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

IN RE:	)	
	)	
MAINE COMMUNITY HEALTH	)	
OPTIONS 2018 INDIVIDUAL RATE	)	**DECISION AND ORDER**
FILING	)	
	)	
	)	
Docket No. INS-17-1002	)	

I. INTRODUCTION

I, Eric Cioppa, Superintendent of Insurance ("Superintendent"), issue this Decision and Order after consideration of Maine Community Health Options' ("Health Options") 2018 rate filing and proposed modifications for its individual health insurance products.[1]

By its initial filing, in which it assumed that reimbursement for the cost-sharing reductions ("CSRs") would be funded in 2018, Health Options proposed an average increase of 19.6%, with a range of 15.0% to 25.9% depending on deductible level and type of contract (the "Base Filing"). On June 23, in accordance with Bulletin 422, Health Options filed alternative rates based on the assumption that CSR reimbursements would not be funded in 2018, proposing a revised increase with a range of 10.1% to 44.7%,[2] depending on deductible level and type of contract (the "Unreimbursed Filing"). Health Options proposes to rate all of its Individual Products on a combined basis as a single risk pool in both its Base Filing and Unreimbursed

[1] Health Options will offer the following individual products in 2018: Community Safe Harbor PPO, Community Focus PPO, Community Choice PPO, Community Edge PPO, Community Reliant HSA PPO, Community Align PPO, Community Advance PPO, Community Value HMO, Community Complete HMO, Community Best HMO, Community Protect HMO, Community Delta HSA HMO, Community Partner HMO, and Community Capital HMO.

[2] The standard methodology for calculating average rate increases yields a result of 15%, but that is not an accurate description of the rate impact because policyholders who switch from Silver plans to other metal levels due to the high rates are not counted as impacted by the rate increase.

Filing. On July 14, as part of its pre-filed testimony in this proceeding, Health Options made changes to its Base Filing. Health Options did not make corresponding updates to its Unreimbursed Filing. The changes in the Base Filing resulted in an average increase of 19.7%, with a range of 13% to 26.9% depending on deductible level and type of contract. At the time of the initial filing, total in-force enrollment was approximately 41,430 individuals who will be affected by the proposed rate revisions. Health Options requests that its proposed rate revisions become effective on January 1, 2018.

As part of both the Base and Unreimbursed Filings, Health Options further proposes to discontinue the Community Preferred, Community Value, and Community Complete PPO plans; consolidating the Preferred and Value PPO plans and mapping both into the Community Choice PPO; and mapping the Community Complete PPO plan into the Community Advance PPO.

For the reasons discussed below, with regard to the Base Filing, I am denying the revised average rate increase of 19.7% as requested, but would approve rates that result in an average increase of 17.5% with additional modifications to product design as described below. With regard to the Unreimbursed Filing, I am denying the alternative rate increase as requested, but would approve an increase that incorporates the same modifications to rate components and product design that apply to the Base Filing.

II. PROCEDURAL HISTORY

On June 2, 2017, Health Options filed a request to increase rates for its Individual Products assuming the CSR reimbursements would be funded for 2018. The Bureau of Insurance designated the matter as Docket No. INS-17-1002.

On June 6, 2017, the Superintendent issued a Notice of Pending Proceeding and Public Hearing, which scheduled a public hearing for July 24, 2017. The Hearing Notice also

established an intervention deadline. The Maine Attorney General filed a timely request to intervene, and was granted intervenor status on June 15, 2017.

On June 7, 2017, the Superintendent issued a Procedural Order establishing procedures for the conduct of the proceeding. Included in the Procedural Order was the requirement that Health Options submit an alternative rate filing by June 23, 2017, in which it assumed CSRs would not be reimbursed in 2018.

On June 7, 2017, the Superintendent issued a Delegation Order whereby Thomas Record, Bureau of Insurance Senior Staff Attorney, was delegated the Superintendent's financial oversight responsibilities vis-à-vis Health Options related to the 2018 Health Options rate filing. As part of the Delegation Order the Superintendent identified other named individuals to participate with Mr. Record. Mr. Record and his other delegation members were subject to, and complied with, the *ex parte* communication restrictions under 9 M.R.S. § 9055.

