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July 15, 2016

Eric Cioppa, Superintendent
Attn: Elena Crowley
Docket No. INS-16-1000
Bureau of Insurance
Maine Department of Professional and Financial Regulation
34 State House Station
Augusta, Maine 04333-0034

Re: Anthem Blue Cross and Blue Shield 2017 Individual Rate Filing

Dear Superintendent Cioppa:

Enclosed for filing please find the following:

SUBMITTED BY: Christopher T. Roach
DATE: July 15, 2016
DOCUMENT TITLE: Prefiled Testimony of Dee Clamp and Zach Fohl
DOCUMENT TYPE: Prefiled testimony
CONFIDENTIAL: **NO**

Thank you for your assistance in this matter.

Very truly yours,

/s/ Christopher T. Roach

cc: Attached service list

NON-CONFIDENTIAL

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

IN RE:) **EXHIBIT 1**
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)
ANTHEM BLUE CROSS AND BLUE) PREFILED TESTIMONY OF DEE
SHIELD 2017 INDIVIDUAL RATE FILING) CLAMP AND ZACH FOHL
)
Docket No. INS-16-1000)
) JULY 15, 2016
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1 **Q. Starting first with you, Mr. Clamp, please state your name and your position with**
2 **Anthem Blue Cross and Blue Shield (“Anthem”).**

3 A. My name is Dee Clamp, and I am the Staff Vice President Actuary III for Anthem’s
4 Commercial and Specialty Business Division. In that role, I oversee the team responsible for
5 commercial pricing across Maine, New Hampshire, Connecticut, Virginia, Georgia and New
6 York, including but not limited to Individual lines of business.

7

8 **Q. Please describe any relevant education or experience that qualifies you as a witness**
9 **today.**

10 A. I am a Fellow of the Society of Actuaries and Member of the American Academy of
11 Actuaries. I have held a variety of actuarial roles within the Anthem organization over the last 13
12 years, including pricing, reserving, trend development, forecasting, advanced analytics and
13 management. Prior to my work at Anthem, I spent 7 years at Milliman USA. There, my work
14 included a wide range of health actuarial consulting for a broad spectrum of clients, including
15 insurance carriers, providers and government agencies.

16

17 **Q. Turning next to you, Mr. Fohl, please state your name and your position with**
18 **Anthem.**

19 A. My name is Zach Fohl, and I am an Actuarial Director, working with a team responsible
20 for commercial pricing for Maine, including but not limited to Individual lines of business.

21

22 **Q. Please describe any relevant education or experience that qualifies you as a witness**
23 **today.**

24 A. I am a Fellow of the Society of Actuaries and Member of the American Academy of
25 Actuaries. I have held a variety of actuarial roles within the Anthem organization over the last 7
26 years, most recently including (i) Actuarial Healthcare Reform Analyst, (ii) Assistant Pricing

1 Director for Georgia, and (iii) currently, Maine Actuarial Pricing Director. Prior roles at Anthem
2 also involved focused experience working on forecasts and valuation.

3

4 **Q. Please state your reasons for testifying at this hearing.**

5 A. We are testifying at this hearing in support of Anthem's individual rate filing and
6 proposed rate modifications effective January 1, 2017.

7

8 **Q. Anthem's initial filing estimated that the average rate increase for 2017 would be**
9 **14.1%. Have you received additional information since the initial filing that affects the**
10 **proposed rate increase?**

11 A. Yes. Based on the 2015 risk adjuster assessments that were issued by CMS on June 30,
12 2016, Anthem's average rate increase for 2017 increased from 14.1% to 19.4%. We have
13 prepared the attached Hearing Exhibit 3, which reflects our revised rate development that results
14 in the 19.4% average rate increase. As will be explained below, now that we know the risk
15 adjuster payment for the base period experience (2015), Anthem can develop rates based on
16 pricing to that average market risk (which in general terms is the result of adding the risk
17 adjuster payment to the carrier's base claims and trending forward to the rating period).
18 Developing rates based on the average market risk simplifies the rating process by eliminating
19 (1) the need to analyze the difference in Anthem's average risk score relative to the market; and
20 (2) the uncertainty of projecting individual carrier risk given the significant movement of
21 members among the different carriers in the market.

