Hearing

IN RE: PUBLIC INFORMATIONAL HEARING ON MEDICAL STOP-LOSS INSURANCE

PUBLIC INFORMATIONAL HEARING
September 28, 2015

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PUBLIC INFORMATIONAL :

HEARING ON MEDICAL :

STOP-LOSS INSURANCE IN :

SELF-FUNDED EMPLOYER :

HEALTH PLANS :

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BEFORE:

AL REDMER, JR.

Insurance Commissioner

Maryland Insurance Administration

200 St. Paul Place

Hearing Room-24th Floor

Baltimore, Maryland 21202

Monday, September 28, 2015

10:00 a.m.

Reported by:

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P R O C E E D I N G S

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MR. REDMER: Pursuant to House Bill 552, the Maryland Insurance Administration is conducting a study of the use of medical stop-loss insurance in self-funded health plans. As a part of the study, the Administration shall solicit information from stakeholders and hold informational hearings as appropriate.

The focus of this hearing is to gather information relating to the study of medical stop-loss insurance used in conjunction with self-funded employer health plans. This includes attachment points, the number of lives insured, and other information relevant to the study as specified in the Act.

Before we proceed, I am going to ask Nancy Egan, our director of Government Relations, just to give an overview of where we are at this point in the study.

Nancy?

MS. EGAN: As you know, I handed out copies

of the study, and I am actually going to go through each part and explain what we have done so far, and where we might need assistance, so if you don't mind following along.

If you haven't done so already, please make sure you sign in on our sign-in sheet and provide us with your contact information. It will help us keep you in the loop as things come up and we need some assistance on different parts of the study.

Starting with the introduction, the Maryland Insurance Administration shall conduct a study of the use of medical stop-loss insurance in self-funded employer health plans. As part of the study, the Administration shall solicit information from stakeholders and hold informational hearings as appropriate.

The stakeholders from whom the Administration shall solicit information shall include carriers offering fully insured health plans in the state; carriers offering medical stop-loss insurance in the state; employers utilizing fully insured health plans; employers utilizing self-funded health plans in

conjunction with medical stop-loss insurance; insurance producers; third-party administrators; consumers; the Office of the Attorney General; Maryland counties and municipalities; and the Maryland Bankers Association. For that, they reach out to the stakeholders.

During the summer, the commissioners conducted a series of eight townhall meetings throughout the state, and welcomed the public and the producer community to comment on the changes that were included in House Bill 552. We had several business owners and producers provide us with feedback at these meetings.

In addition, we have had conference calls, e-mail exchanges and meetings with various stakeholders listed in the study, including the Maryland Bankers Association, MAHU, carriers offering medical stop-loss insurance, MACO, MML, and other producers.

The study has 12 parts, and we are hoping you can assist us in addressing sections where we are not sure if we can obtain the information, or would

welcome your feedback.

The first part of the study, analysis of baseline data, including sample data, where appropriate, on the types and costs of health benefit plans, including self-insured plans, offered in the state by employers with 2 to 50 employees and employers with 51 to 100 employees.

For self-insured plans, the individual and aggregate attachment points of medical stop-loss insurance purchased, and the number of plan designs and carriers available in the small employer market, including market share by carrier, and the number of plan designs and carriers available in the market for health benefit plans utilizing medical stop-loss insurance, including market share by medical stop-loss carrier.

Our staff has worked with the producer community to come up with four sample datasets to quote on both the fully insured and self-insured markets. We have shared the datasets with the three largest medical stop-loss carriers for comment, and will be asking companies to provide its quotes based

on 2015 pricing. Based on some of the comments, we are going to be using a November 1 effective date.

The same datasets will use the 2014 benchmark plan as the plan design for the cost-sharing of the employee. Two of the sample datasets are for employers in the 2 to 50 market, and two of the sample datasets are for employers in the 51 to 100 market. We are using SIC codes representing contractor exposures, as well as office exposures.

In addition, we are asking the medical stop-loss carriers to provide quotes using the attachment points in effect prior to June, 2015 of $10,000 and 115 percent and the new attachment points of $22,500 and 120 percent.

We understand that medical underwriting is one of the rating factors used in quoting self-funded plans, but we are using an assumption of average health, the factor to be 1.0, with no scheduled credits or surcharges. I hope you all realize it would be difficult for us to come up with health conditions to quote out in the medical stop-loss market.

In addition, we will assume that the employer is coming out of the fully insured marketplace, therefore no prior claim data is available. We know that we are missing elements in order to provide a comparative quote in the medical stop-loss market.

We need assistance in how to determine the cost to the employer of the self-insured portion of the risk, as well as some of the associated cost of the fees charged to manage the risk. We welcome your comments and assistance.

I would just like to say I want to thank you. The three medical stop-loss carriers provided us a little bit of that information, and made us realize that we were not obtaining everything we needed to know in order to get a full idea of what it was going to cost the employer if he self-insured in the market. I appreciate the comments we received so far.

In addition, we will send out the four stated datasets in 2016 so we can do comparable quotes based on 2015 prices and 2016 prices. As you are well aware, the group that's 51 to 100 will move from the

large market to the small group market. So there's some design in the way we set up the quote.

I want to thank MAHU and particularly Rodger Bayne, who helped us in developing the quotes, as well as the Avon Dixon Agency, and Avery Hall for their assistance as well.

In addition, our market analysis group has sent a survey out to the 69 medical stop-loss carriers dealing with questions regarding the average group size, attachment points and other data, including policy count. This will also be sent out again in 2016.

A copy of the survey is available on our website, and I can give you the address afterwards. Right now, it's www.mdinsurance.state.md.us/sa/news-center/legislative-information.html. It's under the legislative study. We put it up on the website, the Medical Stop-Loss Study.

I know that many of the carriers are currently working on that, and if you have questions about the survey, you can direct them to me, but Megan

Mason's team is working on that, and I will be introducing her again. Afterwards, if you want to talk to her individually, she is here to answer questions.

Part 2, an overview of employer health plan in contiguous states, including the percentage of fully insured employer health plans and self-insured employer health plans utilizing medical stop-loss insurance. Currently, our staff is reaching out to our counterparts in our neighboring states.

