Statement of Jay Angoff[1] on Maryland Individual Market Rate Filings for 2017
June 29, 2016

I. Introduction

This statement comments on the 2017 individual market rate filings of the three carriers which had significant shares of the Exchange market in 2016 and will also be on the Exchange in 2017--CareFirst, Kaiser, and Evergreen. It also notes the current rates on the Exchange by carrier by metal level, and discusses the issues the distribution of the rate presents.

II. The CareFirst filing

Since its inception, CareFirst ("CF") has been Maryland's dominant carrier in all segments of the health insurance market, and particularly in the individual insurance market. Like all Blue Cross companies, it has benefitted from the strength, recognition, and image of the Blue Cross brand. Due to CareFirst's dominance in the Maryland market and the number of Maryland consumers who depend on it, the Commissioner may wish to scrutinize CareFirst's rate filings particularly closely.

CareFirst has submitted three rate filings for three different companies: CareFirst BlueChoice, Inc. ("CFBC" or "BlueChoice"); CareFirst of Maryland, Inc. ("CFMI"); and Group Hospitalization and Medical Services, Inc. ("GHMSI"). CFBC writes CareFirst's HMO business, while CFMI and GHMSI write its PPO business. CareFirst is seeking a rate increase of 11.9% for its BlueChoice HMO, and an increase of 15.9% for its PPO business, whether written through CFMI or GHMSI. The CFBC filing differs from the CFMI and GHMSI filings in several respects; the latter two filings are almost, but not quite, identical. We note some of the significant differences among the filings in the discussion below.

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A. Targeted MLR

CF says that the 15.9% rate increase it proposes for CFMI and GHMSI will result in a pre-ACA-defined loss ratio of 82.2% and an ACA-defined MLR of 84.6% (for CFMI) or 84.8% (for GHMSI). The 11.9% increase CF is proposing for its Blue Choice business will result in a pre-ACA-defined loss ratio of 78.7% and an ACA-defined MLR of 82.0%. The Commissioner may wish to consider the following questions raised by the differences among these loss ratios:

* CF's targeting of a substantially higher loss ratio for CFMI/GHMSI than for CFBC means that CFBC subscribers are getting less value for their premium dollar than are CFMI/GHMSI subscribers. Is this differential treatment permissible under Maryland law? Under the ACA? If it is permissible, is it desirable? Does the Commissioner have discretion to equalize the targeted loss ratios of the different CF affiliates?

* The difference between CFBC's pre-ACA-defined loss ratio and its ACA-defined MLR is 3.3 points, whereas the difference between the pre-ACA-defined loss ratio of CFMI/GHMSI and its ACA-defined MLR is 2.4 (CFMI) or 2.6 (GHMSI) points. Is the substantial variation between the CFBC and CFMI/GHMSI differentials justified?

B. Trend

1. CF's trend vs. Kaiser's and Evergreen's trend

CF uses an overall trend factor of 8.2% for Blue Choice and 8.7% for CFMI and GHMSI. Because in Maryland all payers must pay the same rates to hospitals, CF's size does not give it a substantial advantage over smaller carriers with respect to hospital costs. With respect to the other components of trend, however, which account for a substantial majority of total medical trend, it does.

Yet notwithstanding its leverage in the market, CF's overall 8%+ trend factors are substantially higher than those used by the other two carriers with significant shares of the Exchange market, Kaiser and Evergreen. Because Kaiser employs its own doctors, it can control physician trend more effectively than CareFirst. But Kaiser would not seem to have an advantage in paying for drugs, or for medical devices and equipment, or for controlling outpatient hospital utilization. And Evergreen--a start-up company with essentially no leverage over providers--would seem to be at an overwhelming disadvantage to CareFirst in negotiating with providers, resulting in its having a substantially higher trend than CF. In fact, however, for most components of trend CareFirst is using a substantially higher trend factor than are either Kaiser or Evergreen, as the following table illustrates:

Figure 1: Trend Assumptions in 2017: MD Individual Market

Type of Trend	CareFirst	CareFirst	Kaiser	Evergreen
	GHMSI/CFMI	CFBC		
Inpatient Hospital Cost	2.0	2.0%	3.0%	1.8%
Inpatient Hospital Util	0.0	-2.0%	0.0%	-0.1%
Oupatient Hospital Cost	2.0	2.0%	5.0%	2.8%
Outpatient Hospital Util	4.0	4.0%	1.3%	0.9%
Professional Cost	2.0	2.0%	0.8%	0.5%
Professional Util	5.5	6.0%	0.8%	0.9%
Other Medical Cost	2.0	2.0%	2.0%	4.0%
Other Medical Util	5.0	3.0%	1.5%	0.9%
Prescription Drug Cost	12.0	12.0%	4.9%	6.0%
Prescription Drug Util	6.0	6.0%	1.0%	2.4%

Source: 2017 Maryland Individual Market Rate Filings.

The following differences between CareFirst's trend on the one hand and Kaiser's and Evergreen's trend on the other hand, as set forth in the above table, are particularly troublesome:

* For Outpatient Hospital Utilization, Kaiser uses 1.3% and Evergreen uses 0.9%, while CareFirst uses 4%--more than 300% of Kaiser's trend and 400% of Evergreen's. Kaiser doesn't

own its own hospitals, so there is no reason that CareFirst should be three times less effective than Kaiser in controlling outpatient hospital costs. And there is certainly no reason it should be four times less effective than Evergreen in controlling such costs.

