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VIA HAND-DELIVERY

Roger A. Sevigny, Commissioner
New Hampshire Insurance Department
21 South Fruit St., Suite 14
Concord, N.H. 03301

Re: *In Re Petition of Frisbie Memorial Hospital, et al.*
Docket No. _____

Dear Commissioner Sevigny:

Enclosed please find for filing with the Commission:

1. Petition for Hearing Pursuant To RSA 400-A:17; and
2. Request for Governmental Records Relating to Qualification of Anthem Health Insurance Plans on New Hampshire Health Insurance Marketplace.

Thank you for your assistance.

Very truly yours,


John A. Malmberg

JAM/mem
Enclosures
cc: Lisa Guertin, President, Anthem
1081016_1

THE STATE OF NEW HAMPSHIRE
INSURANCE DEPARTMENT

In re Petition of Frisbie Memorial Hospital *et al.*

Docket No. _____

PETITION FOR HEARING
PURSUANT TO RSA 400-A:17

Frisbie Memorial Hospital (“Frisbie”) and Margaret McCarthy (collectively the “Petitioners”) petition the New Hampshire Insurance Department (the “Department”) for a hearing and an order requiring Anthem to permit Frisbie to participate in Anthem Blue Cross Blue Shield’s Qualified Health Plans (“QHPs”) under the U.S. Patient Protection and Affordable Care Act (“ACA”), under the same terms and conditions of other participating providers. In support hereof, Petitioners state:

Parties

1. The Petitioners are citizens of New Hampshire, corporate or natural, with the following addresses of record:

- a. Frisbie Memorial Hospital, 11 Whitehall Rd., Rochester N.H. 03867, is a New Hampshire non-profit corporation.
- b. Margaret McCarthy, 30 Cocheco Ave., E. Rochester, N.H. 03868.

Introduction

2. Anthem Blue Cross Blue Shield (“Anthem”) is the only insurer participating in the New Hampshire Health Insurance Marketplace (“Marketplace”), an online exchange linking people in the individual health care market with private insurers. Anthem offers a “narrow network” of health care providers on its Marketplace available plans—a network that excludes Frisbie. In negotiating the narrow network, Anthem

never even contacted Frisbie about participation in the network, despite the fact that Frisbie was ready, willing and able to accept the same rates offered by Anthem to other providers in its narrow network. As a consequence, patients such as Margaret McCarthy will need to sever their relationships with Frisbie-related providers, and travel substantially greater distances for health care. Because there was no public process whatsoever to determine whether the proposed narrow networks meet state and federal network adequacy requirements, the Department violated basic due process requirements, and Petitioners are entitled to a hearing on these issues. Following a hearing, the Petitioners are entitled to an order from the Department requiring Anthem to permit any willing provider willing to accept the Marketplace QHP rates to participate in its Marketplace available plans.

Facts and Argument

3. The ACA is an omnibus act designed to comprehensively reform the health insurance system of the United States. Its key innovation is the establishment of an electronic exchange, or marketplace, where consumers can search online for competing insurance products. In New Hampshire the electronic exchange was created and will be run by the federal government, with the State reserving substantial authority to determine what kinds of plans can be marketed and sold on the exchange. The New Hampshire exchange is called the “New Hampshire Health Insurance Marketplace” or “Marketplace.”

4. Pursuant to the ACA, only QHPs were permitted to be marketed on the Marketplace.

5. On April 10, 2013, the Department called for submissions from insurers for plans that the insurers wished to qualify as QHPs under the ACA in order to make them available to consumers on the Marketplace. *See* Bulletin, Docket No. INS 13-007-AB (the “Bulletin”), attached as Exhibit 1. The Bulletin described the timeline for submission of plans, the authority of the Department and the process by which the Department would exercise its authority to ensure that the plans being offered adhered to New Hampshire’s and the ACA’s requirements for, among other things, network adequacy for health plans. *See* RSA 420-N:5, IV (conferring authority on Commissioner for “form and rate review of insurance products”); RSA 420-N:8, I (including as part of the reservation of authority in the Commissioner to approve health plans the authority to determine whether plans meet network adequacy requirements).

6. The Bulletin further set forth a timeline for when insurance carriers would notify the Department of their intent to participate in the Marketplace, when proposed plans would be submitted, and when the Department would conclude its evaluation of the plans under various metrics. Bulletin at 2-3.

7. In addition, the Bulletin described in tabular form the various metrics against which the plans would be evaluated. Bulletin at 3-11 (generally), 4-5 (setting forth the rules and statutes addressing network adequacy at the State and Federal levels).

8. The timeline required all plans to be submitted by carriers by June 1, 2013, and established a deadline of July 31, 2013 for the Department to issue its determination as to whether the proposed plans qualified as QHPs under the ACA. The Department would certify QHPs to the U.S. Secretary of Health and Human Services by July 31, 2013.

9. The Department issued no other bulletins, orders, notices, press releases or announcements concerning the implementation of the ACA between April 10, 2013 and August 1, 2013.

10. Presumably, during that time, the Department received proposed plans from insurers, including Anthem Blue Cross of New Hampshire; considered and evaluated those proposed plans against the metrics set forth at pages 3-11 of the Bulletin; communicated with submitting insurers; and made determinations about whether the proposed plans qualified as QHPs.

11. On August 1, 2013, the Department published a press release, announcing: “New Hampshire Insurance Department Recommends Plans for Health Insurance Marketplace.” Exhibit 2. The press release explained, “Last night the New Hampshire Insurance Department submitted its recommendations for which health insurance plans should be offered on the New Hampshire Health Insurance Marketplace, or Exchange, beginning October 1, 2013.” The Press Release offered no details about the QHPs, the extent of the available physicians and hospital networks under the QHPs, or the Department’s rationale in arriving at its conclusions.

12. The process by which the Department arrived at its recommendations for which health insurance plans should be offered on the Marketplace was devoid of public input, scrutiny, or review.

13. Sometime in September, 2013, Anthem Blue Cross published details of its QHPs available on the Marketplace. Anthem was the only insurer offering plans on the Marketplace in 2013. Although the full information about the Anthem QHPs was not formally and completely available until the Marketplace opened October 1, 2013, the

plans offered by Anthem on the Marketplace appeared to exclude 11 hospitals, or 40% of hospitals in New Hampshire, as well as all their affiliated physicians groups and other health care providers.

14. RSA 400-A:17 provides that the Department shall provide a hearing “upon written application for a hearing by a person aggrieved by any act or impending act, or by any report, rule, regulation, or order of the commissioner[.]”

15. The Department’s review and approval of Anthem’s QHPs was an act of the commissioner and/or Department. RSA 420-N:8, I (“[T]he commissioner shall retain authority with respect to insurance products sold in New Hampshire on the federally-facilitated exchange ... including but not limited to producer and insurer licensing, form and rate approval, reinsurance and other risk-sharing mechanisms, network adequacy, industry assessments, internal grievance standards, external review, and unfair trade practices.”); *see* Bulletin at 1-2 (explaining the Department’s substantive role in preapproving plan forms, rates and network adequacy, among other factors, prior to submission to CMS and/or the Secretary of Health and Human Services, for approval).

16. Frisbie is aggrieved by the Department’s approval of the Anthem QHPs because it has been excluded, without notice or an opportunity to participate in the networks available under Anthem’s QHPs. Individuals, represented by Ms. McCarthy, are persons aggrieved because they are required to give up health care providers associated with Frisbie in order to obtain insurance on the Marketplace. Although Ms. McCarthy may drive to a hospital in Dover that participates in the plans, other individuals in New Hampshire may also be required by the available QHPs to drive farther than the State’s network adequacy requirements permit, or to wait for care for longer than network

adequacy requirements permit due to the increased flow of patients accessing the smaller narrow network.¹ *See* Bulletin; N.H. Admin. R. Ins. §2701 *et seq.*

17. Although public knowledge of Anthem’s “narrow network” plans arose when Anthem published certain information about them in September, Anthem subsequently added two hospitals that had initially been left off their QHPs, and it was not clear what final form of the Anthem “narrow network” plans would take. October 1, 2013 was the date upon which the Marketplace opened, and the full details of the plans available from Anthem were accessible. *See* Press Release, August 1, 2013 (“The final decision on whether the plans are qualified for sale on the Marketplace will be made by the federal Centers for Medicare and Medicaid Services (CMS), the agency operating the Marketplace... CMS will release plan rates and details by October 1, 2013, when the Marketplace opens for business.”)

18. Petitioners are entitled to a hearing on whether the Anthem plans approved by the Department and offered on the Marketplace meet the requirements of federal and New Hampshire law for, among other things, network adequacy, including distance and time to access providers, wait times for health care, and more. Such a hearing must detail the process by which Anthem arrived at its network inclusion decisions, provide Petitioners and the public with the full breadth of information the Department considered in approving the Anthem “narrow network plans,” and permit the excluded hospitals, at a minimum, to participate in the Anthem networks, if willing, at rates offered to other providers. *See* Exhibit 3, Decision and Order, State of Maine Bureau of Ins., Docket No.

¹ The lack of public information concerning whether the Anthem QHPs meet these network adequacy requirements is a substantial reason why a hearing is required. Data regarding how Anthem’s QHPs meet these requirements has never been scrutinized or verified through public inspection, and it is not clear even as of this writing what populations may have been adversely affected by or excluded from Anthem’s narrow network.

INS-13-803 (describing hearing process for approval of Anthem plans to offer narrow networks in Maine to grandfathered plan holders not participating in the Maine healthcare marketplace or exchange, including the collection of testimony, exhibits, public comment and a statutory appeal mechanism).

19. The Department's failure to provide such a process during the initial review period for QHPs, as described in the Bulletin, was inconsistent with the basic principles of open government and due process guarantees of the New Hampshire and U.S. Constitutions. "Where governmental action would affect a legally protected interest, the due process clause of the New Hampshire Constitution guarantees to the holder of the interest the right to be heard at a meaningful time and in a meaningful manner." *Appeal of Northern New England Telephone Operations, LLC*, _____ N.H. _____, Slip Op., August 21, 2013 at *3 (citing and quoting *Appeal of Pennichuck Water Works*, 160 N.H. 18, 36 (2010); *Appeal of Town of Nottingham*, 153 N.H. 539, 551 (2006) ("where issues of fact are presented for resolution by an administrative agency due process requires a meaningful opportunity to be heard")); U.S. Const., Amendment 14; N.H. Const., Pt. I, Arts 2, 12. This failure of due process must be rectified as to the current plans available on the Marketplace, and in light of the fact that the call for plans for participating Marketplace insurers commencing in 2015 will begin in the first half of 2014.