Part 3, an estimate of the number of employers with 51 to 100 employees whose health benefit plans would change from large group to small group in 2016 as a result of the change in the size of the small group market required by the federal ACA. We can derive that information internally, so we will have that available.

An analysis of statutory and regulatory requirements for medical-stop loss insurance in other states, and the experience of states whose requirements are different from those in Maryland.

Our NAIC liaison, Catherine Grason, is

tracking the information about activities in other states and at the NAIC. At the fall meeting in Chicago, the NAIC adopted a white paper entitled "Stop-Loss Insurance, Self-Funding and the ACA". Much of the information contained in this paper is useful in assessing the national landscape on stop-loss insurance, and the MIA study will contemplate this white paper.

Part 5, a review of any guidance, recommendations, or model legislation regarding medical stop-loss by the NAIC or other groups. Once again, Catherine is tracking information about the activities in other states and at the NAIC level.

Part 6, identification of any incentives and disincentives beginning in 2016 associated with the purchase of health insurance in the small group market compared to self-insurance with the purchase of medical stop-loss insurance for both employers with 2 to 50 employees and employers with 51 to 100 employees.

While we assume that the biggest incentive is the pricing, we welcome your input on this

question. It's obvious that an incentive would be the cost of the plans, but there may be some other ideas that you see in that question that we welcome your assistance.

Part 7, a comparison of the risk profile of small employers that self-insure and the risk profile of some employers that purchase health insurance in the small group market.

We are hoping that some of the information provided by the survey that we sent out to the medical stop-loss carriers would give us some information about SIC codes that those people are currently self-insuring. Once again, we welcome your feedback to understand about these risk profiles.

Part 8, an assessment of the impact on the stability and viability of the small group market, including the possibility of adverse and higher premiums resulting from employers choosing to self-insure instead of purchasing health insurance in the small group market and, after self-insuring, switching to the small group market. Once again, we welcome your input on this question.

Part 9, an assessment of any impact on the Maryland Health Benefit Exchange of small employers choosing to drop coverage for their employees.

We sent out a separate survey letter to the small carriers asking if they are tracking information about where business is placed when a small employer does not renew with that carrier. Examples of this survey letter can be found on our website. In addition, we reached out to the exchange to see if they are tracking any of this information.

I just received an e-mail from them on Friday, and they currently are not tracking this, but they are trying to find resources and ways that they can maybe track that information as well. Once again, this survey is on our website.

Part 10, an assessment of different attachment points for medical stop-loss insurance, the effect that medical inflation could have on the attachment points in statute, and the desirability of maintaining or adjusting the current statutory levels. Again, we welcome your feedback on this particular question.

Part 11, an assessment of the consumer protections in the medical stop-loss insurance policies and contracts and the desirability of maintaining or adjusting the current statutory consumer protections. Once again, we welcome your feedback on this question.

Part 12, an assessment of the impact on local governments and small employers of any changes to the attachment points or consumer protections in medical stop-loss insurance policies and contracts.

We reached out to MML and MACO to provide the impact on their organizations, so we welcome responses from the business community regarding the impact on small employers.

With that, if you have any questions about this part, when you do ask any questions, we have a court reporter here, she needs to hear you, she needs you to identify yourself, and to speak about what organization you represent.

Are there any questions so far?

(No questions from the audience.)

MR. REDMER: As I walked in this morning, a

producer friend of mine asked me if I was going to be able to make this interesting, and I said sadly, the answer is no. This is pretty dry stuff, but we appreciate your attendance and your assistance in putting this study together.

Before we move on, I want to introduce the rest of the folks that are with me representing the Maryland Insurance Administration.

To my left is Van Dorsey, our principal counsel from the Attorney General's Office; to his left is Sarah Li, our chief actuary; to her left is Nick Cavey, the assistant director of Government and External Relations; to my right is Brenda Wilson, the associate commissioner of Life and Health Insurance; and you have already met Nancy Egan.

Also with us, sitting with you in the audience, is Victoria August, the associate commissioner of Compliance and Enforcement, which means she has oversight into the business activities of both carriers and producers. Also, Catherine Grason, who is the director of Regulatory Affairs and our liaison with the National Association of Insurance

Commissioners; Megan Mason, who is our chief market conduct examiner for Life and Health carriers; in the back is Craig Prem, our senior actuarial analyst, and Mary Kwei, who is the chief of Life and Health complaints, appeals and grievances; also Maria Fisher, my executive assistant, who does most of the work.

Also with us in the back is Linda Stahr, counsel for the Health and Government Operations Committee, which, as you know, does all the health insurance work in the house; Patrick Carlson, who is counsel for the Senate Finance Committee that does both health care and health insurance issues; finally, Pat O'Connor, representing the HEAU Unit of the Attorney General's Office.

Just a reminder, as Nancy said, that if you choose to speak while on the phone or here, please identify yourself and the organization you represent. Also, if you are on the phone, if you could mute your phone, that would be helpful as well.

Again, we are here to listen and accept your feedback and observations, and we appreciate you coming. We have some folks that have requested to

provide comment, and we will start with Rodger Bayne.

MR. BAYNE: Good morning. Thank you for inviting me to speak. I have not prepared formal remarks, but I think my comments will be relatively pertinent to this discussion.

MR. REDMER: Please give your name.

MR. BAYNE: I'm sorry. My name is Rodger Bayne. I'm with Benefit Indemnity Corporation and Client First Brokerage Services. We have been a wholesale insurance marketing firm since back in '92, and I have been a broker since 1986.

As an insurance producer in this business for about 28 years now and having had a great deal of experience in self-funded and doing self-funded over that entire 28 years for groups of all sizes all the way down to five, I think it's probably one of the most pertinent things to bring up today, is Maryland's action over the years in small group reform.

In 1993, we passed House Bill 1359, which is a sweeping, small group reform legislation that enacted on July 1 of 1994, put our small group market in 2 to 50 in virtual identical position as the ACA

has done today. Guaranteed issue, no preex, uniform cost-sharing provisions, loss ratio guidelines, the whole gamut, so it looks virtually identical.

