INSURANCE ADMINISTRATION

Report on Health Insurance Rate Review Process and Information Provided to Consumers

August 17, 2011

EXECUTIVE SUMMARY

Last year, pursuant to Section 1003 of the Patient Protection and Affordable Care Act of 2010 (P.L. 114-148), as amended by the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152) (collectively, the "Affordable Care Act" or "ACA"), the Department of Health and Human Services ("HHS") announced Grants to States for Health Insurance Premium Review – Cycle I, in order to help states improve the health insurance rate review and reporting process to ensure consumers receive value for their premium dollars, and to help states increase the transparency of the health insurance system.[1] The Maryland Insurance Administration ("MIA") applied for and received a Cycle I grant. The MIA engaged Oliver Wyman Actuarial Consulting, Inc. ("Oliver Wyman") to provide recommendations on how best to enhance the premium rate review process and how best to provide and present information to consumers about changes in premium rates and key drivers of those changes.

Oliver Wyman's recommendations are presented in two reports, *Recommendations to the Commissioner to Enhance Regulatory Review and Oversight* and *Recommendations to the Commissioner on Information Provided to Consumers*. Following the receipt of these reports, the Insurance Commissioner convened a quasi-legislative hearing to solicit public comment on Oliver Wyman's recommendations. Oliver Wyman's recommendations were informed by regulations recently issued by HHS regarding the review and disclosure of certain premium rate increases.

In order to ensure consumers receive value for their premium payments, the MIA intends to make a number of changes to enhance its rate review process. Some of the key changes are:

- Perform enhanced rate reviews for all rate filings proposing a change in rates in the individual and small group market segments in the following phases:
    i. Beginning September 1, 2011, for all rate filings for non-grandfathered plans under the ACA proposing a rate increase equal to or greater than 10 percent;
    ii. Beginning July 1, 2012, for all rate filings proposing any change in rates in the individual market; and
    iii. Beginning January 1, 2013, for all rate filings proposing any change in rates for rate filings in the small group market.
- Require submission of Preliminary Justification Part I and Part II forms for rate filings subject to an enhanced rate review process and consider the factors included in the Preliminary Justification to determine whether a proposed rate increase is unreasonable.

[1] *See* Department of Health and Human Services, Grants to States for Health Insurance Premium Review – Cycle I, Initial Announcement, Invitation to Apply for FY 2010, CFDA: 93.511 (June 7, 2010), available at http://cciio.cms.gov/resources/fundingopportunities/final_premium_review_grant_solicitation_with_disclosure_statement.pdf.

The MIA also intends to implement certain procedural changes in its rate review process, including, among other things:

- Implementing a standard checklist that carriers can use in preparing individual and small group rate filings; and
- Developing a standardized template for providing HHS with a summary of rate reviews.

To further support an enhanced rate review process, the MIA intends to:

- Continue to explore with the Maryland Health Care Commission and the Health Services Cost Review Commission the feasibility and desirability of using the data available from these agencies to develop benchmark trends;
- Consider seeking express statutory authority to disapprove rate filings of insurers and HMOs based on "any other relevant factors within and outside the State," consistent with such express statutory authority to disapprove rates for nonprofit health service plans.

In order to provide all consumers with sufficient advance notice of premium rate changes, the MIA will pursue a regulatory amendment to provide for advance notice of premium rate changes by insurers and non-profit health service plans in the individual market at least 45 days prior to the implementation of the rate change, consistent with the advance notification period required for HMOs and for all carriers in the group markets. [2]

The MIA will begin to improve the information available to consumers about premium rate filings by providing a link to the HHS website for rate filings requesting a rate increase of 10 percent or more. The MIA will continue to explore options to obtain the resources needed to disclose information on all rate filings in the individual and small group markets on the MIA's website.

Fully implementing an enhanced and transparent rate review process will require additional resources, including additional actuarial staff to carry out an enhanced rate review process and additional information technology staff to develop and maintain a robust website that provides consumers with (1) current information about proposed changes in premium rates; (2) a mechanism for commenting on those proposed changes; and (3) information about the MIA's action regarding those proposed changes. HHS recently announced the availability of additional grant funds to help states continue to enhance their rate review process. The MIA has applied for a Premium Rate Review – Cycle II grant in order to be able to fully implement the plans of action on Oliver Wyman's recommendations identified in this Report. If the MIA is awarded a Cycle II grant, the MIA anticipates having the resources to fully implement an enhanced and transparent rate review process by the end of calendar year 2013.

[2] COMAR 31.10.01.02R currently requires insurers and non-profit health service plans in the individual market to notify policyholders of a rate increase at least 40 days prior to the expiration of the grace period applicable to the first increased premium, which effectively provides such policyholders with 10 days notice before the effective date of a rate increase.

INTRODUCTION

The Patient Protection and Affordable Care Act of 2010 (P.L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152) (collectively, the "Affordable Care Act" or "ACA"), directs the Secretary of the Department of Health and Human Services ("HHS"), in conjunction with the States, to develop a process for the annual review of "unreasonable" increases in premiums for health insurance coverage.[3] The process must include a requirement for health insurance issuers[4] to submit to HHS a justification for an unreasonable premium increase prior to the implementation of the increase, as well as public disclosure of information on such increases.[5] The ACA authorized HHS to award grants during the 5-year period beginning with fiscal year 2010 to assist states in reviewing and, if appropriate under state law, approving premium increases for health insurance coverage and in providing information to HHS.

Last year, HHS announced Grants to States for Health Insurance Premium Review – Cycle I ("Cycle I grants"). The Maryland Insurance Administration ("MIA") applied for and received a Cycle I grant, in part to secure consultant services to provide recommendations on how best to enhance the premium rate review process and how best to provide and present information to consumers and public policymakers about changes in premium rates and key drivers of those changes.

The MIA engaged Oliver Wyman Actuarial Consulting, Inc. ("Oliver Wyman") to carry out this task. Oliver Wyman issued two reports, *Recommendations to the Commissioner to Enhance Regulatory Review and Oversight* and *Recommendations to the Commissioner on Information Provided to Consumers*.[6] Following the receipt of these reports, the Insurance Commissioner ("Commissioner") convened a quasi-legislative public hearing and solicited public comment on Oliver Wyman's recommendations.[7] Written comments were filed by: (1) Scott D. Haglund, FSA, MAAA, FLMI, Federated Life Insurance Company; (2) Michael B. Robbins, Maryland Hospital Association ("MHA"), on behalf of its members; (3) Gene M. Ransom, III, MedChi, The Maryland State Medical Society ("MedChi"); (4) Deborah R. Rivkin, CareFirst BlueCross

[3] Where, as in Maryland, HHS has determined that a State that has an "effective rate review program," an "unreasonable rate increase" means "a rate increase that the State determines is excessive, unjustified, unfairly discriminatory, or otherwise unreasonable as provided under applicable State law." 45 C.F.R. § 154.102.

[4] The terms "health insurance issuer" and "carrier" are used interchangeably in this Report and include an insurer, a nonprofit health service plan, and a health maintenance organization.

[5] *See* ACA § 2794.

[6] Both reports are available on the MIA's website, www.mdinsurance.state.md.us. Oliver Wyman also submitted an addendum to each report to amend its recommendations based on HHS's final regulations, *Rate Increase Disclosure and Review*, 45 C.F.R. Part 154, 76 Fed. Reg. 29985 (May 23, 2011) ("Rate Review Regulations").

[7] The Commissioner held the quasi-legislative hearing on June 23, 2011. A transcript of the hearing is available on the MIA's website.

BlueShield ("CareFirst"); and (5) and Kimberly Y. Robinson, Esq., The League of Life and Health Insurers of Maryland (the "League"). Messrs. Robbins and Ransom and Ms. Robinson also provided oral comments at the public hearing.

This report is organized in two parts. Part 1 addresses the rate review process. This part summarizes Oliver Wyman's findings, recent HHS actions regarding rate review, Oliver Wyman's recommendations, the public comments received (if any) about each recommendation, [8] and the MIA's plan of action with respect to each recommendation. Part 2 addresses information provided to consumers about the rate review process and mechanisms for receiving public comments on proposed rate increases. Part 2 follows the same format as Part 1.

PART 1: PREMIUM RATE REVIEW PROCESS

A. Maryland's Current Rate Review Authority and Process

The MIA asked Oliver Wyman to review the MIA's current rate review authority and process, and to compare them with those of insurance regulators in other states. Oliver Wyman reported that the MIA currently has greater rate approval authority than insurance regulators in most other states, and that Maryland's rate review process is as rigorous as, and in some respects more rigorous than, the process in most other states.

With regard to rate review authority, the MIA has prior approval authority for rates in the individual, small group and large group market segments. By way of comparison, Oliver Wyman reported that 30 states have prior approval authority in the individual market segment and 25 states have prior approval authority in the small group market segment. Only a very few states, however, have the regulatory authority to review and approve rates or rating factors in the large group market segment.