* For Professional--which is mainly physicians--for both cost and utilization both Kaiser and Evergreen use less than a 1% trend, while CareFirst uses a 2.0% trend for unit cost and 5.5% (for CFMI and GHMSI) and 6.0% (for Blue Choice) trends for utilization. Although Kaiser can reasonably be expected to control physician utilization more effectively than CareFirst because it employs its own doctors, one would not expect the difference between Kaiser's and CareFirst's utilization trend to be as great as it is. And there would seem to be no good explanation for CareFirst's utilization trend being 600% of Evergreen's.

* For prescription drugs, Kaiser uses a 4.9% trend and Evergreen uses a 6.0% trend for unit cost, whereas CareFirst uses a 12% trend. And for utilization, Kaiser uses a 1.0% trend and Evergreen 2.4% whereas CareFirst uses 6.0%--250% of Evergreen's trend and 600% of Kaiser's. The Kaiser model would not seem to give it any advantage in dealing with drug companies, and Evergreen certainly has no such advantage, so the justification for CareFirst's far higher trends for drug costs is not apparent.

2. CF's trend vs. the Milliman Index trend

One of the leading actuarial consulting firms relied on by the insurance industry, Milliman, has for each of the last 15 years researched and analyzed the rate of increase in health care costs nationally. For 2016, Milliman found that health care costs had increased by 4.7%--the lowest increase it had found in the 15 years it had been doing its analysis.[2] It also found that the rate of increase--i.e., trend--had been steadily downward over that 15 year period, from over

[2] 2016 Milliman Medical Index at 1 (May 2016).

10% to less than 5%.[3] CareFirst's 8.2% and 8.7% assumed trends are thus inconsistent not only with that of other carriers in Maryland but also with the national data analyzed by Milliman.

3. CF's trend vs. CF's trend

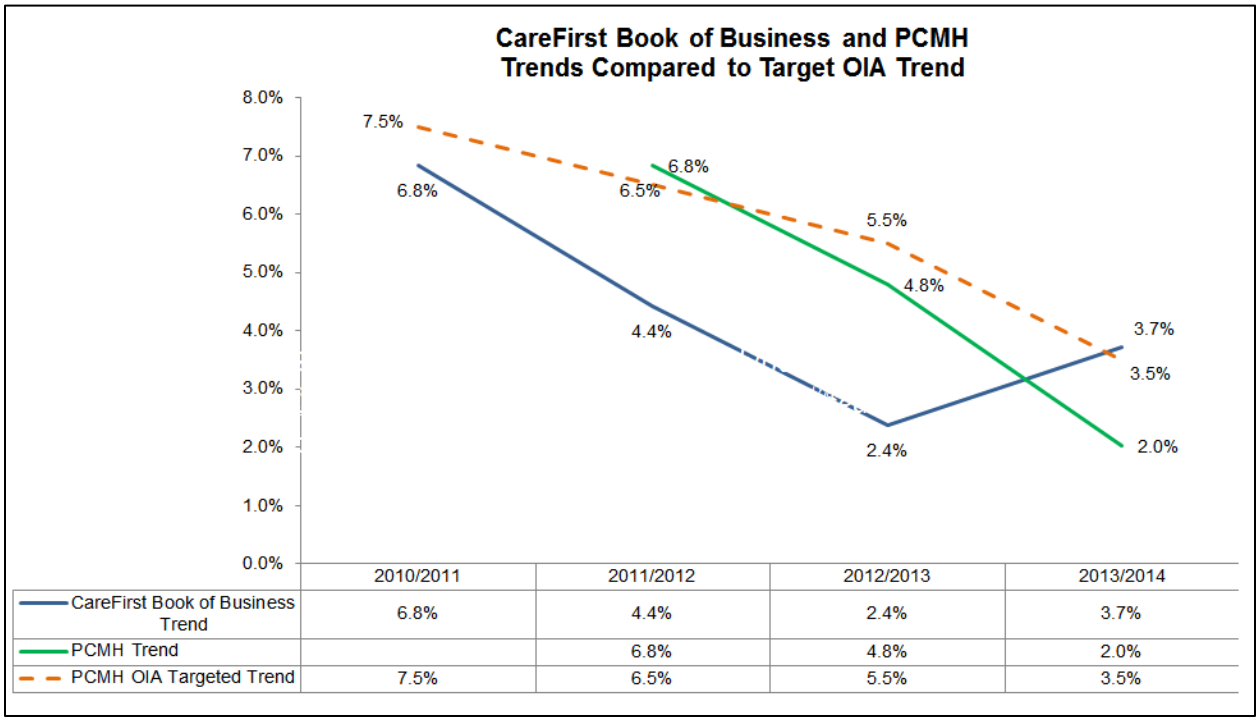
Perhaps most significant, CareFirst's trend assumption in its 2017 individual market rate filings is starkly inconsistent with recent data CareFirst has disclosed about its own true costs.

