

In the Matter Of:

2019 PREMIUM RATES HEARING

HEARING

July 30, 2018

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BEFORE THE MARYLAND INSURANCE ADMINISTRATION

IN RE:

2019 PROPOSED HEALTH INSURANCE
PREMIUM RATES HEARING

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Baltimore, Maryland
Monday, July 30, 2018
1:00 p.m.

Job No.: WDC-182771

Pages: 1 - 92

Reported by: Toni R. Thompson, RMR

1 Hearing held at the office of:
2 Maryland Insurance Administration
3 200 St. Paul Place, Suite 2700
4 Baltimore, Maryland 21202
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8 Pursuant to agreement, before Toni R.
9 Thompson, RMR, Court Reporter and Notary Public in
10 and for the State of Maryland.

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A P P E A R A N C E S

AL REDMER, MARYLAND INSURANCE COMMISSIONER
NANCY GRODIN, DEPUTY COMMISSIONER
CATHERINE GRASON, CHIEF OF STAFF
TODD SWITZER, CHIEF ACTUARY
BRAD BOBAN, SENIOR ACTUARY
BOB MORROW, ASSOCIATE COMMISSIONER, LIFE AND HEALTH

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

2 MR. REDMER: Okay. Good afternoon. If
3 you don't mind, I've got 1:00 so we will go
4 ahead and get started. My name is Al Redmer
5 from the Maryland Insurance Administration, and
6 I would like to welcome you to the public
7 hearing for the proposed rates for 2019 in the,
8 both the individual and the small group
9 marketplace, and this is our continuing effort
10 to conduct business in an open and transparent
11 manner.

12 Before I get started, I'd like to
13 introduce the team that is with me today. To
14 my right is Nancy Grodin, our Deputy Insurance
15 Commissioner. To her right is Bob Morrow. Bob
16 is the Associate Commissioner of Life and
17 Health. To my immediate left is Todd Switzer.
18 Nice to meet you Todd. Todd is our Associate
19 Commissioner and Chief Actuary. To his left is
20 Brad Boban, a Senior Actuary, and to his left
21 is Cathy Grason, who is our Chief of Staff.

22 I also want to introduce for the meeting

1 in the room is Tracy Imm, our Director of
2 Communications. I also want to introduce
3 Michele Eberle, who is the Executive Director
4 of the Health Benefit Exchange, and finally
5 Delegate Cullison from the Health and
6 Government Operations Committee. Appreciate
7 you being here, Delegate. It's always helpful
8 to have legislators who ultimately create the
9 rules for us to be in the room and see what
10 happens in the real life world of insurance
11 regulation.

12 I'm going to apologize in advance, I have
13 to slip out at 1:30 for a brief phone call, I
14 will be right back. In the meantime, as I
15 mentioned this is a public hearing for the 2019
16 proposed rates for the individual and the small
17 group market. This is not a public hearing for
18 the 1332 Waiver or the proposed reinsurance
19 program that we may deal with down the road.
20 If approved, we will do a second rate hearing
21 to make the appropriate changes. So to the
22 extent possible, we would like to keep this to

1 the proposed rates for 2019, and with that I
2 will reintroduce for opening remarks our Chief
3 Actuary, Todd Switzer. Nice to meet you, Todd.

4 MR. SWITZER: Good afternoon. Thank you
5 to the insureds, to the insurers, the consumer
6 advocates and everyone who is here today.
7 Thank you also to the 28 people who submitted
8 public comments. It helps a lot to get your
9 feedback, to get their feedback to round out
10 the view of all people that we're talking about
11 here whom it affects.

12 We believe these meetings play a role in
13 influencing healthcare in Maryland. I think
14 the past meetings, these meetings influence the
15 decisions that will be made. I believe they
16 played a role in accentuating the urgency of
17 some of the matters in the individual market,
18 in the ACA market, toward filing the waiver
19 that the Commissioner mentioned for 2019 with
20 the potential for rate relief. Again the focus
21 of this hearing is not the waiver, but I will
22 make some comments about it later.

1 must be reasonable in relation to benefits, not
2 inadequate or excessive, and not unfairly
3 discriminatory. So there's a lot there,
4 there's a lot of affected parties, and we keep
5 that in our sights.

6 As you know, insureds in the individual
7 non-medigap ACA market have seen increases over
8 the past last three years of 21 percent, 25
9 percent and 44 percent. At the same time,
10 insurers have lost millions of dollars in the
11 individual non-medigap, in this market, since
12 inception in 2014.

13 So to cultivate that dialogue, I have a
14 few slides. They're more broad based to give
15 some context before the insurers summarize
16 their submissions, and any questions that come
17 up we are anxious to field either later or we
18 have the opportunity here after people have
19 spoken.

20 So let me start with the grounding that
21 really builds up, the press release that came
22 out after carriers submitted their filings on

1 May 1st. The top part of this -- this is the
2 entire ACA market, a snapshot, individual
3 market and the small group down below. We have
4 about 212,000 members as of February of this
5 year in the individual market, that's on and
6 off exchange. The top two carriers for market
7 share, only two carriers, are CareFirst and
8 Kaiser, 58 percent for the BlueChoice plan,
9 7 percent for CareFirst PPO, 35 percent for
10 Kaiser. The overall increase was 30 percent,
11 as you've heard, and that breaks down within
12 the column there a range of 18 1/2 for the HMO,
13 91 for the PPO, and 37 for Kaiser.

14 When we move to the small group market,
15 about 266,000 members there, and you can also
16 see here with the growth if you understood how
17 it's changed from last year, I'll leave that to
18 you. The overall increase and what's a little
19 different here is that the groups renew by
20 quarter, first, second, third, fourth. Most of
21 them renew in the fourth quarter, and there's a
22 slight change as you move along the quarters

1 from 6 1/2 percent overall to 7.3. But overall
2 for the year when you weight by who renews, how
3 they renew through the year, about 7 percent,
4 and there's a range there that you can see from
5 4.8 percent up to 13 percent. A little bit of
6 background for that market, for the total
7 market.

8 I wanted to bring out a few pieces of
9 information along the following lines. If we
10 look at the Maryland market -- and this is just
11 for ACA insurers. I was trying -- insurers who
12 either offer the individual or the small group
13 market how have they performed of late in 2017.

14 The first thing when we line up all the
15 other types of coverages that are out there
16 beyond ACA, medigap, self-insured, Medicare
17 Advantage, et cetera, the whole picture, let's
18 look at, well, how many members. Well, we got
19 about 4 million members and the ACA is about
20 11 percent of that total. The second piece of
21 information here is in the gain/loss side, how
22 have they fared. First on the not favorable

1 side, in the individual non-medigap market, you
2 can see it there, in 2017 \$176 million loss.
3 So 16 percent of revenue, that's what I alluded
4 to earlier, problematic to state the obvious.
5 Other markets too that have lost money, the
6 self-insured, 32 million, 15 percent; also the
7 Medicare Advantage, 20 million, 5 percent.

8 But then let's look at the other side, it
9 just begs the question that there's some
10 positive, right. So on the small group side we
11 had an \$80 million gain, 6 1/2 percent of
12 revenue; for the large groups, about 146
13 million, 7 percent; for OPM HMO about
14 7 percent, 82 million. When you roll it all
15 together down to the bottom line, about 1.2
16 percent.

17 So on the premium dollar underwriting gain
18 of 1.2 percent, 1.2 cents, it's not, a
19 relatively thin number. Again, this is before
20 investment income. We're trying again to
21 answer the question, we've lasered in on ACA,
22 as we should. We're just kind of begging the

1 question again of what's the total picture, and
2 that's one way of looking at it.

3 I apologize, I didn't give you that slide.
4 That's the slide I was talking about, so let me
5 briefly: 11 percent of members in the ACA,
6 individual and small group losses 176 million
7 again in the individual, 80 for small group,
8 underwriting gain before investment income 1.2.
9 But you can walk down that Gain/Loss column, I
10 tried to pull out the top three to underwriting
11 loss, top three to underwriting gain, and then
12 roll it all together and that's what I brought
13 out.

