Anthem Blue Cross and Blue Shield
2 Gannett Drive
South Portland, ME 04106

October 17, 2014

Mary M. Hooper, ASA, MAAA
Life and Health Division
Department of Professional and Financial Regulation
Bureau of Insurance
34 State House Station
Augusta, Maine 04333-0034

RE: Anthem Blue Cross and Blue Shield Individual Rates Effective 1/1/2015

Dear Ms. Hooper:

Enclosed for filing, please find a rate filing pursuant to 24-A MRSA §2736 for Anthem's legacy block of individual business, presented on a combined basis for grandfathered and non-grandfathered policies.

This filing contains:

1. Information Required by Rule Chapter 940
2. Statement of Qualified Actuary
3. Supporting Exhibits
4. Rate Schedules

Thank you for your attention to this filing. If you have any questions regarding this matter, please feel free to contact me directly at (203) 200-8501 or michael.bears@anthem.com.

Sincerely,

Michael Bears
Regional Vice President, Actuary III
203 200 8501

INDIVIDUAL HEALTH RATE FILING

HealthChoice, HealthChoice Standard & Basic, HealthChoice HDHP, HMO Standard and Basic, and Lumenos
Effective January 1, 2015

Rule Chapter 940 Requirements

Carrier Information

Anthem Blue Cross and Blue Shield
2 Gannett Drive
South Portland, Maine 04106-6911

Submitted By

Michael Bears
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Scope and Purpose of Filing

This filing contains a January 1, 2015 premium revision to our legacy Anthem Blue Cross and Blue Shield (Anthem) Individual products; that is, those individual products purchased by members before January 1, 2014. This filing is intended to demonstrate compliance with 24-A M.R.S.A. §2736-C and any other applicable statutes and regulations. It is not intended for use for any other purpose.

As discussed in more detail below, the average rate increase for the combined legacy products is 19.60%. This rate revision is being filed primarily to adjust for (i) member migration between legacy and 2014 ACA products, as observed during the first ACA open enrollment period; (ii) an increase to the federal insurer fee; and (iii) claim cost trend, with a small adjustment for emerging and high cost Hepatitis C pharmaceuticals. The effect of each is discussed in turn.

Member Migration Between ACA and Legacy Individual Products

Last year, in filing rates for both our 2014 ACA and 2014 legacy products, we were confronted with forecasting who will remain on legacy plans and who will migrate to an ACA plan – and then determining the associated impact to the morbidity of our risk pools. This forecast was complicated by many new and moving parts, such as (i) who would qualify for subsidies without the benefit of detailed income data), (ii) changes to network offerings that provided lower cost options to consumers, (iii) new market entrants with new products, rates, and an unknown level of market acceptance/uptake, (iv) newly operational exchanges, and (v) new ACA product choices with benefit structures that differ from the pre-2014 offerings. Attempts to model member movement through this complex environment of choice resulted in uncertainty surrounding the extent of migration between legacy and ACA products and, further, whether those migrating members would on average be more or less healthy than those who remained. Therefore, we opted to leave the ACA and Legacy blocks at status quo morbidity levels, neither increasing nor decreasing our morbidity assumption on either risk pool.

Since that time, the individual insurance market completed an extended open enrollment period for ACA policies, and we witnessed the risk movement that can occur when our customers are faced with such choices. The pattern of risk migration is now very clear on our legacy business. Higher risk individuals are remaining on legacy products, especially Grandfathered members. In total, from December 2013 to May 2014, our demographic-adjusted prospective risk score -- meant to represent risk beyond that which is age-related – rose by 4.9% and then remained essentially static from May to June. This clearly aligns with the beginning and ending of the ACA open enrollment period. During the ACA open enrollment period, our Grandfathered risk level increased 7.6% whereas the Non-Grandfathered risk level increased 1.4%.

Further, based on lapse patterns, our Grandfathered business became more prevalent within our business, rising from 43% to 49% of the combined legacy block, further shifting our legacy block toward higher risk members. Note that this only reflects risk movement through the end of the 2014 open enrollment period. Given that Anthem's ACA product premiums for 2015 are reducing and the legacy block premiums will be higher, we expect a similar migration during the 2015 open enrollment.

