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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 William Whitmore  
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

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

IN RE: ) **EXHIBIT 2**  
)  
)  
ANTHEM BLUE CROSS AND BLUE ) PREFILED TESTIMONY OF  
SHIELD 2017 INDIVIDUAL RATE FILING ) WILLIAM WHITMORE  
)  
Docket No. INS-16-1000 )  
) JULY 15, 2016  
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1 **Q. Please state your name and your position with Anthem Blue Cross and Blue Shield**  
2 **(“Anthem”).**

3 **A.** My name is William M. Whitmore. I am the Regional Vice President of Sales with  
4 Anthem in Maine.

5

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

8 **A.** I am an Associate of the Society of Actuaries and a member of the American Academy of  
9 Actuaries. I was a member of the Actuarial Department of Anthem, and its predecessor Blue  
10 Cross Blue Shield of Maine, from 1989 through 2008 (with the exception of fourteen months in  
11 2001 and 2002, during which time I worked for Milliman USA). In 2008, I took on the role of  
12 leading the Underwriting function for Anthem of Maine. In July 2014, I transitioned to my  
13 current role as the head of sales in Maine. For the period February-October of 2015, I also served  
14 as acting President of Anthem in Maine.

15

16 During my career with Anthem I have had numerous responsibilities including individual pricing,  
17 group pricing, trending, reserving, new product development and pricing, and analysis of provider  
18 contracting. I was responsible for the development of a number of HealthChoice individual rate  
19 filings for Anthem from 2002 to 2008.

20

21 I am a lifelong resident of the State of Maine and a graduate of Bowdoin College in Brunswick,  
22 Maine where I earned a Bachelor of Arts degree with a major in mathematics.

1

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

3 **A.** I am testifying at this hearing to discuss the transformation of the Maine individual  
4 marketplace and in support of Anthem's individual rate filing and proposed rate modifications  
5 effective January 1, 2017.

6

7 **Q. Please describe the Maine individual insurance market.**

8

9 **A.** The Maine individual market has changed significantly since the implementation of the  
10 Affordable Care Act ("ACA") in 2014. Prior to the implementation of the ACA, the individual  
11 market in Maine consisted primarily of Anthem's now closed legacy products. After the  
12 implementation of the ACA, membership was dwindling, per-enrollee costs were increasing, and  
13 significant rate increases led to accelerating lapse rates even though by doing so, legacy  
14 members would lose their grandfathered (or grandmothered) status. In short, the legacy  
15 individual market in Maine was in a death spiral. In late 2015, Anthem requested that the  
16 Superintendent approve the discontinuance of Anthem's legacy plans to be replaced with ACA-  
17 compliant plans effective January 1, 2017. Finding that it was in the best interests of the  
18 remaining 3,100 legacy policyholders to do so, the Superintendent approved Anthem's request  
19 and the legacy plans will be discontinued and replaced effective January 1, 2017.

20

21 In contrast to the legacy individual market, four insurers have filed to offer ACA-compliant  
22 products on- and off-exchange in Maine for 2017. The combined individual enrollment among  
23 the four insurers is approximately 90,000; very different from what existed in Anthem's legacy

1 block. Anthem currently covers approximately 16,763 ACA members. The products offered by  
2 each carrier are categorically similar and within the parameters established by the ACA,  
3 however, there are network differences and benefit differentials within the allowed parameters  
4 that each insurer deems appropriate for its block of ACA business in Maine.

