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

RE: ANTHEM BLUE CROSS AND BLUE SHIELD 2003 INDIVIDUAL RATE FILING FOR HEALTHCHOICE, HEALTHCHOICE STANDARD AND BASIC, AND INDIVIDUAL HMO STANDARD AND BASIC PRODUCTS	)	
_____	)	DECISION AND ORDER
IN RE: MAINE PARTNERS HEALTH PLAN 2003 INDIVIDUAL RATE FILING Consolidated Docket No. INS-02-785	)	

The Superintendent issues this Decision and Order in the above-captioned consolidated proceedings.

I. PROCEDURAL HISTORY

On August 2, 2002, Anthem Blue Cross and Blue Shield ("Anthem") and Maine Partners Health Plan ("Maine Partners") (Anthem and Maine Partners sometimes collectively referred to as the "Applicants") submitted for approval by the Superintendent proposed revised rates for certain of the Company's individual health insurance products. Specifically, Anthem proposes revised rates for its HealthChoice products that will produce an average increase of 7.1% for approximately 28,000 current enrolled members. The specific rate revisions range from a decrease of 13.3% to an increase of 14.7%, depending on deductible level and type of contract. Anthem proposes revised rates for its Individual HMO products that will produce a rate increase of no greater than 25.8% for approximately 200 current enrolled members. Anthem requests that these rate revisions become effective on January 1, 2003. Maine Partners proposes rates that are 95% of the proposed rates for Anthem's Individual HMO Standard and Basic products. Maine Partners proposes revised rates for its Individual HMO products that will produce a rate increase of no greater than 25.8% for approximately 75 current enrolled members. Maine Partners requests that these rate revisions become effective on January 1, 2003.

On August 23, 2002, the Superintendent issued a Notice of Pending Proceedings and Consolidated Hearing. The purpose of the hearing is to consider whether the revised rates proposed by Anthem and Maine Partners 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. In accordance with the provisions of 5 M.R.S.A. § 9052, notice to the public was accomplished in the following manner:

(a) Published the Notice in the following newspapers on the dates stated: Portland Press Herald (August 30, 2002), Maine Sunday Telegram (September 1, 2002), Bangor Daily News (August 30 and 31, 2002), Kennebec Journal (August 30 and 31, 2002), Morning Sentinel (August 30 and 31, 2002), and Lewiston Sun Journal (August 30 and 31, 2002).

(b) Electronically posted the Notice on August 30, 2002, at the Maine Bureau of Insurance home web page (www.maine.gov/pfr/insurance).

(c) Mailed the Notice on August 30, 2002, to persons who previously requested to be placed on a Bureau-maintained "interested person" list concerning healthcare issues, including all members of the State of Maine Legislature's Joint Standing Committee on Banking and Insurance, and the members of Maine's Congressional Delegation.

In addition to the foregoing, as required by the provisions of 24-A M.R.S.A. § 2735-A, on or around August 29, 2002, the Applicants provided direct written notice by mail to every affected policyholder advising them of the proposed rate increase and pending proceedings and hearing in this matter. The Superintendent is also aware of certain newspaper and trade press articles regarding the Applicants rate filings that ran in the Portland Press Herald (August 9 and September 10, 2002), Bangor Daily News (August 10, 2002), Kennebec Journal/Waterville Sentinel (August 16, 2002), and Insurance Times (August 20, 2002).

Consumers for Affordable Health Care ("CAHC") and Senator Sharon Anglin Treat on behalf of her constituents in Senate District 18 ("Senator Treat") submitted applications for intervention. The Superintendent granted permissive intervention to CAHC pursuant to the provisions of 5 M.R.S.A. § 9054 (2) as an interested person with full party status.[1] The Superintendent also granted the late-filed application to intervene of Senator Treat with the finding of an interested person with full party status pursuant to the provisions of 5 M.R.S.A. § 9054 (2).[2]

On September 24, 2002, the Superintendent issued a Procedural Order that, among other matters, established certain deadlines in the proceedings.

