Deposition of:

Hearing

July 16, 2019

In the Matter of:

ACA Rate Hearing

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BEFORE THE

MARYLAND INSURANCE ADMINISTRATION

2020 ACA PROPOSED HEALTH INSURANCE PREMIUM RATES HEARING

200 Saint Paul Place, Suite 2700

Baltimore, Maryland 21202

Tuesday, July 6, 2019

2:00 p.m.

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Reported by: Danielle E. Lawrence

A P P E A R A N C E S

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Health Care for All! Coalition

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2020 ACA Proposed Health Insurance Premium Rates Hearing

July 16, 2019

P R O C E E D I N G S

COMMISSIONER REDMER: Good afternoon, everybody. This is Al Redmer of the Maryland Insurance Administration, and welcome to our 2019 rate review for the 2020 proposed rates for the small group and individual health insurance market. For those of you that are on the phone, thank you for joining us and, if you could, please put us on mute until or unless you're going to speak. With me from the Administration today; to my far left is Brad Boban from the actuarial team, to my immediate left and returning to the Insurance Administration our new Chief of Staff Zac Peters. Day, like, four or something?

MR. PETERS: Something.

COMMISSIONER REDMER: To my immediate right is Van Dorsey, our principal counsel from the Attorney General's Office. To the far right is Todd Switzer, our chief actuary. Next to Todd is Nancy Muehlberger, who basically runs everything. Also in the room we have Adam Zimmerman, one of our actuaries, Tyler Hoberstole from the government relations team, Mike Patty, our

director of government relations, and Julie Hatchet, our associate commissioner of Consumer Education and Advocacy. Also with us today is J.P. Cardenas from the Exchange as well as Michelle Everly, the executive director of the Exchange. Thank you for being here, and Pat O'Connor from HEAU of the Attorney General's office.

Before we get started I just want to pause and thank our team. You may or may not know we didn't have air conditioning till about 11:30 or so this morning. The Maryland Insurance Administration actually closed. Everybody went except for the dedicated folks that are here today, so appreciate you hanging around because I sure didn't want to do this by myself.

And with that, again, thank you for being here. This is something we've been doing for, I guess, this is year number five and this hearing is our continuing effort to conduct business in an open and transparent manner, so we appreciate your participation. As you know, we're in a much better place than we were just a couple of years ago through the hard work of Governor Hogan, the Maryland General Assembly, the Insurance

Administration, and the Health Benefit Exchange. Collectively, we received a 1332 waiver from the federal government instituting a reinsurance program in the individual market that has seen some success.

So, we are optimistic, but with that being said, we're going to go through the same thorough review of the proposed rates as we always do. Normally at this time, I forget about Todd Switzer and I launch into something else, but I actually read the agenda this time. So, I will reintroduce Chief Actuary Todd Switzer for his opening remarks and overview of the market.

MR. SWITZER: Thanks, Al. Good afternoon, thank you for being here. Before the carriers come up my aim is to give a background. It covers a variety of topics. I hope it hits one of concern to you and it sets a framework for the discussion.

COMMISSIONER REDMER: Hey, Todd?

MR. SWITZER: Yes.

COMMISSIONER REDMER: Excuse me for interrupting, could you move closer to the phone and speak louder for the folks that are on the phone?

MR. SWITZER: Sure. I was going to access a little bit of the slides so I'll try to speak louder if that works.

COMMISSIONER REDMER: Okay. Yep.

MR. SWITZER: So, just -- I'm going to speak in row 2, as you're familiar, 2 camps. The individual non-Medigap market blew by their coverage without the benefit of an employers contribution or assistance and the small groups with 50 or fewer employees. And it's been a while since the press release came out so let's talk about the individual market.

First, the size of the market is, as of March 31st, of 201,001 people, Marylanders. The market share breaks down as 56 percent for CareFirst HMO. For the PPO about 6 percent, CareFirst PPO, and Kaiser at 40. What was filed on May 1st was a 2.9 percent decrease composite overall. The range within that is a negative 8.9 for CareFirst HMO. That has since come down to negative 10. There's lots of integrations along the way, 9 for the PPO, and 3.9 for Kaiser's HMO. That follows last year where the overall increase was a

negative 13, a negative 17 for CareFirst, negative 11 for the PPO with CareFirst, and negative 7 for Kaiser.

One unique thing I wanted to bring out is that as the rates have been filed for the first time in a long time, Kaiser's not the lowest rate and that's a dynamic that -- a different, unique model just that we took note of. So, this 200,000 members is more than we excepted to have at this time. Wakely, when they did their 1332 modeling thought we would have an average of about 181,000 for the year. We do expect from past patterns a bit of a drop off from this but we're ahead of where we thought we would be at this point. And part of that -- next slide, please.

I just wanted to bring out where some of the growth happened, and by growth I mean I tried to compare this year's open enrollment from the Exchange's data to last year's, so January to January. And over the 26 counties where the top 10 growth happened was in the rural regions in Wicomico County, Caroline, Eastern Shore, Western, Southern Maryland. Double-digit growth at the top, 27.8 in some of the regions of the state

where the uninsured rate is the highest and the need is a little more for access and affordability, and that's where we saw the growth. A lot of the tax credits, as you know, in some regions where CareFirst is the only carrier, some of the tax subsidies are very high which is 800 a month or more, and it produced some of those or at least played in.

Let's go to small group. The size of the market is about 270,000, and we did see a little bit of growth from last year. We used lots of legal entities but we just looked at the 4, rolled them all together. Market share CareFirst at 71, I have United at 25, Aetna at a little more -- little below 1, Kaiser at 4. Last year what was approved was 4.9, an issue that's been filed is similar, 4.4. There's a big range on that. This is the first quarter '20 or first quarter '19, anywhere from 1.6 up to 15.5 so there's a big range composite of 4.4, and that hopefully sets the picture for small group.

Let's go to the next slide. So, it's important that we don't forget looking back we looked at gain loss and for all of the carriers represented in the room,

when we looked back at individual it does exclude some of the carriers that are no longer with us, just wanted to be clear on that. But in the individual market, we looked at privileges one year before ACA and then when ACA or -- I meant small group for the two main pieces of the Affordable Care Act. It's important that we don't forget that over the -- since the start of ACA in individual market, a half a billion dollar loss.

So, for the nonprofit, it's consistent with their mission. They stayed in the batter's box and had those kinds of loss. This year was a welcome change, a 56 million dollar gain, this year being 2018, 4.2 percent. And then just to look at the other counter piece of it of small group, 371 million gain, 6.9 percent over '14 to '18. These are different carriers in here, you got Aetna and United in here as well, and in 2018, a 27-, 28 million dollar gain.

So, trying to provide some context. I'll leave some of this as a legal hind for you if you care to look further, but when we went from '13 to '14 there was some big, big changes and we see how the 5 years have

unfolded. I wanted to just take a minute on the individual to break out the 55 million dollar gain, 56 and point out that for the HMO of CareFirst was 7.4, for the PPO 3.5, and although Kaiser did better, it was 11 million dollar loss. So, that's how we break that apart and understand the rate increases. They seem to align with the financial results directionally that we saw a minute ago. One last thing I'll leave for you.

We just talked about a few numbers, again, for context. We talked about the 55 million for individual ACA, for 28 million for ACA small group. But this is for, again, all the carriers here. Their whole picture, all the other coverages that are offered so we can see the whole picture and see that there are other pressures, on financial pressures. And the self-insured market loss 42 million, '18, Medicaid loss 2 million, it was a wide range among the MCOs. Large group made it 151 million.

