

The Hilltop Institute



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Premium Rate Review of Private Health Insurers in Maryland and Opportunities for State Regulatory Coordination under Health Care Reform

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Premium Rate Review of Private Health Insurers in Maryland and Opportunities for State Regulatory Coordination under Health Care Reform

I. Introduction

The Health Services Cost Review Commission (HSCRC) entered into a memorandum of agreement with The Hilltop Institute to examine ways in which the Maryland Insurance Administration (MIA) and the HSCRC can coordinate activities to restrain the overall growth rate of health care expenditures in the review and approval of private insurers' premium rate requests. Hilltop was specifically tasked with describing current MIA premium rate review processes including public input, examining practices from select other states, describing the HealthChoice rate review process and coordination with the HSCRC, and developing recommendations for more effective coordination of the HSCRC and MIA activities within the current regulatory framework and in the context of changes resulting from health reform legislation and decisions.



II. Background and Legal Authority

The Maryland Insurance Administration

The Maryland Insurance Administration (MIA) is an independent unit of state government under the control and supervision of the Insurance Commissioner. The Commissioner is appointed to a four-year term by the Governor, to whom the Commissioner is directly responsible. Maryland law grants the Commissioner broadly defined powers and duties, including those expressly conferred or “reasonably implied” by the terms of the Insurance Article of the Annotated Code of Maryland. These include the authority to conduct examinations and investigations as required by law and “as necessary to fulfill the purposes of this [Insurance] article,” and the authority to promulgate regulations to carry out its terms (Insurance Article, §§2-101, 2-103, 2-108).

Review Authority – Health Insurance Forms and Premium Rates

Section 12-203(a) and (b) of the Insurance Article prohibit the delivery or issuance for delivery in Maryland of any health insurance policy form that has not been filed with and approved by the Commissioner. Section 12-203(c) requires a health insurance form to be filed 60 days prior to its delivery, and allows the Commissioner to extend this initial filing period by another 30 days, provided notice of the extension is given within the initial 60-day period. Forms filed for approval must be consistent with content and technical requirements specified in COMAR 31.04.17.03 and 31.10.01.02

Unless the Commissioner approves or disapproves the form within the initial or extended filing period, it is deemed approved. However, with prior notice, a showing of cause, and specification of the effective date that is at least 20 days after issuance of the notice, the Commissioner may withdraw approval of a form “at any time” (Insurance Article §12-203(c)(5) and (6)). A \$125 filing fee payable to the Commissioner “for required filings, including form and rate filings” is specified by Insurance Article §2-112(a)(9).

Indicative of the Commissioner’s authority to require that forms filed for review “be accompanied by the filing of premium rates ...” (COMAR 31.10.01.02A)¹, §12-205(b)(6) of the Insurance Article requires the Commissioner to disapprove or withdraw approval of a form that provides for “benefits... that are unreasonable in relation to the premium charged.” Section 12-205(b) additionally requires the Commissioner to disapprove or withdraw approval of a form that includes an ambiguous, misleading, or illegible provision, “fail[s] to provide minimum benefits or coverages that the Commissioner considers necessary to meet the minimum needs of the insured,” contains, “irrespective of the premium charged, a benefit that is not sufficient to be of

¹ See also Insurance Article §11-206.



real economic value to the insured,” or, with respect to a health insurance or nonprofit health service plan application, asks impermissible questions about preexisting conditions or health screenings. Insurance Article §13-126 requires the Commissioner’s prior approval of a rate change or other contract amendment by a nonprofit health service plan. Finally, §19-713 of the Health-General Article requires health maintenance organizations (HMOs) to file subscriber rates and contract forms with the Commissioner before they become effective. HMO rates may not be “excessive, inadequate, or unfairly discriminatory in relation to the services offered.”

General Review Standards

Statutory standards for approval/disapproval of forms filed for review are separately specified for health insurance, nonprofit health service plans, and HMOs. The Commissioner is required to disapprove:

- A **health insurance** form that provides for benefits that are “unreasonable in relation to the premium charged” (§2-205)
- “Or modify” rates proposed by a **nonprofit health service plan** if “the table of rates appears by statistical analysis and reasonable assumptions to be excessive in relation to benefits.” Factors to be considered in making a such a determination include:
 1. Past and prospective loss experience within and outside the state
 2. Underwriting practice and judgment to the extent appropriate
 3. A reasonable margin for reserve needs
 4. Past and prospective expenses, both countrywide and those specifically applicable to the state
 5. Any other relevant factors within and outside the state [(§14-126)]
- **HMO** rates that are “excessive, inadequate, or unfairly discriminatory in relation to the services offered” (Health-General Article, §19-713)²

² See also COMAR 31.12.02.08B, which prohibits HMO rate differentials based on age or sex without actuarial justification.



Small Employer Coverage – Adjusted Community Rating

Maryland’s Comprehensive Standard Benefit Plan for Small Employers (Standard Plan) is mandatory minimum coverage that must be offered by a carrier³ that offers any health benefit plan (health insurance, nonprofit health service plan, or HMO coverage) to a small employer (2-50 employees) in Maryland. The law requires that small group market premiums be based on a community rate established using a rating methodology based on “the experience of all risks covered by that health benefit plan.” (Under ACA, carriers will be required to establish a community rate at the market segment level.) The community rate may be adjusted only on the basis of age, geography, family composition (as approved by the Commissioner), and, under very limited circumstances,⁴ health status. Age and geography adjustments can justify a rate up to 50 percent above or below the community rate. When an adjustment for health status is permitted, the community rate may be additionally adjusted up to 10 percent in the first year of enrollment, 5 percent in the second, and 2 percent in the third, with no health status adjustment permitted thereafter (Insurance Article §15-1205(f)).

Reporting Requirements/Medical Loss Ratio (MLR)

Each Maryland insurer, nonprofit health service plan, HMO, and Medicaid managed care organization (MCO) is required to submit an annual report to the Commissioner on or before March 1 of each year.⁵ For each health benefit plan specific to Maryland, data provided must include: premiums written, premiums earned, total amount of incurred claims, total amount of incurred expenses, loss ratio, and expense ratio. These data must be reported by product delivery system for small employer plans, and in the aggregate for individual plans and MCOs (Insurance Article, §15-605). Annual statements must be prepared in accordance with the Annual Statement Instructions and Accounting Practices and Procedures Manual adopted by the National Association of Insurance Commissioners (NAIC) (COMAR 31.04.04.01).

Section 15-605 of the Insurance Article authorizes the Commissioner to order an insurer, nonprofit health service plan, or HMO to file new rates if their small employer or individual

³ For purposes of Title 15, subtitle 12 of the Insurance Article: “Carrier” means a person that: (1) offers health benefit plans in the state covering eligible employees of small employers; and (2) is: (i) an authorized insurer that provides health insurance in the state; (ii) a nonprofit health service plan that is licensed to operate in the state; (iii) a health maintenance organization that is licensed to operate in the state; or (iv) any other person or organization that provides health benefit plans subject to state insurance regulation.

⁴ A carrier may adjust the community rate on the basis of health status only with respect to a small employer that has not offered health benefit plan coverage to its employees during the 12 month period prior to the employer’s initial enrollment in the health benefit plan.. Under these circumstances, the adjustment is permitted only in the first three years of the employer’s enrollment (Insurance Article §15-1205(f)).

⁵ With the Commissioner’s approval, an HMO may submit its annual report within 60 days of the close of its fiscal year (COMAR 31.04.04.01A(2)(b)(ii)).



market product has a medical loss ratio (MLR) lower than the statutory benchmark of 75 percent (small employer market) or 60 percent (individual market).⁶ Subject to certain conditions that guide their discretion, capitation rates paid to an MCO that result in a MLR lower than 85 percent may be recovered by the Secretary of the Department of Health and Mental Hygiene, in consultation with the Commissioner.⁷

⁶ Effective January 1, 2011, ACA provisions establish new medical loss ratio benchmarks applicable to issuers of individual, small group, and large group health insurance products (Affordable Care Act §1001, amending §2718 of the Public Health Service Act).

⁷ COMAR 10.09.65.19-5G requires the Secretary to consider the MCO's past performance. If the MCO's MLR for the service year is between 80 and 85 percent *and* "[a]ll of the MCO's scores on the Department's core performance measures are in the top two levels of performance," *or* its MLR averages over 85 percent over the three year period ending in the service year, Section H of the regulation limits the state's recovery in the first or second consecutive years of adjustment to 50 and 75 percent, respectively, of the portion of capitation payments made during the service year that resulted in a loss ratio of less than the required (85 percent) benchmark level. Section I provides the affected MCO a right of appeal.



III. MIA Premium Rate Review Process

Introduction

The Hilltop Institute was provided the opportunity to meet—both in person and by conference call—with MIA’s chief actuary and several of his staff to review MIA’s rate approval processes. Given that CareFirst’s small group market share is more than nine times greater than Maryland’s second largest insurer, and that its individual market share is more than thirty times greater than the second largest insurer, information provided to Hilltop focused on CareFirst’s rate review process.

Data Submission Requirement of Carriers

Hilltop was provided with two complete CareFirst rate filings (one individual and one small group) that were approved in July 2010 with an effective date of October 1, 2010. The filing company for the individual market rate request was CareFirst BlueChoice and the filing company for the small group market rate request was Group Hospitalization and Medical Services, Inc. (better known as “GHMSI”). GHMSI, BlueChoice and CareFirst of Maryland, Inc. all have individual and small group products under CareFirst, Inc.

