MHBE

Small Business Programs Advisory Committee

September 27, 2023
1:00PM – 3:00PM
Online Via Google Meets

Members Present:
Jon Frank, Co-Chair
Glenn Arrington
Brandon Burbage
John Barker
Scott Brainard
Rob Cohen
Ileana Gonzalez
Alvin Helfenbein
Robert Poli
Eugene Poole
Michael Rachesky
Sandy Walters
Rick Weldon
Johanna Fabian-Marks
Makeda (Mimi) Hailegeberel
Amelia Marcus
Rita Dyer
Andrew Ratner
Nicole Edge

Members of the Public
Brad Boban
Nikki Blake
Chris McCarten
Eric Charles
Amber Hyde
Allison Mangiaracino
Kathy Sweely

Staff
Theresa Battaglia

Welcome, Agenda, and Meeting Minutes
Jon Frank, Co-Chair, opened the meeting. He started with the approval of the meeting minutes from the June 28 and August 30 meetings. Mr. Frank moved to approve the minutes as presented, and Eugene Poole seconded. The Committee voted unanimously to approve the minutes.

Mr. Frank explained that there are three new members to the Committee: John Barker, Judith Walker, and Scott Brainard. Mr. Brainard introduced himself. He is the owner of a hair salon in Columbia with ten employees and in the past has worked as a policy consultant.

Mr. Frank reported that Brad Boban, the Chief Actuary at the Maryland Insurance Administration (MIA) will be presenting on the 2024 approved health insurance premiums for the individual and small group markets.

2024 ACA Individual Non-Medigap & Small Group Markets Approved Health Insurance Premiums

Mr. Boban provided an overview of the approved health insurance premiums for the individual and small group markets in 2024 including the rate setting process, approved rates, and trends. Detailed slides are available in the presentation for this meeting.

Mr. Boban began by providing an overview of the small group market in Maryland before the implementation of the Affordable Care Act (ACA). While the ACA market reforms had a large impact on the individual market, the impact on the small group market was minimal because Maryland had already enacted small group market reforms in the 1990s. He then explained the ACA rating rules that were applicable to both the individual and small group markets. He also explained the rating rules that are unique to the small group market. Small group plan years can be a non-calendar year and small group rates change on a quarterly basis.

Mr. Boban then explained the MIA's general rate review process. The MIA's fundamental charge under Maryland statute is to make sure that rates are not excessive, inadequate, nor unfairly discriminatory. The general rate filing cycle begins with the MIA's review of historic claims and comparing them to previous years. The MIA also reviews carriers' assumptions used to project claims experience. Key assumptions used during the rate review process include claims trend, morbidity, operating expenses, profit margins, risk adjustment transfer, reinsurance recoveries, COVID-19 impact, and the impact of Medicaid unwinding on enrollment and morbidity.

Mr. Boban explained the rate setting process for small group ACA filings, which is dictated by the ACA regulations. The process begins with analyzing period claims and the total allowed claims per member per month for essential health benefits, called the index rate. Key assumptions in projecting the index rate include medical inflation, which is the number one factor driving rate increases with drug costs being the highest component in recent years. Additional assumptions include morbidity, change in demographics, and other changes such as projecting the cost of a new mandate or the impact of COVID-19.

Mr. Boban then presented a table showing recent trend data for 2023 compared to 2024. He noted that the table shows the final all-in-trend medical and drug claims combined for each carrier with a computed weighted average for the market. The trend increased 1% between 2023 and 2024 but there was variation among the carriers with some carriers not experiencing an increase. Mr. Boban reported that the small group trends have seen upward movement since 2022.

Mr. Walters asked if the 1% increase would translate to a 15% increase year over year. Mr. Boban responded that, per his calculation, there is a 1% difference between 2023 and 2024.

Mr. Boban then explained that after a carrier has projected its index rate (projected allowed claims), it must also project the size of the expected risk adjustment transfer and then add or subtract that amount to get the market-adjusted index rate. The risk adjustment calculation is unique to the ACA market. Carriers generally project risk

adjustment at the metal level because self-selection causes lower metal levels to transfer money to higher metal levels. Healthier people tend to choose bronze plans with higher deductibles and sick people tend to choose plans with low deductibles. Risk adjustment is more difficult for smaller carriers to project because of greater variance. The larger the carrier, the more stable the risk adjustment from year to year.

Mr. Boban showed a snapshot of the risk adjustment transfers for 2022. Some carriers pay into the risk adjustment program and other carriers receive risk adjustment payments. The risk adjustment program is a revenue neutral program--the money is transferred between carriers so the balance is zero. He noted that there is a high-cost risk pool component of the risk adjustment program wherein the federal government covers 80% of claims over $1 million, funded through an assessment on all carriers.

