The Impact of PL90 on Maine's Health Insurance Markets

Prepared for the Maine Bureau of Insurance

December 2011

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1. Executive Summary

In May 2011, the Maine State Legislature passed Public Law Chapter 90 "An Act to Modify Rating Practices for Individual and Small Group Health Plans and to Encourage Value-based Purchasing of Health Care Services" (PL90). The Maine Bureau of Insurance (BOI) has contracted Gorman Actuarial to analyze the actuarial implications of PL90 to the insured markets. We were also asked to look at alternative retrospective reinsurance programs for both the Individual and Small Group Markets. While there are many components to PL90, this analysis focuses on the rating market reforms and the introduction of a reinsurance program on the Individual Market.

Prior to the signing of PL90 into law, in May 2011, Gorman Actuarial co-authored a report on understanding the impacts of the federal Affordable Care Act (ACA) on the Maine markets.[1] This report was also commissioned by the Maine BOI. Due to the passage of PL90 some of our conclusions from our initial analyses on the ACA have been modified. While the focus of this report is on the initial impact of PL90, we have also identified any significant impact to our analysis of the 2014 ACA implementation. Also note that in this report the ACA analysis assumes that by 2014 markets will have already changed due to the impact of PL90. Therefore modeling results shown are in addition to the results of PL90.

PL90 expands the rating bands for the Individual and Small Group Markets. This allows insurers more flexibility in rating and allows insurers to charge higher rates for older individuals and small groups and lower rates for younger individuals and small groups. In addition, the statute allows insurers to charge higher rates for individuals and small groups located in higher costing areas such as Northern Maine and Down East.[2]

Along with expanding the rating bands, PL90 introduces a reinsurance program on the Individual Market. The effect of this reinsurance program will be a premium reduction in the Individual Market. However, the reinsurance program will be partially funded by assessments on the fully-insured and self-insured markets which will result in an increase in premiums to these other market segments.

In addition to these other changes, the law also allows insurers to separate the markets into two rating pools (closed versus open). Separating the risk pools can cause significant premium disruption, especially if these pools are required to be merged back together in 2014 due to the requirements of the ACA. With all of these changes, there will be premium reductions in the Individual Market that may entice new "healthier" entrants into the Individual Market Risk Pool. There may also be some group migration within the Small Group Market as groups that experience increases may drop coverage and other groups may enter the market due to lower premiums.

[1] Gorman Actuarial, Smagula, Jenn, Gruber, Jon, "The Impact of the ACA on Maine's Health Insurance Markets", May 2011

[2] Regional definitions are found in the Appendix.

PL90 will also require insurers to make predictions and projections on many unknowns which can place the insurer at some financial risk, in particular for the Individual Market. Insurers will need to predict how the reinsurance program will impact their Individual Market premiums. Insurers will need to assess which individuals to cede into the reinsurance program.[3] Insurers will need to understand how separating the market into two blocks (open versus closed) will impact their premiums. If insurer's assumptions do not come to fruition, they could significantly underprice or overprice their policies.

The Maine Guaranteed Access Reinsurance Association (MGARA) and the Maine BOI have many decisions to make prior to July 1, 2012, including: designing a health survey, defining the "designation process" (how to cede an individual in the reinsurance pool) for open versus closed blocks of business, and setting premiums for the reinsurance program. In weighing these issues, MGARA and BOI must consider the cost impact of these decisions. However, delaying these decisions would also be problematic. Without some of this information, insurers will have a difficult time in assessing how to modify their premiums in the Individual Market.

Finally, with additional provisions of the ACA occurring in 2014, the Maine markets may again experience some pricing disruption. Due to the premium tax subsidies and cost sharing subsidies, the Individual Market premiums for many will be much lower which will entice individuals into the Individual Market rating pool. However, others will receive premium increases due to the essential benefit requirement. In addition, states will be required to establish a Transitional Individual Market reinsurance program for the Individual Market funded by the privately insured market.

The implementation of PL90 does not significantly impact the results presented in our May 2011 analysis of the ACA. The number of uninsured still decreases significantly and the Individual Market membership still increases significantly. However, PL90 may slightly accelerate this Individual Market growth prior to 2014.

2. Key Findings

This section outlines key findings from this report.

2.1. Individual Market

- **The Individual Market reinsurance program created by PL90 may reduce Individual Market Premiums 12% to 15%.**
  The Maine Guaranteed Access Reinsurance Association (MGARA) established by PL90 will be funded through three mechanisms: a market assessment, an assessment to cover net loss, and premiums paid by insurers that reinsure their members. We have calculated that the $4 per member per month (PMPM) market assessment results

[3] PL90 uses the term "designate" to refer to the act of placing a person into the reinsurance pool. We use the term "cede" to signify that a person has been designated ("ceded") into the reinsurance pool.

in approximately a $21 million subsidy to the Individual Market and a 1% to 2% increase in market premiums outside the Individual Market.

- **In PL90's first year of operation, approximately 80% of the Individual Market will experience lower premiums than they would have in the absence of PL90.**
  Including the effects of the reinsurance program, only 20% of the market will experience higher premiums than they would have in the absence of PL90. These individuals are generally older and live in more costly areas such as Down East and the North.[4] PL90 reduces premiums by more than 20% for 30% of the market. Without MGARA, approximately two thirds of the market would receive higher premiums.

- **There may be significant premium volatility from year to year within the Individual Market.**
  While PL90 allows insurers to open and close blocks of business within the Individual Market, the ACA requires insurers to combine these rating pools by 2014. Without taking into account annual medical trend, premiums in the closed block may increase on average 15% to 20% in the second year of operation. Premiums in the open block could decrease on average 30% to 40% in one year and increase on average 50% to 80% in the next.

- **Maine's Individual Market may grow 6% to 10% prior to 2014 due to lower premiums in the Individual Market.**
  Maine's Individual Market may grow an additional 2,200 to 3,600 new members due to lower premiums in the Individual Market. In addition, since these market entrants may be younger and healthier, they could reduce overall premiums 3% to 5%.

- **PL90 slightly accelerates growth in the Individual Market.**
  By 2019, the Individual Market will have almost tripled in size due to the ACA. PL90 slightly accelerates a portion of this growth to occur sooner but does not significantly change the final outcome. Therefore the results presented in our May 2011 report are still applicable.

2.2. Group Markets

- **A portion of the Small Group Market will experience significant premium changes due to PL90.**
  While the majority of groups (representing 75% of members) will experience less than a 5% impact during the first fifteen months of PL90, there will be some groups experiencing greater premium changes. Seven percent of Small Group members will experience premiums that are more than 10% higher than what they would have experienced in the absence of PL90. Nine percent of Small Group members will

[4] Regional definitions are found in the Appendix.

experience premiums that are more than 10% lower than what they would have experienced in the absence of PL90.

- **Self-insured product offerings may deteriorate the Small Group Market and the Large Group (51 to 100) Market risk pools.**
  As these employer groups experience rate increases, many are exploring other product-offering opportunities to reduce health care costs. Since the self-insured market does not need to adhere to Maine's guaranteed issue and rating laws,[5] health underwriting is used to identify and attract the healthiest risk. While the migration to the self-insured market is low today, this can be a potential risk to the fully-insured markets in the future.

3. Reinsurance

A major component of PL90 is the provision for Individual Market reinsurance and the associated assessments to fund the program, as described in Chapter 54-A, "The Maine Guaranteed Access Reinsurance Association Act". To summarize, the program described in PL90 has the following features:

- It is a prospective program, meaning that insurers designate (or cede) [6] members for reinsurance based on a health statement or the existence of certain health conditions.
- The insurer is responsible for the first $7,500 of annual paid claims, and 10% of the next $25,000. The reinsurance program is responsible for 90% of annual paid claims between $7,500 and $32,500, and 100% of claims above $32,500.
- The insurer pays a premium for each member that it cedes. This premium is to be determined by the Maine Guaranteed Access Reinsurance Association (MGARA).

The reinsurance program, as outlined in PL90, requires insurers to assume some risk when identifying high-risk individuals. There are two ways for individuals to be ceded into the reinsurance pool. One method will automatically cede individuals into a pool based on list of health conditions determined by MGARA. The second method allows insurers to evaluate health statements and assess which members to cede to the

[5] These laws currently only apply to groups with 50 or fewer employees, but by 2016, the ACA will impose similar rules on groups of 51 to 100.
[6] PL90 uses the term "designate" to refer to the act of placing a person into the reinsurance pool. We use the term "cede" to signify that a person has been designated ("ceded") into the reinsurance pool.

reinsurance pool.[7] For each member that is ceded, the insurer must pay the reinsurance pool a premium.

There is a financial risk to the insurer if it does not appropriately evaluate each ceded individual. For example, there will be instances where the insurer will cede an individual to the reinsurance pool, pay a premium to the reinsurance pool and the individual turns out to be a low utilizer of medical services. In this instance, the insurer loses premium and also loses an individual who could have subsidized high-risk individuals in the insurer's rating pool. Insurers that succeed in identifying high-risk individuals are those that have the infrastructure in place to appropriately health underwrite. Insurers without this ability will be exposed to a greater financial risk.

