

**ROACH|HEWITT|RUPRECHT
SANCHEZ & BISCHOFF PC**

Christopher T. Roach

66 Pearl Street, Suite 200
Portland, ME 04101

207-747-4875 voice
croach@roachhewitt.com

March 21, 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 Individual Health Plans

Dear Superintendent Cioppa:

Enclosed for filing please find the following:

SUBMITTED BY: Christopher T. Roach
DATE: March 21, 2016
DOCUMENT TITLE: Prefiled Testimony of Kristine Ossenfort
DOCUMENT TYPE: Prefiled testimony
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:) **EXHIBIT 1**
)
)
ANTHEM BLUE CROSS AND BLUE) PREFILED TESTIMONY OF
SHIELD'S REQUEST TO DISCONTINUE) KRISTINE OSSENFORT
AND REPLACE LEGACY INDIVIDUAL)
HEALTH PLANS EFFECTIVE JANUARY 1,)
2017) MARCH 21, 2016
)
Docket No. INS-15-802)
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1 **Q. Please state your name and your position with Anthem Blue Cross and Blue Shield**
2 **(“Anthem”).**

3 A. My name is Kristine M. Ossenfort. I am the Director of Government Relations with
4 Anthem in Maine.

5

6 **Q. Please describe any relevant education or experience that qualifies you as a witness**
7 **today.**

8 A. I have been Anthem’s Director of Government Relations, and part of the senior
9 management team, since 2009. During my tenure at Anthem, in addition to being the regulatory
10 and legislative liaison for the Company, I have worked with the teams charged with designing
11 Anthem’s product and network mix, obtaining regulatory review and approval of the products and
12 networks, as well as ultimately putting those products into the Maine insurance marketplace. I was
13 also part of the team that developed Anthem’s suite of ACA products for introduction beginning
14 on January 1, 2014. Most recently, I worked with the team that developed the products and
15 formulary for the transition of the grandmothers policyholders to ACA-compliant products, the
16 same products and formulary that Anthem proposes here to replace the grandfathered
17 policyholders’ existing plans.

18

19 Prior to joining Anthem, I was a Senior Government Affairs Specialist for the Maine State
20 Chamber of Commerce, which gave me significant exposure to the Maine business environment
21 and the issues Maine businesses face. I also served as the staff attorney for the Bureau of Banking
22 (now known as the Bureau of Financial Institutions). I graduated from Vassar College with a
23 Bachelor of Arts degree and received my juris doctor in law from Syracuse University College of
24 Law.

25

26 **Q. Please state your reasons for testifying at this hearing.**

27 A. My testimony will describe the ACA plans to which we intend to transition the legacy
28 members; explain why it is in the best interests of the grandmothers policyholders to transition
29 to ACA plans effective January 1, 2017 rather than simply non-renewing those plans; provide the
30 background of the individual health insurance market in Maine; describe our expectations for the

1 future of the grandfathered block if they remain a stand-alone independent block of business; and
2 explain why it is the best interests of the grandfathered policyholders to transition to ACA-
3 compliant plans effective January 1, 2017, coincident with the grandmothers member transition.
4

5 **I. REQUIREMENTS OF ACA-COMPLIANT PLANS**

6
7 **Q. Please describe the requirements for ACA-compliant plans.**

8 A. There are a number of requirements that apply to ACA compliant plans that do not apply
9 to the legacy plans, including the requirements that ACA plans comply with certain out-of-
10 pocket limits and meet actuarial value requirements. ACA-compliant policies must also include
11 essential health benefits (“EHBs”). EHBs are based upon the benefits under a “benchmark plan”
12 for ten required categories of benefits:

- 13 1. Ambulatory patient services
- 14 2. Emergency services
- 15 3. Hospitalization
- 16 4. Maternity and newborn care
- 17 5. Mental health and substance use disorder services, including behavioral health
18 treatment
- 19 6. Prescription drugs
- 20 7. Rehabilitative and habilitative services and devices
- 21 8. Laboratory services
- 22 9. Preventive and wellness services and chronic disease management
- 23 10. Pediatric services, including oral and vision care

