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

IN RE: ANTHEM BLUE CROSS AND BLUE SHIELD 2009 INDIVIDUAL RATE FILING FOR HEALTHCHOICE, HEALTHCHOICE STANDARD AND BASIC, AND LUMENOS CONSUMER DIRECTED HEALTH PLAN PRODUCTS Docket No. INS-09-1000	)	DECISION AND ORDER

I. INTRODUCTION

Mila Kofman, Superintendent of Insurance ("Superintendent"), issues this Decision and Order after consideration of the Anthem Blue Cross and Blue Shield ("Anthem") 2009 rate filing for individual HealthChoice, HealthChoice Standard, HealthChoice Basic, and Lumenos Consumer Directed Health Plan products (collectively, "Individual Products"). Anthem is required, pursuant to the provisions of 24-A M.R.S.A.§ 2736(1), to submit for the Superintendent's approval proposed policy rates for individual health insurance products. In its initial filing, Anthem proposed revised rates for its Individual Products that it asserted would produce an average increase of 14.5%. As identified in its filing, the premium increases varied depending on deductible level and type of contract. The largest increase for the Non-Mandated HealthChoice options would have been 17.2%, for the Mandated Options (HealthChoice Standard and Basic) would have been 7.7%, and for Lumenos would have been 34.1%. Anthem requested that these rate revisions become effective on May 1, 2009. Anthem revised its actuarial analysis with updated data and reflecting a July 1, 2009 effective date. Based on its revised analysis, Anthem requested approval of revised rates with an average increase of 18.1%. As identified in its revised filing, the largest premium increase for Non-Mandated HealthChoice would have been 23.6%, for Mandated HealthChoice would have been 9.5%, and for Lumenos would have been 37.8%. In its pre-filed testimony filed on March 6, 2009, Anthem further revised its analysis resulting in a requested average rate increase of 18.5%. For the Non- Mandated HealthChoice options, the range of increases is 8.7% to 24.5%, with an average of 18.7%. For the Mandated HealthChoice options, the range of increases is 9.0% to 9.7%, with an average of 9.2%. For the Lumenos options, the range of increases is 8.9% to 38.4%, with an average of 30.2%. Anthem requests that its revised rate filing become

effective on July 1, 2009. As of November 2008 there are 12,049 policyholders who will be affected by the proposed rate revisions.

This Decision and Order constitutes final agency action on Anthem's filing.

II. PROCEDURAL HISTORY

On December 22, 2008, Anthem filed proposed revised rates for approval for its HealthChoice, HealthChoice Standard, HealthChoice Basic, and Lumenos Consumer Directed Health Plan products. The Bureau of Insurance designated the matter as Docket No. INS-09-1000.

On January 16, 2009, the Superintendent issued a Notice of Pending Proceeding and Hearing. The notice set a public hearing for March 12, 2009, outlined the purpose of the hearing, set a deadline for intervention, and explained the hearing procedure. Pursuant to 5 M.R.S.A. § 9052, notice to the public was accomplished by publication in newspapers of State-wide circulation and on the Internet.

On January 21, 2009, Anthem filed a revision to its initial filing.

In early February 2009 Anthem provided direct written notice by mail to every affected policyholder, advising policyholders of the proposed rate increases, the pending proceeding, evening public comment sessions, and the scheduled hearing.

On February 10, 2009, as part of the Procedural Order issued by the Superintendent, the Maine Attorney General was granted intervention as of right. The Procedural Order, in accord with Maine Bureau of Insurance Rule Chapter 350, § 2(A)(1), established procedures for the conduct of this proceeding; and established deadlines for serving discovery requests and for submission of pre-filed testimony and exhibits.

During February 2009 the Superintendent and the Attorney General engaged in discovery on Anthem's rate filing. The Superintendent served Anthem with three pre-hearing discovery requests, to which Anthem filed responses. The Attorney General served Anthem with three discovery requests to which Anthem filed responses.

On March 3, 2009, in Orono, and on March 10, 2009, in Portland, the Superintendent held evening public comment sessions providing members of the public an opportunity to make either sworn or unsworn statements for her consideration. Thirty-four (34) individuals provided such statements.