Again, for context to state what we're talking about and then see the whole picture. So, the rate increases we just saw, these are some of the main

assumptions that my team and I look at. You've heard them before, I'll talk about some of the main ones. As you know, if any one of these assumptions changes the rate increases changes. Whether it by a lot or by a little, but they change. And for the individual market, again, filed 5-1, the average trend that was filed was 6.9 percent.

There's a range on that from 4.3 to 9.5. In terms of contribution to reserve or profit, the average is 2.4, ranges from 2 to 3. Administrative costs, $60 per member per month, a very wide range. And for small group, average is 7.4, range was 3.9 to 11.2. Profit contribution to reserve compares at 0 up to 3.4 for an average of 2, and the administrative costs are a little flatter.

On the individual market for risk adjustment for what CMS published not too long ago, Kaiser paid 120 million on risk adjustment transfers. There was about 30 million to CareFirst HMO, 90 million to CareFirst PPO. That dynamic is still very, very real in the part of the filing. On the administrative cost side we're

working with the carriers. We've had some concern, we've looked at some data for the whole country, tried to see where Maryland falls in terms of administrative cost and while we want to get some more data, it's like we're about the 75th percentile and that's something that we want to understand better.

So, we've been asked for other things that we and the actuaries consider, that result is considered. One thing is to look at high claims, and this is the top 10 claims in the individual market by the four carriers. I understand that in a vacuum these don't mean too much, but we've also looked at the claims probability to sedition and tried to look for anomalies and this doesn't look abnormal to us. We expected million dollar claims, we thought we might see some 5 million or even 10 million but we haven't, thankfully.

And we keep monitoring that and when we looked at these claims in light of the reinsurance program we saw how much is still the companies liability and we had about 75-25. I don't know, Brad, if you wanted to add anything to that. I know we talked a little bit.

MR. BOBAN: Yeah, the 75-25, I mean, this is for the most extreme claimants. For less extreme claimants the state's going to be picking up a greater share, and so a lot of this is given by the cap. The reinsurance program only pays up to 250,000, and so we looked at everybody eligible for reinsurance and we didn't have quite this breakdown. But this does demonstrate that carriers still have a lot of liability for these reinsuring members.

MR. SWITZER: And a lot of, in fact, to care management. Another factor that we consider is what came out about monthly growth from the HSCRC on the hospital per capita global budget revenue increase, and that number you may recall, 3.28 for fiscal year of rate year 2020. And the way we're figuring that into our review is that the 3.28 of this year was split into private and public of 4.79 and 3.09, and that tied with the fact that effective of a week or so ago, 7.1. The payments to private carriers -- private payers used to be 6 percent higher than public. That's gone to 7.7, and that's why this 1.7 difference is there.

And as we project for our rate filings from '18 to '20, I believe what happened last year, 1.37, 4.79 for the annualized 3.07, just to be clear on how we're using this data that came out from the HSCRC. There's lots of reason why for the hospital piece which is about 39 percent of the total claim. It won't be exactly this number, it's a mix of hospital use, mix of service changes, et cetera. But that's not to diminish, but it has an impact and it's part of what we're thinking through extensively.

Another aspect we look at for context is the risk-based capital and the net income. So, this is for all the legal entities that have filed. What I'll bring out is from '17 to '18, statutory basis, that the risk-based capital went up 490 to 534 for artificial number of the total adjusted capital where we've authorized control level. But directionally, the right direction and the same with the net income, 4.7 to 1 to 6.0. That wasn't the case if we showed more of these years. There's lots of negatives here and there were negatives before, but some of the moves will hopefully

stabilize and the kind of rate increases we got are tied with this as well.

Take a minute on the reinsurance program. The 5 numbers I wanted to talk about. First, there's the 181 or -82 members that on average for the year '19, we thought we'd have, again, that may be higher. The second number is the estimate for 2019 is that the reinsurance would cost 463 million. That's with the Exchange and their hard consult and our process of evaluating is it 462, is it a different number. It'll be different even if only for the change in enrollment, but an important number.

The second is, as you recall, the state put in 365 million of seed money and, as you know, the tax subsidies and the premium come down, the federal government pays less in subsidies and they give that money back to us in passthrough, so that amount was 779,000,000. So, that 365 leveraged up to 1.1 billion and if you care later this is how the money gets depleted over the 3 years, and this was the estimated rate impact, negative 30. About negative 30, negative

14 but, one, the Exchange is remodeling this. I've cut it off at 4 years, but 10 years. We want to be careful managers of this and make sure that we look at it regularly and that the 10-year projection with the benefit of better information, make sure we're on track.

And, also some legislation, as you know, was passed to have not just this 365 but another 1 percent, which was estimated at 600 million over 4 years or 140 million in 2020 to keep this program able to absorb any fluctuations and provide some other options (inaudible).

So, some question, is the waiver working. The way we're defining working is -- I think it was said well by Health Care For All in their paper yesterday -- one of the next steps in this process of stabilization is attracting a pool that's younger and healthier. And we're to answer the question of who did we attract. And we first looked at 2018, and said for the whole market the single risk total is 194,000 members, and the average age was 40.6. And the new members were about 48,000, 25 percent of the single risk pool ages 37.1.

So, they were younger than the single risk pool,

3.4 years. But that alone but, first of all, demographics are not the same as claims, so we really need the rest of the picture that way. But at least from what we had available, the demographics, they were younger. But I wanted to see if that was any different than last year, and last year 39.7 for the single risk pool, 14 percent new, average age of 38.9. That's a .8 less than the single risk pool. So, I think the answer is we don't know yet if we're attracting the people we want to attract. However, at least directionally it's positive that they're a little younger, 3.4.

The other thing that gave us pause is if you just look at the absolute value of the ages, 38.9 and 37.1, that's a little less than 2 years. But 2 years is 2 years and we'll see how the claims come out. But we're trying to -- as soon as we have data available, see if the reinsurance program is attracting a pool such that we can keep rates stable and accessible.

For the individual market, this slide and one of the public use files from CMS, that quantifies how unique it is was this one. And just walking across for

a minute it says that the percentage in the individual market designs changed as of 2019, 76 percent. It says that 61 percent of the market get a subsidy, a tax credit, and the other 31 percent also get a cost sharing reduction deductible out-of-pocket reduced.

And what that means is if you look at the whole market the average premium was 552, but when you figure in the tax credits for the government, federal government, it's 191. So, there's -- kind of quantifies how heavy the subsidization is, and if you just look at those few who get a subsidy the average subsidy was 477 a month. Such that they're paying 110 a month, those who need financial assistance. So, more than 80 percent of the premium being subsidies among those getting the tax credit.

This is the individual market, all the carriers where the enrollment is by metal, and the two things that stood out to us were last year this 22,000 are an estimate of how many people took that subsidy, the 477 or more, and bought a bronze plan. Maybe a free bronze plan, and that's about the same as last year, 11

percent. But the people that brought up, these 35,000 here to gold or platinum didn't want to pay those 4-, 5-, 6,000 deductibles. It went up considerably, another 11,000.

Last year it was 12 percent of the pool. This year it's 17 and that plays out in some slides that are coming up. I saw this article where we talked about the pressure on consumers, and the author titles it The Most Important Health Insurance Chart You'll See, and it brings out the pressures on the consumers, as you well know, hasn't just been on premium but it's also been on cost share. And it shows in 2014 and then after when we combine the two how sharply things changed.

