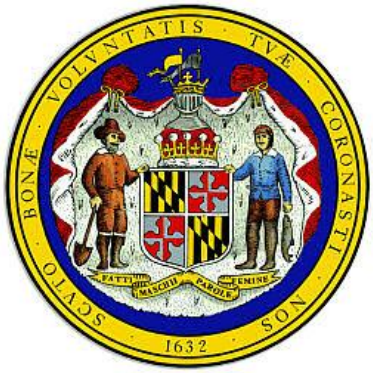
May 17, 2011

Recommendations to the Commissioner On Information Provided to Consumers

Maryland Insurance Administration



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Executive Summary

The Maryland Insurance Administration (the Administration) engaged Oliver Wyman Actuarial Consulting, Inc. (Oliver Wyman) to review information currently made available to consumers and recommend ways to improve it. This work was funded by a Premium Rate Review Grant awarded to the State by the US Department of Health and Human Services (HHS) under the Patient Protection and Affordable Care Act (Pub L. 111-148) (PPACA) and the Health Care and Education Reconciliation Act (Pub L. 111-152) (HCERA), collectively called the Affordable Care Act (ACA).

The Administration's goal for the project was to improve the transparency of the rate making and rate filing review process for consumers. In this report, we provide recommendations to the Administration to assist them in meeting this goal.

Our work began with a kick-off meeting at the Administration's office to discuss the project and its goals. We then reviewed information that the Administration currently shares with consumers. Our review covered the Administration's current website as well as existing brochures and outreach programs.

Next, we conducted background research on information other states provide to consumers regarding rate changes, the rate filing and review process, and key drivers of health care costs. We reviewed the type of information included on the other states' websites and performed legislative research on rate transparency issues. We also drew upon our knowledge from work we have performed or are performing for other states. We updated our legislative research just before releasing a draft version of this report in order to reflect recent actions taken by other states.

To test and validate our preliminary recommendations, we conducted focus groups consisting of consumers and small employers. Our review considered the need to reach all demographic groups of working-age residents throughout the State, including those whose first language is not English. Therefore, one of the focus groups consisted completely of consumers from this particular segment of the population. We prepared draft materials for the focus groups' review and comments, and asked participants to discuss the following topics:

- General impressions of health insurance rates and the market
- General awareness of the Administration and its role
- Notification of rate increase requests filed by health insurance carriers
- Notification of approved rate increases
- Notification of the Administration's decisions on health insurance rate increase filings
- Consumer input into the rate review process
- General information on the rate making and rate review process

We solicited the focus groups' input on each topic, including participants' opinions as to the most effective way this information could be made available to them. By far, the Internet was cited as the most effective way to share this information with consumers. We summarize the results of these focus group discussions in Chapter 4 of our report.

Finally, we provide our recommendations to the Administration in Chapter 5. We include a discussion of the resources that would be required to implement our recommendations. Following is a summary of our recommendations:

- Develop a separate area of the Administration's website dedicated to health insurance rates, within the "Consumer" tab of the current website.

- Post non-confidential portions of rate filings for the individual and small group markets subject to the ACA on the Administration's website for public viewing.

- Create a consumer-friendly summary for each individual and small group rate filing subject to the ACA and post it on the Administration's website.

- Create a consumer-friendly summary outlining the Administration's decision for each rate filing subject to the ACA and post it on the Administration's website.

- Post static information related to the rate making and rate filing review process in the new area of the Administration's website. (We provide several proposed pieces in various appendices of this report.)

- Consider creating brochures on the rate development and rate review process and placing them in locations frequented by consumers, as well as distributing them at outreach appearances.

- Further investigate the IT costs associated with developing and maintaining a bulletin board on the Administration's website where consumers can comment on pending rate increases. Internally discuss how the Administration would use the information gathered through consumer comments if such a bulletin board were developed.

- Survey carriers to determine the cost of enabling consumers to subscribe to receive e-mails when rate filings are submitted to the Administration.

- Research IT costs related to enabling consumers to subscribe to receive automated e-mails when the Administration posts rate filing notification summaries or rate increase decision summaries.

- Research the availability and skills of existing IT resources to determine whether they are sufficient to create and maintain the new portions of the website dedicated to consumer information for rate filings.

- Review and reassess current outreach programs.

We recommend implementing all of these changes as soon as reasonably possible, recognizing that some time may be required for website enhancement, and that legislation may need to be introduced so that rate filings can be made public.

Caveats and Limitations

A portion of our analysis and subsequent recommendations was based on draft regulations titled "Rate Increase Disclosure and Review" and corresponding draft consumer disclosure information. Our recommendations are based on the assumption that final regulations, once published, will not differ from these regulations in their current form. While minor changes may not affect our recommendations, more significant changes may.

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Introduction

On March 23, 2010, the Patient Protection and Affordable Care Act (Pub L. 111-148) (PPACA) and the Health Care and Education Reconciliation Act (Pub L. 111-152) (HCERA) were signed into law. Collectively, they are called the Affordable Care Act (ACA). One goal of this legislation is to increase the transparency of the rate making and rate filing processes to consumers. The Maryland Insurance Administration ("the Administration") has engaged Oliver Wyman Actuarial Consulting, Inc. ("Oliver Wyman") to review current information available to consumers and to recommend ways to improve it. This work was funded by a Premium Rate Review Grant awarded to the State by the federal Department of Health and Human Services (HHS) under the ACA.

The Administration's goal for the project was to find ways to improve the transparency of the rate making and rate filing review process. We were asked to review the information that is currently available to consumers and to present recommendations on improving and expanding communications regarding the rate making and rate filing processes. These processes include complex actuarial concepts that are often viewed as foreign by the general public. The challenge is to translate these concepts into clear terms for the consumer while maintaining accuracy. To test and validate our recommendations, we conducted focus groups consisting of consumers and small employers. Our review considered the need to reach all demographic groups throughout the State, including those whose first language is not English.

This report presents the results of our work and contains five chapters and several appendices. The first chapter consists of the executive summary. This introduction serves as the second chapter. Chapter 3 provides background research on information currently available to consumers in Maryland and other states, as well as recent legislative activity in various states intended to increase the transparency of the rate review process. In Chapter 4, we summarize our findings from the consumer and small employer focus groups. Finally, Chapter 5 provides our recommendations, including a discussion of staffing and other resources that would be required to implement our recommendations.

This report was prepared for the sole use of the Maryland Insurance Administration. All decisions made in connection with the implementation or use of advice or

recommendations contained in this report are the sole responsibility of the Administration. This report is not intended for general circulation or publication, or for any purpose other than those that may be set forth herein or in the definitive documentation pursuant to which this report has been issued. This report is intended to be read and used as a whole and not in parts.

There are no third party beneficiaries with respect to this report, and Oliver Wyman does not accept any liability to any third party. In particular, Oliver Wyman shall not have any liability to any third party in respect of the contents of this report or any actions taken or decisions made as a consequence of the results, advice, or recommendations set forth herein.

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Background and Research

The ACA's Focus on Transparency

In most states today, little information is made public about the factors and processes involved in developing rate increases. Consequently, people enrolled in health insurance plans often lack the tools and information they need to understand why their rates have increased, and whether the increases are justified. This lack of transparency and information limits consumers' ability to make fully informed decisions when purchasing health insurance.

One goal of the ACA's insurance disclosure requirements is to make the health insurance market more consumer-friendly and transparent, enabling consumers to better understand and compare health insurance options. Starting later this year, the ACA will require carriers to submit "preliminary justification" for rate increases for non-grandfathered policies[1] that exceed a given threshold (10% for 2011). HHS will post this information on its website immediately upon receipt; carriers will also be required to post the information on their website. The preliminary justification is intended to provide consumers with a thorough description of the rate increase, including the factors and experience that the carrier cites to justify the increase. This justification will include two parts, as described below:[2]

- **Part I Justification: Rate Increase Summary –** This summary must contain data and a quantitative analysis of the increase, including the following:

  - Historical and projected claim experience
  - Trend projections related to utilization, and service or unit cost
  - Any claim assumptions related to benefit changes
  - Allocation of the overall rate increase to claim and non-claim costs
  - Per-enrollee, per-month allocation of current and projected premium

[1] Technically, this rate filing portion of the ACA applies only to non-grandfathered plans. Rates for grandfathered plans do not have to be submitted to HHS.

[2] These requirements are based on the *draft* rate review regulation published by HHS. The final regulation could modify these requirements.

- Current and projected loss ratio
- Three-year history of rate increases for the related product [3]
- Employee and executive compensation data from the health insurance issuer's annual financial statements

- **Part II Justification: Written Description Justifying the Rate Increase** – This written description of the rate increase includes an explanation of the rating methodology, the most significant factors prompting the rate increase, and the policy's overall experience.

In addition, HHS has made grant money available to states for increasing public awareness and information about health insurance premiums. Many states have begun to use this money to gather input on the type of information that consumers would find valuable, and the type of input they would like to have in the rate review process. Some states have recently passed laws and are beginning to implement new processes to meet these consumer demands and share this information.

Many believe that increased scrutiny of the rate development process by consumers and advocacy groups could help drive change to lower premiums and increase competition. While consumers may only voice their concerns over large rate increases, advocacy groups might have the resources to hire independent actuaries to scrutinize rate development. In 2010, some insurers reduced or withdrew proposed rate increases in response to public hearings. On the other hand, some people are concerned that there will be public pressure to make rates "too low," thereby jeopardizing the solvency of insurance carriers or forcing some out of the market.

Any process that raises the costs of implementing a rate increase or introduces more risk to insurance carriers (for example, by extending the time required to get a rate increase approved) could result in upward pressure on rates over the long term. Either situation could adversely affect consumers in the long run.

Information Currently Available to Consumers in Maryland

Maryland currently offers a great deal of information to consumers regarding many facets of insurance. However, virtually no information is shared regarding how rates are developed or how the Administration reviews them. Following are some examples of the general information provided today.

- Tips for purchasing insurance
- Information on how the Administration can assist consumers (e.g., consumer complaints, appeals)

[3] This presents a conundrum – the rate filing requirements apply only to non-grandfathered plans, whose earliest effective date could be March 23, 2010. Therefore, three years of history solely for non-grandfathered plans will not be available until 2013. Since the rates for non-grandfathered plans are based on the experience and rates for grandfathered plans, at least initially, we assume the three-year history requirement is meant to include experience for grandfathered plans. It is unclear how this would withstand any legal challenge.

- A listing of carriers licensed to sell insurance in Maryland
- A summary of complaints against carriers
- Market share and loss ratio information by carrier

Maryland does not currently provide:

- Online access to rate filings
- Notification to consumers when carriers request rate increases
- Information regarding how the Administration reviews rate increase requests and determines approved rate increase amounts
- General information on how health insurance rates are developed

Information Currently Available to Consumers in Other States

States vary significantly in the amount and types of information they share with consumers regarding the rate review process. We reviewed several states' websites and other information sources in an attempt to answer the following questions:

- Does the state notify the public when a rate increase is filed?
- Can copies of rate filings be accessed electronically?
- Are consumers allowed to post comments on rate increase requests under review by the state?
- Can consumers subscribe to receive e-mail alerts or updates on carriers' pending rate increase requests?
- Does the state notify the public of the amount of rate increase approved for a given request?
- Does the state post a summary of its decision for each rate increase approved?
- Are public hearings held on rate increase requests?
- Is a description of the state's rate review process available?
- Does the state's website contain a "frequently asked questions" (FAQ) section with general information on health insurance?
- Does the state's website include a description of how health insurance rates are developed?
- Are reports posted detailing premium market share by carrier?
- Are reports posted detailing loss ratios by carrier?
- Is information available on mandated benefits?
- Is a glossary of insurance terms available?
- Does the state's website have a link to a separate section dedicated to health care reform?
- Are consumer tips available for purchasing health insurance?
- Is a listing provided of carriers licensed to sell insurance in the state?

The table on the following page summarizes our findings. While the general information that Maryland provides consumers on health insurance and insurance carriers is

consistent with many other states', Maryland currently does not provide consumers with the depth or quantity of information on rate filings and rate development that some other states do. As a result, consumer involvement in Maryland's rate review process is substantially lower than in these other states.

Type of Information	***Maryland***[4]	***Oregon***[5]	***Colorado***[6]	***Maine***[7]	***Florida***[8]	***Connecticut***[9]	***South Carolina***[10]	***Virginia***[11]	***Washington***[12]	***Rhode Island***[13]
Post Notice of Rate Increase Filed		X		X	X	X	X		X	X
Post Copy of Rate Filing		X		X	X	X				X
Allow Consumers to Post Comments on Rate Filings		X				X				
Allow Consumers to Subscribe to Email Updates on Rate Filings		X								
Notification of Approval Posted		X			X	X	X		X	X
Post Summary of State's Decision on Rate Increases On-Line		X		X		X				X
Regular Public Hearings on Rate Filings				X	X					X
Describe State's Rate Review Process		X	X	X		X				X
General Information on Health Insurance (FAQ)	X	X	X	X	X	X	X		X	
General Information on Rate Making Process		X		X		X			X	
Company Specific Market Share Reports	X	X		X	X	X	X		X	X
Company Specific Loss Ratio Reports	X	X		X	X				X	X
Information on Mandated Benefits	X	X				X				
Glossary of Insurance Terms	X	X	X	X		X	X	X	X	
Separate Page Dedicated to HCR	X	X	X	X		X	X	X	X	X
Tips/Guide for Purchasing Health Insurance	X	X	X	X	X	X	X	X	X	
Listing of Licensed Carriers	X		X	X	X		X	X	X	

[4] http://www.mdinsurance.state.md.us/sa/jsp/Mia.jsp
[5] http://www.cbs.state.or.us/external/ins/index.html
[6] http://www.dora.state.co.us/insurance/
[7] http://www.maine.gov/pfr/insurance/
[8] http://www.floir.com/
[9] http://www.ct.gov/cid/site/default.asp?ctportalPNavCtr=|27192|#45066
[10] http://doi.sc.gov/Pages/default.aspx
[11] http://www.scc.virginia.gov/boi/index.aspx
[12] http://www.insurance.wa.gov/
[13] http://www.dbr.state.ri.us/

Recent Regulatory Action Affecting Consumer Transparency

In addition to states such as Connecticut, Oregon, and Rhode Island (which already had processes in place), many other states have passed laws, have held public hearings, or are taking other actions to move toward a more transparent rate review process since the ACA's passage. Following is a summary of the most recent actions taken:

Arizona

The Arizona Department of Insurance held three public hearings (on January 4, 12, and 18 of this year) to increase public awareness and information about health insurance premiums and to identify consumers' concerns about health insurance premiums.

California

On September 30, 2010, Governor Schwarzenegger signed into law SB 1163,[14] which requires a 60-day public notice of rate increases and requires health plans to inform the public about their rating methodology. In addition, all rate filings must be accompanied by a "Plain-Language Rate Filing Description." Results of the rate reviews are posted on the appropriate regulator's website for public access. Almost all supporting experience, with the exception of provider contracts, is included in the public posting. SB 1163 requires an actuarial certification from an independent actuary to be included with any filing, indicating that the rate increase is actuarially justified.

Connecticut

As of this report's publication date, Senate Bill 11[15] is being debated in Connecticut. If passed, the bill would improve transparency in the approval process for health insurance rate increases. Among other items, it would require notice to policyholders when a rate increase is requested and provide for a public comment period before an increase is approved.

