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October 17, 2014

Eric Cioppa, Superintendent
Attn: Sarah Hewett
Docket No. INS-14-1000
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 2015 Legacy Rate Filing

Dear Superintendent Cioppa:

Enclosed for filing please find the following:

SUBMITTED BY: Christopher T. Roach
DATE: October 17, 2014
DOCUMENT TITLE: Prefiled Testimony of Michael Bears
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**
)
)
ANTHEM BLUE CROSS AND BLUE) PREFILED TESTIMONY OF
SHIELD 2015 INDIVIDUAL RATE FILING) MICHAEL BEARS
FOR HEALTHCHOICE, HEALTHCHOICE)
STANDARD AND BASIC, HEALTHCHOICE)
HDHP, HMO STANDARD AND BASIC, AND) OCTOBER 17, 2014
LUMENOS CONSUMER DIRECTED)
HEALTH PLAN PRODUCTS PURCHASED)
BY MEMBERS BEFORE JANUARY 1, 2014)
)
Docket No. INS-14-1000)

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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 Michael Bears, and I am the East Regional Vice President, Actuary III,
4 overseeing a team responsible for commercial pricing across Maine, New Hampshire,
5 Connecticut, Virginia, and New York, including but not limited to Individual lines of business.

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

8 A. I am a Fellow of the Society of Actuaries and Member of the American Academy of
9 Actuaries. I have held a variety of actuarial roles within the WellPoint organization over the last
10 12 years, most recently including (i) Director of Actuarial Advanced Analytics, (ii) Staff Vice
11 President of Actuarial Peer Review, a team intended to review all outgoing rate filings from an
12 independent perspective, and (iii) currently, East Regional Vice President of Commercial
13 Pricing. Prior roles at WellPoint also involved focused experience working on state reinsurance
14 pools, such as the Connecticut Small Employer Health Reinsurance Pool, and the New
15 Hampshire Small Employer Health Reinsurance Pool.

16

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

18 A. I am testifying at this hearing in support of Anthem’s individual rate filing for its legacy
19 products and proposed rate modifications effective January 1, 2015.

20

21 **Q. What are legacy products?**

22 A. Legacy products consist of grandfathered and grandmothers policies. Grandfathered

1 policies are those that were purchased prior to March 23, 2010 (the effective date of the
2 Affordable Care Act) and have been materially unchanged since that date. Grandmothered
3 policies are those that were purchased on or after March 23, 2010, but prior to January 1, 2014 and
4 have been unchanged since purchased.

5 Originally, all non-grandfathered policies were required to comply with all requirements of the
6 ACA beginning on January 1, 2014. In November of 2013, President Obama announced that full
7 implementation of the ACA would be delayed and, accordingly, that state insurance departments
8 and insurers would be permitted to extend policies purchased after March 23, 2010 and before
9 January 1, 2014 (“grandmothered policies”). Anthem thereafter combined its grandfathered and
10 grandmothered policyholders into what we now refer to as legacy products.

11 The key attribute of grandfathered and grandmothered plans is that neither is required to comply
12 with all of the requirements of the ACA. As a result, the legacy plans are treated as a separate risk
13 individual risk pool and rated accordingly.

14

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

16

17 A. The Maine individual market requires modified community rating, allowing some limited
18 pricing flexibility to recognize demographic differences in cost due to age and geographic area.
19 Morbidity differences for gender are not allowed in the individual market.

20 Prior to January 1, 2014, reinsurance of large claims was available for all individual business in
21 Maine under the Maine Guaranteed Access Reinsurance Association (“MGARA”). That
22 program allowed insurers to cede to MGARA a portion of the excess costs for members who

1 were likely to incur large claims. The cost of these claims was funded through an assessment on
2 all Maine insurers. This materially reduced the growth of premium rates for Anthem's
3 individual policyholders.

4 Effective January 1, 2014, MGARA was suspended, which means there is no longer State-based
5 reinsurance for claims in the individual market. Effective that same date, claims from
6 individuals with ACA-compliant plans became subject to federal reinsurance. Unlike ACA
7 plans, Anthem's legacy business does not qualify for federal reinsurance. The legacy plans are,
8 however, subject to the \$5.25 PMPM charge to fund the federal reinsurance program. Thus, in
9 addition to losing the stabilizing effect of reinsurance, the legacy plans are included in the
10 assessment to fund reinsurance for ACA-compliant products.

11

12 **Q. How have the regulations in Maine impacted the individual market?**

13 A. Historically, the concurrent requirements of guaranteed issue, community rating,
14 mandatory benefits and the prohibition on medical underwriting have had a major impact on the
15 level of premium and on the necessity for premium increases in Maine's individual market. The
16 MGARA program dampened the effect of these issues by creating a reinsurance mechanism that
17 socialized over a larger population much of the costs associated with the regulatory constraints
18 on the individual block. With the loss of that program and no replacement, however, the
19 underlying fundamental issues in the non-ACA plans have resurfaced. The regulatory
20 requirements result in a demographic and risk profile with a level of morbidity that drives a
21 higher utilization of medical services than an underwritten population that could be priced to
22 more accurately represent their associated risk characteristics.

23

1 **Q. Please provide an overview of this year's rate application.**

2 A. The proposed rates are intended to become effective on January 1, 2015 at an average
3 annual increase of 19.6%. This rate revision is required to adjust for increasing claim costs,
4 rising health insurer fees, new high cost pharmacy treatments for Hepatitis C (*e.g.*, Sovaldi,
5 Harvoni), and, most materially, the migration of relatively healthier legacy policyholders to other
6 products. As well, we note that poor 2014 financial results for the legacy block suggest that the
7 rates are already insufficient following a negotiated rate increase in 2014 that was ultimately set
8 below what our actuarial calculations suggested, which also supports the need for a material rate
9 increase in 2015. If the rate filing is approved as requested, we anticipate a loss ratio of over 85%
10 for the legacy block, materially above the 80% loss ratio required by federal law.

