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

IN RE:	)	
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ANTHEM BLUE CROSS AND BLUE SHIELD 2014 INDIVIDUAL RATE FILING FOR HEALTHCHOICE, HEALTHCHOICE STANDARD AND BASIC, HEALTHCHOICE HDHP, HMO STANDARD AND BASIC, AND LUMENOS CONSUMER DIRECTED HEALTH PLAN PRODUCTS PURCHASED BY MEMBERS BEFORE JANUARY 1, 2014	)	**DECISION AND ORDER**
	)	
Docket No. INS-14-1000	)	

I. INTRODUCTION

I, Eric Cioppa, Superintendent of Insurance ("Superintendent"), issue this Decision and Order after consideration of the Anthem Blue Cross and Blue Shield ("Anthem") 2014 rate filing for individual HealthChoice, HealthChoice Standard, HealthChoice Basic, HealthChoice HDHP, HMO Standard, HMO Basic, and Lumenos Consumer Directed Health Plan products purchased before January 1, 2014 that are either (a) grandfathered policies under the federal Patient Protection and Affordable Care Act ("ACA") ("Grandfathered Products") or (b) existing non-grandfathered policies that the federal government has deemed exempt from certain requirements of the ACA pursuant to its transitional policy announced on November 14, 2013 and extended on March 5, 2014 ("Transitional Products" and, together with the Grandfathered Products, the "Legacy Individual Products").

By its filing, Anthem proposes to rate all of the Legacy Individual Products on a combined basis as a single risk pool. Anthem initially filed proposed revised rates for the Legacy Individual Products that, calculated on a combined basis, would produce an average increase of 19.60%. As identified in the filing, the increases varied from 18.2% to 21.3%

depending on deductible level and type of contract. Following the conclusion of the public hearing in this matter, Anthem made changes to its rate increase request that resulted in a revised proposed average rate increase of 18.32%.

As of August 28, 2014, total in-force enrollment for the Legacy Individual Products was approximately 7,110 policies, covering approximately 11,350 individuals who will be affected by Anthem's proposed rate revisions. Anthem requests that its proposed rate revisions become effective on January 1, 2015.

For the reasons discussed below, I am denying the average rate increase of 18.32% as filed, but would approve an average increase of 13.40%.

II. PROCEDURAL HISTORY

On August 28, 2014, Anthem filed a request to increase rates for its Legacy Individual Products. The Bureau of Insurance designated the matter as Docket No. INS-14-1000.

On September 4, 2014, the Superintendent issued a Notice of Pending Proceeding and Hearing, which scheduled a public hearing for October 21, 2014.

On September 17, 2014, the Superintendent granted the Attorney General's application for intervention as of right. No other person applied for intervention in the proceeding.

On September 23, 2014, the Superintendent issued a Procedural Order establishing procedures for the conduct of the proceeding, including deadlines for serving discovery requests and for submission of pre-filed testimony and exhibits.

Pre-hearing discovery was conducted, with the Superintendent and the Attorney General each making two sets of information requests to Anthem, to which Anthem filed responses.

On October 17, 2014, Anthem filed the pre-filed testimony and exhibits of Michael Bears, East Regional Vice President, Actuary III. Also on October 17, the Attorney General filed the pre-filed testimony and exhibits of Beth R. Fritchen, Partner with Oliver Wyman Actuarial Consulting.

The public hearing was held as scheduled on October 21, 2014, and was conducted entirely in public session. Members of the public had an opportunity to make either sworn or unsworn statements for consideration by the Superintendent. Members of the public also submitted written comments outside the public hearing which the Superintendent designated a part of the record of this proceeding. The Superintendent has read each of the written comments provided. To the extent unsworn oral or written statements comment on facts that are in the record, they shall be considered for their persuasive value in the same manner as legal arguments and other comments submitted by the parties. However, such statements are not evidence and the Superintendent may not consider them in making factual findings. 5 M.R.S. § 9057.

At hearing, Anthem presented testimonial evidence from its actuary, Michael Bears. The Attorney General presented testimonial evidence from her consulting actuary, Beth Fritchen. The Superintendent admitted into evidence Anthem Exhibits 1, 2, 3, 4a, 4b, 4c, 5a, 5b, 5c, 6, 7, 8 and Attorney General Exhibits 1, 2, 3. The Superintendent also admitted into evidence Anthem's responses to discovery filed throughout the proceeding, and an e-mail chain with the Centers for Medicare and Medicaid Services as reflected in the hearing transcript. There were no objections to any of the evidence being admitted into the record of the proceeding.

