



Deposition of:
Hearing

July 15, 2020

In the Matter of:
ACA Hearing

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1 MARYLAND INSURANCE ADMINISTRATION

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3 2021 ACA PROPOSED HEALTH INSURANCE

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PREMIUM RATES HEARING

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The hearing in Re: 2021 ACA PROPOSED

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HEALTH INSURANCE PREMIUM RATES was held remotely on

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Wednesday, July 15, 2020, at 2:00 p.m., via Google

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Meet, before Ilana E. Johnston, Notary Public.

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Reported by:

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Ilana E. Johnston (via Google Meet)

1 APPEARANCES: (via Google Meet)

2

3 MARYLAND INSURANCE ADMINISTRATION STAFF:

4 KATHLEEN A. BIRRANE, Commissioner

5 GREG DERWART, Chief of Staff

6 TODD SWITZER, Chief Actuary

7 DAVID COONEY, Chief of Life and Health

8 VAN DORSEY, Principal Counsel

9 MICHAEL PADDY, Director of Government Affairs

10 CRAIG EY, Director of Communications

11 JEFF JI, Senior Actuary

12 BRAD BOBAN, Senior Actuary

13 ADAM ZIMMERMAN, Senior Actuary

14

15 COMPANY REPRESENTATIVES: (via Google Meet)

16 REGIS MURAYI, Aetna

17 PETER BERRY, CareFirst BlueCross BlueShield

18 JAMES CHU, Kaiser Permanente

19 RYAN MORGAN, UnitedHealthcare

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1 T H E P R O C E E D I N G S

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3 COMMISSIONER BIRRANE: Good afternoon.

4 I'm Kathleen Birrane, Insurance Commissioner, and I
5 am pleased to welcome you to the Maryland Insurance
6 Administration's virtual public hearing on the 2021
7 Proposed Health Insurance Rate filings. We're
8 going to take a few minutes to give folks a final
9 few moments before we jump into the meat of the
10 meeting, but in the meantime I will go over a few
11 housekeeping items for you.

12 First, this year's hearing on the ACA
13 rates is unique in that it is online. This is a
14 first. And I'm going to thank you all in advance
15 for your patience as we navigate this virtual
16 environment. We will do our best, but this is the
17 first meeting that we've had using Google Meets in
18 this way.

19 Second, this hearing is being taped, and
20 it will be made available for viewing on the MIA's
21 website, along with any materials that have been

1 submitted before this or during the hearing.

2 Third, I appreciate that some of the
3 folks joining us today may not have had an
4 opportunity to sign up to speak in advance. In the
5 past we have invited people to sign up to share
6 their views when they came to our building to
7 participate in the meeting. Obviously, we can't do
8 that here, but what I am going to do is invite you
9 to signal your desire to speak by identifying
10 yourself in the chat function. And we will call on
11 as many people as we can at the end of the prepared
12 presentations.

13 So if you look on your screen and you
14 see a place where you have the ability to chat, if
15 you want to share your views, at any time during
16 the meeting just type your name and your
17 affiliation and the phrase I wish to comment, and
18 then at the end of the prepared comments and those
19 people that signed up in advance, we will call on
20 people and ask them at that point to unmute
21 themselves and then give everybody, if we can, two

1 or three minutes to speak.

2 Now, if for any reason you're unable to
3 use that function or if you're joining us by phone,
4 please understand that we still care about your
5 comments. We want to hear your comments. And you
6 can provide your comments by forwarding them to us
7 at the Administration. At the end of the hearing
8 we will put up a slide with contact information so
9 that if there's something that you wanted to say
10 that you didn't get a chance to say, you can
11 communicate that by e-mail or by writing your
12 thoughts out and sending them to us.

13 Finally, because this is part of every
14 virtual meeting these days, I'm going to ask you to
15 keep yourself on mute throughout the hearing, and
16 when you're called upon, please unmute your line
17 while you are speaking.

18 So with that we'll get started on the
19 merits. As I said, my name is Kathleen Birrane,
20 and I'm the Maryland Insurance Commissioner. The
21 purpose of today's hearing is to discuss the 2021

1 Affordable Care Act health insurance rate filings
2 submitted by those Maryland insurers participating
3 in the individual, non-Medigap and small group
4 markets which are before the Maryland Insurance
5 Administration for consideration.

6 Our Chief Actuary Todd Switzer will
7 provide a high level summary of the filings,
8 together with an overview of key considerations in
9 the Administration's review of those filings. We
10 will then hear from each of the insurers that has
11 submitted a filing.

12 Representatives of each carrier will
13 have the opportunity to explain their filings and
14 the increase or decreases sought, and the MIA will
15 ask questions about the filings. We will then take
16 comments from interested parties. We will first
17 hear from those that signed up to speak in advance
18 and then to the extent that time permits from those
19 that have said they wish to comment by identifying
20 themselves in the chat function.

21 Again, please identify yourself by

1 providing your name, affiliation and policyholder
2 is just fine, just to call yourself a policyholder,
3 that's okay, or concerned citizen or concerned
4 Marylander and say that you want to comment.

5 Maryland's rate review laws provide that
6 only those rates approved by the Insurance
7 Commissioner may be charged to policyholders.
8 Before approval, all filings must undergo a
9 comprehensive analysis of the carrier's statistics
10 and assumptions. Public comments are considered
11 part of the review process.

12 The Commissioner must approve or modify
13 any proposed premium rates, sorry, any proposed
14 premium rates that appear to be inadequate or
15 excessive in relationship to the benefits being
16 offered or that are unfairly discriminatory. More
17 information on the rate review process can be found
18 on the MIA's website. The Maryland Insurance
19 Administration anticipates announcing our approved
20 health insurance rates by September 15th.

21 Before we begin, I would like to take a

1 moment to introduce the folks who are here with me
2 from the Insurance Administration. First, our
3 Chief of Staff Greg Derwart, our Chief Actuary Todd
4 Switzer, Associate Commissioner for Life and Health
5 David Cooney; our Principal Counsel Van Dorsey; our
6 Director of Government Affairs Michael Paddy and
7 our Director of Communications Craig Ey. And there
8 are other members of the team for the MIA's
9 actuarial team that are on the call, and if I
10 failed to introduce you, I apologize.

11 Again, as a reminder, this hearing is
12 being recorded and will be posted to the
13 Administration's website. So before we call up the
14 carriers, our Chief Actuary would like to say a few
15 words. Todd.

16 MR. SWITZER: Thank you. Good
17 afternoon, and thank you for the concern
18 demonstrated by your participation here. I
19 appreciated also some of the comments that we've --
20 that have come in. A couple that came to the
21 forefront to me were Beth Sammis and Lenny Preston,

1 some of their comments that said please try to get
2 the lowest possible premiums, put consumers'
3 concerns in the forefront, also Stephanie Klapper,
4 do everything in your power to bring premiums down,
5 and her e-mail address is coverage for all, and
6 balancing that with a strong market where rates are
7 adequate and a vibrant market.

8 I appreciate the carriers' patient
9 answering of all of our questions and explicitly
10 thank them for the, what I'm calling premium
11 abatement filings in light of the pandemic that
12 they have submitted. We have 31 filings so far.
13 They have stood in the breach as the pandemic has
14 come on, covering treatment and giving rate relief.
15 We're approaching nearly a million Marylanders who
16 have benefited from that. So thank you for that.

17 As we go through the slides, I'm about
18 to share my screen, I'm not intending to read
19 through them. I am intending to give you the
20 chance to look at them and see what catches your
21 attention and follow up if you'd like to. I'll

1 bring out the highlights before the carriers come
2 up. So I'm sharing my screen.

3 So getting to what's been filed,
4 starting with the individual market, a composite
5 for all of the carriers is a negative 6.8 percent,
6 there again, the individual non-Medigap market.
7 That's an update from the press release --

8 COMMISSIONER BIRRANE: Todd, your screen
9 isn't up.

10 MR. SWITZER: Thank you. Let me adjust
11 that. Give me one second please. Did that take
12 care of it?

13 COMMISSIONER BIRRANE: Yes. We can see
14 it now. Thank you, Todd.

15 MR. SWITZER: Thank you. Sorry about
16 that. So the press release stated an average
17 composite rate decrease filed of negative 4.8.
18 That's come down to 6.8. And that follows the
19 preceding two years of negative 13.2, to remind
20 everyone, and negative 10.3, so a nice progression.
21 There's a range in there of negative 12 to 4.3 by

1 legal entity. There's also variances by metal.
2 Some of the silver plans had higher increases. The
3 catastrophic young adult plan had some higher
4 increases. So I want to be clear on what we're
5 communicating here, trying to find the most concise
6 way. And this is what we settled on. But there's
7 some background how it may differ for each
8 circumstance.

