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

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| IN RE:<br><br>ANTHEM BLUE CROSS AND BLUE SHIELD 2006 INDIVIDUAL RATE FILING FOR HEALTHCHOICE AND HEALTHCHOICE STANDARD AND BASIC PRODUCTS<br><br>Docket No. INS-05-820 | ) | DECISION AND ORDER |

## I. INTRODUCTION

Alessandro A. Iuppa, the Superintendent of the Maine Bureau of Insurance (" the Superintendent") issues this Decision and Order, after consideration of Anthem Blue Cross and Blue Shield's ("Anthem's") 2006 rate filing for individual HealthChoice, HealthChoice Standard, and HealthChoice Basic products. Anthem is required, pursuant to the provisions of 24-A M.R.S.A. § 2736(1), to submit for the Superintendent's approval proposed policy rates for individual health insurance products. In its filing, Anthem proposes revised rates for its HealthChoice products that would produce an average increase of 19.8% for currently enrolled members. The specific rate increases requested range from 9.9% to 35.8%, depending on deductible level and type of contract. In its prefiled exhibits, Anthem submitted a revised rate filing that slightly reduced the requested increases to a range from 9.6% to 35.6% with an average increase of 19.2%. Anthem requests that these rate revisions become effective on January 1, 2006. This Decision and Order constitutes final agency action on Anthem's filing.

## II. PROCEDURAL HISTORY

On September 9, 2005, Anthem Blue Cross and Blue Shield filed for approval of proposed revised rates for individual HealthChoice, HealthChoice Standard, and HealthChoice Basic products. The Bureau of Insurance designated the matter as Docket No. INS-05-820.

On September 16, 2005, the Superintendent issued a Notice of Pending Proceeding and Hearing. The notice set public hearing for November 9, 2005, outlined the purpose of the hearing, set a deadline for intervention, and explained the hearing procedure. Pursuant to 5 M.R.S.A. § 9052, notice to the public was accomplished by publication in newspapers of State-wide circulation and on the Internet. In addition, pursuant to 24-A

M.R.S.A. § 2735-A, on or about October 4 and 5, 2005, Anthem provided direct written notice by mail to every affected policyholder, advising policyholders of the proposed rate increases, pending proceeding, and the scheduled hearing.

On September 21, 2005, the Superintendent issued a Protective Order which granted in part Anthem's request for confidential treatment of certain portions of its filing and described the conditions and procedures pertaining to the use and disclosure of confidential information in the course of proceeding.

On September 22, 2005, the Office of the Attorney General filed a motion for intervention pursuant to 5 M.R.S.A. § 9054(1). There was no opposition to that motion.

On October 5, 2005, the Superintendent issued a Procedural Order, in which he identified the parties as Anthem and the Attorney General and, in accord with Maine Bureau of Insurance Rule Chapter 350, § 2(A)(1), established procedures for the conduct of this proceeding. In his Procedural Order, the Superintendent also established deadlines for serving discovery requests and for submission of pre-filed testimony and exhibits.

Between October 14, 2005, and the October 21, 2005, discovery deadline set by the Superintendent's Procedural Order, the Bureau of Insurance and the Attorney General engaged in discovery. The Bureau served Anthem with one pre-hearing discovery request, to which Anthem filed a response. The Attorney General served Anthem with two discovery requests to which Anthem filed responses and subsequent supplemental responses. Anthem filed several additional requests for confidentiality for information it provided pursuant to these discovery requests. On November 3, 2005, Anthem filed its prefiled testimony and exhibits, which included a revised version of the rate filing. At hearing on November 9, 2005, the Superintendent granted these motions, because the motions pertained to the identical or similar information covered by the Superintendent's original Protective Order.

On November 9, 2005, the Superintendent held a public hearing on Anthem's filing. Members of the public had an opportunity to make either sworn or unsworn statements for consideration by the Superintendent. Eleven individuals provided such statements. Members of the public also submitted numerous written comments.

At hearing, Anthem presented testimonial evidence from William Whitmore, Actuary, Harry Page, Finance Account Executive, George Siriotis, Regional Vice-President of Sales, Dan McCormack, Executive Director for Provider Network Management, and Sharon Roberts, Director

of Stakeholder Relations. The Attorney General presented testimonial evidence from Dale Hyers, FSA, Managing Director of Wakely Consulting Group. The Superintendent admitted into evidence several exhibits offered by each of the parties and took official notice of Anthem's responses to discovery requests from the Bureau of Insurance and the Attorney General.

