increase of 19.9% on all grandfathered individual direct pay products including BlueCare HMO, Century Preferred, Lumenos, Tonik to be effective January 1, 2011.
2. 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.
3. The filing included an Actuarial Certification by Jennie Keith Casaday, FSA, MAAA, the Actuarial Director of Individual Product Pricing.

4. Ms. Casaday 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, adopted December 2005 ("ASOP 8"), and that data quality was reconciled to financial statements.
5. The Patient Protection and Affordable Care Act (PPACA), Pub. L. 111-148, as amended by the Health Care and Education Reconciliation Act, Pub. L. 111-152, defines grandfathered plans as either a group health plan that was created, or an individual health insurance policy that was purchased, on or before March 23, 2010. PPACA Part II §1251. Grandfathered plans are exempt from many changes required under PPACA. Plans or policies may lose their grandfathered status if they make certain significant changes that reduce benefits or increase costs to consumers. A health plan must disclose in its plan materials whether it considers itself to be a grandfathered plan.
6. As of September 23, 2010, plans will lose their grandfathered status if significant changes that reduce benefits or increase costs to consumers are made to the plan. However, grandfathered plans were required to modify existing plans in compliance with PPACA to eliminate lifetime limits and restricted annual limits, stop the ability of an insurer to rescind a policy based on unintentional mistakes on applications, extend dependent coverage to young adults under 26 years old regardless of residency or marital status, and eliminate coverage exclusions for children under age 19 with pre-existing conditions without affecting grandfather status.
7. Grandfathered plans are closed blocks of business since PPACA requires new enrollees to be covered under plans which comply with PPACA requirements.

8. Enrollees who wish to implement the PPACA benefits which went into effect on September 23, 2010 are required to terminate coverage under the existing grandfathered plan and enroll in a new plan which is compliant with all PPACA requirements and priced accordingly to reflect those PPACA compliant benefits as well as any other benefits elected by the policyholder.
9. The requested rate increase would not be applicable to individuals who terminate the grandfathered plan and enroll in a PPACA compliant plan.
10. While Anthem has approximately 57,000 individual members, it estimates that approximately 48,000 are in plans considered to be grandfathered. The balance of the members are in plans in which they enrolled between March 24, 2010 and prior to September 23, 2010.
11. The 48,000 members could be further reduced if members terminate current grandfathered plans and enroll in PPACA compliant plans prior to January 1, 2010.
12. Because state law has prohibited rescissions based on unintentional mistakes on applications since 2007, Conn. Gen. Stat. §38a-477b; and since 2009 has required coverage for dependents to age 26 for unmarried children residing in the state, Conn. Gen. Stat. §§38a-497 and 38a-554; a minimal rate impact of .2% was included in the overall requested increase of 19.9%.
13. Public Act 10-63 requires that effective January 1, 2011, individual policies that provide coverage for intravenously administered and orally administered anticancer medications, provide such coverage for orally administered anticancer medications on a basis that is no less favorable than intravenously administered anticancer medications. Anthem identified a rate impact of .2% for the inclusion of this mandate.

14. Anthem testified that health care costs and utilization are the two main drivers of increasing health insurance premiums across all product lines. The rising cost of hospital benefits, diagnostic tests, new technologies and the use of new, more expensive prescription drugs impact the utilization mix as there is a shift to use the newer products and services.
15. Anthem testified that the downturn of the economy has had an impact on the health profile of the population as some younger, healthier members have dropped coverage.
16. Anthem testified that in the early durations of the policy, the health status of individuals is generally favorable due to the underwriting of good risks but as the policy duration ages, the effect of underwriting is diminished and claims can be expected to increase.
17. Anthem testified that cost trend is impacted by underwriting wear-off as an individual policy matures. Anthem's actuarial analysis projected that claims would increase by 8.5% in 2011 because of the underwriting wear-off.
18. Anthem testified that benefit buy-down occurs when individuals choose to change coverage to lower benefits or higher cost sharing to achieve a lower premium. That benefit buy down would be inapplicable to this book of grandfathered business, and therefore this Application, since any change in benefits other than the PPACA required changes would cause the plan to lose grandfathered status and oust it from the impacted block.

19. Claims were adjusted by $4.14 per member per month to account for the following items:

Capitated expense – lab services	$.97
Lumenos Add Admin – for health spending accounts used in conjunction with high deductible plans	$.31
Pharmacy Dispensing Fee	$1.16
Embedded Vision	$1.05
HRA Assessment - on-line tool that is used to assess member health status and eligibility for disease management programs	$1.40
Rx Rebates - provided by pharmaceutical companies and represent a savings that is passed back to the member	($2.46)
Healthcare Management - case management, disease management and utilization review	$1.71
TOTAL	**$4.14**

20. Anthem's Application was made on an aggregated basis segmenting all of the grandfathered direct pay options. Anthem testified that because of the unique nature of the grandfathered closed block, the aggregation provided a more equitable approach to the overall rate increases on this block of business.
21. Section 2718(b) of PPACA requires an aggregation by market size (individual, small group and large group) for purposes of the determination of the minimum loss ratio ("MLR") required for any potential premium rebate should the loss ratio not be met.
22. No changes were proposed to the existing age/gender factors or the HSA aggregate family deductible factors.
23. The annual trend factor used to develop the rates is 12.5%. This is a blended trend factor including both medical and prescription drug claims and is based on Connecticut only experience.

