The
League
of
Life and
Health
Insurers
of
Maryland

200 Duke of Gloucester Street
Annapolis, Maryland 21401
410-269-1554

June 30, 2011

Therese M. Goldsmith
Insurance Commissioner
Maryland Insurance Administration
200 St. Paul Place
Suite 2700
Baltimore, Maryland 21202

Re; Rate Review Hearing- Written Comments

Dear Commissioner Goldsmith:

Thank you for the opportunity to provide written comments subsequent to your hearing on two Maryland Insurance Administration (MIA) commissioned reports- "Recommendations to the Commissioner to Enhance Regulatory Review and Oversight" and "Recommendations to the Commissioner on Information Provided to Consumers" prepared by Oliver Wyman. The League of Life and Health Insurers of Maryland, Inc. (League) appreciates the thoughtful deliberation of the MIA and the desire for public input on the recommendations.

We commend the MIA for undertaking this review process. We agree in large part with the recommendations made by Oliver Wyman and applaud the general adherence to the requirements of the Affordable Care Act (ACA) and related rules and guidance. Since the publication of the Wyman reports, the Rate Increase Disclosure Final Rule was published on May 23, 2011 (Final Rule) by the Department of Health and Human Services (HHS). We urge the MIA to review all of the recommendations for consistency with the Final Rule.

Recommendations to the Commissioner to Enhance Regulatory Review and Oversight

The League supports the MIA's commitment to make appropriate changes to ensure that Maryland's rate review process is deemed to be an effective rate review program, and believes all changes should be based on the Final Rule. Most importantly, the MIA should ensure that rate review remains a technical and objective financial and actuarial analysis (conducted by qualified actuaries) to assess whether rates are adequate to pay projected claims, expenses and supporting risk charges. Review standards that are objectively defined in this way, when coupled with professional review by credentialed actuaries, are what will offer consumers protection, market integrity and stability, and foster ongoing competition in the marketplace.

For each of the recommendations contained in the report, the MIA should consider whether the recommendation is necessary for an effective rate review program under the Final Rule. We recommend that the MIA focus on requirements clearly necessary to meet this requirement. The MIA should consider whether the recommendations add consumer value or protections, or if they could result in

delays in the marketplace. Recommendations that increase carriers' administrative burden to submit filings may not be necessary if they do not enhance the MIA's ability to ensure consumer protection.

Our specific comments based on the Wyman recommendations are as follows:

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

> LEAGUE COMMENT: The Final Rule requires states to review the reasonableness of rates that propose increases that meet or exceed 10% and does not subject rates below the threshold to this review. We recommend that the MIA process remain consistent with this scope.

WYMAN RECOMMENDATION: 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.

> LEAGUE COMMENT: The Final Rule specifically applies only to non-grandfathered policies. We recommend that the MIA process remain consistent with this scope.

WYMAN RECOMMENDATION: Require that all individual and small group rate filings include the Part I Preliminary Justification Rate Summary Worksheet.

> LEAUGE COMMENT: The Final Rule requires submission of the Preliminary Justification Rate Worksheet only for rate filings that seek increases at or above 10%. We recommend that the MIA process remain consistent with the Final Rule.

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

> LEAGUE COMMENT: The MIA should recognize that any benchmark trends developed using information collected by the HSCRC and MHCC would not reflect other factors that may affect carriers' actual and projected experience (e.g., benefit design characteristics, risk in the enrollee population, etc.). We therefore recommend the MIA be cautious and thoughtful in determining the utility of the data available through the HSCRC and the MHCC.

WYMAN RECOMMENDATION: 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.

> LEAGUE COMMENT: Rate review must include consideration of primary drivers of health care cost increases, including medical utilization and provider reimbursement trends. External benchmarks or thresholds (e.g. medical CPI) that are tied to regional or national trends are not indicative of adjustments being requested in rate filings, which are based on actual and projected medical utilization, costs and trends applicable to the specific health plan. HHS explicitly recognized the inadequacy of such benchmarks in its commentary to the Proposed Rule and specifically rejected setting a 'reasonableness' threshold based solely on such benchmarks. While this language exists currently in Maryland's nonprofit health service plan statute, there is no experience applying such measures to a national company and no clear indication of how this standard would be more broadly applied. We recommend the MIA not pursue such a change

WYMAN RECOMMENDATION: Consider only approving factors that do not produce rate increases that would be deemed "subject to review" in the individual and small group markets.

LEAUGE COMMENT: The Final Rule makes clear that the triggering threshold that subject rates to a review of their reasonableness (rate increases that are equal to or greater than 10%) is focused on changes to base rates, not premiums as produced by applying applicable rate factors. We recommend that the MIA process remain consistent with the Final Rule.

