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

IN RE:	)	
	)	
ANTHEM BLUE CROSS AND BLUE	)	
SHIELD REQUEST FOR APPROVAL	)	**DECISION AND ORDER**
OF ACCESS PLANS	)	
	)	
Docket No. INS-13-801	)	

I. INTRODUCTION

Eric A. Cioppa, Superintendent of Insurance ("Superintendent"), issues this Decision and Order in the above-captioned matter after consideration of the Anthem Blue Cross and Blue Shield ("Anthem") requests for approval of two new Access Plan filings. Anthem refers to its Access Plans as the "Anthem Guided Access HMO" and the "Anthem Guided Access POS."[1] Anthem will offer its Guided Access HMO plans to members residing in Androscoggin, Cumberland, Franklin, Kennebec, Knox, Lincoln, Oxford, Sagadahoc, Waldo, and York Counties; and will offer its Guided Access POS plans to members residing in Aroostook, Hancock, Penobscot, Piscataquis, Somerset, and Washington Counties. The health care services that will be available under the Access Plans include inpatient and outpatient medical care and surgical care, ancillary services, mental health and substance abuse services, and pharmacy benefits—with each service being provided subject to and in accordance with the terms of Anthem's applicable health plan contract.

The Anthem Guided Access HMO network has been referred to by the parties to this proceeding as a "narrow network," meaning that a significant number of health care providers in the ten identified southern Maine counties are not included in the proposed HMO network.

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[1] "POS" stands for "point-of-service," and refers to an HMO product that provides enrollees the option to obtain covered services out of network. *See* 24-A M.R.S. §§ 4202-A(16) & (17), 4207-A.

Conversely, the Anthem Guided Access POS network is what has sometimes been referred to as a "broad network," including nearly all of the providers in the six identified northern Maine counties.

Anthem proposed the new Access Plans for use beginning January 1, 2014 in both new and replacement non-grandfathered products in Anthem's small group and individual health maintenance organization (HMO) line of business, including the individual and small-group products to be offered by Anthem next year on Maine's federally facilitated exchange under the federal Affordable Care Act (ACA).

The Superintendent exercised his authority to establish a prompt hearing and expedited procedural timeframes in order that timely final agency action may be achieved in this proceeding. Expedited treatment was necessary because the federal government has set July 31, 2013 as the deadline for state recommendations for federal certification of Qualified Health Plans (QHP). As part of the July 31 recommendation for QHP certification, the Superintendent must certify that Anthem's proposed exchange products meet all applicable state-law requirements, including those relating to network adequacy and those relating to premium rates. In order to conduct a meaningful review of proposed rates prior to July 31, 2013, the Superintendent must first determine, in a timely fashion, whether Anthem's proposed products are designed consistent with applicable statutory and regulatory requirements, including network adequacy standards.

II. PROCEDURAL HISTORY

Anthem Applications for Approval

On Friday, May 31, 2013, Anthem submitted its two Access Plan filings for approval by the Superintendent. On June 18, 2013, Anthem filed updates to its proposed Guided Access HMO and Guided Access POS network provider lists.

Notice of Proceeding and Hearing; Public Comment Session

Upon exercising his discretion to hold a hearing in this matter, on Wednesday, June 5, 2013, the Superintendent issued a Notice of Pending Proceeding and Hearing ("Hearing Notice"). The Hearing Notice provided a statement of the legal authority and jurisdiction under which the proceeding would be conducted; referred to the particular substantive statutory and rule provisions involved; contained a short and plain statement of the nature and purpose of the proceeding; stated the time and place of the hearing; stated the manner and time within which evidence and argument could be submitted to the Superintendent for his consideration in the proceeding; and stated the manner and time within which applications for intervention could be filed with the Superintendent.

As established by the Hearing Notice, the purpose of the proceeding was for the Superintendent to determine whether the Access Plans and their underlying provider networks:

> meet applicable requirements of the Maine Insurance Code and regulations promulgated thereunder relating to network adequacy, including the requirement that Anthem provide its members reasonable access to health care services. *See, e.g.*, 24-A M.R.S.A. § 4303(1) (made applicable to HMOs via 24-A M.R.S.A. § 4204[2-A](L)); *see also* Insurance Rule Chapter 850(7).

Hearing Notice at Section III.

The Hearing Notice was posted to the Bureau of Insurance homepage; was emailed on June 6, 2013 to representatives of the Maine Medical Association and the Maine Hospital

Association, and to attorney Michael R. Poulin; and was published in the Portland Press Herald and Sun Journal on June 12 and 13, 2013, in the Kennebec Journal and Morning Sentinel on June 13 and 14, 2013, and in the Bangor Daily News on June 17 and 18, 2013.

The Hearing Notice set June 12, 2013 as the deadline for making timely intervention applications, and further provided that the Superintendent would grant late-filed intervention applications upon a compelling demonstration of good cause.

Per the Hearing Notice, the public hearing was set for June 28, 2013. Members of the public were invited to attend the June 28 hearing.

On June 21, 2013, the Superintendent issued a Notice of Public Comment Session that established a specific time for members of the public to provide comment during the June 28 hearing. The Notice of Public Comment Session advised the public of their opportunity both to provide sworn or unsworn testimony at the hearing and to submit written public comment for the Superintendent's consideration in the proceeding.

Intervention Applications

On June 11, 2013, the Maine Attorney General ("AG") moved to intervene as of right in the proceeding. The Superintendent issued an order that same day granting the AG intervenor party status.

On the deadline for making timely application, June 12, 2013, intervention filings were made by:

- York Hospital ("York").
- Mercy Hospital ("Mercy").
- Rumford Hospital, Bridgton Hospital, Maureen Harpell, N.P., Albert Aniel, M.D., David Salko, M.D., Brenda Weeks, Julie Rioux, and Lisa Pease (collectively, "Rumford-Bridgton")—represented by attorney Michael R. Poulin.

The Superintendent issued an order that same day granting intervenor party status to York, Mercy, and Rumford-Bridgton.

No other intervention applications were filed with the Superintendent.

Procedural Order

On June 12, 2013, the Superintendent issued a Procedural Order establishing requirements for the conduct of the proceeding. Among other dates, the discovery deadline was set at June 21, 2013, and pre-filed testimony and exhibits were due by June 26, 2013 (later moved to June 27 at noon). *See* Procedural Order at Section I. As discussed below, Rumford-Bridgton made motions to amend the Procedural Order on June 25 and 27, 2013.

Reaffirmed Scope of Proceeding and Hearing

On June 11, 2013, partly in response to a June 10 request by attorney Michael R. Poulin that his clients "may understand the scope of the proceeding before making decisions about requesting intervention," the Superintendent provided guidance on how he would be evaluating Anthem's Access Plan filings. *See* Order Clarifying the Scope of Hearing, dated June 11, 2013. The Superintendent reiterated that the scope of the proceeding was whether Anthem's proposed networks meet adequacy standards applicable to HMOs, including those set forth under 24-A M.R.S. § 4303(1) and Insurance Rule 850(7).[2] *Id.* The Superintendent further established that the Access Plan filings were not subject to the requirements of the Preferred Provider Arrangement Act, 24-A M.R.S. Chapter 32 (§§ 2670–2680), or Insurance Rule 360. *Id.* Parties were provided until June 17 to file objections to the Superintendent's clarification. *Id.*

[2] These were the same statutory and regulatory standards the Superintendent enunciated in his June 5 Notice of Pending Proceeding and Hearing. *See* Hearing Notice at Section III.

On June 17, 2013, Rumford-Bridgton filed opposition to the Superintendent's Order Clarifying the Scope of Hearing. After reviewing the relevant laws and regulations applicable to Preferred Provider Arrangements (PPAs) and HMOs, the Superintendent reaffirmed his prior rulings. *See* Order Reaffirming Clarification of Scope of Hearing, dated June 20, 2013.

Non-Party and Intervenor Motions to Stay the Proceeding

On June 11, 2103, attorney Michael R. Poulin, on behalf of six non-parties to the proceeding,[3] requested that the Superintendent stay the proceeding and "set a deadline to intervene at 10 days after all public records related to the [Anthem] application are released to the public, and set the hearing for 21 days after the deadline to intervene." Anthem opposed the motion. The stated purpose for the requested delay in the proceeding was to permit additional time for the non-parties to review Anthem's filings (portions of which were designated confidential) in order that the non-parties could make a determination whether or not to intervene in the proceeding. By a 6-page ruling, the Superintendent evaluated and denied the non-party motion.[4] *See* Order on Motion for Stay, dated June 12, 2013.

On June 12, 2013, contemporaneous with the filing of its application for intervention, York moved to stay or continue the hearing "for a reasonable time in order to afford York the

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[3] The non-parties were Central Maine Healthcare Corp., Central Maine Medical Center; Dieter Kreckel, M.D.; Alan Verrill, M.D.; William Lee, M.D.; Daniel Trafford. The motion was also purportedly on behalf of "John Doe and Mary Doe," two unknown individual Anthem subscribers treating with primary care physicians practicing in Androscoggin, Oxford, or northern Cumberland Counties, and "Dr. Noe," an unknown physician practicing in Androscoggin, Oxford, or northern Cumberland Counties, with established physician-patient relationships with Anthem individual and small group subscribers. Motion at ¶¶ 7, 8. The legal basis upon which an attorney may make a motion on behalf of a hypothetical person is unclear, although it was unnecessary to rule on this issue since the motion was denied on other grounds.

[4] The non-parties appealed the Superintendent's ruling to the Superior Court under M.R. Civ. P. 80C, but withdrew the Rule 80C portion of the appeal without prejudice.

opportunity to obtain documents filed by Anthem with the Bureau, request and obtain discovery, and prepare for the hearing." After reviewing his order made the day before on a request for similar relief, reaffirming the need for a speedy resolution of the proceeding, and upon finding that York had not made a showing that it would be unable to obtain the information it might need to assess the reasonableness of Anthem's proposed networks in sufficient time to prepare for hearing, the Superintendent denied the motion. *See* Order on Motion for Stay by Intervenor York Hospital, dated June 13, 2013.

On June 21, 2013, Rumford-Bridgton filed a motion to amend the procedural order to continue the hearing until no sooner than July 12, and extend the discovery and pre-filing deadlines. *See* Motion to Amend Procedural Order. Anthem opposed the motion. Upon finding that Rumford-Bridgton had not met their burden of showing that the current schedule for the proceeding was "too contracted" to conduct discovery, prepare testimony, or prepare for hearing, and upon confirming the continuing importance of an expedited decision and his confidence that the parties had the opportunity to meaningfully participate in the proceeding and hearing, the Superintendent denied the motion, but extended the pre-filing deadline to noon on June 27, 2013. *See* Order on Motion to Amend Procedural Order by Intervenors Rumford Hospital, *et al.*, dated June 25, 2013. In his ruling, the Superintendent explained:

> The Notice of Pending Proceeding and Hearing in this matter was emailed to counsel for [Rumford-Bridgton] on June 6, 2013. That Notice, which made clear that this matter was on an expedited timeline, allowed for immediate motions to intervene and advised that discovery could commence immediately upon being granted party status. [Rumford-Bridgton] filed their application on June 12—the last day for timely motions to intervene. I granted that motion the same day. Despite the right to issue discovery beginning June 12, [Rumford-Bridgton] made no discovery requests of Anthem until June 20—eight days after being designated a party and one day prior to the June 21 discovery deadline. On Saturday, June 22, Anthem objected to the discovery, albeit providing some (but not all) responsive information subject to objection. [Rumford-Bridgton's] responsive

> pleading is due by noon today, and I expect to make a prompt ruling in order to ensure that Anthem will be required to comply with any meritorious discovery requests in advance of the hearing.
>
> In a previous order, I put the parties on notice that, in assessing any future motion to continue the hearing, I would expect the parties to show that they "diligently and expeditiously" pursued needed discovery. Here, [Rumford-Bridgton] waited until nearly the last day to seek discovery. Although any discovery that the Superintendent may now compel will, unavoidably, be provided to [Rumford-Bridgton] shortly before the hearing, that is, unfortunately, a difficulty of their own making.

Id. at 1 (footnote omitted).

On June 27, 2013, Rumford-Bridgton filed a second motion, renewing their previous procedural objections.

Procedural Order

On June 12, 2013, the Superintendent issued a Procedural Order establishing requirements for the conduct of the proceeding. Among other dates, the discovery deadline was set at June 21, 2013, and pre-filed testimony and exhibits were due by June 26, 2013. *See* Procedural Order at Section I.