Both filings are similar in content and format, but there are some variations. The following illustrates the main content of the individual BlueChoice actuarial memorandum and filing.

Actuarial Memorandum Content - (The memorandum must comply with Actuarial Standards of Practice #8, “Regulatory Filings for Health Plan Entities.”)

1. Actuarial certification letter (by CareFirst’s credentialed pricing actuary)
2. Rate filing summary
3. Pricing analyses (by coverage and options)
4. Trend information (medical and prescription drugs)
5. Desired Incurred Claims Ratio Derivation (DICR)
6. Base Rates and Rate History (medical and prescription drugs)
7. History of Renewal Rate Increases (by coverage)
8. Demographic Factors (age, contract type) – in the small group market, geographic region is also a demographic factor
9. Historical medical and prescription drug experience by coverage
10. Rate Comparisons (to prior quarter by product, age and contract type)



Rate Filing Content - 14 Individual coverage & option rate schedules of proposed premium rates by demographics.

Analysis Performed by MIA Staff

The following reflects the main procedures involved in MIA's rate review process.

Generally, one actuary is assigned to a rate filing submission and is responsible for preparing a written summary of the filing. Although one actuary takes ownership, there is a peer review process in place within the actuary's department. There are no external data sources used in the evaluation of the submitted rate filing. If more detailed information is needed than provided in filing, then it is requested from the health plan. It may be provided in the form of raw claim data by month by product line on a per member per month (PMPM) basis. Currently, medical experience is neither requested nor provided by category of service (e.g., inpatient or outpatient hospital, physician, and ancillary). The trends incorporated into the rate filings are also provided as "Total Trend" rather than split between unit cost and utilization since units of service are not reported. To support the completed base period reported by the health plan, a reserving analysis for incurred but not reported (IBNR) claims may be requested. In the case of CareFirst, Hilltop was informed that an independent supplemental report prepared by Milliman consultants is provided to MIA.

Regarding any differences in the rate filing process of carriers other than CareFirst, Hilltop was informed that the main difference was in the level of (less) detail provided to MIA. This seems reasonable given the individual and small group market share of the other carriers. For example, in the individual market, the second largest carrier had about 4,400 lives in 2009 (compared to CareFirst having about 135,000 lives). If those 4,400 lives are then sub-divided into various coverage and option benefit categories, the level of credibility of the data becomes more of a concern than with CareFirst experience.

According to MIA's actuaries, these three areas are the main focus in the review process: 1) assessment of the rate increase, 2) the pricing analysis section, and 3) historical trends.

Assessment of the Rate Increase

Part of the assessment process of a rate increase is evaluating what the projected MLR will be. Maryland law specifies MLRs for health benefit plans delivered or issued for delivery in Maryland for the individual (60 percent) and small group (75 percent) markets. When MLRs fall short of these minimums, the Commissioner has the authority to order the responsible insurer,



nonprofit health service plan, or HMO to file new rates (Insurance Article §15-605(c)(1) and (2)).⁸

The current (pre-Affordable Care Act (ACA)) definition of MLR may be modified, however, effective January 1, 2011. The current definition of MLR, as developed by the NAIC, is incurred claims experience divided by earned premium revenue. Under the ACA, the MLR requirement will increase to 80 percent for both individual and small group products. Under The ACA, the numerator will be expanded to include “quality improvements,” or some portion of a health plan’s non-medical expenses designed to improve health care quality and desired health outcomes. Also, the denominator (revenue) will be reduced for taxes and fees. Given these modifications to the MLR definition, it may be possible that a 75 percent MLR under the old definition for small group products may be about the same as an 80 percent MLR under the new ACA definition. However, in the individual market, raising the minimum MLR from 60 percent to 80 percent may be challenging for carriers because the administrative loads on individual products generally are higher than on small group products.

Also new under the ACA is the implementation of rebates for premium rates when the issuer’s MLR is below the applicable ACA benchmark. It is not clear how those rebates would be dispersed. One reasonable possibility would be that future rates would reflect (would be reduced) the rebate impact, with the exception of individuals in small group plans who leave their employer; these individuals would likely receive a direct rebate.

In addition to the projected MLR built into the rate proposal, each year the health plan must provide MIA with three years of claims experience by market segment for review. Plans whose historical three-year average MLRs are below the minimum are subject to action by the Commissioner, who has the authority to require a health plan to reduce its proposed future rates. In essence, the combination of both the new (higher) minimum MLRs and the introduction of rebates will create a retrospective payment review process to help protect both individuals and employers from excessive rates.

One other parameter in the assessment of the rate increase is MIA’s use of a rate cap for CareFirst. As discussed with MIA’s Chief Actuary, prior to 2009, the cap on a rate filing was 20 percent. During 2009, the cap was increased to 24 percent. It is possible for a rate filing to be approved above the cap; however, the process is likely to take longer because additional justification may be needed for such a large increase.

⁸ Similarly, a Medicaid managed care organization (MCO) is required to maintain a medical loss ratio of 85 percent. If it is determined that an MCO has a lower loss ratio, the Secretary of the Department of Health and Mental Hygiene, in consultation with the Commissioner, may adjust the MCO’s capitation rates (§15-605(c)(5)).



Pricing Analysis Section

The pricing analysis section of the rate filing provides the reviewing MIA actuary with the technical analysis of the completed base period trended forward to the projected effective date by coverage and option. This is achieved by incorporating the targeted MLR (also known as the “desired incurred claims ratio derivation”) as well as targeted non-medical expense loads (administrative costs, broker commissions, taxes, contribution to surplus, etc.) to determine the rate needed to cover all expenses and contribute to reserves. The rate proposed by the carrier may be entirely different from the calculated rate. In one of the CareFirst filings Hilltop reviewed, the overall calculated rate was a double-digit increase; the overall rate proposed, however, was negative (i.e., a rate reduction). Given the size of CareFirst in Maryland and all its various product lines, it is possible that maintaining or continued growing of market share for the population may be of more strategic importance at this time than profitability for these specific products.

Historical Trends

Hilltop was provided with three years of historical claims experience broken down by CareFirst entity, small and individual market, and consumer-driven health (CDH) vs. non-CDH plans. Key in these reports is the actual MLRs, the desired or targeted MLR, and the rating trend applied to the associated base period. The average annual rating trends applied for medical services over the last three years in the individual and small group market have ranged from 8 percent to 13 percent. Compared to medical rating trends used in Medicaid managed care (described later), 8 percent to 13 percent trends seem high. However, according to PricewaterhouseCoopers’ Health Research Institute, medical cost trends assumed in setting premiums for health plans are expected to decrease from 9.5 percent in 2010 to 9 percent in 2011.⁹ Even with this level of applied trend, several of the CDH (high deductible) products currently remain unprofitable for CareFirst.

In addition to historical claims experience, Hilltop was also given historical rate increase information broken down by CareFirst entity, small and individual market, and CDH vs. non-CDH plans. Consistent with the claims experience, many of the rate renewals on CDH products have been running at the 24 percent cap on rates, although one CareFirst entity proposed a rate cut on its individual CDH products even though trend calculations indicated it needed a 46 percent rate increase to achieve the desired MLR.

⁹ PricewaterhouseCoopers’ Health Research Institute. (2010, June). Behind the numbers, medical cost trends for 2011 (an in-depth discussion).



Future Rate Filings – Additional Focus

MIA’s dual regulatory role—responsible both for review and approval of carriers’ rate filings and for monitoring carriers’ financial solvency—is a double-edged sword. The higher the approved rate increase, the higher the cost to consumers. The lower the rate increase, the smaller contribution to reserves, which in turn reduces solvency. In the past, MIA did not review CareFirst’s risk-based capital (RBC) ratio as part of the rate review process. Henceforth, it will. The RBC ratio reflects the entity’s surplus as a percentage of risk-based capital-authorized control level (RBC-ACL) and is footnoted on the filing summary page of the actuarial memorandum. The RBC-ACL is an insurer’s theoretical level of capital and surplus that should be maintained. From 2005 to 2009, GHMSI has maintained an RBC ratio of between 845 percent (2008) and 955 percent (2006), with the most recent calculation (2009) being 902 percent. To put this in perspective, the Blue Cross Blue Shield Association will monitor plans at the 375 percent level. Plans risk losing their trademark with an RBC of 200 percent.¹⁰ CareFirst’s consultants recommended an optimum RBC range of 750-1050 percent for GHMSI. MIA’s consultants adopted a range of 700-950 percent for GHMSI.¹¹ This is significant: if, in the future, GHMSI falls below its targeted RBC range, it may be required to build an additional contingency factor into its pricing methodology. Likewise, if the plan’s RBC increases above the range, future rate increases may not be approved until surplus has been reduced to targeted levels.

Required Timeframes and Steps in the Review Process

With regard to the two CareFirst filings provided, it is worth noting that the frequency of the filings submitted by CareFirst appears to have increased over the last five years compared to the prior five years. In recent years, filings appear to be submitted quarterly without fail. Early in the last decade, BlueChoice filings were submitted more on a semi-annual or annual basis and GHMSI filing submissions were more likely to be semi-annual. This would have the effect of additional administrative burden on these two specific filings in recent years. Also, the approval process appears to involve a lot of back and forth between the carrier and MIA. For example, the BlueChoice filing with an effective date of October 1, 2010, was revised five times before being approved. (The first submission occurred on 6/15/10; approval was received on 7/29/10.)

