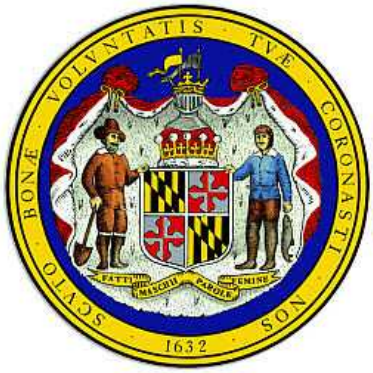
May 18, 2011

Recommendations to the Commissioner To Enhance Regulatory Review and Oversight

Maryland Insurance Administration



OLIVER WYMAN

Tammy Tomczyk, FSA, MAAA
Dianna Welch, FSA, MAAA
Karen Bender, ASA, MAAA

Contents

1

Executive Summary

The Maryland Insurance Administration ("the Administration") engaged Oliver Wyman Actuarial Consulting, Inc. ("Oliver Wyman"), to perform a review of the Administration's current actuarial rate review processes for commercial comprehensive medical health insurance products. The Administration is seeking recommendations for enhancements to the current review process, with the goal of establishing an "effective rate review program," which will be prescribed as a result of the Affordable Care Act (ACA). This work was funded by a Premium Rate Review Grant awarded to the State of Maryland by the US Department of Health and Human Services (HHS).

The Administration's goal for the project was to strengthen protections to Maryland health insurance consumers while maintaining the solvency of health insurers and facilitating a competitive marketplace. In this report, we provide recommendations to assist the Administration in meeting this goal.

We began our work by reviewing current Maryland statutes, regulations, and regulatory bulletins, as well as sample rate filings, a summary of current procedures, and various reports published by the Administration. After reviewing these items, we conducted on-site interviews with key Administration staff in order to gain a better understanding of the current rate review process. These discussions covered all steps of the process – from the Administration's initial receipt of the filing to final approval or disapproval of the filing. We focused our analysis primarily on the review conducted to determine whether proposed rates are reasonable in relation to benefits, and whether statutory minimum loss ratios are expected to be achieved.

We then reviewed draft regulations released by HHS titled "Rate Increase Disclosure and Review." These draft regulations establish a process for reviewing "unreasonable" health insurance premium rate increases. The draft regulations also set out specific criteria for evaluating whether a state has an "effective rate review program" in place. We compared these requirements with those of the Administration's current rate review program and developed a list of changes for the Administration to consider making in order to demonstrate to HHS that it has an "effective rate review program" as defined in the regulations.

We studied various financial measures that could be considered when determining whether a requested rate increase is justified. We assessed the feasibility of incorporating these items into the rate review process and developed a list of pros and cons for including each item in the review. Some of the examined items are included in the current rate review process for certain products, while other items are not incorporated into the current rate review process. The examined items, which are discussed in Chapter 6, include minimum loss ratio requirements, administrative expenses, surplus levels, pricing margins, investment income and loss, and cost containment and quality improvement activities. We also discuss pros and cons of requiring carriers to submit an annual rate certification.

Since trend is typically the most significant driver of premium rate increases, we discussed processes that carriers often use in estimating trend. We also considered options the Administration could use in assessing the reasonableness of a carrier's trend assumption. In addition, our evaluation included an examination of external data sources that the Administration could potentially use.

Next, we examined the data currently received in rate filings, the manner in which it is submitted to the Administration, and the format in which it is provided. We considered the feasibility of implementing a standardized data template that all carriers could be required to use. We also considered the use of a rate filing submission checklist. We reviewed templates and checklists required in other states and studied the requirements for reporting rate filing data to HHS. We also briefly examined data confidentiality concerns that can arise when making this data publicly available in order to increase transparency.

Finally, we developed a series of recommendations for the Administration's consideration. In forming our recommendations, we remained carefully focused on the Administration's goal for this project. We note that our recommendations in this report, including staffing requirements, are exclusive to the implementation of an enhanced rate review program. Additional recommendations regarding enhanced consumer disclosure are presented in another report under a separate contract with the Administration and are not reflected here.

Key to our recommendations are changes that the Administration would need to implement in order to establish an "effective rate review program" as defined by HHS. These recommendations include additional data items and rate support that must be provided for all individual and small group filings. We make recommendations as to additional standards that should be reviewed for each market (individual, small group, and large group) to determine whether rates are reasonable in relation to benefits provided. In addition, we provide a sample checklist of data items that the Administration could require carriers to submit so the Administration would have the data needed to implement our recommendations.

Our recommendations cover issues related to deemer clauses, advance notification to consumers, documentation of procedures, and staffing. Following is a summary of our recommendations:

- Incorporate reviews of over- or under-estimation of prior projections, reserve needs, administrative expenses (including quality improvement expenses), taxes and fees, and risk-based capital 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.

- 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.

- 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.

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

- 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.

- 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.

- 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.

- 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.

- 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.

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

- 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.

- 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.

- 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.)

- 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.

- Require certain data elements to be filed in an Excel spreadsheet format.

- Require that all individual and small group rate filings to include the Part I Preliminary Justification Rate Summary Worksheet.

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

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

- Maintain existing deemer requirements.

- 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.

- 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.

- Develop a procedure manual documenting the rate review process to promote consistency among reviewers and facilitate training of new employees.

We recommend that all of these changes be implemented as soon as reasonably possible, recognizing that some time may be required to introduce necessary legislation and obtain approval.

Caveats and Limitations

A significant portion of our analysis and subsequent development of recommendations was based on two sets of regulations for which final versions were not published at the time this report was drafted. Interim final regulations published in the *Federal Register* under the title "Health Insurance Issuers Implementing Medical Loss Ratio (MLR) Requirements Under the Patient Protection and Affordable Care Act" set forth new federal standards for retrospective minimum loss ratio requirements. A set of draft regulations titled "Rate Increase Disclosure and Review" outlines proposed requirements for an effective rate review program. Our recommendations are based on the assumption that final regulations, once published, will not differ from these regulations in their current form. While minor changes may not impact our recommendations, more significant changes may.

2

Introduction

On March 23, 2010, the Patient Protection and Affordable Care Act (Pub L. 111–148) (PPACA) and the Health Care and Education Reconciliation Act (Pub L. 111–152) (HCERA) were signed into law. Collectively, they are called the Affordable Care Act (ACA). One goal of this legislation is to establish a process for reviewing health insurance premiums to protect consumers from rate increases that are unreasonable, unjustified, and/or excessive.

The Maryland Insurance Administration ("the Administration") has engaged Oliver Wyman Actuarial Consulting, Inc. ("Oliver Wyman") to evaluate the Administration's current rate review processes for comprehensive commercial medical health insurance products, to recommend enhancements, and to identify any new rate review processes that are required due to the ACA. This work was funded by a Premium Rate Review Grant awarded to the State of Maryland by the US Department of Health and Human Services (HHS).

The Administration's goal for the project was to strengthen protections to Maryland's health insurance consumers while maintaining the solvency of health plans and facilitating a competitive marketplace. The Administration asked us to recommend ways to enhance its current rate review processes. Our review covered all types of health plans: insurance carriers, non-profit health service plans (non-profits), and health maintenance organizations (HMOs) providing comprehensive major medical policies.

Given that the term "health plan" is often used to refer to a plan of benefits offered under a policy, throughout this report we will refer to non-profits, HMOs, and insurance carriers collectively as "carriers." In cases where we refer specifically to insurance carriers (separately from nonprofits and HMOs), we will call them "insurance carriers."

We caution the reader that a significant portion of this report is based on our interpretation of federal regulations that were not final when the report was completed.

On December 1, 2010, HHS published interim final regulations to implement Section 2718 of the Public Health Service Act (PHSA). These interim final regulations were

published in the *Federal Register* under the title "Health Insurance Issuers Implementing Medical Loss Ratio (MLR) Requirements Under the Patient Protection and Affordable Care Act." These regulations outline requirements that began to apply to carriers as of January 1, 2011, regarding minimum loss ratios and the potential for premium refunds.

On December 21, 2010, HHS published draft regulations implementing Section 2794 of the PHSA, requiring HHS to establish a process for reviewing "unreasonable" increases in health insurance premium rates. These draft regulations were published under the title "Rate Increase Disclosure and Review" and set out specific criteria for evaluating whether a state has an "effective rate review program" in place.

Our recommendations are based on the assumption that final regulations will not differ from these regulations in their current form. While minor changes may not affect our recommendations, more significant changes may.

This report presents the results of our work and contains nine chapters and several appendices.

- The Executive Summary is included in the first chapter.
- This Introduction serves as the second chapter.
- Chapter 3 describes the data sources we used to perform our analysis.
- In Chapter 4, we describe the current rate review process used by the Administration – based on our review of statutes, regulations, and regulatory bulletins, and on in-person interviews with Administration staff.
- Chapter 5 summarizes the recently released HHS draft regulations, which outline a process for reviewing potentially unreasonable premium rate increases and establish requirements for an effective rate review process.
- In Chapter 6, we discuss various items that could be reviewed when assessing the reasonableness of rate increases. We discuss pros and cons of using these methods and information, and we provide observations on the experience of other states that use them.
- Chapter 7 includes a discussion of issues related to rate filing submission, including process and data considerations.
- In Chapter 8, we discuss outside information sources that the Administration may want to investigate further as potential sources to augment trend analysis. We also consider the feasibility of comparing a carrier's trend assumption with these data sources.
- Chapter 9 includes our recommendations.
- Finally, the appendices contain exhibits and other documents referenced in this report.

This report was prepared for the sole use of the Maryland Insurance Administration. All decisions regarding the implementation or use of advice or recommendations contained in this report are the sole responsibility of the Administration. This report is not intended for general circulation or publication, or for any purpose other than those that may be set

forth herein or in the definitive documentation pursuant to which this report has been issued. This report is intended to be read and used as a whole and not in parts.

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

3

Data and Information

We collected a significant amount of information to perform our review and develop our recommendations for the Administration. The primary data sources upon which we relied were current Maryland statutes, regulations, and regulatory bulletins, as well as information about the current rate review process gathered from on-site interviews with key Administration staff. We also held conference calls with the Maryland Health Care Commission (MHCC) and the Maryland Health Services Cost Review Commission (HSCRC) to gain an understanding of the data that these entities compile and the analysis they regularly perform that the Administration may be able to use to enhance the rate review process.

In addition to these sources, we used other publicly available information, including but not limited to interim final regulations titled "Health Insurance Issuers Implementing Medical Loss Ratio (MLR) Requirements Under the Patient Protection and Affordable Care Act," issued by HHS on December 1, 2010; draft regulations titled "Rate Increase Disclosure and Review," published by HHS on December 21, 2010; information gathered from the websites of insurance regulators of other states; publicly available reports as referenced in this report; general actuarial principles; and our knowledge of rate review processes in other states where we currently assist (or have previously assisted) with the review of rate filings.

This report is based on information related to the current rate review process that the Administration has provided to Oliver Wyman. In cases where information that we received was not completely clear, we asked the Administration to clarify it. The suitability of our analysis and recommendations depends on the accuracy of this information, as documented in Chapter 4 of this report. If the information is found to need revision for any reason, Oliver Wyman should be so informed, and we reserve the right to revise our analysis and recommendations accordingly.

As noted in the previous section, the regulations released by HHS were not final when this report was issued. Therefore, if final regulations differ from those upon which we relied, our analysis and recommendations may not be valid.

4

Current Processes

In order to help the Administration enhance its rate review process, we needed to gain a thorough understanding of the current process. To do so, we completed the following tasks:

- Reviewed the current insurance statutes, regulations, and regulatory bulletins that govern rate review authority
- Observed the current rate filing process from the time a filing is submitted to final approval

This chapter summarizes our observations and understanding of the Administration's current rate review process. In addition, we compare the Administration's rate review process with those processes undertaken by insurance regulators in other states. The scope of our review is limited to comprehensive major medical policies and may not apply to other types of policies.

Current Rate Review Process

Oliver Wyman staff reviewed existing Maryland insurance statutes, regulations, and regulatory bulletins as well as a proposed revision to one of the relevant statutes. We performed an on-site evaluation of the Administration's current rate review process for comprehensive commercial health insurance products. During our visit, we met with Administration staff actuaries (from the Office of the Chief Actuary) who currently perform these reviews.

When discussing regulatory issues, we first describe those regulations that apply to all companies and then describe any additional requirements that apply to only a subset of companies. Therefore, we have divided the companies into three sub-segments, consistent with Maryland regulations: insurance companies (both for-profit and non-profit), non-profit health service plans, and HMOs (both for-profit and non-profit).

Rate Approval Authority

For insurance carriers, Maryland regulations require that the filing of a health insurance form be accompanied by the filing of premium rates for the form. In addition, changes in premium rates for a previously approved form must be filed at least 90 days (or 60 days if the filing is for a rate filing for a new form) before the change in rates is proposed to become effective, and the proposed rates may not be used until they have been submitted to and approved by the Commissioner.[1] These requirements apply generally to all health insurance forms issued under Insurance Article, Title 15, Annotated Code of Maryland.

Nonprofit health service plans are subject to the requirement that precludes them from changing rates until the proposed change has been submitted to and approved by the Commissioner.[2] which is consistent with the general filing requirements. Since nonprofit health service plans are also subject to the general restrictions cited in the previous paragraph, this requirement does not add any additional rating and/or filing requirements, nor any additional burden to these plans.

HMOs must file rates with detailed supporting actuarial data at least 60 days before the date that the rate is proposed to become effective.[3]

Loss Ratio Requirements

The following minimum loss ratio requirements apply to health insurance policies delivered in Maryland:

Policy Type	Minimum Loss Ratio
Individual conversion issued by insurance carriers and non-profit health service plans	120%[4]
Individual non-conversion	60%[5]
Small group	75%[6]

The loss ratio requirements for individual non-conversion policies apply to all types of carriers. The loss ratio requirements for individual conversion policies apply only to conversion policies issued by insurance carriers and nonprofit health service plans. HMO conversion policies are subject to the same loss ratio as individual non-conversion policies. Exceptions to the loss ratio requirement for individual non-conversion policies exist for certain types of policies, such as accident-only, fixed indemnity, short-term, and

[1] COMAR 31.10.01.02[a] and Insurance Article 12-203

[2] Insurance Article 14-126(a)(2)

[3] COMAR 31.12.02.08A

[4] COMAR 31.11.01.09C

[5] Insurance Article 15-605(c)(2)

[6] Insurance Article 15-605(c)(1)

others. The loss ratio requirements in the table above apply prospectively to the period for which the requested rates would apply.

The Commissioner has the authority to require carriers to file new, reduced rates if actual experience results in loss ratios that are below the minimums shown in the table above. However, we note that on April 12, 2011, Governor O'Malley signed into law SB 183/HB 170 Health Insurance – Conformity with Federal Law, effective July 1, 2011. Among other things, this law will require carriers in Maryland to demonstrate prospectively that rates are expected to produce a loss ratio of at least 80% in the individual and small group markets and at least 85% in the large group market, when reported in the manner required under the federal retrospective minimum loss ratio calculations.[7] The federal retrospective minimum loss ratios are not calculated in the traditional method, which is typically incurred claims divided by earned premium. Adjustments apply in the calculation such that a traditional loss ratio that falls below 80%, for example, may equal or exceed 80% as calculated according to the ACA. The federal retrospective MLR is discussed further in Chapter 6.

Additional Requirements

Satisfaction of the minimum loss ratio alone is not sufficient to demonstrate the reasonableness of proposed rates. In general, a health insurance policy form may be disapproved if the form provides benefits that are unreasonable in relation to the premium charged.[8]

As with insurance companies and HMOs, rate filings submitted by a nonprofit health service plan may be disapproved if the rates appear to be excessive in relation to benefits. However, current law clarifies that the Commissioner may consider the following when determining whether to approve the rates for nonprofit health service plans:[9]

- Past and prospective loss experience
- Underwriting practice and judgment to the extent appropriate
- A reasonable margin for reserve needs
- Past and prospective expenses
- Any other relevant factors

While the verbiage for insurance companies and nonprofit health service plans specifies that benefits must be reasonable in relation to the premium charged, the verbiage for HMOs specifies that rates cannot be excessive, inadequate, or unfairly discriminatory.[10]

[7] 45 CFR 158

[8] Insurance Article 12-205(b)(6)

[9] Insurance Article 14-126(b)(3)

[10] COMAR 31.12.02.08D

Time Limits

For insurance carriers, the Commissioner has 90 days to approve or disapprove a rate change filing, and 60 days to approve or disapprove a new rate filing. The Commissioner may also choose to affirmatively approve, or disapprove, a filing before the end of the filing period.[11]

Rate filings submitted by nonprofit health service plans are subject to a 60-day waiting period. A change in rates may not take effect until 60 days after it is filed. If the Commissioner requires additional information, the waiting period begins again after that information is provided. The Commissioner may approve a rate change to take effect before the end of the waiting period, or extend the waiting period. If the Commissioner does not disapprove a rate filing before the end of the waiting period, the filing is deemed approved.[12]

HMO filings become effective 60 days after receipt of the filing if the Commissioner does not disapprove the filing. Or, the Commissioner may set another effective date for the rates.[13]

Notice of any increase in premium rates must be provided to non-HMO policyholders of individual policies at least 40 days before the expiration of the grace period applicable to the first increased premium.[14] Since the grace period expires 30 days after the effective date, notice of any increase in premium must be provided at least 10 days before the effective date of the increase. For HMOs and for all carriers in the small group and large group markets, a longer notification period is required: policyholders of individual and group contracts must be notified of any increase in premium rates at least 45 days before the change takes effect.[15] (Note that for the 45-day notice, the notification period does not include the grace period.)

Additional Filing Requirements

All carriers must submit a report, referred to as the health benefit plan report, to the Commissioner by March 1 of each year.[16] The report must include the following information for the prior calendar year:

- Premiums written
- Premiums earned
- Total incurred claims (including claim reserves)

[11] Insurance Article 12-203(c) and COMAR 31.10.01.02A

[12] Insurance Article 14-126(b)

[13] Health-General Article 19-713(g)

[14] COMAR 31.10.01.02R

[15] COMAR 31.12.02.06I

[16] Insurance Article 15-605(a)

- Total incurred expenses (including commissions, acquisition costs, general expenses, taxes, licenses, and fees)
- Loss ratio
- Expense ratio

This annual reporting requirement provides the Commissioner with the data needed to confirm whether minimum loss ratios are being met in the individual and small group markets. As mentioned earlier, if the loss ratios are below the minimum, the Commissioner has the authority to require the carrier to file new, lower rates.

In the small group market, each carrier must also file an actuarial certification with the Commissioner on or before March 15 of each year. The actuarial certification must state that the carrier complies with the applicable small group statutes and has followed the required rating practices.[17]

Rate Review Process

Currently, the rate review process is performed by two actuaries, with support from one analyst. These three people are responsible for all health filings – including comprehensive major medical insurance products (the subject of our review) as well as other types of health filings (specified disease policies, long-term care, etc.) that are outside the scope of our review. The Administration is currently trying to hire a third actuary.

The current process is very similar for individual and small group products. The primary difference is that different minimum loss ratios apply, so the review of the experience is relative to a different benchmark. The process itself is similar, so we describe it next for both markets, except where otherwise noted.

Individual and Small Group Markets

When a filing is received, it is first compared to the prior filing for the same product or products. In the small group market, each carrier generally files all products together, as the products are required to be pooled for rating purposes. The actuary looks for consistency in the reported experience within the current filing as well with previous filings, and also tries to discern whether the enrollment is stable or if the block is growing or shrinking.

Carriers generally file whenever a rate change is needed. In the past, the Administration has approved prospective trend factors, which would eliminate the need to refile until such time that the previously approved trend factors were no longer applicable or the end of the period for which they were approved, whichever occurs earlier. The Administration currently will approve prospective trend factors for only up to one year, after which rates become locked in absent a request for a rate increase, so carriers generally file at least annually. However, there is currently no requirement to file rates at least annually. The timing of filings varies. The largest carrier in the market, CareFirst, files quarterly.

[17] Insurance Article 15-1206(d)

The filing must contain an actuarial memorandum and supporting data to show that the rates are adequate, not excessive, and not unfairly discriminatory. The memorandum describes the assumptions and methods used to develop the rates, in accordance with Actuarial Standard of Practice #8, "Regulatory Filings for Health Plan Entities." An actuary from the Administration's Office of the Chief Actuary (OCA) reviews the memorandum to gain an understanding of the rating methodology and identify whether any part of the methodology or stated assumptions appears unreasonable, inconsistent with prior filings, or unjustified.

The OCA actuary reviews the historical experience provided. Due to CareFirst's sizeable business, OCA allows the company to provide 12 months of experience with a given filing while other carriers provide 36 months of experience. Since CareFirst submits rate filings for most of its products on a quarterly basis, OCA has historical CareFirst experience information on file. The actuary transfers the data to a spreadsheet to reconcile to the carrier's pricing. The arithmetic is checked to ensure that errors were not made in determining the needed rate increase. The filing should contain sufficient details to enable the OCA actuary to replicate the requested rate increase by applying the trend and other assumptions to the historical experience provided.

The experience data is also used to review historical patterns in enrollment among benefit plans. This analysis is performed at a high level to gain an understanding for how the enrollment has changed over time.

The carrier's medical trend assumption is reviewed. CareFirst is the only carrier in the market that has credible data for trend analysis based on Maryland-specific experience. The Administration requests that the other carriers provide studies based on Maryland and nationwide data (or other external data, such as survey data) to determine whether the trends employed in the pricing are reasonable. Trend assumptions are currently provided by the carriers in aggregate and are not shown separately by type of service, or separate cost versus utilization trends.

To ensure reasonableness, the actuary reviews the justification provided for any additional assumptions incorporated into the development of rates. Assumptions are compared to the assumptions that were used in the prior filing to identify any material modifications. If the carrier has not provided enough support for the assumptions, the actuary will ask for more information.

The actuary reviews both the target and actual historical loss ratios to determine whether the requested increase is reasonable and consistent with the carrier's experience. The carrier must demonstrate that the minimum loss ratios are anticipated to be met over the future pricing period based on the actual experience and the application of reasonable assumptions.

The actuary reviews the carrier's annual health benefit plan reports, evaluating three years of experience. If the experience is consistently under the minimum, the Commissioner may require the carrier to reduce rates prospectively. This has not happened recently, as

the carriers have been meeting the minimum loss ratios. The Commissioner also considers the credibility of the experience and the solvency of the carrier in deciding whether to force a rate reduction.

Any time an assumption has not been sufficiently supported, inconsistencies are found in the filing, or the actuary has questions about the filing, the actuary uses an objection letter process to communicate with the carrier. Carriers often modify the requested rate change as a result of the actuary's concerns that are raised through the objection letter process.

The OCA actuaries use a peer review process, in which a second actuary reviews the filing before an approval is granted.

When the actuaries determine that the rates are approvable, the rate filing is approved directly by the OCA. If the rate filing is for a new form and is part of the new form filing, then the actuary submits a Reviewer Note to the form reviewer in the Life and Health Division, informing that person that the rate review is complete and the rates are approvable. A new form filing is not approved until both the form review and the rate review are complete.

Large Group Market

Carriers are required to file rating manuals and trends for the large group market. The rating manual includes base rates and rating factors that are applied to develop the manual portion of the premium for a given large group.

Large group filings are reviewed at a higher level. Each filing requires 36 months of historical data. The actuary reviews the exposure in Maryland and nationwide. He or she also reviews the trend and looks for justification for any changes to the trend assumption as compared with the prior filing. Any changes to rating factors must include justification. The actuary reviews the target loss ratios, which typically vary by group size. The actuary generally looks for consistency within the filing as well as with previous filings, and verifies that changes to the assumptions and rating factors have been adequately supported.

If the actuary has questions about the filing, the objection letter process is used to communicate directly with the carrier. The approval process is consistent with the one described for individual and small group filings.

Comparison with Other States' Authority and Processes

Rate Approval Authority

In general, most states have rate approval authority that differs based on the type of health insurance product and the legal structure of the filing entity. As an example, most states have little if any approval authority over large group health insurance rates, whereas many states have some oversight responsibility for individual health insurance rates. This differs from the Administration's current statutory rate approval authority. The Administration has greater authority than most other states', as it has prior approval authority for rates in

the individual and small group market and prior approval authority over the large group experience rating formula and factors.

Currently, more than 30 states have rate approval authority over individual health insurance rates similar to the authority granted to the Administration. A large majority of these states also have deemer clauses associated with the rate filing. These deemer clauses generally range from 30 to 90 days (one state has a 120-day deemer clause).[18] A few of the states with rate approval authority have limits placed on their authority that vary either by the legal structure of the filing entity (HMO, nonprofit, or insurance carrier) or by the rate increase request. For example, the regulatory agency in Michigan has prior approval authority over HMOs and the BlueCross BlueShield (BCBS) plan but does not have prior approval authority over other insurance carriers.

There are 14 states with a "file-and-use" policy. They require health insurance carriers to file rates for informational purposes, but these states do not have the authority to approve rates. However, one of the states with a file-and-use policy does require a significantly higher loss ratio (80%) than is generally seen in the industry. Finally, a handful of states do not require any rate filings for individual health insurance.[19] The Administration's current authority over approval for individual health insurance rates is consistent with most other states' approval authority.

Roughly 25 states currently have prior approval authority over small group health insurance rates. In a few cases, the approval authority is limited by the legal structure of the filing entity or by the size of the requested rate increase. The majority of the states with prior approval authority also have deemer clause requirements. The length of the deemer clauses ranges from 30 to 90 days. Nearly 20 states have a file-and-use policy in the small group market. However, about half of these states only require carriers to file the actuarial certification. Two states do not require any rate filings for small group health insurance products.[20] The Administration's current authority over small group rates is more extensive than that given to most regulatory agencies. With the release of draft regulations that require states to review small group rate increases in order to have an "effective rate review program," we anticipate that more states will begin to review small group rates and/or revise their statutes to require prior approval authority.

Only a very few states have the regulatory authority to review and approve rates or rating factors charged to large employer groups. For those states that review large group rates, generally only the base rate, the rating formula, and rating factors (including trend) are

[18] Under a "deemer clause," if the state has not acted on a filing within the specified period, the rates are "deemed" to be approved. In practice, states will deny a filing if the deemer period is approaching and the filing has not been finalized. In some instances, the state still has the authority to retroactively deny a rate increase, even after the deemer period has passed, if the state discovers that the rate increase did not meet regulatory requirements.

[19] http://www.statehealthfacts.org/comparetable.jsp?ind=887&cat=7 (Accessed May 18, 2011). We note that this source should be used with caution, as it reflects a 30-day deemer period in Maryland. However, this is the most comprehensive source we have found for this information, and we believe it gives an accurate, high-level view of the current processes in the states.

[20] http://www.statehealthfacts.org/comparetable.jsp?ind=888&cat=7 (Accessed May 18, 2011). We note that this source should be used with caution, as it shows a 30-day deemer period in Maryland.

reviewed and approved. Most states do not review rates or rate increases in the large group market.

There are many reasons that states have elected to forgo aggressive oversight of large groups. One is the fact that large employers have more negotiating leverage with carriers – generally on the administrative expense and profit component of the rate – than small groups or individuals do. This ability to negotiate often results in multiple iterations, with rates not being finalized until shortly before the effective date of the changes. This process would not be compatible with the timing of rate filings required for individual and small groups. Second, a portion of the rate – which may be a large portion for larger employers – is based on the employer's own claims experience. Also, if the large employer and the carrier agree on the rates, what role would a regulator play? If the large employer and the carrier do not agree, the large employer can "vote with his feet" and switch carriers, which happens regularly.

The large group health insurance market is much more competitive than the individual or small group market when measured by the number of carriers participating. Also, large employers always have the option of electing to self-fund; this kind of leverage generally is not available to small employers. The Administration's current regulatory review process for large group health insurance filings is more rigorous than that of most other states.

Consumer Access to Rate Filings

The Administration currently does not post filings received on its website for public viewing. A carrier can mark portions of the rate filing confidential, or in some cases, request that the entire filing be treated as confidential. While there are several states that post rate filings on their regulatory websites, most of the postings occur after the rate filings have received approval. In other cases, in-person visits to the regulatory agencies' premises are required to obtain a paper copy of approved rate filings. However, many states are moving toward greater transparency and more consumer-friendly access to rate filings. Specifically, 42 states – including Maryland – are planning to increase the transparency of the rate review process and/or make more information available to the public in a consumer-friendly manner.[21] In this respect, the Administration is consistent with most states today.

Rate Hearings

The Administration does not regularly hold rate hearings for the health insurance rate request changes. In our experience, this is consistent with the process used by most states and regulatory agencies.

In those states that do hold rate hearings, most of the hearings are held irregularly. They are typically reserved for individual health insurance products. In general, the hearings are held for cases in which the carrier, the enrollment in the products, or the rate increase is

[21] http://www.healthcare.gov/news/factsheets/rateschart.html (Accessed May 18, 2011).

significantly large. Historically, a handful of states (including Maine and Rhode Island) have held rate hearings on a regular basis. In Rhode Island, the Health Insurance Commissioner is required to hold a hearing for individual health insurance rates offered by service corporations. Rate hearings are held at the option of the Health Insurance Commissioner for individual health insurance rates offered by accident and health corporations. In Maine, the Attorney General has the authority to intervene and request a public hearing for individual rate changes.

The filing review performed during the rate hearing process is usually very extensive and typically includes a rate review by independent actuarial experts.

Use of Loss Ratio Tests

Many states use loss ratio tests to determine the reasonableness of requested premium rates, particularly in the individual market. Actuarial staff at the Administration use a loss ratio test in their review of all individual and small group filings. The loss ratio test for both markets examines rates for the period for which they will be effective; a lifetime loss ratio test is not applied. The actuary reviews the carrier's calculation and the development of each assumption used for reasonableness and accuracy. A detailed calculation (in which the State would obtain premium, claim, and membership information and would independently develop an estimate for each assumption, as well as an estimate for projected claims) is not performed. We find that this type of detailed independent calculation is typically performed only in cases where a rate increase request prompts a rate hearing.

Credible, product-specific data should be used in the loss ratio demonstration. The Administration does not prescribe a credibility formula that must be used by carriers. The Administration prefers Maryland experience. If Maryland experience is not credible, nationwide data for the policy form or a similar form is acceptable. However, it is our understanding that carriers do not generally adjust nationwide experience to Maryland rate levels when performing the loss ratio test.

In general, tests we have observed in other states for individual products are typically lifetime loss ratio tests. The loss ratio test in Maryland is more stringent than in other states, as Maryland carriers are required to demonstrate that the loss ratio test will be met during the projection period. However, the test is less stringent than in states where a lifetime test is coupled with a future loss ratio test, as the test in Maryland would allow a carrier with favorable historical experience to run at the target going forward. A lifetime loss ratio test, by contrast, would require a carrier with favorable historical experience to run below the target loss ratio in the future in order to achieve a lifetime loss ratio at least as great as the target minimum. However, the test applied in Maryland – in conjunction with the Commissioner's ability to require future rate reductions if historical experience results in loss ratios below the regulatory minimum – puts Maryland on par with states that use a lifetime loss ratio approach.

The loss ratio test that Maryland applies for small groups is more rigorous than what we observe in other states. Many other states do not currently have prior approval authority

for small group rates, and of those that do, many do not apply a minimum loss ratio requirement. Instead, they require only that rates are adequate, not excessive, and not unfairly discriminatory.

For large groups, no loss ratio test is currently applied in Maryland. Instead, rates are reviewed for reasonableness, and the certifying actuary must attest that the rates are adequate, not excessive, and not unfairly discriminatory. This level of review of large group rates is consistent with what we observe in other states that review large group rates. We find that most states do not currently review large group rates, as groups of this size are viewed as being more sophisticated – and better able to negotiate affordable rates. Therefore, the Administration's current level of review for large groups is more stringent than the levels we see in other states, and more stringent than proposed HHS rules require.