In 1994, we established this situation, which amounts today to be a laboratory, an experiment. At that time, there was great worry in Maryland, and attempts to regulate small group stop-loss insurance at that time, and, in fact, in years not long after the passage of that law, they passed the $10,000 minimum specific stop-loss law based on this concern that the sky is going to fall, that all of the healthiest small employers are going to flock to the self-funded market and the anti-selection is going to destroy Maryland's small group reform pool.

We conducted this experiment in free market enterprise for 20 years before the passage of the ACA, and during that entire time, none of these changes happened. None of this destruction occurred. In fact, the individual market was a more selective force, as it is today, against the group market than you see the self-funded marketplace.

So based purely on that experiment, I think

we have to look at this study and remember that we are not looking simply at anecdotal studies of what could happen, we have actually seen what does happen. The marketplace is much more dynamic than we all give it credit for, but not so dynamic that everyone flocks at a moment's notice to something that sounds like a panacea.

Self-funded is serious business. It means considerable changes. It is regulated by the Department of Labor under ERISA regulations and guidelines, which are very, very severe. You are not seeing the gaming practices that everyone fears, and frankly, the change to 50 to 99 isn't going to change much at all.

If you look at the number, 66 percent of the groups over 50 in Maryland self-insure already. Sixty-six percent of the employees are already self-insured in that marketplace. The vast majority of those, and that percentage is weighted by those large employers of 1,000 plus, but the numbers pretty much speak for themselves. Self-funded has a viable market share for viable reasons.

Even the RAND study, that was commissioned as a direct result of the orders of the ACA to do a study on the effect of health care reform and small group self-funded, the RAND Corporation study said yes, having a robust self-funded marketplace in the small group arena could in fact change exchange rates a little bit. Their actuaries and their study and their analysis said around three percent, but probably the most important piece of this study is the key finding.

Health care reform is all about getting more Americans covered in health care. As an insurance broker and several producers in this room, I have spent the last 28 years with that singular mission, to get people covered. That's our job. We only get paid when we succeed.

So if our mission of health care reform is to get more people covered, pay special attention to the RAND Corporation study that said yes, rates in the exchange could be affected to a minor degree; however, the net number of people increases, the net number of people insured increases when we have a robust

self-funded marketplace side by side, and they cited the voluntary nature of some employee populations that, when the price is too high, simply don't buy it.

So we need to create alternatives, and self-funded has a vast number of advantages and complexities that are far beyond what we are going to learn today, but I think you will find that the anti-selection argument moot. It doesn't happen. It's not nearly what everyone is portraying, or some parties would like to portray, but the reality is, it is still a viable consumer tool to help more people get coverage and have a net return of greater people covered.

MR. REDMER: Rodger, realizing we're not quite there yet as far as seeing a lot of the changes as a result of the new stop-loss attachment point, what does your experience and your gut tell you as to what the effect of that is going to be from 10 to 22,5 on the size of groups?

MR. BAYNE: That's a very interesting question. The change from $10,000 specific to $22,500 specific probably won't change the size of groups at

all; however, what it will do is imposed greater financial burden on smaller risks and will actually encourage anti-selection.

One of the things I testified during the hearings for this piece of legislation is keep in mind that if you have a small group and that small group wants to find ways to create better alternatives in health care, if they have a willingness to take $10,000 worth of risk, go into the marketplace and run their self-funded health plan, they can do so, and they're going to do so. If something bad happens, some risk goes up, they have a $10,000 exposure, they can endure that. They can muscle it out, and they're likely to continue to self-fund.

The more risk we force upon them, the more likely they are to then bail out and go back to the fully insured market and create that anti-selection. So the higher risk we impose upon employers, the more we corrupt the system ourselves.

MR. REDMER: Do you have a question for Rodger?

MS. EGAN: Rodger, I said during the opening

remarks that we had come up with four quotes to quote in the medical stop-loss marketplace, but we thought that we were missing elements regarding what the cost is to the employer section. We could get the price to them from the carriers to what it would cost the employer for the stop-loss insurance, but we wouldn't know the pricing for the exposure that they face for the attachment points, plus the administration fees for the cost. We don't know how we could derive that information.

MR. BAYNE: That's a good point. The self-funded business, as I mentioned earlier, it's pretty serious business. It's far more complex than everybody thinks. People aren't going to flock to it without understanding the pieces and the components. Self-funded is built with administrative cost, managed care, network leasing, pharmaceutical benefit arrangements, all pretty much separate and apart from the stop-loss piece itself.

When we start looking at stop-loss insurance, we're quoting a number on a premium that protects the employer for financial losses and that

plan to a certain extent, whatever that extent may be. The specific stop-loss is easy. We say it's 22,5, that's the number. The employer is responsible for that much exposure from any one given employee.

When we move to the aggregate stop-loss, now we are talking about actuarial evaluations of a group's demographics in determining what we expect their claims to be, then we apply the expected claims factor, the aggregate claims factor of 120 percent under Maryland law, and say the employer's exposure is 120 percent of what all of our actuarial pools of data would indicate this group should have.

Those are the numbers that may or may not be missing from your numbers if you're getting purely rates for stop-loss, but you also have to trickle all the way down to administrative fees, network leasing, pharmaceutical drug management and banking arrangements and everything that goes into self-funded. It's far more complex than simple stop-loss rates. We can help you get there, but there's a lot of moving parts.

MR. REDMER: Any other questions for Rodger?

(No questions from audience.)

MR. REDMER: Thank you, Rodger.

We have a panel, Rachel Severance from Niles, Barton & Wilmer.

MS. SEVERANCE: Good morning. My name is Rachel Severance from Miles, Barton & Wilmer. I represent the Protect Employer Health Plan Coalition. To my right is Bryson Popham, who, as you know, represents a number of interested parties and stakeholders, many of whom are in the room with us today. I would like to briefly acknowledge them, if I may.

