STATE OF MAINE
DEPARTMENT OF PROFESSIONAL AND FINANCIAL REGULATION
BUREAU OF INSURANCE

IN RE:	)	
	)	
ANTHEM BLUE CROSS AND BLUE SHIELD REQUEST TO DISCONTINUE INDIVIDUAL HEALTH PLANS	)	**DECISION AND ORDER**
	)	
Docket No. INS-13-803	)	

I. INTRODUCTION

Eric A. Cioppa, Superintendent of Insurance ("Superintendent"), issues this Decision and Order in the above-captioned matter after consideration of the Anthem Blue Cross and Blue Shield ("Anthem") request to discontinue and replace certain individual health plans. Specifically, Anthem proposes to cease offering its existing individual health plans and to cease renewing those plans except for policyholders that are grandfathered under the federal Affordable Care Act (ACA). Further, beginning January 1, 2014, Anthem proposes to migrate its existing non-grandfathered individual health plan policyholders to a plan that will be issued outside the health insurance Marketplace, and therefore will not be available for federal subsidies under the ACA, and that will use the Guided Access networks approved by the Superintendent in Docket No. INS-13-801 (*In re Anthem Blue Cross and Blue Shield Request for Approval of Access Plans*). Thus, policyholders residing in Androscoggin, Cumberland, Franklin, Kennebec, Knox, Lincoln, Oxford, Sagadahoc, Waldo, and York Counties would be migrated to Anthem's Guided Access HMO plan that includes a limited network, meaning that a number of health care providers in the ten identified southern and western Maine counties are not included in the HMO network. Policyholders residing in Aroostook, Hancock, Penobscot, Piscataquis, Somerset, and Washington Counties will be migrated to Anthem's Guided Access POS plan that includes a

broad network, including nearly all of the providers in the six identified northern and eastern Maine counties.

For the reasons discussed below, the proposed discontinuance and replacement is approved for the six northern and eastern counties, but disapproved for the ten southern and western counties. In the ten southern and western counties, Anthem must either renew the existing coverage with modifications that are narrowly tailored to conform to the ACA, or, if the existing plans are discontinued and not renewed, the policyholders must be migrated to plans that retain the existing broad network and do not totally exclude benefits for out-of-network services.

II. PROCEDURAL HISTORY

Anthem Request for Approval

On April 12, 2013, Anthem requested approval of product discontinuance and replacement for its non-grandfathered individual health plans. On April 16, May 2, May 17, May 30, and June 18 Anthem filed supplemental information in support of its request.

Notice of Hearing; Public Comment Sessions

Upon exercising his discretion to hold a hearing in this matter, on July 26, 2013 the Superintendent issued a Notice of Pending Proceeding and Hearing ("Hearing Notice").[1]

As described in the Hearing Notice, the purpose of the proceeding was for the Superintendent to determine whether Anthem's proposed product discontinuance and replacement would be "in the best interests of the policyholders," as required by 24-A M.R.S.

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[1] The Hearing Notice incorporated an Order ruling on requests for a hearing and intervention, thereby granting certain requests for intervention and denying other intervention requests. The Superintendent's *sua sponte* decision to initiate the proceeding rendered it unnecessary for him to determine whether any of the persons that were granted intervenor status would have had standing under 24-A M.R.S. § 229 to require a hearing to be held.

§ 2850-B(3)(G)(3)(b), and is otherwise in compliance with applicable law. Hearing Notice at Section III.

Per the Hearing Notice, evening public comment sessions were set at four locations throughout the State: August 15 in Portland, August 16 in Bangor, August 29 in Auburn, and August 30 in Presque Isle. The evidentiary hearing was set for September 9 in Augusta. The Superintendent also set daytime and evening public comment sessions for September 9 in Augusta.

Intervention Applications

By Order issued July 26, 2013, the Superintendent granted intervention to the Maine Attorney General ("AG").

Also by Order issued July 26, 2013, the Superintendent granted intervention to Rumford Hospital, Bridgton Hospital, Maureen Harpell, N.P., Albert Aniel, M.D., David Salko, M.D., Brenda Weeks, Central Maine Healthcare ("CMHC"), Central Maine Medical Center ("CMMC"), Dieter Kreckel, M.D., Alan Verrill, M.D., and William Lee, M.D (collectively, "Rumford-Bridgton"). By that same Order, the Superintendent denied intervention to the remaining applicants for intervention: Julie Rioux, Lisa Pease, Daniel Trafford, and three alleged "unknown" individuals designated as "John Doe," "Mary Roe," and "Dr. Noe."

By Order issued August 12, 2013, the Superintendent granted intervention to Robert L. Kimball.

Procedural Order

On July 29, 2013, the Superintendent issued a Procedural Order establishing requirements for the conduct of the proceeding. Among other dates, the discovery deadline was set at August 28, 2013, and pre-filed testimony and exhibits were due by September 5, 2013.