Small Group Actuarial Certification

All small group carriers writing business in Maryland are required to file an annual actuarial certification. This certification is done retrospectively and confirms that the rates that were charged in the prior year complied with Maryland's small group rating rules. This actuarial certification is almost universal for states that have passed small group rate reforms, which is the vast majority of states. Most of the states that do not currently have prior approval authority over small group rates rely on the small group actuarial certification to ensure that rates are adequate, not excessive, and not unfairly discriminatory – although there are a few states that do not require this particular verbiage as part of the small group certification and also do not have prior approval authority.

Trend

The filed trend factors are reviewed for reasonableness. This is consistent with our experience in other states. If trends do not appear reasonable, rate reviewers generally ask for the analysis that supports the trends utilized. Historically, regulatory agencies in other states have not independently calculated medical trend, although there are a few that either do the calculations themselves or hire independent actuaries to do them. Generally, independent actuaries are hired to do the calculations when a rate hearing may be needed. Most states today perform more general reviews of trend (around the level currently being performed by the Administration).

Credibility Methods

Currently, the Administration does not require the use of a standard credibility formula or table in determining the level of credibility assigned to a block of business or product. The carrier must be able to provide support for the formula or approach employed in the filing. In addition, once a carrier implements an approach or formula, the OCA requires the carrier to continue using the same approach or provide an actuarial justification for changing the approach. For example, if a carrier chooses to pool the experience from several forms in order to establish a more credible base for projection purposes, the carrier must continue to pool the experience in the future.

In our experience, most states that have rate approval authority take an approach similar to the one used in Maryland. No standardized credibility formula or table is specified; rather, the states give the carrier flexibility in determining the pricing. The carrier must be able to provide actuarial justification for the approach used.

In addition, states often require pooled forms to remain together in calculating future rate increases. This important requirement prevents carriers from altering the rate development process from filing to filing (which could lead to "gaming" or to excessive volatility in the experience used as a basis for developing the rates).

Credibility standards have been set in other types of health insurance products. For example, the Centers for Medicare & Medicaid Services (CMS) has established a credibility formula for Medicare Advantage (MA) that is based on member months. In this formula, 24,000 member months is determined to be fully credible. We are aware of a few states that do prescribe credibility formulas for comprehensive health rate filings. For example, Colorado defines full credibility as 2,000 life years AND 2,000 claims. (The lower of the two is taken as the measure.) Partial credibility is defined as the square root of ((actual exposure measure - life years or claims)/2,000).

Rigor of Current Process Relative to Those in Other States

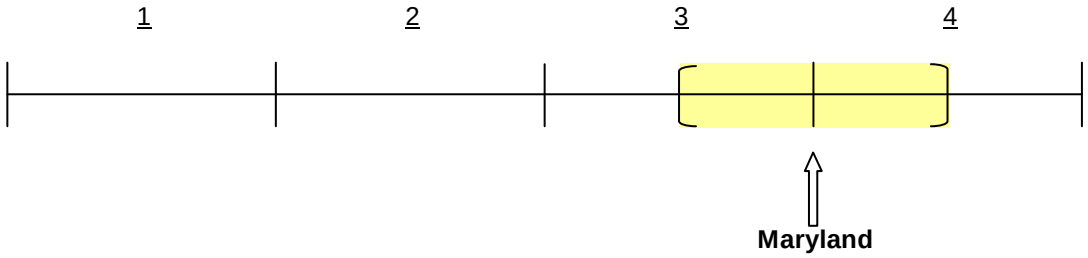
There is a wide range in the intensity of rate review approaches currently used by state agencies. For purposes of comparison, we present four categories below to describe the various levels of review rigor.

Level of Rigor	Characteristics
1	State performs little or no review. Rates may be filed on a "file-and-use" basis or may not be filed at all. This level would include states such as Arizona and Georgia.
2	State performs some review of rates. For example, we would include in this level states that have a process to review individual rates, but do not review any small group or large group rates.
3	State reviews individual and small group rates. The reviews are comprehensive but do not generally result in hearings.
4	State uses rigorous rate review processes and enforces rate levels. This level would generally include those states that review individual and small group rates, perform independent actuarial analyses on most or all rate filings, and/or have a formal rate hearing process (such as Maine, Rhode Island, and Vermont).

In our experience, the Administration's approach to reviewing individual rates is about average in the intensity of review; the requirement that an annual loss ratio test be met in conjunction with the Commissioner's ability to require a carrier with very favorable experience to reduce rates is consistent with many states that employ a lifetime loss ratio

requirement. The review of small group rates is more in-depth than average – given most states do not have prior approval authority over small group rates – but falls slightly short of the highly intensive reviews we have seen in very few states, especially those where rate hearings are held. With regard to large groups, the Administration's current process is much more intensive, in that most states do not currently review large group rates or factors, even though the reviews of large group rates performed by the Administration are not as rigorous as those for individual and small group filings.

Given the current level of review for each comprehensive major medical market segment and type of carrier, we illustrate below where we believe Maryland's current rate review process falls in the spectrum of rate review.



5

Elements of an Effective Rate Review Program

On December 21, 2010, the US Department of Health and Human Services (HHS) released proposed regulations that implement Section 2794 of the Public Health Service Act (PHSA), requiring HHS to establish a process for reviewing "unreasonable" increases in health insurance premium rates. The draft regulations also set out specific criteria for evaluating whether a state has an "effective rate review program" in place. *It is important to note that these criteria do not preempt or replace any existing State laws or rate review processes; they are instead intended to build on and complement the State's current rate review processes.*

In this chapter, we present a discussion of these draft regulations – including the filings to which they apply, rate increases that are subject to review, the review process, and the requirements for an effective rate review program. At the time this report was prepared, HHS had solicited public comments on the draft regulations. *Final regulations had not yet been issued.* Therefore, our analysis in this chapter is based on these draft regulations; if final regulations differ materially from the draft regulations upon which we have relied, part or all of the discussion that follows may be subsequently determined to be invalid.

We also note that areas of the draft regulations are subject to interpretation, and that definitions are not included for some terms that could have more than one meaning. While these areas may become clarified with the final regulations as a result of comments received by HHS, our analysis was based on our interpretation of the draft regulations. As a result, we have had to make assumptions in some areas. In the following discussion, we have attempted to call attention to these areas and clearly indicate where assumptions have been made.

Scope of Regulation

The proposed regulations would apply to non-grandfathered, comprehensive major medical plans in the individual and small group markets. The definition of a small group would follow current state law (two to 50 employees in Maryland), at least until 2014, at which time we believe the range would need to be revised to one to 50 employees. In states where such markets are not defined, the small group market would include groups with 50 or fewer employees. It is our understanding that in 2016 the range would be again

revised to one to 100 employees in all states. We note, however, that the draft rate review regulations are not entirely clear on this issue, in that small group is defined as follows: "Small group market has the meaning given under the applicable State's rate filing laws, except that where the State law does not define the term, it has the meaning given in section 2791(e)(5) of the PHS Act; provided however, that for the purpose of the definition, '50' employees is substituted for '100' employees in the definition of 'small employer' under section 2791(e)(4)." A literal read of this definition appears to imply that states in which the small group market is defined may continue to use that definition. However, given that small group rates inside the exchange will need to be the same as those outside the exchange beginning in 2014, and given that ACA defines small group within the exchange as one to 50 until 2016 and one to 100 thereafter, it would seem that states would need to revise their definition of small group accordingly.

The draft regulations indicate that the outlined review process does not apply to the large group market. However, we note HHS has asked for public comment on whether the review process should differ from the one applied to the individual and small group markets if the large group market becomes subject to review. HHS has left open the possibility that such review could be applied to the large group market in the future.

The regulations would apply to rate increases *filed* on or after July 1, 2011, in states that currently require rate increases to be filed. For states that currently do not require rate increases to be filed, the regulation applies to rate increases *effective* on or after July 1, 2011. These dates appear to be based on whether rates are required to be filed, not whether rates require pre-approval from the state. Further, it appears that determination of the effective date may apply at the filing level and not at the market level. However, we note that these are our interpretations of the draft regulation. The draft regulation does not specifically clarify these issues. If the final regulation is consistent with our current interpretation of the draft regulation, all individual and small group rate requests in Maryland filed on or after July 1, 2011, will be subject to the new regulation.

Rate Increases Subject to Review

While Section 2794 of the PHSA requires HHS to establish a process for reviewing unreasonable rate increases, it does not specify what makes a rate increase unreasonable. Rather than predetermining the reasonableness of a proposed rate increase, the regulations seek to define a threshold for determining whether a rate increase is "subject to review." Only after a rate increase meets the "subject to review" standard will the review process seek to determine whether the increase is unreasonable. Rate increases that are reviewed and deemed unreasonable by HHS may still be implemented by the filing carrier, unless otherwise prohibited by state law.

The draft regulations set an initial threshold for HHS mandatory review of any rate increase at or above 10 percent in 2011. Beginning in 2012, state-specific thresholds may be set based on "the cost of health care and health insurance coverage" in each state. HHS will publish any state-specific thresholds by September 15 of the preceding year. If no state-specific threshold is published for a state, the 10 percent threshold remains in effect.

The draft regulations distinguish between a rate increase and a premium increase – defining a "rate increase" as altering the underlying rate structure of a policy form, while defining a "premium increase" as an increase in premiums paid by a policyholder. Therefore, a premium increase can occur even without any change in the underlying rate structure. A good example is a policy that utilizes an attained age rating methodology. Under attained age rating, as policyholders age, their premiums may increase even if the underlying rate structure has not changed. While Section 2794 of the PHSA is stated to apply to disclosure and review of unreasonable *premium* increases, HHS has interpreted this to mean the underlying rates used to develop premiums. Therefore, it appears that the 10 percent or state-specific threshold applies to changes in the rate structure (e.g., base rates, trend, rating factors to adjust for benefits and case characteristics), rather than changes in premiums paid by any given policyholder.

In determining whether a rate increase meets or exceeds the 10 percent or state-specific threshold described above, the regulation applies the threshold to the average increase in rates for a specific "product" offered in the individual or small group market. "Product" is defined as "a package of health insurance coverage benefits with a discrete set of rating and pricing methodologies that a health insurance issuer offers in a state." The rate increase for a "product" is determined by calculating the "weighted average increase for all enrollees subject to the increase." The weights in this calculation are based on the number of enrollees, rather than the amount of premium. The proposed average increase must be combined with any increases implemented during the 12 months before the effective date when determining whether it meets or exceeds the 10 percent or state-specific threshold.

Review for Unreasonable Rate Increases

A rate increase that exceeds the threshold described above is subject to further review to determine whether the rate increase is reasonable. If a state has an "effective rate review program" in place for a given filing type (e.g., individual HMO, small group non-HMO), the state will perform the review and determine the reasonableness. If the state does not have what HHS has deemed to be an effective rate review program in place, HHS will conduct the review for that filing type.

Preliminary Justification

For a rate increase that is deemed "subject to review," the carrier must submit "preliminary justification" for the increase, regardless of who will perform the review. All preliminary justification must be submitted in the Rate Review Reporting Module of the Health Insurance Oversight System (HIOS). Parts I and II of the preliminary justification must be submitted to both the state and HHS, and will be posted to the HHS website immediately upon receipt. The preliminary justification is intended to provide consumers with a thorough description of the rate increase, including the factors that the carrier asserts justify the increase. The posting will include a disclaimer that the rate increase is subject to review and has not been deemed unreasonable. Part III of the preliminary justification must be submitted only if HHS is performing the review. In addition, only

information deemed non-confidential will be posted to the HHS website. The draft regulations include the following requirements:

- **Part I Justification – Rate Increase Summary –** Must include data and a quantitative analysis of the increase, including the following:

  - Historical and projected claim experience
  - Trend projections related to utilization, and service or unit cost
  - Any claim assumptions related to benefit changes
  - Allocation of the overall rate increase to claim and non-claim costs
  - Per-enrollee per-month allocation of current and projected premium
  - Current and projected loss ratios
  - Three-year history of rate increases for the product associated with the rate increase
  - Employee and executive compensation data from the health insurance issuer's annual financial statements

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

- **Part III Justification – Rate Filing Documentation** – Specific, detailed documentation, sufficient for HHS to conduct a review to determine whether the rate increase is reasonable. The following documentation is required:

  - Description of the type of policy, benefits, renewability, general marketing method, and issue age limits
  - Scope and reason for the rate increase
  - Average annual premium per policy, before and after the rate increase
  - Past experience, and any other alternative or additional data used
  - A description of how the rate increase was determined, including the general description and source of each assumption used
  - The cumulative loss ratio and a description of how it was calculated
  - The projected future loss ratio and a description of how it was calculated
  - The projected lifetime loss ratio that combines cumulative and future experience, and a description of how it was calculated
  - The federal medical loss ratio standard in the applicable market, accounting for any adjustments allowable under federal law
  - If the projected loss ratio is lower than the federal medical loss ratio, a justification for this outcome

The draft regulations indicate that HHS will prescribe a Preliminary Justification Form for rate filings. At the time this report was prepared, only a *draft* set of instructions and a *draft* Rate Summary Worksheet had been released. The draft Rate Summary Worksheet, which serves as Part I of the preliminary justification, is based on the Medicare Advantage Bid

Pricing Tool, but is significantly simpler. A copy is included as Appendix A. In comparing the draft instructions and draft Rate Summary Worksheet to the requirements listed in the draft regulations outlined above, we note the following differences:

- The requirements listed in the draft regulations indicate that the Part I preliminary justification must include trend projections related to utilization, and service or unit cost. The draft Rate Summary Worksheet only reflects trend estimates in total (i.e., for cost and utilization combined).
- The requirements listed in the draft regulations indicate that the Part I preliminary justification must include employee and executive compensation data from the health insurance issuer's annual financial statements. The draft Rate Summary Worksheet does not reflect this information.

The *draft* materials do not include a standardized reporting form for Part II. The *draft* instructions for completing the preliminary justification provide additional insight into the components that must be included in the non-technical description of the rate increase, submitted as Part II of the preliminary justification. Specifically, this description must include:

- The scope and range of the rate increase, including the number of individuals affected and the variation in the increase among individuals
- Financial experience for the product, including a summary of past premium, claims, and profit; a discussion of how the requested rate increase will affect the product's financial experience
- Changes in medical service costs, including a discussion of increases in cost and utilization, and any other significant drivers of cost
- Changes in benefits and a discussion of how these changes will affect the rate increase
- Administrative costs and anticipated profits, including a discussion of how changes in these items will affect rate increases

If HHS Performs the Review

If a state does not have an effective rate review program in place for a given filing type, HHS will perform the review . While HHS will review the rate increase and determine its reasonableness, *HHS does not have the authority to approve or disapprove rates*. HHS will review the rate increase and deem it unreasonable if it is excessive, unjustified, or unfairly discriminatory. The regulations outline a definition that HHS will use for each of these terms.

- **Excessive Rate Increase:** An increase that causes the premium charged to be unreasonably high in relation to the benefits provided. Examples of rate increases that could be deemed excessive are those where:

  - The adjusted projected medical loss ratio is lower than the federal standard for the market (however, it may not be considered excessive if the carrier can demonstrate that the loss ratio is expected to be met across all products in that market)
  - Assumptions are not supported by substantial evidence

- Assumptions are unreasonable

- **Unjustified Rate Increase:** An increase for which the documentation provided to HHS is incomplete, is inadequate, or otherwise lacks a basis on which to assess the reasonableness of the increase.

- **Unfairly Discriminatory Rate Increase:** An increase that results in premium differences among insured individuals within similar risk categories that are not permitted under applicable state law – or, in cases where no state law applies, do not reflect differences in expected costs.

The scope of such reviews would not include assessing the reasonableness of the requested rate increase, but would include assessing the reasonableness of the underlying rates and methods. Specifically, the review would determine whether the anticipated claim plus non-claim expenses are reasonable in relation to the benefits provided. Therefore, a rate increase could be deemed unreasonable if it leads to premiums that are not reasonable in relation to the benefits provided.

Once the review is completed, HHS will post its determination along with an explanation of the analysis it performed on its website. HHS's review should not delay the implementation of a rate increase, as HHS has no authority to disapprove rates. Further, since timing and implementation of rate increases are matters of state law, there will likely be cases where rate increases are implemented before HHS concludes its review.

If a State Performs the Review

If a state has an effective rate review program (as described later in this chapter) the state will perform the review. Carriers will be required to submit only Parts I and II of the preliminary justification; however, state law or regulation may require additional information. Upon completing its review, the state will provide HHS with a summary of the review and the state's determination as to whether the rate increase is reasonable by entering a short text narrative into the Rate Review Reporting Module of HIOS. HHS will adopt the state's determination. There are no prescribed standards that the state must use in determining the reasonableness of a rate increase; the state will apply its own standards as long as they meet the requirements for an effective rate review program.

Final Justification

If HHS has performed the review and has deemed the rate increase unreasonable, the carrier may still implement the increase, as HHS does not have the authority to disapprove rates. It is possible that in cases where the state has performed the review, a rate increase may be deemed unreasonable, but the carrier may still legally be permitted to implement it. In these cases, the carrier will be required to submit final justification of the rate increase to HHS in order to implement the increase. However, this scenario will not exist in Maryland, as the State currently has the authority to deny rate increases for all individual and small group filings for which it believes the requested rates are unreasonable.

The final justification consists of carriers' providing a brief response to HHS's or the applicable state's determination. It allows the carrier to respond to the determination and justify the rate increase to consumers. This information will be submitted through HIOS and posted on the HHS website. The carrier will also be required to post this information prominently on its website, along with the public portions of the preliminary justification and the final determination. This information must remain posted for three years. The required format and location of the posting on the carrier's website had not yet been determined when this report was prepared.

If the carrier decides not to implement a rate increase that has been deemed unreasonable – or decides to implement a rate increase that is below the applicable threshold (i.e., 10 percent in 2011, or possibly state-specific thereafter) – this justification does not need to be provided. However, if the carrier decides to implement a lower increase, but one that still exceeds the applicable threshold, a new preliminary justification must be submitted to both the state and HHS.

Potential for Multiple Reviews

The regulations do not appear to specifically address cases in which a state has a rate review program that is not deemed "effective." It appears that in these cases the proposed rate increase could be reviewed by both the state (under the state requirements in place) and HHS. The carrier could be subjected to duplicative reviews of the same rate increase, but required to submit different documentation and meet different standards under each, with the potential for one regulator to deem the rate increase reasonable while the other deems it unreasonable. However, the HHS determination would not affect the carrier's ability to implement the rate increase, as that is entirely a matter of state law.

Components of an Effective Rate Review Program

The proposed regulations set out specific criteria for evaluating whether a state has an "effective rate review program" in place. HHS will review a state's rate review processes based on four criteria. For each of the criteria, we discuss our opinion as to whether the Administration's current rate review process meets the requirement.

1. *Whether the state has the legal authority to obtain data and documentation from health insurers to conduct an effective examination and determine whether a rate increase is reasonable.*

   The Administration currently has the authority to require carriers to submit data and documentation. It also has the authority to review rate increases in both the individual and small group markets for all carriers. In our opinion, the State currently meets Requirement 1 for both the individual and small group markets.

2. *Whether the state effectively reviews data and documentation provided in support of a rate increase.*

Based on our review of the current processes used by the Administration, it is our opinion that the State currently meets this requirement for all products in both the individual and small group markets.

3. *Whether the state reviews the reasonableness of rating assumptions and the data upon which those assumptions are based.*

   Based on our review of the current processes used by the Administration, it is our opinion that the State currently reviews the reasonableness of rating assumptions and the data upon which those assumptions are based, as applicable to current loss ratio requirements. This review is currently performed in both the individual and small group markets for all carriers.

   However, the draft regulations prescribe 12 specific items that must be reviewed in an effective rate review program. The Administration will need to revise its current process to ensure that each item is included in the review for all products in the individual and small group markets in order to demonstrate that they meet this requirement for an effective rate review program. These 12 items are discussed in detail in the next section.

4. *Whether the state applies a standard (not necessarily a numerical standard) set forth in statute or regulation when determining whether a rate increase is unreasonable.*

   In our opinion, Maryland's rate review currently meets this requirement. In the individual market, all products must currently satisfy a minimum loss ratio of 60%.[22] In the small group market, all products must currently satisfy a minimum loss ratio of 75%.[23] A new law SB 183/HB 170 Health Insurance – Conformity with Federal Law,[24] effective July 1, 2011, will require carriers to demonstrate prospectively that rates are expected to produce a loss ratio of at least 80% in the individual and small group markets and at least 85% in the large group market, when reported in the manner required under the federal retrospective MLR calculations.[25]

HHS will judge whether a state meets the criteria above based on documentation provided by the state, a review of the state's laws, and other information available to HHS. This report could potentially serve as part of the documentation provided to HHS.

We note that HHS recently solicited public comment on whether a fifth criterion should be added, that being whether the public has the ability to comment on a potentially unreasonable rate increase during the review process. However, our understanding is that at this time, HHS's assessment will be based only on the four criteria listed above.

[22] Insurance Article 15-605(c)(2)

[23] Insurance Article 15-605(c)(1)

[24] http://mlis.state.md.us/2011rs/bills/sb/sb0183t.pdf

[25] 45 CFR 158

Factors That Must Be Analyzed

In order to satisfy Criteria 3 in the list above (regarding whether the Administration reviews the rating factors and the reasonableness of assumptions), 12 items must be reviewed for each filing submitted. We expect that the requested rates will be examined much more closely than they are in most state insurance departments today. According to the draft regulations, in order to be considered an "effective rate review program," a state's program must include in its review an analysis of at least the following items that impact rates:

1. Medical trend changes by major service category
2. Utilization changes by major service category
3. Cost-sharing changes by major service category
4. Benefit changes
5. Changes in enrollee risk profile
6. Impact of over- or under-estimating medical trends in prior years
7. Reserve needs
8. Administrative costs related to programs that improve health care quality
9. Other administrative costs
10. Applicable taxes, licensing and regulatory fees
11. Medical loss ratio
12. Insurer's risk-based capital level relative to national standards

The regulations do not require states to develop independent estimates of these items; we believe it will be acceptable for the Administration to review the carrier's development of and support for these items. In cases where the review determines that more support is needed for an item, the Administration could at that time perform an independent estimate if the appropriate data items are provided, or ask the carrier to provide additional support for its calculations.

The items in the preceding list are not explicitly defined in the draft regulations. While the intent for some items is relatively clear, we feel others could arguably take on more than one meaning. HHS could leave it up to the states to define these items, or conversely, the final regulations or final disclosure form could provide clarification based on comments received by HHS. We have reviewed draft instructions and the draft Rate Summary Worksheet that HHS has released for submitting the Preliminary Justification. These documents provide some insight into how some items in the preceding list might be defined, but the documents do not provide clear definitions for these items. Based on this information, our experience developing rates, and our experience reviewing rate filings for regulators, we have developed reasonable expectations as to how HHS might interpret the items outlined above, or how the Administration could interpret them if HHS leaves it up to the states to define these items.[26]

[26] Again, we note that these interpretations are based on the information published to date. HHS's final regulation could differ materially from our interpretations.

We discuss each of these 12 items in turn; however, we have combined items one and two (due to their similarity), and we address them together as one item below. Therefore, only 11 items appear in the list that follows. For each item, we also describe whether – in our opinion – the Administration's current regulations require carriers to submit the information needed to perform the review, whether the Administration is performing a review of the item today, and in cases where the necessary data is not being required today, any additional information that carriers would need to be required to submit in order for the Administration to perform a review that meets HHS's definition of an "effective review." The Administration does not currently have a set of standard data submission requirements. Therefore, without such a requirement, carriers may or may not provide all of the information needed to review these items as part of the initial filing. However, carriers are required to provide support for all assumptions and any changes in rating factors, and the Administration will require them to submit the necessary information for review before approving the filing. We describe only the additional data that is needed here. Chapter 9 includes a comprehensive recommendation for rate filing data requirements.

1. **Medical Trend Changes and Utilization Changes by Major Service Category**
   - ***Major Service Category:*** The draft Rate Summary Worksheet requires a breakdown of services into the following categories: Inpatient, Outpatient, Professional, Prescription Drugs, Other, and Capitation. The corresponding instructions further clarify that the Inpatient and Outpatient categories reflect only facility charges at these locations. HHS appears to intend for carriers to be required to provide trend analysis separately for each of these categories.
   - ***Medical Trend Changes:*** Given that utilization changes are presented as a separate review item, it is likely that this item refers to either the change in total cost PMPM or the change in cost per service.
   - ***Utilization Changes:*** This item likely refers to changes in statistics such as admits per 1,000 members or days per 1,000 members for Inpatient, scripts per 1,000 members for Prescription Drugs, and services per 1,000 members for all other major categories.
   - We expect that the trend analysis performed by carriers will be based on data that has been normalized for the effects of changes in demographics, benefits, other rating factors, large claims, and seasonality.

   While the Administration currently reviews trend assumptions for reasonableness, it is our opinion that the review process is not as thorough as HHS will require it to be to qualify as an effective rate review program, as outlined in the draft regulations. Therefore, the Administration will need to implement this more detailed review.

   While the Administration is reviewing carriers' trend assumptions, we do not believe the data that carriers are submitting today includes the type of data and analysis the Administration will need to operate an effective program. For example, carriers are not providing trend factors or trend analysis by type of service, or separately for cost and utilization trend. Therefore, the State may need

to require carriers to submit trend and supporting analysis by type of service, separately for cost and utilization. CareFirst is the only carrier in the market that has credible data for detailed trend analysis based on Maryland-specific experience. The Administration requests that the other carriers provide studies based on Maryland and nationwide data, or other external data such as survey data, to determine whether the trends employed in the pricing are reasonable. Since detailed trend analysis would not be credible for carriers other than CareFirst, without further guidance or clarification from HHS we believe it would be reasonable to continue to 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."

2. Cost Sharing Changes by Major Service Category

- It is likely that this item refers to a requirement that states review the actuarial values of changes in cost sharing under the plan. This could refer to benefit changes resulting from a carrier changing the benefits under a plan (e.g., unilaterally increasing deductibles or copays). Alternatively, it could require that benefit relativity factors are reviewed for reasonableness. It is not clear whether HHS would expect this review to occur with each filing, only when a carrier is requesting approval to change these factors, or only when the cost sharing features themselves are changed. If HHS does not clarify what is meant by "cost sharing changes" in the final regulations, the Administration will need to decide which type of review should be conducted.

Current regulations do not specifically require carriers to submit actuarial values or benefit factors. While Insurance Article 14-126(b)(3)(ii) does allow the Commissioner to consider any other relevant factors within and outside of the State when determining whether to disapprove or modify rates for nonprofit health service plans, information on actuarial values or benefit factors is not regularly considered today. Furthermore, the regulation that allows the Commissioner to consider any relevant factors does not apply to insurance carriers or HMOs. In our opinion, the reviews currently conducted by the Administration meet this requirement for an effective rate review.

3. Benefit Changes

- This item also has at least two potential meanings. It could mean that a state's rate review processes must verify that the historical experience upon which projected claims are based has been adjusted to current benefit levels. In this case, verification should be performed to ensure that the experience used to develop trend estimates has also been normalized for the impact of benefit changes. Alternatively, this could mean that a review of cost adjustments applied to reflect newly mandated benefits (such as new benefits required under ACA) as well as reductions in the scope of covered services, unilaterally imposed by the carrier (for example, elimination of coverage for brand name drugs) have been supported. If HHS does not clarify what is meant by "benefit

changes" in the final regulations, the Administration will need to decide which type of review to conduct.

If the intent is for a state's rate review process to include a review of the claim adjustments made to account for changes in underlying benefits, the development of base rates should be reviewed to ensure that the experience used to develop them has been properly adjusted, and that the product of the base rate and the benefit factors results in premiums that are reasonable in relation to the benefits provided. Most carriers in the small group market use a multiplicative rating formula, whereby a base rate is multiplied by several rating factors (such as age factor, area factor, benefit factor, underwriting load factor, and retention load factor, as allowed) to arrive at the appropriate premium to charge. The Administration's review should verify that the experience used to develop the base rates has been normalized to reflect the risk presented by an individual or small group with a 1.00 value for each factor. This is done by dividing by the average of each factor effective during the period consistent with the base experience. A review should also be performed to ensure that any additions to or deletions from benefits (e.g., mandated benefits) have been properly incorporated.

A carrier's trend development should also be reviewed to ensure that the experience used has been normalized for changes in benefits, as well as age/gender, area, and morbidity (if these are allowable rating factors) to ensure that these effects are not double-counted, once in trend and again in applying these factors in a carrier's rating formula.

In our opinion, the Administration's current reviews meet this requirement for an effective rate review.

4. Changes in Enrollee Risk Profile

- As with benefit changes, the draft regulations could require a state's rate review processes to verify that historical experience upon which projected claims are based has been adjusted to reflect a normalized enrollee risk profile. In this case, verification should also be performed to ensure that the experience used to develop trend estimates has been normalized for underlying changes in the risk profile. This would, at a minimum, include those aspects of the insureds' risk profiles that can be separately adjusted through the rating process (e.g., age). Furthermore, since an industry-wide risk adjustment process will not be employed until 2014, and many carriers – especially smaller carriers – do not employ robust risk adjustment models, it is reasonable to expect that changes in average rating factors (rather than a risk adjustment mechanism) would be used to adjust the data.

Given that most carriers do not have sophisticated predictive modeling software to assign risk scores, and state-wide risk adjustment programs (which may eventually assign risk scores) are not likely to be established until 2014, we think these risks can be measured by looking at changes in age factors and area factors, and can be

used as a proxy for changes in risk profile in the small group market. In the individual market, changes in these factors as well as changes in the average duration (i.e., how long the policy has been in effect) can be used as a proxy for changes in risk profile. In our opinion, the reviews currently conducted by the Administration meet this requirement for an effective rate review.

5. Impact of Over- Or Under-Estimating Medical Trends in Prior Years

- This likely refers to a rate correction that is needed due to inaccuracies in prior trend estimates. Carriers would need to show the breakdown of the rate increase into components (i.e., over- or under-estimation in prior rate, trend, changes to administrative expense loads, profit loads, other), as this information may not otherwise be readily apparent from the filed data. Reasonableness of the over- or under-estimation component could be checked via an actual-to-expected analysis. The draft Rate Summary Worksheet requires carriers to report the prior estimate of projected net claims embedded in the "current" rate as well as a current estimate of projected net claims for the "current" rate. The "current" rate is defined as the rate in effect 12 months prior to the proposed effective date of the rate increase, and is assumed to represent the 12 months following that date. This actual-to-expected analysis in the draft Rate Summary Worksheet is limited to claims, and does not include administrative expenses and profit.

We could not find any requirements for carriers to submit information related to prior rating inaccuracies. Therefore, the current requirements will need to be revised to include this analysis. Carriers 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 requested due to prior inaccuracies, further scrutiny should be applied to the development of current trend rates.

6. Reserve Needs

- This likely refers to an analysis of the reserves included in the carrier's incurred claim estimates. This type of review would ensure that the reserves used in developing rates are not excessive. Insurance Article 14-126(b)(3)(ii) does allow the Commissioner to consider a reasonable margin for reserve needs for nonprofit health services plans when determining whether to disapprove or modify rates; however, reserve estimates for pricing purposes should not include significant margins.

Current regulations do not specifically require carriers to submit information related to developing incurred but not reported claim reserves. Where claims are separated between the paid portion and the portion that represents a reserve, the Administration does review the information for reasonableness.

We believe carriers could be required to submit claims paid to date and their estimate of incurred claims on a monthly basis for the most recent 36 months.

Using this information, the Administration could examine the completion estimate applied to the base period experience. If the completion appears unreasonably high or unreasonably low, the monthly experience could be used to further examine completion at the monthly level.

The Administration could develop a standard against which to measure these completion factors for general reasonableness. One example would be to develop a two-dimensional grid, where one axis contains the number of months in the experience period examined and the other the number of months of payment runout. Recognizing that speed of payment will vary by carrier, each cell could contain a reasonable range of anticipated completion factors. The table might look similar to that below.