On March 6, 2009, Anthem and the Attorney General filed prefiled testimony and exhibits. Anthem's pre-filing included a revised rate increase request.

On March 11, 2009, the Superintendent issued a Protective Order that accepted in part Anthem's claim for confidential treatment. The only information that was designated confidential is personal health information that is protected from public disclosure under the Maine Insurance Information and Privacy Protection Act[1] and under the privacy regulations promulgated under the Health Insurance Portability and Accountability Act (HIPAA).[2] The specific information protected is limited to information about the diagnoses and treatments of two high-claim individuals.

On March 12, 2009, the Superintendent held a hearing on Anthem's filing. The hearing was conducted entirely in public session. Members of the public had an opportunity to make either sworn or unsworn statements for consideration by the Superintendent. Seventeen (17) individuals provided such statements. Members of the public also submitted in excess of three hundred (300) written comments outside the public hearing that the Superintendent designated a part of the record of this 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 Superintendent is barred by the Maine Administrative Procedure Act from relying on unsworn submissions as evidence when making her substantive decision. 5 M.R.S.A.§ 9057.

At hearing, Anthem presented testimonial evidence from Jennie Casaday, Associate Actuary; Vincent Liscomb, Executive Director of Provider Network Management; and George Siriotis, Regional Vice-President of Sales for the Individual Markets Division, East Region. The Attorney General presented testimonial evidence from Beth Fritchen, Actuary and Principal with Oliver Wyman Actuarial Consulting, Inc. The Superintendent admitted into evidence Anthem Hearing Exhibits 1 through 7, and Attorney General Exhibits 1 through 4.

After the parties rested their cases at hearing, the Superintendent adjourned the hearing for the submission of post-hearing information responses to certain questions posed at the hearing, followed by written closing argument.

On March 16, 2009, the Attorney General filed its post-hearing information responses, as well as an inquiry to Anthem; and on April 2, 2009, filed further post-hearing information.

On March 20, 2009, Anthem filed its post-hearing information responses, to which the Superintendent asked further follow-up questions of Anthem on April 8, 2009. Anthem filed responses to the Superintendent's further inquires on April 13, 2009. A final follow-up question by the Superintendent on April 14, 2009 was responded to by Anthem the same day.

On April 17, 2009, Anthem and the Attorney General filed their written closing arguments.

Per direction of the Superintendent on April 28, 2009, the Attorney General filed clarifying information on May 1, 2009, to which Anthem objected and filed a response on that same day.

III. LEGAL STANDARD

Anthem is required by 24-A M.R.S.A.§ 2736(1) to file proposed policy rates for its individual health insurance products with the Superintendent. The Superintendent may approve the filed rates only if they are not inadequate, excessive, or unfairly discriminatory. 24-A M.R.S.A.§ 2736(2). Pursuant to 24-A M.R.S.A.§ 2736-C(5), the proposed rates should be likely to yield a loss ratio of at least 65% as determined in accordance with accepted actuarial principles and practices. That is, expected claims payments must be at least 65% of premium.

Anthem as proponent of the filed rates bears the burden of proving by a preponderance of the evidence that the proposed rates meet statutory requirements.

IV. DISCUSSION

The Superintendent finds that the proposed rates filed by Anthem in this proceeding are not inadequate. However, the Superintendent does find that the proposed rates as submitted by Anthem are excessive and unfairly discriminatory in contravention of section 2736 for the reasons discussed more particularly below. 24-A M.R.S.A.§ 2736.

This section includes a discussion of challenges to Anthem's proposed rates brought by the Attorney General as well as deficiencies determined by the Superintendent. This section also comprises guidance for Anthem on what filing the Superintendent would approve. 24-A M.R.S.A.§ 2736-B.

A. Trend

At the heart of the ratemaking process is the calculation of trend factors, the term used to refer to the expected rate of increase in costs based on observed changes in recent years. For a number of reasons, as discussed more fully below, the trends differ for different products.

Anthem's filing included two alternative methods of determining the trend. Method 1, Anthem's preferred method, is the one used in past filings. Method 2 develops a trend with large claims excluded and then adds a pooling charge for large claims. This is similar, but not identical, to the method recommended by Ms. Fritchen in past filings, as well as in this one, and adopted in past rate decisions. Ms. Casaday stated that she preferred Method 1 because it reflects actual changes in provider contracts, reflects trends in unit costs and utilization

by service category, and adjusts for service mix. However, she did not explain why she did not include those features in Method 2 or simply make the large claim adjustment to Method 1.

