MHBE

Small Business Programs Advisory Committee

February 22, 2023
1:00PM – 3:00PM
Via Google Meets

Members Present:
Jon Frank, Co-Chair
Lane Levine, Co-Chair
Neil Bergsman
Ainisa Broadway
Brandon Burbage
Rob Cohen
Cindy Hipwell
Mark Khatib
Daniel Koroma
Michael Rachesky
Sandy Walters
Amber Hyde
Richard Hughen

Staff
Theresa Battaglia
Johanna Fabian-Marks
Makeda (Mimi) Hailegeberel
Elizabeth Leo
Amelia Marcus

Guest Presenters
Stephanie Klapper

Members of the Public
Allison Mangiaracino
Fata Antoinette Mensah
Sheena Ogee
Eugene Poole

Welcome and Message from MHBE Leadership
Jon Frank, Co-Chair, welcomed attendees. He encouraged members who have thoughts after any of the meetings to send them to Mimi Hailegeberel, Small Business Programs Manager for the Maryland Health Benefit Exchange (MHBE).

Meeting Minutes Approval
Mr. Frank presented the minutes from the Committee's January 25th, 2023, meeting for approval. Rob Cohen moved to approve the minutes. Daniel Koroma seconded.

Follow up Items
Mr. Frank then reviewed two comments received from members following the Committee's last meeting on January 25th, 2023. The first suggestion was that the Committee should hold an in-person meeting. Mr. Frank praised the idea and shared that, in response, the Committee has discussed holding its April 26th meeting in person, with an option for members who are unable to attend in person to call in. The second comment was that the Committee should focus on how to increase small business participation in the programs it discusses; Mr. Frank noted that the Committee can address this comment during its discussions today.

Uninsured Marylanders Data

Ms. Hailegeberel began presenting on information on the Maryland small business health insurance landscape and the Maryland uninsured. Detailed slides are available in the presentation for this meeting. First, to provide background information, she reviewed results from a 2019 national survey conducted by the Commonwealth Fund regarding small employers' opinions on the challenges barring them from offering health insurance coverage for employees. Many respondents indicated they struggle with the lack of plan choices; the availability of clear, unbiased information; and the burden of administrative paperwork. 91% indicated that having more unbiased information available would be a helpful step toward reducing health care costs for them.

Mr. Frank asked how the 91% who responded that they are not getting unbiased information are getting their information, inquiring whether it comes from carriers. Ainisa Broadway responded that the statistic may reflect how crucial health insurance information can come from biased sources who are incentivized to guide consumers toward particular health insurance products. She noted that the only way this information could be unbiased would be for all available options to be presented. Mr. Frank agreed.

Sandy Walters asked for clarification on what the 91% statistic and the previous number showing that respondents identified information availability as a challenge each measure, respectively. Ms. Hailegeberel answered that the first number represents responses to a question about what major challenges small businesses face in offering health insurance, while the 91% statistic shows what solution small employers indicated would be helpful.

Mr. Frank suggested that the statistic showing the number of respondents who identified administrative paperwork as a major deterrent to offering coverage may underestimate the prevalence of this sentiment among small employers.

Michael Rachesky agreed that there is bias present in Maryland's healthcare industry specifically. Referring to data he recently received, he stated that about 90% of all groups run through an Affordable Care Act platform received a CareFirst quote, while 50% and 40% received United HealthCare and Aetna quotes, respectively. He argued the discrepancy represents bias in the state's distribution platforms that warrants investigation.

Ms. Hailegeberel continued her presentation, sharing a chart produced using 2021 Maryland Insurance Administration (MIA) data depicting the portion of Maryland's insured population covered through various mechanisms: the individual market, Medicare, Medicaid, military and federal health plans, self-insured plans, and fully insured plans. She added the caveat that these numbers are just estimates.

Mr. Walters asked if the MHBE knows what percentage of Maryland's uninsured qualify for Medicaid but have not applied. He noted that more outreach to this population may

be necessary, sharing an example of successful outreach he has seen previously involving meeting people in public spaces to help them learn about getting enrolled. Ms. Hailegeberel responded that about 41% of the lawfully present uninsured in the state make between 138% and 400% of the federal poverty limit (FPL), meaning they qualify for subsidies.