So, we're trying to review these filings with both in mind and other insurances, both after one there's a premium, but there's also the cost sharing. And the next couple of slides, I think, bring out some good things. This is what's been filed, the whole individual market in terms of premiums for four year old silver. That's easy to see which ones are the PPOs, but it goes from catastrophic across the metals, and the

average -- our best estimate of what people are paying today for an average deductible, about 4,122, $4,100 in deductible and out-of-pocket was 7,123.

If they don't buy up again that deductible could come down to 38,995, the out-of-pocket could go up a bit. But I think more telling is some of the plans that -- some of the stability we saw in the individual market and some of the new plans. Specifically, for some people since the start of the ACA every year, five years in a row they saw their benefit change, uniformly modified. They didn't have that stability, but they all had the same plan that they have before.

This year it was starkly different, only 5 out of the 20 plans changed and two of them had to change, change the catastrophic plan. So, there's a lot more in stability at least benefit-wise. Also the value plans have a significant number of services in front of the deductible, so it's a co-pay but in front. For example, for Bronze, three PCP visits before the deductible, (inaudible) for silver. All PCP and specialists, and urgent care, and X-rays, and labs before the deductible,

co-pay before the deductible, including mental health and substance abuse. And as for Gold, you have all of that plus generic drugs before the deductible. And Brad, again, if there was another -- anything I missed here you wanted to bring out, but we tried to graph the value plans.

MR. BOBAN: The only thing I would add is that some of these value plans are uniform modifications from existing plans, meaning people are going to get them without having to take action. But some of these are brand new plans that people are going to take -- have to take affirmative action to move into, and we just highly recommend that the consumers take a look at these value plans and even though the premium might be slightly higher the cost share savings could be considerable and that they definitely are going to be a good correct fit for a lot of consumers. So, we do recommended taking a look at the new options that are on the market.

MR. SWITZER: As -- can you just go back for a second, yes. The value plans, if you care to look later, are all along the way here and there's not a real

spike. They seem pretty affordable relative to the plans around them, but that's for you to see, but that stood out to me. In the small group market it's a different dynamic, as you know. We have about 734 members on the Exchange, SHOP.

As far as what people buy we recognize that when the employer's paying 75 percent of the premium there's a different dynamic and there's the ability to buy (inaudible) benefits, but the way that's quantified is for Bronze -- or as in small group only 7 percent are in Bronze, 22 percent of the individuals are there. And for Platinum, there's an individual market of 1 percent in Platinum where it's just 15 percent here in small group. That's where -- how it is distributed as of March.

So, came across this slide and I just want to talk about wellness for a minute and close. For those making, this is as of -- in 2019, for those making $50,000, that's about 40 percent of the federal poverty level, 65 percent of people said they put off medical care before of costs and another 29 percent said they

put it off for over a year because they couldn't afford it. And even if you're relatively wealthy it's was still 40 percent and 16 percent.

So, I wanted to highlight a lot of the work that the carriers are doing to combat this for everybody's good. We ask for a lot of data related to the primary care medical home; how many people are in wellness plans, how many people are in care plans, how many people are in diabetes prevention screenings, provider quality, exercise programs. We still have to gather some data so I withheld some of those slides, but we think it's an important aspect to support all the other efforts to do everything we can to the core problem of having quality care and controlling costs and getting people healthy rather than just paying claims.

So, there's some data on this, again, we're gathering more to have a rounded picture, but it's the other aspect that's important too. So, thanks a lot for your attention and I'll turn it back to you, Al.

COMMISSIONER REDMER: Okay. Thank you, Todd.

PHONE OPERATOR: This meeting is being recorded.

COMMISSIONER REDMER: I hate when I'm being recorded. I apologize, I forgot to introduce Jeff Li, from the actuary team. Sorry about that, Jeff. Does anybody have any questions for Todd? Michelle?

OBSERVER: I didn't really have a question. I have two comments. I just want to clarify that value plan Silver deductible is 2,500, that's what the rule is. I think you had first input one at 22.50, but just to clarify that. And I also just want to make note that a lot of this effort in getting younger enrollees is the result of real aggressive marketing and outreach effort by the Exchange. So, I think we just have to consider that in context with the premium, that there's a lot of efforts going on as well.

COMMISSIONER REDMER: Thank you. Any other questions, comments? All right, with that we will dive into comments from the carriers, and we'll start with Aetna. And, again, speak up.

MR. MURAYI: Okay.

COMMISSIONER REDMER: Thank you.

MR. MURAYI: All right. Good afternoon,

everyone. Thank you for the opportunity to present information on our small group rate filings and those working hard to make health care simpler, easier, and more convenient for the people in Maryland. So, Aetna files rates in the small group market for two legal entities. Our HMO entity is Aetna Help, Inc., and our PPO entity is Aetna Life Insurance Company.

Approximately 854 individuals in Maryland are covered under the Aetna small group policies as of May 2019. I'd like to start off by noting that the changes discussed here, that I will discuss here, are average rate changes. The exact rate change will depend on the benefit plan that an individual chooses, when the members' group contract renews, and the age and family size of enrolling employee, and employer contributions.

To develop our rates we take historical claims experience from 2018 and project it forward to 2020. There are five main drivers of rates changes. They include, first, medical costs rising, second, plan designs change, third, estimates of the average morbidity in the small group risk pool, fourth, changes

in taxes and, fifth, other items which include experience coming in differently than we had expected. So, I'll discuss these items in more detail.

For our HMO entity, our average rate increase is 14.9 percent for PPO and our average rate increase is 13.9 for -- sorry, about that. For HMO, our average rate increase if 14.9 percent and for PPO, our average rate increase is 13.9 percent. For simplicity from here, I'll average the rate increases of our entities together. Together those two are about 14.2 percent. We have filed three plans, each for our HMO and our PPO entities both on and off Exchange.

As I mentioned, the 14.2 percent is a weighted average of the expected year over year changes. The exact rate change will depend on what benefit plan the individual chooses, when the members group contract renews, the age and family size for enrolling employees, and employer contributions. So, for example, first quarter consumers will see a rate increase of 15.6 percent for HMO, and 14.5 percent for PPO.

So, now I'll go into the main drivers of these

changes in more detail. So, the first driver was medical costs are rising. Medical and pharmacy costs increase mainly for two reasons; first, providers raise the prices and members get more medical care. Our projected paid trend for medical only is 9.8 percent and pharmacy is 16.6 percent. In total, when you blend pharmacy and medical together our trend is 11.2 percent.

For small employers in Maryland, some examples of increasing medical costs we have experienced in the last 12 months include the cost of prescription drugs have gone up 11.7 percent, and the use of physician services have increased 5 percent. The second driver was plan designs change. Changes to cost sharing for some plans were made to comply with actuarial value requirements and/or make plans more attractive to consumers. On average those plan changes increased costs by 4.8 percent.

Third, our estimate of the average morbidity of a small group risk pool. Our estimate of the average population health and the expected risk adjustment transfers from the Affordable Care Act products have

changed to reflect new data on market average premiums and population health. Small Groups purchasing insurance in the market place are sicker than we had initially anticipated. These changes are expected to increase costs by 3.2 percent.