After both parties rested at hearing, the Superintendent requested that they submit written closing arguments. The Superintendent also requested that Anthem respond to several additional requests for specific information. On November 16, 2005, both the Attorney General and Anthem filed written closing arguments. Anthem also filed responses to the Superintendent's requests for additional information at the hearing, for which it also requested that certain portions of these responses be given confidential treatment. With respect to Anthem's request that portions of its response pertaining to policy related items analysis identified as "ANNTHHC 00225," the Superintendent DENIES Anthem's request for confidentiality. The Superintendent GRANTS the remaining requests for confidentiality under the terms of the Protective Order dated September 21, 2005.

In order to clarify information presented in these post-hearing responses and the closing arguments, the Superintendent issued a Supplemental Information Request to Anthem on November 30, 2005, and ordered that the record in this matter be kept open until Anthem provided a response. Anthem responded to this request on December 5, 2005, and requested that certain portions of these responses be given confidential treatment. The Superintendent GRANTS this request for confidentiality under the terms of the Protective Order dated September 21, 2005.

## III. LEGAL STANDARD

Anthem is required by 24-A M.R.S.A. § 2736(1) to file with the Superintendent proposed policy rates for their individual health insurance products. Anthem bears the burden of proving by a preponderance of the evidence that the proposed rates are not inadequate, excessive, or unfairly discriminatory. In addition, Anthem is required pursuant to 24-A M.R.S.A. § 2736-C(5) to show that in accordance with accepted actuarial principles and practices its proposed rates should yield a loss ratio of at least 65%.

## IV. DISCUSSION

Following is a discussion in which the Superintendent addresses certain specific components of Anthem's filing that were issues of contention.

A. Trends

Anthem presented documentary and testimonial evidence projecting an increase in medical claims. The Attorney General challenged Anthem's conclusions contending that its claim projections were not supported by sufficient evidence to establish that these projections would not lead to excessive rates. The Attorney General raises several specific issues to support its contention.

First, the Attorney General argues that Anthem does not adequately support the upward adjustments for the expected effects of deductible leveraging and mix of services. Although Anthem does not provide a mathematical formula for how it derived these estimates, the concept is logical, and Anthem's estimated percentages are not unreasonable. The Attorney General further argues that the anticipated shift of policyholders to higher deductible policies due to the rate increase and the Chapter 940 exception will, to some degree, mitigate the amplifying effects of deductible leveraging to the unit cost increases. While this argument may make some sense, as of June 2005, only 1,017 policyholders (approximately 5% of the total) had policies with deductibles lower than $2,250. Assuming such a shift actually occurs, the impact would be insignificant.

The Attorney General's expert, Mr. Hyers, noted what he referred to as a "good year/bad year" cycle in past claims trends. From 1996 to 2004, the trend was significantly higher in odd-numbered years than in even-numbered years. Mr. Hyers suggested that despite the recent poor experience in 2005, the experience in 2006 would be better. Although such a pattern is present in recent years, Mr. Hyers offered no theoretical basis or plausible explanation for this claims pattern. Without such a basis it is difficult to have confidence that such a pattern would continue. Furthermore, Mr. Whitmore noted that the 2005 trends have been much worse than other "bad" years.

In fact, Mr. Whitmore provided updated experience with his testimony at the hearing that Anthem did not include in the original or revised filings. This data reflects claims incurred for the first three quarters of 2005 as opposed to the two quarters included in the filing and shows a marked increase in the trend. Anthem, however, did not seek to amend the filing to include this additional experience. Instead, Mr. Whitmore suggests that the Superintendent take this recent experience into consideration in the event that there are other issues within the filing that might result in the Superintendent requiring Anthem to apply a downward adjustment. The Superintendent declines to accept this suggestion with respect to items other than the claims trend, but does believe that this recent claims experience strengthens Anthem's contention that the claims trend it uses is not unreasonable.

For the reasons stated above the Superintendent concludes that Anthem's trend factors are reasonable.

