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

MARYLAND HEALTH BENEFIT EXCHANGE

Maryland State Reinsurance Program Regulations Hearing

August 2, 2018
Maryland Health Benefit Exchange
750 E. Pratt Street, 6th Floor
Baltimore, MD 21202

Welcome & Introductions

John-Pierre Cardenas, Director of Policy and Plan Management of the Maryland Health Benefit Exchange (MHBE), welcomed the public to the hearing and introduced himself. He acknowledged the presence of Delegate Bonnie Cullison; Michele Eberle, Executive Director of the MHBE; Secretary Neall of the Maryland Department of Health (MDH) and Chair of the MHBE Board of Trustees (the Board); and staff from the Maryland Insurance Administration (MIA).

Reinsurance Program Regulations Overview

Mr. Cardenas stated that, in its July meeting, the Board was given insight into an analysis of the interaction between the existing federal risk adjustment program and the proposed state reinsurance program. Enrollees whose claims reached the reinsurance threshold could lead to an overpayment to the carrier due to the overlap between the two programs. The Board instructed MHBE staff to address that overlap through the regulatory process for the state reinsurance program.

Mr. Cardenas presented two topics for the hearing. First, he asked for testimony regarding the overlap between the risk adjustment and reinsurance programs. The second topic would be the use of incentive funding through the reinsurance program.

Regarding the first topic, Mr. Cardenas requested stakeholders to provide input on several questions regarding the objectives that modifications to reinsurance payments should accomplish, when accounting for the interaction with the federal risk adjustment program.

- Should this interaction target the lowest premiums possible?
- Should this equalize medical loss ratios (MLRs) across issuers?
- Should it remove all risk adjustment and reinsurance interaction?
- What other objectives should this action accomplish, if any?

Regarding the second topic, Mr. Cardenas noted that the MHBE is projected to receive $462 million in pass-through tax credits in 2019 to fund the state reinsurance program. The MHBE received some stakeholder feedback that incentives should be a part of the program. Mr. Cardenas cautioned that, given the limited time in which to make adjustments, any incentive payment structure would apply only to the 2020 reinsurance program. He asked stakeholders to address several questions on this topic.

- How should incentive funding be determined for the state reinsurance program allocation?
- Should a set amount be sequestered from the allocation at the outset in order to fund the incentives?
- Should incentives be funded through any remaining surplus reinsurance funds?
- How might incentives be incorporated into issuer rate requests?

Public Testimony

Mr. Cardenas then invited any attendee who so desired to offer their testimony for the record on the topic of the interaction between risk adjustment and reinsurance. Three individuals offered testimony.

Jon Kunkle, Chief Financial Officer, Kaiser Permanente of the Mid-Atlantic States, offered the following testimony:

"Good afternoon. I am Jon Kunkle. I am the CFO of Kaiser Permanente of the Mid-Atlantic States. I appreciate the opportunity to testify today. I want to thank the MHBE Board and staff and the MIA for holding this hearing for the reinsurance program and for all of the hard work in developing an approach to stabilize the individual market in Maryland. I want to specifically thank Todd Switzer, who has helped us through this very complex topic, mainly through his interactions has been incredibly transparent with us and very responsive. So, as we think about the best way to recommend a structure for the program to benefit all Marylanders, I want to thank Todd specifically for what he did for the carriers.

But first, so, addressing this program, months ago you noted that we've come a long way. We believe that, before the Board took this action to look at this dynamic, it created a very perverse outcome in terms of altering the competitive dynamic. Of that $460 million, without looking at interaction, we believe that Kaiser would receive approximately $50 of the $460 million, which would mean that our rates would only come down by a somewhat immaterial amount compared to the overall 30 percent that we are targeting, which would create a very different competitive environment than we have today. We don't believe that that is the intent of this new regulation.

We do believe that a payment should account for the entire overlap as identified by the Wakely analysis that we all participated in, and that this should occur from the inception of the program in 2019. We believe that this is the best way to benefit all Marylanders and will optimize the market stabilization effect of the reinsurance program. We believe that adjusting for only a portion of the specified amount would provide a significant financial benefit to one carrier over the other, would alter the competitive dynamic of the market, and would also create the unintended consequence of subsidizing an unmanaged PPO product versus the well-managed HMO products that both carriers have in the market. With the ultimate goal of the SRP is to distribute funds in a way that is most balanced between the two carriers and does not alter the existing competitive dynamic, we do believe that the appropriate approach would be to utilize the Wakely methodology.

To the questions that you asked at the outset of the meeting, we believe that the lowest premiums possible should be a key motivation as you decide on how you want to implement this, and we believe that removing the full interaction between risk adjustment and reinsurance should be targeted."