Fourth, changes in fees. The health insurance fee for 2020 has increased rates as it's been reinstated and that's worth 2.6 percent. And then the last bucket, other items including claims experience coming in different than we had expected contribute to a decrease of 7.6 percent in our rates. We also wanted to update you on what Aetna is doing to keep premiums affordable.

We are taking a number of steps to keep our products as affordable as possible and to address the underlining costs of health care. These actions include developing new agreements, arrangements, and partnerships with health care providers that base provider compensation on the quality of care delivered and not the quantity of services. Second, creating medical management programs that address potential health issues for members earlier, improving health

outcomes and reducing need for high cost health care services.

Finally, we are working to reduce the ability of out of network providers to collect unreasonably excessive payments for services they provide. Again, thank you for this opportunity to present to you today. Thank you.

COMMISSIONER REDMER: Thank you, and any questions for our friend? Todd?

MR. SWITZER: So, I noticed that, as you mentioned, the enrollment's down to 850 members and this time last year it was about 6,500, and that corollaries the cost allocated to brokers, about $3 verus $23 average. I want to ask you the same question as last year, but is there a -- is the hope that this group will grow? I know it shrank 86 percent. Does the broker change indicate a little bit of a retracting from the Maryland small group market or, again, is there anything that you expect to reverse, the enrollment type?

MR. MURAYL: As of now, I think we projected membership further decreases into 2020, so that's

consistent with the trend that we seen over the past couple of years and we expect our share of the small group market to decrease as we go into 2020.

MR. SWITZER: The 5 premiums is about 33 percent above the average. I didn't know if -- you answered the question. Thank you.

MR. MURAYL: Thanks.

COMMISSIONER REDMER: You mentioned your initiatives on primary and preventive health. If offline you could get to us some of those initiatives, I want to ask all the carriers that. If you could get us some of the information. I mean, obviously, we're here to talk about health insurance, but the cost of care and chronic illness is a driver of some of these costs, and we're going to do a little deeper dive into primary and preventive care. So, on the carriers side, any initiatives that you're working on, if you get that to us I would appreciate it. Any other questions for Regis? All right, thank you.

MR. MURAYL: All right. Thank you.

COMMISSIONER REDMER: I appreciate it. If we

can, let's go to CareFirst, Peter.

MR. BERRY: Thank you, Commissioner. My name is Pete Berry. I'm chief actuary and senior vice president of actuarial underwriting for CareFirst. I appreciate the opportunity to come here today and speak. Today, I will be presenting on small group and individual market for the HMO and PPO products sold through CareFirst's three entities in Maryland. I want to start with small group because I believe it's a little briefer and spend more of my time on individual.

As was reported, our first quarter 2020 average rate increase for our small group HMO is currently .6 percent, so about flat. And for the PPO, the rate increase is 8.4 percent. So, just to talk about a little bit of the drivers of the 8.4, really, what the main thing driving that is when we looked at the base period experience from '17 to '18, it went up about that amount. So, we're certainly looking at that to see what's driving it, but we're very happy with single digit rate increases in this market and we're especially happy with flat, just about flat increases in this

market. Let me pause there, any question on small group?

So, if you'll indulge me, I just want to read this first part of my statement. So, for individual, the state reinsurance program has achieved its initial goal of stabilizing individual market rates. The proposed rates CareFirst filed in Maryland reflect the positive developments and are early evidence that the steps taken statewide of the ACA market affect. The attempt of the reinsurance program was for due sharp increases in the individual market rates for 2019 in order to prevent driving healthier individuals from the market.

So, that rate change is moving forward and modest. So, you know, with this, it's been a long road, a two-year road of the 1332 waiver. We've very excited about it. We believe it's great progress. We do believe that the market has stabilized and I want to give you some numbers that's an example of what I'm talking about. This is my fourth year coming to testify for CareFirst and some of you who were there then, back

a few years ago, might remember in '16 and'17, we were talking about rate changes that were very, very high especially for PPO, which is a smaller and sicker pool.

Historically, when we move from one year to the next through open enrollment we had seen in the PPO block that we would lose half our membership, and the people we kept tended to be about 30 to 35 percent sicker than people that left. That was what historically was really driving the instability rates. 2019, we have a preliminary view. Instead of losing half the membership, we still did lose some members. We lost about a quarter of them, but the people we kept were 8 percent sicker not 30 percent sicker. And what this means is that the rate change that we have currently of about 9.1 percent is a single digit rate increase.

Whereas, last year before the 1332 we were talking of rate increases of 90 percent, ten times that amount. Similar numbers there for BlueChoice. Historically, we saw, you know, anywhere from 20 to 25 percent of the people move. This year that is a lot

lower. We saw the morbidity of the people we kept anywhere from 5 to 10 percent on average. This year we did see some people leave but they were about the same illness burden as the people who stayed. That is a -- just a qualitative measure -- or, I'm sorry, a quantitative measure of stability that shows that this 1332 is working.

One update I have as was reported, our original filing for BlueChoice is now minus 10, as to continue to work with the MAA through these. Objections and responses to our rate filings, I'm happy to report that the positive 9.1 for PPO is now down as of Friday to 6.8. We are continuing to sharpen our pencils. We take this very seriously as we did in prior years and I am confident that before we finish that that rate increase for PPO will be below 5 percent, which will be low single digit.

COMMISSIONER REDMER: Did you say minus 5, is that what you said?

MR. BERRY: No, positive 5. Well, let's see, we're not done yet. So, we're about half way through

the process. We continue to work with MAA on objections and responses. What we're seeing generally though is that this year the process is a lot more stable than we've seen in the past with regard to movement. So, for the minus 8 and change, which we filed were minus 10, that's about a point and a half shift. In the past, we could see those move up and down with the substantive changes by double digits. So that's very encouraging.

So, let me finish up by I just want to read this part. These proposed rates generally represent positive progress and good news for many Marylanders and CareFirst is grateful to the Maryland General Assembly for their work to secure additional funding to extend the program through 2023. However, it's important to point out that the reinsurance program approved by Maryland General Assembly is not a long-term solution for stabilizing the individual market. Elected officials, insurers, regulators, hospitals, and others must continue to work toward vasting solutions that reduce the cost of care and help make coverage truly affordable. So, that's the end of my prepared remarks

and now if I can answer any questions.

COMMISSIONER REDMER: Peter, thank you, I appreciate that. I don't know if you have the answer to this or not.

MR. BERRY: Sure.

COMMISSIONER REDMER: I think it was 2015 when the individual rates were much lower than small group. Chet Burral, at the time indicated that, I think, there was 7,000 small employers that disbanded their small group plan, and those 21,000 employees migrated from a CareFirst small group plan to the CareFirst individual plan. I know that a number of providers last year, with the facts that individual rates were much higher, were trying to put some of those groups back in. Any data to suggest to the extent that that occurred? People living - leaving the individual market and migrating to the small group plan with CareFirst?

MR. BERRY: I'm -- not specifically off the top of my head. I have seen our small group market grow. That is certainly something we would be able to identify. We'd have to follow up and give you that

information.

COMMISSIONER REDMER: Just curious. Todd, anything?

MR. SWITZER: In the individual HMO projections into the future so you had estimated, as you know, for '19 that the -- of the trade transfers, existing transfers, that there would be about a 3,000 transfer of members in 2019, but that would go up in 2020 by about 67 percent to 5,000. I understand if that's too much detail, but is that ascribed to a particular driver, that the transfers would increase by that amount, that kind of magnitude?