On June 15, 2017, the Superintendent issued Bulletin 423 setting a uniform deadline of July 14, 2017 for all insurers to file revised rates requests.

Both the Superintendent and the Attorney General issued several information requests, and made oral requests at hearing, to which Health Options filed responses.

On June 23, 2017, Health Options filed its Unreimbursed Filing in accordance with Bulletin 422.

On July 14, 2017, Health Options filed the pre-filed testimony and exhibits of Kevin Lewis, CEO of Health Options; and Kathie Ely, a Consulting Actuary for Milliman, Inc.

On July 21, 2017, Health Options requested permission from the Superintendent to update its rate filings to make modifications to its product offerings.

The public hearing was held as scheduled on July 24, 2017, and was conducted entirely in public session. Members of the public had an opportunity to make either sworn or unsworn statements for consideration by the Superintendent. Members of the public also submitted written comments outside the public hearing which the Superintendent designated a part of the record of this proceeding. The Superintendent has read each of the written comments provided. To the extent that unsworn oral or written statements 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, such statements are not evidence and the Superintendent may not consider them in making factual findings. 5 M.R.S. § 9057.

At hearing, Health Options presented testimonial evidence from Kathie Ely and Kevin Lewis. The Superintendent admitted into evidence Health Options' pre-filed testimony and exhibits as well as Health Options' responses to discovery filed throughout the proceeding. There were no objections to any of the evidence being admitted into the record of the proceeding.

After Health Options rested its case at hearing, the Superintendent adjourned the hearing for the submission of responses to certain hearing panel inquiries and for the filing of a written closing statement.

On July 25, 2017, the Superintendent issued an Order denying Health Options' July 21, 2017 request to modify its rate filings after the July 14, 2017 deadline.

On July 31, 2017, Health Options filed a Motion for Reconsideration of the Superintendent's Order denying the request to modify its rate filings.

On July 31, 2017, Health Options filed its responses to the hearing questions.

On August 7, 2017, the Attorney General filed its written closing statement.

On August 7, 2017, Health Options filed its written closing statement, and the record in this proceeding is now closed.

Health Options has provided direct written notice by mail to every affected policyholder advising of the proposed rate increases.

III. LEGAL STANDARD

A. Rate Increase

Health Options is required by 24-A M.R.S. § 2736(1) to file proposed premium rates for its individual health insurance products with the Superintendent. Because Health Options' initial proposed rate increase of 19.6 % exceeded the 10% threshold for review established under the federal Affordable Care Act (ACA), *see* 45 C.F.R. § 154.200, the rate filing is subject to the Superintendent's review and approval pursuant to 24-A M.R.S. § 2736(1). *See* 24-A M.R.S. § 2736-C(2-B). The Superintendent may approve the filed rates only if they are not excessive, inadequate, or unfairly discriminatory. 24-A M.R.S. § 2736(2). In addition, pursuant to 24-A M.R.S. § 2736-C(5), the Superintendent shall disapprove the rates unless it is anticipated that the rates will yield a loss ratio of at least 65% as determined in accordance with accepted actuarial principles and practices. That is, expected claims payments must be at least 65% of premium. Health Options, as the proponent of the filed rates, bears the burden of proving by a preponderance of the evidence that the proposed rates meet statutory requirements. 24-A M.R.S. § 2736-A.

B. Discontinuance and Replacement of Policy Forms

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 to be the discontinuance of the policyholder's current coverage,[3] and must qualify for a statutory exception to the guaranteed renewal requirement.

Specifically, under Maine law, a carrier may not discontinue a guaranteed-renewable individual plan unless it provides its subscribers with a replacement product meeting certain requirements, including, crucially, that "the superintendent finds that the replacement is in the best interests of the policyholders." 24-A M.R.S. § 2850-B(3)(G)(3). Accordingly, in this matter, because there is no claim that Health Options' proposed discontinuances and replacements of the identified Individual Products are only "minor modifications," it is for the Superintendent to determine whether they meet the best-interests standard and to ensure that they are otherwise in compliance with applicable law.