Ms. Fritchen provided an alternative trend analysis. Like Anthem's Method 2, she excluded large claims and added a pooling charge, but similar to Anthem's Method 1, she based her analysis on "allowed claims" - the total cost of covered services before considering deductibles and other cost-sharing - rather than paid claims, as used in Anthem's Method 2, which reflect the actual benefit paid.

1. Plan Shift

To evaluate the competing trend calculations, it is important to understand the impact on both claims and premiums of the shift from lower- to higher-deductible plans. With respect to claims, the shift affects both utilization (that is, the number of claims) and the cost of each claim. Utilization differences between plans with different deductibles result both from incentives to control utilization when the deductible is large (the "incentive effect") and from adverse selection resulting from the fact that those with health problems are less likely to shift to a high deductible than are healthier individuals (the "selection effect"). The effect on the cost of each claim simply reflects the fact that Anthem pays a smaller proportion of the total cost under high deductible plans (the "benefit effect").

The impact on premiums is less than the impact on claims because, consistent with Maine's statutory prohibition against rating based on health status, Bureau of Insurance Rule 940 limits the difference between the annual premiums for two deductibles to the difference between the deductibles plus an additional allowance for utilization differences that result from the incentive effect. Anthem uses factors that were developed by the actuarial firm Milliman as a mechanism intended to reflect the incentive effect while excluding the selection effect. If every policyholder met the deductible, the portion of the premium differential that equals the difference in deductibles would reflect only the benefit effect and the only portion of the premium differential representing utilization differences would be the additional allowance for the incentive effect. However, because not everyone meets the deductible, the portion of the premium differential that reflects the difference in deductibles also reflects some of the selection effect. Exactly how much cannot be determined from the data on the record, but it is not necessary to fully quantify the selection effect.

As noted earlier, the Anthem filing included both "allowed trends, which are based on the benefit before cost-sharing is applied, and "paid" trends, which reflect the actual benefit paid. Both trends reflect the incentive effect and the selection effect, but only the paid trend reflects the benefit effect. Anthem's Method 1 used allowed trends but made an adjustment to remove the impact of deductible mix on utilization. The resulting trend is therefore the trend that would have resulted if there were no change in deductibles. After the trend was

applied, a further adjustment of 0.945 was applied to reflect the anticipated plan shift based on Anthem's enrollment projections. The resulting claims estimate therefore reflects the full effect of the anticipated plan shift on both benefits and utilization.

Anthem's Method 2, which it characterizes as a reasonableness check on Method 1, used paid trends and includes no adjustment for deductible mix. The resulting trend therefore included the impact of plan shift on both benefits and utilization. Anthem did not apply the 0.945 adjustment factor under Method 2. Therefore the projected claims assumed that plan shift will continue at the same rate as during the experience period. However, the filing indicated that Anthem expects a slowing of the plan shift. To that extent, Method 2 could be expected to slightly understate projected claims, all else being equal.

It should be noted that Anthem's methodology does not apply the trend factor directly to premiums. Instead, the trend is used to project future claims, which are then used to project aggregate required revenue in Exhibit 1 of the filing. Exhibit 3 then calculates the rate changes needed to achieve that revenue based on projected enrollment. Since the projected enrollment used in Exhibit 3 is the same as that used to develop the 0.945 claims adjustment factor, projected claims and premiums are determined on a consistent basis.

Ms. Fritchen developed her trend using allowed claims. She then made an upward adjustment based on the Milliman factors. This adjustment removed the incentive effect but not the selection effect. Therefore the adjusted trend was less than a trend assuming no plan shift. Because she then applied the full 0.945 adjustment factor, the result was an understatement of future claims. The 0.945 factor reflects the selection effect as well as the incentive effect and the benefit effect. Applying this factor to a trend that already reflects the selection effect results in double counting the selection effect.