MR. BERRY: So, let me just make sure I understand what you were talking about. You're saying that the transfers into the individual market for BlueChoice are going up --

MR. SWITZER: From anywhere.

MR. BERRY: Yeah.

MR. SWITZER: But into BlueChoice.

MR. BERRY: Into BlueChoice?

MR. SWITZER: Right.

MR. BERRY: Yes. So, the transfers represent members who currently have -- just so everyone understands what the term -- transfers represent members who currently have CareFirst coverage, but not in the BlueChoice individual ACA market. So, these could come from -- PPOs could come from group coverage. We track these over time. In some cases they tend to be sicker. In some cases they tend to be healthier.

I'm going to have to go back and look at the details on that. We do -- actually, we've submitted quite a rigorous projection of enrollment by the 3 charges of existing, new, and transfers because, as we've discovered over the last few years it's a really, really critical assumption coming up with these rates but that's certainly something we can go back and appreciate it, sir.

MR. SWITZER: Sure.

COMMISSIONER REDMER: Anything else? Okay.

MR. BERRY: Great. Thank you very much.

COMMISSIONER REDMER: Thank you, appreciate it. And moving along let's go to Kaiser.

MR. LIEBERT: Thank you. This is David Liebert and I hope you can all hear me well on the phone.

COMMISSIONER REDMER: We can.

MR. LIEBERT: Can you verify, all right. Sorry I couldn't be there in person. It's not a long trip from Portland, Oregon but I've been working on these filings for quite a few years now and I'm happy that I got the opportunity to present to you today. So, I'm going to talk about, first, the individual market filing for Kaiser, and this filing represents the 13 plans offered both on and off Exchange.

We really have not significant plan changes this year other than changes that are necessary to keep the plans within the metal tiers. And these plans service approximately 75,000 members throughout Maryland, this year apparently. And if you look since the beginning of the ACA in 2014, much like other carriers have indicated, we've seen significance rate increases some as high as 33 percent which was in 2018, and then last year with the creation of the 1332 waiver reinsurance program, we saw a decrease of 7.44 percent.

And, so looking at the impact of that program to continuing on into this year's rate increase we filed a 3.93 percent rate this year. And I estimate that without the reinsurance program that rate would of been 25 to 30 percent higher than what we're filing, than what we filed. Right now, after some adjustments we've gone through the review process, and the rate increase is right about 2 percent with a range of minus 2 percent in some plans up to 4 and a half percent for other plans.

And these increases are really driven primarily just by inflationary trends and medical costs. We've seen in our experience the (inaudible) claims go up about 4 percent from 2017 to 2018, and we've also seen the reintroduction of the federal health insurance provider fee also has some impact on these rates. As previously mentioned, you know, the reinsurance program has had a significant impact on the rate. And we looked at what that's done to the membership.

And much like, I believe, Todd had mentioned earlier that the new members in 2019 are younger than

we've seen before. We're seeing about a 4-year difference between our continuing members from 2018 to 2019. The new members are about 4 years younger on average than the continuing members, and we would attribute that primarily to the reinsurance program and how it's lowered the rates (inaudible).

The reinsurance program has done more steps, the fact that it has lowered rates by 25 to 30 percent, and we will see how that impacts the claims as they emerge throughout the year. Right now, we really don't have a clear picture of that, but it's looking positive with how it's impacted the ages of our members. In the past we typically saw our market, we continued -- our membership continued to get older from the beginning of ACA through 2018, and we typically see the people who are dropping our were a little younger than the people continued.

And the people who were coming on were about the same age as those that were continuing, so it just kept on getting older. And, so we're hoping to see a little reversal in that trend with the lower premiums. And,

so, now I'd like to shift to the small group rate filing. The small group rate filing represents 57 plans both on and off Exchange, and two different provider networks and they currently serve about 10,000 members throughout Maryland.

We initially filing a first quarter rate increase of 9.96 percent with a range of 6 and a half percent to 11.3 percent. And looking at the quarterly rate increases, because our trend for the 2020 rate filing is a little higher than it's been in the past, early trends are also a little higher. So, the overall rate increase accounting for these quarterly trends is 10.23 percent. Unlike the individual market the small group market has been relatively stable since the inception of the ACA.

Now, looking back at the rate changes that we have implemented from 2015 through 2019, and it essentially is flat over that course of time. There's been some ups and some downs year to year but it's effectively been a wash in rates between those periods of time. And so what's driving a 10 percent increase

for 2020, and it comes down to our medical claims history. We've seen a large increase in high claims, high dollar claims, for the experience period for 2018 and on the flip side we haven't seen a significant reduction or, actually, we've seen an increase so we haven't seen the corresponding deduction in our risk adjustment payments or pay outs.

So, between those two we really saw a, for us a worsening market in small group market. And when we're looking at ways that we can actually temper the rate increase to hold it down, and 10 percent is really what we worked it down to through a couple of different measures such as pulling those large -- some of those large claims, we don't really expect them all to continue from 2018 into 2019, and '20. It was an abnormally large year and so we pulled some of those large claims as well as reducing our -- who we built in for risk margin from, typically, we file 2 to 3 percent and we reduced that to 0 for the 2020 filing. And that concludes my prepared comments for today.

COMMISSIONER REDMER: All right, thank you

David. Any questions?

MR. SWITZER: Just, David, the young adult catastrophic plan, I was just curious along these lines, as you know the rate is relatively higher than the competition and where you have, you know, 40 percent market share outside the young adult plan you had about 4 percent market share in the catastrophic. I'm just wondering if there had been any discussions about that plan, the 250 members, to try to, I don't know, alter it's current course, if that's clear?

MR. LIEBERT: Yeah, that's clear. We haven't talked about that and we do price that plan along with our other plans and that's just -- that is where we found it falls in our pricing. We also think it looks like it should be a very cheap plan, but with first dollar office visit, it becomes a fairly rich plan compared to catastrophic -- not a catastrophic but problems offering in the market and, yes, it doesn't have many members and long story short, we haven't focused on ways to increase membership in that plan.

MR. SWITZER: Okay. Thank you.

COMMISSIONER REDMER: Any other questions for David?

MR. BOBAN: Yes, I just have one question. So, you mentioned that you have two provider networks in small group and as you know you only have one in individual. Has there been any consideration in launching the second provider network in the individual market place?

MR. LIEBERT: Yeah, there hasn't been any discussion on that. We've run into this in other states that we operate in. A lot of it comes down to just member confusion. Having fewer plans in the individual market compared to small group market, and having fewer options, sometimes it gets to be an overload. And, so we have gone with the goal of trying to keep it simple and so, no, there hasn't been any discussion.

MR. BOBAN: All right, thank you.

COMMISSIONER REDMER: Anything else? All right, David. Thank you very much, I appreciate it. And we will now move to United. Ryan, how are you doing?

MR. MORGAN: Doing well. Yourself?

COMMISSIONER REDMER: Doing well, thanks.

MR. MORGAN: Good afternoon. Thank you Commissioner Redmer and the Maryland Insurance Administration for the opportunity to present today. My name is Ryan Morgan and I'm an actuary with United Healthcare here to discuss 2020 small group rates that United Healthcare has filed with the Maryland Insurance Administration for United Healthcare Insurance Company, Mamsi Life and Health Insurance Company, Optimum Choice Incorporated, and United Healthcare Mid-Atlantic Incorporated.