Protective Order

On August 14, 2013, the Superintendent issued a Protective Order to address the handling of confidential information in the proceeding. Regarding Anthem's assertions of confidentiality for certain information referred to as the "Business Plans," the August 14 Protective Order provided Anthem an opportunity to provide further legal argument in support of its claim of trade secret protection. On August 19 Anthem moved for continued confidentiality protection for its Business Plans. By Order issued September 6 the Superintendent granted Anthem's motion for continued confidentiality protection.[2]

The Protective Order further directed Anthem to file in the proceeding certain non-confidential public documents and transmittal letters previously submitted with the Superintendent prior to the issuance of the Hearing Notice, which Anthem filed on August 20.

Discovery

The July 26 Hearing Notice advised that intervenors could commence discovery immediately upon being granted party status. *See* Hearing Notice at Section VI.

On August 9, 2013, the AG served a First Discovery Request, to which Anthem responded on August 15.[3] Anthem's August 15 response included a motion to withhold completely from Rumford-Bridgton certain responsive information relating to provider negotiations, on grounds that even an "Attorneys' Eyes Only" designation would not adequately protect the information. No party objected to Anthem's motion. By correspondence dated

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[2] CMHC has appealed the Superintendent's June 21 FOAA ruling that made the Business Plans confidential and exempt from public disclosure, and that matter remains pending before the Superior Court. *See Central Maine Healthcare Corp., et al. v. Bureau of Insurance, et al.*, Docket No. BCD-AP-13-03.

[3] On August 13 the AG withdrew request number 3 from its First Information Request.

August 29, after the deadline for objections had passed, Rumford-Bridgton requested that the Superintendent rule on Anthem's motion. On September 3 the Superintendent issued an order granting Anthem's motion for highly confidential treatment.

On August 16, 2013 (as amended on August 19), Rumford-Bridgton served a First Information Request upon Anthem. On August 20 Anthem objected, simultaneously providing certain responsive information subject to and without waiving its objections. Anthem provided supplemental responses on August 22. On August 23 Rumford-Bridgton requested a ruling on Anthem's objections. On August 27 the Superintendent issued an Order ruling on each of Anthem's objections, sustaining some and overruling others. Anthem provided further supplemental responses on August 29 and 31. Anthem's August 31 supplemental response included a motion for confidential treatment of certain information.

On August 27, 2013, Rumford-Bridgton served a Second Information Request upon Anthem. On August 29 Anthem objected, simultaneously providing certain responsive information subject to and without waiving its objections.

On August 28, 2013, the AG served a Second Information Request upon Anthem, to which Anthem responded on August 31. Anthem's August 31 response included a motion for confidential treatment of certain information.

Conference of Counsel; Official Notice

By correspondence dated August 30, 2013, Rumford-Bridgton requested that the Superintendent address certain procedural matters related to the September 9 evidentiary hearing. On September 4 the Superintendent convened a telephonic conference of counsel, to which all parties were represented, at which the identified procedural issues were addressed.

The August 30 correspondence further requested the Superintendent to take official notice of certain matters, and at the conference of counsel Anthem also requested the taking of official notice of other matters. On September 4 the Superintendent issued an Order taking official notice of identified matters.

Pre-filed Testimony & Exhibits

On September 5 Rumford-Bridgton filed the pre-filed testimony of three witnesses, and Anthem filed the pre-filed testimony of nine witnesses together with certain pre-filed exhibits. Anthem also filed a motion to prevent counsel for Rumford-Bridgton from viewing portions of the pre-filed testimony of Larry Hart and Hart Exhibit A, on grounds that the information was too competitively sensitive. On September 6 Rumford-Bridgton objected. Also on September 6 the Superintendent issued an Order requiring Anthem either to make that information available to Rumford-Bridgton on an "Attorneys' Eyes Only" basis subject to the August 14 Protective Order or to withdraw it. On September 6 Anthem advised of its election to withdraw the highly confidential information from the Larry Hart pre-filed testimony and from Hart Exhibit A.

Evidentiary Hearing

The evidentiary hearing was held as scheduled on September 9, 2013, and was conducted entirely in public session. All parties were present and represented by counsel.

At the hearing, live witness testimony and the following documentary evidence was admitted into the record:

- *Anthem*: The pre-filed testimony of Colin McHugh, Regional Vice President of Provider Engagement and Contracting for Anthem in Maine (Anthem Exhibit 1), and McHugh Exhibits A & B; pre-field testimony of William M. Whitmore, Regional Vice President of Underwriting with Anthem in Maine (Anthem Exhibit 2), and Whitmore Exhibit A; pre-filed testimony of Jeffrey Holmstrom, Medical Director for Anthem in Maine (Anthem Exhibit 3), and Holmstrom Exhibit A; pre-field testimony of Lawrence E. Hart, Actuarial Business Director with Anthem in Maine (Anthem

Exhibit 4A), and Hart Exhibits A & B; pre-filed testimony of John P. (Jack) Burke, principal and consulting actuary with Milliman (Anthem Exhibit 5), and Burke Exhibit A; pre-filed testimony of Albert G. Swallow, III, Vice President of Finance and Chief Financial Officer for Maine Medical Center (Anthem Exhibit 6); pre-filed testimony of Carolyn Kasabian, Chief Financial Officer and Treasurer for St. Mary's Health System and St. Mary's Regional Medical Center (Anthem Exhibit 6); pre-filed testimony of Susan Keiler, Chief Operating Officer for St. Mary's Health System and St. Mary's Regional Medical Center (Anthem Exhibit 8); and pre-filed testimony of Joel Allumbaugh, Principal in National Worksite Benefit Group (Anthem Exhibit 9) were admitted over Rumford-Bridgton's objections to portions of Anthem Exhibits 1, 2, 4A, and 9.