On June 27, 2013, Rumford-Bridgton renewed their previous procedural objections and made an offer of proof for the record, claiming that had the Superintendent not denied or modified certain of its discovery requests, Rumford-Bridgton would have proved certain facts relating to the alleged involvement of MaineHealth, a hospital chain, in creating Anthem's proposed HMO provider network. The Superintendent had ruled in his orders on the discovery objections that the "motivations and general methods" used to create the HMO network were not relevant to the objective question of whether the HMO network would provide reasonable access to health care services. Order on Anthem's Objections to Intervenors' First Information Request

at 2. Regardless of who created the HMO network, or why it was created, Anthem is accountable for the network's compliance with all applicable legal standards.[5]

Protective Order; Documents Made Available by the Superintendent

On June 12, 2013, the Superintendent issued a Protective Order. The Protective Order provided that Anthem's application forms for the two proposed networks would be made public the following day, subject to Anthem's right to submit written argument that specific portions (but not the entire application) should be redacted as trade secrets. Anthem did not do so, and the application forms became public in their entirety at 4:01 p.m. on June 13, 2013. The Protective Order further made the six exhibits to each application form—which Anthem claimed contained its trade secrets—available to all parties to the proceeding on a provisional "Attorneys' Eyes Only" basis. This designation allowed the exhibits to be viewed by counsel of record and independent consultants and experts retained by the party. *See* Protective Order ¶¶ 2, 8. Further, parties and other persons were provided the opportunity at any time to challenge the "Attorneys' Eyes Only" designation. *Id.* ¶¶ 4, 5, 22.

Also on June 12, 2013, the AG requested that the Bureau of Insurance provide her with copies of all materials sought under a May 23, 2013, Freedom of Access request (FOA Request) of attorney Michael R. Poulin on behalf of Central Maine Healthcare Corp. Specifically, the AG requested that the Superintendent (1) provide the public records already provided under the FOA Request; and (2) provide, subject to a protective order, those documents currently being withheld by the Superintendent pending his confidentiality determination under the FOA Request. On

[5] Consistent with this ruling, the Superintendent has granted Rumford-Bridgton's motions to strike those portions of Anthem's testimony relating to Anthem's own explanations of its motives. *See infra* note 8.

June 13, 2013, the Superintendent directed Anthem to indicate whether, in light of the expedited nature of the proceeding, it objected to the Bureau immediately making these documents available to the parties in order to obviate the need for parties to seek the documents through discovery. Anthem advised the same day that it did not object. The materials responsive to the FOA Request were thereupon immediately provided to the AG and made available to all other parties upon request. Public records were provided to the parties free of restriction, while non-public documents and those documents whose status was still being determined by the Superintendent were provided subject to an "Attorneys' Eyes Only" designation. The documents consisted of Anthem's complete provider network applications (which the Protective Order had separately ordered Anthem to provide), and approximately 1300 pages of additional documents, most of which related to proposed forms and rates for Anthem's proposed products.

On June 13, 2013, the AG, pursuant to the Protective Order, moved for immediate public disclosure of Anthem's proposed provider network lists, which were attached as exhibits to Anthem's applications. Anthem opposed the motion. The Superintendent granted the motion (providing Anthem the opportunity to obtain judicial relief, which Anthem elected not to pursue) finding the network provider lists to be public records. *See* Order on Motion for Public Disclosure of Scope of Provider Networks, dated June 17, 2013.

On June 21, 2013, Rumford-Bridgton filed an objection and moved to amend the June 12 Protective Order. Specifically, Rumford-Bridgton requested that the Superintendent make public all of the "Attorneys' Eyes Only" documents under the Protective Order, claiming that the restrictions on the documents were interfering with its ability to prepare and present its case. Later on the same date, the Bureau of Insurance issued its final response to non-party Central Maine Healthcare Corp. on its FOA Request, in which the Bureau determined that a number of

the outstanding documents responsive to that request—which were the same documents at issue in Rumford-Bridgton's motion—were public records. On June 24, 2013, Anthem filed a response to Rumford-Bridgton's motion, acknowledging that certain of the documents were now public records owing to the Bureau's June 21 decision in the FOA matter, but opposing the re-designation of any additional documents. On June 25, 2013, the Superintendent issued an order that (1) confirmed that all documents found to be public records in the FOA matter were no longer subject to the restrictions in the Protective Order; (2) rejected Rumford-Bridgton's request that the remaining "Attorneys' Eyes Only" documents be made public; and (3) ruled, *sua sponte*, that a number of the "Attorneys' Eyes Only" documents should be re-categorized as "Confidential," so that the attorneys for Rumford-Bridgton and the other intervenors could share these documents with their clients.

On June 26, 2013, Rumford-Bridgton made a second objection to the June 12 Protective Order. Anthem opposed the motion. The Superintendent's ruling on Rumford-Bridgton's first objection to the Protective Order had just been issued the day before, on June 25. *See* Order on Motion to Amend Procedural Order by Intervenors Rumford Hospital, *et al.*, dated June 25, 2013. As with their first objection, Rumford-Bridgton asserted that the Protective Order was causing intervenors hardship, but provided no substantive argument as to why the current designations under the Protective Order were wrong. For that and other stated reasons, the Superintendent denied the motion. *See* Order on Second Objection by Intervenors Rumford Hospital, *et al.* to the Protective Order, dated June 27, 2013.

Information Requests (Discovery); Objections; Responses

The June 5 Hearing Notice advised that intervenors could commence discovery immediately upon being granted party status. *See* Hearing Notice at Section V.

On June 18 and 19, 2013, the Superintendent, through one of his hearing panel members, made inquiry of Anthem on certain provider network issues, to which Anthem responded those same days.

On June 20, 2013, Rumford-Bridgton, York, and Mercy served a consolidated Fist Information Request upon Anthem. On June 22, Anthem objected to Intervenors' First Information Request, simultaneously providing certain responsive information subject to and without waiving its objections. Anthem provided supplemental discovery responses on June 25.

On June 21, 2013, the AG served a First Discovery Request, which the AG withdrew on June 24 after concluding that the questions contained in the discovery request were outside the scope of this proceeding.

On June 25, 2013, Rumford-Bridgton, York, and Mercy opposed Anthem's discovery objections. The Superintendent made various discovery rulings that sustained or overruled the objections, in whole or in part. *See* Order on Anthem's Objections to Intervenors' First Information Request, dated June 26, 2013. Anthem filed further supplemental discovery responses on June 26 and 27.

Intervenor Subpoenas; Motions to Vacate or Modify

On June 20, 2013, the Superintendent issued the following 12 subpoenas requested by Rumford-Bridgton seeking the compelled attendance to testify at the June 28 hearing and, in some instances, also seeking the compelled production of documents:

1. Anthem Health Plans of Maine, Inc., d/b/a Anthem Blue Cross and Blue Shield;
2. Colin McHugh, Anthem Vice President, Provider Engagement and Contracting;
3. Andy Ellis, Anthem Regional Director, Provider Engagement and Contracting;
4. MaineHealth;
5. Frank McGinty, MaineHealth Executive Vice President & Treasurer;
6. St. Mary's Health System;
7. Lee Myles, St. Mary's President;

8. Pam Beaule, St. Mary's, Direct of Managed Care;
9. Karen Clark, St. Mary's, Vice President of Physician Network;
10. Stephens Memorial Hospital;
11. Tim Churchill, President of Stephens Memorial Hospital;
12. William Medd, Internal Medicine at Stephens Memorial Hospital.

Anthem moved to vacate 11 of the 12 subpoenas on June 23; Rumford-Bridgton opposed Anthem's motion but withdrew the William Medd subpoena on June 25; and separate motions to vacate or modify were filed on June 25 by MaineHealth, Frank McGinty, St. Mary's Health System, Lee Myles, Pam Beaule, Karen Clarke, Stephens Memorial Hospital, Tim Churchill, and William Medd. The Superintendent granted in part the motions to vacate or modify. *See* Consolidated Order Re Ten Petitions to Vacate or Modify Subpoenas Issued on Behalf of Rumford Hospital *et al.*, dated June 26, 2013. Of the ten then-outstanding subpoenas, the Superintendent's rulings resulted in six subpoenas being vacated, but required Anthem, MaineHealth, St. Mary's, and Stephens Memorial Hospital to each produce witnesses knowledgeable about the subject matters set forth in the corporate-entity subpoenas. *Id.* The scope of testimony under certain of the subpoenas was modified and document production was modified or vacated. *Id.*

All of the remaining subpoenaed witnesses were in attendance at the June 28 hearing, but Rumford-Bridgton did not call any subpoenaed witnesses to testify at the hearing.[6] *See* June 28 Tr. at198-199.

[6] In fact, Anthem attempted to call one or more of the non-party witnesses that appeared at hearing under subpoena, but Rumford-Bridgton objected and the Superintendent sustained that objection. *See* June 28 Hearing Transcript (Tr.) at 199-200.

Intervenor Claims of Superintendent Bias

On June 24, 2013, Rumford-Bridgton filed what the Superintendent understood to be a motion for the Superintendent to disqualify himself as the decision-maker in the proceeding. *See* 5 M.R.S. § 9063. The Superintendent represented that he had not "pre-judged" or "pre-determined" the outcome of the proceeding and, upon addressing other allegations of bias, direct or indirect, in the proceeding, declined to disqualify himself. *See* Order on Rumford *et al.*'s Motion to Disqualify, dated June 25, 2013.

On July 2, 2013, Rumford-Bridgton renewed their prior claim of Superintendent bias. *See* Intervenors' Objection to Order Reopening the Hearing and Claim of Bias Under 5 M.R.S. § 9063. The Superintendent again declined to disqualify himself as the hearing officer and final decision-maker in the proceeding. *See* July 2 Tr.at 5, ln. 12 through 7, ln. 22.

Rumford-Bridgton made a third claim of bias in their post-hearing brief, asserting, among other things, that any ruling approving the proposed HMO provider network would demonstrate bias by the Superintendent in favor of Anthem. Post-Hearing Br. at 10. The Superintendent hereby denies the claim for the reasons set forth in his prior orders.

Superintendent Rulings and Directives

Throughout the course of the proceeding the Superintendent, through his legal counsel, issued nearly 25 additional rulings and directives via email sent to all parties, including but not limited to emails sent on June 10th (2), 11th, 12th (2), 13th (2), 14th (2), 18th (2), 20th (3), 21st, 24th, 26th (3), 27th (3), and July 1st.

Conference of Counsel

On June 24, 2013, the Superintendent convened an hour-long telephonic conference of counsel, to which all parties were represented, at which various matters were addressed including

the hearing process, the scope of discovery and hearing, hearing exhibits, motion practice, and post-hearing briefing.

The Superintendent convened a second conference of counsel at 8:30 a.m. on June 28, 2013, immediately prior to the commencement of the public hearing.

Hearing; Testimony & Exhibits; Public Comment

On June 27, 2013, Anthem, Rumford-Bridgton, York, and Mercy separately submitted their pre-filed testimony and exhibits. The AG did not make any pre-filings.

The public hearing was held as scheduled on June 28, 2013, and was conducted entirely in public session. All parties were present and represented by counsel.

At the June 28 hearing, witness testimony and documentary evidence was admitted, as follows:

- *Anthem*: The pre-filed testimony of Colin McHugh, Regional Vice President of Provider Engagement and Contracting for Anthem in Maine (Anthem Exhibit 1) and William M. Whitmore, Regional Vice President of Underwriting with Anthem in Maine (Anthem Exhibit 2) was admitted, subject to Rumford-Bridgton's objections to portions of Anthem Exhibits 1 and 2, which were sustained in part and overruled in part. McHugh and Whitmore also provided live testimony at hearing. Pre-filed exhibits designated Anthem Exhibits 3 through 7 were admitted, over Rumford-Bridgton's objections to Anthem Exhibits 3 through 6.

  Anthem Exhibit 3 included 17 separate electronic files related to the Guided Access HMO network. Anthem confidential Exhibit 4 included 5 separate electronic files related to provider contracting for the Guided Access HMO network (designated "Attorneys' Eyes Only"). Anthem Exhibit 5 included 17 separate electronic files related to the Guided Access POS network. Anthem Exhibit 6 included separate electronic files related to provider contracting for the Guided Access POS network (designated "Attorneys' Eyes Only"). Anthem Exhibit 7 was a one-page "Guided Access Southern and Northern Hospital Networks" service area map.