Across all 4 of these legal entities we're proposing a total of 87 unique small group plans in 2020, 9 platinum, 39 gold, 32 silver, and 7 bronze. Approximately, half of these plans are available on and off the Exchange, and the other half would be off Exchange only. For 2020, we filed for a rate increase of 12.2 percent for United Healthcare Insurance Company, 13.7 percent on Mamsi Life and Health Insurance Company, 13.3 percent on Optimum Choice, Incorporated, and 7.9 percent on United Healthcare Mid-Atlantic, Incorporated.

So, these may be clear, these figures represent the average rate change for each respective licensed entity. So, the actual rate change experienced by any particular group could be higher or lower depending on a variety of factors. Including the census of the group and also the plan selected.

So, one of the primary drivers of our requested rate change is our trend rate. United Healthcare conducted a full review of all the components that contribute to trend. Using the most recent information available we analyzed unit costs, utilization of healthcare services, and the cost impact of deductible leveraging. And all these components were looked at separately for inpatient, outpatient, professional, pharmacy, and other service categories.

Based on this analysis, we are filing for a trend rate of 7.6 percent in our 2020 small group filings. This is higher than the trend we filed for last year and this change is largely driven by higher projected unit costs. This goes back to something Todd talking about earlier. This is, in part, due to the

increase in the Maryland public pair differential, which was approved by the Health Services cost to do permission that took effect July 1st of this year.

The other major driver of our rate change was recent experience. So, in the 12 months ending with May 2019, our claims have increased by double digits, but due to low approved trends in recent years in combination with customers moving to less expensive plans, our premium has increased by less than 5 percent over the same period.

So, given our premium is locked in for the rest of 2019, we expect this pattern of claims to run exceed premium trends to persist through the end of the year which is a contributing factor to our request for a 2020 rate increase that is higher than the trend. And one final item to consider is taxes. So, there was a moratorium on ACA fees in 2019, but we anticipate these fees will return in 2020. Maryland state-specific taxes are dropping in 2020 which offsets part of this change. But the total tax burden for small group insurers in Maryland is projected to be about 1 percent higher in

2020, which is another factor driving our requested rate increase. So, hopefully this summary of United Healthcare's 2020 filings has been helpful and at this time I'd be happy to address any questions you have. Thank you.

COMMISSIONER REDMER: Thank you, Ryan. Any questions for Ryan?

MR. SWITZER: I was just wondering about your wellness program, the (inaudible) program, the exercise program.

MR. MORGAN: Yes.

MR. SWITZER: And it mentions, as you know, in Exhibit M there the device costs?

MR. MORGAN: Yes.

MR. SWITZER: Is that a Fit Bit?

MR. MORGAN: Something along those lines, yes. It may be other vendors as well.

MR. SWITZER: Okay. Thanks. And, so I'm looking at the 4 filings. The only 1 that wasn't deemed, as you know, fully credible was the Mid-Atlantic.

MR. MORGAN: Right.

MR. SWITZER: So, full credibility to the other three, partial credibility to Mid-Atlantic, but then I noted in the actuary memo a statement that the rate increases were derived based on all 4 legal entities using your actuarial relativity calculator to make sure the actual relativities fit the way you want them to.

MR. MORGAN: Correct.

MR. SWITZER: So, my question is, is there another step beyond the credibility adjustment in the pricing that I -- beyond that to achieve what I just tried to kind of outline?

MR. MORGAN: Right. So, yeah, because, I guess you're saying it's because all 4 grouped together, so you would...

MR. SWITZER: Yes, as far along as to look at them all together and we just wanted to give me a head start of if there's another step beyond the credibility adjustment in the way that you computed each of the entities rates?

MR. MORGAN: Right. No, the differences between

them are just driven by kind of the benefit changes. So, for example, the UHCMA is the lowest because there are different plans changes there such at introduction of the pharmacy side narrower network. So, that was only in UHCMA, which is part of what's driving that lower (inaudible) as well. So, yes, the differences between them are really just based on different benefit changes from entity to entity. That's what's driving. Does that help?

MR. SWITZER: Yes.

COMMISSIONER REDMER: That's everything for Ryan? All right, Ryan. Thank you very much.

MR. MORGAN: Thank you.

COMMISSIONER REDMER: I appreciate it and that concludes the remarks from the carriers. We will now go and hear comments from any interested parties starting with those that signed up, and we will start with Former Commissioner Beth Sammis. Nice to see you, Beth.

MS. SAMMIS: Nice to see you as well. Well, thank you for the opportunity to offer a consumer voice to the rate review process. Consumer Health First did

not submit written comments this year for the first time in a long time, which I'm sure you're happy about. But has authorized me to speak today as our last public act as an organization.

So, it's also a little bit of a trick to come up here after Todd have given such a wonderful overview and then the carriers announce that they have decreased their rates even further. So, we're working off of essentially what's available on the website, and my comments may seen trivial as a result.

COMMISSIONER REDMER: Never.

MS. SAMMIS: But they were done in good faith. So, as everyone has remarked, the 2020 rate files demonstrate really the power of the state's reinsurance program and, you know, the state really should be commended for having taken such an extraordinary step to help stabilize this market. And, but one of the things I think that Todd said in his remarks, if I recall correctly, is that part of this was done to try to attract younger people back into the market and, I guess, from my standpoint I was argue that it was done

primarily to stabilize the market so that we didn't lose.

As I have said for many years, and I'm sure you'll miss this when I'm gone, is that this market has never been a market primarily for the young. It is primarily a market for those who are in between jobs, and for particularly those who are in my end of the age spectrum, where they are often times found to have some difficulty landing on their feet in a job that pays benefits between the ages of 50 and 65. And those are the people for whom they have always relied on this market.

Of course we want to try to attract young people and to keep everyone insured, but the truth is is that the reinsurance program was done to be able to make sure that everybody in Maryland, irrespective of their age, has the ability to be able to purchase health insurance coverage. We like you do not believe it is in consumers interest to simply rely on reinsurance to lower premiums for next year and we're pleased that you agree with this and will be conducting, and have already demonstrated

that you are conducting a thorough rate review to be sure that premiums are as low as possible, including for those that who do not qualify for a subsidy.

I think that it's pretty clear from the information that Todd presented that the subsidies help out a lot but for those who are not able to qualify for the subsidies the actual, you know, dollar amount of the premium makes a big difference. And we don't want to lose them anymore than we want to lose those who qualify for a subsidy. So, before I begin, I want to thank you and your staff for publicly affirming last year and continuing to do so in your remarks today, that you'll consider the experience and impact of high risk members in the individual market, the carriers' programs to manage care and improve health outcomes, and CareFirst's statutory mission when reviewing rates in the individual market.

Considering all of these factors will go a long way to ensuring a thorough rate review that results in individuals paying fair and reasonable premiums. It's certainly not a question for today, but I think that

it's clear from the encouraging continuation of the growth or at least stability of CareFirst surplus that going forward you're going to have to wrestle, I believe, as a regulator and the state policy markers are going to have to write -- to wrestle with what is really a fair profit for CareFirst to make in the individual market, which is essentially a troubled market. Always has been, always will be a troubled market.

Really, what is fair going forward and how much should those individuals be expected to contribute to the contribution of CareFirst, and I would hope that at some point somebody would ask how in the world anyone who's doing self-funded business can lose money, but that's for another day. This year's rate filings, to us anyways, shows some interesting differences between Kaiser and CareFirst. Kaiser assumed a 4.3 percent trend while CareFirst assumed a 8.5 percent trend for it's HMO, and a 9.5 percent trend for its PPO.