- *Rumford-Bridgton*: The pre-filed testimony of Edmund Claxton, Chief Medical Information Officer and Medical Director of the Accountable Care Organization for CMMC; pre-filed testimony of Nicholette Erickson, Medical Director for Cancer Program at CMHC; and pre-filed testimony of David Frum, President and Chief Executive Officer of Rumford Hospital and Bridgton Hospital were admitted over Anthem's objection to portions of Frum's pre-filed testimony.

The Superintendent also took official notice of additional identified matters during the hearing.

Public Testimony & Written Comment

Members of the public provided sworn testimony and unsworn statements for the record during the various sessions held by the Superintendent at five locations throughout the State (Portland, Bangor, Auburn, Presque Isle, and Augusta). Members of the public also submitted written comments outside the public hearings, which the Superintendent has designated a part of the record of the proceeding. The Superintendent has read each of the written comments provided. To the extent that they comment on facts that are in the record, they shall be considered for their persuasive value in the same manner as legal arguments and other comments submitted by the parties. However, the Maine Administrative Procedure Act bars the Superintendent from relying on unsworn submissions as evidence when making his decision. 5 M.R.S. § 9057.

Post-Hearing Filings

On September 10, 2013, Rumford-Bridgton filed the Congressional Research Service report of which the Superintendent took official notice at the September 9 hearing.

On September 18, 2013, Anthem filed its responses to the Superintendent's September 9 hearing requests.

Written Closing Argument; Record Closed

Per the schedule established by the Superintendent at the conclusion of the September 9 hearing, on September 19, 2013 Anthem, the AG, and Rumford-Bridgton each filed written post-hearing briefs as closing arguments.

The record of the proceeding closed at 4 p.m. on September 19, 2013.

III. LEGAL STANDARD

Under longstanding Maine law, individuals purchasing health insurance coverage in the individual market have a right to guaranteed renewal of their insurance policies. This right means that, except in certain narrowly defined circumstances, "coverage may not be cancelled, and renewal must be guaranteed." 24-A M.R.S. § 2850-B(3). Where a policy is subject to guaranteed renewal, it must not only be renewed, but it generally cannot even be modified except within narrow constraints set forth by statute. *See* § 2850-B(3)(I). Any modifications falling outside these constraints are considered product discontinuance, and must qualify for a statutory exception to the guaranteed renewal requirement.

One of the narrow circumstances in which contract terms may be modified in the context of a renewal is if the benefit modifications are "required by law." 24-A M.R.S. § 2850-B(3)(I)(3). Thus, while Anthem has proposed to discontinue its current plans and replace them with new ones in order to make them ACA-compliant, Maine law does not require this approach.

Rather, another option available to Anthem under Maine law—indeed, the default option—is to modify its current plans just enough to bring them into compliance with federal law and then renew them.

Anthem, however, does not wish to renew policyholders' existing coverage, subject only to those modifications necessary to comply with the law. Rather, Anthem proposes to discontinue its non-compliant plans and replace them with ACA-compliant plans that also contain other modifications that would not be allowed in the context of a renewal. Maine law does not forbid this approach, but it strictly regulates it. Specifically, under Maine law, a carrier may not discontinue a guaranteed-renewable individual plan unless it provides its subscribers with a replacement product meeting certain requirements, including, crucially, that "the superintendent finds that the replacement is in the best interests of the policyholders." 24-A M.R.S. § 2850-B(3)(G)(3).

The purpose of this proceeding, as set forth in the Hearing Notice, is for the Superintendent to determine whether Anthem's proposed discontinuance of the non-grandfathered individual health insurance products, and the product replacements proposed by Anthem, meets this best-interests standard, and will otherwise be in compliance with applicable law. *See* Hearing Notice at Section III; *see also* 24-A M.R.S. § 2850-B(3)(G)(3)(b). As set forth in the statute, the "best interests of the policyholders" standard applies to the proposed "replacement" products. The statute directs the Superintendent to protect the interests of Anthem's existing subscribers, not the interests of potential future policyholders. Moreover, the standard is not, as Anthem suggests in its brief, whether the replacement is in the "best interests of a majority of the policyholders." (Anthem Closing Br. at 3.) It is simply whether the replacement is in the best interests of "the policyholders." While this standard does not mean

that the proposed replacement policy must be a good deal for every single current policyholder, it does require a more nuanced analysis than merely considering whether replacement will be marginally preferable to renewal for a bare majority of subscribers. A replacement policy that imparts small benefits to a majority by imposing significant hardships on a minority is not necessarily in the best interests of the policyholders as a whole.

