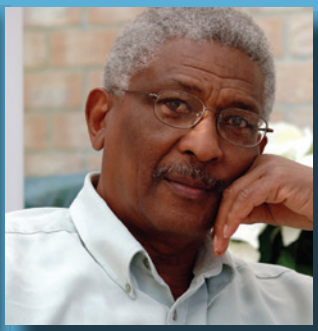
FREQUENTLY ASKED QUESTIONS:

HEALTH INSURANCE RATES AND THE REVIEW PROCESS



MARYLAND
INSURANCE ADMINISTRATION

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Understanding how insurance companies determine how much to charge you for your insurance policy is helpful when you are making the decision on which policy to purchase. Here are a few questions that consumers often ask the Maryland Insurance Administration (MIA) about the health insurance premiums they pay. The term "rate" means the amount the insurance company uses to determine your premium. The "premium" is what you pay when the rate has been adjusted based on your age, deductible, copayment levels, and other factors.

HOW HEALTH INSURANCE COMPANIES DETERMINE RATES

QUESTION: HOW DO HEALTH INSURANCE COMPANIES[1] DEVELOP RATES?

Answer: Health insurance companies develop rates using estimates of future claim costs, administrative expenses, and profits.

- **Claim costs:** The amount a health insurance company expects to pay for health care services and goods, such as physician services, hospital fees, and prescription drugs, on behalf of *all policyholders* with similar policies. This amount does not include any deductible or copayment paid by the policyholders.

- **Administrative expenses:** The cost of administering a health plan. These costs can include:

  – salaries of health plan employees;
  – costs to maintain computer systems to pay claims;
  – costs to manage the provider network (signing up doctors, setting payment rates, etc.);
  – commissions for agents and brokers (called "producers");
  – rent;
  – premium taxes (a percentage of premium that health plans pay to the State of Maryland);
  – certain federal taxes and fees (for example, federal income taxes); and
  – other costs to administer the policy (for example, fraud detection activities).

[1]The term "health insurance companies" used in this brochure includes HMOs and nonprofit health service plans.

- **Profit:** Money that the insurance company has left after paying for claims and administrative expenses. Some of this money is saved to pay for claims and administrative expenses in years when the plans do not collect enough premiums to cover those costs.

QUESTION: HOW DO HEALTH INSURANCE COMPANIES ESTIMATE CLAIM COSTS?

Answer: Health insurance companies estimate total claim costs for *all policyholders* with similar policies based on the following:

- which types of services will be used (for example, x-ray or MRI);
- how many services policyholders will use;
- where policyholders will go for services (for example, a doctor's office or an emergency room);
- the average amount paid to medical providers for each service across all Maryland policyholders with similar policies; and
- the portion of the cost of services that the health plan will pay (total cost minus any deductibles, copayments, or coinsurance amounts for which the member is responsible).

Each item in the list above typically is estimated using past history of the policies, adjusted to reflect expected increases or decreases in total claim costs ("trend"), and any changes in covered services.

QUESTION: WHAT FACTORS CAN CAUSE HEALTH INSURANCE RATES TO CHANGE?

Answer: Rates are determined in large part by medical spending. Medical costs can change for many reasons, including increases in physician or laboratory charges, more use of health care services, new technologies, prescription drugs, an aging population, and unhealthy lifestyles. A health insurance company also may change its rates because of its financial situation. Premiums must be high enough to cover the company's projected claims and administrative costs.

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

Answer: Your premium will not go up solely because you have claims, just as it will not go down solely because you do not have claims. People buy insurance to protect themselves from the full financial burden of future events. Insurance is a pooling of risks, so individuals pay a share of the pooled experience in exchange for

getting the coverage they purchased. If you have an individual or small employer policy, your premium is based on the claims of everyone with your type of policy. If you have coverage under a large employer health plan, your premium will be based in part on the claims of everyone in the group.

QUESTION: WHAT CAUSES MY PREMIUM TO INCREASE AT A DIFFERENT RATE THAN OTHERS WITH THE SAME INSURANCE POLICY?

Answer: If you buy your own health insurance or have coverage through your employer, your premium may change because:

- of your age; or
- you added another family member to the policy.

In addition, if you have coverage through your employer, your premium may change from year to year because your employer is paying more or less of the total premium.

If your rate increased, and you buy your own health insurance, check with your insurance producer to find out the exact cause. If you have coverage through your employer, your human resources benefits office may be able to provide this information.

QUESTION: HOW OFTEN CAN MY PREMIUMS CHANGE?

Answer: If you are covered under an individual or small group health benefit plan, generally your premium will not change more often than once every 12 months. Health plans are permitted to raise or lower premiums more frequently than once every 12 months if the change is due solely to the enrollment of new family members or the removal of one or more family members from coverage under the policy.

