Consumer Health First

Access ▪ Quality ▪ Equity

June 16, 2017

Al Redmer, Jr.
Insurance Commissioner
Maryland Insurance Administration
200 St. Paul Place, Suite 2700
Baltimore, MD 21202

RE: CareFirst Proposed Individual Market Premium Rates for 2018

Dear Commissioner Redmer:

Consumer Health First (CHF) and the 36 signatory organizations identified in the attachment to this letter submit these comments on CareFirst's proposed premium rate increases in the individual market for 2018. We are stunned by the requests for premium rate increases of 45 percent to nearly 70 percent. This comes at a time when the individual market is showing signs of improvement and maturity and CareFirst's overall financial condition remains strong. As you proceed with your review of CareFirst's proposed premium rate increases in the individual market for 2018, ***we urge you to protect Maryland's individual health insurance market so it can continue on its path to stability and maturity. By rejecting CareFirst's proposed increases, you will also protect consumers from the devastating impact these proposed rates will have on their continued access to affordable health care.*** The best way to achieve these goals is for a thorough review of CareFirst's rate filings to ensure compliance with both the provisions of Title 11 Subtitle 6 (Health Benefit Plan Premium Rate Review) and Title 14 Subtitle 1 (Nonprofit Health Service Plans) of the Insurance Article.

Concerned CareFirst's conduct was inconsistent with a nonprofit health service plan, the General Assembly in 2003 amended Maryland law to establish, in statute,

the mission of a nonprofit health service plan.[1] The statute requires CareFirst, as Maryland's only nonprofit health service plan, to "provide affordable and accessible health insurance to the plan's insureds and those persons insured or issued health benefit plans by affiliates or subsidiaries of the plan."[2] As we show below, ***CareFirst's 2018 proposed premium rate increases in the individual market are unaffordable and thereby in violation of the requirements of Title 14 Subtitle 1 of the Insurance Article. We, therefore, believe these must be rejected.***

CareFirst's statutory obligations also include assisting and supporting "public and private health care initiatives for individuals without health insurance."[3] Maryland's law requiring carriers to accept all applicants in the individual market is, along with Medicaid, the state's health care initiative for the uninsured. The proposed 2018 rate increases for the individual market will undermine this health care initiative by halting its path to maturity. ***Therefore, CareFirst's 2018 proposed premium rate increases must also be rejected for failing to support and assist Maryland in its policy objective to ensure health care coverage for the uninsured.***

The future of Maryland's individual market rests in your hands. ***You can help to put the individual market on a solid footing by requiring CareFirst to:***

- Lower its medical trend in line with the medical trend reported by other carriers and supported by data from the Health Services Cost Review Commission (HSCRC) and the Maryland Health Care Commission (MHCC);
- Assume no change in morbidity for 2018, the same assumption made by Kaiser in its rate filing;
- Eliminate the individual market's contribution to CareFirst's reserves this year;

[1] See *Legislative Report of the Maryland Insurance Administration on MIA Order No: 2003-02-032 available at* http://insurance.maryland.gov/Consumer/Appeals%20and%20Grievances%20Reports/legislativecarefirstreport07-03.pdf and Chapter 357 Acts of 2003.
[2] Insurance Article §14–102 (c) (1).
[3] Insurance Article §14–102 (c) (2).

- Provide additional information about administrative expenses to be sure premiums in the individual market do not include amounts to cover losses in other markets or commissions if these are not paid in this market in 2018; and
- Adjust its 2018 rates for the individual health insurance market using a higher traditional MLR target, one that is at least as high as the MLR cited in the filing for its HMO products.

We anticipate the proposed rate increases in the individual market will lead to higher premiums in the small group market. The changes in the individual market since the full enactment of the Affordable Care Act in 2013 have had a positive impact on the small group market. Since that time, the small group market has seen a decrease in claims and premiums on a per member per month (PMPM) basis. This is not surprising as the boundaries between the individual and small group market are fluid as the smallest employers (less than 5-10 employees) form groups and dissolve groups for the purposes of purchasing health insurance based on availability and cost in the individual and small group markets. If rates become exorbitant in the individual market, individuals will move back to the small group market resulting in higher claims and premiums in the small group market. *Maryland's business climate is tied to a stable, mature individual health insurance market one that lowers costs for all small businesses.* This is another reason to reject CareFirst's proposed rate increases in the individual market for 2018.

