

JANET T. MILLS
ATTORNEY GENERAL



TEL: (207) 626-8800
TTY USERS CALL MAINE RELAY 711

STATE OF MAINE
OFFICE OF THE ATTORNEY GENERAL
6 STATE HOUSE STATION
AUGUSTA, MAINE 04333-0006
October 17, 2014

REGIONAL OFFICES:
84 HARLOW ST., 2ND FLOOR
BANGOR, MAINE 04401
TEL: (207) 941-3070
FAX: (207) 941-3075

415 CONGRESS ST., STE. 301
PORTLAND, MAINE 04101-3014
TEL: (207) 822-0260
FAX: (207) 822-0259

14 ACCESS HIGHWAY., STE. 1
CARIBOU, MAINE 04736
TEL: (207) 496-3792
FAX: (207) 496-3291

Eric Cioppa, Superintendent of Insurance
Attn: Sarah Hewett
Docket No. INS-14-1000
Bureau of Insurance
Maine Dept. of Professional and Financial Regulation
34 State House Station
Augusta, Maine 04333-0034

Re: *Anthem Blue Cross and Blue Shield 2014 Individual Rate Filing for Healthchoice, Healthchoice Standard and Basic, Healthchoice HDHP, HMO Standard and Basic, and Lumenos Consumer Directed Health Plan Products Purchased by Members Before January 1, 2014*
Docket No. INS-14-1000

Dear Superintendent Cioppa:

Enclosed for filing please find two hard copies of the following:

SUBMITTED BY: Christina M. Moylan, AAG
DATE: October 17, 2014
DOCUMENT TITLE: Pre-filed Testimony of Beth R. Fritchen
DOCUMENT TYPE: Pre-filed Testimony
CONFIDENTIAL: No

Copies are also being served this date in the manner indicated on the enclosed Certificate of Service. Thank you for your attention.

Sincerely,

/s/ Christina M. Moylan

CHRISTINA M. MOYLAN, AAG
207/626-8838
christina.moylan@maine.gov
SCOTT W. BOAK, AAG
207/626-8566
scott.boak@maine.gov

CMM/s
Enc.
cc: Service list

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

IN RE:)
)
)

ANTHEM BLUE CROSS AND BLUE)
SHIELD 2014 INDIVIDUAL RATE)
FILING FOR HEALTHCHOICE,)
HEALTHCHOICE STANDARD AND BASIC,)
HEALTHCHOICE HDHP, HMO STANDARD)
AND BASIC, AND LUMENOS CONSUMER)
DIRECTED HEALTH PLAN PRODUCTS)
PURCHASED BY MEMBERS BEFORE)
JANUARY 1, 2014)

**PRE-FILED TESTIMONY OF
BETH R. FRITCHEN, FSA, MAAA**

October 17, 2014

Docket No. INS-14-1000)
)

1 Q. What is your name?

2 A. Beth R. Fritchen

3 Q. Please describe your professional and educational background that qualifies you as an
4 expert witness in this matter.

5 A. I am a Fellow of the Society of Actuaries and a Member of the American Academy of
6 Actuaries. I am a Partner with the actuarial consulting firm Oliver Wyman Actuarial Consulting,
7 Inc. and specialize in health insurance management and actuarial services.

8 My qualifications that are relevant to this hearing are that I have provided consulting
9 services to many different regulators including those in Kentucky, Vermont and Virginia. I have
10 reviewed health insurance rate filings in these states. I have testified in the last four rate hearings
11 for HealthChoice. In addition, I have testified in other rate hearings on behalf of the Attorney
12 General regarding DirigoChoice and MEGA Life and Health rates. I have provided consulting
13 services to other regulators in Rhode Island, Massachusetts, Maryland and Maine. I have been
14 involved in approximately 15 rate hearings in Rhode Island regarding individual and Medicare
15 Supplement rate filings. In addition, I have participated in approximately nine rate hearings in
16 Vermont.

17 I have co-authored several papers relating to the health insurance industry including
18 "Impact of Association Health Plan Legislation on Premium and Coverage for Small
19 Employers," "Impact of Prior Approval Requirements for Rate Changes of Small Employers
20 Group and Individual Health Policies," "Government-Sponsored Health Insurance Purchasing

1 Arrangements: Do They Reduce Costs or Expand Coverage for the Individuals or Small
2 Employers,” “Trends in Health Claims for Fully Insured Health Maintenance Organizations in
3 Massachusetts, 2002-2006,” “Analysis of Administrative Expenses of Health Insurance
4 Companies in Massachusetts,” and the semi-annual Oliver Wyman Trend Survey.

5 I have a Bachelor of Science degree in mathematics from the University of Wisconsin –
6 Madison with an emphasis in actuarial science.