9 Enrollment thankfully is up to almost
10 210,000, May to May, this year to last year.
11 Trying to communicate what that would mean for
12 Marylanders, so the family of four, premiums could
13 come down again on average, there's range in here,
14 but by 700 and, call it 70 dollars from, still a
15 significant number for a family, 14,709, but down
16 to 13,940.

17 We're very glad to welcome
18 UnitedHealthcare back to the market in 14 counties.
19 Instead of carrier -- Marylanders having one choice
20 in 13 counties, that will come down to 8 counties.
21 Instead of one choice for about 85 percent of the

1 population, we'll have multiple choices per -- I'm
2 sorry. I said that the reverse way. For 93
3 percent, so moving in the right direction for
4 options.

5 Mentioning the Advance Premium Tax
6 Credit because the second lowest cost Silver, not
7 to get too detailed, but I do want to be
8 transparent, will change and the rates are changing
9 and will change throughout the review process. But
10 in preliminary estimates there could be some cases,
11 as you know, when the rates come down, the federal
12 subsidy comes down and there could be 20 percent of
13 our members who their subsidized premium could go
14 up an average of \$50 a month so far. Again, we
15 didn't get specific numbers because they're
16 changing, but did want to alert to the full gamut
17 of how the dynamics in the market could affect
18 everyone.

19 And as far as COVID, which we will speak
20 about a little more later, one carrier had an
21 explicit adjustment of 1.02, United, in the

1 individual market, everyone citing uncertainty,
2 which is understood.

3 A brief update on our waiver program.
4 When Wakely initially did the modeling back in
5 2018, they estimated that the cost of covering
6 claims over 20,000, there's other details to that,
7 but generally that, would be \$462 million, and so
8 far that's coming in at 353, so the right
9 direction, a variance of 109 million, couple that
10 with an estimate that the dollars that we would get
11 from the federal government because they're paying
12 less in subsidy because the premiums came down,
13 estimated at 319, but CMS that the federal
14 government has estimated at 447, so another
15 favorable variance of 129 million.

16 This is thanks to, on this last point on
17 this page, Stephanie Klapper and Vinny DeMarco and
18 the Easy Enrollment Health Insurance Program and
19 the Special Enrollment Program in general. I
20 didn't update this today, but as of yesterday, not
21 even bringing in the many more Medicaid members

1 that have gained coverage, but we have 18,000 more
2 members from the COVID Special Enrollment in the
3 individual market and almost a thousand in the Easy
4 Enrollment on their tax return. Hopefully there
5 will be more coming in today. And the total is
6 18,951.

7 So it helped me to visualize what
8 United's entry meant and to put that into context
9 of where we left off when we had the last hearing.
10 And on the left is United's service area, the 14
11 counties that I mentioned. And, again, CareFirst
12 is everywhere in this whole page, all of these
13 counties.

14 We got the yellow. And of the nine
15 Eastern Shore counties, we gained three counties of
16 the nine will have another choice. Not Calvert,
17 when you go back over the bridge, but St. Mary's
18 will have United there as well. And then just
19 comparing that to Kaiser, to the right, the blue
20 ones are the full counties where Kaiser is present.
21 The orange ones are partial coverage there. But

1 that's intended to quickly let you see how choices
2 are changing and how we go from 85 percent coverage
3 to 93 percent coverage.

4 So switching to small group, the filed
5 renewal for the whole year, all four quarters, is
6 5.3 following years of 5.0 and 2.9. There is a big
7 range by legal entity on that of negative 9 to
8 10.4. As we've seen unemployment go in Maryland
9 from, in November, about 3 and a half percent to 10
10 percent as of May, we're starting to see some of
11 that enrollment decline, it would seem, May to May,
12 4,600 members down and 2 percent almost, 264,000
13 members.

14 And in the important coverage of dental
15 that we want to bring to attention, flat rates,
16 some enrollment growth, which is good to see, and
17 people enhancing their coverage to again at least
18 almost a third having this coverage, which is
19 important for their total health.

20 Some of the factors that we're using to
21 measure the whole rate review process, one is the

1 medical minimum loss ratio rebates under the
2 Affordable Care Act. And this is the small group
3 market. And the Commissioner mentioned and we've
4 mentioned the balance we're trying to seek. And
5 what this shows from the most recent federal rebate
6 report for 2018, which is a three-year average of
7 experience, is that Maryland as a state, out of --
8 as a state, ranks third, third most in rebates
9 paid. The yellow there is 29 million.

10 And when we tried to give some context
11 in it and understand that better, we just have the
12 population as just one way to look at it, and it
13 kind of got us to a thought of, you know, which of
14 these things doesn't belong here, that we're in the
15 company of California, which has more population
16 than all of Canada, and in the ratio more than six
17 times Maryland's size, and then Florida, which is
18 more than triple our size, and then we're third.
19 So just try and test ourselves for if we are
20 obtaining that optimal balance, and this was the
21 case in prior years. And in a few weeks we'll have

1 the '19 number estimates. And we wanted to make
2 you aware of what we look at, how we try to measure
3 the process, as well as the process itself.

4 There are a few developments that are
5 not done yet but have been in the works for several
6 years and that we are also monitoring that we
7 wanted to talk about, as well as perhaps more
8 importantly the story that has been told and
9 unfolding since the ACA started. And that was when
10 we started in '14 the individual market, I think
11 most of the people on this call have been in
12 several hearings where, you know, we told the --
13 looked at the story. And one thing that jumped out
14 is that the individual market had massive losses
15 for the carriers in the first few years, 528
16 million for everybody through 2017.

17 And what we're trying to do is telling
18 the next chapters in the story. So 2018 and 2019
19 have seen thankfully a change in that general
20 pattern, and we'll look at that in a second, but
21 some other -- these court cases that could also

1 play in are the risk corridor Supreme Court ruling,
2 as you're aware, and this is how we're monitoring
3 it, that the 12 billion that was promised to the
4 carriers, I said that needs to be paid as we see
5 it, as we interpret the court case. And it's
6 estimated at about \$165 million for individual and
7 small group, much more for individual, \$164
8 million. Timing of the payment is unknown. You
9 have how it applies when you ascribe it to year,
10 and the footnote is in the bottom. But that's one.

11 The other is the CSR that's been called
12 damages in the case filed in October of last year
13 that said those need to be paid to the carriers as
14 well. So that's 1.6 billion nationwide, 53 million
15 Maryland portion. This one has more uncertainty
16 though. It's not yet resolved, the timing of the
17 next steps is uncertain, but something that we're
18 tracking, and when you put these two amounts
19 together for the whole market, it's \$200 million
20 and is background.

21 The next slide is the most numbers based

1 slide I'll ask you to look with me, but it's
2 intended to talk about that story. And you have in
3 the top section the individual market, the middle
4 the small group of ACA, and then the bottom is the
5 sum of the two. So there in the top you see all
6 the red, and through '17 the cumulative 528
7 million; however, in '18 we have a \$56 million
8 gain, 4.2 percent of revenue, and in 2019 263
9 million, 20.8 percent. The loss ratio is 65.2.

10 Small group has steadily been in the
11 black, and from '14 through '19 an underwriting
12 gain of 393, 394 million, 5.8 percent. And when
13 you put the two core ACA markets together, you see
14 that '17 was still in the red, but '18 we're in the
15 black, 3.1 percent in that last column, gain, 279
16 million, 10 percent, and for each year from '14 to
17 '19 a total 184 million, 1.5 percent, so at least
18 in the black, and again for the interest of the
19 side of a strong market and a stable market.

20 If we look at COVID, we're looking at
21 several sources like you are, Harvard California

1 report, FAIR Health, Conning, et cetera, et cetera.
2 I understand that an Oliver Wyman report is due out
3 soon. And the one that seemed to bring together
4 the general moving toward any kind of consensus,
5 although we're not there yet, but was this Robert
6 Wood Johnson. And another point about it is just
7 the underlines are intended to communicate how
8 there is equivocation. There certainly is
9 uncertainty.

10 And highlighting a few of these, this
11 paper that came out in June, in this first quote up
12 here that they surveyed about 25 companies
13 nationwide, that the insurers' experience thus far
14 leads them to believe that the financial impact in
15 2021 is likely to be minimal, however, face a
16 significant degree of uncertainty.

17 The second one, 30 to 40 percent
18 elective care deferred and -- but then the -- in
19 addition to less spending overall, related claims
20 have been lower than anticipated while this trend
21 in claims could change at any moment.