Mr. Cardenas noted that the Wakely analysis showed that carriers would experience a lower medical loss ratio on enrollees in lower claims quartiles, meaning that healthier members would be more profitable. He asked Mr. Kunkle to comment on whether such an environment would incentivize carriers to "cherry pick" healthier enrollees, similar to how the market operated before the Affordable Care Act (ACA) and whether guaranteed issue and community rating are sufficient to protections against cherry picking.

Mr. Kunkle responded.

"We believe so—that, with the Affordable Care Act, because of the community rating and guaranteed issue, that there really isn't an approach that a carrier could take to cherry pick in either direction if this was structured such that more acute members were more, quote, profitable. We also don't believe, in that direction, that you could necessarily attract new membership. We think the ACA has kind of removed that incentive, very appropriately, and that neither carrier could really react in a way to target this. The fact the Wakely methodology does tilt slightly in that direction we also think is beneficial because that creates the incentive for all of us to manage the costs and try to target not relying on the backstops of reinsurance and risk adjustment and try to actually pull down the costs of the public pool of members in total. So, if you were to see—it will be impossible to get this perfect, we believe—if you were to see a shift in one direction, then that is where the Maryland regulatory authority would want to see the shift directed."

Mr. Cardenas, noting that the overarching goal of the state reinsurance program is to lower premiums and, thereby, improve the morbidity of the marketplace by getting healthier people in, asked which of the two approaches, either the Wakely or the MIA approach, would achieve the goal most effectively.

Mr. Kunkle responded.

> *"As we look at it, we believe the Wakely approach would reflect the full interaction and that, as you look at the impacts by the carriers, and you brought it to all the carriers, and that creates the least disturbance in the existing competitive dynamic. If the goal is, like you say, rates to come down by 30 percent, we believe the Wakely analysis will come closest to accomplishing that across all carriers. We think it would be unfortunate if we chose an analysis that would direct more membership toward one carrier over another simply because of this program. That's for us to work through in the competitive environment. We think, you know, we completely support the concept of bringing stuff down. We would just like to see them come down as close to uniformly as possible. We believe the Wakely methodology would best approximate that."*

Ms. Eberle asked how the premium relief for Kaiser Permanente's 74,000 members would differ under the two approaches.

Mr. Kunkle responded.

> *"In the initial approach if, of course, you do nothing to it and all just overlap, we think it will be somewhere in the low double digits. Ten percent is a number that we have come up with that I think will probably be somewhat higher than that, but significantly lower than the 30 percent we were targeting for. We believe that, with the MIA approach, that it would be lower 20s vs. the overall 30. We think in the Wakely approach ,we will be just over 30 percent. So, I think between those two—if we're just talking about debating the two approaches, we think there would be about ten points of difference."*

Mr. Cardenas asked for Kaiser Permanente's share of the market.

Mr. Kunkle responded.

> *"So, on-exchange, we have about 46 percent of the market, and if you extend it to the overall individual market, it's a much smaller presence off-exchange, so I think it comes out in the mid-thirties."*

Mr. Cardenas asked for Kaiser Permanente's projected enrollment increase as a result of the waiver and resulting regulations.

Mr. Kunkle responded.

> *"We think, with the Wakely approach, that we'll be able to maintain the share we're at, or maybe potentially… We think that would have a very small impact on that market share. We think that what I call the MIA approach could potentially have us lose share, and we were very, very concerned that, if we did nothing here, that we would lose a significant amount of share, you know, to the point that we would have a very… barely ability to function in the program. Because, again, if our rates only come down by, we'll call it 10 points, now, which will balance the 30s, you would see a significant shift of members from Kaiser to the rest of the market."*

Mr. Cardenas asked how many members would migrate to Kaiser Permanente due to price and how such migration might affect risk adjustment.

Mr. Kunkle responded.

> *"So, we don't think there would be a big migration from the existing carriers to KP because of this. It doesn't really alter the competitive dynamic. Those that were—that chose carriers, including KP, today, we think would continue to make that decision if there's nothing to change the landscape. What we're hopeful about is that all carriers have seen healthier enrollees than the year before. We're hoping that, with the rates coming down, that some of those that decided it became too expensive, when that price point actually comes down for them, they rejoin. And, we don't believe they rejoin disproportionately to the existing*

market share… just will react to the market in a simpler fashion."

Mr. Cardenas asked to what extent the impact of the reinsurance program would offset the attrition from losing the individual mandate.

Mr. Kunkle responded.