7 Q. What is the purpose of your testimony?

8 A. I am here to testify with respect to the Anthem Blue Cross and Blue Shield (“Anthem”)
9 2015 rate filing for Legacy products for individual subscribers. The Legacy products include
10 grandfathered and non-grandfathered HealthChoice, HealthChoice Standard & Basic,
11 HealthChoice HDHP, HMO Standard and Basic and Lumenos policies. My testimony will focus
12 on the reasonableness of the requested rates and demonstrate that the proposed rates do not meet
13 the statutory requirement to be “neither excessive, inadequate or unfairly discriminatory.” In my
14 opinion, the proposed rates are excessive, and in some cases unfairly discriminatory.

15 Q. Can you summarize your findings based on your review and analysis of the proposed
16 rates?

17 A. I reviewed and analyzed the filing and Anthem’s methodology and results extensively. I
18 have concerns regarding the methodology employed in the calculation and with specific
19 assumptions. I developed independent calculations of certain components of the needed rates for
20 the rating period. There are generally three reasons for my opinion that Anthem’s rates are
21 excessive: 1) the projected claims are overstated due to Anthem methodological choices, 2) the
22 administrative expenses and fees are unsupported, and 3) the profit and risk charge is excessive.

23
24 **I. Claim Costs**

25 Q. Have you reviewed Anthem’s development of projected claim costs for the 2015 calendar
26 year?

27 A. Yes.

28 Q. Please comment on Anthem’s methodology.

29 A. Anthem employs a similar methodology in the calculation of the rate increase as it has in
30 previous years. It uses the past experience of the Legacy block of business as the basis for the
31 calculation, making adjustments to the experience for the population the company expects to

1 enroll during the effective period of the rates. However, I believe this block of business should
2 not be rated on its own experience and would instead pool all individual experience as a basis for
3 the Legacy rate development.

4
5 **OW METHODOLOGY**

6 Q. Could you please elaborate?

7 A. There are a couple of factors that should be taken into consideration when setting the
8 premium rates for this block of business. First, this is a closed block of business. As the block
9 decreases, the credibility of the experience lessens. Further, Anthem anticipates a significant
10 decrease in the enrollment in these policies in the next year. It estimates that the member months
11 will decrease from 200,653 to 103,546 (Response to Superintendent's second discovery request,
12 question 9). This represents a significant additional reduction beyond what has already been
13 observed in 2014 where about one-third of the membership migrated out of the block in the first
14 five months of 2014. In a closed block of business as the membership continues to decrease, the
15 stability and predictive power of historical experience decreases. Therefore, having a closed
16 block of business standing on its own in the development of future claim costs can produce
17 unstable and high increases as the remaining members have a smaller base over which to spread
18 the volatility of the claims risk. The claim volatility can be observed in the number and
19 magnitude of large claims in the Legacy block of business in early 2014, where the early months
20 of 2014 have had more large claims as a percentage of total claims than previous periods, with
21 lower membership.

22 For these reasons, I believe a plan should be developed for the management of this block
23 of business. There needs to be a balance between affordability and the need to cover the
24 projected increasing costs of the business. I believe using a pooled approach in generating future
25 claim costs generates this balance.

26 Q. Have you estimated the impact on the rate increase if the entire individual block of
27 business is used in the rate development?

28 A. Yes. We have generated an independent calculation. This is shown in AG - Exhibit 1.
29 The analysis reproduces the rate increase using a pooled approach with the ACA-compliant
30 policies. It should be noted that we used the same adjustments and projection factors that were in
31 the ACA-compliant filing. As much of the detailed development was not in the filing, I am

1 unable to opine that the factors are reasonable. Rather, we used the same adjustments for
2 consistency in the claims cost development of the Legacy plans and the ACA-compliant plans,
3 where applicable. For example, we did not make the same benefit adjustments as they are
4 different between the two lines of business. Given that we are suggesting the Legacy block
5 should be managed on a pooled basis with the ACA-compliant plans this is a reasonable
6 approach. I will note that the administrative expenses are not the same. In some cases, the
7 administrative expenses would not apply. In other cases adjustments need to be made.

8 Q. Can you walk us through the exhibit?

9 A. The exhibit shows our independent calculation in the second column and Anthem's
10 proposed calculation in the third column. The analysis starts with the same base period claims
11 and membership, which are the base claims and membership for the entire Anthem individual
12 block of business in Maine.

13 The next adjustment is for large claim pooling. In our review of the development of the
14 ACA-compliant plans, we did not see an adjustment for large claim pooling. As such, we did not
15 incorporate a pooling adjustment or pooling charge.

16 The claims are then normalized to the new rating period. We used Anthem's factors
17 found in the Legacy rate filing.

18 The next adjustment is for benefit changes. Anthem assumed a factor of 1.000 or no
19 benefit changes. We used Anthem's factors.

20 In the original calculation, Anthem applies a morbidity change for the rating period.
21 Anthem believes the morbidity of the Legacy line of business will significantly increase as
22 healthier members migrate out of these policies. We applied a morbidity adjustment of 1.0051 in
23 our development, which is consistent with the ACA-compliant plans rate development. Our
24 assumption assumes a small worsening in the pool's morbidity, consistent with the ACA
25 development.

