Maryland
Hospital Association

August 14, 2020

Kathellen Birrane
Insurance Commissioner
Maryland Insurance Administration
200 St. Paul Place, Suite 2700
Baltimore, Maryland 21202

Dear Commissioner Birrane:

On behalf of the Maryland Hospital Association's (MHA) 61 hospital and health systems, I am submitting comments on the proposed individual and small group market insurer rate filings for plan year 2021. We thank the administration for increased engagement with stakeholders in recent years and appreciate the opportunity to provide input.

Maryland's hospitals support affordable coverage as an essential pillar of the health care delivery model because affordable coverage provides access to the right services, prevents unnecessary, costly health care use, and advances the health of all Marylanders.

Insurer Filings: Data and Trend Accuracy

As we mention each year, some filings include inaccurate information on the dynamics of hospital costs in the state. UnitedHealthcare's filings contain public to private payer cost-shifting for hospital services as a large factor in their projections for 2021 rates. This assumption is inaccurate. As this insurer enters the individual market in calendar year 2021, it is even more important that their filings are based on accurate, Maryland-specific information.

MHA urges you to review the justifications submitted by insurers to ensure the data shared with the public is accurate.

In addition, the filings vary greatly in the projected trends for hospital utilization and cost. For fiscal year 2021, the Health Services Cost Review Commission (HSCRC) has approved total hospital allowable revenue growth of just 3.5%.We know there are several, product and plan-specific factors that develop the composite cost and utilization trends submitted by insurers. We also appreciate that the Maryland Insurance Adminstration (MIA) works diligently to incorporate the HSCRC's approved global budget update factor in its review of rates. However, given the transparent process undertaken at the HSCRC to develop the hospital global budget update factor, this area of insurance rate review would also benefit from increased transparency.

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

Addressing Insurance Affordability

The COVID-19 pandemic has clearly created cost-savings for insurers. Some reports indicate that health plans and employers who provide insurance have seen an overall decline in healthcare use of about 30% to 40% in recent months; this was confirmed by MIA staff and insurers at the July 15 MIA Rate Review hearing. These savings have improved insurers' medical loss ratios. In turn, insurers are providing their enrollees with premium rebates. While we support any measures to decrease health insurance costs for enrollees, we ask the MIA to consider ways in which to decrease patient out-of-pocket expenses.

The State Health Access Data Assistance Center, or SHADAC, notes that 43% of employees in Maryland are in enrolled in high deductible health plans. The high out-of-pocket costs in these plans deter individuals from accessing appropriate upstream care, and saddle patients with large out-of-pocket costs for the care that they do receive.

We urge MIA to address the continued rise in underinsurance due to the prevalence of high-deductible health plans, which impacts the costs borne by consumers at the point of service.

To address underlying, ongoing affordability, and sustain the decreases in premium rates that the 1332 waiver and state reinsurance program have clearly effectuated, policymakers should review insurer initiatives to better manage care for enrollees. Under the Total Cost of Care Model, the state must meet specified population health targets related to at least two chronic conditions: diabetes and opioid use. These targets, and the efforts related to achieve them, will be on an all-payer basis.

MHA recently provided the Maryland Health Benefit Exchange with comments on the carrier accountability reports, which will collect data on insurer care management initiatives as part of the state reinsurance program. Our comments note that regulators with oversight of insurance coverage should be deliberate in understanding the how insurers select patient populations for interventions, the desired goals of those interventions, and most importantly, the success of those interventions. MHA appreciates that MIA collects information on the number of care management programs insurers have in place as part of its rate review analysis. However, understanding the success of these programs is important.

We ask the MIA to collect information on the success of insurers' care management programs, including the impact on morbidity, high-cost utilization, and health outcomes.

Continuation and Expansion of Existing Telehealth Coverage

Over the past several months, healthcare providers across the continuum have been working through an extraordinary public health crisis. The COVID-19 pandemic has required an all hands-on deck approach by providers, who are focused solely on providing the clinical care needed to care for COVID patients and to continue care for all patients. But, as you know, comprehensive care delivery is facilitated by comprehensive health care coverage.

Early in the pandemic, we raised the need for need robust telehealth coverage policies by commercial payers, noting that telehealth was *the vehicle* providers were using to ensure continuity of care. At that point, commercial insurers throughout the nation — including those offering plans in Maryland — voluntarily implemented a variety of policies on the myriad aspects of telehealth, including eligible providers, cost-sharing, and reimbursement rates. While Maryland's hospitals appreciate the intent behind these policies, their patchwork nature resulted in significant administrative burdens upon providers seeking to implement them. This often led to confusion in coverage and care delivery determinations for patients and providers.

Many commercial health insurers are now sunsetting those policies for telehealth services, despite the federal public health emergency extension until October 23, 2020. There have also been indications that insurers are ending certain policies based on specialties or product type. These added levels of complexity make it harder for providers to identify which patients are eligible for telehealth coverage.

Instead, commercial insurers should recognize the enduring benefits of telehealth, and its need for ongoing continuity of care. Maryland's providers have been increases in patient satisfaction and engagement, reductions in missed appointments for preventive and necessary care, and improved access to care. As insurers and the MIA look at continuing telehealth coverage, for the remainder of the COVID-19 pandemic and beyond, they should take these metrics into account.

MHA urges the MIA to ensure insurers continue the telehealth flexibilities put in place during the COVID-19 pandemic for the duration of the public health emergency, expand on these flexibilities, and require coverage and reimbursement parity for telehealth services on a permanent basis.

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

Sincerely,

Maansi K. Raswant

Maansi K. Raswant
Vice President, Policy