After the parties rested their cases at hearing, the Superintendent adjourned the hearing for the submission of responses to certain hearing panel inquiries and for the filing of written closing arguments.

On October 28, 2014, Anthem filed its responses to the October 21 hearing panel inquiries as well as to a Third Information Request issued by the Superintendent on October 23, 2014.

On October 31, 2014, Anthem and the Attorney General, respectively, filed their written closing arguments.

On October 31, 2014, the Superintendent issued a Fourth Information Request to Anthem, to which Anthem responded on November 4, 2014.

On November 6, 2014, the Superintendent issued a Fifth Information Request to Anthem, to which Anthem responded on November 7, 2014.

On November 7, 2014, the Superintendent issued an order for the taking of official notice of certain identified written communications with the Centers for Medicare and Medicaid Services. Anthem and the Attorney General were provided an opportunity to contest the matter noticed (*see* 5 M.R.S. § 9058). On November 10 in response to Anthem's request, and on November 12 in response to the Attorney General's request, the Superintendent provided clarifications regarding the purpose of the official notice. On November 13, 2014, both Anthem and the AG filed responses to the official notice. Neither party objected to the Superintendent taking official notice of the correspondence; rather, their filings addressed the proper significance and weight of the noticed documents.

Anthem has provided direct written notice by mail to every affected policyholder advising of the proposed rate increases.

III. LEGAL STANDARD

Anthem is required by 24-A M.R.S. § 2736(1) to file proposed policy rates for its individual health insurance products with the Superintendent. Because Anthem's proposed rate increase of 18.32% exceeds the 10% threshold for review established under the ACA, *see* 45 C.F.R. § 154.200, the rate filing is subject to the Superintendent's review and approval pursuant to 24-A M.R.S. § 2736(1). *See* 24-A M.R.S. § 2736-C(2-B). The Superintendent may approve the filed rates only if they are not excessive, inadequate, or unfairly discriminatory. 24-A M.R.S. § 2736(2). In addition, pursuant to 24-A M.R.S. § 2736-C(5), the Superintendent shall disapprove the rates unless it is anticipated that the rates will yield a loss ratio of at least 65% as determined in accordance with accepted actuarial principles and practices. That is, expected claims payments must be at least 65% of premium. Anthem, as the proponent of the filed rates, bears the burden of proving by a preponderance of the evidence that the proposed rates meet statutory requirements. 24-A M.R.S. § 2736-A.

IV. RULINGS

I hereby admit the following additional materials into the record of this proceeding:

1. Anthem's post-hearing responses to hearing panel inquires, including incorporated materials (filed on October 28, 2014).
2. Anthem's post-hearing Exhibit 9 (filed on October 28, 2014).
3. Anthem's post-hearing responses to further Superintendent inquiries (filed on November 4 and 7, 2014).
4. Correspondence from the Superintendent to Barbara Varnhagen of the Centers for Medicare and Medicaid Services, dated October 30, 2014.

5. Two e-mail communications between Robert Wake, Bureau of Insurance General Counsel, and Barbara Varnhagen of the Centers for Medicare and Medicaid Services, dated October 30 and November 3, 2014.

V. DISCUSSION

I find that the proposed rates filed by Anthem in this proceeding are neither inadequate nor unfairly discriminatory. However, I do find that the proposed rates as submitted by Anthem are excessive in contravention of 24-A M.R.S. § 2736 for the reasons discussed more particularly below.

A. Trend

Trend is the rate at which Anthem's overall healthcare costs are projected to increase during the rating period. Anthem's proposed 2015 rates incorporate a trend of 3.9%. The Attorney General contends that, assuming this block is priced based on its own experience, Anthem's trend is excessive, and should be reduced to 2.7%.