20. The Petitioners request that the Department set a hearing in this matter at the earliest possible convenience, but with reasonable advance notice for the Petitioners to review all file documents and records that were considered by the Department as part of its approval of the process for Anthem's QHPs. *See* Letter Request for Governmental

Records Pursuant to RSA 91-A, submitted contemporaneously herewith and incorporated herein by reference.

21. The Petitioners further request an order from the Department requiring Anthem to permit Frisbie to participate in its Marketplace-available QHPs according to the same terms and conditions as other providers.

Respectfully submitted

Frisbie Memorial Hospital
Margaret McCarthy

By and through their attorneys,

Date: November 6, 2013

By: 
John A. Malmberg, No. 1000
Jeremy D. Eggleton, No. 18170

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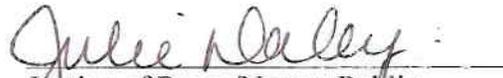
I hereby certify under oath that the information contained in the foregoing Petition is true and complete to the best of my knowledge and belief.

Date: November 6, 2013


John A. Malmberg, Esq.

THE STATE OF NEW HAMPSHIRE
COUNTY OF MERRIMACK, SS.

Personally appeared on this 6th day of November, 2013, the above-named John A. Malmberg, Esq., and made oath that the foregoing is true and complete to the best of his knowledge and belief.


Justice of Peace/Notary Public
My commission expires:

JULIE A. DALEY, Notary Public
My Commission Expires December 18, 2013

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EXHIBIT 1



THE STATE OF NEW HAMPSHIRE
INSURANCE DEPARTMENT

21 SOUTH FRUIT STREET SUITE 14
CONCORD, NEW HAMPSHIRE 03301

Roger A. Sevigny
Commissioner

Alexander K. Feldvebel
Deputy Commissioner

BULLETIN
Docket No.: INS 13-007-AB

TO: All New Hampshire Licensed Health Carriers and Dental Insurers

FROM: Roger A. Sevigny
Insurance Commissioner 

DATE: April 10, 2013

RE: Qualified Health Plan Certification Process in New Hampshire

New Hampshire Qualified Health Plan Certification Bulletin to Issuers – 2014 Plan Year

The purpose of this Bulletin is to detail the process issuers must follow in New Hampshire to have their non-grandfathered individual and small group health plans certified as Qualified Health Plans (QHPs) eligible to be offered in the New Hampshire Health Insurance Marketplace for October 1, 2013 open enrollment and January 1, 2014 effective date coverage.

New Hampshire has chosen to enter into a plan management partnership with the Federally Facilitated Exchange that will be established for New Hampshire, which will be known as the New Hampshire Health Insurance Marketplace, or New Hampshire Marketplace. To be certified as a QHP on the New Hampshire Marketplace, issuers and their health plans must meet all applicable federal and state statutory requirements and standards. Operating in partnership with the US Department of Health and Human Services (HHS), the New Hampshire Insurance Department (NHID) will review and recommend certification of QHPs to the HHS Center for Consumer Information and Insurance Oversight (CCIIO), which will have the opportunity to ratify the certification recommendation.

The New Hampshire Insurance Commissioner "is charged with the rights, powers, and duties pertaining to the enforcement and execution of the insurance laws" of New Hampshire. NH RSA 400-A:3. The Commissioner has general rulemaking and enforcement authority with respect to regulation of the business of insurance in New Hampshire. NH RSA 400-A:15 and 16. Under New Hampshire law, the Insurance Department regulates health insurance carrier licensing (NH RSA chapter 420-A and NH RSA chapter 420-B) and solvency (NH RSA 400-A:36-37), reviews health insurance policy forms, rates, and benefit design (NH RSA chapter 415, NH RSA chapter 420-G), monitors health insurance marketing practices, network adequacy and treatment of consumers (NH RSA chapter 420-J), and has authority to take enforcement action with respect to violations of health insurance regulatory standards (NH RSA 415:20, NH RSA 420-G:16, NH RSA 420-J:14) and unfair trade practices (NH RSA chapter 417).

The Department has adopted many administrative rules that are applicable to some or all health insurance plans and issuers. These include: N.H. Code of Administrative Rules Chapter Ins 200 (Practices and Procedures); Chapter Ins 400 (Filings for Life, Accident and Health Insurance); Part Ins 1001 (Claim Settlement for all Insurers, Except Property and Casualty); Chapter Ins 1900 (Accident and Health Insurance); Chapter Ins 2000 (Medical Utilization Review Entities); Chapter Ins 2200 (Health

Maintenance Organizations); Chapter Ins 2400 (Actuarial Opinion and Memorandum); Part Ins 2601 (Advertisements of Accident and Health Insurance); Chapter Ins 2700 (Managed Care, including Ins Part 2701, Network Adequacy, Ins Part 2702, Parity In Mental Health And Substance Use Disorder Benefits, and Ins Part 2703, External Review); Chapter Ins 3000 (Privacy of Consumer Financial and Health Information); Chapter Ins 3700 (Standards for Safeguarding Customer Information); Chapter Ins 4000 (Uniform Reporting System For Health Care Claims Data Sets); and Chapter Ins 4100 (Requirements For Accident And Health Insurance Rate Submissions).

In reviewing proposed QHPs, the NHID will apply all state regulatory standards except those that are inconsistent with and would prevent the application of federal law. The Affordable Care Act (ACA) establishes the legal authority for QHP certification as well as other operational standards for the Marketplace in the following sections: 1301-1304, 1311-1312, 1321-1322, 1324, 1334, 1401-1402, 1411, and 1412. Federal standards for QHP issuers are codified in 45 CFR 155 and 156. With respect to QHP-specific standards, the New Hampshire Insurance Commissioner has authority to adopt and apply standards consistent with the Affordable Care Act "for form and rate review of insurance products and any other regulatory oversight functions performed by the department." NH RSA 420-N:5, IV. Adoption and application of such standards requires prior approval of the Joint Health Care Reform Oversight Committee under NH RSA 420-N:4, II. The Department received approval to use the standards in this bulletin on April 9, 2013, with the caveat that changes may be made to the bulletin if necessary to conform with the terms of a Memorandum of Understanding between the state and CCIIO.

Health insurance issuers wishing to offer plans in the New Hampshire Marketplace may submit their applications with included rate and form filings between April 10, 2013 and June 1, 2013. Stand alone dental issuers may begin submitting their applications under the same timeframe; however, data templates specific to stand alone dental plans will not be available in SERFF until May 15, 2013. Specific timelines for the QHP certification process are detailed below. Any plan that is not certified under this timeline will be ineligible to be offered in the New Hampshire Marketplace during plan year 2014.

Although New Hampshire has already requested that issuers notify the Department of their intent to participate in the certification process by March 28, 2013, issuers that have not yet made this declaration may still make an application according to the timelines laid out in this Bulletin. Plans will be reviewed in the order received, with priority given to plans submitted by carriers who filed letters of intent.

The timeline for the QHP certification process in New Hampshire will be as follows:

March 28, 2013: Carriers notify NHID of intent to participate in the Marketplace.

April 15, 2013: Health issuers and stand alone dental plans wishing to participate in the Marketplace may begin to submit QHP and company applications.

May 15, 2013: Data templates supporting stand-alone dental plan filings available in SERFF.

June 1, 2013: Final date for QHP submission, including stand-alone dental plans.

July 31, 2013: Final date for NHID to submit certification recommendations for QHP issuers and QHPs to CCIIO.

Spring – Fall 2013: Non-Marketplace health and dental plans may be filed. Please provide enough time for state review pending planned marketing for 2014 plan year.

Late August 2013: Plan Preview Period - CCIIO will give health and dental issuers applying for Marketplace certification an opportunity to address any data errors. However, CCIIO has noted that any changes made to plans during this time period may jeopardize certification.

Early September 2013: CMS will notify issuers of the QHP Certification decision and negotiate certification agreements with carriers.

October 1, 2013 - March 31, 2014: Marketplace is open for annual enrollment.

All filings must be made within the System for Electronic Rate and Form Filings (SERFF). Individual and small group filings must be submitted using different SERFF tracking numbers. Insurers may contact the Health Insurance Oversight System (HIOS) to receive their Marketplace Issuer and Plan Identification numbers. Additional training for HIOS may be offered. More information is available at <http://www.regtap.info>.

Starting in March, insurers may begin registering for training with SERFF to learn how to submit filings and utilize Qualified Health Plan(QHP) Templates. This training is expected to last through April, 2013. Information can be found at <http://www.serff.com/hix.htm>.

The following table provides citations of federal law and the Code of Federal Regulations (CFR) that establish the certification criteria for qualified health plans (QHPs) for specific substantive areas, followed by an explanation of the Department’s planned approach to conducting review to determine whether applicable requirements are met.