Mr. Cohen expressed curiosity regarding how Maryland's uninsured rate compares to other states, noting that many Maryland residents receive health insurance through their positions as federal employees, which may depress the state's uninsurance rate in comparison to others. Mr. Frank responded that it should be possible to find that information but noted the difficulty involved in finding the data being presented.

Johanna Fabian-Marks, Director of Policy and Plan Management for the MHBE, shared a link to a resource showing the uninsurance rates for each US state.

Amber Hyde asked whether the self-insured portion of the chart refers exclusively to large group self-insured plans. Ms. Hailegeberel responded in the affirmative. Ms. Hyde noted that the percentage of Marylanders with that type of plan—27%—is surprisingly high.

Ms. Hailegeberel continued her presentation, explaining that Maryland small group enrollment reached a peak in 2018 but decreased to an all-time low in 2021 and that anticipated rate increases in the small group market in 2024 may further reduce enrollment. She shared that the approved rate change for this market in 2023 is 7.6 percent, which is lower than carriers' initial requested rates by an average of 4.4%. MIA has cited factors including inflation, increased unit costs, and COVID-19-related uncertainty as having contributed to the rate increases, which will affect around 232,000 Marylanders.

Mr. Koroma asked if the available data suggest an uptick in insurance coverage as a result of the pandemic, noting that some consumers may have enrolled after visiting the hospital. Ms. Hailegeberel responded in the negative, noting that small group enrollment has decreased over the course of the pandemic. Ms. Fabian-Marks added that overall health insurance coverage remained relatively unchanged throughout the pandemic, although she noted that the most recent data available are from 2021. She also stated that the data show that coverage did shift, with many consumers losing employer-sponsored coverage and gaining coverage through Medicaid or the individual market.

Mr. Rachesky asked how much membership moved from the small group to the large group market as groups grew in size. Ms. Fabian-Marks responded that the available data are not sufficiently granular to answer that question. Mr. Frank added that data on groups that went self-funded are similarly unavailable.

Mr. Rachesky noted that the stability in the overall uninsured rate indicates that the members leaving the small group market are finding coverage elsewhere, expressing that this is encouraging.

Ms. Hailegeberel presented summary statistics drawn from census data on uninsured Marylanders overall: of the state's total population (6.2 million), 5.8 million are lawfully present, 4.4% of whom are uninsured.

Next, she presented data gathered from the 2021 American Community Survey 1-year samples and the 2022 Current Population Survey by The Hilltop Institute regarding the demographic characteristics of the lawfully present uninsured in Maryland, adding the caveat that these survey instruments have small sample sizes that make them less reliable for state-level estimates than for national ones. She noted that most of this population did not have health insurance through their employer, private, or public payers during the previous year, and the data include cautious estimates that about half work for employers who offer health insurance to their employees.

She moved on to presenting the demographic data: 35% of Maryland's lawfully present uninsured are ages 19 to 34; 58% are male; 42% have incomes between 138% and 400% of the FPL; 49% are employed; non-Hispanic Black or African American Marylanders were the racial/ethnic group most likely to be uninsured, making up 34% of the population; 61% are single or never married.

Mr. Walters stated that those making below 138% of the FPL would be eligible for Medicaid and are a population among whom the MHBE could greatly increase insurance rates. He noted that those making over 400% of the FPL likely have access to health insurance, while those making between 138% and 400% of the FPL likely cannot afford health insurance even if it is subsidized, making them difficult to reach.

Ms. Fabian-Marks noted that, in rough estimates, 100,000 of the 350,000 uninsured Marylanders are undocumented, leaving around 250,000 uninsured Marylanders who can receive coverage through public programs, of whom around half are eligible for Medicaid based on their income.

Mr. Cohen stated that someone being uninsured does not necessarily mean they are not receiving healthcare, noting that many receive care through emergency rooms.