Collectively, these dynamics result in a morbidity increase of 8.72% in our current rate projection, a good portion of which (3.6%) is based on actual risk change already observed through June. This adjustment could actually be increased by approximately 0.50% if we reflected more fully a continued shift to Grandfathered business over time. Importantly, unlike ACA plans, no risk mitigation programs (e.g., reinsurance, risk adjustment) apply to this block of business to address these morbidity changes.

It is important to recognize that our approach to legacy risk turnover is *balanced* with our ACA rate actions, much as we sought to do in our 2014 rates. While the risk level is rising on our legacy block, we made a corresponding *reduction* to our ACA rates by removing higher risk GF claims from our base data, which had the effect of reducing rates for our ACA products. This is offset slightly by an upward adjustment based on Grandfathered members migrating to ACA products.

Increased Federal Insurer Fee

The Affordable Care Act includes a provision that levies a fee on companies that insure health insurance risk: $8 billion dollars in 2014 and $11.3 billion in 2015. This fee helps fund subsidies for lower income purchasers and is not deductible from insurers' federal taxes. Whereas the insurer fee was 2.46% of our 2014 premium, it is 3.48% of our 2015 rates. This expectation essentially tracks the insurer fee cost increase noted above.

Trend

To determine the appropriate claim cost trend for the rating period, Anthem is using a regression analysis methodology that has been approved previously by the Superintendent. The regression-based methodology employed here is a well-established statistical approach for determining trend in time series data (in this case, the monthly allowed claim data). Seasonal, benefit, aging and large claims adjustments are made in separate steps prior to performing the regression analysis which yields the best fitting trend line to the data in a process that minimizes the sum of squared errors. Trend was derived from the normalized allowed claims regression over two 25-month periods. The trend line generated from this approach represents a long-term underlying trend and is not prone to as much of the short-term volatility often found in a small block.

A significant benefit of the trend methodology is that it takes into account the cyclical pattern of our claims trend which is exhibited in our historical experience over multi-year periods. The analysis is

based on allowed cost data (total amount reimbursed prior to member cost sharing) to account for changes in the average level of cost sharing over time. Anthem relies on allowed cost data because, as the average level of cost sharing increases over time, observed paid claims cost trends can be lower than the underlying claim trends and the impact of leveraging on the observed paid claims trend can be masked by changes in the average level of cost sharing. Moreover, with inconsistent changes in average member cost sharing, the leveraging impact can have a significant effect on the trend in observed benefit payments. Our trend development removes this potential bias and, instead, includes a separate explicit adjustment for leveraging.

Claims trend has been applied to the twelve month claim base and trended forward for twenty months in order to estimate claims for the pricing period of twelve months ending December 31, 2015. The underlying claims cost trend is based on a regression methodology utilizing allowed claims cost adjusted (or normalized) for the impacts of large claims, benefit changes, aging and seasonality. The normalized allowed trend is 3.9%. The impact of leveraging is then added to the underlying trend which results in a 4.7% claims cost trend. A graph supporting the projected claim trend is included in Exhibit VIII.

We have also included a 0.34% adjustment to trend to cover high cost drug treatments for Hepatitis C ("HepC"), such as Sovaldi. As coverage for HepC is new, claims associated with these drug treatments are not reflected in our historical data. Having the ability to eradicate HepC will prevent liver disease and death in the coming decades, especially when these treatments are coupled with a push for expanded diagnosis from the Centers For Disease Control (CDC). However, these treatment advances are tremendously expensive, with Sovaldi costing $1,000 per day, and broader population testing for HepC is just beginning. Moreover, the launch of Ledipasvir later this year is expected to expand utilization further. Ledipasvir is a new HepC companion drug that eliminates the need for simultaneous administration of Interferon, a drug with strong side effects. Most HepC infected patients are awaiting this easier regimen before undergoing treatment, and this fact will expand the patient set seeking HepC treatment in 2015.

Therefore, this small item, combined with the regression result, yields a total annual trend of 5.1%.

Benefit Changes

Several new mandates were priced into the rates:

- Autism Age Expansion
- Orally Administered Cancer Therapy
- Human Leukocyte Antigen testing
- Mental Health Parity

Collectively these new mandates were valued at $0.52 PMPM.