5

6 Perhaps the most fundamental difference between the legacy and ACA markets is that the Maine  
7 individual market is now competitive. While the general ratemaking principles that rates must  
8 not be excessive, inadequate or unfairly discriminatory certainly still apply, in the now  
9 competitive marketplace, the Superintendent is not left to evaluate the rate filings in isolation,  
10 nor act as the sole constraining force on rates. Instead, the competition for membership puts  
11 pressure on carriers to keep premiums lower or risk losing market share. This shift in the  
12 paradigm from a marketplace that only had one dominant carrier to one where (1) competition is  
13 thriving among multiple carriers, (2) consumers may choose among multiple products offered by  
14 those carriers with on-line comparison tools that reflect both differences in rates as well as  
15 product variation, and (3) refunds are still required if expenses and profits exceed certain limits,  
16 together lessen the need for regulatory oversight to constrain premium rates. Perhaps the  
17 existence of a competitive individual marketplace may explain in part why the Attorney General  
18 has not intervened in any of the four pending individual rate proceedings, when historically the  
19 AG had participated actively in virtually every Anthem individual rate filing since Anthem  
20 acquired the former Blue Cross and Blue Shield in 2000.

21

1 **Q. Does this mean that the Superintendent should exercise a lesser degree of care in**  
2 **reviewing rate filings in the new ACA marketplace?**

3 A. No, the Superintendent is still charged with ensuring that rates are not excessive,  
4 inadequate or unfairly discriminatory, but a competitive environment and rate comparison tools  
5 will encourage and reward appropriate rate making. The assumptions in rate filings that flow  
6 from a competitive environment are already constrained by virtue of that competition and should  
7 be viewed with less skepticism than might otherwise be attached to rates proposed in a non-  
8 competitive environment. *See, e.g., In re Anthem BCBS 2002 Individual Rate Filing, Decision*  
9 *and Order*, Docket No. INS-01-2532, (“The Attorney General argues that, as a result of Anthem  
10 BCBS’s and MPHP’s dominance of the non-group health insurance market, there are no market  
11 forces to control prices. . . . Anthem BCBS and MPHP together insure approximately ninety  
12 percent of the population currently insured under individual health insurance policies in Maine.  
13 The Superintendent considers this market share dominance relevant to the filing and the  
14 subsequent evaluation of the proposed rates.”) (Emphasis added).

15  
16 While Anthem has always proposed rates that in its view satisfy the applicable statutory  
17 standards, the fundamental difference in a competitive marketplace in which multiple carriers are  
18 offering similar products is that the consequence of failing to implement rates that are naturally  
19 constrained by competition is that consumers will vote with their pocketbooks and the insurer  
20 charging above-market rates in the competitive marketplace will lose, or fail to gain new,  
21 membership. Moreover, if the rates are truly excessive, the carrier will be required to refund a  
22 portion of member premiums. As a result, in a competitive marketplace and one that has the

1 insurer with the largest share of the individual market in financial distress, the rate making  
2 principle that perhaps requires the most focus is ensuring that rates are not inadequate.

3

4 **Q. Why does the “not inadequate” element of the inquiry require more focus in the**  
5 **competitive ACA individual marketplace?**

6 A. As I discussed above, the existence of competition and refund requirements effectively  
7 guard against excessive rates. Compliance with ACA benefit and rating parameters likewise  
8 ensures that rates offered for ACA-compliant plans are not unfairly discriminatory. Depending  
9 on the carrier’s tolerance for losses, however, ensuring the adequacy of rates may be overtaken  
10 by the carrier’s desire for marketshare.

11

12 **Q. Why does it matter if rates are inadequate? Aren’t lower prices better for**  
13 **consumers?**

14 A. To a point. As long as the rates are adequate to cover all costs plus allow for a reasonable  
15 return to contribute to surplus, I would agree that prices need be no higher. There are, however,  
16 two adverse consequences that flow from any carrier offering plans with inadequate rates. First,  
17 the competitive individual insurance market in Maine remains regulated; carriers do not have the  
18 unfettered discretion to charge whatever rates they want. As such, an appropriately competitive,  
19 but regulated, individual insurance marketplace relies upon all carriers pricing their products  
20 within the statutory parameters and no carrier underpricing the market, whether with intent or  
21 not, significantly to obtain market share. Approval of inadequate rates upsets the competitive  
22 marketplace and creates imbalance in a market the successful operation of which depends on an  
23 even playing field. If that imbalance is permitted and, if consumers make financially-rational

1 decisions, the artificially underpriced carrier will get the bulk of the enrollment in the market,  
2 which defeats the fundamental purpose of having multiple carriers competing in the market to  
3 begin with.