Status of the Individual Market: There has been much discussion at the national level about the state of the individual market. This year, Standard and Poor's (S&P) reviewed publicly available data for the performance of most of the U.S. Blue Cross Blue Shield insurers operating in the individual market. The purpose was in part to ascertain if this market is on a path to stability and maturity. S&P compared individual and group MLR, gross profit and loss, and covered lives, and came to the conclusion that the individual market is manageable, improving and needs time to mature before consistent underwriting profits are realized. [4]

[4] See *The U.S. ACA Individual Market Showed Progress In 216, But Still Needs Time to Mature,* April 7, 2017 http://media.kansascity.com/livegraphics/2017/pdf/ACA-market.pdf.

We looked at these same measures for Maryland using the Supplemental Health Care Exhibits CareFirst submitted to the MIA for the years 2013, 2014, 2015, and 2016. The data, shown in **Attachment 1**, supports the conclusion that, as is the case nationally, Maryland's individual market is not in a "death spiral" as some have suggested. Rather it is on a path to stability and maturity, that should be manageable for most health insurers.[5] Specifically,

- CareFirst's MLR in 2016 fell below 100 percent for the first time since 2013.
- CareFirst realized a gross profit in the individual market in 2016 for the first time since 2013.

We would like to call attention to the change in CareFirst's covered lives in the individual market. CareFirst experienced the largest decline (16.4 percent) in the number of covered lives in the individual market between 2015 and 2016, while enrollment through the Maryland Health Benefit Exchange increased 32 percent. While the number of CareFirst covered lives decreased another 7.7 percent between 2016 and 2017, the Maryland Health Benefit Exchange reported a drop of only 3.1 percent.

CareFirst must be required to base its market assumptions on the fact that the individual market is stabilizing.

Medical Trend: This year, CareFirst requests approval for a 9.2 percent medical trend for its HMO products and a 9.8 percent medical trend for its PPO products. By contrast, Kaiser requests a 3.5 percent medical trend. Carriers' medical trends may vary based on differences in risk pool and medical management. However, the significant difference between CareFirst's and Kaiser's medical trend warrants further review.

[5] We combined the data for CareFirst of Maryland, Inc., Group Hospitalization and Medical Services, Inc. and CareFirst BlueChoice for a market-wide view.

The HSCRC staff recently issued its draft recommendations for hospital update factors for 2018 of 3.39 percent.[6] Inpatient and outpatient hospitalization costs account for about 40 percent of CareFirst's total claims. It is difficult to understand how a 9.2 or 9.8 percent medical trend is justified for 2018 given the expected hospital update factors.

The MHCC maintains an all-payer database. Last year, we urged you to take advantage of this unique resource to verify carriers' medical trends. It is even more important for you to do so this year.

We therefore urge you to work closely with the HSCRC and the Maryland Health Care Commission to ascertain a medical trend in the individual market for CareFirst supported by justifiable data.

Morbidity Factor: CareFirst predicates its increased morbidity rate on the assumption that the individual mandate will be further weakened or repealed. Healthier individuals will drop coverage thereby necessitating an increase in its morbidity factor by 20 percent. It is unclear if a weakened individual mandate would cause massive disenrollment although the literature does suggest this would occur if the individual mandate was repealed. It should be recognized that no one knows what changes, if any, will be made at the Federal level this year regarding the individual mandate. We do know, as of the date of this letter, no changes have been made to the individual mandate. The Internal Revenue Service (IRS) has been accepting "silent" returns for several years -- those returns where the filer has not indicated his or her health insurance coverage status – and will continue to do so.[7] Therefore, we believe there is no basis for characterizing the mandate as weakened; it remains in place as it has since 2014.

