SERFF Tracking #:	*AWLP-130050273*	***State Tracking #:***	*201503007*	***Company Tracking #:***	

State:	*Connecticut*	***Filing Company:***	*Anthem Health Plans, Inc dba Anthem Blue Cross and Blue Shield of Connecticut*
TOI/Sub-TOI:	*HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005C Individual - Other*		
Product Name:	*Individual 2016*		
Project Name/Number:	*/*		

Correspondence Summary

Objection Letters and Response Letters

Objection Letters

Status	Created By	Created On	Date Submitted
Requesting Additional Information	Paul Lombardo	05/27/2015	05/27/2015

Response Letters

Responded By	Created On	Date Submitted
John Bryson	06/09/2015	06/09/2015

Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
Anthem Response to CT DOI Questions 5/27/15	Note To Reviewer	John Bryson	06/09/2015	06/09/2015

State: Connecticut **Filing Company:** Anthem Health Plans, Inc dba Anthem Blue Cross and Blue Shield of Connecticut

TOI/Sub-TOI: HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005C Individual - Other

Product Name: Individual 2016

Project Name/Number: /

Objection Letter

Objection Letter Status	Requesting Additional Information
Objection Letter Date	05/27/2015
Submitted Date	05/27/2015
Respond By Date	06/10/2015

Dear John Bryson,

Introduction:

Review and respond to the attached request for additional information as it pertains to this rate filing. Thank you in advance for your cooperation.

Conclusion:

Sincerely,
Paul Lombardo

CID Questions/Comments – Anthem 2016 Individual Rate Filing

May 27, 2015

1. Explain the change in the Paid-to-Allowed from 0.774 in the 2015 benefit year rate filing to 0.799 in the 2016 benefit year rate filing.
2. Explain in more detail and provide numerical actuarial justification for the following:
   - Changes in benefit design that vary by plan
   - Updated measurement of relative benefit between plans
   - Changes in the adjustment factor for Catastrophic eligibility
3. Explain in more detail and quantify anticipated changes due to network contracting.
4. Explain the difference in the projected ACA reinsurance recoveries from the 2015 benefit year rate filing to the 2016 benefit year rate filing and provide actuarial justification as support.
5. The rate filing states that Pent-up demand utilization was backed-out when projecting to 2016, provide more detail, including the value of the pent-up demand that was removed.
6. The rate filing states that Anthems goal is to price to the average risk of the 2016 ACA market. Anthem adjusted the starting experience using the results of a Wakely Consulting survey. Doesn't the Risk Adjustment take in to consideration how Anthem compares to the rest of the market place in Connecticut. Please explain the difference between the Wakely adjustment of 0.9294 and the purpose of the Risk Adjustment.
7. Provide actuarial support for the following Exhibit D, projection period adjustments:
   - Rx adjustment of 1.0007
   - Total morbidity change of 0.9336
   - Medical Management of 1.0002
   - Induced demand for CSR of 0.9970
   - Grace Period of 1.0024
8. Explain in more detail the non-EHBs embedded in the starting paid claims PMPM.
9. Explain why the EHB benefits of pediatric dental and pediatric vision were not included in the starting paid claims PMPM in Exhibit A.

10. Explain in greater detail and provide actuarial justification for the risk adjustment net transfer of -$0.43.
11. Why is the exchange fee included in the Market Adjusted Index Rate Development as well as in Exhibit G: Non-Benefit Expenses and Profit & Risk.
12. Why is the Paid-to-Allowed ratio applied to reinsurance contribution, expected reinsurance payments, risk adjustment fee, risk adjustment net transfer and the exchange fee?
13. Explain in more detail what is meant by Specialty Expenses in Exhibit G.
14. Provide more detailed calculations that support the average claim factors and normalization factors from Exhibit C.
15. Since Anthem is using 100% fully credible 2014 individual experience as the basis for the 2016 rate development, please provide Exhibit Q – Trend Exhibit using historical individual experience for comparison purposes.