Mr. Frank noted that the 127,000 employed individuals among Maryland's lawfully present uninsured population will likely be the Committee's focus given that these are the people small business programs are poised to impact through employer-sponsored health plans. He acknowledged it may be difficult to gauge the income of this subpopulation specifically.

Mr. Rachesky observed that single males lead the Maryland uninsured category and asked whether additional detail is available on whether the population defined in the data as employed is made up of people working full-time, those working part-time, or both. Ms. Hailegeberel responded that she can look into those specifics.

Mr. Rachesky noted that employment and income are likely correlated among this population and stated that those with low income would likely find it difficult to pay for health insurance coverage. He stated that lowering the floor of what is considered full-time eligible for an employer-sponsored health plan could present a solution.

Lane Levine, Co-Chair, asked if the slide showed the largest plurality for each category. Ms. Hailegeberel responded in the affirmative.

Mr. Levine asked whether the statistic that 49% of this population are employed implies that the remaining 51% are unemployed. Ms. Hailegeberel clarified that the responses for the item in question were group into “employed,” “unemployed,” and “not in labor force,” meaning those without a job who are not seeking work.

Mr. Koroma asked whether the data provide details on the industries of Maryland’s employed uninsured population. He noted that surveys his organization has conducted have indicated that many small business owners feel out of the loop regarding government activities. Ms. Hailegeberel responded that the MHBE does not have data on the industries of the overall unemployed but that data on the industries of uninsured small business employees can be found in the appendix section of the presentation for this meeting.

Mr. Rachesky asked if the data offer details regarding what percentage of the uninsured employed population have been offered insurance. Ms. Hailegeberel replied in the negative.

Mr. Rachesky remarked on the fact that African Americans are continually underinsured and face care disparities in Maryland and nationwide. He expressed curiosity about how many uninsured African American Marylanders are employed and how many have been offered insurance. Mr. Cohen added that it may be helpful to know about the data on Black males specifically given that males are also more likely to be uninsured.

Ms. Hailegeberel shared more details on the uninsured population: more than 90% speak English, and not many are military veterans, nor did many report any cognitive, ambulatory, self-care, vision, or hearing disabilities.

Mr. Rachesky asked about whether the data show details on how many of the uninsured have a disability that impairs decision making processes, as this represents another underserved population and a condition correlated with homelessness. Mr. Walters responded that the slide indicates that few of the Maryland uninsured have a disability. Ms. Hailegeberel noted that the slide shows the distribution of disabilities among the Maryland uninsured population in general, while Mr. Rachesky was referring to disabilities among the African American population specifically. Mr. Rachesky expressed interest in both measures.

Ms. Fabian-Marks noted that the source of these data is most effective for estimates at the national level, so narrowing by multiple demographics at once can lead to small sample sizes that result in low reliability.

Ms. Hailegeberel moved on to discussing data regarding gig workers, which include those who do temporary, on-demand, or freelance work such as driving a car, making deliveries, renting out property, running errands, selling goods online, selling equipment, or providing creative or professional services. She shared the results of two national surveys of gig workers, which show that a quarter lack health insurance (with lack of affordability reported as the main reason), that Hispanic and Latino people are the ethnic group most likely to be uninsured among gig workers, and that nearly half of gig workers with coverage did not pay a premium this year due to the American Rescue Plan Act (ARPA)'s increased subsidies. Gig workers composed an estimated 14% of all lawfully present uninsured individuals in 2021.

Mr. Levine asked for clarification on how to interpret the statistic regarding how many gig workers did not pay their premium. Ms. Hailegeberel replied that the gig workers included in this number may or may not have had any premium due but did not pay any.

Mr. Frank asked whether gig workers are included in Maryland's employed uninsured population. Ms. Hailegeberel responded in the affirmative. Elizabeth Leo, Data Specialist for the MHBE, agreed.

Mr. Walters stated that most employer-sponsored health plans do not cover 1099 employees, of which type many gig workers are. He noted that this means they are being counted within the employed population but are ineligible for employer-sponsored health plans.

