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GOVERNOR

STATE OF MAINE
DEPARTMENT OF PROFESSIONAL
AND FINANCIAL REGULATION
BUREAU OF INSURANCE
34 STATE HOUSE STATION
AUGUSTA, MAINE
04333-0034

MILA KOFMAN
SUPERINTENDENT

December 16, 2010

The Honorable Kathleen Sebelius
Via Electronic Mail

Dear Secretary Sebelius:

After a careful review of the regulations implementing the new medical loss ratio standards, I have concluded that an adjustment request pursuant to Section 2718 of the Public Health Service Act is necessary until 2014. Assuming all of the reforms are fully implemented under the Affordable Care Act, consumers in Maine will have new, affordable options for health insurance coverage and a continued waiver will no longer be necessary.

This is a request for an adjustment to the medical loss ratio (MLR) standard for Maine's individual health insurance market pursuant to Subpart C of the interim final regulation. The adjustment would substitute Maine's 65% "pure" loss ratio for the 80% federal MLR. Unlike the federal standard, Maine's standard does not include adjustments for quality improvement expenses or taxes. The requested adjustment is for the reporting years 2011, 2012, and 2013. The detailed information required by Subpart C is included on the following pages and accompanying attachments.

Thank you for your attention to this request. I look forward to continuing to work with you to ensure that federal health care reforms are fully implemented.

Very truly yours,

Mila Kofman
Superintendent of Insurance

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§158.321 Information regarding the State's individual health insurance market.

(a) State MLR standard. The State must describe its current MLR standard for the individual market, if any, and the formula used to assess compliance with such standard.

Maine's current standard is set forth in 24-A M.R.S.A. § 2736-C(5) and Bureau of Insurance Rule 940, § 4(D):

> **5. Loss ratios.** For all policies and certificates issued on or after the effective date of this section, the superintendent shall disapprove any premium rates filed by any carrier, whether initial or revised, for an individual health policy unless it is anticipated that the aggregate benefits estimated to be paid under all the individual health policies maintained in force by the carrier for the period for which coverage is to be provided will return to policyholders at least 65% of the aggregate premiums collected for those policies, as determined in accordance with accepted actuarial principles and practices and on the basis of incurred claims experience and earned premiums. For the purposes of this calculation, any payments paid pursuant to former section 6913 must be treated as incurred claims.
>
> D. "Loss ratio" means the ratio of incurred claims to earned premiums for a given period, as determined in accordance with accepted actuarial principles and practices. For the purposes of this calculation, incurred claims do not include any claim adjustment expenses or cost containment expenses except that any savings offset payments paid pursuant to section 24-A M.R.S.A. §6913 must be treated as incurred claims.

This loss ratio standard does not include an adjustment for quality improvement expenses or taxes. The only adjustment is the inclusion in claims of payments required for the Dirigo Health Agency, which includes the DirigoChoice program (a public-private partnership providing premium assistance for private health insurance coverage).[1]

(b) State market withdrawal requirements. The State must describe any requirements it has with respect to withdrawals from the State's individual health insurance market. Such requirements include, but are not limited to, any notice that must be provided and any authority the State regulator may have to approve a withdrawal plan or ensure that enrollees of the exiting issuer have continuing coverage, as well as any penalties or sanctions that may be levied upon exit or limitations on re-entry.

Maine's requirements mirror those in HIPAA and are found at 24-A M.R.S.A. § 2736-C(4):

> **4. Cessation of business.** Carriers that provide individual health plans after the effective date of this section that plan to cease doing business in the individual health plan market must comply with the following requirements.

[1] The statute refers to "former section 6913," which provided for a "savings offset payment" related to Dirigo. This was replaced by section 6917, which provides for an "access payment" for the same purpose. Both forms of payment were a percentage of certain paid claims. The only change is that the new requirement specifies the percentage (2.14%), while the older law provided for a percentage based on cost savings resulting from the Dirigo program. Although the loss ratio standard only references former section 6913, the Bureau has interpreted it as also including the access fee under section 6917.