Nevada

Assembly Bill 309 was introduced in January 2011. As of this report's publication date the bill has passed the Assembly and has been forwarded to the Senate. If it is passed, rate increase requests and supporting data will be posted on the Department of Insurance website and the insurer's website for 30 days before approval. Carriers would be required to post premium, projected loss ratio, and actual loss ratio information on their website. It would also allow the public to request a rate hearing for any rate change over 10% or for plans that represent more than 5% of the market segment.[16]

[14] http://www.leginfo.ca.gov/pub/09-10/bill/sen/sb_1151-1200/sb_1163_bill_20100930_chaptered.pdf

[15] http://www.cga.ct.gov/2011/FC/2011SB-00011-R000203-FC.htm (Accessed May 17, 2011)

[16] http://www.leg.state.nv.us/Session/76th2011/Bills/AB/AB309.pdf

New Mexico

On April 7, 2011, Governor Martinez signed into law SB 208.[17] Following are some of the key aspects of SB 208 that relate to increasing transparency:

- Strengthening transparency to help consumers understand rate increases, by collecting data and disclosing facts to the public about a carrier's past and present practices in plain language on an Insurance Division website.
- Creating new avenues for consumer participation and representation in the rate review process, including a 30-day comment period and the right of policyholders to request a hearing on a Superintendent's decision regarding a rate increase.

Oklahoma

On January 18, 2011, Senate Bill 354[18] was introduced to the State Legislature. If passed, the bill would require the State Insurance Department to post premium rate filings (along with consumer-friendly summaries) on its website. The summary would explain changes in rates and actuarial values, anticipated impact on premiums, and any other information the Department deems necessary. Any justification for the proposed rate increase provided by the insurer would also be disclosed on the Department's website. It appears that the scope of this proposed law is limited to individual policies and does not include rate filings for small or large employers.

Washington

On April 13, 2011, HB 1220[19] passed the State Legislature and Governor Gregoire signed the bill into law on May 11, 2011. The law becomes effective July 1, 2011and will:

- Require that health insurance rate filings be made available to the public. Actuarial formulas, statistics, and assumptions will remain confidential in order to preserve trade secrets and prevent unfair competition.
- Require the Commissioner to prepare a standardized rate summary form to explain his or her findings after the rate review process is complete. This summary form will have to be included as part of the rate filing electronically available to the public.

As mentioned previously, Maryland does not make rate filing information as accessible to consumers as some other states, or as transparent as the ACA may hope to make it through reforms.

Pros and Cons of Making Rate Filing Information Public

There has been much debate as to whether the information included in rate filings should be shared with the public. The preceding section showed the types of information being

[17] http://www.nmlegis.gov/Sessions/11%20Regular/final/SB0208.pdf

[18] http://newlsb.lsb.state.ok.us/BillInfo.aspx?Bill=sb354 (Accessed May 17, 2011)

[19] http://apps.leg.wa.gov/documents/billdocs/2011-12/Pdf/Bills/House%20Passed%20Legislature/1220-S.PL.pdf

made available today (or scheduled to be made available) in some other states, with the goal of increasing the transparency of the rate filing process. The information in rate filings is actuarially technical in nature, and the average consumer probably will not be familiar with the terms and concepts used. More consumer-friendly summaries would need to be developed to "translate" the technical jargon. Another issue that the Administration would need to address involves the types of information that carriers deem to be proprietary (and the process to use to determine whether the information should be kept confidential). There is always a delicate balance between protecting information that is truly proprietary and satisfying the public's need to know.

We discuss the pros and cons of making rate filing information public from the perspective of the consumer and the Administration.

The pros of making rate filing information public include the following:

- One of the ACA's major goals is to increase transparency in the insurance industry. Sharing rate filing information with the public is consistent with this goal.
- Increasing transparency of the rate filing and approval process could increase consumer awareness of the Administration's role in ensuring that policyholders pay premiums that are reasonable in relation to the benefits they receive.
- Information would be available to consumer advocacy groups; they could choose to act on the policyholders' behalf in public hearings or voice concerns to the Administration.
- Consumers would have the information and the tools to better understand why their rates increase and whether increases are justified. This would improve their ability to act as educated consumers when deciding on health insurance purchases.
- There are ways to protect information that carriers and the Administration deem proprietary and still share major portions of filings with the public.
- Requiring carriers to support requests for confidentiality of data would not create an unreasonable burden, relative to the benefit gained by consumers.
- Carriers could view the opportunity to justify their proposed rate increases as a way to improve the public's knowledge regarding the costs of health care in general and the drivers increasing these costs – some of which the consumers can control. Similarly, carriers could be able to show that some concerns (for example, the concern that executive compensation is driving rate increases) are not accurate.
- Increased scrutiny of proposed rates by consumers and other stakeholders could result in lower rate increases, by putting additional pressure on carriers to reduce costs where possible.

The cons of making rate filing information public include the following:

- Keeping information confidential may increase carriers' willingness to provide more detailed information in their rate filings, allowing the Administration to assess the reasonableness of the rates at a more detailed level. Carriers might not provide the same level of detail if their filings would be made public.

- Mandatory disclosure of trade secrets might lead to unfair or reduced competition.
- A process would need to be established to determine what type of information (if any) should be deemed proprietary. This would require additional resources and could lengthen the rate review process – which, in turn, could put upward pressure on rates. This could also require legislative action.
- The average consumer would not possess the actuarial knowledge to properly assess the information included in rate filings – which could result in their arriving at inaccurate conclusions. Developing a consumer-friendly explanation of each filing could *help* to overcome this, but would not do so entirely and would require additional time and resources on the Administration's part. The ongoing time could perhaps be reduced if resources were used to set up a highly automated process or if the Administration required carriers to produce the information in a specified way.
- To create, maintain, and update an Internet site associated with rate filings, the Administration would have to bear costs covering a multitude of skills, including IT/web development, administration, and actuarial analysis.
- Increased transparency could introduce a new level of politics into the rate filing process. As a result, carriers could feel pressure to consistently file rates that are less than adequate, and/or regulators could feel pressure to approve rates that are consistently inadequate. It is politically difficult for any regulator to require a carrier to use rates that are higher than those requested, and there could be new political pressures for regulators to consistently reduce requested rate increases. Yet, if rates were inadequate over the long run, the carriers' solvency would be jeopardized – which would be harmful to both consumers and providers.

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Consumer Focus Groups

We conducted a series of focus groups so we could establish a "baseline" for consumers' current awareness of the following:

- The Administration in general
- The resources it provides to consumers regarding health insurance premium rates
- The Administration's role in the rate approval process
- Consumers' desire to have access to more information
- The type of information consumers believe would be helpful to them

We also showed the focus groups several drafts of proposed communications to gauge their clarity, readability, and usefulness. The focus groups provided input regarding the best means of disseminating information to consumers. We have incorporated the results of the focus groups in formulating our recommendations to the Administration that appear later in this report.

The focus groups were held March 7 and 8 and consisted of Maryland residents and small businesses domiciled in Maryland. In all, we conducted five focus groups. Three consisted of individual consumers, and two consisted of small employers. Of the three individual consumer groups, one was targeted to include people whose first language was not English. The English as a second language (ESL) group was included so we could identify any special needs that this group of consumers may have.

Focus Group Participants

We engaged a research firm in Bethesda, Maryland, that specializes in conducting focus groups. The firm recruits participants and provides facilities for the focus group sessions. In addition, we contracted a professional moderator to run the focus group sessions. Since the HHS rules to date have concentrated on individual and small group premium rates, we wanted the focus groups to represent consumers in these markets and also not be skewed by any relationship with the health insurance industry. Therefore, we excluded State and federal employees, people who work in the health insurance or health care field, people covered by Medicare or Medicaid, and anyone who had not had health insurance coverage at some point during the past five years.

For the ESL group, we excluded people who did not read any English, as one goal of our research was to gain feedback on material that would be provided to consumers in print format (in English). From this population of consumers, we requested that the mix of individuals by age, gender, ethnicity, and marital status be as representative as possible of the commercial insurance market in Maryland. Appendix A of this report contains the call screen used to recruit these people

For the small employer focus groups, we provided additional criteria in the selection process:

- We excluded businesses that were associated with the insurance industry, beyond simply purchasing insurance.
- We included small employers that had offered health insurance coverage to their employees at some point during the past five years, and had contributed at least a portion of the premium.
- We sought out individuals who are responsible for making their company's decisions related to health insurance purchasing choices.
- We included only businesses with two to 50 employees, and aimed for a mix of employer group sizes within this constraint.

Appendix B includes the call screen used to recruit these small employer groups.

Only Maryland residents and small employers were recruited.

Focus group participants were recruited over the two-week period before the focus group sessions were held. We targeted eight to nine people for each consumer focus group and six businesses for each small employer focus group. Knowing that not all of those recruited would show up, the independent research firm recruited 12 people for each consumer focus group and eight businesses for each small employer focus group. We realized our target participation levels for all of the groups.

Focus Group Participant Demographics

Appendix C contains the detailed demographic information for the people who participated in the consumer focus groups and the businesses that participated in the small employer focus groups. For the consumer groups, we show age, gender, ethnicity, marital status, occupation, and insurance coverage information. For people who participated in the ESL consumer group, we also show primary language. While much of the demographic information was gathered during the screening process, the individual's occupation and insurance coverage information was gathered during the focus group sessions, to the extent possible.[20] Some individuals did not share this information during the sessions; for those people, the information is presented as "unknown" in Appendix C.

[20] While the format of the focus group was organized in general, there is a balance between getting each person to freely share information and strictly adhering to a general structure. Therefore, in some instances a person may have shared some (but not all) of the information regarding occupation and/or insurance. The moderator used her judgment

For the small employer groups, Appendix C shows the type of business, number of employees, gender of the participant (in most cases the business owner), amount that the employer contributes toward the premium for employees, and health insurance carrier. While we targeted small employer groups that had offered health insurance coverage to their employees at some time during the past five years (i.e., they did not currently have to offer coverage), all 14 of the small employers participating currently offer coverage to their employees.

Other than the group size range (number of employees) and the gender of the individuals participating in the focus group on behalf of the small employers, the information in the table in Appendix C was gathered during the focus group. As with the individual consumers, some employers did not share the name of the insurance company that currently covers them. For these employers, this information is presented as "unknown" in Appendix C.

The following sets of tables compare the distributions of various demographic characteristics of the focus groups to the distributions of analogous demographic characteristics for Maryland's general population. From this, we were able to ascertain how well our sample population in the focus groups represented Maryland's population.

Gender

The first comparison reflects the distribution by gender.

Distribution by Gender
Focus Groups vs. Maryland

	Male	Female	Male	Female
Consumers	7	11	39%	61%
ESL Consumers	4	5	44%	56%
Small Employers	9	5	64%	36%
Total	20	21	49%	51%
Maryland			49%	51%

Source: U.S. Census Bureau, 2009 American Community Survey

The table above shows that overall, roughly half of the participants were male and half were female. Using statistics from the U.S. Census Bureau's 2009 population estimates,[21] the table also shows that the focus group sample in total had the same distribution by gender as Maryland's general population.

when pursuing follow-up questions to ensure that the person would feel comfortable actively participating in the ensuing discussions.

[21] http://quickfacts.census.gov/qfd/states/24000.html (Accessed May 17, 2011)

Age

The following chart shows the number of participants by age only for the consumer groups.[22]

Participants by Age - Focus Groups

	26-30	31-40	41-50	51-64
Consumers	3	7	3	5
ESL Consumers	2	4	2	1
Total	5	11	5	6

The next chart shows the distribution of the focus group participants by age versus the distribution by age of Maryland's general population ages 26 through 64.

Distribution by Age
Focus Groups vs. Maryland Population

	26-30	31-40	41-50	51-64
Consumers	17%	39%	17%	28%
ESL Consumers	22%	44%	22%	11%
Total	19%	41%	19%	22%
Maryland *	13%	25%	29%	33%

*http://www.census.gov/popest/states/asrh/files/SC-EST2009-AGESEX-RES.csv

This shows that the focus group participants were slightly younger than the population in general; however, we do not believe that the age distribution differed significantly enough to affect the results of our research. One cause for a slightly younger population could be the exclusion of individuals employed by the State or federal government. These employers may have a higher percentage of older workers. Also, State and federal employers commonly provide some type of subsidized retiree health benefits, and one of the criteria for the consumer focus group was to have as many participants as possible who directly purchased their own insurance. (This would reduce the number of individuals in the 51-64 market available to the focus groups.) People who are employed through government agencies enjoy higher subsidies from their employers and are not the general focus of the reform transparency goals for premium rate development and increases. Focus is instead placed on the individual and small group markets.

Ethnicity

The following chart shows the number of consumer focus group participants by ethnicity.

Participants by Ethnicity - Focus Groups

	African American	Asian	Caucasian	Hispanic	Other
Consumers	5	0	13	0	0
ESL Consumers	1	1	1	5	1
Total	6	1	14	5	1

The next chart shows the distribution by ethnicity of the focus group participants compared to Maryland's general population.

[22] This chart does *not* include statistics for the ages of the small employers.

Distribution by Ethnicity - Focus Groups
Focus Group vs. Maryland

	African American	Asian	Caucasian	Hispanic	Other
Consumers	28%	0%	72%	0%	0%
ESL Consumers	11%	11%	11%	56%	11%
Total	22%	4%	52%	19%	4%
Maryland *	29%	5%	57%	7%	2%

Source: U.S. Census Bureau, 2009 American Community Survey

The ethnicity of the focus groups reflected about the same distribution as Maryland's general population. The Hispanic population was slightly over-represented; this was likely a result of the desire to recruit individuals with English as a second language in one of the three consumer focus groups. In general, we believe the focus group participants fairly represented the mix of Maryland residents by ethnicity.

Insurance Status and Source

The following chart shows the number of participants in the consumer focus groups based on their insurance status and, if they were insured, the source of their insurance (individual or purchased through an employer).

Participants by Source of Insurance

	Private	Employer	Uninsured
Consumers	8	8	2
ESL Consumers	2	6	1
Total	10	14	3

The next chart shows the distribution of individuals by source of insurance in the focus groups and in Maryland's general population. We used information from Kaiser's State Health Facts that showed insurance status for adults age 19 to 64 in 2009.[23] We excluded individuals covered by any form of public insurance or insurance offered by the federal government (e.g., Medicaid, Medicare, FEHBP) from the Kaiser data, leaving only those with individual or employer coverage, and those who are uninsured.

Distribution by Source of Insurance
Focus Groups vs. Maryland

	Private	Employer	Uninsured
Consumers	44%	44%	11%
ESL Consumers	22%	67%	11%
Total	37%	52%	11%
Maryland *	6%	75%	19%

* http://www.statehealthfacts.kff.org/profileind.jsp?ind=130&cat=3&rgn=22&cmprgn=52

The focus groups' distribution between people with health insurance coverage and people without it is about the same as the distribution within Maryland's general population.

[23] http://www.statehealthfacts.kff.org/profileind.jsp?ind=130&cat=3&rgn=22&cmprgn=52 (Accessed May 17, 2011)

However, among the population that currently has health insurance coverage, the focus group had a much higher percentage that purchased coverage themselves through the individual market as opposed to receiving coverage through their employer. This is partly attributable to the criteria used to select the focus group participants. As indicated by the call screen in Appendix A, we targeted half of the consumer focus group participants to have individual insurance and the other half to have employer coverage. Increased transparency is directed toward the individual and small group market. Therefore, we wanted to ensure that we had enough people with individually purchased insurance in the consumer groups.