24. Anthem testified that the overall nationwide experience of its corporate parent, Wellpoint, Inc. is not applicable to the Connecticut rate filing because it is not directly representative of experience in Connecticut due to product offering variations, differences in cost and utilization as well as state mandated provisions and requirements.

25. The experience period used for the rate development is the 12-month period from July 1 2009 through June 30 2010.

26. Projected experience was based on incurred claims in the experience period that were paid through August 31 2010.

27. Anthem used a target loss ratio of 79.3% to develop the required rate increase of 21.5%. This equates to an 82.5% adjusted loss ratio as defined under PPACA for purposes of calculating any necessary rebates.

28. Anthem requested a lower increase of 19.9% that results in a loss ratio of 80.4% that equates to a health care reform adjusted target loss ratio of 83.6%.

29. The retention includes the following components:

Administrative expense	8.00%
Selling expense	3.5%
Premium tax	1.75%
Federal tax (estimated)	2.00%
Profit/margin	4.35%

30. This entire block of business renews on January 1 of each year, therefore, the rating period is the 12-month period from January 1 2011 through December 31 2011.

31. The projected trend factor was applied for the 18-month period from the midpoint of the experience period to the midpoint of the proposed rating period.

32. Trend includes anticipated changes in costs, utilization, savings initiatives, new technology, deductible leveraging, expected changes in demographics and health profile of the population, benefit mix and emerging experience.

33. Anthem testified that trend includes increased costs in hospital care due to increased utilization, new services and technology, high cost implantable devices and drugs, diagnostic imaging and cost shifting because of underfunded government programs.

34. Exhibit III of the Application reflects the trend for the PPO and HMO groups of products, but does not provide this data for each product separately. The trend for the PPO products is 8.6% for medical and 9% for prescription drugs. Trend for the HMO products is 15.8% for medical and 29.4% for prescription drugs. The projected trend combined for medical and prescription drugs is 10.4% and 17% for the PPO and HMO products respectively after an adjustment for benefit and deductible leveraging. The combined trend for the total book in Exhibit III of the Application is 12.5%. Anthem used 12.5% to project the claims for the rating period.

35. Anthem filed supplemental documents to provide the loss ratio and trend data by product with claims paid through June 2009. Supplemental Exhibit III.B of the Application shows that trend by product ranged from 16.4% to 19.6% except for Tonik that was -.2%.

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 the Intervenors and 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.

An additional concern that was raised was that the filing did not contain sufficient information for the Department to complete an appropriate review because the experience was aggregated and discreet rate requests were not filed for each product. Rather, Anthem filed for a rate increase that would be equitably distributed across each product. While this is a change in filing procedure, there is no Connecticut statutory prohibition on this type of filing and it is consistent with the requirements of PPACA. Section 2718(b) of PPACA requires an aggregation by market size (individual, small group and large group) for purposes of the determination of the minimum loss ratio.

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.

Based on the data provided, the Department actuaries found that that the actuarial methodology used by Anthem in aggregating its experience was consistent with ASOP 8 and applied consistently across the block of products. Since this block of business is grandfathered pursuant to PPACA and therefore a closed block, it is an acceptable actuarial practice and neither unreasonable nor discriminatory to pool the risk, or aggregate the experience of the block, to ensure the data remains credible over time. In addition, PPACA does require the calculation of the minimum loss ratio for purposes of determining whether a rebate is due be done on an aggregate basis.

The actuarial review of the retention indicates that the assumptions are reasonable: administrative expense level is set at 8% of the retention while commissions and selling expenses are 3.5%; the underlying profit/margin built into the projected rates is 4.5%; state premium tax is the statutory 1.75% and federal tax is estimated at approximately 2% based on the formula used; yielding an overall retention of 19.6%. The resulting assumed loss ratio is 80.4%.

Anthem applies an adjustment for the wearing off of underwriting. No explicit evidence was provided to support this adjustment, and any increase in claims on this basis should be captured in the actual claims experience. The Department finds no actuarial merit to this adjustment.

PPACA requires that grandfathered plans make some minor benefit adjustments without impacting grandfather status. Although Connecticut mandated coverage for dependents to age 26 in 2009, PPACA removed the requirement that the child be unmarried. The .2% impact of expanding this benefit is deemed reasonable. Effective January 1, 2011, these individual plans are also required to be in compliance with the

oral chemotherapy mandate required by Public Act 10-63. The .2% impact to expand this coverage is deemed reasonable.

The $4.14 adjustment to claims to account for capitated expenses, administration of the HSA account for Lumenos, pharmacy dispensing fees, embedded vision benefits, and the HRA assessment reduced to reflect rebates on prescription drugs is deemed reasonable.