11 **Q. Before addressing specifics, has the discovery process changed your view that the**
12 **proposed rates are not excessive, inadequate or unfairly discriminatory?**

13 A. No. In the course of the discovery process, the Attorney General and Superintendent
14 made some reasonable observations regarding the large claim pooling methodology and insurer
15 fee calculation. The large claim adjustments would result in a slightly higher required rate
16 increase. As discussed below, we also agree that a slight reduction in the insurer fee could be
17 reasonable as well. Because the IBNR is a higher magnitude, the net result would be a slightly
18 higher rate increase than filed. Therefore, while we agree with some of the comments on the
19 insurer fee percentage and large claim IBNR, we do not at all believe that the rate increase
20 requested is excessive as a result. Indeed, applying the suggestions in the aggregate would result
21 in a higher, not lower, rate increase.

22 Along those lines, let me highlight several assumptions in the filing that were set to a level below
23 our best estimates. First, we did not adjust administrative expenses to fully reflect the rise in per
24 member costs that occur when dealing with a shrinking block of business. Current expenses for
25 this block in 2014 are over \$28.00 PMPM; the \$25.00 PMPM that we have used for the filing are

1 materially lower, without taking into account any escalation of current expenses into the rating
2 period. Second, we did not project into the future the fact that grandfathered membership is
3 becoming a higher proportion of this pool over time; had we done so, that would increase the
4 projected risk of our pool beyond that reflected in the rate increase. Third, we did not forecast
5 any morbidity change from May through year end, instead assuming that it would be flat. This is
6 a conservative assumption given that, if anything, healthier members would be more inclined to
7 voluntarily lapse their insurance coverage through year-end versus those who are actively using
8 the insurance to address medical conditions. This would increase risk through year-end versus
9 our static assumption. These three items, combined with the two items of note from the
10 discovery process discussed above, would justify a higher rate increase than we have proposed.
11 That said, we opt to leave the rate increase as filed in the current form.

12

13 **Q. Before going into the substance of the filing, please provide an overview of the main**
14 **factors driving the rate increase.**

15 A. Claim costs represent the dollar amount of claims that we expect the legacy block will
16 incur during the rating period. We project claims based on a recognized regression methodology
17 that is designed to smooth out the claims volatility that often accompanies blocks that are
18 experiencing declining membership. The resulting allowed claims trend from the regression
19 analysis is 3.9% and, when adjusted for deductible leveraging, is 4.7%. This is a very modest
20 trend for this business.

21 There are also new treatments that will increase claim costs. Most notably, Anthem covers new,
22 high cost medications for Hepatitis C. While eventually the costs associated with this new
23 coverage will be part of our base experience, we expect there to be high initial utilization as new
24 Hepatitis C drugs go to market. Sovaldi is the most well-known Hepatitis C medication and is
25 contributing to a first wave of cost increase; later this year, a second wave of new treatments

1 with far less severe side effects will become available (e.g., Harvoni, which received FDA
2 approval on October 10, 2014). These newly approved treatments will appeal to a much larger
3 set of members. Once these new medications undergo initial uptake, the utilization is expected to
4 remain at a stable level. We captured both the initial expected surge and stabilization through a
5 minor adjustment to trend of .34%, which resulted in an overall trend of 5.1%. This trend factor
6 is used to take the base period claims (May 1, 2013 through April 30, 2014) and trend them
7 forward to the rating period (January 1, 2015 through December 31, 2015).

8 As indicated above, the largest driver of the rate increase is the change in morbidity from the
9 base period to the rating period. Generally speaking, as premiums rise, the healthiest members –
10 that is, those who use the fewest services – tend to leave a block first. The corollary is that
11 members who use significant services tend to value the stability of remaining with a carrier and a
12 policy that provides the policyholder with a level of assurance that the member’s health bills will
13 be paid and under what circumstances. Indeed, we have seen that logical phenomenon play out
14 in our claims experience with the legacy block.

15 The risk of a block of business is assessed by examining actual claims experience applied to a
16 predictive model that is designed to determine the likelihood of the need for additional services
17 and at what cost. The result is a risk score for the insured block. Changes in the risk of the block
18 may be assessed by determining the risk score for the base period and comparing it to the risk
19 score at a later point in time. The difference in those risk scores informs whether the block – as a
20 whole – is becoming more or less healthy over time. We performed this exercise on the legacy
21 block using a commercially-available DxCG prospective risk model to establish the risk score
22 for the legacy block. By their nature, the legacy policies have been in effect for a significant
23 period of time and, accordingly, we have a base of claims experience from which to calculate the
24 risk score for the block.

25 During the first open enrollment period, membership in the legacy block declined by 6,483

1 members. The risk score for the remaining members is materially worse than it was prior to that
2 migration. This means that the average legacy member will have higher claims after the
3 migration. Unlike ACA policies (for which reinsurance is available) and pre-2014 individual
4 policies (which could be reinsured through MGARA), there is no mechanism to reimburse or
5 offset the risk of high-cost claimants in the legacy block. Rather, those claims are and will
6 remain part of the claims experience of the block. We reflect the worsening average risk score of
7 the remaining legacy population in the proposed rates through a morbidity adjustment of 8.72%.
8 This does not incorporate the likely ongoing shift toward higher risk grandfathered business.
9 The combination of a worsening risk score and declining membership means that each legacy
10 policyholder will have to pay more to cover the claims of legacy members.

11

12 **Q. How has observed experience changed the analysis of the morbidity adjustment?**

13 A. Last year, in filing rates for both our 2014 legacy products, we were confronted with
14 forecasting who will remain on legacy plans and who will migrate to an ACA plan – and then
15 determining the associated impact to the morbidity of the remaining members. This forecast was
16 complicated by many new and moving parts, such as (i) who would qualify for subsidies without
17 the benefit of detailed income data, (ii) changes to network offerings that provided lower cost
18 options to consumers, (iii) new market entrants with new products, rates, and an unknown level
19 of market acceptance/uptake, (iv) newly operational exchanges, and (v) new ACA product
20 choices with benefit structures that differ from the pre-2014 offerings. Attempts to model
21 member movement through this complex environment of choice resulted in uncertainty
22 surrounding the extent of migration between legacy and ACA products and, further, whether
23 those migrating members would on average be more or less healthy than those who remained.
24 Therefore, we opted to leave the 2014 ACA and Legacy blocks at status quo morbidity levels,
25 neither increasing nor decreasing our morbidity assumption on either risk pool.

