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December 3, 2015

Eric Cioppa
Superintendent of Insurance
Maine Bureau of Insurance
34 State House Station
Augusta, Maine 04333-0034

Re: Anthem Request for Authorization to Discontinue and Replace Legacy Individual Health Plans Effective January 1, 2017

Dear Superintendent Cioppa:

Pursuant to 24-A M.R.S. § 2850-B, Anthem Health Plans of Maine, Inc. (“Anthem”) requests that the Superintendent authorize Anthem to discontinue the existing grandmothers (“GM”) and grandfathered (“GF”) individual health plans effective January 1, 2017 and replace those existing plans with plans that are in compliance with the Affordable Care Act (“ACA”). While for the reasons set out herein it is in the best interests of the policyholders to migrate both segments of the legacy population effective January 1, 2017, the reasons to authorize discontinuance of the GM and GF plans differ.

Because transitional relief for GM members will expire on October 1, 2016, the GM plans cannot be renewed on or after January 1, 2017. To avoid the potential of a gap in member coverage and ease their transition to ACA-compliant products, pursuant to 24-A M.R.S. § 2850-B(3)(G)(3), for the reasons the Superintendent previously found, it is in the best interests of the policyholders to discontinue the existing grandmothers individual health plans effective January 1, 2017 and replace those existing plans with plans that are in compliance with the ACA and in a manner consistent with the Decision and Order issued by the Superintendent in Docket No. INS-13-803 (the “GM Order”).

While GF plans will not expire as a matter of law, it is also in the best interests of GF policyholders to discontinue and replace the GF plans coincident with the GM members’ transition to ACA-compliant products. As will be explained below, Anthem’s individual ACA and legacy blocks are going in very different directions:

- The ACA block is growing in enrollment; the legacy block is rapidly declining;
- The ACA block is open to new enrollment; the legacy block is closed;

- The ACA block already has over 17,500 members; we expect the legacy block will have fewer than 3,500 members by January 1, 2017 when the grandmothers migrate;
- ACA morbidity is stable; legacy morbidity continues to deteriorate and will deteriorate even more rapidly when the healthier grandmothers migrate;
- ACA rates are relatively stable; legacy rates are subject to double-digit increases (18.28% average increase approved for 2016, up from 13.40% the prior year, which demonstrates the block's continuing deterioration) and higher increases when the healthier GM members migrate;
- ACA provides the opportunity for subsidies; legacy policyholders pay for subsidies, but cannot receive them;
- The ACA block is and will remain viable going forward; the legacy block is in a death spiral; and
- Anthem's proposed migration is projected to produce a net premium savings of over \$7.6 million in 2017.

The question here, as in any proposed discontinuance and replacement, is whether it is in the best interests of the GF policyholders to discontinue their current legacy plans and replace them with ACA-compliant plans. Anthem firmly believes the answer is "yes." Remaining in a closed, stand-alone block in an accelerating death spiral does not provide a viable future for GF policyholders. Transitioning to ACA plans does, providing a much-needed lifeline for this cohort of Anthem policyholders.

The background and details of Anthem's proposed migration of these plans follow.

I. BACKGROUND

As of September 2015, Anthem's legacy block consisted of approximately 2,112 grandfathered and 1,753 grandmothers policyholders. GF policyholders are those who purchased plans prior to the enactment of the ACA on March 23, 2010 and have since made no modifications to their plans that would pierce their grandfathered status. GM policyholders are those who purchased their plans on or after March 23, 2010, but before January 1, 2014 and who continue to be enrolled in those plans. While they maintain this status, GF and GM policyholders are not subject to the full requirements of the ACA, most notably the requirements to cover essential health benefits, lower out of pocket maximum limits, and meet actuarial value thresholds. The attached Exhibit 1 reflects the benefit differences between the legacy members' current plans and the ACA-compliant plans to which Anthem proposes to transition those members if Anthem's proposal is approved. The greatest differential is in the cost shares and out of pocket maximums for the ACA plans, both of which act to reduce a policyholder's cost for services.

In 2013, the last time we were on the cusp of GM plans being required to transition to ACA-compliant plans, the Superintendent approved a plan to migrate GM policyholders to ACA-compliant products, recognizing that it was in GM policyholders' best interests to discontinue and replace their GM plans, rather than having those plans cancelled once renewal became prohibited by the ACA. *See* GM Order at 24. After President Obama announced a delay in the full implementation of the ACA (known as "transitional relief"), Anthem agreed to extend the GM policies beyond January 1, 2014, and the Bureau approved legacy rates for both GF and GM plans to facilitate that extension. As a result, instead of transitioning the GM policyholders on January 1, 2014 pursuant to the approved migration plan, the GF and GM policyholders have since remained combined to form Anthem's legacy block.

Once again, the GM plans are faced with an upcoming deadline following which renewal of those plans is prohibited by the ACA. Those policyholders must transition to ACA-compliant products no later than January 1, 2017. *See* CMS Bulletin dated March 5, 2014, entitled Insurance Standards Bulletin Series – Extension of Transitional Policy through October 1, 2016 ("CMS Bulletin").¹ As explained below, Anthem proposes a transition plan materially identical to that previously approved by the Superintendent when this issue last arose in late 2013.

