In re: **Anthem Health Plans of Maine, Inc.** **and** **Maine Partners Health Plan, Inc.**	**Consolidated Docket No. INS 03-418** **CONSENT AGREEMENT**

This document is a Consent Agreement authorized by 10 M.R.S.A. § 8003(5), entered into by and among Anthem Health Plans of Maine, Inc., a Maine corporation ("Anthem Health"); Maine Partners Health Plan, Inc., a Maine corporation ("Maine Partners" and collectively with Anthem Health, the "Anthem Companies"); the Maine Superintendent of Insurance (the "Superintendent"); and the Maine Office of the Attorney General (the "Attorney General"). Its purpose is to resolve, in lieu of an adjudicatory proceeding, alleged violations of 24-A M.R.S.A. §§ 2436, 2673-A and 4303 and Bureau of Insurance Rule Chapters 360(4)(A), 850(7)(B)(5) and 940(8)(B).

GENERAL FACTS

1. The Superintendent is the official charged with administering and enforcing Maine's insurance laws and regulations, and the Maine Bureau of Insurance (the "Bureau") is the administrative agency with such jurisdiction.

2. Anthem Health, NAIC Company Code No. 52618, is a Maine domiciled health insurance company authorized pursuant to 24-A M.R.S.A. Chapter 5 that is authorized to operate a health maintenance organization as a line of business pursuant to 24-A M.R.S.A. Chapter 56.

I.

SPECIFIC FACTS: PPO

3. On June 5, 2000, Anthem Health acquired the assets and liabilities of Associated Hospital Service of Maine (d/b/a Blue Cross and Blue Shield of Maine) ("Blue Cross") and continued offering Blue Cross health plans, including the Comp-Care, Full Service, and HealthChoice plans. Anthem Health is authorized to offer health insurance plans under the Maine Insurance Code and offers these three plans under its non-HMO line of business.

4. Blue Cross was a nonprofit hospital and medical service organization authorized to offer provider network based health plans under 24 M.R.S.A. Chapter 19. Its Comp-Care, Full Service, and HealthChoice plans were not required to be registered as preferred provider (PPO) products.

5. Anthem Health's Comp-Care, Full Service, and HealthChoice plans each include financial incentives for enrollees to obtain services from health care providers who have contracted with Anthem Health to participate in networks utilized by these particular plans.

6. On or about November 14, 2001, Bureau staff met with Anthem Health and advised Anthem Health that its Comp-Care, Full Service, and HealthChoice plans must be registered as PPO products. Additional discussions on this issue between Bureau staff and Anthem Health

continued into 2002. On or about August 22, 2002, Bureau staff again notified Anthem Health that its Comp-Care, Full Service, and HealthChoice plans must be registered as PPO products.

7. On November 25, 2002, Anthem Health filed a PPO application with the Bureau for the Comp-Care, Full Service, and HealthChoice plans. The Superintendent approved the application on March 3, 2003.

8. Bureau staff has determined that Anthem Health's failure to timely register its Comp-Care, Full Service, and HealthChoice plans was an oversight rather than intentional, and Anthem Health has cooperated fully in filing these plans as PPO products in compliance with the registration requirements of 24-A M.R.S.A. § 2673-A and Rule Chapter 360(4)(A).

II.

SPECIFIC FACTS: ACCESS REQUIREMENTS

9. The Bureau received consumer complaints regarding reimbursement levels for services received from non-participating providers under Anthem Health's Comp-Care, Full Service, and/or HealthChoice plans. As a result of its investigation of consumer complaints, the Bureau has determined that some Anthem Health members enrolled in these plans have obtained services from non-participating providers when there was no participating provider available within the travel times provided in Rule Chapter 850, Section 7, Access to Services.

III.

SPECIFIC FACTS: RATE DIFFERENTIALS

10. Insurance Rule Chapter 940(8)(B), effective March 1, 2000, limits rate differences for individual health insurance plans with similar benefits. The Rule promotes fair premium structures and guards against the possibility that a consumer may unknowingly select a more expensive policy that does not provide correspondingly greater benefits.