A. Notice of the decision to cease doing business in the individual health plan market must be provided to the bureau 3 months prior to the cessation unless a shorter notice period is approved by the superintendent. If existing contracts are nonrenewed, notice must be provided to the policyholder or contract holder 6 months prior to nonrenewal.

B. Carriers that cease to write new business in the individual health plan market continue to be governed by this section.

C. Carriers that cease to write new business in the individual health plan market are prohibited from writing new business in that market for a period of 5 years from the date of notice to the superintendent unless the superintendent waives this requirement for good cause shown.

(c) Mechanisms to provide options to consumers. The State must describe the mechanisms available to the State to provide consumers with options in the event an issuer withdraws from the individual market. Such mechanisms include, but are not limited to, a guaranteed issue requirement, limits on health status rating, an issuer of last resort, or a State-operated high risk pool. A description of each mechanism should include detail on the issuers participating in and products available under such mechanism, as well as any limitations with respect to eligibility, enrollment period, total enrollment, and coverage for pre-existing conditions.

Maine requires guaranteed issue and modified community rating in the individual market. Therefore, if one issuer withdraws from the market, consumers losing coverage can buy any individual policy currently offered by any other issuer. The health status of the consumer would not affect eligibility, rates, or coverage under the new policy and preexisting conditions cannot be excluded to the extent that the consumer would have been covered under the prior plan as long as there is not a break in coverage exceeding 90 days. The options available in the individual market are detailed in Appendix C and can be categorized as follows:

1) Commercial insurance coverage. Two insurance companies (as distinguished from HMOs) are actively offering insurance coverage in the individual market.

a) Anthem Blue Cross and Blue Shield of Maine[2] offers PPO products with deductibles ranging from $2,250 to $15,000. After the deductible is met, covered expenses are paid at 100% with no coinsurance. The coverage is comprehensive except for limitations on mental health benefits. As required by Maine law, an optional rider is available to provide full parity for mental health. Policies issued after September 23, 2010 provide first-dollar coverage for preventive care as required by federal law. In addition, Anthem offers the eight standardized plans that all insurers in the individual market are required to offer. These plans have deductibles ranging from $250 to $1,500.

b) In addition to the eight required plans, MEGA Life & Health Insurance Company[3] offers a major medical plan with deductibles ranging from $3,500 to $10,000 and coinsurance of 20% or 50% up to a limit after which covered

[2] Anthem is a Maine subsidiary of the WellPoint group of insurance companies.
[3] MEGA is a subsidiary of the HealthMarkets group.

services are paid at 100%. For the 20% coinsurance option, available coinsurance limits range from $2,000 to $10,000. For the 50% coinsurance option, available limits range from $5,000 to $20,000. Optional riders are available for coverage for physician office visits, as well as mental health and substance abuse. MEGA does not offer coverage for maternity expenses (other than complications of pregnancy), prescription drugs, and skilled nursing care.

2) Health maintenance organization (HMO) coverage. There are three HMOs doing business in Maine – Aetna Health Inc., Anthem Blue Cross and Blue Shield of Maine,[4] and Harvard Pilgrim Health Care, Inc. HMOs are required to offer two standardized HMO plans in the individual market. The combined market-wide enrollment is 33 individuals.

3) DirigoChoice (a public-private partnership). The Dirigo Health Agency (DHA) offers DirigoChoice, private health insurance available to individuals and small businesses in Maine. Currently, HPHC Insurance Company[5] underwrites this product. The premiums and out-of-pocket expenses are income-based on a sliding scale. The availability of coverage is subject to resource limitations. For individuals, enrollment has been closed in the past and reopened on August 1, 2010.

See Appendices B1 through B6 for premium rates. See Appendix C for benefit comparison.