> *"I don't have modeling handy for this, but we believe that the mandate was a relatively small impact—that, you know, many members were—especially on-exchange—were given incentive, so the subsidies they received were so strong that that kept them in the market. So, in our rates we reflected an impact from losing the mandate that some of, the very healthy members that were in, because this is law, like, we follow the law, that you would lose them, but possibly the rates coming down is a bigger driver of consumers' decisions than the mandate as it was produced and enforced."*

Mr. Cardenas asked under which approach the morbidity of the Kaiser Permanente membership would be most improved.

Mr. Kunkle responded.

> *"We believe that the approach where we did not take into account the interaction is where KP would see a material change in our morbidity. Probably the competitive dynamic would change that roughly among those that stay with KP who heavily utilize the system that did not want to change their care delivery. Between the two approaches, I'm not sure I believe that there will be a material change in our morbidity. We pay a very significant amount; about 30 percent of our premium today is for the risk adjustment program. As we model this, we don't necessarily believe that will shift dramatically either way this plays out."*

Deb Rivkin, Vice President Government Affairs, CareFirst BlueCross BlueShield offered the following testimony:

> *"Let me start off by saying I am Debbie Rivkin, Vice President of Government Affairs for CareFirst, and the reason why that's important is because I am not an actuary, nor am I the Chief Financial Officer of our company. I just want everyone to understand that. If you ask me questions, I may tell you I will get you an answer back, but I'm not prepared today to answer that question. So, what I do want to say, and I just want to level-set in the beginning, because it's so important for anyone who is listening to this, be it on the phone or behind me in this room or who read this on the website and they see the notes. It's really important to remember why the state is requesting a 1332 waiver at all. Because I think that remains important as we move forward.*
>
> *So, as your application for the 1332 waiver stated, without further stabilization efforts, premiums are expected to continue to increase at an unsustainable rate, raising concerns about the future viability of the market, a loss of access to coverage for consumers, and potential downstream implications for Maryland's hospital all-payer model. These are huge consequences if we don't stabilize the market. The Governor, in his letter attached to the 1332 application noted, and I quote this, 'Since the implementation of the ACA* [sic]*, rates on the individual market in Maryland have risen by an,' and I quote, 'an outrageous and unsustainable 166 percent, and are set to increase by over 200 percent without action. Unless decisive and corrective action is taken, we anticipate that these rates will continue to rise to unaffordable levels.'*
>
> *What the state decided to do, which we 100 percent supported as you know, was to implement a short-term, targeted reinsurance program with the goal, and its only goal, is to stabilize rates in the individual market. So, I think it's also important to remember that, while we will hopefully be receiving approval of the application, we will be getting two pots of money—the federal portion, as well as state funds. The state funds are only available for one year. Legislation only allows the HIF funding for next year, so we're going to lose, unless we find another funding source, a pot of money. So, we really believe that using the money we have today for 2019, we have to be mindful and intentional on how we use that money, because we only*

have one real shot right now to stabilize the market, and if we can start getting those rates down, then we can start looking at other things. There's stage one and stage two, and I think you've heard CareFirst say that from the beginning of testimony, actually before the session started. You have a short-term solution and you have a long-term solution. The short-term solution is throwing money at this problem to try to stabilize the market. And how you do that is through a reinsurance mechanism for high-risk enrollees, pulling that amount of risk out of the process, which will then pull down the rates for as many people as possible. So, I just think it is imperative that we remember why we did this in the first place. That the goal is to maximize the positive impact of the reinsurance program. With that backdrop, I'll try to answer some of the questions that you have posed.

So, I won't go into the second one now; we'll just talk about the first part. So, you asked what the objective should be in terms of the two programs' interaction—the reinsurance program and risk adjustment program, and which is preferable. So, to CareFirst, there is only one answer, and I think it's pretty obvious from what I just said. There's one objective that the state should be focusing on and that is that we should stabilize the market, targeting the lowest premiums possible for each plan offering coverage in the individual market. That has to be the most important and only purpose of reinsurance. It is the purpose of reinsurance. If you start looking at anything else, we think that is not using the money to its highest and best use. To date, CMS has approved five waiver applications, so we can't wait to be number six. We are hoping that will be quickly. But, every state's application has requested using 100 percent of those reinsurance dollars to immediately and directly reduce rates, and they asked for no other purposes. We think that our application should be consistent with that as well. We do not believe that an objective should be to equalize the medical loss ratio across insurers in phase one. It is not the purpose of reinsurance. And it is not appropriate in trying to take into account an overlap in payments for risk adjustment.