B. Pharmacy Rebates

In its rate filing, Anthem admitted that during the proceeding for the 2005 HealthChoice rates, it erroneously represented that it did not receive pharmacy rebates from its pharmacy benefits manager, Anthem Prescription Management, Inc. ("APM") based on claims from HealthChoice members. Anthem now includes in its rate development a credit to claims for pharmacy benefits it expects to receive from APM in 2006, but also included in its initial filing a corresponding increase in the administrative expense charge to offset the amount of the rebate credit. In its prefiled exhibits, however, Anthem modified its rate filing to remove the corresponding increase in the administrative expense charge. Anthem explained at hearing that the administrative cost for APM was already included in its administrative expense charge.

The Attorney General requests that the Superintendent closely scrutinize the modified filing to ensure that Anthem is properly estimating and crediting these rebates. In particular, the Attorney General expresses a concern that the HealthChoice member months in the modified Exhibit XII differ from those shown in the claim triangles provided in response to the Attorney General's First Discovery Request. After examining this discrepancy, the Superintendent concludes that even if the member months in Exhibit XII are inaccurate and should agree with the data in the claim triangles, correcting the error would result in only a $ 0.02 adjustment, which is a de minimus amount.

The Attorney General also expresses a concern about Anthem's projections of an increase in pharmacy rebates that is significantly less than its projected increase in pharmacy claims, when pharmacy rebates have been increasing faster than pharmacy claims. By a post hearing request, the Superintendent required Anthem to provide an explanation for this apparent inconsistency. Anthem responded that it does not consider its projected increase in pharmacy claims to be a reasonable indication of the increase in rebates because it: (1) reflects leveraging; (2) reflects increases in the cost of drugs, which do not affect rebates; and (3) a number of new generic drugs, which do not qualify for rebates, will enter the market in 2006. Anthem further explained that the large increase in rebates in recent years reflects increased negotiating strength resulting from the merger between Anthem, Inc. and WellPoint Health Networks, Inc. and is not likely to be repeated in 2006. The Superintendent concludes that Anthem's explanation sufficiently substantiates why the pharmacy rebates are expected to grow more slowly than pharmacy claims in 2006.

Missing from Anthem's modified filing was any attempt to make a credit in the rates for the pharmacy rebates that Anthem received for the years 2001 through 2005. Rather, Anthem requests that the Superintendent not include 2005 rebates due to the expected losses in 2005. The Superintendent denies this request. Anthem must determine the pharmacy rebates it received as a result of HealthChoice claims for the years 2001 through 2005 and credit those pharmacy rebates in determining the 2006 HealthChoice rates. If Anthem is unable to compute the amount of rebates specific to HealthChoice claims in any of these years, it may estimate the amount by prorating the total comprehensive rebates based on the amount of HealthChoice pharmacy claims in relation to total pharmacy claims.

C. Investment Income

In response to Mr. Hyer's comments and the Superintendent's request, Anthem provided an analysis of the policy-related liabilities showing that for non-hospital claims, these liabilities are equal to 1.43 months of premium. Based on the eighty-two percent (82%) ratio of claims to premiums assumed in the filing, this amount is equal to 1.74 months of non-hospital claims. Therefore, Anthem should use 1.74 months in its calculation rather than the one month assumed in the filing.

The Attorney General points out that periodic interim payments ("PIP payments") should not apply to out-of-state hospitals. In response to the Superintendent's post-hearing information request, Anthem states that 17.7% of HealthChoice hospital claims are paid to out-of-state hospitals through Blue Cross/ Blue Shield ("BCBS") plans in those other states. Anthem states it has not determined to what extent these plans make PIP payments, but whether these plans do so or not should not matter because the key factor is when Anthem pays the claim, not when these BCBS plans pay the hospitals. Because Anthem pays these claims for services by out-of-state hospitals retrospectively, Anthem should reflect the out-of-state hospital portion of the policy-related liabilities in the investment income adjustment. Anthem should determine the number of months of claims represented by policy-related liabilities for out-of-state hospital claims and apply the short-term interest rate for this period to the portion of the premium representing out-of-state hospital claims.

Anthem's investment income adjustment reflects only the period between the time the claim is incurred and the time it is paid. This method ignores investment income earned between the time the premium is received and the time the claim is incurred. This ignored period would be one-half month for policies with a monthly payment mode and one and one-half months for policies with a quarterly payment mode. Anthem should determine an additional investment income credit by applying the short-term interest rate for these periods.

