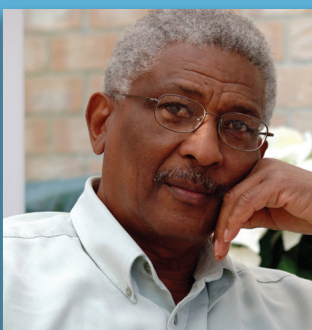


FREQUENTLY ASKED QUESTIONS: HEALTH INSURANCE RATES AND THE REVIEW PROCESS



Maryland
INSURANCE ADMINISTRATION

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TABLE OF CONTENTS

Introduction1

Frequently Asked Questions and Answers:

What Coverages are Subject to Rate Review1

How Health Insurance Companies Develop Rates2

What Causes Rates to Change.....3

The Rate Review Process5

What is the 1332 State Innovation Waiver8

Other Topics8

Learn More10

Definition of Terms.....12

Since premiums are important in deciding whether you can afford a specific health insurance policy, it is important to understand some of the factors that affect premiums. Here are a few questions that consumers often ask the Maryland Insurance Administration (MIA) about the health insurance premiums they pay.

The “premium” is what you pay when the rate has been adjusted based on your age, deductible, copayment levels, and other factors. The term “rate” means the amount the insurance company uses to determine your premium.

WHAT COVERAGES ARE SUBJECT TO RATE REVIEW?

The Office of the Chief Actuary of the MIA reviews rates for:

1. Individual Medicare Supplement insurance (Medigap);
2. Individual Non-Medigap health benefit plans (grandfathered¹ and ACA²);
3. Small Group health benefit plans (50 or fewer employees (grandfathered and ACA));
4. Large Group health benefit plans (51 or more employees) that are not self-insured;
5. Long Term Care Insurance (LTC); and
6. various other types of health insurance, including Stop Loss, Accident, Disability Income, Specified Disease or Illness (e.g., cancer, critical illness, organ transplant, complications of cosmetic surgery), Hospital Indemnity, Fixed Indemnity, Dental (non-ACA and ACA), Vision, Student (ACA), and Short-Term Limited Duration Health Insurance (STLDHI).

Rate filings for Property and Casualty policies are handled in a separate department of the MIA.

¹ A grandfathered plan is an individual health plan purchased on or before March 23, 2010, whose benefits have not substantially changed. These plans are not required to comply with benefit requirements of plans provided under the Affordable Care Act and will include a statement indicating that it is a grandfathered plan.

² An ACA plan is a plan that complies with the federal Affordable Care Act.

The Maryland Department of Health, in consultation with the MIA, establishes the Medicaid rates.

The MIA does not review rates for:

- Large Groups that are self-insured (including “Third Party Administrators” (TPA));
- Federal plans such as Medicare (e.g., Medicare Advantage, Medicare Part D), and TRICARE (formerly “Civilian Health and Medical Program of the Uniformed Services” (CHAMPUS));
- Programs for federal employees (e.g., Federal Employee Health Benefit Program (FEHBP) and Federal Employee Dental and Vision Insurance Program (FEDVIP));
- Federal LTC Insurance; and
- Plans issued in other states.

HOW HEALTH INSURANCE COMPANIES DEVELOP RATES

1. HOW DO CARRIERS DEVELOP RATES?

Carriers use data to predict how much they need to charge to pay claims and operating costs, including profit. Carriers project future claims and operating costs, both in the aggregate and for specific subgroups (or “stratifications”) who share a common trait. Stratifications can include benefit plan, age band, or region. In making these projections, carriers make certain assumptions. Some of the key assumptions include claims trend, risk adjustment, whether the pool of insureds is getting older or sicker overall, legal changes (such as the Affordable Care Act’s requirements), profit need, how much insureds pay in cost-sharing (deductibles, coinsurance), state and federally-based programs (such as reinsurance), and drug manufacturer rebates.