24 All copayments, coinsurance and deductible amounts for EHBs must accumulate to the out-of-
25 pocket maximum and although quantitative limits are allowed, no annual or lifetime dollar limits
26 are permitted for EHBs.
27

28 **Q. What is the significance of actuarial value as it relates to ACA plans?**

29 A. The Actuarial Value or “AV” is the average percent of total allowed cost of benefits paid
30 by a health plan. It is also sometimes referred to as the “metal levels” required under the ACA.
31 The ACA requires policies with an actuarial value within one of the following AV corridors:

- 1 • Bronze 58-62%
- 2 • Silver 68-72%
- 3 • Gold 78-82%
- 4 • Platinum 88-92%

5

6 All ACA-compliant individual products are required to fit within those actuarial value corridors.

7

8 **Q. What is the maximum out of pocket expense allowed for ACA plans?**

9 A. The maximum out of pocket expense for ACA plans for 2016 for individuals and families
10 is \$6,850 and \$13,700, respectively. As discussed below, this is obviously significantly lower
11 than the maximum deductible allowed for legacy plans, which means Anthem begins to pick up
12 100% of member costs sooner for ACA plans than for the high deductible legacy plans.

13

14 **II. IT IS IN THE BEST INTERESTS OF GRANDMOTHERED POLICYHOLDERS**
15 **TO TRANSITION TO ACA-COMPLIANT PLANS EFFECTIVE JANUARY 1, 2017**

16

17 **Q. Please describe the status of grandfathered plans under the ACA.**

18 A. The grandfathered plans are those that were purchased after March 23, 2010, but prior to
19 January 1, 2014. For as long as they retain that status, grandfathered plans do not have to
20 comply with the requirements of the ACA. Originally, the ACA required these plans to
21 transition to ACA-compliant plans no later than January 1, 2014. Accordingly, Anthem
22 previously received approval from the Superintendent to transition those plans to ACA-
23 compliant plans effective January 1, 2014. In late 2013, however, President Obama announced
24 transitional relief that would allow the grandfathered plans to be renewed. Anthem worked
25 with the Bureau to facilitate transitional relief for those policyholders and reached an agreement
26 for 2014 rates for the combined (grandmothered and grandfathered) legacy block. In March of
27 2014, the Centers for Medicare and Medicaid (“CMS”) issued a bulletin authorizing states to
28 allow carriers that chose to do so to extend transitional relief for up to another two years (in
29 Anthem’s case, through December 31, 2016).

30

1 At the time of our filing for discontinuance, transitional relief was scheduled to end with plans
2 effective January 1, 2017. On February 29, 2016, CMS issued a bulletin authorizing states to
3 give carriers the option of extending transitional relief through December 31, 2017. Anthem has
4 carefully considered the CMS bulletin but does not intend to extend the individual
5 grandmothers plans for another year.
6

7 **Q. Given that Anthem previously extended transitional relief, why has the Company**
8 **decided against a further extension?**

9 A. When Anthem first agreed to extend legacy plans for the 2014 plan year, there were
10 nearly 18,000 legacy plan members, the ACA was brand new, and Anthem felt that extending the
11 legacy plans was the right thing to do for those members at that time. We are now three years
12 into the ACA, the legacy block enrollment has declined significantly (*e.g.*, as of January 1, 2016,
13 there are only 1,384 grandmothers policies covering 2,485 members), rate increases are
14 becoming increasingly larger, and the premium differential that existed between the ACA and
15 legacy plans back in 2013 has either been reduced dramatically or eliminated altogether. With
16 this significant change in the environment, it no longer makes sense for Anthem to extend the
17 grandmothers policies for another year. Instead, as set forth in our initial filing and below, we
18 believe it is in the best interests of the entire legacy block to transition to ACA compliant plans
19 effective January 1, 2017.
20