Ms. Fritchen argued that it was only necessary to normalize the experience to the extent that utilization differences are reflected in rates. This would be true if the trend factor were going to be applied to rates. However, as noted above, that is not the case here. Furthermore, even if premium factors were appropriate, the Milliman factors do not incorporate all of the utilization differences reflected in premiums.

2. Aging

Ms. Fritchen asserts that, assuming aging will occur during the rating period at the same rate at which it has occurred during the base period, an adjustment is needed to the trend calculation to the extent that aging is already reflected in the rating structure. Otherwise, according to Ms. Fritchen, the effect of aging will be double-counted. As in the case of plan shift discussed above, this overlooks the fact that the trend factor is to be used to project claims, not directly to adjust rates. If Anthem's enrollment projections reflected anticipated

changes in the age distribution of the covered population, no age adjustment would be needed to the trend. However, the enrollment projections reflect only changes in the distribution by benefit plan. No change in the age distribution within each plan is assumed, although to the extent that the age distribution varies somewhat among the benefit plans, a change in the mix of plans does affect the overall age distribution. If aging in fact continues to occur, revenues produced by the proposed rates will be greater than projected because more subscribers will be paying the higher rates associated with the older age bands. Therefore Ms. Fritchen's adjustment is appropriate. If aging is reflected in the data underlying the trend calculation and aging is expected to continue at the same rate, then unless the enrollment projections are adjusted to reflect that aging, an adjustment should be made to the trend factor to remove the portion of aging that will be accounted for in the rating structure.

Stated another way, the required revenue calculated in Exhibit 1of the filing implicitly assumes continued aging because the utilization trends used in the calculation include the effects of aging. The premiums calculated in Exhibit 3 of the filing implicitly assume no further aging because the current age distribution is assumed for the projected period. Reducing the required revenue calculated in Exhibit 1 based on the age factors used for rating will result in the required revenue assuming no further aging, consistent with the implicit assumption in Exhibit 3. If aging does continue as in the past, both the required revenue in Exhibit 1 and the "Total Annual Income Using Proposed Rates and Current Enrollment" calculated in Exhibit 3 will be understated, but the understatements will offset each other. Based on Ms. Fritchen's analysis, the appropriate reduction is (1+6.5%) /(1+6.0%)-1, or 0.5%' which should be applied to Anthem's 14.1 % trend factor.

As noted above, the projected changes in distribution by benefit plan indirectly result in some change in the overall age distribution. Because the plans with the most growth, the Lumenos plans, have a younger age distribution, the projected enrollment in Exhibit 3 is actually slightly younger than the current enrollment. This is reflected in the calculations presented in Ms. Fritchen's "Explanation of Updated Normalizing of the Trend," which shows an annual change in the age factor of -0.2% for the projection period. Anthem's failure to adjust for this results in a further understatement of projected premium. To offset this, a further 0.2% reduction is needed in the trend factor. The appropriate trend factor is therefore (1+14.1%) x (1-0.5%) x (1-0.2%), or 13.3%.

3. Large Claims

Anthem's Method 1 is susceptible to distortions due to fluctuations in large claims. However, in this instance it results in a slightly smaller increase than does Method 2. As Ms. Fritchen pointed out, this may not always be the case. Anthem should continue to examine this issue in future filings. An ideal methodology would replace large claims with a pooling charge as in Method 2

without sacrificing the strengths of Method 1. If such a methodology cannot be developed, Anthem should continue to use Method 2 as a check.

B. Benefit Modifications

Anthem included an adjustment to the Preventive Care and Supplemental Accident (PCSA) rider to reflect a new benefit that waives the deductible for screening colonoscopy. Maine's guaranteed renewal law prohibits "roll-ons," where consumers are required to buy additional coverage on renewal. In order for a product to incorporate a new benefit that would increase the cost of coverage, the new benefit must either be required by law or be approved by the Superintendent as meeting the "minor modification" standards of 24-A M.R.S.A. § 2850-B(3)(I)(4). Although Anthem had filed the colonoscopy benefit change with the Superintendent, it had asserted that it was required by P.L. 2007, ch. 516. However, in its March 20 Response to Hearing Information Requests, Anthem acknowledged that "there is no legal requirement that the deductible be waived" but that it "has made the decision to do so, in order to promote the health of our members and to address their expectations." Anthem further stated that it would file a revised PCSA rider before the end of March to clarify this benefit. That filing was submitted on March 24. Despite its March 20 acknowledgement that the change is not required by law, the March 24 filing stated, "The rate filing requirements contained in Bureau of Insurance Rule Chapter 940 do not apply as these changes are the result of legislative action." Absent a legal requirement, Anthem can only make a change in benefits for existing policyholders if it demonstrates that it is a minor modification as defined by 24-A M.R.S.A.§ 2850-B(3)(I). Unless and until Anthem does so, it would be inappropriate to allow this benefit to be reflected in increased rates.