Currently, the MIA considers no portion of the rate filing as public information. Hilltop initially estimates that currently only about 25 percent of states make rate filing information public. Part of the federal initiative is to have full public disclosure in all states. Hilltop confirmed in discussions with MIA that it does not currently have in place a process for public comment and/or hearings. With regard to consumer complaints, the Life & Health unit at MIA has a

¹⁰ Milliman. (2008, December 4). CareFirst, Inc., Group Hospitalization and Medical Services, Inc. *Need for statutory surplus and development of optimal surplus target range (minimum capital thresholds)*.

¹¹ Maryland Insurance Administration. (2010, January). *Report on CareFirst premiums and surplus (surplus review)*.



complaint department. Hilltop also confirmed that the disapproval of a rate filing submitted by CareFirst, because it is a nonprofit health service plan, would give rise to rights of hearing and judicial appeal. Disapproval of for-profit insurers' or HMOs' rate filings are not subject to hearing or appeal.¹² these filers must correct any deficiencies in their filings to obtain approval before the rates may be used.

¹² Rate filing disapproval is considered a quasi-legislative function rather than a “contested case” that would trigger a right to judicial review under Maryland’s Administrative Procedure Act. See COMAR 31.02.01.02. However, the General Assembly, by Insurance Article §14-126, has required the Commissioner to hold a hearing before issuing an order that a nonprofit health service plan’s filing is noncompliant, and §14-127 makes the Commissioner’s final decision after the hearing subject to judicial review.



IV. Review of Other States' Premium Rate Review Processes

The rate review process is not uniform across the states. Both the actual review activities and the regulatory oversight responsibility vary widely. Some states have the authority to disapprove rates or rate increases, while other states review rates and the justification, but do not have disapproval power. Other states may not review rates at all, and although some states have no regulation of comprehensive medical rates, they may track and/or publish the rates or rate increases in the state.

Information in this analysis of other states' rate review process was gathered from National Association of Insurance Commissioners' (NAIC's) publications, personal contacts with state health insurance commissioners and staff, and public information produced by the state. The states selected for the analysis included some states recommended by the Maryland Insurance Administration and others chosen based on geographical distribution and diversity of approaches.

Appendix A includes the detailed information for the following states summarized in Table 1.

Table 1. Rate Review Requirements by State

Rate Review Requirements	Arizona	Maine	Massachusetts	Oregon	Rhode Island
SERFF Mandate		X	X		X
Actuarial Certification Required	X	X	X	X	X
Premiums, Claims, Trend History Required	X	X	X	X	X
Prior Approval of Rates	X	X	X	X	X
Use of Rating Bands		X	X	X	X
Mandatory Loss Ratio Requirement	X	X			
Public Comment Option		X		X	X
Rate filings are Public Information	X	X	X	X	X



V. Public Disclosure of the Rate Review Process

As health insurance rates continue to rise, the public desires more information on how and why premiums are increasing. Across the country, states vary on the public disclosure of their rate review process and information about health insurance companies. In some states, the public can easily find information about rate changes on a state's website, while in other states, that information is not published. Table 2 displays a "Public Disclosure Matrix" which shows factors regarding rate review and health insurers that are listed on a state's website. The following is a brief description of each factor listed in the Public Disclosure Matrix:

- *Summary of State's Rate Review Process* - Some states provide a description of their rate review process to inform the public of the steps the state takes after a health insurer submits a rate filing. For example, Oregon lists the type of rate filings reviewed and the factors considered when reviewing a rate filing, such as an insurer's surplus and quality improvement activities.
- *Health Insurance Rate Filings* - States may post the actual rate filing from a health insurer on its web site for the public to view.
- *Rate Filing Decisions* - States may post their decisions regarding a health insurance company's rate filing on their website. For example, Rhode Island lists the rate change a company requests, the rate change that Rhode Island approved, and the reasons for the state's decision.
- *Review of Rate Filing by External Group* - Some states collaborate with an external group to review health insurance rates. Axene Health Partners (AHP), a health consulting group, reviews California's individual health insurance rate filings, and California posts AHP's analysis on its website.
- *Number of People Enrolled by Insurer* - States can list the number of enrollees in a health insurance plan.
- *Premiums Collected* - States may disclose the dollar amount of premiums collected by health insurers from policyholders.
- *Average Premium Per Member Per Month* - States can post on their website the average premium per member per month collected by a health insurance company. Average premium per member per month is calculated by dividing the total amount of money in premiums by the number of member months.
- *Net Income* - To describe an insurance company's profitability, states can use net income, which equals total revenues minus expenses.
- *Surplus Level* - Surplus level is the amount by which an insurer's assets exceed its liabilities.



- *Medical Loss Ratio* - Medical loss ratio is the percentage of premiums collected by a health insurance company that is used to pay for health care claims.
- *Administrative Expenses* - Administrative expenses are the costs incurred by insurers other than health care claims. These costs include salaries, benefits, office space and supplies, advertising and marketing expenses, and so on.
- *Claims Expenses* - Claims expenses is the amount of money insurers paid to hospitals and providers for health care services received by their policyholders.
- *Underwriting Gain/Loss* - Underwriting gain or loss is the amount of premium dollars remaining after administrative and claims expenses are paid.
- *Net Investment Gain* - Net investment gain is the profits earned from invested assets minus the costs associated with investments.
- *Market Share* - Market share is the percentage of total insurance premiums paid to a given health insurer. For example, Oregon lists on its website that Regence BlueCross BlueShield collected 40 percent of all premiums paid in 2008 for individual health insurance coverage issued in the state.
- *Financial Documents about Insurer* - Some states will make publicly available an insurer's financial documents, such as specific information about expenses and revenues.
- *Satisfaction Ratings* - States can post an insurer's satisfaction ratings by policyholders on its website to allow the public to compare plans.
- *Number of Complaints Against insurer*- The number of complaints received from an insurer's policyholders can be disclosed.
- *Quality and Access Measures* - States can list various quality and access measures for health insurance companies. For example, Rhode Island provides information, such as the percentage of members with childhood immunizations and the percentage of members with prenatal care access, to the public.
- *Information about Health Care Cost Trends* - To help the public understand why an insurer may ask for a rate change, some states post information about health care cost trends to help explain how and why health insurance costs are rising.

Public Input on Rate Reviews

The solicitation of public comments regarding rate reviews is area of concern. Some states openly accept and consider comments from the public regarding insurance rate changes, while other states do not. Table 3 is a "Public Input Matrix" that describes how states accept public comments.



The following is a brief description of each factor listed in the Public Input Matrix:

- *Public Hearings/Meetings* - States may hold public hearings or meetings to discuss an insurer's rate filing.
- *Public Comments Accepted* - States can accept comments from the public regarding an insurer's rate filing.
- *Public Comments Accepted within Certain Time Frame* - Some states accept comments from the public regarding an insurer's rate filing, but only if the comments are submitted within a time frame, for instance, 30 days after a rate filing has been posted on the Internet.
- *Public Comments Posted on the Internet* - A state can choose to post the public comments received on its website.
- *E-mail Notifications Sent to Public* - Some states send an e-mail notification to the public when an insurance company has submitted a rate filing.
- *Public Can Review Rate Filings Only at Insurance Office* - States that do not post rate filings on their websites may allow the public to review a rate filing in-person at the state's insurance office.



Table 2. Public Disclosure Matrix

Rate Review and Health Insurance Company Factors Listed on State Insurance Agency Website	State										
	AZ ¹³	CA ¹⁴	ME ¹⁵	MD ¹⁶	MA ¹⁷	MN ¹⁸	NY ¹⁹	OR ²⁰	PA ²¹	RI ²²	VA ²³
Summary of state's rate review process					X			X		X	X
Health insurance rate filings		X						X	X	X	
Rate filing decisions		X	X					X		X	
Review of rate filing by external group		X									
Number of people enrolled by insurer	X		X				X	X		X	X
Premiums collected (amount of money)	X	X	X	X		X	X	X		X	X
Average premium per member per month			X				X	X		X	
Net Income		X	X	X		X	X	X		X	X
Surplus level	X	X		X		X	X	X		X	X
Medical loss ratio				X	X	X		X		X	
Administrative expenses		X	X	X		X	X	X		X	
Claims expenses		X	X	X		X	X			X	X
Underwriting gain/loss		X	X	X		X	X	X			
Net investment gain		X		X		X	X	X			X
Market share	X			X				X		X	X
Financial documents about insurer		X		X		X	X	X			X
Satisfaction ratings							X			X	
Number of complaints against insurer	X	X	X	X			X	X			
Quality & Access measures (e.g. breast cancer screenings, well-child visits)							X			X	
Information about health care cost trends					X			X		X	

¹³ Arizona Department of Insurance. (2010). Retrieved November 2010, from <http://www.id.state.az.us/index.html>

¹⁴ California Department of Insurance. (2010). Retrieved November 2010, from <http://www.insurance.ca.gov/>

¹⁵ Maine Bureau of Insurance. (2010, October 20). Retrieved November 2010, from <http://www.maine.gov/pfr/insurance/>

¹⁶ Maryland Insurance Administration. (2010). Retrieved November 2010, from <http://www.mdinsurance.state.md.us/>

¹⁷ Massachusetts Division of Insurance. (2010). Retrieved November 2010, from

<http://www.mass.gov/?pageID=ocasubtopic&L=4&L0=Home&L1=Consumer&L2=Insurance&L3=Health+Insurance&sid=Eoca>

¹⁸ Minnesota Department of Commerce Insurance Gateway. (2008). Retrieved November 2010, from

<http://www.state.mn.us/portal/mn/jsp/home.do?agency=Insurance>

¹⁹ New York State Insurance Department. (2010). Retrieved November 2010, from <http://www.ins.state.ny.us/>

²⁰ Oregon Insurance Division. (2010). Retrieved November 2010, from <http://www.insurance.oregon.gov/>

²¹ Pennsylvania Insurance Department. (2010). Retrieved November 2010,

http://www.insurance.pa.gov/portal/server.pt/community/insurance_department/4679

²² Office of the Health Insurance Commissioner. (2010). Retrieved November 2010, from <http://www.ohic.ri.gov>

²³ Virginia Bureau of Insurance. (2010) Retrieved November 2010, from <http://www.scc.virginia.gov/division/boi/>



Table 3. Public Input Matrix

Public Input Factors Regarding Rate Reviews	State										
	AZ	CA	ME	MD	MA	MN	NY	OR	PA	RI	VA
Public hearings			X							X	
Written public comments accepted		X	X				X	X	X	X	
Written public comments only accepted within certain time frame		X	X				X	X	X	X	
Public comments posted on the Internet							X	X		X	
E-mail notifications sent to public								X			
Public can review rate filings only at Insurance Office											X

See Appendix B for detailed notes regarding these matrices.



