

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

IN RE:)
)
ANTHEM BLUE CROSS AND BLUE)
SHIELD 2010 INDIVIDUAL RATE)
FILING FOR HEALTHCHOICE,)
HEALTHCHOICE STANDARD) DECISION AND ORDER
AND BASIC, AND LUMENOS)
CONSUMER DIRECTED HEALTH)
PLAN PRODUCTS)
)
Docket No. INS-10-1000)

I. INTRODUCTION

Mila Kofman, Superintendent of Insurance (“Superintendent”), issues this Decision and Order after consideration of the Anthem Blue Cross and Blue Shield (“Anthem”) 2010 rate filing for individual HealthChoice, HealthChoice Standard, HealthChoice Basic, and Lumenos Consumer Directed Health Plan products (collectively, “Individual Products”). Anthem is required, pursuant to 24-A M.R.S.A. § 2736(1), to submit proposed premium rates for individual health insurance products for the Superintendent’s approval. In its initial filing, Anthem proposed revised rates for its Individual Products that it asserted would produce an average increase of 22.9%. This average was based on projected enrollment; the average requested premium would be 23.1% based on current enrollment. As identified in the filing, the largest premium increase depending on deductible level and type of contract for the non-mandated HealthChoice and Lumenos products is 23.6%. There is no rate change proposed for the mandated HealthChoice Standard and Basic products. As of November 2009 there were 10,961 policyholders who would be affected by the proposed rate revisions.¹ Anthem requested that its proposed rate revisions become effective on July 1, 2010. When it became evident that revised

¹ Of Anthem’s 11,066 policyholders as of November 2009, 10,961 are in the non-mandated HealthChoice products with the remaining 105 policyholders in the mandated HealthChoice products for which no rate change is proposed.

rates could not be implemented on the proposed July 1 effective date, Anthem requested that the proposed effective date be modified to October 1, 2010, so that the resulting rates would be effective for the 12-month period running through September 30, 2011. Accordingly, Anthem requested that the proposed rates be modified to include the effect of trend for an additional three months to reflect the higher anticipated costs from the later rating period.

II. PROCEDURAL HISTORY

On January 4, 2010, Anthem filed a request to increase its rates for its HealthChoice and Lumenos Consumer Directed Health Plan products and to maintain its current rates for its HealthChoice Standard and HealthChoice Basic products. The Bureau of Insurance designated the matter as Docket No. INS-10-1000.

On January 29, 2010, the Superintendent issued a Notice of Pending Proceeding, Hearing, and Public Comment Sessions. The notice set a public hearing for April 8, 2010; set public comment sessions for February 22, 2010 in Portland and February 24, 2010 in Bangor; outlined the purpose of the hearing; set a deadline for intervention; and explained the hearing procedure. Also on January 29, 2010, the Attorney General entered her appearance as of right in the proceeding.

In February 2010 Anthem provided direct written notice by mail to every affected policyholder, advising policyholders of the proposed rate increases, the pending proceeding, the evening public comment sessions, and the scheduled hearing.

On February 5, 2010, the Attorney General filed an unopposed motion to re-schedule the April 8th hearing date, which the Superintendent granted, setting a new hearing date of April 15, 2010.

On March 26, 2010, as part of the Procedural Order issued by the Superintendent, the Maine Attorney General was formally 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.

Beginning in February 2010 the Attorney General engaged in discovery on Anthem's rate filing. The Attorney General served Anthem with five discovery requests, to which Anthem filed responses. Beginning in March 2010, the Superintendent issued three pre-hearing discovery requests on Anthem, to which Anthem filed responses. Anthem objected to the Third Information Request of the Superintendent, relating to litigation costs. After briefing by the parties,² the Superintendent overruled Anthem's objection by Order issued May 21, 2010, and Anthem provided the requested information as specified in the Order.