C. Adjustment for High-Cost Claimants

Anthem included in its rate filing an adjustment of $1,292,755 to reflect two high-cost claimants transferring to Healthchoice from a group plan. Ms. Fritchen provided an alternative calculation of this adjustment resulting in $636,000. Ms. Casaday acknowledged that Ms. Fritchen's methodology was reasonable and more rigorous than Anthem's. The Superintendent adopts Ms. Fritchen's alternative calculation.

D. Savings Offset Payments

24-A M.R.S.A.§ 6913(7) requires carriers to "use best efforts to ensure health insurance premiums reflect any such recovery of savings offset payments as those savings offset payments are reflected through incurred claims experience in accordance with subsection 9." Subsection 9 requires that "the claims experience used to determine any filed premiums or rating formula must reasonably reflect, in accordance with accepted actuarial standards, known changes and offsets in payments by the carrier to health care providers in this State, including any reduction or avoidance of bad debt and charity care costs

to health care providers in this State as a result of the operation of Dirigo Health and any increased enrollment due to an expansion in MaineCare eligibility occurring after June 30, 2004 as determined by the board consistent with subsection 1." Anthem presented a witness who described the process of provider negotiations and asserted that best efforts were made as required by subsection 7. No evidence refuted that assertion. Anthem also provided evidence that contracts negotiated with providers are reflected in the trend factor used to project claims experience. This is *prima facie*evidence of compliance with subsection 9, and again has not been refuted.

Nonetheless, the Attorney General argues that no savings offset payment should be included in the rates because "providers have been unable to isolate or calculate those savings and Anthem does not receive an accounting of those savings" and because Anthem's actuary "provided no quantifiable evidence of how she calculated or accounted for those savings in the experience or otherwise." However, the statute does not require a precise accounting. Furthermore, no precise accounting is possible. The savings offset is based on "aggregate measurable cost savings," as determined under subsection 1 of the statute. The methodology used to determine these savings does not allow for tracing the savings to specific providers.

Anthem has met the statutory standard. Any savings are reflected in the projected claim costs and the savings offset payment is appropriately included in the rates.

E. Rate Relativities

1. Healthchoice Standard and Basic Plans

The standardized plans, which all carriers in the individual market are required to offer, were introduced in 1995. At that time, Anthem's predecessor, Blue Cross Blue Shield of Maine, rated those products on a basis consistent with its existing HealthChoice plans. The rate for the Standard plan was about 5% higher than the rate for a traditional HealthChoice plan with the same deductible to reflect differences in benefits, such as first-dollar coverage of preventive care in the Standard plan. At the same time, Blue Cross Blue Shield of Maine stopped offering HealthChoice plans with deductibles below $2,000, so the standardized plans became the only low-deductible plans offered.

In 2005, Anthem began rating the standardized plans based on their own experience rather than on the pooled experience of the standardized and non-standardized plans. This resulted in higher rates for the standardized plans relative to the non-standardized plans, probably because those with health problems are more likely to choose a low deductible than are healthier individuals. Over time, this rate differential increased. Beginning in 2007, by order of the Superintendent, the differential between the $1,000 deductible

Standard plan and the $1,000 deductible non-standardized plan was capped at 50%.

The current filing maintains this 50% differential. However, any differential larger than that justified by benefit differences is inconsistent with the community rating principles embodied in Maine law. Ultimately, the differential should be reduced to 5%, reflecting the benefit differences. However, a sudden change of this magnitude would be disruptive, causing additional rate increases for the non-standardized plans to offset the lost revenues that would result from decreasing rates for the standardized plans. Therefore, rather than decreasing rates for the standardized plans, those rates should be frozen at their current level until the differential shrinks to the 5% target level.

