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

IN RE:	)	
	)	
ANTHEM BLUE CROSS AND BLUE SHIELD 2017 INDIVIDUAL RATE FILING	)	**DECISION AND ORDER**
	)	
	)	
Docket No. INS-16-1000	)	

I. INTRODUCTION

I, Eric Cioppa, Superintendent of Insurance ("Superintendent"), issue this Decision and Order after consideration of the 2017 rate filing by Anthem Health Plans of Maine, Inc., *d/b/a* Anthem Blue Cross and Blue Shield ("Anthem") and Anthem's proposed benefit modifications for its individual health insurance products.[1]

As required by law, Anthem proposes to rate all of its Individual Products on a combined basis as a single risk pool. By its initial filing, Anthem proposed an average rate increase of 14.1% for the individual risk pool, with a range of 7.6% to 19.4% depending on deductible level and type of contract. On July 15, as part of its pre-filed testimony in the proceeding, Anthem made changes to its request that resulted in a revised average increase of 19.4%, with a range of 12.5% to 24.8%. At the time of the initial filing, total in-force enrollment was approximately 15,650 individuals who will be affected by the proposed rate revisions. Anthem requests that its proposed rate revisions become effective on January 1, 2017.

[1] Anthem will offer the following individual products in 2017: Anthem Bronze HMO, Anthem Bronze POS, Anthem Bronze X HMO, Anthem Bronze X POS, Anthem Catastrophic HMO, Anthem Catastrophic POS, Anthem Catastrophic X HMO, Anthem Catastrophic X POS, Anthem Gold HMO, Anthem Gold POS, Anthem Gold X HMO, Anthem Gold X POS, Anthem Silver HMO, Anthem Silver POS, Anthem Silver X HMO, Anthem Silver X POS (the "Individual Products").

For the reasons discussed below, I am denying the revised average rate increase of 19.4% as requested, but would approve an average increase of 18.0%.

II. PROCEDURAL HISTORY

On May 10, 2016, Anthem filed a request to increase rates for its Individual Products. The Bureau of Insurance designated the matter as Docket No. INS-16-1000.

On May 16, 2016, the Superintendent issued a Notice of Pending Proceeding and Public Hearing, which scheduled a public hearing for July 20, 2016. The Hearing Notice also established an intervention deadline, but no person applied (timely or otherwise) to intervene as a party in the proceeding.

Also on May 16, 2016, the Superintendent issued a Procedural Order establishing procedures for the conduct of the proceeding.

On June 3, 2016, the Superintendent issued an Order Regarding Rate Revisions setting a uniform deadline for all insurers to file revised rate requests, if any.

The Superintendent issued one information request and made oral requests at hearing, to which Anthem filed responses.

On June 13, 2016, Anthem filed a correction to its Actuarial Memorandum.

On July 7, 2016, the Superintendent issued a Second Order Regarding Rate Revisions, to which Anthem responded on July 15, 2016.

On July 15, 2016, Anthem filed the pre-filed testimony and exhibits of Dee Clamp, Staff Vice President Actuary III; Zach Fohl, Actuarial Director; and William Whitmore, Regional Vice President of Sales.

The public hearing was held as scheduled on July 20, 2016, 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 the proceeding. The Superintendent has read each of the written comments provided. To the extent that 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 Dee Clamp, Zach Fohl, and William Whitmore. The Superintendent admitted into evidence Anthem's pre-filed testimony and exhibits as well as Anthem's responses to discovery filed throughout the proceeding. There were no objections to any of the evidence being admitted into the record of the proceeding.

After Anthem rested its case at hearing, the Superintendent adjourned the hearing for the submission of responses to certain hearing panel inquiries and for the filing of a written closing statement.

On July 28, 2016, Anthem filed its written closing statement together with its responses to the hearing questions.

On August 4, 2016, Anthem filed a motion to reopen the record of the proceeding for the purpose of submitting a supplemental written closing statement, and simultaneously filed a supplemental written closing statement.

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 premium rates for its individual health insurance products with the Superintendent. Because Anthem has requested a rate increase of 10% or more, thereby triggering the threshold for review established under the Affordable Care Act (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 make the following post-hearing rulings:

1. Anthem's post-hearing responses (filed on July 28, 2016) to the hearing panel inquiries are admitted into the record of the proceeding, with no objection by Anthem.

