STATE OF CONNECTICUT

INSURANCE DEPARTMENT

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In The Matter Of:	:	
ANTHEM BLUE CROSS AND BLUE SHIELD	:	Docket No. LH 09-69
OF CONNECTICUT	:	
Medicare Supplement Insurance	:	

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ORDER

I, Thomas R. Sullivan, Insurance 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, 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:

	Rate Change
Pre-standardized	
BC-65 High Option	
Group	0.00%
Direct Pay	0.00%
High Option Alt.	
Group	0.00%
Direct Pay	0.00%
BC-65 Low Option	
Group	0.00%
Direct Pay	0.00%
Low Option Alt.	
Group	0.00%
Direct Pay	0.00%
Drug Riders	
P1	-10.00%
P3	-10.00%
P5	-10.00%
$0 copay, 80% coins., $2,000 max	
Group	-10.00%
Direct Pay	-10.00%

BS-65 Plan 81	
Group	0.00%
Direct Pay	0.00%
BS-65 Plan 82	
Group	10.00%
Direct Pay	10.00%
BS-65 Plan 83	
Group	0.00%
Direct Pay	0.00%
CarePlus	
Hospital	0.00%
Medical	0.00%

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.

	Increases
Standardized	
Plan A	5.16%
Plan B	5.16%
Plan C	5.16%
Plan D	2.50%
Plan F	5.16%
High Ded. Plan F	-15.00%
Plan H (w/Rx)	4.00%
Plan H (w/o Rx)	2.50%
Plan J (w/Rx)	2.50%
Plan J (w/o Rx)	0.00%
CHCP Plan J (w/ Rx)	2.50%
CHCP Plan J (w/o Rx)	0.00%

These rate changes (pre-standardized and standardized) 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 is directed to file its revised rate schedules with the Insurance Department by Friday, October 16, 2009.

Dated at Hartford, Connecticut, this 25th day of September, 2009.

Thomas R. Sullivan
Insurance Commissioner

STATE OF CONNECTICUT

INSURANCE DEPARTMENT

In The Matter Of:	:	
ANTHEM BLUE CROSS AND BLUE SHIELD OF CONNECTICUT	:	**Docket No. LH 09-69**
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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 10, 2009 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.

Two representatives from Anthem BCBS participated in the hearing and four other company representatives were in attendance.

In addition to the hearing officer and a department actuary, one other Insurance Department staff member attended 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 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 L).

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 L 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 L 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 6/30/09	Current	Proposed	% Difference
BC-65 High Option				
Group	9,328	$103.23	$103.23	0.00%
Direct Pay	6,139	$141.71	$141.71	0.00%
High Option Alt.				
Group	36	$98.49	$98.49	0.00%
Direct Pay	3,126	$131.00	$131.00	0.00%
BC-65 Low Option				
Group	1,231	$40.25	$43.34	7.68%
Direct Pay	33	$43.96	$47.34	7.69%

Low Option Alt.				
Group	0	$36.50	$39.30	7.67%
Direct Pay	33	$40.15	$43.23	7.67%
CarePlus Hospital				
Group,Direct Pay	202	$116.29	$116.29	0.00%
BS-65 Plan 81				
Group	6,422	$94.43	$94.43	0.00%
Direct Pay	8,125	$103.08	$103.08	0.00%
BS-65 Plan 82				
Group	2,713	$69.91	$78.03	11.61%
Direct Pay	1,309	$83.37	$93.05	11.61%
BS-65 Plan 83				
Group	1,067	$54.65	$54.65	0.00%
Direct Pay	33	$58.07	$58.07	0.00%
CarePlus Medical				
Group, Direct Pay	202	$101.29	$101.29	0.00%
CarePlus Drug Riders				
P1	16	$206.12	$206.12	0.00%
P3	10	$167.21	$167.21	0.00%
P5	0	$171.36	$171.36	0.00%
$0 copay, 80% coins., $2000 Max				
Direct	102	$191.65	$191.65	0.00%
Group	12	$89.96	$89.96	0.00%

Standardized

In-Force Members

	6/30/09	Current	Proposed	% Difference
Plan A	600	$143.12	$150.50	5.16%
Plan B	2,200	$174.04	$183.02	5.16%
Plan C	6,401	$218.27	$229.53	5.16%
Plan D	1,118	$204.87	$215.44	5.16%
Plan F	11,906	$218.70	$229.98	5.16%
High Ded. Plan F	3,369	$57.00	$57.00	0.00%
Plan H (w/ Rx)	229	$261.59	$275.09	5.16%
Plan H (w/o Rx)	343	$204.86	$215.43	5.16%
Plan J (w/ Rx)	428	$324.95	$341.72	5.16%
Plan J (w/o Rx)	3,212	$220.95	$232.35	5.16%
CHCP Plan J (w/ Rx)	59	$324.23	$340.96	5.16%
CHCP Plan J (w/o Rx)	58	$220.23	$231.59	5.16%

Anthem BCBSCT calculated incurred claims based on 2008 claims experience and in-force counts, with an experience period of January 2008 through December 2008 and

claim run-out through April 2009. Trend was then applied for a 24-month period to the middle of 2010.