- *AG*: A hearing exhibit designated AG Exhibit 1 was admitted, over Anthem's objection.

  AG Exhibit 1 was a multi-page, multi-document compilation of Anthem "Accessibility Analyses" or reports, sometimes referred to as geo-access time studies,

measuring member accessibility to health care services on a time basis (*e.g.*, primary care providers within 30 minute drive times, high-volume specialists and hospitals within 60 minute drive times).

- *Rumford-Bridgton*: The pre-filed testimony of Sharron Sieleman, Vice President of Nursing at Central Maine Medical Center, Michael Huppe, Vice President of Practice Operations at Central Maine Medical Group, and John Ludwig, Vice President of Operations for Rumford Hospital and Bridgton Hospital was admitted. Sieleman, Huppe, and Ludwig also provided live testimony at hearing. Pre-filed exhibits designated Rumford-Bridgton Exhibits A through I were admitted, over Anthem's objection to Rumford-Bridgton Exhibit C.

  Rumford-Bridgton Exhibit A lists the 22 cities and towns that Central Maine Medical Center (CMMC) designates as its primary service area. Rumford-Bridgton Exhibit B is the Maine Department of Human Services' October 2000 determination on CMMC's certificate of need approval for its cardiac surgery/angioplasty program. Rumford-Bridgton Exhibit C is a list of hospital services offered at CMMC but not at St. Mary's. Rumford-Bridgton Exhibit D lists the specialty physician office services that are not provided by HMO network physicians in the Lewiston/Auburn area. Rumford-Bridgton Exhibit E lists the specialty physician office services that are not provided by HMO network physicians in the Rumford area. Rumford-Bridgton Exhibit F lists the specialty physician office services that are not provided by HMO network physicians in the Bridgton area. Rumford-Bridgton Exhibit G lists the services offered by Bridgton Hospital Specialty Clinics. Rumford-Bridgton Exhibit H lists the 14 towns that Rumford Hospital designates as its primary service area. Rumford-Bridgton Exhibit I lists the 17 towns that Bridgton Hospital designates as its primary service area.

- *Mercy*: The pre-filed testimony of Eileen F. Skinner, Chief Executive Officer of Mercy Hospital, was admitted. Skinner also provided live testimony at hearing.

Members of the public had an opportunity to make either sworn or unsworn statements for consideration by the Superintendent. Public comment was provided by the organization Consumers for Affordable Health Care (identifying questions and concerns), and by six individuals (one testifying and four commenting in support of Anthem's Guided Access HMO

filing; Brenda Weeks, a party in this proceeding, testified in opposition to Anthem's Guided Access HMO).[7]

During the hearing Anthem acknowledged that there were errors in the HMO provider directories that it had submitted, and that the directories also included providers who had not yet agreed to participate in the HMO network. The Superintendent directed Anthem to make a supplemental filing with an up-to-date list of providers, distinguishing between the providers who had finalized agreements to participate in the network and the providers with which Anthem merely intended to contract, and based on the updated network data, to update or verify the analyses previously provided in the proceeding. Anthem was further directed to quantify the extent to which the contracting process was still ongoing, and to analyze, if possible, which provider practices in the network were open or closed. *See, e.g.*, June 28 Tr. at 165-171, 176-177, 237-240, 245.

Anthem Supplemental Filing; Reconvened Hearing

On June 30, 2013, in response to the Superintendent's June 28 directive, Anthem filed Exhibits 8 through 10 together with a 4-page brief in support of the filing. Anthem Exhibit 8 was a so-called "Unique Provider List" of the primary care providers and high volume specialists used to calculate the per-county and per-specialist ratios (comprising twelve separate files). Two files are the provider lists; ten files are accessibility analyses. Anthem Exhibit 9 was the complete provider list for the proposed Guided Access HMO

[7] Members of the public also submitted 106 written comments outside the public hearing which the Superintendent has designated a part of the record of the proceeding. The Superintendent has read each of the written comments provided. To the extent that they 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, the Maine Administrative Procedure Act bars the Superintendent from relying on unsworn submissions as evidence when making his decision. 5 M.R.S. § 9057.

network. Anthem Exhibit 10 was the complete provider list for the proposed Guided Access POS network.

Because portions of Anthem's supporting brief appeared testimonial in nature, the Superintendent, *sua sponte*, reconvened the hearing for the sole purposes of receiving Anthem's offer of Exhibits 8–10 for admission into the record and for an Anthem witness to provide direct, cross-examination, and rebuttal testimony regarding Exhibits 8–10 and those portions of Anthem's supporting brief that were testimonial in nature. *See* Order to Reconvene the Hearing, dated July 1, 2013.

On July 2, 2013, Rumford-Bridgton filed an objection to the Superintendent's Order to Reconvene the Hearing. *See* Intervenors' Objection to Order Reopening the Hearing and Claim of Bias Under 5 M.R.S. § 9063. The Superintendent overruled Rumford-Bridgton's objection. *See* July 2 Tr. at 5, ln. 12 through 7, ln. 22.

The reconvened hearing commenced at 1 p.m. on July 2, 2013, with counsel for all parties present. Anthem witness McHugh provided live testimony at hearing. Anthem Exhibits 8 through 10 were admitted, over Rumford-Bridgton's, York's, and Mercy's objections.

Written Closing Argument; Record Closed

Per the schedule established by the Superintendent at the conclusion of the July 2 hearing, on July 10, 2013 Anthem, the AG, Rumford-Bridgton, York, and Mercy each filed written post-hearing briefs as closing arguments.

The record of the proceeding closed at 4 p.m. on July 10, 2013.

Reopened Record; Official Notice

The Superintendent, *sua sponte*, reopened the record for the limited purposes of taking official notice and entering into evidence three identified matters, also simultaneously providing

parties an opportunity to object to the substance or materiality of the noticed matters. *See* Order to Reopen the Record for the Limited Purpose of Taking Official Notice, dated July 16, 2013. By filing made on July 18, 2103, Rumford-Bridgton objected to the Superintendent taking official notice of any of the three identified matters. That same day, Anthem filed a response to Rumford-Bridgton's objection, arguing that official notice was proper.

III. RULINGS ON PRE-FILED TESTIMONY & MATTERS NOTICED

Pre-filed Testimony

Upon the offer for admission of Anthem's pre-filed testimony of witnesses McHugh (Anthem Exhibit 1) and Whitmore (Anthem Exhibit 2), Rumford-Bridgton objected and moved to strike portions of the testimony largely on relevancy grounds as being outside the scope of the proceeding. *See* June 28 Tr. at 12-25. Consistent with the Superintendent's discovery rulings made in the proceeding, the objections related to the insurance premium costs and impacts of the ACA on Maine's healthcare market are hereby sustained.[8] *See* Order on Anthem's Objections to Intervenors' First Information Request. In all other respects, Rumford-Bridgton's objections are hereby overruled. Anthem Exhibit 1 and Anthem Exhibit 2 are admitted as modified by the Superintendent's rulings.

[8] Accordingly, the Superintendent strikes the following lines from the McHugh pre-filed testimony: p. 4, ln. 15-16 (provided, however, that the objection to the response "No" at line 15 is overruled), and lines 18-27; p. 5, ln. 1-16 (provided, however, that the objection to the following modified sentence at ln. 12-14 is overruled: "From those efforts, Anthem has developed a focused network that is designed to comply with the ACA and to provide members with reasonable access to quality care."), and ln. 21-25. And the Superintendent strikes the following lines form the Whitmore pre-filed testimony: p. 3, ln. 22-27; p. 4, ln. 1-31; p. 5, ln. 1-3; p. 6, ln. 7 (striking only the phrase "and with favorable pricing terms that will also benefit our members"), ln. 9 (striking only the word "affordable"), and ln. 23-24 (striking only the phrase "and consistent with our goal of achieving the best possible prices for our members").

Matters Noticed

The Superintendent advised the parties that, as authorized by 5 M.R.S. § 9058(1), he intended to take Official Notice of the following three matters:

1. HPHC Insurance Company, 2012 Maine Annual Report Supplement (Rule 945). *See* www.state.me.us/pfr/insurance/reports/rule945reports.htm. [Superintendent Exhibit 1.]

2. Current provider network data for Anthem's BlueChoice PPO small group plan. *See* http://www.anthem.com. [Superintendent Exhibit 2.]

3. Anthem's BlueChoice PPO as identified in item (2), above, includes a typical, broad network that has been approved by the Superintendent.

See Order to Reopen the Record for the Limited Purpose of Taking Official Notice, dated July 16, 2013. Parties were provided an opportunity to contest the substance or materiality of the three-identified matters. *Id.* Rumford-Bridgton opposed the Superintendent's taking official notice of the three identified matters, and Anthem argued in reply that official notice was proper. I find that the three identified matters are material to the issues in this proceeding, that they are within the scope of the Superintendent's authority under the Administrative Procedure Act to take official notice, and their substance is not materially in dispute.[9] Accordingly, the three-identified matters are hereby admitted as evidence in the record. The documentary evidence is designated Superintendent Exhibits 1 and 2, respectively.

[9] Official notice of Anthem's existing BlueChoice PPO provider network does not constitute a finding by the Superintendent that the provider directory is accurate. The BlueChoice provider directory is subject to the same concerns that were raised on the record regarding Anthem's proposed 2014 HMO provider directory. Official notice is taken, rather, for the limited purpose of illustrating the "broad" network to which the proposed "narrow" network has been implicitly compared by all parties to this proceeding. Likewise, HPHC's Rule 945 report has not been audited, and is admitted for the limited purpose of providing a public record that reports the enrollment in DirigoChoice, which was introduced by intervenor testimony but not quantified.

IV. LEGAL STANDARD

Scope of Hearing

The purpose of this proceeding, as set forth in the Hearing Notice, is for the Superintendent to determine whether Anthem's proposed networks meet adequacy standards applicable to HMOs, including 24-A M.R.S. § 4303(1) and Insurance Rule 850(7).[10] Pursuant to 24-A M.R.S. § 4303(1), Anthem may not utilize its proposed Guided Access HMO and Guided Access POS networks for its health plans unless those networks will provide Anthem's members with "reasonable access to health care services." It is the Superintendent's responsibility to determine whether access is reasonable. In making this determination, the Superintendent is limited by the evidence in record, but need not rely solely on the evidence or rationales proffered by Anthem. If the network as proposed by Anthem is generally reasonable but has problematic elements, the Superintendent may approve the network conditioned upon Anthem making specified modifications that would bring those problematic elements into statutory compliance. In short, it is the network *as approved* that must be reasonable, not the network proposed.

In addition to the general reasonableness requirement in 24-A M.R.S. § 4303(1), Anthem must also meet more specific access requirements set forth in Insurance Rule 850, Section 7. In particular, Paragraph 7(A)(3) requires a carrier's access plan to include:

> Written standards for providing a network that is sufficient in numbers and types of providers to assure that all services to covered persons will be reasonably accessible without unreasonable delay. Standards must be realistic for the community, the delivery system, and clinical safety. In establishing these standards, the carrier may incorporate standards published by independent standard-setting organizations and approved by the Superintendent.

[10] The requirements of section 4303(1) and Chapter 850 are made applicable to HMOs via 24-A M.R.S. § 4222-B(9).

In addition, specific criteria on the number and geographic distribution of providers and practitioners are set forth in Rule 850(7), as follows:

1. **Primary Care Providers (PCPs).** "To the extent reasonably possible," Anthem "shall maintain a minimum ratio of one full-time equivalent primary care provider to 2000 enrollees." Rule 850(7)(B)(1). Anthem "shall ensure the availability of practitioners who provide primary care services, including general and internal medicine, family practice, and pediatrics." *Id.*

2. **High-Volume Specialty Care Practitioners.** To ensure reasonable access to specialty care practitioners within its delivery system, Anthem "shall establish quantifiable and measurable standards for the number and geographic distribution of each type of high-volume specialty care practitioner." Rule 850(7)(B)(2). Anthem "shall define the types of practitioners who serve as high-volume specialty care practitioners (at a minimum, including obstetrics/gynecology, cardiology, dermatology, ophthalmology, orthopedic surgery, gastroenterology, and other specialties that Anthem determines to be high-volume)." *Id.* (internal punctuation omitted).

