

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

IN RE:	)	
MAINE COMMUNITY HEALTH OPTIONS	)	PRE-FILED TESTIMONY OF
INDIVIDUAL RATE HEARING	)	KEVIN LEWIS
	)	
	)	
	)	July 15, 2016
Docket No. INS-16-1002	)	

1    **1. Please state your name and your position with Community Health Options.**

2    My name is Kevin Lewis, and I am the President and Chief Executive Officer of Community Health  
3    Options.

4    **2. What is the scope of your testimony?**

5    My testimony will provide an overview of the individual market in Maine, as well as Community Health  
6    Options' position within that market; the proposed changes to the individual plan portfolio; the strategy  
7    driving those changes; and the impact the proposed changes will have on our policyholders.

8    **3. What is your educational and professional background?**

9    I received by Bachelor of Arts from Dartmouth College, prior to obtaining my Masters in Public Policy from  
10   the University of Michigan. I also completed the Johnson & Johnson Health Care Executive Program at  
11   UCLA. Prior to my work with Community Health Options, I served as Chief Executive Officer at Maine  
12   Primary Care Association. I also acted as the director of continuing care at the Maine Hospital Association  
13   and as the legislative liaison at the Wisconsin Department of Health and Family Services.

14   **4. Please discuss Community Health Options' mission and its position within the individual market in**  
15   **Maine.**

16 Our mission is to partner locally with Members, businesses and health professionals to provide affordable,  
17 high-quality benefits that promote health and wellbeing. Community Health Options strives to be a leader  
18 in transforming and improving individual and community health and positively affecting local economies.  
19 Community Health Options currently has about two-thirds of the membership in the individual  
20 marketplace.

21 **5. Why has Maine Community Health Options filed for the proposed premiums changes?**

22 There are several reasons underlying the proposed rate increase for 2017. These include 2015 claims  
23 experience, modifications to plan designs, increased utilization trends, termination of the federal  
24 transitional reinsurance program, and changes to Health Options' profit margin.

25 **6. Please explain what provision this filing makes for a profit?**

26 This filing incorporates a risk charge of 4% of premium.

27 **7. How did you set your profit target?**

28 Medical Loss Ratio measures the percentage of premiums spent on healthcare and quality improvement  
29 as compared to that spent on administrative expenses and profit. The ACA requires at least 80% of  
30 premium dollars be used on clinical service and quality improvement.

31 The rates are designed with conservatism to assure pricing is adequate to cover claims and administrative  
32 expenses in 2017.

33 **8. Please explain Health Options' philosophy on excess profit.**

34 The Mission of Community Health Options is to partner locally with Members, businesses and health  
35 professionals to provide affordable, high-quality benefits that promote health and wellbeing. Within the  
36 context of this mission, Health Options' philosophy is to earn enough profit to begin to accumulate  
37 regulatory required capital, allow for sustainable growth and be in position to repay our federal loans that  
38 capitalized Health Options at the outset. Furthermore, any excess profit, that is profit above and beyond  
39 what is needed to maintain reserves at 500% RBC and repayment of the federal loan, will be rebated to

40 the Membership. Health Options will also rebate excess profits to consumers in a year that our Medical  
41 Loss Ratio might fall below 80% as occurred with the 2014 plan year.

42 **9. Please discuss Community Health Options' performance in the individual market for 2014, 2015,**  
43 **and the first quarter of 2016, including loss ratio.**

44 The loss ratio for 2015 was 91.1%. For the first quarter of 2016, the loss ratio was 93.4%. Both of these  
45 figures represent a substantial increase from the 75.1% loss ratio in 2014. These increased loss ratios  
46 resulted in the \$31 million deficit experienced in 2015 and are the grounds for the ongoing premium  
47 deficiency in 2016 for which Health Options established a \$43 million premium deficiency reserve (PDR)  
48 at the end of the 2015 plan year for the expected results in 2016. This contrasts significantly with the  
49 \$7.3 million profit earned in 2014 which served to bolster Health Options' capital position at that time.

