Section 1332 State Innovation Waiver Application – Public Comments

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Maryland 1332 Waiver Hearing #1

Eastern Maryland

April 26, 2018
Talbot County Department of Parks and Recreation
10028 Ocean Gateway
Easton, MD 21601

Welcome & Introductions
Michele Eberle, Executive Director of the Maryland Health Benefit Exchange (MHBE), welcomed the public to the hearing and introduced herself along with other MHBE staff in attendance. She acknowledged the presence of staff from the Maryland Insurance Administration (MIA), as well as Delegate John Mautz and a staff member from the office of Senator Adelaide Eckardt.

Ms. Eberle provided a brief overview of the proposed state reinsurance program then 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. He explained that the reinsurance program's attachment point is not yet finalized since it depends on the available funding.

Next, Mr. Cardenas 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 then 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 allowing carriers to factor the reinsurance program into their premium rates, thus reducing those premiums, the MHBE expects the program to result in a 5.8 percent increase in enrollment in 2019.

Next, Mr. Cardenas laid out the four guardrails in which all 1332 State Innovation Waivers must comply. He explained that the proposed reinsurance program would be compliant with these 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 concluded his presentation by describing the upcoming opportunities to gather stakeholder feedback, including three 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.

An attendee asked whether, in the event that the reinsurance program does not meet its savings targets, consumers will have to make up the difference. Mr. Cardenas replied in the negative.

An attendee asked whether the reinsurance program would affect only on-exchange policies. Mr. Cardenas replied that the program would involve all individual market policies, both on- and off-exchange.

An attendee asked whether the 30 percent reduction in average premium is expected in the first year, or averaged over two years. Mr. Cardenas replied that the program is expected to realize the 30 percent reduction in the first year and maintain that level into the second year.

An attendee asked whether the reinsurance program would cover Medigap policies. Mr. Cardenas replied in the negative, noting that the waiver only has jurisdiction over individual market policies governed by the Affordable Care Act.

An attendee asked the likelihood that the waiver program would continue into 2020. Mr. Cardenas replied that the waiver application covers a five-year period, meaning that the program would run from 2019 through 2023, with the opportunity for extensions beyond 2023.

An attendee asked what the MHBE expects to happen with premium prices in 2021 and beyond. Mr. Cardenas replied that, while they do not know exactly what is going to happen at that point, they hope for continued savings. He added that the chief strategy for market health in that extended period is to attract additional insurance carriers into the market and a healthier risk pool.

An attendee, noting that some portion of the funding for this program would come from a fee on insurance companies, asked whether that fee would negatively impact premiums in the group market. Mr. Cardenas replied that, since the fee was already calculated into the rates, the affect on group premium would be neutral.

Public Testimony

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

James Burdick offered the following testimony:

> *"As a doctor, I'd like to see everybody get health care. And, actually, I meant what I said about Maryland. Congratulations to the work that's been done and other good things that are happening in Maryland compared to other states, so this isn't a criticism. But, long run, as I said, stepping back, a national health program, improved Medicare for all, single payer system would get rid of the admittedly confusing, or at least complicated, details and also save money, cover everybody, and improve quality. It's really true. Senator Pinsky has introduced a bill in the Senate and there is some enthusiasm for a state single-payer bill. I'd like to see a national program, ideally, but I just want to provide that perspective on the complexity and the potential lack of insurance or uncertain insurance for so many Marylanders still, in spite of the great work that you have been doing."*

Closing

Ms. Eberle closed the hearing and thanked everyone who attended.

Participants

Maryland Health Benefit Exchange
Tony McCann, 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

Maryland Insurance Administration
Todd Switzer, Chief Actuary
Brad Boban, Senior Actuary
Joseph Fitzpatrick, Assistance Chief Examiner

Maryland Department of Health
Robert Neall, Secretary
Nikki Laska, Director, Communications

Maryland General Assembly
Delegate Johnny Mautz
Melissa Einhorn, Office of Senator Addie Eckhardt

Members of the Public
Kathy Ruben
Elizabeth Carson
Larry Carson
Matt Celentano
Laurie Kuiper
Dan Mosebach
Chester King
Billy D. Weber
Karen Millison
Jim Burdick
Paul Davin

Maryland 1332 Waiver Hearing #2

Central Maryland

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.*
>
> *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.*
>
> *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.

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.

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
Jen Brock-Cancellieri
Scott Brown
Jackie Cahill
Kim Cammarata
Matt Celentano
Tim Curtis
Xue Dai
Linda Dietsch
Morgan Eichensehr
Calvin Holmes
Laura Hooper
Stephanie Klapper
Laurie Kuiper
Jon Kunkle
Diane Lawrence
Mark Longerbeam
Natasha Murphy
Maansi Raswant
Jeff Ratnow
Dourakine Rosarion
Kathy Ruben
Beth Sammis
Delora Sanchez
Jared Sussman
Bill Wehrle
Wayne Wilson
Bryant Woodford

Maryland 1332 Waiver Hearing #3

Western Maryland

May 7, 2018
Frederick County Health Department
350 Montevue Lane
Frederick, MD 21702

Welcome & Introductions
Michele Eberle, Executive Director of the Maryland Health Benefit Exchange (MHBE), welcomed the public to the hearing and introduced herself along with other MHBE staff in attendance. She acknowledged the presence of staff from the Maryland Insurance Administration (MIA), as well as Delegate Carol Krimm and Robert Neall, the Secretary of the Maryland Department of Health and Chair of the MHBE Board.

Ms. Eberle provided a brief overview of the proposed state reinsurance program then 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. He explained that the reinsurance program's attachment point has not been finalized because it depends on available funding. Mr. Cardenas explained that the reinsurance program is intended to address the large premium increased that have occurred over the past several years.

Next, Mr. Cardenas 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 then 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 allowing carriers to factor the reinsurance program into their premium rates, thus reducing 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 these 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 these estimates are based on average premiums and are not specific to any single carrier. An attendee asked if the expected premium decrease factors in subsidies, and Mr. Cardenas responded that that the estimate of the premium decrease is based on premiums without a subsidy.

Mr. Cardenas concluded his presentation by describing the upcoming opportunities to gather stakeholder feedback, including one additional hearing later in the week. 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.

An attendee commented that the reinsurance program will lower premiums, but asked if it will increase the number of plan options available through the exchange because the attendee is

currently paying $600 per month for a bronze plan with a $7,000 deductible. Mr. Cardenas responded that affordability is very important to the MHBE and that the reinsurance program will create a more favorable environment for insurers, which will hopefully encourage more insurers to participate in the exchange. Todd Switzer, Chief Actuary of the MIA, noted that the reinsurance program will have a greater impact on premium prices than one might think. For example, if a carrier files for a 50 percent rate increase, then the estimated 30 percent decrease from the reinsurance program would not result in a 20 percent rate increase but only a 5 percent rate increase because of how premiums are calculated. Mr. Switzer also asked if the attendee was referring to the fact that CareFirst recently decided to offer only one option for each metal level and that the number of Affordable Care Act (ACA) plans has decreased. The attendee responded that BlueCrossBlueShield is widely accepted, so it is difficult to look at another plan and determine the network; the only plan she can afford has a $7,000 deductible. The attendee reported that it is sometimes cheaper to self-pay rather than use insurance. Mr. Switzer thanked the attendee for her comments.

An attendee asked whether the MHBE was concerned that the option of federal pass-through funding for the reinsurance program could disappear given the changes the current administration has made to weaken the ACA. Mr. Cardenas responded that the section 1332 waiver is protected by statute and that there are currently no proposed regulations that would threaten the waiver. Furthermore, the administration is encouraging states to apply for waivers to implement state based reinsurance programs.

An attendee then asked if the waiver is working in other states. Mr. Cardenas responded that the states that are focusing their 1332 waiver solely on a reinsurance program have had success with their programs; states with multiple programs have had more difficulty. For example, Minnesota has a reinsurance program and basic health plan that both draw from the same pot of money.

An attendee asked if the reinsurance program is still a short-term solution and if there is a long-term plan. Mr. Cardenas confirmed that the reinsurance program is intended to be a short-term solution to control premium costs. Ms. Eberle noted that the waiver application is for five years, though the funding is for two and a half years. New state funding will need to be secured at that point.

An attendee expressed concern about limited carrier participation in the exchange. Ms. Eberle responded that the MHBE is reaching out to carriers and have heard that carriers are interested in the reinsurance program as a way to control the costs of high-risk enrollees. Bob Morrow, Associate Commissioner of the MIA, added that the MIA is constantly reaching out to carriers to encourage participation in the exchange and that it is a top priority. Ms. Eberle noted that a carrier must build its network before entering the marketplace, which can take well over a year.

An attendee asked whether wellness programs, which have been proven to lower healthcare costs, will be part of the reinsurance program. Ms. Eberle responded that public testimony is always helpful and will become part of the application. A section of the 1332 waiver addresses issuer incentives for containing costs and utilization, and the MHBE is interested in that issue.

Regarding carrier participation, Mr. Switzer added that there were seven carriers in the individual market and now there are two; all carriers have been invited to participate. The $365 million in state funding combined with the federal pass-through funding is expected to last for two years,

reducing premiums by 30 percent. This gives Maryland time to look for a long-term solution and the ultimate goal of attracting a more robust and healthier pool to stabilize the market.

An attendee expressed concern that the reinsurance program is a patch until the next step is figured out. She also expressed support of a previous comment regarding well care, stating it has been statistically proven to reduce the cost of healthcare. She commented that the reinsurance program looks like the beginning of a single-payer system; other countries have shown that a single-payer system reduces administrative overheard. She asked where the conversation is heading since the reinsurance program is only a short-term solution. She also commented that the estimated savings for the future tend to be optimistic and she expressed concern that there will continue to be a downward spiral. She commented that insurance companies are for-profit and are not interested in reducing healthcare costs; she reiterated that a single-payer system for Maryland may be a better long-term solution and that it has been shown to work. Mr. Cardenas thanked the attendee for her insight, and noted that SB 387 included a series of studies for the Maryland Health Insurance Coverage Protection Commission, such as Medicaid buy-in and an individual mandate. He encouraged attendees to supply comments. Mr. Morrow noted that these public hearings are not the right place to advocate for a single-payer system because the MIA and MHBE are implementing the rules that are passed. They may provide information to legislators, but they are not involved in the policy making process. He explained that this group is trying to implement the reinsurance program and receive federal approval of the Section 1332 waiver that the legislature authorized. The attendee commented that this group would be uniquely qualified to be the administrators of the single-payer system. Mr. Morrow responded that if single-payer legislation was passed that directed the MIA or MHBE to implement a single-payer system, then they would do so.

Regarding wellness programs, Mr. Switzer added that some carriers have such programs, and the MIA is seeking more information regarding the effectiveness of these programs and trying to bolster them. He noted that the MIA will be looking at whether there is a better way to distribute the premium tax credit. Mr. Morrow added that every carrier in the individual and group markets has some wellness program or component in their plans and that could be improved on.

An attendee commented that she is confused by the distribution of the tax credit because she is self-employed. Sometimes it makes more sense for her to file separately from her husband, but that in turn caused her to lose her subsidy, which she feels is not helpful or productive for someone in her situation. Mr. Cardenas responded that the ACA requires married couples to file jointly in order to be eligible for a tax subsidy. If a married couple files separately, then they are ineligible for a subsidy. A future Section 1332 waiver could fix that problem, but that would be further in the future. Ms. Eberle added that the MHBE can connect the attendee to a navigator or a broker to receive assistance with this problem.

An attendee asked if the MHBE and other medical groups are working towards a federal single-payer system because as long as insurance companies are involved, then it will always be for-profit and will not benefit consumers. Ms. Eberle responded that this is not the charge of the MHBE, which was created to roll out health coverage and provide a marketplace for individual insurance through the ACA. Any activity at the federal level must be done through federal policy, and she recommended contacting the federal delegation for Maryland. The attendee commented that the MHBE staff are the experts who should tell the federal government what they want. Ms. Eberle responded that the state legislators would need to direct the MHBE to take that action, as

they are a state agency implementing the rules. She noted that the MHBE can connect the attendee to the people to speak to.

An attendee asked if Maryland will act as the reinsurer if the waiver is approved. Mr. Cardenas responded in the affirmative. The attendee asked if Maryland was considering transferring the risk into the traditional reinsurance market after the program is established. He commented that this is a subsidy not a reinsurance plan, and asked if Maryland considered transferring the risk to the traditional reinsurance instead of taking the risk on their own. Mr. Morrow clarified that the attendee meant that Maryland could purchase a reinsurance plan to cover their obligations; he responded that Maryland has not considered this option but could do so in the future.

An attendee asked if the reinsurance program will be in place in time to affect 2019 rates since open enrollment starts on November 1, 2018. The attendee expressed concern that rates could change halfway through open enrollment. Mr. Cardenas responded that the Centers for Medicare & Medicaid Services (CMS) encouraged Maryland to apply for a waiver starting in 2019, to get relief to as many Marylanders as soon as possible. The MIA and MHBE stand ready to implement adjusted rates after the reinsurance program is established. The recommended approval date for the waiver is the end of July, and previous states have had their waivers approved quickly. For example, Oregon's waiver was approved in 99 days, so a quick approval is possible. The MHBE is trying to submit the application as quickly as possible. Mr. Morrow added that they recognize that time is of the essence and everyone is working very hard to get the waiver done quickly.