2. Lumenos Plans

The Lumenos plans were introduced in 2007. The rates were based on the rates for the HealthChoice $5,000 deductible plan with appropriate adjustments. When HealthChoice rates were increased in 2008, Anthem did not file increased rates for the Lumenos plans. Anthem now requests, in effect, a double increase reflecting both the 2008 and proposed 2009 increases in the HealthChoice rates. Anthem's explanation for not filing Lumenos rates for 2008 is that the experience was favorable but not credible (only six months and 200 policies), the loss ratio was below 65%, and Anthem did not believe the Superintendent would grant an increase.

The fact that the experience was favorable and the loss ratio low is not significant because the plan-specific experience was not credible, because general trends in health care costs clearly indicated that rate increases should be considered, and because midyear loss ratios do not reflect an accurate comparison of claims to premiums: as explained by Ms. Casaday, one would expect a low loss ratio in the first six months because it takes more time for many people to reach their deductible. No basis was offered for the belief that the Superintendent would not grant an increase under these circumstances. Trend increases have often been approved for new products that have not reached credible experience levels. Had Anthem simply pooled its Lumenos and HealthChoice experience, there is no reason to assume similar increases would not have been granted for both products. Therefore there is no valid reason for Anthem waiting 2 1/2 years to adjust the rates on these products.

In order to avoid an unduly large rate increase for Lumenos policyholders, the rate increase for current policyholders should be capped so that the largest increase will be 20%. Anthem should not increase the size of the HealthChoice rate increase to make up the revenue lost due to this cap because HealthChoice policyholders should not pay for Anthem's failure to file Lumenos rates in a timely manner. Anthem should not apply this cap to its new business rates because that likely would result in consumers buying the product at artificially low rates only to be faced with a large rate increase next year.

The Attorney General argued that the Anthem's 6% rate differential between the $5,000 deductible HealthChoice and Lumenos plans is too small and suggests 15% based on Ms. Fritchen's testimony about how other companies rate "consumer-driven" health plans. This argument is not valid for two reasons. First, as Anthem pointed out, much of the difference in utilization observed in other markets results from the large difference in deductibles, with consumer-driven health plans having significantly higher deductibles than other plans. That is not the case here. Most of the HealthChoice plans in force have deductibles that are as large as or larger than those for the Lumenos plans. Second, much of the difference in utilization observed in other markets results from differences in health status between those choosing consumer-driven health plans and those choosing other plans. To reflect these differences in rates would be inconsistent with the community rating principles embodied in Maine law.

F. Lumenos Age 65+ Rates

As the Attorney General pointed out, the Lumenos 65+ rates do not comply with Rule 940 and are also inconsistent with the HealthChoice 65+ rates. For these reasons, the Lumenos 65+ rates should be the same as the Lumenos 55-64 rates.

G. Profit and Risk Margin

Anthem included a 3% pre-tax profit and risk margin in its rate development based on past orders, and asserted that a 5% margin would be justified. Anthem repeatedly cited losses on its individual products over the last four years as evidence that a 3% margin is inadequate to cover the risks associated with these products. However, those losses are entirely attributable to 2005 and 2006. As shown in Exhibit 9 of the filing, for the nine years Anthem has owned the company (2000-2008),[3] these two years were the only ones that showed a loss. The pre-tax gain was 5.3% in 2007 and 2.8% in 2008. Over the nine-year period, the pre-tax operating gain totaled nearly $16 million and averaged 3.2% of total revenue.

The Attorney General recommended allowing no margin, citing "(1) a unique economic situation resulting in extreme financial hardship for subscribers, and (2) the extreme financial health of the company." The large number of policyholders who testified at the public hearings and sent written comments provides ample evidence of the first point and Anthem's financial statements provide ample evidence of the second. Under these circumstances, it is reasonable to allow no profit and risk margin this year. While a break-even rate level would not contribute further to the company's surplus, it would not be a drain either. Furthermore, the existence of the individual line would continue to provide an indirect benefit to the company because it provides a larger base over which to spread fixed expenses.