2. HOW DO CARRIERS ESTIMATE CLAIM COSTS?

Carriers analyze past actual experience by types of services, and which services are being used more or less often. Some categories of services include inpatient hospital, outpatient hospital, professional, other medical (e.g., home health, prosthetics), capitations, and prescription drug. The Health Service Cost Review Commission (HSCRC) sets hospital budget constraints each year in June, and carriers also use this information in their estimates. Carriers also develop models of member behavior to determine, for example, whether wellness programs or cost sharing affects how many health care services members receive. Changes in the mix of services and/or places of services (e.g., hospital setting versus ambulatory surgical center (ASC), doctor's office or emergency room) can be examined as well; different settings have different costs, so more services in an expensive setting can drive up costs. New technologies or drugs (e.g., biologics) are considered, as are changes in the insured's cost-sharing.

WHAT CAUSES RATES TO CHANGE

1. WHAT FACTORS CAN CAUSE RATES TO CHANGE?

Rates are determined in large part by medical spending. Medical costs can change for many reasons, including increases in provider charges, greater use of health care services, new technologies, costs for prescription drugs, an aging population, and unhealthy lifestyles. A carrier also may change its rates because it needs to increase its reserves to pay future claims. Premiums must be high enough to cover the company's projected claims and operating costs. Changes to laws, government subsidies, and risk profiles of the insured population can also be factors.

2. WHY DID MY RATES GO UP WHEN I DIDN'T HAVE ANY CLAIMS (DIDN'T SEE A DOCTOR, GO TO THE HOSPITAL, OR GET ANY PRESCRIPTIONS)?

Your premium will not go up solely because you have claims, just as it will not go down solely because you do not have claims. People buy insurance to protect themselves from the full financial risk of future events. Insurance is a pooling of risks. The goal is to set premiums so that there will not be big swings from year to year due to one or two very large claims. If you have an individual or small group policy, your premium is based on the claims of everyone with your type of policy.

If you have coverage under a large employer health plan, your premium will be based in part on the claims of everyone in your group. Insurers can predict the type of claims they are likely to pay, and set premiums so that the costs are spread out across the pool.

3. WHAT CAUSES MY PREMIUM TO INCREASE AT A DIFFERENT RATE THAN OTHERS WITH THE SAME POLICY?

If you buy your own health insurance, your specific premium may change due to you: 1) age (aging one year has differing impacts and, generally, the cost increases with age since you are more likely to file claims as you get older); 2) selected benefit plan, including the deductible level you select and applicable copays; 3) family composition change; or 4) location/residence change since some areas of the state have higher costs than other areas. Your insurance producer or carrier can help identify the exact cause in your situation.

If you have coverage through your employer, your premium includes both the amount you pay and the amount your employer pays. If your employer pays less, it may seem like a premium increase even if the actual premium is the same. You may also pay a different amount if you select a new benefit plan, add or remove family members, or move. (Rates for the whole group may change dramatically for groups if the average age changes significantly.) Your human resources benefits office should be able to assist.

4. HOW OFTEN CAN MY PREMIUMS CHANGE?

Generally, premiums cannot change more than once every 12 months (or the plan year). However, carriers are permitted to raise or lower premiums more frequently than once every 12 months if the change is only because you added or removed family members from the policy. For non-ACA products, premiums may also change during the plan year if benefits change or optional riders are added or removed. Also, in the Individual non-Medigap ACA market, rates change every January 1. Therefore, if someone purchases a policy after January 1 in a given year, his/her rate can change on the next January 1 for the first renewal period, even if though it has been less than 12 months since the policy was purchased.

5. MUST CARRIERS SUBMIT RATE FILINGS EACH YEAR?

In most cases, carriers only need to submit a rate filing if they are requesting a change in rates. However, carriers must submit rate filings for Medicare Supplement plans annually, even if they are not requesting a change in rates. In addition, carriers must submit a certification each year for small group policies, confirming that the rates charged during the past year complied with the law.

THE RATE REVIEW PROCESS

1. DOES ANYONE REVIEW CARRIERS' RATE CHANGES BEFORE THEY GO INTO EFFECT?

Yes. Maryland law requires carriers to file rates and have them approved by the MIA before implementation.

