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

IN RE:	)	
	)	
MAINE COMMUNITY HEALTH OPTIONS 2017 INDIVIDUAL RATE FILING	)	**DECISION AND ORDER**
	)	
	)	
Docket No. INS-16-1002	)	

I. INTRODUCTION

I, Eric Cioppa, Superintendent of Insurance ("Superintendent"), issue this Decision and Order after consideration of Maine Community Health Options' ("Health Options"): (a) 2017 individual rate filing,[1] and (b) request to discontinue and replace its 2016 Community Preferred product ("2016 Preferred Plan") and to materially modify the benefits of its 2016 Community Edge ("2016 Edge Plan"), 2016 Community Value ("2016 Value Plan"), and 2016 Community Safe Harbor ("2016 Harbor Plan") products for 2017.

As required by law, Health Options proposes to rate all of its Individual Products on a combined basis as a single risk pool. By its initial filing, Health Options proposed an average rate increase of 22.8% for the individual risk pool, with a range of 17.09% to 44.92% depending on deductible level and type of contract. On July 15, as part of its pre-filed testimony in the proceeding, Health Options made changes to its request that resulted in a revised average increase of 25.5%, with a range of 19.2% to 31.3%. At the time of the initial filing, total in-force enrollment was approximately 58,750 individuals who will be affected by the proposed rate

[1] Health Options will offer the following individual products in 2017: Community Safe Harbor, Community Reliant HSA, Community Focus, Community Choice, Community Value, Community Edge, Community Align, Community Complete, and Community Advance ("Individual Products").

revisions. Health Options requests that its proposed rate revisions become effective on January 1, 2017.

Additionally, by its filing, Health Options requested to discontinue and replace one of its Individual Products, the 2016 Preferred Plan, and to materially modify the benefits under three Individual Products: the 2016 Edge Plan, 2016 Value Plan, and 2016 Harbor Plan. Health Options proposes to replace the 2016 Preferred Plan with its 2017 Community Choice Plan.

For the reasons discussed below, I am approving Health Options' revised average rate increase of 25.5% as requested.[2] Furthermore, I am approving Health Options' discontinuance and replacement of its 2016 Preferred Plan and the benefit modifications to the 2016 Edge Plan, 2016 Value Plan, and 2016 Harbor Plan.

II. PROCEDURAL HISTORY

On May 10, 2016, Health Options filed a request to increase rates for its Individual Products. The Bureau of Insurance designated the matter as Docket No. INS-16-1002.

On May 16, 2016, the Superintendent issued a Notice of Pending Proceeding and Public hearing, which scheduled a public hearing for July 26, 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 May 17, 2016, the Superintendent issued a Delegation Order whereby Thomas Record, Bureau of Insurance Senior Staff Attorney, was delegated the Superintendent's financial

[2] Health Options began operations in 2014 with initially established rates that generated a profit. Health Options then decreased its rates in 2015, by an average of 0.8%, and sought approval of only a modest 0.5% average rate increase in 2016. As became apparent in late 2015, both the 2015 and 2016 rates were in fact inadequate, thereby resulting in substantial losses to the Company.

oversight responsibilities vis-à-vis Health Options related to the 2017 Health Options rate filing. As part of the Delegation Order the Superintendent identified other named individuals to participate with Mr. Record. Mr. Record and the other members of the designated oversight team were subject to, and complied with, the *ex parte* communication restrictions under 5 M.R.S. § 9055.

The Superintendent issued several information requests and made additional oral requests at hearing, to which Health Options filed responses.

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.

On June 17, 2016, the Superintendent issued an Order on Health Options' request for confidential treatment of certain information in its filing, thereby denying the request subject to rights of appellate review which were not exercised.

On July 7, 2016, the Superintendent issued a Second Order Regarding Rate revisions, to which Health Options responded on July 12, 2016.

On July 15, 2016, Health Options filed the pre-filed testimony of Kevin Lewis and William Thompson, along with supporting exhibits.