The Superintendent issued a First Discovery Request on September 11, 2002, a Second Discovery Request on September 27, 2002, and Oral Information Requests on October 17, 22, and 23, 2002.CAHC issued its First Discovery Request on October 1, 2002.[3] The Applicants' filed written objections to portions of CAHC's discovery that was ruled on by Order of the Superintendent issued October 4, 2002. Following CAHC's motion for reconsideration of the Superintendent's discovery Order, the Superintendent issued a further discovery Order on October 10, 2002. Senator Treat did not issue any discovery.

On October 8 and 9, 2002, CAHC and Senator Treat, respectively, filed motions for enlargement of time and to establish an advocacy panel. The Applicants opposed the motions. The Superintendent issued Orders on October 9 and 10, 2002, respectively, granting in part and denying in part the motions of CAHC and Senator Treat. Specifically, the Superintendent granted an enlargement of time and denied the establishment of an advocacy panel. Following CAHC's motion for reconsideration of the Superintendent's denial of an advocacy panel, the Superintendent issued a further Order on October 16, 2002, upholding the prior ruling.

Following motions by the Applicants for confidentiality protection for certain proprietary commercial and/or trade secret information the Superintendent issued Protective Orders on September 19 and 24, 2002, October 18, 2002, and an oral ruling on confidentiality at the public hearing on October 28, 2002. The Applicants asserted the information was proprietary because its disclosure would benefit competitors; reveals methodology and information that goes into calculating rates; and/or reveals the Company's internal financial data. Neither CAHC nor Senator Treat opposed the Applicants' requests for confidentiality nor sought reconsideration of any Protective Order or ruling on confidentiality made by the Superintendent.

On October 16, 2002, the Applicants submitted the prefiled testimony and exhibits of its witnesses James Parker, Vice President and General Manager of Anthem; William M. Whitmore actuary of Anthem; and Mark Talluto, Director of Sales for Anthem in Maine and for Maine Partners. That same day, CAHC submitted late-filed prefiled testimony and exhibits of witnesses Nedra Foster and Ward Webster. Senator Treat did not submit any prefiled testimony or exhibits.

On October 17, 2002, the Applicants submitted a motion for order clarifying scope of proceedings, for which CAHC submitted its response on October 18, 2002. The Superintendent addressed the motion and responded orally on the record on the first day of the public hearing (October 22, 2002). [4]

At the public hearing held in Augusta, Maine, on October 22, 23, and 28, 2002, members of the public were provided an opportunity to make either sworn or unsworn statements for consideration by the Superintendent in the proceedings. Twelve (12) individuals provided such oral statements. The Superintendent also received approximately ninety-five (95) public written comments. Testimonial evidence of the Applicants' witnesses was presented at the public hearing, as was the following documentary evidence that was admitted into the record:

EXHIBIT	REFERENCE
Hearing Officer Exhibit 1	The Applicants' responses to all discovery issued in the proceedings (portions of which are confidential)
Hearing Officer Exhibit 2	Written public comments comprised of approximately