11. On August 17, 2001, Anthem Health submitted its 2002 rate filing to the Bureau for its individual HealthChoice plans. The filing stated in part:

"Percentage increases are larger for high deductible plans, due to the effect of deductible leveraging. Deductible leveraging refers to the expectation that claims in excess of a fixed deductible are likely to trend upwards at a higher rate than overall claims. The dollar increases are smaller for high deductible plans, because the increases are based on existing rates that are smaller. The proposed rates also comply with past Bureau orders, further codified in Rule Chapter 940, that differences in proposed rates not exceed the differences in deductible value."

12. On August 2, 2002, Anthem Health wrote to the Bureau to request rate approvals for policies issued and renewed in 2003 for its individual health plans. Anthem Health's letter advised that its individual HealthChoice policies were currently out of compliance with Rule 940(8)(B), stating in part:

"HealthChoice Increases by Plan…The proposed rates, except for certain HealthChoice rates, also comply with past Bureau orders, further codified in rule Chapter 940, that differences in proposes rates not exceed the differences in deductible value. Certain HealthChoice deductible levels in some age bands are slightly out of compliance with this rule as they were discovered to be in the current rates as well. No adjustments were made to bring these rates into compliance as it would have created significant increases for subscribers currently enrolled in these benefit options."

13. During calendar years 2001, 2002, and 2003 some Anthem Health HealthChoice policyholders with lower deductibles were charged rates that exceeded the rates for higher deductibles by more than the difference between the deductibles for contracts covering one individual or by more then the allowable difference in deductibles for contracts covering two or more family members. Anthem Health estimates that the overcharges in 2001 were approximately $42,757.00, that the overcharges in 2002 were approximately $206,482.00 and that the overcharges during the first six months of 2003 were approximately $6,298.00.

14. The Superintendent acknowledges that in charging premiums in excess of amounts permitted by Rule 940, Anthem Health's actions appear to have resulted solely from mistake and oversight and that the rates and Anthem Health's implementation of them were approved by the Bureau. The Superintendent also acknowledges that Anthem Health voluntarily brought the mistake to the attention of the Bureau. The Superintendent further acknowledges that while some Anthem Health members received premium overcharges, other Anthem Health members received premium undercharges.

IV.

SPECIFIC FACTS: PROMPT PAYMENT INTEREST

15. Maine Partners, NAIC Company Code No. 95728, is a Maine domiciled health maintenance organization authorized pursuant to 24-A M.R.S.A. Chapter 56 and is a wholly-owned subsidiary of Anthem Health.

16. Anthem Health provides all administrative and management services for Maine Partners pursuant to certain management services agreements.

17. Central Maine Partners Health Plan, Inc., NAIC Company Code No. 95727 ("Central Maine Partners" and collectively with Maine Partners, the "Partners Plans"), was a Maine domiciled health maintenance organization authorized pursuant to 24-A M.R.S.A. Chapter 56 and was a wholly-owned subsidiary of Anthem Health as of September 1, 2000. Pursuant to a Decision and Order of the Superintendent dated December 21, 2000, Central Maine Partners merged with and into Anthem Health, and Anthem Health assumed all of the rights, obligations and liabilities of Central Maine Partners. Prior to the merger, Anthem Health provided all administrative and management services for Central Maine Partners pursuant to certain management services agreements.

18. Pursuant to the provisions of 24-A M.R.S.A. § 221, the Superintendent directed Bureau staff to conduct a targeted market conduct examination of the Anthem Companies.

19. The targeted examination was limited in scope to test for compliance with the so-called "prompt-pay statute" codified at 24-A M.R.S.A. § 2436.

20. The targeted examination was further limited to testing claims paid during the 2nd quarter of 2002, including April 1, 2002 through June 30, 2002.

21. The findings of the targeted examination are summarized in a certain Examination Report dated January 11, 2003.

22. The Anthem Companies fully implemented a new ACES claims system to process all claims paid on or after April 1, 2002.

23. The Anthem Companies advised the examiners that the Anthem Companies did not have an automated system for the payment of interest on overdue claims prior to April 1, 2002.

24. The Anthem Companies acknowledge that they have been aware of 24-A M.R.S.A. § 2436 as amended by P.L. 1999, c. 256 since the enactment of said public law.

25. The Anthem Companies did not implement a system to automatically calculate and pay required interest on overdue claims until April 1, 2002, when the new ACES claims system became operational.