Description of Benefits

HealthChoice is an individual PPO product with deductibles ranging from $150 – $15,000. For deductibles of $150 – $2,000 and $4,000, coinsurance applies up to an annual out-of-pocket maximum. A preventive care and supplemental accident amendment is available with the deductible options of $2,250, $5,000, $10,000, and $15,000. An additional optional amendment may be elected to cover listed mental illnesses at the benefit level provided for medical treatment for physical illnesses.

HealthChoice Standard & Basic are the statutory individual products that were required to be offered by any carrier that offers individual PPO products. Deductibles of $250, $500, $1,000 and $1,500 are available for each product consistent with Rule Chapter 750 requirements. An optional amendment may

be elected to cover listed mental illnesses at the benefit level provided for medical treatment for physical illnesses.

HealthChoice HDHP is an HSA compatible plan that has deductibles of $2,600 or $5,000. After the deductible, most services are covered at 100%. The HealthChoice HDHP plan options were closed to new entrants when the Lumenos products were launched. HealthChoice HDHP policyholders were allowed to purchase an amendment to cover preventive benefits at 100% before the deductible. Without the preventive amendment, preventive services were only covered for children and were subject to the deductible.

HMO Standard and Basic are the statutory individual products that were required to be offered by any carrier that offers a Group HMO product.

Lumenos Consumer Directed Health Plans are five individual PPO products with three distinct health care account funding options. There are two plans that qualify to be offered along with a Health Savings Account (HSA) which is funded by the policyholder. There is one plan that offers a Health Incentive Account (HIA) which is funded by policyholders by earning financial rewards for participating in various health management tools. There are two plans that offer a Health Incentive Account Plus (HIA Plus) which is funded with both an HIA and a contribution to a fund through Anthem. Lumenos deductibles range from $2,500 to $10,000. Coinsurance applies to out-of-network services only up to an annual out-of-pocket maximum; in-network services are covered in full after satisfying the deductible. Preventive care, as defined in the contract, is covered 100% under all Lumenos plan designs.

For "non-grandfathered" policyholders that purchased coverage after March 23, 2010 or otherwise severed their "grandfathered" status under the ACA[1], Anthem requires an ACA rider. The ACA rider provides compliant benefit coverage including preventive benefits in full before the deductible, expanded dependent eligibility, removal of the annual maximums for essential benefits and removal of any lifetime maximums. The benefit summaries and proposed premium rate sheets included in this rate application contain details related to the ACA provisions.

The HealthChoice, HealthChoice Standard and Basic, HealthChoice HDHP, HMO Standard and Basic, and Lumenos plans were closed to new entrants on June 30, 2012 (some options were previously closed) and became Anthem's closed block on July 1, 2012. Anthem will still renew existing business on these products. In the balance of this memo we will refer to these products as the Legacy block.

Anthem's HealthChoice HSA $5,000 with mental health benefits was opened after July 1, 2012, constituting part of the open block, and was closed on December 31, 2012. Going forward it will be considered part of the Legacy block.

HealthChoice Plus is an individual non-grandfathered PPO product with deductibles ranging from $2,000 – $12,000. Coinsurance applies up to an annual out-of-pocket maximum, 30% in network for deductibles $2,000 – $7,500 and 20% in network for the $12,000 deductible. HealthChoice Plus was launched July 1, 2012, constituting part of the open block, and was closed on December 31, 2013. Going forward it will be considered part of the Legacy block.

[1] See ACA regulations and information available thru Health and Human Services for additional detail.

In Force Business

Total in force enrollment for the individual legacy block is approximately 7108 contracts as of April 2014 with an annualized premium of approximately $57.1 million for 2013.

Proposed Effective Date

These proposed rates are intended to become effective on January 1, 2015.

Average Annual Premium

The following table shows the average annual premium per contract based on current rates and with the proposed rate revision based on the rating period distribution of contracts in Anthem's individual legacy block.

	All Plans
Before rate revision	$7225
After rate revision	$8641

Premium Changes

The average premium increase proposed is 19.60%. Additional support can be found in exhibit V. The largest rate change is on the HMO plans at 21.3%. The minimum rate increase is 18.2% on the HealthChoice HDHP plans. Based on the requirements of Rule 940 and prior order of the Superintendent regarding those requirements, the minimum rate increase is 0.0% on the Standard and Basic plans.