EXHIBIT	REFERENCE
	ninety-five (95) letters received from consumers
Applicant Exhibit C-1	Confidential parts of Anthem's initial filing
Applicant Exhibit 1A	Non-confidential parts of Anthem's initial filing
Applicant Exhibit 2	Maine Partners initial filing
Applicant Exhibit 3	Second revised Exhibits VIII-X of the Applicants' initial filing
Applicant Exhibit 4	Revised Exhibit XI
Applicant Exhibit 5	Revised Exhibit XII
Applicant Exhibit 6	Second revised Exhibit XIV of the Applicants' initial filing
Applicant Exhibit C-7	Confidential - Exhibit XV
Applicant Exhibit 8	Revised Schedule VI and Attachment D of the Applicants' initial filing
Applicant Exhibit C-9	Confidential - Anthem Blue Cross and Blue Shield Premium v. Claim Slope Relativity
Applicant Exhibit C-10	Confidential - revised Schedule II of the Applicants' initial filing
Applicant Exhibit C-11	Confidential - revised Schedule IV of the Applicants' initial filing
Applicant Exhibit C-12	Confidential - revised Schedule V of the Applicants' initial filing
Applicant Exhibit 13	Schedule VIII of the Applicants' initial filing
Applicant Exhibit 14	Prefiled testimony of James Parker
Applicant Exhibit C-15	Confidential version of prefiled testimony of William Whitmore
Applicant Exhibit 16	Non-confidential version of prefiled testimony of William Whitmore
Applicant Exhibit 17	Prefiled testimony of Mark Talluto
Applicant Exhibit C-18	Confidential response to oral information request of the Superintendent
Applicant Exhibit 19	Non-confidential response to oral information request of the Superintendent
CAHC Exhibit 1	Bar graph charts depicting projected changes in enrollment due to price increases.
CAHC Exhibit 2	Prefiled testimony and exhibits of Nedra Foster
CAHC Exhibit 3	Prefiled testimony and exhibits of Ward Webster
Treat Exhibit 1	Newspaper insert advertising of the Applicants'

The public hearing concluded on October 28, 2002, and the record was closed at that time.

II. STANDARD OF REVIEW

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

III. DISCUSSION

The Superintendent specifically addresses certain components of the Applicants' 2003 rate filings as follows:

A. Rate Making Methodology

The Superintendent makes the following observations regarding the rate making methodology used by Anthem:

1. The Superintendent's Decision and Order on the Applicants' 2002 rate filing in Docket Nos. INS-01-2532 and INS-01-2534 required that:

   [Anthem] and [Maine Partners] shall include in all future rate filings projected changes in enrollment and shifting from one plan to another and an analysis of the impact that these changes will have on the experience.

   Although this analysis is included in Applicant Exhibit XIV to its filing (Applicant Exhibit 6), which showed that projected plan shifts would result in a lower loss ratio, the Applicants did not use this information in determining the proposed rates.[5]

2. The subsidy from HealthChoice to HMO was determined to be revenue-neutral only if enrollment is static. Since the Applicants actually anticipate increased enrollment in HealthChoice (increasing the subsidy dollars collected) and decreased enrollment in HMO (decreasing the subsidy dollars applied), the subsidy would not be revenue-neutral and would result in increased profit.
3. As noted in the Superintendent's discovery requests and as highlighted in the closing statements of both intervenors, the Applicants' various Exhibits and Schedules were not prepared on a consistent basis. It may be appropriate to use different assumptions for different purposes, but both the assumptions and the purposes need to be made clear. Better documentation would facilitate the review of rate filings and minimize the need for extensive discovery.

B. Trend

A significant assumption used for determining rates is the trend factor. This factor represents the anticipated increase in claim costs from the experience period (the most recent period for which claims experience is available) to the

rating period (the period in which the proposed rates will be in effect). The experience period relevant to the Applicants' filing is the 12-month period ending March 31, 2002. The evidence in the record demonstrates that the process used by the Applicants to estimate the trend factor was actuarially sound. There is nothing in the record that would indicate that the trend factor used by the Applicants is excessive, inadequate, or unfairly discriminatory. Applicant witness William Whitmore testified that based on subsequent information, he would have used a higher trend factor. The Applicants did not amend the filing to reflect a higher trend factor, and there is insufficient evidence in the record to find that the trend factor used is inadequate.

C. Adjustments to Claims

Claims over $100,000 - The methodology used, as adjusted by the response to the Superintendent's Oral Discovery Request, appears reasonable. Because the number and amount of large claims tends to fluctuate significantly from year to year, the Applicants substituted an estimate for the actual amount. This approach appears reasonable.