1 The second -- the next quote, has led to
2 some new costs, most indicated these costs have not
3 have been as high as originally expected,
4 considerable geographic variation. And then the
5 last one, insurers broadly expect 2021 premium
6 increases to be modest or even zero, although many
7 reported that actuaries are modeling a wide range
8 of possibilities.

9 So there's a few more, a little bit more
10 information as to what we're trying to go
11 everywhere we can to get the best thought on this.
12 A few of the other thoughts here in the second and
13 third point are what the infection rate is in
14 Maryland, and you'll see why, how we use that in a
15 minute, at 1.2 percent. I understand as of today
16 the case count is up to 75,000. And then some
17 other states to look for context.

18 And this last bullet from Beckers
19 Hospital Review is that Maryland had the 8th
20 slowest spread. When I checked more recently,
21 we've slipped on that in infection rate, and we're

1 not as good as 8th anymore, but we're trying to
2 look at that.

3 The Society of Actuaries has made
4 available an Excel, as you know, based model. And
5 my colleague Brad Boban prepared this as just one
6 of many many ways you could try to capitalize on
7 that and see what other thought is on the COVID
8 impact.

9 And to left is a successful suppression
10 defined in the box below with the assumptions
11 there. There's our, in very light purple, 1.2
12 percent infection rate. Successful suppression
13 defined as by the end of December of next year, if
14 that were to get up to 2.7 or be held to 2.7, and
15 if then there's a large second wave, the other
16 extreme at least for this first look, 7.9 percent.

17 On the graphs the lines on each side
18 split the chart into 2020 and 2021. And then
19 there's the 100 percent line of compared to without
20 COVID. So with the successful suppression you see
21 the big dip in 2020 of costs below 100, then the

1 big increase for that elective care, deferred care,
2 and then a flat 2021. If there's a large second
3 wave, you see in '20 costs up and then down again
4 and then up and down, but a slight move toward
5 steadying out in 2021, all toward the very bottom
6 line of this of the 20 -- under the successful
7 scenario of the 2020 claims impacted minus 6, but a
8 2021 of plus 1 and in the large second wave, as
9 we've called it, a negative 20 in the year 2020 and
10 a positive 8 in 2021 and just one of many ways to
11 look at this and wanted to share with you what
12 we're looking at.

13 Another website that is tracking this
14 type of information is in the footnote here, but
15 the first thing that I got from here, for the nine
16 states where information was conveyed, Maryland is
17 at least the lowest of rate increases so far. That
18 was nice to see. And then the COVID factor
19 composite ranges anywhere from zero, at least so
20 far, to 4.8 in New York for a composite 1.5 and
21 then some relative premiums. We'll keep watching

1 that as well to, again, try to work with the
2 carriers to funnel in on what's the best thought.

3 So there are many factors with COVID-19
4 that you can see here. They've affected so many
5 aspects of health care. We're looking at the
6 impact on mental health and behavioral health, a
7 vaccine, a resurgence, the waiving of cost shares,
8 et cetera. At all of these hearings we've conveyed
9 what we look at for rate review in the second
10 point, so they're listed again here, as well as
11 some new ones for you to be reminded.

12 And just to highlight what the
13 Commissioner had said about timing, I know there's
14 an Exchange board meeting on Monday. We've asked
15 the carriers to please update their data through
16 June before we kind of make our second and last
17 run-through of the data. Public comments are
18 through August 14th, and you have the information
19 for that toward an approval no later than the 15th.

20 Before I close, I'll share -- I'll
21 unshare my screen in a minute, and I'll share this

1 again later, but your comments are very much sought
2 in the Office of the Chief Actuary. Your questions
3 lead to other questions and good questions and a
4 better dialogue, and we benefit from your
5 collective wisdom. And I just want to encourage
6 you to share with us information you'd like to see,
7 thoughts that you have, as well as the other
8 information and how to submit your public comments.

9 So thanks again. And through the
10 pandemic I hope and pray that you and your loved
11 ones are well and stay well and, again, encourage
12 you to talk to us and let us know how we can help.
13 Commissioner, I'll turn it back to you.

14 COMMISSIONER BIRRANE: Thank you, Todd.
15 You're going to unshare your screen?

16 MR. SWITZER: Yes, I am. Give me one
17 second.

18 COMMISSIONER BIRRANE: Thank you. So we
19 will put that slide back up at the end so everybody
20 has the opportunity to know where it is that they
21 can go for further information and where they can

1 submit comments.

2 So the carriers will now provide their
3 comments with respect to their individual filings.
4 I'll remind you that as I call on you, I'll call on
5 you by company name. And we will then unmute you
6 so that you can speak or, actually, you'll unmute
7 yourself so that you can speak.

8 All the prefiled remarks by the carriers
9 will be available on our website, and just a
10 reminder that this is being recorded. So let me
11 start with the representative from Aetna, if you
12 want to unmute yourself.

13 MR. MURAYI: Hello. Can you hear me
14 okay?

15 COMMISSIONER BIRRANE: We can. Thank
16 you.

17 MR. MURAYI: Okay. Wonderful. I'll go
18 ahead and get started. Good afternoon, everyone.
19 Thank you for this opportunity to present
20 information on our small group rate filings. Aetna
21 is working hard to make health care simpler, easier

1 and more convenient for the people of Maryland.
2 Aetna files rates in the small group market for two
3 legal entities. Our HMO entity is Aetna Health,
4 Inc. and our PPO entity is Aetna Life Insurance
5 Company. Approximately 570 individuals in Maryland
6 are covered under Aetna's small group policies as
7 of May 2020.

8 I would like to start off by noting that
9 the changes discussed here are going to be average
10 rate changes. The exact rate change will depend on
11 what benefit plan an individual chooses, when the
12 member's group contract renews, the age and family
13 size for enrolling employees and employer
14 contributions.

15 To develop these rates, we take the
16 historical claims experience from 2019 and project
17 it forward to 2021. There are five main drivers
18 for these rate ranges. They include, first,
19 medical costs rising; plan designs change;
20 estimates of the average morbidity in the small
21 group risk pool; changes in taxes and fees and

1 other items, including claims experience coming in
2 different than what we expected.

3 So I will now discuss each of these
4 items in more detail. For HMO, our average rate
5 decrease is minus 7.7 percent and for PPO our
6 average rate decrease is minus 9 percent. For
7 simplicity, from here on I will average the
8 decreases of our entities together. Together that
9 is about a minus 8.8 percent rate change. We have
10 filed three plans each for HMO and PPO, offered
11 both on and off Exchange. All the 2020 plans are
12 renewing into 2021.

13 As I mentioned, this is a weighted
14 average of the expected year over year changes.
15 The exact rate changes will depend on what benefit
16 plan the individual chooses, when the member's
17 group contract renews and the age and family size
18 for enrolling employees. First quarter consumers
19 will see a rate decrease of minus 7.7 percent for
20 HMO and minus 9 point -- or 9 percent for PPO.

21 I'll now review the main drivers of

1 these changes in more detail. So first, medical
2 costs are rising. Medical and pharmacy costs
3 increase mainly for two reasons, providers raise
4 their prices and members get more medical care.
5 Our projected paid trend for medical only is 10.1
6 percent and pharmacy is 14.3 percent for a total
7 average of 11.1 percent.

8 For small employers in Maryland, some
9 examples of increasing medical costs we've
10 experienced in 2019 include the cost for
11 prescription drugs has gone up 9.7 percent, which
12 is lower than prior years. Use of inpatient
13 services has increased 3.5 percent, which is lower
14 than prior years as well.

15 Second, plan design changes. Changes to
16 cost sharing for some plans were made to comply
17 with the actuarial value requirements and/or make
18 our plans more attractive to consumers. On
19 average, the impact of these plan design changes
20 increased costs 1.1 percent.

21 Third, our estimate of the average

1 morbidity in the small group risk pool. Our
2 estimate of average population health and the
3 expected risk adjustment transfers for Affordable
4 Care Act products have changed to reflect new data
5 on market average premiums and population health.
6 Small groups purchasing insurance in the
7 marketplace are sicker than we had initially
8 anticipated. These changes are expected to
9 increase costs by 3.6 percent.

10 Fourth, changes in taxes and fees. The
11 Health Insurance Fee, also known as HIF, for 2021
12 has been repealed. No changes have been included
13 for the reinstatement of the Patient-Centered
14 Outcomes Research Institute, PCORI, fee as it had
15 not been announced at the time we submitted our
16 filings.

17 And then fifth, other items, including
18 2019 claims experience is different than we had
19 expected. A bucket of other items contributes a
20 decrease of minus 20.3 percent, including claims
21 experience emerging differently than we had

1 originally anticipated.