II. THE GRANDMOTHERED PLANS SHOULD BE MIGRATED EFFECTIVE JANUARY 1, 2017

A. The GM plans must be discontinued and should be replaced with ACA-compliant plans effective January 1, 2017.

Individual health plans may be discontinued and replaced pursuant to 24-A M.R.S. §2850-B(3)(G)(3), which provides in pertinent part:

3. Renewal. Coverage may not be cancelled, and renewal must be guaranteed to all individuals, to all groups and to all eligible members and their dependents in those groups except:

...

G. When the carrier ceases offering a product and meets the following requirements:

...

(3) In the individual market:

(a) The carrier replaces the product with a product that complies

¹ Pursuant to the CMS bulletin, GM policies with policy years beginning on or before October 1, 2016 may be extended for the applicable policy year. CMS Bulletin at 2. Because the policy year for GM policyholders begins on January 1st, this would allow a maximum extension of the GM policies until December 31, 2016, requiring a transition to an ACA-compliant policy no later than January 1, 2017.

with the requirements of this section, including renewability, and with section 2736-C;

(b) The superintendent finds that the replacement is in the best interests of the policyholders; and

(c) The carrier provides notice of the replacement to the policyholder and, if a group policy subject to section 2736-C, to a certificate holder at least 90 days before replacement, including notice of the policyholder's or certificate holder's right to purchase any other product currently being offered by that carrier in the individual market pursuant to section 2736-C, subsection 3;

Here, the GM plans cannot be renewed as of January 1, 2017. Rather than simply cancel those plans as of that date and leave the members who have GM plans vulnerable to gaps in their health insurance coverage, Anthem is proposing to migrate these members to ACA-compliant plans that comply with the Maine Insurance Code and most closely match the members' current GM plans. For these reasons, Anthem's proposal is in the best interests of the GM policyholders and, if approved, Anthem will provide notice of the replacement at least 90 days in advance (that is, on or before October 1, 2016), in full compliance with the provisions of 24-A M.R.S. §2850-B(3)(G)(3)(c).

While not dispositive, Anthem's proposal and logic articulated above are in conformity with the Superintendent's 2013 findings in the GM Order.

B. If Anthem's proposal is approved, GM policyholders will be migrated to ACA-compliant, broad network coverage provided by Anthem and a broad, but more economical, drug formulary.

As reflected in Exhibit 1, the plans to which the GM policyholders will be transitioned in many cases cover more services and require less out of pocket expenses than their current legacy plans. In addition to covering all EHBs, ACA-compliant plans must meet actuarial value limits and have lower out of pocket maximums. If Anthem's proposal is approved, GM members will have plans that cover more services and start covering 100% of the cost of services sooner, thereby allowing members to seek out services when needed, rather than delaying or foregoing services that would result in an out of pocket expense for a member with a \$15,000 deductible, an underlying premise of the ACA's lower deductible plans. For some members, delaying or foregoing care leads to worsening health and, ultimately, higher claims in the future. With lower deductible plans and lower cost shares, those same members are more likely to seek services sooner and, in some cases, will have better health outcomes and better overall health. While difficult to quantify in dollars and cents, the enhanced cost shares and lower out of pocket expenses will lead to real, valuable, benefits for the GM members.

It is also the case that each year, a number of high-deductible legacy members have claims that exceed the \$6,850 ACA out of pocket maximum. For example, in the 21-

months ending September 30, 2015, nearly 600 high-deductible legacy members had claims that exceeded \$6,850 and, for that group, the average claims were over \$30,000. With an out of pocket maximum differential of over \$8,000, most (if not all) of these members would have benefited from being insured via an ACA product.

Consistent with the GM Order, *see* GM Order at 2, Anthem herein proposes that GM policyholders will be transitioned to ACA-compliant plans that include the same type of broad network to which those policyholders currently have access.² Thus, migrated GM policyholders will have the option of remaining with a broad-network ACA-compliant Anthem plan, or choosing among the other options currently available in the individual market.³ As a result, Anthem's proposal would transition each GM policyholder to the most comparable Anthem ACA-compliant, broad network plan available.⁴

In Docket INS-13-803, Anthem proposed to transition GM members to plans that included cost-saving changes to the prescription drug formulary. After reviewing the proposed changes, the Superintendent found, in relevant part, as follows:

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.

(GM Order at 21.)

Anthem proposes to use the same formulary for the migrated GM plans as the Superintendent previously approved for use with the migrated GM plans. That formulary provides coverage for over 24,000 drugs. It includes one drug in every category and class, and therapeutically-equivalent drugs for the vast majority of the drugs currently covered under the legacy formulary. A small number of drugs (approximately 150) currently covered under the legacy formulary are not covered by a therapeutically-

² As noted in prior proceedings, provider networks are not static, but rather in a constant state of flux. Thus, by "same" network, Anthem means the providers in its broad network.

³ As approved in the GM Order, Anthem would migrate GM policyholders to an off-exchange, broad network plan. As has been Anthem's practice, Anthem will include in the discontinuance and replacement notice additional notification that the policyholder may qualify for subsidies when purchasing insurance through the health exchange and provide links to sites that guide the consumer in making that determination.