2. WHO REVIEWS RATE CHANGE REQUESTS AT THE MIA?

The MIA's Office of the Chief Actuary (OCA), which is staffed by credentialed actuaries, is responsible for reviewing all filed rates for health benefit plans. Actuaries are insurance professionals trained to analyze risks and develop premium rates. Credentials are earned from the Society of Actuaries (SOA) and the American Academy of Actuaries (AAA) through extensive study, testing, practical experience, and training. Continuing education requirements must be fulfilled annually for credentialed actuaries.

3. HOW DOES THE MIA DECIDE WHETHER TO APPROVE A REQUESTED RATE CHANGE?

Carriers must demonstrate that requested rates comply with Maryland law. Specifically, Section 11-603(c)(2) of the Insurance Article, Annotated Code of Maryland requires that rates be based on reasonable assumptions, and that rates are not inadequate, unfairly discriminatory or excessive in relation to benefits. An excessive rate reduces access and affordability. An inadequate rate means the company may not be able to pay claims in the long run. A rate is unfairly discriminatory if, for example, it is not applied consistently to members of the same demographic or benefit rating profile.

Additionally, federal and state minimum loss ratios must be projected to be met. Under the ACA, if the actual loss ratio falls below 80.0% for the Individual Non-Medigap, Small Group, or Student ACA markets and 85.0% for Large Groups (fully insured), rebate checks must be issued by the carrier to the contract holder or employer.

All of the assumptions outlined above are tested and examined in detail by the MIA's OCA. "Net income" and "gains/losses from operations" from financial statements provide context.

4. WHAT OTHER INFORMATION DOES THE MIA EXAMINE WHEN REVIEWING A RATE CHANGE REQUEST?

Model laws and regulations adopted by the National Association of Insurance Commissioners (NAIC) are reviewed, and sometime adopted by the MIA for rate review. The MIA considers the history of rate changes, the carriers' financial strength, the absolute level of the rate versus competitors in the market, and the comparison of renewal rates to new business rates. If rates need to go up, the MIA considers how quickly the rates can rise. Sometime the rise is gradual and spread over multiple years. Mathematical computations are also checked for accuracy. Each year, new market dynamics lead to new information being requested by the MIA (e.g., for 2019 rates the Tax Cuts and Jobs Act (TCJA)). For small sample sizes, the credibility of the data is measured. Additionally, if the carrier delayed correcting rating missteps, that may reduce a requested rate increase. If a carrier is partly to blame for incorrect assumptions, that can also reduce a requested rate increase. Oftentimes, carriers take the prior two actions on their own.

5. DO CARRIERS ALWAYS GET APPROVAL FOR THE RATE CHANGES THEY REQUEST?

No. A rate request will be modified if it is not proven to be fully justified and/or sufficiently supported. A rate request will be withdrawn if the carrier does not respond. A rate request will be denied if it is not proven to be needed. In some cases, a carrier is asked to withdraw a filing if it affects a small number of Marylanders (e.g., less than 10) where a rate approval would have little impact to the carrier, but a big impact to the member.

6. CAN THE MIA APPROVE A REQUESTED RATE CHANGE FOR SOME POLICIES AND DENY A REQUESTED RATE CHANGE FOR OTHER POLICIES FOR THE SAME CARRIER?

Yes. The MIA reviews the rates for each health benefit plan. If the rates for some plans are not supported, the requested rates for those products are not approved.

7. WHAT IF THE CARRIER DISAGREES WITH THE MIA'S DECISION?

The carrier has the right to request a rate hearing if it disagrees with the MIA's rate filing decision.

8. DO CARRIERS HAVE TO NOTIFY POLICYHOLDERS ABOUT RATE CHANGES?

Yes. Maryland law requires carriers to provide an annual notice to their policyholders, and to post a notice on their websites, explaining that policyholders may find proposed ACA rate changes on the MIA's website. Depending upon the type of health benefit plan (e.g. individual or group, grandfathered or nongrandfathered, or Medicare Supplemental insurance), a notice of a rate increase must be received 30 to 60 days prior to the effective date. LTC insurance carriers must provide notice at least 45 days prior to the effective date and are also required to provide the form number annually so that policyholders may identify rate filings and hearings that pertain to their plan.