50 **10. If the proposed rates are approved, what loss ratios are anticipated for Community Health**  
51 **Options' 2017 products?**

52 With the proposed changes for the 2017 plan year, the projected loss ratio is 85.72%.

53 **11. Have your enrollment projections changed since last year's filing? If yes, what changes have you**  
54 **made in your assumptions?**

55 Yes, enrollment projections have been revised downward since last year's filing. Anticipated enrollment  
56 for 2016 was 864,000 member months; however, through May 2016, our actual member months are  
57 294,314. End of year 2016 membership has been reduced in light of ongoing attrition, principally within  
58 the individual market, and the lack of any acquisition of individual membership through Marketplace SEPs.  
59 2017 enrollment projections have been rebased since previous pro formas to acknowledge the lower  
60 starting position and focus on slower growth trajectories. We are currently projecting 483,000 member  
61 months across our Maine individual and family plans for 2017.

62 **12. How will you respond if membership falls short of projections?**

63 Many of our administrative costs are variable in keeping with our membership levels and so a membership  
64 reduction will automatically reduce such costs. Health Options' administrative expenses would  
65 necessarily be reduced to keep in step with the plan management needs of a smaller membership. Health  
66 Options effectively reduced administrative costs this past year even with a modest membership increase,  
67 and so there is precedent to Health Options' cost cutting and effective ability to curtail administrative  
68 costs.

69 **13. What are Area Rating Factors?**

70 Area Rating Factors are coefficients that are applied to the index rate of the plan that express the variation  
71 of costs among different geographies as defined by the state regulator and in accordance with the  
72 parameters established by the ACA. There are four geographic rating factors in Maine.

73 **14. Are you familiar with the rate filing submission to the Bureau of Insurance? If so, what was the**  
74 **process used for the 2017 rate development?**

75 Yes, I am familiar with the submission. In developing our 2017 rate submission, we performed an analysis  
76 of our current portfolio structure, our plan benefit designs were reviewed and updated, our medical loss  
77 ratio evaluated, and the relative position of our competitors was assessed.

78 **15. Has your rate filing been updated since the initial submission? If so, why?**

79 Yes, our rate filing has been updated. Subsequent to the initial filing, additional information has been  
80 provided. We have re-examined our claims experience, and we have received the results from the  
81 Transitional Reinsurance Program as well as the Risk Adjustment review. The impact of this information  
82 will be discussed in detail through the testimony of our actuarial consulting firm, Milliman.

83 **16. Are the proposed changes excessive?**

84 No, they are not.

85 **17. Are the proposed changes adequate?**

86 Yes, they are.

87 **18. Are the proposed changes unfairly discriminatory?**

88 No, they are not.

89 **19. Please discuss the proposed changes to the individual portfolio for the 2017 plan year and the**  
90 **strategy informing those changes.**

91 For the 2017 plan year, Community Health Options developed an overarching plan methodology that  
92 analyzed and accounted for the ACA Actuarial Values of our offerings, index rates, and federally mandated  
93 benefit inclusions, and the impacts resulting from benefit modifications both on other plans within the  
94 portfolio and on our policyholders. The proposed changes resulting from those efforts are as follows:

95 Community Health Options has elected to terminate its Community Preferred plan (HIOS ID  
96 33653ME0010004) effective January 1, 2017 and crosswalk those members to its Community Choice plan  
97 (HIOS ID 33653ME0010003).

98 Additionally, global changes have been made across products including an increase in maximum out-of-  
99 pocket, deductibles, and coinsurance for emergency room visits; a transition from a copay to coinsurance  
100 structure for a number of services including Physical, Occupational, and Speech Therapy; the creation of  
101 two tiers of generic drugs; and the elimination of coverage for Non-Essential Health Benefits. Exhibit 1  
102 details these uniform portfolio changes.