In short, given policyholders' guaranteed-renewal rights, Anthem can only cease offering its current individual products if the Superintendent finds the replacement product to be in the best interests of the policyholders.[4] 24-A M.R.S. § 2850-B(3)(G)(3)(b). The burden of proof rests with Anthem.

IV. ANALYSIS, FINDINGS, AND CONCLUSIONS

For the reasons discussed below, Anthem has not proven that the proposed replacement coverage it is offering its renewing policyholders in the ten southern and western counties is in the best interests of the policyholders, as required by 24-A M.R.S. § 2850-B(3)(G)(3)(b).

A. Anthem's proposal to terminate certain policyholders' rights to an open plan with a broad network is not in their best interests.

1. *The nature of Anthem's proposal and the available alternatives.*

The ACA requires Anthem to make a number of changes to its line of individual insurance products for 2014. Thus, some features of Anthem's proposed discontinuance and replacement are inevitable. Most notably, the ACA requires most individual insurance products to provide policyholders with at least 60% actuarial value. In practice, this requirement means that high-deductible policies, such as Anthem's popular $15,000-deductible policy, cannot be

[4] Anthem does have the right to cease offering individual health plans and to not renew any existing policies in the individual market. *See* 24-A M.R.S. §§ 2850-B(3)((F-1), 2736-C(4).

renewed for 2014 in their current form, unless the subscriber qualifies for "grandfathered" status.[5] Whether or not consumers would prefer to stay in plans with high out-of-pocket costs and a correspondingly low premium, that option simply will not be available to most in 2014. Therefore, it is beyond dispute that Anthem must either amend their contracts to reduce the cost sharing to permissible levels or replace their contracts with coverage that meets the actuarial value requirements.

On the other hand, other components of Anthem's proposal are not necessary to comply with the ACA. Nothing in state or federal law requires replacing open-access preferred-provider coverage with closed-access HMO coverage, nor does the law require replacing broad-network coverage with limited-network coverage. If Anthem's proposal is approved, renewing policyholders in the ten-county region would lose their existing contractual right to elect out-of-network care in return for higher cost-sharing. Furthermore, at the same time their right to out-of-network coverage is taken away completely, their choice of network providers would be significantly restricted. Specifically, Anthem's new networks exclude 6 of 20 hospitals in southern Maine and also significantly reduces the number of participating providers. Under Anthem's proposal, then, many of its subscribers would lose coverage for their existing providers, not as a result of the occasional changes in Anthem's existing broad network that policyholders could reasonably anticipate, but solely as a result of the nonrenewal of their existing contracts and the decision not to offer a new contract that preserves the existing network.

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[5] Generally speaking, a policyholder can qualify for grandfathered status if she purchased her current policy prior to March 23, 2010.

The portion of Anthem's current subscriber base that would be directly impacted by these network changes appears to be small, but is hardly negligible. A quarter of Anthem's current hospital expenditures in Southern Maine are for services received at the six hospitals that will be excluded from the limited network. (Anthem Ex. 1, at 11.) Anthem's data also shows that 489 enrollees in the ten-county region, 6.8% of the current enrollment base in those counties, have received services within the past year from PCPs who will be excluded from the limited network. That figure understates the potential demand for such providers, because patients interested in access to a particular provider will not necessarily see that provider every year. Moreover, as was recognized in the proceeding approving Anthem's provider network, Anthem's limited network will require subscribers in some areas not only to change providers, but also to travel longer distances to see a network provider or obtain non-emergency services from a network hospital.

Notably, Anthem is not seeking to discontinue its broad network entirely at this time. Anthem is keeping its broad-network contracts in force, and will continue to operate the broad network on a statewide basis for all of its grandfathered business, and for all employers that choose to buy broad-network small group and large group plans.

Thus, neither the law nor changes in the market make it impossible or impractical for Anthem to offer renewing customers the same broad network they have under their current contracts, and the same open plans they have under their current contracts, either by renewing the existing preferred-provider provisions or replacing them with point-of-service (POS) HMO provisions, as they will be using in the six northern and eastern counties. Instead, Anthem justifies the termination of the policyholders' existing contractual rights as being in their best interests because continuing their existing plan structure is supposedly too expensive.

2. *It is in the policyholders' best interests to let them decide for themselves whether preserving their existing contractual rights is too expensive.*

Anthem has already been approved to offer its "Guided Access" HMO products for 2014. Anthem made a persuasive case that those products, despite having a limited network and no coverage for non-emergency out-of-network care, will be a good deal for many consumers.[6] However, the best way to decide whether a product is a good deal for the price is to make it available in the free market alongside competing products and let the buyers choose. If exercising their guaranteed-renewal rights is too expensive, existing policyholders can vote with their pocketbooks and either buy a "Guided Access" HMO plan or buy a competing insurer's plan. Price alone cannot be an adequate reason to abrogate a policyholder's guaranteed-renewal rights, and make replacement with a cheaper product mandatory rather than optional.