Now, you also asked whether an objective should be to remove all risk adjustment/reinsurance interaction. If the state does choose to go forward in that direction, we believe that the Insurance Administration's analysis, through their Office of the Actuary, actually removes the interaction. That's what the Insurance Commissioner should say. We believe that their analysis will remove the interaction, or the overlap, between risk adjustment and reinsurance, and we think that their proposal is thoughtful, balanced, and fair. They did an incredible analysis. As you just heard before me, there was a lot of conversation between the two carriers. We spent a lot of time looking at this. I think if you review their report, you will see that they carefully lay out why they think the Wakely analysis, the Wakely model, is not appropriate for the two carriers. So, I think, at the end of the day, the MIA, in their analysis, does take into account the interaction, and so you will have met your objective from what you have heard from advocates to take out any interaction between the two programs, and the Wakely method overstates that overlap. So we support the MIA's proposal."

Ms. Eberle asked Ms. Rivkin why her organization's CFO or actuarial staff were not present to give testimony.

Ms. Rivkin responded.

"Number one because our position is consistent with the Insurance Administration, so we 100 percent agree with that position. How they laid out the proposal, I can carry the message. We fully support the Insurance Administration."

Ms. Eberle stated that CareFirst's actuary noted in a recent rate hearing that the proposed increase in premium is the lowest of any they have filed under the ACA, and that such news, along with good outcomes in Pennsylvania and North Carolina, seems to indicate an overall downward trend.

Ms. Rivkin responded.

"May I respond to that for a second? Because I think it's important. While it's fantastic that the rate increase of 18.5 percent is less than we have ever had before. What was spoken about, I think, across the board in the legislature and others was that last year's rates were unsustainable, and if you look at the

marketplace, there have been a lot of people who dropped from 2016 to 2017. And I am not sure if the Insurance Administration numbers have gone out, but there has been more droppage from 2017 to 2018. So, rates that have been set last year, what we're saying is that while it's great that the increase is less, the rates are still at an unsustainable level. So, I just want to make sure that that's clear. I'm thrilled that they… it's not that the rates are going down, the increase is not as steep."

Ms. Eberle asked how CareFirst intends to reduce morbidity by reducing premium on its PPO product.

Ms. Rivkin responded.

"So, clearly—yes, I will take that back to get a full answer for you, but I don't think anyone has an expectation that the PPO rates will go down to the level of the HMO rates. They will still be more expensive, but maybe more affordable than today. You have got to remember that people purchase the PPO for a reason; they are sicker than the HMO. They want to be in the PPO product, and we offer the only one. By definition, it's been adversely selected leading it to be more expensive."

Ms. Eberle asked whether reducing the premium on the PPO product will allow the morbidity of that pool to increase.

Ms. Rivkin responded.

"That I can't answer for you. I would rather ask that question back at the office."

Mr. Cardenas asked for Ms. Rivkin's thoughts on the differences between the Wakely-recommended 36 percent dampening of risk adjustment versus the MIA's proposal of a 16.5 percent dampening, given that the MIA proposal would leave some overpayment in the system, and whether guaranteed issue and community rating are sufficient structures to prevent issuers from seeking out high risk enrollees in order to take advantage of overpayments.

Ms. Rivkin responded. 37:30

"I think it is two different things. I will tell you that, if you look at the population, guaranteed issue has not… The reason we have risk adjusters in the first place that started when the ACA began was because the government knew, they created the 3Rs, because of the fact that it's guaranteed issue. So, guaranteed issue does not create that balance. If it did, we wouldn't need risk adjusters. Risk adjustment is based on the assumption that healthier risks would migrate one way and sick persons somewhere else. And that bears out because, for example, Kaiser Permanente pays CareFirst millions of dollars in risk adjustment."

Mr. Cardenas, noting that the proposed reinsurance plan would have carriers receiving an overpayment for enrollees with more than $20,000 in claims, asked whether CareFirst would have an incentive to enroll sicker people in order to secure that overpayment.

Ms. Rivkin responded.

"I just want to remind everybody we have lost over 500 million dollars on this individual market since the beginning of the ACA. The amount of money that we would get to attract sicker people will never, ever be a reason to try to get our… those losses… improve our line. That is the exact opposite. And I think if… The way I read what the Office of the Actuary wrote, while they agree that there may be a slight difference across the board, the Wakely method created more imbalances in different categories in which they thought were creating more unintended consequences than the slight overpayment. Categorically it will not cause any influence in any possible way for us to attract sicker members."

Mr. Cardenas asked, given the state's responsibility for good stewardship of the federal money in the program, asked to what degree overpayments are an efficient utilization of those funds.

Ms. Rivkin responded.

> *"I'm saying there is no overpayment. I think we believe there will be no overpayment under the Insurance Administration's analysis, the overlap has been taken care of—has been dampened to the point that it is not an issue at all."*

Mr. Cardenas stated that the MHBE thinks they have a responsibility to be good stewards.

Ms. Rivkin responded.