Months in Experience Period		**Months of Claims Runout**					
		1	2	3	…	…	12
	1						
	2						
	3						
	4						
	.						
	.						
	.						
	.						
	12						

7. Administrative Costs Related to Programs That Improve Health Care Quality

- We believe this item refers to a review of any expenses related to quality improvement programs that are included in developing projected claims.

Carriers may wish to include the cost of programs that improve health care quality as an incurred claim cost in the development of their rates, as they will be allowed to include these costs in the numerator of the federal MLR calculation. Therefore, our understanding of this review item is that the Administration is expected to review these costs for reasonableness. Since the Administration is not performing this type of review today, its process as well as its data submission requirements will need to be modified.

Carriers should be required to provide support for any expenses related to quality improvement programs that are included in developing projected claims. Since the statutory statement has been revised to include the Supplemental Health Care Exhibit for purposes of calculating the federal MLR, the Administration 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.

8. Other Administrative Costs

- We believe this item is relatively straightforward; the regulator is expected to review the development of anticipated costs (such as general administrative expenses and commissions) to determine whether these amounts are consistent with prior financial results and whether projected changes are fully supported.

Carriers are not currently required to provide information regarding administrative expenses. The draft Rate Summary Worksheet for the Part I preliminary justification, which must be submitted for rate filings deemed "subject to review," requires carriers to report administrative expenses in aggregate for both the base period and the projection period. However, HHS would not require this information to be submitted for all increases for which the Administration conducts an "effective rate review" (i.e., all non-grandfathered individual and small group filings).

Therefore, the State will need to revise its rate submission requirements to ensure that carriers are required to submit this information for review for all non-grandfathered individual and small group filings, and not only those "subject to review" as defined by HHS. Carriers should be required to submit actual expenses for a period corresponding to the base period used for claims experience, including identifying those that are covered by surplus and not directly supported by current premiums, as well as those anticipated during the projection period. This information should be required for all individual and small group filings in categories similar to the following, with support for the change in each item.

- Salaries, wages, employment taxes, and other employee benefits
- Commissions
- Taxes, licenses, and other fees
- Cost containment programs / quality improvement activities
- All other administrative expenses

The Administration could then review the change in these expenses on a PMPM basis for reasonableness. If the increase in expenses for a given category is outside expected norms, the carrier could be required to provide additional information to support the assumption.

9. Applicable Taxes, Licensing and Regulatory Fees

- We believe this item is straightforward – the regulator is expected to verify that amounts for these items included in rate development are appropriate.

Currently, the Administration does not separately review the level of taxes, licensing and regulatory fees included in rate development. The filing requirements will need to be revised to include the requirement to provide support for any taxes, licensing and regulatory fees involved in rate development. The Administration could review these taxes and fees relative to statutory requirements found in Title 6 of the Insurance Article of the Code of Maryland.

A cursory review would be sufficient, as the Administration already applies a minimum loss ratio requirement as well as a requirement that rates be "not excessive, not inadequate, and not unfairly discriminatory" for purposes of determining whether premiums are reasonable in relation to benefits.

10. Medical Loss Ratio

- Since the listing above refers to factors that must be examined under a state's effective rate review program, the medical loss ratio should be reviewed for compliance with any loss ratio requirements included in state statutes and regulations, rather than the federal MLR requirements.
- HHS may want states with effective rate review programs to review the medical loss ratio in relation to the federal MLR requirement, even though a state's statutes and regulations may not require carriers to prospectively meet the federal loss ratio requirement. This may be the intent, given that the Part III preliminary justification (which must be provided if HHS performs the review) requires that if the projected loss ratio is lower than the federal MLR, a justification for this outcome must be provided.

The Administration currently reviews projected loss ratios for compliance with statutory requirements for both individual and small group filings. In the individual market, all products must satisfy a minimum loss ratio of 60%.[27] In the small group market, all products must satisfy a minimum loss ratio of 75%.[28] A new law, SB 183/HB 170 Health Insurance – Conformity with Federal Law (effective July 1, 2011), will require carriers to demonstrate prospectively that rates are expected to produce a loss ratio of at least 80% in the individual and small group markets and at least 85% in the large group market, when reported as required under the federal retrospective MLR calculations.[29]

In our opinion, the Administration's current procedures meet this requirement for effective rate review (in markets where the Administration has authority to review rates).

11. Insurer's Risk-Based Capital Level Relative to National Standards

- It is unclear whether states would need to address RBC levels that are too low, too high, or both. To our knowledge, there are no national standards for *excessive* RBC levels. We anticipate that either HHS or the NAIC would need to issue a national standard for states to conduct this review. Until a national standard is issued, one potential standard for *inadequate* RBC is a stated multiple of the Authorized Control Level (ACL) under the NAIC Risk-Based Capital System. It seems reasonable that something greater than 200% of ACL would be an appropriate benchmark to trigger further examination to ensure that the risk-based capital is not *inadequate*, as 200% of ACL is the level at which some type of remedial action is

[27] Insurance Article 15-605(c)(2)

[28] Insurance Article 15-605(c)(1)

[29] 45 CFR 158

taken. For BlueCross BlueShield plans, a minimum RBC ratio of 375% must be maintained to remain in good standing, and a minimum of 200% must be maintained for continued use of the association's trademark.

- An examination of the trend in the RBC ratio could also be intended. In 2009, the NAIC introduced the Health RBC trend test (RBC ratio is less than 300% and the combined ratio is greater than 105%), and failure to meet this test could be used as a trigger for further review, such as a request for financial projections; however, the Administration may feel a different threshold is more appropriate. Carriers falling below the determined threshold could be required to provide additional support to demonstrate that rates are not *inadequate* in light of low RBC levels. This could entail completion of financial projections similar to those currently required for HMO rate filings.

  While Insurance Article 14–126(b)(3)(ii) does allow the Commissioner to consider any relevant factors within and outside of the State when determining whether to disapprove or modify rates for nonprofit health service plans, the current regulations do not specifically require carriers to submit information on their RBC levels in their rate filings. The MIA has ready access to this information since carriers must include this in their annual statutory filing submitted to the Administration.

  The NAIC Risk-Based Capital System is focused on solvency and therefore does not provide an upper threshold for RBC levels. We are aware of one study (conducted for the Pennsylvania General Assembly Legislative Budget and Finance Committee) that attempts to develop upper limits for RBC levels. However, that study focuses on not-for-profit plans, and the results may not be appropriate for other plans.

  Specific to the State of Maryland, in December of 2008, Group Hospitalization and Medical Services, Inc. (GHMSI) engaged Milliman to quantify an optimal surplus target range within which GHMSI should strive to operate.[30] Milliman's report indicated a target surplus range of 750%–1050% of the RBC ACL level for GHMSI. In a similar report for CareFirst of Maryland, Inc. (CFMI), Milliman recommended a target surplus range of 900%–1200% of the RBC ACL level.[31] In 2009, the Administration performed a study to evaluate and recommend the appropriate amount of surplus for CFMI and GHMSI.[32] As a result of this study, the Administration's consultant recommended a range of 825%–1075% for CFMI and 700%–950% for GHMSI. In October of 2009, GHMSI engaged The Lewin Group to perform a study similar to the one performed by Milliman.[33] The Lewin report recommended a range of 750%–1000% for GHMSI. However, these studies take into account many unique characteristics of CFMI and GHMSI that preclude

[30] http://www.mdinsurance.state.md.us/sa/documents/MilimanReport2008.pdf

[31] http://www.mdinsurance.state.md.us/sa/documents/MillimanTestimony11-19-09.pdf

[32] http://www.mdinsurance.state.md.us/sa/documents/InvotexReporttoMIA-10-30-09FINAL.pdf

[33] http://www.mdinsurance.state.md.us/sa/documents/LewinReport2009.pdf

the results from being used as benchmarks for other carriers in the State. Incorporating upper RBC thresholds applicable to for-profit insurers becomes more problematic in that a for-profit carrier can easily reduce its RBC levels by distributing these funds to stockholders or parent corporations in the form of dividends, or by repurchasing stock.

6

Considerations for Determining the Reasonableness of Rate Increases

In this section, we describe various financial measures that could be considered when determining whether a requested rate increase is justified. We discuss pros and cons of incorporating each of these items into the rate review process, from the perspectives of the consumer and the Administration. In our experience, only a few of these items are included in the rate review process of most states. However, as we discussed in Chapter 5, most of these items will need to be included in an "effective rate review program" as defined by HHS. Therefore, most of these items will probably be reviewed by most states in the near future.

Loss Ratio Requirements

In Chapter 4, we discussed the loss ratio tests that are currently used by the Administration's actuarial staff for individual and small group products. As discussed in that chapter, until the passage of SB 183/HB 170 (which will become effective July 1, 2011), carriers were required to demonstrate that proposed premiums for any individual policy were expected to generate a loss ratio of at least 60%.[34]

Until SB 183/HB 170 was passed, carriers were required to demonstrate that proposed premiums for any small group filing were expected to generate a loss ratio of at least 75%. While most states do not currently require that carriers satisfy a minimum loss ratio requirement in the small group market, there are a few states that currently apply a loss ratio requirement. The following table shows the minimum loss ratio requirements that apply in the small group market of some sample states.

[34] SB 183/HB 170, Health Insurance – Conformity with Federal Law, requires that premiums reflected in filings effective on or after July 1, 2011, be expected to produce loss ratios equal to or greater than the minimum loss ratios set forth in the ACA for individual, small group, and large group policies. More details of this bill are discussed later in this chapter.

State	Minimum Loss Ratio
Colorado	70%[35]
Florida	Greater of initially filed or 65%[36]
Maine	75% (78% if guaranteed)[37]
Minnesota	75%[38]
New York	82%[39]
Rhode Island	80%[40]

States vary in whether a refund is required if the actual loss ratio for a given period falls below the minimum.

The ACA now requires that individual and small group products meet an MLR of 80%, and that large group products meet an 85% MLR, measured retrospectively on a calendar year basis in 2011 (transitioning to a rolling 3-year basis by 2013). The MLR loss ratio requirements apply to the aggregation of all policy forms within a given market (e.g., individual, small group, and large group), state, and legal entity.

The ACA MLR is not strictly the common incurred claims divided by earned premium loss ratio. Rather, specific adjustments are allowed to both the incurred claims and the earned premium amounts. For example, expenditures on activities to improve health care quality are added to claims in the numerator.[41] State taxes, assessments, and federal taxes are subtracted from premiums in the denominator. Other adjustments apply as well (e.g., credibility as well as adjustments for product portfolios consisting of higher-than-average deductibles). The effect of these adjustments is that carriers may have a traditional loss ratio (incurred claims divided by earned premium) that falls below the minimum but exceeds the federal MLR after adjustments are made. If the MLR is not met for a given calendar year, as measured on a retrospective basis using actual experience, refunds must be paid.

The ACA does not explicitly require that the MLR be satisfied on a prospective basis. However, as we discussed in Chapter 5, one of HHS's considerations for determining whether a requested rate increase is excessive is whether the MLR is expected to be met prospectively. However, this requirement applies only when HHS performs the rate

[35] http://www.dora.state.co.us/insurance/regs/4-2-11.pdf (Accessed May 18, 2011).

[36] https://www.flrules.org/gateway/notice_Files.asp?ID=6182894 (Accessed May 18, 2011).

[37] http://www.mainelegislature.org/legis/statutes/24-a/title24-Asec2808-B.html (Accessed May 18, 2011).

[38] https://www.revisor.mn.gov/statutes/?id=62A.021 (Accessed May 18, 2011).

[39] http://public.leginfo.state.ny.us/LAWSSEAF.cgi?QUERYTYPE=LAWS+&QUERYDATA=$$ISC3231$$@TXISC03231+&LIST=LAW+&BROWSER=EXPLORER+&TOKEN=15666872+&TARGET=VIEW (Accessed May 18, 2011).

[40] http://www.ohic.ri.gov/documents/Insurers/Regulations/regulation11smallemployerins/1_Regulation%2011%20Final.pdf (Accessed May 18, 2011).

[41] Activities to improve health care quality are generally defined as activities that increase the likelihood of desired health outcomes that are objectively measured and produce verifiable results and achievements. The expenses associated with these activities exclude expenses billed or allocated by a provider for care delivery.

review, unless a state adopts the same requirement. Even on a prospective basis, similar to the retrospective refund calculation, the MLR is evaluated by HHS across all policy forms within a market, state, and legal entity. There is no federal requirement for a single policy form to meet the federal MLR.

In light of the new federal requirements, many states are considering whether their current loss ratio requirements need adjusting. Considerations include the following:

1. Should lifetime loss ratio requirements in the individual market continue to be applied on a lifetime basis or be changed to an annual basis? (This does not apply to Maryland since it does not have a lifetime loss ratio requirement.)
2. Should minimum loss ratio requirements be maintained at current levels or changed to be consistent with the federal level?
3. Should an incurred claims divided by earned premium calculation be maintained, or should the federal calculation be adopted?
4. Should loss ratio requirements be applied at the policy form level or the market level, across all policy forms?

On April 12, 2011, Governor O'Malley signed into law SB 183/HB 170 Health Insurance – Conformity with Federal Law, effective July 1, 2011. Among other things, this law requires that carriers in Maryland must demonstrate prospectively that rates are anticipated to produce a loss ratio of at least 80% in the individual and small group markets and at least 85% in the large group market, when reported in the manner required under the federal retrospective MLR calculations.[42] Passage of this law has addressed questions 2 through 4 above, enabling Maryland to focus on the implementation considerations.

The new law does not appear to address whether the credibility adjustment detailed in the retrospective MLR formula should be applied when developing rates for future periods, or whether a traditional actuarial approach (blending experience that is not fully credible with a manual rate) can be used to achieve fully credible experience upon which to base the rates. Therefore, we discuss this issue further in the following section.

MLR Credibility vs. Traditional Actuarial Approach to Credibility

The federal MLR requirement includes a credibility adjustment intended to address claim variability of smaller carriers. The credibility adjustment adds percentage points to the initially calculated MLR. The additional percentage points vary by the number of life-years covered by the carrier, and were developed so that an insurer that charges premium intended to produce an 80% MLR will pay a rebate less than 25% of the time. The credibility adjustment was intended to reduce the chance that a carrier would be required to pay a rebate simply as a result of random fluctuation.[43]

[42] 45 CFR 158

[43] The actual credibility factors adopted reflect the 50th percentile, which means the probability of claims being above or below that target loss ratio due to random fluctuation is 50% in each case. When the credibility adjustment is incorporated, the probability of paying a rebate solely attributable to random fluctuation is reduced to 25%. It is important to note that the credibility adjustment's sole purpose is to try to minimize the risk associated with random

Using credibility to determine whether a rebate is payable under the ACA is very different from using the traditional actuarial approach when developing rates. Actuarial Standard of Practice #25 states, "The purpose of credibility procedures is to blend information from subject experience with information from one or more sets of related experience when the subject experience does not have full credibility in order to improve the estimate of expected values."[44] Rates are typically developed from a credible data source. When the experience underlying the block of business for which rates are being developed is not fully credible, a manual rate is blended with the less than fully credible experience (hereafter called the subject experience) to arrive at a credible data source. There are various ways an appropriate manual rate could be developed:

1. It could be developed by pooling the Maryland experience of all of the carrier's policy forms for the corresponding market.
2. It could be developed by pooling all of the carrier's experience for the same policy forms nationwide. If nationwide experience is used, the nationwide premium must be adjusted to reflect Maryland rate levels.
3. It could be defined as the target MLR (80% or 85%, depending on the market).

There are several reasons to use the traditional credibility adjustment methodology (rather than the MLR credibility) when projecting claims forward, and developing premiums based on those projections:

- The credibility adjustment factors included in the MLR regulations were not intended for use in developing rates. Applying such factors to develop rates would not result in rates that represent the 50th percentile, or expected costs, but rather something higher. This is because the credibility adjustments outlined in the MLR regulations were developed to result in a rebate being paid less than 25% of the time when premiums developed are intended to produce an 80% MLR.
- Application of the MLR credibility adjustment is a "one-tailed test." The credibility adjustment will always result in an addition to the loss ratio calculated from the subject experience. The more traditional approach (which blends the subject experience with a manual rate) follows a mean reversionary approach. Theoretically, the manual rate should be expected to produce a loss ratio close to the target MLR. If the subject experience reflects costs that are higher than those reflected in the manual rate, blending the higher emerging experience with the manual rate will reduce the projected claims (and the corresponding projected loss ratio). Conversely, if the subject experience reflects costs that are lower than those reflected in the manual rate, blending the lower emerging experience with the manual rate will increase the projected claims (and the corresponding projected loss ratio). This reflects the theoretical purpose of credibility – to adjust experience that varies from the expected results because of random fluctuation back toward the expected, or norm.

---

events. It does not consider any risks associated with misstatement of other rating factors such as trend, changing utilization patterns by age, etc.

[44] http://www.actuarialstandardsboard.org/pdf/asops/asop025_051.pdf

- If the subject experience reflects costs that are higher than those reflected in the manual rate, the MLR credibility adjustment approach will always result in a higher rate increase being justified than the traditional approach, all else being equal. This is again because the MLR credibility approach always results in adding a positive adjustment to the projected loss ratio based on the subject experience, while blending the poor subject experience with a manual rate will result in reducing the projected loss ratio based on the subject experience. (Again, this assumes that the manual rate will produce a loss ratio close to the target loss ratio.)
- If the subject experience is expected to produce a loss ratio less than the target MLR, the results of the two approaches will vary depending on how far below the target the loss ratio is.
  - If the expected loss ratio of the subject experience is below the target loss ratio, but by an amount less than the MLR credibility adjustment, the MLR credibility approach will result in no change in rates or a small increase (no greater than the amount of the credibility adjustment), while blending the subject experience with a manual rate will always result in a rate decrease being required, all else being equal. This is because the addition to the loss ratio under the MLR credibility adjustment pushes the loss ratio based on the subject experience above the target MLR, while blending the subject experience with the manual rate (which produces a loss ratio close to the target MLR) will result in a loss ratio that remains less than the target MLR.
  - If the expected loss ratio is below the target loss ratio by an amount greater than the MLR credibility adjustment, both methods will produce a rate decrease. As the subject experience falls further below the target MLR, the MLR credibility approach will result in a larger required rate decrease.
- From a purely actuarial perspective, the traditional method is preferred since it is based on mathematical credibility theory studied over the years.

However, if the goal is to align the premium development with the rebate calculation, then adopting the MLR approach would better accomplish this. This would also result in requiring all carriers to use a common credibility table to demonstrate compliance with the loss ratio requirement. If the MLR approach is used, then the credibility adjustment should be applied to the actual experience of all policies in the market for that legal entity (and not experience that has been blended with nationwide or other experience), to avoid adjusting for credibility twice.

Application of the MLR Requirement at the Policy Form vs. Market Level

The federal MLR requirement will be applied retrospectively at the market level. This is inconsistent with many existing state regulations which require that loss ratio tests be met at the policy form level. Current Maryland statute requires that the loss ratio tests be applied at the health benefit plan level.[45] The newly passed Health Insurance - Conformity with Federal Law requires that carriers develop rates that meet the federal MLR loss ratio

[45] Insurance Article 15-605(c) – reference to "health benefit plan level" in this article has been interpreted by the State as meaning "market level."

requirements at the market level. However, for completeness we discuss pros and cons to requiring the test be met at the policy form level versus the market level.

Apply the MLR Requirement at the Policy Form Level

The pros of this option (cons of application at the market level) include:

- Since the loss ratio is applied at the form level, it allows the Administration to mitigate subsidization across products.
- The filing would not need to address the projected experience of the carrier's other forms in the same market.
- Theoretically, if each policy form meets the MLR, the aggregation of all policy forms within that market for that legal entity should meet the MLR.
- Carriers are accustomed to supporting rates on this basis in the individual market and providing the necessary data to the Administration.

The cons of this option (pros of application at the market level) include:

- In cases where current loss ratios are above 80% for some forms and below 80% for others, requiring the MLR requirement to be met for each form could result in large rate increases for some forms while others would require large decreases to bring the loss ratio for each form closer to 80%. While carriers would not be required to increase rates for forms that exceed 80%, carriers could need to increase rates for those forms to maintain overall profitability levels since the forms that fall below 80% would have to have their rates reduced. This could result in disruption in the market. This is probably more of an issue in the individual market where the previous minimum loss ratio was 60%.
- This application is inconsistent with the federal retrospective requirement.
- This application is inconsistent with the preliminary directions supplied by HHS pertaining to filings HHS would review.
- Current small group rating requirements already pool the experience of all products, so filings are already essentially prepared and reviewed on an aggregate market level basis.
- Carriers often do not have the same target loss ratio for all products. For example, fixed administrative costs represent a higher percent of premium for lower priced products than higher priced products. Requiring carriers to meet an 80% loss ratio on each policy form may require some products to subsidize the administrative expenses of other products. Or, carriers could cease offering lower cost products resulting in less affordable options for consumers.
- Requires quality improvement expenses, taxes and assessments to be allocated to each policy form. Carriers do not currently do this and would not be required to do this for the federal calculation. Carriers may be able to allocate these items to products in a manner that is most favorable to the carrier and least favorable to the consumer.

Administrative Expenses

In many states today, rates in the individual market are determined to be reasonable solely based on the carrier's ability to demonstrate that the minimum loss ratio requirement is

anticipated to be met. In these cases no additional consideration is given to the portion of premium which is not anticipated to be used to pay claims expenses. This remaining premium is typically called the retention load and is used to cover administrative expenses, commissions and premium tax, as well as provide for a risk charge and a contribution to surplus. The loss ratio review approach does not consider how the retention load is allocated among the various components and the reasonableness of the components. Some states do have a minimum loss ratio requirement and also perform a review of administrative expenses and pricing margins for reasonableness.

In the small group market, where most states do not have a requirement, rates are typically developed as projected claims costs plus a retention load. In states that do not have the authority to review small group rates, the retention load is not scrutinized for reasonableness. In states that do have the regulatory authority to review small group rates, the state may not currently have the resources to perform a detailed review of administrative expenses and may simply perform a high level check for reasonableness. This high level check might entail a comparison to the prior filing to check for significant changes, or a comparison to other carriers with similar characteristics. In addition, some regulators may not feel they have the authority for a review of retention loads if current regulations do not specifically grant this authority. These states may instead rely on competition in the group market to keep these loads at reasonable levels.

While many states do not require carriers to submit information on administrative expenses beyond what is typically included in rate filings and annual statements, we are aware of some states that have the authority (or will soon have the authority to examine administrative expenses as part of their regulatory review.

- In Massachusetts, recently passed House Bill 2585, signed as Chapter 288, grants their insurance Division the authority to disapprove rates based on inclusion of excessive administrative costs or surplus margins. Premium increases will be presumptively disapproved if:
    - Insurer administrative expenses, excluding taxes and assessments, increase by more than the New England medical inflation rate, or
    - The contribution to surplus load exceeds 1.9%, or
    - The aggregate medical loss ratio for all plans is less than 88%, or 90% in year two. (These requirements sunset in year three.)

  In addition, 211 CMR 66.09 requires rate filings to include projected administrative expenses broken into eleven components.
- In Oregon, House Bill 2009 requires insurance companies to separately report and justify increases or decreases in administrative expenses, such as salaries, broker commission, and advertising.
- In Colorado, when a carrier requests a rate increase, the Division of Insurance looks at many factors, including the cost of medical care and prescription drugs, the company's past history of rate changes, the financial strength of the company, actual and projected claims, premiums, administrative costs, and profit. The Division of Insurance approves the request if the carrier can show that the new rate is reasonable in relation to the

benefits provided. If the carrier's data does not fully support the increase, the Division can ask for more information, approve a smaller increase, or reject an increase.
- In addition, we know of a few other states where the regulatory agencies review administrative expenses for reasonableness. In some cases, it is the Department of Insurance and in other cases it is the Office of the Attorney General that takes the interpretation that their authority includes the review of retention items. In some states the authority extends only to the individual market, such as Maine and Rhode Island. In other states, such as Kentucky and Vermont, small group retention loads are also reviewed for reasonableness.

A review of administrative expenses may include a requirement that carriers utilize recent financial statement experience as a base and support projected changes anticipated to occur between the base period experience and the rating period. When this type of review is conducted, expenses are typically broken down into various categories and the carrier is required to support changes in anticipated expenses by category. While expenses could be required to be broken down in more detail at the cost center level (generally very detailed functional accounting records at the department level), expenses would at a minimum be broken down into broad categories such as the following:

- Salaries, wages, employment taxes, and other employee benefits
- Commissions
- Taxes, licenses, and other fees
- Cost containment programs / quality improvement activities
- Other administrative expenses

The first category listed above could further be broken down between categories such as billing and enrollment, underwriting, customer service, compliance and government relations, etc.

There are likely to be special circumstances that must be taken into consideration when performing a review of administrative expenses. Examples include:

- Start-ups will have a different administrative structure than established carriers.
- Investments in items that improve health care quality may increase administrative expenses in the near-term, but reduce overall health care expenditures in the long-term.
- One-time expenses need to be considered such as adopting new reporting requirements due to ACA and ICD-10 implementation, though we note that these types of expenses represent longer-term investments and may be financed through surplus or other means to acquire capital, rather than through administrative expenses.

A review of administrative expenses should consider the distribution of fixed and variable expenses, and the impact that it has on administrative costs on either a per member per month (PMPM) basis or a percent of premium basis. For example, smaller carriers will tend to have a higher concentration of fixed costs than larger carriers. Therefore, the inability of smaller carriers to spread their fixed costs over a larger population will lead to higher costs being allocated to each policyholder, all else equal.

The review should also examine the methodology used to allocate expenses to each line of business (e.g., individual, small group, Medicare, and Medicaid). The allocation methodology should use metrics (e.g., per contract, per member, or percent of premium) that can be supported by the carrier, and that are reasonable given differences in the populations.

New MLR regulations will require that carriers spend 80% of premium on claims costs in the individual and small group markets and refund to policyholders premiums in cases where the loss ratio test is not met, although some adjustments for quality improvement expenses, taxes, carrier size, and average deductible offered will be allowed in calculating a carrier's loss ratio for this purpose. This will put significant pressure on some carriers to reduce administrative expenses in the individual market as MLR requirements are currently often as low as 60%, as it was until recently in Maryland. Therefore, some states may be tempted not to enhance their oversight in this area, relying instead on the more restrictive, federal loss ratio requirement.

Pros and Cons of Including a Review of Administrative Expenses

There are several pros and cons associated with including a review of administrative expenses in the rate review process. We discuss the pros and cons from the perspective of the consumer and the Administration.

The pros of incorporating a review of administrative expenses into the rate review process are:

- A detailed review and a requirement to separately justify these expenses would ensure excessive expenses are not included in rates, which could occur if administrative expenses are loaded as a percent of premium that is consistent with prior years.
- A process with increased scrutiny of all expenses may be positively perceived by consumers. As an example, "excessive" executive salaries and bonuses could be prevented from being passed along to consumers.
- Additional oversight and scrutiny of expenses may cause carriers to become more diligent in their efforts to contain or reduce these expenses. This could lead to lower premiums.
- Other expenses that may not be an appropriate charge to be paid for by consumers may be removed from the administrative expenses, such as political contributions.
- The ACA requires that effective rate review programs incorporate a review of administrative costs related to programs that improve health care quality, and other administrative costs. Changing the Maryland rate review process to include a review of administrative expenses would be compliant with federal requirements.

The cons of incorporating a review of administrative expenses into the rate review process are:

- Additional analysis would be required by the Administration, and the review would need to ensure that all factors that may cause administrative loads as a percentage of premium to differ (such as carrier size and low-premium products) have been properly

considered. Current staffing levels may not be able to accommodate this additional workload.

- Carriers' cost accounting systems rarely track costs at the policy form level. Direct costs, such as commissions, premiums taxes, assessments based on lives, premiums or claims, may be tracked at the market level. There will need to be some type of allocation of administrative expenses across markets. Determining the reasonability of some of these allocations may necessitate different skill sets, such as cost accounting, which are not currently available to the Administration.
- Defining what is "excessive" with respect to administrative expenses may be problematic unless set forth in statute.
- Requires a change in statute or regulation in order for the Administration to disapprove a rate increase request based on unreasonable administrative expense levels for insurance carriers and HMOs.

Surplus Levels

A fundamental actuarial principle is that premiums must be sufficient to cover expected claims, administrative expenses, and to provide for a contribution to surplus (or profit margin). In general, most regulatory rate review processes primarily focus the effort on reviewing the development of the expected claims for the rating period. There are a handful of regulatory agencies that historically have taken corporate surplus levels into account during the rate review process (e.g., Maine, Oregon, and Colorado). However, all state regulatory agencies monitor and review the surplus levels of domiciled insurance corporations, HMOs, and other types of insurance entities. These reviews generally take place as part of the financial examination, rather than during the rate review process. It is critical, however, that premiums are sufficient in the long run or companies will be forced to withdraw from the market and/or go out of business.

Types of Surplus Requirements

There are several methods and tools used to evaluate a company's surplus position, the most common being the NAIC's family of Risk-Based Capital ("RBC") formulas that vary with the type of company involved (life insurance, health insurance, property and casualty insurance, etc.). The health RBC formula considers four components: asset risk, credit risk, underwriting risk and business risk. A significant advantage of the RBC formula is that the approach takes into account the characteristics and risks of each corporation. However, the RBC formula is designed to identify minimum surplus levels and companies in financial distress. There is no maximum surplus as a percentage of a company's RBC that is considered reasonable. This can be an area of contention when regulatory agencies attempt to use RBC requirements in the rate review process for those companies with large surplus levels. Maryland has performed several studies to assess what a reasonable RBC ratio for CareFirst might be. This analysis was previously discussed in Chapter 5.

Another approach used to regulate surplus levels is the establishment of minimum and maximum allowed amounts. Historically, these surplus requirements generally applied to non-profit service corporations. The requirements were generally defined in terms of

number of months of paid claims. The disadvantage to this approach is that the required surplus level does not reflect the risk profile of the plan.

Other States That Review Surplus

While most states have not historically reviewed surplus levels as part of the regulatory premium rate review process, our research shows that states are beginning to do so.

- In Oregon, House Bill 2009, which became effective in April 2010, allows their insurance department to consider an insurance carrier's overall financial position, including but not limited to profitability, surplus, reserves and investment savings when determining whether proposed rates are reasonable and not excessive, inadequate or unfairly discriminatory.
- In Colorado, House Bill 1289, which took effect in July 2008, granted their insurance division the authority to consider an insurance carrier's overall finances, including profits, investment income and surplus when reviewing a proposed rate increase.
- In Washington, House Bill 1301 was introduced in January 2011. If passed, the bill would allow their Office of the Commissioner of Insurance to review surplus levels of non-profit insurers in the individual and small group markets.

The states listed above that do perform such reviews do so under broad regulations that simply grant the state authority to perform the review. We are aware of a few states that have enacted specific laws, regulations or administrative orders limiting the accumulation of surplus. The Pennsylvania Department of Insurance conducted research and as a result ordered that Highmark and Independence Blue Cross hold operating surplus resulting in an RBC ratio in the range of 550-750% and Capital Blue Cross and Blue Cross of Northeastern Pennsylvania hold operating surplus resulting in an RBC ratio in the range of 750-950%.[46] In addition, the report revealed information on the following requirements of other states:

- Michigan enacted a provision in July 2003 stipulating that a health care corporation (meaning Blue Cross Blue Shield of Michigan), shall not maintain a surplus in an amount greater than five times the authorized control level risk-based capital amount.
- Hawaii law states that if a non-profit health plan's net worth exceeds 50% of the prior year's total health care expenditures plus operating costs, the health plan is required to refund the money to clients.
- New Hampshire has a law on its books capping a not-for-profit health insurer's "contingency reserve fund" at 20% of annual premium income. The same law also specifies a minimum amount for such fund of 8% of annual premium income.
- Minnesota had a maximum capital level for nonprofit health service plan corporations in the amount of three months' worth of medical claims expense; however, Minnesota replaced this statutory provision with the NAIC Model Health Risk-Based Capital Act effective in early 2005.

