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MARYLAND HEALTH BENEFIT EXCHANGE

# Maryland 1332 Waiver Hearing

**May 3, 2018**
**Maryland Health Benefit Exchange**
**750 E. Pratt Street, 6th Floor**
**Baltimore, MD 21205**

## Welcome & Introductions

Michele Eberle, Executive Director of the Maryland Health Benefit Exchange (MHBE), welcomed the public to the hearing and introduced herself. She explained the process and purpose of the 1332 waiver hearings and provided a brief overview of the current state of the marketplace and the proposed state reinsurance program.

She acknowledged the presence of staff from the MHBE and the Maryland Insurance Administration (MIA) and introduced John-Pierre Cardenas, the MHBE Director of Policy and Plan Management.

## 1332 Waiver Presentation

Mr. Cardenas began by describing the state legislation enabling the reinsurance program—House Bill (HB) 1795 – Establishment of a Reinsurance Program and Senate Bill (SB) 387 – Maryland Health Care Access Act of 2018.

Mr. Cardenas emphasized the importance of stakeholder input on the proposed reinsurance program and gave a brief summary of the proposed reinsurance program, including funding sources. He explained that the reinsurance program's attachment point has not been finalized because it is dependent on the available funding.

Mr. Cardenas then described how two outside organizations contributed to the waiver application process. The Wakely Consulting Group prepared the actuarial and economic analysis, and The Hilltop Institute developed the narrative portion of the waiver application.

Mr. Cardenas provided a basic description of the waiver, explaining that it would reduce premiums by an average of 30 percent in the first year using a combination of state funds and federal pass-through funds. By waiving Section 1312(c)(1) of the Affordable Care Act, carriers are allowed to factor the reinsurance program into their premium rates, resulting in a reduction of those premiums. The MHBE expects the program to result in a 5.8 percent increase in individual market enrollment in 2019.

Next, Mr. Cardenas presented the four guardrails in which all 1332 State Innovation Waivers must comply. He explained that the proposed reinsurance program would be compliant with the guardrails. He added that, absent the waiver, the average premium is estimated to rise from $604.50 per month to $735.66 per month in 2019, whereas under the waiver, the average premium is expected to decrease from $604.50 per month to $508.03 per month. Mr. Cardenas emphasized that the estimations presented are based on average premiums and are not specific to any single carrier.

Mr. Cardenas concluded his presentation by describing the upcoming opportunities to gather stakeholder feedback, including two additional hearings in the coming weeks. He noted that there will be additional opportunities for stakeholder involvement in the regulatory process over the summer of 2018.

## Q&A/Discussion

Mr. Cardenas then opened the floor for questions and discussion from the attendees.

There were no questions.

**Public Testimony**

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

John Kunkel, Chief Financial Officer, Kaiser Permanente, offered the following testimony:

> *"I am proud to represent Kaiser today. We are the only insurer that participates in both the exchanges and the Medicaid program, so we are very much impacted by the 1332 waiver. I would reiterate what JP said at the outset. This is something very cool. Kaiser Permanente supports this waiver. What is important to us is that it is done in a very thoughtful and balanced way, and so I will focus my brief comments today around how we believe that should work. And for us it is all about impacting all Marylanders equally regardless of who your insurance carrier is. As the board is aware, Kaiser is concerned that the program could advantage one health plan over the other. We want to make sure that this rate relief that was referenced is spread across everyone and that no carrier has the ability to be paid twice, a double dip concept for both the risk adjustment program as well as this reinsurance program that will hopefully be created for 2019. The issue of double payments is something that has been written about widely by experts, such as the American Academy of Actuaries and Milliman.*
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> *We have asked the staff of MHBE to seek an estimate from Wakely who is uniquely positioned to look at this because they have the data for the carriers in Maryland. We understand that that work is forthcoming, and we are very appreciative of that. We think that will be important and very instructive to understand the dynamics and ensure that we create the right program for Maryland. So why would this matter to a consumer? During the presentation, it was referenced that this could bring rates down by 30 percent. What is important to Kaiser is that this brings everyone's rates down 30 percent or at least as well as you can model that. We are afraid that the minority will see a disproportionate level of rate decrease and the majority, including the 75,000 members that utilize Kaiser Permanente's care delivery system today will see less than a balanced shift. We would also urge the MHBE to include language in the draft Section 1332 waiver that would indicate the state's intent to implement this type of program.*
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> *We believe CMS would not hesitate to approve a waiver with this language. And finally, we believe that a program that treats all carriers equally will increase the chances of additional carriers coming to the state. Today, we only have two carriers: Kaiser Permanente and CareFirst, and Kaiser Permanente is not statewide. Our delivery system does not cover all of Maryland. A balanced program that treats carriers equally, particularly those who are incentivized around controlling costs would make Maryland more attractive to additional competitors. In conclusion, Kaiser Permanente believes three important things. One, the program should not allow duplicate payments to be made to any health plan. Two, the program should benefit all Marylanders as equally as possible and not disproportionately those enrolled in just one type of plan. And finally, that this is a solvable problem that we have the data and we have the time to design a program that would accomplish the goals that I have laid out today. So, thank you for your consideration."*