VI. Review of Maryland HealthChoice Rate Review Process

Introduction

This review and analysis of the Maryland rate setting process for the HealthChoice program is intended to illustrate the interagency use of medical trend data and to provide an overview of the data tools, reporting requirements, and analytic methods used to establish adequate, efficient, and actuarially approved rates for Managed Care Organizations which receive capitation payments totaling almost \$3 billion dollars annually. The MIA rate review process has a different purpose, i.e., to ensure that carriers charge a fair and reasonable premium. This difference in purpose precludes any oversimplified transposition of methods or techniques.

Fiscal Year (FY) 2011 marks the fourteenth year that the Maryland HealthChoice program has been in operation. The HealthChoice program is Maryland's under 65 acute Medicaid managed care program that provides coverage to more than three-quarters of all Maryland Medicaid recipients. Populations covered under HealthChoice are: people with disabilities, HIV and/or AIDS, pregnant women, low income adults and children including the MCHP program, and, beginning in FY 2009, includes an adult expansion.

There are currently seven MCOs managing medical care for close to 700,000 members. HealthChoice is a "full risk" capitated managed care program, meaning the MCOs assume the financial risk of providing the program's covered benefits to their enrollees for a predetermined capitation payment. The HealthChoice program requires that recipients in all counties of the state have a "choice" of MCOs.

The HealthChoice Rate Review Process

Given the size of the program, not just in the number of Medicaid recipients enrolled in HealthChoice but also in budgeted dollars (capitation payments of \$2.8 billion in total funds for FY 2011), the HealthChoice rate review is an intense, collaborative year-round process. The process begins with the submission from each MCO of their experience starting in late November and finishes with DHMH receiving written confirmation from CMS that the actuarially certified rates have been accepted, usually about one year later.

One of the keys to the success of the HealthChoice rate setting process has been the annual building of an efficient rate base to contain cost, rather than just setting "cost plus" rates. The following is provided to illustrate the process of building the HealthChoice rate base used for rates to be implemented January 1, 2011.



A. MCO submission of HFMR for services provided during 2008 (preliminary report provided May of 2009, final report was submitted in November of 2009)

The HealthChoice Financial Monitoring Report (HFMR) provides the state with an enhanced Medicaid managed care encounter database. It provides detailed revenue, utilization, and cost information incurred by major categories of services of each MCO by region and rate cell. It reflects a full calendar year's worth of utilization and cost data that has been restated to reflect only the revenue and medical expenses for a specific incurred (service) year. Each MCO incorporates data from their claims processing systems in developing its paid medical expenses as well as the costs associated with sub-capitated arrangements.

B. Reconciliation Process of MCO Submission (provided with HFMR)

To supplement the Medicaid managed care database, MCOs are required to submit additional financial data reports. These supplemental reports enhance the HFMR report in the following manner:

Provides assistance in reconciling the HFMR report to the MCO's Maryland Insurance Administration (MIA) filings. Since the HFMR reflects restated (calendar year) results and the MIA filings are submitted on a reported basis (which includes prior period adjustments), it is important that a financial tool be incorporated that captures data on an incurred and paid basis.

Provides administrative expense information not included in the encounter data. During the annual independent review, administrative expenses are reviewed and inappropriate expenses are disallowed as eligible HealthChoice expenses.

C. Independent Review Process (November of 2009 – May 2010)

The final HFMR reports are independently reviewed (currently by the auditing firm of Myers & Stauffer) once a year as part of the validation process. This validation process (including test procedures) relates to the actual sources of the data such as Medicaid claims, revenue, and eligibility data. As of result of these reviews, millions in MCO reported expenses are reduced, mainly in administrative expenses. This review process adds credibility to the overall rate setting process. It also provides the state with an unbiased evaluation of each MCO's financial performance.

D. Independent Claim Reserve Review (November of 2009 – May 2010)

Estimated unpaid medical expenses are also incorporated into the reports, as required by CMS. Due to the significant lag factor (nine months in the final MCO submission) of the independently reviewed data, estimated unpaid medical claims reflect a very small percentage of total medical expense. However, a separate independent actuarial review of the unreported component of unpaid medical expenses is also provided by the state.



E. Third-Party Liability (TPL) Adjustment to the base (April 2010)

The state targets TPL benchmarks annually (adjusted for trend and enrollment growth) that MCOs are expected to achieve. A TPL target was developed based on bringing all deficient MCOs' TPL levels up to 97 percent of the overall mean TPL (on a PMPM basis). Over recent years the MCOs have significantly improved in this area and thereby avoided additional reductions to the base.

F. MCO Outlier (Efficiency) Adjustment (May 2010)

This adjustment to the base was implemented into the rate setting process about three years ago. The calculation compares the independently reviewed financials' combined (medical and administrative) ratios of each MCO against the mean combined ratio plus two additional points. The base is reduced for the differences of any MCOs with combined ratios above this target times the MCO's net revenues. Medicaid managed care programs in other neighboring states have adopted similar adjustments in their rate setting processes. Some of the advantages to this form of outlier adjustment are that the ratio-based results are already normalized and the only subjectivity in the calculation is where to set the target.

G. Adjustment to Reduce the Non-Medical Expense Load (July 2010)

Given the continued strong rate of growth in the HealthChoice program during the last two years, it is important to recognize that part of the MCOs cost structure is fixed (regardless of the size of the MCO) and that these growth periods present an opportunity to lower the administrative loads in developing rates.

H. Restated Profit Load (July 2010)

Part of the HealthChoice rate setting methodology is to build a modest profit margin into the rates. Since the rates are "re-based" annually, the profit load incorporated into the rates is generally smaller than the base year's margin. Therefore, each year the MCOs have to "achieve" new profits.

I. Evaluation of Provider-Sponsored MCOs (PSOs - part of annual review)

Several of the MCOs participating in HealthChoice are either owned or have very strong ties to large hospital systems in Maryland. Given these relationships to hospitals, the financial performance of these particular MCOs is closely monitored by the HSCRC and PSOs need their approval to participate in HealthChoice. Requiring PSOs to remain profitable helps to contain over-use of higher cost facility settings as well as keep in check higher payments to their hospital affiliated physician groups.



J. Testing of MCOs' MLR

COMAR 10.09.65.19-5 authorizes the state's retrospective recovery of a portion of capitation payments made to an MCO in a given reporting year if its MLR results are consistently below the benchmark prescribed by regulation.²⁴ It can be argued that the regulation should be revised to reduce its contingencies.²⁵ The current language defines the MLR benchmark as 85 percent. It is important to note, however, that the methodology used for calculating MLR for HealthChoice Medicaid MCOs (or for the Medicaid product of a commercial HMO) differs from the standard practice of defining MLR as claims expense divided by earned premiums. The components of the numerator in the HealthChoice MLR calculation include claims expense, and *also* the expense of providing medical management. This results in a higher MLR than would be the case using the standard methodology. The difference is significant: MCOs' reported expenses associated with medical management represent approximately two percent of their earned revenue. The MLR methodology for HealthChoice defines²⁶ medical management services to include case management, disease management, outreach, quality management, and utilization management.

HealthChoice Rating Trends: Although actuaries like to make the disclaimer that “trends do not equal rate increases,” trends are usually the major contributing factor (from a technical perspective) in determining a rate increase, regardless of insurance model. For HealthChoice, the final rating trends incorporated into the rate development process reflect both a quantitative and qualitative process.

With regard to the quantitative process, the resources available to the actuaries include HealthChoice encounter and financial experience, as well as Maryland hospital data from the HSCRC specifically focusing on HealthChoice MCOs. On the qualitative side, the actuary will have their own internal trend information which can be from neighboring states as well as various public sources (CPI information from the Bureau of Labor Statistics, CMS expenditures per enrollee, etc.). For hospital unit cost projections, the HealthChoice actuaries rely heavily on the expertise of the HSCRC staff. Besides their warehousing of the Maryland hospital payment database, their ability to quantify the impact of the HSCRC regulatory activity as well as other program activities on hospital charges (especially Medicaid) is invaluable to the trend development portion of the HealthChoice rate setting process.

To observe the correlation between the rating trends incorporated and the rate increase implemented in HealthChoice, the following table illustrates this relationship for the last five years.