In terms of the rate review process, Oliver Wyman reported that many states use loss ratio tests to determine the reasonableness of requested premium rates, particularly in the individual market segment. Generally, other states use lifetime loss ratio tests in the individual market. In Maryland, loss ratio requirements apply prospectively to the period for which the requested rates would apply. Oliver Wyman concluded that the test applied in Maryland, in conjunction with the Commissioner's authority to require future rate reductions if historical experience results in loss ratios below the regulatory minimum, puts Maryland on par with states using a lifetime loss ratio approach.

Maryland also requires small group carriers to submit an annual actuarial certification confirming rates charged in the prior year complied with Maryland's small group rating rules. Oliver Wyman reported this practice is universal among the states that have passed small group rate reforms.

[8] Certain of the public comments that MIA received exceeded the scope of Oliver Wyman's recommendations. Although the MIA appreciates those comments and shall consider them when appropriate, those comments are not specifically addressed in this Report.

Further, Maryland reviews trend factors included in rate filings for reasonableness. Oliver Wyman pointed out that regulatory agencies in other states do not independently calculate medical trend. Generally, independent actuaries are hired to do the calculations when a rate hearing is needed. Most states today perform more general reviews of trend at the level currently performed by the MIA.

Maryland does not require the use of a standard credibility formula or table. This is the approach taken in other states.[9]

Oliver Wyman concluded that Maryland's approach to reviewing individual rates is about average in intensity of review as compared with other states. The review of small group rates is more in-depth than average. Using a scale of 1 (little or no review) to 4 (rigorous review) to provide an overall assessment of Maryland's rate review approach, Oliver Wyman gave Maryland a score of 3.5.

B. Effective Rate Review

Pursuant to HHS Rate Review Regulations, beginning September 1, 2011, all rate increases in the individual and small group market segments, except for grandfathered health plans,[10] of 10 percent or more must be reviewed by a State or HHS to determine whether the proposed rate increases are unreasonable (hereinafter referred to as rate filings "subject to review").[11] A proposed rate is unreasonable if it is excessive,[12] unjustified,[13] or unfairly discriminatory.[14]

For each rate increase subject to review, a health insurance issuer must submit a Preliminary Justification for each product affected by the increase on a form and in the manner prescribed by the Secretary of HHS ("Secretary"). The Preliminary Justification includes three parts. Preliminary Justification Part I must include:

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

[9] Credibility standards have been set for Medicare Advantage.
[10] HHS Rate Review Regulations exempt grandfathered plans. *See* 45 C.F.R. § 154.103(b).
[11] HHS may modify this review threshold each year and establish a specific threshold for a specific state. 45 C.F.R. § 154.200.
[12] HHS will consider a proposed rate increase excessive if it results in a projected medical loss ratio below the applicable Federal standard, if one or more of the assumptions is not supported by substantial evidence, or if the choice of assumptions (or combination thereof) is unreasonable. 45 C.F.R. § 154.205(b).
[13] HHS will consider an increase unjustified if the issuer provides data or documentation that is incomplete, inadequate, or otherwise does not provide a basis upon which the reasonableness of an increase may be determined. 45 C.F.R. § 154.205(c).
[14] HHS will consider an increase unfairly discriminatory if it results in premium differences between insureds with similar risks that are not permitted under State law or, in the absence of an applicable State law, do not reasonably correspond to differences in expected costs. 45 C.F.R. § 154.205(d).

- Three-year history of rate increases for the product associated with the rate increase.[15]

Preliminary Justification Part II must include a simple, brief narrative describing the data and assumptions used to develop the rate increase, including the rating methodology, the most significant factors causing the increase, and a brief description of the policies' overall experience.[16] Preliminary Justification Part III must include rate filing documentation sufficient for HHS to determine whether the requested rate increase is an unreasonable rate increase.[17]

A state may make the final determination as to whether a rate filing subject to review is unreasonable if HHS finds the state has an "effective rate review program."[18] An effective rate review program means that the state's review process includes an examination of the:

- Appropriateness of the assumptions used by the carrier to develop the proposed rate increase and the validity of the historical data underlying the assumptions;
- Carrier's data related to past projections and actual experience; and
- Impact of the following factors to the extent applicable to the filing under review:
    - Medical trend changes by major service categories;
    - Utilization changes by major service categories;
    - Cost-sharing changes by major service categories;
    - Benefit changes;
    - Changes in enrollee risk profile;
    - Any overestimate or underestimate of medical trend for prior year periods related to the rate increase;
    - Changes in reserve needs;
    - Changes in administrative costs related to programs that improve health care quality;
    - Changes in other administrative costs;
    - Changes in applicable taxes, licensing or regulatory fees;
    - Medical loss ratio ("MLR"); and
    - The carrier's capital and surplus.[19]

A state with an effective rate review program also must provide access from its website to Preliminary Justification Part I and Part II of the proposed rate increase for those rate filings subject to review. In addition, the state must have a mechanism for receiving public comments on the proposed rate increase.[20]

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[15] 45 C.F.R. § 154.215(e).
[16] 45 C.F.R. § 154.215(f).
[17] 45 C.F.R. § 154.215(g).
[18] In that case, the Rate Review Regulations provide that the health insurance issuer need not submit Preliminary Justification Part III. *See* 45 C.F.R. § 154.215(b)(3).
[19] 45 C.F.R. § 154.301(a).
[20] 45 C.F.R §154.301(b).

HHS notified the MIA on July 1, 2011 that Maryland has an effective rate review program. Carriers proposing a rate increase of 10 percent or more for policies in the individual or small group market segments will be required to submit Preliminary Justification Part I and Part II to the MIA. The MIA will be required to:

- Publicly disclose Preliminary Justification Part I and Part II submitted with any rate filing subject to review; and
- Provide a mechanism for the public to submit comments about such rate filings.[21]

Moreover, the MIA will need to change its rate review process for rate filings subject to review. Specifically, to the extent applicable, the rate review process will need include an assessment of the impact of all 12 factors set forth in the Rate Review Regulations.

C. Recommendations to Enhance Regulatory Review and Oversight

Oliver Wyman developed a series of recommendations for the MIA's consideration based on its detailed review of the MIA's current rate review process, its understanding of an effective rate review program, information about the rate review process in other states, and its professional expertise. Oliver Wyman's recommendations, the public comments received on each specific recommendation (if any), and the MIA's related plans of action are set forth below.

Recommendation 1: Incorporate reviews of over- or under-estimation of prior projections, reserve needs, administrative expenses (including quality improvement expenses), taxes and fees, and capital and surplus into the review process of all individual and small group filings in order to gain acceptance as an effective rate review program as defined by HHS.[22]

Summary of Oliver Wyman's Basis for the Recommendation:

As noted above, the Rate Review Regulations require an analysis of the impact of these factors to the extent applicable to the filing under review. With respect to each of the factors specified in Recommendation 1, Oliver-Wyman made the following observations, among others:

(a) Over- or under-estimation of prior projections: Oliver Wyman noted that "[c]arriers will need to submit an actual-to-expected review of claims, comparing claim projections from a prior filing to actual emerged experience. If a significant correction is being

[21] 45 C.F.R. § 154.301(b).

[22] In its report, Oliver Wyman suggested a review of risk-based capital, as this factor was identified in the proposed regulations issued by HHS. The final Rate Review Regulations substituted capital and surplus for risk-based capital. Oliver Wyman's addendum revised this recommendation to substitute a review of capital and surplus levels in lieu of risk-based capital. This Report reflects the recommendation as modified in the Oliver Wyman addendum.

requested due to prior inaccuracies, further scrutiny should be applied to the development of current trend rates."[23]

(b) Reserve needs: Currently, the MIA reviews for reasonableness certain information regarding claim reserves. Oliver Wyman suggested the MIA require carriers to submit claims paid to date and their estimate of incurred claims on a monthly basis for the most recent 36 months.[24]

(c) Administrative expenses (including quality improvement expenses): Carriers are permitted to include the cost of programs that improve health care quality as an incurred claim cost in the development of their rates. In order to review these costs for reasonableness, the MIA "could require carriers to compare base period and projected expenses included in the rate filing with those in the carrier's most recent Supplemental Health Care Exhibit."[25] Carriers also will need to submit information about other administrative costs. Oliver Wyman suggested requiring carriers to submit actual expenses for a period corresponding to the base period used for claims experience as well as those anticipated during the projection period.[26]

(d) Taxes and fees: Oliver Wyman noted that Maryland's filing requirements will need to be revised to require the submission of support for any taxes, licensing fees, and regulatory fees involved in rate development. [27]

(e) Capital and surplus: Oliver Wyman noted the pros and cons of reviewing surplus levels during the rate review process and concluded that "a review of surplus must take into consideration the fact that different requirements may need to be applied to not-for-profit and for-profit carriers."[28]

Public Comment: During the public hearing, the League of Life and Health Insurers ("League") noted that the Rate Review Regulations do not provide guidance on the aforementioned items and the League would be interested in developing a better understanding of how the MIA will look at these items in a rate filing. Following the public hearing, the League followed up with more detail in its written comments.