From Cigna, we have Katy Stewart, Matt Kenyon, Dan Arenas and Pat Gillespie, from Etna, we have Dan Fitzgerald, Catherine Bresler from Trustmark Insurance, Gary Becker from ScriptSourcing, Adam Brackemyre, who is sitting to my left, from the Self Insurance Institute of America, Rodger Bayne, who you just heard from, and we also have Michael O'Halloran from the NFIB.

The Protect Employer Health Plan Coalition, is a coalition of employers and interested parties

whose mission is to preserve health insurance options for employers in Maryland. To my left, I have our chairman, Adam Brackemyre, and he will speaking to you shortly, but, first, I would like to invite Debbie Johanson to speak. She is one of our employer members. She is the director of Human Resources for PEPCO, a company that's been in Maryland for over 35 years and employs about 90 people, and it also currently uses the self-funded plan.

Debbie, if you would like to go ahead.

MS. JOHANSON: Again, I am Debbie Johanson from PEPCO. I will tell you a little bit about my company. We have been in business over 35 years. We are family-owned. What PEPCO does, is we manufacture, sell and install pneumatic tube systems.

It's like a bank drive-thru, but in our industry, probably 96 percent of our customers are in the health care industry; University of Maryland, Shock Trauma, Johns Hopkins, Mercy Medical, Union Memorial, major hospitals in Philadelphia. We have probably about 600 customers throughout the U.S.

What is a pneumatic tube system? Again,

it's like your bank drive-thru. You're rushed to the ER, and instead of a nurse running that little blood sample, that you painstakingly had removed, down to the lab, they're going to put it in a carrier and send it through the hospital. I'm very passionate about the company I work for.

It's a family-owned business. We manufacture all of our parts here in the U.S. We have just recently expanded to international sales, which is phenomenal. Again, we're family-owned. We are founded by Fred Ballarino, Sr. (ph.) who is 89 years old, and is still a very active member of our company. It's very hard to keep up with him, and he's got patents and running like crazy.

I have been with the company for 18 years. We have about 90 employees, like Rachel said. Being a small company in the world of big competitors, and one of our biggest competitors, it's really tough. One of the things that we look forward to and one of the things I use in a selling point when I'm trying to sell my company to a candidate who's got many other options is the insurance.

We are self-funded. We have the stop-loss protection, and it means a lot to us. It means that we can affordably keep offering benefits to our company. We are with Cigna. We have a great relationship with Cigna. We have tossed around the idea of going self-insured for many years, but our claims are running very well under being fully insured. We took that leap of faith two years ago with the direction of Cigna and our broker and went with that.

We are very passionate about our employees, the well-being of our employees. The stop-loss has definitely impacted us because we do have a few big claims out there. I don't want to turn around to my coworker and say I'm sorry you're wife is dying of cancer, but we can't afford to continue to help her. I don't want to turn around to the young person who's got a young baby who has some problems and it's going to be very costly in insurance and say, you know what, that's not something we offer anymore.

If we stop being able to offer affordable insurance to our company, that stops us growing. We

have a vision. Our owners really take pride in what we do, and as far as taking care of our company, we're a family-owned business, we treat all of our employees like family.

If somebody's got a problem, we want to be able to help them, and with the insurance rates as they are now and where we've been able to go with self-funded, wellness programs, that a clear vision of being able to look and see who's taking medication for what, who's got this issue going on, so let's tailor these wellness programs.

I think the commercial says the best treatment is going to be preventive care. This is the other opportunity it gives us to afford to know what's going on with our employees and being able to help our employees. You can tell I'm very passionate about it.

MS. EGAN: Do you know what your current attachment points are for the record?

MS. JOHANSON: As far as?

MS. EGAN: Under the plan with Cigna, do you know what --

MS. JOHANSON: Our stop-loss?

MS. EGAN: Yes.

MS. JOHANSON: $25,000.

MS. EGAN: It's $25,000 and the aggregate is the 115, do you know?

MS. JOHANSON: Yes.

MR. REDMER: When was the last time you compared your self-funded plan to a fully-insured plan?

MS. JOHANSON: We take a look at that probably every other year. We are two years into our plan and we'll probably review that when our open enrollment comes up in April.

MR. REDMER: What is the difference in premium between a competitive fully-insured premium and your maximum cost under the self-funded plan?

MS. JOHANSON: We took a review and looked at that I think about two years ago. It was absolutely huge. It really was. We have been able to keep our cost down, and I think we have not gone above maybe 10 to 12 percent in an increase every year. The year that we switched from fully funded to the self-insured, we actually had a decrease in our cost,

and then I believe the last two years, maybe we looked at 10 to 12 percent. So we have been able to keep our cost down. We have been able to manage our cost. Again, taking a look at that, having that clear picture of what's happening with our employees and be able to help them and be proactive, I've seen a lot of transformation in our employees.

MR. REDMER: So your maximum total out of pocket cost is less than what a fully insured plan would be?

MS. JOHANSON: Right, yes.

MR. BRACKEMYRE: My name is Adam Brackemyre. I am with the Self Insurance Institute of America. I am the director of State Government Relations, and, unfortunately, my presentation will not be as passionate. I'm going to talk about state laws.

First, as part of the study, we are required to look at policy guidance from agencies like the NAIC, and the NAIC does have a stop-loss model law for stop-loss. I'm sure the Insurance Administration is aware of this. This was adopted about two decades ago, and about three years ago, some commissioners

looked at raising attachment points.

That proposal was voted down by a majority of insurance commissioners. Insurance commissioners looked at it and said no, we're not going to do that, we're going to stick with the old law, because it appears to be working for our states.

As part of that, they also looked at inflation adjustment component, and that was covered in Milliman study that was part of this NAIC study effort, and that inflation protection amendment was not viewed as necessary by the Milliman study as well. So some of these questions that we are reviewing from the study, there is some literature on them.

And as Nancy mentioned, there is a stop-loss white paper, and I'm sure you have access to it. It's not necessarily a policy paper. It did not follow the NAIC guidelines to be adopted as policy, so it's more meant to serve as information for you.