This principle is especially true when Anthem's proposed replacement product limits policyholders' benefits in ways that may not be immediately apparent to those policyholders. While premium cost is a highly visible feature of any insurance policy, the access to providers that a policy will provide is far less obvious. Even if Anthem provides sufficient notice to policyholders of the changes, not all policyholders will grasp how substantial they are or foresee how they will be affected. As one witness pointed out, many consumers do not know the limitations of their health coverage until they need to use it. (9/9/13 Evid. Hearing Tr. 259.) The risk is heightened when a carrier is seeking to impose new limitations on a guaranteed renewable product, since purchasers of those products have a reasonable expectation, grounded in Maine law, that their coverage will not radically change upon renewal. Moreover, Anthem's prior

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[6] Anthem has noted that in addition to premium savings, some consumers (particularly those with a moderate level of hospital costs – enough to be significant but not enough to reach the deductible) will also realize savings from the deeper provider discounts under the "Guided Access" plans.

disclosures to its subscribers have not adequately highlighted the substantial nature of the network changes. In its letter to subscribers touting its replacement plan, Anthem claimed that the proposed replacement products were "as close as possible" to the existing products as the ACA would allow. In short, the significant risk that some policyholders will allow themselves to be renewed without fully understanding the scope of the proposed changes further confirms that it is in the best interests of policyholders to give them the option to "opt in" to a narrow, closed network rather than requiring them to take affirmative action to "opt out" of such a network, especially if the only way to opt out is to choose coverage from another carrier.

Anthem's response is that offering broad network plans to renewing subscribers would jeopardize the discounts it has negotiated with hospitals participating in the limited network, who agreed to lower reimbursement rates in return for Anthem providing them with increased patient volume. Anthem thus suggests that the Superintendent must choose between protecting the interests of a minority of subscribers who will be adversely affected by the new network restrictions and protecting the interests of all subscribers in mitigating the price shock that will result from the federally required shift to more expensive levels of coverage.[7] Abrogating guaranteed-renewal rights is the lesser evil, according to Anthem, and is in the interests of policyholders as a whole.

However, even if Anthem were correct that the best interests of one group of policyholders can only be met at the expense of the best interests of another group, so that their

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[7] Anthem asserts that premiums for its Guided Access HMO products are approximately 8% lower than they would be absent the discounts it negotiated with hospitals. (Anthem Ex. 4A, at 5.) There was a dispute at hearing over whether there was sufficient evidence in the record to substantiate Anthem's claim, owing to Anthem's decision to withdraw certain evidence relating to the calculation of that premium differential. The evidence did clearly establish, however, that a discount was negotiated. For purposes of this Decision and Order, I have assumed without deciding that Anthem's figures regarding the effect of that discount are accurate.

interests must be balanced against one another, Anthem has not met its burden of proving that it has struck the appropriate balance. That would require showing that the policyholders who would want to keep their broad-network open-access plans are few enough in number that they must be regarded as "holdouts" whose preferences must yield to the majority to allow a transaction that is beneficial overall to move forward. As already noted, Anthem's own numbers suggest that a non-negligible number of current subscribers will have their current provider and hospital relationships disrupted by the limited network.

Moreover, although Anthem disparages the feasibility of consumer choice, asserting that "the parallel universe in which Anthem offers *both* a limited and broad network product does not exist" (Anthem Closing Br. at 9), Anthem itself has demonstrated that such a "parallel universe" is possible by offering precisely that choice in the group market. Anthem admitted at hearing that it kept the broad network available in the small group market because "small groups, in particular small group employers, often are reluctant to want to make a narrowing decision on behalf of their employees." (9/9/13 Evid. Hearing Tr. 104.) In other words, when faced with the same choice between access and price, decisionmakers in the real world who are accountable to a group of consumers "often are reluctant" to decide that the cheaper plan is in the best interests of the group as a whole. I share that reluctance.

Furthermore, Anthem's evidence that it cannot sustain the discounts it secured from participating hospitals without sacrificing its current subscribers' renewal rights is unpersuasive. Anthem argues that the benefits of the limited network depend on the ability to deliver participating hospitals a captive audience, because otherwise they would not be willing to offer the discounts they have agreed to. However, Carolyn Kasabian, the hospital executive who

testified on Anthem's behalf, was not nearly so categorical.[8] She testified that her hospital "has relied upon the anticipated patient volume steerage to validate the discounts granted. If patient volume steerage does not occur, our financial performance will suffer and the pricing concessions we agreed to with Anthem will not be sustainable" (Anthem Ex. 7, at 4), that "[t]he discounts we agreed to were premised on *a significant majority* of Anthem's non-grandfathered enrollment shifting to" her hospital (*id.*, *emphasis added*), and that "pricing discounts without some reasonable assurance of patient volume steerage are simply not sustainable." (*Id.* at 5.)