State: Connecticut **Filing Company:** Anthem Health Plans, Inc dba Anthem Blue Cross and Blue Shield of Connecticut

TOI/Sub-TOI: HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005C Individual - Other

Product Name: Individual 2016

Project Name/Number: /

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	06/09/2015
Submitted Date	06/09/2015

Dear Paul Lombardo,

Introduction:

Anthem responded to the CT DOI questions from 5/27/15 in a Note to reviewer

Response 1

Comments:

Please see note to reviewer dated 6/9/15

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Conclusion:

Please let us know if you have any further questions.

Sincerely,

John Bryson

State: *Connecticut* **Filing Company:** *Anthem Health Plans, Inc dba Anthem Blue Cross and Blue Shield of Connecticut*

TOI/Sub-TOI: *HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005C Individual - Other*

Product Name: *Individual 2016*

Project Name/Number: */*

Note To Reviewer

Created By:

John Bryson on 06/09/2015 07:57 PM

Last Edited By:

John Bryson

Submitted On:

06/09/2015 07:59 PM

Subject:

Anthem Response to CT DOI Questions 5/27/15

Comments:

Attached are two files. The first contains the responses to the questions received 5/27/15. The second is the trend exhibit requested in question 15.

CID Questions/Comments – Anthem 2016 Individual Rate Filing
May 27, 2015

1. Explain the change in the Paid-to-Allowed from 0.774 in the 2015 benefit year rate filing to 0.799 in the 2016 benefit year rate filing.

   In the 2016 filing, Anthem introduced 10 new plans, closed 3 plans, and renewed 21 of 2015 plans. The renewing plans project higher Paid-to-Allowed ratio compared with 2015. (0.801 in 2016 vs 0.781 in 2015). New plans have an average Paid-to-Allowed 0.776 while closed plans only have 0.675. In 2016, the estimated membership is based on actual early 2015 Individual ACA membership for renewing plans and estimates for new plans. For renewal plans, the actual 2015 membership distribution is overall lower than our expectations for the 2015 rate filing. This can be seen in the table below. We expect membership decrease of higher metal plans will be slightly more than that in the lower metal plans. A major factor in the Average Paid-to-Allowed increase is the benefit change from non-embedded to embedded for the CDH plans. For new plans, the majority of membership is in Silver and Gold plans. For closed plans, the majority of membership is in Bronze plans. The Silver and Gold plans have higher Paid-to-Allowed ratios compared to the Bronze and Catastrophic plans due to the richer benefits. Therefore, the member-weighted Paid-to-Allowed ratio in 2016 has increased.

	2016			2015			2014		
AV Metal Level	Projected Membership	Claims Factor for Normalization	Paid /Allowed	Projected Membership	Claims Factor for Normalization	Paid /Allowed	Experienced Membership	Claims Factor for Normalization	Paid /Allowed
Gold	12,400	0.8076	0.8917	15,997	0.8315	0.8816	13,222	0.8227	0.8396
Silver	24,000	0.6845	0.8177	29,574	0.6970	0.7926	21,562	0.7023	0.7514
Bronze	12,600	0.4945	0.6645	14,356	0.5161	0.6377	6,682	0.4560	0.6028
Catastrophic	800	0.4442	0.6498	1,434	0.4960	0.6451	409	0.4466	0.5958

2. Explain in more detail and provide numerical actuarial justification for the following:
   - Changes in benefit design that vary by plan.
     The benefit changes differ by Plan. The table below identifies the medical and Rx benefit components that changed by Plan and the resulting factor adjustment.

2016 HIOS Plan ID	Factor	Change to Embedded Deductible	In-Network Single Deductible	In-Network Coinsurance	In-Network OOP Max	PCP/SCP Copay	Home Health	UC/ER Copay	OP Copay	Rx Deductible	Rx Copay / Coinsurance
86545CT1330002	1.0599		x	x	x	x		x	x	x	
86545CT1230002	0.9736	x			x						
86545CT1310019	1.0756				x						
86545CT1330009	0.9595		x	x	x		x	x	x		x
86545CT1340005	1.0753				x						
86545CT1310024	0.9925				x				x		
86545CT1230001	1.0777				x						
86545CT1230005	0.9918		x		x						