Moving on to what surrounding states do, Maryland is actually in the middle or leaning more restrictive compared to neighboring states. States such as Pennsylvania, Delaware and Virginia have much

more lenient stop-loss laws and regulation. I'm told that West Virginia enforces the NAIC Model Act on policies, but that's not in law or regulation, and D.C. is more restrictive, and that was a policy endeavor meant to increase shop enrollment in the District.

There are a variety of approaches to stop-loss regulation that states have taken, and we haven't seen any demonstrated adverse effects on small group markets. We haven't seen anything like an actuarial death spiral occur in any of these states. Although in D.C., there isn't much of a stop-loss market anymore because the attachment points were raised to a point at which the employers could not bear the risk and, therefore, cannot self-fund.

Rodger mentioned, and I will just cover this very briefly, that Maryland has prohibited health status underwriting since 1994, and we haven't seen any demonstrated adverse effects on the small group market nor any growth in the stop-loss market.

I pulled some of our numbers, which includes stop-loss carriers, TPAs and employers, and we haven't

seen any increased cases of self-funding recently, and we haven't noticed any increase for the upcoming year, so we would be shocked if there was any uptake in small group self-funding in this upcoming year.

Nancy also mentioned that the stop-loss pricing, we would love to help with that. Some of our members have some additional information requests, such as TPAs, which TPA shall we use, which network are we using. We also have concerns about anything that may disclose proprietary pricing information, but we certainly want to help, and we will pledge our support with you as you study this issue.

That's all I have. Thank you very much.

MR. REDMER: Rodger mentioned the effects of small group over the last couple decades. In January, we now go from 51 to 100. Debbie mentioned that they save significant amount of money in self-funded market, and we have to presume, obviously, that they have reasonable health status.

So now, in Maryland, with the expansion of 51 to 100, we have employers in that space that are pretty competitively priced because they do have

reasonable health, we have some that are pretty highly priced because they are not as good with their experience, so I have to assume, listening to Debbie's testimony, that those that are in that 51 to 100 that have good experience and good pricing are really going to get whacked in January. You don't anticipate that that self-funded market is going to grow substantially just because of that?

MR. BRACKEMYRE: Not substantially, and I would say in response that there's more that employers take into account when they self-fund. They have to be able to pay claims. If you look at the balance sheet and they can't pay claims, they can't self-fund. They will also have to manage a health plan. If you are not going to manage your self-insured health plan, your costs are going to increase. You may not see any savings at all.

Something that a RAND study commissioned by the Department of Health and Human Services found is that there are a lot of employers that simply are not interested in self-funding, although if you look on paper, they would make ideal self-funding candidates.

So there's something that we just are not measuring there, and I suspect that would be the case for each individual business as they make their benefits decisions in the upcoming year.

MR. POPHAM: Good morning, Commissioner. Bryson Popham, I am a lawyer and lobbyist from Annapolis, and, as Rachel said, I represent a number of stakeholders, producer associations, including the Maryland Association of Health Underwriters and MAIF of Maryland, and also companies like Aetna and Cigna, who are in the room today.

I want to thank in particular Debbie Johanson for taking the time to be here today and share the employer's perspective, and just want to go on the record with the conversation that you and I had before there are other employees who would like an opportunity to meet with you as well. So I hope we are able to arrange that at some point. They couldn't be here this morning.

I just want to share one quick anecdote that is really responsive to the question you just raised. We had an employer come to Annapolis in January when

the Bill was pending before the General Assembly. It was a contractor from Washington County, and you may have heard from them in one of your meetings around the state, and they had gone last year from a fully insured plan to a self-funded plan. This was a contractor that had been in existence for 10 years, always offered benefits, always offered them on a fully insured basis, but they got hit with a very substantial increase last year.

To make a long story short, the owner of the business said to the legislators, and would say if she were here today, that the choice she was facing was not between renewing her fully insured plan with several tens of thousands of dollars increase and a self-funded plan, it was between the self-funded plan and no plan. She would have terminated her plan, sent her employees out to seek coverage themselves.

We do know now since the Affordable Care Act has passed there is an option for those people and they can get insurance; however, they would not have enjoyed the benefit of an employer subsidy. Some of them may have been eligible for subsidies, some not,

and who knows if they would have individually gotten insurance.

I think it's reasonable to expect that a number of those employees, I think there were 37 of them covered under the plan, may not have ended up covered. That is an anecdote I recognize, but I think it does illustrate both the value of a self-funded approach to keep people insured and the pressure that employers, like Debbie's company, faces to make the decisions to continue to offer this kind of employee benefit.

Our position would be, my clients' position would be we understand what went into the passage of House Bill 552. We commend the work you're doing in this study. I think at this point, anyway, we haven't seen anything that indicates further changes are needed, and we hope that that will be one of the results of the study. Thank you.

MR. REDMER: Does anybody have any questions for the panel?

MS. EGAN: I do.

Adam, you had said something about the

proprietary nature of the rates, and I think Megan can address that when we send out the market surveys, that we are not identifying any of the rates specifically, that we were only going to say that this is the range of what the pricing would be. So there's no concern about that.

MR. BRACKEMYRE: I was just relaying a concern that was given to me.

MS. EGAN: And we do welcome working with you about setting up these quotes in the medical stop-loss arena. Thank you.

MR. REDMER: We have a number of people here, but nobody else has signed up to speak, but has anybody changed their mind and would like to say something?

SPEAKER: I think we have a local government panel.

MR. REDMER: Sure, absolutely.

MS. EGAN: While you are getting assembled, I just want to let you know we are leaving the record open until October 15th for written comments in case you wanted to submit additional information to us, and

they get sent to nick.cavey@maryland.gov, N-I-C-K, C-A-V-E-Y @maryland.gov.

MS. MANSFIELD: Good morning. Thank you for the opportunity to be here today and speak about the legislation and the study that you will be undertaking in this interim. I will first go ahead and introduce our panel, I know it's a lengthy panel, and provide a few more comments.

My name is Andrea Mansfield, and I am the legislative director with the Maryland Association of Counties. To my right is Tim Ailsworth. He is with the Local Government Insurance Trust, and he is their executive director, and the Local Government Insurance Trust oversees a local government health cooperative that we do want to share some comments about today.