Overall trend was developed from Anthem experience exhibits dating from 10/2005 to 4/2009

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

	2007	2008	Since Inception
BC-65 High Option	77.9%	73.7%	85.7%
BC-65 Low Option	73.7%	82.8%	91.4%
BS-65 Plan 81	83.5%	85.9%	81.6%
BS-65 Plan 82	83.4%	86.5%	81.1%
BS-65 Plan 83	77.9%	81.8%	82.2%
CarePlus	80.5%	82.8%	81.0%

	2007	2008	Since 1992
Plan A	100.5%	102.3%	122.7%
Plan B	102.2%	102.9%	91.5%
Plan C	95.7%	100.7%	91.0%
Plan D	106.7%	79.1%	85.7%
Plan F	77.6%	81.0%	80.6%
High Ded. Plan F	37.6%	37.7%	35.9%
Plan H (w/ Rx)	71.5%	78.9%	79.4%
Plan H (w/o Rx)	71.0%	78.7%	71.2%
Plan J (w/ Rx)	80.5%	79.5%	71.5%
Plan J (w/o Rx)	75.5%	73.1%	73.6%

The projected 2010 loss ratios are as follows:

	Loss Ratio
BC-65 High Option(incl. CarePlus)	
Group	89.28%
Direct Pay	65.37%
High Option Alt.	
Group	89.83%
Direct Pay	67.54%
BC-65 Low Option	
Group	81.16%
Direct Pay	74.30%
Low Option Alt.	
Group	n/a
Direct Pay	73.14%

BS-65 Plan 81(incl. CarePlus)	
Group	85.48%
Direct Pay	78.31%
BS-65 Plan 82	
Group	87.80%
Direct Pay	73.63%
BS-65 Plan 83	
Group	81.86%
Direct Pay	77.04%
Standardized	
Plan A	96.3%
Plan B	96.6%
Plan C	95.9%
Plan D	75.5%
Plan F	77.4%
High Ded. Plan F	40.8%
Plan H w/ Rx	81.7%
Plan H w/o Rx	75.4%
Plan J w/ Rx	80.1%
Plan J w/o Rx	67.4%
CHCP Plan J w/ Rx	80.1%
CHCP Plan J w/o Rx	67.4%

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 regulatory loss ratio of 75%.

Anthem BCBSCT's 2009 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 Increase	**Recommended Increase/Decrease**
Pre-Standardized		
BC-65 High Option	0.00%	0.00%
High Option Alt.	0.00%	0.00%
BC-65 Low Option	7.69%	0.00%
Low Option Alt.	7.67%	0.00%
BS-65 Plan 81	0.00%	0.00%
BS-65 Plan 82	11.61%	10.00%

BS-65 Plan 83	0.00%	0.00%
CarePlus Hospital	0.00%	0.00%
CarePlus Medical	0.00%	0.00%
CarePlus Drug Riders (All Rx Riders)	0.00%	-10.00%

The undersigned also recommends the approval of the following increases for the standardized plans.

	Proposed Increase	**Recommended Increase/Decrease**
Standardized		
Plan A	5.16%	5.16%
Plan B	5.16%	5.16%
Plan C	5.16%	5.16%
Plan D	5.16%	2.50%
Plan F	5.16%	5.16%
Plan F High Ded.	0.00%	-15.00%
Plan H w/Rx	5.16%	4.00%
Plan H w/o Rx	5.16%	2.50%
Plan J w/Rx	5.16%	2.50%
Plan J w/o Rx	5.16%	0.00%
CHCP Plan J w/ Rx	5.16%	2.50%
CHCP Plan J w/o Rx	5.16%	0.00%

Where the proposed rate increases were reduced, adjustments were made to the trend assumptions as well as updated experience.

In addition, high deductible Plan F has reached a duration of 3.059 years and the current rates are considered excessive based upon the Connecticut statutory loss ratio requirements

Dated at Hartford, Connecticut, this 25th day of September, 2009.

Danny K. Albert
Hearing Officer