Public Testimony

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

Gene M. Ransom, III, CEO of MedChi, offered the following testimony:

> *"First of all, I'm Gene Ransom. I'm CEO of MedChi, which is the Maryland State Medical Society, and on behalf of our members, we'd like to strongly support the application but we have three issues that we think need to be addressed before it moves forward. First and foremost, I'd say most important, we would like that language be included in the draft 1332 waiver that indicates the state's intent to include an adjustment in 2019 for federal risk adjustment payments. We think this is really important. This plan should be designed to stabilize the entire market for everybody and benefit all Maryland consumers equally. We don't want a situation where certain patients of my members are benefited more than others, and we think this is, from a fairness point of view, really important—that everybody be treated equally. We don't want a situation where the state is essentially picking winners and losers in the market. We also think, if you make this adjustment, it will be another incentive to solve the problem we've heard about where there are not carriers in the market and, if we're clear that we're treating everybody fairly and equally, we might attract more folks into the market. My members and MedChi have complained about the concentration in the health insurance market for years. Our rating is off the charts. We're one of the most heavily concentrated markets and it creates all kinds of problems. It creates problems on the cost side for patients. It creates problems for my physician members when they're negotiating contracts with the insurers, and this is an opportunity to either make it worse by subsidizing one carrier more than the others*

or make it better by subsidizing everybody equally, creating a fair and equal playing field.

The second issue that we think needs to be addressed is that specific payment incentives should be included in the reinsurance program that are aligned with the state's broader policy goals related to quality, cost effectiveness, and innovation. I also think that this would be an opportunity to address the wellness issues that came up before that Delegate Krimm and others have brought up. We also believe, specifically in that section, that the carriers should be required to participate and work collaboratively with CRISP, the other HIE, the HIE that's not here. We think that's really important. The population health tools and the work of the health information exchange can create a lot of opportunities for savings and better quality and better outcomes. We have one of the most highly recognized HIE's, again, health information exchange—the same acronym. I don't know why they do that. They should have given you guys different names. CRISP is recognized as one of the best-run HIEs in the country. There needs to be alignment. I don't think this is something that is a major problem. I think you might be able to do this even possibly with a resolution, maybe after the fact if it's a problem including in the application for approval reasons, but we just need to incentivize the carriers, particularly the dominant carrier, to participate with the information exchange so we can have better information and better outcomes.

The third thing, and I'm not saying you guys haven't done this, I just think that it's so important and it's such a high priority. We really just think that it's important for you to look at the newly approved—newly soon-to-be-approved hospital all payer Medicare waiver and make sure that this is properly aligned with the Medicare waiver. The Medicare waiver is really important to Maryland. MedChi has been working proactively with the state to get that approved, and we hopefully will have that approved in the matter of a few weeks or months maybe. We just think it's really important that that unique model that keeps our hospitals funded appropriately is aligned with this. And, again, I'm not saying it isn't, I'm just saying let's make a point to not screw that one up by accident. Let's look at it and combine the two.

So, in closing, I just want to reiterate that we really appreciate the work of Governor Hogan, of Commissioner Redmer, Secretary Neall who's in the back, and the Democrats in the General Assembly who really worked together in a bipartisan fashion to come up with this solution. We think it makes sense, and I think these three tweaks are positive changes that can be achieved before the application deadline. Thank you."

David Hexter, MD, Emergency Physician and Physician in Chief at Mid-Atlantic Permanente, offered the following testimony:

"Good afternoon, my name is David Hexter. I am an Emergency Physician and Physician-in-Chief at Mid-Atlantic Permanente. We care for the patients of Kaiser Permanente in the Baltimore area in general and the Baltimore area as well. Kaiser Permanente is one of only two carriers—we mentioned this several times—that is still on the exchange, and we're also the only one that cares for Medicaid patients. We first of all want to express our support for the section 1332 waiver reinsurance program and really applaud the state legislature, the Hogan administration, and Exchange for working to

move forward with this waiver application. And we believe that a reinsurance program like this if it's implemented fairly will go a long way to stabilizing the market and improve affordability, many of the problems of which you've heard today. But we think it must be, we believe it must be implemented fairly because the reinsurance program that Maryland develops should stabilize the entire insurance market and not just part of it. My fellow Permanente physicians are concerned that the reinsurance program as it is currently proposed will give an advantage to one health plan over another. We want to make sure that the rate relief that is provided by the program is spread across all Marylanders, not just those that enroll in one company's products. So unless a specific adjustment is made, the proposed program would allow carriers that are paid substantial amounts under the current federal risk adjustment program to be paid twice for accepting those higher-risk members under the reinsurance program. But why does this matter to consumers and patients? Well, if an adjustment is not included in the program, then the relief is going to be concentrated among a small minority of the individual market enrollees. And the majority of the consumers and patients will share less in the relief, and some including the 75,000 Marylanders who choose Kaiser Permanente through the exchange, many of whom are my patients, will experience much less premium relief. And as a Maryland physician, I want my patients to benefit from this reinsurance program that we're putting together to help keep their premiums affordable like everyone else in the state.

So we encourage the Exchange to include language in the draft section 1332 waiver application that indicates the state will adjust for this dynamic. And we also believe that Maryland should include incentives similar to what Mr. Ransom said in the reinsurance program that will align with broader state policy goals to improve quality and cost effectiveness of the care that is provided. To give you some ideas of some of these incentives that could be provided, you could reward high clinical ratings, for example breast cancer screening or colorectal cancer screening, controlling high-blood pressure. You mentioned the diabetes program before, we're able to control diabetes in the population. Shouldn't we be incentivized to do that? And thus designing a program that treats all carriers equitably and that includes these incentives for high-quality patient care and effective care management would attract new healthcare plans into the market, we want more choices as many of the people here today have indicated they want. And we want these carriers to focus on keeping people well, not just having them for a year and moving onto another carrier.

So in conclusion, we at Mid-Atlantic Permanente or Kaiser Permanente believe that the reinsurance program Maryland implements should not allow duplicate payments to be made to any one health plan. There can and should be an adjustment built into the program that makes sure that all patients who purchase their coverage in Maryland's individual market will benefit equally from this reinsurance. Finally, we should include incentives in the reinsurance program that are aligned with the state's broader policy goals in healthcare related to quality and cost effectiveness of care. Thank you very much, and I'm happy to answer any questions."

Ellen Lerner, consumer, offered the following testimony:

"I want to thank this group and the Maryland Health Benefit Exchange. I know your work is not easy; I think I am putting that mildly. I am certainly in favor of the application for this waiver. I hope we get it and we get it quickly. My sole purpose is to benefit those, well to everyone in the state of Maryland; I believe that everyone should be insured. I do want to caution as I did in my questions that this appears to be a patch, a very complicated patch. I hope it works. My husband is a physician. He practices as a teacher, teaching people about how to take care of themselves, how to be healthy, and he even still makes house calls to help people. To me, I know this isn't the purview of the Health Benefit Exchange ,but yet it is. I recognize this group as being the one who helps people to find the best insurance they can with what they have available to them and this will help make more available to them. But I also urge caution in that you are dealing with for-profit insurance companies and that, ultimately, I hope that this will be the beginning as I see it of trickling into, kind of backing ourselves into, a single-payer system. I truly think in the end that's what will be the best, and I highly encourage that this be recognized as that little crack. Thank you."

Delegate Carol Krimm of District 3A offered the following testimony:

"Just to update people on how this process went during General Assembly, so when we came into session the federal government had just taken their actions, and it was communicated to all the legislators that this was going to have a devastating effect on our budget because of the cost involved in trying to repair what the federal government had done to our health exchange. So the Speaker and the Health and Government Operations Committee put this special committee into place, a special task force. The Chairman is Delegate Joseline Peña-Melnyk who in my estimation is probably one of the most knowledgeable legislators on healthcare, and they started meeting on a weekly basis with people in the industry, other legislators, and we just tried to get everyone at the table and we were getting updated through this process. So what I want to communicate to you is that this is not over. You know this is what we have to do, I think you've heard the words short-term. So we will continue to work on this, and we had to make very quick decisions because of the impact that came done from the federal government and that's what we did and not to say we're not moving towards some goals you think we should have in healthcare. But this is where we are, and these are the people that are going guide us through the short-term, but we are going to continue the task force. So I would encourage the people here who have some very strong ideas on where we should be heading to get in touch with your legislators and let them know where you think we should be going because we're not done."

Annette Breiling, Healthcare as a Human Right, Chapter of Frederick, offered the following testimony:

"I'm sorry I came in late, and I'm with Healthcare as a Human Right, Chapter of Frederick and have long believed that everyone needs to get healthcare. And my understanding is that single-payer is the way that is ultimately going to have to happen, and the Medicare for all legislation is the way we're going to have to ultimately end up. My understanding also is that there are so many federal rules right now that are preventing a state to achieve this and the state whatever we can do to kind of move us in

that direction is what I advocate. So that's why I came here and wanted to promote any steps that are going to move us to be able to get everybody healthcare."

Closing

Ms. Eberle informed the audience that the MHBE has a navigator program and producers that can help consumers with assessing their options and navigate the system. Ms. Eberle closed the hearing and thanked everyone who attended.

Participants

Maryland Health Benefit Exchange
Michele Eberle, Executive Director
Andrew Ratner, Chief of Staff
John-Pierre Cardenas, Director of Policy and Plan Management
Kris Vallecillo, Senior Health Policy Analyst

Maryland Insurance Administration
Todd Switzer, Chief Actuary
Bob Morrow, Associate Commissioner

Maryland Department of Health
Robert Neall, Secretary

Maryland Department of Human Services
Lourdes, R. Padilla, Secretary

Maryland General Assembly
Delegate Carol L. Krimm

Members of the Public
Gene Ransom
David Hexter
Will Fawcett
Judith Rogers
Ellen Lerner
Mary Benove
Dan Mosebach
Amy Podd
Lisa Horner
Laurie Kuiper
Tinna Quigley
Rose McNeely
Kathy Ruben
James French
Mike Cumberland

Jeannette Bartlett
Natalie Ziegler
Annette Breiling

Maryland 1332 Waiver Hearing #4

Southern Maryland

May 10, 2018
Charles County Health Department
4545 Crain Highway
White Plains, MD 20695

Welcome & Introductions
Michele Eberle, Executive Director of the Maryland Health Benefit Exchange (MHBE), welcomed the public to the hearing and encouraged their participation.

1332 Waiver Presentation
John-Pierre Cardenas, MHBE Director of Policy and Plan Management, noted that this is the final of four public hearings. He 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. He explained that HB 1795 directs the MHBE to apply for a 1332 waiver, and SB 387 places a 2.75 percent assessment on premiums to fund the program. An attendee asked whether the tax applies to employer-sponsored or individual health plans. Mr. Cardenas responded that the tax will apply to any policy that is subject to the authority of the state. He further explained that the reinsurance program's attachment point has not been finalized because it depends on available funding and stakeholder input. The MHBE Board has already voted to approve a reinsurance cap of $250,000 and a coinsurance rate of 80 percent. Mr. Cardenas explained that the reinsurance program is intended to address the large premium increased that have occurred over the past several years.

Next, Mr. Cardenas 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 then 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 allowing carriers to factor the reinsurance program into their premium rates, thus reducing those premiums, the MHBE expects the program to result in a 5.8 percent increase in individual market enrollment in 2019. A member of the public asked whether the 5.8 percent increase refers to the percentage of individuals or the percentage of premiums. Mr. Cardenas responded that it is a 5.8 percent increase in the number of people enrolled.

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 these 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 these estimates are based on average premiums and are not specific to any single carrier.

Mr. Cardenas concluded his presentation, noting that there is still opportunity to submit written comments. He also noted that there will be additional opportunities for stakeholder involvement in the regulatory process over the summer of 2018.

Michele Eberle acknowledged several audience members, including MHBE Board Vice Chair Tony McCann, MHBE Standing Advisory Committee member Evelyne Ward, Maryland Insurance Administration (MIA) staff, and MHBE staff.

Q&A/Discussion
Mr. Cardenas then opened the floor for questions and discussion from the attendees.

An attendee asked whether non-core benefits will change under the waiver. Mr. Cardenas responded that the ten core essential health benefits will not change. Non-essential benefits are determined by the insurance company, and the waiver will not have a direct impact on these. The attendee also asked for the list of essential health benefits. Mr. Cardenas and Joseph Fitzpatrick, Assistant Chief Examiner, of the MIA listed the following benefits: ambulatory care, behavioral health, emergency services, hospitalizations, prescriptions, maternal and prenatal health, primary care, laboratory services, pediatric services, and rehabilitative and habilitative services.

An attendee asked if there is a "Plan B" if the federal government does not approve the waiver as expected. Mr. Cardenas responded that the MHBE has been working very closely with the federal government to ensure that the application is complete and ready for a quick response. He noted that the legislation authorizing the program is contingent upon federal approval, so further legislative action would be required if the federal government does not approve the waiver. Ms. Eberle commented that this would require a special session of the Maryland General Assembly.

An attendee asked about the program's effect on people who do not buy coverage through the exchange. Mr. Cardenas responded that the program applies to individual market rates both on and off of the exchange.

An attendee asked about the income requirements for participating on the exchange and what happens if someone's income exceeds that amount for a few months. Mr. Cardenas responded that subsidies are available to those up to 500 percent of the federal poverty level. He noted that individuals are expected to report income changes to the exchange within 30 days. Income for the upcoming plan year is predicted at the time of application, and this information is reconciled at the end of the year when taxes are filed. Ms. Eberle clarified that individuals with any income level can purchase on the exchange, but individuals can only obtain tax credits through the exchange.

