In the Matter Of:

2019 PREMIUM RATES HEARING

HEARING

July 30, 2018

BEFORE THE MARYLAND INSURANCE ADMINISTRATION

IN RE:

2019 PROPOSED HEALTH INSURANCE PREMIUM RATES HEARING

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Pursuant to agreement, before Toni R. Thompson, RMR, Court Reporter and Notary Public in and for the State of Maryland.

A P P E A R A N C E S

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CATHERINE GRASON, CHIEF OF STAFF

TODD SWITZER, CHIEF ACTUARY

BRAD BOBAN, SENIOR ACTUARY

BOB MORROW, ASSOCIATE COMMISSIONER, LIFE AND HEALTH

C O N T E N T S

P R O C E E D I N G S

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

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

I also want to introduce for the meeting

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

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

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

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

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

One of our aims here is to, or some of them is to offer transparency to the rate review process, to spur dialogue, and to raise the right questions with a factual bedrock, and one of my favorite parts of these meetings are the questions that it raises, and as you know once you raise one question it leads to another question, and I think it improves the quality of the public discourse toward a better decision making again.

I know you've heard about some of our guiding principles before. I don't want it to be perfunctory because it helps me to keep a balance in what we're doing, and what I mean is there's ten of us in the Actuary's Office reviewing the rates. One of our guiding principles is our Standards of Practice for Actuaries, so that calls for an approach where the assumptions, every assumption is looked at individually, looked at in aggregate to make sure that it's reasonable, as well as Maryland Insurance Article 11-603 requires that rates

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

lot of information there.

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

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

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

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

Broker costs, $26 with a range of 3 to 30. And the loss ratios, the one that you're accustomed to seeing, those of you who look into these things, 76.2 claims over premium with a range of 75.6 to 79.8, and then the NAIC, 80.5 above the minimum of 80 with a range of 80 to 85.5.

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

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

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

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

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

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

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

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

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

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

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

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

through and engaging the insurers about.

So my comment about the waiver. The estimated rate impact is minus 30 percent. It will vary by legal entity. For example, there's some entities that have a lot proportionately sicker people, they'll have more claims over $20,000, but overall 30 percent, and that's what we're waiting and trying to give CMS everything they need, and working with the exchange giving them what they need, to come back with more information on that.

So a couple other -- on bullet No. 4, when we were in Annapolis one of the good pieces of information that came out that we were asked to summarize is how does this affect a typical Maryland family, and this being the rates, the 2018 rates in the individual market, and for -- we tried to pick a family that wasn't quite at the average income, was not getting any subsidy, what does this mean to them in premiums, and for such a family of four making

$100,000 the estimate is that -- there's a range on this, but just premiums are $19,000. That's 28 percent of after-tax income, and then if that family is sick and they hit their out-of-pocket max, they pay their deductible, it will be $34,000. Premium plus their portion of the insurance cost would be 50 percent of their after-tax income.

In reading the public comments, one of the requests was don't express these increases in terms of percentages, express them in terms of dollars. I understand their point that it -- that I think makes it a little more tangible and this is one way to do that, to put myself in the shoes of the people who are paying this. And some people -- some of the public comments there are avoiding preventative -- it said avoiding preventative care, dropping insurance are things that we want to deter, getting a second job.

So on the waiver I think we're already up to our first milestone of the submission being

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

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

MR. BERRY: Sure.

MR. SWITZER: Appreciate it, so the floor

is yours.

MR. BERRY: Great, thank you.

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

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

MR. SWITZER: Yes, hi.

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

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

AUDIENCE MEMBER: Thank you.

MR. REDMER: Yes?

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

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

Anything else? Okay.

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

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

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

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

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

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

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

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

important.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

for 2018 but it does look like the performance is better than it's been. Maybe not positive, but a lot less negative than it used to be. That's very good news and that leads to the 18.5 percent increase, which includes some morbidity deterioration, people get sicker, but it gives us something to work with. The new people joining, they are still sicker than the ones we currently have and we have to price that in.

