



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

## 1 A P P E A R A N C E S

2 MARYLAND INSURANCE ADMINISTRATION STAFF:

3 AL REDMER, Maryland Insurance Commissioner

4 TODD SWITZER, Chief Actuary

5 VAN DORSEY, Principal Counsel

6 ZACHARY PETERS, Chief of Staff

7 BRAD BOBAN, Senior Actuary

8

9 COMPANY REPRESENTATIVES:

10 REGIS MURAYI, Aetna

11 PETER BERRY, CareFirst BlueCross BlueShield

12 DAVID LIEBERT, Kaiser Permanente (via telephone)

13 RYAN MORGAN, United Healthcare

14

15 INTERESTED PARTIES:

16 BETH SAMMIS, Consumer Health First

17 STEPHANIE KLAPPER, Maryland Citizens' Health Initiative

18 Health Care for All! Coalition

19 MAANSI RASWANT, Maryland Hospital Association

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1 P R O C E E D I N G S

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

14 MR. PETERS: Something.

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

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

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

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

1 Administration, and the Health Benefit Exchange.

2 Collectively, we received a 1332 waiver from the federal  
3 government instituting a reinsurance program in the  
4 individual market that has seen some success.

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

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

17 COMMISSIONER REDMER: Hey, Todd?

18 MR. SWITZER: Yes.

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

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

4 COMMISSIONER REDMER: Okay. Yep.

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

12 First, the size of the market is, as of March  
13 31st, of 201,001 people, Marylanders. The market share  
14 breaks down as 56 percent for CareFirst HMO. For the  
15 PPO about 6 percent, CareFirst PPO, and Kaiser at 40.  
16 What was filed on May 1st was a 2.9 percent decrease  
17 composite overall. The range within that is a negative  
18 8.9 for CareFirst HMO. That has since come down to  
19 negative 10. There's lots of integrations along the  
20 way, 9 for the PPO, and 3.9 for Kaiser's HMO. That  
21 follows last year where the overall increase was a

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

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

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

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

8 Let's go to small group. The size of the market  
9 is about 270,000, and we did see a little bit of growth  
10 from last year. We used lots of legal entities but we  
11 just looked at the 4, rolled them all together. Market  
12 share CareFirst at 71, I have United at 25, Aetna at a  
13 little more -- little below 1, Kaiser at 4. Last year  
14 what was approved was 4.9, an issue that's been filed is  
15 similar, 4.4. There's a big range on that. This is the  
16 first quarter '20 or first quarter '19, anywhere from  
17 1.6 up to 15.5 so there's a big range composite of 4.4,  
18 and that hopefully sets the picture for small group.

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

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

9 So, for the nonprofit, it's consistent with  
10 their mission. They stayed in the batter's box and had  
11 those kinds of loss. This year was a welcome change, a  
12 56 million dollar gain, this year being 2018, 4.2  
13 percent. And then just to look at the other counter  
14 piece of it of small group, 371 million gain, 6.9  
15 percent over '14 to '18. These are different carriers  
16 in here, you got Aetna and United in here as well, and  
17 in 2018, a 27-, 28 million dollar gain.

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

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

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

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

1 assumptions that my team and I look at. You've heard  
2 them before, I'll talk about some of the main ones. As  
3 you know, if any one of these assumptions changes the  
4 rate increases changes. Whether it by a lot or by a  
5 little, but they change. And for the individual market,  
6 again, filed 5-1, the average trend that was filed was  
7 6.9 percent.

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

16           On the individual market for risk adjustment for  
17 what CMS published not too long ago, Kaiser paid 120  
18 million on risk adjustment transfers. There was about  
19 30 million to CareFirst HMO, 90 million to CareFirst  
20 PPO. That dynamic is still very, very real in the part  
21 of the filing. On the administrative cost side we're

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

7           So, we've been asked for other things that we  
8 and the actuaries consider, that result is considered.  
9 One thing is to look at high claims, and this is the top  
10 10 claims in the individual market by the four carriers.  
11 I understand that in a vacuum these don't mean too much,  
12 but we've also looked at the claims probability to  
13 sedition and tried to look for anomalies and this  
14 doesn't look abnormal to us. We expected million dollar  
15 claims, we thought we might see some 5 million or even  
16 10 million but we haven't, thankfully.

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

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

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

1           And as we project for our rate filings from '18  
2 to '20, I believe what happened last year, 1.37, 4.79  
3 for the annualized 3.07, just to be clear on how we're  
4 using this data that came out from the HSCRC. There's  
5 lots of reason why for the hospital piece which is about  
6 39 percent of the total claim. It won't be exactly this  
7 number, it's a mix of hospital use, mix of service  
8 changes, et cetera. But that's not to diminish, but it  
9 has an impact and it's part of what we're thinking  
10 through extensively.

