MAINE

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

IN RE:	)	
	)	
ANTHEM BLUE CROSS AND BLUE SHIELD 2009 INDIVIDUAL RATE FILING FOR HEALTHCHOICE, HEALTHCHOICE STANDARD AND BASIC, AND LUMENOS CONSUMER DIRECTED HEALTH PLAN PRODUCTS	)	DECISION AND ORDER
	)	
Docket No. INS-09-1000	)	

I. INTRODUCTION

Mila Kofman, Superintendent of Insurance ("Superintendent"), issues this Decision and Order after consideration of the Anthem Blue Cross and Blue Shield ("Anthem") 2009 rate filing for individual HealthChoice, HealthChoice Standard, HealthChoice Basic, and Lumenos Consumer Directed Health Plan products (collectively, "Individual 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 initial filing, Anthem proposed revised rates for its Individual Products that it asserted would produce an average increase of 14.5%. As identified in its filing, the premium increases varied depending on deductible level and type of contract. The largest increase for the Non-Mandated HealthChoice options would have been 17.2%, for the Mandated Options (HealthChoice Standard and Basic) would have been 7.7%, and for Lumenos would have been 34.1%. Anthem requested that these rate revisions become effective on May 1, 2009. Anthem revised its actuarial analysis with updated data and reflecting a July 1, 2009 effective date. Based on its revised analysis, Anthem requested approval of revised rates with an average increase of 18.1%. As identified in its revised filing, the largest premium increase for Non-Mandated HealthChoice

would have been 23.6%, for Mandated HealthChoice would have been 9.5%, and for Lumenos would have been 37.8%. In its pre-filed testimony filed on March 6, 2009, Anthem further revised its analysis resulting in a requested average rate increase of 18.5%. For the Non-Mandated HealthChoice options, the range of increases is 8.7% to 24.5%, with an average of 18.7%. For the Mandated HealthChoice options, the range of increases is 9.0% to 9.7%, with an average of 9.2%. For the Lumenos options, the range of increases is 8.9% to 38.4%, with an average of 30.2%. Anthem requests that its revised rate filing become effective on July 1, 2009. As of November 2008 there are 12,049 policyholders who will be affected by the proposed rate revisions.

This Decision and Order constitutes final agency action on Anthem's filing.

II. PROCEDURAL HISTORY

On December 22, 2008, Anthem filed proposed revised rates for approval for its HealthChoice, HealthChoice Standard, HealthChoice Basic, and Lumenos Consumer Directed Health Plan products. The Bureau of Insurance designated the matter as Docket No. INS-09-1000.

On January 16, 2009, the Superintendent issued a Notice of Pending Proceeding and Hearing. The notice set a public hearing for March 12, 2009, 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.

On January 21, 2009, Anthem filed a revision to its initial filing.

In early February 2009 Anthem provided direct written notice by mail to every affected policyholder, advising policyholders of the proposed rate increases, the pending proceeding, evening public comment sessions, and the scheduled hearing.

On February 10, 2009, as part of the Procedural Order issued by the Superintendent, the Maine Attorney General was granted intervention as of right. The Procedural Order, in accord with Maine Bureau of Insurance Rule Chapter 350, § 2(A)(1), established procedures for the conduct of this proceeding; and established deadlines for serving discovery requests and for submission of pre-filed testimony and exhibits.

During February 2009 the Superintendent and the Attorney General engaged in discovery on Anthem's rate filing. The Superintendent served Anthem with three pre-hearing discovery requests, to which Anthem filed responses. The Attorney General served Anthem with three discovery requests to which Anthem filed responses.

On March 3, 2009, in Orono, and on March 10, 2009, in Portland, the Superintendent held evening public comment sessions providing members of the public an opportunity to make either sworn or unsworn statements for her consideration. Thirty-four (34) individuals provided such statements.

On March 6, 2009, Anthem and the Attorney General filed prefiled testimony and exhibits. Anthem's pre-filing included a revised rate increase request.

On March 11, 2009, the Superintendent issued a Protective Order that accepted in part Anthem's claim for confidential treatment. The only information that was designated confidential is personal health information that is protected from public disclosure under the Maine Insurance Information and Privacy Protection Act[1] and under the privacy regulations

[1] 24-A M.R.S.A. Chapter 24 (§§ 2201 *et seq.*).

promulgated under the Health Insurance Portability and Accountability Act (HIPAA).[2] The specific information protected is limited to information about the diagnoses and treatments of two high-claim individuals.

On March 12, 2009, the Superintendent held a hearing on Anthem's filing. The hearing was conducted entirely in public session. Members of the public had an opportunity to make either sworn or unsworn statements for consideration by the Superintendent. Seventeen (17) individuals provided such statements. Members of the public also submitted in excess of three hundred (300) written comments outside the public hearing that the Superintendent designated a part of the record of this 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 Superintendent is barred by the Maine Administrative Procedure Act from relying on unsworn submissions as evidence when making her substantive decision. 5 M.R.S.A. § 9057.

At hearing, Anthem presented testimonial evidence from Jennie Casaday, Associate Actuary; Vincent Liscomb, Executive Director of Provider Network Management; and George Siriotis, Regional Vice-President of Sales for the Individual Markets Division, East Region. The Attorney General presented testimonial evidence from Beth Fritchen, Actuary and Principal with Oliver Wyman Actuarial Consulting, Inc. The Superintendent admitted into evidence Anthem Hearing Exhibits 1 through 7, and Attorney General Exhibits 1 through 4.

[2] 45 C.F.R. Parts 160 and 164.

After the parties rested their cases at hearing, the Superintendent adjourned the hearing for the submission of post-hearing information responses to certain questions posed at the hearing, followed by written closing argument.

On March 16, 2009, the Attorney General filed its post-hearing information responses, as well as an inquiry to Anthem; and on April 2, 2009, filed further post-hearing information.

On March 20, 2009, Anthem filed its post-hearing information responses, to which the Superintendent asked further follow-up questions of Anthem on April 8, 2009. Anthem filed responses to the Superintendent's further inquires on April 13, 2009. A final follow-up question by the Superintendent on April 14, 2009 was responded to by Anthem the same day.

On April 17, 2009, Anthem and the Attorney General filed their written closing arguments.

Per direction of the Superintendent on April 28, 2009, the Attorney General filed clarifying information on May 1, 2009, to which Anthem objected and filed a response on that same day.

III. LEGAL STANDARD

Anthem is required by 24-A M.R.S.A. § 2736(1) to file proposed policy rates for its individual health insurance products with the Superintendent. The Superintendent may approve the filed rates only if they are not inadequate, excessive, or unfairly discriminatory. 24-A M.R.S.A. § 2736(2). Pursuant to 24-A M.R.S.A. § 2736-C(5), the proposed rates should be likely to yield a loss ratio of at least 65% as determined in accordance with accepted actuarial principles and practices. That is, expected claims payments must be at least 65% of premium.

Anthem as proponent of the filed rates bears the burden of proving by a preponderance of the evidence that the proposed rates meet statutory requirements.

IV. DISCUSSION

The Superintendent finds that the proposed rates filed by Anthem in this proceeding are not inadequate. However, the Superintendent does find that the proposed rates as submitted by Anthem are excessive and unfairly discriminatory in contravention of section 2736 for the reasons discussed more particularly below. 24-A M.R.S.A. § 2736.

This section includes a discussion of challenges to Anthem's proposed rates brought by the Attorney General as well as deficiencies determined by the Superintendent. This section also comprises guidance for Anthem on what filing the Superintendent would approve.
24-A M.R.S.A. § 2736-B.

A. Trend

At the heart of the ratemaking process is the calculation of trend factors, the term used to refer to the expected rate of increase in costs based on observed changes in recent years. For a number of reasons, as discussed more fully below, the trends differ for different products.

Anthem's filing included two alternative methods of determining the trend. Method 1, Anthem's preferred method, is the one used in past filings. Method 2 develops a trend with large claims excluded and then adds a pooling charge for large claims. This is similar, but not identical, to the method recommended by Ms. Fritchen in past filings, as well as in this one, and adopted in past rate decisions. Ms. Casaday stated that she preferred Method 1 because it reflects actual changes in provider contracts, reflects trends in unit costs and utilization by

service category, and adjusts for service mix. However, she did not explain why she did not include those features in Method 2 or simply make the large claim adjustment to Method 1.

Ms. Fritchen provided an alternative trend analysis. Like Anthem's Method 2, she excluded large claims and added a pooling charge, but similar to Anthem's Method 1, she based her analysis on "allowed claims" – the total cost of covered services before considering deductibles and other cost-sharing – rather than paid claims, as used in Anthem's Method 2, which reflect the actual benefit paid.

1. Plan Shift

To evaluate the competing trend calculations, it is important to understand the impact on both claims and premiums of the shift from lower- to higher-deductible plans. With respect to claims, the shift affects both utilization (that is, the number of claims) and the cost of each claim. Utilization differences between plans with different deductibles result both from incentives to control utilization when the deductible is large (the "incentive effect") and from adverse selection resulting from the fact that those with health problems are less likely to shift to a high deductible than are healthier individuals (the "selection effect"). The effect on the cost of each claim simply reflects the fact that Anthem pays a smaller proportion of the total cost under high deductible plans (the "benefit effect").

The impact on premiums is less than the impact on claims because, consistent with Maine's statutory prohibition against rating based on health status, Bureau of Insurance Rule 940 limits the difference between the annual premiums for two deductibles to the difference between the deductibles plus an additional allowance for utilization differences that result from the incentive effect. Anthem uses factors that were developed by the actuarial firm Milliman as a mechanism intended to reflect the incentive effect while excluding the selection effect. If every

policyholder met the deductible, the portion of the premium differential that equals the difference in deductibles would reflect only the benefit effect and the only portion of the premium differential representing utilization differences would be the additional allowance for the incentive effect. However, because not everyone meets the deductible, the portion of the premium differential that reflects the difference in deductibles also reflects some of the selection effect. Exactly how much cannot be determined from the data on the record, but it is not necessary to fully quantify the selection effect.

As noted earlier, the Anthem filing included both "allowed" trends, which are based on the benefit before cost-sharing is applied, and "paid" trends, which reflect the actual benefit paid. Both trends reflect the incentive effect and the selection effect, but only the paid trend reflects the benefit effect. Anthem's Method 1 used allowed trends but made an adjustment to remove the impact of deductible mix on utilization. The resulting trend is therefore the trend that would have resulted if there were no change in deductibles. After the trend was applied, a further adjustment of 0.945 was applied to reflect the anticipated plan shift based on Anthem's enrollment projections. The resulting claims estimate therefore reflects the full effect of the anticipated plan shift on both benefits and utilization.

Anthem's Method 2, which it characterizes as a reasonableness check on Method 1, used paid trends and includes no adjustment for deductible mix. The resulting trend therefore included the impact of plan shift on both benefits and utilization. Anthem did not apply the 0.945 adjustment factor under Method 2. Therefore the projected claims assumed that plan shift will continue at the same rate as during the experience period. However, the filing indicated that Anthem expects a slowing of the plan shift. To that extent, Method 2 could be expected to slightly understate projected claims, all else being equal.

It should be noted that Anthem's methodology does not apply the trend factor directly to premiums. Instead, the trend is used to project future claims, which are then used to project aggregate required revenue in Exhibit 1 of the filing. Exhibit 3 then calculates the rate changes needed to achieve that revenue based on projected enrollment. Since the projected enrollment used in Exhibit 3 is the same as that used to develop the 0.945 claims adjustment factor, projected claims and premiums are determined on a consistent basis.

Ms. Fritchen developed her trend using allowed claims. She then made an upward adjustment based on the Milliman factors. This adjustment removed the incentive effect but not the selection effect. Therefore the adjusted trend was less than a trend assuming no plan shift. Because she then applied the full 0.945 adjustment factor, the result was an understatement of future claims. The 0.945 factor reflects the selection effect as well as the incentive effect and the benefit effect. Applying this factor to a trend that already reflects the selection effect results in double counting the selection effect.

Ms. Fritchen argued that it was only necessary to normalize the experience to the extent that utilization differences are reflected in rates. This would be true if the trend factor were going to be applied to rates. However, as noted above, that is not the case here. Furthermore, even if premium factors were appropriate, the Milliman factors do not incorporate all of the utilization differences reflected in premiums.

2. Aging

Ms. Fritchen asserts that, assuming aging will occur during the rating period at the same rate at which it has occurred during the base period, an adjustment is needed to the trend calculation to the extent that aging is already reflected in the rating structure. Otherwise, according to Ms. Fritchen, the effect of aging will be double-counted. As in the case of plan

shift discussed above, this overlooks the fact that the trend factor is to be used to project claims, not directly to adjust rates. If Anthem's enrollment projections reflected anticipated changes in the age distribution of the covered population, no age adjustment would be needed to the trend. However, the enrollment projections reflect only changes in the distribution by benefit plan. No change in the age distribution within each plan is assumed, although to the extent that the age distribution varies somewhat among the benefit plans, a change in the mix of plans does affect the overall age distribution. If aging in fact continues to occur, revenues produced by the proposed rates will be greater than projected because more subscribers will be paying the higher rates associated with the older age bands. Therefore Ms. Fritchen's adjustment is appropriate. If aging is reflected in the data underlying the trend calculation and aging is expected to continue at the same rate, then unless the enrollment projections are adjusted to reflect that aging, an adjustment should be made to the trend factor to remove the portion of aging that will be accounted for in the rating structure.

Stated another way, the required revenue calculated in Exhibit 1 of the filing implicitly assumes continued aging because the utilization trends used in the calculation include the effects of aging. The premiums calculated in Exhibit 3 of the filing implicitly assume no further aging because the current age distribution is assumed for the projected period. Reducing the required revenue calculated in Exhibit 1 based on the age factors used for rating will result in the required revenue assuming no further aging, consistent with the implicit assumption in Exhibit 3. If aging does continue as in the past, both the required revenue in Exhibit 1 and the "Total Annual Income Using Proposed Rates and Current Enrollment" calculated in Exhibit 3 will be understated, but the understatements will offset each other. Based on Ms. Fritchen's analysis,

the appropriate reduction is (1+6.5%) / (1+6.0%) -1, or 0.5%, which should be applied to Anthem's 14.1% trend factor.

As noted above, the projected changes in distribution by benefit plan indirectly result in some change in the overall age distribution. Because the plans with the most growth, the Lumenos plans, have a younger age distribution, the projected enrollment in Exhibit 3 is actually slightly younger than the current enrollment. This is reflected in the calculations presented in Ms. Fritchen's "Explanation of Updated Normalizing of the Trend," which shows an annual change in the age factor of -0.2% for the projection period. Anthem's failure to adjust for this results in a further understatement of projected premium. To offset this, a further 0.2% reduction is needed in the trend factor. The appropriate trend factor is therefore (1+14.1%) x (1-0.5%) x (1-0.2%), or 13.3%.

3. Large Claims

Anthem's Method 1 is susceptible to distortions due to fluctuations in large claims. However, in this instance it results in a slightly smaller increase than does Method 2. As Ms. Fritchen pointed out, this may not always be the case. Anthem should continue to examine this issue in future filings. An ideal methodology would replace large claims with a pooling charge as in Method 2 without sacrificing the strengths of Method 1. If such a methodology cannot be developed, Anthem should continue to use Method 2 as a check.

B. Benefit Modifications

Anthem included an adjustment to the Preventive Care and Supplemental Accident (PCSA) rider to reflect a new benefit that waives the deductible for screening colonoscopy. Maine's guaranteed renewal law prohibits "roll-ons," where consumers are required to buy additional coverage on renewal. In order for a product to incorporate a new benefit that would

increase the cost of coverage, the new benefit must either be required by law or be approved by the Superintendent as meeting the "minor modification" standards of 24-A M.R.S.A. § 2850-B(3)(I)(4). Although Anthem had filed the colonoscopy benefit change with the Superintendent, it had asserted that it was required by P.L. 2007, ch. 516. However, in its March 20 Response to Hearing Information Requests, Anthem acknowledged that "there is no legal requirement that the deductible be waived" but that it "has made the decision to do so, in order to promote the health of our members and to address their expectations." Anthem further stated that it would file a revised PCSA rider before the end of March to clarify this benefit. That filing was submitted on March 24. Despite its March 20 acknowledgement that the change is not required by law, the March 24 filing stated, "The rate filing requirements contained in Bureau of Insurance Rule Chapter 940 do not apply as these changes are the result of legislative action." Absent a legal requirement, Anthem can only make a change in benefits for existing policyholders if it demonstrates that it is a minor modification as defined by 24-A M.R.S.A. § 2850-B(3)(I). Unless and until Anthem does so, it would be inappropriate to allow this benefit to be reflected in increased rates.

C. Adjustment for High-Cost Claimants

Anthem included in its rate filing an adjustment of $1,292,755 to reflect two high-cost claimants transferring to HealthChoice from a group plan. Ms. Fritchen provided an alternative calculation of this adjustment resulting in $636,000. Ms. Casaday acknowledged that Ms. Fritchen's methodology was reasonable and more rigorous than Anthem's. The Superintendent adopts Ms. Fritchen's alternative calculation.

D. Savings Offset Payments

24-A M.R.S.A. § 6913(7) requires carriers to "use best efforts to ensure health insurance premiums reflect any such recovery of savings offset payments as those savings offset payments are reflected through incurred claims experience in accordance with subsection 9." Subsection 9 requires that "the claims experience used to determine any filed premiums or rating formula must reasonably reflect, in accordance with accepted actuarial standards, known changes and offsets in payments by the carrier to health care providers in this State, including any reduction or avoidance of bad debt and charity care costs to health care providers in this State as a result of the operation of Dirigo Health and any increased enrollment due to an expansion in MaineCare eligibility occurring after June 30, 2004 as determined by the board consistent with subsection 1." Anthem presented a witness who described the process of provider negotiations and asserted that best efforts were made as required by subsection 7. No evidence refuted that assertion. Anthem also provided evidence that contracts negotiated with providers are reflected in the trend factor used to project claims experience. This is *prima facie* evidence of compliance with subsection 9, and again has not been refuted.

Nonetheless, the Attorney General argues that no savings offset payment should be included in the rates because "providers have been unable to isolate or calculate those savings and Anthem does not receive an accounting of those savings" and because Anthem's actuary "provided no quantifiable evidence of how she calculated or accounted for those savings in the experience or otherwise." However, the statute does not require a precise accounting. Furthermore, no precise accounting is possible. The savings offset is based on "aggregate measurable cost savings," as determined under subsection 1 of the statute. The methodology used to determine these savings does not allow for tracing the savings to specific providers.

Anthem has met the statutory standard. Any savings are reflected in the projected claim costs and the savings offset payment is appropriately included in the rates.

E. Rate Relativities

1. HealthChoice Standard and Basic Plans

The standardized plans, which all carriers in the individual market are required to offer, were introduced in 1995. At that time, Anthem's predecessor, Blue Cross Blue Shield of Maine, rated those products on a basis consistent with its existing HealthChoice plans. The rate for the Standard plan was about 5% higher than the rate for a traditional HealthChoice plan with the same deductible to reflect differences in benefits, such as first-dollar coverage of preventive care in the Standard plan. At the same time, Blue Cross Blue Shield of Maine stopped offering HealthChoice plans with deductibles below $2,000, so the standardized plans became the only low-deductible plans offered.

In 2005, Anthem began rating the standardized plans based on their own experience rather than on the pooled experience of the standardized and non-standardized plans. This resulted in higher rates for the standardized plans relative to the non-standardized plans, probably because those with health problems are more likely to choose a low deductible than are healthier individuals. Over time, this rate differential increased. Beginning in 2007, by order of the Superintendent, the differential between the $1,000 deductible Standard plan and the $1,000 deductible non-standardized plan was capped at 50%.

The current filing maintains this 50% differential. However, any differential larger than that justified by benefit differences is inconsistent with the community rating principles embodied in Maine law. Ultimately, the differential should be reduced to 5%, reflecting the benefit differences. However, a sudden change of this magnitude would be disruptive, causing

additional rate increases for the non-standardized plans to offset the lost revenues that would result from decreasing rates for the standardized plans. Therefore, rather than decreasing rates for the standardized plans, those rates should be frozen at their current level until the differential shrinks to the 5% target level.

2. Lumenos Plans

The Lumenos plans were introduced in 2007. The rates were based on the rates for the HealthChoice $5,000 deductible plan with appropriate adjustments. When HealthChoice rates were increased in 2008, Anthem did not file increased rates for the Lumenos plans. Anthem now requests, in effect, a double increase reflecting both the 2008 and proposed 2009 increases in the HealthChoice rates. Anthem's explanation for not filing Lumenos rates for 2008 is that the experience was favorable but not credible (only six months and 200 policies), the loss ratio was below 65%, and Anthem did not believe the Superintendent would grant an increase.

The fact that the experience was favorable and the loss ratio low is not significant because the plan-specific experience was not credible, because general trends in health care costs clearly indicated that rate increases should be considered, and because midyear loss ratios do not reflect an accurate comparison of claims to premiums: as explained by Ms. Casaday, one would expect a low loss ratio in the first six months because it takes more time for many people to reach their deductible. No basis was offered for the belief that the Superintendent would not grant an increase under these circumstances. Trend increases have often been approved for new products that have not reached credible experience levels. Had Anthem simply pooled its Lumenos and HealthChoice experience, there is no reason to assume similar increases would not have been granted for both products. Therefore there is no valid reason for Anthem waiting 2 ½ years to adjust the rates on these products.

In order to avoid an unduly large rate increase for Lumenos policyholders, the rate increase for current policyholders should be capped so that the largest increase will be 20%. Anthem should not increase the size of the HealthChoice rate increase to make up the revenue lost due to this cap because HealthChoice policyholders should not pay for Anthem's failure to file Lumenos rates in a timely manner. Anthem should not apply this cap to its new business rates because that likely would result in consumers buying the product at artificially low rates only to be faced with a large rate increase next year.

The Attorney General argued that the Anthem's 6% rate differential between the $5,000 deductible HealthChoice and Lumenos plans is too small and suggests 15% based on Ms. Fritchen's testimony about how other companies rate "consumer-driven" health plans. This argument is not valid for two reasons. First, as Anthem pointed out, much of the difference in utilization observed in other markets results from the large difference in deductibles, with consumer-driven health plans having significantly higher deductibles than other plans. That is not the case here. Most of the HealthChoice plans in force have deductibles that are as large as or larger than those for the Lumenos plans. Second, much of the difference in utilization observed in other markets results from differences in health status between those choosing consumer-driven health plans and those choosing other plans. To reflect these differences in rates would be inconsistent with the community rating principles embodied in Maine law.

F. Lumenos Age 65+ Rates

As the Attorney General pointed out, the Lumenos 65+ rates do not comply with Rule 940 and are also inconsistent with the HealthChoice 65+ rates. For these reasons, the Lumenos 65+ rates should be the same as the Lumenos 55-64 rates.

G. Profit and Risk Margin

Anthem included a 3% pre-tax profit and risk margin in its rate development based on past orders, and asserted that a 5% margin would be justified. Anthem repeatedly cited losses on its individual products over the last four years as evidence that a 3% margin is inadequate to cover the risks associated with these products. However, those losses are entirely attributable to 2005 and 2006. As shown in Exhibit 9 of the filing, for the nine years Anthem has owned the company (2000-2008),[3] these two years were the only ones that showed a loss. The pre-tax gain was 5.3% in 2007 and 2.8% in 2008. Over the nine-year period, the pre-tax operating gain totaled nearly $16 million and averaged 3.2% of total revenue.

The Attorney General recommended allowing no margin, citing "(1) a unique economic situation resulting in extreme financial hardship for subscribers, and (2) the extreme financial health of the company." The large number of policyholders who testified at the public hearings and sent written comments provides ample evidence of the first point and Anthem's financial statements provide ample evidence of the second. Under these circumstances, it is reasonable to allow no profit and risk margin this year. While a break-even rate level would not contribute further to the company's surplus, it would not be a drain either. Furthermore, the existence of the individual line would continue to provide an indirect benefit to the company because it provides a larger base over which to spread fixed expenses.

It must be acknowledged, however, that the rates indicated by this Decision and Order will not be full break-even rates if all of the assumptions hold. This is due to two items discussed above: the disallowance of the cost of the colonoscopy benefit change, and the 20% cap on the rate increase for current Lumenos policyholders. The disallowance of the cost of the

[3] Anthem owned the company for only part of the year 2000.

colonoscopy benefit change will result in a loss to Anthem of $348,747 based on Anthem's estimate. If all current Lumenos policyholders renew, Anthem would lose approximately another $650,000 for a total loss just under $1 million. However, as explained above, both of these losses result from Anthem's own action or inaction. Losses of this magnitude will not render the rates inadequate. Anthem has more than enough surplus to absorb this loss and the HealthChoice and Lumenos policyholders have contributed to that surplus.

V. FINDINGS AND CONCLUSIONS

On the basis of a preponderance of the credible evidence in the record, and for reasons set forth in Section IV above, the Superintendent finds and concludes that Anthem's proposed rates are excessive and unfairly discriminatory. If the changes to the rates proposed by Anthem are applied consistent with this Decision and Order, as discussed in Section IV, the Superintendent could lawfully approve the resulting rates. The necessary revisions to the proposed rates can be achieved by the following changes to the spreadsheet (Prefiled 2009JULY Lumenos and HealthChoice thruDec08 2009030 (W1322955).XLS):

Exhibit 1:

- Change cell C12 from 14.1% to 13.3%.
- Change cell C30 from $348,747 to 0.
- Change cell C31 from $1,292,755 to $636,000.
- Change cell C36 from 3.0% to 0.

Exhibit 13:

- Change cell B33 from $348,747 to 0.
- Change cell B11 from $26.68 to $20.41.

Exhibit 3:

- Change cell AF25 from 1.500 to 1.2.
- Change cells in the range B398:F405 to equal the values in the cells in the range B362:F369.
- Change cell D384 from $1,158.13 to $1,108.18.

This will result in appropriate HealthChoice rates and Lumenos new business rates. Lumenos renewal rates require one further adjustment:

Exhibit 3:

- Change cell AH52 from formula to $815.80.

The Superintendent finds and concludes that such revised rates, appropriately developed per this Decision and Order, would not be excessive, inadequate, or unfairly discriminatory; and would likely yield a loss ratio of at least 65%.

As a result of the changes proposed by the Superintendent, the total average rate increase proposed by Anthem of 18.5% would be reduced to 10.9%, with the specific rate changes ranging from -5.0% to 20.0%. For the Non-Mandated HealthChoice options, the range of increases would be 6.1% to 12.4%%, with an average of 10.8%. For the Mandated HealthChoice options, there would be no rate change. For current Lumenos policyholders, rate changes would range from a decrease of 5.0% to an increase of 20.0%, with an average increase of 15.6%. For Lumenos new business rates, rate changes would range from a decrease of 8.0% to an increase of 32.4%.

VI. ORDER

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

1. Approval of the rates filed December 22, 2008, as revised, by Anthem Blue Cross and Blue Shield for individual HealthChoice, HealthChoice Standard, HealthChoice Basic, and Lumenos Consumer Directed Health Plan products is DENIED. Accordingly, the proposed rates filed by Anthem for its individual HealthChoice, HealthChoice Standard, HealthChoice Basic, and Lumenos Consumer Directed Health Plan products do not enter into effect.

2. Anthem is authorized to submit revised rates for review and they shall be APPROVED if the Superintendent finds them to be consistent with the terms of this Decision and Order and that the effective date of those rates will assure a minimum of 30 days' prior notice to policyholders.

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 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.A. § 11004.

PER ORDER OF THE SUPERINTENDENT OF INSURANCE

May 18, 2009

MILA KOFMAN
Superintendent of Insurance

Filing at a Glance

Company: Anthem Blue Cross and Blue Shield

Product Name: 2009 Rate Filing for HealthChoice and Lumenos Product Lines	SERFF Tr Num: MALH-125969281	State: Maine
TOI: H16I Individual Health - Major Medical	SERFF Status: Closed-Approved	State Tr Num: 2009 RATE FILING FOR HEALTHCHOICE AND LUMENOS PRODUCT LINES
Sub-TOI: H16I.005A Individual - Preferred Provider (PPO)	Co Tr Num:	State Status: Approved
Filing Type: Rate		Reviewer(s): Richard Diamond (LH)
	Author:	Disposition Date: 05/26/2009
	Date Submitted: 12/22/2008	Disposition Status: Approved
Implementation Date Requested: 05/01/2009		Implementation Date: 07/01/2009

State Filing Description:

2009 Rate Filing for HealthChoice and Lumenos Product Lines

General Information

Project Name:	Status of Filing in Domicile:
Project Number:	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Group Market Size:
Overall Rate Impact:	Group Market Type:
Filing Status Changed: 05/26/2009	Explanation for Other Group Market Type:
	State Status Changed: 05/26/2009
Deemer Date:	Created By: Lisa Lewis (LH)
Submitted By: Lisa Lewis (LH)	Corresponding Filing Tracking Number:
PPACA: Pre-PPACA Submission	
Filing Description:	

Company and Contact

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Filing Company Information

Anthem Blue Cross and Blue Shield	CoCode: 6	State of Domicile: Maine
2 Gannett Drive	Group Code: -99	Company Type:
South Portland, ME 04106	Group Name:	State ID Number:
(207) 822-7111 ext. [Phone]	FEIN Number: 01-0468581	

Filing Fees

Fee Required?	No
Retaliatory?	No
Fee Explanation:	
Per Company:	No

SERFF Tracking Number:	*MALH-125969281*	*State:*	*Maine*
Filing Company:	*Anthem Blue Cross and Blue Shield*	*State Tracking Number:*	*2009 RATE FILING FOR HEALTHCHOICE AND LUMENOS PRODUCT LINES*
Company Tracking Number:			
TOI:	*H16I Individual Health - Major Medical*	*Sub-TOI:*	*H16I.005A Individual - Preferred Provider (PPO)*
Product Name:	*2009 Rate Filing for HealthChoice and Lumenos Product Lines*		
Project Name/Number:	*/*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Richard Diamond (LH)	05/26/2009	05/26/2009

Disposition

Disposition Date: 05/26/2009

Implementation Date: 07/01/2009

Status: Approved

Comment: This filing was the subject of a public hearing. Related documents are attached.

Rate data does NOT apply to filing.

Schedule	**Schedule Item**	**Schedule Item Status**	**Public Access**
Supporting Document	Explanatory Memorandum LH	Approved	Yes
Supporting Document	Actuarial Justification for Rate (Change) LH	Approved	Yes

Attachment "W1249808.DOC" is not a PDF document and cannot be reproduced here.

Attachment "W1249926.DOC" is not a PDF document and cannot be reproduced here.

Attachment "W1250041.XLS" is not a PDF document and cannot be reproduced here.

A MILLIMAN GLOBAL FIRM

Milliman

Consultants and Actuaries

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Wayne, PA 19087-5572
Tel +1 610 687.5644 Fax +1 610 687.4236
www.milliman.com

August 15, 2005

Mr. Bill Whitmore
Actuarial Services
Anthem Blue Cross and Blue Shield of Maine
2 Gannett Drive
South Portland, ME 04106-6911

Re: Coverage Utilization Adjustments

Dear Bill:

Anthem Blue Cross Blue Shield of Maine has requested that Milliman provide it with factors that reflect differences in utilization due to member cost sharing for several of its existing plans. These factors do not reflect any difference in utilization due to the population expected or actually enrolled in each plan design. These Coverage Utilization Adjustments are shown in the attached chart. The plan description in the attached chart is just enough to distinguish among the plans. It does not attempt to completely describe the plans.

The adjustments are based on Milliman's 2005 Health Cost Guidelines. The Milliman Guidelines are based on multiple data sources and reflect the combined experience and judgment of many Milliman Health actuaries.

The intended use of this letter is to provide Anthem BCBS of Maine with pricing adjustments for its internal use. Our analysis and results may not be appropriate for any other use.

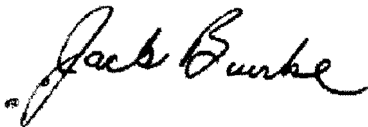
This report has been prepared for the use of and is only to be relied upon by the management of Anthem BCBS of Maine. No portion of this report may be provided to any other party without Milliman's prior written consent, except as needed for filing with its state regulatory authorities. In the event such consent is provided, the report must be provided in its entirety.

Mr. Bill Whitmore
August 15, 2005
Page Two

It is certain that actual experience will not conform exactly to the assumptions used in this analysis. To the extent that actual experience is different from the assumptions used in the projections, the actual results will also deviate from the projected amounts.

Let me know if you have any questions regarding the attached. My number is 610-975-8093.

Sincerely,



Jack P. Burke, F.S.A.
Consulting Actuary

JPB/go

Anthem Blue Cross Blue Shield of Maine
Coverage Utilization Adjustments
Based on Milliman Health Cost Guidelines - 2005

HealthChoice Plans	Plan Coinsurance Rate	Utilization Adjustment Factor
$150 deductible with $1,000 coinsurance	80%	0.997
$300 deductible with $1,000 coinsurance	80%	0.986
$500 deductible with $1,000 coinsurance	80%	0.970
$750 deductible with $1,000 coinsurance	80%	0.960
$1000 deductible with $1,000 coinsurance	80%	0.950
$2000 deductible with $1,000 coinsurance	80%	0.910
$4000 deductible with $1,000 coinsurance	80%	0.859
$150 deductible with $1,000 coinsurance, $20,000 annual benefit maximum	80%	0.996
$150 deductible with $1,000 coinsurance, $10,000 annual benefit maximum	80%	0.995
$2,250 deductible	100%	0.922
$5,000 deductible	100%	0.857
$10,000 deductible	100%	0.793
$15,000 deductible	100%	0.750
Standard Plans:		
Standard: $250 deductible, $1,000 coinsurance	80%	0.990
Standard: $500 deductible, $1,000 coinsurance	80%	0.970
Standard: $1000 deductible, $1,000 coinsurance	80%	0.950
Standard: $1500 deductible, $1,000 coinsurance	80%	0.930
Basic Plans:		
Basic: $250 deductible, $1,000 coinsurance	60%	0.966
Basic: $500 deductible, $1,000 coinsurance	60%	0.945
Basic: $1000 deductible, $1,000 coinsurance	60%	0.925
Basic: $1500 deductible, $1,000 coinsurance	60%	0.913

Attachment "W1250089.XLS" is not a PDF document and cannot be reproduced here.

Attachment "7_SEND 2009 Current and Proposed Rate Sheet 20091222.xls" is not a PDF document and cannot be reproduced here.

Christopher T. Roach

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January 22, 2009

Eric Cioppa, Deputy Superintendent of Insurance
Maine Bureau of Insurance
Docket No. INS-09-1000
34 State House Station
Augusta, Maine 04333-0034

Re: Anthem Blue Cross and Blue Shield 2009 Rate Filing for HealthChoice and Lumenos Product Lines (REVISED)

Request for July 1, 2009 Effective Date without Suspension or Hearing

Dear Deputy Superintendent Cioppa:

On January 16, 2009, the Superintendent issued a Notice of Pending Proceeding and Hearing in this matter setting this matter for hearing on March 12, 2009. In its initial filing in this matter, Anthem Health Plans of Maine, Inc., d/b/a Anthem Blue Cross and Blue Shield ("Anthem BCBS") requested a May 1, 2009 effective date, but indicated that the Company would need a final decision no later than February 25, 2009 in order to meet that proposed effective date.

Given the March 12 hearing date and that the Superintendent has 30 days from the close of the evidence to issue a decision, a July 1, 2009 effective date is now more realistic. To that end, Anthem BCBS has revised the Actuarial Memorandum, Exhibits and Attachments, as applicable, to reflect a July 1, 2009 effective date. Anthem BCBS has also included additional credible experience in this revised filing including rolling forward the base experience period to reflect an additional month of paid claims and updating certain assumptions based on emerging experience. This filing includes the following enclosures: information as required by Rule Chapter 940; an Actuarial Memorandum with Exhibits I-XV; Attachments A - E and a Statement of Qualified Actuary. Also enclosed is a draft of Anthem's Notice to Members of the proposed rate increase.

The proposed average rate increase for the Anthem BCBS's HealthChoice and Lumenos products is 18.1%.

Thank you for your consideration of this rate filing.

Very truly yours,

/s/ Christopher T. Roach

Enclosures

cc: Richard H. Diamond, F.S.A., M.A.A.A., Life & Health Actuary
Christina Moylan, Esq.
Lendall Smith, Esq.

Attachment "Sent_CRoach_20090121.zip" is not a PDF document and cannot be reproduced here.

Attachment "Response to Question 9_REDACTED (W1328815).XLS" is not a PDF document and cannot be reproduced here.

Christopher T. Roach

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February 17, 2009

Mila Kofman, Superintendent
c/o Pat Galouch
Docket No. INS-09-1000
Maine Bureau of Insurance
34 State House Station
Augusta, Maine 04333-0034

Re: Anthem BCBS 2009 HealthChoice Individual Rate Filing
Filing coversheet

Dear Superintendent Kofman:

Enclosed for filing please find the following:

SUBMITTED BY: Christopher T. Roach

DATE: February 17, 2009

DOCUMENT TITLE: Anthem BCBS Response to First Information Request of the Superintendent

DOCUMENT TYPE: Response to Information Requests

CONFIDENTIAL: **No**

Thank you for your assistance in this matter.

Very truly yours,

/s/ Christopher T. Roach

cc: Thomas C. Sturtevant, Esquire
Christina M. Moylan, Esquire

NON-CONFIDENTIAL

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

IN RE:	)	
	)	
ANTHEM BLUE CROSS AND BLUE	)	
SHIELD 2009 INDIVIDUAL RATE	)	APPLICANT'S RESPONSE TO
FILING FOR HEALTHCHOICE,	)	FIRST INFORMATION REQUEST
HEALTHCHOICE STANDARD AND	)	OF THE SUPERINTENDENT
BASIC AND LUMENOS CONSUMER	)	
DIRECTED HEALTH PLAN	)	
PRODUCTS	)	February 17, 2009

Docket No. INS-09-1000

NON-CONFIDENTIAL

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

IN RE:	)	
	)	
ANTHEM BLUE CROSS AND BLUE	)	
SHIELD 2009 INDIVIDUAL RATE	)	APPLICANT'S RESPONSE TO
FILING FOR HEALTHCHOICE,	)	FIRST INFORMATION REQUEST
HEALTHCHOICE STANDARD AND	)	OF SUPERINTENDENT
BASIC AND LUMENOS CONSUMER	)	
DIRECTED HEALTH PLAN	)	
PRODUCTS	)	February 17, 2009

Docket No. INS-09-1000

Applicant Anthem Health Plans of Maine, Inc., d/b/a Anthem Blue Cross and Blue Shield ("Anthem BCBS") hereby responds to the First Information Request of the Superintendent dated February 9, 2009 as follows:

1. Questions (1)(a) - (1)(e) refer to Anthem's 12/31/2007 Annual Statement "Exhibit of Premiums, Enrollment and Utilization" (hereinafter, "PEU") and the revised 12/31/2007 and revised 12/31/2006 "Analysis of Operations by Lines of Business" (hereinafter, "OLB").

   (a) What does PEU Column 10 represent?
   (b) What does OLB Column 9 represent?
   (c) How does the $2.15M health premium written credit balance reported on the 12/31/2007 PEU Column 10 line 12 relate to the $16.06M general administrative expenses credit balance reported on the revised 12/31/2007 OLB Column 9 line 20?
   (d) What comprised the $16.06M credit balance reported on the revised 12/31/2007 OLB column 9 row 20?
   (e) What caused the 281% credit balance increase reported on the revised 12/31/2007 OLB column 9 row 20 from the revised 12/31/2006 OLB column 9 row 20?

Response:

1a. Stop Loss Premiums and Claims

1b. Stop Loss and Administrative Services Only (ASO) business

1c. The $2.15 million health premium written on PEU line 12, column 10 is shown on OLB line 1 column 9. Expenses and reimbursements for

ASO business are not reported on the PEU, but they are required to be reported on the OLB. We changed the presentation on the OLB in 2006 to reflect the ASO gain/loss. Unfortunately, the OLB does not have a column for ASO itself, so it is combined with Stop Loss in OLB column 9 (OTHER). Of the $16.06 million shown on line 20 column 9, $15.7 is the gain from ASO operations.

1d. Of the $16.06 million shown on line 20 column 10, $15.7 million is the gain from ASO operations. The difference of $.36 million represents General Administrative Expenses for Stop Loss business.

1e. As noted above, the ASO business was reflected on the OLB beginning in 2007. Excluding this balance, the comparable numbers are 88K vs. 34K.

The overall explanation is that these lines of the Annual Statement, per the instructions, include Stop Loss/ASO gains which are not relevant to Individual business.

2. Questions (2)(a) and (2)(b) refer to the "Exhibit IX" from Anthem's filing dated 01/21/2009 which described HealthChoice & Lumenos (hereinafter, "HCL") financial results and the "Statement of Revenue and Expenses" from various Annual Statements.

   (a) The Bureau considered the data presented on "Exhibit IX". Specifically, HCL Total Expense and Member Month data were analyzed. A ratio, hereinafter, "TEMM" was calculated by dividing "Total Expense" by "Member Months". As such, why did TEMM increase from $15.45 in 2000 to $30.67 in 2008?

   (b) The Bureau considered the HCL TEMM measurements and attempted to compare them to Anthem's Annual Statement results. The Bureau considered AHPM TEMM to be "Claims adjustment expenses" plus "General administration expenses", the sum of which divided by Member Months (lines 20, 21 and 1 of the "Statement of Revenue and Expenses," respectively, from several Annual Statements). As such, please consider the following results:

Total Expense per Member Month (TEMM)

	2004	2005	2006	2007
HCL	$27.39	$27.31	$3595	$30.26
AHPM	$2405	$25.67	$24 29	$19.50

Please explain why the HCL measure, as indicated in the aforementioned table, appears to exceed the AHPM measure in each year presented. Please explain the trends with special attention paid to the 2006 and 2007 results.

Response: 2a. Allocation system issues in 2000 and 2001 resulted in an understatement of costs allocated to the individual line. In addition, Anthem BCBS implemented an administrative expense allocation system in late 2003. Prior to implementation of that system, as reflected in its rate filings, Anthem BCBS used the administrative expenses from its group business as a proxy for the individual products. As such, comparing the pre-2004 to post-2004 period is not altogether meaningful. Beginning in 2004, the allocation system has been more consistent. That said, the previous submission (Exhibit IX) had a mistaken administrative expense amount for 2006 which did not reflect the adjustments approved by the Superintendent in the 2006 HealthChoice proceeding. The attached file has the corrected figure, which yields a 2006 TEMM of $31.81 (instead of $35.95). Comparing administrative figures for 2002 - 2008, the increase in administrative expenses has been primarily due to increases in commissions PMPM, premium tax PMPM, and SOP, while general administrative expense PMPM has generally remained flat, and declined in 2007. The attached file "Response to Superintendent Questions 2 and 12.xls" calculates PMPMs for the four relevant HCL categories which are included in Exhibit IX.

2b. The Annual statement (AHPM) and HCL are not directly comparable. A significant difference is that SOP is included in admin for the HCL but in claims for the Annual Statement. Additionally, the Annual statement includes more business in Individual than HealthChoice and Lumenos; for example, it includes Dirigo. The attached file "Response to Superintendent Questions 2 and 12.xls" provides PMPMs for the relevant HCL categories. One can see that the SOP and premium tax are a major portion of the expense.

3. Why did Anthem not propose any change in Lumenos rates last year?

Response: Lumenos was introduced into the Maine market effective January 1, 2007. In mid-2007 when Anthem was preparing our 2008 HealthChoice rate filing, the Lumenos experience was very new and not yet credible. We only had 6 months of claims to review and just over 200 members in the product. We now have a larger population and credible experience that reflects that a rate adjustment is necessary.

4. Page 5 of the filing states the anticipated loss ratio for calendar year 2009. However, the rates are intended to be in effect from 7/1/09 through 6/30/10. What is the anticipated loss ratio for the rating period?

Response: The anticipated loss ratio for the rating period is 87.7% as supported in Revised Exhibit IX in the attached file "Response to Superintendent Questions 2 and 12.xls."

5. In last year's HealthChoice rate proceeding, in its closing statement dated October 26, 2007, Anthem described a methodology for rating those 65 and older in a way that is consistent with rule 940 and stated its intent to use this methodology in a future filing. The current filing does not use this methodology but instead continues to use the 55-64 rates for those 65 and older. Please explain why Anthem decided against using the new methodology.

Response: Anthem has been unable to implement the proposed rating methodology due to system constraints. We are only allowed to charge the higher rate (1.5 factor) for new enrollees and not those contracts that have been grandfathered at the current 1.2 factor. Anthem has not been able to implement the system changes that would be required in order to charge different people that are the same age enrolled in the same product different rates. The Superintendent has approved Anthem's proposed rates for those members who are 65 and over, but we are unable to implement the approved rates due to this constraint.

Anthem continues to request the approval of the 1.5 factor for the 65 and older contracts for the HealthChoice products. We still plan to implement this rate change at some time in the future.

6. With regard to combining the HealthChoice and Lumenos pools, the filing states, "combining the pools is also in keeping with the intent of Maine pooling and Rule 940 requirements that seek to share the risk of the entire pool across all members." However, Anthem continues to rate the mandated plans separately by applying a factor of 1.5. Please explain why the same logic leading to combining the HealthChoice and Lumenos pools would not also apply to the mandated plans.

Response: The experience for the HealthChoice non-mandated and mandated plan designs have been treated as one pool in this and prior HealthChoice filings. The mandated plan designs had only 147 members as of December 2008 and in our actuarial judgment continue to lack credible experience to merit a separate review. The 1.5 factor applied to the mandated HealthChoice plans represents a utilization based adjustment to reflect the lower average deductible levels and differences in experience between the non-mandated plans and the mandated plans.

Using the summarized experience on Exhibit II, the claim cost during the experience period was $371.90 PCPM for the non-mandated options and $823.28 PCPM for the mandated HealthChoice options excluding Lumenos. This experience indicates that the factor of 1.5 is insufficient to address the difference in utilization between the non-mandated and mandated options. As such, if the Superintendent continues the 1.5 factor cap, Anthem will continue to subsidize the mandated options with

the experience of the non-mandated options.

We have treated Lumenos in a consistent manner as the mandated and non-mandated HealthChoice options by reviewing the combined experience of the pool and then applying a utilization based factor to the premium rates.

7. Page 9 of the filing lists three benefit differences as the basis for the rate differential of -2.5% between the Lumenos $5000 HSA option and the HealthChoice $5000 deductible: (1) Out-of-network coinsurance (20% member share); (2) Annual limit for pharmacy benefit; and (3) Enhanced preventive care benefits.

   (a) Please provide the specific rate impact of each of these three items and the basis for Anthem's determination of those impacts.
   (b) Please explain more fully how the out-of-network coinsurance provisions differ between these products.
   (c) In correspondence on the initial Lumenos rate filing, Anthem stated that the $2,000 calendar year pharmacy limit would not be administered. Is that still the case?

Response:

7a. A review of the original pricing documentation from the October 2006 filing shows the following claim cost differences were assumed and the following pricing was implemented effective 1/1/2007.

Lumenos H.S.A. $5000 Deductible Pricing	Claim Cost Difference PMPM	Claim Cost Cumulative Change
from HealthChoice $5000 with PCSA Rider		
OON Change	-0.4%	-0.4%
Pharmacy benefit	-1.5%	-1.9%
Preventive Benefit Enhancements	+2.6%	+0.6%
Cost Adjustment for % Increase of Adult Contracts	-3.4%	-2.8%
Utilization Adjustment for $5000 Deductible and Up	-6.0%	**-8.6%**

Premium Effective 1/1/2007 for a Single Contract Age 40-44	Premium PCPM	Premium Rate Difference
Lumenos HSA $5,000	$271.98	
HealthChoice $5000	$279.08	-2.5%
HealthChoice $5000 with PCSA Rider	$298.94	**-9.0%**

An internal model based on Milliman Health Cost Guidelines data was used to value each difference in benefits. The premium rate differential as of 1/1/2007 between the Lumenos H.S.A. $5000 Deductible and the HealthChoice $5000 Deductible with PCSA rider was 9.0% which is only slightly more than the underlying claim cost difference of 8.6%.

The 2.5% difference to the HealthChoice $5000 Deductible without the

PCSA Rider was used in the 2009 filing because the benefits included in the Preventive Rider for HealthChoice have changed dramatically effective 1/1/2009 and the 9.0% rate differential no longer applies.

7b. The HealthChoice OON coinsurance amount is 0% member cost share after deductible. For Lumenos H.S.A. OON coinsurance amount is 20% member cost share after deductible.

7c. A $2,000 calendar year pharmacy limit is not administered for Lumenos products.

8. On page 12 of the filing, under the heading "Proposed Change in Pharmacy Benefits," Anthem discusses a change implemented effective January 1, 2008, but docs not mention any proposed changes. Please clarify whether further changes are proposed.

Response: No additional changes are proposed since the January 1, 2008 benefit change. This section is mislabeled and should read simply "Change in Pharmacy Benefits." The section is meant to address the continued savings estimates from the 1/1/2008 benefit change that was implemented.

9. Pages 12-13 of the filing discuss an adjustment made due to migration of two high-cost claimants into the Health Choice pool. Were there any high-cost claimants in the Health-Choice pool during the experience period who have since lapsed or died? If so, should an adjustment be made to reflect this?

Response: Out of the members that had claims in excess of $100,000 for the 12 months ending October 2008, 5 of the 70 members have lapsed as of year-end 2008. We are unable to track members that have died in our data warehouses.

In order to maintain consistency, we have not attempted to reflect persistent business only (non-lapsing) in either the claims in excess of $100,000 or the underlying claims experience. When calculating an appropriate pooling charge, we review the total claims for each rolling 12 month period for all members that were active during that period.

We have added the cost of the migrating members in separately due to the extremely high claim volume that both members have had in the past and will continue to have going forward. These members have claims experience that is exceptional in the sense that it does not represent normal levels of high-cost claimants in our HealthChoice and Lumenos pool. Further, there is some certainty that these members are high

claimants rather than the randomness of high claim status exhibited by a block of policies or other new entrants.

As shown in Exhibit XV, our high-cost claimant experience has actually been very steady as a percentage of the total claims excluding claimants in excess of $100,000. The high level of claim cost experience by both migrating members is not reflected in the underlying high-cost claimant experience and we anticipate that future levels of high-cost claimant activity will be affected by the entry of these two members into the pool.

10. Page 13 of the filing states, "The impact of the shifting enrollment has lessened over time as the percentage of members in the higher deductible options has stabilized." Page 16 states, "The analysis indicated that overall, deductible mix had an impact of less than 1% for rolling 12-month periods through mid 2006, but in the following periods the impact had ramped up until mid 2007 when trends were suppressed by 4% or more due to deductible mix." Please explain how both statements can be true.

Response: For the reasons that follow, these statements do not contradict each other. On page 13, the entire paragraph reads:

> "The distribution of enrollment across benefit options has changed over time with a shift toward higher member cost sharing levels and the new Lumenos products. The impact of the shifting enrollment has lessened over time as the percentage of members in the higher deductible options has stabilized. However, enrollment projections still assume an increase in the average member cost sharing level and the impact of this shift on claims needs to be reflected in order to accurately project future claims."

As stated, enrollment projections still assume an increase in the average member cost sharing level. However, our projections reflect that this overall cost sharing increase has a decreasing impact on projected claim costs due to shifts in enrollment, also known as benefit buy-downs. The calculated benefit buy-down is .945 for the total HealthChoice and Lumenos block or .934 for HealthChoice alone in the 2009 filing. In the 2008 filing, the calculated level of benefit buy-downs was .926. The impact on projected claim cost for HealthChoice in 2009 is -6.6% (1 - .934) and in 2008 was -7.4% (1 - .926) such that the calculated level of benefit buy-downs is decreasing. In summary, while members continue to shift to higher deductibles and are projected to do so into 2008, the impact on projected claim costs has lessened over time.

The statement on page 16 reads:

> "The impact of changing deductible mix was measured for each rolling 12-month period by comparing the actual trend for all deductible levels combined to an adjusted trend based on holding

membership constant at the membership in effect during the base year. The analysis indicated that overall, deductible mix had an impact of less than 1% for rolling 12-month periods through mid 2006, but in the following periods the impact had ramped up until mid 2007 when trends were suppressed by 4% or more due to deductible mix. This impact continues to be prevalent in the year-to-date experience for 2008."

As stated above, Anthem continues to project membership shifts to higher deductible plan options. This change in deductible mix is causing observed claim cost trends to be suppressed by 4% or more. As members continue to shift to higher deductible levels at a steady rate, similarly to the change in the level of benefit buy-downs, Anthem projects that the suppression in claim cost trends will level off and the impact should decrease from the current level of 4%.

11. Page 16 of the filing states that the allowed cost trends were based on (1) data from provider contracting representatives, (2) a review of long term reimbursement contract provisions, and (3) data from NextRx, coupled with observations of actual data. Please explain the impact of each of these three factors.

Response: Anthem BCBS has analyzed observed historical claim data patterns for both the cost and utilization of services rendered to HealthChoice members in hospitals, by physicians, and through the purchase of prescription drugs. Along with the analysis of historical patterns, we gather information from Anthem BCBS associates responsible for contracting with providers of healthcare. From this data, we produce an estimate of the expected changes in what Anthem BCBS will pay providers for the services they provide to HealthChoice members. Anthem BCBS then accounts for changes in the mix of services rendered and the impact of deductible leveraging in order to determine a trend which is applied to current claim costs to estimate what claim costs will be during the time when the proposed premiums will be available to pay these claims.

The following comments provide additional detail into the components of allowed cost trend discussed above:

(1) Contracting increases are up for inpatient, outpatient and professional claims compared to the average increases seen going back to 2006. The impact of mix of services is expected to remain relatively flat for outpatient and professional claims compared to recent historical averages. The projected impact of inpatient mix of services is having a beneficial effect on pricing trends compared to the average mix seen over the last several years.

(2) The estimated increase in what Anthem BCBS will pay

providers for the services they provide to HealthChoice members has gone up compared to the average contracting increases inherent in the last several years of observed claims data.
(3) Projected pharmacy cost trends are higher than the average observed cost trends over the last several years. Pharmacy cost trends in recent years have been held down by significant increases in the generic dispensing rate. Although the generic dispensing rate is expected to continue to increase, it is not expected to increase at the same rate as it has over the last few years.

12. Exhibits IX and X of the filing shows projections of financial performance for calendar years 2008 and 2009. Please provide a split of the 2009 column between the first half of the year (prior to the proposed increase) and the second half. Please also provide projections for the first half of 2010 and a column combining the second half of 2009 and the first half of 2010 to include the entire rating period.

Response: See revised Exhibit IX in the attached file "Response to Superintendent Question 2 and 12.xls." Note that while adding the detail requested, Anthem updated some of the calculations used to estimate calendar year 2009 components in an attempt to better reflect projected results.

13. Please provide a copy of the Preventive Care and Supplemental Accident Rider.

Response: See attached "Response 13 HealthChoice Prev Care Amendment Benefit.pdf" for details of the PCSA Rider benefits.

DATED: February 17, 2009

/s/ Christopher T. Roach
Christopher T. Roach, Esq.

PIERCE ATWOOD LLP
One Monument Square
Portland, Maine 04101
Attorney for Applicant

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

IN RE:	)	
ANTHEM BLUE CROSS AND BLUE SHIELD 2009 INDIVIDUAL RATE FILING FOR HEALTHCHOICE, HEALTHCHOICE STANDARD AND BASIC AND LUMENOS CONSUMER DIRECTED HEALTH PLAN PRODUCTS	)	**CERTIFICATE OF SERVICE**
Docket No. INS-09-1000	)	

The undersigned counsel 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 Applicant's Response to the First Informational Request of the Superintendent upon the persons and at the addresses indicated below.

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DATED: February 17, 2009

/s/ Christopher T. Roach
Christopher T. Roach, Esq.

PIERCE ATWOOD LLP
One Monument Square
Portland, Maine 04101
Attorney for Applicant

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

IN RE:	)	
	)	
ANTHEM BLUE CROSS AND BLUE SHIELD 2009 INDIVIDUAL RATE FILING FOR HEALTHCHOICE, HEALTHCHOICE STANDARD AND BASIC, AND LUMENOS CONSUMER DIRECTED HEALTH PLAN PRODUCTS	)	UPDATE REGARDING ANTHEM REVISED RATE INCREASE REQUEST
	)	
Docket No. INS-09-1000	)	

On January 16, 2009, I issued a Notice of Pending Proceeding and Hearing in the above-captioned matter. That Notice set a public hearing on Anthem's filing at 9:00 a.m. on March 12, 2009, in the Central Conference Room, Department of Professional and Financial Regulation, Gardiner Annex, 122 Northern Avenue, Gardiner, Maine. In addition to at the March 12th hearing, Anthem policyholders and other members of the public may provide comments for my consideration at public input sessions that I am holding at the following times and places:

Orono: March 3, 2009, beginning at 5:30 p.m.
Room 3, Wells Conference Center
University of Maine
Orono, Maine

Portland: March 10, 2009, beginning at 5:00 p.m.
Talbot Lecture Hall
Luther Bonney Hall
University of Southern Maine
Portland, Maine

Comments may also be provided for my consideration in this matter as follows:

By email: Pat.Galouch@maine.gov

By mail: Superintendent of Insurance
Attn: Pat Galouch (INS-09-1000)
34 State House Station
Augusta, Maine 04333

In the Notice I also set the intervention deadline at February 3, 2009, and the Maine Attorney General has petitioned for and been granted intervenor status as of right. Anthem and the Attorney General are the only parties to the proceeding.

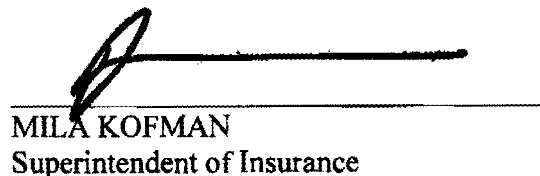
Subsequent to my Notice, on January 21, 2009 Anthem revised its filing for its HealthChoice, HealthChoice Standard and Basic, and Lumenos Consumer Directed Health Plan products. Anthem's initial filing and its revised filing are described below. As of November 2008 there are 12,049 policyholders who will be affected by Anthem's proposed rate revisions.

Initial Anthem Filing

As identified in my Notice, Anthem initially proposed revised rates for the identified products that it asserted would produce an average increase of 14.5%. As identified in its filing, the largest premium increase depending on deductible level and type of contract for HealthChoice is17.2%, for HealthChoice Standard and Basic is 7.7%, and for Lumenos is 34.1%. Anthem initially requested that these rate revisions become effective on May 1, 2009.

Revised Anthem Filing

As explained in Anthem's January 21st revised filing, given the March 12th hearing date and that the Superintendent has 30 days from the close of the evidence to issue a decision, a July 1, 2009 rate effective date appears more realistic (as opposed to its initial requested May 1, 2009). Accordingly, Anthem revised its actuarial analysis with updated data and reflecting a July 1, 2009 effective date. Based on its revised analysis, Anthem now requests approval of revised rates with an average increase of 18.1%. As identified in its revised filing, the largest premium increase depending on deductible level and type of contract for HealthChoice is 23.6%, for HealthChoice Standard and Basic is 9.5%, and for Lumenos is 37.8%. Anthem requests that its revised rate filing become effective on July 1, 2009.



February 25, 2009

MILA KOFMAN
Superintendent of Insurance

Christopher T. Roach

One Monument Square
Portland, ME 04101

207-791-1373 voice
207-791-1350 fax
croach@pierceatwood.com

pierceatwood.com

March 5, 2009

Mila Kofman, Superintendent
c/o Pat Galouch
Docket No. INS-09-1000
Maine Bureau of Insurance
34 State House Station
Augusta, Maine 04333-0034

Re: *Anthem BCBS 2009 HealthChoice Individual Rate Filing*
Filing coversheet

Dear Superintendent Kofman:

Enclosed for filing please find the following:

SUBMITTED BY: Christopher T. Roach

DATE: March 5, 2009

DOCUMENT TITLE: Anthem BCBS Response to Second Information Request of the Superintendent

DOCUMENT TYPE: Response to Information Requests

CONFIDENTIAL: **No**

Thank you for your assistance in this matter.

Very truly yours,

/s/ Christopher T. Roach

cc: Thomas C. Sturtevant, Esquire
Christina M. Moylan, Esquire

{W1320308.1}

NON-CONFIDENTIAL

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

IN RE:	)	
	)	
ANTHEM BLUE CROSS AND BLUE	)	
SHIELD 2009 INDIVIDUAL RATE	)	APPLICANT'S RESPONSE TO
FILING FOR HEALTHCHOICE,	)	SECOND INFORMATION
HEALTHCHOICE STANDARD AND	)	REQUEST OF THE
BASIC AND LUMENOS CONSUMER	)	SUPERINTENDENT
DIRECTED HEALTH PLAN	)	
PRODUCTS	)	
		March 5, 2009
Docket No. INS-09-1000		

NON-CONFIDENTIAL

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

IN RE:	)	
	)	
ANTHEM BLUE CROSS AND BLUE	)	
SHIELD 2009 INDIVIDUAL RATE	)	APPLICANT'S RESPONSE TO
FILING FOR HEALTHCHOICE,	)	SECOND INFORMATION
HEALTHCHOICE STANDARD AND	)	REQUEST OF SUPERINTENDENT
BASIC AND LUMENOS CONSUMER	)	
DIRECTED HEALTH PLAN	)	
PRODUCTS	)	March 5, 2009

Docket No. INS-09-1000

Applicant Anthem Health Plans of Maine, Inc., d/b/a Anthem Blue Cross and Blue Shield ("Anthem BCBS") hereby responds to the Second Information Request of the Superintendent dated and received February 27, 2009 as follows:

1. Anthem's response to item 3 of the First Information Request of the Superintendent states that Anthem did not propose any change in Lumenos rates last year because the experience was new and not yet credible. Did Anthem consider an increase based on trends in other products or general health care cost trends? If not, why?

Response: At the time of the 2008 HealthChoice filing in mid-2007, the Lumenos product was running a loss ratio lower than the required minimum 65% (for the first six months of 2007). Anthem BCBS expected that a trend increase would not be approved based on this early experience.

2. For each of the five members referred to in Anthem's response to item 9 of the First Information Request of the Superintendent, please provide the amount of claims paid for the 12 months ending October 2008 and for the 12 months ending October 2007.

Response:

	Total Paid Claims	
Member	200611-200710	200711-200810
A	$31,684	$102,651
B	$133,964	$177,981
C	$0	$119,626
D	$32,305	$102,196
E	$0	$173,496

3. With regard to the factors discussed in Anthem's response to item 11 of the First Information Request of the Superintendent, how was the impact of each factor quantified in adjusting the historical trends? Was the net result a higher or lower trend than would have been projected based only on historical data?

Response: Anthem BCBS projects two separate components of cost trends: the impact of changes in contractual arrangements with providers, and the impact of changes in mix of services. The projected annual impact of contracting increases is obtained from Anthem BCBS associates responsible for negotiating contracts with providers and reflects the impact of actual contractual increases for providers with whom that information has been finalized, along with expected contractual increases for providers with whom contracts have not yet been finalized. Mix of service projections are based on an examination of historical mix in the observed trend data adjusted to reflect any anticipated changes in that mix. As projected contracting increases are higher than they were on average during the period for which we have observed trend data, medical cost trend projections are higher than they would have been had they been based only on historical data. The impact of mix of services is expected to remain relatively flat for outpatient and professional claims compared to recent historical averages. The projected impact of inpatient mix of services is having a beneficial effect on pricing trends compared to the average mix seen over the last several years.

4. In Anthem's response to item 12 of the First Information Request of the Superintendent, how are projected claims allocated between the two halves of 2009? How are trend and seasonality accounted for in this calculation?

Response: Based on Exhibit V claims experience, the January to June claims experience is approximately 88% of the full year PMPM. 88% is an average of the 2007 and 2008 claims experience. The following table supports the 88% assumption:

PMPM	2007	2008	Average
Jan to June	$180.19	$191.58	
Total	$198.90	$222.90	
Ratio	90.6%	85.9%	**88%**

Trend and seasonality are accounted for in this assumption since it is based on a review of unadjusted claims experience.

5. Anthem's response to item 1b of the Attorney General's First Information Request indicates that colorectal cancer screenings are covered under the Preventive Care and Supplemental Accident (PCSA) rider. Please explain where this benefit is specified in

the copy of the rider provided in response to item 13 of the First Information Request of the Superintendent.

Response: This benefit is covered in the Endorsement to the rider. Please see the attached file "Superintendent2_Question5_ Endorsement_Colonoscopy.pdf"

6. Anthem's response to item 27a of the Attorney General's First Information Request states that the $506 calculation is based on a $200 deductible difference between the $2,000 and $2,250 plans and should be $250. That analysis appears to reflect only the difference in deductibles and not the difference in coinsurance provisions. Considering the 20% coinsurance on the $2,000 plan, is there any way the benefit under the $2,000 plan could exceed that under the $2,250 plan by more than $200?

Response: We have reviewed the plan design difference and the original $200 difference was correct due to the coinsurance effect discussed above. This amount is not applied in any other calculations and does not impact the requested increase or the premium rates for each product.

7. Please provide a copy of the HealthChoice contract.

Response: Please see the attached files "Superintendent2_Question7_HealthChoice_Contract_Base.pdf", "Superintendent2_Question7_HealthChoice_Amendment.pdf", and "Superintendent2_Question7_HealthChoice_Dependents.pdf"

DATED: March 5, 2009

/s/ Christopher T. Roach
Christopher T. Roach, Esq.

PIERCE ATWOOD LLP
One Monument Square
Portland, Maine 04101
Attorney for Applicant

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

IN RE:	)	
ANTHEM BLUE CROSS AND BLUE SHIELD 2009 INDIVIDUAL RATE FILING FOR HEALTHCHOICE, HEALTHCHOICE STANDARD AND BASIC AND LUMENOS CONSUMER DIRECTED HEALTH PLAN PRODUCTS	)	**CERTIFICATE OF SERVICE**
Docket No. INS-09-1000	)	

The undersigned counsel 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 Applicant's Response to the Second Information Request of the Superintendent upon the persons and at the addresses indicated below.

Thomas C. Sturtevant, Jr., Assistant Attorney General
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[e-mail and hand delivery]

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DATED: March 5, 2009

/s/ Christopher T. Roach
Christopher T. Roach, Esq.

PIERCE ATWOOD LLP
One Monument Square
Portland, Maine 04101
Attorney for Applicant

In Maine, Anthem Blue Cross and Blue Shield is a trade name of Anthem Health Plans of Maine, Inc., an independent licensee of the Blue Cross and Blue Shield Association
® Registered marks of the Blue Cross and Blue Shield Association

Amendment to HealthChoice Individual Certificate of Coverage

Your Anthem Blue Cross and Blue Shield HealthChoice Individual Certificate of Coverage (028645, 028645A, 028645B) is changed as stated in this amendment. This amendment replaces any previous version of the HealthChoice amendment (5772ME) you may have received.

The "Introduction" section is changed by deleting the "Paying Subscription Charges and Renewal" provision and replacing it with the following:

Paying Subscription Charges and Renewal

Paying your HealthChoice Subscription Charges.

When choosing to purchase HealthChoice, you may elect to be billed for your subscription charges monthly or quarterly. Payment for subscription charges is due the first day of each month, or the first day of each quarter of coverage. You have a grace period of 31 days to pay the subscription charges, during which you will not experience a lapse in coverage. If payment is not received within 31 days of the due date, coverage may be cancelled at the expiration of the grace period. We reserve the right to take necessary action to collect subscription charges for the grace period. We reserve the right to unilaterally modify the terms of the Contract consistent with state and federal laws.

Renewing your HealthChoice Coverage.

When you pay your HealthChoice subscription charges, as described above, your coverage renews. Periodically, your subscription charges may change, subject to approval by the Bureau of Insurance. When this occurs, you will receive written notification from us, advising you of the new subscription charges and the effective date the change will occur. The change in your subscription charges will appear on your next bill. It is important to note that if you pay your subscription charges quarterly and the effective date for the change has already been billed to you, the additional subscription charges due for that quarter will be included on your next quarterly bill.

The "Eligibility, Termination and Continuation of Coverage" section is changed as follows:

The "Paying Subscription Charges" provision is deleted and replaced with the following:

Paying your HealthChoice Subscription Charges.

When choosing to purchase HealthChoice, you may elect to be billed for your subscription charges monthly or quarterly. Payment for subscription charges is due the first day of each month, or the first day of each quarter of coverage. You have a grace period of 31 days to pay the subscription charges, during which you will not experience a lapse in coverage. If payment is not received within 31 days of the due date, coverage may be cancelled at the expiration of the grace period. We reserve the right to take necessary action to collect subscription charges for the grace period. We reserve the right to unilaterally modify the terms of the Contract consistent with state and federal laws.

Renewing your HealthChoice Coverage.

When you pay your HealthChoice subscription charges, as described above, your coverage renews. Periodically, you subscription charges may change, subject to approval by the Bureau of Insurance. When this occurs, you will receive written notification from us, advising you of the new subscription charges and the effective date the change will occur. The change in your subscription charges will appear on your next bill. It is important to note that if you pay your subscription charges quarterly and the effective date for the change has already been billed to you, the additional subscription charges due for that quarter will be included on your next quarterly bill.

The "Eligibility, Termination and Continuation of Coverage" section is changed as follows:

The "Membership Additions" subsection is changed by deleting the third paragraph and replacing it with the following:

> Family members who are eligible because of birth, adoption, marriage, court order, or dependent losing eligibility under the other coverage after the Subscriber's effective date of coverage may be added as follows:
>
> **Dependent Losing Eligibility Under Other Coverage** When a dependent with other coverage loses that coverage, if we receive the application for change:
>
> - **Within 31 days of the date the dependent loses coverage,** coverage will begin on the date of application for enrollment.
> - **After 31 days from the date of the court order,** coverage will begin on the Group's next annual Late Enroll Enrollment Period.
>
> If the eligible individual is not already enrolled or is enrolled in a different benefit package, the individual may enroll during this period.

The "Pre-existing Condition Limitation" subsection is changed by adding the following:

An individual seeking to reduce or eliminate a Pre-existing Condition limitation period based on his/her prior Creditable Coverage may do so by providing a Certificate of Creditable Coverage or proof of prior coverage to us. We will assist in obtaining a certificate from any prior plan or issuer, if necessary.

The "Pre-existing Conditions Limitation" subsection is further changed by adding the following:

> For the purpose of identifying a pre-existing condition, claims submitted with a total provider charge under $1,000 (the threshold), are generally not subject to review. Any claim(s) submitted in excess of the threshold, for members with pre-existing condition exclusions, may be reviewed to determine if the condition is pre-existing. Once a pre-existing condition has been established, all subsequent claims, regardless of provider charge amount, may be subject to review. As Anthem may apply a threshold in its claims review, the payment of claims with a charge amount below the threshold should not be relied upon as a representation that future claims related to the condition will be paid.

The "Termination of Coverage" section is changed by adding the following to the "Cancellation of the Member's Contract" subsection:

No Longer Residing or Working in Maine Your coverage will end if you no longer reside or work in Maine for at least 6 months per year. You must notify us if you fail to reside or work in Maine for at least 6 months per year.

The "Covered Services" section is changed as follows:

The "Dental Services" provision is changed by deleting the last two bullets and replacing them with the following:

- Treatment within six months of an accidental injury to repair or replace natural teeth or within six months of the effective date of coverage, whichever is later
- Repairing or replacing dental prostheses caused by an accidental bodily injury within six months of the injury or within six months of the effective date of coverage, whichever is later.

"Hearing Care" is added by including the following:

Hearing Care We provide benefits for wearable hearing aids for covered Members up to age 18.

Coverage is limited to $1,400 per hearing aid for each hearing-impaired ear every 36 months. Related items such as batteries, cords, and other assistive listening devices, including but not limited to, frequency modulation systems, are not covered. A hearing aid is defined as a wearable instrument or device designed for the ear and offered for the purpose of aiding or compensating for impaired human hearing.

The "Home Health Care Services" provision is changed by adding the following:

Home health care visits are limited to 90 visits per calendar year.

"Infant Formula" provision is added by including the following:

Infant Formula We provide Benefits for Medically Necessary Amino Acid-based elemental Infant Formula for children 2 years of age and under. Benefits are provided when a licensed physician has diagnosed and through medical evaluation has documented one of the following conditions:

- Symptomatic allergic colitis or proctitis;
- Laboratory – or biopsy-proven allergic or eosinophilic gastroenteritis;
- A history of anaphylaxis'
- Gastroesophageal reflux disease that is nonresponsive to standard medical therapies;
- Severe vomiting or diarrhea resulting in clinically significant dehydration requiring treatment by medical provider;
- Cystic fibrosis; or
- Malabsorption of cow milk-based or soy milk-based infant formula.

Benefits for amino acid-based elemental infant formula are provided when a licensed physician has submitted documentation that the amino acid-based elemental infant formula is medically necessary health care as defined in section 4301-A subsection 10-A, that the amino acid based elemental infant formula is the predominant source of nutritional intake at a rate of 50% or greater and that other commercial infant formulas, including cow milk-based and soy milk-based formulas have been tried and have failed or are contraindicated. A licensed physician may be required to confirm and document ongoing Medical Necessity at least annually.

Coverage for amino acid-based elemental infant formula must be provided without regard to the method of delivery of the formula.

Prior Authorization is required. Please see the "Utilization Management" section of this document for more information.

The "Inpatient Hospital Services" provision is changed by adding the following to the first bullet:

Benefits are provided for up to a maximum of 365 days per inpatient stay, excluding mental health and substance abuse services.

The "Outpatient Services" provision is changed by deleting the following:

- Outpatient educational programs such as asthma education and diabetes education. Please check with us to see if you are eligible for Benefits.

and replacing it with the following:

- Outpatient educational programs such as diabetes education. Please check with us to see if you are eligible for Benefits.

Benefits for outpatient rehabilitation programs and outpatient educational programs have a combined lifetime limit of $2,500.

The "Preventive and Well-Care Services" provision is changed by deleting the third bullet under the Well-adult care paragraph and replacing it with the following:

- Annual gynecological examinations, including routine pelvic and clinical breast examinations performed by a physician, certified nurse practitioner or certified nurse midwife;

The "Preventive and Well-Care Services" subsection is changed with the addition of the following language under "Well Adult Care:

- Colorectal cancer screening

The "Preventive and Well-Care Services" subsection is changed with the addition of the following Note at the end of the subsection.

> Note: Screenings and other services are generally covered as Preventive Care for adults and children with no current symptoms or prior history of a medical condition associated with that screening or service. Members who have current symptoms or have been diagnosed with a medical condition are not considered to require Preventive Care for that condition but instead benefits will be considered under the Diagnostic Services benefit and subject to the coinsurance and /or deductible applicable to your plan.

The "Reconstructive Services" provision is changed by deleting the following:

Reconstructive Services We provide Benefits for reconstructive services, unless otherwise excluded in this Contract, to improve or restore bodily function or to correct deformity resulting from disease, trauma, or previous therapeutic process, or for congenital or developmental anomalies. Benefits are provided only when there is a functional impairment. Benefits will be provided for reconstruction of a breast on which mastectomy surgery has been performed and for surgery and reconstruction of the other breast to produce a symmetrical appearance when the mastectomy is for the treatment of breast cancer.

and replacing it with the following:

Reconstructive Surgeries, Procedures and Services Benefits are available for reconstructive surgeries, procedures and services, when considered to be Medically Necessary Health Care, only if at least one of the following criteria is met. Reconstructive surgeries, procedures and services must be:
necessary due to accidental injury; or
necessary for reconstruction or restoration of a functional part of the body following a covered surgical procedure for disease or injury; or
Medically Necessary Health Care to restore or improve a bodily function, or
necessary to correct a birth defect for covered dependent children who have functional physical deficits due to the birth defect. Corrective surgery for children who do not have functional physical deficits due to the birth defect is not covered under any portion of this Certificate
for reconstruction of a breast on which mastectomy surgery has been performed and for surgery and reconstruction of the other breast to produce a symmetrical appearance when the mastectomy is for the treatment of breast cancer.

Reconstructive surgeries, procedures and services that do not meet at least one of the above criteria are not covered under any portion of this Certificate.

In addition to the above criteria, benefits are available for certain reconstructive surgeries, procedures and services subject to Anthem Medical Policy coverage criteria. Some examples of reconstructive surgeries, procedures and services eligible for consideration based on Anthem Medical Policy coverage criteria are:

Mastectomy for Gynecomastia
Mandibular/Maxillary orthognathic surgery
Adjustable Band for Treatment of Non-synostotic plagiocephaly and Brachycephaly in infants
Port Wine Stain surgery

The "Surgical Services" provision is deleted in its entirety and replaced with the following:

Surgical Services
Benefits are provided for covered surgical procedures, including services of a surgeon, specialist, anesthetist or anesthesiologist, and for preoperative and postoperative care.

For covered surgeries, services of surgical assistants are payable as a surgery benefit if included on the list of payable Anthem surgical assistant codes. If you have questions about your surgical procedure, please contact your physician or Customer Service.

The "Exclusions" section is changed as follows:

The "Hearing Care" exclusion is deleted in its entirety and replaced with the following:

Hearing Care We do not provide Benefits for hearing examinations except when related to injury or disease. Please see Hearing Care in the Covered Services section for benefits for hearing aids.

The "Medicare" exclusion is changed by deleting the references to Medicare Part D and replacing it with the language in your Certificate of Coverage which reads as follows:

Medicare We may not provide Benefits in situations where Medicare would have primary liability for health care costs under federal Medicare Secondary Payor regulations. If you are enrolled in Medicare Part A and/or Part B, and Medicare is the primary payor, we may provide Benefits only for balances remaining after Medicare has made payment. If you are eligible for premium free Medicare Part A, and Medicare would be the primary payor, we may pay Benefits as if Medicare had made their primary payments for Medicare Part A and/or Part B, even if you fail to exercise your right to premium free Medicare Part A coverage.

The "Orthognathic Surgery" exclusion is deleted in its entirety and replaced with the following:

Orthognathic Surgery We do not provide Benefits for Orthognathic Surgery, except as stated in the Covered Services Reconstructive Surgeries, Procedures and Services section.

The "Benefit Determinations, Payments and Appeals" section is changed as follows:

The "Provider and Professional Payment Methods" subsection is deleted and replaced with the following:

Provider and Professional Payment Methods
When a Network Professional renders a Covered Service, the payment for the service is based on a Maximum Allowance agreed to by him or her. In addition to the Maximum Allowance, an eligible Network Professional can receive additional payments if he or she has met certain quality standards.

Payment will be based *on* the most cost effective means that can safely be administered. You can contact us to find out the Maximum Allowance agreed to by him or her. In addition to the Maximum Allowance, an eligible Network Professional can receive additional payments if he or she has met certain quality standards.

Payment will be based on the most cost effective means that can safely be administered. You can contact us to find out the Maximum Allowance for a service by calling the telephone number on your ID card; the Maximum Allowance is calculated by various methodologies.

Network Providers are paid in several different ways, including but not limited to Discounts from regular charges and fixed fees agreed to by them.

The "Special Information If You Become Eligible for Medicare" subsection is changed by deleting the references to Medicare Part D and replacing it with the language in your Certificate of Coverage which reads as follows:

Special Information If You Become Eligible For Medicare

You must notify us if you become eligible for premium free Medicare Part A. Failure to notify us could result in retroactive benefit adjustments if Medicare would have been or is the primary payor. You may choose to continue your coverage once you are eligible for premium free Medicare Part A and Medicare Part B coverage. However, your contract will not provide benefits that duplicate any benefits payable under Medicare Part A or Part B. This is true even if you fail to exercise your rights to premium free Medicare Part A and Medicare Part B coverage. If you become eligible for Medicare, you may want to enroll in a Medicare Supplement Plan. Medicare Supplement plans are specifically designed to pay many of the health care costs not covered by Medicare. Because Medicare Supplement plans have limited enrollment periods, it is important to evaluate these plans as soon as you are eligible for Medicare.

The "Complaints and Appeals" subsection is changed by deleting the second paragraph under "Level Two Appeal Process (Voluntary)" and replacing it with the following:

> On a Level Two Appeal, the entire record will be reviewed. Appeals of a clinical nature will be reviewed by an appropriate clinical peer or peers who have not been involved with the prior decision. Additional information may be submitted by or on behalf of the Member, any treating Professional, or Anthem BCBS. You or your authorized representative may appear before the review panel. If you do not request the opportunity to appear in person, the decision for second level grievance reviews will be issued within 30 calendar days. If you do request the opportunity to appear in person, the review will be conducted within forty-five (45) working days of receipt of the Member's Level Two Appeal. A written decision will be issued to the Member within five (5) working days of completing the review. Once a final decision has been issued by the Second Level Appeal panel, the Member may request an external review, file a complaint with the Bureau of Insurance and/or bring legal action against Anthem BCBS. The Superintendent of Insurance may be contacted toll-free at 1-800-300-5000.
>
> In any appeal under the grievance procedure in which a professional medical opinion regarding a health condition is a material issue in the dispute, you may be entitled to an independent second opinion, of a provider of the same specialty, paid for the plan.