3. **Behavioral Health Care Practitioners.** To ensure the reasonable availability of behavioral health care practitioners, Anthem "shall establish quantifiable and measurable standards for the number and geographic distribution of each type of high-volume behavioral health care practitioner." Rule 850(7)(B)(3). Anthem "shall define the types of practitioners who are considered high-volume behavioral health care practitioners." *Id.* (internal punctuation omitted).

4. **Emergency and Urgent Services.** Anthem "must provide enrollee access to medically necessary emergency services at all times, and access to urgent services." Rule 850(7)(B)(4). *See also* Rule 850(7)(E) (requiring emergency services to be provided in accordance with 24-A M.R.S. § 4320-C).

The regulatory criteria for providing "reasonable access" also require Anthem to make the health care services accessible to its members "on a timely basis in accordance with medically appropriate guidelines consistent with generally accepted standards of care." Rule 850(7)(C)(1).

Legislative History of 24-A M.R.S. § 4303(1)

A recent amendment to 24-A M.R.S. § 4303(1) has resulted in significant changes to Rule 850 and has implications for the Superintendent's methodology in assessing the reasonableness of the geographic distribution of providers in Anthem's proposed networks.

Section 4303 was enacted by the Maine Health Care Reform Act of 1996.[11] Originally, in addition to the requirement to provide reasonable access to health care services, the statute expressly directed the Superintendent to adopt standards that "consider the geographical and transportational problems in rural areas." Accordingly, the Superintendent adopted Rule 850, effective October 25, 1997, which included the following time and distance standards at Subsection 7(C):[12]

C. Geographic Accessibility

1) Except as provided in subsection 7(C)(3), primary care services shall be available within 30 minutes travel time by automobile of each enrollee's residence. The following distances shall be used as guidelines in determining distances corresponding to 30 minutes travel time under normal conditions:
   a) Areas with primary road available: 20 miles.
   b) Areas with only secondary roads available: 15 miles.
   c) Areas connected by interstate highways: 25 miles.

2) Except as provided in subsection 7(C)(3) specialty care and hospital services shall be available within 60 minutes travel time by automobile of each enrollee's residence. The following distances will be used as guidelines in determining distances corresponding to 60 minutes travel time under normal conditions:
   a) Areas with primary road available: 40 miles.

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[11] P.L. 1995, ch. 673, § C-1. As originally worded, 24-A M.R.S. § 4303(1) read as follows: "**Demonstration of adequate access to providers.** 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 before January 1, 1997. These standards must consider the geographical and transportational problems in rural areas."

[12] Initially, this section of Rule 850 applied only to HMOs. Section 4303 was amended in 2002 to make the same standards applicable to all managed care plans, PPAs as well as HMOs. P.L. 1999, ch. 742, § 6.

b) Areas with only secondary roads available: 30 miles.
c) Areas connected by interstate highways: 50 miles.

3) Exceptions to the above travel times are permitted where:
a) an HMO can establish to the satisfaction of the Superintendent that customary practice and travel arrangements in the local area exceed the standards of this section and either:
i) no qualified providers or facilities are available within the requisite travel time of an enrollee's residence; or,
ii) the HMO has taken appropriate steps to mitigate any detrimental impact to enrollees where the HMO has not contracted with providers or facilities within the requisite travel time of an enrollee's residence.
b) an enrollee has chosen a plan with full knowledge that the HMO has no participating providers within the requisite distances of the enrollee's place of residence, and has signed a written disclosure to that effect, or
c) an HMO can establish to the satisfaction of the Superintendent that the exception permits the provision of better quality services, and the quality improvements either significantly outweigh any detrimental impact to covered persons forced to travel longer distances to access services, or the HMO has taken steps to effectively mitigate any detrimental impact associated with requiring covered persons to travel longer distances to access services.

The time and distance requirements were controversial from the beginning, and there were a variety of amendments to both the rule and the statute in subsequent years to revise the exception clause and to experiment with alternatives on a pilot-project basis. Eventually, in 2011, the Legislature repealed the statutory requirement to consider the geographical and transportational problems in rural areas.[13] The legislative summary described this amendment as follows: "Part F repeals the geographic access standards."

The Superintendent amended Rule 850 consistent with this legislation. This is a major substantive rule, and the finally adopted amendments, as approved by the Legislature, took effect May 24, 2012. The Basis Statement describes the revisions to the access standards as follows:

[13] P.L. 2011, ch. 90, § F-7.

> Before it was amended by Chapter 90, 24-A M.R.S.A. § 4303(1) required the Superintendent to adopt rules establishing specific time and distance standards for access to services. This requirement has been repealed, along with detailed provisions for limited exemptions from the geographic access requirements, and replaced with a more flexible requirement that "A carrier offering or renewing a managed care plan shall provide to its members reasonable access to health care services." Accordingly, Section 7 has been amended to repeal most of the detailed access standards in existing Subsections 7(C) and 7(D). Instead, each carrier's access plan, filed with the Bureau of Insurance, must include the carrier's own standards for compliance with the law's reasonable access requirements, subject to basic requirements set forth in Subsections 7(A) through 7(C). In particular, Paragraph 7(A)(3) has been amended to require that the carrier's network must be "sufficient in numbers and types of providers to assure that all services to covered persons will be reasonably accessible without unreasonable delay," and that the carrier's standards "must be realistic for the community, the delivery system, and clinical safety."

This legislative history makes clear that, while the Superintendent certainly may—indeed, must—still consider the distance that members must travel to providers, the Superintendent may not reject a network simply because it requires some members to travel more than 30 minutes to a PCP or 60 minutes to a specialist. Rather, the Superintendent must consider and balance various relevant factors, such as the remoteness of the location, the number of members in those locations, and the level of demand for various types of providers.

V. ANALYSIS, FINDINGS, AND CONCLUSIONS

For the reasons discussed more particularly below, I find and conclude that Anthem's proposed Access Plans for its Guided Access HMO and Guided Access POS products, as modified by the conditions established in this Decision and Order, comply with the requirements of 24-A M.R.S. § 4303(1) and Rule 850(7), including but not limited to the requirement to provide its members with reasonable access to health care services.

A. Accuracy of Anthem's Provider Networks

Anthem's May 31, 2013 initial filing included the Guided Access HMO and Guided Access POS networks, as Anthem represented that they then existed. Anthem submitted revised HMO and POS provider networks, dated June 15, 2013. On June 27, 2013, as pre-filed exhibits, Anthem submitted further revised versions of its HMO and POS provider networks. *See* Anthem Exhibits 3 and 5, attachments 1 through 3.

At the June 28 hearing, during witness examination concerning Anthem's Guide Access HMO network, it became apparent that Anthem Exhibit 3 contained data errors. For example, the provider network list in Exhibit 3 included physicians employed by excluded hospitals. Other providers identified by Anthem as network providers had not yet agreed to participate in the network, and some of them had not yet even received contract offers for the HMO network. (*See* June 28 Tr. at 121-124, 133-134, 179-182.)

Because of various issues surrounding the provider network lists and the resulting ratio analyses, I directed Anthem to make a supplemental filing. (*See, e.g.*, June 28 Tr. at 165-171, 176-177, 237-240, 245.) Anthem made that filing on June 30,[14] and I, *sua sponte*, convened a continued hearing on July 2, 2013. (*See* Order to Reconvene the Hearing, dated July 1, 2013.)

At the July 2 hearing, Anthem offered, and I admitted, Exhibit 8, which is an amendment to Anthem's initial application for its Guided Access HMO network. (*See* July 2 Tr. at 8-18.) Exhibit 8 contains an updated provider list for the HMO network and revised ratio analyses. According to McHugh, the provider list in Exhibit 8 contains only those providers who have signed contracts with Anthem. (*Id.* at 16.) McHugh specifically identified six cardiologists and

[14] *See* Anthem Exhibits 8 through 10.

one surgeon, who were excluded from the provider list in Exhibit 8 because they did not have contracts with Anthem. (*Id.* at 11.) The cardiologists are employed by CMMC but had previously been listed at their alternate practice locations at St. Mary's, where they also do EKG readings. McHugh further identified five providers that were re-categorized from gastroenterologists to internists on the new provider list. (*Id.*) McHugh testified that Anthem used this list to create the new ratio analyses that were also submitted as part of Exhibit 8. (*Id.* at 13–14.) He testified further that this list was a "unique provider list" in which each provider was "counted only with their primary location code." (*Id.* at 9-10.) Anthem uses unique provider lists for its ratio analyses to avoid double-counting in the ratio analyses resulting from some providers having multiple locations.[15]

McHugh explained that psychiatrists were not included in the unique provider list because Anthem was still in the process of unilaterally amending its provider agreements with 32 psychiatrists in its current network. McHugh acknowledged that those psychiatrists have an opportunity to object to the unilateral amendment of their contracts, but stated that Anthem has no reason to believe that any will. (*Id.* at 12.)

Exhibit 8 also indicates which primary care providers are currently taking new patients. McHugh testified that Anthem had received confirmation from the MaineHealth hospitals, Midcoast, St. Mary's, and Maine General (including Franklin Memorial Hospital) that each are committed to providing primary care access for every member enrolled in the Guided Access HMO plan. (*Id.* at 16–17.) McHugh further testified that St. Mary's already has an office in

[15] By contrast, for purposes of determining geographic availability, all practice locations are relevant, so the unique provider list should not be viewed as a "correction" to the complete list of participating practices and their locations.

Rumford and has plans to bring a primary care provider to that practice four days a week beginning January 1, 2014. (*Id.* at 17.)

In addition to Exhibit 8, Anthem also offered Exhibits 9 and 10, which update the "complete provider lists" Anthem had previously submitted for the HMO and POS networks. In contrast to the unique provider list in Exhibit 8, the complete provider list shows all provider locations, including any secondary locations. McHugh testified that Exhibit 9 also differs from the list in Exhibit 8 because it includes all providers Anthem "intend[s]" to be part of the network. (*Id.* at 17-18.)

McHugh described the dynamic nature of networks, with providers changing locations, entering and leaving the state, or changing affiliations. (*Id.* at 18.) McHugh candidly acknowledged that, even though Exhibit 9 reflects Anthem's current intentions, the network will inevitably change between now and January 1, 2014. (*Id.*) McHugh also acknowledged that Anthem relies upon its contracted providers to alert Anthem about changes in their practice locations. (*Id.* at 27.)

Although perfect accuracy of Anthem's HMO and POS provider networks is not possible, I find that Anthem has corrected the errors in its original submission and that Anthem's proposed provider network information, as set forth in Anthem Exhibits 8–10, is sufficiently reliable to enable me to make the determinations required in this proceeding.

B. The "Written Standards" Requirement

Anthem's Access Plans must include "[w]ritten standards for providing a network that is sufficient in numbers and types of providers to assure that all services to covered persons will be

reasonably accessible without unreasonable delay."[16] Rule 850(7)(A)(3).[17] Those "standards must be realistic for the community, the delivery system, and clinical safety." *Id.* More specifically, Anthem's Access Plans must include "quantifiable and measurable standards" for ensuring that its network provides reasonable access, by "number and geographic distribution," to high-volume specialty care practitioners and behavioral health care practitioners. *See* Rule 850(7)(B)(2)(b) & (3)(b).

The Initial Registration Form used by Anthem asks in various places for the applicant to provide its written standards for network access. The most directly applicable request is for the applicant to provide "written standards for access to basic health care services and a description of the basis for determining that the network is sufficient to meet those standards," to which Anthem responded:

> To ensure we have a sufficient proposed network, we seek to maintain a ratio of at least 1 provider per 2000 members for primary care, and 1 provider per 6000 for high volume specialty care as defined in Rule Chapter 850 as well as any additional high volume specialties that Anthem identifies. These are the standard guidelines that we use for membership access in our existing networks.

(Anthem Exhibit 3, 2013 Initial Registration Form for Guided Access HMO ("Registration Form"), at 5, § IV(4)(j).) The applicant also is asked to provide "written appointment scheduling guidelines and timeliness standards," to which Anthem responded:

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[16] Anthem also is required to make health care services accessible to its members "on a timely basis in accordance with medically appropriate guidelines consistent with generally accepted standards of care." Rule 850(7)(C)(1).

[17] Rule 850 is replete with non-capitalized, technical terms that have specifically-defined meanings (*e.g.*, "emergency services," "health care services," "network," "participating provider," "primary care provider," "urgent care," etc.). *See* Rule 850(5).