1 Since that time, the individual insurance market completed an extended open enrollment period
2 for ACA policies, and we witnessed the risk movement that can occur when our customers are
3 faced with such choices. The pattern of risk migration is now very clear on our legacy business.
4 Higher risk individuals are remaining on legacy products, especially Grandfathered members. In
5 total, from December 2013 to May 2014, our demographic-adjusted prospective risk score --
6 meant to represent risk beyond that which is age-related or risk beyond that which would be
7 covered by age related increases in premiums – rose by 4.9% and then remained essentially static
8 from May to June. This clearly aligns with the beginning and ending of the ACA open
9 enrollment period.

10 We also observed that the greatest morbidity changes occurred for Grandfathered policies.
11 During the ACA open enrollment period, our Grandfathered risk level increased 7.6% whereas
12 the Non-Grandfathered risk level increased 1.4%.

13 Further, based on lapse patterns, our Grandfathered business became more prevalent within our
14 business, rising from 43% to 49% of the combined legacy block, further shifting our legacy
15 block toward higher risk members. Note that this only reflects risk movement through the end of
16 the 2014 open enrollment period. Given that Anthem’s ACA product premiums for 2015 are
17 reducing and the legacy block premiums are increasing, we expect a similar migration during the
18 2015 open enrollment. While other assumptions could be made, we believe that the best
19 evidence of the expected migration during the second open enrollment is what occurred during
20 the first open enrollment period. When making this assessment, we studied the patterns of lapse
21 and could not find a subset of members based on the intersection of product, risk score level, or
22 grandfathered status that had fully or even largely migrated to ACA. In other words, sufficient
23 membership remains in all legacy subsets such that we can expect 2014 patterns and levels of
24 migration can and will recur in 2015. The same opportunity and similar circumstances present
25 themselves.

1 Collectively, these dynamics result in a morbidity increase of 8.72% in our current rate
2 projection, a good portion of which (3.6%) is based on actual risk change already observed
3 through June. This adjustment could actually be increased by approximately 0.50% if we
4 reflected more fully a continued shift to Grandfathered business over time, which we have not, a
5 somewhat forgiving assumption. Again, unlike ACA plans, no risk mitigation programs (e.g.,
6 reinsurance, risk adjustment) apply to this block of business to address these morbidity changes.

7

8 **Q. Please explain the calculations that resulted in the 8.72% morbidity adjustment.**

9 A. The calculation is the result of a multi-step process. First, the actual change in morbidity
10 from the base period average (May 2013 to April 2014) to June of 2014 was 3.6%. We then
11 estimated the morbidity change from June 2014 to December 2014, which we expect to be
12 essentially flat. This is a conservative assumption given that, if anything, healthier members
13 would be more inclined to voluntarily lapse their insurance coverage through year-end versus
14 those who are actively using the insurance to address medical conditions. This would increase
15 risk through year-end versus our static assumption. Finally, we used the actual change in
16 morbidity during the first open enrollment period as a proxy for the anticipated change in
17 morbidity during the 2015 ACA enrollment. The combination of these three components yields
18 our estimated change in morbidity of 8.72%, as set out below:

- 19 1. The already observed morbidity change from the experience period to June 2014: 3.6%
20 2. June 2014 to December 2014: 0%
21 3. The change in morbidity during 2015 ACA open enrollment: 4.9%

22

23 This yields the total change in morbidity from base period of 8.72%

24

25 **Q. How did you calculate each of the morbidity changes noted above?**

26 A. We had demographic-adjusted prospective risk score data from June of 2014 so we

1 calculated the observed change in morbidity from the experience period to June of 2014. The
2 next step was to estimate how the morbidity of the legacy block would change from June 2014 to
3 December 2014. We expect little movement in the legacy population from June to December, so
4 we assumed that the block's risk score would remain constant over this period. This is a
5 conservative assumption given that the healthiest members (that is, those who are not using
6 services) are more likely to lapse their coverage throughout the year than those who are using
7 services.

8 To determine the impact of the 2015 ACA open enrollment period on the morbidity of the legacy
9 block we used the observed data from the 2014 ACA open enrollment period. While certainly a
10 number of relatively healthier policyholders have already left the legacy block, that next level of
11 somewhat-less-yet-still-relatively-healthy policyholders remains. And, as premiums for the
12 legacy block rise and become closer to premiums for ACA-compliant products, we expect
13 continued significant migration from that risk tranche during the next open enrollment period.
14 The observed data reflects that the healthiest policyholders are the first to drop coverage, leaving
15 on average a less healthy, more risky population.

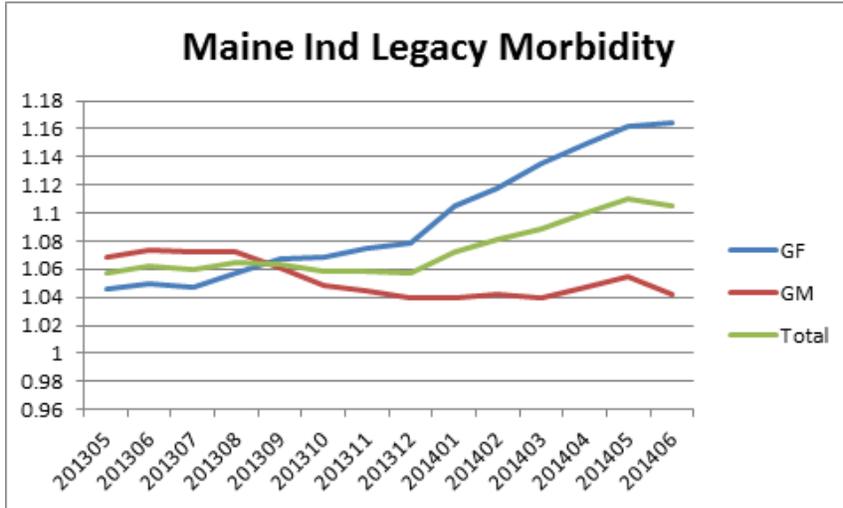
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17 **Q. How did you calculate the 3.6% change in actual risk noted above?**

18 A. To determine the risk score for the base experience period (May 2013 to April 2014), we
19 calculated the average risk score for the period and compared it to the risk score of the legacy
20 block in June, 2014. The resulting 3.6% change in morbidity represents the deterioration that we
21 have *already seen* in the average demographic-adjusted prospective risk score from our base
22 period to June 2014. Thus, that 3.6% change in morbidity relative to the experience period has
23 already occurred.

