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

IN RE:	)	
	)	
ANTHEM BLUE CROSS AND BLUE SHIELD REQUEST FOR AUTHORIZATION TO DISCONTINUE AND REPLACE LEGACY INDIVIDUAL HEALTH PLANS EFFECTIVE JANUARY 1, 2017	)	**DECISION AND ORDER**
	)	
Docket No. INS-15-802	)	

I. INTRODUCTION

Eric A. Cioppa, Superintendent of Insurance ("Superintendent"), issues this Decision and Order in the above-captioned matter after consideration of the Anthem Blue Cross and Blue Shield ("Anthem") request to discontinue and replace certain individual health plans. Specifically, effective January 1, 2017, Anthem proposes to cease renewing those individual health plans purchased before January 1, 2014 that are either (a) grandfathered ("GF") plans under the federal Affordable Care Act (ACA), or (b) non-grandfathered plans (commonly referred to as "grandmothered" ("GM") plans) that the federal government has deemed exempt from certain requirements of the ACA pursuant to its transitional policy announced on November 14, 2013, as extended on March 5, 2014 and February 29, 2016. Anthem's GM and GF plans are collectively referred to as the "Legacy Individual Health Plans." The Legacy Individual Health Plans include Anthem's HealthChoice, HealthChoice Standard and Basic, HealthChoice HDHP, HMO Standard and Basic, and Lumenos Consumer Directed Health Plan products.

Further, beginning January 1, 2017, Anthem proposes to migrate its existing GF and GM individual health plan policyholders to Anthem's most comparable ACA-compliant plans, paired with Anthem's ACA drug formulary. These will be new off-Exchange plans with the same benefit structure as Anthem's current ACA Qualified Health plans, modified to include the same type of broad network to which those policyholders currently have access, to retain benefits for out-of-network services, maintain current long-term prescriptions (*i.e.*, prescribed for at least 6 months), and provide access to out-of-state services through Blue Card contracted providers. Anthem's members also have the ability to choose among the other insurance options available in the individual market, both from Anthem and from other carriers, instead of remaining with their designated broad-network, ACA-compliant Anthem plans.

For the reasons discussed below, Anthem's proposed product discontinuance and replacement for its Legacy Individual Health Plans is approved, subject to specified conditions.

II. PROCEDURAL HISTORY

On December 3, 2015, Anthem requested approval of product discontinuance and replacement for its grandfathered and grandmothered individual health plans.

On January 7, 2016, the Superintendent issued a Notice of Pending Proceeding and Hearing. As described in the Hearing Notice, the purpose of the proceeding was for the Superintendent to determine whether Anthem's proposed product discontinuance and replacement would be "in the best interests of the policyholders," as required by 24-A M.R.S. § 2850-B(3)(G)(3)(b), and is otherwise in compliance with applicable law. Per the Hearing Notice, the public hearing was set for March 28 in Gardiner.

By Order issued February 25, 2016, the Superintendent granted intervention to the Maine Attorney General.

Also on February 25, the Superintendent issued a Procedural Order establishing requirements for the conduct of the proceeding.

Information requests by the Superintendent (one set) and the Attorney General (two sets) were made, to which Anthem filed responses.

On March 21, 2016, Anthem submitted the pre-filed testimony of four witnesses: Kristine Ossenfort, Dee Clamp, Zach Fohl, and Jeffrey Holmstrom.

The evidentiary hearing was held as scheduled on March 28, 2016, and was conducted entirely in public session. All material filed in the proceeding was made publicly available for access and inspection, including posting to the Bureau's webpage.

At the hearing, live witness testimony was provided and the following documentary evidence was admitted into the record:

- The pre-filed testimony of Kristine Ossenfort, Director of Government Relations for Anthem in Maine (Anthem Hearing Exhibit 1); pre-filed testimony of Dee Clamp, Staff Vice President Actuary III for Anthem's Commercial and Specialty Business Division, and Zach Fohl, Actuarial Director for Anthem in Maine (Anthem Hearing Exhibit 2); pre-filed testimony of Jeffrey Holmstrom, Medical Director for Anthem in Maine (Anthem Hearing Exhibit 3).
- Anthem's Initial Filing and Exhibits 1–4.
- All information requests made and responses provided in the proceeding.

