REPORT OF MARKET CONDUCT EXAMINATION

ANTHEM HEALTH PLANS OF MAINE, INC.

2 Gannett Drive
South Portland, Maine 04106

NAIC Company Code 52618

NAIC Examination Tracking System Number ME114-M17

Examination Period:

January 1, 2013 through May 31, 2014

December 12, 2016

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

Dear Superintendent Cioppa:

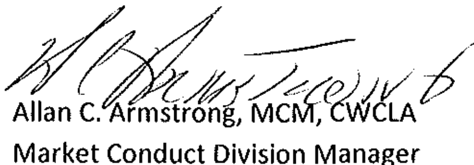
Pursuant to 24-A M.R.S. §§ 211 and 221, and in accordance with your instructions, a targeted market conduct examination ("Examination") has been made of:

Anthem Health Plans of Maine, Inc.

The Examination reviewed Anthem Health Plans of Maine, Inc.'s ("Company") Maine complaint handling practices for the Accident and Health line of business. The Examination covered the period from January 1, 2013 through May 31, 2014 ("Review Period"). The Maine Bureau of Insurance ("Bureau") staff conducted the on-site phase of the Examination, from September 10, 2014 through October 21, 2014, and again on April 13, 2015 through April 24, 2015, at the Company's offices located at 2 Gannett Drive South Portland, Maine.

Additional examination work conducted at the Bureau included; preliminary review of information provided by the Company; transactional testing; and follow-up communications.

The following report is respectfully submitted.



Allan C. Armstrong, MCM, CWCLA
Market Conduct Division Manager

Pursuant to 24-A M.R.S. §§ 211 and 221, I have caused a targeted market conduct examination to be conducted of Anthem Health Plans of Maine, Inc. I hereby accept this Report of Examination and make it an official record of the Bureau of Insurance.

12-14-16

Honorable Eric A. Cioppa

Date

Superintendent
Maine Bureau of Insurance

TABLE OF CONTENTS

SALUTATION 2

COMPANY PROFILE 5

EXECUTIVE SUMMARY 6

SCOPE OF EXAMINATION 8

METHODOLOGY 9

FINDINGS 10

RECOMMENDATION 20

ACKNOWLEDGEMENT 21

ATTESTATION 22

COMPANY PROFILE

Anthem Health Plans of Maine Inc. is a Maine domiciled insurance company. Per the 2013 Management's Discussion and Analysis report the Company is a wholly-owned subsidiary of ATH Holding Company, LLC ("ATH Holding"). ATH Holding is a wholly-owned subsidiary of Anthem, Inc. a publicly traded company (NYSE: ANTM) and one of the largest health benefits companies in terms of membership in the United States, serving approximately 35.7 million medical members as of December 31, 2013. This number contrasts with the approximately 36.1 million medical members as of December 31, 2012, as reflected in the 2012 Management's Discussion and Analysis report.

The Company's 2013 Maine Annual Report Supplement (Rule 945) reflects that there were 24,992 policies in force as of December 31, 2013; covering 211,504 lives[1]. The Report also reflects that the Company realized a net underwriting gain of $49.3 million from $956.9 million in direct earned premium. The Company has been a Maine insurer licensed to sell health insurance since 1938.

[1] See, http://www.maine.gov/pfr/insurance/reports/rule945reports.htm

EXECUTIVE SUMMARY

In February 2014, the Bureau noticed that the Company had not timely responded to certain consumer complaint inquiries that the Bureau had sent. The Company maintained that responses to those complaints had been sent timely, but the Bureau had no record of receiving the responses. With respect to those responses, the Company provided copies of letters that were dated timely but it could not provide evidence that it had timely sent the responses. As a result, the Bureau decided to conduct an examination of the Company's complaint handling processes, both for complaints consumers made to the Bureau ("BOI Complaints") and complaints that consumers made directly to the Company ("Non-BOI Complaints") The Examination focused on the area of complaint handling for the Company's Accident and Health product line.

