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April 1, 2016

Eric Cioppa, Superintendent
Attn: Elena Crowley
Docket No. INS-15-802
Bureau of Insurance
Maine Department of Professional and Financial Regulation
34 State House Station
Augusta, Maine 04333-0034

*Re: Anthem Blue Cross and Blue Shield Request to Discontinue and Replace Legacy
Individual Health Plans*

Dear Superintendent Cioppa:

Enclosed for filing please find the following:

SUBMITTED BY: Christopher T. Roach

DATE: April 1, 2016

DOCUMENT TITLE: Closing Statement

DOCUMENT TYPE: Closing Statement

CONFIDENTIAL: **NO**

Thank you for your assistance in this matter.

Very truly yours,

/s/ Christopher T. Roach

cc: Attached service list

NON-CONFIDENTIAL

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

IN RE:)
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)
ANTHEM BLUE CROSS AND BLUE) ANTHEM CLOSING STATEMENT
SHIELD'S REQUEST TO DISCONTINUE)
AND REPLACE LEGACY INDIVIDUAL)
HEALTH PLANS EFFECTIVE JANUARY 1,)
2017) APRIL 1, 2016
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Docket No. INS-15-802)
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NON-CONFIDENTIAL

As the Superintendent noted in his opening remarks at the hearing, the question presented in this case is whether it is in the best interests of the legacy policyholders to discontinue their existing legacy plans and migrate them to ACA-compliant plans effective January 1, 2017.

Anthem Health Plans of Maine, Inc. (“Anthem”) respectfully suggests the evidence in the record establishes that standard has been met.

I. It is in the best interests of the legacy policyholders to discontinue their legacy plans and replace them with ACA-compliant plans effective January 1, 2017.

As of January 1, 2016, there were 1,801 grandfathered policyholders (“GF policyholders”) and 1,384 grandmothereed policyholders (“GM policyholders”). (Ossenfort Prefiled, p.6, ln.13; *id.*, p.9, ln.24.) The GM policyholders’ plans will not be continued in 2017. While the GM policyholders will always have the option to purchase other plans, if they so choose, during open enrollment, the evidence in the record establishes that it is in the best interests of the GM policyholders to transition them to an ACA-compliant plan as Anthem proposes, rather than to simply non-renew their plans and subject them to the potential of a gap in coverage. There was no evidence presented to the contrary.

Consideration of the best interests of the GF policyholders requires more analysis, but leads to the same conclusion.

The choices for the GF policyholders are (1) transition them to an ACA-compliant plan, in a product line that is growing and offers greater premium stability, richer benefits for those currently in high deductible plans, with the potential of subsidized premium, and a net benefit of over \$6.1 million; or (2) maintain their enrollment in a death-spiraling block that will more likely than not be subject to rate increases of 20-30+% annually. While it is up to the Superintendent to determine which path is in the best interests of the GF policyholders, Anthem firmly believes the record establishes that it is in their best interests to discontinue and replace the GF plans.

As evidenced by the \$6+ million in net premium savings in 2017 alone the majority of policyholders (over 70%) will benefit immediately on a pure premium basis. As the Superintendent noted, the percentage grows to 93% when one considers the disparity in benefit levels for those legacy policyholders in high deductible plans versus the richer-benefit ACA plans. While Mr. Clamp testified that Anthem had not done a calculation of the added benefit to the policyholders, we do know that the \$6.1 million net premium saved would increase materially. For example, simply using the policyholder counts from the information provided by Anthem in response to the Superintendent's First Information requests reflects that there are 690 GF policyholders on a \$15,000 deductible legacy plan and 90 on a plan with a \$10,000 deductible. If we factor in the differential between each high deductible plan and the \$6,850 out of pocket maximum of an ACA plan, that would add another \$5.9 million to the net savings figure, resulting in a total net savings for 2017 of approximately \$12 million (*i.e.*, $(\$15,000 - \$6,850) * 690 = \$5,623,500 + (\$10,000 - \$6,850) * 90 = \$283,500 = \$5,907,000 + \$6,162,041 = \$12,069,041$).¹ The evidence in the record also demonstrates that, while not every high deductible GF policyholder will exceed the ACA out of pocket maximum in every year, a significant number do and when they do, it is by a significant amount. (*See* Clamp/Fohl Prefiled, p.12 ("average claim was over \$30,000").) As the closed block ages with each passing year, it is reasonable to assume that a material number of policyholders will continue to "guess wrong" each year and be hit with significant expenses that would have been covered by an ACA-compliant plan.

