STATE OF CONNECTICUT

INSURANCE DEPARTMENT

In The Matter Of	:	
Anthem Blue Cross and Blue Shield	:	
of Connecticut	:	**Docket No. LH 18-69**
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 Standardized products, is approved as submitted. This will result in the following rate changes for the company's respective plans:

Individual Standardized Medicare Supplement Insurance Plans

Plans	Rate Changes
A	20.00%
B	0.00%
C	0.00%
D	0.00%
F	0.00%
High Deductible F	20.00%
H (w/Rx)	0.00%
H (w/o Rx)	0.00%
J (w/Rx)	0.00%
J (w/o Rx)	9.90%
CHCP Plan J (w/Rx)	0.00%
CHCP Plan J (w/o Rx)	0.00%

Individual Standardized Modernized Medicare Supplement Insurance Plans

Plans	Rate Changes
A	20.00%
F	0.00%
High Deductible F	20.00%
G	0.00%
N	6.00%

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 23rd day of October, 2018.

Katharine L. Wade
Commissioner

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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, October 11, 2018 to consider whether or not the rate increase filing made by Anthem Health Plans Inc. (dba Anthem Blue Cross and Blue Shield of Connecticut) on its Standardized Medicare supplement insurance products should be approved.

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

Four company representatives from Anthem Blue Cross and Blue Shield of Connecticut attended the hearing. One representative presented oral testimony, relative to the filing 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 standardized book of business:

Standardized

	In-Force Members June 2018	Current	Proposed	% Difference
Plan A	53	$575.26	$690.31	20.00%
Plan B	525	$238.58	$238.58	0.00%
Plan C	1,172	$334.93	$334.93	0.00%
Plan D	309	$266.94	$266.94	0.00%
Plan F	4,241	$261.45	$261.45	0.00%

High Ded. Plan F	2,661	$52.99	$63.59	20.00%
Plan H (w/ Rx)	56	$319.80	$319.80	0.00%
Plan H (w/o Rx)	128	$280.50	$280.50	0.00%
Plan J (w/ Rx)	170	$376.55	$376.55	0.00%
Plan J (w/o Rx)	2,126	$242.01	$265.97	9.90%
CHCP Plan J (w/ Rx)	14	$411.65	$411.65	0.00%
CHCP Plan J (w/o Rx)	32	$325.22	$325.22	0.00%

Modernized Plans

		Current	**Proposed**	**% Difference**
Plan A	192	$575.26	$690.31	20.00%
Plan F	6,524	$261.45	$261.45	0.00%
High Ded. Plan F	4,723	$52.99	$63.59	20.00%
Plan G	1,451	$192.05	$192.05	0.00%
Plan N	10,493	$148.19	$157.08	6.00%

Anthem BCBSCT calculated incurred claims based on an experience period of June 2017 through May 2018 with paid run-out through June 2018. Trend was then applied for a 19-month period to the middle of 2019.

Medical and Drug trends were developed by plan for the standardized and modernized plans. The trend assumption used in the development of the January 2019 rates ranged from 3.99% to 9.66% for medical claims and 0.0% to 8.03% for drug claims.

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

	2016	2017	Since Inception
Plan A	137.7%	123.6%	130.1%
Plan B	77.3%	69.2%	89.3%
Plan C	75.0%	72.3%	91.5%
Plan D	83.9%	72.7%	84.1%
Plan F	72.3%	74.6%	79.5%
High Ded. Plan F	113.4%	104.2%	73.9%
Plan G	65.7%	67.7%	79.0%
Plan H (w/ Rx)	65.2%	65.2%	79.1%
Plan H (w/o Rx)	86.5%	63.7%	77.4%
Plan J (w/ Rx)	92.3%	79.9%	72.9%
Plan J (w/o Rx)	84.6%	84.0%	75.2%
Plan N	75.2%	78.7%	75.0%

The projected 2019 loss ratios are as follows:

Standardized	Loss Ratio
Plan A	94.6%
Plan B	72.9%
Plan C	76.8%
Plan D	74.1%
Plan F	78.4%
High Ded. Plan F	79.5%
Plan G	88.9%
Plan H w/ Rx	75.9%
Plan H w/o Rx	63.9%
Plan J w/ Rx	87.7%
Plan J w/o Rx	82.6%
Plan N	83.4%

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 2018 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:

Standardized	**Proposed Change**	**Recommended Change**
Plan A	20.00%	20.00%
Plan B	0.00%	0.00%
Plan C	0.00%	0.00%
Plan D	0.00%	0.00%
Plan F	0.00%	0.00%
Plan F High Ded.	20.00%	20.00%
Plan H w/Rx	0.00%	0.00%
Plan H w/o Rx	0.00%	0.00%
Plan J w/Rx	0.00%	0.00%
Plan J w/o Rx	9.90%	9.90%
CHCP Plan J w/ Rx	0.00%	0.00%
CHCP Plan J w/o Rx	0.00%	0.00%

	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	0.00%	0.00%
Plan N	6.00%	6.00%

Dated at Hartford, Connecticut, this 23rd day of October, 2018.

Danny K. Albert
Hearing Officer