Bureau Rule 850 - The HealthChoice plan meets the statutory definition of a managed care plan[6] because it utilizes a network of providers and pays lesser benefits for non-network providers. Rule 850's access standards requires full coverage for non-network providers in situations where a network provider is not available within a specified distance of the insured's home.[7] Applicant witness James Parker testified that the Company faced increased costs resulting from the application of Rule 850. The factor used by the Applicants to reflect these increased costs was based on business judgment and appears reasonable. There is no evidence in the record that the factor is excessive, inadequate, or unfairly discriminatory.

Other Adjustments - The adjustment for Professional Pay Adjustments reflects changes in Anthem's contracts with providers. The Patient's Bill of Rights adjustment to HMO rates reflects the anticipated impact of statutory changes enacted in 2000. Both adjustments appear reasonable. There is no evidence in the record that either adjustment is excessive, inadequate, or unfairly discriminatory.

D. Administrative Expenses

There is no evidence in the record that would indicate that the administrative expense factor is unreasonable or that the new allocation system is unfair or inequitable. This is the first Anthem rate filing in several years that based the administrative expense factor on actual expense allocations. The Superintendent intends to review the expense allocation system as part of the next financial exam of the Company pursuant to the provisions of 24-A M.R.S.A. § 221.

E. Investment Income

Investment income appears to be appropriately credited in the rate calculation, though it was not reflected in the financial results in the Applicants' filing Exhibits VIII, IX, and X (Applicant Exhibit 3).

F. Profit

The profit margin target for this line of business is higher than the percentage utilized for Anthem as a whole in the Comparative Premium Rate Analysis prepared by the actuarial consulting firm of Milliman and Robertson for the then Blue Cross/Blue Shield of Maine, as required by Maine law in support of the conversion and acquisition proceedings (Consolidated Docket No. INS-99-14).[8] Applicant witness James Parker testified that the higher risk on this line of business (non-group) warrants a higher profit margin. It is reasonable and prudent for profit margins to be correlated to risk. High deductibles and guaranteed issue requirements would tend to increase volatility and claim severity for this line of business. These effects, however, must be weighed against other considerations. The Comparative Premium Rate Analysis was prepared in 1999 at a time when Anthem's predecessor had been unprofitable and in financial distress. In contrast, most recently Anthem has been able to operate profitably and to contribute to the Company's surplus position as demonstrated in year-end filings made with the Bureau of Insurance. Furthermore, Applicant witness James Parker testified as to the premium levels that Anthem's large group customers had been able to negotiate whereby Anthem anticipated achieving lower profit margins than projected for the non-group lines. Individuals covered under the non-group lines that are the subject of these proceedings do not have the same ability to negotiate lower premiums with Anthem. While it would not be proper or prudent for the Superintendent to require Anthem to write its non-group business at a loss,[9] or with inadequate rates in violation of Maine law (see 24-A M.R.S.A. § 2736 establishing that rates not be "inadequate, excessive, or unfairly discriminatory"), these considerations warrant a lower profit margin than reflected in the Company's proposed rates.

G. Other Rate Components

The provisions for commissions and premium tax are straight-forward and appropriate.

H. Non-Compliance with Bureau Rule 940

Rule 940 limits the difference between rates for different benefit plans to the maximum possible difference in benefits.[10] The Applicants are not in compliance with the requirements of Rule 940. The impact of achieving compliance, based on the Applicants filing Schedule VIII (Applicant Exhibit 13), does not appear severe. Furthermore, the impact does not need to be as severe

as illustrated by the Applicants, since Schedule VIII makes greater adjustments than are necessary to achieve compliance.

I. Contract Type Factors

The factor applied to individual rates to produce full family rates [2 adults + child(ren)] as stated in the Applicants' filing (Applicant Exhibit 1A) is 2.65. However, for the HealthChoice plans with no coinsurance ($2,250, $5,000, $10,000, $15,000, and $25,000 deductibles), the ratio of the proposed full family rate to the proposed individual rate is 2.671.