26. Prior to April 1, 2002, the Anthem Companies paid interest for overdue claims only upon receiving an inquiry requesting such interest.

27. Prior to April 1, 2002, the Anthem Companies paid the following amounts in interest for overdue claims pursuant to 24-A M.R.S.A. § 2436:

1999 – 4th Quarter	$0.00
2000	$0.00
2001	$23.00
2002 – 1st Quarter	$15,699.99

28. The Anthem Companies have retrieved certain claims data from September 19, 1999 through March 31, 2002, to ascertain approximately how many claims were paid over 30 days from the date of receipt.

29. Given the format in which such data has been archived, the Anthem Companies are unable to readily identify those claims paid over 30 days from receipt that were "overdue" within the meaning of 24-A M.R.S.A. § 2436 within an acceptable timeframe and without disruption of services to current customers. Without reviewing each paper claim file, the Anthem Companies are not able to verify whether the companies asked for reasonable additional information within the original 30-day timeframe thereby tolling the time in which a claim is due for payment.

30. To date, the Anthem Companies have identified approximately 387,000 claims from September 19, 1999 through March 31, 2002 that were paid after 30 days from the date of receipt and may be due interest. The Anthem Companies further estimate that it would take numerous staff members approximately one year to review every such claim file to determine whether these claims were in fact "overdue" within the meaning of 24-A M.R.S.A. § 2436. The Anthem Companies further believe that this process could have a detrimental effect on its current customers.

31. The Superintendent and the Anthem Companies have agreed upon a fair and equitable process for the payment of interest to claimants whose claims were not paid within 30 days of receipt from September 19, 1999 through March 31, 2002. For the claims identified to date and assuming every such claim was "overdue" within the meaning of 24-A M.R.S.A. § 2436, the estimated total interest owed for this entire time period, excluding claims paid to Maine hospitals, is approximately $858,000.00. To date, the Anthem Companies estimate that approximately an additional $370,000.00 of interest may possibly be owed to Maine hospitals, but at least a portion of that amount may not in fact be owed due to certain periodic interim payment ("PIP") arrangements in place during this timeframe.

CONCLUSIONS OF LAW

I.

CONCLUSIONS OF LAW: PPO

32. Title 24-A M.R.S.A. §2673-A provides in part: "A carrier or administrator who proposes to offer a preferred provider arrangement shall file with the superintendent proposed agreements, rates, geographic service areas, provider networks and other materials relevant to the proposed arrangement."

33. Rule Chapter 360(3)(G) defines a preferred provider arrangement to mean: "a contract, agreement, or arrangement between a carrier or administrator and a provider in which the provider agrees to provide services to a health plan enrollee whose plan benefits include incentives for the enrollee to use the services of that provider."

34. Rule Chapter 360(4)(A) provides: "No person, partnership, carrier, or corporation shall commence offering a preferred provider arrangement after the effective date of this Rule, until the person, partnership, carrier or corporation has registered with the Superintendent as required by this Rule."

35. Anthem Health failed to timely comply with the PPO registration requirements of 24-A M.R.S.A. § 2673-A and Rule Chapter 360 by failing to submit a PPO application until November 25, 2002.

36. Pursuant to 24-A M.R.S.A. § 12-A, the Superior Court, upon an action brought by the Attorney General, may assess a civil penalty of up to $15,000, or the Superintendent may assess

a civil penalty of up to $10,000, per violation against any corporation or other entity that violates a provision of the Maine Insurance Code.

II.

CONCLUSIONS OF LAW: ACCESS REQUIREMENTS

37. Title 24-A M.R.S.A. § 4303(1) provides:

A carrier offering a managed care plan shall provide to its members reasonable access to health care services in accordance with standards developed by rule by the superintendent. These standards must consider the geographical and transportational problems in rural areas. All managed care plans covering residents of this State must provide reasonable access to providers consistent with the access-to-services requirements of any applicable bureau rule.
(24-A M.R.S.A. § 4303(1), as amended by P.L. 1999, c. 742, § 6)

38. Title 24-A M.R.S.A. § 4301-A(9) defines a "managed care plan" as follows:

"Managed care plan" means a plan offered or administered by a carrier that provides for the financing or delivery of health care services to person enrolled in the plan through:

A. Arrangements with selected providers to furnish health care services; and

B. Financial incentives for persons enrolled in the plan to use the participating providers and procedures provided for by the plan.
(24-A M.R.S.A. § 4301-A(9))

39. Pursuant to P.L. 1999, c. 742, Rule Chapter 850 was amended to make the access requirements of Section 7 of the Rule applicable to all managed care plans, including PPOs. Rule Chapter 850(7)(B)(5) provides: "In any case where the carrier has an insufficient number or type of participating providers to provide a covered benefit, the health carrier shall ensure that the covered person obtains the covered benefit at no greater cost to the covered person than if the benefit were obtained from participating providers, or shall make other arrangements acceptable to the Superintendent."