Farther over, Tom Curtin, he is the government relations and research associate for the Maryland Municipal League; we then have Jim Hechler, vice president for Actuarial Services with the Benecon Group, Martin Hale is the director of Human Resources with Kent County, and Andrew Bowen is the town administrator for Middletown on the far end.

I would like to thank Nancy for pulling us together beforehand a couple weeks ago to talk about the study and the type of information that you will be looking for. As you know, during the session, we did have concerns with the legislation. We expressed those at the time. We are really pleased the study was incorporated into the Bill, and, really, our main point of concern right now is the Local Government Insurance Trust that Tim and Jim will speak about.

What we thought we would do today and based on that meeting is kind of provide you with information about the health cooperative, how that works, the benefits it provides, as well as have you hear from a couple of the members from that, and why they made the decision to join the health cooperative, and how it has really been one that's allowed them to put their employees into good plans, but also save taxpayers' money at the same time.

I will touch briefly on some of the data that we have to provide to you from MACO. We are in the process right now of collecting the aggregate points for the stop-loss insurance for our

self-insured counties. We should have that probably the middle of October timeframe. We also have some information on counties that are fully insured versus self-insured that we can provide to you, and, as you perform the study and move forward, we would be happy to help you with surveys and gather more information from our local members.

With that, I'll turn it over to Tom to make a few comments as well from MML.

MR. CURTIN: Thanks, Andrea. I'm Tom Curtin with the Maryland Municipal League. I just want to thank the MIA for the opportunity to come in and speak about our program and our experiences. As Andrea said, we will be collecting data from our participants in the co-op. We have some of our experts here today, so I won't really take up much of their time.

I just want to emphasize from the local government perspective, the dollars that we can save or that our members can save on health insurance go directly back to their taxpayers. Any budget items in their entire budget is looked at and accountable to the taxpayers and the savings go directly back to

providing services. I have people here to speak to their experiences. I will be surveying the rest of our members to provide some data that Nancy mentioned and we will get that to you.

MR. AILSWORTH: Good morning. My name is Tim Ailsworth. I am the executive director of the Local Government Insurance Trust. We were created in 1987 to solve another insurance crisis that's unrelated to this matter. We have grown in that program to about 182 members and assets of about 60 million-dollars, so it's been a very successful mission.

I took over as executive director in 2009 of the Trust, and was commissioned immediately by my board of directors, which are trustees, which is made up of local government officials, to solve an ongoing problem of health insurance cost for our local governments.

With that, my board had already contacted the Benecon Group out of Pennsylvania, and we were negotiating with different carriers to run a network and also be our claims administrator, which we have

selected Cigna ultimately, and have enjoyed a great relationship.

The programs began July 1, 2010, and since that time, we have grown not significantly, but we have grown from an initial five members up to 19 members. We cover 1,300 local government employees. Here today, I brought two of our members. One county member and one municipal member came, Mr. Bowen representing municipalities and Mr. Hale representing Kent County, to talk about the experience and the results that they have had.

Mr. Hale's group was an initial member and Mr. Bowen's group I think joined the second year of the program and their experience since then. Before that, I want to introduce James Hechler, who is sitting two down from me, and James is the actuarial vice president for the Benecon Group that does the pricing.

Some of you may ask or remember Jim at one time had another health pool that didn't do so well. It was reformed this way, so we took the keys to the car away from the children. We actually have Benecon

prices each member rather than letting my board set the pricing. It seems to be working very well.

With that, I'll turn it over to James.

MR. HECHLER: Thank you, Tim.

Again, my name is James Hechler with the Benecon Group, and we manage the Maryland Local Government Health Cooperative here in Maryland. We also have municipal cooperatives in Pennsylvania that we have managed for quite a few years for local governments, for county governments, and also for school districts. I think that's a long, successful track record in the state of Pennsylvania, and, as Tim mentioned, we have been here in Maryland since 2010.

Our model is really about helping groups to take advantage of the efficiencies of self-funding, and helping to save those dollars and return those dollars back to our members. The advantage of the model are really the savings and then also the transparency of our groups.

As they are in, they see their experience throughout the year, they understand what's going on, and they know what to expect throughout the year.

It's not just sitting at the end of the year coming up on open enrollment period with some unknown rate increase.

With that, I'll turn it back over to Marty and let him talk a little bit about some of their experiences.

MR. HALE: Hi, I'm Marty Hale, director of Human Resources for Kent County, Maryland, and we joined the Health Cooperative for our FY-12 fiscal year, and we have been a member ever since.

I have been asked to speak a little bit about the background and reasons for joining the co-op, as well as some of the benefits of the co-op. Kent County is a little bit larger than the groups you're talking about. We employ approximately 200 people.

For FY-14, which is the last year I have concrete data, FY-15 is being rolled up now, our average employee age was 44.9 years of age, and our average member age was 37.7. I don't know if we are a typical group, but like a lot of employers, our employee population is aging, and every year we see

that number increase a little bit.

We offer 100 percent paid medical coverage to our workforce and share the cost for dependent coverage with the employee for any dependents that are eligible for the plan. In 2004, the cost to medically insure our workforce was approximately 1.3 million-dollars eventually doubling by 2009, just five years later. Premium costs were raising so quickly at a time when salary increases were unrealistic due to the economy.

In an effort to save money, we began bidding out our medical policy yearly. We bid it out yearly, and being on the Eastern Shore, we have a limited number of providers. In fact, there are three. The insurance carriers eventually figured that we were pitting each of them against each other, and, in fact, by 2009, one of them wouldn't even bid on our group, and we only had three to begin with that could handle our population.

By FY-09, we began searching for ways to curb expenses and save the county money and the taxpayers' money and the employees' money. We looked

into shifting some of the premium costs to employees, raising deductibles and copayments, and lowering the level of coverage offered, which is all things that you do when you are facing some financial issues. By FY-12, we joined a legit pool.

Some of the reasons for joining premium stabilization. The first year we went in, the initial premium was comparable to what we were paying for a fully insured high-deductible plan. The possibility of smaller premium increases was a strong possibility. In fact, our premium increases, or our history is as follows.

