Consumer Health First

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Briefing - 2017 Approved Health Insurance Rates
Senate Finance & House Health and Government Operations Committees
26 October 2016
Submitted by: Leni Preston, President

Thank you for the opportunity to provide testimony on the 2017 health insurance rates as approved by the Maryland Insurance Administration. I am here on behalf of ***Consumer Health First*** (formerly Maryland Women's Coalition for Health Care Reform). We have a new name but the same mission - to promote health equity through access to high-quality, comprehensive and affordable health care for all Marylanders. In light of that mission we are proud of our role as the lead policy and advocacy organization representing the interests of consumers in the rate review process.

For the past three years we have commissioned Jay Angoff of Mehri & Skalet to conduct an actuarial analysis of one or more of the rate filings for carriers in the individual market. As the former Missouri Insurance Commissioner and as the first Director of the HHS Office of Consumer Information and Insurance Oversight Mr. Angoff is particularly well suited to conduct such an analysis. This year he analyzed the rate requests for CareFirst, Kaiser Permanente and Evergreen. His report included what we believe was sufficient evidence to warrant a decrease in the proposed rates for both Kaiser and CareFirst. The report, which can be found on the CHF website, was provided to the MIA in June and Mr. Angoff joined CHF in testifying at the rate hearings in July and August. Given that the 2017 rates have been approved I thought it would be most helpful to discuss Mr. Angoff's key findings within the context of recommendations on ways to improve the rate review process, increase competition in the market, and decrease costs overall.

First, however, I want to express our **appreciation for the thorough and fair review process** conducted by the Insurance Commissioner and his staff. This required not just one hearing but two due to CareFirst's unprecedented filing of a second rate increase request well into the MIA's review period. We also appreciate Commissioner Redmer's willingness to fully engage with us during the course of his decision-making process.

It should come as no surprise, however, that we were **extremely disappointed in the Commissioner's final decision** and particularly so for CareFirst. It is our firm belief that the approved 2017 increases, added to those for 2016, will only make a bad situation worse. These will place an unfair impact on the some 260,000 consumers who buy their own insurance. And, this will be particularly burdensome for the approximately 130,000 who do not qualify for financial assistance.

CHF raised this issue at the rate review hearings where we were joined by two small business owners. Each spoke of the personal impact these rates would have which would put health insurance beyond their reach. Since the rates were approved we have received emails from consumers who are irate about the approved rates. Among those was a woman who wrote, "Medical insurance was meant to keep medical expenses from driving you in[to] financial ruin, NOT for the medical insurance to drive you in[to] financial ruin."

With 2017 rates now approved, we believe it is most useful to look at ways to **address rate increases and other challenges** moving forward. Therefore we suggest the following for your consideration:

(1) Examine Trends for Administrative Expenses

In the case of Kaiser, Mr. Angoff raised the issue of what he deemed as an incorrect assumption for trend for administrative expenses. This led to a recommendation for a decrease in their proposed rates. The Kaiser rate filing included a 3.5 percent trend for administrative expenses and only a 2.9 percent trend for health care costs. Given the number of individuals, who purchase individual insurance through the Exchange, it does not make intuitive sense for a carrier to assume administrative expenses that will increase at a higher rate than health care costs.

(2) Consider Requiring One Medical Loss Ratio (MLR) Target for CareFirst

Mr. Angoff questioned the fairness of CareFirst using a higher MLR target for its BlueChoice (CFBH) than for CareFirst of Maryland (CFMI) and Group Hospitalization and Medical Services (GHMSI). A higher MLR target means consumers joining CFBH will get better value for their premium dollar than consumers joining CFMI or GHMSI. While this may be permissible under federal and state law, we believe it is not only unfair to the latter population, but it also runs counter to the spirit of CareFirst's mission to provide affordable health care coverage for all its customers.

(3) Independently Verify Medical Trend

CareFirst cited trends for each of its three companies that were above 8.0% -- greater than either Kaiser or Evergreen. They were also higher than those cited by the actuarial consulting firm Milliman. They found that over a 15-year period the national trend had been moving downward from 10% to less than 5%. We would ask - why is CareFirst's trend inconsistent with both Maryland and national carriers? And, we would note that it is also inconsistent with the cost savings CareFirst has cited for its Patient Centered Medical Home and Total Care and Cost Improvement programs. Why aren't consumers seeing these savings, along with savings from the All-Payer Model, in lower premiums? And, with its dominance in the market, shouldn't CareFirst have greater negotiating power with the result of greater savings for consumers?

