STATE OF CONNECTICUT

INSURANCE DEPARTMENT

In The Matter Of:

ANTHEM BLUE CROSS AND BLUE SHIELD OF CONNECTICUT

Docket No LH 15-112
Docket No LH 15-113

Medicare Supplement Insurance

ORDER

I, Katharine L Wade, Commissioner of the State of Connecticut, having read the record, do hereby adopt the findings and recommendations of Danny K. Albert, Hearing Officer in the above matter, and issue the following order, to wit:

The Medicare supplement insurance rate filing submitted by Anthem Blue Cross and Blue Shield of Connecticut, for its pre-standardized products, is not approved as submitted. However, rate changes on some of the subject products are approved. This will result in the following rate changes for the company's respective plans:

Pre-Standardized	Rate Change
BC-65 High Option	
Group	2.43%
Direct Pay	2.43%
High Option Alt.	
Group	2.43%
Direct Pay	2.43%
BC-65 Low Option	
Group	0.00%
Direct Pay	0.00%
Low Option Alt.	
Group	0.00%
Direct Pay	0.00%
Drug Riders	
P1	0.00%
P3	0.00%
P5	0.00%
$0 copay, 80% coins., $2,000 max	
Group	0.00%
Direct Pay	0.00%

BS-65 Plan 81	
Group	2.84%
Direct Pay	2.84%
BS-65 Plan 82	
Group	0.00%
Direct Pay	0.00%
BS-65 Plan 83	
Group	0.00%
Direct Pay	0.00%
CarePlus	
Hospital	2.43%
Medical	2.84%

The company's proposed rate increases on its standardized Medicare supplement insurance products are not approved as requested. However, the following rate changes are approved for the company's products.

Standardized	Increased
Plan A	20.00%
Plan B	0.00%
Plan C	6.13%
Plan D	7.90%
Plan F	7.17%
Plan F (High Ded)	10.00%
Plan H (w/Rx)	2.99%
Plan H (w/o Rx)	9.90%
Plan J (w/Rx)	9.90%
Plan J (w/o Rx)	9.90%
CHCP Plan J (w/ Rx)	1.70%
CHCP Plan J (w/o Rx)	5.00%

Modernized	Increased
Plan A	20.00%
Plan F	7.17%
Plan F (High Ded)	10.00%
Plan G	6.80%
Plan N	-8.66%

These rate changes (pre-standardized and standardized) approved herein, are reasonable in relation to the plan benefits, projected claim costs and anticipated loss ratios the company expects to realize on the plans.

Anthem Blue Cross and Blue Shield of Connecticut is directed to file its revised rate schedules with the Insurance Department by Friday, October 23, 2015. The Revised Rate schedules must reflect the rate changes approved herein.

Dated at Hartford, Connecticut, this 7th day of October, 2015.

Katharine L Wade
Commissioner

STATE OF CONNECTICUT

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PROPOSED FINAL DECISION

1. INTRODUCTION

The Insurance Commissioner of the State of Connecticut is empowered to review rates charged for individual and group Medicare supplement policies sold to any resident of this State who is eligible for Medicare. This regulatory authority is carried out in accordance with statutes found in Chapter 700c of the Connecticut General Statutes.

After due notice, a public hearing was held at the Insurance Department in Hartford on September 24, 2015 to consider whether or not the rate filings by Anthem BlueCross and BlueShield on its Medicare supplement business should be approved.

No members of the general public or public officials attended the hearing.

One company representative participated in the hearing.
No members from the general public attended the meeting.

The hearing was conducted in accordance with the requirements of Section 38a-474, Connecticut General Statutes, the Uniform Administrative Procedures Act, Chapter 54 of the Connecticut General Statutes, and the Insurance Department Rules of Practice, Section 38a-8-1 et seq. of the Regulations of Connecticut State Agencies.

Background
A Medicare supplement (or Medigap) policy is a private health insurance policy sold on an individual or group basis which provides benefits that are additional to the benefits provided by Medicare. For many years Medicare supplement policies have been highly regulated under both state and federal law to protect the interests of persons eligible for Medicare who depend on these policies to provide additional coverage for the costs of health care.

Effective December 1, 2005, Connecticut amended its program of standardized Medicare supplement policies in accordance with Section 38a-495a of the Connecticut General Statutes, and Sections 38a-495a-1 through 38a-495a-21 of the Regulations of Connecticut Agencies. This program, which conforms to federal requirements, provides that all

insurers offering Medicare supplement policies for sale in the state must offer the basic "core" package of benefits known as Plan A. Insurers may also offer any one or more of eleven other plans (Plans B through N).

