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MARYLAND HEALTH BENEFIT EXCHANGE

Maryland State Reinsurance Program Regulations Hearing

July 26, 2018
Maryland Health Benefit Exchange
750 E. Pratt Street, 6th Floor
Baltimore, MD 21205

Welcome & Introductions

John-Pierre Cardenas, Director of Policy and Plan Management of the Maryland Health Benefit Exchange (MHBE), welcomed the public to the hearing and introduced himself. He acknowledged the presence of MHBE Board of Trustees members; Michele Eberle, Executive Director of the MHBE; and staff from the Maryland Insurance Administration (MIA). Mr. Cardenas gave an overview of the agenda for the hearing and explained that individuals could submit spoken or written testimony at the hearing or written testimony through the MHBE's public comment email address, mhbe.publiccomments@maryland.gov.

Reinsurance Program Regulations Overview

Mr. Cardenas provided an overview of the status of the reinsurance program, including the enabling legislation and the submitted 1332 waiver application. Mr. Cardenas explained that the MHBE is required to promulgate regulations for the reinsurance program no later than January 1, 2019. Mr. Cardenas outlined the process and timeline of the hearings for the regulations and explained that the hearings are focused on different topics. Mr. Cardenas stated that this hearing is focused on the administration and priorities of the program.

Mr. Cardenas provided an overview of the administration of the program and explained that the MHBE has requested assistance from the federal government in administering the program through leveraging the existing EDGE server infrastructure, which the Centers for Medicare & Medicaid Services (CMS) currently maintain for the federal risk adjustment program. Mr. Cardenas added that leveraging the EDGE server infrastructure reduces administrative burden, but stated that the purpose of the hearing is to also contemplate alternatives if leveraging the EDGE server infrastructure is not possible.

Public Testimony

Mr. Cardenas then invited any attendee who so desired to offer their testimony for the record. Five individuals offered testimony.

Beth Sammis, President, Consumer Health First, Board of Directors, offered the following testimony:

> *"My name is Beth Sammis. I am President of Consumer Health First, a health advocacy organization throughout the state of Maryland. We have submitted testimony before about the 1332 waiver in support of the state reinsurance program, and at that time, we asked you to consider the issue of double payment between risk adjustment and reinsurance. We have been heartened to hear that both Wakely and the MIA agree that there is an overlap of payment and that there needs to be taken into account a way to make sure that there is not double payment. So, in terms of a priority, we would ask you, particularly in this year, in which we will lose the individual mandate. So, from our perspective, it is more important than ever that the insurance premiums are perceived as being fair by consumers, so that they continue to buy the insurance product and do not drop out and that the maximum be done to lower premiums this year and lower them in a fair way for both PPO and HMO members. That the double counting be taken into account on a dollar by dollar basis so that no carrier is actually making more money than the other off of these two programs, so that is basically our position. I would be happy to answer any questions."*

Mr. Cardenas asked Ms. Sammis to explain what her definition of fair might mean in this context.

Ms. Sammis responded:

> *"In terms of fairness, they would want to see the premium reduced in a manner that takes into account both*

the reinsurance payments and the risk adjustment payments that are made to both the CareFirst PPO products and the CareFirst and Kaiser HMO products, so that premiums are brought down in a manner that reflects the actual payments that are not being made in a double way ,but whatever the risk adjustment and the reinsurance money is that comes to both, that they are both brought down and that it is not double stacked up onto the PPO to reduce the PPO payment more than would be equitable given the claims that are being paid by reinsurance and by risk adjustment."

Bill Wehrle, Vice President of Health Insurance Exchanges, Kaiser Permanente, offered the following testimony:

"Good afternoon. Bill Wehrle, Vice President Health Insurance Exchanges with Kaiser Permanente. On behalf of our organization, first we want to thank you and the MIA staff for holding these hearings and really for all of the remarkable work that you have done to date to think through and examine and bring data to some of the issues that are in front of you. And you have managed to do that under pretty strong time constraints that would tend to make people edgy, so we really appreciate the work that you have done. You asked us to talk about two issues, the first being the administration of the program, and we strongly think that the program should use data collected through the EDGE server system. The EDGE server system was used by Maryland in prior years for the state's supplemental insurance program. It is what the federal government uses for the risk adjustment program. One of the issues that we have all talked about a lot is the interaction between the two. It seems to us that if the state is going to take any account of the risk adjustment program, you would want to use the same data source, so that is another reason to use the EDGE server. Finally, the All-Payer Claims Database (APCD), which is I guess the potential alternative, in our view would need to be customized for that purpose. So, we are quite weary of the time constraints that we're under and would worry about that approach. So, it seems like the EDGE server is a pretty straightforward way to go, and I hope you don't have any questions about that part because I don't claim to be an expert on the EDGE server process, but we are very comfortable with it, and we use it.

