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**Maine Bureau of Insurance**

**Maine Individual and Small Group Health Insurance Rate Review**

**Rate Considerations for Maine State Insurance Regulators**

When companies propose rate increases of greater than 15% for plans sold on the Individual and Small Group Market, the federal Affordable Care Act (ACA) requires that a state’s insurance regulator review the rates. In Maine, the Superintendent of the Bureau of Insurance is the regulator who makes the final decision on rates. The Superintendent works with the Bureau’s team of actuaries, who carefully review all the mathematical assumptions made by the insurance company to justify their rate request, and with the Bureau’s attorneys and consumer health staff on questions of federal and state law and consumer protection.

**Some of the questions that the Superintendent and Bureau staff must consider when reviewing a company’s requested rate increase include:**

1. **Are the rates “excessive?”** Proposed rates must be justified based on the claims experience (previous claims paid) by the company and the projected claims (amounts the company can reasonably expect to pay in the coming year), while also allowing a reasonable margin for administrative expenses and profit (for for-profit companies). The way this is measured is through a requirement by the ACA: insurance companies must meet a “medical loss ratio” of at least 80%. This means that 80% of all the premium payments they receive from policyholders must be spent on health care claims. The remaining 20% can be spent at the company’s discretion to set salaries, invest in capital, pay operating expenses, etc.
2. **Are the rates “unfairly discriminatory?”**  The requirement that rates not be unfairly discriminatory means that differences in rates must be justified and based on factors that are permitted by law. Insurers may vary premiums according to age and geography.
3. **Are the rates “inadequate?”** Setting appropriate rates is one way companies can guarantee that they have the necessary funds to pay future claims. Having enough money to pay claims is a factor in a company’s “solvency.” Solvency standards are set by state and national regulations and determine whether a company can keep operating and selling new plans. A company at risk of “insolvency” presents risks to policy holders and to medical providers because a company that is insolvent cannot pay its bills.

**Other Important Facts About Individual and Small Group Health Insurance Rates and Plans**

1. Rate filings do not provide enough information to predict what an individual consumer’s premiums will actually be in the coming plan year, because the filings do not account for the rate review process, consumer shopping behavior, tax credits, or age factors (see number 2 below).

The premium tax credit (available for individual plans only, and only through the Marketplace at [CoverME.gov](http://www.CoverME.gov)) is designed to ensure that affordable options are available. An eligible consumer’s tax credit amount is based on the premium of the second-lowest cost silver plan (also known as the benchmark plan) that is available to them. The tax credit amount adjusts if the premium for the benchmark plan changes. If premiums for all plans in an area rise similarly, then the increase is essentially fully offset because the premium tax credit will also increase.

1. Individuals will have an age factor that may increase each year. Age factors are not part of a company’s increase request. The mathematical age factors are set by the Affordable Care Act. All insurers are required to use a prescribed age rating curve (Maine uses the federal default curve) when determining how to vary premiums by age.

All insurers in Maine apply the same premium variations by age. Most individual consumers will experience a premium increase each year, due to aging one year. The change in premium based on age is about 2 to 3 percent per year for individuals older than 24.