Mr. Rachesky spoke from his experience working in healthcare in Florida, where much of the Hispanic population is uninsured. He described learning that differences in how healthcare was provided in the countries where many immigrated from may lead immigrants to not purchase health insurance. He expressed curiosity over the immigration status of the uninsured Hispanic population in Maryland. Ms. Hailegeberel reiterated the difficulty of breaking up the data by several demographics at once but noted that the MHBE will look into additional data about uninsured gig workers in Maryland.

Ms. Hailegeberel then presented on further data provided by Hilltop narrowed to uninsured gig workers in Maryland: the MHBE provided Hilltop with North American Industry Classification System (NAICS) codes for certain industries likely to contain gig workers. She shared the results regarding the age, gender, income, racial, and ethnic makeup of uninsured Maryland gig workers. 50% of this population is single, while of the other half who are married, 62% have spouses who are employed, but few of their spouses have employer-sponsored health coverage.

Ms. Hailegeberel then presented on data regarding uninsured small business employees in Maryland, noting that their demographic profile is different from the overall Maryland uninsured population; for this group, the majority are between the ages of 35 and 50, likely because people in that age range have more skills and experience than younger age groups, contributing to greater employment in small businesses. The majority of this population work full time and have incomes over 150% of the FPL. Men make up the majority of the group, as do single individuals, but among those who are married, their spouses are likely to be employed and have health insurance coverage.

Richard Hughen noted that many gig workers piece together multiple gig work jobs, working too few hours at each to gain insurance from any employer if it is offered, making them natural candidates for health insurance through Maryland Health Connection (MHC).

Mr. Koroma identified the lack of any type of formal association where gig workers congregate as a challenge in reaching them. He also noted the existence of cultural and language barriers given that many gig workers are immigrants from Africa. He stated that special strategies may be necessary to reach them. Ms. Broadway agreed and suggested that the companies employing these workers provide them with health insurance information, in addition to the placement of posters in workers' languages in the clinics where they receive services.

Ms. Hailegeberel noted that providing information in a variety of languages is a major initiative that carriers and clinics are undertaking.

Ms. Hyde acknowledged expanded language services would be helpful but remarked that brokers have information available in a variety of languages but argued that it may be impossible to reach everyone in their specific language given the multitude of languages and dialects spoken by Marylanders.

Mr. Cohen noted that many gig workers are drivers for Uber or Lyft and suggested having these companies publish health insurance information for their employees. He expressed doubt regarding the utility of posters as a medium for the information.

Mr. Rachesky stated that posters may be more effective for certain industries where workers regularly report to a physical location, such as the service and hospitality industries. He suggested analyzing the percentage of Maryland's uninsured gig workers who work in these industries. Mr. Cohen responded that gig workers are unlikely to spend much time in an office.

Ms. Hailegeberel closed by sharing 5-year average rates of uninsurance among Maryland small business employees: the rates are 8.7% when considering only lawfully present individuals and 11.6% if Marylanders are included regardless of documentation status.

Mr. Hughen cautioned against homogenizing gig workers to just Uber and Lyft drivers, noting the breadth of types of work they perform.

Legislative Update

Next, Stephanie Klapper, Deputy Director of the Maryland Health Care for All! Coalition, presented an update on legislation relevant to the Committee. Detailed slides are available in the presentation for this meeting. The first piece of legislation, Senate Bill (SB)59 — House Bill (HB)107 — was drafted in response to the recommendations of the previously convened Small Business and Nonprofit Health Insurance Subsidy Program (SBNHISP) Workgroup and would appropriate $5 million per year for five years for the MHBE to do outreach to help small businesses get their employees enrolled in health care plans. She noted that the bill is poised to help equity because of the density of businesses in Maryland owned by people of color.

Ms. Klapper continued, presenting on SB601/HB814 next. The bill would continue the Young Adult Health Insurance Subsidy Program, which has completed a two-year pilot program and has helped 45,000 Marylanders get coverage, including 17,000 who are new to the marketplace, as well as reducing racial and ethnic disparities, especially among Latino young adults. She also stressed that the program's continuation will cushion the impact of the public health emergency (PHE) and the subsequent Medicaid unwinding, which may have otherwise allowed some enrollees to lose coverage.