Anthem calculated its trend factor using a linear regression for a 50-month period, rather than the 40-month period used in past filings. Anthem's actuary, Mr. Bears, argued that a longer regression period was necessary to avoid over-weighting the 18-month period during which certain insurance reforms enacted by P.L. 90 were in effect, most notably the availability of subsidized reinsurance through the Maine Guaranteed Access Reinsurance Association ("MGARA"). Mr. Bears contended that the P.L. 90 reforms led to a one-time influx of younger, healthier customers, temporarily suppressing trend. The Attorney General's consultant, Ms. Fritchen, argued that a 40-month period is more appropriate because it is consistent with past filings. She also compared trends based on periods ranging from 24 to 60 months and found that Anthem chose the regression period that produced the highest trend of any period.

Another difference between Anthem's and the Attorney General's trend analysis is that while Anthem used a linear regression to calculate its trend factor, the Attorney General used an exponential regression, resulting in a slightly higher trend factor that would result from a linear regression.

I agree that Anthem's 50-month period overstates the trend, but have concerns with the Attorney General's approach as well. Both Anthem's 50-month period and the Attorney General's 40-month period include the first four months of 2014. While it typically makes sense to conduct a regression analysis starting with the most recent data available, it does not make sense here due to Anthem's decision to include in the rates a separate adjustment to account for a deterioration in morbidity that was observed during the first four months of 2014.

In previous rate filings, Anthem's proposed rates have not included a separate morbidity adjustment. Rather, changes in morbidity over time were captured in the trend factor. That approach was reasonable so long as morbidity changes were at a fairly steady rate over the trend period. In this case, however, data provided by Anthem show that morbidity for the Legacy block, after changing little during the last eight months of 2013, increased notably during the first four months of 2014. This increase was presumably driven by certain Legacy policyholders migrating into ACA plans during the open enrollment period.

Based on its assumption that morbidity in 2015 would follow a similar pattern as 2014, Anthem incorporated into its proposed rates a special morbidity adjustment of 8.72%. Given the 2014 experience, a special morbidity adjustment is reasonable. The problem with Anthem's approach is that it uses the same morbidity changes to support both its morbidity adjustment and its trend analysis. As a result, the morbidity changes during open enrollment are, to some degree, double counted in Anthem's proposed rates. The changes are incorporated into the

morbidity adjustment, and also simultaneously serve to boost the trend. By shifting the regression analysis to remove the 2014 enrollment period, that double counting is eliminated.

An alternative approach to address the double-counting of morbidity would be to use an 18-month trend period ending December 2013. This approach would measure trend exclusively for the period when MGARA was in effect. Because morbidity was fairly flat during this period, it could be well suited to determining a trend factor that excluded morbidity changes. This approach yields a trend of 2.36%. I decline to take this approach, however, for two reasons: First, an 18-month period may be too short to smooth out fluctuations. Second, since morbidity factors were only provided for the last eight months of this period, it cannot be concluded with any certainty that morbidity was flat during the first 10 months and not actually improving. Also, while Anthem attributed the lower trends during this period to MGARA, other changes occurred during the same period that may have influenced trend. Permissible rating bands for age were expanded and Anthem introduced a new plan design. Also Ms. Fritchen testified, "We've seen that in other states, as well, that in the last few years trends really have flattened out."

For these reasons, I conclude that the most appropriate trending period is the 40 months ending December 2013. Also, because trend reflects a rate of change, I agree with the Attorney General that an exponential regression is more appropriate than a linear regression for calculating trends. The resulting trend is 2.75%, compared to 3.9% used by Anthem and 2.7% recommended by the Attorney General. Multiplying the 2.75% trend by the leveraging factor and compounding for 20 months results in a medical trend factor of 1.0563.

While I have concluded that a 40-month period most appropriately balances all of the above considerations, it should not be assumed that this will be an appropriate number of months

in future filings. The 40- month period was initially used because it fit an observed 20-month cyclical pattern. Anthem has asserted that this pattern has changed and is now a 25-month cycle. A cycle that changes from year to year calls into question whether it is a cycle at all. In future filings, it may be necessary to take a fresh look at the appropriate trending period.