The trend used in the pricing was combined for medical and prescription drug coverage across all products. The Department completed an actuarial analysis of the rolling twelve-month claim cost trends for the aggregated block using data from Exhibit II.A of the Application as set out below.

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Anthem Health Plans - Connecticut Grandfathered Direct Pay Plan Options Effective 1/1/2011

Claims and member months are on a rolling twelve month basis*

Incurred Date	Claims	Member months**	Per Member Per Month Claims Cost	Trend
Dec-07	$132,434,012	651,642	$203.23	
Jan-08	$131,502,130	652,962	$201.39	
Feb-08	$132,854,502	654,463	$203.00	
Mar-08	$133,496,056	655,643	$203.61	
Apr-08	$135,254,247	656,858	$205.91	
May-08	$135,035,892	657,927	$205.24	
Jun-08	$136,134,416	659,179	$206.52	
Jul-08	$138,521,368	660,468	$209.73	
Aug-08	$140,441,475	661,769	$212.22	
Sep-08	$142,636,811	662,824	$215.20	
Oct-08	$144,884,100	663,868	$218.24	
Nov-08	$146,152,705	664,717	$219.87	
Dec-08	$149,264,950	665,230	$224.38	10.41%
Jan-09	$149,997,183	665,654	$225.34	11.89%
Feb-09	$150,798,239	666,042	$226.41	11.53%
Mar-09	$151,236,870	666,693	$226.85	11.41%
Apr-09	$152,545,106	667,444	$228.55	11.00%
May-09	$153,382,334	668,252	$229.53	11.83%
Jun-09	$155,023,685	668,921	$231.75	12.22%
Jul-09	$156,458,571	669,581	$233.67	11.41%
Aug-09	$156,566,097	670,391	$233.54	10.05%
Sep-09	$158,712,803	671,473	$236.37	9.84%
Oct-09	$159,931,634	672,526	$237.81	8.96%
Nov-09	$163,006,922	673,750	$241.94	10.04%
Dec-09	$164,746,200	674,987	$244.07	8.78%
Jan-10	$164,116,926	675,503	$242.96	7.82%
Feb-10	$163,705,660	675,799	$242.24	6.99%
Mar-10	$163,832,873	675,689	$242.47	6.89%
Apr-10	$163,572,645	675,244	$242.24	5.99%
May-10	$162,935,533	674,660	$241.51	5.22%
Jun-10	$162,680,558	673,737	$241.46	4.19%

*Rolling twelve basis sums the values for the twelve months ending on the incurred date
**Member months represents the sum of the covered members members over a rolling 12 month period as of the incurred date.

The Department's actuarial analysis indicates trend in 2009 was consistently between 10-12% until the fourth quarter when the values began to decline. The trend

for the twelve-month period ending in December 2009 was 8.8%. The rolling twelve-month trend continued to decline steadily for the twelve month periods ending in the first six months of 2010. The trend for the twelve-month period ending in June 2010 was 4.1%. The Department's actuarial analysis determined that the 12.5% trend used for pricing was excessive. Since the trend for the twelve-month periods ending in the first half of 2010 showed a steady decline and ranged from 4% to 7%, the Department deems 5% to be a reasonable trend factor to project claims for the rating period.

The actuarial analysis by the Department developed revised projected rates effective January 1, 2011 using the Department's revised annual trend of 5%, and reducing the underwriting wear-off adjustment to 0%. Using Anthem's claims and modifying the development of the rate increase in Exhibit IV of the Application based on the Department's revised assumptions yields the following results:

Total Fully Incurred Claims PMPM		$237.32
Trend Projected to Rating Period (5% per annum for 18 months) or 7.6%		x 1.076
Equals Trended Claim Cost PMPM Effective 1/1/2011		$255.34
Claim Cost Adjustments:		
Trended Claim Cost PMPM effective 1/1/11		$255.34
Underwriting Wearoff Impact	0%	
Benefit Factor (Buy-down) impact	0%	x 1.00
		$255.34
Benefit changes	.4%	x 1.004
		$256.36
Trended Claim Cost adjusted for claim cost adjustments		$256.36
Other PMPM (capitation, etc.)	$4.14	+ 4.14
		$260.50

Adjusted Claim Cost PMPM Effective 1/1/2011		$260.50
Loss ratio used for pricing	80.4%	÷ .804
Required Premium PMPM 1/1/2011 (rounded)		$324.00

Required PMPM	$324.00
Premium at current Rates PMPM	$324.45
Calculated (Required) Increase (Rounded)	0%

Therefore, as demonstrated by these calculations, the resulting rate increase applicable to all direct pay products that is determined to be reasonable and actuarially sound in relation to the benefits provided as of January 1, 2011 is 0%.

IV. CONCLUSION AND RECOMMENDATION

Based on the foregoing and the record of the November 20, 2010 public hearing, the undersigned concludes that the rates filed by Anthem to be effective January 1, 2011 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 based on the actuarial analysis presented in the discussion section, the current rates 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 recommendation to disapprove the proposed rate increases to be effective January 1, 2011.

Dated at Hartford, Connecticut, this 2nd day of December, 2011

Mark Franklin
Hearing Officer