2 We also wanted to update you on what
3 Aetna is doing to keep premiums affordable. We are
4 taking a number of steps to keep our products as
5 affordable as possible and to address the
6 underlying cost of health care. These actions
7 include developing new agreements, arrangements and
8 partnerships with health care providers that base
9 provider compensation on the quality of care and
10 not the quantity of services; creating medical
11 management programs that address potential health
12 issues for members earlier, improving health
13 outcomes and reducing the need for high cost health
14 care services; and working to reduce the ability of
15 out of network providers to collect unreasonably
16 excessive payments for services they provide.

17 Again, thank you for this opportunity to
18 present to you today. Thank you.

19 COMMISSIONER BIRRANE: Any questions
20 from anyone on the MIA?

21 MR. SWITZER: Sure. This is Todd.

1 Thank you, Regis. I gather that you've seen an
2 increase in telehealth services. Is that accurate?

3 MR. MURAYI: That is correct.

4 MR. SWITZER: Is it tapering with the
5 change in -- I know the pandemic has changed, but
6 it looks -- does it look like that has changed
7 fundamentally how much that will be used going
8 forward?

9 MR. MURAYI: Yeah, generally in terms of
10 utilization data, I can share that with you
11 afterwards if you want a more precise answer, but
12 high level, generally we've seen a significant
13 increase in telemedicine services. We do expect
14 that that increase will continue going forward and
15 become a new, a new normal in the environment as
16 people -- we've actually seen pretty favorable
17 experiences with telemedicine, and some people have
18 found they prefer the use and convenience of
19 telemedicine where they had not used it before.

20 So an increase and we do expect, you
21 know, while it will decrease as we get back into a

1 more normal environment, we do expect that to be a
2 more present part of our health care environment in
3 the future.

4 MR. SWITZER: Thanks, Regis. And the
5 last is just a comment. Appreciated the step
6 toward the rate decreases and becoming more
7 accessible to Marylanders, just encourage that
8 continued process, and as we work with you
9 toward -- I know the members are down to 650, and
10 increasing that might be something we'll engage you
11 more on as we go -- move toward closer, but thanks
12 again.

13 MR. MURAYI: Yep. You're welcome.
14 Thank you.

15 COMMISSIONER BIRRANE: Regis, this is
16 Kathleen. Do you have any data in terms of whether
17 you're beginning to see an uptick again in
18 utilization outside of telehealth, which you've
19 talked to Todd about, but -- I know the data for
20 Maryland at least is small but --

21 MR. MURAYI: Uh-huh. In general, we are

1 seeing utilization return back to closer to
2 pre-COVID levels. So in the, you know, directly in
3 March we saw a significant reduction in medical
4 utilization, and, you know, as of the most recent
5 months we're seeing that return close to pre-COVID
6 levels. You know, again, that's a general comment,
7 but if you guys would like a little more
8 information, we could provide more detail offline.

9 COMMISSIONER BIRRANE: That's great.
10 We'd appreciate that.

11 MR. MURAYI: Okay.

12 MR. JI: Regis, this is Jeff.

13 MR. MURAYI: Hello, Jeff.

14 MR. JI: Yeah, I have a question. So
15 you mentioned the membership as of May 2020. Does
16 that mean June's membership is ready yet?

17 MR. MURAYI: As of, as of now in the
18 preparing of these materials, it wasn't ready. We
19 do have June membership at this time that, you
20 know, particularly in your review. If you need
21 that information, we can send that to you as well.

1 MR. JI: Okay. Good. Yeah, I have a
2 projection from you. We want updated experience
3 through June 2020.

4 MR. MURAYI: Okay. Yes, we definitely
5 have June membership experience. We do have a lag
6 on generally from the time the experience gets in
7 and when we update our data warehouse, but we
8 definitely will get you -- can get you the
9 membership as of June.

10 MR. JI: Okay. Thank you.

11 MR. MURAYI: You're welcome.

12 COMMISSIONER BIRRANE: Is there anyone
13 else from the Maryland Insurance Administration
14 that has questions of Aetna? Well, with that,
15 thank you very much, Regis, for the presentation.
16 We will follow up on some of the points that, you
17 know, we've talked about today, but we thank you
18 for your presentation and your time.

19 MR. MURAYI: All right. Thank you.

20 COMMISSIONER BIRRANE: And now I'll call
21 on CareFirst Blue Cross Blue Shield.

1 MR. BERRY: Hi. This is Pete Berry.
2 Can you hear me?

3 COMMISSIONER BIRRANE: We can, Pete.
4 Thank you.

5 MR. BERRY: Wonderful. I've got someone
6 cutting down a tree outside my window, so hopefully
7 that won't distract too much from my presentation.
8 That just started, by the way, five minutes ago
9 so --

10 COMMISSIONER BIRRANE: Of course.

11 MR. BERRY: Good. All right. Well,
12 good afternoon. My name is Pete Berry. I'm a
13 Chief Actuary and Senior Vice President of
14 Actuarial and Underwriting for CareFirst. I
15 appreciate the opportunity to present today. I
16 will be discussing CareFirst's 2021 ACA rate
17 filings for small group and individual markets.

18 CareFirst offers small group and
19 individual HMO and POS products through Blue Choice
20 and PPO products through CareFirst of Maryland,
21 Incorporated and Group Hospital and Medical

1 Services, Incorporated.

2 Small group first. The average 2021
3 small group rate change for HMO and POS is 5.9
4 percent while the average rate change for PPO is
5 2.3 percent. This is the fifth year in a row that
6 CareFirst has submitted relatively modest increases
7 for our small group business. The small group
8 market segment is relatively stable, and so the
9 main driver for the rate changes is the underlying
10 force of medical trend. We had seen moderation in
11 our PPO claims costs which led us to reduce the
12 expected trend to 6.5 percent, which is the driver
13 of the lower rate increase in PPO. Additional
14 downward pressure on rates is the result of the
15 removal of the Health Insurance Tax in 2021.

16 For the individual line of business,
17 CareFirst filed a minus 1.1 percent decrease for
18 HMO and a minus 12 percent decrease for PPO. As a
19 result of discussions with the Administration, our
20 BlueChoice rate change is now minus 4.3. And we'll
21 continue to work with the Administration through

1 the next few weeks and additional changes are
2 possible.

3 This is the third year in a row that
4 CareFirst has filed rate reductions in individual
5 for both HMO and PPO product lines since the
6 implementation of the Section 1332 waiver, which
7 has served to stabilize morbidity in the individual
8 pool. For BlueChoice, additional stability in the
9 morbidity of the pool is driving the lower rates in
10 2021. On the PPO side, that block is much smaller
11 and much sicker than average and, as such, tends to
12 be more volatile. For example, the rate change of
13 minus 12 in 2021 is largely driven by the
14 additional stability in morbidity but also by the
15 expected changes in risk adjustment. Like small
16 group, there's additional downward pressure on
17 rates due to the removal of the Health Insurance
18 Tax in 2021.

19 Looking ahead, we will continue to
20 monitor the impacts of COVID-19 on health care
21 costs in 2020 and the anticipated impact to the

1 2020 rating period. This includes the expected
2 impact of deferred care that reemerges in 2021, the
3 growth in the individual segment due to the Special
4 Enrollment period and any economic impact that
5 occurs to our group business. And over the next
6 few weeks we'll continue to work with the
7 Administration to quantify these impacts, and we'll
8 make appropriate adjustments to our 2021 rates.

9 I want to thank you again for the
10 opportunity to present today, and I would be happy
11 to answer any questions.

12 COMMISSIONER BIRRANE: I'll ask my team
13 first if people have questions.

14 MR. BERRY: I can answer the two that
15 were asked before, if you like, on telehealth and
16 the reemerging care.

17 COMMISSIONER BIRRANE: That's where I
18 was going to go, so please.

19 MR. BERRY: Sure, absolutely. So I'll
20 start with the reemerging care. We just closed
21 June, and we'll update the data in the submission

1 once we get those tables populated. But like Aetna
2 we're seeing, we're seeing stuff come back almost
3 to the point of the pre-COVID levels. Obviously,
4 there was different impacts for medical and drug
5 and dental. It was interesting. Drug we actually
6 saw go up as people started filling their 90-day
7 prescriptions early. So we would expect now that
8 would see that drop since they don't have to fill
9 them now.

10 Medical we saw the 30 to 40 percent
11 drop. Dental we saw drop 90 percent in April. And
12 all of those now are coming back up, not quite to
13 where they were, but pretty close. And we would
14 expect, kind of like Brad's first chart, where
15 we'll be over 100 percent of expected for a little
16 bit, but we'll have to see. But that, I think that
17 would be a situation where you would see the
18 emerged care probably return more in '20 than '21.
19 And then we agree with the MIA that if a second
20 wave hits, then that's really where you'll see a
21 question in 2021.