On February 22nd in Portland, February 24th in Bangor, April 8th in Gardiner, and April 15th in Augusta, the Superintendent held public comment sessions providing members of the public an opportunity to make either sworn or unsworn statements for her consideration. Sworn testimony was received from 70 members of the public, and seven members of the public provided unsworn comments.³

On April 2, 2010, Anthem moved for confidential treatment of an exhibit containing certain provider contracting information included in its response to the Fifth Information Request of the Attorney General. At hearing on April 15, 2010, the Superintendent heard further

² Anthem and the Attorney General simultaneously filed briefs on April 29 and 30, 2010, and simultaneously filed reply briefs on May 5, 2010.

³ These comments appear in the transcript and are part of the record of this proceeding. The sworn comments have been admitted into evidence pursuant to 5 M.R.S.A. § 9057(3). The unsworn comments shall be considered for their persuasive value to the extent that they are relevant to facts in the record.

argument on Anthem's confidentiality request. In response to the Bureau's concern that not everything in the exhibit should be held confidential, Anthem provided a proposed redacted exhibit for public distribution. After review of the redacted exhibit, the Superintendent granted the request pursuant to 24-A M.R.S.A. § 2736(2) and admitted the confidential version of the exhibit under seal. On July 1, 2010, Anthem formally filed the non-confidential redacted exhibit in furtherance of the Superintendent's ruling at hearing.

On April 8, 2010, Anthem submitted a supplemental filing with revised exhibits including claims data through February 2010 and a supplemental memorandum explaining changes related to the updated data, updated assumptions based on information available since the time of the initial filing, and additional analysis completed since the January 4, 2010 filing was submitted. While the supplemental filing stated Anthem's position that a larger rate increase would be justified, Anthem did not request a modification to the rates proposed in the initial filing.

On April 12, 2010, Anthem and the Attorney General filed prefiled testimony and exhibits. The public hearing on April 15, 2010, was conducted entirely in public session. Members of the public had an opportunity to make either sworn or unsworn statements for consideration by the Superintendent. Members of the public also submitted in excess of 300 written comments outside the public hearing, which the Superintendent designated a part of the record of this proceeding. The Superintendent has read each of the written comments provided. To the extent 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 her substantive decision. 5 M.R.S.A. § 9057.

At hearing, Anthem presented testimonial evidence from Jennie Casaday, its Actuarial Director, and Patrick Quirk, its Product Director. 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 6, and Attorney General Exhibits 1 and 2. The Superintendent also admitted into evidence responses to discovery filed throughout the proceeding. After the parties rested their cases at hearing, the Superintendent adjourned the hearing for the submission of responses to certain questions posed at the hearing, followed by written closing argument.

On April 23, 2010, Anthem and the Attorney General filed their responses to the hearing requests, and on April 27, 2010, each party filed its written closing argument.

On May 10, 2010, June 9, 2010, and July 7, 2010, the Superintendent issued post-hearing information requests, to which Anthem and the Attorney General filed responses, as applicable.

On May 12, 2010, the Attorney General moved to admit a newly available post-hearing exhibit, among other requests. On May 14, 2010, Anthem filed an opposition to the Attorney General's motion. By Order issued May 25, 2010, the Superintendent granted the Attorney General's motion in part.

On May 25, 2010, the Superintendent issued a Disclosure Notice regarding her engagement of the consulting firm Compass Health Analytics, Inc. to assist in the performance of her rate review in this proceeding.

On July 2, 2010, Anthem moved to modify the rate effective date from July 1, 2010, to October 1, 2010, and to modify the proposed rates to include the effect of trend for the additional three months, based on the assumption that the rates will be effective through September 30, 2011.

The record closed on July 13, 2010, with the submission of Anthem's response to the Superintendent's July 7 information request.⁴

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 excessive, inadequate, or unfairly discriminatory.

24-A M.R.S.A. § 2736(2). Pursuant to 24-A M.R.S.A. § 2736-C(5), the rates must 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.

⁴ Given the need for the Superintendent to reconcile certain data due to errors and inconsistencies in some of Anthem's information responses, the Superintendent finds good cause to extend the 30-day period for issuing a decision, pursuant to 24-A M.R.S.A. § 2736-B.

