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

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| IN RE: | ) | |
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| AETNA HEALTH, INC. 2017 | ) | |
| "WHOLE HEALTH" INDIVIDUAL | ) | **DECISION AND ORDER** |
| RATE FILING AND REQUEST FOR | ) | |
| DISCONTINUANCE | ) | |
| | ) | |
| Docket No. INS-16-1001 | ) | |

## I. INTRODUCTION

I, Eric Cioppa, Superintendent of Insurance ("Superintendent"), issue this Decision and Order after consideration of Aetna Health, Inc.'s: (a) 2017 "Whole Health" individual rate filing and (b) request to discontinue and replace its Whole Health Bronze $35 Copay ("2016 Bronze Plan") and Whole Health Silver $10 Copay ("2016 Silver Plan") plans for 2017.

As required by law, Aetna proposes to rate all of its individual products on a combined basis as a single risk pool. Aetna initially proposed an average increase of 14.2%, with a range of 13.3% to 14.9% depending on deductible level and type of contract. On July 15, as part of its pre-filed testimony in the proceeding, Aetna made changes to its request that resulted in a revised average rate increase of 15.6%, with a range of 14.0% to 17.0%. At the time of the initial filing, total in-force enrollment was approximately 700 individuals who will be affected by the proposed rate revisions. Aetna requests that its proposed rate revisions become effective on January 1, 2017.

Additionally, by its filing dated June 22, 2016, Aetna requested to discontinue offering two of its individual Whole Health plans, the 2016 Bronze Plan and the 2016 Silver Plan. Aetna proposes to replace the 2016 Bronze Plan with its Leap Basic Whole Health Maine plan ("2017

Leap Basic Plan") and to replace the 2016 Silver Plan with its Leap Everyday Whole Health Maine plan ("2017 Leap Plan"). As of the time of the filing, total in-force enrollment for the 2016 Bronze Plan was approximately 352 individuals and for the 2016 Silver Plan approximately 218 individuals.

For the reasons discussed below, I am denying Aetna's revised average rate increase of 15.6% as requested but would approve an average increase of 11.4 %. Additionally, I am denying Aetna's request to discontinue and replace the 2016 Bronze Plan and the 2016 Silver Plan.

## II. PROCEDURAL HISTORY

On May 10, 2016, Aetna filed a request to increase rates for its individual Whole Health products. The Bureau of Insurance designated the matter as Docket No. INS-16-1001.

On May 16, 2016, the Superintendent issued a Notice of Pending Proceeding and Public Hearing, which scheduled a public hearing for July 22, 2016. The Notice also established an intervention deadline, but no person applied (timely or otherwise) to intervene as a party in the proceeding.

Also on May 16, 2016, the Superintendent issued a Procedural Order establishing procedures for the conduct of the proceeding.

On June 3, 2016, the Superintendent issued an Order Regarding Rate Revisions setting a uniform deadline for all insurers to file revised rate requests, if any.

The Superintendent issued several information request and made oral requests at hearing, to which Aetna filed responses.

On June 22, 2016, Aetna filed its request to discontinue its 2016 Bronze Plan and 2016 Silver Plan.

On July 7, 2016, the Superintendent issued a Second Order Regarding Rate Revisions, to which Aetna responded on July 14, 2016.

On July 15, 2016, Aetna filed the pre-filed testimony and supporting exhibits of Geoffrey S. Shannon, Brian St. Hilaire, and William J. Swacker.

The public hearing was held as scheduled on July 22, 2016, 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 the 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, Aetna presented testimonial evidence from Geoffrey S. Shannon, Brian St. Hilaire, and William J. Swacker. The Superintendent admitted into evidence Aetna's pre-filed testimony and exhibits as well as Aetna's 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 Aetna rested its case at hearing, the Superintendent adjourned the hearing for the filing of a written closing statement.

On July 29, 2016, Aetna filed its written closing statement.