[46] "Considerations for Regulating Surplus Accumulation and Community Benefit Activities of Pennsylvania's Blue Cross Blue Shield Plans." The Lewin Group. June 13, 2005.

Pros and Cons

There are several pros and cons associated with including a review of surplus levels in the rate review process. We discuss the pros and cons from the perspective of the consumer and the Administration.

The pros of incorporating a review of surplus levels into the rate review process are:

- Rate review programs that incorporate surplus levels will focus not only on the adequacy of the premium rates but will help ensure the financial solvency of the carrier. Maintaining financial soundness of carriers protects both the consumers and carriers, as well as enhances consumer confidence in the regulatory agency.
- ACA requires that effective rate review programs incorporate a review of a carrier's RBC level relative to "national standards." Changing the Maryland rate review process to include a review of the RBC would be compliant with federal requirements.
- The incorporation of a review of surplus levels into the process may give the Administration the authority to limit the amount of profit charge incorporated in the rates if surplus levels are deemed to be too high. The ability to limit profit charges included in rates can be strengthened if State statutes were changed to include a maximum level as well.

The cons of incorporating a review of surplus levels into the rate review process are:

- Additional analysis would be required by the Administration and current staffing levels may not be able to accommodate this.
- Consumers may have a negative perception of the Administration in the case where rate increases are approved and the consumers believe corporate surplus levels are too high. The Administration will need to educate and communicate with consumers regarding justification of rate increases in order to overcome this perception.
- Including a review of surplus levels may lead to the determination that a carrier is financially distressed, and the Administration may need to require higher rates than requested by the carrier due to surplus concerns. Consumers may not understand the need for the approval of higher rates. Clear communication and education will be required to make the rate increase approval more understandable to consumers.
- Requires a change in statute or regulation for insurance carriers and HMOs in order for the Administration to disapprove a rate increase request based on surplus levels which are deemed unreasonable.

It is important to note that not-for-profit carriers typically hold larger surplus levels than for-profit insurers. This is due, in part, to the fact that for-profit carriers often pay dividends to shareholders, which reduces their surplus. Another reason that not-for-profit carriers hold higher levels of surplus is that they do not have access to additional surplus from a parent or the ability to acquire capital from the sale of additional stock and must therefore rely entirely on their surplus to cover underwriting and investment losses. Therefore, 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.

Pricing Margins

Premium rates are expected to cover the anticipated costs associated with claims and administrative expenses. In addition, premium rates should include a component for the risk associated with the product and a contribution to surplus. We define these two components, the risk charge and the contribution to surplus, as the pricing margin.

In general, carriers employ a best estimate in the development of future claims expected during the rating period. Therefore, approximately half of the time the claim costs are overstated and half of the time claim costs are understated. Given this expectation associated with a best estimate for claim costs, carriers must have additional funds to cover the variation in costs. In addition to pricing margins incorporated in the premium, the carrier's surplus may also be used to cover the claims variation in a specific rating period.

The situation in Maryland is unique in that a best-estimate pricing approach would effectively result in an actual loss ratio above the federal MLR. The passage of SB 183/HB 170 requires carriers to demonstrate prospectively that their rates are expected to result in a loss ratio at least as high as the federal MLR over time. When this minimum loss ratio requirement is combined with the federal MLR requirement, which is a "one-tailed test," carriers will be required to refund premiums if their loss ratio is below their best estimate target but will not be able to require additional premiums when their loss ratio is above their best-estimate target. In essence, the carrier's expected loss ratio after rebates will be something higher than the MLR target loss ratio when using best-estimate assumptions. The retrospective MLR calculation is based on three years of experience (starting in 2013, the third year in which the federal MLR test applies), recognizing the volatility in claims from year to year. Therefore, while it is typically not preferred to include a risk margin in pricing assumptions (e.g., trend, IBNR estimates) but instead use an explicit risk margin added to a best-estimate claim projection, the Administration may want to allow carriers to include some margin for misestimating their pricing assumptions. The margin need not be large, since the refund will be based on three years of experience smoothing some of the fluctuations, but a small margin may be considered appropriate.

The level of pricing margin incorporated in the premium is dependent upon various characteristics of the carrier and the product. There are different risks associated with various types of markets (e.g., individual, small group) and actuarial practice would have the pricing margin reflect these differences. In addition, other characteristics, such as the size of the block, the overall corporate surplus level and type of products may also impact the level of the pricing margin.

As a general rule, each line of business or market segment should be designed to stand on its own without subsidization from other segments. For example, policyholders in Maryland should not be expected to subsidize policyholders in other states, and group business should not subsidize individual business.

The level of the pricing margin should be reviewed, taking into account the surplus level of the corporation. Since the pricing margin includes an expected amount of contribution

to the overall surplus, the corporation's surplus needs should be considered. For example, corporations with low surplus levels would have the need for greater pricing margins than corporations with large surplus levels.

Other States That Review Pricing Margins

While most states have not historically reviewed pricing margins as part of the regulatory premium rate review process, our research shows that some states are beginning to do so.

- In Oregon, House Bill 2009, which became effective in April 2010, allows their insurance department to consider an insurance company's overall financial position, including but not limited to profitability, surplus, reserves and investment savings when determining whether proposed rates are reasonable and not excessive, inadequate or unfairly discriminatory.
- In Colorado, House Bill 1289, which took effect July 2008, granted their insurance division the authority to consider an insurance company's overall finances, including profits, investment income and surplus when reviewing a proposed rate increase.
- In Massachusetts, recently passed House Bill 2585, signed as Chapter 288, grants the Division of Insurance the authority to disapprove rates based on inclusion of excessive surplus margins. Premium increases will be presumptively disapproved if the amount set aside for surplus or profits exceeds 1.9% of the total premium.
- In addition, we know of a few other states where the regulatory agencies review pricing margins for reasonableness. In some states, it is the Department of Insurance and in other states it is the Office of the Attorney General that takes the interpretation that their authority includes the review of all items included in the rates. In most cases the authority extends only to the individual market. This is the case in the states of Maine, Rhode Island and Vermont.

Pros and Cons of Including a Review of Pricing Margins

There are several pros and cons associated with including a review of pricing margins in the rate review process. We discuss the pros and cons from the perspective of the consumer and the Administration.

The pros of incorporating a review of pricing margins into the rate review process are:

- Reducing excessive pricing margins through the review process protects consumers from unnecessarily large rate increases and premium levels.
- Reviewing pricing margins ensures that the Administration is able to respond to consumer complaints and is able to address the profit component, which may be a primary concern for consumers.
- The review is able to coordinate the pricing margin with overall surplus levels to ensure reasonableness of the margin in the requested rates.
- The Administration can ensure that some forms are not being subsidized by other forms or lines of business.

The cons of incorporating a review of pricing margins into the rate review process are:

- Potential negative perception by consumers who might not agree with levels the Administration determines is reasonable.
- The rate review process will become even more politicized than it already is, especially if there is pressure from consumers to eliminate any contributions to surplus or profit. If insurance carriers' contributions for profit are not perceived by rating agencies and investors as sufficient for the risk being assumed by their investments, then rating agencies or stock analysts may lower their forecasts and stockholders will lose value. Carriers may withdraw from the market as a result, reducing competition and minimizing consumer choice.
- This could be an intrusive process, and settling on a "reasonable" margin could be very difficult unless provided for in statute.
- Requires a change in statute or regulation for insurance carriers and HMOs in order for the Administration to disapprove a rate increase request based on unreasonable pricing margins.

Investment Income and Losses

While investment income is a key component of the pricing structure for some products, such as long-term care insurance, the role investment income plays in comprehensive major medical products is much more limited due to the short duration between when premiums are collected and when the majority of those funds are paid out in claims and administrative expenses. As a result, a review of investment income has not historically been included in most states' rate review process.

However, carriers are still required to hold surplus, and they earn investment income on this surplus and on other assets supporting their liabilities. As discussed above in the section on surplus levels, it is important to note that not-for-profit carriers typically hold larger surplus levels than for-profit carriers. This again is due to the fact that for-profit carriers often pay dividends to shareholders – which reduces their surplus – while not-for-profits need to hold higher levels of surplus due to lack of access to the capital markets. As a result, not-for-profit carriers will typically experience higher investment income on a PMPM basis. Therefore, if a review of investment income is conducted, the reviewer must be cognizant of the fact that different requirements may need to be applied to not-for-profit and for-profit carriers.

Other States That Review Investment Income

While many states do not require carriers to submit information on investment income beyond that which is typically included in rate filings and annual statements, we are aware of some states that have the authority to or will soon have the authority to examine investment income as part of their regulatory review.

- In Oregon, House Bill 2009 which became effective in April 2010, allows their insurance department to consider an insurance company's overall financial position,

including but not limited to profitability, surplus, reserves and investment savings when determining whether proposed rates are reasonable and not excessive, inadequate or unfairly discriminatory.
- In Colorado, House Bill 1289, which took effect July 2008, granted their insurance division the authority to consider an insurance company's overall finances, including profits, investment income and surplus when reviewing a proposed rate increase.

Pros and Cons of Including a Review of Investment Income

There are several pros and cons associated with including a review of investment income in the rate review process. We discuss the pros and cons from the perspective of the consumer and the Administration.

The pros of incorporating a review of investment income into the rate review process are:

- Requiring credit for investment income in the development and justification of rates could work to hold premiums down for consumers.
- Given the requirements for an effective rate review program may necessitate that changes be made to the current statutes in order to require carriers to submit the information necessary to incorporate a review of investment income, no additional statutory changes will be required.

The cons of incorporating a review of investment income into the rate review process are:

- An unstable financial market may lead to significant volatility in investment income results. Including these results in the determination of premiums may in turn lead to some rate instability.
- Incorporating investment income or loss into the determination of the reasonableness of rates would cause policyholders to bear some investment risk.
- Requiring carriers to pass investment earnings on to policyholders may result in suboptimal investment strategies being employed by carriers.
- Additional analysis would be required by the Administration and current staffing levels may not be able to accommodate this.
- It may be difficult to ensure that carriers that are subsidiaries of larger companies that are able to dividend surplus and earnings up to their parent, are treated consistently with those carriers that are not part of a larger corporate structure and must maintain capital entirely on their balance sheet, earning larger investment earnings.
- Carriers use investment earnings as a source of surplus growth. Requiring carriers to return some or all of the investment earnings to policyholders would likely cause carriers to look elsewhere for surplus growth.
- Requires a change in statute or regulation for insurance carriers and HMOs in order for the Administration to disapprove a rate increase request based on credit for investment income at a level that is determined to be unreasonable.

Cost Containment and Quality Improvement Activities

We are aware of two states that formally require that information on cost containment expenses be included in rate filings. Massachusetts requires rate filings to include "A detailed description of all cost containment programs the carrier is employing or will employ during the rating period to address health care delivery costs and the realized past savings and projected savings from all such programs."[47]

Oregon requires each small group and individual rate filing to include a description of changes in the insurer's cost containment and quality improvement efforts.[48] The carrier's cost containment and quality improvement activities document must discuss the carrier's efforts in these areas and include both the cost expended and the benefits that will accrue from these efforts. The carrier must specifically address where the efforts will reduce costs by improving efficiency, improving outcomes, or eliminating waste.
It is not apparent exactly how these states use the information obtained in determining whether to approve the requested rate increase. Presumably, they would want to ensure that expenses spent in this area are being used wisely by either improving patient outcomes or efficiency of care.

As discussed in the loss ratio section earlier in this chapter, the federal medical loss ratio includes expenditures to improve quality in the numerator with claims. The definition of quality improvement expenses that was published by reference in the interim final MLR regulation is the NAIC definition:[49]

> *"Quality Improvement (QI) expenses are expenses, other than those billed or allocated by a provider for care delivery (i.e., clinical or claims costs), for all plan activities that are designed to improve health care quality and increase the likelihood of desired health outcomes in ways that are capable of being objectively measured and of producing verifiable results and achievements. The expenses must be directed toward individual enrollees or may be incurred for the benefit of specified segments of enrollees, recognizing that such activities may provide health improvements to the population beyond those enrolled in coverage as long as no additional costs are incurred due to the non-enrollees other than allowable QI expenses associated with self insured plans. Qualifying QI expenses should be grounded in evidence-based medicine, widely accepted best clinical practice, or criteria issued by recognized professional medical societies, accreditation bodies, government agencies or other nationally recognized health care quality organizations. They should not be designed primarily to control or contain cost, although they may have cost reducing or cost neutral benefits as long as the primary focus is to improve quality. Qualifying QI activities are primarily designed to achieve the following goals set out in Section 2717 of the PHSA and Section 1311 of the ACA:*

[47] 211 CMR 66.09(3)(k)

[48] http://arcweb.sos.state.or.us/rules/OARS_800/OAR_836/836_053.html (Accessed May 18, 2011).

[49] http://www.naic.org/documents/committees_ex_mlr_reg_asadopted.pdf (Accessed May 18, 2011).

- *Improve health outcomes, including increasing the likelihood of desired outcomes compared to a baseline and reducing health disparities among specified populations;*
- *Prevent hospital readmissions;*
- *Improve patient safety and reduce medical errors, lower infection and mortality rates;*
- *Increase wellness and promote health activities; or*
- *Enhance the use of health care data to improve quality, transparency, and outcomes.*

NOTE: Expenses which otherwise meet the definitions for QI but which were paid for with grant money or other funding separate from premium revenues shall NOT be included in QI expenses."

The pros of incorporating a review of cost containment and quality improvement activities into the rate review process are:

- A review could help identify activities that are consistently not producing the desired results and prevent members from paying higher premiums to cover the cost of activities that are not adding value, consistent with the MLR treatment of these expenses.
- The HHS proposed regulations require that effective rate review programs incorporate a review of a carrier's administrative costs related to programs that improve health care quality, as well as the impact of changes in other administrative costs. Changing the Maryland rate review process to include a comprehensive review of the cost containment and quality improvement activities would be compliant with federal requirements.
- NAIC has developed new exhibits that require carriers to provide any quality improvement costs to be considered as part of the MLR testing. Therefore this information will be readily available at the market, legal entity level.
- Given the requirements for an effective rate review program may necessitate that changes be made to the current statutes in order to require carriers to submit the information necessary to incorporate a review of cost containment and quality improvement activities, no additional statutory changes would be required.

The cons of incorporating a review of cost containment and quality improvement activities into the rate review process are:

- While available at the market, legal entity level, quality improvement allowable costs may not be readily available at the policy form level.
- Historically, quality improvement has been difficult to measure. It requires longitudinal studies which can be very difficult to carry out given member terminations. It may be even more difficult in the future, as guarantee issue and health care exchanges make it easier for individuals to switch carriers.

- A consistent methodology must be developed for measuring quality improvement. How will the carrier incorporate these programs into rates? Will they reduce trend? How will this be measured? Are carriers expected to price for the hope of savings before they can be demonstrated? If yes, then carriers could be less likely to try programs that might improve quality but have not already been demonstrated to succeed in other settings first.
- A comprehensive review of cost containment and quality improvement activities may entail a more in depth analysis than demanded by HHS' requirements for an effective rate review program; the draft regulations appear to only require that administrative expenses related to these programs be reviewed.
- Requires a change in statute or regulation for insurance carriers and HMOs in order for the Administration to disapprove a rate increase request based on unreasonable cost containment and quality improvement activities. However, to the extent the inclusion of expenses for these activities is included along with claims in the loss ratio in a manner that is not compliant with the new loss ratio requirements that take effect July 1, 2011 the Administration could disapprove the rate increase request if the loss ratio is not adequately demonstrated to equal or exceed the minimum requirement.

Annual Rate Certification

In most cases, carriers will reassess their experience and file rates at least annually. This is particularly true in states where regulators will only pre-approve the use of a trend factor for a period of time, such as 12 months (In these states it is typically the case that rates no greater than those produced using the last approved rate, increased by 12 months of trend, may be used until new rates are filed). However, if experience is running much more favorably than anticipated, carriers may be comfortable using the rates from the 12^{th} month for as many as six months or more beyond the expiration date of the approved trend factor, absent the requirement that rates be filed each year.

We are not aware of a source that tracks how many states require rates be filed at least annually. In our experience working for other states, we have found that most states do not; however, we are aware of a few that do, at least for some market segments. Most states do require carriers to annually file a retrospective certification for their small group business, indicating that rates charged for the prior year were developed in compliance with the applicable law(s). In cases where rates are found to be out of compliance, several states require rates be adjusted retrospectively and refunds provided, although many allow the error be corrected prospectively.

ACA has drawn more attention than ever to the level of health insurance premiums and anticipates an increased level of scrutiny of rates by state regulators. Requiring carriers to file an annual rate certification could bring this 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. ACA does provide a "safety net" in the MLR and required rebates.

An annual rate certification could take several different forms. At one level, carriers could be required to provide a certification similar to that currently used for small group. The actuary would certify that rates for the following year are anticipated to meet the minimum loss ratio requirements, perhaps without supporting documentation. In cases where the carrier is also filing for a rate increase this certification could be filed simultaneously with the rate filing. In cases where a rate increase is not being submitted, the certification would be separately filed and could also require that the actuary certify that all rating factors will remain unchanged.

At a second, more detailed level, the certification could be required to also include a high level numerical demonstration to support the actuary's certification that the minimum loss ratio requirement is anticipated to be met. This would not include support at the level of detail found in a rate filing, and a detailed review of all items required under an effective rate review program would not be conducted since a rate filing would not be submitted.

Finally, at the third and highest level of scrutiny, carriers could be required to submit an annual rate filing which includes all of the information required in any rate filing and a review of all of the information required under an effective rate review program, including a certification that the minimum loss ratio requirement is anticipated to be met. The information required to be submitted would be similar to any other rate filing, however the requested rate increase would be zero.

The pros of requiring carriers to submit an annual rate certification are:

- Carriers are required to demonstrate that loss ratio requirements are anticipated to be met prospectively at the market level.
- Carriers would be required to implement justified rate decreases which might otherwise not be implemented, reducing the overall level of premiums and anticipated premium refunds.

The cons of requiring carriers to submit an annual rate certification are:

- Regardless of the level of scrutiny selected, the Administration would need to track certifications received in order to ensure each carrier submits one, if applicable.
- Requiring carriers to include some level of quantitative support will increase the workload of the Administration somewhat and requiring a full rate filing could significantly increase additional analysis required. Current staffing levels may not be able to accommodate this.
- The MLR provides a safety net in the form of premium rebates for excessive premiums. Therefore, the additional work required by the Administration may not result in lower ultimate premiums paid (i.e., after the rebate).

Pre-Approved Trend Factors

The decision of whether to pre-approve the use of a trend rate for future use could be considered an item to be reviewed in determining the reasonableness of future rates; therefore, we place this discussion in this chapter. Maryland currently allows carriers to file a future trend rate to be applied for up to one year for large group manual rate filings

and companies that file once per year. We present the following information for consideration by the Administration when deciding whether to continue to allow the use of a pre-approved trend rate, and if so for how long.

Other States
We are not aware of a source that tracks how many states allow trend factors to be filed. However, in our experience, we are aware of states that allow trend factors to be filed and used to develop rates for future periods (e.g., Nevada) and others that require the use of only one set of approved rates until subsequent rate change requests are filed and approved (e.g., Maine).

HHS's Draft Rate Review Regulations
HHS' draft rate review regulation is silent regarding the filing of future trend factors. Therefore, it is not clear what requirements HHS may apply regarding future trend factors or how the final regulation might handle a future trend factor that results in annual increases exceeding the threshold for being "subject to review."

Adequacy of Rates
The filing of a future trend factor makes it more difficult for the Administration to determine whether the rates in effect are adequate, and not inadequate or excessive. For example, if the filed trend factor is 15% annualized and the realized trend is 10%, after one year (assuming the company does not choose to re-file before the end of the year to adjust the rates) the rates would exceed the necessary rate level by roughly 5%. If the entire block of policies in that market (individual, small group, large group), state, and legal entity are over-priced, then the federal MLR requirements will necessitate that rebates be paid. But if some policies are more over-priced than others, the rebate will not necessarily be paid to the policies that were over-priced.

Conversely, the carrier could also underestimate trend. If the rates are inadequate, it can lead to solvency concerns or large required rate increases in a future period. Of course, the carrier can certainly avoid these situations by continuing to monitor trend more frequently internally and re-filing if needed. The most effective way to ensure that the rates remain adequate is to require that all rates be filed before use, without the use of a trend factor. However, if a trend factor is allowed, the future period for which it can be used could be limited (for example, to no more than one year). This would minimize the rate shock that could otherwise be felt if a trend did not emerge as originally estimated.

Consistency
Allowing trend factors for individual business would put those filings on a consistent basis with group business, where pre-approved trend factors are already allowed.

Volume of Filings
The final consideration regarding allowing future trend rates is the resources available to the Administration to review rate filings. If the Administration discontinues allowing carriers to adopt a future trend rate, it would increase the number of filings the

Administration needs to review, as some carriers would be filing more frequently than previously (i.e., some that now file annually may instead file semi-annually or quarterly).

If a pre-approved trend is allowed after the effective date of the federal rate review regulations, the Administration may want to consider an upper limit, such as the HHS standard under 45 CFR 154.

7

Trend Analysis

Aside from selection of the base experience, trend is the single most important assumption affecting the development of health insurance rates because it is typically the primary driver of rate increases. Therefore, the trend assumption employed in the rate development process warrants a thorough analysis and justifies close scrutiny in any review of requested change in rates. Because of its importance, we are including a separate, focused discussion on the development and analysis of trend. In this chapter, we discuss:

- The primary drivers of trend
- Data used for trend analysis
- Methods for calculating trend
- Adjustments that should be applied to claim experience in the trend analysis process
- The Administration's review of trend assumptions used by carriers
- Outside sources of information that the Administration may consider using when assessing the reasonableness of a carrier's trend assumption employed in rate filings

Primary Drivers of Trend

In simple terms, trend represents the annualized rate of change in claims costs per capita from one period to the next. The components of trend can be classified into two primary categories, the "secular trend" and "other factors" that cause costs to vary over time, or from carrier to carrier. Secular trend is defined as the underlying trend that would be observed if the population being covered remained constant, that is the same age, gender, morbidity, etc. throughout the period being measured, as well as benefits provided under the policies. The secular trend can be decomposed into changes in cost per service and changes in utilization. However, changes in the mix of services utilized must also be considered and may be included in either the cost component or the utilization component of a carrier's trend.

Key components that affect trend include, but are not limited to:

- Changes in provider reimbursement costs, including changes in how providers are reimbursed
- 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 (not applicable to hospital costs in Maryland)[50]
- Changes in claim coding methodologies by providers
- Changes in morbidity
- Changes in care management, including wellness programs
- Catastrophic claims
- Changes in benefits (minimally affecting allowed claim trends)
- Selection[51]

Data Used for Trend Analysis

In this and the next several sections, we discuss the process that the carriers go through when developing trend estimates for rating. It is important to first understand the process of estimating trend before determining how the Administration can determine whether a filed trend rate is reasonable.

The first decision to make when developing trend estimates is which data to use for the analysis. Ideally, the same data source selected as the base experience would be used for the trend analysis. It is preferable to use Maryland experience consisting of the policies whose existing rates are being assessed. If this experience is not fully credible, blending this with Maryland experience of other similar policies is the preferred method, as the data likely reflects relatively similar provider discounts, benefits, demographics, and care management practices of the block being assessed. If Maryland experience in total is not credible, then nationwide data for the same policy forms may be used to enhance the credibility. Use of these other data may require further adjustments.

Nationwide data will likely not reflect the same provider reimbursement levels, or changes in provider reimbursement levels, as the Maryland-specific experience underlying the form for which a rate increase is being requested. Likewise, the Maryland experience of other forms may not reflect the same demographics that underlie the form for which a rate increase is being requested. Some carriers, especially those new to the market, may not have any credible data of their own – Maryland or nationwide. In that case, additional industry data may need to be relied upon.

A period of data must be selected for the analysis. Typically, the most recent 36 months of data would be the basis for the development of trends. Shorter periods may be used if data is limited; however, it may be more difficult to identify anomalies that may warrant further analysis. Also, 36 months of data are typically needed to identify any effects of

[50] Cost shifting can occur when providers receive less than full cost from some payers (e.g., uninsured, Medicare, Medicaid) and then charge higher amounts to other payers (such as commercial insurers) to recoup the losses.

[51] Selection occurs when people purchase insurance with some knowledge of their probable need for services. This could include purchasing coverage only when needed (if protections are not in place to prohibit this) or choosing benefit design based on perceived need of services. If the amount of selection changes over time, it can affect the trend.

seasonality. Using periods longer than 36 months may introduce periods that no longer represent the current environment. However, longer periods may be needed to enhance credibility if the size of the block is small and if it has experienced significant volatility.

The use of full calendar years is preferred, as the effect of seasonality would be reduced. Even if seasonality adjustments are applied as described later in this chapter, they may not fully capture the effects.

Finally, a decision must be made regarding whether to use allowed claims (amounts before member cost sharing has been removed) or paid claims (allowed amounts after member cost sharing has been removed). Allowed claims are typically preferred since the impact of changes in benefits is not as prevalent. However, even if allowed claims are used, some adjustment for benefits is still required, as discussed later in this chapter. Whether using allowed or paid claims, the claims should be adjusted to reflect amounts that have been incurred but not reported/paid (IBNR) in each monthly value.

Methods for Calculating Trend

The most common methods used for calculating trend include an examination of rolling 12-month loss ratios, rolling 12-month average costs on a PMPM basis, or a least squares regression methodology applied to monthly costs PMPM. When a rolling 12-month approach is used, each month's value is calculated as the average of the previous 12 months' points.

Changes in these rolling 12-month averages are examined to estimate the annual rate of change. When a rolling 12-month loss ratio method is used, historical premiums must be restated to current rate levels before calculating the loss ratios. Advantages of using a rolling 12-month methodology are that seasonal fluctuations are smoothed out and the calculations are simple to perform. Specific advantages of using loss ratios are that the data may not need to be adjusted for changes in demographics and benefits since these changes are assumed to affect premium and claims consistently. However, there are several disadvantages to a method that uses rolling 12-month averages:

- It is difficult to observe the kinds of changes that have occurred over time – including sudden shifts in results, such as the addition of newly mandated benefits or catastrophic claims.
- It is difficult to determine exactly when such changes occurred (e.g., when they began and when they ended) if data is for each calendar year.
- It is difficult to determine the exact scope or impact of the changes.
- Due to the smoothing aspect of using rolling 12-month averages, calculated trends are slower to reflect underlying changes.
- The endpoints in the calculation – the oldest and the newest months – tend to be underweighted, while the midpoints are over-weighted.

An alternative to using rolling 12-month averages is to use a PMPM regression methodology. A regression methodology involves calculating monthly claim costs on a per-member basis and performing least squares regression on the PMPMs. Both linear and

exponential regression methodologies are employed in practice; however, an exponential regression is preferred since changes in medical claim costs typically increase in a multiplicative rather than additive manner. The biggest advantage of this method is that it eliminates the disadvantages of a rolling 12-month methodology. Carriers can observe and adjust for patterns in actual values over time, rather than just gradual increases and decreases. In addition, regression analysis can provide information about the range of the true underlying trend rate and projected values. The main disadvantage of a rolling 12-month methodology is that it is slightly more complex.

Adjustments to Data Used for Trend Analysis

When analyzing trend to develop an estimate for use in projecting recent claim experience to a future period, the underlying data must be "normalized" for other factors to the extent they are captured elsewhere in the rating formula – such as age, gender (where allowed), and benefit factors – or not expected to repeat in the future. This normalization process will expose and isolate the secular trend.

If a rolling 12-month method or a regression method is used, adjustments are necessary to normalize the data for changes in underlying factors that influence claims but are captured through other rating variables (e.g., age, gender, benefit factors), in order to isolate the secular trend.

If the carrier is using a loss ratio approach, only the adjustments that are not reflected in the rating formula would be included in the analysis. For example, adjustments for large claims would still be needed with a loss ratio approach.

The following is a discussion of all the items that could potentially drive the need for an adjustment. In reality, carriers may lack the resources to make all of these adjustments. For example, a small carrier may not have access to a risk adjustment model for use in normalizing data for changes in morbidity. However, it is beneficial to be cognizant of all the possible factors affecting trend and to appreciate why trends that are used to develop rates are, themselves, estimates.

Large Claims

Unusually large claims may skew the observed trends. This is particularly true if large claims occur near the beginning or the end of the experience period used for the analysis when using a regression methodology. Unusually large claims that occurred in the last couple of months will exert upward pressure on the regression estimates, causing an overstatement of the underlying secular trends. Conversely, a large claim that occurred in the early months will exert downward pressure on regression estimates, causing an understatement of the secular trend. Large claims are more easily identified if monthly claims data are received and reviewed.

When large claims occur, a portion of the large claims over a stated threshold (e.g., $100,000) is removed from the experience and a pooling charge is added. The pooling charge may be calculated by removing the total excess amounts over the period examined,

and smoothing them over the entire experience period. Alternatively, the pooling charge may be calculated using a claim probability distribution from a large, stable population.

Benefit Changes

To at least partially mitigate increases in premiums, members have been increasing their cost sharing, or "buying down" benefits over time. As benefits are bought down, the portion of claims paid by the insurer will decrease, all else being equal. Therefore, benefit buydowns can have a dampening effect on observed trends. If adjustments are not made, trends will be understated. Adjustments are typically made to restate the experience to current benefit levels.

If paid claims are used for the analysis, each period's claims experience is divided by the weighted average actuarial value of the benefits embedded in the base experience for that period. If allowed claims are used, the impact of cost sharing changes is reduced. However, if allowed claims are used, an adjustment may still be necessary to reflect changes in utilization patterns as member benefits change over time, as well as changes in covered benefits, such as newly added mandated benefits.

Demographic Changes

Normalization is required to adjust for changes in the demographic mix of a population over time. If not adjusted, these changes will skew the observed trends. Experience is typically normalized for differences in demographics using techniques similar to those described in the Benefit Changes section, that being to divide the claims for a given period by the average demographic factor applicable for that period. At a minimum, the experience should be normalized for each demographic factor that is reflected in the rating structure. For example, Maryland permits small group carriers to adjust premiums based on age and area.

Seasonality Adjustment

Medical claims typically vary from month to month due to factors other than random fluctuation including seasonal impacts, such as cold and flu season or variation in the number of days in a given month. Adjustment for the effects of seasonality can be particularly important if trend analyses are based on paid claims and/or the underlying benefits have high front end deductibles. In other situations, (e.g., with low deductible or copay-type benefits) seasonality may not have a pronounced effect on trend, and it may not be necessary to adjust for seasonality.

If trends are calculated using a rolling 12 month approach, adjustments for seasonality are likely not needed. However, when a regression methodology is used, and it appears as though claims are exhibiting a strong seasonal pattern, seasonality factors should be calculated for each calendar month. Claims for each month would be divided by the seasonality factor for that calendar month in order to restate them on a normalized basis.

Morbidity Changes

Experience should also be adjusted for changes in morbidity beyond that which is captured through the demographic change described above, as they impact the rate at which claims costs change over time. These changes can occur due to changes in the average health of individuals covered or the wear-off of medical underwriting, where underwriting is allowed. Duration is not an allowable rating factor in Maryland in the small group market (with the exception of groups that have insurance coverage for the first time, and then only for the first three years); therefore, in this case projected claims must represent the anticipated average morbidity of the entire block. However, if the rate at which morbidity is expected to change in the future differs from the rate at which it changed in the past (i.e., during the period used for the trend analysis) adjustments are needed.

Where morbidity is an allowable rating characteristic, the data used for developing trend estimates should be normalized for changes in morbidity so as not to double count this effect, once through the trend when projecting claims and again through the rating formula. For medically underwritten business, such as individual policies, duration is often a proxy for changes in morbidity. Average durational factors should be considered in the development of the secular trend. If the average duration has been stable, then there may not be a need to adjust the data.