14 Our rate review, so we got thousands of
15 pages of filings on May 1. This is an attempt
16 to briefly let you know what we're looking at,
17 and individual non-medigap market just walk
18 down the assumptions. Morbidity from '17 to
19 '19 is how healthy or sick the pool is, so 1.33
20 in rough terms is saying that overall everybody
21 who filed assumes they'll get 33 percent
22 sicker. There's a range in that from

1 10 percent to 95 percent, we're examining that.

2 On risk adjustment, as you know a zero sum
3 process where the healthier carriers write a
4 check to, so to speak, to the not as healthy
5 carriers. Zero sum, but there's a lot of money
6 changing hands. There's quite a gap there
7 where a carrier believes they will get
8 55 million, another believes they will say 159
9 to 170 million. We're working through
10 narrowing that gap. That's a major assumption.

11 Trends, the overall trend, the rise in
12 healthcare costs, plus some unit costs and
13 utilization, is 8 percent overall. The
14 high/low is 5.3 to 9.5. We'll talk a little
15 bit more about that later.

16 Contribution to reserve is, depending on
17 what type of carrier you are, profit. For
18 every premium dollar it was 2.7 percent, 2.7
19 cents for profit contribution to reserve with a
20 range of 2 to 5.

21 Administrative costs, how much it costs
22 the insurer to run their business per member

1 per month, which is a dollar amount, 66 on
2 average, but there's a range of 35 to 108.
3 It's another one we look closely at.

4 Broker costs, \$6 per member per month,
5 with a range of 4 to 7. And the loss ratio,
6 the claims divided by premium, how much of the
7 premium dollar is going to pay claims, on a
8 traditional basis it's 83.4 overall and a range
9 of 82 to 87. But the federal requirement that
10 it has to be below 80 for individual and small
11 group, on those terms it's a slightly different
12 formula, it's 87 overall and a range of 86 to
13 91.

14 Again, just trying to give you a sense of
15 what's been filed, what we're reviewing. This
16 is a small sample of what we're looking at, but
17 it's some of the big ones, kind of the top
18 view.

19 For small group there's a lot less
20 assumption that the pool will get less healthy,
21 1.003, a range of 1.0 to 1.01. We're looking
22 at that one, the carrier has been providing a

1 lot of information there.

2 Risk adjustment, they're a lot closer
3 apart there. When we roll together all the
4 companies there's a \$24 million difference, \$8
5 PMPM. We're still working with the carriers on
6 risk adjustment.

7 Overall trend is 7.8, with a range of 3.6
8 to 10.9.

9 Contribution to reserve, or profit,
10 average of 1.7, a range of zero to 6.

11 Administrative costs, 60 with a range of
12 42 to 73.

13 Broker costs, \$26 with a range of 3 to 30.

14 And the loss ratios, the one that you're
15 accustomed to seeing, those of you who look
16 into these things, 76.2 claims over premium
17 with a range of 75.6 to 79.8, and then the
18 NAIC, 80.5 above the minimum of 80 with a range
19 of 80 to 85.5.

20 One of the components, as you know, of the
21 Affordable Care Act was the patient-centered
22 Outcomes Research Institute. One of the core

1 issues is just runaway costs and trying to have
2 a component of the ACA that thinks about that,
3 that researches that, and a lot of the carriers
4 are doing some things along those lines that we
5 wanted to be aware of, wanted to advocate. I
6 know Kaiser has a diabetes program, a
7 behavioral health program that's five-star
8 rated by CMS. CareFirst has a nationally
9 lauded patient-centered medical home. United
10 has a motion program for exercise and wellness.
11 Aetna has an incentive program for their
12 providers. So all these -- this is a slide in
13 progress, but trying to look over time to see
14 what's the uptake. Are insureds taking
15 advantage of these things, and if so how much
16 and what's the pace.

17 So a rough estimate here of anyone
18 involved in some of the programs I just
19 mentioned, a prevention program, or chronic
20 care, a care plan where the doctor tells you
21 here's what you should do to stay healthy,
22 here's what you should do to get healthy, 1.9

1 percent in '15, 2.3 in '16, 2.7 in '17. So I
2 was hoping it would be a bigger number, but at
3 least it's on the upswing, and something that
4 we again believe is a key component to making
5 things better. And although these percentages
6 are small on the surface relatively speaking,
7 it's a very small number of claimants that can
8 generate a lot of the claims dollars, as you
9 know. I believe 3 percent generate 50 percent
10 of the claims costs, but still we'd like to
11 help the carriers raise those numbers.

12 A couple of -- to be circumspect in what
13 we're looking at for ACA, we've seen the
14 individual non-medigap market but we wanted to
15 see kind of holistically how have other markets
16 been affected, and trying to be factual, see,
17 interpret those facts, and this is one area
18 where it led us. If you look at what's
19 happened to the group markets, small and large,
20 since the ACA, there's a couple of charts here
21 to the right. One is how many were offering
22 health insurance before ACA and today, and one

1 thing that caught our attention is just looking
2 at the first chart it shows pre-AC as 2010,
3 47.2 percent of small employers were offering
4 health insurance to his or her employees,
5 that's come down to 32.9, so that's a
6 14 percent drop. We had -- it was more marked
7 for the under 10 of the real small groups, and
8 I know they're having their struggles too
9 paying the premiums. The average small group
10 in Maryland I believe is seven contracts, about
11 11 members, so there's -- we've seen some data
12 from the carriers of a migration out of the
13 small group market to individual. It would
14 stand to reason that the draw of the premium
15 tax credits, cost sharing reductions, and some
16 evidence is still being explored that believing
17 some of the less healthy have gone to the
18 individual market and trying to see what those
19 tangential effects are.

20 Another little bit harder to measure, but
21 one that we've started to try to look at, is
22 down at the bottom chart. You'll get small

1 group premium increases for the 15 years before
2 ACA and for large group, and in the two years
3 since, after ACA there's been an improvement,
4 and this one just look down for small group
5 average increase after benefit buy-downs from
6 5.6 percent to 3, so a 3-point drop in small
7 group. Large group was 6.4 to 2.3, a 4.2
8 percent drop, and then you have as a little bit
9 of a reference Consumer Price Index.

10 So as of late small group overall
11 increases in Maryland, according to the Medical
12 Expenditure Panel, could be dropping below CPI,
13 they've been on a downward movement, that's
14 something we're trying to understand and just
15 figure into our thinking.

16 Last couple of thoughts. As you know, the
17 Tax Cuts and Jobs Act was passed as of
18 December 22nd of '17. For Maryland ACA
19 insurers the amount of federal income tax paid
20 on earnings, again on a composite basis, came
21 down by 11 points from 28 percent to 17 percent
22 starting in 2018. So that affects the

1 contribution to reserve risk-based capital a
2 bit and had a tangible impact on bottom lines,
3 and that's part of our review.

4 We've had some great feedback from the
5 Maryland Hospital Association. I know a lot
6 about the HSCRC and the actions that they've
7 taken, I want to speak to that for a minute,
8 that we did note that the report that recently
9 came out with a projection of increasing costs
10 for fiscal year '19 is 1.37 percent versus 2.77
11 percent last year, so 140 basis points down, on
12 the second bullet point, and while -- there's
13 lots of reasons that the trend won't be exactly
14 1.37 percent, some of them are listed here.
15 Which hospitals are being used affects the
16 trend, mix of services being performed affects
17 the trend, if you're having more cardiac
18 surgeries, for example out-of-area utilization,
19 but I don't want it to get lost that the fact
20 that that's a projected is a factor is viewing
21 the trend and the direction of where the trend
22 is moving and is something that we're looking

1 deemed complete. That happened on July 5th and
2 I'll walk you through the timeline there. The
3 federal comment period ends on Saturday, so
4 we're keep tracking every little bit of
5 progress. We have asked HHS for a decision on
6 the waiver by August 22nd. I think that's
7 asking a lot of them, but I know that they're
8 trying, that it may be a little later than
9 that. I know the Commissioner mentioned a
10 second rate hearing about that decision to
11 focus on that for September 17th, and we're
12 aiming to have rates approved by September 19th
13 and open enrollment 11/1.

14 Thank you for going through all that. I
15 look forward to having the insurers, and I
16 appreciate again them coming in and answering
17 all of our questions. There's been a slight
18 change in the schedule per a request of one of
19 the carriers. So, CareFirst, is it okay if you
20 come up next?