Many unanswered questions remain as to how the reinsurance program will work as defined in PL90. MGARA, as well as the Bureau of Insurance, will need to answer many questions and complete many tasks prior to the implementation of the reinsurance program, scheduled to begin in July 2012, including:

1. What should the health statement look like? MGARA will need to consider the length of the questionnaire. The longer and more comprehensive the questionnaire, the greater the ability of the insurer to cede risk. However, this can also act as a barrier for individuals to enroll in the market. MGARA will need to balance an insurer's ability to cede risk with the burden of filling out a questionnaire.
2. Which health conditions will automatically cede individuals into the reinsurance pool? MGARA may want to consider the health conditions that U.S. Department of Health and Human Services (HHS) has designated for the federal Pre-Existing Condition Insurance Plan (PCIP) qualification of high risk.
3. How will insurers be allowed to cede closed block members into the reinsurance pool? Will insurers be allowed to use claims experience or will they only be allowed to use the health statement to cede risk? Allowing insurers to use historical claims experience will increase the probability that the insurer will cede a high-risk individual into the pool, thus increasing the reinsurance pool funding requirement, as described in Section 3.2. In addition, having two different methods for ceding individuals into the reinsurance pool (one for closed blocks and one for open blocks) may cause operational issues.
4. What should the premiums be for insurers who cede individuals into the reinsurance pool? One possibility is that premiums are calculated based on an average Maine insured population. Another is to base it on the population that would be insured if medical underwriting were permitted, although this may be difficult to determine. If the premiums are set too low, there will be more of an

[7] The rules for ceding closed block individuals to the reinsurance pool have not yet been determined. For our analysis we have assumed that insurers will be using health statements to determine how to cede open and closed block members.

incentive for insurers to cede individuals into the pool, which could cause a funding shortfall. If the premiums are set too high, insurers may not use the reinsurance pool.

5. Will the PL90 reinsurance program be compliant with national health reform? The ACA requires states to implement a Transitional Reinsurance Program for the Individual Market. Proposed federal regulations, released in the summer of 2011, indicate the PL90 program may not satisfy the federal requirements.

3.1. Program Funding

The reinsurance program is funded primarily by assessments on members in Maine's health insurance markets and the premiums that insurers pay for each member ceded into the program. In all, there are four potential sources of funding:

1. Market Assessment
    a. Up to $4 PMPM for all members in the Individual, Small Group, Large Group and Self-insured Markets (excluding State and Federal employees)
2. Assessments to Cover Net Loss
    a. Up to $2 PMPM to cover losses (optional)
3. Organizational Assessment
    a. Nominal $500 fee for each insurer
4. Ceded Member Premium
    a. To be determined by MGARA
    b. Total dollars collected depends on the monthly premium and how many members are ceded into the program

To estimate the amount to be collected from the first two assessments we estimated the total number of members subject to the assessment. Assuming the full $4 PMPM and 5.6 million member months results in $22.4 million being collected for the market assessment which translates to a 1% to 2% increase to the private market premiums. Similarly, the optional assessment to cover net losses could be as high as $11.2 million, if the full $2 PMPM is assessed. Table 1 shows the membership estimates.[8]

[8] Based on December 31, 2010 enrollment:
http://www.maine.gov/pfr/insurance/consumer/financial_results_health_insurers.htm

Table 1 – Membership Estimates

Market	Total Membership	Adjustment for State/Federal Members	Net Membership	Net MM
Individual	35,486		35,486	372,603
Small Group	97,712		97,712	1,025,976
Large Group	207,271	37,725	169,546	1,780,233
Self-insured	261,060	31,400	229,660	2,411,430
Total	601,529	69,125	532,404	5,590,242

Another component of program funding is the premium that the insurer is charged for each member ceded to the reinsurance pool. This premium will be set by MGARA and it is unclear how it will be calculated. As mentioned earlier, if the premiums are set too low, there is the potential for a funding shortfall within the reinsurance pool. If the premiums are set too high, there is the potential that the reinsurance pool will not be used. PL90 suggests that premiums may reflect an average population in the market. Using 2009 claims experience for the combined Maine Individual and Small Group Markets and making adjustments for administrative costs, trend and benefits, we calculate a monthly premium of $225. The total revenue that MGARA will collect from this monthly premium is contingent on the number of individuals that will be ceded into the pool. We have modeled a possible range of individuals ceded, as described in Section 3.2.

3.2. Program Cost

The reinsurance program cost is a function of several variables. The more high-cost members in the program, the higher the program cost. However, the total claims costs are offset by the amount of premium collected from the insurers for the ceded members. The insurer will limit the number of members ceded due to the cost of the premium. If the premium is set low then insurers will cede more members; if the premium is set high the insurer will cede fewer members. To estimate the range of likely program costs, we modeled the size of the population in the pool and the success rate of the insurer in predicting whether or not a member will have high costs.[9] The ability to predict which members will have high costs will vary by insurer and is dependent on the effectiveness of the health statement and comprehensiveness of the list of health conditions for which a person is automatically designated for reinsurance. The better an insurer predicts which members will have high claim costs, the higher the total program cost.

We performed sensitivity analyses on both the size of the population and on the ability of the insurer to correctly identify members with high costs. We developed a reinsurance model using 2009 claims distributions for Maine's Individual Market. We projected 2009 claims cost to the midpoint of the reinsurance program, which we assume runs from July 2012 through December 2013. Our modeling showed that 7% of the Individual

[9] Gorman Actuarial has assumed that the health survey will be used for both open and closed blocks of business to identify high-risk individuals.

Market members would reach the $7,500 reinsurance deductible. Based on this analysis, we assumed that insurers will cede between 8% and 12% of their members, or approximately 4,000 to 6,000 members to the reinsurance pool. We also assumed that insurers' success rate in identifying high cost members would be 20% to 40%.[10] Based on these two factors, we have estimated that the reinsurance pool claims costs could range from $22 million to $65 million. Using the middle of these ranges results in an estimate of $41 million in total claims costs. Note that these estimates are annual amounts and have been adjusted for medical trend. If the program continues past December 2013, the funding requirement will continue to increase due to medical trend and leverage effects. For example, under the PL90 plan design, reinsurance will cover $4,500 of a $12,500 claim (90% of [12,500 - $7,500]). If health care costs increase 10 percent, the $12,500 claim becomes $13,750, and the reinsurance will then cover $5,625, which is a 25 percent increase compared to the $4,500 previously covered.

In addition to estimating reinsurance pool claims costs, we estimated the total revenue the pool would collect in insurer member premiums. As mentioned previously, we estimated an insurer member premium of $225 per month. Using our membership estimates in the reinsurance pool, we have estimated that $13 million in premiums will be collected. The program claims cost is offset by these member insurer premiums and the amount of assessments collected. Table 2 shows the estimated amounts for this scenario, which results in a $5 million deficit after applying the full $4 PMPM market assessment. The optional assessments to cover net loss could be used to cover this deficit. Using the membership estimates in Table 1, this translates to 89 cents per assessed member per month, in addition to the $4 PMPM. Note that we have not reflected administrative costs to operate a reinsurance pool in our analysis.

Table 2 – Individual Market Prospective Reinsurance Program Estimates

Reinsurance Costs and Funding	$ Million
Reinsurance Claims Cost	$ 41
- Carrier Premium	$ 13
Subtotal	$ 27
- $4 PMPM Assessment	$ 22
Total	$ 5

The modeling of the reinsurance program is based on a series of assumptions. Two assumptions in particular can significantly influence the outcome of the funding requirement of the reinsurance program. Currently, we have modeled that the insurer is allowed to cede members using a health statement. However, if the insurer is allowed to use other means (such as claims experience) to cede members, the funding requirement may increase significantly. That is, insurers will be able to predict high cost claimants

[10] There is no literature that indicates how successful health surveys are in predicting claims costs. However, the most sophisticated predictive modeling tools have R-squared values of 15% to 20%.

more accurately than using a health statement alone. Another assumption that will impact the funding requirement is the insurer reinsurance premium level. If the premiums are set too low, there will be more of an incentive for insurers to cede individuals into the reinsurance pool, which may also increase the funding requirement.

3.3. Premium Impact to Individual Market

The reinsurance program as described in PL90 will ultimately reduce premiums in the Individual Market. This is done by reimbursing insurers for high-risk individuals using subsidies from other market segments, as well as premiums and assessments paid by the Individual Market itself. To consider how premiums will be impacted for the Individual Market we focus on subsidies coming from other market segments. As shown in Section 3.2, the full $4 PMPM market assessment results in $22 million being collected. Excluding the Individual Market assessment results in a $21 million subsidy to the Individual Market. This translates into a 12% to 15% reduction in premium. Any amount collected under the assessments to cover net loss would result in additional premium reductions, but due to the uncertainty in the amount and timing of the assessment it is not included in this analysis.

3.4. Retrospective Reinsurance Programs

The federal Affordable Care Act provides for a Transitional Reinsurance Program for the individual market in each state for the years 2014 – 2016. Recently proposed regulations for this program call for a retrospective program structure, as opposed to a prospective program as established by PL 90. We were asked to look at options for a retrospective program in the event Maine chooses to modify the state program to also serve as the federal program. Other differences between PL90 and the proposed federal rules are discussed below in Section 6.1.4.

In contrast to the prospective reinsurance program described previously, in which only members designated by the insurer at time of issue are eligible for reinsurance benefits, in a retrospective reinsurance program claims are automatically reinsured for any member that reaches the reinsurance threshold. This allows for a greater degree of certainty of the program costs because it is not dependent on decisions made by the insurer.

Under a retrospective program, the insurer does not pay any premium for the reinsurance. Programs are typically structured with an "attachment point", which is the dollar amount above which the reinsurer begins paying claims, a coinsurance amount (the percentage of claims above the attachment point that the reinsurer pays), and a ceiling, which is the dollar amount above which the reinsurer no longer pays claims. There are many ways the programs can be structured, but for this analysis we assume that the percent reinsured applies only to the corridor (the range between the attachment point and the ceiling), and that amounts above the ceiling are the responsibility of the insurer. Having a ceiling creates an incentive for insurers to manage high cost claims. It is worth noting that the

prospective reinsurance program prescribed in PL90 has the reinsurance program covering 100% of claims above the ceiling of $32,500.