22

23 **Q. With that summary in mind, what is the risk adjuster?**

24 A. Under the ACA, CMS reviews claims data for each carrier in the market to determine the

1 risk of each carrier's enrollment as it relates to the overall market in which the carrier operates.
2 If the carrier's enrollment during that period was riskier than the average, the carrier receives a
3 positive risk adjustment, meaning an influx of dollars to help offset the riskiness of the claims for
4 the measured period, in this case 2015. If on the other hand the carrier's enrollment relative to
5 the market is less risky, that carrier would be assessed a negative risk adjustment, which means
6 that carrier must pay an assessment to adjust that carrier to the average risk in the market. In
7 theory, this is intended to ensure that all carrier's generally share equally in the risk of the entire
8 individual market, not just the risk of the carrier's particular enrollment.

9

10 **Q. What were the results of the 2015 risk adjustment?**

11 A. According to the information released by CMS, the risk of Anthem's enrollment in 2015
12 was lower than the overall market and, accordingly, Anthem was assessed a \$3.9 million risk
13 adjustment. Because Community Health Options ("CHO") currently insures the majority of the
14 individual block, the results of the individual market risk adjustment process were driven by the
15 risk of CHO. The Maine Individual Market enrollment had greater claims risk in 2015 than
16 Anthem's enrollment and, as a result, Anthem was assessed risk adjustment dollars.

17

18 **Q. What effect does the risk adjustment have on Anthem's 2015 financial results?**

19 A. In our June 13, 2016 response to the First Information Request of the Superintendent, we
20 reported that Anthem's after tax margin for 2015 was 4.80% and the pre-tax margin was 6.6%
21 (or approximately a \$3.9 million pre-tax gain). Anthem received the \$3.9 million risk
22 adjustment assessment for the 2015 year on June 30, 2016. Applying that assessment reduces
23 the 2015 financial results from a positive pre-tax 6.6% to just 0.2%, which on a post-tax basis

1 means essentially \$0 profit for 2015. This new information also affects our response to question
2 15 of the Superintendent's requests in that the claims for 2015 would increase by the \$3.9
3 million risk adjustment and the corresponding "after 5Rs" loss ratio for 2015 increases from 73%
4 to 79%.

5
6 **Q. Did Anthem expect this significant risk adjustment assessment for 2015?**

7 A. No. Our inability to predict the risk adjustment (even whether it would be positive or
8 negative) is driven by two primary factors: (1) the significant turnover of each carrier's
9 enrollment and corresponding reduced ability to assess each carrier's individualized future risk;
10 and (2) the fact that the carrier with the largest market share (CHO) does not provide data to the
11 Wakely Consulting Group to develop its risk assessment model. The other three carriers
12 (Anthem, Harvard Pilgrim and Aetna) participate in Wakely. Because Wakely requires at least
13 70% of the market in order to do a risk assessment for the particular state, Wakely does not
14 produce a risk assessment model for Maine individual due to CHO's lack of participation. This
15 hampers the ability of the participants in the Maine individual market to perform accurate risk
16 assessment projections.

17
18 For example, Anthem's enrollment in 2014 was marginally riskier than the overall market, which
19 resulted in Anthem receiving a positive risk adjustment with respect to its 2014 results.

20 Anthem's average risk score improved as the market expanded in 2015. Unfortunately the
21 overall market morbidity for Maine Individual did not show similar improvement. Therefore
22 Anthem's risk relative to the rest of the individual market (most notably CHO's) was lower,
23 which resulted in the \$3.9 million risk adjustment assessment for 2015. Part of the

1 unpredictability is the result of the market being brand new with members moving between
2 carriers, and part is due to the fact that we simply do not have meaningful information with
3 which to assess the risk of the carrier with by far the largest individual enrollment, which as
4 noted above makes estimating the morbidity of the market difficult if not impossible.