21 MR. BERRY: Sure.

22 MR. SWITZER: Appreciate it, so the floor

1 is yours.

2 MR. BERRY: Great, thank you.

3 MR. REDMER: Excuse me, Todd, Bryson's
4 (phonetic) got a question.

5 AUDIENCE MEMBER: Quick question by Bryson
6 Hopper (phonetic).

7 MR. SWITZER: Yes, hi.

8 AUDIENCE MEMBER: The statistic you gave
9 earlier about the decline in participation in
10 the small group market by employers from, I
11 think, 47 percent to 32 percent, would that
12 capture any migration to the self-funded
13 market?

14 MR. SWITZER: I'm still trying to parse
15 that out. It was intended to, but I haven't
16 quantified it yet. But I'll be happy to off
17 line and show you how much we have parsed out.

18 AUDIENCE MEMBER: Thank you.

19 MR. REDMER: Yes?

20 AUDIENCE MEMBER: On a similar note, do
21 you have any data on migration back for 2018
22 yet?

1 MR. SWITZER: I don't, but I'd be happy to
2 explore it if you'll just find me after.

3 Anything else? Okay.

4 MR. BERRY: Good afternoon. My name is
5 Pete Berry, I am Chief Actuary for CareFirst.
6 I don't have any slides I'm going to be
7 showing, but I'll be referring to some notes
8 here as I walk through my presentation.

9 So as Todd mentioned, all the carriers
10 submitted rate filings for ACA on May 1st.
11 Like past years, since that time we have
12 received what's called objections from the MIA.
13 Those are really just questions, they're called
14 objections, but, and we continue to work with
15 them. Since May 1st to date we've received
16 over 45 objection letters containing over 200
17 questions for our individual and small group
18 rate filings, and this is pretty typical.

19 Every year there's quite a thorough review
20 by MIA, and starting last year they had an
21 external consultant also participate last year
22 who is Oliver Wyman. It's our understanding

1 that this year it will be Lewis & Ellis will be
2 the external consulting reviewing the
3 individual filings and some components of the
4 small group filings, and that review has yet to
5 begin. So the 200 I'm referring to are just
6 from MIA.

7 We'll continue to work with MIA and Lewis
8 & Ellis working through this process, as we
9 always do. It's through a system called SERFF,
10 and so that will be the technical review. What
11 I wanted to do today was walk through each of
12 the filings and talk about some of the major
13 drivers, some of the categories that Todd
14 included in his presentation, and I'll be
15 addressing mostly individual but also some
16 small group, but most of my time, for obvious
17 reasons, will be spent on individual.

18 So just to summarize where we are with
19 individual, as Todd mentioned there's been
20 substantial losses in the individual market
21 since the ACA began. I know we've, in hearings
22 in the past we've put up some numbers, and

1 those losses continue. Last year our approved
2 rate increases, and I'm giving the approvals
3 before what I'll call CSR adjustment, it's a
4 little more straightforward, is we had a
5 36 percent increase approved for HMO and a
6 49 percent increase for PPO, and those were
7 both lower than we filed, and PPO was
8 substantially lower than we filed.

9 So as we move through 2018, while it's too
10 early to really see definitively how the
11 performance, financial performance is going to
12 be, it does look like HMO is in better shape
13 than it ever has been in the past, but PPO is
14 still woefully inadequate, unfortunately. The
15 proposed rate increases that we have in 2019
16 that CareFirst has submitted, as Todd showed,
17 are 18.5 percent for HMO and 91.4 percent for
18 PPO, and those increases, as he also mentioned,
19 don't reflect any of the impact of an approval
20 for 1332 Waiver that would introduce a
21 reinsurance program. So these, all these
22 numbers are before that, which I think is very

1 important.

2 CareFirst is very supportive of the waiver
3 process. We've been involved pretty deeply in
4 working with MIA sharing data. We believe it's
5 an important step in attaining a stable
6 individual market. I can tell you that my
7 team, a year and a half ago we started at
8 CareFirst modeling what it would look like to
9 the individual market if we were able to have a
10 reinsurance system here. So we've been
11 thinking about it for a long time, and we are
12 very encouraged by the progress that has been
13 made and all the great work that the exchange
14 and the MIA has done in moving this forward.
15 It is a very -- for those of you who don't
16 know, it's a very complicated process with a
17 very short timeframe, and we're very excited
18 that they've met all these deadlines and CMS is
19 now on the verge of being able to review that.

20 One thing I can say is that if the 1332
21 Waiver is approved that the increases I
22 mentioned, the 18.5 and 91.4, will be

1 substantially lower, and that is very, very
2 good news.

3 So I want to start by talking about
4 individual PPO, that's the 91.4 percent
5 increase, and that, that sounds so high to me
6 too, and so one question is how could it
7 possibly be necessary to have a 91.4 percent
8 increase. Well, I want to give a little bit of
9 context.

10 Right now as of June we have about 13,000
11 members in that product. A year and a half ago
12 it was twice that many. Two and a half years
13 ago there were four times that many. So we
14 have a lot of people leaving this product
15 because the rates are so high. And as Todd
16 mentioned, you can have 3 percent of those
17 members account for 50 percent of the cost,
18 that's pretty typical in health insurance. So
19 you can have a lot of people leave and still
20 have most of the cost left over. That's called
21 anti-selection, and this is in a selection
22 spiral, this product. In fact, the last two

1 years as we've filed it, we have to have an
2 actuary certify to this rate filing, it has
3 been a qualified certification because we've
4 said this product is in a selection spiral,
5 which basically means no increase is going to
6 be adequate.

7 Let me give you an example. Every year we
8 get new people coming in. Believe it or not,
9 new people are still buying this product.
10 We've looked at the past and said, okay, how
11 sick are these new people compared to who we
12 currently have in there, and the data says
13 they're twice as sick, twice as sick as the
14 people already there. When we priced this for
15 2019 we didn't assume they were twice as sick,
16 we only assumed -- we assumed half of that,
17 because if we assumed it was twice as sick that
18 91.4 would have been even higher, and at some
19 point we have to make a decision as to how much
20 are we going to drive this knowing that no rate
21 increase will be adequate. So these are the
22 struggles we have, and it's one of the reasons

1 why we're so excited about the 1332 Waiver and
2 the opportunity to introduce reinsurance to try
3 to stabilize this market.

4 To give you another number, when we set
5 these rates we looked at a base period. So
6 this year it was 2017, last year it was 2016,
7 and we project out two years. So last year it
8 was 2016 to 2018, this year it's 2017 to 2019.
9 The change in the per-member cost from '16 to
10 '17, this is actual data, it went up
11 50 percent, 50 percent. So if we got a
12 49 percent increase last year, half of that,
13 basically all of that is taken out just in the
14 one year moving. It's a little bit more
15 complicated than that, but that's directionally
16 true.

17 So we're sitting there -- and I'll give
18 you the number. In 2016 the PMPM, per member
19 per month, cost for the PPO was \$658.93, a year
20 later it was \$947. Now, that's the, that's the
21 time when I mentioned to you that we lost all
22 that membership. So like I said, two and a

1 half years ago we had four times as many
2 members as we have now. That goes right into
3 these rate increases.

4 So when you start thinking about how can
5 you have a 91 percent rate increase, when you
6 have the cost going up 50 percent per year all
7 of a sudden you can see how you can have such a
8 large rate increase, and that's some of the
9 things we're struggling with, and those are the
10 main drivers. It's really how the experience
11 is emerging and how we think it's going to go
12 going forward. So for 2018 we can see who we
13 kept and who we lost, and the people we kept
14 were 35 percent sicker than the average person
15 the year before, so that gets added on. So
16 very quickly you get to a very high increase.

17 Some of the other factors there, there's
18 demographics. These people are getting older,
19 and while there's some adjustment for that in
20 the back end it doesn't really take into
21 account. So really the main drivers are the
22 base period going up, the continued

1 deterioration of the people we kept and some of
2 this population getting older, and that's
3 really what's driving that 91. There's some
4 other issues like trend and ebb and all those
5 things, but once you start talking about 91
6 percent increase all those things are little
7 details and what I talked about is really
8 what's driving it.