B. Morbidity Adjustment

Anthem proposed an 8.72% morbidity adjustment to the required premium rates in Exhibit I of the rate filing. This adjustment reflects the predicted change in risk factors of the Legacy block as policyholders lapse their coverage. Anthem has not included separate morbidity adjustments in its rate development for prior rate increases on this block of business. Anthem stated that they observed a 3.6% deterioration in risk factors from the experience period (May 2013 to April 2014) until June 2014 and a 4.9% deterioration during the 2013–14 ACA open enrollment period. Anthem built into the 2015 rates a morbidity adjustment consisting of the observed 3.6% plus 4.9% for the upcoming open enrollment period based on its assumption that the deterioration observed in the first open enrollment period would repeat itself in the second.

The Attorney General recommended substituting the morbidity adjustment used in Anthem's filing of ACA plans as part of a general approach relying on assumptions used in that filing. That recommendation is addressed elsewhere in this Decision.

While I do not doubt the observed deterioration in the morbidity, it is difficult to confirm the reasonableness of the assumption that this deterioration will continue at the same rate for the second open enrollment. Differences between the two enrollment periods and the lack of information about those lapsing make it difficult to determine who will lapse their policies.

Many policyholders that would lapse their Anthem Legacy policies may have done so already during the first ACA open enrollment. Those that found the ACA metal plans a better

deal or better suited to their needs may have already left the Legacy block. Unlike some other states, Maine had a large enrollment in ACA plans during the initial enrollment. Enrollment in individual plans grew from approximately 33,000 in 2013 to approximately 65,000 in 2014. It is therefore unlikely that overall lapses during the 2015 open enrollment period will be as high as in 2014.

Furthermore, to the extent there are additional lapses in 2015, they are unlikely to be concentrated among healthier, lower-risk members. The highest deductible available in an ACA-compliant plan is currently $6,600. Many of Anthem's Legacy plans, in contrast, have deductibles well above $6,600. These high deductibles allow Anthem to price these plans lower than any available ACA-compliant plans. Thus, the policyholders in these high deductible plans—who tend to be healthier than those with low deductibles—have little incentive to switch to more costly ACA-compliant coverage. Moreover, given the substantial increase in the individual mandate penalty in 2015—2% of household income (and, in some cases, more)—there is little incentive for these policyholders to drop insurance coverage completely, even in the face of a rate increase.

Based on member months for each of the plans provided by Anthem in Exhibit IV of the filing, slightly over half the Legacy block has deductibles over $6,600. Data provided by Anthem in response to a request from the Attorney General confirms that these policyholders have lower risk scores and that these plans have lower loss ratios, both of which indicate that these policyholders are healthier than those with lower deductibles. Given the economic incentives for these healthier policyholders to remain in high-deductible Legacy plans, it is unlikely that Anthem will see these policyholders lapse at the same rate as in the 2013–14 open enrollment.

For these reasons, I find that Anthem has not satisfied its burden of proof for the morbidity adjustment. The evidence provided does not support the assumption that policyholders lapsing during this second open enrollment will mimic the change during the first open enrollment. I accept Anthem's proposed value of 3.6% for the experienced change in risk factors but only half of the proposed 4.9% adjustment, or 2.45%, for the second enrollment, for a total morbidity adjustment of 6.14%.

C. Prescription Drug Rebates

Anthem initially estimated savings from prescription drug rebates to be $3.50 per member per month, but later amended it to $3.97, based on trending the values from 2011-2014. Ms. Fritchen calculated that the value would be $4.31 if the values were trended from 2012-2014, and recommended using $4.14, the average of the two values. Ms. Fritchen conceded, however, that $3.97, while not her preferred number, was at the low end of a range of reasonable numbers. I conclude that $3.97 is reasonable and will allow that value.

D. Risk and Profit Margin

Anthem has requested a 3% margin for risk and profit.[1] Except in unusual circumstances, that is a margin that the Superintendent has long considered reasonable for this line of business and I find this margin appropriate for the 2015 Legacy rates.

The Attorney General opposes the 3% profit margin for two reasons. The first is that Anthem made a substantial profit on this line of business in 2013, in large part due to higher-than-anticipated MGARA reimbursements. However, insurance is the business of risk. A consumer who buys insurance is paying a fixed amount to the insurer in return for the insurer's

[1] Anthem prefers to describe this figure as a "2% post-tax" margin. Taxes are always with us, and it is understood that corporate earnings are taxable when considering the appropriate margin to allow in a for-profit insurer's rates.

promise to be responsible for the unpredictability of the future. In some years, the insurer makes more than expected, in others less. The price for each year is based on the risk the insurer is assuming that year, not on the disgorgement of past profits or the recapture of past losses. Separate from the ratemaking process, the minimum loss ratio requirements do require rebates when the medical loss ratio does not meet the minimum of 80% – to the customers who paid those premiums, not to next year's customers – and federal officials have confirmed that MGARA reimbursements are taken into consideration when calculating those rebates.