Specifically, in its Program Description and Guidelines for its Patient-Centered Medical Home (PCMH) and Total Care and Cost Improvement (TCCI) programs, CareFirst disclosed extensive data on its trend for the last several years both for its PCMH business and for its business as a whole.[4] Figure 8 from that report shows CareFirst's overall trend for all its business declining from 6.8% in 2011 to 4.4% in 2012 to 2.4% in 2013 and then up somewhat to 3.7% in 2014; it shows trend for its PCMH business declining from 6.8% in 2012 to 4.8% in 2013 to 2.0% in 2014.

[3] Id.

[4] CareFirst, Program Description and Guidelines for CareFirst Patient-Centered Medical Home Program and Total Care and Cost Improvement Program (2016).

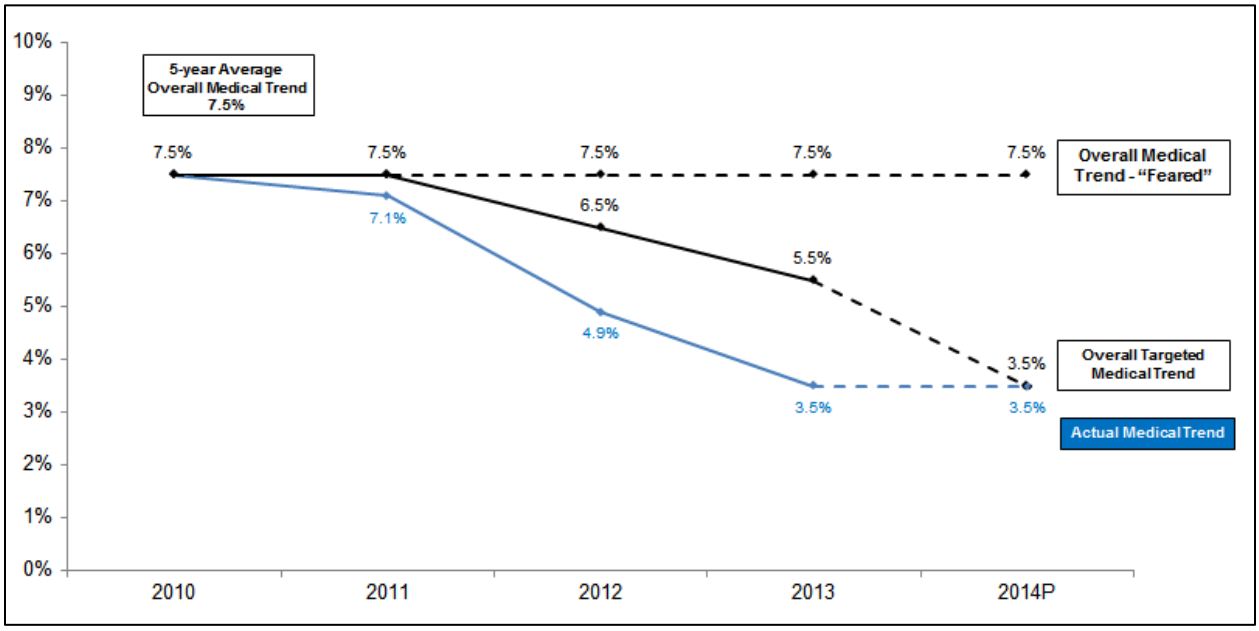
Figure 2: Figure 8 from CareFirst PCMH Report



	2010/2011	2011/2012	2012/2013	2013/2014
CareFirst Book of Business Trend	6.8%	4.4%	2.4%	3.7%
PCMH Trend		6.8%	4.8%	2.0%
PCMH OIA Targeted Trend	7.5%	6.5%	5.5%	3.5%

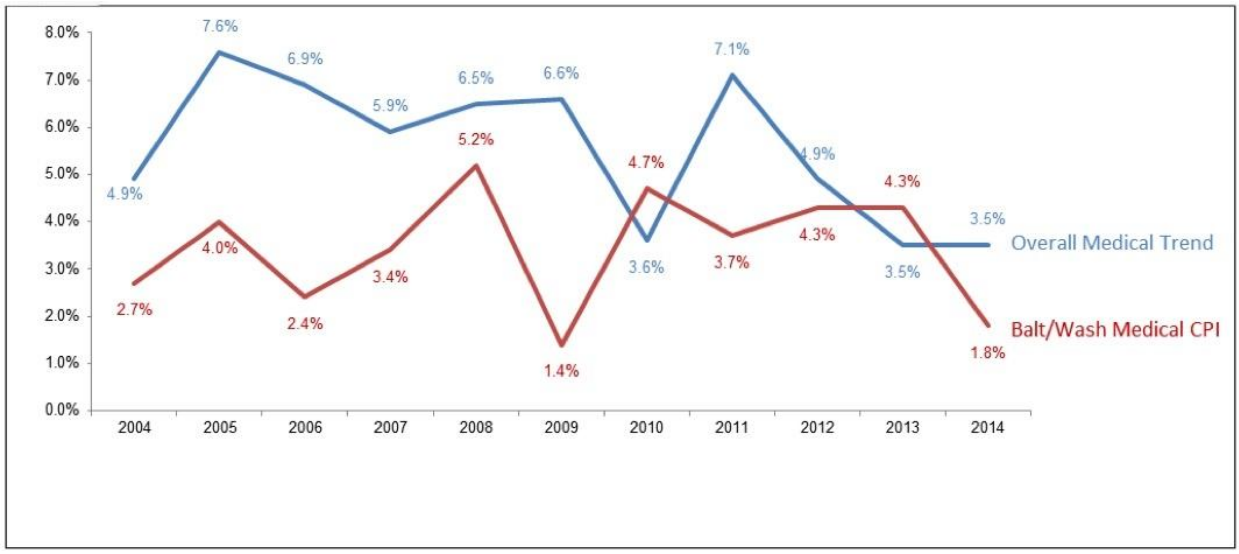
Figure 9 from CF's PCMH report, which is based on CareFirst's entire book of business, is perhaps even more significant. It shows CareFirst's trend at 7.5% in 2010, and indicates that CareFirst had feared that that same 7.5% trend would continue for the next three years. But CareFirst targeted a decline in trend over five years, to 3.5% in 2014, and it not only achieved that 3.5% trend in 2014 but saw its trend decline at a steeper rate than it had projected.