40. Anthem Health's Comp-Care, Full Service, and HealthChoice plans are subject to the access requirements of Rule 850(7)(B)(5). Some consumers enrolled in these plans have received services from nonparticipating providers when there was no participating provider available within the travel times provided in Rule Chapter 850(7). In certain circumstances, Anthem Health failed to provide members with benefits in accordance with the requirements of Rule Chapter 850(7).1

41. The Superintendent has the authority to require Anthem Health to refund overcharges pursuant to 24-A M.R.S.A. Section 12-A(4).

III.

CONCLUSIONS OF LAW: RATE DIFFERENTIALS

42. Pursuant to Rule Chapter 940(8)(B), rates for different benefit plans that vary based on benefit differences may not exceed the maximum possible difference in benefits. For example, the difference in annual premium between a plan with a $250 deductible and an otherwise identical plan with a $500 deductible may not exceed $250. Anticipated differences in utilization may not be used to justify a premium difference larger than this permitted variance.

43. The premiums that Anthem Health charged certain consumers for certain individual HealthChoice policies in 2001, 2002 and 2003 exceeded the premiums permitted by Rule 940(8)(B).

44. The Superintendent has the authority to require Anthem Health to refund overcharges pursuant to 24-A M.R.S.A. Section 12-A(4).

IV.

CONCLUSIONS OF LAW: PROMPT PAY INTEREST

45. Title 24-A M.R.S.A. § 2436 provides in relevant part as follows:

A claim for payment of benefits under a policy or certificate of insurance delivered or issued for delivery in this State is payable within 30 days after proof of loss is received by the insurer and ascertainment of the loss is made either by written agreement between the insurer and the insured or beneficiary or by filing with the insured or beneficiary of an award by arbitrators as provided for in the policy. For purposes of this section, "insured or beneficiary" includes a person to whom benefits have been assigned. A claim that is neither disputed nor paid within 30 days is overdue. If, during the 30 days, the insurer, in writing, notifies the insured or beneficiary that reasonable additional information is required, the undisputed claim is not overdue until 30 days following receipt by the insurer of the additional required information…If an insurer fails to pay an undisputed claim or any undisputed part of the claim when due, the amount of the overdue claim or part of the claim bears interest at the rate of 1 ½ % per month after the due date. (24-A M.R.S.A. § 2436(1) and (3))

46. Any overdue claim within the meaning of 24-A M.R.S.A. § 2436 bears interest at the rate of 1 ½ % per month after the due date. The Superintendent interprets this provision as requiring an insurer to automatically pay such interest when due regardless of whether a claimant specifically demands interest at the time of claim or otherwise.2

47. Pursuant to 24-A M.R.S.A. § 12-A, the Superior Court, upon an action brought by the Attorney General, may assess a civil penalty of up to $15,000, or the Superintendent may assess a civil penalty of up to $10,000, per violation against any corporation or other entity that violates a provision of the Maine Insurance Code. The Superintendent may order restitution pursuant to 24-A M.R.S.A. § 12-A(6).

GENERAL COVENANTS

48. The Anthem Companies, the Superintendent, and the Attorney General agree to the following.

49. This Consent Agreement is entered into in accordance with 10 M.R.S.A. § 8003(5)(B) and is not subject to review or appeal. This Consent Agreement is enforceable by an action in the Superior Court.

50. The Anthem Companies understand and acknowledge that this Consent Agreement will constitute a public record within the meaning of 1 M.R.S.A. § 402, and will be available for public inspection and copying as provided for by 1 M.R.S.A. § 408, and will be reported to the NAIC "RIRS" database.

