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

IN RE:	)	
	)	
ANTHEM BLUE CROSS AND BLUE	)	
SHIELD 2007 INDIVIDUAL RATE	)	
FILING FOR HEALTHCHOICE AND	)	DECISION AND ORDER
HEALTHCHOICE STANDARD	)	
AND BASIC PRODUCTS	)	
	)	
Docket No. INS-06-1000	)	

I. INTRODUCTION

Alessandro A. Iuppa, the Superintendent of the Maine Bureau of Insurance ("Superintendent") issues this Decision and Order, after consideration of the Anthem Blue Cross and Blue Shield ("Anthem") 2007 rate filing for individual HealthChoice, HealthChoice Standard, and HealthChoice Basic products. Anthem is required, pursuant to the provisions of 24-A M.R.S.A. § 2736(1), to submit for the Superintendent's approval proposed policy rates for individual health insurance products. In its filing, Anthem proposed revised rates for its HealthChoice products that would produce an average increase of 20.5% for currently enrolled members. In its prefiled exhibits, Anthem submitted a revised rate filing that slightly reduced the requested increases to a range from 3.3% to 34.8% with an average increase of 19.6%. Anthem requests that these rate revisions become effective on January 1, 2007. This Decision and Order constitutes final agency action on Anthem's filing.

II. PROCEDURAL HISTORY

On September 1, 2006, Anthem filed for approval proposed revised rates for individual HealthChoice, HealthChoice Standard, and HealthChoice Basic products. The Bureau of Insurance designated the matter as Docket No. INS-06-1000.

On September 6, 2005, the Superintendent issued a Notice of Pending Proceeding and Hearing. The notice set a public hearing for October 13, 2006, outlined the purpose of the hearing, set a deadline for intervention, and explained the hearing procedure. Pursuant to 5 M.R.S.A. § 9052, notice to the public was accomplished by publication in newspapers of State-wide circulation and on the Internet.

On September 8, 2006, the Superintendent issued a Protective Order which accepted in part Anthem's claim for confidential treatment of certain portions of its filing and described the conditions and procedures pertaining to the use and disclosure of confidential information in the course of the proceeding.

On September 12, 2006, the Superintendent issued a Procedural Order which, in accord with Maine Bureau of Insurance Rule Chapter 350, § 2(A)(1), established procedures for the conduct of this proceeding. The Procedural Order also established deadlines for serving discovery requests and for submission of pre-filed testimony and exhibits.

On September 14, 2006, the Superintendent issued an order granting intervention as of right to the Maine Attorney General. No party opposed the Attorney General's application for intervention.

On September 18, 2006, the Superintendent issued an order granting the Attorney General's motion for a continuance and revising the schedule of the proceeding in part; specifically extending the deadlines for discovery and prefiling, and continuing the public hearing to October 24, 2006. Anthem opposed the Attorney General's motion for continuance.

On September 20, 2006, the Superintendent issued an order granting permissive intervention, with full party status, to Consumers for Affordable Health Care ("CAHC"). Anthem filed a pleading in response to CAHC's intervention application. CAHC also moved for

reconsideration of the Superintendent's September 20th order, arguing for grant of intervention as of right. On September 28, 2006, the Superintendent issued an order denying CAHC's request for reconsideration.

Pursuant to 24-A M.R.S.A. § 2735-A, on or about September 29, 2006, Anthem provided direct written notice by mail to every affected policyholder, advising policyholders of the proposed rate increases, pending proceeding, and the scheduled hearing.

Between September 19, 2006, and the October 10, 2006 discovery deadline the Superintendent, the Attorney General, and CAHC engaged in discovery. The Superintendent served Anthem with three pre-hearing discovery requests, to which Anthem filed responses. The Attorney General served Anthem with two discovery requests to which Anthem filed responses and subsequent supplemental responses. CAHC served Anthem with one discovery requests to which Anthem filed responses and subsequent supplemental responses.

Anthem filed several additional requests for confidentiality for information provided pursuant to these discovery requests. At hearing on October 24, 2006, the Superintendent granted these motions, because the motions pertained to the identical or similar information covered by the Superintendent's original Protective Order. There were also certain discovery disputes between some of the parties, to which the Superintendent issued orders on September 26, 2006, October 13, 2006, and October 18, 2006.[1]

On October 19, 2006, Anthem and the Attorney General filed prefiled testimony and exhibits. CAHC did not make any prefiling. Anthem's prefiling included a revised version of its rate filing.