The "Definitions" section is changed as follows:

The definition of "Creditable Coverage" is deleted and replaced with the following:

Creditable Coverage (Prior Coverage) Coverage under an individual or group contract or policy that was in effect within 3 months before you were eligible for coverage under this Contract if you apply when initially eligible, or within 3 months of your effective date if you apply as a Late Enrollee. Creditable coverage includes Group or individual health insurance, Medicare, Medicaid, CHAMPUS, Indian Health Care Improvement Act, state health benefit risk pool, federal employees health benefit plan, qualified public health plan, the Peace Corps health benefit plan, S-CHIP, or a qualified foreign health plan. In calculating the period of Creditable

Coverage, all periods of coverage under all types of Creditable Coverage are added together unless there is a consecutive 90-day or longer break in the time period the individual has Creditable Coverage.

The definition of "Professional" is changed by adding the following:
Licensed Marriage and Family Therapist
Licensed Pastoral Counselor

The following definitions are added:

Effective Date The first day of coverage with Anthem Blue Cross and Blue Shield

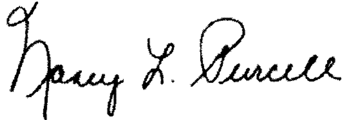
Surgical Assistant A physician (Doctor of Medicine or Osteopathy) or dentist (Doctor of Dental Medicine or Dental Surgery), or other qualified professionals as permitted by law and recognized by us who actively assists the operating surgeon in performing a covered surgical service.

The "Definitions" section is changed by deleting the definition of "Maximum Allowance" and replacing it with the following:

Maximum Allowance The highest dollar amount that will be paid by the Member and Anthem for a Covered Service based on our agreements with Network Providers and Professionals. Payment will be based on the most cost effective means that can be safely administered.

For Covered Services provided by Non-Network Providers and Professionals, the Member's portion of the payment will include charges over and above what would have been paid to a Network Provider or Professional.

All other terms, conditions, exclusions and limitations of your Anthem Blue Cross and Blue Shield HealthChoice Individual Certificate of Coverage (028645, 028645A, 028645B) apply to this amendment.



Nancy L. Purcell
Corporate Secretary
Anthem Blue Cross and Blue Shield

Attachment "AG's 2nd IR's Response to No. 2 (W1310877).XLS" is not a PDF document and cannot be reproduced here.

Attachment "Response to Question 5_REDACTED (W1328816).XLS" is not a PDF document and cannot be reproduced here.

Attachment "6_Example of Cost Trend Projection.xls" is not a PDF document and cannot be reproduced here.

Christopher T. Roach

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March 5, 2009

Mila Kofman, Superintendent
c/o Pat Galouch
Docket No. INS-09-1000
Maine Bureau of Insurance
34 State House Station
Augusta, Maine 04333-0034

Re: *Anthem BCBS 2009 HealthChoice Individual Rate Filing*
Filing coversheet

Dear Superintendent Kofman:

Enclosed for filing please find the following:

SUBMITTED BY:	Christopher T. Roach
DATE:	March 5, 2009
DOCUMENT TITLE:	Anthem BCBS Response to Third Informational Request of the Attorney General
DOCUMENT TYPE:	Response to Information Requests
CONFIDENTIAL:	**No**

Thank you for your assistance in this matter.

Very truly yours,

/s/ Christopher T. Roach

cc: Thomas C. Sturtevant, Esquire
Christina M. Moylan, Esquire

NON-CONFIDENTIAL

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

IN RE:	)	
	)	
ANTHEM BLUE CROSS AND BLUE	)	
SHIELD 2009 INDIVIDUAL RATE	)	APPLICANT'S RESPONSE TO
FILING FOR HEALTHCHOICE,	)	THIRD INFORMATIONAL
HEALTHCHOICE STANDARD AND	)	REQUEST OF THE ATTORNEY
BASIC AND LUMENOS CONSUMER	)	GENERAL
DIRECTED HEALTH PLAN	)	
PRODUCTS	)	

Docket No. INS-09-1000 March 5, 2009

NON-CONFIDENTIAL

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

IN RE: ANTHEM BLUE CROSS AND BLUE SHIELD 2009 INDIVIDUAL RATE FILING FOR HEALTHCHOICE, HEALTHCHOICE STANDARD AND BASIC AND LUMENOS CONSUMER DIRECTED HEALTH PLAN PRODUCTS	)	APPLICANT'S RESPONSE TO THIRD INFORMATIONAL REQUEST OF THE ATTORNEY GENERAL
Docket No. INS-09-1000		March 5, 2009

Applicant Anthem Health Plans of Maine, Inc., d/b/a Anthem Blue Cross and Blue Shield ("Anthem BCBS") hereby responds to the Third Informational Request of the Attorney General dated February 26, 2009 and received February 27, 2009 as follows:

1. In regards to Anthem's response to question 7 of the Superintendent's first informational request:

   a. HealthChoice rates in effect on 1/1/07 have been increased such that the current HealthChoice $5,000 rate is $327.11 (not $279.08). The premium rate differential between Lumenos HSA $5,000 and HealthChoice $5,000 is therefore now 17%, not 2.5%. Why are you continuing to apply a 2.5% rate differential between Lumenos HSA $5,000 and HealthChoice $5,000?

   b. What is the reason for the 17% difference? We assume this is the result of no rate increases in the Lumenos product since the initial development in calendar year 2007, is this correct?

   c. Why didn't the Lumenos product receive a rate increase in 2008, even a trend rate increase, if you feel the correct differential is closer to 2.5%?

Response:

1a. We applied the 2.5% premium differential as of the original Lumenos filing because this is the rate differential that the Superintendent approved in our original Lumenos filing. The 2.5% premium differential reflects actual benefit design differences and the resulting differences in utilization of services.

1b. Yes, the statement above is correct.

{W1320100 1}

1c. At the time of the 2008 HealthChoice filing in mid-2007, the Lumenos product was running a loss ratio lower than the required minimum 65% (for the first six months of 2007). Anthem expected that a trend increase would not be approved based on this early experience.

2. Please provide the following missing information shown in the table below. This is the information found on Exhibit XV of the filing with additional time periods (September 2002 through September 2005) and one additional field, namely the number of high-cost claimants (i.e., those with claims over $100K).

   To clarify, please fill in the information in the cells in the table below that are shown as [XXXX].

Experience Period 12 Months Ending	Member Months	Total Paid High-Cost Claimants	Claims in Excess of $100K Threshold	Excess Claims PMPM	Total Incurred All Claims	Total Incurred Excluding High Cost Claimants	Experience % of High-Cost Claimants	Number of High-Cost Claimants
200209	[XXXX]	[XXXX]	[XXXX]	[XXXX]	[XXXX]	[XXXX]	[XXXX]	[XXXX]
200309	[XXXX]	[XXXX]	[XXXX]	[XXXX]	[XXXX]	[XXXX]	[XXXX]	[XXXX]
200409	[XXXX]	[XXXX]	[XXXX]	[XXXX]	[XXXX]	[XXXX]	[XXXX]	[XXXX]
200509	[XXXX]	[XXXX]	[XXXX]	[XXXX]	[XXXX]	[XXXX]	[XXXX]	[XXXX]
200609	366,670	$20,707,328	$10,107,328	$27.57	$68,181,284	$58,073,956	17.4%	[XXXX]
200709	298,007	17,901,910	9,101,910	30.54	59,821,044	50,719,135	17.9%	[XXXX]
200809	255,110	15,768,682	7,768,682	30.45	54,956,165	47,187,483	16.5%	[XXXX]

Response: Please see attached "Response_to_AG3_Question2.xls."

3. In response to question 5 of the Attorney General's second informational request, Anthem provided a list of claim line detail for Claimant A and Claimant B. However, it appears that for many of the claim line detail, the ICD9, the service location and CPT code are filled in with a " * ." This is especially true for the larger claims in the file.

   Please fill in the missing information so we are able to determine the reason of the specific large claims.

Response: The asterisk shown in the file is for the drug claims related to Large Claimant B. The asterisk refers to the drug that Large Claimant B is taking each month which is identified in our Confidential response to the Attorney General's first informational request.

4. In the response to question 4b of the Attorney General's second informational request, Anthem states that Method 2 does not take into account the impact of prospective information with regard to the provider contracting.

Please provide the prospective impact of the provider contracting component of the cost trend that is above and beyond the cost trend inherent in any trend values developed from historical data.

Response: We can not provide this information for Method 2. Prospective impacts of provider contracting are valued on an allowed cost basis. We do not attempt to value these changes on a benefit paid cost basis since the cost sharing for each member varies and could not be reflected in such an analysis.

5. Please describe the methodology used to arrive at your $55,053,257 estimate of incurred claims for the twelve months ending October 31, 2008. In particular:

    a. Please provide a detailed description of the methodology you employed to develop your estimate of incurred but unpaid claims.

    b. Describe how large claims were handled in this process. For example, were large claims removed before developing completion factors, then non-large claims completed, and then the non-completed large claims added back in?

    c. If the removed large claims are completed separately from the non-large claims, please describe the methodology for completing the large claims and indicate the value of the completed large claims.

    d. Please provide the detailed work papers, electronic files and data that demonstrate the development of the estimated incurred claim amount of $55,053,257.

Response: 5a. Reserves are calculated using a development methodology based on historical paid claims grouped by period of incurral and period of payment. Completion factors are calculated using this historical data, estimating the percentage of incurred claims that have been paid after a given number of months. The completion factors are applied to the claims that have been incurred and paid-to-date to estimate the ultimate total incurred claims for a given month. The reserve is the difference between the estimated ultimate total incurred claims and the claims paid-to-date. For the more recent months, the completion factors may not be credible and several different methods are reviewed for estimating the ultimate total incurred claims. One method often considered for the more recent months is a trended per member per month cost. In addition to this methodology, we consider other factors which may be affecting claim costs or payment patterns when establishing the reserve.

5b. All claims (large and non-large) were completed.

5c. Not applicable.

5d. The incurred claim cost is based on the claim triangle as provided in Exhibit V. The total incurred amount of $55,053,257 is net of the two high-cost claimants experience as shown in Exhibit I.

6. Please clarify the criteria used for including claimants in the triangles provided in response to question 6 of the Attorney General's first informational request. For example, what was the period over which $100,000 or more in claims had to be incurred in order for a member's claims to be pulled into the triangle?

Response: As stated in our original response and as requested, claim costs shown are for members that exceeded $100,000 in claims during the 24-month period ending October 2008. Note that this membership base does not correspond to the membership used in the high-cost claimant analysis Exhibit XV or the experience period high-cost claimants which is based on members that exceed $100,000 in claims during a 12-month period.

7. Please confirm that the claims in the triangles provided in response to question 6 of the Attorney General's first informational request represent all claims for large claimants and not just the excess amounts over $100,000. If they do include only the excess over $100,000, please provide a revised set of triangles that include all claims for large claimants.

Response: The claim triangle referenced includes the total claim amounts and not just the excess amount over $100,000.

8. With respect to the $7,823,506 in large claims you pooled as reflected in Exhibit 1, please:

    a. Indicate how many members' claims were pooled and, for each member, show the total amount before pooling and whether the person is enrolled in HealthChoice or Lumenos.
    b. Please demonstrate that after subtracting $100,000 from each of the member's claim amount in item (a) above, the total is $7,823,506 as used in the rate increase calculation.
    c. Please demonstrate that the total of all claims provided in response to item (a) above equals the amounts in the claims triangles provide in response to question 6 of the Attorney General's first informational request for the 12 month period ending October 31, 2008. The amount of claims incurred during the 12 month period ending October 31, 2008 in the triangles is $18,192,485 for HealthChoice and $899,827 for Lumenos.

Response: 8a. The experience for the 83 members with claims in excess of $100,000 during the 12 month period ending October 2008 is shown in the attached "Response_to_AG3_Question8.xls."

8b. Please see attached "Response_to_AG3_Question8.xls."

8c. As noted in the original request, this membership base does not correspond to the membership used in the high-cost claimant analysis Exhibit XV or the experience period high-cost claimants which is based on members that exceed $100,000 in claims during a 12-month period.

9. Please fill in the tables below regarding historical paid pharmacy claims and the corresponding rebates received for HealthChoice and Lumenos products.

HealthChoice Experience

Year	Paid Pharmacy Claims	Rebates
2003		
2004		
2005		
2006		
2007		
2008		

Lumenos Experience

Year	Paid Pharmacy Claims	Rebates
2007		
2008		

Response:

HealthChoice

Year	Paid Pharmacy Claims	Rebates
2003	$4,778,927	$209,336
2004	$5,909,285	$338,711
2005	$6,916,482	$716,010
2006	$6,999,212	$695,406
2007	$6,456,945	$739,946

Lumenos

Year	Paid Pharmacy Claims	Rebates
2007	$109,067	$11,000

Due to the lag in payment patterns of rebates the amounts for calendar year 2008 would be meaningless at this time.

10. Please fill in the tables below for the historical experience of the HealthChoice and Lumenos products.

HealthChoice Experience

Year	Generic Paid Claims	Number of Generic Scripts	Brand Drugs: Paid Claims for Drugs that receive Rebates	Brand Drugs: Paid Claims for Drugs that do not receive Rebates	Brand Drugs: # of Scripts that receive Rebates	Brand Drugs: # of Scripts that do not receive Rebates
2003						
2004						
2005						
2006						
2007						
2008						

Lumenos Experience

Year	Generic Paid Claims	Number of Generic Scripts	Brand Drugs: Paid Claims for Drugs that receive Rebates	Brand Drugs: Paid Claims for Drugs that do not receive Rebates	Brand Drugs: # of Scripts that receive Rebates	Brand Drugs: # of Scripts that do not receive Rebates
2007						
2008						

Response: As requested in the 2008 HealthChoice Decision & Order, we have adjusted our expected rebate calculation to set the rebate credit as a percentage of pharmacy claims. In calendar year 2007, Anthem BCBS received rebates equal to 11.46% of total pharmacy incurred claims associated with HealthChoice members. We did not include additional years of experience since prior year rebates would reflect a different mix of members by benefit plan design and a resulting difference in pharmacy utilization. Next, we calculated expected pharmacy claim cost for the rating period as shown in Exhibit VIII. The estimated rebates as a percentage of paid claims (11.46%) was then applied to the estimated pharmacy paid claims for the rating period. Although this amount is greater than in recent years, it is based on historical data which should provide a reasonable expectation of future rebates.

Additionally, Anthem BCBS reconciles the estimated rebates to the actual rebates received in future rate filings. Any difference between the actual rebates and the estimated rebates for the rating period will be reflected in next year's rate filing. In this manner, our HealthChoice and Lumenos subscribers are credited with the appropriate amount of rebates.

With that said, Anthem BCBS is unable to provide this level of claims detail because we do not track generic versus brand paid pharmacy claims or the rebates associated with these drugs.

11. Please provide a detailed description of the allocation process used to distribute the total rebates the corporation receives on a national basis to the individual business lines of Anthem.

Response: We track scripts by group IDs associated with the HealthChoice and Lumenos products and the rebates associated with these scripts. The total amount of rebates associated with the groups IDs for HealthChoice and Lumenos is reflected in the data for #9 above.

12. Please provide the total pharmacy paid claims for the corporation on a national basis, the total rebates for the corporation on a national basis and the total member months of the corporation on a national basis for each calendar year from 2003 through 2008.

Response: Please reference the response to question #10 above. We are unable to provide the data as requested on a basis that is consistent with the HealthChoice and Lumenos rebates. For the HealthChoice and Lumenos filing, we review rebates on a billed date basis as opposed to the received date so that the information is meaningful when compared to pharmacy claims for a given incurred period. Anthem BCBS does not maintain national information on that same basis.

13. Please provide the total pharmacy paid claims for Anthem-Maine, the total rebates for Anthem-Maine and the total member months for Anthem-Maine for each calendar year from 2003 through 2008.

Response: Please reference the response to question #12 above.

14. The current rates were supposed to build in a credit to claims for rebates in the amount of $4.30 PCPM. How are the actual rebate amounts received for 2008 comparing to the $4.30 PCPM estimate?

Response: Due to the lag in payment patterns of rebates the amounts for calendar year 2008 would be meaningless at this time.

15. This year's estimated rebates are being credited at $6.72 PCPM. Please explain why it is so much greater than recent years.

Please reference the response to question #10 above.

Response:

16. In Anthem's response to question 6 of the Superintendent's first informational request, Anthem states that "the 1.5 factor applied to the mandated HealthChoice plans represents a utilization based adjustment to reflect the lower average deductible levels and differences in experience between the non-mandated plans and the mandated plans."

    a. Please provide the detailed work papers, electronic files and data that supports the development of the 1.5 utilization factor applied to the $1,000 deductible State-Mandated benefit plan.

       We assume the 1.5 utilization factor is based on a benefit relativity analysis rather than actual experience since Anthem stated in the response to question 6 of the Superintendent's first informational request that the State-Mandated plans "continue to lack credible experience to merit a separate review" with only 147 members in the plans. Please confirm.

    b. Please provide the detailed work papers, electronic files and data that supports the development of the 1.06 utilization factor applied to the $5,000 deductible Lumenos plan. This utilization factor is presented in Anthem's response to question 7a of the Superintendent's first informational request.

    c. Please explain how the 1.5 utilization factor that is applied to the rates of $1,000 deductible plan for the non-mandated plans to generate the rates of the $1,000 deductible plan for the State-Mandated plan is consistent with the 1.06 utilization factor applied to the Lumenos pricing of the $5,000 deductible plan when compared with the $5,000 deductible HealthChoice plan.

Response:

16a. There are no work papers related to this factor. The 1.5 factor was imposed by the Superintendent in the 2007 HealthChoice Decision and Order. The Superintendent limited Anthem's ability to rate the mandated plan designs based on the underlying claims experience because "the [premium rate] difference becomes so large as to be inequitable regardless of the differences in experience."

16b. There are no work papers related to the 6% utilization factor applied to the Lumenos rate development. To support the 6% utilization factor applied to the Lumenos rate development, Anthem used a best estimate of possible utilization-based savings for consumer-driven health plans (CDHP). Industry articles from other carriers have placed a broad range around savings for CDHPs. We reviewed plan design differences between the HealthChoice and Lumenos products in order to narrow the range of potential savings. In particular, while we expected

inpatient utilization to decrease, the utilization of preventive services is likely to increase as more members take advantage of the rich preventive benefit available. Because experience is still immature, we are unable to review actual utilization-based savings against our current assumption. We feel that the 6% utilization factor applied takes into account all of the information available and is appropriate for the guaranteed issue population in Maine.

16c. Both factors are adjustments from the base HealthChoice portfolio to the expected utilization of the mandated products and the expected utilization of the Lumenos products. In the case of the mandated products, this factor is limited by the Superintendent and does not reflect the entire amount of utilization-based differences between these mandated products and the other HealthChoice products.

DATED: March 5, 2009

/s/ Christopher T. Roach
Christopher T. Roach, Esq.

PIERCE ATWOOD LLP
One Monument Square
Portland, Maine 04101
Attorney for Applicant

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

IN RE: ANTHEM BLUE CROSS AND BLUE SHIELD 2009 INDIVIDUAL RATE FILING FOR HEALTHCHOICE, HEALTHCHOICE STANDARD AND BASIC AND LUMENOS CONSUMER DIRECTED HEALTH PLAN PRODUCTS Docket No. INS-09-1000	)	**CERTIFICATE OF SERVICE**

The undersigned counsel 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 Applicant's Response to the Third Informational Request of the Attorney General upon the persons and at the addresses indicated below.

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DATED: March 5, 2009

/s/ Christopher T. Roach
Christopher T. Roach, Esq.

PIERCE ATWOOD LLP
One Monument Square
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Attorney for Applicant

Attachment "Response_to_AG3_Question2.xls" is not a PDF document and cannot be reproduced here.

Attachment "1_Support_for_DeductibleMix_Adjustment.xls" is not a PDF document and cannot be reproduced here.

Attachment "030309bi - Vol. 1.Rtf" is not a PDF document and cannot be reproduced here.

In Maine: Anthem Blue Cross and Blue Shield is a trade name of Anthem Health Plans of Maine, Inc.
an independent licensee of the Blue Cross and Blue Shield Association.
® Registered marks of the Blue Cross and Blue Shield Association.

Amendment to Certificate of Coverage
Dependent Children to Age 25

Your Anthem Blue Cross and Blue Shield HealthChoice HDHP (029247), HealthChoice (028645), HealthChoice A (028645A), HealthChoice B (028945B), HealthChoice Standard (048066), HealthChoice Basic (048065), Individual HMO Standard (052105), Individual HMO Basic (052106), Lumenos® Individual HIA Plan (7116ME), Lumenos® Individual HIA Plus Plan (7117ME), or Lumenos® Individual HSA Plan (7118ME) Certificate of Coverage is changed as stated in this amendment.

The "Eligibility, Termination and Continuation of Coverage" section is changed as stated below:

The "Who Is An Eligible Individual Member?" subsection is deleted in its entirety and replaced with the following:

Who is an Eligible Individual Member?

1. The Subscriber;
2. The Subscriber's legal spouse;
3. The Subscriber's/spouse's unmarried child under age 25, including (a) newborn children; (b) biological children, adopted children or children placed for adoption, stepchildren or legally placed foster children who live with the subscriber; and (c) other children who live with or depend on the subscriber for financial support (we reserve the right to determine if they may be covered under this Contract), when that child::
   (i) has no dependent of the child's own;
   (ii) is a resident of the State or is enrolled as a full time student at an accredited public or private institution of higher education; and
4. The Subscriber's/spouse's unmarried child who is mentally or physically disabled. The disability must have begun before the child's 25th birthday, and the child must have been covered by us on and continuously since his or her 25th birthday.

Note: Coverage may continue for an unmarried dependent child while he or she is unable to remain enrolled in school on a full-time basis due to a mental or physical illness or accidental injury until the dependent child reaches the dependent age limit listed in the certificate of coverage.

We will determine the effective date of coverage for the Subscriber and other eligible family members. If your coverage has changed or you are unsure of your effective date, please call us.

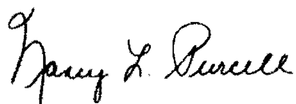
We reserve the right to verify continued eligibility for all Members.

The "Cancellation of a Member's Contract" subsection is changed by deleting the "Covered Children" provision and replacing it with the following:

Covered Children Your coverage will be canceled if you are a covered child and:

- You marry. Coverage will end on the first day of the month that occurs immediately on or after your date of marriage.
- You reach age 25 Coverage will end on the first day of the month that occurs immediately on or after your 25th birthday.
- You cease to meet the definition of an eligible Dependent.

All other terms, conditions, limitations and exclusions of your Anthem Blue Cross and Blue Shield Your Anthem Blue Cross and Blue Shield HealthChoice HDHP (029247), HealthChoice (028645), HealthChoice A (028645A), HealthChoice B (028945B), HealthChoice Standard (048066), HealthChoice Basic (048065), Individual HMO Standard (052105), Individual HMO Basic (052106), Lumenos® Individual HIA Plan (7116ME), Lumenos® Individual HIA Plus Plan (7117ME), or Lumenos® Individual HSA Plan (7118ME) Certificate of Coverage apply to this amendment and are not changed.



Nancy L. Purcell
Corporate Secretary
Anthem Blue Cross and Blue Shield

8472ME -7/08

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

IN RE: ANTHEM BLUE CROSS AND BLUE SHIELD 2009 INDIVIDUAL RATE FILING FOR HEALTHCHOICE, HEALTHCHOICE STANDARD AND BASIC AND LUMENOS DOCKET NO. INS-09-1000	)	APPLICANT'S EXHIBIT LIST March 6, 2009

EXHIBIT NO.	DOCUMENT DESCRIPTION	CONFIDENTIAL ?	OFFERED	ADMITTED
1	Non-Confidential Version of Prefiled Testimony of Jennie Casaday	No		
2	Non-Confidential Version of Prefiled Testimony of Vincent Liscomb	No		
3	Non-Confidential Version of Prefiled Testimony of George Siriotis	No		
4	Non-Confidential Version of Revised Filing	No		

Christopher T. Roach

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March 6, 2009

Mila Kofman, Superintendent
c/o Pat Galouch
Docket No. INS-09-1000
Maine Bureau of Insurance
34 State House Station
Gardiner, Maine 04333-0034

RE: ANTHEM BCBS HEALTHCHOICE & LUMENOS INDIVIDUAL RATE FILING EFFECTIVE JULY 1, 2009

I. FILING COVERSHEET

Dear Superintendent Kofman:

Enclosed for filing please find the following:

SUBMITTED BY: Christopher T. Roach

DATE: March 6, 2009

DOCUMENT TITLE: Prefiled Testimony of George Siriotis

DOCUMENT TYPE: Prefiled Testimony

CONFIDENTIAL: **No**

Thank you for your assistance in this matter.

Very truly yours,

/s/ Christopher T. Roach

cc: Thomas C. Sturtevant, Esquire
Christina M. Moylan, Esquire

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

IN RE:	)	EXHIBIT 3
	)	
ANTHEM BLUE CROSS AND BLUE SHIELD 2009 INDIVIDUAL RATE FILING FOR HEALTHCHOICE, HEALTHCHOICE STANDARD AND BASIC AND LUMENOS	)	PREFILED TESTIMONY OF GEORGE SIRIOTIS
DOCKET NO. INS-09-1000	)	
	)	March 6, 2009

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1 **Q. Please state your name, your position with Anthem Health Plans of Maine,**
2 **Inc. d/b/a Anthem Blue Cross and Blue Shield ("Anthem BCBS"), and how you**
3 **came to hold that position.**
4 A. My name is George Siriotis and I am the Regional Vice President of Sales for the
5 Individual Markets Division of Anthem Blue Cross and Blue Shield's East Region.
6 During my 18 years with Anthem BCBS, I have held a number of sales management
7 roles in the East region. During my tenure with the company, I have gained detailed
8 knowledge about Anthem BCBS, its operating philosophy, financial strength and
9 commitment to serving the health care needs of its members in the Blue Cross Blue
10 Shield tradition. I am committed to those same philosophies and goals in my present
11 position with Anthem BCBS.
12
13 **Q. What is the scope of your testimony?**
14 A. My testimony will provide an overview of the individual market in Maine, the
15 financial status of the HealthChoice and Lumenos lines of business in Maine, and the
16 fairness of the requested rate increase generally.
17
18 **Q. Please describe the Maine individual market, including Anthem BCBS's**
19 **position relative to that market and an overview of who purchases these products**
20 **now.**
21 A. Approximately 40,000 individuals are covered by individual insurance in the state
22 of Maine. Anthem BCBS has a long standing history of serving the health benefit needs
23 of Maine's individual market. At the present time, Anthem BCBS is the leading
24 insurance carrier that is actively marketing individual products in the sate of Maine. The
25 HealthChoice product has been marketed in the state of Maine since 1991. We have seen
26 a steady decrease in our individual health plan membership over the past several years,
27 from a high of approximately 35,000 members in 2004 to approximately 21,000 as of
28 January, 2009. The Lumenos products were introduced on January 1, 2007 with
29 approximately 1,800 members currently enrolled.
30 All Anthem BCBS individual products are offered on a guaranteed issue basis.
31 No medical underwriting is done during the enrollment process. Anthem BCBS

1 determines which new members will have pre-existing condition (PEC) restrictions
2 applied to their coverage. If and when these members incur claims during the applicable
3 period, the medical underwriting process is used to administer the PEC limitations,
4 according to state statutes.
5 In comparison to other states, the cost for an individual policy in the state of
6 Maine is significantly more expensive. This is driven by many factors, including the cost
7 of care in the state of Maine, the age of the membership combined with the regulatory
8 requirements of guaranteed issue and community rating. The result of the high premium
9 costs is reflected in the deductible options that are purchased by our members. The
10 $15,000 deductible option was the most popular HealthChoice option in terms of new
11 enrollment in 2008, and is purchased by members to get to the lowest premium rate
12 possible. The regulatory environment in many other states is different than in Maine and,
13 as a result, insurance premiums are far more affordable. In fact, in many other Anthem
14 states, a $15,000 deductible plan is not even offered as an individual product option.
15 Lower deductible options in those states can provide pricing that is manageable to
16 consumers in those markets.
17
18 We continue our ongoing efforts to help our members get and stay healthy,
19 including several innovative programs. These programs, all of which are available to
20 eligible members at no additional cost, continue to see increased population and
21 participation:
22
23 • MYHEALTH@ANTHEM.COM – as part of Anthem BCBS's effort to help our
24 members achieve a healthy lifestyle, we also provide the MyHealth@Anthem
25 Web site. MyHealth@Anthem features thousands of health and wellness articles,
26 newsletters, tools and databases for members to use in answering health-related
27 decisions.
28
29 • SpecialOffers@Anthem offers some of the deepest discounts on health and
30 wellness products and services, and is the most dynamic and user-friendly
31 shopping site in the health care industry. SpecialOffers@Anthem was developed

1 specifically to help better the health and wellness of its members, complement
2 their existing benefits, and save them money.
3
4 **Q. Please explain why Anthem BCBS is seeking this increase.**
5 **A.** While Anthem BCBS is aware of the impact of any premium increase on its
6 members, the short answer is that the increase is necessary due to the rising cost of
7 healthcare. Health care costs nationally and in Maine continue to increase. Driven by a
8 multiplicity of factors, the underlying cost of care is directly reflected in the increases in
9 health insurance premiums over the last several years. Additionally, Anthem BCBS has
10 been experiencing a decline in its individual membership over the past several years.
11
12 While recognizing how difficult it is for our customers to absorb increases in their health
13 insurance premiums, those premiums must keep pace with these increasing costs so that
14 they cover all costs plus allow for a reasonable rate of return.
15
16 **Q. Please explain what provision this filing makes for profit?**
17
18 **A.** In recognition of prior orders from the Superintendent, the filing includes a pre-
19 tax profit margin of 3%, which will yield a post-tax profit of 2% if all assumptions are
20 achieved.
21
22 **Q. Based on recent experience, has a 3% pre-tax profit target been sufficient to**
23 **cover all costs, including risk, and provide for a reasonable rate of return?**
24
25 **A. No.**
26
27 From 2005 to 2008, Anthem BCBS lost a total of $3.3 million dollars on the
28 HealthChoice and Lumenos lines of business. The fact remains that the Maine individual
29 market is in desperate need of reform, but until that occurs, the state of the market should
30 be taken into account when establishing appropriate rates, otherwise rates will not cover
31 costs plus provide for a reasonable rate of return.

1 Relative to markets in other states, the market in Maine for individual health products is
2 very risky. Unfortunately, the Maine population seeking individual health insurance has
3 increased health risk; the population is on average older, less healthy and there are higher
4 incidents of asthma, diabetes, heart disease, and obesity than in the rest of the country.
5 Additionally, due to the guaranteed issue and guaranteed renewable requirements,
6 individuals have the ability to buy in and drop out of the pool at will, which increases the
7 insurance risk of this product line. Also, the membership in our HealthChoice Plan is
8 shrinking, and the average age of our membership is rising, introducing greater risk for
9 Anthem BCBS in this line of business.
10
11 **Q. What do the Anthem BCBS sales associates and appointed producers do to**
12 **market the individual products?**
13
14 A. The individual products are marketed directly to Maine consumers in an efficient
15 process of lead generation and in-house telemarketing and use of over 230 appointed
16 producers statewide. The HealthChoice and Lumenos products are sold by appointed
17 producers throughout Maine who receive sales commissions on all products sold.
18 Commission rates are the same for each individual product option.
19
20 **Q. How will this premium increase affect your efforts to sell the HealthChoice and**
21 **Lumenos products?**
22
23 A. Any increase in premium affects members, and correspondingly, sales.
24 We anticipate that some members will elect to alter their coverage to control the potential
25 increase in their monthly premium costs. Individual members may select from a range of
26 benefit and deductible options. Our sales associates and customer service staff along
27 with our appointed producers are available to assist members in identifying what the best
28 choices are for their specific needs.
29
30 **Q. Is the proposed rate increase fair?**

1 A. Yes. We have been diligent in reducing to the extent possible the amount of
2 necessary increases and have requested premium adjustments that are fair, particularly in
3 light of the ever-increasing cost of health care. We are particularly pleased that Anthem
4 BCBS's cost containment measures have continued to have a positive impact on the
5 administrative costs associated with the HealthChoice and Lumenos lines, resulting in a
6 steady decline in those costs as a percentage of total premium. This year those
7 efficiencies have resulted in a decline in the per member per month charge,
8 notwithstanding the declining membership.
9
10 **Q. Does this conclude your testimony?**
11 A. Yes

{W1320056.1}

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

IN RE:	)	
ANTHEM BLUE CROSS AND BLUE SHIELD 2009 INDIVIDUAL RATE FILING FOR HEALTHCHOICE, HEALTHCHOICE STANDARD AND BASIC AND LUMENOS CONSUMER DIRECTED HEALTH PLAN PRODUCTS	)	**CERTIFICATE OF SERVICE**
Docket No. INS-09-1000	)	

The undersigned counsel 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 Prefiled Testimony of George Siriotis upon the persons and at the addresses indicated below.

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DATED March 6, 2009

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March 6, 2009

Mila Kofman, Superintendent
c/o Pat Galouch
Docket No. INS-09-1000
Maine Bureau of Insurance
34 State House Station
Gardiner, Maine 04333-0034

RE: ANTHEM BCBS HEALTHCHOICE & LUMENOS INDIVIDUAL RATE FILING EFFECTIVE JULY 1, 2009

I. FILING COVERSHEET

Dear Superintendent Kofman:

Enclosed for filing please find the following:

SUBMITTED BY:	Christopher T. Roach
DATE:	March 6, 2009
DOCUMENT TITLE:	Prefiled Testimony of Jennie Casaday
DOCUMENT TYPE:	Prefiled Testimony
CONFIDENTIAL:	**No**

Thank you for your assistance in this matter.

Very truly yours,

/s/ Christopher T. Roach

cc: Thomas C. Sturtevant, Esquire
Christina M. Moylan, Esquire

NON-CONFIDENTIAL

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

IN RE:	)	EXHIBIT 1
	)	
ANTHEM BLUE CROSS AND BLUE SHIELD 2009 INDIVIDUAL RATE FILING FOR HEALTHCHOICE, HEALTHCHOICE STANDARD AND BASIC AND LUMENOS	)	PREFILED TESTIMONY OF JENNIE CASADAY
DOCKET NO. INS-09-1000	)	
	)	March 6, 2009

NON-CONFIDENTIAL

1 **Q. Please state your name and your position with Anthem Blue Cross and Blue**
2 **Shield ("Anthem BCBS").**
3 A. My name is Jennie Keith Casaday. I am an Associate Actuary for Anthem
4 Blue Cross and Blue Shield supporting Individual product pricing.
5
6 **Q. Please describe any relevant education or experience that qualifies you as a**
7 **witness today.**
8 A. I am a Fellow of the Society of Actuaries and a member of the American
9 Academy of Actuaries. I have been a member of the Actuarial Department of
10 Anthem BCBS and its subsidiaries since 2004. During my career with Anthem
11 BCBS I have had numerous responsibilities including individual pricing, group
12 pricing, trending, reserving, new product development and pricing, analysis of
13 provider contracting, legislative review and analysis, medical policy review, and
14 forecasting of future results. Currently I am responsible for individual (under age
15 65) product pricing for Maine and our other east zone states.
16
17 Prior to joining Anthem BCBS, I worked in the Life & Health practice of
18 Tillinghast-Towers Perrin for four years. During that time, I provided actuarial
19 consulting services to insurance carriers regarding asset/liability management,
20 pricing, cash flow testing, securitization of insurance policies, and mergers and
21 acquisitions.
22
23 I have a Bachelor of Science degree in Mathematical Sciences with a
24 concentration in Operations Research from Carnegie Mellon University in
25 Pittsburgh, Pennsylvania and an additional major in Economics.
26
27 **Q. Please state your reasons for testifying at this hearing.**
28 A. I am testifying at this hearing to respond to questions about proposed July
29 2009 premium rates for Anthem BCBS's HealthChoice and Lumenos products.

1 **Proposed Premium Changes**

2 **Q. What is the primary reason that Anthem BCBS has filed for the**
3 **proposed premium changes?**

4 A. Before getting to the primary reason, it is important to note that the
5 proposed change has nothing to do with profit (which remains at the minimal 3%
6 pre-tax profit level set by the Superintendent in prior rate proceedings), or
7 administrative expenses, which have remained relatively flat and, indeed, declined
8 as a percentage of premium. The primary reason continues to be increases in
9 claim costs. As in recent years, the claim costs associated with HealthChoice
10 continue to increase, and the current level of premium will not be sufficient to
11 cover the cost of claims along with the cost of administering the services
12 associated with the health insurance product. In addition, the Lumenos product
13 has two years of experience that is now credible. The rising claim costs for the
14 Lumenos product also necessitate a premium increase in order to cover
15 underlying cost.

16 Claim costs continue to increase in all types of services and settings
17 including hospital, physician, and pharmacy. Claim costs are increasing not only
18 due to medical inflation in the cost of services but due to an increasing use of
19 those services every year. These cost increases are exacerbated by the current
20 regulatory requirements that mandate guarantee issue and guarantee renewal with
21 limited rate variation between benefit and age levels. These requirements result
22 in a small number of HealthChoice and Lumenos subscribers consistently driving
23 the level of claim costs higher. With no ability to rate those subscribers according
24 to their risk and claim experience, the required premiums must rise for all
25 members in order to cover the underlying costs.

26

27 **Q. Briefly summarize the proposed premium changes.**

28 A. The average premium increases across all HealthChoice and Lumenos
29 products is 18.5%. For the Non-Mandated HealthChoice options the range of
30 increases is 8.7% to 24.5% with an average of 18.7%. For the Mandated
31 HealthChoice options the range of increases is 9.0% to 9.7% with an average of

1 9.2%. For the Lumenos options the range of increases is 8.9% to 38.4% with an
2 average of 30.2%
3
4 **Lumenos and HealthChoice Combined Pools**
5 **Q. Why is Anthem BCBS combining the HealthChoice and Lumenos**
6 **pools when reviewing experience for the proposed premium change?**
7 A. First, we have chosen to combine the HealthChoice and Lumenos pools
8 because the HealthChoice and Lumenos basic benefit structures are materially
9 similar with similar deductible levels, coinsurance and preventive benefits. If the
10 pools were rated separately, the premium rate differential between the
11 HealthChoice $5000 deductible with preventive rider and the Lumenos H.S.A.
12 $5000 deductible would be almost 30%. The premium rate differential becomes
13 excessive when compared to the benefit difference, which if left unadjusted likely
14 would result in extreme anti-selection.
15
16 Second, the experience of the two pools should be combined because
17 members from HealthChoice can freely migrate to Lumenos and the reverse in the
18 current guaranteed issue individual market. Combining the pools is consistent
19 with our treatment of the HealthChoice mandated and non-mandated benefits
20 whose experience has been combined in prior HealthChoice rate filings.
21 Allowing for unrestricted migration effectively creates one pool because the same
22 members can choose to enter HealthChoice mandated and non-mandated products
23 or Lumenos products.
24
25 **Q. Why did Anthem BCBS not file for a rate change for the Lumenos**
26 **product in 2008?**
27 A. Lumenos was introduced into the Maine market effective January 1,
28 2007. In mid-2007 when Anthem BCBS was preparing our 2008 HealthChoice
29 rate filing, the Lumenos experience was very new and not yet credible. We only
30 had 6 months of claims to review and just over 200 members in the product. We
31 now have a larger population and credible experience that reflects that a rate

1 adjustment is necessary. In its infancy the Lumenos product was also running at
2 an approximately 65% loss ratio, which further militated against requesting an
3 adjustment to the Lumenos rates for 2008.
4
5 **Trend Projection**
6 **Q. Compared to last year's filing, have you made any changes in the way**
7 **you determined the projected trend in this year's filing?**
8 A. The methodology for projecting trend is the same for our traditional
9 method of rate development (Method 1). Our Method 1 rate development
10 analyzes trend both retrospectively and prospectively. Observed claim data is
11 reviewed on both an allowed and paid benefit basis by category: inpatient,
12 outpatient, professional, and prescription drug. Information concerning known
13 and anticipated changes to provider contracts and care management initiatives are
14 considered for their potential impact on future claims. With this combination of
15 historical and prospective information, trends are then selected for the categories
16 noted previously.
17
18 In addition, Anthem BCBS has provided historical allowed trends adjusted
19 for the impact of deductible mix in this year's filing. We measured the impact of
20 the change in deductible mix for each rolling 12-month period by comparing the
21 actual trend for all deductible levels combined to an adjusted trend based on
22 holding membership constant at the membership in effect during the base year.
23 The analysis indicated that overall, deductible mix had an impact of less than 1%
24 for rolling 12-month periods through mid 2006, but in the following periods the
25 impact had ramped up until mid 2007 when trends were suppressed by 4% or
26 more due to deductible mix. This impact continues to be prevalent in the year-to-
27 date experience for 2008.
28
29 As a reasonableness check of our traditional method (Method 1) and in
30 response to comments made by the Superintendent in the Decision and Order for
31 the 2008 HealthChoice proceeding ("2008 D&O"), Anthem BCBS has included a

1 second method of developing rates that applies a paid claims trend to the claims
2 that are not in excess of $100,000 and adds a pooling charge separately to account
3 for the effect of high-cost claimants (Method 2). Method 2 reviews historical
4 observed benefit paid expense trend but with no prospective view. Further, the
5 trends analyzed after the removal of the high-cost claimants are extremely erratic
6 (ranging from 3.9% to 14.6%) compared to the allowed trends adjusted for
7 deductible mix that support Method 1 (ranging from 11.9% to 16.7%). The
8 selection of an appropriate trend for Method 2 involves selecting an assumption
9 from a much broader range of historical trends with no consideration for
10 prospective impact from provider contracting or other care management
11 initiatives.
12
13 **Q. Can you provide additional support for the trend assumptions used in**
14 **the rate development? For the trend utilized in the second method, why did**
15 **Anthem BCBS not reflect the lower trends in the experience shown?**
16 A. Our traditional rate development method (Method 1) uses a trend of 14.1% in this
17 year's filing with adjustments for benefit buy-downs which reduce the actual applied
18 annualized trend to 10.3%. As stated earlier, the selected trend is based on a
19 retrospective and prospective review of claims trends. When compared to historical
20 observed values adjusted for the impact of deductible mix, the selected service category
21 trends and the weighted average combined trend are in the middle of the range of recent
22 observances.
23
24 Regarding the trend selected for the second rate development method, the trend
25 selected is in the middle of the range of historical observed values. Although some recent
26 periods exhibited lower trend rates, it is clear from the rolling 12 month period ending
27 September 2008 that trends are currently on the rise. Because Method 2 does not take
28 into account prospective trend information (as stated above) and relies on greater
29 actuarial judgment in selecting the underlying claims trend and the pooling charge,
30 Method 1 is the basis of our required 18.5% premium increase.
31

1 **Q. What was your projection of trend last year and what was the**
2 **resulting profit margin during the 2008 rating period?**
3 A. In the 2008 filing, the underlying trend assumption was 15.2% with
4 adjustments for benefit buy-downs which reduced the actual applied annualized
5 trend to 10.0%. At the time actual observed benefit paid trends were around 16%.
6 As of December 2008, Anthem BCBS's pre-tax operating margin for calendar
7 year 2008 was 2.8% for the combined HealthChoice and Lumenos pools.
8 While lower than the 3% margin upon which the rates were based, this
9 demonstrates that Anthem BCBS's methodology that includes retrospective and
10 prospective view of trends applied in both the 2008 filing and this year's filing is
11 a reasonable method of determining future claim cost.
12
13 **Q. Can you go into more detail describing how the trend is being applied**
14 **to determine future claim costs?**
15 A. Yes. Method 1 is the rate development method used in the required
16 premium calculation. In Method 1, the trend applied to observed claim costs is
17 14.1%. This is an annual trend that is applied in the following manner:
18 Incurred claims for the 12-month experience period ending October 31,
19 2008 were estimated as (a) claims paid during the experience period, plus
20 (b) the estimated liability for claims outstanding on October 31, 2008.
21 Liability estimates were based on an analysis of claims paid through
22 December 30, 2008. This particular twelve month period was chosen as it
23 allowed for a some amount of "runout" to ensure that the restatement of
24 the estimated outstanding liability would be minimal. Incurred claims for
25 current benefits were projected using the 14.1% annual trend factor
26 applied to services for the twenty months between the experience period
27 and the rating period. The resulting projection factor is approximately
28 1.246 ($1.141^{20/12}$).
29
30 As required by previous order of the Superintendent of Insurance, claims
31 are adjusted in order to compensate for anticipated shifts of enrollment

1 among the various benefit options. This adjustment is calculated using
2 observed claim amounts on a PCPM basis coupled with the anticipated
3 subscriber distribution among the benefit options during the rating period.
4 The direct impact of lower claims through anticipated shifts in enrollment
5 will result in an actual benefit paid trend well below the 14.1% trend
6 applied to claims. Isolating the trend and the adjustments from Exhibit I
7 present a clear picture of the expected claim trend after adjustments. First,
8 the 14.1% trend is applied for twenty months, as noted above, which
9 results in an adjustment to claims by a factor of 1.246. Second, claims are
10 directly reduced by the estimate of the impact of shifts in benefit plan of
11 0.945 resulting in an actual claim adjustment of 1.177. Finally, this
12 projection factor is annualized and results in an expected change in
13 benefits paid of 1.103 ($1.177^{12/20}$), or 10.3%.
14
15 In Method 2, the trend of 10.1% is applied to observed claim cost removing high-
16 cost claimants and adding a pooling charge to account for the high-cost claimant
17 experience in the following manner:
18 Incurred claims for the 12-month experience period ending October 31,
19 2008 were estimated in the same manner as Method 1. Paid claims for the
20 high-cost claimants (members that had more than $100,000 in paid claims
21 during the 12-month period ending October 2008) in excess of $100,000
22 were subtracted from the incurred claims estimate. Incurred claims
23 excluding high-cost claimants were projected using the 10.1% annual
24 trend factor applied to services for the twenty months between the
25 experience period and the rating period. The resulting projection factor is
26 approximately 1.174 ($1.101^{20/12}$). The estimated cost of the high-cost
27 claimants is added to the incurred claims by multiplying a pooling charge
28 by the estimated incurred claims above. The pooling charge selected is
29 17.3%. The total estimated incurred claims is equal to 1.173 times the
30 incurred claims excluding high-cost claimants.
31

1 **Q. Could you also give an overview of information that you use in order**
2 **to determine the trends that are used to determine future claim costs?**
3 A. Yes, we complete a retrospective and prospective review of trends for our
4 traditional rate development method (Method 1). As described in detail in the
5 Actuarial Memorandum Anthem BCBS has analyzed observed historical claim
6 data patterns for both the cost and utilization of services rendered to HealthChoice
7 and Lumenos members in hospitals, by physicians, and through the purchase of
8 prescription drugs. Along with the analysis of historical patterns, we gather
9 information from Anthem BCBS associates responsible for contracting with
10 providers of healthcare. From this data, we produce an estimate of the expected
11 changes in what Anthem BCBS will pay providers for the services they provide to
12 HealthChoice and Lumenos members. Anthem BCBS then accounts for changes
13 in the mix of services rendered and the impact of deductible leveraging in order to
14 determine a trend which is applied to current claim costs to estimate what claim
15 costs will be during the time when the proposed premiums will be available to pay
16 these claims.
17
18 **Pooling Charge**
19 **Q. Why did Anthem include two different rate development methods this**
20 **year?**
21 A. As I testified earlier, Anthem BCBS added an additional rate development
22 method to this year's filing based on comments included in the Superintendent's
23 2008 D&O and as a reasonableness check for our traditional rate development
24 method.
25
26 **Q. How was the pooling charge for Method 2 selected?**
27 A. Anthem BCBS filed HealthChoice and Lumenos rates without the use of
28 a pooling charge because we have been able to place great validity on the recent
29 stability shown by the block in our traditional (Method 1) rate projections. In
30 situations where there is less volatility in the high-cost claimant experience (as is
31 the case with the HealthChoice and Lumenos recent experience), a pooling charge

1 has little effect on the overall claims trend. This is exhibited in the very similar
2 net claims trend resulting from Method 1 and Method 2 in the HealthChoice and
3 Lumenos filing.

4 In any event, to select the pooling charge for Method 2, Anthem BCBS
5 reviewed experience for members with more than $100,000 in paid claims during
6 the 12-month periods ending in December 2005 through September 2008. After
7 identifying the high-cost members for each period, their paid claims in excess of
8 the $100,000 were totaled. Excess claims as a percentage of incurred claims
9 excluding high-cost claimants were calculated for each period. In reviewing the
10 observed values, Anthem BCBS noted that the percentages or pooling charge
11 values have been steadily increasing since mid-2007. The average pooling charge
12 for the most recent 6 periods excluding the lowest and highest values results in a
13 value of 17.3%. Anthem BCBS also calculated an alternate pooling charge that
14 takes into account the trend on the claims which produces a pooling charge of
15 17.8%. The 17.3% assumption used is near the low end of the reasonable range
16 generated by these alternate estimates.

17

18 **Q. Can you explain why Anthem BCBS reviewed paid claims experience**
19 **for the high-cost claimants instead of attempting to complete the claims?**

20 A. Anthem BCBS feels that it is a reasonable assumption to review patterns in high-
21 cost claimants for the HealthChoice and Lumenos products without completing claims.
22 The following are reasons supporting this decision:

23 - As a general rule, large claims are a high severity low frequency event that is
24 extremely difficult to predict much less determine run-out for.
25 - Completion on a subset of high-cost claimant only data becomes impossible
26 due to the extreme volatility.
27 - The number of HealthChoice and Lumenos members with claims exceeding
28 $100,000 in a 12-month period has been in the range of 77 to 106 members.
29 The claim triangle for this subset of members lacks credibility.

1 • There are likely HealthChoice and Lumenos members who are presently in the
2 hospital incurring charges in excess of $100,000 that have not yet resulted in
3 claims.
4 • Normal completion factor estimation does not address this type of claim
5 because the member does not have any paid claims yet.
6
7 When analyzing claims at a member level, we generally avoid attempting
8 to complete claims since completion factors, by definition, are meant to be
9 applied to a broader set of claims (i.e., all members within a pool) and not meant
10 to be applied at the specific claim or member level. The important thing is that the
11 total claims for the pool are maintained such that when a subset is carved out of
12 the pool (i.e., the high-cost claimants for the 12-month period ending October
13 2008), a corresponding subset is added back in (i.e., the pooling charge calculated
14 in a consistent manner).
15
16 In the Method 2 rate development, Anthem BCBS chose to complete the
17 claims for the entire pool first, consistent with the intended use of the underlying
18 completion factors. In this way, we are capturing the entire amount of estimated
19 claims for the experience period before removing the high-cost claimant
20 experience in excess of $100,000. In essence, the run-out or removal of claims is
21 equal to the run-in or addition of claims.
22
23 **Q. Why is Anthem BCBS not relying on the pooling charge calculation in**
24 **its required premium rate development?**
25 A. The second rate development method has been added to this year's filing
26 as primarily a reasonableness check. The recent experience for the HealthChoice
27 and Lumenos high-cost claimants in excess of $100,000 has been very steady as a
28 percentage of total claims. As I stated earlier, in situations where there is less
29 volatility in the high-cost claimant experience, a pooling charge has little effect on
30 the overall claims trend. With the relative high-cost claimant stability shown by
31 this block in recent years, the Method 1 rate development is a more reasonable

1 method of projecting future claim cost that analyzes trend both retrospectively
2 and prospectively.
3
4 **Other Rate Components (Rebates, Mandates, and Retention)**
5 **Q. There are other components of rates. How have these changed from**
6 **the previous filing?**
7 A. The other rate components have all changed slightly from last year's
8 filing. They reflect updated expectations of future costs and credits.
9 - Anthem BCBS projected pharmacy rebate credits at a level of $6.72
10 PCPM. This represents 11.5% of the expected pharmacy claims during
11 the rating period. The rebates as a percentage of claims are based on
12 calendar year 2007 actual experience.
13 - Administrative expenses for 2009 are projected at $35.73 PCPM which is
14 lower than the $37.01 PCPM assumed for 2008.
15 - Projected commissions are based on actual levels of commissions paid for
16 the HealthChoice and Lumenos products in recent experience.
17 - The profit and risk charge remains at 3% as required by the
18 Superintendent.
19 Additional adjustments to projected claims were also made for the following:
20 - Additional claims were projected to account for the impact of the
21 colonoscopy benefit added to the HealthChoice preventive rider. We have
22 allocated the entire additional cost of this mandate to the policyholders
23 with the PCSA rider since they will be the ones benefiting from additional
24 coverage.
25 - Additional claims were also added to account for two high-cost claimants
26 migrating from large group policies to individual HealthChoice products.
27 Both members have had extremely high levels of claim cost and Anthem
28 BCBS assumes that these members will negatively impact future claims
29 experience in the combined HealthChoice and Lumenos pool.
30

1 **Q. Can you provide more detail on the change in benefits for the**
2 **HealthChoice preventive care and supplemental accident (PCSA) rider?**
3 **Why is the increase in the rider premium so high?**
4 A. Effective January 1, 2009, Anthem BCBS reimburses colonoscopies as a
5 preventive benefit covering 100% of the cost of the screenings for PCSA
6 members. Benefits covered under the rider prior to 2009 were limited to the
7 following major categories: prenatal and newborn care, well-child care, well-adult
8 care limited to $100 annual maximum, and a list of other services. The
9 introduction of the colonoscopy coverage represents a significant increase in the
10 coverage provided for "well-adults" and, hence, a significant impact to projected
11 claim cost. Anthem BCBS proposes a 58.2% increase to the base PCSA rider
12 premium rate of which 51.2% is due to the addition of the colonoscopy benefit.
13
14 **Q. Can you provide more detail on the two migrating members?**
15 A. It is a rare case when an insurance carrier has knowledge of not
16 one but two high-cost claimants that are entering a pool such as the HealthChoice
17 and Lumenos pool. In the case of a larger pool of members with higher margin
18 for risk included in the premiums, the entry of one high-cost claimant might not
19 make a material difference in a carrier's ability to cover the projected claims and
20 expenses. In the case of this small pool with essentially no margin allowed for
21 risk, however, the known introduction of two abnormally high-cost claimants
22 presents a significant potential for premiums not adequately covering expected
23 claims and expenses.
24
25 Although predicting high-cost claimants is usually not possible, these two
26 members have persistent conditions that will most certainly incur a significant
27 amount of claim cost during the projection period. Because these members
28 experience was not included in the base claims experience, our traditional rate
29 development method and the second reasonableness check method fail to capture
30 this higher level of claims. The high level of claim cost experience by both
31 migrating members is not reflected in the underlying experience and we anticipate

1 that future levels of high-cost claimant activity will be affected by the entry of
2 these two members into the HealthChoice and Lumenos pool.
3
4 If the rates do not account for the expected claims for these two members
5 and the remainder of the pool performs as expected, Anthem BCBS will not
6 achieve the 3% pre-tax profit margin and, indeed, Anthem BCBS may not earn
7 any profit on the HealthChoice and Lumenos products for the rating period. Put
8 differently, if these significant expected claims are not included, the rates will not
9 be adequate; that is, they will not cover all costs plus allow for even the limited
10 profit margin that the Superintendent has determined is reasonable.
11
12 **Q. Have your enrollment projections changed since last year's filing?**
13 A. No, Anthem BCBS continues to project enrollment through the use of
14 observed patterns applied to future periods. For each benefit option members are
15 projected on a month by month basis through the end of the rating period using an
16 observed trend in enrollment over the past year. Anthem BCBS then adjusted the
17 projected change in members by benefit option to consider that the lapse rate on
18 certain higher deductible options is slowing down and the rate of sales in the
19 Lumenos products is likely to slow with the proposed rate increase. The projected
20 contracts are then determined by applying the members per contract ratio by
21 benefit option. Anthem BCBS projects that our overall membership will decline
22 slightly in 2009 and into 2010. After experiencing significant losses in
23 membership in past years, Anthem BCBS believes that this rate of membership
24 loss can not continue and that membership is likely to remain relatively flat with
25 some decrease between now and mid 2010.
26
27 **Q. How do you arrive at a required revenue amount after you have accounted**
28 **for the claim portion of the rate?**
29 A. The required revenue is determined by calculating what will be needed in
30 order to pay projected claims, administrative expenses, premium tax,
31 commissions, profit and risk, and savings offset payment, with an offset for

1 investment income. Following is a summary of how the necessary premiums are
2 calculated:

3 1. Incurred claims are projected as described previously along with a
4 credit to account for pharmacy rebates earned by HealthChoice and
5 Lumenos prescription drug claims.

6 2. Provisions for retention items (administrative expenses,
7 commissions, premium tax, risk and profit, savings offset payment
8 – net of interest income on tax flow) were developed based on
9 projected enrollment, benefits, and administrative costs.
10 Administrative expenses included in the filed rates are $35.73
11 PCPM and are based on actual 2008 administrative expenses.
12 The commission rate component is based on actual commissions
13 paid in calendar year 2008. A projected pre-tax amount of 3% for
14 profit and risk (2% post-tax) is included in this filing.
15 Premium tax is included at the statutory level of 2% of premium.
16 An amount has been included as a credit for investment income on
17 cash flow based on the Decision and Order in the 2007
18 HealthChoice proceeding.
19 The SOP is included at 2.14%. The value applied to determine
20 rates, 1.64%, is lower than the 2.14% due to the fact that the SOP
21 is applicable to claims incurred with in-state providers only.

22 3. Revenue requirements for the rating period are calculated as (a)
23 projected benefit costs, plus (b) the provision for retention items.

24

25 <u>**Rule 940 Compliance**</u>

26 **Q. During the discovery process it was determined that some of the**
27 **proposed rates were out of compliance with the rating requirements included**
28 **in Rule Chapter 940. How are you responding to this issue?**

29 A. Anthem BCBS discovered errors in the formulas used to calculate the
30 rates for the Lumenos plan designs in Exhibit III. We were applying the Rule 940
31 premium difference to the age 40-44 rates instead of the 55-64 rates. Anthem

1 BCBS has provided revised exhibits resulting in proposed rates now in
2 compliance with the rating requirements of Rule Chapter 940.
3
4 **Q. Current HealthChoice rates include adjustments approved by the**
5 **Superintendent for certain benefit plans beyond the allowed rating**
6 **requirements of Rule 940. Are these adjustments included in the proposed**
7 **rates included in this filing?**
8 A. Yes, Anthem BCBS used the same adjustments as exceptions to Rule 940
9 as were approved by the Superintendent in last year's Decision and Order.
10 As it did last year, Anthem BCBS applied these adjustments in order to reflect
11 more appropriately "reasonably anticipated differences in utilization" as the result
12 of differences in benefits. The utilization factors upon which the adjustments are
13 based are small, ranging from 1.0% to 7.6%. They are applied as utilization
14 factors within pricing for the six Non-Mandated options with deductibles $150,
15 $300, $500, $750, $1,000, and $2,250. Both the allowable benefit difference and
16 the utilization factors are used in their entirety. The largest adjustment, 7.6%, is
17 applied to the $2,250 deductible option in relation to the $5,000 deductible option.
18 The other adjustments are applied to the $150, $300, $500, $750 and $1,000
19 deductible options in relation to the next higher deductible option (e.g., $150
20 relative to $300 deductible).
21
22 **Q. What premium rate differential is Anthem BCBS proposing for**
23 **Lumenos effective 7/1/2009? Is this an exception to Rule 940?**
24 A. Anthem BCBS is proposing a rate decrease between the HealthChoice
25 $5000 deductible with PCSA Rider and Lumenos H.S.A. $5000 deductible of
26 8.9%. This rate decrease is based on a belief that the Lumenos plan designs
27 modify member behavior by encouraging preventive care and better managing
28 chronic conditions to reduce utilization. These benefit plan differences should
29 lead to better health outcomes for the Lumenos plan designs. This proposed
30 utilization adjustment represents an exception to Rule 940. To support the 6%
31 utilization factor applied to the Lumenos rate development, Anthem used a best

1 estimate of possible utilization-based savings for consumer-driven health plans
2 (CDHP). Industry articles from other carriers have placed a broad range around
3 savings for CDHPs. We reviewed plan design differences between the
4 HealthChoice and Lumenos products in order to narrow the range of potential
5 savings. In particular, while we expected inpatient utilization to decrease, the
6 utilization of preventive services is likely to increase as more members take
7 advantage of the rich preventive benefit available. Because experience is still
8 immature, we are unable to review actual utilization-based savings against our
9 current assumption. We feel that the 6% utilization factor applied takes into
10 account all of the information available and is appropriate for the guaranteed issue
11 population in Maine.
12
13 **Other**
14 **Q. Anthem BCBS negotiates reimbursement rates with providers in**
15 **Maine. Do HealthChoice members receive these discounts when paying**
16 **claims subject to their member cost sharing?**
17 A. Yes, Anthem BCBS negotiates reimbursement rates with providers and the
18 benefit of these negotiated rates are passed on to our members. Participating
19 providers are contractually required to accept the Anthem BCBS allowed amount
20 when providing services to Anthem BCBS members. Members receive the
21 benefit of these negotiated rates through both lower premiums and lower out of
22 pocket expenses when paying for claims subject to member cost sharing. It is true
23 that some HealthChoice and Lumenos members may not satisfy their annual
24 deductible and thus will not receive reimbursed benefits in any given year.
25 However, they do benefit from Anthem BCBS's negotiated discounts for every
26 service they receive and as such they will pay considerably less for those services
27 than if they were paying for them without the benefit of Anthem BCBS's
28 negotiated discounts. As an example, consider a 35 year old adult subscriber with
29 a $10,000 deductible who receives services from participating providers with an
30 allowed amount of $10,000 and actual charges of $12,500. Anthem BCBS's
31 discount for these services is 20% off the actual charge. In the absence of this

1 discount the charge to the patient would have been $12,500, but based on the
2 discounts Anthem BCBS was able to secure through provider negotiations, the
3 HealthChoice member saves $2,500. The proposed annual premium in this filing
4 for this subscriber would be $2,801.52. As such, even though the member's
5 deductible is not satisfied, the savings realized in this example is nearly the full
6 value of the annual premium paid by the subscriber.
7
8 HealthChoice and Lumenos members benefit from discounts for all
9 medical service types, including hospital, physician, and pharmacy claims.
10
11 **Q. What is the loss ratio permitted for these plans and, if the proposed rates are**
12 **approved, what loss ratios are anticipated for these products?**
13 A. Maine law permits a minimum loss ratio of 65% for products such as
14 HealthChoice. If the proposed rates are approved as filed, and all projections turn
15 out to be accurate, the anticipated loss ratio is 87.7% for the rating period.
16
17 **Q. Are you filing revised exhibits?**
18 A. Yes. For ease of reference, Anthem BCBS is providing with this
19 testimony a complete copy of the entire filing, including all Exhibits (as revised),
20 Rule 940 requirements, and the Actuarial Memorandum.
21
22 **Q. Please summarize the revisions you have made to the exhibits and**
23 **memorandum and why they were made.**
24 A. The revisions were made as a result of an error in the premium calculation
25 formula in Exhibit III. The overall premium dollars stayed the same but the
26 average premium rate increase changed slightly to 18.5%. Additionally, Anthem
27 BCBS corrected the administrative expense amount for 2006. Exhibits changing
28 only as a result of changes made to other exhibits are not noted below. Below is a
29 summary of the revisions to the exhibits.

1 ▪ Exhibit III: Lumenos premium rates were corrected to apply the Rule 940 rate
2 differential to the age 55-64 two adult family contract type. HealthChoice rates
3 changed accordingly such that the total premium required stayed the same.
4 ▪ Exhibit IX: Anthem BCBS corrected the 2006 administrative expense amount and
5 added the projection period (7/1/2009 to 6/30/2010) to this exhibit based on the
6 Superintendent's first discovery questions.
7
8 No material changes were made to the Actuarial Memorandum other than
9 updating the premium rate increases that resulted from the change to the Lumenos
10 rates as described.
11
12 **Q. In your actuarial judgment, are the proposed rates excessive,**
13 **inadequate or unfairly discriminatory?**
14 A. In my judgment the rates as amended and accompanying this testimony
15 are not excessive, inadequate, or unfairly discriminatory.
16
17 **Q. Does this conclude your testimony?**
18 A. Yes.

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

IN RE:	)	
ANTHEM BLUE CROSS AND BLUE SHIELD 2009 INDIVIDUAL RATE FILING FOR HEALTHCHOICE, HEALTHCHOICE STANDARD AND BASIC AND LUMENOS CONSUMER DIRECTED HEALTH PLAN PRODUCTS	)	**CERTIFICATE OF SERVICE**
Docket No. INS-09-1000	)	

The undersigned counsel 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 Prefiled Testimony of Jennie Casaday upon the persons and at the addresses indicated below.

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DATED March 6, 2009

/s/ Christopher T. Roach
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March 6, 2009

Mila Kofman, Superintendent
c/o Pat Galouch
Docket No. INS-09-1000
Maine Bureau of Insurance
34 State House Station
Gardiner, Maine 04333-0034

RE: ANTHEM BCBS HEALTHCHOICE & LUMENOS INDIVIDUAL RATE FILING EFFECTIVE JULY 1, 2009

I. FILING COVERSHEET

Dear Superintendent Kofman:

Enclosed for filing please find the following:

SUBMITTED BY: Christopher T. Roach

DATE: March 6, 2009

DOCUMENT TITLE: Prefiled Testimony of Vincent Liscomb Jr.

DOCUMENT TYPE: Prefiled Testimony

CONFIDENTIAL: **No**

Thank you for your assistance in this matter.

Very truly yours,

/s/ Christopher T. Roach

cc: Thomas C. Sturtevant, Esquire
Christina M. Moylan, Esquire

NON-CONFIDENTIAL

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

IN RE:	)	EXHIBIT 2
	)	
ANTHEM BLUE CROSS AND BLUE SHIELD 2009 INDIVIDUAL RATE FILING FOR HEALTHCHOICE, HEALTHCHOICE STANDARD AND BASIC AND LUMENOS	)	PREFILED TESTIMONY OF VINCENT LISCOMB JR.
	)	
DOCKET NO. INS-09-1000	)	
	)	March 6, 2009

NON-CONFIDENTIAL

1 **Q. Please state your name and your position with Anthem Blue Cross and Blue**

2 **Shield ("Anthem BCBS").**

3 A. My name is Vincent Liscomb Jr. and I am Executive Director of Provider

4 Network Management.

5

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

7 **witness today.**

8 A. I have worked in the health care industry for nineteen years in a variety of

9 positions, with a primary focus on hospital and physician contracting and provider

10 network management. For the last five years, I have been employed by WellPoint, first

11 as Regional Vice President of Network Development and Management at Blue Cross

12 Blue Shield of Georgia, and more recently as Executive Director of Provider Network

13 Management for Anthem BCBS of Maine.

14

15 Dan McCormack, and Amy Cheslock held this position in years past and provided

16 testimony at previous hearings.

17

18 **Q. What is the scope of your testimony?**

19 A. My testimony will describe Anthem BCBS's philosophy and process for

20 negotiating provider agreements and ensuring that Anthem BCBS obtains the lowest

21 possible contract prices for our members, while balancing the need to ensure that we

22 maintain the stable and broad network to serve our members' healthcare needs. As has

23 been described in prior HealthChoice and DirigoChoice rate hearings, part of that process

24 is to ensure that all cost savings, whether or not they are as a result of the operation of

25 Dirigo Health, are included in the contract rates that we have negotiated with providers

26 and, therefore, included in the assumptions for the proposed HealthChoice and Lumenos

27 rates.

28

29 **Q. Please describe the status of the 2009 savings offset payment.**

1 A. On August 11, 2008, the Board of Directors of the Dirigo Health Agency issued a
2 decision finding aggregate measurable cost savings ("AMCS") of approximately $150
3 million. On September 23, 2008, the Superintendent issued a decision finding $48.7
4 million AMCS to be reasonably supported by the record evidence. Based on that AMCS
5 determination, the DHA Board determined that the SOP assessment effective July 1,
6 2009 is 2.14%.
7
8 **Q. You and your predecessors testified in proceedings before the**
9 **Superintendent in, among others, last year's HealthChoice and DirigoChoice and**
10 **AMCS proceedings. Before describing the process your team uses in provider**
11 **negotiations, please state whether that process has changed at all since your prior**
12 **testimony.**
13 A. No, our negotiation strategy and process have not changed.
14
15 **Q. Please describe the process Anthem BCBS uses to negotiate with providers.**
16 A. Anthem BCBS is constrained by the network adequacy requirements of Rule 850,
17 but our team engages in an extensive and vigorous negotiation process with Anthem
18 BCBS's providers to get the best possible contract price for our members. We generally
19 start the process many months in advance of the renewal. During the negotiation process,
20 we have internal discussions concerning financial data from the provider, as well as
21 extensive discussions with the provider to get their perspective of their financial status,
22 the factors that are impacting that status, and how to achieve the best possible contractual
23 arrangement that, while responsive to their concerns, ensures we achieve the absolute
24 best possible price. The impacts, if any, of Dirigo are included in those extensive
25 discussions, as well as any changes to bad debt and charity care costs.
26
27 **Q. You mentioned that you include in the negotiation process discussions**
28 **surrounding Dirigo. Does Anthem BCBS include in its discussions with providers**
29 **questions aimed at assuring that all cost savings categories determined by the**
30 **Superintendent to be includable in the calculation of AMCS are included in the**
31 **providers' rates?**

1 A. Yes. In our negotiations, we probe to ensure that all savings, from whatever
2 source, are included in the final negotiated rate. Hospital finance is complex and, as
3 such, it may never be possible to isolate with precision the cause of any cost savings or
4 reduction in the growth of expenses. To ensure any such savings are embedded in the
5 rates we negotiate with providers, we take a global perspective, asking specifics related to
6 Dirigo and other impacts, but in the end, working diligently to ensure that any cost
7 savings – no matter the source or cause – are reflected in our provider contracts.
8
9 **Q. Understanding that isolating the cause of any particular cost savings driver**
10 **may be impossible to ascertain, have providers indicated that the contract rates**
11 **include any cost savings that have resulted from Dirigo?**
12 A. Yes, providers have given us that assurance to the extent there are savings our
13 detailed discussions and analyses ensure that we get the best possible contract rates for
14 our members, which would include any cost savings, if any that have resulted from
15 Dirigo.
16
17 **Q. Do your discussions also include the impact of expansions in MaineCare?**
18 A. Yes, but it is important to recognize that expansions in MaineCare do not
19 necessarily reduce a provider's costs. For example, the rate of reimbursement to a
20 hospital for a MaineCare member seeking particular services is clearly higher than if that
21 same individual is uninsured and does not pay for the services rendered by the hospital.
22 In that situation, all else equal, the reimbursement from MaineCare has a positive effect
23 on the hospital's financials. If instead, however, the MaineCare member formerly had
24 commercial insurance, the member's migration to MaineCare would have a negative
25 impact on the hospital financially because the MaineCare reimbursement rate is lower
26 than the rate paid by commercial insurers.
27
28 **Q. Are you confident that Anthem BCBS has used its best efforts to recover in**
29 **negotiated rates all cost savings that are as a result of the operation of Dirigo Health**
30 **or expansions in MaineCare?**
31 A. Yes, I am confident of that.

1
2 **Q. What duration of contract does Anthem BCBS typically seek in a provider**
3 **agreement?**
4 A. For network stability and predictability, we prefer a multi-year agreement.
5
6 **Q. If provider agreements are for multiple years, how do you ensure that cost**
7 **savings attributable to Dirigo Health are included in the out years of the contract?**
8 A. As I have previously testified, we negotiate vigorously to ensure that we get the
9 best possible contract rates, including any cost savings that may be attributable to Dirigo.
10 In multi-year deals, we often negotiate inflationary factors that would maintain the lowest
11 possible rates for the duration of the contract. As such, if additional cost savings yield
12 better financial results for the provider, we have the ability to recapture those savings in
13 the out years.
14
15 **Q. For those multi-year contracts in which you do not have an inflationary**
16 **factor, would you suggest re-opening the contract in the event that cost savings**
17 **proved to be greater than expected?**
18 A. No, I would not suggest that contracts should be re-opened in the out years. Our
19 negotiation process is vigorous and there are many concessions made by both sides to the
20 agreement that are important to the totality of the agreement. As such, if we were to
21 suggest re-opening the agreement in an out-year due to higher than expected AMCS,
22 undoubtedly the provider would want to re-open other aspects of the agreement that will
23 have been favorable to Anthem BCBS and its members. Attempting to re-open
24 negotiations midway through the contract term would also undermine our approach to
25 multi-year deals, which provide stability that benefits our members.
26
27 **Q. Once your team has negotiated a contract rate with a provider, how does that**
28 **provider rate become embedded in premium rates, such as the rates proposed for**
29 **HealthChoice and Lumenos members?**
30 A. There is an impact in really two ways. First, our contract team communicates
31 regularly with a forecasting team so that they can include in their cost projections the

1 most up to date information concerning expected contract rates. That forecasting team
2 includes representatives from underwriting, actuarial and forecasting. In addition to
3 using this up to date information in forecasting costs, all of the discounts that are in place
4 in our current agreements are embedded in the HealthChoice and Lumenos claim
5 experience upon which the proposed rates are based.
6
7 So in summary, any cost savings that are attributable to Dirigo are captured in Anthem
8 BCBS's provider agreements and those contract rates are used to develop premium rates,
9 such as those proposed for HealthChoice and Lumenos for 2009.
10
11 **Q. Does this conclude your testimony?**
12 A. Yes.

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

IN RE:	)	
ANTHEM BLUE CROSS AND BLUE SHIELD 2009 INDIVIDUAL RATE FILING FOR HEALTHCHOICE, HEALTHCHOICE STANDARD AND BASIC AND LUMENOS CONSUMER DIRECTED HEALTH PLAN PRODUCTS	)	**CERTIFICATE OF SERVICE**
Docket No. INS-09-1000	)	

The undersigned counsel 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 Prefiled Testimony of Vincent Liscomb Jr. upon the persons and at the addresses indicated below.

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DATED March 6, 2009

/s/ Christopher T. Roach

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Attachment "Prefiled 2009JULY Lumenos and HealthChoice thruDec08 2009030 (W1322955).XLS" is not a PDF document and cannot be reproduced here.

EXHIBIT 4

INDIVIDUAL HEALTH RATE FILING
HealthChoice, HealthChoice Standard & Basic, and Lumenos
Effective July 1, 2009

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1. Information Required by Rule Chapter 940

2. Actuary's Memorandum

3. Statement of Qualified Actuary

4. Rate Schedules

INDIVIDUAL HEALTH RATE FILING

HealthChoice, HealthChoice Standard & Basic, and Lumenos
Effective July 1, 2009

Rule Chapter 940 Requirements

Carrier Information

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

Submitted By

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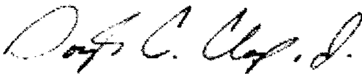
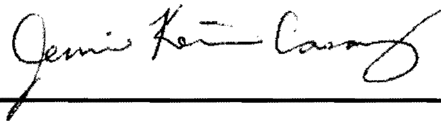



SIGNATURE

Scope and Purpose of Filing

This memorandum is provided to support the proposed rate revisions for the individual HealthChoice (including Standard and Basic) and Lumenos Consumer Directed Health Plan (CDHP) products. It is intended to demonstrate compliance with 24-A M.R.S.A. §2736-C and any other applicable statutes and regulations. It is not intended for use for any other purpose.

This rate revision is being filed because claim costs associated with the benefits offered have increased and are expected to continue increasing and the rates for these products, if not increased, are and would continue to be inadequate.

Description of Benefits

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

HealthChoice Standard & Basic are the statutory individual products that must be offered by any carrier that offers individual PPO products. Deductibles of $250, $500, $1,000 and $1,500 are available for each product consistent with Rule Chapter 750 requirements. An optional amendment may be elected to cover listed mental illnesses at the benefit level provided for medical treatment for physical illnesses.

{W1249825 1}

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

In Force Business

As of December 2008, HealthChoice and Lumenos individual products in force enrollment included 11,965 contracts with an annualized premium of approximately $64.9 million based on current rates.

Proposed Effective Date

These proposed rates are intended to become effective on July 1, 2009. The analysis and loss ratio calculations in this filing contemplate that the proposed rate revision will be implemented for all policies with the applicable premium payment for July 2009. In order to implement revised rates coincident with the July 2009 effective date, Anthem BCBS requests that the Bureau issue its D&O on this filing no later than April 24, 2009. Delay in the implementation of the proposed increase would have an impact on the increases needed to ensure revenue is adequate to cover all underlying costs as set forth herein. Accordingly, if the Bureau determines that the D&O will not be issued by April 24, 2009, Anthem BCBS requests that the Bureau advise Anthem BCBS as soon as possible so that the filing may be amended to contemplate a later implementation date.

Morbidity Assumed

Actual claim experience for the individual HealthChoice and Lumenos products of Anthem BCBS for the incurred period November 1, 2007 through October 31, 2008, paid through December 31, 2008, and completed was utilized for development of the proposed rates. This experience is assumed to be 100% credible.

Mortality Assumed

Not applicable.

Issue Age Range

There is no limitation on issue age. However, new policies are issued to subscribers age 65 and over only if they are not eligible for Medicare Part A without paying a premium.

Premiums are on an attained age basis.

Average Annual Premium

In this filing, there are two blocks for rating purposes: HealthChoice and Lumenos Non-Mandated Options and HealthChoice Mandated Options. The following table shows the average annual premium per contract based on current rates and with the proposed rate revision based on the experience period distribution of contracts.

	Non-Mandated	Mandated
Before rate revision:	$5,831	$13,355
After rate revision:	$6,924	$14,579
Dec. 2008 contracts:	11,846	119

Largest Premium Increase

The largest premium increase for the Non-Mandated HealthChoice Options is 24.5% for the $15,000 deductible with PCSA rider option. The largest premium increase for the Lumenos options is 38.4% for the H.S.A. $5000 Deductible option. For HealthChoice Mandated Standard and Basic, the largest premium increase is 9.7% for both the Standard and Basic options with $1,500 deductible/$1,000 coinsurance limit. These increases reflect changes in the community rate for subscribers remaining in their current age band only. Additionally, any HealthChoice subscriber entering a new age band will incur an additional increase of:
(1) 3.1%, for those moving into the 30 to 39 from the under 30 age band, or
(2) 21.2% for those moving into the 40 to 44 from the 30 to 39 age band, or
(3) 7.5% for those moving into the 45 to 54 from the 40 to 44 age band, or
(4) 11.6% for those moving into the 55 to 64 from the 45 to 54 age band.
Any Lumenos subscriber entering a new age band will incur an additional increase of:
(1) 3.1%, for those moving into the 30 to 39 from the under 30 age band, or
(2) 11.1% for those moving into the 40 to 44 from the 30 to 39 age band, or
(3) 7.5% for those moving into the 45 to 54 from the 40 to 44 age band, or
(4) 9.1% for those moving into the 55 to 64 from the 45 to 54 age band, or
(5) 25.0% for those moving into the 65+ from the 55 to 64 age band.
Note that the HealthChoice and Lumenos age band steps vary in 2009 because of the change to the Lumenos age band factors shown below.

Number of Policyholders

As of December 2008 there are 11,965 policyholders who will be affected by the rate revision.

Medical Trend Assumptions

The medical trend assumption varies by projection method from 10.1% for claims excluding high-cost claimants up to 14.1% allowed claims plus leveraging trend as detailed in the Actuary's Memorandum.

Maine Experience on the Form (Past and Future Anticipated)

Please refer to Exhibit X for experience information.

National Experience

Not applicable.

{W1249825 1}

History of Average Rate Adjustments

Average rate increases for HealthChoice products:

Effective Date	Increase	Effective Date	Increase
Jul-92	9.40%	Feb-02	12.70%
Jul-93	14.00%	Jan-03	3.40%
Jun-95	15.30%	Jan-04	0.00%
Sep-96	17.00%	Mar-05	14.50%
Oct-97	6.30%	Mar-06	16.30%
Jan-99	20.40%	Jan-07	16.70%
Nov-99	15.70%	Jul-07	1.30%
Jan-01	23.50%	Jan-08	12.50%

Renewability Clause

Individual HealthChoice and Lumenos products are guaranteed renewable.

Loss Ratio

Rule Chapter 940, Section 7 and 24-A M.R.S.A. §2736-C refer to several loss ratio standards. The minimum loss ratio under any of these standards is 65%, which means that the loss ratios projected for these products must be at or above 65%.