Second, you asked us to talk about priorities. We would say, somewhat like the prior speaker, that the first priority should be to achieve the most stabilization that you can with the money that will be available both state and federal. So, when you think about that, it seems to us that you should be thinking about who is the marginal buyer. We don't mean marginal human beings, but just the person trying to decide whether to purchase coverage or not, who is making the decision whether to sit out or participate. That person, stereotypically, is young and healthy. Simply put, they are trying to decide whether the cost of insurance, which is always substantial, is worth the benefit they are going to get from it, and those tend to be the healthier folks. Typically, that person is almost never going to be thinking about a very expensive PPO product. They are going to be looking at the cheapest product out there. It is usually going to be on the bronze tier, and it is almost always going to be an HMO product. So, if you think about that person, the person enrolling in an unsubsidized bronze product, probably picking an HMO, you want to direct as much of your stabilization dollars in that direction to get the maximum value on that score. So, we would put that out there as a significant and important priority.

You have certainly heard us comment about not paying twice for risk adjustment and reinsurance. Fortunately, those two things work together. If you direct dollars to the benefit of all HMOs in the market and by avoiding the double payment, you achieve both goals. We also do think that whether it is this year or in subsequent years, the state should pay attention to the opportunity to incorporate incentives through bonus payments or another mechanism that seems like the most straightforward. In our view, those incentives should be pretty clearly aligned to other programmatic goals. You have the total cost of care program with both the hospital side and now the outpatient side. It seems like you ought to align those things. The incentives that you're looking to put in place as a state to encourage provider behavior on those fronts would be good candidates for the kinds of incentives that you would want to build into this program, so that the private part of the market, on the individual side at least, is sending the same message. And, I am not sure what our time limit is, but I feel like I have said enough. I am happy to answer any questions."

Trina Palmore, Authorized Producer, offered the following testimony:

> *"Good afternoon everyone. I am born and raised in Baltimore, MD, an authorized producer with Maryland Health Connection, and I have been in this industry for about 18 years. I have been with the Exchange from day one, and I am here to let everyone know about the clients that I serve. Often times their voices are not heard. I work with them every day, and it is estimated that the reinsurance program will reduce average premiums by approximately 30 percent in 2019. That is what I want to focus on. This is desperately needed. I just got off the phone with a couple today. Older couple, husband is on Medicare, and wife is on a qualified health plan. They were weighing. Their income went up by about $1,000 in the last month, so you know they were calling trying to see what is going to happen. I was explaining to them that because of that increase in income, their premium could possibly go up by about $80 each month because as the income increase, the advance payments of the premium tax credit (APTC) decreases. So, they were weighing, and she is already in a bronze plan. She is already in the lowest costing plan, so this reinsurance program, if it is going to help reduce premium costs, I would certainly urge it. It is absolutely necessary, critically for people who need that. They need that savings.*
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> *The other thing is when I first started with the Exchange, there were several carriers on the list, and now as you know, there are only two. That impacts enrollments because now people don't have as many choices. As we know, there is only one that is state-based [statewide], and we know that the state-based one is more expensive than the non-state-based one. So, people who want to hold onto their doctors, they have been working with their doctors for 10, 15, 20 years. If this can help reduce premiums by 30 percent, hopefully it will even help to encourage other carriers to come back to the Exchange. That would be marvelous.*
> *Just want to go over one more case example. Young couple, they both work 10 hours a day. They had a baby, and the baby was born with health challenges. The baby ended up dying, but through the Exchange, the baby was eligible based on their income for state health through MCHP. The parents were eligible for a qualified health plan (QHP). The parents were trying to weigh if they could afford this QHP on top of all of the other costs associated with child illness, and it was tight. I had to express to them that they had to have it, but I had to convince them that if they are not healthy or something happens to them, they won't be able to take care of each other or their baby. So, the couple was faced with the question of if they could afford the QHP. That concludes my testimony, and thank you so much for all of the work that you do. I appreciate all of you in this room."*

Mr. Cardenas thanked Ms. Palmore and recognized her and all active partners in the broker community and all other consumer assistance workers for their work.