Members of the public provided sworn testimony for the record during the March 28 public hearing. Members of the public also submitted written comments outside the public hearing, which the Superintendent has designated a part of the record of the proceeding. The Superintendent has read each of the written comments provided. To the extent that they comment on facts that are in the record, they shall be considered for their persuasive value in the same manner as legal arguments and other comments submitted by the parties. However, the

Maine Administrative Procedure Act bars the Superintendent from relying on unsworn submissions as evidence when making his decision. 5 M.R.S. § 9057.

On March 29, 2016, Anthem filed its responses to certain hearing requests.

On April 1, 2016, Anthem and the AG each filed written closing arguments. That same day, Anthem requested leave to file, and filed, a reply to the Attorney General's closing argument.

The record of the proceeding closed on April 1, 2016.

III. FURTHER SUPERINTENDENT RULINGS

The Superintendent rules as follows regarding Anthem's post hearing filings:

1. Anthem's Hearing Responses filed on March 29 shall be admitted into the record; subject, however, to the opportunity for the Attorney General to make objection. Any objection must be filed no later than two (2) business days following issuance of this Decision and Order. Absent timely objection by the Attorney General, the Hearing Responses will be admitted as evidence in the proceeding.

2. Anthem's request for leave to file a reply to the Attorney General's written closing argument is granted. Anthem's reply is admitted into the record of the proceeding.

IV. STATUS OF GRANDMOTHERED PLANS UNDER THE ACA

As explained above, grandmothered individual health insurance plans are those that were purchased after the enactment of the ACA on March 23, 2010, but before its implementation on January 1, 2014, by members who continue to be enrolled in those plans. Originally, the ACA required these plans to be transitioned to ACA-compliant plans no later than January 1, 2014. In late 2013, however, President Obama announced "transitional relief" that would allow a carrier the option, if permitted by the State, to renew grandmothered plans unchanged for one additional

year, on or before October 1, 2014, without having to comply with most requirements of the ACA. Anthem elected to provide such transitional relief to policyholders, and renewed its GM policies in 2014. Thereafter, in March 2014, the federal Centers for Medicare and Medicaid Services (CMS) authorized states to allow carriers the option to continue extending transitional relief for up to another two years. Again, Anthem elected to provide such continued transitional relief thereby renewing its GM policies through October 1, 2016. Most recently, in February 2016, CMS renewed its authorization for states to allow carriers the option to continue extending transitional relief for policy terms ending on or before December 31, 2017. Anthem has explained that it does not intend to extend the GM policies for another year. (Hearing Ex. 1 at 6, ln. 3–5.)

Because the GM policies do not comply with state and federal law, and Anthem has elected to let their limited transitional exemption expire, Maine's guaranteed renewal laws do not directly apply to this block of business. *See* Section VI, Legal Standard, below.

V. THE INS-13-803 PROCEEDING

The issues presented in this proceeding are not matters of first impression for the Superintendent. In 2013, the Superintendent previously had occasion to consider an individual health plan discontinuance and replacement proposal by Anthem. *See* In Re: Anthem Blue Cross and Blue Shield Request to Discontinue Individual Health Plans, Docket No. INS-13-803 (decided Oct. 4, 2013). The facts and circumstances of this proceeding are similar in several respects to those presented in the INS-13-803 proceeding, but there are also material differences.

In the INS-13-803 proceeding, Anthem proposed to discontinue the plans that are now known as the GM plans rather than modifying them to make them ACA-compliant. Although that proposal was never implemented by Anthem, because it elected to renew the plans on a

closed-block basis when transitional relief became available, the Superintendent approved the proposal on condition that Anthem preserve the broad provider network to which the policyholders currently had access and not totally exclude benefits for non-emergency out-of-network care. *See*, *e.g.*, INS-13-803 Decision and Order at 20. In that proceeding the Superintendent also approved Anthem's proposed formulary changes (again, not implemented)—which are the same formulary changes that Anthem now proposes in this proceeding (*see* Initial Filing at 5)—finding that all essential classes of medications remained fully covered, and that the new structure resulted in significant cost savings, was consistent with certain of Anthem's other products and with widely used industry standards, and was expressly permitted by the ACA. *Id.* Decision and Order at 21.