All carriers remain concerned about the continuing national debate regarding the rules governing the individual market and consumer reaction in 2018. Yet, Kaiser makes no change in its morbidity factor for 2018. Anthem, in its rate filing for the individual market in Connecticut, provided evidence that the lapse rate accelerated in

[6] http://www.hscrc.maryland.gov/documents/md-maphs/pay/20170503/2-DRAFT-FY2018-Update-Factor-Recommendation.pdf
[7] http://www.insurancejournal.com/news/national/2017/02/16/442006.htm

2017 and used this as a basis to increase its morbidity factor to 1.0998.[8] Anthem's morbidity factor is much lower than CareFirst's proposed morbidity factor of 1.413 for its HMO products or 1.488 for its PPO products.

We urge the MIA to require CareFirst to remove its unsubstantiated assumption that consumers will significantly drop coverage in 2018 from its filings and assume no change in morbidity for 2018.

Contribution to Reserve: CareFirst continues with a contribution to reserves of 2 percent. The Annual Supplemental Health Care Exhibits indicate the Company experienced a cumulative underwriting loss of about $250 million between 2014 and 2016 in Maryland. We were concerned this loss may have placed CareFirst in a precarious financial position. However, we were relieved to see the financial position of its nonprofit health service plans remain strong as measured by the percentage of risk-based capital as shown in **Attachment 2**. *Given CareFirst's financial strength, it would be prudent to eliminate CareFirst's contribution to reserve for the individual market to lower premiums and to further support the stabilization of this market,*

Administrative Expenses: There is much management discretion in how administrative expenses are allocated across subsidiaries and lines of business. From the rate filings, we do not know how CareFirst makes these allocations for administrative expenses.[9]

The most recent financial examination report for CareFirst of Maryland, Inc. (CFMI) issued by the Maryland Insurance Administration in 2016 noted a loss of about $21 million in 2011, 2012, and 2013 and $24 million in 2014 in CFMI's administrative services only line of business. *We urge you to review CareFirst's administrative expense allocation to ensure that the individual market is not subsidizing losses in other markets.*

Each of CareFirst's rate filings includes a per member per month (PMPM) amount for broker commissions ranging from about $7 to $8 PMPM. It is our

[8] http://www.catalog.state.ct.us/cid/portalApps/images/reports/10434922.pdf
[9] For our purposes, we included claims adjustment expenses and general expenses as reported on the Annual Supplemental Health Care Exhibits to calculate CareFirst's administrative loss ratio.

understanding CareFirst has communicated its intent to eliminate broker commissions in the individual market in 2018. *We remain concerned this step could significantly decrease consumer access to individual health insurance. Of the 158,000 MHBE enrollments, 16,000 were broker assisted. Of those, 15,000 were for CareFirst plans. If CareFirst stops paying broker commissions in the individual market it should not be allowed to include the dollar amounts cited in its rate filings for broker commissions.*

Medical Loss Ratio: The MLR measures the percentage of the premium used to pay claims. CareFirst proposes a traditional MLR of 84.2 percent for its PPO products and 81.4 percent for its HMO products. *We see no reason why the HMO products should have a lower traditional MLR than PPO products and urge you to require CareFirst to use the higher traditional MLR in all its rate filings to improve affordability.*

Impact on Consumers: As you look at the rate filings for 2018, you must consider the impact the final rates will have on Maryland consumers who are dependent on the individual market for health insurance coverage. Their concerns are clear from the postings on your website that include:

- "I feel that the insurance commission should put a moratorium on premium rate increases until more is known on the status of the AHCA in the Senate or until such time as a new health bill becomes federal law."
- "Maybe some of the increase could be spread more evenly among small companies as well so the individual policy holders do not see such an incredibly high increase."
- "A rate increase of this nature would cause young healthy people like myself to drop my insurance all together and therefore make if (sic) more expensive to cover the elderly sick patients."
- "I don't qualify for any subsidies at this point. A huge increase like this will put me in a situation where I'll have to choose to risk it and go uninsured or work a second job to pay for healthcare."