The public hearing was held as scheduled on July 26, 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, Health Options presented testimonial evidence from Kevin Lewis and William Thompson. 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. The Superintendent, without objection by Health Options, also took official notice of Health Options' 2015 Annual Statement and 2016 First Quarterly Financial Statement as publicly available on the Bureau of Insurance webpage.

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 August 2, 2016, Health Options filed its written closing statement together with its responses to the hearing questions.

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 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. 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. **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).

As a threshold matter, a modification to a policy that includes an increase to Actuarial Value of less than 5% and a decrease to Actuarial Value of less than 5%, is a minor modification that does not implicate 24-A M.R.S. § 2850-B(3). The increase and decrease must be evaluated separately to determine whether, individually, it crosses the 5% threshold, and the increase and decrease cannot offset one another. *See* 24-A M.R.S. § 2850-B(3)(I)(4)(c). Any modification falling outside these constraints is considered a product discontinuance, and must qualify for a statutory exception to the guaranteed renewal requirement.

I find that the proposed changes to the 2016 Community Reliant HSA, Community Focus, Community Choice, Community Align, Community Complete, and Community Advance Plans all fall below the statutory materiality threshold and do not implicate their policyholders' guaranteed renewal rights. However, the proposed changes to the 2016 Edge Plan, 2016 Value Plan, and 2016 Harbor Plan are sufficiently material that the 2017 Edge Plan, 2017 Value Plan, and 2017 Harbor Plan must be reviewed as replacement products rather than simple renewals of the existing products.

Under Maine law, 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). If the modifications are required by law, the changes will be deemed a "minor modification" even if the changes are greater than the 5% materiality threshold established under the law. *See* § 2850-B(3)(I)(4). In short, if the proposed modifications to a plan were required by law, the changes will be approved, irrespective of whether they exceed the materiality threshold. However, 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 replacement coverage meeting certain requirements, and 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 Superintendent must find that the discontinuance is in the best interests of policyholders, irrespective of whether the plan in its current form complies with the law.

Accordingly, in this matter, it is for the Superintendent to determine whether Health Options' proposed discontinuance and replacement of the 2016 Preferred Plan is "in the best interests of policyholders" and the substantial modifications (which are treated as product

discontinuances for purposes of the relevant statutes) of the 2016 Edge Plan, 2016 Value Plan, and 2016 Harbor Plan are either "required by law" or meet the best-interests standard, and to otherwise ensure that all plans are in compliance with applicable law.

As set forth in the statute, in the absence of any changes required by law, the "best interests of the policyholders" standard applies to the proposed "replacement" products. 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 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 admit Health Options' post-hearing responses (filed on August 2, 2016) to the hearing panel inquires, with no objection by Health Options.

V. DISCUSSION

For the reasons set forth below, I find that the proposed rates filed by Health Options in this proceeding are not excessive, inadequate, or unfairly discriminatory. I further find that: (a) the proposed discontinuance and replacement of the 2016 Preferred Plan is necessary because the proposed replacement is substantially equivalent to the benefit modifications that would

otherwise be required by law; (b) that the benefit modifications to the 2016 Edge Plan and 2016 Value Plan are in the best interests of policyholders; and (c) that the modification to the 2016 Harbor Plan is a modification required by law.

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.[3] Under the Maine Insurance Code, an insurer may not implement an excessive or unfairly discriminatory rate increase at all.[4]

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 Affordable Care Act.[5] Heightened scrutiny for increases of this magnitude is required in recognition of the hardship that significant price increases pose to consumers.[6] 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

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

[4] 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).

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

[6] Sometimes, it is suggested that the Affordable Care Act'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.

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.

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. Health Options projects that the increased claims costs due to the loss of these reimbursements in 2017 will result in a premium increase of an additional 5.1%, above and beyond the increase required to keep pace with the underlying cost of health care.