9. IS THERE A FORUM FOR PUBLIC COMMENTS?

Public comments are an important part of the process. In the past, excerpts have been shared at MIA hearings, with the press, with carriers, and with legislators in Annapolis. ACA individual non-Medigap market and small group rate filings are open to public comment. When a carrier submits a rate change request, consumers can read the carrier's justification for the request and submit comments on the MIA's website for at least 30 days from the date the request is posted on its website.

10. HOW OFTEN ARE ACA RATE HEARINGS HELD?

The answer depends on the specific plan and carrier. A rate hearing is required prior to approval and any LTC filing. LTC hearings have been held quarterly since 2015. Generally speaking, there have been 1-2 hearings per year since inception for ACA plan rates effective since 2014.

11. HOW LONG DOES THE RATE REVIEW PROCESS TAKE?

From submission to approval, it usually takes between 10 days to more than a year to complete the rate filing review process; ACA filings usually take about four months. During this time, the MIA may ask carriers for additional data, and the carrier then has 10 days to respond to the request unless an extension is requested.

WHAT IS THE 1332 STATE INNOVATION WAIVER?

FOR THE ACA, WHAT WAS THE SIGNIFICANCE OF THE SECTION 1332 STATE INNOVATION WAIVER APPROVAL?

Under the Affordable Care Act, a state can ask the federal government to waive certain requirements; this is known as a Section 1332 waiver request. On August 22, 2018, the Centers for Medicare & Medicaid Services (CMS) approved Maryland's request to deviate from federally-prescribed rating practices for the ACA and to allow a state-based reinsurance program (SBRP) effective 2019, in an effort to help lower premium rates. Maryland became the seventh state to implement a SBRP. The 2020 rates submitted by the carriers for the individual non-Medigap market include the estimated impacts from the SBRP. For 2019, the overall rate impact of the SBRP was -30% ranging from -45% to -27% by legal entity.

OTHER TOPICS

1. HOW MIGHT THE 2020 ACA INDIVIDUAL NON-MEDIGAP FILINGS AFFECT SUBSIDIES?

On March 1, 2019, carriers submitted benefit plan carriers submitted their proposed benefit plans. Twenty benefit plans have been filed On-Exchange compared to only seventeen last year. An area of close examination has been the impact on the benchmark "second lowest cost Silver plan" (SLCSP). The difference between the SLCSP premium and the IRS-defined maximum amount that those earning under 400% of the Federal Poverty Limit (or \$49,960 for an individual in

2019) will pay is the “Advance Premium Tax Credit” (APTC) or subsidy. Based on the carriers’ filings to date, despite the average rate decrease, preliminary estimates indicate that subsidies could still increase in both rural regions where only CareFirst (CF) is available, and regions where both CF and Kaiser (KP) are available by +10% and +4%, respectively, for those earning 150% of FPL (\$18,735 for an individual).

2. FOR THE INDIVIDUAL NON-MEDIGAP ACA MARKET, WHAT ARE THE NEW “VALUE” PLANS?

“Value” plans have been added with more first-dollar coverages, preventive services, and less insured cost-sharing. More details are available at the link below.

3. FOR THE ACA INDIVIDUAL NON-MEDIGAP MARKET, WHY ARE RATES HIGHER FOR SILVER PLANS AVAILABLE ON THE MARYLAND’S HEALTH BENEFIT EXCHANGE (MHBE) THAN THOSE AVAILABLE OFF OF THE MHBE?

Tax credits are based on the premiums for Silver Plans available on the Maryland Health Benefit Exchange (On-Exchange Silver Plans). In 2018, the federal government stopped funding “cost-sharing reductions” (CSRs), and carriers in turn increased their premium rates to replace the federal CSR payments. Maryland required that carriers apply this new cost only to Silver-On Exchange rates to maximize subsidies. As a result, for Silver Plans, similar to last year, On-Exchange rates are 9%-19% higher than Off-Exchange rates.

