OLIVER WYMAN

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Recommendations to the Commissioner to Enhance Regulatory Review and Oversight

Maryland Insurance Administration

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Overview

Review Current Processes Employed by the Administration

Rate Increase Disclosure and Review Regulations

- Scope of the regulations
- Requirements to have an “effective rate review program”

Methods for Determining the Reasonableness of Rate Increases

Trend Analysis

- Drivers and calculation of trend
- External sources of trend

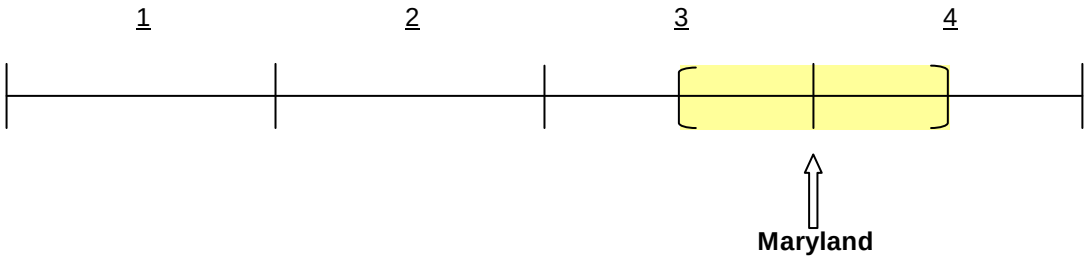
Rate Filing Submission Requirements

Recommendations

Current Processes

Current Processes

- Reviewed current statutes, regulations and bulletins
- Reviewed current rate filing requirements
  - Information required to be included in filings
  - Loss ratio requirements
  - Timing (deemer clauses, submission in advance of effective date)
- Met with Office of the Chief Actuary (OCA) staff to walk through current process for reviewing filings in the individual, small group and large group markets
- Reviewed recent rate filings from all market segments and OCA correspondence
- Compared current process with other states
  - Approval authority, consumer access, rate hearings, loss ratio tests, trend, credibility, small group actuarial certifications



Rate Increase Disclosure and Review Regulations

Rate Increase Disclosure and Review Regulations

- Apply to non-grandfathered, comprehensive major medical policies in the individual and small group markets
  - State's definition of small group may apply until 2014 when one life groups would be included
  - Definition must be revised again in 2016 to include groups 1 - 100
  - HHS considering revising to include fully insured association business

- Apply to filings submitted to the Administration September 1, 2011 and later*

- Apply to rate increases that exceed a stated threshold ("Subject to Review")
  - 10% for 2011
  - HHS can define state specific threshold beginning in 2012 (to be set by July 1, 2011)
  - Thereafter, threshold will be reset each June 1 to be effective for the 12 month period starting that September*

*Reflects change from draft regulations used for Oliver Wyman's analysis and final regulations released after Oliver Wyman's report was issued

Rate Increase Disclosure and Review Regulations

What Information Must Carriers Submit for increases "Subject to Review?"

Part I Justification – Rate Increase Summary

- Data and a quantitative analysis of the requested increase
- Prescribed Excel worksheet

Part II Justification – Written Description Justifying the Increase

- Significant factors prompting the rate increase
- Brief description of the overall experience of the policy

Part III Justification – Rate Filing Documentation

- Specified, detailed documentation

- Part I and II submitted to both HHS and State; posted on HHS website
- Part III submitted only if HHS is performing the review

Rate Increase Disclosure and Review Regulations

To Have an Effective Rate Review Program the State Must:

1. Receive data and documentation from health insurers to conduct an effective review and determine whether a rate increase is reasonable
2. Effectively review data and documentation provided in support of a rate increase
3. Review the reasonableness of rating assumptions and data related to past assumptions
   - Specified list of items that need to be reviewed
4. Apply a standard set forth in statute or regulation for determining whether a rate increase is unreasonable
   - Doesn't need to be a numerical standard
5. *States must provide access to Part I and Part II preliminary justification through their website and accept public comment on them **
   - Must report to HHS on each filing reviewed that is "Subject to Review"

*Final regulations had not yet been released by HHS at the time our analysis was conducted. Therefore, our report dated May 17, 2011 was based on draft regulations. This requirement was not part of the draft regulations, however was included in the final regulations released May 19, 2011.

Rate Increase Disclosure and Review Regulations

Specific Rating Assumptions that Must be Reviewed (where applicable)

- Medical Trend Changes by Major Service Category
- Utilization Changes by Major Service Category
- Cost Sharing Changes by Major Service Category
- Benefit Changes
- Changes in Enrollee Risk Profile
- Impact of Over- Or Under-Estimating Medical Trends in Prior Years
- Reserve Needs
- Administrative Costs Related to Programs That Improve Health Care Quality
- Other Administrative Costs
- Applicable Taxes, Licensing and Regulatory Fees
- Medical Loss Ratio
- *Insurer's Capital and Surplus**

*Draft regulations referenced RBC ratio

Considerations for Determining the Reasonableness of Rate Increases

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Factors that Could be Considered

- Loss Ratio Requirements
  - Currently 60% for individual and 75% for small group
  - Will be revised to 80% for small group and individual effective July 1, 2011
  - Applied at the policy form level or market segment level?
  - How should credibility be applied?
- Administrative Expenses
- Surplus Levels
- Pricing Margins
- Investment Income and Loss
- Cost Containment and Quality Improvement Activities