24

1 This change in morbidity is reflected graphically below:
2



3
4

5 **Q. How did you calculate the 4.9% change in morbidity during the first enrollment**
6 **period?**

7 A. We compared the risk score for the block as of December 2013 (i.e., before member
8 migration occurred during the open enrollment period) and as of May 2014 (i.e., after the open
9 enrollment migration). The resulting risk scores increased by 4.9% over this period. What this
10 means is that relatively healthier legacy policyholders dropped their products during the first
11 open enrollment period that started in late 2013 and ended in the spring of 2014, resulting in an
12 increase in the block's risk score of 4.9%. Put differently, the 4.9% shows how much the block
13 deteriorated as a result of the first ACA open enrollment period.

14

15 **Q. Is it reasonable to assume the same level of morbidity deterioration will occur**
16 **during the second open enrollment period?**

17 A. Other assumptions could be made, but yes, we believe what occurred during the first
18 open enrollment period is the best evidence of what likely will occur during the second such
19 period. ACA plans will be the subject of heavy marketing and the comparison this time around

1 will be to a legacy product that will be subject to a significant rate increase. Under those
2 circumstances, we would once again expect significant migration and that the average member
3 dropping a legacy product will be healthier than the average legacy member who remains,
4 resulting in an increased average risk score for the block.

5

6 **Q. You mentioned that the legacy plans cannot take the benefit of the federal**
7 **reinsurance program. Are they affected by federal reinsurance at all?**

8 A. Unfortunately, the answer is yes and no. The legacy plans are subject to the \$5.25
9 PMPM charge to fund the temporary federal reinsurance program. However, legacy plans are
10 specifically excluded from reimbursement under the federal reinsurance program. Subscribers
11 must pay the same cost for the program, but cannot take advantage of the lower premiums when
12 claims are reinsured. Accordingly, the federal reinsurance program is a net negative for legacy
13 plans.

14

15 **Q. Is your inclusion of a margin for risk and profit driving the rate increase?**

16 A. No. Increases in claims cost and morbidity drive the need for rate increases in the legacy
17 block. The calculation of the proposed rate increase reflects the requirement that premium rates in
18 the individual market must be adequate, which means they must be designed to cover all costs
19 (including claims previously reinsured away by MGARA or through federal reinsurance for ACA
20 products) plus allow for a reasonable rate of return that will allow the individual products under
21 consideration here to contribute to Anthem's surplus. Anthem's margin for risk and profit (3%
22 pre-tax/2% post-tax) is consistent with its prior filings as well as margins the Superintendent has

1 most recently approved for individual products.

2

3 **Q. How does the risk of this block of business inform your opinion that the 2% after-**
4 **tax margin is reasonable?**

5 A. As the migration of legacy members to ACA products continues, the overall health of the
6 block deteriorates leaving fewer members to cover the same (or at least similar) costs. With no
7 reinsurance mechanism available for this block of business, the 2% margin looks all the more
8 thin. The margin may be eliminated entirely by a single large claim.

9 Another vantage point is this. If you calculate the average profit margin for the entire period
10 spanning back to 2000 in Exhibit IX (when Anthem acquired the former BCBSME) through year-
11 end 2014, our Individual line of business shows an average post-tax profit of 1.62%,
12 approximately on target. Fourteen years of business effort culminated in a margin that sits even
13 relative to our target. These cumulative financials are based on annual results that vary from an
14 after-tax low of (-6.4%) in 2014 (projected) to 11.4% in 2013, which we note occurred when
15 certain high-dollar claims were reimbursable through MGARA. Over the course of the last decade
16 (from 2005 through projected year-end 2014), the average after tax profit is .46%, roughly 75%
17 below the 2% target. Four of the five most profitable years for this line occurred in 2003 or earlier.
18 Financial performance for the legacy block in 2014 is projected to be a materially unprofitable and
19 below average year. While future margins should not be set to make up for prior losses or profits,
20 the significant decline in legacy block financial performance, occasioned by a material increase in
21 costs per covered member, further supports the requested rate action.

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Q. What about non-claim cost expenses - how have other expenses changed?

A. Other components of the premium rate include administrative expenses, premium tax and assessments. Administrative expenses are included on Exhibit I.

The proposed rates contained in this filing include administrative expense charges of \$25.00 PMPM, or approximately 5.9% of premium, on average. As indicated in our filing, administrative expenses for the legacy block continue to rise as the block shrinks and to date are \$28.34 PMPM in 2014 and would be higher if escalated into the rating period. For two reasons, Anthem determined to include only \$25.00 PMPM in the proposed rates. First, while we expect administrative expenses in 2015 will be materially higher than \$25.00, it is as yet unclear whether all of the increase in administrative expenses will continue. Second, even if this higher level of cost is a reality that will continue, Anthem believes it more appropriate to transition members to this increased cost over a period of time, rather than include the full cost in the proposed rates, particularly in a year when the necessary rate increase is over 19%.

Substantively, the level of administrative expense that Anthem proposes (\$25.00 PMPM/5.9% of premium) compares very favorably to the average administrative expenses for carriers in the individual market. *See, e.g., American Academy of Actuaries: Critical Issues in Health Reform: Premium Setting in the Individual Market* (administrative expenses “typically make up about 10 percent to 20 percent of premiums”); *see also* Milliman, *Administrative Expenses: 2010 commercial health insurance*, Figure 1, p.5 (average health insurer administrative expenses in the individual market were above \$40 PMPM as of 2010, for an average of 19% of premium).¹

Premium tax is 2 percent of premium, the ACA insurer tax is 3.48% and the assessment for the ACA reinsurance program is \$5.25 PMPM. These are amounts set by the State and Federal

¹ The full text of this article is available at <http://www.milliman.com/uploadedFiles/insight/health-published/commercial-health-insurance-admin-2010.pdf>

1 governments and, like the payment of claims on behalf of our members, are out of Anthem's
2 control.