Except in 1993, past actual loss ratios have been higher than 65%. The lifetime incurred loss ratio for individual HealthChoice and Lumenos combined is 82.5% through year-end 2007.

If the rates are increased as proposed in this filing and made effective July 1, 2009, the estimated anticipated loss ratio for calendar year 2009 will be 88.7%. For the 12 month rating period ending June 30, 2010, the anticipated loss ratio is 87.7%.

Premium Classes

Contract type factors are as follows:

	HealthChoice		Lumenos*	
	Current	Proposed	Current	Proposed
One Adult	1.000	1.000	1.000	1.000
Two Adults**	2.000	2.000	1.800	1.800
Two Adults/Child(ren)**	2.527	2.527	2.650	2.527
One Adult/Child(ren)	1.568	1.568	1.551	1.568
Child(ren)	0.650	0.650	0.650	0.650

*Lumenos two-adult contract type factor is 90% of the HealthChoice factor because the deductible is aggregate instead of embedded consistent with current factors.

**Rates for any contract types with two adults in different age bands are determined by the younger of the two adults.

{W1249825.1}

Age band factors are as follows:

	HealthChoice		Lumenos	
	Current	Proposed	Current	Proposed
Age less than 30	0.800	0.800	0.800	0.800
Age 30 to 39	0.825	0.825	0.900	0.825
Age 40 to 44	1.000	1.000	1.000	1.000
Age 45 to 54	1.075	1.075	1.100	1.075
Age 55 to 64	1.200	1.200	1.200	1.200
Age 65 and above	1.200*	1.200*	1.500	1.500

*Age 65 and above rates for HealthChoice are approved to use a 1.500 factor for new business, but Anthem BCBS has not implemented this rate change.

On the occasion when a subscriber changes age bands due to a birthday in the course of the calendar year the new rate for the higher age band will go into effect on January 1 of the following calendar year or coinciding with the next approved rate action e.g. July 1, 2009. In 2009, subscribers with birthdays from 1/1/2008 through 12/31/2008 will receive any required age band increases on January 1, 2009 and subscribers with birthdays from 1/1/2009 through 6/30/2009 will receive any required age band increases on July 1, 2009. The next anticipated age band increase is 1/1/2010 for subscribers with birthdays from 7/1/2009 to 12/31/2009.

Marketing Method

This product is typically marketed through direct mail and newspaper advertising. An in-house staff of account executives responds to telephone inquiries. Product information is available on the Anthem BCBS website. Every telephone directory in Maine lists an 800 number for Anthem BCBS. Appointed producers also sell individual products throughout the state.

Enrollment kits sent in response to any inquiry include information about all individual products sold by Anthem BCBS, including Standard and Basic HealthChoice, that potentially meet the needs specified in the inquiry.

Medical Underwriting

All Anthem BCBS individual products are offered on a guaranteed issue basis. No medical underwriting is done during the sales or acceptance/enrollment processes. Anthem BCBS determines which new members will have pre-existing condition ("PEC") restrictions applied to their coverage. If and when these members incur claims during the applicable period, the medical underwriting process is used to administer the PEC limitations, according to state statutes.

Notice to Policyholders

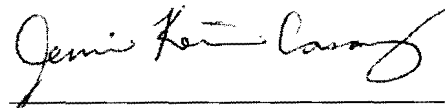
Notice of the proposed rate revision will be mailed on or about February 9, 2009. Written confirmation of the notice will be provided to the Bureau of Insurance when the notices have been sent. A draft letter is included with this filing.

Statement of Qualified Actuary

I have examined the assumptions and methods used in determining the claim assumptions and the premium rates for the HealthChoice, HealthChoice Standard, HealthChoice Basic, and Lumenos rate filing. In my opinion, the claims and premium rates are calculated in accordance with accepted actuarial standards consistently applied and are reasonable in relation to the benefits provided. In my opinion, the proposed premium rates are neither excessive, inadequate, nor unfairly discriminatory.

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

Douglas C. Clamp, Jr., FSA, MAAA
RVP & Actuary
Anthem Blue Cross and Blue Shield



Jennie Keith Casaday, FSA, MAAA
Actuary
Anthem Blue Cross and Blue Shield

March 6, 2009

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ACTUARY'S MEMORANDUM

This memorandum is filed in support of individual product premium rates proposed to be effective July 1, 2009.

Introduction

This memorandum describes the development of proposed premium rates for the individual HealthChoice and Lumenos products of Anthem Health Plans of Maine, Inc., d/b/a Anthem Blue Cross and Blue Shield ("Anthem BCBS") effective July 1, 2009. The products affected are:

- HealthChoice
- HealthChoice Standard (Standard Plan A)
- HealthChoice Basic (Standard Plan B)
- Lumenos Consumer Directed Health Plans (CDHP)

Where appropriate, Anthem BCBS has incorporated suggestions recommended by the Superintendent in the Decision and Order for the 2008 HealthChoice proceeding ("2008 D&O").

Summary of Filing Exhibits and Proposed Premium Increases

Exhibit I

Anthem BCBS has pooled the experience for the HealthChoice and Lumenos books of business for rating purposes. The primary objective of Exhibit I is to project premium levels which will cover all costs and allow for what the Superintendent has determined to be a reasonable amount for profit and risk. Anthem BCBS does not agree that a 3% pre-tax profit and risk charge is reasonable considering the risks of the Maine insurance market generally, and the HealthChoice and Lumenos membership specifically. Given the Superintendent's prior orders on this point, however, Anthem BCBS has incorporated in the proposed rates the 3% pre-tax profit charge. Exhibit I shows the derivation of the required premium increase through the projection of claims forward to the future rating period, including projected administrative expenses, commissions, premium tax, pre-tax profit/risk charge, investment income, rebates related to pharmacy claims, the savings offset payment ("SOP"), and an adjustment for changes as the result of laws passed in the first session of the 123rd Maine Legislature.

In this year's filing, Anthem BCBS is presenting two versions of our premium projection based on feedback in the 2008 D&O. Each method utilizes the same underlying claim experience but different claim cost trends are applied and pooling methods vary. The following describes each method:

- Method 1: Our traditional method of projecting premium used in prior filings. Trends are appropriate for total claims, not those excluding high-cost claimants.
- Method 2: In this version of our projection, claim cost trends are applied to claims after removing excess claims for high-cost claimants (defined as members with more than $100,000 in claims over 12 months) and a pooling charge is applied to estimate the impact of these claimants.

We have chosen to combine the HealthChoice and Lumenos pools. The HealthChoice and Lumenos basic benefit structures are relatively similar with similar deductible levels, coinsurance and preventive benefits. While we feel that the HealthChoice and Lumenos products could merit separate treatment based on experience and market segmentation, combining the pools is also in keeping with the intent of Maine pooling and Rule 940 requirements that seek to share the risk of the entire pool across all members.

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Due to Rule 940 requirements, the result of combining the HealthChoice and Lumenos pools is that HealthChoice members will receive a lower increase than their experience would otherwise warrant and Lumenos members will receive significantly higher increases than their experience only would suggest. Anthem BCBS is proposing to maintain the original premium differential between the Lumenos $5000 HSA option and the HealthChoice $5000 deductible of -2.5%. This rate differential was approved in our original filing for Lumenos effective 1/1/2007 and based on the following plan design differences that lead to lower utilization of services for Lumenos members:

1. Out-of-network coinsurance (20% member share)
2. Annual limit for pharmacy benefit
3. Enhanced preventive care benefits

A comparison of utilization statistics for Lumenos versus HealthChoice members shows that Lumenos members have significantly lower rates of hospitalization and less utilization of prescription drugs. Professional utilization is higher for the period but could be driven by the improved preventive care benefit. The following table is a summary of experience for the 12 months ending June 2008:

	Inpatient Days per 1000	Outpatient Services per 1000	Professional Services per 1000	Pharmacy Scripts per 1000
HealthChoice	244	6,491	13,755	7,011
Lumenos	158	6,839	14,115	6,478
Lumenos to HealthChoice	64.8%	105.4%	102.6%	92.4%

Anthem BCBS requests that the Superintendent continue to accept the current exception to Rule 940 to mitigate the required rate increase for Lumenos subscribers and in order to maintain existing rate relationships to the HealthChoice plan designs. The proposed rate relationship of -2.5% to the HealthChoice $5000 deductible keeps the Lumenos rate increases around 30%. Without the proposed exception, Lumenos plans would receive premium rate increases in excess of 40%. Lumenos plan designs offer health incentives and financial accounts which allow members to better manage their health and health care and thus have a positive impact on the overall claim experience. Consumers selecting these plan designs choose to play an active role in their health care spending which ultimately results in better experience (lower claim costs) than that of a traditional major medical health insurance product. For these reasons, the exception to Rule 940 for the Lumenos subscribers is reasonable and should continue.

Claim Base: Our experience period is the twelve month period ending October 31, 2008 which was completed with two months of claim run-out to account for claims incurred but not yet paid (Exhibit V provides the historical claim triangle on which the completion for claims incurred but not yet paid was based).

Claim Trend: Claims trend has been applied to the twelve month claim base and trended forward for nineteen months in order to estimate claims for the pricing period of twelve months ending June 30, 2010. Claims trend varies by projection method as follows:

- Method 1: We utilized our traditional method of applying trends which resulted in a 14.1% trend. Significant detail supporting this version of the projected claim trend is included in the summary section for Exhibit VI.A.
- Method 2: We applied an annual claims trend for claims excluding high-cost claimants of 10.1%. Detail supporting this version of the claim trend is shown in Exhibit VI.B.

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Proposed Anthem BCBS rates reflect the trend method that resulted in the lowest required premium in Exhibit I in order to hold premiums at the lowest level possible while covering projected cost.

High-Cost Claimants: Paid claims in excess of $100,000 for members that had over $100,000 in claims during the experience period are removed from the claim base in Method 2. The projected cost of high-cost claimants is estimated using a pooling charge as calculated in Exhibit XV. The assumed pooling charge of 17.3% is based on an analysis of prior period experience to determine the percentage of excess claims for a 12-month period out of the total claims excluding high-cost claimants. This method follows the one outlined in the 2008 D&O and is detailed in Exhibit XV.

Projected Enrollment: Enrollment in HealthChoice has been decreasing consistently since late 2005 while Lumenos enrollment has steadily grown since product inception in 2007. Anthem BCBS has projected enrollment through the end of the effective rating period based on historical enrollment patterns associated with past rate adjustments coupled with the premium increases proposed in this filing. Enrollment is projected in detail at the benefit level and then reviewed in the aggregate for reasonableness. Based on the level of rate increase proposed for the Lumenos contracts, we have anticipated a decline in the level of growth in the book of business. Additionally, as HealthChoice enrollment begins to level off, we have projected a decrease in the lapse rate for the actively sold plan designs. Projected enrollment is used to project adjustments to both claims (Exhibit II) and premium (Exhibit III).

Pharmacy Rebate Credit: Certain pharmacy claims incurred by HealthChoice and Lumenos members are eligible for and receive rebates from pharmaceutical manufacturers. Estimated pharmacy rebates are credited as a reduction to claims in Exhibit I. Details of the pharmacy rebate calculation are presented in the summary section for Exhibit VIII.

Administrative Expenses: The proposed rates contained in this filing include administrative expense charges of $35.73 per contract per month ("PCPM") or $21.02 on a per member per month ("PMPM") basis. The members/contracts ratio used to adjust the PCPM value is based on the rolling 12-month average ratio as of October 2008, as requested in the 2008 D&O. The WellPoint Hyperion System, a cost allocation system, has been used in order to determine the appropriate administrative costs associated with administering all functions related to HealthChoice. The cost allocation system allocates administrative expenses down to the product level. Each cost center within Anthem BCBS submits its budget along with a survey detailing what products the cost center supports and the function provided. Additionally, weighted membership and/or headcount are principally used in order to determine the percentage of each cost center's budget that will be allocated to a particular product.

The administrative expense currently projected for 2009 is $21.02 PMPM based on projected expenses for HealthChoice in calendar year 2008; this estimate is reasonable based on prior actual expenses. We do not expect the admin to change materially from the prior projected level of $20.91 PMPM in the 2008 HealthChoice filing. Anthem BCBS continues to make every effort to administer its business as efficiently as possible. Although there may be cost increases during 2009 that are unknown at this time, Anthem BCBS has determined not to include an inflation factor to determine the projected administrative expenses for 2009. In this way, the filing holds premiums at a level as low as possible to cover all associated costs.

Commissions: The proposed rates contained in this filing include a commission amount of $1.99 PCPM or $1.17 PMPM. This estimate is based on 2008 year-to-date actual commissions as shown in

Exhibit IX. Further, we are assuming that our mix of members (new and renewing, % broker-related, and persistency rates) will stay the same. The commission PCPM is higher than our 2008 filing because of the addition of the Lumenos business which consists mainly of new sales sold through brokers. Our broker business pays out a commission for the first 36 months of the policy for policies sold since 1/1/2007 and for the first 24 months for policies sold prior to 1/1/07.

Pre-Tax Targeted Profit and Risk Percentage: Anthem BCBS has consistently contended, with no disagreement from intervening parties or the Superintendent, that the rating of health insurance in general, particularly individual health insurance with high deductibles in a guaranteed issue and renewable environment, carries a high level of risk due to the potential for claim volatility and adverse selection. Due to the guaranteed issue and guaranteed renewable requirements, individuals have the ability to buy in and drop out of the pool at will, which also has the tendency to increase the risk that projections will not be achieved. As Anthem BCBS remains the only significant insurer in this market, HealthChoice has become a de facto individual high-risk pool for the State of Maine. The pool's experience is clearly deteriorating significantly and rapidly as evidenced in claim trends consistently in the mid to high teens.

In prior orders, the Superintendent determined that a 3% pre-tax margin for profit and risk for the HealthChoice products was sufficient. As illustrated by the significant losses for this product in 2005 and 2006 followed by moderate profits in 2007 and year-to-date 2008 (shown in Exhibit IX), the experience of the pool is extremely volatile and a 3% pre-tax margin is inadequate to cover the risks associated with providing individual insurance in this market. In this filing, Anthem BCBS has not embedded any component in the proposed rates to recover prior losses, but the volatility of the pool is relevant when considering what level of margin is necessary going forward to ensure that these products remain commercially viable products for Anthem BCBS to offer in the State of Maine. Despite Anthem BCBS's consistent and valid contention that a pre-tax profit and risk charge of 5.0% is justified and arguably at the low end of reasonableness based on prior HealthChoice performance, an amount of 3% for a targeted pre-tax profit and risk component is included in this filing in order to hold the required level of premium increase as low as possible. The inclusion of the 3% level in this filing does not reflect a belief on Anthem BCBS's part that this is an adequate level based on the risks associated with this product and the market and regulatory environment in which it is sold.

Premium Tax: This filing assumes that premium tax of 2.0% will apply to premiums.

Investment Income Percentage: The proposed rates contained in this filing include an investment income credit in the amount of –0.02%. Details supporting the investment income amount are presented in the summary section for Exhibit VIII.

Savings Offset Payment: The proposed rates include the SOP of 1.85% as determined by the Dirigo Health Agency Board ("DHA Board") to be effective from July 1, 2008 through June 30, 2009 and 2.14% to be effective July 1, 2009 through June 30, 2010. Details supporting the SOP amount included in the proposed rates are in the summary section for Exhibit VIII. In prior year's HealthChoice proceedings, the Superintendent determined 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." (*See* INS-05-820, December 20, 2005 D&O, §IV.D) Anthem BCBS continues to use those efforts to recover any available savings through negotiated reimbursement rates with health care providers. Anthem BCBS continues to aggressively pursue the lowest possible unit cost increases in all rate negotiations with hospitals. Our

rate negotiations consistently result in rates of increase that are at or below the hospitals' board-approved rate increases. In the event that trends are more favorable due to the Dirigo legislation than they would otherwise be, it is reflected in the proposed rates through lower base claims. Additionally, anticipated unit cost trends reflecting any savings included in the aggregate measurable cost savings determination are reflected in the projected unit cost trends incorporated in this filing.

Newly Mandated Benefits: There were a number of laws passed in the first session of the 123rd Maine Legislature that directly impact HealthChoice. Each law is summarized here along with a description of how it is addressed within this filing.

1. Public Law Chapter 516 (LD 2109) *"An Act Relating to Insurance Coverage for Colorectal Cancer Early Detection."*
Effective January 1, 2009, this law requires that all individual health insurance policies and contracts provide coverage for colorectal cancer screening for asymptomatic individuals who are fifty years of age or older; or less than 50 years of age and at high risk for colorectal cancer.

With the exception of the Preventive Care and Supplemental Accident Rider (PCSA) rider, Anthem BCBS already covers the cost of colorectal cancer screenings after member cost-sharing and at 100% for Lumenos members; there is no additional claim impact for non-PCSA and Lumenos policyholders. For PCSA policyholders, Anthem BCBS will implement a claims methodology that reimburses colonoscopies as a preventive benefit; Anthem BCBS will cover 100% of the cost of the screenings effective January 1, 2009 and reflect the additional cost in the rates effective July 1, 2009. We have allocated the entire additional cost of this mandate to the policyholders with the PCSA rider since they will be the ones benefiting from additional coverage. Further discussion of the impact of the colonoscopy benefit is included in the discussion of Exhibit XII below.

2. Public Law Chapter 595 (LD 658) *"An Act To Protect the Health of Infants."*
Effective January 1, 2009, this law requires that all individual health insurance policies, contracts and certificates must provide coverage for amino acid-based elemental infant formula for children 2 years of age when a licensed physician has submitted documentation that the amino acid-based elemental infant formula is medically necessary.

Anthem BCBS already covers claims for medically necessary amino acid-based infant formula when submitted through a licensed provider. We plan to update our notice of coverage to inform members of this benefit provision. We do not anticipate an impact on claim costs due to this mandate.

Change in Pharmacy Benefits: Effective January 1, 2008, Anthem BCBS implemented a change in pharmacy coverage to exclude higher cost drugs in certain classes where there are lower cost alternatives that are clinically comparable in safety and efficacy. We included a claim reduction in the January 2008 rates to reflect this benefit change. For 2009 rates, we continue to reflect a portion of the claim cost savings reduced to account for the amount of savings included in the experience data. We do not have data available regarding actual versus expected claim cost savings; therefore we have chosen to rely on our original estimates. The savings estimate for the proposed rating period is $0.03 PCPM which is equal to $0.18 PCPM (our original estimate) * 2 / 12; the remaining 10 months of the experience period reflects the new benefit.

Migration of High-Cost Claimants: Effective October 1, 2008, two high-cost claimants (in excess of $100,000) are migrating from a large experience-rated group to HealthChoice policies. Both members

have been diagnosed with chronic illness; one member experienced just short of $1 million in paid claims and the other member experienced approximately $330,000 during the 12 months ending October 31, 2008. We expect both members to continue to have on-going costly medical care and have added their paid claims experience to the required premium for the rating period. We have chosen not to trend these claims forward since the utilization of these members is unlikely to act like the remainder of our population. In order not to double-count this experience, we chose to carve-out the paid claims for these members in the month of October from the base claim experience.

The method we have utilized to project their cost during the rating period could easily under estimate the total claims for both members since both members will continue to have high cost claims and could likely experience multiple inpatient stays based on their medical history. In an effort to control costs next year, we have asked that our Disease Management team reach out to both members so that they may benefit from programs available at Anthem BCBS and reduce future hospitalizations.

Exhibit II

The distribution of enrollment across benefit options has changed over time with a shift toward higher member cost sharing levels and the new Lumenos products. The impact of the shifting enrollment has lessened over time as the percentage of members in the higher deductible options has stabilized. However, enrollment projections still assume an increase in the average member cost sharing level and the impact of this shift on claims needs to be reflected in order to accurately project future claims.

The method for measuring the impact is the same as in past filings. Observed levels of claims are determined on a PCPM basis. Total average claim levels are then calculated using the current and estimated future enrollment distribution. The ratio of the future to the current average PCPM is calculated as the impact. The adjustment included in this filing is 0.945 for claims. In other words, it is expected that future enrollment shifts will reduce claims by 5.5%.

Exhibit III

In order to collect premium that will cover future costs and allow for a targeted profit and risk amount it is necessary to measure the impact of the increase on subscribers categorized by benefit option, age band, and contract type. Anthem BCBS is proposing small changes to the age band or contract type factors for Lumenos plan designs in order to make these consistent with the HealthChoice rating factors. Therefore premium increases will vary across age bands and contract types for Lumenos members only. Additionally, due to the constraints of Rule 940 and the impact of benefit leveraging on carrier liability it is impossible to apply the same increase for all benefit options across HealthChoice and Lumenos. Exhibit III presents the current and projected enrollment distribution by benefit option, age band, and contract type and the current and proposed premiums associated with this distribution that result in an aggregate future premium set equal to the required premium as determined in Exhibit I (the total amount in Exhibit III differs slightly from Exhibit I due to rounding).

Rates were determined for the Lumenos options by first applying a factor of .975 to the HealthChoice $5000 deductible option and then adding the Rule 940 deductible differences and the cost of funding the incentive arrangements under the HIA and HIA Plus plan designs. The 2.5% decrease from the HealthChoice rates is equal to the approved premium rate differential as of 1/1/2007. Also consistent with currently approved premium rates, the HIA incentive costs are $1.81 per contract for the single

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contract and $3.62 per contract for all other contract types and the HIA Plus incentive costs are $14.85 per contract for the single contract and $29.70 per contract for all other contract types.

Rates were determined for Mandated options by first applying a factor of 1.5 to the Non-Mandated $1,000 deductible option to set the Standard $1,000 deductible. This step is as recommended by the Superintendent in his D&O for the 2006 HealthChoice proceeding and ultimately approved in the final Decision. In the next step, the remainder of the Non-Mandated rates are determined through compliance with Rule 940 rating restrictions.

As reflected in Exhibit III, the total average increase based on current enrollment is 18.5%.

Exhibit IV

In order to satisfy the component of Rule 940 that applies to allowable rate differences ("rates for different benefit plans that vary based on benefit differences may not exceed the maximum possible difference in benefits") it is necessary for the rate for the oldest age band and the greatest number of average dependents to first satisfy the requirements and then the younger ages and contracts with fewer average dependents will automatically be in compliance. Exhibit IV presents the proposed differences in premium between benefit differences and that these differences comply with Rule 940. Also included are utilization factors approved in prior HealthChoice Decisions and Orders. The Superintendent approved a requested exception to Rule Chapter 940 within the Non-Mandated Options based on differences in utilization at various levels of cost sharing confirmed in analyses by Milliman, USA. Consistent with the Superintendent's determination, Anthem BCBS has applied the same utilization factors within pricing for the five non-mandated options with deductibles $150, $300, $500, $750, $1,000, and $2,250. Both the allowable benefit difference and the utilization factors are used in their entirety. As health care costs are increasing the impact on utilization patterns would be to increase the magnitude of expected differences between varying levels of benefits. Anthem BCBS has chosen not to implement new utilization factors in this rate action as these factors should change very slightly over time.

Exhibit V

Presented in Exhibit V are HealthChoice and Lumenos combined claims by incurred and paid month from April 2003 through December 2008. This is typically referred to as a "claim triangle" and represents payment patterns for a historical period.

Exhibit VI

Presented in Exhibit VI.A are historical and projected claim trends. The enrollment distribution across benefit options has changed over time. This change, coupled with the levels of cost sharing inherent in the contract benefits, has had noticeable impacts on the observed trends in benefit payments. Changes in the average level of cost sharing create a two-tiered impact on the trend in benefits paid. First, as the average level of cost sharing increases over time, this can create observed trends of average benefit payments per member that are lower than the underlying claim trends. Second, the impact of leveraging on the observed benefit payment trend can be masked by changes in the average level of cost sharing. Moreover, with inconsistent changes in average member cost sharing, the leveraging impact can have a significant effect on the trend in observed benefit payments. Due to these impacts on benefit paid trends Anthem BCBS also analyzes average allowed amount (total amount reimbursed prior to member cost

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sharing) costs per member per month by service types over the past few years in order to gain a better understanding of true underlying changes in provider payments and utilization of services and the trends associated with these changes. These costs are broken up into categories: hospital inpatient, hospital outpatient, physician, and prescription drugs. Also, within each category, changes in payments are broken down and reviewed for the impact of both the cost and utilization component of the change. As reflected in the Exhibit, benefit paid trend, which for some time was lower than the allowed amount trend, surpasses the allowed amount trend in certain periods. This reflects the stagnation of the average member cost sharing and the impact of leveraging on the benefit paid trend.

Anthem BCBS conducts trend analysis and selection both retrospectively and prospectively. Observed claim data is reviewed on both an allowed and paid benefit basis by category: inpatient, outpatient, professional, and prescription drug. Information concerning known and anticipated changes to provider contracts and care management initiatives are considered for their potential impact on future claims. With this combination of historical and prospective information, trends are then selected for the categories noted previously. Each trend, and the composite trend, is reviewed for reasonableness based on observance of history and expectations for the future. As will be explained in more detail below, Anthem BCBS proposes trend factors that are in the range of observed data and reflect our expectations of trends going into the rating period. While Anthem BCBS believes this is reasonable, if recent trend observations do not moderate, the rates resulting from the proposed trend factors may be inadequate. Anthem Individual products have clearly become the coverage of last resort in Maine and acts as a de facto high risk pool without the benefit of any subsidization of premiums for policyholders with lower incomes.

Lumenos observed trend data is combined with HealthChoice for this analysis due to a lack of a persistent membership in order to review trends for Lumenos alone. Further, HealthChoice membership makes up almost 90% of the combined pool and drives most of the overall experience. Because the basic benefit structure for Lumenos plans is generally similar to HealthChoice, we feel that it is reasonable to combine the data when reviewing trends for the combined pool.

Following is a description of the information considered in selecting the projected trends presented in Exhibit VI.A and used in the Method 1 premium projection:

- ***Leveraging***
  Anthem BCBS utilizes deductible leveraging factors included in the Milliman Health Cost Guidelines. These factors are intended to reflect the impact of deductibles on unit cost trends. Anthem BCBS uses the factors coupled with the unit cost trend within each category in order to calculate the leveraging factors. The factors are calculated as follows:

  Illustrative Example:

A. Annual underlying trend:	5.0%
B. Deductible level:	$7,500
C. Trend leveraging factor:	1.38
D. Effective annual trend:	(0.05 x 1.38) = 0.069 or 6.9%
E. Leveraging factor:	1.069/1.050 = 1.018 or 1.8%

  In order to determine a leveraging factor for the entire block Anthem BCBS has utilized the methodology as presented in Attachment A in the D&O issued by the Superintendent in the 2007 HealthChoice proceeding. This methodology determines a leveraging factor for each deductible

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level and then weights these factors by the anticipated enrollment distribution. The calculation is presented in Exhibit VII and results in a leveraging factor of 1.24.

Allowed Trends by Service Category
The following table is based on data from provider contracting representatives, a review of long term reimbursement contract provisions, and data from NextRx (the Pharmacy Benefit Manager for Anthem BCBS), coupled with observations of actual data. Trends shown represent the anticipated annual increase in average unit cost for the projection period. This hospital unit cost increase reflects any savings experienced by Anthem BCBS due to lower hospital unit price increases as the result of the impact of Dirigo Health. Anticipated changes in the mix of services are included in the selected allowed trends. Leveraging is added to the allowed unit cost trend to determine the total unit cost trend (sum of components). Utilization trend is measured in days per 1000 member months (days/1000) for hospital services, services per 1000 member months (services/1000) for professional services and scripts per 1000 member months for pharmacy services.

	Service Category				
Component	**Inpatient**	**Outpatient**	**Professional**	**Pharmacy**	**Total***
Allowed Cost Trend	5.5%	6.2%	3.9%	8.6%	
Leveraging	1.2%	1.4%	0.9%	1.9%	
Total Unit Cost	6.8%	7.7%	4.8%	10.6%	
Utilization trend	2.2%	9.2%	9.3%	4.8%	
Combined trend	*9.2%*	*17.6%*	*14.5%*	*15.9%*	***14.1%***

Notes: Total unit cost trend = (1+Allowed trend)*(1+Leveraging) - 1
Combined trend = (1 + Total Unit Cost) * (1 + Utilization trend) – 1
* Total trend is weighted using paid claim cost PMPM by service category in Exhibit VI.A

As shown in Exhibit VI.A, the selected allowed and unit cost trends are reasonable and in the range of observed statistics after adjusting for changes in deductible mix. The impact of changing deductible mix was measured for each rolling 12-month period by comparing the actual trend for all deductible levels combined to an adjusted trend based on holding membership constant at the membership in effect during the base year. The analysis indicated that overall, deductible mix had an impact of less than 1% for rolling 12-month periods through mid 2006, but in the following periods the impact had ramped up until mid 2007 when trends were suppressed by 4% or more due to deductible mix. This impact continues to be prevalent in the year-to-date experience for 2008.

Based on our actuarial judgment and the preceding analysis, we are using an average benefit paid claim trend of 14.1% in the Method 1 projection of claim costs shown in Exhibit I. When compared to historical observed benefit paid trends, the selected service category trends and the weighted average combined trend are in the middle of the range of recent observances.

In Exhibit VI.B, Anthem BCBS has presented an aggregate (not split out between categories) benefit paid expense trend after the removal of claim cost in excess of $100,000 for members with claim cost exceeding $100,000 during a 12-month period. The trends resulting from the removal of the high-cost claimants are extremely erratic therefore we have calculated the annualized trend excluding claims in excess of $100,000 from the 12-month period ending December 2005 to the 12-month period ending

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September 2008. Additionally, more recent months of experience are still incomplete since large claims often have a longer payment lag. The resulting trend of 10.1% is in the middle of the range of observed values.

Healthcare trends continue to exceed general inflation trends. Both inflation in the cost of services and increases in the utilization of services by members are contributing to the magnitude of the trends.

Exhibit VII

As mentioned previously, Exhibit VII presents the detailed calculation of an aggregate leveraging factor as presented in Attachment A in the D&O issued by the Superintendent in the 2006 HealthChoice proceeding.

Exhibit VIII

Numerous components applicable to the proposed rates are included in Exhibit VIII.

First, Anthem BCBS has incorporated the same methodology as ordered by the Superintendent in a past HealthChoice proceeding, which results in an investment income credit of -0.02%. Investment income represents an interest rate of 0.15% based on the 13-week T-bill Rate for November 28, 2008, which is the same standard used in last year's filing.

Second, the calculation of the SOP component of the rates is presented. The DHA Board set the SOP at 1.85% through June 30, 2009 and 2.14% effective July 1, 2009 through June 30, 2010 of applicable claims (claims incurred by a Maine resident with a Maine provider). The percent of HealthChoice and Lumenos claims which are subject to the SOP is 76.8% for 2008 year-to-date. Further, the two SOP components are blended based on the number of months effective during the rating period. When applied to all claims in Exhibit I, the percentage applied to total claims is 1.64%.

Third, consistent with prior HealthChoice filings, Anthem BCBS is crediting an estimate of rebates related to pharmacy claims anticipated in 2009. As requested in the 2008 D&O, we have adjusted our expected rebate calculation to set the rebate credit as a percentage of pharmacy claims. In calendar year 2007, Anthem BCBS received rebates equal to 11.46% of total pharmacy incurred claims associated with HealthChoice members. Lumenos rebates were excluded from this analysis since the membership during calendar year 2007 was so small such that the rebate data was not reliable during the period. This percentage was applied to the projected pharmacy claim cost during the rating period for an expected rebate level of $6.72 PCPM on Exhibit I. This rebate level is consistent with prior estimates and actual rebates received. Further, we believe that Lumenos rebates as a percentage of pharmacy claims should be similar to the HealthChoice experience. Also credited in this filing is an additional amount for calendar year 2007 HealthChoice rebates. At the time of last year's filing the rebates for HealthChoice in 2007 were estimated, but have since been finalized with actual data. The 2007 HealthChoice pharmacy rebate amount was higher than was estimated, so an additional amount is included in this filing as a credit to claims.

Exhibit IX

The financial performance of HealthChoice and Lumenos over the past eight years along with projections for 2008 and 2009 are presented in Exhibit IX. Lumenos products were introduced in

January 2007, therefore HealthChoice and Lumenos combined experience is shown for 2007 and beyond. As of this filing and based on paid data through December 31, 2008, Anthem BCBS anticipates pre-tax operating gains of 2.8% of total revenue for 2008. Based on the assumptions in this filing, Anthem BCBS anticipates that the loss ratio in 2008 will be 86.5% (including the savings offset payment in claims for the calculation of the loss ratio). The 2009 projected loss ratio for the combined pool is 88.7% and 87.7% for the 12 month rating period ending June 30, 2010.

Exhibit X

HealthChoice experience since inception is presented in Exhibit X. Lumenos experience is combined with HealthChoice for 2007 and beyond. Experience is presented for Mandated, Non-Mandated, and all benefits combined. Actual experience through 2007 is included along with projections for 2008 and 2009.

Exhibit XI

Presented in Exhibit XI are historical distributions of enrollment by benefit option along with the rates of change in those distributions.

Exhibit XII

The determination of the impact of the colonoscopy mandate is presented in Exhibit XII. Anthem calculated the additional cost of the benefit change as the difference in paid versus allowed cost for the 12-months ending October 2008 for members with the PCSA rider and projected this forward to the rating period. The paid claim cost represents our current claims liability with member cost sharing. The allowed cost represents the amount Anthem will pay when the benefit is covered 100% under the preventive rider. A claim cost trend of 15.3% is used to project the additional cost forward to the rating period based on a blend of 75% Outpatient and 25% Professional trend from Exhibit VI.A excluding the impact of leveraging. This mix of services is consistent with the actual experience data. In an effort not to overstate the change in coverage, we have chosen not to include the impact of additional utilization of this benefit due to the increase in coverage (no member cost sharing). Instead, we are assuming that the additional utilization would be an offset due to a small number of colonoscopies that would not be classified as preventive. Further, we have not included the impact of covering any polyp removal if found during the colonoscopy which is a covered benefit under the mandate. Overall, we feel that we have likely underestimated the potential cost of the colonoscopy mandate in an effort to mitigate the rate increase. The projected cost of the additional benefit is added into the claim projection in Exhibit I and allocated in full to members with the PCSA Rider in Exhibit XIII.

Exhibit XIII

Preventive Care and Supplemental Care Accident Rider Derivation

Anthem BCBS has utilized the rating methodology for the Preventive Care and Supplemental Accident Rider that was reviewed and approved by the Bureau of Insurance. The benefits of the optional preventive care and supplemental accident amendment are two-fold:

1. The preventive care portion of the amendment removes the application of the deductible from a list of preventive care services.
2. The supplemental accident portion of the amendment pays up to $500 for treatment of an accidental injury.

The methodology used was to analyze 2007 claim experience for those members with the rider and determine the total value of claims that Anthem BCBS paid due to the presence of the rider that would otherwise have accumulated to the member's deductible. Calendar year experience was used in order to analyze data including the deductible carryover from 4th quarter 2006 when determining whether a subscriber satisfied their deductible during the period. The experience claim cost is trended forward to the rating period and the cost of the colonoscopy mandate is added to determine the projected claim cost. The total required premium is set equal to the projected claim cost adjusted for premium tax, pre-tax profit and risk, investment income, and the savings offset payment.

In order to set the proposed premium rates, the projected distribution of contracts is used to weight the proposed premiums and calculate a total premium projected during the rating period. The total premium shown varies slightly from the calculated required premium due to rounding.

We are proposing a 58.2% increase to the base PCSA rider premium rate. The biggest driver of the increase in the PCSA rider is the introduction of the 100% coverage for colonoscopies. The colon cancer screening mandate increases the cost of the PCSA Rider by 51.2%. Benefits covered under the rider prior to 2009 were limited to the following major categories: prenatal and newborn care, well-child care, well-adult care limited to $100 annual max, and a list of other services. The introduction of the colonoscopy coverage represents a significant increase in the coverage provided for "well-adults" and, hence, a significant impact to projected claim cost once the benefit is change is effective. As stated above in the discussion of the colonoscopy costs, Anthem has attempted to understate the additional cost of the mandate in order to mitigate the higher than average premium increase for the PCSA members.

Exhibit XIV

Community rate increases by benefit option, contract type and age band are presented within Exhibit XIV.

Exhibit XV

The development of the pooling charge for high-cost claimants is developed in Exhibit XV. High-cost claimants are defined as members exceeding $100,000 in paid claims during a 12-month period. The 12-month periods used in the analysis are the 12-month periods ending in the incurred date shown. After identifying the high-cost members for each period, their claims in excess of the $100,000 threshold are summarized. Excess claims as a percentage of incurred claims excluding high-cost claimants have been steadily increasing since mid-2007. Based on the experience data, we have selected a pooling charge based on the average of the most recent experience excluding the lowest and highest values of 17.3% applied to the claims in Exhibit I Method 2.

As shown in Exhibit XV, we also calculated the pooling charge by trending the claims under the threshold and claims in excess of the threshold to the rating period. The projected claims excluding large claims were trended using the same trend from Exhibit I Method 2. The claims in excess of $100,000 were trended using the annualized claim trend from December 2005 to June 2008 to eliminate some of the volatility in the large claim trend. The alternative method results in a pooling charge of 17.8%. Although we feel that this is a reasonable method of calculating the appropriate pooling charge, Anthem has selected a lower pooling charge based on more recent experience to mitigate the overall rate increase while still requesting a reasonable premium increase based on experience.

Attachment A
Included in this attachment are the HealthChoice Non-Mandated proposed rates, reflecting rates effective July 1, 2009.

Attachment B
Included in this attachment are the Lumenos proposed rates, reflecting rates effective July 1, 2009.

Attachment C
Included in this attachment are the HealthChoice Mandated proposed rates, reflecting rates effective July 1, 2009.

Attachment D
Attachment D presents the rating factors for the mandated mental health optional amendment for HealthChoice contracts. This amendment is priced by applying a rate factor to the base premium for the primary policy. These factors have not been increased from the factors currently approved and in use.

Attachment E
Included in Attachment E is the letter and accompanying utilization factors based on benefit differences as provided by Milliman USA and currently in use and approved for HealthChoice rates.

{W1249825.1}

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

IN RE:	)	
	)	
ANTHEM BLUE CROSS AND BLUE SHIELD 2009 INDIVIDUAL RATE FILING FOR HEALTHCHOICE, HEALTHCHOICE STANDARD AND BASIC AND LUMENOS CONSUMER DIRECTED HEALTH PLAN PRODUCTS	)	**PRE-FILED TESTIMONY OF BETH R. FRITCHEN, FSA, MAAA WITH ATTACHED EXHIBITS**
	)	March 6, 2009
Docket No. INS-09-1000	)	

1

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

Q. What is your name?

A. Beth Fritchen

Q. Please describe your professional and educational background that qualifies you as a witness in this matter.

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

My qualifications that are relevant to this hearing are that I currently provide consulting services to regulators in Kentucky, Vermont and Virginia. I review health insurance rate filings in these states. I have testified in the last two rate hearings for HealthChoice. In addition, I testified in other rate hearings on behalf of the Attorney General regarding the rate filing for the DirigoChoice and MEGA Life and Health rates. I have provided consulting services to other regulators in Rhode Island, Massachusetts, Maryland and Maine. I have been involved in approximately 15 rate hearings in Rhode Island regarding individual and Medicare Supplement rate filings. In addition, I have participated in approximately 8 rate hearings in Vermont.

I have co-authored several papers relating to the health insurance industry including "Impact of Association Health Plan Legislation on Premium and Coverage for Small Employers," "Impact of Prior Approval Requirements for Rate Changes of Small Employers Group and Individual Health Policies," "Government-Sponsored Health Insurance Purchasing Arrangements: Do They Reduce Costs or Expand Coverage for the Individuals or Small Employers," "Trends in Health Claims for Fully Insured Health Maintenance Organizations in Massachusetts, 2002-2006," "Analysis of Administrative Expenses of Health Insurance Companies in Massachusetts," and the semi-annual Oliver Wyman Trend Survey.

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

Q. What is the purpose of your testimony?

A. I am here to testify with respect to the Anthem Blue Cross and Blue Shield ("Anthem BCBS") HealthChoice rate filing for individual subscribers. My testimony will focus on the reasonableness of the requested rates and demonstrate that the proposed HealthChoice rates do

1 not meet the statutory requirement to be "neither excessive, inadequate or unfairly
2 discriminatory." In my opinion, the proposed rates are excessive and unfairly discriminatory.
3
4 **Claim Costs**
5
6 Q. Anthem provided two methods for estimating claim costs for the rating period: Method 1
7 simply applies a single trend to all estimated incurred claims and Method 2 applies a trend to
8 claims exclusive of excess claims over $100,000, then adds a pooling charge to account
9 separately for the expected excess large claims. Which of these methods is more appropriate in
10 your opinion?
11 A. Method 2 is more appropriate in my opinion because of the volatility reflected in the
12 large claims for this block of business.
13 Q. Did you perform your own calculation following the framework of Method 2?
14 A. Yes, I did.
15 Q. Could you explain your analysis and results?
16 A. Sure. Both Methods start with a projection of total incurred claims for the base period, so
17 I started there.
18
19 **Base Claims**
20 Q. What is your independent estimate of the base incurred claims?
21 A. I calculated an independent estimate of the incurred claims for the base period
22 (November 1, 2007 through October 31, 2008) using standard lag development techniques and
23 compared my estimate with Anthem's estimate in Exhibit 1 of their revised rate filing dated
24 January 22, 2009. My estimate is $55,284,872, slightly higher than Anthem's estimate of
25 incurred claims which is $55,053,257.
26 Q. Are you satisfied that this is the best estimate of base claims?
27 A. No. In my opinion the preferred way to develop estimates of incurred claims would be to
28 subtract the triangle of catastrophic claims from the triangle containing all claims to arrive at a
29 triangle without catastrophic claims (hereafter referred to as the 'non-catastrophic' claims) and
30 then apply standard lag development techniques to the non-catastrophic claims triangle to arrive
31 at an estimate of incurred claims for these members. An estimate for incurred catastrophic claims

1 would then be added back in. In my opinion the catastrophic incurred claim estimate should be
2 developed by examining the diagnosis and prognosis for each large claimant and establishing a
3 case reserve to add to the claims paid to date. This is essentially a more precise version of the
4 pooling methodology I discuss in more detail below.
5 Q. Why didn't you do that?
6 A. In responding to questions 4 through 7 of the Attorney General's First Informational
7 Request, Anthem provided claim triangles for all claimants and separate triangles for
8 catastrophic claimants (defined as those members with more than $100,000 in claims) for the
9 period November 1, 2006 through October 31, 2008, with claims paid through December 31,
10 2008. However, the preferred method I described above requires detailed claim information for
11 each catastrophic claimant which was not available.
12 Q. What was your next step in developing an independent calculation of the projected claims
13 for the rating period?
14 A. Given that I was unable to utilize the preferred case reserve methodology for developing
15 total incurred large claims utilizing a case reserve methodology, consistent with Anthem's
16 Method 2, I pooled and removed large claims (claims in excess of $100,000) from the base
17 period incurred claims, then added back in a separate pooling charge to account for expected
18 large claims.
19
20 **Pooled Claims**
21 Q. Do you agree with Anthem's methodology for removing pooled claims?
22 A. No, I disagree with the manner in which Anthem removed pooled claims in two
23 respects. First, the excess large claims which were pooled were not consistent with the base
24 claims since Anthem did not include an estimate for claims that have been incurred but not
25 reported claims (IBNR). Second, the pooling charge that Anthem added back into the base
26 claims was developed from claims that for the most part include run out and is therefore also
27 inconsistent with the pooled claims.
28 Q. How did you develop an independent estimate of the claims that should be removed
29 from the base claims as part of the pooling methodology?
30 A. Using the large claims pooled by Anthem as a starting point, I applied a completion
31 factor to account for IBNR. To develop a completion factor for the pooled large claims, I

1 calculated incurred claims using an alternate approach whereby I subtracted the triangle of
2 catastrophic claims (provided in response to Question 6 of the Attorney General's First
3 Informational Request) from the triangle containing all claims to arrive at a triangle of non-
4 catastrophic claims. I then applied standard lag development techniques to the resulting non-
5 catastrophic claims triangle to arrive at an estimate of incurred claims for the non-catastrophic
6 members. My estimate of incurred claims for these members for the period November 1, 2007
7 through October 31, 2008 is $33,762,741.
8 Next, I subtracted my incurred claim estimate for non-catastrophic members from my
9 incurred base claim estimate for all claimants. This difference of $21,522,131 (= $55,284,872 -
10 $33,762,741) represents my estimate of completed incurred claims for catastrophic claimants.
11 The uncompleted claims for catastrophic claimants for this same period were $20,793,473. I
12 divided the completed large claims by the uncompleted large claims to arrive at my estimate of
13 the completion factor for the large claims of 1.035.
14 Finally, I applied this completion factor estimate to the excess catastrophic claims pooled
15 by Anthem of $7,823,506 to arrive at my estimate of pooled excess catastrophic claims of
16 $8,097,662 (= $7,823,506 x 1.035). This is the amount I have removed for excess claims in my
17 independent calculation.
18
19 **Trend**
20 Q. Anthem employed two projection methodologies resulting in different trends, one
21 including high cost claimants (Method 1) and one excluding high cost claimants (Method 2).
22 Do you have an opinion as to which is the better approach?
23 A. Yes, as I discussed above, I believe that Method 2 is the better method, but would make
24 some adjustments.
25 Q. Why is Method 2 a better approach?
26 A. Method 1 is the same approach Anthem has consistently utilized in its rate filings. This
27 approach does not take into account the impact of that the variability of large claims can have on
28 the resulting trends. In my opinion, in order to use the HealthChoice data to develop trends, the
29 data should be adjusted to reduce the variation caused by the large claims. My recommended
30 methodology removes the large claims from the data and adds a pooling charge to reflect the
31 expected level of large claims for the block of business. By using this approach, the data is

1 smoothed to remove the large variations observed from year to year, generating a more stable
2 trend factor and one that is not skewed by a significant increase in large claims in the earliest or
3 latest periods.
4 Anthem has generally taken this approach in its Method 2 development. However, there
5 are a few aspects of the analysis that I would complete differently.
6 First, I would use allowed data rather than paid data to develop trends. I would then add the
7 estimated impact of future provider contracting to the selected allowed trend. Finally an
8 adjustment should be made to take deductible leveraging into account.
9 Q. Do you agree with the 10.1% trend assumption used by Anthem to project claims under
10 Method 2?
11 A. No.
12 My analysis, which is based on allowed as opposed to paid claims, results in a 10.8% trend.
13 Since that figure is developed from allowed claims, enrollment shifts over the rating period must
14 be taken into account. Anthem's factor for enrollment shifts is 0.945, which I agree is
15 appropriate.
16 Q. Could you elaborate on your trend analysis?
17 A. I reviewed allowed claims information Anthem provided in response to information
18 requests for the period November 2006 through October 2008, with payments through December
19 2008. I removed the catastrophic claims (those in excess of $100,000) from the data, smoothing
20 them over the entire time period, and then added the smoothed catastrophic claims back to the
21 remaining claims. By using this approach, the data is smoothed to remove the large variations
22 observed from year to year, generating a more stable trend factor and one that is not skewed by a
23 significant increase in catastrophic claims in the earliest or latest periods.
24 Q. How did you smooth catastrophic claims?
25 A. I started by removing all allowed charges for members with claims of $100,000 or more
26 using the triangles provided in response to question 2 of the Attorney General's Second
27 Informational Request. I then smoothed the catastrophic claims that were removed such that the
28 charge PMPM increased each month by a stated trend amount and that the aggregate amount
29 added back to the one-month rolling claim costs PMPM, excluding charges for members with
30 $100,000 or more in claims (non-catastrophic claim costs), was equal to the $44,150,134 which
31 is the aggregate amount of claims that had been removed for the period November 2006 through

1 September 2008. The following table summarizes the results when using a 20%, 25% and 30%
2 trend assumption for large claims.

Rate at which Claims Over $100,000 Trend	Linear Trend	Exponential Trend
20%	5.3%	5.4%
25%	6.3%	6.5%
30%	7.3%	7.6%

3

4 Q. Which of those do you believe is the appropriate trend rate to use for large claims?
5 A. In my opinion the 25% trend rate is appropriate to apply to large claims. A 25% trend rate
6 is consistent with the overall large claim trend observed for this period. Analysis of the allowed
7 large claims during the period generates an annual trend amount of 22%.
8 Q. So does that mean your estimate of trend is in the range of 6.3% to 6.5%?
9 A. No. Claim trend analysis should be prospective when using experience to project future
10 expected claims, which is the purpose of the trend application in Exhibit 1 of Anthem's rate
11 filing. Therefore, an adjustment should be made for anticipated provider contracting adjustments
12 that are over and above those inherent cost trends underlying the historical data. We asked
13 Anthem to provide its estimate of the impact of future provider contracting amounts. In response,
14 Anthem stated that it does not calculate the provider contracting impact on a paid basis but rather
15 on an allowed basis (even though the question did not request the impact on a specific basis)
16 Given the lack of information, I have assumed a two percentage point adjustment to our trends
17 for the impact of future provider contracting due to the current economic environment. Our
18 clients are seeing additional pressure from providers for increased fees in order to offset recent
19 lower utilization.
20 Further, since allowed claims were used for the analysis, an additional amount needs to
21 be added to our trend estimate to account for deductible leveraging. Given the size of the
22 deductibles applicable to these products, it is my opinion that two percentage points should be
23 added for leveraging.
24 After making these adjustments I developed trend estimates of 10.6% (1.063 x 1.02 x
25 1.02) and 10.8% using linear and exponential methodologies, respectively. In my opinion an
26 exponential trend is more appropriate unless there are significant differences between a linear

1 and exponential trend estimate in which case further analysis would be warranted. Therefore, my
2 estimate of trend is 10.8%.
3 Q. Are there any other comments you would like to make related to your trend estimate?
4 A. Yes. It is my understanding based on reading the actuarial memorandum that Anthem
5 removed claims in excess of $100,000 when calculating trends under method 2. This approach is
6 appropriate since the trends are ultimately applied to base claims which have large claims in
7 excess of $100,000 removed. I was unable, however, to develop trends removing only the excess
8 claims, since the catastrophic claims triangles Anthem provided included all claims and not just
9 the excess amounts. Further, my trend development above includes smoothed large claims.
10 Given large claims trend at a higher rate, my trends are higher than what they otherwise would
11 have been had I removed the excess large claims and therefore should be viewed to contain some
12 conservatism.
13 Finally, since I used allowed claims to develop my trends, they do not incorporate an
14 adjustment for enrollment shifts by benefit plan. Therefore, similar to Anthem's method 1 which
15 utilizes a trend assumption based on allowed costs, I need to make an explicit adjustment for
16 enrollment shifts. Anthem proposes using a factor of 0.945 for this purpose. I have reviewed the
17 development of this factor and agree that it is appropriate.
18
19 **Development of Pooling Charge**
20 Q. Do you agree with the approach Anthem used to develop pooling charges to estimate
21 large claims under Anthem's Method 2?
22 A. No. I believe the pooling charge and the amount of large claims removed from the base
23 experience are not calculated consistently. Anthem stated in request to question 8 of the Attorney
24 General's First Informational Request that even though the excess of claims over $100,000 are
25 not completed, "the important thing is that the total claims for the pool (paid + IBNR) are
26 maintained such that when a subset is carved out of the pool (i.e., the high-cost claimants for the
27 12-month period ending October 2008), a corresponding subset is added back in (i.e. the pooling
28 charge calculated in a consistent manner)." I agree with that statement but do not believe that the
29 pooling charge calculated by Anthem is generated in a consistent manner.
30 Q. Please explain.

1 A. First, the pooling charge level of 17.3% is calculated as the average of excess large
2 claims from the 12-month period of claims ending December 2005 through the 12-month period
3 of claims ending September 2008. As such, most of the claims during this time period would
4 include claims run-out longer than the claims run-out associated with the excess claims of over
5 $100,000 that were removed from the base period ($7,768,682). While the last data point shown
6 on Exhibit XV of Anthem's revised filing is consistent with the excess claims removed from the
7 base period (i.e. contain the same number of months of run-out), other previous data points
8 would not be. In fact, the percentage of high cost claimants in excess of $100,000 for the twelve
9 months ending September 2008 is 16.5% which is lower than other corresponding percentages
10 and probably reflects some of the missing IBNR amounts.
11 Second, the pooling charge incorporated in the Exhibit XV of the Anthem revised filing
12 is based on multiple years of data. In general, pooling charges are expected to reflect an average
13 charge from a credible block of experience that should be included to remove the volatility
14 associated with large claimants that can distort the year to year results. The pooling charge in
15 Exhibit XV does reflect completion since it is based on several years of experience, but the
16 excess claims reflect only the most current year without completion. Therefore the two are
17 inconsistent.
18 Q. Did you review the reasonableness of the pooling charge generated by Anthem?
19 A. Yes. I performed an independent analysis of Anthem's large claims data provided for the
20 12 month period ending September 2002 through September 2008. In addition, I used the
21 individual large claims experience that Anthem provided in response to question 2 of the
22 Attorney General's Third Informational Request.
23 Using the individual claims data for those claimants in excess of $100,000, I generated a
24 90% confidence interval for the number of members required in order to be 90% confident that
25 my estimate of large claims would fall within +/-10% of the true mean. I used a Compound
26 Poisson distribution to estimate the minimum number of members required to meet this
27 confidence level. Based on the data, I estimate that the number of members required would be
28 approximately 150,000 members. Based on Anthem's historical experience, this would represent
29 between 5 and 6 years of HealthChoice experience.
30 Next I used the data from question 2, described above to determine the pooling charge.
31 The data for each period in question 2 needs to be trended to the most current period to take into

1 account leveraging. As such, I used trends consistent with our trend analysis. Taking the most
2 recent 6 years of data generates a pooling charge of 17.4%. This is consistent with the pooling
3 charge generated by Anthem.
4
5 **Adjustments to Claims**
6
7 Q. Did you review the adjustments to the claims that Anthem incorporated into their
8 projected claim costs?
9 A. Yes.
10 Q. Do you have any concerns with the adjustments made by Anthem?
11 A. Yes. I have two concerns. The first is the credit provided for pharmacy rebates and the
12 second is the level of additional claims added for the two known high-cost claimants that
13 transferred in from the large group business.
14
15 **Pharmacy Rebates**
16 Q. Have you reviewed the calculation of the rebates Anthem included in the estimated
17 claims projection?
18 A. Yes. I have reviewed the information found in Exhibit VIII of their filing. In addition I
19 reviewed the answers to the questions they provided in response to questions 9, 10, 11, 12 and 13
20 of the Attorney General's Third Informational Request.
21 Q. Do you have any concerns with the responses provided by Anthem?
22 A. Yes. I have several concerns: 1) the lack of separate paid claims data for generic and
23 brand drugs, 2) how company rebates are allocated to HealthChoice, and 3) the lack of an
24 explanation for the recent jump in projected rebates.
25 First, I am concerned that Anthem in unable or unwilling to track prescription drugs by
26 the classifications of generic and brand name drugs (see response to question 10 of the Attorney
27 General's Third Informational Request "Anthem BCBS is unable to provide this level of claims
28 detail because we do not track generic versus brand paid pharmacy claims…" In general, there
29 is a very large difference in the level of costs associated with brand name drugs and generic
30 drugs, with generic drugs costing approximately one-third of the cost of brand name drugs. By
31 monitoring drug experience, through benefit designs and other incentive programs, health
32 insurance companies have been able to persuade/incent members towards the lower cost generic

1 drug options. This reduces the overall cost of drug coverage and presents savings for the entire
2 block of business.
3 Additionally, in response to question 6 of the Advocacy Panels' First Information
4 Request in the proceeding relative to the 2008 HealthChoice rates, Anthem was able to provide
5 the calculation of trends for brand and generic drugs for the HealthChoice product. The company
6 provided the number of scripts by brand and generic and the average allowed cost per script by
7 brand and generic. I am surprised paid costs are not also available.
8 Q. What is your concern about the allocation process used to distribute rebates to the
9 HealthChoice line of business?
10 A. In general, the level of rebates is a function of the volume of prescription drugs utilized
11 that are associated with those rebates. Therefore, it generally requires an allocation of the rebates
12 received well after the pharmacy claims have been processed. Anthem acknowledges this lag,
13 indicating in response to question 9 of the Attorney General's Third Informational Request that
14 patterns of rebates for 2008 would be meaningless. While Anthem may be implementing an
15 appropriate allocation method, very little detail was provided regarding the process used to
16 assign the rebate level to the prescriptions. For example, are the rebates split equally per
17 prescription among the various lines of business in the various units of Anthem or is there
18 another method used?
19 Q. What is your concern about the large increase in the rebate credits assumed in the rating
20 period from those projected in the current rates?
21 A. We asked for an explanation to understand this difference to make sure the projections
22 seem reasonable. Anthem did not provide an explanation of the change but rather stated it is
23 based on historical experience. While actual experience is the basis in the development of rates
24 and projections, it is important to understand the cause behind significant changes such as the
25 rebates in order to understand if the change can be expected to continue in the future.
26 Given the level of information provided, I am unable to determine whether the rate of
27 change reflected in the projection can be expected to continue and therefore I am unable to
28 determine if the rebate credits assigned are reasonable.
29
30
31

1 **Migration of High-Cost Claimants**

2 Q. You also mentioned you had a concern regarding the level of claims that Anthem added
3 into the projection for specific high-cost claimants. What is your concern regarding this
4 adjustment?

5 A. In section E of Anthem's Exhibit 1, Anthem adds approximately $1.3 million dollars
6 more in claims to the projected claim costs. This is the result of two high-cost claimants that
7 transferred from group coverage into the HealthChoice product. This represents about 1.7% of
8 the total projected claims for both HealthChoice and Lumenos products combined or 2.3% of the
9 projected claims for HealthChoice. This is a significant amount of claims to incorporate into the
10 projection and falls almost entirely to the bottom line of the rate increase calculation. Therefore,
11 care should be taken when estimating these amounts.

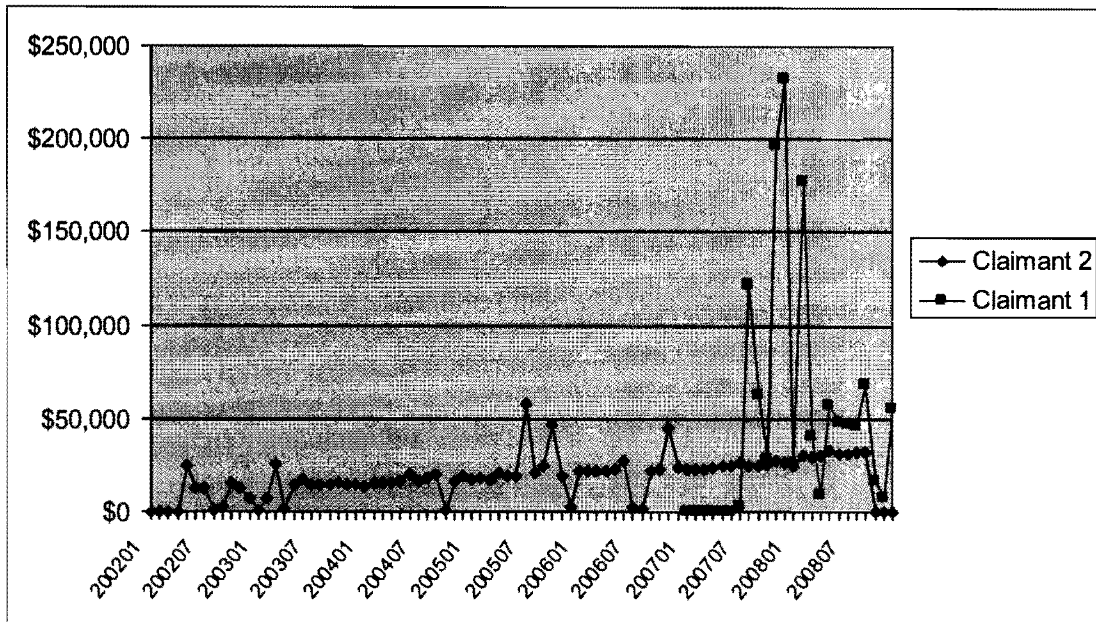
12 Q. Isn't it reasonable for Anthem to project additional claims since these identified high cost
13 claimants are known?

14 A. Yes. The projection of future claims should be adjusted if any extenuating circumstances
15 are known. However, there are several items that should be taken into account when projecting
16 this additional level of claims.

17 First, it is critical to understand the future prognosis of each of these claimants in order to
18 understand and estimate the level of anticipated claims that should be incorporated into the
19 projected claims. In these specific cases, Anthem assumed the claims would be approximately
20 the same as those that were incurred during the twelve month period ending October 31, 2008.
21 One claimant had claims just under $1 million while the other had claims just over $300,000.

22 Upon further analysis of the detailed claims provided, the historical claims for the
23 claimant with claims in the range of $300,000 appear to occur on a consistent recurring basis.
24 However, the claims for the other claimant show significantly more volatility. In these types of
25 cases more information is required than just one year of historical experience in order to project
26 future claims. For example, if the claims were analyzed by calendar year for this claimant, the
27 average size of the claims based on the previous two years of data would generate an estimated
28 cost of $625,000 per year, which is significantly below the $1.0 million included in the projected
29 claims.

30 The chart below shows the historical monthly claims for each of these claimants.



1
2
3 There are a couple of observations to note regarding the experience of both of these
4 claimants.
5 1. Claims for Claimant 1 experience display significant volatility; making future claims
6 estimates very difficult.
7 2. The majority of claims for Claimant 1 appear to have occurred between August 2007
8 through February 2008, with the two largest months occurring in November 2007 and
9 December 2007.
10 Taking into account the information provided by Anthem, the historical claims and the volatility
11 of each claimant, I recommend reducing the anticipated claims of Claimant 1 for the projection
12 period. It is not reasonable to include the entire level of incurred claims observed unless it is
13 known with 100% certainty that they will reoccur at the same level. Instead, the amount to
14 include as anticipated future claims should take into consideration the probability that they will
15 reoccur, and at the same level. Based on the information provided by Anthem, it appears that the
16 claims for Claimant 1 have most recently been running around $50,000 per month. This
17 generates $600,000 in annual claims. I added an additional $100,000 as margin for the possibility
18 of an additional inpatient stay. This would results in anticipated overall claims for this member
19 of $700,000. We agree with the amount of claims used for Claimant 2 of $330,000

1 Q. Is there anything else about Anthem's projection of additional claims for these two
2 claimants that concerns you?
3 A. I am concerned that adding the costs of these new high cost claimants and the pooling
4 charge incorporated by Anthem is double-counting a portion of the claims for these members
5 since Anthem did not remove claims for deceased members in the base experience period.
6 The pooling charge methodology employed by Anthem in the Method 2 rate development
7 is intended to smooth the impact of large claims on small to medium size blocks of business. As
8 we have discussed previously, the size of a block of business required to generate fully credible
9 experience without adjusting for the volatility of large claims is significantly larger than the
10 current HealthChoice block of business. Since the pooling charge is anticipated to take into
11 account all of the large claimants including any new large claims that may develop during the
12 projection period, a portion of the anticipated claims for Claimants 1 and 2 are already taken into
13 account via the base period experience and pooling charge.
14 Based on Anthem's historical experience provided in response to question 2 of the
15 Attorney General's Third Informational Request, the average claim per claimant with claims in
16 excess of $100,000, is $197,000. Therefore, the pooling charge and base claims used by Anthem
17 already account for $197,000 for each of these two large claimants. As such, we believe this
18 amount should not be included in the additional claims for these two claimants during the
19 projection period. This would generate claims of $503,000 and $133,000 for Claimant 1 and
20 Claimant 2, respectively. The overall amount of claims we recommend including in the
21 projection period for these members is $636,000. This is a reduction of about 50% in the amount
22 added by Anthem for these two large claimants. I have used this amount in my independent
23 calculation.
24
25 **Merging of Pools**
26 Q. Anthem has pooled the experience for the HealthChoice and Lumenos books of business
27 for rating purposes for the first time. What is your understanding of why they have taken that
28 approach?
29 A. Anthem points out that the benefit and cost-sharing structures are relatively similar and
30 argues that pooling the experience is in keeping with the intent of Rule 940 to spread risk and

1 that extreme anti-selection could occur since HealthChoice members can freely migrate in
2 Maine's guaranteed issue environment.
3 Q. Do you have an opinion on whether these books of business should be combined for
4 rating purposes?
5 A. I see legitimate advantages and disadvantages to combining these products. All things
6 considered, I believe that the Superintendent can strike an appropriate balance by combining the
7 pools, as Anthem has done, but by giving greater credit to the Lumenos rates based on favorable
8 utilization.
9 Q. Please elaborate on the advantages and disadvantages.
10 A. The obvious advantage is spreading the risks inherent in Maine's individual market over
11 a greater pool, moderating the impact of rate increases on high cost individuals. This appears to
12 be a policy built into Maine's insurance laws. On the other hand, Lumenos has the potential to
13 grow as a lower-cost alternative for people willing and able control some of their own health care
14 costs, who should be rewarded for cost-effective behavior. Implementing rate increases that are
15 not in keeping with the better experience of Lumenos members undermines that potential.
16 Lower Lumenos rates are good for Maine and HealthChoice. The low cost option of the
17 Lumenos product along with the consumer driven incentives may attract more members into
18 Anthem's individual block of business. Since the purpose of these products is to change health
19 care behavior, and experience to date has shown positive utilization impacts by these products,
20 the members attracted to these products could improve the performance of the overall block for
21 Anthem.
22 Q. Do you share Anthem's concern that HealthChoice members will transfer to Lumenos if
23 it is rated on its own better experience leaving fewer and more expensive members in
24 HealthChoice?
25 A. I think Anthem's concern is overstated. Anti-selection has not occurred to any significant
26 degree to date, even though the current rates are over 17% apart. In fact, Anthem indicated that
27 only about 12% of the current Lumenos members (as of October 2008) previously held a
28 HealthChoice policy. In general, whenever members are offered the option of multiple plans
29 anti-selection in the market can occur. Even if Lumenos rates were based entirely on combined
30 experience with HealthChoice, with no credit for utilization, would not shield Anthem from anti-

1 selection as long as there are other lower cost options in the marketplace, which presently is the
2 case.
3 Q. Are there any studies assessing the cost-effectiveness of consumer-driven health plans
4 such as Lumenos?
5 A. While it is still very early for thorough actuarial studies of these programs, there is early
6 evidence that consumer driven health care plans lower costs and generate lower trends. Most
7 recently CIGNA released a study that showed the first year medical cost for members enrolled in
8 a consumer driven health plan was 13% lower than the traditional plan. (Fritchen Exhibit 1.) The
9 study also showed that trends for these plans continue to be lower than the trends for traditional
10 plans in the subsequent years. This means that the consumer driven health plans are able to
11 maintain and even grow the cost savings.
12 Q. Anthem does credit Lumenos experience to some degree by applying a favorable rate
13 differential from HealthChoice, doesn't it?
14 A. Anthem has merged the experience together and generated rates based on a benefit
15 relativity analysis and an additional utilization adjustment to account for the expected utilization
16 savings for the consumer driven aspect of the product. In response to question 7 of the
17 Superintendent's First Information Request, Anthem provides the detail behind the requested rate
18 differential of 2.5% between these products. It is clear from the analysis that the difference is the
19 result of a benefit analysis and an additional 6% utilization factor. The actual experience of the
20 Lumenos product (as a whole or even partial credit) is not taken into account in the differential.
21 Q. Assuming the HealthChoice and Lumenos are combined, what is an appropriate rate
22 differential?
23 A. As a preliminary matter, it bears note that Anthem does not follow the same approach to
24 merging HealthChoice and Lumenos as it did the non-mandated and mandated plans within
25 HealthChoice.
26 Q. How do the approaches differ and why does it matter?
27 A. Anthem states that the rate differential of 1.50, for example, between the $5,000
28 deductible for the State-Mandated plan and the $5,000 deductible for the HealthChoice plans is
29 based on benefit difference and the corresponding expected utilization differences only, but in
30 my opinion, it is not. Anthem's response to questions 16a of the Attorney General's Third
31 Informational Request states that "the Superintendent limited Anthem's ability to rate mandated

1 plan designs based on the underlying claims experience because the [premium rate] difference
2 becomes so large as to be inequitable regardless of the difference in experience." My
3 interpretation of the Superintendent's order is that it is an acknowledgement that Anthem's
4 proposed method of rating the plans on their own experience would have generated rates such
5 that the premium differences would be greater than the corresponding benefit and utilization
6 differences that would normally be expected. As such, a limit or cap was placed on the amount
7 of difference that could be allowed based on the experience alone.

8 Anthem has since adopted this 1.50 factor for the rate differential between the
9 HealthChoice products and the Lumenos products. By default, Anthem ***is*** rating these plans
10 based on historical experience, but only to the extent allowed by the Superintendent.

11 For the Lumenos rates, as discussed above, the difference is the result of a benefit
12 analysis and an additional 6% utilization factor, not Lumenos experience.

13 Q. Should the approaches be consistent?

14 A. Yes, in general consistent approaches should be used in the determination of pooling and
15 rating, but there are extenuating circumstances. For example, the credibility of each block should
16 be taken into account when determining the pooling approach and rating methodology. Some
17 blocks of business, such as the State-Mandated HealthChoice plans, are too small to be fully
18 credible and rated on their own. In other instances, the block of business may be new and
19 adjustments may need to be made to account for significant growth and/or changes in
20 demographics. Both of these circumstances apply in the case of the State-Mandated Plans and
21 Lumenos Plans. As such, it is appropriate to make adjustments.

22 The inconsistent rating approaches in this case, however appear to place more weight or
23 credibility on the poor experience of the State-Mandated plans by using a 1.50 factor than on the
24 positive experience associated with the Lumenos plans.

25 Q. What is your proposed methodology for rating these plans?

26 A. I believe the rate differential between Lumenos and HealthChoice should be greater for
27 two reasons. First, I believe some credibility should be placed with the current favorable
28 experience Lumenos has enjoyed. If we are to credit the State-Mandated plan with its poor
29 experience, as I believe Anthem does, then the Lumenos plan should receive some favorable
30 credit. Second, the Lumenos product is a consumer driven product with health incentives in place
31 to persuade members to make better, more cost efficient health care purchases. Each member is

charged a monthly fee for these incentives. The fee ranges from $1.81 per contract per month to $14.85 per contract per month for single coverage depending upon the plan. Since these members are paying for this incentive program, they should be credited with at least a portion of the positive experience the plan is enjoying.

Q. What differential do you recommend?

A. While Anthem has credited the plan with a utilization adjustment of 6% for the Lumenos plans, I have observed adjustments in the industry in the range of 10% to 30% for consumer-directed health plans. In general, it is my experience that most companies employ a utilization factor in the range of 10% to 15%. Since Anthem used the same trend for the Lumenos product as the HealthChoice product, the initial pricing could be viewed as conservative. Thus, for the $5,000 deductible plan, I recommend the utilization factor be more at the high end of the range or around 15%.

Rule 940 Tests

Q. Do all of the proposed rates shown in the rate filing meet the rate relativity requirements reflected in Section 8(B) of Rule 940?

A. No.

Q. Please explain which rates in the current rate filing do not meet these requirements.

A. As Anthem confirms in its response to question 29 of the First Informational Request of the Attorney General, the Lumenos for ages 65+ do not comply with Rule 940.

Q. Anthem explains that it is merely continuing for the rate relationships initially approved for Lumenos in 2007, which included an exception for this age band. Do you believe an exception is presently warranted?

A. No. First and foremost, Anthem has produced no basis for a Rule 940 exception, such as demonstrated acceptable differences in utilization within this age band.

Second, the rate differentials between the HealthChoice and Lumenos products are inconsistent by age band. This causes the rates and benefit relativities to appear out of alignment. Please see the table below.

Age Band	Lumenos HIA Products	HealthChoice Products	Percent Difference
< 30	$756.07	$772.09	-2.1%
30 – 39	$779.58	$796.22	-2.1%
40 – 44	$944.18	$965.11	-2.2%
45 – 54	$1,014.72	$1,037.49	-2.2%
55 – 64	$1,132.29	$1,158.14	-2.2%
65+	$1,414.46	$1,158.14	22.1%

1

2 In my opinion, there is no basis for the Lumenos 65+ rates to bear such a dramatically
3 different relationship to the HealthChoice rates as compared to the other age bands. As such,
4 selection issues could occur in the market as a result of the significantly higher rates for the
5 Lumenos product when the benefit differential is much smaller. As such, I recommend the 1.50
6 factor used to generate the 65+ rates for the Lumenos product be rejected. I believe the 65+
7 factor used to develop the rates for the Lumenos product should be consistent with the 65+ factor
8 used to develop the rates for the HealthChoice product.

9

10 **Administrative Expenses**

11 Q. Did you review the administrative expenses proposed in the filing?

12 A. Yes.

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

15 A. I have no basis to believe the projected administrative expenses are unreasonable.

16

17 **Risk and Profit Charges**

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

19 A. In general, the 3% pre-tax risk and profit charge is within the range we have observed in
20 the industry. However, the reasonableness of the risk and profit charge ultimately depends upon
21 several factors such as, the adequacy of the corporate surplus, level the specific line contributes
22 and other items. For example, there have been situations in other states where risk and profit
23 margins have been limited due to excessive surplus levels of the corporation. These issues should
24 be taken into account in the analysis.

25

26

1 **Independent Calculation**

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

3 A. Yes.

4 Q. How did you calculate your independent estimate?

5 A. I used the general format that Anthem BCBS used under Method 2 to generate its
6 estimate of the required rate increase found in Exhibit I and made five adjustments:

7

8 1. I developed an independent estimate of incurred claims for the period November 1, 2008
9 through October 31, 2008 for all claimants of $55,284,872.

10 2. I revised the trend to 10.8%

11 3. I added $274,156 to the pooled claims to reflect IBNR

12 4. I included an enrollment shift factor of 0.945 due to the fact that our trends were
13 developed using allowed claims

14 5. I revised the estimate of additional large claims to add for the two high cost claimants
15 migrating from large group to $636,000.

16 Each of these adjustments has been previously discussed in my testimony in detail.

17 Q. Please state the needed premium increase you have calculated and explain how it
18 compares with the increase calculated by Anthem BCBS in the filing?

19 A. Attached as Fritchen Exhibit 2 is my independent calculation. I have calculated a needed
20 premium increase of 14.9% to the base rates. Anthem's initial requested increase to the base
21 claims is 18.1% as shown on Exhibit I of the revised filing dated January 22, 2009.

22

23 Q. Does that conclude your testimony?

24 A. Yes.

25

26

27
28

CIGNA Choice Fund® Experience Study

SUMMARY OF KEY FINDINGS JANUARY 2009

CIGNA recently completed a multi-year study of the health care claims experience of nearly 440,000 individuals enrolled in CIGNA Choice Fund® consumer-driven health plans and traditional HMO and PPO plans. The results demonstrate that *CIGNA Choice Fund plans can improve the health, well-being and security of the individual and the cost savings from these plans can help in an ailing economy.*

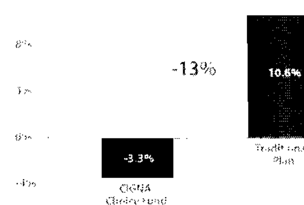
The study shows:

- Medical cost trend for consumer-driven health plans (CDHP) continues to be less than the trend for HMOs and PPOs: Medical cost trend for first year CIGNA Choice Fund enrollees was more than 13% lower, and lower cost trend continues in subsequent years.
- Use of preventive care increased: First-year preventive visits increased, and renewal year visits remained significantly higher than traditional plans.
- Use of best medical practices was constant: Individuals with CIGNA Choice Fund continued to receive recommended care at similar compliance rates as individuals with traditional plans.
- Reduction in costs for chronic diseases: Compared to individuals in traditional plans, medical cost trends were substantially less for individuals in CIGNA Choice Fund plans with diabetes (20% less) or hypertension (18% less), and these individuals maintained similar treatment regimens.
- Medication compliance improved, while costs decreased: Use of maintenance medications that support chronic conditions increased while costs decreased, and Choice Fund enrollees' use of generic drugs was at a higher rate than individuals in traditional plans.

Key Findings – Medical Cost Trend and Use

- Medical cost trend for the CIGNA CDHP was lower than that of CIGNA's HMO and PPO plans in both the first and renewal plan years.
- CIGNA Choice Fund medical cost trend was more than 13% lower than traditional plans in the first plan year; with first-year cost savings occurring in all health status categories, across all categories of service, and for both Health Reimbursement Account and Health Savings Account plans.

Medical Cost Trends
2007 vs. 2008



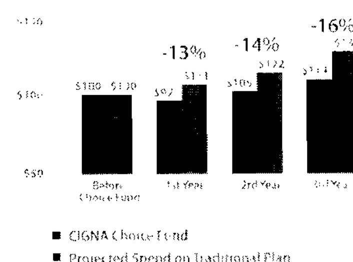
Medical (non-pharmacy) analysis excludes catastrophic claims [illegible] and capitated services

Data is standardized for both populations. Values are adjusted to reflect the overall health status mix of the entire study group

Results are relatively insensitive to the method of standardization [illegible]

- The study shows that lower medical cost trend for CDHP continues in subsequent years. This means that the cost reduction associated with CDHPs are sustainable and in fact increase over time.

Projected Medical Costs per $100 Spent
CIGNA Choice Fund vs. Traditional Plans

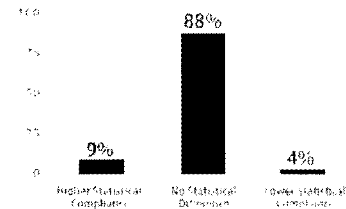


Analysis excludes catastrophic claims > $50,000 and capitated services

Key Findings – Medical Cost Trend and Use (continued)

- CIGNA Choice Fund enrollees continued to receive recommended care at the same or higher levels as when these individuals were enrolled in traditional plans in the previous year. This evaluation was based on more than 300 evidence-based measures of health care quality (for example, women having a mammogram in the past 24 months or diabetes patients having a physician visit in the last six months).
  - This experience was similar for renewal-year CDHP enrollees (not pictured).

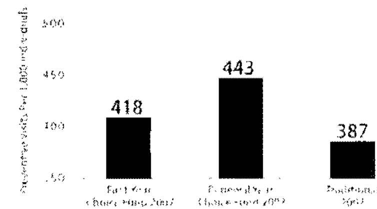
Medical Best Practice Measure Comparison
CIGNA Choice Fund* vs. Traditional Plans



*New Choice Fund individuals in 2007
Total is greater than 100% due to rounding

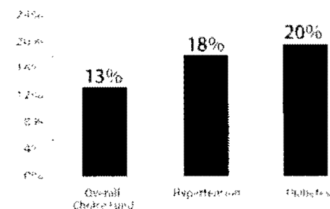
- In addition, CIGNA Choice Fund enrollees were far more likely to take advantage of preventive care visits than individuals enrolled in traditional plans.

Preventive Care Visits
CIGNA Choice Fund vs. Traditional Plans



- Chronic conditions: Compared to individuals in traditional plans, medical cost trend was substantially less for individuals enrolled in CIGNA Choice Fund with diabetes (20% less) or hypertension (18% less).
  - Individuals with chronic conditions maintained similar treatment regimens regardless of whether they were covered by CDHP or traditional plans. This suggests that reduction in cost trend is a result of better chronic disease management, rather than individuals covered by CDHP's foregoing recommended care.

Medical Cost Trend Reduction
Compared to Traditional Plans

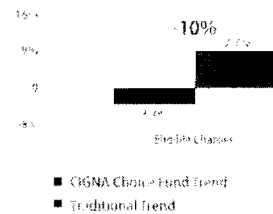


Key Findings – Pharmacy

- Pharmacy cost trend for individuals new to CIGNA Choice Fund was 10% lower than traditional plan cost trend:
  - Usage was higher for new CIGNA Choice Fund enrollees when compared to prior year.
  - Average unit cost was lower for both maintenance and acute medications.

  This suggests that individuals were compliant with their medications while exercising lower cost options such as generic medications and mail-order purchasing.

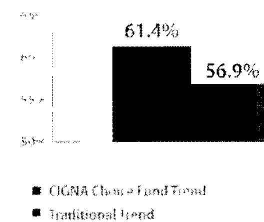
Pharmacy Costs
CIGNA Choice Fund vs. Traditional Plans



- Generic usage was nearly 5% higher for individuals enrolled CIGNA Choice Fund plans.

  Utilization trend and cost-per-day trend were both lower for new CIGNA Choice Fund enrollees. Utilization was similar for maintenance medications, and lower for acute medications.

Percent of Prescriptions filled with Generic Drugs, 2007
CIGNA Choice Fund vs. Traditional Plans



Overall, CIGNA's consumer-driven health plans save money without compromising care. Evidence suggests that individuals in these plans are increasingly engaged and smarter about their health care. Contributing to the success of the CIGNA Choice Fund plans are:

- CIGNA's award-winning communications of the Choice Fund plans;
- Access to personal health advisor;
- Higher usage of preventive services; and
- Individuals being twice as likely to register to use CIGNA's online health care quality, cost and health improvement resources.