3.4.1. Individual Market

The total program cost for a retrospective reinsurance program using the PL90 plan design (the reinsurance program is responsible for 90% of annual paid claims between $7,500 and $32,500, and 100% of claims above $32,500) would be much higher than a prospective version. Every member with claims greater than $7,500 would be included in a retrospective program whereas only ceded members are eligible for reinsurance in a prospective program. Therefore a retrospective model under the PL90 plan design is an unrealistically generous program since the funding requirement would be extremely high. However, it provides an upper bound of various reinsurance program structures. We have estimated that a retrospective reinsurance program under a PL90 plan design would result in a funding requirement of $91 million (compared to $41 million in the prospective model under PL90). In addition, we estimate that Individual Market premiums would be reduced approximately 60% (compared to 12% to 15% in the prospective model under PL90).

An infinite number of unique retrospective reinsurance programs can be designed to generate a particular goal – either to meet a predefined funding level or to achieve a premium reduction goal. Several examples are shown in Table 3. The column definitions are:

- **Claims in Excess of**: This is the "attachment point"; the insurer is responsible for each member's annual claims below this amount. The reinsurer pays for a portion of each member's annual claims that are between the attachment point and the ceiling. This portion is found under "Percent Reinsured".
- **Claims Less Than**: This is the "ceiling"; the reinsurer pays for a portion of each member's annual claims that are between the attachment point and the ceiling. The insurer is responsible for claims above the ceiling.
- **Percent Reinsured**: This is the percentage that the reinsurer pays of claims between the attachment point and the ceiling (the corridor).
- **Reinsurance Program Dollars Required**: Shows the total required program cost. This does not include administrative costs to run the reinsurance program.
- **Estimated Premium Reduction**: This is the estimated premium reduction due to the reinsurance program.
- **Assessment as a PMPM Charge**: This is what every assessed member would have to pay to fund the total cost of the program. The assessment would apply to members within the Individual, Small Group, Large Group and Self-insured Markets (excluding State and Federal employees).
- **Assessment as a % of Premium**: This is what every assessed member would have to pay as a percent of their health insurance premium.

Table 3 – Individual Market Retrospective Reinsurance Program Estimates

Claims in Excess of	Claims Less Than	Percent Reinsured	Reinsurance Program Dollars Required ($ Million)	Estimated Premium Reduction	Assessment as a PMPM Charge	Assessment as a % of Premium
$5,000	$75,000	90%	$ 71	46%	$13	4%
$5,000	$50,000	80%	$ 54	35%	$10	3%
$25,000	$100,000	90%	$ 36	24%	$7	2%
$5,000	$50,000	50%	$ 34	22%	$6	2%
$50,000	$5,000,000	50%	$ 19	12%	$3	1%

It can be seen from the examples in Table 3 that a reinsurance program can be designed to meet either a funding goal or a premium reduction goal. For example, if the State of Maine wants to reduce premiums in the Individual Market by 24%, they may want to consider a program that has a $25,000 attachment point with 90% coinsurance and a $100,000 ceiling. This may result in a $7 PMPM assessment on the other market segments which in turn may increase their premiums by about 2%. These are just a subset of examples for the Individual Market.

4. Impacts to the Maine Individual Market

4.1. Open and Closed Blocks and Rating Rule Changes

For the Individual Market, PL90 provides additional rating flexibility by allowing an insurer to close its current block of business on July 1, 2012, and open a new block of business. In addition, the law allows two sets of rating rules for these blocks of business. These rating rules are shown in Table 4. Currently, insurers can charge age and geography adjustments within a 1.5-to-1 band, or +/-20% of a community rate. Beginning July 1, 2012, insurers can charge rates using a 3-to-1 age band on the open block and additionally can surcharge premiums up to 50% for geography.[11] This change will result in higher premiums for the older demographics and for individuals who live in more expensive regions. Beginning July 1, 2012, insurers can charge rates using a 2-to-1 age band on the closed block and in addition can adjust for geography up to a 50% surcharge. This change will also increase rates for the older demographic but resulting rates will not be as high as rates in the open block. Note that the age band expands to 4-to-1 for the open block in 2014 and 5-to-1 in 2015, but only to the extent permitted by the ACA. Since these age bands are not compliant with the ACA in its current form, we assume that the age band will remain at the 3-to-1 age band prescribed by the ACA. We also assume the open and closed blocks will merge back into one rating pool in 2014 because the ACA requires a single rating pool for all non-grandfathered individual

[11] PL90 states that the rating factor for geographic area may not exceed 1.5. The Bureau of Insurance has interpreted this to mean that the rating factors must be within a 1.5-to-1 band.

policies. The closed block age band increases each year and reaches 3-to-1 in 2014, the same year the ACA rating restrictions take effect.

Table 4 – PL90 Individual Market Rating Rule Changes

INDIVIDUAL MARKET	Current	Open Block			Closed Block		
Rating Factor	Up to July 2012	July 2012 to Dec 2013	Jan 2014 to Dec 2014	Jan 2015 to Dec 2015	July 2012 to Dec 2012	Jan 2013 to Dec 2013	Jan 2014 to Dec 2014
Age	1.5 to 1 band	3 to 1	4 to 1*	5 to 1*	2 to 1	2.5 to 1	3 to 1
Geography	1.5 to 1 band	1.5 to 1	1.5 to 1	1.5 to 1	1.5 to 1	1.5 to 1	1.5 to 1
Smoking Surcharge	Yes, no limit	1.5 to 1	1.5 to 1	1.5 to 1	1.5 to 1	1.5 to 1	1.5 to 1
Age and Area within one band	Yes	No	No	No	No	No	No

* To the Extent Permitted by the Federal ACA

Due to these changes, the Individual Market may transform temporarily into two rating pools. Premiums for the older demographic may be slightly more attractive in the closed block as compared to the open block. These individuals may stay in the closed block. In addition, from July 2012 through December 2013, insurers may establish separate base premiums for the open block and the closed block so that resulting premiums will be more attractive in the open block to attract new entrants into the rating pool. If insurers choose this strategy, they will have to anticipate this separation of the pools when setting these premiums. In addition, this strategy will cause some rating disruption as pools are separated and then rejoined 18 months later in 2014.

We have separated our analysis into three sections. The first section is an analysis of premium changes the first year PL90 is in effect, which will include the expansion of rating bands, the geography surcharge of up to 50%, the separation of rating pools, and the impact of the individual market reinsurance program described earlier. The second section is an analysis of possible new entrants into the Individual Market due to the lower premiums in effect. The third section includes possible premium disruptions that may occur upon renewal in 2013 and when the ACA takes effect in 2014.

4.1.1. PL90 Premium Changes Time Period 1 (July 2012 through June 2013)

We have made a series of assumptions to model the impact of PL90:

- Timing: PL90 introduces several complexities in timing and implementation. In the first 18 months, there is a different set of rating rules for the open and closed blocks. In addition, the rating rules for the closed block change after the first 6 months on 1/1/2013. Then the ACA rating rules take effect on January 1, 2014. Due to these different effective dates, we simplified our modeling exercise into Time Period 1 (July 2012 to June 2013), Time Period 2 (July 2013 to December 2013), and Time Period 3 (January 2014 to December 2014).
- Insurers will maintain two rating pools, one for the open block and one for the closed block. In addition, on July 1, insurers will expand the age band to 3-to-1 on the open block and 2-to-1 on the closed block.

- If insurers currently do not use geographic rating adjustments in the Individual Market, we assume insurers will begin to use the same geographic adjustments used in their Small Group rates.
- Insurers will reduce their existing rates 10% for the open block and increase their rates 5% for the closed block due to expected differences in morbidity (health status).
- Individuals will move to the open block if they experience premium savings greater than 5%.
- The new Individual Market reinsurance program will impact the open and closed blocks uniformly.

Based on these modeling assumptions, we have estimated that 37% of the existing market would move to the open block and 63% would stay in the closed block in Time Period 1. We performed sensitivity testing on our assumptions. For example, if we assumed a deeper discount due to morbidity on the open block rates, premiums in the closed block would be higher than the open block premiums for all ages. Insurers may experience many more individuals moving to the open block. However, there will still be individuals that stay in the closed block due to inertia. After performing sensitivity analysis we concluded that a 10% decrease in open block rates and a 5% increase in closed block rates due to morbidity differences would result in a reasonable balance in market premium change.

Our results are shown in the tables below. Combining the effects, the expansion of the age band to 3-to-1, and an additional 10% rate reduction in the open block, the younger demographic (less than 40 years old) is receiving premiums ranging from 22% to 30% less than they would be without these changes. There are a few older individuals that receive modest increases in the open block. Many of these individuals are part of family policies that would have received higher premiums in the closed block. In the closed block, on average, almost everyone is receiving a premium increase; however, the older demographic is receiving the greatest increase due to the expansion of the 2-to-1 age band.

Table 5 – PL90 Time Period 1 Open Block Premium Change by Age[12]

Open Block	37% of Market	
Age Category	**Distribution**	**Premium Change***
<29	18%	-30%
30 to 39	9%	-22%
40 to 49	9%	-4%
50 to 59	1%	2%
60+	0%	6%
Total	37%	

***Premium Change compared to what the premium would have been in the absence of PL90**

[12] Premium changes shown are only due to PL90 and do not reflect the impact of medical trend.