Furthermore, the required premium increase for Health Options is even higher in 2017 because its 2016 premiums are an artificially low point of comparison. Because this year's premiums were priced substantially below cost, a premium increase that merely kept pace with the cost increase would cause Health Options to lose money on its individual products at the same rate in 2017 that it is losing in 2016. That would not be sustainable. Health Options

cannot recapture its past losses, but, under the circumstances presented, it must be permitted to close this gap going forward. There are also some additional cost factors affecting this year's premium increase to a lesser degree, as discussed more fully below in the actuarial analysis.[7]

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 2017 rates incorporate an allowed cost trend of 7.2% based on a recommendation from their consulting actuary, Milliman, on December 15, 2015. "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,

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[7] 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.
> (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.

distribution of claim utilization, and pharmacy rebates. Several of Health Options' hospital contracts have annual caps on the amount of fee increases resulting in a reduction in trend. Mr. Thompson, the Milliman actuary with principal responsibility for this rate filing, stated during the hearing that his review of more recent experience confirmed that the "distribution of services allowed amongst hospital inpatient, outpatient, professional, pharmacy, other services, the mix hasn't shifted materially from what was used in the December 15th report." Based on the evidence presented, I find that the proposed 7.2% annual allowed trend will not cause the rates to be excessive or inadequate.

3. Adjustments

Health Options made several adjustments to reflect differences between the 2015 experience used as a basis for projection and its expectations for the 2017 projection period. I find that none of these adjustments will cause the rates to be excessive or inadequate.

a. Morbidity Adjustment

A "morbidity adjustment" may be necessary when the average health of the covered population that will be paying the proposed rates is expected to be materially different from the average health of the population whose experience was used to calculate the expected claims costs. In its initial filing, Health Options proposed a downward adjustment of 1%, anticipating that a lower proportion of consumers receiving cost sharing reductions would indicate a slight improvement in average morbidity. However, Health Options' July 15 revision to its rate filing added an upward morbidity adjustment of 4% to adjust for the population currently covered by grandfathered plans that will be terminating at the end of 2016.[8]

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[8] *See In Re Anthem Blue Cross And Blue Shield Request For Authorization to Discontinue and Replace Legacy Individual Health Plans Effective January 1, 2017*, No. INS-15-802.

In addition to changes in morbidity for the individual market as a whole, Health Options also considered the health of its own enrollee population relative to the overall population. Because Health Options' current share of Maine's individual market is nearly two-thirds, its population will be broadly representative of the market as a whole, but its morbidity will not be exactly the same. The ACA includes a risk adjustment mechanism by which carriers that cover members with below-average risk pay in and carriers that cover members with above-average risk receive payments. The intent is to share the risk among all carriers in order to create a level playing field. Health Options will receive $2.7 million from the risk adjustment system for 2015, indicating that its members had a slightly above-average risk level. There are two ways an insurer can account for this in its pricing. The methodology chosen by Health Options was to base its prices on the average risk across the entire individual market, and assume that it would neither be paying nor receiving any risk adjustment payments in 2017. If its 2017 risk level remains above average, the claim costs may be more than projected, but the loss would be offset by a risk adjustment assessment. An alternative methodology would have been to assume continued above-average risk in projecting claims, and estimating the risk adjustment payment that would be receivable as a result. Either methodology is acceptable and should yield similar results.

b. Age and Gender

Health Options calculated a 4.4% adjustment to reflect differences between the age, gender, and geographic distribution of members reflected in the experience and the projected 2017 demographic distribution.

c. Area and Network

The area factors used are reflective of differences in delivery cost (including unit cost and provider practice pattern differences) and do not reflect differences in population morbidity. The only change in area factors for 2017 is an increase of 5% for Area 4. During the hearing, Mr. Lewis (page 63 of the transcript) confirmed that the change to the Area 4 factor "[r]eflects the increased cost observed in Area 4, consistent with what was filed in our small group filing earlier this year." Mr. Thompson added that analysis "shows that the unit costs in Area 4 are higher than in other areas."