THE RATE REVIEW PROCESS

QUESTION: DOES ANYONE REVIEW HEALTH INSURANCE COMPANIES' RATE CHANGES BEFORE THEY GO INTO EFFECT?

Answer: Yes. Maryland state law requires insurers, HMOs, and nonprofit health service plans (such as CareFirst BlueCross BlueShield) that offer health benefit plans in the state to file rates and have them approved by the MIA before using them.

QUESTION: ARE ANY HEALTH PLAN RATES NOT SUBJECT TO REVIEW BY THE MIA?

Answer: Yes. The MIA does not have the authority to review rates for:

- health benefit plans that are offered through the federal government, including the federal employee health plans and TRICARE;
- Medicare, Medicaid, or other federal health plans;
- employee plans that are self-funded by an employer (for example, the State of Maryland, Verizon, Montgomery County Public Schools, and General Motors); and
- some plans issued in other states.

QUESTION: WHO REVIEWS RATE CHANGE REQUESTS AT THE MIA, AND HOW ARE THEY QUALIFIED?

Answer: The MIA has actuaries on staff who review rate change requests. Actuaries are insurance professionals trained to analyze risks and develop premium rates.

QUESTION: HOW DOES THE MIA DECIDE WHETHER TO APPROVE A REQUESTED PREMIUM RATE CHANGE?

Answer: Health insurance companies must show that a requested premium rate follows Maryland law. Also, the requested premium rate must meet or exceed the federal and state loss ratio requirements. The loss ratio is the percentage of premium used to pay claims. The MIA does not approve a requested rate change if it is:

- **Excessive** (A rate that is unreasonably high in relation to the benefits provided and the underlying risks);
- **Inadequate** (A rate that is unreasonably low in relation to the benefits provided and the underlying risks. If a rate is inadequate, the health plan may not be able to pay future claims.); or
- **Unfairly Discriminatory** (A rate that is not applied consistently within a rating category, such as age, geographic area, family tier, or plan of benefits.)

QUESTION: WHAT OTHER INFORMATION DOES THE MIA EXAMINE WHEN REVIEWING A RATE CHANGE REQUEST?

Answer: When reviewing a rate filing, MIA actuaries also examine the data, methods, and assumptions used by the health insurance company to support that requested rate. The company must explain and justify any significant changes from prior filings. In addition, the MIA examines:

- the proposed rates and benefits to make sure they comply with Maryland law;
- the future estimated loss ratio using the requested premium rate to make sure it meets the minimum requirements;
- 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;
- profit history, future profit goals, and any changes to profit goals 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 change; and
- any other factors that contribute to the requested rate change.

QUESTION: DO HEALTH INSURANCE COMPANIES ALWAYS GET APPROVAL FOR THE RATE CHANGES THEY REQUEST?

Answer: No. A health insurance company must show that the change is justified. If the company does not provide sufficient support for the requested rate, the MIA asks the company to send more information. If the company does not send the information, or the information does not show the change is justified, the requested rate will not be approved.

QUESTION: CAN THE MIA APPROVE A REQUESTED RATE CHANGE FOR SOME POLICIES AND DENY A REQUESTED RATE CHANGE FOR OTHER POLICIES FOR THE SAME HEALTH INSURANCE COMPANY?

Answer: Yes. The MIA reviews the rates for each health insurance product. If the rates for some products are not supported, the requested rates for those products are not approved.

QUESTION: WHAT IF THE HEALTH INSURANCE COMPANY DISAGREES WITH THE MIA'S DECISION?

Answer: The company has the right to request a rate hearing if it disagrees with the MIA's decision.

LEARN MORE

QUESTION: HOW CAN I FIND OUT MORE ABOUT RATE CHANGES REQUESTED BY HEALTH INSURANCE COMPANIES?

Answer: Maryland law requires health insurance companies to provide an annual notice to their policyholders, and to post a notice on their websites, explaining that policyholders may find proposed rate changes on the MIA's website and may submit comments regarding those proposed rate changes.

- Rate filings for individual health and small group insurance products are open to public comment. When a health insurance company submits a rate change request that is open to public comment, consumers can read the company's justification for the request and submit comments on the MIA's website. The MIA generally accepts public comments for 30 days from the date the rate change request is posted on its website. You can find all of this information at *www.healthrates.mdinsurance.state.md.us.*

- Once the MIA completes its review and makes a decision about the rate filing, a summary of the decision is posted on the MIA website at *www.healthrates.mdinsurance.state.md.us.*

People with disabilities may request this document in an alternative format. Requests should be submitted in writing to the Director of Public Affairs at the address listed below.

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