While the Superintendent's prior decisionmaking in the INS-13-803 proceeding is not binding on the Superintendent, it is instructive and assists the analysis to be made on similar issues at this time. Noteworthy for this proceeding, Anthem has altered those elements of its prior proposal that the Superintendent disapproved in the INS-13-803 proceeding (such as Anthem's prior imposition of a "limited" provider network on renewing policyholders and the exclusion of benefits for non-emergency out-of-network care).

VI. LEGAL STANDARD

Under longstanding Maine law, individuals purchasing health insurance coverage in the individual market have a right to guaranteed renewal of their insurance policies. This right means that, except in certain narrowly defined circumstances, "coverage may not be cancelled, and renewal must be guaranteed." 24-A M.R.S. § 2850-B(3). Where a policy is subject to guaranteed renewal, it must not only be renewed, but it generally cannot even be modified except

within narrow constraints set forth by statute. *See* § 2850-B(3)(I).[1] Any modifications falling outside these constraints are considered product discontinuance, and must qualify for a statutory exception to the guaranteed renewal requirement.

Specifically, under Maine law, a carrier may not discontinue a guaranteed-renewable individual plan unless it provides its subscribers with a replacement product meeting certain requirements, including, crucially, that "the superintendent finds that the replacement is in the best interests of the policyholders." 24-A M.R.S. § 2850-B(3)(G)(3). Accordingly, the purpose of this proceeding, as set forth in the Hearing Notice, is for the Superintendent to determine whether Anthem's proposed discontinuance of the Legacy Individual Health Plans, and the product replacements proposed by Anthem, meets this best-interests standard, and will otherwise be in compliance with applicable law.

As set forth in the statute, the "best interests of the policyholders" standard applies to the proposed "replacement" products. The statute directs the Superintendent to protect the interests of Anthem's existing subscribers, not the interests of potential future policyholders. Moreover, the standard is not whether the replacement is in the "best interests of a majority of the policyholders." It is simply whether the replacement is in the best interests of "the policyholders." While this standard does not mean that the proposed replacement policy must be a good deal for every single current policyholder, it does require a more nuanced analysis than merely considering whether replacement will be marginally preferable to renewal for a bare majority of subscribers. A replacement policy that imparts small benefits to a majority by

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[1] One of the narrow circumstances in which contract terms may be modified in the context of a renewal is if the benefit modifications are "required by law." 24-A M.R.S. § 2850-B(3)(I)(3). Because Anthem has elected to waive the GM plans' transitional exemption from certain ACA requirements, those plans must, at a minimum, be modified to be brought into full compliance with the ACA, and the "best interests" analysis would not be required if such a modification were the only exception to guaranteed renewal that Anthem sought.

imposing significant hardships on a minority is not necessarily in the best interests of the policyholders as a whole. *See* INS-13-803 Decision and Order at 8–10.

The guaranteed-renewal laws apply differently to the GF plans and the GM plans. Grandfathering means that the GF plans are permanently exempt by law from most ACA requirements, and there is no legal impediment to Anthem renewing these plans in their current form.[2] For the GM plans, however, the exemption from full ACA compliance is temporary, terminating no later than the end of 2017, and it may be terminated at any earlier time at the discretion of the carrier and state regulators. Anthem has stated its current intention to make the GM plans fully subject to the ACA no later than January 1, 2017.

VII. ANALYSIS, FINDINGS, AND CONCLUSIONS

For the reasons discussed, and subject to the conditions of approval set forth below, I find and conclude that Anthem has met its burden of proving that the product replacement proposal for its Legacy Individual Health Plans is in the best interests of the policyholders and otherwise in compliance with the law.