5
6 **Q. Why does an adjustment for 2015 have an effect on the 2017 rates?**

7 A. Anthem's rate development uses base period claims experience from 2015 and projects
8 that forward to 2017 by applying the estimated paid claims trend from the midpoint of the
9 experience period to the rating period and adjusting for estimated changes in morbidity. When
10 making the initial filing, Anthem had to estimate the 2015 claims and financial results without
11 the benefit of the ACA market's overall experience and without knowing whether it would
12 receive, or pay, based on the risk adjuster analysis provided by CMS.

13
14 The risk adjustment is intended to level the claims risk for all of the carriers in the market. As
15 noted above, Anthem's claims expense for 2015 will be adjusted by \$3.9 million. This has two
16 implications for purposes of rate development. First, this increases Anthem's base claims
17 experience to match the market. Since Anthem's relative risk was better than initially projected
18 and results in Anthem being a risk adjuster payer for 2015, our starting point claims are higher
19 resulting in a higher proposed rate increase.

20
21 The second implication is on the morbidity adjustment. In our initial rate development, we did
22 not have the benefit of knowing Anthem's actual risk relative to the market and, as a result, had
23 to estimate how our block's morbidity would change from the base period to the rating period

1 based in large part on an estimate of the average risk of CHO's enrollment that we project would
2 shift to Anthem. That resulted in the 1.028 morbidity adjustment. Now that we know the actual
3 risk of the entire Maine individual ACA block of business, we develop rates based on that
4 average risk and do not need to adjust for morbidity. As a result, in our revised rate
5 development, the morbidity adjustment is eliminated by setting it to 1.0. This is consistent with
6 the methodology that we have used in the past to account for risk adjusters and reflects a more
7 straightforward rate development than having to estimate changes in Anthem's individual
8 morbidity.

9

10 **Q. Why does setting Anthem's risk to be in line with the market and removing the**
11 **morbidity adjustment produce a more straightforward rate development?**

12 A. Anthem ultimately pays claim costs based on average market risk because as noted
13 above, we pay or receive risk adjuster dollars to match Anthem's actual risk relative to the
14 average risk in the market. Once that is done, we can then assess whether we expect the average
15 risk of the entire 80,000 member market to rise, fall or remain the same. While carriers gain and
16 lose membership regularly, the entire market enrollment is far less volatile. That is, it is far
17 easier to assess whether the entire market's average risk score will change versus attempting to
18 assess whether Anthem's portion of that market will change. Given the reconciliation that
19 occurs through the risk adjustment process, setting the base claims to reflect the risk adjustment
20 and then assessing whether the risk in the overall market will change from the experience period
21 to the rating period is more straightforward and removes the need to estimate the individual
22 market's risk as it relates to Anthem's risk or to predict specific member movement among
23 carriers.

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Q. Could you have excluded the risk adjustment from the 2015 base claims and adjusted the morbidity adjustment instead?

A. Yes, but that in our view would unnecessarily complicate the analysis and would not change the ultimate rate development. That is, we now know that the average market risk for 2015 was materially greater than Anthem’s individual enrollment. We could account for the likelihood of enrollment shifts and corresponding increase in Anthem’s average risk score by increasing the morbidity adjustment. In addition to requiring us to estimate the average risk score for the “black box” that is CHO’s risk, Anthem’s claims ultimately will be set to match the market through the risk adjustment process. And if the morbidity adjustment and resulting 2017 risk adjustment are calculated accurately, applying the morbidity adjustment to the existing base claims would yield the same result as including the risk adjustment in the 2015 base claims, as we have done.

Q. Would your methodology differ if Anthem had received a positive risk adjustment?

A. No. We followed this same methodology when Anthem received a risk adjustment for its individual business for 2014. That is, in that instance, the experience period claims were reduced by the risk adjustment and rates calculated accordingly. As described above, an individual carrier’s membership in Maine can vary substantially from year to year. It is easier to project what will happen to the market as a whole rather than look at the impact of how an individual carrier’s membership will change. The most important thing to project is how the overall market morbidity will change because the risk adjustment is designed to increase or decrease each carrier’s ultimate claims and financial results if their risk is different than the market.

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Q. You mentioned that Anthem eliminated any adjustment for morbidity in your revised rate development. Does this mean that you anticipate that the risk of the Maine individual ACA block from the experience period to the rating period will remain unchanged?