The On and Off-Exchange Silver Plans cover the exact same Essential Health Benefits (EHBs)³, with identical cost-sharing on those EHBs. EHBs represent more than 99% of claims. The key differences between the on and off exchange silver plans though are that the Off-Exchange plans lack coverage for certain non-EHBs, but may cost less and be a good value for people who do not qualify for subsidies. To reiterate, subsidies are only available On-Exchange. Those subsidies may still enable a lower final premium for a Silver Plan. The subsidy could make a Bronze Plan available for free or a richer Gold Plan at a good overall value.

³ The federal Affordable Care Act requires that individual and small group plans (these plans are available for employers with 50 or fewer employees) that are not grandfathered plans and that began or are renewed on or after January 1, 2014, provide certain benefits. These benefits are called, “Essential Health Benefits”. For more information about essential health benefits for individual and small group health benefit plans in Maryland, see the MIA’s Essential Benefits Chart, (link to: <https://insurance.maryland.gov/Consumer/Documents/publicnew/essentialbenefitschart.pdf>)

4. HOW DOES MARYLAND'S REINSURANCE PLAN (SBRP) PROGRAM WORK?

When the federal government announced another moratorium for 2019 of the ACA “health insurer fee” (HIF), Maryland enacted legislation to redirect it to fund a RI program since it was already in rates. This generated approximately \$365 million dollars. For 2019, claims will be reinsured above \$20,000 up to \$250,000 with 80% coinsurance in between. By using the \$365 million to reduce rates the federal government’s Maryland subsidy payments go down. The federal government passes this savings to Maryland, estimated over three years at \$779 million so that the total program size becomes \$1.144 billion, leveraging the \$365 million. The ACA Individual Non-Medigap premium impact for the years 2019, 2020, and 2021 has been estimated at -30%, -30%, and -14%, respectively. However, legislation enacted during the 2019 General Assembly Session added 1.0% annually through 2023 to augment the \$365 million.

LEARN MORE

HOW CAN I FIND OUT MORE ABOUT RATES AND RATE CHANGES REQUESTED BY CARRIERS?

Rate Filings and Supporting Documents

Public access is available shortly after submission and public comments may be entered and viewed. The supporting documentation for individual non-Medigap and Small Group ACA rate filings submitted by carriers can be found on the OCA’s web site for data and public comments; www.healthrates.mdinsurance.state.md.us.

At this site you will find “frequently asked questions” (FAQs), filed rates, the actuarial memorandum (a.k.a., Part III), a written description of the filing (a.k.a., Part II), the “Unified Rate Review Template” (URRT), the press release, and notices about upcoming hearings.

The national system that houses rate filings is called the “System for Electronic Rate and Form Filing” (SERFF). Upon approval, the final support can be viewed along with correspondence between the MIA and the carriers along with a “decision document” outlining key reasons for the approval rendered for filings for

all markets. An archive of past approvals is available for public viewing, and can be viewed at <https://filingaccess.serff.com/sfal/home/MD>. Carriers can redact certain portions of the actuarial support. If they do, the public can still submit a “Public Information Act” (PIA) request to see the unredacted version. Rate guides for Medigap are also available. Below are some links outlining available resources.

PIA

<https://insurance.maryland.gov/Pages/public-information-act-requests.aspx>

Rate Review Process

<https://insurance.maryland.gov/Consumer/Pages/HealthInsuranceRateReviewProcess.aspx>

LTC for data and public comments

<https://insurance.maryland.gov/Consumer/pages/LongTermCare.aspx>

Medicare Supplement Rate Guide

<https://insurance.maryland.gov/Consumer/Documents/publications/Medicare-Supplement-Rate-Guide.pdf>

MHBE

<https://www.marylandhbe.com/wp-content/uploads/2012/10/Carrier-Reference-Manual.pdf>



DEFINITION OF TERMS

Actuarial Value (AV): The ratio of the paid amount to the allowed amount. Said another way, this is a measure of the richness of the benefit plan. It is the portion or percentage of the health care bill paid by the carrier after insured cost-sharing.