The next bill, SB365/HB588, would open the individual market for Marylanders to purchase coverage and access subsidies regardless of immigration status, assisting the over 100,000 uninsured Marylanders whose immigration status currently prevents them from doing so. SB806/HB363 would require the Maryland Department of Health and the MHBE to conduct a study comparing options for making coverage affordable for residents ineligible for Medicaid, the Children's Health Insurance Program, or state qualified health plans. CASA is playing a major role in the advancement of both bills.

Ms. Klapper closed by describing SB26/HB111, which would make it so those enrolled in the Supplemental Nutrition Assistance Program (SNAP) are automatically enrolled in Medicaid. She projected that the bill could dramatically reduce the uninsured rate in Maryland as well as improving health equity in the state. She clarified that those already enrolled in SNAP and Medicaid would remain enrolled in both, which is crucial as the Medicaid unwinding resulting from the end of the PHE takes effect.

Mr. Frank asked what the income eligibility requirements are for SNAP. Ms. Klapper replied that she would have to check the exact income requirements but that everyone enrolled in SNAP is eligible for Medicaid.

Mr. Cohen asked for confirmation that SNAP was formerly known as Food Stamps. Ms. Klapper responded in the affirmative.

Mr. Frank asked whether undocumented Marylanders can currently purchase insurance through the open market. Mr. Walters responded that he thinks that is true.

Mr. Cohen asked whether one needs a social security number (SSN) to purchase insurance on the open market. Ms. Hailegeberel replied that, while some forms include questions asking for an SSN, insurance companies generally do not follow up if these items are not filled in. Ms. Hyde agreed that an SSN is not necessary on the individual or group market, noting that it is only necessary to receive a subsidy.

Mr. Hughen shared a link to a resource containing additional information on SNAP eligibility.

Discussion

Next, Ms. Hailegeberel reviewed the programs the MHBE hopes to implement by Fall 2024. Detailed slides are available in the presentation for this meeting. The programs include the following: an end-to-end shopping, tax credit eligibility, enrollment, and billing services platform for small businesses (MHC for Small Business); an outreach, marketing, and preferred producer program to help expose Maryland underinsured small business employees to the MHBE's messaging; and integration of Individual Coverage Health Reimbursement Arrangement (ICHRA) and Qualified Small Employer Health Reimbursement Arrangement (QSEHRA) services into MHC for Small Business. She welcomed suggestions from the Committee regarding the platform.

Ms. Hailegeberel then presented the group with several discussion questions regarding how the MHBE can best assist in getting small business employees covered and the demographic considerations involved. The questions are included in full in the presentation for this meeting.

Mr. Levine encouraged the Committee to discuss how they can apply what they found interesting from the demographic data presented throughout the meeting to the initiatives the MHBE hopes to implement by Fall 2024.

Mr. Koroma shared details from his own professional experience during the COVID-19 pandemic. Many of the businesses with whom his organization worked faced challenges regarding a lack of access to information, as traditional channels of distributing information may not be universally effective. He suggested leveraging businesses that can connect the MHBE with other small businesses.

Mr. Frank expressed curiosity as to where the Maryland small businesses not offering health insurance are located, noting the lack of information at the Committee's disposal regarding pockets of uninsured residents that can be approached geographically.

Mr. Hughen noted that the data should be used to point toward the places where uninsured individuals may aggregate, such as churches, barbershops, or community organizations. He also noted that many Marylanders lack internet access and stated that there may be a distrust factor involved for some segments of the uninsured population, necessitating in-person outreach.

Ms. Leo linked to an interactive dashboard that allows users to explore data from the MHBE's most recent uninsured analysis, which include information on where in the state the uninsured are located.

Ms. Fabian-Marks reminded the Committee that the MHBE has an outreach unit focusing on outreach to individuals but no specific small business-focused division, highlighting that the MHBE welcomes suggestions on how best to reach this population.