As set forth in the statute, the "best interests of the policyholders" standard applies to the proposed "replacement" products, except to the extent that changes to the policyholder's coverage are required by law. The statute directs the Superintendent to protect the interests of Health Options' existing subscribers, not the interests of potential future policyholders. Moreover, the standard is not whether the replacement is in the "best interests of a majority of the policyholders." It is simply whether the replacement is in the best interests of "the policyholders." While this standard does not mean that the proposed replacement policy must be a good deal for every single current policyholder, it does require a more nuanced analysis than

[3] The Maine statute refers to the discontinuance of a "product," but does not use the term in the same sense in which it is now used in the ACA. For example, discontinuing a plan with a $500 deductible and replacing it with an otherwise identical plan with a $5,000 deductible would be a "product discontinuance" under the standards of 24-A M.R.S. § 2850-B(3)(I), but the two plans would be closely enough related, despite the significant difference in the level of coverage, to belong to the same "product" as that term is used in the ACA.

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. *See* INS-13-803 Decision and Order at 8–10.

IV. RULINGS

A. Post-Hearing Responses

I hereby admit Health Options' post-hearing responses to the hearing panel's inquires, including incorporated materials (filed on July 31, 2017), with no objection by any party.

B. Motion for Reconsideration

On July 31, 2017, Health Options filed a Motion for Reconsideration of the Superintendent's July 25, 2017 Order denying Health Options' request to modify its filing after the July 14, 2017 deadline. In its Motion, Health Options asserts that it will be irreparably harmed by Anthem's proposed product design if it is not allowed to alter its rates and asks the Superintendent to reconsider the Order based on the potential harm to both Health Options and the market at large. However, Health Options fails to set forth any new information or legal argument that would alter the analysis set forth in the Superintendent's Order of July 25, 2017. Health Options was aware of the uniform deadline of July 14, 2017 for final rate filings in this proceeding. It has failed to justify its failure to adhere to the deadline.[4] Accordingly, Health Options' Motion for Reconsideration is hereby DENIED.

V. DISCUSSION

With regard to the Base Filing, I find that the rates filed by Health Options in this proceeding are neither inadequate nor unfairly discriminatory. However, I do find that the

[4] Furthermore, Health Options' substantive allegations about the competitive impact of Anthem's product design lack merit. *See In re Anthem Blue Cross and Blue Shield 2018 Individual Rate Filing*, No. INS-17-1000, at 12–14.

proposed rates as submitted by Health Options are excessive, in contravention of 24-A M.R.S. § 2736, for the reasons discussed more particularly below.

With regard to the Unreimbursed Filing, I find that the rates filed by Health Options in this proceeding are neither inadequate nor unfairly discriminatory. However, I do find that the proposed rates as submitted are excessive, in contravention of 24-A M.R.S. § 2736, for the reasons discussed more particularly below.

A. Base Filing

1. Overview and Recent Market-wide Changes

I have heard extensively from consumers, both in the hearing process and in carrying out my general responsibilities as a public official, about the hardships posed by the high costs of health insurance. Unfortunately, the high cost of insurance is primarily the result of the high and steadily increasing cost of health care, and the shortage of effective cost containment measures. It has been exacerbated by the additional risks created by the climate of uncertainty that has enveloped federal health insurance law at this time. Another factor that increases costs for insurers is referred to in technical terms as "adverse selection." If healthy consumers leave the insurance pool while less healthy consumers stay, the insurer's average cost per member would go up even if the underlying cost of health care did not change at all. This has been a major factor in rate increases this year both in Maine and in other states, and is the basis for the "morbidity adjustment" discussed below.

One of my highest priorities as Superintendent of Insurance is to do everything in my power to look for solutions that will ease the burdens on consumers. This includes continuing the Bureau's dedication to strict enforcement of the statutory prohibition of excessive health insurance rates. Nevertheless, premiums must be adequate to pay claims and expenses, so I

cannot approve premiums that fail to keep pace with the rising cost of health care and the impact of adverse selection on the risk pool. Therefore, although I am rejecting the rates that Health Options has filed, I must nevertheless reluctantly approve another double-digit increase next year for Maine consumers.