J. Mixed-Age Contracts and Age-Related Rate Changes

Anthem states that the introduction of a new billing system renders the Company unable to administer rating in the same manner as previously. While the Applicants cite administrative savings as the reason for the new system, the Applicants' witness testified that the Company does not project any administrative savings for the individual line as a result.

Although the Superintendent could require the Applicants to either maintain the old system or find some other way to maintain the prior rating methods, such action is not warranted. Recognizing that mixed-age rates are relatively more "accurate," the inaccuracy introduced by rating based only on the policyholder's age is insignificant compared to the subsidies among different age groups that result from the statutory community rating bands. Similarly, the delay in implementing age-related increases is insignificant given the broad age bands used.

The issue, therefore, is how these rating changes should affect the rates, if at all. Despite Anthem's stated intent not to recoup the lost revenues, the Company's filing has the effect of recouping those lost revenues resulting from the mixed-age contract change.

The change in the effective date of age-related increases will also result in much more frequent occurrences of "double" increases - i.e. the policyholder gets a 20% or 25% age increase at the same time as a general increase. Applicant witness William Whitmore testified that this would not adversely affect persistency, but the basis for that conclusion is not clear. It is reasonable to conclude that lapses are more likely to result from a large rate increase than from a series of smaller ones, even if the ultimate premium is the same. Nonetheless, this concern does not rise to the level where it is appropriate to require the Company to implement age-related increases sooner.

Another issue concerns implementation of the change relating to mixed-age contracts. The Applicants' filing states that they will offer policyholders the opportunity to make the younger spouse the policyholder and the Company assumes all will do so. The basis for that conclusion is not clear.

K. Supplemental Accident & Preventive Care Rider

In response to discovery, the Applicants state that they have never split out the experience for the Supplemental Accident & Preventive Care Rider from the base policy. Applicant witness William Whitmore testified that the Company is working on this and will have the data in about a month. Since the filing is designed to produce the required revenue for the line as a whole, the issue here isn't really adequacy or excessiveness of the rates, but equity between policyholders who have the rider and those who don't. The methodology used (as demonstrated in revised Applicant Exhibit VIII) appears appropriate at this time.

IV. FINDINGS AND CONCLUSIONS

On the basis of the record of the proceedings, the Superintendent makes the following findings and conclusions:

1. Anthem and Maine Partners insure a majority of the population currently insured under individual health insurance policies in Maine. The Superintendent considers this market share dominance relevant to the filing and the subsequent evaluation of the proposed rates.
2. Anthem's and Maine Partners' proposed rates are neither inadequate nor unfairly discriminatory.
3. Anthem and Maine Partners have established, in accordance with accepted actuarial principles and practices, that their rates will yield loss ratios of at least 65% in compliance with the requirements of Maine law under the provisions of 24-A M.R.S.A. § 2736-C (5).
4. Anthem is not in compliance with Bureau of Insurance Rule Chapter 940.
5. Anthem's rating methodology for 2003 rates should be revised to:
    a. reflect the anticipated savings (lower loss ratios) demonstrated by the projected plan shifts;
    b. make the subsidy from HealthChoice to the individual HMO line revenue-neutral based on projected enrollment;
    c. make the minimum adjustments necessary to comply with Bureau of Insurance Rule 940 in a revenue-neutral manner;
    d. use a factor of 2.65 for all contracts covering two adults with one or more children or justify the use of a different factor; and
    e. amend the profit margin to three percent (3%) before consideration of revenues lost due to administrative changes with respect to mixed-age contracts and the age-related rate changes.