3 The overall level of non-claim cost expenses represents a declining portion of the overall premium
4 rate. In particular, the percentage of premium dollars spent to cover our members' claims is well
5 in excess of the 80% level required under the ACA. With only 3% of premium on a pre-tax basis
6 to cover profit and risk, this means that for every premium dollar our members spend, they are
7 getting approximately 97 cents returned directly in the form of payment of services they obtain or
8 devoted to the costs of delivering those member services. Taken together, these facts demonstrate
9 that Anthem has made consistent and continuous efforts to administer benefits efficiently and keep
10 premium rate increases as low as possible.

11

12 **Q. How did you determine the ACA insurer fee?**

13 **A.** The ACA insurer fee is set by CMS as a dollar amount, rather than a percentage of
14 premium. The nationwide insurer tax in 2014 was \$8 billion and will be \$11.3 billion in 2015,
15 an increase of 41% that contributes to the rate increase. The premiums that are subject to this tax
16 will increase modestly due to rate increases (which we note are trending lower in 2014) but that
17 increase is partially off-set by buydowns and groups moving from fully insured to self-funded
18 status (ASO accounts are not subject to the ACA Insurer Fee). Because the dollar fee increased
19 by 41%, we assume in the filing that the insurer tax will likewise increase by 41% (from 2.46%
20 to 3.48%), though we acknowledge that some slight dilution could occur, resulting in an ever so
21 slightly lower percentage than our simplifying assumption yields.

22 When considering the questions raised during discovery, we examined the gross percentage
23 increase in premium that we expect for 2015. The best available information we have is a study

1 that compiles industry premiums from publically available financial reporting, which indicated
2 that fully insured premiums have risen by 4-4.7% per year recently. Rate increases have abated
3 somewhat in 2014 based on lower cost trends, which would reduce that historical average. On
4 the other hand, we expect some individual market growth to offset that abatement. While
5 estimates vary, adding two million previously uninsured members at a national premium average
6 of \$350 PMPM would grow the national premium level in the study around 1.5%. Putting those
7 factors together, an increase in annual premium subject to the ACA Insurer Fee of 5%, for
8 example, would change the ACA fee percentage by .17%, decreasing it to 3.31%. Even at that
9 level, the decrease in the ACA fee would be more than offset by modifying the large claim
10 IBNR, as discussed below, or by setting administrative expenses to the fully required level, or by
11 fully incorporating ongoing migration to grandfathered business, or by making an assumption
12 that risk will rise through year end as healthier members voluntarily lapse coverage. In other
13 words, yes, the insurer fee could be slightly lower, but several other assumptions in the rate
14 development could be slightly higher, which would more than fully offset that slight decrease
15 and result in a net higher increase than we have proposed. That said, we suggest no changes in
16 any of the assumptions, noting, however, if Superintendent determines to change those
17 assumptions that would all else equal reduce the proposed rates, we request that all of the
18 identified changes should be made.

19 **Projection of Future Claims Cost: Trend Regression and Pooling of Large Claims**

20 **Q. What process did Anthem follow when developing the regression methodology in**
21 **this rate application?**

22 A. Consistent with prior decisions from the Superintendent (*e.g.*, INS-11-1000), Anthem is
23 using a regression analysis to develop trend. The regression-based methodology employed here
24 is a well-established statistical approach for determining trend in time series data (in this case,
25 the monthly allowed claim data). Seasonal, benefit, aging and large claims adjustments are made

1 in separate steps prior to performing the regression analysis which yields the best fitting trend
2 line to the data in a process that minimizes the sum of squared errors. (*See, e.g.*, INS-11-1000,
3 Hearing Decision, IV.A.2.) Trend was derived from the normalized allowed claims regression
4 over two 25-month periods. The 25-month claim cycle was derived from a combination of
5 empirical analysis of the movement of the rolling-12 normalized allowed PMPMs throughout
6 time and quantitative analysis of normalized claims to determine a period whose length was
7 adequate and whose claim makeup consisted of an equal number of months with claims levels
8 above and below the weighted average premium of the entire period. The trend line generated
9 from this approach represents a long-term underlying trend that smooths out short-term
10 volatility.

11 The trend methodology takes into account the cyclical pattern of our claims trend, which is
12 exhibited in our historical experience over multi-year periods, reflected in Exhibit VIII. The
13 analysis is based on allowed cost data (total amount reimbursed prior to member cost sharing) to
14 account for changes in the average level of cost sharing over time. Anthem relies on allowed
15 cost data because (i) as the average level of cost sharing increases over time, observed paid
16 claims cost trends can appear to be lower than the underlying claim trends and (ii) the impact of
17 leveraging on the observed paid claims trend can be masked by changes in the average level of
18 cost sharing. Moreover, with inconsistent changes in average member cost sharing, the
19 leveraging impact can have a significant effect on the trend in observed benefit payments. Our
20 trend development includes a separate explicit adjustment for leveraging.

21 Claims trend has been applied to the twelve month claim base and trended forward for twenty
22 months in order to estimate claims for the pricing period of twelve months ending December 31,
23 2015. The underlying claims cost trend is based on a regression methodology utilizing allowed
24 claims cost adjusted (or normalized) for the impacts of large claims, benefit changes, aging and
25 seasonality. The normalized allowed trend is 3.9%. The impact of leveraging is then added to the
26 underlying trend, which results in a 4.7% claims cost trend. A graph supporting the projected

1 claim trend is included in Exhibit VIII.

2 We have also included a 0.34% adjustment to trend to cover high cost drug treatments for
3 Hepatitis C (“HepC”), such as Sovaldi. As coverage for HepC is new, claims associated with
4 these drug treatments are not reflected in our historical data. The Center for Disease Control
5 (“CDC”) estimates that approximately 1% of the U.S. population is infected with HepC. It is
6 also more prevalent among those born before 1966, which accounts for approximately 50% of
7 the legacy block members. Many infected will go undiagnosed for a period of time, but as the
8 CDC pushes for expanded testing and the availability of treatment options promises increased
9 utilization – and these treatment advances are tremendously expensive. Sovaldi costs \$1,000 per
10 day and approximately \$90,000 for a full course of treatment. Anthem’s experience with HepC
11 treatments to date is consistent with these cost assumptions; that is, the cost of treatment for each
12 affected member is approximately \$90,000. The availability of Harvoni later this year is
13 expected to expand utilization further. These new HepC companion drugs eliminate the need for
14 simultaneous administration of Interferon, a drug with strong side effects. Most HepC infected
15 patients are awaiting this easier regimen before undergoing treatment, and this fact will expand
16 the patient set seeking HepC treatment in 2015. The .34% adjustment assumes only
17 approximately one HepC patient during 2015, a conservative assumption given the CDC
18 estimates of infection.