4  
5 The second adverse consequence arises when that scenario (inadequate rates + unnatural market  
6 share) reaches its natural conclusion. At best, the carrier charging inadequate rates loses money  
7 and its members receive larger increase(s) in the future to achieve rate adequacy. At worst, the  
8 carrier's financial viability may become at risk. If the carrier ultimately is unable to pay claims  
9 and/or fails altogether, in addition to the loss of a carrier from the market, the claims that should  
10 have been reimbursed by that carrier (or some percentage of them) will become bad debts for the  
11 providers. Members of the failed carrier will also have to seek coverage elsewhere and, if the  
12 failure and coverage transition occurs on anything other than the policy anniversary, there will be  
13 deductible issues for the insured, the new insurer, or both. The provider bad debts will also need  
14 to be recovered in rates charged to other carriers or within other insured markets, which will then  
15 be passed on in the rates paid by the other carriers' insured members.

16  
17 For these reasons, the focus in this market should be on ensuring that all carrier rates are  
18 adequate, guarding against any one carrier offering inadequate rates that, while consumer  
19 friendly in the short term, lead to the market imbalances and the potential domino effect  
20 described above.

21  
22 **Q. How has the competitive ACA market actually developed in Maine?**

1 A. In the first two years following implementation, rates among the traditional carriers were  
2 relatively similar. Community Health Options (“CHO”), however, went to market with prices  
3 (particularly in 2015) that were lower than others, significantly in certain rating regions, even  
4 though CHO offers only broad-network plans. While CHO indeed grew its membership and  
5 currently insures the majority of the individual ACA business in Maine (over 58,000 members),  
6 CHO’s significant losses in 2015 and on-going financial difficulties reflect that CHO’s 2015  
7 rates – while certainly attractive to consumers – were not actually adequate to cover the claims  
8 and expenses of insuring its membership. In late 2015, the Superintendent suspended CHO’s  
9 ability to enroll additional members, but by the time Center for Medicare and Medicaid Services  
10 (“CMS”) could effectuate the suspension in the marketplace, the open enrollment period was  
11 already well underway and CMS denied the Superintendent’s proposal to require CHO to reduce  
12 its 2016 membership.

13

14 CHO has now requested an average increase of 22.8% for 2017. If all of the rate filings are  
15 approved as filed, CHO will no longer have the level of pricing advantage in 2017 as it has in  
16 prior years.

17

18 **Q. Will CHO’s financial issues affect Anthem’s enrollment?**

19 A. CHO’s financial issues will and already have affected Anthem’s enrollment. Because  
20 the CHO was permitted to sell during the 2016 Open Enrollment period, but not required to  
21 accept members who qualify for a special enrollment period, Anthem will continue to receive a  
22 greater percentage of the SEP enrollment. The members who sign up during the SEP historically  
23 have been a less healthy population compared to the members purchasing coverage during the

1 open enrollment period. *See, e.g.,* Oliver Wyman, *Special Enrollment Periods and the Non-*  
2 *Group, ACA-Compliant Market* (February 24, 2016), p. 1 (“We have found that individuals  
3 enrolling during an SEP represent a significant and growing share of exchange enrollment.  
4 Moreover, we found that SEP enrollees have higher morbidity than those who enrolled during  
5 the open enrollment period (OEP) and were much more likely, on average, to lapse coverage  
6 than those that enrolled during the OEP. . . . PMPM claim costs for SEP enrollees during 2014  
7 were 24% higher on average during the first three months of enrollment than for OEP enrollees. .  
8 . . In 2015, the difference in PMPM claims costs increased to 41% for the first three months of  
9 enrollment.”) Anthem is receiving approximately 500 new enrollees per month during the SEP,  
10 while CHO must take none of these potentially higher risk individuals.

