Department of Legislative Services

Maryland General Assembly
2012 Session

FISCAL AND POLICY NOTE
Revised

Senate Bill 456 (Senator Middleton)
Finance Health and Government Operations

Health Insurance - Health Benefit Plan Premium Rate Review

This bill prohibits health insurers, health maintenance organizations (HMOs), and nonprofit health service plans (carriers) that issue or deliver a health benefit plan in the State, including an association plan, from charging a premium rate or changing the premium rate charged without approval from the Maryland Insurance Commissioner. The bill lists the factors that the Commissioner must consider when reviewing a rate filing and specifies that each proposed rate and any supporting information filed must be open to public inspection. In effect, the bill clarifies and codifies the rate filing and approval process by applying the same review standards to all carriers.

The bill takes effect on July 1, 2012, and applies to all health benefit plan rate filings received by the Commissioner on or after that date.

Fiscal Summary

State Effect: None. The bill largely codifies and clarifies current practice for the Maryland Insurance Administration (MIA). Any impact on State finances is not material.

Local Effect: None.

Small Business Effect: None.

Analysis

Bill Summary: Carriers must file proposed premium rates or premium rate changes in accordance with existing provisions of law, which vary by carrier type.

The Commissioner must disapprove or modify a proposed premium rate filing if the proposed premium rates appear, based on statistical analysis and reasonable assumptions, to be inadequate, unfairly discriminatory, or excessive in relation to benefits. In making this determination, the Commissioner must consider specified factors, to the extent appropriate.

Each premium rate filing and any supporting information must be open to public inspection as soon as filed. A carrier may request a finding by the Commissioner that certain information included in a rate filing be considered confidential commercial information and not subject to public inspection. On request and payment of a reasonable fee, a person may obtain copies of a premium rate filing and any supporting information.

The Commissioner, at any time, may require a carrier to demonstrate that, based on statistical analysis, reasonable assumptions, and other specified factors, the carrier's premium rates for a health benefit plan are not inadequate, unfairly discriminatory, or excessive in relation to benefits.

If, after the applicable review period, the Commissioner finds that proposed premium rates are inadequate, unfairly discriminatory, or excessive, the Commissioner must hold a hearing, for which the carrier must be provided at least 10 days prior written notice. The Commissioner must then issue to the carrier an order that specifies the reasons why the premium rate filing is inadequate, unfairly discriminatory, or excessive in relation to benefits and states when, within a reasonable period after the order, the premium rate filing will no longer be effective. Each decision or finding of the Commissioner about premium rates is subject to judicial review.

Current Law: Maryland law carriers to file rates and have them approved by MIA. However, the procedures used for rate review and approval vary for different types of carriers and are located in several different places through the Annotated Code and Code of Maryland Regulations (COMAR).

For insurers, the rate review process is part of the review and approval of forms, whereas the process is more explicit for HMOs and nonprofit health service plans. The standards used to approve premium rate filings for nonprofit health service plans are the same as those outlined in the bill, but they do not currently apply to other carriers. Rate filings for health benefit plans are not required to be public, although they are public for property and casualty insurance and for health benefit plans in at least 12 other states.

COMAR 31.10.01.02A requires insurers to file rate changes with supporting data at least 90 days prior to the proposed effective date. When submitting rates for review and approval, carriers must show that the requested premium rates must meet or exceed the State's minimum loss ratio requirement (the percentage of premium used to pay claims).

MIA does not approve requested rates if they are excessive (unreasonably high in relation to the benefits provided and the underlying risks), inadequate (unreasonably low in relation to the benefits provided and the underlying risks), or unfairly discriminatory (actuarially unsound or inconsistently applied and thus unreasonable in relation to the benefits and underlying risks).

MIA actuaries examine the data, methods, and assumptions used by carriers to support the requested rate. The company must explain and justify any significant changes from prior filings. MIA also examines the proposed rates and benefits; changes in the number of members covered under the policies; changes in medical and pharmacy costs; past and future administrative expenses; changes in cost sharing; changes in benefits; historical profits, future profit goals, and any changes from previous rate filings; history of loss ratios; history of rate changes; the company's financial strength; the accuracy of the calculations supporting the rate increase; and the future estimated loss ratio using the requested premium rates.

As of September 1, 2011, the federal Patient Protection and Affordable Care Act (ACA) requires health insurance companies to submit certain information to MIA and to the U.S. Department of Health and Human Services (HHS) if the companies propose any individual or small group health insurance rate increase of 10% or more. MIA must review and approve the rate increase before it may take effect. For proposed rate increases greater than 10% in the individual and small group market, MIA must make the carrier's justification for the rate increase public. As of November 1, 2011, ACA requires association plans both in Maryland and out of state to file proposed health benefit plan rates for MIA approval. Association plans were previously not subject to the rate review and approval process.

Association health plans provide an alternative to individual policies for those who do not have access to employer-based group coverage; however, they are not group insurance plans and therefore are not subject to the same regulation. Generally, Maryland law does not apply to contracts through associations in other states, even when coverage is provided to residents of Maryland.

Background: ACA provides grants to help states improve the health insurance rate review and reporting process. MIA received a Cycle I grant from HHS and commissioned Oliver Wyman Actuarial Consulting, Inc. to provide recommendations on how best to enhance the premium rate review process and provide and present information to consumers about changes in premium rates and key drivers of those changes.

Oliver Wyman issued two reports: *Recommendations to the Commissioner on Information Provided to Consumers* and *Recommendations to the Commissioner to*

Enhance Regulatory Review and Oversight. The reports concluded that MIA currently has greater rate approval authority than insurance regulators in most other states, and that Maryland's rate review process is as rigorous as, and in some respects more rigorous than, the process in most other states. The reports included numerous recommendations to improve the transparency of the rate making and rate filing process for consumers and assist MIA in enhancing the current actuarial rate review by strengthening protections to Maryland health insurance consumers while maintaining the solvency of health insurers and facilitating a competitive marketplace. This bill is intended to clarify and consolidate the rate review process to fully reflect those recommendations of the Oliver Wyman reports and the feedback solicited by MIA on them.

Additional Comments: HHS recently announced the availability of additional grant funds to help states continue to enhance their rate review process. MIA has applied for a Cycle II grant in order to be able to fully implement the recommendations made by Oliver Wyman. If successful, MIA anticipates having the resources to fully implement an enhanced and transparent rate review process by fiscal 2014.

Additional Information

Prior Introductions: None.

Cross File: HB 465 (Delegate Hammen) - Health and Government Operations.

Information Source(s): Department of Health and Mental Hygiene, Maryland Insurance Administration, Department of Legislative Services

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