About the Study

The experience study – one of the most extensive to date – was an analysis of claims data for two groups of individuals from the same 171 client groups:

- 152,500 individuals were continuously enrolled in a CIGNA Choice Fund plan in 2006 and/or 2007.
  - 30,800 individuals were in their first year with a CIGNA Choice Fund medical plan.
  - 121,700 individuals were in a renewal year with CIGNA Choice Fund, split roughly 50/50 between their second year and beyond.
- 286,600 traditional HMO and PPO enrollees from the same employer groups served as a control group.
- 65,000 Choice Fund enrollees with a pharmacy and medical combined deductible were used in the pharmacy analysis against a control population of 186,000 individuals who have a separate pharmacy plan (i.e., not a combined deductible).
- 29,000 enrollees were in a renewal year with CIGNA Choice Fund with a combined medical and pharmacy deductible.
- 36,400 individuals were in their first or renewal year with a CIGNA Choice Fund medical plan and in their first year of having a combined medical and pharmacy deductible.
- The study examined the total cost of claims for both employers and individuals to isolate behavior changes associated with enrollment in consumer-directed plans. Observed differences were not the result of changes in coverage or increases in consumer cost-sharing.
- Results were standardized. This process adjusts for differences in health status mix (the number of low, moderate and high risk individuals) between CIGNA Choice Fund and traditional plan groups. Values are adjusted to reflect the overall health status mix of the entire study group. This allows for valid, consistent comparisons between groups.
- Standardized data better estimates the potential impact of the CIGNA Choice Fund plan when offered as the only coverage option (full replacement).
- The study excluded catastrophic claims in excess of $50,000 from all populations to reduce random variations within smaller sets of data.

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Attachment "Fritchen Exhibit 2.xls" is not a PDF document and cannot be reproduced here.

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March 9, 2009

Mila Kofman, Superintendent
c/o Pat Galouch
Docket No. INS-09-1000
Maine Bureau of Insurance
34 State House Station
Augusta, Maine 04333-0034

Re: Anthem BCBS 2009 HealthChoice Individual Rate Filing
Filing coversheet

Dear Superintendent Kofman:

Enclosed for filing please find the following:

SUBMITTED BY: Christopher T. Roach

DATE: March 9, 2009

DOCUMENT TITLE: Anthem BCBS Response to Third Information Request of the Superintendent

DOCUMENT TYPE: Response to Information Requests

CONFIDENTIAL: **No**

Thank you for your assistance in this matter.

Very truly yours,

/s/ Christopher T. Roach

cc: Thomas C. Sturtevant, Esquire
Christina M. Moylan, Esquire

{W1325129.1}

NON-CONFIDENTIAL

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

IN RE:	)	
	)	
ANTHEM BLUE CROSS AND BLUE	)	
SHIELD 2009 INDIVIDUAL RATE	)	APPLICANT'S RESPONSE TO
FILING FOR HEALTHCHOICE,	)	THIRD INFORMATION REQUEST
HEALTHCHOICE STANDARD AND	)	OF THE SUPERINTENDENT
BASIC AND LUMENOS CONSUMER	)	
DIRECTED HEALTH PLAN	)	
PRODUCTS	)	March 9, 2009

Docket No. INS-09-1000

NON-CONFIDENTIAL

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

IN RE:	)	
	)	
ANTHEM BLUE CROSS AND BLUE	)	
SHIELD 2009 INDIVIDUAL RATE	)	APPLICANT'S RESPONSE TO
FILING FOR HEALTHCHOICE,	)	THIRD INFORMATION REQUEST
HEALTHCHOICE STANDARD AND	)	OF SUPERINTENDENT
BASIC AND LUMENOS CONSUMER	)	
DIRECTED HEALTH PLAN	)	
PRODUCTS	)	March 9, 2009

Docket No. INS-09-1000

Applicant Anthem Health Plans of Maine, Inc., d/b/a Anthem Blue Cross and Blue Shield ("Anthem BCBS") hereby responds to the Third Information Request of the Superintendent dated and received March 3, 2009 as follows:

1. Please provide a reconciliation between the 2008 results shown in Exhibit 9 of Anthem's filing and the results reported in the Individual column of Anthem's 2008 Rule 945 report.

Response:

Anthem BCBS's Rule 945 report is fundamentally different than Exhibit 9 for two primary reasons. First, the Rule 945 report contains information for all individual products offered by Anthem BCBS, and Exhibit 9 contains information for two products – HealthChoice and Lumenos. Second, Exhibit 9 presents GAAP information and Rule 945 filing presents STAT information.

The following are specific differences of the Rule 945 filing as compared to Exhibit 9:

- Premium, Claims, and Administrative Expense: The inclusion of other products besides HealthChoice and Lumenos in the Rule 945 filing increases premium, claims, and administrative expense amounts over the Exhibit 9 amounts listed.

- Premium: The STAT premium excludes a change to GAAP premium related to reducing a reserve for bad debt.
- Claims: The claims are reduced in Rule 945 filing for reclassification of assessments from claims to administrative expense.
- Claims: Additionally, as the note on Exhibit 9 explains, claims in Exhibit 9 include restatements of outstanding claims.
- Administrative Expense: The administrative expense is increased in the Rule 945 filing for reclassification of assessments from claims to administrative expense.
- Administrative Expense: The administrative expense in Rule 945 filing is reduced for an allocation of group ASO profit across the various lines of business.

DATED: March 9, 2009

/s/ Christopher T. Roach
Christopher T. Roach, Esq.

PIERCE ATWOOD LLP
One Monument Square
Portland, Maine 04101
Attorney for Applicant

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

IN RE: ANTHEM BLUE CROSS AND BLUE SHIELD 2009 INDIVIDUAL RATE FILING FOR HEALTHCHOICE, HEALTHCHOICE STANDARD AND BASIC AND LUMENOS CONSUMER DIRECTED HEALTH PLAN PRODUCTS Docket No. INS-09-1000	)	**CERTIFICATE OF SERVICE**

The undersigned counsel 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 Applicant's Response to the Third Information Request of the Superintendent upon the persons and at the addresses indicated below.

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DATED: March 9, 2009

/s/ Christopher T. Roach
Christopher T. Roach, Esq.

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Attachment "Anthem Hearing Exhibit 6 (W1326241).XLS" is not a PDF document and cannot be reproduced here.

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March 10, 2009

Mila Kofman, Superintendent
c/o Pat Galouch
Docket No. INS-09-1000
Maine Bureau of Insurance
34 State House Station
Gardiner, Maine 04333-0034

RE: ANTHEM BCBS HEALTHCHOICE & LUMENOS INDIVIDUAL RATE FILING EFFECTIVE JULY 1, 2009

I. FILING COVERSHEET

Dear Superintendent Kofman:

Enclosed for filing please find the following:

SUBMITTED BY: Christopher T. Roach

DATE: March 10, 2009

DOCUMENT TITLE: Supplemental Prefiled Testimony of Jennie Casaday

DOCUMENT TYPE: Prefiled Testimony

CONFIDENTIAL: **No**

Thank you for your assistance in this matter.

Very truly yours,

/s/ Christopher T. Roach

cc: Thomas C. Sturtevant, Esquire
Christina M. Moylan, Esquire

NON-CONFIDENTIAL

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

IN RE:	)	EXHIBIT 5
	)	
ANTHEM BLUE CROSS AND BLUE SHIELD 2009 INDIVIDUAL RATE FILING FOR HEALTHCHOICE, HEALTHCHOICE STANDARD AND BASIC AND LUMENOS	)	SUPPLEMENTAL PREFILED TESTIMONY OF JENNIE CASADAY
DOCKET NO. INS-09-1000	)	

March 10, 2009

NON-CONFIDENTIAL

1 **Q. Please state your name.**

2 A. My name is Jennie Keith Casaday.

3

4 **Q. Did you submit prefiled testimony in this matter on March 6, 2009?**

5 A. Yes, that prefiled testimony was marked as Anthem BCBS's Exhibit 1.

6

7 **Q. Why are you submitting supplemental prefiled testimony?**

8 A. I have reviewed the prefiled testimony from the Attorney General's
9 consultant, Beth Fritchen, and thought it would be beneficial to provide
10 preliminary comments on Ms. Fritchen's trend analysis in advance of the hearing
11 to allow additional time for review of my analysis and accompanying data.

12

13 **Q. At page 7 of her prefiled testimony, Ms. Fritchen suggests an**
14 **exponential base trend of 6.5% and then adjusts that base trend by 2% for**
15 **provider contracting and 2% for deductible leveraging, for a total trend of**
16 **10.8%. Do you agree with Ms. Fritchen's analysis?**
17 A. No. As an initial matter, Ms. Fritchen adopted our Method 2, which was
18 intended solely as a reasonableness check on our Method 1 analysis. As I stated
19 in responses to discovery requests and in my prefiled testimony, we strongly
20 believe that our Method 1 is the appropriate methodology for calculating an
21 accurate trend for HealthChoice and Lumenos.

22

23 Beyond our disagreement with her choice of trend methods, Ms.
24 Fritchen's modified Method 2 analysis is materially flawed. First, Ms. Fritchen
25 provided no support for the percentages that she selected for provider contracting
26 and deductible leveraging. The far more serious flaw in her analysis, however, is
27 that Ms. Fritchen made no adjustment for changes in the business/deductible mix
28 of this block of business. As I will explain later, when this appropriate adjustment
29 is made, Ms. Fritchen's modified Method 2 calculation would yield a trend of
30 15.2%, not the 10.8% reflected in her prefiled testimony.

1

2 **Q. Before explaining your calculation, what do you mean by changes in the**
3 **business/deductible mix?**
4 A. Anthem BCBS offers a number of different product options and deductible
5 levels in Maine. When premiums are adjusted, members change their deductible
6 levels. In order to determine an accurate trend, we must understand those
7 deductible changes and account for them in order to put the current claims on an
8 "apples to apples" basis with the claims that we are projecting. We call that
9 "normalizing" the claims.
10

11 Anthem BCBS would need to make a similar adjustment if other aspects
12 related to our mix of business changed significantly from one period to the next.
13 For example, if we had an infusion of new members that were under the age of
14 40, our observed claims trends would appear to decrease. We would need to
15 account for this impact when reviewing claims trends by removing the affect of
16 the change in membership distribution before comparing claim cost between the
17 two periods.
18

19 **Q. What happens if you do not normalize the claims?**
20 A. The actuary will not get an accurate trend if claims are not normalized.
21

22 **Q. What adjustment should be made to normalize the claims that Ms.**
23 **Fritchen used in her calculation?**
24 A. The trend Ms. Fritchen calculated should be adjusted by 4% to account
25 for changes in the business/deductible mix. Anthem BCBS grouped observed
26 trend data into three categories based on deductible level: Less Than $5000 Ded,
27 $5000 Ded, and $10,000 & $15,000 Ded. Rolling 12 month allowed PMPMs and
28 member months were compiled for inpatient, outpatient, professional and
29 pharmacy claims for each category and in total. The impact of changing
30 deductible mix was measured for each rolling 12 month period by comparing the
31 actual trend for all deductible levels combined to an adjusted trend based on

1 holding membership constant at the membership in effect during the base period.
2 The following table illustrates the calculation of the adjusted allowed trend after
3 normalizing for changes in deductible mix:

Deductible Level	Prior PMPM	Current PMPM	Prior Mbr Mths	Current Mbr Mths
Less Than $5,000	$833.33	$1,012.92	33,333	26,425
$5,000	$278.14	$285.32	224,824	152,552
$10,000 & $15,000	$129.93	$151.58	91,417	99,609
Total - All Deductibles	$292.32	$306.52	349,574	278,586

Adj Current PMPM based on Prior Mbr Mths: $319.73
(($1012.92 x 33,333)+($285.32 x 224,824)+($151.58 x 91,417))/349,574 = $319.73

Observed (Actual) Trend	4.9%	=$306.52 / $292.32 -1
Normalized (Adjusted) Trend	9.4%	=$319.73 / $292.32 -1
Deductible Mix Adjustment	**4.3%**	=1.094/1.049 – 1

4
5 In my Exhibit VI.A of the revised HealthChoice and Lumenos filing and
6 as attached to my prefiled testimony, Anthem BCBS provided the "Impact of
7 Deductible Mix on Utilization" by service category for rolling 12 month periods
8 from March 2006 through September 2008. The impact varies slightly based on
9 service category, but on average the impact of changes in our deductible mix has
10 suppressed observed trends by 4% or more in recent periods. These impacts were
11 also discussed in the Actuarial Memorandum in our initial and revised filings.
12 (*See* Actuarial Memorandum, p.16.)
13
14 **Q. What overall trend would result if this adjustment is made to Ms.**
15 **Fritchen's trend calculation?**
16 A. Using Ms. Fritchen's 6.5% base trend and her 2% adjustments for provider
17 contracting and deductible leveraging, respectively, yields a trend of 10.8%
18 (1.065 x. 1.02 x 1.02). Applying the appropriate adjustment for
19 business/deductible mix to normalize the claims yields a trend of 15.2% (1.108 x
20 1.04).
21

1 **Q. The trend calculated with Ms. Fritchen's modified Method 2,**
2 **properly adjusted for business/deductible mix, is higher than the trend**
3 **Anthem BCBS used in its initial filing. What premium increase would be**
4 **required if you used the 15.2% trend?**
5 A. Using the 15.2% trend, the average premium increase would be 21.9%
6 based on projected enrollment or 19.7% based on current enrollment.
7
8 **Q. Do you have other information to suggest that Ms. Fritchen's trend is**
9 **understated?**
10 A. Yes. Ms. Fritchen's analysis implies a paid claims trend of 7.2% (total
11 adjusted claims of $61,733,529/147,661 = $418.44 over the base claims
12 experience of $55,284,872/148,282 = $372.84 and adjusted for the months of
13 trend ($418.44/372.84)^(12/20) – 1 = 7.2%). The difference between Ms.
14 Fritchen's implied paid trend of 7.2% and the paid claims trend of 10.3% in our
15 revised filing is due to Ms. Fritchen's failure to adjust for changes in the
16 business/deductible mix. Ms. Fritchen's trend also relies on trends that we
17 indicated were, in our view, understated and unlikely to persist.
18
19 **Q. Have you reviewed additional data that suggests that Ms. Fritchen's**
20 **trend is understated and supports your view that low trends were unlikely to**
21 **persist?**
22 A. Yes. We now have additional runout that demonstrates that even Anthem
23 BCBS's allowed trend of 14.1%, or net paid trend of 10.3%, were understated.
24 More specifically, attached to this supplemental testimony as Exhibit 6 are trends
25 that have been restated using runout through February, 2009. These restated
26 claims reflect that the paid claims trend, year over year, from 2007 to 2008 was
27 12.9% and that the 12-month rolling trend through February, 2009 was 14%.
28 These dramatic increases in trend demonstrate that Ms. Fritchen's trend is
29 significantly understated. Not only does it fail to account for changes in our
30 business mix, but it relies heavily on the low trends that were observed in the
31 most recent observed trends. For a period of time in mid-2007 to mid-2008,

1 Anthem BCBS experienced historically low claims trends. As Anthem BCBS
2 noted in its discovery responses, however, those low trends were unlikely to
3 persist and, indeed, trends are returning to the levels that have historically
4 predominated this product.
5
6 Further, Anthem projects trends for the HealthChoice and Lumenos book
7 of business that are in the middle of the range of historic observed values. When
8 recent trends are particularly low, we do not forecast future results from these
9 values. Similarly, when our trends are particularly high, we do not forecast future
10 results using inflated trends. It is unreasonable to project future claim cost based
11 only on the most recent observed values because the trends on the HealthChoice
12 and Lumenos products have clearly varied over time with cycles of increasing and
13 decreasing claims trends. The only reasonable way to project future claims is to
14 remove the volatility from the observed claims trends and attempt to smooth the
15 projected claim experience.
16
17 **Q. Does this conclude your supplemental testimony?**
18 A. This concludes my prefiled supplemental testimony, but I anticipate providing
19 supplemental direct testimony at the hearing.

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

IN RE:	)	
ANTHEM BLUE CROSS AND BLUE SHIELD 2009 INDIVIDUAL RATE FILING FOR HEALTHCHOICE, HEALTHCHOICE STANDARD AND BASIC AND LUMENOS CONSUMER DIRECTED HEALTH PLAN PRODUCTS	)	**CERTIFICATE OF SERVICE**
Docket No. INS-09-1000	)	

The undersigned counsel 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 Supplemental Prefiled Testimony of Jennie Casaday upon the persons and at the addresses indicated below.

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DATED March 10, 2009

/s/ Christopher T. Roach
Christopher T. Roach, Esq.
Nikolas Kerest, Esq.

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Attachment "1_Support_for_DeductibleMix_Adjustment.xls" is not a PDF document and cannot be reproduced here.

Attachment "HC and Lumenos rate filing attachments and exhibits (W1296701).XLS" is not a PDF document and cannot be reproduced here.

SERFF Tracking Number:	*MALH-125969281*	*State:*	*Maine*
Filing Company:	*Anthem Blue Cross and Blue Shield*	*State Tracking Number:*	*2009 RATE FILING FOR HEALTHCHOICE AND LUMENOS PRODUCT LINES*
Company Tracking Number:			
TOI:	*H16I Individual Health - Major Medical*	*Sub-TOI:*	*H16I.005A Individual - Preferred Provider (PPO)*
Product Name:	*2009 Rate Filing for HealthChoice and Lumenos Product Lines*		
Project Name/Number:	*/*		

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Attachment "031209 - Vol. 1.Rtf" is not a PDF document and cannot be reproduced here.

Attachment "usm31009 - Vol. 1.Rtf" is not a PDF document and cannot be reproduced here.

SERFF Tracking Number:	*MALH-125969281*	*State:*	*Maine*
Filing Company:	*Anthem Blue Cross and Blue Shield*	*State Tracking Number:*	*2009 RATE FILING FOR HEALTHCHOICE AND LUMENOS PRODUCT LINES*
Company Tracking Number:			
TOI:	*H16I Individual Health - Major Medical*	*Sub-TOI:*	*H16I.005A Individual - Preferred Provider (PPO)*
Product Name:	*2009 Rate Filing for HealthChoice and Lumenos Product Lines*		
Project Name/Number:	*/*		

Attachment "Adjusted Trend Analysis 040209.xls" is not a PDF document and cannot be reproduced here.

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OFFICE OF THE ATTORNEY GENERAL
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April 17, 2009

Mila Kofman, Superintendent
Attn: Pat Galouch (Docket No. INS-09-1000)
Bureau of Insurance
Maine Dept. of Professional and Financial Regulation
34 State House Station
Augusta, Maine 04333-0034

Re: Anthem BCBS 2009 Individual Rate Filing for HealthChoice & Lumenos

Dear Superintendent Kofman:

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

SUBMITTED BY:	Christina M. Moylan, AAG
DATE:	April 17, 2009
DOCUMENT TITLE:	Attorney General's Closing Argument
DOCUMENT TYPE:	Closing argument
CONFIDENTIAL:	No

Copies are also being served this date in the manner indicated on the enclosed Certificate of Service.

Sincerely,

/s/ Christina M. Moylan

CHRISTINA M. MOYLAN
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207/626-8838
christina.moylan@maine.gov

CMM/s
Enc.
cc: Thomas Sturtevant, Jr., AAG
Christopher Roach, Esq.

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

IN RE: ANTHEM BLUE CROSS AND BLUE SHIELD 2009 INDIVIDUAL RATE FILING FOR HEALTHCHOICE, HEALTHCHOICE STANDARD AND BASIC AND LUMENOS CONSUMER DIRECTED HEALTH PLAN PRODUCTS Docket No. INS-09-1000	**ATTORNEY GENERAL'S CLOSING ARGUMENT**

The Attorney General ("AG") submits this Closing Argument in support of its position that Anthem Blue Cross and Blue Shield ("Anthem") has failed to meet its burden of demonstrating that the proposed rates are not excessive or unfairly discriminatory under 24-A M.R.S.A. § 2736. Consequently, its request should be denied.

I. The Trend Anthem Applied to Project Claims for the Rating Period Is Overstated.

The Attorney General's consultant, Beth Fritchen, calculated base claims very close to Anthem's ($55,284,872 v. $55,053,257).[1] The 10.6% trend she calculated to project claims into the rating period, however, differs materially from Anthem's 14.1%.[2]

A. General Methodology

Anthem employed a methodology for applying a trend that does not adequately account for the impact of variability in large claims (Method 1). According to Ms. Fritchen, large claims should be removed from the base claims prior to applying trend. A pooling charge should then be added to the trended non-large claims. Fritchen Pre-filed at 5. This is the basic approach that Anthem employed in Method 2 to test the reasonableness of its Method 1 results. Ms. Fritchen used a hybrid of the two Anthem methods by excluding large claims and adding back a pooling charge to account for catastrophic claims (like Method 2), but developed the trends using

[1] While the estimates are very close, Ms. Fritchen pointed out in her pre-filed testimony that she would have utilized a slightly different methodology to more accurately estimate catastrophic claims had she had detailed claim information for each catastrophic claimant.

allowed as opposed to paid claims data (like Method 1). Tr. at 205-206. Anthem and Ms. Fritchen agree that using allowed claims to develop trends requires an adjustment for changes in provider contracts, as well as an adjustment for the impact of deductible leveraging. Transcript ("Tr."). at 219-220. Ms. Fritchen adopted Anthem's 2% adjustment for deductible leveraging and apparent 1% adjustment for provider contracting.[3] *Id.* Anthem and Ms. Fritchen also agree that the observed trend must be normalized to account for underlying changes in risk characteristics which impact costs, such as age or deductible mix. Applicant's Response to Hearing Requests at 10. They also agree that "the portion of the impact of these changes which is also captured in the rating formula must be normalized in the trend calculation so as not to double count." *Id.* They disagree on how that normalization should be done. *Id.*

B. Large claims

Like Anthem did in Method 2, Ms. Fritchen removed high cost claimants (those in excess of $100,000) from the base claims, trended the remaining claims, and then added a pooling charge. While Ms. Fritchen noted several points where her analysis differed from Anthem's, her 17.3% pooling charge is very close to Ms. Casaday's 17.4%. Fritchen Pre-filed at 9-10. Anthem does not appear to take issue with Ms. Fritchen's analysis. Instead, Ms. Casaday argues that smoothing for large claims by removing excess claims and applying a pooling charge is not necessary because this block of business has experienced relatively stable large claims in recent years. Tr. at 91-92. Indeed, other than arguing that Ms. Fritchen's approach to large claims was unnecessary since it produced such similar results to her preferred approach (Method 1) which makes no adjustment for large claims at all, the only real problem Ms. Casaday seemed to have with Ms. Fritchen's approach related to accounting for changes in risk characteristics (or "normalizing"), specifically as to deductible mix.

[2] Ms. Fritchen's pre-filed testimony suggests a maximum trend of 10.8%. The slight downward revision to 10.6% is the result of updated calculations prepared upon receipt of Anthem's post-hearing data.

[3] In her live testimony, Ms. Fritchen noted that her original 2% for provider contracting was an estimate subject to change with more information from Anthem. Tr. at 220. In her updated analysis ("Explanation of Updated Normalizing of the Trend" submitted by the Attorney General on April 2, 2009), Ms. Fritchen estimated increases in provider reimbursement to be 1%, based upon the additional trend detail Anthem submitted post-hearing (March 20, 2009 filing). While it is not entirely clear what value Anthem assigns for projected increases in provider contracts, Tr. at 125, the post-hearing observed data and projected unit cost trend example reflected in the Excel document titled "6_Example of Cost Trend Projection" show only a 0.5% contracting increase.

C. Normalizing

Ms. Casaday correctly noted in her supplemental pre-filed testimony that Ms. Fritchen's original analysis of trend failed to take into account anticipated changes in deductible mix, which she suggested required a 4% positive adjustment to Ms. Fritchen's trend. While agreeing that such an adjustment was appropriate, Ms. Fritchen asserted that expected changes in any other risk characteristics should be considered as well, and also that corresponding offsets had to be factored in only to the extent such changes in risk characteristics are already considered in the rating structure. Tr. at 210-212.

In her post-hearing analysis based on additional information produced by Anthem, Ms. Fritchen pointed out that the only two risk characteristics by which premium rates may differ under Maine law are age and anticipated utilization differences due to cost sharing, both with limitations. Explanation of Updated Normalization of the Trend at 3. Therefore, changes in all other risk characteristics must be reflected in the trend and require no normalization.

While Ms. Fritchen and Ms. Casaday agreed that trends should be normalized for changes in risk characteristics which impact costs and are also adjusted for in the rating formula, they disagree on whether premium relativity factors or claim cost relativity factors should be used in performing the normalization. Ms. Casaday argued that the claim cost relativity factors should be used ("the purpose of normalizing the allowed cost trend is to account for the underlying cost differences and not simply the rating factors which are restricted by law"). Applicant's Response to Hearing Requests at 10. Ms. Fritchen explained the importance of using the premium relativity factors to normalize for shifts in age and benefits since they represent the portion of the expected shift in claims costs that is captured directly through the rating formula, and therefore the remainder must flow into the rates through trend. Explanation of Updated Normalization of the Trend at 2.

In her post-hearing analysis, Ms Fritchen performed an analysis normalizing observed trend for changes in the two risk characteristics that are captured in the rating formula, namely age and benefit related utilization. Her method and analysis are described at length in her post-hearing supplement, Explanation of Updated Normalizing of the Trend. After normalizing for expected changes in age and utilization which are also captured through the rating formula, Ms. Fritchen calculated a maximum trend of 10.6%.

II. Anthem's Rates for Lumenos Products Relative to HealthChoice Products.

Another area of partial agreement between Anthem and the Attorney General is in the rate relationship between HealthChoice and Lumenos products. There is agreement that the products should be combined for rating purposes, but that some utilization credit should be factored in for the benefit of Lumenos subscribers. Tr. at 117, 224. The question is to what degree should Lumenos be credited for favorable experience. Anthem builds in 6%; the Attorney General suggests 15% (for the $5,000 deductible). *Id.*

Ms. Fritchen testified that most companies employ a utilization reduction factor for consumer-driven health plans in the range of 10-15%, but has seen reductions as high as 30%. Fritchen Pre-filed at 18. While not all of the factors Ms. Fritchen has observed may have been in the individual market, Anthem's 6% is significantly below the low end of the scale. Furthermore, it bears noting that if HealthChoice and Lumenos were rated entirely on their own experience, the differential would actually be 25% to 33%. Tr. at 224. Applying too small a differential risks losing Lumenos customers altogether, thereby further deteriorating the combined pool, and would by unfairly discriminatory. Striking a reasonable balance between rewarding Lumenos subscribers for behavior the product is designed to encourage, and spreading risk within the individual population is not a precise exercise. In Ms. Fritchen's judgment, however, 15% is more likely to have positive effects on the individual pool overall.

III. Anthem's Proposed Rates Do Not Comply With Rule 940.

Ms. Fritchen's pre-filed testimony explains how some of the proposed rates fail to meet the rate relativity requirements of Section 8(B) of Rule 940, namely the Lumenos 65+ rates. Fritchen Pre-filed at 18-19. The differential between 65+ Lumenos rates and 65+ HealthChoice rates is far greater than in the other age bands, a differential not justified by benefit differences. *Id.* Anthem fails to justify this excess differential. Indeed, no witness refuted Ms. Fritchen's testimony.

IV. Anthem's Profit and Risk Margin Is Excessive.

As the Superintendent heard repeatedly from subscribers, these are extraordinarily difficult economic times we live in. Rate increases of any size will have particularly painful repercussions. On the other hand, Anthem's surplus is extremely healthy. Extraordinary times

call for extraordinary measures. The Attorney General has supported a 3% profit and risk charge under normal circumstances in prior filings. However, the combination of (1) a unique economic situation resulting in extreme financial hardship for subscribers, and (2) the extreme financial health of the company, makes any retention for risk and profit at this particular time excessive.

There is no guidance in the health insurance chapter (Chapter 33) of the Maine Insurance Code to assist the Superintendent in interpreting "excessive." While there is no dispute regarding the governing standard, namely that rates shall not be "excessive, inadequate or unfairly discriminatory," the requirement does not appear affirmatively in Chapter 33. Instead, it is simply referenced and presumed to apply in certain sections within the chapter.[4] Nor could the Attorney General find any Maine cases interpreting "excessive, inadequate or unfairly discriminatory" relative to health insurance rates. Thus, the Superintendent is left with little guidance, and necessarily a great deal of discretion in interpreting and applying the standard.

There is statutory illumination of the same three-pronged standard in another chapter of the Maine Insurance Code standard. 24-A M.R.S.A. § 2303. Chapter 25, Rates and Rating Organizations, expressly applies to casualty and motor vehicle insurance, surety insurance, property and marine insurance and title insurance, and is made expressly inapplicable to other forms of insurance, including health insurance. 24-A M.R.S.A. § 2302. While not required, there is no prohibition on the Superintendent looking to those § 2303 factors in exercising her broad discretion under Chapter 33 governing health insurance contracts.

Among the factors to be considered under § 2303 are: "past and prospective loss experience within and outside this State" and "all other relevant factors within and outside this State." 24-A M.R.S.A. § 2303(1)(C)(1) and (6). Further, "[r]ates *may* contain a provision for contingencies and an allowance permitting a reasonable profit." 24-A M.R.S.A. § 2303(1)(I).

Anthem's loss experience in and outside of this state has been extremely favorable. Anthem's surplus is almost eight times the authorized control level, the minimum required surplus. Tr. at 227-228. That sizable surplus is slightly down from recent years due to $76 million transferred to stockholders in 2008. Tr. at 228. Anthem's surplus is available for any line of business that needs to tap into it. Tr. at 257-58. So if Anthem has miscalculated its

[4] The Superintendent shall hold a hearing if "a filing does not meet the requirements that rates not be excessive, inadequate, unfairly discriminatory." 24-A M.R.S.A § 2736-A. The Superintendent shall require more information if she "does not have sufficient information to determine whether such filing meets the requirements that rates not be excessive, inadequate or unfairly discriminatory." 24-A M.R.S.A. § 2736(1).

revenue needs and runs a deficit during the rating period, plenty of surplus is available to help offset the loss. While a company obviously cannot rely on its surplus for potential shortfalls year after year, using the surplus alone as a buffer in a particular year because of unique and extraordinary circumstances (the global recession and extreme financial condition of subscribers combined with the sizable surplus) is not unreasonable.

HealthChoice itself has contributed amply to the current surplus. Notwithstanding losses in 2005 and 2006, overall this line has contributed 3% to the company's surplus from 2000 to 2008. HealthChoice ratepayers have helped the company stockpile and now deserve to benefit from their own significant past contributions.

Among the other relevant factors the Superintendent should consider are policy concerns. As one Maryland court noted, an insurance regulator may consider a state policy regarding health care that was established by another agency as a relevant factor in determining the reasonableness of rates. *Insurance Comm'r of the State of Maryland v. Care-First of Maryland, Inc.,* 816 A.2d 126, 137 (Md. 2003). Both the State Health Plan (Dirigo Health Reform "established as a priority the creation of [the State Health Plan] to improve the health of our state, and to make quality health coverage *more affordable and accessible* to all Maine citizens") and the creation of the Dirigo Health Agency (designed to provide individuals and small groups access to affordable care) reflect affordable health insurance as a State policy priority. While from a purely actuarial standpoint, the Attorney General's expert could not recommend a margin of less than 1%, Tr. at 251, actuarial judgment should not be the starting and ending point for the Superintendent in determining whether a profit and risk charge is excessive. She should consider the totality of the circumstances, including policy concerns which may be outside the specialized expertise of an actuary.

At no profit and risk charge, if Anthem's projections are accurate, the company will break even and still be a financially healthy company. If the revenue falls short of claims and administrative expenses, then the surplus is there to help and is ample enough that Anthem will still be a financially healthy company. The Attorney General recognizes that Anthem is a for-profit corporation, not a charity. Breaking even is not part of a for-profit's business model and is not sustainable. Nonetheless, breaking even under these unique circumstances for a single rating cycle is not unreasonable -- especially considering the significant losses suffered almost

uniformly by businesses across virtually all other sectors of the U.S. economy. Making additional profit here, in these uniquely difficult times, would be excessive.

V. Anthem's Inclusion of the Savings Offset Payment Results in Excessive Rates.

Anthem's proposed rates include a 1.64% savings offset payment ("SOP"), but it has failed to carry its burden to support the SOP as required by Maine law. Specifically, Anthem has failed to demonstrate compliance with the statutory requirement that it *account* for the savings offset payment or any recovery in that offset payment *in its experience* and in accordance with *accepted actuarial principles*. 24-A M.R.S.A. §§ 2736-C(2)(F) and 6913(9). This provision is intended to safeguard against subscribers bearing the full brunt of the offset payment the insurer must remit to the Dirigo Health Agency if those subscribers do not also get the full benefit of that amount in the rate calculation.

The payment is an "offset" against "savings"-- no savings, no offset; some savings, some offset. The burden is on the company, not the subscribers, to ensure that they are actually realizing the precise amount of savings for which they are paying through the SOP. If the company is saving HealthChoice subscribers $1 million dollars by virtue of paying providers $1 million less than it would have in the absence of the Dirigo reforms, then subscribers are justifiably required to pay the million dollars over to Dirigo through the savings offset payment. They should not pay one dollar more than they are saving and it is up to the company to demonstrate that.

Anthem's chief contract negotiator expressed confidence the company had used best efforts to recover in its negotiated rates all cost savings attributable to Dirigo Health initiatives. Tr. at 83. However, he also testified that providers have been unable to isolate or calculate those savings and Anthem does not receive an accounting of those savings. Tr. at 83, 150. Moreover, Ms. Casaday, the actuary responsible for developing the proposed premiums, provided no quantifiable evidence of how she calculated or accounted for those savings in the experience or otherwise. While it may be difficult, that is what the law requires and failure to do so may result in an unfair shouldering by subscribers of that expense, without a quantifiably accurate corresponding credit from embedded savings. Anthem has failed to meet its statutory obligation and should not be permitted to build in any savings offset payment.

VI. Conclusion

Anthem has not satisfied its burden to establish that the rates it proposes are not excessive or unfairly discriminatory. Ms. Fritchen's pre-filed testimony included an independent calculation of rates that resulted in a 14.9% average increase. As indicated in the "Explanation of Updated Normalizing of the Trend," she has revised her trend estimate slightly from 10.8% to 10.6% based on post-hearing information. She indicated in her live testimony that she was not recommending the 3% profit and risk charge embedded in the independent calculation and stated that 1% would be more appropriate. The Attorney General has concluded that any profit and risk charge at all would be excessive, as would inclusion of 1.64% for the savings offset payment. Thus, the Attorney General recommends that the Superintendent exclude that 4.64% from the rates altogether and consider approving an increase of no more than 10-11%.

Dated: April 17, 2009

/s/ Christina M. Moylan
CHRISTINA M. MOYLAN
SCOTT BOAK
Assistant Attorneys General
6 State House Station
Augusta, Maine 04333-0006
Counsel for Attorney General

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

IN RE:	)	
	)	
ANTHEM BLUE CROSS AND BLUE SHIELD 2009 INDIVIDUAL RATE FILING FOR HEALTHCHOICE, HEALTHCHOICE STANDARD AND BASIC AND LUMENOS CONSUMER DIRECTED HEALTH PLAN PRODUCTS	)	**CERTIFICATE OF SERVICE**
	)	
Docket No. INS-09-1000	)	

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 Attorney General's Closing Argument upon the persons and at the addresses indicated below.

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Dated: April 17, 2009

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INS-09-1000
May 1, 2009

Attorney General's Additional Submission in Accordance with Superintendent's April 28, 2009 E-mail.

I. Ms. Fritchen's 10.6% trend selection, not Anthem's 6.9%, is her estimated paid claim trend (calculated as allowed trend adjusted for deductible leveraging).

Ms. Fritchen's ultimate trend of 10.6% is derived from an allowed trend of 6.8%, normalized to account for historical changes in age and utilization changes resulting from shifts in enrollment ("benefit buy-downs"). Adding 2% for deductible leveraging and 1% for changes in provider contracts results in a revised exponential trend estimate of 10%. Fritchen supplemental at 4. A further adjustment of .5% is made to account for expected future changes in the rates of aging and benefit buy-downs.[1] Fritchen supplemental at 5. While the starting point of the analysis is an allowed trend (the 6.8%), the resulting 10.6% is functionally a proxy for the paid trend since deductible leveraging has been factored in. See attached e-mail from Beth Fritchen dated April 30, 2009, attached hereto as Exhibit A.

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[1] Her normalizing for these expected changes is indeed, as Anthem notes in the cited sentence of the closing statement, based on premium factors as opposed to claim factors. Anthem is wrong elsewhere in the closing in quoting Ms. Fritchen as stating that using *premium* factors, rather than *claim* factors "will result in premium collected which will be short." Anthem Closing Statement at 4, citing Fritchen supplemental at 2, paragraph 3. She explicitly makes the opposite point in that paragraph, namely that the premium collected would be short "[i]f the trend is normalized using the *claim* age factors." Anthem not only transposes "premium" and "claim" in describing Ms. Fritchen's supplemental statement, its summary reliance on a portion of a sentence inaccurately implies a consistent directional result from using one or the other factor (shortfall if premium factors used), even though the cited passage is limited to the situation where the population is aging at a rate that exceeds the age factor in the rate structure. If instead the population were decreasing in age, the use of claim factors in the normalization process would instead overstate the required premium.

Similarly, Anthem incompletely (and as a result inaccurately) attributes to Ms. Fritchen the statement that "the impact of anticipated future aging should remain in the trend since additional premium revenues would not be collected given premium rates do not vary with age," suggesting thereby that Ms. Fritchen recommends leaving the entire impact in the trend in this case. Anthem Closing Statement at 4, citing Fritchen supplemental at 1, paragraph 3. Anthem omits the beginning of the sentence limiting her statement to community rating structures, where no additional premium is permitted as people age. Anthem also omits the very next sentence, in which Ms. Fritchen states that if "some portion of aging is reflected in the rating structure, the aging must be removed from the trend to the extent it is also captured in the rating formula, so as not to double count the impact of aging in both the claims and the revenue." She goes on to describe that situation, which exists under Maine law, at great length.

Anthem again is inaccurate on this point at page 5 of its Closing Statement, where it states that if premium and claim cost factors are not interchangeable, "Ms. Fritchen acknowledges that . . . *claim* cost factors should be used to project trend." No citation is given for this attribution, which is counter to her consistent recommendation that *premium* factors be used in such circumstances. *See, e.g.*, Fritchen Supplement at 2, paragraph 1 ("Therefore, it is important that the premium age factors and not the claims age factors be used in the normalization"); page 2, paragraph 3 ("Therefore, the premium age factors must be used for the normalization so that the observed trend is only decreased by 1.3%, the same amount which is recaptured through the age rating methodology"); page 4, paragraph 2 ("As can be seen in the table above, after normalizing for both age and utilization changes which will be reflected in the premium rating formula, the resulting trend of 6.8% is not significantly different from the unadjusted trend of 6.5%.")

II. The 0.945 is a one-time adjustment to claims, not part of the trend.

The 10.6% trend already includes an adjustment for historical benefit buydowns shifts. Fritchen Pre-filed at 7, lines 20-23. The 0.945 adjustment is a one-time reduction to future claims to reflect future benefit buydowns. *See, e.g.,* Fritchen April 24, 2009 email to Scott Boak, attached hereto as Exhibit B; Fritchen Pre-filed at 20. It is an adjustment to already trended claims, in the same way expected pharmacy rebates are a one-time adjustment to already trended claims. Anthem applies this adjustment to Ms.Fritchen's 10.6% proxy for paid trend (which it calls her allowed trend, reflecting the starting point) to get 6.9%. It is not Ms. Fritchen's paid claims trend, nor does it belong in the trend equation at all. To be clear on an apples to apples basis, the 0.945 factor applies to Ms. Fritchen's 10.6% trend estimate just as it applies to Anthem's 14.5% trend estimate (which Anthem refers to as its adjusted allowed trend). Anthem Closing Statement at 7.

Exhibit A

From: Fritchen, Beth [mailto:Beth.Fritchen@oliverwyman.com]
Sent: Thursday, April 30, 2009 6:16 PM
To: Moylan, Christina
Cc: Boak, Scott; Tomczyk, Tammy
Subject: Anthem rate filing - analysis of paid trends

Tina:

I do not agree with the classification that the 6.9% trend, as calculated by Anthem, is a paid trend and that the 10.6% trend, as I calculated, is an allowed trend. In generating my estimated trend of 10.6%, I used allowed claims data to generate those trends. However, I next added 2% to the trend for the impact of deductible leveraging. By adding the deductible leveraging portion, the trend based on allowed claims data can now be used as a proxy for paid claims trend. This allows me to apply the resulting trend to paid claims in order to determine the rate increase.

Please let me know if you have any questions.

Beth

Exhibit B

From: Fritchen, Beth [mailto:Beth.Fritchen@oliverwyman.com]
Sent: Friday, April 24, 2009 12:56 PM
To: Boak, Scott
Subject: RE: Anthem BCBS - INS-09-1000

Scott - We would not consider the 0.945 adjustment a "trend" since our allowed trend already includes a normalization adjustment for historical benefit buydowns. The 0.945 adjustment represents a reduction to future claims to reflect anticipated future benefit buydowns. They have made a corresponding adjustment in the anticipated future premium assuming no rate increase which is then used to generate the proposed the rate increase. As such the two adjustment are somewhat offsetting.

What really should be compared is our 10.6% trend to Anthem's 14.5% (in their closing or 14.1% in their filing). In addition, they are mixing historical emerging trends (of 12.9% in the example below) with a "estimated paid trend" in the future (that they calculated to be 6.9%) which has been adjusted by a factor that is misstating trend. This factor (0.945) is an adjustment to claims.

Hope this helps.

Beth

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

IN RE:	)	
	)	
ANTHEM BLUE CROSS AND BLUE	)	
SHIELD 2009 INDIVIDUAL RATE	)	
FILING FOR HEALTHCHOICE,	)	DECISION AND ORDER
HEALTHCHOICE STANDARD	)	
AND BASIC, AND LUMENOS	)	
CONSUMER DIRECTED HEALTH	)	
PLAN PRODUCTS	)	
	)	
Docket No. INS-09-1000	)	

I. INTRODUCTION

Mila Kofman, Superintendent of Insurance ("Superintendent"), issues this Decision and Order after consideration of the Anthem Blue Cross and Blue Shield ("Anthem") 2009 rate filing for individual HealthChoice, HealthChoice Standard, HealthChoice Basic, and Lumenos Consumer Directed Health Plan products (collectively, "Individual 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 initial filing, Anthem proposed revised rates for its Individual Products that it asserted would produce an average increase of 14.5%. As identified in its filing, the premium increases varied depending on deductible level and type of contract. The largest increase for the Non-Mandated HealthChoice options would have been 17.2%, for the Mandated Options (HealthChoice Standard and Basic) would have been 7.7%, and for Lumenos would have been 34.1%. Anthem requested that these rate revisions become effective on May 1, 2009. Anthem revised its actuarial analysis with updated data and reflecting a July 1, 2009 effective date. Based on its revised analysis, Anthem requested approval of revised rates with an average increase of 18.1%. As identified in its revised filing, the largest premium increase for Non-Mandated HealthChoice

would have been 23.6%, for Mandated HealthChoice would have been 9.5%, and for Lumenos would have been 37.8%. In its pre-filed testimony filed on March 6, 2009, Anthem further revised its analysis resulting in a requested average rate increase of 18.5%. For the Non-Mandated HealthChoice options, the range of increases is 8.7% to 24.5%, with an average of 18.7%. For the Mandated HealthChoice options, the range of increases is 9.0% to 9.7%, with an average of 9.2%. For the Lumenos options, the range of increases is 8.9% to 38.4%, with an average of 30.2%. Anthem requests that its revised rate filing become effective on July 1, 2009. As of November 2008 there are 12,049 policyholders who will be affected by the proposed rate revisions.

This Decision and Order constitutes final agency action on Anthem's filing.

II. PROCEDURAL HISTORY

On December 22, 2008, Anthem filed proposed revised rates for approval for its HealthChoice, HealthChoice Standard, HealthChoice Basic, and Lumenos Consumer Directed Health Plan products. The Bureau of Insurance designated the matter as Docket No. INS-09-1000.

On January 16, 2009, the Superintendent issued a Notice of Pending Proceeding and Hearing. The notice set a public hearing for March 12, 2009, 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.

On January 21, 2009, Anthem filed a revision to its initial filing.

In early February 2009 Anthem provided direct written notice by mail to every affected policyholder, advising policyholders of the proposed rate increases, the pending proceeding, evening public comment sessions, and the scheduled hearing.

On February 10, 2009, as part of the Procedural Order issued by the Superintendent, the Maine Attorney General was granted intervention as of right. The Procedural Order, in accord with Maine Bureau of Insurance Rule Chapter 350, § 2(A)(1), established procedures for the conduct of this proceeding; and established deadlines for serving discovery requests and for submission of pre-filed testimony and exhibits.

During February 2009 the Superintendent and the Attorney General engaged in discovery on Anthem's rate filing. The Superintendent served Anthem with three pre-hearing discovery requests, to which Anthem filed responses. The Attorney General served Anthem with three discovery requests to which Anthem filed responses.

On March 3, 2009, in Orono, and on March 10, 2009, in Portland, the Superintendent held evening public comment sessions providing members of the public an opportunity to make either sworn or unsworn statements for her consideration. Thirty-four (34) individuals provided such statements.

On March 6, 2009, Anthem and the Attorney General filed prefiled testimony and exhibits. Anthem's pre-filing included a revised rate increase request.

On March 11, 2009, the Superintendent issued a Protective Order that accepted in part Anthem's claim for confidential treatment. The only information that was designated confidential is personal health information that is protected from public disclosure under the Maine Insurance Information and Privacy Protection Act[1] and under the privacy regulations

[1] 24-A M.R.S.A. Chapter 24 (§§ 2201 *et seq.*).

promulgated under the Health Insurance Portability and Accountability Act (HIPAA).[2] The specific information protected is limited to information about the diagnoses and treatments of two high-claim individuals.

On March 12, 2009, the Superintendent held a hearing on Anthem's filing. The hearing was conducted entirely in public session. Members of the public had an opportunity to make either sworn or unsworn statements for consideration by the Superintendent. Seventeen (17) individuals provided such statements. Members of the public also submitted in excess of three hundred (300) written comments outside the public hearing that the Superintendent designated a part of the record of this 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 Superintendent is barred by the Maine Administrative Procedure Act from relying on unsworn submissions as evidence when making her substantive decision. 5 M.R.S.A. § 9057.

At hearing, Anthem presented testimonial evidence from Jennie Casaday, Associate Actuary; Vincent Liscomb, Executive Director of Provider Network Management; and George Siriotis, Regional Vice-President of Sales for the Individual Markets Division, East Region. The Attorney General presented testimonial evidence from Beth Fritchen, Actuary and Principal with Oliver Wyman Actuarial Consulting, Inc. The Superintendent admitted into evidence Anthem Hearing Exhibits 1 through 7, and Attorney General Exhibits 1 through 4.

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[2] 45 C.F.R. Parts 160 and 164.

After the parties rested their cases at hearing, the Superintendent adjourned the hearing for the submission of post-hearing information responses to certain questions posed at the hearing, followed by written closing argument.

On March 16, 2009, the Attorney General filed its post-hearing information responses, as well as an inquiry to Anthem; and on April 2, 2009, filed further post-hearing information.

On March 20, 2009, Anthem filed its post-hearing information responses, to which the Superintendent asked further follow-up questions of Anthem on April 8, 2009. Anthem filed responses to the Superintendent's further inquires on April 13, 2009. A final follow-up question by the Superintendent on April 14, 2009 was responded to by Anthem the same day.

On April 17, 2009, Anthem and the Attorney General filed their written closing arguments.

Per direction of the Superintendent on April 28, 2009, the Attorney General filed clarifying information on May 1, 2009, to which Anthem objected and filed a response on that same day.

III. LEGAL STANDARD

Anthem is required by 24-A M.R.S.A. § 2736(1) to file proposed policy rates for its individual health insurance products with the Superintendent. The Superintendent may approve the filed rates only if they are not inadequate, excessive, or unfairly discriminatory. 24-A M.R.S.A. § 2736(2). Pursuant to 24-A M.R.S.A. § 2736-C(5), the proposed rates should be likely to yield a loss ratio of at least 65% as determined in accordance with accepted actuarial principles and practices. That is, expected claims payments must be at least 65% of premium.

Anthem as proponent of the filed rates bears the burden of proving by a preponderance of the evidence that the proposed rates meet statutory requirements.

IV. DISCUSSION

The Superintendent finds that the proposed rates filed by Anthem in this proceeding are not inadequate. However, the Superintendent does find that the proposed rates as submitted by Anthem are excessive and unfairly discriminatory in contravention of section 2736 for the reasons discussed more particularly below. 24-A M.R.S.A. § 2736.

This section includes a discussion of challenges to Anthem's proposed rates brought by the Attorney General as well as deficiencies determined by the Superintendent. This section also comprises guidance for Anthem on what filing the Superintendent would approve. 24-A M.R.S.A. § 2736-B.

A. Trend

At the heart of the ratemaking process is the calculation of trend factors, the term used to refer to the expected rate of increase in costs based on observed changes in recent years. For a number of reasons, as discussed more fully below, the trends differ for different products.

Anthem's filing included two alternative methods of determining the trend. Method 1, Anthem's preferred method, is the one used in past filings. Method 2 develops a trend with large claims excluded and then adds a pooling charge for large claims. This is similar, but not identical, to the method recommended by Ms. Fritchen in past filings, as well as in this one, and adopted in past rate decisions. Ms. Casaday stated that she preferred Method 1 because it reflects actual changes in provider contracts, reflects trends in unit costs and utilization by

service category, and adjusts for service mix. However, she did not explain why she did not include those features in Method 2 or simply make the large claim adjustment to Method 1.

Ms. Fritchen provided an alternative trend analysis. Like Anthem's Method 2, she excluded large claims and added a pooling charge, but similar to Anthem's Method 1, she based her analysis on "allowed claims" – the total cost of covered services before considering deductibles and other cost-sharing – rather than paid claims, as used in Anthem's Method 2, which reflect the actual benefit paid.

1. Plan Shift

To evaluate the competing trend calculations, it is important to understand the impact on both claims and premiums of the shift from lower- to higher-deductible plans. With respect to claims, the shift affects both utilization (that is, the number of claims) and the cost of each claim. Utilization differences between plans with different deductibles result both from incentives to control utilization when the deductible is large (the "incentive effect") and from adverse selection resulting from the fact that those with health problems are less likely to shift to a high deductible than are healthier individuals (the "selection effect"). The effect on the cost of each claim simply reflects the fact that Anthem pays a smaller proportion of the total cost under high deductible plans (the "benefit effect").

The impact on premiums is less than the impact on claims because, consistent with Maine's statutory prohibition against rating based on health status, Bureau of Insurance Rule 940 limits the difference between the annual premiums for two deductibles to the difference between the deductibles plus an additional allowance for utilization differences that result from the incentive effect. Anthem uses factors that were developed by the actuarial firm Milliman as a mechanism intended to reflect the incentive effect while excluding the selection effect. If every

policyholder met the deductible, the portion of the premium differential that equals the difference in deductibles would reflect only the benefit effect and the only portion of the premium differential representing utilization differences would be the additional allowance for the incentive effect. However, because not everyone meets the deductible, the portion of the premium differential that reflects the difference in deductibles also reflects some of the selection effect. Exactly how much cannot be determined from the data on the record, but it is not necessary to fully quantify the selection effect.

As noted earlier, the Anthem filing included both "allowed" trends, which are based on the benefit before cost-sharing is applied, and "paid" trends, which reflect the actual benefit paid. Both trends reflect the incentive effect and the selection effect, but only the paid trend reflects the benefit effect. Anthem's Method 1 used allowed trends but made an adjustment to remove the impact of deductible mix on utilization. The resulting trend is therefore the trend that would have resulted if there were no change in deductibles. After the trend was applied, a further adjustment of 0.945 was applied to reflect the anticipated plan shift based on Anthem's enrollment projections. The resulting claims estimate therefore reflects the full effect of the anticipated plan shift on both benefits and utilization.

Anthem's Method 2, which it characterizes as a reasonableness check on Method 1, used paid trends and includes no adjustment for deductible mix. The resulting trend therefore included the impact of plan shift on both benefits and utilization. Anthem did not apply the 0.945 adjustment factor under Method 2. Therefore the projected claims assumed that plan shift will continue at the same rate as during the experience period. However, the filing indicated that Anthem expects a slowing of the plan shift. To that extent, Method 2 could be expected to slightly understate projected claims, all else being equal.

It should be noted that Anthem's methodology does not apply the trend factor directly to premiums. Instead, the trend is used to project future claims, which are then used to project aggregate required revenue in Exhibit 1 of the filing. Exhibit 3 then calculates the rate changes needed to achieve that revenue based on projected enrollment. Since the projected enrollment used in Exhibit 3 is the same as that used to develop the 0.945 claims adjustment factor, projected claims and premiums are determined on a consistent basis.

Ms. Fritchen developed her trend using allowed claims. She then made an upward adjustment based on the Milliman factors. This adjustment removed the incentive effect but not the selection effect. Therefore the adjusted trend was less than a trend assuming no plan shift. Because she then applied the full 0.945 adjustment factor, the result was an understatement of future claims. The 0.945 factor reflects the selection effect as well as the incentive effect and the benefit effect. Applying this factor to a trend that already reflects the selection effect results in double counting the selection effect.

Ms. Fritchen argued that it was only necessary to normalize the experience to the extent that utilization differences are reflected in rates. This would be true if the trend factor were going to be applied to rates. However, as noted above, that is not the case here. Furthermore, even if premium factors were appropriate, the Milliman factors do not incorporate all of the utilization differences reflected in premiums.

2. Aging

Ms. Fritchen asserts that, assuming aging will occur during the rating period at the same rate at which it has occurred during the base period, an adjustment is needed to the trend calculation to the extent that aging is already reflected in the rating structure. Otherwise, according to Ms. Fritchen, the effect of aging will be double-counted. As in the case of plan

shift discussed above, this overlooks the fact that the trend factor is to be used to project claims, not directly to adjust rates. If Anthem's enrollment projections reflected anticipated changes in the age distribution of the covered population, no age adjustment would be needed to the trend. However, the enrollment projections reflect only changes in the distribution by benefit plan. No change in the age distribution within each plan is assumed, although to the extent that the age distribution varies somewhat among the benefit plans, a change in the mix of plans does affect the overall age distribution. If aging in fact continues to occur, revenues produced by the proposed rates will be greater than projected because more subscribers will be paying the higher rates associated with the older age bands. Therefore Ms. Fritchen's adjustment is appropriate. If aging is reflected in the data underlying the trend calculation and aging is expected to continue at the same rate, then unless the enrollment projections are adjusted to reflect that aging, an adjustment should be made to the trend factor to remove the portion of aging that will be accounted for in the rating structure.

Stated another way, the required revenue calculated in Exhibit 1 of the filing implicitly assumes continued aging because the utilization trends used in the calculation include the effects of aging. The premiums calculated in Exhibit 3 of the filing implicitly assume no further aging because the current age distribution is assumed for the projected period. Reducing the required revenue calculated in Exhibit 1 based on the age factors used for rating will result in the required revenue assuming no further aging, consistent with the implicit assumption in Exhibit 3. If aging does continue as in the past, both the required revenue in Exhibit 1 and the "Total Annual Income Using Proposed Rates and Current Enrollment" calculated in Exhibit 3 will be understated, but the understatements will offset each other. Based on Ms. Fritchen's analysis,

the appropriate reduction is (1+6.5%) / (1+6.0%) -1, or 0.5%, which should be applied to Anthem's 14.1% trend factor.

As noted above, the projected changes in distribution by benefit plan indirectly result in some change in the overall age distribution. Because the plans with the most growth, the Lumenos plans, have a younger age distribution, the projected enrollment in Exhibit 3 is actually slightly younger than the current enrollment. This is reflected in the calculations presented in Ms. Fritchen's "Explanation of Updated Normalizing of the Trend," which shows an annual change in the age factor of -0.2% for the projection period. Anthem's failure to adjust for this results in a further understatement of projected premium. To offset this, a further 0.2% reduction is needed in the trend factor. The appropriate trend factor is therefore (1+14.1%) x (1-0.5%) x (1-0.2%), or 13.3%.

3. Large Claims

Anthem's Method 1 is susceptible to distortions due to fluctuations in large claims. However, in this instance it results in a slightly smaller increase than does Method 2. As Ms. Fritchen pointed out, this may not always be the case. Anthem should continue to examine this issue in future filings. An ideal methodology would replace large claims with a pooling charge as in Method 2 without sacrificing the strengths of Method 1. If such a methodology cannot be developed, Anthem should continue to use Method 2 as a check.

B. Benefit Modifications

Anthem included an adjustment to the Preventive Care and Supplemental Accident (PCSA) rider to reflect a new benefit that waives the deductible for screening colonoscopy. Maine's guaranteed renewal law prohibits "roll-ons," where consumers are required to buy additional coverage on renewal. In order for a product to incorporate a new benefit that would

increase the cost of coverage, the new benefit must either be required by law or be approved by the Superintendent as meeting the "minor modification" standards of 24-A M.R.S.A. § 2850-B(3)(I)(4). Although Anthem had filed the colonoscopy benefit change with the Superintendent, it had asserted that it was required by P.L. 2007, ch. 516. However, in its March 20 Response to Hearing Information Requests, Anthem acknowledged that "there is no legal requirement that the deductible be waived" but that it "has made the decision to do so, in order to promote the health of our members and to address their expectations." Anthem further stated that it would file a revised PCSA rider before the end of March to clarify this benefit. That filing was submitted on March 24. Despite its March 20 acknowledgement that the change is not required by law, the March 24 filing stated, "The rate filing requirements contained in Bureau of Insurance Rule Chapter 940 do not apply as these changes are the result of legislative action." Absent a legal requirement, Anthem can only make a change in benefits for existing policyholders if it demonstrates that it is a minor modification as defined by 24-A M.R.S.A. § 2850-B(3)(I). Unless and until Anthem does so, it would be inappropriate to allow this benefit to be reflected in increased rates.

C. Adjustment for High-Cost Claimants

Anthem included in its rate filing an adjustment of $1,292,755 to reflect two high-cost claimants transferring to HealthChoice from a group plan. Ms. Fritchen provided an alternative calculation of this adjustment resulting in $636,000. Ms. Casaday acknowledged that Ms. Fritchen's methodology was reasonable and more rigorous than Anthem's. The Superintendent adopts Ms. Fritchen's alternative calculation.

D. Savings Offset Payments

24-A M.R.S.A. § 6913(7) requires carriers to "use best efforts to ensure health insurance premiums reflect any such recovery of savings offset payments as those savings offset payments are reflected through incurred claims experience in accordance with subsection 9." Subsection 9 requires that "the claims experience used to determine any filed premiums or rating formula must reasonably reflect, in accordance with accepted actuarial standards, known changes and offsets in payments by the carrier to health care providers in this State, including any reduction or avoidance of bad debt and charity care costs to health care providers in this State as a result of the operation of Dirigo Health and any increased enrollment due to an expansion in MaineCare eligibility occurring after June 30, 2004 as determined by the board consistent with subsection 1." Anthem presented a witness who described the process of provider negotiations and asserted that best efforts were made as required by subsection 7. No evidence refuted that assertion. Anthem also provided evidence that contracts negotiated with providers are reflected in the trend factor used to project claims experience. This is *prima facie* evidence of compliance with subsection 9, and again has not been refuted.

Nonetheless, the Attorney General argues that no savings offset payment should be included in the rates because "providers have been unable to isolate or calculate those savings and Anthem does not receive an accounting of those savings" and because Anthem's actuary "provided no quantifiable evidence of how she calculated or accounted for those savings in the experience or otherwise." However, the statute does not require a precise accounting. Furthermore, no precise accounting is possible. The savings offset is based on "aggregate measurable cost savings," as determined under subsection 1 of the statute. The methodology used to determine these savings does not allow for tracing the savings to specific providers.

Anthem has met the statutory standard. Any savings are reflected in the projected claim costs and the savings offset payment is appropriately included in the rates.

E. Rate Relativities

1. HealthChoice Standard and Basic Plans

The standardized plans, which all carriers in the individual market are required to offer, were introduced in 1995. At that time, Anthem's predecessor, Blue Cross Blue Shield of Maine, rated those products on a basis consistent with its existing HealthChoice plans. The rate for the Standard plan was about 5% higher than the rate for a traditional HealthChoice plan with the same deductible to reflect differences in benefits, such as first-dollar coverage of preventive care in the Standard plan. At the same time, Blue Cross Blue Shield of Maine stopped offering HealthChoice plans with deductibles below $2,000, so the standardized plans became the only low-deductible plans offered.

In 2005, Anthem began rating the standardized plans based on their own experience rather than on the pooled experience of the standardized and non-standardized plans. This resulted in higher rates for the standardized plans relative to the non-standardized plans, probably because those with health problems are more likely to choose a low deductible than are healthier individuals. Over time, this rate differential increased. Beginning in 2007, by order of the Superintendent, the differential between the $1,000 deductible Standard plan and the $1,000 deductible non-standardized plan was capped at 50%.

The current filing maintains this 50% differential. However, any differential larger than that justified by benefit differences is inconsistent with the community rating principles embodied in Maine law. Ultimately, the differential should be reduced to 5%, reflecting the benefit differences. However, a sudden change of this magnitude would be disruptive, causing

additional rate increases for the non-standardized plans to offset the lost revenues that would result from decreasing rates for the standardized plans. Therefore, rather than decreasing rates for the standardized plans, those rates should be frozen at their current level until the differential shrinks to the 5% target level.

2. Lumenos Plans

The Lumenos plans were introduced in 2007. The rates were based on the rates for the HealthChoice $5,000 deductible plan with appropriate adjustments. When HealthChoice rates were increased in 2008, Anthem did not file increased rates for the Lumenos plans. Anthem now requests, in effect, a double increase reflecting both the 2008 and proposed 2009 increases in the HealthChoice rates. Anthem's explanation for not filing Lumenos rates for 2008 is that the experience was favorable but not credible (only six months and 200 policies), the loss ratio was below 65%, and Anthem did not believe the Superintendent would grant an increase.

The fact that the experience was favorable and the loss ratio low is not significant because the plan-specific experience was not credible, because general trends in health care costs clearly indicated that rate increases should be considered, and because midyear loss ratios do not reflect an accurate comparison of claims to premiums: as explained by Ms. Casaday, one would expect a low loss ratio in the first six months because it takes more time for many people to reach their deductible. No basis was offered for the belief that the Superintendent would not grant an increase under these circumstances. Trend increases have often been approved for new products that have not reached credible experience levels. Had Anthem simply pooled its Lumenos and HealthChoice experience, there is no reason to assume similar increases would not have been granted for both products. Therefore there is no valid reason for Anthem waiting 2 ½ years to adjust the rates on these products.

In order to avoid an unduly large rate increase for Lumenos policyholders, the rate increase for current policyholders should be capped so that the largest increase will be 20%. Anthem should not increase the size of the HealthChoice rate increase to make up the revenue lost due to this cap because HealthChoice policyholders should not pay for Anthem's failure to file Lumenos rates in a timely manner. Anthem should not apply this cap to its new business rates because that likely would result in consumers buying the product at artificially low rates only to be faced with a large rate increase next year.

The Attorney General argued that the Anthem's 6% rate differential between the $5,000 deductible HealthChoice and Lumenos plans is too small and suggests 15% based on Ms. Fritchen's testimony about how other companies rate "consumer-driven" health plans. This argument is not valid for two reasons. First, as Anthem pointed out, much of the difference in utilization observed in other markets results from the large difference in deductibles, with consumer-driven health plans having significantly higher deductibles than other plans. That is not the case here. Most of the HealthChoice plans in force have deductibles that are as large as or larger than those for the Lumenos plans. Second, much of the difference in utilization observed in other markets results from differences in health status between those choosing consumer-driven health plans and those choosing other plans. To reflect these differences in rates would be inconsistent with the community rating principles embodied in Maine law.

F. Lumenos Age 65+ Rates

As the Attorney General pointed out, the Lumenos 65+ rates do not comply with Rule 940 and are also inconsistent with the HealthChoice 65+ rates. For these reasons, the Lumenos 65+ rates should be the same as the Lumenos 55-64 rates.

G. Profit and Risk Margin

Anthem included a 3% pre-tax profit and risk margin in its rate development based on past orders, and asserted that a 5% margin would be justified. Anthem repeatedly cited losses on its individual products over the last four years as evidence that a 3% margin is inadequate to cover the risks associated with these products. However, those losses are entirely attributable to 2005 and 2006. As shown in Exhibit 9 of the filing, for the nine years Anthem has owned the company (2000-2008),[3] these two years were the only ones that showed a loss. The pre-tax gain was 5.3% in 2007 and 2.8% in 2008. Over the nine-year period, the pre-tax operating gain totaled nearly $16 million and averaged 3.2% of total revenue.

The Attorney General recommended allowing no margin, citing "(1) a unique economic situation resulting in extreme financial hardship for subscribers, and (2) the extreme financial health of the company." The large number of policyholders who testified at the public hearings and sent written comments provides ample evidence of the first point and Anthem's financial statements provide ample evidence of the second. Under these circumstances, it is reasonable to allow no profit and risk margin this year. While a break-even rate level would not contribute further to the company's surplus, it would not be a drain either. Furthermore, the existence of the individual line would continue to provide an indirect benefit to the company because it provides a larger base over which to spread fixed expenses.

It must be acknowledged, however, that the rates indicated by this Decision and Order will not be full break-even rates if all of the assumptions hold. This is due to two items discussed above: the disallowance of the cost of the colonoscopy benefit change, and the 20% cap on the rate increase for current Lumenos policyholders. The disallowance of the cost of the

[3] Anthem owned the company for only part of the year 2000.

colonoscopy benefit change will result in a loss to Anthem of $348,747 based on Anthem's estimate. If all current Lumenos policyholders renew, Anthem would lose approximately another $650,000 for a total loss just under $1 million. However, as explained above, both of these losses result from Anthem's own action or inaction. Losses of this magnitude will not render the rates inadequate. Anthem has more than enough surplus to absorb this loss and the HealthChoice and Lumenos policyholders have contributed to that surplus.

V. FINDINGS AND CONCLUSIONS

On the basis of a preponderance of the credible evidence in the record, and for reasons set forth in Section IV above, the Superintendent finds and concludes that Anthem's proposed rates are excessive and unfairly discriminatory. If the changes to the rates proposed by Anthem are applied consistent with this Decision and Order, as discussed in Section IV, the Superintendent could lawfully approve the resulting rates. The necessary revisions to the proposed rates can be achieved by the following changes to the spreadsheet (Prefiled 2009JULY Lumenos and HealthChoice thruDec08 2009030 (W1322955).XLS):

Exhibit 1:

- Change cell C12 from 14.1% to 13.3%.
- Change cell C30 from $348,747 to 0.
- Change cell C31 from $1,292,755 to $636,000.
- Change cell C36 from 3.0% to 0.

Exhibit 13:

- Change cell B33 from $348,747 to 0.
- Change cell B11 from $26.68 to $20.41.

Exhibit 3:

- Change cell AF25 from 1.500 to 1.2.
- Change cells in the range B398:F405 to equal the values in the cells in the range B362:F369.
- Change cell D384 from $1,158.13 to $1,108.18.

This will result in appropriate HealthChoice rates and Lumenos new business rates. Lumenos renewal rates require one further adjustment:

Exhibit 3:

- Change cell AH52 from formula to $815.80.

The Superintendent finds and concludes that such revised rates, appropriately developed per this Decision and Order, would not be excessive, inadequate, or unfairly discriminatory; and would likely yield a loss ratio of at least 65%.

As a result of the changes proposed by the Superintendent, the total average rate increase proposed by Anthem of 18.5% would be reduced to 10.9%, with the specific rate changes ranging from -5.0% to 20.0%. For the Non-Mandated HealthChoice options, the range of increases would be 6.1% to 12.4%%, with an average of 10.8%. For the Mandated HealthChoice options, there would be no rate change. For current Lumenos policyholders, rate changes would range from a decrease of 5.0% to an increase of 20.0%, with an average increase of 15.6%. For Lumenos new business rates, rate changes would range from a decrease of 8.0% to an increase of 32.4%.

VI. ORDER

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

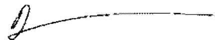
1. Approval of the rates filed December 22, 2008, as revised, by Anthem Blue Cross and Blue Shield for individual HealthChoice, HealthChoice Standard, HealthChoice Basic, and Lumenos Consumer Directed Health Plan products is DENIED. Accordingly, the proposed rates filed by Anthem for its individual HealthChoice, HealthChoice Standard, HealthChoice Basic, and Lumenos Consumer Directed Health Plan products do not enter into effect.

2. Anthem is authorized to submit revised rates for review and they shall be APPROVED if the Superintendent finds them to be consistent with the terms of this Decision and Order and that the effective date of those rates will assure a minimum of 30 days' prior notice to policyholders.

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 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.A. § 11004.

PER ORDER OF THE SUPERINTENDENT OF INSURANCE



May 18, 2009

MILA KOFMAN
Superintendent of Insurance

Christopher T. Roach

One Monument Square
Portland, ME 04101

207-791-1373 voice
207-791-1350 fax
croach@pierceatwood.com
pierceatwood.com

May 19, 2009

Mila Kofman, Superintendent
c/o Pat Galouch
Docket No. INS-09-1000
Maine Bureau of Insurance
34 State House Station
Augusta, Maine 04333-0034

Re: Anthem BCBS 2009 HealthChoice Individual Rate Filing
Filing coversheet

Dear Superintendent Kofman:

Enclosed for filing please find the following:

SUBMITTED BY: Christopher T. Roach

DATE: May 19, 2009

DOCUMENT TITLE: Applicant's Compliance Filing

DOCUMENT TYPE: Compliance Filing

CONFIDENTIAL: **No**

Thank you for your assistance in this matter.

Very truly yours,

/s/ Christopher T. Roach

cc: Thomas C. Sturtevant, Esquire
Christina M. Moylan, Esquire

NON-CONFIDENTIAL

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

IN RE:	
ANTHEM BLUE CROSS AND BLUE SHIELD 2009 INDIVIDUAL RATE FILING FOR HEALTHCHOICE, HEALTHCHOICE STANDARD AND BASIC AND LUMENOS CONSUMER DIRECTED HEALTH PLAN PRODUCTS	APPLICANT'S COMPLIANCE FILING May 19, 2009

Docket No. INS-09-1000

NON-CONFIDENTIAL

{W1407542.1}

Anthem BCBS received the Superintendent's Decision and Order in this matter on May 18, 2009. Anthem BCBS has reviewed the Decision and Order and is considering its appellate options with regard to the Decision and Order. Because the rates currently in place are significantly inadequate, Anthem BCBS is making this compliance filing subject to and without waiving its rights to appeal. Therefore, without waiving its right to appeal the Decision and Order, Anthem BCBS encloses this filing in compliance with the Superintendent's Decision and Order issued in this matter on May 18, 2009. Anthem BCBS respectfully requests that the Superintendent review and, if appropriate, approve of this compliance filing at the earliest opportunity so that these rates may be implemented by July 1, 2009.

DATED: May 19, 2009

/s/ Christopher T. Roach
Christopher T. Roach, Esq.

PIERCE ATWOOD LLP
One Monument Square
Portland, Maine 04101
Attorney for Applicant

{W1407542.1}

CERTIFICATE OF SERVICE

The undersigned hereby certifies that on May 19, 2009 a copy of Applicant's Compliance Filing was served in the manner indicated on each of the persons listed below:

Thomas C. Sturtevant, Jr., Assistant Attorney General
OFFICE OF THE ATTORNEY GENERAL
6 State House Station
Augusta, Maine 04333-0006
Tom.Sturtevant@maine.gov
[e-mail and U.S. Mail]

Christina M. Moylan, Assistant Attorney General
OFFICE OF THE ATTORNEY GENERAL
6 State House Station
Augusta, Maine 04333-0006
Counsel for Attorney General
christina.moylan@maine.gov
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Karma Y. Lombard
Karma.Y.Lombard@maine.gov
[e-mail]

Mila Kofman, Superintendent
c/o Pat Galouch
pat.galouch@maine.gov
[e-mail and U.S. Mail]

DATED May 19, 2009

/s/ Christopher T. Roach
Christopher T. Roach, Esq.

PIERCE ATWOOD LLP
One Monument Square
Portland, Maine 04101
(207) 791-1100
Attorney for Applicant

Attachment "SEND 2009 Health Choice Compliance Rate Filing 20090519.xls" is not a PDF document and cannot be reproduced here.

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

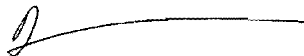
IN RE:	)	
	)	
ANTHEM BLUE CROSS AND BLUE SHIELD 2009 INDIVIDUAL RATE FILING FOR HEALTHCHOICE AND HEALTHCHOICE STANDARD AND BASIC, AND LUMENOS CONSUMER DIRECTED HEALTH PLAN PRODUCTS	)	DECISION AND ORDER
	)	
Docket No. INS-09-1000	)	

By Decision and Order dated May 18, 2009, Superintendent of Insurance Mila Kofman denied the request of Anthem Blue Cross and Blue Shield ("Anthem") for approval of its rate filing for 2009 individual HealthChoice, HealthChoice Standard, HealthChoice Basic, and Lumenos Consumer Directed Health Plan products, but granted Anthem an opportunity to submit a revised filing consistent with the findings and conclusions set forth in Sections IV and V of the Decision and Order. Anthem made a revised filing on May 19, 2009. The revised filing provides for renewal rate changes ranging from -5.0% to 20.0% and for new business rate changes ranging from -8.0% to 32.4%, depending upon the benefit design of the plan selected. The average rate increase is 10.9%.

The Superintendent finds that Anthem's May 19, 2009, revised filing is consistent with the May 18, 2009, Decision and Order. Pursuant to 24-A M.R.S.A. §§ 2736 and 2736-B, the Superintendent hereby ORDERS that Anthem's filing of May 19, 2009, is APPROVED, effective July 1, 2009.

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.

PER ORDER OF THE SUPERINTENDENT OF INSURANCE



Dated: May 19, 2009

MILA KOFMAN
Superintendent of Insurance

SERFF Tracking Number:	*MALH-125969281*	*State:*	*Maine*
Filing Company:	*Anthem Blue Cross and Blue Shield*	*State Tracking Number:*	*2009 RATE FILING FOR HEALTHCHOICE AND LUMENOS PRODUCT LINES*
Company Tracking Number:			
TOI:	*H16I Individual Health - Major Medical*	*Sub-TOI:*	*H16I.005A Individual - Preferred Provider (PPO)*
Product Name:	*2009 Rate Filing for HealthChoice and Lumenos Product Lines*		
Project Name/Number:	/		

Attachment "W1249825.DOC" is not a PDF document and cannot be reproduced here.

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We keep the health and financial information of our current and former members private as required by law, accreditation standards, and our rules. This notice explains your rights. It also explains our legal duties and privacy practices. We are required by federal law to give you this notice.

Your Protected Health Information

We may collect, use, and share your Protected Health Information (PHI) for the following reasons and others as allowed or required by law, including the HIPAA Privacy rule:

For Payment: We use and share PHI to manage your account or benefits; or to pay claims for health care you get through your plan. For example, we keep information about your premium and deductible payments. We may give information to a doctor's office to confirm your benefits.

For Health Care Operations: We use and share PHI for our health care operations. For example, we may use PHI to review the quality of care and services you get. We may also use PHI to provide you with case management or care coordination services for conditions like asthma, diabetes, or traumatic injury.

For Treatment Activities: We do not provide treatment. This is the role of a health care provider such as your doctor or a hospital. But, we may share PHI with your health care provider so that the provider may treat you.

To You: We must give you access to your own PHI. We may also contact you to let you know about treatment options or other health-related benefits and services. When you or your dependents reach a certain age, we may tell you about other products or programs for which you may be eligible. This may include individual coverage. We may also send you reminders about routine medical checkups and tests.

To Others: You may tell us in writing that it is OK for us to give your PHI to someone else for any reason. Also, if you are present, and tell us it is OK, we may give your PHI to a family member, friend or other person. We would do this if it has to do with your current treatment or payment for your treatment. If you are not present, if it is an emergency, or you are not able to tell us it is OK, we may give your PHI to a family member, friend or other person if sharing your PHI is in your best interest.

As Allowed or Required by Law: We may also share your PHI, as allowed by federal law, for many types of activities. PHI can be shared for health oversight activities. It can also be shared for judicial or administrative proceedings, with public health authorities, for law enforcement reasons, and to coroners, funeral directors or medical examiners (about decedents). PHI can also be shared for certain reasons with organ donation groups, for research, and to avoid a serious threat to health or safety. It can be shared for special government functions, for workers' compensation, to respond to requests from the U.S. Department of Health and Human Services and to alert proper authorities if we reasonably believe that you may be a victim of abuse, neglect, domestic violence or other crimes. PHI can also be shared as required by law.

If you are enrolled with us through an employer sponsored group health plan, we may share PHI with your group health plan. We and/or your group health plan may share PHI with the sponsor of the plan. Plan sponsors that receive PHI are required by law to have controls in place to keep it from being used for reasons that are not proper.

Authorization: We will get an OK from you in writing before we use or share your PHI for any other purpose not stated in this notice. You may take away this OK at any time, in writing. We will then stop using your PHI for that purpose. But, if we have already used or shared your PHI based on

your OK, we cannot undo any actions we took before you told us to stop.

Your Rights

Under federal law, you have the right to:

- Send us a written request to see or get a copy of certain PHI or ask that we correct your PHI that you believe is missing or incorrect. If someone else (such as your doctor) gave us the PHI, we will let you know so you can ask them to correct it.
- Send us a written request to ask us not to use your PHI for treatment, payment or health care operations activities. We are not required to agree to these requests.
- Give us a verbal or written request to ask us to send your PHI using other means that are reasonable. Also let us know if you want us to send your PHI to an address other than your home if sending it to your home could place you in danger.
- Send us a written request to ask us for a list of certain disclosures of your PHI.

Call Customer Service at the phone number printed on your identification (ID) card to use any of these rights. They can give you the address to send the request. They can also give you any forms we have that may help you with this process.

How we protect information

We are dedicated to protecting your PHI. We set up a number of policies and practices to help make sure your PHI is kept secure.

We keep your oral, written, and electronic PHI safe using physical, electronic, and procedural means. These safeguards follow federal and state laws. Some of the ways we keep your PHI safe include offices that are kept secure, computers that need passwords, and locked storage areas and filing cabinets. We require our employees to protect PHI through written policies and procedures. The policies limit access to PHI to only those employees who need the data to do their job. Employees are also required to wear ID badges to help keep people who do not belong, out of areas where sensitive data is kept. Also, where required by law, our affiliates and non-affiliates must protect the privacy of data we share in the normal course of business. They are not allowed to give PHI to others without your written OK, except as allowed by law.

Potential Impact of Other Applicable Laws

HIPAA (the federal privacy law) generally does not preempt, or override other laws that give people greater privacy protections. As a result, if any state or federal privacy law requires us to provide you with more privacy protections, then we must also follow that law in addition to HIPAA.

Complaints

If you think we have not protected your privacy, you can file a complaint with us. You may also file a complaint with the Office for Civil Rights in the U.S. Department of Health and Human Services. We will not take action against you for filing a complaint.

Contact Information

Please call Customer Service at the phone number printed on your ID card. They can help you apply your rights, file a complaint, or talk with you about privacy issues.

Copies and Changes

You have the right to get a new copy of this notice at any time. Even if you have agreed to get this notice by electronic means, you still have the right to a paper copy. We reserve the right to change this notice. A revised notice will apply to PHI we already have about you as well as any PHI we may get in the future. We are required by law to follow the privacy notice that is in effect at this time. We may tell you about any changes to our notice in a number of ways. We may tell you about the changes in a member newsletter or post them on our website. We may also mail you a letter that tells you about any changes.

Si necesita ayuda en español para entender este documento, puede solicitarla sin costo adicional, llamando al número de servicio al cliente que aparece al dorso de su tarjeta de identificación o en el folleto de inscripción.

STATE NOTICE OF PRIVACY PRACTICES

As we told you in our HIPAA notice, we must follow state laws that are more strict than the federal HIPAA privacy law. This notice explains your rights and our legal duties under state law.

Your Personal Information

We may collect, use and share your nonpublic personal information (PI) as described in this notice. PI identifies a person and is often gathered in an insurance matter. PI could also be used to make judgments about your health, finances, character, habits, hobbies, reputation, career, and credit.

We may collect PI about you from other persons or entities such as doctors, hospitals, or other carriers.