In FY-13, after double-digit increases, we received a 9.87 percent increase, FY-14, 5.62, FY-15, 2.86 and FY-16, this year, we had a 3.39 increase. The last two years were less than the medical inflation, so our group is doing very well.

Transparency, with fully insured plans, we regularly had difficulty obtaining the claims history and experiences, which may or may not support the increases that the carriers wanted. I know it takes a while to compile the information, but one of the last

years we were fully insured, we were told that there was going to be a 40 percent increase across the board, and it had nothing to do with our claims experience. That was a big motivator for going to self-insurance.

Also, the Cigna Group that we are with now is an option that wasn't available at the time. As I mentioned, we only had three insurance carriers that could handle our group on the Eastern Shore that had the providers, the doctors that we needed.

United Healthcare, BlueCross and BlueShield, which did not include the Delaware hospitals or coverage. Our group regularly seeks Delaware hospitals, Philadelphia, Children's Hospital and DuPont, the services of DuPont. They weren't covered with BlueCross. And the last one was Coventry. So it was another option available that wasn't before.

We actually worked Benecon to develop the network for Cigna on the Eastern Shore. As a matter of fact, the last six months, I actually contacted office managers myself and said we are a larger employer on the Eastern Shore, being a county, and if

they didn't join, then they were going to lose some of their patients because they weren't going to have coverage. The coverage wasn't going to cover them if they didn't go into Cigna.

The benefits of self-insurance is the surplus return. After satisfying a pledge share across our surplus to help offset other people in the co-op, the remaining surplus was returned to the county for other uses. Kent County, we actually trend out the medical usage and budgets and estimate surplus in the same year. This allows the county to make decisions about the necessity of raising taxes in realtime, not after the fact.

So if we take the middle of the road and the middle of the road is 1.5 and we are putting 1.7 in the claims bucket after we pledge a 25 percent cost share, we get that money back. So we trend that out, and it stays with us for other uses, which ultimately benefits the citizens.

As I mentioned before, transparency, we request information on a regular basis, and the team at Benecon churn the numbers, and, within a week, we

get the information we are looking for, and that helps us make good decisions as well.

Finally, Cigna has been a great group to work with. Benecon, the company that is handling it, is a great company. They have very knowledgeable staff, and their service at this point has been impeccable.

MR. BOWEN: My name is Andrew Bowen. I am the town administrator for the town of Middletown. Middletown is located in Frederick County near Washington County. It's a very small town, very rural. We have basically 12 full-time employees, so we are a very small system. As you have heard throughout the testimony today, obviously, one of the reasons we went to the self-insurance was due to the cost. We were looking at 35 percent rate increases, looking at having to cut different types of coverage, so we went to self-insurance and saved a substantial amount of money.

You have heard a lot about that today, but what I really want to focus on is something that Middletown does that we never did before, and it

really came out of the self-insurance program, and that comes to the wellness programs with actually getting involved with helping the employees.

When we were with the fully insured, we never knew where our claims were going. We didn't know what the issues were. We didn't know where prescriptions were being spent. We didn't know any of that information. Now, we sit down with Benecon and with Cigna and they tell us what are the major prescriptions that we are purchasing, and then what we can do is we develop wellness programs that address that.

Being in local government are higher prescriptions because of our aging population because of the nature of the work we do. It's a combination of, the two highest are your high blood pressure medicine or antidepressants. So that's local government, and that's sort of what you've got to deal with. We then target programs for that. We never had that before.

Being a small group as we are, we never looked at it. We just didn't know. We had no idea

what the claims were. We didn't know, when we had the health insurance, whether anybody was using it, or they weren't using it. None of that was known. Now we know what that is.

Last year, we worked with Benecon and said hey, one of the number one things you can do for your employees is if everybody gets a physical every single year, you will catch many things before you get the big cost. What the town did is the town funded a program where if you got a physical and you have a form signed by the doctor, we didn't want to know how your physical went, just that you went, you get a $75 gas card. Every single one of our employees did it and got a $75 gas card.

Again, this is one of those program where it was not only helping the town keep its rates low, but it's also keeping the employees healthier. The town has received, since we have been in the program, anywhere between $17,000 and $25,000 a year in rebates.

As was mentioned before, the board funds about 2 to $3,000 for a wellness program that year,

and the rest goes right back to the general fund, whether it goes to parks, street maintenance, whatever the issue is, it goes right back to the taxpayer.

In fact, our program this year is FitBit, and we have a quarterly challenge. Whoever gets the highest number of steps, gets $250. We do that through the whole year. So if you see me walking down the steps when I leave here today, I'm a little behind, so I have to kind of get caught up with it.

We think it's a great program. It puts the town and the elected officials really involved with the health of its employees where they never really did that before. It's not that they didn't care. It wasn't that. It's a small town and we all know everybody, but there was no incentive. There was no drive for it, and you didn't know why you were doing it. Every time they see that number and Tim and Benecon come down and they provide the rebate check for the year, that makes the board feel good.

Just as you said, we don't have to talk about raising taxes. It goes right back in the general fund. So we very much believe in the program.

It's provided one of those few situations that we've run into where it really is a win-win. It's a win for the employer, it's a win for the employee, and it's a win for the taxpayer. I don't see that anybody losses in this deal.

In our group that we have, we have some systems that have bad years, and I'm always warned by the actuaries, look, we've got 1 in 7, you're going to have your bad year, it's going to happen, and that's what the stop-loss is there for, and that's how that helps you through those situations. We very much believe in the program and hope it can continue. Thank you very much.

MR. REDMER: Jim, can you walk through a little more detail the actuarial and the underwriting fees as far as what you are looking at?

MR. HECHLER: When we are looking through for our existing block, obviously, we're looking at the members, we're looking at their claims history. Within the model, you've got two different components or two different layers of your claims. There's the claims in that attachment point, the claims below the

specific deductible, and then the stop-loss insurance that you need to purchase for those high-dollar claims when they come up.