⁴ Anthem will migrate the GM policyholders to plans for 2017 that reflect the most recent actuarial value calculator approved by CMS.

equivalent drug under the new formulary (a “non-formulary drug”). For those instances in which a legacy member is currently using a non-formulary drug, Anthem will confirm that the drug is pre-authorized and, if so, continue to cover the drug after the member transitions. In short, if the member needs the drug, the drug will be covered.

For the same reasons articulated by the Superintendent in the GM Order, substitution of the new formulary is in the best interests of the GM policyholders.

Anthem has attached as Exhibit 2 a draft notice to GM policyholders that would be mailed at least 90 days in advance of the January 1, 2017 discontinuance of the GM plans.

III. THE GRANDFATHERED PLANS SHOULD BE MIGRATED EFFECTIVE JANUARY 1, 2017

A. GF plans may be discontinued under Maine law if discontinuance and replacement is in the best interests of the policyholders.

Before discussing the facts and circumstances that support Anthem’s discontinuance and replacement request, it is first proper to discuss whether discontinuance and replacement of the GF plans is permissible under state and federal law. It is.

The GF plans are grandfathered from having to comply with the full requirements of the federal ACA because those plans were purchased prior to the enactment of the ACA and have remained substantially unchanged since that time (“GF plans” or “GF policyholders”). There is nothing in the ACA – or federal law generally – that prohibits an otherwise lawful change to GF plans that results in those plans becoming ACA compliant. More specifically, GF plans do not, as a result of that status under federal law, become immunized from the provisions of Maine state law.⁵ To the contrary, GF plans are subject to the requirements of Maine law, including guaranteed renewal, *see* 24-A M.R.S. §2850-B(3). They are also subject to discontinuance and replacement, just like any other Maine plan.

As noted above, discontinuance and replacement of individual health insurance plans is governed by 24-A M.R.S. § 2850-B(3)(G)(3), which provides in relevant part as follows:

⁵ The intent of the ACA is to grow the number of persons covered by ACA-compliant plans; indeed, those non-grandfathered individuals who fail to obtain minimum essential coverage must pay a monetary penalty. It is thus not surprising that nothing in the ACA prohibits non-compliant plans from becoming ACA compliant as a result of the operation of a state law. Also, nothing in the ACA requires continuation of GF plans.

3. Renewal. Coverage may not be cancelled, and renewal must be guaranteed to all individuals, to all groups and to all eligible members and their dependents in those groups except:

...

G. When the carrier ceases offering a product and meets the following requirements:

...

(3) In the individual market:

(a) The carrier replaces the product with a product that complies with the requirements of this section, including renewability, and with section 2736-C;

(b) The superintendent finds that the replacement is in the best interests of the policyholders; and

(c) The carrier provides notice of the replacement to the policyholder and, if a group policy subject to section 2736-C, to a certificate holder at least 90 days before replacement, including notice of the policyholder's or certificate holder's right to purchase any other product currently being offered by that carrier in the individual market pursuant to section 2736-C, subsection 3 . . .

Importantly, the statute does not require that all policyholders concur in the discontinuance and replacement. Indeed, if that were the case, the statute would be a nullity, relying instead solely on each individual policyholder's preference and requiring that existing plans remain in place so long as any policyholders choose to keep their plans, whether or not it makes sense for the policyholders as a group to do so. That is not the law. Instead, Section 2850-B(3)(G) places the decision for the policyholders squarely with the Superintendent, tacitly acknowledging that it is up to the Superintendent to decide if and when it is in the best interests of the policyholders as a group to transition to new plans.⁶

Consistent with the GM Order in INS-13-803, the GF plans will be mapped to the closest-matching ACA-compliant plans, will use a broad network, and will otherwise meet the requirements of the Maine Insurance Code. Anthem will provide the required notice to the affected policyholders at least 90 days before the January 1, 2017 replacement (that is, on or before October 1, 2016). Attached hereto as Exhibit 3 is Anthem's proposed GF mapping, which includes the in-force counts by product and

⁶ This is also consistent with the pooling concept of insurance: costs are spread among a group, meaning that some will pay more than they cost individually, and some will pay less than their actual individual cost. The collective good – rather than individualized circumstances – is the focus.

deductible.⁷ As is demonstrated below, the replacement is also in the best interests of the GF policyholders.

B. Background

We noted in Section I above the partial implementation of the ACA on January 1, 2014 and effect of the interim transitional relief. In addition to being the date that officially closed the legacy block to new policyholders, January 1, 2014 also marked the termination of reinsurance for high dollar claimants previously provided by the Maine Guaranteed Access Reinsurance Association (“MGARA”).

As early as 2001, the Bureau warned that the Maine individual insurance market was in a death spiral:

Rates have risen steeply in the past two years, making coverage unaffordable for many. This not only results in more people becoming uninsured, it also can cause a deterioration of the average health of the remaining pool of risks. This is because those who have health problems and utilize their insurance benefits are much less likely to drop coverage than are healthy individuals. In turn, deterioration of the risk pool could lead to further rate increases, causing more people to drop coverage. If this cycle were to continue, it could lead to a collapse of the individual health insurance market. This phenomenon of a shrinking pool of risks and higher insurance rates is sometimes referred to as a “death spiral.”

(Maine Bureau of Insurance White Paper: Maine’s Individual Health Insurance Market (Updated January 22, 2001), Executive Summary at 1.)