We may share PI with persons or entities outside of our company without your OK in some cases.

If we take part in an activity that would require us to give you a chance to opt-out, we will contact you. We will tell you how you can let us know that you do not want us to use or share your PI for a given activity.

You have the right to access and correct your PI.

We take reasonable safety measures to protect the PI we have about you.

A more detailed state notice is available upon request. Please call the phone number printed on your ID card.

Si necesita ayuda en español para entender este documento, puede solicitarla sin costo adicional, llamando al número de servicio al cliente que aparece al dorso de su tarjeta de identificación o en el folleto de inscripción.

This Notice is provided by the following companies:

In Connecticut, Anthem Blue Cross and Blue Shield is the trade name of Anthem Health Plans, Inc. In New Hampshire, Anthem Blue Cross and Blue Shield is the trade name of Anthem Health Plans of New Hampshire, Inc. In Maine, Anthem Blue Cross and Blue Shield is the trade name of Anthem Health Plans of Maine, Inc. Independent licensees of the Blue Cross and Blue Shield Association. ® Registered marks of the Blue Cross and Blue Shield Association.

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

IN RE:	)	
	)	
ANTHEM BLUE CROSS AND BLUE	)	
SHIELD 2009 INDIVIDUAL RATE	)	NOTICE OF PENDING
FILING FOR HEALTHCHOICE,	)	PROCEEDING AND HEARING
HEALTHCHOICE STANDARD	)	
AND BASIC, AND LUMENOS	)	
CONSUMER DIRECTED HEALTH	)	
PLAN PRODUCTS	)	
	)	
Docket No. INS-09-1000	)	

Superintendent of Insurance Mila Kofman issues this Notice of Pending Proceeding and Hearing in the above-captioned matter.

I. PENDING PROCEEDING

Pursuant to 5 M.R.S.A. § 9052, 24-A M.R.S.A. § 230, and Bureau of Insurance Rule chapter 350, the Superintendent hereby gives notice that Anthem Blue Cross and Blue Shield ("Anthem") has filed for approval of proposed revised rates for certain of its individual health insurance products, specifically its HealthChoice, HealthChoice Standard and Basic, and Lumenos Consumer Directed Health Plan products. Anthem proposes revised rates for these products that it asserts will produce an average increase of 14.5%. As identified in its filing, the largest premium increase depending on deductible level and type of contract for HealthChoice is17.2%, for HealthChoice Standard and Basic is 7.7%, and for Lumenos is 34.1%. As of November 2008 there are 12,049 policyholders who will be affected by the proposed rate revisions. Anthem requests that these rate revisions become effective on May 1, 2009.

II. PUBLIC HEARING

Pursuant to the authority granted in 24-A M.R.S.A. § 229 and the requirements of 24-A M.R.S.A. § 230, 5 M.R.S.A. § 9052, and Insurance Rule chapter 350 the Superintendent hereby gives notice that she will hold a public hearing in the above-captioned matter beginning at 9:00 a.m. on March 12, 2009, in the Central Conference Room at the Department of Professional and Financial Regulation, Gardiner Annex, 122 Northern Avenue, Gardiner, Maine. Members of the public are invited to attend the hearing.

III. HEARING OBJECTIVE

The purpose of the hearing is to consider whether the revised rates proposed by Anthem are excessive, inadequate, or unfairly discriminatory as set forth in 24-A M.R.S.A. § 2736, and otherwise meet the requirements of the Maine Insurance Code and regulations promulgated thereunder.

IV. INTERVENTION

At this time, the only party to this proceeding is Anthem. At her discretion, the Superintendent may establish a Bureau of Insurance Staff panel as an independent party, authorized pursuant to 5 M.R.S.A. § 9054(5). Persons wishing to intervene as parties in this proceeding shall file their applications in writing with the Superintendent no later than 3:00 p.m. on February 3, 2009. If granted party status, an intervenor may immediately commence discovery as provided in Section V below.

Applicants should either hand deliver their intervention applications to the attention of Pat Galouch at the offices of the Bureau of Insurance, 124 Northern Avenue, Gardiner, Maine or mail them to the Superintendent at the following address:

> Mila Kofman, Superintendent
> Attn: Pat Galouch
> Docket No. INS-09-1000
> Bureau of Insurance
> Maine Department of Professional and Financial Regulation
> #34 State House Station
> Augusta, Maine 04333-0034

Only those persons willing to undertake the responsibilities placed upon parties to an adjudicatory proceeding under Maine law and Bureau of Insurance Rule chapter 350 should seek intervenor status.

An applicant claiming intervention as of right pursuant to 5 M.R.S.A. § 9054(1) shall include in the application a statement either explaining how the applicant is or may be, or is a member of a class that is or may be, substantially and directly affected by the proceeding or identifying the applicant as an agency of federal, state, or local government. Applications for permissive intervention pursuant to 5 M.R.S.A. § 9054(2) shall contain a statement explaining and substantiating the applicant's interest in the proceeding. The Superintendent will not grant late applications without a compelling demonstration of good cause.

Any party that opposes an application for intervention shall file a statement in opposition to the application with the Superintendent by 3:00 p.m. on February 5, 2009. The Superintendent in her discretion may rule on intervention applications at any time, without having to wait for the expiration of the statement in opposition to intervention filing deadline.

V. DISCOVERY

Upon being designated or granted party status in this proceeding by the Superintendent, a party may immediately commence discovery by the issuance of information requests as provided for by Insurance Rule Chapter 350(10). Notwithstanding the timelines established by Chapter 350(10)(B)(4), the period for responding to each information request is hereby set at five (5) business days. In cases where timely objection to discovery has been made and the objection is subsequently overruled by the Superintendent, the requested information shall be provided

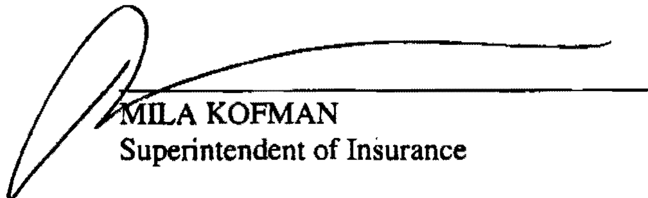
within three (3) business days of receipt of the Superintendent's ruling on the objection or such other period as may be provided in that ruling.

VI. HEARING PROCEDURE

The Superintendent will conduct this proceeding in accordance with the provisions of the Maine Administrative Procedure Act, 5 M.R.S.A. chapter 375, subchapter 4; 24-A M.R.S.A. §§ 229 to 236; Bureau of Insurance Rule chapter 350; and any rulings of the Superintendent. All parties to the proceeding have the right to present evidence and witnesses at the hearing and have the right to be represented by counsel. Failure of any party to appear may result in disposition by default with respect to that party. The Superintendent, however, may set aside a default for good cause.

The Department of Professional and Financial Regulation does not discriminate on the basis of disability in the admission to, access to or operation of its programs, services or activities. Individuals in need of auxiliary aid for effective communication in this hearing are invited to make their needs and preference known to Pat Galouch at the Bureau of Insurance, telephone (207) 624-8437, sufficiently in advance of the hearing so that appropriate arrangements can be made.

January 16, 2009



MILA KOFMAN
Superintendent of Insurance

Christopher T. Roach

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Portland, ME 04101

207-791-1373 voice
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croach@pierceatwood.com
pierceatwood.com

March 11, 2009

Mila Kofman, Superintendent
c/o Pat Galouch
Docket No. INS-09-1000
Maine Bureau of Insurance
34 State House Station
Augusta, Maine 04333-0034

Re: *Anthem BCBS 2009 HealthChoice Individual Rate Filing*
Filing coversheet

Dear Superintendent Kofman:

Enclosed for filing please find the following:

SUBMITTED BY: Christopher T. Roach

DATE: March 11, 2009

DOCUMENT TITLE: Anthem BCBS Response to First Information Requests of AG

DOCUMENT TYPE: Response to Information Requests

CONFIDENTIAL: **No**

Thank you for your assistance in this matter.

Very truly yours,

/s/ Christopher T. Roach

cc: Thomas C. Sturtevant, Esquire
Christina M. Moylan, Esquire

{W1328918.1}

NON-CONFIDENTIAL

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

IN RE:	)	
	)	
ANTHEM BLUE CROSS AND BLUE	)	
SHIELD 2009 INDIVIDUAL RATE	)	APPLICANT'S RESPONSE TO
FILING FOR HEALTHCHOICE,	)	FIRST INFORMATION REQUEST
HEALTHCHOICE STANDARD AND	)	OF ATTORNEY GENERAL
BASIC AND LUMENOS CONSUMER	)	
DIRECTED HEALTH PLAN	)	
PRODUCTS	)	March 11, 2009

Docket No. INS-09-1000

NON-CONFIDENTIAL

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

IN RE:	)	
	)	
ANTHEM BLUE CROSS AND BLUE	)	
SHIELD 2009 INDIVIDUAL RATE	)	APPLICANT'S RESPONSE TO
FILING FOR HEALTHCHOICE,	)	FIRST INFORMATION REQUEST
HEALTHCHOICE STANDARD AND	)	OF ATTORNEY GENERAL
BASIC AND LUMENOS CONSUMER	)	
DIRECTED HEALTH PLAN	)	
PRODUCTS	)	March 11, 2009

Docket No. INS-09-1000

Applicant Anthem Health Plans of Maine, Inc., d/b/a Anthem Blue Cross and Blue Shield ("Anthem BCBS") hereby responds to the First Information Request of the Attorney General dated February 4, 2009 as follows:

1. Please provide a detailed description of the benefits for the HealthChoice products, including an indication of the following:
   a. which services are subject to deductibles and co-pays;
   b. which services, if any, are paid even if the deductible has not yet been met; and
   c. as to which services, if any, the deductible applies before co-pays.

Response: 1.a. All covered benefits are subject to the deductible for the HealthChoice plan. Medical and pharmacy services share the same deductible. After the deductible, most covered services are paid 100% by Anthem.

Anthem will only pay for a portion of the following covered services after the deductible:

- Inpatient mental health and substance abuse – subject to a 20% coinsurance
- Outpatient mental health and substance abuse – subject to a 50% coinsurance.

1.b. The HealthChoice plans with a deductible of $2,250 or greater offer an optional preventive care and supplemental accident benefit. Subscribers that choose this option have additional coverage for the cost for the following services before the deductible:

- Well-baby care, including prenatal care and initial hospital care;
- Well-child care including standard routine pediatric immunizations (up to $50 per exam and $50 for related lab/x-ray each visit);
    - 6 visits age 0-1
    - 2 visits age 1-2
    - Annual visit ages 3-17
- Well-adult care (up to $100 per exam and $100 for related lab/x-ray each visit);
    - Annual screening mammograms for women (Benefits are limited to two radiographic views per breast);
    - Annual screening Pap tests performed by a physician, certified nurse practitioner, or certified nurse midwife when recommended by a physician;
    - Annual gynecological examinations, including routine pelvic and clinical breast examinations performed by a network physician, certified nurse practitioner or certified nurse midwife;
    - Annual prostate specific antigen testing and digital rectal examinations.
    - Colorectal cancer screenings
- Up to $500 for covered services to treat an accident if services are received within 90 days of the accident.

1.c. There are no co-pays (i.e., $25 per visit) for the HealthChoice plans.

Additional HealthChoice Benefit Information

The following benefits have limits:

- Home Health Care (limited to 90 visits per calendar year)
- Hospitalizations (365 days per admission)
- Physical Manipulations (25 visits per calendar year)
- Physical, Speech and Occupational Therapy (combined limit of $3,000 per calendar year)
- Asthma education ($200 per member per calendar year)
- Smoking Cessation Education Program ($35 per program, $70 lifetime - subject to deductible)
- Physician Follow-up Visits for smoking cessation education (2 visits per calendar year - no deductible)
- Medications prescribed by a physician for smoking cessation (gum, patch, nasal spray, Zyban; $200 per calendar year; $400 per lifetime)
- Mental Health and Substance Abuse treatment ($25,000 combined)

- Mental Health and Substance Abuse inpatient treatment (31 days per calendar year)
- Mental Health and Substance Abuse outpatient treatment (25 visits per calendar year)

Other than the limits noted above, all covered services are paid without any annual maximum. Lifetime maximums for the HealthChoice products are $3 million for all covered services combined.

The key differences between the HealthChoice plans and the HealthChoice Standard plan include the following:
- Deductibles are lower for the Standard plan ($250 - $1,500)
- After the deductible, members pay 20% coinsurance up to $1,000
- Preventive care is included in the base product rather than an optional rider.
- The lifetime maximum is $2 million
- Some of the limits are different between the two plans

The key differences between the HealthChoice plans and the HealthChoice Basic plan include the following:
- Deductibles are lower for the Basic plan ($250 - $1,500)
- After the deductible, members pay 40% coinsurance up to $1,000
- Preventive care is included in the base product rather than an optional rider.
- The lifetime maximum is $1 million
- There is a maximum benefit of 60 inpatient hospitalization days per calendar year
- There is a maximum benefit $2,000 per calendar year for diagnostic services
- Some of the limits are different between the two plans
- Prescription drugs are not subject to the deductible and are covered with a $20 co-pay for generics and $30 co-pay for brand drugs

Additional details about the benefits, limitations and exclusions for HealthChoice and all of Anthem BCBS of Maine's Individual plans can be found at:

http://www.anthem.com/healthinsurance/maine/index.html

2. Please provide a detailed description of the benefits for the Lumenos products, including an indication of the following:
    a. which services are subject to deductibles and co-pays;
    b. which services, if any, are paid even if the deductible has not yet been met; and
    c. as to which services, if any, the deductible applies before co-pays.

Response:

2.a. All covered benefits are subject to the deductible for the Lumenos plans except for preventive/wellness benefits. Medical and pharmacy services share the same deductible.

2.b. The preventive/wellness benefits are paid 100% by Anthem before the deductible. The wellness benefits include the following services:

- Preventive health examinations
- Routine Gynecological care: pap smear and pelvic exams
- Routine ancillary services (e.g.; prostate screening, screening mammography, colorectal cancer screening, sigmoidoscopy and colonoscopy screenings, total cholesterol screening, lipid screenings and panels, diabetic screening, preventive immunizations and vaccines)

For all other covered services, the member must pay the deductible and then the benefits are covered in full by Anthem if the member is using an in-network provider. If the member receives non-emergent care outside of the network, the member must pay a 20% co-insurance for those services.

2.c. There are no co-pays (i.e., $25 per visit) for the Lumenos plans.

Additional Lumenos Benefit Information

The following benefits have limits:

- Skilled Nursing Facility (limited to 100 days per calendaryear)
- Home Health Care (limited to 100 visits per calendar year)
- Physical Manipulations (40 visits per calendar year)
- Physical, Speech and Occupational Therapy (combined limit of $3,000 per calendar year)
- Smoking Cessation Education Program ($35 per program, $70 lifetime - subject to deductible)
- Physician Follow-up Visits for smoking cessation education (2 visits per calendar year - no deductible)
- Medications prescribed by a physician smoking cessation (gum, patch, nasal spray, Zyban; $200 per calendar year; $400 per lifetime)
- Mental Health - Non-listed (30 days of inpatient and 40 outpatient visits per calendar year)

- Nutritional Counseling (3 visits per calendar year)

Other than the limits noted above, all in network covered services are paid without any annual or lifetime maximums. Additional details about the benefits, limitations and exclusions for Lumenos and all Anthem BCBS of Maine's Individual plans can be found at:

http://www.anthem.com/healthinsurance/maine/index.html

3. Membership in the Lumenos products has grown significantly while membership in the HealthChoice products has declined. Please indicate the percentage of the total growth in Lumenos membership which represents policyholders who have migrated from HealthChoice.

Response: 12% of the Lumenos members as of October 2008 had also held a HealthChoice policy at some point since January 2005.

4. Please provide separate claim triangles for the HealthChoice and Lumenos experience for the period November 2006 through October 2008, with payments through December 2008.

Response: Please see revised Exhibits V.A and V.B with HealthChoice and Lumenos experience split out. Attachment is "2009JULY Rate Development thruDec08 20090204.xls."

5. Please provide monthly membership corresponding to each of the triangles requested in item 4 for the period November 2006 through October 2008.

Response: Please see revised Exhibits V.A and V.B with HealthChoice and Lumenos experience split out. Attachment is "2009JULY Rate Development thruDec08 20090204.xls."

6. Please provide, separately for HealthChoice and Lumenos, claims triangles which include only the claims for those members with claims in excess of $100,000 for the period November 2006 through October 2008, with payments through December 2008.

Response: See attached exhibit "Response_to_AG_Question_6and7.xls" with the claims triangle and corresponding membership for members that exceeded $100,000 in claims during the 24-month period ending October 2008. Note that this membership base does not correspond to the membership used in the high-cost claimant analysis Exhibit XV which is based on members that exceed $100,000 in claims during a 12-month period.

7. Please provide the monthly membership corresponding to each of the triangles requested in item 6 for the period November 2006 through October 2008.

Response: See attached exhibit "Response_to_AG_Question_6and7.xls" with the claims triangle and corresponding membership for members that exceeded $100,000 in claims during the 24-month period ending October 2008.

8. Does the large claim estimate of $7,823,506 for the 12 month period ending October 2008 shown in Exhibit I include an estimate for completion? If so, please explain how the estimate of completion was determined and provide numerical support. If not, please explain, since it appears this would result in not removing enough pooled claims.

Response: $7,823,506 is the amount of paid claims only for the 12 month incurred period ending October 2008 with no completion. We did not apply completion to this amount in order to maintain consistency with the pooling charge which is based on high cost claimants' paid claims without completion.

Anthem feels that it is reasonable assumption to review patterns in high-cost claimants for the HealthChoice and Lumenos products without completing claims. The following are reasons supporting this decision:

- Large claims are a high severity low frequency event that is extremely difficult to predict much less determine run-out for.
  - Completion on a subset of high-cost claimant only data becomes impossible due to the extreme volatility.
  - The number of HealthChoice and Lumenos members with claims exceeding $100,000 in a 12-month period has been in the range of 77 to 106 members. The claim triangle for this subset of members lacks credibility.
  - For example, Anthem is aware of a HealthChoice member who is presently in the hospital waiting to receive a transplant which will likely lead to charges in excess of $500,000. When completing claims for the high-cost members, it is impossible to estimate future claims that have not yet hit our billing records.
- There are likely HealthChoice and Lumenos members who are presently in the hospital incurring charges in excess of $100,000 that Anthem is not yet aware of.

When analyzing claims at a member level, we generally avoid attempting to complete claims since completion factors, by definition, are meant to be applied to a broader set of claims (i.e. all members within a pool) and not meant to be applied at the specific claim or member level. Completion factors are meant to estimate claims for members with claims that have been incurred but not reported, not

necessarily additional claims for claims already in process. The important thing is that the total claims for the pool (paid + IBNR) are maintained such that when a subset is carved out of the pool (i.e. the high-cost claimants for the 12-month period ending October 2008), a corresponding subset is added back in (i.e. the pooling charge calculated in a consistent manner).

****

CONFIDENTIAL INFORMATION REDACTED IN RESPONSE TO REQUEST NO. 9

****

9. For the fifth item in Exhibit I, Section E (Additional Claims Due to Migration of High-Cost Claimants from Large Group), please address the following:

   a. Please provide the actual historical claims experience, separately for each of these two members, by incurred month.
   b. Please provide detailed information related to the diagnosis, prognosis and planned treatments for these two members.
   c. Please confirm that no claims related to these two insureds are also included in the $55,053,257 base period claims (first item of Exhibit I, Section A). If claims for these insureds are included in the base experience, please indicate the total amount.
   d. Please confirm that no claims related to these two insureds are included in Exhibit XV. If claims for these insureds are included in this Exhibit, please provide a revised copy of this exhibit excluding claims for these members.
   e. Please provide support for your assumption that these two members will generate additional claims during the rating period which are equal to those incurred during the 12 month period ending September 2008.. The support should be more detailed than the general explanation provided in the actuarial memorandum, including but not limited to information and analyses based on diagnosis information, prognosis information and input from any case management or disease management personnel.
   f. Please describe the medical management efforts being employed for these two members and an estimate of the impact that it is expected to have on their claims during the rating period.
   g. Please explain how adding the full amount of projected claims for these two members in the development of the rates is not accounting for the cost of these claims twice, given the pooling charge for claims in excess of $100,000 already included in the development of the rates.

****

Response: **CONFIDENTIAL INFORMATION REDACTED IN ATTACHED SPREADSHEET AND 9(e) CONSISTENT WITH MARCH 11, 2009 PROTECTIVE ORDER**

****

9a. See attached exhibit "Response_to_AG_Question_9.xls. This file includes diagnosis codes for each claim related to each member. Note

that for Large Claimant A (the first member), the total claims value changed slightly from our rate development. This is due to updates in the data warehouse that have occurred since we originally pulled the data in January.

9b. Prognosis and treatment information is provided in 9e below.

9c. The paid claims for the two migrating members are removed from the total incurred claims in Exhibit I in order to avoid double-counting.

9d. The paid claims for the two migrating members are excluded in Exhibit XV because these two members were not part of HealthChoice during the experience periods shown.

9e. According to our internal medical management, the first high-cost claimant [redacted] . [redacted] has been admitted with [redacted] , [redacted] . The meds [redacted] is on are [redacted] meds, which [redacted] will continue to require. [redacted] was opened in Case Management this past year, but has been subsequently closed. We would anticipate that [redacted] will continue to be a high utilizer of services and medications." Further research indicates that the [redacted] meds ([redacted]) are extremely expensive and will lead to on-going high cost drug utilization in addition to repeated future inpatient admissions. Note that the first high-cost claimant has more than $[redacted] of claims incurred in [redacted] 2008 as of [redacted] 2008.

The second high-cost claimant has more than $[redacted] per month in pharmacy claims from the drug [redacted], which is used to treat [redacted] . This [redacted] . Case Management worked with this member for some time last year but it has been subsequently closed. The following article contains details on this disease: [redacted].

9f. Both of these members have participated in Case Management in the past but have presently declined participation in case management. In late 2008 when both families transferred to direct pay plans, we attempted to reach out again with offers to participate and have a positive impact on their future claims experience and health outcomes. As of January 2009, both families have declined Anthem case management again.

The experience period claims included in the rate development already reflect any effects of medical management. We would expect that future claim cost would be similarly affected but are unable to provide

estimated savings amounts since this is not something that is tracked in the member's file.

9g. We are not accounting for the experience of these members twice because neither member's claims are included in the experience period used for the rate development. Their claims are also excluded from the pooling charge estimate since they were not HealthChoice members during the experience period reviewed.

10. On the bottom of page 5 of the rate filing, in the section titled "Premium Classes" the table includes a footnote stating that the "Lumenos two-adult factor is 90% of the HealthChoice factor because the deductible is aggregate instead of embedded consistent with current factors." Does that mean that the deductible for the Lumenos plans is consistent with the IRS definition of an "Umbrella" deductible for family plans?

Response: Yes, the Lumenos products have an aggregate family deductible as defined in the IRS regulations.

11. If our understanding as described in question 10 above is correct, please explain why the contract type factors for the HSA qualified Lumenos plans are not also lower for the Two Adults/Child(ren) policies and the One Adult/Child(ren) policies given these contract types would also include an umbrella deductible.

Response: Anthem has estimated the paid claim cost under different contract types and family deductible definitions and found that only the two-adult contracts are significantly affected by the change from embedded to aggregate deductibles. Internal analysis estimates that family policies (those with 3 or more members) receive similar benefits under embedded and aggregate deductible plans while two-adult (Employee + Spouse) contracts receive significantly less benefit because they are no longer able to satisfy the combined deductible (two times the single level).

This rate relationship is as approved in our 1/1/2007 rate submission and are reflected in current rates.

12. With regard to the Lumenos HIA plans

    a. Please provide a description of the HIA incentive program. This would include the benefits/incentives offered to members, the purpose of the incentives, the overall goal of this incentive plan, etc.
    b. Please describe the health management tools in which policyholders must participate in order to receive deposits into their HIA account. Please also state the amount(s) that will be deposited for each tool participated in.
    c. If applicable, what is the maximum amount that a policyholder may have deposited into their HIA account in a given calendar year?
    d. Can unused amounts in a policyholder's HIA account be rolled forward to the next year, or are unused balances forfeited at year end?
    e. Please identify what restrictions are placed on the use of amounts in a policyholder's HIA account (e.g. limited to certain activities/programs/procedures)? Can policyholders use amounts in this account to satisfy deductibles or other cost sharing?
    f. Has Anthem performed any studies to determine the success of the HIA incentive program in attaining its goals? If so, please provide the results of those studies.

Response:

12.a. An HIA is similar to a PPO plan, but the HIA has the added benefits of the Healthy Rewards financial incentives from Anthem. The incentives are intended to encourage lifestyle changes that will improve member's health and wellbeing. Most of the incentives are targeted to address existing medical conditions or risk factors (smoking or weight management). For this reason, members with existing conditions and a commitment to improving their health will have more of an opportunity to earn incentives.

12.b. Members can earn Healthy Rewards dollars by:

- Completing an online Health Assessment = $50
- Joining a personal Health Coach program = $100
- Graduating from a personal Health Coach program = $100
- Completing our Smoking Cessation Program = $50
- Completing our Weight Management Program = $50

Each family member on a contract who completes a Healthy Reward will earn the applicable incentive allowance.

Conditions that are covered by the Health Coach program include, but are not limited to the following:

- Asthma (Adult, Pediatric)
- Arthritis (includes osteoarthritis, osteoporosis and Rheumatoid Arthritis)
- Cardiology
- Coronary Artery Bypass
- Chronic Obstructive Pulmonary Disease (COPD)
- Diabetes Mellitus (Type I,II and Gestational)
- Low Back Pain
- Maternity
- Oncology (Breast, Colon, Lung, Prostate, Skin)
- Pediatric (Special Conditions)
- Other Chronic Conditions / Rehabilitation (e.g. Traumatic Brain Injury, Stroke, Multiple Sclerosis)

12.c. There are no limits to how much a subscriber and family can earn through the Healthy Reward program, but there are certain limits to how often a member can earn his/her rewards.

- Members with multiple health conditions will be enrolled in one, holistic Health Coach program.
- Only one family member can earn a reward for completing a Health Assessment in a given calendar year.
- Members may only receive one Healthy Reward incentive allowance for the Smoking Cessation and Weight Management

programs.

- Members may only receive a Healthy Reward incentive once per calendar year for the Health Assessment and Health Coaching programs.

12.d. Any unused incentive funds roll over from year to year as long as the subscriber remains enrolled on the product. The balance of unused allowances is forfeited back to Anthem if the subscriber's coverage ends for any reason or if the member switches to any Anthem plan other than the Individual HIA Plus plan.

12.e. Incentives earned are used to pay for medical care and prescription drugs before the deductible. These funds can only be used for covered benefits and are applied for the covered benefits automatically. After incentive dollars are used, the consumer pays the remaining portion of the deductible (i.e., the "bridge amount") out of pocket.

12.f. Anthem has not conducted studies on the effectiveness of the Healthy Incentive program for the Individual market in Maine. Membership is limited in the HIA and HIA Plus plans and would not be credible.

13. Please provide the detailed support for the development of the HIA incentive costs of $1.81 per contract for single contract and $3.62 per contract for all other contract types.

Response: See attached exhibit "Response_to_AG_Question_13and15_HIA_HIAPlus.xls" The program completion assumptions and other assumptions used in the pricing were provided from Lumenos based on limited experience with participating groups.

14. With regard to the Lumenos HIA Plus plans

    a. Please provide a description of the HIA Plus incentive program. This would include the benefits/incentives offered to members, the purpose of the incentives, the overall goal of this incentive plan, etc.
    b. Please describe the health management tools in which policyholders must participate in order to receive deposits into their HIA account. Please also state the amount(s) that will be deposited for each tool participated in.
    c. Please describe the additional fund through Anthem that policyholders receive under the HIA Plus plan which they do not receive under the HIA plan. Are there different actions required by the policyholder to receive a deposit into this additional fund?
    d. If applicable, what is the maximum amount that a policyholder may have deposited into their HIA account in a given calendar year? What is the maximum amount that a policyholder may have deposited into their additional account funded through Anthem BCBS in a given calendar year?

e. Are there any differences in the rules and restrictions applicable to regular HIA accounts and the consumer-funded portions of the HIA Plus accounts (e.g. restrictions on use and whether funds can be rolled over)?
f. Can unused amounts in the additional account funded through Anthem BCBS be rolled forward to the next year, or are unused balances forfeited at year end?
g. How is Anthem funding the contribution to the additional account? Is the funding represented by the additional cost of $14.85 per single contract and $29.70 for all other contracts?
h. Please identify what restrictions are placed on the use of amounts in the additional account which is funded through Anthem BCBS? (e.g. limited to certain activities/programs/procedures)? Can policyholders use amounts in this account to satisfy deductibles or other cost sharing?
i. Has Anthem performed any studies to determine the success of the HIA Plus incentive program in attaining its goals? If so, please provide the results of those studies.

Response:

14.a. The HIA Plus plan works identical to the Lumenos HIA plan with one significant exception. For the HIA Plus plan, Anthem partially funds the incentive account automatically whether or not the subscriber earns the designated Healthy Rewards incentives. This funding helps to defer the cost to members for medical services and encourages members to retain their coverage.

14.b. Members can increase the funding in their accounts by earning Healthy Reward incentives under the same rules as the HIA plan. See the response to 12.b. above for details on the incentives.

14.c. The automatic funding for the HIA Plus consists of $200 for a single contract or $400 for a multi-person contract each calendar year. Allocations are paid quarterly with 25% of annual contribution paid per quarter. Regardless of start date, new enrollees receive their first quarterly allocation on the plan start date. All future quarterly contributions are paid on a set quarterly schedule: January 1, April 1, July 1, and October 1.

14.d. Use of the account funds (automatic plus the Healthy Rewards) follow the same rules as the HIA plan. See the response to 12. c. above for additional details.

14.e. There are no differences in the rules for the automatic HIA Plus funding versus the Healthy Reward incentive payments.

14.f. Unused amounts in the incentive account roll over from year to year. See response to question 12.d. above for additional details.

14.g. Yes, the additional cost of $14.85 per single contract and $29.70 for all other contracts is used to fund the HIA Plus account contribution

of $200 for single contracts and $400 for all other contracts.

14.h. See the response to question 12.e. above.

14.i. See the response to question 12.f. above.

15. Please provide the detailed support for the development of the HIA Plus incentive costs of $14.85 per contract for the single contract and $29.70 per contract for all other types of contracts.

Response: See attached exhibit "Response_to_AG_Question_13and15_HIA_HIAPlus.xls" The estimated payout percentage is an estimate of the amount of the account contribution that a member will use before terminating with the plan. The payout assumptions used in the pricing were provided from Lumenos based on limited experience with participating groups. Due to the small value of the account contribution ($200), it would be easy for a member to utilize their entire account value (100%) as opposed to the 87.5% assumed.

16. For the HIA and HIA Plus plans, have you assumed any offsetting reduction in claims will occur as the result of members participating in the health management tools required to receive deposits into their account? In no, please explain why you would not expect a reduction in claims for these members.

Response: There is no offsetting reduction in claims assumed for the HIA and HIA Plus plan designs due to lack of supporting experience. At some point in the future, participation in one of these health management programs may lead to better health outcomes but it is unclear the extent to which this will be the case and, in any event, immeasurable at present. Without credible experience that exhibits a reduction in claims costs, we cannot reasonably assume an offsetting claims reduction as part of the pricing.

17. Given that these products have incentive programs in place designed to modify members' behavior, would it not be reasonable to assume these plans will have different utilization patterns than the HealthChoice plans with similar deductibles? Did Anthem consider applying a utilization adjustment factor for these plans on Schedule IV regarding compliance with Rule 940?

Response: Anthem did include utilization adjustments in our original Lumenos pricing effective 1/1/2007. As submitted and approved in the original filing, we assumed a 6% consumerism credit for the $5000 and up deductible levels.

We have requested an exception to Rule 940 that includes the utilization

adjustment above based on the original premium relationship that was approved for Lumenos as of 1/1/2007. The Lumenos H.S.A. $5000 deductible is priced 2.5% less than the HealthChoice $5000 deductible. While this doesn't seem like a large amount, benefits provided by the Lumenos product are relatively rich and there is some uncertainty about a products ability to modify behavior on a guaranteed issue, high cost population. Lumenos benefits include 100% preventive care while the HealthChoice product without the preventive rider does not include this. The rate relationship proposed for the H.S.A. $5000 to the HealthChoice $5000 with PCSA Rider is an 8.9% decrease.

The other important note is that due to the change in the preventive rider benefits for HealthChoice (PCSA Rider), we did not want to use a comparison of the Lumenos H.S.A. $5000 to the HealthChoice $5000 with PCSA Rider. The change in benefits on the PCSA Rider plans means that the current premium relativities no longer apply.

18. Please provide numerical support for the estimated savings for the projection period of $0.03 per member per month due to the implementation of the mandatory generic substitution program.

    To the extent that you have performed any experience studies for the period that the mandatory generic substitution program has been in effect, please provide the results of those studies.

Response: Anthem applied a ratio of two months over twelve (2/12) times the original cost savings estimate of $0.18 PMPM. The estimate of $0.18 PMPM was taken directly from last year's filing and has not been updated. Further, we do not have any experience studies to support the additional savings. Most of the underlying base claim experience already reflects any savings associated with this benefit change.

19. The information shown on Exhibit I includes claims, members, premium, etc. for both the HealthChoice members and the Lumenos members.

    Please provide two revised copies of Exhibit I. Please provide one that includes only data for HealthChoice members and one that includes only data for Lumenos members. For comparison purposes, please use the same time period of data (i.e., twelve months of data ending September 30, 2008, paid through November 30, 2008).

Response: Please see revised Exhibit I with HealthChoice and Lumenos experience split out. Attachment is "2009JULY Rate Development thruDec08 20090204.xls."

20. Please provide the average annual premium shown in the Actuarial Memorandum for HealthChoice members separately from Lumenos members. Please provide the separate information for both the rate before the rate revision and after the rate revision.

Response:

Average Annual Premium	HealthChoice	Lumenos
Current	$5,375	$4,872
Proposed	$6,305	$6,342

21. Please provide the history of rate actions taken for the Lumenos product. This should include the effective date of the rate action and the level of the rate action.

Response: There have been no rate actions on Lumenos since inception on 1/1/2007.

22. The actuarial memorandum states that the HealthChoice members will receive a lower increase and Lumenos members will receive a higher increase than their experience dictates. What would the HealthChoice increase be if the pools were not combined? What would the Lumenos increase be if the pools were not combined?

Response: HealthChoice average increase: 20.6% and Lumenos: 7.1%
Please see revised Exhibit I and Exhibit III Alternate in the attachment is "2009JULY Rate Development thruDec08 20090204.xls."

Anthem believes strongly that the experience of the two pools should be combined because members from HealthChoice can freely migrate to and from Lumenos in the current guaranteed issue individual market. As described above, the underlying plan designs are materially the same which does not merit separate pools. Exhibit III Alternate in the revised exhibits shows that separating the pools leads to a premium rate differential between the Lumenos H.S.A. $5000 deductible and the HealthChoice $5000 deductible with PCSA Rider of almost 30%. Anthem would risk extreme anti-selection from pricing that does not reflect true underlying benefit differences.

23. The Actuarial Memorandum contains a table with utilization statistics separately for HealthChoice members and Lumenos members for the period twelve months ending June 2008. Please provide the associated member months for the HealthChoice and Lumenos products separately.

Response:

	Member Months 12-months Ending 6/30/2008
HealthChoice	145,329
Lumenos	8,032

24. We assume the administrative expenses of $21.02 pmpm are based on the combined expectation of expenses for both the HealthChoice and Lumenos products. What would be the respective administrative expense loads for the rating period if HealthChoice and Lumenos rates were developed separately for Calendar Year 2009?

Response: Anthem does not anticipate that the administrative expenses would be materially different for HealthChoice versus Lumenos. The product benefits are very similar which would lead to very similar levels of administrative expense.

25. Please provide two revised versions of Exhibit IX, one reflecting HealthChoice financial results only and one reflecting Lumenos financial results only.

Response: Please see revised Exhibits IX.A and IX.B with HealthChoice and Lumenos experience split out. Attachment is "2009JULY Rate Development thruDec08 20090204.xls."

26. Please provide two revised versions of Exhibit X, one reflecting HealthChoice experience only and one reflecting Lumenos experience only.

Response: Please see revised Exhibits X.A and X.B with HealthChoice and Lumenos experience split out. Attachment is "2009JULY Rate Development thruDec08 20090204.xls."

27. On Exhibit IV of the revised filing, the "Annual Rule 940 Maximum Allowable Rate Difference" for the plan design of "$2000/$1000 compare to $2,250" is $506.

   a. Please demonstrate how the $506 is derived. The demonstration should include your detailed work papers.
   b. Please complete the row referenced above ("Proposed Age 55-64 Two Adult Family Effective May 1, 2009" rate is missing). Please demonstrate how the $42.16 proposed premium difference is derived for this row.

Response: 27a. The $506 calculation seems to have an error. It is based on a $200 deductible difference to the $2,250 plan which should be $250. The correct calculation is $250 * 2.53 (the members/contract ratio) which equals $632.50 annually. The maximum monthly rate difference is $52.71. The Rule 940 calculation for the $2000 deductible compared to the $2250 deductible is not applied in any of the rate development formulas.

27b. The premium for the $2000 plan is based on the minimum rate as calculated by the difference to the $4000 deductible ($421.66) and the

difference to the $2250 deductible ($52.70). In this instance, the minimum rate is the one associated with the $4000 deductible plan design. The Rule 940 calculation for the $2000 deductible compared to the $2250 deductible is not applied in any of the rate development formulas.

Please see revised Exhibit III and IV. Attachment is "2009JULY Rate Development thruDec08 20090204.xls."

28. On Exhibit IV of the revised filing,

   a. Please demonstrate the calculation of the "Proposed Rate Difference Prior to Utilization Adjustment" of $416.66 for the plan design Lumenos $2,500.
   b. We assume you are comparing the Lumenos HSA $2,500 plan with the Lumenos HSA $5,000 plan in order to generate the difference in the deductible of $5,000 (for a two adult family contract). Please confirm.
   c. If the above is true, we would generate a difference in the rates charged for a two adult family contract (ages 55-64) of $499.99 (=$1,623.98 – $1,123.99). This assumes no utilization differences, since none are specified on Exhibit IV. We would like to understand the difference between the $416.66 and the $499.99.
   d. Please provide a comparable demonstration for the Lumenos HIA Plus calculations between the $5,000 and $10,000 plans.

Response:

28a. $416.67 = $2500 (deductible difference to $5000) * 2.0 (the members/contract ratio) / 12. $416.66 is one penny less than the maximum allowable monthly rate difference.

28b. Yes, we are comparing the Lumenos H.S.A. $2500 to the Lumenos H.S.A. $5000 in order to generate the difference in the deductible for a two adult contract.

28c. We have discovered an error in the formulas. The maximum rate difference for Lumenos is being applied to the 40-44 age band instead of the 55-64 age band. We have corrected this issue in the revised exhibits.

28d. $833.33 = $5000 (deductible difference to $5000) * 2.0 (the members/contract ratio) / 12. $300 is the selected rate differential in order to maintain consistency with the HealthChoice premium differentials. The same error in the premium calculations applies and has been corrected.

Please see revised Exhibit III and IV. Attachment is "2009JULY Rate Development thruDec08 20090204.xls."

29. In his Decision and Order relative to the HealthChoice 2008 rate request (INS-07-1000) Acting Superintendent of Insurance Cioppa noted that the proposed rates for members age 65 and over did not comply with the Rule 940 restrictions on premium differentials between deductibles and that Anthem was opting to continue to charge the age 55-64 rate to members age 65 and over in 2008. Those noncompliant proposed rates used the age factor of 1.50 to generate the rates for members age 65 and over, as do the proposed rates in this filing for the Lumenos products. Please provide a demonstration that shows the rates for the Lumenos products at this age band are compliant with Rule 940.

Response: Lumenos rates for members age 65 and over were approved effective 1/1/2007 with the exception to Rule 940. Note that the rate relationships for the 65+ current rates in Exhibit III do not comply with Rule 940.

Because the exception was approved for our Lumenos rates at 1/1/2007, we have continued to apply this exception in our rates going forward.

30. The trend of 10.1%, which is based on experience after removing claims over $100,000, is the overall average trend from 12 months ending December 2005 to 12 months ending September 2008 (shown in Exhibit VI.B). Yet, the pooling charge development is based on data that is 12 month ending June 2007 to 12 months ending September 2008 (reflected in the formula embedded in the electronic version of Exhibit XV). Please explain why consistent data periods were not used to develop the trends and the pooling period.

Response: The selected trend and pooling charge assumptions were calculated using different periods because of differences in the volatility level in the underlying experience. The trend rates for the claims under $100,000 have been extremely volatile. The pooling charge percentage has been very steady lending more credibility to rely on the most recent experience.

The calculation of the pooling charge that utilizes a 10 of 12 method (average of all 12 periods less the minimum and maximum values) produces a pooling charge of 17.1% which is only 0.2% different from the value selected. However, the alternate calculation of the pooling charge, that takes into account the trend on the claims, produces a pooling charge of 17.8% which is significantly higher. The 17.3% assumption used is near the low end of the reasonable range generated by these alternate estimates.

31. Anthem uses trend of 10.1% for claims under $100,000. This is for the period 1/05 – 9/08. However, trends in recent periods have been much lower (3-4% range). Why not incorporate some of the lower recent trends?

Response: Although some recent periods exhibited lower trend rates, it is clear from the rolling 12 month period ending 9/2008 that trends are currently on the rise. Further, the high level of deductible leveraging which is evident in Exhibit VI indicates that higher trend rates on the under $100,000 experience are appropriate.

Note that both rate development methods shown in Exhibit I result in required premium increases within 0.3% of each other which lends credibility to the trends selected for Method 2.

DATED: March 11, 2009

/s/ Christopher T. Roach
Christopher T. Roach, Esq.

PIERCE ATWOOD LLP
One Monument Square
Portland, Maine 04101
Attorney for Applicant

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

IN RE: ANTHEM BLUE CROSS AND BLUE SHIELD 2009 INDIVIDUAL RATE FILING FOR HEALTHCHOICE, HEALTHCHOICE STANDARD AND BASIC AND LUMENOS CONSUMER DIRECTED HEALTH PLAN PRODUCTS Docket No. INS-09-1000	**CERTIFICATE OF SERVICE**

The undersigned counsel 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 Applicant's Response to the First Informational Request of the Attorney General upon the persons and at the addresses indicated below.

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[e-mail and U.S. Mail]

DATED: March 11, 2009

/s/ Christopher T. Roach
Christopher T. Roach, Esq.

PIERCE ATWOOD LLP
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Attorney for Applicant

Attachment "Response to Nos. 6 and 7 of AG's First IR (W1296706).XLS" is not a PDF document and cannot be reproduced here.

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Amendment to

HealthChoice
Certificate of Coverage

Preventive Care
Supplemental Accident Benefits

Your Anthem Blue Cross and Blue Shield HealthChoice Certificate of Coverage (028645, 028645A or 028645B) is changed as stated in this amendment.

The "Covered Services" section is changed by deleting the "Preventive and Well-Care Services" subsection and replacing it with the following:

Preventive and Well-Care We provide benefits for the following preventive and well-care services. These services are paid at 100% of the maximum allowance and are not subject to the deductible

- **Prenatal care**
  One prenatal office visit per month during the first two trimesters of pregnancy
  Two office visits per month during the seventh and eighth months of pregnancy
  One office visit per week during the ninth month and until term
  Coverage for each visit shall include necessary and appropriate screening, including history, physical examination, and such laboratory and diagnostic procedures as may be deemed appropriate by the physician based upon recognized medical criteria for the risk group of which the patient is a member.
- **Newborn care**
  Routine inpatient hospital nursery care
  Routine inpatient physician services
  Vaccines, immunizations, vitamins, routine eye care, metabolic screening administered to the newborn prior to discharge
- **Well-child care;**
  Includes periodic evaluation of a child's physical and emotional status, a history; a complete physical examination, a developmental assessment, anticipatory guidance, appropriate immunizations and laboratory tests in keeping with prevailing medical standards
  6 physical examinations age 0-1
  2 physical examinations per year age 1-2
  Annual physical examinations age 3 through 17
  Vaccines and immunizations
  Maximum benefit for the physician's charge $50
  Screening X-ray and laboratory services charges up to a maximum of $50

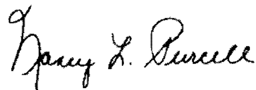
- **Well adult care;**
  Annual physical examinations
  Maximum benefit for physician charge $100
  Screening X-ray and laboratory services charges up to a maximum of $100.
  Prostate specific antigen test and digital rectal examinations for men;
  Gynecological examinations, which include breast and pelvic examinations, and Pap smears when performed by a physician, certified nurse practitioner, or certified nurse midwife participating in the plan;
  Screening pap tests recommended by a physician;
  Screening mammograms;
  Flu vaccines

The "Covered Services" section is changed by adding the following:
$500 Supplemental Accident Benefit Within 90 Days We provide benefits for covered services when they are the direct result of an accidental bodily injury. The injury must occur while the member is covered under this contract. The covered services must be ordered by a doctor and furnished within a 90-day period starting on the date of the injury. The maximum payment is $500 per accident.

Covered services related to this amendment will not be subject to the deductible and coinsurance provision. However, all payments are included in the lifetime maximum.

Once the $500 maximum is reached, any additional covered services that are the direct result of the accidental bodily injury will be subject to the deductible and coinsurance as stated in this contract.

All other terms, conditions, limitations, and exclusions of your Anthem Blue Cross and Blue Shield HealthChoice Certificate of Coverage (028645, 028645A or 028645B) apply to this amendment.



Nancy L. Purcell
Corporate Secretary
Anthem Blue Cross and Blue Shield

Attachment "Exhibit to Nos. 2 and 12 of Superintendent's First Set of IR (W1302081).XLS" is not a PDF document and cannot be reproduced here.

Attachment "Response_to_AG_Question_6and7_RESEND.xls" is not a PDF document and cannot be reproduced here.

Introduction

This Certificate contains information that you need to know about your Individual Preferred Provider Organization (PPO) coverage from Anthem Blue Cross and Blue Shield (Anthem). You are urged to read this Certificate of Coverage carefully.

The terms WE, US and OUR in this Contract refer to Anthem Blue Cross and Blue Shield and its designated affiliates. When we use the term YOU or YOUR, we are talking about the Subscriber and all Dependents whom we accept for coverage under this Contract.

This Certificate of Coverage explains how your HealthChoice plan works. It explains the terms, Benefits, conditions, exclusions, and limitations of your coverage. It also includes information about eligibility requirements, enrollment for Benefits, claim procedures and termination provisions.

The Benefits described in this Certificate of Coverage are interpreted and administered according to the provisions and limitations herein. If there are coverage questions, Anthem will base all decisions on the provisions in this Certificate of Coverage.

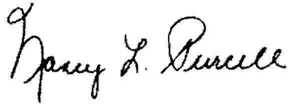
Paying Subscription Charges and Renewal

HealthChoice coverage may be purchased on a monthly or quarterly basis and coverage will automatically renew upon payment of subscription charges. Payment for subscription charges is due the first day of each month, or quarter of coverage. If payment is received within 31 days of the due date - - the grace period, coverage will continue without a lapse in coverage. If payment is not received within 31 days of the due date, coverage may be cancelled at the expiration of the grace period. We reserve the right to take necessary action to collect premiums for the grace period. We reserve the right to unilaterally modify the terms of the Contract consistent with state and federal laws.

10 Day Certificate Review

The Certificate of Coverage, any amendments or attached papers, and your individual application make up your Contract and your complete coverage with Anthem for health care Benefits. This Certificate of Coverage replaces any previous Certificates of Coverage you may have received.
Services provided during an inpatient stay that started during an existing Contract will continue to be covered by the terms of that Contract until you are discharged or reach any of the Contract's limits or maximums, whichever occurs first.

If you decide not to accept this Certificate, return it to our home office (Anthem Blue Cross and Blue Shield; 2 Gannett Drive; South Portland, ME 04106-6911) within 10 days after its delivery date. Please include a written request to cancel it. We will then refund any subscription charges you've paid for this Contract.



Nancy L. Purcell
Corporate Secretary
Anthem Blue Cross and Blue Shield
2 Gannett Drive
South Portland, ME 04106-6911

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Section One — Eligibility and Termination of Coverage
This section explains how and when you become eligible for coverage, how and when coverage can end.

Section Two —Utilization Management
This section explains the Admission Review, and Individual Care Management provisions.

Section Three — Covered Services
This section explains the types of health care services included in your coverage.

Section Four — Exclusions
This section lists health care services that are not covered.

Section Five — Benefit Determinations, Payments, and Appeals
This section explains how we determine Benefits, how to file a claim, how we pay approved claims, and how to Appeal a claim denial.

Section Six — Definitions
This section defines words and phrases that have special meanings.

Claims Information
For questions about covered services or claims, please call a Customer Service Representative at the number on your ID card. Be sure to have your identification number ready when you call so we can answer your questions promptly.

Section One
Eligibility and Termination of Coverage

Beginning Coverage

Before your coverage begins we must accept your application and payment for your coverage. Payment is due the first day of the month for that month's coverage.

Paying Subscription Charges

HealthChoice coverage may be purchased on a monthly or quarterly basis and coverage will automatically renew upon payment of subscription charges. Payment for subscription charges is due the first day of each month, or quarter of coverage. If payment is received within 31 days of the due date - - the grace period, coverage will continue without a lapse in coverage. If payment is not received within 31 days of the due date, coverage may be cancelled at the expiration of the grace period. We reserve the right to take necessary action to collect premiums for the grace period.

Who is an Eligible Individual Member?

1. The subscriber;
2. The subscriber's legal spouse;
3. The subscriber's/spouse's unmarried children under age 19:
   a. Newborn children;
   b. Biological children, adopted children or children placed for adoption, stepchildren or legally placed foster children who live with the subscriber;
   c. Other children who live with or depend on the subscriber for financial support. (We reserve the right to determine if they may be covered under this Contract.)
4. The subscriber's/spouse's unmarried children aged 19 and older if they are dependent on their parents for at least fifty percent of their support, and are:
   a. Under age 23, not married and enrolled full-time as a student in an accredited college or university; or,
   b. Mentally or physically disabled. The disability must have begun before the child's 23rd birthday, and the child must have been covered by us on and continuously since his or her 23rd birthday.
5. The subscriber's grandchild under age 23, living with the subscriber in a parent-child relationship and primarily supported by the subscriber. The subscriber may not enroll a child and grandchild at the same time under the same identification/policy number. The eligible child or grandchild may be covered under a separate identification/policy number.

When a covered child reaches age 19, we will send you an application. You must file this application with us if you want the child's coverage to continue.

We will determine the effective date of coverage for the subscriber and other eligible family members. If your coverage has changed or you are unsure of your effective date, please call us.

We reserve the right to verify continued eligibility for all members.

Qualified Medical Child Support Order

If a qualified medical child support order is issued for your child, that child will be eligible for medical coverage as stated in the order. A qualified medical child support order is a judgment, decree, or order issued by a court of law which:

- Specifies your name and last known address;
- Specifies the child's name and last known address;
- Provides a description of the coverage to be provided or the manner in which the type of coverage is to be determined;
- States the period of time to which it applies; and
- Specifies each plan to which it applies.

A Qualified Medical Child Support Order may not require health care coverage that is not already included under the Plan.

Continuity of Coverage

If you or any covered family member had prior creditable coverage, within 90 days of the effective date of this Contract, we will waive pre-existing condition restrictions to the extent that Benefits would have been payable under your prior Contract or government program if that Contract or government program were still in effect. Even when pre-existing condition restrictions have been to some extent waived, we will only provide Benefits that are described in this Certificate regardless of whether they would be available under your prior Contract or government program.

Federally Eligible Individuals with an effective date of coverage under this Contract on or after 1/1/98 will have all pre-existing condition restrictions waived. (For the definition of "Federally Eligible Individual" please refer to the Definition section.)

An individual seeking to reduce or eliminate a pre-existing condition limitation period based on his/her prior creditable coverage may do so by providing a Certificate of Creditable Coverage to us. We will assist in obtaining a Certificate from any prior plan or issuer, if necessary.

Membership Additions

If you wish to add eligible family members after we have accepted your application, you must:

- File an application; and
- Pay the applicable subscription charge.

In most cases, the effective date of coverage for added family members will not be the same as your effective date of coverage.

Family members who are eligible because of birth, adoption, marriage or court order after the subscriber's effective date of coverage may be added as follows:

Birth A newborn is automatically covered for 31 days from the moment of its birth unless the subscriber notifies us that the child will not be covered under the Contract. For coverage beyond 31 days, if we receive a completed application for change:

- **Within 31 days from the date of birth**, coverage is continuous from the moment of birth. We will collect applicable charges.
- **After 31 days from the date of birth**, coverage may be issued subject to pre-existing condition restrictions as described in the "Pre-existing Condition" paragraph in the Exclusions section and the "Continuity of Coverage" paragraph in this section. Coverage begins on the first of the month after we accept the application and receive the applicable charges.

Adoption If we receive an adopted child's application for change:

- **Within 31 days from the date the child is adopted or placed for adoption with the subscriber and/or spouse**, coverage will begin on the date of placement. We will collect applicable charges. If a child placed for adoption is not adopted, all health care coverage will cease when placement ends. No continuation provisions will apply.
- **After 31 days from the date the child is adopted or placed for adoption** with the subscriber and/or spouse, coverage may be issued subject to pre-existing condition restrictions as described in the "Pre-existing Condition" paragraph in the Exclusion section and the "Continuity of Coverage" paragraph in this section. Coverage begins on the first of the month after we accept the application and we receive the applicable charges.

Court Order Changing Custody When a court order is issued changing custody of a dependent child, if we receive the application for change:

- **Within 31 days of the date of the court order**, coverage will begin on the date of the court order.
- **After 31 days from the date of the court order**, coverage may be issued subject to Pre-existing Condition restrictions as described in the "Pre-existing Condition" paragraph in the Exclusions section and the "Continuity of Coverage" paragraph in this section. Coverage begins on the first of the month after we accept the application and receive the applicable charges.

Marriage When the Subscriber marries, if we receive the spouse's (and children's, if applicable) completed application for change:

- **Within 31 days from the date of marriage**, coverage begins the first of the month that occurs immediately on or after the date we receive the application.
- **After 31 days from the date of marriage**, coverage may be issued subject to Pre-existing Condition restrictions as described in the "Pre-existing Condition" paragraph in the Exclusions section and the "Continuity of Coverage" paragraph in this section. Coverage begins on the first of the month after we accept the application and receive the applicable charges.

Pre-existing Condition Limitation The pre-existing condition exclusion will not apply to conditions discovered through genetic testing that have not manifested as conditions requiring treatment; to newborns who are enrolled by the thirty-first day after birth or who are covered by prior creditable coverage; or to a child who is adopted or placed for adoption and who is enrolled by the thirty-first day after adoption or being placed for adoption or who are covered by prior creditable coverage.

Termination of Coverage

The subscriber or we can cause your coverage to end. If your coverage ends for any reason except misrepresentation, fraud or nonpayment, it will end on the first day following the grace period (see "Paying Subscription Charges" earlier in this section for additional information). If termination of coverage is requested before the completion of the period for which we have accepted payment, payment may not be refunded, and coverage may continue until the end of that period. We reserve the right to take necessary action to collect premiums for the grace period.

Cancellation of the Member's Contract

Ending Eligibility If the subscriber ends membership, or if you cease to meet the definition of eligible, as described in this section, your coverage will be canceled. We reserve the right to verify your initial and continued eligibility.

Deletion from Membership If you have been deleted from membership, your coverage will be canceled. The subscriber must delete a member from coverage if the member is no longer eligible for reasons such as a child's marriage, the subscriber's divorce or legal separation, or a member's death. The subscriber must notify us of these events and complete a form to remove a member. If you do not promptly disenroll your dependents when they are no longer eligible, you will be fully responsible for all claims they incurred and for which Benefits have been paid after they were no longer eligible.

Covered Children Your coverage will be canceled if you are a covered child and:

- You marry. Coverage will end on the first day of the month that occurs immediately on or after your date of marriage.
- You reach age 19 and we have not received and accepted an application for continued coverage under the employee's coverage. Coverage will end on the first day of the month that occurs immediately on or after your 19th birthday.
- We have accepted your application for coverage after age 19 and you then reach age 23. Coverage will end on the first day of the month that occurs immediately on or after your 23rd birthday unless you are an eligible disabled dependent, as defined in the subsection "Who is an Eligible Individual Member?" We reserve the right to request verification of continued eligibility between the ages of 19 and 23.
- You cease to meet the definition of an eligible dependent.

Non-Payment of Charges Your Contract will be canceled for non-payment of subscription charges by the due date. However, if we receive payment within the grace period, your Contract will remain in effect. We will not allow reinstatement once the grace period has ended.

Misrepresentation or Fraud If you make any intentional misrepresentation, intentional omission, or use fraudulent means to continue coverage when you no longer meet the eligibility requirements, your Contract will be canceled as of the last date of eligibility. Any claims incurred after the date of eligibility for which we are unable to recover payment from the provider will be the responsibility of the subscriber.

Notice of Cancellation If your coverage is canceled for non-payment of subscription charges or other lapse or default, we will send you a notice of cancellation. We will offer you the opportunity to reinstate your coverage as set forth below. The charges will be the same amount they would have been if the Contract had remained in force.

You have the right to designate another person to receive notice of cancellation of this Contract for non-payment of charges or other lapse or default. We will send the notice to you and the person you designate at

the last addresses you provided to us. You also have the right to change the person you designate if you wish. In order to designate a person to receive this notice or to change a designation, you must fill out a Third Party Notice Request Form. You can obtain this form by contacting us.

Right to Reinstatement You may be eligible to reinstate the Contract within 90 days after the date of cancellation if non-payment of charges or other lapse or default took place because you suffered from organic brain disease at the time of cancellation. For the purposes of this provision, organic brain disease means a mental or nervous disorder of demonstrable origin that causes significant cognitive impairment.

If you request reinstatement, we may require a physician examination at your own expense or request medical records that confirm you suffered from organic brain disease at the time of cancellation. If we accept the proof, we will reinstate your coverage without a break in coverage. We will reinstate the same coverage you had before cancellation or the coverage you would have been entitled to if the Contract had not been canceled, subject to the same terms, conditions, exclusions, and limitations. Before we can reinstate your Contract, you must pay the amount due from the date of cancellation through the month in which we bill you. The charges will be the same amount they would have been if the Contract had remained in force.

If we deny your request for reinstatement, we will send you a Notice of Denial. You have the right to an Appeal, or to request a hearing before the Superintendent of Insurance within 30 days after the date you receive the Notice of Denial from us.

Certificate of Creditable Coverage When your medical coverage ends, Anthem will give you a written record of the coverage you received under the Contract, and the waiting period, if any. You will receive a Certificate of creditable coverage when your coverage ends, and upon your request (if the request is made within 24 months following termination of coverage). You may need to submit the Certificate of Creditable Coverage to reduce the duration of any subsequent Pre-existing Condition limit, if there is one, by one day for each day of prior coverage (subject to certain requirements).

Section Two
Utilization Management

All services you receive are subject to the provisions in this section. Failure to comply with any or all of the requirements listed below will result in a penalty, or in denial or reduction of your Benefits. If you have any questions, please call the number on the back of your Identification Card.

If you have a health concern, please contact your physician.

The purpose of Utilization Management is to review your medical care while you are in the hospital to determine if you are receiving medically necessary hospital services. The program includes an ongoing monitoring of your health care needs and possible assignment of a care manager to work with you and your physician to optimize your Benefits.

This review is to determine financial reimbursement if the requested benefit is a Covered Service. The decision for treatment is solely between the patient and physician, regardless of the decision made regarding reimbursement.

None of our employees or the providers we contract with to make medical management decisions are paid or provided incentives to deny or withhold Benefits for services that are medically necessary and are otherwise covered under the Contract. In addition, we require members of our clinical staff to sign an annual statement. This statement verifies that they are not receiving payments that would either encourage or reward them for denying Benefits for services that are medically necessary and are otherwise covered under the Contract.

Anthem Medical Policy

The purpose of medical policy is to assist in the interpretation of Medical Necessity. However, the Certificate of Coverage takes precedence over medical policy. Medical technology is constantly changing and we reserve the right to review and update medical policy periodically.

Prior Authorization

Some services require prior authorization before Benefits will be provided. If you have any questions regarding Utilization Management or to determine which services require prior authorization, please call the number on the back of your Identification Card. Prior Authorization does NOT guarantee coverage for or payment of, the service or procedure reviewed. Contact your physician or Anthem to be sure that prior authorization has been obtained.

Members' Rights and Responsibilities

You have the right to:

- Request in writing a copy of our clinical review criteria used in arriving at any denial or reduction of Benefits;
- Appeal any adverse determinations based on medical necessity;
- Refuse treatment for any condition, illness, or disease without jeopardizing future treatment.

Procedure for Appeal of Medical Necessity

If you disagree with our determination of medical necessity, you have the right to Appeal as outlined in the "Benefit Determinations, Payments and Appeals" section of this Certificate.

Inpatient Admission Review

Pre-Admission Review All inpatient admissions, with the exception of emergency and maternity admissions, require pre-admission review.

You, your physician or the provider must call the telephone number on your ID card for review before you are admitted. It is your responsibility to make sure the call has been placed. If you do not receive preadmission review before you are admitted for non-emergency services, Benefits will be reduced by up to $500 for the admission. This penalty amount does not count toward your Deductible or Coinsurance limit.

We will notify you and your physician of the results of the pre-admission review within 2 working days of our obtaining all necessary information regarding the proposed admission. For special rules that apply to maternity admissions, see the "Continued Inpatient Stay Review" provision in this section.

Post-Admission Review All inpatient admissions for emergency and maternity services are subject to post-admission review. For post-admission review of an emergency admission, you, a family member, your physician, or the provider should call within 48 hours after you are admitted. For maternity post-admission review, you, a family member, your physician, or the provider should call if the hospital stay exceeds 48 hours for a vaginal delivery or 96 hours for a cesarean section. We will notify you and your physician of the results of the post-admission review within 2 working days of receiving all necessary information.

If you are admitted to a non-participating hospital or other non-participating health care facility, Benefits are provided at the higher benefit level only until we determine that your condition reasonably permits your transfer to a participating hospital or other participating health care facility. If you choose not to be moved once your condition permits, Benefits will be provided at the lower benefit level from that point forward.

For emergency and maternity admissions, call the telephone number on your ID card. You can call 24 hours a day, seven days a week. During non-business hours, you may be asked to leave your information on a confidential voice messaging system.

For special rules that apply to maternity admissions, see the "Continued Inpatient Stay Review" provision in this section.

Continued Inpatient Stay Review During your stay in the hospital, our registered nurses and physician advisors evaluate your progress to determine the appropriateness of the services being rendered, appropriateness of the setting, discharge planning needs and coordination of alternatives to inpatient care. If we determine that inpatient Benefits are no longer approved, your attending physician will be notified immediately by telephone and you will be notified by letter that Benefits will not be available beyond a certain date specified in the letter, if you are liable for the entire cost of continued care.

If you elect to continue your hospital stay after you have been notified by letter that no further inpatient days are approved, Benefits for inpatient days beyond the date specified in the notification letter will be denied. You are entitled to Appeal this determination as outlined in this Certificate.

Note:

Maternity Admissions - This Contract generally may not, under federal law, restrict Benefits for a mother or newborn child for any hospital length of stay in connection with childbirth to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). The inpatient length of stay for a maternity admission will be determined by the attending physician in consultation with the patient as outlined in the "Covered Services" section. In any case, this Contract may not, under federal law, require authorization from us for prescribing a length of stay that does not exceed 48 hours (or 96 hours as applicable).

Admissions for the Treatment of Breast Cancer - The inpatient length of stay for a mastectomy, a lumpectomy, or a lymph node dissection for the treatment of breast cancer, will be determined by the attending physician in consultation with the member as outlined in the "Covered Services" section.

Discharge Planning You may be ready to be discharged from a provider even though you still need medical care. In that case, we will work with you and your physician to make arrangements for treatment even after you are released from the provider.

Inpatient Mental Health/Substance Abuse Review Authorization for mental health and substance abuse services must be obtained through the behavioral health care manager. You, your doctor, or the provider must call for authorization. Unless you have an emergency medical condition, you must call the telephone number on your ID card for prior authorization of all inpatient mental health and substance abuse services before you receive the services. It is your responsibility to make sure you receive prior authorization for all non-emergency inpatient mental health and substance abuse services. If you do not call for prior authorization for inpatient mental health and substance abuse services before you receive the services, your Benefits may be reduced by up to $500. Benefits may be denied if it is determined that services received were not medically necessary.

Individual Care Management

Anthem has a care management program that is tailored to the individual. Our care managers work collaboratively with members and their families and providers to coordinate the member's health care Benefits.

In certain extraordinary circumstances involving intensive care management, we may provide Benefits for alternate care that is not listed as a Covered Service. We may also extend Covered Services beyond the contractual benefit limits of this plan. We will make our decision case-by-case. A decision to provide extended Benefits or approve alternate care in one case does not obligate us to provide the same Benefits again to you or to any other member. We reserve the right, at any time, to alter or cease providing extended Benefits or approving alternate care. In such case, we will notify you or your representative in writing.

Second Surgical Opinion

A second surgical opinion is an opinion given by a network board certified surgeon when your doctor recommends surgery. It is important to note that although you may receive a second surgical opinion, the choice of having the surgery is always yours.

To receive Benefits for a second surgical opinion, you must receive approval from us prior to seeking the second surgical opinion. We pay up to the maximum allowance for second surgical opinions. Deductibles and Coinsurance do not apply to this benefit.

For approval of a second surgical opinion, call toll-free customer service number on the back of your ID card.

Network Provider or Professional Unavailable

If you are unable to obtain services from a Network Provider or Professional, you or your doctor should call the telephone number on your ID card. Our care managers will work with you or your doctor to locate a Network Provider or Professional. If it is determined by the care manager that no Network Provider or Professional is available, we will authorize Covered Services from a Non-Network Provider or Professional. Benefits will be reimbursed at the higher network level.

Section Three
Covered Services

This section, along with the "Exclusions" section, explains health care services for which we will and will not provide Benefits. All Benefits and covered services are subject to the Deductibles, Coinsurance, maximums, exclusions, limitations, terms, provisions and conditions of this Contract, including any attachments and amendments or riders. Benefits for Covered Services are based on the maximum allowable amount. To receive maximum Benefits for Covered Services, you must follow the terms of the Certificate, including, use of in-network providers and obtaining any required prior authorization.

Our payment for covered services will be limited by any applicable Deductible or annual or lifetime maximum. Please see the "Utilization Management" section for conditions that apply to all inpatient admissions.

Benefits for covered services may be payable subject to an approved treatment plan. Only medically necessary care is covered. Although we do not provide Benefits for covered services that do not meet our definition of medical necessity, you and your physician must decide what care is appropriate. The fact that a physician may prescribe, order, recommend or approve a service, treatment or supply does not make it Medically Necessary or a Covered Service and does not guarantee payment. If you choose to receive care that is not a covered service or does not meet our definition of medical necessity, we will not provide Benefits for it. Anthem bases its decisions about referrals, prior authorization, medical necessity, experimental services and new technology on medical policy developed by Anthem. Anthem may also consider published peer-review medical literature, opinions of experts and the recommendations of nationally recognized public and private organizations which review the medical effectiveness of health care services and technology.

Unless specifically stated otherwise, all Benefits, limitations and exclusions under this Contract apply separately to each covered family member.

A member's right to Benefits for Covered Services provided under this Certificate is subject to certain policies or guidelines and limitations, including, but not limited to, Anthem Medical Policy, Continued Inpatient Stay Review, Pre-admission Review, Post-Admission Review, and Prior Authorization. A description of each of these guidelines explaining its purpose, requirements and effects on Benefits is provided in the "Utilization Management" section. Failure to follow the Utilization Management guidelines for obtaining Covered Services will result in reduction or denial of Benefits.

Allergy Testing and Injections We provide Benefits for allergy testing and injections.

Ambulance Service We provide Benefits for local transportation by a licensed vehicle that is specially designed and equipped to transport the sick and injured. This service is covered only when used locally to or from a hospital when other transportation would endanger your health.

If no hospital in your local area is equipped to provide the care you need, we will provide Benefits for ambulance transportation to the nearest facility outside your area that can provide the necessary care. If you are transported to a hospital that is not the nearest hospital that can meet your needs, Benefits will be based on transport to the nearest hospital that can meet your needs.

Ambulatory Surgery Centers We provide Benefits for certain covered services provided by ambulatory surgery centers. Covered services vary according to the scope of an individual facility's licensure.

Anesthesia Services We provide Benefits for anesthesia only if administered while a covered service is being provided, except as outlined in the 'Dental Procedures' provision. We do not provide Benefits for local or topical anesthesia unless it is part of a regional nerve block.

Asthma Education We provide Benefits for approved asthma education programs for our covered members with asthma and their families. Benefits are provided for up to a Calendar Year maximum of $200 per patient when the program is received from an approved network provider or professional. Please call us for a listing of approved providers and professionals.

Blood Transfusions We provide Benefits for blood transfusions including the cost of blood, blood plasma, and blood plasma expanders, and administrative costs of autologous blood pre-donations.

Chemotherapy Services We provide Benefits for antineoplastic drugs and associated antibiotics and their administration when they are administered by parenteral means such as intravenous, intramuscular, or intrathecal means. This does not include the use of drugs for purposes not specified on their labels except for the diagnoses of cancer, HIV or AIDS unless approved by us for medically accepted indications or as required by law. Any FDA Treatment Investigational New Drugs are not covered unless approved by us for medically accepted indications or as required by law.

Chiropractic Care We provide Benefits for chiropractic care. See the "Manipulative Therapy" provision for additional information.

Clinical Trials We provide Benefits for routine patient costs for items and services furnished in connection with participation in approved clinical trials. A member is eligible for coverage in an approved clinical trial if the following conditions are met:

- The member has a life-threatening illness for which no standard treatment is effective;
- The member is eligible to participate according to the clinical trial protocol with respect to treatment of such illness;
- The member's participation in the trial offers meaningful potential for significant clinical benefit; and
- The member's referring physician has concluded that the member's participation in the trial would be appropriate based on the above named criteria.

Routine costs do not include the costs of the tests or measurements conducted primarily for the purpose of the clinical trial or for costs of items and services that are reasonably expected to be paid for by the sponsors of an approved clinical trial.

An approved clinical trial means a clinical research study or clinical investigation approved and funded by the federal Department of Health and Human Services, National Institutes of Health or a cooperative group or center of the National Institutes of Health.

Contraceptives We provide Benefits for prescription contraceptives approved by the federal Food and Drug Administration (FDA) to prevent pregnancy, including related consultations, examinations, procedures, and medical services provided on an outpatient basis.

Dental Procedures We will provide Benefits for general anesthesia and associated facility charges for dental procedures rendered in a hospital when the member is classified as vulnerable. Examples of vulnerable members include, but are not limited to the following:

- Infants
- Individuals exhibiting physical, intellectual or medically compromising conditions for which dental treatment under local anesthesia, with or without additional adjunctive techniques and modalities, can not be expected to provide a successful result and for which dental treatment under general anesthesia can be expected to produce a superior result
- Individuals with acute infection
- Individuals with allergies
- Individuals who have sustained extensive oral-facial or dental trauma
- Individuals who are extremely uncooperative, fearful or anxious

Dental Services We provide Benefits only for the following:

- Setting a jaw fracture
- Removing a tumor (but not a root cyst)
- Removing impacted or unerupted teeth in a non-hospital or non-rural health center setting
- Treatment within six months of an accidental injury to repair or replace natural teeth

Diabetic Services We provide Benefits for diabetes medication and supplies which are medically appropriate and necessary. Medication encompasses insulin, insulin pumps, and oral hypoglycemic agents. Covered supplies and equipment are limited to glucose monitors, test strips, syringes and lancets. Covered Benefits also include outpatient self-management and educational services used to treat diabetes if services are provided through a program that is approved by us.

Diagnostic Services We provide Benefits for diagnostic services, including diagnostic laboratory tests and x-rays, when they are ordered by a professional to diagnose specific signs or symptoms of an illness or injury, or when the services are part of well-baby or well-adult care stated as covered under this contact.

Durable Medical Equipment and Prostheses If more than one treatment, prosthetic device, or piece of durable medical equipment may be provided for your disease or injury, Benefits will be based on the least expensive method of treatment, device, or equipment that can meet your needs.

Durable Medical Equipment We provide Benefits for the rental or purchase of durable medical equipment. Whether you rent or buy the equipment, we provide Benefits for the least expensive equipment necessary to meet your medical needs. If you rent the equipment, we will make monthly payments only until our share of the reasonable purchase price of the least expensive equipment is paid or until the equipment is no longer necessary, whichever comes first.

Benefits for replacement or repair of purchased durable medical equipment are subject to our approval. We do not provide Benefits for the repair or replacement of rented equipment.

Supplies are covered if they are necessary for the proper functioning of the durable medical equipment. Supplies for durable medical equipment are not subject to any durable medical equipment maximum applicable to this plan.

Prostheses We provide Benefits for prostheses. Prostheses include artificial limbs and prosthetic appliances. Prostheses to replace limbs (ie: arms or legs) are not subject to the plan Deductible. All other prostheses are subject to the Deductible. Please refer to the "Exclusions" section for additional information.

Emergency Room Care We provide Benefits for emergency room treatment received for medical emergencies. You or a designated person should contact your physician within 48 hours from the time you receive care.

Family Planning We provide Benefits for family planning. See the "Contraceptives" provision within this section for details.

Foot Care We provide Benefits for podiatry services, including systemic circulatory disease. Routine foot care is not covered.

Freestanding Imaging Centers We provide Benefits for diagnostic services performed by freestanding imaging centers. All services must be ordered by a professional.

Home Health Care Services We provide Benefits for home health care services when services are performed and billed by a home health care agency. A home health care agency must submit a written plan of care, and then provide the services as approved by us.

We provide Benefits for the following home health care services:

- Physician home and office visits;
- Registered nurse (RN) or licensed practical nurse (LPN) nursing visits;
- Services of home health aides when supervised by an RN;
- Paramedical services, including physical therapy, speech therapy, occupational therapy, inhalation therapy, and nutritional guidance;
- Supportive services, including prescription drugs, medical and surgical supplies, and oxygen.

Home Infusion Therapy We provide Benefits for home infusion therapy when provided and billed by a Home Infusion Therapy provider. Supplies and equipment needed to appropriately administer home infusion therapy are covered.

Hospice Care Services We provide Benefits for hospice care services furnished in your home by a home health agency to a member who is terminally ill and the member's family. A member who is terminally ill means a person who has a medical prognosis that the person's life expectancy is 12 months or less if the illness runs its normal course.

We provide Benefits for hospice care services by a home health agency up to 24 hours during each day of care. Hospice care services are provided according to a written care delivery plan developed by a hospice care provider and the recipient of hospice care services. Prior approval is required when care exceeds eight hours a day. In this case, the agency must submit a plan of care to receive approval. The agency must then submit a plan of care every 14 days to maintain approval. To be eligible for hospice care services, the patient need not be homebound or require skilled nursing services. Coverage for hospice care services is provided in either a home or inpatient setting.

Hospice care services include, but are not limited to: physician services, nursing care, respite care, medical and social work services, counseling services, nutritional counseling, pain and symptom management,

medical supplies and durable medical equipment, occupational, physical or speech therapies, home health care services, bereavement services and volunteer services.

Hospice Respite Care We provide Benefits for up to a 48-hour period for respite care. Respite care is intended to allow the person who regularly assists the patient at home, either a family member of other nonprofessional, to have personal time solely for relaxation. The patient may then need a temporary replacement to provide hospice care.

Before the patient receives respite care at home, a home health agency must submit a plan of care for approval. Prior approval is also required when respite care is provided by an inpatient hospice.

Inpatient Hospice Services We provide Benefits for inpatient hospice care at an acute care hospital or skilled nursing facility. The same services are covered for inpatient hospice care as are covered under inpatient hospital services.

Inborn Errors of Metabolism We provide Benefits for metabolic formula and up to $3,000 per member per Calendar Year for special modified low-protein food products. They must be specifically manufactured for patients with diseases caused by inborn errors of metabolism. This benefit is limited to those members with diseases caused by inborn errors of metabolism.

Independent Laboratories We provide Benefits for diagnostic services performed by independent laboratories. All services must be ordered by a professional.

Inhalation Therapy We provide Benefits for inhalation therapy by a licensed therapist for the administration of medications; gases such as oxygen, carbon dioxide, or helium; water vapor; or anesthetics.

Inpatient Hospital Services We provide Benefits for the following inpatient hospital services:

- Room and board, including general nursing care, special duty nursing, and special diets;
- Use of intensive care or coronary care unit;
- Diagnostic services;
- Medical, surgical, and central supplies;
- Treatment services;
- Hospital ancillary services including but not limited to use of operating room, anesthesia, laboratory, x-ray, and inpatient occupational therapy, physical therapy, inhalation therapy, and radiotherapy services;
- Phase I Cardiac Rehabilitation;
- Medication used when you are an inpatient, such as drugs, biologicals, and vaccines. This does not include the use of drugs for purposes not specified on their labels except for the diagnoses of cancer, HIV or AIDS unless approved by us for medically necessary accepted indications or as required by law. Any FDA Treatment Investigational New Drugs are not covered unless approved by us for medically accepted indications or as required by law;
- Blood and blood derivatives;
- Prostheses or orthotic devices;
- Newborn care, including routine well-baby care.

Benefits for an inpatient stay in a hospital will end with the earliest of the following events:

- You are discharged as an inpatient;
- You reach any Contract limits or maximums;
- Your physician, hospital personnel, or we notify you that inpatient care no longer meets our guidelines for continued hospital admission.

Manipulative Therapy We provide Benefits for up to 25 therapeutic adjustments and manipulations per member per Calendar Year for treating acute musculo-skeletal disorders. No Benefits are provided for ancillary treatment such as massage therapy, heat and electrostimulation unless in conjunction with an active course of treatment. Benefits are not provided for maintenance therapy for chronic conditions.

Medical Care We provide Benefits for medical care and services including office visits and consultations, hospital and skilled nursing facility visits, and pediatric services.

Medical Supplies We provide Benefits for medical supplies furnished by a provider in the course of delivering medically necessary services. This benefit does not apply to bandages and other disposable items that may be purchased without a prescription, except for syringes which are medically necessary for injecting insulin or a drug prescribed by a physician.

Mental Health and Substance Abuse Services We provide Benefits for inpatient, outpatient, and day treatment services for mental health and substance abuse when you receive them from a provider. You will receive maximum Benefits for mental health services when you receive care from network providers and professionals.

The "Utilization Management" section contains additional information and requirements for mental health and substance abuse services. If you do not call for preadmission review for nonemergency inpatient mental health and substance abuse services, your Benefits will be reduced by as much as $500 per admission.

If you receive provider services from a community mental health center or substance abuse treatment facility, services must be:

- Supervised by a licensed physician, licensed clinical psychologist, or licensed clinical social worker; and
- Part of a plan of treatment for furnishing such services established by the appropriate staff member.

We provide Benefits for only the following mental health and/or substance abuse treatment services:

- Room and board, including general nursing;
- Prescription drugs, biologicals, and solutions administered to inpatients;
- Supplies and use of equipment required for detoxification and rehabilitation;
- Diagnostic and evaluation services;
- Intervention and assessment;
- Facility-based professional and ancillary services;
- Individual, group and family counseling;
- Psychological testing;
- Emergency treatment for the sudden onset of a mental health or substance abuse condition requiring immediate and acute treatment.
- Intervention and assessment.

All covered inpatient and day treatment mental health and substance abuse services are paid at 80% of allowed charges after you have met your Deductible. The Deductible is waived if you receive covered non-residential services. We provide Benefits up to 31 inpatient days, or 31 non-residential rehabilitation days per Calendar Year. This 31 day limit applies as a combined maximum for all covered inpatient mental health and substance abuse treatment services.

All covered outpatient and office visit mental health and substance abuse services are paid at 50% of allowed charges after you have met your Deductible. We provide Benefits for up to 25 visits per member per Calendar Year. This limit applies as a combined limit for all covered outpatient mental health and substance abuse treatment services.

Obstetrical Services and Newborn Care We provide Benefits for prenatal and postnatal care, delivery of a newborn, care of a newborn, and complications of pregnancy. We do not provide Benefits for routine circumcisions.
Routine newborn care does not include any services provided after the mother has been discharged from the hospital. All other plan provisions such as deductible and coinsurance, if applicable, will apply to the newborn if the mother is discharged and the newborn remains in the hospital.