21 **Q. Is Anthem's proposed migration of the grandmothers plans consistent with the**
22 **Superintendent's prior order approving that transition?**

23 A. Yes. The Superintendent previously determined that our proposed legacy-to-ACA
24 mapping and ACA formulary were both appropriate. The Superintendent denied Anthem's
25 request to migrate the grandmothers members to the more focused network, deciding instead
26 that decision was best left to individual member choice. Consistent with that prior decision,
27 Anthem now proposes to transition the grandmothers members to the most comparable ACA-
28 compliant plan, paired with our ACA drug formulary, and the same type of broad provider
29 network to which the grandmothers members now have access.
30
31

1 **Q. Will the transitioned legacy members have access to services out of state?**

2 A. Yes. Once transitioned to an ACA plan, the legacy members will have access to out of
3 state services through our Blue Card system. This means that the legacy members can use any
4 out of state provider that is contracted with a Blue Cross/Blue Shield plan.
5

6 **Q. Has Anthem developed an exhibit reflecting the difference in benefits between**
7 **products the legacy policyholders have now versus those that will be in effect following the**
8 **transition to an ACA-compliant plan?**

9 A. Yes. As reflected in Initial Filing Exhibit 3, the most significant benefit differentials are
10 observed in those currently in high-deductible (*e.g.*, \$10,000 and over) plans. In those plans, the
11 policyholder's out of pocket annual maximum can be as high as \$15,000. In contrast, ACA
12 plans allow a maximum out of pocket expense of \$6,850. Those high deductible legacy plans
13 will be mapped to the highest allowable out of pocket ACA-compliant plan (*i.e.*, one with a
14 \$6,850 out of pocket maximum).
15

16 **Q. Are the plans reflected in Initial Filing Exhibit 3 those that will be in effect in 2017?**

17 A. No. The 2017 plans are still in development and have yet to be filed or approved. As a
18 result, the plans reflected in Initial Filing Exhibit 3 are those that are in effect for 2016. To the
19 extent there are material changes for 2017 that would affect the legacy member mapping,
20 Anthem will submit an update.
21

22 **Q. What will this mean for the transitioned legacy members?**

23 A. Many will have lower deductibles and out of pocket maximums, which means the legacy
24 members will have more services covered sooner. As explained below, this can lead to better
25 health outcomes for our members. Given the lower out of pocket maximum, it also means that
26 when a member has a significant claim, the insurance coverage will kick in sooner and the
27 financial impact on the policyholder will be reduced.
28
29
30

1 **Q. Why transition the grandmothered members instead of simply allowing their**
2 **coverage to terminate?**

3 A. Anthem could simply not renew the grandmothered policies, but in our view, it is in the
4 grandmothered policyholders' best interests to transition them to ACA-compliant plans to ensure
5 there are no unintended gaps in the policyholders' coverage. Some will choose to transition to
6 an ACA-compliant plan before January 1, 2017, but for those who do not, Anthem's plan
7 provides a coverage backstop and helps to avoid an inadvertent loss of coverage. Even after the
8 transition, the previously grandmothered policyholders will have the option to purchase different
9 coverage – on or off exchange – through the open enrollment period.

10

11 **Q. Why is Anthem proposing to transition legacy policyholders to off-exchange plans,**
12 **instead of transitioning them to plans on the health insurance exchange and thereby**
13 **potentially qualify for a subsidy?**

14 A. The short answer is that we cannot transition members to plans through the health
15 insurance exchange. The only way for a member to purchase an ACA plan on-exchange is for
16 the enrollment to be processed through the federally facilitated marketplace or “FFM”, in part to
17 determine whether the individual qualifies for a subsidy. We would not have the information
18 needed, nor would we be in a position to know if the policyholder wants to apply for a financial
19 subsidy. Once legacy members transition to, and become more comfortable with, ACA plans,
20 however, we do expect that a number of legacy members will register on-line and attempt to
21 qualify for a subsidy of their premium.