The Examination was conducted using the standards set forth in the National Association of Insurance Commissioners' (NAIC) Market Regulation Handbook as guidance in accordance with 24-A M.R.S. § 223(2). The Examination tested the Company's compliance with Maine rules and statutes and the Company's internal procedures. One of the initial objectives of the Examination was to identify an accurate list of both BOI Complaints and Non-BOI Complaints. For the BOI Complaints, the examiners determined that the Company's BOI Complaint number did not match the Bureau's. For the Non-BOI Complaints, the Company provided inconsistent numbers and had to re-run its report for the examiners several times. The inconsistencies demonstrated that the Company did not accurately record complaints on its grievance register and also lacked management oversight of its complaint handling process.

The examiners then looked at the timeliness of the complaint responses. Maine law requires a company to respond to all lawful inquiries of the superintendent that relate to resolution of consumer complaints within 14 days of receipt of the inquiry. If a company is unable in good faith to provide a substantive response within 14 days, the company must request and obtain an extension from the Bureau. Although there is no statutory or regulatory definition, the Bureau considers "a substantive response" to be one that provides all requested documentation and information and that addresses each issue raised in the inquiry. During the review period, Bureau staff sent 106 inquiries related to consumer complaints. The Company responded untimely to 67 of those 106 complaint inquiries.

With respect to the Bureau inquiries that had initially triggered the examination, the examiners identified 7 inquiries to which the Bureau had no record of ever receiving a response. Those 7 are among the 67 complaint inquiries that the examiners deemed untimely. The examiners concluded that with respect to the submission of those 7 responses, the Company provided incorrect information to the Bureau.

The Company attested to receiving 58 Non-BOI Complaints directly from consumers during the Review Period. The examiners concluded that the Company responded timely to all 58 Non-BOI Complaints it received directly from consumers.

The examiners looked at the Company's complaint handling procedures, including procedures related to the handling of mail and faxes. Although the Company's written procedures addressed these areas, there was limited management oversight over complaint handling processes and as a result, Company procedures were not enforced consistently. The Company also did not maintain a readily available database to ensure that timely responses to Bureau inquiries were made.

The examiners determined that the information the Company was required to report to the Bureau on its annual Health Report Card Survey was not accurate for the time period in question, and that its grievance register was not maintained in a manner that was reasonably clear and accessible.

The examiners determined that they had not received complete and accurate complaint files from the Company. Maine law requires that entities being examined facilitate the examination and freely make available all records, documents, files and information relating to the examinations. As indicated above, there were numerous instances in which the Company did not provide the examiners with requested data, or the data turned out to be incorrect or incomplete. Although the Company eventually provided correct and complete data, these incidents ultimately caused delay and extended the cost and duration of the examination. As a result of the Company's difficulties, detailed above, the examiners concluded that the Company failed to facilitate the examination.

SCOPE OF EXAMINATION

The objective of the Examination was to review complaint handling practices for the Company's Accident and Health product line. The examiners used transactional testing[1] to determine compliance with applicable statutes.

The Examination was conducted in accordance with 24-A M.R.S. §§ 211, 221 and 223. It was conducted in a manner that was consistent with the standards set forth in the MRH as required by 24-A M.R.S. § 223(2). The MRH was used for purposes of sample determination and overall guidance. Some unacceptable or non-compliant practices may not have been discovered in the course of the Examination. Failure to identify or comment on specific practices does not constitute the Bureau's approval of such practices.

This report is by test rather than by exception, in that each test applied is stated and the results are reported.

[1] Transactional testing is the review of actual complaints.

METHODOLOGY

Using the standards set forth in the MRH as guidance in accordance with 24-A M.R.S. § 223(2), the examiners reviewed the Company's handling of BOI Complaints, Non-BOI Complaints, and matters coded as Grievances and Appeals. All files reviewed were initiated during the Review Period. The examiners reviewed the Company's responses to Complaints for timeliness and completeness. The BOI Complaints were reviewed under 24-A M.R.S. § 220(2).

The examiners used Audit Command Language ("ACL") audit software to obtain samples of the matters coded as Grievances and Appeals. The sample parameters specify results at a 95% confidence level and allow an error ratio of 5%. A sample of 60 events coded as Inquiries and a separate sample of 60 events coded as Grievances and Appeals were selected using ACL software. Examiners tested 100% of the selected files for proper coding.

FINDINGS

A. Complaint Handling

Standard: A health carrier shall maintain written records to document all grievances received during a calendar year ...