9 So let me move on to HMO. This is a much
10 better story. It's a much bigger population
11 and it is more stable than PPO, and that is
12 good news. However, it is susceptible to the
13 forces of anti-selection and so we are
14 concerned. This increase is 18.5 percent.
15 That is the -- I believe, someone will check me
16 on this I'm sure, but I believe that is the
17 lowest increase that CareFirst has ever
18 requested in the ACA since filing requested
19 rate increases in 2015. What that says is last
20 year when we got our 36 percent increase that
21 was in the range of what we thought we would
22 need, and, like I said, it's too early to tell

1 HMO. Still higher than what we would like to
2 see and that it's driven by the anti-selection,
3 but certainly much more manageable. So that
4 was really what I wanted to focus on with
5 individual. It's really all about how sick
6 these people are, morbidity.

7 There's certain things with risk
8 adjustment, as Todd mentioned. The way risk
9 adjustment works is they didn't want people --
10 anyone who's been around for a while might
11 remember the old golden rule in New York. They
12 used to -- when HMOs were first introduced they
13 would peel off all the young and healthies and
14 make a million dollars. They didn't want
15 people doing that, selecting all the healthy
16 risk, and so what they said was if you have a
17 healthier population than another carrier we're
18 going to use a formula so that you pay them
19 some money so that when you're selling these
20 you're not trying to target the young and
21 healthies. That's what risk adjustment is
22 about.

1 something that Lewis & Ellis, one of the
2 factors that Lewis & Ellis will be reviewing.
3 From our perspective we consider it an
4 important factor for the following reasons. As
5 Todd mentioned, most of the groups renew in the
6 fourth quarter, and that has to do with
7 something that happened way back in 2015 that
8 caused early renewals. So what that means is
9 when those groups renew in the fourth quarter
10 of 2019 they're going to get an annual contract
11 which locks in their rates well into 2020 in
12 the third quarter. So when we're working on
13 rates right now we're locking in a lot of
14 revenue all the way through the end of 2020,
15 and trend is one of the numbers we're going to
16 want to really look at. If our trends are too
17 low we've just locked in revenue for way in the
18 future and there's nothing we can do.

19 Now, what if they're too high? Well, ACA
20 has a mechanism in place for that, it's called
21 MLR rebates, and Todd alluded to it a little
22 bit with regard to an 80 percent loss ratio,

1 which is claims over premium. If a carrier has
2 basically prices too high and they make too
3 much money, we got to give it back. So there's
4 an upside, you know, if you make too much you
5 got to give back; no down side, if you don't
6 have enough, you don't get someone giving you
7 any money. So that's one of the things we have
8 to consider, especially as we're locking in
9 rates so far into the future. We want to make
10 sure these rates are adequate, but not
11 excessive. And as I said, we understand Lewis
12 & Ellis will be looking at some of our small
13 group assumptions, including trend, and we look
14 forward to working with them on that.

15 So that ends my portion.

16 MR. SWITZER: So as you know, Standard &
17 Poors talking about stability in the individual
18 market, it's a little bit of a while ago, April
19 of '17, but they summarize, said: Publicly
20 available data for BlueCross & BlueShield
21 insurers we expect a five-year path to
22 stability. 2018 would be year five and we

1 are -- the last part of their quote is: We're
2 seeing the first signs in 2016 that this market
3 could be manageable for most health insurers.
4 So my question is you alluded to it in the fact
5 that the 18.5 is the lowest in the lineup, and
6 that was great, is it your opinion that there's
7 cautious optimism that leaving the PPO aside,
8 which is, I think, a distinctly different case,
9 there could be some movement toward stability
10 or any feedback along some -- I know there's
11 lots of opinions about whether the market is
12 stabilizing or not, this is one that is in this
13 camp. Any feedback or thoughts about that
14 possibility, please?

15 MR. BERRY: Yeah, so let me give you my
16 opinion, and again this is just my opinion, not
17 necessarily CareFirst's opinion, as I think
18 about this and read about it. I think it's
19 possible. I think that there's some unique
20 things to Maryland that may have put us on,
21 outside of the scope of what they're talking
22 about, and let me give you an example. Florida

1 Blue down in Florida, they made money in the
2 ACA every year, and the reason why it started
3 with what's called a narrow network. So they
4 basically came in and said, okay, we're going
5 to cut out a bunch of hospitals, we're going to
6 have a lot fewer doctors, we're going to
7 negotiate better deals with those doctors, and
8 that's how we're going to build our ACA
9 products. So when it came out in the first
10 year their rates were a lot lower than they
11 otherwise would have been, okay, because they
12 made all those deals with the narrow network,
13 which meant they didn't lose as many healthy
14 people. They did that the first year and
15 they've been able to maintain that.

16 If you look at the states that have had
17 success, it's the states that started off with
18 narrow networks. It's also the states that
19 have a very high proportion of what's called
20 subsidized members on the exchange. They get,
21 you know, their premium subsidies which
22 immunes, helps you have immunity from rate

1 increases. My recollection, and again, you
2 know, everyone can test this, my recollection
3 is that Maryland has a pretty high percent of
4 off-exchange members, which means they are not
5 immune from these rate increases and tend to
6 drop out.

7 So that's why I think that article that
8 Todd was referencing, I think that's right for
9 a lot of the states, like Florida and others,
10 and maybe at the time that article applied a
11 little less to Maryland. Having said that,
12 setting aside PPO, the fact that we were able
13 to file an 18.5 percent increase for BlueChoice
14 does give me hope, because that's in the
15 ballpark. If we can get the 1332 approved and
16 we can actually bring those rates down some,
17 then I think we're starting to talk about a
18 positive future.

19 Thank you.

20 MR. SWITZER: Next we have Mr. Murayi from
21 Aetna, please.

22 MR. MURAYI: Hello. Good afternoon, my

1 name is Regis Murayi, I am here from Aetna, and
2 I am here to talk about our filings. We have
3 two entities for Aetna, and they are both in
4 the small group market, so no individual.
5 Everything I talk about today will be for small
6 group.

7 For our HMO entity, our average rate
8 increase is 10 percent, for our or PPO our
9 average rate increase is 9 percent. We filed
10 three plans for both entities, offered both on
11 and off exchange. So I'll note that these rate
12 increases are average rate increases. The
13 exact change will depend on what benefit plan
14 an individual chooses, the members that
15 contract, the members' group contract, the age
16 and family size for the enrolling employees,
17 and employer contributions. So what I stated
18 there earlier is a range, and it will vary.

19 In developing these rates we take our
20 historical claims experience from 2017 and
21 project that forward to 2019. So for
22 simplicity, as I pointed out earlier, we have

1 10 percent for HMO, 9 percent for PPO. Going
2 forward, let's assume an average of 9 percent.

3 For these rate increases, there are five
4 main drivers that drive this rate increase.
5 First, medical costs go up; second, plan design
6 changes; third, our estimate of the average
7 morbidity in the ACA market; fourth, changes in
8 fees; and then fifth, call it a catch-all
9 bucket that includes a number of small items
10 that don't impact the rates as much. I'll go
11 into details of those five drivers now.

12 So first, medical costs go up. We expect
13 total medical costs to go up from '17, what our
14 experience was, to 2019. Medical costs go up
15 for a number of reasons, but for two main
16 reasons: First, providers raise their prices,
17 and, second, members get more medical care.
18 For small employers in Maryland, some examples
19 of increasing medical costs we've experienced
20 in the last 12 months include the cost of
21 prescription drugs going up, also includes the
22 use of physician services in Maryland.

1 Assessment. In combination that still leads to
2 a decrease in our rates.

3 Finally, I said the catch-all bucket. We
4 have a bucket for impacts to rates that mainly
5 includes our experience differing from what we
6 had initially priced in 2018.

7 So with that, we also wanted to use this
8 opportunity to update you on what Aetna is
9 doing to keep premiums affordable. We are
10 taking a number of steps to keep our products
11 as affordable as possible and to address the
12 underlying cost of healthcare. Among these
13 include we are developing new agreements with
14 healthcare providers that base provider
15 compensation on the quality of care that's
16 delivered, rather than the quantity of
17 services. Second, we're creating medical
18 management programs that address potential
19 health issues for members earlier and improving
20 their health outcomes. Third, we're working to
21 reduce the ability of out-of-network providers
22 to collect unreasonably excessive payments for

1 services they provide.