> We ensure existing appointment scheduling guidelines and timeliness standards are met in accordance with our provider contracts as noted below. This also complies with Rule 850.
>
> > Routine Physical (PCP) – within 45 days
> > Symptomatic care – within 3 days
> > Urgent Care – within 24 hours
> > Emergency coverage – 24/7

(*Id.* at 6, § IV(4)(k).) And the applicant is asked to describe its "standards and procedures for access to emergency services," to which Anthem responded:

> As required by Maine law, the plan provides benefits for health care services received in an emergency care facility or setting. To receive benefits for emergency care services, the member must have symptoms of sufficient severity that a prudent lay person would reasonably expect that the absence of immediate medical attention could result in serious physical and/or mental jeopardy; serious impairment to body functions; or serious dysfunction to any body organ or part.

(*Id.* at 7, § IV (6)(e).) At hearing, Anthem clarified that the prudent lay person standard permits members who meet the above criteria to obtain full coverage for emergency services at their nearest hospital, even if it is not in the network. (June 28 Tr. at 87–88.)

Lastly, in a related inquiry, the applicant is asked to provide a "map subdivided by town indicating the geographic distribution by service location of primary care and specialty [providers] and contracted facilities" including "correlative data." In response, Anthem provided various attachments, including the results of its provider capacity ratio analyses, and a map of the contracted hospitals within the network. (*See* Registration Form at 8, § IV(12); *see also* Anthem Exhibit 3, attachment 6; Anthem Exhibit 7.)

As confirmed by McHugh,[18] capacity ratios are an essential component of Anthem's written standards for providing members with reasonable access to healthcare services. The

[18] *See, e.g.*, June 28 Tr. at 52; 68, ln. 15-20.

network must meet a 1:2000 primary care provider-to-member ratio and a 1:6000 high-volume specialty care provider-to-member ratio. Anthem evaluated its targeted PCP and specialist ratios on a county-wide basis, further providing city/town data within each county. (*See* Anthem Exhibit 3, attachment 6 (multiple documents, by PCP and specialist)—labeled "Managed Care Accessibility Analyses"; *see also* Anthem Exhibit 8 (multiple documents, by PCP and Specialist)—labeled "Accessibility Analyses.")

These standards are not unreasonable. The 1:2000 primary care ratio and the 1:6000 specialist ratio are the guidelines the Anthem-Wellpoint companies have been following for their existing networks (*see* June 28 Tr. at 53), and the primary care ratio is identical to the minimum ratio required by Rule 850(7)(B)(1). Anthem's designation of high-volume specialties is reasonable and is in compliance with the requirements of Rule 850(7)(B)(2).[19] Questions have been raised about Anthem's compliance with these standards, as discussed more fully below, but those issues do not cast any doubt on whether the standards themselves are appropriate.

However, even when applied on a county-by-county basis, these ratio analyses are not, by themselves, sufficient to ensure reasonable access. In order for services to be reasonably accessible without unreasonable delay, as required by Rule 850, providers must also be geographically accessible. As the experience with Rule 850's strict time and distance guidelines illustrates, this is not a concept that is amenable to simple formulas, but it must be taken into account. Anthem did so by supplementing its county-by-county ratio analysis with geo-access studies that measured driving time from every zip code in the service area to the nearest PCP, nearest hospital, and nearest specialist in each designated high-volume category ("Geo-Access

[19] McHugh testified that Anthem did not simply rely on the specialties enumerated in Rule 850, but gave consideration to adding additional specialties. (*See* June 28 Tr. at 68-69.)

Reports") (AG Exhibit 1). The Geo-Access Reports, which Anthem did not submit in support of its Access Plan but produced in discovery, indicate an "Access Standard" of PCPs within 30 minutes of every zip code, and hospitals and high-volume specialists within 60 minutes of every zip code. McHugh testified that these 30 and 60 minutes standards are an industry standard (June 28 Tr. at 70) and "a benchmark we strive for," but "not a standard we feel obligated to hit." (June 28 Tr. at 71.)

I find that Anthem's Access Plan filings are in substantial, but not full, compliance with the requirements for written standards to assure reasonable access without unreasonable delay. Specifically, I find Anthem's written standards reasonable for (i) adequate numbers of primary care providers and numbers and types of high-volume specialty care providers, as modified to reflect the uncertainty in anticipated enrollment (*see* V(C)(1), below); (ii) appointment scheduling and timeliness; and (iii) emergency services. (*See* Registration Form at 5 § IV(4)(j), 6 § IV(4)(k), 6 § IV(6)(e).) However, Rule 850(7)(B)(2)(b) and (3)(b) expressly require the carrier's access standards to include "quantifiable and measurable standards for the . . . geographic distribution of each type of" high-volume specialty care practitioner and behavioral health care practitioner. Anthem's written standards, as submitted, did not adequately comply with these requirements.

I therefore direct Anthem to file its geographic access standards in writing for incorporation as a part of Anthem's Access Plans. This must not be construed as requiring strict adherence to the same "time/distance" limits that were recently expressly repealed. Anthem's use of its travel-time standards as benchmarks rather than as strict requirements is reasonable and appropriate. As benchmarks, Anthem's 30-minute and 60-minute standards would be safe harbors that establish reasonable geographic access, while departures from those standards would

need to be justified as reasonable based on specific factors such as the remoteness of the location or the lack of providers in the area. This directive does not preclude Anthem from proposing a different standard for assuring adequate geographic distribution of providers in future Access Plans.[20]

Subject to and by reason of the foregoing, I find that, upon incorporation of the modifications ordered above, Anthem's Guided Access HMO Access Plan will contain written standards for reasonable access to health care services that are realistic for the community, the delivery system, and clinical safety. Specifically, the written standards include reasonable standards for ensuring that the network has sufficient capacity to accommodate the needs of members, in the form of county-by-county ratios for PCPs, hospitals, and specialists, and in the form of timeliness standards for obtaining various services. The standards include adequate provision for access to emergency services, by allowing members to obtain such services from the closest hospital, whether in-network or not. The written standards, as modified pursuant to the above directive, are also sufficient to ensure adequate geographic distribution of providers. The amended standards will require Anthem to meet, in most cases, the industry-standard 30-minute PCP and 60-minute hospital and specialist travel-time criteria.[21] However, by allowing Anthem the needed flexibility to depart from those criteria in situations where it is reasonable to do so, the standards also comply with the spirit of the new Rule 850, which

[20] Pursuant to Rule 850(7)(A) and 850(11), Anthem is required to file by March 1st of each year any necessary Access Plan updates, including changes to previously filed information.

[21] *See* June 28 Tr. at 69, ln. 20-24.

eschews rigid formulas in favor of a more pragmatic approach. In short, Anthem's written standards, as modified, fully comply with Rule 850(7).[22]

In addition to requiring the written standards addressed above, Rule 850(7)(A) also requires an access plan to include:

> (4) A description of the carrier's plan for providing services for rural and underserved populations and for developing relationships with essential community providers.
>
> (5) A description of the carrier's plan for addressing the needs of patients needing coordinated care, frequent services, or other needs that might impede access to care.

I find that Anthem reasonably addressed these requirements in its Registration Forms. (*See* Registration Forms at 7-8 § IV(8), (9), (10).) Accordingly, I conclude that Anthem's Access Plans comply with Rule 850(7)(A)(4) and (5).

C. Network Capacity

The fundamental question to be decided in this proceeding is whether or not the proposed HMO and POS networks have the capacity to deliver "reasonable access to health care services" for enrollees in these products. As noted in the previous section, provider capacity ratios are not by themselves sufficient to ensure reasonable access, but they are necessary threshold conditions.

1. Enrollment projections for Anthem's Guided Access HMO plans.

In order to determine the provider-to-member ratio, it is necessary to determine the membership base. Ordinarily, existing enrollment is a reasonable starting point for projecting anticipated enrollment in the coming year, but 2014 is not an ordinary year. The ACA will

[22] McHugh also testified that Anthem's appointment timeliness standards (*see* Registration Form at 6 § IV(4)(k)) appear to be generally accepted industry guidelines. (June 28 Tr. at 86, ln. 8-18.)

restructure the individual health insurance market completely, and the impact of these changes is literally unpredictable. Therefore, according to McHugh's testimony, Anthem "made a concerted decision not to speculate what was going to happen after 1/1/14 with—with these products. There's too many variables for us to try to determine how much membership was going to come into this." (June 28 Tr. at 46.)

While Anthem's acknowledgment of the market uncertainty was reasonable and prudent, its response to that uncertainty was not. McHugh testified further that "we thought we took a very conservative approach by taking our entire individual and small group membership" to use as the enrollment base in calculating its provider capacity ratios. (June 28 Tr. at 46.) To the contrary, this projection was not at all conservative. It is true that many of Anthem's existing members are in grandfathered products, or in small group products for which Anthem intends to offer the option to renew with the existing broad network.[23] Other members might choose to disenroll from Anthem entirely. On the other hand, as Mercy CEO Eileen Skinner testified, U.S. census data show that as of 2010, there were approximately 114,430 uninsured Mainers under age 65 with income below 400% of the federal poverty level. (Mercy Exh. 3 at 3.) This figure is more than twice the size of Anthem's existing individual and small group enrollment put together. These people will be eligible for subsidized coverage under the ACA, and Anthem must be prepared for the possibility that a significant number of them will buy individual coverage from Anthem.

Other cohorts that might enter the individual market in 2014, while smaller by comparison, cannot be disregarded. The Dirigo Health program, which had approximately 3600

[23] Anthem also intends to offer broad-network products as an option for new small group business.

individual enrollees as of the beginning of this year,[24] will terminate at the end of this year, and some individuals currently covered by Medicaid or by small group coverage with other carriers might buy Anthem individual coverage next year. Mega Life and Health Insurance Company, currently Anthem's only active competitor in the individual health insurance market, will not be offering subsidized coverage on the exchange next year, which could result in additional migration to Anthem products.

As noted, the 2014 market transition will bring unique uncertainties, and a new carrier will likely be entering the market, so it is entirely possible that Anthem will actually lose rather than increase enrollment in 2014. However, that cannot be assumed. A truly conservative estimate needs to anticipate the possibility that Anthem's HMO network might be called upon to serve a significant influx of new members. It is highly unlikely that the number of new members would be as high as 150,000, but in these circumstances, prudence calls for using a worst-case analysis to test network capacity. A less mechanical calculation that took into account likely consumer behavior might have reduced this number considerably, but Anthem offered no evidence at hearing that would allow me to perform a more nuanced analysis. Therefore, rather than the statewide enrollment base of 50,000 covered lives used in the HMO filing, a potential enrollment base with 150,000 new covered lives should be used, for a total of 200,000. In other words, in light of the uncertainties associated with the ACA transition in 2014, the HMO network should be evaluated in terms of its capacity to handle the risk that enrollment might quadruple from 2013 to 2014. This means adjusting Anthem's provider-to-member ratio standards by a factor of 4 to 1 for purposes of determining whether the ratios have sufficiently

[24] This information was provided by HPHC Insurance Company in its 2012 report filed with the Bureau of Insurance pursuant to Rule 945. (*See* Superintendent Exhibit 1.)

demonstrated reasonable access—that is, the ratios must meet a standard of 1:500 for primary care providers and 1:1500 for specialists in order to be accepted as sufficient demonstration of reasonable capacity.[25]

The intervenors have noted that providers do not exclusively serve Anthem patients, so their true capacity is understated. This is true, but the argument cuts both ways, because for the same reasons, it is likely that if Anthem takes on a significant number of new members, many of them will be seeing the same providers with Anthem that they were already seeing before they enrolled in Anthem.

Due to the inherent uncertainty around any enrollment projections in the current health insurance marketplace, I require Anthem to conduct the following monitoring activities:

(a) Anthem is directed to report to the Bureau on a quarterly basis the percentage of open practices for both primary care and high-volume specialists.

(b) Anthem is directed to survey individual and small group members (in non-grandfathered plans) from the 10 southern counties on a quarterly basis, using questions from the CAHPS® (Consumer Assessment of Healthcare Providers and Systems) Survey Adult Version, Commercial; the CAHPS Survey Child Version, Children with Chronic Conditions; and the CAHPS Survey Child Version, Children without Chronic Conditions. The sample frame shall consist of the real world and Anthem's numbers—monitoring necessary to make the members who had at least one visit to a provider within the prior quarter. Topics shall include:

- Accessing care needed right away
- Accessing routine care at a doctor's office or clinic
- Accessing specialist care
- Accessing care, tests, or treatment through the health plan.