26 We applied the same medical trend used in the ACA-compliant plans. The trend used in
27 the ACA-compliant plans is 6.6%. This is slightly higher than the trend used by Anthem in the
28 proposed rate increase for the Legacy population.

29 The next adjustment is for the Hepatitis C drugs. Since this adjustment was included in
30 the 6.6% medical trend in the ACA-compliant plans, we do not need to make this adjustment.

1 Pharmacy rebates are subtracted from the projected claims and reflect the expected
2 rebates used in the ACA-compliant plans. We used a value of \$6.60 PMPM in the calculation.
3 This is higher than the amount credited by Anthem's in its calculation of rate increase. Anthem
4 used pharmacy rebates of \$3.50 PMPM. Further discussion of the pharmacy rebates can be found
5 later in my testimony.

6 There are a few other adjustments required in the calculation of the rate increase. These
7 are mandated benefits and healthcare management. We have accepted Anthem's adjustment for
8 mandated benefits. We have incorporated a revised healthcare management cost based on
9 Anthem's calculation. This is also discussed later in my testimony.

10 Our independent analysis generates an expected claims cost of \$339.12 PMPM compared
11 with Anthem's projected claim costs of \$359.90 PMPM, or a reduction of 5.8%.

12 Administrative expenses risk and profit loads are applied to the expected claim costs to
13 generate the average required premium. We used the administrative expenses consistent with
14 those in Anthem's development for the Legacy products. The only adjustment to the
15 administrative expenses is in the Insurer Fee. We have made an adjustment in the calculation of
16 this fee. This is also discussed later in my testimony.

17 The final adjustment included is a 3% charge for risk and profit. Since I did not review
18 the ACA-compliant policies, I am not opining on the reasonableness of this load. We included
19 the 3% charge to be consistent with the risk and profit charge in the ACA-compliant policies.

20 Overall, my independent calculation generates an increase of 12.8%, which is 6.8% lower
21 than Anthem's requested increase of 19.6%

22 23 **ANTHEM METHODOLOGY**

24 Q. Do you have any other concerns with the rate increase development, in addition to the
25 appropriateness of the stand-alone methodology?

26 A. Yes. We have some general concerns with the development of the retention items.
27 Further, if the Superintendent determines the Legacy block should be rated on its own, we have
28 additional concerns with the development of the morbidity adjustment, trend, pharmacy rebates,
29 and Hepatitis C adjustment.

30 31 **Morbidity Adjustment**

1 Q. Assuming the Superintendent allows Anthem to rate this block on its own experience,
2 please discuss the concerns you have with Anthem's rate development, starting with the
3 morbidity adjustment.

4 A. I reviewed Anthem's development of morbidity adjustments due to the ongoing
5 migration of membership from this closed block to other alternatives in the market. Anthem
6 included an adjustment factor of 1.0872 to the paid claims. In other words, Anthem is expecting
7 that the enrolled population for this block will be more costly, due to the migration of healthier
8 individuals to other policies than these Legacy policies.

9 Q. Do you have any concerns with Anthem's adjustment and if so, could you please explain
10 your concerns?

11 A. Yes. Anthem did not perform an explicit migration analysis allowing an external
12 reviewer to understand the assumptions underlying its projected worsening in morbidity. Rather,
13 its approach is to assume the morbidity changes observed in early 2014 will repeat in 2015,
14 without analysis of the drivers of the observed morbidity change.

15 Given the continuing development of the ACA market, and a lack of information
16 regarding the drivers of the past migration, I cannot opine at this stage on whether that
17 assumption is reasonable or unreasonable. Additionally, we believe there is a technical flaw in
18 the development of the morbidity factor, based on the information provided.

19 Q. Can you please elaborate?

20 A. Yes. As background - Anthem uses demographically adjusted prospective risk scores as
21 its measure of morbidity. Prospective risk scores are values that attempt to measure the
22 anticipated or future level of claims costs for an individual using diagnosis codes, drug claims or
23 some other indicator from prior experience. Generally, included in the development of
24 prospective risk scores is a component for the impact of demographics (*i.e.*, age and gender) on
25 expected claim costs. For example, older members are expected to have higher costs. Since
26 premiums are allowed to vary by age, Anthem adjusts the risk score by a demographic score to
27 generate a proxy for morbidity.

28 Conceptually, removing the impact of the demographic score for the estimation of
29 morbidity is logical. However, we believe there is a technical flaw in the calculation. In
30 Anthem's calculation, the company adds all of the risk scores for each person enrolled in a
31 month to get an aggregate risk score. Next it adds all of the demographic scores for each person

1 enrolled in that month. The total risk score is then divided by the total demographic score to
2 generate a demographically-adjusted risk score for a specific month. The overall morbidity
3 change from one time period to a different time period is compared to generate the morbidity
4 change assumption used in the rate calculation. This methodology overstates the impact to the
5 change in morbidity from those members with the highest demographic scores.