V. ORDER

Pursuant to the provisions of 24-A M.R.S.A. §§ 2736 and 2736-B, the Superintendent hereby ORDERS as follows:

1. Approval of the filed rates for the Anthem HealthChoice non-group product lines and Anthem and Maine Partners individual HMO product lines is DENIED.
2. Revised rate filings may be submitted for review on or before November 18, 2002, and shall be APPROVED, effective January 1, 2003, if found by the Superintendent to be consistent with the terms of this Decision and Order, and the Required Adjustments to Proposed Rates specified in Exhibit A attached hereto and incorporated herein by reference.
3. Anthem and Maine Partners shall take vigilant measures to ensure that affected policyholders under mixed-age contracts are aware of their opportunity to make the younger spouse the policyholder by means of initial direct mail notification, follow-up direct mail notification where a policyholder is non-responsive to the initial mailing, and a single telephone notification if a policyholder continues to be non-responsive. This requirement applies both to those policyholders initially affected by the change and to those who are affected in the future as the older spouse reaches an older age band. Anthem and Maine Partners also shall take similarly vigilant measures to ensure that those applying for family coverage are aware of the savings available by making the younger spouse the policyholder.
4. Anthem and Maine Partners shall include in all future rate filings experience data for the Supplemental Accident & Preventive Care Rider.
5. Anthem and Maine Partners shall undertake in all future rate filings to prepare exhibits and schedules on consistent bases, as appropriate. The assumptions underlying each exhibit and schedule shall be disclosed. Where different assumptions are used for different purposes, a clear explanation shall be provided. Unless readily apparent, the source of each item in each exhibit and schedule shall be shown.
6. Anthem and Maine Partners shall continue to submit all informational filings required pursuant to prior Decisions and Orders of the Superintendent including but not limited to the following requirements established in the Superintendent's November 30, 2001, Decision and Order issued in Docket Nos. INS-01-2532 and INS-01-2534:

   (i) Anthem and Maine Partners shall include in all future rate filings a comparison of actual to projected loss ratios for recent filings as well as an analysis of any disparities and what improvements, if any, they have made to the methodology to reduce the likelihood of similar disparities in the future.

   (ii) Anthem and Maine Partners shall include in all future rate filings projected changes in enrollment and shifting from one plan to another and an analysis of the impact that these changes will have on the experience.

VI. NOTICE OF APPEAL RIGHTS

This Decision and Order is a final agency action of the Superintendent of Insurance within the meaning of the Maine Administrative Procedure Act. It may be appealed to the Superior Court in the manner provided by 24-A M.R.S.A. § 236, 5 M.R.S.A. § 11001, et seq. 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: November 8, 2002

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ALESSANDRO A. IUPPA
Superintendent

EXHIBIT A

REQUIRED ADJUSTMENTS TO PROPOSED RATES

Step 1. Adjust revenue at current rates in Exhibit I Revised (in Applicant Exhibit C-18) to reflect projected enrollment (both increased number of contracts and plan shifts). For HealthChoice, this is based on calculations from revised Schedules II and IV (Applicant Exhibits C-10 and C-11). Multiply current rates by projected enrollment and divide the total by the total based on current enrollment. Apply this ratio to the "Revenue @ Current Rates" in Exhibit I Revised. For HMO, no plan shifts are projected, so only a volume adjustment is needed. [11] A 30% enrollment decrease should be used.

Step 2. Adjust projected claims to reflect projected enrollment (both increased number of contracts and plan shifts). For HealthChoice, this is based on calculations from the first expanded Exhibit XIV (attached to Response to First Discovery Request of the Superintendent in Hearing Officer Exhibit 1). (As noted in the footnote referenced above, the Superintendent interprets the second revision to be inaccurate.) Projected claims in Exhibit I Revised should be increased in proportion to the projected increase in enrollment (3.7% per Exhibit XIV and Schedules II and IV) and then decreased by a factor reflecting the smaller claims per contract due to plan shifts to higher deductibles. This factor is calculated from Schedule XIV by dividing the average claim based on projected enrollment by the average claim based on current enrollment. The average claim is determined by dividing total claims by total enrollment. For

HMO, no plan shifts are projected, so only a volume adjustment is needed. As noted above, a 30% enrollment decrease should be used.