The Bureau’s prediction about the future of the individual market in Maine turned out to be accurate.

For much of the decade that followed the 2001 whitepaper, premiums in the Maine individual insurance market were subject to double digit premium increases annually as increasing claim costs and a shrinking population combined to drive up per-policyholder costs. For example, the average approved rate increase from 2005-2010 was 12.4%, even when including the anomalously low 1.3% increase in 2007. *See* attached Exhibit 4 reflecting the average rate increases since inception of the legacy block business. Excluding 2007, the average increase approved by the Superintendent during that period was 14.5%. Even with those increases, Anthem incurred significant losses on the legacy

⁷ Exhibit 3 reflects GF member mapping to Anthem’s products for 2016. The products have been updated to reflect the most recent actuarial value calculator approved by CMS, but are subject to change based on further guidance from CMS.

business. This means that those increases were not sufficient to cover the claims and costs plus provide the profit margin approved by the Superintendent.

MGARA became effective in July of 2012 and had a significant effect on the individual market in Maine. For example, Anthem's 2012 rate increase was only 1.7%; the increase would have been over 20% in the absence of MGARA. MGARA was suspended effective January 1, 2014, the date that federal reinsurance under the ACA became effective. *See* 24-A M.R.S. § 3953(1) (suspending MGARA while federal transitional reinsurance is in force).⁸

With no reimbursement mechanism for large claims and the block estopped from attracting new (healthy) members, premiums for GF and GM policyholders are once again on the rise. *See In re Anthem Blue Cross and Blue Shield 2014 Rate Filing*, Docket No. INS-14-1000, Decision and Order at 16 (approving an increase of 13.40% for the legacy block effective January 1, 2015); *In re Anthem Blue Cross and Blue Shield 2015 Rate Filing*, Docket No. INS-15-1000, Decision and Order at 13 (approving an increase of 18.28% for the legacy block effective January 1, 2016). With a shrinking block that is closed to new enrollees and the imminent exit of all GM members, it is virtually certain that the trend of rising premiums will continue.

While legacy plan policyholders are not eligible for subsidies, their premiums include the federal insurer fee, which is used to fund those subsidies. At an estimated 2.90% of premium, this fee is not insubstantial and, like the fee to fund the federal reinsurance program, is a cost to legacy plan policyholders, with no corresponding benefit.

C. The combination of a closed block, declining membership and removal of the GM membership will lead to significant rate increases for the remaining GF policyholders.

i. Enrollment in the closed legacy block is declining rapidly.

As noted above, the legacy block is closed and, as a result, its enrollment can only get smaller. During the first open enrollment period, the legacy block enrollment declined by more than 6,483 members, to 7,110 policies covering 11,350 members, a decline of approximately 37%. A similar decline occurred during the second open enrollment period. As of May 2015, the legacy block consisted of 4,093 policies covering 7,366 members, a decline of over 35%. This is in sharp contrast to the block's peak of approximately 35,000 members in 2003, when the block was open. The decline in legacy membership is represented graphically below.

⁸ Prior to January 1, 2016, the joint standing committee of the Legislature will study MGARA and the federal reinsurance program and make a recommendation to the Superintendent whether MGARA should resume operations and may submit a bill to the Legislature based on its findings following the study.



Effective January 1, 2017, all of the GM members must migrate to ACA plans. This means that even if no GF members lapse during the third open enrollment period beginning in November, 2016, the dwindling legacy block will have fewer than 4,000 members as of January 1, 2017.

So far, as policyholders have lapsed from the closed legacy block, the overall experience of the block has deteriorated. With no reinsurance available to subsidize large claimants, a smaller and smaller number of legacy block policyholders will have to shoulder 100% of the block's claims. This in and of itself will lead to large annual rate increases.

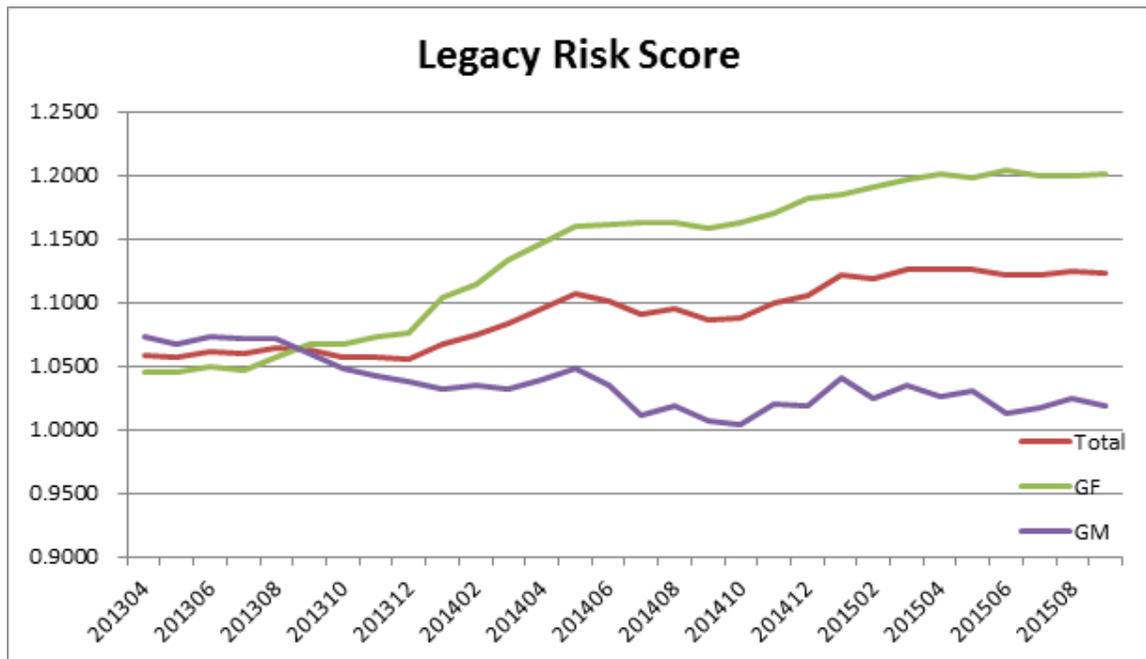
- ii. **When the healthier GM members transition to ACA plans, rate increases for the remaining, less healthy, legacy block will accelerate.**

