STATE OF CONNECTICUT

INSURANCE DEPARTMENT

In The Matter Of	:	
Anthem Blue Cross and Blue Shield	:	
of Connecticut	:	**Docket No. LH 17-93**
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 filings submitted by Anthem Blue Cross and Blue Shield of Connecticut, for its Pre-Standardized and 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 Medicare Supplement Insurance Plans

Plans	Rate Changes
BC-65	
High Option Group	0.00%
High Option Direct Pay	0.00%
High Option Alternative Group	0.00%
High Option Alternative Direct Pay	0.00%
Low Option Group	9.90%
Low Option Direct Pay	9.90%
Low Option Alternative Group	9.90%
Low Option Alternative Direct Pay	9.90%
BS-65	
Plan 81 Group	7.54%
Plan 81 Direct Pay	7.54%

Plan 82 Group	0.00%
Plan 82 Direct Pay	0.00%
Plan 83 Group	0.00%
Plan 83 Direct Pay	0.00%
CarePlus Hosptial	0.00%
CarePlus Medical	7.54%

CarePlus Drug Riders:

P1	0.00%
P3	0.00%
P5	0.00%
$0 Copay, 80% Coins., $2k max Direct Pay	0.00%
$0 Copay, 80% Coins., $2k max Group	0.00%

Individual Standardized Medicare Supplement Insurance Plans

Plans	Rate Changes
A	20.00%
B	0.00%
C	0.00%
D	3.32%
F	0.00%
High Deductible F	20.00%
H (w/Rx)	-10.00%
H (w/o Rx)	4.81%
J (w/Rx)	1.83%
J (w/o Rx)	4.14%
CHCP Plan J (w/Rx)	9.90%
CHCP Plan J (w/o Rx)	3.81%

Individual Standardized Modernized Medicare Supplement Insurance Plans

Plans	Rate Changes
A	20.00%
F	0.00%
High Deductible F	20.00%
G	-14.546%
N	0.00%

The rate action approved herein is reasonable in relationship to the benefits and estimated claim costs the company can reasonably expect to realize under these products.

Dated at Hartford, Connecticut, this 10th day of October, 2017.

Katharine L Wade
Commissioner

STATE OF CONNECTICUT

INSURANCE DEPARTMENT

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PROPOSED FINAL DECISION

I. 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. The source for this regulatory authority is contained in Chapter 700c and Section 38a-495a of the Connecticut General Statutes.

After due notice, a hearing was held at the Insurance Department in Hartford on Thursday, September 28, 2017 to consider whether or not the rate increase filings made Anthem Health Plans Inc. (dba Anthem Blue Cross and Blue Shield of Connecticut) on its Pre-Standardized and Standardized Medicare supplement insurance products should be approved.

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

Three company representatives from Anthem Blue Cross and Blue Shield of Connecticut attended the hearing. One representative presented oral testimony, relative to the two filings before the department. The company's actuary participated in the hearing via speaker phone.

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

A Medicare supplement 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-496a 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 a "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 Plans 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.

Effective October 1, 1998, carriers that offer Plan B or Plan C must make these plans as well as Plan A, available to all persons eligible for Medicare by reason of disability.

Insurers must also make the necessary arrangements to receive notice of all claims paid by Medicare for their insureds so that supplement benefits can be computed and paid without requiring insureds to file claim forms for such benefits. This process of direct notice and automatic claims payment is commonly referred to as "piggybacking" or "crossover".

Sections 38a-495 and 38a-522 of the Connecticut General Statutes, and Section 38a-495a-10 of the Regulations of Connecticut Agencies, state 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. 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 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 5/31/17	Current	Proposed	% Difference
BC-65 High Option Group	5,009	$112.81	$112.81	0.00%
Direct Pay	912	$154.85	$154.85	0.00%

High Option Alt.				
Group	29	$107.62	$107.62	0.00%
Direct Pay	652	$143.15	$143.15	0.00%
BC-65 Low Option				
Group	599	$42.47	$46.47	9.89%
Direct Pay	1	$46.38	$50.97	9.90%
Low Option Alt.				
Group	0	$38.51	$42.32	9.89%
Direct Pay	2	$42.36	$46.55	9.89%
CarePlus Hospital				
Group,Direct Pay	40	$119.12	$119.12	0.00%
BS-65 Plan 81				
Group	3,701	$111.87	$121.94	9.00%
Direct Pay	1,494	$122.13	$133.12	9.00%
BS-65 Plan 82				
Group	1,492	$85.20	$85.20	0.00%
Direct Pay	125	$101.59	$101.59	0.00%
BS-65 Plan 83				
Group	371	$72.66	$72.66	0.00%
Direct Pay	1	$77.20	$77.20	0.00%
CarePlus Medical				
Group, Direct Pay	40	$120.02	$130.82	9.00%
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	12	$153.52	$153.52	0.0%
Group	5	$72.05	$72.05	0.0%