Bureau Rule Chapter 850 § (10)(A)(1)

The examiners reviewed the Company's grievance register for compliance with standards set forth in the Maine Insurance Code, Bureau of Insurance Rule 850 and the Company's internal complaint handling procedures. One of the initial objectives of the Examination was to identify an accurate list of complaints that consumers made to the BOI ("BOI Complaints") and complaints that consumers made directly to the Company ("Non-BOI Complaints").

BOI Complaints

On June 5, 2014, the Bureau requested that the Company provide the number of complaints for the examination period. On July 7, 2014, the Company provided the requested data.

The examiners discovered that the Company's grievance register did not match the known number of Bureau complaints. Sixteen known Bureau complaints were not included on the Company's register. On July 11, 2014 the examiners emailed the Company requesting an explanation for the variance. On August 5, 2014, the Company provided the following explanation:

- 8 complaints were "inadvertently excluded"
- 1 complaint was excluded as "it involved a pending appeal"
- 1 complaint was excluded "because our records documented it as an informal request"
- 6 complaints "were excluded in error"

This inconsistency led the examiners to conclude that the Company did not accurately record complaints on its grievance register. It also evidenced a lack of Company management oversight of the complaint handling process which is discussed beginning on page 14.

There were 106 BOI Complaints handled by the Company during the Review Period.

Non-BOI Complaints

The Company had difficulty producing an accurate list of Non-BOI Complaints. The Company's grievance register initially identified 153 Non-BOI Complaints. On September 8, 2014 the Company advised the examiners that at least 50 of the Non-BOI Complaints should not have been included on the register as they were actually inquiries. At the request of the examiners, the Company provided an attestation on

November 04, 2014, that the final list identifying 58 complaints was the complete and total list of written Non-BOI Complaints.

Finding 1

Certain complaints were not recorded accurately on the Company's grievance register.

> **Standard: All insurers...shall respond to all lawful inquiries of the superintendent that relate to the resolution of consumer complaints involving the licensee within 14 days of receipt of the inquiry...If a substantive response cannot in good faith be provided within the time period, the person required to respond shall so advise the superintendent and provide the reason for the inability to respond.**
>
> 24-A M.R.S. § 220(2)

<u>BOI Complaints</u>

Under the statute, if the Company is unable in good faith to provide a substantive response within 14 days, it must timely request and be granted an extension. The Bureau considers a "substantive response" to be one that provides all requested documentation and information and addresses each issue raised in the inquiry.

During the Review Period, Bureau staff sent 106 inquiries relating to consumer complaints for response to the Company. Of the 106 complaint inquiries, the Company responded timely (a substantive response within 14 days of receipt of the inquiry) to 39 complaint inquiries. The Company responded in an untimely manner to 67 complaint inquiries. The 67 untimely responses consisted of those that were untimely because either the Company did not respond at all, did not obtain an extension, or because the response provided within 14 days was not substantive. There were cases in which the Company failed to respond timely to the Bureau's request for information multiple times.[1]

Forty-three of the 67 untimely Company responses were sent to the Bureau 30 days or more after the receipt of the inquiry. Figure 1 represents an array of the 67 late complaint responses showing how late the responses were. Twenty-four responses were received between 15-30 days after the Company's receipt of the inquiry. Twenty-five responses were received between 31-45 days after the Company's receipt of inquiry. Seven responses were received between 46-59 days after the Company's receipt of inquiry. Eleven responses were received 60 days and beyond. Within those 11 responses, 1 response was received 88 days after the Company's receipt of the inquiry, 1 response was received 91 days after the Company's receipt of the inquiry, and 1 response was received 105 days after receipt of the inquiry.

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[1] For the purposes of this Examination, case files that contained multiple non-timely responses were counted as a single untimely response.

On February 18, 2014, the Bureau wrote to the Company with a list of consumer complaints for which, according to Bureau records, responses were past due. The Company answered via e-mail on February 26, 2014, stating "our records indicate that responses have been submitted". With that e-mail, the Company attached 10 of the outstanding responses in letter form. Each letter reflected a date that would have been timely if the letter had been sent. However, the Company was unable to provide evidence that it had transmitted these letters to Bureau via e-mail or regular mail on or before the original due date. On March 17, 2014, the Bureau sent the Company a letter noting that it had not received those response letters before February 26, 2014. On May 21, 2014, for 7 complaints,[1] the Company stated "we have not been able to locate information that demonstrates transmission" for each of the letters in question. On August 29, 2014, the Company wrote, "we were unable to demonstrate that the responses had, in fact, been transmitted".