Since the focus group members were more likely to pay for health insurance coverage themselves, they may have been slightly more engaged and shown more interest in understanding what is driving increases in health insurance premium rates than Maryland consumers in general. In addition, the call screen specifically asked potential participants if they were interested in knowing more about how insurance rates are developed and the role the State plays in approving rates. If they answered "no," they were not recruited to participate. Given the purposes of our research, it is preferable to have this segment over-represented, since our group likely contained more consumers who are making the insurance purchasing decisions than in the general population – and who are the primary target for increased transparency.

Distribution by Insurance Carrier

The chart below shows the number of participants who were covered by the following carriers.

Participants by Insurance Carrier

	Aetna	CareFirst	Guardian	Kaiser	UnitedHealthcare	Unknown
Consumers	2	6	0	3	2	1
ESL Consumers	1	5	1	0	0	1
Small Employers	0	7	0	1	2	4
Total	3	18	1	4	4	6

The next chart shows the distribution of participants by insurance carrier.

Distribution by Insurance Carrier
Focus Groups vs. Maryland

	Aetna	CareFirst	Guardian	Kaiser	UnitedHealthcare	Unknown
Consumers	14%	43%	0%	21%	14%	7%
ESL Consumers	13%	63%	13%	0%	0%	13%
Subtotal Consumers	14%	50%	5%	14%	9%	9%
Small Employers	0%	50%	0%	7%	14%	29%
Total Focus Groups	8%	50%	3%	11%	11%	17%
Maryland *	10%	59%		9%	13%	

* http://dhmh.maryland.gov/healthreform/pdf/Exchange/100810insurancemarketpp.pdf

No direct comparison could be made between the focus groups and the Maryland population based on insurance carrier. As mentioned previously, not all focus group

participants shared information related to their current insurance carrier. These individuals appear in the "Unknown" column for the rows representing the focus group participants. However, despite these inconsistencies in reporting, the distribution of focus group members with current health insurance coverage appears reasonably consistent with the Maryland market in general.

Small Employer Focus Groups – Group Size and Employer Contribution

We included two additional statistics for small employer groups: group size and employer contribution.

The following chart shows the distribution of groups by number of employees (group size).

Small Employer Focus Groups
Distribution by Group Size

Group Size (No. of EEs)	Groups
2 - 5	29%
6 - 10	29%
11 - 20	7%
21 - 30	7%
31 - 40	14%
41 - 50	14%

The next chart shows the distribution of employers by the percentage of total premium the employer contributes. In the "100% Single" category, the employer pays 100% of the cost for the employee only to purchase insurance. The employer does not contribute anything toward the additional cost of dependent coverage.

Small Employer Focus Groups
Distribution by Employer Contribution

Employer Contribution	Groups
50%	21%
60%	7%
70%	7%
100%	21%
100% Single	36%
Flat $	7%

We were unable to find comparable statistics for Maryland's general population for either of these items. However, in our experience working with insurers and other state regulatory agencies, these distributions appear to be reasonably representative of the small group market in general. We note that the distribution by group size results in an average group size of 18 employees. This is much higher than the average group size of about seven employees that we typically observe in the small group market. However, even though the small employers in the focus groups represented slightly larger small

groups, we believe that their concerns related to health insurance premiums, the role the Administration plays in regulating insurers, and consumer disclosure are similar to those of the Maryland small group market in general.

Demographics Overall

The statistics provided in this section indicate that the demographics reflected in the focus groups are representative of the population targeted to benefit most from the ACA's goal of improving transparency in the premium rate development and review processes. We have every reason to believe that the input provided by the focus groups will reflect the concerns of the consumers who purchase individual and small employer insurance in Maryland.

Consumer Input Obtained from Focus Groups

In this section, we summarize the results of the information gathered from the focus groups. Before the focus group sessions were held, we developed a guide that included a series of questions and topics we wanted to be discussed, organized under the following five general topics:

- Consumer expectations about health insurance premiums
- The Maryland Insurance Administration
- Access to information about health insurance
- Consumer notification of rate increases for health insurance
- Development of health insurance rates

For each topic above, several subtopics were developed and questions were posed to the focus group participants to facilitate further discussions. For some of the topics, participants were shown draft versions of what were presumed to be consumer-friendly materials to review. These materials were examples that the Administration could post on its website or include in brochures that would be distributed to consumers. Participants were asked to make comments directly on the draft materials and to discuss aspects that were clear and understandable, as well as suggest areas for improvement. Participants were asked to focus on the content of the materials and to note how easy or difficult they were to read and understand.

Consumer Expectations About Health Insurance Premium Rates

After introductions were made and background information was shared, participants were asked to discuss their general observations related to health insurance premiums and rates. Almost unanimously, participants agreed that rates were going up by 10% to 15% per year. They indicated that rates increased with age and agreed it was reasonable to expect that they would, given that individuals use more medical services as they age. More than one participant also commented that their cost sharing (i.e., deductible, copayments) and/or the amount that they were asked to contribute toward their employer-sponsored insurance had been increasing rapidly in recent years.

When asked if rates for health insurance should increase each year, respondents agreed that it was reasonable to expect that they should, given the cost of yearly medical care increases. A few respondents, however, commented that they did not understand why health insurance premiums were going up so much faster than general inflation. One participant felt that rate increases should be capped at the increase in the cost of living or some other measure of inflation. Another felt health insurance premium increases were not correlated with the rate at which providers increase their fees, and others agreed. These comments appear to indicate that consumers may not understand the many other drivers of premium rate increases other than increases in provider costs (such as increases in the use of services, deductible leveraging, and new technology).

Drivers of Rate Increases

Participants were next asked to discuss what they felt were the drivers of health insurance premium rate increases. A variety of responses were provided by each group; however, the following list reflects the most common responses from the focus groups, including both consumers and small employers.

- Increases in physician and hospital fees
- Significant increases in the cost of pharmaceuticals
- Aging of the population
- Cost of malpractice lawsuits
- Profits demanded by the insurance industry

A few participants from different consumer groups commented that they did not feel insurance companies should make any profit. It was apparent that they considered any money left over after paying claims and expenses to be profit, and that they did not understand the concept of solvency or the fact that these companies need to make small contributions to surplus each year just to maintain constant solvency levels. The small employers did comment that the insurance industry is a for-profit industry, and seemed to better understand the need for them to include risk and profit margins in their rates. One small employer had experienced the trauma associated with an insolvency of a health insuring pool several years ago and fully appreciated the need for regulators to ensure there are adequate funds to pay claims.

Other responses pertaining to drivers of rate increases include:

- The cost of covering unhealthy individuals
- The cost of covering the uninsured
- Fraud in the system
- Administrative costs associated with a fragmented delivery system
- Increases in executive compensation
- Adverse selection

One participant in the small employer focus group commented that small groups lack the buying power that larger groups have. This participant felt that as a result small groups pay higher rates than larger groups.

One other notable item that received comment in more than one consumer focus group but did not receive comment among the small employer groups involved the relationship between rates and an insured's health status. Participants commented that they felt healthy individuals should receive premium discounts (much as good drivers receive discounts for auto insurance). We were unable to discern from these comments whether the participants making them were aware that rates are not allowed to vary by health status in Maryland, or whether they just felt they themselves were in good health and were paying higher rates than they should. It was also interesting to note that when the conversation shifted to a discussion about individuals in poor health being charged higher rates, consumers did not feel it was fair to do so. This appears to indicate that the consumer focus group participants may not understand the concept that charging an individual in good health a rate that is lower than the average rate needed to cover all the insureds' claims would necessitate charging another individual within the same pool who is in poor health a higher-than-average rate, all else being equal.

The State of Maryland's Role in Reviewing Rates

After participants shared their initial impressions regarding health insurance premiums and rates, they were asked for their thoughts on the State of Maryland's current role in overseeing health insurance premium rates. Participants were also asked what they felt the State's role should be. At this point, mention of the Maryland Insurance Administration was intentionally excluded in order to gauge whether any of the participants knew of the Administration and its current activities regarding premium rate reviews.

The two small employer groups differed substantially in their awareness of the Administration. In one of these groups, only one individual was aware that the "Insurance Department" reviewed rates. Another individual stated he would be surprised to find out that the State currently reviews premium rates since insurers are private companies, but wouldn't be surprised if the State starts reviewing them as a result of health care reform[24].

By contrast, the other small employer group seemed to be very much aware of the State's involvement. One participant indicated that he thought the State establishes the rates, while another thought that the State reviews the rates. Yet another indicated that she thought there was a commission that regulates the products and that she had worked with the State to resolve a complaint in the past. A fourth individual stated that he had contacted the insurance commissioner in the past, and commented that they are "good to work with once you are able to get through to them." We are unsure how to interpret this last individual's comments, but it seems he may have had trouble trying to locate the correct department to handle his concern.

[24] Note that in this report, gender-specific pronouns are used randomly when referring to focus group participants.

The consumer focus groups' comments were not significantly different from the small employers' comments. Most consumers were not aware that the State is already involved in regulating health insurance rates. Individuals in two different consumer focus groups, including the ESL group, stated that they believe the State should be involved if it helps the consumer. As in the small employer groups, a participant in one of the consumer groups stated he or she would be surprised if the State currently reviews premium rates since insurers are private companies, but wouldn't be surprised if the State starts reviewing them as a result of health care reform.

Other responses from the consumer groups include:

- The State sets rules for providers.
- The State should oversee premium rates. (Note that the respondent admitted he or she did not know if the State currently does so.)
- The State should regulate rates by setting caps on the increases that carriers can implement.
- The State is not involved since it doesn't have any control over rates.
- Carriers should have to justify rate increases before they can implement them.
- The State should ensure that rates are based on income.
- The State should investigate fraud.
- The State should research what average costs *should* be.

The Maryland Insurance Administration

Participants were then introduced to the Maryland Insurance Administration as the State agency that reviews carriers' requests to increase premium rates and has the authority to disapprove such requests.

Familiarity with the Administration

Most consumer respondents were not familiar with the Administration. When the consumer respondents were asked if they had heard of the Administration, one person indicated that she thought she had heard of it when appealing a denied claim, but also thought the name was "The Maryland Insurance Commission." Only one other individual, in a different group, had heard of the Administration.

The small employers were more familiar with the Administration. In one of the groups, three individuals had heard of the Administration. In the other group, one had heard of the Administration and another had heard of the Commissioner of Insurance.

When asked why they thought most people had not heard of the Administration, one consumer group respondent indicated that the Administration and its function had not been marketed to the public very well. All five groups commented that the Administration's name was a possible reason, and all five commented that the acronym "MIA" was not favorable given the Administration's role. Participants in multiple groups commented that the name should be "The Maryland Insurance Commission" or "The Maryland Insurance Department."

There was confusion among all the groups about the nature of the Administration. Some thought it was a private entity; others thought individuals at the Administration were elected or political appointees. Others thought the Administration was somehow related to the insurance industry, like rating agencies are for bonds. Almost none of them realized that the Administration is a State agency that has existed for over 100 years.

Familiarity with the Administration's Role

After being introduced to the Administration, participants were asked what they thought the Administration's role should be. Responses were fairly similar among the groups. Most participants felt the Administration should oversee premium rate levels, investigate fraud, function as an arbitrator, and oversee insurance companies to ensure they follow the rules. One currently uninsured individual reported he had been the victim of a couple of insurance scams and said he hoped the Administration could do more to catch and prosecute these companies that prey on consumers.

Sample Materials Describing the Administration's Role

Participants were given a two-page narrative describing the Administration's role, presented as Exhibit A. This exhibit is included in Appendix D of this report, as it was presented to the focus groups. Participants were asked to read the materials and make comments directly on them, indicating which information was clear and which was confusing – and which information seemed important and which seemed unnecessary. Afterward, participants were asked to provide general comments on the materials.

In general, all five groups thought the document successfully provided a high-level overview of the Administration's general purpose for existence and a basic description of what the Administration does. They liked the format and commented that the use of bullets made the document easy to read. With the exception of a few areas that are discussed below, participants thought the wording was basic and easy to understand. Participants from several groups commented that they did not feel that a separate glossary of terms was needed. We found that the ESL group's opinions in these areas were consistent with the other consumer groups'. In other words, the ESL group did not raise any additional concerns about being able to understand the document, beyond the use of certain words that seemed to challenge all groups. One person commented that the three bullets at the beginning (summarizing the three main roles of the Administration) were not necessary; however, an individual in a different group liked the fact that they were there, as they allowed readers to get a quick summary and decide whether or not they wanted to read further for more detail.

All of the groups suggested improvements in two particular areas. The first involved the Administration's role in reviewing rates. It was quite clear that the consumer groups – and to a large extent the small employer groups – did not understand the Administration's role in this area. Not only did these participants not understand the purpose or details of the rate review process, many were not even aware that the process exists. Participants commented that more detail is needed in this area, and that the document does not clearly state exactly what the Administration does when it checks rates. Comments included:

- What do they check the rates against?
- Who checks the rates, and what makes them qualified to do so?
- Do they just check the rates, or can they do something about them based on the results of their checking?
- How does the expert forming the independent opinion calculate the rate?
- Stating that they "check rates" to determine if they are "too high" or "too low" is subjective and does not provide detail as to what the quoted terms mean.

We note that we aimed to keep this document simple and provide a general description of the Administration's various roles. We intended to provide a second, more detailed document outlining the rate review process for consumers who wanted to learn more. We did not show a second document to the groups, for two reasons. First, we had a limited amount of time with each group and wanted to cover as many broad topics as possible. Second, we wanted to see whether Maryland residents would seek this additional information without being specifically prompted.

Both the oral and written responses to Exhibit A clearly indicate that participants do not currently know of or understand the process, and that they strongly believe more detailed information should be offered to consumers. However, almost all of the small employers indicated they would not read this, as they rely on their brokers for this type of information. Their brokers are probably well aware of the Administration and its function.

Another area that generated several comments involved the discussion of the Administration's role in ensuring that companies remain solvent. Many people in the small employer groups seemed to have at least a basic understanding of the need for ensuring solvency; however, those in the consumer groups definitely did not. They commented that the Administration seemed to worry more about whether insurers charge enough in premiums than whether they charge too much, and that it seemed to focus more on the insurance companies than on consumers. Many people indicated they did not understand what is meant by the word *solvency*. As we indicated in the section on drivers of rate increases, consumers do not appear to clearly understand the need for the Administration to ensure that carriers remain solvent.

At least one person in each of the five groups noted that the document does not provide consumers with contact information (e.g., a street address, website, or phone number). Participants also suggested that the Administration's contact information should be included on all insurance policies.

The third topic covered in the exhibit was consumer protections. Consumers appreciated hearing that the Administration is there to protect them; they thought this was a very important part of the document. At least two groups commented that it was so important that it should be listed first – before the discussions on solvency and rate review. More specifically, participants wanted to know how the Administration protects them and how laws are enforced when a consumer protection is violated.

A few participants indicated that it is misleading to state that one of the Administration's duties is to ensure health plans write clear policies, as the policies are not in fact clear. These respondents commented that the policies are confusing and the average consumer cannot understand them. There was no discussion of the fact that these policies are legal documents and that some of the necessary language may not be entirely consumer-friendly.

Finally, many of the groups commented that it was unclear why the Administration does not regulate certain products (referring to plans listed as not being subject to the Administration's authority).