Todd Switzer, Chief Actuary of the MIA, thanked the attendees for their participation and offered some additional comments. He stated that this waiver affects about 200,000 people in Maryland. Noting that the press release in regard to carrier rate increases was released earlier in the week, he explained that the impact of the reinsurance program is multiplicative. Mr. Switzer provided the theoretical example of a 50 percent rate increase coupled with the 30 percent decrease from the reinsurance program. He explained that this does not mean that there will still be a 20 percent increase in rates. He added that, if the increase is 50 percent, you multiply 1.5 by 0.7, and the increase in rates would be 5 percent and not 20 percent. Mr. Switzer explained that the reinsurance program has a much more leveraged impact, and he added that if the waiver is passed, it will have more of an impact than you might think. He stated that the reinsurance program will be more of an impact than just subtracting 30 percent.

Mr. Switzer emphasized the importance of the waiver and explained that the $365 million, over the full five years, gets leveraged up to $970 million, which is why the initial modeling can be stretched to try to improve the profile and risk of the pool to stabilize rates. Mr. Switzer stated

that there are still 360,000 uninsured in the state of Maryland, and about half of those people are eligible for a subsidy, whether it is Medicaid or a premium tax credit. He added that some of those uninsured people could get a free bronze plan, and economically speaking, people are making an irrational economic decision and leaving money on the table. Mr. Switzer expressed the hope that shining the light on this program will encourage people to take another look at insurance coverage.

An attendee noted that some of the literature she read stated that the waiver would limit the increase in premiums rather than decrease premiums. She asked if it is true that the waiver is supposed to decrease premiums, rather than just limit the increase in premiums. Mr. Switzer responded that a decrease in premiums is the hope, but there is no guarantee that it will happen. Mr. Cardenas added that the estimates provided are based on the data available currently, and a lot of it is projecting what will happen in 2019.

An attendee asked Mr. Switzer to explain the equation to determine the impact of the reinsurance program again. Mr. Switzer, using the example of a 50 percent overall increase, explained that you add 1 to the overall increase, which gives you 1.5, and then, with the reinsurance being a 30 percent decrease, you subtract the reinsurance percentage decrease from 1, which gives you 0.7. He continued by saying that when you multiply 1.5 by 0.7, you get 1.05. Mr. Switzer stated that whatever you get from that multiplying (1.05), you subtract 1, and that is what you can expect the impact of reinsurance to be. Mr. Cardenas added that every dollar magnifies its impact.

An attendee asked if any other states have applied for a Medicare waiver. Mr. Cardenas responded by clarifying that this is a 1332 waiver, which is for the Affordable Care Act, not necessarily Medicare. He note that a number of states have applied for 1332 waivers, and Minnesota, Oregon, and Alaska have been approved for reinsurance programs.

An attendee asked if there are any results from these other states. Mr. Cardenas responded yes and that the results have been promising. Mr. Cardenas provided Alaska's model as an example, stating that rates in Alaska were estimated to increase 40 percent, and rates only ended going up 7 percent. Mr. Cardenas added that Alaska is a unique example because Alaska is a small state with high costs. Mr. Cardenas also added that Oregon's and Minnesota's reinsurance programs have had downward impacts with lower rates of premium increases. Mr. Cardenas stated that the impact on each insurance company was also different because each company is different, and each company calculates their premiums differently. Mr. Switzer stated that Maryland is attempting to achieve the deepest discount that has been attempted so far. Mr. Switzer provided national context by adding that Minnesota attempted 20 percent and Oregon attempted 7 percent.

An attendee asked about the markets of the other states and if they only have two carriers like Maryland. Mr. Cardenas answered that Alaska has one, and Minnesota and Oregon have several participating insurance companies.
An attendee asked if this waiver could entice other carriers to come to the market. Mr. Cardenas answered that nothing is more attractive to an insurance company than a state that is committed to making the markets work, and the MHBE believes that a reinsurance program creates a more favorable environment. Mr. Cardenas stated that both the MHBE and the MIA work constantly to entice new insurance companies into Maryland.

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

Lore Rosenthal, consumer, offered the following testimony:

> *"Hi, my name is Lore Rosenthal, and I may be the only person in this room who is actually on the Maryland health exchange. So, I guess I just wanted to share my personal story. I am sure the insurance carriers here have heard it before, and I am sure some of the panelists have heard it before. But, it is good to hear from a real person I think. So, I work three days a week. I am not a wealthy person, but I earn more than the cut-off, which is $43,000, which is not a lot of money. This year, my premium, without any subsidy, is $1,000, and at the time when my premiums went up from whatever they were last year to the $1,000, there was not an increase in that cut-off of $43,000. So, you would think if they were going to double your premiums, they would have said, 'Oh, now you can earn like $53,000 and still get a subsidy.' Last year, with my old plan, my deductible was $2,500, and believe it or not, you can use up the entire $2,500 with one hospital stay. I happened to be in the hospital for a mental health reason, and it turns out my carrier did not cover inpatient mental health. So, I just blew through that money in five days.*
>
> *This year, my deductible has gone up to $3,500, and I am hoping that nothing is going to happen to me that I am actually going to blow through that money. You say that there is going to be a decrease of 30 percent, but so far the examples you have given is more that there was a decrease in the increase. So, I am very concerned that next year I may be paying $1,100, and yippee, it is $1,100 instead of $1,400. People cannot afford, and I think you realize that, if you're not on this subsidy, you cannot continue to afford that. It would never occur to me to just drop out of the program. I feel fortunate. I am a self-employed person, so I can't go through a company. I feel fortunate to have insurance. For some people, it must be like 50 percent of their income. People are saying that housing costs are going up, and electricity costs are going up. For poor people, they are paying exorbitant amounts. I am sure this is all in the newspaper too, but people are just paying too much for insurance, and it shouldn't be that way. I hope that you get the waiver, but I hope that in this case that the waiver gives us a 30 percent decrease, so I would only be paying like $700 a month instead of $1,000. Thank you."*

Michael Hartman, consumer, offered the following testimony:

> *"Hello, my name is Michael Hartman, and I am wondering if instead of a monetary amount for income, would it be possible to say that health costs should only be a percentage of your income? Let's say, 15 percent or whatever. Might that be a more fair way of looking at things and understanding that a person earning $10,000, if it's 10 percent then it's $1,000. If you're earning $20,000, it would be $2,000. It seems to me that might be a fairer way of looking at things. We look at things like Ms. Rosenthal mentioned about housing costs and generally, what is thought to be a good percentage is*

30 percent of your income for housing. Wouldn't it also be a good thing to put a percentage of your health care instead of a monetary amount? Thank you."

Closing

Ms. Eberle thanked everyone who attended; she encouraged consumers to look closely at the plan options available and to download the mobile application, which provides GPS-located assistance. She also noted the helpline and Navigator program as sources of consumer assistance.

An attendee expressed gratitude to the MIA for exemplary service in interceding with an insurance company on her behalf. She also commended the navigators. Ms. Eberle thanked the attendee for her comments and closed the meeting.

Participants

Maryland Health Benefit Exchange
Michele Eberle, Executive Director
John-Pierre Cardenas, Director of Policy and Plan Management
Kris Vallecillo, Senior Health Policy Analyst
Tony McCann, Member, Board of Trustees

Maryland Insurance Administration
Todd Switzer, Chief Actuary
Bob Morrow, Associate Commissioner
Joseph Fitzpatrick, Assistant Chief Examiner

Members of the Public
Robert Axelrod
Tinna Quigley
R. Aaron Aist
Evalyne B. Ward
Sue Ehlenberger
Angela Deal
Louise Hayman
Lore Rosenthal
Michael Hartman

Comments Received Directly From Public

Commenter: Chet Burrell, CEO, CareFirst BlueCross BlueShield
Comment Received: Tuesday, April 24, 2018
Comment:

CareFirst's View

Kaiser Permanente's proposal to offset reinsurance with risk adjustment payments seeks to do what has never been done before and takes a position that was rejected by CMS when it operated the national ACA reinsurance program for three years.

The reinsurance and risk adjustment programs are wholly separate concepts and are designed to address different issues:

- Risk adjustment reflects the illness levels of all enrollees that have chosen each payer in a market and transfers funds from plans with low-risk enrollees to plans with high-risk enrollees in order to equalize the costs of the risk burden borne by each payer.

- Reinsurance covers a portion of the costs of a very small percentage (3-5 percent) of high cost enrollees in order to reduce premiums for all.

The suggestion of offsetting risk adjustments against the reinsurance calculation – in order to avoid a possible double payment - mixes the two concepts inappropriately with the effect of materially lessening the premium reducing impact of reinsurance on premiums. This undermines the central purpose intended in the recently enacted legislation.

CMS considered and explicitly chose not to subtract federal risk adjustment payments when implementing the federal reinsurance program. CMS explained its reasoning at the outset of ACA in the Proposed 2014 Notice of Benefit and Payment Parameters as follows:

> *"Adjusting for reinsurance payments in the HHS risk adjustment model would address the concerns that reinsurance and risk adjustment could compensate twice for the same high-risk individuals. Despite this potential, we **propose not** to adjust for reinsurance in the HHS risk adjustment model for a number for reasons:*
>
> > *First, removing reinsurance payments from risk adjustment would reduce protections for issuers of reinsurance-eligible plans that enroll high-cost individuals.*
> >
> > *Second, it would be difficult to determine what portion of reinsurance payments were made for conditions included in each HHS risk adjustment model, and the appropriate model adjustment for these payments."*

The MHBE should strongly take into consideration the analysis that CMS conducted and its conclusions.

Implementing Kaiser Permanente's recommendation could delay Maryland's 1332 waiver approval thereby threatening the State's ability to reduce premiums in 2019.

CMS has indicated that the expedited approval timeframe that Maryland seeks is based on current 1332 waivers that have already been approved in other states. No other state has attempted to include a modification to its reinsurance program to offset risk adjustment payments.

Kaiser's proposal assumes there is a 100 percent double payment by subtracting the entirety of risk adjustment payments from the reinsurance calculation. This is not true, and moreover, ignores the impact that a robust reinsurance program will have on risk adjustment transfers.

If Maryland were to operate the reinsurance program as CMS and other states have, the full impact of the reinsurance program would reduce statewide average premium by as much as 30 percent from the levels that otherwise would have occurred (based on the analyses done to date).

This, in turn, will reduce risk adjustment transfers – accomplishing much of what Kaiser seeks without lessening the power of reinsurance to maximally hold premiums down.

Kaiser seeks to justify its proposal, in part, because it makes an erroneous assumption that CareFirst is not managing costly PPO enrollees.

Kaiser appears to suggest that CareFirst is not managing the care of its PPO members. This is fundamentally untrue. CareFirst actively manages care for all members in both PPO and HMO products through its Patient Centered Medical Home (PCMH) and Total Care and Cost Improvement (TCCI) programs. In fact, a disproportionate number of ACA individual PPO enrollees are in care plans through which intense care coordination efforts are made for these enrollees.

The central idea in PPO plans is to allow enrollees access to a broad array of providers. This attracts a more adverse risk population to these products. If the State wishes to continue a PPO offering, this must be recognized.

To design a reinsurance program in a way that does not equally treat PPO products with reinsurance protection would make PPO products even more unaffordable than they already are. This would be directly counter to the intended purpose of the market stabilization legislation just enacted and to the enormous efforts made by the State to expand network access and adequacy to ensure all Marylanders have the broadest possible access to providers in the State.

CareFirst Recommendation.

It is essential to recognize that any lessening of the impact of reinsurance through a risk adjustment offset will drive up PPO (as well as HMO) premiums and undermine the purpose of

the recently enacted market stabilization legislation. Accordingly, prior to taking any further action in regulation or otherwise, the MHBE should direct Wakely to consider this impact and assess the impact of what Kaiser has proposed. CareFirst stands ready to cooperate with this effort and to work with Wakely toward an approach that fulfills the intent of the State to keep premiums for all individuals and their families as low as possible.

Commenter: Gene M. Ransom, III, CEO, The Maryland State Medical Society
Comment Received: Monday, May 7, 2018
Comment:

Your Advocate.
Your Resource.
Your Profession.

May 7, 2018

Maryland Health Benefit Exchange
750 East Pratt Street
6th Floor
Baltimore, Maryland 21202
Sent: mhbe.publiccomment@maryland.gov

RE: 1332 Waiver Application

Dear Board Members:

MedChi, The Maryland State Medical Society, which represents more than 8,000 Maryland physicians and their patients, appreciates the opportunity to comment on the DRAFT Maryland 1332 Waiver Application being submitted by the Maryland Health Benefit Exchange (MHBE) to the United States Department of Treasury and the United States Department of Health and Human Services. MedChi strongly supports the Section 1332 waiver for the development of a reinsurance program. However, we have several minor adjustments that we feel are needed to improve the application prior to formal submission at the end of the month.

We understand and support the bipartisan action taken by the Governor and General Assembly to address the vital need to stabilize the individual health insurance market to ensure that the greatest number of Marylanders have access to affordable insurance. It is on this premise that MedChi believes that the program designed must stabilize the entire market and equally benefit all Maryland consumers. Specific comments are articulated below.

First, MedChi is concerned that the reinsurance program as articulated in the DRAFT Section 1332 Waiver Application will effectively advantage only some health plans and provide premium relief primarily to the consumers enrolled in those companies' products. Under the proposal, some health plans could essentially receive a "double payment," being reimbursed twice for higher-risk members because it fails to adjust carriers' reinsurance payments by the amount they already receive under the federal risk adjustment program. By favoring these carriers, the program is essentially determining "winners and losers." Ultimately, this has the impact of limiting the benefit received by consumers who choose those health plans for their coverage. Designing a program that treats all carriers equitably would have the added benefit of attracting new health plans into the market.