Mr. Boban explained that, after each carrier has projected their market adjusted index rate, they derive the rates for each of their benefit plans. In general, there are only three allowable adjustments in the small group market at the plan level: benefit design, network, and administrative factor.

Mr. Boban noted that, after all the plan-level rates are calculated, the plan-level rates must be calibrated to a 1.00 so that member-level rating factors can be applied. The index rate reflects the average age of the single risk pool, so the average age is backed out to get the calibrated rate to which a 1.00 rating factor for a 21-year-old is applied. He explained that all carriers have to go through these steps when setting rates that will be charged to consumers but there may be some variation.

Mr. Boban presented a slide displaying the rates the MIA recently approved for the 2024 plan year. He noted that the carriers' original rates filed in May 2023 resulted in an average rate increase of 7.5% but the rates approved by the MIA resulted in an average rate increase of 6.9%. There is variation among the carriers with Aetna Life Insurance only increasing rates by 1.4% and Aetna Health Inc. (HMO) increasing rates by 15.4%.

Mr. Boban then showed a table displaying the distribution of enrollment by metal level in the small group market. He noted that enrollment in bronze plans is much smaller than in the individual market and that platinum plans are more popular in the small group market compared to the individual market. While the small group market leans heavily towards HMOs, it is not as dominated by HMOs as the individual market.

Mr. Boban provided an overview of sample small group silver rates for a 40-year-old Baltimore City resident. The carriers' rates for the lowest silver plan ranged from $335 to $439 for an HMO and $351 to $496 for a PPO.

Mr. Boban then presented a table showing the history of small group rate approvals from 2021 through 2024. He noted that there has been an upward trend in the approved rates in recent years. In 2021 the approved rates increased by 2.1%, which was in line with the very low rate increases that occurred during the beginning of the ACA for the small group market. However, the rates increased by 4.4% in 2022, 7.6% in 2023, and

6.9% in 2024. Mr. Boban noted that this trend is in line with the average increases the MIA is seeing in the large group and non-ACA markets.

Glenn Arrington asked what can be done in the small group market to prevent individuals who could receive coverage through the small group market from moving to the individual market where insurance could be less expensive. He noted that the individual market and small group are competing for enrollment which can be a challenge. Mr. Boban responded that enrollment in the small group market has been steadily declining for several years but he is not sure that enrollment from the small group market has been moving into the individual market and he acknowledged that it is a difficult problem. Mr. Boban explained that the claims in the individual market are significantly higher than the small group market, but the individual market premiums are lower because the state reinsurance program reduces the individual claims. He noted that nationwide, individual coverage Health Reimbursement Arrangements (ICHRA) and Qualified Small Employer Health Reimbursement Arrangements (QSEHRA) which allow employers to provide a fund to their employees to buy coverage on the individual exchange are becoming more popular in the 15 states with a state reinsurance program where premiums in the individual market are lower than the small group market. ICHRAs or QSEHRAs may be an option. Mr. Boban acknowledged that this is a difficult situation to navigate, and it may not be solvable without funding to lower the small group rates.

Mr. Walters commented that Maryland has always tried to protect the small group market. He noted that with the subsidies in the individual market, enrollment from the small group market is moving to the individual market and asked how that problem could be solved to keep the small group market viable in Maryland. Mr. Boban responded that the small group market is still larger than the individual market and the small group market has fluctuated over the years. The small group enrollment is currently at a level similar to enrollment in 2017. Mr. Boban noted that the data he is looking at does not show a large decline in the small group market with a corresponding increase in the individual market. Instead, it shows small group enrollment fluctuating over the years and on the downward path right now with small decreases year over year. He hasn’t seen data to link the enrollment growth in the individual market to the enrollment decrease in the small group market.

Mr. Walters expressed concern that a business owner with six employees in the small group market could decide to get rid of the small group coverage and get individual coverage, leaving the employees to struggle to get insurance coverage on their own. Mr. Frank agreed with this concern and commented that it is difficult for small businesses with fewer than 10 employees to purchase small group coverage.

Mr. Poole commented that the administrative burden on small business owners to provide small group coverage is large and the tax credit is only available for two years. This may discourage small business owners from providing small group coverage, especially when the individual market is available with subsidies. Mr. Poole recommended reducing the administrative burden on business owners and the

minimum participation rates so it's easier for businesses such as restaurants that don't have a stable cash flow to provide small group coverage to employees. He noted that small businesses that have government contracts are in a better position to participate in the small group market because they have a stable cash flow and can bill the government for fringe benefits.

Mr. Arrington disagreed with Mr. Poole. Mr. Arrington commented that it is easier for small businesses to administer a small group plan with one employee rather than having each employee choose a health plan and then creating an ICHRA to wrap around it. He noted that option is a better fit for companies with 11-50 employees but 80% of companies have fewer than 10 employees. He added that it is very difficult for small employers to understand all their options and navigate the small group market and they rely on brokers for assistance.