WYMAN RECOMMENDATION: According to the final rule, in order to be considered an "effective rate review program," a state's program must include in its review an analysis of at least 12 enumerated items that impact rates. The rule does not define or clarify what is meant or expected under each item. The report provides a suggested interpretation of each item, some of which causes the League concern. Specifically-

1. Over - Or Under Estimating Medical Trend in Previous Years:

LEAGUE COMMENT: There are a variety of factors and assumptions that will be included in the future claims projection, such as the demographics of the population, mix of benefits, risk and demographics of new sales, risk and demographics of existing sales, utilization trends, unit cost trends, and large claimants. Along with low membership when claims are segmented to a filing block, this could lead to large variances in expected versus actual claims. It may not be possible to differentiate between these variables in a reasonable timeframe, if at all. In addition, none of the variables may be credible within a short period of time. The League believes it is important to continue to focus on the projection of medical expenses from the current period to the pricing period, and such retrospective analysis would not be beneficial or useful. As a result, we recommend the MIA be cautious in the extent to which it emphasizes this factor in its review.

2. Reserve Needs:

LEAGUE COMMENT: Due to low membership, some carriers combine statutory entities and blocks of businesses in their IBNR (incurred but not reported) processes and do not have IBNR factors by filing segment. For carriers with relatively smaller blocks of businesses, the refined IBNR analysis would not be actuarially sound. IBNR is currently subject to a great deal of audit and regulatory oversight, which provides adequate protection to the market regarding the adequacy of reserves. The League recommends the MIA rely on these other government agencies to ensure the adequacy of reserves.

3 Other Administrative Costs:

LEAGUE COMMENT: For many carriers, resources (e.g., rent, overhead) are shared between several markets and/or lines of business and a detailed allocation of certain admin fields are both highly subjective and subject to bona fide differences in allocation approach by carriers. As a result, similarly situated carriers could knowingly or unknowingly have different outcomes. If this proposed provision is included in the final regulation, we recommend that the MD MIA develop guidance to ensure a consistent treatment by plans and level the competitive playing field.

WYMAN RECOMMENDATION: 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.

LEAGUE COMMENT: Carriers are required to meet MLR requirements based on existing federal rules for calculation, classification of expenses, aggregation, etc. Carriers should not be required to meet federal MLR requirements at the individual product level for which rate filings would be submitted. In addition, we suggest the MIA consider allowing benefit changes to rates with the existing requirement that carriers apply solid actuarial methods and standards. As the MD MIA's consultant highlighted, in large group, most states allow for benefit adjustments to pricing for plan design changes as long as the benefit filing is approved. Currently, Maryland requires that rates be filed for every benefit offering. An outcome of this requirement is that it

limits the ability of large groups to customize plan designs to best suit their specific needs and population.

WYMAN RECOMMENDATION: 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.

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.

LEAGUE COMMENT: Carriers are required to meet MLR requirements based on existing federal rules for calculation, classification of expenses, aggregation, etc. Carriers should not be required to meet federal MLR requirements at the individual product level for which rate filings would be submitted.

WYMAN RECOMMENDATION: 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.

LEAGUE COMMENT: Carriers are required to meet MLR requirements based on existing federal rules for calculation, classification of expenses, aggregation, as well as credibility standards. In addition, federal MLR requirements are calculated retrospectively rather than prospectively. We recommend against establishing a different state methodology for MLR reporting.

Recommendations to the Commissioner on Information Provided to Consumers

During the June 23 hearing, one witness suggested that Maryland should consider requiring hearings on all rate filings. However, in developing requirements for public input under the Final Rule, HHS specifically did not require a state's public input process to require public hearings. The League believes that public hearings on rate filings are not the most effective way for the MIA to obtain public comment or the most efficient use of MIA staff or insurer staff time. In fiscal year 2009 and fiscal year 2010, the Office of the Chief Actuary reviewed 512 and 450 rate filings from carriers (nonprofit health service plans, insurers and health maintenance organizations), respectively, Requiring public hearings on even a fraction of these filings will require a substantial investment in time and resources, while likely substantially slowing down the review process. The MIA, through use of the internet and other widely available public print sources, could provide opportunity for public comment which would be equally likely to yield useful commentary while minimizing additional regulatory burdens. For these reasons, the League does support a recommendation that the MIA implement public hearings on rate filings.

We hope that you will find our comments useful. Again, the members of the League appreciate this opportunity to provide you with feedback on this very important matter.

Very truly yours,

Kimberly Robinson

Kimberly Y. Robinson, Esq.
Executive Director