19 This small adjustment, combined with the regression result, yields a total annual trend of 5.1%.

20

21 **Q. The Attorney General has through discovery asked questions that would combine**
22 **legacy experience with experience from the ACA products. Would doing so enhance the**
23 **credibility of the legacy experience?**

24 A. No. To the contrary, adding claims experience from the ACA products would not

1 enhance the credibility of the legacy filing. In the first instance, the legacy block is credible on
2 its own. It has sufficient membership to be considered credible. The experience is also very
3 mature. All grandfathered policies have been in existence for at least four years and the claims
4 experience of the block is well known. By contrast, the ACA experience is derived from a very
5 distinct set of products and is both relatively immature and incomplete. Rather than the years of
6 observed experience in the legacy block, the bulk of the ACA policies were purchased in the
7 spring of 2014. With deductibles for many not having yet been met and little if any runout, the
8 claims experience from the ACA products is at this point subject to interpretation. As a result,
9 adding this experience into the legacy block would reduce, not enhance, the credibility of the
10 legacy filing.

11

12 **Q. Do you have any concerns about the regression methodology for establishing trend**
13 **for the legacy block?**

14 A. I think that there are some items of note, particularly in the current environment where
15 the legacy population is changing substantially. A regression analysis has the advantage of
16 smoothing out experience, but that very process may result in a lag in recognizing the declining
17 membership numbers and corresponding effect on claims for the rating period. Put differently, a
18 regression methodology is more reliable when the target population is relatively stable in numbers
19 and average health. When as here the target block is in significant decline and there are material
20 changes in average health of the population, some of the short-term increases in trend that are
21 smoothed out by the regression analysis may in fact be part of the actual expected experience of
22 the declining block going forward. Anthem's use of that regression analysis, accordingly, puts a
23 thumb on the scale in favor of policyholders that performance during the rating period will be

1 consistent with longer-term experience, which for the legacy block, is unlikely to be the case.

2

3 **Q. Is that concern alleviated by the morbidity adjustment?**

4 A. The morbidity adjustment alleviates, but does not eliminate, this concern. Adjusting for
5 the increased risk of the block as healthier members leave does account for the fact that the block
6 during the rating period will be materially less healthy/more risky than it was over the base period.
7 This adjustment does not, however, counteract entirely the effect of setting future claims for this
8 block based on a 50 month, long-term trend analysis that predicts future claims by removing (or at
9 least dampening) the reality of the legacy business. This concern is evident in the results: one
10 would not expect allowed claims for this block to grow by only 3.9% to the rating period. We are
11 not asking to move away from the previously approved regression methodology, but rather note
12 that in these circumstances, it creates the potential – if not likelihood – of a material
13 understatement of future claims, which we are perhaps seeing in the 2014 emerging financials on
14 this block. Prior rate actions have proven too low to cover our 2014 emerging costs and at least
15 part of the culprit may be the long-term regression analysis in an environment where no
16 reinsurance of high-dollar claims is available.

1 **Q. What other items affect the calculated claims cost for the rate effective period?**

2 A. As shown in Exhibit VI of the rate application, Anthem also adjusted for large claims
3 using a pooling charge. We then apply the impact of pharmacy rebates, healthcare management
4 expenses and mandated benefit changes to calculate the total projected claims cost for the rating
5 period.

6

7 **Q. Can you describe the pooling methodology used in this year's rate application?**

8 A. In this year's rate application, Anthem followed the detailed calculations described in the
9 2011 Decision and Order in order to develop the pooling charge calculations shown in Exhibit I.
10 As it has in prior filings, Anthem defined large claims consistent with the trend regression
11 methodology which requires a large claim methodology based on monthly claims cost. We
12 made two adjustments: we increased the pooling level from \$50,000 to \$75,000 and we
13 accounted for deductible leveraging.

14

15 **Q. Why did you increase the pooling level?**

16 A. The key issue with high dollar claims pooling, as done historically with this filing, stems
17 from the mathematical reality of deductible leveraging, an accepted element of the regression
18 trend methodology in this filing. Deductible leveraging is the mathematical fact that claims in
19 excess of a fixed amount rise faster than the underlying cost trend. For example, imagine a claim
20 worth \$2001 for a member in a \$2000 deductible plan. There is a paid claim for the insurer of \$1.
21 If medical trends increase that claim only slightly to \$2002, then the amount over the deductible
22 is now \$2 – a **doubling** of the excess claims amount. So, the general idea is that the rate of
23 growth of claims over a fixed threshold runs at a higher level.

1 The exact same reality extends to large claims. In a given year, if a claim sits at the \$50,001
2 level, only one dollar of excess claims exists, given a \$50,000 large claim threshold. However,
3 if trend increases that claim to \$50,002, two dollars of excess claims exist. Notice that the rise in
4 excess claims – doubling from \$1 to \$2 – vastly outstrips the underlying trend that was required
5 to produce this result. The key point being that as claims trend pushes costs upward, an
6 accelerating amount of claims exceed a fixed threshold - \$50,000 in this simplified example.

7 So how has the method generally worked for this rate filing? Continuing on with our
8 hypothetical, the rate development removes the most current year of high dollar claims – those
9 exceeding \$50,000 – and replaces that with an average *derived from the most recent four years*.
10 Our concern lies with the interaction of this trailing four year average with the concept of
11 deductible leveraging. Let's continue with the simplified example. Say year one has a single high
12 dollar claim of \$50,001 – so there is \$1 of excess claims. Say that medical trend pushes that up to
13 a single high dollar claim of \$50,002 the following year. And so on – say this produces a
14 sequence of high dollar excess claims of \$1, \$2, \$3, and \$4. Given that an unrelenting trend is
15 pushing claims up such that they “peek” over the \$50,000 level in ever-growing amounts, a
16 simple awareness of high dollar claims leveraging in this situation would yield a future
17 prediction of, probably, something close to \$5 – a continuation of that sequence. However, the
18 legacy large claims pooling method in this rate filing takes a trailing four year average as the
19 projection, in other words $(\$1 + \$2 + \$3 + \$4) / 4 = \$2.5$. This yields only half of the required
20 level in this simplified example. This method fails to incorporate high dollar claim leveraging
21 effects.

