Deposition of:

Hearing

July 15, 2020

In the Matter of:

ACA Hearing

Veritext Legal Solutions
888.777.6690 | cs-midatlantic@veritext.com | 215-241-1000

MARYLAND INSURANCE ADMINISTRATION

2021 ACA PROPOSED HEALTH INSURANCE

PREMIUM RATES HEARING

The hearing in Re: 2021 ACA PROPOSED HEALTH INSURANCE PREMIUM RATES was held remotely on Wednesday, July 15, 2020, at 2:00 p.m., via Google Meet, before Ilana E. Johnston, Notary Public.

Reported by:

Ilana E. Johnston (via Google Meet)

APPEARANCES: (via Google Meet)

MARYLAND INSURANCE ADMINISTRATION STAFF:
KATHLEEN A. BIRRANE, Commissioner
GREG DERWART, Chief of Staff
TODD SWITZER, Chief Actuary
DAVID COONEY, Chief of Life and Health
VAN DORSEY, Principal Counsel
MICHAEL PADDY, Director of Government Affairs
CRAIG EY, Director of Communications
JEFF JI, Senior Actuary
BRAD BOBAN, Senior Actuary
ADAM ZIMMERMAN, Senior Actuary

COMPANY REPRESENTATIVES: (via Google Meet)
REGIS MURAYI, Aetna
PETER BERRY, CareFirst BlueCross BlueShield
JAMES CHU, Kaiser Permanente
RYAN MORGAN, UnitedHealthcare

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

- - - - - - - - - - - - - -

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

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

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

submitted before this or during the hearing.

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

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

or three minutes to speak.

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

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

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

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

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

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

Again, please identify yourself by

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

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

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

Before we begin, I would like to take a

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

individual market, everyone citing uncertainty, which is understood.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The next slide is the most numbers based

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

submit comments.

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

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

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

COMMISSIONER BIRRANE: We can. Thank you.

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

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

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

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

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

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

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

I'll now review the main drivers of

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

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

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

Third, our estimate of the average

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

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

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

originally anticipated.

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

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

COMMISSIONER BIRRANE: Any questions from anyone on the MIA?

MR. SWITZER: Sure. This is Todd.

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

MR. MURAYI: That is correct.

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

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

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

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

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

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

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

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

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

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

MR. MURAYI: Okay.

MR. JI: Regis, this is Jeff.

MR. MURAYI: Hello, Jeff.

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

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

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

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

MR. JI: Okay. Thank you.

MR. MURAYI: You're welcome.

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

MR. MURAYI: All right. Thank you.

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

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

COMMISSIONER BIRRANE: We can, Pete. Thank you.

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

COMMISSIONER BIRRANE: Of course.

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

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

Services, Incorporated.

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

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

the next few weeks and additional changes are possible.

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

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

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

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

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

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

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

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

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

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

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

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

MR. ZIMMERMAN: Hi, Peter. This is Adam

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

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

MR. ZIMMERMAN: All right. Thank you.

MR. BERRY: Sure.

MR. SWITZER: Go ahead, Brad.

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

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

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

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

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

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

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

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

MR. BOBAN: Yeah, definitely.

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

MR. BERRY: Great.

COMMISSIONER BIRRANE: Thanks, Pete.

MR. BERRY: Sure. Thank you.

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

MR. CHU: Hey, can you hear me?

COMMISSIONER BIRRANE: We can.

MR. SWITZER: Yes.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MR. BOBAN: Thank you.

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

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

MR. JI: Thank you.

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

MR. CHU: Yeah, on the professional

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

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

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

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

MR. MORGAN: Can you hear me okay?

COMMISSIONER BIRRANE: We can, Ryan. Thank you.

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

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

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

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

of the group.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MR. SWITZER: Sounds good. Thank you.

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

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

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

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

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

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

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

MR. JI: Thank you.

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

MR. MORGAN: Thank you.

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

MR. MORGAN: Yep.

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

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

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

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

COMMISSIONER BIRRANE: Yes.

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

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

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

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

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

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

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

claims and claims costs.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

COMMISSIONER BIRRANE: We can. Thank you.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MS. KLAPPER: Yes.

MR. SWITZER: Okay.

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

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

MR. SWITZER: Great. Thank you.

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

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

MR. EY: That's correct.

COMMISSIONER BIRRANE: Is that correct?

MR. EY: That's correct.

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

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

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

would like to see what happened.

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

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

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

STATE OF MARYLAND

SS:

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

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

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

Ilana Johnston

My commission expires

December 16, 2020 Notary Public

d

n