Following is a summary of other comments and questions from the focus groups regarding Exhibit A:

- What happens if companies don't comply with the requirements? Can the State do anything?
- "Actuarial practice" needs to be defined, or alternate wording is needed.
- How does the Administration respond to consumer complaints?
- How do I find out more about the Administration?
- How is the Administration funded?
- How are positions at the Administration filled? Are they appointed or elected?
- How does the Administration help consumers find health insurance?
- Can the Administration require carriers to decrease rates if consumers are unsatisfied with them?
- What does "discriminate unfairly" mean? Why should carriers be allowed to discriminate at all? (One participant responded that he thought maybe discrimination based on pre-existing conditions was "fair discrimination," while another individual commented that health care reform will eliminate this.)
- One small employer liked the document and stated she would consider sharing it with her employees so they would know there is a consumer advocate working for them and the employer is not just passing cost along to them.
- It is unclear what is meant by "rates on file" and whether this information is available to the public.
- One small employer commented that this was the first time he had heard of the Maryland Insurance Administration.
- One small employer commented that information about solvency should not be included in the document because the dual role of solvency along with premium rate review and consumer protection is conflicting. This further demonstrates that consumers do not understand that ensuring carrier solvency is another way in which the Administration protects consumers.

Access to Health Insurance Information

Since the ACA is placing greater emphasis on consumer access to health insurance information, we wanted to obtain feedback from the focus group participants on where

they look for answers about health insurance, the type of information they would like to access, and the most efficient and effective ways the Administration could disseminate this information.

Where Consumers and Small Employers Look for Answers About Health Insurance

Responses regarding sources of information for health insurance differed between the consumer groups and the small employers. Almost all small employers said they rely on their brokers for this type of information. They indicated that they are busy running their businesses and have delegated this to their brokers, who are reimbursed for these services through commissions. Small employers did indicate that, if needed, they would:

- Call the insurance company directly
- Discuss questions with colleagues and associates
- Perform Internet research
- Gain information through the media

Consumers did not appear to rely on brokers to the same extent small employers did. Participants who purchased individual policies were more apt to call their broker with questions, while participants who purchased coverage through their employer went to their human resources department with inquiries. The most common response from the consumer groups was to call the insurance company. Other responses provided by the consumer groups include:

- Perform Internet research
- Check for rates on eHealth.com
- Ask a spouse, friends, or other family members
- Ask questions of their provider

Information That Consumers and Small Employers Would Like to Access

The next topic involved areas for expanded access. We wanted to explore the type of health insurance information that the focus groups would like to access. We note that, since questions were posed to the participants in the same order the topics are presented in this report, their responses may have been somewhat biased by earlier discussions.

Most of the discussion on this topic was generated by the consumer groups. The small employer groups reiterated that they receive the information they need from their brokers. The key pieces of information the consumers sought involved the benefit plans available and the associated premium rates. It appeared that they may be seeking a place to comparatively shop for coverage, and the introduction of the health benefit exchange(s) in 2014 will likely help satisfy this need.

In addition, all three consumer groups wanted to know more about how the Administration reviews premium rates and determines whether to approve increase requests submitted by carriers. Two participants in the small employer groups also

commented that they would be interested in learning more about how the Administration reviews rates. However, as mentioned above, it is difficult to determine the impact that earlier discussions on this topic had on consumers' desire to know more about the process. Regardless of the impact, consumers eagerly expressed interest in having access to this information.

In addition, consumers indicated they would like to know the following:

- Where to complain about their premium rates
- How profitable companies are (by company each year)
- Where to find out about premium rate increases that have been filed with the Administration (One respondent felt that if he knew about the source of premium rate increases – e.g., "big pharma" – he could lobby his member of congress.)
- One person indicated that he wanted the ability to comment on premium rate increases that have been filed with the Administration. However, he also recognized that having the ability to comment on a bulletin board on the Administration's website may just amount to his "venting," and he questioned whether his comments would be considered during any premium rate review process.

Disseminating Information to Consumers and Small Employers

The final discussion topic involving access to health insurance information addressed how this information could best be disseminated to consumers.

A majority of individuals in both groups (consumer and small employer) felt the Internet was by far the best way of making information available to consumers. They believed that including this type of information on both the Administration's website and insurance carriers' websites would be appropriate. Information on the insurance carriers' websites would likely include a description of the Administration and contact information.

Both groups felt that insurance carriers should be required to provide information related to the Administration – at a minimum, making policyholders aware of the Administration's existence and providing a phone number. They felt the carriers could do this through multiple venues, including a brochure provided along with their policy at issuance, as an addendum to policies, with the premium invoice/bill, or at the bottom of explanation of benefits statements.

A common recommendation was to place brochures at various locations that are frequented by consumers, such as doctors' offices, hospitals, and pharmacies. Other suggestions were to place the brochures at other commonly visited places, such as post offices, libraries, and Motor Vehicle Administration (MVA) offices. The Administration (MIA) indicates that it currently has brochures in libraries, MVA offices, and other public places.

Other suggestions were as follows:

- Include information with tax refunds. (Two groups made this recommendation. However, we note this approach would not reach consumers who do not receive a tax refund or have their refund direct-deposited to a bank account.)
- Give employers information to disseminate to their employees through their human resources department.
- Share information at booths at various conferences.
- Run TV/radio ads that introduce the Administration, explain what it can do for consumers, and provide the Administration's contact information.[25]
- Distribute information through direct mail.[26]
- Give brokers information to disseminate to consumers and small employers.
- Give information to local chambers of commerce so they can share them with their members. (This suggestion was made by small employers.)
- Have a representative speak and/or answer questions at business meetings. (This was also suggested by a small employer.) (The Administration currently has an active outreach program through which representatives regularly attend business meetings and other venues where consumers can pose questions.)

Notifying Consumers of Health Insurance Rate Increases

To purchase health insurance wisely, consumers need to have easy access to information regarding premium rates and changes. We sought input from the focus groups regarding their interest in being notified of premium rate increases, and asked how this information should be disseminated.

Notification When Insurance Companies Request a Rate Increase

Responses from the consumer groups and the small employer groups differed substantially. All three consumer groups felt strongly that consumers should be notified when an insurance company files a rate increase request with the Administration. Several individuals from all three groups felt that the information should be posted on the Internet. Others suggested that it should be posted on the insurance carriers' websites as well as the Administration's website. Individuals from more than one group commented that the insurer should be required to e-mail policyholders to notify them of such requests for increases.

By contrast, most of the small employers generally had no interest in learning about when a rate increase request was filed with the Administration. They admitted that they have a direct interest in the process; however, they didn't feel that they could affect the results, and they didn't have time to go to hearings. As with the previous topic, small employer groups cited their reliance on their broker for this. They feel they are able to "vote" by choosing where to place their business. Almost all of the small employers indicated that they "shop" their health insurance every year to obtain the most favorable premium rates.

[25] We note that the individual making this comment works in radio; therefore, the comment may have been biased.

[26] We note that the individual making this comment was a small employer who owns a direct mail company; therefore, the comment may have been biased.

There were a couple of exceptions to these perspectives. One small employer's comments were more consistent with the consumer groups' in that he thought small employers should be made aware of pending increases; another participant stated that the insurance carrier should be required to include a notice with the monthly bill, notifying the employer when a rate increase has been filed with the Administration.

Participants who believe that consumers should be notified when an insurance company files a rate increase request with the Administration feel the insurer should be required to provide:

- Justification for the requested increase
- The frequency with which the carrier has raised rates in the past
- A history of previous rate increases
- The carrier's profitability
- The criteria that the Administration uses to determine who gets a rate increase

Public Comment on Rate Increase Requests Filed with the Administration

As with the notification of rate increases, the consumer groups and small employer groups differed on the topic of allowing public comment on premium rate increase requests filed with the Administration. While all groups felt that consumers should have the opportunity to make public comments regarding premium rate filings submitted to the Administration, the small employer groups again cited their lack of available time to be involved at public hearings and stated their reliance on their broker, who could represent them at any such events. One small employer expressed that consumers, including small employers, should have the opportunity to offer input into the premium rate decision process.

Another way to offer input could be to post comments on the Administration's website. While many individuals agreed with this approach, several were skeptical regarding the effect such input would have on the Administration's decision – believing this would function more as a way to vent frustrations, rather than actually provide comments that would be considered as part of the Administration's review.

Sample Materials Summarizing the Administration's Review of a Rate Filing

To test two prototypes of materials designed to explain the results of the Administration's review of a specific premium rate filing, participants were asked to review two documents, presented as Exhibits B1 and B2. These two exhibits represented samples of a potential rate decision summary that the Administration could complete for each filing it reviews and then post to a dedicated location on the Administration's website. These exhibits are included in Appendix D as they were presented to the focus groups.

The premium rate development and review process involves highly technical and complex information. While it is important to translate this information into terms that will be of value to consumers, it is also important to maintain the underlying meaning and structure of the process. We developed two versions of the summary so we could

determine whether consumers and small groups preferred a more quantitative summary or one with more narrative.

Participants were asked to read the material and write comments on the exhibits to indicate which information was clear and which was confusing. Similarly, participants were asked to note which information seemed important and which seemed unnecessary. Finally, they were asked to write general comments on the material.

Often, when someone is shown two different versions of the same material, she will indicate that the second version read is easier to understand. This result may be largely due to the fact that once a person has read and digested the first version, the second is already somewhat familiar to her. To attempt to control for this, we alternated between which version the different groups were shown first. The following table shows the order in which the information was presented to each group.

	Shown First	**Shown Second**
Consumer Group 1	B1	B2
Consumer Group 2	B2	B1
ESL Consumer Group	B2	B1
Small Employer Group 1	B1	B2
Small Employer Group 2	B2	B1

Participants Shown Exhibit B1 First

Following are general comments from those who were shown Exhibit B1 first:

- It was confusing.
- The language was too complex.
- The glossary was very helpful.
- Having the percentage increases was good.
- It would be more meaningful to have actual dollar amounts attached as well.

One person indicated the glossary should be presented toward the beginning of the document.

Everyone thought that the top half of the exhibit (summarizing the increase requested by the carrier and the increase approved by the Administration) was good; however, it did not explain why these two amounts differed or how the Administration arrived at its approved increase. They agreed that the remainder of the exhibit attempted to do this, but that it was difficult to follow. One respondent indicated that there should be two versions of this type of information – one that is consumer-friendly and written at an eighth-grade level – and another that is intended for a more technically sophisticated audience. One individual commented that more "layperson language" needed to be used.

In general, participants were happy to see that the approved rate increase was much lower than requested. They felt assured that the Administration was looking out for consumers;

however, they still would like to understand more about the difference between the requested and approved increases.

Following are some other notable comments from these groups regarding Exhibit B1:

- They weren't assured that the Administration was reviewing the profit margins and assessing their reasonableness.
- Several consumers felt that a rate increase history should be included.
- One person wondered whether it was common practice for insurance companies to ask for larger rate increases, knowing that the approved amount will be less.

These same groups were then asked to read and comment on Exhibit B2. Participants in both groups felt that Exhibit B2 was much easier to read and understand. They felt that the table that included a breakdown of the rate increase components was helpful in that it was more concise and could be read quickly. They also said that the headings helped separate the topics.

Participants still felt that Exhibit B2 should include a numerical example with real dollars, as well as a comparison with the Administration's decision. They indicated that they still did not understand how the Administration arrived at its decision.

Participants Shown Exhibit B2 First

Three groups were shown Exhibit B2 first. As with the other groups, they liked the information at the top summarizing the insurance carrier's request and the rate increase that the Administration approved. They commented that this showed that the Administration is working for the consumer. They also liked the idea that they could see that administrative expenses and profit are not driving the sample rate increase.

Unlike the groups that were shown Exhibit B2 second, these groups felt that the table in Exhibit B2 was confusing. They indicated that it was not clear how the numbers in the table added up, and they didn't know the source(s) for the numbers. Other comments were that it did not define "non-grandfathered plan," that it did not clarify the experience upon which the rate increase was based, and that the underlined terms should be hyperlinked to the glossary terms if this information is posted on the Internet.

Similar to the other groups, they said that including real-dollar examples would make the information in the exhibit more meaningful to them, since percentages can be misleading. They also found the glossary to be helpful, although one person commented that she did not want to have to read a glossary in order to understand the information. They also agreed that a history of prior rate increases should be included.

These three groups were then asked to read and comment on Exhibit B1. All three groups felt that Exhibit B1 was much easier to read and understand. However, a fair number of individuals (still a minority) indicated they liked Exhibit B2 better. In general, most individuals in these groups felt that Exhibit B1 was clearer. They thought that it did a better job of describing how the Administration arrived at its conclusion, and that the

words flowed better. People from each group indicated they liked the table in Exhibit B2; they believed that incorporating it into Exhibit B1 would work well.

Summary of Overall Impressions of Exhibits B1 and B2

Overwhelmingly, all five groups thought that this type of information should be made available to consumers, and that posting it on the Administration's website was the best way to share it with consumers. All groups felt that the exhibit that was presented to them second was the better of the two, and easier to understand. However, most individuals liked features of both exhibits and thought that blending them would be the best way to present the information.

They liked the summary information at the top, the table that included a breakdown of the requested rate increase, and the idea of including some narrative describing the Administration's review. The ESL consumer group did not seem to find the information any more difficult to understand than the other two consumer groups.

They all felt that two items were missing from both exhibits: "real dollar" examples of how the rate increase would affect the average premium, and a history of prior rate increases. A few individuals asked whether this type of information was currently available to consumers. When they were told it wasn't, they asked why not.

While most individuals stated that they were interested in this information and that consumers should have access to it, several admitted that they probably would not use it. In particular, the small employers reiterated that they do not have time to review this information and that they pay their brokers to do this. However, they did agree that it would be beneficial for their brokers to have access to this information. One individual in the small employer group commented that he felt this information should be made available only if producing it would not cost taxpayers too much.

Roughly half of those in the consumer groups indicated they would actually look at this information if it were made available to them. A few of those who indicated they would not look at it clarified that they were covered through their employer – adding that if they were shopping for individual coverage they would find this information valuable.

Development of Health Insurance Rates

The final focus group discussion involved consumers' desire to understand how health insurance rates are developed. Topics included how carriers develop rates, how carriers estimate claim costs in future periods, and what causes premiums to increase (both for all policyholders and for specific individuals).

Participants were shown Exhibit C, which consisted of three pages. (Appendix D of this report includes Exhibit C as it was presented to the focus groups.) Each page of the exhibit builds on information from the prior page and drills down into more detail. At first, participants were asked to read only the first page, which provides a general overview of how health insurance rates are developed (describing the three main

components: claim cost, administrative expenses, and profit). We specifically asked them not to read ahead, as we wanted to first obtain their feedback on this basic summary and determine whether they would seek additional detail.

Everyone thought page one of Exhibit C was clear and straightforward, providing a simple overview in an easy-to-follow format. A few people commented that they did not understand what premium taxes or costs to manage the provider network were. They also commented that they were curious about the "other costs to administer the policy." Some commented that, while page one describes the components of the process, it does not describe the steps taken to develop the rates. One person also commented that he was left with a lot of questions, such as how claims were estimated and what the rates were based on.

Participants were then asked to read page two of Exhibit C, which describes how health plans estimate claim costs. As with page one, participants felt the information was clear, straightforward, and simple to understand; however, they agreed that some areas needed clarification. Two groups commented that the first page states that the deductible was not considered but the second page indicates that it was. To these individuals, this appeared to be contradictory. Other comments on the second page of Exhibit C included:

- The information is too generic; it does not provide enough detail.
- It is unclear what "average amount paid to medical providers" means.
- It is unclear whether the five bullet points represent the major items included or all items included.
- Outside factors such as epidemics and pandemics are not included.
- It is not clear how the carriers are coming up with the estimates.
- If the carriers used prior history in coming up with the claim estimates, this should be stated.