6 I believe that the correct methodology for measuring the change in the morbidity, using
7 Anthem's demographically-adjusted risk score, would be to take each individual's risk score and
8 divide by Anthem's demographic score which generates a demographically-adjusted risk score
9 for every individual. Next we would average the demographically-adjusted risk scores across all
10 individuals enrolled in the month. The overall morbidity change is generated comparing the
11 demographically-adjusted risk score for various time periods.

12 The table below shows the results of the morbidity adjustment using Anthem's
13 methodology and our methodology, based on the data provided in Anthem's response to the
14 AG's first discovery request, question 13.

	Anthem Approach	Plan-level Averaging
2014 Changes	3.6%	2.8%
2015 Changes	4.9%	3.8%
Rate Filing Impact	8.7%	6.8%

16
17 The impact of this adjustment on the rate request using our approach is 1.9%.

18
19 **Trend**

20 Q. What is the next step in the analysis?

21 A. The next step is to review Anthem's development of the trend to apply to the base claims
22 exclusive of excess large claims.

23 Q. Do you consider the 3.9% trend assumption used by Anthem in this filing to be out of
24 line with trend levels generally observed in the market?

25 A. No. In our experience we have observed trend levels for much of the industry between
26 5.5% and 8%. This does not mean that there are not cases where higher or lower trends are
27 reasonable and justified based on the actual experience underlying the products being priced.

1 Also, the Anthem trend as presented is not directly comparable to the market
2 benchmarks, mainly because the Anthem trend calculation excludes large claims whereas most
3 benchmarks include these claims. This has two impacts. First, the Anthem trend is reduced as
4 large claims tend to trend at a higher rate than claims in aggregate, with smaller claims tending to
5 trend at a lower than average rate. Second, by removing claims over a threshold from the
6 calculation of trend, the trend is further deflated. As an example, consider a case where the
7 threshold for large claims is \$50,000 and there is a claim in a prior year of \$49,000. In the
8 following year that claim is \$52,000 but only \$50,000 of the claim is considered in the trend
9 calculation. The \$2,000 excess claims amount is removed from the buildup of trend in this case
10 and therefore lowers the trend. Each of these reasons causes the Anthem trend to appear lower
11 relative to benchmarks.

12 Q. Do you have any concerns with Anthem's derivation of the trend rates used in the rate
13 filing?

14 A. Yes. While the approach used by Anthem is based on generally accepted methods and is
15 broadly consistent with the approach used in prior periods, Anthem did change its data period for
16 the trend calculation from 40 months to 50 months, which materially impacts the resultant trend
17 rate. In addition, Anthem continues to use a linear regression of the PMPM expenses to develop
18 trend, whereas I have found that an exponential regression tends to be a better approach to model
19 growth elements in time-series data.

20 Q. Did you develop your own trend estimate for the Legacy blocks of business?

21 A. Yes, I did. To facilitate comparison, I followed the Anthem approach for the majority of
22 the calculation. I relied on the Anthem factors to adjust for large claims, seasonality and benefit.
23 I fit an exponential trend to the adjusted Normalized Allowed PMPM using the most recent 40
24 months' worth of data, consistent with prior filings.

25 Q. Why did you adopt Anthem's approach to adjusting experience to derive the Normalized
26 Allowed PMPM in the trend analysis?

27 A. This approach allowed us to segregate the impact of different concerns within the rate
28 filing, reduces the need for additional assumptions and improves comparability of the estimates.
29 Additionally, these adjustments are consistent with historical Anthem practices - using consistent
30 assumptions whenever appropriate is a good way to ensure that results are not unduly influenced
31 by the preparer over time.

1 Q. What was the outcome of your analysis?

2 A. My calculation yielded a trend of 2.7% per year, compared to the 3.9% calculated by
3 Anthem when applying a linear regression using data from the last 50 months. I would note that
4 the result would have been 2.6% had I applied a linear regression, rather than an exponential
5 regression to the 40 months of data.

6 Q. Would you recommend that Anthem use this lower trend value in its rate filing?

7 A. Yes. To test the reasonableness of the assumption, we compared the results with the trend
8 estimates that would have been produced if alternative periods were used for applying the
9 regression. The results, shown in the table below, confirm that the 2.7% estimate is close to the
10 median value across different durations. It also indicates that the 50-month period selected by
11 Anthem yields the highest trend of all durations tested.