Aetna currently provides individual coverage only off the federal Marketplace, but had initially proposed to begin offering plans on the Marketplace in 2017. On August 5, 2016, Aetna

moved to reopen the record of the proceeding in order to notify the Bureau of the Company's decision not to offer plans on the Marketplace in 2017.

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

## III. LEGAL STANDARD

### A. Rate Increase

Aetna 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 Aetna's has requested a rate increase of 10% or more, thereby triggering the threshold for review established under the 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. Aetna, 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. Product Discontinuance and Replacement

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). Furthermore, when a carrier proposes to discontinue offering a health plan (as opposed to merely modifying it), the discontinuance will not be allowed unless it provides its subscribers with a replacement product meeting certain requirements, and "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, it is for the Superintendent to determine whether Aetna's proposed discontinuance and replacement of the 2016 Bronze Plan and 2016 Silver Plan meets this legal requirement.

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 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

I hereby GRANT Aetna's August 5 motion to reopen the record of the proceeding, and the Company's notification of its decision not to offer plans On-Exchange in 2017 is included in the record.

## V. DISCUSSION

For the reasons discussed below, I am denying the revised average rate increase of 15.6% as requested but would approve an average increase of 11.4%. Also as discussed, I am denying

the proposed discontinuance and replacement of both the 2016 Bronze Plan and the 2016 Silver Plan because they are not in the best interests of policyholders.

## A. Rate Increase

### 1. Overview and Recent Market-wide Changes

Under the Affordable Care Act, an insurer may not implement an unreasonable rate increase unless it files and publishes a justification for the increase.[1] Under the Maine Insurance Code, an insurer may not implement an excessive or unfairly discriminatory rate increase at all.[2]

All rate increases in excess of 10% have been specifically identified as "potentially unreasonable" within the meaning of Bureau of Insurance Rule 940 and the regulations implementing the ACA.[3] Heightened scrutiny for increases of this magnitude is required in recognition of the hardship that significant price increases pose to consumers.[4] However, whether a rate increase is actually excessive depends on many factors. In some circumstances, a rate could be excessive even though it is well under the 10% threshold, while in others, a double-digit rate increase is unquestionably necessary. Each rate request must be evaluated on a case-by-case basis, considering both insurer-specific and market-wide factors.

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[1] Public Health Service Act, § 2794(a)(2).

[2] 24-A M.R.S. § 2736(2). Maine law also prohibits inadequate rates, which means that when an increase is necessary to prevent harm to the public, such as a potential threat to the financial integrity of an insurer, it is not only permitted but required. *See Anthem Health Plans of Maine, Inc. v. Superintendent of Insurance*, 2012 ME 21, ¶¶ 11–21 (approving the Superintendent's interpretation of the "not inadequate" standard).

[3] Bureau of Insurance Rule 940, § 4(F); 45 C.F.R. § 154.200(a)(1).

[4] Sometimes, it is suggested that the ACA's premium subsidies make the size of the premium increase less important, because for many consumers, most or all of the increase is paid for by the taxpayers. However, many consumers do not qualify for these subsidies. Others would be forced to change plans to take full advantage of the available subsidies, because the subsidies are based on the price of the second-cheapest Silver plan, which could be a different plan from year to year. For subsidized consumers who wish to keep their current plans, the percentage increase in the net amount they pay could in some cases be even higher than their underlying gross premium increase.

This year, all four insurers in Maine's individual market are requesting rate increases in excess of 10%, with their average increases ranging from 15.6% to 25.5%. Many states are seeing even larger requested increases. One reason for these increases is "trend" – the year-to-year increase in the underlying cost of health care – but trend alone would not support rate increases of this magnitude. While this year's rise in health care costs has been significant, and is expected to continue into 2017, it remains under 10% according to all four insurers' trend projections, which range from 7.2% to 9.6%.