Therefore, MedChi requests that MHBE include language in the DRAFT Section 1332 Waiver Application that indicates the state's intent to include an adjustment in 2019 for federal risk adjustment payments to ensure that the program doesn't unfairly advantage some health plans

1211 Cathedral Street • Baltimore, MD 21201-5516 • 410.539.0872 • Fax: 410.547.0915 • 1.800.492.1056 • www.medchi.org

over others. We believe including this language will improve the waiver application and would be accepted by CMS.

Second, MedChi believes specific payment incentives should be included in the reinsurance program which are aligned with the State's broader policy goals related to quality, cost-effectiveness and innovation. Incentives should be included that directly reward quality in care delivery through strategies like payment multipliers for high clinical quality ratings in preventive care measures such as breast cancer screening, colorectal cancer screening, controlling high blood pressure and care for diabetes and cardiovascular conditions. MedChi also believes that it is equally important to require all participating carriers to collaboratively work with the State's Health Information Exchange (CRISP). We think participation and working with CRISP and the population health tools should be considered as a broader policy goal alignment as well.

Since the central issue for applying for a reinsurance program is to make sure that costs can be stabilized for both the carriers as well as the consumers, MedChi believes that utilization practices of participating carriers should be examined. We also suggest not allowing non-staff model HMO product sold through the exchange to utilize prior authorization procedures.

In closing, we would also ask that the State make sure that the policies and procedures created and outlined in this waiver align with the term sheet agreement of the unique Maryland Medicare Hospital All Payer Waiver.

MedChi again strongly supports getting this application done, and we understand the importance of expediency. However, we need to take the time to make sure we don't create new problems or unintended consequences.

Sincerely,

Gene M. Ransom, III
Chief Executive Officer

1211 Cathedral Street • Baltimore, MD 21201-5516 • 410.539.0872 • Fax: 410.547.0915 • 1.800.492.1056 • www.medchi.org

Commenter: Vincent DeMarco, President, Maryland Citizens Health Initiative
Comment Received: Thursday, May 10, 2018
Comment:

2600 ST. PAUL STREET BALTIMORE, MD 21218 P: (410)235-9000 F: (410)235-8963 WWW.HEALTHCAREFORALL.COM

MARYLAND CITIZENS' HEALTH INITIATIVE

May 10, 2018

Michele Eberle
Executive Director
Maryland Health Benefit Exchange
750 East Pratt Street, 6th Floor
Baltimore, MD 21202

Dear Executive Director Eberle,

The Maryland Citizens' Health initiative strongly supports the Reinsurance and Market Stabilization programs established for Maryland in the 2017 General Assembly Session and we very much agree that your agency should work to support this program through an application for a State Innovation Waiver under section 1332 of the Affordable Care Act. This proposal will help stabilize Maryland health insurance markets and protect consumers from large rate increases, and represents a win for both consumers and the health insurance industry— all at no net cost to the federal government. Maryland consumers have faced large double-digit rate hikes in the individual health insurance market in both 2016 and 2017, though, as you know, the much larger increases have happened more recently since the Trump Administration and Congress have been trying to undermine the ACA.

This Maryland Reinsurance Program is a needed first step toward a stable and sustainable individual health insurance market, but it is only a first step. We also urge the state to take action to address the underlying causes of instability and higher costs in the individual market. These causes include insurance market dynamics such as adverse selection, but they also include the excessive and rising cost of health care services and prescription drugs. And, we believe Maryland must move quickly to replace the soon to be defunct federal individual mandate with our proposed health insurance down payment plan. By providing needed immediate relief for consumers, we hope that the Maryland Reinsurance Program will help buy our state and our health care system time to do the hard work necessary to address the underlying drivers of health care costs.

We understand that you have been asked by Kaiser Permanente to make two adjustments to the proposed reinsurance plan -- to include incentives to continue to manage health care cost and utilization and to account for any risk adjustment payments received by carriers to avoid duplicate payments. We agree with Senate Finance Committee Chairman Thomas "Mac" Middleton in his letter of April 10 to you and Commissioner Redmer (attached) that you should give "serious consideration" to these ideas.

HEALTH CARE for All

2600 ST. PAUL STREET BALTIMORE, MD 21218 P: (410)235-9000 F: (410)235-8963 WWW.HEALTHCAREFORALL.COM

MARYLAND CITIZENS' HEALTH INITIATIVE

In considering Kaiser's proposal and other ideas related to the reinsurance plan, including those put forward by Carefirst, we know that you will put first and foremost what is in the best interest of Maryland's health care consumers. To assist you in doing this, we recommend that you put two questions to the Wakely Group the answers to which we believe could be very helpful to you as you work to develop a reinsurance plan that will make health care more affordable. We suggest that you ask Wakely to compare the impact of a standard approach to reinsurance with Kaiser's proposal on:

1. The extent to which reinsurance and risk-transfer payments would duplicatively cover the same claims, and,

2. The median consumer's health premium costs and the total risk level of the individual market.

On behalf of our Maryland Health Care For All! Coalition we heartily commend you and everyone at the Maryland Health Benefit Exchange for all the great work you have done and are doing to make the Affordable Care Act a success in our state. We stand ready to help you in any way that we can to build on this success to achieve our common goal of quality, affordable health care for all Marylanders.

Thank you for your consideration.

Sincerely,

Vincent DeMarco, President

Thomas M. Middleton
Chair

John C. Astle
Vice Chair

Joanne C. Benson
Brian J. Feldman
Stephen S. Hershey, Jr.
J. B. Jennings
Katherine Klausmeier
James N. Mathias, Jr.
Nathaniel T. Oaks
Edward R. Reilly
Jim Rosapepe

THE SENATE OF MARYLAND
Finance Committee

April 10, 2018

Michelle Eberle
Executive Director
Maryland Health Benefit Exchange
750 E. Pratt Street, 6th Floor
Baltimore MD 21202

Alfred W. Redmer, Jr.
Insurance Commissioner
Maryland Insurance Administration
200 St. Paul Street, Suite #2700
Baltimore MD 21202

Dear Executive Director Eberle and Commissioner Redmer:

Thank you for attending the meeting that Chairman Pendergrass and I convened recently with representatives of Kaiser Permanente and Carefirst to discuss certain amendments that Kaiser requested to Senate Bill 387/House Bill 1782, the legislation which will generate funding in calendar year 2019 for a reinsurance mechanism for individual health insurance market stabilization. As you know, the legislation establishes a health insurance provider fee assessment at the rate of 2.75% on all amounts used to calculate the provider's premium tax or premium tax exemption value in calendar year 2018, with the proceeds of the assessment to be distributed to the Maryland Health Benefit Exchange Fund to support the reinsurance program. The intent is to recoup the aggregate fee that otherwise would have been assessed under § 9010 of the Affordable Care Act as a bridge to stability in the individual health insurance market.

The amendments requested by Kaiser Permanente would have required the reinsurance program under § 31-117 to (1) include incentives to continue to manage health care cost and utilization, and (2) account for any risk adjustment payments received by the carrier under 42 U.S.C. § 18063 to avoid duplicate payments, a potential circumstance noted in the March 15, 2018 report of the State's actuarial consultant, Wakely Consulting Group.

After discussion, the consensus at the meeting was that, in establishing the reinsurance program for 2019 and beyond, the MHBE, in consultation with the MIA, has the power to include incentives to manage health care cost and utilization and to account for risk adjustment payments to avoid duplication with reinsurance payments, if appropriate, even without the language requested by Kaiser being in the statute. There was also general agreement at the meeting that in

designing the reinsurance program, consideration should be given to including in the design incentives to manage cost and utilization and, if practicable, a mechanism to avoid duplication between risk adjustment and reinsurance to ensure the most effective use of the limited funding available.

We decided not to adopt the amendments requested by Kaiser because it is our understanding that you plan to consider inclusion of incentives to manage cost and utilization and a mechanism to avoid duplication between reinsurance payments risk adjustment payments in the reinsurance program. Accordingly, it is my hope and expectation that these elements will receive serious consideration as the parameters for the reinsurance program are established.

Thank you, again, for your assistance and cooperation during the 2018 session on this important legislation.

Sincerely,

Thomas McClain Middleton
Chairman, Senate Finance Committee

TMM/PDC

Commenter: Mary Wontrop, Executive Director, Epilepsy Foundation Maryland; Philip Gattone, President & CEO, Epilepsy Foundation
Comment Received: Monday, May 14, 2018
Comment:

May 14, 2018

Michele S. Eberle, Executive Director
Maryland Health Benefit Exchange
750 East Pratt Street, 16th Floor
Baltimore, MD 21202

Re: Maryland Section 1332 State Innovation Waiver

Dear Director Eberle:

The Epilepsy Foundation and the Epilepsy Foundation Maryland appreciate the opportunity to submit comments on Maryland's Section 1332 State Innovation Waiver.

The Epilepsy Foundation is the leading national voluntary health organization that speaks on behalf of the at least 3.4 million Americans with epilepsy and seizures. We foster the wellbeing of children and adults affected by seizures through research programs, educational activities, advocacy, and direct services. Epilepsy is a medical condition that produces seizures affecting a variety of mental and physical functions. Approximately 1 in 26 American will develop epilepsy at some point in their lifetime. For the majority of people living with epilepsy, prescription medications are the most common and cost-effective treatment for controlling and/or reducing seizures, and they must have meaningful and timely access to physician-directed care.

The Epilepsy Foundation and Epilepsy Foundation Maryland believe everyone should have quality and affordable healthcare coverage. A strong, robust marketplace is essential for people with epilepsy to access the coverage that they need. Epilepsy Foundation and Epilepsy Foundation Metropolitan Washington support Maryland's efforts to strengthen its marketplace by submitting this 1332 State Innovation Waiver to implement a reinsurance program.

Reinsurance is an important tool to help stabilize health insurance markets. Reinsurance programs help insurance companies cover the claims of very high cost enrollees, which in turn keeps premiums affordable for other individuals buying insurance on the individual market. Reinsurance programs have been used to stabilize premiums in a number of healthcare programs, such as Medicare Part D. A temporary reinsurance fund for the individual market was also established under the Affordable Care Act and reduced premiums by an estimated 10 to 14 percent in its first year.[i]

Maryland's proposal will create a reinsurance program starting for the 2019 plan year and continuing for 5 years. This program is projected to reduce premiums by 30 percent and increase the number of individuals obtaining health insurance through the individual market by 5.8 percent. This would help patients with pre-existing conditions, including patients with epilepsy, obtain affordable, comprehensive coverage.

The Epilepsy Foundation and Epilepsy Foundation Maryland believe the 1332 State Innovation Waiver will help stabilize the individual market in Maryland and protect patients and consumers. Thank you for the opportunity to provide comments.

Sincerely,

Mary Wontrop
Executive Director
Epilepsy Foundation Maryland

Philip M. Gattone, M.Ed.
President & CEO
Epilepsy Foundation

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[i] American Academy of Actuaries, Individual and Small Group Markets Committee. *An Evaluation of the Individual Health Insurance Market and Implications of Potential Changes.* January 2017. Retrieved from https://www.actuary.org/files/publications/Acad_eval_indiv_mkt_011817.pdf.

Commenter: Deborah P. Brown, Chief Mission Officer, American Lung Association
Comment Received: Tuesday, May 15, 2018
Comment:

AMERICAN LUNG ASSOCIATION.
IN MARYLAND

May 15, 2018

Michele Eberle
Executive Director
Maryland Health Benefit Exchange
750 E. Pratt Street, Baltimore, MD 21202

Re: Maryland 1332 State Innovation Waiver Application

Dear Director Eberle:

The American Lung Association in Maryland appreciates the opportunity to submit comments on Maryland's 1332 State Innovation Waiver Application.

The American Lung Association is the oldest voluntary public health association in the United States, currently representing the 33 million Americans living with lung diseases including asthma, lung cancer and COPD, including over 729,000 Maryland residents. The Lung Association is the leading organization working to save lives by improving lung health and preventing lung disease through research, education and advocacy.

The Lung Association believes everyone should have quality and affordable healthcare coverage. A strong, robust marketplace is essential for people with lung disease to access the coverage that they need. The Lung Association supports Maryland's efforts to strengthen its marketplace by submitting this 1332 State Innovation Waiver to implement a reinsurance program.

Reinsurance is an important tool to help stabilize health insurance markets. Reinsurance programs help health insurance companies cover the claims of very high cost enrollees, which in turn keeps premiums affordable for other individuals buying insurance on the individual market. Reinsurance programs have been used to stabilize premiums in a number of healthcare programs, such as Medicare Part D. A temporary reinsurance fund for the individual market was also established under the Affordable Care Act and reduced premiums by an estimated 10 to 14 percent in its first year.[i]

Maryland's proposal will create a reinsurance program starting for the 2019 plan year and continuing for five years. The state estimates that the program will reduce premiums by approximately 30 percent and increase the number of individuals obtaining health insurance through the individual market by an estimated 5.8 percent in 2019. This would help patients with pre-existing conditions, including patients with asthma, COPD, lung cancer, and other lung diseases, obtain affordable, comprehensive coverage.

The American Lung Association in Maryland believes the proposed 1332 State Innovation Waiver will help stabilize the individual market in Maryland and protect patients and consumers, and we urge its adoption. Thank you for the opportunity to provide comments.

Sincerely,

Deborah P. Brown
Chief Mission Officer
American Lung Association

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[i] American Academy of Actuaries, Individual and Small Group Markets Committee. *An Evaluation of the Individual Health Insurance Market and Implications of Potential Changes*. January 2017. Retrieved from https://www.actuary.org/files/publications/Acad_eval_indiv_mkt_011817.pdf.