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

> *"I am President of the Board of Consumer Health First, a statewide consumer advocacy organization, and I am here today to deliver our strong support for the 1332 waiver for all of the reasons that JP so eloquently stated. Obviously, all of us know that consumers who do not qualify for financial assistance have borne the brunt of the eye-popping premium increases over the last four years of the Affordable Care Act, and from the data that was provided by the MIA to the General Assembly of this year, we know that premiums in the individual market for consumers who do not qualify for financial assistance range from 26-73 percent of their after tax income. I would submit to you that if any of us in the group market were required to pay anything close to that then we would respectfully decline that coverage from our employers, and so to us this is a crisis deserving of some solution. Although I must say that we see the reinsurance program together with a very thorough rate review, which we are going to be working with the MIA to ensure happens, is one way to modestly impact the rates, but long-term we believe that there is going to have to be other solutions. One of the solutions that we advocate is a Medicaid buy-in.*

*We understand that there is still a lot of work to do before the reinsurance program is launched. You've made many of the decisions about some of the technical aspects of this program already. Regarding the cap on the reinsurance payments, it is much lower than the cap was at the federal level, the federal reinsurance program, and it is much lower than, at least what we understand, what other states have done. We understand that is being done primarily because you want deeper coverage, and so we would certainly support that. We are concerned for slightly different reasons but along the same lines of concern that Kaiser has already expressed, that this reinsurance program will not equitably impact all consumers. It is not so much that we are concerned about what happens to Kaiser, with all due respect. But, there is a difference between the PPO market and the HMO market. In the PPO market, we know that the risk adjustment program that has been put in place at the federal level, all of those monies go to the PPO product, and the monies raised for that program are from the HMO market. Those HMO premiums are in effect increased in order to subsidize the PPO product because the PPO product has higher risks.*

*We know that theoretically there are many who have argued that when you have a reinsurance program and it is combined with a risk adjustment program that nothing further needs to be done, but we are concerned that that is not the truth. And, that it is particularly not going to be the case given the level and the scale of this particular program. So, our ask is that during this time period between now and the end of the year that you take the claims data from 2017 and do a simulation of what exactly would have happened if there had been in effect the risk adjustment program, which of course we know will be in place, and you know what those payouts will be for the 2017 plan year in June and then simulate what the reinsurance payments would have been in 2017 to be sure that the attachment points and whether or not there should be any true up between the risk adjustment program and the reinsurance program so that the percentage decrease in premiums that we expect on average is the same for HMO products and PPO products. I think that we are well aware of the fact that there can be plan differences, there can be differences between Kaiser and CareFirst, but at the end of the day, if we are looking at a 30 percent reduction in rate increase, that should be the same whether or not you are enrolled in an HMO or a PPO. Otherwise, we believe that that is an unfair subsidy again on the part of HMO members.*

*We also understand that, to us anyways, there is the potential, and I wouldn't say that it is absolute, but it is a potential, that consumers would see this in an inequitable way if their premium decreases were not similar for the HMO and PPO products. This could also lead to some market distortions and would lead some carriers, in particular Kaiser Permanent, to rethink their commitment to this market. After all, Kaiser Permanente is not required by law to remain in the individual market. It is another reason why we have seen other carriers depart; they are a business, and they get to decide if they want to stay in this line of business or not. That is not true for CareFirst. CareFirst is the state's only non-profit health service plan, and under the provisions of Section 14-106 (d)(1)(ii) of the Insurance Article, they are required to offer products in the individual market and thus, may not exit. It is not in consumers' interest to have only CareFirst HMO and PPO products. It is in our interest to have more carriers. I am doubtful about the number of other carriers coming in, but at least we should try to hang on to those that are already here. And, obviously some consumers have elected to join Kaiser Permanente and believe that it best meets the needs of them and their families.*