A. Although there are several factors that could result in further deterioration of the individual market overall and lead to a higher average risk in 2017, that’s generally right. Based on the 2015 CMS Risk Adjustment results, the average morbidity of the block was largely unchanged from 2014 to 2015. Again, individual carrier enrollment risk may change materially, but the overall block consists of a significant number of enrollees, which reduces both the impact of new risky members enrolling as well as the effects of member movement among different carriers (which would be felt at the individual carrier level, not by the block as a whole). While individual carriers are still subject to significant risk and volatility in their individual blocks, we believe these factors militate in favor of making no adjustment in the rate development for morbidity.

Q. With that understanding of the revised rate development, do you have comments on how rate filings should be reviewed in the context of a competitive market?

A. Yes. First, we agree with the comments by Mr. Whitmore that there is a significant difference in focus when assessing rates in a competitive market versus a market with one dominant carrier. The ACA market in Maine has four carriers that are competing for enrollment. This, combined with the backstop of the medical loss ratio refund process, essentially ensures that no (successful) carrier will propose excessive rates and the ACA effectively prevents rates

1 that are discriminatory, leaving the regulatory focus on ensuring that carrier rates are not
2 inadequate.

3
4 Second, because it involves projections of claims and expenses in a future period, there is no
5 single actuarially-correct premium rate below which the rate is inadequate and above which it is
6 excessive. Rather, there is a range around all assumptions that is within the province of
7 reasonable actuarial judgment. To that point, when making the assessment of whether rates are
8 excessive, consistent with actuarial standards, the Superintendent reviews the individual
9 components of the rate development to determine whether any are unreasonable. *See, e.g., In re*
10 *Anthem BCBS 2006 Individual Rate Filing*, INS-05-820 Decision and Order (December 19,
11 2005) (approving assumptions that were “not unreasonable”); *Actuarial Standard of Practice No.*
12 *8* (March 2014), Section 3.12 (“The actuary should review the assumptions employed in the
13 filing for reasonableness.”). We firmly believe that our assumptions and resulting rates are not
14 unreasonable.

15

16 **Q. What are the main factors that drive the development of Anthem’s 2017 proposed**
17 **rates?**

18 A. The main factors that drive the rate development are as follows:

- 19 • Base period experience
- 20 • Trend
- 21 • Benefit modifications
- 22 • Changes in taxes, fees and some non-benefit expenses; and
- 23 • Discontinuance of the Federal Transitional Reinsurance Program.

24 Each is discussed in turn below.

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I. Base Claim Experience.

Q. Where did you begin your 2017 ACA rate development?

A. We start with the 2015 base experience period claims adjusted for risk adjusters and reinsurance, which establish the starting point PMPM for the 2017 rate development. Our goal is then to trend those experience period claims forward to the rating period, accounting for estimates of trend, changes in morbidity of the entire market, changes in benefits, and other factors that must be taken into account because they reflect differences between the 2015 experience period claims and what we expect during the rating period. While Anthem expects the risk of its actual enrollment to increase as a result of an influx of higher-risk grandfathered and CHO members, as noted above, setting the base claims to the average risk in the market dampens the need to adjust for this added risk because of the relatively small effect that the addition of grandfathered members will have on the overall market risk.

II. Increasing Trend.

Q. Please describe Anthem's development of trend for the ACA business.

A. Because of the inherent volatility that occurs during the start-up of any block, we use small group data as a proxy for the individual ACA block. As reflected in our initial filing and in Hearing Exhibit 3, the annual pricing trend used in the development of the rates has accelerated and is now projected at 9.6%. The trend is developed by normalizing historical benefit expense for changes in the underlying population and known cost drivers, which are then projected forward to develop the pricing trend. Examples of such changes include contracting, cost of care initiatives, workdays, costs associated with Hepatitis C, compound drugs, average wholesale price, and expected introduction of generic drugs. For projection, the experience period claims are trended 23.8 months from the midpoint of the experience period, which is July 7, 2015, to the midpoint of the projection period, which is July 1, 2017.

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Q. How does Anthem’s 9.6% trend compare to the trends used in the development of rates for the other three carriers?