Allowed Amount: The cost of a medical service from a hospital or physician with discounts negotiated by carriers. (Discounts can be substantial (e.g., as much as -50%)).

Billed Charges: The cost of a medical service from a hospital or physician without discounts negotiated by carriers.

Carrier: An insurer, Health Maintenance Organizations (HMO), dental plan organization, or nonprofit health service plan.

Claims Costs: The amount a carrier pays for health care services and goods, such as physician services, hospital fees, durable medical equipment (DME), dental, vision, and prescription drugs, on behalf of policyholders. This amount does not include any deductible or copayment paid by the policyholders.

Claims Trend: Annual increase in “cost per service” (intensity) and “utilization/ services per member” (frequency).

Cost-Sharing Reductions (CSR): Reduced insured cost-sharing plans offered under the ACA in the Individual Non-Medigap market for Silver plans On-Exchange only, which are available to those earning between 100% and 250% of the Federal Poverty Level (FPL) in three tranches of “actuarial value” (AV) of 73%, 87%, and 94%.

First-Dollar Coverage: Benefits for which a member does not pay a deductible. However, copays or coinsurances may apply.

Health Benefit Plan (HBP): A contract stipulating benefits for medical care offered by a carrier to an individual, group, or Association. This does not include excepted benefits insurance such as accident-only, disability income, worker’s compensation, automobile medical payment insurance, credit-only insurance, long

term care (LTC), specified disease, hospital indemnity, fixed indemnity, Medicare Supplement, liability supplement insurance, on-site medical clinics, and limited scope dental or vision.

Health Insurer Fee (HIF): A charge to health insurers (including HMOs) based on each insurer's share of the taxable health insurance premium base (among all health insurers of U.S. Health Risks) to fund the ACA. Carriers estimate that this fee will amount to about 3% of premium in 2020.

Individual Mandate: A federal requirement under the Affordable Care Act as enacted that individuals obtain qualifying health insurance coverage or pay a tax penalty.

Insured Cost-Sharing: The portion of the claims cost paid by the member before the carrier starts to pay. It includes deductibles, copayments, and coinsurance amounts up to the out-of-pocket maximum.

Medical Loss Ratio (MLR): The percentage of the premiums that go toward claims cost (e.g., 80.0%).

Metal Level: An ACA categorization of benefit plans based on AV or benefit richness. The least rich is Bronze (central AV = 0.60), the most rich is Platinum (central AV = 0.90), and in between are Silver (central AV = 0.70), and Gold (central AV = 0.80).

Morbidity: A measure of the relative health of a population.

Operating Costs: The non-claims costs incurred by a carrier such as administrative expenses, taxes, fees and assessments (federal and state), and payments to brokers. The costs of administering a health plan can include overhead (e.g., rent, salaries), computer systems, provider network maintenance, and fraud detection.

Paid Amount: The portion of the allowed amount paid by the carrier after insured cost-sharing.

Profit/Contribution to Reserve: The remaining money after all claims and operating costs have been paid in a given year, before investment income. These

funds go into surplus to protect against future volatility in business operations, and for purposes such as investing in infrastructure to improve customer service, or marketing. Surplus sufficiency is measured by a statistic called a “Risk-Based Capital” (RBC) ratio. (“Contribution to Reserve” is the term used for nonprofits.)

Reinsurance (RI): A financial program whereby someone other than the carrier pays a portion of the claims costs in a given year.

Risk Adjustment (RA): Federal program under the Affordable Care Act (ACA) to compensate carriers who enroll relatively sicker members and vice versa. It seeks to “equalize/level the field” by transferring money from insurers with healthy members and low claims costs to those with relatively unhealthy members and high claims costs.

Drug Manufacturer Rebates: Dollars given back to insurers or pharmacy benefit managers (PBMs) from pharmaceutical companies in return for prescribing certain drugs.

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