A. Data Quality

The Bureau's consultants discovered a material discrepancy between the allowed-charge values in Exhibit VI.A of the rate filing (Historical and Projected Claim Trends) and the allowed-charge claim triangles provided to the Attorney General. The Superintendent asked Anthem to explain these discrepancies on June 9th. On June 14th, Anthem acknowledged that the allowed-charge triangles were incorrect and explained the nature and cause of the error. The Attorney General did not comment on this new information and did not provide any revised analysis based on the corrected claim triangles.

The failure to provide accurate data impairs the ability to conduct meaningful review, and Anthem must take steps to prevent such problems in the future.

B. Rating Period

The initial filing was based on a rating period of July 1, 2010 through June 30, 2011. As discussed above, Anthem now requests that rates be effective for the 12-month period beginning October 1, 2010, and modified to include the effect of trend for the additional three months. The Superintendent rejects this request. While there were a number of reasons for the delays in this proceeding, which resulted in the request for a modification, at least some of those were within Anthem's control. In particular, as discussed above, Anthem did not provide correct allowed-charge triangles until June 14th. It was then necessary for the Bureau's consultants to analyze that data to determine an appropriate trend factor. It would have been impossible at that point to issue a Decision in time to allow implementation by July 1st and, as Anthem explained in its July 2nd submission, implementing rates other than at the end of a quarter is not practical due to limitations of Anthem's computerized billing system. It would therefore be unfair to

policyholders to further increase this already large rate increase. Instead, rates should be based on the originally proposed rating period, despite the delay in implementation.

C. Trend

The most fundamental assumption underlying the determination of health insurance premium rates for a future rating period is the expected level of incurred claims. This estimate is developed by application of trend assumptions to actual incurred claims for a recent period. This estimate is complicated for the HealthChoice product because of the rapid shift toward higher deductibles that has been occurring for many years. To deal with the resulting distortion in the trend, Anthem developed its estimated incurred claims for the rating period in several steps:

- Estimate of trend for allowed charges,⁵ which reflects the increase in the underlying utilization of health care and eliminates the impact of changes in deductible and cost sharing.
- A set of factors that adjust for the impact of deductible leveraging⁶ and the ongoing shift to higher deductibles.
- Other factors and adjustments that reflect the specific circumstances that Anthem deems to be relevant to this rate filing.

As part of her review, Ms. Fritchen developed an alternative set of trend assumptions and related assumptions, which included special treatment of large claims.

1. Allowed-Charge Trend

Anthem developed an allowed-charge trend assumption of 11.7%,⁷ and applied it to project 21 months from the experience of October 2008 through September 2009 to the rating

⁵ "Allowed charges" means charges covered by the policy before reduction for deductibles and coinsurance.

⁶ "Deductible leveraging" is the effect of a fixed deductible on the paid-claims trend. Claim payments will increase at a higher rate than the underlying health costs because a larger proportion of the costs will exceed the deductible. For example, if the allowed payment is \$2,000 and the policy has a \$1,000 deductible, a 10% increase in the underlying cost (from \$2,000 to \$2,200) will result in a 20% increase in the amount paid (from \$1,000 to \$1,200).

period of July 2010 through June 2011. The Attorney General developed an allowed-charge trend assumption of 6.2%, including a base trend determined by a regression analysis plus an adjustment for provider contracting.⁸

Anthem criticized the Attorney General's trend assumption as flawed because it did not consider the effects of seasonality and because it excluded the fourth quarter of 2009, a seasonally high value. The Attorney General criticized Anthem's trend assumptions as lacking transparency and inadequately supported by the claim data in the record.

The Attorney General's regression analysis of allowed-charge trend was based on the claim triangles provided by Anthem, which Anthem later acknowledged to be inaccurate, as discussed above.