A. Trend is simply a reflection of how we expect claims to grow from those observed during the experience period to the rating period. Anthem’s 9.6% trend is a paid (not allowed) trend, which means it takes into account the effect of cost share leveraging. The amount of paid claims for each carrier is unique in that claims reflect the carrier’s population, benefit mix and provider reimbursement rates. With that context in mind, all of the carriers are projecting higher trends during the rating period than those used in last year’s filing. Harvard Pilgrim is assuming approximately the same paid trend (9.5%) as Anthem. The other two carriers (Aetna and CHO) provided their estimated trends on an allowed (not paid) basis, which means their trends do not take into account cost share leveraging. Moreover, neither estimate gives us any pause about the reasonableness of our estimate: Aetna has only very limited membership and CHO’s financial experience so far reflects that it has under-estimated claims trend in the Maine individual market.

Q. Would you expect the trends from the other carriers to be identical to Anthem’s?

A. No. For the reasons discussed above, we would not expect the paid claims trends for each carrier to be identical even if the same actuarial team estimated a trend for all four carriers. There would be differences based on the individual carrier’s population, benefit mix and provider reimbursement rates.

Q. Why did your estimate of trend for the projected rating period increase from the last rate filing?

A. We are observing increases in cost and utilization generally, but the acceleration in trend is due in large part to increases in the cost of pharmaceutical drugs, including Hepatitis C drugs like Harvoni, as well as increased utilization within the ACA block of business.

1 **Q. Given that Anthem started to cover Hepatitis C drugs in 2015, why are costs such as**
2 **those for Harvoni not already part of Anthem’s base claims experience?**

3 A. Certainly, some members received coverage for Harvoni in 2015. We expect that
4 number to increase going forward because the standards to qualify for treatment coverage have
5 changed significantly. Specifically, Anthem’s medical policy originally required the member to
6 have advanced scarring (Fibrosis level F3 or greater) to receive coverage for Harvoni. Anthem
7 changed this policy effective January 1, 2016 to allow members with little scarring (Fibrosis
8 level F0 or greater) to receive coverage for Harvoni. While Anthem’s new, broader policy is
9 better for members with Hepatitis C, it will also increase the number of Hep C claims that
10 Anthem will cover beyond those that are reflected in our base claims experience.

11

12 **Q. Do you remain confident that your 9.6% paid claims trend is reasonable?**

13 A. Yes. Our trend is based on a reasonable methodology that has been reviewed and
14 approved previously for this block of business and includes reasonable assumptions based on
15 observed medical and pharmaceutical drug claims, all of which support the overall 9.6% paid
16 claims trend.

17

18 **III. Benefit modifications**

19 **Q. What role did the modification in benefits play in developing Anthem’s proposed**
20 **rates for 2017?**

21 A. Every year, Anthem makes adjustments to benefit levels to comply with metal levels,
22 other guidance from CMS and to address conditions in the market. This year, there are slight
23 changes to the essential health benefits (“EHB”) for 2017. Adjustments are made to reflect the
24 2017 requirement to provide separate but equal visit limits for rehabilitative and habilitative
25 therapies per HHS Notice of Benefit and Payment Parameters. This factor also adjusts for the
26 change in the state EHB benchmark plan for 2017. There was an additional non-discrimination

1 requirement established after our initial filing that results in an increase of \$0.11 PMPM to the
2 proposed rates. This additional cost is included in Hearing Exhibit 3.

3

4 **IV. Changes in taxes, fees and some non-benefit expenses**

5

6 **Q. What amount of administrative expenses is included in the projected rates?**

7 A. As reported in the Whitmore prefiled, the administrative expenses, exclusive of quality
8 improvement, selling, specialty and miscellaneous expenses, are currently \$36.70 PMPM for the
9 ACA block of business. Rather than including any escalation factor, the proposed rates include
10 only this actual, observed expense level.