51. Nothing herein shall prohibit the Superintendent from seeking an order to enforce this Consent Agreement, and nothing herein shall prohibit the Superintendent or the Attorney General from seeking further enforcement action in the event that the Anthem Companies do not comply with the terms of this Consent Agreement or in the event the Superintendent or the Bureau receives evidence that further legal action is necessary for the protection of Maine consumers.

52. Nothing in this Consent Agreement shall be interpreted as affecting in any way the authority of the Superintendent to bring additional enforcement action(s) for any actual or alleged violations of the laws that he is charged with enforcing.

53. Nothing in this Consent Agreement shall affect the rights or interests of any person who is not an undersigned signatory to this Consent Agreement.

54. This Consent Agreement may be modified only by the written consent of all of the parties.

55. The Anthem Companies have been advised of their right to consult counsel and have, in fact, done so prior to executing this Consent Agreement.

I.

SPECIFIC COVENANTS: PPO

56. Anthem Health agrees to pay a civil penalty of $1,000 for failing to timely submit a PPO application as required by Rule Chapter 360, such payment being due no later than August 31, 2003.

II.

SPECIFIC COVENANTS: ACCESS REQUIREMENTS

57. On or before August 31, 2003, Anthem Health, in consultation with the Bureau, will identify and will provide the Bureau with a report documenting any medical specialty (Gap specialty) in which the Comp-Care, Full Service, and HealthChoice plan members may not have been able to

obtain benefits from Maine network providers in accordance with the access requirements of Rule Chapter 850(7) for the period of April 1, 2002 through March 31, 2003.

58. On or before August 31, 2003, Anthem Health will identify whether there were non-participating providers in a Gap specialty for the period of April 1, 2002, through March 31, 2003. In the event that there existed non-participating Gap specialty providers in geographic areas of Maine for this period, Anthem Health will review all claims for the non-participating providers in the Gap specialty for the period from the effective date of this Consent Agreement retroactively to April 1, 2002. Anthem Health's review will determine where the member lives and whether there was a participating Maine specialty provider within the access requirements of Rule Chapter 850(7). In the event that there was a non-participating provider available to the member within the Rule Chapter 850 geographic access standard area but no participating specialty provider and the member's benefits were not adjudicated consistent with Rule Chapter 850(7), Anthem Health will calculate an adjustment due to the member.

59. Anthem Health will also make adjustments to prior claims payments if there was neither a participating nor a non-participating provider available to the member within the access standard and the member traveled to an area where there were both participating and non-participating providers available within the specialty, and the member received services from a nonparticipating provider.

60. On or before September 30, 2003, Anthem Health will document to the Bureau that Comp-Care, Full Service, and HealthChoice plan members, described in these Specific Covenants, who were not able to obtain covered services from participating providers within the travel time requirements of Rule 850(7) have been appropriately reimbursed so that the members receive benefits in accordance with the requirements of Rule 850(7)(B)(5), and Anthem Health will pay the adjustments directly to the plan members.

61. On or before September 19, 2003, Anthem Health will provide a detailed analysis of a random sample of at least 50 claims representing that population described in these Specific Covenants. The sample will be used to determine an average amount of underpayment in benefits for treatment received from a non-participating provider. From that average Anthem Health will develop a weighted average taking into account geographic areas that have the largest gaps in the provider network.

62. On or before November 1, 2003, Anthem Health will pay 75% of the amount based on the weighted average to affected members covered by Comp-Care, Full Service, or HealthChoice from April 1, 2002, through March 31, 2003, who received services from non-participating providers. The remaining 25% will be designated by way of a general ledger account to be used to pay enrollees who are entitled to more than the amount received in the first set of payments.

63. Along with the November 1st payments, Anthem Health shall enclose a letter explaining the purpose of the payment and indicating that if the enrollee received treatment from a non-participating provider from April 1, 2002, through March 31, 2003, because no participating providers were available within the access standards, and the enrollee believes he or she may be entitled to reimbursement greater than that received in the November 1st payment, the enrollee

should call a toll free number for more information. The enrollee will be given information by a customer service representative on how to request a specific claims review to ascertain if further payment is due.

64. Enrollees will be given until December 19, 2003, to contact Anthem Health for specific claims review.

65. Anthem Health will complete all specific claims reviews on or before January 19, 2004, including the issuance of any additional payments to enrollees. Any funds remaining in the 25% withheld will be distributed equally among the remaining enrollees who did not request specific claims review. Anthem Health will document to the Bureau that all distributions have been made.