d. Pharmacy Benefit Manager Contract

Health Options entered into a new Pharmacy Benefit Manager contract effective July 1, 2016. The expected pharmacy cost reductions from the new contract are equivalent to a premium reduction of 1.24%.

e. Provider Contracts

The average allowed provider contract amounts are expected to be lower in 2017 than in the 2015 experience period due to recent re-negotiated contracts with network providers. The anticipated average allowed amounts are expected to be 1.9% lower than in 2015.

f. Benefit Modifications

Health Options' plans will no longer cover benefits that are not Essential Health Benefits under the ACA, such as elective abortions, non-emergency services outside the United States, or adult vision. Other changes to benefits include a switch in some of the cost sharing from copayments to coinsurance, and making some benefits subject to the deductible that had not been in 2016. Health Options has eliminated most of its out-of-state network, and will no longer cover any other non-emergency services outside their service area as in-network. The effect of

these benefit reductions is a premium decrease of 8.1% on average. *See* Section V(B) for a more detailed analysis. Premium adjustments vary by plan.

4. Contribution to Surplus

Health Options' 2016 individual rates include a 1% contribution to surplus. A nonprofit insurer's contribution to surplus is the equivalent of a for-profit insurer's margin for profit and risk. For 2017, Health Options has filed for approval of revised rates which increase this margin to 4%.

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 currently running a significant operating loss for a second consecutive year. After running a profit in 2014, its first year of operations, Health Options decreased its individual rates for 2015, by an average of 0.8%. This resulted in operating losses in excess of $40 million. However, before the 2015 operating losses became apparent, Health Options requested and received a 2016 average rate

increase of only 0.5% for its Maine individual health plans. The inadequacy of its 2016 rates was only discovered after it was too late to change them, and high enrollment has exacerbated the problem. The Company's financial integrity depends on its ability to operate with adequate rates in 2017, 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. Accordingly, in light of its financial condition and the need to protect against the potential threat to the financial integrity of the Company, I find that Health Options' requested 4% contribution to surplus will not cause the rates to be excessive or inadequate.

5. Administrative Costs

The administrative cost assumptions are based on Health Options' March 2016 updated financial projections and the 2017 business plan. Health Options' filing provided for administrative costs of $69.48 per member per month (PMPM), or 12.2% of premium, for rates effective January 1, 2017. This dollar amount represents a 15% increase over the 2016 rate filing, which included $60.30 PMPM, or 13.17% of premium. This amount reflects the unit cost that cover 100% of the costs expected in 2017. I therefore find Health Options' administrative costs will not cause the rates to be excessive or inadequate.

B. Discontinuance and Replacement; Benefit Modifications

1. 2016 Preferred Plan

Health Options is proposing to discontinue offering the 2016 Preferred Plan and to replace it with the 2017 Community Choice Plan. I must determine whether the discontinuance and replacement is in the best interests of policyholders, and otherwise complies with Maine law.

See 24-A M.R.S. § 2850-B(3)(G). The 2016 Preferred Plan was at the upper end of the ACA Actuarial Value (AV) spectrum for Silver level plans. With no changes to the benefit design for 2017, it would have exceeded the maximum permitted AV. In order for Health Options to continue offering the Preferred Plan in 2017, benefit modifications would have been required by law. However, once the necessary adjustments were made to the 2016 Preferred Plan to bring it into the Silver AV spectrum, it became clear that it was not meaningfully different from the 2017 Community Choice Plan. Meaningful difference between a company's health plan offerings is required by law and it is not in the best interests of policyholders to offer them a confusing choice between products with no meaningful difference between them.