Commenter: Janet Harvey, Private Member of Public
Comment Received: Tuesday, May 15, 2018
Comment:

To whom it may concern;

Hello my Name is Janet Harvey from Accident, MD. I'm sending this e-mail as I am unable to attend a hearing due to my work.

Health Care Concerns of the working middle class;

I have been a Maryland resident all my life I work 3 jobs and I am self-employed. I have never [drawn] a day's unemployment is my life. My average income a year is around $53,000.00. [The] first year that Insurance became a mandate my cost with Care First Blue Cross was $368.00 per year with a deductible of $3,500.00 year 2015. The next year 2016 my premium went to $412.00 with a $4,500.00 deductible, 2017 the premium went to $687.00 with a $6,550.00 deductible!!

That's when I decided I had to make a change and that is when I went to Christian Ministries and started paying $150.00 per month and joined a Brothers Keeper increase of $25.00 a Quarter for higher level care. This prevented the IRS from penalizing me at the end of the year. I have [driven a] school bus for 26 years and with the costs of Maryland Health care I was making myself sick worrying how I was to pay the premium and keep a roof over my head and a school bus on the road with working 3 jobs to survive. There is no cap on the deductible so at the start age of 54 when this system came to be at this rate my deductible would be with the current increase of $3,050.00 is two years by the age of 65 my deductible could well be $24,400.00 plus....ludicrous!!!! While I had Care First it would cost me $125.00 to go to Urgent Care which I had to pay because my deductible had not been met. With no insurance it cost me $35.00. A CDL physical cost $200.00 with Insurance and $75.00 with no Insurance. Also the fact that LAB CORP monopolizes blood work and completely over charges customers for labs that were never performed is a great concern!! When you have a Urine Culture sent out and they think you still have Insurance and bill an old policy number and you receive a denial of payment and come to find out that they was including Phlebotomy charge of $25.00 when no blood was drawn.... awful if they did this to 100,000.00 people a day....terrible !!!!
There are no caps on your deductibles which is ridiculous! Please feel free to contact me at any time!

I feel we need to be heard regarding the issue of affordable health care. Also we that live in GC should be able to go to Morgantown, WV for care and they are affiliated with Garrett Regional Medical Center in Oakland MD. We should not have to pay more to go to Morgantown it is so much closer than Baltimore or John Hopkins. Thank you!

Sincerely yours

Janet Harvey
Concerned Citizen

Commenter: Lydia L. Seiders, Maryland Volunteer State Ambassador, Rare Action Network
Comment Received: Tuesday, May 15, 2018
Comment:

May 15, 2018

Maryland Health Benefit Exchange

Re: Maryland Section 1332 State Innovation Waiver

Dear MHBE Board Members,

As Maryland State Ambassador for the Rare Action Network, powered by the National Organization for Rare Disorders (NORD), I appreciate the opportunity to submit comments on Maryland's Section 1332 State Innovation Waiver.

NORD is a unique federation of voluntary health organizations dedicated to helping people with rare "orphan" diseases and assisting the organizations that serve them. Since 1983, we have been committed to the identification, treatment, and cure of rare disorders through programs of education, advocacy, research, and patient services.

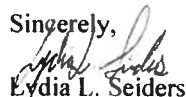
We believe everyone should have quality and affordable healthcare coverage. A strong, robust marketplace is essential for people with rare disorders to access the coverage that they need. NORD supports Maryland's efforts to strengthen its marketplace by submitting this 1332 State Innovation Waiver to implement a reinsurance program.

Reinsurance is an important tool to help stabilize health insurance markets. Reinsurance programs help insurance companies cover the claims of very high cost enrollees, which in turn keeps premiums affordable for other individuals buying insurance on the individual market. Reinsurance programs have been used to stabilize premiums in a number of healthcare programs, such as Medicare Part D. A temporary reinsurance fund for the individual market was also established under the Affordable Care Act and reduced premiums by an estimated 10 to 14 percent in its first year.[i]

Maryland's proposal will create a reinsurance program starting for the 2019 plan year and continuing for five years. This program is projected to reduce premiums by 30 percent and increase the number of individuals obtaining health insurance through the individual market by 5.8 percent. This would help patients with pre-existing conditions, including patients with rare disorders obtain affordable, comprehensive coverage.

I believe, as Ambassador, the 1332 State Innovation Waiver will help stabilize the individual market in Maryland and protect patients and consumers. Thank you for the opportunity to provide comments.

Sincerely,



Lydia L. Seiders
Maryland Volunteer State Ambassador

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[i] American Academy of Actuaries, Individual and Small Group Markets Committee. *An Evaluation of the Individual Health Insurance Market and Implications of Potential Changes.* January 2017. Retrieved from https://www.actuary.org/files/publications/Acad_eval_indiv_mkt_011817.pdf.

Commenter: Laurie G. Kuiper, Senior Director of Government Relations, Kaiser Permanente
Comment Received: Thursday, May 17, 2018
Comment:

May 14, 2018

Maryland Health Benefit Exchange Board
Baltimore, MD

Dear Maryland Health Benefit Exchange Board,

As the people of Kaiser Permanente, we applaud the Governor and Legislature's attention to the reinsurance issue to ensure Maryland maintains a strong, stable individual market that provides access to high quality care and choices. We believe the goal of the Maryland reinsurance program should be to stabilize the entire individual market and benefit all Maryland consumers equally — not to pick competitive "winners and losers" by favoring one company over another in the program's design.

We are concerned that — as drafted — the waiver outlining the program effectively advantages one health plan, CareFirst, and specifically their PPO product, over all Maryland consumers. It would lead to CareFirst being paid twice for their participation in the individual market, as they also receive compensation for their risk through the federal risk adjustment program — amounting to a "double dip." We are concerned that most Maryland consumers will receive much less benefit from the reinsurance program overall.

We recommend adjusting the waiver proposal so that the structure accounts for these payments being made towards this same end — participation in the individual market. The program should put into place incentives that would result in lower rates for all Marylanders, and reward cost-effective, high quality care. We would also encourage policymakers to ensure that the final waiver includes incentives to both manage cost and utilization and encourage delivery system innovation. Such a shift would be consistent with Maryland's broader policy objectives around affordability and access.

This is a solvable problem, and there can and should be an adjustment as we build a solid individual market into the future. There are only two health plans remaining in the individual market in Maryland. This means that any policy proposals should be particularly mindful of how reinsurance, risk adjustment, and other requirements of this market will work in this specific context, and the critical need to encourage new plans to come into this market.

Sincerely,

The undersigned of the Kaiser Permanente Mid-Atlantic community

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
2101 E. Jefferson St.
Rockville, MD 20852

Geneane	Adams	Anne Arundel
Ilene	Aiken	Montgomery
Jamie	Anderson	Prince Georges
Marbla	Atatsi	Montgomery
Valerie	Beckett	Montgomery
Mari-Viola	Bocchetto	Anne Arundel
Jayme	Brenneman	Montgomery
Laird	Burnett	Charles
Charlyn	Chandler	Baltimore
Maryam	Charmchi	Lane
Anne-Marie	Cox	Montgomery
Jill	Feldon	District of Columbia
Kelley	Flesher	Frederick
Kimberly	Fox	Montgomery
Mardela	Gonzalez	Prince Georges
Vilma	Gordon	Charles
Pamela	Hamorsky	Montgomery
Jeffrey	Hart	Montgomery
Denise	Hathaway	Alameda
Tara	Herberth	Baltimore City
Lena	Hershkovitz	Montgomery
Debbie	Jochum	Montgomery
Lauren	Kalastein	Anne Arundel
Becky	Kepple	Montgomery
Ryan	Mach	Alameda
Robin	McClave	Frederick
Gracelyn	McDermott	Howard
Shannon	Mcmahon	Montgomery
Dawda	Njie	Montgomery
Sam	Ongwen	Montgomery
William	Raisner	Montgomery
Marwan	Rateb	Baltimore City
Alma	Riberts	Montgomery
Daiga	Rutins	Montgomery
Jill	Sacks	Montgomery
Evetta	Sherman	Montgomery
Terri	Syme	Anne Arundel
Stephanie	Waszkiewicz	District of Columbia
Scott	Weier	District of Columbia

Please consider this very carefully. KP is a wonderful organization and benefits a major market in our state both from an insurer perspective and an employer perspective. Thank you.
Geneane Adams
Anne Arundel County

We are raising our voices to ensure a stable health insurance market that works for all Maryland consumers.
Jamie Anderson
Prince Georges County

Thank you for tackling this most difficult issue. Maryland should be the leader in providing affordable health care to all its constituents.
Mari-Viola Bocchetto
Frederick County

I urge you to put into place a measure that will provide lower health care costs for all Marylanders.
Jayme Brenneman
Anne Arundel County

It would be absurd and unconscionable to take the money that people pay to KP for an efficient and high-quality plan and give it to Carefirst, for their more expensive and lower quality plan (beyond the reasonable risk adjustment payments required by the ACA.) That's not stability or fairness, it's highway robbery.
Laird Burnett
Montgomery County

The decision you make will mean life and/or death to many Marylanders. Please reconsider how to move forward equitably in regards to the Maryland Health Exchange.
Anne Marie Cox
Baltimore County

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
2101 E. Jefferson St.
Rockville, MD 20852

While we need to stabilize the individual plan market, Maryland needs to make sure its solution is fair to all those who live in the state, not just those with CareFirst insurance. Thank you.

Jill Feldon
Montgomery County

I support Kaiser Permanente's initiative to revise the current proposed legislation to be more equitable to all Marylander's.

Pamela Hamorsky
Charles County

Please ensure a stable health insurance market that works for ALL Maryland consumers.

Jeffrey Hart
Montgomery County

I am concerned that the bill as drafted is not equal for all. Please look closely at the impact and that it doesn't advantage CareFirst.

Debbie Jochum
Montgomery County

Please be sure your proposal creates incentives that reward cost-effective, high-quality care and result in lower costs for all Marylanders.

Robin McClave
Howard County

Kaiser Permanente is the only plan with the mission to provide affordable health care to all people. Unduly burdening this non-profit plan will give an unfair advantage to other plans that do not necessarily hold this goal as their priority. Please make the rule fair to Kaiser Permanente so they can continue to provide the region's highest quality care to their members and communities.

Jill Sacks
Montgomery County

As somebody who closely follows health policy, I'm deeply concerned that the re-insurance provision, as currently drafted, will further destabilize the market that it's seeking to fix. Why pump all that money to PPO plans and not support HMO plans that are proven to better integrate and coordinate care and get better value? This just doesn't make any sense.

Scott Weier
District of Columbia

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
2101 E. Jefferson St.
Rockville, MD 20852

Commenter: Scott Hancock, Executive Director, The Maryland Municipal League
Comment Received: Tuesday, May 15, 2018
Comment:

Maryland Municipal League
The Association of Maryland's Cities and Towns

May 17, 2018

Maryland Health Benefit Exchange
750 East Pratt Street
Baltimore, MD 21202

SUBJECT: Maryland 1332 Waiver Application & Reinsurance Program

Dear Sir or Madam:

Thank you for the opportunity to provide public comment on the Maryland Health Benefit Exchange's draft Section 1332 waiver application. The Maryland Municipal League applauds the State of Maryland's proposed immediate steps to stabilize the individual health insurance market.

The Maryland Municipal League (MML) represents 1.5 million Maryland residents living in the 157 incorporated cities and towns. It is estimated that a large percentage of municipal residents have taken advantage of Maryland's health exchange program since its inception and would be impacted by the actions proposed in the Section 1332 waiver and the reinsurance program.

MML believes a reinsurance program could be beneficial in reducing health insurance premium increases for the residents of municipalities that purchase their coverage in the individual market. The reinsurance program that Maryland develops, however, should be designed to stabilize premiums in the entire market and equally benefit all Maryland consumers that get their coverage through the individual market.

The League is concerned that the reinsurance program, as currently proposed, would benefit the enrollees of one health plan over the other. We want to make sure that the premium relief provided by the program is spread among all residents of our communities and not just those who are enrolled in one company's product. We fear that if an adjustment is not included in the proposed program, instead of all Marylanders seeing premium relief compared to what they would otherwise be required to pay in 2019, the relief will be concentrated among a much smaller number of individual market enrollees.

1212 West Street, Annapolis, Maryland, 21401
410-295-9100 | www.mdmunicipal.org | 800-492-7121

In conclusion, MML believes:

- All 1.5 million municipal residents throughout the State should benefit from reinsurance - to keep their premiums affordable – not just those who enroll in specific plans.

- There can and should be an adjustment built into the program to make sure all consumers and patients that purchase their coverage in Maryland's individual market benefit fairly and equally from reinsurance.

Thank you for your consideration.

Sincerely,

Scott Hancock
Executive Director

Commenter: Lisa B. Williams, CEO/Executive Director, Baltimore City Medical Society
Comment Received: Thursday, May 17, 2018
Comment:

BCMS
Baltimore City Medical Society

1211 Cathedral Street, 3rd Floor
Baltimore, Maryland 21201-5516

(410) 625-0022
FAX (410) 385-0154
info@bcmsdocs.org
www.bcmsdocs.org

May 16, 2018

Board of Directors
Maryland Health Benefit Exchange
750 Pratt Street, 6th Floor
Baltimore, MD 21202

Re: *Maryland Section 1332 Waiver Application (Draft)*

Dear Members of the Board:

Baltimore City Medical Society, a component of MedChi, The Maryland State Medical Society, the professional membership organization of physicians, supports the *Section 1332 Waiver Application ("Application")* for the development of a reinsurance program. We appreciate the opportunity to offer further comments on the Application.

