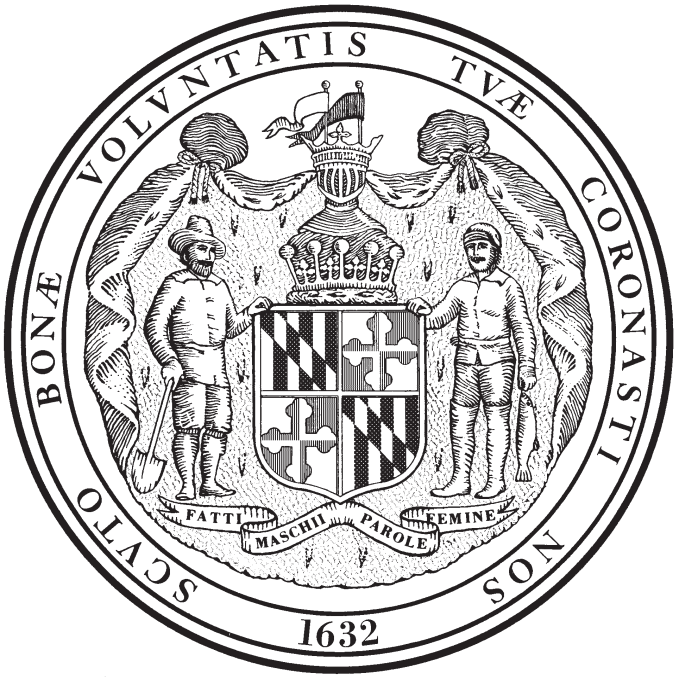
Joint Legislative Task Force on Small Group Market Health Insurance

Final Report



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MARYLAND GENERAL ASSEMBLY

JOINT LEGISLATIVE TASK FORCE ON
SMALL GROUP MARKET HEALTH INSURANCE

October 22, 2007

The Honorable Thomas V. Mike Miller, Jr.
President of the Senate
State House
Annapolis, Maryland 21401-1991

The Honorable Michael E. Busch
Speaker of the House
State House
Annapolis, Maryland 21401-1991

Gentlemen:

House Bill 1017 of 2005 established the Joint Legislative Task Force on Small Group Market Health Insurance to study and make recommendations regarding several aspects of small group market health insurance. Because the task force did not have sufficient time to complete its work, Senate Bill 325 of 2006 extended the due date for the task force report until July 1, 2007, and also added items to the task force study.

The report is attached. We appreciate the assistance provided by the various presenters at the task force meetings.

Sincerely,

Senator Thomas M. Middleton
Senate Chairman

Delegate Peter A. Hammen
House Chairman

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Joint Legislative Task Force on Small Group Market Health Insurance

Introduction

House Bill 1017 established a Joint Legislative Task Force on Small Group Market Health Insurance to study and make recommendations regarding small group market health insurance, including:

- the use of health status as a risk factor for rate adjustment purposes;
- the permissible variation in the community rate;
- expanding the permissible range of products;
- the number of employers offering the Limited Benefit Plan;
- medical loss ratios, according to group size;
- availability of association health plans in the small group market; and
- any other issue or factor the task force considers important.

House Bill 1017 required the task force to submit a report by January 1, 2006. The task force was appointed in fall 2005 and held meetings on November 8 and December 13, 2005. Because the task force did not have sufficient time to complete its work, Senate Bill 325 of 2006 extended the due date for the task force report until July 1, 2007, and added the following two items to the task force study:

- the use of a State-subsidized reinsurance pool to lower prices in the small group market; and
- the feasibility of establishing a health insurance exchange to strengthen the small group market.

This report provides an overview of small group market regulation in the State, presents a summary of the task force meetings, discusses legislative actions at the 2006 and 2007 sessions, and makes recommendations for future policy direction.

Overview of Small Group Market Regulation in the State

Comprehensive reform of Maryland's small group insurance market was enacted through House Bill 1359 of 1993. As in other states enacting similar measures around this time, Maryland's action addressed concerns about insurer practices that affected access to coverage by small businesses and their employees. In the absence of regulation, many insurers refused to offer insurance to small firms due to the size and instability of the group. When insurance was offered, medical underwriting was used to identify workers with high expected costs. The presence of these high-cost workers increased premiums for these firms, discouraging employers from offering insurance, and reducing acceptance among employees in the firms that did offer coverage.