Mr. Levine asked whether gig workers are included when considering the population of small business employees or are seen as separate. Ms. Hailegeberel replied that they do not universally qualify as small business employees but that many gig workers are uninsured, so it is another population for whom to consider targeted outreach.

Mr. Levine asked for confirmation that small businesses are the main focus rather than gig workers. Ms. Hailegeberel replied in the affirmative.

Mr. Rachesky suggested targeting outreach at the overlap of the most possible uninsured groups that the data identify; he gave the example of single, employed, uninsured African American males.

Mr. Franks noted that Mr. Rachesky's suggestion is in line with the directions given by SB632, which directed the creation of communications targeted toward small employers not offering insurance benefits and presenting unbiased information explaining their options, including offering an employer-sponsored plan, referring employees to MHC as individuals, and using an ICHRA.

Eugene Poole noted that gig workers and small business employees are often not considered full employees but 1099 workers, which he contended should be covered through the individual market rather than the small group market. He also stated that the employers who purchase employer-sponsored plans for their employees tend to have government contracts that provide fringe benefit billing that helps them foot the cost. He remarked that going through churches and community organizations is an effective way to reach the uninsured population but highlighted the importance of explaining health insurance terminology to them and noted that virtual outreach is all that many brokers can afford, especially given that many of the people they talk to enroll in Medicaid, for which the brokers receive no compensation.

Ms. Leo welcomed feedback on what types of analysis and maps would be of most use for Committee members' small business outreach efforts.

Neil Bergsman expressed hope that the Committee's next meeting will focus less on broad considerations such as the demographic characteristics in the data presentation during this meeting and more on specific, tactical strategies in order for the Committee to be a useful resource for the MHBE. He argued that even without further refinement the data give a strong profile of the target population. He asked for the MHBE staff's

professional thoughts about what tools and messaging can be used to most effectively reach small employers and ultimately give small business employees health coverage.

Ms. Hailegeberel asked for confirmation that Mr. Bergsman means to say having several options for how to approach this task would be helpful. Mr. Bergsman replied in the affirmative. Ms. Hailegeberel noted that this is doable.

Theresa Battaglia, Small Business Outreach Manager for the MHBE, explained that she has been working with the MHBE's Director of Marketing and Web Strategies on a planned marketing rollout for small businesses. Her initial focus has been on how to leverage partnerships with state agencies such as the Maryland Department of Commerce. She underscored the need for feedback on the specifics of how small employers should be instructed to educate and enroll their employees. She also noted that messaging can touch on the importance of offering health insurance to employees as a form of effective recruitment given that insurance is one of the demands shared by many selective potential applicants. She assured the Committee that the marketing plan will be consistent with the organization's outreach efforts on the individual market and welcomed feedback from the Committee.

Mr. Poole asked whether the MHBE does outreach to tax preparers and certified public accountants (CPAs). Ms. Battaglia responded in the affirmative, noting the MHBE's requests for these individuals to distribute health insurance information to their clients, the organization's work with the CASH Campaign of Maryland, and its "Check the Box" initiative. She welcomed suggestions for additional marketing avenues the MHBE can explore. Mr. Poole remarked that he works closely with multiple CPAs and that the MHBE is not leveraging them enough given the sway they have over their clients. He also argued for transparency to ensure brokers favored by the MHBE are consistently acting in consumers' best interest.

Mr. Walters expressed concern that some of the MHBE's plans, such as the integration of ICHRAs into the MHC for Small Business platform, may benefit the individual market rather than the small group market. He stated his understanding of the Committee's mission as the expansion of the small group market and noted that the subsidies available on the individual market make it difficult to sell small group plans on price, necessitating an emphasis on other benefits of the small group market such as the ability to enroll an employee at any time of year.

Mr. Levine explained that his understanding of the Committee's purpose is that it should be an extension of the SBNHISP Workgroup's work, noting that the Workgroup agreed that getting workers insured was paramount and that and one of the most compelling ways to do so was to make them aware of individual subsidies.