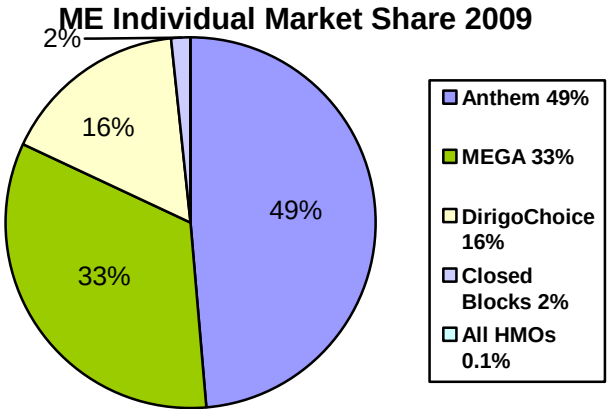
As the detailed data in the attached spreadsheet demonstrates, one of the two insurers actively issuing coverage in the individual market is unlikely to be able to meet the 80% federal standard.

Please note that the products in the individual market vary in benefits and prices. For example, for a family of 4:

MEGA (age 42)
$5,000 deductible, 20% coinsurance:
Nonsmoker: $570.21 or $593.06 depending on geographic area
Smoker: $667.14 or $693.88 depending on geographic area
$10,000 deductible, 20% coinsurance:
Nonsmoker: $428.22 or $444.01 depending on geographic area
Smoker: $501.02 or $519.50 depending on geographic area

Anthem (age 40-44)
$5,000 deductible, no coinsurance: $1,111.65
$10,000 deductible, no coinsurance: $822.19
$15,000 deductible, no coinsurance: $ $523.07

[4] Unlike Aetna and Harvard Pilgrim, which offer insurance coverage and HMO coverage through separate companies, Anthem is licensed to offer both types of coverage through a single legal entity.
[5] HPHC Insurance Company is a subsidiary of Harvard Pilgrim Health Care.



(d) Issuers in the State's individual market. Subject to §158.320 of this subpart, the State must provide:
(1) For each issuer who offers coverage in the individual market in the State its number of individual enrollees by product, available individual premium data by product, and individual health insurance market share within the State;

The information required by Section 158.321(d)(1) is presented in the first tab of the accompanying Excel spreadsheet.

(2) For each issuer who offers coverage in the individual market in the State to more than 1,000 enrollees, the following additional information:
(i) Total earned premium on individual market health insurance products in the State;
(ii) Reported MLR pursuant to State law for the individual market business in the State;
(iii) Estimated MLR for the individual market business in the State, as determined in accordance with §158.221 of this part;
(iv) Total agents' and brokers' commission expenses on individual health insurance products;
(v) Estimated rebate for the individual market business in the State, as determined in accordance with §158.221 and §158.240 of this part;
(vi) Net underwriting profit for the individual market business and consolidated business in the State;
(vii) After-tax profit and profit margin for the individual market business and consolidated business in the State;
(viii) Risk-based capital level; and
(ix) Whether the issuer has provided notice of exit to the State's insurance commissioner, superintendent, or comparable State authority.

The information required by Section 158.321(d)(2) is presented in the second tab of the accompanying Excel spreadsheet.

§158.322 Proposal for adjusted medical loss ratio. A State must provide its own proposal as to the adjustment it seeks to the MLR standard.

We propose substituting Maine's existing 65% "pure" loss ratio for the 80% federal MLR. Unlike the federal standard, a "pure loss ratio" is the ratio of incurred claims to earned premiums and does not reflect any adjustments for quality improvement expenses or taxes. We are requesting this adjustment for the reporting years 2011, 2012, and 2013. Credibility adjustments would apply as in the final interim regulation. Maine's current standard does not contain a credibility adjustment because credibility adjustments are not relevant to a prospective loss ratio standard. As explained above, Maine's current standard applies to anticipated future experience and does not require rebates in the event that the actual loss ratio does not meet the standard, whether due to random variations, unforeseen changes, or cost trends that turn out lower than had been projected. Because we propose to apply this standard retrospectively and require rebates if it is not met, credibility adjustments are necessary.