Exhibit VI.A of the April 8 supplemental filing summarizes allowed-charge trends for rolling twelve-month periods ending between April 2007 and October 2009. These values started at 13.4% in April 2007, declined to a low of 2.2% in April and May of 2008, rebounded to a high of 12.6% in July 2009, and then begin to decline again. After May 2007, there are 27 of these periods for which the allowed-charge trend is less than the 11.7% assumed by Anthem, one period for which it is equal to 11.7%, and one period for which it is more.

Furthermore, it is informative to look at the range of annualized allowed-charge trends over rolling 21 month development periods, because Anthem proposes to apply its trend assumption to a 21-month projection period. Based on the allowed-charge data in Exhibit VI.A,⁹ there has been no 21-month period over which the annualized allowed-charge trend exceeded

⁷ This figure is the allowed trend prior to leveraging, derived from Exhibit VI.A. of the original filing and unchanged in the supplemental filing.

⁸ Detail is shown in the confidential version of Fritchen Exhibit D submitted by the Attorney General on April 13, 2010.

⁹ This table provides claim figures compiled over rolling 12-month periods.

10%. Yet Anthem has proposed 11.7% for the 21-month span from the experience period to the rating period.

When asked at the hearing to justify an assumption that is so far in excess of historic levels, Ms. Casaday responded that periods of negative trends were considered to be outliers and implied that those periods were given less weight. She also referred several times to an acceleration in trend but provided no data or other evidence to support that position. In addition, she referred to an internal communication process at Anthem among actuaries, cost management teams, provider engagement teams and pharmacy benefit management groups, but could not provide meaningful details to document or quantify the resulting trend adjustments, despite specific requests from the Attorney General.

The Superintendent therefore finds that Anthem has failed to provide adequate support for its assumed 11.7% allowed-charge trend. Unfortunately, the analysis provided by Ms. Fritchen was based on the incorrect allowed-charge triangles provided by Anthem, so it is not directly usable, either.

To provide a basis for an appropriate allowed-charge trend assumption, consultants retained by the Bureau performed several regressions using Ms. Fritchen's exponential regression formula, but with corrected allowed data as previously discussed. After carefully considering the extensive commentary by all parties on the validity of the various regression analyses, they determined that the most valid approach for an objective determination of an allowed-charge trend should incorporate the following features:

- Corrected allowed-charge claim data with large claims removed.
- Quarterly claim amounts rather than monthly, to reduce the volatility of the observed data points.

- Complete calendar years, because utilization in each quarter for high-deductible policies is significantly affected by the utilization in the prior quarters of the same calendar year.
- Seasonality adjustments based on actual trend in each calendar year.

The Bureau's consultants performed one exponential regression based on the full 16 quarters of claim data for the years 2006 through 2009 and another based on the most recent 12 quarters, excluding 2006. The 16-quarter regression resulted in an allowed-charge trend of 7.0%, while the 12-quarter regression resulted in an allowed-charge trend of 7.6%. Based on this evidence, the Superintendent has determined that an allowed-charge trend of 7.3%, the average of the 16- and 12-quarter trends, is supported by the evidence in the record. For future filings, Anthem should consider including forecasting techniques that are appropriate for estimating seasonality and trend simultaneously.¹⁰

2. Treatment of Large Claims

When rating a product such as HealthChoice, a common practice is to base trend analysis on claims below a certain threshold, to eliminate distortion that could result from a small and random incidence of very large claims. The resulting figure is then adjusted upwards by a factor reflecting the long-term relationship between claims below the threshold and total claims.