As we consider the future, the internal demographics of the closed legacy block are also important. The two segments (GF and GM) each represent approximately 50% of the current legacy block enrollment. While the legacy block premium rates will increase in 2016 by an average of 18.28%, the experience of the GF block was materially worse than the GM block.

This disparity is significant for two reasons. First, it reflects that for so long as GM members are included with GF members in the legacy block, legacy rates will be suppressed on a per-enrollee basis by both the number and relative health of the GM members. That per-enrollee cost will increase materially when the GM members migrate.

Second, there is no reason to expect that in the future, the closed GF-only legacy block will reverse course and somehow become healthier. To make such an assumption, particularly in the face of significant annual premium increases, would be contrary to actuarial judgment and experience. (*See, e.g.* Docket No. INS-14-1000 Decision and Order at 7 (“Given the 2014 experience, a special morbidity adjustment is reasonable.”); *see also* Docket INS-14-1000, Hearing Transcript at 181, Ins. 20-24: AG actuary Fritchen agreeing that policyholders who use more services are more likely to keep their plan when faced with a rate increase.)

The risk scores for the GF and GM policyholders since 2013 are consistent with the disparity in the claims experience between the two segments of legacy policyholders. The graph below reflects the disparity in risk scores and the generally poorer health of the GF members relative to GM members.



These morbidity statistics are important for two reasons.

First, the legacy block enrollment will decline by approximately 50% on January 1, 2017. As a block shrinks, the effect of large claims on the block becomes more pronounced. Declining membership in a closed block, in and of itself, will drive rate increases greater

than even the pre-MGARA levels. Second, the loss of the GM membership will mean that the legacy block (at that point consisting entirely of GF members) will be alone in absorbing the deteriorating GF morbidity that is currently spread out among a larger block that includes, on average, healthier GM members. In effect, then, the risk score for the legacy block will match the green “GF” line depicted in the graph above.

When (not if) legacy block membership declines significantly and when (not if) the GM members transition to ACA-compliant products, necessary rate increases for the remaining GF policyholders will (not may) accelerate.

D. It is in the best interests of GF policyholders to transition them to ACA-compliant, broad-network plans effective January 1, 2017.

i. Maintaining the status quo will result in an accelerating death spiral for the GF policyholders.

Anthem has expressed its desire to allow the GF policyholders to maintain that status for as long as it was practicable. As we look to what the future holds for GF policyholders, however, it has become clear that the question is not if GF policyholders should transition to ACA-compliant plans, but when.

GF policyholder costs currently are subsidized both by a relatively large number of policyholders (approximately 4,000) and by the relatively healthier GM members (see discussion of morbidity differentials, above). Even with those additional, healthier, policyholders absorbing costs, rates will increase by 18.28% in 2016.

As demonstrated above, both of these elements – the relative size of the legacy block and inclusion of GM policyholders – are shortly coming to an end, which will lead to higher rate increases. As the level of increases rises, the number of lapses will follow suit, which will lead to even higher costs and premium increases; a classic example of a death spiral.

Remaining in the death spiral of a closed block is not in the best interests of GF policyholders, particularly when there are other alternatives available to them.

ii. Transitioning GF policyholders to ACA compliant plans will effectively halt the death spiral and place the GF policyholders in a more stable and larger growing (not declining) block of business, thereby spreading GF member claims over a broader base.

If maintaining GF plans post-GM migration is unsustainable, the question then becomes whether January 1, 2017 is the right time to transition the GF policyholders. After careful consideration, we believe the answer is yes. Relative to the average legacy plan,

ACA plans cover more services and generally have lower maximum out of pocket costs. Thus, at a high level, the only reasons it would be in the best interests of GF policyholders to remain in their current legacy plans is if (1) the policyholder prefers Anthem as a carrier and the proposed replacement would not provide a comparable Anthem ACA-compliant product; or (2) the legacy plans are, and will remain, materially less expensive. As we discuss each in turn, it is important to recognize the block (versus subscriber) level view implied in the Superintendent's responsibility to approve discontinuance if it is in the best interest of this GF block.