House Bill 1359 addressed these concerns through the following reforms:

- ***Guaranteed Issue:*** It required insurers to issue health insurance to any small employer group willing to purchase, regardless of medical history or claims experience.

- ***Guaranteed Renewal:*** It required insurers to renew all insurance policies, as long as premiums were paid timely.

- ***Coverage of Preexisting Conditions:*** It prohibited insurers from limiting coverage for a preexisting condition.

- ***Modified Community Rating:*** It required insurers to offer the same premium rate to all groups, subject to certain demographic modifications, without regard to health status or claims experience.

- ***Rate Bands:*** It allowed insurers to vary premium rates, subject to permissible rating factors, by no more than a certain percentage above or below the community rate.

To keep insurance premiums affordable, House Bill 1359 also established a cap on rates, requiring the Maryland Health Care Commission (MHCC) to adjust benefits to keep rates below 12 percent of the State's average wage.

The 1993 reforms worked well for several years, with employer participation surging by 34 percent and the number of covered lives rising by 22 percent in the late 1990s. By 2004, however, employer participation and the number of covered lives had dropped by 13 and 8 percent, respectively, leading to creation of the task force.

November 8, 2005 Meeting

At this meeting, the task force received several presentations regarding the small group market in Maryland and across the country.

Department of Legislative Services

The Department of Legislative Services provided an overview of the small group insurance market. The overview covered:

- history of small group market reform;
- current trends;
- recent changes;
- factors required to be studied by the task force; and
- effectiveness of small group market reform nationwide.

Since enactment of House Bill 1359 in 1993, early increases in the number of covered lives and employer groups in the small group health insurance market have eroded with the spiraling cost of health insurance. The General Assembly addressed this situation by reducing the "affordability cap" on the insurance premium from 12 to 10 percent of the average wage in the State, creating a limited benefit plan for employers with lower income workers, and removing self-employed individuals from the small group market. Other changes that were proposed but not enacted prior to creation of the task force would have:

- allowed greater variation in the community rate that carriers may charge, included adjustments for health status, and provided incentives for healthy behavior (prior to 2007, carriers could only adjust rates within a corridor 40 percent above or below the community rate and may still only adjust for age, geography, and family composition);
- expanded the range of products that may be offered, such as a basic plan (currently, the Comprehensive Standard Health Benefit Plan (Standard Plan) is the only product that may be sold, though carriers may offer riders to reduce employee cost-sharing or add benefits; a limited benefit plan is available to certain employers with lower income workers, but that plan has not proven popular);
- authorized association health plans, to give small firms the same clout in the marketplace enjoyed by bigger firms (opponents argue that association health plans would cherry-pick the healthier workers); and

- required carriers in the small group market to participate in a reinsurance pool or provide State-subsidized reinsurance (the larger carriers oppose a mandatory reinsurance pool, and State-subsidized reinsurance is expensive).

A review of the literature showed mixed results of the small group market reforms enacted by states during the 1990s. Some studies cited better availability of insurance to higher-risk individuals since the reforms.

Maryland Health Care Commission

MHCC discussed the trade-off that has occurred in the small group market, with higher-risk individuals obtaining insurance heavily subsidized by lower-risk individuals, resulting in adverse selection and a premium spiral. Premiums in Maryland's small group market exceed the national average, as well as premiums available in the individual market and the Maryland Health Insurance Plan (MHIP). Modifications to the Standard Plan have mostly focused on higher deductibles, coinsurance, and copayments to stay under the affordability cap. Yet, employers almost always purchase riders to reduce employee out-of-pocket costs. MHCC concluded that more affordable health care requires addressing the drivers of health care costs and incentivizing consumers and doctors to make health care choices that produce real value. Strategies suggested by MHCC included consumer incentives to choose a healthy lifestyle and high-value health care, provider incentives to deliver high quality care, health information technology, and improved competition.

MHCC stated in its presentation that its goal was to transition the Standard Plan from a highly prescriptive to a more permissive plan design, thereby providing:

- greater choice for employers and employees in benefits and cost;
- flexibility for insurers in benefit design and price;
- increased employer participation; and
- increased participation by the young and healthy.