Mr. Frank commented that the preferred approach for small employers not currently offering coverage would be to educate them on advantages of offering a plan but acknowledged that a secondary strategy for those who still will not offer coverage would be to educate them on the benefits available for their employees on the individual

market. He noted that an ICHRA would allow an employer to make a commitment without sponsoring a specific plan, which may be helpful given the point raised during the SBNHISP Workgroup's discussions that offering an employer-sponsored plan could make some employees ineligible for federal subsidies on the individual market. He suggested that the messaging could encourage small business owners to deliberate with their employees about the best option.

Mr. Bergsman stated that small nonprofit businesses are included in Maryland's small businesses, adding that his organization, Maryland Nonprofits, and other regional nonprofit associations can serve as effective messengers during this outreach process.

Citing the resource shared previously showing uninsured rates by state, Mr. Hughen noted that Massachusetts's rate is at 2.5% and Vermont's is at 3.3% and suggested that the Committee identify the best practices in which these states are engaging.

Mr. Frank encouraged members of the Committee to continue thinking about the questions discussed and the information provided, suggesting that members should feel free to submit additional thoughts over email.

Ms. Hailegeberel reminded the Committee that the next meeting is on Wednesday, March 29, 2023.

Public Comment
None offered.

Adjournment
The meeting adjourned at 2:55 PM.

Chat Log

00:16:29
Johanna Fabian-Marks -MHBE-: National uninsured rates by state: https://www.census.gov/library/stories/2022/09/uninsured-rate-declined-in-28-states.html

00:18:30
Johanna Fabian-Marks -MHBE-: Here's a sortable table view of uninsured rates by state: https://www.kff.org/other/state-indicator/total-population/?currentTimeframe=0&selectedDistributions=uninsured&sortModel=%7B%22colId%22:%22Uninsured%22,%22sort%22:%22asc%22%7D

00:24:52
Elizabeth Leo -MHBE-: Just to add to the resources available, MHBE did an analysis of the potential impact of COVID on the uninsured rate based on 2019 American Community Survey data (the best resource for sub-state detailed estimates, but unfortunately doesn't break down employment by number of employees like the CPS

does) and we'll be doing an updated analysis of the uninsured in Maryland using the most recent 2021 ACS data this year. We did not complete an analysis of 2020 ACS data due to COVID-related data (1/2)

00:25:24
Elizabeth Leo -MHBE-: quality issues. Here is the URL for the COVID impact analysis: https://www.marylandhbe.com/wp-content/docs/COVID_Uninsured_Analysis_Dashboard_April2021.html (2/2)

00:47:32
Richard Hughen: A percentage (high I believe) of gig workers are actually "multiple-gig" workers piecing together multiple part time gigs to support a full time income. Thus, each part time gig is too few hours to gain insurance from that employer IF offered. Natural candidates for the exchange

01:00:50
Richard Hughen: We should not homogenize gig workers to the Uber/Lift profile. Gig workers include freelance graphic designers, photographers, artists, engineers, MD's (doing Locum work), writers, medical writers and many more.

01:07:18
Richard Hughen: SNAP eligibility: https://www.benefits.gov/benefit/1276

01:20:40
Elizabeth Leo -MHBE-: I would love to hear from anyone about what would be helpful to the Small Business outreach efforts you folks are engaging in at least in terms of what kinds of analyses or maps would be of most use.

01:36:19
Michael Rachesky: have to drop. thank you everyone

01:40:12
Neil Bergsman: and it goes without saying, small nonprofit businesses are small businesses. MD Nonprofits (where I work) and regional associations of np's in many counties can be good messengers.

01:43:16
Richard Hughen: If Mass is at 2.5% and VT at 3.3% can we identify what they are doing differently or additionally and take those best practices home.

01:50:19
Neil Bergsman: For some employers (especially if their pay rates are high enough that a lot of employees are not eligible for subsidies), a small group plan may be a good option, especially if they value health insurance for recruitment, retention, and good employee relations purposes. In the workgroup, we DID agree that as Jon says, the employer should get reliable information about the full range of options.