The Attorney General raises two other issues in arguing that the investment income is understated. First, the Attorney General hypothesizes: ". . . surely there are ultimate benefit payments to even pre-paid hospitals in excess of the pre-payments in the course of the year." Second, the Attorney General questions the appropriateness of applying a short-term interest rate when calculating the projected investment income. The Superintendent finds neither of these arguments convincing. There appears to be no basis to believe that year-end settlements are more likely to result in a significant net aggregate credit to the hospitals as opposed to a credit to Anthem, and the use of a short-term interest rate is not unreasonable in this instance.

D. Savings Offset Payments

The Attorney General correctly argues that Anthem should not be permitted to pass through the savings offset payment that it is required to make pursuant to 24-A M.R.S.A. § 6913(3) unless it demonstrates that it has made best efforts to ensure recovery of the savings offset payment through negotiated reimbursement rates with health care providers that reflect the health care providers' savings as a result of Dirigo health care initiatives as required by 24-A M.R.S.A. § 6913(7).

At the hearing, Mr. McCormack testified about the process that Anthem follows in negotiating contracts with healthcare providers and described the "extreme vigor" with which Anthem pursues the lowest possible reimbursement rates. Mr. McCormack described how Anthem had discussed Dirigo-related savings with healthcare providers, which experienced varying cost saving effects from Dirigo initiatives. He also explained how the requirements of Insurance Rule 850 sometimes give healthcare providers greater leverage during theses negotiations. He explained, too, how entering three-year contracts with providers is more advantageous than shorter term contracts because the longer term contracts promote network stability and price predictability. He testified that he was confident that the current contracts with healthcare providers were the best contracts that Anthem could secure and that imbedded in those contract rates were the savings attributable to Dirigo. Furthermore, Mr. Whitmore testified these savings attributable to Dirigo had been incorporated into the filed rates.

The Superintendent concludes that Anthem has made best efforts to ensure recovery of the savings offset payment through negotiated reimbursement rates with health care providers that reflect the health care providers' savings as a result of Dirigo health care initiatives. Therefore, Anthem may include a charge in its rates for the actual savings offset payment. However, Anthem must modify the rates to reflect the actual savings offset payment attributed to HealthChoice based on the percentage amount of the savings offset payment and the definition for

"paid claims" adopted pursuant to rule by the Dirigo Board. The Dirigo Board held a public hearing on its proposed rule November 29, 2005, with a deadline for written comments of December 9, 2005. If the final rule has not been adopted by the Dirigo Board by the time of Anthem's refiling, Anthem must use the definition as contained in the proposed rule. If the final rule adopted by the Dirigo Board differs from its proposed rule such that the amount of paid claims used by Anthem in its refiling is reduced, Anthem must file amended rates reflecting the correct amount of paid claims based upon the definition contained in the adopted rule.

E. Rate Relativities

At issue at hearing was whether Anthem required an exception to the requirements of Rule Chapter 940 for its proposed rate differential for its mandated and non-mandated plans. Chapter 940 reads in relevant part:

Unless the Superintendent grants an exception in accordance with this subsection, rates for different benefit plans that vary based on benefit differences may not exceed the maximum possible difference in benefits. For example, the difference in annual premium between a plan with a $250 deductible and an otherwise identical plan with a $500 deductible may not exceed $250 unless an exception is granted.

Bureau of Insurance Rule Chapter 940 § 8(B). To satisfy this requirement, the insurer must only show that there is a possible scenario in which the more expensive policy could pay benefits that exceed the cost differential between the two policies. Anthem has satisfied this requirement with respect to the rate differential between its mandated and non-mandated plans and no exception is required. As Anthem explains in its response to the Superintendent's post-hearing request, the difference in the lifetime limits for mental health and substance abuse benefits in these plans creates the possibility that benefits under the mandated plan could exceed the difference in the rates between a mandated and a non-mandated plan which have the same deductible.

Anthem does, however, require an exception to the Rule Chapter 940 § 8(B) standard for the proposed rate differentials between its HealthChoice policies of varying deductibles. The rule reads in relevant part:

The Superintendent will grant exceptions based on the following criteria and conditions:

1. The rate differential between plans must be justified based on actual or reasonably anticipated differences in utilization that are independent of differences in health status or demographics. Generally, some of the difference in utilization between richer and leaner benefit plans is due to self-selection (based on health status or demographics) by those choosing one plan over the other, while some of the difference is due to the incentives associated with different cost-sharing levels. While it may not be possible to definitively determine how

much of the difference in utilization is related to health status and demographics, the carrier must make a good faith effort to make this distinction.