11  
12 We also anticipate that CHO’s financial issues will affect consumer behavior in 2017 because (1)  
13 some of its existing membership may lose confidence in CHO’s ability to pay claims and (2)  
14 CHO will charge more appropriate rates in 2017, meaning that its prior pricing advantage will be  
15 dampened if not eliminated altogether. As to the former, additional oversight from the  
16 Superintendent will certainly help to ensure that CHO’s rates for 2017 will be adequate, but rates  
17 for 2016 cannot be changed. Despite taking a \$10 million favorable restatement of claims  
18 (which would have a positive \$10 million effect on CHO’s 2016 financials), CHO reports that it  
19 lost another \$8 million in the first quarter of 2016 and an additional \$4 million in April and as of  
20 May had already drawn down over 40% of its premium deficiency reserve with the most  
21 expensive claim months for 2016 to come, further reaffirming that its 2016 rates are inadequate.  
22 Because claims paid by the carrier typically grow through the year as deductibles and out of  
23 pocket maximums are satisfied and CHO currently insures the majority of the ACA population,

1 it remains to be seen whether CHO's actual losses in 2016 will be more or less than its \$43  
2 million Premium Deficiency Reserve and how this may affect its viability going forward. Other  
3 cooperatives like CHO that started up with the implementation of the ACA are suffering similar  
4 financial issues. As of July 15, 2016, approximately 70% (16 of 23) of the cooperatives have  
5 already failed outright. Just in the past two weeks, it was announced that three co-ops  
6 (Connecticut, Oregon and Illinois) are no longer viable, forcing members to find coverage  
7 elsewhere. *See Connecticut Obamacare Co-op Going Out of Business* (July 7, 2016); *Oregon*  
8 *Fail: Another Obamacare co-op collapses* (July 9, 2016); *Illinois Moves to Shut Down Failed*  
9 *Co-Op* (July 13, 2016); *Why Obamacare Co-ops Keep Failing* (November 26, 2015).<sup>1</sup> Two of  
10 the recently failed co-ops (Oregon and Illinois) have plans for a special enrollment for the  
11 displaced members, with all of the problems coincident to a mid-year transition.

12  
13 **Q. What are the potential implications for Anthem if CHO fails or its enrollment is**  
14 **significantly restricted?**

15 A. The implications of the carrier with dominant marketshare failing or in essence capping  
16 membership are very significant and introduce additional risk for Anthem and the other carriers.  
17 As discussed in the Prefiled testimony of Dee Clamp and Zach Fohl ("Clamp/Fohl prefiled"),  
18 CHO does not participate in Wakely, so there is no assessment of the risk of the market until we  
19 receive the risk adjuster determinations from CMS. The data reflect that, while Anthem's  
20 enrollment was less risky in 2015 than 2014, the market as a whole (dominated by CHO), was  
21 materially more risky than Anthem's enrollment. If CHO fails or is forced to limit its enrollment

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<sup>1</sup> The full text of these articles are available at <http://www.breitbart.com/big-government/2016/07/07/connecticut-obamacare-co-op-going-business/>; <http://hotair.com/archives/2016/07/09/oregon-fail-another-obamacare-co-op-collapses/>; <http://abcnews.go.com/Health/wireStory/illinois-moves-shut-failing-insurance-op-40531933>; and <http://reason.com/archives/2015/11/26/why-obamacare-co-ops-keep-failing>.

1 significantly, the members that drive CHO's heightened risk will be absorbed by the other  
2 carriers in the market (including Anthem) and, if after 2016, at a time when the federal  
3 reinsurance safety net has been eliminated.

4

5 **Q. If Anthem's enrollment becomes more risky because of an influx of riskier members**  
6 **from CHO, won't Anthem receive compensation for that risk through the risk adjuster**  
7 **process?**

8 A. It depends. The risk adjuster will not cover the risk of significant numbers of high risk  
9 members transitioning to Anthem because the risk adjuster reconciles only to the average risk for  
10 each illness, not for those who use more services than average. In addition, the risk adjustment  
11 for 2017 will not be determined until 2018. If CHO is no longer viable by that point, the risk  
12 adjustment dollars that might otherwise be due may not be paid. The risk to Anthem is even  
13 worse if CHO fails mid-year (as the most recent three co-ops did) or not sufficiently in advance  
14 of a policy anniversary for adequate planning to occur.