66. Payments to enrollees can be made in the form of direct refunds or premium credits.

67. Anthem Health shall file detailed progress reports on these Specific Covenants with the Director of the Consumer Health Care Division on a bi-weekly basis commencing two weeks after the effective date of this Consent Agreement.

68. Subject to documentation of compliance with the other Specific Covenants herein relating to access requirements, the Superintendent will not impose civil penalties against Anthem Health in connection with consumer complaints the Bureau received prior to the effective date of this Consent Agreement for failing to administer its Comp-Care, Full Service, and/or HealthChoice plans in compliance with the access requirements of Rule 850(7)(B)(5).

III.

SPECIFIC COVENANTS: RATE DIFFERENTIALS

69. Anthem Health agrees to pay a civil penalty of $2,000 for violations of Rule 940(8)(B) as set forth above, such payment being due no later than August 31, 2003.

70. Anthem Health agrees to fully reimburse HealthChoice subscribers who were subject to overcharges. For current HealthChoice subscribers, reimbursement may be made through credits toward current premiums, by inclusion in a claim payment with appropriate identification of the purpose of the payment, or by a separate refund check.

71. Within 30 days of the execution of this Consent Agreement, Anthem Health agrees to provide the Superintendent with a detailed report stating the amount of the overcharge for each affected consumer and the proposed method of reimbursement.

72. Within 90 days of the execution of this Consent Agreement, Anthem Health agrees to provide the Superintendent with documentation showing that consumers have been reimbursed, stating the date, amount, and method of reimbursement for each consumer.

73. Anthem Health agrees not to recoup any reimbursements for overcharges through future rate increases, and Anthem Health agrees not to charge any consumer for undercharges that may have resulted due to the non-compliance with Rule Chapter 940(8)(B).

74. Subject to documentation of compliance with the other Specific Covenants herein relating to permissible rating differentials under Rule Chapter 940(8)(B), the Superintendent agrees not to order additional rating adjustments pursuant to Rule Chapter 940(8)(B) for the affected health plans in 2001, 2002, and 2003.

IV.

SPECIFIC COVENANTS: PROMPT PAY INTEREST

75. For all claims received on or after September 19, 1999 and paid through March 31, 2002, the Anthem Companies agree to accurately ascertain all claims that were paid more than 30 days from the date of receipt and that may be due interest. Such data retrieval, the methodologies employed, and supporting documentation must be made available to the Superintendent or Bureau staff within 15 days from the date of this Consent Agreement.

76. After verification by the Superintendent or Bureau staff that the methodologies employed, the number of claims identified and the total amount of interest owed is accurate, the Anthem Companies agree to make interest payments to each affected claimant as further outlined in these Specific Covenants.

77. Given the impracticability of any timely determination of whether each claim paid over 30 days from the date of receipt is in fact "overdue" within the meaning of 24-A M.R.S.A. § 2436 and in order to expedite payments to affected claimants, the Anthem Companies agree to pay interest to all subscriber members for claims in the time period referenced in Item 75 that were paid more than 30 days from the date of receipt with the assumption that all such claims were "overdue" pursuant to 24-A M.R.S.A. § 2436 for each day over 30 days from the date of receipt until the date the claim was paid.

78. For health care provider claims for the time period referenced in Item 75 but excluding claims from Maine hospitals, the Anthem Companies agree to review the 3 largest claims (in terms of interest possibly owed) to determine whether, in fact, interest is owed pursuant to 24-A M.R.S.A. § 2436. For the 3 largest claims, the Anthem Companies agree to pay all interest that is actually owed to the claimant pursuant to the requirements of 24-A M.R.S.A. § 2436. For any such claim that the Anthem Companies believe interest is not, in fact, owed to the claimant, this determination must be subject to verification and agreement by Bureau staff. For all other health care provider claims but excluding claims from Maine hospitals, the Anthem Companies agree to pay interest to all such claimants with the assumption that each claim was "overdue" within the meaning of 24-A M.R.S.A. § 2436 for each day over 30 days from the date of receipt until the date the claim was paid.

