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February 29, 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: February 29, 2016  
DOCUMENT TITLE: Responses to Second Information Requests of the Attorney  
General  
DOCUMENT TYPE: Responses to Information Requests  
CONFIDENTIAL: **NO**

Thank you for your assistance in this matter.

Very truly yours,

/s/ Christopher T. Roach

cc: Attached service list



1. The number of policyholders expected to receive premium savings from moving to ACA compliant plans and the magnitude of those savings is dependent upon a 5% annual increase in premiums for the ACA compliant plans in 2017. If the proposed 5% increase turns out to be low, the impact would overstate the amount of expected premium savings and the number of policyholders impacted. As such, has Anthem considered the following items in the development or estimation of the 2017 rate increase in the ACA compliant plans?

- a. In 2017, the federal transitional reinsurance program expires for the ACA compliant policies which would result in an increase in the expected claims in the individual market.
  - i. Was this taken into account in the estimation of the 5% increase?
  - ii. If so, what was the expected rate increase impact of the program expiration?
  - iii. If not, please explain why you believe it should not be taken into account
- b. In our estimation, medical cost and utilization trends have recently been in the range of 5% to 9% for the individual medical market. This may suggest Anthem's assumed medical trends are well below the market averages.
  - i. What is the medical trend assumed in the estimation of the 5% increase?
    1. What support do you have for this assumption?
  - ii. What is the pharmacy trend assumed in the estimation of the 5% increase?
  - iii. What support do you have for this assumption?
- c. Based on the response to the AG's First Information Request (AG's First") question 1(c), it appears the 5% annual rate change assumes no adjustment for changes in morbidity.
  - i. Would this assumption change if the Grandmothered plans are terminated and those policyholders migrate into the ACA plans?
    1. If the answer is no and the 5% takes the migration into account, what is the value or adjustment included in the increase for the migration?
    2. If the answer is yes and the 2017 increase on the ACA plans would likely change, what is the estimate of the impact on the rate increase of those members moving into the ACA compliant plans?
  - ii. Would this assumption change if the Grandfathered plans are terminated and those policyholders migrate into the ACA plans?
    1. If the answer is no and the 5% takes the migration into account, what is the value or adjustment included in the increase for the migration?
    2. If the answer is yes and the 2017 increase on the ACA plans would likely change, what is the estimate of the impact on the rate increase of those members moving into the ACA compliant

plans?

- d. Does the estimation of the 5% annual rate increase for the ACA compliant plans take into account the announcement by Community Health Options to limit enrollment in the individual market?
  - i. If so, what was the impact?
  - ii. If not, please explain why not.
- e. Does the estimation of the 5% annual rate increase for the ACA compliant plans take into account the 2015 financial experience of this block?
  - i. What is the 2015 loss ratio for the individual ACA compliant block of business?

Response	<p>The premise of the question – that the analysis reflected in the filing relies upon a 5% premium increase in ACA rates for 2017 – is not quite correct. Rather than predicting future specific rates for either ACA or legacy plans going forward, the filing assumes that the historical rate differential between ACA and legacy plans will continue, with two logical modifications: one that takes into account the effect on the medical loss ratio of cutting the legacy block in half and that the remaining Grandfathered (“GF”) half is materially less healthy and the other adjustment was a minor increase in the administrative expense charge to account for the fact that the fixed costs of the legacy block will be borne by a materially smaller number of policyholders.</p> <p>Each of your questions would be logical if we had performed a rate development for this discontinuance filing, but as we have discussed in the filing, in response to the AG’s First Requests and above, this filing is intended to reflect – directionally – the impact of continuation of the historical rate differential as it relates to whether a policyholder would be benefited by transitioning to an ACA-compliant product. As such, the analysis is intended to depict the premium savings that result from the differential spread in rate increases between the ACA and legacy products. As a result, items that would affect both rates (e.g., medical cost and utilization trend) would have no effect on the spread between ACA and legacy rate increases.</p> <p>We agree that it is unlikely that the actual future rate increases for the ACA and legacy plans will be precisely 5% and 30%. Our analysis does not depend on the 2017 rate increases being 5% and 30% for ACA and legacy plans, respectively. It instead is focused on the spread between the increases for those plans that is supported by historical data and the observed risk score data for the cohort of members that will remain in the legacy plans as of January 1, 2017. There are drivers that could push either rate increase either way. In our view, however, the driver that is likely to have the greatest effect is the legacy block’s accelerated death spiral if the proposed migration is not approved. <i>See, e.g.,</i> <u>Maine Bureau of Insurance White Paper: Maine’s Individual Health Insurance Market</u> (Updated January 22, 2001), Executive Summary at 1 (noting the existence of the death spiral). Thus, the actual observed future spread between ACA and legacy rate increases may well be greater than the spreads assumed in</p>
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the filing. In any event, however, we remain convinced that our assumptions are directionally reasonable.