22 Put differently, for a value that trends upward over time (as large claims will do with a fixed
23 threshold, because of deductible leveraging), replacing the most recent value with the average
24 of the four prior will always substitute a number that is too low.

25 So, in order to improve the core methodology, we made two adjustments to the method. First, we

1 increased the claims threshold to \$75,000 from \$50,000. To reiterate, over time, due to trend, an
2 increasing percentage of claims have exceeded the fixed \$50,000 threshold to the point that, in
3 our view, too much valid data for the block was being ignored. That \$50,000 threshold has been
4 in place for many years, when medical trends have pushed more and more claims above that cost
5 level. For example, with a 6% medical trend compounded annually, that \$50,000 threshold
6 equates to \$75,000 after only 7 years. We believe that \$75,000 is a more reasonable pooling
7 threshold for this block at this point in time; it certainly needs to increase at *some* point. We also
8 note the converse, that holding the threshold at \$50,000 indefinitely seems inappropriate, as this
9 eliminates a growing percent of claims data over time. To reiterate, this is problematic in
10 conjunction with the pooling method used for this filing, because the pooling method removes
11 the most current level of high dollar claims and substitutes the average of the previous four
12 years, which are going to, all else equal, tend to be lower due to the mathematical realities of
13 deductible leveraging. The trailing four year average will generally sit at a lower level than the
14 most recent level and at a lower level than a reasonable, go-forward expectation (i.e., is
15 insufficient). Using a trailing four year average of a value that is growing over time leads to an
16 understated and insufficient projection.

17 After adjusting the threshold to \$75,000, we then calculated deductible leveraging based on that
18 \$75,000 level to ensure that this dynamic is adequately addressed.

19

20 **Q. Did you base the decision to change the threshold from \$50,000 to \$75,000 on the**
21 **resulting rate increase?**

22 A. No, we did not pre-test the impact of this change on the rate increase for one main reason.
23 Deductible leveraging is a mathematical consequence or reality, and the outcome of a stress test
24 is not needed to indicate that it is worth reflecting in methodology. Put differently, our
25 methodology is not results-driven and, accordingly, the outcome of a stress test (lower rates,
26 higher rates, or equivalent rates) would not affect our view that these changes are appropriate.

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Q. Did you examine the percentage of claims excluded by the \$75,000 threshold to determine if it was reasonable?

A. In response to discovery requests, we noted that using a \$50,000 threshold would exclude over 9% of claims and using \$75,000 reduced the excluded claims to 5.7%. To gauge the reasonableness of the \$75,000 threshold, we reviewed an older filing to determine the percentage of claims that were historically excluded using the \$50,000 threshold, which reaffirmed our belief that \$75,000 is appropriate for this block. For example, in the 2011 filing, the \$50,000 threshold excluded 5.9% of claims; nearly the identical amount of claims excluded by using \$75,000 today. This data demonstrates my earlier point: maintaining a constant threshold that does not account for trend will result in excluding an increasing percentage of claims and, in this case, a \$75,000 threshold today does almost precisely the same “work” as a \$50,000 threshold did previously.

The problem that results from using a low – and stagnant – threshold in a block that is deteriorating is exacerbated by a methodology that excludes current year large claims and then uses the average of the prior four years as a substitute for those current year large claims. That is, more claims are excluded using an outdated threshold and then old data, which includes periods of time when the block was healthier, is averaged and used as a proxy for large claims during the rating period. This combination is bound to lead to an understatement of large claims.

Q. Did your pooling methodology produce a material smoothing of the observed results?

A. Yes. Absent large claim pooling there is greater claims volatility due to random incidence of large claims. Without pooling, the historical range of rolling twelve-month trends is from a minimum of -5.7% to a maximum of 21.2%; with pooling that range narrows to 0.1% to 10.2%. Consistent with the Superintendent’s directive in Docket No. INS-11-1000, the pooling

1 charge has a material effect on the results, serving to smooth out the higher peaks and valleys
2 caused by large claims in the experience.

3

4 **Q. Did the questions in discovery change your view that the large claim methodology is**
5 **reasonable?**

6 A. No. The Attorney General noted some anomalous results in which the IBNR for the large
7 claims was greater than the IBNR for the total claims. As reflected in our response to the
8 Attorney General's requests, we reviewed the large claim triangles and completion factors and as
9 explained below, if anything, the IBNR for total claims was too low for those months.

10 First, we went back and reviewed the large claim triangles and completion factors one more
11 time. Those completion factors have been reasonably stable over time and indeed show that large
12 claims complete more slowly than total claims. We also checked the claims triangle specific to
13 this block of business to check whether having a particularly high amount of high dollar claims
14 after only two months of runout comes with a materially different level of completion. But, no, a
15 similar completion factor resulted. Meaning, if we look at the high dollar claims triangle and
16 focus only on those incurred months that are very high after only a few lags – say, having
17 \$800,000 or more of high dollar claims after only lag2 - we still derive a level of completion
18 reasonably close to that derived from the full triangle. This re-examination demonstrates that the
19 high dollar completion factors used are certainly reasonable and remain reasonably applicable to
20 the elevated level of high dollar claims that we have seen recently.

21 We then turned to the total valuation triangle for those two months to see whether the completion
22 factors applied to total claims for those two months might be *too low*. For January 2014, the
23 corporate valuation analysis suggested that \$4,033,503 of paid claims will complete to
24 \$4,111,458 all said and done – that they are 98.1% complete, with an IBNR of ~\$78,000.

1 However, from our large claims triangle work for this filing, we know that \$1.17 million of large
2 claims are sitting in that incurred amount for January. History suggests that such claims are only
3 about 92% complete by this time, suggesting a high dollar claim IBNR alone of just over
4 \$100,000. We believe this \$100,000 to be reasonable. Therefore, holding \$78,000 on total paid
5 claims appears to be *lower* than ideal. This explains why the large claim IBNR looks high – total
6 IBNR is likely lower than ideal, and the more detailed approach in this filing brings this to light.
7 Some of these dynamics surely arise from working with a smaller block of business.