The following are examples from specific cases which illustrate how the Company failed to respond substantively to a Bureau inquiry within 14 days:

- The Bureau requested a copy of the complainant's policy but never received it.
- The Bureau requested copies of a claim denial and subsequent appeal letters but never received them.
- The Company's response to a Bureau inquiry was not accurate, as the Company stated that claims had been forwarded for adjustment when they had not been forwarded.
- The Bureau requested that the Company address interest it had promised to a complainant, but the Bureau never received a response on that issue.

The MRH standards establish a benchmark of 90% compliance for the market evaluation of a general business practice. The Company was 37% compliant in responding to Bureau complaints in a timely manner (a 63% error rate), which is well below the 90% compliance benchmark.

[1] The Company discussed the letter responses in 10 complaints, but the examiners determined that 3 of those complaints involved self-insured plans and did not include them in the scope of the Examination.

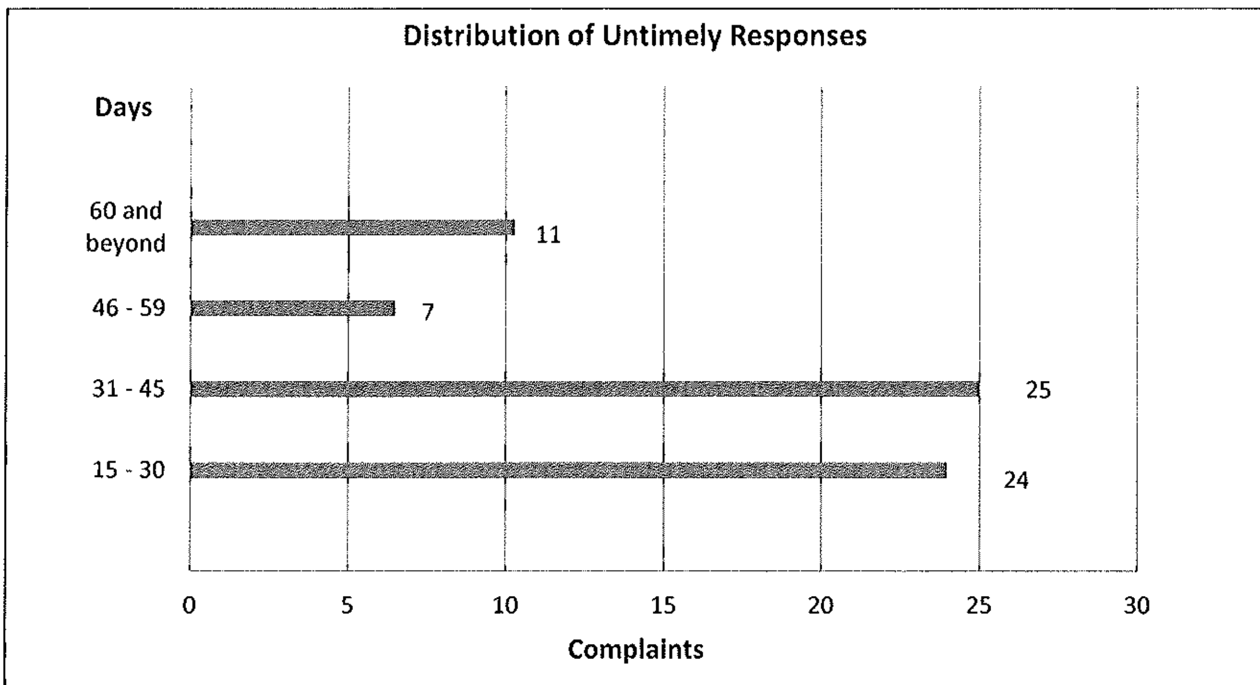


Figure 1

Finding 2

The Company did not respond in a timely manner to Bureau inquiries relating to consumer complaints in 67 out of 106 complaints.

Finding 3

In 7 of the 67 untimely complaint responses, the Company asserted that a response had been provided, but it was unable to substantiate that the response had been transmitted. Therefore, the Company incorrectly indicated to the Bureau that it had sent responses timely.