Finally, we asked the participants to review page three of Exhibit C, which describes the underlying drivers of rate increases. Drivers that affect all policyholders covered under a policy type are described separately from those that affect an individual policyholder's premium differently from others with the same policy.

The small employer group participants felt that this page was easy to understand and that it provided good information for them as employers. They thought that it would be helpful in answering their employees' questions and that it was the most meaningful of the three pages. They thought there was value in offering this information to the end consumer. One person did say she thought that the word "profit" was not a good choice and that "contribution to reserve" might be a better choice. Another person felt this page could be enhanced by adding other factors (such as fraud) to the top half. He also suggested adding a section called "What can I do to help keep my premiums low?", which could include tips such as asking for generic drugs and seeking care at a physician's office rather than an emergency room.

The consumer groups also thought page three of Exhibit C was clear, and they felt better informed after reading it. They particularly liked the section that explained why an individual's rates differed from those of other people with the same policy, and they were glad to learn that their premium was not affected solely by their individual claims. Individuals in two of the groups commented that they didn't understand the phrase "changes in contributions to profit" and thought clarification was needed.

In general, all five groups felt that Exhibit C contained information that consumers would value. As previously mentioned, the small employer groups thought it would be particularly valuable to share with their employees.

Summary

In summary, consumers and small employers were happy to learn of the Maryland Insurance Administration and its role. They felt that modified versions of the sample materials they reviewed would be valuable resources for consumers. All five groups strongly supported the idea of making information regarding rate increase review and approval more transparent and accessible to consumers. They felt that the Internet was the most convenient way to do so, but also felt that there were other ways to get the information into the hands of consumers.

Consumers and small employers differed in whether they would actually visit the Administration's website and use the information if it were made available to them. Consumers indicated that now that they are aware of the Administration, they would use this information. However, this reaction was more prevalent among those consumers who purchase coverage themselves than among those who receive coverage through their employer. Small employers, on the other hand, clearly communicated the degree to which they rely on their broker for this type of information. While most admitted that they would not visit the Administration's website themselves, they did say they would like this information available so their broker could access it.

All groups unanimously agreed that one challenge facing the Administration is making consumers aware of its presence and its purpose. They also agreed that the Administration needs to publicize its contact information. The groups suggested how they felt the Administration could promote itself and increase its recognition with consumers. They felt there would be no value in offering information to consumers if the consumers were unaware of the Administration and its resources.

Finally, we did not find that any of the sample materials shared with the focus groups presented any barriers to the group of consumers for whom English was not a first language. For the most part, this group's questions and concerns regarding clarity of language and concepts were consistent with those expressed by the other groups.

5

Recommendations

Based on our review of the information currently available to consumers in Maryland,– and on the Administration's goal for the project, which was to improve the transparency of the rate filing review process by enhancing communications with consumers – we present the following recommendations for consideration. To validate our initial recommendations, we conducted a series of focus groups consisting of consumers and small employers. In forming the following recommendations, we revised our preliminary recommendations (where needed) to reflect consumer input received through the focus groups.

Recommended Methods for Informing Consumers

We were asked to recommend the best ways to disseminate information to consumers regarding the rate filing review process. We have divided our recommendations into three categories: notification of premium rate increases, consumer input into the rate review process, and general information on the rate making and rate review process.

Without question, focus group participants felt that the most efficient way to provide this type of information to consumers was through the Internet. Participants suggested that the most appropriate place on the Internet for a majority of this information would be the Administration's website – in an easy-to-navigate, consumer-friendly section dedicated to health insurance rates. Almost all participants indicated that they have access to the Internet, and only a few said they do not use the Internet on an almost daily basis. Most consumers stated they would access the information on the Internet themselves. The small employers were less likely to access the information themselves, but they wanted their brokers to have access to the information on their behalf. Participants frequently recommended other ways to make certain types of information available. As we discuss each type of information below, we recommend the most efficient means for that particular material.

Notification of Premium Rate Increases

In forming our recommendation for the most efficient and informative way to notify consumers and public policymakers of rate increases, we relied heavily on the input

received from the focus group participants. We provide recommendations on how best to notify consumers of rate increase requests, rate increase approvals, and the Administration's rate decisions.

Notification of a Health Plan's Request for a Rate Increase

Consumer focus group participants felt strongly that they should be notified when a carrier files for a rate increase, and that the information should be posted on the Internet. They understood that health insurance rates need to increase each year, but felt that having this information before increases are approved would give them time to shop for a new policy if the pending increase was large. By contrast, most participants in the small employer groups generally were not interested in learning about proposed rate increases, since they do not have time to attend rate hearings and they generally shop for new coverage each year anyway. They did, however, indicate that they would like their broker to have access to this information.

Those who would like to be notified of rate increases felt that the Administration's website definitely would be the most appropriate place for that notice, and they felt that justification for the increase should be included.

Therefore, we recommend that the Administration develop an area of its website dedicated to health insurance rates and post all non-confidential portions of all individual and small group rate filings for public viewing when they are submitted for consideration. In addition, we recommend that the Administration consider posting a consumer-friendly summary of the filing.

If the Administration accepts our recommendation to require that the Part I Preliminary Justification Rate Summary Worksheet be submitted with all individual and small group filings (recommended under a separate contract to review and suggest enhancements for the rate review program), the information needed to create these rate filing notification summaries will be readily available. However, since HHS requires preliminary justification only for filings that are "subject to review,"[27] we do not anticipate that the consumer-friendly template that HHS creates from the data will be available for all filings.

The Administration would need to create its own template to pull data from the Rate Summary Worksheet into a format for use on the website. We believe this template could easily be developed in Excel, and we would be happy to help develop this template under our existing contract if the Administration accepts our recommendation. For filings that are "subject to review," the Administration may consider adding to its website a link to the area on the HHS website that will contain the full Part I and Part II Preliminary Justification Worksheet.

[27] The HHS draft rate review regulation (45 CFR Part 154) deems a filing "subject to review" if the annual rate increase is 10% or more in 2011. The 10% threshold moves to a state-specific threshold that is reevaluated annually in subsequent years. However, we note that these are draft regulations that are subject to change. For more information on the draft regulation and preliminary justification requirements, please refer to the rate review report that was created under a separate contract.

Before discussing this topic, participants were asked a more general question about where consumers go to look for information on health insurance rates. Several people said they would visit the carrier's website. When specifically discussing the topic of notifying consumers of rate increases that have been filed, several respondents felt that, in addition to the Administration's posting notices on its website, carriers should also be required to post notices on their websites. We note that for increases that are deemed "subject to review," carriers would be required to post the Part I and Part II Preliminary Justification, so this need would be met for many increases. However, respondents felt this information should be available for all filings.

We understand that certain costs would be incurred by carriers if they were required to post this information for all filings, and that these costs could be passed on to consumers; however, new State and federal loss ratio requirements would significantly reduce carriers' ability to increase administrative charges. Therefore, since requiring carriers to post this information on their websites may cost consumers directly, our recommendation is for the Administration to further research the burden that this would place on carriers and, if it is found to be minimal, require carriers to post this information on their website for all filings.

Carriers will become accustomed to completing the Part I Preliminary Justification Rate Summary Worksheet, and if the Administration accepts our recommendation to require carriers to submit this information for all filings, the Administration will produce a consumer-friendly rate filing notification summary that could be provided to carriers to post on their websites.

Notification of an Approved Rate Increase

Focus group participants indicated that the most efficient way to be notified of an approved rate increase is through their carrier. Individuals are usually notified of rate renewals directly by their carrier; while small employers are usually notified by their broker. Consumers and small employers seem content with the way they are notified of approved rate increases that directly affect them; therefore, we do not recommend any changes in this regard. However, participants did want to know more about how the Administration determines whether an approved rate increase is appropriate. We discuss this topic in the following section.

While participants indicated that the current way they are being notified of their own approved rate increases is most efficient, several also expressed a desire to be notified further in advance of the effective date, which would allow them to comparison-shop for other coverage. We do not know what type of coverage these individuals have; however, we note that under current Maryland law, insurance companies and nonprofits are only required to provide notice 40 days before expiration of the grace period for rate changes in the individual market – essentially providing notification only 10 days before the effective date of the new rate. If the Administration accepts our recommendation to revise the notification period for insurance companies and nonprofits to 45 days before the effective date for all rate changes in the individual and group markets (recommended

under a separate contract to review and suggest enhancements for the rate review program), this consumer concern could potentially be resolved.

Notification of the Administration's Rate Decision

The focus group participants who suggested that the Administration post a notification on its website when a rate increase request is filed also felt consumers should be provided more information on the Administration's decision to approve an increase. They were strongly in favor of having the Administration post a consumer-friendly summary of their final decision. Most individuals preferred the idea of a hybrid of the two documents they reviewed. Again, they felt the best way to provide this information to consumers would be through the Administration's website, in the same place where the notifications of filed rate increases were posted.

Therefore, we recommend that the Administration post this information in the new section of the Administration's website that we have suggested dedicated to health insurance rates for each individual and small group filing reviewed. We also recommend that this information be posted in a way that consumers will be able to easily determine which rate decisions correspond with which rate filing notification summaries. We recommend a format that represents a hybrid of Exhibits B1 and B2 presented to the focus groups for comment – similar to the revised exhibit shown in Appendix E. (As discussed in Chapter 4, these two exhibits were presented to the focus groups as alternatives for the same purpose.) In addition, we have incorporated into the revised exhibit in Appendix E additional recommended changes that were consistently suggested by the focus group participants.

We also note that, shortly after the draft materials were prepared for presentation to the focus groups, HHS released its Part I Preliminary Justification Worksheet, which must be completed by carriers for filings deemed "subject to review." We have also incorporated features of this form into the revised exhibit. Some of the issues that emerged from the focus group feedback – including a desire to see dollar amounts in the chart and information on the carrier's profit charges – are addressed through HHS's presentation of the preliminary justification data. Therefore, the revisions that were made based on the preliminary justification forms are consistent with the focus group feedback.

We note that the exhibit in Appendix E is shown only as an example. It was developed from data in HHS's sample Part I Preliminary Justification Rate Summary Worksheet, and assumes that our recommendations made under a separate contract to review and suggest enhancements for the rate review processes are implemented. (These include, for example, a recommendation that the Administration obtain statutory authority to include "any other relevant factors within and outside the State" as part of its review and criteria for approval.)

We have designed the revised form so that a significant portion of the information, including the data needed to develop the pie chart shown, can be pulled from the Rate Summary Worksheet. We note that if the Administration accepts our recommendation to post notification of a rate increase when it is requested, much of the information needed

to create these rate decision summaries will be readily available from the same consumer-friendly summary of the proposed rate that will be posted to notify consumers of a requested rate revision.

Further, we believe that a majority of the website development needed to establish the functionality for posting this information would be consistent with the development for posting the rate filing notification summaries. Therefore, we believe that implementing this recommendation would not generate significant additional cost for web development; however, additional resources would be needed to develop and post each summary. These additional staffing requirements are summarized later in this report.

E-mail Notifications of Rate Increases and Decisions

Focus group participants were asked whether they would be interested in subscribing to an e-mail list through which they could be notified whenever a rate filing notification summary or a rate increase decision summary was posted. While the participants were not overly interested in this option, several did feel their insurer should be required to send them an e-mail notifying them that a rate increase had been filed with the Administration – at which point they could go to either the carrier's or the Administration's website for further details, if they were interested.

Again, we note that the carriers would incur costs in providing this service, and to some extent those costs could be passed on to the consumer. Managing an e-mail distribution list and ensuring that consumers receive e-mails for the appropriate rate increases would likely involve more cost and resources than the previously discussed request to have carriers post rate filing notification summaries on their website. Most carriers probably do not provide this service today. We do not recommend that the Administration require carriers to develop these e-mail distribution lists at this time, as we feel the participants felt more strongly about other actions we are recommending. However, we do recommend that the Administration consider surveying carriers and asking them what this type of service would add to their costs, so the Administration can make a fully informed decision on this option.

In addition, we suggest the Administration research the cost involved in setting up an e-mail notification system. If a separate section of the website is developed (as we have suggested), the developer may be able to advise the Administration as to the cost and other resources needed to establish and maintain such a system. If the cost is low, the system may be beneficial to set up. As consumers learn about the information being provided on the website, they may gain interest in subscribing to such a service.

Consumer Input into the Rate Review Process

We asked the focus group participants to discuss their interest in being able to provide public comment on a proposed rate increase – either through an online bulletin board on the Administration's website, or at public hearings. While many people expressed an interest in having the opportunity to comment on a proposed rate increase, several were skeptical regarding the impact such input would have on the Administration's decision

(believing this would function more as a means for venting frustrations than actually providing comments that would be considered in the Administration's review. Therefore, the Administration would need to further consider how it would use this information, given the participants' expectation that any solicited input should be used.

Given this feedback from the consumer groups, we do not recommend that the Administration develop a bulletin board for public comment at this time. We suggest that the Administration focus initially on other recommendations we have made – those that consumers have more strongly supported implementing. If a separate section of the website is developed (as we have suggested), the developer responsible for making those changes may be able to advise the Administration as to the cost and other resources needed to establish and maintain such a system. As with the e-mail notification system, if the cost is low, it may be beneficial to set up.

General Information on the Rate Making and Rate Review Process

We were also asked to recommend the most efficient way to inform consumers about the Administration and its role in reviewing health insurance rates, as well as other aspects of the rate making and rate filing process. We focus our recommendations on the following topics:

- The Administration's role
- How health insurance rates are determined
- The procedure for carriers requesting a rate increase
- How the Administration reviews health insurance rates

We asked focus group participants to comment on these items. In addition to presenting Exhibits B1 and B2 (Rate Decision Summary), which were already discussed, we asked the focus groups to review additional draft materials covering two of the topics listed above. The participants felt that the information presented should be made available to consumers. They also provided comments on the draft materials, which we considered during the revision process.

For most of these items, participants felt that the Administration's website was the most effective way to share this information with consumers. However several people commented that this material would also work well in brochure format and that a brochure would make the information available to those without Internet access.

The Administration's Role in Regulating Health Plans

We presented the focus group participants with a draft copy of material providing a basic overview of the Administration's role. The draft copy was presented to the focus groups as Exhibit A (which is included in Appendix D of this report). Participants wanted more information on how the Administration performs the tasks noted in the draft handout, and how the Administration can respond when it finds that carriers are not meeting Maryland's legal requirements.

Based on feedback from the focus groups, we revised this exhibit. (The revised version is shown in Appendix F of this report.) Consumers felt that the best way to provide this information would be on the Administration's website or in a brochure. We recommend that the Administration post information similar to the revised exhibit to the newly recommended section of its website dedicated to health insurance rates. We also recommend that the Administration consider including this type of material in a brochure, as the focus group participants felt it provided a good general overview of the Administration. Brochures could be handed out at consumer outreach events and posted in locations frequented by consumers.

How Health Insurance Rates and Premium Increases Are Determined

Draft materials explaining the determination of health insurance rates and premium increases were presented to the focus groups as Exhibit C (which is included in Appendix D of this report). Most participants found Exhibit C to be informative and clear. However, a few participants thought several areas needed clarification. We used our judgment in determining which comments to incorporate while keeping in mind the document's readability.