2 Aetna is dedicated to increasing
3 transparency within the healthcare system and
4 helping members best utilize the plans that
5 they have. Members can access Aetna Navigator,
6 which is a secure member site, website, which
7 allows them to research their specific plan
8 benefits, healthcare providers in a given area,
9 and in some locations the actual cost of the
10 healthcare services that they're going to
11 obtain.

12 With that, I just want to thank you for
13 the opportunity to be transparent in our rate
14 development.

15 MR. SWITZER: Thank you very much.

16 MR. REDMER: I've got a couple. First,
17 for anybody on the phone, if you could refrain
18 from putting us on hold we would appreciate
19 that.

20 Two things: You mentioned at some point
21 in your presentation you were projecting
22 increased physician usage, I think was the term

1 you used, and you also mentioned increased
2 morbidity. I'm curious why you believe that
3 the morbidity is going to increase and by how
4 much, and then secondly if you can elaborate on
5 the increased usage of physicians.

6 MR. MURAYI: Yes, I'll take your first
7 question. I would say we're -- we see an
8 increase in physician utilization, so generally
9 as we look year over the year the amount of
10 medical care that actually occurs we have seen
11 physician utilization increase. We expect that
12 to continue in the future.

13 Second, your second question was about the
14 average morbidity. So for the small group
15 market we are expecting a slight increase in
16 the average morbidity of the small group ACA
17 risk pool, and that has -- because of that that
18 has an impact on our rates as we relate to the
19 average. The magnitude is in the low single
20 digits.

21 MR. REDMER: But what is it that you're
22 seeing that causes you to believe that the

1 morbidity's actually going to increase?

2 MR. MURAYI: Our analysis is based off of
3 historical evidence, or historical experience
4 and then we project that forward. You know,
5 it's our opinion as we look at the, just the
6 average composition of the market that leads to
7 an average increase in small group morbidity.

8 MR. REDMER: Thank you.

9 MR. SWITZER: So I noticed that enrollment
10 dropped from last year to this year by about
11 33 percent. I know that the brand recognition
12 for Aetna is very good, and my question is with
13 that enrollment pattern declining and the rates
14 being relatively higher than others in the
15 market is there a strategy, or maybe that's not
16 the right word, but to grow, or are you
17 expecting to still shrink in enrollment in
18 Maryland? Or if there's any thoughts you can
19 share about the presence in Maryland and the
20 direction you're going and want to go, that
21 would be appreciated.

22 MR. MURAYI: Yeah, unfortunately I can't

1 speak about the overall strategy in the market.
2 I will say that for our premium rate
3 development we, you know, we look at the costs,
4 the underlying costs that we are incurring, and
5 we project it forward for a rate that we
6 believe to be reasonable in the marketplace.

7 The strategic question is outside of my
8 realm of responsibility.

9 MR. SWITZER: Sure, thanks.

10 Last question from me. I notice that the
11 broker costs are relatively small, \$3 per
12 member per month. Are the brokers not relied
13 heavily upon for this market in Maryland?

14 MR. MURAYI: We set broker compensation
15 amounts every year, and, you know, as you noted
16 they're relatively lower. So, you know, that's
17 just the compensation structure that we've set
18 out with those brokers.

19 MR. SWITZER: Okay. Thank you.

20 MR. REDMER: On the left.

21 AUDIENCE MEMBER: Is the morbidity rate
22 projected for ACA in any way affected by

1 Aetna's transition towards the self-funded
2 model for small group?

3 MR. MURAYI: Let me make sure I heard the
4 question correctly. You said is it affected in
5 any way by a transition to a small group
6 market?

7 AUDIENCE MEMBER: Towards the self-funded
8 model.

9 MR. MURAYI: To the self-funded models?
10 So we look at the average of the current
11 composition of the ACA risk pool and we
12 consider things, you know, risks going forward
13 that may change the composition of the market.
14 So, you know, first we look at the average
15 morbidity in that pool, but also things that,
16 you know, things that may change, new things on
17 the landscape that will change the definition
18 of that marketplace.

19 So, yes, we consider all those pieces in
20 the projection of our morbidity. To parse that
21 out, we generally look at it in the aggregate
22 and make a projection forward for overall how

1 we think that will affect the market dynamics.

2 MR. SWITZER: Morbidity is one of the key
3 assumptions we're kind of in the middle of our
4 deliberation with Aetna on, so that's one of
5 the factors, that's one of the key ones that
6 we're asking for more information and working
7 toward assent.

8 Is there another question? Go ahead.

9 AUDIENCE MEMBER: (Inaudible.)

10 MS. GRASON: Speak up a little bit.

11 MR. SWITZER: I'm sorry, would you please
12 speak up a little.

13 MS. GRASON: Stand and speak.

14 AUDIENCE MEMBER: Since we're talking
15 about --

16 MR. SWITZER: I'm sorry, would you please
17 stand up and speak a little louder for the
18 Court Reporter and everybody. I'd like to
19 hear.

20 AUDIENCE MEMBER: Since you're talking
21 about the prescriptions, is it appropriate to
22 ask a pharmacy question?

1 MR. SWITZER: Sure.

2 MR. REDMER: Related to the ACA, sure.

3 AUDIENCE MEMBER: (Inaudible.)

4 MR. REDMER: Can you repeat that?

5 MR. MURAYI: Yeah, and correct me if I get
6 this wrong. Your question was for our plans,
7 what are the preferred pharmacies that we offer
8 as part of our medical benefit?

9 AUDIENCE MEMBER: Yes.

10 MR. MURAYI: Unfortunately I don't have
11 that answer right now, but we can follow up
12 with you afterwards if you would like.

13 MR. SWITZER: Thanks again.

14 MR. MURAYI: All right. Thank you.

15 MR. SWITZER: I know that Kaiser is
16 calling in from Portland, Oregon, and I had a
17 request, I want to accommodate that. So
18 Kaiser, if they can go next, if that's all
19 right with United. I'll do the slides.
20 Mr. Liebert, whenever you're ready.

21 MR. LIEBERT: All right, thank you. Thank
22 you for your patience and thank you for letting

1 me participate. My name is Dave Liebert and
2 I'm an actuary with Kaiser Foundation Health
3 Plans here in Portland, and I've worked on the
4 Maryland individual rate filings for three or
5 four years now and so I'm going to present on
6 both the individual and the small group rate
7 filings. Unfortunately Rob Picker, the actuary
8 on the small groups filing, could not be here
9 today, but I'm going to present on his behalf.

10 So on the first slide, or actually I guess
11 it's the second slide, on the components of the
12 rate change for the small group ACA filing, you
13 can see that we are -- we have filed a
14 3 percent rate change, actually a 3.3 percent
15 rate change, and this is on a -- we have
16 approximately 9,000 members in the market as of
17 February 2018, which is about a 3 percent
18 market share, and we have 44 plans covering all
19 the metal tiers from Bronze, Silver, Gold and
20 Platinum, and they are all HMO plans, and we
21 have seen a slight decrease over the years in
22 our experience.

1 see here is a graph that shows that we are, for
2 the on-exchange market we're about 40
3 percent -- I'm sorry, 46 percent of the
4 on-exchange market in Maryland, about
5 35 percent overall, and this is as of early
6 2018. 2017 we were overall about 28 percent of
7 the total market, so we have grown
8 substantially even just from 2017 to 2018, and
9 the growth has been pretty substantial since
10 the beginning of the ACA, and one of the
11 problems with that is that it does affect our
12 ability to project the morbidity of our
13 membership. By the time we file the rates, for
14 example in this case by the time we file the
15 rates for 2019 we really don't know what our
16 2018 membership looks like and we know that
17 it's different than our 2017 membership, and so
18 we're projecting through a year that has pretty
19 substantial changes. So, you know, we do the
20 best we can with that, but it does present
21 some, just some instability in the actual rate
22 projections.