Office Visits We provide Benefits for office visits.

Organ and Tissue Transplants We provide Benefits for organ and tissue transplant procedures listed below. You must receive prior approval from us before you are admitted for any transplant procedure. Your physician will work with our registered nurses and physician advisors to evaluate your condition and determine the medical appropriateness of a transplant procedure. **Failure to receive approval prior to admission may result in a denial or reduction of Benefits.**

Transplants include:
heart, heart/lung, lung, islet tissue, liver, adrenal gland, bone, cartilage, muscle, skin, tendon, heart valve, blood vessel, parathyroid, kidney, cornea, allogeneic bone marrow, pancreas, and autologous bone marrow.

No other organ or tissue transplant is covered. We will not pay any Benefits for any services related to a transplant we do not cover.

We provide Benefits as follows:
- If both the donor and the recipient are covered members of ours, we will provide Benefits to cover both patients for organ and tissue transplants;
- If the recipient is a member under a Contract with us but the donor is not, then we will provide Benefits for both the recipient and donor as long as similar Benefits are not available to the donor from other sources;
- If the recipient is not a member under a Contract with us but the donor is a member, we will not provide Benefits to either the donor or the recipient.

Orthotic Devices We provide Benefits for certain orthotic devices, such as orthopedic braces, back or surgical corsets, and splints. We do not provide Benefits for the following whether available over the counter or by prescription: arch supports, shoe inserts, other foot support devices, orthopedic shoes (unless attached to a brace), support hose, and garter belts.

Outpatient Services We provide Benefits for the following hospital outpatient and rural health center services:

- Emergency room services/emergency care;
- Removal of sutures;
- Application or removal of a cast;
- Diagnostic services;
- Surgical services;
- Removal of impacted or unerupted teeth;
- Endoscopic procedures;
- Blood administration;
- Radiation therapy;
- Outpatient rehabilitation programs including covered Phase II cardiac rehabilitation, physical rehabilitation, head injury rehabilitation, pulmonary rehabilitation, and dialysis training. Benefits for these services have special requirements. Please check with us to see if you are eligible for Benefits;
- Outpatient educational programs such as asthma education and diabetes education. Please check with us to see of you are eligible for Benefits.

Parenteral and Enteral Therapy We provide Benefits for parenteral and enteral therapy. Supplies and equipment needed to appropriately administer parenteral and enteral therapy are covered. Nutritional supplements for the sole purpose of enhancing dietary intake are not covered unless they are given in conjunction with enteral therapy.

Prescription Drugs We provide Benefits under your prescription drug card program for FDA approved prescription drugs and medicines bought for use outside a hospital. This includes coverage of necessary supplies and equipment needed to appropriately administer medications, including clinically approved hyperalimentation supplies.

Certain prescription drugs (or the prescribed quantity of a particular drug) may require prior authorization of Benefits. Prior authorization helps promote appropriate utilization and enforcement of guidelines for prescription drug benefit coverage. At the time you fill a prescription, the network pharmacist is informed of the prior authorization requirement through the pharmacy's computer system and the pharmacist is instructed to contact Anthem Prescription Management (APM). APM is a pharmacy benefit management company with which we contract to manage your pharmacy Benefits. Please see the "Benefit Determinations, Payments and Appeals" section for additional information about APM.

APM uses pre-approved criteria, developed by Anthem's Pharmacy and Therapeutics Committee and reviewed and adopted by Anthem. APM communicates the results of the decision to the pharmacist. APM may contact your prescribing physician if additional information is required to determine whether prior authorization should be granted. If prior authorization is denied, you have the right to Appeal through the Appeals process outlined in the "Benefit Determinations, Payments and Appeals" section of this Certificate.

For a list of current drugs requiring prior authorization, please contact a customer service representative at the number on the back of your ID card or consult APM's website at **www.anthemprescription.com.** The formulary is subject to periodic review and amendment. Inclusion of a drug or related item on the formulary is not a guarantee of coverage.

We may determine, after consideration of recommendations from our Pharmacy & Therapeutics Committee, dispensing limitations for certain prescription drugs. Please call our Customer Service department at the telephone number on your ID card for information on dispensing limitations.

Prescription Drugs From A Retail Pharmacy When your prescription is filled at a retail pharmacy, you pay the pharmacy the price of the prescription in full. The pharmacy will file the claim for you and Anthem will pay you directly, minus any Deductible and Coinsurance amount, if applicable.

Prescription Drugs By Mail Your Contract may allow you to obtain prescription drugs by mail. To obtain Benefits for prescription drugs by mail, complete a mail order pharmacy form, available through our Customer Services Department, and mail it with your prescription. Please call the telephone number on the mail order pharmacy form to speak with a representative regarding the amount to include with your order.

Prescription Supplies Benefits are provided for up to a 90-day supply if prescribed by your physician as medically appropriate.

Changes In Your Prescription Your pharmacist may check your prescription to determine if there may be harmful interactions between the prescription you are filling and any other prescription you may be taking. The pharmacist may contact your physician to discuss possible changes to your prescription.

Refills on Prescriptions Your physician will indicate the number of refills for your prescription. We will cover the refill for your prescription when you have taken 75% of the medication (based on the dosage schedule prescribed by the physician) or within 10 days of the refill date, whichever is greater. We will not provide Benefits for refills that are filled sooner.

Vacation Supplies If you are going out of the area for an extended period of time and your supply of medications is not sufficient for this period, you may contact your pharmacy or the prescribing physician prior to leaving the area to receive an early refill or an extended-day supply of medications while you are away from home.

Preventive and Well-Care Services We provide Benefits for the following preventive and well-care services.

Well-baby/child care:

- Prenatal care;
- Initial hospital care;
- Well-child care through age 2 (8 exams) including standard routine pediatric immunizations.

Well-adult care:

- Annual screening mammograms for women (Benefits are limited to two radiographic views per breast);
- Annual screening Pap tests performed by a physician, certified nurse practitioner, or certified nurse midwife when recommended by a physician;
- Annual gynecological examinations, including routine pelvic and clinical breast examinations performed by a network physician, certified nurse practitioner or certified nurse midwife;
- Annual prostate specific antigen testing and digital rectal examinations.

Radiation Therapy We provide Benefits for radiation therapy.

Reconstructive Services We provide Benefits for reconstructive services, unless otherwise excluded in this Contract, to improve or restore bodily function or to correct deformity resulting from disease, trauma, or previous therapeutic process, or for congenital or developmental anomalies. Benefits are provided only when there is a functional impairment. Benefits will be provided for reconstruction of a breast on which mastectomy surgery has been performed and for surgery and reconstruction of the other breast to produce a symmetrical appearance when the mastectomy is for the treatment of breast cancer.

Skilled Nursing Facility Services We provide Benefits for inpatient skilled nursing facility services. Skilled nursing facility services are limited to 365 days per member per Calendar Year. We do not cover custodial confinement.

Smoking Cessation We provide Benefits for nicotine replacement therapy (NRT) products and any other medication specifically approved by the FDA for smoking cessation. To be eligible for Benefits, these products and medications must be prescribed by your physician.

- NRT products can include but are not limited to, nicotine patches, gum, or nasal spray. Benefits are limited to $200 per member per Calendar Year with a $400 lifetime maximum benefit.
- We provide Benefits for up to two physician office visits per Calendar Year for follow-up smoking cessation education and counseling.
- We provide Benefits for completing an approved smoking cessation program. Benefits are limited to $35 per program with a $70 lifetime maximum benefit.

Any applicable Deductibles and Coinsurance apply.

Speech, Physical and Occupational Therapy We provide Benefits for short-term speech, physical and occupational therapy on an outpatient basis for conditions that are subject to significant improvement. Benefits are subject to a combined of $3,000 per Calendar Year. Services are covered only when provided by a licensed professional acting within the scope of his/her license.

No Benefits are provided for treatments such as: massage therapy, paraffin baths, hot packs, whirlpools, or moist/dry heat applications unless in conjunction with an active course of treatment.

No Benefits are provided for speech therapy for deficiencies resulting from mental retardation, or dysfunctions that are self-correcting, such as language treatment for young children with natural dysfluency or developmental articulation errors

Surgical Services We provide Benefits for covered surgical procedures, including services of a surgeon, specialist, anesthetist or anesthesiologist, and for preoperative and postoperative care. We provide Benefits for a surgical assistant when the complexity of the surgery warrants an assistant. We reserve the right to determine when surgical assistant services are required.

Section Four
Exclusions

This section, along with the "Covered Services" section, explains the types of health care services we will and will not provide Benefits for. The exclusions listed below are in addition to those set forth elsewhere in this Certificate. Charges you pay for services related to non-covered services do not count toward any Deductible, Coinsurance, or out-of-pocket limits.

Acupuncture We do not provider Benefits for acupuncture.

Alternative Medicines or Complementary Medicines We do not provide Benefits for alternative or complementary medicine. Alternative or complementary medicine is any protocol or therapy for which the clinical effectiveness has not been proven or established, as determined by Anthem Blue Cross and Blue Shield's Medical Director. Services in this category include, but are not limited to, , , holistic medicine, homeopathy, hypnosis, aroma therapy, massage therapy (unless otherwise stated in the Covered Services section), reike therapy, herbal, vitamin or dietary products or therapies, naturopathy, thermography, orthomolecular therapy, contact reflex analysis, bioenergial synchronization technique (BEST) and iridology-study of the iris.

Artificial Hearts We do not provide Benefits for services and supplies related to artificial and/or mechanical hearts or ventricular and/or atrial assist devices related to a heart condition or for subsequent services and supplies for a heart condition as long as any of the above devices remain in place. This exclusion includes services for implantation, removal and complications. This exclusion does not apply to Left Ventricular Assist Devices when used as a bridge to a heart transplant.

Benefits Available from Other Sources We do not provide Benefits for any services to the extent that there is no charge to you or to the extent that you can recover expenses through a federal, state, county, or municipal law. This is the case even if you waive or fail to assert your rights under these laws. However, this exclusion does not apply to Medicaid.

Biofeedback We do no provide Benefits for biofeedback.

Blood We do not provide Benefits for any blood, blood donors, or packed red blood cells when participation in a voluntary blood program is available.

Cosmetic Services We do not provide Benefits for cosmetic services intended solely to change or improve appearance, or to treat emotional, psychiatric or psychological conditions. Examples of cosmetic services include, but are not limited to: surgery or treatments to change the size, shape or appearance of facial or body features (such as your nose, eyes, ears, cheeks, chin, chest or breasts). Benefits will be provided for reconstruction of a breast on which mastectomy surgery has been performed and for surgery and reconstruction of the other breast to produce a symmetrical appearance when the mastectomy is for the treatment of breast cancer.

Custodial Care We do not provide Benefits for services, supplies or charges for Custodial Care, domiciliary or convalescent care, whether or not recommended or performed by a professional.

Dental Services We do not provide Benefits for orthognathic surgery, dentistry, dental surgery, dental implants or any other services unless specifically listed as covered in the "Covered Services" section.

Department of Veterans Affairs We do not provide Benefits for any treatments, services, or supplies provided to veterans by the Department of Veterans Affairs, its hospitals, or facilities if the treatment is related to your service connected disability.

Experimental/Investigational Services We do not provide Benefits for any drugs, supplies, providers, medical, or health care services that are experimental/investigational. This exclusion includes the cost of all services from a provider or professional including the cost of all services while you are an inpatient receiving an experimental/investigational service or surgery. Drugs classified as Treatment Investigational New Drugs (IND) by the FDA and devices with the FDA Investigational Device Exemption (IDE), except as required by law, and any device to which the FDA has limited access or otherwise limited approval are considered experimental/investigational.

Facilities of the Uniformed Services We do not provide Benefits for any treatments, services, or supplies provided by or through any health care facility of the uniformed services. This exclusion does not apply if you are a military dependent or retiree.

Family Planning Services We do not provide Benefits for services to reverse voluntarily induced sterility; non-prescriptive birth control preparations (such as foams or jellies); and over-the-counter contraceptive devices.

Genetic Testing and Counseling We do not provide Benefits for genetic testing or genetic counseling to diagnose a condition. Genetic testing and counseling performed on a previously diagnosed patient is covered only if the genetic testing and counseling is required to plan treatment of the diagnosed condition.

Government Institutions We do not provide Benefits for any services provided to you by any institution that is owned or operated by the federal government or any state, county, or municipal government.

Hearing Care We do not provide Benefits for hearing examinations except when related to injury or disease. We do not provide Benefits for the prescription, fitting, or purchase of hearing aids including audiant bone conductors.

Infertility We do not provide Benefits for diagnostic services, procedures, treatment or other services related to infertility. This exclusion also applies to drugs used to enhance fertility. We do not provide Benefits for costs associated with achieving pregnancy through surrogacy.

Leased Services and Facilities We do not provide Benefits for any health care services or facilities that are not regularly available in the provider you go to, that the provider must rent or make special arrangements to provide, and that are billed independently.

Maintenance Therapy We do not provide Benefits for maintenance services, treatments or therapy.

Major Disaster, Epidemic, or War In the event of a major disaster, epidemic, war (declared or undeclared), or other circumstances beyond our control, we will make a good faith effort to provide or arrange for covered services. We will not be responsible for any delay or failure to provide services due to lack of available facilities or personnel. Benefits are not provided for any disease or injury that is a result of war, declared or undeclared, or any act of war.

Medically Unnecessary Services We do not provide Benefits for any treatment, services, or supplies that do not meet the definition of medically necessary health care.

Medicare We may not provide Benefits in situations where Medicare would have primary liability for health care costs under federal Medicare Secondary Payor regulations. If you are enrolled in Medicare Part A and/or Part B, and Medicare is the primary payor, we may provide Benefits only for balances remaining after Medicare has made payment. If you are eligible for premium free Medicare Part A, and Medicare would be the primary payor, we may pay Benefits as if Medicare had made their primary payments for Medicare Part A and/or Part B, even if you fail to exercise your right to premium free Medicare Part A coverage.

Mental Health, Substance Abuse Treatment, and Lifestyle Services We do not provide Benefits for any of the following services or any services relating to:

- Smoking clinics;
- Sensitivity training;
- Encounter groups;
- Educational programs except as indicated in the "Covered Services" section;
- Marriage, guidance, and career counseling;
- Codependency;
- Adult Children of Alcoholics (ACOA);
- Pain control (except as required by law for hospice care services);
- Activities whose primary purpose is recreational and socialization;
- Services by an independently billing professional for treating substance abuse.

Miscellaneous Expenses We do not provide Benefits for provider or professional charges to provide required information to process a claim or application for coverage. We do not provide Benefits for any additional costs associated with an Appeal of a claim decision.

Missed Appointments We do not provide Benefits for missed appointments. Providers and/or professionals may charge you for failing to keep scheduled appointments without giving reasonable notice to the office. No Benefits are available for these charges. You are solely responsible for these charges.

Orthognathic Surgery We do not provide Benefits for orthognathic surgery.

Orthotic Devices We do not provide Benefits for orthotic devices unless stated as covered in the "Covered Services" section of this Contract.

Personal Comfort Items We do not provide Benefits for any personal comfort items such as television rentals, newspapers, telephones, and guest meals.

Physical and Occupational Therapy We do not provide Benefits for massage therapy, treatment such as paraffin baths, hot packs, whirlpools, or moist/dry heat applications unless in conjunction with an active course of treatment.

Pre-existing Conditions Limitation We may not provide Benefits for any treatments, services, supplies, prescription drugs, medical equipment or prostheses provided to you for a pre-existing condition for up to 12 months from your enrollment date. In certain circumstances this pre-existing condition restriction may be partially or wholly waived. Please see the "Continuity of Coverage" provision in the "Eligibility, Termination, and Continuation of Coverage" section for more information.

Pregnancy Which Began Before the Effective Date We do not provide Benefits for pre- and postnatal care or delivery if conception occurs prior to the effective date of this Contract unless the mother qualifies for a waiver of pre-existing condition restrictions as described in the "Continuity of Coverage" subsection of the "Eligibility and Termination of Coverage" section.

Protheses We do not provide Benefits for dental prostheses, or prosthetic devices to replace, in whole or in part, an arm or a leg that are designed exclusively for athletic purposes or contain a microprocessor.

Prescription Drugs We do not provide Benefits for the following:

- Any refill in excess of the number specified by the physician or for refills dispensed after one year from the date of original prescription order;
- Non-prescription vitamins, prescription and non-prescription multivitamins (other than prescription prenatal vitamins for perinatal care), cosmetics, dietary supplements, health or beauty aids, dermatologicals used for cosmetic purposes, topical dental fluorides;
- Nonlegend (over-the-counter) prescriptions, including but not limited to, prescriptions for which there is an over-the-counter (OTC) equivalent in both strength and dosage form;
- Prescription drugs for the treatment of weight reduction/anorectics;
- Medication that is taken by or administered to an inpatient;
- Experimental or investigational drugs or any Food and Drug Administration (FDA) Treatment Investigational New Drugs (IND), unless the intended use of the drug is included in the labeling authorized by the federal Food and Drug Administration or if the use of the drug is recognized in one of the standard reference compendia or in peer-reviewed medical literature;
- Disposable supplies such as alcohol, cotton balls, or bandages used to administer medications;
- Prescription drugs dispensed by a physician;
- Prescription drugs used to enhance fertility;
- Prescription drugs approved by the Federal Drug Administration (FDA) used for purposes not specified on their labels except for the diagnoses of cancer, HIV or AIDS, unless approved by us for medically accepted indications or as required by law.

Preventive Care We do not provide Benefits for preventive care and well-care services, unless otherwise stated in the "Covered Services" section.

Refractive Eye Surgery We do not provide Benefits for refractive eye surgery, such as radial keratotomy, for conditions that can be corrected by means other than surgery.

Routine Circumcisions We do not provide Benefits for routine circumcisions.

Routine Foot Care We do not provide Benefits for any services rendered as part of routine foot care.

Services After Your Contract Ends We do not provide Benefits for services that are provided after your Contract ends unless you are an inpatient at the time. All Benefits will stop when you are discharged as an inpatient or when you reach any of this Contract's maximum, whichever comes first.

Services Before the Effective Date We do not provide Benefits for any treatment, services, supplies, medical equipment, or prostheses rendered to you or received before your individual effective date of coverage. We do not provide Benefits for any services you receive, including, a hospital stay that started prior to the effective date of coverage or while Benefits were available under a previous Contract.

Services by Ineligible Providers or Professionals We do not provide Benefits for services provided by any provider or professional not listed as an eligible provider or professional in this Contract.

Services by Relatives or Volunteers We do not provide Benefits for any services provided in any capacity by immediate family members or step-family members, for example, spouse, father, mother, brother, sister, son or daughter. We do not provide Benefits for services by volunteers, except as outlined in the "Hospice Care Services" provision.

Services Not Listed As Covered We do not provide Benefits for any service, procedure, or supply not listed as a covered service in this Contract.

Services Related to Non-Covered Services We do not provide Benefits for services related to any non-covered service or to any complications and conditions resulting from any non-covered service.

Sex Changes We do not provide Benefits for any services related to any transsexual operation.

Shoe Inserts We do not provide Benefits for shoe inserts.

Speech Therapy We do not provide Benefits for deficiencies resulting from mental retardation and/or dysfunctions that are self-correcting, such as language treatment for young children with natural dysfluency or developmental articulation errors.

Sterilizations and Reversals of Sterilizations We do not provide Benefits for sterilizations or services to reverse voluntarily induced sterility.

Temporomandibular Joint (TMJ) Syndrome Services We do not provide Benefits for surgical and non-surgical examination; diagnosis, including invasive (internal) and non-invasive (external) procedures and tests; and all services related to diagnosis and treatment, both medical and surgical, of temporomandibular joint dysfunction or syndrome also called myofascial pain dysfunction or craniomandibular pain syndrome. Examples of non-Covered Services include but are not limited to: physiotherapy, such as therapeutic muscle exercises, galvanic or transcutaneous nerve stimulation; vapocoolant sprays, ultrasound, or diathermy; behavior modification such as biofeedback, psychotherapy; appliance therapy such as occlusal appliances (splints) or other oral Prosthetic Devices and their adjustments; orthodontic therapy such as braces; prosthodontic therapy such as crowns, bridgework; and occlusal adjustments.

This exclusion does not apply to services listed as covered in the "Dental Services" provision.

Travel Expenses We do not provide Benefits for any travel expenses, whether or not the travel is recommended by a professional.

Vision Care We do not provide Benefits for vision therapy, including treatment such as vision training, orthoptics, eye training, or eye exercises. We do not provide Benefits for the prescription, fitting, or purchase of glasses or contact lenses except when medically necessary to treat accommodative strabismus, cataracts, or aphakia.

Weight Reduction Programs We do not provide Benefits for weight reduction programs.

Workers' Compensation We do not provide Benefits for any condition, ailment, or injury that arises out of and in the course of employment or any disability that develops because of an occupational disease. We do not provide Benefits for services or supplies, to the extent that they are obtained, either completely or partially, under any Workers' Compensation Act or similar law, or would be obtainable under these laws but for a waiver or failure to assert your rights under these laws. However, we do provide Benefits if you are entitled under the applicable workers' compensation law to waive all workers' compensation coverage, and do so before the condition, ailment, or injury occurs. We will pay Benefits on a provisional basis for treatment of a contested work-related condition, ailment, or injury **only if all the following conditions are met**:

- You are making a claim under the Workers' Compensation Act;
- Your health care coverage is provided through an employee health plan;
- Your employer or your employer's workers' compensation insurer has filed a notice of controversy stating that your claim is being denied for work-relatedness;
- The Workers' Compensation Board has not made a determination on your claim;
- Your employer has made no payment on or settlement of your claim.

Even though you may be submitting a claim under the Workers' Compensation Act, you should also submit your claims under this plan, as discussed in the "Benefit Determinations, Payments and Appeals" section.

Section Five
Benefit Determinations, Payments and Appeals

Benefit Determinations

We, or anyone acting on our behalf, shall determine the administration of Benefits and eligibility for participation in such a manner that has a rational relationship to the terms of the Contract. However, We, or anyone acting on our behalf, have complete discretion to determine the administration of your Benefits. Our determination shall be final and conclusive and may include, without limitation, determination of whether the services, care, treatment, or supplies are Medically Necessary, Investigational/Experimental, whether surgery is cosmetic, and whether charges are consistent with our Maximum Allowance. However, you may utilize all applicable Complaint and Appeal procedures, as outlined later in this section.

You may have some responsibility for the cost of health services under your Contract. Your responsibility may take the form of a Coinsurance percentage or a Deductible amount. Please see the "Covered Services" section for the Coinsurance and Deductible amounts that apply to your coverage. If you have some responsibility for the cost of health care services you receive, you will pay your Coinsurance and Deductible amount directly to the professional or hospital or other provider of care. Note: We cannot prohibit Non-Network Providers from billing you for the difference in the Non-Network Provider's charge and the Maximum Allowance.

All Benefits for covered services will be based on any discounted charge for hospital service or our Maximum Allowance for professional services.

If you have Coinsurance responsibility that is based on a percentage, you will pay your Coinsurance percentage based on the hospital's or provider's discounted charge or negotiated amount, or our Maximum Allowance for professionals.

We may subcontract particular services to organizations or entities that have specialized expertise in certain areas. This may include, but is not limited to, prescription drugs, mental health, behavioral health and substance abuse services. Such subcontracted organizations or entities may make Benefit determinations and/or perform administrative, claims paying, or customer service duties on our behalf.

Benefit Levels There are two levels of Benefits under this Contract:

Network Providers If your claim from a network provider is approved, we will pay Benefits directly to the network provider. Except for Deductibles and Coinsurance, you are not required to pay any balances to the provider for covered services until after we determine the Benefits we will pay.

Non-Network Providers If you receive covered services or supplies from a provider that does not have a written agreement with us, we will determine Benefits based on the provider's eligibility and licensing. If we do approve your claim, Benefits will be paid at the non-network level of Benefits. You will be responsible for the difference between the non-network provider's charge and our Maximum Allowance amount, in addition to any applicable Deductible and Coinsurance. We cannot prohibit non-network providers from billing you for the difference in the non-network provider's charge and our Maximum Allowance.

If a Network Provider of the same specialty is not reasonably accessible, as defined by state law, services received from a Non-network Provider will be paid at the higher level of Benefits. In this circumstance, please call the number on the back of your ID card to coordinate care through a non-network provider.

How Your Deductible Works

Each Calendar Year before Benefits can be paid for covered services, you must pay your Deductible. The Deductible is the amount you must pay toward the cost of covered services before Benefits are paid.

Deductible and coinsurance, if applicable, will apply to a newborn if the mother is discharged and the newborn remains in the hospital.
When you receive covered services during the last three months of the Calendar Year and charges for these covered services are applied toward that year's Deductible, except for mental health and substance abuse services, then these same charges will also be applied toward the Deductible for the following year.

Family Deductible Under family coverage, if the total family expenses for covered services exceed two times the individual Deductible, then your family Deductible under this Contract has been met for the Calendar Year. In this case, all family members will be eligible for Benefits for the rest of the Calendar Year without meeting further Deductibles. One family member may not meet the family Deductible amount. The family Deductible amount must be satisfied by at least two family members.

One Deductible For a Common Accident Under family coverage, if two or more family members are injured in the same accident, only one Deductible will apply for all covered services resulting from that accident during a Calendar Year.

Coinsurance

For some services, your share of the cost is a percentage which is limited to an annual dollar amount. This is the Coinsurance amount.

If your Contract has a Coinsurance requirement it applies after you have satisfied your Deductible. Your share of the costs for most covered services is 20% and is limited to an annual dollar limit. The annual dollar limit is called the Coinsurance limit. Your individual Coinsurance limit is shown on your ID card.

Under family coverage, if the total family Coinsurance expenses exceed two times the individual Coinsurance limit, your family Coinsurance limit under this Contract has been met for the Calendar Year. In this case, all family members will be eligible for Benefits for the rest of the Calendar Year without paying further Coinsurance. One family Member cannot meet the family Coinsurance limit.

If you have a Contract that pays 100% of the hospital's or provider's discounted charge or negotiated amount or our Maximum Allowance for professionals, for most covered services after your meet your Deductible, your ID card will show $0 as the Coinsurance limit that you must meet before Benefits are paid at 100% of our Maximum Allowance.

If services are received from a provider or professional that does not have a written participation agreement with us there may be instances in which you may be responsible for any remaining balances beyond the Maximum Allowance in addition to any applicable Coinsurance or Deductible. We cannot prohibit Non-Network Providers from billing you for the difference in the Non-Network Provider's charge and the Maximum Allowance.

For most provider and professional services, once you meet your individual or family Coinsurance limit, if applicable, Benefits will be paid at 100% of the hospital's or provider's discounted charge or negotiated amount or our Maximum Allowance for professionals for the remainder of the Calendar Year, up to the lifetime maximum for all covered services. Mental health and substance abuse services and services received from a non-network provider or professional will paid at the levels specified in your Contract up to any Benefit or lifetime maximum. For more information on the Coinsurance percentages, please refer to the "Mental Health and Substance Abuse" provision in the "Covered Services" section of this Certificate. Coinsurance amounts you pay toward mental health and substance abuse Benefits do not count toward your Coinsurance limit.

Out-of-Pocket Limits

Your annual out-of-pocket expenses for your Deductible and Coinsurance may be limited. Once you reach the annual out-of-pocket limit, no further Deductibles and Coinsurance, apply for the remainder of the Calendar Year (except for mental health and substance abuse Coinsurance).

Lifetime Maximums

Your Contract has a limit on the maximum amount for which we are responsible during the lifetime of any covered member. The lifetime maximum under this Contract is $3,000,000. The lifetime maximum for mental health and substance abuse is $25,000. All Benefit amounts for which we are responsible, over and above your Coinsurance payments, are accumulated toward your lifetime maximum under your Contract. Once Benefit amounts equal to the lifetime maximum have been accumulated, we will not be liable for any further payments for covered services you incur. The amount we credit toward any lifetime maximum is the undiscounted hospital charge or our maximum allowance for professional services.

Benefit Maximums

Specific Benefit maximums for each covered member may apply for mental health or substance abuse and other services. These maximums are listed in the Contract. The amount we credit toward any specific Benefit maximum is the undiscounted hospital or provider charge or our maximum allowance for professional services.

Contract Changes

We may change this Contract at any time provided the changes are in accordance with all applicable laws and we send written notice thirty days in advance to the subscriber's latest address in our records. After we notify the subscriber of a change, payment of billed charges indicates the acceptance of the change.

Compliance with Laws

If federal laws or the relevant laws of the state of Maine change, the provisions of this Contract will automatically change to comply with those laws as of their effective dates. Any provision that does not conform with applicable federal laws or the relevant laws of the state of Maine will not be rendered invalid, but will be construed and applied as if it were in full compliance.

Confidentiality

Any information pertaining to your diagnosis, treatment or health obtained from either your physician, provider or you will be held in confidence. We may use or disclose this information only to the extent required or permitted by law. Please refer to Anthem's privacy protection annual notice for our privacy policies and procedures.

Statements and Representations

The statements you make on your application for coverage with us are representations and not warranties.

Annual Reports

Annual reports are prepared and made available to all employees. The annual report contains information about our activities including audited financial statements.

Severability

If any term or provision in this Certificate is deemed invalid or unenforceable, this does not affect the validity or enforceability of any other term or provision.

Benefit Payments

Claims Procedure

How to Claim Benefits In most instances, providers and professionals will file your claims with us. However, you may need to submit a claim for reimbursement for services from non-network providers and professionals.

To receive claim forms, contact your employer or call our Customer Service Department. When you submit your claim, please include originals of all of your bills and retain a copy for your files.

Time Limit for Filing Claims We must receive proof of a claim for reimbursement for a covered service no later than 365 days after that service is received. We recognize that there may be special circumstances which would prevent a claim from being submitted within the 365-day time limit. Claims denied for timely filing may be reviewed through the Member Appeal process, which will consider whether the claim was filed as soon as reasonably possible.

Releasing Necessary Information Providers and professionals often have information we need to determine your coverage. As a condition for receiving Benefits under this Contract, you or your representative must give us all of the medical information needed to determine your eligibility for coverage or to process your claim.

Non-Transfer of Benefits Your Benefits under this Contract are personal to you. You cannot assign or transfer them to any other person.

Assignment of Payments You may assign Benefits provided for covered services to the provider of the care.

Non-Compliance If we do not enforce compliance with any provision of this Contract, we have not waived compliance are not required to allow non-compliance with that provision or any other provision at any time, in any case.

Examination of Insured To ensure that all claims are valid, we may require the member to have a physical or mental examination at our expense.

Claims Payment

This section explains how Benefits for covered services will be paid. Benefits will never be more than the actual charge. You will receive maximum Benefits when you receive services from network providers and professionals. We reserve the right to pay Benefits to another person if so ordered by a court of competent jurisdiction. You have the right to Appeal as outlined later in this section.

Payment of Provider Services

Network Providers If your claim from a network provider is approved, Benefits will be paid directly to the provider. Our payment will be based on the most cost effective means that can be safely administered. Except of Deductibles and Coinsurance, if applicable, you are not required to pay any balances to the provider until after we determine the Benefits we will pay. Network providers who render covered services that are based on a Maximum Allowance agree to limit their charges to the Maximum Allowance.

Non-Network Providers If you receive covered services or supplies from a provider that does not have a written participation agreement with us, we will decide if we will pay Benefits. We will base this decision on factors such as the provider's ability to meet certain standards for licensure and expertise to meet the needs of the member. Our payment will be based on the most cost effective means that can be safely administered. If we do approve your claim, Benefits will not be more than 80% or what we normally pay to network provider. We will pay Benefits directly to you or the provider. However, if you receive emergency room care, we will not reduce the Benefits. We cannot prohibit Non-Network Providers from billing you for the difference in the Non-Network Provider's charge and our Maximum Allowance.

Payment for Professional Services

Network Professionals If your claim from a network professional is approved, Benefits will be paid directly to the professional. Our payment will be based on the most cost effective means that can be safely administered. Except of Deductibles and Coinsurance, if applicable, you are not required to pay any. balances to the professional until after we determine the Benefits we will pay. Network professionals who render covered services that are based on a Maximum Allowance agree to limit their charges to the Maximum Allowance unless you and the professional make prior arrangements.

Your Network Professional's agreement for providing covered services may include financial incentives or risk sharing relationships related to provision of services or referrals to other Professionals, including Network Professionals and Non-network Professionals and disease management programs. If you have questions regarding such incentives or risk sharing relationships, please contact your Professional or us.

Non-Network Professionals If you receive covered services or supplies from a professional that does not have a written agreement with us, we will decide if we will pay Benefits. We will base this decision on factors such as the professional's ability to meet certain standards for licensure and expertise to meet the needs of the member. Our payment will be based on the most cost effective means that can be safely administered. If we do approve your claim, Benefits will be 80% of what we normally pay a network professional. We will pay Benefits directly to you. If you receive Accident Care within 72 hours of the accident, Benefits will be reimbursed at the network professional. We cannot prohibit Non-Network Providers from billing you for the difference in the Non-Network Provider's charge and our Maximum Allowance.

Provider and Professional Payment Methods

The Maximum Allowance for a service is determined based upon the resources needed to provide a given service. The resources taken into account are a provider's or professional's total work, practice costs, and malpractice costs which are added together. The total is multiplied by a common scale monetary conversion factor to establish the Maximum Allowance. Our payment will be based on the most cost effective means that can safely be administered. You can contact us to find out the Maximum Allowance for a service by calling the telephone number on your ID card.

We generally pay providers in several different ways. These ways may include discounts from regular charges and fixed fees.

We generally pay specialists and professionals for each covered service they provide, based on a Maximum Allowance.

Out-of-State Providers and Professionals We cannot prohibit out-of-state providers from billing you any balance remaining after we have made our payment based on the maximum allowable amount, except as otherwise provided under the BlueCard program.

BlueCard Program

When you obtain health care services through the BlueCard program outside of Maine, the amount you pay for covered services is calculated on the lower of:

- The billed charges for your covered services, or
- The negotiated price that the on-site Blue Cross and/or Blue Shield Plan ("Host Plan") passes on to us.

The negotiated price may consist of any or all of the following:

1. A simple discount which reflects the actual price paid by the Host Plan.
2. An estimated price that factors into the actual price expected settlements, withholds, non-claims transactions, or other types of variable payments, with your health care provider or with a specified group of providers.
3. Billed charges reduced to reflect an average expected savings after taking into account the same special arrangements used to obtain an estimated price.

The price that reflects average savings may result in a greater variation (more or less) from the actual price paid than will the estimated price.

The negotiated price will also be adjusted in the future to correct for over- or underestimation of past prices. However, the amount you pay is considered a final price.

Also, laws in a small number of states may require Blue Cross and/or Blue Shield Plans to add a surcharge or to use a basis for calculating member liability for covered services that does not reflect the entire savings realized, or expected to be realized, on a particular claim. Should any state laws require a surcharge or member liability calculation methods that differ from the method outlined above, we would then calculate your liability for any covered health care services in accordance with the applicable state statute in effect at the time you received your care.

Hospitals Outside of the United States

We provide Benefits for inpatient and outpatient services in a foreign hospital. If you obtain covered services outside of the United States, in most cases you will have to pay your bill when you leave the hospital. Please refer to the "Utilization Management" section for details pertaining to authorizations. When you return home, send the following to us with your claim form:

- A statement of the nature of the illness or injury;
- An itemized statement translated into English (accompanied by the original statement) showing the services received and the date(s) of service;
- Your Contract number; and
- The dollar rate of exchange at the time you received the service(s), if possible.

When we receive this information, we will reimburse you for covered services according to the terms of this Contract.

Anthem Prescription Management (APM)

The pharmacy Benefits available to you under this Plan are managed by our affiliate, Anthem Prescription Management (APM). APM is a pharmacy Benefits management (PBM) company with which we contract to manage your pharmacy Benefits. APM has a nationwide network of retail pharmacies, a mail service pharmacy, and clinical services that include formulary management.

The management and other services APM provides include, among others, making recommendations to, and updating, the formulary and managing a network of retail pharmacies and operating a mail service pharmacy. APM, in consultation with Anthem, also provides services to promote and enforce the appropriate use of pharmacy Benefits, such as review for possible excessive use; proper dosage; drug interactions or drug/pregnancy concerns.

You may review a copy of the current formulary on APM's website at: www.anthemprescription.com. You may also request a copy of the formulary by calling a customer service representative at the number of the back of your ID card. The formulary is subject to periodic review and amendment. Inclusion of a drug or related item on the formulary is not a guarantee of coverage. Refer to the prescription drug Benefit sections in this Certificate for information on coverage, limitations and exclusions.

Payment for Prescription Drug Claims To obtain Benefits for prescription drugs, present your identification card to any pharmacy that has an agreement with APM, in this or any other state. You must pay the price of the prescription in full. The participating pharmacy will submit the claim for you and Anthem will pay you directly, minus any Deductible and Coinsurance amount, if applicable. Please call Customer Service at the telephone number on your ID card if you have questions about the participation status of a pharmacy.

If you use a pharmacy that does not have an agreement with APM, or if you do not use your identification card, you must pay the pharmacy the entire cost for the prescription and submit a claim form to APM for reimbursement. Claim forms are available by contacting a Customer Service Representative. If you receive prescription drugs from a non-participating pharmacy or if you do not use your identification card, you may receive a reduced Benefit. We will reimburse you based on the amount we would have paid to a participating pharmacy less your share of the cost.

Prescription Drugs By Mail To obtain Benefits for prescription drugs through mail order pharmacy, complete a mail order pharmacy form, available through our Customer Service Department, and mail it with your prescription. Please call the telephone number on the mail order pharmacy form to speak with a representative regarding the amount to include with your order.

Your financial responsibility (Coinsurance, Deductibles, out-of-pocket limit, lifetime maximum, etc.) will not be reduced by any discounts, rebates or other funds received by the Pharmacy Benefits Manager from drug manufacturers, or similar vendors or funds received by the plan from the Pharmacy Benefits Manager.

Coordination of Benefits

All Benefits of the Contract are subject to coordination of benefits (COB). COB is a formula that determines how benefits are paid to members covered by more than one contract. It helps keep down the cost of health coverage by ensuring that the total benefits you receive from all contracts do not exceed the cost of covered services.

COB sets the payment responsibilities for any contract that covers you, such as:

- Group, individual (also known as non-group), self-insured plans, franchise, or blanket insurance, including coverage through a school or other educational institution but excluding school accident type coverage;
- Group practice, individual practice, and other prepaid group coverage, labor-management trustee plan, union welfare plan, employer organization plan, or employee benefit organization plan; or
- Other insurance that provides medical benefits.

The contract with primary responsibility provides full benefits for covered services as if there were no other coverage. The contract with secondary responsibility may provide benefits for covered services in addition to those of the primary contract. When there are more than two contracts covering the person, the contract may be primary to one or more contracts, and may be secondary to another contract or contracts. All Benefits are limited to the contract maximums or to the Maximum Allowance for the services you receive.

When you have duplicate coverage:

- If the other contract does not contain a COB clause or does not allow coordination of benefits with this contract, the benefits of that contract will be primary;
- If both contracts contain a COB clause allowing the coordination of benefits with this contract, we will determine benefit payments by using the first of the following rules that applies:

1. **Non-Dependent/Dependent** The benefits of the contract that covers you as an employee or subscriber will be determined before the benefits of the contract that covers you as a dependent are determined.
2. **Dependent Children (Parents Not Legally Separated or Divorced)** For claims on covered dependent children, the contract of the parent whose birthday occurs first in the year will be primary. If both parents have the same birthday, the contract that has covered one parent longer will be primary over the contract that has covered the other parent for a shorter period. If the other contract does not include the rule described immediately above, but instead has a rule based on the gender of the parent, and as a result the contracts do not agree on the order of benefits, the rule in this contract will determine the order of benefits.
3. **Dependent Children (Parents Legally Separated or Divorced)** In the case of legal separation or divorce, the coverage of the parent with custody will be primary. If the parent with custody has remarried, coverage of the parent's spouse will be secondary, and the coverage of the parent without custody will be last. Whenever a court decree specifies the parent who is financially responsible for the dependent's health care expenses, the coverage of that parent's contract will be primary. If a court decree states that the parents have joint custody, without stating that one or the other parent is responsible for the health care expenses of the child, the order of benefits is determined by following rule two.

4. **Active/Inactive Employee** The benefits of a contract that covers a person as an employee who is neither laid-off nor retired (or as that employee's dependent) are determined before those of a contract that covers the person as a laid-off or retired employee (or as that employee's dependent). If the other coverage does not include this provision, and as a result, the contracts do not agree on the order of benefits, rule six applies.
5. **Continuation of Coverage** If a person whose coverage is provided under the right of continuation pursuant to a federal or state law is also covered by another contract, the benefits of the contract covering the person as an employee or subscriber, or as the dependent of an employee or subscriber, will be primary. The benefits of the continuation coverage will be secondary. If the other contract does not include this provision regarding continuation coverage, rule six applies.
6. **Longer/Shorter Length of Coverage** If none of the rules above determines the order of benefits, the benefits of the contract that has covered the employee or subscriber longer will be determined before those of the contract that has covered the person for a shorter period.

We reserve the right to:

- Take any action needed to carry out the terms of this section;
- Exchange information with an insurance company or other party;
- Recover the Plan's excess payment from another party or reimburse another party for its excess payment; and
- Take these actions when we decide they're necessary without notifying the covered persons.

Special Information If You Become Eligible For Medicare

You must notify us if you become eligible for premium free Medicare Part A. Failure to notify us could result in retroactive benefit adjustments if Medicare would have been or is the primary payor. You may choose to continue your coverage once you are eligible for premium free Medicare Part A and Medicare Part B coverage. However, your Contract will not provide benefits that duplicate any benefits payable under Medicare Part A or Part B. This is true even if you fail to exercise your rights to premium free Medicare Part A and Medicare Part B coverage. If you become eligible for Medicare, you may want to enroll in a Medicare Supplement Plan. Medicare Supplement plans are specifically designed to pay many of the health care costs not covered by Medicare. Because Medicare Supplement plans have limited enrollment periods, it is important to evaluate these plans as soon as you are eligible for Medicare.

Subrogation: Payments Resulting from Claim or Legal Action

When another party may have caused or may be responsible for your injury or illness, you may be entitled to payment from a claim or legal action against that party. When we provide health care benefits for treatment of your injury or illness, we have the right to recover, from any such payment (whether by judgment, suit,
compromise, settlement or otherwise) up to the total benefit we paid, on a just and equitable basis. The process of recovering these expenses is called subrogation.

We also have subrogation rights against your own insurance, including medical payments, uninsured, and underinsured motorist provisions in your auto insurance policy.

Subrogation applies whether any of the payment or settlement is allocated for medical expenses.

If the services related to your illness or injury are covered by a capitation fee, we are entitled to the reasonable cash value of the services.

By accepting plan coverage you agree:

- Your signed application for coverage is your authorization of our right of subrogation;
- To notify us of any event which could result in legal action, a claim against a third party, or a claim against your own insurance;
- To notify us of any payments you receive as a result of legal action, a claim against a third party, or a claim against your own insurance;
- To cooperate with us in exercising our right of subrogation by providing all information requested;
- To sign documents we deem necessary to protect our rights; and
- To do nothing to interfere with our subrogation rights.

If you do not comply with the above, you may be responsible for expenses we incur in enforcing our subrogation rights.

Complaints and Appeals

Complaints

Our Customer Service Representatives are available to assist members in the resolution of complaints concerning claims administration, benefit determination, eligibility, or medical care provided to you by your provider or professional. A Customer Service Representative may need to forward your complaint to the appropriate internal department for response. The internal staff receiving the member complaint will conduct an investigation and promptly issue a decision to the member on the complaint, either in writing or by telephone. You will receive a response within twenty (20) working days of Anthem's receipt of your complaint.

If additional information is needed, a final decision will be issued within twenty (20) working days of our receipt of the additional information. If your complaint is not satisfactorily resolved, you may seek help through the Appeal process outlined below.

Complaints Requiring Immediate Intervention

If you are dissatisfied with a decision regarding an urgent care situation, we will immediately work with the health care professional or provider involved to respond quickly to the concern. This will occur before the need for services, whenever possible. If services are already in progress, we will promptly notify the member of the decision, so that he or she may decide, if an adverse determination is given, whether to receive services for which he or she may be financially responsible and which may not be covered by us.

Appeals

Level One Appeal Process

You or your authorized representative, if dissatisfied with our initial decision or the decision on a registered complaint, may Appeal the decision to the Appeals Department at Anthem. An Appeal may be submitted orally or in writing and must include specific reasons why you or your authorized representative do not agree with the issued decision. Appeal of a decision must be filed within one-hundred-eighty (180) calendar days of the date the decision was issued, unless there are extenuating circumstances. We reserve the right to investigate the reason for the delay and determine whether the circumstances warrant acceptance of the Level One Appeal beyond the 180-day time frame.

Your authorized representative is a person to whom you have given express written consent to represent you in an external review; a person authorized by law to provide consent to request an external review for you; or a family member or your treating health care provider when you are unable to provide consent to request an external review.

On Appeal, the entire record will be reviewed. Appeals of a clinical nature will be reviewed by an appropriate clinical peer or peers who have not been involved with a prior decision. Additional information may be submitted by or on behalf of the member, any treating professional, or Anthem. A decision will be issued within twenty (20) working days of receipt of the request for an Appeal.

Once a decision is issued, the member, or member representative, if dissatisfied with the outcome, may submit a voluntary second level Appeal to Anthem, request an external review, file a complaint with the Bureau of Insurance and/or bring legal action against Anthem. The Superintendent of Insurance may be contacted toll-free at **1-800-300-5000.**

If you choose to pursue a voluntary second level Appeal, you will have the opportunity to appear before the review panel to present your concerns regarding our adverse benefit determination.

Level Two Appeal Process (Voluntary)

You or your authorized representative, if dissatisfied with the outcome of the Level One Appeal, may Appeal the decision to the Appeals Department at Anthem. An Appeal must be in writing and include specific reasons you or your authorized representative do not agree with the issued decision. It must be filed within one-hundred-eighty (180) calendar days of the date the Level One Appeal decision was issued, unless there are extenuating circumstances. Anthem reserves the right to investigate the reason for the delay and determine whether the circumstances warrant acceptance of the Level Two Appeal beyond the 180-day time frame.

On a Level Two Appeal, the entire record will be reviewed. Appeals of a clinical nature will be reviewed by an appropriate clinical peer or peers who have not been involved with the prior decision. Additional information may be submitted by or on behalf of the member, any treating professional, or Anthem. **You or your authorized representative, may appear before the review panel.** The review will be conducted within forty-five (45) working days of receipt of the member's Level Two Appeal. A written decision will be issued to the member within five (5) working days of completing the review. Once a final decision has been issued by the Second Level Appeal panel, the member may request an external review, file a complaint with the Bureau of Insurance and/or bring legal action against Anthem. The Superintendent of Insurance may be contacted toll-free at **1-800-300-5000.**

External Review Process

You or your authorized representative, if dissatisfied with the outcome of the Level One or Voluntary Level Two Appeal relating to an adverse health care treatment decision rendered by Anthem, may make a written request for external review to the Bureau of Insurance. A health care treatment decision involves issues of medical necessity, preexisting condition determinations and determinations regarding experimental or investigational services. An adverse health care treatment decision is a decision made by us or on our behalf denying payment. The request must be made within 12 months of the date the member has received the final adverse health care treatment decision of the Level One or Voluntary Level Two Appeal panel.

You or your authorized representative may not make a request for external review until you have exhausted Level One of the internal Appeals process unless:

- Anthem has failed to make a decision on an Appeal within the time period required;
- Anthem and you mutually agree to bypass the internal Appeals process;
- The life or health of the member is in serious jeopardy; or
- The member has died.

The Bureau of Insurance will oversee the external review process. Except as stated below, a written decision must be made by the independent review organization within thirty (30) days of receipt of a completed request for external review from the Bureau of Insurance. An external review decision must be made as expeditiously as a member's medical condition requires but no more than 72 hours after receipt of the completed request for external review if the 30-day time frame described above would seriously jeopardize the life or health of the member or would jeopardize the member's ability to regain maximum function.

An external review decision is binding on Anthem. You or your representative, may not file a request for a subsequent external review involving the same adverse health care treatment decision for which you have already received an external review decision.

Legal Action Against Anthem

No legal action may be brought against Anthem until the member or the member's authorized representative has exhausted the complaint and Appeals process outlined above. Any action must be initiated within three (3) years from the earlier of:

- The date of issuance of the written external review decision; or
- The date of issuance of the underlying adverse Level One Appeal decision or the Level One grievance determination notice.

Section Six
Definitions

This section explains the meaning of some of the words in Certificate. Other words may be defined in the text.

Accident Care Treatment of an accidential bodily injury sustained by the Member that is the direct cause of the condition for which Benefits are provided and that occurs while the insurance is in force.

Ambulatory Surgical Facility A facility that meets both of the following requirements:
- Licensed as an ambulatory surgery center, or is Medicare certified; and
- Meets our standards for participation.

Amendment An addition, change, correction, or revision to the terms and conditions of this Contract.

Annual Out-of-Pocket Limit The limit on the Deductible and Coinsurance you pay each year. After you meet the annual out-of-pocket limit, you pay no further Deductible or Coinsurance for most services.

Appeal A request for a review of our initial decision, a decision on a registered complaint, or determination of medical necessity.

Benefits Payments we make on your behalf under this Contract.

Calendar Year The period starting on the effective date of your coverage and ending on December 31 of that year or the date your coverage ends, whichever occurs first. Each succeeding Calendar Year starts on January 1 and ends on December 31 of that year or the date your coverage ends, whichever occurs first.

Certificate The document that specifies the health care Benefits available to members under this Contract.

Chiropractor A person who is licensed to perform chiropractic services, including manipulation of the spine.

Coinsurance The percentage paid toward the cost of some covered services.

Community Mental Health Center An institution that meets both of the following requirements:
- Licensed as a comprehensive level community mental health center; and
- Meets our standards for participation.

Contract This Certificate, any amendments, riders, or attached papers and your application.

Cosmetic Services Medical/surgical procedures or services intended solely to change or improve appearance or to treat emotional, psychiatric, or psychological conditions.

Covered Service Services, supplies or treatment as described in this Certificate. To be a Covered Service the service, supply or treatment must be:

a. Medically Necessary or otherwise specifically included as a benefit under this Certificate.
b. Within the scope of the license of the Professional performing the service.
c. Rendered while coverage under this Certificate is in force.
d. Not experimental or investigational or otherwise excluded or limited by this Certificate, or by any amendment or rider thereto.
e. Authorized in advance by us if such preauthorization is required in Certificate.

Creditable Coverage Coverage under an individual or group contract or policy that was in effect within 3 months before you were eligible for coverage under this Contract if you apply when initially eligible, or within 3 months of your effective date if you apply as a late enrollee. Creditable coverage includes group or individual health insurance, Medicare, Medicaid, CHAMPUS, Indian Health Care Improvement Act, state health benefit risk pool, federal employees health benefit plan, public health plan or the Peace Corps health benefit plan. In calculating the period of creditable coverage, all periods of coverage under all types of creditable coverage are added together unless there is a consecutive 90-day or longer break in the time period the individual has creditable coverage.

Custodial Care Care primarily for the purpose of assisting you in the activities of daily living or in meeting personal rather than medical needs, and which is not specific treatment for an illness or injury. It is care which cannot be expected to substantially improve a medical condition and has minimal therapeutic value. Such care includes, but is not limited to:

- Assistance with walking, bathing, or dressing;
- Transfer or positioning in bed;
- Normally self-administered medicine;
- Meal preparation;
- Feeding by utensil, tube, or gastrostomy;
- Oral hygiene;
- Ordinary skin and nail care;
- Catheter care;
- Suctioning;
- Using the toilet;
- Enemas; and
- Preparation of special diets and supervision over medical equipment or exercises or over self-administration of oral medications not requiring constant attention of trained medical personnel.

Care can be Custodial whether or not it is recommended or performed by a professional and whether or not it is performed in a facility (e.g. hospital or skilled nursing facility) or at home.

Day Treatment Patient A patient receiving mental health or substance abuse care on an individual or group basis for more than two hours but less than 24 hours per day in either a hospital, rural mental health center, substance abuse treatment facility, or community health center. This type of care is also called partial hospitalization.

Deductible The amount you may be required to pay each year toward the Maximum Allowance for certain covered services before this Contract provides Benefits.

Dental Service Items and services provided in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting the teeth. Structures directly supporting the teeth

include: the periodontium, which includes the gingiva, dentogingival junction, cementum (the outer surface of a tooth root), alveolar process (the laminar dura, or tooth socket, and supporting bone), and the periodontal membrane (the connective tissue between the cementum and the alveolar process).

Dependent The eligible employee's lawful spouse, unmarried children and others as outlined in the "Eligibility, Termination and Continuation of Coverage" section of this Certificate.

Diagnostic Service A service performed to diagnose specific signs or symptoms of an illness or injury, such as: x-ray exams (other than teeth), laboratory tests, cardiographic tests, pathology services, radioisotope scanning, ultrasonic scanning, and certain other methods of diagnosing medical problems.

Discount Favorable rates or discounts we have negotiated with hospitals and other providers. Members benefit from these rates or discounts since they are applied prior to calculating your share of costs. Discounted charges reduce the expenses paid by us which helps to lower the contract costs.

Domiciliary Care Care provided in a residential institution, treatment center, halfway house, or school because a member's own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.

Durable Medical Equipment Equipment that meets all of the following criteria:
- Can withstand repeated use;
- Is used only to serve a medical purpose;
- Is appropriate for use in the patient's home;
- Is not useful in the absence of illness, injury, or disease; and
- Is prescribed by a physician.

Durable medical equipment does not include fixtures installed in your home or installed on your real estate.

Emergency Medical Condition A physical or mental condition, manifesting itself by acute symptoms of sufficient severity such that the absence of immediate medical attention could reasonably be expected to result in:
- Placing the physical or mental health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- Serious impairment to body functions; or
- Serious dysfunction of any body organ or part; or

With respect to a pregnant woman who is having contractions:
- That there is inadequate time to safely transfer to another hospital before delivery; or
- That transfer may pose a threat to the health or safety of the woman or unborn child.

Emergency Service Health care services that are provided in an emergency facility or setting after the onset of an illness or medical condition that manifests itself by symptoms of sufficient severity, that the absence of immediate medical attention could reasonably be expected by the prudent lay person, who possesses an average knowledge of health and medicine, to result in:
- Placing the member's physical and/or mental health in serious jeopardy;
- Serious impairment to body functions; or
- Serious dysfunction of any body organ or part.

Examples of illnesses or conditions that may require emergency services include, but are not limited to: heart attack, stroke or severe hypertensive reaction, coma, blood or food poisoning, severe bleeding, shock, obstruction (airway, gastrointestinal or urinary tract), and allergic or acute reactions to drugs.

Experimental or Investigational Any drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply used in or directly related to the diagnosis, evaluation, or treatment of a disease, injury, illness, or other health condition which Anthem determines to be experimental or investigational.

Anthem will deem any drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply to be experimental or investigational if it determines that one or more of the following criteria apply when the service is rendered with respect to the use for which Benefits are sought.

(a) The drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply:

(i) Cannot be legally marketed in the United States without the final approval of the Food and Drug Administration (FDA) or any other state or federal regulatory agency and such final approval has not been granted; or

(ii) Has been determined by the FDA to be contraindicated for the specific use; or

(iii) Is provided as part of a clinical research protocol or clinical trial or is provided in any other manner that is intended to evaluate the safety, toxicity, or efficacy of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply, unless otherwise required by law; or

(iv) Is subject to review and approval of an Institutional Review Board (IRB) or other body serving a similar function; or

(v) Is provided pursuant to informed consent documents that describe the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply as experimental or investigational or otherwise indicate that the safety, toxicity, or efficacy of the drug, biologic, device, diagnostic, product equipment, procedure, treatment, service, or supply is under evaluation.

(b) Any service not deemed experimental or investigational based on the criteria in subsection (a) may still be deemed to be experimental or investigational by Anthem. In determining whether a service is experimental or investigational, Anthem will consider the information described in subsection (c) and assess the following:

(i) Whether the scientific evidence is conclusory concerning the effect of the service on health outcomes;

(ii) Whether the evidence demonstrates the service improves the net health outcomes of the total population for whom the service might be proposed by producing beneficial effects that outweigh any harmful effects;

(iii) Whether the evidence demonstrates the service has been shown to be as beneficial for the total population for whom the service might be proposed as any established alternatives; and

(iv) Whether the evidence demonstrates the service has been shown to improve the net health outcomes of the total population for whom the service might be proposed under the usual conditions of medical practice outside clinical investigatory settings.

(c) The information considered or evaluated by Anthem to determine whether a drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is experimental or investigational under subsections (a) and (b) may include one or more items from the following list which is not all inclusive:

(i) Published authoritative, peer-reviewed medical or scientific literature, or the absence thereof; or

(ii) Evaluations of national medical associations, consensus panels, and other technology evaluation bodies; or

(iii) Documents issued by and/or filed with the FDA or other federal, state or local agency with the authority to approve, regulate, or investigate the use of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply; or

(iv) Documents of an IRB or other similar body performing substantially the same function; or

(v) Consent document(s) used by the treating physicians, other medical professionals, or facilities or by other treating physicians, other medical professionals or facilities studying substantially the same drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply; or

(vi) The written protocol(s) used by the treating physicians, other medical professionals, or facilities or by other treating physicians, other medical professionals or facilities studying substantially the same drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply; or

(vii) Medical records; or

(viii) The opinions of consulting providers and other experts in the field.

(d) Anthem identifies and weighs all information and determines all questions pertaining to whether a drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is experimental or investigational.

Family Planning Agency An agency that meets both of the following requirements:

- Is a delegated family planning agency under Title X of the Public Health Service Act and is in good standing with all applicable state and federal regulatory bodies; and
- Meets our standards for participation.

Federally Eligible Individual To qualify as a Federally Eligible Individual, you must meet **all** of the following criteria:

- You must have had 18 months of continuous creditable coverage through one or more health plans, with no break in coverage exceeding 63 days. (Please see the definition of "Creditable Coverage" in this section.)
- Your most recent prior creditable coverage must have been in effect within 63 days of applying for this insurance coverage.
- Your most recent prior creditable coverage must have been a group, government or church health plan, not an Individual health plan.
- You must not qualify for any group health plan or government program, such as Medicare or Medicaid.
- Your most recent prior creditable coverage must not have been terminated because of nonpayment of premiums, fraud or intentional misrepresentation of a material fact.
- If offered COBRA, you must have elected and exhausted COBRA Benefits.

Formulary The list of pharmaceutical products, developed in consultation with physicians and pharmacists, approved for their quality and cost effectiveness.

Freestanding Imaging Center An institution that meets both of the following requirements:

- Licensed (where available) as a freestanding imaging center, freestanding diagnostic center, or freestanding radiology center; and
- Meets our standards for participation.

Freestanding Surgical Facility An institution that meets all of the following requirements:

- Has a medical staff of physicians, nurses and licensed anesthesiologists;
- Maintains at least two operating rooms and one recovery room, as well as diagnostic laboratory and x-ray facilities;
- Has equipment for emergency care;
- Has a blood supply;
- Maintains medical records;
- Has agreements with hospitals for immediate acceptance of patients who need hospital confinement on an inpatient basis;
- Is licensed in accordance with the law of the appropriate legally authorized agency; and
- Meets our standards for participation.

Grace Period The 31 days that begin with and follow the due date of an unpaid subscription charge.

Home Health Agency An institution that meets both of the following requirements:

- Licensed as a home health agency; and
- Meets our standards for participation.

Hospice A facility that meets both of the following requirements:

- Licensed as a hospice; and
- Meets our standards for participation.

Hospice Care Services that furnish pain relief, symptom management, and support to terminally ill patients and their families.

Hospital An institution that is duly licensed by the state of Maine as an acute care, rehabilitation or psychiatric hospital and is certified to participate in the Medicare program under Title XVIII of the Social Security Act.

Inborn Error of Metabolism A genetically determined biochemical disorder in which a specific enzyme defect produces a metabolic block that may have pathogenic consequences at birth or later in life.

Independent Laboratory An institution that meets both of the following requirements:

- Licensed as an independent medical laboratory; and
- Meets our standards for participation.

Infertility The inability to conceive a pregnancy after a year or more of regular sexual relations without contraception or the presence of a demonstrated condition recognized as a cause of infertility by the American College of Obstetrics and Gynecology, the American Urologic Association, or other appropriate independent professional associations.

Inpatient A registered bed patient who occupies a bed in a hospital, skilled nursing facility, or residential treatment facility. A patient who is kept overnight in a hospital solely for observation is not considered a registered inpatient. This is true even though the patient uses a bed. In this case, the patient is considered an outpatient.

Inpatient Stay One period of continuous, inpatient confinement. An inpatient stay ends when you are discharged from the facility in which you were originally confined. However, a transfer from one acute care hospital to another acute care hospital as an inpatient when medically necessary is part of the same stay.

Maintenance Therapy Any treatment, service, or therapy that preserves the member's level of function and prevents regression of that function. Maintenance therapy begins when therapeutic goals of a treatment plan have been achieved or when no further functional progress is apparent or expected to occur.

Maximum Allowance The highest dollar amount we will pay for a covered service based on our contracts with providers and professionals. Our payment will be based on the most cost effective services that can be safely administered.

Medicaid Title XIX of the United States Social Security Act, Grants to States for Medical Assistance Programs.

Medically Necessary Health Care Health care services or products provided to a member for the purpose of preventing, diagnosing or treating an illness, injury or disease or the symptoms of an illness, injury or disease in a manner that is:

- Consistent with generally accepted standards of medical practice;
- Clinically appropriate in terms of type, frequency, extent, site and duration;
- Demonstrated through scientific evidence to be effective in improving health outcomes;
- Representative of "best practices" in the medical profession; and
- Not primarily for the convenience of the member or physician or other health care practitioner.

Medicare The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as then constituted or later amended.

Member The subscriber and all family members who are eligible for coverage and who we accept for coverage under this Contract.

Mental Health Service A service to treat any disorder that affects the mind or behavior regardless of origin.

Morbid Obesity A condition of persistent and uncontrolled weight gain existing for a minimum of five consecutive years that constitutes a present or potential threat to life. This is characterized by weight that is at least 100 pounds over or twice the weight for frame, age, height, and sex in the most recently published Metropolitan Life Insurance table.

Network Providers and Professionals Health care providers and professionals that have a written agreement with Anthem to furnish health care services under this Contract. Also referred to as participating providers and professionals.

Non-Network Providers and Professionals Health care providers and professionals that do not have a written agreement with Anthem to furnish health care services under this Contract. Also referred to as non-participating providers and professionals. Providers and Professionals who have not contracted or affiliated with our designated Subcontractor(s) for the services they perform under this plan are also considered Non-Network Providers and Professionals.

Orthognathic Surgery A branch of oral surgery dealing with the cause and surgical treatment of malposition of the bones of the jaw and occasionally other facial bones.

Orthotic Device A device that restricts, eliminates, or redirects motion of a weak or diseased body part.

Our See definition of "We, Us, or Our."

Outpatient A patient who receives services at a provider and who is not a registered inpatient or a day treatment patient. A patient who is kept overnight in a hospital solely for observation is considered an outpatient. This is true even though the patient uses a bed.

Pharmacy Any retail establishment operating under a license and in which a registered pharmacist dispenses prescription drugs.

Pharmacy and Therapeutics Committee Our committee made up of Maine-based physicians and other experts in medicine and pharmacy.

Physician See definition of "Professional."

Pre-existing Condition The existence of symptoms which would cause an ordinarily prudent person to seek medical advice, diagnosis, care or treatment; or a condition for which medical advice or treatment was recommended by, or received from a provider of health care services during the 12 months immediately preceding the effective date of coverage.

Prescription Drugs A narcotic or medicine approved by the federal Food and Drug Administration (FDA) for use outside of a hospital dispensed under a physician's written order. Prescription drugs are: required by state law to be dispensed only with a prescription; required by law to display the notice, "Caution: Federal law prohibits dispensing without a prescription"; any other drug we may approve through our drug approval process.

Professional An independently billing, licensed health care specialist acting within the scope of his or her license. Only the following professionals are eligible for payment under this Contract:
Physicians
- Doctor of Medicine
- Doctor of Osteopathy

Other Professionals
- Doctor of Optometry
- Doctor of Chiropractic
- Doctor of Podiatry
- Doctor of Dentistry
- Doctor of Psychology
- Licensed Audiologist
- Licensed Psychiatric Nurse Specialist
- Licensed Clinical Social Worker
- Physical Therapist
- Occupational Therapist
- Speech Therapist
- Registered Nurse
- Licensed Practical Nurse
- Certified Nurse Midwife
- Ambulance Services
- Licensed Certified Professional Counselor
- Other professionals that have written participating agreements with us;
- Other professionals as required by law.

Prostheses Prostheses are appliances that replace all or part of a body organ (including contiguous tissue) or replace all or a part of the function of a permanently inoperative, absent, or malfunctioning body part.

Provider A licensed health care institution, facility, or agency. Only the following providers are eligible for payment under this Contract:

- Acute-care hospitals
- Skilled nursing facilities
- Rural health centers
- Home health agencies
- Ambulatory surgery centers
- Hospices
- Community mental health centers
- Substance abuse treatment centers
- Licensed pharmacies
- Acute care psychiatric and rehabilitation hospitals
- Independent laboratories
- Freestanding imaging centers
- Family planning agencies
- Durable medical equipment providers
- Home infusion providers
- Other providers that have written contracts with us;
- Other providers, as required by law.

Radiation Therapy The use of high energy penetrating rays to treat an illness or disease.

Reconstructive Procedures Procedures performed on structures of the body to improve or restore bodily function or to correct deformity when there is functional impairment resulting from disease, trauma, previous therapeutic process, or congenital or developmental anomalies.

Rural Health Center An institution that meets both of the following requirements:

- Certified by the Department of Human Services under the United States Rural Health Clinic Services Act; and
- Meets our standards for participation.

Sitter/Companion A person who provides short-term supervision of hospice patients during the temporary absence of family members.

Skilled Nursing Facility (SNF) An institution that meets all of the following requirements:

- Licensed as a skilled nursing facility;
- Accredited in whole or in a specific part as a skilled nursing facility for the treatment and care of inpatients;
- Engaged mainly in providing skilled nursing care under the supervision of a physician in addition to providing room and board;
- Provides 24-hour-per-day nursing care by or under the supervision of a registered nurse (RN);
- Maintains a daily medical record for each patient;
- Is a freestanding unit or a designated unit of another licensed health care facility; and
- Meets our standards for participation.

Specialist Service A service by a professional practicing in specialty areas such as cardiology, neurology, surgery, and other specialties.

Subcontractor An organization or entity that provides particular services in specialized areas of expertise. Examples of subcontractors include, but are not limited to, prescription drugs, mental health/ behavioral health and substance abuse services. Such subcontracted organizations or entities may make benefit determinations and/or perform administrative, claims paying, or customer service duties on our behalf.

Subscriber The person who applied for coverage under this Contract and whose application and payment of required subscription charges we have accepted.

Subscription Charge The rates established by us as consideration for Benefits offered in this Contract.

Substance Abuse The misuse, excessive use, or improper use of alcohol or drugs to the extent that such use contributes to physical, mental, or social dysfunction, regardless of origin.

Substance Abuse Treatment Facility A residential or nonresidential institution that meets all of the following requirements:
- Licensed or certified as a substance abuse treatment facility;
- Provides care to one or more patients for alcoholism and/or drug dependency;
- Is a freestanding unit or a designated unit of another licensed health care facility; and
- Meets our standards for participation.

Surgical Assistant A physician (Doctor of Medicine or Osteopathy) or dentist (Doctor of Dental Medicine or Dental Surgery), or other qualified professionals as permitted by law and recognized by us who actively assists the operating surgeon in performing a covered surgical service.

Surgical Service A service performed by a professional acting within the scope of his or her license that is:
- A generally accepted operative and cutting procedure;
- An endoscopic examination or other invasive procedure using specialized instruments; or
- The correction of fractures and dislocations.

Terminal Illness A terminal illness exists if a person becomes ill with a prognosis of 12 months or less to live, as diagnosed by a physician.

Utilization Management The process we use to determine the medical necessity, appropriateness, efficacy or efficiency of health care services. Techniques include inpatient admission review, continued inpatient stay review, discharge planning, post admission review and case management.

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March 11, 2009

Mila Kofman, Superintendent
c/o Pat Galouch
Docket No. INS-09-1000
Maine Bureau of Insurance
34 State House Station
Augusta, Maine 04333-0034

Re: *Anthem BCBS 2009 HealthChoice Individual Rate Filing*
Filing coversheet

Dear Superintendent Kofman:

Enclosed for filing please find the following:

SUBMITTED BY: Christopher T. Roach

DATE: March 11, 2009

DOCUMENT TITLE: Anthem BCBS Response to Second Informational Request of the Attorney General

DOCUMENT TYPE: Response to Information Requests

CONFIDENTIAL: **No**

Thank you for your assistance in this matter.

Very truly yours,

/s/ Christopher T. Roach

cc: Thomas C. Sturtevant, Esquire
Christina M. Moylan, Esquire

NON-CONFIDENTIAL

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

IN RE:	)	
	)	
ANTHEM BLUE CROSS AND BLUE	)	
SHIELD 2009 INDIVIDUAL RATE	)	APPLICANT'S RESPONSE TO
FILING FOR HEALTHCHOICE,	)	SECOND INFORMATIONAL
HEALTHCHOICE STANDARD AND	)	REQUEST OF THE ATTORNEY
BASIC AND LUMENOS CONSUMER	)	GENERAL
DIRECTED HEALTH PLAN	)	
PRODUCTS	)	

Docket No. INS-09-1000 March 11, 2009

NON-CONFIDENTIAL

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

IN RE:	)	
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ANTHEM BLUE CROSS AND BLUE	)	
SHIELD 2009 INDIVIDUAL RATE	)	APPLICANT'S RESPONSE TO
FILING FOR HEALTHCHOICE,	)	SECOND INFORMATIONAL
HEALTHCHOICE STANDARD AND	)	REQUEST OF THE ATTORNEY
BASIC AND LUMENOS CONSUMER	)	GENERAL
DIRECTED HEALTH PLAN	)	
PRODUCTS	)	

Docket No. INS-09-1000 March 11, 2009

Applicant Anthem Health Plans of Maine, Inc., d/b/a Anthem Blue Cross and Blue Shield ("Anthem BCBS") hereby responds to the Second Informational Request of the Attorney General dated February 20, 2009 as follows:

1. Please provide separate claims triangles for the HealthChoice and Lumenos experience for the period November 2006 through October 2008, with payments through December 2008 on an allowed basis. Please provide the information in the same format as your response to question 4 of the Attorney General's first informational request.

Response: Please see attached "Response_to_AG2_Question1.xls."

2. Please provide, separately for HealthChoice and Lumenos, claims triangles which include only the claims for those members with claims in excess of $100,000 for the period November 2006 through October 2008, with payments through December 2008 on an allowed basis. Please provide the information in the same format as your response to question 6 of the Attorney General's first informational request.

Response: Please see attached "Response_to_AG2_Question2.xls."

3. In response to question 8 of the first informational request of the Attorney General, Anthem states that "[c]ompletion factors are meant to estimate claims for members with claims that have been incurred but

not reported, not necessarily additional claims already in process." In addition, you provided the example of a member that is in a hospital waiting to receive a transplant.

a. Please describe the coding of the incurred dates and payment dates Anthem typically utilizes for inpatient hospital services, outpatient hospital services, professional services, pharmacy claims, etc. Specifically, please explain what the incurred date coded in your claim file represents (e.g. date of admission, date of discharge, etc.)

b. Specifically, please describe the coding of the incurred and payment date of the following example. A patient is admitted to the hospital on January 1 and incurs room and board costs and ancillary services until he receives a transplant on March 1. The patient undergoes transplant surgery within the same hospital to which he was admitted on January 1. For the purpose of this example, assume the hospital room and board costs of $10,000 per month and the transplant surgery is $100,000. Also assume Anthem has paid the bills in the following manner:

January stay	$10,000	paid on February 15
February stay	$10,000	paid on March 15
March surgery	$100,000	paid on April 15

How are these claims coded with respect to incurred and paid dates and reflected in the claims triangle?

Response: 3a. The incurred date is the admission date for inpatient claims and the date of service for all other types of claims. Paid date represents the date that Anthem sends payment to the service provider.

3b. The claims are coded in the same manner as described in 3a. Therefore the January, February and March inpatient stays would have an incurred date of January and a paid date as shown.

4. With regard to pooling for large claims:

   a. Please describe your understanding of the concept of pooling.
   b. Please provide your definition of a "pooling charge" and what it is intended to represent.
   c. In your opinion, how much experience is required in order for the experience to be considered fully credible for the purpose of developing a pooling charge?
   d. In your opinion, when is pooling strictly a formulaic calculation and under what circumstances is some judgment or discretion introduced in the process? Please provide some examples where discretion may be utilized.

Response: 4a. Pooling in health insurance is usually intended to remove volatility from the claims experience for high-cost claimants in order to avoid over- or under-estimating the future claims experience. In situations where there is less volatility in the high-cost claimant experience (i.e. HealthChoice and Lumenos recent experience), a pooling charge has

little effect on the overall claims trend. This is exhibited in the very similar net claims trend resulting from Method 1 and Method 2 in the HealthChoice and Lumenos filing.

4b. Pooling methods are intended to remove random fluctuations from the experience. A pooling charge is an expectation of high-cost claims over the entire pool to replace an experience period's high-cost claim activity.

In the case of the Maine individual HealthChoice and Lumenos pool, the pooling charge is being used to smooth out the effect of high-cost claimants in the experience period. For example, if Anthem had 100 members with claims in excess of $100,000 in 2008, we would not immediately assume that we would have 100 members with claims in excess of $100,000 in 2009. We would review additional years of experience to gain a better feel for block average or expected members with claims in excess of $100,000. We would then use the average cost for these members to develop a pooling charge that smoothes the experience to a more reasonable expectation of high-cost claimants during the projection period. Exhibit XV shows that the amount of excess claims as percentage of claims excluding the excess has been stable for the last few years. Specifically, for the rolling 12 month periods from September 2006 through September 2008, the percentage has ranged from 16.5% to 18.6%.

With the relative high-cost claimant stability shown by this block in recent years, the Method 1 rate development is a more reasonable method of projecting future claim cost that analyzes trend both retrospectively and prospectively. Observed claim data is reviewed on both an allowed and paid benefit basis by category: inpatient, outpatient, professional, and prescription drug. Information concerning known and anticipated changes to provider contracts and care management initiatives are considered for their potential impact on future claims. With this combination of historical and prospective information, trends are then selected for the categories noted previously. Conversely, Method 2 reviews historical observed benefit paid expense trend only with no prospective view. Further, the trends analyzed after the removal of the high-cost claimants are extremely erratic (ranging from 3.9% to 14.6%) compared to the allowed trends adjusted for deductible mix that support Method 1 (ranging from 11.9% to 16.7%). The selection of an appropriate trend for Method 2 involves selecting an assumption from a much broader range of historical trends with no consideration for prospective impact from provider contracting or other care management initiatives.

Anthem included the Method 2 rate development to address comments

made in the 2008 HealthChoice Decision and Order and as a reasonableness check of our primary rate development, Method 1. Because Method 2 does not take into account prospective trend information and relies on greater actuarial judgment in selecting the underlying claims trend and the pooling charge, Method 1 is the basis of our required 18.1% premium increase.

4c. The credibility of a pool depends on the historical volatility of the claims experience. There is no universal standard regarding the number of lives needed for block experience to be deemed credible. In the case of the Maine individual HealthChoice and Lumenos pool, the experience for members with claims in excess of $100,000 has been very steady. The lack of volatility in the claims for these members gives credibility to their experience and gives validity to the Method 1 rate development.

4d. The calculation of a pooling charge can always involve some level of judgment. Such judgment, particularly when it deviates from experience data, should reflect reasonable expectations that projected experience will be different than emerging trends. With regards to the high-cost claimant levels in the HealthChoice and Lumenos experience, we place great validity on the recent stability shown by the block in our Method 1 rate projections. Conversely, Method 2 relies on actuarial judgment when selecting trends from a broad range of observed values.

****

CONFIDENTIAL INFORMATION REDACTED IN RESPONSE TO REQUEST NO. 5

****

5. For the two large claimants, please provide a file which shows claim line detail for the same period provided in response to question 9 of the Attorney General's first informational request. For each line, please show the following information:

   Incurred Date
   Paid Date
   Date of Service
   Admit Date (For hospital claims)
   ICD-9 Code
   Place of Service (hospital inpatient, hospital outpatient, professional office, etc.)
   CPT or Revenue Code
   Amount Paid

****

Response: **CONFIDENTIAL INFORMATION REDACTED IN ATTACHED SPREADSHEET CONSISTENT WITH MARCH 11, 2009 PROTECTIVE ORDER**

****

Please see attached "Response_to_AG2_Question5.xls."

DATED: March 11, 2009

/s/ Christopher T. Roach
Christopher T. Roach, Esq.

PIERCE ATWOOD LLP
One Monument Square
Portland, Maine 04101
Attorney for Applicant

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

IN RE: ANTHEM BLUE CROSS AND BLUE SHIELD 2009 INDIVIDUAL RATE FILING FOR HEALTHCHOICE, HEALTHCHOICE STANDARD AND BASIC AND LUMENOS CONSUMER DIRECTED HEALTH PLAN PRODUCTS Docket No. INS-09-1000	**CERTIFICATE OF SERVICE**

The undersigned counsel 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 Applicant's Response to the Second Informational Request of the Attorney General upon the persons and at the addresses indicated below.

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DATED: March 11, 2009

/s/ Christopher T. Roach
Christopher T. Roach, Esq.

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Attachment "AG's 2nd IR's Response to No. 1 (W1310880).XLS" is not a PDF document and cannot be reproduced here.

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March 20, 2009

Mila Kofman, Superintendent
c/o Pat Galouch
Docket No. INS-09-1000
Maine Bureau of Insurance
34 State House Station
Augusta, Maine 04333-0034

Re: Anthem BCBS 2009 HealthChoice Individual Rate Filing
Filing coversheet

Dear Superintendent Kofman:

Enclosed for filing please find the following:

SUBMITTED BY: Christopher T. Roach

DATE: March 20, 2009

DOCUMENT TITLE: Anthem BCBS Response to Hearing Information Requests

DOCUMENT TYPE: Hearing Request Responses

CONFIDENTIAL: **No**

Thank you for your assistance in this matter.

Very truly yours,

/s/ Christopher T. Roach

cc: Thomas C. Sturtevant, Esquire
Christina M. Moylan, Esquire

{W1339551.1}

NON-CONFIDENTIAL

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

IN RE:	)	
	)	
ANTHEM BLUE CROSS AND BLUE	)	
SHIELD 2009 INDIVIDUAL RATE	)	APPLICANT'S RESPONSE TO
FILING FOR HEALTHCHOICE,	)	HEARING INFORMATION
HEALTHCHOICE STANDARD AND	)	REQUESTS
BASIC AND LUMENOS CONSUMER	)	
DIRECTED HEALTH PLAN	)	
PRODUCTS	)	March 20, 2009

Docket No. INS-09-1000

NON-CONFIDENTIAL

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

IN RE:	)	
	)	
ANTHEM BLUE CROSS AND BLUE	)	
SHIELD 2009 INDIVIDUAL RATE	)	APPLICANT'S RESPONSE TO
FILING FOR HEALTHCHOICE,	)	HEARING INFORMATION
HEALTHCHOICE STANDARD AND	)	REQUESTS
BASIC AND LUMENOS CONSUMER	)	
DIRECTED HEALTH PLAN	)	
PRODUCTS	)	March 20, 2009

Docket No. INS-09-1000

Applicant Anthem Health Plans of Maine, Inc., d/b/a Anthem Blue Cross and Blue Shield ("Anthem BCBS") hereby responds to the Hearing Information Requests as follows:

1. Provide e-copy of deductible mix spreadsheet (Anthem BCBS Exhibit 7) to Bureau and AG.

Response: Please see attached file "1_Support_for_DeductibleMix_Adjustment.xls"

2. Confirm that both high cost claimants are still policyholders.

Response: Anthem BCBS confirmed that both migrating high cost claimants are active policyholders as of March 18, 2009.

3. High Cost Claimants: What is the current dollar value of HealthChoice claims for the two high-cost claimants? Are there any annual limits that come into play for the two high cost claimants?

Response: With claims paid through February 2009, large claimant A has completed $176,000 in claims and large claimant B has completed $7,000 in claims both towards the $3 million lifetime max on their

HealthChoice policies. The $7,000 in claims for large claimant B does not change Anthem BCBS's expected claims for this member, but does reflect financial assistance received by large claimant B as described below.