103 **20. Are you familiar with the renewability requirements of 24-A M.R.S.A. §2850-B, and if so, please**  
104 **explain your understanding of those requirements?**

105 Yes. 24-A M.R.S.A. §2850-B requires guaranteed renewability of coverage of an individual health plan by  
106 a carrier that continues to offer other products within the state, subject to certain exceptions. In addition  
107 to discontinuing to offer a particular plan, non-renewal can also occur when benefit modifications are  
108 made to a plan that result in an increase or decrease to benefits that cause the actuarial value to increase  
109 or decrease by greater than 5%. Changes that are mandated by law are considered minor modifications  
110 and are not considered when determining this 5% calculation. Exceptions to the renewability requirement

111 can be made when it is determined by the Superintendent that cancellation of a plan is in the best  
112 interests of the policyholders.

113 **21. Do any of the proposed portfolio changes result in an increase or decrease that exceeds the 5%**  
114 **threshold of 24-A M.R.S.A. §2850-B?**

115 Yes, as seen in Exhibit 2, there are three plans in which the benefit changes result in a reduction greater  
116 than the 5% threshold. The Community Edge plan (previously named Community Advantage), the  
117 Community Safe Harbor plan, and the Community Value plan.

118 **22. Please describe how these three products conform to exception to renewability requirement**  
119 **provision of 24-A §2850-B.**

120 The benefit modifications to the Community Edge plan, the Community Safe Harbor plan, and the  
121 Community Value plan are in the best interests of policyholders. The rating methodology for individual  
122 products is based on a single risk pool. Therefore, any adjustments to one plan cannot be executed  
123 without having a corresponding effect on the remaining plans within the portfolio. The increase in the  
124 market-adjusted index rate that would result from enhancing the benefits in one plan would necessarily  
125 cause the premiums for all other plans in the company's portfolio to increase to the detriment of all  
126 Members.

127 The benefit modifications to these three plans were consistent with the corporate portfolio methodology  
128 for the 2017 plan year, and thereby maintain meaningful difference among products while creating a  
129 consistent portfolio design. This not only simplifies administrative efforts, but also facilitates operational  
130 implementation and reduces the risk of errors in service.

131 With respect to the three plans, specifically:

132 The Community Edge plan is our gold level plan. The high benefit levels for that plan without the proposed  
133 changes for 2017 would have left the plan with a significant exposure to risk of adverse selection and the  
134 high utilization experienced in 2015. The benefit adjustments to the Community Edge plan are consistent

135 with those made across all plans in the portfolio and are necessary to position it at the lower end of the  
136 gold level. Increasing the benefits beyond those proposed for the 2017 plan year would result in a higher  
137 index rate thereby increasing the premium not only for this product, but for others in the portfolio to the  
138 disadvantage of Community Health Options' policyholders.

139 Although the benefit changes to the 2017 Community Safe Harbor plan amounted to a decrease in  
140 benefits greater than 5%, the ACA Actuarial Value calculations were greatly impacted by the federally  
141 mandated inclusion of three Primary Care Physician visits with no cost-sharing to the Member. Again, the  
142 elimination of Non-Essential Health Benefits is in conformity with their removal across the portfolio. The  
143 slight increase in the deductible and out-of-pocket maximum was required to reduce the ACA Actuarial  
144 Value from 62.90% to 62.01% thereby maintaining an actuarial value close to the Bronze plan threshold  
145 while preventing it from being a richer plan than our Bronze offerings.

146 The Community Value plan was always intended to be our low-end Silver offering. The proposed 2017  
147 plan adjustments permitted Community Health Options to maintain the same ACA Actuarial Value as the  
148 2016 product while allowing us to continue carrying this level of Silver plan. The changes are consistent  
149 with the overall strategic portfolio methodology.

150 Meaningful differences among Community Health Options' offerings are a regulatory requirement. The  
151 Community Choice plan is the portfolio's mid-level Silver option. Without the proposed changes to the  
152 Value plan, the Value plan will have a higher ACA Actuarial Value than the mid-level Choice plan, and  
153 therefore, there would remain little meaningful difference between the two products.