2. Trend

Trend is the rate at which Health Options' overall healthcare costs, including unit costs and utilization, are projected to increase during the rating period. Health Options' proposed 2018 rates incorporate an allowed cost trend of 6.7% based on a recommendation from their consulting actuary, Milliman. "Allowed costs" refers to the total charges for covered services, consisting of both the insurer's paid claims and the consumer's cost sharing. Milliman started with their Health Cost Guidelines Managed Care Rating Model and made adjustments based on Health Options' contracting arrangements, care management, distribution of claim utilization, and pharmacy rebates. Kathie Ely, the Milliman actuary with principal responsibility for this rate filing, stated during the hearing that Milliman's practice is to include only these allowed trend factors in their trend figure rather than using the paid trend figure that other carriers in the market have used. Milliman splits-out other components as separate factors rather than grouping them into the trend figure, making Health Options' trend of 6.7% appear artificially lower when compared to the other carriers. However, Health Options' filing stated that the trend factors reflect their expectations regarding increases in in-network contractual reimbursement and the impact of trends in both projected in-network and out-of-network costs. Based on the evidence presented, I find that the proposed 6.7% annual pricing trend will not cause the rates to be excessive or inadequate.

3. Morbidity Adjustment

Health Options applied a 15% increase to rates for increased morbidity over 2016 experience based on the expectation of adverse selection, motivated in large part by higher premiums and enabled by a weak individual mandate penalty. They calculated a 1.236 morbidity factor, basing their projection in large part on predicted market contraction for 2017 and 2018 and on its observation that 2017 claims experience is developing worse than expected. Health Options contends that the observed deterioration in claims experience, by itself, would justify a 9.5% increase in premium when extrapolated into 2018.

It is true that when claim payments increase faster than the underlying cost trend, as appears to be the case, this is evidence that the morbidity of the risk pool is increasing, and it is evidence that corroborates the expectation that the members who are leaving when the market contracts are, on the whole, healthier than the members who are staying. However, the evidence in the record does not support the degree of market contraction that Health Options is predicting. Despite the overall market contraction and Health Options' current decline in membership, Health Options' filing anticipates that their enrollment will increase in 2018 to 39,054 members despite the proposed rate increase. This indicates that while the market as a whole may be contracting, a substantial enrollment base remains.

I estimate the contraction of the combined on- and off-Exchange market in Maine to be in the range of 5.1%, determined as follows. I take official notice of the Maine Rule 940 reporting posted on the Bureau website,[5] which shows a total of 88,472 insured lives as of March 31, 2016 for the three carriers proposing rates for 2018. The enrollment reported in recent rate filings totals 82,584 insured lives in 2017. Based on these numbers the Maine individual market experienced a 5.1% reduction this year. This observed level of market contraction does not

[5] http://www.maine.gov/pfr/insurance/publications_reports/yearly_reports/rule940/rule940_reports.html.

demonstrate sufficient adverse selection to not justify a full 15% increase to rates. I find the morbidity adjustment to be excessive, and find that a more modest adjustment would result in non-excessive rates given the current market conditions and reasonable predictions for the future. Accordingly, the morbidity factor stated in the hearing request response should be reduced from 1.211 to 1.198.

4. Contribution to Surplus (Profit Margin)

Health Options' 2018 individual rates include a 4% contribution to surplus. A nonprofit insurer's contribution to surplus is the equivalent of a for-profit insurer's margin for profit and risk. This is the same margin that was approved for Health Options' 2017 rates. The Attorney General does not oppose the requested 4% margin.

In normal circumstances, the Superintendent has generally found a 3% profit margin to be reasonable for this line of business. *See, e.g.*, *In re Anthem Blue Cross and Blue Shield 2014 Individual Rate Filing*, No. INS-14-1000. However, as previously explained and found reasonable by the Law Court:

> [T]he Superintendent's determination of what is an approvable rate for a one-year period (including what, if any, built-in expected profit to provide) involves a balancing of investor and consumer interests. In other words, the *amount* at which to approve a built-in expected profit in regulated rates, must balance the need for a rate not to threaten the company's or enterprise's financial integrity against the legitimate government interests of protecting the viability of the insurance pool, keeping insurance premiums as reasonable as possible, and minimizing adverse selection. There is no bright-line test.