22

23 **Q. Does Anthem know how many current legacy policyholders will qualify for a**
24 **subsidy of their ACA premium?**

25 A. No. According to CMS approximately 87% of Mainers who enrolled through the FFM
26 qualified for subsidies,¹ but we do not have direct information about each legacy policyholder's
27 income to calculate who would (or would not) qualify for a subsidy. Again, we expect that the
28 transition we have proposed will facilitate members becoming more familiar and more
29 comfortable with ACA plans. Once members see that they have a variety of options for

¹ <https://aspe.hhs.gov/pdf-report/health-insurance-marketplaces-2016-open-enrollment-period-final-enrollment-report>

1 coverage, not only from Anthem but other carriers as well, and can get both broad and more
2 focused network coverage through the health exchange, we would expect most will attempt to
3 qualify for a subsidy for the plan that best suits their individual circumstances. While we do not
4 have enough information to estimate how many will qualify, this is an obvious additional benefit
5 to the proposed migration. Put differently, whether due to resistance to change, lack of
6 knowledge or concerns about the “unknowns” of ACA plans or other reasons, there are almost
7 certainly legacy policyholders who would qualify for significant subsidies through the exchange
8 that could get them a richer plan for less than they are paying now. Anthem’s proposed
9 transition will assist in overcoming some of those hurdles, which ultimately will benefit the
10 policyholders.

11
12 For all of these reasons, it is in the best interests of GM policyholders to transition them to ACA-
13 compliant plans, effective January 1, 2017, as reflected in Anthem’s proposal.

14
15 **III. IT IS IN THE BEST INTERESTS OF GRANDFATHERED POLICYHOLDERS**
16 **TO TRANSITION TO ACA-COMPLIANT PLANS EFFECTIVE JANUARY 1, 2017**

17
18 **Q. Before going into the details of your testimony, please explain why it is in the best**
19 **interests of the grandfathered policyholders to transition coincident with the**
20 **grandmothered policyholders.**

21 A. We at Anthem intended to maintain the legacy products for the benefit of grandfathered
22 policyholders until it became impracticable to do so. But a block that is its own separate risk
23 pool and closed to new entrants becomes unsustainable at some point in time. That time has
24 come. As of January 1, 2016, the GF policyholder block has already dwindled to only 1,801
25 policies covering 3,321 members; reduced numbers that Anthem did not expect to see until a
26 year from now. Without reinsurance, the rate increases necessary to cover the costs of the legacy
27 block member claims are once again on the rise. Increasing premiums in a closed block will lead
28 to lapses, which will lead to even higher rates to cover the costs, which will lead to additional
29 lapses: a death spiral for the legacy block.

30

1 The death spiral will be exacerbated by the make-up of the legacy block. Currently, the block
2 consists of approximately 50% grandmothereed members and 50% grandfathered members.
3 When the grandmothereed members transition effective January 1, 2017, the enrollment in the
4 legacy block will immediately shrink by 50%, which all else being equal, would result in higher
5 rate increases. But all else is not equal. On average the grandmothereed members are far more
6 healthy, and use fewer services, than grandfathered members. When those relatively healthier
7 members transition, the higher claims from the grandfathered members will need to be paid by a
8 smaller number of enrollees. As reflected in the Prefiled Testimony of Dee Clamp and Zach
9 Fohl (the “Clamp/Fohl testimony”), rates for the grandfathered policyholders will increase
10 sharply. It is not in the best interests of grandfathered policyholders to remain in a stand-alone
11 block that is in an accelerating death spiral.

12
13 Unlike the legacy block, Anthem’s ACA block of business is growing in size and, with the
14 increased penalties associated with the individual mandate and relatively stable premiums, the
15 block promises continued growth. In 2015 alone, the legacy block rates were increased by
16 13.40% whereas ACA rates were reduced by 1.1%. That rate increase disparity continued in
17 2016 with an approved average rate increase of 18.28% for legacy plans and only 4.8% for ACA.
18 With the loss of the grandmothereed members effective January 1, 2017, legacy rates will
19 continue to rise significantly in the future. As a result, we expect that the majority of the
20 grandfathered policyholders would pay less in premium for an ACA plan in 2017 than a legacy
21 plan. When we consider the out of pocket maximum differentials, nearly 100% of current legacy
22 policyholders would be better off today in an ACA-compliant product.