154 **23. Could you discuss the impact of the single risk pool on your plan strategy?**

155 The proposed benefit modifications are appropriate because of the impact on the entire individual  
156 market. Insurers in the individual market are required to consider the claims experience and demographic  
157 characteristics of all enrollees in all plans as a single risk pool when determining the Market Adjusted  
158 Index Rate.

159 **24. Please describe how the discontinuance of the Community Preferred Plan meets the renewability**  
160 **requirements of 24-A M.R.S.A. §2850-B.**

161 Community Preferred Members will be crosswalked to the Community Choice plan. The Community  
162 Choice Plan, in which Community Preferred Members will be enrolled unless they opt to enroll in a  
163 different plan, is substantially similar to the Community Preferred product. Had the Community Preferred  
164 product not been discontinued, required benefit changes would have resulted in the plan almost mirroring  
165 the 2017 Community Choice offering. Community Health Options will provide 90 days' notice of the  
166 discontinuance of the Community Preferred policy and the replacement with the Community Choice  
167 policy.

168 In addition, the replacement of the Community Preferred policy is in the best interests of policyholders.  
169 If we are required to continue the Community Preferred policy, we would expect to only offer the policy  
170 off of the Health Insurance Marketplace. The policyholders would no longer benefit from the advantages  
171 of the Advance Premium Tax Credit available from offerings available on the Health Insurance  
172 Marketplace.

173 **25. Why is Community Health Options seeking these modifications?**

174 We currently offer products at the high end of the metal spectrum. Community Health Options is seeking  
175 the proposed modifications to keep our plans competitive within the market. The proposed benefit  
176 modifications were consistent across the entire portfolio resulting in uniformity that will simplify  
177 administrative efforts and facilitate operational implementation.

178 While certain plans have decreases in benefits that are greater than the 5% requirement for guaranteed  
179 renewability, we feel these changes are necessary for the stability of Community Health Options due to  
180 the single risk pool. Failure to make these changes in benefits will result in:

- 181 1. More burdensome administration of the plans by Community Health Options due to the  
182 increased variation between plans;

- 183           2. Increased adverse plan selection where the highest utilizers select the plan with the greatest  
184           benefit for his/her own needs at the expense of the entire membership, and  
185           3. Community Health Options being forced to introduce rates much higher than currently  
186           proposed and ending up in a precarious and uncompetitive market position.

187   **26. Does Community Health Options have a system in place to assist Members and consumers with**  
188   **any issues that may arise as a result of these changes?**

189   Yes, Health Options' Member Services Department, consisting of 39 representatives (and an additional 4  
190   members of our lead team), is available to assist members who may have concerns or questions regarding  
191   the 2017 plan changes. All Member Services Representatives will be knowledgeable of the portfolio  
192   modifications. Our Member Services Representatives can be reached Monday through Friday from 8:00  
193   am to 6:00 pm at 1-855-624-6463.

194   **27. Are you familiar with the benefit level differential limitations of 24-A M.R.S. §2677-A(2), and if so,**  
195   **please explain your understanding of those requirements?**

196   Yes. 24-A M.R.S. §2677-A(2) requires that the benefit level differential between preferred and non-  
197   preferred providers does not exceed 20% of the contracted rate for a particular service.

198   **28. Does the cost sharing structure of the proposed 2017 products meet the requirements of 24-A**  
199   **M.R.S. §2677-A(2)?**

200   Yes, it does. 24-A M.R.S. §2677-A(2) provides that compliance can be determined on an aggregate basis.  
201   Based on the reasonably anticipated mix of claims, our actuarial consulting firm, Milliman, has determined  
202   that the combined Out-of-Network paid claims as a per cent of In-Network paid claims is 86%. Exhibit 3  
203   provides the respective benefit differentials for each of our plans. The assumptions and analysis on which  
204   this was derived will be detailed in the testimony of our actuarial consulting firm.

205   **29. Does this conclude your testimony?**

206   Yes.