Figure 3: Figure 9 from CareFirst PCMH Report
(Targeted vs. Actual Trend for CareFirst Whole Book of Business)



A third chart, at E-2 of Appendix E to the CF PCMH Report, raises further questions about the validity of CareFirst's current overall 8%+ trend assumptions. That chart, reproduced below, shows CareFirst's annual overall medical trend since 2004. Like the previous charts, it shows that CareFirst's trend has declined steadily since 2011. It also shows, however, that even before 2011 CareFirst's trend was never as high as the 8%+ trends it is using in its current filings, and in only one year was it as high as 7%.

Figure 4: from Appendix E of CareFirst PCMH Report
(CareFirst's Overall Medical Trend Since 2004)



Importantly, the CareFirst PCMH Report, although highlighting the effectiveness of CareFirst's PCMH program, documents CF's actual medical trend for its entire book of business, as the preceding charts make clear. The health status of different segments of CF's business may vary, but CF has already separately and explicitly factored into the rate the health status of each segment before considering trend. The health status of CF's individual business relative to CF's other business segments, or to the health status of other carriers' individual business, is thus not a valid justification for CF's use of a higher trend factor than it uses for its group business, or than other carriers use for their individual business.

In short, it is difficult to justify CareFirst's use of 8.2% and 8.7% trend factors in its current filings in the face of all the data to the contrary in other Maryland carriers' rate filings, in the latest Milliman Index, and in CareFirst's PCMH report. In addition, the data CF includes in its Trend Analysis Summaries in its rate filings, which differ substantially by company, do not appear to support CF's 8%+ trends. CF appears to set forth the trends it used in its 2016 rate filing, and the trends it is using in its current filing, but it doesn't set forth what the actual increase in health care costs was in 2016, or in any prior year.[5] The actual trend--the actual increase in healthcare costs--is what CF should be basing its trend assumption for 2017 on. Those trends are documented in its PCMH Report.

C. Changes in morbidity

It is undisputed that the universe of people enrolling in 2014--the first year in which people could buy insurance regardless of health status--can reasonably be assumed to be less healthy than average, since people with health conditions who formerly were unable to buy insurance could now buy it. We have argued previously that 2014 enrollees being disproportionately in bad health means that enrollees in subsequent years necessarily have to be in better health than 2014 enrollees. CF disagreed, however, and assumed substantially worse morbidity in 2015 and then still worse morbidity for 2016.

This year, for the first time, CF acknowledges that the new enrollees it will have in 2017 will be healthier than its current book of business. This conclusion necessarily follows from CF's assumption that without new entrants its morbidity would increase--by 3.4% for Blue Choice, and by 4.2% for CFMI and GHMSI--but that its total projected business for 2017 shows

[5] BlueChoice, Inc. Rate Filing #2110, Rates Effective 1/1/2017, Actuarial Memorandum at 12 (May 2, 2016); CareFirst of Maryland, Inc., Rate Filing # 2111, Rates Effective 1/1/2017, Actuarial Memorandum at 13 (May 2, 2016); Group Hospital and Medical Services, Inc., Rate Filing #2109, Rates Effective 1/1/2017, Actuarial Memorandum at 13 (May 2, 2016).

either a flat (for Blue Choice) or almost flat (for CFMI/GHMSI) distribution when new entrants are added.

CF also acknowledges that more than 3% of its membership for both Blue Choice and CFMI/GHMSI will be migrating from either CF group business or CF grandfathered policies. Both are in better health than current CF individual membership--CF has said so in previous years' rate filings--and thus should further reduce the morbidity of CF's 2017 business.

Notwithstanding the more favorable morbidity of new entrants, including those migrating from CF group business and CF grandfathered products, CF assumes a slight increase in morbidity for its total 2017 book of business. While its magnitude is negligible, many carriers in other states are acknowledging a net improvement in morbidity for 2017. It is unclear why CF should continue to assume slightly worsening morbidity for 2017 rather than acknowledging, as so many other carriers have, that overall morbidity is improving.

In addition, CF states that it had higher than anticipated claims in 2015 for its PPO business (4.1% higher for CFMI, and 2.7% higher for GHMSI). It is proper for CF to consider claims costs for 2015 that were higher than it initially anticipated in estimating the morbidity of people it projects it will insure in 2017. It is not proper, however, for CF to charge any part of those higher-than-anticipated claims for 2015 to 2017 enrollees. The MIA should satisfy itself that CF's proposed 2017 rates do not include any charge for 2015 business on which CF either lost money or earned less than its target profit.