Mr. Frank added that if he was a small employer with fewer than 4 employees, he would prefer to provide his employees information on enrolling in the individual exchange rather than sponsor a plan and pay 50% of the premium. He noted that many small employers have fewer than ten employees and are not offering coverage and may need some assistance to get their employees insurance coverage either through the individual market with subsidies or the small group market.

Scott Brainard commented that, as a hair salon owner with lower wage employees, even if he subsidizes insurance coverage in a small group plan, the employee's contribution would be more than what they would pay in the individual market. Mr. Brainard would like to offer coverage to his employees but having his employees enroll in coverage through the individual market puts the business and employees in a better financial position.

Mr. Boban acknowledged that the Committee members raise a good point, that with the generous subsidies available in the individual exchange it might not make sense for a small employer to offer coverage.

Brandon Burbage asked how the MIA is not seeing a move from the small group market to the individual market given that the individual market may be a better option for many people. Mr. Frank responded that some employers like offering a group insurance plan and use it to attract high value employees. He feels that there will not be a mass exodus from the small group market and that some employers may embrace the small group design in the future.

Mr. Burbage commented that Kaiser is seeing most small groups including new businesses move to the individual market, specifically employers with fewer than 10 employees–the majority of the small group sector.

Mr. Boban responded that the percentage of small employers that offer coverage has always been small compared to the large group market, where most employers offer coverage. He noted that the small employers that do offer coverage tend to have higher

paid employees that are less likely to be eligible for subsidies. While there is movement of small groups into the individual market, Mr. Boban feels that it is mainly lower income employees that would not have been offered employer sponsored insurance and may be eligible for individual subsidies. Higher paid employees are getting coverage through the small group market, but he does not have hard data to support that speculation.

Mr. Arrington noted that he has companies with higher earning employees that may not be eligible for individual subsidies and would prefer to pay a little more to get a better-quality plan through the small group market. However, there are employers with two to nine employees for whom the small group market is not a good option due to the cost. Mr. Arrington noted that the small group market still serves an important purpose, for example it has a couple hundred different products compared to 33 plans in the individual market.

Mr. Burbage added that, from the carrier perspective, it seems that every year they are forced to reduce the number of plans they are allowed to offer through the individual exchange.

Mimi Hailegeberel asked Mr. Boban about the possible impact of merged individual and small group market in Maryland, similarly to the merged market in California. Mr. Frank responded that the merger of the individual and small group markets has been studied several times and the largest challenge is that the individual market has a January 1st effective date, and the small group market effective dates are variable. It would be disastrous to force the individual and small group markets to have the same effective date.

Ms. Hailegeberel noted that a merged market has contributed to reducing rates and asked Mr. Boban his perspective on this issue. Mr. Boban responded that if there was not a reinsurance program then merging the markets would raise the small group rates and lower the individual rates because small group is the healthier market. The only way to lower small group rates would be to keep the reinsurance program and expand it to the small group market but then there would be no funding in the individual market due to the loss of federal pass-through funding. The state would have to provide hundreds of millions a year to lower small group rates or merged market rates through a reinsurance program.

Mr. Poole commented that he had a client who wanted in vitro fertilization (IVF) and learned from the carrier that a company must have at least 50 employees before the carrier will consider offering IVF, but it is available as a benefit in the individual market. He was flabbergasted by this and asked Mr. Boban why that is the case in Maryland. Mr. Boban responded that is has to do with how the federal government defined essential health benefits. Each state was able to choose an essential health benefit package and the Maryland General Assembly chose to include IVF as an essential health benefit in the individual market, but the Health Services Cost Review Commission (HSCRC) chose not to add IVF to the small group benefit plan, so it was not included as an essential health benefit.

Mr. Frank thanked Mr. Boban for the excellent presentation. Mr. Boban offered to respond to any follow-up questions from members after the meeting through email.

Mr. Poole recommended subsidizing the small group market on a monthly basis to lower rates and reverse the decrease in small group enrollment in recent years.

Public Comment
None offered.

Adjournment
The meeting adjourned at 2:25 PM.

Chat Log
00:00:39
Amelia Marcus -MHBE-: Reminder to all too that this meeting is being recorded

00:27:01
Brandon B: Can we have this presentation

00:30:04
Amelia Marcus -MHBE-: Absolutely! I'll re-share the slide deck with this group after the meeting concludes

00:55:10
Glenn Arrington: The state funding to help along with the state funding is causing the shift but what when the state doesn't offer the additional funding - so the ICHRA has potential however it has issues as well.

00:55:55
Glenn Arrington: Sorry I disagree with Eugene where that is why they hire us as the broker to administer the plan

01:17:20
Scott Brainard: good info thanks

01:20:26
Amber Hyde: Thank you