[25] Because hospitals are relatively few in number, and vary so much in capacity, I find that an analysis that simply compares the number of hospitals to the number of members is not instructive. Given the overall capacity of the participating hospitals, reasonable access to hospital services, in the context of this network, is better understood as a geographic availability issue than as a capacity issue.

Anthem is then directed to report to the Bureau, on a quarterly basis, a comparison of the results of these CAHPS surveys, and the results of the access-related questions from CAHPS surveys conducted on members in the 10 southern counties in 2013.

(c) Anthem is directed to compile consumer complaints and phone inquiries from individual and small group members (in non-grandfathered plans) in these 10 counties. Anthem shall report statistics on these complaints and inquiries—by issue raised, type of provider, and county—to the Bureau on a quarterly basis.

(d) Anthem is directed to compile all requests by individual and small group members in these 10 counties (in non-grandfathered plans) for approval of out-of-network services. Anthem shall report statistics on these requests, and their outcome—by type of provider and county—to the Bureau on a quarterly basis.

As applicable, I will evaluate the results of the above-identified monitoring activities against Anthem's written timeliness standards. (*See* Registration Form at 6 § IV(4)(k).) To the extent the monitoring activity results demonstrate Anthem's non-compliance with its timeliness standards, Anthem will be required to take prompt and effective remedial measures, including but not limited to engaging additional network providers or providing full coverage for out-of-network services.

In addition, as the intervenors have pointed out, capacity ratios must be calculated on a full-time equivalent (FTE) basis in order to correlate with the actual number of patients a provider can serve. For PCPs, this is required by Rule 850(7)(B)(1). While Anthem corrected its provider counts to eliminate duplication of providers working from multiple locations, it did not make any adjustments for providers who do not work on a full-time basis. I therefore direct Anthem to develop a reasonable methodology for recalculating its PCP and specialist ratios on a full-time equivalent (FTE) basis, and to conduct a new capacity analysis no later than October 1, 2013. To the extent that the recalculated ratios for Anthem's Guided Access HMO plan do not

comply with capacity standards, Anthem shall immediately undertake to add PCPs and/or specialists to the HMO network so as to meet the applicable standards on an FTE basis.[26]

With these conditions, I find that the 4:1 "worst-case" adjustment provides a sufficient safety margin that no additional adjustment to the basic ratio analysis is necessary. I note further that both the monitoring conditions above and the additional conditions imposed below may be subject to reevaluation once the effects of the ACA on Maine's individual and small group markets become clearer. In particular, the ratio analyses below will almost certainly look different once the possibility of massive swings in enrollment numbers from one year to the next can be reasonably ruled out. When Anthem's next Access Plan is due, on March 1, 2014, Anthem will be free to make the case that the conditions imposed herein should be scaled back or eliminated. In the context of the current uncertainty in Maine's individual and small group markets, however, both the monitoring and the specific conditions identified below are necessary to ensure reasonable access to a membership of unknown size that clearly could be substantially larger than Anthem's analyses suggest.

2. Capacity analysis for PCP and High-volume Specialty Care Provider services under Anthem's Guided Access HMO plan.

Primary Care Providers (PCPs)

I find the capacity of family/general medicine physicians, adult/family nurse practitioners, and internists in the proposed HMO network to comply with Anthem's modified

[26] Given that Anthem's currently calculated PCP-to-member ratios range from a low of 1:20 and a high of 1:102 (with the modified standard being 1:500) and currently calculated specialist-to-member ratios range from a low of 2.1:6000 and a high of 204:6000 (with the modified standard being 1:1500), I would not expect Anthem's refined ratio analyses to exceed the modified standards. (*See, e.g.*, July 2 Tr. at 13, ln. 20 through 14, ln. 20; Anthem Response to Hearing Request at 4-5.)

standard. Thus, the ratio of members to these types of primary care providers is well within the 1:500 ratio. Anthem has submitted evidence that the current ratio of open practices is adequate, and I have ordered additional monitoring to ensure that it remains adequate if enrollment increases. *See* V(C)(1), *supra.*

With regard to pediatricians, I have concerns about the capacity of Anthem's proposed HMO network in Sagadahoc and, potentially, Androscoggin Counties. To evaluate the proposed HMO network, I used Anthem's BlueChoice network,[27] which is, as officially noticed, a broad provider network. It thus includes the vast majority of Maine providers. This evidence demonstrates that nine pediatricians are available in Sagadahoc County. None of these nine have been contracted for the Guided Access HMO network. Therefore, Anthem HMO members residing in Sagadahoc County needing pediatric care would seek it in Androscoggin, Cumberland, Kennebec, or Lincoln Counties. While Cumberland's, Kennebec's, and Lincoln's member-provider ratios are well below 1:500, Androscoggin's ratio is 1:453, as only seven of the available 25 pediatricians participate in the Guided Access HMO network. An influx of patients from Sagadahoc County could overwhelm existing capacity. Therefore, Anthem is directed to contract, no later than September 1, 2013, with at least three additional pediatricians in Sagadahoc County,[28] or, if Anthem is unable to contract with at least three additional pediatricians after offering standard contracts to all qualified providers, to submit to the Bureau

[27] "Find a Doctor" results for BlueChoice PPO (the small group plan with the largest Maine enrollment), www.anthem.com, as of July 21-22, 2013. (*See* Superintendent Exhibit 2.)

[28] Sagadahoc County's current Anthem enrollment would require at least 4 or 5 pediatricians for strict adherence to the modified 1:500 PCP-to-member ratio. However, it is normal for some members in Sagadahoc County to choose to seek their children's primary care in surrounding counties, which have pediatrician-to-member ratios comfortably above 1:500. I therefore find that three additional pediatricians practicing within Sagadahoc County can be expected to provide adequate capacity.

an action plan to monitor the number of open pediatric practices in the four surrounding counties (Androscoggin, Cumberland, Kennebec, and Lincoln) and to ensure that Sagadahoc County members have reasonable access to pediatric care.

High-Volume Specialty Care Providers

Cardiology/Cardiovascular Disease. I find the capacity of cardiology/cardiovascular disease specialists in the proposed HMO network to comply with Anthem's modified standard. The ratio of specialists to members is well below 1:1500 in six of the 10 counties. In three of the four remaining counties, Anthem has contracted with nearly all the available cardiovascular specialists: all of them in Knox and Sagadahoc Counties, and all but one in Lincoln County. The network has ample capacity in neighboring Cumberland and Kennebec Counties, where the provider-to-member ratios would remain well under 1:1500 if the residents of Knox, Sagadahoc, and Lincoln Counties were added to the membership base. York County's provider-to-member ratio is 1:1679, somewhat above the 1:1500 modified standard. However, many York County residents are within a reasonable distance of Cumberland County cardiologists/cardiovascular disease specialists. If they seek care there, Cumberland's provider-to-member ratio would remain well below 1:1500.

Dermatology. The capacity of dermatology specialists in the proposed HMO network is not sufficient in most counties because of the shortage of available dermatologists. Using BlueChoice contracted providers as a proxy for available providers, the chart below demonstrates Maine's dermatologist shortage, and the geographic concentration of providers in this specialty:

Dermatologists		
County	Available providers[29]	Guided Access participating providers
Androscoggin	2	2
Cumberland	18	17
Franklin	1	1
Kennebec	2	1
Knox	0	0
Lincoln	0	0
Oxford	0	0
Sagadahoc	0	0
Waldo	0	0
York	8	3

However, in contrast to the other nine counties, the chart demonstrates that the shortage of network dermatologists in York County is not the result of a lack of available providers.[30] The number of available dermatologists there is more than double the number in the Guided Access network. Therefore, Anthem is directed to contract, no later than September 1, 2013, with at least three additional dermatologists in York County, or, if Anthem is unable to contract with at least three additional dermatologists after offering standard contracts to all qualified providers, to ensure that members are able to obtain dermatology services in York County at no greater cost to the covered person than if the benefit were obtained from participating providers.

Gastroenterology. I find the gastroenterologist specialist capacity in the proposed HMO network to comply with Anthem's modified standard. Among the counties with no gastroenterologists, if (1) Androscoggin, Franklin, and Oxford County residents seek care in Cumberland County, and if (2) Sagadahoc, Knox, Lincoln, and Waldo County residents seek

[29] *See* Superintendent Exhibit 2.

[30] Furthermore, the failure to contract with most of the dermatologists in York County results in a non-compliant provider-to-member ratio of 1:1683 over the entire ten-county region.

care in Kennebec County, provider-to-member ratios would still be less than 1:1500 (1:1220 in the first grouping; 1:1315 in the second grouping). York County has a 1:1679 ratio, but the HMO network includes all available gastroenterologists in York County, and some York County residents could seek care in Cumberland County with the capacity of the first grouping remaining below 1:1500.

OB/GYN. I find the capacity of OB/GYN specialists in the proposed HMO network to comply with Anthem's modified standard. The provider-to-member ratio within all counties is well below 1:1500.

Ophthalmology. I find the capacity of the overall ophthalmology specialists in the proposed HMO network to comply with Anthem's modified standard. Provider-to-member ratios are well below 1:1500, except in Lincoln and Oxford Counties. If Lincoln County residents seek care in Kennebec County, and Oxford County residents seek care in Androscoggin County, the provider-to-member ratios of those counties remain well below 1:1500.

Orthopedic Surgery. I find the capacity of the orthopedic surgery specialists in the proposed HMO network to comply with Anthem's modified standard. Provider-to-member ratios are well below 1:1500, except in Sagadahoc County which has no available orthopedic surgeons. If Sagadahoc County residents seek care in Androscoggin or Cumberland Counties, the provider-to-member ratios in those counties remain well below 1:1500.

Surgery. I find the capacity of the overall surgery specialists in the proposed HMO network to comply with Anthem's modified standard. Provider-to-member ratios are well below 1:1500, except in Sagadahoc County which has no contracted surgeons. If Sagadahoc County residents seek care in Androscoggin or Cumberland Counties, the provider-to-member ratios in those counties remain well below 1:1500.

Behavioral Health. Anthem designates all behavioral health providers except psychiatrists as "ancillary providers." Anthem testified that its proposed HMO network would not narrow its ancillary network. (*See* June 28 Tr. at 180-181 236-237.) The evidence in the record supports this assertion. I find the capacity of these ancillary behavioral health providers to be reasonable. I am concerned, however, that Anthem has not filed a roster of contracted individual psychiatrists. Anthem is directed to file a roster of psychiatrists who have signed these amendments no later than September 1, 2013. Approval of the HMO network is conditioned upon Anthem contracting with additional psychiatrists (or covering members' costs, pursuant to Rule 850(7)(B)(5), for seeing out-of-network psychiatrists) if I determine, based on the information submitted, that the network has too few contracted psychiatrists.

Non High-volume Specialty Care Providers

Finally, intervenors have raised concerns about access to various non-high-volume specialties. By their nature, non-high-volume specialties do not require large numbers of network providers, and with limited exceptions, as discussed more fully in the geographic access section, I find that the proposed HMO network has adequate capacity to deliver non-high-volume specialty care.

D. Geographic Distribution

1. Geographic access standards.

Reasonable access to health care services encompasses not only whether the proposed provider network is robust enough to cope with demand, but also whether the geographic dispersal of providers will provide meaningful access to health care services to all parts of the

health plan's proposed service area.[31] Although the repeal of time-and-distance requirements in Rule 850 provides carriers with considerably more flexibility in how they demonstrate that the geographic distribution of the various types of providers is sufficient to ensure reasonable access, geographic distribution remains an aspect of the reasonableness analysis.

In their brief, Rumford-Bridgton acknowledge that an insurer "does not have an obligation to place providers where there are none or where there are an insufficient number." (Post-Hearing Br. at 2.) However, Rumford-Bridgton contend that "when a proposed plan excludes qualified providers, artificially reducing access to covered persons, the applicant is obligated to demonstrate that it will still provide reasonable access to all covered services despite excluding available providers." (*Id.*) Rumford-Bridgton's proposed standard implies that the default provider network under Maine law is one that contracts with every willing and qualified provider, and that a more limited network is a disfavored alternative because it "artificially reduc[es] access."