In re Anthem Blue Cross and Blue Shield 2011 Individual Rate Filing, No. INS-11-1000 (footnote omitted); *Anthem Health Plans of Maine, Inc. v. Superintendent of Insurance*, 2012 ME 21, ¶ 21.

As the evidence in the record demonstrates, Health Options is endeavoring to recover from two consecutive years of substantial operating losses, and has limited capital left to absorb

any further losses at this time. Although Health Options had projected a 4% operating gain (a nonprofit insurer's equivalent of profit) at the time its 2017 rates were set, its revised actuarial projections indicate a much smaller gain. While its performance remains substantially on track with this plan, it is within the margin of error whether that represents a small gain or a small loss.

Health Options' financial integrity depends on its ability to operate with adequate rates in 2018, and to replenish a capital base that has been seriously depleted. Although Health Options is a nonprofit enterprise, the only way it can rebuild its surplus to healthy levels is to do business "profitably," *i.e.*, to take in more money in premiums than it pays out in claims and expenses. As discussed above, there are already signs suggesting that some adverse selection is currently taking place, which is one possible contributing factor to diminished expectations in 2017 by Health Options and other carriers.

In light of Health Options' financial condition and the need to protect against the potential threat to the financial integrity of the Company, I find that the requested 4% contribution to surplus will not cause the rates to be excessive or inadequate.

5. Administrative Costs

Health Options' filing provided for administrative costs of $78.80 per member per month (PMPM) for rates effective January 1, 2018, which is 11.83% of premium. This dollar amount represents a 13.4% increase from the 2017 rate filing, which included $69.48 PMPM. Health Options stated in its filing that administrative fees have increased as a percentage of premium, mainly due to a reduction in membership assumed in 2017 compared to that assumed for 2018. This has the effect of reducing the base of members over which fixed expenses are spread. I therefore find that Health Options' administrative costs will not cause the rates to be excessive or inadequate.

6. Product Design

Title 24-A M.R.S. § 4315 requires carriers to provide coverage for prosthetic devices in all health plans. Benefits and payment for coverage of prosthetic devices must be equal to that provided under federal Medicare law. Currently, Medicare provides coverage for 80% of the actual charge or the amount recognized as the purchase price for the device, whichever is less. Benefits for prosthetic devices under health plans issued for use in connection with health savings accounts are subject to the same deductibles and out-of-pocket limits such as coinsurance that apply to overall benefits under the contract. Plans not in compliance with the mandate must be revised.

B. Unreimbursed Filing

1. Overview of the CSR Program and Adjustments to the Base Filing

The ACA provides two major subsidy programs to help low-income consumers with the costs associated with individual health insurance. The premium tax credit program provides assistance with the premium, and the CSR program provides assistance with out-of-pocket costs such as deductibles and coinsurance. The way CSR operates is that when a policyholder with household income between 100% and 250% of the federal poverty level (FPL) buys a Silver plan on the Exchange, the plan is upgraded to a "Variant Plan" with less cost sharing, at no additional cost to the policyholder.

The actuarial value of a CSR Variant Plan ranges from 73% to 94%, depending on income level. For consumers with income between 100% and 200% of FPL, if they pay the applicable premium for a Silver plan, they receive a plan that is either within (87%) or slightly above (94%) the Platinum range. The insurance contract commits the carrier to pay the enhanced "CSR Variant" benefits, and the ACA provides that the federal Department of Health

and Human Services (HHS) will reimburse the carrier for all additional claims paid by the carrier; *i.e.*, the difference between the claims actually paid by the carrier and the claims the carrier would have paid if the policy had been a standard Silver plan rather than a CSR Variant plan.