Table 6 – PL90 Time Period 1 Closed Block Premium Change by Age[13]

Closed Block	63% of Market	
Age Category	**Distribution**	**Premium Change***
<29	10%	6%
30 to 39	0.1%	4%
40 to 49	9%	4%
50 to 59	25%	8%
60+	19%	11%
Total	63%	

***Premium Change compared to what the premium would have been in the absence of PL90**

We also analyzed premium changes by region.[14] Table 7 and Table 8 show premium changes by region for the open and closed blocks. Premium increases are higher for individuals who live in Down East, North and North Central (which represent approximately 26 % of the combined market), due to the higher surcharges that are applied in these areas.

Table 7 – PL90 Time Period 1 Open Block Premium Change by Region[15]

Open Block	**Distribution**	**Premium Change***
Down East	3%	1.1%
Lakes & Mountains	6%	-18.7%
Mid Coast	6%	-19.2%
North	2%	2.2%
North Central	4%	-8.5%
South	15%	-26.9%
Unknown	1%	-28.2%
Total	37%	

***Premium Change compared to what the premium would have been in the absence of PL90**

[13] Ibid.
[14] Regional definitions are found in the Appendix.
[15] Premium changes shown are only due to PL90 and do not reflect the impact of medical trend.

Table 8 – PL90 Time Period 1 Closed Block Premium Change by Region[16]

Closed Block	Distribution	Premium Change*
Down East	7%	30.7%
Lakes & Mountains	10%	6.3%
Mid Coast	11%	6.7%
North	3%	28.0%
North Central	7%	17.6%
South	23%	-3.1%
Unknown	1%	4.0%
Total	63%	

***Premium Change compared to what the premium would have been in the absence of PL90**

In addition to the rating band changes and separating the pool, PL90 also introduces MGARA. We have described this program and provided our modeling results earlier in this report. As described in Section 3.3, we have estimated that the premium reduction due to this program in the Individual Market will be approximately 12% to 15%. The tables below adjust for this reduction[17]. Due to the many uncertainties around how the reinsurance program will be implemented, we have assumed a uniform reduction across the closed and open blocks.

Table 9 – PL90 Time Period 1 Open Block Distribution of Premium Change with Reinsurance[18]

Open Block Premium Change	Distribution	Premium Change*
Less than -20%	24%	-38%
-10% to -20%	8%	-17%
0% to -10%	3%	-4%
0% to 10%	2%	5%
10% to 20%	1%	14%
Greater than 20%	0%	23%
Total	37%	

***Premium Change compared to what the premium would have been in the absence of PL90**

[16] Ibid.
[17] We have assumed a 14.5% premium reduction, which represents the actual claims reduction due to the reinsurance program.
[18] Premium changes shown are only due to PL90 and do not reflect the impact of medical trend.

Table 10 – PL90 Time Period 1 Closed Block Distribution of Premium Change with Reinsurance[19]

Closed Block Premium Change	Distribution	Premium Change*
Less than -20%	5%	-25%
-10% to -20%	28%	-15%
0% to -10%	14%	-6%
0% to 10%	7%	3%
10% to 20%	8%	14%
Greater than 20%	1%	22%
Total	63%	

***Premium Change compared to what the premium would have been in the absence of PL90**

As shown, with the application of the reinsurance program, 82% of the combined Individual Market may experience lower premiums than they would have in the absence of PL90 and 29% may experience a reduction in excess of 20%. These individuals are either younger or live in less costly areas, or both. 18% of the combined Individual Market may experience higher premiums than they would have in the absence of PL90 and less than 1% may experience an increase in excess of 20%. These individuals are either older or live in more costly areas, or both.

Premium changes will vary by age and region due to the rating rule changes. There will also be premium changes due to expected morbidity assumptions resulting from the separation of the closed and open blocks and from the reinsurance program. Table 11 summarizes our assumptions for both blocks.

Table 11 – PL90 Time Period 1 Rate Changes[20]

	Time Period 1
Open Block	-10% Expected Morbidity Adjustment -15% Reinsurance **-23% Total**
Closed Block	+5% Expected Morbidity Adjustment -15% Reinsurance **-11% Total**

4.1.2. New Entrants in Individual Market

One of the policy goals of PL90 is to make premiums more attractive in the Individual Market which will attract new individuals into the market. We define new entrants as individuals who enter the individual market due to premium reductions brought about by PL90. Since premiums will be more attractive for the younger demographic, we believe

[19] Ibid.
[20] Ibid.

new individuals entering the market will improve the risk pool and eventually lower overall premiums.

There is very little literature on the elasticity of demand of health insurance. A literature review performed by the Institute for Health Policy, Muskie School of Public Service, University of Southern Maine, for a previous study for the BOI suggests that most studies estimate a price elasticity of -0.3 to -0.7, meaning a 10% decrease in price would lead to an increase of between 3% to 7% in the number of individuals purchasing insurance[21]. This study uses a price elasticity of -0.5, which means that for every 10% decrease in price, the number of individuals purchasing insurance would increase 5%.

Using this elasticity of demand algorithm, we project that the open block will increase in membership by about 16% during Time Period 1 of PL90. Using July 2010 membership as reported in our May 2011 analysis of the ACA (36,400)[22], we estimate this to be approximately 2,200 members, or a 6% increase across the entire market.

It is difficult to predict how these new market entrants will impact the rating pool. Our modeling shows that 60% of the new market entrants will be under the age of 30 and 25% will be between the ages of 30 and 40. Due to their younger demographic, it is believed that they will improve the Individual Market rating pool.

We have calculated age factors for each population to understand the impact of these new entrants into the rating pool. Age factors assign a risk score to a population based on its age demographics. Table 12 shows the age factor for the closed block and the open block before the impact of the new entrants. As shown, the age factor for the closed block after Time Period 1 is 125% higher than the open block.

Table 12 – Individual Market Age Factor Analysis

Population	Estimated Enrollment	Age Factor
Closed Block	22,900	1.26
Open Block	13,500	0.56
Total	**36,400**	**1.00**

We also calculated an age factor for the new entrants in the open block which is 0.50. When we combine the new entrants with the open block the resulting age factor is 0.55. This indicates that the premium reduction due to the new entrants in the open block may be 1.5%.

[21] Gorman Actuarial, Muskie School, BOI "Reform Options for Maine's Individual Health Insurance Market", May 2007

[22] Gorman Actuarial, Smagula, Jenn, Gruber, Jon, "The Impact of the ACA on Maine's Health Insurance Markets", May 2011

Table 13 – New Entrants Age Factor Analysis

Population	Estimated Enrollment	Age Factor	Premium Change
New Entrants	2,200	0.50	
Open Block	13,500	0.56	
Total	**15,700**	**0.55**	**-1.5%**

We then calculated the overall age factor for the entire Individual Market including the closed and open blocks and new entrants. The overall age factor is 0.97 which could potentially result in a 2.9% premium reduction over the entire Individual Market.

Table 14 – New Individual Market Age Factor Analysis

Population	Estimated Enrollment	Age Factor	Premium Change
New Entrants	2,200	0.50	
Open Block	13,500	0.56	
Closed Block	22,900	1.26	
Total	**38,600**	**0.97**	**-2.9%**

In addition to the above assumptions, we also performed sensitivity analyses on new market entrants. If instead of a 6% increase in Individual Market membership, we assume a 10% increase, the resulting impact on premiums is a 5% decrease rather than the 3% decrease described above.

4.1.3. Possible Market Premium Disruption

PL90 allows insurers to create two rating pools within the Individual Market. This separation will cause some premium disruption as pools are segregated and selection occurs. The open block will experience premium decreases as the older, higher utilizers of health care stay in the closed block. The closed block will experience premium increases as the younger, healthier individuals exit to enroll in the open block. This dynamic will only occur for a short period from July 2012 through December 2013. In 2014, once the ACA requirements are in effect, these two rating pools will become one. Depending on how insurers rated these blocks previously, in 2014 the open block may experience some premium increases and the closed block may experience some premium decreases.

As described previously, we have modeled one possible scenario on how insurers may rate these two pools. In our analysis we have assumed that in Time Period 1 insurers will decrease open block rates 10% and increase closed block rates 5%. In addition, we have assumed that insurers would reduce rates uniformly for the reinsurance program. These assumptions are outlined in Section 4.1.1.

Subsequent to Time Period 1, insurers will analyze their data to understand the underlying claims costs for each risk pool. Table 15 illustrates how segregating the risk pools can impact the average claims costs for each rating pool. From our modeling of 2009 data, we find that the closed block allowed claims costs on average are 24% higher than the Individual Market average. In addition, the open block claims costs are 46% below the Individual Market average. On renewal, insurers can reflect these differences in their premiums. They may increase closed block premiums an additional 15% to 20% upon renewal and reduce open block premiums an additional 30% to 40%. However, both rating pools will be recombined in 2014 due to the ACA.

Table 15 – Closed versus Open Block Claims Costs: 2009 Data

	Distribution	Allowed Claims PMPM	Allowed Ratio
Closed	63%	$ 402	23.6%
Open	37%	$ 177	-45.7%
Total		$ 325	

Table 16 shows one possible scenario on how premiums may change from year to year. In Time Period 1, insurers may adjust rates for expected morbidity differences and reinsurance reductions. Upon renewal, insurers may reflect actual claims costs due to the separation of the pool and new entrants into the open block. Finally, in January 2014, when both pools are recombined, the closed block may experience a premium reduction of 20% to 25%, while the open block may experience premium increases ranging from 50% to 80%. In addition, the Individual Market may experience a 3% to 5% reduction as compared to premiums prior to PL90 due to new entrants into the pool.

As modeled, maintaining large premium disparities between the closed and open blocks can cause significant premium volatility. It may be more prudent for the insurer to maintain a small premium variance between the closed and open blocks to limit significant disruption in 2014. However, doing this would make premiums in the open block less attractive, as well as less competitive relative to an insurer that does not use the same rating strategy.