In addition, the Attorney General asserts that the Legacy block "has already paid its dues to surplus and will never be able to fully cover its costs going forward." To be sure, there are some lines of business, such as life insurance and long-term care, that are designed to provide decades of coverage and are often priced in whole or part on a "level premium" basis, meaning that customers in their early years of coverage pay much more than their immediate risk, in return for the promise that as they age, coverage will be renewed at rates that will eventually be much lower than the immediate risk. But that is not how single-year health insurance policies are priced in a guaranteed-issue environment. Therefore, I do not find the Attorney General's arguments persuasive.

E. Other Issues

1. Management of Closed Block.

Ms. Fritchen argued that it is inappropriate to treat the closed block of business that is the subject of the proceeding as a distinct risk pool for rating purposes because (1) as the size of the block declines, the experience becomes less credible and (2) the sharp decline in enrollment expected during the rating period makes past experience a less reliable predictor of the block's future experience.

The Attorney General's argument conflates two different issues. A separate risk pool is not necessarily a credible risk pool. It is essential to understand what it means for a block of business to be a "risk pool." When insurance is sold, the cost of coverage must be based on the expected cost of claims for the coming year, and the risk pool is the level at which that comparison is made. Some individuals will pay less than their expected cost, others will pay more, but in the aggregate, a risk pool's premiums will inevitably equal the pool's expected cost of claims, plus the pool's expected expenses, plus or minus the pool's expected profit or loss. The reason this is inevitable is because it is how the pool's expected profit or loss is defined.

The law requires Anthem's ACA-compliant products to be rated as a separate risk pool from Anthem's other products, so the Superintendent has no choice in that matter. As noted above, there might in some circumstances be reasons why the expected profit margin for the Legacy risk pool might be set higher or lower than the expected margin for the ACA-compliant risk pool, but they do not apply this year. Moreover, requiring Anthem to essentially subsidize its Legacy plans with premiums collected from its ACA pool would seem to be in tension with the federal policy of excluding Legacy policies from the single risk pool.

The credibility of a risk pool is an entirely separate issue. Pricing a risk pool requires the best possible estimate of the pool's expected claims and expenses, and if the pool is too small, that cannot be based entirely on information developed from the pool's own experience. The Attorney General has therefore raised valid points that must be considered. However, even if the Attorney General's arguments ultimately prove persuasive, it would be premature to act on them in this year's rates.

With regard to the Attorney General's first point, I agree that credibility decreases with the size of the block, but in this case, current size of the block – over 11,000 members – is still

large enough to be considered fully credible. With regard to the second point, while it is clear that the morbidity is likely to change after the sharp reduction in membership based on which members choose to retain their plans and which do not, it is possible to reasonably estimate this impact. Whether Anthem's estimate of the morbidity change is the most reasonable one has been an issue in this proceeding and is discussed elsewhere in this Decision. Furthermore, the solution proposed by the Attorney General – to substitute the assumptions used in Anthem's rate filing for ACA plans – is problematic. That filing involves at least as much change between the experience period and rating period as the current filing because the experience period reflects only pre-ACA plans. Ms. Fritchen proposed using a morbidity factor and other assumptions that were estimated for anticipated enrollment in the ACA plans. Given the extent to which that filing necessarily relied on assumptions, those factors are no more reliable than those used in the current filing and they are not relevant to the same population.

For these reasons, it is appropriate to treat the Grandfathered and Transitional Products as a stand-alone block for the current filing. However, that may not remain the case in future years as the size of the block continues to decline, and Anthem will need to give consideration to appropriate rating methods at that time.