The League recommended the MIA be cautious in the extent to which it emphasizes the over- and under-estimation of prior projections in rate review because it may not be possible to differentiate the variables impacting future trends in a reasonable period of

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[23] *See* Exhibit 3 to the June 23, 2011 Public Hearing, *Recommendations to the Commissioner to Enhance Regulatory Review and Oversight,* at 35. Unless otherwise noted, all Exhibits referenced in this Report are Exhibits to the June 23, 2011 Public Hearing, which are posted on MIA's website.
[24] *Id.*
[25] *Id.* at 36.
[26] *Id.* at 37.
[27] *Id.*
[28] *Id.* at 52. Currently, the MIA has a process in place to consider surplus as a factor in rate reviews for two nonprofit health service plans, CareFirst of Maryland, Inc. and Group Hospitalization and Medical Services, Inc. *See* Consent Order, *In Re Targeted Surplus Ranges for CareFirst of Maryland Inc, et al.,* MIA-2011-05-040.

time. The League also noted some carriers combine statutory entities and blocks of business in their incurred but not reported claims reserves ("IBNR") and that IBNR is subject to appropriate regulatory review through an analysis of the adequacy of reserves. Also, many carriers share resources between several markets and/or businesses and a detailed allocation of certain administrative fields are highly subjective, in the League's view. For administrative costs, the League recommended that the MIA develop guidance to ensure consistent treatment.[29]

CareFirst maintained that investment earnings should not be used in the evaluation of rates given the volatility in the capital markets. The company noted that it uses investment earnings to moderate rates.[30]

Plan of Action: The MIA will include the factors recommended by Oliver Wyman in its rate review process for filings in the individual and small group markets to maintain an effective rate review program under the Rate Review Regulations. MIA will remain mindful of the League's caution, working cooperatively with carriers to appropriately include over- and under-estimations of prior projections, consideration of investment earnings, reserve needs and other administrative costs. The MIA also recognizes the concern expressed by Oliver Wyman that introducing a review of investment earnings into the rate review process could potentially lead to rate volatility.[31]

Recommendation 2: Incorporate a review of trend by major service category (separately for cost and utilization) into the rate review process of all individual and small group filings – again, to gain acceptance as an effective rate review program.

Summary of Oliver Wyman's Basis for the Recommendation: Oliver Wyman pointed out that CareFirst of Maryland, Inc., Group Hospitalization and Medical Services, Inc. and CareFirst BlueChoice (collectively "CareFirst") are the only carriers with credible data for detailed trend analysis based on Maryland specific experience.

> "Since detailed trend analysis would not be credible for carriers other than CareFirst, without further guidance or clarification from HHS we [Oliver Wyman] believe it would be reasonable to continue reviewing trend in total for these carriers. Part I of the preliminary justification would likely show the same trend factor for each type of service for those filings deemed 'subject to review.'"[32]

Public Comment: MHA stated that to ensure an effective rate review process, the MIA must receive medical trend information that is broken out in great detail.[33]

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[29] *See* Exhibit 13, League letter dated June 30, 2011.
[30] *See* Exhibit 10, CareFirst letter dated June 23, 2011.
[31] Exhibit 3, *Recommendations to the Commissioner to Enhance Regulatory Review and Oversight*, at 56.
[32] *Id*. at 33.
[33] *See* Exhibit 6, MHA letter dated June 16, 2011.

Plan of Action: The MIA will incorporate a review of trend by major service category for rate filings that are subject to review in the individual and small group market segments to maintain an effective rate review program. As the MIA expands to other rate filings its enhancements to the rate review process, the review of trend by major service category will be incorporated into the MIA's review of those additional filings.

Recommendation 3: Develop a standardized template for providing HHS with a summary of reviews conducted for rate increases deemed "subject to review," to encourage consistency across reviewers and filings.

Summary of Oliver Wyman's Basis for the Recommendation: Oliver Wyman anticipates HHS will want a separate report for each filing subject to review summarizing the MIA's findings. Oliver Wyman suggested the MIA include the following information in each such report:

- Average rate increase requested by the carrier;
- Average rate increase approved by the MIA;
- Minimum and maximum rate increase approved for a given policyholder;
- The number of groups (if applicable), policies, and members affected by the rate increase;
- The applicable standard set forth in statute for determining whether a rate increase is unreasonable and a description of how the filing compares to that standard;
- A narrative of the MIA's review, including an explanation of how the MIA's analysis of the factors prompted that determination; and
- If the rate increase approved by the MIA is lower than that requested by the carrier, an explanation of which rating component led to the difference, if applicable.

Because these components will be very similar, if not identical, across many filings, Oliver Wyman recommends that the MIA set up templates for each rate review scenario. Indeed, in its separate report, *Recommendations to the Commissioner on Information Provided to Consumers,* Oliver Wyman provided a consumer-friendly Rate Decision Summary document that the MIA may use for some of the information to create the templates.[34]

Public Comment: None.

Plan of Action: Implement the recommendation.

Recommendation 4: Perform enhanced reviews for all individual and small group filings, regardless of whether they are deemed "subject to review" as defined by the ACA.

[34] Exhibit 3, *Recommendations to the Commissioner to Enhance Regulatory Review and Oversight,* at 90.

Summary of Oliver Wyman's Basis for the Recommendation: The purpose of rate review is to determine whether a proposed rate increase is unreasonable. Oliver Wyman pointed out that any proposed rate increase may be unreasonable. In Oliver Wyman's view, performing enhanced reviews for all individual and small group filings would provide equity among Maryland consumers.[35]

Public Comment: The League commented that all changes made to Maryland's rate review process should be based on the Rate Review Regulations. The League recommended that the MIA proceed with an enhanced rate review for rate filings in the individual and small group markets that meet or exceed a 10 percent increase.[36]

Plan of Action: The MIA is persuaded by Oliver Wyman's reasoning that any proposed rate increase may be unreasonable. But the MIA is mindful of the implementation challenges that enhanced rate reviews for all rate filings in the individual and small group markets could pose for carriers and the MIA. The MIA therefore proposes to phase in this requirement beginning first with rate filings subject to review under the Rate Review Regulations, followed by all other rate filings proposing a rate change in the individual market beginning July 1, 2012, and then by all other rate filings proposing a rate change in the small group market beginning January 1, 2013. To allow for further public comment on this proposed course of action, the MIA will issue proposed regulations specifying the new filing and review requirements.

Recommendation 5: Perform enhanced reviews for both grandfathered and non-grandfathered policies in the individual and small group markets, resulting in equity among Maryland consumers and a consistent process for reviewing filings in these markets.

Summary of Oliver Wyman's Basis for the Recommendation: Oliver Wyman cited the following considerations in support of this recommendation:[37]

- The MIA already has a robust rate review process in place for these policies; therefore, the additional requirements of the enhanced review would not be a significant burden to the carriers.
- It would provide equity to all consumers in the individual and small group markets.
- It would ease the workflow for the MIA by applying consistent reviews to all filings.

Public Comment: The League commented that all changes made to Maryland's rate review process should be based on the Rate Review Regulations, and that those changes therefore should not apply to grandfathered plans.[38] At the public hearing, the League maintained that the enhanced rate review process is new for carriers and for the State, and

[35] *Id.* at 92.
[36] Exhibit 13, League letter dated June 30, 2011.
[37] Exhibit 3, *Recommendations to the Commissioner to Enhance Regulatory Review and Oversight,* at 91.
[38] Exhibit 13, League letter dated June 30, 2011.

that until all parties have had sufficient experience with the new process, it should not be applied more broadly.

Plan of Action: The MIA is persuaded by Oliver Wyman's reasoning that any proposed rate increase may be unreasonable for either grandfathered or non-grandfathered plans. But the MIA is mindful of the implementation challenges that enhanced rate reviews for both grandfathered and non-grandfathered policies in the individual and small group markets could pose for carriers and the MIA. The MIA therefore proposes to phase in this requirement beginning first with rate filings subject to review under the Rate Review Regulations, followed by all other rate filings proposing a rate change in the individual market beginning July 1, 2012, and then by all other rate filings proposing a rate change in the small group market beginning January 1, 2013. To allow for further public comment on this proposed course of action, the MIA will issue proposed regulations specifying the new filing and review requirements.

Recommendation 6: Continue performing large group reviews as they are currently being performed, with the addition of requiring carriers to demonstrate that the minimum loss ratio is expected to be satisfied with the filed rates.