However, the defining characteristic of a network is that some providers and facilities are in the network while others are not. Thus, all networks, by their nature, "reduce access" by excluding certain providers and facilities. There is no meaningful distinction between networks that "artificially reduce access" and those that do so "naturally," because all networks are the product of intentional business decisions made by carriers and providers. Managed care influences a consumer's choice of health care providers; thus, the decision to buy a managed care product entails tradeoffs for the consumers. In Maine, the Insurance Code recognizes these tradeoffs by allowing carriers to enter into selective contracting arrangements, but only if they

[31] *See* former Rule 850(7)(C)(1) & (2), quoted above at Page 23.

satisfy a range of consumer protection standards, including the network adequacy requirements of Rule 850.[32]

The legal standard is not whether the network is "narrow" or "broad."[33] Rather than comparing a proposed network to a hypothetical ideal in which all providers are included, the geographic reasonableness of a network must be considered on its own terms: does the network that has been proposed allow members to access health care services within a reasonable distance of their homes? The existence of providers that are not in the network becomes relevant to this inquiry only in those situations in which the only in-network providers are unreasonably distant from members. In those situations, the lack of any closer providers may excuse an otherwise unreasonable network. But where in-network providers exist within a reasonable distance of members, the mere fact that there are closer providers does not render the network unreasonable. To take an easy example, that a member lives within 5 minutes of a provider does not make it unreasonable to require her to travel 20 minutes to see an in-network provider. On the other hand, a network that requires a member to drive two hours to see a provider, despite the availability of a considerably closer out-of-network provider willing to contract with the insurer, may well fail to provide reasonable access to health care services.

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[32] Rumford-Bridgton argue that Anthem's proposal is inconsistent with the Superintendent's decision in an early proceeding construing the Preferred Provider Act, No. INS-89-1. However, in that case, the Superintendent invalidated a PPA under which "non-preferred providers would never be reimbursed in full, and would be reimbursed even at the full preferred provider rate only if 'travel or transport to the nearest preferred provider would endanger [the subscriber's] life.' The superintendent finds that the narrowness of this exception is an unreasonable restriction on access and availability." This case arose years before the adoption of Rule 850, which now expressly prohibits any clause of that type, and requires carriers to provide full benefits for out-of-network care whenever the network is insufficient to provide reasonable access to an enrollee. *See* Rule 850(7)(B)(5).

[33] Even in states which—unlike Maine—have "any willing provider" laws, those laws do not prohibit narrow networks. They only require that if a carrier wishes to create a narrow network, it must allocate membership by open competition rather than direct contracting.

Thus, the relevant question is whether the providers that *are* included in the network have a reasonable geographic distribution throughout the service area. As long as that distribution is reasonable, Anthem is not required to justify why it chose to exclude some providers from the network.

To demonstrate the geographic distribution of its providers, Anthem submitted "Accessibility Analyses" listing the number of various types of providers in each town in the service area, as well as statewide maps showing the locations of members and providers. *See* Anthem Exhibits 3 (Attachment 6), 5 (Attachment 5), and 8. Many towns, however, have no network providers at all located within the town.[34] For these towns, Anthem's Accessibility Analyses are a crude tool for assessing geographic access, as they do not show in any convenient form whether providers are located nearby. Particularly in large counties such as Franklin or Oxford, the existence of a certain number of providers somewhere in the county does not establish that members can reach those providers in a reasonable amount of time. Anthem's analysis of driving times to providers from various zip codes, provides the granular data that is necessary to begin an assessment of geographic reasonableness. (*See* AG Exhibit 1.)

Because these Geo-Access Reports are an important part of my analysis below, and because the reports were not updated like the Accessibility Analyses to reflect the most up-to-date provider lists, approval of the provider network is conditioned upon Anthem's filing an updated geo-access analysis reflecting the most up-to-date provider list and a summary of changes from the prior analysis, within 14 days after issuance of this Decision and Order, and

[34] York argues that the number of towns without network primary care physicians is in itself evidence that the network will not provide reasonable access. (Post-Hearing Br. at 2.) However, even the prior version of Rule 850 did not require "same town" as the minimum access standard for primary care. Indeed, there are many towns in Maine where no primary care practices exist.

further upon Anthem making any additional adjustments to its network as may be required in the event that the data on the updated report has changed.

Finally, I emphasize that simply because Rule 850 no longer contains rigid driving-time standards does not mean that insurers are no longer required to consider the geographic distribution of providers vis-à-vis their members. Travel time (or some other measure of geographic distribution that provides more detail than county-by-county ratios) remains relevant to whether a network provides members with reasonable access to health care services pursuant to 24-A M.R.S. § 4303(1). Particularly where Anthem in fact performed the driving-time analysis internally as part of its own assessment of the network's reasonableness (*see, e.g.*, June 28 Tr. at 53, 62), it should have submitted the Geo-Access Reports as an affirmative part of its application for approval of the HMO network.

2. Geographic distribution analysis for health care services provided under Anthem's Guided Access HMO plan.

Hospitals

Much of the evidence presented by the intervenors concerned the issue of whether the proposed HMO network provides members with adequate access to hospital services. After considering the evidence, I find that the proposed network complies with Anthem's geographic distribution standards.

At the outset, it should be noted that Anthem's proposed HMO plans contain no restrictions on the use of emergency services. Members suffering a medical emergency, as defined using prudent lay person standards, can be treated at the nearest hospital, whether that hospital is part of Anthem's network or not. Members are required to travel to network hospitals

only for non-emergency treatment. This feature is essential to my ultimate finding that the proposed HMO network complies with Anthem's standards.

With regard to non-emergency services, the overall geographic distribution of hospitals in the proposed HMO network is, without question, sufficient to cover the greater Portland area (Maine Medical Center), the greater Brunswick area (Mid-Coast Hospital), mid-coast Maine (Penobscot Bay Medical Center, Miles Memorial Hospital, St. Andrews Hospital, Waldo County General Hospital), the Augusta/Waterville area (Maine General Medical Center), and the greater Lewiston-Auburn area (St. Mary's Hospital). Intervenors claim, however, that access to hospitals is not reasonable in portions of York County and western Maine owing to the proposed network's exclusion of certain hospitals in those regions.

Anthem's network includes two hospitals in York County: Goodall Hospital in Sanford—near the geographic center of York County—and Southern Maine Medical Center in Biddeford. In addition, Maine Medical Center in Portland is not far from the northeastern border of York County in Portland. Anthem's Geo-Access Report shows that not a single zip code in York County is more than a 30-minute drive from an in-network hospital. Indeed, more than half are within 15 minutes. These figures make it clear that no York County resident will be required to travel a significantly long time to reach an in-network hospital. As already discussed, the fact that already reasonable driving times could be reduced even further by the addition of another hospital does not make the network unreasonable.

Although a closer call, the proposed HMO network complies with Anthem's geographic distribution standards for community hospitals serving western Maine. The network in western Maine includes Franklin Memorial Hospital in Farmington and Stevens Memorial Hospital in Norway. The geographic placement of these hospitals will provide access for population centers

in Franklin and Oxford Counties respectively. (*See* Anthem Exhibit 9 (showing current combined individual and small group enrollment for various towns in Oxford and Franklin Counties).) Although the distribution of network hospitals is less than ideal for members in certain parts of far western Maine, Anthem's Geo-Access Report shows that even they will face a travel time of less than 60 minutes to an in-network hospital.[35] Members living in Fryeburg—which appears to be the most populous area facing significantly longer travel times in this network—are well within 60 minutes of the nearest in-network hospital, according to the Geo-Access Report. (AG Exhibit 1 at 3.6.) While the 60-minute benchmark is no longer mandated by Rule 850, compliance with that standard is strong evidence of reasonableness. And, again, the ability to reduce travel times even further by adding more hospitals to the network does not make the network unreasonable.

Anthem's decision not to include Lewiston's Central Maine Medical Center (CMMC) in its network raises a special issue. CMMC is one of only three hospitals in Maine that offers a comprehensive level of services known as "tertiary" medical care. The other two tertiary hospitals in Maine are Maine Medical Center in Portland and Eastern Maine Medical Center in Bangor. The intervenors contend that it is not reasonable to require members residing in Franklin, Oxford, and Androscoggin Counties—most of whom are closer to CMMC than to Maine Medical Center—to travel to Portland to receive tertiary medical care. There is no dispute that St. Mary's Hospital, the Lewiston hospital included in the proposed HMO network, does not offer such care.

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[35] Although not necessary to support my decision, I note that many of the towns with the longest drive times—such as Eustis (50.5 minutes), Rangeley (48.3 minutes), and Kingfield, (37.6 minutes)—appear to have no closer out-of-network hospital.

Looking at the overall geographic distribution of tertiary care hospitals in Maine, however, it seems clear that the inclusion of CMMC is not necessary for the proposed HMO network to comply with § 4303(1). Maine Medical Center and CMMC are clustered within 40 miles of each other. Eastern Maine Medical Center, in contrast, is over 100 miles from either CMMC or Maine Medical Center, and is the closest tertiary hospital for a region of the state considerably larger than the region that would be served by Maine Medical Center in the proposed network. In light of the realities of how tertiary care is geographically distributed throughout the entire state, it is not unreasonable for a provider network to include one tertiary care hospital to serve the southern portion of the state, just as only one such hospital serves the far larger northern portion of the state.

In their post-hearing brief, Rumford contend that it is not enough for Anthem to show that the hospitals in its network have sufficient geographic distribution. Rather, Rumford contends, Anthem must further show that "removing the services available at [the six excluded] hospitals would not [un]reasonably restrict access to the full range of hospital services by the subscribers in that plan." (Post-Hearing Br. at 5.) As a preliminary matter, this contention, again, flips the standard on its head. The question is not how the proposed HMO network compares to a hypothetical network including every hospital in Maine. It is whether the proposed HMO network contains enough providers over a wide enough area to provide reasonable access to health care services to members. If the access provided is reasonable, it is irrelevant that the network could be bigger or better.

More to the point, Rumford-Bridgton go too far by suggesting that an insurer must meet the burden of enumerating every service offered by every hospital in its network and then compare it to the services offered by any hospitals excluded from the network. As already

discussed, Anthem's proposed HMO network includes a tertiary care hospital, Maine Medical Center, which provides the full panoply of hospital services. Anthem testified that Maine Medical Center is capable of providing all of the tertiary services offered by CMMC (June 28 Tr. at 141); indeed, that it offers the most comprehensive services of any hospital in the State. (*id.* at 137-38) As for the remaining community hospitals, it is sufficient for the purposes of § 4303(1) analysis that such hospitals, in order to be licensed by the State, are required by law to provide certain core medical services. 10-144 C.M.R. 112 § 1.5. Notably, while four different community hospitals intervened in this proceeding, none presented evidence that they provided particular services that their in-network competitors did not.[36] I further note that if, in fact, there were some essential medical service not offered at any in-network hospital within a reasonable distance of the member but that was offered by an out-of-network hospital within such a distance, Anthem would be required to cover the member's treatment at the out-of-network hospital and hold the member harmless for any additional cost. *See* Rule 850(7)(B)(5).

Finally, that some of the hospitals not included in the proposed HMO network are designated as "critical access hospitals" under state and federal law does not mean, as the intervenors seem to suggest, that such hospitals must automatically be included in a provider network for it to be reasonable. That legal term of art describes small, rural hospitals that are entitled to receive reimbursement from the federal Medicare program under a more favorable formula than other hospitals. (Ludwig Pre-Filed Testimony at 2) That the federal government has made a policy decision to give hospitals meeting certain objective criteria favorable financial treatment does not show that the hospital must be included in a provider network to comply with

[36] As already discussed, there is no dispute that CMMC, as a tertiary hospital, offers more services than its nearest competitor, St. Mary's Hospital.

§ 4303(1). Indeed, some of the criteria, such as the requirement that the hospital have fewer than 25 beds, or an average length of stay of no more than 96 hours for acute inpatient care, would seem, if anything, to cut against a finding that the hospital must be included in any provider network. The only geography-based criterion for a "critical access" designation is that the hospital be no less than 35 miles from another hospital, or, in the case of "mountainous terrain or in areas with only secondary roads," 15 miles. As already discussed, whatever else § 4303(1) might require, it does not require hospitals to be closer than 60 minutes' travel from a member.

Primary Care Providers (PCPs)

I find that the distribution of non-pediatrician PCPs in the proposed HMO network complies with Anthem's standard. I am unable to determine, however, whether the distribution of pediatricians in the proposed HMO network in Androscoggin and Sagadahoc Counties complies with the standard.