Anthem's primary rate development did not include any special treatment of large claims. The company's alternate calculation, which is described as a "reasonableness check," removed claims in excess of \$100,000 per claimant per year from the trend analysis, and applied a large-

¹⁰ To validate these results, the Bureau's consultants also analyzed the claim data using univariate forecasting techniques. The Holt-Winters multiplicative smoothing technique, which is a forecasting formula that is suitable for data that includes seasonality and trend, was chosen as fitting the data well. The Holt-Winters technique indicated an allowed-charge trend of 7.4%. This technique was used only as a reasonableness check rather than as the primary method because it was not addressed at the hearing or in the written record.

claim factor of 17.6%,¹¹ as documented in Appendix III of the original filing (revised to 17.3% in the supplemental filing). Ms. Fritchen also removed claims in excess of \$100,000 and applied a large-claim factor of 17.5%. The Bureau's consultants also based their regression analysis on claims with large claims removed, and determined that the appropriate large-claim factor is 17.4%, based on the average values for calendar years 2006-2008.¹² That figure is consistent with those used by the parties, being midway between Anthem's 17.3% and the Attorney General's 17.5%.

3. Deductible Leveraging and Plan Shift

Allowed-charge trend requires a significant adjustment because of the migration to higher deductibles. As discussed in last year's proceeding, these impacts include a selection effect (the tendency of healthier subscribers to elect higher deductible), a utilization effect (the tendency of a high deductible to curb the use of health care resources) and a benefit effect (the lower benefit payment because of the higher deductible).

The following factors were developed by Anthem in its original and supplemental filings and by Ms. Fritchen in her analysis:

	<u>Original</u>	<u>Supplemental</u>	<u>AG proposal</u>
Deductible Leveraging	1.4%	2.6%	4.1%
Deductible Mix	2.8%	2.9%	0.8%
Claim Adjustment/Benefit Mix	.952	.964	.997

The first two items are trend adjustments and the third item is an adjustment to the resulting claim costs. The approaches taken by Ms. Casaday and Ms. Fritchen to determining

¹¹ In other words, Anthem determined, based on historical data, that the average annual payment on large claims is 17.6% of the amount paid on claims below the threshold.

¹² They did not use the 2009 data because recently incurred large claims are subject to a significant range of uncertainty.

these factors are fundamentally different and make it inappropriate to combine portions of each approach. All three items should be considered together when evaluating how to adjust allowed-charge trend and the resulting incurred claim projections to reflect the ongoing migration to higher deductibles.

The Superintendent finds Ms. Fritchen's assessment of a deductible leveraging effect of 4.1% to be inconsistent with the evidence in the record. According to the description in the Attorney General's July 13th response to the Superintendent's post-hearing information request, she used proprietary Oliver Wyman data to construct a claim probability distribution with an average deductible of \$8,400, which she determined to be the average deductible of the HealthChoice enrollment. Based on that distribution, she determined that 36.6% of the total allowed claims would currently be in excess of the deductible. After trending claim amounts forward by a year, she determined that 38.1% of the claims would be in excess of the deductible in the following year. She then determined a deductible leveraging factor of 4.1% as the increase from 36.6% to 38.1%; i.e. $(38.1/36.6) - 1$.

The problem with this result is that it is based on a data source for which paid claims are in the range of 35% to 40% of allowed charges. An examination of Exhibit VI.A of the rate filing shows that Anthem's paid claims are in the range of 65% to 68% of allowed charges in recent periods. The higher the ratio of paid claims to allowed claims, the less effect deductible leveraging will have on the paid-claims trend. For Ms. Fritchen's methodology to be applicable to this filing, her claim distribution must more closely match the actual paid-to-allowed ratio inherent in Anthem's experience.

There is not sufficient information in the record to correct this deficiency, so Ms. Fritchen's various assumptions regarding the impact of the migration deductibles are not adequately supported.

The Superintendent therefore finds that Anthem's deductible leveraging methodology, which is consistent with previous approved rates, is not called into question by Ms. Fritchen's contrary result. However, the resulting leveraging factor of 2.6% (in the supplemental filing) is based on an assumed allowed-charge trend of 11.7%. Substituting the appropriate allowed-charge trend of 7.3%, the recalculated deductible leveraging factor is 1.7%.

The Superintendent also finds Anthem's proposed deductible mix trend adjustment of 2.9% and its proposed claim adjustment for enrollment shift by benefit of .964 to be reasonable. These factors were presented in Anthem's supplemental filing.