Thus, the hospitals' own testimony confirms the common-sense expectation that hospitals' continued willingness to provide the necessary discounts depends not simply on whether the Superintendent waives Anthem's guaranteed-renewal obligation, but on whether such a waiver would in fact have a significant effect on the volume of new patients "steered" to the limited-network hospitals. Anthem never promised, and could never credibly promise, that it could deliver its entire enrollment base to the hospitals that signed up for the limited network. Policyholders who place an especially high value on one or more ongoing provider relationships will drop Anthem for a competing insurer if the providers are excluded from the limited network and Anthem offers no broad-network option at any price. Other policyholders will be glad to choose the less expensive alternative even if it means restricting their choice of providers. For the remaining policyholders, as Anthem's economic expert testified, it all depends on the price

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[8] Anthem presented a panel of three executives from participating hospitals. However, one executive offered no testimony on the discounts, and the third executive acknowledged that he was not involved in the negotiations with Anthem or the hospital's decisionmaking process with regard to the discounts, and was testifying only to the underlying economic principles. (9/9/13 Evid. Hearing Tr. 249.) His testimony on those principles was consistent with Ms. Kasabian's: "In order to justify the pricing concessions, there must be the opportunity to realize incremental patient volumes and associated revenues to offset the decreases in revenue that MaineHealth hospitals will experience from those lower reimbursement rates for existing patients."

point—if given the choice, they will voluntarily switch to the limited-network plan as long as the price is right. (9/9/13 Evid. Hearing Tr. 285–286.)

The evidence presented by Anthem simply does not establish that allowing current subscribers to choose between the two Anthem networks will substantially reduce the volume of new patients at Anthem's limited-network hospitals. First, Anthem's enrollment projections for 2014 show that the vast majority of new enrollees in its limited-network products—approximately 16,000 in the mid-range estimate—will come from the currently uninsured, not renewing members. (Anthem Ex. 2 at Ex. A.) In contrast, Anthem predicts that only about 3,000 of its current non-grandfathered subscribers in Southern Maine—about 45%—will choose to remain in the limited-network products if migrated to them. The remaining 55% will presumably choose a broad-network product offered by a competing carrier. Thus, there is no question that the vast majority of the increased patient volume generated by the limited network will come from the currently uninsured, not from migrated current subscribers.

Moreover, of the 3,000 subscribers that Anthem believes it can successfully migrate to limited-network products, most will likely be people whose providers of choice are already in Anthem's limited network. Anthem's data shows that 489 of their current individual subscribers have visited PCPs excluded from the limited network in the last year, that 186 subscribers have seen excluded specialists, and that approximately 25% of Anthem's "hospital spend" currently goes to hospitals that will be excluded from the limited network. (Anthem Ex. 1, at 11.) While it is impossible to extrapolate from these statistics exactly how many current Anthem subscribers are candidates to be "steered" to a hospital that they would not otherwise use, it is safe to say that it will be a minority of the projected 3,000 migrated subscribers. Indeed, one would expect that, among the 45% of current subscribers who agree to be migrated, those who will not have to

change providers will be disproportionately represented, with many of those subscribers with excluded providers going to another carrier. The number of current subscribers that Anthem could credibly promise to "steer" to participating hospitals is thus likely a fairly small fraction of the 3,000 projected migrated subscribers.

Finally, whatever the size of the subgroup of 3,000 enrollees who would (a) prefer to pay more to have access to providers outside of Anthem's limited network, but (b) would not change carriers in order to preserve that ability, many of these subscribers are likely to wind up in Anthem's limited network anyway. Anthem has opted to offer only its limited-network plans on Maine's federally facilitated health insurance Marketplace. Federal subsidies for purchasing insurance are only available for plans purchased through the Marketplace. Given that these subsidies are available for families earning up to four times the federal poverty level ($94,200 for a family of four), it is likely that many of the projected 3,000 enrollees are subsidy-eligible. (Tr. 133.) It thus can be expected that, even given the option of a broad-network Anthem plan, many current subscribers who are Anthem loyalists will opt to go onto the Marketplace to purchase Anthem's limited-network product, so as to qualify for subsidies.[9]

In short, the "swing bloc"—the patients whose choice of hospitals might conceivably be influenced by the approval or disapproval of Anthem's request to abrogate their guaranteed-renewal rights—are likely to form only a tiny share of the total enrollment in Anthem's limited-

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[9] For this reason, the provider and patient intervenors have argued that it is not in existing policyholders' best interests to renew or "map" them into *any* off-Marketplace plan. (Rumford-Bridgton Closing Br. at 10.) Although it is not desirable, there is no other choice. Anthem does not have the authority to enroll a consumer into the Marketplace, so the only possible "default options" for renewal or replacement are an off-Marketplace plan or no plan at all. Even if terminating coverage completely were not prohibited by 24-A M.R.S. § 2850-B(3)(G)(3)(a), it is not in the policyholder's best interests by any stretch of the imagination. However, this underscores the need, as discussed more fully below, to ensure that consumers are fully and clearly informed of the choices they will need to make.

network plans, and it seems unlikely that they would have a material impact on whether or not Anthem can deliver the "significant majority" of patients that would give hospitals a sufficient incentive to participate in the limited network. Furthermore, as discussed earlier, the swing bloc are likely to be precisely the patients who are most sensitive to the price differential between the broad-network and limited-network plans.[10] Even though allowing them a choice is in their best interests, they will exercise that right by switching to "Guided Access" if Anthem makes that switch worthwhile. If not, then abrogating their guaranteed-renewal rights is clearly not in their best interests—especially for those subsidy-eligible consumers, if any, whose preference to keep their existing network is so strong that they would be willing to give up the subsidies if offered the chance on renewal. If Anthem is correct that "Guided Access" is objectively a good deal for the typical consumer, then an overwhelming majority of the swing bloc will buy in, and in the unlikely event that the handful that remain would send the whole arrangement over the tipping point so that it is no longer worthwhile for hospitals to participate, then the arrangement could not have been stable to begin with and could not be relied on as a way to keep consumers' premiums down.