86545CT1310030	0.9727		x		x						
86545CT1230004	0.9742				x						x
86545CT1310031	0.9361		x		x						x
86545CT1470002	0.9707	x			x						x
86545CT1310032	0.9742				x						x
86545CT1330003	1.0107	x				x		x	x		
86545CT1340007	0.9970				x						
86545CT1330001	0.9816		x		x				x		x
86545CT1340006	0.9969				x						
86545CT1310033	0.9918		x		x						
86545CT1330004	0.9904				x						x
86545CT1480002	0.9904				x						x
86545CT1310035	0.9707	x			x						x

- Updated measurement of relative benefit between plans

  Anthem's benefit relativity model was updated to more accurately measure the cost impact of benefit differences between plans. The data for 2016 pricing was updated to reflect the higher cost of health care in the Northeast geographical region. The average impact for these updates was a -3.1% reduction to benefit relativities.

- Changes in the adjustment factor for Catastrophic eligibility.
  We revised our analysis of the catastrophic adjustment factor for 2016. We viewed the risk-adjusted experience for catastrophic plans across 11 Anthem states for 2014 to improve the credibility of our sample. We then developed the catastrophic adjustment factor that would achieve the same percentage operating gain as our Metal plans. This resulted in an adjustment factor of 0.8267 from our standard ACA pool. The corresponding 2015 factor had been 0.7532, which was estimated based on early catastrophic and Bronze risk score data across several Non-CT Anthem states.

3. Explain in more detail and quantify anticipated changes due to network contracting.
   Contracts with network providers are established for a 12 month period often with multiple year extensions. Anticipated changes in upcoming provider network contract arrangements (which will be negotiated between the filing date and the end of the rate period) are considered in the development of our pricing trend. The expected results of those negotiations coupled with existing contractual arrangements are compared to the contractual arrangements in place for the experience period to determine the impact to trend.

4. Explain the difference in the projected ACA reinsurance recoveries from the 2015 benefit year rate filing to the 2016 benefit year rate filing and provide actuarial justification as support.

Anthem 2015 reinsurance recovery included in the 2015 rate filing was -$72.40 based on DOI guidance ($45,000 attachment point and 70% coinsurance). It was developed from the 2013 Milliman Health Cost Guidelines (HCG) Commercial Claims Probability Distribution (CPDs).

2016 Reinsurance recoveries of -$34.85 is the weighted average of reinsurance based on 2014 HCG CPDs and projection of actual 2014 reinsurance recoveries which produced reinsurance recoveries above what was expected..

Anthem assumed the same "Average" Exchange Plan Design and HHS Benefit Payment Parameters (FBPP) Ruling of a $90,000 attachment point and coinsurance of 50% for 2016.

5. The rate filing states that Pent-up demand utilization was backed-out when projecting to 2016; provide more detail, including the value of the pent-up demand that was removed.

   Pent up demand factor of 0.9886 is calculated as follows:

   (a) 2014 Actual Previously Insured Member Months = 409,438
   (b) 2014 Actual Previously Uninsured Member Months = 117,769
   (c) 2014 Previously Uninsured Morbidity Load = 1.052
   *(d) 2014 Pent-Up Demand Impact = (c – 1) * b / (a + b) + 1 = 1.0116*

   2016 Pent-Up Demand Rebound Factor = 1 / d = 0.9886

6. The rate filing states that Anthems goal is to price to the average risk of the 2016 ACA market. Anthem adjusted the starting experience using the results of a Wakely Consulting survey. Doesn't the Risk Adjustment take in to consideration how Anthem compares to the rest of the market place in Connecticut? Please explain the difference between the Wakely adjustment of 0.9294 and the purpose of the Risk Adjustment.
   Wakely adjustment (0.9294): Anthem will either receive or make payments under the ACA Risk Adjustment program depending on how the adjusted risk score compares to the risk of the market. Anthem has participated in the Wakely study to estimate how the 2014 Risk Adjustment transfer will impact us. It develops the risk scores according to the HHS risk adjustment transfer formula for Anthem and for the Market (other carriers who have participated in the Wakely study). The end result of the risk adjustment transfer then, is that each issuer is at the market level risk. Therefore, when we develop our pricing for 2016, we price to the 2016 market morbidity. Since we are pricing to the 2016 market morbidity level, we are not pricing in any Risk Adjustment Transfer payments/receipts in 2016.