1 For telehealth and telemedicine, it's
2 really interesting. We did see obviously a massive
3 spike in telehealth where we had, you know, nominal
4 use of that before COVID. We saw it increase
5 dramatically. And one of the most interesting
6 things we saw was that the vast majority of the top
7 CPT codes that we were paying were for mental
8 health conditions, which is not surprising, I
9 guess, during a pandemic.

10 But one of the thoughts we had was, you
11 know, for access for rural members, oftentimes they
12 may have to drive very far to get to a mental
13 health professional, and this may be an opportunity
14 to provide those services to those members going
15 forward. It would mean that there might be a net
16 increase to utilization since that care hadn't been
17 provided before. But I would agree with the other
18 speakers that I think telehealth will be part of
19 the health care landscape going forward much much
20 more than it was in the past.

21 MR. ZIMMERMAN: Hi, Peter. This is Adam

1 Zimmerman from the Insurance Administration. I
2 just had a question for you. In one of the
3 previous responses you provided you had indicated
4 about an ongoing reorganization and its impact on
5 cost allocation. I was just wondering if you could
6 provide more details about that, if any were
7 available.

8 MR. BERRY: Yeah, sure. Just real high
9 level, at the end of last year, the beginning of
10 this year, CareFirst reorganized how it's
11 structured, and basically for the first part of
12 this year the cost allocation folks are still
13 trying to reconstitute all the cost centers back
14 into the general ledger properly. So some of the
15 reported administrative expense numbers that we're
16 seeing aren't complete yet. That's what we were
17 referring to, but we hope to get that rectified and
18 to be able to provide you guys with the numbers you
19 were asking for before we get to the end of the
20 review process.

21 MR. ZIMMERMAN: All right. Thank you.

1 MR. BERRY: Sure.

2 MR. SWITZER: Go ahead, Brad.

3 MR. BOBAN: Okay. This is Brad. I just
4 wanted to know if you've had a range of estimated
5 net COVID impacts that you could share with us
6 based on your internal modeling. I understand a
7 point estimate would probably be harder to give,
8 but is there a range of model results you could
9 share?

10 MR. BERRY: Yeah, so, you know, there's
11 a lot of different -- I guess we would consider,
12 you know, 2020 is the middle year, right, for the
13 rate development, so it's really just what carries
14 over to next year that would impact the rates. And
15 so one of the considerations, you know, you talk
16 about with the deferred care in 2020 and the lower
17 costs is it would increase your MLR rebate exposure
18 in 2020, which wouldn't necessarily impact the
19 rates.

20 So it's really, I guess, in our view
21 kind of what you modeled out. If there's a second

1 wave, then you have both COVID costs and deferred
2 care getting pushed into 2021. The numbers I've
3 seen with regards to your first graph where we just
4 have the first wave and deferred care, I think I
5 saw a PWC report that said 4 percent. I've seen
6 others that have said 2 percent. I haven't seen
7 anyone who thinks the costs will be lower in 2021.
8 But one of the things we're looking at is the
9 results of the open enrollment period where we
10 picked up, you know, 11,000 plus members, and we
11 want to see well, who are those people. Are those
12 younger people? Are they people that lost their
13 job? How does that impact the morbidity of the
14 pool that we're reinsuring or insuring?

15 So it's one of the things we're looking
16 at. It's kind of hard to judge because we don't
17 have very many claims on them, but we do have their
18 demographics. That's, I think that's one factor
19 that could lead to possibly a lower 2021, although,
20 of course, risk adjustment is offsetting to that.
21 So with regards to range of impacts, at this point

1 we're really still gathering data, but I would say
2 probably zero to 4 is probably a reasonable range
3 from what you would expect for '21.

4 MR. BOBAN: All right. Great. Thanks.
5 I really appreciate that.

6 MR. BERRY: Yeah, sure, and we'll be,
7 we'll be working with you guys over the next month
8 or so in a lot more detail.

9 MR. BOBAN: Yeah, definitely.

10 MR. SWITZER: I think that's it for the
11 OCA.

12 MR. BERRY: Great.

13 COMMISSIONER BIRRANE: Thanks, Pete.

14 MR. BERRY: Sure. Thank you.

15 COMMISSIONER BIRRANE: So now I would
16 invite the representative from Kaiser Permanente.

17 MR. CHU: Hey, can you hear me?

18 COMMISSIONER BIRRANE: We can.

19 MR. SWITZER: Yes.

20 MR. CHU: I will address the individual
21 filing first. This rate filing represents 14 plans

1 offered both on and off the Exchange, with minor
2 benefit changes necessary to keep plans similarly
3 positioned within their metal tiers from year to
4 year. We also added a new cheaper Bronze plan as
5 an additional option for individual members. These
6 plans currently service approximately 65,000
7 members throughout Maryland.

8 For 2021, we have currently filed for an
9 average decrease of 11 percent, though depending
10 upon the exact plan, rate decreases for metallic
11 plans may range from 9 percent to 16 percent.
12 Given the eligibility requirements for the
13 catastrophic plan, we revised our pricing approach
14 and reduced catastrophic rates by 33 percent.

15 The new for 2019 state-based reinsurance
16 program has had a significant impact on rates.
17 Without this program, our estimate is that the 2021
18 rates would need to be up to 30 percent higher than
19 filed.

20 For the small group market, our filing
21 represents 60 plans, including both on and off the

1 Exchange, and two different provider networks.
2 These plans currently service approximately 11,000
3 members throughout Maryland. We have currently
4 filed for an average rate decrease of 5 percent for
5 2021. The rates changes vary from minus 15 percent
6 to 1 percent depending on the plan they have chosen
7 and when the group renews. Unlike the individual
8 market, our small group rates have been relatively
9 stable since the inception of the ACA.

10 The individual and small group rate
11 changes may be impacted by final risk adjustment
12 results and other data as it becomes available.
13 Additionally, the removal of the health insurance
14 provider fee and favorable claims experience
15 resulted in lower rates for both individual and
16 small group.

17 We are not currently assuming any impact
18 of COVID-19, though we are actively monitoring the
19 situation; however, at this point it is unclear
20 what impact it will have on medical expenses in
21 2021. That concludes my prepared comments.

1 COMMISSIONER BIRRANE: Great. Thank
2 you. Anybody from the MIA have questions?

3 MR. SWITZER: This is Todd. Thanks
4 James. On a higher level question, back in
5 November Kaiser in the Mid-Atlantic had announced
6 expansion plans. And I know a lot has changed
7 obviously from November to today. I was just
8 wondering if you can provide or are able to provide
9 any information related to -- I know it even talked
10 about building medical centers in Timonium and
11 Columbia and Odenton and Owings Mills, White Marsh
12 area, if that's been delayed or if there's any
13 update that you're able to share. I was curious.

14 MR. CHU: I personally don't have an
15 update. I don't know if Sheila is available;
16 otherwise, we can definitely get back to you on the
17 progress of those expansion plans.

18 MR. SWITZER: Sure. I think I saw
19 Sheila joined.

20 MR. CHU: But yeah, we can definitely
21 let you know about those.

1 MR. SWITZER: Thanks, James. That was
2 it for me.

3 MR. BOBAN: Hi, James. This is Brad.
4 Similar to CareFirst, I was just wondering if you
5 had a range of initial COVID estimates and if you
6 could maybe speak to how this staff model HMO might
7 interact differently with the utilization decline
8 and the deferred utilization.

9 MR. CHU: In terms of specific COVID
10 impacts, we don't have a range. I mean, even our
11 risk adjustment range is, you know, plus or minus
12 several percent of premium. But, you know, I think
13 there's still a lot of indicators as to, you know,
14 why costs might be higher or lower in 2021. So
15 we're still monitoring that.

16 In terms of our physician arrangement,
17 so we pay physicians on a salary basis, and we
18 don't pay them more or less depending on the
19 services that they provide. And because of that, I
20 think that really stabilizes our costs, and it's
21 not going to be as impacted by COVID in 2021.

1 MR. BOBAN: Thank you.

2 Mr. JI: Hey, James, this is Jeff from
3 MIA. So as your rate reduction in 2021, so what
4 kind of impact to your membership in 2021? Any
5 projection changes?

6 MR. CHU: Obviously, we're waiting to
7 see how the rest of the rate increases shake out.
8 We did lose quite a bit of rate position in 2020,
9 which did lead to a decrease in membership, and
10 hopefully our rate position will improve slightly
11 in 2021 and we'll gain back some members. But, you
12 know, again, a lot of the rates are still
13 preliminary.

