



Maryland  
Hospital Association

July 19, 2019

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

Dear Commissioner Redmer:

On behalf of the Maryland Hospital Association's (MHA) 61 hospital and health systems, we are submitting comments on the proposed individual and small group market insurer rate filings for plan year 2020. We thank the administration for elevating engagement with stakeholders in recent years and we appreciate the opportunity to give input.

Maryland's hospitals support affordable coverage as an essential pillar of the health care delivery model. Affordable coverage equates to access for patients to the right services. It also helps people get preventive care, saving unnecessary, costly health care use. That advances the health of all Marylanders.

This year, the state began the Total Cost of Care Model with the federal government. At the core of this agreement is a commitment to improve the health of our state, across the entire population. Success under the model is contingent on all health care stakeholders delivering high-value care and investing in population health. In your review of the rate filings for 2020, we ask that you:

- Ensure the filings use accurate hospital spending and utilization growth trends
- Review insurer primary care, preventive and chronic disease management programs
- Focus your attention beyond premiums to look at rising out-of-pocket costs for patients

### **Review of Insurer Filings for Accurate Trends and Data**

As we mention each year, some filings include inaccurate information on the dynamics of hospital costs in the state. UnitedHealthcare's small group filings describe public to private payer cost-shifting for hospital services as a large factor in their projections for 2020 rates. This assumption is inaccurate in our state.

In Maryland, the all-payer rate setting system equalizes the cost of care across public and private payers. As a result, there is, at best, a nominal difference between public and private payer payments. Effective July 1, the Health Services Cost Review Commission approved this difference to be 7.7% — a 1.7% increase from years past. HSCRC implemented the change to account for growth in uncompensated care delivered by hospitals to Marylanders who have

private insurance. This slight change in hospital payments cannot be the driver for UnitedHealthcare's requests for an average 10.5% rate increase.

*We urge you to review the justifications submitted by insurers to ensure the data shared with the public is accurate.*

In addition, for fiscal year 2020, the HSCRC has approved total hospital allowable revenue growth of just 3.29% per capita. Some rate filings inexplicably use trends that are double this amount. In the individual market, CareFirst's preferred provider organization products include inpatient hospital utilization trends of 6.5%. In the small group market, Aetna's products also include inpatient hospital utilization trends of 6.5%.

We acknowledge that each product filing is built upon myriad factors that develop these composite trends. We also appreciate the administration's overview of how it accounts for the HSCRC's approved global budget update factor in its review of rates. However, given the transparent process undertaken at the HSCRC to develop the hospital global budget update factor, this area of insurance rate review would also benefit from greater transparency.

*We request that insurers explain how the hospital update factor aligns with their reporting of utilization and cost trends.*

### **State Should Not Rely Solely on the Reinsurance Program**

Maryland's hospitals strongly supported the creation of the reinsurance program and we are pleased to see it bearing fruit. For several years prior, the insurance rates rose by high, unsustainable amounts. With these rate filings, we see the second year of the individual and small group market stability.

The state cannot, however, look to the reinsurance program as the sole solution to address long-term stability. While the program subsidizes the cost of care for individuals who are high-cost, it does not address root causes of their high consumption of care. To ensure sustained viability of these markets, it is important to pay attention to populations exhibiting high service utilization and improve morbidity. In other words, insurers must be accountable for improving these individuals' health and health care. This happens through expanded access to preventive and upstream care, improved care management and coordination, and a focus on chronic diseases.

The administration's initiative to collect information on available insurer wellness and preventive care programs and to understand enrollee uptake of these programs is promising. We ask that you also require insurers to show impact on chronic disease management. As hospitals partner with the state and insurers to improve population health, we must go beyond measuring mere uptake, and understand the actual impact of these programs.

*We prevail on you to ask the following questions in your review of these programs:*

- *Which of these programs best impact utilization and health outcomes?*
- *How do they lower costs of care?*
- *Where the cost of care was reduced, how have those savings been passed back to consumers?*

### **Address Rising Out-of-Pocket Costs**

In May, the attached publication, *MHA Insight*, noted that a recent report by the Health Care Cost Institute, an independent, nonprofit research institute, found Maryland had the fifth lowest commercial insurance per capita spending across the country in 2017. For hospital services, the news is even better. Maryland ranked second lowest for inpatient and outpatient per capita spending. The conclusion is clear: the Maryland model is working, and the health care system is realizing savings — not just for Medicare, but for commercial insurers as well.

*MHA Insight* also noted that while spending growth has slowed, consumer costs have not followed suit. In fact, from 2013 to 2017, premiums grew by nearly 15%, and deductibles grew by 43%. Further, as noted in the HSCRC's final recommendation on the payer differential in December 2018, health plans have changed benefit design so that enrollees are covering higher portions of their care.