23
24 Given what we know about the future of the legacy block (loss of at least 50% of membership
25 and large rate increases), the question is when, not if, the grandfathered policyholders should
26 migrate to ACA-compliant plans.

27
28 As demonstrated below and in the prefiled testimonies from Messrs. Clamp and Fohl and Dr.
29 Holmstrom, we firmly believe it is in the best interests of the grandfathered policyholders to
30 transition to ACA-compliant plans on January 1, 2017.

31

1 **Q. Please describe the relevant historical background of the individual health**
2 **insurance market in Maine.**

3 A. As of January 1, 2016, Anthem's legacy block consisted of approximately 1,801
4 grandfathered and 1,384 grandmothers policyholders. For much of the period from Anthem's
5 acquisition of the former Blue Cross Blue Shield of Maine through the effective date of the
6 Maine Guaranteed Access Reinsurance Association ("MGARA"), premiums in the Maine
7 individual insurance market were subject to double digit premium increases annually as
8 increasing claim costs and a shrinking population combined to drive up per-policyholder costs.
9 And for some of that time, Anthem was the only carrier offering major medical coverage in
10 Maine.

11
12 Implementation of MGARA's reinsurance program removed much of the risk of large claims
13 from the individual block and, as a result, premium rates stabilized. MGARA was suspended on
14 January 1, 2014 when the federal reinsurance program became effective. With the loss of a
15 reinsurance mechanism and a closed block with declining membership, there are fewer and fewer
16 enrollees to cover claims that previously were reinsured. The unsurprising result is that the
17 legacy block is starting to perform as it did historically: rising per-enrollee costs mean large,
18 double-digit annual rate increases.

19
20 **Q. Based on your understanding of the individual health insurance market in Maine,**
21 **what does the future look like for the GF policyholders?**

22 A. In a word, the future for GF policyholders is bleak. In 2014, the legacy block declined
23 by over 6,000 members. Without reinsurance of large claims, Anthem lost more than \$6 million.
24 For 2015, Anthem estimated the need for a rate increase of 18.32% to cover all of the costs of the
25 legacy business, plus provide for the approved 3% pre-tax profit margin. With premium of
26 approximately \$47 million, this would have yielded a pre-tax profit of \$1.4 million. The
27 Superintendent approved the 3% profit margin, but determined that an average increase of 13.4%
28 should achieve that 3% margin. Rather than earning the approved 3% profit, Anthem lost \$4.2
29 million on this block on revenues of approximately \$34 million in 2015 (or an approximately
30 negative 12.5% pre-tax return). For Anthem to have earned the approved 3% profit, rates for
31 2015 should have increased by approximately 31.5% (rather than either the 18.32% requested or

1 the 13.4% approved increase). This is in addition to having lost \$5.9 million in 2014 on the
2 Legacy block.

3
4 That trend continued in 2015 and the block is now subject to an average rate increase of 18.28%
5 for 2016. We do expect this trend to continue. As rates rise, additional members will lapse,
6 leaving fewer members to cover the block's claims. Even if there were no disparities in the
7 relative health of those lapsing versus those remaining, the legacy block would be in a death
8 spiral.

9
10 **Q. Has the Bureau previously determined that the individual health insurance market**
11 **in Maine was in danger of being in a death spiral?**

12 A. Yes. More than a decade ago in a whitepaper, first issued in 2000 and updated in 2001,
13 the Bureau predicted that Maine's individual market could not survive as structured:

14 Rates have risen steeply in the past two years, making coverage unaffordable for
15 many. This not only results in more people becoming uninsured, it also can cause
16 a deterioration of the average health of the remaining pool of risks. This is
17 because those who have health problems and utilize their insurance benefits are
18 much less likely to drop coverage than are healthy individuals. In turn,
19 deterioration of the risk pool could lead to further rate increases, causing more
20 people to drop coverage. If this cycle were to continue, it could lead to a collapse
21 of the individual health insurance market. This phenomenon of a shrinking pool
22 of risks and higher insurance rates is sometimes referred to as a "death spiral."