²⁴ See COMAR 10.09.65.19-5

²⁵ Some of these contingencies are explained in note 7, above.

²⁶ The definition is found in reporting instructions applicable to HealthChoice Financial Monitoring Reports (HFMRs) that MCOs must employ in preparing annual reports for submission to DHMH. COMAR 10.09.65.15E(5).



Table 4. Comparison of HealthChoice Rating Trends to January Rate Increases

Calendar Payment Year	Average annualized 36 month rating Trends	January Rate Increase
2007	6.6%	5.2%
2008	5.9%	4.4%*
2009	5.3%	4.3%
2010	4.5%	5.3%
2011	5.1%	4.4%

*Actual increase of 6.7% was reduced to account for HIV/AIDS Rx carve out.

The effect of co-pays and deductibles on rating trends of commercial insurers is significant. In contrast, with HealthChoice cost sharing limited to nominal pharmacy copayments,²⁷ the relatively low rating trends incorporated into the HealthChoice rates are basically immune to this issue, unlike on the commercial side. A simple but effective way to look at the effect of cost sharing on trend is illustrated in the table below.

**Table 5. Cost Sharing Example and Its Impact on Commercial Trends
\$500 Claim in Year 1 and 5% Inflation Year 1 to Year 2**

Deductible (Insured Pays)	Copay (Insured Pays)	Deduct. & Copay (Insured Pays)	Insurer Pays (Year 1)	Insurer Pays (Year 2) Trends	Year 1 to Year 2 change in Insurer's Costs
HealthChoice					
\$0	\$0	\$0	\$500	\$525	5.0%
Commercial	Insurer				
\$100	\$15	\$115	\$385	\$410	6.5%
\$100	\$50	\$150	\$350	\$375	7.1%
\$200	\$15	\$215	\$285	\$310	8.8%
\$200	\$50	\$250	\$250	\$275	10.0%

Given that both the Maryland hospital (HSCRC) and Medicaid MCO experience exclude the effects of cost sharing, the use of HSCRC data in HealthChoice analysis is strongly applicable. Commercial rate setting experience excludes the insured's out of pocket share of the costs and

²⁷ The HealthChoice program permits no copays or other forms of cost sharing to be charged except that non-pregnant, non-institutionalized adult enrollees may be charged a copay for prescription drugs other than for family planning (\$3 for brand name drugs, \$1 for generics) (COMAR 10.09.67.01D).



therefore HSCRC data will not validate commercial experience as well as Medicaid MCO experience, especially trend analysis. As discussed earlier, the very high deductible CDH products are very susceptible to this effect. Also, current HSCRC data only identifies the commercial carrier (GHMSI, BlueChoice, etc.). There are no indicators on the data to identify lines of business within a carrier (individual, small group, large group, etc.) much less various products and options.

HealthChoice Mid-Year Rate Adjustments: Although the MCOs are fully at risk to provide the contracted medical care at the agreed to capitated payment levels, there are several service areas that MCOs have no control over and the capitation rates need to be adjusted (either higher or lower) to reflect those changes. Those changes in services include the carving in or out benefit coverage, increasing or lowering of Medicaid provider fees, and HSCRC updates in the statewide inpatient hospital charge per case or changes in the statewide outpatient rate update factor. Any of these changes can trigger a retrospective review of the original calendar year rates implemented.

Use of Health-Based Risk Adjustment: Excluding the pregnant women program (a little over one percent of HealthChoice membership), all rate cells in the HealthChoice program are risk adjusted in some manner. Because the demographics of each MCO are unique, the application of health-based risk adjustment is needed to fairly compensate each MCO and maintain financial stability of the program. The following illustrates the various type of health-based risk adjustment implemented in the HealthChoice program.

Diagnosis-Based Risk Adjustment: Excluding pregnant women and members who are HIV positive, individuals with 6 months or more of HealthChoice experience within a calendar year are assigned to a diagnosis-based risk adjusted rate cell for the payment period two year after the assignment period.

HIV-Positive Recipients: Individuals verified by the AIDS Administration as HIV positive (populations sub-divided among those diagnosed and not diagnosed with AIDS) are further identified (flagged) as also having Hepatitis C. For payment purposes, budget neutral MCO level risk scores are determined for this population.

Delivery Events and the Under 1 Population: Delivery (“kick”) payments and under-one capitation payments are risk adjusted based on the birth weight of the infant (normal vs. 1,500 grams and under).

Age/Gender Rates for Ages 1-64 (Generally New Enrollees): Individuals not falling into one of the above categories are risk-adjusted by MCO based on the type of new enrollees particular MCOs tend to attract (healthier vs. sicker than average). These rates are implemented on a budget neutral basis.



Use of Incentives to Strengthen Program: As discussed earlier, the HealthChoice program requires recipients to have a “choice” of MCOs in all counties of the state. When the former CareFirst HMO, FreeState, exited the HealthChoice program in March of 2001, the program was left with only one statewide MCO. This threatened to reduce HealthChoice to a regional rather than a statewide program. To rectify this situation, an incentive (about 0.6 percent of total MCO capitation) was created to encourage MCOs to set up provider networks throughout Maryland. The incentive worked as three additional MCOs achieved statewide status. Unfortunately, over time state budget pressures have eroded the incentive (now less than 0.2 percent of total MCO capitation) and as of September 2010, there are only two statewide MCOs.

Actuarial Soundness and Certification of HealthChoice Rates: The end product of the HealthChoice rate development process is the actuaries providing a *range* of actuarially sound rates. The actuaries certifying the rates are members of the American Academy of Actuaries and must meet the qualification standards to certify the rate range. The implementation of certifying a range of rates has worked well for both state Medicaid programs as well as MCOs. Given the budget crisis facing many states in recent years, the lower bound of the rate range has actually protected the MCOs from unlimited budget cuts by states.

Financial Stability and Solvency of HealthChoice MCOs: The initial years of the HealthChoice program saw a lot of instability of MCOs (exiting of First American Health, FreeState, Prime Health, the purchase of the Prudential’s book of business by Amerigroup, etc.). However, since the spring of 2001, no additional MCOs have left the program and one MCO (Coventry) has been added. From 2000 to 2008, underwriting margins for the program have ranged annually from flat to just under four percent. It is anticipated that for 2009 the program will report its first underwriting loss but will recover in 2010 based on recent MCO projections.



VII. Conclusion and Recommendations

In any consideration of the premium rate review process exercised by MIA either currently or in the future, it is important to consider two realities:

- Maryland small group and individual market is dominated by one insurer: CareFirst
- MIA is undergoing a major analysis of its rate review and public disclosure processes and is committed to the adoption of significant changes in view of Health Reform/ACA expectations

Premium Rate Review and Approval

The market dominance of CareFirst creates unique challenges, and along with other factors, has helped shape MIA's regulatory policies and practices especially in the following areas:

Solvency: The importance of guaranteeing continued viability while also protecting consumers from excessive or unreasonable rates and rate increases is of paramount importance in a single carrier dominated market. Directly associated with the solvency responsibility is the regulation of acceptable levels of *risk based capital* surplus by the single dominate carrier.

Collaborative Process: The MIA employs an iterative collaborative process with the carrier when it is determined that the initial premium rate application submission is excessive or unreasonable. The process is completed when there is a final agreement on proposed rates.

Public Input: There is currently no process in place for MIA to notify the public of a proposed rate increase or receive public input as it reviews a premium rate increase request.

The rate analysis conducted by MIA currently will change with the enactment of the ACA and the various federal regulations under development that will guide the implementation of the ACA. The change areas that will require significant modification by the MIA include:

MLRs: New guidelines adopted by the NAIC will have the effect of modifying the calculation of the MLR and this may result in an increase in the actual MLRs in Maryland's individual and small group markets..

MLR's Inclusion of Quality Improvements: The ACA allows the medical expense to include certain quality improvements that will allow the MIA to guide and direct insurance carriers in this area should it choose to do so. However, the MIA has noted that it currently lacks statutory authority to compel a carrier to embark on specified cost containment activities and lacks the resources to take on this task.



Reliance on Data and Certifications Submitted by Carrier: The MIA does not currently use external data sources in evaluating a rate filing. The RFP issued by MIA specifically requests the contractor to “discuss the feasibility and desirability of comparing a carrier’s trend assumptions to publicly available information...from such sources as the HSCRC, the MHCC, etc” (See Section on Regulatory Coordination).

Category of Service Data: Medical experience by category (e.g., inpatient, physician) is not currently requested by MIA in a rate filing. Data at this service level as well as units of service would be necessary in order to conduct analysis and properly assess cost and use trends submitted by the carrier. The category of service data would also be needed to compare with external data held by the HSCRC and other sources. This would likely require new data modification by the external sources as well as the carriers. The RFP issued by MIA specifically requests the contractor to “identify any additional data elements needed for a more detailed review of a request for a proposed premium rate increase by a carrier.”

Public Disclosure/Transparency

It has been previously noted that there is wide variation among the states regarding the level of transparency and availability of the specifics of a carrier’s premium rate filing, actuarial certification, and state insurance agency analysis. Some states make all of these available through a state website and do not allow for the exclusion of “proprietary” information. Some state agencies also include all correspondence between the carrier and the state and the contracted actuary. Maryland is among a minority of states that provide no information on rate filings or approvals via the Internet. The MIA Acting Commissioner has expressed the need to provide more transparency and the MIA has issued an RFP that requests the contractor to advise on how best to notify and inform consumers regarding proposed premium rate increases.