Table 16 – Premium Volatility from Time Period to Time Period[23]

Time Period over Time Period Premium Change			
	Time Period 1	**Time Period 2**	**Time Period 3**
Open Block	-10% Expected Morbidity Adjustment -15% Reinsurance **-23% Total**	-30% to -40% Due to Separating Blocks -1% to -3% due to New Entrants **-31% to -42% Total**	**+50% to +80%**
Closed Block	+5% Expected Morbidity Adjustment -15% Reinsurance **-11% Total**	**+15% to +20% Due to Separating Blocks**	**-20% to -25%**
Total			**-3% to -5%**

5. Impacts to the Maine Small Group Market

5.1. Small Group Rating Impacts of PL90 and ACA

Similar to the Individual Market, PL90 provides additional rating flexibility for the insurers in the Small Group Market. The law allows insurers to close their current block of business and open a new block of business. In addition, the law changes the rating rules as detailed in Table 17 and Table 18.

Table 17 – Open Block PL90 Rating Rules

Maine Small Group- Open Block Rating Rules						
	Up to Oct 2011	**Oct 2011 - Dec 2012**	**Jan 2013 - Dec 2013**	**Jan 2014 - Dec 2014***	**Jan 2015 - Dec 2015***	**Jan 2016 - Dec 2016***
Age	1.5 to 1 band	2 to 1 band on group	2.5 to 1 band on group	3 to 1 band on group	4 to 1 band on group	5 to 1 band on group
Geography	1.5 to 1 band	1 5 to 1 band	1.5 to 1 band	1.5 to 1 band	1.5 to 1 band	1.5 to 1 band
SIC	1.5 to 1 band	Allowed	Allowed	Allowed	Allowed	Allowed
Group Size	Allowed	Allowed	Allowed	Allowed	Allowed	Allowed
Age, Geography, SIC in one band?	Yes	No	No	No	No	No

**To the extent permitted by the ACA.*

Table 18 – Closed Block PL90 Rating Rules

Maine Small Group- Closed Block Rating Rules					
	Oct 2011 - Dec 2012	**Jan 2013 - Dec 2013**	**Jan 2014 - Dec 2014***	**Jan 2015 - Dec 2015***	**Jan 2016 - Dec 2016***
Age	2 to 1 band on group	2.5 to 1 band on group	3 to 1 band on group	4 to 1 band on group	5 to 1 band on group
Geography	1.5 to 1 band	1.5 to 1 band	1.5 to 1 band	1.5 to 1 band	1.5 to 1 band
SIC	Allowed	Allowed	Allowed	Allowed	Allowed
Group Size	Allowed	Allowed	Allowed	Allowed	Allowed
Age, Geography, SIC in one band?	No	No	No	No	No

**To the extent permitted by the ACA.*

The rating bands are the same in both the closed and open blocks. Discussions with several insurers in Maine revealed that it is not likely that insurers will create a closed block in the Small Group Market as there does not appear to be any advantage to doing this. Therefore, our modeling assumed a single, open block in the Small Group Market. Under the previous law, insurers could adjust rates for age and geography within +/-20%

[23] Premium changes shown are due to PL90 and the ACA and are incremental from time period to time period. Premium changes do not reflect the impact of medical trend.

of a community rate, which is equivalent to a 1.5-to-1 band. Under PL90, insurers can charge rates using a 2-to-1 age band and additionally can surcharge premiums up to 50% for geography.[24] In general, this results in higher premiums for the older demographics and for individuals who live in more expensive regions. Note that the rating rules under PL90 will be subject to the restrictions under the ACA starting in 2014. For example, rate differentiation by group size and SIC is not allowed under the ACA and age rating adjustments are limited to a 3-to-1 band on adult age factors. Given this information, we have modeled the impacts to the Maine Small Group Market under the rating rule assumptions shown in Table 19.

Table 19 – Small Group PL90 and ACA Rating Rules

Maine Small Group Rating Rules				
	Up to Oct 2011 (Current State)	Oct 2011 - Dec 2012 (PL90_1)	Jan 2013 - Dec 2013 (PL90_2)	Jan 2014 and beyond (ACA_1)
Age	1.5 to 1 band	2 to 1 band on group	2.5 to 1 band on group	3 to 1 band on group
Geography	1.5 to 1 band	1.5 to 1 band	1.5 to 1 band	1.5 to 1 band
SIC	1.5 to 1 band	Allowed	Allowed	Not allowed
Group Size	Allowed	Allowed	Allowed	Not allowed
Age, Geography, SIC in one band?	Yes	No	No	No

The summary in Table 20 shows the distribution of expected premium change (compared on an incremental basis) due to the rule changes described in Table 19. While we expect these rating rule changes to have an overall revenue neutral impact on the Small Group Market, there will be "winners and losers" within this market depending on different rating characteristics.

Table 20 – Small Group PL90 Premium Change[25]

Distribution of Expected Year to Year Premium Changes*						
	Oct 2011 - Dec 2012 (PL90_1)			Jan 2013 - Dec 2013 (PL90_2)		
	% Members	% Groups	Average % Change compared to Prior Time Period	% Members	% Groups	Average % Change compared to Prior Time Period
Less than -10%	8.6%	13.4%	-16.6%	1.1%	2.5%	-18.7%
-10% to -5%	5.8%	5.7%	-7.5%	0.7%	1.2%	-7.1%
-4.9% to 0%	69.6%	54.7%	-0.8%	91.8%	78.8%	-0.5%
0.1% to 5%	5.4%	9.8%	2.3%	1.5%	2.1%	2.3%
5.1% to 10%	3.6%	5.2%	7.5%	4.5%	14.8%	6.5%
Greater than 10%	7.0%	11.2%	20.3%	0.5%	0.7%	32.8%

***Premium Change compared to what the premium would have been in the absence of PL90, and does not include medical trend**

[24] PL90 states that the rating factor for geographic area may not exceed 1.5. The Bureau of Insurance has interpreted this to mean that the rating factor must be within a 1.5-to-1 band.

[25] Premium changes shown are only due to PL90 and are incremental from time period to time period. Premium changes do not reflect the impact of medical trend. Premium changes do not include the reinsurance assessment of about 1%.

From October 2011 to December 2012, 65% of groups, which include 75% of members, will experience less than a 5% impact due to PL90. While the majority of groups will experience little impact during the first fifteen months of PL90, there will be some groups experiencing greater impacts. 11% of groups which include 7% of Small Group members will experience premiums more than 10% higher (average 20%) than what they would have experienced in the absence of PL90. In general, these are groups with higher average ages or groups located in areas of Maine with higher geography rating factors (Down East, North and North Central). Conversely, the groups that will experience a positive impact from PL90 in these first fifteen months are typically the younger groups or groups located in areas of Maine with lower geography rating factors (South). Due to these rating changes, 13% of groups, which include 9% of Small Group members, will experience premiums more than 10% lower (average -17%) than what they would have experienced in the absence of PL90.

In 2013, the majority of members and groups will experience minimal premium changes compared to the first fifteen months of PL90 as the only change between the first and second time periods shown in Table 20 is the expansion of the age rating band from 2-to-1 to 2.5-to-1. The groups experiencing a savings will be groups with a younger average demographic while the groups experiencing an increase will be groups with an older average demographic.

5.2. Membership Shifts

We expect minimal changes in the Small Group Market membership as a result of PL90, but we conducted sensitivity testing around membership shifts to understand a possible range of outcomes. There may be an expectation that PL90 will attract lower costing Small Groups not currently offering health insurance to start offering health insurance given the more favorable rating rules for younger groups and groups in lower costing rating regions. There is also a possibility that some groups adversely impacted by PL90 will choose to drop coverage. Our results show the following:

- A 5% increase in Small Group membership could result in a 3% decrease in overall premiums. This assumes that the lowest utilizers of care join the market.[26]
- A 5% decrease in membership may increase premiums 1%. This assumes groups are highly sensitive to increases in price. We assumed that 50% of groups with more than a 5% increase due to the rating changes will drop coverage.
- A 3% decrease in membership may increase premiums less than 1%. This assumes groups are less sensitive to increases in price.

Given these results we have assumed that the overall Small Group Market will experience minimal premium change due to member migrations as a result of PL90.

[26] This analysis of the lowest-costing groups was developed by taking actual 2009 incurred claims by group and normalizing for differences in rating region, age demographics and benefits.

5.3. Sole Proprietors

The Maine BOI requested that we analyze the impact of removing sole proprietors from the Small Group Market. To perform this analysis, we assumed that groups with one subscriber were sole proprietors. 4% of members and 21% of groups in the Maine Small Group Market had one subscriber in 2009. These groups have average allowed claims 22% higher than all other groups and an average subscriber age 11% higher than all other groups. Removing these groups from the Small Group Market would reduce premiums by less than 1%. This minimal impact is due to the relatively small size of this segment of the Small Group Market. Many sole proprietors are covered through the Individual Market. Insurers who participate in the Individual Market can require sole proprietors to enroll in this market rather than the Small Group Market.

5.4. Micro-group Market (5 or fewer subscribers)

5.4.1. PL90 Premium Impact

The Maine BOI requested that we analyze the micro-group market to understand if the effect of PL90 is more significant in these smaller groups. We analyzed age and geography distributions for this segment to see if they were different than for the larger groups. Our analysis showed that while the impact of PL90 is about the same, premium changes are more variable for the micro-groups than for the rest of the Small Group Market. As shown in Table 21, 41% of micro-groups experience impacts greater than 5% in either direction, compared to 24% of the larger groups.