Provider Reimbursement Changes

Contracts with providers change over time. If the rate at which reimbursement changes occurred during the base period is different from the rate they are anticipated to occur in the future, adjustments are needed. These adjustments can be applied to the base experience to restate claims to levels that would have been paid under provider contracts that will be in place during the projection period. If this is done, experience used for trend analysis must be normalized for historical changes in provider contracts, and no prospective adjustment is required to be made to the calculated trend rate. The resulting trend estimate includes only the utilization trend and the trend that results from changes in provider and service mix. If adjustments are not made to the base experience for changes in provider contracts, then further prospective adjustments must be made to the trend rate calculated from the normalized experience to reflect the anticipated provider unit cost trend.

If no adjustments are made to either the base experience or the trend calculation, ideally the carrier should be able to demonstrate that reimbursement to providers is anticipated to increase going forward at the same rate as it did during the base period. Some of the items that must be considered when estimating changes in provider reimbursement and the need for adjustment include:

- Changes in the mix of services among providers with different reimbursement rates.
- Changes in the mix of services among providers reimbursed on a fee-for-service basis and those reimbursed on a capitated basis, since capitation tends to “immunize” the carrier from changes in utilization, whereas services reimbursed on a fee-for-service basis do not.

Changes in Managed Care

Adjustments may be necessary if a managed care program was introduced or revised during the experience period over which trends are measured. An example includes beginning or revising a utilization management program. Utilization management programs may lead to shifts in care from an inpatient setting to a lower cost, outpatient setting. This may result in observed trends that are dampened, all else equal.

Adjusting for the impact of these changes is typically somewhat subjective. Claims experience prior to the implementation of the program may be adjusted downward by the estimated impact of savings that the program is anticipated to have on claims cost, in order to restate them to levels that would have been expected had the program been in place for the entire period.

Another method commonly used to assess these impacts is a more detailed examination of trends separately by major type of service. This approach is discussed later in this chapter.

Other Considerations When Developing Trend Assumptions

Deductible Leveraging

If allowed claims experience is used as the basis for developing trends, and trends are to be applied to paid claims (those net of member cost sharing), an adjustment for deductible leveraging must be applied.[52] Since allowed claims represent the cost of claims prior to member cost sharing, trends developed from them represent the increase in total cost rather than the increase in the cost of claims for which the carrier is liable. For plans with front end deductibles, the carrier's liability is represented by the amount over the fixed deductible amount. As underlying costs increase, the cost of claims over the deductible increases at a rate faster than the rate at which total claims increase.

Deductible leveraging factors are typically calculated by first estimating the allowed claims, and the anticipated claims the carrier will pay (i.e., those in excess of the deductible). The second year allowed claims are then estimated by applying one year of secular trend to the first year allowed claims. The carrier's anticipated paid claims in the second year for this specific claimant are then calculated by subtracting the deductible from the second year anticipated allowed claims. The amount by which the carrier's paid claims increase from year one to year two, in excess of the secular trend rate, represents the impact of leveraging. The following example presents this concept assuming a secular trend rate of 10%.

[52] Leveraging occurs whenever there is fixed dollar cost sharing, including deductibles, copayments, and out-of-pocket maximums, and claims are increasing. Over time the real value of this fixed dollar cost sharing decreases as a result of inflation. Typically, the deductible has the greatest impact; therefore, we simply refer to this concept as deductible leveraging.

	Allowed Claims	Less Deductible	Carrier's Paid Claims
1. Year One	$1,000	$250	$750
2. Secular Trend *(allowed claims only)*	1.10		
3. Year Two *(1) x (2) for allowed claims only*	$1,100	$250	$850
4. Paid Claim Trend *(3) ÷ (1) for paid claims only, translated into a percentage increase*			13.3%

The example above shows that, while the allowed claims increased at the secular trend rate of 10%, the carrier's paid claims increased by 13.3% (= $850 / $750 – 1). The additional 3.3% represents the impact of deductible leveraging.

Aggregate Trends vs. Trends by Component or Service Category

Another decision that must be made is whether to calculate trends in aggregate for all services or by major service category. Further, trends could be calculated for cost and utilization combined, or for each component separately. While an analysis that decomposes experience into cost and utilization (and further by major service category) is more complex, it does allow shifts in services to be analyzed – and adjusted in the analysis if they are not expected to continue at the same rate.

For example, some procedures may be shifted from an inpatient setting to a lower cost, outpatient setting. Further, technological advances may allow some tests to be performed in an office setting that were previously performed elsewhere, and advances in medical technology can lead to acceleration in trend in certain service categories.

Trend decomposition can help carriers understand and isolate these effects and allow for adjustment. The disadvantage of trying to decompose trends into the various components is that more experience is required to achieve credible results for each component. Some carriers may not have the experience needed to analyze results at this lower level.

Another example of how shifts in utilization can affect trends is observed in pharmacy claims. Utilization patterns and unit costs can be altered by the introduction of "blockbuster" drugs, drugs' losing patent protection, the subsequent introduction of generic drugs, the transition of drugs to over-the-counter status, and changes in formularies. The effects of these changes are buried in a trend analysis that examines claims at an aggregate PMPM level. Breaking the analysis down between cost and utilization, and further by type of script (e.g., generic, brand formulary, brand non-formulary), or even by therapeutic class, can aid in adjusting for the impact of these effects.

We note that one requirement for an effective rate review program, as outlined in draft regulations recently released by HHS and discussed in Chapter 5 of this report, is that regulators review trends separately for cost and utilization, and also by major service

category. To perform this review, the Administration will likely need to require carriers to submit more detailed data than they currently do. As previously stated, credibility will become more of an issue as attempts are made to decompose trend.

The Administration's Review of Trend Analysis

Not only will the Administration probably need to gather more detailed data from carriers, it will likely need to start conducting slightly more thorough analysis. The Administration does not currently review trends by major service category but will be required to do so if the draft regulations are approved in their current form. The Administration has several options available for performing this enhanced analysis:

- Have staff with actuarial expertise review the carriers' analysis to determine the appropriateness of the base experience used, the methodology employed, the adjustments made, and the reasonableness of the results.
- Require all carriers to employ a standardized methodology for estimating trend through the use of a template (which could be provided in the form of an Excel spreadsheet).
- Allow carriers to use their own methodologies to calculate trend, but require all carriers to submit common data elements so the Administration can perform an independent analysis using a consistent methodology for all carriers.

External Data Sources for Trend Estimates

Just as carriers may in some cases rely on outside sources on information in forming their trend assumptions, the Administration may choose to examine outside sources of trend information to utilize as benchmarks when performing their review of requested rate increases. Administration actuaries performing rate filing reviews are required to follow Actuarial Standards of Practice as promulgated by the American Academy of Actuaries in their work. This includes Actuarial Standard of Practice #23, which covers data quality and states that the actuary "must select data with due consideration for the appropriateness for the intended purpose of the analysis, including whether the data are sufficiently current." Therefore, if Administration actuaries rely on external sources for assessing the reasonableness of trend assumptions used by carriers, they must have an understanding of these external data at a level that allows them to assess whether such data is appropriate for the purpose of the analysis.

Health Services Cost Review Commission Data

Oliver Wyman had the opportunity to participate in a discussion with the Administration and the Health Services Cost Review Commission (HSCRC), along with its consultant from The Hilltop Institute, concerning data that the HSCRC could potentially make available to the Administration for use in its rate review process. Specifically, we were asked to assess the feasibility of comparing such data with carriers' trend assumptions used in rate filings submitted to the Administration for approval.

The HSCRC is responsible for setting reimbursement rates for acute-care hospitals under Maryland's all-payer system. As a result, the HSCRC accumulates a significant amount of

claims data for hospital payments across all payer types (e.g., commercial, Medicare, Medicaid). The data is provided to the HSCRC by each hospital and has indicators to identify, among other things, the payer type and carrier. The data does not currently contain an indicator to distinguish between fully insured and self-insured business, market segment (e.g., individual, small group, large group) or product (i.e., a specific carrier's product offering).

The HSCRC indicated that data for each quarter is available 45-60 days after the end of a quarter. This would mean, for example, that calendar year 2010 HSCRC data would have become available approximately February 15, 2011. Carriers will typically use three months of claim runout in the development of their rates to allow for completion. Therefore, the rates that carriers would develop based on 2010 incurred claims experience would use runout through approximately March 2011. The carriers would likely perform their rate development calculations based on this data during the month of April and perhaps submit their rate filing to the Administration in May. Since carriers are required to file rates 90 days prior to the requested effective date (60 days for HMOs), this filing might be for an August 1, 2011 effective date. Therefore, it appears the HSCRC data could be available and analytical reports could be developed by the time the Administration would perform their review of the filing, sometime around May or June.

However, we note that the carrier's trend projection would not represent simply a retrospective look at trends, but rather a prospective estimate. Therefore, the HSCRC data would need to be used not to measure historical trends, but rather to develop future trend estimates. The HSCRC indicated that they set rates for the following fiscal year[53] during the second quarter of each calendar year and that these fiscal year projections could be developed at the carrier level.

Barriers to Using HSCRC Data to Develop Trend Assumptions for Specific Rate Filings

The following barriers to using the HSCRC data to develop trend estimates to compare to carriers' trend assumptions used in rate filings currently exist:

- Membership exposure is not part of the HSCRC current dataset(s). Therefore, only the cost component of trend could be developed; neither utilization trend statistics nor overall claims per member per month trends can be calculated.
- Carriers file rates at the form or form grouping level. While the HSCRC dataset can separately identify data by payer type and carrier, the dataset specifications would need to be modified to include indicators to also allow for separation between self-insured and fully-insured business, market segment.
- The HSCRC data can only be used to develop cost trends for hospital services. This represents only a portion of the total trend rate and it may not be cost effective to expend the funds and resources required to develop these trend estimates for only a limited portion of the total cost trend.

[53] The fiscal year runs from July through June.

- The HSCRC claims data will reflect the demographic mix by age and gender that underlies the population, as well as changes in this mix. Given HSCRC does not currently have a dataset that contains corresponding demographic information, the impact that aging has on the mix of services utilized cannot be removed from the data.
- The HSCRC dataset consists of data from Maryland hospitals only. Many carriers allow members to obtain care outside of Maryland, e.g., in the District of Columbia. Furthermore, small group and large group contracts often cover employees that work and obtain services in all parts of the country. The carriers' trends will reflect all members' services, not only those rendered in Maryland.
- The trends developed using the HSCRC data would represent allowed trends. Carriers' trend estimates will represent paid trends given they are applied to only the portion of claims which are paid by the carrier. As a result, a leveraging factor to reflect the impact of deductibles and other fixed cost sharing must be applied to convert the calculated allowed trend into a paid trend estimate. Developing deductible leveraging factors to adjust the allowed trends becomes difficult at the service level. The value of any deductible would need to be allocated to each major type of service. Carriers that analyze trend at the major service category level typically aggregate the type of service based allowed trend estimates into an overall trend estimate prior to applying a leveraging factor. Therefore, it would be very difficult to compare an allowed trend estimate representing only inpatient costs to a carriers paid trend estimate for inpatient services.
- Carriers typically submit support for their trend assumptions at an aggregate level in their rate filings; they do not include support at the major service category level, or separately for cost and utilization. Since the HSCRC data currently can only be used to develop trend estimates for hospital services, and further only for the cost component of trend, changes to rate filing requirements would be needed to require carriers submit support for their trends at this level in order to compare HSCRC trends to this component of a carrier's trend assumption.

Under an effective rate review as defined by HHS in its draft regulations, states must review a carrier's trend assumptions, separately for cost and utilization, and by major service category. Therefore, the last barrier listed will be removed shortly. However, even if the remaining barriers were to be removed, there are still credibility concerns that would need to be considered, and adjustments that would need to be made.

Credibility is an issue for rate filings that cover a small population. When the experience is separated by major service category, and further by cost and utilization, credibility of the segmented data is reduced even further. Even in larger populations where data is credible in total, data split in this manner may lack full credibility. Carriers are required to base their trend assumptions on credible data and therefore the carrier's trend assumption may not be able to be decomposed in this manner or may be not be based on the same population that is represented by benchmarks developed by the HSCRC.

In summary, it appears the HSCRC has access to some very robust datasets. However these datasets only include facility claims and they do not currently have access to corresponding membership information which are needed to calculate utilization rates or

cost trends on a per member per month basis. Therefore, any benchmarks developed from the current datasets would be limited to the cost component of facility service trend only.

Maryland Health Care Commission Data

Oliver Wyman, the Administration, and the Maryland Health Care Commission (MHCC) discussed data sources that the MHCC has that may potentially be useful to the Administration in its rate review process. Specifically, we were asked to assess the feasibility of comparing such data with carriers' trend assumptions used in rate filings submitted to the Administration for approval.

The MHCC is responsible for providing timely and accurate information on the availability, cost, and quality of health care services to policymakers, purchasers, providers, and the public. One of MHCC's duties is to maintain a statewide medical care database, which includes services rendered by providers. The database includes the following information on patient encounters: the patient's demographic characteristics, the principal diagnosis, the procedure performed, the date and location of the procedure, and the amount charged for the procedure.[54] One of the MHCC's goals is to monitor changes in spending and utilization in the State, and provide this information as a resource for other State agencies to use in their work.

Payers submit data annually on all fee-for-service, managed care, and specialty care encounters involving Maryland residents. Historically, this database contained only professional and pharmacy claims; however, beginning with calendar year 2009 the MHCC began gathering hospital claims as well. Eligibility information (data on covered members) will be collected for the first time for calendar year 2010. Information from each of the datasets can be linked together using an encrypted patient identifier. The MHCC is currently working on developing a common patient ID, which will allow the Commission to follow an individual's claims when he or she migrates from one carrier to another.

Data from both the insured and self-insured markets are collected, and are separately identifiable in the dataset. Data can also be separately identified by market (e.g., individual, small group, large group) and coverage type (e.g., PPO, HMO, indemnity). Currently, only payers with earned premium of at least one million dollars are required to submit data. Twenty-five legal entities are required to submit data for calendar year 2010.[55]

The 2010 claims data is required to reflect payments through April 2011 and is due to the MHCC by June 30, 2011. Once the MHCC receives the data, it will be "homogenized" over approximately four to six months so it can be used for analysis. Therefore, calendar year 2010 data will not be ready for use until late fall of 2011. Given that 2010 is the first year for which eligibility information will be collected, utilization trends and overall cost

[54] http://mhcc.maryland.gov/payercompliance/datsubman2010_20110405.pdf

[55] http://mhcc.maryland.gov/payercompliance/payers2010_20110405.pdf

PMPM trends (which will need to be based on at least two years of experience) will not be available for the first time until approximately late fall of 2012.

Barriers to Using MHCC Data to Develop Trend Assumptions for Specific Rate Filings

The following barriers to using the MHCC data to develop trend estimates to compare to carriers' trend assumptions used in rate filings currently exist:

- Data for a given experience period does not become available until nearly 12 months after the period ends. Carriers submitting rate filings in the summer of 2011 will base those filings, including trend estimates, on calendar year 2010 data. The 2010 data collected by the MHCC will not be available for use until the late fall of 2011, after these filings have been reviewed by the Administration.
- Carriers file rates at the form or form grouping level. While the MHCC dataset can separately identify data by carrier, payer type, market segment, fully insured vs. self-insured status, and coverage (e.g., HMO, PPO, etc.), adjustments to the data may be warranted for a specific filing which will not be reflected in the MHCC data. For example, a filing for a group of high deductible health plans may warrant a significant leveraging adjustment and the average trend rates produced from the MHCC data may not be applicable to that filing.
- Given eligibility information will first be collected for 2010 experience, the earliest this data could be used to develop benchmark trend estimates would be for filings reviewed in the late fall of 2012.
- The MHCC dataset consists of data for Maryland residents only. However, small group and large group contracts often cover employees that reside in all parts of the country. The carriers' trends will reflect all members' services, not only those rendered to Maryland residents.

Even if these barriers can be overcome, there are several other factors that would need to be considered, and adjustments that would need to be made, in order to produce a valid comparison to a carrier's trend assumption. Some of these are similar to those presented for the HSCRC data.

- Carriers with a small presence in Maryland may use a rental network which could result in significantly different reimbursement levels for non-facility services than would be reflected in trend benchmarks developed from the MHCC data.
- The trends developed using the MHCC data would represent allowed trends. Carriers' trend estimates will represent paid trends given they are applied to only the portion of claims which are paid by the carrier. As a result, a leveraging factor to reflect the impact of deductibles and other fixed cost sharing must be applied to convert the calculated allowed trend into a paid trend estimate.
- The MHCC claims data will reflect the demographic mix by age and gender of the underlying population, as well as changes in this mix. Therefore, the data used to develop trends will need to be normalized for these changes to the extent that they are not anticipated to reoccur at the same rate during the projection period.

- The MHCC data will reflect provider reimbursement contracts in place during the experience period while the carrier's trend assumption will also reflect anticipated changes in these contracts. While information for changes in hospital reimbursement could be gathered from the HSCRC, the MHCC will not know what these prospective provider contract changes are for physician and prescription drug services. The carrier's trend assumption will reflect these changes.

In summary, it appears the MHCC also has access to some very robust datasets. However these data sets have only recently been enhanced to include hospital claims and membership information. Therefore, the MHCC will need to collect a couple of years of data before cost and utilization trend benchmarks for all services can be developed. There is a significant lag between when claims are incurred and when the datasets are ready for use. Therefore, it is important to note that any analyses based on this data would reflect a retrospective look at how costs have changed, and at best could be used to develop benchmarks from historical data and not point estimates of the prospective trend. The Administration may then compare these benchmarks to the trends that carriers requested for rating purposes.

Other Publicly Available Sources for Trend Assumptions

Other potential sources of trend estimates include trend surveys conducted by consultants, the National Health Expenditure portion of GDP, or medical CPI, among others. Care must be used when relying on these outside sources to ensure they measure changes in cost, utilization, and mix of services and that they measure changes in claims trend rather than premium trend. In any case, if a carrier relies on one of these outside sources, they must be able to demonstrate why trends reported from these other sources are appropriate given the benefits, demographics and provider contracts underlying the block being priced.

8

Rate Filing Submission Requirements

In this chapter, we discuss rate filing submission requirements – both the content of the submission and the format in which the data is to be provided. In subsequent sections of this chapter, we discuss rate filing checklists and standardized templates that the Administration may want to consider requiring of carriers. These could be very prescriptive if the Administration wants them to be. Some states prefer to be less prescriptive and allow flexibility for the carriers. Even if the Administration decides not to prescribe the use of a checklist or a standardized data submission template in a specific format, it may want to require carriers to submit filings electronically, at a minimum. We understand that the Administration currently allows carriers to submit filings via System for Electronic Rate and Form Filing (SERFF), e-mail, or paper filings. When e-mail or paper is provided, the Administration uploads the data into SERFF, but correspondence between the Administration and the carrier is done outside of SERFF.

The use of SERFF is growing. Due to health care reform, states that have never used SERFF in the past are now requiring carriers to use SERFF for rate submission. SERFF has been modified to perform reporting functions for states to fulfill HHS requirements. In addition, in most states, the volume of rate filings will increase to meet the requirements of an effective rate review program. Administration resources may be better spent on these additional filings, rather than keying rate filing data into SERFF. For these reasons, we recommend that the Administration require rate filings to be submitted through SERFF. Now that the use of SERFF is mandated in nearly half of the states nationwide, carriers should not consider themselves burdened if they are required to use the system.[56]

To facilitate analysis and increase efficiency, the Administration may also want to consider requiring certain sections of the filings be submitted in an Excel spreadsheet. For example, assume the Administration required carriers to provide detailed support for their trend analysis. If this type of analysis were provided only in .pdf version, the Administration could have to transfer numbers to Excel, or a similar program, to compare the data to the information provided in prior filings, to test the reasonableness of certain results, or to check carriers' calculations. This could become a time-consuming task for

[56] http://www.serff.com/index_state_mandates.htm (Accessed May 18, 2011).

the Administration's staff. In addition, errors could occur during the data entry process. As mentioned earlier, with the increasing volume of filings expected, it will be important for the Administration to use its resources efficiently. Requiring carriers to provide certain data items – such as trend analyses – in Excel with formulas intact would reduce the amount of time spent on data entry, leaving the reviewers more time for evaluating the filing. The reviewer would also be able to trace back through the formulas to determine exactly how the carrier arrived at the results. In Chapter 9, we recommend which data elements to request in Excel format.

In the sections that follow, we discuss more standardized formats in which the Administration could require carriers to submit rate filings, including fully standardized data submission templates and standardized checklists. The first format that we discuss is the Medicare Advantage bid tool. We discuss this particular tool since it is the most comprehensive standardized submission tool of which we are aware. While the tool would require revision for use in the commercial market, we believe it is helpful to review the full spectrum of tools available in evaluating the options available to the Administration.

Use of a Standardized Template for Data Submission

Medicare Advantage Bid Process

Overview of the Medicare Advantage Bid Process

The Medicare Advantage (MA) bidding process is conducted by the Centers for Medicare & Medicaid Services (CMS). Every year, each MA contractor must submit a bid for each benefit plan for each service area where it intends to offer that benefit plan. The format for the bids is standardized in an Excel spreadsheet called the Bid Pricing Tool (BPT). When these carriers submit the BPT to CMS, they must also submit an actuarial certification, along with substantial documentation.

The BPT consists of seven worksheets. We have included a copy of the first four worksheets of the 2011 BPT in Appendix B. Worksheet 1 contains the base period experience. Every filer is required to provide data for the same base experience period and develop rates for the same projection period. The base period information includes premium, membership, administrative expenses, and historical incurred claims. The incurred claims are split into roughly 20 service categories and further divided into a utilization rate per 1,000 members, a unit cost, and patient cost sharing. Filers also include in Worksheet 1 the assumptions used to project the base period experience to the period when the bids will be effective, including cost and utilization trends, as well as additive adjustments (e.g., adding a new benefit).

The base period and trend information from Worksheet 1 are combined to produce the projected allowed experience (before patient cost sharing) in Worksheet 2. If the base period experience is not fully credible, it is blended with a manual rate in Worksheet 2, resulting in a blended rate.

Worksheet 3 develops the projected value of cost sharing by type of benefit. This worksheet allows for copay, deductible, coinsurance, and other types of cost-sharing arrangements.

Worksheet 4 develops required revenue by first developing the net cost of benefits and then adding PMPMs for administrative expenses and gain/loss margin. The net cost of benefits is calculated by taking the allowed PMPMs by service category from Worksheet 2, subtracting the value of patient cost sharing from Worksheet 3, and then adding the value of any other non-Medicare covered benefits (e.g., dental). Anticipated administrative expenses PMPM are then added. The result is the "Total Revenue Requirement" PMPM. This would be equivalent to a premium rate PMPM in a commercial setting.

Worksheet 5 includes information specific to the operation of the MA program and the development of bids. Worksheet 6 is a summary of the BPT and develops the plan premium (the revenue the health plan will receive from the insured, which is in addition to the payment that the health plan will receive from CMS). Worksheet 7 develops the cost of optional supplemental benefits (e.g., rider benefits) and is rarely used.

Considerations in Adopting the Medicare Advantage Bid Process for Use in Commercial Rate Filings

If Maryland were to adopt an MA bid-like process for evaluating premium rate filings, the following pros and cons would apply.

Factors that support use of a tool such as the BPT for commercial rate review in Maryland:

- Experience and trend data would be provided in a uniform manner within and across carriers.
- The information would be standardized and easily compared across carriers.
- The medical claim information provided would be at a fairly granular level that would allow the Administration to see trend differences by type of service split into utilization and cost components.
- The data could be easily incorporated into tools created by the Administration for various analyses, such as trend and rating analyses.
- The MA bid process requires filers to develop rates based on a population with a 1.00 risk score; standardizing experience for risk allows for valid cross-company comparisons.
- Some carriers in the commercial market (e.g., Kaiser Permanente and CareFirst) are likely to be very familiar with the process.

Factors working against using a tool such as the BPT for commercial rate review in Maryland:

- The MA bid process is rigid and would likely force carriers to significantly change the way they currently develop their commercial premium rates.

- To make the processes as meaningful as possible, it would be useful (though not necessary) for all carriers to use the same base experience period for claims – which, again, would likely force carriers to change the way they develop rates.
- The MA bid process contains only one year of historical experience; the process would have to be adjusted if the Administration wanted to examine more historical data to evaluate trend rates. This could be accomplished by requiring additional documentation.
- The process would probably have to be adjusted in some way, as MA plans currently must complete a bid pricing file for each benefit plan they offer in each region in which they operate. Given the very large number of benefit plans available in the small group and individual markets, requiring a separate BPT for each would be unwieldy.
- Because the MA bids are purely community rated, the process includes no provision to introduce rating factors such as age or area. The Administration would have to adapt the filing templates to collect such information.
- Normalizing the bids to a 1.00 risk factor would require implementing a risk adjuster, though this would not be essential. In 2014, under PPACA, each state will be required to adjust risk so that "high actuarial risk plans" will receive payments from "low actuarial risk plans."
- This type of submission does not work well for staff model HMOs and/or other risk-sharing arrangements (potentially including Accountable Care Organizations) where the staff model HMO does not develop its costs in the traditional manner of segregating encounters between cost and utilization, and/or where a material portion of the costs is attributable to retrospective adjustments.

Preliminary Justification Form

In Chapter 5, we discussed in detail the draft rate review regulation that was issued by HHS. The draft regulation requires filers to complete the Preliminary Justification Form for any requested rate increase that exceeds a certain threshold amount. As mentioned in Chapter 5, HHS modeled the *draft* Rate Summary Worksheet on the MA BPT, but made the *draft* Rate Summary Worksheet "significantly less burdensome." The worksheet eliminates some of the cons of the MA BPT, as they relate to the carriers' burden or the need to modify the form that HHS has already drafted. It maintains the pro of having all carriers submit data in a standardized manner, and carriers will become familiar with it since it will have to be filed with the state and HHS for rate increases that exceed the threshold to be "subject to review."

The Administration could choose to establish its own form that carriers would use to submit data. Another option for the Administration would be to require that carriers provide the Preliminary Justification Form that is ultimately adopted by HHS. It could be required only for those rate requests that exceed the threshold (since the information would have to be prepared for HHS for these filings), or the Administration could require it for every filing.

Commercial Rate Filing Templates in Other States

Some states, such as New York and Colorado, already use rate filing templates in the commercial market. (Copies of the templates are shown in Appendix C.) New York's template includes some descriptive information, such as the effective date and market segment. In addition, it includes financial information related to the filed rates, and the experience period used to develop the filed rates (premium and claims for the base period, projected loss ratio, etc.). The template also includes separate trend factors for unit cost and utilization.

Colorado's template is more comprehensive. There is a mandatory Form HR-1 (see Appendix C) containing summary data related to the rate filing. In addition, there is a template for the entire Actuarial Memorandum (also shown in Appendix C). Detailed assumptions, including trend and credibility, must be provided. The state predetermines the credibility formula. This is the most comprehensive, standardized template that we have seen in the commercial market.

There are advantages to mandating a specific format for all required data, and specifying the data elements and definitions for all carriers to use:

- Each carrier would provide the data for a specific requirement in the same location of the filing, making the review process more efficient for the Administration's staff.
- Data could be compared easily across the various carriers.
- Data could be transferred easily into the Administration's analytical tools, such as those used for trend and rating analysis.

The disadvantages include:

- Carriers who are used to their own formats may push back.
- Revising the template and requesting additional data may be more difficult.

Use of a Rate Filing Checklist

Several states require carriers to submit a checklist with each rate filing. The checklist is intended to ensure that the filer has reviewed the filing for completeness before submitting it to the applicable regulatory agency. Although the checklist does not guarantee a filing's completeness, if someone at a company is required to certify that each box is checked (indicating that the filing contains all of the needed information), the filing is more likely to be complete upon initial submission. Usually the checklist must be dated, to ensure that a single copy of the checklist is not submitted over and over, and that someone at the company is consciously signing off on the filing's completeness. Following are examples of checklists that are currently required.

Oregon:
Oregon's checklist[57] contains some general information about the filing on the first page. This is followed by eight pages containing a table showing the category of the

[57] http://www.oregoninsurance.org/docs/serff/4872.doc (Accessed May 18, 2011).

requirement, reference to the statutory or regulatory citation that requires it, a description of the specific requirement, and the checkboxes for the carrier to complete.

Washington:
Washington's form[58] also includes high-level summary information regarding the rates being filed, such as experience period premium and claims and a breakdown of the rate into various components (claims, expenses, contribution to surplus or risk charges, and investment earnings). While it is more than a typical checklist, it is not as comprehensive as the standardized data submission templates that were discussed in the previous section, so we include it here instead.

New York:
Like other states' checklists, New York's[59] contains the review requirement, reference to statutory or regulatory language, and a description of the requirements. However, it also requires more than simply checking each box. The filer must identify the location of the required information in the filing. This can be very helpful to a reviewer. If the state does not require a standardized format for submitting rates and the support for the filed rates, then each carrier may file their support in a different format and order. Having carriers identify the location of the required information can help the reviewer find information quickly.

Minnesota:
Similar to New York's, Minnesota's checklist[60] directs companies to identify the location of required information in the filing. It also lists each requirement and its statutory or regulatory citation.

Colorado:
Colorado takes a slightly different approach. The state has created a company checklist that outlines all information that must be included in a health rate filing, along with the statutory or regulatory citations supporting it. However, the state specifically asks carriers not to include the checklist in the filing. The following items must be included in the filing:[61]

- Letter of Authority (if a third party is submitting the filing)
- Form HR–1 (this form was discussed in the previous section on standardized templates)
- Actuarial Certification

[58] http://apps.leg.wa.gov/wac/default.aspx?cite=284-43-945 (Accessed May 18, 2011).

[59] http://www.ins.state.ny.us/health/pa_ComRateChklt.pdf (Accessed May 18, 2011).

[60] http://www.state.mn.us/mn/externalDocs/Commerce/Small_Employer_Group_Plans_(62)_031003011117_lh62chk.pdf (Accessed May 18, 2011).

[61] http://www.dora.state.co.us/insurance/regs/B4.18_0510.pdf (Accessed May 18, 2011).

- Actuarial Memorandum, including each sub-bullet required (please note that sub-bullet descriptions appear to be cut off at the right in some sections, e.g., blue areas in Sections H, J, L, and M)
- Additional requirements, by line of business

Requirement to Submit a Distribution of Rate Increases

General Discussion

Currently, carriers' rate filings in many states indicate little more about the requested rate increase than the average increase across all policyholders. Reviewers may be left to compare the rates and factors to a prior filing to determine which specific rates or rating factors are changing. Even then, without detailed enrollment data by rating factor, the reviewer may be unable to ascertain the range or distribution of rate increases that will be implemented.

Seeing the distribution of rate increases (the percentage of groups, subscribers, or members in various rate increase ranges), either in aggregate or separately by geographic region or product, can help reviewers understand the impact of a requested rate increase and focus on specific rate segments – for example, either specific policy forms or rating factors, which result in the largest rate changes. These large changes should be actuarially supported before approval. For example, if different policy forms (or products within a form) are receiving varying rate increases, then the benefit relativities of the forms or products are changing. Some changes over time are anticipated due to, for example, leveraging of fixed dollar cost sharing amounts or revisions to assumptions based on updated information. Support should be provided for any changes.

Communicating the average rate increase to consumers can be especially confusing. If consumers are told the average rate of increase – either through statements made in the press or through other consumer resources, such as rate filing documents posted on the Administration's website – they will probably expect to receive the average rate of increase. When a consumer with this information receives a renewal notice indicating an increase much larger than average, he or she may get confused and voice complaints. Requiring a range or distribution of rate increases can help produce information that better explains the rate increases that are being sent to consumers. The Administration has engaged Oliver Wyman to write a separate report providing recommendations on disclosing rate filing information to consumers. We discuss recommendations related to consumer information in that report. Requiring the distribution and explaining the causes of variation may also help the Administration respond to consumer complaints when they arise.

The Administration may also want to consider requiring carriers to provide a distribution of policyholder effective months, if the filed rate change is to be implemented on policy anniversary as opposed to all policies receiving the increase on a given date. We are aware of a scenario where a carrier assumed uniform anniversaries in projecting future premium. The anniversaries were significantly skewed so that when the projections were refined, the requested increase could not be supported.