   Risk Adjustment Net Transfer ($-0.43) shown in Exhibit A item 24 is an Enterprise Strategic Initiatives that is explained in our answer to question 10 below.

7. Provide actuarial support for the following Exhibit D, projection period adjustments:
   - Rx adjustment of 1.0007

     The "Rx Adjustment" factor of 1.0007 reflects the impact of Rx formulary changes between the experience period and the rating period. The 2014 experience data was used to calculate the forecasted 2016 impact of narrowing the Select Rx formulary list compared to the National Rx formulary and re-classing tiers for certain drugs for cost sharing purposes. Data shows the savings between the National formulary and Select formulary is shrinking over time. The Select formulary captured savings in earlier years by excluding certain brand name drugs. Some of those brand name drugs have had generic launches that now create lower costs on the National formulary, narrowing the savings gap between the Select and National formularies. As a result, when we rate for 2016 plans, the Rx Adjustment factor is greater than 1.0 because we are adjusting 2014 experience to reflect the reduction in savings between the National and Select formulary.

- Total morbidity change of 0.9336

  The morbidity impacts of population movement are based on health status determined from prospective DxCG risk scores normalized for demographics.

  (a) Average CT Risk Score for the 2014 ACA Experience Period = 1.3011
  (b) Average CT Risk Score for the 2016 ACA Projection Period = 1.2288
  (c) 2014 to 2016 Morbidity Adjustment (excluding Pent-Up Demand Rebound) = b / a = 0.9444
  (d) 2016 Pent-Up Demand Rebound Factor: = 0.9886

  Total Morbidity Adjustment (2014 to 2016): = c x d = 0.9336

- Medical Management of 1.0002

  The adjustment of 1.0002 is the impact of unlimited visits related to autism spectrum disorders beginning in 2015. These services were not unlimited during the experience period in 2014; therefore an increase to the base experience is required.

- Induced demand for CSR of 0.9970

  Induced demand for CSR of 0.9970 is calculated as follows:

  (A) Induced Demand factor based on 2016 projected membership = 1.0203

  (B) Induced Demand factor inherent in the 2014 experience data = 1.0234

  Take (A) / (B) to get the Induced Demand factor needed to get from the 2014 experience period to the 2016 projection period.

- Grace Period of 1.0024

  The 1.0024 grace period load is generated by the following methodology:

  Based on 2014 CT ACA experience, 9.28% of the total ON&OFF Individual population did not pay their last month's premium and 9.11% of their total premiums were not paid. The member portion (total premium – APTC portion) percentage was 28%. Thus the adjustment we're making to our base rate is 0.24% (= 0.00928 x 0.00911 x 0.28).

8. Explain in more detail the non-EHBs embedded in the starting paid claims PMPM.

   The Non-EHB item embedded in the starting paid claims PMPM is the benefit for elective abortion only. The cost of the Non-EHB was subtracted from the projected paid claims in order to calculate the index rate. The same cost was added back to the projected claims as this is still a covered benefit in the rating period.

9. Explain why the EHB benefits of pediatric dental and pediatric vision were not included in the starting paid claims PMPM in Exhibit A.

   The starting paid claims PMPM in Exhibit A represents the fully incurred medical and drug claims for Individual ACA experience in 2014. Pediatric dental and pediatric vision benefits are adjudicated on a separate claims processing system and do not need the same adjustments for morbidity, medical/rx trend,

and other normalization adjustments. The expected 2016 claims PMPM for pediatric dental and vision were calculated for each benefit type and added to the 2016 benefit plans separately during the rate buildup.

10. Explain in greater detail and provide actuarial justification for the risk adjustment net transfer of -$0.43.

    The $ -0.43 is the multiplication of 0.1% pricing impact of sales timing strategy on projected paid claims. This strategic initiative is to attract members for earlier effective months within Open Enrollment. The model predicts a 1% increase on open enrollment period membership.