Under IRS rules, health insurance coverage is unaffordable if it is more than 8.05 percent of family income and if this is the case, the individual/family are exempt from

the individual mandate. The MIA's May 4th press release provided proposed monthly premium rates for an individual 40 years of age for the lowest cost silver plan. Assuming this individual has the State's annual median income of $75,847, he or she would spend 8.2 percent of income on the CareFirst HMO product and 11.3 percent on the PPO product, both of which would exempt this individual from the individual mandate.

Approving unaffordable premiums may be all it takes to move the individual market off its current positive path. Equally important is the impact on individuals who would then be unable to afford health insurance. *Consumers should not be the ones to bear the burden of the uncertainties that CareFirst may face due to actions, or in-action by legislators and policy makers in Washington. We implore you to hold CareFirst to its statutory mission of providing affordable and accessible health insurance to its insureds.*

Small Group Market: Using the Supplemental Health Care Exhibits CareFirst submitted to the MIA for the years 2013, 2014, 2015, and 2016, we looked at the changes in claims and premiums PMPM in the small group market (See Attachment 3). In 2013, claims PMPM were $301.21 dropping to $262.44 in 2016. Premiums also dropped from $374.73 PMPM to $332.89 PMPM. *Keeping the individual market on its path to stability by approving affordable premium rate increases, we submit, is important for Maryland's business climate as it lowers premiums in the small group market.*

In closing, we ask you to consider our comments as you move forward with reviewing CareFirst's proposed rates for 2018. We are grateful to the MIA for the opportunity to provide input to this important process. We are confident the data you gather will demonstrate these rate filings do not comply with Title 11 Subtitle 6 (Health Benefit Plan Premium Rate Review) and Title 14 Subtitle 1 (Nonprofit Health Service Plans) of the Insurance Article and must be rejected. Thank you for taking the time to consider our recommendations, and please do not hesitate to contact us if you have any questions.

Sincerely,

Leni Preston, President

Beth Sammis, Secretary

Signatories

Advocates for Children and Youth

Baltimore City Substance Abuse Directorate

Behavioral Health System Baltimore

Center for Children, Inc.

Community Behavioral Health Association of Maryland

Disability Rights Maryland

Drug Policy and Public Health Strategies Clinic, Univ. of Maryland Carey School of Law

FIRN, Inc.

Greater Baltimore HIV Health Services Planning Council

League of Women Voters of Maryland

Licensed Clinical Professional Counselors of Maryland

Maryland Affiliate of the American College of Nurse Midwives

Maryland Assembly of School-Based Health Care

Maryland Center on Economic Policy

Maryland Coalition of Families

Maryland Nonprofits

Maryland Nurses Association

Maryland Occupational Therapy Association

Maryland United for Peace and Justice

Mental Health Association of Maryland

Montgomery County Department of Health and Human Services

NAMI Maryland

NARAL Pro-Choice Maryland

National Council on Alcoholism and Drug Dependence - Maryland Chapter

National Women's Health Network

Noir Consultants and Training Inc.

On Our Own of Maryland, Inc.