General Requirements	
<p>Federal Standard 45 CFR 155 and 156 45 CFR 156.20 42 USC §18021 42 USC §18022 42 USC §18031 CMS Guidance Rules ACA §1311 ACA §1002</p>	<p>A QHP issuer must—</p> <ol style="list-style-type: none"> (1) Comply with all certification requirements on an ongoing basis; (2) Ensure that each QHP complies with benefit design standards; (3) Be licensed and in good standing to offer health insurance coverage in New Hampshire; (4) Implement and report on a quality improvement strategy or strategies consistent with the standards described within the ACA, disclose and report information on health care quality and outcomes as will be later defined by the Centers for Medicaid and Medicare Services (CMS), and implement appropriate enrollee satisfaction surveys as required by the ACA; (5) Agree to charge the same premium rate for each QHP of the issuer without regard to whether the plan is offered through the Marketplace or whether the plan is offered directly from the issuer or through an agent; (6) Pay any applicable user fees assessed; (7) Comply with the standards related to the risk adjustment program administered by CMS; (8) Notify customers of the effective date of coverage; (9) Participate in initial and annual open enrollment periods, as well as special open enrollment periods; (10) Collect enrollment information, transmit it to the Marketplace and reconcile enrollment files with the Marketplace enrollment files monthly; (11) Provide and maintain notices of termination of coverage. A standard policy must be established and include a grace period for certain enrollees that is applied uniformly. Notice of payment delinquency must be provided; (12) Segregate funds for services for which Federal funding is prohibited under section 1303 of the ACA, if the QHP covers such services; (13) Timely notify the Marketplace if it plans not to seek recertification, and in such

	<p>event fulfill coverage obligations through the end of the plan/benefit year, fulfill data reporting obligations from the last plan/benefit year, provide notice to enrollees, and terminate coverage for enrollees, providing written notice;</p> <p>(14) In the event that the QHP becomes decertified, terminate coverage only after notification of enrollees and after enrollees have had an opportunity to enroll in other coverage; and</p> <p>(15) Meet all readability and accessibility standards.</p>
New Hampshire Insurance Department Certification Procedure	<p>NHID will review rates, forms and QHP application filings. For QHPs that meet applicable standards, NHID will recommend certification.</p> <p>At least one carrier has notified NHID of its intent to offer a stand-alone dental QHP on the Marketplace. Therefore, NHID will not require QHP issuers to include pediatric dental benefits in their non-grandfathered individual and small group plans.</p>
Licensure and Solvency	
Federal Requirements 45 CFR 156.200	A QHP issuer must be licensed and in good standing with the State.
New Hampshire Insurance Department Certification Procedure	<p>In order to be considered "in good standing" and to offer a QHP through the Marketplace, a QHP issuer must have unrestricted authority to write its authorized lines of business in New Hampshire. NHID is the sole source of a determination of whether an issuer is in good standing.</p> <p>An issuer will be allowed to apply for New Hampshire licensure and QHP issuer and plan certification simultaneously during the first QHP certification cycle; however, a QHP issuer may not be certified for participation in the Marketplace until state licensure has been established.</p>
Network Adequacy	
Federal Standard 45 CFR 156.230 45 CFR 156.235 Public Health Services Act (PHS) §2702(c)	<p>A QHP issuer must ensure that the provider network of each of its QHPs is available to all enrollees and:</p> <p>(1) (a) Includes essential community providers (ECP) in sufficient number and geographic distribution where available to ensure reasonable and timely access to a broad range of such providers for low income and medically underserved individuals in QHP service areas. This must be done by demonstrating one of the following during the first year of the Marketplace:</p> <ul style="list-style-type: none"> • That the issuer achieved at least 20% ECP participation in network in the service area, agreed to offer contracts to at least 1 ECP of each type available by county; • That the issuer achieved at least 10% ECP participation in the network service area and submits a satisfactory narrative justification as part of its issuer application; or • That the issuer failed to achieve either standard but submitted a satisfactory narrative justification as part of its issuer application.

	<p style="text-align: center;">OR</p> <p>(b) If an issuer provides a majority of covered services through employed physicians or a single contracted medical group complying with the alternate ECP standard identified within federal regulations, the issuer must verify one of the following:</p> <ul style="list-style-type: none"> • That the issuer has at least the same number of providers located in designated low income areas as the equivalent of at least 20% of available ECPs in the service area; • That the issuer has at least the same number of providers located in designated low income areas as the equivalent of at least 10% of available ECPs in the service area, and submits a satisfactory narrative justification as part of its issuer application; or • That the issuer failed to achieve either standard but submitted a satisfactory narrative justification as part of its issuer application. <p>(2) Maintains a network that is sufficient in number and types of providers, including providers that specialize in mental health and substance use disorder treatment services, to assure that all services will be accessible without unreasonable delay; and</p> <p>(3) Makes its provider directory for a QHP available to the Marketplace for publication online in accordance with guidance from the Marketplace and to potential enrollees in hard copy upon request noting which providers are not accepting new patients.</p>
<p>New Hampshire Insurance Department Certification Procedure</p>	<p>Issuers of medical QHPs must comply with New Hampshire Code of Administrative Rules Part INS 2701 (Network Adequacy). The Department’s specific approach to this review will be as follows:</p> <ol style="list-style-type: none"> 1. An adequacy report must be made, or on file, pursuant to Part INS 2701. The Department will accept and review changes to previously filed adequacy reports. 2. The issuer must submit an attestation that the network is in compliance with the essential community provider requirements. 3. Issuers shall make their provider directory available for online publication and in print as requested. 4. Mental Health network adequacy is also required. <p>Issuers of stand-alone dental plans must submit an adequacy report demonstrating that their network has sufficient numbers and types of providers to assure that all services will be accessible without unreasonable delay.</p>
<p>Accreditation</p>	
<p>Federal Standard 45 CFR 156.275 45 CFR 155.1045</p>	<p>QHP issuers must maintain accreditation on the basis of local performance in the following categories by an accrediting entity recognized by HHS: Clinical quality measures, such as the HEDIS; Patient experience ratings on a standardized CAHPS survey; Consumer access; Utilization management; Quality assurance; Provider credentialing; Complaints and appeals; Network adequacy and access; and Patient information programs.</p> <p>Existing commercial or Marketplace health plan accreditation from HHS-recognized</p>

	<p>accrediting entities will be accepted. For the purposes of QHP issuer certification in 2013, these are the National Committee for Quality Assurance (NCQA) and URAC.</p> <p>QHP issuers without existing commercial or Marketplace health plan accreditation from HHS-recognized accrediting entities must schedule an accreditation review during their first year of certification and receive accreditation on QHP issuer policies and procedures prior to their second year of QHP issuer certification.</p> <p>Prior to the QHP issuer's fourth year of QHP issuer certification and annually thereafter, a QHP issuer must be accredited in accordance with 45 CFR 156.275</p> <p>QHP issuers will be required to authorize the release of their accreditation survey data and any official correspondence related to accreditation status to NHID.</p>
New Hampshire Insurance Department Certification Procedure	NHID will follow federal requirements related to accreditation and will require an authorization from the issuer for the release of all accreditation data upon request from NHID. Additionally, NHID will require an attestation by QHP issuers not already accredited that those QHP issuers will schedule, become accredited on policies and procedures in the plan types used, and provide proof of such accreditation on policies and procedures prior to submission of any application for recertification. The QHP issuer must also indicate that it will receive and provide proof of receipt of full Marketplace accreditation prior to its third recertification application.
Service Area	
Federal Standard 45 CFR 155.30 & 155.70	Service area is the geographic area in which an individual must reside or be employed in order to enroll in a QHP. A QHP issuer must specify what service areas it will be utilizing. The service area must be established without regard to racial, ethnic, language or health status related factors or other factors that exclude specific high utilization, high cost or medically underserved populations.
New Hampshire Insurance Department Certification Procedure	NHID will allow the QHP issuers to choose their service area(s), except that requested service areas may not be smaller than a county.
Rating Area	
Federal Standard 45 CFR §156.255	As it applies to QHPs, the ACA defines a "Rating Area" as a geographic area established by a state that provides boundaries by which issuers can adjust premiums. The ACA requires that each state establish one (1) or more rating areas within that State for purposes of applying the requirement of this title.
New Hampshire Insurance Department Certification Procedure	Present New Hampshire law prohibits geographic rating in the individual and small group markets. In addition, HB 668, which is now pending in the New Hampshire legislature, would establish a single rating area for QHP certification for 2014. Prospective QHP issuers should proceed under the assumption that they will not be able to vary premiums by regions within the state in 2014.
Quality Improvement Standards	
Federal Standard 45 CFR 156.20 ACA §1311 ACA §2717	<p>A QHP issuer must implement and report on a quality improvement strategy or strategies consistent with standards of the ACA to disclose and report information on healthcare quality and outcomes and implement appropriate enrollee satisfaction surveys which include but are not limited to the implementation of:</p> <ul style="list-style-type: none"> • A payment structure for health care providers that provides incentives for

	<p>improving health outcomes through the implementation of activities that shall include quality reporting, effective case management, care coordination, chronic disease management, medication and care compliance initiatives, including through the use of the medical home model, for treatment or services under the plan or coverage;</p> <ul style="list-style-type: none"> • Activities to prevent hospital readmissions through a comprehensive program for hospital discharge that includes patient-centered education and counseling, comprehensive discharge planning, and cost discharge reinforcement by an appropriate health care professional; • Activities to improve patient safety and reduce medical errors through the appropriate use of best clinical practices, evidence based medicine, and health information technology under the plan or coverage; • Wellness and health promotion activities; and • Activities to reduce health and health care disparities, including through the use of language services, community outreach, and cultural competency trainings.
<p>New Hampshire Insurance Department Certification Procedure</p>	<p>NHID will require all QHP issuers to report on the implementation of their quality improvement standards. The carrier shall submit an attestation of intent to comply with all regulatory guidelines issued by HHS relating to quality improvement standards.</p>
<p>General Offering Requirements</p>	
<p>Federal Standard 45 CFR 155 and 156 45 USC §18022 45 C.F.R. § 156.130(a) 45 CFR §147.126 45 CFR §147.120 45 CFR §147.138 CMS Guidance Rules</p>	<p>A QHP issuer must offer at least one QHP at the silver coverage level and at least one QHP at the gold coverage level, along with and a child-only plan at the same level of coverage as any QHP offered through either the individual Marketplace or SHOP to individuals who, as of the beginning of the plan year, have not attained the age of 21. Additionally, a catastrophic plan may be filed to be sold on the Marketplace in addition to the tiered metal levels.</p> <p>All offerings by a QHP issuer, excluding stand-alone dental issuers, on a single metal tier must show a meaningful difference between the plans and comply with standards in the best interest of the consumer.</p> <p>Moreover, the QHP, excluding stand-alone dental, must provide coverage for dependents up to age 26 if the Plan offers dependent coverage. Pediatric dental and vision services must be covered for dependents up to age 19. Additionally, the QHP must cover emergency services with no prior authorization, no limitation to participating or in-network providers. Emergency services must be covered at the in-network cost-sharing level.</p> <p>QHP issuers will be required to meet all annual limitation and cost sharing requirements without affecting the actuarial value of the plans within each of the tiers. The QHP issuer must demonstrate in an Exhibit filed with the plan that annual out of pocket cost sharing under the plan does not exceed the limits established by federal and state laws and regulations. Moreover, the QHP must contain no lifetime limits on the dollar value of any Essential Health Benefits (EHB), including the specific benefits and services covered under the EHB-Benchmark Plan.</p>