Upon further review of large claimant B's pharmacy claims, we have learned that Anthem BCBS's case management team found a community resource for large claimant B that is paying for the prescription drugs for this member. Our understanding is that the community resource intends to pay those costs for the first 12 months of large claimant B's HealthChoice policy (October 2008 through September 2009). While this community resource thus far seems to be carrying out this intention, it is in no way legally obligated to pay for this member's prescription drugs. Therefore, large claimant B's claims for prescription drugs could be submitted to Anthem BCBS at any time, and Anthem BCBS's legal obligation to pay the claims remains. Although an argument could be made that claimant B's pharmacy claim assumptions should be reduced by 25% because the community resource may pay them through September, 2009, in our view, the full measure of claimant B's pharmacy claims should be included for claim projection purposes because the absence of any legal obligation renders speculative the expectation that the community resource will actually pay 100% of claimant B's pharmacy claims through September, 2009.

HealthChoice policies have annual maximums on the following services: mental health and substance abuse, home health care, physical manipulations/adjustments, physical/occupational therapy and speech therapy. These benefit limits should not come into play for either member.

4. Provide further answer as to why no Lumenos premium adjustment was requested last year.

Response: As stated in Anthem BCBS's response to the Second Information Request of the Superintendent and confirmed with the management in place at the time of the decision, at the time of the 2008 HealthChoice filing in mid-2007, the Lumenos product had just been introduced into the market and was running a loss ratio lower than the required minimum 65% (for the first six months of 2007). Anthem BCBS expected that a trend increase would not be approved by the Superintendent based on this early experience. Additionally, Anthem BCBS did not believe that a rate increase for the Lumenos products was merited based on this early experience.

5. Amendment to Certification of Colonoscopy Coverage: What are the changes? How does it amend or endorse the Rider? Why are Standard and Basic policies listed at the bottom of the Amendment noted as being amended? In the HealthChoice certificate of coverage before amendment, under what provision is colonoscopy covered? What is the law requiring waiver of the deductible for colonoscopy?

Response: Colonoscopies are recommended preventative procedures, since they are highly effective in reducing the risk of colon cancer. Most colonoscopies are preformed as preventive screenings; however, in some instances, pre-cancerous polyps may be identified and removed during the procedure. In this instance, the procedure may then be coded for polyp removal, which is a diagnostic code and not a screening code.

Prior to January 2009, colonoscopies were covered based on the diagnosis code listed in the provider bill, which resulted in some being covered under the preventive benefit and others covered generally under "diagnostic services" and "surgical services." Our members expected Anthem to cover colonoscopies the same as any other preventive benefit and indicated significant dissatisfaction with the non preventive payment of screening colonoscopies that included a polyp removal, which they felt should be paid as a preventive benefit.

In addition, last year the Legislature enacted P.L. 2007, c. 516, requiring that all policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State on or after January 1, 2009, include coverage for colorectal cancer screening and requiring providers to bill a screening colonoscopy as such, even when lesions are discovered and removed during the procedure.

Effective January 1, 2009, colonoscopies are covered as a preventive benefit under the HealthChoice Preventive Care and Supplemental Rider ("PCSA Rider") and for the HealthChoice, HMO, HealthChoice Standard & Basic, and HealthChoice High Deductible Health Plan products. For those products that include preventive care benefits (including the PCSA Rider), the intent of the change is to cover the colonoscopy consistently with the member's other preventive benefits. In the case of the PCSA Rider, preventive services such as mammography are covered 100% before the deductible. In order to cover colonoscopies in a consistent manner to mammography, Anthem BCBS covers colonoscopies at 100% before the deductible under the PCSA Rider. While there is no legal requirement that the deductible be waived; in this manner, Anthem BCBS has made the decision to do so, in order to promote the health of our members and to address their expectations, as noted above.

Upon further review of the Colonoscopy amendment ("Amendment to

Certificate of Coverage - Colonoscopy Coverage") filed with the Bureau of Insurance in late 2008, Anthem BCBS recognizes that it is not immediately clear whether the PCSA rider is amended under the preventive care subsection in regard to the colonoscopy benefit change. In order to avoid any member confusion over this change in coverage, Anthem BCBS will file a revised PCSA rider (Form #048906) that specifies that colonoscopies are covered as a preventive benefit with no annual max. Anthem BCBS is currently administering the benefit for the PCSA rider in the manner intended and described above. We anticipate filing the revised PCSA rider before the end of March 2009. In addition, we noted that the form number referenced in the Colonoscopy amendment for the HealthChoice Individual Certificate of Coverage is incorrect and should read 5772ME R 1/09. We will file a correction to this amendment also.

6. Provide a more detailed description of your method for calculating trend as it relates to Second Information Request of the Superintendent Question #3.

Response: Anthem BCBS projects allowed cost trends for unit cost and utilization separately and for each service category: inpatient, outpatient, professional and pharmacy. The utilization component of the trend is based on a review of historical utilization trend adjusted for the impact of deductible mix, which was discussed in depth at the hearing. The unit cost impact is based on a formula that combines the impact of changes in contractual arrangements with providers, and the impact of changes in mix of services ("mix"). Historical observed unit cost trends are used to establish the mix and to verify the reasonableness of the calculated trends.

Anthem BCBS completes the following steps to calculate the allowed unit cost trend used in our rate development:

- Observed unit cost trends are reviewed separately by type of service e.g. inpatient, outpatient, professional, and pharmacy
- Observed cost trends are broken down into contracting and mix components.
- Mix is backed into for the observed periods by removing the calculated impact of contracting increases from actual observed trends (aka historical observed mix).
- Mix is selected for the projected period based on the historical observed mix adjusted for any expected changes during the projection period. For example, if utilization of more expensive services has been increasing faster than less expensive services, but that trend is not expected to continue, then projected mix

would be less than observed mix.

- Projected contracting increases and the projected mix are combined to arrive at projected annual cost trends.
- Based on the experience period reviewed and rating period used in pricing, trend projections for the appropriate periods are combined resulting in the pricing trend.

The attached file "6_Example of Cost Trend Projection.xls" contains a numerical example of the process outlined above for calculating unit cost trends.

The next step in the process is to review the calculated trends against the historical observed values. The values reviewed are shown in Exhibit VI.A of the rate filing. Anthem BCBS determined that the projected trends are in the middle of the range of observed values shown. Additionally, we took into account that as projected contracting increases are higher than they were on average during the period for which we have observed trend data, medical cost trend projections are higher than they would have been had they been based only on historical data.

7. Provide a projection of the HealthChoice population assuming the rates are approved as proposed, including a comparison of the experience for the lapsed members and remaining members.

Response: Anthem BCBS believes that our projection of membership included in the filing is our best estimate of future results. For the following reasons, Anthem BCBS is not changing our projection of membership and does not believe that our total membership will be materially affected by varying rate increases:

1. The proposed rate increase is not significantly higher than prior HealthChoice rate increases which were as high as 23.5% in 2001 and have been in the mid-teens (12.5% to 16.7%) since 2002. Our projection of membership is based on the observed membership trends which include rate increases at a similar level to those proposed.

2. We expect that sales will increase (and offset lapses) as more Maine residents lose employer-based coverage due to the economy:

- Other members may receive subsidies from their

employers to purchase individual coverage instead of employer-based coverage.

- Although some members will have a COBRA option, the premium for COBRA is typically very expensive and reflective of richer benefits compared to the leaner coverage options available in the Individual market.

3. Upon further review, even though the Lumenos rate increase is large, it still represents a viable cost saving (lower premium) option for many of our HealthChoice members. Specifically, members with $2250 and $5000 HealthChoice plan designs can move to the Lumenos plan designs and reduce their premiums while maintaining the same level of benefits. Anthem BCBS expects that membership in the Lumenos product will continue to grow as members look for less expensive health insurance options in these difficult economic times.

Anthem BCBS reviewed the paid claims experience for the lapsing members as of January 2009 versus the remaining population. Using data incurred in calendar year 2008 and paid through February 2009, the claims experience for the members that lapsed was 1.9% better than the members that remained. Anthem BCBS believes that members drop coverage from the HealthChoice and Lumenos pools for a myriad of reasons, only one of which is that their positive health status does not necessitate that they maintain coverage under the plan. Members that have poor health status will also drop coverage as their situation changes and they are able to find employer-based insurance, apply for subsidized health products, or choose to go without health coverage. The small difference in claims experience between the lapsing and remaining members indicates that the members dropping coverage represent a mixture of members by health status.

8. Provide the administrative expenses (as reflected on AG Exhibit #4 -- $40 million) by line of business. Also, provide any additional adjustments made to the administrative expenses reflected in the proposed rates.

Response: The following table outlines the administrative expenses from AG Exhibit #4 by line of business:

Large Group (Included FEP)	23,779,656
Small Group	17,189,734
Individual	3,121,746
Medicare Supplement	6,650,999
Dental	256,011
Vision	117,935

Stop loss and ASO Gains (10,756,355)
TOTAL 40,359,726
G&A (Per 5 Yr Historical Data per page 8 AS)

Please note that the administrative expense assumed in the proposed rates is based on a projection of the full calendar year 2008 administrative expenses as of November 2008 and include only the HealthChoice and Lumenos products. In addition to there being GAAP to STAT differences, AG Exhibit #4 is different from the administrative expenses included in the filing because it reflects (1) expenses for all products in the individual line of business (*i.e.*, not just HealthChoice and Lumenos), (2) expenses as of a different point in time (*i.e.*, November 2008 for the filing and February 2009 for the annual statement exhibits), and (3) to some degree, different expense components. The combination of these differences does not permit a meaningful comparison between the expenses reflected in AG Exhibit #4 those included in the filing. The additional adjustments made to the administrative expense that were discussed at the hearing are part of our annual review of allocations and are reflected in the final allocated expenses shown in the financial summary (AG Exhibit #4).

9. Provide example of why the two-person contract is the only one affected for the Lumenos aggregate versus HealthChoice embedded deductible adjustments.

Response: Please see attached file "9_Lumenos_Aggregate_Family_Deductible.xls"

10. [BETH FRITCHEN DATA REQUEST RE: NORMALIZATION] When performing trend analysis, changes in risk characteristics which impact costs (i.e. age, gender, utilization due to changes in benefits, morbidity, etc.) must be normalized to the extent that shifts in these characteristics are also accounted for in the rating formula. Specifically for HealthChoice and Lumenos, changes in utilization due to benefit shifts and age are at least in part accounted for in the rating formula. Therefore, the portion of the impact of these changes which is adjusted via the rating formula must be normalized in the trend calculation so as not to double count.

    In my opinion, the theoretically correct manner in which to make these adjustments is on a seriatim basis. Claims for each contract for each month would be adjusted to estimate what those claims would have been had all members been the same age and held a policy with the same benefits. These adjustments should be made using the rating factor differentials, rather than experience based differentials, since the goal is

to normalize for the portion of these changes which is also captured in the rating process. To perform this type of adjustment I would require claims by benefit, contract holder age, and tier for each month. Given the amount of effort required compile experience in this format and the time constraints in place, I recommend using a distribution of either contracts or members by age band and benefit as a proxy to determine the average age factor and average utilization factor in place each month.

Response:

Correction of the Attorney General's Proposed Method

Anthem BCBS agrees that "the portion of the impact of these changes which is adjusted via the rating formula must be normalized in the trend calculation so as not to double count." However, Anthem BCBS believes that the methodology described above fails to account for the fact that there are premium relativities for benefit design and age band as well as claim cost relativities for benefit design and age band. The statement above "[t]hese adjustments should be made using the rating factor differentials, rather than experience based differentials, since the goal is to normalize for the portion of these changes which is also captured in the rating process" is not correct because any attempt to normalize should account for differences accounted for in the rating formula as well as the underlying claim trend. The purpose of normalizing the allowed cost trend is to account for the underlying cost differences and not simply the rating factors which are restricted by law and do not reflect true claim cost differences. The normalized allowed cost trend that is applied in the rate development will lead to a more accurate projected claim cost and any offsets to premium from the rating structure should be accounted for separately. Offsets to premium do not affect the projected claim cost.

Ms. Fritchen's analysis of changes in age band indicates that the effect on premium is approximately +0.7%. Anthem BCBS is providing additional analysis using claim cost factors that indicates an adjustment to claims in the projection period of +2.7% (annualized impact). The 2.7% additional claims trend is due to the continued aging of our population as shown in the attached exhibit "10_Milliman_Utilization_Effects.xls." While some aging is reflected in our underlying claims trend (2.1% as shown in the exhibit), we expect the average age of the HealthChoice and Lumenos product pools to continue increasing (4.8% projected in the exhibit). In order to properly account for the impact of aging, the +0.7% premium impact (a reduction in required premium or a premium offset) and the +2.7% claim cost impact would both need to be applied as separate steps in the rate development.

During the hearing, there was discussion about the need to normalize

allowed claim cost for demographic differences including age and contract type. In the Anthem BCBS rate filing, the impact of deductible mix (+4%) and the benefit buy-down factor (-5.5%) are calculated using actual experience and in a consistent manner that does not normalize for age and contract mix. The benefit buy-down factor that Ms. Fritchen applies, however, is not calculated in a consistent manner or on an "apples to apples" basis to the deductible mix adjustment. This is because Ms. Fritchen's deductible mix calculation is based on theoretical factors, and the benefit buy-down factor she applies is based on actual experience.

If Ms. Fritchen chooses to employ a method of determining the enrollment shift (or deductible mix) that is based on theoretical (Milliman) factors, then the benefit buy-downs should be determined in the same manner using theoretical differences in benefit plan designs. These theoretical factors are not skewed by differences in demographics or actual experience, which has more credibility for certain plan designs versus others since some plans have credible membership for reviewing experience and others do not. In order to calculate benefit buy-downs in a consistent manner to the Milliman utilization factors applied in Ms. Fritchen's method, the benefit buy-downs should be calculated using theoretical benefit relativity factors and not actual experience. Therefore, the appropriate benefit buy-down factor rather than .945 based on actual experience would be in the range of .97 to .98 using the Milliman factors in a similar manner to Ms. Fritchen's analysis.

Anthem's Analysis

Returning to the impact of enrollment shifts in our Maine HealthChoice and Lumenos products, Anthem BCBS has accounted for both the impact to premium and the impact to claim cost in our traditional rate development method. We normalize the claim cost using the impact of deductible mix (4%) to project future claim cost and we normalize the premiums for the impact of shifting enrollment. In Exhibit III of the rate filing, the projected enrollment for each benefit plan is used to solve for the total required premium. In this manner, the distribution of membership by plan design is taken into account in the rate filing.

Furthermore, Anthem has not adjusted for the 0.7% premium impact from increasing age bands nor have we accounted for increasing claim costs due to aging of 2.7%. In this way, Anthem BCBS's assumed claim trend is understated. The net impact on the required premium increase would be at least an additional 2%. Also, the net claims trend assumed in our rate development is 10.3% which is materially lower than the 12.9% paid claim trend experienced for 2008 over 2007. In sum, the overall result is that the required premium increase is lower

than what would be required if we updated our analysis to account for these additional pieces of information. This analysis is consistent with the actual claims experience with runout through February, 2009 that we presented at the hearing, which reflected that actual claims are far worse than originally projected.

To perform this proposed analysis I request the following information:

(a) Please provide the number of contracts in force by age band and benefit plan for each month over the period November 2006 through October 2008. Please use the attached Excel file as a template for providing this information.

Response: Please see attached "10_Contracts by Age and Plan.xls"

(b) Please provide the number of members in force by age band and benefit plan for each month over the period November 2006 through October 2008. Please use the attached Excel file as a template for providing this information.

Response: Please see attached "10_Contracts by Age and Plan.xls"

(c) Please provide the utilization adjustment factors underlying the pricing for each plan offered. In other words, the portion of the benefit relativity factors that represent utilization differences between plans. For example, in Exhibit 4 of the filing you show this factor to be 1.1% for the $150 HealthChoice plan, 1.6% for the $300 HealthChoice plans, etc. Please provide the corresponding factors for all other plans.

Response: Utilization adjustments are not permitted under Rule 940 other than those shown in Exhibit IV of the filing. The factors applied in Exhibit IV are those included in the Milliman letter which is included in the rate filing.

DATED: March 20, 2009

/s/ Christopher T. Roach
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Attorney for Applicant

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

IN RE: ANTHEM BLUE CROSS AND BLUE SHIELD 2009 INDIVIDUAL RATE FILING FOR HEALTHCHOICE, HEALTHCHOICE STANDARD AND BASIC AND LUMENOS CONSUMER DIRECTED HEALTH PLAN PRODUCTS Docket No. INS-09-1000	)	**CERTIFICATE OF SERVICE**

The undersigned counsel 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 Applicant's Response to the Hearing Information Requests upon the persons and at the addresses indicated below.

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DATED: March 20, 2009

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Attorney for Applicant

INS-09-1000 HealthChoice /Lumenos Rate filing

Beth Fritchen Post-hearing Supplement
EXPLANATION OF UPDATED NORMALIZING OF THE TREND

When performing trend analysis, it is important that observed trends be adjusted for the impact of changes in risk characteristics embedded in the data (*e.g.*, age, gender, morbidity, utilization changes due to benefit changes, etc.) such that the final trend estimate represents the underlying secular trend plus anticipated future shifts in these risk characteristics. There are several scenarios of the normalization process that are dependent upon the specific situation of the environment.

> If changes in the average risk characteristics occurred during the base period used for trend analysis, but future changes in these risk characteristics are not anticipated, the entire impact of these changes should be normalized from the observed trend. For example, if aging has occurred at a rate that is believed to have added 2% per year to claims cost, but no future aging is anticipated, the effect of the historical aging should be removed or trends, and correspondingly projected claims, will be overstated.
>
> If instead future aging is anticipated to occur and a community rating methodology is used, the impact of anticipated future aging should remain in the trend since additional premium revenues would not be collected given premium rates do not vary with age.
>
> However if aging, or some portion of aging, is reflected in the rating structure, the aging must be removed from the trend to the extent it is also captured in the rating formula, so as not to double count the impact of aging in both the claims and the revenue. This same logic would apply to all other risk factors (e.g. gender, morbidity, utilization changes due to benefit changes). An example may aid in demonstrating this point.

If we assume the underlying secular trend is 10%, and we are presented with a population of credible size which is in a steady state (*e.g.,* constant average demographics, no changes in benefits, no changes in morbidity, etc.), the trend as measured using the observed claims data will be 10%. If we now start with these same assumptions but assume the population ages at a rate that is expected to add 2% per year to claims cost, the observed claims trend will instead be roughly 12%, the underlying 10% secular trend plus the 2% trend attributable to aging.

If the product is age rated such that when the population ages and claims cost increase by 2% per year the premium will correspondingly increase by 2% per year due to the age rating methodology, the 2% attributable to aging must be removed from the trend. In this case, not removing the 2% due to aging from the trend would increase total premium collected by 2% through higher projected claims and resulting in a higher rate increase and another 2% through the age rating formula as the distribution by age rating band

shifts. This would lead to a total premium increase of 4% while claims are only projected to increase 2%.

In this example, if the set of age factors used for rating purposes (hereafter referred to as 'premium age factors') is identical to the set of age factors which represent expected changes in claims cost by age (hereafter referred to as 'claims age factors'), it obviously makes no difference which set of factors are used to normalize the claims for purposes of determining the proper trend rate to use for pricing. However, if we introduce rating limitations on age factors such that the claims age factors differ from the premium age factors, as is present in Maine, a different normalized trend rate may result depending upon which set of age factors is used. Therefore, it is important that the premium age factors and not the claims age factors be used in the normalization.

We once again assume that the secular trend is 10%, the population ages at a rate that is expected to add 2% per year to claims cost, and all other characteristics represent a steady state. In other words, we assume the annual increase in the average age factor when using the claims age factors is 2%. However, in this case we assume that statutory limitations are placed on the age factors that may be used for determining premiums such that this same shift in the average age of the population generates only a 1.3% increase in total premium. Said otherwise, we assume the annual increase in the average age factor when using the premium age factors is 1.3%.

Again, the measured trend when examining the observed claims will be 12%, the 10% secular trend and an additional 2% increase in observed claims cost due to the impact of aging. If the trend is normalized using the claim age factors, the entire 2% impact that aging has on claims would be removed from the trend. At the same time, premium during the rating period would only increase 1.3% as a result of the rating formula which includes statutory limits on the premium age factors. This will result in premium collected which will be short by roughly 0.7%. Please note that implicit in the statement that 'premium collected will be short by roughly 0.7%' and the example to this point is the assumption that aging will occur during the rating period at the same rate at which it has occurred during the base period for which claims were used for the trend analysis. Therefore, the premium age factors must be used for the normalization so that the observed trend is only decreased by 1.3%, the same amount which is recaptured through the age rating methodology.

As noted, in the examples above we have assumed up to this point that the rate at which aging occurs during the projected rating period is identical to the rate at which aging occurred during the period of claims used for the trend analysis. If this is not the case, a two step process would be required. First, the entire 2% impact of aging should be removed from the historical observed trend to derive the underlying secular trend. Next, an estimate of the anticipated future aging should be added back to the trend. However, as with the approach above, only the portion of anticipated future aging which is not captured via the rating formula should be added back to the claims trend so as not to double count. For example, if it is anticipated that aging in the future will occur at a rate which increases claims by only 1% per year and due to restrictions on premium age

factors future premiums are anticipated to increase by only 0.6% as the average age of the inforce business changes, the normalization adjustment to trend would be approximately 1.6% (= -2% + (1% - 0.6%)).

The methodology just described applies similarly to changes in all risk characteristic that impact both claims costs and premium. In Maine, the only two risk characteristics by which premium rates may differ are age and benefit plan. Therefore, changes in all other risk characteristics (*e.g.*, gender, morbidity) must be reflected in the trend. If it is anticipated that aggregate future changes in these other characteristics which are not explicitly rated for will occur at the same rate at which they have changed in the recent past, no additional adjustment to the observed trend is necessary. If instead it is anticipated that the rate at which aggregate future changes in these characteristics will differ from that observed in the recent past, an adjustment to trend would be required.

During the hearing, the commissioner requested that the Attorney General issue a data request to Anthem in order to perform a more detailed trend analysis, consistent with the methodology outlined above. The Attorney General requested and Anthem provided an array containing the number of contracts by age and plan design for each month during the period November 2006 through October 2008. I performed an analysis as described above, normalizing observed trend for changes in the two risk characteristics which are captured through the rating formula, those being changes in the average age and changes in anticipated utilization as members change benefit plans.

Using the membership array provided and the age factors underlying the development of the rates, I calculated the average age factor for each month. Likewise, using the membership array and the Milliman utilization reduction factors for each plan I calculated the average utilization reduction for each month.

Next, using the allowed incurred claims estimates I previously developed, I normalized each monthly estimate, first for changes in the average premium age factor and next for changes in the average utilization factor which are embedded in the premium rate structure so as not to double count the effect of these changes in the trend. I applied the normalization factors by first dividing the allowed claims for each month by the corresponding average age factor and average utilization reduction factor and then multiplying the result by the average age factor and average utilization reduction factor for November 2006. This normalized all claims to the average age and utilization level present in November 2006.

In making these normalization adjustments, I only adjusted the portion of the claims for each month which were not attributable to catastrophic claims. Catastrophic claims are a random event and are not expected to vary significantly by age or benefit level. For example, we would not expect the level at which the catastrophic claimants utilize services to vary significantly depending upon whether they have a $5,000 deductible plan or a $10,000 deductible plan.

Once the non-catastrophic claims were normalized for underlying shifts in age and gender, the same trend analysis was applied as was applied to the raw claims data made available to me prior to the hearing. I performed the analysis once normalizing for age only, once for utilization only, and once for both age and utilization in order to understand the impact that each had on trend. The following table summarizes the results of my analysis when smoothing catastrophic claims using a trend rate of 25%:

Normalization	Linear Trend	Exponential Trend
No Normalization	6.3%	6.5%
Age Normalization	5.8%	6.0%
Utilization Normalization	7.1%	7.3%
Age and Utilization Normalization	6.6%	6.8%

As can be seen in the table above, after normalizing for both age and utilization changes which will be reflected in the premium rating formula, the resulting trend of 6.8% is not significantly different from the unadjusted trend of 6.5%. These trend estimates would need to be adjusted for leveraging and changes in provider contracting. In my prefiled testimony I added 2% for leveraging and 2% for increases in provider reimbursement levels above those embedded in the trend. Based upon the additional information provided by Anthem, as requested by the Superintendent, it appears that our estimate of the 2% for increases in provider reimbursement levels above those embedded in the trend is overstated. Historical evidence and projected estimates show this amount to be closer to 1%. Therefore, I have revised my estimate to be consistent with this additional information. Adding 2% for leveraging and 1% for increases in provider reimbursement levels above those embedded in the trend results in a revised linear trend estimate of 9.8% (= 1.066 x 1.02 x 1.01 - 1) and a revised exponential trend estimate of 10.0% (= 1.068 x 1.02 x 1.01 - 1). Given the general similarity between the two estimates, I have selected the exponential estimate of 10.0%.

As discussed previously, inherent in these trend estimates is the assumption that aging and benefit buydowns will occur at the same rate in the future as they have in the past. To the extent that they are not anticipated to occur at the same rate in the future, a further adjustment must be made to the trend estimate for it to be appropriate for use prospectively. I examined the annual rate at which these risk factors changed during the base period and compared them with the rate at which they are projected to change in the future, using Anthem's projected distribution of membership by age and benefit plan for the 12 month period ending June 2010 as presented in the rate filing as the estimate for the future distribution. I used the premium based rating factors for this comparison. The following table compares the historical vs. projected rate of change:

	12 Mo. Ending 10/07 to 12 Mo. Ending 10/08	**12 Mo. Ending 10/08 to 12 Mo. Ending 6/10**
Annual Change in Age Factor	0.7%	-0.2%
Annual Change in Premium Utilization Factor	-1.0%	-0.5%
Combined Annual Change	-0.3%	-0.7%

- From the table above, one can see that during the experience period the combination of changes in age and utilization due to shifts in benefits resulted in a 0.3% reduction in premiums collected due to the rating formula. This point estimate change is consistent with the 0.3% difference between the observed trends and the normalized trends using the regression methodology, as previously described.

  The change in premium due to the combination of aging and benefit utilization reductions was occurring at a rate of -0.3% annually but is projected to occur during the rating period at a rate of -0.7% annually. Therefore, the difference between the historical changes in these risk characteristics and anticipated future changes in these risk characteristics will have a very small impact on future trends. Based on this small differential above, we believe a reasonable adjustment to our trend estimate to reflect expected changes in aging and utilization in the future would be no more than 0.5%. Therefore, the maximum trend we would generate would be 10.6% (= 1.10 x 1.005 - 1).

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April 13, 2009

Mila Kofman, Superintendent
c/o Pat Galouch
Docket No. INS-09-1000
Maine Bureau of Insurance
34 State House Station
Augusta, Maine 04333-0034

Re: *Anthem BCBS 2009 HealthChoice Individual Rate Filing*
Filing coversheet

Dear Superintendent Kofman:

Enclosed for filing please find the following:

SUBMITTED BY: Christopher T. Roach

DATE: April 13, 2009

DOCUMENT TITLE: Anthem BCBS Response to Inquiries of the Superintendent to Anthem's Response to Hearing Requests

DOCUMENT TYPE: Hearing Request Responses

CONFIDENTIAL: **No**

Thank you for your assistance in this matter.

Very truly yours,

/s/ Christopher T. Roach

cc: Thomas C. Sturtevant, Esquire
Christina M. Moylan, Esquire

{W1364328.1}

NON-CONFIDENTIAL

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

IN RE:	)	
	)	
ANTHEM BLUE CROSS AND BLUE	)	
SHIELD 2009 INDIVIDUAL RATE	)	APPLICANT'S RESPONSE TO
FILING FOR HEALTHCHOICE,	)	INQUIRIES OF THE
HEALTHCHOICE STANDARD AND	)	SUPERINTENDENT TO
BASIC AND LUMENOS CONSUMER	)	ANTHEM'S RESPONSE TO
DIRECTED HEALTH PLAN	)	HEARING REQUESTS
PRODUCTS	)	

Docket No. INS-09-1000

April 13, 2009

NON-CONFIDENTIAL

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

IN RE:	)	
	)	
ANTHEM BLUE CROSS AND BLUE	)	
SHIELD 2009 INDIVIDUAL RATE	)	APPLICANT'S RESPONSE TO
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HEALTHCHOICE STANDARD AND	)	SUPERINTENDENT TO
BASIC AND LUMENOS CONSUMER	)	ANTHEM'S RESPONSE TO
DIRECTED HEALTH PLAN	)	HEARING REQUESTS
PRODUCTS	)	

Docket No. INS-09-1000 April 13, 2009

Applicant Anthem Health Plans of Maine, Inc., d/b/a Anthem Blue Cross and Blue Shield ("Anthem BCBS") hereby responds to the Inquiries of the Superintendent to Anthem's Response to Hearing Requests as follows:

1. Please clarify Response # 5 as follows:

    a. The response states, "Prior to January 2009, colonoscopies were covered based on the diagnosis listed in the provider bill, which resulted in some being covered under the preventive benefit and others covered generally under 'diagnostic services' and 'surgical services.'" Does this apply to all products? If not, please answer separately for HealthChoice with PCSA rides, HealthChoice without PCSA rider, HealthChoice Standard and Basic, and Lumenos. Also, for each of these products, please specify whether the deductible was waived when covered under the preventative benefit.

Response: Yes, it is true that for all products prior to January 2009 colonoscopies were covered based on the diagnosis listed in the provider bill, which resulted in some being covered under the preventive benefit and others covered generally under diagnostic services and surgical services. Preventive benefits were covered as follows:

- For HealthChoice with PCSA rider, colonoscopies were not included as part of the rider benefit prior to January 2009 and as such the deductible would not be waived.
- For HealthChoice without PCSA rider, the deductible is not waived for preventive benefits nor is it waived for colonoscopies

before and after January 2009.

- For HealthChoice Standard and Basic products, the deductible is waived for preventive benefits. However, prior to January 2009, the Standard and Basic plans did not cover colonoscopy benefits under the preventive benefit and as such the deductible would not have been waived for colonoscopies.
- Pre- and Post- January 2009, Lumenos products waive the deductible for preventive benefits which includes colonoscopy benefits. The deductible was and is waived for colonoscopies on the Lumenos product.

b. The response states, "Effective January 1, 2009, colonoscopies are covered as a preventive benefit under the HealthChoice Preventive Care and Supplemental Rider ('PCSA Rider') and for the HealthChoice, HMO, HealthChoice Standard & Basic, and HealthChoice High Deductible Health Plan products." What effect does this change have for HealthChoice without the PCSA rider, HMO, HealthChoice Standard & Basic, and HealthChoice High Deductible Health Plan products?

Response: There is no effect on member cost sharing due to the change in the preventive language for HealthChoice without the PCSA rider, HMO, and HealthChoice High Deductible Health Plan. The change in language was made to clarify for all parties that colonoscopies are covered as required by the mandate and that they were paid as part of the preventive benefit.

For HealthChoice Standard & Basic, colonoscopies are now covered as part of the preventive benefits which are covered at 100% before the deductible (deductible is waived as stated in 1a.).

c. The response states, "In order to cover colonoscopies in a consistent manner to mammography, Anthem BCBS covers colonoscopies at 100% before the deductible under the PCSA Rider." Does this statement apply only to the period after January 1, 2009?

Response: Yes, colonoscopy benefits were only added to the PCSA rider effective January 1, 2009.

2. Please clarify Response # 6 as follows:

a. The response states, "Mix is selected for the projected period based on the historical observed mix adjusted for any expected changes during the

projection period. For example, if utilization of more expensive services has been increasing faster than less expensive services, but that trend is not expected to continue, then projected mix would be less than observed mix." Is this a judgmental adjustment or is it calculated? In either case, please provide further detail as to how this adjustment is determined.

Response: It is neither simply judgment nor a formulaic calculation. We review the mix by service category for the observed period against the historical observed values as a reasonableness check. For example, if the observed mix for the most recent period is +8% and the observed values have been from 2%-4%, we would complete additional research into the mix of service patterns to better understand the driver of the increase in mix. As stated in our prior response, if we determined that utilization of more expensive services was increasing faster than utilization of less expensive services and that this difference was the driver of the +8% mix of service trend, we would then try to determine whether this trend was expected to continue. We complete a thorough review of the observed data when selecting an appropriate mix of service for the projection period and, in this way, the mix of service assumption is based on actual and expected experience.

The mix of service trends assumed for the projection period in the HealthChoice and Lumenos rate filing are all at or below observed values. Our review of the detailed claims experience indicated an expectation that mix of service trends would remain at current levels or dampen going forward.

Based on the most recent observed trends, with 4 months of additional run-out in the claims experience, it is clear that Anthem's projected allowed trend is actually understated. Paid claim trends and the underlying allowed trends are materially higher than the level observed when the detailed trend analysis was completed. Our rate development includes a net or paid claim trend level (allowed trend less buy-down) of 10.3% but the observed paid claim trend for 2008 over 2007 with data through February 2009 is 12.9%. Paid claim cost trend reflects the full cost sharing and utilization impact of benefit buy-downs as well as the impacts of aging and, as such, should be used to compare to the allowed trend after benefit buy-downs are applied.

b. Are projected contracting increases calculated as a weighted average of various contracts or are they estimated based on a review of contracts?

Response: Actual (finalized) and projected (presumed) contracting increases for the rating period are weighted for each service category (e.g. inpatient, outpatient, and professional) by the allowed dollars associated with the provider during the most recent observed period. For inpatient and

outpatient, the weights are based on the allowed dollars at each facility for each service category, and for professional, the weights are based on the allowed dollars for the provider.

3. Response # 9 presents an example for which the two-person contract is the only one affected for the Lumenos aggregate versus HealthChoice embedded deductible adjustments. However, if the example were constructed differently, wouldn't the results be different? For instance, if the annual claim cost for children were $200 rather than $1,700, wouldn't the Plan Portion for the family be less under the aggregate deductible than under the embedded deductible? If so, what adjustment to the Lumenos family factor would be appropriate?

Response: The premise of your question is correct: under that specific scenario the plan portion for the family would be less under the aggregate deductible than under the embedded deductible. When determining the adjustment factor, however, we considered literally hundreds of scenarios. More specifically, the actual .90 factor was priced using Monte Carlo simulation to value the full range of potential annual claim cost on all contract types under embedded and aggregate family deductibles. The following steps were taken in the simulation for a 2-adult contract:

1. Create all the possible combinations and permutations for 2 adults using the appropriate Milliman claim probability distributions ("CPD") A CPD table includes ranges of potential annual claim cost and the frequency associated with each range. In the evaluation, 60 factors were used from the CPD tables.
2. Create a table with the joint probabilities and joint claims.
3. Create a joint CPD table for 2 adult using the combined claim cost and resulting frequency from all possible permutations.
4. Calculate the value of the plan with a given deductible level for the embedded deductible option.
5. Using the joint CPD calculate the value of the plan with 2 times the given deductible level for the aggregate deductible option.

Similar steps were taken to determine the projected annual cost under all contract types and a range of deductible levels for the Lumenos products. The results of the analysis indicated that the two-adult contract was at a financial disadvantage to the other contract types when switching from an embedded to aggregate family deductible. Contract types with more than 2 members per contract had a greater chance of meeting the combined or aggregate deductible since the multiplier is the same for all contract types (2 times the single contract level). The simulation represents the average ratio over time and should reflect our long-term expectation of differences in cost.

DATED: April 13, 2009

/s/ Christopher T. Roach
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STATE OF MAINE
DEPARTMENT OF PROFESSIONAL AND FINANCIAL REGULATION
BUREAU OF INSURANCE

IN RE: ANTHEM BLUE CROSS AND BLUE SHIELD 2009 INDIVIDUAL RATE FILING FOR HEALTHCHOICE, HEALTHCHOICE STANDARD AND BASIC AND LUMENOS CONSUMER DIRECTED HEALTH PLAN PRODUCTS Docket No. INS-09-1000	**CERTIFICATE OF SERVICE**

The undersigned counsel 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 Applicant's Response to Inquiries of the Superintendent to Anthem's Response to the Hearing Information Requests upon the persons and at the addresses indicated below.

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DATED: April 13, 2009

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April 17, 2009

Mila Kofman, Superintendent
c/o Pat Galouch
Docket No. INS-09-1000
Maine Bureau of Insurance
34 State House Station
Augusta, Maine 04333-0034

Re: Anthem BCBS 2009 HealthChoice Individual Rate Filing
Filing coversheet

Dear Superintendent Kofman:

Enclosed for filing please find the following:

SUBMITTED BY: Christopher T. Roach

DATE: April 17, 2009

DOCUMENT TITLE: Anthem BCBS Written Closing Statement

DOCUMENT TYPE: Closing Statement

CONFIDENTIAL: **No**

Thank you for your assistance in this matter.

Very truly yours,

/s/ Christopher T. Roach

cc: Thomas C. Sturtevant, Esquire
Christina M. Moylan, Esquire

NON-CONFIDENTIAL

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

IN RE:	)	
	)	
ANTHEM BLUE CROSS AND BLUE	)	
SHIELD 2009 INDIVIDUAL RATE	)	APPLICANT'S WRITTEN
FILING FOR HEALTHCHOICE,	)	CLOSING STATEMENT
HEALTHCHOICE STANDARD AND	)	
BASIC AND LUMENOS CONSUMER	)	
DIRECTED HEALTH PLAN	)	April 17, 2009
PRODUCTS	)	

Docket No. INS-09-1000

NON-CONFIDENTIAL

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

IN RE:	)	
	)	
ANTHEM BLUE CROSS AND BLUE	)	
SHIELD 2009 INDIVIDUAL RATE	)	APPLICANT'S WRITTEN
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HEALTHCHOICE STANDARD AND	)	
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DIRECTED HEALTH PLAN	)	April 17, 2009
PRODUCTS	)	

Docket No. INS-09-1000

The laws governing the scope of this proceeding are well established – the Superintendent must approve the proposed rates unless they are excessive, inadequate, or unfairly discriminatory. The evidence before the Superintendent demonstrates that the proposed rates effective July 1, 2009 are not excessive or unfairly discriminatory. Anthem BCBS and the Attorney General ("AG") appear to agree generally on the appropriate process to establish rates and on most key components of the proposed rates (*e.g.*, administrative expenses, commissions, the savings offset payment calculation). The areas of remaining disagreement appear to be limited to (1) the appropriate profit and risk charge, and (2) a portion of the methodology for calculating trend.

With respect to the profit and risk charge, the financial statements reflect that, rather than achieving the profits previously authorized by the Superintendent, Anthem BCBS has lost several million dollars on these individual products over the course of the preceding four years. While the proposed rates are not designed to recoup those loses, these prior period results demonstrate that Anthem BCBS's 3% pre-tax/2% post-tax profit and risk charge has been inadequate to cover the risks associated with these

products and provide a reasonable contribution to the surplus of Anthem BCBS. These results also reflect that a reduction in the proposed profit and risk charge could only be characterized as requiring an indirect subsidy of the individual products by the group products that Anthem BCBS offers; a subsidy not authorized by the Maine Insurance Code and not required of any other insurer in the Maine insurance market. Requiring Anthem BCBS to subsidize its individual business with its group business would put the company at a competitive disadvantage with all of the carriers in Maine that offer group, but not individual, insurance products. Ironically then, in exchange for Anthem BCBS's continued willingness to serve the individual market the company's "reward" would be losses that would act as a competitive drag on the other business it writes in Maine. Establishing individual rates in this manner would be fundamentally unfair and discriminatory.

With regard to the trend calculation, Anthem BCBS notes that Ms. Fritchen's overall methodology to normalize observed claim trends reflected in her post-hearing supplement ("Supplement") is consistent with Anthem BCBS's hearing testimony and responses to the hearing requests from the Superintendent. As set forth below, however, Ms. Fritchen's application of that methodology – which focuses on premium factors – fails to account accurately for the impact of demographic changes on claim trend and her resulting paid claims trend of 6.9% (allowed trend less buy-downs) is demonstrably insufficient given the evidence reflecting that Anthem BCBS's emerging paid claims trend through December 2008 is 12.9%. Paid claim cost trend reflects the full cost sharing and utilization impact of benefit buy-downs as well as the impacts of aging and, as such, should be used to compare to the allowed trend after benefit buy-downs are

applied. If the Superintendent adopts Ms. Fritchen's trend methodology (which at a high level is reasonable), but correctly accounts for the actual anticipated impact of demographic changes on claims, the resulting paid claims trend would be 10.7%. While materially lower than Anthem BCBS's most up to date information, this is far more consistent with the real expected experience for HealthChoice and Lumenos and, accordingly, should be used in the development of rates. Further, using a realistic rate of claim trend reduces future required rate increases.

The following discusses the primary areas of disagreement between Anthem BCBS and the AG (trend and risk and profit charge) in detail as well as a summary of some of the rating factors and retention items discussed at the rate hearing.

I. Calculation of a Reasonable Allowed Claim Cost Trend

A. Claim Cost Factors, Not Premium Factors, Must Be Used To Normalize Accurately The Underlying Claims Cost Trend

In her Supplement Ms. Fritchen appeared to make a tacit admission that premium factors are not the equivalent of claim cost factors. In the Supplement, Ms. Fritchen correctly states that "the impact of anticipated future aging should remain in the trend since additional premium revenues would not be collected given premium rates do not vary with age." (Page 1 of Supplement, paragraph 3; *see also* page 2, paragraph 3: Ms. Fritchen acknowledges that using premium age factors, rather than claim factors, "will result in premium collected which will be short"). In contrast to these correct statements, however, Ms. Fritchen used premium (rather than claim cost) factors for the normalization analysis. This was in error.

Claim cost trend is affected by actual cost differences related to an aging population and not the restricted premium factor differences. As an example, consider a

single male contract holder turning 50. Using the Milliman Health Cost Guidelines, the expected claim cost for this member will increase by 33% when he moves from the 45-49 age band to the 50-54 age band (1.535/1.152 – 1 = 33% as shown in Anthem's exhibit "10_Milliman_Utilization_Effects.xls" included in Anthem BCBS's responses to the hearing information requests). By contrast, due to the premium factor restrictions, the same member's premium rate will only increase by 7.5% (1.075/1.000 -1 shown in the same exhibit). The effect of the restricted premium factors is that, unless trend is adjusted by the appropriate claim cost factor, the resulting premium collected would be insufficient to cover the expected additional claim cost changes resulting as members age.

Moreover, using Ms. Fritchen's assertion and applying it to the age band changes, the claim cost factors for age band should be applied in the absence of appropriate premium factors. Because the premium factors are limited by regulation and do not represent true underlying cost differences, using those factors to determine expected claim costs is insufficient to project claim cost trend. Indeed, while her Supplement suggests that premium and claim cost factors are interchangeable, Ms. Fritchen acknowledges that if they are not, claim cost factors should be used to project trend. Because for the reasons set forth above premium factors do not capture the true underlying benefit differences, Ms. Fritchen's own analysis would suggest that claim cost factors must be used to project the claims trend.

B. Applying Ms. Fritchen's Analysis Appropriately Using Claim Cost Factors Yields an Allowed Trend of 14.5%

Using appropriate age band factors based on underlying claim cost differences, Anthem BCBS reviewed the resulting claim trend provided in Ms. Fritchen's analysis.

Using Ms. Fritchen's approach, we started with the utilization normalized exponential trend of 7.3%. Next, we normalized for the observed impact of aging (-2.1%) from Anthem BCBS's previously submitted analysis and added the projected impact of aging in the rating period (+4.8%). The resulting age adjusted trend is 10.1% as shown in the table below. Deductible leveraging and the impact of provider contracting are added to the age adjusted claim trend. Anthem BCBS applied 2% for deductible leveraging and 2% for provider contracting. As discussed at the rate hearing, provider contracts have been affected by economic conditions that have resulted in higher requested increases and cost shifting continues to be an issue as government and subsidized programs restrict provider reimbursement. The resulting allowed claim trend is 14.5% as follows:

Item	Trend Impact	Description
Exponential trend	7.3%	
Observed age impact	-2.1%	
Projected age impact	+4.8%	
Age Adj claim trend	10.1%	= 1.073 * (1-.021) * (1+.048) - 1
Deductible leveraging	+2.0%	
Provider contracting	+2.0%	
Allowed claim trend	14.5%	= 1.101 * 1.02 * 1.02 - 1

Adjustments that affect premium collected, including additional revenue from age band changes and changes in revenue from benefit shifts, should be accounted for separately from the claim trend analysis. Changes in revenue from benefit shifts are already accounted for in the Exhibit III premium projection since contracts are projected by benefit plan design when reviewing the total premium dollars required. Additional revenue from age band changes is estimated at +0.8% and should be removed from the overall required premium increase. If the required increase is 18.9%, the increase in

premium from age band changes should be removed from the total such that the total required increase is 18.1%.

C. The Paid Claims Trend Of 10.7% Calculated Based On Ms. Fritchen's Analysis, But Using Claim Cost Factors Is Consistent With Anthem BCBS's Actual Paid Claims Experience

The next step in any analysis of trend is to review the resulting paid claim trend against observed claim trends. With claims paid through February 2009, Anthem BCBS's claim trend for calendar year 2008 over calendar year 2007 is 12.9% (shown in Anthem BCBS's Hearing Exhibit 6). In contrast, using Ms. Fritchen's allowed trend of 10.6% and applying benefit buy-downs of .945, the resulting paid trend is 6.9% (= (1.106^(20/12) *.945) ^ (12/20) - 1). That resulting paid trend is clearly insufficient when compared to Anthem BCBS's actual claim experience. As stated previously, paid claim cost trend reflects the full cost sharing and utilization impact of benefit buy-downs as well as the impacts of aging and, as such, should be used to compare to the allowed trend after benefit buy-downs are applied. Using Anthem BCBS's adjusted allowed trend of 14.5% and applying benefit buy-downs of .945, the resulting paid trend is 10.7% (= (1.145^(20/12) *.945) ^ (12/20) - 1). While the resulting 10.7% trend is lower than emerging claim cost trends and suggests that Anthem BCBS may have underestimated trend, this is an appropriate assumption to project future claim cost. As discussed at the hearing, Anthem BCBS makes every effort to project claim cost using a trend that represents the long-term average expectation; not raising trends based on recent poor experience or lowering trends due to recent favorable experience. Further, the result of applying a steady rate of trend (14.5% for the 2009 filing, 15.2% in the 2008 filing) is a consistent rate of premium increase for our policyholders.

For all of these reasons, the 14.5% and 10.7% allowed and paid trends, respectively, reflected in Anthem BCBS's above analysis are reasonable and should be reflected in the approved premium rate development. The 6.9% paid claims trend suggested by Ms. Fritchen is demonstrably inadequate and, accordingly, would produce inadequate rates.

II. The Profit/Risk Charge is Reasonable

The Superintendent is charged with determining whether Anthem BCBS's proposed rates are excessive, inadequate, or unfairly discriminatory. To be adequate, the rates must cover all costs plus allow for a reasonable rate of return. March 12, 2009 Hearing Transcript, p. 233 (Ms. Fritchen: acknowledging that rates must be sufficient to cover all claim costs, administrative costs plus provide for a reasonable after tax profit to contribute to the surplus of the company).

The rating of health insurance in general, particularly individual health insurance with high deductibles in a guaranteed issue and renewable environment carries a high level of risk due to the potential for claim volatility and adverse selection. As Anthem BCBS remains the only significant insurer in this market, HealthChoice has become a de facto individual high-risk pool for the State of Maine. The pool's experience continues to deteriorate as evidenced in the claim trends. In prior orders, the Superintendent determined that a 3% pre-tax margin for profit and risk for the HealthChoice products was sufficient. As illustrated by the significant losses for this product in 2005 and 2006 followed by moderate profits in 2007 and 2008, the 3% pre-tax margin has been inadequate to cover the risks associated with providing individual insurance in this market, much less provide a reasonable contribution to surplus.

The AG acknowledges that premium rates must cover all costs plus allow for a reasonable contribution to the surplus of the company, but suggests that Anthem BCBS's overall financial status should be considered when determining what "reasonable" means. While Anthem BCBS would agree that profit margins should be increased if an insurer has inadequate risk based capital levels or is otherwise in danger of being unable to cover claims, the existing 3% profit and risk charge has yielded negative actual profit for Anthem BCBS since 2005. As such, the 3% pre-tax charge has not even covered the risks of offering the individual products in Maine. With this backdrop, the AG's argument for consideration of Anthem BCBS's surplus levels is nothing more than a suggestion that Anthem BCBS must subsidize its individual products with its group business.

This sort of subsidization is not required by law and not required of any other carrier doing business in Maine. If there is going to be an individual high risk pool in Maine, then it should recognized as such, and, if it needs to be subsidized, require all carriers in the State to share in that effort. To require Anthem BCBS to shoulder this burden alone would be discriminatory, inequitable and, in any event, contrary to Maine's requirement that rates must be adequate.

III. Savings Offset Payment

On August 11, 2008, the Board of Directors of the Dirigo Health Agency issued a decision finding aggregate measurable cost savings ("AMCS") of approximately $150 million. On September 23, 2008, the Superintendent issued a decision finding $48.7 million AMCS to be reasonably supported by the record evidence. The DHA Board determined that the SOP assessment effective July 1, 2009 is 2.14%.

The pre-filed testimony of Vincent Liscomb demonstrates that during the negotiation process with providers, Anthem BCBS has internal discussions concerning financial data from the provider, as well as extensive discussions to ascertain the provider's financial status, the factors that are impacting that status, and how to achieve the best possible contractual arrangement that ensures Anthem BCBS achieves the absolute best possible price. Furthermore, Mr. Liscomb testified that Anthem BCBS takes a global perspective to ensure that all savings, from whatever source but certainly including those savings attributable to Dirigo and expansions in MaineCare, are included in the final negotiated rate with providers. In sum, Mr. Liscomb's testimony demonstrates that Anthem BCBS has used its best efforts to recover all cost savings that are as the result of the operation of Dirigo Health or the MaineCare expansions identified in 24-A M.R.S.A. §6913. There was no evidence presented to the contrary.

Anthem BCBS's process in ensuring that it obtains the best possible contract rates from its providers has not changed and, accordingly, the evidence presented to the Superintendent has not changed materially since the inception of the SOP. In every rate proceeding – whether HealthChoice or DirigoChoice when Anthem BCBS administered that program – the Superintendent found that the evidence presented by Anthem BCBS demonstrated that the Company complied with the statute by using its best efforts to recover all applicable cost savings that resulted from the operation of Dirigo Health or the MaineCare expansions. *See, e.g.*, Docket No. INS-05-820, *In re Anthem Blue Cross and Blue Shield 2006 Individual Rate Filing for HealthChoice and HealthChoice Standard and Basic Products*, Decision and Order issued December 19, 2005, p.10 ("[Mr. McCormack] testified that he was confident that the current contracts with healthcare

providers were the best contracts that Anthem could secure and that embedded in those contract rates were the savings attributable to Dirigo. Furthermore, Mr. Whitmore [Anthem BCBS's actuary] 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.").

IV. Lumenos Products Should be Priced Using An Appropriate Utilization-Based Adjustment to the HealthChoice Rates

Anthem BCBS combined the HealthChoice and Lumenos pools when reviewing experience because the HealthChoice and Lumenos basic benefit structures are materially similar with similar deductible levels, coinsurance and preventive benefits. Also, the experience of the two pools is combined because members from HealthChoice can freely migrate to Lumenos and the reverse in the guaranteed issue individual market.

Anthem BCBS is proposing a rate decrease between the HealthChoice $5000 deductible with PCSA Rider and Lumenos H.S.A. $5000 deductible of 8.9% which includes a 6% utilization based factor. During the hearing, Ms. Fritchen suggested that 15% was a more appropriate factor based on the industry study provided in her pre-filed testimony. Anthem believes a 15% utilization factor between Lumenos and HealthChoice is inappropriate for two primary reasons: first, Lumenos deductible levels are not higher than those of HealthChoice products and second, the study sited was based on group policyholders, not Individual. March 12, 2009 Hearing Transcript, p. 115-16. The 6% utilization based factor used in Anthem's proposed rates is based on a review of plan design differences and expected utilization based savings and is appropriate for the

Individual market in Maine. If the utilization factor is significantly increased, as suggested by Ms. Fritchen, the resulting rate differential becomes excessive compared to the difference in benefits. This excessive rate differential puts Anthem at risk of extreme anti-selection and would result in continued deterioration of the Lumenos products. Applying the 6% utilization based discount to the Lumenos product rates continues to offer a viable cost-saving alternative in the Maine Individual market.

Conclusion

For all of the reasons stated above, Anthem BCBS respectfully requests that the Superintendent approve the rates as proposed by Anthem BCBS. Thank you for your time and attention to this filing.

DATED: April 17, 2009

/s/ Christopher T. Roach
Christopher T. Roach, Esq.
PIERCE ATWOOD LLP
One Monument Square
Portland, Maine 04101
Attorney for Applicant

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

IN RE:	)	
	)	
ANTHEM BLUE CROSS AND BLUE SHIELD 2009 INDIVIDUAL RATE FILING FOR HEALTHCHOICE, HEALTHCHOICE STANDARD AND BASIC AND LUMENOS CONSUMER DIRECTED HEALTH PLAN PRODUCTS	)	**CERTIFICATE OF SERVICE**
	)	
Docket No. INS-09-1000	)	

The undersigned counsel 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 Applicant's Written Closing Statement upon the persons and at the addresses indicated below.

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DATED: April 17, 2009

/s/ Christopher T. Roach
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Portland, Maine 04101
Attorney for Applicant

Supporting Document Schedules

		Item Status:	Status Date:
Unsatisfied - Item:	Explanatory Memorandum LH	Approved	05/26/2009
Comments:			

		Item Status:	Status Date:
Unsatisfied - Item:	Actuarial Justification for Rate (Change) LH	Approved	05/26/2009
Comments:			

BUDGET NARRATIVE

Maintenance of Effort: The Bureau hereby certifies that grant funds, if awarded, will only be used to enhance the state's existing rate review efforts, and will not supplant any existing state expenditures or funding. Generally, while the Work Plan contemplates significant Bureau staff time, the grant award will not fund Bureau staff time. The one exception is that the grant is needed to fund the Bureau's internal Examiners' time spent on these initiatives. Examiner time currently is billed to insurers for examinations. If that time is diverted to these initiatives, insurers cannot be billed and therefore there would be a loss in revenue. The grant will not be used to supplant any State of Maine funding of staff salaries. The Bureau has had preliminary discussions with potential consultants to perform the analysis of the market reforms, which serve as the basis of the proposed budget for that initiative. However, the Bureau has not entered into a contract for that project and has not allocated any funds.

Program Areas: The Bureau proposes to allocate the grant among three program areas:

1. The bulk of the grant funds ($931,200) are allocated to initiatives directly related to the Bureau's rate review program, as described in more detail in the Project Narrative and in the Work Plan. These are itemized as follows:

Initiative	Budget
Small group rate review	$ 139,500
Trend data collection and analysis	46,500
Testing the validity of data submitted by insurers	88,800
Review of medical loss ratio information	44,400
Enhanced staff training	12,000
Enhanced rate review information technology	50,000
Analysis of changes in the market	250,000
Stronger consumer participation and greater transparency	300,000
TOTAL	**$ 931,200**

2. Maine's share of the multi-state initiative to enhance SERFF in order to participate in the HHS data reporting program is $18,800.

3. The remaining $50,000 is allocated to the Maine Health Data Organization (MHDO) for the data center program.

Direct and Indirect Administration: The Bureau would directly administer all initiatives within rate review program area, would directly engage and supervise all consultants, and would directly supervise and monitor all disbursements of grant funds for consumer participation. While funding for the other two program areas is included in the proposed budget, these are not for the use by the Bureau and would be administered externally – the data reporting initiative by NAIC and its SERFF affiliate, and the data center initiative by MHDO.

Notes on Major Expenditures and Contractual Costs: The Bureau's estimates are approximate; final amounts would be available after contracts with consultants are executed:

- Actuarial consultants for review of rates and trend survey: 930 contractor hours: $186,000
- Examinations to test validity of data: 440 contractor hours, $88,800
- Consumer education and training programs: 1000 contractor hours, $100,000
- Analysis of changes in market: 1000 hours for actuarial consultants and their subcontracted economist, $250,000
- Analysis of medical loss ratio information: 250 hours for actuarial consultants and internal examiners, $44,400
- Consumer advocacy support for hearing and rate review participation: $200,000
- Direct information technology expenditures for rate review: approximately $50,000

STATE OF MAINE
DEPARTMENT OF PROFESSIONAL
AND FINANCIAL REGULATION
BUREAU OF INSURANCE
34 STATE HOUSE STATION
AUGUSTA, MAINE
04333-0034

JOHN ELIAS BALDACCI
GOVERNOR

MILA KOFMAN
SUPERINTENDENT

July 7, 2010

Jacqueline Roche
Gladys Bohler
The Office of Consumer Information and Insurance Oversight
U.S. Department of Health and Human Services
Jacqueline.Roche@HHS.gov
Gladys.Bohler@HHS.gov

Submitted via e-mail only

RE: Application for Health Insurance Premium Review Grant-Cycle 1 (CFDA #93.511)
Maine Bureau of Insurance, Department of Professional and Financial Regulation

Dear Ms. Roche and Ms. Bohler:

Please find enclosed the Maine Bureau of Insurance, Department of Professional and Financial Regulation, application for a $1,000,000 health insurance premium review grant for Cycle 1.

Per your request:

Point of Contact Information:

Mila Kofman
Superintendent
Maine Bureau of Insurance
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Augusta, ME 04344
(207) 624-8550
Mila.kofman@maine.gov

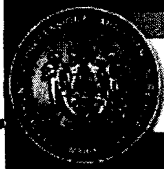
Authorized Organization Representative (AOR) and Project Director:
Thomas M. Record
Senior Staff Attorney
Maine Bureau of Insurance
34 State House Station
Augusta, ME 04344
(207) 624-8426
thomas.m.record@maine.gov

The Maine Bureau of Insurance has regulatory authority over health insurance rates (pursuant to 24-A M.R.S.). The Bureau has authority to oversee and coordinate the rate-related activities proposed in this Application. The Maine Health Data Organization, a sister state agency, has authority over its proposed initiative.

Thank you for your consideration. If you have any questions, please contact me directly at 207-624-8550 or Tom Record. I look forward to working with you and your team through this process.

Sincerely,

Mila Kofman
Superintendent



Professional &
Financial Regulation

- OFFICE OF SECURITIES
- BUREAU OF INSURANCE
- CONSUMER CREDIT PROTECTION
- BUREAU OF FINANCIAL INSTITUTIONS
- OFFICE OF LICENSING AND REGISTRATION

PRELIMINARY REPORT: THE HEALTH INSURANCE MARKET IN MAINE

PREPARED BY BUREAU OF INSURANCE STAFF
FEBRUARY 2010

John Elias Baldacci
Governor

Anne L. Head
Commissioner

Mila Kofman
Superintendent

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APPENDIX A: Federal Health Reform Bills summary prepared by Kaiser Family Foundation (reprinted with permission from KFF)
APPENDIX B: Market Snapshot – individual medical
APPENDIX C: Market Snapshot – small group health

I. INTRODUCTION

This report is submitted pursuant to P.L. 2009, ch. 439, § D-4, which directs the Superintendent of Insurance to:

> review possible ways to improve the availability and affordability of the State's individual health insurance market, including, but not limited to, increases in the minimum loss-ratio standards applicable to that market and consideration of an insurer's loss experience in all lines of insurance marketed by a carrier in this State when reviewing health insurance rate filings [and to] report the results of the review, including any recommendations for legislation, to the Joint Standing Committee on Insurance and Financial Services.

This is a preliminary report. Options for future state reforms will vary depending on what (if any) federal reforms are enacted. The U.S. House of Representatives passed H.R. 3962, the Affordable Health Care for America Act, on November 7, 2009. The U.S. Senate passed H.R. 3590, the Patient Protection and Affordable Care Act, on December 24, 2009. The Bureau will supplement this report after the nature and extent of any federal health reform legislation is known.

This preliminary report provides background on both Maine's individual and small group markets, including information about types of policies available, prices, number of insurers, market share, and medical loss ratios, as well as standards and consumer protections under current law. Unless otherwise indicated, the data on the Maine insurance market are from annual reports filed by health insurers pursuant to Bureau of Insurance Rule 945 and from insurers' rate filings.[1] The report summarizes some of the insurance reforms in the two pending federal bills, and how they relate to the Maine market.

[1] The reports are available at: http://www.maine.gov/pfr/insurance/consumer/financial_results_health_insurers.htm, http://www.maine.gov/pfr/insurance/employer/snapshot_individual.htm, and http://www.maine.gov/pfr/insurance/employer/snapshot_small_group.htm

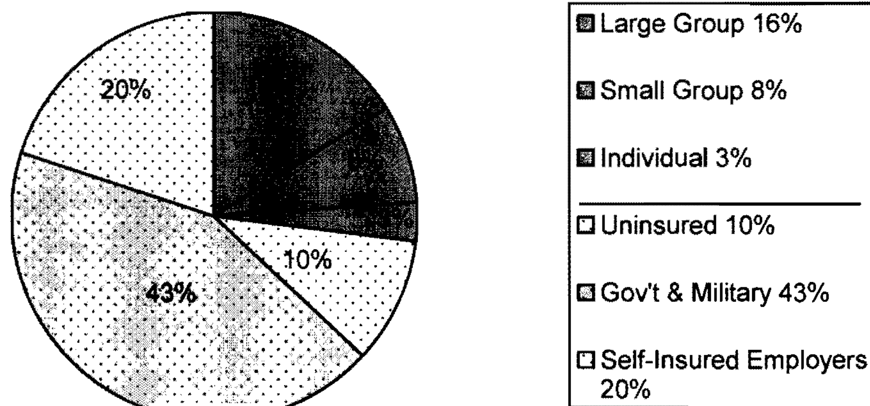
II. OVERVIEW OF THE INDIVIDUAL AND SMALL GROUP MARKETS

This section of the report provides information on the individual and small group health insurance markets in Maine.

A. SOURCES OF COVERAGE

According to the most recent data available, approximately 40,000 Mainers have major medical coverage in Maine's individual market, and approximately 106,000 have coverage as employees or dependents in the small group market. Maine's uninsured rate of 9.6% is the sixth lowest in the nation, well below the national average of 15.4%.[2]

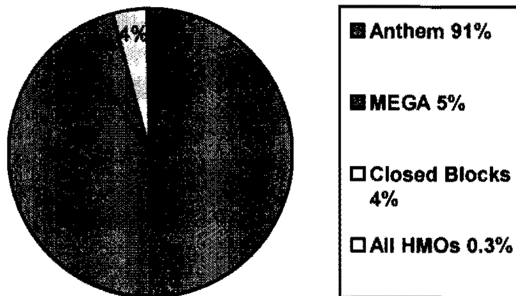
The following chart shows the sources of coverage by percentage of the Maine population. Slightly more than a quarter of the population has individual or group health insurance coverage that is regulated by the Bureau of Insurance. The others are covered by Medicare, MaineCare (Medicaid), military, self-insured employer plans exempt from state insurance regulation, or are uninsured.

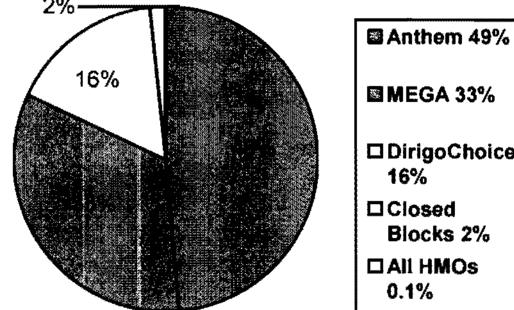


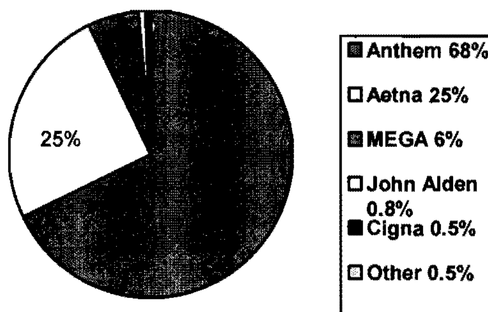
[2] See Current Population Survey, compiled jointly by the U.S. Census Bureau and Bureau of Labor Statistics, and the health coverage statistics compiled by the Kaiser Family Foundation at http://www.statehealthfacts.org.

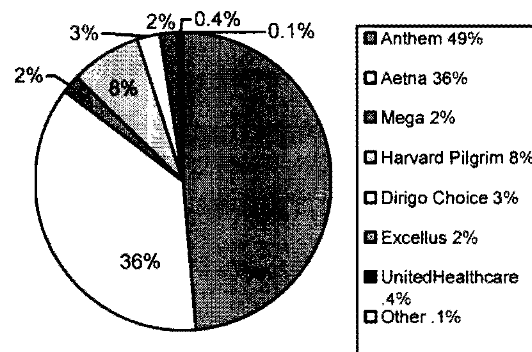
B. INSURERS AND MARKET SHARE

The following charts show the market shares of insurers in the individual and small group markets – providing a comparison between the markets before and after State health care financing reforms.[3]



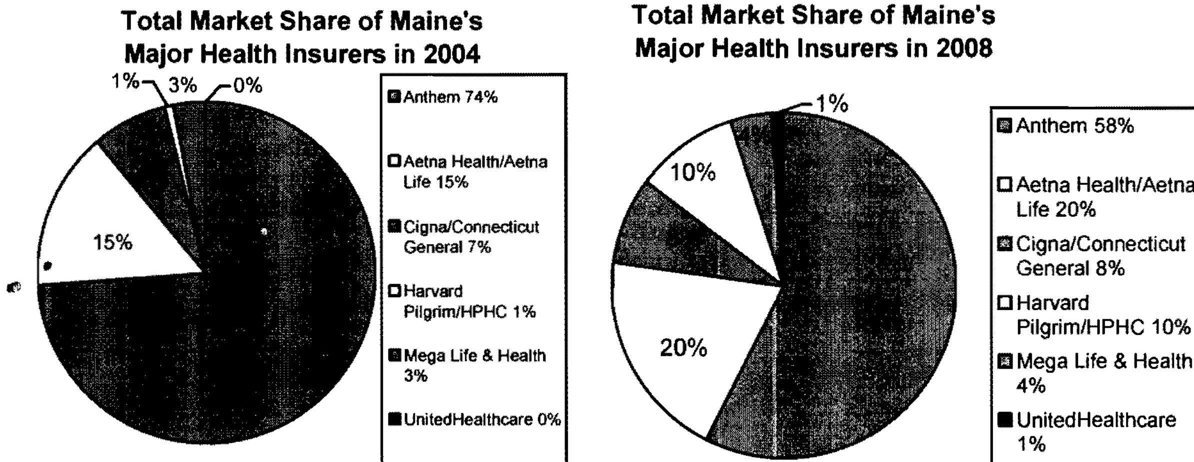






[3] Individual market data as of December 31, 2004, and September 30, 2009, small group data as of December 31, 2004, and December 31, 2008. "Closed blocks" consist of individual policies written by insurers that have left the market but continue to renew existing policies. Affiliated companies are recorded together in these charts. HPHC is an insurance subsidiary of Harvard Pilgrim, which currently provides the coverage for DirigoChoice enrollees. Harvard Pilgrim small group figures include HPHC's private market coverage, but not DirigoChoice.

Total market share of the major health insurers is shown below. This reflects the insurers' individual, small group and large group business in Maine.



The following table shows total Maine health insurance premium in 2008, by company and by market sector, along with the change from the previous year. These figures include Dirigo Health Plan premium, so the changes for Anthem and Harvard Pilgrim reflect the transfer of DirigoChoice coverage from Anthem to HPHC as of January 1, 2008.

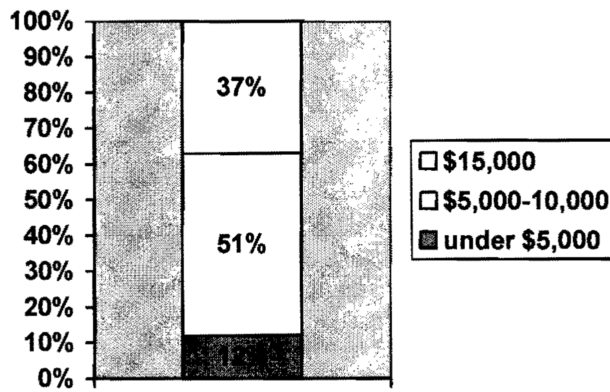
2008 Maine Premiums								
	Totals		Large Group		Small Group		Individual	
Insurers	12/31/08	% Change	12/31/08	% Change	12/31/08	% Change	12/31/08	% Change
Aetna Health Inc & Aetna Life Ins. Co	$278,628,101	17%	$154,913,707	14%	$123,583,562	22%	130,832	25%
Anthem Health Plans of ME Inc.	$928,388,393	-8%	$635,899,126	3%	$225,316,648	-20%	$67,172,619	-38%
Cigna Healthcare of Me Inc & Connecticut General Life Ins. Co.	$143,006,708	13%	$142,942,246	13%	$0	0%	$64,462	-17%
Harvard Pilgrim Health Care Inc. and HPHC	$151,925,919	74%	$46,007,999	-8%	$50,838,450	38%	$55,079,470	(new to market)[4]
MEGA Life & Health Ins. Co.	$27,025,064	14%	$0	0%	$5,475,463	-25%[5]	$21,549,601	31%
United Healthcare Ins. Co.	$11,152,427	39%	$9,428,899	37%	$1,723,528	48%	$0	0%
All Other Companies	$9,248,451	-23%	$3,858,380	-34%	$1,572,883	-8%	$3,817,188	-14%
Totals:	**$1,549,375,063**	**3%**	**$993,050,356**	**6%**	**$408,510,534**	**-5%**	**$147,814,172**	**14%**

[4] HPHC wrote no individual business before 2008. Harvard Pilgrim had six covered lives in individual HMO products in 2007.
[5] Renewal business only. Ceased writing new small group business in 2004.

C. TYPE OF COVERAGE

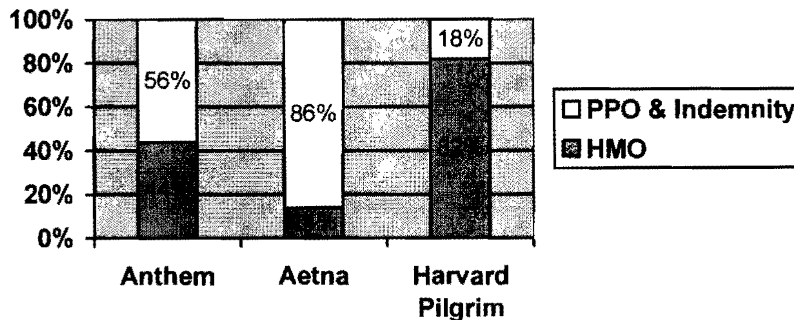
There has been significant movement in the market away from coverage with relatively low deductibles. This is especially pronounced in the individual market. Although statistics on the type of plan purchased are not reported on a market-wide basis, rate filing information from Anthem, the largest health insurer, shows that approximately 88% of Anthem's individual enrollees have deductibles of $5000 per year or higher, with almost 37% covered under policies that have a $15,000 annual individual deductible and a $30,000 family deductible.

Annual Deductibles for Anthem Enrollees in Maine



HMO coverage in the individual market represents only one-tenth of one percent (0.1%) of the covered lives. HMO coverage in the small group market accounts for one-third of the covered lives:[6]

Maine Small Group Coverage by Type



[6] Anthem provides HMO coverage through its HMO Maine business unit. All other HMOs in Maine are incorporated as separate companies. PPO data for Harvard Pilgrim excludes HPHC's DirigoChoice coverage.

D. PREMIUMS

The average premium per covered life in 2008 was $299 per month (approximately $3600 per year) for individual coverage, $324 per month (approximately $3900 per year) for small group coverage, and $380 for large group coverage. However, these prices are not comparable because the products purchased differ in each sector of the market. More comprehensive benefits and lower deductibles are more common in the large group market, where the employer is more likely to pay a substantial share of the premium.[7] The following table shows the 2008 average monthly premium per person. It is important to note that these "per covered life" estimates are averages and do not reflect what businesses and individuals are actually charged. The actual price depends on the benefits package purchased and adjustments for permissible rating factors such as age.

2008 Average Monthly Premium per Person in Maine						
	Large Group		Small Group		Individual	
	2008	% Change	2008	% Change	2008	% Change
Aetna (Aetna Health Inc & Aetna Life Ins. Co.)	$387	9%	$282	-4%	$221	65%
Anthem Health Plans of ME Inc.	$379	5%	$347	9%	$254	-19%
CIGNA (Cigna Healthcare of ME Inc. & Connecticut General Life Ins. Co)	$421	26%	$0	0%	$366	-13%
Harvard Pilgrim Health Care Inc.	$258	-19%	$370	12%	$519	-54%
Mega Life & Health Ins. Co.	$0	0%	$202	-8%	$174	4%
United Healthcare Ins. Co.	$452	31%	$279	-16%	$0	0%
Total:	**$380**	**8%**	**$324**	**5%**	**$299**	**6%**

Note: The average premium is calculated by dividing the premium from the 2008 Premium table by the number of member months.

A recent Commonwealth Fund report lists Maine as the state with the ninth-highest premiums for employer-sponsored coverage in 2008. Massachusetts was highest, followed by Minnesota, New Hampshire, Indiana, Connecticut, Delaware, Alaska, Rhode Island and Maine, in that order.[8]

Premiums for health insurance have been increasing across the country. Average family premiums for employer-sponsored coverage increased from $9249 in 2003 to $12,298 in 2008.[9] This year, Oregon's largest individual health insurer has requested a 25.3% rate increase in

[7] There are 166 people in the individual market (0.4% of the total enrollment) with coverage under standardized plans offered pursuant to Bureau of Insurance Rule 750. Depending on the insurer and the plan design prices range from $678.40 to $1068.42 for single coverage, and from $1663.45 to $2619.80 for family coverage per month.
[8] *See* Schoen, Nicholson, & Rustgi, "Paying the Price: How Health Insurance Premiums Are Eating Up Middle-Class Incomes," available at http://www.commonwealthfund.org/Publications.aspx.
[9] *See* Schoen, Nicholson, & Rustgi, "Paying the Price: How Health Insurance Premiums Are Eating Up Middle-Class Incomes," available at http://www.commonwealthfund.org/Publications.aspx.

addition to the 24.4% increase last year according to news reports.[10] In California, rate increases of up to 39% have been announced; the insurer indicated that rates may be adjusted more frequently than its typical yearly increases.[11] According to news reports, rate increases in Indiana are up to 38%.[12] In Rhode Island, insurers had deferred rate increases last year at the request of the Health Insurance Commissioner, but recently requested small group increases ranging from 4% to 14.6%.[13] A few of the states reporting increases last year are Michigan (56% requested, 22% approved)[14], Pennsylvania (46.5% requested[15], 15% approved[16]), and Connecticut (22% to 30% requested, 13% to 20% approved).[17]

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[10] *See* "Insurers Ready Another Round of Double-Digit Hikes," The Lund Report, February 4, 2010: http://www.thelundreport.org/resource/insurers_ready_another_round_of_double_digit_hikes

[11] Insurance Commissioner Poizner has requested that the insurer postpone implementation of the rate increase http://www.insurance.ca.gov/0400-news/0100-press-releases/2010/release020-10.cfm
See also "Anthem Blue Cross dramatically raising rates," Los Angeles Times, February 5, 2010: http://www.latimes.com/business/la-fi-insure-anthem5-2010feb05,0,3002094.story

[12] *See* "Hoosiers livid over insurance increases," Indianapolis Star, February 11, 2010: http://www.indystar.com/apps/pbcs.dll/article?AID=/20100211/BUSINESS03/2110419

[13] *See* "Lynch seeks hearing on insurance rates," Providence Journal, February 12, 2010: http://www.projo.com/news/stategovernment/content/AG_REACTS_TO_HIKES_02-12-10_TBHE6VQ_v14.3b3e406.html

[14] Final Order Granting Rate Increase for BCBSM Nongroup and Group Conversion Subscribers, Order Comm'r (Aug. 12, 2009).

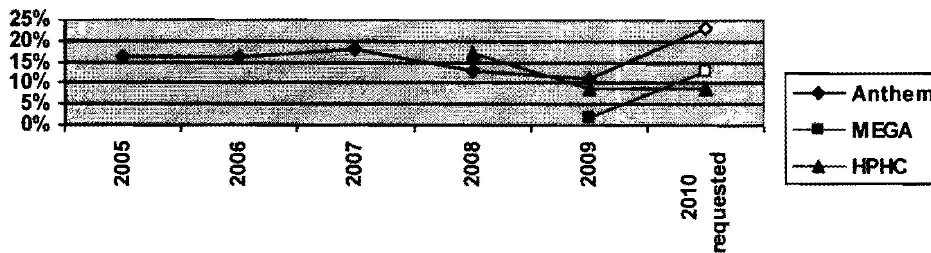
[15] Blue Cross of Northeastern Pennsylvania Filing # 1535-BLC-33-PPO-BASERATE

[16] E-mail from Melissa Fox, Deputy Press Secretary, Pennsylvania Insurance Department, Communications Office (Feb. 4, 2010, 14:20 EST) (on file with author).

[17] Proposed Rate Increase Application of Anthem Blue Cross and Blue Shield, Docket No. LH09-51, Order Comm'r (Aug. 6, 2009).

The following charts show the rate increase history over the last five years for the three major carriers in the individual and small group markets in Maine:

Maine Individual Market Rate Increases						
	2005	2006	2007	2008	2009	2010
Anthem	16%	16%	18%	13%	11%	23% request
MEGA[18]	N/A	N/A	N/A	N/A	2%	13% request
HPHC	(entered market 2008)			17[19]%	9%[20]	9%



Maine Small Group Market Rate Increases[21]						
	2005	2006	2007	2008	2009	2010
Anthem	13%	7%	15%	10%	16%	20%
Aetna	10%	10%	12%	9%	15%	25%
Harvard Pilgrim	(entered market 2006)	9%	15%	13%	10%	15%

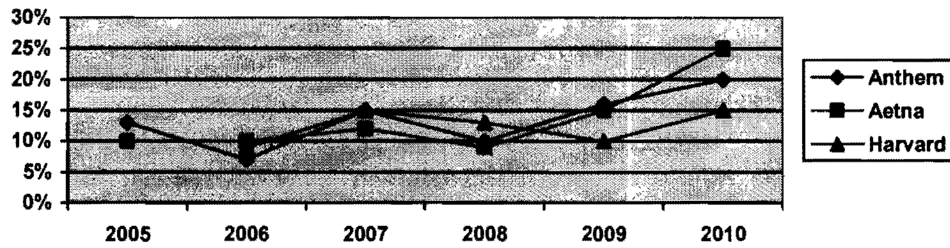
[18] Averages are not available for rate changes in 2005 through 2008. The most significant was a 14% rate reduction for the "catastrophic" plan, which represents the majority of MEGA's individual business, and a 10% rate increase for the same plan in 2008 and for the required standardized plans. Also in 2008, rates for the scheduled benefit plan were reduced by 25%. In addition, there were rate increases and decreases in 2005 and 2008 that applied only to certain optional benefits.

[19] This is the 2008 rate increase for DirigoChoice individual coverage, which was issued by Anthem in 2007.

[20] In its rate filings, HPHC indicated that the rate increase would have been 11% if the benefits had remained at 2008 levels.

[21] The earliest data in the Bureau's market snapshot series is for May 2005 renewals.

Maine Small Group Market Rate Increases



The table below shows the average increases for individual market products with most enrollment -- requested rate and approved rate.

Maine: HealthChoice Individual Rate Increases

Effective Date	Requested	Approved
January 2001	23.5%	23.5%
February 2002	13.6%	12.7%
January 2003	7.1%	3.4%
March 2005	14.7%	14.5%
March 2006	19.8%	16.3%
January 2007	20.5%	16.7%
January 2008	18.6%	12.5%
July 2009	18.5%	10.9%
Pending request for effective date July 2010	23.6%	Pending rate hearing

The following table includes average annual small group rate increases between 2001 and 2009. This table does not show requests. Most small group coverage has been exempt from the prior review rate approval process,[22] because it was issued on a guaranteed loss ratio basis, meaning that it is subject to premium refunds if benefit payments do not equal or exceed 78% of premium.

[22] Rate review in Maine did not apply to any group rates taking effect before 2004.

Maine: average annual small group increases	
Year	Average
2001	33%
2002	29%
2003	16%
2004	6%
2005	13%
2006	8%
2007	14%
2008	10%
2009	15%
2010	21%

E. MEDICAL LOSS RATIOS, PROFIT INFORMATION, AND DIVIDENDS

The following tables show medical loss ratios and underwriting gain (a way to measure the profitability of a line of business, before taxes and investment income), expressed as a percentage of premium, for each of the major insurers in the individual and small group markets, and combined figures for each market.

