STATE OF CONNECTICUT
INSURANCE DEPARTMENT

In The Matter Of	**:**	
Anthem Health Plans Inc.	**:**	**Docket No. LH 20-86**
dba Blue Cross Blue Shield of Connecticut	**:**	
Medicare Supplement Insurance	**:**	

ORDER

I, Andrew N. Mais, Commissioner of the State of Connecticut, having read the record, do hereby adopt the findings and recommendations of Eric C. Vieweg, Hearing Officer in the above matter and issue the following order, to wit:

The undersigned recommends approval of the proposed rate changes with modifications to some plans as follows:

	Proposed	Recommended
Pre-Standardized	Change	Change
BC-65 High Option	1.3%	0.0%
High Option Alt.	1.3%	0.0%
BC-65 Low Option	0.0%	0.0%
Low Option Alt.	0.0%	0.0%
BS-65 Plan 81	9.9%	9.9%
BS-65 Plan 82	9.9%	9.9%
BS-65 Plan 83	0.0%	0.0%
CarePlus Hospital	1.3%	0.0%
CarePlus Medical	9.9%	9.9%
CarePlus Drug Riders	0.0%	0.0%

The company is hereby directed to submit a revised rate schedule containing the approved rates on or before Tuesday October 6, 2020.

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 policy forms.

Dated at Hartford, Connecticut, this 28th day of September, 2020.

Andrew N. Mais
Insurance Commissioner

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INSURANCE DEPARTMENT

In the Matter Of	**:**	
Anthem Health Plans Inc.	**:**	**Docket No. LH 20-86**
dba Blue Cross Blue Shield of Connecticut	**:**	
Medicare Supplement Insurance	**:**	

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, CT on Thursday, Tuesday September 16, 2020, to consider whether or not the rate increase requested by Anthem Health Plans Inc. dba Blue Cross Blue Shield of Connecticut on its Medicare supplement insurance business should be approved.

No members from the general public attended the hearing.

Five company representatives from Anthem Health Plans Inc. dba Blue Cross Blue Shield of Connecticut the hearing.

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 book of business:

Pre-standardized

	Members	Current 2020	Proposed 2021	Difference
	Mar-20	Monthly Rates	Monthly Rates	(%)
BC-65 High Option				
Group	4,159	$112.81	$114.28	1.3%
Direct Pay	379	$154.85	$156.86	1.3%
High Option Alt				
Group	23	$107.62	$109.02	1.3%
Direct Pay	288	$143.15	$145.01	1.3%
Low Option				
Group	537	$46.67	$46.67	0.0%
Direct Pay	-	$50.97	$50.97	0.0%
Low Option Alt				
Group	-	$42.32	$42.32	0.0%
Direct Pay	1	$46.55	$46.55	0.0%
BS-65 Plan 81				
Group	2,972	$120.30	$132.21	9.9%
Direct Pay	651	$131.34	$144.34	9.9%
BS-65 Plan 82				
Group	1,357	$85.20	$93.63	9.9%
Direct Pay	46	$101.59	$111.65	9.9%
BS-65 Plan 83				
Group	336	$72.66	$72.66	0.0%
Direct Pay	1	$77.20	$77.20	0.0%
CarePlus				
Hospital	16	$119.12	$120.67	1.3%
Medical	16	$129.07	$141.85	9.9%
Drug Rider P1	2	$165.10	$165.10	0.0%
Drug Rider P3	2	$133.94	$133.94	0.0%
Drug Rider P5	-	$137.26	$137.26	0.0%
$0 Copay 80% Coin				
Direct Pay	3	$153.52	$153.52	0.0%
Group	2	$72.05	$72.05	0.0%

COVID-19 Impact on 2021 Rate Determination:
Anthem has experienced lower claims in 2020 to-date since the onset of COVID-19. Due to uncertainty, Anthem has chosen to eliminate the effects of COVID-19 by pricing off experience before the onset. No adjustments were made to future morbidity projections due to the pandemic.

Anthem BCBSCT calculated incurred claims based on an experience period of Feb 2019 through January 2020. Trend was then applied for a 23-month period to the middle of 2021.

Trends were developed in aggregate split between medical and drug. Based on the observed Connecticut pre-standard trends, a medical trend of 6.0% was chosen, while 0.0% was applied to drug claims.

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

			Since
	2018	2019	Inception
BC-65 High Option	64.7%	69.1%	85.9%
BC-65 Low Option	70.9%	66.8%	90.2%
BS-65 Plan 81	79.2%	86.8%	82.2%
BS-65 Plan 82	73.5%	77.8%	81.1%
BS-65 Plan 83	57.3%	61.9%	80.4%
CarePlus	99.8%	217.6%	81.3%

The projected 2020 and 2021 loss ratios are as follows:

	Projected	Projected
	2020	2021
BC-65 High Option	74.6%	78.0%
BC-65 Low Option	70.0%	74.2%
BS-65 Plan 81	91.8%	88.5%
BS-65 Plan 82	82.8%	79.9%
BS-65 Plan 83	65.4%	69.4%
CarePlus	228.2%	232.6%

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.

Anthem BCBSCT's 2020 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.

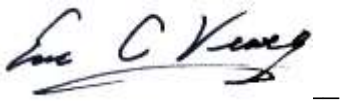
III. RECOMMENDATION

The undersigned recommends the approval of the following rate changes and in some instances no rate changes:

	Proposed	Recommended
Pre-Standardized	Change	Change
BC-65 High Option	1.3%	0.0%
High Option Alt.	1.3%	0.0%
BC-65 Low Option	0.0%	0.0%
Low Option Alt.	0.0%	0.0%
BS-65 Plan 81	9.9%	9.9%
BS-65 Plan 82	9.9%	9.9%
BS-65 Plan 83	0.0%	0.0%
CarePlus Hospital	1.3%	0.0%
CarePlus Medical	9.9%	9.9%
CarePlus Drug Riders	0.0%	0.0%

While the Department supports the decision to reflect no future morbidity changes due to COVID-19, the Department believes the trend assumption used to project claims from the experience period to 2021 should reflect the suppressed utilization experienced in 2020. Based on the trend exhibits submitted, the Department determined the 6.0% annual trend assumption used for 23 months is excessive and should be reduced to 4.0% for 11.5 months and 6.0% for 11.5 months. As a result, the requested rate increases were reduced in some instances.

Dated at Hartford, Connecticut, this 23rd day of September, 2020.



Eric C. Vieweg
Hearing Officer