1 substantial increases in our claims expenses,
2 and we can attribute this to a variety of
3 things. A major thing that we know is playing
4 out in this market is just the effect, we
5 assume it's the effect of the, partially the
6 effect of the individual mandate going away,
7 but it's also just the increase, the main
8 increases over the last couple of years are
9 driving people out of the market and this is
10 causing the healthy people to leave, and to the
11 overall we've seen the market size drop fairly
12 substantially over the last couple of years.
13 Here I show that it's a 13 percent reduction
14 from, in the market as a whole from 2017 to
15 2018. And it sounds like we have the hold
16 music back in play so I apologize, that's not
17 my music.

18 MR. REDMER: Poor music, to say the least.

19 MR. LIEBERT: So the components of -- I'm
20 sorry, can you hear me, because I --

21 MR. REDMER: We can, we can, or at least I
22 can.

1 MR. LIEBERT: Okay. The hold music is
2 getting very loud for me. I'm sorry, this is
3 very distracting.

4 The components of our rate change, as I
5 said we're estimating a 14 percent increase due
6 to the increased claims expenses, and that's a
7 big part due to the reduction in the market and
8 the departure of healthy members, and
9 additionally we're projecting about 20 percent
10 of our rate increase is due to risk adjustment
11 transfer increases. For 2017 we had about \$115
12 per member per month that we paid into the
13 market for risk adjustment, and due primarily
14 to the increases in the premiums and the
15 effects that they have on the formula we are
16 projecting that the 2019 risk adjustment will
17 be \$199 per member per month, which as shown
18 here has about a 20 percent impact on our
19 rates.

20 And then we also have an impact, a slight
21 impact from fees, such as the Maryland state
22 assessment, the new Maryland state assessment,

1 and then the moratorium on the Health Insurance
2 Provider Fee.

3 And then moving on to Slide 6, we have an
4 exhibit showing our relative rates of our
5 cheapest plans in each of the metal tiers to
6 the CareFirst HMO and CareFirst PPO plans, and
7 as you can see here other than in the
8 catastrophic tier those rate increases still
9 maintain the Kaiser premiums as the lowest in
10 the market.

11 That is the end of my presentation. I
12 don't know if there are any questions you may
13 have.

14 MR. REDMER: David, thank you for
15 struggling through that. I can assure you
16 we're going to launch an investigation to see
17 if somebody from CareFirst put you on hold.

18 Anybody have any questions for Dave?

19 MR. SWITZER: Yeah, Mr. Liebert, thanks
20 again. For the individual market you had
21 shared in Annapolis, and other places, that the
22 underwriting gain/loss in 2015 was negative

1 40 percent and negative 30, and then you
2 projected --

3 MR. LIEBERT: I'm sorry, I'm hearing about
4 every other word.

5 MR. SWITZER: So just back for a second to
6 the theme of rate stability or the potential
7 for it in the individual market. We know that
8 losses have been in the 40 to 30 percent in the
9 past, '15 and '16. I know in the fall either
10 projected a '17 underwriting loss of negative
11 13 percent of revenue and you have provided
12 that that's come in about minus 6. Is there
13 any early indications that '18 is on the same
14 kind of path toward improvement, as much as you
15 can share directionally? I know that the rate
16 increase with the CSRs defunded was about
17 43 percent. So just trying to look to '18 to
18 see if that progression toward stability is
19 playing out at all in '18.

20 MR. LIEBERT: So in 2018 the Kaiser rate
21 increase with the CSR changes was about 32.9
22 percent, and unfortunately that's not leading

1 to the profitability or the stability in this
2 market for us because at the same time as a
3 large rate increase we also are paying out more
4 in risk adjustment than we had anticipated, and
5 that is while our claims expenses are on track
6 for where we thought they should be our
7 non-claims expenses, which is in this case the
8 risk adjustment, are much higher than were
9 anticipated, than we originally anticipated
10 with the rate filing.

11 MR. SWITZER: Okay. Thanks.

12 And just on the small group market, you
13 mentioned the market share, I know you've taken
14 some steps to be competitive there. It seems
15 like growth is part of the plan for the small
16 group market. Would that be relatively
17 accurate, enrollment growth?

18 MR. LIEBERT: Yes, it is, that is accurate
19 to state.

20 MR. SWITZER: Thank you.

21 All right. From there we'll go to
22 Mr. Morgan, please, from United.

1 MR. MORGAN: Good afternoon. My name is
2 Ryan Morgan, I'm an Actuarial Director with
3 UnitedHealthcare, and I'm here today to present
4 our proposed Maryland small group rates for our
5 four legal entities, which are UnitedHealthcare
6 Insurance Company, UnitedHealthcare of the
7 Mid-Atlantic, Optimum Choice and MAMSI Life and
8 Health Insurance Company.

9 Before we get into 2019 rates, please
10 allow me to briefly discuss our recent rate
11 history to provide some context. Our Maryland
12 small group block has seen low rate increases,
13 and even some decreases in recent years. For
14 2018 our file rate increase averaged just 0.2
15 percent across all four legal entities. In
16 2017 rates reduced 2.6 percent, and rate
17 increases for this block were negative or in
18 low single digits in the years prior as well.

19 In 2019 across all of our legal entities
20 we are proposing a total of 84 plans; ten
21 Platinum, 36 Gold, 33 Silver, and five Bronze,
22 but half of these plans are available both on

1 and off exchange, and the other half are sold
2 off exchange only. For small group business in
3 2019 we filed for a rate increase of
4 13 percent, as was stated. And please note
5 rate changes vary by plan, and other things
6 like census changes can influence those as
7 well, so for any given group obviously it could
8 be significantly higher or lower than that,
9 just to give that caveat.

10 So the main drivers were base rate changes
11 and trend, which was approved in 2018 for
12 5 percent and was filed at 7.3 percent for
13 2019. We didn't propose any changes to age or
14 area factors in any of these filings.

15 I guess the one other thing I wanted to
16 mention is Maryland's, the health insurance tax
17 that others mentioned as well has an impact on
18 rates. So in some other states with the ACA
19 fee moratorium there was a decrease for that,
20 and so in Maryland this new tax almost exactly
21 offset the impact of that going away so there
22 was really no change in Maryland for that.

1 carriers' filings are finalized. But, yeah, I
2 wouldn't expect the pace of growth we had to
3 continue, but I still think we may continue to
4 grow depending on where everyone lands.

5 MR. SWITZER: Sure.

6 As related to the Tax Cuts and Jobs Act,
7 has there been any quantification of how that's
8 affected your RBC for '18, out of curiosity?

9 MR. MORGAN: I'm not -- I guess I'd have
10 to get back to you on that. I'm not aware
11 offhand.

12 MR. SWITZER: Sure.

13 MR. MORGAN: I mean, you know, given the
14 size of United, and many of the other companies
15 as well, I don't think that would be a huge
16 concern, but I can certainly confirm that for
17 you.

18 MR. SWITZER: That would be great. For
19 Maryland specifically?

20 MR. MORGAN: Yep.

21 MR. SWITZER: Great.

22 MR. MORGAN: Thank you.

1 MR. SWITZER: Thank you.

2 MR. REDMER: All right. That's it for the
3 carriers, and let's see who has signed up to
4 speak. Russ Mirabile?

5 MR. MIRABILE: I'm going to waive that
6 now.

7 MR. REDMER: You're going to waive, okay.

8 MR. MIRABILE: Thank you, though.

9 MR. REDMER: Sure.

10 I assume if it's the carrier folks they
11 are not interested, they've already spoken,
12 correct me if I'm wrong. Beth Sammis, Consumer
13 Health First.

14 MS. SAMMIS: Thank you for the opportunity
15 to offer a consumer voice to the rate review
16 process. My name is Beth Sammis and I am the
17 President of Consumer Health First. Consumer
18 Health First submitted written comments to you
19 via your website, which I distributed to you
20 and your staff today. This testimony is
21 submitted on behalf of 40 advocacy
22 organizations and individuals, about 20

1 organizations and 20 individuals.

2 I want to -- I'm not going to bore you
3 with all of the testimony, but I do want to
4 highlight a few of our key points, and before I
5 begin I want to expressly thank you,
6 Mr. Commissioner and your staff, for publicly
7 affirming and doing so again here today that
8 you would consider the experience and impact of
9 high-risk members, carriers' programs to manage
10 care and improve health outcomes, and
11 CareFirst's statutory mission when reviewing
12 2019 rates. We're very grateful for you for
13 doing that.