One factor we did not fully incorporate into the revised exhibit was the consumers' interest in understanding how much premium is represented by each of the three main components (claims, administrative expense, and profit). While we had already included information about the loss ratio requirements in the draft exhibit presented to the focus groups, the exhibit was presented in pieces, and most of these comments were made before participants reviewed the section including the loss ratio information.

Nevertheless, the loss ratio discussion does not tell the consumer how much of the non-claim expense is administrative expense and how much is profit. We did not include further discussion or a pie chart to show the value of each of the three components, as this information will change over time and the exhibit is intended to be a static document. This information is in the Rate Summary Decision document, as it pertains to a specific filing. If the Administration is willing to update the static document at least annually with this information, it could be included in the exhibit in aggregate for the market as a whole.

Taking into consideration the focus groups' comments, we developed a revised version of this information, which is shown in Appendix G. We recommend that the Administration consider posting this information on the newly recommended section of its website dedicated to health insurance rates, and potentially including this information as part of a brochure.

Procedures That Health Plans Must Follow When Requesting a Rate Increase

Focus group participants were interested to learn that carriers are required to file rates with the Administration for approval prior to their use. We note that most participants were satisfied knowing this requirement was in place, and they showed little interest in researching the topic further. However, they felt that this information should be made available to consumers, and that the most efficient way of communicating it would be

through the Administration's website. While we did not present draft materials on this topic to the focus group participants, we have included draft content in Appendix H. We recommend that the Administration consider posting this information on the newly recommended section of its website dedicated to health insurance rates, and potentially including it in brochures.

How the Administration Reviews Requests for Rate Increases

When we shared the draft materials of the rate increase decision summaries with the focus groups, participants asked many questions regarding what information the Administration examines when it reviews rates, and how it decides whether to approve rate increases.

Specific questions included:

- What do they check the rates against?
- Who checks the rates, and what makes them qualified to do so?
- Do they just check the rates, or can they do something about them based on the results of their checking?
- How does the expert forming the independent opinion calculate the rate?

In addition, a participant commented: "Stating that they 'check rates' to determine if they are 'too high' or 'too low' is subjective and does not provide detail as to what the quoted terms mean."

Based on all of this feedback, we prepared the attached Appendix I, which is a list of frequently asked questions regarding the rate review process, along with their answers. We recommend that the Administration consider posting this type of information on the newly recommended section of its website dedicated to health insurance rates, and potentially including it in brochures.

Outreach and Staffing Resources Needed to Implement Recommendations

Outreach Programs

The Administration is acutely aware of the critical need to educate Maryland citizens on the scope of its duties, the information it provides to consumers, and the process for addressing insurance grievances. The Administration currently conducts a significant number of outreach programs – averaging two to three programs each business day and occurring in a variety of locations, ranging from churches and libraries to conventions, universities, and more. The Administration's outreach calendar shows that these programs are reaching a broad geographic and demographic population, and reflect a concerted effort to make the Administration visible and accessible to the public. Administration officials indicated that carriers are required to provide the

Administration's telephone number on every explanation of benefit (EOB) sent to consumers when a claim is adjudicated.

If this project's focus group participants accurately represent the larger Maryland population, these efforts to increase the Administration's visibility are falling short of their goal. As discussed in Chapter 4, very few focus group participants were aware that the Administration exists. The focus group members in both categories (consumers and small employers) indicated that the Administration needed to promote itself more and increase public awareness. Participants suggested achieving broader visibility in the following ways:

- Increase the probability of the Maryland Insurance Administration "popping up" more readily on the Internet via various search engines
- Advertise on billboards, busses, and subways
- Air public service announcements on TV and radio, preferably with a well-known local celebrity willing to donate his or her services
- Adopt a name that is more consistent with consumers' expectations, such as Maryland Insurance Department or Maryland Commissioner of Insurance
- Operate booths at conferences
- Place brochures in locations that consumers would likely visit, such as:
  - Medical providers' offices
  - YMCAs
  - Motor Vehicle Administration (MVA) locations
  - Libraries
- List the Administration's telephone number and website address on insurance policies
- Require carriers' websites to provide a link to the Administration's website

The Administration already provides brochures in many of the suggested locations and currently operates booths at many conferences and fairs. We recommend that the Administration reassess the resources it is using in its many outreach programs to determine if different types of resources could more effectively increase visibility, or if the existing resources need to be used differently. Research needs to be conducted to determine the costs and logistics of requiring carriers (especially those operating in multiple states) to incorporate Administration information on more of their communications – and to determine which types of communications would be most effective. Research also needs to be done to explore the costs, processes, and resources that would be involved in changing the Administration's name to one more recognizable by the public. This research would need to be completed in order for the Administration to determine whether such a change is feasible or desirable.

We do note that the average age of the focus group participants was below that of the Maryland population in general, with a disproportionately higher share of individuals in the 31 – 40 age group and a disproportionately lower share in the 41 – 64 age group. This bias in age distribution could indicate that the current outreach programs are not reaching the 31 – 40 demographic well, but may be more successful in reaching older groups. The

Administration may want to keep this in mind when reassessing its current outreach efforts.

We also note that the Administration is a large entity that regulates much more than health insurance. Efforts to enhance visibility of the Administration in general should be handled outside the purview of health insurance rates, at a much broader level.

Staffing

In this section, we explain the resources that would likely be required to implement our recommendations (assuming all of the recommendations above are implemented).[28] We discuss both staffing and IT-related issues.

We feel that, based on the focus group feedback, the most important recommendation is to develop an area of the Administration's website dedicated to health insurance rates, within the current consumer section. This effort will require IT costs related to redesigning the website – including not just the overall design and functionality, but also a "behind the scenes" database to hold the rate filings, rate increase notifications, and rate increase summaries. The Administration will need to work with the State's IT resources to assess the availability and skill sets of existing IT staff and to determine hardware or software that may be used to develop and maintain these new initiatives. If existing resources and skills are not sufficient, the Administration may need to obtain additional resources, either by adding staff or by working with one or more contractors.

In addition to the initial redesign and set-up costs, there will be ongoing maintenance costs involved with these efforts. Posting the recommended static content on items such as the Administration's rate review process will not involve significant ongoing IT maintenance costs, although this content will need to be monitored and periodically updated as market practices change. In addition, if the Administration decides to convert some or all of this information into brochures, the cost of printing and distributing the materials will need to be considered.

Additional ongoing resources will be needed to develop and post rate filings, rate increase notifications, and rate increase summaries. In our discussions with the Administration's actuaries, they estimated that approximately 300 of the 600 rate filings they received in 2010 were covered by the ACA. We anticipate that most of these filings involve the individual and small group markets – which are the focus of our recommendations to post rate increase notifications and rate increase summaries. It is unknown at this time how reforms might affect the frequency with which carriers submit rate increase filings in the future. Therefore, we estimate that our recommendation would affect approximately one to two rate filings each workday. This means that the following tasks would need to be performed approximately one to two times each workday:

[28] The staffing considerations in this report reflect only those recommendations made in this report. Any increased workload related to enhanced rate review processes, as recommended under a separate contract with the Administration, are not reflected here.

- A carrier's Part I Preliminary Justification Rate Summary Worksheet submitted with each filing would need to be used to populate the proposed tool to create the rate filing notification summary.
- A rate filing notification summary would need to be posted to the area of the website dedicated to health insurance rates.
- A rate increase decision summary would need to be developed by the actuary that reviewed and issued the decision for the filing.
- A rate increase decision summary would need to be peer-reviewed by another qualified individual.
- A rate increase decision summary would need to be posted to the area of the website dedicated to health insurance rates.

We note that if the Administration did not accept our recommendation (made under a separate contract to review and suggest enhancements for the rate review program) to require that the Part I Preliminary Justification Rate Summary Worksheet be submitted with all individual and small group filings, the Administration's time spent developing the rate increase notifications and summaries would be significantly greater.

We believe that lower-level staff, such as an actuarial student, could create rate filing notification summaries and post them on the Administration's website (along with posting rate increase decision summaries). However, we anticipate that rate increase decision summaries will need to be developed by the credentialed actuary responsible for the rate increase decisions, since this person will be most familiar with the details of the filing and the rationale for the approved rate level. The rate increase decision summary will also need to be peer-reviewed by another qualified individual before it is posted.

Given that rate increase decision summaries need to be written in consumer-friendly language, and given that actuaries tend to be more technically oriented, additional writing resources may be required. For instance, staff members who deal with consumers on a regular basis could review these summaries and give the actuaries tips and guidance on how to write them as clearly as possible.

We recommend that the Administration conduct further research in the following areas:

- Surveying carriers to determine the cost of enabling consumers to subscribe to be notified by e-mail when a rate filing is submitted to the Administration.
- Researching IT costs for developing an option for consumers to subscribe to receive automated e-mails when the Administration posts a rate filing notification summary or a rate increase decision summary. (This may also include discussions with other states that currently offer this option on their website.)
- Researching the availability and skill sets of existing IT resources to determine whether they are sufficient to create and maintain the new portions of the website dedicated to consumer information for rate filings.
- Reassessing the Administration's current outreach efforts.

We anticipate that Administration employees could conduct the recommended research.

Finally, as visibility and recognition improve, the Administration can expect to experience a significantly higher volume of calls and contacts – electronically and through traditional mail. The Administration may need additional resources to support these consumer requests and inquiries.

Appendix A

Consumer Focus Group Screen

This appendix contains the screening questions used to recruit individuals for the consumer focus groups.

Consumer Focus Group Screen

1. What state or district are you a legal resident? _____

   All must be Maryland residents.

2. Are you employed by the Federal Government or the State of Maryland?
   - Yes [ ] – Terminate
   - No [ ]

3. What is your marital Status? (Read list, only accept one answer)
   - Single, Never married [ ] – Skip to question 6
   - Divorced / Separated [ ] – Skip to question 6
   - Married [ ]
   - Widowed [ ] – Skip to question 6

4. Is your spouse employed by the Federal Government or the State of Maryland?
   - Yes [ ]
   - No [ ] - Skip to question 6

5. Do you currently have health insurance through your spouse's employer?
   - Yes [ ] – Terminate
   - No [ ]

6. Are you currently covered by Medicare or Medicaid?
   - Yes [ ] – Terminate
   - No [ ]

7. Do you currently have health insurance or have you had health insurance in the past 5 years?
   - Yes [ ]
   - No [ ] – Terminate

8. Is/Was your health insurance…
   - Through your employer or your spouse's employer. [ ]
   - Purchased privately i.e. though an insurance broker, or directly from a health insurance company. [ ]

   Attempt to recruit a 50/50 split per group

9. Are you interested in knowing more about how insurance rates are developed and the role the State plays in approving rates?
   - Yes [ ]
   - No [ ] – Terminate

Consumer Focus Group Screen (Cont.)

10. We're looking for people who work in a variety of fields. Do you or does anyone in your household work in one of the following areas
    - Healthcare [ ]
    - Insurance [ ]
    - Health insurance related field [ ]

    If yes to any terminate

11. Which one of the following age ranges do you fall?
    - 25 or under [ ] - Terminate
    - 26 – 30 [ ]
    - 31 – 40 [ ]
    - 41 – 50 [ ]
    - 51 – 64 [ ]
    - 65 and older [ ] - Terminate

    Recruit a mix

12. What is your gender?
    - Male [ ]
    - Female [ ]

    Attempt to recruit a 50/50 split per group

13. Did you learn English as a second language?
    - Yes [ ] – Recruit for ESL group.
    - No [ ] – Skip to question 17 – Recruit for consumer groups.

14. What is your primary language? _____

    If English continue screening, hold and check with project manager.

15. How well do you read English?
    - I do not read English [ ] - Terminate
    - I read basic English only [ ]
    - I read English fairly well but with some difficulty [ ]
    - I read English well [ ]
    - I am completely fluent in English [ ]

16. Where, if at all, do you use your primary language (i.e. at home, work etc)_____

Consumer Focus Group Screen (Cont.)

17. What is your ethnicity?
    - African American / Black [ ]
    - Caucasian / White [ ]
    - Hispanic / Latino [ ]
    - Asian [ ]
    - Other, Please specify:_____

Recruit a mix

Appendix B

Small Employer Focus Group Screen

This appendix contains the screening questions used to recruit employers for the small employer focus groups.

Small Employer Focus Group Screen

1. In what state is your business domiciled?_____

   All must be in Maryland

2. How many full time employees does your business have?
   - 1 [ ] – Terminate
   - 2 – 5 [ ]
   - 6 – 10 [ ]
   - 11 – 20 [ ]
   - 21 – 30 [ ]
   - 31 – 40 [ ]
   - 41 – 50 [ ]
   - 51 and over [ ] – Terminate

   Recruit a mix

3. Are you the person in your business responsible for making the decision related to health insurance purchasing choices?
   - Yes [ ]
   - No [ ] – Terminate AND ask for referral within company
   -

4. Do you currently offer health insurance or have you offered health insurance in the last 5 years?
   - Yes [ ]
   - No [ ] – Terminate

5. Does your company currently contribute part, or all, of the premium toward your employee's health insurance (or did your company contribute when it did offer health insurance)
   - Yes [ ]
   - No [ ] - Terminate

6. Is your company currently affiliated with the insurance industry, beyond simply buying insurance?
   - Yes [ ] – Terminate
   - No [ ]

7. Is/was your health insurance coverage offered through an association such as a chamber of commerce or trade association?
   - No [ ]
   - Yes, please specify :_____

Small Employer Focus Group Screen (Cont.)