The members of the public who testified at the hearing spoke about the importance of choice and suggested that, rather than discontinue and replace their policies, the Superintendent

¹ There are certainly some policyholders who will transition to plans that have out of pocket maximums that are higher than their current legacy deductible. The analysis presented here is intended to at a high level explain that the differential when we include the deductible to out of pocket maximum (1) grows; and (2) is significant.

should instead allow each policyholder to determine when the rate increases on their legacy plans – to them as individual policyholders – justify the move to an ACA plan. As the Superintendent noted at the start of the hearing, 24-A M.R.S. 2850-B is contrary to that suggestion.

The record in this case is precisely the type of situation that is meant to be addressed by 24-A M.R.S. 2850-B, which requires the Superintendent to authorize discontinuance and replacement when it is in the best interests of the policyholders as a group to do so. It does not require the Superintendent to continue plans in spite of the group’s best interests while policyholders make their decisions piecemeal, based on each policyholder’s unique circumstances and beliefs. Indeed, if the latter were correct, it would nullify 24-A M.R.S. 2850-B(3)(G)(3).

The net benefits to the GF policyholders as a group are demonstrated in the record; there is no evidence to the contrary in the record. Indeed, delaying the migration as some suggested would harm the policyholders as a group and, accordingly, is not in their best interests.

II. Anthem’s ACA formulary is consistent with industry standards and Anthem’s proposed processes to ease member transition, including the exceptions to authorize non-formulary drug coverage, are reasonable.

As Anthem testified, the legacy formulary covers approximately 5,800 unique drugs and the ACA formulary covers 1,814. The vast majority of the additional drugs on the legacy formulary are covered by a therapeutically-equivalent (“TE”) drug on the ACA formulary, which Dr. Holmstrom testified is consistent with other ACA formularies in the industry. To this point, there are only 150 drugs currently on the legacy formulary that are not covered by a TE drug on the ACA formulary. As Dr. Holmstrom testified, this does not mean that the ACA formulary does not provide coverage for 150 maladies that are currently covered by the legacy formulary. Rather, the ACA formulary in most cases covers drugs that are used for the maladies, but may not be considered TE drugs because the mechanism of treatment differs from the legacy-covered

drug. Perhaps most importantly, Anthem provides exceptions to cover non-formulary drugs when (1) the member has been taking the non-formulary drug for at least six months; or (2) if the non-formulary drug is for some reason medically necessary.

The focus of the questions from the Attorney General's Office and Bureau Panel was on assisting policyholders with the transition from the legacy formulary to Anthem's ACA formulary. Anthem shares the goals of ensuring a smooth transition for members and eliminating, to the extent possible, the risk of any disruption in our members' medications. In its responses to the hearing requests, Anthem proposed providing additional instructions to the transitioning policyholders through the notice letter that they will receive on or before October 1, 2016 and, for those who, despite that notice, seek to fill a prescription for a non-formulary drug, a one-time 30-day supply of their medications to allow them to seek authorization for coverage for their non-formulary drug will be available. (*See Anthem's Responses to Hearing Requests, Requests 2 & 3*). Given that Anthem will respond to a request for such authorization within 72 hours of receipt, we believe this provides for a very reasonable, member-friendly, transition to Anthem's ACA formulary.

More could be said, but the evidence in the record establishes that Anthem's proposed discontinuance and replacement of the GM and GF policies effective January 1, 2017 is in the best interests of the legacy policyholders. If the Superintendent so finds, Anthem will provide a compliance filing reflecting the proposed migration mapping once the 2017 plans are approved and work with the Bureau and its counsel in modifying the notice letters to policyholders in the manner suggested in Anthem's hearing responses. Inasmuch as the ACA and legacy rate filing processes depend on whether the Superintendent authorizes the proposed discontinuance and

replacement, Anthem respectfully requests that the Superintendent issue an order on this case at the earliest opportunity.

Anthem appreciates the Superintendent and his panel's time and attention to this filing and the opportunity to present this case and address the questions raised during the hearing process.

