750 EAST PRATT STREET, 6TH FLOOR
BALTIMORE, MD 21202
marylandhbe.com

MARYLAND HEALTH BENEFIT EXCHANGE

Maryland State Reinsurance Program Regulations Hearing

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

Supplemental Comments

Following the July 26th Public Hearing, CareFirst provided additional written comments in response to questions asked by Michele Eberle. MHBE has included these additional comments, provided below, in the public record.

At the MHBE Hearing –Administration & Priorities on July 26th, you asked me [two] questions while I was testifying. Below are CareFirst's responses which we would like to be part of the record as part of my testimony.

1. You asked whether CareFirst thought that rates should be brought down by the State Reinsurance Program the same percentage for the HMO and PPOs offering coverage in the individual market or whether the percentage of rate reduction should be different for HMO and PPO rates.

Our first, and strongest, recommendation is to have a purely claims based reinsurance program, so that each entity would reflect its own risk in its population. The rate impact of the program would vary depending on the illness in the population. If the state wants to address the interaction of risk adjustment and reinsurance, we believe the best way to do so is to take the percentage dampening factor that MIA estimated – 83.4% - and use that percentage to vary the amount of reinsurance received.

2. You asked whether CareFirst believes that $20,000 is the appropriate attachment point to reflect what an actual "high claims individual" would be.

CareFirst strongly believes the goal of the attachment point, cap and coinsurance level should be to actuarially support the use of every available dollar in the State Reinsurance Program over the next two years to reduce all rates based upon each carrier's claims profile. The singular goal should be to exert downward pressure on premiums for as many members as possible in an effort to stabilize the individual market. The only exception to this use of dollars would be to adjust for the interaction of RA and RI, which does not impact the attachment point. We believe the $20,000 attachment point represents Wakely's best estimate of how to most effectively and efficiently use the available dollars in the State Reinsurance Program. The attachment point of $20,000 should not be changed to divert money for any other purpose other than reinsurance. We believe that the specific combination of the $20,000 attachment point, 80% coinsurance level and $250,000 cap are the appropriate levels to ensure that the available reinsurance dollars will maximize the reduction in premium for members in the individual market throughout the state in both HMO and PPO plans.