79. Recognizing that the Anthem Companies have entered into certain periodic interim payment ("PIP") arrangements with hospitals in Maine whereby fees for certain services are pre-paid and

subject to reconciliation, but acknowledging that certain claims submitted to the Partners Plans may not have been subject to such PIP arrangements, the Anthem Companies agree to determine whether any claims identified as being paid to a Maine hospital more than 30 days from the date of receipt for the time period referenced in Item 75 were subject to a PIP arrangement. For any said claims that were not subject to a PIP arrangement, the Anthem Companies agree to reconcile any interest owed to a Maine hospital as part of the next PIP settlement with each affected hospital.

80. Notwithstanding the foregoing Specific Covenants, the Anthem Companies shall not be required to pay interest to a claimant for any claim for which the Anthem Companies have previously paid interest.

81. The Anthem Companies agree to use their best efforts whenever possible to pay all amounts owed to a particular claimant in one check. All payments made pursuant to Items 77 and 78 must be mailed to the last known address of the claimant and must include a letter of explanation regarding the payment. The Anthem Companies agree to provide a copy of the proposed correspondence letter to the Bureau for review prior to mailing. The Anthem Companies will use their best efforts to locate any claimants whose checks are returned as undeliverable to ensure, if at all possible, that each claimant receives the amount owed.

82. The Anthem Companies shall provide regular status reports to the Superintendent not less often than bi-weekly until all amounts are paid as contemplated by these Specific Covenants. The Anthem Companies agree to maintain and provide access to all relevant systems, data, reports and documentation to Bureau staff sufficient to verify that the Anthem Companies have complied with the terms of this Consent Agreement.

83. The Anthem Companies agree to commit the necessary resources to ensure that interest payments made pursuant to Items 77 and 78 above will commence no later than 30 days from the date of this Consent Agreement and that all such payments will be made no later than 90 days from the date of this Consent Agreement.

84. Anthem Health agrees to pay a civil penalty of $250,000 for violations of 24-A M.R.S.A. § 2436 by Anthem Health and Central Maine Partners, such payment being due no later than August 31, 2003.

85. Maine Partners agrees to pay a civil penalty of $100,000 for violations of 24-A M.R.S.A. § 2436, such payment being due no later than August 31, 2003.

86. The Anthem Companies agree not to recoup any payments of interest or civil penalties made under these Specific Covenants or any costs associated with complying with these Specific Covenants in any future rate adjustments.

87. The Anthem Companies agree to maintain records sufficient to calculate and report interest payments owed and paid pursuant to 24-A M.R.S.A. § 2436. For a period of one year from the date of this Consent Agreement, the Anthem Companies agree to provide quarterly reports to the Bureau demonstrating compliance with 24-A M.R.S.A. § 2436.

88. The remainder of this page is intentionally left blank.

1 Anthem Health concedes to the Superintendent's interpretation of Rule 850 (7)(B)(5) in order to resolve this matter without resort to an adjudicatory hearing without waiving its right to raise arguments as to interpretation in the future.
2 The Anthem Companies concede to the Superintendent's interpretation of 24-A M.R.S.A. § 2436 in order to resolve this matter without resort to an adjudicatory hearing and without waiving the Anthem Companies' right to raise arguments as to interpretation in the future.

ANTHEM HEALTH PLANS OF MAINE, INC.

Anthem Health Plans of Maine, Inc.
Dated:_____, _____ By:
_____

_____
(printed name)

Its: _____
(Title)

State of Maine

Subscribed and Sworn to before me
_____
this _____ day of _____, _____. Notary Public

MAINE PARTNERS HEALTH PLAN, INC.

Maine Partners Health Plan, Inc.
Dated:_____, _____ By:
_____

_____
(printed name)

Its: _____
(Title)

State of Maine

Subscribed and Sworn to before me
_____
this _____ day of _____, _____. Notary Public

Signature Page 2 - **In Re:** **Anthem Health Plans of Maine, Inc.**
Maine Partners Health Plan, Inc.
Consent Agreement
Consolidated Docket No. INS 03-418

THE MAINE BUREAU OF INSURANCE

Dated: _____, _____ _____
Alessandro A. Iuppa
Superintendent

THE OFFICE OF THE ATTORNEY GENERAL

Dated: _____, _____ _____
Linda M. Pistner
Chief Deputy Attorney General