12

Trend Assumption Based on Months Used for Trend Calculation

	Trend Rate	Number of Alternative Choices of Same Type	
		Resulting in Higher trend	Resulting in Lower Trend
Anthem Value	3.9%	0	26
40-month Exponential	2.7%	14	12

Months in Regression	Linear Trend	Exponential Trend
50	3.9%	4.2%
49	3.8%	4.1%
48	3.6%	3.9%
47	3.4%	3.6%
46	3.1%	3.3%
45	3.1%	3.2%
44	3.1%	3.2%
43	3.0%	3.2%
42	3.0%	3.2%
41	3.1%	3.3%
40	2.6%	2.7%
39	2.4%	2.4%
38	2.2%	2.2%

37	2.5%	2.6%
36	2.4%	2.4%
35	2.3%	2.3%
34	2.4%	2.5%
33	2.6%	2.7%
32	2.3%	2.3%
31	2.2%	2.2%
30	1.8%	1.8%
29	2.0%	2.0%
28	3.0%	3.0%
27	3.2%	3.2%
26	3.1%	3.1%
25	2.6%	2.6%
24	3.4%	3.3%

1

2 Absent additional information that would support the change in trend period from the 40 months
3 previously used to the 50 months included in the current filing, I would recommend that Anthem
4 use the 2.7% trend estimate derived using a consistent approach to prior years. The impact on the
5 rate increase from changing the trend assumption to our recommended 2.7% trend factor is 2.5%.

6

7 **Pharmacy Rebate Allowances**

8 Q. What is the next step in the analysis?

9 A. The next step is to reduce any base period experience to account for anticipated pharmacy
10 rebates.

11 Q. Why should this be done?

12 A. Rates should only be set at levels to cover the net cost of the health plan to provide the
13 coverage under the policy. Consequently, offsets to costs, such as pharmacy rebates should be
14 included in the rate development, as Anthem has done. The higher the rebates projected, the
15 larger the offset to costs, and the lower the rate level required by the health plan.

16 Q. Do you agree with Anthem’s estimate for the Pharmacy rebate offsets?

17 A. No. I believe that these offsets may be understated. First, while Anthem has provided
18 support showing that the offset included in its rate development is consistent with historical
19 averages, this ignores the fact that these rebates have been increasing over time. More
20 significantly, it is not clear why the pharmacy rebates projected on the ACA-compliant products
21 is anticipated to be almost double the level assumed for Legacy products, at \$6.60 PMPM

1 compared to \$3.50 PMPM in the current filing. Pharmacy rebates tend to be volume driven so
2 the clear delineation of rebates by product, and such a large difference across the product lines
3 (Legacy vs. ACA-compliant) is unexpected.

4 Q. Do you have a recommendation for an appropriate Pharmacy rebate offset?

5 A. I have not developed an independent estimate of this adjustment as I do not have the
6 information I need to do so. I was, however, able to quantify the impact to the rates filed of
7 ignoring the trend in pharmacy rebates in the development of this estimate. My approach was to
8 use the PMPM rebate data by calendar quarter as provided by Anthem. I performed a regression
9 analysis on the data using an approach similar to the approach adopted by Anthem for
10 developing a trend estimate for projecting experience. I performed the regression 2 ways –
11 considering all the data provided and then separately considering only the data from 2012 to
12 current (such that more recent observations could be provided more weight). Based on the
13 regression results, I then projected rebate amounts for each of the four quarters in 2015 and
14 averaged these values to produce an estimate for calendar year 2015. In developing my best
15 estimate I assume the midpoint of the 2015 estimates derived using the two different time
16 periods for regression. The results of my analysis and a comparison to the values included in the
17 filing are shown in the table below.

	Rx Rebate Offset
Amount in Filing	\$3.50 PMPM
Average since 2011 (no trend)	\$3.47 PMPM
Trended Values	From 2011-2014 data: \$3.97 PMPM
	From 2012-2014 data: \$4.31 PMPM
	Average: \$4.14 PMPM

18
19 I would recommend using a projected pharmacy rebate amount of \$4.14 PMPM. This has an
20 impact on the rates of 0.2% on the rate increase.

21
22 **Hepatitis C Impact**

23 Q. What other concerns do you have with Anthem’s projected claim costs?

24 A. I also reviewed Anthem’s adjustment to claims costs for the impact of advanced Hepatitis
25 C drug treatments.

1 Q. Do you have any concerns about Anthem’s estimate of the impact of covering Hepatitis-
2 C drugs?

3 A. I have some concern that the impact has been overstated. Anthem’s approach is to
4 include the additional costs related to Hepatitis C drugs, and reasonably exclude savings from
5 reduced medical claims to be realized over time as a result of the drug treatment. Anthem
6 estimates the impact to drug claims and then translates that to an impact on overall claims costs,
7 by multiplying the drug cost impact with the share of total claims that relate to drugs. My
8 concern related to this translation of impact to total medical costs. Throughout the rate filing,
9 Anthem uses a “Paid Claims” approach, i.e. historical paid claims are projected to the future
10 period, including making adjustments for changes in benefits. However, in this one instance,
11 Anthem selected “Allowed Claims” when estimating the share of total claims attributable to drug
12 claims. This choice inflates the share of claims attributable to drug spending, and increases the
13 projected impact of the Hepatitis C drugs being introduced.

14 Q. Did you estimate the impact on premium rates using Anthem’s approach of selecting
15 allowed claims as opposed to paid claims?

16 A. Yes. Based on information provided in Anthem’s filing for ACA-compliant products I
17 was able to quantify the impact, as shown in the table below.