History of Rate Adjustments

Anthem's Maine Individual rates have been adjusted in the past as follows:

Feb 2014: 13.75% overall
July 2013: 2.4% overall
July 2012: 1.7% overall
July 2011: 5.2% overall

Rule 940, Subsection 8B

Rule Chapter 940, Subsection 8B requires that products cannot vary in premium more than the maximum possible difference in benefits. Compliance is demonstrated in Exhibit III.

Minimum Loss Ratio

Anthem has maintained a loss ratio above the federal and state mandated minimums and anticipates continued compliance should rates be implemented as filed. If rates are approved as filed Anthem's projected loss ratio will be 85.08%.

Rating Factors

The factors used to derive the final premium rates are shown in Exhibit II.

Attained Age

Rates contained within this filing are rated by attained age. Subscriber age as of the effective date of these rates will be used to rate the contract.

Expenses

The cost to administer the legacy business has risen dramatically since implementation of the ACA both because membership continues to decline and because separate systems must be maintained for the legacy and ACA business. The decline in membership causes increased PMPM expenses because administrative expenses include both variable costs, which rise or fall with membership counts, and fixed expenses, which are unaffected by membership. Customer service and operational expenses likewise have increased as members require more customer service resources both to explain the changing environment and assist with information about different product offerings. New systems were developed to manage the ACA business, but the systems used to manage the legacy business must be fully maintained, despite the reduction in the size of the legacy block of business. The combination of these circumstances – increased costs and shrinking membership – has resulted in actual administrative expenses of over $28 PMPM so far in 2014.

For two reasons, Anthem has determined to include in the proposed rates only $25.00 PMPM for administrative expenses. First, while Anthem is confident that the cost to administer the legacy plans in 2015 will be materially higher, given that we remain in a period of transition to the ACA, it is as yet unclear whether the increased administrative expenses will be sustained over the longer term. Second, Anthem is mindful of the impact of rate increases on its members and, if the higher administrative expenses will indeed continue going forward, Anthem believes it more appropriate to transition members to this higher level over a period of time, rather than include the full costs immediately.

Anthem continues to make every effort to administer the legacy products as efficiently as possible and will continue to monitor these expenses closely going forward to determine whether the observed increase expenses will subside.

Investment Income

Investment income is not explicitly reflected in the rate, as is typical for the types of policies contained within this rate filing.

Profit and Risk

Consistent with other approved rate filings, Anthem has included a 3% pre-tax/2% after-tax margin to cover risk and provide for a reasonable return.

While the margin is reasonable on its face, the risk for this block of business is increased going forward because of a shrinking set of membership under volatile circumstances of anti-selection between the legacy and ACA marketplace. This risk is exacerbated because, unlike ACA products and prior legacy products, no risk mitigation programs apply – be that a legacy reinsurance program such as MGARA or any new risk mitigation programs under the ACA. By way of example, Anthem currently estimates a loss of $3.1 million on the legacy products for 2014. While Anthem is not in this rate filing attempting to recoup these 2014 losses, those losses further support the risks Anthem has identified are actually occurring in the market. Despite these incremental risks, we have not increased our profit and risk charge from that of past filings.

Rate Filing Checklist

The completed checklist is included as an attachment to this filing.

Notice to Policyholders

Notice of the rate revision was mailed on October 2, 2014. A copy of the letter is included with this filing.

Additional Exhibits

Anthem is including exhibits beyond those required by Rule Chapter 940 to proactively provide the Bureau with data that was requested during the Bureau's review of Anthem's prior rate filings.

Statement of Qualified Actuary

I, Michael Bears, am a Regional Vice President and Actuary for Anthem Health Plans. I am a member of the American Academy of Actuaries and a Fellow of the Society of Actuaries. I meet the Qualification Standards of the American Academy of Actuaries to render the actuarial opinion herein. I certify that to the best of my knowledge and judgment that the enclosed rate filing is in compliance with the applicable laws, regulations and bulletins of the State of Maine and is in accordance with generally accepted actuarial principles. In my opinion, these rates are not excessive, inadequate, or unfairly discriminatory, subject to the provisos in the administrative expense section of this memorandum. My determination was based on information provided by other employees of Anthem Health Plans, and my own analysis.

The purpose of this filing is to demonstrate compliance with 24-A M.R.S.A. §2736, and any other applicable statutes. This rate filing is not intended to be used for other purposes.

Michael Bears, FSA, MAAA
Regional Vice President and Actuary III
Anthem Blue Cross and Blue Shield