Comprehensive Analysis of Medical Cost Trends and Insurance Premiums: Some state insurance reports provide a broad medical cost/use analysis in order to provide a context for explaining the premium changes.

Comparative Analysis of Plans/Products: Some states provide detailed analysis of premium cost trends by insurance carrier, including MLR findings and administrative expense (executive salaries, company profit/loss, complaints, satisfaction surveys, etc.)

It is important to note that the types of reporting performed in other states as discussed above would likely require additional staffing and oversight by MIA, depending on the level of detail that is made public. Also, the more information made public supporting the rates (e.g., trend information), the more likely that various parties (e.g., consumers and advocates) will use that additional public information to challenge the approved rates (again requiring additional oversight).



Interagency Regulatory Coordination

Interagency coordination efforts could positively contribute to statewide quality initiatives, cost containment activities, and actuarial analyses. However, in order to advance these activities through the rate filing review process, the hospital discharge and outpatient data collected by the HSCRC and MHCC would have to be significantly augmented due to the current inability to match claims with specific market groups and insurance products. Adding these data fields would likely require considerable time and effort. While acknowledging these limitations, there are, nevertheless, reasons for collaboration.

Quality Improvement: As noted earlier, the ACA expressly allows the inclusion of quality improvement activities as medical costs in the formulation of the MLR, affording MIA the opportunity to guide and direct in this area although statutory and resource limitations have been previously identified by MIA as an impediment. With the establishment of quality improvement strategies (e.g., reducing hospital re-admission rates) among commercial insurance payers, Medicare and Medicaid could provide an effective multi-dimensional approach to quality improvement efforts. Establishing quality objectives and measuring the success of such quality improvement initiatives would require collaborative data (e.g., hospital discharge) exchange and analysis between the HSCRC, the Exchange, and MIA.

Development of Medical Cost Trend: As described elsewhere in this report, the HealthChoice rate development and trend analysis is significantly informed by the HSCRC inputs regarding the impact of regulatory activity on hospital charges. For hospital unit cost projections, MIA could likewise engage the HSCRC and possibly MHCC in developing their own actuarial benchmarks for hospital and non-hospital costs. Again, this would require additional coding not currently performed by hospitals and not available in the discharge or outpatient data.

Service Category Comparison: If service category data were provided by carriers in the rate filings (both the units of service as well as cost), then potential target areas for enhanced cost containment activities could be examined and usage among various payers, including governmental insurance programs, could be compared. The lack of statutory authority and resources to compel a carrier to embark on specified cost containment activities has been noted by MIA.

It has been noted that it would be necessary for the HSCRC to collect additional data to effectively examine cost and use trends across lines of business and among products or plans. Additionally, it would be necessary to achieve some comparability regarding cost sharing requirements across carriers and within lines of business in order to properly compare and assess premium rate applications at the disaggregated line of business or product offering. This may become feasible once the essential benefits are defined under the ACA and carriers establish a community rate at the market segment level.



Appendix A. Detailed Rate Review Requirements for States in Table 1

Arizona

Arizona's rate review process is described in the following section.

Use of System for Electronic Rate and Form Filing (SERF)

The System for Electronic Rate and Form Filing (SERFF) is a web-based program where insurance carriers submit rate and form filings. Arizona has not yet made rate filing using SERFF mandatory as of October 2010.

Requirement of Actuarial Certification

The Arizona Department of Insurance (DOI) requires actuarial certification for all individual and small group health insurance rate filings.

Premiums, Claims, Utilization and Other Experience Reporting Requirements

Arizona requires carriers to submit the following information with each rate filing:

- NAIC Transmittal form
- Certification of Qualified Actuary form that states that the rate filing complies with Arizona laws and the requested rates are reasonable compared to the benefits provided
- Five contiguous years of experience data, including current and anticipated loss ratios, number of members, and nationwide and Arizona-specific experience
- Description of the formula used to develop rates and the factors involved
- Actuarial validation of the methodology and assumptions used
- Trend worksheet that displays the calculation of the annual trend using factors such as inflation, utilization, change in medical expenses, and so on
- Rate history (dates of rate changes and the percentage of each change)
- Load factors (age, sex, weight, etc.) that apply to the rate filing and a description of its effect on the rate
- Justification of increases in expense categories, such as administrative, commissions, reserves, and so on
- Rate schedule that shows the amount that will be charged to policyholders



Prospective/Retrospective Rate Review

For the individual health insurance market, Arizona screens rate revisions for completeness. For the small group market, carriers must submit actuarial certification that the rates follow state rating laws. There are no filing requirements for large group carriers or HMOs.²⁸

Rate Review Process

There is a standardized process for the submission of rates and forms that are required to be filed prior to use, and the corresponding review. The review process has two segments: administrative completeness review and substantive review. The DOI determines whether a submission is administratively complete within 15 days after receipt, and informs the filing party of its determination. Next, the DOI completes its substantive review and determines whether to approve or disapprove the filing within 30 days after the filing is considered administratively complete. Arizona law requires benefits to be reasonable compared to the premium charged.

Loss Ratio Requirements

Arizona regulation requires that each rate submission include an actuarial certification of the loss ratio and the method of calculation.²⁹ The minimum loss ratio for the individual health market is 55 percent.³⁰

For both individual and small groups, Arizona follows the NAIC Model for policies with annual premiums of at least \$200. For policies with annual premiums between \$100 and \$200, and with annual premiums less than \$100, the regulation requires the insurer to subtract 5 percent, and 10 percent, respectively from the allowable MLRs.

Analysis Performed by the Arizona Department of Insurance

The DOI produces some reports and publications. One example is the “Report on Arizona Health Insurers” that shows the market share and the number of enrollees, complaints, enforcement actions, and health care appeals for each carrier.³¹

²⁸ HealthCare.gov. (2010). Health Insurance Premium Grants: Detailed State by State Summary of Proposed Activities. Retrieved November 12, 2010, from <http://www.healthcare.gov/news/factsheets/rateschart.html>

²⁹ America’s Health Insurance Plans. (2010, April 15). *State mandatory medical loss ratio (MLR) requirements for comprehensive, major medical coverage: Summary of state laws and regulations*. Washington, DC.

³⁰ HealthCare.gov. (2010). *Health insurance premium grants: Detailed state by state summary of proposed activities*. Retrieved November 14, 2010, from <http://www.healthcare.gov/news/factsheets/rateschart.html>

³¹ Arizona Department of Insurance. (2010). *2007/2008 report on Arizona health insurers*. Retrieved November 11, 2010, from http://www.id.state.az.us/publications/AZ_Health_Insurer_Comparison_print_bw.pdf



Public Comment Opportunity/Public Hearings on Filings

Rate filings and supporting information are open to public inspection after the filing becomes effective.

Maine

Maine's rate review process is described in the following section.

Use of SERFF

Maine has made rate filing using SERFF mandatory since September 12, 2009.

Requirement of Actuarial Certification

The Maine Bureau of Insurance ("Bureau") requires that each rate submission include an actuarial certification of the loss ratio and the method of calculation.

Premiums, Claims, Utilization and Other Experiences Reporting Requirements

The Bureau requires insurers to file the following data annually by market segment:

- The number of people enrolled
- Premiums (dollar amount)
- Claims expenses
- Administrative Expenses
- Underwriting Gain or Loss

Prospective/Retrospective Approval Requirement

Before they can be implemented, the Bureau reviews individual and some small group health insurance rates. Maine law does not require a rate approval for a small group carrier if the carrier agrees to a three-year MLR averaging at least 78 percent.

Rate Review Process

The Bureau must approve individual health insurance rates before they are implemented. Small group rates are reviewed by the Bureau in certain situations. Carriers must have evidence that their rate filings meet the minimum loss ratio standards and are neither too high, too low, nor



unfairly discriminatory. Large group rate filings are submitted to the Bureau for informational purposes.³²

Use of Rating Bands

Health plans are permitted to vary the rates of individuals and small businesses within a 1.5:1 rating band, meaning the premiums charged to the policyholders with the highest risk are not more than 150 percent of the premiums charged to policyholders with the least risk.

Rates cannot vary based on gender, health status/claims experience, and policy duration. Rates are allowed be based on age and geography. Non-smoker discounts are allowed, but must be actuarially justified.

Loss Ratio Requirements

The Bureau requires individual health insurance carriers to have at least a 65 percent loss ratio. Maine law requires small group rates to meet a 75 percent loss ratio. A carrier can avoid a prior rate approval requirement if the carrier guarantees a three-year average MLR of 78 percent. Refunds are required if the carrier does not achieve the 78 percent MLR.

Analysis Performed by the Maine Bureau of Insurance

Studies performed by the staff at the Bureau provide background on both Maine's individual and small group markets, including information about types of policies available, prices, number of insurers, market share, and MLRs, as well as standards and consumer protections under current law. Reports also show the total Maine health insurance premium, by company and by market sector, along with the change from the previous year.³³

Public Comment Opportunity/Public Hearings on Filings

The Bureau requires insurers to notify policyholders with an individual health insurance plan of a rate increase at least 60 days in advance of implementation. Policyholders can request a public hearing regarding the rate increase, although the request may not be granted. If a public hearing is held, comments will be accepted at the hearing. On behalf of consumers, the Maine Attorney General usually partakes in hearings. The public comment period is 40 days (R. Diamond, personal communication, November 1, 2010).