- a. **If Anthem's proposal is approved, GF policyholders will be migrated to ACA-compliant, broad network coverage similar to the plans approved in the GM Order and using a formulary previously approved for the GM migration.**

In the GM Order, the Superintendent approved migration of the GM policyholders to ACA products that Anthem planned to have in place effective January 1, 2014. *See generally*, GM Order. Since that time, CMS has made changes to the actuarial value calculator and adjusted the out-of-pocket maximums, which in turn required changes to some of the plans approved for migration in the GM Order. Anthem also has the benefit of nearly two years of experience with ACA plans and factored that experience in when developing plans that best serve the market and keep premiums reasonable. While the plans Anthem proposes for transition here are materially similar to those approved for the GM migration, Anthem developed products for January 1, 2016 that are consistent with the GM Order, that meet the new actuarial value requirements, and best serve the ACA market.⁹

Similar to its migration plan for GM policyholders, GF policyholders would be transitioned to ACA-compliant plans that include the same type of broad network to which those policyholders currently have access. Like the GM policyholders, migrated GF policyholders would have the option of remaining with a broad-network ACA-compliant Anthem plan, or choosing among the other options currently available in the individual market.¹⁰ Anthem's proposal is thus consistent with the GM Order's approved migration of the GM policyholders.¹¹

⁹ CMS has not yet finalized the actuarial value calculator that will be in effect for 2017. As a result, Anthem proposes that the Superintendent approve the migration and mapping proposed in this docket, subject to Anthem submitting a compliance filing in 2016 after CMS has finalized the new AV calculator and Anthem has made any changes to the proposed mapping that result from changes to the AV calculator.

¹⁰ Similar to the migration plan for the GM policyholders, Anthem would migrate GF policyholders to an off-exchange, broad network plan. As has been Anthem's practice, Anthem will include in the discontinuance and replacement notice additional notification that the policyholder may qualify for subsidies when purchasing insurance through the

Nearly half of GF members are in plans with deductibles greater than the ACA out of pocket maximum (\$6,850 for 2016). As we pointed out above, with lower deductible plans and lower cost shares, some members may seek out services sooner and, in some cases, this may result in better health outcomes. Certainly for those high-deductible GF policyholders who experience a significant claim, the lower out of pocket cost for the policyholder will be a direct benefit.¹² While difficult to quantify in dollars and cents, the enhanced cost shares and lower out of pocket expenses will lead to real, valuable, benefits for the high-deductible GF members. Some of the high-deductible GF members may also qualify for catastrophic plans under the ACA. While those plans are not subsidy-eligible, members may still find high-deductible/reduced premium plans that are also ACA compliant if they qualify for catastrophic plans.¹³

Policyholders currently with lower deductible legacy plans may be transitioned to plans with higher out of pocket maximums, but the premium savings associated with those plans in most cases is greater (and often materially greater) than the difference between the policyholder's current deductible and their new ACA out of pocket maximum. Traditionally, those opting for lower deductible plans tend to incur more claims and, accordingly, the trade-off of a lower premium for a somewhat higher out of pocket maximum will be a net benefit to those policyholders.

Anthem proposes to use the same formulary for migrated GF members as for migrated GM members. For the same reasons articulated by the Superintendent in the GM Order, substitution of the new formulary is in the best interests of the GF policyholders.

health exchange and provide links to sites that guide the consumer in making that determination.

¹¹ Anthem previously filed for approval of ACA-compliant, broad network plans for purposes of migrating GM policyholders. Anthem has developed updated plans that comply with the new actuarial value calculator and will be in place for 2016. Those updated plans would be used for the GF migration pending changes to the actuarial value required by CMS.

¹² As discussed above, each year a number of high-deductible legacy policyholders experience claims that exceed the \$6,850 ACA maximum. With claims for these members averaging over \$30,000, a \$6,850 out of pocket maximum would be a significant benefit.

¹³ Exemptions that would allow the purchase of a catastrophic plan are also available under certain circumstances.

iii. Projected pricing differentials will not justify GF policyholders maintaining legacy plans.

Because of the disparity between premium increases for ACA versus legacy products, the gap between legacy and ACA rates has narrowed considerably and, in many cases, been eliminated altogether.