Because the 2016 Preferred Plan, as modified to meet 2017 AV requirements, was not meaningfully different from the 2017 Community Choice Plan, Health Options proposed to discontinue the 2016 Preferred Plan and replace it with the 2017 Community Choice Plan. I find that the proposed discontinuance and replacement is in the best interests of policyholders as it prevents Health Options from offering two products with no meaningful difference between them and is therefore approved.

2. 2016 Edge Plan

The proposed benefit reductions to the 2016 Edge Plan for offering in 2017 result in a decrease in benefits of 9%, above the 5% threshold for the changes to be considered a minor modification. Furthermore, the benefit reductions were not necessary to remain in compliance with any legal requirement. Accordingly, in order to approve the proposed benefit modification, I must find that the proposed modifications are in the best interests of policyholders. *See* 24-A M.R.S. §§ 2850-B(3)(I) & (G)(3).

The testimony presented at hearing, in addition to the pre-filed testimony and exhibits, established that the reductions to benefits were made in order to minimize the increase to premiums necessary to cover claims for the 2017 plan year. The evidence shows that without the reduction in benefits offered for 2017, premiums would have increased even more substantially. This plan already is receiving the highest premium increase of 31.3% compared to the other plans offered. Due to the changing area 4 factor, the increase for this plan combined with the area factor increase results in a 46% increase for policyholders in area 4. In the case of area 4 policyholders, the increase would exceed 50% if benefits were restricted to a 5% reduction.

Reviewing the numerous comments submitted by members of the public, it is clear that the overwhelming concern regarding Health Options' filing is the increase in premiums over past years. Because these benefit reductions, while significant, offset a substantial portion of the premium increase that would otherwise be necessary, I find that the proposed modifications to the 2016 Edge Plan are in the best interests of policyholders and are therefore approved.

3. 2016 Value Plan

Because the 2017 Value Plan incorporates benefit reductions totaling 5.8%, the modifications are subject to the best-interests standard, notwithstanding offsetting benefit increases that bring the net impact on policyholders to 4.4%, which would be within the 5% threshold.[9] *See* 24-A M.R.S. §§ 2850-B(3)(I) & (G)(3). However, it is appropriate to consider the mitigating impact of these increases as one factor in the analysis. Furthermore, the modifications to the Value Plan are consistent with Health Options' modifications to other plans, and they act to preserve the Value Plan's availability as a "discount" Silver Plan. Health Options enrollees looking for a benefit design that is closer to their current plan will have other choices

[9] *See* 24-A M.R.S. §§ 2850-B(3)(I)(4)(a) & (c).

available. I therefore find the modifications to the 2016 Value Plan, although they incorporate benefit decreases that are slightly above the 5% threshold, are in the best interests of policyholders and are approved.

4. 2016 Harbor Plan

The proposed modifications to the 2016 Harbor Plan were necessary to comply with the mandatory provisions of the ACA relating to catastrophic plans. Accordingly, Health Options' proposed modification is deemed a minor modification through operation of 24-A M.R.S. § 2850-B(3)(I)(3) and is therefore approved.

VI. FINDINGS AND CONCLUSIONS

On the basis of a preponderance of the credible evidence in the record, and for the reasons set forth in Section V above, I find and conclude that Health Options' proposed rates are not excessive, inadequate, or unfairly discriminatory; and that the discontinuance and replacement and/or benefit modifications to Health Options' 2016 Preferred Plan, 2016 Edge Plan, 2016 Value Plan, and 2016 Harbor Plan are in compliance with Maine law.

VII. 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 May 10, 2016, as revised, by Health Options for its Individual Products are APPROVED; provided, however, that the effective date of those rates must assure a minimum of 30 days' prior notice to policyholders.

2. The discontinuance and replacement and/or benefit modifications of Health Options' 2016 Preferred Plan, 2016 Edge Plan, 2016 Value Plan, and 2016 Harbor Plan are APPROVED; provided, however, that the effective date of product discontinuance and replacement must assure a minimum of 90 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 16, 2016

ERIC A. CIOPPA
Superintendent of Insurance