14 MR. JI: Thank you.

15 COMMISSIONER BIRRANE: So, James, thank
16 you. I appreciate that your model is different,
17 but to the extent that you can share data on what
18 you are seeing in terms of people returning to
19 care, you know, the impacts of telemedicine, it
20 would be helpful to know.

21 MR. CHU: Yeah, on the professional

1 side, at the peak of the pandemic, face-to-face
2 visits decreased by about 80 percent, and about
3 half of them were replaced by telehealth. We are
4 seeing an increase of professional visits in the
5 most recent months, but, you know, like a lot of
6 the speakers have alluded to, it's unclear whether
7 or not this is sort of like a new normal and people
8 will be using more telehealth going forward or
9 whether or not face-to-face visits will return back
10 to original levels.

11 On the facilities side, that data is not
12 as recent, but we can provide updates on that as it
13 becomes available. But again, even with all of
14 that, I mean, it's still tough to say what 2021
15 will look like in terms of telehealth utilization,
16 the prevalence of COVID treatment costs, as well
17 as, you know, the potential of a second wave.

18 COMMISSIONER BIRRANE: Great. Thank you
19 very much. Anyone else from the Maryland Insurance
20 Administration, questions? Thank you very much,
21 James. I appreciate your time.

1 And now I'll invite the representative
2 from UnitedHealthcare. If you want to unmute
3 yourself, we'll take your prepared remarks.

4 MR. MORGAN: Can you hear me okay?

5 COMMISSIONER BIRRANE: We can, Ryan.
6 Thank you.

7 MR. MORGAN: Okay. Terrific, yeah.
8 Good afternoon. Thank you, Commissioner Birrane
9 and the Maryland Insurance Administration for the
10 opportunity to present today. My name is Ryan
11 Morgan. I'm an actuary with UnitedHealthcare, and
12 I'm here this afternoon to discuss the 2021 small
13 group and individual rates that UnitedHealthcare
14 has filed with the Maryland Insurance
15 Administration.

16 UnitedHealthcare continues to offer
17 small group policies on four legal entities:
18 UnitedHealthcare Insurance Company, MAMSI Life and
19 Health Insurance Company, Optimum Choice,
20 Incorporated and UnitedHealthcare of the
21 Mid-Atlantic, Incorporated. Across all four of

1 these legal entities, we are proposing 95 unique
2 small group plans in 2021. Those break down in
3 terms of metal levels 11 platinum, 43 gold, 36
4 silver and 5 bronze. Approximately half of these
5 plans are available both on and off Exchange. The
6 other half will be available on -- off Exchange
7 only.

8 In the small group market for 2021, we
9 submitted our rate filings back in May and
10 requested the following rate increases. So it
11 broke down as 9.9 percent for UnitedHealthcare
12 Insurance Company, 4.8 percent for MAMSI Life and
13 Health Insurance Company, 3.1 percent for Optimum
14 Choice, Incorporated and 8.4 percent for
15 UnitedHealthcare of the Mid-Atlantic. And so let
16 me be clear, yeah, as others have given kind of a
17 similar disclaimer, these figures are average rate
18 increases for each respective entity, so the actual
19 rate change experience by any specific group could
20 be higher or lower depending on a variety of
21 factors, such as the plan selected and the census

1 of the group.

2 So one of the primary drivers of our
3 requested rate changes is our trend rate.
4 UnitedHealthcare conducted a full review of all of
5 the components that contribute to trend. Using the
6 most recent information available at the time, we
7 analyzed unit costs, utilization of health care
8 services and the impact of deductible leveraging,
9 and all of these components were looked at for
10 inpatient, outpatient, professional, pharmacy and
11 other services. Based on this analysis, we are
12 filing for a trend rate of 8.4 percent in our 2021
13 rate filing.

14 However, primarily due to relatively
15 favorable experience in 2019, we were able to file
16 for rate increases that are significantly below
17 trend on our MAMSI and Optimum Choice licenses.
18 Experience was less than favorable on the
19 UnitedHealthcare Insurance Company license, so that
20 resulted in that rate increase being a little bit
21 higher than trend. And then on the

1 UnitedHealthcare of the Mid-Atlantic license, our
2 experience was favorable, but we're a very large
3 risk adjustment payer on that license, so when that
4 all netted out, we actually wound up just at our
5 trend rate, yeah, so it was the same as trend on
6 that entity. So that's small group.

7 Turning to individual, UnitedHealthcare
8 is excited to be reentering the individual Exchange
9 market in Maryland in 2021 through our Optimum
10 Choice, Incorporated license. We will be offering
11 nine individual HMO plans on Exchange in the gold,
12 silver and bronze metal levels, plus the required
13 cost share reduction variants. And as Chief
14 Actuary Switzer stated earlier, we plan to offer
15 these plans in all rating areas for -- for all
16 counties in rating areas 1 and 3 and selected
17 counties in rating areas 2 and 4.

18 So although we don't have an in force
19 block from which to develop our pricing for
20 individual, we utilized data and expertise of
21 Wakely Consulting Group, Incorporated to build what

1 we believe will be a well-priced product portfolio
2 for Maryland residents. Premium rates have been
3 built using our knowledge of the existing Maryland
4 marketplace, along with the large proprietary
5 Wakely database of historical individual ACA
6 experience. Using this knowledge and data, we
7 developed Maryland-specific rates, taking into
8 account many factors, including expected 2021 unit
9 costs in Maryland, utilization patterns of
10 individual ACA members, the impact of medical
11 management programs, expected payments related to
12 the federal risk adjustment program, expected
13 reductions in claim costs due to the Maryland
14 Reinsurance Program, sales, general, and
15 administrative costs and federal and Maryland taxes
16 and fees as well.

17 So hopefully this summary of
18 UnitedHealthcare's 2021 small group and individual
19 rate filings has been helpful. At this time I'd be
20 happy to address any questions you may have
21 regarding our small group rate filings, and then we

1 also have Adam Rudin from Wakely Consulting Group
2 who's available to answer any questions about the
3 individual rates. Thank you.

4 MR. SWITZER: This is Todd. Thank you,
5 Ryan. Are you able to share how the decision was
6 made to enter certain service areas in the
7 individual market? Was it actuarially driven,
8 network driven, market dynamic differences between
9 individual and small group? Is there anything
10 along those lines you could share please?

11 MR. MORGAN: Yeah, I don't think I have
12 a good answer to that. Adam, do you have any
13 comments on that question?

14 MR. RUDIN: No. That's a good question.
15 I think we'll have to get back to you with that
16 one, but I do believe that was primarily network
17 driven in terms of where we could build an
18 appropriate network.

19 MR. SWITZER: Thank you. And my second
20 one, Ryan, and last one, I'm just wondering -- I
21 mean, we're tracking the enrollment month by month.

1 And do you have a sense that -- obviously, the
2 economic downturn and the unemployment of 10
3 percent is affecting things, but have you seen --
4 should we expect when we look at the May and the
5 June data a significant impact to your small group
6 enrollment since you have a quarter of our small
7 group market in the ensuing months? And I'm not --
8 I won't hold you to it. I'm just wondering if
9 you're getting a read on the economic impacts to
10 small groups.

11 MR. MORGAN: Yeah, I think we're seeing
12 somewhat of an impact. I'd have to get back to you
13 on specifics, but yeah, I think a little bit in
14 that direction, yeah.

15 MR. SWITZER: Sounds good. Thank you.

16 MR. MORGAN: And then I can also
17 comment, I mean, I guess I don't have too much to
18 add beyond the other carries in terms of
19 telehealth, yeah, we definitely saw huge upticks,
20 as I'm sure everyone did. Yeah, I think it is kind
21 of an open question, I guess. I think it will

1 clearly be higher than the old levels, but will it
2 stay kind of at this new level, I think that is
3 very much an open question.

4 And then yeah, in terms of just the
5 overall claims cost, yeah, in our most recent month
6 we were back very close to kind of our pre-COVID
7 expectations, so yeah, definitely trending in that
8 direction, as others have said.

9 COMMISSIONER BIRRANE: Well, thank you
10 for anticipating in answering the question. I
11 appreciate that. Anybody else from the MIA have
12 questions?

13 MR. JI: Hi, Ryan. This is Jeff. So
14 for risk adjustment, do you think you're going to
15 be a receiver or a payer in 2021, and where is your
16 assumption from?

17 MR. MORGAN: Yeah, so it does vary
18 considerably across entities, but yeah, overall
19 definitely a payer, as we've been in prior years,
20 yeah. And we use a large consultant study, as I
21 think some others do, in the market. So yeah, I

1 guess -- I don't know. I think it's supposed to
2 come out today, right? I guess we'll see exactly
3 how accurate that was, but yeah, generally it's
4 pretty close.