> *"If I may, I'd like to remind everyone again that no other state has looked at this. They felt, and I didn't actually write this, but I believe that they are using all reinsurance dollars that they will be getting from the federal government for the 1332 waiver specifically for reinsurance without looking at risk adjusters. They all believe that they are being good stewards of the money with the goal of getting rates down, as was the federal reinsurance program that was from 2014 to 2016 that did not look as the interaction as well, and it never did anything to change that. I don't believe the federal government would say they were not being good stewards of their own money. And the federal government would not be giving those five states money if they were not being good stewards."*

Mr. Cardenas noted that the characteristics of the Maryland program, including its size and proposed attachment point, make it quite different from programs in other states.

Ms. Rivkin responded.

> *"We take the position that every other state has used zero for their number of the interaction between the two. The Insurance Administration—we think their analysis was balanced and we believe that we can fully support that to try to take out that interaction that we feel is the best steward of this money. We fully support their position, and we think it is the most balanced.*

Ms. Eberle noted that the MIA analysis indicated that overpayments under their model would still occur for claimants in both the fourth quartile and in the reinsurance group.

Ms. Rivkin responded.

> *"But they believe they got rid of that. Their analysis was more appropriate because, I think it was the first quartile and there was a lot of—too much money in those in the Wakely method and they felt that that was completely imbalanced and this was more appropriate. We think the Insurance Administration analysis is the appropriate way to deal with the level of overlap."*

Ms. Eberle asked whether she was correct that guaranteed issue does not affect selection whereas plan design does.

Ms. Rivkin responded.

> *"So, what I was trying to say is PPOs in the individual market have attracted sicker members. So, that plan design, the PPO, has attracted sicker members. And it's that they had the opportunity to purchase an HMO, and they chose the PPO, and we find that those members are sicker. So guaranteed issue did not neutralize that. I do believe that network has an impact that has nothing to do with guaranteed issue. Our network is statewide. Kaiser's model, which is a great model, is not statewide. And so, if you want to pick your doctor, our plan design will cause people to come to us. If you are more comfortable going to a closed model HMO, you have that option. But because we have different products in the marketplace, different networks, statewide hospitals—we have every hospital, they do not by design—that's what causes people to choose, not guaranteed issue.*

Ms. Eberle asked whether risk adjustment helped offset losses for CareFirst and how much premium relief CareFirst

expects will accrue to both their products.

Ms. Rivkin responded.

> *"I will have to double check on that and get back to you."*

Mr. Cardenas thanked those who testified on the risk adjustment/reinsurance interaction topic and announced the beginning of testimony on the incentive payment discussion.

David Stewart of AHEC West offered the following testimony.

> *"I'm David Stuart of the Maryland Area Health Education Center West, more easily described as AHEC West. I serve as the Program Director for the Connector entity. And I think… this is just going to be, like, a reference point… I found this discussion we just had really interesting, and, you know, my main goal is to talk about social determinants and social risk factors. I don't have a formula or something like that, but when we deal with all these huge issues, it's easy to lose sight of the fact that we don't all start from the same place. Income, while a very important part of social determinants of health, everyone in this room is familiar with the correlation between poor health and what is going on in your life. Income is just one factor; it matters where you live. City and rural are very different from suburban areas. It doesn't matter how much money you have. It matters who you love and the language you speak. It matters how able we are, how old we are. It matters whether we were born here in this country or somewhere else. And the kind of data that determines formulas that creates risk adjustments and reinsurance programs is very aggregate, and it doesn't look at where people actually come from. What I am advocating for, and what I'm asking you for is that these social factors be a part of the discussion. I don't know whether they're part of the solution for this year or even next year, but given the relationship between social risks and health, if we really want to lower costs of health care, we have to have a healthier population. And the only way to have a healthier population is to tackle these issues.*
>
> *Where I'm from, we only have CareFirst. We don't have Kaiser Permanente. I know they're losing money in my area. Cumberland was recently described as the sickest city in Maryland by a website called 24-7 Wall St. Cumberland continually shows up in the top ten worst cities in the country for its size. We have the second-lowest-cost housing market in the country, so when you're talking about social determinants, they are all there. I see it every day on my job. I've seen the social determinants come in. They way I've described it is, the Affordable Care Act has one main thing to it. It adjusts for income. But also it's like giving everyone a car but skipping the driver's ed part. So, I would like to see built into whatever the people in this room come up with represent a larger scope. That we start tackling some of these issues head on and be included in the process somewhere that makes sense.*
>
> *I would love to see incentives that encourage broader networks, particularly broader behavioral health networks. In Allegany County, somewhere between 1 in 5 and 1 in 4 babies are born drug-affected. That's a lot. And it's not moving in the right direction. Last year it was 1 in 5. Now it's somewhere in between. Deaths are going down, but overdoses are still going up. When we talk about these kinds of things, I don't think we can leave it out.*
>
> *I did put in the record—I sent an email that I hope it's in there—there were two things that I read. One was from the National Academies Press is a thing that was based on the Medicare system, and it's called 'Accounting for Social Risk Factors in Medicare Payment.' You can say, 'It's Medicare," but, honestly, I—as I read it, I could apply everything to risk adjustment and reinsurance. They really tackle the issues. The other one was Families USA recently did a publication called, 'Framework for Enhancing Health Equity." What was interesting to me was that they pointed out that there was a couple things that really work to tackle these things. I don't know how you make an incentive that encourages the community health workers that come into Maryland. But you read about community health workers and how they help with non-clinical indicators. But, what the health system can't do right now is it can't go home with patients. Community health workers can visit home. We get very—we have people, like, that have come to us as*