D. Other Factors Affecting Projected Incurred Claims

1. Change in Pharmacy Benefits Manager

In its supplemental filing, Anthem asserts that the transition to a new pharmacy benefits manager (PBM) will increase pharmacy costs by 4.7%. It proposes an adjustment of 0.6% to its overall trend assumption to build this into its rates.

In her testimony, Ms. Fritchen correctly pointed out that any adjustment should be on a one-time basis rather than an adjustment to trend, and Ms. Casaday agreed. However, Ms. Casaday later stated at the public hearing, in response to questioning by Bureau staff, that it is possible that the changes in rebates might more than offset the increase and result in a decrease. Both Ms. Casaday and Mr. Quirk testified that the PBM transaction would enhance value to Mainers rather than creating costs. Based on this, in her closing argument, the Attorney General

took the position that no adjustment should be allowed in this rate increase. The Superintendent agrees that there should be no adjustment.

2. Pharmacy Rebates

Anthem proposes a downward adjustment of \$6.56 per member per month (“PMPM”) for pharmacy rebates earned by the PBM on behalf of the individual subscribers. It also proposes a downward adjustment of \$1.41 PMPM to account for the difference between pharmacy rebates assumed in the 2008 rate filing and the amounts actually earned for 2008 (“true-up adjustment”).

The Attorney General accepts Anthem’s pharmacy rebate projection of \$6.56 PMPM, which is a reduction to net expected claims. The Superintendent agrees with this projected credit for rebates anticipated during the rating period. However, the Superintendent notes the following apparent errors in Anthem’s calculation of the true-up adjustment for prior rebates:

- Anthem calculated the per contract month rebate amount for 2008 using enrollment from July 2008 – June 2009 rather than calendar year 2008.
- Anthem compared this amount to the \$3.91 per contract amount in the original 2008 rate filing, rather than the \$4.30 that was determined by the Superintendent in the 2008 Decision and Order.
- Anthem determined the dollar amount that needed to be credited to the proposed rates by multiplying the per contract per month amount of the credit by the projected enrollment for the rating period rather than the actual enrollment for 2008.

Correcting these errors results in a per contract per month credit of \$0.78, which should be applied in place of the \$1.41 calculated by Anthem.

3. Colonoscopy Benefit

Effective January 1, 2009, Anthem enhanced the benefit for the Preventive Care and Supplemental Accident (“PCSA”) rider to include 100% coverage for colorectal cancer screenings. As explained in the filing, only a portion of the base claims experience reflects this

additional coverage. Therefore an adjustment is needed to fully reflect this benefit in the projected claims for the rating period. Anthem proposes an addition of \$23,330 to projected incurred claims. The Attorney General has accepted Anthem's estimate and the Superintendent agrees.

4. Provider Contracting

Anthem did not make an explicit adjustment to reflect changes in its provider contracts but included this as one of the justifications for its higher allowed-charge trend assumption. In response to an information request from the Attorney General, Anthem quantified the impact. The Attorney General agreed with Anthem's assessment of the impact of provider contracting, and included it as a component of allowed-charge trend. The Superintendent finds that this estimate is adequately supported but has determined that this adjustment is more appropriately reflected as a one-time adjustment to expected claim costs rather than a component of trend, because the supporting work papers showed it as a one-year impact, not as an ongoing impact to be assumed to continue at the same rate for 21 months.

E. Rate Relativities

Bureau of Insurance Rule 940, Subsection 8(B), provides that the difference in an insurer's rates for different benefit plans may not exceed the maximum possible difference in benefits, unless the Superintendent grants an exception. Exceptions can only be granted if the rate differential between plans is based on actual or reasonably anticipated differences in utilization that are independent of differences in health status or demographics and if disclosure is provided to prospective and renewing policyholders. In past years, the Superintendent has

granted an exception for HealthChoice plans with low deductibles based on analysis and utilization factors provided to Anthem by Milliman, USA.