15

16 Perhaps of greater impact, there will be no reinsurance to cover high dollar claims in 2017. CHO  
17 received approximately \$41 million in reinsurance for 2015, more than six times the amount that  
18 Anthem received. This means that CHO has in its current enrollment a significant number of  
19 members with very high-dollar claims, higher average high-dollar claims or some combination  
20 of both, particularly as it compares to Anthem's large claims. Anthem's rate development does  
21 not include the risk of taking on a significant number of CHO's enrollment, including these high-  
22 dollar claims for which there will be no reinsurance safety net available.

23

1 **Q. Why does Anthem's risk increase if CHO were to fail mid-year?**

2 A. Because of the potential that the transitioning members would be allowed to take credit  
3 for the amounts that they accumulated toward their deductibles and coinsurance prior to  
4 transitioning to their new carrier. If that were permitted, the new carrier would essentially take  
5 on the risk of the new members and with a reduced deductible for the member and without  
6 having received any of that member's premium. For example, assume a CHO member has  
7 \$3,000 of qualifying health care expenses prior to transitioning on July 1, 2017 to an Anthem  
8 policy with a \$6,650 out of pocket maximum. In that hypothetical, Anthem would take on the  
9 risk of that member while receiving only half a year's premium (the first half a year's premium  
10 would have been paid to CHO) and only \$3,650 remaining on the policy before Anthem would  
11 have to pick up 100% of the member's healthcare costs. Neither Anthem's existing rates for  
12 2016 nor its proposed rates for 2017 contemplates taking on that very considerable risk,  
13 particularly considering the absence of any state or federal reinsurance in 2017. That risk is  
14 exacerbated because of the inability to modify rates once they are approved. This means that  
15 rates that by virtue of the federal deadline must be developed 18 months in advance are set in  
16 stone for the rating year, even if then extant circumstances would under state law otherwise  
17 authorize a change due to their inadequacy. As evidenced by CHO's financial distress and  
18 inability to change its rates for 2016, this is a very real risk.

19

20 **Q. How big a risk is it that CHO will fail?**

21 A. I don't have access to CHO's financials, modeling, or its business plan, so it is impossible  
22 for me to know; however, I have reviewed all of the monthly reports from the Bureau as well as  
23 other publicly available information and CHO's future is uncertain. The \$10 million favorable

1 restatement for 2015 means that CHO's premium deficiency reserve should have been reduced to  
2 \$33 million, but by the end of May, CHO had already drawn down 40% of the \$43 million PDR  
3 (or approximately \$17.2 million). This leaves only \$25.8 million for the remaining seven  
4 months of the year, which are by far the most expensive from a claims perspective given that  
5 deductibles and out of pocket maximums are becoming satisfied toward the end of the year.  
6 With the inability to change its rates and nearly 60,000 members for whom it must pay claims,  
7 CHO will be very fortunate to end the year with losses of only the \$43 million PDR. It then  
8 remains to be seen how many members CHO will be able to insure going forward as its capital  
9 reserves are depleted.

10

11 **Q. What do you take away from this potential enhanced risk?**

12 A. Anthem's rates should be approved as reflected in Anthem Hearing Exhibit 3. Again, our  
13 proposed rates do not account for the potential of having to take on significant CHO  
14 membership. Reducing our rates below the level that we propose in light of the present  
15 uncertainty in this market would place Anthem at unreasonable risk and limit the  
16 Superintendent's ability to deal effectively with future unknown circumstances in a way that  
17 would not result in significant losses to the carriers in the market.