Stephanie Klapper, Deputy Director, Maryland Citizens' Health Initiative, offered the following testimony:

> *"I just want to first thank you for working to implement this very important reinsurance program and to everyone in this room who has worked to make this happen. It is very important that Marylanders have access to quality, affordable health care. We commend all of you for working to create this program to respond to the high cost of premiums, which have been recently exacerbated by decisions at the federal level. We urge you in figuring out how to implement it to make reducing the high cost of premiums across the state a top priority for this program. Once the 1332 waiver is approved by CMS, we urge you to use the federal funds and Maryland's $380 million stabilization fund to implement the reinsurance program as efficiently as possible to reduce premiums for Marylanders across the state. This is a really important short-term solution to stabilize premiums.*
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> *Long-term, there are a few challenges contributing to high premiums and will contribute to high premiums, including the fact that the individual mandate will no longer be enforced at the federal level. When that happens, we are urging Maryland to put together a health insurance down payment plan, which would create a state-level individual mandate, but it would be better than the federal version. The way it would work I,s at tax time when Marylanders are asked if they had a qualifying health coverage plan this past year, if they say no, they would be given the option to either pay the fee to the state or use the fee money to purchase a health coverage plan. We estimate that there are at least 60,000 Marylanders who would be*

able to get coverage this way for no more than the fee plus the subsidies that they would receive from the federal government, which would bring many more Marylanders into the individual market. That would provide stabilization in and of itself in addition to getting many more Marylanders coverage. Another thing that could help stabilize premiums is doing something about skyrocketing drug prices. We are hoping to implement a drug cost commission in Maryland, which would give relief to Marylanders from high drug costs which are hurting Marylanders in the form of higher premiums. Thank you again very much for working to implement the reinsurance program and for everything that you do for Marylanders."

Deb Rivkin, Vice President Government Affairs, CareFirst BlueCross BlueShield offered the following testimony:[1]

"Hello everyone. For the record, I am Debbie Rivkin, Vice President of Government for CareFirst BlueCross BlueShield. I would like to talk about both of the issues that you had on the agenda for today. I could tell you that CareFirst is 100 percent in agreement with Kaiser Permanente that the EDGE server is the best, most efficient, least administratively burdensome vehicle that we could use to make sure that we look at where the reinsurance dollars should go. I don't want to reiterate a lot of the things that my colleagues said prior, but it is already being used for risk adjustment. It was used for reinsurance prior. I can tell you my company, and I am sure Kaiser Permanente and the other companies as well, spent numerous hours going back and forth with CMS. Testing, making sure the data was valid, scrubbed, and so to reinvent that wheel would be extremely costly and timely. I understand that one of the options is the APCD. At this point, none of those mechanisms have been in place to really scrub the data and make sure it can be used appropriately. Unfortunately, it is not a great alternative that we have at the time. There would be a tremendous amount of work that would have to be done, especially in a short period of time to get that up in running in a way that the data could be sliced and diced to make sure it is used appropriately. At least for CareFirst, we feel the most urging can be done that we can say to CMS to please allow this to happen would be best for all of us. So, that is how we feel about that.

As to the second issues about priorities, we strongly feel that there is one priority and one priority only for the reinsurance mechanism and that is to reduce rates by using the reinsurance for the high-claim enrollees, which is exactly what reinsurance is supposed to be for. So use it for its purpose and that goal would try to get the rates down across the state for as many people as possible. You have to remember this is a short-term solution as you heard Stephanie say prior to me. As everyone spoke during this session, this is a short-term, two-year possible solution. Really we have state money for one year. There is no funding after one year, and the federal money right now we're hoping to take the state and federal and spread it among two years, but we do not have the funding source for part of that money. So, if we are going to do the highest and best use possible in the short-term period of time, we should take that money and use it for its purpose, which is to have downward pressure on all premiums by pulling out the high-claim enrollees. We think that is truly the most important. If you want to start talking about other initiatives, we feel several things. Number one, that is a great goal we actually have that goal as well, but not necessarily in the context of a reinsurance program. That is not what the purpose was, and you have to remember that the individual market is only five percent of our business. And, probably across the state when you look at everyone who is insured: self-funded, large group, midsize, and small group, it is a very small sliver. I think it is five to six percent. If we really want to bend the cost curve across the state and align with the waiver system, the next phase of the waiver, we have to look at the entire state. Not just a small sliver of the population, and again, it doesn't make sense to do that in the context of a reinsurance dollar that we only have for a short period of time.