18

	Allowed Claims Basis	Paid Claims Basis
Rx Share of Total Claims	17%	13%
Source	Current filing	Exhibit B of ACA Filing
Hepatitis Premium Impact	0.57%	0.44%

19

20 I recommend using a factor of 0.44% in the premium rate development. This has a 0.15% impact
21 on the rate increase.

22 **Mental Health Parity**

23 Q. You mentioned early in your testimony that you found the rates to be unfairly
24 discriminatory in some cases. Can you elaborate?

25 A. Yes. My concern relates to the application of the adjustment for mental health parity. The
26 concern includes two components. First, applying the charge to those individuals that have
27 already purchased the mental health rider, is an unfair charge to those individuals. Second, with

1 the costs related to the Federal mandate now applied to all individuals, the price of the rider
2 benefits should reduce by more than the increase in the charge to the block as a whole, to reflect
3 the fact that pricing for rider benefits typically includes assumptions for higher utilization of
4 benefits. It is appropriate to expect higher utilization of services from those individuals that
5 actively purchased a rider benefit, but if these costs are going to be spread across the whole pool,
6 then that adjustment for utilization should be removed from the rider benefit pricing as well.

7 Q. Anthem has agreed in responses to our questions to remove the \$0.20 PMPM load for
8 Grandmothered plans. Does this address your concerns?

9 A. Partially, the proposal would address the unfairness concerns provided that this is done
10 across all Grandmothered plans and not just those plans that include rider benefits. However, this
11 approach results in separating the development of the rates for Grandfathered and
12 Grandmothered plans and may complicate future analyses of emerging experience for rate
13 development. Additionally, this response is based on the assumption that Federal Mental Health
14 Parity does not apply to grandmothered plans, which the Superintendent has questioned during
15 Discovery.

16 Q. Do you have any additional concerns regarding the Mental Health Parity riders and the
17 costs charged by Anthem, if Federal Health Parity means that these benefits need to be offered to
18 Grandmothered plans as well?

19 A. Yes. Given that much of the current benefits for this rider will be covered under the base
20 plan, I am very concerned with the premium that Anthem has charged for this rider and the lack
21 of support for the pricing. Anthem states that the cost for these benefits is 37.7% of the entire
22 base cost for these reduced benefits. See response to Superintendent's second discovery request,
23 question 3. Clearly this pricing reflects some inflated utilization of services by those that had
24 historically selected the rider benefit, as in my experience **all** mental health services generally
25 represent about 3% of medical services. Also, while this level is consistent with the prior pricing,
26 it should be materially reduced to reflect that much of the historical benefits will be included in
27 the base plan. I am unable, however, to quantify how much this benefit is overpriced in this
28 scenario because we do not have the detail required to complete the analysis.

29
30 **II. Retention Items**

31 **Administrative Expenses, Taxes and Fees**

1 Q. Did you review the administrative expenses, taxes and fees proposed in the filing?

2 A. Yes.

3 Q. Do you have an opinion as to whether this component of the proposed rates is
4 reasonable?

5 A. I do not believe that all components of the administrative expenses, taxes and fees as
6 proposed are reasonable. Anthem did not provide adequate support for the \$3.47 PMPM
7 Healthcare Management expense included in the rate filing. Additionally, the allowance included
8 in Anthem's pricing for recoveries of the ACA Insurer Fee is overstated.

9 Q. What is your concern with the Healthcare Management expense?

10 A. The Healthcare Management expense relates to Anthem's quality improvement programs
11 and it is common for health plans to include an allowance for such expenses, but the information
12 Anthem provided does not support the level of the expense it included in the rate filing.

13 Q. What level of expense would be supported by the Anthem information provided?

14 A. Anthem provided a projection of the expenses in the relevant cost centers (Anthem's
15 response to AG first discovery request, question 9), amounting to \$3.04 PMPM. This compares
16 against a \$2.99 PMPM allowance included for this item in prior filings. Based on these two
17 pieces of information I believe that Anthem has provided support for a charge of \$3.04 PMPM
18 for Healthcare Management expense, as reflected in the cost center information referenced
19 above.

20 Q. Why do you believe the allowance for the ACA Insurer Fee is excessive?

21 A. Anthem appears not to have included an assumption for premium growth in its
22 development of the ACA Insurer Fee estimate. As background, the ACA includes a non-tax
23 deductible assessment on health plan issuers. The total dollar amount of the assessment is
24 specified in legislation, with the assessment levied based on premium volume. Consequently, as
25 premiums in the market increases, the assessment decreases in percentage terms. Anthem
26 assumes in its rate filing that the assessment will grow at the same rate in dollar terms and
27 percentage terms, as shown in the table below.

28

Item	2014	2015	Change
Aggregate Insurer Fee	\$8bn	\$11.3bn	+41%
Anthem Pricing Allowance	2.46%	3.48%	+41%

1 This approach assumes that aggregate health insurance premiums in the market is unchanged
2 across calendar years, and overestimates the ACA Insurer Fee given that there will likely be
3 growth in aggregate premium levels.