The claims in the aggregate, as you cut off those volatile claims, they become much more stable over a longer period of time even for smaller groups. If each group within the cooperative, as we develop their renewal, it's primarily going to be based on their own experience in that layer of claims.

The stop-loss is much more violative from one year to the next. That layer is really purely based on what's our longterm expectation of claims. We at Benecon, there are a total of 11 actuaries that work for Benecon, we price the stop-loss for all of our consortiums.

One of the things that we can do with our municipal consortiums is actually pull risks together. Once we set that price, we send that to our stop-loss partner and say basically here's the risk, here's the appropriate premium for this risk, and if you don't want it, I know there's a vibrant stop-loss market where I can find another carrier who's willing to give

me that price. We are not accepting any of the risk internally at Benecon. It's all purchased through the stop-loss market.

As far as underwriting of new groups that come in, if the group is over 100 and we are able to get claims experience, we can certainly use that claim history to develop what is an appropriate price for that risk going forward. If they are under 100 employees and they are fully insured, they don't have claim data available, we can look at where their fully insured rates are set, what are the demographics, what is their plan design, and we will develop the rates from there.

The employers will also fill out a disclosure statement only in their first year at inception, any known issues that they have going on, and then one of the components of our program, again, the leverage of bringing all of those groups together, we do not allow any lasers at renewal to be applied by the stop-loss carrier.

That's one of the deals of here's a block of business, here's a sizable amount of premium for you

to renew all at one time, it will all stay with you, but you can't target a specific risk and try to laser that off and push that risk away from you back to the employers.

We represent the employers, the local government employers in Maryland, and it's our responsibility to price that risk appropriately, but not push risk back down to the members. If you're in the insurance business, you're in the business of managing and accepting rates.

MR. REDMER: Where you have claim experience, to what extent, if at all, are you doing any predictive modeling?

MR. HECHLER: We are doing I wouldn't say any predictive modeling on individual claimants, because that gets to be very unstable, unreliable models for predicting your claims on any one individual, but, again, looking at the aggregate for the group in total claims up to their specific deductible, yes, we are looking at what had their claim history been, and where do we need to set those attachment point rates to make sure that we're having

it funded appropriately.

MR. REDMER: And are the individual employer groups able to select their own aggregate and specific stop-loss?

MR. HECHLER: We recommend the specific deductible for each employer, again, based on their size. Smaller employers can't afford to take as much risk. They don't want the volatility. That's what we're trying to protect them from. Larger employers that have more cash flow have a bigger budget, have the ability to take a little bit more risk on themselves so they don't need to buy quite as much insurance. As far as the attachment points go, up until this year, it was 115 percent attachment point. Obviously, it will go to 120 percent for any new members.

MR. REDMER: Does anybody else have any questions for the panel?

(No questions from the audience.)

MR. REDMER: All right. Thank you.

Is there anybody else that has anything that they would like to add; observations, requests,

complaints?

MS. HEBB: I just hope that everybody here has heard the value of the self-funding arena.

MR. REDMER: Excuse me. Could you introduce yourself?

MS. HEBB: I'm Deb Hebb with Keller Stonebraker from Hagerstown, Maryland.

I'm a big advocate, as some of you know already, about self-funding, and that's the main reason that you are here today. First and foremost, we have a problem with health care and the cost of health care. It's very hard to understand that if we don't have the numbers and the information about what the problem is.

With respect to the self-funding arena, because we can see the types of medications being taken, and the other issues are how much will that therapy be, how much urgent care, ER care, we can't resolve the problem if we don't know what the problem is. Unfortunately, with the fully insured market, an employer does not get any information whatsoever regarding what is happening with claims, not even just

for their own party, but, in reality, for the entire group.

I'm in Western Maryland, so, of course, in Western Maryland, we got our rates based on the groups in Western Maryland. I even asked just give me a generality, how is our preventive care in Washington County, how is our cancer, how is this, so that we can help to figure out what the problem is and then try to contain it. We could not even get that type of information for fully insured accounts.

It is very important, if you want the problem solved, we must understand what the problems are. That's something employers are asking. They're fine. I have some that get back claims more than one time, but because they can see what the problems were and then justify oh, my, I understand it now, I see it, then they're so much more willing to say, okay, I need to do this, or I need to do this to help my group out.

We do have high costs. I have one group right now, approximately 90 employees who use self-funding. They have one drug that somebody's been

on for five years called Kliovance. In the U.S., Kliovance costs $10,700 a month even though it's been around since 2001. It started off approximately $3,000 in 2001. If you go to Canada, you can get a year's supply for $45,000. For my client, it's costing $120,000.

He now has somebody who is going to be taking Hepatitis C. The Harvoni that you see on TV, it's $95,000 for that as well for a 12-week period. He didn't qualify for that because he has what's called genotype 3 versus genotype 1, but they did put him on a new one, and it's $50,000 per month, so they're going to pay $150,000 for a 12-week regime. They see that.

They're not jumping off of self-funding. They understand their claims, and they want to treat those people and make sure that they are healthy. By understanding it, they are able to move forward, and move forward with everything else that they are working with. They see where there meds are and what's causing it. They see where the problems are with their employees, and they can help to resolve it.

I guess maybe what I'm saying is maybe the fully insured market might want to look at what some of the self-funding market is doing and maybe try to adopt some of it so that the employers have more information in order to help resolve the problem. That's what I would like to say. Thank you.

MR. REDMER: Thank you.

Does anybody else have anything? Going once, twice.

(No questions from the audience.)

MR. REDMER: Thank you, again, for your participation, and you will be hearing more from us in the weeks and months to come. Thank you.

(Proceedings concluded at 11:17 a.m.)

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STATE OF MARYLAND

SS.

I, Stephanie Sturm, Notary Public of the State of Maryland, do hereby certify that the within proceeding was recorded stenographically by me and this transcript is a true record of the proceeding.

I further certify that I am not of counsel, nor related to any of the parties, nor in any way interested in the outcome of this action.

As witness my hand and notarial seal this 4th day of October, 2015.

My Commission expires
January 4, 2019

Stephanie Sturm
NOTARY PUBLIC

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