To achieve these goals, MHCC offered a variety of options for consideration, grouped under the following categories:

- Strengthen the integrity of the small group market pool and limit adverse selection.
- Strengthen the pooling implicit in the community-rated Standard Plan, through incentives to individuals and businesses or through an individual mandate.

- Allow premiums to reflect health factors in addition to age and place of business, or increase the rate band.

- Reduce premiums through reinsurance or a risk-transfer pool.

- Establish a separate high-risk pool with active health management.

- Establish a statewide purchasing pool modeled on the Federal Employee Health Benefit Program.

- Improve plan competition in the market.

Maryland Insurance Administration

The Maryland Insurance Administration (MIA) provided background on small group market reform and MIA's role and offered recommendations for improving the vitality of the small group market. Carriers must file rates with MIA, and MIA may require new rates if the loss ratio for a plan is less than 75.0 percent. The combined loss ratio for all small group market products was 80.6 percent in 2004. MIA is seeing more frequent adjustments from carriers and a particular focus on drug costs. Carrier consolidation is affecting the market through new strategies and pricing.

MIA provided information on rating restrictions in surrounding states. MIA expressed concern that the continued increase in the cost of the small group market product in Maryland may lead to the collapse of the market. MIA recommended allowing health status to be used as a pricing factor, utilizing caps, and considering some form of subsidy outside of the small group market to limit the impact on individuals. Also, the rigidness of the Standard Plan and rating controls discourage new entrants into the small group market, creating a lack of competition and less pressure for carriers to hold down prices. MIA recommended attracting new carriers to the market by expanding the rating bands. MIA also expressed concern about the increasing number of self-funded arrangements entering the Maryland market. MIA noted that these self-funded plans harm the small group market because lower cost healthy groups leave and higher cost less healthy groups remain. Groups that self-fund may re-enter the small group market without penalty when expenses and claims experience increase. MIA recommended imposing rating surcharges and incentives to encourage small employers to enter the small group market and discourage them from leaving. MIA also recommended requiring fuller disclosures of the risks of self-funding by licensed producers offering self-funded arrangements to small employers.

National Perspective – Scott Leitz

Scott Leitz, Director of the Office of Health Policy and Research, Minnesota Department of Health, provided a national perspective on the small group health insurance market. Mr. Leitz

noted that a policy focus on small employers is appropriate, considering that employment is the main source of health insurance for almost two-thirds of the non-elderly population and the uninsured are disproportionately represented in small businesses. He also noted that small employers are less likely than large employers to offer insurance, and small employers do not have the economies of scale enjoyed by large employers. The small group market reforms of the 1990s likely had limited impact on either coverage or affordability, though they may have made the market more "fair" for certain small groups. Small group market initiatives are aimed at three separate but related problems:

- getting more small employers to offer health coverage;
- making coverage more affordable for those small employers who do offer it; and
- getting more eligible workers to take up offers of coverage.

Mr. Leitz cited the challenges in getting small employers to offer health coverage, noting that small employers who do not offer coverage are less likely to see the need to offer coverage, and a large reduction in premium may be necessary to increase offer rates. Strategies to increase the offer rate include mandate-free or limited benefit plans (which have not generated much interest), however, insurance partnerships among the state, the employer, and the employees, allowing carriers to access state employee insurance reimbursement rates and drug purchasing plans (West Virginia model), and reinsurance strategies.

Finally, Mr. Leitz testified that making coverage more affordable for those who do offer it has proven difficult. Small employers are increasing the cost-sharing burden on their employees, and many are looking into high deductible consumer-directed plans. Shifting the cost-sharing burden onto employees, results in fewer employees taking up the offer of insurance. Some states have addressed this problem through subsidies to low-income workers.