D. Contribution to reserves and risk margin.

CF includes a 2% contribution to surplus or risk margin in all three rate filings. Many non-profit Blues include smaller contributions to surplus or risk margin--if they include any such

contribution at all--and instead rely primarily on investment income to make a profit. The MIA may wish to hold CF to the same standard.

In addition, in ruling on CF's rate requests for Maryland the Commissioner may wish to consider the current posture of the D.C. Department of Insurance, Securities and Banking ("DISB") proceeding regarding CF's surplus. In particular, the D.C. Commissioner has frozen GHMSI's rates for at least one year,[6] has found that GHMSI has excess surplus,[7] and is developing a plan to dedicate GHMSI's excess surplus in a fair and equitable manner.[8] There clearly is a tension between GHMSI's surplus being reduced in the District at the same time that GHMSI is seeking a 2% increase in its surplus in Maryland. More fundamentally, there is a tension between GHMSI maintaining its current rates for its D.C. policyholders but raising its rates by 15.9% for its Maryland policyholders. The Commissioner may wish to consider whether such a situation is unfairly discriminatory and/or inequitable and, if so, whether there is any action he can take to eliminate or reduce any inequities involving similarly situated GHMSI policyholders, either alone or in conjunction with the D.C. Commissioner.

E. Administrative Expense Load

CF says that for all three of its companies it is assuming the same level of administrative costs that it assumed in 2016. However, there is an argument that insurance company administrative expenses should be decreasing because of the Exchange distribution system, the elimination of underwriting, the enrolling of people in private insurance by ACA-authorized Navigators, and the marketing of private insurance by governmental entities, foundations, and

[6] DISB, In the Matter of Surplus Review and Determination for Group Hospitalization and Medical Services, Order No.: 14-MIE-16, at 19 (June 14, 2016).

[7] Id. at 14-15.

[8] Id. at 19.

non-profit organizations. The MIA may therefore wish to consider whether to continue to allow CF to pass through to consumers 100% of its assumed administrative costs.

F. Rebate adjustment factor

CF changed its Pharmacy Benefits Manger in 2014, which has enabled it to receive higher rebates, which in turn has allowed it to reduce its prescription drug costs by 2.5% for CFMI and GHMSI, and by 4% for Blue Choice. Evergreen, however, which is a much smaller company than CF, entered into a new contract with Optum based on which it has reduced its prescription drug costs by 13%. It is possible that the prices Evergreen had been paying for prescription drugs were so much higher than what CF was paying that a 13% reduction from Evergreen's original costs still leaves it paying more than CF. However, because Evergreen's rates are substantially lower than CFBC's for Bronze coverage, and substantially lower than both CFBC's and CFMI's for Silver and Gold coverage, the more likely conclusion is that CF is paying unnecessarily high prices to drug companies. Should the MIA so conclude, it may wish to prevent CF from passing 100% of those prices through to consumers.

G. Cessation of traditional reinsurance

CF will not be receiving any reinsurance payments based on its results for 2017, since the ACA's reinsurance program expires at the end of 2016. On the other hand, in 2017 CF may well be receiving reinsurance payments attributable to prior years. In addition, reinsurance payments to CF (and other insurers) substantially exceed the amounts HHS originally told carriers they would receive, which is the amount the carriers assumed in their rate filings that they would receive. The MIA should ensure that any higher-than-assumed reinsurance payments received by CF are passed through to policyholders.

In addition, the MIA may want to satisfy itself that the 6.7% increase which CF assumes for CFMI and GHMSI because the reinsurance program is ending does not exceed the amount CF estimated that reinsurance payments would reduce its claims costs by for 2016--particularly in view of a recent American Academy of Actuaries analysis finding that for 2016 the reinsurance program would likely reduce net claims by between 4 and 6%.[9]

H. The effect of risk-adjustment

CF assumes that for 2017 Blue Choice will make a risk-adjustment payment of $17, and that CFMI/GHMSI will receive a risk-adjustment payment of $71 PMPM . The MIA may wish to ensure that CF's assumptions with respect to the risk-adjustment payments Blue Choice will be making and that CFMIA/GHMSI will be receiving are realistic, particularly in view of the uncertainty regarding Evergreen's risk-adjustment liabilities.

I. Three cost-reducing factors which CareFirst has failed to consider

CareFirst has ignored, or at least has not explicitly factored into its rate filing, three factors that can reasonably be expected to reduce costs in 2017. The first is the fulfillment of pent-up demand: enrollees with health conditions may well have worse-than-average health status over the long run, but they will have gotten their high initial needs taken care of when they first enrolled. Over the long run, therefore, they will not have as high costs as they did in the first year they were insured.[10]

[9] American Academy of Actuaries, Issue Brief: Drivers of 2016 Health Insurance Premium Changes, at 2 (Aug. 2015).

[10] See John Bertko, What to Expect for 2015 ACA Premiums: An Actuary Opens the Black Box, at 2 (NIHCM Foundation May 2014); see also UCLA Center for Health Policy Research, Increased Service Use Following Medicaid Expansion Is Mostly Temporary: Evidence from California's Low Income Health Program, at 3 (Oct. 2014) ("Pent-up demand for care appears to decline rapidly after the first year of enrollment and becomes comparable to the demand of those with previous comprehensive coverage.")