2. Anthem's August 4 motion to reopen the record of the proceeding is GRANTED, and the supplemental written closing statement is a part of the record of the proceeding.

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. Overview and Recent Market-wide Changes

Under the Affordable Care Act, an insurer may not implement an unreasonable rate increase unless it files and publishes a justification for the increase.[2] Under the Maine Insurance Code, an insurer may not implement an excessive or unfairly discriminatory rate increase at all.[3]

All rate increases in excess of 10% have been specifically identified as "potentially unreasonable" within the meaning of Bureau of Insurance Rule 940 and the regulations implementing the ACA.[4] Heightened scrutiny for increases of this magnitude is required in recognition of the hardship that significant price increases pose to consumers.[5] However, whether a rate increase is actually excessive depends on many factors. In some circumstances, a rate could be excessive even though it is well under the 10% threshold, while in others, a double-digit rate increase is unquestionably necessary. Each rate request must be evaluated on a case-by-case basis, considering both insurer-specific and market-wide factors.

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[2] Public Health Service Act, § 2794(a)(2).

[3] 24-A M.R.S. § 2736(2). Maine law also prohibits inadequate rates, which means that when an increase is necessary to prevent harm to the public, such as a potential threat to the financial integrity of an insurer, it is not only permitted but required. *See Anthem Health Plans of Maine, Inc. v. Superintendent of Insurance*, 2012 ME 21, ¶¶ 11–21 (approving the Superintendent's interpretation of the "not inadequate" standard).

[4] Bureau of Insurance Rule 940, § 4(F); 45 C.F.R. § 154.200(a)(1).

[5] Sometimes, it is suggested that the ACA's premium subsidies make the size of the premium increase less important, because for many consumers, most or all of the increase is paid for by the taxpayers. However, many consumers do not qualify for these subsidies. Others would be forced to change plans to take full advantage of the available subsidies, because the subsidies are based on the price of the second-cheapest Silver plan, which could be a different plan from year to year. For subsidized consumers who wish to keep their current plans, the percentage increase in the net amount they pay could in some cases be even higher than their underlying gross premium increase.

This year, all four insurers in Maine's individual market are requesting rate increases in excess of 10%, with their average increases ranging from 15.6% to 25.5%. Many states are seeing even larger requested increases. One reason for these increases is "trend" – the year-to-year increase in the underlying cost of health care – but trend alone would not support rate increases of this magnitude. While this year's rise in health care costs has been significant, and is expected to continue into 2017, it remains under 10% according to all four insurers' trend projections, which range from 7.2% to 9.6%.

Unfortunately, additional factors have combined this year to yield indicated rate increases substantially in excess of the health care cost trend. One major issue affecting the entire market is the discontinuance of the federal reinsurance program. This three-year transitional program, financed by assessments on the entire health insurance market, reimbursed insurers for a substantial portion of their high-cost claims. In 2016, the final year of the program, the reinsurance absorbs half of each claim in excess of $90,000, up to a cap of $250,000 per claim. Anthem projects that the loss of these reimbursements in 2017 will raise its claim costs by an additional 4.6%, above and beyond the increase required to keep pace with the underlying cost of health care. Additional cost factors affecting this year's premium increase to a lesser degree are discussed more fully below in the actuarial analysis.[6]

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[6] The ACA regulations, at 45 C.F.R. § 154.301(4), enumerate the following factors that can combine to drive premium increases:

> (i) The impact of medical trend changes by major service categories.
> (ii) The impact of utilization changes by major service categories.
> (iii) The impact of cost-sharing changes by major service categories, including actuarial values.
> (iv) The impact of benefit changes, including essential health benefits and non-essential health benefits.
> (v) The impact of changes in enrollee risk profile and pricing, including rating limitations for age and tobacco use under section 2701 of the Public Health Service Act.
> (vi) The impact of any overestimate or underestimate of medical trend for prior year periods related to the rate increase.
> (vii) The impact of changes in reserve needs.