8 Similarly, for March 2014, the overall valuation picture suggests that \$4,444,035 of paid claims
9 will complete to \$4,660,337 all said and done – that they are 95.4% complete, with an IBNR of
10 ~\$216,000. From our large claims triangle work for this filing, we know that \$1.6 million of
11 large claims reside in the March incurreds. History suggests that such claims are about 78.1%
12 complete by this time, suggesting a high dollar claim IBNR of just over \$450,000. We believe
13 this \$450,000 to be reasonable. Even if one were to put a substantial range around that estimate,
14 it exceeds the \$216,000 of total claims IBNR. That in mind, holding \$216,000 on total paid
15 claims appears to be lower than ideal.

16 All of this suggests that IBNR for a few key months could be revised upward relative to what
17 was used in the rate development because slower to complete high dollar claims dominate those
18 months. This would cause the rate increase to rise very slightly. We are not proposing to do so;
19 just noting the effect if IBNR were increased for the under-estimates discussed above.

20 We also performed another review of this item using a completely distinct approach, a stress test
21 of sorts. We completed large claims using the same valuation completion factors that were
22 applied to total claims and then update all aspects of the rate development that incorporate the
23 large claims (e.g., pooling charge, trend, etc.). Similar to the analysis above, the resulting rate
24 increase would be higher than that which we propose here.

25

1 **Q. How did the Federal mental health mandate factor into the rate filing?**

2 A. According to guidance issued by the federal regulators with oversight over mental health
3 parity, the Federal mandate applies to grandfathered policies and ACA policies, but not to
4 transitional (*i.e.*, grandmothers) policies. We since have received information from the
5 Superintendent reflecting communications with CMS indicating CMS's belief that effective
6 January 1, 2015, the Federal mandate for mental health parity may in fact apply to
7 grandmothers policies. Given the inconsistency between the prior guidance we received and
8 this recent interpretation from CMS, we continue to investigate this issue.

9

10 **Q. How do you arrive at a required revenue amount after you have accounted for the**
11 **claim portion of the rate?**

12 A. The required revenue is determined by calculating what will be needed in order to pay
13 projected claims, administrative expenses, premium tax, the ACA assessments and provide a
14 reasonable rate of return.

15

16 **Q. Did you and your team make any changes to the filing as a result of the discovery**
17 **process?**

18 A. Yes. We made the modifications to the exhibits noted in our responses to the discovery
19 requests and have resubmitted those filing exhibits along with this prefiled testimony. I
20 supervised the team responsible for developing and modifying the exhibits. The re-filed
21 actuarial memorandum and exhibits are marked as "Hearing Exhibit 2."

1

2 **Q. Anthem negotiates reimbursement rates with providers in Maine. Do the legacy**
3 **block members receive these discounts when paying claims subject to their member cost**
4 **sharing?**

5 A. Yes, Anthem negotiates reimbursement rates with providers and the benefit of these
6 negotiated rates are passed on to our members. Participating providers are contractually required
7 to accept the Anthem allowed amount when providing services to Anthem members. Members
8 receive the benefit of these negotiated rates through both lower premiums and lower out of pocket
9 expenses when paying for claims subject to member cost sharing. It is true that some legacy
10 members may not satisfy their annual deductible and thus will not receive reimbursed benefits in
11 any given year. However, they do benefit from Anthem's negotiated discounts for every service
12 they receive and as such they will pay considerably less for those services than if they were paying
13 for them without the benefit of Anthem's negotiated discounts. As an example, consider a 35 year
14 old adult subscriber with a \$10,000 deductible who receives services from participating providers
15 with an allowed amount of \$6,000 and actual charges of \$9,000. Anthem's discount for these
16 services is 33 percent off the actual charge. In the absence of this discount the charge to the
17 patient would have been \$9,000, but based on the discounts Anthem was able to secure through
18 provider negotiations, the legacy member saves \$3,000. The proposed annual premium in this
19 filing for this subscriber would be \$3,013.20. As such, even though the member's deductible is
20 not satisfied, the savings realized in this example is nearly the full value of the annual premium
21 paid by the subscriber.

22 Legacy members benefit from discounts for all medical service types, including hospital,
23 physician, and pharmacy claims.

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

3 A. Federal law requires an 80 percent minimum loss ratio. If the proposed rates are
4 approved as filed, and all projections turn out to be accurate, the anticipated loss ratio will be
5 85.08% for the rating period based on Exhibit IX of the filing, well in excess of that standard.

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

7 A. No, the rates are designed to cover all costs (claims, administrative expenses, taxes, and
8 assessments) and allow for a 2% after-tax return. Claims for this block are expected to be over
9 \$40 million, which is considerable risk for Anthem to take on for an expected return of only
10 approximately \$900,000, an amount that could be eliminated entirely by one large, unexpected
11 claim.

12

13 **Q. Has Anthem prepared a notice that would go out to legacy policyholders following**
14 **the Superintendent's decision in this case?**

15 A. Yes. The rate change notification process takes time. To get notices out to policyholders
16 as soon after the decision as possible, Anthem has provided with its prefiled testimony a
17 proposed notice letter to policyholders to which we would attach the rates as approved by the
18 Superintendent. The proposed notice to policyholders is marked as "Hearing Exhibit 3." To
19 facilitate prompt notification to policyholders, we request that the Bureau provide its guidance on
20 this letter at the Bureau's earliest convenience.

21

1 Q. Does this conclude your testimony?

2 A. Yes.

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

IN RE:)	
)	
ANTHEM BLUE CROSS AND BLUE)	
SHIELD 2015 INDIVIDUAL RATE)	
FILING FOR HEALTHCHOICE,)	
HEALTHCHOICE STANDARD AND)	CERTIFICATE OF SERVICE
BASIC, HEALTHCHOICE HDHP, HMO)	
STANDARD AND BASIC, AND)	
LUMENOS CONSUMER DIRECTED)	
HEALTH PLAN PRODUCTS)	
PURCHASED BY MEMBERS BEFORE)	
JANUARY 1, 2014)	

Docket No. INS-14-1000

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

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DATED: October 17, 2014

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