[1] The October 18, 2006, discovery dispute ruling was made on behalf of the Superintendent by his legal counsel, Assistant Attorney General Thomas Sturtevant, pursuant to e-mail communication.

On October 24, 2006, the Superintendent held a public hearing on Anthem's filing. Members of the public had an opportunity to make either sworn or unsworn statements for consideration by the Superintendent. Fourteen individuals provided such statements. Members of the public also submitted numerous written comments outside the public hearing that the Superintendent designated a part of the record of this proceeding. However, the Superintendent is barred from relying on these submissions in making his substantive decision by the strictures of the Maine Administrative Procedure Act regarding what may be properly relied upon as evidence in an administrative proceeding. 5 M.R.S.A. § 9057.

At hearing, Anthem presented testimonial evidence from William Whitmore, Actuary, John Cooper, Regional Vice-President of Sales for Maine, Amy Cheslock, Executive Director of Provider Network Management, and John Gallina, Vice President of Corporate Financial Planning and Analysis for WellPoint, Inc. The Attorney General presented testimonial evidence from Beth Fritchen, Principal with Mercer Oliver Wyman Actuarial Consulting, Inc. The Superintendent admitted into evidence several exhibits offered by each of the parties and also admitted into evidence Anthem's responses to the Superintendent's discovery requests.

After the parties rested their cases at hearing, the Superintendent provided an opportunity for the submission of written closing arguments. On October 27, 2006, Anthem filed written closing arguments. On October 30, 2006, the Attorney General and CAHC filed written closing arguments.

III. LEGAL STANDARD

Anthem is required by 24-A M.R.S.A. § 2736(1) to file with the Superintendent proposed policy rates for their individual health insurance products. The Superintendent may approve the

filed rates only if they are not inadequate, excessive, or unfairly discriminatory. 24-A M.R.S.A. § 2736(2). In addition, pursuant to 24-A M.R.S.A. § 2736-C(5) the proposed rates should be likely to yield a loss ratio of at least 65% as determined in accordance with accepted actuarial principles and practices. Anthem as proponent of the filed rates bears the burden of proving by a preponderance of the evidence that the proposed rates meet statutory requirements.

IV. DISCUSSION

The Superintendent finds that the proposed rates filed by Anthem in this proceeding are not inadequate. However, the Superintendent does find that the proposed rates as submitted by Anthem are excessive and unfairly discriminatory in contravention of section 2736 for the reasons discussed more particularly below. 24-A M.R.S.A. § 2736. This section includes a discussion of challenges to Anthem's proposed rates brought by the Attorney General and CAHC as well as deficiencies determined by the Superintendent. This section also comprises guidance for Anthem on what filing the Superintendent would approve. 24- M.R.S.A. § 2736-B.

A. Claim Costs

1. Large Claims

The Attorney General argued that for purposes of trend analysis, large claims should be removed and replaced by a pooling charge to reflect the expected level of large claims. Presumably, the expected level would be based on actual large claims smoothed to remove large variations from year to year. It is not clear whether the recommendation entails a flat pooling charge that is the same each year or one that increases each year. However, a flat charge would not be reasonable given price inflation and utilization increases. If an increasing pooling charge is used, it is not clear what impact this would have on the overall trend for HealthChoice.

Despite the Attorney General's statement that Anthem's failure to adjust for large claims overstates the trend, it could in fact understate the trend if a steep trend is used in developing the pooling charges. The Attorney General stated that based on the 64.5% trend in claims over $100,000 from 2004 to 2005, the level of these claims in 2005 is an anomaly. However, it would be equally consistent with the data to assume that 2004 is the anomaly, particularly in light of the relatively low trend from 2003 to 2004. It is not at all clear from the data how steep an increase in the pooling charge would be appropriate.