A. Background.

1. ***Legacy Block.*** Upon the commencement of ACA implementation in 2014, there were nearly 18,000 Legacy Individual Health Plan members in this closed block. (Hearing Ex. 1 at 6, ln. 9–10.) Now, three years into the ACA, the Legacy block enrollment has declined significantly (*e.g.*, as of January 1, 2016, there were under 6,000 members.) (*See* Hearing Ex. 1 at 6, ln. 12–13; 9, ln. 24–25.) Anthem projects that the Legacy block will have fewer than 4,000 members as of January 1, 2017—when its GM members must be enrolled in ACA-compliant

[2] The grandfathering provisions of the ACA are found at PPACA § 1251, and are incorporated into Maine law at 24-A M.R.S. § 4320-G.

plans and be part of the ACA risk pool—with the remaining membership in the GF closed block continuing to decline absent a product replacement. (Initial Filing at 10.)

Since 2014, when the Legacy Individual Health Plan closed block first operated separate from Anthem's ACA products, the Legacy plans have incurred double-digit average rate increases of 12.6% in 2014, 13.4% in 2015, and 18.28% in 2016. (Initial Filing Ex. 4.)

The reason the Superintendent approved rate increases of this magnitude was in large part due to the rate at which claims in the Legacy block have increased, which is faster than the rate of increase for claims in the ACA-compliant block. This adverse claims experience relative to the general population, together with higher policyholder risk scores, is evidence of a so-called "death spiral" in the Legacy block—increasing premium in a closed block leading to policy lapses, resulting in even higher rates to cover the costs spread over fewer remaining (and often costlier) policyholders, leading to additional lapses. (Hearing Ex. 1 at 9, ln. 27–29.)

2. ***The ACA Market.*** In contrast to what has occurred for the Legacy Individual Health Plan business, Anthem explains that its ACA open block of business is growing in size, with over 17,500 members in December 2015, and anticipated continued enrollment growth. (Initial Filing at 1, 2; Hearing Ex. 1 at 10, ln. 13–15.) ACA rates have been relatively stable, with average increase of 1.1% in 2015 and 4.8% in 2016. (Hearing Ex. 1 at 10, ln. 15–17.) According to Anthem, its ACA block is and will remain viable going forward. (Initial Filing at 2.)

B. <u>Anthem's product replacement proposal</u>.

Pursuant to 24-A M.R.S. § 2850-B(3) and other applicable law, Anthem proposes to cease renewing its Legacy Individual Health Plans beginning January 1, 2017, and to replace them with new plans containing the following features.

1. ***ACA-compliant.***

(a) Coverage. The coverage provided by the replacement plans would be significantly and materially different from the Legacy plans, particularly with respect to out-of-pocket limits and actuarial value, in order to comply with ACA requirements. (Hearing Ex. 1 at 4, ln. 8–26.) To become ACA-compliant, the replacement policies must also include all essential health benefits ("EHBs"). EHBs are based upon the benefits under a "benchmark plan" for ten required categories of benefits:

1. Ambulatory patient services
2. Emergency services
3. Hospitalization
4. Maternity and newborn care
5. Mental health and substance use disorder services, including behavioral health treatment
6. Prescription drugs
7. Rehabilitative and habilitative services and devices
8. Laboratory services
9. Preventive and wellness services and chronic disease management
10. Pediatric services, including oral and vision care

All copayments, coinsurance, and deductible amounts for EHBs must be credited toward the out-of-pocket maximum. Although quantitative limits are allowed, no annual or lifetime dollar limits are permitted for EHBs.

Under Anthem's proposal, high-deductible policies such as its popular $15,000-deductible for individuals will no longer exist. This means that GF and GM policyholders who prefer to stay in plans with high out-of-pocket costs will lose that option in 2017.

Conversely, the maximum out-of-pocket expense for ACA plans in 2016 is $6,850 for individuals ($13,700 for families). This is significantly lower than the maximum deductible allowed for Legacy pans, which means Anthem begins to pick up 100% of member costs sooner

for ACA plans than for high-deductible plans (*i.e.*, members will have more services covered sooner). (Hearing Ex. 1 at 5, ln. 10–12; 7, ln. 23–24.)

(b) Best-Interests Analysis. Although the GM and GF policyholders are grouped together for rating purposes as a single risk pool, they are distinct blocks of business.