³² HealthCare.gov. (2010). Health Insurance Premium Grants: Detailed State by State Summary of Proposed Activities. Retrieved November 12, 2010, from <http://www.healthcare.gov/news/factsheets/rateschart.html>

³³ Maine Bureau of Insurance. (2010, October 20). Retrieved November 11, 2010, from <http://www.maine.gov/pfr/insurance/>



Number of State Staff/Actuaries Assigned

The Bureau typically uses one actuary to analyze a rate filing. If there is a hearing and other parties are involved, those parties often use their own actuaries (R. Diamond, personal communication, November 1, 2010).

Massachusetts

Massachusetts' rate review process is described in the following section.

Use of SERFF

Massachusetts has made rate filing using SERFF mandatory since January 1, 2009.

Requirement of Actuarial Certification

According to NAIC's Compendium of State Laws on Insurance Topics (02/09), rate filings for small groups is not a requirement with Massachusetts, but actuarial certification is required.

Premiums, Claims, Utilization and Other Experiences Reporting Requirements

Massachusetts requires that each rate submission include the method of calculation and three years of historic claims payment experience and three years of historic utilization experience, shown separately for each year and differentiating among:

- Inpatient Hospital Care
- Outpatient Hospital Care, with separate experience for:
 - Radiological/laboratory/pathology costs; and
 - All other outpatient costs
- Health care provider charges for:
 - Medical and osteopathic physicians
 - Mental health providers
 - All other health care practitioners.
- Supplies
- Outpatient prescription drugs

The trend factors and all non-fee-for-service payments to providers are also required to be shown separately by the above categories.



Prospective/Retrospective Approval Requirement

Individual health insurance rates require prior approval, but rate filings for small groups are not a requirement with the state.

Rate Review Process

Before 2006, individuals were guaranteed coverage under a separate pool. As of 2006, as part of a comprehensive reform package, all residents were required to have adequate health coverage and individuals were merged into the small group market. For individual health insurance policies that were issued before the markets merged, the Massachusetts Division of Insurance (Division) requires prior rate approval.

Use of Rating Bands

Health plans are permitted to vary the rates of individuals and small businesses within a 2:1 rating band, meaning the premiums charged to the policyholders with the highest risk are not more than twice the premiums charged to the policyholders with the lowest risk.

In the individual health insurance market, rates can only vary according to age and geography.

Small group rates may vary based on the following group specific factors:

- Age
- Geography
- Industry
- Family size
- Tobacco use
- Wellness program participation³⁴

Massachusetts allows carriers to vary premiums outside the 2:1 rating band for the following additional factors:

- The size of the group
- The geographic location of the account compared to the base region; and
- The richness of the benefit plan, compared to the base plan.

³⁴ HealthCare.gov. (2010). Health Insurance Premium Grants: Detailed State by State Summary of Proposed Activities. Retrieved November 12, 2010, from <http://www.healthcare.gov/news/factsheets/rateschart.html>



In addition to the above factors, health plans are allowed to apply what is called a rate basis adjustment factor for different tiers, such as single, two adults, one adult and child(ren), and family.

Loss Ratio Requirements

The regulation requires that each rate submission include an actuarial certification of the loss ratio and the method of calculation.³⁵

Analysis Performed by the Massachusetts Division of Health Care Finance and Policy

Since health care cost trend is the most important factor contributing to rate increases, the Massachusetts Division of Health Care Finance and Policy (DHCFP) has published reports that provide information and analysis on health care cost trends and the factors that underlie these trends.

The reports' findings serve as a tool for employers and consumers to better understand the value of the health care services they receive and the impact that their purchasing decisions can have on health trends.³⁶

Public Comment Opportunity/Public Hearings on Filings

The Massachusetts Division of Insurance ("Division") does not hold a scheduled public comment period for rate changes. Rate filings are made public after they are either disapproved or put on file (K. Beagan, personal communication, October 13, 2010).

In October 2009, Governor Deval Patrick directed the Division to schedule informational hearings to examine health premium increases for small businesses and actions that health plans are taking to address costs. During this time, the Division invited each health plan offering products to small businesses to explain their systems and the reasons why they believe costs are rising. The Division also invited Massachusetts hospitals and health care provider trade associations to present comments at several hearings, or to submit written materials, detailing the rising costs from the perspective of the hospital and provider.

The Division examined the information presented in the hearings to develop policy options to be considered for implementation in statutes, benefit designs, or administrative practices to mitigate

³⁵ America's Health Insurance Plans. (15 April, 2010). State Mandatory Medical Loss Ratio (MLR) Requirements for Comprehensive, Major Medical Coverage: Summary of State Laws and Regulations. Washington, DC.

³⁶ Massachusetts Division of Insurance. (2010). Retrieved November 2010, from <http://www.mass.gov/?pageID=ocasubtopic&L=4&L0=Home&L1=Consumer&L2=Insurance&L3=Health+Insurance&sid=Eoca>



the substantial annual increases that have impacted not only the small group market, but the overall Massachusetts health care market.

Number of State Staff/Actuaries Assigned

Massachusetts employs one in-house actuary who reports to the Commissioner of Insurance. Massachusetts relies on external consulting actuaries to review filings on an as-needed basis, depending on the quantity and complexity of the material being reviewed. In their most recent reviews, Massachusetts used two external actuarial firms to assist with the review of filings (K. Beagan, personal communication, October 13, 2010).

Oregon

Oregon's rate review process is described in the following section.

Use of SERFF

Oregon has not yet made rate filing using SERFF mandatory as of October 2010.

Requirement of Actuarial Certification

The Oregon Department of Consumer and Business Services (DCBS), through its Insurance Division, require carriers to submit actuarial certification with a rate filing.

Premiums, Claims, Utilization and Other Experience Reporting Requirements

Before approving a rate change, the DCBS will consider a carrier's history of rate changes, financial strength, actual and estimated claims, premiums, administrative costs, profit, and the cost of medical care and prescription drugs. Carriers are required to submit this information to the Insurance Division to justify their rate request.

Prospective/Retrospective Approval Requirement

DCBS must approve rates for the individual and small group health insurance markets, as well as portability health plans, before the rates are implemented.

Rate Review Process

Health insurance rates in the individual, small group, and portability markets must receive approval by DCBS. Rate filings are disapproved if the filings are considered unjust or unfair, or if the benefits are not reasonable compared to the premium charged.



In order to determine whether an overall rate increase is actuarially justified, DCBS monitors the following factors for each carrier:

- Historical and projected MLR
- Historical and projected trend (the rate of increase in the claims segment of a carrier's MLR due to medical inflation and use)
- Historical and projected administrative costs
- Net income target

For each of the above factors, DCBS actuaries review if the assumptions being made are reasonable and the carrier's past experience, the effect of the rate on policyholders, and the rates used by competitors. DCBS may ask the carrier to submit additional information.³⁷

Use of Rating Bands

In the individual health insurance market, premium rates cannot be based on health status or claims experience, but they can be based on age. Carriers are not allowed to raise rates for an individual more than once per year.

In the small group market, the most expensive rate charged by a carrier can be no more than three times the lowest rate charged. The factors that can be used to set rates include age, wellness program participation, employer contributions, customer loyalty, tobacco use, and projected claims, which is limited to a five percent difference.³⁸

Loss Ratio Requirements

There is no specific MLR requirement, but Oregon regulations require the carrier to state the MLR for that year.³⁹

Analysis Performed by the DCBS' Insurance Division

DCBS publishes an annual report called "Health Insurance in Oregon" which lists data by carrier and by market segment for the last five (more in some cases) years. These data include number of enrollees, premiums earned, MLRs, net income, underwriting gain/loss, and so on.⁴⁰

³⁷ Oregon Insurance Division. (January 2010). Health Insurance in Oregon. Retrieved November 12, 2010, from http://www.insurance.oregon.gov/health_report/3458-health_report-2010-online.pdf

³⁸ Ibid.

³⁹ America's Health Insurance Plans. (15 April, 2010). State Mandatory Medical Loss Ratio (MLR) Requirements for Comprehensive, Major Medical Coverage: Summary of State Laws and Regulations. Washington, DC.



Public Comment Opportunity/Public Hearings on Filings

Oregon has a 30-day public comment period for individuals to submit comments about rate reviews. These comments are posted on the DCBS' website (D. Ball, personal communication, October 27, 2010).

Number of State Staff/Actuaries Assigned

DCBS employs two life and health actuaries. One of these actuaries works on major medical filings, while the other actuary concentrates on other medical filings, such as Medicare supplements, long-term care, disability, and limited benefit plans, as well as annuities and life insurance plans. A third actuary may be hired to assist with the non-major medical filings. As for supporting staff, a staff member helps keep track of the rate filings and conducts a partial evaluation to determine whether the minimum requirements are met. Another staff member analyzes each company's administrative expenses over the past few years (D. Ball, personal communication, October 27, 2010).

Rhode Island

Rhode Island's rate review process is described in the following section.

Use of SERFF

Rhode Island has made rate filing using SERFF mandatory since October 1, 2007.

Requirement of Actuarial Certification

According to NAIC's Compendium of State Laws on Insurance Topics (02/09), Rhode Island requires actuarial certification and prior approval of health insurance rates.

Premiums, Claims, Utilization and Other Experiences Reporting Requirements

The Rhode Island Office of the Health Insurance Commissioner (OHIC) developed rate factor templates that break down insurance premiums into five medical service categories. The five medical service categories are hospital inpatient, hospital outpatient, primary care, pharmacy, and all other medical care. The templates also include estimated administrative costs and profits/surplus. The above experiences are required to be reported for the past three years.