Table 21 – PL90 Premium Change by Group Size, Micro-groups Compared to Others[27]

Distribution of Expected Premium Change* Compared to Current State due to Rating Changes Only Oct 2011 - Dec 2012 (PL90_1)				
	Group Size: less than 6		Group Size: 6 or more	
	% Members	% Groups	% Members	% Groups
Less than -10%	14.6%	15.9%	6.0%	8.0%
-10% to -5%	7.1%	6.0%	5.3%	5.0%
-4.9% to 0%	56.4%	47.6%	75.3%	70.1%
0.1% to 5%	7.9%	11.7%	4.4%	5.7%
5.1% to 10%	4.3%	5.8%	3.3%	3.9%
Greater than 10%	9.7%	13.0%	5.8%	7.2%
Total	100.0%	100.0%	100.0%	100.0%

***Premium Change compared to what the premium would have been in the absence of PL90, and does not include medical trend**

[27] Premium changes shown are only due to PL90 and do not reflect the impact of medical trend. Premium changes do not include the reinsurance assessment of about 1%.

5.4.2. Prospective Reinsurance Program for the Micro-group Market

In addition to analyzing the impact of PL90 on micro-groups, the BOI also requested that we perform a reinsurance analysis on these smaller groups. Our analysis of the micro-group market assumed that a prospective reinsurance program similar in structure to that described for the Individual Market in PL90 was applied to the micro-group market. The following assumptions were used:

1. The monthly premium to be paid by the insurer for each member is $225, the same estimate used for the Individual Market reinsurance program.
2. The insurer can cede individuals within a small group rather than being limited to ceding either the whole group or none of it.
3. The insurer targets a higher percentage of members for reinsurance, since a slightly higher percentage of high-cost members are eligible for reinsurance in the micro-group market (10-14%).[28]
4. Insurers are equally successful in identifying high-cost members in the micro-group market as they are in the Individual Market (20% to 40%).

Using the same methodology described in Section 3.2, we estimate the likely range of annual program claims costs to be between $13 million and $35 million, with the middle of the range being $23 million. The total program cost is offset by the premiums collected, which we estimate to be $11 million. For this scenario, the program costs exceed the premium collected by $12 million, as shown in Table 22.

Table 22 – Micro-group Market Prospective Reinsurance Program Estimates

Reinsurance Costs and Funding	$ Million
Reinsurance Claims Cost	$ 23
- Carrier Premium	$ 11
Subtotal	$ 12

The funding to cover this shortfall could come from an outside source or from an additional assessment on the health insurance market. If the latter, and further assuming that this assessment applies to the same entities as the assessment for the Individual Market reinsurance program, this results in an additional $2 PMPM, applied to the Individual Small Group, Large Group and Self-insured Markets. If it is possible to target these subsidies to the micro-group market, premiums could decrease approximately 10%. This may be difficult since micro-groups are part of the Small Group Market, and it is unclear how the State could ensure that this subsidy mitigates just the micro-group premiums.

[28] The higher percentage of reinsured claims in the micro-group market is likely due to richer benefit designs.

5.4.3. Retrospective Reinsurance Program for the Micro-group Market

The total program cost for a retrospective reinsurance program using the PL90 plan design (in which the reinsurance program is responsible for 90% of annual paid claims between $7,500 and $32,500, and 100% of claims above $32,500) will be much higher than a prospective version. Every member with claims greater than $7,500 would be included in a retrospective program whereas only ceded members are eligible in a prospective program. A retrospective model under the PL90 plan design is an unrealistically generous program since the funding requirement would be extremely high. However, it provides an upper bound of various reinsurance program structures. We have estimated that a retrospective reinsurance program for micro-groups under a PL90 plan design would result in a funding requirement of $57 million. If reinsurance subsidies could be directed to the micro-group market, premiums could decrease by approximately 49%.

Table 23 – Micro-group Market Retrospective Reinsurance Program Estimates

Claims in Excess of	Claims Less Than	Percent Reinsured	Reinsurance Program Dollars Required ($ Million)	Estimated Premium Reduction	Assessment as a PMPM Charge	Assessment as a % of Premium
$5,000	$75,000	90%	$ 51	41%	$9	3%
$5,000	$50,000	80%	$ 41	33%	$7	2%
$5,000	$50,000	50%	$ 25	21%	$5	1%
$25,000	$100,000	90%	$ 20	16%	$4	1%
$50,000	$5,000,000	50%	$ 10	8%	$2	1%

Table 23 shows that a reinsurance program can be designed to meet either a funding goal or a premium reduction goal. These are just a subset of examples for the micro-group market.

5.4.4. Elimination of Group Size Adjustment in the Small Group Market

PL90 does not address group size adjustment in the Small Group Market. Insurers can continue to use these adjustments. The adjustment factors currently used by insurers result in premium adjustments ranging from a 15% discount to a 40% surcharge. In 2014, the ACA will no longer permit group size adjustments. This will affect groups differently based on whether they are smaller or larger groups. As shown in a previous analysis,[29] micro-groups will, on average, receive premium deceases and larger groups will experience premium increases under the ACA. We also modeled the effect of eliminating the insurer's ability to rate based on group size earlier than 2014. If this change were to occur in 2013, micro-groups would experience premiums on average about 10% lower than without this change, whereas larger groups will experience

[29] Gorman Actuarial, Smagula, Jenn, Gruber, Jon, "The Impact of the ACA on Maine's Health Insurance Markets", May 2011, Table 26

premiums between 2% and 7% higher, depending on group size, as shown in the last column of Table 24.

Table 24 – Premium Change due to Elimination of Group Size Adjustment

	Average Premium Change from Group Size Factor Elimination		
	% Members	% Groups	Elimination of Group Size Change Only
less than 6	30.5%	68.5%	-10.3%
6 to 9	15.8%	12.3%	2.1%
10 to 25	32.2%	13.7%	5.9%
25 to 50	21.5%	5.5%	6.8%
Total	100.0%	100.0%	0.0%

We estimated the funding level required to offset the increases to the larger groups to be approximately $18 million, or approximately 4% of the fully insured Small Group Market premium. One way to offset the $18 million is through a reinsurance program targeted towards the micro-groups. Table 25 shows examples of retrospective reinsurance programs for the micro-group market targeting expected costs of $18 million.

Table 25 – Micro-group Market Retrospective Reinsurance Program Estimates

Claims in Excess of	Claims Less Than	Percent Reinsured	Reinsurance Program Dollars Required ($ Million)	Estimated Premium Reduction	Assessment as a PMPM Charge	Assessment as a % of Premium
$5,000	$15,000	70%	$ 18	15%	$3	1%
$10,000	$25,000	85%	$ 18	15%	$3	1%
$15,000	$32,500	100%	$ 17	14%	$3	1%
$20,000	$50,000	100%	$ 18	15%	$3	1%
$25,000	$75,000	95%	$ 18	15%	$3	1%
$25,000	$100,000	80%	$ 18	15%	$3	1%

The $18 million funding could come from an outside source, or could be generated from an assessment on the health insurance market. If the latter and further assuming that this assessment applies to the same entities as the assessment for the Individual Market reinsurance program described in PL90, this would result in a 1% premium increase, or a $3 PMPM assessment.

6. Modifications to ACA Analyses

The Maine Bureau of Insurance (BOI) commissioned Gorman Actuarial and Dr. Jon Gruber to analyze the impact of various components of the Affordable Care Act (ACA).[30]

[30] Gorman Actuarial, Smagula, Jenn, Gruber, Jon, "The Impact of the ACA on Maine's health Insurance Markets", May 2011, Table 2

This analysis was completed prior to the implementation of PL90. The report was released in May 2011. This section highlights the changes to the original analyses in light of PL90.

6.1. Individual Market

6.1.1. Membership Projections

As described in earlier sections, PL90 introduces a reinsurance program to the Individual Market, allows insurers to temporarily maintain two rating pools, and expands the rating bands. Our results show that the overall Individual Market membership may increase 6% (approximately 2,200 members) between July 2012 and Dec 2013.

The ACA introduces premium tax subsidies, cost sharing subsidies and an individual mandate, which we projected in our May 2011 report to increase the Individual Market approximately 170% or about 95,000 members by 2019. We believe these estimates will not change as PL90 slightly accelerates the membership growth in the Individual Market but does not impact final membership projections.

We also assume the new membership growth will come from the uninsured population. In our May 2011 report, we estimated that the number of uninsured is projected to decrease by 60% or 69,000 Maine residents,[31] leaving 46,000 individuals still uninsured. PL90 does not affect our remaining uninsured estimate. However, since it does accelerate the Individual Market growth, some of this decrease in the number of uninsured will occur earlier with the bulk of the decrease, approximately 59% or 67,000 residents, occurring after the introduction of the ACA.

Due to the modest membership change in the Individual Market before 2014, we do not believe the ultimate morbidity of the Individual Market in 2019 will be substantially different than what we had predicted in our May 2011 report. Our overall conclusions are the same for the Small Group Market and therefore the results of many of our analyses in our original report remain unchanged. Sections 6.1.2 and 6.2.1 summarize the premium changes to the Individual Market and the Small Group Market due to the ACA. These premium changes are in addition to the PL90 premium changes.