	<p>Catastrophic plans can be sold to individuals who have not attained the age of 30 before the beginning of the plan year, or to an individual who has a certification in effect for any plan year that the individual is exempt from the Shared Responsibility Payment by reason of lack of affordable coverage or hardship. If offered, catastrophic plans are offered only in the individual Marketplace and not in the SHOP.</p> <p>A QHP issuer must comply with all federal and state laws related to rating rules, factors and tables used to determine rates. Such rates must be based upon the analysis of the plan rating assumptions and rate increase justifications in coordination with NHID.</p>
<p>New Hampshire Insurance Department Certification Procedure</p>	<p>Issuers must comply with all federal and state laws related to rating rules, factors and tables used to determine rates.</p> <p>The Department will post a revised checklist on its website integrating state and federal rate and form filing requirements.</p>
Essential Health Benefit Standards	
<p>Federal Standards 45 CFR 156.115 42 U.S.C. § 18022 45 CFR §147.130 45 CFR §148.170 45 CFR §155.170 45 CFR §156.110 45 CFR §156.125</p>	<p>The QHP issuer must offer coverage that is substantially equal to the coverage offered by the state's base benchmark plan. This may be done by substituting benefits within EHB categories only if the QHP issuer demonstrates actuarial value of the substituted benefits. Services for which federal funding is prohibited under section 1303 of the ACA are subject to financial segregation requirements; the QHP issuer must provide notice through its summary of benefits if such coverage is being made available.</p> <p>The QHP must cover preventive services without cost sharing requirements including deductibles, co-payments, and co-insurance. Covered preventive services include evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force (USPSTF); certain immunizations, screenings provided for in HRSA guidelines for infants, children, adolescents, and women (including compliance with standards related to benefits for and current recommendations of the USPSTF regarding breast cancer screening, mammography, and prevention). Additionally, coverage for the medical treatment of mental illness and substance use disorder must be provided under the same terms and conditions as that coverage provided for other illnesses and diseases.</p>
<p>New Hampshire Insurance Department Certification Procedure</p>	<p>New Hampshire has adopted the Matthew Thornton Blue Plan as the Base Benchmark Plan to set the essential health benefits for New Hampshire. The U.S. DHHS has supplemented the Matthew Thornton Blue Plan with the Federal Employee Dental and Vision Insurance Plan (FEDVIP) for pediatric dental and vision benefits, and has determined that habilitative services are already included in New Hampshire's base benchmark plan. Carriers must comply with the Mental Health Parity and Addiction Equity Act (MHPAEA) requirements.</p>
Essential Health Benefit Formulary Review	
<p>Federal Standards 45 CFR 156.120 45 CFR §156.295</p>	<p>The QHP must cover at least the greater of one drug in every U.S. Pharmacopeial Convention (USP) category and class or the same number of drugs in each category and class as the base benchmark plan.</p> <p>Issuers must report data such as the following to U.S. DHHS on prescription drug distribution and costs (paid by Pharmacy Benefit Management (PBM) or issuer): Percentage of all prescriptions that were provided through retail pharmacies compared</p>

	to mail order pharmacies; percentage of prescriptions for which a generic drug was available and dispensed compared to all drugs dispensed, broken down by pharmacy type; Aggregate amount and type of rebates, discounts or price concessions that the issuer or its contracted PBM negotiates that are attributable to patient utilization and passed through to the issuer; Total number of prescriptions that were dispensed; Aggregate amount of the difference between the amount the issuer pays its contracted PBM and the amounts that the PBM pays retail pharmacies, and mail order pharmacies.
New Hampshire Insurance Department Certification Procedure	NHID will require an attestation of compliance with EHB Formulary Standards.
Non-Discrimination Standards in Marketing and Benefit Design	
Federal Standard 45 CFR 156.125 45 CFR 156.200 45 CFR 156.225 45 FR 155.1045 42 U.S.C. § 300gg-3 45 CFR §148.180	<p>(1) A QHP issuer must:</p> <ul style="list-style-type: none"> • Be able to pass a review and an outlier analysis or other automated test to identify possible discriminatory benefits; and • Refrain from: <ul style="list-style-type: none"> ○ Adjusting premiums based on genetic information; ○ Discriminating with respect to its QHP on the basis of race, color, national origin, disability, age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, sex, gender identity, sexual orientation or other health conditions; ○ Utilizing any preexisting condition exclusions; ○ Requesting/requiring genetic testing; or ○ Collecting genetic information from an individual prior to, or in connection with enrollment in a plan, or at any time for underwriting purposes. <p>(2) A QHP issuer may not employ marketing practices or benefit designs that will have the effect of discouraging the enrollment of individuals with significant health needs.</p>
New Hampshire Insurance Department Certification Procedure	<p>QHP issuers and QHPs must comply with state laws and regulations regarding marketing by health insurance issuers. QHP issuers may inform consumers in QHP marketing materials that the QHP is certified by the Marketplace. The QHP issuer may not inform consumers that the certification of a QHP implies any form of further endorsement or support of the QHP.</p> <p>NHID will require prior approval of QHP marketing material and an attestation that the QHP issuer meets all marketing standards. If NHID determines through its regulatory efforts that unfair or discriminatory marketing is occurring, NHID will enforce through use of state remedies and will recommend the QHP for decertification.</p>
Actuarial Value Standards	

<p>Federal Standards 45 CFR 156.135</p>	<p>Plans being offered at the various metal tiers within the Marketplace must meet the specified levels of actuarial value (or fall within the allowable variation):</p> <p>Bronze plan: 60% (58 to 62%) Silver plan: 70% (68 to 72%) Gold plan: 80% (78 to 82%) Platinum plan: 90% (88% to 92%)</p> <p>Stand-alone dental plans must offer plans at either a 70% or 85% actuarial value level (also within the allowable \pm 2% variations).</p> <p>Percent of actuarial value means the share of total plan costs that would, on average across the entire benefit, be paid by the plan and not the member.</p>
<p>New Hampshire Insurance Department Certification Procedure</p>	<p>NHID will require issuers to submit the completed actuarial value calculator provided by CCIIO to verify compliance with AV standards. NHID will also require issuers to submit an actuarial certification. The actuary shall certify that either the AV calculator accommodated the plan design or specify the methodology used to accommodate the plan for calculation purposes. In the event accommodation was necessary, the actuary shall certify that such accommodations were in accordance with generally accepted actuarial principles and practices. See Federal Register, Vol. 78, Number 37, February 25, 2013, p. 12844 for further detail.</p>
Quality Rating Standards	
<p>Federal Standard 45 CFR §156.265 (b)(2) 45 CFR §156.265 (f); 45 CFR §156.400 (d) 45 CFR §156.285 (c) PHSA 2794</p>	<p>HHS intends to propose a phased approach to new quality reporting and display requirements for all Marketplaces with reporting requirements related to all QHP issuers expected to start in 2016. HHS intends to support the calculation of the QHP-specific quality rating for all QHP issuers in all Marketplaces. The results of such surveys and rating will be available to consumers. HHS intends to issue future rulemaking on quality reporting and disclosure requirements. The carrier shall submit with its application an attestation to comply with all regulatory guidelines issued by HHS by the date of certification.</p> <p>QHP issuers must also provide plain language information/data on claims payment policies and practices, periodic financial disclosures, data on enrollment and disenrollment, number of denied claims, rating practices, cost-sharing and payments for out-of-network coverage, and enrollee rights must be submitted to the Marketplace, HHS, and the state insurance commissioner.</p>
<p>New Hampshire Insurance Department Certification Procedure</p>	<p>NHID will address the issue of Quality Rating Standards after the federal guidance has been issued.</p>
Rate Filing	
<p>Federal Standard</p>	<p>Under the ACA, premiums may be varied by geographic rating area, but premium rates must be the same inside and outside the Marketplace.</p> <ul style="list-style-type: none"> • Rating will be allowed on a per member basis. • ACA: premium rate may vary only by individual/family, rating area, age (3:1), and tobacco use (1.5:1) • All rates filed for individual QHPs will be set for an entire benefit/plan year. <p>States have authority to further limit the variables by which issuers may vary premium</p>

	rates, so long as the state does not add additional rating factors or exceed the ratios set by federal law.
New Hampshire Insurance Department Certification Procedure	<p>NHID will continue to effectuate its rate review program, inclusive of federal rating standards and state specific standards, and will review all rate filings for prior approval. Final rating rules are currently being deliberated by New Hampshire's General Court via HB 668. For more info on the status of this bill, visit http://www.gencourt.state.nh.us/legislation/2013/HB0668.html</p> <p>NHID will accept any rate filing that complies with the bill's current text. Carriers shall monitor this bill and amend their rates, if necessary, to accommodate statutory changes. Rate filing information must be submitted to NHID prior to the implementation of said rates.</p>
Plan Variations for Individuals Eligible for Cost Sharing	
Federal Standard 45 CFR §155.1030 45 CFR §156.420	<p>Each QHP issuer must offer three silver plan variations for each silver QHP, and one zero cost sharing plan variation and one limited cost sharing plan variation for each metal level QHP. Silver plan variations must have a reduced annual limitation on cost sharing, cost sharing requirements and AVs that meet the required levels within a de minimis range. Benefits, networks, non-EHB cost sharing, and premiums cannot change. All cost sharing must be eliminated for the zero cost sharing plan variation. Cost sharing for certain services must be eliminated for the limited cost sharing plan variation.</p> <p>This will be completed via rate and benefit templates.</p>
New Hampshire Insurance Department Certification Procedure	NHID will require an attestation of compliance with Plan Variation Standards.

For questions regarding this bulletin, contact Michael Wilkey or Sonja Barker at 603-271-2261 or email at michael.wilkey@ins.nh.gov or sonja.barker@ins.nh.gov.

EXHIBIT 2

PRESS RELEASE

New Hampshire Insurance Department
21 South Fruit St, Suite 14, Concord, NH 03301 – 603-271-2261 – www.nh.gov/insurance

For Immediate Release

New Hampshire Insurance Department Recommends Plans for Health Insurance Marketplace

August 1, 2013 – Concord, New Hampshire - Last night the New Hampshire Insurance Department submitted its recommendations for which health insurance plans should be offered on the New Hampshire Health Insurance Marketplace, or Exchange, beginning October 1, 2013.