Standardized

	In-Force Members 5/31/17	Current	Proposed	% Difference
Plan A	71	$479.38	$575.26	20.00%
Plan B	624	$238.58	$238.58	0.00%
Plan C	1,406	$334.93	$334.93	0.00%
Plan D	377	$258.36	$274.38	6.20%
Plan F	4,856	$261.45	$261.45	0.00%
High Ded. Plan F	2,840	$44.16	$52.99	20.00%
Plan H (w/ Rx)	64	$355.33	$355.33	0.00%
Plan H (w/o Rx)	147	$267.63	$288.51	7.80%
Plan J (w/ Rx)	185	$369.78	$387.53	4.80%

Plan J (w/o Rx)	2,315	$232.39	$248.89	7.10%
CHCP Plan J (w/ Rx)	17	$374.57	$411.65	9.90%
CHCP Plan J (w/o Rx)	34	$313.28	$334.27	6.70%

Modernized Plans

		Current	Proposed	% Difference
Plan A	236	$479.38	$575.26	20.00%
Plan F	6,560	$261.45	$261.45	0.00%
High Ded. Plan F	5,021	$44.16	$52.99	20.00%
Plan G	145	$224.74	$192.05	-14.546%
Plan N	7,653	$148.19	$148.19	0.00%

Anthem BCBSCT calculated incurred claims based on an experience period of March 2016 through February 2017 with paid run-out through May 2017. Trend was then applied for a 22-month period to the middle of 2017.

Medical and Drug trends were developed by plan for the standardized and modernized plans. The trend assumption used in the development of the January 2018 rates is 2.0% for medical claims and 0.0% 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 2.0% was chosen, while 0.0% was applied to drug claims.

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

	2015	2016	Since Inception
BC-65 High Option	76.9%	71.3%	85.6%
BC-65 Low Option	72.8%	88.6%	89.7%
BS-65 Plan 81	80.5%	82.5%	81.6%
BS-65 Plan 82	65.4%	71.2%	80.9%
BS-65 Plan 83	60.4%	63.8%	81.10%
CarePlus	81.5%	88.8%	81.1%

	2015	2016	Since Inception
Plan A	175.1%	138.3%	130.6%
Plan B	81.9%	75.7%	89.6%
Plan C	76.8%	75.6%	91.7%
Plan D	82.8%	84.0%	84.3%
Plan F	77.5%	72.4%	79.8%
High Ded. Plan F	133.5%	113.0%	71.0%
Plan G	73.4%	65.4%	81.0%
Plan H (w/ Rx)	110.6%	76.7%	79.3%
Plan H (w/o Rx)	81.4%	79.9%	76.7%
Plan J (w/ Rx)	139.3%	131.1%	73.9%
Plan J (w/o Rx)	86.3%	81.1%	73.8%
Plan N	65.0%	75.2%	71.8%

The projected 2018 loss ratios are as follows:

Pre-standardized	Loss Ratio
BC-65 High Option	74.5%
BC-65 Low Option	82.9%
BS-65 Plan 81	77.6%
BS-65 Plan 82	74.0%
BS-65 Plan 83	67.0%
CarePlus	87.7%

Standardized	Loss Ratio
Plan A	99.3%
Plan B	73.3%
Plan C	75.9%
Plan D	76.1%
Plan F	75.4%
High Ded. Plan F	81.6%
Plan G	73.4%
Plan H w/ Rx	62.4%
Plan H w/o Rx	75.9%
Plan J w/ Rx	84.3%
Plan J w/o Rx	74.5%
Plan N	78.9%

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 2017 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 and in some instances no rate change:

	Proposed Change	**Recommended Change**
Pre-Standardized		
BC-65 High Option	0.00%	0.00%
High Option Alt.	0.00%	0.00%
BC-65 Low Option	9.90%	9.90%
Low Option Alt.	9.90%	9.90%
BS-65 Plan 81	9.00%	7.54%
BS-65 Plan 82	0.00%	0.00%

BS-65 Plan 83	0.00%	0.00%
CarePlus Hospital	0.00%	0.00%
CarePlus Medical	9.00%	7.54%
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	0.00%	0.00%
Plan D	6.20%	3.32%
Plan F	0.00%	0.00%
Plan F High Ded.	20.00%	20.00%
Plan H w/Rx	0.00%	-10.00%
Plan H w/o Rx	7.80%	4.81%
Plan J w/Rx	4.80%	1.83%
Plan J w/o Rx	7.10%	4.14%
CHCP Plan J w/ Rx	9.90%	9.90%
CHCP Plan J w/o Rx	6.70%	3.81%

	Proposed Change	**Recommended Change**
Modernized		
Plan A	20.00%	20.00%
Plan F	0.00%	0.00%
Plan F High Ded.	20.00%	20.00%
Plan G	-14.546%	-14.546%
Plan N	0.00%	0.00%

The Department requested that Exhibit V for both pre-standardized and standardized be updated with more current experience. Anthem did not submit the updated Exhibit V's. Based on the trend exhibits, medical trend was reduced from 2% to 1% for the pre-standardized plans and from 2.0% to 0.0% for the standardized and modernized plans, the Department, in some instances reduced the requested rate increases.

Dated at Hartford, Connecticut, this 10th day of October, 2017.

Danny K. Albert
Hearing Officer