MARYLAND INSURANCE ADMINISTRATION
2014 HEALTH INSURANCE PREMIUM RATE DECISION
NON-GRANDFATHERED PLAN

Insurance Company and Filing Information

Company Name	CareFirst of Maryland, Inc.	Company NAIC#	47058
Product Name	BluePreferred PPO	SERFF #	CFBC-128965513
Type of Insurance	Medical	Rate Filing Date	April 1, 2013
Market Segment	Individual	Rate Decision Date	July 26, 2013
Product ID #	45532MD025 45532MD026	Rate Effective Date	January 1, 2014

Requested and Approved Average Premium Rate

Average Premium Rate Requested by the Company	$252.31	Approximate Number of Maryland Policyholders Enrolled in a Similar Product Currently Offered by the Company	11,164
Average Premium Rate Approved by the MIA	$222.56	Estimated Difference Between the Company's Current Average Premium Rate and the Approved Average Premium Rate**	15.4%
Difference Between Requested and Approved Average Premium Rates*	-12%		

The difference is rounded to the nearest full percentage point.
****This estimate reflects the difference between the Company's approved average premium rate, per member, per month (PMPM) for non-grandfathered plans in the individual market in 2014 as compared with its existing average premium rate PMPM for non-grandfathered plans in the individual market. The estimate involves assumptions about which plans current policyholders will choose for 2014.***

These rate figures are averages. Your own premium rate may be higher or lower, depending upon your age, whether you use tobacco, where you live, and cost-sharing under your plan.

Rate Review Standards and Considerations

The Insurance Commissioner approves health insurance rates in Maryland. Under Maryland law, rates may not be inadequate, unfairly discriminatory or excessive in relation to benefits. Each rate filing is reviewed on its own merits. The Commissioner's rate decisions must be based on statistical analysis and reasonable assumptions. To assist the Commissioner in making these decisions, Maryland Insurance Administration (MIA) actuaries examine the data, methods, and assumptions used by each insurance company. They review numerous factors related to proposed premium rates, including the company's actual and projected claims experience, medical and prescription costs, administrative costs, and profits or losses. The Commissioner also considers the impact premium rates will have on Maryland consumers. Under the federal Patient Protection and Affordable Care Act and Maryland law, in the individual and small group markets, 80 cents of every premium dollar must be spent on paying claims or on quality improvement activities; that figure increases to 85 cents in the large group market. If an insurance carrier does not meet these targets, the carrier must pay rebates to policyholders.

Modifications to Requested Rates and Reasons for Those Modifications

Some of the data provided by the Company and some of the Company's assumptions did not support the originally proposed premium rates.

The MIA objected to the Company's original model of its anticipated membership in the 2014 individual market because: (a) the Company used an unreasonable assumption about the number of policyholders who will move from a Preferred Provider Organization (PPO) to a Health Maintenance Organization (HMO); and (b) the Company did not allocate the cost of out-of-network benefits for certain contracts to the companies providing those benefits. The Company modified its proposed rates in response to these objections. Those changes resulted in a 4.7% reduction to the proposed average premium rate, consisting of 4.5% because of (a) and 0.2% because of (b).

During the course of the rate review process, the Company proposed additional modifications to the originally proposed premium rates as follows. The Company:

- updated its claims experience with more recent data (resulting in a 0.8% decrease to the average premium rate);
- changed its reinsurance recovery request to be consistent with a federal estimate (resulting in a 6.2% decrease to the average premium rate);
- corrected its age normalization calculation (resulting in a 3.1% increase to the average premium rate);
- removed tobacco rating factors (resulting in a 3.6% increase to the average premium rate);
- made an adjustment to its estimated cost of enhanced mental health and substance abuse benefits (resulting in a 0.5% decrease to the average premium rate);
- updated its cost for vision benefits to reflect a new contract (resulting in a 0.1% increase to the average premium rate); and
- increased the charge for abortion services to comply with the federal minimum (resulting in a 0.1% increase to the average premium rate).

The effect of these changes was a net 1.0% decrease in the proposed average premium rate.

Additionally, the Company corrected calculation errors in the average premium rate contained in its initial filing. This resulted in an additional 6.5% decrease to the average premium rate. The average premium rate, as corrected by the Company and as modified during the rate review process, decreased by approximately 12% from the average premium rate as proposed in the Company's filing.

Final Determination

Pursuant to § 11-603(c)(2) of the Insurance Article, Annotated Code of Maryland, the Company's requested premium rates, as corrected by the Company and as modified by the Company during the rate review process, are not inadequate, unfairly discriminatory, or excessive in relation to benefits.