Once the 1332 Waiver is approved, and I say when hopefully and not if, there is a possibility, we have to get all the details but there is a possibility that rates could actually drop in 2019 from the 2018 level. If that happened that would go a long way in moving towards stabilizing this market. It's not the end of the war, but it's a good first step, and we would be very excited to see that.

To give you a similar number, I mentioned that the increase in 16-17 for PPO went up almost 50 percent, that went up 15 percent for

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

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

It is a forecast, two years, so there's a lot of variability and we're working with MIA to come to a reasonable number, and that certainly is impacting some of this. You can imagine the PPO being so sick receives a lot of risk adjustment, and it does, and that can vary a lot, so that's certainly one of the factors we're looking at.

Trend is another one. Trend is the measure of how much we think the cost per service and utilization of those services is going to increase over time separate from how sick the population is, and that's certainly something we're looking at and something I'm going to talk about when I get to small group now.

Moving to small group, it is much, much more stable. The proposed increases that CareFirst has put in for 2019 are 4.7 percent for HMO and 3.5 percent for PPO, so those are low, single-digit increases. As I mentioned trend is a very important factor here, and its

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

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

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

So that ends my portion.

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

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

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

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

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

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

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

Thank you.

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

MR. MURAYI: Hello. Good afternoon, my

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

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

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

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

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

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

Second, another impact to our rates is for plan design changes. So changes to cost sharing for some plans from our 2018 offering to 2019 were made to comply with actuarial value requirements, and/or to make the plans more attractive to consumers. So those plan design changes have an impact on the rates that we file.

Third, I said the estimate of the average morbidity. So our estimate of the average population health, so the average morbidity, in the ACA risk pool, as well as our estimate for risk adjustment transfers, have impacts on the rates. We expect that the average morbidity in the small group market will increase from 2018 to 2019.

Fourth, changes in fees have an impact on our rates, so we have a slight decrease to our rates due to changes in fees. So the Federal Health Insurer Fee was eliminated and so that has a downward impact, offset somewhat by the Maryland Specific Health Insurer Provider Fee

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

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

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

services they provide.

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

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

MR. SWITZER: Thank you very much.

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

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

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

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

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

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

morbidity's actually going to increase?

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

MR. REDMER: Thank you.

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

MR. MURAYI: Yeah, unfortunately I can't

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

The strategic question is outside of my realm of responsibility.

MR. SWITZER: Sure, thanks.

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

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

MR. SWITZER: Okay. Thank you.

MR. REDMER: On the left.

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

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

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

AUDIENCE MEMBER: Towards the self-funded model.

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

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

we think that will affect the market dynamics.

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

Is there another question? Go ahead.

AUDIENCE MEMBER: (Inaudible.)

MS. GRASON: Speak up a little bit.

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

MS. GRASON: Stand and speak.

AUDIENCE MEMBER: Since we're talking about --

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

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

MR. SWITZER: Sure.

MR. REDMER: Related to the ACA, sure.

AUDIENCE MEMBER: (Inaudible.)

MR. REDMER: Can you repeat that?

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

AUDIENCE MEMBER: Yes.

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

MR. SWITZER: Thanks again.

MR. MURAYI: All right. Thank you.

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

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

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

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

So as you can see from our slide, the projected claims expenses are actually a little lower than they have been in the past, and this is leading to a slight reduction effect in our rates. But to counter that we are projecting a higher risk adjustment transfer out, and so the balance of that is a 3.3 percent rate change.

Additionally, there's the new Maryland state assessment for 2019, which is about a 2.4 percent increase, countered by the moratorium on the Health Insurance Provider Fee, which is a 1 percent decrease for us. So as I said, overall we're at about a 3.3 percent rate increase.

So any questions on our small group rate filing? I didn't prepare much because there's not -- we're a pretty small piece of the market and it's a pretty small rate change request at the moment.

MR. REDMER: We're good.