Under the Affordable Care Act, the federal government is building and operating the New Hampshire Health Insurance Marketplace, which will be a website where people and small businesses (through the SHOP Exchange) will be able to buy health insurance and, for those who qualify, to receive subsidies to lower the cost of coverage.

New Hampshire has entered into a partnership for Plan Management, which means the Insurance Department is responsible for reviewing and approving the rates, forms and plan design for the health insurance plans that will be offered on the Marketplace. The final decision on whether the plans are qualified for sale on the Marketplace will be made by the federal Centers for Medicare and Medicaid Services (CMS), the agency operating the Marketplace.

CMS will release plan rates and details by October 1, 2013, when the Marketplace opens for business. Once the coverage takes effect on January 1, 2014, the Insurance Department will continue to play its traditional role in overseeing the conduct of the companies offering the plans, and will be available to assist New Hampshire consumers with any issues that arise regarding their health insurance, including plans offered on the Marketplace.

“New Hampshire’s Health Insurance Marketplace will help individuals and businesses compare plans in order to access health coverage that fits their needs, and I commend my rate and form staff for their heroic efforts to meet the July 31st deadline for reviewing the proposed Marketplace health insurance plans,” said Insurance Commissioner Roger Sevigny. “While we cannot make rates or plan details public at this time, we are encouraged by the filings that were made, and we are confident that New Hampshire consumers will have good options for coverage through the Marketplace when it opens in October.”

EXHIBIT 3

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

IN RE:)
)
ANTHEM BLUE CROSS AND BLUE)
SHIELD REQUEST TO DISCONTINUE) **DECISION AND ORDER**
INDIVIDUAL HEALTH PLANS)
)
Docket No. INS-13-803)

I. INTRODUCTION

Eric A. Cioppa, Superintendent of Insurance (“Superintendent”), issues this Decision and Order in the above-captioned matter after consideration of the Anthem Blue Cross and Blue Shield (“Anthem”) request to discontinue and replace certain individual health plans. Specifically, Anthem proposes to cease offering its existing individual health plans and to cease renewing those plans except for policyholders that are grandfathered under the federal Affordable Care Act (ACA). Further, beginning January 1, 2014, Anthem proposes to migrate its existing non-grandfathered individual health plan policyholders to a plan that will be issued outside the health insurance Marketplace, and therefore will not be available for federal subsidies under the ACA, and that will use the Guided Access networks approved by the Superintendent in Docket No. INS-13-801 (*In re Anthem Blue Cross and Blue Shield Request for Approval of Access Plans*). Thus, policyholders residing in Androscoggin, Cumberland, Franklin, Kennebec, Knox, Lincoln, Oxford, Sagadahoc, Waldo, and York Counties would be migrated to Anthem’s Guided Access HMO plan that includes a limited network, meaning that a number of health care providers in the ten identified southern and western Maine counties are not included in the HMO network. Policyholders residing in Aroostook, Hancock, Penobscot, Piscataquis, Somerset, and Washington Counties will be migrated to Anthem’s Guided Access POS plan that includes a

broad network, including nearly all of the providers in the six identified northern and eastern Maine counties.

For the reasons discussed below, the proposed discontinuance and replacement is approved for the six northern and eastern counties, but disapproved for the ten southern and western counties. In the ten southern and western counties, Anthem must either renew the existing coverage with modifications that are narrowly tailored to conform to the ACA, or, if the existing plans are discontinued and not renewed, the policyholders must be migrated to plans that retain the existing broad network and do not totally exclude benefits for out-of-network services.

II. PROCEDURAL HISTORY

Anthem Request for Approval

On April 12, 2013, Anthem requested approval of product discontinuance and replacement for its non-grandfathered individual health plans. On April 16, May 2, May 17, May 30, and June 18 Anthem filed supplemental information in support of its request.

Notice of Hearing; Public Comment Sessions

Upon exercising his discretion to hold a hearing in this matter, on July 26, 2013 the Superintendent issued a Notice of Pending Proceeding and Hearing (“Hearing Notice”).¹

As described in the Hearing Notice, the purpose of the proceeding was for the Superintendent to determine whether Anthem’s proposed product discontinuance and replacement would be “in the best interests of the policyholders,” as required by 24-A M.R.S.

¹ The Hearing Notice incorporated an Order ruling on requests for a hearing and intervention, thereby granting certain requests for intervention and denying other intervention requests. The Superintendent’s *sua sponte* decision to initiate the proceeding rendered it unnecessary for him to determine whether any of the persons that were granted intervenor status would have had standing under 24-A M.R.S. § 229 to require a hearing to be held.

§ 2850-B(3)(G)(3)(b), and is otherwise in compliance with applicable law. Hearing Notice at Section III.

Per the Hearing Notice, evening public comment sessions were set at four locations throughout the State: August 15 in Portland, August 16 in Bangor, August 29 in Auburn, and August 30 in Presque Isle. The evidentiary hearing was set for September 9 in Augusta. The Superintendent also set daytime and evening public comment sessions for September 9 in Augusta.

Intervention Applications

By Order issued July 26, 2013, the Superintendent granted intervention to the Maine Attorney General (“AG”).

Also by Order issued July 26, 2013, the Superintendent granted intervention to Rumford Hospital, Bridgton Hospital, Maureen Harpell, N.P., Albert Aniel, M.D., David Salko, M.D., Brenda Weeks, Central Maine Healthcare (“CMHC”), Central Maine Medical Center (“CMMC”), Dieter Kreckel, M.D., Alan Verrill, M.D., and William Lee, M.D (collectively, “Rumford-Bridgton”). By that same Order, the Superintendent denied intervention to the remaining applicants for intervention: Julie Rioux, Lisa Pease, Daniel Trafford, and three alleged “unknown” individuals designated as “John Doe,” “Mary Roe,” and “Dr. Noe.”

By Order issued August 12, 2013, the Superintendent granted intervention to Robert L. Kimball.

Procedural Order

On July 29, 2013, the Superintendent issued a Procedural Order establishing requirements for the conduct of the proceeding. Among other dates, the discovery deadline was set at August 28, 2013, and pre-filed testimony and exhibits were due by September 5, 2013.

Protective Order

On August 14, 2013, the Superintendent issued a Protective Order to address the handling of confidential information in the proceeding. Regarding Anthem's assertions of confidentiality for certain information referred to as the "Business Plans," the August 14 Protective Order provided Anthem an opportunity to provide further legal argument in support of its claim of trade secret protection. On August 19 Anthem moved for continued confidentiality protection for its Business Plans. By Order issued September 6 the Superintendent granted Anthem's motion for continued confidentiality protection.²

The Protective Order further directed Anthem to file in the proceeding certain non-confidential public documents and transmittal letters previously submitted with the Superintendent prior to the issuance of the Hearing Notice, which Anthem filed on August 20.

Discovery

The July 26 Hearing Notice advised that intervenors could commence discovery immediately upon being granted party status. *See* Hearing Notice at Section VI.

On August 9, 2013, the AG served a First Discovery Request, to which Anthem responded on August 15.³ Anthem's August 15 response included a motion to withhold completely from Rumford-Bridgton certain responsive information relating to provider negotiations, on grounds that even an "Attorneys' Eyes Only" designation would not adequately protect the information. No party objected to Anthem's motion. By correspondence dated

² CMHC has appealed the Superintendent's June 21 FOAA ruling that made the Business Plans confidential and exempt from public disclosure, and that matter remains pending before the Superior Court. *See Central Maine Healthcare Corp., et al. v. Bureau of Insurance, et al.*, Docket No. BCD-AP-13-03.

³ On August 13 the AG withdrew request number 3 from its First Information Request.

August 29, after the deadline for objections had passed, Rumford-Bridgton requested that the Superintendent rule on Anthem's motion. On September 3 the Superintendent issued an order granting Anthem's motion for highly confidential treatment.

On August 16, 2013 (as amended on August 19), Rumford-Bridgton served a First Information Request upon Anthem. On August 20 Anthem objected, simultaneously providing certain responsive information subject to and without waiving its objections. Anthem provided supplemental responses on August 22. On August 23 Rumford-Bridgton requested a ruling on Anthem's objections. On August 27 the Superintendent issued an Order ruling on each of Anthem's objections, sustaining some and overruling others. Anthem provided further supplemental responses on August 29 and 31. Anthem's August 31 supplemental response included a motion for confidential treatment of certain information.

On August 27, 2013, Rumford-Bridgton served a Second Information Request upon Anthem. On August 29 Anthem objected, simultaneously providing certain responsive information subject to and without waiving its objections.

On August 28, 2013, the AG served a Second Information Request upon Anthem, to which Anthem responded on August 31. Anthem's August 31 response included a motion for confidential treatment of certain information.

Conference of Counsel; Official Notice

By correspondence dated August 30, 2013, Rumford-Bridgton requested that the Superintendent address certain procedural matters related to the September 9 evidentiary hearing. On September 4 the Superintendent convened a telephonic conference of counsel, to which all parties were represented, at which the identified procedural issues were addressed.

The August 30 correspondence further requested the Superintendent to take official notice of certain matters, and at the conference of counsel Anthem also requested the taking of official notice of other matters. On September 4 the Superintendent issued an Order taking official notice of identified matters.

Pre-filed Testimony & Exhibits

On September 5 Rumford-Bridgton filed the pre-filed testimony of three witnesses, and Anthem filed the pre-filed testimony of nine witnesses together with certain pre-filed exhibits. Anthem also filed a motion to prevent counsel for Rumford-Bridgton from viewing portions of the pre-filed testimony of Larry Hart and Hart Exhibit A, on grounds that the information was too competitively sensitive. On September 6 Rumford-Bridgton objected. Also on September 6 the Superintendent issued an Order requiring Anthem either to make that information available to Rumford-Bridgton on an "Attorneys' Eyes Only" basis subject to the August 14 Protective Order or to withdraw it. On September 6 Anthem advised of its election to withdraw the highly confidential information from the Larry Hart pre-filed testimony and from Hart Exhibit A.

Evidentiary Hearing

The evidentiary hearing was held as scheduled on September 9, 2013, and was conducted entirely in public session. All parties were present and represented by counsel.