Step 3. Adjust administrative expenses in Exhibit I Revised to reflect the projected increase in HealthChoice enrollment (3.7%) and decrease in HMO enrollment (30%).

Step 4. Adjust the profit margin in Exhibit I Revised to be three percent (3%).

Step 5. Deduct $641,000 from HealthChoice required revenue in Exhibit I Revised and $5,000 from HMO. Since Schedules II, IV, and V (Applicant Exhibits C-10, C-11, and C-12) automatically adjust rates for non-mixed-age contracts to make up for reductions in mixed-age contracts in order to achieve the desired increase in revenue, this amount needs to be deducted from the revenue requirement in order to avoid recoupment. The $641,000 and $5,000 figures are from the revised Exhibit VIII submitted in response to the Superintendent's Oral Discovery Request (Applicant Exhibit C-13). No adjustment needs to be made for the change in the effective date of age increases as Schedules II, IV, and V do not adjust for this.

Step 6. In Exhibit I Revised, as further amended by Steps 1 through 5 above, divide the total required revenue by the revenue at current rates, as adjusted in Step 1 above to reflect projected enrollment, to get the average rate increase before subsidy.

Step 7. Adjust the result derived from Step 6 above to reflect the HMO subsidy. Increase the HealthChoice revenue by one percentage point. Determine the revenue-neutral HMO subsidy by dividing 1% of the HealthChoice revenue at current rates, as adjusted in Step 1 above, by the HMO revenue at current rates, as adjusted in Step 1 above. Subtract this result from the HMO average rate increase before subsidy. The resulting HealthChoice and HMO average rate increases after subsidy are the percentage increases to be targeted, as described in Step 9 below.

Step 8. Unless justification is provided for the use of a 2.671 factor for full family rates for HealthChoice plans with no coinsurance, a factor of 2.65 should be used in Schedule II.

Step 9. Determine an adjustment factor that when applied to the proposed rates in Schedules II, IV, and V [with Schedule II adjusted per Step 8 above] would result in percentage increases in revenue based on projected enrollment (i.e., the increase in the product of 2003 rates and projected enrollment over the product of current rates and projected enrollment) equal to the rate increases targeted in Step 7 above.

Step 10. Further adjust the rates as adjusted in Step 9 above to achieve compliance with Rule 940. The necessary adjustments are as follows:

- The difference between the monthly rate at ages 55+ for the $4000 deductible and the $5000 deductible must be capped at $800/12. (Because the $4000 deductible plan has coinsurance and the $5000 deductible plan does not, the difference in benefits can never be $1000. The maximum difference in benefits would be for $5000 in covered expenses, for which the $4000 deductible plan would pay $800 and the $5000 deductible plan would pay nothing.)
- The difference between the monthly rate at ages 55+ for the $2250 deductible and the $5000 deductible must be capped at $2750/12.
- The monthly rate at ages 55+ for the $2000 deductible must be capped at the lesser of (a) the rate for the $4000 deductible plus $2000/12, and (b) the rate for the $2250 deductible + $200/12. (Because the $2000 deductible plan has coinsurance and the $2250 deductible plan does not, the difference in benefits can never be $250. The maximum difference in benefits would be for $2250 in covered expenses, for which the $2000 deductible plan would pay $200 and the $2250 deductible plan would pay nothing.)
- The difference between the monthly rate at ages 55+ for the $1000 deductible and the $2000 deductible must be capped at $1000/12.
- The difference between the monthly rate at ages 55+ for the $750 deductible and the $1000 deductible must be capped at $250/12.
- The difference between the monthly rate at ages 55+ for the $500 deductible and the $750 deductible must be capped at $250/12.
- The difference between the monthly rate at ages 55+ for the $300 deductible and the $500 deductible must be capped at $200/12.
- The difference between the monthly rate at ages 55+ for the $150 deductible and the $200 deductible must be capped at $150/12.