However, in contrast to the premium tax credits paid to consumers, the ACA did not include any specific appropriation for the CSR reimbursements, and Congress did not include such an appropriation in any subsequent spending bill. Instead, HHS has paid the CSR reimbursements from the same general Treasury funds that are used to pay the premium tax credits. The House of Representatives sued the Secretary of HHS, claiming that the reimbursement payments are unlawful because there is no valid appropriation of funds to pay them. A federal District Court agreed, concluding that "the consequence at issue here is that a permanently authorized benefit program was made dependent on non-permanent appropriations," and that necessary appropriation was not made. *House of Representatives v. Burwell,* 185 F.Supp.3d 165, 185 (D.D.C. 2016).

The court therefore issued an injunction prohibiting future CSR reimbursements "until a valid appropriation is in place," but stayed the injunction pending appeal. *Id*. at 189. The court recognized that the CSRs themselves must continue regardless of whether they are reimbursed. It explained that insurers on the Exchange "cannot escape cost-sharing reductions, which are a mandatory feature of participation in the Exchanges. If the insurers are not reimbursed, they will charge higher premiums to cover their expenses." *Id*. at 183.

Although the stay permits CSR reimbursements to continue, it does not require them to continue. To date, the reimbursements have been paid in full when due, but this is being done on an interim, *ad hoc* basis. All three branches of the federal government have the power to bring

more certainty, but the courts have not resolved the pending appeal, Congress has considered a variety of legislative options but has not enacted any of them, and HHS has continued to make interim reimbursements but has not committed to pay them even through the remainder of 2017, let alone into 2018.

Accordingly, I issued Bulletin 422, advising that on or before June 23, 2017, "unless definitive Congressional or judicial action is taken that is sufficient to ensure that CSR reimbursements will be fully funded through December 31, 2018, carriers shall, if applicable, submit amended or alternative filings that include the rates they intend to use in 2018 in the event that CSR reimbursements terminate." No such action was taken, and all three carriers with pending individual rate filings submitted their alternative Unreimbursed Filings.

Health Options' Unreimbursed Filing is based on the premise that if insurers are required to provide the CSRs out of their own pockets, with no reimbursement for the additional cost, this is a fundamental change in the plan design of Silver Qualified Health Plans (QHPs). It would not be a general cost of doing business to be spread across all policyholders, but rather, it would be a specific benefit provided to Silver policyholders, and thus should be paid for by Silver plan premiums. Accordingly, Health Options calculated its Unreimbursed rates by changing the "pricing actuarial value" of its Silver QHPs to reflect the actual expected cost, averaging the expected cost of each CSR variant in proportion to the expected mix of enrollees in the various CSR bands. I find this approach to be reasonable and appropriate.

Health Options' modeling assumed significant migration between plans if the CSR reimbursements are not funded, Silver QHP rates are raised accordingly, and premium tax credits increase to absorb the increased cost of the second-cheapest Silver plan. Except for enrollees who qualify for CSRs, there would be negligible retention in Silver QHPs. Furthermore, even

for enrollees who qualify for CSRs at the 73% level, the value of the enhanced premium tax credit would be much higher if it is applied to purchase a Bronze or Gold plan. I find Health Options' enrollment projections to be reasonable.

Based on Milliman's analysis of the consequences of those enrollment shifts, Health Options filed Unreimbursed rates for its Silver QHPs that are 22% higher than the initial Base rates,[6] while the Unreimbursed rates for Health Options' Bronze and Gold QHPs are 4% lower than the initial Base rates. Health Options has also designated certain Silver plans that would not be offered as QHPs in 2018, meaning that they would only be sold off the Exchange and would therefore not provide CSRs to any of their enrollees. Accordingly, Health Options proposed retaining the Base rates for its non-QHP Silver plans.

I find that Health Options' proposed relativities between its Base rates and its Unreimbursed rates, applied to the Base Filing as modified to comply with this Decision and Order, would result in rates that are not excessive, inadequate, or unfairly discriminatory.

2. Trend

Trend was adjusted only slightly, from 6.7% in the Base Filing to 6.75% in the Unreimbursed Filing, in order to account for the changed expectations in membership and plan distribution if CSRs are not reimbursed. Based on the evidence presented, I find that the proposed 6.75% annual pricing trend will not cause the rates to be excessive or inadequate in the event that CSR reimbursements are not funded.