B. Trend

Trend is the rate at which Anthem's overall healthcare costs including unit costs and utilization are projected to increase during the rating period. Anthem's proposed 2017 rates incorporate an annual pricing trend of 9.6%. Anthem stated the trend was developed by normalizing historical benefit expense for changes in the underlying population and cost drivers. Anthem also explained that the 9.6% trend is a paid claim trend, which takes into account the effect of cost share leveraging, as distinguished from an allowed cost trend methodology, which would measure the growth in the total cost of covered services and would make a separate adjustment for changes the share paid by enrollees. Anthem's estimate of trend reflected a recent acceleration in trend that was partly due to increases in the cost of pharmaceutical drugs, especially Hepatitis C drugs. Anthem's standards to qualify for treatment of Hepatitis C expanded effective January 1, 2016. Based on the evidence presented, I find that the proposed 9.6% annual pricing trend will not cause the rates to be excessive or inadequate.

C. Adjustments

Anthem made several adjustments to reflect differences between the 2015 experience used as a basis for projection and its expectations for the 2017 projection period. I find none of these adjustments will cause the rates to be excessive or inadequate.

(viii) The impact of changes in administrative costs related to programs that improve health care quality.
(ix) The impact of changes in other administrative costs.
(x) The impact of changes in applicable taxes, licensing or regulatory fees.
(xi) Medical loss ratio.
(xii) The health insurance issuer's capital and surplus.
(xiii) The impacts of geographic factors and variations.
(xiv) The impact of changes within a single risk pool to all products or plans within the risk pool.
(xv) The impact of reinsurance and risk adjustment payments and charges under sections 1341 and 1343 of the Affordable Care Act.

1. Morbidity Adjustment

Anthem's July 15 revision to its rate filing provided for a morbidity adjustment of 7.84% to adjust its experience to the average morbidity level for Maine's individual ACA market. The ACA includes a risk adjustment mechanism by which carriers that cover members with below-average risk pay in and carriers that cover members with above average risk receive payments. The intent is to share the risk among all carriers in order to create a level playing field. Anthem will pay $3.9 million into the risk adjustment system for 2015, indicating that its members have a below-average risk level. This was the basis for the 7.84% morbidity adjustment. Due to this adjustment, Anthem's projected 2017 claim costs assume that its 2017 risk level will be average and therefore no risk adjustment assessment or payment will be due. If its 2017 risk level remains below average, the claim costs may be less than projected but the savings would be offset by a risk adjustment assessment. An alternative methodology would have been to assume below-average risk in projecting claims and estimating the risk adjustment assessment that would be payable as a result. Either methodology is acceptable and should yield similar results.

The ACA rules require a Unified Rate Review Template (URRT) that shows the rate development in a prescribed format. The methodology actually used to set the rates does not need to be the one encompassed in the URRT, but the resulting rates must be the same. The rules also require an Actuarial Memorandum to support the URRT. Anthem's Actuarial Memorandum reflected the methodology actually used to set the rates and therefore did not match up to the URRT. In the case of the morbidity adjustment, the Actuarial Memorandum made the 7.84% adjustment *to the base experience* and then used a 0% morbidity adjustment in projecting to 2017, while the URRT *starts from unadjusted experience* and applies the 7.84% morbidity adjustment when projecting to 2017. Accordingly, the Actuarial Memorandum

showed the 7.84% as an adjustment to the base experience but the URRT showed the same figure as a morbidity adjustment. The result of each calculation is identical. However, for future filings, Anthem's Actuarial Memorandum should, as required, provide support for the URRT. It may also include an alternative methodology that more accurately describes the basis actually used to develop the rates, but the Actuarial Memorandum must at a minimum include a supporting explanation that matches the URRT that the Memorandum supports.

2. Age and Gender

Anthem calculated a downward 0.15% adjustment to reflect differences between age and gender distribution of members reflected in the experience and the projected 2017 geographic distribution.

3. Area and Network

Anthem included a 6.39% adjustment to reflect differences in the geographic and network distribution of members. This adjustment was calculated based on an analysis of allowed claims by network, mapped to the prescribed rating areas.

4. Benefit Plan

Anthem calculated a downward 5.81% adjustment to reflect a change in the average benefit level from the projection period. The benefit relativities Anthem used for this calculation include the value of cost shares and anticipated changes in utilization due to the difference in average cost share requirements. Cost sharing was considered in addition to utilization because Anthem developed its rates by projecting paid claims rather than allowed claims.