4 Q. Did you perform an independent calculation of the ACA fee allowance?

5 A. No. My approach in reviewing the reasonableness of the Anthem filing was to consult an
6 industry report and then review the reasonableness of the values from the report against the
7 Anthem estimates. America's Health Insurance Plans (AHIP), the national trade association
8 representing the health insurance industry, worked with Oliver Wyman to produce widely cited
9 estimates for the ACA Insurer Fee Impact on premiums. For 2015 the range of impact was
10 estimated at between 2.6% and 3.2%, as compared to Anthem's 3.48%. See Estimated Premium
11 Impacts of Annual Fees Assessed on Health Insurance Plans, Exhibit 2.

12 I then calculated the implied growth in premium that would support the difference
13 between the values from the report and the values included in Anthem's 2015 rate filing,
14 assuming the 2014 Anthem estimate was accurate. I calculated that, if Anthem were to assume
15 market premium growth of 8.75% ($3.48\% / 3.2\% - 1$), its development of an ACA Fee allowance
16 would yield an assumption at the high end of the AHIP report. Given the impact of premium
17 trend, and growth in the individual market and managed Medicaid, I believe the 8.75% growth
18 factor is reasonable. Based on this I concluded that a 3.2% ACA fee allowance would be
19 reasonable.

20 Q. Do you have a recommendation for the Superintendent relative to administrative
21 expenses?

22 A. Yes. Based on my review I question the appropriateness of the allowances for
23 administrative fees and taxes in the Anthem filing. Specifically I recommend that the allowance
24 for Health Management expense be reduced to \$3.04 PMPM and the allowance for the ACA fee
25 to 3.2% of premium.

26

27 **Risk and Profit Charges**

28 Q. Do you have an opinion on the risk and profit charge of 3% in the proposed rates?

29 A. In general, the 3% pre-tax risk and profit charge is within the range I have observed in the
30 industry. However, the reasonableness of the risk and profit charge ultimately depends upon

1 several factors such as the adequacy of the corporate surplus, as well as the historic contributions
2 the specific line of business has made, in this case the Direct Pay line of business.

3 Q. Have you had a chance to review the corporate surplus levels associated with Anthem?

4 A. Yes. I have reviewed the Five-Year Historical Data included with the 2013 Statement and
5 page 4 from the 2009 to 2013 Annual Statements for Anthem BCBS of Maine. These pages are
6 marked as Exhibit 3. The table below shows the net income and surplus (in millions of dollars),
7 among other information, for the Anthem of Maine business for calendar years 2009 to 2013.

Calendar Year	Net Income	Revenues	Net Income as a Percent of Revenue	Dividends to Stockholders	Capital and Surplus	RBC Ratios
2009	\$20.8	\$993.2	2.09%	\$47.7	\$209.5	6.9
2010	\$48.8	\$1,010.0	4.83%	\$20.9	\$229.2	7.6
2011	\$45.0	\$1,025.4	4.39%	\$48.8	\$224.6	7.6
2012	\$39.9	\$1,019.2	3.91%	\$110.0	\$142.8	5.3
2013	\$48.4	\$1,030.8	4.70%	\$39.9	\$163.1	7.6
Total	\$202.9	\$5,078.60	4.00%	\$267.3		

8

9 Q. What conclusions do you draw from that financial information regarding the financial
10 health of Anthem?

11 A. The current RBC ratio has been maintained at sufficient levels despite large regular
12 dividends to Stockholders (*i.e.* the parent). Over this four year period, Anthem of Maine
13 provided \$267.3 million in dividends to its parent corporation. After the decrease in surplus due
14 to the large dividend paid to the parent in 2012, surplus increased again in calendar year 2013,
15 reflecting the positive operating experience Anthem of Maine enjoyed.

16 In my opinion, the corporation has a healthy surplus and a large risk and profit margin for
17 the Legacy individual business is not necessary.

18 Q. You also mentioned the historic contributions from the Direct Pay business as being
19 relevant to the profit and risk margin. Please elaborate.

20 A. From 1999 to 2012, the Direct Pay line of business has contributed over \$18 million in
21 profits to Anthem of Maine or about 2.2% of total revenue, before Federal Income taxes. That is
22 a significant contribution and indicates that this block of business has more than contributed its
23 fair share when actively marketed. Additionally, in 2013 Anthem realized windfall profits on this
24 line of business, with MGARA payments significantly exceeding expected levels. In 2013,

1 profits were over 10 million on the Direct Pay business, representing a realized margin of 17.5%
2 on revenue. Including 2013, total profits from 1999 come to \$28 million or 3% of revenue.