The Attorney General's point is well taken with respect to the potential effect of volatility in large claims. In fact, in filing its 2002 HealthChoice rates, Anthem made an adjustment for large claims very similar to that proposed by the Attorney General. Anthem should analyze the impact of large claims in future filings and make adjustments as needed. However, with respect to the current filing, application of this methodology would not necessarily reduce the overall trend, nor would it necessarily reduce the claims in the base experience period. The Attorney General's consultant stated that she was unable to calculate the impact with the information available. The very volatility in large claims that makes the use of a pooling charge desirable also makes it difficult to establish what charge, and what rate of increase in the charge, is appropriate. Actuarial judgment must be exercised and the range of reasonable values would be relatively wide.

2. Adjustment for Expected Changes in Enrollment

The Attorney General argued that the adjustment in claim costs to reflect the expected shift from low to high deductibles likely understates the favorable impact of those deductible shifts on claims, thereby overstating claims. No sufficient explanation is given for this conclusion. The Attorney General's consultant illustrated this point with an example involving

someone who had a $500 deductible but had no claims, pointing out that if this person moves to a $5,000 deductible, there will be no impact on claims. However, those with no claims are already reflected in the claims data. Therefore, Anthem's proposed adjustment appears reasonable.

3. Use of 12-Month Moving Data

The Attorney General also challenged the use of 12-month moving data on the grounds that this method results in overlapping data points with months in the middle of the experience period affecting more points than those at the beginning and end. While this must be kept in mind in analyzing the data, the impact can be neutralized, for instance by looking at every twelfth data point to remove overlapping points. In the case of the current filing, almost any analytical method applied to the experience would result in a substantial and increasing trend.

Based on the already articulated reasoning, Anthem's trend projections, prior to the application of the deductible leveraging adjustment, fall within the range of reasonableness.

4. Deductible Leveraging

Anthem adjusted the projected trend upward to reflect deductible leveraging, since a fixed deductible increases the impact of trend with higher deductibles having the greatest impact. Anthem determined an average deductible for all HealthChoice plans and applied a leveraging factor based on that deductible. This resulted in a larger adjustment than would have resulted from a weighted average of the leveraging factors for each deductible. Anthem argued that either methodology is reasonable and that the higher trend resulting from the methodology it used was compared to the observed benefit paid trend for reasonableness. The Superintendent finds that the two methodologies are not equally reasonable. The Superintendent concludes that

using a weighted average of the leveraging factors for each deductible is mathematically more accurate than using a leveraging factor based on the average deductible.

As for the resulting trend being reasonable in relation to the observed benefit paid trend, it is not clear what constitutes a reasonable relationship. It cannot be assumed that the future observed benefit paid trend will be the same as in the past. If Anthem believed that were the case, it could have based its projection on that trend rather than on the trend in allowed charges. Instead, Anthem explained in detail in its actuarial memorandum that the observed trend can be affected by changes in enrollment and other factors. In addition, relying on the assumption that the future observed benefit paid trend will be the same as in the past ignores information Anthem has about the future, such as changes to provider contracts and care management initiatives. As noted in the actuarial memorandum, the methodology used by Anthem takes these known factors into account, which the Superintendent finds appropriate.

Despite the over-adjustment for leveraging, it does not necessarily follow that the projected trend is overstated. It is clear that a considerable amount of actuarial judgment was used in selecting the trends and it is possible that if a smaller leveraging adjustment had been used, a higher base trend, still within the range of reasonableness, would have been selected to achieve what the actuary considered a reasonable final result. However, that is pure conjecture and there is no evidence in the record as to how actuarial judgment would have been applied if a more appropriate leveraging adjustment had been used.

In order to calculate an appropriate trend adjustment, it is necessary to have a leveraging factor for each deductible. Anthem provided factors from Milliman for only a few deductibles. An appropriate curve-fitting technique must be used to determine factors for other deductibles.

One possible approach is shown in Attachment A hereto.[2] The Superintendent finds such an approach would lead to rates that the Superintendent could lawfully approve.