Second, CareFirst has not factored into its rate filings the effect of the more than 700% increase between 2014 and 2017 in the penalty for not buying insurance. Notably, a recent Kaiser study finds that 7 million uninsured people are currently eligible for premium subsidies, and that 48% of them could buy a bronze plan for less than the penalty they owe if they remain uninsured.[11] That the penalty exceeds the cost of coverage for so many people can reasonably be expected to increase both the number of CF insureds and the number of healthy CF insureds, thus improving the health status of and lowering costs for its entire individual book of business.

Third, the ACA has authorized various health care delivery system reform programs. The evidence of their effectiveness has been mixed,[12] but CF itself has done an extensive study--its PCMH study--documenting that at least some of these reforms have saved CF money. No justification for CareFirst's highlighting the effectiveness of these reforms in its PCMH report, but ignoring them in its rate filing, is immediately apparent.

III. The Kaiser filing

Kaiser has asked for a rate increase of 25%. During its base experience period--calendar year 2015--Kaiser took in $74.7 million in premium and received a reinsurance payment of $3.6 million, while paying out $75.8 in claims, $14.5 million for administration, and another $19.9 million as a risk adjustment payment. It thus had a net loss of $31.9 million, or 42% of what it took in in premium. So a rate increase for Kaiser is justified. However, at least two assumptions Kaiser makes indicate that the full 25% increase it proposes should not be approved. In particular:

[11] Kaiser Family Foundation, The Cost of the Individual Mandate Penalty for the Remaining Uninsured, at 3 (Dec. 2015).

[12] See, e.g., Commonwealth Fund, The Affordable Care Act's Payment and Delivery System Reforms: A Progress Report at Five Years (May 2015).

* Kaiser assumes that the new business it will receive in 2017 will have health status that is approximately the same as the health status of its current enrollees. This is contrary to the belated but nevertheless welcome realization by CareFirst that new business in 2017 is likely to be healthier than renewal business, and also contrary to the assumptions of many carriers in other states. Because people with health conditions were much more likely to sign up when they first had the opportunity to--i.e., in 2014--as time goes on new business should be healthier, and the experience of the total pool should be better due both to the superior experience of new business and the fact that the pent-up demand of those renewing has been fulfilled. So in Exh. 4 to its Actuarial Memorandum, Kaiser's morbidity development exhibit, it would be more reasonable for Kaiser to assume less than 1.000 for the morbidity both of its renewal business (line 3) and its new business (line 4).

* Kaiser assumes an administrative expense trend of 3.5%.[13] It uses a health care cost trend of 2.9%. There is no rational basis for assuming a higher trend for administrative expenses. To the contrary, the Exchanges are designed to reduce administrative expenses, and as time goes on and carriers become more accustomed to doing business through the Exchange, administrative expenses should decrease, not increase. In any event, there is no justification for an administrative expense trend that exceeds medical trend.

In addition, the Commissioner should satisfy himself that the assumptions Kaiser has made that should lead to lower rates have been given full weight in the rate filing. For example, in Exhs. 9 and 10 of its Actuarial Memorandum Kaiser acknowledges that its 2017 plans will require enrollees to pay more of their own costs, primarily as a result of higher deductibles and higher out-of-pocket maximums. As a result, Kaiser projects that utilization will be only 87% of

[13] Kaiser Actuarial Memorandum at 6; Id. at Exh. 17.

what it currently is. The Commissioner should ensure that the full effect of that substantially reduced utilization is reflected in Kaiser's rates for 2017.

Similarly, Kaiser assumes a very low overall trend factor: 2.9%, which is almost two full points less than the national 4.7% increase in health care costs, and just 1/3 of the trend CareFirst is using for its PPO business.[14] The Commissioner should ensure that Kaiser's 2017 rates are in fact based on a 2.9% trend factor.

IV. The Evergreen filing

The most significant aspect of the Evergreen filing is the manner in which it treats the risk-adjustment payment Evergreen owes. The actuaries who have prepared the Evergreen filing--Milliman--note that they are making an assumption that is contrary to their actuarial judgment but that they have been directed to make by management: that Maryland will cap its risk adjustment payment at 3% of premium for 2017, and that it will make that 3% cap retroactive so that it also applies to the 2015 and 2016 calendar years.[15] Milliman states that that such a cap would limit Evergreen's risk-adjustment payment to $1.62 million, though it does not specify the year for which it would so limit its payment.[16] Most importantly, although Milliman also does not disclose the amount Evergreen would have to pay if its risk-adjustment liability is not capped, it says that absent such a cap the rates in the rate filing will be inadequate, and Evergreen could become insolvent.[17]

[14] Id., Exh. 11.

[15] Milliman, Evergreen Health Cooperative Inc. Individual market 2017 Part III Actuarial Memorandum, at 4.

[16] Id. at 9.

[17] Id. at 4, 9, 10.