This year, Anthem has posited an alternative interpretation of Rule 940 and proposes a uniform percentage rate increase for all non-mandated HealthChoice plans. Anthem states that this is in response to concerns raised by members in public comment sessions in last year's proceeding, and echoed in this year's proceeding. These concerns were expressed primarily by members who have high deductibles and do not have enough health care costs to meet the deductible. As a result, they have no claims paid by their policies, although they do benefit from Anthem's negotiated discounts with health care providers. However, the Superintendent cannot approve a uniform percentage rate increase for several reasons, as explained below.

First, it is the nature of health insurance that those who remain in relatively good health throughout the policy period will pay more in premiums than they will receive in claims payments. They are paying for protection against the risk that their health will change and that they will have substantial health care costs as a result. With any insurance, the premiums of a relatively large number of policyholders finance the claims of a smaller number of policyholders.

Anthem, however, points to claim experience persuasively demonstrating that the premiums for its high-deductible policies are more than would be needed to cover the claims and administrative expenses for these policies. The difference pays claims and administrative expenses for low-deductible policies. However, to the extent that this flow of premium dollars results from high-deductible policyholders being younger and healthier than low-deductible policyholders, it is entirely consistent with Maine's modified community rating law. To the extent that it results from other factors, primarily the incentive for those with high deductibles to curb their use of health services, Rule 940 does allow an exception. This is the exception the

Superintendent has granted in the past and is willing to grant this year as well. The wider exception requested this year, however, does not satisfy Rule 940's requirement that the difference in premiums must bear some rational relationship to the difference in benefits.

Anthem offers two reasons why they believe the Superintendent has authority to grant the wider exception. The first is that many members with higher deductibles testified during the public sessions that they need services, but forego them because they cannot afford to pay for the services on their own. From this, Anthem concludes that "their lower utilization is not as a result of their health status, but rather their decision to avoid utilizing services not covered by their policy." However, even if this is true for those policyholders that gave this testimony, there is no indication that is true for all policyholders. It is far more likely that some policyholders choose their deductible based on their anticipated need for services. It is also clear that those with high deductibles are younger. Data in the filing shows that 64% of those in the older plans with low deductibles, which have not been offered to new members for several years, are now 55 or older, as compared to only 44% of high-deductible policyholders. Although the correlation between higher age and claim cost is well known, the age factors allowed under Maine's modified community rating law limit the amount Anthem may charge for that risk. Therefore, the higher claim costs of the older subscriber pool are not an appropriate basis for charging low-deductible policyholders more than the difference in benefits can support.

Anthem argues further that Rule 940 does not explicitly require premium relationships filed and approved in the past to be re-calculated with each new rate filing. In other words, Anthem argues that because the current rate relationship was approved last year, the same percentage relationship can be approved again this year even though the rate increase raises the incremental dollar cost of low-deductible coverage beyond the maximum permitted by Maine

law. This argument has no merit. The rate relativity formula was approved in the past because it produced lawful rates. Once it ceases to produce lawful rates, it may no longer be used.

Therefore, the record provides no basis for any exception other than one based on the Milliman factors used in past years. Anthem provided the methodology for applying these factors in Appendix IV of the filing. However, there are two flaws in the methodology. First, the formulas for the lower deductibles refer back to column E of Exhibit IV, while column D would be more appropriate, as it reflects the maximum allowable difference before applying the utilization factor. Second, the calculation in Exhibit 4 uses a family factor of 2.53 for the low-deductible plans. This factor was erroneously allowed in prior years based on Anthem's explanation of how the family deductible applies to these plans. However, this year, Anthem has provided testimony and evidence that its previous explanation was in error and that the family deductible can never exceed twice the individual deductible. Therefore a family factor of 2.0 should be used.