*Finally, we would ask that we take this opportunity with the development of a state reinsurance program where essentially carriers are going to be given a pretty significant amount of money to help out with their travails in this market to put in place meaningful health improvement programs. There is no requirement in Maryland, that I know of, that the Exchange has placed on carriers in the individual market or any other market to demonstrate they are in fact well aware of the healthcare conditions that are driving up premiums and that they have developed meaningful interventions to control those costs going forward. I believe that is in consumers' interests for two reasons. One is that if they are effective, they will lead to a lower rate of increase, which is in consumers' interests, and second of all, if they are effective, it should mean that consumers who have these chronic conditions lead healthier, more productive lives, which is in all of our interests as well as theirs. Again, I would like to close by thanking you for moving forward with this effort, to the Secretary for being here to listen, and we look forward to working with you to try to bring as much benefit to the market as possible to all consumers. Thank you."*

Jeff Ratnow, consumer, offered the following testimony:

> *"I am a consumer on the Exchange. I am going to give you my personal story. In 2015, I was fired, and I decided that now was the time to start my business. I started my business. My parents said to me, 'What are you going to do for health insurance?' because health insurance was always provided by my company, and I didn't really think about that. I was so grateful that Obamacare was in effect, and I went to a broker on Eastern Avenue in Highlandtown. He said, 'You're all set. You qualify for Medicaid,' so through the Affordable Care Act, because I was making no money, I got to build my business. As soon as I made $75,000, I got my bill of $650 a month, $3,500 premium [deductible]. That isn't bad. That is kind of reasonable. That is a good deal. The next year, I grew my business a little bit more, and the reward is $1,200 a month, about the same premium [deductible]. Okay, still alright, but now, it is getting tight at home. I have two kids and a wife, a wife with a pre-existing condition. I found out that I do because I had a sleep apnea test 20 years ago that has been flagged since then, so we are essentially uninsurable without the public markets.*
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> *So, those of you who buy on the market, I am sure you watched with bated breath when the Republicans tried to kill Obamacare. I had nightmares. When John McCain voted against it, it was better than any Ravens SuperBowl ever. It was literally preserving my chance to live the American dream and build my business because without that, I knew I would have to give up and go get a job. So, the next year, my premium then went up to $1,350 a month with a $13,000 deductible. We go skiing, and now we have to make choices. My son breaks his arm. I didn't know if he broke his arm. We kind of waited it out a little bit. Urgent care is about $300, and they are just going to put him in a splint. What do I do here? My friend is an ER doctor, so we went and saw him. He said, 'I think you need to get it taken care of.' Anyway, it changes how you take care of your family because the monetary pressures are so big.*
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> *This year, I probably have an exposure of about $30,000, which is going to be about 30 percent of my net income. That is more than housing and is more than any other expense, and when I read that the state of Maryland was thinking about doing this, I thanked God that I live in a progressive state that really cares about the people. This will help me grow my small business. I will be able to instead pull money out of my business and right into a health savings account and my health insurance. I could look at hiring people. I could look into creating a better life for other folks as well, which I learned through the Goldman Sachs 10,000 Small Businesses Program how to do that. My constraints have been financial, and now this, hopefully if it works out the way that it is written, it will provide stabilization and insulate us from the craziness going on 40 miles south of here. And really create a state where people really want to move to and live in. Thank you."*

**Closing**

Ms. Eberle recognized Jeff Ratnow and thanked him for sharing his story. Ms. Eberle closed the hearing and thanked everyone who attended.

**Participants**

*Maryland Health Benefit Exchange*
Ben Steffen, Member, Board of Trustees
Dana Weckesser, Member, Board of Trustees
Michele Eberle, Executive Director
Andrew Ratner, Chief of Staff
John-Pierre Cardenas, Director of Policy and Plan Management
Kris Vallecillo, Senior Health Policy Analyst
Betsy Plunkett, Marketing Director

*Maryland Insurance Administration*
Todd Switzer, Chief Actuary
Cathy Grason, Chief of Staff
Brad Boban, Senior Actuary
Bob Morrow, Associate Commissioner
Joseph Fitzpatrick, Market Conduct Examiner

*Maryland Department of Health*
Robert Neall, Secretary
Laura Goodman, Division Chief

*Members of the Public*
Rich Albertoni
Zena Alhija
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Scott Brown
Jackie Cahill
Kim Cammarata
Matt Celentano
Tim Curtis
Xue Dai
Linda Dietsch
Morgan Eichensehr
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