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Maryland 1332 Waiver Hearing

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."

<u>Closing</u>

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.

<u>Participants</u>

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