B. Rate Relativities

For the third year in a row, Anthem has proposed rate increases for the mandated plans[3] that are significantly larger than for the non-mandated plans. This would result in rates for the Standard Plan with deductibles of $500 or $1,000 that are nearly double the rate for the non-mandated plan with the same deductible. While there are differences in benefits between the two plans that Anthem has not quantified, the benefits are substantially similar and the difference in the actuarial value of the benefits should not be large. Five years ago, the difference in the rates was not large either, as shown in the following table:

	Ratio of Rate for Mandated Plan to Rate for Non-mandated Plan				
Deductible	2002	2003	2005	Current	Proposed
$500	1.04	1.20	1.45	1.56	1.81
$1,000	1.05	1.22	1.50	1.65	1.91

The growing disparity between rates for the mandated and non-mandated plans has two causes. First, rates for the non-mandated plans with deductibles of $1,000 or less were reduced in 2003 to comply with Rule 940 restrictions on the difference in rates between higher and lower deductibles. Second, beginning in 2005, Anthem began applying larger rate increases to the mandated plans to reflect the worse experience under those plans. While the non-mandated

[2] Attachment A is the non-confidential version with confidential material redacted. The confidential version of Attachment A is subject to the terms of the September 8, 2006, Protective Order issued by the Superintendent in this proceeding.

[3] The mandated plans are the plans required to be offered pursuant to Bureau of Insurance Rule 750.

plans with low deductibles have had similarly poor experience, the Rule 940 restrictions have prevented this from being fully reflected in the rates.

The Attorney General argued that the volume of business in the mandated plans is too small to be fully credible. The Attorney General's consultant stated that her firm's credibility factors would assign only 46% credibility to this block. She suggested that the other 54% be based on the experience of the larger non-mandated block. Anthem's approach was to give 100% credibility to the experience of the mandated plans as a starting point in calculating projected claims but to assign it no credibility in determining the trend factor to be applied to that starting point. Both methodologies have flaws. The Attorney General ignored the large difference in the average deductible between the two blocks, which results in adverse selection against the mandated plans. Anthem assigns too much credibility in determining the starting point and too little credibility in determining the trend. These two errors may cancel each other to some extent. However, an additional complication results from the application of the deductible leveraging adjustment. Although the mandated plans have much lower deductibles on average and therefore should see much less impact from leveraging, the same leveraging adjustment was used to determine the trend factor for both blocks. Therefore, although the trend factor for both blocks was based on the combined experience, it implicitly assumes a higher base trend for the mandated plans offset by the lesser impact of leveraging.[4]

Anthem's proposed rate differences between the two blocks should be rejected even in the absence of these methodological weaknesses. At some point, the difference becomes so large as to be inequitable regardless of the differences in experience. An appropriate restriction would be to cap the difference such that the rate for the Standard Plan with a $1,000 deductible is no

[4] *See* Anthem's response to item 2 of the Third Information Request of the Superintendent.

more than 1.5 times the rate for the non-mandated plan with a $1,000 deductible. (Because of the Rule 940 restrictions, this would result in a ratio of less than 1.5 for the $500 deductible plans.) However, in combination with the other changes to the proposed filing as reflected in this discussion, this standard would require a small decrease in rates for the mandated plans at most ages. Instead, it is more reasonable that the rates for the mandated plans be kept at their current level for another year with the exception of the two new age bands.[5] This will result in ratios of 1.55 for the $1,000 deductible and 1.47 for the $500 deductible.

C. Administrative Expense

Anthem provided a corrected administrative expense calculation the day before the hearing and proposed that the Superintendent approve the filing with the revised charge. Anthem has not provided an amended filing reflecting this change. Although the Attorney General's consultant raised concerns about the expense charge in the initial filing, she found Anthem's revised charge reasonable.

The remaining issue concerns the cost of correcting three errors made by Anthem in implementing the 2006 rate increase. The Superintendent does not consider it appropriate to pass this cost on to policyholders. Anthem stated that this cost was $15,500.[6] In its closing statement, Anthem agreed to remove this cost if so ordered by the Superintendent. For the future guidance of Anthem, the Superintendent will not approve rates that include this charge.

[5] In this filing, Anthem has split the former "under 40" age band into an "under 30" band and a 30-39 band and has split the former 40-54 age band into a 40-44 band and a 45-54 band. The rating factors for the new 30-39 and 45-54 bands are higher than those used previously. Thus, mandated plans in those age bands will see a rate increase.

[6] *See* Anthem's response to item 1 of the First Information Request of the Superintendent.