Summary of Oliver Wyman's Basis for the Recommendation: Oliver Wyman noted that large groups generally are more sophisticated buyers than individuals or small groups. In Oliver Wyman's view, this fact, combined with the competitive nature of the large group market segment, means that large employers are better able to negotiate premium rates with carriers. Therefore, the benefits of an enhanced rate review process would be less apparent in this market segment than in the individual or small group market segments.[39]

Public Comment: The League observed that other states allow for benefit adjustments to pricing for plan design changes as long as the benefit filing is approved. In Maryland, rates must be filed for every benefit offering, limiting the ability of large groups to customize plan designs.[40]

CareFirst agreed that the current process for reviewing large group rate filings works well and should be unchanged.[41]

Plan of Action: Implement the recommendation and consider allowing benefit adjustments to pricing for plan design changes.

Recommendation 7: Require carriers in the individual, small group, and large group markets to demonstrate that the minimum loss ratio is expected to be met at the market level with the filed rates.

Summary of Oliver Wyman's Basis for the Recommendation: Oliver Wyman discussed the pros and cons of applying the minimum MLR to a policy form or at the market level.

[39] Exhibit 3, *Recommendations to the Commissioner to Enhance Regulatory Review and Oversight,* at 91.
[40] Exhibit 13, League letter dated June 30, 2011.
[41] Exhibit 10, CareFirst letter dated June 23, 2011.

Applying the minimum MLR to a policy form mitigates subsidization across products. Doing so, however, could result in large rate increases for some forms and large decreases for others to bring the MLR closer to the minimum for each policy form, resulting in market disruption. Carriers do not have the same target MLR for all products because fixed administrative costs represent a higher percent of premium for lower priced products than higher priced products; therefore, requiring the minimum MLR for each policy form may result in carriers withdrawing lower cost products from the market.[42]

Public Comment: The League agreed that carriers should not be required to meet the MLR requirements at the individual product level.[43]

Plan of Action: Implement the recommendation.

Recommendation 8: To demonstrate that the loss ratio is expected to be met at the market level, consider allowing carriers in the individual and large group markets to satisfy the requirement by demonstrating that the products in a given filing are expected to meet the minimum loss ratio requirement. If the products in the filing do not meet the minimum, then the carrier would be required to include experience of the other products in that market to demonstrate compliance at the market level. In the small group market, require carriers to demonstrate compliance at the market level, as the small group market is currently required to be priced as one common pool for setting base rates.

Summary of Oliver Wyman's Basis for the Recommendation: Currently, small group market rating requirements already pool the experience of all products.[44] In this market segment, rate filings already are prepared and reviewed on an aggregate market level basis.[45]

In the individual and large group market segments, if all products are filed simultaneously, then the MLR is demonstrated at the market segment level. In Oliver Wyman's view, if a subset of products if filed, and if the prospective MLR is satisfied for that subset, the filing may be approved. Oliver Wyman recommended that if the subset does not meet the MLR requirement, then the carrier should be required to demonstrate that when the subset is combined with all other products in the individual or large group market segments, the MLR requirement is expected to be met.[46]

Public Comment: The League agreed that carriers should not be required to meet the MLR requirements at the individual product level.[47]

Plan of Action: Implement the recommendation.

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[42] Exhibit 3, *Recommendations to the Commissioner to Enhance Regulatory Review and Oversight,* at 46.
[43] Exhibit 13, League letter dated June 30, 2011.
[44] Maryland Small Group Reform statutes require adjusted community rating. *See* Md. Code Ann., Ins. § 15-1205.
[45] Exhibit 3, *Recommendations to the Commissioner to Enhance Regulatory Review and Oversight,* at 46.
[46] *Id.* at 96.
[47] Exhibit 13, League letter dated June 30, 2011.

Recommendation 9: In demonstrating prospective compliance with the minimum loss ratio requirement, apply traditional credibility methods, rather than the credibility table in the federal retrospective MLR calculation.

Summary of Oliver Wyman's Basis for the Recommendation: In determining compliance with the ACA's minimum MLR, smaller carriers may use a credibility adjustment to address claim variability. The credibility adjustment adds percentage points to the initially calculated MLR to reduce the chance that a carrier would be required to pay a rebate simply as a result of random fluctuations.[48]

Oliver Wyman noted that determining whether a rebate is payable under the ACA is very different from the traditional actuarial approach when developing rates. Rates are developed from a credible data source. If the experience for a block of business is not fully credible, a manual rate is blended with the less than fully credible experience to arrive at a credible data source. This may be done by pooling the Maryland experience of all policy forms or pooling the experience for the same policy forms nationwide. Oliver Wyman recommended the traditional actuarial approach for several reasons including the fact that it is based on mathematical credibility theory studied over the years.[49]

Public Comment: The League agreed that carriers' traditional credibility standards should apply.[50]

Plan of Action: Implement the recommendation.

Recommendation 10: Collaborate with the Health Services Cost Review Commission (HSCRC) and the Maryland Health Care Commission (MHCC) to determine how the hospital rate increases implemented by the HSCRC and the databases maintained by the MHCC could be used to develop benchmark trends.

Summary of Oliver Wyman's Basis for the Recommendation: Oliver Wyman noted the MIA may choose to examine outside sources of trend information to utilize as benchmarks when performing rate review. Any use of such benchmarks by MIA actuaries would be subject to Actuarial Standard of Practice #23, which requires the actuary to "select data with due consideration for the appropriateness of the intended purpose of the analysis, including whether the data are sufficiently current."[51]

Based upon a discussion among representatives from Oliver Wyman, the HSCRC, the Hilltop Institute, and the MIA, Oliver Wyman reported that HSCRC data is available 45 days to 60 days after the end of a quarter and could be available to the MIA for rate review purposes. Oliver Wyman noted that HSCRC data "would need to be used not to

[48] Exhibit 3, *Recommendations to the Commissioner to Enhance Regulatory Review and Oversight,* at 43 (citing 45 C.F.R. Pt. 158).
[49] *Id. at* 45.
[50] Exhibit 13, League letter dated June 30, 2011.
[51] Exhibit 3, *Recommendations to the Commissioner to Enhance Regulatory Review and Oversight,* at 71.

measure historical trends, but rather to develop future trend estimates." Oliver Wyman identified several barriers to using this data, including:

- Only the cost component of trend could be developed.
- The dataset combines self-funded and fully insured business and is not broken down by market segment.
- The data can only be used to develop cost trends for hospital services.
- The impact of aging on the mix of services used cannot be removed from the data.
- The dataset consists of Maryland hospitals only.
- The trends developed by the HSCRC would represent allowed trends; carriers estimate paid trends.

During the public hearing, Oliver Wyman reiterated that the utility of HSCRC data in the rate review process is questionable today because it provides only information about the cost component of hospital trend − not the utilization component.

Oliver Wyman noted that MHCC data is available by carrier and market segment. It includes hospital, professional and pharmacy claims. However, the data for a given experience period is not available until nearly 12 months after the period ends and it is limited to data concerning Maryland residents. Even if these barriers can be overcome, Oliver Wyman concluded the following would have to be considered and adjustments made to produce a valid comparison to a carrier's trend assumption:

- Use of rental networks by smaller carriers.
- Trends developed using the MHCC data would represent allowed trends; a leveraging factor would need to be developed to convert to a paid trend estimate.
- The data would need to be normalized.
- The data would reflect provider reimbursement contracts in place during the experience period, whereas the carrier's trend assumption will consider anticipated changes in these contracts.[52]

During the public hearing, Oliver Wyman stated the greatest barrier to using the MHCC data in the rate review process is its timing. In Oliver Wyman's view, because there is a significant lag in the availability of MHCC data, that data cannot be used effectively in the rate review process at this time. In its report, Oliver Wyman noted that MHCC data sets have only recently been enhanced to include hospital claims and membership information, and suggested that "MHCC will need to collect a couple of years of data before cost and utilization trend benchmarks for all services can be developed."[53] At the public hearing, Oliver Wyman suggested that it may be possible to develop some leading indicators through a combination of sufficient MHCC historical information and HSCRC data.[54]

[52] *Id.* at 71–76.
[53] *Id.* at 76.
[54] *See* Transcript of Public Hearing – Health Insurance Premiums (June 23, 2011) ("Tr.") at 39-50.

Public Comment: The League commented that the MIA should recognize that any benchmark trends would not reflect other factors that may affect a carrier's actual and projected experience, such as benefit design characteristics and enrollee risk profile. The League recommended the MIA be cautious and thoughtful in determining the utility of the data available from the HSCRC and the MHCC.[55]

MHA stated that it fully supports the efforts to encourage the HSCRC and the MIA to collaborate to take advantage of the data maintained by the HSCRC.[56]

Plan of Action: The MIA will continue to explore with the HSCRC and the MHCC the feasibility and desirability of using the data available from these agencies to develop benchmark trends.

Recommendation 11: Incorporate an evaluation of pricing margins into the review process of all individual and small group filings.