18

19 **Q. Will Anthem's risk increase even if CHO remains viable going forward?**

20 A. Yes. Even assuming CHO survives and the Superintendent lifts the suspension on new  
21 enrollment, CHO's financial difficulties have been well-publicized. Those current members who  
22 use significant services (and rely on CHO to pay for those services) may well shift their  
23 enrollment to Anthem or another carrier during the next open enrollment period. This shift may

1 be even more pronounced given that the prior premium rate disparity between the CHO and the  
2 rest of the market will be dampened or disappear entirely for 2017. With no pricing advantage  
3 and a challenging financial record, we would expect a fair number of CHO's current members to  
4 make the decision to switch to Anthem or another carrier. As explained in the Clamp/Fohl  
5 prefiled, based on the risk adjustment information provided by CMS on June 30, 2016, the  
6 average risk of the ACA individual market (largely driven by CHO's experience) was materially  
7 worse than Anthem's 2015 ACA individual population.

8

9 **Q. The rate increases proposed by the four insurers for 2017 are higher than in the**  
10 **first two years of the ACA; why?**

11 A. The development of Anthem's proposed rates for 2017 is explained in the Clamp/Fohl  
12 prefiled. At a high level, however, claims costs – particularly pharmacy costs – are increasing at  
13 a rapid rate because of expanded coverage of drugs to treat Hepatitis C and relatively new  
14 ground breaking specialty drugs, both of which are expensive. To make matters worse, the  
15 federal reinsurance program that formerly covered large claims for ACA members is being  
16 phased out and will not be in force in 2017. This means that there is no reinsurance safety net  
17 for the ACA population effective January 1, 2017. That increased risk must be accounted for in  
18 2017 rates.

19

20 **Q. Is the ACA individual market in Maine completely stable?**

21 A. It is certainly more stable than the legacy market, but no, the individual ACA market is  
22 not completely stable. The premise of the ACA is not just that everyone eligible will have  
23 insurance coverage, but that all eligible consumers must obtain coverage. Rather than solely

1 guaranteeing availability and renewability with no underwriting (as Maine regulations provide),  
2 the ACA mandates that all individuals must obtain coverage. The theory being that younger,  
3 healthier members are nonetheless required to participate in the ACA and obtain coverage and  
4 those premium payments (without a corresponding level of claims) would help absorb the costs  
5 of older, less healthy members among a larger, and overall healthier, population. This social  
6 contract would then lead to greater premium rate stability than an environment (like the pre-ACA  
7 Maine individual market) in which participation was guaranteed, but not required. While that to  
8 some degree has occurred and the individual marketplace in Maine is more stable than in the pre-  
9 ACA days, full implementation of the ACA was delayed, the penalties for failing to obtain  
10 coverage have not been significant enough to drive younger and healthier members to enroll in  
11 sufficient numbers to offset the significant increases in claim costs, driven primarily by  
12 pharmaceutical cost increases, and the 90-day premium grace period still allows consumers to  
13 game the system by maintaining coverage for the full year without paying the corresponding  
14 premiums. The industry as a whole has also learned that the ACA business is far more risky than  
15 anticipated. *See, e.g., Blue Cross and Blue Shield Association, Statement for the Record to*  
16 *Committee on Energy and Commerce Subcommittee on Health, U.S. House of Representatives*  
17 *(June 9, 2016), p. 2 (“Experience from the past two and a half years shows that the newly*  
18 *enrolled individuals are older than originally projected; have higher rates of certain conditions*  
19 *(e.g., hypertension, diabetes, depression, coronary artery disease, HIV and Hepatitis C); use*  
20 *more medical services; and have much higher costs.”).*