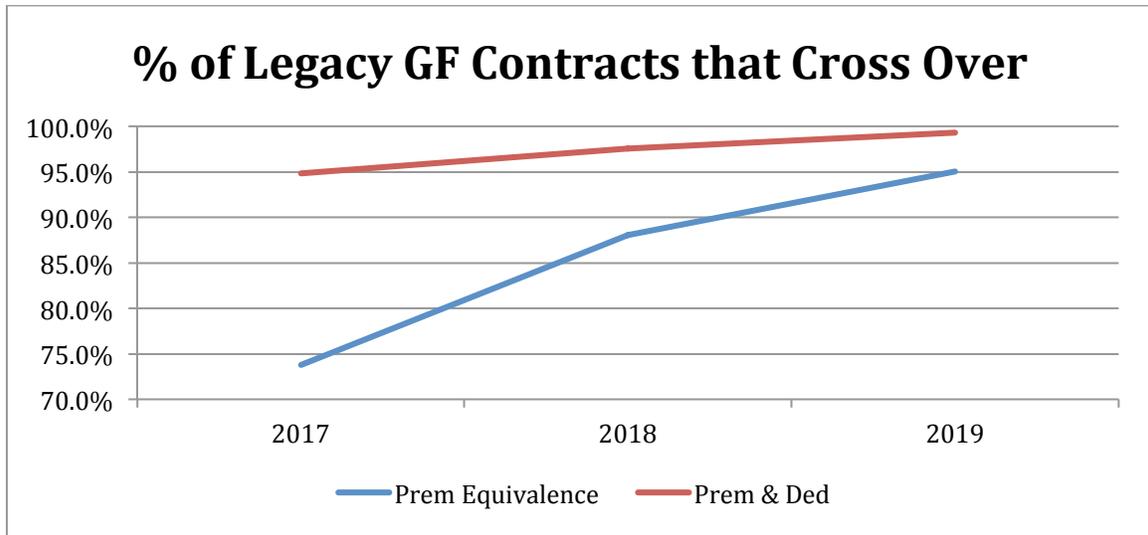
If the migration is denied, Anthem will need to file for a rate increase effective January 1, 2017. Because it is too soon to develop a detailed rate development, to analyze how premiums would compare with and without the proposed migration on a go-forward basis, Anthem assumed that the existing (*i.e.*, 2016) rate differential between legacy and ACA rates – with some objectively-necessary adjustments – would persist. For 2017 premiums, Anthem compared the approved 2016 ACA rate increase (4.8%) to the legacy rate increase approved for 2016 (18.28%), adjusted solely to reflect (1) the effect on morbidity of the loss of all of the healthier GM members; and (2) a slight increase in the PMPM administrative expenses to reflect the fact that the fixed expenses of the legacy block would be absorbed by approximately 50% fewer policyholders.¹⁴ Anthem applied that historical rate increase to the actual GF membership, making no lapse assumptions.

The data and graph below reflect that a majority of policyholders immediately benefit from transitioning and it is just a matter of time before all of the policyholders would pay less in premium for an ACA plan than their existing legacy plan (the blue line). When considering deductible differentials, the percentage of policyholders who benefit from the proposed migration increases significantly (the red line). Neither analysis takes into account the increased likelihood that, once transitioned to an ACA plan, the existing policyholders are more likely to seek out (and many will find) a subsidy or that some existing GF members would qualify for a catastrophic ACA plan:

¹⁴ For years beyond 2017, legacy rates are assumed to increase by the average of the 2016 approved increase and the assumed 2017 increase. We made this simplifying assumption to address the fact that, starting in 2018, the GF morbidity would be reflected in the experience period (which all else equal would result in a lower rate increase), but also acknowledging that the legacy block enrollment will continue to decline (which all else equal would likely result in a higher rate increase).

% of Legacy GF Contracts that Cross over*

	Prem Equivalence	Prem & Ded
2017	73.8%	94.8%
2018	88.0%	97.6%
2019	95.0%	99.3%



*GF policyholder premiums within 5% of ACA premiums were included as having crossed over (*i.e.*, the ACA plan was deemed financially advantageous relative to the legacy plan).¹⁵

The blue line above compares legacy versus ACA premiums alone, demonstrating that a majority of the legacy policyholders would pay less in premium for an ACA plan right away and 95% would pay less by 2019. Transition to ACA plans should not be denied because some GF policyholders would pay marginally lower premiums over a very short period of time. Put another way, to deny replacement on this basis, the Superintendent would have to find that rates for the closed GF block will not rise significantly following the loss of half of its enrollment when that half (the GM members) is healthier. Even if actuarial principles would support such a conclusion about a hypothetical block of individual health insurance business (which they do not), the history of the actual legacy block at issue here would not. Premiums will indeed rise significantly.

The red line takes into account the differential in the legacy members' current deductible versus the deductible in the applicable ACA plan. It shows that 95% of legacy members

¹⁵ We believe that a 5% bandwidth is a modest differential for migrating from a closed, death-spiraling block with high deductibles and no possibility of subsidies, to a growing block with stable premiums, richer benefits and the ability to apply for a premium subsidy.

are better off immediately (*i.e.*, in 2017) with the proposed migration. Thus, even if one were to restrict consideration of Anthem's proposal to current premiums, the differential resulting from the discontinuance and replacement would be justified based on the benefit differentials between the types of plans being compared. The deductible differences between the GF plans and ACA-compliant plans to which the GF plans would be migrated are reflected in Exhibit 3. As that exhibit reflects, the differential in the deductible would dwarf the premium differential for these policyholders. Some may argue that in some years, when the policyholder and his/her family are healthy, they do not reach even the lower-deductible ACA product level, which means the out of pocket maximum – to that policyholder and in that year – is financially irrelevant. That may be true, but those same policyholders obviously want to cover the risk that they may need the coverage at some point during that plan year, otherwise, they would not purchase the insurance in the first place (and they certainly would not be a GF policyholder who of necessity has had their policy in place for more than five years, *i.e.*, since at least March 23, 2010.)¹⁶

