

March 16, 2016

Eric Cioppa, Superintendent
Attn: Elena Crowley
Docket No. INS-15-802
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 Request to Discontinue and Replace Legacy
Individual Health Plans*

Dear Superintendent Cioppa:

Enclosed for filing please find the following:

SUBMITTED BY: Christopher T. Roach
DATE: March 16, 2016
DOCUMENT TITLE: Responses to First Information Requests of the Superintendent
DOCUMENT TYPE: Responses to Information Requests
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:)
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ANTHEM BLUE CROSS AND BLUE) ANTHEM RESPONSES TO FIRST
SHIELD'S REQUEST TO DISCONTINUE) INFORMATION REQUESTS OF THE
AND REPLACE LEGACY INDIVIDUAL) SUPERINTENDENT
HEALTH PLANS EFFECTIVE JANUARY 1,)
2017)
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Docket No. INS-15-802) MARCH 16, 2016
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1. Provide an updated enrollment count of insured legacy members by plan and deductible after open enrollment for 2016 was completed. In responding, indicate which are grandfathered and which are grandmothered.

Response	Please see attached.
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2. How many high deductible policyholders (both grandfathered and grandmothered) exceeded \$6,850 in premium and costs by year end?

Response	<p>The \$6,850 is the out of pocket maximum for individual members with ACA plans. To provide as meaningful data as possible, we analyzed legacy claims at the member level to determine which members in high deductible plans had claims that exceeded that out of pocket maximum during calendar year 2015. We have identified 273 members with single deductibles greater than or equal to \$9,999 that have claims that exceed \$6,850 (the 273 observations would obviously be higher if we attributed premium to each member; we did not do so because premium for legacy plans is determined at the policyholder level, rather than the member level as it is for ACA plans). The data reported in our initial filing (nearly 600 high-deductible legacy members that had claims that exceeded \$6,850) was over a longer observed period (21 months versus 12 months here) and with a greater enrollment. When taking those two factors into account, the 273 observations in calendar year 2015 continue to demonstrate that a significant number of high-deductible legacy members have materially higher claims than they anticipated when determining to remain in their high-deductible legacy plan.</p>
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3. How many insureds have legacy plans and are also enrolled in Medicare?

Response	<p>A total of 68 legacy members are also enrolled in Medicare Part A or Part B (one of these members is set to cancel as of the end of March). Of the remaining 67 legacy members, 35 are aged 65 or older. It is unclear why these members have retained their legacy plans instead of purchasing a Medicare supplement policy. Much like those who have retained legacy plans when there are cheaper ACA plans with richer benefits, some may be more comfortable with their existing plan, unwilling/reluctant to change, some are on contracts with an under 65-year-old spouse, or some other reason. It is certainly possible to simply non-renew (rather than discontinue and replace) these policies as part of this proceeding, if the Superintendent so orders.</p>
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4. How does the possibility of MGARA reactivating affect Anthem’s proposal?

<p>Response</p>	<p>For several reasons, it does not.</p> <p>First, the IFS Committee has unanimously voted in favor of a proposal (L.D. 1545) which will continue the suspension of MGARA until at least January 1, 2018. As of the date of this response, that Committee Report has been accepted and passed to be engrossed by both the House and the Senate. We thus have no assurance that MGARA will ever restart.</p> <p>Second, the likelihood of MGARA restarting is diminished due to the fact that a majority of Maine consumers currently qualify for federal subsidies under the ACA, so rather than reducing the premiums an individual pays, MGARA reinsurance may have the effect of reducing the amount of federal subsidies, thereby having no (or negligible) net effect on Maine individual premium rates. In other words, the impetus for the MGARA program is diminished in a marketplace in which a majority of individuals qualify for federal subsidies.</p> <p>Third, at the time that MGARA was implemented, the individual market in Maine was relatively small, the number of lives ceded to MGARA was likewise small and a relatively modest assessment on the insurance marketplace, with a ceding premium of approximately 90%, had a significant effect on premium rates for the legacy block. Now, however, the individual market has grown significantly and consists of both ACA and legacy products, so the effect on legacy premium rates of a similarly-sized assessment would be significantly diluted to the point where the ceding premium would in all likelihood need to be increased significantly and we do not know if the reinsurance would have even a marginal effect.</p> <p>Finally, the legacy block is closed, which means its already small enrollment will only decline. After January 1, 2017, that block will consist of fewer than 1,500 policyholders, many of whom would clearly be financially better off moving to an ACA plan and some of whom in all likelihood qualify for an ACA subsidy, which would reduce their premium further. Even if MGARA is somehow able to develop a reinsurance mechanism that has a material effect on premium rates in a subsidized marketplace, the earliest that would happen is 2018; after the legacy policyholders would have endured another premium increase, likely in the range of 30%. As we have said in our initial filing, it is not in the best interests of the grandfathered policyholders to remain in a block that is in a death spiral. This is particularly so when the alternative is the ACA – a program that requires richer benefits, is growing, and has relatively stable premiums because it is able to spread costs over a larger number of enrollees that is also on average much more healthy than the grandfathered block.</p> <p>It is certainly possible that the MGARA Board will at some point in the future design a reinsurance mechanism that works effectively to lower premium rates</p>
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	in a subsidy rich environment. The possibility of some future as yet unidentifiable solution, however, does not offset the very real benefits of migrating the grandfathered block effective January 1, 2017 and the very real costs to those policyholders of delay.
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5. Will Anthem issue a POS plan to replace legacy plan coverage for all policyholders, even those in the service areas where only the HMO limited network plan is sold to individuals?

Response	Yes. All of the legacy policyholders will be transitioned to a plan with broad network coverage, off exchange. It remains the case, however, that Anthem’s on-exchange plans use the more focused network where applicable.
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6. How will prescription drug coverage decisions be made for those legacy members who currently use non-formulary drugs? Is there a limit to how long the drug will continue to be covered? How is the pre-authorized decision made? Will this decision-making process be seamless for the member at the pharmacy counter? Will legacy members be restricted to mail-order for non-formulary drugs?

Response	<p>Legacy members are not restricted to mail-order for non-formulary drugs. If a legacy member presents a prescription for a non-formulary drug, the pharmacist will advise that the drug is not covered and discuss whether the member wants to use a therapeutically-equivalent drug that is covered, or consult with the member’s physician. If the latter, the member may contact the physician (typically this happens over the phone) and, if the member has been using the non-formulary drug for six months, the physician will fill out Anthem’s authorization form and the non-formulary drug will be covered automatically for one year. After a year passes, if the member is continuing to take the non-formulary drug, the member would follow the same process: asking the member’s physician to fill out the pre-authorization form and the drug will be approved for another year.</p> <p>In most cases, reasonable (therapeutically equivalent) substitute medications used to treat the member’s condition(s) will be available in the new formulary and should be used by the member. In other cases, however, the circumstances may dictate that the member’s existing, non-formulary, medications should be covered even if they have not been taking the medication for the prior six months. For example, a member currently undergoing chemotherapy and a specific drug regimen will continue to be covered for those medications even if the medications are not included in the new formulary. In others, certain medications, while therapeutically equivalent from a pharmacological</p>
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	<p>performance perspective, may not be tolerated by the individual and would prompt an exception to be made. Our team will use its professional judgment, in accordance with plan policies and procedures, in making these distinctions, with higher-level review/appeal opportunities available to the member should that be requested.</p>
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