Step 11. Apply an adjustment factor to increase the rate for the $5000 deductible to make the changes in Step 10 above revenue-neutral based on projected enrollment. Rates for all other plans listed in Step 10 above should be simultaneously adjusted to maintain the caps without over-adjusting.

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[1] CAHC also applied for intervention as a matter of right pursuant to the provisions of 5 M.R.S.A. § 9054 (1), which the Superintendent denied. The Applicants filed a written opposition to CAHC's intervention in the proceedings as a matter of right, pursuant to an Order of the Superintendent issued September 16, 2002, establishing a deadline for making statements in opposition to intervention.

[2] Upon request of Senator Treat, their being no objection by the Applicants, the Superintendent issued an Order on September 26, 2002, allowing access to confidential information by the Senator's aide, William MacDonald.

[3] The Superintendent issued an Order on October 2, 2002, directing CAHC to promptly file with the Superintendent and to provide the parties with a public, non-confidential version of the Discovery Request with only Designated Confidential Information redacted. CAHC made that filing on October 10, 2002.

[4] In substance, the Superintendent reiterated the scope of proceedings as stated in the Notice of Pending Proceedings and Consolidated Hearing as follows:

The purpose of the hearing is to consider whether the revised rates proposed by Anthem and Maine Partners 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.

[5] Initially, the Applicants used the projected enrollment in determining the administrative expense component of the required revenue, but the result was combined with claims projected assuming static enrollment. In the response to the Superintendent's Oral Discovery Request, the Applicants revised the methodology to determine all components assuming static enrollment. The result is internally consistent, but does not reflect the anticipated improvement in experience due to plan shifts.

[6] See, 24-A M.R.S.A. § 4301-A(11).

[7] See, Bureau of Insurance Rule 850, § 7(B)(5).

[8] The Comparative Premium Rate Analysis is in the record of these proceedings as part of Hearing Officer Exhibit 1.

[9] While there are good public policy arguments for requiring individual products to be subsidized, requiring the subsidy to come only from Anthem would put the Company at a competitive disadvantage in the group market.

[10] See, Rule 940, § 8(B). For example, if two plans are identical except that one has a $300 deductible and the other has a $500 deductible, the difference in the annual premiums cannot exceed $200.

[11] There is a discrepancy in the Applicants' Exhibits as to how much of an enrollment decrease is anticipated. The Applicants' original filing showed a 30% decrease in HMO enrollment from the experience period (Y/E 3/31/02) to the rating period (Y/E 12/31/03). This appears in Exhibit I, Exhibit XIV as expanded in response to the First Discovery Request of the Superintendent, and in Schedule V as expanded also in response to the First Discovery Request of the Superintendent. The 30% enrollment decrease also was assumed in Exhibit IX. Exhibit XIV was amended in response to the Second Discovery Request of the Superintendent to show only a 14% decrease. The Superintendent interprets the first expanded Exhibit XIV to be correct and that the "corrected" version contained an error. The top portion of Exhibit XIV, showing HealthChoice data, is labeled current and projected "contract enrollment." The bottom portion, reflecting HMO, is labeled current and projected "member enrollment." However, the numbers in the first version correspond to the number of contracts shown in Schedule V and Exhibit IX. The revised version of Exhibit

XIV shows a number corresponding to the number ofmembers in Exhibit IX. For these reasons, the Superintendent interprets the revised version as actually comparing projected members to current contracts to arrive at the 14% decrease. The revised Schedule V provided in response to the Superintendent's Oral Discovery Request still shows a 30% enrollment decrease. The revised Exhibit IX provided in response to the Superintendent's Oral Discovery Request still assumes a 30% enrollment decrease. The revised Exhibit I provided in response to the Superintendent's Oral Discovery Request does not use projected enrollment. A 30% enrollment decrease is therefore assumed.