These questions lead us to suggest that there should be an independent verification process for carriers' medical trend. In so doing this would open an opportunity to examine medical trend more closely as a tool to lowering health care costs - both within the system and for consumers. We believe that one avenue to do that would be

through greater use of Maryland's All-Payer Claims Database (APCD), which is maintained by the Maryland Health Care Commission (MHCC). Indeed, the MHCC received $1.2 million from the Department of Health and Human Services to develop a dashboard for this purpose. It has yet to be fully implemented, which would include its adoption for use by the MIA.

(4) Use Maryland's All Payers Claims Database to Address Health Care Costs

The MHCC's APCD has the potential to provide both regulators and policy makers with key information that could be used in a number of important areas, including analysis of medical trend as cited above. In addition, it could be used to gain a better understanding of the factors, such as health conditions and treatments, that are driving up health care costs in the individual market. This information could then serve as the basis for identifying appropriate benefit changes, perhaps along the lines of value-based insurance designs, and/or programs that carriers should have in place to meet the specific health care needs of consumers.

(5) Limit the Number of Carriers' Filings

Maryland's transparent rate review process includes the release of rate filings on the MIA's website with a hearing process and public comment. This year, the Commissioner was required to hold two hearings due to CareFirst's second, and unprecedented, rate filing. We are unaware of an instance in any other state where the dominant insurer has withdrawn and resubmitted a rate filing after the public hearing. To address this some states limit the time period for resubmissions. For example, Connecticut, Delaware and Minnesota allow carriers to change their filing up until a date specified each year, unless a change is requested by the commissioner. Maine allows carriers to change their filing up until the public hearing. Washington goes the furthest by prohibiting a carrier from changing its original rate filing. We will be advocating that the Commissioner consider a similar change to reduce any undue burden on consumers who require a wholly transparent and fair process in the future.

(6) Investigate Ways to Increase Competition

In 2016, Maryland consumers had a choice of CareFirst, Cigna, Evergreen, Kaiser or United Healthcare. Next year, United Healthcare will exit the individual market, and Evergreen will, we assume, move from a nonprofit to a for-profit model. As these shifts occur it becomes increasingly important to ensure a competitive market to hold down costs for consumers. To address this we believe the following avenues should be explored:

- Mandate that Managed Care Organizations, and all those in the small group market, provide coverage in the individual market;
- Establish a public option;
- Reestablish Maryland's reinsurance program;

- Pursue selective contracting in the individual market by the Maryland Health Benefit Exchange;

- Merge the individual and small group markets; and

- Consider options to make it easier for consumers to compare costs and benefits between carriers such as a standard benefit plan.

In addition, we would note that the imperative to build a **competitive marketplace** with **affordable coverage rests, in part upon decreasing the number of currently uninsured while encouraging maximum re-enrollments.** This requires effective outreach and enrollment initiatives. We appreciate the efforts of the Maryland Health Benefit Exchange in this regard and we have also noted a greater emphasis on consumer assistance on the MIA website. However, it is important to acknowledge, based upon the experience at both the state and national level since 2014, that **in-person assistance is absolutely critical**. Consumers, whether first-time buyers or re-enrollees continue to need personal assistance. This was affirmed by the recent EurekaFacts survey conducted for the MHBE. Therefore, we wish to, once again, express our concern about the continued decrease in funding for in-person assistance**.** We believe that it is now at levels that are not in the best interest of consumers and, taken with rising premiums, may undercut the goals of maximizing enrollment and creating a robust Exchange. Therefore, we strongly urge that the funding for in-person assistance, specifically, be addressed in the future. We would also recommend that for the upcoming Open Enrollment period there be a concerted effort to **gather data at a granular level** that will show any decline in enrollments, including a decrease in re-enrollments. This information will be important in analyzing the options suggested above, as well as devising new, and more effective strategies.

In closing let me say, again, how much Consumer Health First appreciates the opportunity to provide our perspective today. We look forward to working with the General Assembly, Commissioner Redmer and others as we seek to achieve a healthy and robust insurance market and an effective rate review process. And, more importantly, to ensure that Marylanders, no matter their financial status, can afford the health insurance that they both need and deserve.