11. Why is the exchange fee included in the Market Adjusted Index Rate Development as well as in Exhibit G: Non-Benefit Expenses and Profit & Risk?

    Exhibit A: Market Adjusted Index Rate Development shows the development of the Market Adjusted Index rate. By definition, the Market Adjusted Index Rate = Index Rate + ((Reinsurance + Risk Adjustment Fee + Risk Adjustment Net Transfer + Exchange Fee) ÷ Paid-to-Allowed Ratio). Therefore, the Exchange Fee is shown in the exhibit on a PMPM basis to complete the development of the Market Adjusted Index Rate.

    Exhibit G: Non-Benefit Expenses and Profit & Risk shows all non-benefit components of the premium rate including expenses applied as a PMPM and as a percentage. In this exhibit, the Exchange Fee is shown as 1.35% percent of premium.

    Exhibit N: Plan Adjusted Index Rate and Consumer Adjusted Premium Rates show the development of the Plan Adjusted Index Rates. It includes an additive adjustment for Administrative Cost 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 developed in Exhibit A: Market Adjusted Index Rate Development.

12. Why is the Paid-to-Allowed ratio applied to reinsurance contribution, expected reinsurance payments, risk adjustment fee, risk adjustment net transfer and the exchange fee?

    CMS published instructions for completing the URRT exhibit which included definitions of the Market Adjusted Index Rate. Section 4.6.3 of the instructions state "The Market Adjusted Index Rate is calculated as the Index Rate adjusted for all allowable market-wide modifiers defined in the market rating rules, 45 CFR § 156.80(d)(1). The following market-wide adjustments to the Index Rate are allowable under these rules:

    - *Federal reinsurance program adjustment (market-wide adjustment)*
    - *Risk adjustment (market-wide adjustment)*
    - *Marketplace user fee adjustment (market-wide adjustment)*

    Since the Index Rate is on an allowed claims basis, the market level adjustments for the Federal reinsurance program, risk adjustment program, and the Marketplace user fees should be on an allowed basis."

    Following this definition, Exhibit A: Market Adjusted Index Rate Development applies the Paid-to-Allowed ratio to the reinsurance contribution, expected reinsurance payments, risk adjustment fee, risk adjustment net transfer and the exchange fee in order to put these costs on an allowed basis for the Market Adjusted Index Rate calculation.

13. Explain in more detail what is meant by Specialty Expenses in Exhibit G.

The Specialty Expenses of $0.62 PMPM represent the administrative expense on Pediatric Dental and Pediatric Vision benefits. These expenses are not included in the $30.54 PMPM amount for medical administrative expenses.

14. Provide more detailed calculations that support the average claim factors and normalization factors from Exhibit C.

	Average Claim Factors - Experience Rate		
	Experience Period Population	Future Population	Normalization Factor
Age/Gender	1.0432	1.0377	0.9887
Area	0.9591	0.9598	1.0007
Network	0.9511	0.9590	1.0083
Benefit Plan	0.6895	0.6591	0.9559
Total			0.9536

- *Age/Gender: Based on 2014 Individual ACA experience data, the member-weighted age factor was 1.0432. Based on 2016 rating period distribution of members by age, the assumed member-weighted age factor is 1.0377. The projected 2016 membership by county is based off of early 2015 Individual ACA membership, which reflects that the average age is one year younger than 2014. The Age/Gender Normalization Factor = 1.0377 / 1.0432 = 0.9887.*

- *Area: Based on 2014 Individual ACA experience data, the member-weighted area factor was 0.9591. Based on projected 2016 Individual ACA membership by county, the member-weighted area factor is 0.9598. The projected 2016 membership by county is based off of early 2015 Individual ACA membership by county and reflects an increased membership proportion in Fairfield (Area Factor = 1.10) and New Haven (Area Factor = 0.95), but decreased membership proportion in most other Areas (Area Factor = 0.87). This increases the overall average area factor. The Area Normalization Factor = 0.9598 / 0.9591 = 1.0007.*