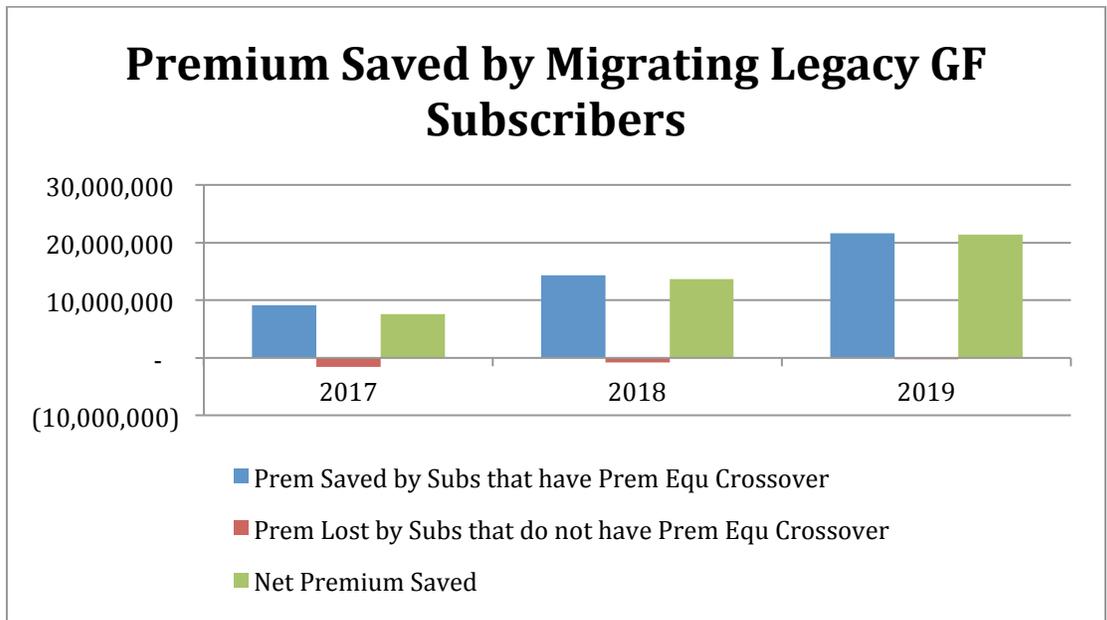
One relatively small claim can exceed even the \$6,850 maximum out-of-pocket on an ACA plan, at which point the differential in out of pocket maximums between the highest deductible legacy and ACA plans is either paid by the carrier (with an ACA plan) or paid by the policyholder (with the high deductible legacy plan).¹⁷ As discussed above, a number of those policyholders in any given year will have claims that exceed the \$6,850 ACA out of pocket maximum.

¹⁶ Again, some may qualify for a high-deductible catastrophic ACA plan.

¹⁷ Some may argue that allowing this to happen will result in GF policyholders making the choice to purchase ACA plans and, so it goes, individual preference should rule the day. That inaction, however, would ignore Section 2850-B, which requires the Superintendent to approve a discontinuance and replacement if it is in the best interests of the policyholders.

It is also very significant that the GF policyholders who would benefit by the proposed transition would benefit to a much larger extent than the increased amount paid by those who would pay more for an ACA plan:

Premium Saved by Migrating Legacy GF Subscribers			
	Prem Saved by Subs that have Prem Equ Crossover	Prem Lost by Subs that do not have Prem Equ Crossover	Net Premium Saved
2017	9,146,895	(1,534,660)	7,612,235
2018	14,380,581	(737,686)	13,642,896
2019	21,605,284	(265,592)	21,339,692



As these data and graphs reflect, the GF policyholders achieve a net benefit of over \$7.6 million if transitioned in 2017. The corollary is that the GF policyholders – as a group – would lose \$7.6 million in 2017 alone if the proposed migration is delayed. The detriment to the GF policyholders grows to over \$20 million if the migration is delayed beyond 2019.

The “premiums lost” category includes a number of high-deductible policyholders in Region 4 that have not crossed over simply due to the presence of geo rating of ACA plans, and the absence of geo rating for legacy plans. This is noteworthy because the absence of geo rating means that the legacy policyholders in Region 4 have been subsidized by the policyholders in Regions 1 and 2. Fundamental fairness would thus

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suggest that the policyholders in Regions 1 and 2 should not have to forego the significant migration benefit so that the subsidization of Region 4 may continue.¹⁸

These data points demonstrate that it is in the best interests of the GF policyholders to transition them to ACA plans coincident with the GM members, effective January 1, 2017.

Anthem has attached as Exhibit 5 a draft notice to GF policyholders that would be mailed at least 90 days in advance of the January 1, 2017 discontinuance of the GF plans.

* * *

For the reasons set forth above, replacing the GM plans and GF plans as Anthem proposes is in the best interests of the legacy policyholders. See 24-A M.R.S. § 2850-B(3)(G)(3). Anthem respectfully requests that the Superintendent issue an order authorizing Anthem to migrate the GM and GF policyholders to ACA-compliant plans effective January 1, 2017.

Anthem appreciates the Superintendent's attention to this request and looks forward to discussing it further.

Very truly yours,

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¹⁸ We recognize that the policyholders in Regions 1 and 2 could make the financially-rational decision to purchase an ACA plan. History suggests, however, that for any number of reasons, policyholders maintain plans well beyond the time when it would be financially-rational to transition to another plan. That is the very premise of the statute authorizing discontinuance and replacement when it is in the best interests of the policyholder group to do so.