National Perspective – Deborah Chollet

Ms. Deborah Chollet, Senior Fellow, Mathematical Policy Research, Inc., and Senior Advisor to The Robert Wood Johnson Foundation's *State Coverage Initiatives* program, focused her presentation on state reinsurance programs as vehicles to expand coverage. According to Ms. Chollet, state-sponsored reinsurance targets the small proportion of insured lives that account for most health plan costs and pools those costs statewide. Although there has been no formal evaluation, Ms. Chollet indicated that state-sponsored reinsurance may stabilize premiums, actually reduce premiums by reducing small insurers' margin for risk aversion and encourage small insurers to remain in the market. States that sponsor reinsurance plans may also, but do not always, subsidize reinsurance to reduce premiums for specific groups. For example, the Healthy New York program which targets low-wage employers, sole proprietors, and individual workers, reduces premiums by one-third, in comparison to unsubsidized insurance policies. Challenges facing state-sponsored reinsurance pools include adverse selection and, for

subsidized reinsurance, crowding out conventional insurance. These challenges may be addressed by requiring high participation within groups, covering only full-time regular workers, and targeting subsidies only to low-wage workers. New Mexico, Arizona, New York, and Idaho have experienced success with reinsurance.

December 13, 2005 Meeting

At this meeting, stakeholders in the small group market were invited to make presentations regarding their experience and recommendations for improvements. Panels representing insurance carriers, employers, insurance producers, consumers, and health care providers made presentations. Following the stakeholder presentations, the task force received an update from MHIP regarding sole proprietor enrollment trends.

Insurance Carriers

Representatives from Aetna, United-MAMSI, CareFirst, Kaiser, Coventry, Assurant, and America's Health Insurance Plans (AHIP) advocated for more flexibility in product offerings in the small group market. CareFirst, Coventry, and United-MAMSI recommended broadening the rate bands so that they may offer lower rates to younger groups. They also suggested changes to the limited benefit plan. Coventry and Assurant recommended that health status be a permissible factor in adjusting rates and that a reinsurance pool be considered. AHIP pointed out that 38 states allow the use of health status as a rating factor, within certain limits. AHIP strongly supports high-deductible plans with health savings accounts.

Employers

The Maryland Chamber of Commerce and Maryland Business for Responsive Government reiterated the need for greater flexibility and more choice in product offerings, as well as broadening the rate bands. These groups testified that making these changes would stimulate competition among carriers and reduce costs. Mr. Jeff Levin, a small business owner, argued against the use of health status as a rate factor and voiced support for high deductible plans, rather than limited benefit plans, to keep costs down. He also noted that high deductible plans still provide comprehensive coverage.

Insurance Producers

Voicing concern over the dearth of young people in the small group market, producers supported use of health status as a rating factor to expand the risk pool. Producers reported that they were increasingly seeing young people buy insurance in the individual market, rather than through their small employer, to get lower premiums. They also testified that employers may be subsidizing the purchase of individual insurance through higher wages. Producers concluded

that keeping the younger healthier lives in the small group risk pool is the best way to spread the cost of the older and sicker lives.

Consumers

The task force heard testimony from the Mental Health Association, the Maryland Citizens Health Initiative, and sole proprietors. The Mental Health Association expressed strong support for the 1993 reforms and opposition to changes in the rate bands, rate adjustment factors, or pharmacy benefit. Likewise, the Maryland Citizens Health Initiative defended the community rating structure and urged support for the Healthy Maryland Initiative bill, which includes tax credits for small employers. Ms. Barbara Wendell and Ms. Sheila Campbell, sole proprietors, expressed disappointment over their exclusion from the small group market and the use of medical underwriting in the individual market. It is very difficult for sole proprietors, especially those over age 50, to obtain affordable health insurance.

Health Care Providers

The Maryland Hospital Association and Med Chi would like to see more competition among carriers and more choices of insurance products. While health savings accounts may offer a more affordable choice, they can also make providers the bill collectors.

Maryland Health Insurance Plan

Senate Bill 1014 of 2005 excluded the self-employed and sole proprietors from the small group insurance market, because these individuals accounted for more health care costs than they were supporting through premiums. Other small employers were subsidizing these losses. In enacting Senate Bill 1014, it was understood that healthy individuals could obtain insurance in the individual market, while individuals with preexisting conditions could obtain insurance through MHIP. MHIP reported that self-employed individuals consistently account for about 25 percent of the program's applicants. MHIP has seen an uptick in enrollment, particularly since the availability of the MHIP+ program for lower-income individuals, and program expenditures are increasing.