Oliver Wyman stated that this adds a valuable consumer protection by ensuring that profit charges are not increased without solid justification. Increases in profit should be well documented and justified by the carrier.[57]

Public Comment: CareFirst supported this recommendation, observing that it adds important consumer protections "by ensuring that profit margins are justified in the filings."[58]

Plan of Action: Implement the recommendation.

Recommendation 12: Consider obtaining statutory authority to disapprove rates for insurance carriers and HMOs based on "any other relevant factors within and outside the State," as nonprofits currently have.

Summary of Oliver Wyman's Basis for the Recommendation: Oliver Wyman noted that the MIA's statutory basis for denying a rate increase based on certain factors such as administrative expenses and profit is unclear for insurers and health maintenance organizations. For nonprofit health service plans, the MIA may disapprove a rate request based on, among other things, "any other relevant factors within and outside the State."[59]

Public Comment: CareFirst supported this recommendation.[60]

The League, on the other hand, contended that "there is no experience applying such measures to a national company and no clear indication of how this standard would be

[55] *See* Exhibit 13, League letter dated June 30, 2011.
[56] Exhibit 6, MHA letter dated June 16, 2011.
[57] Exhibit 3, *Recommendations to the Commissioner to Enhance Regulatory Review and Oversight,* at 98.
[58] Exhibit 10, CareFirst letter dated June 23, 2011.
[59] *See* Md. Code. Ann., Ins. §14-126(b)(3)(ii).
[60] Exhibit 10, CareFirst letter dated June 23, 2011.

more broadly applied."[61] Thus, the League urged the MIA not to implement this recommendation.

Plan of Action: As discussed earlier in this Report, under the Rate Review Regulations, the MIA must consider other relevant factors before determining whether a proposed rate increase is unreasonable and, thus, must now apply such measures to national insurers. The MIA has experience with including other relevant factors in the rate review process for nonprofit health service plans and property and casualty insurers, including large, national property and casualty insurers. The MIA will consider seeking express statutory authority to clarify that it may disapprove rate filing of insurers and HMOs based on "any other relevant factor within and outside the State." [62]

Recommendation 13: Continue allowing carriers to file pre-approved trend factors for up to one year. Consider only approving factors that do not produce rate increases that would be deemed "subject to review" in the individual and small group markets.

Summary of Oliver Wyman's Basis for the Recommendation: The MIA currently allows rate filings that reflect current trend assumptions for up to four future quarters. Oliver Wyman noted, however, that at the time of its report, it was unclear how HHS intended to apply ACA rate review requirements to filings that include future trend factors. Oliver Wyman recommended, therefore, that the MIA consider only approving trend factors that do not result in a rate increase that would be subject to review (which initially will be a rate increase equal to or greater than 10 percent in one year).[63]

Public Comment: The League noted that the Rate Review Regulations apply to base rates, not premiums as produced by applying applicable rate factors. The League recommended that the MIA's process remain consistent with the Rate Review Regulations.[64]

Plan of Action: The MIA will continue to allow rate filings that reflect current trend assumptions for up to four future quarters, consistent with the Rate Review Regulations and any subsequent relevant guidance from HHS.

Recommendation 14: Do not require a new annual rate certification from carriers that file less frequently than annually. (But do not eliminate any existing certification requirements, such as the small group annual actuarial certification.)[65]

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[61] Exhibit 13, League letter dated June 30, 2011.
[62] Although § 11-202(a)(1) of the Insurance Article provides that the subtitle "applies to all types of insurers," Title 11 has not historically been utilized in the review of rates submitted by health insurers.
[63] Exhibit 3, *Recommendations to the Commissioner to Enhance Regulatory Review and Oversight,* at 99.
[64] Exhibit 13, League letter dated June 30, 2011.
[65] Currently, each small group carrier writing business in Maryland must file an actuarial certification with the Commissioner on or before March 15 of each year. The certification must state that the carrier is in compliance with the Maryland Health Insurance Reform Act, and has followed the rating practices imposed under § 15-1205 of the Insurance Article. *See* Md. Code Ann., Ins. § 15-1206(d).

Summary of Oliver Wyman's Basis for the Recommendation: Oliver Wyman presented potential advantages and disadvantages of requiring annual rate certifications beyond those currently required in Maryland. According to Oliver Wyman, requiring such additional certifications "could bring [an] increased level of scrutiny to blocks of business with potentially unreasonable rates that might otherwise go without review in cases where carriers would simply elect not to file for a rate increase until trend has increased claims to a level where one is justified."[66] In Oliver Wyman's view, however, the potential advantages of such additional rate certifications are offset by the following considerations:

- The ACA provides a "safety net" against potentially unreasonable rates insofar as the carrier must pay a rebate if, in hindsight, the aggregate premiums charged at the market segment level did not satisfy the required MLR.
- The MIA already receives information from carriers on an annual basis that provides a check on the adequacy of rates.
- The tracking of rate certifications would require time and resources for little consumer benefit.
- It is unlikely carriers can go much longer than one year between filings without incurring financial losses.[67]

Public Comment: None.

Plan of Action: Implement the recommendation.

Recommendation 15: Consider implementing a rate filing checklist that carriers can use in preparing individual and small group rate filings – and possibly a separate checklist for large group rate filings.

Summary of Oliver Wyman's Basis for the Recommendation: The MIA currently requires carriers to include with rate filings an actuarial memorandum that describes the assumptions and methods used to develop the proposed rates, and to provide support for the carrier's assumptions and any changes in rating factors before the MIA will approve the filing. Oliver Wyman noted, however, that the MIA does not currently have a set of standard data submission requirements defining specific data elements to be included in rate filings. In the absence of such standard data submission requirements, carriers may not provide all the information needed to conduct an enhanced rate review. In Oliver Wyman's view, a checklist setting forth all standard data submission elements would speed the time from the initial filing date to the review's completion and reduce the time the MIA spends requesting additional information. Oliver Wyman included a draft checklist in its report for MIA's consideration.[68]

[66] Exhibit 3, *Recommendations to the Commissioner to Enhance Regulatory Review and Oversight,* at 59.
[67] *Id.* at 60, 99.
[68] *Id.* at 99-100.

Public Comment: CareFirst supports a checklist that includes specific references or citations to the applicable regulation or statute.[69]

Plan of Action: Implement the recommendation, consistent with State and federal law.

Recommendation 16: Require certain data elements to be filed in an Excel spreadsheet format.

Summary of Oliver Wyman's Basis for the Recommendation: Currently, rate filings are submitted in .pdf format, requiring MIA staff to transfer parts of the data into Excel to check formulas and analyze data. The data transfer creates the possibility of errors. According to Oliver Wyman, by requiring certain data elements to be filed in an Excel spreadsheet, the possibility of errors will be reduced and staff time will be spent more appropriately.[70]

Public Comment: None.

Plan of Action: Implement the recommendation to enhance the efficiency of the MIA's rate review process.

Recommendation 17: Require that all individual and small group rate filings to [sic] include the Part I Preliminary Justification Rate Summary Worksheet.

Summary of Oliver Wyman's Basis for the Recommendation: Preliminary Justification Part I is a one-page Excel file that provides the data elements needed for an enhanced rate review. Oliver Wyman recommended requiring carriers to submit this for all individual and small group filings because:

- It provides some basic data in a standardized format that could facilitate comparisons from filing to filing.
- A standardized format may enable the MIA to quickly summarize data from several filings, potentially providing benchmarks for use in determining the reasonableness of assumptions.
- Since carriers must complete Preliminary Justification Part I for rate filings subject to review, it should not represent a significant burden for carriers to submit that same file for all individual and small group filings.
- The data will be needed for enhanced consumer disclosures.[71]

Public Comment: The League commented that Preliminary Justification Part I should be required only for rate filings subject to review.[72]

[69] Exhibit 10, CareFirst letter dated June 23, 2011.
[70] Exhibit 3, *Recommendations to the Commissioner to Enhance Regulatory Review and Oversight,* at 101.
[71] *Id.* at 100.
[72] Exhibit 13, League letter dated June 30, 2011.

Plan of Action: Preliminary Justification Part I is needed to perform an enhanced rate review. As noted previously, the MIA proposes to phase in an enhanced rate review for all rate filings in the individual and small group market. Consistent with this, Preliminary Justification Part I will be required beginning first with rate filings subject to review under the Rate Review Regulations, followed by all other rate filings proposing a rate change in the individual market beginning July 1, 2012, and then by all other rate filings proposing a rate change in the small group market beginning January 1, 2013. To allow for further public comment on this proposed course of action, the MIA will issue proposed regulations specifying the new filing requirements.

Recommendation 18: Consider requiring that all filings be submitted through SERFF (System for Electronic Rate and Form Filing).

Summary of Oliver Wyman's Basis for the Recommendation: By requiring rate filings to be submitted through SERFF, the MIA will not have to spend time transferring data into SERFF.[73]

Public Comment: None.

Plan of Action: Implement the recommendation to enhance the efficiency of the MIA's rate review process.