Planned Parenthood of Maryland

Progressive Cheverly

Public Justice Center

Raising Women's Voices for the Health Care We Need

The Women's Law Center of Maryland

Together We Will - Baltimore Area

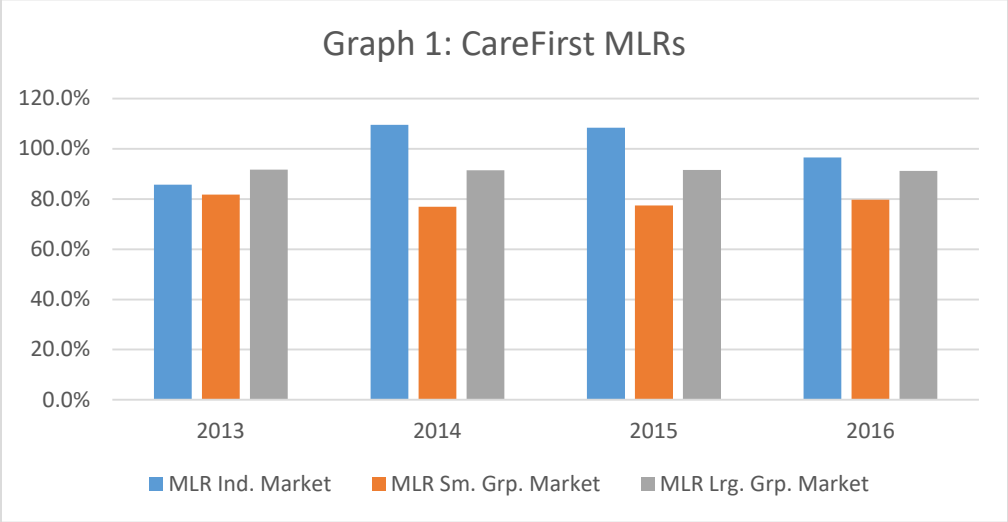
Unitarian Universalist Legislative Ministry of Maryland

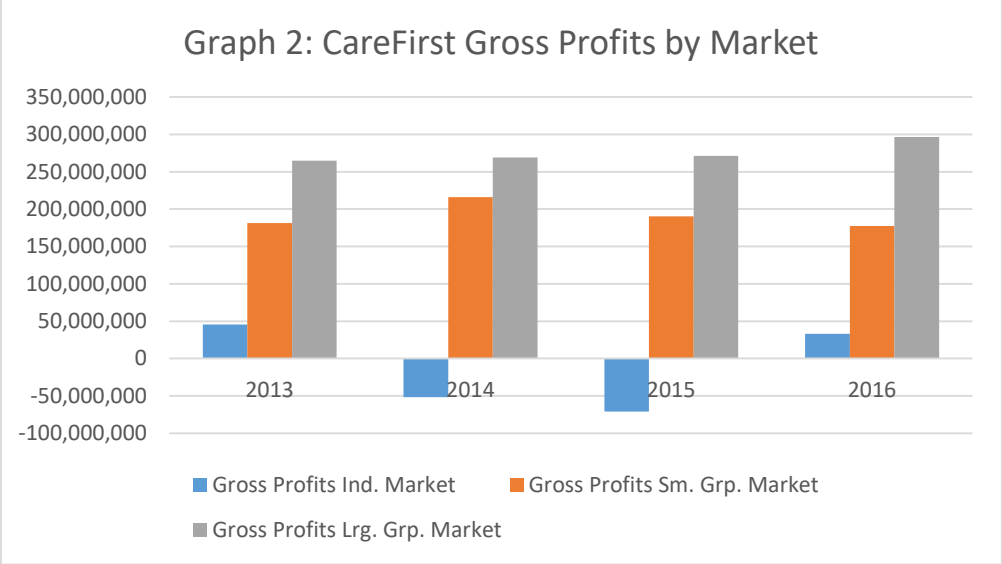
Voices for Quality Care, Inc.