21

22 **Q. What tells you that the ACA business is riskier than expected?**

23 A. Several factors. First, as explained above, our own observations of Anthem’s Individual

1 ACA block tell us that claim costs are rising and those increases are not being offset by the  
2 influx of younger, healthier members. Second, as we look across the Maine individual market,  
3 the carrier with the largest enrollment (CHO) is experiencing serious financial issues to the point  
4 that it is subject to increased regulatory oversight and its continued, long-term viability is  
5 unknown. Third, the risk associated with Individual ACA plans has not been confined to Maine.  
6 As reflected by carriers sustaining losses nationwide in the billions of dollars, federally  
7 sponsored co-ops failing, and some of the nation's largest health insurers pulling out of the  
8 Individual ACA space entirely, it has become clear that the Individual ACA marketplace with its  
9 existing population is far riskier than anticipated. Given the similarity of plan requirements and  
10 lack of "teeth" to the penalty for the individual mandate and 90-day premium grace period  
11 during which coverage remains whether or not premiums are paid, it is not surprising that  
12 carriers nationwide are experiencing unexpected risk levels in the Individual ACA marketplace.  
13 Finally, the elimination of the reinsurance safety net means the full claims risk is borne by the  
14 carrier and, with the annual re-enrollment process, members routinely transition among the four  
15 carriers, making it difficult to assess forward-looking risk at the carrier level.

16

17 **Q. Is Anthem proposing any changes to its filing as a result of this increased risk?**

18 A. Yes. As explained in the Clamp/Fohl prefiled, we are proposing a modest increase in the  
19 margin that is included in the current rates for post-tax profit and risk.

20

21 **Q. Why should the Superintendent approve rates that include an increase in the**  
22 **margin for risk and profit?**

23 A. For several reasons. First, as reflected above and in the Clamp/Fohl prefiled, the ACA

1 plans are materially more risky than expected and the existing margin is too slim to account for  
2 that risk.

3

4 Second, and relatedly, our significant experience in the Maine individual market is that, once we  
5 get behind in charging adequate rates, it is very difficult to return to a level of appropriate  
6 adequacy. That is, rates that are less than adequate for a given year may be very slightly more  
7 popular with consumers, but that is often followed by losses and higher rate increases in the  
8 future because the delta between the existing rate and an adequate rate for the rating period is  
9 larger than it should be, which leads to greater rate shock for members. The result is that any  
10 minimal benefit gained by the prior lower premium rate is substantially overtaken by the adverse  
11 impact of future rate increases that are higher than they would need to be if rates are set more  
12 appropriately for the risk involved.

13

14 Third, as we have seen, rates that are not adequate can result in unnatural marketshare, which  
15 exacerbates losses and can ultimately cause far-ranging effects to providers and insurers and  
16 their members.

17

18 Fourth, the ACA market is growing and healthier than the pre-ACA marketplace, but it has not  
19 yet stabilized for any carrier. The annual re-enrollment process likewise adds to the risk as  
20 analysis of existing enrollment has more limited value than when membership is more constant.

21

22 Fifth, the loss of federal reinsurance is significant, particularly as the membership freely  
23 transitions among multiple carriers, thereby limiting our ability to assess claim patterns over an

1 extended period of time.

2

3 Finally, based on our filing, we estimate that approximately 87 cents of every premium dollar  
4 our members spend will be used to cover medical claims and improve health care quality, well  
5 above the ACA-required amount. This further demonstrates that Anthem's rates are reasonable,  
6 but in any event, not excessive.

7

8 **Q. Do Anthem's financial results support an increase in the margin covering risk and**  
9 **profit?**

10 A. Yes. We have reviewed the 2014-15 financial results and discovered that they were  
11 influenced significantly by lower than expected national enrollment, which led to higher than  
12 expected reinsurance reimbursements (*i.e.*, the enrollment was lower, but the amount available  
13 for reinsurance did not change, so the per-enrollee amount available for reinsurance increased).  
14 Even with those factors playing in Anthem's favor, the positive financial results that we thought  
15 had occurred in 2015 were eliminated almost entirely by the \$3.9 million risk adjustment  
16 payment that CMS assessed on Anthem as part of its June 30, 2016 announcement. That is, even  
17 with reinsurance protection, the risk of Anthem's individual ACA business (in the form of the  
18 risk adjustment) took up the entire 2015 risk/profit margin, leaving essentially \$0 in post-tax  
19 profit for Anthem having taken on the risk of paying approximately \$45 million in claims. The  
20 risk outlook for both the current year of 2016 and the upcoming 2017 year are potentially worse.