We, too, are concerned that, as drafted, the reinsurance program outlined in the Application will advantage only some health plans and their patient subscribers. It is our position that the program must stabilize the entire market and equally benefit all plans and their subscribers. Adding language in the *Application* to address this concern would enhance the *Application*.

We encourage these additional enhancements to the Application: (1) delineating specific payment incentives to address quality of care, cost-effectiveness and innovation; (2) requiring all participating carriers engage with Maryland's health information exchange, Chesapeake Regional Information System for our Patients or CRISP; (3) examining utilization practices of participating carriers; and (4) assuring that the policies and procedures in the Application align with the term sheet agreement of the unique Maryland Medicare Hospital All Payer Waiver.

Again, we support the Application and appreciate your consideration of our concerns.

Sincerely,

Lisa B. Williams
CEO/Executive Director

Commenter: Maansi K. Raswant, Director of Policy and Data Analytics, Maryland Hospital Association
Comment Received: Friday, May 18, 2018
Comment:

Maryland
Hospital Association

May 18, 2018

Secretary Robert Neall
Chairman, Board of Trustees
Maryland Health Benefit Exchange
750 E. Pratt Street, 6th Floor
Baltimore, Maryland 21201

Dear Secretary Neall:

On behalf of the 64 hospitals and health system members of the Maryland Hospital Association (MHA), I offer support for and feedback on the state's application for a waiver under section 1332 of the Affordable Care Act.

Maryland's hospitals support broad-based, continuous health coverage as an essential pillar of the state's unique agreement with the federal government, otherwise known as the All-Payer Model. The current model started in 2014 as a five-year demonstration, at the same time coverage was expanded; the synergy between the two has made Maryland a model in the nation for holding costs down and improving quality. Hospitals therefore wholly back the state's application for a section 1332 waiver and efforts to develop a reinsurance program. The following suggestions will improve the state's application and the resulting reinsurance program.

First, the Maryland Health Benefit Exchange, working with the Maryland Insurance Administration, should hold carriers accountable to generate meaningful reductions in out-of-pocket costs, encouraging increased enrollment.

While the short-term goal of the reinsurance program is to stabilize the individual insurance market, it should also bolster health care coverage (the state projections that the reinsurance program will increase enrollment by 6 percent are encouraging). Ultimately, efforts to cushion losses for carriers via reinsurance should translate to lower premiums and, in turn, increased coverage. Expanded coverage ensures that more Marylanders will receive preventive care, and care in the most appropriate setting, thereby reducing avoidable hospital utilization; a key metric under the All-Payer Model. Also, growth in coverage is directly proportional to reductions in the amount of uncompensated care built into hospital rates, increasing cost savings to commercial carriers, the state, and federal government.

Second, the Board should include language in the 1332 waiver application indicating that the Maryland Health Benefit Exchange will explore care management incentives for carriers as part of the state reinsurance program.

The reinsurance program offers a unique opportunity to strengthen the link between health care coverage and delivery via the creation of care management incentives for carriers, specifically those aimed at high-risk, high-cost enrollees. To develop these incentives, target conditions and

6820 Deerpath Road, Elkridge, MD 21075 ▪ 410-379-6200 ▪ www.mhaonline.org

populations could be identified using current data sources, such as carrier submissions for the federal risk adjustment program, the state's all-payer claims database, and Health Services Cost Review Commission analyses. While specific incentives would be determined via a state regulatory process following the submission of the 1332 waiver application, incentives focused on management of chronic conditions, better primary care, or behavioral health care access would all result in significant improvement in quality of care and cost reduction, matching the goals of the All-Payer Model. Any reduction in the cost of care would also decrease reliance on a reinsurance program.

Thank you for your leadership on this effort. Hospitals believe that patient-centered, quality, and efficient care depends on broad-based health care coverage and reiterate our strong support of the 1332 waiver application. Maryland's hospitals stand ready to continue to work with payers, other providers, and the state to provide Marylanders with a high-performing health care system, one where insurance carriers offer affordable coverage so that hospitals can continue to deliver efficient, high-quality care.

Please contact me should you need additional information.

Sincerely,

Maansi K. Raswant
Director, Policy and Data Analytics

Commenter: Anna Davis, Health Policy Director, Advocates for Children and Youth
Comment Received: Friday, May 18, 2018
Comment:

May 10, 2018

Michele Eberle
Executive Director
Maryland Health Benefit Exchange
750 E. Pratt Street, 6th Floor
Baltimore, Maryland 21202

Dear Executive Director Eberle:

Thank you for the opportunity to comment on the Maryland Health Benefit Exchange's proposed Section 1332 waiver application. Advocates for Children and Youth strongly supports the waiver application and the Maryland Reinsurance program. On behalf of all Maryland families with children, ACY commends the MHBE Board and staff for all that you are doing to help stabilize the individual insurance market and to protect consumers from high rate increases.

Access to health care is essential for achieving and maintaining proper health throughout the life course. The assaults on the ACA and ongoing repeal efforts at the federal level have made it more difficult for consumers to find affordable coverage and to keep healthier people in plans that meet the requirements of the ACA. The Maryland Reinsurance program is a critical and much needed first step toward stabilizing the individual health insurance market. MHBE acknowledges that the Reinsurance program is but a short-term fix for market stability. ACY is optimistic that the Reinsurance program will buy time for the state and insurers to work together to develop a long-term solution that will address the underlying causes of market distortion and rising health care costs.

It is ACY's understanding that numerous stakeholders have advocated that the MHBE consider including incentives for issuers to manage high risk enrollees and to coordinate the reinsurance program to account for the ACA's risk adjustment program. ACY agrees with the suggestion of Senate Finance Committee Chairman Thomas "Mac" Middleton that the MHBE, in consultation with the Maryland Insurance Administration (MIA), has the authority to include incentives to manage health care cost and utilization and to account for risk adjustment payments to avoid duplication with reinsurance payments. In designing the Reinsurance program, ACY urges the MHBE to take these stakeholder concerns into account and to employ those policy options that will promote consumer choice and achieve the broader goals of the reinsurance program.

Thank you for your consideration.

Best,

Anna Davis

Anna Davis, JD, MPH
Health Policy Director

1 N. Charles Street, Suite 2400, Baltimore, MD 21201 / info@acy.org / 410.547.9200 / www.acy.org
Advocates for Children and Youth @MarylandACY

Commenter: Steve Butterfield, Regional Director of Government Affairs, Leukemia & Lymphoma Society
Comment Received: Friday, May 18, 2018
Comment:

May 18 2018

Michele Eberle
Executive Director
Maryland Health Benefit Exchange
750 East Pratt St.
6th Floor
Baltimore, MD 21202

The Leukemia & Lymphoma Society (LLS) appreciates the opportunity to submit comments on Maryland's Section 1332 State Innovation Waiver, and respectfully submits the following.

At LLS, our mission is to cure leukemia, lymphoma, Hodgkin's disease and myeloma, and improve the quality of life of patients and their families. LLS exists to find cures and ensure access to treatments for blood cancer patients. LLS believes firmly that all patients and consumers should have access to high quality, stable coverage to ensure that they are able to receive appropriate and timely care. It is in service to these principles that we offer these comments in support of a reinsurance program in Maryland that prioritizes improved access to stable, affordable coverage for patients and consumers, as is proposed to be established by this waiver.

Cancer patients need access to meaningful health insurance coverage in order to access necessary care and treatment. LLS has adopted a set of Coverage Principles that outline what, exactly, from the organization's perspective, constitutes "meaningful" health insurance coverage.[1] Among these, LLS knows that meaningful coverage for cancer patients must be both affordable and stable. We feel that instituting a reinsurance program will help Maryland meet these standards.

Reinsurance programs in other states have shown promising initial results in controlling overall premium growth, and even, in some cases, resulting in premium reductions. Alaska, Oregon, and Minnesota all currently operate reinsurance programs on models similar to that proposed by this waiver[2], and all have received significant federal pass-through funding returned as a result of reductions in premium growth and, consequently, advanced premium tax credit (APTC) payments in their states.

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[1] *Principles for Meaningful Coverage*. The Leukemia & Lymphoma Society. Retrieved from http://www.lls.org/cancercost/Principles

[2] *State 1332 Waiver Reinsurance Proposals: Wisconsin Releases Draft 1332 Waiver Seeking $170 Million in Pass-Through Funding*. State Health Access Data Assistance Center. March 30 2018. Retrieved from http://www.shadac.org/news/state-1332-waiver-reinsurance-proposals-wisconsin-releases-draft-1332-waiver-seeking-170

National Office
3 International Drive
Suite 200
Rye Brook, NY 10573
main 914.949.5213
www.LLS.org

BEATING CANCER IS IN OUR BLOOD.

In addition, Maine, prior to the implementation of the Affordable Care Act (ACA), operated a state-based reinsurance program that was estimated to reduce premiums by 12% to 15%.[3] Maine is now also seeking a 1332 waiver to reactivate their reinsurance association.

At the federal level, reinsurance programs have been used to stabilize premiums in a number of healthcare programs, such as Medicare Part D. A temporary reinsurance fund for the individual market was also established under the ACA and reduced premiums by an estimated 10% to 14% in its first year.[4]

Because LLS believes Maryland's 1332 State Innovation Waiver will help stabilize the individual market in Maryland and protect patients and consumers, we are pleased to support the establishment of a reinsurance program as proposed by this waiver.

Thank you for the opportunity to provide comments. Questions or requests for further information on LLS and our position can be addressed to Steve Butterfield, Regional Director of Government Affairs, at either 207-213-7254 or steve.butterfield@lls.org.

---

[3] *The Impact of PL90 On Maine's Health Insurance Markets*. Gorman Actuarial LLC. December 2011. Retrieved from http://www.maine.gov/pfr/insurance/publications_reports/archived_reports/pdf/gorman_actuarial_report.pdf

[4] *An Evaluation of the Individual Health Insurance Market and Implications of Potential Changes.* American Academy of Actuaries, Individual and Small Group Markets Committee. January 2017. Retrieved from https://www.actuary.org/files/publications/Acad_eval_indiv_mkt_011817.pdf.

National Office
3 International Drive
Suite 200
Rye Brook, NY 10573
main 914.949.5213
www.LLS.org

BEATING CANCER IS IN OUR BLOOD.

Commenter: Ashley Kenneth, Director of Advocacy and Policy, National Multiple Sclerosis Society
Comment Received: Friday, May 18, 2018
Comment:

National Multiple Sclerosis Society
Comments Regarding Maryland's Application for a Section 1332 State Innovation Waiver

Ashley Kenneth
Director, Advocacy & Policy

May 17, 2018

The National Multiple Sclerosis Society (the Society) is grateful for the opportunity to submit comments regarding Maryland's Section 1332 State Innovation Waiver application.

Multiple sclerosis (MS) is an unpredictable, often disabling disease of the central nervous system that disrupts the flow of information within the brain, and between the brain and body. Symptoms range from numbness and tingling to blindness and paralysis. The progress, severity and specific symptoms of MS in any one person cannot yet be predicted, but advances in research and treatment are leading to better understanding and moving us closer to a world free of MS. There are over 1 million people in the United States diagnosed with the disease, including at least 12,000 people in Maryland.

The National MS Society believes that everyone should have access to quality and affordable healthcare. Since 2014, the Affordable Care Act (ACA) health insurance marketplace has been an extremely important avenue to affordable, quality coverage for people living with MS. A strong, robust marketplace is essential for people with MS to access the coverage and care that they need.

However, insurance premiums are rising and will soon price people out of the healthcare system. The Society is committed to ensuring that people living with MS have reliable access to comprehensive health insurance plans with affordable premiums, deductibles, and out-of-pocket costs. Without market stabilization measures like reinsurance, Marylanders who are currently relying on the marketplace for their health insurance could lose their only affordable coverage option. The Society supports Maryland's efforts to strengthen its marketplace by submitting this 1332 State Innovation Waiver to implement a reinsurance program.

Reinsurance is an important tool to help stabilize the health insurance market by covering a percentage of the claims of very high cost enrollees. This will help make premiums more affordable for all individuals who buy insurance on the individual market. Maryland's proposed reinsurance program is projected to reduce premiums by 30% in 2019 and increase the number of individuals obtaining health insurance through the individual market by 5.8%. The program

will undoubtedly help people who live with MS, an expensive pre-existing condition, to obtain and retain affordable, comprehensive coverage.

The Society applauds Maryland for moving forward with this application and believes the 1332 State Innovation Waiver will help stabilize the individual market in Maryland while protecting consumers. If we can be of any assistance in the future to help increase access to health care in Maryland, please contact me at ashley.kenneth@nmss.org.

Commenter: Beth Sammis, President, Consumer Health First
Comment Received: Friday, May 18, 2018
Comment:

May 18, 2018

Michelle Eberle
Executive Director
Maryland Health Benefit Exchange
mhbe.publiccomments@maryland.gov

Dear Ms. Eberle:

Consumer Health First (CHF), along with the undersigned 10 organizations and 11 indviduals, very much appreciates the opportunity to provide our strong support for Maryland's 1332 State Innovation Waiver Application. In doing so we wish to acknowledge the commitment of the General Assembly, the Insurance Commissioner and the Board of the Maryland Health Benefit Exchange (MHBE) to address the needs of Maryland's consumers by taking steps to stabilize the individual health insurance market.