23 (2001 Whitepaper, Executive Summary at 1.)

24 The legacy block today operates in much the same environment as was described in that
25 whitepaper.

26
27 **Q. Is there reason to believe that the legacy block is and will remain in a death spiral?**

28 A. Yes. The Bureau's prediction in 2001 turned out to be accurate, but there are two major
29 differences between the market the Bureau described in 2001 and the legacy block of today that
30 will lead to a death spiral that accelerates even beyond the Bureau's prediction. First, the market
31 the Bureau described as in a death spiral was open to new enrollees. That meant that there were
32 members moving in and out of the block each year. To the extent the new members were at least
33 no less healthy than the average existing member, the block benefited from those additional

1 members. By contrast, the legacy block is closed to new members. It can only get smaller,
2 meaning that over time, the costs of the block will be spread out among fewer and fewer
3 members, driving up the per-enrollee cost.

4
5 Second, as reflected in the Clamp/Fohl testimony, there is a significant disparity in the average
6 health of the GM and GF membership. GM policyholders are lapsing at a more rapid rate than
7 GF policyholders, which in and of itself makes the aggregate average legacy population less
8 healthy, which translates into higher claims spread among a smaller enrollment base. As
9 explained in the Clamp/Fohl testimony, this will be exacerbated when the GM members
10 transition no later than January 1, 2017, resulting in an accelerating death spiral.

11
12 **Q. Should the Superintendent simply allow the annual rate increase process to drive**
13 **GF policyholders to migrate over time, rather than transitioning the block all together on**
14 **January 1, 2017 as Anthem has proposed?**

15 A. No. My understanding is that Anthem is permitted to propose discontinuance and
16 replacement of existing products and that proposal should be approved if it is in the best interests
17 of the policyholders. It is not in the best interests of policyholders to be part of a block that is in
18 an accelerating death spiral, particularly when there are other options available – options that did
19 not exist prior to 2014. Each year, during the extensive rate review process, we hear from legacy
20 members about the stress of annual rate increases and its effect on them financially and
21 emotionally. We also hear about members who do not seek treatment because they are in higher
22 deductible plans that were purchased to reduce their monthly cost.

23
24 This is only going to get worse.

25
26 Rate increases for the combined (GM/GF) legacy block are on the rise; a trend that is highly
27 unlikely to change even if the GM members were to continue as part of that block. As described
28 in the Clamp/Fohl prefiled testimony, our best estimate is that when the GM members transition
29 to ACA-compliant products, rates for the remaining GF policyholders will rise sharply, which
30 will lead to increased lapses, which will continue to lead to significant rate increases. It is not in

1 the best interests of GF policyholders to put them through a spiral that leads to death, but by a
2 thousand cuts.

3

4 **Q. What does Anthem propose for its existing non-compliant plans?**

5 A. Anthem intends to discontinue its existing non-compliant plans and replace them with
6 new plans that comply with the ACA effective January 1, 2017. Just as with the GM plans, GF
7 members will be transitioned to the most comparable ACA-compliant plan, paired with our ACA
8 drug formulary and a broad provider network.