- *Network: Based on 2014 Individual ACA experience data, the member-weighted network factor was 0.9511. Based on projected 2016 Individual ACA membership and new plans, the member-weighted network factor is 0.9590. For non-narrow network, PPO plans with high network factors of 1.01 will be joining the market. For narrow network, we project 2016 membership to shift more towards PPO plans. HMO plans have a lower network factor than the PPO plans. This shift increases the average network factor in 2016. The Network Normalization Factor = 0.9590/ 0.9511 = 1.0083.*

- *Benefit Plan: Based on 2014 Individual ACA experience data, the member-weighted benefit relativity factor was 0.6895. Based on projected 2016 Individual ACA membership and new plans, the member-weighted benefit relativity factor is 0.6591. The 2016 Individual portfolio of plans includes leaner plan options than 2014 and we expect membership to shift towards leaner plan designs, lowering the average benefit relativity factor in 2016. The Benefit Plan Normalization Factor = 0.6591/ 0.6895 = 0.9559.*

15. Since Anthem is using 100% fully credible 2014 individual experience as the basis for the 2016 rate development, please provide Exhibit Q – Trend Exhibit using historical individual experience for comparison purposes. A revised Exhibit Q is included in a separate document.

Exhibit Q - Trend Exhibit

Rating Trend

Anthem proposes a 7.6% rating trend based on the Small Group experience. The 2014 Individual experience represented a different population and benefit portfolio. The rating trend developed using that experience didn't provide a reasonable basis for creating a trend for the 2016 rate period.

Observed Paid Trends

Observed trends have been normalized to remove the impact of aging and morbidity, shifts in gender, medical initiatives and mandates, and impact of medical benefit changes.

Benefit Buy Downs

Cost and utilization data in the experience periods includes the impact of benefit buy-downs. The trend process is normalized for benefit buy-down to develop a projected trend for 2015 and 2016.

Provider Contracting

Provider contracting is included in the Unit Cost Data.

Leveraging

The use of Paid Claims removes the need to adjust for Leveraging.

Other Trend Components

Medical technology trend is included in observed experience and not an independent assumption.

Historical Cost and Utilization Paid Data

	Inpatient	Outpatient	Professional	Rx Drug	Total
Unit Cost Data					
CY 2011	$3,548.41	$641.84	$124.16	$43.13	
CY 2012	$3,727.00	$772.41	$122.82	$47.24	
CY 2013	$3,758.66	$847.34	$127.44	$51.87	
CY 2014	$3,369.18	$797.25	$126.37	$79.47	
CY 2015	$3,478.08	$830.61	$135.16	$90.90	
CY 2016	$3,662.86	$885.27	$146.69	$103.97	
Utilization Data (per thousand members)					
CY 2011	17.5	113.3	791.0	630.3	1,552.2
CY 2012	16.7	117.0	803.8	646.9	1,584.4
CY 2013	14.7	121.0	817.2	684.4	1,637.3
CY 2014	35.2	187.0	940.9	986.7	2,149.8
CY 2015	37.0	196.6	960.6	1,028.3	2,222.5
CY 2016	38.0	201.6	965.7	1,071.6	2,276.8
			-	-	-
Paid PMPM					
CY 2011	$62.20	$0.00 $72.74	$98.21	$27.19	$260.35
CY 2012	$62.07	$0.00 $90.36	$98.72	$30.56	$281.71
CY 2013	$55.39	$0.00 $102.51	$104.14	$35.50	$297.55
CY 2014	$118.66	$0.00 $149.12	$118.90	$78.41	$465.09
CY 2015	$128.75	$0.00 $163.28	$129.84	$93.47	$515.33
CY 2016	$139.05	$0.00 $178.47	$141.66	$111.42	$570.58
Paid Trend					
2012/2011	-0.2%	24.2%	0.5%	12.4%	8.2%
2013/2012	-10.8%	13.5%	5.5%	16.2%	5.6%
2014/2013	114.2%	45.5%	14.2%	120.9%	56.3%
2015/2014	8.5%	9.5%	9.2%	19.2%	10.8%
2016/2015	8.0%	9.3%	9.1%	19.2%	10.7%