Notably, risk-adjustment works much better in theory than in practice. In theory, it requires insurers with relatively favorable risks to pay the carriers with less favorable risks an amount that compensates them for all costs resulting from unfavorable risk selection. In fact, however, all risk adjustment systems account for only a small fraction of pure differences in risk, and all can be gamed: a December 2013 article by three Milliman actuaries, for example, argued that insurers who attracted less healthy risks would actually be *better* off under the HHS risk-adjustment system--as long as they attracted the right kind of less healthy risks.[18]

The limited efficacy of risk-adjustment systems is not an argument for excusing Evergreen from making risk-adjustment payments. To the contrary, it is reasonable to assume that all else equal, a well-established carrier with a well-recognized brand like CareFirst is likely to attract a larger percentage of people with health conditions than a start-up carrier. Despite the irony of the start-up making payments to the long-time dominant carrier in the state, a risk-adjustment payment from Evergreen to CareFirst may well be warranted. The commissioner should seek to ensure, however, that the risk-adjustment system does not over-correct for differences in risk, and that it is not being gamed. He may also wish to keep in mind that because of the dramatic difference between the size of CareFirst and the size of Evergreen, a payment from Evergreen to CareFirst that would drive Evergreen into insolvency would make very little difference to CareFirst.

In addition, although Evergreen is understandably concerned with the risk-adjustment issue, a fundamental problem for all the ACA-authorized COOPS that have not already failed is that they were not designed to succeed. Three provisions of the ACA section establishing the COOPS make this clear. First, Congress required the COOPS to comply with all state solvency

[18] Milliman, When Adverse Selection Isn't: Which members are likely to be profitable (or not) in markets regulated by the ACA (Dec. 2013).

requirements that the established carriers must comply with, and thus as a practical matter prohibited state insurance commissioners from taking any action to assist the COOPS. ACA secs. 1324(c), 1324(b)(7). Such a requirement makes it very difficult for COOPS to compete with experienced, much larger carriers.

A counter-example--an example of a thinly-capitalized government-authorized carrier successfully competing with incumbent carriers--is the mutual workers compensation insurer authorized by the Missouri legislature in 1993, known as Missouri Employers Mutual, or MEM. The Missouri legislature established MEM with a loan of $5 million, which under the risk-based capital and premium-to-surplus ratio standards applying to traditional workers compensation carriers would not have permitted MEM to write a meaningful amount of business. The legislature also, however, included a provision empowering the Insurance Commissioner to allow MEM to gradually come into compliance with statutory solvency standards, rather than having to comply with such standards all at once. See 287.920.5, RSMo. ("The company is subject to all provisions of the statutes which relate to private insurance carriers and to the jurisdiction of the department of insurance…in the same manner as private insurance carriers, *except as provided by the director*.") The Commissioner exercised the discretion the statute conferred on him, and as a result MEM was able to write more business than it could have otherwise, and is today the largest workers comp carrier in Missouri. The most obvious interpretation of the ACA provision authorizing the COOPS is that it does not permit state insurance commissioners to take similar actions regarding the COOPS. But should the Commissioner conclude that the statutory language can reasonably be interpreted to not completely preempt his discretion regarding the solvency standards applicable to Evergreen, he may wish to consider exercising that discretion.

Second, the ACA prohibited the COOPS from spending any federal money on marketing. ACA sec. 1322(b)(2)(C)(ii)(II). In view of the fact that the COOPS are competing with such established brands as Blue Cross and Kaiser, such a prohibition is a major handicap. In this area too Missouri Employers Mutual provides a counter example: it heavily advertised on radio and in print throughout Missouri, participated in numerous community events, and sponsored the half-time programs at the University of Missouri basketball games. It thereby became a recognized brand.

Third, the ACA prohibited the COOPS from banding together to pool their bargaining power in dealing with health care providers. ACA sec. 1322(d)(2). They therefore could not take advantage of the volume discounts larger carriers receive.

In short, the larger-than-expected risk adjustment payment Evergreen owes surely exacerbates its problems. But the fundamental problem with the COOPS is that the rules Congress required the COOPS to follow when it enacted the ACA were not designed to help them succeed. To overcome the inherent deficiencies of the statute, the creativity of the Commissioner and the cooperation of the industry--as well as the performance of Evergreen--are essential.

V. Troubling aspects of the current rate distribution by metal level by company, and the distributive effects of 2017 rate changes

The extent to which and basis on which insurers vary their rates by metal level has received very little attention. The extent of the Commissioner's discretion to limit such variation has also received little attention. This section discusses some troubling aspects of the current distribution of the rate by metal level by company, which the Commissioner may wish to ameliorate if he concludes that he has discretion to do so.