Maine's Small Group and Individual Market: MLR and Underwriting Gain/Loss

Maine Small Group Loss Ratios

	2004	2005	2006	2007	2008	5 year average
Aetna Health Inc	78%	76%	81%	83%	87%	80%
Aetna Life Ins Co	67%	64%	74%	77%	76%	74%
Anthem	76%	79%	79%	79%	82%	79%
Harvard Pilgrim Health Care	112%	76%	94%	91%	86%	89%
HPHC Insurance Company	entered market 2006		75%	95%	86%	87%
Small Group Totals (5 Companies)	**76%**	**77%**	**79%**	**81%**	**82%**	**79%**

Maine Individual Loss Ratios

	2004	2005	2006	2007	2008	5 year average
Anthem	83%	90%	90%	88%	85%	88%
MEGA (before refunds)[23]	14%	43%	38%	53%	62%	51%
HPHC Insurance Company	entered market 2008				90%	90%
Individual Totals (3 Companies)	**81%**	**87%**	**85%**	**84%**	**83%**	**84%**

Maine Small Group Underwriting Gain

	2004	2005	2006	2007	2008	5 year average
Aetna Health Inc	8%	11%	3%	4%	-3%	6%
Aetna Life Ins Co	8%	17%	10%	8%	10%	10%
Anthem	12%	11%	10%	9%	5%	10%
Harvard Pilgrim Health Care[24]	-20%	12%	-9%	-5%	1%	-3%
HPHC Insurance Company	entered market 2006		8%	-12%	1%	-2%
Small Group Totals (5 Companies)	**11%**	**11%**	**8%**	**7%**	**5%**	**8%**

Maine Individual Underwriting Gain

	2004	2005	2006	2007	2008	5 year average
Anthem	-4%	-7%	-5%	1%	5%	-2%
MEGA (before refunds)	10%	3%	12%	-1%	-11%	-2%
HPHC Insurance Company	entered market 2008				0%	0%
Individual Totals (3 Companies)	**-4%**	**-6%**	**-3%**	**0%**	**1%**	**-2%**

[23] In 2008, the Bureau of Insurance found that MEGA Life & Health Insurance Company used a flawed method to determine premiums for individual health insurance policies. To remedy the violations of law, the insurer agreed to refund $4.6 million plus interest to policyholders in Maine and to pay a fine of $1 million to the State's general fund.
[24] Harvard Pilgrim is a nonprofit health plan.

In Maine, three nationwide insurance groups conduct some or all of their health insurance business through Maine subsidiaries.[25] These insurers have paid the following dividends to their parent companies in the last five years, shown in dollars and as a percentage of premium:[26]

Maine: Dividends Paid					
INSURER	2005	2006	2007	2008	2009 (as of third quarter)
Anthem	0	$35,600,000 (3.3%)	$40,400,000 (3.8%)	$75,700,000 (7.6%)	$47,700,000 (6.3%)
Aetna	$12,100,000 (6.9%)	0	$4,400,000 (2.8%)	$18,400,000 (12.1%)	$6,200,000 (6.1%)
Cigna	$18,700,000 (29.1%)	$3,000,000 (5.3%)	0	$4,500,000 (36.7%)	N/A[27]

Note: percentage information in table represents proportion of each Maine premium dollar that went to parent company out of state.

III. REGULATORY FRAMEWORK

A. MAINE'S REGULATORY FRAMEWORK

1. Guaranteed issue and rating reforms

Maine has been a pioneer in the areas of guaranteed issue and rating reforms. The Maine Continuity of Coverage Act was first enacted in 1990,[28] and guaranteed issue and community rating were extended to the individual market in 1993.[29] All Maine residents who are not eligible for Medicare have the right to buy health insurance from any insurer selling coverage in the individual market, and all small businesses have the same guaranteed issue right in the small group market.

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[25] New York Governor David Paterson announced on December 10, 2009, that the New York Insurance Department "has received requests from three New York State insurers or their subsidiaries to issue dividends of more than $1.2 billion, which will be sent to out-of-state corporate parents. The requests follow initial dividend actions from the same three insurers last year that totaled $948 million." The Governor's press release, "Increase from Last Year Reinforces Need to Give Insurance Department the Authority to Review Insurance Rates," may be found at http://www.ins.state.ny.us/press/2009/p0912102.htm.

[26] Information on insurer dividends and investments in subsidiaries for prior years is available from the Bureau. Note that historically, many insurers have a practice of declaring dividends once per year.

[27] Cigna has discontinued offering HMO plans in many states, including Maine. It is closing its Maine subsidiary and renewing subscribers are being offered PPO coverage with another Cigna company.

[28] 24-A M.R.S.A. §§ 2848 through 2850-D, *enacted by* P.L. 1989, chapter 867.

[29] 24-A M.R.S.A. § 2736-C, *enacted by* P.L. 1993, chapter 477.

The following rate standards apply:

- Individual market: gender, health status/claims experience, and policy duration prohibited; age and geography allowed but limited to a maximum variation of 1.5 to 1 (for both factors combined).[30] Nonsmoker discounts allowed but must be actuarially justified.
- Small group market (2-50): gender, health status/claims experience, and policy duration prohibited; age, geography, and industry allowed but limited to a maximum variation of 1.5 to 1 (for all three factors combined). Smoking status, participation in wellness programs, and group size variations allowed but must be actuarially justified.
- Self-employed (groups of 1): Must be offered small group coverage; small group rate restrictions apply. If the insurer offers individual market coverage, then it does not have to offer small group coverage to groups of one; individual market rate restrictions apply.

Insurers also vary rates based on how many family members are covered, *e.g.*, single, two adults, children.

2. Premium rate approval and medical loss ratio requirements

The Bureau of Insurance reviews individual health insurance rates prior to their use by insurers.[31] Since 1993, Maine law has required a 65% medical loss ratio for individual health insurance.[32] This means that at least 65 cents of every premium dollar must be spent by the insurer on medical care and services. After an investigation by the Bureau, pursuant to a consent agreement, MEGA paid a $1 million fine and refunded $4.6 million plus interest to individual policyholders for charging excessive rates that were based on improper loss ratio calculations.[33]

Small group rates are subject to review by the Bureau in certain circumstances. Medical loss ratio requirements and rate review were extended to small group coverage as part of the Dirigo health reform act in 2003.[34] If an insurer guarantees a three year medical loss ratio averaging at least 78%, Maine law does not require rates to be approved by the Superintendent. Refunds are required if the insurer fails to achieve the 78% medical loss ratio. Aetna refunded $6.6 million in 2008 to small businesses under this provision. Maine law requires all other small group rates to be filed and approved prior to their use, and to meet a 75% loss ratio standard.

The Bureau holds public hearings on most major health insurance rate filings that are subject to prior approval. The insurer must prove by a preponderance of the evidence that the rates it has filed will meet the minimum loss ratio standards and are neither excessive, inadequate nor

[30] Pursuant to 24-A M.R.S.A. § 2736-C(2)(D)(4), insurers may reduce rates for the lower age brackets to reflect savings from the Maine Individual Reinsurance Association, as long as the maximum rate variation for any product does not exceed 2½ to 1 for age and geography combined. However, the Maine Individual Reinsurance Association is not operational because its funding mechanism was repealed.
[31] 24-A M.R.S.A. § 2736.
[32] 24-A M.R.S.A. § 2736-C(5), *enacted by* P.L. 1993, chapter 477.
[33] *See* In re *MEGA Life and Health Insurance Company Rates for Individual Health Plans,* No. INS-07-1010 (April 3, 2008, amended May 27, 2008).
[34] 24-A M.R.S.A. §§ 2808-B(2-B) & (2-C), *enacted by* P.L. 2003, chapter 469.

unfairly discriminatory.[35] The Maine Attorney General usually participates as a party in rate hearings on behalf of consumers.

B. FEDERAL INITIATIVES

The discussion below summarizes a few provisions in the House (H.R. 3590) and Senate (H.R 3962) bills, and does not include all the proposed changes that would impact cost, delivery or financing of medical care.[36]

The insurance-related changes generally would not preempt existing Maine laws. The approach in the legislation is a federal "floor," which means the federal standards would be minimums and states could have stronger consumer protections.

1. Guaranteed issue and rating reforms

The federal government has enacted certain reforms applicable to private health insurance. Enacted in 1996, HIPAA[37] required insurers to offer coverage on a guaranteed-issue basis to all small businesses, but had only limited protections for people relying on the individual market. HIPAA did not establish standards for premiums. In other words, unless states had standards, insurers could use a variety of factors to vary rates, for example charging higher rates to small businesses with older and sicker workers. In the 1980s, continuation rights (known as COBRA) were enacted.[38] COBRA requires employers with 20 or more workers to allow people who no longer qualify for coverage, e.g., no longer employed, divorced, etc. to continue that coverage for a period of time.

Under current proposals, both the U. S. House and Senate bills would extend guaranteed issue rights to the individual market in every state, and establish "exchanges" to facilitate access to health insurance coverage. These bills would also establish rating standards. Insurers would be prohibited from setting premiums based on health status or claims experience – in individual and small group markets. Rates based on gender would not be allowed. Variation based on the size of a small business would also be prohibited. Under the House bill, premiums for any given health insurance policy may vary only based on one's age, geographic area and family composition. The House bill would limit variation based on age to 2:1, while the Senate bill would limit variation based on age to 3:1. The Senate bill would also allow variation based on tobacco use, limited to 1.5:1.[39]

[35] 24-A M.R.S.A. § 2736-A.
[36] For example, the bills contain funding for community health centers, expand public programs like Medicaid, have Medicare reforms, health care quality research, liability reform pilot projects, and funding for a range of private and public initiatives.
[37] Health Insurance Portability and Accountability Act of 1996, Pub. L. 104-191.
[38] *See* Consolidated Omnibus Budget Reconciliation Act of 1985, Pub.L. 99-272.
[39] The Senate bill includes a 10-state pilot project that would allow discounts in the individual market for participation in wellness programs.

2. Minimum coverage levels (actuarial value)

Both bills would require a qualified plan to cover an essential package of health care services, based on a typical employer health plan, and to have a minimum actuarial value. In the House bill, the plan must be actuarially equivalent to at least 70% of the full actuarial value of the covered benefit package. In the Senate bill, the minimum is 60%, except for individuals who are under 30 or are unable to afford a qualified plan. A plan with an actuarial value of 60% means that a covered person pays approximately 40% of the total cost of covered medical care and services, and the insurer pays 60%. By comparison, the $15,000 deductible plan currently purchased in Maine by approximately 37% of Anthem's individual enrollees – this is 16.8% of the total individual market – has an estimated actuarial value of approximately 27%, according to estimates from Anthem.[40]

3. Subsidized coverage

Both the House and Senate bills would pay for a portion of the premium for low- and moderate-income families and individuals. The premium credit (also called "subsidies") would be based on one's income level and the cost of coverage. This would be available to all individuals and families with income up to four times the federal poverty level (FPL) who are not eligible for Medicaid. As of October 2009 federal poverty level for a family of four is $22,050. A family of four with income up to $88,200 would be eligible for some assistance.

In addition to the reduction in premium, both bills would lower out-of-pocket expenses like deductibles, copayments, and coinsurance. The House bill would lower out of pocket expenses for everyone who is eligible for the premium credits. The Senate bill would lower out of pocket expenses for people with incomes of up to two times FPL, currently $44,000 for a family of four.

For example, a family of four with income of $46,419 (median income in Maine in 2008) would pay a monthly premium of $233 under the House bill. Additional subsidies would cut in half the average out of pocket cost (including deductible, coinsurance, and copays); and out of pocket costs could not be greater than $2000 per person per year.[41] Under the Senate bill, the premium would be $258 per month with an out-of-pocket limit of $5000 (this is a 70% actuarial value plan, meaning that the average out of pocket cost would be 30%).[42]

4. Individual and employer responsibility

Under both bills, with limited exceptions such as financial hardship, all people would be required to have either individual or job-based health insurance.

Both bills would require employers to help pay for coverage. However, both bills exempt small businesses from these requirements. Large and mid-sized employers would be required to offer

[40] "Health Care Reform Premium Impact in Maine," WellPoint Corp. (Oct. 2009). Explanations of the underlying actuarial data were provided to the Bureau of Insurance by Anthem.

[41] The base plan would have a 70% actuarial value, meaning the consumer's average out-of-pocket share is approximately 30%. The House cost sharing subsidies for this income level would increase the actuarial value to 85%, meaning the consumer's share would be reduced by half, to 15%.

[42] Based on the Kaiser Family Foundation Subsidy Calculator, http://healthreform.kff.org/SubsidyCalculator.aspx.

coverage to their workers or pay a fee. The Senate bill exempts businesses with 50 or fewer workers. Others would have to pay a fee of $750 per worker if coverage is not provided by the employer. The House bill would require businesses with payroll of $500,000 and higher to either provide coverage (paying for at least 72.5% of premium) or pay a fee of 8% of payroll. Employers with payroll between $500,000 and $1 million would pay a reduced fee.

5. Loss ratio requirements

Both federal bills would establish medical loss ratio (MLR) requirements for group market coverage. The Senate bill would also establish MLR requirements for individual market coverage. These require insurers to pay a specified percentage of what they collect in premiums for medical care and services. Minimum MLR standards would be the following:

- House bill: 85% for large group and small group;
- Senate bill: 85% for large group; 80% for small group and for individual coverage.

Both bills would use premium net of taxes and fees, rather than the total premium, as the base for the MLR. The Senate bill would consider "activities that improve health care quality" as part of medical care or service expenses in calculating whether the insurer has met the minimum requirement. Maine's MLR is different – subtracting taxes is not allowed. Except for an adjustment for Dirigo savings offset payments, MLR in Maine is simply the ratio of claims to earned premium.[43]

6. Immediate help for individuals and businesses

Although both bills provide grants to the states for making coverage available to the uninsured, assistance under the Senate bill generally would be limited to high-risk pools. Under the House bill, these grants would also be available to states like Maine that have already enacted guaranteed-issue reforms and make coverage available to the uninsured through public-private partnerships such as DirigoChoice.

The Senate bill would also provide assistance beginning in tax year 2010 directly to small businesses, through a tax credit for providing coverage to low- and moderate-wage workers. The employer must have 25 or fewer workers and must contribute at least 50% of the premium. The full credit would be available to businesses with 10 or fewer workers and average annual wages of less than $25,000, and phases out as firm size and average wage increase. The House bill includes tax credits for small businesses, beginning in 2013.

7. Health insurance exchange

Both bills establish health insurance exchanges, which would facilitate enrollment in health coverage and the administration of premium subsidies, determine whether health insurance products meet the standards for qualified health plans, and provide a web based informational tool for consumers to make it easier to shop for health insurance, to compare policies and to buy coverage. The Senate bill would allow states to establish and operate these. Federal regulators

[43] 24-A M.R.S.A. §§ 2736-C(5); 2808-B(2-B)(A) & (2-C)(C).

would establish these if a state is not willing or unable to do so. The House bill would set up one national exchange but allow states to opt-out and establish their own.

Individuals and small businesses would be able to purchase coverage through these exchanges. In the Senate bill, small businesses would be able to purchase coverage through Small Business Health Options exchanges, or "SHOP" for short. This is based on the SHOP Act sponsored by Senator Olympia Snowe.

8. Risk adjustment

Both bills include risk adjustment provisions, intended to ensure that prices for different health insurance policies are based on the benefits provided and not on differences in the health of the populations enrolled in each. The Senate bill would apply risk adjustment within the individual market and within the small group market both in and out of the exchanges (except for grandfathered plans). The Senate bill allows states to merge the individual and small group markets for rating purposes. The House bill adjusts risk within the exchange.

	House Bill	Senate Bill	Maine
Guaranteed Issue for individual market coverage	✔	✔	✔
Rating Reforms for individual and small group markets	✔	✔	✔
Premium and out of pocket cost subsidies for individuals	✔	✔	*
Tax credits for small businesses	✔	✔	
Individual Responsibility	✔	✔	
Required contribution by employers	✔	✔	
Medical Loss Ratio	✔	✔	✔

*DirigoChoice

IV. CONCLUSION

Options for continuing to address ways to improve access, affordability and security of health insurance for Mainers will depend on the nature and extent of federal health care reforms and flexibility for states to move ahead building on federal reforms. The Bureau will supplement this preliminary report.

APPENDIX A: Federal Health Reform Bills summary prepared by Kaiser Family Foundation (reprinted with permission from KFF)
APPENDIX B: Market Snapshot – individual medical
APPENDIX C: Market Snapshot – small group health

STATE OF MAINE
OFFICE OF THE GOVERNOR
1 STATE HOUSE STATION
AUGUSTA, MAINE
04333-0001

JOHN ELIAS BALDACCI
GOVERNOR

July 1, 2010

The Honorable Kathleen Sebelius
Secretary, Department of Health & Human Services
200 Independence Avenue, SW
Washington, DC 20201

RE: Health Insurance Rate Review Proposal
Grant CFDA 93.511
Letter of Support

Dear Secretary Sebelius:

This letter is to express my strongest support for the Maine Department of Professional and Financial Regulation, Bureau of Insurance's application for a $1 million grant to enhance regulatory review of health insurance rates.

Access to affordable, quality health care is part of my vision for investing in Maine people and creating a fair and stable business environment. My goal is to make Maine the healthiest state in the nation and to assure consumers are fully protected.

I am confident that the Department will make wise use of the grant funds in support of these goals should Maine be successful in its grant application.

Sincerely,

John E. Baldacci
Governor

PRINTED ON RECYCLED PAPER

PHONE: (207) 287-3531 (Voice) 888-577-6690 (TTY) FAX: (207) 287-1034
www.maine.gov

APPLICATION COVER SHEET AND CHECK-OFF LIST

Maine

REQUIRED CONTENTS

A complete proposal consists of the following material organized in the sequence below:

X SF-424: Grant Application Package/Application for Federal Assistance (Grants.gov)

X Key Contacts Form

X Project/Performance Site Location(s) Form

X SF-424B: Assurances-Non-Construction Programs

X SF-LLL: Disclosure of Lobbying Activities

X Objective Work Plan and Time Line (**note:** States may use the standard objective work plan or a non-standard form, the time line may be embedded in the work plan or provided as a separate document.)

X Project Abstract

X Project Narrative

X Budget Narrative

Maintenance of Effort (in narrative or submitted as a separate document)

Appendices/Attachments

X Application Cover Sheet

Letters of support

Resume/Job Description for Project Director and Assistant Director

Organization Chart

☐ Other included documents: None

Notes:

APPLICATION COVER SHEET AND CHECK-OFF LIST

Maine

REQUIRED CONTENTS

A complete proposal consists of the following material organized in the sequence below:

X SF-424: Grant Application Package/Application for Federal Assistance (Grants.gov)

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X Budget Narrative

Maintenance of Effort (in narrative or submitted as a separate document)

Appendices/Attachments

X Application Cover Sheet

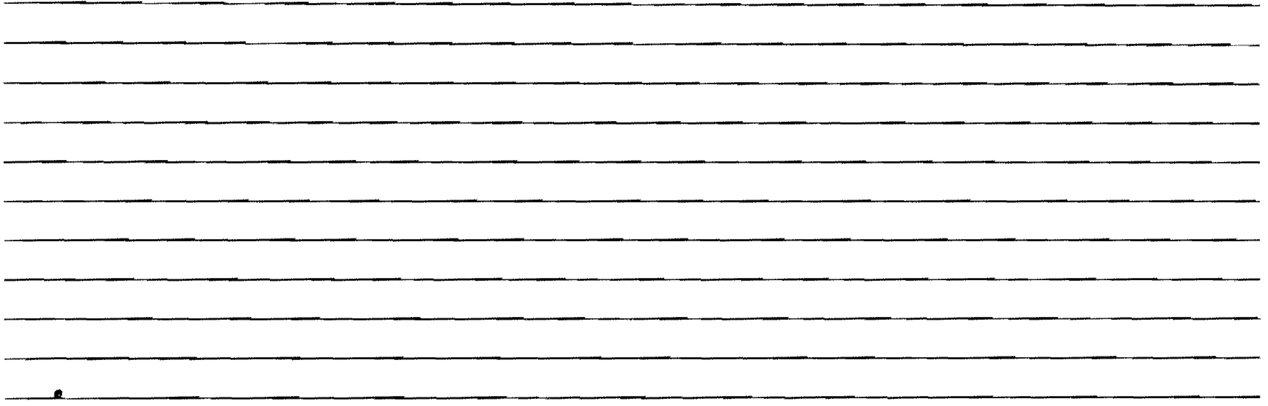
Letters of support

Resume/Job Description for Project Director and Assistant Director

Organization Chart

☐ Other included documents: None

Notes:



GRANTS.GOV

Grant Application Package

Opportunity Title:	"Grants to States for Health Insurance Premium Review-C
Offering Agency:	Ofc of Consumer Information & Insurance Oversight
CFDA Number:	93.511
CFDA Description:	Affordable Care Act (ACA) Grants to States for Health I
Opportunity Number:	RFA-FD-10-999
Competition ID:	ADOBE-FORMS-B
Opportunity Open Date:	06/07/2010
Opportunity Close Date:	07/07/2010
Agency Contact:	Gladys Melendez-Bohler Grant Specialist E-mail: Gladys.Melendez-Bohler@fda.hhs.gov Phone: 301-827-7168

This electronic grants application is intended to be used to apply for the specific Federal funding opportunity referenced here.

If the Federal funding opportunity listed is not the opportunity for which you want to apply, close this application package by clicking on the "Cancel" button at the top of this screen. You will then need to locate the correct Federal funding opportunity, download its application and then apply.

☐ **This opportunity is only open to organizations, applicants who are submitting grant applications on behalf of a company, state, local or tribal government, academia, or other type of organization.**

*** Application Filing Name:** Health Insurance Premium Review-Cycle 1

Mandatory Documents

Move Form to Complete

Move Form to Delete

Mandatory Documents for Submission

Optional Documents

Move Form to Submission List

Move Form to Delete

Optional Documents for Submission

Instructions

1 Enter a name for the application in the Application Filing Name field.

- This application can be completed in its entirety offline; however, you will need to login to the Grants.gov website during the submission process.
- You can save your application at any time by clicking the "Save" button at the top of your screen.
- The "Save & Submit" button will not be functional until all required data fields in the application are completed and you clicked on the "Check Package for Errors" button and confirmed all data required data fields are completed.

2 Open and complete all of the documents listed in the "Mandatory Documents" box. Complete the SF-424 form first.

- It is recommended that the SF-424 form be the first form completed for the application package. Data entered on the SF-424 will populate data fields in other mandatory and optional forms and the user cannot enter data in these fields.

- The forms listed in the "Mandatory Documents" box and "Optional Documents" may be predefined forms, such as SF-424, forms where a document needs to be attached, such as the Project Narrative or a combination of both. "Mandatory Documents" are required for this application. "Optional Documents" can be used to provide additional support for this application or may be required for specific types of grant activity. Reference the application package instructions for more information regarding "Optional Documents".

- To open and complete a form, simply click on the form's name to select the item and then click on the => button. This will move the document to the appropriate "Documents for Submission" box and the form will be automatically added to your application package. To view the form, scroll down the screen or select the form name and click on the "Open Form" button to begin completing the required data fields. To remove a form/document from the "Documents for Submission" box, click the document name to select it, and then click the <= button. This will return the form/document to the "Mandatory Documents" or "Optional Documents" box.

- All documents listed in the "Mandatory Documents" box must be moved to the "Mandatory Documents for Submission" box. When you open a required form, the fields which must be completed are highlighted in yellow with a red border. Optional fields and completed fields are displayed in white. If you enter invalid or incomplete information in a field, you will receive an error message.

3 Click the "Save & Submit" button to submit your application to Grants.gov.

- Once you have properly completed all required documents and attached any required or optional documentation, save the completed application by clicking on the "Save" button.
- Click on the "Check Package for Errors" button to ensure that you have completed all required data fields. Correct any errors or if none are found, save the application package.
- The "Save & Submit" button will become active; click on the "Save & Submit" button to begin the application submission process.
- You will be taken to the applicant login page to enter your Grants.gov username and password. Follow all onscreen instructions for submission.

OMB Number: 4040-0004
Expiration Date: 03/31/2012

Application for Federal Assistance SF-424

* 1. Type of Submission:	* 2. Type of Application:	* If Revision, select appropriate letter(s):
☐ Preapplication	☒ New	
☒ Application	☐ Continuation	* Other (Specify):
☐ Changed/Corrected Application	☐ Revision	

* 3. Date Received: Completed by Grants.gov upon submission.
4. Applicant Identifier:

5a. Federal Entity Identifier:
5b. Federal Award Identifier:

State Use Only:

6. Date Received by State:
7. State Application Identifier:

8. APPLICANT INFORMATION:

* a. Legal Name: Maine Department of Professional and Financial Regulation

* b. Employer/Taxpayer Identification Number (EIN/TIN): 016000001
* c. Organizational DUNS: 8090459250000

d. Address:

* Street1:	35 State House Station
Street2:	
* City:	Augusta
County/Parish:	
* State:	ME: Maine
Province:	
* Country:	USA: UNITED STATES
* Zip / Postal Code:	04333-0035

e. Organizational Unit:

Department Name: Professional & Financial Reg.
Division Name: Bureau of Insurance

f. Name and contact information of person to be contacted on matters involving this application:

Prefix:	Mr.
* First Name:	Thomas
Middle Name:	Michael
* Last Name:	Record
Suffix:	

Title: Senior Staff Attorney

Organizational Affiliation:

* Telephone Number: 207-624-8424
Fax Number: 207-624-8599

* Email: Thomas.m.record@maine.gov

Application for Federal Assistance SF-424

*** 9. Type of Applicant 1: Select Applicant Type:**

A: State Government

Type of Applicant 2: Select Applicant Type:

Type of Applicant 3: Select Applicant Type:

* Other (specify):

*** 10. Name of Federal Agency:**

Ofc of Consumer Information & Insurance Oversight

11. Catalog of Federal Domestic Assistance Number:

93.511

CFDA Title:

Affordable Care Act (ACA) Grants to States for Health Insurance Premium Review

*** 12. Funding Opportunity Number:**

RFA-FD-10-999

* Title:

"Grants to States for Health Insurance Premium Review-Cycle I" Office of Consumer Information and Insurance Oversight (OCIIO)

13. Competition Identification Number:

ADOBE-FORMS-B

Title:

14. Areas Affected by Project (Cities, Counties, States, etc.):

Add Attachment | Delete Attachment | View Attachment

*** 15. Descriptive Title of Applicant's Project:**

Health Insurance Rate Review Enhancement

Attach supporting documents as specified in agency instructions.

Add Attachments | Delete Attachments | View Attachments

Application for Federal Assistance SF-424

16. Congressional Districts Of:

* a. Applicant: ME-All   b. Program/Project: ME-All

Attach an additional list of Program/Project Congressional Districts if needed.

[ ] Add Attachment | Delete Attachment | View Attachment

17. Proposed Project:

* a. Start Date: 09/01/2010   * b. End Date: 09/30/2011

18. Estimated Funding ($):

* a. Federal	1,000,000.00
* b. Applicant	0.00
* c. State	0.00
* d. Local	0.00
* e. Other	0.00
* f. Program Income	0.00
* g. TOTAL	1,000,000.00

*** 19. Is Application Subject to Review By State Under Executive Order 12372 Process?**

[ ] a. This application was made available to the State under the Executive Order 12372 Process for review on [ ].

[ ] b. Program is subject to E.O. 12372 but has not been selected by the State for review.

[X] c. Program is not covered by E.O. 12372.

*** 20. Is the Applicant Delinquent On Any Federal Debt? (If "Yes," provide explanation in attachment.)**

[ ] Yes   [X] No

If "Yes", provide explanation and attach

[ ] Add Attachment | Delete Attachment | View Attachment

21. *By signing this application, I certify (1) to the statements contained in the list of certifications and (2) that the statements herein are true, complete and accurate to the best of my knowledge. I also provide the required assurances** and agree to comply with any resulting terms if I accept an award. I am aware that any false, fictitious, or fraudulent statements or claims may subject me to criminal, civil, or administrative penalties. (U.S. Code, Title 218, Section 1001)**

[X] ** I AGREE

** The list of certifications and assurances, or an internet site where you may obtain this list, is contained in the announcement or agency specific instructions.

Authorized Representative:

Prefix: Mr.   * First Name: Thomas

Middle Name:

* Last Name: Record

Suffix:

* Title: Senior Staff Attorney

* Telephone Number: 2076248424   Fax Number: 2076248599

* Email: thomas.m.record@maine.gov

* Signature of Authorized Representative: Completed by Grants.gov upon submission.   * Date Signed: Completed by Grants.gov upon submission.

OMB Number: 4040-0003
Expiration Date: 7/30/2011

Key Contacts Form

*** Applicant Organization Name:**

Maine Department of Professional and Financial Regulation

Enter the individual's role on the project (e.g., project manager, fiscal contact).

*** Contact 1 Project Role:** Point of Contact

Prefix: Ms.

* First Name: Mila

Middle Name:

* Last Name: Kofman

Suffix:

Title: Superintendent

Organizational Affiliation:

Maine Bureau of Insurance

* Street1: 76 Northern Avenue

Street2:

* City: Gardiner

County: Kennebec

* State: ME: Maine

Province:

* Country: USA: UNITED STATES

* Zip / Postal Code: 04333-0034

* Telephone Number: 207-624-8550

Fax: 207-624-8599

* Email: mila.kofman@maine.gov

Delete Entry | Previous Person | Next Person

OMB Number: 4040-0003
Expiration Date: 7/30/2011

Key Contacts Form

*** Applicant Organization Name:** Maine Department of Professional and Financial Regulation

Enter the individual's role on the project (e.g., project manager, fiscal contact).

*** Contact 2 Project Role:** AOR

Prefix: Mr.

* First Name: Thomas

Middle Name: Michael

* Last Name: Record

Suffix:

Title: Senior Staff Attorney

Organizational Affiliation: Maine Bureau of Insurance

* Street1: 76 Northern Avenue

Street2:

* City: Gardiner

County: Kennebec

* State: ME: Maine

Province:

* Country: USA: UNITED STATES

* Zip / Postal Code: 04344-1539

* Telephone Number: 207-624-8424

Fax: 207-624-8599

* Email: thomas.m.record@maine.gov

Delete Entry | Previous Person | Next Person

OMB Number: 4040-0010
Expiration Date: 08/31/2011

Project/Performance Site Location(s)

Project/Performance Site Primary Location

☐ I am submitting an application as an individual, and not on behalf of a company, state, local or tribal government, academia, or other type of organization.

Organization Name: Maine Department of Professional and Financial Regulation

DUNS Number: 8090459250000

* Street1: 76 Northern Avenue

Street2:

* City: Gardiner

County: Kennebec

* State: ME: Maine

Province:

* Country: USA: UNITED STATES

* ZIP / Postal Code: 04333-0035

* Project/ Performance Site Congressional District: ME-all

Project/Performance Site Location 1

☐ I am submitting an application as an individual, and not on behalf of a company, state, local or tribal government, academia, or other type of organization.

Organization Name:

DUNS Number:

* Street1:

Street2:

* City:

County:

* State:

Province:

* Country: USA: UNITED STATES

* ZIP / Postal Code:

* Project/ Performance Site Congressional District:

Additional Location(s) Add Attachment | Delete Attachment | View Attachment

ATTACHMENTS FORM

Instructions: On this form, you will attach the various files that make up your grant application. Please consult with the appropriate Agency Guidelines for more information about each needed file. Please remember that any files you attach must be in the document format and named as specified in the Guidelines.

Important: Please attach your files in the proper sequence. See the appropriate Agency Guidelines for details.

1) Please attach Attachment 1		Add Attachment	Delete Attachment	View Attachment
2) Please attach Attachment 2		Add Attachment	Delete Attachment	View Attachment
3) Please attach Attachment 3		Add Attachment	Delete Attachment	View Attachment
4) Please attach Attachment 4		Add Attachment	Delete Attachment	View Attachment
5) Please attach Attachment 5		Add Attachment	Delete Attachment	View Attachment
6) Please attach Attachment 6		Add Attachment	Delete Attachment	View Attachment
7) Please attach Attachment 7		Add Attachment	Delete Attachment	View Attachment
8) Please attach Attachment 8		Add Attachment	Delete Attachment	View Attachment
9) Please attach Attachment 9		Add Attachment	Delete Attachment	View Attachment
10) Please attach Attachment 10		Add Attachment	Delete Attachment	View Attachment
11) Please attach Attachment 11		Add Attachment	Delete Attachment	View Attachment
12) Please attach Attachment 12		Add Attachment	Delete Attachment	View Attachment
13) Please attach Attachment 13		Add Attachment	Delete Attachment	View Attachment
14) Please attach Attachment 14		Add Attachment	Delete Attachment	View Attachment
15) Please attach Attachment 15		Add Attachment	Delete Attachment	View Attachment

OMB Number: 0980-0204
Expiration Date: 12/31/2009

Objective Work Plan

Project:

Health Insurance Rate Review Enhancement

* Year:

* Funding Agency Goal:

* Objective:

* Results or Benefits Expected:

* Activities	* Position Responsible	* Time Period Begin	* Time Period End	* Non-Salary Personnel Hours

OMB Number: 0980-0204
Expiration Date: 12/31/2009

Objective Work Plan

* Activities	* Position Responsible	* Time Period Begin	* Time Period End	* Non-Salary Personnel Hours

* Criteria for Evaluating Results or Benefits Expected:

OMB Number: 0980-0204
Expiration Date: 12/31/2009

Objective Work Plan

You may attach up to 17 additional Objective Work Plan forms here. To extract, fill and attach each additional form, follow these steps:

- Select the "Select to Extract the Objective Work Plan Attachment" button below.

- Save the file using a descriptive name to help you remember the content of the supplemental form that you are creating. When assigning a name to the file, please remember to give it the extension ".pdf" (for example, "Objective_1.pdf"). If you do not name your file with the ".pdf" extension you will be unable to open it later, using Adobe Reader.

- Use the "Open Form" tool on Adobe Reader to open the new form you just saved.

- Enter your additional Objective information in this supplemental form, similar to the Objective Work Plan form that you see in the main body of your application.

- When you have completed entering information in the supplemental form, save and close it.

- Return to this page and attach the saved supplemental form you just filled in, to one of the blocks provided on this "attachments" form.

Important: Attach additional Objective Work Plan forms, using the blocks below. Please remember that the files you attach must be Objective Work Plan PDF forms that were previously extracted using the process outlined above. Attaching any other type of file may result in the inability to submit your application to Grants.gov. Note: It is important to attach completed forms only. Attach ONLY PDF (.pdf) forms where ALL required fields are filled out. Incomplete or missing data will cause your application to be rejected.

Select to extract the Objective Work Plan Attachment

1) Please attach Attachment 1		Add Attachment	Delete Attachment	View Attachment
2) Please attach Attachment 2		Add Attachment	Delete Attachment	View Attachment
3) Please attach Attachment 3		Add Attachment	Delete Attachment	View Attachment
4) Please attach Attachment 4		Add Attachment	Delete Attachment	View Attachment
5) Please attach Attachment 5		Add Attachment	Delete Attachment	View Attachment
6) Please attach Attachment 6		Add Attachment	Delete Attachment	View Attachment
7) Please attach Attachment 7		Add Attachment	Delete Attachment	View Attachment
8) Please attach Attachment 8		Add Attachment	Delete Attachment	View Attachment
9) Please attach Attachment 9		Add Attachment	Delete Attachment	View Attachment
10) Please attach Attachment 10		Add Attachment	Delete Attachment	View Attachment
11) Please attach Attachment 11		Add Attachment	Delete Attachment	View Attachment
12) Please attach Attachment 12		Add Attachment	Delete Attachment	View Attachment
13) Please attach Attachment 13		Add Attachment	Delete Attachment	View Attachment
14) Please attach Attachment 14		Add Attachment	Delete Attachment	View Attachment
15) Please attach Attachment 15		Add Attachment	Delete Attachment	View Attachment
16) Please attach Attachment 16		Add Attachment	Delete Attachment	View Attachment
17) Please attach Attachment 17		Add Attachment	Delete Attachment	View Attachment

OMB Number: 4040-0003
Expiration Date: 09/30/2011

Project Abstract

The Project Abstract must not exceed one page and must contain a summary of the proposed activity suitable for dissemination to the public. It should be a self-contained description of the project and should contain a statement of objectives and methods to be employed. It should be informative to other persons working in the same or related fields and insofar as possible understandable to a technically literate lay reader. This Abstract must not include any proprietary/confidential information.

* Please click the add attachment button to complete this entry.

Add Attachment | Delete Attachment | View Attachment

Project Narrative File(s)

*** Mandatory Project Narrative File Filename:**

Add Mandatory Project Narrative File | Delete Mandatory Project Narrative File | View Mandatory Project Narrative File

To add more Project Narrative File attachments, please use the attachment buttons below.

Add Optional Project Narrative File | Delete Optional Project Narrative File | View Optional Project Narrative File

Budget Narrative File(s)

*** Mandatory Budget Narrative Filename:**

Add Mandatory Budget Narrative | Delete Mandatory Budget Narrative | View Mandatory Budget Narrative

To add more Budget Narrative attachments, please use the attachment buttons below.

Add Optional Budget Narrative | Delete Optional Budget Narrative | View Optional Budget Narrative

BUDGET INFORMATION - Non-Construction Programs

OMB Approval No. 4040-0006
Expiration Date 07/30/2010

SECTION A - BUDGET SUMMARY

Grant Program Function or Activity (a)	Catalog of Federal Domestic Assistance Number (b)	Estimated Unobligated Funds		New or Revised Budget		
		Federal (c)	Non-Federal (d)	Federal (e)	Non-Federal (f)	Total (g)
1. Enhancement of Rate Review		$	$	$ 931,200.00	$	$ 931,200.00
2. Reporting to Secretary of HHS on Rate Increase Patterns				18,800.00		18,800.00
3. Enhanced Data Collection				50,000.00		50,000.00
4.						
5. Totals		$	$	$ 1,000,000.00	$	$ 1,000,000.00

SECTION B - BUDGET CATEGORIES

6. Object Class Categories	GRANT PROGRAM, FUNCTION OR ACTIVITY				Total
	(1) Enhancement of Rate Review	(2) Reporting to Secretary of HHS on Rate Increase Patterns	(3) Enhanced Data Collection	(4)	(5)
a. Personnel	$	$	$	$	$
b. Fringe Benefits					
c. Travel					
d. Equipment					
e. Supplies					
f. Contractual	881,229.00	18,800.00	50,000.00		950,029.00
g. Construction					
h. Other	50,000.00				50,000.00
i. Total Direct Charges (sum of 6a-6h)	931,229.00	18,800.00	50,000.00		$ 1,000,029.00
j. Indirect Charges					$
k. TOTALS (sum of 6i and 6j)	$ 931,229.00	$ 18,800.00	$ 50,000.00	$	$ 1,000,029.00
7. Program Income	$	$	$	$	$

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SECTION C - NON-FEDERAL RESOURCES

	(a) Grant Program	(b) Applicant	(c) State	(d) Other Sources	(e)TOTALS
8.		$	$	$	$
9.	Reporting to Secretary of HHS on Rate Increase Patterns				
10.	Enhanced Data Collection				
11.					
12. TOTAL (sum of lines 8-11)		$	$	$	$

SECTION D - FORECASTED CASH NEEDS

	Total for 1st Year	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
13. Federal	$ 1,000,000.00	$ 498,120.00	$ 359,320.00	$ 94,320.00	$ 48,240.00
14. Non-Federal	$				
15. TOTAL (sum of lines 13 and 14)	$ 1,000,000.00	$ 498,120.00	$ 359,320.00	$ 94,320.00	$ 48,240.00

SECTION E - BUDGET ESTIMATES OF FEDERAL FUNDS NEEDED FOR BALANCE OF THE PROJECT

	(a) Grant Program	FUTURE FUNDING PERIODS (YEARS)			
		(b)First	(c) Second	(d) Third	(e) Fourth
16.		$	$	$	$
17.	Reporting to Secretary of HHS on Rate Increase Patterns				
18.	Enhanced Data Collection				
19.					
20. TOTAL (sum of lines 16 - 19)		$	$	$	$

SECTION F - OTHER BUDGET INFORMATION

21. Direct Charges:		22. Indirect Charges:	
23. Remarks:			

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OMB Approval No.: 4040-0007
Expiration Date: 07/30/2010

ASSURANCES - NON-CONSTRUCTION PROGRAMS

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0040), Washington, DC 20503.

PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THE OFFICE OF MANAGEMENT AND BUDGET. SEND IT TO THE ADDRESS PROVIDED BY THE SPONSORING AGENCY.

NOTE: Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant, I certify that the applicant:

1. Has the legal authority to apply for Federal assistance and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project cost) to ensure proper planning, management and completion of the project described in this application.

2. Will give the awarding agency, the Comptroller General of the United States and, if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standards or agency directives.

3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.

4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.

5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the 19 statutes or regulations specified in Appendix A of OPM's Standards for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).

6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C.§§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee- 3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to nondiscrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and, (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.

7. Will comply, or has already complied, with the requirements of Titles II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally-assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.

8. Will comply, as applicable, with provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.

9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally-assisted construction subagreements.

10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.

11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetlands pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clean Air) Implementation Plans under Section 176(c) of the Clean Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended (P.L. 93-523); and, (h) protection of endangered species under the Endangered Species Act of 1973, as amended (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.

13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).

14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.

15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.

16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead-based paint in construction or rehabilitation of residence structures.

17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act Amendments of 1996 and OMB Circular No. A-133, "Audits of States, Local Governments, and Non-Profit Organizations."

18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations, and policies governing this program.

* SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL	* TITLE
Completed on submission to Grants.gov	Senior Staff Attorney
* APPLICANT ORGANIZATION	* DATE SUBMITTED
Maine Department of Professional and Financial Regulation	Completed on submission to Grants.gov

DISCLOSURE OF LOBBYING ACTIVITIES

Complete this form to disclose lobbying activities pursuant to 31 U.S.C.1352

Approved by OMB
0348-0046

1. * Type of Federal Action:
- [ ] a. contract
- [x] b. grant
- [ ] c. cooperative agreement
- [ ] d. loan
- [ ] e. loan guarantee
- [ ] f. loan insurance

2. * Status of Federal Action:
- [ ] a. bid/offer/application
- [x] b. initial award
- [ ] c. post-award

3. * Report Type:
- [x] a. initial filing
- [ ] b. material change

4. Name and Address of Reporting Entity:

[x] Prime [ ] SubAwardee

* Name: Maine Department of Professional & Financial Regulation
* Street 1: 76 Northern Avenue Street 2:
* City: Gardiner State: ME: Maine Zip: 04333-0035

Congressional District, if known: ME-all

5. If Reporting Entity in No.4 is Subawardee, Enter Name and Address of Prime:

6. * Federal Department/Agency: HHS, OICI

7. * Federal Program Name/Description: Affordable Care Act (ACA) Grants to States for Health Insurance Premium Review

CFDA Number, *if applicable:* 93.511

8. Federal Action Number, *if known:* RFA-FD-10-999

9. Award Amount, *if known:* $ 1,000,000.00

10. a. Name and Address of Lobbying Registrant:

Prefix: * First Name: N/A Middle Name:
* Last Name: N/A Suffix:
* Street 1: N/A Street 2:
* City: N/A State: ME: Maine Zip:

b. Individual Performing Services (including address if different from No. 10a)

Prefix: * First Name: N/A Middle Name:
* Last Name: N/A Suffix:
* Street 1: N/A Street 2:
* City: N/A State: Zip:

11. Information requested through this form is authorized by title 31 U.S.C. section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when the transaction was made or entered into. This disclosure is required pursuant to 31 U.S.C. 1352. This information will be reported to the Congress semi-annually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

*** Signature:** Completed on submission to Grants.gov

***Name:** Prefix: Mr. * First Name: Thomas Middle Name: Michael
* Last Name: Record Suffix:

Title: Senior Staff Attorney **Telephone No.:** 207-624-8424 **Date:** Completed on submission to Grants.gov

OMB Number: 2125-0611
Expiration Date: 03/31/2010

Basic Work Plan

1. Estimated date of established funding agreement with State:

Note: Tasks starting before this date are not eligible for funding, and cannot be counted toward matching funds.

Describe the tasks in the work plan:

2 a. Describe this task or milestone:

b. Name of person or organization responsible for carrying out task:

c. How long will this task take to complete? months

d. Justify how this project task contributes to project completion: (800 character limit - about 133 words)

OMB Number: 0980-0204
Expiration Date: 12/31/2009

Project Abstract Summary

Program Announcement (CFDA)

93.511

*** Program Announcement (Funding Opportunity Number)**

RFA-FD-10-999

*** Closing Date**

07/07/2010

*** Applicant Name**

Maine Department of Professional and Financial Regulation

*** Length of Proposed Project**

Application Control No.

Federal Share Requested (for each year)

* Federal Share 1st Year	* Federal Share 2nd Year	* Federal Share 3rd Year
$	$	$
*** Federal Share 4th Year**	*** Federal Share 5th Year**	
$	$	

Non-Federal Share Requested (for each year)

* Non-Federal Share 1st Year	* Non-Federal Share 2nd Year	* Non-Federal Share 3rd Year
$	$	$
*** Non-Federal Share 4th Year**	*** Non-Federal Share 5th Year**	
$	$	

*** Project Title**

Health Insurance Rate Review Enhancement

OMB Number: 0980-0204
Expiration Date: 12/31/2009

Project Abstract Summary

*** Project Summary**

*** Estimated number of people to be served as a result of the award of this grant.**

Other Attachment File(s)

* Mandatory Other Attachment Filename:

Add Mandatory Other Attachment | Delete Mandatory Other Attachment | View Mandatory Other Attachment

To add more "Other Attachment" attachments, please use the attachment buttons below.

Add Optional Other Attachment | Delete Optional Other Attachment | View Optional Other Attachment

Project Abstract

The Maine Bureau of Insurance proposes to use $1 million in federal grant funds to improve health insurance rate review in the State of Maine. $931,200 would be allocated, as described in more detail in the Budget Narrative, to enhance the Bureau's current rate oversight functions in three ways: 1) expand our rate review process; 2) identify opportunities to lower premiums through greater understanding of changes in the market and 3) empower insurance consumers to participate in the rate review process through greater transparency and new participation tools. Maine would allocate $18,800 to leverage resources with other states to underwrite the cost of enhancements to the State Electronic Rate and Form Filing (SERFF) System to comply with the requirements for reporting to the Secretary on rate increase patterns. Finally, $50,000 would be allocated for enhancements to the Maine Health Data Organization's publicly available information regarding health care reimbursements for various medical services. ($50,000)

APPLICATION COVER SHEET AND CHECK-OFF LIST

Maine

REQUIRED CONTENTS

A complete proposal consists of the following material organized in the sequence below:

X SF-424: Grant Application Package/Application for Federal Assistance (Grants.gov)

X Key Contacts Form

X Project/Performance Site Location(s) Form

X SF-424B: Assurances-Non-Construction Programs

X SF-LLL: Disclosure of Lobbying Activities

X Objective Work Plan and Time Line (**note:** States may use the standard objective work plan or a non-standard form, the time line may be embedded in the work plan or provided as a separate document.)

X Project Abstract

X Project Narrative

X Budget Narrative

Maintenance of Effort (in narrative or submitted as a separate document)

Appendices/Attachments

X Application Cover Sheet

Letters of support

Resume/Job Description for Project Director and Assistant Director

Organization Chart

☐ Other included documents: None

Notes:

INTRODUCTION

The Maine Bureau of Insurance (Bureau) has a tradition of balanced and comprehensive regulatory oversight. The Bureau regulates health insurance that covers approximately 40,000 Mainers in the individual market, 106,000 in the small group market, and 217,000 in the large group market. A copy of the Superintendent's February 2010 report to the Legislature on the state of the insurance market is attached. The extent of the Bureau's authority varies by market segment, but includes all products offered by insurance companies, health maintenance organizations (HMOs), and nonprofit health plans (collectively referred to here as "insurers").

Adjusted community rating: Maine requires adjusted community rating in the individual and small group markets:

- Individual market: gender, health status/claims experience, and policy duration prohibited; age and geography allowed but limited to a maximum variation of 1.5 to 1 (for both factors combined). Nonsmoker discounts allowed but must be actuarially justified.
- Small group market (2-50): gender, health status/claims experience, and policy duration prohibited; age, geography, and industry allowed but limited to a maximum variation of 1.5 to 1 (for all three factors combined). Smoking status, participation in wellness programs, and group size variations allowed but must be actuarially justified.
- Self-employed (groups of 1): Must be offered small group coverage; small group rate restrictions apply. If the insurer offers individual market coverage, then it does not have to offer small group coverage to groups of one; individual market rate restrictions apply.

Insurers also vary rates based on how many family members are covered, e.g., single, two adults, children.

Premium rate approval and medical loss ratio requirements: The Bureau reviews individual health insurance rates prior to their use by insurers.[1] Maine law requires a 65% medical loss ratio for individual health insurance.[2] This means that at least 65 cents of every premium dollar must be spent by the insurer on medical care and services. After an investigation by the Bureau, pursuant to a consent agreement, MEGA paid a $1 million fine and refunded $5.6 million plus interest to individual policyholders for charging excessive rates that were based on improper loss ratio calculations.[3]

Small group rates are subject to review by the Bureau in certain circumstances. Since 2003, insurers have had two options. If an insurer guarantees a three-year medical loss ratio averaging at least 78%, Maine law does not require rates to be approved prior to their use. Refunds are required if the insurer fails to achieve the 78% medical loss ratio. Aetna refunded $6.6 million in 2008 to small businesses under this provision. Maine law requires all other small group rates to be filed and approved prior to their use, and to meet a 75% loss ratio standard. One carrier uses prior approval (closed block).

Although the Bureau does not currently regulate large group rates, insurers are required to file these rates for informational purposes.

Grant: The $1 million federal rate review grant would provide much needed additional resources and would significantly enhance existing oversight. To ensure that rates are not unreasonable, to ensure compliance with the federal reforms (e.g., MLR), and to enhance transparency, the grant would help fund new initiatives discussed below.

A. CURRENT HEALTH INSURANCE RATE REVIEW CAPACITY AND PROCESS

The Bureau uses a variety of regulatory tools to review premiums. Actuarial staff review all rate filings that are subject to prior approval to ensure that the rates are not inadequate, excessive, or unfairly

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[1] 24-A M.R.S.A. § 2736.

[2] 24-A M.R.S.A. § 2736-C(5), *enacted by* P.L. 1993, chapter 477.

[3] *See* In re *MEGA Life and Health Insurance Company Rates for Individual Health Plans,* No. INS-07-1010 (April 3, 2008, amended May 27, 2008).

discriminatory, and that they comply with the adjusted community rating requirements, MLR, and other applicable laws. The burden of proof is on the insurer. The Bureau can review rates with or without a public hearing. The last two years, the Superintendent has held public hearings on most major health insurance rate filings.

Maine's policymakers recognize the importance of the Attorney General's office in representing the public's interests in rate proceedings. Insurers are required to provide copies of all individual health insurance rate filings to the Attorney General. The AG may but is not required to intervene as a party in any hearing convened by the Superintendent. The AG may require that a hearing be held. The AG's expert witnesses, including actuaries, testify.

At the hearing, all parties may present witnesses and evidence, subject to questioning by other parties and by the Superintendent's hearing panel. Typically, the insurer presents an actuary and one or more executives to testify in support of the filing, and the Attorney General presents an actuary with an independent analysis, following an extensive pre-hearing discovery process allowing all parties the information needed to prepare. Additional sessions are held, sometimes at multiple locations around the state, at which consumers may testify under oath or offer comments. After the hearing, the Superintendent and her actuarial and legal staff review the record and issue a written decision approving or denying the rate request, which may be appealed to the Maine Superior Court. If a rate request is denied, the decision outlines a rating plan that would be approved. Attached are a representative rate order and the Superior Court decision affirming it on appeal.

In the past two years, the Bureau has held four individual rate hearings: one per year, encompassing all products, for each of the two companies actively marketing in Maine. The 19,000 covered lives represent a total market share of 84% (99% if the public-private Dirigo Health program is excluded). Three of these, one of which is under appeal, have resulted in substantial reductions in the insurer's requested rates, and the remaining decision is still pending. There has been one small group rate hearing because most small group filings are exempt from prior approval. In this case, involving renewal rates for a discontinued block of business, the insurer withdrew the request before the hearing after

negotiations with the Attorney General, and the Superintendent approved the revised request after a public hearing. In addition, the Bureau reduced two individual and two small group rate increases without holding hearings, benefiting nearly 4,000 policyholders.

To increase public participation, in addition to a formal hearing at the Bureau's offices during the work day, the Superintendent has held field hearings around the state in the evenings to allow consumers to participate. Consumers have also been encouraged to email or send letters on proposed rates. Additionally, under state law, the insurer must provide at least 60 days' advance notice of any requested rate increase to all affected policyholders, including notice of their right to request a hearing before the Superintendent. In addition to reviewing draft notice to policyholders, the Bureau takes additional measures to maximize the transparency of the process, including e-mails to consumers and other interested persons and press releases regarding significant filings. The Bureau posts the filing, briefs and information on the hearing process on its website. Transcripts of all hearings are available to the public. In the past two years, the Bureau has received approximately 700 letters, e-mails or other types of complaints about proposed rate increases, 48 consumers provided sworn testimony and many provided unsworn testimony at hearings.

When individual or small group rates are filed for prior approval, the filing must include the proposed rate, including all rating formulas and classifications, the average and maximum increase over current rates, the projected loss ratio, the proposed effective date, and all supporting information. The Superintendent may require the insurer to furnish additional information necessary for the review process. All rate filings are made through the System for Electronic Rate and Form Filings (SERFF). A representative rate filing is attached, along with Bureau Rule 940, which specifies the required filing contents. Rate filings and all supporting information are public records, with limited confidentiality exceptions for personal health information and provider contract information.

The table below shows the average requested and approved increases for the individual market products with the most enrollment:

Maine: HealthChoice Individual Rate Increases

Effective Date	Requested	Approved
January 2001	23.5%	23.5%
February 2002	13.6%	12.7%
January 2003	7.1%	3.4%
March 2005	14.7%	14.5%
March 2006	19.8%	16.3%
January 2007	20.5%	16.7%
January 2008	18.6%	12.5%
July 2009	18.5%	10.9%
Pending request for effective date July 2010	23.6%	Pending rate hearing

In addition to a comprehensive rate review process, the Bureau requires certain data to be filed annually. Insurers in all sectors of the market must file extensive annual reports on their health insurance business, breaking down premiums, benefits paid, expenses, reserve adjustments, and underwriting gain by line of business. The Bureau compiles summaries based on this data, including medical loss ratios and other performance measures, and publishes them on its website. The Bureau also compiles and publishes "market snapshot" reports for the individual and small group markets, comparing market share and rate history information for the insurers doing business in Maine.

The Bureau's total budget for State Fiscal Year 2011 is $10,313,711. No specific amount is allocated for rate review activities. Three Bureau actuaries work on health insurance rate reviews. Two are Fellows of the Society of Actuaries; one is a fellow of the Conference of Consulting Actuaries; and all are members of the American Academy of Actuaries. The Bureau also obtains contracted actuarial assistance from Compass Health Analytics, Inc. In 2009, the Bureau received 91 total filings, and staff reviewed 12 individual filings and 34 small group filings. When hearings are held, substantial staffing is required. A hearing panel includes the Superintendent, a Deputy Superintendent, General Counsel, Chief Life and Health Actuary, and an Assistant Attorney General. Resources are also used for court reporters,

bureau investigators (including financial and market conduct examiners when needed) and Bureau support staff. Salaries and overhead for staffing is built into the Bureau's budget.

B. RATE OVERSIGHT: PROPOSED ENHANCEMENT

The Bureau proposes to enhance its current rate oversight functions in three ways: 1) expand the rate review process; 2) identify opportunities to lower premiums through greater understanding of changes in the market; and 3) empower consumers of insurance to participate in the rate review process and make more informed decisions through greater transparency and new participation tools.

1. Expand Rate Review Process

Small Group Rate Review: In 2010, premium increases have been significant (21% average) in the small group market. Some small businesses have reported premiums much higher than the average increase of 21%. All insurers actively offering small group business guarantee a 78% MLR, which means they do not have to file rates for prior approval and therefore currently file only limited information. Although the Bureau reviews small group filings for compliance with adjusted community rating (to ensure correct rate factors are used), informational filings provided by small group insurers do not provide sufficient information to determine the basis for the rates or to determine whether the rate increases violate the law. With the limited filings, currently the Bureau also cannot determine whether rate increases are being allocated consistent with state law.

$139,500 would enable the Bureau (through consultants) to collect additional information on small group rates, beginning with the cycle of rate increases taking effect on January 1, 2011. Additional rate filing information and analysis would help the Bureau determine whether the rates (and allocation of increases) are appropriate in light of reasonably expected claims and administrative expenses. This new information would help the Bureau evaluate whether to propose legislative changes to require prior approval of all small group rates. The enhanced information may also lead to additional enforcement actions (if there is evidence of non-compliance).

All markets – Trend Data Collection and Reporting: The Bureau currently obtains valuable market data from the supplemental report that Maine law requires health insurers to file with their annual financial statements. To enhance this, we propose to collect and analyze insurers' historical and projected cost trends in the individual, small group, and large group market, broken down separately by price and utilization and by specific categories of care, e.g., projected trend for in-patient, out-patient, etc. Market-wide data, comparing insurers and markets, would improve our analysis of specific company filings by providing benchmark data against which the filing could be compared. Currently, variations in the size of rate increases suggest there are significant differences among insurers in terms of controlling claim costs and administrative expenses, but the reasons for these differences are not completely understood.

$46,500 would fund collection and analysis of this information. Increased scrutiny and understanding of these factors would allow the Bureau to evaluate the appropriateness of requested rate increases more effectively. Additionally, trend information would be posted on the Bureau's website as part of the transparency initiative.

All Markets – Testing the Validity of Data Submitted by Insurers: The accuracy of the information submitted by insurers, and used as underlying assumptions for rate filings, is crucial for ensuring the Bureau's ability to assess the need for a rate increase. In a 2010 proceeding (still on-going), the Bureau identified potential inconsistencies and inaccuracies in underlying data used by insurers to support their filings. The Bureau's examination team conducted a "first of its kind" examination to reconcile rate filing data with actual provider bills. In contrast to traditional market conduct or financial examinations which are paid for by the insurer, the cost of $26,000 for this examination was not billed to the insurer but had to come out of the Bureau's budget.

The goal of this project is to ensure data integrity in rate filings. This would be done through a validation process – limited scope examinations of three leading insurers in Maine. Consultants would construct queries in order to ascertain whether existing health care provider invoicing has been properly

allocated to the line of business for which an increase is sought. The extracted data would then be sorted and test procedures developed in order to trace the information back to the original supporting documentation (e.g., provider bills). This process involves validating that claims experience proffered by insurers in support of requests for rate increases actually occurred. If errors are found, the correct data would be used for the rate review. Validity testing would also be conducted in support of the medical loss ratio analysis, with four random examinations of insurers scheduled for that purpose. The estimated budget for this is $88,800.

All Markets – Review of Medical Loss Ratio Information: Maine requires individual and small group rates to be set at a level expected to provide a medical loss ratio (MLR) that meets or exceeds statutory requirements. Currently, the Bureau conducts its own actuarial review of expected medical loss ratios when health insurance rates are filed for prior approval, administers a rebate program when insurers elect to file small group rates on a guaranteed loss ratio basis in lieu of submitting rates for prior approval, and publishes market reports that include loss ratios and other performance measurements. The Affordable Care Act requires additional reporting and analysis of MLR information and the administration of an expanded rebate program, beginning on January 1, 2011.

The goal of this project is to ensure that the medical loss ratios submitted by insurers are valid. This would be done by verifying the accuracy of the underlying medical loss ratio data provided. The Bureau would conduct an additional financial analysis of MLR calculations, and follow up when necessary to obtain the corrected MLR. The Bureau would also monitor the rebate process to ensure that calculations were made correctly and sent to consumers in a timely manner. Finally, unresolved cases would be subject to a targeted examination. The estimated budget for this is $44,400.

All Markets – Staff Training: In order to enhance the effectiveness of rate reviews, the Bureau would increase the opportunities available to rate review staff to attend seminars and programs related to health insurance rating and review. One Actuary, two Actuarial Assistants, and one Senior Insurance Analyst

would each attend a training program before September 30, 2011. The estimated budget for this is $12,000.

All Markets – Rate Review Information Technology: The rate review process depends on the Bureau's capacity to project trends based on claims data and other information. In order to enhance this capacity, the Bureau staff would research available software, purchase the most appropriate package, and train two actuarial assistants and one senior insurance analyst in use of the software. The software designed to project trends would be in use by January 31, 2011. The estimated budget for the software is $50,000.

2. Identify opportunities to lower premiums through greater understanding of market changes

In order to review and determine whether rates are reasonable, the Bureau needs to understand the impact of changes to plan design and the enrolled population resulting from the Affordable Care Act (ACA). These changes include:

- Benefit requirements, including elimination of lifetime limits, elimination of preexisting condition exclusions for those under age 19, first-dollar coverage of preventive care, and, later, establishment of the essential benefits package;
- Premium subsidies and individual and employer coverage responsibilities;
- Possibly merging the small group and individual markets in 2014; and
- Expanding the small group market to include employers with up to 100 employees in 2014.

To understand these impacts, the Bureau would contract with an actuarial consultant and a health economist to collect relevant data on the Maine market and model the changes resulting from the ACA. The consultants would be asked to provide information on the impact on rates for businesses and individuals of 1) the possible merger of the individual and small group markets; and 2) expansion of the small group market to 100. While the Bureau has anticipated the need to do much of this work, no

existing funds have been allocated for its performance. Grant funds, if awarded, will not be used as a substitute for existing funding. The estimated budget for this is $250,000.

3. Stronger consumer participation and greater transparency

All Markets – Rate Review and Participation: Empower insurance consumers to participate in the rate review process through greater transparency and new participation tools. Based on questions the Bureau receives and the public rate hearings held around the state, it is apparent that insurance consumers need useful and practical information about how rates are set, the process for reviewing rates, rate hearings (including the role of the Attorney General), and opportunities to participate in rate reviews and hearings. Due to the technical nature of rate reviews, there is also a need for actuarial experts. The need for this will expand as the Bureau collects and posts more information on the small group market premiums.

Approximately $100,000 would be used to fund a consultant to develop new educational materials and train consumer advocacy groups on rate filings and the rate review process. This training would assist consumers and advocacy groups to more effectively participate in rate hearings.

The Bureau proposes a fund of $200,000 to provide grants to qualified consumer advocacy groups for rate hearings. This would provide resources that consumer groups need to file as intervenors in rate hearings (funding consumer group staff time, legal assistance, and actuarial experts) and to present their own experts and actuarial analysis. Although in the past, some groups have participated in rate hearings, due to resource constraints and lack of pro bono actuarial and legal help, consumer groups have not had an opportunity to participate effectively.

All Markets – Transparency Initiatives: The Bureau recognizes that the steps Maine and other states have taken to make the cost of health insurance understandable are an important first step. To make good decisions, consumers must have reliable and understandable information about how health insurance is priced and about what they are purchasing with their premium dollars. Although the Bureau publishes on its webpage comparison data on rates, administrative expenses, profits, and medical loss ratios, few

consumers know the information is there and even fewer consumers use it to make decisions about their insurance options. There is a strong need to develop ways to present this information that is more useful for insurance consumers (e.g., to enable consumers to select insurers that are efficient and provide high quality service). There is also a strong need to educate consumers how this information can be used to make decisions about insurance options.

Information submitted from rate filings and related insurer reports would be "translated" into material that consumers can understand, and posted on the Bureau's Web site along with a guide to understanding the data. The Bureau would also expand its public outreach programs and training. To develop this material and programs, and to provide training, we would use a consultant. The above consultant budget of $100,000 includes this initiative.

C. Reporting to the Secretary on Rate Increase Patterns

The Bureau attests that it will comply with the reporting requirements outlined in Section 2794 of the Public Health Service Act. To meet this obligation, the Bureau will be participating in a multi-state program to leverage resources on a cooperative basis by contributing to the cost of enhancements to the SERFF system. The enhancements would allow for data collection and reporting to HHS on the specified template. The project would be completed within 8 months after HHS provides the reporting template. The estimated budget for Maine's share is $18,800 to be paid to the NAIC for cost of changes to SERFF system.

D. Data Center Funding

States may use up to 5 percent of their Cycle One grants ($50,000) to establish data centers to compile and publish fee schedule information. This program would enhance the capabilities of Maine's data center, the Maine Health Data Organization (MHDO).

The MHDO was established by the Maine Legislature in 1996 as an independent executive agency to collect clinical and financial health care information and to exercise responsible stewardship in

making this information accessible to the public. MHDO policy is established by a twenty-one-member board that represents health care providers, payors, and consumers. The MHDO maintains a website of the total median payments made to health care facilities and practitioners for twenty-nine services rendered to Maine residents.

The MHDO would add twenty-five new procedures (by CPT code) to their existing list of median payments made by the ten largest (by member volume) commercial payors in Maine, Medicare, and Medicaid. The Organization would place the information in a "queriable" database available on its HealthCost website. The MHDO would also modify its website to enable users (e.g., the public, providers, researchers) to view three years of data to look at trends in payments. The Bureau would use the additional data provided by the MHDO in the rate review process to better understand the wide variation in payments made for services by the major insurance carriers.

Maine Department of Professional and Financial Regulation
Bureau of Insurance
Health Insurance Rate Review Grant Application CFDA 93.511

Response to Question 14

The areas affected by the Project are statewide throughout Maine.

OBJECTIVES, WORK PLAN and TIMELINE

Funding Agency Goal: The goal of the Cycle I grants is to provide awards to states to enhance their current rate review process for health insurance premiums. Applicants must demonstrate that they will use grant funds to create and/or augment rate review and approval processes and/or data based systems used to support these activities. The grant period runs from August 9, 2010 through September 30, 2011.

The Bureau proposes to enhance its current rate oversight functions in three ways: 1) expand our rate review process; 2) identify opportunities to lower premiums through greater understanding of changes in the market; and 3) empower insurance consumers to participate in the rate review process through greater transparency and new participation tools. The Bureau proposes to comply with the requirements for reporting to the Secretary on rate increase patterns through cooperation with other states in developing enhancements to the SERFF system. The Maine Health Data Organization would enhance the state's existing health care charge data system.

Generally, while the Work Plan contemplates significant Bureau staff time, the grant award will not fund Bureau staff time. The one exception is that the grant is needed to fund the Bureau's internal Examiners' time spent on these initiatives. Examiner time currently is billed to insurers for examinations. If that time is diverted to these initiatives, insurers cannot be billed and therefore there would be a loss in revenue. The grant will not be used to supplant any State of Maine funding of staff salaries.

I. Enhancement of Bureau's Rate Review Program

1) Expand Rate Review

The Bureau would expand its review of health insurance rates through six initiatives: A) small group rate review; B) trend data collection and analysis in all markets; C) testing the validity of data submitted by insurers in all markets; D) review of medical loss ratio information in all markets; E) additional actuarial staff training; and F) investment in rate review information technology.

A. Small Group Rate Review

The Bureau would require insurers to submit information not currently submitted with the rate filings. Consultants would analyze the data and report to the Bureau.

Objective: To determine whether small group health insurance rate increases and their allocations among employers are consistent with state law and whether changes in rate regulation are needed.

Results/Benefits Expected: Better information to allow meaningful analysis of rates and market conditions and increased understanding of underlying factors used to determine rate increases; potential regulatory and state law changes based on findings.

Activities, Positions Responsible, Timeline

Require informational filings provided by small group insurers to meet the same information requirements as small group filings subject to prior approval. This includes: Projected experience, including claims, premiums, administrative expenses, profit; Assumptions used in projections, particularly claims trend; Support for assumptions; Methodology used to set rates for different benefit plans. This would require Bureau staff to conduct a data call and/or change rate filing checklists. Substantial Bureau staff time would be spent (none would be supported by this grant due to grant restrictions).

- Analyze 23 small group rate filings to determine whether rate increases are excessive in relation to reasonably expected claims and administrative expenses, or otherwise violate existing law: Consultant analysis; determination by Bureau staff; November 1, 2010 – September 30, 2011
- Determine whether rate increases are allocated fairly among different employers: Consultant analysis; determination by Bureau staff; November 1, 2010 – September 30, 2011

B. Trend Data Collection and Analysis (Improve rate filing requirements)

Objective 1: To understand the reasons for differences in medical claim and administrative cost trends among insurers.

Results/Benefits Expected: Improved basis for evaluating medical cost and administrative expense components of rate filings. Improve regulation of individual, small group, and large group private health insurance.

Activities, Positions Responsible, Timeline

- Collect information on observed and expected medical claims utilization, cost trends, administrative expenses, and profits from major carriers offering expense-incurred health insurance plans in Maine's individual (2 carriers), small group (5 carriers), and/or large group (7 carriers) markets. Trend data: Separately for individual, small group, and large group markets; Within each market, separately for hospital inpatient, hospital outpatient, pharmacy, primary care, and all other medical care; Within each category, separately for utilization and cost; Projected portion of premium for administrative costs; Projected portion of premium for reserves and profit:
- Design survey to collect trends in medical utilization, cost per service, administrative expenses, and profits: Bureau staff (not paid for by this grant); August 2010 – September 2010
- Distribute survey to major carriers offering expense-incurred health insurance; respond to carrier questions about the survey; review and analyze survey response and follow up with carriers as needed: Bureau staff (grant does not pay for) and Consultant; September 2010 –December 2010
- Use the survey data to enhance the depth of the Bureau's actuarial review of rate filings: Bureau staff (grant does not pay for)

Objective 2: Enhance publicly available information to empower consumers to make more informed decisions.

Results/Benefits Expected: Make information available on trends in utilization, costs, and other newly collected and analyzed data on individual, small group, and large group health insurance. Improve transparency for consumers.

Activities, Positions Responsible, Timeline

- Develop material for consumers and post on Bureau website: Bureau staff (not funded by grant) and Consultant; November 1, 2010 – September, 2011

C. Testing the Validity of Data Submitted by Insurers

Objective: To determine the accuracy and validity of claims data as presented by health insurance companies in rate filings.

Results/Benefits Expected: Independently validate whether the medical cost data underlying insurers' trend projections in rate filings is accurate.

Timeline: Between August 9, 2010 and September 30, 2011. Specific begin and end dates depend on when the selected filings are received.

Activities, Positions Responsible

- The Bureau would examine insurers in order to reconcile rate filing data with actual provider bills. The Bureau anticipates examining three filings during the grant Cycle 1 period.
- Review all rate filing documents submitted by the health insurance company and any supplementary documentation provided to the Bureau's actuarial department: Bureau staff (grant does not pay for) and Consultant
- Obtain additional data from insurance company, including aggregate claims paid presented by specific product line: Bureau staff (grant does not pay for) and Consultant

- Reconcile aggregate claims paid data to the annual financial statement and reconcile the individual claim data to loss triangles submitted in the original rate filing: Bureau staff (grant does not pay for) and Consultant
- Obtain detail by claim number of individual claims and reconcile total: Bureau staff (grant does not pay for) and Consultant
- Using claim detail, select a sample and verify sampled claim data to specific claim detail: Bureau staff (grant does not pay for) and Consultant

D. Review of Medical Loss Ratio Information

Under this initiative the Bureau would conduct four random, detailed examinations of medical loss ratio reports submitted by insurers.

Objective: To determine whether medical loss ratio reports submitted by insurers are accurate.

Results/Benefits Expected: Ensuring accurate reporting and appropriate and timely issuance of rebates. Improved understanding of the relationship between premiums and health care costs.

Activities, Positions Responsible, Timeline

- Conduct four random, detailed examinations of medical loss ratio (MLR) reports submitted by insurers as follows:
- Review the MLR calculations for accuracy and reasonableness of the reported data: Bureau staff (not funded by grant) and Consultant (including internal Examiners); Summer 2011
- If MLR calculation not correct or if the data appears to be unreasonable, follow-up with company: Bureau staff (not funded by grant) and Consultant (including internal Examiners)
- Bureau enforcement actions may be necessary if issues with MLR report can not be resolved. Bureau staff (not funded by grant)

E. Staff Training

Objective: Enhance the capacity of staff to conduct effective rate reviews.

Results/Benefits Expected: Updated and improved staff expertise.

Activities, Positions Responsible, Timeline

- Attendance at seminars/trainings related to health insurance rating and review by Actuary, 2 Actuarial Assistants, and Senior Insurance Analyst; By September 30, 2011 (grant would not fund Bureau staff time for attendance)

F. Rate Review Information Technology

Objective: Enhance the Bureau's capacity to project trends based on claims data and other information.

Results/Benefits Expected: More accurate projection and analysis of trends.

Activities, Positions Responsible, Timeline

- Explore available software to determine the most appropriate package: Bureau staff; By November 30, 2010. Grant would not fund Bureau staff time for this market research.
- Purchase software: Bureau; By December 31, 2010. Grant would fund the cost of the software package.
- Train Actuary, 2 Actuarial Assistants, and Senior Insurance Analyst in use of software; By January 31, 2011 (grant would not fund Bureau staff time for training)

2) Identify Opportunities to Lower Premiums Through Greater Understanding of Market Changes

Objective: To develop an understanding of the effect of changes in plan design and in enrolled populations resulting from the Affordable Care Act on health insurance rates.

Results/Benefits Expected: Enhanced rate reviews. This information is crucial to the rate review process because it would enable us to evaluate the reasonableness of experience projections used by issuers to determine proposed rates.

Activities, Positions Responsible, Timeline

- Develop data specifications: Bureau staff and Consultants; August 9 – August 31, 2010
- Collect data from health plans: Consultants; September 1 – October 31, 2010
- Synthesize and analyze data: Consultants; October 1 – December 15, 2010
- Economic modeling to determine migration among different types of coverage and between coverage and uninsurance: Health Economist Consultant; November 1, 2010 – February 11, 2011
- Provide information and results to Bureau: Consultants, March 2011

3) Stronger Consumer Participation and Greater Transparency

Objective 1: Improve consumer understanding of how rates are set, the process for reviewing rates, and opportunities to participate in rate reviews and hearings.

Results/Benefits Expected: Enhanced transparency in the rate filing and review process and increased consumer understanding and empowerment.

Activities, Positions Responsible, Timeline

- Develop new educational materials and training about rate filings and the rate review process to the public and to consumer advocacy groups as follows:
- Develop a consumer guide for understanding rate filing data and review process: Consultant; November 2010 – April 2011
- Collect and publish rate filing information on Bureau website: Consultant; November 2010 – September 2011
- Develop training presentation for consumer groups; Bureau staff (grant would not fund) Schedule and provide training sessions to consumer groups throughout the state: Bureau staff (grant would not fund); December 2010 – September 2011

Objective 2: Improve consumers' ability to make health coverage decisions based on reliable and understandable information about how health insurance is priced and premiums are spent..

Results/Benefits Expected: Better decisionmaking by consumers.

Activities, Positions Responsible, Timeline

- Develop guides for consumers on how to use existing web-based comparison data on rates, administrative expenses, profits, and medical loss ratios to make insurance purchase decisions: Consultant; Fall 2010
- Develop and maintain and enhanced presentation of comparative rate information in order to make it more useful for consumers: Bureau staff (grant would not fund) and Consultant; November 2010 - September 2011

Objective 3: Provide resources to qualified consumer advocate groups to enable their effective participation in the rate review process.

Results/Benefits Expected: Enhanced capacity of consumer groups to participate fully in the rate review hearing process, including presentation of actuarial expert testimony. Enhanced consumer group capacity to review available and new data on small group and large group markets, as well as MLR-related data.

Activities, Positions Responsible, Timeline

- Develop criteria and a mechanism for administering this new grant fund: Bureau staff (grant would not pay for staff). HHS grant would provide 100% of the funding to be given to consumer groups); Fall 2010
- Identify consumer groups in Maine and educate those groups about availability of grant funding to support activities and participation in rate hearings and reviews. Bureau staff (grant would not support) Fall 2010
- Review grant applications and award grants. Bureau staff (Fall 2010)

- Develop criteria to review and assess grant funding for consumer group participation in rate reviews and hearings; September 30, 2011

II. Reporting to the Secretary on Rate Increase Patterns

Objective: To comply with the data reporting requirements outlined in Section 2794 of the Public Health Service Act.

Results/Benefits Expected: Fulfill requirements established by the Affordable Care Act and develop national framework for collecting and reporting rate increase information in a manner as cost effective to States and least burdensome to the private sector as possible. Phased implementation will allow a period of time during which data can be submitted by insurers before any reporting to HHS, thus avoiding manual data collection processes.

Positions Responsible: NAIC and SERFF staff (funding would be from this grant).

Activities, Timeline

- Participate in the national modification of SERFF to meet federal data collection and reporting needs as follows:
- The SERFF enhancements incorporating HHS reporting requirements will be implemented in a phased approach. The initial release, 3 months after receipt of HHS requirements for the uniform reporting template, will focus on implementing the means for data collection.
- Subsequent releases will incorporate reporting needs.
- Based on the requirements known at this time, the development will occur over an 8-month period beginning when the NAIC receives the reporting template and supporting documentation.

III. Enhance Data Center

Objective: Expansion of the number of services for which the Maine Health Data Organization (MHDO) makes information available to the public on payments by insurers for health care.

Results/Benefits Expected: Improved access to information on average reimbursements.

Positions Responsible, Timeline: Executive Director of MHDO and consultant; August 9, 2010 – September 30, 2011.

Activities

- Expand the existing list of total median payments by 25 specific services (by CPT code) for Maine providers
- Array the information in the "queriable" database on the MHDO's HealthCost website by the ten largest (by member volume) commercial payors in Maine, Medicare, and Medicaid
- Modify the website to enable users to view three years of data to look at trends in payments

MAINE

Thomas M. Record

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PROFESSIONAL EXPERIENCE

December 1978 to present

Maine Bureau of Insurance, Gardiner, Maine
Senior Staff Attorney, October 1993 to present.

- As a working supervisor, continue to perform all functions of a staff attorney as well as supervise office professional staff.
- Chair, State Commission on Lead Paint Poisoning and Liability Insurance.
- Received Departmental Manager of the Year Award, 2005

Acting Deputy Superintendent, July 1993 to January 1994.

- Assist Superintendent in managing 65 employee agency.
- Supervise agency in absence of Superintendent.
- Participate in recruitment process for permanent Deputy Superintendent.
- Participate in agency public policy decision making process.

Staff Attorney, March 1983 to October 1993.

- Analyze, research and render opinions and decisions on a broad range of legal issues.
- Provide counsel to Superintendent and other associates of a 65 employee agency on a wide range of issues.
- By correspondence and phone, counsel hundreds of consumers and insurance professionals on regulatory matters.
- Participate in administrative hearings on license code enforcement issues, corporate matters and rate filings.
- Draft, present and monitor legislation on insurance regulatory issues such as workers' compensation, tort reform and administrative law.
- Give public presentations on insurance to groups such as insurance trade organizations, senior citizens and community counselors.
- Represent Maine at National Association of Insurance Commissioners meetings.
- Commended by Governor McKernan for achievements in 1987 workers' compensation law reform.

PROFESSIONAL EXPERIENCE
(continued)
1977 - 1983

Insurance Contract Examiner, December 1978 to March 1983.

- Review proposed life and health insurance products to validate compliance with provisions of state insurance code.
- Perform wide variety of duties similar to those described above as staff attorney.

Center for Real Estate Education, Portland, Maine
Research Associate, 1977-78.

- Research and write examination questions for Maine Real Estate broker's license test.
- Collaborate in preparation of book on Maine real estate practice.

EDUCATION

UNIVERSITY OF MAINE SCHOOL OF LAW
Attended 1975-1978. Earned J.D. in May 1978.

UNIVERSITY OF MAINE AT ORONO
Attended 1971-1974. Earned B.A. (History) in August 1974.

OXFORD HILLS HIGH SCHOOL, SOUTH PARIS, MAINE
Attended 1967-71. Earned Diploma in June 1971.

PROFESSIONAL CREDENTIALS

Admitted to the Maine Bar, September 1978
Maine State Bar Association

- Co-chaired a continuing legal education seminar on administrative law practice before the Maine Bureau of Insurance.
- Participated in development of curriculum for continuing legal education seminar on governmental attorney ethics.

Member, American Bar Association
Tort and Insurance Practice Section

COMMUNITY AFFILIATIONS

Boy Scouts of America

- Former member, Kennebec Valley District Committee
- Former Scoutmaster, Troop 684, Augusta, Maine
- Former Cubmaster, Pack 647, Hallowell, Maine

Former President, Kennebec Valley Stamp Club

Former Treasurer, Maine Philatelic Society

Former Agency Coordinator, Combined Charitable Appeal

PERSONAL

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REFERENCES

Available upon request.