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

- *Anthem*: The pre-filed testimony of Colin McHugh, Regional Vice President of Provider Engagement and Contracting for Anthem in Maine (Anthem Exhibit 1), and McHugh Exhibits A & B; pre-field testimony of William M. Whitmore, Regional Vice President of Underwriting with Anthem in Maine (Anthem Exhibit 2), and Whitmore Exhibit A; pre-filed testimony of Jeffrey Holmstrom, Medical Director for Anthem in Maine (Anthem Exhibit 3), and Holmstrom Exhibit A; pre-field testimony of Lawrence E. Hart, Actuarial Business Director with Anthem in Maine (Anthem

Exhibit 4A), and Hart Exhibits A & B; pre-filed testimony of John P. (Jack) Burke, principal and consulting actuary with Milliman (Anthem Exhibit 5), and Burke Exhibit A; pre-filed testimony of Albert G. Swallow, III, Vice President of Finance and Chief Financial Officer for Maine Medical Center (Anthem Exhibit 6); pre-filed testimony of Carolyn Kasabian, Chief Financial Officer and Treasurer for St. Mary's Health System and St. Mary's Regional Medical Center (Anthem Exhibit 6); pre-filed testimony of Susan Keiler, Chief Operating Officer for St. Mary's Health System and St. Mary's Regional Medical Center (Anthem Exhibit 8); and pre-filed testimony of Joel Allumbaugh, Principal in National Worksite Benefit Group (Anthem Exhibit 9) were admitted over Rumford-Bridgton's objections to portions of Anthem Exhibits 1, 2, 4A, and 9.

- *Rumford-Bridgton*: The pre-filed testimony of Edmund Claxton, Chief Medical Information Officer and Medical Director of the Accountable Care Organization for CMMC; pre-filed testimony of Nicholette Erickson, Medical Director for Cancer Program at CMHC; and pre-filed testimony of David Frum, President and Chief Executive Officer of Rumford Hospital and Bridgton Hospital were admitted over Anthem's objection to portions of Frum's pre-filed testimony.

The Superintendent also took official notice of additional identified matters during the hearing.

Public Testimony & Written Comment

Members of the public provided sworn testimony and unsworn statements for the record during the various sessions held by the Superintendent at five locations throughout the State (Portland, Bangor, Auburn, Presque Isle, and Augusta). Members of the public also submitted written comments outside the public hearings, which the Superintendent has designated a part of the record of the proceeding. The Superintendent has read each of the written comments provided. To the extent that they comment on facts that are in the record, they shall be considered for their persuasive value in the same manner as legal arguments and other comments submitted by the parties. However, the Maine Administrative Procedure Act bars the Superintendent from relying on unsworn submissions as evidence when making his decision.

5 M.R.S. § 9057.

Post-Hearing Filings

On September 10, 2013, Rumford-Bridgton filed the Congressional Research Service report of which the Superintendent took official notice at the September 9 hearing.

On September 18, 2013, Anthem filed its responses to the Superintendent's September 9 hearing requests.

Written Closing Argument; Record Closed

Per the schedule established by the Superintendent at the conclusion of the September 9 hearing, on September 19, 2013 Anthem, the AG, and Rumford-Bridgton each filed written post-hearing briefs as closing arguments.

The record of the proceeding closed at 4 p.m. on September 19, 2013.

III. LEGAL STANDARD

Under longstanding Maine law, individuals purchasing health insurance coverage in the individual market have a right to guaranteed renewal of their insurance policies. This right means that, except in certain narrowly defined circumstances, "coverage may not be cancelled, and renewal must be guaranteed." 24-A M.R.S. § 2850-B(3). Where a policy is subject to guaranteed renewal, it must not only be renewed, but it generally cannot even be modified except within narrow constraints set forth by statute. *See* § 2850-B(3)(I). Any modifications falling outside these constraints are considered product discontinuance, and must qualify for a statutory exception to the guaranteed renewal requirement.

One of the narrow circumstances in which contract terms may be modified in the context of a renewal is if the benefit modifications are "required by law." 24-A M.R.S. § 2850-B(3)(I)(3). Thus, while Anthem has proposed to discontinue its current plans and replace them with new ones in order to make them ACA-compliant, Maine law does not require this approach.

Rather, another option available to Anthem under Maine law—indeed, the default option—is to modify its current plans just enough to bring them into compliance with federal law and then renew them.

Anthem, however, does not wish to renew policyholders' existing coverage, subject only to those modifications necessary to comply with the law. Rather, Anthem proposes to discontinue its non-compliant plans and replace them with ACA-compliant plans that also contain other modifications that would not be allowed in the context of a renewal. Maine law does not forbid this approach, but it strictly regulates it. Specifically, under Maine law, a carrier may not discontinue a guaranteed-renewable individual plan unless it provides its subscribers with a replacement product meeting certain requirements, including, crucially, that “the superintendent finds that the replacement is in the best interests of the policyholders.” 24-A M.R.S. § 2850-B(3)(G)(3).

The purpose of this proceeding, as set forth in the Hearing Notice, is for the Superintendent to determine whether Anthem's proposed discontinuance of the non-grandfathered individual health insurance products, and the product replacements proposed by Anthem, meets this best-interests standard, and will otherwise be in compliance with applicable law. *See* Hearing Notice at Section III; *see also* 24-A M.R.S. § 2850-B(3)(G)(3)(b). As set forth in the statute, the “best interests of the policyholders” standard applies to the proposed “replacement” products. The statute directs the Superintendent to protect the interests of Anthem's existing subscribers, not the interests of potential future policyholders. Moreover, the standard is not, as Anthem suggests in its brief, whether the replacement is in the “best interests of a majority of the policyholders.” (Anthem Closing Br. at 3.) It is simply whether the replacement is in the best interests of “the policyholders.” While this standard does not mean

that the proposed replacement policy must be a good deal for every single current policyholder, it does require a more nuanced analysis than merely considering whether replacement will be marginally preferable to renewal for a bare majority of subscribers. A replacement policy that imparts small benefits to a majority by imposing significant hardships on a minority is not necessarily in the best interests of the policyholders as a whole.

In short, given policyholders' guaranteed-renewal rights, Anthem can only cease offering its current individual products if the Superintendent finds the replacement product to be in the best interests of the policyholders.⁴ 24-A M.R.S. § 2850-B(3)(G)(3)(b). The burden of proof rests with Anthem.

IV. ANALYSIS, FINDINGS, AND CONCLUSIONS

For the reasons discussed below, Anthem has not proven that the proposed replacement coverage it is offering its renewing policyholders in the ten southern and western counties is in the best interests of the policyholders, as required by 24-A M.R.S. § 2850-B(3)(G)(3)(b).

A. **Anthem's proposal to terminate certain policyholders' rights to an open plan with a broad network is not in their best interests.**

1. *The nature of Anthem's proposal and the available alternatives.*

The ACA requires Anthem to make a number of changes to its line of individual insurance products for 2014. Thus, some features of Anthem's proposed discontinuance and replacement are inevitable. Most notably, the ACA requires most individual insurance products to provide policyholders with at least 60% actuarial value. In practice, this requirement means that high-deductible policies, such as Anthem's popular \$15,000-deductible policy, cannot be

⁴ Anthem does have the right to cease offering individual health plans and to not renew any existing policies in the individual market. *See* 24-A M.R.S. §§ 2850-B(3)(F-1), 2736-C(4).

renewed for 2014 in their current form, unless the subscriber qualifies for “grandfathered” status.⁵ Whether or not consumers would prefer to stay in plans with high out-of-pocket costs and a correspondingly low premium, that option simply will not be available to most in 2014. Therefore, it is beyond dispute that Anthem must either amend their contracts to reduce the cost sharing to permissible levels or replace their contracts with coverage that meets the actuarial value requirements.

On the other hand, other components of Anthem’s proposal are not necessary to comply with the ACA. Nothing in state or federal law requires replacing open-access preferred-provider coverage with closed-access HMO coverage, nor does the law require replacing broad-network coverage with limited-network coverage. If Anthem’s proposal is approved, renewing policyholders in the ten-county region would lose their existing contractual right to elect out-of-network care in return for higher cost-sharing. Furthermore, at the same time their right to out-of-network coverage is taken away completely, their choice of network providers would be significantly restricted. Specifically, Anthem’s new networks exclude 6 of 20 hospitals in southern Maine and also significantly reduces the number of participating providers. Under Anthem’s proposal, then, many of its subscribers would lose coverage for their existing providers, not as a result of the occasional changes in Anthem’s existing broad network that policyholders could reasonably anticipate, but solely as a result of the nonrenewal of their existing contracts and the decision not to offer a new contract that preserves the existing network.

⁵ Generally speaking, a policyholder can qualify for grandfathered status if she purchased her current policy prior to March 23, 2010.

The portion of Anthem's current subscriber base that would be directly impacted by these network changes appears to be small, but is hardly negligible. A quarter of Anthem's current hospital expenditures in Southern Maine are for services received at the six hospitals that will be excluded from the limited network. (Anthem Ex. 1, at 11.) Anthem's data also shows that 489 enrollees in the ten-county region, 6.8% of the current enrollment base in those counties, have received services within the past year from PCPs who will be excluded from the limited network. That figure understates the potential demand for such providers, because patients interested in access to a particular provider will not necessarily see that provider every year. Moreover, as was recognized in the proceeding approving Anthem's provider network, Anthem's limited network will require subscribers in some areas not only to change providers, but also to travel longer distances to see a network provider or obtain non-emergency services from a network hospital.

Notably, Anthem is not seeking to discontinue its broad network entirely at this time. Anthem is keeping its broad-network contracts in force, and will continue to operate the broad network on a statewide basis for all of its grandfathered business, and for all employers that choose to buy broad-network small group and large group plans.

Thus, neither the law nor changes in the market make it impossible or impractical for Anthem to offer renewing customers the same broad network they have under their current contracts, and the same open plans they have under their current contracts, either by renewing the existing preferred-provider provisions or replacing them with point-of-service (POS) HMO provisions, as they will be using in the six northern and eastern counties. Instead, Anthem justifies the termination of the policyholders' existing contractual rights as being in their best interests because continuing their existing plan structure is supposedly too expensive.