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[10] The provider and patient intervenors have suggested further that the premium savings are largely illusory from the consumer perspective, because most Mainers are eligible for subsidized coverage and the benefit from cheaper premiums for subsidized coverage goes to the federal Treasury, not to the consumers, because the cost of subsidized coverage is largely income-based. (9/9/13 Evid. Hearing Tr. 145.) But that is argument about whether a discount in premium is valuable to individuals seeking to purchase new, subsidized coverage on the federal Marketplace. The scope of this proceeding is limited to the best interests of those consumers who wish to exercise their guaranteed-renewal rights to renew unsubsidized policies, rather than going to the Marketplace. Those consumers are either ineligible for subsidies or would choose to forgo them. Moreover, even if the intervenors' argument were relevant, their argument that the savings from the narrow network reduce the available subsidies dollar-for-dollar misunderstands how the ACA's subsidies work. The subsidies are based on the cost of the second-cheapest silver plan, and the intervenors' "dollar-for-dollar" analysis depends on the false assumption that the two cheapest silver plans in the Marketplace, if Anthem had not used the narrow network for its Marketplace plans, would still have both been Anthem plans.

Anthem cannot have it both ways, and argue that consumers want this product but won't buy it in sufficient numbers if they have a choice. Either the limited network will remain viable if consumers are given the ability to opt out if they pay the price—in which case Anthem has posed a false choice between giving some consumers their guaranteed-renewal rights and giving others their cheaper coverage—or a significant critical mass of consumers do not agree with Anthem that denying them their guaranteed-renewal rights is objectively in their best interests—in which case I cannot agree either. On the record in this proceeding, I find that in the unlikely event that preserving consumers' guaranteed-renewal rights would jeopardize the savings to be realized from the limited network, those savings would not be worth the cost of depriving consumers of the right to decide for themselves, and taking away that choice would not be in the best interests of the policyholders.

B. It is in the best interests of northern policyholders to be mapped into the POS plan.

Anthem's Guided Access POS plan contains neither a limited network nor a complete lack of coverage for non-emergency out-of-network care. It thus lacks either of the features that prevented the Guided Access HMO plan from being in the best interests of the policyholders. Moreover, none of the parties have disputed that the POS plan meets the best interests standard. Anthem's discontinuance and replacement is therefore approved for this product.

C. Anthem's proposed formulary changes do not infringe policyholders' guaranteed renewal rights.

As Anthem observes, formularies change regularly, and Anthem argues that for that reason, formulary changes should not be subject to analysis under 24-A M.R.S. § 2850-B. However, as with the change in network structure, these plans introduce a change in the formulary structure that goes beyond the changes to the status of particular medications that

consumers must reasonably expect in the ordinary course of business. Routine turnover would not produce a savings of 4.2%.

On the other hand, when all essential classes of medications remain fully covered, it would not be appropriate to regard the change as a cut in benefits. The new formulary structure results in significant cost savings, is consistent with Anthem's other non-grandfathered products and with widely used industry standards, is expressly permitted by the ACA, and has not been called into question by any intervenor or any member of the public who participated in this proceeding. I therefore find that Anthem's substitution of the new formulary on replacement or renewal is in the best interests of the policyholders and it is hereby approved.

V. ANTHEM'S OPTIONS FOR COMPLIANCE

Anthem cannot replace policyholders' coverage with these products in their present form. On the other hand, the reason Anthem has requested approval to discontinue the existing products is that the current plan design will no longer comply with federal law, and the products cannot simply be amended in some mechanical fashion that will bring them into compliance.

Therefore, as soon as reasonably possible, Anthem must submit an alternative proposal that will provide ACA-compliant coverage to those non-grandfathered policyholders in the ten-county region who choose to renew their current plans.[11] Anthem may structure this proposal either as a discontinuance and replacement, as currently proposed, or as a uniform modification of coverage upon renewal as permitted by 24-A M.R.S. § 2850-B(3)(I). Anthem should note that it will be easier to comply with statutory notice requirements if Anthem modifies the coverage

[11] Or if Anthem proceeds with discontinuing the current plans, to policyholders who accept the default replacement plan offered in lieu of renewal in accordance with 24-A M.R.S. § 2850-B(3)(G)(3)(a).

rather than replacing it, and in the unique circumstances presented at this time, the Superintendent is prepared to approve a proposed modification of coverage submitted in compliance with this Decision and Order as a minor modification for purposes of compliance with the ACA, pursuant to 24-A M.R.S. § 2850-B(3)(I)(3). The Superintendent will also approve a request to cease marketing the modified products and run them off as closed blocks of business.