Unfortunately, additional factors have combined this year to yield indicated rate increases substantially in excess of the health care cost trend. One major issue affecting the entire market is the discontinuance of the federal reinsurance program. This three-year transitional program, financed by assessments on the entire health insurance market, reimbursed insurers for a substantial portion of their high-cost claims. In 2016, the final year of the program, the reinsurance absorbs half of each claim in excess of $90,000, up to a cap of $250,000 per claim. Aetna projects that the loss of these reimbursements in 2017 will raise its claim costs by an additional 6.2%, above and beyond the increase required to keep pace with the underlying cost of health care. Additional cost factors affecting this year's premium increase to a lesser degree are discussed more fully below in the actuarial analysis.[5]

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[5] The ACA regulations, at 45 C.F.R. § 154.301(4), enumerate the following factors that can combine to drive premium increases:

> (i) The impact of medical trend changes by major service categories.
> (ii) The impact of utilization changes by major service categories.
> (iii) The impact of cost-sharing changes by major service categories, including actuarial values.
> (iv) The impact of benefit changes, including essential health benefits and non-essential health benefits.
> (v) The impact of changes in enrollee risk profile and pricing, including rating limitations for age and tobacco use under section 2701 of the Public Health Service Act.
> (vi) The impact of any overestimate or underestimate of medical trend for prior year periods related to the rate increase.

### 2. Trend

Aetna's rate filing provided a historical breakdown of unit cost and utilization trends based on actual provider billing and claim payment practices. Aetna also provided a list of adjustments to trend that included events to reflect possible volatility in claim costs. Pharmacy unit cost trend results reflect an increase due to specialty drug cost against a leveling-off of brand to generic conversions. The decrease to outpatient utilization was not considered sustainable as economic indicators continue to improve, so a 1% increase for Maine is expected compared to a 5% increase observed nationally. Based on the evidence presented, I find that the proposed 7.3% allowed (8.4% paid) trend would not cause the rates to be excessive or inadequate.

### 3. Adjustments

Because Aetna's Maine individual market experience is not large enough to be fully credible, Aetna uses a blend of this experience, weighted 10.3%, and a manual rate based on the 2015 small group experience of Aetna and its affiliate, Aetna Life Insurance Company, weighted 89.7%. Several adjustments were made to reflect differences between the experience period and the projection period. I find that none of these adjustments will cause the rates to be excessive or inadequate.

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(vii) The impact of changes in reserve needs.
(viii) The impact of changes in administrative costs related to programs that improve health care quality.
(ix) The impact of changes in other administrative costs.
(x) The impact of changes in applicable taxes, licensing or regulatory fees.
(xi) Medical loss ratio.
(xii) The health insurance issuer's capital and surplus.
(xiii) The impacts of geographic factors and variations.
(xiv) The impact of changes within a single risk pool to all products or plans within the risk pool.
(xv) The impact of reinsurance and risk adjustment payments and charges under sections 1341 and 1343 of the Affordable Care Act.

### a. Morbidity Adjustment

Aetna's July 15 revision to its rate filing provided for a morbidity adjustment of 2.5% to its individual experience and a morbidity adjustment of 6.5% to its small group experience. The 2.5% adjustment is based on Aetna's analysis of 2015 Risk Adjustment and Transitional Reinsurance data published June 30, 2016, by the U.S. Centers for Medicare and Medicaid Services (CMS), as well as the expected impact of Anthem's grandfathered and transitional membership that will enter the ACA market effective January 1, 2017. The 6.5% morbidity adjustment applied to 2015 small group experience includes this 2.5% individual risk pool adjustment, combined with a 3.9% adjustment to reflect differences between the individual and small group populations. The 3.9% population relativity adjustment was determined by comparing Aetna's experience on one- and two-life groups, which are considered similar to individual, to its overall small group experience.