Effective January 1, 2006, in accordance with Section 38a-495c of the Connecticut General Statutes (as amended by Public Act 05-20) premiums for all Medicare supplement policies in the state must use community rating. Rates for Plans A through N must be computed without regard to age, gender, previous claims history or the medical condition of any person covered by a Medicare supplement policy or certificate.

The statute provides that coverage under Plan A through N may not be denied on the basis of age, gender, previous claims history or the medical condition of any covered person. Insurers may exclude benefits for losses incurred within six months from the effective date of coverage based on a pre-existing condition.

Section 38a-495a-10 of the Regulations of Connecticut Agencies, states that individual and group Medicare supplement policies must have anticipated loss ratios of 65% and 75%, respectively. Under Sections 38a-495-7 and 38a-495a-10 of the Regulations of Connecticut Agencies, filings for rate increases must demonstrate that actual and expected losses in relation to premiums meet these standards, and anticipated loss ratios for the entire future period for which the requested premiums are calculated to provide coverage must be expected to equal or exceed the appropriate loss ratio standard.

Section 38a-473 of the Connecticut General Statutes provides that no insurer may incorporate in its rates for Medicare supplement policies factors for expenses that exceed 150% of the average expense ratio for that insurer's entire written premium for all lines of health insurance for the previous calendar year.

II. FINDING 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 Insurance Department, the undersigned makes the following findings of fact:

Anthem Blue Cross and Blue Shield of Connecticut has requested the following rate changes to its pre-standardized and standardized books of business:

Pre-Standardized

	In-Force Members 5/31/15	Current	Proposed	% Difference
BC-65 High Option				
Group	5,907	$110.13	$115.42	4.80%
Direct Pay	1,544	$151.18	$158.44	4.80%
High Option Alt.				
Group	35	$105.07	$110.11	4.80%
Direct Pay	1,079	$139.75	$146.46	4.80%
BC-65 Low Option				
Group	620	$42.47	$42.47	0.00%

Direct Pay	2	$46.38	$46.38	0.00%
Low Option Alt.				
Group	0	$38.51	$38.51	0.00%
Direct Pay	3	$42.36	$42.36	0.00%
CarePlus Hospital				
Group,Direct Pay	59	$116.29	$121.87	4.80%
BS-65 Plan 81				
Group	4,068	$103.60	$113.08	9.15%
Direct Pay	2,450	$113.10	$123.45	9.15%
BS-65 Plan 82				
Group	1,809	$85.20	$85.20	0.00%
Direct Pay	240	$101.59	$101.59	0.00%
BS-65 Plan 83				
Group	563	$72.66	$72.88	0.30%
Direct Pay	4	$77.20	$77.43	0.30%
CarePlus Medical				
Group, Direct Pay	59	$111.14	$121.31	9.15%
CarePlus Drug Riders				
P1	6	$165.10	$165.10	0.0%
P3	2	$133.94	$133.94	0.0%
P5	0	$137.26	$137.26	0.0%
$0 copay, 80% coins., $2000 Max				
Direct	19	$153.52	$153.52	0.0%
Group	7	$72.05	$72.05	0.0%

Standardized

In-Force Members

	5/31/15	Current	Proposed	% Difference
Plan A	149	$332.90	$399.48	20.00%
Plan B	828	$221.73	$221.73	0.00%
Plan C	2,014	$306.10	$329.36	7.60%
Plan D	516	$223.78	$241.46	7.90%
Plan F	6,161	$243.96	$262.01	7.40%
High Ded. Plan F	3,158	$33.45	$40.14	20.00%
Plan H (w/ Rx)	91	$313.93	$327.12	4.20%
Plan H (w/o Rx)	189	$221.58	$243.52	9.90%
Plan J (w/ Rx)	240	$306.16	$336.47	9.90%
Plan J (w/o Rx)	2,627	$192.41	$211.46	9.90%
CHCP Plan J (w/ Rx)	27	$363.58	$385.76	6.10%
CHCP Plan J (w/o Rx)	39	$298.36	$327.90	9.90%

Modernized Plans

		Current	Proposed	% Difference
Plan A	291	$332.90	$399.48	20.00%
Plan F	5,735	$243.96	$262.01	7.40%
High Ded. Plan F	5,508	$33.45	$40.14	20.00%
Plan G	196	$210.43	$224.74	6.80%
Plan N	1,623	$162.24	$150.88	-7.00%

Anthem BCBSCT calculated incurred claims based on an experience period of March 2014 through February 2015 with paid run-out through May 2015. Trend was then applied for a 22-month period to the middle of 2016.

Medical and Drug trends were developed by plan for the standardized and modernized plans. The trend assumption used in the development of the January 2016 rates is 1.5% for medical claims and 0% for drug claims.