8. Are you interested in knowing more about how insurance rates are developed and the role the State plays in approving the rates?
    - Yes [ ]
    - No [ ] – Terminate

Appendix C

Demographic Information from Focus Groups

Consumer Groups								
Session	**Age**	**Gender**	**Ethnicity**	**Marital Status**	**Occupation/Employer**	**Coverage Type**	**Insurer**	**Primary Language**
Consumer Group 1	51-64	F	Caucasian	Married	Artist	Private	UnitedHealthcare	N/A
Consumer Group 1	51-64	F	Caucasian	Divorced	Unemployed	Private	CareFirst	N/A
Consumer Group 1	41-50	F	Caucasian	Single	Self Employed	Uninsured	Uninsured	N/A
Consumer Group 1	31-40	M	African American	Single	Construction	Private	CareFirst	N/A
Consumer Group 1	26-30	F	African American	Single	Construction	Employer	Aetna	N/A
Consumer Group 1	51-64	M	Caucasian	Single	Writer/Radio	Uninsured	Uninsured	N/A
Consumer Group 1	41-50	F	Caucasian	Married	Retired	Private	Kaiser	N/A
Consumer Group 1	31-40	M	Caucasian	Single	Priest	Employer	Unknown	N/A
Consumer Group 1	31-40	F	African American	Married	Actor	Private	Kaiser	N/A
Consumer Group 2	31-40	F	African American	Single	Unknown	Employer	Kaiser	N/A
Consumer Group 2	51-64	M	African American	Married	Self Employed	Private	Uninsured	N/A
Consumer Group 2	51-64	F	Caucasian	Divorced	Self Employed	Private	Aetna	N/A
Consumer Group 2	31-40	M	Caucasian	Single	Unknown	Employer	Uninsured	N/A
Consumer Group 2	26-30	M	Caucasian	Single	Unknown	Employer	CareFirst	N/A
Consumer Group 2	41-50	F	Caucasian	Single	Unknown	Employer	CareFirst	N/A
Consumer Group 2	31-40	M	Caucasian	Married	Unknown	Employer	CareFirst	N/A
Consumer Group 2	26-30	F	Caucasian	Married	Unknown	Private	CareFirst	N/A
Consumer Group 2	31-40	F	Caucasian	Married	Unknown	Employer	UnitedHealthcare	N/A
ESL Consumers	31-40	M	Caucasian	Divorced	Federal Contractor	Private	CareFirst	French
ESL Consumers	41-50	F	Hispanic	Single	Financial Planner	Employer	CareFirst	Spanish
ESL Consumers	31-40	F	Asian	Married	Broker	Employer	Aetna	Burmese
ESL Consumers	31-40	F	Other	Married	Medical Association	Employer	Guardian	Zulu
ESL Consumers	41-50	M	Hispanic	Divorced	Energy Broker	Private	CareFirst	Spanish
ESL Consumers	26-30	F	Hispanic	Single	Embassy Worker	Employer	CareFirst	Spanish
ESL Consumers	31-40	M	African American	Single	Variety Store Owner	Uninsured	Unknown	Spanish
ESL Consumers	51-64	M	Hispanic	Single	Restaurant Manager	Employer	Uninsured	Spanish
ESL Consumers	26-30	F	Hispanic	Married	Non-Profit Organization	Employer	CareFirst	Spanish

Small Employer Groups						
Session	**Business**	**Number of Employees**	**Covered Employees**	**Gender**	**ER Contrib**	**Insurer**
Small Employer Group 1	Office Furniture Store	2 - 5	2	F	100%	Unknown
Small Employer Group 1	Physician Management Practice	21 - 30	28	M	100% Single	Unknown
Small Employer Group 1	Food Distributor	6 - 10	7	M	70%	CareFirst
Small Employer Group 1	Physicians Office	11 - 20	11	F	100% Single	Unknown
Small Employer Group 1	Property Management Company	41 - 50	40	M	100% Single	UnitedHealthcare
Small Employer Group 1	Direct Mail Company	6 - 10	6	F	100%	CareFirst
Small Employer Group 1	Technology Company	31 - 40	32	M	60%	CareFirst
Small Employer Group 2	Personal Organizer	2 - 5	3	M	100% Single	UnitedHealthcare
Small Employer Group 2	Distributes Library Supplies	6 - 10	10	M	50%	CareFirst
Small Employer Group 2	Music Industry	2 - 5	2	F	100%	CareFirst
Small Employer Group 2	Payroll Company	41 - 50	30	M	50%	CareFirst
Small Employer Group 2	Physical Therapy Practice	6 - 10	9	M	Flat $	Kaiser
Small Employer Group 2	Cleaning Service	2 - 5	12	F	50%	CareFirst
Small Employer Group 2	Window and Door Company	31 - 40	39	M	100% Single	Unknown

Appendix D

Draft Materials Presented to Focus Groups

In this appendix, we show the draft materials exactly as they were presented to each of the five focus groups.

EXHIBIT A

How does the Maryland Insurance Administration Regulate Health Benefit Plans?

- By making sure health plans have enough money to operate
- By protecting consumers
- By reviewing rates

To make sure health plans are solvent, we:

- Make sure that health plans have enough saved money (reserves) to pay for claims and expenses, even when the companies don't collect enough premiums to cover claims and expenses. (Insurance companies have to build reserves when they are making money … to use when they are losing money.)
- Make certain that health plans charge their customers enough money to stay in business. (If a company doesn't charge enough premiums and doesn't have enough money in reserves, the company won't be able to pay claims. One of the MIA's main duties is to make sure that doesn't happen.)

To protect consumers, we:

- Make sure all companies that offer health benefit plans in Maryland are licensed.
- Make sure all companies obey consumer protection laws by:
  - covering required benefits
  - writing clear and accurate policies
  - using marketing materials that are not misleading.
- Provide information about insurance and consumers' rights.
- Research complaints from consumers.
- Examine companies' business practices.

EXHIBIT A (Cont.)

When reviewing rates, we:

- Check to see that policy rates follow the law and standard actuarial practices.
- Check rates for all individual and small group comprehensive major medical policies.
- Develop an independent, expert opinion on whether the rates being requested are reasonable for the benefits being provided. (We make sure that the rates aren't too high or too low, that they don't discriminate unfairly, and that they comply with all state regulations.)
- Check rates before increases are passed on to consumers.

  If we don't allow a rate increase, an insurance company may ask for a hearing to explain why it believes its rates are reasonable.

  If a consumer complains about a premium, we make sure the rate charged is the one on file.

Note: Not all health benefit plans are subject to Maryland law. The MIA does not regulate:

- Health benefit plans that are offered through the federal government
- Employee plans that are self-funded by an employer
- Plans issued in other states
- Medicare or Medicaid (They are federal health plans)

EXHIBIT B1

Rate filing Decision Summary
March 7, 2011

Health Plan: ABC Insurance Company
Coverage: Individual Non-Grandfathered Health Plans
Policy Form(s): MD1003
Number of Members Affected: 2,182

Company Request:
Average Rate Increase: 22%
Minimum Increase for Any Policyholder: 20%
Maximum Increase for Any Policyholder: 25%
Effective Date: April 1, 2011

Maryland Insurance Administration (MIA) Approval:
Average Rate Increase: 15%
Minimum Increase for Any Policyholder: 12%
Maximum Increase for Any Policyholder: 18%
Effective Date: May 1, 2011

Summary of the MIA's Decision
The health plan requested a 22% rate increase. The Administration approved a 15% increase. The approved increase is needed to cover the increased cost of health care claims.

During the base experience period, total costs for these plans increased at an annual rate of 13.2% over the prior period. This reflects increases in the number of health care services used and the costs for those services. Total costs paid to medical providers are expected to increase in the near future at the same rate. The MIA considers the assumption reasonable.

These plans have deductibles ranging from $1,500 to $5,000. These high deductibles lead to deductible leveraging, which causes claims paid by the health plan to increase faster than total costs. Therefore, the health plan assumed the costs they pay under the policy will increase at a rate of 15% next policy period. The MIA believes the 15% assumption is reasonable.

The health plan is also changing factors they use to vary rates by age. The changes are supported by a study of medical and drug costs by age. The change in these factors does not add to the average increase across all policies. However, the change will cause the rate increase for any individual policyholder to be higher or lower than the average.

During the base experience period, the observed loss ratio was 79.7%. After the approved average 15% increase, the loss ratio during the period the rates will apply is expected to be 80.4%.

EXHIBIT B1 (Cont.)

Glossary of Terms:

Base Experience Period: The period of claims used to determine if a rate increase is needed.

Deductible: The dollar amount an insured person must pay each policy period for medical care before the insurance policy starts paying claims.

Deductible Leveraging: Occurs when a deductible stays the same while total costs rise. Since the deductible paid by an insured person does not increase, the costs paid by the health plan increase faster than the total increase in claims.

Loss Ratio: The percentage of each premium dollar that a health plan spends on claims.

Rate Increase: The amount by which premium rates will rise from their current level. This does not include additional increases resulting from changes in benefits, age, adding a family member to your policy, etc.

EXHIBIT B2

Rate filing Decision Summary
March 7, 2011

Health Plan: ABC Insurance Company
Coverage: Individual Non-Grandfathered Health Plans
Policy Form(s): MD1003
Number of Members Affected: 2,182

Company Request:
Average Rate Increase: 22%
Minimum Increase for Any Policyholder: 20%
Maximum Increase for Any Policyholder: 25%
Effective Date: April 1, 2011

Maryland Insurance Administration Approval:
Average Rate Increase: 15%
Minimum Increase for Any Policyholder: 12%
Maximum Increase for Any Policyholder: 18%
Effective Date: May 1, 2011

Summary of the Maryland Insurance Administration's Decision
The health plan requested a 22% rate increase. The Administration approved a 15% increase.

Components of the Average Rate Increase

Component	***Rate Impact***
Actual to Expected Adjustment	0% to 1%
Trend	12% to 13%
Deductible Leveraging	2% to 3%
Changes in Administrative Expense/Profit	0%
TOTAL	15%

Differences in Policyholder Rate Increases
The health plan is changing factors they use to vary rates by age. The changes are supported by a study of medical and drug costs by age. The change in these factors does not add to the average increase across all policies. However, the change will cause the rate increase for any individual policyholder to range from -3% to +3%, in addition to the average rate increase.

Loss Ratios
During the prior period, the observed loss ratio was 79.7%.

After the approved average 15% increase, the loss ratio during the period the rates will apply is expected to be 80.4%.

EXHIBIT B2 (Cont.)

Glossary of Terms:

Actual-to-Expected Adjustment: The difference between claims costs during the base period and the health plan's prior estimate of those costs.

Administrative Expense: Costs the health plan pays to operate the insurance plan. These include all costs not directly related to paying claims (such as, but not limited to, salaries of health plan employees, the cost of the health plan's offices, agents' commissions to sell and service policies, and taxes).

Base Period: The period of claims reviewed to determine if a rate increase is needed.

Deductible: The dollar amount an insured person must pay each policy period for medical care before the insurance policy starts paying claims.

Deductible Leveraging: Occurs when a deductible remains the same while medical costs rise. Since the deductible paid by an insured person does not increase, the costs paid by the health plan increase faster than the total increase in claims.

Loss Ratio: The percentage of each premium dollar that a health plan spends on claims.

Profit: Money the health plan has left after paying for claims and administrative expenses. (*Margin* is the comparable term for a nonprofit health plan.)

Rate Increase: The amount by which premium rates will rise from their current level. This does not include additional increases resulting from changes in benefits, age, adding a family member to your policy, etc.

Trend: The annual increase in total medical claims costs.

EXHIBIT C (Page 1)

How Do Health Plans Develop Rates?

To develop rates, health plans estimate future claims costs, administrative expenses, and profits and then add them together.

- **Claims Cost:** The amount a health plan has to pay providers of medical care (physicians, hospitals, drug companies, etc.) on behalf of *all policyholders* with similar policies. This amount does not include any deductible or copayment paid by the policyholders.

- **Administrative Expense:** The cost of administering an insurance plan. This includes:

  - Salaries of health plan employees (for example, customer service agents)
  - Costs to maintain computer systems to pay claims
  - Costs to manage the provider network
  - Commissions for agents and brokers
  - Rent
  - Premium taxes
  - Other costs to administer the policy

- **Profit:** Money that the health plan has left after paying for claims and administrative expenses.

EXHIBIT C (Page 2)

How do Health Plans Estimate Claim Costs?

Health plans estimate total claim costs for *all policyholders* with similar policies based on the following factors:

- How many services policyholders will use
- Which types of service will be used (for example, x-ray or MRI)
- Where policyholders will go for services (for example, a physician's office or emergency room)
- Average amount paid to medical providers for each service
- Portion of the cost of services that the policyholder will pay (deductible, copayment, etc.)

EXHIBIT C (Page 3)

What Makes Premiums go up for all Policyholders Covered Under a Policy Type?

- **Increases in total claims costs for policyholders with similar policies.** Health plans typically call this "trend." These increases can be caused by:
  - Changes in the number of services provided
  - Changes in the type of services provided, including new medical technology
  - Changes in where patients go for services.
  - Changes in the amount paid to medical providers.

- **New services covered by the policy** (typically due to changes in federal or state laws).

- **Changes in administrative expenses.**

- **Changes in contributions to profit.**

- **Adjustments to earlier estimates.** If the estimate was too low, a larger increase is needed to get to the new estimate of future costs.

Since most of the premium is used to pay claims, the increase in claims costs is usually the main reason rates go up.

What Causes my Premium to Increase at a Different Rate than Others with the Same Insurance Policy?

- Reaching a higher age
- Adding a new family member to the policy
- Changing benefits

In addition, if you get your coverage through your employer,

- Your premium may change because your employer's premium changes. Your employer's premium may change because of changes in the average age and family size of the whole group.
- Your cost may change because your employer is paying more or less of the total premium.

Note that your own (and your covered family members') claims experience and health conditions do *not* affect your rates.

Appendix E

Rate Filing Decision Summary Template

Rate Filing Decision Summary

March 7, 2011

For definitions of underlined words, see the glossary of terms at the end of this document.

Health plan: ABC Health Insurance Company
Coverage: Health plans purchased by individuals (and their families)
Policy form(s): 25574
Plan name(s): Green Earth Plus, Green Earth Savers
Number of members affected: 900

Company Request:

Average rate increase: 11.8%
Minimum increase for any policyholder: 5.0%
Maximum increase for any policyholder: 13.6%
Effective date: April 1, 2011

Maryland Insurance Administration Approval:

Average rate increase: 10.8%
Minimum increase for any policyholder: 4.0%
Maximum increase for any policyholder: 12.6%
Effective date: May 1, 2011

Your rate increase may differ from the average approved rate increase. Your premium may increase by less than the minimum increase or more than the maximum increase shown above, since your premium increase may include age changes.

Summary of the Maryland Insurance Administration's Decision

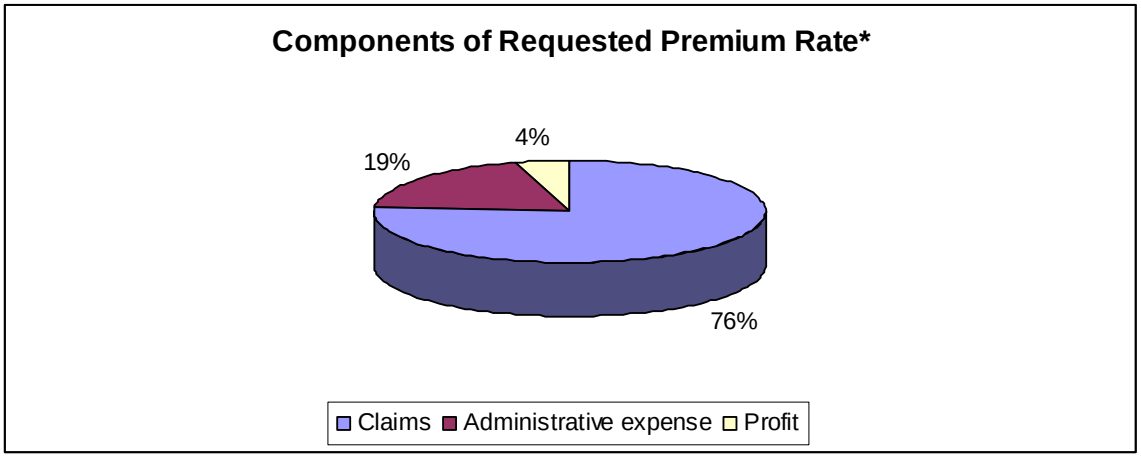
The health plan requested an 11.8% rate increase.

Components of the Average Rate Increase Requested by the Health Plan

	Company Request		***Administration Approval***	
Component	***Rate***	***Percentage of Total Rate Impact****	***Rate***	***Percentage of Total Rate Impact****
Prior year average rate	$210.23		$210.23	
Changes in medical and pharmacy costs	$19.91	80%	$19.91	88%
Changes in profit	$2.49	10%	$0.37	2%
Changes in administrative expense	$2.42	10%	$2.42	11%
Total average rate	**$235.05**		**$232.93**	

** Percentages may not add to 100% due to rounding.*

The requested average premium reflects the following components:



** Percentages may not add to 100% due to rounding.*

Claim Costs

During the base experience period, total medical and pharmacy costs for these plans increased at an annual rate of 8.2% over the prior period. This reflects increases in the number of health care services used and the costs for those services.