(i) Grandmothered policyholders. As explained above, since the inception of grandmothering following ACA implementation, GM policyholders have always possessed temporary guaranteed-renewal rights contingent on the federal government's periodic authorization and a carriers' agreement (subject to state insurance regulatory allowance) to continue to provide non-ACA-compliant coverage. At this time, such non-ACA-compliant coverage for GM policies has been authorized by the federal government to continue until December 31, 2017. However, Anthem has elected not to extend transitional relief to GM policyholders beyond their current policy expiration of December 31, 2016. In this context, there are essentially no guaranteed renewability rights beyond the current policy period (it is now April 2016). The best-interests analysis for this block of business, therefore, should not be based on a comparison to their current non-ACA-compliant plans, because retaining those plans in their current form is no longer a lawful option.

Anthem has complied with the conditions I imposed in INS-13-803 based on a similar best-interests analysis; in particular, a transition to Anthem's most comparable ACA-compliant plan, paired with Anthem's ACA drug formulary, including the same type of broad provider network to which Anthem's GM policyholders now have access. I therefore find and conclude that my prior analysis remains valid and that the proposed migration to ACA-compliant plans is substantially equivalent to a plan modification for purposes of compliance with the law, and as such it is in the best interests of the GM policyholders.

Furthermore, even if the best-interests analysis for the GM policyholders were based solely on a comparison to their current plans, the record as a whole demonstrates that Anthem has met its burden of proof, for the reasons discussed below in my analysis of why the proposed transition has been found to be in the best interests of GF policyholders.

(ii) Grandfathered policyholders. Several of Anthem's arguments in support of its discontinuance and replacement proposal for GF policyholders have comparable applicability to the GM policyholders. For example, for both GF and GM policyholders, many members will have lower deductibles and out-of-pocket maximums, which means that they will have more health care services covered sooner. Also, the lower out-of-pocket maximums mean that when a member has a significant claim, the insurance coverage will apply sooner and the financial impact on the policyholder will be reduced (compare the Legacy $15,000 deductible policies with the ACA-compliant $6,850 policies).

Anthem provided uncontroverted evidence demonstrating that following the migration of the GM members (whose current products Anthem has elected to discontinue), GF policyholders as a group achieve a net benefit of over $6 million of savings if transitioned in 2017 as proposed. (Hearing Ex. 2, ln. 9–10; Hearing Ex. 2 at 10–14.) According to Anthem, a majority of GF policyholders (over 70%) would be better off with an ACA plan immediately solely from a premium perspective. (Hearing Ex. 1 at 15, ln. 18–20.) Anthem further explained that an even larger percentage of policyholders (upwards of 95% in 2017) will benefit when considering the richer ACA benefits, based solely on likely expenses without giving consideration to the enhanced protection against major unexpected expenses. (Hearing Ex. 1 at 15, ln. 20–21; Hearing Ex. 2 at 10–14.)

The healthiest members in the Legacy block tend to be those with the highest deductibles, and their desire to keep their cheaper but riskier plans has up till now served as a counterweight to the "death spiral." However, most of these members will now have a strong incentive to migrate to ACA-compliant plans. As a result, it would be expected that even if the GF plans remained open for renewal, voluntary migration of healthier individuals into ACA-compliant plans would contribute to an upward spiraling of claims costs that would accelerate the "death spiral," leaving a Legacy pool that is too small to be self-sustaining due to a lack of statistical credibility and continuing large, double-digit rate increases, thereby significantly reducing the value that would otherwise be provided to the small number of policyholders that might otherwise have an incentive to remain in the Legacy pool.

For the foregoing reasons and as further demonstrated in the record as a whole (*see*, *e.g.*, Hearing Ex. 1 at 16 & 17, ln. 1–10), I find that Anthem's proposed migration of GF policyholders to ACA-compliant plans is in the best interests of the policyholders, subject to the conditions of approval set forth below.