Trend Analysis

Trend Analysis

Primary Drivers of Trend

- Changes in provider reimbursement
- Changes in the number of services utilized
- Changes in the mix of services utilized
- Changes in the mix of providers utilized
- Technological advances
- Aging of the population
- Cost shifting
- Changes in claim coding methodology
- Changes in morbidity
- Changes in care management, including wellness programs
- Catastrophic claims
- Changes in benefits
- Selection

Trend Analysis

Adjustments to Data Used for Trend Analysis

- Large claims
- Benefit changes
- Demographic changes
- Seasonal effects
- Morbidity changes
- Provider reimbursement changes
- Changes in care management levels

Other Considerations

- Deductible leveraging
- Aggregate trends vs. trends by type of service

Trend Analysis

Health Services Cost Review Commission (HSCRC) Data

- Data collected for use in setting rates for acute hospital's all-payer system
- Can identify data by hospital and insurer
- Cannot identify insured status (fully vs. self insured), market segment, and product
- Data available 45-60 days after a quarter end

Current Barriers to Using HSCRC Data to Develop Trend Assumptions

- Corresponding membership data is not available
  - Only the cost component of trend can be developed
  - Data cannot be normalized for changes in the demographic mix
- Data is not available at the level included in a rate filing
- Data is not available for professional or prescription drug services
- Dataset only contains Maryland hospitals
- Results would represent allowed trends and cannot easily be adjusted to represent paid trends

Maryland Health Care Commission (MHCC) Data

- Maintains a statewide medical care database with many data fields
- Historically, contained only professional and prescription drug claims
- Began collecting hospital data in 2009, membership information in 2010
- Data segmented by carrier, insured status (self vs. fully insured), market segment, and coverage
- Contains payers with at least $1 million in earned premium

Current Barriers to Using MHCC Data to Develop Trend Assumptions

- Data is not reported until six months after year end, and is available 10-12 months after year end
- Full set of utilization and cost trends first available during the fall of 2012
- Trends calculated from the MHCC data may need to be “normalized”
- Dataset only includes information for Maryland residents
- Results would represent allowed trends and would need to be adjusted to represent paid trends
- Data will reflect the changes in the underlying demographic mix and need to be normalized

Rate Filing Submission Requirements

Rate Filing Submission Requirements

Use of a Standardized Template

- Medicare Advantage bid process
- Preliminary Justification Form

Commercial Rate Filing Templates in Other States

- New York, Colorado

Rate Filing Submission Checklist

- Oregon, Washington, Minnesota, Colorado
- Developed recommended checklist for the Administration

Content of Rate Filing

- Actuarial Standard of Practice #8

Recommended Enhancements to the Administration's Rate Review Program

Recommended Enhancements to the Administration's Rate Review Program

Incorporate Changes Necessary to Demonstrate an "Effective Rate Review Program" (where applicable)

- Review of prior over- or under-estimation
- Review of reserve needs
- Review of administrative expenses, taxes and fees
- *Review of Capital and Surplus**
- Review trends by type of service

Type of Review

- Perform enhanced reviews on all individual and small group filings
  - Provides equity for consumers
  - Allows for a consistent process for reviewing filings
- Continue performing reviews for the large group market as they are today
- Require carriers to demonstrate that the loss ratio test is met at the market level
  - For individual, if the test is met for the filing, then no further demonstration needed
  - Traditional credibility methods applied

Recommended Enhancements to the Administration's Rate Review Program

Timing

- No change to lead time required for filing prior to effective date
- Maintain existing deemer periods
- Require policyholder be notified 45 days prior to the effective date for all rate changes
  - Currently 40 days prior to expiration of grace period for insurance carriers and non-profits in the individual market

Filing Requirements

- Require all filings be submitted through SERFF
- Utilize a rate submission checklist (Appendix D)
  - Promote consistency among filings
  - Reduce the amount of follow-up information requested from carriers
- Require certain data elements be filed in Excel format
  - Membership, claims experience, trend analysis
- Require all small group and individual filings include Part I Preliminary Justification Rate Summary Worksheet

Recommended Enhancements to the Administration's Rate Review Program

Other

- Collaborate with HSCRC and MHCC to investigate further ways in which their datasets could be used to develop effective benchmark trends
- Incorporate a review of pricing margins into the review of all small group and individual filings
- Obtain statutory authority to disapprove filings based on "any other relevant factors" for HMOs and insurance carriers, as is currently in place for non-profits
- Develop a standardized template for reporting to HHS on filings "subject to review"
- Allow carriers to file pre-approved trend factors for up to one year
  - Consider only pre-approving factors that would not result in a rate increase that would be deemed "subject to review"
- Consider hiring an actuary and actuarial student to meet increased workflow demands
  - Increased volume of reviews (grandfathered/non-grandfathered)
  - More detailed reviews
  - Increased consumer disclosure (consumer friendly notifications and rate decisions)
  - Reporting to HHS for filings deemed "subject to review"
  - Trend benchmarks / work with HSCRC/MHCC
- Develop a procedures manual to document rate review process
  - Promotes consistency among reviewers
  - Aids in training new employees
  - Increased efficiency at lower staffing level

Questions