### b. Area Shift

Aetna included adjustments to its base experience and to its manual rate to reflect differences between geographic distribution of members reflected in the experience and the projected 2017 geographic distribution. These adjustments were calculated to be a reduction of 4.6% for the individual experience and a reduction of 5.1% for the small group experience.

### c. Network Adjustment

Aetna included a downward 7.1% adjustment to its manual rate to reflect differences in network composition and provider contracting between its 2015 small group experience and its 2017 individual projections.

### d. Demographics

Aetna included adjustments to its base experience and to its manual rate to reflect differences between age and sex distribution of members reflected in the experience and the projected 2017 geographic distribution. These adjustments were calculated to be 14.5% for the individual experience and 12.4% for the small group experience.

## 5. Profit Margin and Risk

Aetna has requested a 3% pre-tax margin for profit and risk. This is unchanged from 2016, and except in unusual circumstances, it is a margin that the Superintendent has long considered reasonable for this line of business.[6] A 3% margin continues to be reasonable under current market conditions, and I find that it will not cause the rates to be excessive or inadequate.

## 6. Administrative Costs

Aetna's filing provided for administrative costs of $45.33 per member per month (PMPM), or 10.65% of premium, for rates effective January 1, 2017. Aetna also includes taxes, fees, risk, and profit of 7.51% of premium. This total includes 3.08% for the ACA Exchange User Fee. On August 5, 2016, after the record closed, Aetna announced that while it originally filed to offer plans both On- and Off-Exchange, the Company subsequently made the decision not to offer products On-Exchange in Maine for 2017. Aetna's administrative costs filed for approval, however, still include the ACA Exchange User Fee. I find that retaining this fee causes Aetna's administrative costs to be excessive, and I direct the Company to remove the ACA Exchange User Fee from its expense load and to adjust the rates accordingly.

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[6] *See, e.g., In re Anthem Blue Cross and Blue Shield 2014 Individual Rate Filing*, No. INS-14-1000.

## B. Product Discontinuance and Replacement

Aetna proposes discontinuing and replacing both the 2016 Bronze Plan and 2016 Silver Plan. Aetna has proposed mapping the Bronze Plan members to its 2017 Leap Basic Whole Health Maine Plan and its Silver Plan members to the 2017 Aetna Leap Everyday Whole Health Maine Plan. I find that the proposed discontinuance and replacement of these Plans is not in the best interests of policyholders and deny Aetna's requests.

When a plan is *modified* to assure compliance with the Actuarial Value requirements of the ACA, the modifications will be deemed a minor modification pursuant to 24-A M.R.S. § 2850-B(3)(I)(3). However, when a plan is *discontinued* because it has fallen out of Actuarial Value or otherwise, the Superintendent is required to determine whether the discontinuance is in the best interests of policyholders. *See* 24-A M.R.S. 2850-B(3)(G)(3).

Aetna put forth evidence at hearing and in its pre-filed testimony that, in addition to changes that were required to comply with Actuarial Value requirements for 2017, the modifications to the Bronze and Silver Plans were designed to make the Plans "easier to understand and use by eliminating complexities, such as multiple networks, separate deductibles for medical and pharmacy benefits, and varied copays." St. Hilaire Prefiled Testimony at 6. Developing policies that are easier for consumers to understand is important and valuable. Aetna indicated in its testimony that it would be eliminating the multi-tier aspect of its 2016 Bronze and Silver Plans, in favor of a single-tier network in its 2017 Plans. Again, reducing complexity is important for consumers.

However, the filings submitted by Aetna indicate that the simplified, single-tier network of the 2017 Plans will be materially narrower than the network offered in the 2016 Plans. Rather than eliminating the current distinction between tiers within the network, Aetna proposes to

exclude the second-tier providers from the network entirely. In Exhibit 3 of Mr. St. Hilaire's Prefiled Testimony, in the summary of benefit changes between the 2016 Bronze Plan and the 2017 Leap Basic Plan, non-designated providers are transferring from "covered" to "not covered." *See* St. Hilaire Prefiled Testimony Exhibit 3, p. 2. Reinforcing this conclusion, St. Hilaire Prefiled Testimony Exhibit 3, at Exhibit A, shows that the 2016 Plans covered policyholders for services in Aetna's Whole Health Network (Tier 1) *and* Aetna's non-designated network providers (Tier 2), while the 2017 Plans only cover policyholders for services in Aetna's Whole Health Network, with non-designated network providers no longer covered at all.