9

10 **Q. How will members be migrated to the new plans?**

11 A. We have developed plans that are, and will be in 2017, compliant with the ACA and will
12 include a broad network of providers, similar to the network to which the GF policyholders
13 currently have access. We propose to transition each GF policyholder to the new product that
14 most closely matches the policyholder's existing benefit level. For example, policyholders
15 currently enrolled in HSA products are being migrated to ACA-compliant HSA plans, those with
16 non-HSA plans are being migrated to non-HSA plans. Those with deductibles that exceed the
17 maximum out of pocket limits allowed by the ACA are being migrated to those maximums to
18 reduce, to the extent possible, the increase in premium resulting from reducing those out of
19 pocket limits. As our letters to policyholders reflect, if the policyholder wants to retain the plan
20 that Anthem suggests as the best match, the policyholder will be automatically enrolled in that
21 new product. While defaulting to the best match plan makes sense, policyholders will have the
22 ability to select a different Anthem plan or any other product that is available on or off the
23 exchange. This process should make the transition simple for the majority of our members; that
24 is, to maintain coverage with a plan that most closely resembles the policyholder's existing plan,
25 they do not need to take any action.

26

27 **Q. Were you involved with the development of the plan to map grandfathered plans to**
28 **ACA-compliant plans in mid-2013?**

29 A. Yes. Recall that at that time, the ACA was to be fully implemented on January 1, 2014,
30 meaning that all non-grandfathered plans were required to transition to ACA-compliant plans by

1 that date. Because GM plans could not exist as of January 1, 2014, Anthem proposed a transition
2 to ACA-compliant plans as of that date.

3
4 **Q. Did Anthem take the same approach when developing a strategy for mapping the**
5 **GF policyholders for 2017?**

6 A. Yes. Anthem's 2017 product offerings differ to some degree from those offered back in
7 2014, but as reflected in our proposed mapping spreadsheet (Initial Filing Exhibit 3), we
8 followed the same approach in mapping our GF policyholders to the closest ACA-compliant plan
9 from a cost perspective. As explained above, the mapping document will be updated (if
10 necessary) when 2017 plans are announced.

11
12 We also followed the Superintendent's guidance from 2013: we are not proposing to use a more
13 focused network for these plans. Rather, the transitioned GF policyholders will use the same
14 network that the Superintendent approved for use with the GM policyholder transition.

15
16 **Q. Will GF policyholders suffer harm beyond the annual rate increase if the**
17 **Superintendent denies the requested discontinuance and replacement?**

18 A. Yes. As reflected in the Clamp/Fohl prefiled testimony, while the majority of GF
19 policyholders (over 70%) would be better off with an ACA plan immediately even solely from a
20 premium perspective, an even larger percentage (upwards of 95% in 2017) will benefit when
21 considering the richer ACA benefits. On a premium only level, the GF policyholders would save
22 over \$6 million in premium in 2017 alone. The corollary is that if the migration is delayed, GF
23 policyholders as a group would lose more than \$6 million.

24
25 **Q. Will all GF policyholders pay less in premium in 2017 if they are transitioned as**
26 **Anthem proposes?**

27 A. No. As indicated above, a majority will pay less in premium and the GF policyholders as
28 a group will save \$6 million, but some will pay more, particularly those who have high
29 deductible legacy plans.

1 **Q. Why should the Superintendent approve the proposed migration if some**
2 **policyholders will pay more in premium?**

3 A. There are numerous reasons.

4
5 First, because the statute authorizes discontinuance and replacement if it is in the best interests of
6 the policyholders as a group to do so. With a net premium savings of over \$6 million in 2017
7 alone, it is clearly in the best interests of the GF policyholders as a group to discontinue and
8 replace their plans as Anthem has proposed.

9
10 Second, the high-deductible policyholders will pay more, but for materially-richer ACA-
11 compliant health insurance plans. There are two facets to this latter point. First, with better
12 insurance coverage, members will be more inclined to seek services when necessary, rather than
13 forego treatment. While difficult to quantify, logic suggests some will have better health
14 outcomes by seeking treatment earlier or in a preventive phase. Second, it is noteworthy that,
15 over a 21-month period, approximately 600 high-deductible legacy members exceeded the
16 \$6,850 ACA maximum out of pocket expense and, on average, had claims of over \$30,000.
17 Certainly, these members who unexpectedly had significant claims would have benefited from
18 being in a product with a materially lower out of pocket maximum.