Certainly there are many differences between CareFirst and Kaiser and most everyone in the room is well aware of these. Needless to say, the models are

quite different. The types of individuals that they cover, there's a concentration of Kaiser members in the Baltimore, Washington, D.C. metro area. Whereas, CareFirst has many more rural members, but that does not strike us as something that can actually explain why CareFirst's assumption that trend in Maryland will be nearly double that of what Kaiser assumes.

And we were particularly given the all payer hospital system and I certainly realize the that differential has gone up, but we shouldn't consider that catastrophic to go from 6 percent to 7.7 percent. And the differential will be equitably divided in a noncompetitive way across all carriers. And so, therefore, why aren't the trends more similar for the two carriers?

Looking more closely at medical services, as Todd pointed out, CareFirst estimates 39 percent of its HMO premium will be spent on inpatient and outpatient services, 28.6 percent on professional services, and 24.8 percent on prescription drugs with a similar pattern for its PPO. Contrast this with the allocation

of spending by Kaiser; 24.3 percent on inpatient and outpatient services, 59.9 percent for professional services, and 13.8 on prescription drugs. Now, maybe CareFirst should hire whoever negotiates the PPO contract from Kaiser, but there's obviously something going on there.

Maybe it has to do with differences in membership, but it's hard to understand how it could be that great. Moreover, Kaiser is spending nearly twice as much on professional services as CareFirst. Certainly, that could be due to the fact that Kaiser relies more on budgeting than on claims. But, again, twice as much is a big difference, and I think in particular one of the things that's important for us to understand as a state, both as consumers and as policy makers and regulators, is really does that emphasis on professional services, the emphasis on the relationship between the doctor and the patient allow Kaiser to better manage its members health conditions.

And, if so, should we expect CareFirst to began to allocate more to professional services as well to try

to incentive-wise providers to have that same type of relationship that the Kaiser members may have with their doctors. In the public filings CareFirst and Kaiser did not provide any information about the number of the percent of the high risk individuals, their demographic characteristics, or their most common health conditions.

So, we're glad that you are asking for that information, but we believe that it is important for you to provide that information in a summary fashion in the aggregate for CareFirst and Kaiser both to the public, to the MHBE, and to the General Assembly so that we all have a better understanding of the individual market and what carriers are doing to improve the health of their members. Kaiser's rate filings for 2019 and 2020 noted the loss of the individual mandate as a reason for increasing its morbidity factor.

Maryland has taken steps to dampen the impact of the loss of the individual mandate both by re-implementing the reinsurance program, and I always forget the name of Stephanie's program or at least what they call it --

COMMISSIONER REDMER: She'll remind us in a minute.

MS. SAMMIS: -- but the easy enrollment plan or program, whatever it is, beginning in 2020 and given Maryland's efforts in this regard, wouldn't it be more reasonable to require Kaiser to return to a 1.0 morbidity factor since we haven't really seen any detrimental impact on the loss of the mandate in enrollment in Maryland? In its filing CareFirst states it is applying a 1.3 morbidity factor for new members and a 1.0 morbidity factor for existing members, essentially arguing in my mind anyway, that new members are more likely to be high risk than existing members. How can this be?

So, I didn't replay the CareFirst testimony for the easy enrollment plan but unless I've totally lost my mind which is always possible given the fact that I am approaching that age, you know, I thought that CareFirst suggested and agreed with Health Care For All during the legislative session that the easy enrollment plan would encourage younger, healthier individuals to enroll in

coverage in 2020. And, so are they now saying that that wasn't true? And if they are sticking with at least what I recall was their story, then shouldn't we really be asking them to go back and modify the morbidity factor for new members?

CareFirst has priced its HMO product assuming an 80.2 percent loss, medical loss ratio, using the federal calculations. I think as we saw using the traditional medical loss ratio calculation it's below 80 percent, which I think is fairly eye popping for a company with a unique mission in our state. Kaiser assumes an 85 -- 88.5 percent medical loss ratio. I wasn't sure if that was traditional or federal, but in any case it's certainly higher than CareFirst.

And given CareFirst's statutory mission we believe that you should require it to assume a higher medical loss ratio in keeping with the examples set by Kaiser. We're not asking you to go to the full 88 percent, but certainly something much higher than 80 percent where they are including quality care initiatives whose utility is something of question. So,

thank you again for the opportunity to testify before you today. We've appreciated your openness to our comments about individual rate filings over the years, and have confidence you will not forget your unique responsibility and trust that you will use all your powers to keep premiums in the individual market affordable for all consumers.

And as my last comment, I will simply say that this reinsurance program is here to stay or we are all in trouble, unless you'd like to do what I argue for, which is a public option. Thank you very much.

COMMISSIONER REDMER: Thank you, and on behalf of all of us thank you for your many, many years of public service. Most people don't know this, when I was a very young delegate Beth was a very young staffer. What was it, economic matters?

MS. SAMMIS: Economic matters then, yeah.

COMMISSIONER REDMER: Economic matters, so we dealt -- and this was '91, '92, and so on.

MS. SAMMIS: Yeah.

COMMISSIONER REDMER: So, I've enjoyed working

with you.

MS. SAMMIS: The many years.

COMMISSIONER REDMER: Hey, that's right.

MS. SAMMIS: I'm not dead. You just won't see me as often.

COMMISSIONER REDMER: Not only thanks to you but also thanks to the organization.

MS. SAMMIS: Yes, thank you.

COMMISSIONER REDMER: Consumer Health has been a strong advocate for consumers and we've all benefited from them.

MS. SAMMIS: Thank you very much. I will let our board know. Thank you.

COMMISSIONER REDMER: Next, Stephanie Klapper, Maryland Citizens' Health Initiative.

MS. KLAPPER: First, I want to thank Commissioner Redmer and the Maryland Insurance Administration for holding this hearing, for looking at the rates in individual and small group markets. We, at the Maryland Citizens' Health Initiative, hope that you continue to make protecting consumers and stabilizing

insurance premiums your top priorities and we're glad that the reinsurance program created by Governor Hogan and Maryland General Assembly has been helping to keep premiums from skyrocketing.

As was mentioned earlier, we believe that the next step to stabilize the individual market is to get as many young and healthy individuals enrolled in health coverage as possible, and that's why we're so excited that the Maryland General Assembly and Governor Hogan have created the Maryland Easy Enrollment Health Program. The Maryland Easy Enrollment Health Program is going to make it so that folks, when they go to fill out their tax forms at tax time, they can use the information from their tax returns they're already filling out and use it to enroll in health coverage.

A lot of people who qualify for federal subsidies, which can make health coverage very low cost or even free for them, and we estimate there are at least 70,000 Maryland who could get health coverage for free. Allowing Marylanders to apply for health coverage through their tax forms we're hoping is going to

encourage a lot of young and healthy Marylanders to enroll in health coverage, and that's going to stabilize the individual market in the long run.

Now, I know that the Maryland Insurance Administration today is just looking at these proposed rates, but no discussion of health insurance cost would be complete without also talking about overall rising health care costs. And the main culprit is prescription drug prices. Brian Pieninck, the CEO of BlueCross BlueShield said that prescription drug costs are rising at an alarming rate and now represent the single largest component of health care expense.