Woman's Democratic Club of Montgomery County

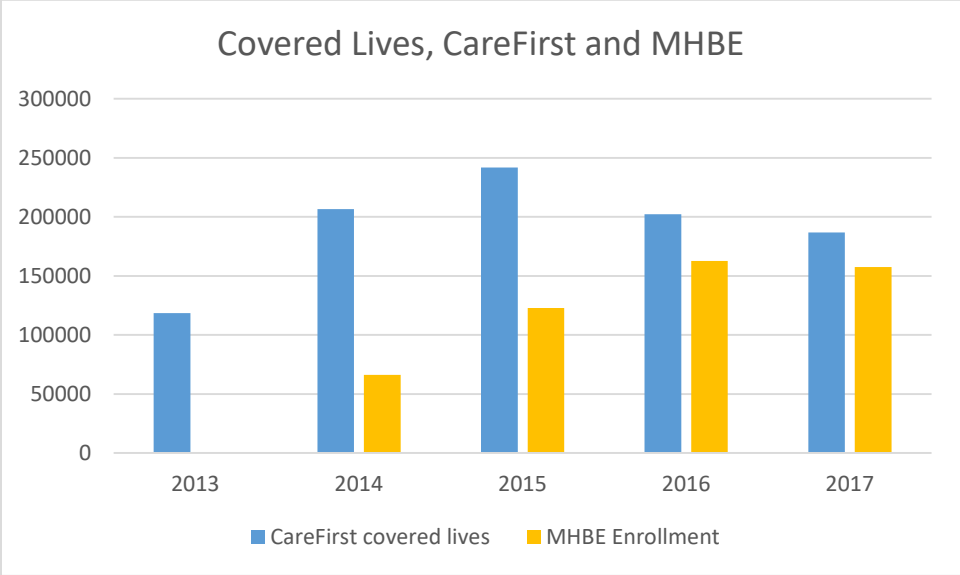
Attachment 1: CareFirst's Operating Performance by Market

Since 2013, the year before the ACA market changes took effect, CareFirst's group MLRs have been stable and while that has not been the case for the individual market, this market's MLR fell below 100% in 2016. A similar pattern is seen for gross profits with these turning positive in 2016. S&P also found stability in the medical loss ratio (MLR) and gross profits for the group market and improvement in the individual market MLR and gross profits in 2016.



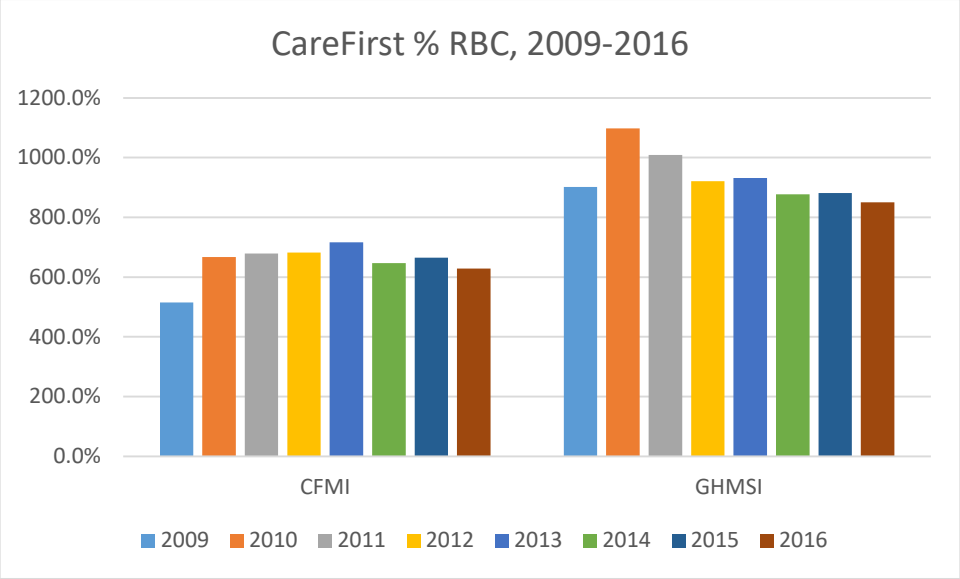


In terms of covered lives, S&P concluded the sharp premium rate increases in 2017 did not lead to a significant drop in enrollment, in part because of the stabilizing effect of the premium subsidy available to individuals enrolled through the Federal or state-based exchanges. The number of covered lives in CareFirst's products decreased 7.7 percent between 2016 and 2017 while the number of covered lives enrolled in qualified health benefit plans through Maryland's exchange decreased only 3.1 percent.



The data for covered lives and enrollment in the individual market for 2016 and 2017 demonstrates Maryland followed the national pattern observed by S&P. Altogether the data supports the conclusion that Maryland's individual market is improving and on a path to stability.

Attachment 2: CareFirst Percent of Risk-Based Capital (RBC) 2009-2016



Attachment 3: CareFirst's Small Group Market