3 Q. Do you have a recommendation regarding an appropriate profit and risk margin for this
4 filing?

5 A. My recommendation is based on the current rate filing and may be different if the block
6 were to be priced and managed as part of a broader single risk pool with the ACA-compliant
7 plans, which I strongly recommend, as discussed earlier in my testimony. If the block is to be
8 priced on its own, as proposed by Anthem, I recommend reducing the profit and risk charge to
9 1%. The Legacy block of business is a closed block which needs to be managed carefully to
10 consider the affordability of those members still enrolled in the plans as the block winds down.
11 The members in this block have already contributed more than their fair share towards the
12 Anthem surplus and it is unfair and unsustainable for them to expect them to continue to
13 contribute 3% to Anthem's surplus. Considering Anthem's current financial health, the recent
14 excess profits from the policies covering these individuals, the ongoing affordability of the
15 products offered, and the fact that this is a declining closed block, I recommend a very modest
16 risk and profit margin, of 1% and certainly less than the 3% requested by Anthem.

17
18 **III. Independent Calculation – Anthem Methodology**

19 Q. Have you calculated an independent estimate of the needed premium increase?

20 A. I calculated an independent estimate only for those components for which I had enough
21 information to do so with any confidence.

22 Q. How did you calculate your independent estimate?

23 A. I used the general rating format that Anthem used and made the adjustments as shown in
24 the table below. Each of these adjustments has been previously discussed in my testimony in
25 detail. The table does not include the adjustments required for more equitable implementation of
26 Federal Mental Health Parity requirements, nor does it include adjustments to reflect the need to
27 manage Legacy products as part of the larger Anthem individual block of business.

28 Based on my review of the filing and rate development, there seems to be conservatism
29 built into most if not all of Anthem's assumptions. While the impact of each individual item
30 shown below may appear to be small, the cumulative effect is significant.

31

Item	Filing Value	Independent Calculation	Rate Impact
Morbidity Adjustment	8.72%	6.8%	-1.9%
Trend	3.9%	2.7%	-2.5%
Pharmacy Rebate	\$3.50 PMPM	\$4.14 PMPM	-0.2%
Hep C Impact	0.57%	0.44%	-0.1%
Healthcare Management Expense	\$3.47 PMPM	\$3.04 PMPM	-0.1%
ACA Fee Allowance	3.48%	3.2%	-0.4%
Risk and Profit Margin	3.0%	1.0%	-2.6%
Total Impact			-7.6%

1

2 Q. Understanding that this is not your preferred approach since you believe this block should
3 be combined with ACA-compliant plan experience for rate development purposes, were you able
4 to generate your own recommend overall premium increase using Anthem’s stand-alone rating
5 approach?

6 A. No. Since I was unable to quantify the impact of the Federal Mental Health Parity
7 implementation, my results were limited to changes from the original Anthem rate filing. Per the
8 table above, the items I was able to quantify would indicate a reduction in required revenue of
9 7.6% compared to the rate levels proposed if the Legacy block is rated on its own. As I discussed
10 earlier, if a combined approach is used, I generate a reduction in the required revenue of 6.8%
11 compared to the rate levels proposed. This also does not include the impact of the Federal Mental
12 Health Parity implementation.

13

14 Q. Does this conclude your testimony?

15 A. Yes, it does.

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

IN RE:)
)
ANTHEM BLUE CROSS AND BLUE)
SHIELD 2014 INDIVIDUAL RATE)
FILING FOR HEALTHCHOICE,)
HEALTHCHOICE STANDARD AND BASIC,)
HEALTHCHOICE HDHP, HMO STANDARD)
AND BASIC, AND LUMENOS CONSUMER)
DIRECTED HEALTH PLAN PRODUCTS)
PURCHASED BY MEMBERS BEFORE)
JANURY 1, 2014)
)
Docket No. INS-14-1000)

CERTIFICATE OF SERVICE

The undersigned counsel for the Attorney General hereby certifies that on this date I caused to be mailed by electronic mail, hand-delivery or United States first class mail, postage prepaid, as indicated, copies of the Pre-filed Testimony of Beth R. Fritchen upon the persons and at the addresses indicated below.

Thomas C. Sturtevant, Jr., Assistant Attorney General
6 State House Station
Augusta, Maine 04333-0006
Thomas.C.Sturtevant@maine.gov
[e-mail and hand delivery]

Jonathan Bolton, Assistant Attorney General
6 State House Station
Augusta, Maine 04333-0006
Jonathan.Bolton@maine.gov
[e-mail]

Christopher Roach, Esq.
66 Pearl Street, Suite 200
Portland, Maine 04101
croach@roachhewitt.com
[e-mail]

Sarah Hewett
34 State House Station
Augusta, Maine 04333-0034
sarah.hewett@maine.gov

[e-mail]

Mary M. Hooper
34 State House Station
Augusta, Maine 04333-0034
Mary.M.Hooper@maine.gov
[e-mail]

Dated: October 17, 2014

/s/ Christina M. Moylan
Christina M. Moylan, Assistant Attorney General
6 State House Station
Augusta, Maine 04333-0006
Counsel for Attorney General
207/626-8838
christina.moylan@maine.gov