For pre-standardized plans, trends were developed in aggregate split between medical and drug. Based on the observed Connecticut pre-standard 12-month trends, a medical trend of 1.5% was chosen, while 0% was applied to drug claims.

The loss ratio history for pre-standardized, standardized and modernized plans is as follows:

	2013	2014	Since Inception
BC-65 High Option	86.0%	78.3%	85.7%
BC-65 Low Option	71.2%	84.7%	89.6%
BS-65 Plan 81	80.8%	78.5%	81.6%
BS-65 Plan 82	68.4%	66.3%	80.9%
BS-65 Plan 83	60.7%	66.3%	81.2%
CarePlus	84.2%	97.6%	81.1%

	2013	2014	Since Inception
Plan A	147.4%	174.5%	127.0%
Plan B	82.1%	74.5%	90.1%
Plan C	82.4%	81.6%	92.2%
Plan D	88.3%	80.8%	84.3%
Plan F	80.4%	83.0%	80.1%
High Ded. Plan F	93.9%	111.4%	59.9%
Plan G	82.2%	92.4%	82.7%
Plan H (w/ Rx)	90.5%	87.8%	79.2%
Plan H (w/o Rx)	77.5%	91.3%	76.7%
Plan J (w/ Rx)	82.2%	87.9%	72.4%
Plan J (w/o Rx)	75.3%	82.9%	72.6%
Plan N	65.5%	65.3%	72.4%

The projected 2016 loss ratios are as follows:

Pre-standardized	Loss Ratio
BC-65 High Option	77.5%
BC-65 Low Option	74.7%
BS-65 Plan 81	74.0%
BS-65 Plan 82	72.6%
BS-65 Plan 83	72.3%
CarePlus	94.5%

Standardized	Loss Ratio
Plan A	126.8%
Plan B	76.2%
Plan C	77.4%
Plan D	75.0%
Plan F	75.9%
High Ded. Plan F	96.1%
Plan G	81.7%
Plan H w/ Rx	80.8%
Plan H w/o Rx	84.5%
Plan J w/ Rx	82.4%
Plan J w/o Rx	77.9%
Plan N	75.6%

Anthem BCBSCT certified that their expense factor is in compliance with section 38a-473, C.G.S. They have also conformed to subsection (e) of section 38a-495c, C.G.S., regarding the automatic claims processing requirement.

The proposed rates are designed to satisfy the Connecticut statutory loss ratio of 75%.

Anthem BCBSCT's 2015 Medicare supplement rate filing proposal is in compliance with the requirements of regulation 38a-474 as it applies to the contents of the rate submission as well as the actuarial memorandum.

III. RECOMMENDATION

The undersigned recommends the approval of the following rate changes, in some instances no rate change, for the pre-standardized rate filing:

	Proposed Change	**Recommended Change**
Pre-Standardized		
BC-65 High Option	4.80%	2.43%
High Option Alt.	4.80%	2.43%
BC-65 Low Option	0.00%	0.00%
Low Option Alt.	0.00%	0.00%
BS-65 Plan 81	9.15%	2.84%
BS-65 Plan 82	0.00%	0.00%

BS-65 Plan 83	0.30%	0.00%
CarePlus Hospital	4.80%	2.43%
CarePlus Medical	9.15%	2.84%
CarePlus Drug Riders	0.00%	0.00%

The undersigned also recommends the approval of the following rate changes for the standardized as well as modernized plans.

	Proposed Change	**Recommended Change**
Standardized		
Plan A	20.00%	20.00%
Plan B	0.00%	0.00%
Plan C	7.60%	6.13%
Plan D	7.90%	7.90%
Plan F	7.40%	7.17%
Plan F High Ded.	20.00%	10.00%
Plan H w/Rx	4.20%	2.99%
Plan H w/o Rx	9.90%	9.90%
Plan J w/Rx	9.90%	9.90%
Plan J w/o Rx	9.90%	9.90%
CHCP Plan J w/ Rx	6.10%	1.70%
CHCP Plan J w/o Rx	9.90%	5.00%

	Proposed Increase	**Recommended Increase/Decrease**
Modernized		
Plan A	20.00%	20.00%
Plan F	7.40%	7.17%
Plan F High Ded.	20.00%	10.00%
Plan G	6.80%	6.80%
Plan N	-7.00%	-8.66%

Based upon trend exhibits for standardized and pre-standardized business the Department reduced the standardized prescription drug trend from 0% to -5%. The Department also reduced pre-standardized medical trend from 1.5% to 0.00% and the pre-standardized prescription drug trend from 0.00% to -10.00%.

Dated at Hartford, Connecticut, this 7th day of October, 2015.

Danny K. Albert
Hearing Officer