As Anthem observes, the Superintendent does not have the authority to order a carrier to replace a policy with a "Superintendent-designed plan." (Anthem Closing Br. 2.) However, as when a rate request is denied, it is appropriate and potentially helpful to provide guidance on an alternative request that would be approved with minimal further review. In this case, the same products whose proposed limited-network replacements have been disapproved are also offered in the six northern and eastern counties, and the Superintendent has approved Anthem's product "mapping" to approved point-of-service (POS) forms for those policyholders; Anthem has a statewide broad network that is already approved for use with many of Anthem's group products; and the Superintendent has already approved Anthem's rate relativities for limited-network and broad-network products in the group market. The Superintendent will approve a product modification consistent with those parameters for policyholders in the ten southern and western counties, and will consider any alternative proposal Anthem might choose to submit.

In addition, it should be clear that nothing in this Decision and Order limits Anthem's ability to encourage its policyholders to purchase Anthem's approved limited-network plans rather than accepting the renewal (or default replacement) contract that Anthem offers, as long as policyholders are given a choice and Anthem clearly and accurately explains the consequences of that choice, consistent with the requirements of this Decision and Order.

VI. COMMUNICATIONS WITH SUBSCRIBERS

The six public comment sessions held in this matter included many thoughtful comments from members of the public. The sessions also, unfortunately, confirmed that there is widespread public confusion over Anthem's discontinuance and replacement proposal as well as, more generally, who will be affected by Anthem's new "Guided Access" plans, and how. Some members of the public appeared unaware, for example, that Anthem's networks do not restrict hospital choice for emergency care, that other carriers will be offering individual insurance policies both on and off the federal Marketplace, or that Anthem's replacement proposal was limited to individual, non-grandfathered subscribers.

Much of this confusion is understandable given the significant market changes that are taking place owing to the implementation of the ACA. Nevertheless, the inherently confusing nature of the current individual insurance market obligates Anthem to do everything possible to assist its subscribers in making informed choices about their health coverage for 2014. Therefore, once Anthem's renewal plans are approved, Anthem should send a letter to all affected subscribers that includes the following:

- A description of the subscriber's renewal plan, which includes an explanation of how it differs from the subscriber's current plan in terms of cost and benefits, and which clearly states that it uses a broad, open network. The description should also explain that, if the subscriber does nothing, he or she will be renewed into this plan by default.

- A description of the "Guided Access" plan as an alternative to the renewal plan, which explains the premium savings while also clearly disclosing that the provider network in the "Guided Access" plan excludes many providers and hospitals available in the renewal plan and that non-emergency out-of-network care is not covered. The description should also include instructions for how to check whether a specific provider or hospital is included in the network.

- A notice that federal subsidies might be available to the subscriber to purchase insurance and instructions on how to access the federal Marketplace through www.healthcare.gov. The notice could also include a reference to other consumer

resources such as www.enroll207.com. The letter should also make clear that subsidies are not available for the renewal product, but that in the Marketplace, the subscriber would be able to choose a Guided Access product or a product offered by another carrier.

This letter should be submitted to the Bureau of Insurance for approval before it is sent to subscribers.

VII. ORDER

Pursuant to 24-A M.R.S. § 2850-B the Superintendent hereby ORDERS that:

(a) Anthem's proposal to discontinue its current individual non-grandfathered products in southern and western Maine and replace them with the Guided Access HMO products is DENIED. Anthem shall promptly submit an alternative renewal or replacement proposal, consistent with the terms of this Decision and Order, to provide these policyholders with ACA-compliant coverage.

(b) Anthem's proposal to discontinue its current individual non-grandfathered products in northern and eastern Maine and replace them with the Guided Access POS products is GRANTED.

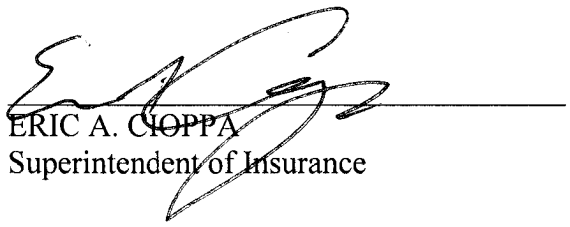
VIII. NOTICE OF APPEAL RIGHTS

This Decision and Order is final agency action of the Superintendent of Insurance, within the meaning of the Maine Administrative Procedure Act, 5 M.R.S. § 8002(4). It may be appealed to the Superior Court in the manner provided for by 24-A M.R.S. § 236, 5 M.R.S. §§ 11001 through 11008, and M.R. Civ. P. 80C. Any party to the proceeding may initiate an appeal within thirty days after receiving this notice. Any aggrieved non-party whose interests are substantially and directly affected by this Decision and Order may initiate an appeal within

forty days after the issuance of this Decision and Order. There is no automatic stay pending appeal. Application for stay may be made in the manner provided in 5 M.R.S. § 11004.

PER ORDER OF THE SUPERINTENDENT OF INSURANCE

October 4, 2013



ERIC A. CIOPPA
Superintendent of Insurance