19
20 Third, the large annual increases that we anticipate for the GF policyholders means that any
21 remaining differential between ACA and GF rates will be overtaken in a relatively short period
22 of time. To assume otherwise, the Superintendent would have to find that the shrinking block,
23 with less healthy members, will not require significant increases going forward. While we do
24 not have the ability to predict future rates with perfect accuracy, it would be unreasonable to find
25 that a shrinking, closed block that will lose the healthiest 50% of its membership will not require
26 significant increases.

27
28 Fourth, it is not in the best interests of GF policyholders to remain in a block that is in a death
29 spiral. The stress of annual (large) rate increases is difficult to quantify, but nevertheless real.
30 By contrast, once GF policyholders transition to an ACA-compliant plan, they will be part of a

1 larger, growing block of business that has a much greater chance of relative rate stability and a
2 larger enrollment over which to spread the GF member costs.

3
4 Finally, once GF policyholders are part of, and become more familiar and more comfortable
5 with, an ACA plan, they may well be more inclined to examine their eligibility for a subsidy
6 through the health insurance exchange. Anthem does not have sufficient income information to
7 evaluate who among the GF policyholders may qualify for a subsidy, but movement to an ACA-
8 compliant plan increases the likelihood that GF policyholders may explore this opportunity. To
9 the extent existing GF policyholders would qualify for a subsidy, the savings from Anthem's
10 proposed migration would increase.

11
12 **Q. Based on your background and experience, is the proposed discontinuance and -**
13 **replacement with ACA-compliant policies in the best interests of Anthem's subscribers?**

14 A. Yes. It is in the best interests of the GM policyholders to transition them to ACA-
15 compliant plans effective January 1, 2017. While the Superintendent could simply allow the
16 plans to non-renew, Anthem firmly believes it is in the best interests of GM policyholders to
17 transition them to ACA compliant plans and ensure there will be no gap in coverage.

18
19 The need to transition GF policyholders to ACA-compliant plans is only a matter of time. The
20 legacy block is declining, becoming less healthy and is in a death spiral that will accelerate with
21 the transition of the GM policyholders at the end of 2016. By contrast, Anthem's ACA block is
22 growing, healthier members are enrolling and, as a result, premiums are more stable. While the
23 ACA covers more, the premium differential between ACA and legacy products has all but
24 disappeared. This means the GF policyholders can either remain in the spiraling legacy block or
25 transition to the growing ACA block and enjoy richer plans with more stable premiums. In our
26 view, the best interest of GF policyholders is clear: transitioning to ACA compliant plans
27 effective January 1, 2017 in coordination with the GM members is in the best interests of GF
28 policyholders.

29
30 **Q. Does this conclude your testimony?**

31 A. Yes.

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

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ANTHEM BLUE CROSS AND BLUE)	
SHIELD'S REQUEST TO)	
DISCONTINUE AND REPLACE)	CERTIFICATE OF SERVICE
LEGACY INDIVIDUAL HEALTH)	
PLANS EFFECTIVE JANUARY 1, 2017)	
)	
Docket No. INS-15-802)	
)	

The undersigned counsel hereby certifies that on this date I caused to be mailed by electronic mail, copies of the Prefiled Testimony of Kristine Ossenfort on the persons and at the addresses indicated below.

<p>Thomas C. Sturtevant, Jr., Assistant Attorney General 6 State House Station Augusta, Maine 04333-0006 Thomas.C.Sturtevant@maine.gov [e-mail]</p> <p>Elena Crowley Elena.I.Crowley@maine.gov [e-mail]</p>	<p>Christina Moylan Assistant Attorney General OFFICE OF THE ATTORNEY GENERAL 6 State House Station Augusta, Maine 04333-0006 Christina.Moylan@maine.gov [e-mail]</p>
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/s/ Christopher T. Roach
Christopher T. Roach
Roach Hewitt Ruprecht Sanchez & Bischoff PC
66 Pearl Street, Suite 200
Portland, Maine 04101
Tel. (207) 747-4875

Attorney for Applicant