Maryland
Hospital Association

June 24, 2016

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

Dear Commissioner Redmer:

On behalf of the 64 hospitals and health systems of the Maryland Hospital Association (MHA), I am writing to provide feedback on the recent insurer filings seeking rate changes for the 2017 plan year, in both the individual and small group markets. Of greatest concern: the rate increase requests in many cases far exceed spending and use trends for health services in our state.

With insurers realizing savings as a result of hospitals controlling the rate of growth in both spending and utilization, it would be reasonable to expect at least some of those savings to be passed on to individuals enrolled in their plans. After all, a key point of Maryland's health care transformation under our unique all-payer rate setting system is to make health care more affordable.

There is ample evidence demonstrating that insurers have both the ability and a duty to pass on additional savings to enrollees:

- a discrepancy between hospital spending growth and the cost trends included in insurer filings
- impact of the Transitional Reinsurance Program's cessation
- savings provided to insurers through actions by the Health Services Cost Review Commission (HSCRC)
- the need to preserve access to care and ensure continuity of care for individuals

Medical Spending Growth Is Slowing

While insurers have included hospital cost trend increases of as much as 5.4 percent for the fiscal year that begins July 1, 2016, the HSCRC has approved total hospital allowable revenue growth of only 2.72 percent — well below the numbers used to construct some insurers rate requests. And these trends are highly sustainable: for the 42-month period ending June 30, 2017, HSCRC has indicated that total hospital revenue will grow annually by 2.5 percent, less than half of the cost trends used by some insurers. The chart below illustrates the discrepancy between actual hospital spending and the trend data being used by some insurers.

	Cost		Utilization	
	Inpatient	Outpatient	Inpatient	Outpatient
Individual Market	1.4 percent (Cigna) to 5.3 percent (Freedom Life Insurance Company of America)	1.0 percent (Cigna) to 5.3 percent (Freedom Life Insurance Company of America)	-2.0 percent (CareFirst) to 2.6 percent (Freedom Life Insurance Company of America)	0.6 percent (CIGNA) to 4.0 percent (CareFirst)
Small Group Market	1.8 percent (Evergreen) to 4.3 percent (CareFirst)	1.8 percent (Evergreen) to 4.3 percent (CareFirst)	-2.1 percent (CareFirst) to 2.9 percent (UnitedHealthcare)	1.0 percent (Evergreen) to 5.4 percent (CareFirst)

This wide range of cost trend assumptions is inconsistent with the total hospital spending trends being reported by the HSCRC. Further, utilization trends, particularly those for inpatient benefits, have in many instances actually decreased. These variances should be thoroughly reviewed so that they can be reconciled with HSCRC data.

Such a reconciliation would help assure the public that their insurance rates are based on all the relevant data, including the broader, public hospital data already reported, as well as data being submitted by the state to the Centers for Medicare & Medicaid Services (CMS) to maintain Maryland's unique all-payer model.

A close look at the requested increases reveals a reflexive and somewhat troubling effort by some insurers to increase rates beyond what is necessary, thereby withholding savings from Marylanders. For example, the MAMSI Life and Health Insurance Company small group filing attempts to claim a burden on private payers due to cost-shifting that results from lower payments by Medicare and Medicaid. As you know, but apparently MAMSI does not, there is negligible cost-shifting in Maryland. Under Maryland's all-payer model, public and commercial payers pay the same rates for the same services at the same hospital.

Further, Maryland's new waiver agreement with CMS, effective January 1, 2014, has placed an **annual limit on total hospital spending** set by the HSCRC; this is unlike prior years, where only the unit rate increase was known by insurers and total utilization growth had to be estimated. It is critical to demonstrate that the significantly lower rates of growth in hospital spending translate into significantly lower rates of growth in insurer premiums.

Termination of Transitional Reinsurance Program Should Have Minimal Impact
The Affordable Care Act's (ACA) Transitional Reinsurance Program (TRP), in effect for plan years 2014-2016, has ended. A common theme in carriers' requests for rate increases is the loss of the TRP.

However, because the TRP will no longer operate in plan year 2017, insurers will no longer have to make payments into the TRP reinsurance fund. There is also a one-year moratorium on the ACA insurance provider fee. Both of these factors should somewhat offset any increases in rates attributed to the ACA's TRP and other risk mitigation programs.

More importantly, the amount of the proposed increases attributed to the sunset of the TRP is questionable. The TRP has gradually reduced reinsurance payments to carriers. Now, in the third year of the post-ACA market, most of the previously uninsured have already enrolled in health plans, a fact confirmed by the Maryland Health Benefit Exchange. It is well established that those with greater health needs enroll in insurance and utilize services sooner than those who do not foresee themselves needing health care. As such, and as acknowledged by CMS when developing a program to provide reinsurance for the *transitional* period of the first three years under the ACA, carriers now encounter a more stable market, and ***less, not more***, risk of high-cost or catastrophic claims. It's difficult to see how enrollee risk profiles would have changed much over past year, to a level that would justify the significant amounts of proposed rate increases tied to the loss of the TRP.

Global Budget Decision Saves Insurers $100 Million
The HSCRC's June 8 decision to increase hospital global budgets included a revamped policy on shared savings resulting from reduced utilization. As a result, the commission "shared" the savings resulting from lower hospital rates – totaling $100 million – with insurers. This savings is more than triple the amount previously provided, a result of lower utilization. It would be appropriate for the insurers, in turn, to pass on at least a portion of those savings to consumers in the form of lower increases in health insurance premiums, rather than holding on to those savings.

Requested Rates Pose Concerns for Access to Care
The substantial rate increases insurers are seeking this year are compounded by the significant rate increases approved last year. New entrants into the state's insurance market (those who joined after the initial launch of Maryland's health exchange), which may have sought relatively lower rate approvals last year, are now pursuing some of the steepest increases.

Unaffordable coverage stifles access to appropriate levels and types of care, and disrupts continuity of care. Under the new CMS waiver agreement, Maryland's hospitals are focused not only on the care provided within their four walls, but also on providing patients and communities with health services beyond the hospital, to decrease unnecessary utilization and ensure that the right care is provided at the right time, in the right setting. These efforts, however, cannot be

successful if patients do not have the insurance coverage necessary to avail themselves of those services.

Rate-Setting Should be a Transparent, Public Process
We appreciate the more open rate review process MIA has instituted in recent years and hope it will consider additional opportunities for public input. We also applaud the commissioner's decision to again hold a public hearing on the proposed rates. Without this process, only those who regularly review MIA's website are able to understand the magnitude of these proposed requests.

An even more open approach could be feasible, particularly given the limited number of insurers and plan rate requests that have been submitted in the individual and small group markets. Such a process would allow MIA to provide responses to the comments made by the public. Stakeholders could also help inform the data used by insurers and the state in developing rates. For example, as noted above, the HSCRC collects extensive hospital data. In addition, the Maryland Health Care Commission houses Maryland's all-payer claims database, which could be useful in informing rate change decisions.

Finally, we appreciate MIA's extension of the public comment period this year, and its willingness to address the concerns of stakeholders. We ask that MIA consider permanently extending the timeframe for public review and comment on future rate requests, to provide a minimum of 60 days. Given the level of detail that must be reviewed to understand the justification behind the requests, it is important that the public have sufficient time to analyze and digest the information in order to provide meaningful feedback.

Thank you for the opportunity to comment and we appreciate your consideration. Please do not hesitate to contact us should you need additional information or clarification.

Sincerely,

Maansi K. Raswant
Director, Policy & Data Analytics