Something that I think is really, I am afraid to use the Secretary's words. It really struck me, something that he said during the last Exchange meeting, and I want to put it on the record. And, he can tell me if I don't use his words exactly. When you were doing your presentation, the Secretary said that, in my words, that the goal was to minimize the premium for as many members as possible. And then he spoke about the street price and that the street price is a really big influencer, and I think you heard that from a lot of people who

[1] Following the July 26th Public Hearing, CareFirst provided additional written comments in response to questions posed by Michele Eberle. These responses are included in a separate supplemental document.

spoke before me. If the cost is too high, people are not going to buy, and they are also going to drop. Number one, we want to try to get more people in, but we also want people not to drop.

When you look at the MIA's report that they do every year on how many people are insured in each market segment, you will see we have had a precipitous drop in the individual market. So not only are we trying to bring more in, we are trying to make sure people don't drop. Why is that important? Because if that street price gets too high, and that could be a very small amount compared to what was on the market last year, then less people will be buying insurance. We will have more uncompensated care, and with more uncompensated care, that could potentially impact the next phase of the waiver. According to the health Secretary, he said that if we have uncompensated care increase by just one percent more, that will equate to $170 million that we will have to make up somewhere else to try to get back to ground zero to where we are today with uncompensated care. It is absolutely imperative that in this short period of time, we try to reduce the rates as much as possible, so that we can stabilize right now and then start looking at long-term solutions. So, that is my point of view."

Ms. Eberle stated that the public comment period is open until August 4, 2018. Ms. Eberle encouraged everyone to submit comment to the federal government to support the waiver and added that it is a great opportunity to support the use of the EDGE server as well.

Ms. Eberle asked Ms. Rivkin to explain how she would define high-claim enrollees.

Ms. Rivkin responded:

"You know what, I actually didn't ask that question. I thought $20,000 was what you all were looking at. I can certainly go back and ask. But that is the purpose of reinsurance. It has been in your PowerPoint presentations, if you look at any peer reviewed article. Everyone will tell you that the purpose of reinsurance is to try and take the high-risk enrollees out of the system, so that we can stabilize rates and reduce rates for the rest. Just one thing on the record because there has been a lot of talk about our PPO. We have 15,000 PPO members. We have 122,000 HMO members. So, we are looking to have this stabilize across the state, in all jurisdictions, and for all products."

Ms. Eberle asked Ms. Rivkin if she would put lowering the street price to maintain individuals and encourage new enrollments as a priority for this program.

Ms. Rivkin responded:

"Yes, so I think in what you have written for your 1332 application and what has been stated by the Legislature, Wakely, and others is that the goal is to get the rates down 30 percent. That is what you should be doing. Get the rates down as much as possible across the board. By doing what reinsurance is supposed to be doing, which is hit that level, take those people out, which is going to cause rates to go down. It is not to play around with one or another. It is to use pure reinsurance as it is meant, which will in fact reduce premiums in all markets, in all places in this state, so that we can start keeping people in the marketplace where they are and not leaving and also bringing more in. That is the priority."

Ms. Palmore asked how to submit written documentation. Mr. Cardenas responded that written testimony may be supplied through mhbe.publiccomments@maryland.gov. Mr. Cardenas added that federal comments may also be submitted, and the federal site can be accessed through www.marylandhbe.com.

Mr. Cardenas invited anyone on the phone who so desired to offer their testimony for the record. There was no testimony from people on the phone.

Mr. Cardenas then invited any attendee who so desired to offer testimony for the record that is related to the reinsurance program, but not specific to the items on the agenda. No one offered testimony.

Closing

Mr. Cardenas closed the hearing and thanked everyone who attended. Mr. Cardenas added that the next hearing will be focused on risk adjustment and reinsurance interaction, as well as incentive funding. Mr. Cardenas stated that if anyone wished to communicate with members of the staff, they may do so through mhbe.policy@maryland.gov.

Participants

Maryland Health Benefit Exchange
Tony McCann, Member, Board of Trustees
Dana Weckesser, Member, Board of Trustees
Michele Eberle, Executive Director
John-Pierre Cardenas, Director of Policy and Plan Management
Cassandra Leach, Program Coordinator

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Maryland Insurance Administration
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