11           Another aspect we look at for context is the  
12 risk-based capital and the net income. So, this is for  
13 all the legal entities that have filed. What I'll bring  
14 out is from '17 to '18, statutory basis, that the  
15 risk-based capital went up 490 to 534 for artificial  
16 number of the total adjusted capital where we've  
17 authorized control level. But directionally, the right  
18 direction and the same with the net income, 4.7 to 1 to  
19 6.0. That wasn't the case if we showed more of these  
20 years. There's lots of negatives here and there were  
21 negatives before, but some of the moves will hopefully

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

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

13 The second is, as you recall, the state put in  
14 365 million of seed money and, as you know, the tax  
15 subsidies and the premium come down, the federal  
16 government pays less in subsidies and they give that  
17 money back to us in passthrough, so that amount was  
18 779,000,000. So, that 365 leveraged up to 1.1 billion  
19 and if you care later this is how the money gets  
20 depleted over the 3 years, and this was the estimated  
21 rate impact, negative 30. About negative 30, negative

1 14 but, one, the Exchange is remodeling this. I've cut  
2 it off at 4 years, but 10 years. We want to be careful  
3 managers of this and make sure that we look at it  
4 regularly and that the 10-year projection with the  
5 benefit of better information, make sure we're on track.

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

11 So, some question, is the waiver working. The  
12 way we're defining working is -- I think it was said  
13 well by Health Care For All in their paper yesterday --  
14 one of the next steps in this process of stabilization  
15 is attracting a pool that's younger and healthier. And  
16 we're to answer the question of who did we attract. And  
17 we first looked at 2018, and said for the whole market  
18 the single risk total is 194,000 members, and the  
19 average age was 40.6. And the new members were about  
20 48,000, 25 percent of the single risk pool ages 37.1.

21 So, they were younger than the single risk pool,

1 3.4 years. But that alone but, first of all,  
2 demographics are not the same as claims, so we really  
3 need the rest of the picture that way. But at least  
4 from what we had available, the demographics, they were  
5 younger. But I wanted to see if that was any different  
6 than last year, and last year 39.7 for the single risk  
7 pool, 14 percent new, average age of 38.9. That's a .8  
8 less than the single risk pool. So, I think the answer  
9 is we don't know yet if we're attracting the people we  
10 want to attract. However, at least directionally it's  
11 positive that they're a little younger, 3.4.

12 The other thing that gave us pause is if you  
13 just look at the absolute value of the ages, 38.9 and  
14 37.1, that's a little less than 2 years. But 2 years is  
15 2 years and we'll see how the claims come out. But  
16 we're trying to -- as soon as we have data available,  
17 see if the reinsurance program is attracting a pool such  
18 that we can keep rates stable and accessible.

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

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

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

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

1 percent. But the people that brought up, these 35,000  
2 here to gold or platinum didn't want to pay those 4-,  
3 5-, 6,000 deductibles. It went up considerably, another  
4 11,000.

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

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

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

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

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

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

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

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

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

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

16 So, came across this slide and I just want to  
17 talk about wellness for a minute and close. For those  
18 making, this is as of -- in 2019, for those making  
19 \$50,000, that's about 40 percent of the federal poverty  
20 level, 65 percent of people said they put off medical  
21 care before of costs and another 29 percent said they

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

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

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

20 COMMISSIONER REDMER: Okay. Thank you, Todd.

21 PHONE OPERATOR: This meeting is being recorded.

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

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

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

19           MR. MURAYI: Okay.

20           COMMISSIONER REDMER: Thank you.

21           MR. MURAYI: All right. Good afternoon,

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

8 Approximately 854 individuals in Maryland are  
9 covered under the Aetna small group policies as of May  
10 2019. I'd like to start off by noting that the changes  
11 discussed here, that I will discuss here, are average  
12 rate changes. The exact rate change will depend on the  
13 benefit plan that an individual chooses, when the  
14 members' group contract renews, and the age and family  
15 size of enrolling employee, and employer contributions.

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

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

4 For our HMO entity, our average rate increase is  
5 14.9 percent for PPO and our average rate increase is  
6 13.9 for -- sorry, about that. For HMO, our average  
7 rate increase is 14.9 percent and for PPO, our average  
8 rate increase is 13.9 percent. For simplicity from  
9 here, I'll average the rate increases of our entities  
10 together. Together those two are about 14.2 percent.  
11 We have filed three plans, each for our HMO and our PPO  
12 entities both on and off Exchange.