D. Profit and Risk Margin

Anthem proposed an increase in the profit and risk margin from the current level of 3%. Anthem argued that this is justified due to the high level of risk associated with this line due to guaranteed issue and renewal. To an extent, Anthem's argument confuses high claim costs with high risk. Guaranteed issue and renewal certainly result in higher claim costs, but if those costs are predictable, they do not increase risk. As the Attorney General points out, guaranteed issue and renewal have been in place for several years and due to the large size of its block of business, Anthem has extensive experience to rely on in predicting future costs. Nonetheless, there are factors that make costs less predictable. As discussed above, there is substantial volatility in large claims. The large majority of these plans have high deductibles, which eliminate a lot of the smaller claims that tend to add more stability. This makes the large claims a larger proportion of the total.

Under other circumstances, the level of risk might justify a higher margin. However, two factors outweigh this argument. First, as Anthem has noted, rising rates have caused adverse selection in this line. Adding to the profit and risk margin, thereby increasing rates even more than dictated by the high claims trend, would only exacerbate this problem. Second, while there is a significant risk that this line will lose money in any given year, there is very little risk that this will impair the Company's solvency, both because this line is small relative to the Company's total business and because the Company currently enjoys an extremely healthy surplus. Therefore, the Superintendent continues to find that 3% is an appropriate margin for profit and risk.

E. Rates for Ages 65+

For several years, Anthem has filed rates for ages 65+ that were 25% above the rates for ages 55-64. As provided in 24-A M.R.S.A. § 2736-C(2)(E), this rate would only apply to those eligible for Medicare Part A without paying a premium. In addition, it would not apply if both the Medicare eligibility date and the issue date are prior to the effective date of the 65+ age band. In this proceeding, Anthem stated that it has never implemented this age band due to the administrative complexities and does not intend to implement it in 2007. Anthem stated that Attachments A and B of the filing, which show the higher rates for this band, would need to be revised. However, no revisions have yet been provided.

F. Calculation of Average Rate Increase

Anthem's filing calculates average rate increases in different ways in different exhibits. Exhibit I shows average increases of 20.5% for the non-mandated plans, 27.9% for the mandated plans, and 20.7% overall. Exhibit XII shows average increases of 19.2% for the non-mandated plans, 26.8% for the mandated plans, and 19.6% overall. The latter are the averages stated in the actuarial memorandum. The calculations differ in two ways. Exhibit XII is based on current enrollment and is not weighted by premium. Exhibit I is based on projected enrollment and is weighted by premium. The more appropriate method is to use current enrollment and weight it by premium. This can be calculated in Exhibit III by dividing "Total Income Using Proposed Rates and Current Enrollment" by "Total Income Using Current Rates and Current Enrollment." Accordingly, in order to submit rates the Superintendent could lawfully approve Anthem should amend their filing as follows :

- Exhibit I: Delete everything below the line "Total Required Premium at Anticipated Enrollment Level." The rest serves no purpose other than to calculate

the average required premium increase which, as noted, differs from that calculated elsewhere.

- Exhibit III: Add the following lines to the summary at the bottom:
    - In the "Non-Mandated Options" and "Mandated Options" sections, add a line labeled "Average Rate Increase Based on Current Enrollment" calculated by dividing "Total Annual Income Using Proposed Rates and Current Enrollment" by "Total Annual Income Using Current Rates and Current Enrollment" and subtracting 1.
    - In the "HealthChoice All Options" section, add a line labeled "Average Rate Increase Based on Current Enrollment" calculated by dividing the sum of "Total Annual Income Using Proposed Rates and Current Enrollment" for the non-mandated and mandated options by the sum of "Total Annual Income Using Current Rates and Current Enrollment" for the non-mandated and mandated options and subtracting 1.
- Exhibit XII: Delete the entire exhibit.

G. Savings Offset Payment

Anthem did not include a provision for the savings offset payment ("SOP") in its proposed rates but "requests that the Superintendent include in his Decision and Order in this proceeding a provision permitting Anthem BCBS to make a later compliance filing with the Bureau to adjust the approved rates to include any SOP that the DHA Board assesses for 2007." The Attorney General argued against this on the grounds that "Anthem has failed to demonstrate compliance with the statutory requirement that it account for any recovery of savings in its experience and in accordance with accepted actuarial principles. 24-A M.R.S.A. §§ 2736-C(2)(F) and 6913(9)." CAHC makes a comparable argument. Similar arguments were made in last year's Anthem 2006 rate proceeding. Like last year, the Superintendent finds that Anthem has met the requirements of the statute. Therefore, the Superintendent will grant Anthem's request.