11

12 **Q. Did you take into account the suspension of the ACA insurer fee for 2017 when**
13 **developing the proposed rates?**

14 A. Yes. We set the insurer fee to \$0 when developing the proposed rates.

15 **Q. What provision did you include in rates for anticipated risk adjusters for 2017?**

16 A. Because we are setting our base claims to match the average risk in the market, we are
17 not including any risk adjustment transfer for 2017, which will be settled in 2018. If as we
18 expect the average overall market risk will remain relatively static through the rating period, any
19 payment (or receipt) of risk adjuster dollars by Anthem will simply reconcile Anthem's financial
20 results to the level estimated in our rate development, so there is no need to make any adjustment
21 for assumed risk transfers in 2017.

22

23 Moreover, as evidenced by the results for the 2015 risk adjuster process, it is difficult to predict
24 future risk adjusters due to the annual re-enrollment process, as well as lack of data available for
25 CHO. See, e.g., American Academy of Actuaries issue brief, *Drivers of 2017 Health Insurance*
26 *Premium Changes* (the "Annual individual market turnover limits the ability to use 2014 and

1 2015 experience data to project risk profiles in 2017”). The risk that Anthem is taking is that if it
2 turns out that Anthem is a receiver of 2017 risk adjustment dollars (which are paid out in 2018),
3 Anthem may not be able to collect the full amount of any transfer if not all carriers remain in the
4 Maine individual market in 2018.

5

6 **Q. What provision is included in the filing to cover risk and profit?**

7 A. We have included a 2.24% post-tax margin as a buffer to offset the risk of the ACA block
8 and, it is hoped, achieve a modest return. This amounts to a .56% increase in the post-tax margin
9 compared with the existing rates. This increase in the margin to cover risk and profit is modest
10 relative to the risk of the ACA block.

11

12 **Q. What evidence do you have that Anthem’s ACA block in 2017 will be subject to**
13 **more risk than in the past?**

14 A. For several reasons, the level of uncertainty in the ACA marketplace is increasing.
15 First, and most obviously, a primary driver of rate stability (federal reinsurance) is no longer
16 available. Second, the Individual ACA market in Maine has become somewhat destabilized as
17 not all carriers remain authorized to enroll new business during the special enrollment period.
18 Because members who enroll during the SEP typically generate greater claims, eliminating one
19 carrier from SEP enrollment means that the other carriers will have an increased number of SEP
20 enrollees, thereby increasing our risk. The carrier with the largest share of the Maine individual
21 market (CHO) experienced significant losses in 2015 to the point that the Superintendent ordered
22 CHO to suspend enrolling new members last December. This is to some degree consistent with
23 national emerging experience as carriers experienced multi-billion dollar losses, with one of the

1 largest carriers exiting the ACA market altogether. Given CHO's financial status and request for
2 an average increase of nearly 23% in its rates, Anthem expects a number of current CHO
3 enrollees will choose to enroll in Anthem's ACA plans in 2017, which will increase Anthem's
4 overall ACA risk profile. As the American Academy of Actuaries noted, the ACA individual
5 market is exhibiting greater uncertainty and "greater levels of uncertainty typically result in
6 higher risk margins and higher premiums".

7
8 Finally, the 2015 risk adjustment results reflect that significant risk and volatility for individual
9 carriers remain in the ACA individual market in Maine. Those results demonstrate that the
10 Maine Individual Market membership is materially more risky than Anthem's enrollment and
11 how financial results are affected by the risk adjustment process. For its part, when filing its
12 initial rate filing, Anthem's 2015 ACA individual financial results were positive and assumed
13 that Anthem made approximately \$3.9 million (6.6%) on a pre-tax basis. Anthem paid taxes on
14 those assumed results for tax-year 2015, ending the year with an after-tax margin of 4.8%. With
15 the risk adjustment payment of approximately \$3.9 million and adjusting for reinsurance
16 receipts, Anthem's pre-tax gain for 2015 is reduced to \$95,000 or 0.2% before taxes, which
17 would be further reduced for the effective tax rate on that *de minimis* gain. In short, the
18 perceived gain for 2015 assumed in our initial filing was effectively eliminated by the risk
19 adjustment results.