5. Seasonality Maturing Adjustment

Anthem included a 0.5% adjustment to reflect policies that have less than 12 months of experience. The seasonality factors take into account claim seasonality during the year and the

effect of calendar-year deductibles in health insurance. This adjustment was calculated by comparing the distribution by number of months covered for the experience and projected periods.

6. Induced Demand Due to Cost Share Reductions

Anthem included a 0.39% adjustment to reflect changes in induced demand due to cost share reductions. Individuals who fall below 250% of the Federal Poverty Level and enroll in On-Exchange silver plans will be eligible for cost share reductions ("CSR"), which result in increased utilization. This adjustment was calculated by comparing the percentage of enrollment in CSR Plans in the experience period to that of the projection period to adjust for the different induced demand level due to CSR between the two periods.

7. Grace Period

The ACA allows a 90-day grace period during which the insurer cannot cancel coverage for non-payment of premium. If the premium is still unpaid at the end of 90 days, coverage may be cancelled but the insurer is still liable for claims incurred during the first month of the grace period. Anthem calculated a 0.66% adjustment to account for incidences of enrollees not paying premiums due during the first month of the 90-day grace period when the Qualified Health Plan is liable for paying claims, and the uncollectibility of the resulting premium debt.

8. Benefit Modifications

Anthem included a 0.2% adjustment to reflect two benefit modifications: separate and equal annual visit limits for habilitative and rehabilitative therapy services will be required and,

due to a new benchmark plan for 2017, Skilled Nursing Facility benefits will be limited to 150 days.[7]

9. Prescription Drug Rebates

Anthem reduced its projected claims by $8.04 per member per month to reflect prescription drug rebates.

10. Additional Essential Health Benefits

Anthem increased its projected claims by $0.85 per member per month to reflect additional Essential Health Benefits. This included $0.20 for pediatric dental, $0.54 for pediatric vision, and $0.11 for compliance with the non-discrimination requirements of 45 C.F.R. Part 92.

D. Profit and Risk Margin

Anthem's 2016 individual rates include a 3% pre-tax margin for profit and risk, as they have for a number of years. Except in unusual circumstances, it is a margin that the Superintendent has long considered reasonable for this line of business.[8]

For 2017, Anthem has filed for approval of revised rates that increase this margin from 3% to 4%. Anthem asserts that the ACA market poses considerable risks, and points to the losses other insurers have incurred, both in Maine and nationwide. However, as Anthem emphasized in earlier rate filings, the individual market also imposed considerable risks before the ACA. It is true that the market continues to evolve and will need more time to stabilize, and that the ACA has introduced some new risk factors. On the other hand, the ACA has also introduced new tools for mitigating risk. In particular, although risk adjustment is by no means

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[7] Because the values of these adjustments are below the 5% statutory threshold, the product changes are deemed to be minor modifications under the law (and not product discontinuances). *See* 24-A M.R.S. § 2850-B(3)(I).

[8] *See, e.g., In re Anthem Blue Cross and Blue Shield 2014 Individual Rate Filing*, No. INS-14-1000.

perfect, it does mitigate the risk that one insurer will draw a less favorable enrollee base than its competitors.

Furthermore, the profit and risk margin is not the only mechanism in Anthem's filing that addresses the risk and cost factors that Anthem has identified. While there are significant cost drivers this year, such as the elimination of the transitional reinsurance program, Anthem has incorporated those into its filing as costs to be recovered through the rates themselves. The uncertainty of next year's health care costs is addressed not only by the profit and risk margin, but also by a volatility factor that is built into Anthem's trend projection.

Another buffer against volatility is the expense provision for taxes. Anthem's requested 4% profit margin is separately itemized in the filing as a 2.24% after-tax charge and a 1.76% allowance for expected federal income taxes. Anthem will pay additional taxes on any marginal profit in excess of the projected amount, but if experience is adverse and the business is less profitable, or runs a loss, Anthem will be liable for less federal income tax than the amount that has been passed through to policyholders as an expense component in the proposed rates.[9]

On balance, this year's market does not present an unusually high level of risk that would warrant higher margins than would normally be approved.[10] Maine's individual market remains

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[9] Anthem suggests that pre-tax profit fails to provide an accurate comparison between nonprofit and for-profit insurers. However, taxes are properly addressed as an expense that is taken from profits after the fact, and nonprofit insurers' tax-exempt status is fully reflected in their rate filing by the absence of any tax allowance.