21

22 With the elimination of federal reinsurance, the factor that drove even the \$0 financial results for  
23 2015 will not exist in 2017. Starting in 2017, the stabilization from federal reinsurance will be

1 gone and there will likely be a material shift in enrollment: with CHO likely no longer  
2 underpricing the other competitors and with the need for regulatory oversight to ensure its  
3 ongoing viability, a significant number of the very enrollees that produced the losses for CHO  
4 likely will enroll with Anthem or another carrier. Maintaining a stagnant risk/profit rate  
5 component in light of this increasing risk would increase the likelihood of losses in 2017 and,  
6 correspondingly, the need for higher rate increases in future years. A modest increase in the risk  
7 component now does not yield excessive rates and will also assist in muting future rate increases,  
8 in the absence of which the gap between existing and adequate rates grows and the market could  
9 begin the tailspin that plagued the legacy individual block for more than a decade.

10

11 **Q. Does the increase in time and attention required for ACA plans increase the costs of**  
12 **providing the ACA plans?**

13 A. Yes, administering the ACA plans is expensive. While the ACA plans contain similar  
14 benefits, the volume and extent of consumer calls is significantly greater than for non-ACA plans  
15 and includes plan questions, changes in benefits, questions concerning subsidies and claims  
16 process for Cost Sharing Reduction subsidy members. Plans also change each year as benefits  
17 have to comply with AV levels and/or we discover in this new and evolving market that changes  
18 should be made. Given the early plan and rate filing requirements of the ACA, a team at Anthem  
19 begins to meet more than a year ahead of time to start planning for new products; in fact, we are  
20 already working on our 2018 product portfolio. In addition to the ACA requirements surrounding  
21 rates and products, Anthem must also support developing and analyzing the mid-year risk  
22 adjusters process. All of this means the actuarial team assigned to the ACA plans is engaged from  
23 April-October of each year to do the actuarial work to support filings for rates and plans that will  
24 become effective 18 months later. This is a far more complex process than was required to  
25 manage non-ACA business.

1

2 **Q. Is that increased complexity reflected in the administrative expense charge in the**  
3 **proposed rates?**

4 A. Yes. We previously had hoped that certain of the costs would abate and/or find them to  
5 be non-recurring. We have since learned, however, that it simply costs more to administer this  
6 business in light of the complexities and processes noted above. Notwithstanding this increase,  
7 the \$36.70 PMPM in the proposed rates represents less than 8% of the average premium and, with  
8 an estimated 87.4% Federal Medical Loss Ratio, Anthem's members receive very good value for  
9 their premium dollars.

10

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

12 A. No, as noted above, the competitive marketplace effectively prevents carriers from  
13 offering rates that are too high, and so it is here: Anthem's rates are designed to cover all costs  
14 (claims, administrative expenses, taxes, and assessments) with an estimated 87.4% Federal  
15 Medical Loss Ratio, well above the ACA requirement, and allow for a modest 2.24% after-tax  
16 safeguard to cover the risk of the business, plus allow for a reasonable return. Those same factors  
17 demonstrate that Anthem's rates are not inadequate: they are designed to cover the full cost of all  
18 expected claims (which expectation is based on the assumption that CHO will remain viable  
19 through the rating period), the cost to administer the ACA plans, and include a small amount for  
20 risk and profit. Finally, having complied with the AV and other requirements of the ACA, the  
21 rates are not discriminatory.

22

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

1 A. Yes.

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

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IN RE:	)	
	)	
ANTHEM BLUE CROSS AND BLUE	)	
SHIELD 2017 INDIVIDUAL RATE	)	
FILING	)	CERTIFICATE OF SERVICE
	)	
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 William Whitmore on the persons and at the addresses indicated below.

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DATED: July 15, 2016

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