Actions at the 2006 and 2007 Legislative Sessions

Several bills altering the rules for small group market insurance were introduced at the 2006 and 2007 legislative sessions. Senate Bill 325 of 2006 extended the task force and modified its duties. At the 2007 session, several bills were adopted with significant changes to the small group market.

House Bill 339 (Chapter 600) increased the range of rates a carrier may charge by authorizing carriers in the small group market to charge a rate that is between 40 percent above

and 50 percent below the community rate. The bill also allows carriers to offer a discount of up to 20 percent to a small employer for participation in a wellness program. Any discount for participation in a wellness program must be (1) applied to reduce the rate otherwise payable by the small employer; (2) actuarially justified; (3) offered uniformly to all small employers; and (4) approved by the Insurance Commissioner. The bill terminates June 30, 2011.

Senate Bill 427/House Bill 579 (Chapter 243) authorized health insurance carriers to offer an administrative discount to a small employer if the small employer elects to purchase for its employees additional types of insurance through the carrier. The administrative discount must be offered under the same terms and conditions for all qualifying small employers.

Senate Bill 952 (Chapter 59) permitted self-employed individuals and sole proprietors enrolled in the small group market on September 30, 2005, to remain covered under any policy issued by the carrier to small employers and selected by the enrollee at renewal.

In addition, as originally introduced, Senate Bill 149/House Bill 132 (Administration bills) and House Bill 754 would have established a health insurance exchange to facilitate the availability, choice, and purchase of private health insurance plans to and by individuals and small employers. While the exchange was stricken from later versions of the bills, the chairmen of the Senate Finance Committee and House Health and Government Operations Committee sent a joint letter to the Maryland Health Care Commission requesting a study of the feasibility and desirability of establishing an exchange. The results of the study were requested by January 2008.

Findings and Recommendations

Having reviewed the trends in small group market insurance in Maryland and the nation, the task force finds that the problems experienced in the State are similar to those across the country. The cost of health care continues to rise more rapidly than wages and overall inflation. Health insurance premiums have become increasingly unaffordable for small employers and their employees. The General Assembly has made moderate changes over the years – reducing the premium affordability cap from 12 to 10 percent of the State's average wage, shifting high-cost sole proprietors to the individual market, enacting a limited benefit plan for small firms with low-wage workers, expanding the community rate band to lower premiums for younger workers (yet shielding older workers from higher premiums), and authorizing premium discounts for participation in wellness activities. MHCC has also made changes over the years, increasing deductibles and copayments to stay under the affordability cap, authorizing health savings account-compatible products, and providing more flexibility in prescription drug benefits. These changes have allowed carriers more flexibility in product offerings, while maintaining a comprehensive benefit package.

Despite these changes, over 20 percent of adult workers in Maryland small businesses remain uninsured. These adult workers represent over half of the uninsured workers and almost one-third of the 780,000 total uninsured in the State. MHCC reported in its January 2007 publication *Health Insurance Coverage in Maryland Through 2005* that, of the 440,000 uninsured workers in the State:

- 80,000 were employed by private firms with less than 10 employees;
- 50,000 were employed by private firms with between 10 and 24 employees;
- 70,000 were employed by private firms with between 25 and 99 employees; and
- 50,000 were self-employed in a firm with less than 10 employees.

The task force finds that the modest changes put in place in recent years are likely to have only marginal impact on the market. The fundamental problem of making insurance affordable for small business may ultimately require more substantial intervention, including financial assistance, from the State. Such assistance could take the form of premium subsidies, tax credits, or subsidized reinsurance. Financial assistance should be targeted to low- and moderate-income workers and their employers. Incentives should be provided to prevent further erosion of the small group market, as well as to expand participation in the market. While premium discounts for participation in wellness activities are a good first step, additional incentives are needed to reward healthy behavior and bring healthier groups into the market. Increasing the number of healthier lives in the market can lower rates for all. A health insurance exchange such as the Massachusetts "Connector" may offer promise, and the task force looks forward to the MHCC report on the exchange, especially as it relates to the potential tax benefits of an exchange for individuals through 26 U.S.C. § 125 cafeteria plans offered by their employers. Finally, as the State moves to a broader strategy to address health care coverage for the State's uninsured, incentives directed at the small group market should be considered.