3. Morbidity Adjustment

For the reasons discussed in the analysis, the morbidity factor should be reduced to 1.180. In addition, Health Options' initial Base Filing included a 1% risk adjustment factor, which it

[6] Health Options indicated that its Unreimbursed Filing ought to be updated to conform to its changes to its Base Filing, but did not file the updated rates that it indicated were in order. The changes are small enough that they would not cause the original Unreimbursed Filing rates to be excessive, inadequate, or unfairly discriminatory.

removed when it updated the Base Filing. This factor should also be removed from the Unreimbursed Filing. Without these adjustments, the Unreimbursed rates would be excessive.

4. Contribution to Surplus (Profit Margin)

No changes from Base Filing analysis.

5. Administrative Costs

Health Options' alternative filing provided for administrative costs of $78.82 (PMPM) for rates effective January 1, 2018 in the event that CSR reimbursements are not funded. This represents 10.81% of premium. Thus, the Unreimbursed Filing stated that Health Options allocated all expenses to plans using a constant percent of premium. This is reasonable, and I find that Health Options' administrative costs will not cause the Unreimbursed rates to be excessive or inadequate.

6. Product Design

No changes from Base Filing analysis.

C. Proposed Product Discontinuances

Health Options proposes to discontinue its Community Preferred, Community Value, and Community Complete products as PPO products, assuming that its application for an HMO license is granted. For 2018, they will be offering HMO products with similar plan designs and the same product names. However, because PPO enrollees are entitled to guaranteed renewal into a suitable PPO plan, the default mapping for current Community Preferred and Community Value enrollees will enroll them in Community Choice PPO plans on renewal in 2018, and the default mapping for current Community Complete enrollees will enroll them in Community Advance PPO plans.

The new HMO option provides an addition to the Health Options portfolio with the potential to be a valuable new alternative for consumers. Enrollees in the discontinued plans who are looking for a more cost-effective version of their current coverage will be able to switch to one of the new HMO plans. Enrollees who place a high value on robust out-of-network coverage can accept the default enrollment into another Health Options PPO plan with a similar actuarial value to their current coverage. In addition to these options, enrollees also have the right to switch to any other individual health plan offered in his or her service area by Health Options or by any other carrier. I therefore find that the proposed restructuring of Health Options' product lines is in the best interests of policyholders.

VI. FINDINGS AND CONCLUSIONS

On the basis of a preponderance of the credible evidence in the record, and for reasons set forth in Section V above, I find and conclude that Health Options' proposed Base and Unreimbursed rates are excessive. If the changes to the rates proposed by Health Options are applied consistent with this Decision and Order, as discussed in Section V, I could lawfully approve the resulting rates. The necessary revisions to the proposed rates can be achieved by making the following changes:

- Revise coinsurance coverage for arm and leg prosthetics to comply with the benefit mandate.
- Reduce the morbidity factor from 1.211 to 1.198 for both the Base and Unreimbursed Filings.
- Remove the risk adjustment factor of 1% from the Unreimbursed Filing.

VII. ORDER

Pursuant to the provisions of 24-A M.R.S. §§ 2736, 2736-A, 2736-B and authority otherwise conferred by law, I hereby ORDER:

1. The Base Filing rates filed June 2, 2017, as revised, by Health Options for its Individual Products are DISAPPROVED. Accordingly, the proposed rates shall not enter into effect.

2. The Unreimbursed Filing rates filed June 23, 2017, as revised, by Health Options for its Individual Products are DISAPPROVED. Accordingly, the proposed rates shall not enter into effect.

3. Health Options is authorized to submit revised Base and Unreimbursed rates on August 11, 2017 for review and they shall be APPROVED if the Superintendent finds them to be consistent with the terms of this Decision and Order and that the effective date of those rates will assure a minimum of 30 days' prior notice to policyholders.

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

August 10, 2017

Eric A. Cioppa

ERIC A. CIOPPA
Superintendent of Insurance