navigators because they trust us. Because, year five or six, they still don't understand exactly what they have. They haven't completed their driver's ed. Um, and I just want to give a couple of examples, and I don't want people to think that I'm promoting community health workers because AHEC trains community health workers and we employ community health workers, which, honestly, we do that because it's right. It's not our job. We don't want to be a long-term community health worker agency. We want other people to take it on. We want community health workers embedded in private provider practices. We want them in the community where they can do the most good. We have grants that are not sustainable for the past three or four years that get great results. I would just like to get some of those kinds of things in this room in front of these people.

So, I will tell you about a guy named Richard. He's 72 years old. He's on both Medicaid and Medicare. In my region, and I bet this is true in the QHP market across the state, the line between Medicaid and QHPs is very thin and there's always this back-and-forth, back-and-forth… There are a lot of people in the QHP pool who need community health workers, who need peer recovery specialists. And, I was telling folks today that we're seeing this bump in the minimum wage law–something happened… I wasn't tracking it. All of sudden, the Washington County Health Department and the navigators of the Allegany County Health Department saw these people get a raise as the minimum wage went up, now are no longer eligible for Medicaid. These are people that are coming right into the QHP system, who had been on Medicaid their whole lives. They do not understand the health care that they are now in. So, I think that there—and right now, the only people who can get the services of a community health worker are typically people who are on Medicaid or Medicare because it's all income-based. That again is not the only social risk factor.

So, let's talk about Richard. 72 years old. He lives on $752 a month. He has Medicare but, until last year, he didn't have supplemental Medicaid. He spends $400 a month on his mortgage. He spends approximately $240 a month on his electric bill. We'll talk about that later. His water and sewer bill is $30. His cable and internet is $79. His trash is picked up by a friend, so he can eliminate that bill. And we understand why, because when you add all that up, it comes to $749, which means there's $3 to spare over his base expenses. So, he got referred to Linda, an oral health community health worker because he needed a full-mouth extraction because he needed heart surgery to repair a heart valve and they didn't do the surgery because he had so many infections. So that happened, and he eventually got dentures through a denture program in Allegany County. When she came, she found out through conversations with neighbors that for 13 years he had not had gas. His gas was turned off because it didn't meet code and he couldn't afford to fix it, right? It wasn't because he couldn't pay his bill; it was his gas line. So, that's 13 years without gas and then his water was turned off since 2013. He collects rainwater in barrels to bathe in, to do his laundry, and he would purchase drinking water when he could. So… Now, this is a very extreme case, but it's not that unusual. I have met people who share electricity between two or three houses, running extension cords all over the place. People who have water shut off in one house will get it from another house. It's all dependent on the neighbors. His health care providers knew none of this. The community health worker found this stuff out and got it back to the health care providers. And I know the fact that he was drinking rain water was affecting his health, for sure.

The other story is really much shorter. We work with Western Maryland Health System, and they alerted the behavioral health community health worker that one of her clients wasn't getting the right results from giving her insulin for her diabetes. So, she went to the house, and what does she see? She sees all this woman's medications sitting all neatly labeled and organized, taking the medications exactly as prescribed. So the community health worker goes through the home, and her insulin is sitting there with all the rest of her medications, not in the refrigerator. She did not understand that insulin needed to be refrigerated to work. Now her blood sugar is in control.