<u>Non-BOI Complaints</u>

The Company attested that it received 58 Non-BOI Complaints directly from consumers during the Review Period. The examiners examined all 58 Non-BOI Complaints to determine whether the Company responded to the complaints in a timely manner.

Of the 58 Non-BOI Complaints reviewed, the Company responded in a timely manner to all 58 Non-BOI Complaints (a 0% error rate), which is within the 90% compliance benchmark.

Finding 4

The Company responded in a timely manner to all 58 Non-BOI Complaints that it received directly from consumers.

Standard: A health carrier shall establish and implement written procedures for receiving and resolving grievances from covered persons…

Bureau Rule Chapter 850 § 10(B)

The Company has a written procedure for handling state regulatory complaints. One part of the procedure required that a clerk date stamp and scan complaints into an e-mail format. There was a difference in how the Company handled incoming mail, marking some, but not all, with a date received stamp. There appeared to be limited management oversight to ensure that this complaint-handling procedure was implemented consistently.

Another part of the written procedure required that if the Company's final response is faxed, the manager will retain a copy of the daily fax transmittal log. The log was to be reviewed monthly. There was no evidence that management enforced this procedure.

The Company did not maintain a readily available data base or have a management system in place to ensure that timely responses were made to Bureau requests. In 7 instances, the Company was unable to confirm that responses contained in the Company's files were in fact sent to the Bureau. As explained more fully on pages 11-12, the Company was unable to demonstrate whether it had sent responses to the Bureau's inquiries for these 7 complaint cases.

Finding 5

The Company did not have adequate grievance handling procedures in place.

B. Company Operations/Management

Standard: Every domestic insurer shall have and maintain its principal place of business and home office in this State and shall keep therein accurate and complete accounts and records of its assets, transactions and affairs in accordance with the usual and accepted principles and practices of insurance accounting and record keeping as applicable to the kinds of insurance transacted by the insurer.

24-A M.R.S. § 3408

The Company did not provide complete complaint files upon initial request. As explained more fully on pages 18-19, the incomplete records caused unnecessary delay for the examiners and extended the duration and cost of the Examination beyond what it would have been otherwise.

The following is a chronology of some of the difficulty the examiners encountered in accessing complete records.

- On August 29, 2014, the examiners requested 2 sample files to review prior to the on-site exam. Those files were received on September 3, 2014. The examiners discovered that those files were incomplete.

- On August 29, 2014, the Company offered the date of September 10, 2014, that would work for their staff for the on-site portion of the examination. The Company stated that complete copies of the selected files would be made available to the exam team upon their arrival. On September 10, 2014, the examiners arrived on site and discovered that files were incomplete.

- On September 11, 2014, while on-site, the Company provided additional documents for some files. However, several files remained incomplete.

- On September 19, 2014, while on-site, the Company discussed the difficulties it was having locating some of the documents.

- On November 21, 2014, the examiners requested data on Maine Appeals. The Company provided timely data but the data contained 6 appeals that involved either self-insured group members, or members of plans issued in states other than Maine. The Company corrected the reports and explained that the out-of-state members were included as the result of user error at the time the reports were generated.

- On November 21, 2014, the examiners requested data on Maine Inquiries and Maine Grievances. The Company provided data that was rendered unusable for statistical purposes because of the inclusion of data from other states. However, the examiners did evaluate the Maine data and determined the items were coded correctly.

- On February 27, 2015, the examiners requested data on a selection of inquiries received by telephone by the Company's customer service representatives. The request asked for, "...complete copies, i.e., any and all communications and or documentation in the Company's possession pertaining to the event". During the April 14, 2015, on-site visit, despite the expansive nature of the examiners' February 27 request, the examiners discovered the Company failed to include in the data files the recordings of all the telephone calls. The data provided included some inquiries not within the Bureau's jurisdiction. Some of the calls were not provided. Some of the calls were not accessible to the examiners due to the Company's software.

- On April 23, 2015, the examiners, while on-site, requested the use of Company computers that had software required to access requested telephone calls. The Company assured the examiners that the computers would be made available later that day, but they were not.

- On April 24, 2015, the Company called to advise that it had located 19 call recordings and would provide them to the examiners the following week. On May 11, 2015, the Company emailed the examiners 33 call recordings.