[10] As previously explained, and found reasonable by the Law Court:

> [T]he Superintendent's determination of what is an approvable rate for a one-year period (including what, if any, built-in expected profit to provide) involves a balancing of investor and consumer interests. In other words, the *amount* at which to approve a built-in expected profit in regulated rates, must balance the need for a rate not to threaten the company's or enterprise's financial integrity against the legitimate government interests

more competitive than it had been in earlier years. Other insurers have demonstrated their interest in participating in the market and assuming its risks, and Anthem has demonstrated an ability to manage these risks effectively. I therefore find that Anthem's 4% profit and risk margin will cause the rates to be excessive, but that a revised margin of 3% will not cause the rates to be inadequate or excessive under current market conditions.[11]

E. Administrative Costs

Anthem's filing provided for administrative costs of $47.22 per member per month (PMPM) for rates effective January 1, 2017, which is 9.872% of premium with the requested 4% profit margin and 9.978% of premium with the approved 3% profit margin. This dollar amount represents a 31.5% increase over the 2016 rate filing, which included $35.90 PMPM, or 8.99% of premium. Anthem stated that some costs it has been paying on an ongoing basis were not included as administrative costs in the previous filing because the Company assumed that they were one-time costs associated with the roll-out of the Affordable Care Act. However, according to Anthem, these costs have not abated. Anthem is now including these expenses as general administrative costs since they have documented the increased costs of administering ACA products on an ongoing basis. Anthem included a table showing the breakdown of

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> of protecting the viability of the insurance pool, keeping insurance premiums as reasonable as possible, and minimizing adverse selection. There is no bright-line test.

In re Anthem Blue Cross and Blue Shield 2011 Individual Rate Filing, No. INS-11-1000 (footnote omitted); *Anthem Health Plans of Maine, Inc. v. Superintendent of Insurance*, 2012 ME 21, ¶21. At a time when individual health insurance consumers are facing double-digit rate increases market-wide, it is particularly important to scrutinize proposed increases in insurer profit margins in order to keep insurance premiums reasonable.

[11] At hearing, Anthem's counsel represented that the Company was "not here claiming insufficient surplus or capitalization" (*i.e.*, that rate inadequacy was not at issue in the proceeding); and Anthem's witness confirmed that for its Maine business in 2015 Anthem was profitable company-wide. July 20 Hearing Transcript at p. 39, ln. 11 – p. 40, ln. 10. Moreover, I find that the revised rates that would be approved, with a built-in 3% profit and risk margin, will not threaten the financial integrity of the Company and, therefore, are not inadequate.

administrative costs going back to 2014 in their post hearing response. This table omitted three minor cost categories that totaled $3.63 PMPM in the 2017 filing. For the remaining categories, actual administrative costs were $60.41 PMPM in 2014 and $43.78 PMPM in 2015 while the proposed cost for these categories in the 2017 filing is $43.59 PMPM, essentially the same level as the actual 2015 expenses. I therefore find that Anthem's administrative costs will not cause the rates to be excessive or inadequate.

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 approve the resulting rates as not being excessive, inadequate, or unfairly discriminatory and therefore in compliance with Maine law. The necessary revisions to the proposed rates to reflect a reduction of the pre-tax profit margin from 4% to 3% can be achieved by making the following changes to the filing:

1. Reduce the after-tax profit margin from 2.239% to 1.679%.
2. Reduce the taxes and fees from 4.551% to 4.111% to reflect the reduction in federal income tax resulting from the reduced profit margin.
3. Increase the administrative expenses from 9.872% to 9.978%, because costs that are unchanged on a PMPM basis represent a larger percentage of premium when the premium is reduced.

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 May 10, 2016, as revised, by Anthem for its Individual Products are DISAPPROVED. Accordingly, the proposed rates 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.

3. Anthem shall make its compliance filing with the Superintendent no later than August 18, 2016, addressing item (2) above.

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

August 16, 2016

ERIC A. CIOPPA
Superintendent of Insurance