6.1.2. Individual Market Premiums

Many changes will take place in 2014 that will affect premiums within the Individual Market. Some changes will affect portions of the Individual Market and others will affect the market as a whole. We focused our analysis on four categories of premium change, described below:

(1) **The impact of rating limitations:** PL90 has revised the rating bands and by 2014, will be more consistent with the ACA. Table 26 highlights the rating

[31] Ibid.

limitations required by PL90 in 2013 and 2014, and contrasts these limitations to the ACA. The last column shows our assumption on how insurers will be allowed to rate in 2014. PL90 allows the age band to be 4-to-1 for the open block in 2014 to the extent permitted by the ACA. That is, the highest rate due to age could be four times the lowest rate, if permitted under the ACA. The ACA allows the age band to be 3-to-1. Since the ACA is more limiting than PL90, we have assumed that the age band allowed in Maine will be 3-to-1 for the closed and open blocks in 2014. The closed block will experience an age band change from 2.5-to-1 to 3-to-1 in 2014. This expansion will increase rates for the old and decrease rates for the young. However, these premium changes will most likely be negated by the fact that the ACA will require the open and closed blocks to be merged into one rating pool. In addition, PL90 allows up to a 50% geographic adjustment.[32] There are no geographic rating limitations within the ACA. It is our assumption that Maine will continue with the 50% adjustment limit in 2014. The impact of rating limitations does not have a significant impact on overall average premiums in the Individual Market. However, there will be "winners and losers" within the market. As described in Section 4.1.3, if insurers choose to separate the closed and open blocks into two separate risk pools, the "winners" in 2014 could be the closed block and the "losers" could be the open block.

Table 26 – PL90 versus ACA Individual Market Rating Rules

Rating Factor	PL90-2013	PL90 - 2014	ACA	ME 2014
Age	3 to 1 for Adults - OB 2.5 to 1 for Adults - CB	4 to 1 for Adults - OB 3 to 1 for Adults - CB	3 to 1 Band for Adults	3 to 1 Band for Adults
Geography	up to 50%	up to 50%	No Limit	up to 50%
Smoking	up to 50%	up to 50%	up to 50%	up to 50%

(2) The impact of product limitations: While PL90 may decrease premiums, we do not believe it will have a significant impact on benefit offerings in the Individual Market. Some individuals may "buy up" and increase benefits due to the premium decreases, however, we believe this to be unlikely. While the essential benefits coverage under the ACA has yet to be defined, we believe benefits such as pharmacy and physician visits will be included. In addition, we believe that the minimum actuarial value allowed in 2014 will be 0.60. The exception to this is the catastrophic plan for the 18 to 30 year olds; we have assumed a minimum

[32] PL90 states that the rating factor for geographic area may not exceed 1.5. The Bureau of Insurance has interpreted this to mean that the rating factors must be within a 1.5-to-1 band.

actuarial value of 0.45 for this plan.[33] This will require the majority of the market to "buy up" and will therefore result in premium increases. However, along with premium increases comes more comprehensive health insurance coverage, as well as premium and cost sharing subsidies for those below 400% of the federal poverty level. We have estimated the premium impact due to product limitations to the entire Individual Market to be **33%**.[34] These results are no different from our May 2011 analysis of the ACA.

(3) The impact of sole proprietors exiting the Individual Market: Gorman Actuarial has received further clarification on whether the ACA defines the Small Group Market as 1 to 50 employees or 2 to 50 employees. We believe the Small Group Market will not include sole proprietors and therefore do not believe there will be a large migration of sole proprietors from the Individual Market to the Small Group Market. We believe there will be no premium impact to the Individual Market.

(4) The impact of the new exchange market: PL90 slightly accelerates the growth in the Individual Market with the healthiest risks coming into the market first. This will put a downward pressure on premiums. We have estimated that the resulting premiums will be lower than they otherwise would be by 3% to 5%, depending on enrollment and the health risk of the new entrants. However, in 2014, with the introduction of the individual mandate and the tax subsidies provided within the exchange, there will also be new Individual Market entrants. Many of these individuals will be lower-income and eligible for tax subsidies. These new Individual Market members will come primarily from the uninsured and to a lesser extent from employer sponsored insurance. These new members will have an impact on the existing Individual Market premiums and the magnitude of the impact will depend on how their risk profile compares to the risk profile of the Individual Market. Our May 2011 results showed that prior to PL90, the morbidity of the existing Individual Market and the new Individual Market due to the ACA were very similar.[35] However, with the passage of PL90, the Individual Market morbidity improves slightly creating a wider gap between the existing Individual Market and the new Individual Market due to the ACA. We find that premiums for the entire Individual Market may increase an additional **3.5%** compared to the changes that have already taken place due to PL90.

[33] Gorman Actuarial is unaware of any regulation or guidance pertaining to the Catastrophic Plan as allowed within the ACA. The 0.45 actuarial value limit is an assumption.

34 Gorman Actuarial, Smagula, Jenn, Gruber, Jon, "The Impact of the ACA on Maine's Health Insurance Markets", May 2011, Section 5.

[35] Our previous reported showed that the new Individual Market Risk Pool in 2019 would increase overall premiums in the Individual Market by 0.4%.

Overall, we find that the total premium impact to the Individual Market due to the ACA is approximately 38% over and beyond the impacts to PL90. In our May 2011 analyses, we had projected that premiums for the Individual Market would increase approximately 40%.[36] Due to the modest difference in outcome, there is no significant impact to our previous analyses on the ACA.

6.1.3. Federal Individual Market Transitional Reinsurance Program

We have assumed that PL90's Individual Market reinsurance program will be modified to serve as the Transitional Reinsurance Program under the ACA, which will apply to the Individual Market for the years 2014 – 2016. However, there is a risk in that the ACA program may not fully reduce overall premiums by 12% to 15% as we have projected for PL90. In our May 2011 analyses, we estimated that the ACA's Transitional Reinsurance Program could reduce premiums by 7% to 15% in 2014, decreasing to 3% to 5% in 2016.[37] These percentages are not incremental, and premium reductions decrease as membership grows in the Individual Market and the federal assessments decrease over a three-year period (nationally $10B in 2014, $6B in 2015, and $4B in 2016). If the ACA program does not maintain the same premium reductions as PL90 (12% to 15%), the Individual Market may experience additional premium shocks in later years. Maine may want to consider expanding the reinsurance program and increasing the assessment beyond the federal minimum to alleviate this premium shock.

6.1.4. Differences between Reinsurance Programs of PL90 and ACA

There are several differences between the reinsurance program detailed in PL90 and the program outlined in proposed federal rules for the Transitional Reinsurance Program under the ACA. We highlight some major differences:

- The main difference is that the PL90 reinsurance program is a prospective program, requiring the insurers to choose which members will be part of the program, whereas the federal program as proposed is a retrospective program using claims experience.
- A prospective program requires setting a member premium that insurers pay for each member ceded, whereas a retrospective program has no such component.
- The reinsurance program of PL90 begins July 2012 and has no end date, while the federal program begins January 2014 and ends in December 2016.
- The federal program as proposed places a cap ("ceiling") on the amount of annual claims covered by reinsurance for each individual. This puts the onus on the

[36] Gorman Actuarial, Smagula, Jenn, Gruber, Jon, "The Impact of the ACA on Maine's Health Insurance Markets", May 2011
[37] Gorman Actuarial, Smagula, Jenn, Gruber, Jon, "The Impact of the ACA on Maine's Health Insurance Markets", May 2011, Section 5.1

insurer to manage care efficiently for high-cost members. There is no annual cap in the PL90 program. It is possible states may request (and subsequently be granted) a waiver from the requirement for a cap.

6.2. Small Group Market

6.2.1. Small Group Market Premiums

Several changes will take place in 2014 that will affect premiums within the Small Group Market. Some changes will affect portions of the Small Group Market and others will affect the market as a whole. Please note that this modeling is performed on the total small group premium which includes both the employer and employee portions of the premium. We focused our analysis on four categories of premium change:

(1) **The impact of rating limitations:** PL90 has revised the rating bands and by 2014, they will be more consistent with the ACA. Table 27 highlights the rating limitations as required by PL90 in 2011 through 2014, and contrasts these limitations to the ACA. The last column shows our assumption on how insurers will be allowed to rate in 2014 in Maine. PL90 allows the age band to be 3-to-1 in 2014 which is consistent with the age band under the ACA. In addition, PL90 allows up to a 50% geographic adjustment.[38] There are no geographic rating limitations within the ACA. It is our assumption that Maine will continue with the 50% adjustment limit in 2014. Rating by industry and group size is allowed under PL90 but is not allowed under the ACA. Therefore we have assumed in 2014 that this will not be allowed for Maine. The impact of rating limitations does not have an impact on overall average premiums in the Small Group Market. However, there will be "winners and losers" within the market.

Table 27 – PL90 versus ACA Small Group Rating Rules

Maine Small Group Rating Rules					
	Oct 2011 - Dec 2012 (PL90_1)	Jan 2013 - Dec 2013 (PL90_2)	Jan 2014 - Dec 2014 (PL90_3)	Jan 2014 and beyond (ACA_1)	ME 2014
Age	2 to 1 band on group	2.5 to 1 band on group	3 to 1 band on group	3 to 1 band on adult factors	3 to 1 band on group
Geography	1.5 to 1 band	1.5 to 1 band	1.5 to 1 band	Allowed- No Limit	1.5 to 1 band
Industry	Allowed	Allowed	Allowed	Not allowed	Not allowed
Group Size	Allowed	Allowed	Allowed	Not allowed	Not allowed

The primary driver of the difference between the premium impact in the first two time periods under PL90 compared to ACA is the elimination of the group size rating. Table 28 shows the impact of the rating changes by group size.

[38] PL90 states that the rating factor for geographic area may not exceed 1.5. The Bureau of Insurance has interpreted this to mean that the rating factors must be within a 1.5-to-1 band.