2. *Off-Exchange.*

Anthem's migration proposal is to transition Legacy members to off-Exchange products. (Hearing Ex. 1 at 8, ln. 11–21.) That is because Anthem cannot transition members to plans through the health insurance Exchange, also known as the federally facilitated Marketplace, the "Marketplace," or "FFM." (*Id.*) The only way for a member to purchase an ACA plan on-Exchange is for the enrollment to be initiated by the member and processed by on-line registration through healthcare.gov, in part to determine whether the individual qualifies for an insurance premium subsidy. (*Id.*)

As the Legacy Individual Health Plans, by definition, are off-Exchange plans, the fact that the replacement plans are also off-Exchange is not material to the best-interests analysis. For those enrollees who are eligible for subsidized premiums or cost sharing, those subsidies are only available if they enroll through the Exchange. Therefore, they will not receive ACA subsidies if they choose to stay in their designated replacement plans. However, their current plans are not subsidized either. Regardless of whether Anthem's proposal is approved, the only way a current Legacy enrollee could take advantage of any ACA subsidies to which he or she might be entitled would be to exercise his or her guaranteed-issue rights and make the affirmative decision to switch to a qualified health plan (QHP) purchased on the Exchange.

3. ***Continued broad provider network with out-of-state services.*** Largely unchanged under the product replacement, Anthem will continue to provide members with "the same type of broad provider network to which [the Legacy members] now have access." (Hearing Ex. 1 at 6, ln. 28–29; 14, ln. 12–13; Hearing Ex. 3 at 4, ln. 25–30.) Additionally, the transitioned Legacy members will have access to out-of-state health care services through Anthem's "Blue Card" system. (Hearing Ex. 1 at 7, ln. 2–4.) Thus, the Legacy members will be able to use any out-of-state provider that is contracted with a Blue Cross/Blue Shield plan. (*Id.*)

For the foregoing reasons, the health care provider aspects of Anthem's proposal vis-à-vis the in-state network and out-of-state coverage raise no concerns from a best-interests analysis because there are no adverse material provider network changes from the current Legacy plans. In other words, the proposed migration adequately addresses continuity of care issues for the transitioned GF and GM members. I therefore find that Anthem's broad network proposal with out-of-state coverage is in the best interests of the policyholders, subject to the conditions of approval set forth below.

4. ***New Pharmaceutical Formulary.*** Anthem proposes to use a formulary for the transitioned Legacy policyholders that differs from the formulary currently in place for the Legacy Individual Health Plans.[3] (Hearing Ex. 3 at 5, ln. 2–8.) Thus, the transitioned members would be migrated to ACA-compliant plans that use Anthem's ACA formulary. (*Id.*) Under the ACA, as a cost savings measure, carriers are authorized to reduce the number of drug offerings within each drug class. This does not mean that medications treating specific conditions will not be covered. Rather, the result is that members may have fewer choices for medications used to treat the same conditions.

Specifically, as Anthem explains, currently Legacy members have an "open" formulary that covers multiple drugs in every category and class, including approximately 5,800 unique drugs.[4] (Hearing Ex. 3 at 5, ln. 17, 27–28.) In contrast, Anthem's ACA formulary (which is "closed" because it limits the number of drugs that cover the same condition) includes approximately 1,800 unique drugs—but includes at least one drug in every category and class, and therapeutically-equivalent drugs for the vast majority of drugs currently covered under the

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[3] The modified formulary proposed by Anthem in this proceeding is materially identical to the formulary I approved in the INS-13-803 proceeding, but which Anthem did not implement at that time due to their decision to extend transitional relief as authorized by CMS. *See* INS-13-803 Decision and Order at 21.

[4] A member of the public testifying at the March 28 hearing raised concerns regarding Anthem's new formulary and alleged that it expands coverage for contraceptives. The individual wanted contraceptives—especially Plan B and Ella—not to be covered under the new formulary (more specifically, he wanted the existence of contraceptive coverage under the new formulary to be a basis for the Superintendent to disapprove Anthem's product replacement proposal in its entirety). No other Anthem policyholder expressed these same concerns regarding a coverage benefit that was being provided under the new formulary.

In response to a hearing panel question of whether Anthem's current Legacy formulary covers contraceptives and the so-called morning after pill, Anthem responded "yes." (Hearing Response 1.) Although the testifying individual then provided subsequent unsworn written comment disputing Anthem's assertion, I find Anthem's response persuasive evidence of how the disputed contract language is interpreted in practice. Therefore, even if the addition of this benefit is a cognizable harm, I find that it is not a new benefit and therefore is not material to the best-interests analysis.