So, I'm just pointing out that there are things out there that work, that can attack and get at the need for all these increases in expenses in health insurance. There's other ways to go about looking at the health of a population that improves, and I think, I hope that insurance carriers would be interested in these kinds of things. I don't know how. I don't have an answer for how you get that in to the algorithms. I just really feel like, from here on down, we need to talk about social determinants. And we need to keep this on our minds as we create all these programs that may have unintended consequences. If you're going to rate a hospital

on performance, and that hospital is in inner city Baltimore or Allegany County, the baseline health of people in some of those wards is way lower than in a suburban hospital or wherever else and… The point is, when you judge them on their results, and pay them according to the health of their population, it's not fair because you're dealing with a problem that's much more significant than other places. When we're talking about incentives, my concern is you don't want to make it so that there's an incentive vacuum designed to just suck up all that money. And I believe CareFirst when they said that wouldn't work for them. I believe them. That's one of the theoretical risks out there. The other risk is the cherry picking, only going after the healthy people. You're still leaving behind a population which is never really addressed, right? And it's important to the QHP side of things because they're just so close to that line—Medicaid this year, QHP next year, back to Medicaid. We could bring some of these things that are working on the Medicaid side into the QHP side."

Ms. Eberle stated that the MHBE will continue to work closely with MDH and keep in mind issues of social determinants of health.

Mr. Cardenas asked whether others had testimony to offer on the topic of incentives in the reinsurance program.

Mr. Kunkle offered the following testimony. 1:05

"After as much time as I spent up here on the first topic, this will be very brief. Kaiser supports the incentives. We think it is an inherent part of the Kaiser model. We think it's something Maryland has always been out in front of as a state, so we would appreciate seeing that in this program. We believe incentives around healthcare utilization, providing care efficiently, quality or—quality ratings from the Maryland Health Care Commission… we could leverage building some of these programs if you incentivize the right behavior and this would be a way to continue to drive that forward for the state. In terms of the methodology for how you use it, I would say we're somewhat agnostic. One suggestion that we would put out there is when the ACA did the reinsurance program, they left the coinsurance as a floating number to ensure they paid out the totality of the money they collected. You knew the attachment points. They had a target coinsurance, but it was always a little bit different from what was paid out. Not a penny less. Not a penny more. If we were to set aside a sum of money, whatever you decide is appropriate, and use the coinsurance that would pay out, maybe 400 million and left 60 or whatever your number is, that might be a very workable way to make the math work as opposed to trying to guess the projected pass attachment point. Just a suggestion I'd share, I think, as long as there is some money put aside for this thing, Kaiser would be supportive of that."

Mr. Cardenas asked how carriers can incorporate potential incentive payments into their models for calculating premium rates, given they would have to guess as to their own performance in the future.

Mr. Kunkle replied.

"Everything that we put into rates is a projection like that to me, so as long as we knew: here's the scale we're using for tallying for awarding incentives, we would make a projection for whether we believe Kaiser will be able to achieve… just like every other projection we make, we can do utilization, we can do with other cost control initiatives. I'm not sure we hit it exactly but it would be a component over our overall rate build and, frankly, wouldn't be any less scientific than all the other things in the process.

Mr. Cardenas asked whether incentives should be designed to have an impact on rates or, alternatively, the incentives should be simply a reward payment to carriers.

Mr. Kunkle replied.

"I think we would build it into rates as well. We target a reasonable margin for the business, and so we would project what we would get back from these incentives and build that into rates versus… I don't think the alternative would be excess margin to the carriers. We've all quoted our losses… far from replacing

that excess margin, but we would build it into the rates and we would do that transparently and show what our assumption is so that the actuarial team who evaluates that can see what we are expecting and how that equated to a lower price."

Mr. Cardenas asked how incentives might be structured to ensure that both market participants can perform toward those targets.

Mr. Kunkle responded.

"I felt very comfortable with that math equation for how you structure incentives, but I believe our perspective would be as long as we have a transparent methodology, I would like to see the targets be the same for all of the market. We would be glad to work with the MHBE in determining what those are. There are already some things that exist that are incorporated into various programs in Maryland. Kaiser has experience in other states as well that we could bring to the table."

Mr. Cardenas asked how Kaiser Permanente's participation as a Medicaid managed care organization with its value-based purchasing incentives impacts the bottom line.

Mr. Kunkle responded.

"It has certainly focused us on a handful of initiatives that the Maryland Medicaid team has determined and so we actually have, we believe, the ability to perform even better there and we can even grow. We're very comfortable with the approach there, and it takes… we focus on our quality program broadly, no matter what. There are a handful of initiatives very specific to this population that the Maryland Medicaid program has deemed critical with financial incentives."

Ms. Rivkin offered the following testimony.