One of the most important steps is to establish a state reinsurance program. We believe this should be designed to accomplish three goals: (1) equitably lower costs for HMO and PPO products; (2) improve health outcomes; and (3) promote consumer choice. We explain our thinking on each of these below with the understanding that there is still a lot more work to do to launch a state reinsurance program. During this process, we look forward to engaging with you and other stakeholders to be sure that the design of a state reinsurance program meets these three goals.

(1) Equitably Lower Costs for HMO and PPO products: There is a strong correlation between health status (the focus of the risk adjustment program) and claims (the focus of a state reinsurance program). It is theoretically possible that monies from both programs will overlap and benefit the product receiving all the risk adjustment monies thus reducing PPO premiums more than HMO premiums. Such an outcome runs counter to what we believe should be one goal of the state reinsurance program, equitable premium decreases for HMO and PPO products. To be sure this is achieved, we respectfully request that you simulate the impact of alternative attachment points on HMO and PPO premiums with, and without, adjusting for risk adjustment payments. We also recommend that the results of the simulation be made available to the public. This would help to guide the public discussion of the alternatives for the technical aspects of the state reinsurance program. In addition, it would lead to greater confidence on the part of the public in the final design of the reinsurance program.

(2) Improve health: A state reinsurance program provides an opportunity to incentivize carriers to develop meaningful health improvement programs. Such programs should, over time, reduce premium increases and help consumers lead healthier, more productive lives. A carrier's eligibility to receive funds from a state reinsurance program should be predicated on having such programs in place and we commend you for considering such an approach.

(3) Promote consumer choice: Consumers generally benefit when there is more choice. Today, consumers may select a PPO product offered by CareFirst or an HMO product offered by CareFirst or Kaiser Permanente. The reinsurance program should be designed, at a minimum, to maintain the participation of these two carriers in the individual market. Optimally, we hope that it will encourage other carriers to join the market. CareFirst, the state's only nonprofit health service plan, is required under the provisions of section 14-106 (d) (1) (ii) of the Insurance Article to offer products in the individual market, and so it cannot exit the market. Therefore, it is important that the design of Maryland's reinsurance program does not unintentionally competitively disadvantage Kaiser Permanente or other carriers.

In closing, we would like to thank you and the MHBE Board and staff for your efforts to recognize the challenges consumers are facing in finding affordable health insurance in the individual market. We believe that the pursuit of a 1332 waiver to establish a state reinsurance program is critical and we reiterate our strong support for this program. We very much appreciate the opportunity to provide our perspective on this issue and look forward to working with you and other stakeholders to be sure this program results in lower costs, better quality, and more consumer choice.

Sincerely,

Beth Sammis
President, Consumer Health First
bethsammis@gmail.com

Signatory Organizations:

Advocates for Children and Youth

League of Women Voters of Maryland

Maryland-DC Society of Addiction Medicine

Maryland Occupational Therapy Association

Mental Health Association of Maryland

NARAL-Pro Choice Maryland

National Alliance on Mental Illness Maryland

Primary Care Coalition

Progressive Cheverly

Public Justice Center

Signatory Individuals:

Rabbi Charles Arian

Laurie Caldwell

Laura Carr

Holly Cooper

Ward Cooper

Frank Mahlmann

Barbara Manns

Joan Moyers

Dee Schofield

Carol Stemple

Patricia Tice

Commenter: Susan G. D'Antoni, Executive Director, Montgomery County Medical Society
Comment Received: Friday, May 18, 2018
Comment:

MCMS
MONTGOMERY COUNTY, MD
MEDICAL SOCIETY

May 16, 2018

Maryland Health Benefit Exchange
750 East Pratt Street
6th Floor
Baltimore, Maryland 21202

Sent: mhbe.publiccomments@maryland.gov

RE: 1332 Waiver Application

Dear Board Members:

Montgomery County Medical Society (MCMS), a professional association for physicians practicing/resident in Montgomery County, Maryland, represents more than 1,600 Maryland physicians and their patients. We are a component of MedChi, The Maryland State Medical Society.

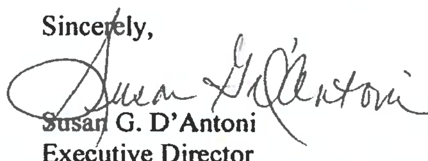
We appreciate the opportunity to comment on the *DRAFT Maryland 1332 Waiver Application* being submitted by the Maryland Health Benefit Exchange (MHBE) to the United States Department of Treasury and the United States Department of Health and Human Services. Overall, MCMS supports the Section 1332 waiver for the development of a reinsurance program. We understand the importance of stabilizing the individual health insurance market to ensure that the greatest number of Marylanders have access to affordable insurance. It is on that premise that MCMS believes that the program designed must stabilize the entire market and equally benefit all Maryland consumers.

We encourage inclusion of the following elements:

- Designing a program that treats all carriers equitably. This added benefit of attracting new health plans into the market. Under the current proposal, some health plans could receive double payments for higher risk members. We encourage the MHBE to include language in the draft Section 1332 waiver application that indicates the state's intent to include an adjustment in 2019 for federal risk adjustment payments to ensure that the program doesn't unfairly advantage some health plans over others.
- Payment incentives should be included in the reinsurance program which are aligned with the State's broader policy goals related to quality, cost-effectiveness and innovation. Incentives should be included that directly reward quality in care delivery through strategies like payment multipliers for high clinical quality ratings in preventive care measures such as breast cancer screening, colorectal cancer screening, controlling high blood pressure and care for diabetes and cardiovascular conditions.
- MCMS believes that it is important to require all participating carriers to collaboratively work with the State's Health Information Exchange (CRISP).
- Because the central issue for applying for a reinsurance program is to make sure that costs can be stabilized for both the carriers as well as the consumers, MCMS does believe that utilization practices of participating carriers should be examined, including not allowing non-staff model HMO product sold thru the exchange to utilize prior authorization procedures.

Thank you for the opportunity to provide comment re: *DRAFT Maryland 1332 Waiver Application.*

Sincerely,



Susan G. D'Antoni
Executive Director

Working for Physicians and Their Patients in Montgomery County

15855 Crabbs Branch Way | Rockville, MD 20855 | t 301 921 4300 | f 301 921 4368 | montgomerymedicine.org | info@montgomerymedicine.org

Commenter: Teresa Healey-Conway, Executive Director, Anne Arundel & Howard County Medical Societies
Comment Received: Friday, May 18, 2018
Comment:

224 Main Street
Annapolis, MD 21401
410-544-0312

May 18, 2018

Maryland Health Benefit Exchange
750 East Pratt Street
6th Floor
Baltimore, Maryland 21202
Sent: mhbe.publiccomment@maryland.gov

RE: 1332 Waiver Applications

Dear Board Members:

The Anne Arundel & Howard County Medical Societies (AAHCMS) wishes to comment on the *DRAFT Maryland 1332 Waiver Application* being submitted by the Maryland Health Benefit Exchange (MHBE) to the United States Department of Treasury and the United States Department of Health and Human Services. Overall, PGCMS supports the Section 1332 waiver for the development of a reinsurance program. However, we have a few concerns.

First, AAHCMS is concerned that the reinsurance program as outlined in the *DRAFT Section 1332 Waiver Application* does not treat all carriers equally. Under the current proposal, some health plans will be put at a disadvantage resulting in a limited benefit to people who choose those health plans for their coverage. Furthermore, unequal treatment amongst carriers will deter new carriers from joining the market.

AAHCMS proposes that the draft Section 1332 waiver application be revised to include a commitment to equitable treatment of all of the health plans. We believe this will improve the waiver application and be accepted by CMS.

Second, AAHCMS supports the creation of specific payment incentives be included that directly reward delivery of quality care.

Lastly, PGCMS believes that all participating carriers should work with the State's Health Information Exchange (CRISP) to make sure that costs can be stabilized for both the carriers as well as the consumers.

Sincerely,

Teresa Healey-Conway
Executive Director, AAHCMS

Commenter: Teresa Healey-Conway, Executive Director, Prince George's County Medical Society
Comment Received: Friday, May 18, 2018
Comment:

224 Main Street
Annapolis, MD 21401
410-544-0312

May 18, 2018

Maryland Health Benefit Exchange
750 East Pratt Street
6th Floor
Baltimore, Maryland 21202
Sent: mhbe.publiccomment@maryland.gov

RE: 1332 Waiver Applications

Dear Board Members:

The Prince George's County Medical Society (PGCMS) wishes to comment on the *DRAFT Maryland 1332 Waiver Application* being submitted by the Maryland Health Benefit Exchange (MHBE) to the United States Department of Treasury and the United States Department of Health and Human Services. Overall, PGCMS supports the Section 1332 waiver for the development of a reinsurance program. However, we have a few concerns.

First, PGCMS is concerned that the reinsurance program as outlined in the *DRAFT Section 1332 Waiver Application* does not treat all carriers equally. Under the current proposal, some health plans will be put at a disadvantage resulting in a limited benefit to people who choose those health plans for their coverage. Furthermore, unequal treatment amongst carriers will deter new carriers from joining the market.

PGCMS proposes that the draft Section 1332 waiver application be revised to include a commitment to equitable treatment of all of the health plans. We believe this will improve the waiver application and be accepted by CMS.

Second, PGCMS supports the creation of specific payment incentives be included that directly reward delivery of quality care.

Lastly, PGCMS believes that all participating carriers should work with the State's Health Information Exchange (CRISP) to make sure that costs can be stabilized for both the carriers as well as the consumers.

Sincerely,

Teresa Healey-Conway
Executive Director, PGCMS

Commenter: Kim K. Horn, President, Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
Comment Received: Saturday, May 19, 2018
Comment:

Mid-Atlantic Permanente Medical Group, P.C.
Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.

Submitted electronically to: *mhbe.publiccomments@maryland.gov*

May 20, 2018

Maryland Health Benefit Exchange
750 East Pratt Street
Baltimore, MD 21202

Re: *Draft Maryland 1332 Waiver Application*

Dear Sir or Madam:

Kaiser Permanente offers the following comments in response to the Draft Maryland 1332 Waiver Application published on April 20, 2018 by the Maryland Health Benefit Exchange (MHBE). Kaiser Permanente supports the Section 1332 waiver and a reinsurance program benefitting all Marylanders equally. We appreciate MHBE's commitment to stabilizing the individual market and offer recommendations in support of its waiver application.

Kaiser Permanente of the Mid-Atlantic States provides and coordinates complete health care services for over 780,000 members through 30 medical office buildings in the District of Columbia, Maryland and Virginia. Kaiser Permanente is a total health organization composed of Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., the Mid-Atlantic Permanente Medical Group, P.C., an independent medical group that is comprised of approximately 1,500 physicians who provide or arrange care for patients throughout the region, and Kaiser Foundation Hospitals which contracts with community hospitals for the provision of hospital services to our patients. Kaiser Permanente is committed to the individual market and the consumers who do not have access to group coverage.

Maryland's reinsurance program will significantly impact Kaiser Permanente and our members. As one of two carriers currently operating in the individual market in Maryland, Kaiser Permanente provides care and coverage to 46 percent of Maryland's on-exchange individual market as of April 2018. We experienced losses of $117 million in the individual market, or an average of negative 28 percent annually, between 2014 and 2017.[1]

A properly designed and fairly implemented reinsurance program may help stabilize individual market premiums. To ensure the greatest number of consumers realize the program's benefits, MHBE should include the following specific elements in its final Section 1332 waiver application:

1. A description and analysis of the varying impact of reinsurance on market participants.

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[1] This represents Kaiser Permanente's loss on the Individual market from 2014-2016 plus an estimate for 2017.

2. Language describing MHBE's intent to ensure that the federal risk adjustment program and the Maryland reinsurance program do not duplicate payments for the same high-risk membership.
3. Language describing MHBE's intent to determine the extent of overlap between payments made under the federal risk adjustment program and the state reinsurance program.
4. Program incentives rewarding quality and cost-management.

We discuss these requests below.

MHBE Should Include a Description and Analysis of the Varying Impact of Reinsurance on Market Participants.

An equitably designed state-based reinsurance program mitigates the impact of high risk individuals on premiums caused by elimination of the Affordable Care Act (ACA)'s individual mandate penalty in 2019 and uncertainty at the federal level. It could also provide an incentive for more carriers to enter the individual market.

A poorly designed reinsurance program has the potential to reward carriers who are not effectively managing costs. MHBE should design its program to reward cost-management. The first step is an account and analysis of the varying impact of reinsurance on market participants. As the March 2018 Wakely Consulting Group report for the Maryland legislature noted "individual issuers may be affected differently by reinsurance. Issuers with relatively higher claims cost will receive relatively more reinsurance payments."[2] Accordingly, the final waiver application should acknowledge that variation and break out the anticipated effect on premiums by plan.

MHBE Should Account for Risk Adjustment in Structuring Its Reinsurance Program.

MHBE's final waiver application should clarify that the state intends to account for federal risk adjustment payment and to design a reinsurance program that pays only for uncompensated high risk. This will ensure that reinsurance funds have the broadest impact for all consumers, incentivize new market entrants and encourage current participants to remain. Kaiser Permanente is concerned that the reinsurance program proposed by the draft waiver application will effectively favor one health plan's membership and provide rate relief disproportionately to those consumers.

The ACA compensates carriers for high-risk members through a federal risk adjustment program that transfers money among carriers based on their enrollment of individuals with high cost diagnoses. As the Centers for Medicare and Medicaid Services (CMS) noted in its 2019 Notice of Benefit and Payment Parameters regulation, the scale of such transfers plays a crucial role in issuer decisions to participate in the individual market. Kaiser Permanente will transfer

[2] Wakely Consulting Group. (March 15, 2018). *State of Maryland: Individual Market Stabilization – Reinsurance Analysis*, 7.

approximately $80 million to CareFirst for the 2017 plan year to account for its higher risk membership in Maryland. We expect that amount to increase substantially in 2018 and beyond.

