

RULE CHAPTER 940
REQUIREMENTS FOR HEALTH INSURANCE RATE FILINGS AND DATA
REPORTING
BASIS STATEMENT AND SUMMARY OF COMMENTS

The Superintendent of Insurance held a public hearing on November 3, 2015 to consider proposed amendments to Maine Insurance Rule Chapter 940, Requirements for Health Insurance Rate Filings and Data Reporting. Notice of this hearing was provided to interested persons on October 6, 2015, and notice of the hearing appeared in the State of Maine's consolidated rulemaking notice in newspapers of general circulation on October 14, 2015. A written comment period remained open following the hearing until November 16, 2015. The stated purpose of the proposed amendments is to update the current rule for consistency with Affordable Care Act requirements and procedures.

No members of the public provided comments at the public hearing. Written comments were received during the comment period from Kristine Ossenfort, Director of Government Relations for Anthem Blue Cross/Blue Shield.

Anthem commented on Sections 4, 8, 9, 12 and 13 of the proposed amendments. Its comments are discussed below.

Section 4—Definitions

Anthem suggested two changes to Section 4. First, it suggested that for consistency with the Affordable Care Act, it would be advisable for the new definition of "transitional coverage" to refer to policies issued before January 1, 2014, rather than January 2.

Additionally, Anthem noted that Section 12 of the proposed rule uses the term "potentially unreasonable," but that term is not defined in the rule. Anthem suggests that the following definition be included in either Section 4 or Section 12: "'Potentially unreasonable' means a rate filing which exceeds the threshold requiring review pursuant to Section 2794(a)(2) of the ACA."

Both of these suggestions are accepted and the rule has been revised accordingly, with the definition of "potentially unreasonable" appearing in Section 4.

The definition of "transitional coverage" in Section 4(I) has also been adjusted to reference the February 2016 extension of the federal transitional policy.

Section 6 Requirements for Individual and Small Group Rate Submissions

Upon advice of Counsel, the Bureau has adjusted the title of this subsection to better reflect its applicability as amended therein.

Section 8—Individual Health Plans Subject to Title 24-A M.R.S.A. § 2736-C

Anthem commented that if Subsection 8(B) is retained, Anthem supports the proposed revisions that would exempt “plans subject to ACA rating requirements” from the limitations on rate differentials between plans, noting that the exemption would presumably apply to those ACA-compliant plans offered on or after January 1, 2014 that are not grandfathered or transitional relief plans. Anthem suggested, however, that the proposed amendment does not go far enough and that Subsection 8(B) should be repealed entirely, stating: “In past rulemaking, we have expressed the concern that subsection 8(B) prohibits products from being rated appropriately, causing plans with lower deductibles and richer benefits to be subsidized by higher deductible plans.” The Bureau declines to adopt the request to repeal subsection 8(B) entirely. It is a basic premise of community rating, supported by both Congress and the Maine Legislature, that healthy people subsidize sick people.

The applicability of portions of Section 8 to federal transitional plans has also been clarified.

Section 9— Section 9. Small Group Health Plans Subject to Title 24-A M.R.S.A. § 2808-B

□ Subsection 9(B)(6)(b)—Association health plans

○ Anthem observes that Subparagraph b seems to be of little value in today’s ACA environment—there is no real ability to compare to association group rates for other small employers; therefore, she suggests deleting this subparagraph. The Bureau agrees with this observation and the subparagraph has been deleted in the final rule.

○ Subparagraph 9(B)(6)(c)—The restrictions applicable to association health plans are extremely problematic. To the extent the Bureau has any flexibility under the ACA, we strongly urge that different community rates within an association health plan be permitted. At a minimum, we suggest that the Rule recognize that association health plans can be offered by bona fide associations. While the Bureau appreciates the concern, we don’t believe we have the flexibility under the ACA to allow different community rates within an association health plan.

The applicability of portions of Section 9 to federal transitional plans has also been clarified.

Section 12-- Review Pursuant to the ACA

Anthem requests: “To the extent the State has any flexibility in determining whether the ‘potentially unreasonable’ threshold is applied at the product level or the plan level for legacy plans, we would suggest that it should be applied at the product level – it is extremely burdensome to have this requirement applied at the plan level.” The Bureau does not believe it has this flexibility and has not changed this section to address the level at which the threshold is to be applied.

Anthem also expressed the understanding that the requirements set forth in proposed Subsection 12(A-1) apply not only to transitional relief plans, but grandfathered plans as well. If that is the case, Anthem suggests amending Subsection 12(A-1) to refer to “transitional coverage as defined in Section 4 *and grandfathered plans.*” The Bureau does not believe that grandfathered plans are subject to ACA rate review, and therefore has not made the requested change.

Finally, Anthem observes that Section 12 could be confusing as currently drafted, as the Preliminary Justification requirements differ for ACA-compliant plans, grandfathered plans,

or transitional plans. Anthem suggests that a revision similar to the following would clarify the applicable requirements:

Section 12. Review Pursuant to the ACA

- A. All rate filings that have been identified as “potentially unreasonable” in accordance with the ACA and are subject to Section 13 of this Rule must include the ACA Preliminary Justification; ~~Part III description justifying the rate increase in addition to Parts I and III required by Section 13 summary and Part II written explanation of the rate increase.~~

1. **Part I, Uniform Rate Review Template** (a form that summarizes the data used to determine rate increases for the entire single risk pool);
2. **Part II, Written Explanation of the Rate Increase** (a simple and brief narrative describing the data provided in Part I for any product(s) within the single risk pool which have rate increases subject to review, and the assumptions used to develop the rate increase, including an explanation of the most significant factors causing the rate increase); and
3. **Part III, Actuarial Memorandum** (rate filing documentation that states and CMS use to understand the actuarial assumptions, justifications and methodologies used to comply with the market rating rules and to complete the Part I template).

- A-1. All rate filings that have been identified as “potentially unreasonable” ~~in accordance with the ACA~~ and which relate to transitional coverage as defined in Section 4 and grandfathered plans must include the ACA Preliminary Justification; ~~Part I rate increase summary and Part II written explanation of the rate increase.~~

1. **Part I, Rate Increase Summary** (a form that summarizes the data used to determine the rate increase); and
2. **Part II, Written Explanation of the Rate Increase** (a simple and brief narrative describing the data provided in Part I and the assumptions used to develop the rate increase, including an explanation of the most significant factors causing the rate increase).

The Bureau appreciates these suggestions and has revised Sections 12 and 13 to incorporate the descriptions of Parts I through III and clarify the organization.

Section 13—Policies Subject to the ACA Rating Requirements

Anthem suggests that Subsection 13(A) should exclude grandfathered plans as well as transitional relief plans and therefore suggests revising Subsection 13(A) as follows:

- A. This section applies to individual and small group health plans that were issued or renewed on or after January 1, 2014 other than transitional coverage and grandfathered plans.

The Bureau agrees and has added a reference to grandfathered plans.

Several non-substantive formatting and grammatical changes have also been made throughout the final adopted amendments.