Legacy formulary. (Hearing Ex. 3 at 5, ln. 20–22, 27–31.) The result is that approximately 150 drugs currently covered under the Legacy formulary are not covered by a therapeutically-equivalent drug under the new formulary (a "non-formulary" drug). (Hearing Ex. 3 at 5, ln. 22–24.)

Anthem described the process whereby transitioned members may obtain a non-formulary drug. (*See*, *e.g.*, Hearing Ex. 3 at 6, ln. 12–30; Hearing Response 2 & 3.) Generally, a member may seek authorization from Anthem for an exception to continue coverage for the non-formulary medication if (1) the member has been taking the medication for at least six months; or (2) the member can otherwise demonstrate that it is medically necessary. (Hearing Response 2.) During any appeal review process, if the non-formulary drug was previously covered by the member's Legacy plan, the member will be granted a one-time 30-day supply for the drug. (Hearing Response 3.) If the member's request for an exception for the non-formulary drug is approved, coverage for the drug will continue. (*Id.*) If the exception is denied, the member will be limited to the one-time 30-day supply and required to obtain a therapeutically-equivalent drug under the new formulary. (*Id.*)

The new formulary structure results in significant cost savings, is expressly permitted by the ACA, is consistent with Anthem's other ACA products, and protects those enrollees who have a particular need for non-formulary drugs. I therefore find that Anthem's substitution of the new formulary on replacement is in the best interests of the policyholders, subject to the conditions established below.

C. Attorney General's Recommendations.

The Attorney General neither supports nor opposes Anthem's product discontinue and replacement proposal, but instead urges the Superintendent—if he decides to approve the

request—to impose the following conditions of approval on Anthem in order to ensure that Legacy members are minimally disrupted:

> (1) notice to all members that all Anthem transitions of Legacy members will be to plans with unrestricted broad provider networks and Anthem "blue card" services;[5]
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> (2) mandatory continued coverage for all existing prescribed non-formulary drugs, regardless of how long the policyholder had been on the non-formulary drug, during the entire pendency of any and all Anthem medical justification and/or appeals processes;
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> (3) notice to all members of this extended non-formulary drug coverage and of Anthem's procedures and timelines for requesting continued coverage of non-formulary drugs; and
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> (4) enhanced and more prominent notice to all Legacy members regarding their other insurance options, apart from the Anthem plans they will be mapped to, and the potential availability of subsidies.

(AG Closing at 1.)

Generally speaking, Anthem asserts that it has already indicated its intent to comply with conditions 1–3, and has no objection to condition 4. (Reply at 1.) The Superintendent discerns a closeness between the parties' positions, but sees differences too. Apart from the meaning of "broad provider network" (discussed in the footnote), the Attorney General's condition (2), which would require "mandatory continued coverage" during a medical justification and/or appeal process for existing prescribed non-formulary drugs, materially differs from Anthem's

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[5] As Anthem points out in its Reply, condition (1) has the following additional language when it is repeated at p. 4 of the Attorney General's closing argument: "as long as those plans are maintained by the transitioned member". (Reply at 2.) Anthem objects to this additional language, but otherwise agrees with the condition (subject to Anthem's meaning of the phrase "unrestricted broad provider network"). (*Id.* at 1.) The Superintendent agrees with Anthem's meaning of the phrase as established in the proceeding. Additionally, the Superintendent declines, if it was intended, to incorporate the additional language contained at p. 4 of the Attorney General's closing argument. It is already well established that Anthem cannot unilaterally change provider networks from a so-called "broad" network to a "narrow" or "limited" network absent Superintendent approval for compliance with network adequacy requirements.

proposal. Thus, Anthem proposes to continue non-formulary drug coverage during a medical justification and/or appeal process *only if* the member has been taking the medication for at least six months, or it is medically necessary; and *only for* an extended one-time 30-day period. (Hearing Response 2.) Conversely, as the Superintendent understands the Attorney General's request, both the six-month prior treatment requirement and the limitation of a single 30-day extension period would be removed. In other words, the Attorney General's position is that so long as the medication has been prescribed for any period of time prior to policy migration (not at least six months), Anthem would be required to continue coverage during the entire duration of the medical justification and/or appeal period (*i.e.*, for so long as the review process is ongoing—whether or not completed within a 30-day period).