It must be acknowledged, however, that the rates indicated by this Decision and Order will not be full break-even rates if all of the assumptions hold. This is due to two items discussed above: the disallowance of the cost of the colonoscopy benefit change, and the 20% cap on the rate increase for current Lumenos policyholders. The disallowance of the cost of the colonoscopy benefit change will result in a loss to Anthem of $348,747 based on Anthem's estimate. If all current Lumenos policyholders renew, Anthem would lose approximately another $650,000 for a total loss just under $1 million. However, as explained above, both of these losses result from Anthem's own action or inaction. Losses of this magnitude will not render the rates inadequate. Anthem has more than enough surplus to absorb this loss and the HealthChoice and Lumenos policyholders have contributed to that surplus.

V. FINDINGS AND CONCLUSIONS

On the basis of a preponderance of the credible evidence in the record, and for reasons set forth in Section IV above, the Superintendent finds and concludes that Anthem's proposed rates are excessive and unfairly discriminatory. If the changes to the rates proposed by Anthem are applied consistent with this Decision and Order, as discussed in Section IV, the Superintendent could lawfully approve the resulting rates. The necessary revisions to the proposed rates can be achieved by the following changes to the spreadsheet (Prefiled 2009JULY Lumenos and HealthChoice thruDec08 2009030 (W1322955).XLS):

Exhibit 1:

- Change cell C12 from 14.1% to 13.3%.
- Change cell C30 from $348,747 to 0.
- Change cell C31 from $1,292,755 to $636,000.
- Change cell C36 from 3.0% to 0.

Exhibit 13:

- Change cell B33 from $348,747 to 0.
- Change cell B11 from $26.68 to $20.41.

Exhibit 3:

- Change cell AF25 from 1.500 to 1.2.
- Change cells in the range B398:F405 to equal the values in the cells in the range B362:F369.
- Change cell D384 from $1,158.13 to $1,108.18.

This will result in appropriate HealthChoice rates and Lumenos new business rates. Lumenos renewal rates require one further adjustment:

Exhibit 3:

- Change cell AH52 from formula to $815.80.

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

As a result of the changes proposed by the Superintendent, the total average rate increase proposed by Anthem of 18.5% would be reduced to 10.9%, with the specific rate changes ranging from -5.0% to 20.0%. For the Non-Mandated HealthChoice options, the range of increases would be 6.1% to 12.4%, with an average of 10.8%. For the Mandated HealthChoice options, there would be no rate change. For current Lumenos policyholders, rate changes would range from a decrease of 5.0% to an increase of 20.0%, with an average increase of 15.6%. For Lumenos new business rates, rate changes would range from a decrease of 8.0% to an increase of 32.4%.

VI. ORDER

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

1. Approval of the rates filed December 22, 2008, as revised, by Anthem Blue Cross and Blue Shield for individual HealthChoice, HealthChoice Standard, HealthChoice Basic, and Lumenos Consumer Directed Health Plan products is DENIED. Accordingly, the proposed rates filed by Anthem for its individual HealthChoice, HealthChoice Standard, HealthChoice Basic, and Lumenos Consumer Directed Health Plan products do not enter into effect.
2. Anthem is authorized to submit revised rates for review and they shall be APPROVED if the Superintendent finds them to be consistent with the terms of this Decision and Order and that the effective date of those rates will assure a minimum of 30 days' prior notice to policyholders.

VII. NOTICE of APPELLATE RIGHTS

This Decision and Order is final agency action of the Superintendent of Insurance, within the meaning of the Maine Administrative Procedure Act, 5 M.R.S.A.§ 8002(4). It may be appealed to the Superior Court in the manner provided for by 24-A M.R.S.A.§ 236, 5 M.R.S.A. §§ 11001 through 11008, and M.R. Civ.P. 80C. Any party to the proceeding may initiate an appeal within thirty days after receiving this notice. Any aggrieved non-party whose interests are substantially and directly affected by this Decision and Order may initiate an appeal within forty days 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.A. § 11004.

PER ORDER OF THE SUPERINTENDENT OF INSURANCE

May 18, 2009

_____

MILA KOFMAN
Superintendent of Insurance

[1] 24-A M.R.S.A. Chapter 24 (§§ 2201 *et seq*.).

[2] 45 C.F.R. Parts 160 and 164.

[3] Anthem owned the company for only part of the year 2000.