MR. LIEBERT: All right. So then moving on to the individual market on slide 3, what we

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

But for 2018 we have approximately 74,000 members as of February 2018, which again as I mentioned is about 35 percent of the overall market share. We have 13 HMO plans covering all the tiers, Catastrophic, Bronze, Silver, Gold and Platinum, and our original filing was for 37.5 percent, and through some of the objections and some updates to the risk adjustment projections right now the rate increase request is at 34.75 percent.

So moving on to -- this is actually Exhibit 4, or Slide 4 shows our, actually shows our original rate increase of 37 percent compared to the CareFirst rate increase request, which, as Pete Berry mentioned earlier, are 91 percent and 18 percent for an overall average on the market of 30 percent. And again, our revised rate increase right now is lower than shown here.

Then if we go on to Slide 5, this shows the components of the rate change. So unlike the small group market, we are seeing fairly

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

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

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

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

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

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

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

and then the moratorium on the Health Insurance Provider Fee.

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

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

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

Anybody have any questions for Dave?

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

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

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

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

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

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

MR. SWITZER: Okay. Thanks.

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

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

MR. SWITZER: Thank you.

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

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

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

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

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

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

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

So that's really all I had prepared here. Hopefully that summary was helpful, and thank you for the opportunity to present today. At this time I'd be happy to address any questions that you may have.

MR. SWITZER: Thank you very much.

So I noticed that enrollment growth has been swift, so it was 33 percent, 38 percent enrollment growth, and a 13 percent increase, as you mentioned, is about a flat increase for 2018. Has there been concern about, or anything you're seeing of who you're attracting to want to slow down that growth, or is something in the rate increase that would, that you've seen from who you brought on that would lead to the 13 percent, please?

MR. MORGAN: I don't know specifically what -- you're saying, I think, with just the reality of our increase versus the others it's likely the growth would slow at least --

MR. SWITZER: Yes.

MR. MORGAN: -- or it depends how other

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

MR. SWITZER: Sure.

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

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

MR. SWITZER: Sure.

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

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

MR. MORGAN: Yep.

MR. SWITZER: Great.

MR. MORGAN: Thank you.

MR. SWITZER: Thank you.

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

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

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

MR. MIRABILE: Thank you, though.

MR. REDMER: Sure.

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

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

organizations and 20 individuals.

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

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

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

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

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

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

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

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

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

The data indicates that Maryland has a stabilizing market for HMOs and a continuing challenged market for PPOs. As shown on Page 3 of our written comments, the membership in the HMO products has grown for both CareFirst and Kaiser since 2013. Premiums for CareFirst HMO product cover about the same amount for healthcare services now as in 2013, with about 94 cents of every premium dollar going to pay for healthcare services.

Premiums for Kaiser's HMO didn't cover healthcare services in 2013, but now Kaiser collects more in premiums than needed to cover healthcare services, and so we ended up concluding that things have in fact gotten better and were on their way to stability before we won't get into everything that has happened since 2016.

By contrast, CareFirst PPO has, have lost about half their members since 2013 and premiums no longer cover the cost of healthcare services, as shown on Page 4 of our written

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

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

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

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

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

assume the same medical loss ratio it had in 2017, 98 percent, I know that's rather shocking, when building its rates for 2019. But I have some specific reasons for why we think from a consumer perspective it's appropriate for CareFirst to continue to lose money at such a high rate for 2019, and I'll harken back to the words of then CEO of CareFirst, Chet Burrell, when he stated in 2013 about the individual market, quote: We're not expecting to make money, we're expecting to lose money. If we're going to lose it, we're going to lose it on behalf of subscribers and the community. And we would ask you to continue to ask CareFirst to do that for at least one more year, and one of the reasons we ask CareFirst to do that is because of their strong financial position. This position makes it possible for them to continue to lose money, particularly in the PPO product, for an additional year.

On Page 6 of our written testimony we

present data from CareFirst annual reports on its capital and surplus levels from 2009 to 2017. While CareFirst certainly lost money on its individual health insurance business, its capital and surplus position has markedly improved since the enactment of the Affordable Care Act. Today its capital and surplus levels are high, with 642 million in the Maryland Blues and $1 billion in the D.C. Blues.