These plans have deductibles ranging from $1,500 to $5,000. These high deductibles lead to deductible leveraging, which causes claims paid by the health plan to increase faster than total costs. Therefore, the health plan is assuming that the costs it pays under the policy will increase at a rate of 2% next annual policy period, in addition to the trend in medical costs. The health plan is using a trend assumption, including leveraging, of 8.7%. The Administration believes this assumption is reasonable based on past increases in claim costs.

The requested 11.8% rate increase exceeds the 8.7% trend estimate. The rates increased by an additional 3.5% above and beyond trend because the prior year rates were based on projected claims that turned out to be 3.5% higher than initially anticipated.

Trend is the most significant driver of the rate increase. Trend is the result of increasing fees paid to medical and drug providers, as well as increases in the number or intensity of services used by members.

Administrative Expenses

The health plan is increasing its charges for administrative expenses. The administrative expense charges per member are increasing by 5.6%. This increase is above inflation; however, the Administration believes the increase is reasonable based on support provided by the health plan. The health plan is undergoing a computer upgrade, the costs of which are being spread over several years.

Profit
The health plan is also attempting to increase its profit charges by 32.3% per member. This change is not adequately supported, and would result in an increase significantly above trend.

Benefit Changes
The benefits covered by the policy have not changed.

Differences in Policyholder Rate Increases
The health plan is changing the factors it uses to vary rates by age. The changes are supported by a study of medical and drug costs by age. The change in these factors will not add to the average increase across all policies. However, the change will cause the rate change for any individual policyholder to range from -2% to +2%, in addition to the average rate increase.

The health plan is also changing area factors. The Western Maryland region is receiving rate reductions of 5%. The revision is supported by a consultant's study. The health plan has little enrollment in this area. Therefore, its own claims experience is not reliable for studying costs in this area, and the change does not significantly affect the average rate.

Decision: The Administration approved a 10.8% average rate increase. The approved increase is lower than requested due to unreasonable profit charges. The approved increase is needed to cover the increased cost of health care claims and expense increases.

Loss Ratios
During the prior period, the observed loss ratio was 79.8%.

After the approved average 10.8% increase, the loss ratio during the period the rates will apply is expected to be 76.9%, and the adjusted loss ratio is expected to be 80.3%.The minimum allowed adjusted loss ratio under Maryland law is 80.0%. The approved rates comply with Maryland's law.

History of Average Rate Increases

Calendar Year	Requested	Implemented
2010	10.0%	10.0%
2009	8.0%	8.0%
2008	13.0%	7.0%

Glossary of Terms

actual-to-expected adjustment: The difference between claim costs during the base period and the health plan's prior estimate of those costs.

administrative expense: Costs the health plan pays to operate the insurance plan. These include all costs not directly related to paying claims (such as salaries of health plan employees, the cost of the health plan's offices, agents' commissions to sell and service policies, and taxes).

adjusted claims: Claims plus costs to improve health care quality.

adjusted premium: Premium with taxes, licenses, fees, and other state-required expenses removed.

adjusted loss ratio: A ratio calculated by dividing adjusted claims by adjusted premium.

base experience period: The period of claims reviewed to determine whether a rate increase is needed.

changes in medical and pharmacy costs: The total increase in claim costs from the estimate in the prior rate to the estimate in the requested rate. This includes the actual-to-expected adjustment, trend, and deductible leveraging.

deductible: The dollar amount an insured person must pay each policy period for medical care before the insurance policy starts paying claims.

deductible leveraging: Occurs when a deductible remains the same while medical costs rise. Since the deductible paid by an insured person does not increase, the costs paid by the health plan increase faster than the total increase in claims.

loss ratio: The percentage of each premium dollar that a health plan spends on claims. In other words, a loss ratio of 75% means 75 cents of every premium dollar is used to pay claims.

member: A person covered under a health insurance policy. Members include the subscriber who purchased the policy and his or her covered dependent(s).

profit: Money that the health plan has left after paying for claims and administrative expenses. (*Margin* is the comparable term for a nonprofit health plan.) Some of this money is saved to pay for claims and administrative expenses in years when the plans don't collect enough premiums.

rate increase: The amount by which premium rates will rise from their current level. This does not include additional increases resulting from benefit changes, age changes, adding a family member to a policy, etc.

trend: The annual increase in total medical and pharmacy claim costs.

Appendix F

Maryland Insurance Administration's Role in Regulating Health Plans

The Administration's role in regulating health plans?

- By protecting consumers
- By making sure health plans have enough money to pay claims for their customers
- By reviewing and approving all rates subject to Maryland laws

To protect consumers, we:

- Make sure all health plans that offer health benefit plans in Maryland are licensed; post consumer alerts when health plans are operating without a license
- Make sure all health plans obey consumer protection laws by:
  - covering required benefits (for example, mental illness)
  - writing accurate policies that state all policy benefits
  - using marketing materials that are not misleading
- Provide information about insurance and consumers' rights
- Research complaints from consumers and suggest actions that consumers can take to resolve problems; require health plans to take corrective action, if needed
- Examine companies' business practices to make sure they comply with Maryland law; take corrective action as needed.

To make sure health plans have enough money, we:

- See that health plans have enough reserves built (money saved) to pay for claims and expenses, even when the plans don't collect enough premiums to cover claims and expenses. (Health plans have to build reserves when they are making money … to use when they are losing money.)
- Make certain that health plans charge their customers enough money to pay all claims promised to customers. If a health plan doesn't charge enough premiums and doesn't have enough money in reserves, it won't be able to pay claims. One of the Maryland Insurance Administration's

main duties is to make sure that doesn't happen.

When reviewing rates, we:

- Check to see that policy rates follow Maryland law and standard insurance pricing practices
- Check rates for all individual and small group comprehensive major medical policies to make sure the health plan is not charging more for expenses and profit than Maryland law allows
- Make health plans reduce rates if they have charged too much in the past

A health plan may not charge a rate until we approve it. If we don't allow a rate to be charged, a health plan may ask for a hearing to explain why it believes its rates are reasonable.

If a consumer complains about a premium, we make sure the rate charged is one we have reviewed and approved. If the health plan is using an unapproved rate, we require the plan to make any necessary changes.

Not all health benefit plans are subject to Maryland law. The Maryland Insurance Administration does not have the authority to regulate plans that are subject to federal law or another state's laws, such as:

- Health benefit plans that are offered through the federal government
- Employee plans that are self-funded by an employer
- Plans issued in other states
- Medicare or Medicaid (which are federal health plans)

How to contact the Maryland Insurance Administration:
[To be filled in by the Administration]

Appendix G

How Health Insurance Rates and Premium Increases Are Determined

How do health plans develop rates?

To develop rates, health plans estimate future claim costs, administrative expenses, and profits and then add them together.

- **Claim cost:** The amount a health plan has to pay medical care providers (physicians, hospitals, drug companies, etc.) on behalf of *all policyholders* with similar policies. This amount does not include any deductible or copayment paid by the policyholders.

- **Administrative expense:** The cost of administering an insurance plan. This includes:

  - Salaries of health plan employees (for example, customer service agents)
  - Costs to maintain computer systems to pay claims
  - Costs to manage the provider network (signing up doctors, setting payment rates, etc.)
  - Commissions for agents and brokers
  - Rent
  - Premium taxes (a percentage of premium that health plans pay to the state of Maryland)
  - Other costs to administer the policy (for example, checking for fraud)

- **Profit:** Money that the health plan has left after paying for claims and administrative expenses. Some of this money is saved to pay for claims and administrative expenses in years when the plans don't collect enough premiums.

How do health plans estimate claim costs?

Health plans estimate total claim costs for *all policyholders* with similar policies based on the following factors:

- How many services policyholders will use
- Which types of services will be used (for example, x-ray or MRI)
- Where policyholders will go for services (for example, a physician's office or an emergency room)
- The average amount paid to medical providers for each service (average of all Maryland policyholders with similar policies)
- The portion of the cost of services that the health plan will pay (total cost minus deductible, copayment, etc.)

Each item in the list above is typically estimated using past history of the policies, adjusted to reflect expected increases in total claim costs ("trend") and any changes in covered services.

What makes premiums go up for all policyholders covered under a policy type?

- **Increases in total claim costs for policyholders with similar policies.** Health plans typically call this "trend." These increases can result from changes in the following:
  - The number of services provided
  - The type of services provided, including new medical technology
  - Where patients go for services
  - The amount paid to medical providers

- **New services covered by the policy** (typically due to changes in federal or state laws – for example, a requirement to treat mental illness).

- **Changes in administrative expenses.**

- **Changes in contributions to profit.**

- **Adjustments to earlier estimates.** If an estimate was too low, a larger increase is needed to get to the new estimate of future costs. If an estimate was too high, a smaller increase is needed.

Since most of the premium is used to pay claims, an increase in claim costs is usually the main reason rates go up. (The items in the list above can also reduce rates; however, usually the items that increase rates more than offset the items that reduce rates.)

What causes my premium to increase at a different rate than others with the same insurance policy?

If you purchase your own health insurance or have coverage through your employer, your premium may change because of:

- Reaching a higher age
- Adding a new family member to the policy
- Changing benefits

In addition, if you have coverage through your employer,

- Your premium may change because your employer's premium changes. Your employer's premium may change because of changes in the average age and family size of the whole group.
- Your cost may change because your employer is paying more or less of the total premium.

Note that your own (and your covered family members') claim experience and health conditions

do *not* directly affect your rates. Rates are based on costs of everyone with similar policies.

How much of my premium is used to pay claims?

Federal and state law now says that at least 80% of the premium collected by a health plan must be used to pay claims for coverage purchased by individuals or small employer groups. This means that for every dollar of premium collected, 80 cents must be used to pay claims. At least 85% of premium must be used to pay claims for coverage bought by large employer groups.

- If a health plan does not meet the minimums, it must return some money to policyholders in order to meet the minimums. This returned premium is called a "rebate."
- The amounts given back are shared by everyone in a given market (individual, small group, or large group) based on the health plan's results for the entire market. Even though you may not have had any claims during the year, you may not receive any money back since the premiums to be returned are determined for all members of your health plan in your market. (If the health plan meets the minimum in total for all members in your market, then none of the health plan's members will receive a refund.)
- For more information on rebates, refer to: http://www.naic.org/documents/ppaca_sub_draft_mlr_rebate_reg.pdf.

Appendix H

Procedures Health Plans Must Follow When Requesting a Rate Increase

Procedures Health Plans Must Follow When Requesting a Rate Increase

State law requires health insurance companies, HMOs, and health service corporations to file rates and have them approved by the Maryland Insurance Administration before using them.

How long before the effective date do health plans have to file a request?

- Health insurance companies and health service corporations must file their rates at least 90 days before the rates will become effective.
- HMOs must file their rates at least 60 days before the rates will become effective.

What do health plans have to include in a rate filing?

The rate filing must contain information that the Administration needs to determine whether the requested rates are reasonable in relation to the benefits. This includes information such as:

- The average rate increase requested by the health plan
- The minimum and maximum rate increase requested
- The product(s) that would be affected by the increase
- The claim experience used to develop the rates
- The number of policyholders covered by the policy form
- The health plan's estimate of trend, which reflects how much claims are expected to increase the following year
- An actuarial memorandum

What is an actuarial memorandum?

This is a document prepared by the actuary who developed the rates. The memorandum describes the steps that were completed in making the rate filing and outlines each of the assumptions that the actuary made. The memorandum must also include support for those assumptions. Key items in the actuarial memorandum include:

- The reason for the rate increase
- The period for which the rates will be effective
- A summary of historical rate increases
- A description of the benefits
- A description of how the proposed rates were developed
- The expected loss ratio (a loss ratio is the percentage of premium that is used to pay claims)
- Trend assumption(s)
- A comparison of the current rates to the proposed rates

What does the health plan have to do to support the requested rate increase?

The health plan must demonstrate that the requested premiums are anticipated to generate a loss ratio at or above the minimum required by law.

Do health plans have to submit a rate filing each year?

Health plans only need to submit a rate filing if they are requesting to change the rates. Plans must submit a certification each year for small group products, confirming that the rates charged during the past year complied with the law.

How often can a health plan submit a filing to change the rates?

There are no limits on how often rate changes can be requested. Most health plans file their rates once a year; however, some file them each quarter. Each time a rate change request is filed, the health plan must demonstrate that the loss ratio test is expected to be met. Regardless of how often a health plan files and is approved for a rate increase, a policyholder's premium in the individual market may not increase more than once every 12 months except in cases where a new family member is added.

Appendix I

How the Administration Reviews Requests for Rate Increases

How the Administration Reviews Requests for Rate Increases

State law requires health plans to file rates and have them approved by the Maryland Insurance Administration before using them. The Administration reviews and approves rates for individual, small group, and large group markets.

Are any health plan rates *not* subject to review by the Administration?

Yes. The Administration does not have the authority to review rates for:

- Health benefit plans offered through the federal government
- Employee plans that are self-funded by an employer
- Plans issued in other states
- Medicare or Medicaid (which are federal health plans)

Who reviews rate increase requests at the Administration, and how are they qualified?

The Administration has actuaries on staff who review rate increase requests. Actuaries have strong math skills and are trained in developing insurance rates.

What information does the Administration look at when reviewing a rate increase request?

The Administration reviews the filing by looking at:

- Information in the filing to make sure it is consistent with information in the previous filing
- Changes in the number of members covered under the policies
- Changes in medical and pharmacy costs
- Past and future administrative expenses
- History of loss ratios (a loss ratio is the percentage of premium that is used to pay claims)
- History of rate changes
- Changes in cost sharing
- Changes in benefits
- Historical profits, future profit goals, and any changes from previous rate filings
- The company's financial strength
- The accuracy of the math supporting the rate increase
- The loss ratio (to make sure it meets the minimum requirement in Maryland)
- The proposed rates and benefits (to make sure they follow Maryland law)

Do health plans always get approval for the rate increases they request?

No. If a health plan does not provide strong enough support for a requested increase, the Administration either asks for more supporting information or approves a smaller increase that, in the Administration's opinion, is supported by the information in the rate filing. If the health plan does not respond to the Administration's request for more information, the increase is denied.

How does the Administration decide whether to approve a requested rate increase?

Health plans must show that the requested rates will generate premiums that meet the state's minimum loss ratio requirement. If a health plan cannot show this, the Administration does not approve the rates as requested.

Can the Administration approve the rate increase for some products and deny others for the same health plan?

Yes. The Administration reviews the rates for each product. If the rates for some products are not supported, those products' rates are not approved.

How long does the Administration take to review a rate filing?

The Administration takes as much time as needed to approve or disapprove a rate filing.

How can consumers find out more about rate increase requests filed by their carrier?

- The Administration posts rate filings on its website for consumers to view. (These are filings submitted for individual and small group plans.) Consumer-friendly summaries are also posted.
- Once the Administration completes the review and makes a decision, a summary of the results is also posted.
- Consumers can find this information at the following link:
  [Website link to be filled in by the Administration]

What if the health plan disagrees with the Administration's decision?

If health plan officials feel that they have provided enough support for the requested rate

increase but the Administration either denies the request or approves a smaller increase, the health plan has the right to a rate hearing before an administrative law judge.

Will the Administration reduce or deny a rate increase if consumers cannot afford it?

No. While, the Administration understands that health insurance premiums are very expensive and continue to increase faster than people's incomes and the cost of living, Maryland law requires that premium rates be reasonable in relation to the benefits provided. The Administration has to make sure companies have enough money to pay for claims and expenses. This money comes from premiums; if premiums are not high enough, claims and expenses cannot be covered.

How can I contact the Administration if I still have questions?

To contact the Administration, [*to be filled in by the Administration*]

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