14 We understand the rates before you today
15 will significantly change if Maryland receives
16 the State Innovation 1332 Waiver, and we, like
17 the carriers, are cautiously optimistic that
18 this will be approved and carriers will then
19 file new rates based on anticipated reinsurance
20 payments. We do not believe, though, that it
21 is in consumers' interests to simply rely on
22 reinsurance to lower premiums for next year.

1 We must do as much as possible beyond
2 reinsurance to lower premiums for all
3 consumers.

4 As you know, the individual mandate will
5 no longer apply in 2019, and with premiums well
6 beyond what's affordable for consumers who do
7 not qualify for federal subsidies we run the
8 risk that the gains we've made in expanding
9 insurance coverage since 2014 will be lost.

10 In 2013, 11 percent of all Marylanders
11 below the age 65 were uninsured, today that's
12 down to 6 percent. For consumers who do not
13 qualify for federal subsidies, those with
14 incomes over 400 percent of the federal poverty
15 level without access to employer-based
16 insurance year over year increases of 20 to
17 40 percent have resulted in unaffordable
18 premiums, as Todd has documented here today.
19 We're concerned these consumers will now make
20 the bet that they won't need healthcare
21 services, particularly the young and the
22 healthy, with them more likely to forego buying

1 healthcare coverage because of the loss of the
2 individual mandate. These decisions will place
3 individuals at personal financial risk, as well
4 as their families --

5 MR. REDMER: Excuse me. For those of you
6 that are on the phone, if you could please
7 place us on mute we would appreciate it. Thank
8 you.

9 MS. SAMMIS: -- as well as place our
10 state's innovative delivery systems models at
11 risk if the number of uninsured goes
12 dramatically up.

13 So this year Consumer Health First looked
14 at the data provided in the rate filings for
15 the years 2013 to 2017. Yes, I am a nerd, I
16 admit that, and I'm a little bit -- I'm always
17 worried about my math because I'm a
18 sociologist, not a mathematician, but I'm glad
19 to hear that much of what CareFirst and Kaiser
20 had to say here today reinforces my
21 conclusions. So I guess that's good. Maybe it
22 means there's some truth, huh.

1 testimony. CareFirst spends more for claims
2 for healthy PPO members than it does for
3 healthy HMO members. So even though they are
4 both classified as being healthy, the PPO
5 members cost more than the HMO members, and we,
6 of course, think that this matters, that there
7 is a difference in costs. The greater the
8 difference in premiums and claims between the
9 HMOs and the PPOs the higher the risk
10 adjustment payment the HMOs must make. I do
11 realize that CareFirst HMO will receive some
12 risk adjustment payment this year, but 93
13 percent of the total amount that was collected
14 from Kaiser for risk adjustment will go to the
15 PPOs and not to the two HMOs.

16 Unless we figure out how to minimize the
17 difference between the HMO and PPO premiums and
18 claims, consumers will pay high premiums even
19 with the reinsurance program. In fact, we
20 think this dual market of HMOs and PPOs is
21 unusual across the country, and may be the key
22 factor for why our market has not stabilized as

1 much as other states, and we have a
2 recommendation for that at the end.

3 For this reason we ask you to direct
4 CareFirst to answer a series of questions about
5 its PPO products, and I appreciate the fact
6 that they did some of that here today, but
7 there are additional questions that we would
8 like answered. For example: Do out of network
9 claims drive up overall claim costs in the PPO?
10 Is that part of what explains the difference in
11 the claims costs between healthy PPO members
12 and healthy HMO members, or are the fee
13 schedules slightly different between the PPOs
14 and the HMOs. It's quite possible they have
15 one fee schedule, but it's also possible they
16 have multiple schedules for the two products.

17 One way to reduce the difference in
18 premium between the PPOs and HMOs is for
19 CareFirst to continue to heavily subsidize the
20 PPO in 2019, basically at the same level that
21 they subsidize the PPO in 2018, and the best
22 way to do this is to require CareFirst to

1 offer coverage in the individual market and it
2 is not possible for them to withdraw, but we do
3 not believe that there is anything in the
4 statute that requires these two companies to
5 offer a PPO. In effect PPOs by law are
6 authorized to offer exclusive provider
7 organizations that mimic HMO coverage on a PPO
8 license. EPO plans may be better suited to
9 meet the access, quality and affordability
10 needs of consumers in the individual market
11 than PPO plans. We ask you to consider this
12 and to provide public guidance to all of us on
13 this point.

14 Finally, we ask you to do what was done
15 previously in the rate review process, to issue
16 a detailed decision document. This would let
17 consumers know what factors you consider during
18 rate review, why these justify approval or
19 modification of the rates, and the state of the
20 individual market, and I do this as a personal
21 ploy because otherwise I have to go back
22 through the SERFF documents in January and they

1 are annoying to read. So I would ask you to
2 save me from that, and to give all of the
3 consumers of Maryland the ability to be able to
4 understand why it was that you reached the
5 conclusions that you do.

6 I thank you again for the opportunity to
7 address you today and to be part of this
8 important process. On behalf of Consumer
9 Health First, I'd like to reiterate that we
10 look forward to your decision and your
11 conclusions about the individual market and to
12 working with you in the future.

13 MR. REDMER: Thank you, Beth.

14 Any questions? All right. Appreciate it,
15 thank you.

16 Delegate Cullison, did you want to make
17 any remarks while you're here? You don't have
18 to. It's up to you.

19 DELEGATE CULLISON: No, that's all right.
20 You guys are doing a great job.

21 MR. REDMER: All right. Let's see.

22 Stephanie Klapper, Maryland Citizens' Health

1 Initiative.

2 MS. KLAPPER: Sorry, I only have four
3 copies.

4 MS. GRASON: That's all right.

5 MS. KLAPPER: Hi, I'm Stephanie Klapper
6 with Maryland Citizens' Health Initiative. We
7 are a nonprofit that works for quality
8 affordable healthcare for all Marylanders, and
9 our Maryland Healthcare For All Coalition is
10 comprised of hundreds of business, labor,
11 faith, community and other organizations all
12 across the state.

13 I first want to thank you, Commissioner,
14 and for your team for taking comments on the
15 proposed rates for the market next year, and we
16 commend Maryland for working to create a
17 reinsurance program to respond to the high cost
18 of premiums on the market. As we've heard
19 today affordability is a serious concern, and
20 once the 1332 Waiver is hopefully approved we
21 encourage the state to use the funds from the
22 federal government and the \$380 million state

1 stabilization fund to implement the program as
2 efficiently as possible to result in the
3 greatest reduction in premiums for all
4 Marylanders across the state.

5 We've heard today from several people that
6 the loss of enforcement of the individual
7 mandate at the federal level is going to create
8 market instability, and we propose creating a
9 Health Insurance Down Payment Plan at the state
10 level in response to that. This plan would
11 make it so that at tax time when the consumer
12 is asked did you have quality coverage last
13 year, if the person says no they would have the
14 option to either pay a penalty to the state or
15 instead use that penalty money to instead
16 purchase health coverage, and we anticipate
17 that there would be at least 60,000 people in
18 Maryland who could be able to get health
19 coverage right then and there for the same
20 amount of the penalty fee combined with the
21 federal subsidies, which would bring many more
22 people into the market stabilizing it, at the

1 same time getting many more people covered.

2 We also heard today that the high cost of
3 drugs is a contributing factor to increases in
4 premiums, and so to that effect we would
5 propose a health insurance -- I'm sorry, a Drug
6 Cost Commission created at the state level in
7 order to look at these really, really high-cost
8 drugs, the ones that cost \$30,000 a year or
9 more, that are really driving premium rates up
10 and take a look at that and figure out what is
11 reasonable for Maryland to pay.

12 So again, thank you very much for this
13 opportunity to comment, and I'm happy to take
14 any questions.

15 MR. REDMER: Thank you, Stephanie.
16 Welcome to the first two bill hearings of 2019.

17 DELEGATE CULLISON: And maybe you know the
18 answer, but in terms of the down payment that
19 would require a state mandate, correct? And
20 are we within our purview to -- are we
21 authorized by the federal government to have a
22 state mandate for healthcare?