2. In cases where approved rate differences do exceed the maximum possible differences in benefits, it must be clearly disclosed to prospective policyholders and renewing policyholders. A copy of the disclosure to be used and a description of when and how it will be distributed must accompany the proposed rate filing.

Bureau of Insurance Rule Chapter 940 § 8(B).

Anthem hired Milliman Inc. to develop utilization adjustment factors that reflect differences in utilization due to member cost sharing independent of difference in health status or demographics for its HealthChoice policies. These coverage utilization adjustments are based on Milliman's 2005 Health Cost Guidelines. The Attorney General's expert challenges the way in which Milliman applied these factors. The issue of whether the factors were appropriately applied is essentially a question of how Rule 940 should be interpreted.

Under the interpretation implied by Mr. Hyers' criticism, the first step is to determine what the rate differential between the plans would be assuming no difference in utilization. The second step is to increase this differential to reflect "reasonably anticipated differences in utilization that are independent of differences in health status or demographics." Rule 940(8)(B)(1). If the resulting differential exceeds the maximum possible difference in benefits, an exception may be granted.

The Superintendent, however, reads the rule differently than Mr. Hyers. In order to determine whether an exception should be granted one should first determine the maximum possible difference in benefits, because the Rule already allows this much variation in rates before requiring an exception. The Superintendent may then grant an exception for a rate differential greater than the maximum possible benefits when the greater differential is based on "reasonably anticipated differences in utilization that are independent of differences in health status or demographics." Id. The Superintendent concludes that Anthem has justified the rate differential based on anticipated differences in utilization. Furthermore, granting the exception has several beneficial consequences. First, it avoids the need for an even larger rate increase on the higher deductible plans. Second, While Anthem has little competition in the individual market, there is at least theoretical potential for an unlevel playing field if Anthem must charge more for its high-deductible plans to subsidize its low-deductible plans while a competitor that does not have an old block of low-deductible plans is able to charge less for high-deductible plans. Finally, the individual market is very precarious and forcing Anthem to charge more for its currently marketed plans in order to subsidize the older plans only exacerbates the problem.

The Superintendent notes that Anthem did not request an exception with regard to the rate differential between the $2,250 deductible and the $5,000 deductible. As a result, the proposed percentage increase for the $2,250 deductible is smaller than for the higher deductibles despite the fact that the claims experience for this plan is much worse. This in turn results in higher rates for the $5,000 and higher deductibles than would be the case if Anthem had requested an exception. Therefore, the Superintendent grants Anthem an exception under Rule Chapter 940 in this instance in order to facilitate lower rates for HealthChoice policies with $5000 and higher deductibles.

In satisfying the notice requirements of Chapter 940 §8(B)(2), Anthem must provide the notice of the approved exception to the rate differential limits with the rate increase notice rather than earlier as Anthem has previously proposed.

## V. FINDINGS AND CONCLUSIONS

On the basis of a preponderance of the credible evidence before him, the Superintendent makes the following findings and conclusions:

1. Anthem's proposed rates are neither inadequate nor unfairly discriminatory.
2. Anthem's proposed rates are likely to yield a loss ratio of at least 65%.
3. For reasons set forth above in Sections IV(B), (C), and (D) Anthem's proposed rates are excessive.

## VI. ORDER

Pursuant to the provisions of 24-A M.R.S.A. §§ 12-A(6), 2736 and 2736-A and authority otherwise conferred by law, the Superintendent hereby ORDERS:

1. Approval of the rates filed September 9, 2005, and revised on November 3, 2005, by Anthem Blue Cross and Blue Shield for individual HealthChoice, HealthChoice Standard and HealthChoice Basic products is DENIED.
2. Revised rate filings may be submitted for review and shall be APPROVED, effective on such date as will assure a minimum of 30 days prior notice to policyholders, if the Superintendent finds them to be consistent with the terms of this Decision and Order.

## VII. NOTICE of APPELLATE 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.A. § 8002(4). It may be appealed to the Superior Court in the manner provided for by 24-A M.R.S.A. § 236, 5 M.R.S.A. §§ 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 of the issuance of this decision. There is no automatic stay pending appeal. Application for stay may be made in the manner provided in 5 M.R.S.A. § 11004.

Dated this 19th day of December 2005 at Gardiner, Maine.

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ALESSANDRO A. IUPPA
Superintendent of Insurance