Table 28 – Premium Change by Group Size under ACA[39]

Average Year to Year Premium Change* by Group Size			
Group Size	**% Members**	**% Groups**	**Jan 2014 and beyond (ACA)**
Less than 6	30.5%	68.5%	-10.1%
6 to 9	15.8%	12.3%	2.0%
10 to 25	32.2%	13.7%	5.6%
25 to 50	21.5%	5.5%	7.3%
Total	100.0%	100.0%	0.0%

*** Premium changes shown are only due to the ACA and do not reflect the impact of medical trend**

Currently, smaller groups are typically rated higher than larger groups within the Small Group Market. When group size rating is eliminated in 2014, the smaller groups will experience favorable premium impacts while the larger groups will experience a negative impact. Industry rating is also eliminated in 2014 under the ACA. This has a minimal impact as few insurers currently use industry rating in the Small Group Market.

(2) The impact of product limitations: Since we expect PL90 to have a minimal impact on overall premiums in the Small Group Market, we do not believe it will have a significant impact on benefit offerings in this market. While the essential benefits coverage under the ACA has yet to be defined, we believe benefits such as pharmacy and physician visits will be included. In addition, we believe that the minimum actuarial value allowed in 2014 will be 0.60. This will require some groups in this market "buy up" and will therefore result in premium increases. However, along with premium increases comes more comprehensive health insurance coverage, as well as tax subsidies for some small employers. Since there are few small employers with health plans having an actuarial value below 0.60, we have estimated the premium impact due to product limitations to the entire Small Group Market to be **1.1%.**[40] These results are no different from our May 2011 analysis of the ACA.

(3) The impact of sole proprietors entering the Small Group Market: Gorman Actuarial has received further clarification on whether the ACA defines the Small Group Market as 1 to 50 employees or 2 to 50 employees. We believe the Small Group Market will not include additional sole proprietors and therefore do not believe there will be a large migration of sole proprietors from the Individual Market to the Small Group Market. Therefore, we believe there will be no premium impact to the Small Group Market.

(4) The impact of the new exchange market: We expect PL90 to have no significant impact on the membership in the Small Group Market. However, in

[39] Premium changes shown are only due to the ACA and do not reflect the impact of medical trend.
[40] Gorman Actuarial, Smagula, Jenn, Gruber, Jon, "The Impact of the ACA on Maine's Health Insurance Markets", May 2011, Section 8.

2014, with the introduction of the subsidies provided for lower-income individuals within the exchange, some small employers will drop coverage to have their employees seek coverage within the Individual Market exchange, and some individuals will add coverage through their employers. The combined effect is a net decline in the Small Group Market. Dr. Gruber's modeling results estimate that the selection impact of this to be an approximate **6% to 7%** increase in premiums. These results are no different from our May 2011 analysis of the ACA.

Overall, we find that the total premium impact to the Small Group Market due to the ACA is approximately 7% to 8%. In our May 2011 analyses, we had projected that premiums for the Small Group Market would increase approximately 8% to 9%.[41] We do not consider this difference in outcome to be significant. Table 29 shows the distribution of premium impacts in 2014 as a result of ACA compared to PL90.

Table 29 – Distribution of Premium Impacts under ACA, Compared to PL90 (2014)[42]

Distribution of Expected Premium Change* Under ACA Compared to PL90			
Premium Change	% Members	% Groups	Average % Change compared to Prior Time Period
Less than -10%	8.5%	30.0%	-20.3%
-10% to -5%	1.6%	4.8%	-7.2%
-4.9% to 0%	1.1%	3.7%	-1.7%
0.1% to 5%	6.7%	9.9%	3.1%
5.1% to 10%	21.8%	21.6%	7.9%
Greater than 10%	60.4%	30.1%	14.7%
Total	100.0%	100.0%	7.7%

*** Premium changes shown are only due to the ACA and do not reflect the impact of medical trend**

6.3. Issues of Self-Insurance in the Group Market

6.3.1. Small Groups Self-Insuring

Gorman Actuarial surveyed many industry experts in Maine, including brokers, TPA's and insurers, to understand the likelihood of small employers self-insuring. There is evidence that small employers are showing increased interest in becoming self-insured. This would primarily include small groups with relatively healthy risk seeking ways to possibly decrease health care costs. While a self-insured small group runs the risk of a high-cost claim, this can be mitigated with stop-loss insurance. Also, these small groups can choose to return to the fully-insured market at any time given guaranteed issue in the Small Group Market. While our discussions with brokers indicate there is an interest

[41] Gorman Actuarial, Smagula, Jenn, Gruber, Jon, "The Impact of the ACA on Maine's Health Insurance Markets", May 2011, Section 8.
[42] Premium changes shown are only due to the ACA and do not reflect the impact of medical trend.

today, it is still not prevalent. However, there is a belief that this will become more prevalent over the next few years and the effects of the ACA may exacerbate this issue. The results of this occurrence may siphon the best risk out of the fully insured market leaving higher utilizers behind. This could impact overall Small Group Market premiums. Based on our modeling, if 5% of members in the lowest-costing groups choose to self-insure, this would increase Small Group Market premiums by 3%.

6.3.2. Large Groups (51 to 100) Self-Insuring

Currently, all insurers in the Maine Large Group (51 to 100) Market use some degree of experience rating when setting premiums for these employer groups. In 2016, the definition of Small Group will be expanded to include groups up to a size of 100 eligible employees. Therefore, in 2016, the Large Group (51 to 100) Market will no longer be allowed to use any sort of experience rating for these groups. It is most likely that the groups with better relative claims may choose to take advantage of their favorable experience by self-insuring, possibly prior to 2016 in anticipation of these changes. Conversely, employer groups with less favorable experience will choose to remain in the privately insured market to take advantage of adjusted community rating. Therefore, as groups self-insure, this leads to adverse selection and a deterioration of the claims pool. In 2009, the Maine Small Group and Large Group (51 to 100) Markets have similar morbidity. Therefore, as in our Small Group analysis, we can assume that if 5% of the Large Group (51 to 100) members in the lowest costing groups choose to self-insure, this could increase average premiums in the Large Group (51 to 100) market by 3%.

7. Conclusions

As PL90 implementation begins, the Individual and Small Group Markets will experience some market disruption. Many of the Small Group Market changes already took place in October 2011. While the majority of groups will experience relatively small impacts from PL90, some will experience greater premium changes. Seven percent of Small Group members will experience premiums that are more than 10% higher than what they would have experienced in the absence of PL90. Nine percent of Small Group members will experience premiums that are more than 10% lower than what they would have experienced in the absence of PL90. Coupled with annual medical trends of 10% to 15% and any demographic changes, there will be groups that may experience high double digit increases. The majority of the Individual Market may experience some premium decreases when PL90's Individual Market changes take effect in July 2012, but depending on how insurers rate their closed and open blocks of business, the Individual Market could experience significant volatility in price. In addition, the reinsurance subsidy for the Individual Market will have to be maintained each year, or there will be even greater price disruption. The results described in this report should be considered in the context of the results shown in our May 2011 analysis of the ACA.[43] Due to the

[43] Gorman Actuarial, Smagula, Jenn, Gruber, Jon, "The Impact of the ACA on Maine's Health Insurance Markets", May 2011

ACA, the Individual Market will likely experience significant growth. PL90 slightly accelerates this growth but does not significantly change the final outcome of the ACA.

8. Appendix

8.1. Limitations and Data Reliance

Gorman Actuarial prepared this report solely for the use of the Maine Bureau of Insurance. While we understand that this report may be distributed to third parties, Gorman Actuarial assumes no duty or liability to any third parties who receive this information herein. This report should only be distributed in its entirety.

Any user of this report must possess a reasonable level of expertise and understanding of healthcare, health insurance markets and financial modeling so as not to misinterpret the information presented. The report addresses certain provisions of PL90 and The Patient Protection and Affordable Care Act, but is not intended to act as an official or comprehensive interpretation of the statutes themselves.

Analysis in this report was based on data provided by insurers in the Maine health insurance markets. Gorman Actuarial has not audited this information for accuracy. We have performed a limited review of the data for reasonableness and consistency. If the underlying data is inaccurate or incomplete, the results of this analysis may likewise be inaccurate or incomplete.

The assumptions and projections included in this report are based on our understanding of PL90 and the ACA and associated regulations as of the report date. Future regulatory and legislative actions may significantly change the impact of the ACA and invalidate certain assumptions or projections presented in this report. Therefore this report should be considered time-sensitive and results may change as new information becomes available.

8.2. Qualifications

This report includes results based on actuarial analyses conducted by Bela Gorman and Jenn Smagula. Bela and Jenn are Members of the American Academy of Actuaries and Fellows of the Society of Actuaries, and meet the qualification standards for performing the actuarial analyses presented in this report.

8.3. Acknowledgements

We thank the Maine Bureau of Insurance for their support of this analysis and for providing important feedback during their review of the report. A special thanks to Rick Diamond, FSA who peer reviewed the actuarial components of our analysis. We would also like to thank the insurers for providing data upon which much of the analysis depends. The following business leaders gave generously of their time and provided insight on the Maine market:

- Joel Allumbaugh, Center for Health Reform Initiatives
- Michael Deschaine, Cross Insurance
- Alan Parks, Bay State Financial
- Scott Strout, Health Plans, Inc
- Jim Ward, Patient Advocates

8.4. Region Definitions

For analyses that considered geographic location, region definitions were based on the county mappings described in Table 30.

Table 30 – Maine Region Definitions

County	Region
Aroostook	North
Somerset	North Central
Piscataquis	North Central
Penobscot	North Central
Washington	Down East
Hancock	Down East
Oxford	Lakes & Mountains
Franklin	Lakes & Mountains
Kennebec	Lakes & Mountains
Androscoggin	Lakes & Mountains
Sagadahoc	Mid Coast
Waldo	Mid Coast
Lincoln	Mid Coast
Knox	Mid Coast
York	South
Cumberland	South