The MIA has posted a very helpful premium comparison by insurer, by metal level--using the lowest-priced plan at each metal level--and by age at its website. That premium comparison is reproduced below:

Figure 5: Maryland Insurance Administration Baltimore Metro Area Approved Rate Examples for 2016 Individual Plans Per Person Before Financial Help

	All Savers (UnitedHealthcare)	CareFirst (CareFirst of Md.)	CareFirst (BlueChoice)	CareFirst (GHMSI)	Cigna Health and Life Insurance Co.	Evergreen Health Cooperative	Kaiser Foundation	UnitedHealthcare of the Mid-Atlantic
Age 21	$180.77	N/A	$121.76	N/A	N/A	$144.56	$140.15	N/A
	$205.86	$196.86	$139.26	$196.86	$205.71	$157.28	$153.63	$164.27
	$243.12	$276.31	$231.67	$276.31	$247.20	$197.31	$190.44	$194.55
	$290.34	$399.40	$307.76	$399.40	$317.29	$241.76	$243.25	$222.86
	N/A	N/A	N/A	N/A	N/A	$277.74	$271.74	N/A
Age 40	$263.09	$251.59	$177.97	$251.59	$262.90	$201.00	$196.34	$209.93
	$310.71	$353.12	$296.07	$353.12	$315.92	$252.16	$243.38	$248.62
	$371.05	$510.44	$393.32	$510.44	$405.49	$308.96	$310.87	$284.80
	N/A	N/A	N/A	N/A	N/A	$354.95	$347.28	N/A
Age 60	$558.70	$534.29	$377.94	$534.29	$558.31	$426.85	$416.95	$445.82
	$659.82	$749.90	$628.75	$749.90	$670.89	$535.49	$516.85	$527.98
	$787.98	$1,083.98	$835.27	$1,083.98	$861.12	$656.13	$660.18	$604.82
	N/A	N/A	N/A	N/A	N/A	$753.78	$737.50	N/A

Evident from the above chart are the following (using rates for 40-year olds; the same relationships hold for the other ages because CMS sets the age differentials):

* Blue Choice, at $178 a month, is the lowest-priced Bronze (60% actuarial value) plan: it is $19, or 10%, cheaper than the next-lowest-priced plan, which is Kaiser.

* For Silver (70% AV), on the other hand, Blue Choice is far higher than either Kaiser or Evergreen: Kaiser is $243 and Evergreen $252, whereas CareFirst is $296.

* The difference between the prices of the Kaiser and Evergreen Bronze and Silver plans is less than $50, or about 25%. The difference between the price of the Blue Choice Bronze and Silver plans, on the other hand, is $118, or 66%.

* Similarly, the differences between the prices of the Kaiser and Evergreen Silver and Gold (80% AV) plans are, respectively, $68 or 27%, and $57 or 23%. For Blue Choice, on the other hand, the difference between Silver and Gold is $97, or 32%.

* At any metal level, CFMI/GHMSI is always the highest or second highest priced plan in the market. For Gold, it is 26% higher than Cigna, the next highest, and it is 65%--about $200--higher than Kaiser and Evergreen. It is also by far the highest-priced Silver plan, and the second highest priced Bronze plan, more than 25% higher than both Kaiser and Evergreen.

* No CareFirst company offers Platinum (90% AV) coverage. Evergreen and Kaiser do, and their Platinum is much less expensive than either CFBC's or CFMI/GHMSI's Gold.

What conclusions can we draw from the above? First, it is pretty apparent that CareFirst is trying to drive as many as people as possible into its most limited coverage. CF also appears to be seeking to drive people out of both CFMI and Blue Choice Gold coverage and into either A CareFirst Silver plan or other carriers' Gold coverage, since both of those alternatives are much less expensive than either the CFMI/GHMSI Gold plan or the Blue Choice gold plan.

Second, because CareFirst does not offer Platinum while both Evergreen and Kaiser do--and at a lower price than CareFirst's less generous coverage--it is reasonable to assume that a substantial portion of high-cost insureds would opt for Evergreen or Kaiser platinum coverage over the less generous, more expensive CareFirst coverage. If that is true, it is inconsistent with Evergreen owing a big risk-adjustment to CareFirst. It is possible that CareFirst has figured out a way to attract healthier people than Evergreen but to have the risk-adjustment mechanism work

in its favor, in line with the Milliman December 2013 article. It is also possible that the difference in the breadth of the CareFirst network and the Evergreen network is so great that people with health conditions prefer to stay with CareFirst even at a much higher price.

In any event, to the extent he concludes that he has the discretion to do so, the Commissioner may wish to compress the differentials between the metal levels of CareFirst's plans--particularly the 66% differential between Blue Choice's bronze and silver plans, and the 44% differential between CFMI/GHMSI's gold and silver plans. It is difficult to see how differences of that magnitude--which are so much greater than either Evergreen's or Kaiser's differentials--could be actuarially justified.

Finally, the chart below uses the same data in the preceding chart from the MIA (although excluding United, which is no longer on the Exchange in 2017), but rearranges it to highlight the lowest-priced plan at each metal level and the hierarchy of plans by price at each metal level. The Commissioner may wish to consider both the relationship between the current rates of the different carriers, and the rates charged by individual carriers at different metal levels, in determining what rates he will approve for 2017.

Figure 6: 2016 Exchange Monthly Premium for 40 Year Old, Baltimore Metro Area

Metal Level	**Monthly Premium**				
Bronze	$177.97 (BC)	$196.34 (K)	$201.00 (E)	$251.59 (CF)	$262.90 (C)
Silver	$243.38 (K)	$252.16 (E)	$296.07 (BC)	$315.92 (C)	$353.12 (CF)
Gold	$308.96 (E)	$310.87 (K)	$393.32 (BC)	$405.49 (C)	$510.44 (CF)
Platinum	$347.28 (K)	$354.95 (E)	N/A	N/A	N/A

BC = Blue Choice
C = Cigna
CF = CFMI/GHMSI
E = Evergreen
K = Kaiser