State Reinsurance Program Regulations

Summary of Public Hearings and Comments

September 17, 2018

A service of Maryland Health Benefit Exchange

Public Hearings Process

- The Maryland Health Benefit Exchange held four public hearings to discuss the State Reinsurance Program ("SRP") regulations and receive the public's questions and testimony

- The public hearings were held in two locations to receive as much feedback as possible from the public on the following dates:
  - Hearing #1: July 26, 2018 (Office of the Maryland Health Benefit Exchange)
  - Hearing #2: August 2, 2018 (Office of the Maryland Health Benefit Exchange)
  - Hearing #3: August 9, 2018 (Maryland Department of Transportation)
  - Hearing #4: August 16, 2018 (Office of the Maryland Health Benefit Exchange)

- MHBE designated topics to be discussed at each hearing in order to organize and facilitate discussion

- In total, approximately 30 members of the public attended these hearings, many of whom also provided testimony and 8 respondents submitted written testimony regarding the SRP regulations

- The public comment period drew responses from a diverse group of people, including carriers, professional organizations, advocacy organizations, and consumers

Hearing #1 Agenda

- Hearing #1: Administration & Priorities
  - Administration
    - As the administering agency for the SRP, how can MHBE minimize the burden of administering the SRP on issuers?
    - Assuming claims data is collected through the EDGE Server, what issues might arise from using this data source?
    - What other options are available if the EDGE server cannot be leveraged for the SRP?
  - Priorities
    - What priorities/objectives should be addressed by the State Reinsurance Program?

Hearing #1 Testimony

- Testimony was provided by:
  - Stephanie Klapper, Authorized Producer
  - Trina Palmore, Maryland Citizens' Health Initiative
  - Beth Sammis, Consumer Health First
  - Debbie Rivkin, CareFirst BlueCross BlueShield
  - Bill Wehrle, Kaiser Permanente
- Administration
  - Kaiser Permanente and CareFirst both request that MHBE leverage the EDGE server for the SRP
  - Kaiser and CareFirst also both agree that the All-Payer Claims Database is not a feasible option because it would have to be customized for the purpose of the SRP
- Priorities
  - A majority of respondents believe that lower premiums are a main priority of the SRP
  - Kaiser Permanente emphasized stabilization of the market and focusing on the marginal buyer.
- General Comments
  - Kaiser Permanente and Consumer Health First expressed concern about the interaction between risk adjustment and reinsurance
  - CareFirst emphasized the importance of using the SRP to lower rates and looking at long-term solutions separately from the SRP
  - The Maryland Citizens' Health Initiatives asked MHBE to consider long-term solutions to stabilize premiums

Hearing #2 Agenda

- Hearing #2: Risk Adjustment/Reinsurance Interaction & Incentive Funding
  - Federal Risk Adjustment Program / State Reinsurance Program (SRP) Interaction
    - What objectives should modifications to payments from the SRP accomplish when taken to account for interaction with the federal risk adjustment program?
  - Incentive Funding
    - How should incentive funding be determined from the State Reinsurance Program allocation?
    - Should a set amount be separated from the initial allocation?
    - Should incentives be funded through any remaining reinsurance allocation?
    - How might incentive payments be incorporated into issuer rate requests?

Hearing #2 Testimony

- Testimony was provided by:
  - Jon Kunkle, Kaiser Permanente
  - Debbie Rivkin, CareFirst BlueCross BlueShield
  - David Stewart, AHEC West
  - Beth Sammis, Consumer Health First*
- Interaction of reinsurance and risk adjustment
  - Kaiser Permanente supports the Wakely method as the best way to reduce premium for the most members without disrupting the competitive landscape for carriers
  - Kaiser Permanente thinks it is important to remove the entire interaction between RI and RA, to do otherwise would be to subsidize PPO plans
  - Carefirst supports the MIA method and believes it will remove the RI/RA interaction
  - Carefirst supports trying to equalize medical loss ratios (MLRs) across claims tiers or between carriers
  - Consumer Health First supports the Wakely method

** Testimony offered on August 16. Could not attend the August 2 session.*

Hearing #2 Testimony

- Using state reinsurance dollars to fund incentive programs
  - AHEC West believes any incentive program should address social determinants of health
  - Carefirst contends that the reinsurance program, as designed, has incentives built in, there is no need to add more
  - Carefirst believes that reinsurance is an inappropriate vehicle for broader incentives around utilization, efficiency, and quality
    - Reinsurance is focused on high-risk, sick members while incentives should be based on all members regardless of health status
  - Kaiser Permanente supports utilizing a portion of reinsurance funds for incentives, provided that all market participants have identical targets
  - Kaiser Permanente believes incentives should be included in 2019
  - Kaiser Permanente would project their performance against incentive targets and build expected incentive payments into their premium rates
  - Consumer Health First believes that, if the entire RA/RI interaction is removed, there is no need for incentives