Recommendation 19: Maintain existing requirements regarding how long before the requested effective date a filing must be submitted.

Summary of Oliver Wyman's Basis for the Recommendation: Currently, insurers and nonprofit health service plans are required to file rates 90 days before the requested effective data; HMOs are required to file 60 days prior to the requested effective date. However, HMOs typically file earlier. Oliver Wyman noted that requiring all carriers to file 90 days in advance would require a statutory change. Based upon its interviews with MIA staff, Oliver Wyman concluded that the existing filing deadlines do not currently pose a problem, and therefore did not recommend a change in those requirements.[74]

Public Comment: None.

Plan of Action: Maintain existing requirements for the reasons stated by Oliver Wyman.

Recommendation 20: Maintain existing deemer requirements.

Summary of Oliver Wyman's Basis for the Recommendation: For initial rate filings, the deemer period is 60 days for all carriers. For proposed rate changes, the deemer period is 90 days. This has provided adequate time to review filings and thus no change was recommended.[75]

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[73] Exhibit 3, *Recommendations to the Commissioner to Enhance Regulatory Review and Oversight,* at 101.
[74] *Id.*
[75] *Id.* at 102.

Public Comment: None.

Plan of Action: Maintain existing requirements for the reasons stated by Oliver Wyman.

Recommendation 21: Consider changing the advance policyholder notification of a rate change from 40 days before the end of the grace period to 45 days before the effective date of the rate change, for insurance carriers and non-profits in the individual market. Maintain the existing requirement to notify policyholders 45 days before the effective date of the rate change for HMOs and all group carriers, resulting in a consistent requirement for all rate changes.

Summary of Oliver Wyman's Basis for the Recommendation: The current advance policyholder notification of a rate change gives individuals, in effect, 10 days before the renewal date to consider other policy options. For this reason, Oliver Wyman recommended the MIA consider changing the advance policyholder notification of a rate change in the individual market.[76]

Public Comment: In its comments, CareFirst agreed that carriers should provide a minimum 45-day notice to their members of any rate changes and that strengthening this requirement in regulation makes sense.[77]

Plan of Action: The MIA agrees it is in the interest of consumers to have as much advance notice of premium changes as is practicable. Consequently, the MIA will explore the best way in which to require all carriers to provide consumers with 45 days advance notice of a premium change in the individual market.

Recommendation 22: Consider hiring an actuary and an actuarial student, in addition to filling the currently open actuary position and addressing staffing issues related to consumer transparency initiatives not included in this report.

Summary of Oliver Wyman's Basis for the Recommendation: Oliver Wyman noted that at the time of its Report, MIA rate review for all health insurance filings was performed by two actuaries, with support from one analyst, and that the MIA was recruiting to fill a vacancy for a third actuary. Oliver Wyman concluded that even after the third actuary is hired, the MIA will not be adequately staffed once the enhanced rate review process is in place. Rather, four actuaries will be needed to implement the enhanced rate review process. Additionally, an actuarial student could work with HSCRC and MHCC to explore possibilities for additional trend analysis, and also could assist in the review of rate filings.[78]

Public Comment: None.

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[76] *Id.*
[77] Exhibit 10, CareFirst letter dated June 23, 2011.
[78] Exhibit 3, *Recommendations to the Commissioner to Enhance Regulatory Review and Oversight,* at 103.

Plan of Action: Implement the recommendation to ensure an effective and efficient rate review process.

Recommendation 23: Develop a procedures manual documenting the rate review process to promote consistency among reviewers and facilitate training of new employees.

Summary of Oliver Wyman's Basis for the Recommendation: Oliver Wyman noted the following benefits to a rate review procedures manual:[79]

- Documented procedures promote consistency in the review process from one filing to the next.
- A procedures manual could enable an actuarial student to perform a significant portion of the preliminary rate review work.
- A procedures manual could serve as a checklist to ensure that all applicable items are reviewed on a regular basis and that key items and assumptions are not overlooked.
- A procedures manual would facilitate cross-training among the various types of reviews performed by market segment.

Public Comment: None.

Plan of Action: Implement the recommendation to ensure a consistent rate review process.

Recommendation 24: Implement the changes necessary to the MIA website to provide access to Parts I and II of the Preliminary Justification and put in place a mechanism for receiving public comment.

Summary of Oliver Wyman's Basis for the Recommendation: In its "Addendum to Report Issued May 18, 2011 titled 'Recommendations to the Commissioner to Enhance Regulatory Review and Oversight'," filed on June 29, 2011, Oliver Wyman noted that since its Report was issued, HHS published final regulations providing that, in addition to previously published criteria, an effective rate review program must "provide access on a State website to Parts I and II of the Preliminary Justifications for those proposed rate increases that meet or exceed the threshold [as subject to review]," and must "have a mechanism for receiving public comments on those proposed rate increases[.]" Oliver Wyman therefore recommended that the MIA implement the changes necessary to its website to provide access to Parts I and II of the Preliminary Justification and put in place a mechanism for receiving public comment.

Public Comment: None.

[79] *Id.* at 104.

Plan of Action: Provide access to Parts I and II of the Preliminary Justification for proposed rate changes in accordance with the Plan of Action set forth under Recommendation 2 in Part 2 of this Report, and put in place a mechanism for receiving public comment in accordance with the Plan of Action set forth under Recommendation 7 in Part 2 of this Report.

PART 2: DISCLOSURE OF INFORMATION TO CONSUMERS

A. Maryland's and Other States' Disclosure of Rate Review Information to Consumers

Although the MIA offers a plethora of information to consumers about various facets of insurance, virtually no information is provided about how health insurance premiums are developed or reviewed.[80] Oliver Wyman reviewed several states' websites and other information sources to assess how Maryland compares to other states in this regard.

The general information the MIA provides consumers on health insurance is consistent with that provided in many other states. However, some other states provide consumers with more information about rate filings and rate development. Oliver Wyman observed that "[a]s a result, consumer involvement in Maryland's rate review process is substantially lower than in these other states."[81]

The type of information available to consumers on certain other state websites includes:[82]

- A notice of each rate increase filed;
- A copy of the rate filings themselves;
- Consumer comments on rate filings;
- Notification of approval of rate filings;
- Summaries of the state's decisions on requested rate increases;
- A description of the rate review process; and
- General information on ratemaking process.

Other states have taken additional action recently to move toward a more transparent rate review process. Oliver Wyman noted the following examples:[83]

- Arizona held three public hearings to increase public awareness and information about premiums and to identify consumers' concerns about health insurance premiums.
- California requires carriers to provide public notice of rate increases and all rate filings must be accompanied by a "Plain-Language Rate Filing Description."

[80] In contrast, property and casualty insurers are required to make "a filing and any supporting information...open to public inspection as soon as filed." Md. Code Ann. Ins. § 11-206(d).
[81] Exhibit 2, *Recommendations to the Commissioner on Information Provided to Consumers,* at 9.
[82] The states providing this information include Oregon, Maine, Florida, Connecticut, South Carolina, Washington, and Rhode Island. *See id*. at 10.
[83] *Id.* at 11-12.

- New Mexico will collect data and disclose facts to the public about a carrier's past and present practices and give policyholders the right to request a hearing regarding a rate increase.
- Washington now requires that health insurance rate filings be made available to the public[84] and requires the Commissioner to prepare a standardized rate summary form to explain the Commissioner's findings.

Oliver Wyman pointed out the pros and cons of making health insurance rate filing information public. According to Oliver Wyman, sharing rate information with the public is consistent with the goal of the Affordable Care Act to increase transparency. Consumers would better understand why their premiums increase. Consumer advocacy groups could choose to act on the policyholders' behalf in hearings or through a public comment process. Increased rate scrutiny could result in lower rate increases.

On the other hand, Oliver Wyman opined that keeping rate information confidential may increase carriers' willingness to give the MIA more detailed information in rate filings, making it easier for the MIA to assess the reasonableness of a proposed rate increase. Mandatory disclosure of proprietary and confidential information could lead to unfair or reduced competition. Significant staff resources would be needed to make rate filing information available to the public. Finally, according to Oliver Wyman, increased transparency could introduce a new level of politics into the rate filing process, putting pressure on the regulator to consistently reduce requested rate increases.

During the public hearing, Oliver Wyman noted that no information is available in the public domain about the extent to which consumers in other states actually access and use the information available to them about rate filings.