20

21 **Q. Is this risk accounted for by effectively matching Anthem's 2015 base claims to the**
22 **market?**

23 A. No. Setting the base claims to account for the risk adjustment and thereby matching the

1 market removes the need for a further adjustment to account for Anthem’s enrollment claims risk
2 relative to the overall market, but it does not account for the volatility in a start-up block, and
3 particularly one like the ACA that includes an annual “shopping” period for consumers and
4 corresponding significant shifts in enrollment among the carriers.

5
6 The fact that accounting for the risk adjustment in base claims does not fully address the risk of
7 this book of business is evident in our financial results. For example, we followed the process
8 outlined above of accounting for the risk adjustment in base claims when setting rates previously
9 and ended 2015 with taking the risk of over \$45 million in claims for essentially \$0 profit. That
10 is, virtually 100% of the 1.68% post-tax margin that was embedded in rates to cover risk and
11 profit was taken up to cover the risk of the business. Our proposal to increase that buffer by
12 .56% is modest and necessary and certainly does not result in excessive rates.

13

14 **V. Discontinuance of the Federal Transitional Reinsurance Program.**

15

16 **Q. How does the elimination of the federal reinsurance program affect Anthem’s 2017**
17 **rates?**

18 A. We estimated that federal reinsurance had a 4.6% effect on Anthem’s financial results for
19 2015. Accordingly, we anticipate that the loss of federal reinsurance beginning in 2017 will
20 have a 4.6% effect on rates. This 4.6% impact on rates is at the very low end of the range
21 projected by the American Academy. *See American Academy of Actuaries issue brief, Drivers*
22 *of 2017 Health Insurance Premium Changes* (estimating that the discontinuance of federal
23 reinsurance will have an impact on 2017 rates of 4-7%).

1

2 **Q. Do Anthem’s proposed rates contemplate that CHO will leave the market, or have**
3 **its enrollment significantly limited, in 2017?**

4 A. No. Our rate development includes the assumption that some number of current CHO
5 members will transition to Anthem (approximately 8,500), but in no way accounts for the risk of
6 CHO failing or having its 2017 enrollment significantly curtailed. As explained in the Whitmore
7 prefiled, CHO received \$41 million in reinsurance for 2015, which means relative to Anthem
8 (which received \$6.6 million), CHO obviously has a significant number of high-dollar claimants,
9 a much higher cost per high-dollar claimant, or some combination of both. As explained above,
10 Anthem’s 4.6% reinsurance adjustment was made relative to our own block, consisting of
11 Anthem’s high-dollar claimants. It would be wholly insufficient to account for loss of
12 reinsurance for six times the amount of claims that were eligible for reinsurance in 2015, but
13 would not be subject to reinsurance in 2017. If CHO fails to survive or must significantly limit
14 its enrollment, that would materially increase Anthem’s risk; a risk that is not included in
15 Anthem’s proposed rates for 2017.

16

17 **Q. What is the loss ratio permitted for these plans and, if the proposed rates are**
18 **approved, what loss ratios are anticipated for these products?**

19 A. Federal law requires an 80 percent minimum loss ratio. If the proposed rates are
20 approved as filed, and all projections turn out to be accurate, the anticipated federal loss ratio
21 will be 87.4% for the rating period, well in excess of that standard.

22

23 **Q. Are the proposed premium rates excessive, inadequate or unfairly discriminatory?**

1 A. As explained in the Whitmore prefiled, the focus in a competitive market should be to
2 ensure that rates are not inadequate; the excessive and discriminatory aspects having been
3 constrained by the competitive market and ACA, respectively. Anthem's proposed rates use
4 reasonable assumptions and are designed to cover all costs (claims, administrative expenses,
5 taxes, and assessments) and allow for a modest after-tax return. The proposed rates are not
6 excessive, inadequate or unfairly discriminatory.

7

8 **Q. Does this conclude your testimony?**

9 A. Yes.

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

IN RE:)	
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ANTHEM BLUE CROSS AND BLUE SHIELD 2017 INDIVIDUAL RATE FILING)))	CERTIFICATE OF SERVICE
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Docket No. INS-16-1000)))))	

The undersigned counsel hereby certifies that on this date I caused to be mailed by electronic mail, copies of the Prefiled Testimony of Dee Clamp and Zach Fohl on the persons and at the addresses indicated below.

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DATED: July 15, 2016

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