1 MR. REDMER: That's not my bailiwick.

2 Beth is saying yes, Michele is saying yes.

3 MR. MORROW: I think the answer is, and
4 I'm not 100 percent sure about this, but I
5 think the answer is the states have been
6 encouraged to do what they need to do, more
7 control coming back from the federal government
8 to the states, and I'll ask Joe maybe if I'm
9 wrong about this but I do think that they have
10 said that they would allow states to do
11 state-based mandates.

12 AUDIENCE MEMBER: Yes.

13 AUDIENCE MEMBER: And Massachusetts has
14 had one for years.

15 MR. MORROW: Yeah, they've had one since
16 2007, so.

17 DELEGATE CULLISON: Thank you.

18 MR. REDMER: All right. Delegate
19 Cullison, thank you.

20 I don't have anybody else that has signed
21 up to speak, unless I've missed anything. Yes?

22 MS. RASWANT: Maansi Raswant from the

1 Maryland Hospital Association.

2 MR. REDMER: Sure, sure. I'm sorry, I
3 missed you.

4 MS. RASWANT: Great, thank you.
5 Apologies, I came in late, so I may have missed
6 on the sign-in sheet there.

7 MR. REDMER: That's okay.

8 MS. RASWANT: So thank you. Good
9 afternoon. Again, Maansi Raswant on behalf of
10 the Maryland Hospital Association representing
11 64 hospitals and health systems across the
12 state.

13 I want to start off by thanking you,
14 Commissioner Redmer, and the MIA staff, for the
15 opportunity to provide our comments, and
16 honestly also for just the thorough process
17 that you're undertaking. I really appreciate
18 it, and our members do as well.

19 We did submit written comments earlier
20 today, so I'll keep my testimony brief, and I
21 want to say that it is promising to hear that
22 so much of what I'll outline and cover is being

1 planned on being reviewed as part of the
2 written review process.

3 So I'll start off with what we know every
4 year. This year, again, there is a large
5 variation in underlying cost trends cited by
6 the insurers specific to the hospital cost
7 trends. Insurers have used rates as high as 3
8 percent in the individual market and 13 percent
9 in the small group market. These projections,
10 as Todd noted, are inconsistent with the Health
11 Services Cost Review Commission's recent
12 approval of the total hospital revenue growth
13 of only 1.37 percent per capita for fiscal year
14 2019, and as Todd mentioned we recognize that
15 all products have unique factors that are
16 impacting the projected trends. But again, the
17 variation is so wide that we believe it
18 warrants accountability from insurers to
19 explain exactly how these higher costs and
20 utilization trends are calculated, so I'm glad
21 to hear that MIA is undertaking that effort.
22 And more importantly, insurers should show how

1 the hospital savings realized under the model
2 are passed on to consumers.

3 In addition, we're seeing high
4 double-digit increases or increased requests
5 every year, particularly for the preferred
6 provider products, as Beth Sammis just
7 mentioned, and while the independent actuarial
8 analysis of the MIA Commission last year is
9 helpful, and I'm glad to hear again it's
10 happening this year, it doesn't work to
11 identify the root causes of the trends and
12 characteristics, and to understand for example
13 what is driving the constant increase in
14 morbidity.

15 To do this, in addition to your expertise
16 here at the MIA, we'd invite you to look at the
17 HSCRC's processes to analyze the Medicare
18 population and to leverage the all-payers
19 claims database. It would also be prudent to a
20 member of any programs insurers have in place
21 to manage their populations against the higher
22 increases to understand their effectiveness, so

1 I was very happy to see the slide just looking
2 at the types of programs that insurers have in
3 place, what their uptick looks like and, Todd,
4 I agree that it would be great to see that
5 number increasing every year.

6 And then to that point I'd like to end by
7 encouraging the MIA as it works with the Health
8 Benefit Exchange on the state reinsurance
9 program to consider the value of care
10 management incentives. The reinsurance program
11 presents a unique opportunity to understand and
12 address high rate increases by better linking
13 healthcare coverage and healthcare delivery,
14 and it would allow the state to create webbers
15 (phonetic) that impact long-term stability of
16 the insurance market by increasing quality and
17 reducing costs, and in addition any reduction
18 in the cost of care would also decrease
19 reliance on a reinsurance program.

20 So as we move to the total cost of care
21 model, it's increasingly critical that insurers
22 offer plans that accurately reflect the cost of

1 care, pass savings on to consumers, and, more
2 importantly, facilitate the delivery of care
3 that meets their needs. While the model holds
4 providers accountable for holding costs down
5 and increasing quality, consumers need
6 equitable and affordable coverage to access
7 these high-value services. After all, it is
8 the synergy between accountable care and
9 affordable coverage that has made Maryland a
10 model in the nation. Thank you.

11 MR. REDMER: Thank you.

12 Any questions? I think we're good.

13 I am going to take questions from the
14 phone in a second. Anybody else here have any
15 questions, comments, observations? Yes?

16 AUDIENCE MEMBER: With regards to the
17 discrepancy between the PPO clients and the HMO
18 clients, has it been looked at how that
19 transition has happened? Because I'm wondering
20 how many PPO clients are now HMO clients,
21 they've migrated from one to another and
22 whether that in and of itself is affecting the

1 morbidity rates of the PPO pool.

2 MR. REDMER: I'll let Todd address this if
3 he chooses to, but I think the answer is yes.
4 We've heard, you know, that the PPO is in a
5 death spiral because of adverse selection. So
6 those sicker folks that have left the PPO, my
7 own speculation is part of them have migrated
8 to no coverage at all and some have, the
9 healthier of them have migrated to the HMO, and
10 the population that's left is certainly much
11 sicker than the population that did leave.

12 MR. SWITZER: Since the morbidity
13 assumption is so critical, we have tried to
14 pull that apart in several ways: One, the
15 people that are in the pool today so far in
16 2018, what's their origin, did they come from
17 small group, did they come from large group,
18 were they previously uninsured as best we can
19 tell, did they come from within the insurer,
20 their other markets, or did they come from
21 competitors are some of the ways that we're
22 trying to parse it.

1 and, you know, and that trend is accelerating a
2 lot. You know, it was 30 percent in 2014, it's
3 down to 15 percent as of 2016, 10 percent as of
4 '17, and now we're down to about 7 percent of
5 the pool and it's just kind of becoming
6 exponential.

7 So it's really one of the key assumptions
8 in this rate filings, and another thing is this
9 impacts all of the rate filings, and so we see
10 the HMO experience look a lot better than the
11 PPO experience, but all carriers need to price
12 to the entire state's average risk. So it's
13 just as important for Kaiser's rate filings as
14 for CareFirst's rate filings to take into
15 account these PPO members and to accurately
16 estimate just how bad the PPO has gotten from
17 year to year.

18 Any other questions?

19 AUDIENCE MEMBER: It was just sort of a
20 trend question.

21 MR. REDMER: Debbie, if you could ask the
22 question I'd also be interested in the flip

1 side of that. I'm curious as to if there are
2 members that are in the HMO, they get a
3 significant health issue and they migrate up to
4 the PPO because of the expanded network
5 options.

6 AUDIENCE MEMBER: I will check that out.

7 MR. REDMER: Just curious.

8 Any other questions, comments? If not, we
9 will go to the phone. Is there anybody on the
10 phone that has any comments or observations?
11 One more time, anybody on the phone?

12 All right.

13 TELEPHONE MEMBER: We're all on the phone,
14 we just don't have a question.

15 MR. REDMER: All right. Well, thank you.

16 With that I'll ask the room one more time.
17 Anybody else?

18 All right. Well, thank you once again.
19 Hopefully we're going to have an opportunity to
20 come back and do this again real soon. Thank
21 you.

22 (The hearing concluded at 2:40 p.m.)

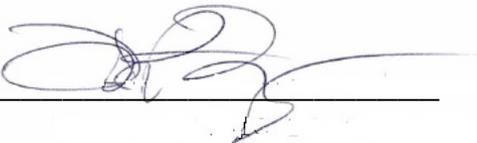
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