2. Cost Controls.

Joe Edwards, a Legacy policyholder with a long career in the insurance industry, testified that the nature of the current market for health insurance and health care will inevitably lead to excessive premiums because the manner in which responsibility for payment is divided between insurers and patients does not give anyone sufficient incentives to control costs. As he describes the system, insurers are paying for health care claims out of premium revenues rather than out of their own money, so their incentive is to take the costs of health care as they find them, and

charge a premium that will cover those costs plus a reasonable margin. Meanwhile, insurance means that the patient has already paid in advance for care and has no incentive to shop for the most cost-effective provider.

He gave an example from his own experience. Recently, he needed a clinical procedure, and was told it could be done at his local hospital. Most insured patients would simply schedule the procedure and not even think to ask about the cost, let alone set about comparison-shopping. But Mr. Edwards asked, and after considerable effort found out that it would cost about $4,500 at his local hospital. He then called around and discovered that another hospital, not much further away, would do the same procedure for less than $2,000. This situation happens constantly, but almost always, the insurer foots the bill, and then passes it along to consumers by building those costs into the premium rates.

Mr. Edwards recognized that rates resulting from this system might not be "excessive" as a matter of law. However, the lack of effective controls on health care costs is well known to be a serious structural failure in the American health care system, with crippling consequences both for individual consumers and the economy as a whole. Insurers must do their part, and these issues will continue to be revisited in future rate cases as long as the current dysfunctional market persists.

VI. FINDINGS AND CONCLUSIONS

On the basis of a preponderance of the credible evidence in the record, and for reasons set forth in Section V above, I find and conclude that Anthem's proposed rates are excessive. If the changes to the rates proposed by Anthem are applied consistent with this Decision and Order, as

discussed in Section V, I could lawfully approve the resulting rates. The necessary revisions to the proposed rates can be achieved by making the following changes to the filing:

1. In Exhibit I of the filing, change pharmacy rebates, mental health parity, healthcare management expense, and the insurer fee as proposed in Anthem's closing statement;
2. In Exhibit I of the filing, change medical trend factor from 1.0796 to 1.0563;
3. In Exhibit I of the filing, change the morbidity adjustment from 1.0872 to 1.0614.
4. In Exhibit V.A of the filing, set the rates for plans with the mental health rider equal to the rates for the comparable plan without the mental health rider.
5. In Exhibit V.A of the filing, change the rate in cell D856 such that the average rate increase in Exhibit V, cell D566 will equal 13.4%.

I find and conclude that such revised rates, appropriately developed per this Decision and Order, would not be excessive, inadequate, or unfairly discriminatory; and would likely yield a loss ratio of at least 65%.

As a result of the changes specified in this Decision and Order, the total average rate increase requested by Anthem of 18.32% would be reduced to 13.40%.

VII. ORDER

Pursuant to the provisions of 24-A M.R.S. §§ 2736, 2736-A, 2736-B and authority otherwise conferred by law, I hereby ORDER:

1. The rates filed August 28, 2014, as revised, by Anthem Blue Cross and Blue Shield for individual HealthChoice, HealthChoice Standard, HealthChoice Basic, HealthChoice HDHP, HMO Standard, HMO Basic, and Lumenos Consumer Directed Health Plan products purchased before January 1, 2104 are DISAPPROVED. Accordingly, the proposed rates

filed by Anthem for its individual HealthChoice, HealthChoice Standard, HealthChoice Basic, HealthChoice HDHP, HMO Standard, HMO Basic, and Lumenos Consumer Directed Health Plan products shall not enter into effect.

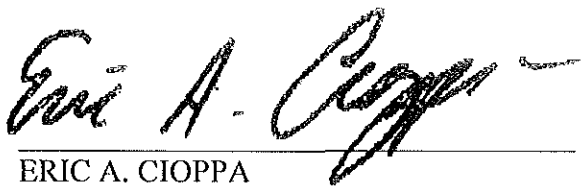
2. Anthem is authorized to submit revised rates for review and they shall be APPROVED if the Superintendent finds them to be consistent with the terms of this Decision and Order and that the effective date of those rates will assure a minimum of 30 days' prior notice to policyholders.

VIII. NOTICE of APPEAL 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. § 8002(4). It may be appealed to the Superior Court in the manner provided for by 24-A M.R.S. § 236, 5 M.R.S. §§ 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 after 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. § 11004.

PER ORDER OF THE SUPERINTENDENT OF INSURANCE

November 14, 2014



ERIC A. CIOPPA
Superintendent of Insurance