"So, for the record again, I'm Debbie Rivkin, Vice President for Government Affairs for CareFirst Blue Cross Blue Shield. We have a very different philosophy than Kaiser Permanente on this topic. So, I think what you've asked here is how incentive funding should be a built into the reinsurance program. I think it's really important that it's 'built into the reinsurance program,' that you think the reinsurance program itself, again, which is supposed to take down high risk to bring down rates for everyone, should have an incentive program built in. First, I just want to make it very clear that scholarly articles, ourselves, the Insurance Administration I believe added a slide for the Exchange that has stated that reinsurance mechanism design itself that in particular we are planning on using in this state inherently creates incentives for care management, coordination, cost control to manage those high risk enrollees. How does it do that? We're on the hook for the first 20,000 dollars. We're on the hook, again, for 20 percent of anything that's above 20,000 dollars to the 250,000 dollar mark and then we're on the hook for the entire amount above 250,000. So it's not like we're completely taking away any responsibility for costs, and so, by its very nature, there is incentive to manage those costs. So, we would argue it already exists in the reinsurance program today the way we have set it up. Other types of reinsurance programs don't have as strong as an incentive.

Secondly, I just really want to reiterate that if you're going to implement or design any kind of incentive it really should not be through the reinsurance program. It is not the appropriate use of the dollars. I keep going back to that. We feel very strongly that they are two separate thoughts, and reinsurance should be used for reinsurance incentives. And that is really to drive down the pressure on premiums So we really do have limited time to try to stabilize the market. Again, I talked about a stage one and stage two. To us, this is stage two. It's not stage one. It's not the appropriate use of reinsurance dollars. We're not saying that incentives are wrong. We're not saying they are something that shouldn't be done. If you really want to have a real impact, you need to look at all market segments. We don't treat the individual market any differently than we do the small group market, the large group market, and our self-funded. We have programs across the continuum that we use. And the individual market, remember, is about 5 percent of the

insured market, so if we really want to bend the curve of incenting individuals to get the appropriate care that they need, it's not through a reinsurance mechanism. And it's not just in the individual market. It has to be done throughout the continuum. And, I really want to suggest to you all that, before you really decide to go down this path, you really should—I would ask that you sit down with Kaiser and CareFirst and any other carrier that chooses to come into the individual market and really ask us what we're doing today. And hopefully the next couple of hearings, I'll talk a bit more about that. But we have a lot of programs in place that we think try to optimize health outcomes and reduce or eliminate barriers to care. The important thing about that is these programs are across the continuum of care from infants to the elderly. From very healthy to the very sick. So, that, again, is not the purpose of reinsurance. Reinsurance is talking about this high risk individual claims, and sometimes those claims are not because someone has a condition. It's because someone had an accident or something and they are really healthy individuals. So they don't have to have a high risk, right? So, we have programs, both longitudinal, vertically, and horizontally. And I think it's really important to sit down before you move forward with this to see what we have, what makes sense. And, therefore, putting an incentive on top of whatever's—pulling money out of the reinsurance payments—is not appropriate. It's not appropriate use of dollars. We are happy to have a dialogue in the future about how we can try to bend the cost curve and increase quality. but you need to know what is out there first before you move forward. And I know you are talking about 2020 but that's still part of the dollars we are getting right now and, if you want to look at that, please do it outside of reinsurance. And so I really think that this is the most meaningful way to use those reinsurance dollars to tamp down rates.

Mr. Cardenas acknowledged the existing incentives in the system of care and thanked Ms. Rivkin for her comments on the subject.

Ms. Eberle asked whether the existing programs at CareFirst have demonstrated year-over-year results that show a trend.

Ms. Rivkin replied.

"We're starting to see that type of thing. We are adding new programs and finding which ones are working. I want to make it clear that it's not just for those who are sick. There are programs for the sickest that need care coordination, care management. We also have things for the healthy to try to keep them healthy. And that's part of it, and that's why we don't believe it belongs in the reinsurance program We do other things too. It's really imperative to look throughout You could have, for example, high claims because you had an injury that has nothing to do with our PCMH program. I just don't want to try to—I think it's mixing apples and oranges. It's still laudable. It's still something important for the state to be looking at, but I think this conversation should start with, 'Where are we? What are we doing?' And so, before you start pulling out money from the program, that is short-term to keep the rates down as low as possible, let's really focus on that and keep them separate. It's still something that we are absolutely committed to 100 percent across out entire book of business from our self-funded to our individual market."

Closing

Mr. Cardenas closed the hearing and thanked everyone who attended, including Delegate Cullison.

Participants

Maryland General Assembly
Bonnie Cullison, Delegate, District 19 and Chair, Insurance Subcommittee of the Health and Government Operations Committee

Maryland Health Benefit Exchange
Dana Weckesser, Member, Board of Trustees
Michele Eberle, Executive Director
John-Pierre Cardenas, Director of Policy and Plan Management

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

Maryland Department of Health
Robert Neall, Secretary

Members of the Public
Jon Kunkle
David Stewart
Deb Rivkin
Natasha Murphy
Matt Celentano
Laurie Kuiper
Susan Lyon
L. Jones
D. Rosarion
Aguayo Vivian
Vanessa Purnell