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

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

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

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

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

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

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

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

1 outcomes and reducing need for high cost health care  
2 services.

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

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

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

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

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

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

7 MR. MURAYL: Thanks.

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

20 MR. MURAYL: All right. Thank you.

21 COMMISSIONER REDMER: I appreciate it. If we

1 can, let's go to CareFirst, Peter.

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

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

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

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

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

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

4 Historically, when we move from one year to the  
5 next through open enrollment we had seen in the PPO  
6 block that we would lose half our membership, and the  
7 people we kept tended to be about 30 to 35 percent  
8 sicker than people that left. That was what  
9 historically was really driving the instability rates.  
10 2019, we have a preliminary view. Instead of losing  
11 half the membership, we still did lose some members. We  
12 lost about a quarter of them, but the people we kept  
13 were 8 percent sicker not 30 percent sicker. And what  
14 this means is that the rate change that we have  
15 currently of about 9.1 percent is a single digit rate  
16 increase.

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

1 lower. We saw the morbidity of the people we kept  
2 anywhere from 5 to 10 percent on average. This year we  
3 did see some people leave but they were about the same  
4 illness burden as the people who stayed. That is a --  
5 just a qualitative measure -- or, I'm sorry, a  
6 quantitative measure of stability that shows that this  
7 1332 is working.

8 One update I have as was reported, our original  
9 filing for BlueChoice is now minus 10, as to continue to  
10 work with the MAA through these. Objections and  
11 responses to our rate filings, I'm happy to report that  
12 the positive 9.1 for PPO is now down as of Friday to  
13 6.8. We are continuing to sharpen our pencils. We take  
14 this very seriously as we did in prior years and I am  
15 confident that before we finish that that rate increase  
16 for PPO will be below 5 percent, which will be low  
17 single digit.

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

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

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

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

1 and now if I can answer any questions.

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

5 MR. BERRY: Sure.

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

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

1 information.

2 COMMISSIONER REDMER: Just curious. Todd,  
3 anything?

4 MR. SWITZER: In the individual HMO projections  
5 into the future so you had estimated, as you know, for  
6 '19 that the -- of the trade transfers, existing  
7 transfers, that there would be about a 3,000 transfer of  
8 members in 2019, but that would go up in 2020 by about  
9 67 percent to 5,000. I understand if that's too much  
10 detail, but is that ascribed to a particular driver,  
11 that the transfers would increase by that amount, that  
12 kind of magnitude?

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

17 MR. SWITZER: From anywhere.

18 MR. BERRY: Yeah.

19 MR. SWITZER: But into BlueChoice.

20 MR. BERRY: Into BlueChoice?

21 MR. SWITZER: Right.

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

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

17 MR. SWITZER: Sure.

18 COMMISSIONER REDMER: Anything else? Okay.

19 MR. BERRY: Great. Thank you very much.

20 COMMISSIONER REDMER: Thank you, appreciate it.

21 And moving along let's go to Kaiser.

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

3 COMMISSIONER REDMER: We can.

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

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

1           And, so looking at the impact of that program to  
2 continuing on into this year's rate increase we filed a  
3 3.93 percent rate this year. And I estimate that  
4 without the reinsurance program that rate would of been  
5 25 to 30 percent higher than what we're filing, than  
6 what we filed. Right now, after some adjustments we've  
7 gone through the review process, and the rate increase  
8 is right about 2 percent with a range of minus 2 percent  
9 in some plans up to 4 and a half percent for other  
10 plans.

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

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

1 we've seen before. We're seeing about a 4-year  
2 difference between our continuing members from 2018 to  
3 2019. The new members are about 4 years younger on  
4 average than the continuing members, and we would  
5 attribute that primarily to the reinsurance program and  
6 how it's lowered the rates (inaudible).

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

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

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

6 We initially filing a first quarter rate  
7 increase of 9.96 percent with a range of 6 and a half  
8 percent to 11.3 percent. And looking at the quarterly  
9 rate increases, because our trend for the 2020 rate  
10 filing is a little higher than it's been in the past,  
11 early trends are also a little higher. So, the overall  
12 rate increase accounting for these quarterly trends is  
13 10.23 percent. Unlike the individual market the small  
14 group market has been relatively stable since the  
15 inception of the ACA.

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

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

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

21 COMMISSIONER REDMER: All right, thank you

1 David. Any questions?

2 MR. SWITZER: Just, David, the young adult  
3 catastrophic plan, I was just curious along these lines,  
4 as you know the rate is relatively higher than the  
5 competition and where you have, you know, 40 percent  
6 market share outside the young adult plan you had about  
7 4 percent market share in the catastrophic. I'm just  
8 wondering if there had been any discussions about that  
9 plan, the 250 members, to try to, I don't know, alter  
10 it's current course, if that's clear?