Other States' Requirements

Oregon Administrative Rule 836-053-0471 requires carriers to provide a distribution of rate increases in health rate filings.[62] Specifically, the actuarial memorandum must include "The range of rate impact to groups or members including the distribution of the impact on members." Furthermore, the rate tables and factors section requirements include the following: "The document must indicate whether the rate increases are the same for all policies. The document must clearly explain how the rate increases apply to different policies including the entire distribution of rate changes and the average of the highest and lowest rates resulting from the application of other rating factors."

We reviewed a few of the public filings on Oregon's website.[63] Some carriers provide the required information in tabular form, showing groups, subscribers, and members by various ranges of rate increases. Other carriers provide the information in graphical form, with number of groups and members in each range below the graph. For example, a tabular form may look similar to the following:

Rate Increase	# Groups	# Subscribers	# Members
Less than -10%			
-10.01% to 0%			
0.01% to 10%			
10.01% to 20%			
20.01% to 30%			
30.01% to 40%			
40.01% to 50%			
50.01% or greater			

Massachusetts recently modified its regulation of the merged individual and small group market to require that each rate filing effective on or after July 1, 2011 include the following:[64]

> *Overall rate impacts, including:*
> *a. Illustration of rate changes for each product, after application of the rating factors, and any changes in the demographic make-up of the individual or group contract using the following ranges:*
> *i. reduction of 10% or more;*
> *ii. reduction between 5.01% and 9.99%;*
> *iii. reduction of 5% or less (including no change);*
> *iv. increase of less than 5%;*
> *v. increase of between 5.01% and 9.99%;*
> *vi. increase of between 10.0% and 14.99%; and*
> *vii. increase of 15% or more.*

[62] http://arcweb.sos.state.or.us/rules/OARS_800/OAR_836/836_053.html (Accessed May 18, 2011).

[63] http://www4.cbs.state.or.us/ex/ins/filing/

[64] 211 CMR 66.09(3)(m)(9)

> *b. Explanation of the reasons, distinguishing by base rate changes and the application of rate adjustment factors, for which rates of any groups increase by more than 15%.*

We are not aware of any other states that require a full distribution in a formalized manner. Many states require inclusion of the minimum and maximum rate increases that policyholders could receive, and SERFF currently has fields available for this. Some states ask for a full distribution during the review process, if necessary – or if prompted by other information in the filing, such as a large maximum increase.

Connecticut published rate filing submission guidelines in October 2010.[65] The guidelines specify: "The requested increase for each product should be identified as a specific percent increase or if appropriate a range with an explanation of what the variance is that produces the range."

HHS Data Reporting Requirements

As a condition of accepting the premium review grant money, Maryland must meet certain requirements when reporting rate filing data to HHS. Our understanding is that the SERFF system has already been modified so that it will summarize the required data. If our understanding is incorrect, or if this situation changes, the Administration will need to ensure that it is requiring the necessary data fields to perform this reporting. In this case, we would recommend requiring the data in a standardized format so that it can be summarized easily. For example, if all carriers fill out the same Excel spreadsheet with each filing, macros could be written to summarize the data in an automated fashion, saving the Administration significant time and resources (as well as ensuring the information's accuracy) once the programs are written.

Data items needed to support implementation of other PPACA provisions should also be considered in determining reporting requirements. This might include data needed to certify health plans for the Health Benefit Exchange, confirm the actuarial value of health plans, provide information regarding risk adjustment and reinsurance programs, etc.

Content of the Rate Filing Submission

All of the checklists and data submission templates we have cited provide examples of format as well as data elements that could be required in the rate filing. Below we briefly discuss other considerations for rate filing content. In Chapter 5, we discussed the federal requirements for an effective rate review. In Chapter 9, we will use all of this information to recommend data elements to require in a rate filing.

[65] http://www.ct.gov/cid/lib/cid/Bulletin_HC-81__Health_Insurance_Rate_Filing_Submission_Guidelines.pdf (Accessed May 18, 2011).

Actuarial Standards of Practice

There are several Actuarial Standards of Practice (ASOPs) that apply to rate makings and rate filings. These may include the following:

ASOP Number	Title
5	Incurred Health and Disability Claims
8	Regulatory Filings for Health Plan Entities
12	Risk Classification (for All Practice Areas)
23	Data Quality
25	Credibility Procedures applicable to Accident and Health, Group Term Life, and Property/Casualty Coverage
26	Compliance with Statutory and Regulatory Requirements for the Actuarial Certification of Small Employer Health Benefit Plans
41	Actuarial Communication

ASOP 8 applies most directly to requirements for a rate filing submission.[66] This ASOP lays out the following issues and recommended practices for health filings:

1. The actuary should include a statement of purpose, such as demonstrating that the filed rates are anticipated to meet minimum loss ratio or other applicable requirements.
2. The actuary should consider which assumptions are necessary for the filing, which may include:

    a. Premium levels and future rate changes;
    b. Enrollment projections;
    c. Morbidity, mortality, and lapsation levels and trends;
    d. Expenses, commissions, and taxes;
    e. Investment earnings and the time value of money;
    f. Health cost trends;
    g. Expected financial results, such as profit margin, surplus contribution, and surplus level;
    h. Expected impact of contractual arrangements with health care providers and administrators; and
    i. Expected impact of reinsurance and other financial arrangements.

3. The actuary should review any relevant business plans for the entity subject to the filing, and consider the information therein as part of setting assumptions and methodologies in the filing.
4. The actuary should adjust past experience for any known or expected changes that are likely to materially affect future results when setting assumptions. These may include:

    a. Selection of risks;

[66] http://www.actuarialstandardsboard.org/pdf/asops/asop008_100.pdf (Accessed May 18, 2011).

b. Demographic and risk characteristics of the insured population;
c. Policy provisions;
d. Business operations;
e. Premium rates, claim payments, expenses, and taxes;
f. Trends in mortality, morbidity, and lapse; and
g. Administrative procedures.

5. The actuary should consider pertinent plan provisions such as administrative procedures and arrangements with health care providers.
6. The actuary should consider available data relevant to new plans or benefits.
7. The actuary may be called upon to project future capital or surplus for the entity or a portion of it (e.g., one business unit). The actuary should base the projection on reasonable assumptions that account for future actions that are likely to have a material impact on capital or surplus.
8. In projecting results relative to a regulatory benchmark, the actuary should base the projection on appropriate available information about the book of business.
9. The actuary should review the assumptions for reasonableness, in the aggregate and individually. Relevant information that may be reviewed is company business plans, past experience of the entity or benefit plan, and relevant industry and government studies.

ASOP 8 serves as the primary guide for rate filings. The additional ASOPs that are listed in the preceding table contain more detailed considerations for items such as claim reserves and credibility. These more specific considerations are discussed elsewhere in this report. The Administration already requires rate filings to conform to the requirements of ASOP 8.

Confidentiality of Data

Carriers in Maryland are currently allowed to mark portions of rate filings as confidential, or in some cases, request that an entire filing be treated as confidential. ACA brings an increased level of scrutiny and transparency to the rate review process. As discussed above, carriers will be required to complete the Preliminary Justification Form for any requested rate increase that exceeds a certain threshold amount. In some cases, this alone may require disclosure of some items not previously made available to the public. In our report on disclosing rate filing information to consumers, we discuss further the impact that ACA will have on data confidentiality.

9

Recommended Enhancements to the Administration's Rate Review Program

Based on our review of the Administration's current processes and Maryland's statutes and regulations, we have identified changes the Administration may consider making to enhance its rate review program. In forming our recommendations, we have focused carefully on the Administration's three-part goal for the project: to strengthen protections to Maryland health insurance consumers while maintaining the solvency of health insurers and facilitating a competitive marketplace.

Recommended Changes for an Effective Rate Review Program

We believe that the Administration would benefit greatly from taking the required steps to make its rate review program an "effective" one according to HHS standards. In Chapter 5, we presented our understanding and interpretations of the definition of an effective rate review program as prescribed in the draft regulations. With an effective rate review program, the Administration will be able to enhance consumer protections and maintain a single level of rate oversight at the state level. Without an effective rate review program, HHS would perform independent rate reviews for certain filings, potentially subjecting carriers to dual oversight with different data reporting requirements – which could expose the State to inconsistent standards, reduced competition, and additional administrative burdens.

In Chapter 5, we compared the Administration's current rate review process with the proposed requirements for an effective rate review program. We recommend that the Administration consider making the following changes in order to meet these requirements. The draft regulations apply to rate increases on non-grandfathered, comprehensive major medical plans in the individual and small group markets. Therefore, none of the recommendations in this section regarding an effective rate review program apply to the large group market. We again caution the reader that the requirements outlined in Chapter 5 are based on draft regulations; neither interim final nor final regulations implementing Section 2794 of the PHSA have been issued at the time of this report.

Recommendations for Qualifying as an Effective Rate Review Program

The proposed regulation (45 CFR Part 154.301) sets out four specific criteria for evaluating whether a state has an effective rate review program in place. In Chapter 5, we discussed these criteria and provided our opinion as to whether the Administration's current rate review process meets each one. In cases where the Administration's current process does not appear to meet the requirement, we recommend changes that, if implemented, would result in the revised program meeting the requirements, in our opinion.

Requirement 1

The state must have the legal authority to obtain data and documentation from health insurers to conduct an effective examination and determine whether a rate increase is unreasonable.

The Administration currently has the authority to require that carriers submit data and documentation, and to review rate increases in both the individual and small group markets for all carriers. In our opinion, the State currently meets Requirement 1 for both the individual and small group markets.

Requirement 2

The state effectively reviews data and documentation provided in support of rate increases.

Based on our review of the Administration's current processes, it is our opinion that the State currently meets this requirement for all products in both the individual and small group markets.

Requirement 3

The state reviews the reasonableness of rating assumptions and the data upon which those assumptions are based.

The draft regulation prescribes 12 specific items that must be reviewed in meeting this requirement. In Chapter 5, we discussed these 12 items in detail and described the type of review we expect HHS will require of states.

We recommend that the Administration revise its rate review program to include a review of each of these items in the individual and small group markets, as described in Chapter 5 and required by HHS to qualify as an effective rate review program.

Requirement 4

The state applies a standard set forth in statute or regulation when determining whether a rate increase is unreasonable.

In our opinion, the Administration currently meets this requirement. The Administration has a minimum loss ratio requirement set forth in statute in both the individual and small group markets.

Reporting to HHS Rate Filings Deemed "Subject to Review"

For each individual and small group filing the Administration reviews that is classified as "subject to review" under the draft regulations, the Administration must provide HHS with a summary of the review and a determination as to whether the rate increase is unreasonable. While some of the information that might be required in this reporting is captured through SERFF and reported to HHS under the requirements of the premium review grant, we expect that HHS will want to review a separate report for each of these filings, including additional information beyond what is currently reported through SERFF. The regulations do not specify the content or format, and we do not know if HHS plans to release guidance on the information they would like to see in this report. Absent any guidance from HHS, we suggest the Administration consider including information such as the following:

1. Average rate increase requested by the carrier
2. Average rate increase approved by the Administration
3. Minimum and maximum rate increase approved for a given policyholder
4. The number of groups (if applicable), policies, and members affected by the rate increase
5. The applicable standard set forth in statute for determining whether a rate increase is unreasonable (e.g., minimum loss ratio requirement), and a description of how the filing compares to that standard
6. A narrative of the Administration's review, including an explanation of how the Administration's analysis of the factors prompted that determination
7. If the rate increase approved by the Administration is lower than that requested by the carrier, an explanation of which rating component (e.g., trend assumption) led to the difference, if applicable

Several components in the list above will be very similar, if not identical, across many filings. For example, while the narrative describing the review performed may vary between individual and small group carriers, the review performed among small group carriers will be similar. Therefore, we recommend that the Administration set up templates for each rate review scenario.

Under a separate contract, we are recommending a consumer-friendly Rate Decision Summary document that would be produced for each individual and small group rate filing. Much of the information in the list above will be included in that document. The Administration may be able to submit the Rate Decision Summary, with some supplemental information describing the review process in more detail, to satisfy this requirement.

Markets That Would Benefit from Enhanced Review

For purposes of acquiring "effective" status for its rate review program, Maryland would need to enhance its review process only for the individual and small group markets. The draft rate review regulation does not apply to the large group market. However, we note that HHS has asked for public comment on whether the review process should differ from that applied to the individual and small group markets if the large group market becomes subject to review. HHS has left open the possibility that such review could be applied to the large group market in the future.

At this time, we do not recommend that the Administration perform an enhanced review in the large group market like the review that is recommended for individual and small group reviews (as described in Chapter 5). Many states do not review large group rates. Large groups are generally more sophisticated buyers than individuals and small groups, and are better able to negotiate premium rates. The large group market is typically more competitive and does not allow excessive rates to be charged. Therefore, the benefit of an enhanced review would be less apparent for the large group market than it would be for smaller purchasers. Only the manual portion of the rate is being reviewed, so the benefit of the review is limited to the portion of the rate that is based on the manual.

We are not suggesting that the Administration should stop reviewing large group rates. Rather, we recommend that the Administration continue the reviews as they are currently performed and add a verification that the projected loss ratio is expected to meet the 85% minimum loss ratio requirement that becomes effective July 1, 2011, with the enactment of SB 183/HB 170. A review of the experience and assumptions that the carrier uses to demonstrate compliance with the loss ratio requirement will need to be incorporated into the Administration's analysis of the filing. We believe that the current review process already includes a review of the projected claims. The review will need to include quality improvement expenses and taxes and fees that are used in calculating the loss ratio.

In the individual and small group markets, while the draft rate review regulation applies only to non-grandfathered policies, we recommend that the Administration perform enhanced reviews for both grandfathered and non-grandfathered policies, for the following reasons:

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

Specific Filings That Would Benefit from Enhanced Review

The Administration requested a recommendation as to whether an enhanced review should be performed for all rate filings in those markets for which the enhanced review will apply

(individual and small group, if our recommendation is accepted), or only those rate increases that are "unreasonable" as defined by the ACA. The draft regulation that would implement the review of "unreasonable" rate increases does not define any rate increase as being de facto unreasonable prior to a review of the filing. Rather, it deems certain filings "subject to review." It is only through the review process that a rate increase can be determined reasonable or unreasonable. HHS recognizes that rate increases that fall below the threshold of "subject to review" may be unreasonable rate increases, and that states would apply standards set forth in state law or regulation when determining whether a rate increase is unreasonable.

It is our interpretation of the draft regulation that an effective rate review program would apply the enhanced review to all filings, whether deemed "subject to review" or not, by HHS' definition. The draft regulation notes that the purpose of the effective rate review program is to determine whether a rate increase is an unreasonable rate increase. Since rate increases that are not "subject to review" may still be unreasonable, we believe the intent is for states to review all rate increase requests. Furthermore, the stated reason for establishing a threshold is to avoid unnecessary filing burdens for health insurance issuers with regard to increases that are likely reasonable. Since Maryland already has a requirement to file all rate increases and has a robust rate review process in place for all filings, which carriers are accustomed to, we do not see this as a significant burden.

A potential reason to not perform enhanced reviews on filings not "subject to review" (if HHS were to allow states to qualify as having an effective rate review program without performing an enhanced review of these filings) is the Administration's inability to act on the findings of the enhanced review. Our understanding is that current statutory authority allows the Administration to disapprove a rate request only if the minimum loss ratio is not anticipated to be satisfied, for insurance carriers and HMOs. Therefore, a review of administrative expenses, for example, may lead the Administration to determine a rate increase is unreasonable but the loss ratio requirement may be anticipated to be satisfied, so the Administration lacks the authority to disapprove the filing. This could also occur with filings "subject to review;" however, in that case although the carrier could still implement the rate increase, by deeming the rate increase unreasonable the filing would be subject to additional HHS's requirements for unreasonable rate increases. Since filings for rate increases below the threshold are not "subject to review," HHS's additional requirements related to unreasonable rate increases would not apply. In that case, there may be no effect to deeming the rate increase unreasonable.

The Administration has the authority to disapprove nonprofits' rate requests based on factors including "any other relevant factors within and outside the State." We recommend the Administration strongly consider obtaining additional statutory authority to disapprove rate filings based on "any other relevant factors within and outside the State" for insurance carriers and HMOs as well, to avoid the potential situations described in this section. This would seem consistent with the intent of reviewing all of the necessary items to have an effective rate review program, and would give the Administration the necessary authority to act on those items in addition to the loss ratio requirement. This would also provide equity to all Maryland consumers, regardless of the entity issuing coverage.

Level at Which Enhanced Review Should Be Performed

The Administration requested a recommendation regarding the level at which enhanced reviews be performed – market level or product level. It is not clear what HHS intended with respect to the level at which the review is applied. The draft rate review regulation states the consideration of rate increases is at the "product" level for purposes of determining whether the increase is subject to review. It further states that product would be defined as "a package of health insurance coverage benefits with a discrete set of rating and pricing methodologies that a health insurance issuer offers in a State." The product could, for example, be a policy form where within the policy form there are several different cost sharing options, such as varying deductible levels. However, the "product" distinction is not clearly defined in the regulation and appears to leave open the possibility that different states may apply it differently.

Our understanding is that the Administration is currently requiring that in the individual market the loss ratio be satisfied for each policy form. While some carriers may choose to file all individual products in a single filing, it is not required. The level of aggregation in the filing is determined by each carrier.

In the small group market, the rating regulations require the experience of all small groups be pooled together for determining the small group base rate. Different premiums are charged for different products through the application of benefit adjustment factors, or benefit relativities. However, since there is a common base rate, rate filings are submitted for the entire market in a single filing.

We recommend that the level at which the enhanced review is applied be consistent with the rating rules in the market and with the loss ratio requirements that apply based on Maryland law. As was discussed in Chapter 6, our understanding is that SB 183/HB 170 Health Insurance - Conformity with Federal Law requires the loss ratio requirement be applied at the market level. We also discussed pros and cons of applying the loss ratio requirements at the policy form versus the market level, and would have recommended the market level had it been open to interpretation. This is consistent with the federal MLR requirements that apply retrospectively, and recognizes that different products may have a need for different administrative charges as a percent of premium.[67]

Applying the loss ratio requirement at the market level should be straightforward for the small group market since there is a common base rate and all products are filed at the same time. Therefore, the enhanced review would be performed at the market level for small group.

In the individual market, application of the loss ratio at the market level represents a change from the current practice. Given that individual rating rules do not require a

[67] Lower cost products, such as high deductible products, typically have higher administrative expense charges as a percent of premium. Administrative expenses that are incurred as fixed costs per member per month represent a larger percent of premium for lower premium products.

common base rate for all individual products, rate increases for different forms are, in many cases, currently filed at different times throughout the year. In order to implement the loss ratio requirement at the market level in the individual market, we recommend the Administration do one of the following:

1. Require carriers to file all individual products together in a single filing, even if rate changes are not being requested for all policy forms. This way, the Administration would be able to review all individual experience together, along with the projection of that experience to the rating period, to determine whether the loss ratio requirement is anticipated to be met at the market level.
2. Continue to allow carriers to file individual products at different times in separate filings. Therefore, the level of the enhanced review would vary depending on how carriers are filing their products. Carriers should not be allowed to change the manner in which products are filed from filing to filing. Once a set of products has been pooled together for rating, it typically should remain pooled.[68] For purposes of demonstrating that the loss ratio is anticipated to be met, the Administration could either require carriers to provide projected experience for all products including those for which no rate change is being requested, or establish a "safe harbor" such that if the products in the filing can demonstrate satisfaction of the loss ratio then the market level is assumed to satisfy the loss ratio. This presumes that if each filing could demonstrate satisfaction of the loss ratio requirement on its own, then the market level loss ratio requirement would be satisfied.

We believe these are both viable and reasonable options. We recommend the Administration consider option 2, applying the loss ratio prospectively such that if the individual product (or grouping of products) being filed can demonstrate an anticipated loss ratio of 80% or greater on its own (with the adjustments for quality improvement expenses and taxes and fees), that the prospective loss ratio requirement has been satisfied. (Application of credibility in this calculation is discussed in the next section.) If the product being filed does not, on its own, meet the 80% requirement, then the carrier would be required to demonstrate that when combined with all other individual products the 80% loss ratio requirement is satisfied in total at the market level. This is consistent with our interpretation of how HHS would review rates for excessiveness if HHS were performing the review.

It is possible that some products might be projected to experience loss ratios below the minimum, and therefore a rate increase request is not filed. This in turn may result in an aggregate loss ratio for the market that is below the minimum; however, there are several reasons we do not see this as a major concern:

- The retrospective loss ratio requirement will require rebates if the aggregate loss ratio falls below the minimum.

[68] There may be exceptions to this. For example, a new product may be pooled with other products to enhance credibility. Once the product has grown to sufficient size, it could be rated on its own. They key is to not allow carriers to change the pooling back and forth, potentially "gaming" the requirements.

- Medical trend will cause the loss ratio for products that have not been filed to increase over time, limiting the amount of time such products could be priced to a loss ratio below the minimum.
- Competitive forces are unlikely to result in significant enrollment in products with low loss ratios.

We also note that over time, the manner in which individual products are filed may change. Starting in 2014, non-grandfathered individual products will be priced more similar to how small group products are currently priced. At that time, it may become more feasible or necessary to require all individual products be filed in a single filing. Since the details of the 2014 requirements are not well defined and could change as 2014 approaches, we are not able to make specific recommendations regarding the rate review that should be in place at that time.

Recommended Review Process

The Administration currently has a comprehensive rate review process in place. We are not recommending significant changes to the process described in Chapter 4. Earlier in this chapter, we recommended the Administration implement additional elements in the review of individual and small group filings in order to have an effective rate review program. Our additional recommendations in these markets follow. Since we are not recommending changes to the large group review process, aside from implementing the new loss ratio requirements, these recommendations do not apply to large group unless otherwise specified.

Loss Ratio Requirements

With the passage of SB 183/HB 170 Health Insurance - Conformity with Federal Law, carriers will need to revise the calculation of the projected loss ratio for purposes of demonstrating that the minimum loss ratio is expected to be met in the individual and small group markets. The Administration will need to review this calculation.

Prior to passage of SB 183/HB 170, a loss ratio requirement did not exist in the large group market. A review of the projected loss ratio using the federal methodology for calculating loss ratio will need to be incorporated into the large group rate review process.

In Chapter 6, we identified two areas of consideration in testing on a prospective basis whether the loss ratio requirement is anticipated to be met, given the federal loss ratio requirement is intended to be a retrospective requirement. They are the application of credibility adjustments for less than fully credible blocks of business, and whether satisfaction of the loss ratio requirement may be demonstrated at the market level or the policy form level.

We recommend that traditional credibility methods be used in demonstrating the prospective loss ratio, rather than the federal credibility adjustment. The federal adjustment was not intended for use in pricing, while traditional methods are applicable to pricing and follow Actuarial Standard of Practice No. 25, Credibility Procedures

Applicable to Accident and Health, Group Term Life, and Property/Casualty Coverages. Furthermore, application of the federal adjustment would allow small blocks with poor experience to increase rates even further than the already poor experience supports. This is not the intent of a credibility adjustment for prospective pricing purposes.

Above, we discussed our recommendation to require carriers to demonstrate that the prospective loss ratio requirement is expected to be met at the market level for the small group market, and to allow rate filings in the individual market to demonstrate the loss ratio either for the forms in the filing, or in aggregate at the market level. In the large group market, there are fewer requirements today. Carriers generally file a rate manual that applies to all products, or all products of a given type (e.g., HMO, PPO, indemnity) at the same time.

We recommend that the loss ratio requirement be applied in a manner similar to the individual market, and that review of the loss ratio is done in the manner that products are being filed today. Similar to the individual market, if all products are filed simultaneously, then the loss ratio requirement should be demonstrated in aggregate for the market. If a subset of products is filed together, then as long as the prospective loss ratio is satisfied for that subset, the filing may be approved. If the subset does not independently meet the loss ratio requirement, then the carrier would have to demonstrate that when the subset is combined with all other large group products, the loss ratio requirement is expected to be met.

Trend Assumptions

For purposes of demonstrating the loss ratio requirements discussed above, the claims must be projected using a reasonable trend assumption.

While the Administration currently reviews trend assumptions for reasonableness, it is our opinion that the current review process is not as in depth as will be required by HHS to have the process be considered an effective rate review program, as outlined in the draft regulations. In Chapter 7 we discussed the various components of trend, as well as adjustments to the experience data that the Administration may need to consider when reviewing the requested trends. The Administration does not currently review trends by major service category, but will be required to do so should the draft regulations be approved in their current form.

In Chapter 7, we discussed the following options for satisfying the requirements for an enhanced rate review:

1. Have Administration staff with actuarial expertise review the analysis performed by the carriers to determine the appropriateness of the adjustments made and the reasonableness of the results.
2. Require that all carriers use a standardized methodology through the use of a template that could be provided in the form of an Excel spreadsheet.

3. Allow carriers to maintain their own methodologies used for calculating trend, but require that all carriers submit common data elements to allow the Administration to perform an independent analysis using a consistent methodology for all carriers.

We recommend the Administration implement option 1 above. We believe this option will satisfy the requirements to have an effective rate review, will allow the Administration to determine the reasonableness of the requested rates, and balances resource needs for both the carriers and the Administration.

The Administration will have to consider the need to obtain information from external sources, as identified in Chapter 7, to enhance their reviews. Each of these sources has current limitations, since they will not reflect the identical population covered by any specific rate filing and, therefore, should only be used as one of several potential benchmarks in determining the reasonableness of a carrier's trend assumption.

While there has been discussion regarding the ability of the Administration to incorporate the HSCRC hospital rate setting process into the Administration's assessment of the reasonableness of trend assumptions included in rate filings, we identified several barriers that currently exist in the HSCRC database that precludes its use as an external source at this time. We recommend that the Administration continue to work with HSCRC to determine whether the benefits of being able to use this database as a benchmark for assessing the cost component of hospital trend assumptions outweigh the costs and resources required to remove the barriers indentified in Chapter 7.

There has also been discussion regarding the ability of the Administration to incorporate data gathered by the MHCC as an independent source for trend into the Administration's review of a proposed rate filing. We have identified barriers that preclude this data from effectively enhancing the process at this time. We recommend that the Administration work closely with the MHCC to monitor the evolution of its databases to determine if it can eventually be used to develop benchmarks against which a carrier's trend could be compared. This would not be possible until the MHCC has at least two years of enrollment data. At that time, the MHCC data could provide a useful source for benchmarking. The Administration could estimate secular trends over a two to three year period using the MHCC data, and compare a carrier's trend assumption to the historical trends. If the filed trend assumption is outside of the historic norms, the carrier could be required to provide additional support.

We recommend that the Administration, the HSCRC and the MHCC collaborate to test the consistency of the various databases and determine how the hospital rate increases implemented by the HSCRC are ultimately reflected in the MHCC experience. Once these tests are completed, it may be possible that the MHCC databases in conjunction with the HSCRC database (with adjustments to reflect the population covered under a specific filing) could serve as benchmarks for assessing trends. However, the time and resources to perform these tests could be significant. Similarly, the time and resources to analyze and adjust the data to develop the benchmarks could be significant. Use of the databases is not likely to be possible in the very near term.

Other Methods for Determining the Reasonableness of Rates

In Chapter 6, we discussed the following methods that could be used for determining reasonableness of rates, in addition to loss ratio requirements:

1. Administrative expenses
2. Surplus levels
3. Pricing margins
4. Investment income or loss
5. Cost containment or quality improvement activities

Items 1, 2, and 5 from the list above are required to be reviewed in order to have an effective rate review program. Therefore, we recommend the Administration include a review of these items in the rate review process. The remaining methods for consideration are pricing margins and investment income or loss.

We discussed earlier the limitation in current statute, which does not grant authority to the Administration to apply criteria other than a loss ratio requirement in determining the reasonableness of rates for the purposes of approving or disapproving a rate request for insurance carriers and HMOs. As long as that limitation exists, there is little apparent benefit to including a review of pricing margins or investment income in the review process for insurance carriers and HMOs.

For nonprofits (and insurance carriers and HMOs if the Administration is able to gain authority to disapprove rates based on "any other relevant factors within and outside the State"), we recommend the Administration include a review of pricing margins in the review of individual and small group rates. We believe this adds a valuable consumer protection by ensuring that profit charges are not increased without solid justification. Under a separate contract, we conducted focus groups to obtain consumer feedback related to health insurance rates. The focus groups consistently expressed opinions that they would want to know that profit was not increasing. While there may be valid reasons for profit charges to increase at times, any increases in profit as a percent of premium, should be well documented and justified by the carriers. Given the increased transparency that is anticipated related to rate increases, the Administration should also be prepared to respond to questions from consumers related to profit charges.

We do not recommend that investment income be part of the review process. The potential benefit of including it is very small in our opinion. Investment income can fluctuate greatly. We do not believe that premiums would be reduced by a significant amount if this review is added. Therefore, the much longer list of cons more than outweighs the potential benefit of the review.

As discussed earlier, we are not recommending an enhanced review for large group products. Similarly, we do not recommend including these factors in the review of large group rates. Our recommendation for large group is that the current review process is

continued, with the addition of reviewing the projected loss ratio relative to the minimum 85% loss ratio requirement.

Pre-Approved Trend Factors

The Administration currently allows carriers to file pre-approved trend factors for up to a one-year period. We recommend the Administration continue this practice. However, it is unclear how HHS intends to apply the rate review requirements to filings that include future trend factors. Therefore, absent additional guidance from HHS, we would suggest the Administration consider only approving trend factors that do not result in future rate increases that would be subject to review (which is initially 10% or greater).

Annual Rate Certification

We are not recommending implementation of a requirement to submit an annual rate certification if a rate request and accompanying detailed rate filing has not been filed. The advantage of having such a requirement is that premium rates can be reduced if the rates on file are not anticipated to meet the loss ratio requirement. We believe this advantage is more than offset by the following factors:

- The retrospective federal MLR will require rebates be paid if, in hindsight, the premiums charged in aggregate at the market level did not produce the required loss ratio.
- The Administration has the annual report requirement that provides an annual check on the adequacy of rates and can lead to required rate reductions.
- The tracking of rate certifications would require Administration time and resources for little benefit to the consumers.
- It is unlikely that carriers could go much longer than one year between filings without incurring financial losses (provided pre-approved trend factors are not approved for a period longer than one year).

Rate Filing Submission Data Requirements

Data Submission Checklist

The Administration does not currently have a set of standard data submission requirements, except that carriers are expected to provide an actuarial memorandum that describes the assumptions and methods used to develop the rates, in accordance with Actuarial Standard of Practice #8, “Regulatory Filings for Health Plan Entities.” This standard of practice does not define specific data elements to include in rate filings. Therefore, carriers may not provide all of the information needed to perform an enhanced review of the initial filing. However, carriers are required to provide support for all assumptions and any changes in rating factors, and the Administration will require carriers to submit the necessary information for review before approving the filing.

We recommend that the Administration consider developing a checklist for carriers to use when preparing each individual and small group rate filing. The checklist would include all of the items that the Administration needs to conduct the review. We recommend

implementing a checklist – to speed the time from the initial filing date to the review's completion and to reduce the Administration's time spent reviewing the filing and the subsequent responses. Each time the Administration has to send an objection letter to the carrier asking additional questions or requesting more information, the approval is delayed. Each time the Administration receives a response, some time is spent re-familiarizing the reviewer with the specific issues that needed to be addressed. Using a checklist may streamline the process – both for carriers and for the Administration's reviewers. A draft checklist is provided in Appendix D.

Data Elements Needed

New data elements will be needed to perform the recommended enhanced reviews in the individual and small group markets. Large group filings will need to include a demonstration that the projected loss ratio meets the minimum required loss ratio. The draft checklist in Appendix D contains a description of the recommended data elements to be required of carriers.