*The administration should focus attention on the spike in out-of-pocket expenses. These high out-of-pocket costs deter people from using health care services appropriately. The underinsurance created by burgeoning out-of-pocket costs could jeopardize the state's success under the Total Cost of Care Model.*

We thank you once again for the opportunity to comment. Please contact us should you need additional information.

Sincerely,



Maansi K. Raswant  
Vice President, Policy

# MHA Insight

May 2019

## Maryland outperforms nation on health spend

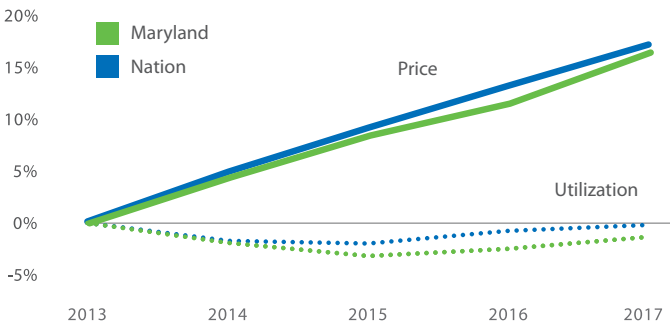
National health care costs continue to rise, but Maryland, led by its hospitals and health systems, has worked to lower cost growth while improving the quality of care. Maryland ranked second-lowest in the U.S. on inpatient and outpatient hospital spending in employer-sponsored insurance (ESI) plans in 2017.

This issue of *MHA Insight* focuses on hospital spending and employer-sponsored plans' cost experience and trends in premiums.

The state has an agreement with the Centers for Medicare & Medicaid Services requiring all payers — Medicare, Medicaid, ESI plans, individual plans, and others — to pay the same rate. In addition, the model incentivizes hospitals to reduce unnecessary hospital use, focus on upstream and preventive care, and improve care coordination across the health care continuum. This model is overseen by Maryland's Health Services Cost Review Commission and holds hospitals accountable at a level unseen in other states.

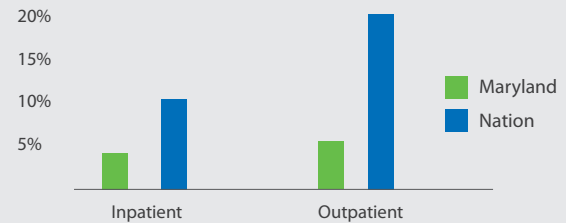
### Maryland beats the nation on controlling health care prices and usage in ESI

Maryland's prices for all health services combined (hospital, professional, prescription drug) grew by 16.5% between 2013 and 2017, versus 17.1% for the U.S. Maryland's utilization fell by 1.4%, versus only 0.2% for the U.S.



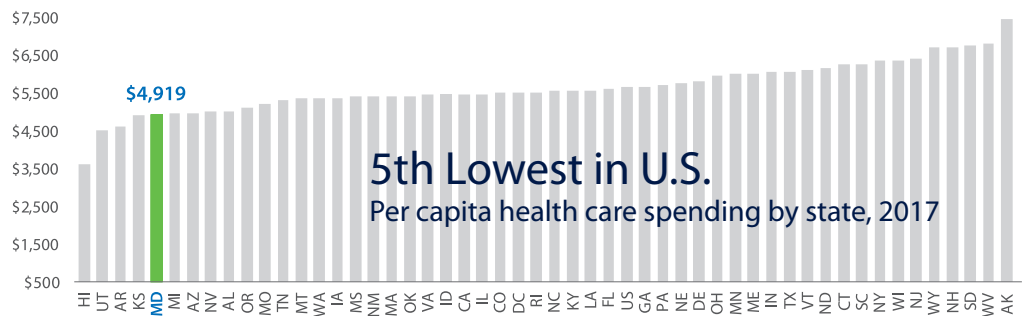
### The Maryland Model succeeds in limiting hospital spending