That's why Maryland's newly enacted Prescription Drug Affordability Board legislation is so important. This board is going to look at this very high cost drugs, figure out why they costs so much, and make recommendations for how to address those costs including upper payment limit which should help stabilize premiums in the long run.

So, again, I want to thank you Commissioner Redmer for this opportunity to comment and for doing

everything in your power to stabilize premiums and give Marylanders access to quality affordable health care.

COMMISSIONER REDMER: Thank you, Stephanie. I appreciate it. Any questions for Stephanie. All right, thank you. And the last person who signed up, and I'm going to, in order to prevent myself from public humiliation, I'll introduce the Maryland Hospital Association.

MS. RASWANT: Thank you Commissioner Redmer, members of the public here, and the Insurance Administration. Before I start I actually also do want to thank Beth Sammis in particular, first, for all of her work particularly in the insurance space. It's been several years since we've been in touch and working with you. Maansi Raswant here on behalf of the Hospital Association here today.

Again, we appreciate the process that the Administration has taken over the past few years and more actively sought out public comment. You've kept stakeholders engaged in the process of morbidity, which we're appreciative of that. Maryland's Hospitals

support affordable coverage as an essential pillar of the model of health care delivery that we have here in the state because affordable coverage provides access to the right services and prevents unnecessary hospital use.

This year everyone knows that we started a new model with the federal government, the Total Cost of Care model, and at the core of this agreement is a commitment to improve the health of the entire state and across the entire population. The association has correspondingly set out a new mission advancing not just the health care but the health of all Marylanders. So, at the outset of my testimony, I'll note the carriers filings vary greatly in the protected trends for hospital utilization and costs.

I know, Todd, you've spoke to this. We've raised this, you know, over the past several years. I understand that each filing has a myriad of factors that develop these composite trends, but as a reminder the HSCRC did just approve a total allowable hospital revenue growth of 3.3 percent, as you noted in your

slide. We'd be interested in understanding more on how that annualized growth that we sent is actually factored into the trends because we do have some filings that inexplicably contain double this amount in trends. So, we'd like to understand that a bit more.

I do know that the Administration follows the update process of the HSCRC and consults with them, so I do believe that you will be addressing any discrepancies there. I also want to mention something that might be seemingly small, but it's impactful to the extent that this is a public process. You have at least one national insurer that consistently notes cost-shifting for hospital services from public to private payers as a large factor in projections.

This is something that Ms. Sammis noted as well, I think it was mentioned here earlier, as you know it's not the case in Maryland given our all-payer rate setting system. We did have modest differential between public and private payer rates of now 7.7 percent, and that's actually to account for uncompensated care that's being delivered to commercial (inaudible). And, so to

the extent that this is a meaningful process and we want the public to engage, the information needs to be accurate for people to look at.

Beyond this, this year we see the benefits of the government reinsurance program in lower rates -- rate increases, excuse me, than we have in past years. Maryland's hospitals supported this initiative so we're pleased to see it bearing fruit. For several years prior the rates rose by high unsustainable amounts and with these rate filings we see at least two years of market stability. We can't, however, look to the reinsurance program as the only solution because while the program does subsidize high cost care for individuals who have high cost claims it doesn't address the root causes for high assumption of care.

So, I'm happy to hear that you are collecting information on some of the wellness programs and have sought information on the primary preventive care, because we really do have to try to build on the success of the reinsurance program and figure out how to include the health and health care of these individuals. We

need to better coordinate and manage care. We need to provide access to preventative upstream services and also address chronic diseases.

As we partner with the state and insurers on improving population health I think that's it's going to be important that we not just measure what types of programs exist and what the uptake looks like but also what the impact is. So, which one of these programs best impacts utilization and health outcomes? Which one of them actually lowers cost of care and where we do see savings, how are those savings being passed back to the consumers?

And finally to this last point, in May we issued a publication, MHA Insight, which noted that a recent report by the Health Care Cost Institute, which is an independent, non-profit research institute found that Maryland had fifth lowest per capita spending across the country. And this is using employer-sponsored claims and it is for all service categories, so inpatient and outpatient hospital, professional and drug. The news was even better for hospital spending for both inpatient

and outpatient, we ranked second lowest for capita sending. So, what this tells us is that the Maryland model is working and the system is realizing savings not just for Medicare as we have under the contract, but also for commercial insurers.

Our publication also noted, again, based on publicly available data by independent research organizations looking at employer-sponsored coverage that while spending growth has slowed and we have such lower spending, consumer costs have not slowed down. In fact, from 2013 to 2017, premiums grew by nearly 15 percent and deductibles grew by 43 percent. So, again, appreciate the charts that you had up earlier looking at how those deductibles have changed.

And we do believe that you need more focused attention on rising out-of-pocket costs, because high out-of-pocket costs make using coverage and care unaffordable and deter people from using health care services appropriately. So, with that I'll end my testimony and I'm happy to take any questions.

COMMISSIONER REDMER: Great, thank you. Any

questions? All right.

MS. RASWANT: Thank you.

COMMISSIONER REDMER: Thank you very much. That is all that signed up. I will give anybody a chance to make comments in a couple of minutes. I'm now going to pause and we will turn to the folks on the phone to see if they have any comments and I'm going to begin by asking if there are any legislators in the phone that would like to introduce themselves and make any comments. Okay. Hearing none, we'll move on to see if there's anybody else on the phone that has any questions or comments regarding the proposed rates for 2020.

Okay. Hearing none, I'll come back to the room and see if there's any last minutes questions from anybody. Good, bad, different, questions, comments, observations, complaints? Drink orders, anything at all?

MR. SWITZER: I just want to comment a little on what Beth said. First, I just wanted to clarify that I don't suscribe to the view that the most important thing is to go after the younger people. When we -- all we

have available currently is the demographics. The claims are more telling. I do think to stabilize the market we can't have every year the morbidity getting worse and worse. That's what I meant. I want that to be clear. I think that's an important point you raised.

I also agree very much with the point that with the cliff between 400 percent total poverty and 401 and 50,000 in 2001, it's a really odd difference in what you pay and Brad, you brought that up and that's a glaring issue that I agree remains to be thought about. Also, just wanted to echo that we really appreciated your questions. I won't want to call you the loyal opposition but your questions obviously indicated that you cared. Appreciate you fighting for the individual.

Also wanted to let you know that we have collected data from '14 to the present in pyramid-type form. We just have to get it in the same form from everybody before we can share it. So, that has not gone on deaf ears it's just that's the situation there as well as conditions. We have a little bit more work to do on that so, thank you.

COMMISSIONER REDMER: Great. Again, any final questions, comments? Okay. To that extent that any do come up we're going to keep the record open for how long?

MR. SWITZER: Till August 16th.

COMMISSIONER REDMER: August 16th, so you have plenty of time to comment going forward. Once again, thank you for your participation. This helps us a lot and thank you on the phone and we will stand adjourned. Thank you.

(Hearing adjourned at 3:26 p.m.)

CERTIFICATE OF SHORTHAND REPORTER - NOTARY PUBLIC

I, Danielle Lawrence, court reporter, the officer before whom the foregoing proceedings were taken, do hereby certify that the foregoing transcript and said proceedings were taken by me stenographically and thereafter reduced to typewriting under my supervision; and that I am neither counsel for, related to, nor employed by any of the parties to this case and have no interest, financial or otherwise, in its outcome.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my notarial seal this 5th day of August 2019.

NOTARY PUBLIC IN AND FOR THE
STATE OF MARYLAND

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