B. Maryland Consumers

Oliver Wyman conducted a series of focus groups with Maryland residents and small businesses to assess Maryland consumers' awareness of the MIA and the rate review process, as well as to identify the type of information Maryland consumers would like to have about health insurance premium rate increases.[85]

Most focus group participants were not aware of the MIA's role in reviewing health insurance premiums.[86] Small employer participants indicated that they rely on their brokers for information about health insurance. Consumers with individual health insurance also turn to brokers for information, although not to the same extent as small employers. Participants who purchased coverage through their employer turn to their

[84] Actuarial formulas, statistics and assumptions filed in Washington will remain confidential.
[85] For more detailed information about the focus groups, including demographic information about the participants, see *Recommendations to the Commissioner on Information Provided to Consumers*, pages 15 through 22, available on the MIA's website. During the public hearing, Oliver Wyman pointed out that during the screening for focus group participants, individuals were asked if they had any association with the health care industry. In contrast, small employers were asked if they had any association with the insurance industry. Oliver Wyman did not believe this inconsistency caused any bias in the groups.
[86] Indeed, most participants were not aware of the MIA. *Id.* at 25.

human resources department. Other sources of information include calling the carrier, performing research on the Internet, and discussing with friends, family, or colleagues.[87]

All participants wanted to know more about how the MIA reviews premium rates. Most felt that the best way to provide this information to consumers is through the Internet. Other communication avenues mentioned by focus group participants included, among other things, placing brochures at various locations such as doctor's offices, hospitals and pharmacies; including information with tax refunds; giving employers information to disseminate to their employees; running TV/radio ads; distributing information through direct mail; and providing information to producers and local chambers of commerce.[88]

Individual consumers who participated in the focus groups felt strongly that they should be notified when a carrier files a proposed rate increase, with the notice posted on the carrier's website and the MIA's website.[89] In contrast, none of the small employers participating in the focus groups had an interest in learning when a rate increase request was made. While they all felt consumers should have the opportunity to comment on rate increase requests, small employers noted that they would rely on their brokers to represent them.

C. Effective Rate Review: Public Transparency and Comment

As noted previously, a state, such as Maryland, with an effective rate review program must provide access from its website to Preliminary Justification Part I and Part II of the proposed rate increase for rate filings subject to review. In addition, the State must have a mechanism for receiving public comments on the proposed rate increase.[90]

D. Recommendations on Information Provided to Consumers and Mechanism(s) for Consumer Comment

Based on its review of activity in other states, assessment of the information gathered from consumers through the focus groups, and its understanding of the Rate Review Regulations, Oliver Wyman developed a series of recommendations for the MIA's consideration. The recommendations, the public comments received on each specific recommendation (if any), and the MIA's related plans of action are set forth below.

Recommendation 1: Develop a separate area of the MIA's website dedicated to health insurance rates, within the "Consumer" tab of the current website.

Summary of Oliver Wyman's Basis for the Recommendation: Relying heavily on the input received from the focus group participants, Oliver Wyman concluded it is important

[87] *Id*. at 29.
[88] *Id.* at 30-31.
[89] Although the focus group participants expressed interest in this information, during the public hearing Oliver Wyman pointed out that most of the focus group participants said they probably would not look at information about rate filings and the rate review process. *See* Tr. at 110. The extent to which consumers will avail themselves of information about rate reviews and rate filings remains an open question.
[90] *See* 45 C.F.R §154.301(b).

to develop an area on the MIA's website dedicated to health insurance rates. Implementing this recommendation will require the development of a database for rate filings, rate increase notifications, and rate increase summaries. It also will require some redesign of the MIA's website. The necessary database development and website redesign will require additional staff and information technology ("IT") resources. Once the database development and website redesign is accomplished, ongoing resources will be needed in the Office of the Chief Actuary to develop and/or post rate filings, rate increase notifications, and rate increase summaries.[91]

Public Comment: MedChi stated that it is encouraged by this recommendation.[92]

Plan of Action: The MIA recognizes the substantial resources needed to fully implement this recommendation and will explore options to do so.

Recommendation 2: Post non-confidential portions of rate filings for the individual and small group markets subject to the Affordable Care Act on the MIA's website for public viewing.

Summary of Oliver Wyman's Basis for the Recommendation: Consumer focus group participants felt strongly that they should be notified when a carrier files for a rate increase, and that this information should be posted on the Internet. For this reason, Oliver Wyman recommended posting non-confidential portions of all rate filings for the individual and small group markets on the MIA's website. For rate filings subject to review, the MIA could link to the HHS website to provide consumers with access to Preliminary Justification Part I and Part II.[93]

Public Comment: MHA supports making the rate filing and rate approval process more transparent to the public through the use of the Internet, but pointed out that not all consumers have ready access to the Internet. For this reason, MHA also recommended that notice of the request for a premium rate increase be published in the *Maryland Register* and in local newspapers.[94]

Scott Haglund, of Federated Life Insurance Company, urged the MIA to take care in defining proprietary and confidential information, particularly if claims experience for specific products for large employers or associations is to be posted. He also noted that the availability of rate filing information may be useful for carriers as well as consumers.[95]

Plan of Action: As noted previously, the Rate Review Regulations require public disclosure of Preliminary Justification Parts I and II. The MIA intends to include a link on its website to the Centers for Medicare and Medicaid Services' (CMS's) website,

[91] Exhibit 2, *Recommendations to the Commissioner on Information Provided to Consumers,* at 47-48.
[92] Exhibit 8, MedChi letter dated June 22, 2011.
[93] *Id*.
[94] Exhibit 6, MHA letter dated June 16, 2011.
[95] Exhibit 4, E-mail from Scott Haglund dated June 1, 2011.

where information contained in Parts I and II of each Preliminary Justification for rates subject to review will be posted. The MIA will explore options to make this information available on its website for all other rate filings proposing a rate change in the individual market beginning July 1, 2012, and then for all other rate filings proposing a rate change in the small group market beginning January 1, 2013.

Recommendation 3: Create a consumer-friendly summary for each individual and small group rate filing subject to the Affordable Care Act and post it on the MIA's website.

Summary of Oliver Wyman's Basis for the Recommendation: Consumer focus group participants felt strongly that information about rate filings should be available to them on the Internet. Oliver Wyman suggested using a template to pull data from Preliminary Justification Part I into a format for use on the MIA's website.[96] Oliver Wyman further recommended that the MIA research the burden that would be imposed upon carriers by requiring carriers to post this information on their websites and, if the burden is found to be minimal, that the MIA require carriers to post this information on their websites for all rate filings.

Public Comment: MedChi stated that it is encouraged by this recommendation.[97] Mr. Haglund noted that the experience in states that have websites for health insurance rates suggests this helps to clarify what the carrier has in effect in the state.[98]

Plan of Action: The MIA recognizes the substantial resources needed to fully implement this recommendation and will explore options to do so.

Recommendation 4: Create a consumer-friendly summary outlining the MIA's decision for each rate filing subject to the Affordable Care Act and post it on the MIA's website.

Summary of Oliver Wyman's Basis for the Recommendation: Consumers participating in the focus groups wanted more information about the MIA's decision to approve a rate increase. Oliver Wyman developed a format to provide this information, drawing from Preliminary Justification Part I.[99]

Public Comment: None.

Plan of Action: The MIA recognizes the substantial resources needed to fully implement this recommendation and will explore options to do so.

Recommendation 5: Post static information related to the rate making and rate filing review process in the new area of the MIA's website.

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[96] Exhibit 2, *Recommendations to the Commissioner on Information Provided to Consumers,* at 39.
[97] Exhibit 8, MedChi letter dated June 22, 2011.
[98] Exhibit 4, E-mail correspondence from Scott Haglund dated June 1, 2011.
[99] *Id*. at 41.

Summary of Oliver Wyman's Basis for the Recommendation: Oliver Wyman considered the most efficient way to inform consumers about the MIA's rate review process. In its report, *Recommendations to the Commissioner on Information Provided to Consumers,* Oliver Wyman provided a series of document templates for the MIA's consideration to provide consumers with general information on the ratemaking and rate review process, the MIA's role in regulating carriers, how health insurance rates and premium increases are determined, procedures carriers must follow when requesting a rate increase, and how the MIA reviews filings for proposed rate increases.[100]

Public Comment: MedChi stated that it is encouraged by this recommendation.[101]

Plan of Action: Using the templates provided by Oliver Wyman, the MIA will prepare the recommended content for a new area of the MIA's website as it explores options to develop this area of the website.

Recommendation 6: 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.

Summary of Oliver Wyman's Basis for the Recommendation: Although the Internet was recognized by focus group participants as the most efficient way to communicate information about health insurance rates, participants also identified other ways to disseminate that information, such as through brochures placed at various locations. Oliver Wyman noted that the MIA currently produces numerous brochures and participates in a significant number of outreach programs.[102]

Public Comment: MedChi stated that it is encouraged by this recommendation.[103]

Plan of Action: Using the templates provided by Oliver Wyman, the MIA will prepare brochures describing and explaining the rate review process in the individual and small group markets.

Recommendation 7: Further investigate the IT costs associated with developing and maintaining a bulletin board on the MIA's website where consumers can comment on pending rate increases. Internally discuss how the MIA would use the information gathered through consumer comments if such a bulletin board were developed.

Summary of Oliver Wyman's Basis for the Recommendation: Focus group participants were asked about their interest in providing public comment on a proposed rate increase, either through an on-line bulletin board on the MIA's website, or at public hearings.