F Mental Health Parity Rider

As required by 24-A M.R.S.A. § 2749-C, Anthem offers an optional rider providing mental health benefits at the same level as benefits for physical illnesses. Since its inception, the price for the rider has been several times the cost of the base policy and no one has ever purchased the rider. In response to a request from the Bureau at hearing, Anthem proposed a greatly reduced rate for the rider equal to 0.377 times the rate for the base policy. The Superintendent finds this reasonable but directs Anthem to report its experience for the rider in future filings.

G. Preventive Care

Anthem's witnesses testified about their cost containment efforts, including their case management program. However, in response to questioning by the Superintendent, they said their contract does not allow them to waive the deductible for things such as diabetic self-test strips. This limitation would seem to hamper the effectiveness of the program, and changes should be considered on a voluntary basis to the extent that they are not mandated by federal law.

H. Litigation Costs

In its rates, Anthem is entitled to recover the costs of the benefits it provides to its enrollees and the necessary administrative costs of providing those benefits. For this purpose, however, it is not appropriate to recognize the costs of appealing the Superintendent's regulatory actions as recoverable expenses.

The pending appeal of the Superintendent's 2009 individual rate decision was not undertaken for the benefit of Anthem's individual policyholders. To the contrary, if Anthem prevails, Anthem's shareholders will benefit at the expense of those policyholders. As the costs of this appeal have been undertaken with the goal of maximizing the return to investors, they are properly borne out of profits and surplus and not charged back to individual ratepayers, either directly through the incorporation of future litigation costs as an item of anticipated expense, or indirectly through the incorporation of past litigation costs into the historic experience used to project future expenses.

For this reason, the Superintendent requested, and Anthem provided, information about whether the costs of prosecuting the pending appeal were incorporated in the proposed rates. In its response, Anthem represented that the total litigation costs included in its 2009 administrative

expenses were \$2572, that only a fraction of this figure was included in the \$4,776,000 administrative expense figure for the individual line of business, and that inclusion of this amount in its historic expenses has no calculable impact on the resulting rates. No adjustment was made to projected expenses during the rating period to recover anticipated future litigation costs. Therefore, based on Anthem's representations, which are subject to validation on examination, the requested rates do not directly or indirectly incorporate the costs of the pending appeal, so no corrective adjustment is necessary.

I. Risk and Profit Margin

Anthem included a 3% pre-tax risk and profit margin in its rate development, the amount allowed by the Superintendent in several filings prior to 2009, but stated that it does not agree that this level is reasonable considering the risks involved.

In 2009, the Superintendent approved a 0% risk and profit margin, as recommended by the Attorney General, based in part on a unique economic situation resulting in extreme financial hardship for subscribers and the extreme financial health of the company. This year the Attorney General again recommended a 0% margin, arguing that the conditions she cited last year still have not changed.

The Superintendent agrees that the conditions cited by the Attorney General in 2009 still exist today, as fully supported by the evidence in the record. While these were among the factors supporting a one-time 0% risk and profit margin last year, it does not necessarily follow that a 0% margin is appropriate on a long-term basis. Any decision whether to approve a built-in expected profit in rates must be balanced against the legitimate governmental interests of protecting the viability of the insurance pool, keeping insurance premiums as reasonable as

possible, and minimizing adverse-selection. While a 3% risk and profit margin might be appropriate in many situations, the Superintendent finds it would make this year's individual rates excessive. Balancing all of these considerations, the Superintendent would approve a risk and profit margin of 0.5% in Anthem's rates.

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 steps detailed in Attachment A.¹³ The rates resulting from these changes are shown in Attachment B.

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 23.1% (before the requested additional trend adjustment) would be reduced to 14.1%. For the Mandated HealthChoice options, there would be no rate change. For the Non-Mandated HealthChoice and Lumenos options, the average increase would be 14.4%, with the specific rate changes ranging from a 1.4% decrease to a 15.8% increase.

¹³ Portions of Attachment A are confidential, pursuant to 24-A M.R.S.A. § 2736(2), because they disclose confidential provider contract information.

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 January 4, 2009, 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 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.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

September 2, 2010



MILA KOFMAN
Superintendent of Insurance