2. *It is in the policyholders' best interests to let them decide for themselves whether preserving their existing contractual rights is too expensive.*

Anthem has already been approved to offer its "Guided Access" HMO products for 2014. Anthem made a persuasive case that those products, despite having a limited network and no coverage for non-emergency out-of-network care, will be a good deal for many consumers.⁶ However, the best way to decide whether a product is a good deal for the price is to make it available in the free market alongside competing products and let the buyers choose. If exercising their guaranteed-renewal rights is too expensive, existing policyholders can vote with their pocketbooks and either buy a "Guided Access" HMO plan or buy a competing insurer's plan. Price alone cannot be an adequate reason to abrogate a policyholder's guaranteed-renewal rights, and make replacement with a cheaper product mandatory rather than optional.

This principle is especially true when Anthem's proposed replacement product limits policyholders' benefits in ways that may not be immediately apparent to those policyholders. While premium cost is a highly visible feature of any insurance policy, the access to providers that a policy will provide is far less obvious. Even if Anthem provides sufficient notice to policyholders of the changes, not all policyholders will grasp how substantial they are or foresee how they will be affected. As one witness pointed out, many consumers do not know the limitations of their health coverage until they need to use it. (9/9/13 Evid. Hearing Tr. 259.) The risk is heightened when a carrier is seeking to impose new limitations on a guaranteed renewable product, since purchasers of those products have a reasonable expectation, grounded in Maine law, that their coverage will not radically change upon renewal. Moreover, Anthem's prior

⁶ Anthem has noted that in addition to premium savings, some consumers (particularly those with a moderate level of hospital costs – enough to be significant but not enough to reach the deductible) will also realize savings from the deeper provider discounts under the "Guided Access" plans.

disclosures to its subscribers have not adequately highlighted the substantial nature of the network changes. In its letter to subscribers touting its replacement plan, Anthem claimed that the proposed replacement products were “as close as possible” to the existing products as the ACA would allow. In short, the significant risk that some policyholders will allow themselves to be renewed without fully understanding the scope of the proposed changes further confirms that it is in the best interests of policyholders to give them the option to “opt in” to a narrow, closed network rather than requiring them to take affirmative action to “opt out” of such a network, especially if the only way to opt out is to choose coverage from another carrier.

Anthem’s response is that offering broad network plans to renewing subscribers would jeopardize the discounts it has negotiated with hospitals participating in the limited network, who agreed to lower reimbursement rates in return for Anthem providing them with increased patient volume. Anthem thus suggests that the Superintendent must choose between protecting the interests of a minority of subscribers who will be adversely affected by the new network restrictions and protecting the interests of all subscribers in mitigating the price shock that will result from the federally required shift to more expensive levels of coverage.⁷ Abrogating guaranteed-renewal rights is the lesser evil, according to Anthem, and is in the interests of policyholders as a whole.

However, even if Anthem were correct that the best interests of one group of policyholders can only be met at the expense of the best interests of another group, so that their

⁷ Anthem asserts that premiums for its Guided Access HMO products are approximately 8% lower than they would be absent the discounts it negotiated with hospitals. (Anthem Ex. 4A, at 5.) There was a dispute at hearing over whether there was sufficient evidence in the record to substantiate Anthem’s claim, owing to Anthem’s decision to withdraw certain evidence relating to the calculation of that premium differential. The evidence did clearly establish, however, that a discount was negotiated. For purposes of this Decision and Order, I have assumed without deciding that Anthem’s figures regarding the effect of that discount are accurate.

interests must be balanced against one another, Anthem has not met its burden of proving that it has struck the appropriate balance. That would require showing that the policyholders who would want to keep their broad-network open-access plans are few enough in number that they must be regarded as “holdouts” whose preferences must yield to the majority to allow a transaction that is beneficial overall to move forward. As already noted, Anthem’s own numbers suggest that a non-negligible number of current subscribers will have their current provider and hospital relationships disrupted by the limited network.

Moreover, although Anthem disparages the feasibility of consumer choice, asserting that “the parallel universe in which Anthem offers *both* a limited and broad network product does not exist” (Anthem Closing Br. at 9), Anthem itself has demonstrated that such a “parallel universe” is possible by offering precisely that choice in the group market. Anthem admitted at hearing that it kept the broad network available in the small group market because “small groups, in particular small group employers, often are reluctant to want to make a narrowing decision on behalf of their employees.” (9/9/13 Evid. Hearing Tr. 104.) In other words, when faced with the same choice between access and price, decisionmakers in the real world who are accountable to a group of consumers “often are reluctant” to decide that the cheaper plan is in the best interests of the group as a whole. I share that reluctance.

Furthermore, Anthem’s evidence that it cannot sustain the discounts it secured from participating hospitals without sacrificing its current subscribers’ renewal rights is unpersuasive. Anthem argues that the benefits of the limited network depend on the ability to deliver participating hospitals a captive audience, because otherwise they would not be willing to offer the discounts they have agreed to. However, Carolyn Kasabian, the hospital executive who

testified on Anthem's behalf, was not nearly so categorical.⁸ She testified that her hospital "has relied upon the anticipated patient volume steerage to validate the discounts granted. If patient volume steerage does not occur, our financial performance will suffer and the pricing concessions we agreed to with Anthem will not be sustainable" (Anthem Ex. 7, at 4), that "[t]he discounts we agreed to were premised on a *significant majority* of Anthem's non-grandfathered enrollment shifting to" her hospital (*id.*, *emphasis added*), and that "pricing discounts without some reasonable assurance of patient volume steerage are simply not sustainable." (*Id.* at 5.)

Thus, the hospitals' own testimony confirms the common-sense expectation that hospitals' continued willingness to provide the necessary discounts depends not simply on whether the Superintendent waives Anthem's guaranteed-renewal obligation, but on whether such a waiver would in fact have a significant effect on the volume of new patients "steered" to the limited-network hospitals. Anthem never promised, and could never credibly promise, that it could deliver its entire enrollment base to the hospitals that signed up for the limited network. Policyholders who place an especially high value on one or more ongoing provider relationships will drop Anthem for a competing insurer if the providers are excluded from the limited network and Anthem offers no broad-network option at any price. Other policyholders will be glad to choose the less expensive alternative even if it means restricting their choice of providers. For the remaining policyholders, as Anthem's economic expert testified, it all depends on the price

⁸ Anthem presented a panel of three executives from participating hospitals. However, one executive offered no testimony on the discounts, and the third executive acknowledged that he was not involved in the negotiations with Anthem or the hospital's decisionmaking process with regard to the discounts, and was testifying only to the underlying economic principles. (9/9/13 Evid. Hearing Tr. 249.) His testimony on those principles was consistent with Ms. Kasabian's: "In order to justify the pricing concessions, there must be the opportunity to realize incremental patient volumes and associated revenues to offset the decreases in revenue that MaineHealth hospitals will experience from those lower reimbursement rates for existing patients."

point—if given the choice, they will voluntarily switch to the limited-network plan as long as the price is right. (9/9/13 Evid. Hearing Tr. 285–286.)

The evidence presented by Anthem simply does not establish that allowing current subscribers to choose between the two Anthem networks will substantially reduce the volume of new patients at Anthem’s limited-network hospitals. First, Anthem’s enrollment projections for 2014 show that the vast majority of new enrollees in its limited-network products—approximately 16,000 in the mid-range estimate—will come from the currently uninsured, not renewing members. (Anthem Ex. 2 at Ex. A.) In contrast, Anthem predicts that only about 3,000 of its current non-grandfathered subscribers in Southern Maine—about 45%—will choose to remain in the limited-network products if migrated to them. The remaining 55% will presumably choose a broad-network product offered by a competing carrier. Thus, there is no question that the vast majority of the increased patient volume generated by the limited network will come from the currently uninsured, not from migrated current subscribers.

Moreover, of the 3,000 subscribers that Anthem believes it can successfully migrate to limited-network products, most will likely be people whose providers of choice are already in Anthem’s limited network. Anthem’s data shows that 489 of their current individual subscribers have visited PCPs excluded from the limited network in the last year, that 186 subscribers have seen excluded specialists, and that approximately 25% of Anthem’s “hospital spend” currently goes to hospitals that will be excluded from the limited network. (Anthem Ex. 1, at 11.) While it is impossible to extrapolate from these statistics exactly how many current Anthem subscribers are candidates to be “steered” to a hospital that they would not otherwise use, it is safe to say that it will be a minority of the projected 3,000 migrated subscribers. Indeed, one would expect that, among the 45% of current subscribers who agree to be migrated, those who will not have to

change providers will be disproportionately represented, with many of those subscribers with excluded providers going to another carrier. The number of current subscribers that Anthem could credibly promise to “steer” to participating hospitals is thus likely a fairly small fraction of the 3,000 projected migrated subscribers.

Finally, whatever the size of the subgroup of 3,000 enrollees who would (a) prefer to pay more to have access to providers outside of Anthem’s limited network, but (b) would not change carriers in order to preserve that ability, many of these subscribers are likely to wind up in Anthem’s limited network anyway. Anthem has opted to offer only its limited-network plans on Maine’s federally facilitated health insurance Marketplace. Federal subsidies for purchasing insurance are only available for plans purchased through the Marketplace. Given that these subsidies are available for families earning up to four times the federal poverty level (\$94,200 for a family of four), it is likely that many of the projected 3,000 enrollees are subsidy-eligible. (Tr. 133.) It thus can be expected that, even given the option of a broad-network Anthem plan, many current subscribers who are Anthem loyalists will opt to go onto the Marketplace to purchase Anthem’s limited-network product, so as to qualify for subsidies.⁹

In short, the “swing bloc”—the patients whose choice of hospitals might conceivably be influenced by the approval or disapproval of Anthem’s request to abrogate their guaranteed-renewal rights—are likely to form only a tiny share of the total enrollment in Anthem’s limited-

⁹ For this reason, the provider and patient intervenors have argued that it is not in existing policyholders’ best interests to renew or “map” them into *any* off-Marketplace plan. (Rumford-Bridgton Closing Br. at 10.) Although it is not desirable, there is no other choice. Anthem does not have the authority to enroll a consumer into the Marketplace, so the only possible “default options” for renewal or replacement are an off-Marketplace plan or no plan at all. Even if terminating coverage completely were not prohibited by 24-A M.R.S. § 2850-B(3)(G)(3)(a), it is not in the policyholder’s best interests by any stretch of the imagination. However, this underscores the need, as discussed more fully below, to ensure that consumers are fully and clearly informed of the choices they will need to make.

network plans, and it seems unlikely that they would have a material impact on whether or not Anthem can deliver the “significant majority” of patients that would give hospitals a sufficient incentive to participate in the limited network. Furthermore, as discussed earlier, the swing bloc are likely to be precisely the patients who are most sensitive to the price differential between the broad-network and limited-network plans.¹⁰ Even though allowing them a choice is in their best interests, they will exercise that right by switching to “Guided Access” if Anthem makes that switch worthwhile. If not, then abrogating their guaranteed-renewal rights is clearly not in their best interests—especially for those subsidy-eligible consumers, if any, whose preference to keep their existing network is so strong that they would be willing to give up the subsidies if offered the chance on renewal. If Anthem is correct that “Guided Access” is objectively a good deal for the typical consumer, then an overwhelming majority of the swing bloc will buy in, and in the unlikely event that the handful that remain would send the whole arrangement over the tipping point so that it is no longer worthwhile for hospitals to participate, then the arrangement could not have been stable to begin with and could not be relied on as a way to keep consumers’ premiums down.