With that background, we respond below to the remaining parts of your question that are not addressed by the general commentary above.

- a. The discontinuance of the federal transitional reinsurance program was accounted for implicitly in our analysis. As previously stated we used the rounded 2016 approved ACA rate increase as the demonstrated 2017 ACA rate increase. The Federal Reinsurance program was never intended to be permanent and the reimbursement stepped down from 2014 to 2016 to minimize the rate shock of this program going away. The program estimated that they would collect enough money to lessen the impact of adverse selection in the Individual ACA market by \$10 Billion in 2014, \$6 Billion in 2015, and \$4 Billion in 2016. In actuality, however, the program collected more money in 2014 than it could pay out in 2014 so these funds rolled over to 2015, which reduced the reinsurance payment for 2015. As a result, the reinsurance payment from 2015 to 2016 will be similar to the increase that would occur from the reinsurance payment going from \$4 Billion in 2016 to \$0 in 2017.
- b. See above discussion explaining why trend would affect both ACA and legacy rates.
- c. Again, our analysis focuses on the spread between the rate increases, not the actual rates themselves. The Grandmothered (“GM”) members must migrate to ACA-compliant plans effective January 1, 2017. Some number of those members will remain with Anthem; others will choose different options. We did not make assumptions concerning the number of GM members who will remain with Anthem once they transition. What we do know, however, is that these are the healthiest legacy members so the “drag” if any on ACA morbidity is not expected to have a material difference on the spread of rate increases between the ACA and legacy plans going forward. Indeed, the average risk score for the ACA population as of December, 2015 (1.06) is slightly higher than the risk score for the GM population as of December, 2015 (1.05). If the Superintendent approves the proposed discontinuance and migration for the entire legacy block at once (as we have proposed), we again do not know how many of those initially transitioned members will remain with Anthem and how many will choose other options. At a very high level, the average risk score for the GF population as of December, 2015 is 1.20 and the average risk score for the ACA population is 1.06.

	<p>Assuming all of the GF members (<i>i.e.</i>, 3,665) remain in their transitioned Anthem products and Anthem's individual ACA and GM enrollment remains static at (16,664 and 2958, respectively), the resulting average risk score would be approximately 1.08. Again, these numbers are wholly speculative because we do not know the extent to which transitioned members will remain in an Anthem ACA product. While this data indicates a potential minor change in morbidity for the migrated population, there is significant uncertainty around the financial impact of this morbidity shift due to risk adjustment.</p> <p>d. Anthem made this filing before Community Health Options announced that it was suspending its enrollment. The announcement was made only shortly before the end of the 2016 open enrollment period, which limits the effect of the announcement on 2016 enrollment.</p> <p>e. See comments above explaining how we derived the analysis for this filing.</p>
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2. Relative to the imputed 2017 Legacy premium rates and the estimated premium savings:

- a. Please clarify whether the savings calculation assumes a 2017 rate increase amount from 2016 rates to 2017 rates of 30%.
- b. Please provide support for the 2% increase in administrative expenses for the Legacy block.
  - i. Why aren't the administrative expenses allocated to the individual block as a whole, rather than the ACA block and the Legacy block?
  - ii. Is this a new approach in the allocation of administrative expenses?
- c. If the savings calculation assumes an annual increase of 30% from 2016 rates to 2017 rates, please address the following:
  - i. Please demonstrate and support that the 18.28% portion of the increase does not include any change in morbidity that is included in the 8% adjustment based on the MLR calculation.
  - ii. What are the medical and pharmacy trends assumed in the estimated 30% rate increase?
  - iii. Please provide quantitative support that it is reasonable to assume the 2016 rate increase of 18.28% would be supported for 2017.

