MARTIN O'MALLEY
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ANTHONY G. BROWN
Lt. Governor

THERESE M. GOLDSMITH
Commissioner

KAREN STAKEM HORNIG
Deputy Commissioner

MARYLAND
INSURANCE
ADMINISTRATION

200 St. Paul Place, Suite 2700, Baltimore, Maryland 21202
Direct Dial: 410-468-2090 Fax: 410-468-2020
Email: tgoldsmith@mdinsurance.state.md.us
1-800-492-6116 TTY: 1-800-735-2258
www.mdinsurance.state.md.us

October 21, 2011

The Honorable Edward J. Kasemeyer, Chairman
Senate Budget & Taxation Committee
Miller Senate Office Building, 3 West Wing
11 Bladen Street
Annapolis, MD 21401-1991

The Honorable Norman H. Conway, Chairman
House Committee on Appropriations
House Office Building, Room 121
6 Bladen Street
Annapolis, MD 21401-1991

The Honorable Thomas McLain Middleton, Chairman
Senate Finance Committee
Miller Senate Office Building, 3 East Wing
11 Bladen Street
Annapolis, MD 21401-1991

The Honorable Peter A. Hammen, Chairman
House Health and Government Operations Committee
House Office Building, Room 241
6 Bladen Street
Annapolis, MD 21401-1991

RE: Maryland Insurance Administration Report on mechanism developed to identify hospital rate adjustments and assessments in rate reviews
Budget Amendment D80Z01.01

Dear Chairmen:

The Maryland Insurance Administration (MIA) is requesting release of $100,000 that was restricted from the agency's Special Fund Appropriation. As required by the 2011 Joint Chairmen's Report (JCR),[1] the MIA has worked with the Health Services Cost Review Commission (HSCRC) and the Maryland Health Care Commission (MHCC) to develop a mechanism for identifying hospital rate adjustments and assessments as components to be considered in the Administration's process for reviewing and approving premium rates for health insurance policies and contracts issued or delivered in the State by insurers, nonprofit health service plans, and health maintenance organizations.

The MIA met with HSCRC and MHCC to review data collected by each agency, and considered how the data would need to be supplemented or modified to be more useful and meaningful for purposes of MIA premium rate review. Although the MIA would prefer to have more detailed data from both agencies, HSCRC and MHCC currently collect financial,

[1] Joint Chairmen's Report – Operating Budget, April 2011, at 17.

administrative and claims data that may be considered as one factor of trend. In addition, MHCC collects membership information that may be used, in conjunction with other data that it collects, to analyze medical trend. The MIA will continue to work closely with both agencies in the coming months to further examine their respective reports and identify what data collection modifications, if any, would improve the usefulness of the data provided.

Background

During the course of its work with the HSCRC and MHCC, the MIA has taken the following four factors into account, in accordance with JCR instructions.

1. The tools available to the MIA for supporting active premium rate review under laws regulating medical loss ratios.

Recently enacted legislation has given the MIA additional tools to support its premium rate review process:

- Section 15-605(c)(1)(i) of the Insurance Article was amended to require carriers to comply with loss ratio requirements of the Affordable Care Act (ACA), effective July 1, 2011; and
- Section 15-605(c)(1)(iii) of the Insurance Article authorizes the Commissioner to require carriers to file new rates if their loss ratios are less than those required under the ACA.

As part of their rate filings, carriers must demonstrate satisfaction of the applicable minimum loss ratio(s) on a prospective basis. Carriers make this showing by using past claims and premium experience for a given period, and projecting that experience forward using trend assumptions that generally are based on the carrier's experience. All rate filings are accompanied by an actuarial memorandum, which includes a certification that the filing actuary adhered to actuarial standards of practice. Those standards require, among other things, that all assumptions (including trend) are reasonable and appropriate.

2. The requirements of Section 1003 "Ensuring That Consumers Get Value For Their Dollars" of the federal Patient Protection and Affordable Care Act, as amended by the federal Health Care and Education Reconciliation Act of 2010, and any regulations adopted or guidance issued under the Acts ("Affordable Care Act").