The Company advised the examiners that contacts with the Company were coded as Complaints, Grievances, Appeals, and Inquiries. The default designation for a contact was "Inquiry." In order to check the accuracy of the coding, the examiners requested data on the total number of Maine Grievances and Appeals received during the period of Examination. The Company provided data supporting a conclusion that the Company received 803 Grievances and Appeals during the examination period. The examiners drew an ACL sample of 60 of the 803 Grievances and Appeals and reviewed them to test the accuracy of the coding. As indicated in the bulleted discussion above on the requests made on November 21, 2014, the examiners found that out of the 60 samples, 16 should not have been included in the data provided. The Company acknowledged that the 16 were erroneously included – they involved Grievances or Appeals from self-insured member groups or from plans issued in states other than Maine. One file (control number 15) was a complaint file and should not have been included. In addition to raising concerns about the adequacy and consistency of the Company's record keeping, this rendered the sample invalid for extrapolation purposes.

The examiners also requested data on the total number of Inquiries, 270,336, received during the period of examination. The examiners drew an ACL sample of 60 of these Inquiries and reviewed them to test the accuracy of the coding. The examiners found that out of the 60 samples, one sample Inquiry should not have been included in the data provided. One file (control number 4) was a non-resident of Maine and should not have been included. In addition to raising concerns about the adequacy and consistency of the Company's record keeping, this rendered the sample invalid for extrapolation purposes.[1]

Finding 6

The records maintained by the Company were neither accurate nor complete.

Standard: The register shall be maintained in a manner that is reasonably clear and accessible to the Superintendent.

Bureau Rule Chapter 850 § 10(A)(2)

24-A M.R.S. § 4302

As already noted on pages 10-11, the Company could not provide a complete and accurate grievance register upon request.

[1] The samples reviewed of the Company's Grievances and Appeals and Inquiries were rendered invalid by the inclusion of erroneous data. Despite this, the examiners reviewed the Grievances and Appeals and Inquiries that were properly included in each sample and found no miscoding.

Finding 7

The Company's grievance register was not reasonably clear or accessible.

Standard: A carrier shall provide annually to the superintendent information for each health plan that it offers or renews on plan complaints, adverse decisions and prior authorization statistics. 24-A M.R.S. § 4302(2)

The Examination revealed that the Company provided report was not accurate in that it contained appeals from states other than Maine. It is implicit in the statute that the reported data required by section 4302(2) must be complete and accurate.

The Company's Health Report Card Survey submitted to the Bureau in 2014 (reporting data for the 2013 calendar year) indicated 2,144 as the total number of enrollee complaints and grievances. When the examiners asked for an explanation of the data, the Company advised that the report included telephonic complaints and erroneously included out-of-state and self-insured group member appeals. Upon further review, the examiners discovered additional errors, such as the inclusion of data from an enrollee enrolled in an Anthem Medicare Advantage Plan.

Finding 8

The Company did not report accurate data to the Bureau on each health plan that it offers or renews on plan complaints, adverse decisions and prior authorization statistics.

Standard: Every person being examined, its officers, attorneys, employees, agents and representatives shall make freely available to the superintendent or designated examiners the accounts, records, documents, files, information, assets and mattes of that person in that person's possession or control relating to the subject of the examination and shall facilitate the examination. 24-A M.R.S. § 223(4)

Throughout the Examination, there were a number of instances where the Company had difficulty timely or substantively providing the examiners with requested data, thereby extending the duration and cost of the Examination. A discussion of some of these instances appears on pages 15-16. The following chronology illustrates some of the problems the examiners encountered during the course of the examination which delayed the Examination:

- On June 5, 2014, the examiners requested data in a specific format as to complaint prefixes, dates, and names. The Company failed to provide the data in the requested format, which required Bureau reformatting before the data could be properly sorted.

- On June 5, 2014, the examiners requested the Company's files on all Bureau complaints within the scope of the Examination. The Company omitted 16 complaints from the list.

- On June 5, 2014, the examiners requested complete copies of the complaint files to be examined and sought assurances that the files would be both ready and complete before starting the on-site portion of the Examination. Prior to the examiners' arrival, the Company provided assurances that the files would be complete. However, when examiners arrived (9/10/14), the files were not complete.