¹⁰ The provider and patient intervenors have suggested further that the premium savings are largely illusory from the consumer perspective, because most Mainers are eligible for subsidized coverage and the benefit from cheaper premiums for subsidized coverage goes to the federal Treasury, not to the consumers, because the cost of subsidized coverage is largely income-based. (9/9/13 Evid. Hearing Tr. 145.) But that is argument about whether a discount in premium is valuable to individuals seeking to purchase new, subsidized coverage on the federal Marketplace. The scope of this proceeding is limited to the best interests of those consumers who wish to exercise their guaranteed-renewal rights to renew unsubsidized policies, rather than going to the Marketplace. Those consumers are either ineligible for subsidies or would choose to forgo them. Moreover, even if the intervenors’ argument were relevant, their argument that the savings from the narrow network reduce the available subsidies dollar-for-dollar misunderstands how the ACA’s subsidies work. The subsidies are based on the cost of the second-cheapest silver plan, and the intervenors’ “dollar-for-dollar” analysis depends on the false assumption that the two cheapest silver plans in the Marketplace, if Anthem had not used the narrow network for its Marketplace plans, would still have both been Anthem plans.

Anthem cannot have it both ways, and argue that consumers want this product but won't buy it in sufficient numbers if they have a choice. Either the limited network will remain viable if consumers are given the ability to opt out if they pay the price—in which case Anthem has posed a false choice between giving some consumers their guaranteed-renewal rights and giving others their cheaper coverage—or a significant critical mass of consumers do not agree with Anthem that denying them their guaranteed-renewal rights is objectively in their best interests—in which case I cannot agree either. On the record in this proceeding, I find that in the unlikely event that preserving consumers' guaranteed-renewal rights would jeopardize the savings to be realized from the limited network, those savings would not be worth the cost of depriving consumers of the right to decide for themselves, and taking away that choice would not be in the best interests of the policyholders.

B. It is in the best interests of northern policyholders to be mapped into the POS plan.

Anthem's Guided Access POS plan contains neither a limited network nor a complete lack of coverage for non-emergency out-of-network care. It thus lacks either of the features that prevented the Guided Access HMO plan from being in the best interests of the policyholders. Moreover, none of the parties have disputed that the POS plan meets the best interests standard. Anthem's discontinuance and replacement is therefore approved for this product.

C. Anthem's proposed formulary changes do not infringe policyholders' guaranteed renewal rights.

As Anthem observes, formularies change regularly, and Anthem argues that for that reason, formulary changes should not be subject to analysis under 24-A M.R.S. § 2850-B. However, as with the change in network structure, these plans introduce a change in the formulary structure that goes beyond the changes to the status of particular medications that

consumers must reasonably expect in the ordinary course of business. Routine turnover would not produce a savings of 4.2%.

On the other hand, when all essential classes of medications remain fully covered, it would not be appropriate to regard the change as a cut in benefits. The new formulary structure results in significant cost savings, is consistent with Anthem's other non-grandfathered products and with widely used industry standards, is expressly permitted by the ACA, and has not been called into question by any intervenor or any member of the public who participated in this proceeding. I therefore find that Anthem's substitution of the new formulary on replacement or renewal is in the best interests of the policyholders and it is hereby approved.

V. ANTHEM'S OPTIONS FOR COMPLIANCE

Anthem cannot replace policyholders' coverage with these products in their present form. On the other hand, the reason Anthem has requested approval to discontinue the existing products is that the current plan design will no longer comply with federal law, and the products cannot simply be amended in some mechanical fashion that will bring them into compliance.

Therefore, as soon as reasonably possible, Anthem must submit an alternative proposal that will provide ACA-compliant coverage to those non-grandfathered policyholders in the ten-county region who choose to renew their current plans.¹¹ Anthem may structure this proposal either as a discontinuance and replacement, as currently proposed, or as a uniform modification of coverage upon renewal as permitted by 24-A M.R.S. § 2850-B(3)(I). Anthem should note that it will be easier to comply with statutory notice requirements if Anthem modifies the coverage

¹¹ Or if Anthem proceeds with discontinuing the current plans, to policyholders who accept the default replacement plan offered in lieu of renewal in accordance with 24-A M.R.S. § 2850-B(3)(G)(3)(a).

rather than replacing it, and in the unique circumstances presented at this time, the Superintendent is prepared to approve a proposed modification of coverage submitted in compliance with this Decision and Order as a minor modification for purposes of compliance with the ACA, pursuant to 24-A M.R.S. § 2850-B(3)(I)(3). The Superintendent will also approve a request to cease marketing the modified products and run them off as closed blocks of business.

As Anthem observes, the Superintendent does not have the authority to order a carrier to replace a policy with a "Superintendent-designed plan." (Anthem Closing Br. 2.) However, as when a rate request is denied, it is appropriate and potentially helpful to provide guidance on an alternative request that would be approved with minimal further review. In this case, the same products whose proposed limited-network replacements have been disapproved are also offered in the six northern and eastern counties, and the Superintendent has approved Anthem's product "mapping" to approved point-of-service (POS) forms for those policyholders; Anthem has a statewide broad network that is already approved for use with many of Anthem's group products; and the Superintendent has already approved Anthem's rate relativities for limited-network and broad-network products in the group market. The Superintendent will approve a product modification consistent with those parameters for policyholders in the ten southern and western counties, and will consider any alternative proposal Anthem might choose to submit.

In addition, it should be clear that nothing in this Decision and Order limits Anthem's ability to encourage its policyholders to purchase Anthem's approved limited-network plans rather than accepting the renewal (or default replacement) contract that Anthem offers, as long as policyholders are given a choice and Anthem clearly and accurately explains the consequences of that choice, consistent with the requirements of this Decision and Order.

VI. COMMUNICATIONS WITH SUBSCRIBERS

The six public comment sessions held in this matter included many thoughtful comments from members of the public. The sessions also, unfortunately, confirmed that there is widespread public confusion over Anthem's discontinuance and replacement proposal as well as, more generally, who will be affected by Anthem's new "Guided Access" plans, and how. Some members of the public appeared unaware, for example, that Anthem's networks do not restrict hospital choice for emergency care, that other carriers will be offering individual insurance policies both on and off the federal Marketplace, or that Anthem's replacement proposal was limited to individual, non-grandfathered subscribers.

Much of this confusion is understandable given the significant market changes that are taking place owing to the implementation of the ACA. Nevertheless, the inherently confusing nature of the current individual insurance market obligates Anthem to do everything possible to assist its subscribers in making informed choices about their health coverage for 2014.

Therefore, once Anthem's renewal plans are approved, Anthem should send a letter to all affected subscribers that includes the following:

- A description of the subscriber's renewal plan, which includes an explanation of how it differs from the subscriber's current plan in terms of cost and benefits, and which clearly states that it uses a broad, open network. The description should also explain that, if the subscriber does nothing, he or she will be renewed into this plan by default.
- A description of the "Guided Access" plan as an alternative to the renewal plan, which explains the premium savings while also clearly disclosing that the provider network in the "Guided Access" plan excludes many providers and hospitals available in the renewal plan and that non-emergency out-of-network care is not covered. The description should also include instructions for how to check whether a specific provider or hospital is included in the network.
- A notice that federal subsidies might be available to the subscriber to purchase insurance and instructions on how to access the federal Marketplace through www.healthcare.gov. The notice could also include a reference to other consumer

resources such as www.enroll207.com. The letter should also make clear that subsidies are not available for the renewal product, but that in the Marketplace, the subscriber would be able to choose a Guided Access product or a product offered by another carrier.

This letter should be submitted to the Bureau of Insurance for approval before it is sent to subscribers.

VII. ORDER

Pursuant to 24-A M.R.S. § 2850-B the Superintendent hereby ORDERS that:

- (a) Anthem's proposal to discontinue its current individual non-grandfathered products in southern and western Maine and replace them with the Guided Access HMO products is DENIED. Anthem shall promptly submit an alternative renewal or replacement proposal, consistent with the terms of this Decision and Order, to provide these policyholders with ACA-compliant coverage.
- (b) Anthem's proposal to discontinue its current individual non-grandfathered products in northern and eastern Maine and replace them with the Guided Access POS products is GRANTED.

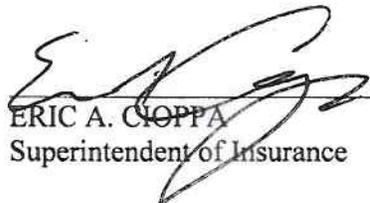
VIII. NOTICE OF APPEAL RIGHTS

This Decision and Order is final agency action of the Superintendent of Insurance, within the meaning of the Maine Administrative Procedure Act, 5 M.R.S. § 8002(4). It may be appealed to the Superior Court in the manner provided for by 24-A M.R.S. § 236, 5 M.R.S. §§ 11001 through 11008, and M.R. Civ. P. 80C. Any party to the proceeding may initiate an appeal within thirty days after receiving this notice. Any aggrieved non-party whose interests are substantially and directly affected by this Decision and Order may initiate an appeal within

forty days after the issuance of this Decision and Order. There is no automatic stay pending appeal. Application for stay may be made in the manner provided in 5 M.R.S. § 11004.

PER ORDER OF THE SUPERINTENDENT OF INSURANCE

October 4, 2013



ERIC A. CIOPPA
Superintendent of Insurance