

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

IN RE:)	
MAINE COMMUNITY HEALTH OPTIONS INDIVIDUAL RATE HEARING)	RESPONSE TO THE SECOND INFORMATION REQUEST OF THE SUPERINTENDENT
)	
)	
Docket No. INS-16-1002)	

Maine Community Health Options (“Community Health Options”) responds to the request of the Superintendent by providing written responses to requests 1, 2, 3 and 4 of the Second Information Request. This submission is consistent with our agreement to supplement the responses provided should the information change or more information become available at any time during the pendency of this proceeding.

Requests:

1. Please provide an explanation and demonstration that the proposed plan cost-sharing complies with the requirements of 24-A M.R.S. §2677-A(2).

The proposed plan cost sharing meets the requirements of Title 24-A M.R.S. §2677-A(2) which provides that the differential between services rendered by preferred providers and non-preferred providers may not exceed 20% of the allowable charge for the services rendered. We have provided an analysis of the differential on an aggregate basis based on the reasonably anticipated mix of claims certified by our actuarial consulting firm, Milliman.

The assumptions employed in the analysis are that the out of network paid claims amounts were estimated based on the assumed provider reimbursements and benefit levels if 100% of the services were provided by non-preferred providers and the in network paid claim amounts were estimated based on the assumed provider reimbursements and benefit levels if 100% of the services were provided by preferred providers. The in and out of network claim costs were developed employing Milliman’s Managed Care Rating Model. This model has been consistently applied in the 2017 rate development process for our individual products.

Plan	Out of Network Paid Claims as a % of In Network Paid Claims	Enrollment Distribution
Safe Harbor	105%	0.7%
Focus	99%	14.0%
Choice	81%	8.8%
Value	84%	57.9%
Edge	74%	9.6%
Reliant HSA	102%	5.2%
Align	99%	0.8%
Complete	85%	2.6%
Advance	82%	0.4%

While the Edge plan at the gold metallic level does not exceed 80%. In aggregate for all individual plans the combined out of network paid claims as a per cent of in network paid claims is 86%.

2. Please explain why the written premium change for this program on the rate/rule schedule tab in SERFF is a negative number when rates are increasing. Is this due to an enrollment decrease?

The written premium change is a negative number due to an expected decrease in enrollment. The written premium change was calculated by subtracting the 2017 projected written premium in the 2017 URRT from the 2016 projected written premium in the 2016 URRT.

3. Is an adjustment to the 2017 proposed rates needed based on a recent reduction in the CSR amounts received for 2015 affecting claims experience for that year? Please explain.

No adjustment is needed to the 2017 proposed rates based on a recent reduction in the CSR amounts received for 2015.

The Cost Share Reduction (CSR) program is a federal program designed to offer an additional level of benefit to QHP enrollees who earn less than 250% of the Federal Poverty Level or enrollees of American Indian descent. This program provides for more generous cost share than would otherwise be available at no additional cost to the enrollee.

Issuers are compensated for the additional expense associated with the reduced cost sharing through a monthly Advance CSR Payment which is estimated and calculated as a function of the plan premium although the ultimate amount to be recovered by the issuer is unrelated to the plan premium. A final CSR Reconciliation is performed in the 2nd quarter following the plan year to “true-up” the actual amount the issuer should have received, and the final payment is due or received in the 3rd quarter. Under the reconciliation, there are three methods used to calculate the final CSR reconciliation; however, only the Standard Methodology is generally accepted as adequate. The Standard Method calls for every claim paid under a CSR eligible plan variant to be

re-priced as if it were paid under the Base Plan. The amount the Issuer may recover to offset lower enrollee CSR cost share equals the difference between the Plan Paid Amount under the CSR less the Plan Paid Amount re-calculated under the Base Plan, irrespective of plan premium.

In its CSR reconciliation for plan year 2015, Health Options determined that it received approximately \$4.4M in excess advance payments which will need to be paid back during the 3rd quarter of 2016. While this true-up serves to reduce incurred claims reported, it has no impact on the actual claims experienced. In other words, the 2015 experience, upon which 2017 pricing is based, is not understated by the lower CSR payments. The basis for pricing is the allowed claims cost rather than the paid claims cost. Because of this, the fact the enrollee receives a reduced cost share is irrelevant.

In projecting its 2017 experience for purposes of pricing, Health Options has adjusted its 2015 experience to reflect the impact of anticipated changes in the mix of CSR and non-CSR members and their utilization; however, there is no separate pricing associated with the CSR plans.

4. Please provide a final copy of the policyholder notice letter and identify the date when the letter was mailed to policyholders.

See Attachment A. Letters were mailed to policyholders on June 16th and 17th.

July 6, 2016

Submitted by:

/s/Kevin Lewis

Kevin Lewis,

Chief Executive Officer

/s/Nancy H. Johnson

Nancy H. Johnson, Esq.,

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