I find the Attorney General's conditions 1, 3, & 4, as more specifically delineated in the conditions of approval set forth below in Section VIII, to be necessary protections to ensure that the proposed migration is in the best interests of the policyholders.[6] Regarding condition 2, I find that it is in the best interests of the policyholders to require Anthem to continue non-formulary drug coverage during the entire pendency of a medical justification and/or appeal process—but only for those non-formulary drugs that have been prescribed for at least six-months. If the non-formulary drug has been prescribed for less than six-months, a migrated Legacy member may pursue the "medical necessity" alternative together with her provider, and I find that this procedure satisfies the best-interests standard.[7]

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[6] The Superintendent understands Anthem's objection to providing links to specific plan options from other carriers in its notice letters, and agrees that it is more appropriate for Anthem to include links to Bureau and Exchange sites. (*See* Reply at 1.)

[7] It is noteworthy that this authorization procedure is materially the same as that for Anthem's other ACA products, and Anthem described at hearing the extent to which formulary makeup

VIII. ORDER

Pursuant to 24-A M.R.S. § 2850-B the Superintendent hereby ORDERS that Anthem's proposal to discontinue its current HealthChoice, HealthChoice Standard and Basic, HealthChoice HDHP, HMO Standard and Basic, and Lumenos Consumer Directed Health Plan products—collectively referred to as the Legacy Individual Health Plans—and to replace the Legacy Individual Health Plan products with off-Exchange ACA-compliant products, as further described and set forth in this Decision and Order, is APPROVED; subject, however, to the following conditions:

(a) Anthem shall work with Bureau staff to ensure that the policyholder notice letters clearly describe the broad provider network and out-of-state coverage that is being provided under the transitioned Anthem plans. The Superintendent shall approve the policyholder notices before being mailed.

(b) Anthem shall work with Bureau staff to ensure enhanced and more prominent notice to Legacy policyholders regarding their other insurance options available on the Exchange and the potential availability of subsidies. The Superintendent shall approve the policyholder notices before being mailed.

(c) For all prescribed non-formulary drugs that (1) a Legacy member has been taking for at least six months, or (2) are shown to be medically necessary, Anthem shall provide continued drug coverage during the entire pendency of any and all Anthem medical justification and/or appeals processes for so long as any such process remains ongoing (whether or not completed within a 30-day period).

(d) Anthem shall work with Bureau staff to ensure that adequate notice is provided to Legacy policyholders of this extended non-formulary drug coverage and of Anthem's procedures and timelines for requesting continued coverage of non-formulary drugs. The Superintendent shall approve the policyholder notices before being provided.

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changes as a matter of routine course (and how consumers and providers can address these issues with Anthem on a case-by-case basis).

IX. EFFECTIVE DATE

The effective date of this Decision and Order is delayed for a minimum of two (2) business days following its issuance to allow the Attorney General the opportunity to make a filing in opposition to the admission of Anthem's post hearing responses as evidence in the record of the proceeding. Should the Attorney General elect not to make an objection filing within the 2-day period, this Decision and Order shall thereupon become effective on the third business day following its issuance. If the Attorney General makes a timely objection filing to the admission of the post hearing evidence, this Decision and Order shall be stayed until further order of the Superintendent.

X. NOTICE OF APPEAL RIGHTS

This Decision and Order is final agency action of the Superintendent of Insurance, within the meaning of the Maine Administrative Procedure Act, 5 M.R.S. § 8002(4). It may be appealed to the Superior Court in the manner provided for by 24-A M.R.S. § 236, 5 M.R.S. §§ 11001 through 11008, and M.R. Civ. P. 80C. Any party to the proceeding may initiate an appeal within thirty days after receiving this notice. Any aggrieved non-party whose interests are substantially and directly affected by this Decision and Order may initiate an appeal within forty days after the issuance of this Decision and Order. There is no automatic stay pending appeal. Application for stay may be made in the manner provided in 5 M.R.S. § 11004.

PER ORDER OF THE SUPERINTENDENT OF INSURANCE

April 12, 2016

ERIC A. CIOPPA
Superintendent of Insurance