Although Aetna's narrower network has been approved as adequate for consumers who voluntarily enroll in plans with this network, changing the terms of an existing health plan presents different concerns.[7] I have previously found that narrowing the network of service providers covered under a health plan is not in the best interests of policyholders, for reasons including but not limited to a policyholder's guaranteed renewal rights under Maine law, unless policyholders retain the option of renewing their existing broad-network plans. *See In re Anthem Blue Cross and Blue Shield Request to Discontinue Individual Health Plans*, No. INS-13-803. There is no evidence in the record of this proceeding that causes me to change my analysis in this regard. While Aetna's attempt to simplify its offerings for consumers may generally be a worthy goal, doing so by narrowing the network of covered providers historically enjoyed by policyholders under the Bronze and Silver Plans is not in their best interests as required by Maine law. Accordingly, Aetna's request to discontinue the 2016 Bronze Plan and replace it with the 2017 Leap Basic Plan and to discontinue the 2016 Silver Plan and to replace it with the

[7] *See, e.g., In re Anthem Blue Cross and Blue Shield Request for Approval of Access Plans*, INS-13-801 at Section (V)(F).

2017 Aetna Leap Everyday Whole Health Maine plan is denied. I direct the Company to either: (1) continue the 2016 Bronze and Silver Plans, either in lieu of or as an alternative to the 2017 Leap Plans; or (2) discontinue the 2016 Plans and expand the network in the 2017 Bronze and Silver Plans to include Aetna's broad network and not just the Aetna Whole Health Network.

## VII. FINDINGS AND CONCLUSIONS

On the basis of a preponderance of the credible evidence in the record, and for reasons set forth in Section VI above, I find and conclude that Aetna's proposed rates are excessive. I also find and conclude that Aetna's proposed rates are not inadequate or unfairly discriminatory. I further find and conclude that Aetna's proposed discontinuance and replacement of its 2016 Bronze Plan and 2016 Silver Plan are not in the best interests of policyholders and are therefore denied. If the changes to the rates proposed by Aetna are applied consistent with this Decision and Order, I could lawfully approve the resulting rates. The necessary revisions to the proposed rates can be achieved by making the following changes to the filing:

1. Remove the 3.08% Exchange Fee.

2. Submit a revised URRT, Actuarial Memorandum and Part II Justification through SERFF and HIOS to reflect removal of the ACA Exchange User Fee and the fact that all plans will be Off-Exchange only.

## VIII. ORDER

Pursuant to the provisions of 24-A M.R.S. §§ 2736, 2736-A, 2736-B, 2850-B and authority otherwise conferred by law, I hereby ORDER:

1. The rates filed by Aetna on May 10, 2016, as revised, for its "Whole Health" individual products are DISAPPROVED. Accordingly, the proposed rates shall not enter into effect.

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

3. The discontinuance and replacement of Aetna's 2016 Bronze Plan and 2016 Silver Plan are DENIED. Aetna shall either: (1) continue the 2016 Bronze and Silver Plans, either in lieu of or as an alternative to the 2017 Leap Plans; or (2) discontinue the 2016 plans and expand the network in the 2017 Bronze and Silver Plans to include Aetna's broad network and not just the Aetna Whole Health Network.

4. Aetna shall make its compliance filing with the Superintendent no later than September 7, 2016, addressing items (2) and (3) above.

## IX. 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 16, 2016

ERIC A. CIOPPA
Superintendent of Insurance