⁴⁰ Oregon Insurance Division. (January 2010). Health Insurance in Oregon. Retrieved November 10, 2010, from http://www.insurance.oregon.gov/health_report/3458-health_report-2010-online.pdf



Using the template, insurers display their estimates for the effects of price and utilization changes in each medical service category. Also, insurers display their estimates for the percentage of the premium that will be used for administrative costs and the percentage that will be used for profits/surplus. In addition, OHIC includes the overall estimated average increase in health insurance premiums in the template. An employer will receive a rate increase different from the average because of changes in employee demographics and utilization experience.⁴¹

Prospective/Retrospective Approval Requirement

According to NAIC's Compendium of State Laws on Insurance Topics (02/09), Rhode Island requires prior approval of health insurance rates.

Rate Review Process

OHIC reviews both small group and large group insurance rates. OHIC will approve, deny, or change the "inflation factors" which insurers use to calculate their insurance rates. OHIC also reviews the insurance plans' rating formulas to confirm that they are fair and are applied.⁴²

OHIC requires that the following documents be included in a rate filing for insurance policies that become effective during the 2011 calendar year:

- Rate factor template for large group and small employer groups, as defined by Rhode Island law
- Actuarial and financial analysis to justify the rate factors requested
- Completed Provider Plan Contracting Survey
- Completed Resources for Health Systems Improvement Survey
- Completed Administrative Costs Survey
- Other materials at the discretion of the applicant, which support its request

After a rate filing is submitted, OHIC does a basic analysis that takes approximately three weeks. Then, the filings and analysis are posted on OHIC's website. Public comments are collected for six weeks and public meetings may be held. During the public comment period, OHIC conducts plan-specific analysis and actuarial investigation. After the public comment period, OHIC makes

⁴¹ Office of the Health Insurance Commissioner. (8 February, 2010). Health Insurer Rate Factor Review – Public Comment Solicitation. Retrieved November 10, 2010 from http://www.ohic.ri.gov/documents/Insurers/Regulatory%20Actions/2010_Rate_factor_review_public_comment/2_Public%20Comment%20Solicitation.pdf

⁴² *Ibid.*



recommendations to the insurer, who has the option of accepting the recommendations or going to a public hearing (C. Koller, personal communication, October 13, 2010).

Use of Rating Bands

In the individual health insurance market, carriers are allowed to vary premiums based on health status, age, and gender.

Loss Ratio Requirements

Actuarial certification is required on the anticipated loss ratio and the method of calculation.

Analysis Performed by the OHIC

OHIC publishes two reports that are posted on their website. The first publication, called “The Health of RI’s Health Insurers”, based on 2008 data, provides objective information on RI’s health insurers’ financial operations. The second report is an annual publication called the “RI Health Plans’ Performance Report”, which examines clinical and satisfaction measures for each health insurance company.⁴³

While comparing the health care cost drivers and the financial measures of the major health insurers, OHIC also compares the experience of Rhode Island health insurers to the regional averages.

Public Comment Opportunity/Public Hearings on Filings

OHIC collects public comments regarding rate filings for about six weeks after OHIC posts a basic analysis of the rate filing on its website. Public hearings may be held (C. Koller, personal communication, October 13, 2010).

Number of State Staff/Actuaries Assigned

The rate review process takes up half of the health insurance commissioner’s time and 0.3 FTE of an actuary. Legal counsel is also used. OHIC anticipates having more non-actuary analytical resources with the rate review (C. Koller, personal communication, October 13, 2010).

⁴³ Office of the Health Insurance Commissioner. (2010). Retrieved November 2010, from <http://www.ohic.ri.gov>



Appendix B. Notes for Tables 2 and 3 (Matrices)

Arizona

Public Disclosure – The factors listed under Arizona can be found using a database on the Arizona Department of Insurance’s (ADOI) website. In this database, the name of an insurance company can be typed in the search engine, resulting in a short profile of the insurer that displays the factors. Also, the factors can be found in ADOI’s reports and publications.

Public Input – Rate filings are considered public records in Arizona. A member of the public can complete a public records request form to view a rate filing or other information about a health insurance company. Public records can be viewed at the ADOI office or Arizona can provide copies of records for a fee.

California

Public Disclosure – Individual health insurance rate filings are posted on the California Department of Insurance’s website, as well as a review note from the Department that states whether the insurer used reasonable assumptions and methods. A review note is not posted for every individual health insurance rate filing. The Department contracts with Axene Health Partners (AHP), a health consulting group, which reviews rate filings for the individual health insurance market. AHP’s analysis is posted on the Department’s website. Also on the Department’s website is a company profile database where the public can search for an insurer and view the insurer’s complaint information and financial documents, which include many of the factors listed in the matrix under California.

Public Input – California allows the public to submit comments about rate filings up to 30 days after the filing date through the Department’s website.

Maine

Public Disclosure – The Maine Bureau of Insurance posts tables and graphs on its website that describe the factors checked under Maine in the matrix.

Public Input – A policyholder must request a public hearing regarding a rate increase. However, the request may not be granted. Also, unless there is a public meeting, only policyholders can send in written comments and not the general public (R. Diamond, personal communication, November 1, 2010). Health insurance rate filings are considered public record, but it is unclear if the public can only view rate filings at the offices of the Bureau.



Maryland

Public Disclosure – The Maryland Insurance Administration (MIA) website has exam reports of some health insurers that operate in Maryland. These exam reports include financial indicators listed in the matrix. MIA also has a report called “Report on the Use of the Medical Loss Ratio” that lists the MLR for Maryland health insurers.

Public Input – The public can view health insurance rate changes, except the small group market, and financial statements of insurers by making an appointment to visit the MIA office. Forms can also be copied and mailed to an individual after a processing fee is paid. On the MIA website, an individual can sign-up to receive e-mail notifications about the life and health insurance industry. However, it is unclear if these notifications are about rate filings and rate approvals or denials.

Massachusetts

Public Disclosure – The Massachusetts Division of Insurance has a report on its website that lists the MLR of insurers operating in the state.

Public Input – Massachusetts does not have a scheduled public comment period. Rate filings are made public only after they are disapproved or put on file (K. Beagan, personal communication, October 13, 2010). It is unclear if the public can only view rate filings at the offices of the Division.

Minnesota

Public Disclosure – The website of the Minnesota Department of Commerce has a report that describes the premiums collected, claims expenses, and MLR of insurers in the individual and small group health insurance markets. In addition, the website had financial statements and exam reports of insurers, which include many of the factors listed on the matrix.

Public Input – It is unclear from the Department’s website if public comments are accepted or how the public can view rate filings.

New York

Public Disclosure – The New York State Insurance Department (NYSID) produces a publication called “New York Consumer Guide to Health Insurers” that lists the number of complaints, satisfaction ratings, and quality and access measures for health insurers. NYSID also has market and financial reports, which contain many of the factors found in the matrix, posted on its website.



Public Input –Individuals can view public records after submitting a request form and paying copying and postage fees. The public can also view public records at the offices of the NYSID. Individuals can submit comments about health insurance rate filings up to 30 days after a notice is posted on the NYSID website, and these comments are published on the website.

Oregon

Public Disclosure – The Oregon Department of Consumer and Business Services (DCBS) publishes an annual report called “Health Insurance in Oregon” that lists profiles and financial indicators of the largest insurers in Oregon. In this report, some of the factors checked in the matrix under Oregon are displayed as percentage of another factor. For example, Oregon shows the underwriting gain/loss as a percentage of premiums earned. DCBS also briefly describes the rate review process and how health care costs are rising, leading to higher insurance premiums. Oregon has a database on the DCBS website where the public can search for an insurance company, and the website will display the rate filings for that company and the decision made by DCBS.

Public Input – Oregon has a 30-day public comment period (D. Ball, personal communication, October 27, 2010). On the DCBS website, an individual can sign-up to receive e-mail notifications when an insurance company submits a rate filing and when DCBS makes a decision about the request.

Pennsylvania

Public Disclosure – The Pennsylvania Department of Insurance posts rate filing documents from insurance companies on its website.

Public Input – Pennsylvania has a 30-day public comment period after a notice for a rate filing request is published in the Pennsylvania Bulletin. The public can view health insurance company rate filings and financial statements by making an appointment to visit the Insurance Department’s Public Documents Room between Tuesdays and Thursdays from 8:00 a.m. to 3:30 pm. The public can obtain copies of documents by submitting a Public Document Room request form and paying copying and postage fees.

Rhode Island

Public Disclosure – The Rhode Island Office of the Health Insurance Commissioner (OHIC) produces an annual report called “RI Health Plans Performance Report” that list financial indicators of insurers, as well as quality and access measures and satisfaction ratings. OHIC also briefly describes the rate review process and how health care costs are rising, leading to higher insurance premiums.



Public Input – Rhode Island accepts public comments for about six weeks after a rate filing and OHIC’s basic analysis is posted on the Internet. Public hearings may be held (C. Koller, personal communication, October 13, 2010).

Virginia

Public Disclosure – The Virginia Bureau of Insurance places the financial statements of insurers on its website, where many of the factors listed in the matrix under Virginia are located.

Public Input – Virginia does not have a public comment period (Supervisor, Forms and Rates Section, Bureau of Insurance, personal communication, October 28, 2010). The public is allowed to review rate and form filings from insurance companies at the Bureau office during weekdays between 8:15 a.m. and 5:00 p.m.





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