Anthem's Geo-Access Report states that the proposed HMO network includes 619 primary care providers—an aggregate of general/family medicine, adult/family nurse practitioners, internists, and pediatricians—at 164 locations. Except for island communities, all zip codes in the ten southern counties would face less than 30 minutes travel time to a participating PCP. Access to participating PCPs would be less convenient for residents of certain towns—such as Fryeburg (25.9 minutes) and Kittery (24.4 minutes)—but these travel times are within Anthem's 30-minute benchmark.

While I find the overall PCP network to comply with Anthem's geographic distribution standard, I am nevertheless concerned that the network does not provide a reasonable geographic distribution of pediatricians in Androscoggin and Sagadahoc Counties. Anthem's Accessibility Analysis aggregates all PCPs, making it impossible to ascertain specifics on pediatricians. Since

the HMO network contains only seven pediatricians in Androscoggin County and none in Sagadahoc County, understanding the locations of available participating pediatricians becomes critical.

It may be that Anthem's compliance with the directive in V(C)(2), *supra*, to supplement its pediatrician network in these counties will address my concern about geographic access. Nevertheless, when Anthem re-submits its geo-access analysis as directed above, it is directed to include a report that specifically analyzes travel time to pediatricians by zip code. If the distribution in this analysis shows inadequate geographic access, and if, further, Anthem's compliance with the directive in Part V(C)(2) does not address these access issues, Anthem, as a condition of approval, shall make available additional pediatricians in this region of the state, as I may direct at that time.

High-Volume Specialty Care Providers

Cardiology/Cardiovascular Disease. I find that geographic access to cardiologists/cardiovascular disease specialists in the proposed HMO network complies with Anthem's standard. These specialists are dispersed throughout the 10 counties, and the Geo-Access Report shows no zip codes beyond a 60-minute drive time.

Dermatologists. The AG identified several communities in which the 60-minute travel-time benchmark was not met: Frankfort, Stockton Springs, Isle au Haut, and Winterport in Waldo County (Post-Hearing Br. at 5); Anthem's Geo-Access Report also identifies Matinicus and Vinalhaven in Knox County. The issue, as noted above in the capacity section, is Maine's shortage of available dermatologists. The chart in that section shows that Anthem contracts with 75% (24 of 31) of the available dermatologists for the proposed HMO network. The major difference is in York County (eight available; three within the proposed HMO network) which

also has access to dermatologists in Cumberland County, as well as providers within its own county. I have already ordered that Anthem contract with additional York County dermatologists to address capacity issues. The other counties have either all available dermatologists contracted, or one fewer than all available providers. With these conditions, I find that within the constraints Anthem must operate, the proposed HMO network provides an adequate geographic distribution of dermatologists.

Gastroenterology. While geographic access complies with Anthem's standard for most of the 10 counties, the AG identified several communities in which the 60-minute travel-time benchmark was not met: Andover in Oxford County, and Oquossoc, Eustis, Rangeley, and Stratton in Franklin County. (*See* Post-Hearing Br. at 5.) Franklin County has no available gastroenterologists, so I find the proposed HMO network to be realistic for the community and the delivery system for this category of specialty care providers. However, the proposed HMO network does not include any of the six available gastroenterologists in Oxford County. Therefore, in order to provide adequate geographic access in western Maine, Anthem is directed to either (a) contract with at least one network gastroenterology provider to be available in Oxford County or (b) ensure that members living more than 60 minutes from a gastroenterology provider are able to obtain services from at least one of these specialty care providers at no greater cost to the covered person than if the benefit were obtained from participating providers.

Obstetrics/Gynecology. I find that geographic access to OB/GYNs in the proposed HMO network complies with Anthem's standard. These specialists are dispersed throughout the 10 counties, and the Geo-Access Report shows no zip codes beyond a 60-minute travel time.

Ophthalmology. The AG identified Andover in Oxford County as a community in which the 60-minute travel-time standard was not met. (*See* Post-Hearing Br. at 5.) The only available

provider in Oxford County participates in the proposed HMO network, so I find the proposed HMO network to be realistic for the community and the delivery system and to provide members with adequate geographic access to ophthalmologists throughout the 10 counties.

Orthopedic Surgery. I find that geographic access to orthopedic surgeons in the proposed HMO network complies with Anthem's standards. These specialists are dispersed throughout the 10 counties, and the Geo-Access Report shows no zip codes beyond a 60-minute travel time.

Surgery. I find that geographic access to surgeons in the proposed HMO network complies with Anthem's standards. These specialists are dispersed throughout the 10 counties, and the Geo-Access Report shows no zip codes beyond a 60-minute travel time.

Behavioral Health. As noted in the capacity section of this Decision and Order, Anthem considers all behavioral health providers excepting psychiatrists as ancillary providers, and has not narrowed its ancillary network. (*See* June 28 Tr. at 180-181, 236-237). These behavioral health providers are dispersed throughout the 10 counties, and the Geo-Access Report shows no zip codes beyond a 60-minute drive time. I find that the geographic access of these ancillary behavioral health providers in the proposed HMO network complies with Anthem's standards. However, also as noted in the capacity section, Anthem has not provided the Superintendent with a roster of contracted individual psychiatrists, and is hereby directed to do so.

Non High-volume Specialty Care Providers

As the AG observed in her post-hearing brief, Anthem's task is to demonstrate access to specialists providing all covered services, not just to high-volume specialists. I analyzed Anthem's specialty provider lists, and compared Anthem's tallies to tallies of available providers (where such data was available), in the following provider categories:

- Allergy/immunology

- Anesthesiology
- Cardiac subspecialties, including interventional cardiology, pediatric cardiology, and cardiac electrophysiology
- Critical care medicine
- Emergency medicine
- Endocrinology, pediatric endocrinology, and reproductive endocrinology,
- Pediatric gastroenterology
- Hematology and pediatric hematology
- HBP pathology
- Hospice/palliative medicine
- Infectious disease and pediatric infectious disease
- Maternal and fetal medicine
- Neonatal/perinatal medicine
- Nephrology and pediatric nephrology
- Neurology and pediatric neurology
- Neuromusculoskeletal medicine
- Clinical neurophysiology
- Occupational medicine
- Osteopathic manipulative therapy
- Medical oncology and gynecological oncology
- Otolaryngology
- Pain medicine
- Anatomic and clinical pathology
- Pediatric development
- Physical medicine and rehabilitation
- Podiatry
- Proctology
- Pulmonary disease and pediatric pulmonary disease
- Radiology, diagnostic radiology, and outpatient radiology oncology
- Rheumatology
- Sleep medicine
- Sports medicine
- Surgical subspecialties, including colon/rectal surgery, foot/ankle surgery, hand surgery, neurological surgery, pediatric surgery, plastic surgery, surgical critical care, thoracic surgery, and vascular surgery
- Urology.

I also analyzed lists of Anthem's ancillary and allied providers in the proposed HMO network.

I have determined that in general, the proposed HMO network provides reasonable geographic access to the range of non-high-volume services, consistent with standards that are realistic for the community, the delivery system, and clinical safety. However, there is inadequate availability of nephrology and of pulmonary disease medicine in far western Maine. I therefore direct that Anthem must make available one specialist in nephrology and one specialist in pulmonary disease medicine within Oxford County. Anthem may make these providers available by contracting with additional providers, establishing office hours for existing network providers within Oxford County, or by holding members in Oxford County financially harmless if they choose to see out-of-network providers practicing these specialties within Oxford County.

E. Anthem's POS Network

Although Anthem's POS network, proposed for northern and eastern Maine, was also at issue in this proceeding, it is virtually the same as Anthem's current, approved network for this region of the state. I have fully analyzed the access to health care services provided by the proposed POS network and conclude that the network meets the applicable standards in 24-A M.R.S. § 4303(1) and Rule 850(7). The POS Access Plan is therefore approved, subject to supplementation of Anthem's written access standards to address geographic distribution of providers.

F. Matters Yet to Be Considered

Overall, I find Anthem's network—with the modifications and conditions imposed herein—to be capable of providing "reasonable access to health care services." That is the principal question at issue in this proceeding. Not at issue in this proceeding is the potentially more difficult question that arises from the fact that Anthem is proposing to move large numbers

of current members—who currently enjoy access to a much broader network of providers—into these new HMO products. In order to move its current membership into these new products, Anthem has to demonstrate not only that the new products meet basic standards for reasonable access, but, in addition, that moving members from broad-network products into narrow-network products will be "in the best interests of the policyholders." 24-A M.R.S. § 2850-B(G)(3)(b). Simply because I am permitting Anthem to offer these narrow-network plans for sale in Maine does not necessarily mean I will also permit Anthem to move its current customer base into these plans.

I will shortly be issuing a Notice of Hearing, scheduling a hearing on the latter question for September 9, 2013. To demonstrate that these proposed HMO plans are in the best interests of their current policyholders, Anthem will have to demonstrate that, for current members, the reduced choice in these new plans is offset by a corresponding benefit, presumably in the form of lower rates than what members would otherwise pay. Thus, some evidence that I excluded from this proceeding may well have more relevance in the § 2850 proceeding. Moreover, some of the alleged deficiencies in the HMO provider networks, while not significant enough to fail the "reasonable access" standard, may still be relevant to my determination of whether the narrow network is in current members' best interests. Anthem should be prepared to address these issues at the September 9, 2013 hearing.

VI. ORDER

Pursuant to the provisions of 24-A M.R.S. § 4303(1) and Insurance Rule Chapter 850(7), the Superintendent hereby ORDERS Anthem to:

1. File written standards to incorporate geographic distribution criteria as part of the Access Plans. *See* V(B).

2. File the Geo-Access Report, as updated, to be incorporated as part of the Guided Access HMO Access Plan. *See* V(D)(1).

3. As part of the geo-access analysis filed under item (2), above, include a report that specifically analyzes travel time to pediatricians by zip code. *See* V(D)(2).

4. If the pediatrician report filed pursuant to item (3), above, shows non-compliance with Anthem's geographic distribution standards, supplement the number of participating pediatricians as the Superintendent may direct. *See* V(D)(2).

5. File updated primary care provider (PCP) and high-volume specialty care provider ratio analyses, calculated on a full-time equivalent (FTE) basis. *See* V(C)(1).

6. If the revised ratio analyses filed pursuant to item (5), above, do not meet the 1:500 or 1:1500 modified provider-to-member ratios, take prompt and effective remedial measures. *See* V(C)(1).

7. Monitor member experience and report regularly on the results of these monitoring activities. *See* V(C)(1).

8. If Anthem or the Superintendent identifies concerns as a result of the monitoring and reporting conducted pursuant to item (7), above, take prompt and effective remedial measures as directed by the Superintendent. *See* V(C)(1).

9. If possible, contract with at least three additional pediatricians in Sagadahoc County. *See* V(C)(2).

10. If possible, contract with at least three additional York County dermatologists. *See* V(C)(2) and (D)(2).

11. If possible, contract with at least one gastroenterologist in Oxford County. *See* V(D)(2).

12. Make available one specialist in nephrology and one specialist in pulmonary disease medicine within Oxford County. *See* V(D)(2).

13. Submit an updated list of participating psychiatrists, and take prompt and effective remedial measures if the Superintendent determines that psychiatrist capacity is inadequate. *See* V(C)(2) and (D)(2).

14. Provide clear written notice to enrollees, in a form approved by the Superintendent, that Anthem will make arrangements to provide full coverage for an out-of-network provider or facility in the event that necessary services are not available within the network.

Based on and by reason of conditions (1) through (14) above, the Superintendent concludes that Anthem's Guided Access HMO plan will comply with the requirements of 24-A M.R.S. § 4303(1) and Insurance Rule Chapter 850(7), and therefore APPROVES SUBJECT TO CONDITIONS Anthem's Guided Access HMO Access Plan.

The Superintendent further concludes that Anthem's Guided Access POS plan will comply with the requirements of 24-A M.R.S. § 4303(1) and Insurance Rule Chapter 850(7), and therefore APPROVES Anthem's Guided Access POS Access Plan.

Pursuant to 24-A M.R.S. § 235(4), this Decision and Order reaffirms all actions theretofore taken by the Superintendent in this proceeding, including but not limited to all prior orders, rulings, and directives made by or on behalf of the Superintendent.

VII. 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

July 25, 2013

ERIC A. CIOPPA
Superintendent of Insurance