This proposal must include:
(a) An explanation and justification of how the proposed adjustment to the MLR was determined;

Maine has had a medical loss ratio requirement of 65% in the individual market since 1993. Premium rates are subject to prior approval by the Superintendent and the burden is on the insurer to demonstrate that it will meet the MLR requirement. Maine's MLR does not allow taxes or other expenses to be deducted nor does it add quality improvement expenses to incurred claims. The only adjustment provided under Maine law is for the Dirigo savings offset assessment.

As noted, one carrier (with a substantial presence in the individual market) will not be able to meet the federal 80% MLR. In its most recent quarterly filing with the Securities and Exchange Commission, the insurer stated: "With respect to the minimum loss ratio requirements effective beginning in 2011, we expect that a mandated minimum loss ratio of 80% for the individual and small group markets will have a material adverse impact on our financial condition and results of operations.... Subject to the outcome of final rulemaking, a minimum medical loss ratio at or near the 80% level could, at an appropriate time in the future, compel us to discontinue the underwriting and marketing of individual health insurance and/or to non-renew coverage of our existing individual health customers in one or more states pursuant to applicable state and federal requirements.... After September 23, 2010, the effective date for many aspects of the Health Care Reform Legislation, the Company discontinued marketing its health insurance products in all but a limited number of states."[6]

Based on preliminary discussions with the insurer, the company could continue to operate successfully in the Maine market in compliance with our current MLR standard, but would probably need to withdraw from this market if the minimum loss ratio requirement were increased.

[6] See September 30, 2010 Quarterly Report of HealthMarkets, Inc., Form 10-Q, available online at: http://www.secinfo.com/dsvr4.r35m4.htm#1stPage.

(b) An explanation of how an adjustment to the MLR standard for the State's individual market will permit issuers to adjust current business models and practices in order to meet an 80 percent MLR as soon as is practicable;

A three-year adjustment would allow time for MEGA to adjust its business model. Even if MEGA does not remain in the market after 2013, assuming ACA is fully implemented, consumers in Maine will have new options. Options include: new insurance companies likely to enter the market (similar to our Medigap market which has 16 carriers actively marketing in part due to a more structured marketplace similar to a market that will result once ACA is fully implemented); the required two new multi-state insurance plans offered in every state beginning 2014; and a nonprofit health insurer under the CO-OP program incentivized to be established.

Transitional relief is necessary to ensure that people with MEGA coverage can continue to keep it if they choose until new options become available in 2014.

(c) An estimate of the rebates that would be paid if the issuers offering coverage in the individual market in the State must meet an 80 percent MLR for the applicable MLR reporting years;

We estimate that MEGA would have paid approximately $1.5 million in rebates had the 80% standard been in effect in 2009 (See spreadsheet). However, our experience with guaranteed loss ratio programs is that once the program is operational, rebates are rare. Maine enacted a guaranteed loss ratio option for small group health insurers in 2003, which sets a higher minimum standard than the ACA after adjusting for differences between state and federal formulas. Since that time, one insurer has had to pay rebates one year. Others priced their products to the MLR and have not had to pay rebates. Rather than paying rebates on an ongoing basis, we would anticipate that if MEGA is unable to meet the 80% standard it is likely to withdraw from the market. We would not expect other issuers to pay rebates because their MLRs already meet the ACA standard.

(d) An estimate of the rebates that would be paid if the issuers offering coverage in the individual market in the State must meet the adjusted MLR proposed by the State for the applicable MLR reporting years.

If MEGA's experience is consistent with projections, no rebates would be paid. Rebates could result from favorable claims experience due to lower-than-projected trends, unforeseen changes in costs, or random variations greater than provided for in the credibility adjustment.

§158.323 State contact information.
A State must provide the name, telephone number, e-mail address, and mailing address of the person the Secretary may contact regarding the request for an adjustment to the MLR standard.

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