These companies now have over 1,000 more -- 1,000 percent of risk-based capital, more surplus and capital than is needed to remain solvent. Moreover, thanks to federal tax reform, industry sources report that CareFirst will receive a $78 million federal tax windfall for this year. Their tax windfall we would expect to be much higher than it would be for the for-profit insurers. The tax code made an explicit change to how taxes would be collected for the Blues plans, and I believe that CareFirst is on the low side of what the windfall will be for Blues across the country.

For the good of all consumers dependent upon the individual market, as well as our all payer hospital system, we urge you to direct CareFirst to assume a 98 percent loss ratio when building its 2019 rates for its PPO products. We understand both the state reinsurance program and high subsidization in the individual market by CareFirst may not be sustainable in the long run, or even more sustainable than one or two years.

Consumer Health First looks forward to working with the Health Insurance Coverage Protection Commission to explore longer-term solutions. For us these include two things: A state individual mandate, as well as an option for Maryland consumers to buy into Medicaid or into the State Employee Benefit Program.

We also believe it is time to consider whether it is in the consumers' interest for CareFirst to continue to offer a PPO product. We understand that by statute CareFirst's two Blues plans, a CFMI and GHMSI, are required to

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

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

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

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

MR. REDMER: Thank you, Beth.

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

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

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

MR. REDMER: All right. Let's see. Stephanie Klapper, Maryland Citizens' Health

Initiative.

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

MS. GRASON: That's all right.

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

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

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

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

same time getting many more people covered.

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

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

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

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

MR. REDMER: That's not my bailiwick. Beth is saying yes, Michele is saying yes.

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

AUDIENCE MEMBER: Yes.

AUDIENCE MEMBER: And Massachusetts has had one for years.

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

DELEGATE CULLISON: Thank you.

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

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

MS. RASWANT: Maansi Raswant from the

Maryland Hospital Association.

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

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

MR. REDMER: That's okay.

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

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

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

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

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

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

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

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

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

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

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

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

MR. REDMER: Thank you.

Any questions? I think we're good.

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

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

morbidity rates of the PPO pool.

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

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

To your specific question my colleague Brad worked on that a bit and I'll give it to him.

MR. BOBAN: On the basic question of HMO versus PPO morbidity, it is something we've been monitoring very closely and it's been changing a lot over the past couple of years. Just as a history, pre-ACA PPO had the lower morbidity in the market. That was driven mainly by the fact that the HMOs had a statutory requirement to offer maternity services, whereas the PPOs did not. So in 2013, right before ACA, PPO was probably twice as healthy as the HMO, and in 2014 we probably had about 30 percent PPO membership and 70 percent HMO membership, and since that time every year we've been seeing the members continually buy down from PPO to HMO.

CareFirst provides that data in their rate filings that tracks their inner company movement, and that's a key part of both the morbidity assumptions for HMO and PPO, so --

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

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

Any other questions?

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

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

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

AUDIENCE MEMBER: I will check that out.

MR. REDMER: Just curious.

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

All right.

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

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

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

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

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

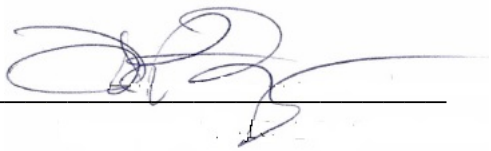
CERTIFICATE OF SHORTHAND REPORTER-NOTARY PUBLIC

I, Toni R. Thompson, RMR, Court Reporter, the officer before whom the foregoing proceedings was taken, do hereby certify that the foregoing transcript is a true and correct record of the proceedings; that said proceedings were taken by me stenographically and thereafter reduced to typewriting under my supervision; and that I am neither counsel for, related to, nor employed by any of the parties to this case and have no interest, financial or otherwise, in its outcome.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my notarial seal this 14th day of August 2018.

My Commission Expires:

January 18, 2021



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