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[100] *Id.* at 75-88.
[101] Exhibit 8, MedChi letter dated June 22, 2011.
[102] Exhibit 2, *Recommendations to the Commissioner on Information Provided to Consumers,* at 45.
[103] Exhibit 8, MedChi letter dated June 22, 2011.

Oliver Wyman reported that while many participants expressed an interest in having an opportunity to comment on a proposed rated increase, some participants expressed the view that such opportunities might serve "more as a means of venting frustrations than actually providing comments that would be considered in the [MIA's] review." Consequently, Oliver Wyman did not recommend developing a bulletin board at this time, but instead recommended that the MIA further explore this option.[104]

Public Comment: MedChi stated that it is encouraged by this recommendation.[105] MHA believes a public hearing process provides a formal mechanism for public input into the ratemaking process and pointed to the successful experience at the HSCRC. MHA recommended a public hearing process begin with carriers with at least three to five percent of the market share in Maryland.[106] During the public hearing, MHA stated this is the threshold used in West Virginia.[107]

On the other hand, the League does not support implementing public hearings on rate filings. In the League's view, the large number of rate filings (512 in FY 2009 and 450 in FY 2010) means that establishing a hearing process would require a substantial investment in time and resources and would slow down the review process. The League contended that providing the opportunity for public input through the Internet would provide useful commentary and minimize additional regulatory burdens.[108] During the public hearing, the League also noted that consumers without regular Internet access could submit written comments by other means.[109]

Mr. Haglund noted that responding to each comment submitted by a consumer would be time consuming and that if a response is contemplated, clearly defining this responsibility as the MIA's or the carrier's would be important.[110]

Plan of Action: The MIA recognizes the substantial resources needed to fully implement this recommendation and will explore options to do so.

Before issuing an order to disapprove a proposed rate filed by a nonprofit health service plan, the Commissioner must hold a hearing.[111] There is no other formal procedure established by statute or regulation for hearings on proposed changes to health insurance rates.

The MIA's first priority with regard to transparency of the rate review process is to implement the recommendations made by Oliver Wyman to provide information about rate filings and to solicit comments from the public about rate filings through the Internet. The MIA also will consider, however, whether a formal procedure for a rate hearing

[104] Exhibit 2, *Recommendations to the Commissioner on Information Provided to Consumers,* at 43.
[105] Exhibit 8, MedChi letter dated June 22, 2011.
[106] Exhibit 6, MHA letter dated June 16, 2011.
[107] Tr. at 132.
[108] Exhibit 13, League letter dated June 30, 2011.
[109] Tr. at 133-134.
[110] Exhibit 4, E-mail from Scott Haglund dated June 1, 2011.
[111] *See* Md. Code Ann., Ins. §14-126(d).

should be established to enhance public transparency and confidence in the rate review process.

Recommendation 8: Survey carriers to determine the cost of enabling consumers to subscribe to receive e-mails when rate filings are submitted to the MIA.

Summary of Oliver Wyman's Basis for the Recommendation: Focus group participants were asked if they would like to subscribe to an e-mail list to receive notification of a rate filing. There was not much interest in this, but some consumers felt their insurer should send them an e-mail notification of a rate filing.

Oliver Wyman noted that there is a cost to developing and maintaining such a system. Because of the tepid interest of focus group participants, Oliver Wyman did not recommend requiring carriers to develop an e-mail list. Rather, Oliver Wyman recommended that the MIA explore this with carriers to more fully understand the associated costs and benefits.[112]

Public Comment: MedChi stated that it is encouraged by this recommendation.[113] Mr. Haglund observed that there may be privacy concerns with such e-mails, as well as difficulties in maintaining an accurate list.[114]

Plan of Action: The MIA's first priority with regard to transparency of the rate review process is to implement the recommendations made by Oliver Wyman to provide information about rate filings and to solicit comments from the public about rate filings through the Internet. The MIA will explore the relative costs and benefit of requiring carriers to send an e-mail to their members about a proposed rate filing.

Recommendation 9: Research IT costs related to enabling consumers to subscribe to receive automated e-mails when the MIA posts rate filing notification summaries or rate increase decision summaries.

Summary of Oliver Wyman's Basis for the Recommendation: Although focus group participants did not indicate much interest in an e-mail notification system, Oliver Wyman suggested the MIA research the cost involved in setting up an e-mail notification system. Oliver Wyman concluded that if the cost is low, it may be beneficial to establish such an e-mail notification system. As consumers learn about the information provided on the MIA's website, they may opt to subscribe to such a system.[115]

Public Comment: None.

Plan of Action: The MIA has an e-mail notification system for interested parties to receive notification about the issuance of a new bulletin or other action by the MIA. The

[112] Exhibit 2, *Recommendations to the Commissioner on Information Provided to Consumers,* at 42.
[113] Exhibit 8, MedChi letter dated June 22, 2011.
[114] Exhibit 4, E-mail from Scott Haglund dated June 1, 2011.
[115] Exhibit 2, *Recommendations to the Commissioner on Information Provided to Consumers,* at 42.

MIA will explore the feasibility of using this system to allow consumers to sign-up to receive a notification when the MIA posts rate filing notification summaries or rate filing decision summaries.

Recommendation 10: 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.

Summary of Oliver Wyman's Basis for the Recommendation: In its report, Oliver Wyman explained the staffing and IT resources that likely would be required to implement its recommendations regarding disclosure of information about rate filings to consumers. Understanding the MIA's current capability is important in order to plan and obtain the resources needed to provide more robust information to consumers about rate filings.[116]

Public Comment: None.

Plan of Action: Implement the recommendation.

Recommendation 11: Review and reassess current outreach programs.

Summary of Oliver Wyman's Basis for the Recommendation: Oliver Wyman noted that the MIA currently conducts a significant number of outreach programs, averaging two to three each business day. These programs reach a broad geographic and demographic population. Assuming the focus group participants are representative of all consumers, Oliver Wyman concluded that the MIA's efforts to increase its visibility fall short of the goal. Consequently, Oliver Wyman recommended that the MIA conduct research to determine how best to deploy its outreach resources.[117]

Public Comment: None.

Plan of Action: The MIA will continue to review and assess its outreach activities.

Recommendation 12: Implement the changes necessary to the MIA website to provide access to Parts I and II of the Preliminary Justification and put in place a mechanism for receiving public comment.

Summary of Oliver Wyman's Basis for the Recommendation: In its "Addendum to Report Issued May 18, 2011 titled 'Recommendations to the Commissioner to Enhance Regulatory Review and Oversight'," filed on June 29, 2011, Oliver Wyman noted that since its Report was issued, HHS published final regulations providing that, in addition to previously published criteria, an effective rate review program must "provide access on a State website to Parts I and II of the Preliminary Justifications for those proposed rate increases that meet or exceed the threshold [as subject to review]," and must "have a

[116] *Id.* at 48.
[117] *Id.* at 45-46.

mechanism for receiving public comments on those proposed rate increases[.]" Oliver Wyman therefore recommended that the MIA implement the changes necessary to its website to provide access to Parts I and II of the Preliminary Justification and put in place a mechanism for receiving public comment.

Public Comment: None.

Plan of Action: Provide access to Parts I and II of the Preliminary Justification for proposed rate changes in accordance with the Plan of Action set forth under Recommendation 2 in Part 2 of this Report, and put in place a mechanism for receiving public comment in accordance with the Plan of Action set forth under Recommendation 7 in Part 2 of this Report.

CONCLUSIONS

As Oliver Wyman's report and recent HHS action show, Maryland has an effective rate review program. The comprehensive review undertaken by Oliver Wyman identified ways in which the MIA can enhance the rate review process to ensure consumers receive value for their premium dollars and have confidence in the regulatory oversight of health insurance premiums. It also identified ways in which the MIA can provide more information to consumers about rate filings and how the rate review process works in the individual and small group markets, and suggested ways in which to solicit public comment about proposed rate increases.

This Report described Oliver Wyman's specific recommendations and the manner in which the MIA intends to proceed with implementing those recommendations. Implementing some of Oliver Wyman's recommendations may require statutory or regulatory changes. Implementing others will require additional resources, including additional actuarial staff to carry out an enhanced rate review process, and additional IT staff to develop and maintain a robust website that provides consumers with (1) current information about proposed changes in premium rates; (2) a mechanism for providing public comment on those proposed changes; and (3) information about the MIA's action regarding those proposed changes.

HHS recently announced the availability of additional grant funds to help states continue to enhance their rate review process. The MIA has applied for a Premium Rate Review – Cycle II grant in order to be able to fully implement the recommendations made by Oliver Wyman. If the MIA is awarded a Cycle II grant, the MIA anticipates having the resources to fully implement an enhanced and transparent rate review process by the end of calendar year 2013.

Signature on file with original
Therese M. Goldsmith
Commissioner

August 17, 2011
Date