The goal of the Maryland reinsurance program should be to stabilize the entire individual market by benefitting all Maryland consumers equally. The draft application does not account for federal risk adjustment payments and thus fails to stabilize the entire market. Rather, the reinsurance funds will pay twice for the same members – first from the federal risk adjustment program and a second time for claims reimbursable under the Maryland reinsurance program. As previously discussed, this effect magnifies the existing distortion under risk adjustment and thereby picks competitive "winners and losers."

In addition, providing rate relief to healthier consumers, who overwhelmingly enroll in HMOs, is of paramount importance if the reinsurance program is to achieve its stated goal of stabilizing the Maryland individual market. As presently designed, the program directs over *one third* of reinsurance funds to premium relief for fewer than seven percent of the state individual market enrollment that chooses a PPO, while the remaining funds will provide significantly less rate relief to over 200,000 Marylanders enrolled in HMOs offered by both of the state's individual market carriers. This approach is sub-optimal for Maryland's individual market and produces an inequitable result for the vast majority of Maryland consumers.

MHBE's expert recognized this disparity in its own March 2018 analysis: "Some enrollees with Hierarchical Condition Categories (HCCs) will get compensated both for risk adjustment and reinsurance. The result could be very different profitability patterns within the market than currently exists, and the result could also vary depending on the chosen funding level and reinsurance parameters."[3]

Actuarial experts endorse the reinsurance-level adjustments for risk adjustment as sound policy. Milliman notes that "the current federal risk adjustment methodology does not account for payments from a state-based reinsurance program and can result in double compensation for high-risk members, both from the reinsurance program and from risk adjustment. This finding may be important to many other states considering reinsurance-like proposals under Section 1332 to help stabilize their markets. Specifically, if appropriate changes to risk-adjustment are not made, a reinsurance program could lead to pricing inefficiencies and distortions that negatively impact the market and could work against the goals of the reinsurance program overall."[4] Similarly, the American Academy of Actuaries has recommended against compensating insurers twice for the same risk.[5]

We do not believe including these adjustments will delay or compromise federal approval of Maryland's waiver. During a May 4, 2018 meeting with Kaiser Permanente, senior CMS career staff informed Kaiser Permanente that they did not foresee the inclusion of an element

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[3] Wakely Consulting Group. (March 15, 2018). *State of Maryland: Individual Market Stabilization – Reinsurance Analysis*, 7.
[4] Milliman. (August 2017). *Paring Risk Adjustment to Support State 1332 Waiver Activities*. Retrieved from http://www.milliman.com/insight/2017/Pairing-risk-adjustment-to-support-state-1332-waiver-activities/#.
[5] American Academy of Actuaries. (May 2017). *How Changes to Health Insurance Market Rules Would Affect Risk Adjustment*. Retrieved from http://www.actuary.org/content/how-changes-health-insurance-market-rules-would-affect-risk-adjustment.

accounting for federal risk adjustment payments to prevent carriers from receiving double compensation slowing their review of the waiver.

Maryland's program should not have the unintended effect of creating market distortions among products offered by the remaining two carriers in the individual market. The program design should promote stabilization and create a market that is more attractive to new entrants. We recommend that the waiver application specify that individual market plans that receive risk adjustment transfers will have those transfers "netted out" from claims on reinsurance funds.

MHBE Should Direct Wakely to Quantify Risk Adjustment Overlap.

While Kaiser Permanente believes the degree of overlap between risk adjustment payments and claims reimbursable through reinsurance is substantial, an actual estimate of the amount is unavailable without access to all carriers' claims data. Wakely Consulting Group, MHBE's retained actuary for purposes of this waiver, possesses the data necessary to quantify the overlap. We appreciate that MHBE has directed Wakely to project the overlap and inform stakeholders on the projection.

We ask that the analysis compare scenarios that would more evenly distribute reinsurance funding and avoid distorting the competitive balance in Maryland's individual insurance market. The analysis should also evaluate the impact of risk adjustment transfer reductions in 2020 on enrollment or affordability, should the state choose to exercise this authority.

We believe this analysis will be useful to regulators, MHBE and relevant stakeholders in the regulatory process for reinsurance program design.

MHBE Should Include Quality and Utilization Management Incentives.

As the United States moves towards value-based payment in health care, Maryland's reinsurance program should not move its individual market in the opposite direction. MHBE should include incentives in the reinsurance program aligned with the state's broader policy goals related to quality, cost-effectiveness and innovation. Incentives should reward quality in care delivery through strategies like payment multipliers for high clinical quality ratings in preventive care measures.

Integrated, managed care frequently outperforms PPO models in quality and cost-effectiveness. PPOs may be more expensive because of inefficiencies, such as ineffective care management, not just higher risk profiles. Maryland's reinsurance program should reward high-performing models and avoid compensating plans for inefficiencies.

In its final waiver application, MHBE should specify incentives for quality and cost-management. The CMS Checklist for Section 1332 State Innovation Waiver Applications requires states to address "whether the reinsurance program includes incentives for providers, enrollees, and plan issuers to continue managing health care cost and utilization for individuals

eligible for the described reinsurance (if any)."[6] A stated commitment in the application will strengthen the final application.

We recommend the state include multiplication factors in its design of reinsurance payments based on 1) third-party estimates of product and network cost-effectiveness and efficiency for each of Maryland's individual market products; and 2) achieving the highest ratings in clinical quality from the Maryland Health Care Commission's independent quality rating program. We believe this approach is consistent with the broader health policy goals of the MHBE.

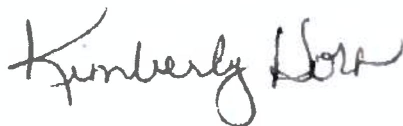
With regard to the network efficiency factor, in the attached letter, Milliman estimates that a well-managed HMO in the Maryland marketplace has a 27 percent advantage over the state's PPO. MHBE should allocate reinsurance program dollars to reward this efficiency.

Taken together, these recommendations would distribute the benefits of the Maryland Reinsurance program roughly equally to all Marylanders enrolled in HMOs. Those enrolled in the PPO would still benefit disproportionately, but to a lesser extent. Specifically, with these adjustments, HMO enrollees would see significantly reduced proposed 2019 rates close to the expected overall market reduction and PPO enrollees would see proposed 2019 rates cut roughly in half (rather than by a significant 95 percent if no adjustments for double payment, cost effectiveness and clinical quality are made).

* * *

Thank you for your time and consideration. Please do not hesitate to contact Laurie Kuiper, Senior Director of Government Relations, at 301-816-6480 or Laurie.Kuiper@KP.org, if you have any questions or require additional information.

Sincerely,



Kim K. Horn
President
Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.

[6] *See* https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/Checklist-for-Section-1332-State-Innovation-Waiver-Applications-5517-c.pdf.

650 California Street
21st Floor
San Francisco, CA 94108
USA

Tel +1 415 403 1333
Fax +1 415 403 1334

milliman.com

Via email only: Andrew.L.See@kp.org

May 18, 2018

Mr. Andrew L. See, FSA, MAAA
Vice President, Pricing
Kaiser Foundation Health Plan, Inc.
300 Lakeside Drive
Oakland, CA 94612

Re: Cost Benchmarks – Maryland

Dear Andrew,

At the request of Kaiser Foundation Health Plan ("Kaiser"), Milliman, Inc. ("Milliman") developed combined medical and pharmaceutical cost estimates for best-practices well-managed HMO networks and loosely-managed PPO networks in the state of Maryland. This letter provides the expected allowed cost differential of these networks and also describes the methodology and assumptions used in developing the cost estimates.

Consulting Services Agreement

This work was done under the terms of the Consulting Services Agreement between Milliman and Kaiser signed May 16, 2018.

Background

Kaiser desires our assistance in obtaining a comparison of expected combined medical and pharmaceutical costs for well-managed HMOs and loosely-managed PPOs in the state of Maryland.

Summary of Results

We developed illustrative combined medical and pharmaceutical cost models projecting the 2019 cost of care per member per month (PMPM) under each network assumption using the Milliman 2018 Commercial Health Cost Guidelines (HCGs)[1]. We used national standard demographics for the large-group market. The estimated allowed costs for a well-managed HMO is approximately 27% less than the costs for a loosely-managed PPO in the state of Maryland. **The cost projections used in estimating this differential represent a composite plan, network and medical management practices, not any specific plan, network or set of medical management practices.**

[1] The HCGs are a cooperative effort of all Milliman health actuaries and represent a combination of their experience, research and judgment. An extensive amount of data is used in developing the HCGs and that data is updated annually.

METHODOLOGY AND ASSUMPTIONS

To develop the cost estimates, we used the 2018 Milliman Commercial Health Cost Guidelines. The HCGs consider utilization and average charge levels for roughly 60 benefit categories. These models make provision, by type of service category, for benefit characteristics and cost-sharing such as copays, deductibles, coinsurance and out-of-pocket maximums. The model was adjusted for the following characteristics:

- Region: Maryland (Statewide)
- Product type: commercial HMO (well-managed) and PPO (loosely-managed)
- Network discounts: 60% Facility, 40% Professional

We used a single representative plan design for both the HMO and PPO plan, with no Out-of-Network component for the PPO plan, to determine the cost differences attributable solely to Degree of Health Management. The plan designs are shown in **Table 1**:

Table 1: Summary Plan Design:

Benefit	Cost Sharing
Deductible (Single/Family)	$1,500 / $3,000
Out-of-Pocket Maximum (Single/Family)	$3,500 / $6,000
Inpatient	$500/Day
Emergency Department	20%
Outpatient Surgery	20%
Preventive	$0
Primary Care Physician	$20
Specialist	$30
Other Medical Services	20%
Pharmacy:	
Generic	$10
Preferred Brand	$30
Non-Preferred Brand	$35
Specialty	20%

We applied trend to estimate claims incurred in 2019. We did not adjust for changes in morbidity or selection considerations.

VARIABILITY OF RESULTS

Differences between our estimates and actual amounts depend on the extent to which future experience conforms to the assumptions made for this analysis. It is almost certain that actual experience will not conform exactly to the assumptions used in this analysis. Actual amounts will differ from projected amounts to the extent that actual experience is better or worse than expected.

LIMITATIONS

It is our understanding that the information contained in this letter will be shared with the state of Maryland and may be utilized in a public document. Any distribution of the information should be in its entirety. Any user of the data must possess a certain level of expertise in actuarial science and healthcare modeling so as not to misinterpret the information presented.

Milliman makes no representations or warranties regarding the contents of this letter to third parties. Likewise, third parties are instructed that they are to place no reliance upon this report prepared for Kaiser Foundation Health Plan by Milliman that would result in the creation of any duty or liability under any theory of law by Milliman or its employees to third parties.

Data Reliance

For our analysis, we have relied on information provided to us by data contributors and vendors. We have not audited or verified this data. If the underlying data or information is inaccurate or incomplete, the results of our analysis may likewise be inaccurate or incomplete.

Professional Qualifications

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. The author of this letter, Susan E. Pantely, is a member of the American Academy of Actuaries, and meets the qualification standards for performing the analysis in this letter.

Sincerely,

Susan E. Pantely, FSA, MAAA
Principal and Consulting Actuary

Commenter: Tinna Quigley, Executive Director, Alliance of Maryland Dental Plans
Comment Received: Saturday, May 19, 2018
Comment:

May 20, 2018

Michelle Eberle
Executive Director
Maryland Health Benefit Exchange
750 East Pratt Street, 6th Floor
Baltimore, MD 21202

RE: Maryland 1332 Innovation Waiver Application

Dear Executive Director Eberle,

Thank you for the opportunity to provide input as the State prepares the 1332 Waiver Application. I am writing on behalf of the Alliance of Maryland Dental Plans to express the concerns of our member dental plan companies about the proposed reinsurance program.

Our members think that it is of paramount importance for the State to find a long-term, broad-based funding solution to address our current challenges with the health insurance markets in the State that create stability for funding, require all stakeholders to be a part of the solution, limit the impact on any one constituency, and minimize the cost to individual Marylanders who will ultimately carry the burden. We look forward to being actively engaged in the Maryland Health Insurance Coverage Protection Commission as it continues its work on this issue throughout the interim and are willing to serve on any workgroups and provide stakeholder input as the co-chairs deem appropriate.

Our members are committed to Maryland and are supportive of steps taken to stabilize the State's insurance markets. While we understand that the 2.75% assessment is a short-term fix, we are concerned that stand-alone dental plans are subject to the assessment in Senate Bill 387/House Bill 1782 despite the fact the dental plans will not see any benefit from the proposed reinsurance program.

We would respectfully inquire how the Maryland Health Benefit Exchange (MHBE), in conjunction with the Maryland Insurance Administration, plan to use reinsurance funds, if any, to enhance dental plans.

As the MHBE has used ample opportunity to promote the expanded take-up of dental coverage in promotion of the Exchange's value as an organization and as a pathway to better health for Marylanders, we think it is appropriate to continue to extend dental coverage in appropriate ways as we move forward in conjunction with a new reinsurance program framework. We would ask that if our

companies are subject to an assessment in which they will see no return, there be a continued commitment in which our companies would be presented with a landscape to thrive.

Please do not hesitate to contact me at 240-476-9308 or tquigley@fblaw.com should you have any questions or concerns. Members of the Alliance of Maryland Dental Plans greatly appreciate the consideration of our concerns.

Sincerely,

Tinna Quigley
Executive Director
Alliance of Maryland Dental Plans