Hearing #3 Agenda

- Hearing #3: Incentives I: Utilization Management & Quality Improvement
  - Existing Incentives
    - What incentives currently exist for issuers to better manage high risk enrollees? What demonstrated effectiveness have they achieved?
    - How might existing incentives be included in the State Reinsurance Program?
  - Utilization Management
    - How could the State Reinsurance Program best measure issuer utilization management performance?
    - What methodology would be appropriate to measure performance?
    - Should network type/network management factor into utilization management performance?
  - Quality Improvement
    - How could the State Reinsurance Program best measure improvement on clinical efficiency, plan administration, and enrollee experience indicators?
    - Which indicators should be measured?
  - Disincentives
    - Should MHBE contemplate the use of modifiers to reduce program payments for underperformance on incentive measures?
  - Other Utilization Management/Quality Improvement Incentives

Hearing #3 Testimony

- Testimony was provided by:
  - Debbie Rivkin and Jennifer Baldwin, CareFirst BlueCross BlueShield
  - Wayne Wilson, Kaiser Permanente
  - David Stewart, AHEC West
  - Barbra Banks-Wiggins, Prince George's Health Care Alliance
- Existing incentives
  - CareFirst has the Patient Centered Medical Home (PCMH) program which provides care coordination for high-risk, high-claim members
    - The program applies to all members across all markets and products
    - Physicians are given financial incentives to participate in the program and receive a portion of the costs savings
    - The PCMH program has been successful in reducing costs and hospitalizations

Hearing #3 Testimony

- Inclusion of incentives in reinsurance program
  - CareFirst strongly believes that all reinsurance funds should only be used for reinsurance and should not be used for incentives
    - CareFirst already has several programs such as the PCMH program that manages the care of high-risk members
  - Kaiser Permanente believes that the SRP should be designed to incentivize the individual market to manage care because incentives are needed to further drive down costs
  - Kaiser Permanente recommends a simple funding mechanism such as an annual percentage that is allotted to the incentive program
    - If an insurer achieves the performance goal then the incentive payment would be a multiplier that would apply retroactively

Hearing #3 Testimony

- Other topics
  - Two advocates recommended that social determinants of health be taken into consideration
  - Prince George's Health Care Alliance recommended that the SRP or another state program should focus on reimbursing providers who address social determinants of health
    - Community health workers provide an important service by connecting with individuals in their homes and helping them access care but are currently not able to receive reimbursement from insurers

Hearing #4 Agenda

- Hearing #4: Incentives II: Value Based Performance Measures - Chronic Diseases & Population Health
  - Chronic Disease
    - How can the State Reinsurance Program be leveraged to address the utilization management of high claims chronic diseases?
    - Which diseases might be included for such measures?
    - Which methodology should be utilized to select included diseases?
    - Which metrics should be utilized to measure performance on chronic disease management?
  - Population Health
    - How can the State Reinsurance Program be leveraged to expand access to health care for under-served populations?
    - How can the State Reinsurance Program be leveraged to expand preventive care to their enrolled populations?
    - Which metrics should be utilized to measure performance on preventive care/wellness?
  - Other Value Based Performance Measures for Chronic Diseases/Population Health
  - Value-Based Benefit Design

Hearing #4 Testimony

- Testimony was provided by:
  - Beth Sammis and Leni Preston, Consumer Health First
  - Maansi Raswant, Maryland Hospital Association
  - Debbie Rivkin, CareFirst BlueCross BlueShield
  - Dourakine Rosarion, Montgomery County Department of Health
  - Stacey Shapiro and Bill Wehrle, Kaiser Permanente
- Chronic Disease and Population Health
  - Kaiser Permanente and CareFirst both spoke to how they engage and manage their members and address chronic disease and population health
  - Kaiser Permanente suggested focusing on conditions with higher prevalence among Marylanders or conditions that tend to have a higher rate of inpatient utilization and suggested HEDIS, CAHPS, and the QRS as metrics to measure performance
  - CareFirst does not believe it is appropriate to address these issues through the SRP but believes that these issues should be addressed in all markets, not just in the individual market
  - Consumer Health First cited the model of the Oregon Health Authority for outcome, quality, and equity measures
  - The Maryland Hospital Association believes that the addition of care management incentives are important for long-term stability and provide the opportunity to align coverage and delivery
  - Ms. Rosarion highlighted community agencies as potential partners to manage and engage individuals in their care

Hearing #4 Testimony

- Value-Based Benefit Design
  - Kaiser Permanente and CareFirst both spoke to how their organizations implement value-based benefit design
  - Consumer Health First emphasized the importance of stratified data and that value-based benefit design must be based on evidence of improved outcomes with a publicly available, independent assessment with information on plans comprehensible to all consumers
- General Comments
  - Consumer Health First also emphasized alignment across all healthcare initiatives
  - Ms. Rosarion spoke to the affordability issues that she sees individuals experience when deciding to take-up coverage or not

Written Comments

- Written comments provided by:
  - Associated Charities / County United Way (Allegany/Garrett) / Worcester Youth and Family Counseling Services*
  - Caroline County Health Department
  - Kaiser Permanente
  - MedChi
  - A private citizen
- Opposed to incentives funded by reinsurance dollars
  - Associated Charities, et al., Caroline County Health Department
  - Strongly oppose incentives or use of RI funds for anything other than directly and maximally reducing premium rates
- Supports incentives funded by reinsurance dollars
  - Kaiser Permanente, MedChi
- Need for additional carriers in Maryland
  - Private citizen, MedChi

**These organizations submitted identical comments.*