Response	<p>a. Yes, the imputed rate increase for the legacy block for 2017 is 30%, but again, our focus was on the spread between ACA and legacy, not the rate increases themselves.</p> <p>b. GF policies make up 55.3% of the total Individual legacy block. If the discontinuance is denied and only the GM members migrate, then this block would be reduced by roughly 50% as of January 1, 2017. Anthem maintains a legacy system for the legacy membership which has substantial fixed costs. As the legacy membership declines, the fixed costs persist leading to a higher admin PMPM. Anthem allocates administrative expenses to the lines of business that incur the claims. The 2% increase is a rough approximation of the impact of maintaining the system for a reduced block. This is not a new approach in the allocation of administrative expenses.</p> <p>c. The 18.28% increase is the approved 2016 Individual legacy block rate increase. The 8% morbidity adjustment is calculated by taking the 2015 GF loss ratio and dividing it by the individual legacy loss ratio during the experience period that was used for the 2016 rate development, which represents how the experience data will deteriorate. Anthem did not try to project how the morbidity would change because of the 2017 rate increase. Implicitly Anthem has assumed similar morbidity deterioration as in past years (which had lower rate increases) so if anything we are most likely understating the morbidity impact of the GM block migrating to ACA combined with typical selective lapse.</p> <p>Anthem does not believe that it is reasonable to assume that the 2016 rate increase of 18.28% is a reasonable rate increase for 2017. As noted in our response to the AG’s first set of questions, we believe that 30% is a more reasonable rate increase for a legacy block that only includes GF members in 2017. Please see comments above that explain the analysis used in this filing.</p>
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3. The response to AG’s First, request 3c contains the results of the rate relationships by plan and rating region from the Legacy plans to the ACA compliant plans – which underlies the savings calculation. Given the above issues, we would like to know the rate relationships, the savings calculation and the number of members that would have lower rates in the ACA compliant plans under the following scenarios:

- a. ACA increases 10% and Legacy increases 20%
- b. ACA increases 15% and Legacy increases 15%

Response

We do not agree that the “issues” suggested in your questions support a lower spread between the ACA and legacy rate increases for 2017. If the Superintendent denies the proposed migration and the legacy block consists solely of GF members beginning in 2017, we may well find that the 30% increase assumed in our filing would be insufficient to produce adequate rates for the dwindling legacy block. In any event, we do not believe that the hypothetical spreads reflected in your questions are reasonable in light of these two very different blocks. With those introductory comments, the mathematical answers to your questions are as follows:

- a. 60.8% of the GF contracts would have reached premium equivalence and \$6.8M would have been saved by subscribers that have reached premium equivalence for a net premium saved of \$4.2M. *See table below.*
  
- b. 55.5% of the GF contracts would have reached premium equivalence and \$5.5M would have been saved by subscribers that have reached premium equivalence for a net premium saved of \$2.1M. *See table below.*

Year	ACA Increase	Legacy Increase	% of Legacy GF Contracts that Crossover		Premium Saved by Migrating Legacy GF Subscribers		
			Prem Equivalence	Prem & Ded	Prem Saved by Subs that have Prem Equ Crossover	Prem Lost by Subs that do not have Prem Equ Crossover	Net Premium Saved
2017	10%	20%	60.8%	92.2%	6,862,810	(2,569,046)	4,293,765
2017	15%	15%	55.5%	89.8%	5,541,189	(3,429,959)	2,111,230