Pursuant to final regulations issued by the United States Department of Health and Human Services (HHS) on May 23, 2011,[2] beginning September 1, 2011, all proposed rate increases in the individual and small group market segments[3] of 10 percent or more must be reviewed in accordance with federal regulations to determine whether the proposed rate increases are unreasonable.[4] HHS has determined that the MIA has an "effective rate review program,"[5]

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2 45 C.F.R. Part 154 (2011).

3 Grandfathered health plans are not subject to enhanced review under HHS regulations.

4 45 C.F.R. § 154.102 sets the threshold for rate increases that may be considered "unreasonable".

meaning HHS will adopt the MIA's determination of whether or not a rate increase of 10 percent or more is unreasonable. A proposed rate is unreasonable if it is excessive,[6] unjustified,[7] or unfairly discriminatory.[8]

For each rate increase subject to review, a health insurance issuer must submit a Preliminary Justification[9] for each product affected by the increase. The Preliminary Justification includes:

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

The Preliminary Justification also includes 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.

In addition, federal regulations require an assessment of the impact of 12 specific factors including, but not limited to, "the impact of medical trend changes by major service categories" and "the impact of utilization changes by major service categories."[10] Statistics developed from certain data collected by HSCRC and MHCC could be useful to the MIA as benchmarks when assessing those factors.

3. The observations relating to premium rate review and approval and interagency regulatory coordination contained in the Hilltop Institute report "Premium Rate Review of Private Health Insurers in Maryland and Opportunities for State Regulatory Coordination under Health Care Reform" issued on January 20, 2011.

In its January 20, 2011 report to the HSCRC, the Hilltop Institute noted that the MIA does not use "external data sources" in its review of health insurance premium rate filings.[11]

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5 Letter from the Center for Consumer Information and Insurance Oversight to Commissioner Goldsmith, (July 1, 2011) (on file with MIA).

6 HHS considers an 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).

7 HHS considers 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).

8 HHS considers 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).

9 The Preliminary Justification must be submitted on a form and in the manner prescribed by the Secretary of HHS. 45 C.F.R. § 154.215(a).

10 45 C.F.R. §154.301(a)(4).

11 The Hilltop Institute, *Premium rate reviews of private health insurers in Maryland and opportunities for state regulatory coordination under health care reform*, 4 (January 2011).

Rather, if information is needed beyond that provided in the rate filing, such as trend data or raw claim data, the MIA requests that information from the carrier. The Hilltop Institute concluded that "for hospital unit cost projections, MIA could engage the HSCRC and possibly MHCC in developing their own actuarial benchmarks for hospital and non-hospital costs."[12] The Hilltop Institute acknowledged, however, that such an undertaking "would require additional coding not currently performed by hospitals and not available in the [HSCRC and MHCC] discharge or outpatient data"[13] due to the current inability to match claims with specific market groups and insurance products, and that such additional coding "would likely require considerable time and effort."[14]

4. Any recommendations that result from the analysis of rate review and public disclosure processes undertaken by the Administration with grant money provided under the Affordable Care Act.

The MIA has received two rate review grants from HHS. Grant money was used, in part, to hire an outside consultant, Oliver Wyman Actuarial Consulting, Inc. ("Oliver Wyman"), to perform a review of the MIA's rate review processes for commercial comprehensive medical health insurance products and make recommendations to enhance the process. In its May 18, 2011 report entitled, "Recommendations to the Commissioner to Enhance Regulatory Review and Oversight," Oliver Wyman examined, among other things, external data sources that the MIA could potentially use as part of its assessment of the reasonableness of a carrier's trend assumption.[15] Based upon that examination, Oliver Wyman recommended that the MIA collaborate with the HSCRC and 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."[16]

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 measure historical trends, but rather to develop future trend estimates."[17] 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.

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12 *Id.* at 24.
13 *Id.*
14 *Id.*
15 Oliver Wyman, *Recommendations to the Commissioner to Enhance Regulatory Review and Oversight,* 2 (May 28, 2011) ("Oliver Wyman report").
16 *Id.* at 4.
17 *Id.* at 72.