One data element of note is that we are recommending all filings in the individual and small group markets include the Part I Preliminary Justification Rate Summary Worksheet. While still in draft form, the worksheet is a one-page Excel file that contains experience data and pricing assumptions such as trend, administrative expense, and profit in a standardized format. We are recommending this of all individual and small group filings for the following reasons:

- It provides the Administration some basic data from all filings in a standardized format, easing comparisons from filing to filing.
- Having some data in a standardized format may enable the Administration to create an Excel file that can quickly summarize data from several filings, potentially providing benchmarks for use in determining the reasonableness of assumptions.
- Since carriers will become accustomed to populating the form, which will be required of any filing that is "subject to review," it should not represent a significant burden for the carriers.
- The data will be needed for enhanced consumer disclosure, and to populate the Administration's Rate Filing Notification Summary and Rate Filing Decision Summary documents that we are recommending under a separate contract with the Administration.

In drafting the checklist, we have incorporated data elements we believe are needed for the Administration to continue the current review process, as well as those additional elements that we recommend incorporating into the review as described in this chapter. We relied on our interviews with and the sample rate filing supplied by the Administration staff to determine the data that is currently reviewed. We recognize that we received a small sample of rate filings and defer to the Administration, which has a much more thorough understanding of the current data elements that are provided by all carriers, for inclusion of additional data elements or clarification to the checklist.

We show one draft checklist and indicate the markets in which certain data elements might apply. The Administration may want to consider a separate checklist for each market, or a combined individual and small group checklist with a separate large group checklist. Another option for large group would be to not implement a checklist and simply communicate to carriers that they need to demonstrate satisfaction of the new loss ratio requirement. This option could work well if the Administration is generally satisfied with the current large group filings.

Finally, we have not included a check box on the draft checklist. This shows a format that might be used if the Administration prefers to distribute the checklist as guidance to the carriers, rather than requiring it be submitted with each filing. If the Administration prefers to require carriers "check the boxes" and submit the checklist with each filing, a column for check boxes should be added along with a signature and date field, to ensure that the same checklist is not copied and submitted with each filing, without review. We defer to the Administration regarding whether to require the checklist as a part of each filing.

Format of Data Submission

With the exception of the Part I Preliminary Justification Rate Summary Worksheet, we do not recommend requiring filings be provided in a standard data submission template. As noted above, requiring the Rate Summary Worksheet provides some basic information in a standardized template to allow ease of comparison or creation of benchmarks. It is our opinion that requiring the entire filing be standardized represents a greater burden on the carriers than is justified by the benefit provided to the Administration. Carriers have different pricing methodologies that may not lend themselves to a standardized format. By allowing carriers to use their own format, the Administration will be able to observe the actual data and factors being used in the pricing.

Currently, filings are submitted in pdf format. The Administration spends some amount of time transferring parts of the rate filing data into Excel to check formulas and analyze the data. This time could be better spent on enhanced reviews rather than transferring data. In addition, transferring data creates the possibility of errors in the process of transferring. We recommend the Administration require that carriers provide certain data elements in the filing in Excel format. The draft checklist in Appendix D indicates which data elements should be provided in Excel. Finally, we recommend the Administration consider requiring the use of SERFF for filing submission so the Administration does not have to spend time transferring filing data into SERFF.

Timing of Rate Submissions and Reviews

Rate Filing Submissions

Currently, insurance carriers and non-profits are required to file rates 90 day prior to the requested effective date. HMOs are required to file rate 60 days prior to the requested effective date. Based on our interviews with Administration staff, we do not see a need to revise the required timing. HMOs are generally filing earlier than 60 days in advance. The carriers are aware that the earlier the rates are filed, the more likely they are to be approved in time to implement the rate change on the requested effective date. While the

Administration could consider requiring all carriers to file 90 days in advance, we see this as a low priority given that it would require a statutory change and does not currently represent a problem.

Deemer Periods

The current deemer period is 60 days for non–profits', HMOs', and insurance carriers' initial rate filing, and 90 days for insurance carriers' rate change filings. Again, based on our interviews with the Administration staff, this seems to be adequate time to review the filing and either approve it or disapprove the filing due to additional questions being asked or data requested. We recommend keeping the current deemer periods.

Advance Notice of Rate Changes

For insurance carriers and nonprofits, policyholder notification of rate changes must occur 10 days before the effective date in the individual market.[69] This 10-day requirement for insurance carriers and non-profits leaves little time for the policyholder to research potential changes to benefits or to consider changing carriers after the rate increase is received. HMOs must notify individuals of rate changes 45 days before the effective date. All carriers in group markets must also notify policyholders of rate changes 45 days before the effective date. We recommend that the Administration consider changing the regulatory language to require a 45-day notice of all carriers in the individual and group markets.

Staffing Considerations

Currently, the rate review process for all health filings (including those outside of the scope of our review) is performed by two actuaries with support from one analyst. The Administration is currently trying to hire a third actuary. We understand that this open position is intended to provide needed support for filings already being received and being reviewed under the current rate review processes. The Administration's workload has increased related to filings both in and out of the scope of this review, all of which are currently reviewed by the two actuaries and one analyst on staff. Therefore, we believe that even after the third actuary is hired, the Administration will not be adequately staffed once the enhanced rate review process is in place.

While the Administration's reviews under the existing standards are comprehensive, there will be a need for additional staff to implement additional analyses required by the enhanced review, formalize and document certain procedures as well as new reporting requirements for HHS.

Staffing considerations will depend on whether the Administration accepts certain recommendations in this report. For example, if the Administration prefers to discontinue

[69] The actual requirement is 40 days before the end of the grace period of the first increased premium. Since the grace period is 30 days, this means the notification requirement is equivalent to 10 days before the effective date of the rate change. Source: COMAR 31.10.01.02 R

approving future trend factors, the number of filings could increase potentially requiring additional staff.

The staffing needs will also depend on the extent to which the Administration performs independent benchmarking analysis. We identified one benefit of requiring that all filings include the Part I Preliminary Justification Rate Summary Worksheet: The Administration can use the submitted data to develop benchmarks. We also recommended that the Administration work with HSCRC and the MHCC to explore possibilities for additional trend analysis, and consider using the MHCC data to develop trend benchmarks when at least two years of enrollment become available.

Creating and maintaining these benchmarks – particularly the trend benchmarks, which would require detailed trend analysis of the MHCC data, would take additional time. The Administration may need to hire an actuarial student to support such analyses. This person could also assist in the review of filings. A credentialed actuary would need to be the primary person responsible for studying the initiatives pertaining to the use of other data sources and overseeing the ongoing process of analyzing these data sources. Therefore, with these recommended initiatives and the enhanced rate reviews, we believe one additional actuary and one analyst may be needed.

The staffing considerations in this report reflect only the rate review recommendations made in this report. Any increased workload related to consumer transparency activities, as we recommended under a separate contract with the Administration, are not reflected here. Those activities may be significant. For example, if our recommendations are accepted, an Administration actuary will need to document each rate decision in a consumer-friendly manner for posting on the Administration's website. That documentation, along with additional detail, will also need to be sent to HHS in accordance with the effective rate review program. Consumer-friendly notifications of rate requests were also recommended. If the Administration accepts these recommendations, additional actuarial staff will be needed to perform these functions. As transparency improves, more rate increase inquiries will likely be directed toward Administration actuaries. These types of inquiries can be very time consuming to address and support.

Rate Review Procedures Manual

We recommend that the Administration's actuarial staff develop a procedures manual that documents the rate review process from receipt of the filing to final approval. The manual could also include guidelines for certain items that the Administration would need to begin examining as a result of the new effective rate review process. For example, the Administration will need to review reserve needs. A procedures manual could contain guideline ranges for completion factors based on the number of months of claims included in the period and the number of months of runout.

Following are some of the many benefits to establishing a manual:

- A documented procedure forces consistency in the review process. If a checklist or step-by-step process is in place, the entire rate review is more likely to be performed consistently from one filing to the next.
- Establishing a documented procedure would enable an actuarial student to perform a significant portion of the preliminary work. For example, the student could complete an initial review of the filing and confirm that all data is submitted in the required format. The student might also be able to compare basic assumptions (from filing to filing, or to benchmarks established by the Administration and included in the manual) for reasonableness. As we have discussed, more time will be spent performing rate filing reviews as more information needs to be reviewed.
- The procedures manual is a checklist of sorts for the Administration. By using the procedures manual during the review process, the Administration ensures that all items are reviewed on a regular basis and that key items and assumptions are not overlooked.
- The documentation will allow for cross-training among the various types of reviews performed by market segment (individual, small group, etc.). This will allow multiple staff members to perform reviews and share workloads while maintaining consistency across the reviews.

Appendix A

Draft Rate Summary Worksheet

In this appendix, we show the draft rate summary worksheet that carriers will be required to complete as part of the Part I Preliminary Justification.

Rate Summary Worksheet

Per the Instructions, health insurance issuers proposing rate increases above the threshold fill in only those cells that are highlighted in GREY. The other cells are auto-populated.

A. Base Period Data

Start Period: 05/01/2009 **End Period:** 04/30/2010

Service Categories	Member Months	Total Allowed	Net Claims	Member's Cost Sharing	Member's Cost Sharing PMPM	Net PMPM	Allowed PMPM
Inpatient	10,000	$ 313,250.00	$ 244,355.00	$ 68,895.00	$ 6.89	$ 24.44	$ 31.33
Outpatient	10,000	$ 311,000.00	$ 242,580.00	$ 68,420.00	$ 6.84	$ 24.26	$ 31.10
Professional	10,000	$ 774,000.00	$ 603,720.00	$ 170,280.00	$ 17.03	$ 60.37	$ 77.40
Prescription Drugs	10,000	$ 498,000.00	$ 368,500.00	$ 129,500.00	$ 12.95	$ 36.85	$ 49.80
Other	10,000	$ 45,800.00	$ 35,700.00	$ 10,100.00	$ 1.01	$ 3.57	$ 4.58
Capitation	10,000	$ 75,000.00	$ 75,000.00	$ -	$ -	$ 7.50	$ 7.50
Total	10,000	$ 2,017,050.00	$ 1,569,855.00	$ 447,195.00	$ 44.72	$ 156.99	$ 201.71

B. Claim Projections

B1. Adjustment to the Current Rate

Start Period: 01/01/2010 **End Period:** 12/31/2010

Service Categories	Overall Medical Trend	Projected Allowed PMPM	Net Claims	Member's Cost Sharing
Inpatient	1.0154	$ 31.81	$ 25.13	0.21
Outpatient	1.0462	$ 32.54	$ 25.70	0.21
Professional	1.0284	$ 79.60	$ 62.88	0.21
Prescription Drugs	1.0669	$ 53.13	$ 39.85	0.25
Other	1.0155	$ 4.65	$ 3.67	0.21
Capitation	1.0100	$ 7.58	$ 7.58	0.00
Total		$ 209.30	$ 164.81	0.21

B2. Claims Projection for Future Rate

Start Period: 01/01/2011 **End Period:** 12/31/2011

Service Categories	Overall Medical Trend	Projected Allowed PMPM	Net Claims	Member's Cost Sharing
Inpatient	1.0783	$ 34.30	$ 26.75	0.22
Outpatient	1.1185	$ 36.39	$ 28.39	0.22
Professional	1.0877	$ 86.58	$ 67.53	0.22
Prescription Drugs	1.1316	$ 60.12	$ 44.79	0.26
Other	1.0812	$ 5.03	$ 3.92	0.22
Capitation	1.0210	$ 7.73	$ 7.73	0.00
Total		$ 230.15	$ 179.11	0.22

C. Components of Current and Future Rates

	Future Rate PMPM	Future Rate %	Prior Estimate of Current Rate PMPM	Prior Estimate of Current Rate %	Difference PMPM	Difference %
1. Projected Net Claims	$ 179.11	76.20%	$ 159.20	75.73%	$ 19.91	80.22%
2. Administrative Costs	$ 45.75	19.46%	$ 43.33	20.61%	$ 2.42	9.75%
3. Underwritng Gain/Loss	$ 10.19	4.34%	$ 7.70	3.66%	$ 2.49	10.03%
4. Total Rate	**$ 235.05**	100.00%	**$ 210.23**	100.00%	**$ 24.82**	100.00%
5. Overall Rate Increase		**11.81%**				

D. Components of Rate Increase

	Impact on Rate	Percent
Claims Components		
1. Inpatient	$ 1.97	9.87%
2. Outpatient	$ 3.05	15.30%
3. Professional	$ 5.51	27.68%
4. Prescription Drugs	$ 5.24	26.32%
5. Other	$ 0.30	1.50%
6. Capitation	$ 0.16	0.80%
7. Cost Share Change	$ (1.92)	-9.66%
8. Correction of Prior Net Claims Estimate	$ 5.61	28.18%
9. Total	$ 19.91	100.00%
Claims Restatement for Current Rate Period (1/1/2010-12/31/2010)		
8.a. Prior Net Claims Estimate for Current Rate Period	$ 159.20	
8.b. Re-Estimate of Net Claims PMPM for Current Rate Period	$ 164.81	

E. List of Annual Average Rate Changes Requested and Implemented in the Past Three Calendar Years

Calendar Year	Requested	Implemented
2010	10.00%	10.00%
2009	8.00%	8.00%
2008	13.00%	7.00%

F. Range and Scope of Proposed Increase

Number of Covered Individuals
900
Number of Covered Policyholders
800

	Current Premium (Individual)	Proposed Premium (Individual)	% Change
Minimum % Increase	$ 200.00	$ 210.00	5.00%
Maximum % Increase	$ 220.00	$ 250.00	13.64%

Appendix B

Medicare Advantage Bid-Pricing Tool Worksheets

In this appendix, we show the first four worksheets from the 2011 bid-pricing tool[70] that is used in the Medicare Advantage bidding process.

[70] http://www.cms.gov/MedicareAdvtgSpecRateStats/09_Bid_Forms_and_Instructions.asp

WORKSHEET 1 - MA BASE PERIOD EXPERIENCE AND PROJECTION ASSUMPTIONS

MA-2011.1
OMB Approved # 0938-0944

I. General Information

1. Contract Number:		5. Organization Name		9. Enrollee Type:		13. Region Name:	N/A
2. Plan ID:		6. Plan Name:		10. MA Region:	N/A		
3. Segment ID:		7. Plan Type:		11. Act. Swap/Equiv Apply:			
4. Contract Year:	2011	8. MA-PD:		12. SNP:		14. SNP Type:	N/A

II. Base Period Background Information

Note: DE# refers to Dual Eligible Beneficiaries without full Medicare cost sharing liability

			Total	Non-DE#	DE#		Contract-Plan ID	Member Months	Contract-Plan ID	Member Months
1. Time Period Definition		2. Member Months (excl ESRD)			0	5. Plans In Base				
Incurred from:	1/1/2009	3. Non-ESRD Risk Score			0.0000					
Incurred to:	12/31/2009	4. Completion Factor								
Paid through:										
6. Describe the source of the base period experience data (1000 character limit)										

III. Base Period Data (at Plan's non-ESRD Risk Factor) for 1/1/2009-12/31/2009

IV. Projection Assumptions

	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)	(k)	(l)	(m)	(n)	(o)	(p)	(q)
					Total Benefits			Util. Adjustments to Contract Period				Unit Cost Adjustment		Additive Adjustments	
Service Category		Net PMPM	Cost Sharing	Util Type	Annualized Util/1000	Avg Cost	Allowed PMPM	Util/1000 Trend	Benefit Plan Change	Population Change	Other Factor	Inflation Trend	Other Factor	Util/1000	PMPM
a.	Inpatient Facility		$0.00			$0.00									
b.	Skilled Nursing Facility		0.00			0.00									
c.	Home Health		0.00			0.00									
d.	Ambulance		0.00			0.00									
e.	DME/Prosthetics/Supplies		0.00			0.00									
f.	OP Facility - Emergency		0.00			0.00									
g.	OP Facility - Surgery		0.00			0.00									
h.	OP Facility - Other		0.00			0.00									
i.	Professional		0.00			0.00									
j.	Part B Rx		0.00			0.00									
k.	Other Medicare Part B		0.00			0.00									
l.	Transportation (Non-Covered)		0.00			0.00									
m.	Dental (Non-Covered)		0.00			0.00									
n.	Vision (Non-Covered)		0.00			0.00									
o.	Hearing (Non-Covered)		0.00			0.00									
p.	Health & Education (Non-Covered)		0.00			0.00									
q.	Other Non-Covered		0.00			0.00									
r.	COB/Subrg. (outside claim system)		0.00												
s.	**Total Medical Expenses**	**$0.00**	**$0.00**				**$0.00**								
t.	Subtotal Medicare-covered service categories						$0.00								

V. Description of Other Utilization Adjustment Factor, Other Unit Cost Adjustment Factor, and Additive Adjustments (1000 character limit)

VI. Base Period Summary for 1/1/2009-12/31/2009 (excludes Optional Supplemental)

1. CMS Revenue		Non-Benefit Expenses:		6. Gain/(Loss) Margin	$0.00
2. Premium Revenue		5a. Marketing & Sales			
3. Total Revenue	$0.00	5b. Direct Administration		Percent of Revenue:	
3b. Subset Revenue (ESRD and hospice)		5c. Indirect Administration		7a. Net Medical Expenses	0.0%
4. Net Medical Expenses		5d. Net Cost of Private Reinsurance		7b. Non-Benefit Expenses	0.0%
4b. Subset Net Medical Expense (ESRD and hospice)		5e. Total Non-Benefit Expenses	$0.00	7c. Gain/(Loss) Margin	0.0%

CMS - 10142 (5/31/2011)

WORKSHEET 2 - MA PROJECTED ALLOWED COSTS PMPM

I. General Information

1. Contract Number:		5. Organization Name:		9. Enrollee Type:	13. Region Name: N/A
2. Plan ID:		6. Plan Name:		10. MA Region: N/A	
3. Segment ID:		7. Plan Type:		11. Act. Swap/Equiv Apply:	
4. Contract Year:	2011	8. MA-PD:		12. SNP:	14. SNP Type: N/A

II. Projected Allowed Costs

Note: DE# refers to Dual Eligible Beneficiaries without full Medicare cost sharing liability

Contract Year Allowed Costs at Plan's non-ESRD Risk Factor:

	Total	Non-DE#	DE#
1. Projected member months	0	0	0
2. Projected risk factor	0.0000	0.0000	0.0000

(c)	(e)	(f)	(g)	(h)	(i)	(j)	(k)	(l)	(m)	(n)	(o)	(p)	(q)	(r)
		Projected Experience Rate			Manual Rate			Exper.	Blended Rate					% of svcs
Service Category	Util Type	Annual Util/1000	Avg Cost	Allowed PMPM	Annual Util/1000	Avg Cost	Allowed PMPM	Cred. %	Annual Util/1000	Avg Cost	Total Allowed PMPM	Non-DE# Allowed PMPM	DE# Allowed PMPM	provided OON
a. Inpatient Facility		0	$0.00	$0.00		$0.00			0	$0.00	$0.00			
b. Skilled Nursing Facility		0	0.00	0.00		0.00			0	0.00	0.00			
c. Home Health		0	0.00	0.00		0.00			0	0.00	0.00			
d. Ambulance		0	0.00	0.00		0.00			0	0.00	0.00			
e. DME/Prosthetics/Supplies		0	0.00	0.00		0.00			0	0.00	0.00			
f. OP Facility - Emergency		0	0.00	0.00		0.00			0	0.00	0.00			
g. OP Facility - Surgery		0	0.00	0.00		0.00			0	0.00	0.00			
h. OP Facility - Other		0	0.00	0.00		0.00			0	0.00	0.00			
i. Professional		0	0.00	0.00		0.00			0	0.00	0.00			
j. Part B Rx		0	0.00	0.00		0.00			0	0.00	0.00			
k. Other Medicare Part B		0	0.00	0.00		0.00			0	0.00	0.00			
l. Transportation (Non-Covered)		0	0.00	0.00		0.00			0	0.00	0.00			
m. Dental (Non-Covered)		0	0.00	0.00		0.00			0	0.00	0.00			
n. Vision (Non-Covered)		0	0.00	0.00		0.00			0	0.00	0.00			
o. Hearing (Non-Covered)		0	0.00	0.00		0.00			0	0.00	0.00			
p. Health & Education (Non-Covered)		0	0.00	0.00		0.00			0	0.00	0.00			
q. Other Non-Covered		0	0.00	0.00		0.00			0	0.00	0.00			
r. COB/Subrg. (outside claim system)				0.00							0.00			
s. Total Medical Expenses				**$0.00**			**$0.00**	**0%**			**$0.00**	**$0.00**	**$0.00**	
								0%	CMS Guideline Credibility					
t. Subtotal Medicare-covered service categories				$0.00			$0.00	0%			$0.00	$0.00	$0.00	

u. Briefly describe the source for the manual rate, including what trend assumptions were used, if applicable (1000 character limit)

WORKSHEET 3 - MA PROJECTED COST SHARING PMPM

I. General Information

1. Contract No:		5. Org Name:	9. Enrollee Type:		13. Region Name:	N/A
2. Plan ID:		6. Plan Name	10. MA Region:	N/A		
3. Segment ID:		7. Plan Type:	11. Act. Swap/Equiv			
4. Contract Year:	2011	8. MA-PD:	12. SNP:		14. SNP Type:	N/A

II. Maximum Cost Sharing Per Member Per Year

Is there a plan-level OOP maximum? (Yes/No, then enter amount)	1. In Network	NO	2. Out of Network	NO	3. Combined	NO

4. Briefly explain the methodology for reflecting the impact of maximum cost sharing in Section III (1000 character limit):

III. Development of Contract Year Cost Sharing PMPM (Plan's non-ESRD Risk Factor)

(c) Service Category	(d) Description	(e) Measure-ment Unit Code	(f) In-Network Effective Plan-Level Deduct PMPM*	(g) In-Network Cost Sharing After Plan-Level Deductible: In-Network Util/1000 or PMPM	(h) Description of Cost Sharing / Add'l Days / Benefit Limits	(i) Effective Copay / Coin Before OOP Max	(j) **Effective Copay / Coin After OOP Max	(k) In-Network PMPM	(l) Total In-Network Cost Share PMPM	(m) Out-of-Network Description of Cost Sharing / . . . Benefit Limits	(n) Out-of-Network Cost Sharing PMPM***	(o) Grand Total Cost Share PMPM (INN+OON)
a.1. Inpatient Facility	Acute							$0.00	$0.00			$0.00
a.2. Inpatient Facility	Mental Health							0.00	0.00			0.00
b. Skilled Nursing Facility								0.00	0.00			0.00
c. Home Health								0.00	0.00			0.00
d. Ambulance								0.00	0.00			0.00
e.1. DME/Prosthetics/Supplies	DME							0.00	0.00			0.00
e.2. DME/Prosthetics/Supplies	Prosthetics/Supplies							0.00	0.00			0.00
f. OP Facility - Emergency								0.00	0.00			0.00
g. OP Facility - Surgery								0.00	0.00			0.00
h.1. OP Facility - Other	Lab							0.00	0.00			0.00
h.2. OP Facility - Other	Radiology							0.00	0.00			0.00
h.3. OP Facility - Other	Observation							0.00	0.00			0.00
h.4. OP Facility - Other	Renal Dialysis							0.00	0.00			0.00
h.5. OP Facility - Other	Other							0.00	0.00			0.00
i.1. Professional	PCP							0.00	0.00			0.00
i.2. Professional	Specialist excl. MH							0.00	0.00			0.00
i.3. Professional	Mental Health (MH)							0.00	0.00			0.00
i.4. Professional	Therapy (PT/OT/ST)							0.00	0.00			0.00
i.5. Professional	Radiology							0.00	0.00			0.00
i.6. Professional	Other							0.00	0.00			0.00
j. Part B Rx								0.00	0.00			0.00
k. Other Medicare Part B								0.00	0.00			0.00
l. Transportation (Non-Covered)								0.00	0.00			0.00
m. Dental (Non-Covered)								0.00	0.00			0.00
n.1. Vision (Non-Covered)	Professional							0.00	0.00			0.00
n.2. Vision (Non-Covered)	Hardware							0.00	0.00			0.00
o.1. Hearing (Non-Covered)	Professional							0.00	0.00			0.00
o.2. Hearing (Non-Covered)	Hardware							0.00	0.00			0.00
p. Health & Education (Non-Covered)								0.00	0.00			0.00
q. Other Non-Covered								0.00	0.00			0.00
								0.00	0.00			0.00
								0.00	0.00			0.00
								0.00	0.00			0.00
								0.00	0.00			0.00
								0.00	0.00			0.00
								0.00	0.00			0.00
								0.00	0.00			0.00
								0.00	0.00			0.00
								0.00	0.00			0.00
								0.00	0.00			0.00
Total			$0.00					$0.00	**$0.00**		**$0.00**	**$0.00**

Actual combined plan level deductible:

*Actual in-network plan level deductible:

** PMPM impact of in-network OOP max:

***Actual OON plan level deductible:

***PMPM impact of OON OOP max:

WORKSHEET 4 - MA PROJECTED REVENUE REQUIREMENT PMPM

I. General Information

1. Contract Number:		5. Organization Name:	9. Enrollee Type:	13. Region Name:	N/A
2. Plan ID:		6. Plan Name:	10. MA Region: N/A		
3. Segment ID:		7. Plan Type:	11. Act. Swap/Equiv Apply:		
4. Contract Year:	2011	8. MA-PD:	12. SNP:	14. SNP Type:	N/A

II. Development of Projected Revenue Requirement

A. Non-DE# (Non-Dual Eligible Beneficiaries AND Dual Eligible Beneficiaries with full Medicare cost sharing liability)

Cost and Required Revenue PMPM at Plan's non-ESRD Risk Factor: 0.0000

(c)	(e)	(f)	(g)	(h)	(i)	(j)	(k)	(l)	(m)	(n)	(o)	(p)	(q)	(r)
	Total Benefits				**% for Cov. Svcs**		FFS Medicare	Plan cost sh.	**Medicare Covered (w/AE cost sh.)**			**A/B Mand Suppl (MS) Benefits**		
Service Category	Allowed PMPM	Plan Cost Sharing		Net PMPM	Allowed	Cost Sharing	Actl. Equiv. cost sharing	for Medicare-covered svcs.	Allowed PMPM	FFS AE Cost Sharing	Net PMPM	Net PMPM for Add'l Svcs.	Reduction of A/B Cost Sh.	Total
a. Inpatient Facility	$0.00	$0.00		$0.00			0.0%	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
b. Skilled Nursing Facility	0.00	0.00		0.00			0.0%	0.00	0.00	0.00	0.00	0.00	0.00	0.00
c. Home Health	0.00	0.00		0.00			0.0%	0.00	0.00	0.00	0.00	0.00	0.00	0.00
d. Ambulance	0.00	0.00		0.00			0.0%	0.00	0.00	0.00	0.00	0.00	0.00	0.00
e. DME/Prosthetics/Supplies	0.00	0.00		0.00			0.0%	0.00	0.00	0.00	0.00	0.00	0.00	0.00
f. OP Facility - Emergency	0.00	0.00		0.00			0.0%	0.00	0.00	0.00	0.00	0.00	0.00	0.00
g. OP Facility - Surgery	0.00	0.00		0.00			0.0%	0.00	0.00	0.00	0.00	0.00	0.00	0.00
h. OP Facility - Other	0.00	0.00		0.00			0.0%	0.00	0.00	0.00	0.00	0.00	0.00	0.00
i. Professional	0.00	0.00		0.00			0.0%	0.00	0.00	0.00	0.00	0.00	0.00	0.00
j. Part B Rx	0.00	0.00		0.00			0.0%	0.00	0.00	0.00	0.00	0.00	0.00	0.00
k. Other Medicare Part B	0.00	0.00		0.00			0.0%	0.00	0.00	0.00	0.00	0.00	0.00	0.00
l. Transportation (Non-Covered)	0.00	0.00		0.00	0.00%	0.00%	0.0%	0.00	0.00	0.00	0.00	0.00	0.00	0.00
m. Dental (Non-Covered)	0.00	0.00		0.00	0.00%	0.00%	0.0%	0.00	0.00	0.00	0.00	0.00	0.00	0.00
n. Vision (Non-Covered)	0.00	0.00		0.00	0.00%	0.00%	0.0%	0.00	0.00	0.00	0.00	0.00	0.00	0.00
o. Hearing (Non-Covered)	0.00	0.00		0.00	0.00%	0.00%	0.0%	0.00	0.00	0.00	0.00	0.00	0.00	0.00
p. Health & Education (Non-Covered)	0.00	0.00		0.00	0.00%	0.00%	0.0%	0.00	0.00	0.00	0.00	0.00	0.00	0.00
q. Other Non-Covered	0.00	0.00		0.00	0.00%	0.00%	0.0%	0.00	0.00	0.00	0.00	0.00	0.00	0.00
r. COB/Subrg. (outside claim system)	0.00	0.00		0.00		0.00%	0.0%	0.00	0.00	0.00	0.00	0.00	0.00	0.00
s. Total Medical Expenses	**$0.00**	**$0.00**		**$0.00**			**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**

B. DE# (Dual Eligible Beneficiaries without full Medicare cost sharing liability)

Cost and Required Revenue PMPM at Plan's non-ESRD Risk Factor: 0.0000

(c)	(e)	(f)	(g)	(h)	(i)	(j)	(k)	(l)	(m)	(n)	(o)	(p)	(q)	(r)
	Total Benefits				**% for Cov. Svcs**		State Medicaid	Actual cost sh.	**Medicare Covered (w/Medicaid cost sh.)**			**A/B Mand Suppl (MS) Benefits**		
Service Category	Reimb + Actual Cost Sh.	Plan Cost Sharing	Actual Cost Sharing	Plan Reimb	Allowed	Cost Sharing	Required Bene. cost sharing	for Medicare-covered svcs.	Allowed PMPM	Medicaid Cost Sharing	Net PMPM	Net PMPM for Add'l Svcs.	Reduction of A/B Cost Sh.	Total
a. Inpatient Facility	$0.00	$0.00	$0.00	$0.00				$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
b. Skilled Nursing Facility	0.00	0.00	0.00	0.00				0.00	0.00	0.00	0.00	0.00	0.00	0.00
c. Home Health	0.00	0.00	0.00	0.00				0.00	0.00	0.00	0.00	0.00	0.00	0.00
d. Ambulance	0.00	0.00	0.00	0.00				0.00	0.00	0.00	0.00	0.00	0.00	0.00
e. DME/Prosthetics/Supplies	0.00	0.00	0.00	0.00				0.00	0.00	0.00	0.00	0.00	0.00	0.00
f. OP Facility - Emergency	0.00	0.00	0.00	0.00				0.00	0.00	0.00	0.00	0.00	0.00	0.00
g. OP Facility - Surgery	0.00	0.00	0.00	0.00				0.00	0.00	0.00	0.00	0.00	0.00	0.00
h. OP Facility - Other	0.00	0.00	0.00	0.00				0.00	0.00	0.00	0.00	0.00	0.00	0.00
i. Professional	0.00	0.00	0.00	0.00				0.00	0.00	0.00	0.00	0.00	0.00	0.00
j. Part B Rx	0.00	0.00	0.00	0.00				0.00	0.00	0.00	0.00	0.00	0.00	0.00
k. Other Medicare Part B	0.00	0.00	0.00	0.00				0.00	0.00	0.00	0.00	0.00	0.00	0.00
l. Transportation (Non-Covered)	0.00	0.00	0.00	0.00	0.00%	0.00%		0.00	0.00	0.00	0.00	0.00	0.00	0.00
m. Dental (Non-Covered)	0.00	0.00	0.00	0.00	0.00%	0.00%		0.00	0.00	0.00	0.00	0.00	0.00	0.00
n. Vision (Non-Covered)	0.00	0.00	0.00	0.00	0.00%	0.00%		0.00	0.00	0.00	0.00	0.00	0.00	0.00
o. Hearing (Non-Covered)	0.00	0.00	0.00	0.00	0.00%	0.00%		0.00	0.00	0.00	0.00	0.00	0.00	0.00
p. Health & Education (Non-Covered)	0.00	0.00	0.00	0.00	0.00%	0.00%		0.00	0.00	0.00	0.00	0.00	0.00	0.00
q. Other Non-Covered	0.00	0.00	0.00	0.00	0.00%	0.00%		0.00	0.00	0.00	0.00	0.00	0.00	0.00
r. COB/Subrg. (outside claim system)	0.00	0.00	0.00	0.00		0.00%		0.00	0.00	0.00	0.00	0.00	0.00	0.00
s. Total Medical Expenses	**$0.00**	**$0.00**	**$0.00**	**$0.00**			**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**