Employer-Sponsored Insurance Hospital Spending Growth 2013-2017



### How Maryland compares to other states on employer-sponsored health care spending

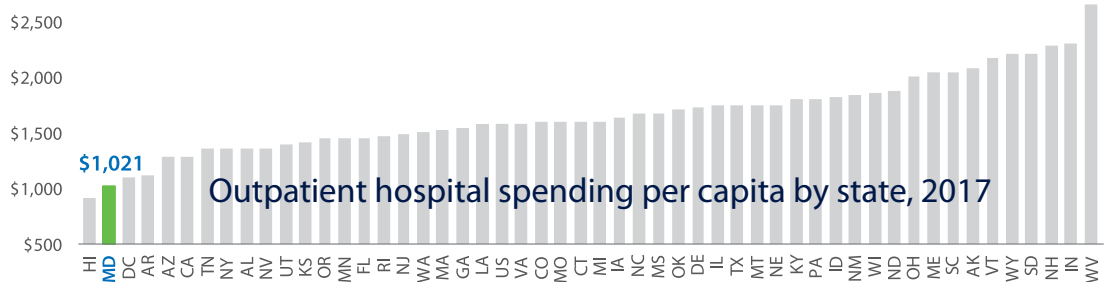
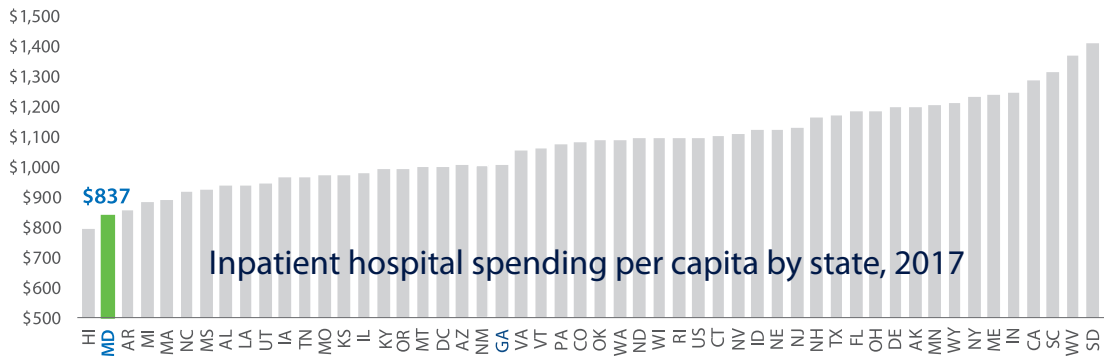
SOURCE: The Health Care Cost Institute 2017 Health Care Cost and Utilization Report compares per person spending across the U.S., by service categories, and growth in spending between 2013-2017. The report is based on 40 million claims from Aetna, Humana, Kaiser, and United Healthcare for approx. 40 million individuals up to age 65 with employer-sponsored coverage.



**5th Lowest in U.S.**  
Per capita health care spending by state, 2017

## 2nd lowest in U.S. in hospital spending

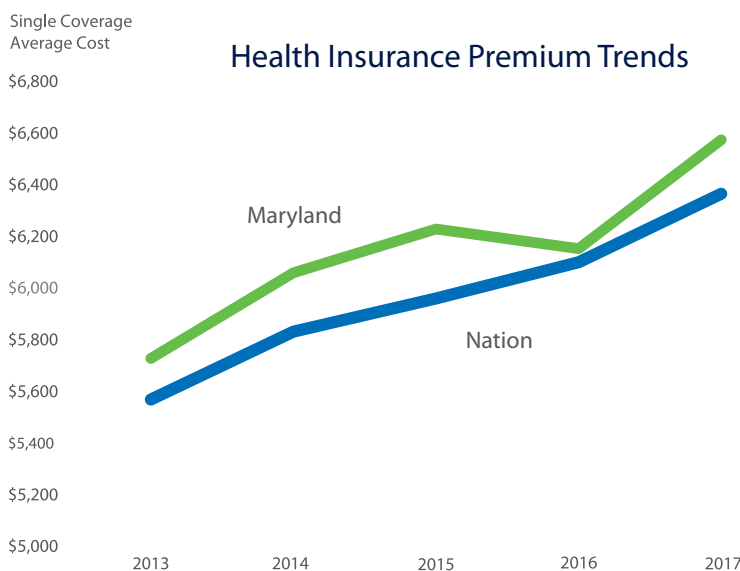
Maryland's hospitals and health systems are successfully controlling spending, particularly in inpatient and outpatient settings where they have the most direct control.



SOURCE: The Health Care Cost Institute 2017 Health Care Cost and Utilization Report compares per person spending across the U.S., by service categories, and growth in spending between 2013-2017. The report is based on 40 million claims from Aetna, Humana, Kaiser, and United Healthcare for approx. 40 million individuals up to age 65 with employer-sponsored coverage.

## The Maryland Model is successful. Why aren't consumer costs going down?

Maryland's hospitals are managing to slow the rising cost of care. Consumers are not seeing the benefit. As health care spending slows in Maryland, data from employer-sponsored insurance plans show that both premiums and patient cost-sharing continue to rise steeply.



From 2013 to 2017 single coverage premiums in Maryland **grew by 14.8%**. Average out-of-pocket caps **grew by 45.6%**, and deductibles **grew by 42.9%**.

SOURCE: State Health Access Assistance Center (SHADAC) analysis of the Medical Expenditure Panel Survey - Insurance Component. State-Level trends in employer-sponsored health insurance (ESI), 2013-2017.