- The dataset consists of Maryland hospitals only.
- The trends developed by the HSCRC would represent allowed trends; carriers estimate paid trends.[18]

During the Public Hearing on Health Insurance Premiums held at MIA on June 23, 2010, Oliver Wyman reiterated that the utility of HSCRC data in the rate review process was questionable, because it provides only information about the cost component of hospital trend – not the utilization component.[19]

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; and
- 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.[20]

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.[21] 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."[22] 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.[23]

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18 *Id.* at 72 - 73.

19 Transcript of Public Hearing on Health Insurance Premiums at 33 (June 23, 2011) ("Transcript"), available at http://www.mdinsurance.state.md.us/sa/docs/documents/consumer/healthratereviewdocs6-11/ratereviewhearingtranscript.pdf

20 Oliver Wyman report at 75.

21 Transcript at 46.

22 Oliver Wyman report at 76.

23 Transcript at 49.

MIA Consultation with MHCC and HSCRC

For rate filings subject to enhanced review, the MIA must examine changes to both utilization and unit cost by service category. The data reported to HSCRC by Maryland hospitals does not differentiate between funding type (fully insured vs. self funded), or market segment (individual vs. small group vs. large group). As stated above, the MIA requires information by carrier and market segment including membership information in order to conduct appropriate trend analysis as part of its rate review for each rate filing. For example, HSCRC collects data on the number of inpatient admissions by carrier. This data would be substantially more useful for benchmarking purposes if it were broken down by funding type, market segment, and product, consistent with the categories used when carriers file their rates. Membership information (*i.e.,* covered lives by funding type, market segment, and product) also would be useful. In addition, the MIA will benefit from a greater understanding of the HSCRC's "update factor" that is applied when hospital rates increase. The "update factor" and volume trends could be considered as one of many general indicators that could be used to assist the MIA in inquiring about how such trends apply to a particular carrier or a particular product line during the rate review process.

The MHCC collects many data sets that may be useful to the MIA, including the Medical Care Data Base (MCDB). That database includes information on health care claims and encounters collected by private insurance plans and health maintenance organizations (HMOs) that serve residents in the State of Maryland from calendar year 2001 to present. For the 2010 reporting year, MHCC started collecting membership information. The data becomes available eighteen months from the end of each calendar year.

The MHCC recently increased the number of data elements collected and the level of detail. The MIA is particularly interested in the "Medical Eligibility file" which, in combination with MHCC's claims databases, can be used to analyze medical trend broken down to carrier, market, and product type. MHCC started collecting the Medical Eligibility file for the 2010 reporting year, so it is expected that a full year of data will be available during the first quarter of 2012. MHCC collects both the claims data and the membership data which can be combined to calculated observed medical cost trend rates. Once MHCC collects data for the 2011 reporting year, MIA should be able to start developing historical trends in the appropriate categories.

Conclusion and Next Steps

The MIA will enter into a Memorandum of Understanding with each agency (HSCRC and MHCC) in order to maintain each agency's confidentiality requirements. The MIA has started recruiting for additional staff and a new actuary will be the point of contact for discussions with HSCRC and MHCC. Since not all data collected is relevant to rate review, the MIA initially will request reports (identifying specific fields) rather than access to entire databases. As reports are received, the MIA actuary will correspond with HSCRC and MHCC staff to seek clarification and additional information.

Collaboration between agencies is essential even though some data currently is lacking sufficient detail for direct use in premium rate review. As noted in the Hilltop Institute Report and Oliver Wyman's report, there will be challenges to adapting one agency's data for another agency's purpose. Additional information may be required during data collection. All three agencies have expressed a willingness to make reasonable modifications and look forward to increased dialogue during what will be an ongoing process.

Very truly yours,

Therese M. Goldsmith

Therese M. Goldsmith
Commissioner

cc: House Committee on Appropriations
House Health & Government Operations Committee
Senate Budget & Taxation Committee
Senate Finance Committee
Stacy Mayer, Governor's Legislative Office
Steven D. McCulloch, DLS
Cathy Kramer (via email)
Sarah Albert, DLS (five copies)
Ben Steffen, Acting Executive Director, MHCC
Stephen Ports, Active Executive Director, HSCRC
Charles Spannare, MIA