C. All Beneficiaries

Cost and Required Revenue PMPM at Plan's non-ESRD Risk Factor: 0.0000

(c) Service Category	(e)	(f)	(g)	(h) Total Benefits Net PMPM	(i)	(j)	(k)	(l)	(m)	(n) Medicare Covered	(o) Net PMPM	(p) A/B Mand Suppl (MS) Benefits Net PMPM for Add'l Svcs.	(q) Reduction of A/B Cost Sh.	(r) Total
a. Inpatient Facility				$0.00							$0.00	$0.00	$0.00	$0.00
b. Skilled Nursing Facility				0.00							0.00	0.00	0.00	0.00
c. Home Health				0.00							0.00	0.00	0.00	0.00
d. Ambulance				0.00							0.00	0.00	0.00	0.00
e. DME/Prosthetics/Supplies				0.00							0.00	0.00	0.00	0.00
f. OP Facility - Emergency				0.00							0.00	0.00	0.00	0.00
g. OP Facility - Surgery				0.00							0.00	0.00	0.00	0.00
h. OP Facility - Other				0.00							0.00	0.00	0.00	0.00
i. Professional				0.00							0.00	0.00	0.00	0.00
j. Part B Rx				0.00							0.00	0.00	0.00	0.00
k. Other Medicare Part B				0.00							0.00	0.00	0.00	0.00
l. Transportation (Non-Covered)				0.00							0.00	0.00	0.00	0.00
m. Dental (Non-Covered)				0.00							0.00	0.00	0.00	0.00
n. Vision (Non-Covered)				0.00							0.00	0.00	0.00	0.00
o. Hearing (Non-Covered)				0.00							0.00	0.00	0.00	0.00
p. Health & Education (Non-Covered)				0.00							0.00	0.00	0.00	0.00
q. Other Non-Covered				0.00							0.00	0.00	0.00	0.00
r. ESRD				0.00							0.00	0.00	0.00	0.00
s. Additional Benefits (employer bids only)				0.00							0.00	0.00	0.00	0.00
t. COB/Subrg. (outside claim system)				0.00							0.00	0.00	0.00	0.00
u. Total Medical Expenses				**$0.00**							**$0.00**	**$0.00**	**$0.00**	**$0.00**
v. Non-Benefit Expense:														
1. Marketing & Sales											$0.00			$0.00
2. Direct Administration											0.00			0.00
3. Indirect Administration											0.00			0.00
4. Net Cost of Private Reinsurance											0.00			0.00
5. Total Non-Benefit Expense				**$0.00**							**$0.00**	0.00	0.00	**$0.00**
w. Gain/(Loss) Margin											**$0.00**	0.00	0.00	**$0.00**
x. Total Revenue Requirement				**$0.00**							**$0.00**	0.00	0.00	**$0.00**
y. Percent of Revenue (excluding ESRD)														
1. Net Medical Expense				**0.0%**							**0.0%**			**0.0%**
2. Non-Benefit				**0.0%**							**0.0%**			**0.0%**
3. Gain/(Loss) Margin				**0.0%**							**0.0%**			**0.0%**

III. Development of Projected Contract Year ESRD "Subsidy"

Non-ESRD CY member months	0		
ESRD CY member months			
Basic benefits (user entries must be reported as "per ESRD member per month")		Supplemental Benefits	
CY Revenue			
- CMS capitation		Non-ESRD CY cost sharing reductions	$0.00
		Non-ESRD CY additional benefits	$0.00
CY Medical Expenses for Basic Services			
CY Non-Benefit Expenses for Basic Services		ESRD CY cost sharing reductions	
CY Margin Requirement for Basic Services	$0.00	ESRD CY additional benefits	
CY Gain/(Loss) Margin for Basic Services	$0.00		
		Incremental CY cost of cost sharing reductions	$0.00
Cost for CY basic benefits allocated to all plan members	$0.00	Incremental CY cost of additional benefits	$0.00
		Total CY ESRD "subsidy" =	$0.00

IV. For Employer Bid Use Only ("800-series")

1. PMPM for additional/ unspecified MS benefits (see instructions for additional information)	

V. Projected Medicaid Data for DE#

Entries must be reported as "Per DE# Member Per Month."	
1. Medicaid Projected Revenue	
2. Medicaid Projected Benefits (not in bid)	

Appendix C

Commercial Rate Filing Templates

New York

Summary template for submitting certain identifying information for base medical policy form included in renewal medical rate filing[71]

Complete a separate response for each base medical policy form included in the medical renewal rate filing.				
Information requested applies to New York State business only.				
Include in each policy form response the associated riders that the policyholders with that policy form also have.				
Copy last column to right as often as needed to provide response for all base medical policy forms included in this rate filing.				
Product type is HMO, HMO based POS, POS-OON, EPO, PPO, Comprehensive Major Medical, Non-HMO based POS,				
Consumer Driven Health Plans, Hospital Only, Medical Only, Base+Supplemental, Supplementary Major Medical, Other Limited Benefit,				
Medicare Supplement (A, B, C, D, E, F Basic, F High, G, H, I, J Basic, J High, K, L, M, N, or Other - indicate appropriate designation for				
policy form), etc.				
Put cursor in cell and select from drop down menu, or make an entry.				
NOTE: The prior experience period data is required if the rate filing includes rate tables to be effective July 1, 2011 or later.				
If members, covered lives or member months are not known, use reasonable estimates.				
Data Item for Rate Filing	**Response**			
A. Company Name				
B. Phone number of contact person				
C. Email address of contact person				
D. Type of insurer (for-profit, non-profit) [drop down menu]				
Data Item for Specified Base Medical Policy Form	**Response**	**Response**	**Response**	**Response**
1. Base medical policy form number				
2. Aggregated for rate development with these base medical policy form numbers				
3. Effective date of rate change (MM/DD/YYYY)				
4. Market Segment (large group, small group, individual) [drop down menu]				
5. Product type (see above for examples) [drop down menu]				
6. Is a rolling rate structure used for this base medical policy form? (Yes or No) [drop down menu]				
7. Has base medical policy form aggregation changed from previous filing? (Yes or No) [drop down menu]				
8. Is base medical policy form open (new sales allowed) or closed (no new sales) [drop down menu]				
9. Rate guarantee period incorporated into rate tables - in months (e.g., 12 for a 12 month rate guarantee period)				
10. Weighted average rate change % requested across base medical policy form from current rate charged policyholder (including all associated riders)				
11. Number of policyholders affected by rate change				
12. Number of covered lives affected by rate change				
13. Expected NY statewide loss ratio for base medical policy form, including associated riders				

Continued on next page

[71] http://www.ins.state.ny.us/health/pa_Medical_Renewal_Rate_Filing_Template.xls

Most recent experience period - NY statewide experience (base medical policy form + associated riders)				
14.1 Experience period from date (MM/DD/YYYY)				
14.2 Experience period to date (MM/DD/YYYY)				
14.3 Member months for experience period				
14.4 Earned premiums for experience period - in $				
14.5 Standardized earned premiums for experience period - in $				
14.6 Paid claims for experience period in $				
14.7 Incurred claims for experience period - in $				
14.8 Administration expenses for experience period - in $ (including commissions and premum taxes, but excluding federal and state income taxes)				
14.9 Earned premiums for experience period - in $pmpm	0.00	0.00	0.00	0.00
14.10 Standardized premiums for experience period - in $pmpm	0.00	0.00	0.00	0.00
14.11 Paid claims for experience period - in $pmpm	0.00	0.00	0.00	0.00
14.12 Incurred claims for experience period - in $pmpm	0.00	0.00	0.00	0.00
14.13 Administration expenses for experience period - in $pmpm (including commissions and premium taxes, but excluding federal and state income taxes)	0.00	0.00	0.00	0.00
14.14 Ratio: Incurred Claims / Earned Premiums	0.000	0.000	0.000	0.000
14.15 Ratio: Incurred Claims / Standardized Earned Premiums	0.000	0.000	0.000	0.000
14.16 Ratio: Administration Expenses / Earned Premiums	0.000	0.000	0.000	0.000
14.17 Ratio: (Incurred Claims + Admin) / Earned Premiums	0.000	0.000	0.000	0.000
Prior experience period - NY statewide experience (base medical policy form + associated riders)				
15.1 Experience period from date (MM/DD/YYYY)				
15.2 Experience period to date (MM/DD/YYYY)				
15.3 Member months for experience period				
15.4 Earned premiums for experience period - in $				
15.5 Standardized earned premiums for experience period - in $				
15.6 Paid claims for experience period in $				
15.7 Incurred claims for experience period - in $				
15.8 Administration expenses for experience period - in $ (including commissions and premum taxes, but excluding federal and state income taxes)				
15.9 Earned premiums for experience period - in $pmpm	0.00	0.00	0.00	0.00
15.10 Standardized premiums for experience period - in $pmpm	0.00	0.00	0.00	0.00
15.11 Paid claims for experience period - in $pmpm	0.00	0.00	0.00	0.00
15.12 Incurred claims for experience period - in $pmpm	0.00	0.00	0.00	0.00
15.13 Administration expenses for experience period - in $pmpm (including commissions and premium taxes, but excluding federal and state income taxes)	0.00	0.00	0.00	0.00
15.14 Ratio: Incurred Claims / Earned Premiums	0.000	0.000	0.000	0.000
15.15 Ratio: Incurred Claims / Standardized Earned Premiums	0.000	0.000	0.000	0.000
15.16 Ratio: Administration Expenses / Earned Premiums	0.000	0.000	0.000	0.000
15.17 Ratio: (Incurred Claims + Admin) / Earned Premiums	0.000	0.000	0.000	0.000
Annualized Medical Trend Factors (%)				
16.1 All benefits combined, composite				
16.2 * Due to utilization				
16.3 * Due to unit cost				
17. Discuss comparison of claims cost pmpm changes over last 3 years with rate changes over last 3 years				

Colorado - Form HR-1[72]

State Of Colorado

Health **Rate Filing Form**

Form HR-1

Reset Form

Must Be Completed For All Products	**SERFF FILING #**	
1. Company:		
2. Person Responsible For Filing:	3. Title:	
4. Address Of Responsible Person:	5. Telephone #:	ext.
6. Email Address:		
7. **Type Of Coverage**: Select One	Other :	
8. Medicare Supplement: Select One	Not Applicable ☐	
(1) Prestandardized Plan(s):		
(2) Standardized Plan(s): ☐ A ☐ B ☐ C ☐ D ☐ E ☐ F ☐ FHD ☐ G ☐ H ☐ I ☐ J ☐ JHD ☐ K ☐ L		
(3) 2010 Plans: ☐ A ☐ B ☐ C ☐ D ☐ F ☐ FHD ☐ G ☐ K ☐ L ☐ M ☐ N		
9. **Sub Category:** Select One		
10. A. Group Information: Select One Select One Select One Select One		
B. Name of association or trust *(if applicable)*:		
C. Description of discretionary group*(if applicable)*:		
11. **Colorado State Code(s)**: Select One Select One Select One Select One Select One		
12. **Brief Filing Description** (Disability, Major Medical, LTC, Etc. Also Describe All Methodology Changes.):		
13. **Reason For Filing:**		
Increase In Benefits?	☐ Yes	☐ No
Reduction In Benefits?	☐ Yes	☐ No
Increase in Profits?	☐ Yes	☐ No
Change Needed To Meet Projected Losses?	☐ Yes	☐ No
Trend Only?	☐ Yes	☐ No
Change In Rating Methodology?	☐ Yes	☐ No
New Product (Initial Offering As Opposed To Rate Revision)?	☐ Yes	☐ No
Other?	☐ Yes	☐ No
(If other, please explain)		
14. **Policy Form(s) Affected**:		

[72] http://www.dora.state.co.us/insurance/regs/B4.18_0510.pdf

15. If Rider Or Endorsement, **Type Of Benefits**?	
16. Closed Block(s)? ☐ Yes ☐ No Date Block Closed:	
17. **Number Of Colorado Covered Lives** (Including Employees And Dependents):	
18. A. Rating Period: Select One From To B. Experience Period: From To C. Reason for Rate Change: D. Average Change In Rates From One Year Prior To Effective Date: 0.00%	☐ N/A (New Product)
19. A. **Rate Change Without Trend:** 0.00% B. **Trend for Rating Period (if trend factor is used in rates):** 0.00% C. Overall Rate Impact Change: 0.00%	
20. A. **Current Underlying *Annualized* Trend Assumption** (If Applicable): 0.00% B. Requested Underlying *Annualized* Trend Assumption (If Applicable): 0.00%	
21. A. **What Is The Maximum Rate Change That Can Affect A Policyholder?** 0.00% B. **What Is The Minimum Rate Change That Can Affect A Policyholder?** 0.00% **(If the selected rate change differs from the indicated rate change, please fully detail in the actuarial memorandum in section 6K.)**	
Benefits Ratios (**On Colorado only basis**) 22. A. Targeted Benefits Ratio over Rating Period (assumed in calculation of rates): 0.00%	
B. Actual Benefits Ratio over Experience Period: 0.00%	☐ N/A (New Product)
23. A. **Projected Benefits Ratio With Rate Change over Rating Period** 0.00% B. Projected Benefits Ratio **Without** Rate Change over Rating Period 0.00% ☐ Colorado ☐ Colorado/Nationwide ☐ Nationwide Basis **(If projected benefits ratios on a Colorado only basis are not available, then ratios developed on a blended Colorado/Nationwide or Nationwide basis are acceptable. Please indicate above.)**	☐ N/A (New Product)
24. **Proposed Effective Date:**	
25. A. **Total Annual *Colorado* Written Premium Before Change(s)**: $ B. **Total Annual *Colorado* Written Premium After Change(s)**: $ C. Written Premium Change For This Product (Net Change): $	☐ N/A (New Product)
26. A. **Effective Date** of Previous Rate Filing for this Form (including initial filing): B. Previous SERFF Filing Number(s): C. Overall Percentage of Last Rate Change for Affected Policy Forms: 0.00%	☐ N/A (New Product)
27. **Experience Provided:** ☐ **Nationwide** ☐ **Colorado** Select One ☐ **other (specify)**	☐ N/A (New Product)
28. ***Small Group Filings Only*: Unique Single Index Rate** (Effective For All Small Group Plans):	

When completed, please hit the button to the right and also attach to filing in SERFF. **SUBMIT TO DIVISION**

RESET

ACTUARIAL MEMORANDUM

Pursuant to Colorado Regulation 4-2-11 Section 6, rate filings must contain an Actuarial Memorandum. The Division of Insurance developed this template Memorandum, to reduce the number of returned incomplete filings. **For additional information and tables to be added please enter in the "additional information" field under each section where appropriate.** Review Colorado Regulation 4-2-11 Section 6 for detailed instructions at: http://www.dora.state.co.us/insurance/regs/F4-2-11_1109.pdf

General filing requirements, Actuarial Certification requirements, and submission requirements are identified in Section 5 of Colorado Regulation 4-2-11. For requirements by line of business, see Section 7 of this regulation. Rate filings submitted without ALL requirements of the regulations could be disapproved or rejected by the Colorado Division of Insurance.

Company:	
NAIC #:	
SERFF Filing #:	

A. SUMMARY	
1. Reason(s):	
2. Marketing method(s):	☐ Agency / Broker ☐ Internet ☐ Direct Response ☐ Other:
3. Premium Classification(s):	
4. Product Description(s):	
5. Policy Forms Impacted:	
6. Age Basis:	☐ Issue Age ☐ Renewal Age ☐ Attained Age ☐ Both Issue & Attained Age Other:
Additional Information:	

B. ASSUMPTION, MERGER OR ACQUISITION		
1. Is product part of assumption, acquisition, or merger (from or with another company)?		
Assumption:	Yes ☐	No ☐
Acquisition:	Yes ☐	No ☐
Merger:	Yes ☐	No ☐
2. If yes, provide name of company(s):		
3. Closing Date of assumption, merger or acquisition:		
Additional Information:		

C. RATING PERIOD	
Proposed Effective Date:	(MM/DD/YYYY)
Rating Period:	to
Additional Information:	

D. UNDERWRITING	
1. ☐ New Product Provide a brief description, including expected impact on claim costs by duration and in total:	
2. ☐ Existing Product Provide Changes:	
Additional Information:	

E. EFFECT OF LAW CHANGES	
Identify and quantify changes resulting from mandated benefits and other law changes:	
☐ N/A	
Additional Information:	

F. RATE HISTORY

Provide rate changes made in at least the last three years (If available) ☐ Initial Filing

COLORADO

State Tracking Number	Effective Date	% OF CHANGE			
		Minimum	Average	Maximum	Cumulative for past 12 Months
			0%		0.00%
			0%		0.00%
			0%		0.00%
			0%		0.00%
			0%		0.00%
			0%		0.00%
			0%		0.00%

NATIONWIDE

Effective Date	Average % of change	Cumulative for past 12 Months
	%	%
	%	%
	%	%
	%	%
	%	%
	%	%

Additional Information:

G: COORDINATION OF BENEFITS	
Provides actual loss experience net of any savings:	Yes ☐ No ☐
Additional Information:	

H. RELATIONSHIP OF BENEFITS TO PREMIUM

1. *Medicare Supplement and Long-Term Care Policies*: See Section 7(E) and 7(F) of this regulation.
2. *Retention Percentage*:
   - Adequately support the reasonableness of the relationship of the projected benefits to projected earned premiums for the rating period.
   - Each component should reflect the average assumption used in pricing averaged over all pricing cells, policy durations, benefit levels, etc.
   - If the product **was not** initially priced using a lifetime loss ratio standard, the retention percentage is equal to 1 minus the **targeted** loss ratio.
   - If the product was initially priced using a lifetime loss ratio standard, the retention percentage is equal to 1 minus the **lifetime** loss ratio.

Description	Percentage	Support
Commissions	%	
General expenses	%	
Premium taxes	%	
Profit/Contingencies	%	
Investment Income	%	
Other	%	
	%	
	%	
Total Retention	0.00%	

Benefits Ratio Guidelines: The Division recommended benefit ratio guidelines are listed below. Targeted loss ratios below these

Minimum Loss Ratio Guidelines	
Comp Major Med (Individual)	65%
Comp Major Med (Small Group)	70%
Comp Major Med (Large Group)	75%
Specified or Dread Disease	60%
Limited Benefit Plan	60%
Disability Income	60%
Dental/Vision	60%
Stop Loss	60%
Conversion Products (mandatory minimum)	125%

For individual products issued to HIPAA eligible individuals, the premiums for these products cannot be more than 2 times the

Targeted Loss Ratio: (This number should equal 1 minus the total retention percentage listed above.)	100%
Additional Information:	

I. LIFETIME LOSS RATIO					☐ N/A
1. Was the product priced initially using a lifetime loss ratio standard?	☐Yes ☐No If so please provide %				
2. Average policy duration in years as of the end of the experience period:					
3. Experience Period:					
Experience Period					
Year	Earned Premiums	Incurred Claims	Actual Benefit	Expected Benefits Ratio	Ratio of Actual/ Expected Benefits Ratio
			NaN%	0%	0
			NaN%	0%	0
			NaN%	0%	0
			NaN%	0%	0
			NaN%	0%	0
Rating Period					
Year	Earned Premiums	Incurred Claims	Projected Benefits Ratio	Expected Benefits Ratio	Ratio of Projected/
			NaN%	0%	0
			NaN%	0%	0
			NaN%	0%	0
			NaN%	0%	0
			NaN%	0%	0
Note If additional information is required (extremely large tables) Please copy and paste tables into the row below labeled "additional information" or attach properly labeled exhibits and list exhibit name under additional information.					
4. Interest Rate used to determine accumulated values and present values in the above tables:	%				
Additional information:					

J. PROVISION FOR PROFIT AND CONTINGENCIES	
If material, investment income from unearned premium reserves, reserves from incurred losses, and reserves from incurred but not	
1. Provision for Profit and Contingencies:	% **Pre-FIT** ☐ **After tax** ☐
2. Proposed load in excess of 7% after tax. Provide detailed support:	%
Additional information:	

K. DETERMINATION OF PROPOSED RATES	
Include all underlying rating assumptions, with detailed support for each assumption. This explanation may be on an aggregate expected loss basis or as a per-member-per-month (PMPM) basis.	
1. Explain, in detail, how rates and/or rate changes were developed:	
2. Provide adequate support for all assumptions and methodologies used:	
Additional Information:	

L. TREND

- Describe the trend assumptions used in pricing. Each assumption must be separately discussed, adequately supported, and
- Any and all factors affecting the projection of future claims must be presented and adequately supported.
- If practical, separately list each trend component using the categories below. The Total Average Annualized Trend MUST be
- Underwriting wearoff means the gradual increase from initial low expected claims that result from underwriting selection to

Itemized trend component	Trend (%)
MEDICAL TREND (total)	%
Medical provider price increase	%
Utilization changes	%
Medical cost shifting	%
Medical procedures and new technology	%
INSURANCE TREND (total)	%
Underwriting wearoff	%
Deductible leveraging	%
Antiselection	%
PHARMACEUTICAL TREND (total)	%
Price increases	%
Utilization changes	%
Cost shifting	%
Introduction of new brand and generic drugs	%
TOTAL AVERAGE ANNUALIZED TREND (required)	%
Additional information:	

M. CREDIBILITY

The Colorado standard for fully credible data is 2,000 life years and 2,000 claims. Both standards must be met within a maximum of

- Discuss the credibility of the Colorado data with the proposed rates based upon as much Colorado data as possible.
- Identify and discuss the source, applicability and use of collateral data used to support partially credible Colorado data. The
- The formula for determining the amount of credibility to assign to the data is SQRT{(#life years or claims)/full credibility

1. Credibility Percentage (Colorado Only):	If other, please specify
The above credibility percentage is based upon:	☐ Life Years ☐ Claims ☐ Other (please specify)
2. Number of years of data used to calculate above credibility percentage:	
3. Discuss how and if aggregated data meets the Colorado credibility requirement and how the rating methodology was modified for the partially credible data, if applicable.	
Additional Information: (Including collateral data, if used)	

N. DATA REQUIREMENTS

Colorado-only basis for at least 3 years. **Include** national, regional or other appropriate basis, if the Colorado data is not fully credible.

COLORADO

Year*	Earned Premium	Incurred	Loss Ratio	Average Covered Lives	Number of	Colorado On Rate Level Premium
2007	$0.00	$0.00	NaN%			
2008	$0.00	$0.00	NaN%			
2009	$0.00	$0.00	NaN%			
01/2010 –MM/2010	$0.00	$0.00	NaN%			
	$0.00	$0.00	NaN%			
	$0.00	$0.00	NaN%			

*This column should be Calendar Year. If fractional year is used, identify period as MM/YYYY – MM/YYYY

Above data is for: ☐ N/A ☐ Existing Product ☐ Comparable Product ☐ Other _____(please specify)

OTHER DATA

	Earned Premium	Incurred Claims	Average Covered Lives	Number of Claims

Above data is for: (Check all the apply) ☐ N/A ☐ Existing Product ☐ Comparable Product ☐ National ☐ Other (please specify)_____

Experience Period: From to

Additional Information:

O. SIDE-BY-SIDE COMPARISON ☐ N/A			
If the proposed rating factor(s) are new, the memorandum must specifically so state, and provide detailed support for each of the factors.			
Description	**Current Rate/ Rating Factor/**	**Proposed Rate/ Rating**	**Percentage Increase/**
	%	%	%
	%	%	%
	%	%	%
	%	%	%
	%	%	%
	%	%	%
If the above table is not used, please identify the location of the Side-by-Side Comparison in the rate filing:			
Description and detailed support for new rating factor(s):			
Additional Information:			

P. BENEFITS RATIO PROJECTIONS			
PROJECTED EXPERIENCE FOR RATING PERIOD			
	Premiums	**Incurred Claims**	**Benefits Ratio**
Projected Experience Without Rate Change	$0.00	$0.00	0.00%
Projected Experience With Rate Change	$0.00	$0.00	0.00%
If priced using a lifetime loss ratio standard, the above projections should show the projected lifetime loss ratios and should include the entire lifetime of the product(s), or a time frame over which the lifetime loss ratio will be achieved. Above projections include (check only one box):	☐ Colorado ☐ Nationwide ☐ Blended CO/Nationwide ☐ Other (please specify)_____		
Additional Information:			

Q. OTHER FACTORS	
Identify and provide support for other rating factors and definitions, including area factors, age factors, gender factors, etc.:	
Additional Information:	

Submit & Attach in SERFF

Appendix D

Maryland Comprehensive Health Insurance Rate Filing Requirements

Maryland Comprehensive Health Insurance Rate Filing Requirements

At a minimum, include all elements in the table below in the Actuarial Memorandum that is filed with the requested rates.

Data Element	Requirement	Is the data element required?		
		Individual	**Small Group**	**Large Group**
Purpose of Filing	Statement of purpose. Identify the law it is intended to comply with. Provide a general summary of the proposed changes to the base rates and rating factors.	Yes	Yes	Yes
Effective Date	The requested effective date of the rate change.	Yes	Yes	Yes
Market	Indicate whether the products are sold in the individual, small group, or large group market.	Yes	Yes	Yes
Status of forms	Indicate whether the forms are open to new sales, closed, or a mixture of both. Indicate whether the forms are grandfathered, non-grandfathered, or a mixture of both.	Yes	Yes	Yes
Average Rate Increase Requested	The weighted average rate increase being requested. There should be two separate averages; the weighting for one should be based on enrollment, and the weighting for the other should be based on premium volume.	Yes	Yes	Yes
Maximum Rate Increase Requested	The maximum rate increase that could be applied to a policyholder based on changes to the base rate and rating factors. (Does not include changes in the demographics of the covered members.)	Yes	Yes	Yes
Minimum Rate Increase Requested	The minimum rate increase that could be applied to a policyholder based on changes to the base rate and rating factors. (Does not include changes in the demographics of the covered members.)	Yes	Yes	Yes
Benefits	Basic description of the benefits of the policies included in the filing.	Yes	Yes	Yes

Data Element	Requirement	Is the data element required?		
		Individual	**Small Group**	**Large Group**
Rate History	Rate history of the policies included in the filing. If nationwide experience is used in developing the rates, provide the rate history separately for Maryland and nationwide average.	Yes	Yes	Yes
Covered Members	Most current membership count available.	Yes	Yes	Yes
Member Months	Number of members in force during each month of the base experience period used in the rate development, and each of the two preceding 12-month periods. **Provide this in Excel format with any formulas intact.**	Yes	Yes	Yes
Past Experience	Provide monthly earned premium and incurred claims for the base experience period used in the rate development and each of the two preceding 12-month periods. **Provide this in Excel format with any formulas intact.**	Yes	Yes	Yes
Rate Development	Show base experience used to develop rates, and all adjustments and assumptions applied to arrive at the requested rates. **Provide this in Excel format with formulas intact.** For less than fully credible blocks, disclose the source of the base experience data used in the rate development and discuss the appropriateness of the data for pricing the policies in the filing.	Yes	Yes	Yes
Credibility Assumption	If the experience of the policies included in the filing is not fully credible, state and provide support for the credibility formula used in the rate development.	Yes	Yes	Yes
Trend Assumption	Show trend assumptions by major types of service as defined by HHS, separately by unit cost, utilization, and in total. Provide the development of the trend assumptions. **Provide this in Excel format with formulas intact.**	Yes	Yes	Provide aggregate trend with support.
Enrollee risk profile	Show the change in enrollee risk profile over time, and show how the experience used in trend development and rate development has been adjusted to account for this change.	Yes	Yes	No

Data Element	Requirement	Is the data element required?		
		Individual	**Small Group**	**Large Group**
Cost-sharing changes	Disclose any changes in cost sharing for the plans between the base experience period for rating and the requested effective date. Show how the experience has been adjusted for cost-sharing changes in the rate development. Provide support for the estimated cost impact of the cost-sharing changes.	Yes	Yes	Yes
Benefit changes	Disclose any changes in covered benefits for the plans between the base experience period for rating and the requested effective date. Show how the experience has been adjusted for changes in covered benefits in the rate development. Provide support for the estimated cost impact of the benefit changes.	Yes	Yes	Yes
Plan relativities	If the rate increase is not uniform for all plan designs, provide support for all changes in plan relativities. Disclose the minimum, maximum, and average impact of the change on policyholders.	Yes	Yes	Yes
Rating factors	Disclose any changes to rating factors, and the minimum, maximum, and average impact on policyholders. Provide support for any changes.	Yes	Yes	Yes
Distribution of rate increases	Anticipated distribution of rate increases due to changes in base rates, plan relativities, and rating factors. This need not include changes in demographics of the individual or group.	Yes	Yes	No
Reserve needs	Provide the claims for the base experience period separately for paid claims, and estimated incurred claims (including claim reserve). Indicate the incurred period used for the base period. Indicate the paid-through date of the paid claims, and provide a basic description of the reserving methodology.	Yes	Yes	No
Administrative costs related to programs that improve health care quality	Show the amount of administrative costs included with claims in the numerator of your loss ratio calculation, demonstrating compliance with 15-605(c). Show that the amount is consistent with the most recently filed Supplemental Health Care Exhibit, or provide support for the difference.	Yes	Yes	Yes

Data Element	Requirement	Is the data element required?		
		Individual	**Small Group**	**Large Group**
Other administrative costs	Show the assumed administrative costs in the following categories: ▪ Salaries, wages, employment taxes, and other employee benefits ▪ Commissions ▪ Taxes, licenses, and other fees ▪ Cost containment programs / quality improvement activities ▪ All other administrative expenses ▪ Total Show analogous statistics from the previous filing and provide support for any changes.	Yes	Yes	No
Taxes and licensing or regulatory fees	Show the amount of taxes, licenses, and fees subtracted from premium in the denominator of your loss ratio calculation, demonstrating compliance with 15-605(c). Show that the amount is consistent with the most recently filed Supplemental Health Care Exhibit, or provide support for the difference.	Yes	Yes	Yes
Medical loss ratio	Demonstrate that the projected loss ratio, including the requested rate change, meets the minimum loss ratio requirements of 15-605(c). Show the premium, claims, and adjustments separately, with the development of the projected premium and projected claims (if not already provided in the rate development section). **Provide this in Excel format with formulas intact.** If the loss ratio falls below the minimum for the subset of policy forms in the filing, demonstrate that when combined with all other policy forms in the market segment in the state of Maryland, the loss ratio meets the minimum.	Yes	Yes	Yes

Data Element	Requirement	Is the data element required?		
		Individual	**Small Group**	**Large Group**
Risk-based capital	Provide your risk-based capital status for each of the three most recent calendar years.	Yes	Yes	No
Profit margin/contribution to surplus	State the profit margin/contribution to surplus charge included in the proposed rates. Show how this has changed from prior filings, and provide support for any change.	Yes	Yes	No
Part I Preliminary Justification	Rate Summary Worksheet required under Part I of the Preliminary Justification. Provide for *all* filings (whether or not they are "subject to review"). **Provide in Excel format.**	Yes	Yes	No
Other	Any other information needed to support the requested rates or to comply with Actuarial Standard of Practice No. 8.	Yes	Yes	Yes
Actuarial Certification	Certification by a qualified actuary that the anticipated loss ratio meets the minimum requirement, the rates are reasonable in relation to benefits, the filing complies with the laws and regulations of Maryland and all applicable Actuarial Standards of Practice, including ASOP No. 8, and the rates are not unfairly discriminatory.	Yes	Yes	Yes

OLIVER WYMAN

411 East Wisconsin Avenue, Suite 1600
Milwaukee, WI 53202-4419
414 223 7989