- On June 5, 2014, the examiners requested that the Company provide an attestation as to the completeness and accuracy of the material provided. The Company failed to provide the requested attestation thereby necessitating Bureau follow-up.

- On August 29, 2014, the examiners requested direct access to the Company's systems sufficient to allow the examiners read-only capability of all data bases relevant to the Examination. The Company advised that it was unable to provide read-only access to the examiners.

- On August 29, 2014, the Company agreed to September 10, 2014 as an acceptable date for the on-site portion of the exam and stated that complete copies of files would be made available to the exam team. Complete files were not available to the exam team on September 10, 2014.

- On August 29, 2014, the examiners requested 2 sample files to review prior to the on-site exam. Those files were received on September 3, 2014. The examiners discovered those files were incomplete.

- On September 10, 2014, the on-site exam start date, the Company failed to provide complete files.

- On September 11, 2014, while on-site, the Company provided additional documents for some files. However, several files remained incomplete.

- On November 21, 2014, the examiners requested data on Maine Appeals. The Company provided timely data but the data contained 6 appeals that involved either self-insured group members, or members of plans issued in states other than Maine. The Company failed to verify the data before providing it to the examiners.

- On November 21, 2014, the examiners requested data on Maine Inquiries and Maine Grievances. The Company provided data that was rendered unusable for statistical purposes because of the inclusion of data from other states. However, the examiners did evaluate the Maine data and determined the items were coded correctly.

- On February 27, 2015, the examiners requested data on a selection of Inquiries received by telephone by the Company's customer service representatives. The request asked for "...complete copies, i.e., any and all communications and or documentation in the Company's possession pertaining to the event". During the on-site visit of April 14, 2015, despite the expansive nature of

the examiners' February 27 request, the examiners discovered the Company failed to include in the data files the recordings of all the telephone calls. The data provided included some inquiries not within the Bureau's jurisdiction. Some of the calls were not provided. Some of the calls were not accessible to the examiners due to the Company's software.

- On April 23, 2015, the examiners, while on site, requested Company computers that had software required to access requested telephone calls. The Company made assurances that the computers would be made available later that day. The computers were not made available as promised.

Finding 9

The Company did not facilitate the exam due to their difficulty in providing data to the examiners.

RECOMMENDATION

The Bureau recommends that the Company review its procedures to ensure that it responds to Bureau complaints in a timely manner and that management establish and implement protocols to ensure that the Company responds timely and substantively when it receives a Bureau complaint. If the Company is unable to respond timely, it should request additional time to respond and provide a good faith reason why it cannot respond timely. This request must be made within the original time period allowed for response under section 220(2). Any request for an enlargement of time should be specific as to the number of additional days needed to respond substantively. Although the Bureau will often grant requests, the Company should not assume that requests for enlargement of time will automatically be granted.

The Company should address this matter in a detailed corrective action plan that provides for substantially enhanced management oversight of the complaint handling process.

ACKNOWLEDGMENT

The courtesy and hospitality extended by the officers and employees of the Company during the course of the Examination are gratefully acknowledged. The Examination was conducted and is respectfully submitted by the undersigned.

STATE OF MAINE

COUNTY OF KENNEBEC, SS

Allan C. Armstrong, MCM, CWCLA, Examiner in Charge, being duly sworn according to law, deposes and says that in accordance with the authority vested in him by Eric A. Cioppa, Superintendent of Insurance, pursuant to the Insurance Laws of the State of Maine, he has made an Examination on the condition and affairs of

Anthem Health Plans of Maine, Inc.

as of May 31, 2014, and that the foregoing report of Examination, subscribed to by him, is true to the best of his knowledge and belief.

The following examiners from the Bureau assisted:

Mary Masi, MCM, CIE

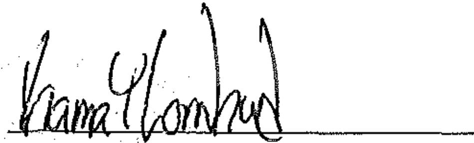
Suzanne Murphy, AIC, AINS, MCM

Kendra Coates, CPA, CIE, CFE

Allan C. Armstrong, MCM, CWCLA
Market Conduct Division Manager

Subscribed and sworn to before me

This **12th** day of **December, 2016**



Notary Public My commission expires:

KARMA LOMBARD
Notary Public, Maine
My Commission Expires June 12, 2023