V. FINDINGS AND CONCLUSIONS

On the basis of a preponderance of the credible evidence in the record, the Superintendent makes the following findings and conclusions:

1. Anthem's proposed rates are not inadequate.
2. Anthem's proposed rates are likely to yield a loss ratio of at least 65%.
3. For reasons set forth above in Sections IV(A)(4), (D), and (E), Anthem's proposed rates are excessive.
4. For reasons set forth above in Sections IV(B), Anthem's proposed rates are unfairly discriminatory.

A summary of the changes discussed in this Decision and Order to Anthem's proposed rates is included as Attachment B hereto.[7] If these changes are applied consistent with this Decision, as discussed in Section IV above, the Superintendent could lawfully approve the resulting rates. The impact of the Superintendent's changes to the proposed rates is shown in Attachment C hereto. As a result of the changes proposed by the Superintendent, the total average rate increase initially proposed by Anthem of 20.4% would be reduced to 16.7%, with the non-mandated plan average increase of 19.9% being reduced to 17.7% and the mandated

[7] Attachment B is the non-confidential version with confidential material redacted. The confidential version of Attachment B is subject to the terms of the September 8, 2006, Protective Order issued by the Superintendent in this proceeding.

plans average increase of 27.0% being reduced to 2.5%, as shown below:

Average Rate Increase (based on current enrollment, weighted by premium)

	Filed[8]	Resulting from Decision
Non-Mandated Plans	19.9%	17.7%
Mandated Plans	27.0%	2.5%
Total	20.4%	16.7%

Included as Attachment D hereto is a revised version of Exhibits I through XV and Attachments A through D of Anthem's revised filing and a new Exhibit XVI. These exhibits and attachments show the adjustments found reasonable by the Superintendent in this Decision and Order.[9]

VI. ORDER

Pursuant to the provisions of 24-A M.R.S.A. §§ 12-A(6), 2736, 2736-A, and 2736-B and authority otherwise conferred by law, the Superintendent hereby ORDERS:

1. Approval of the rates filed September 1, 2006, and revised on October 19, 2006, by Anthem Blue Cross and Blue Shield for individual HealthChoice, HealthChoice Standard and HealthChoice Basic products is DENIED. Accordingly, the proposed rates filed by Anthem for its individual HealthChoice, HealthChoice Standard, and HealthChoice Basic products do not enter into effect.

2. Anthem is authorized to submit revised rates for review and they shall be APPROVED if the Superintendent finds them to be consistent with the terms of this Decision and Order. Rates approved in this manner are to be effective on such a date as will assure a minimum of 30 days prior notice to policyholders.

[8] The column marked "Filed" indicates the percentage rate increases that were submitted by Anthem on September 1, 2006. On October 19, 2006, Anthem made revisions to its rate request that included slight reductions in the proposed increases; and on October 23, 2006, Anthem proposed an additional change to its rate request that further slightly reduced the proposed increases.

[9] Attachment D is the non-confidential version with confidential material redacted. The confidential version of Attachment D is subject to the terms of the September 8, 2006, Protective Order issued by the Superintendent in this proceeding.

VII. NOTICE of APPELLATE RIGHTS

This Decision and Order is final agency action of the Superintendent of Insurance, within the meaning of the Maine Administrative Procedure Act, 5 M.R.S.A. § 8002(4). It may be appealed to the Superior Court in the manner provided for by 24-A M.R.S.A. § 236, 5 M.R.S.A. §§ 11001 through 11008, and M.R. Civ.P. 80C. Any party to the proceeding may initiate an appeal within thirty days after receiving this notice. Any aggrieved non-party whose interests are substantially and directly affected by this Decision and Order may initiate an appeal within forty days of the issuance of this Decision and Order. There is no automatic stay pending appeal. Application for stay may be made in the manner provided in 5 M.R.S.A. § 11004.

PER ORDER OF THE SUPERINTENDENT OF INSURANCE

Dated: November 9, 2006

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ALESSANDRO A. IUPPA
Superintendent of Insurance