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

21 MR. SWITZER: Okay. Thank you.

1           COMMISSIONER REDMER: Any other questions for  
2 David?

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

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

17           MR. BOBAN: All right, thank you.

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

21           MR. MORGAN: Doing well. Yourself?

1 COMMISSIONER REDMER: Doing well, thanks.

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

12 Across all 4 of these legal entities we're  
13 proposing a total of 87 unique small group plans in  
14 2020, 9 platinum, 39 gold, 32 silver, and 7 bronze.  
15 Approximately, half of these plans are available on and  
16 off the Exchange, and the other half would be off  
17 Exchange only. For 2020, we filed for a rate increase  
18 of 12.2 percent for United Healthcare Insurance Company,  
19 13.7 percent on Mamsi Life and Health Insurance Company,  
20 13.3 percent on Optimum Choice, Incorporated, and 7.9  
21 percent on United Healthcare Mid-Atlantic, Incorporated.

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

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

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

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

4 The other major driver of our rate change was  
5 recent experience. So, in the 12 months ending with May  
6 2019, our claims have increased by double digits, but  
7 due to low approved trends in recent years in  
8 combination with customers moving to less expensive  
9 plans, our premium has increased by less than 5 percent  
10 over the same period.

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

1 2020, which is another factor driving our requested rate  
2 increase. So, hopefully this summary of United  
3 Healthcare's 2020 filings has been helpful and at this  
4 time I'd be happy to address any questions you have.  
5 Thank you.

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

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

11 MR. MORGAN: Yes.

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

14 MR. MORGAN: Yes.

15 MR. SWITZER: Is that a Fit Bit?

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

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

1 MR. MORGAN: Right.

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

8 MR. MORGAN: Correct.

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

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

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

21 MR. MORGAN: Right. No, the differences between

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

10               MR. SWITZER: Yes.

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

13               MR. MORGAN: Thank you.

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

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

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

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

11 COMMISSIONER REDMER: Never.

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

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

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

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

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

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

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

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

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

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

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

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

16           Looking more closely at medical services, as  
17 Todd pointed out, CareFirst estimates 39 percent of its  
18 HMO premium will be spent on inpatient and outpatient  
19 services, 28.6 percent on professional services, and  
20 24.8 percent on prescription drugs with a similar  
21 pattern for its PPO. Contrast this with the allocation

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

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

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

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

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

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

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

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

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

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

6 CareFirst has priced its HMO product assuming an  
7 80.2 percent loss, medical loss ratio, using the federal  
8 calculations. I think as we saw using the traditional  
9 medical loss ratio calculation it's below 80 percent,  
10 which I think is fairly eye popping for a company with a  
11 unique mission in our state. Kaiser assumes an 85 --  
12 88.5 percent medical loss ratio. I wasn't sure if that  
13 was traditional or federal, but in any case it's  
14 certainly higher than CareFirst.

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

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

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

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

17            MS. SAMMIS: Economic matters then, yeah.

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

20            MS. SAMMIS: Yeah.

21            COMMISSIONER REDMER: So, I've enjoyed working

1 with you.

2 MS. SAMMIS: The many years.

3 COMMISSIONER REDMER: Hey, that's right.

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

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

8 MS. SAMMIS: Yes, thank you.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

21 COMMISSIONER REDMER: Great, thank you. Any

1 questions? All right.

2 MS. RASWANT: Thank you.

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

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

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

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

6 I also agree very much with the point that with  
7 the cliff between 400 percent total poverty and 401 and  
8 50,000 in 2001, it's a really odd difference in what you  
9 pay and Brad, you brought that up and that's a glaring  
10 issue that I agree remains to be thought about. Also,  
11 just wanted to echo that we really appreciated your  
12 questions. I won't want to call you the loyal  
13 opposition but your questions obviously indicated that  
14 you cared. Appreciate you fighting for the individual.

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

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

5           MR. SWITZER: Till August 16th.

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

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

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## 1 CERTIFICATE OF SHORTHAND REPORTER - NOTARY PUBLIC

2  
3 I, Danielle Lawrence, court reporter, the  
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5 taken, do hereby certify that the foregoing transcript  
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7 and thereafter reduced to typewriting under my  
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10 have no interest, financial or otherwise, in its  
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12 IN WITNESS WHEREOF, I have hereunto set my  
13 hand and affixed my notarial seal this 5th day of August  
14 2019.

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