5 MR. JI: Thank you.

6 COMMISSIONER BIRRANE: Okay, Ryan.
7 Thank you and thank Adam for your comments and your
8 answers. We appreciate that.

9 MR. MORGAN: Thank you.

10 COMMISSIONER BIRRANE: And we'll look
11 forward to getting the update information on, you
12 know, the area selections. Thank you.

13 MR. MORGAN: Yep.

14 COMMISSIONER BIRRANE: That concludes
15 the portion of the hearing with respect to carrier
16 comments, so we will now hear from individuals and
17 interested parties who signed up in advance. So as
18 a reminder, I'm going to call on you. I'll ask you
19 to just restate your full name and your position or
20 affiliation. All of the prefiled remarks that came
21 in some written form will be available on our

1 website. And remember that you are being recorded.
2 And if you would just unmute yourself when you're
3 called on I'd appreciate it.

4 So I would first invite Ms. Maansi
5 Raswant from the Maryland Hospital Association to
6 speak.

7 MS. RASWANT: Yes, hi. Can you hear me
8 and see me?

9 COMMISSIONER BIRRANE: Yes.

10 MS. RASWANT: Perfect. Thank you,
11 Commissioner. Fantastic. Thank you everyone at
12 the Maryland Insurance Administration for your work
13 on the rate review and for the opportunity to
14 comment. MIA's rate review process has become more
15 robust every year, you know, making active requests
16 for public feedback, and so we really appreciate
17 the engagement, particularly with Todd and his
18 team.

19 And we encourage the Insurance
20 Administration to continue incorporating new ways
21 to promote transparency in rate filings and of the

1 other line data so that we can ensure that we have
2 this robust public engagement every year.

3 So at the outset I want to mention just
4 a few observations and remarks. The first is we
5 come to you every year to talk about -- we've taken
6 a look at the inpatient and outpatient trends
7 contained in the rate filings for utilization and
8 for costs and understand that, you know, each part
9 filing has several factors that are included it to
10 develop the composite trends, but there still is a
11 great variety across the different trends for both
12 inpatient and outpatient cost utilization. And as
13 a reminder to everyone that the HSCRC did recently
14 approve that hospital revenue growth factor of 3.5
15 percent. We know that MIA is looking at the rate
16 filings for the insurers and talking to the HSCRC,
17 so we're confident that you all will address
18 discrepancies that exist there.

19 Relatedly there is one insurer, United
20 in particular, that I'll note continues to say in
21 the written description that part of the

1 assumptions in the filing is cost shifting between
2 public and private payers. And because of the rate
3 setting system that we have here in Maryland we
4 know that that cost shifting doesn't occur. It's
5 virtually nominal, if any, if anything. And I
6 think if we look at United's entering the
7 individual market, I appreciated the comments from
8 Ryan about all the specific Maryland factors that
9 you're looking at. I'd say, you know, to include
10 this notion of the rate setting system that we have
11 and so that we don't have that cost shifting that
12 occurs, and that is a unique Maryland factor to
13 look at as well. It's going to be important that
14 we highlight that particularly as United enters the
15 individual market here.

16 The other thing I want to note is the
17 COVID pandemic has clearly created a cost savings
18 for insurers. I appreciate the overview that Todd
19 provided and the analysis. It seems like it's very
20 in depth that you will be going through to
21 understand what the impact of COVID has been on

1 claims and claims costs.

2 But for now we have seen, you know, a
3 significant reduction in utilization. I think 30
4 to 40 percent is the number that we've heard as
5 well. And it sounds like that is what we've heard
6 from carriers too in terms of decrease in
7 utilization. Those savings have resulted in
8 improved medical loss ratios. We know that there's
9 premium rebates going back to enrollees. As well
10 we support any measure that exists to decrease
11 health insured's cost for enrollees. What we say
12 is the MIA should also think about ways in which to
13 decrease out-of-pocket expenses. And so in
14 particular, as we've measured in years past, we
15 encourage the MIA to address the continued rise in
16 high deductible health plans, which impact costs at
17 the point of service.

18 According to the State Health Access
19 Data Assistance Center or SHADAC, it notes that 43
20 percent of employees in Maryland through
21 self-insured or employee sponsored plans are in

1 high deductible health plans. And so we've noted
2 previously that these high deductible plans deter
3 individuals from accessing care. And then when
4 they do access care, they saddle them with high
5 out-of-pocket costs.

6 So again, we would encourage that if
7 there's an opportunity for us to think about -- you
8 know, I understand some of this is federally
9 regulated in terms of what we can do within
10 different corridors, but there's an opportunity for
11 us to think about how to lever some of the savings
12 here to actual address high deductible health
13 plans. We are more than willing to engage in any
14 way to be able to do that with you all.

15 Further on that point, with regards to
16 the underlying affordability and sustain the
17 decrease of the rates that we've seen and the
18 reinsurance program has clearly effectuated in the
19 individual market, we continue to emphasize that
20 policymakers should review insured initiatives
21 related to better management of enrollees.

1 Under the total cost of care model, as
2 you know, the state has to meet specified
3 population health goals. And those goals and
4 targets related to the goals and the underlying
5 work are all on an all payer basis. And so for at
6 least the two first conditions that we're talking
7 about, diabetes and opioid use, it's important for
8 us to understand the types of care management
9 initiatives that carriers have in place.

10 We recently shared some comments with
11 the Health Benefit Exchange related to their
12 carrier accountability reports that collect
13 information on a lot of carriers' care management
14 programs as part of the state reinsurance program.
15 Our comments noted that regulators who oversee
16 insurance coverage should be really deliberate in
17 understanding those care management programs, how
18 the carriers select populations for specific
19 interventions, what the targeted outcomes are for
20 those interventions and whether they're actually
21 succeeding. And I know the MIA looks at what --

1 looks at the number of different types of care
2 management programs that might be in place with the
3 specific carrier, but I think going a little bit
4 deeper in understanding whether we're actually, you
5 know, seeing what the outcomes are, whether we're
6 seeing changes in morbidity and high costs of
7 health care utilization and health outcomes is very
8 important here.

9 Finally I'll note, it's gotten a lot of
10 air time through the presentations so far, but in
11 the past several months health care providers
12 across the continuum have been focused on this
13 extraordinary public health crisis. The COVID-19
14 pandemic has required an all hands on deck approach
15 by providers who really have been focused solely on
16 delivering the clinical needed care for COVID
17 patients and then also continuing to care for all
18 patients, right, because we needed to make sure
19 that that continuity of care exists for patients
20 and access to care exists for patients throughout
21 this crisis.

1 But, as we all know, comprehensive care
2 delivery is facilitated by comprehensive coverage.
3 And so early on we did note for the Insurance
4 Administration and for our payer partners that we
5 needed robust whole health coverage because it is
6 the vehicle that providers have been using to
7 ensure continuity of care. We urge the Insurance
8 Administration to continue these flexibilities, and
9 they should remain in place throughout the duration
10 of the public health emergency. We know that some
11 of those states have been, you know, coinciding in
12 terms of what carrier coverage in some of the
13 states are and what's been put out for the federal
14 public health emergency, but then also we need to
15 expand on these and think about ways that coverage
16 and reimbursement parity stays intact on a
17 permanent basis.

18 I think that when we look at how we talk
19 about the uptick related to telehealth and, you
20 know, I think the questions that you're asking,
21 Commissioner, related to that uptake, well, so much

1 of that is driven by the coverage, right? And so
2 if we're not actually going to have the coverage in
3 place, then that's going to impact the utilization
4 and the ability for us to leverage telehealth and I
5 think, you know, we have looked at the use of
6 telehealth solely traditionally in one lens that's
7 utilization.

8 What I'd offer is, you know, how are we
9 looking at this as a high value service? How are
10 we looking at the types of utilization and what's
11 appropriate to deliver via telehealth and the
12 impact on overall health outcomes. And so I think
13 going through, if there's been any silver lining of
14 this crisis, going through the COVID crisis has
15 really been able to showcase the benefits of
16 telehealth. We've heard both from our providers
17 and our patients a high level of satisfaction. And
18 I'd offer to you that if you'd think about
19 continuing telehealth or expanding telehealth
20 coverage here in the state that not just look at
21 impact and utilization, you know, as being one

1 dimensional here, but also look at all these other
2 different factors related to what really high value
3 care is.

4 And then the last thing I want to note
5 is very recently the state has been committed to
6 broad asymptomatic testing across Maryland. State
7 officials have turned to hospitals to administer
8 these tests and serve as a core component of the
9 testing strategy. And so it's important for us to
10 address insurance coverage and provider
11 reimbursement of this function as well. Currently
12 federal law, as we understand it, is not requiring
13 insurance coverage of asymptomatic testing, largely
14 specific to just diagnostic. But there is CMS
15 guidance that notes that testing for purposes of
16 employment or public health surveillance is
17 generally not mandated to be covered. Our research
18 correspondingly shows that there's a patchwork of
19 testing coverage and reimbursement policies across
20 the major parities in Maryland. And so we
21 therefore would urge the MIA to issue uniform

1 guidance requiring coverage and reimbursement of
2 asymptomatic testing in order to further the goals
3 of the state and help in the road of recovery for
4 COVID.

5 So I'll stop there. I'm happy to answer
6 any questions as best as possible right now and
7 then, of course, look forward to the continuing
8 follow-up with the Insurance Administration.

9 COMMISSIONER BIRRANE: Thank you very
10 much for your comments. Anybody from the
11 Administration have any questions? So I thank you.
12 You and I have had several discussions on these
13 topics, so I will not question you further today,
14 but, you know, there are many things that we will
15 continue the conversation on, so thank you.

16 MS. RASWANT: Thank you very much,
17 Commissioner. Thank you. Thank you all.

18 COMMISSIONER BIRRANE: And now I would
19 invite Ms. Stephanie Klapper from the Maryland
20 Citizens Health Initiative Education Fund who also
21 filed -- prefiled a statement. If you want to

1 unmute and we'd be happy to hear from you today.

2 MS. KLAPPER: Thank you. Can you hear
3 me?

4 COMMISSIONER BIRRANE: We can. Thank
5 you.

6 MS. KLAPPER: Okay. Thank you. Yes.
7 So I am Stephanie Klapper, Deputy Director at
8 Maryland Citizens Health Initiative, and we thank
9 you, Commissioner, and the Maryland Insurance
10 Administration for this opportunity to comment.

11 Our mission is to advocate for quality
12 affordable health care for all Marylanders. And
13 our Health Care For All Coalition is the largest
14 consumer health advocacy coalition in the state,
15 made up of hundreds of faith, labor, business,
16 health and community organizations. During the
17 COVID-19 pandemic, access to quality affordable
18 health care is more important than ever before.

19 So with that in mind, I first want to
20 thank the Maryland Insurance Administration for its
21 important role on the Health Insurance Consumer

1 Protection Work Group and also thank the Maryland
2 General Assembly for using that work group's
3 recommendations to pass a measure to enshrine
4 affordable care protection, consumer protection
5 into Maryland State law, including protection for
6 preexisting conditions.

7 I would also like to thank the Maryland
8 General Assembly and Governor Hogan for several
9 pieces of legislation over the past two years to
10 improve the individual market, including creating a
11 reinsurance program during the 2018 legislative
12 session which has successfully helped to lower
13 insurance premiums, as well as creating the
14 Maryland Easy Enrollment Program, which this year
15 for the first time is letting uninsured Marylanders
16 start the enrollment process by checking a box on
17 their state income tax return.

18 In considering the proposed rates, we
19 encourage the Administration to continue to make
20 protecting consumers and reducing the high cost of
21 premiums as top priorities. And, more broadly,

1 there are several policies that Maryland could
2 adopt to work towards these priorities in the
3 long-term. It continues to be very important to
4 encourage as many young and healthy individuals to
5 enroll in coverage as possible to stabilize rates
6 in the market.

7 So to that we've very excited to see
8 that the COVID-19 Special Enrollment period and the
9 Easy Enrollment Program are both attracting young
10 enrollees at higher rates than the traditional
11 annual open enrollment period. And to continue
12 making progress, we suggest that Maryland consider
13 creating a state individual subsidies program to
14 help make coverage even more affordable for
15 Marylanders. When Massachusetts has their own
16 program with their state subsidies overlapping with
17 the federal subsidies, they were able to reduce
18 their uninsured rate to 3 percent. And last year
19 the Maryland Health Benefit Exchange convened an
20 affordability work group, which suggested targeting
21 state subsidies toward younger adults, which would

1 create a healthier risk pool and could stabilize
2 premiums for everyone in the individual market.

3 To encourage affordability in the small
4 group market, we also encourage Maryland to create
5 a state subsidy program for small businesses
6 because even with federal tax credits available
7 under the SHOP program, unfortunately many small
8 businesses are still struggling to afford coverage.

9 And finally, no examination of
10 affordability in the market would be complete
11 without taking into account rising health care
12 costs, in particular skyrocketing drug costs, which
13 are directly contributing to the cost of health
14 coverage premiums. And that's why Maryland's
15 Active Prescription Drug Affordability Board is so
16 important. This board is going to evaluate
17 expensive drugs and recommend appropriate methods
18 for addressing these costs, including setting upper
19 payment limits on what Marylanders would pay for
20 them, which in the long-term should result in more
21 stabilized premiums overall.

1 So once again, I just want to thank you
2 for this opportunity to comment and for doing
3 everything in your power to bring down premiums for
4 Marylanders across the state, moving the state
5 closer to having quality affordable health coverage
6 for all.

7 COMMISSIONER BIRRANE: Thank you,
8 Ms. Klapper. I appreciate it. Is there anyone
9 from the MIA that has questions for Ms. Klapper?

10 MR. SWITZER: Thank you, Stephanie.
11 This is Todd. And thanks for all your work. Am I
12 right that both of the open enrollments close
13 today, is that right, the tax plan and the COVID?

14 MS. KLAPPER: Yes.

15 MR. SWITZER: Okay.

16 MS. KLAPPER: They both close today;
17 however, I want to add the caveat that people who
18 checked the box on their state tax return, they'll
19 receive a letter in the mail from the Exchange, and
20 then they'll have about another 30 days after
21 receiving that letter to enroll. So they'll have,

1 depending on when they submitted their tax return,
2 they could have beyond today to get that coverage.

3 MR. SWITZER: Great. Thank you.

4 COMMISSIONER BIRRANE: Okay. Well,
5 thank you very much for your comments. We
6 appreciate them very much, and we appreciate that
7 they were prefiled. They will be posted on our
8 website.

9 So I -- Craig, I don't think that anyone
10 who hadn't previously indicated a desire to speak,
11 I don't think anyone else has requested an
12 opportunity.

13 MR. EY: That's correct.

14 COMMISSIONER BIRRANE: Is that correct?

15 MR. EY: That's correct.

16 COMMISSIONER BIRRANE: So what I would
17 say then is that we're at the close of the hearing.
18 I want to thank everybody for their participation.
19 Todd, I want to invite you to put your screen back
20 up, so that way we can show the e-mail addresses
21 and, you know, the website information.

1 You know, as Todd said, and I've said
2 several times, and this is really, you know, quite
3 sincere, we really do want to invite broad
4 commentary from everybody who is a stakeholder
5 here. And that includes, you know, policyholders
6 and not just formal advocates, but, you know, we
7 want to hear what every Marylander has to say here.
8 It is a very important part of the process, and we
9 do take every comment into consideration. It just
10 doesn't go to some mailbox that nobody looks at.
11 We do read every single one of them. And if you
12 have questions, we do take those questions. Todd's
13 team takes those questions and poses them to the
14 companies, as they will all attest to.

15 So with that, we do have contact
16 information that's up on the screen, and we have
17 the e-mail address or the URL for where we've
18 posted the rate filing information. So we would
19 invite you to go there. This hearing will also be
20 posted on that site, if there's anyone that you
21 know that wasn't able to participate today that

1 would like to see what happened.

2 And, of course, if you have comments or
3 questions about the rates, you can contact Todd
4 Switzer whose e-mail address is here. And if you
5 have more general inquiries, you are invited to
6 contact Mr. Ey, whose e-mail address is here, our
7 Director of Communications.

8 Okay. And with that, I really want to
9 thank everybody, and we will call this a close.
10 Thank you.

11 (Examination concluded -- 3:21 p.m.)

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1 STATE OF MARYLAND

2 SS:

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4 I, ILANA E. JOHNSTON, a Notary Public of
5 the State of Maryland, do hereby certify that the
6 above proceedings were reported by me in the
7 above-captioned matter.

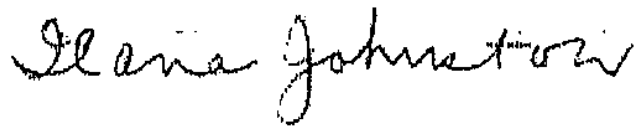
8

9 I further certify that I am not of
10 counsel to any of the parties, nor an employee of
11 counsel, nor related to any of the parties, nor in
12 any way interested in the outcome of this action.

13

14 As witness my hand and notarial seal
15 this 29th day of July, 2020.

16



17

18 My commission expires

19 December 16, 2020

Notary Public

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