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MARYLAND HEALTH BENEFIT EXCHANGE

December 1, 2016

The Honorable Larry Hogan
Governor
State of Maryland
Annapolis, MD 21401-1991

The Honorable Thomas V. Mike Miller, Jr.
President of the Senate
H-107 State House
Annapolis, MD 21401-1991

The Honorable Michael E. Busch
Speaker of the House
H-101 State House
Annapolis, MD 21401-1991

Re: HB 443 (Chapter 152 of the Acts of 2012) – Merging Markets Report

Dear Governor Hogan, President Miller, and Speaker Busch:

Pursuant to Section 7 of Chapter 152 of the Acts of 2012 (HB 443), the Maryland Health Benefit Exchange (MHBE) submits this report on the individual and small group health insurance markets. Specifically, HB 443 requires the MHBE to conduct a study and report findings and recommendations on whether Maryland should continue to maintain separate small group and individual health insurance markets or merge the two markets.

Thank you for your consideration of this information. If you have any questions regarding this report, please contact Michele Eberle at (443) 750-2987 or at michele.eberle@maryland.gov.

Sincerely,

Jonathan Kromm
Acting Executive Director

Merging the Individual and Small Group Health Insurance Markets: A Report to the Governor and Maryland General Assembly

Maryland Health Benefit Exchange
December 1, 2016

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I. Introduction

The Affordable Care Act (ACA) provides states with the option of merging their individual and small group health insurance markets. In the fall of 2011, under the direction of the Maryland General Assembly, the newly created Maryland Health Benefit Exchange (MHBE) convened several stakeholder advisory committees to help the state consider a number of policy options for establishing and operating the MHBE. One of these policy considerations was whether the state should merge the individual and small group health insurance markets. At that time, the MHBE Board of Trustees recommended against merging markets for a number of reasons, including:

- Maryland's small group market was twice as large as the individual market.
- Prior to the ACA, the individual market in Maryland was underwritten, whereas the small group market was guaranteed issue. With guaranteed issue for individuals under the ACA, there was concern that individuals with higher costs would drive up the costs of the small group market. Further, some small businesses in the state were self-insured, and stakeholders were concerned that, if premiums became too high, small groups would be more inclined to self-insure. Self-insurance refers to plans for which the employer, rather than an insurer, assumes the risk for paying for covered services.
- Not all carriers participated in both markets.

The Maryland General Assembly enacted legislation requiring the MHBE to revisit this issue in the future. Specifically, the MHBE Act of 2012 requires the MHBE to study and report on "whether to continue to maintain separate small group and individual markets or to merge the two markets."[1] This report is due on December 1, 2016. In accordance with this requirement, the MHBE submits this report to the Governor and the Maryland General Assembly.

II. Federal Requirements

The ACA provides states with the option of merging their individual and small group health insurance markets,[2] creating a single risk pool for both markets.[3] This arrangement would require carriers to participate in both markets and offer plans at the same age-rated premiums. Specific ACA requirements of a merged market include:

- Insurers must consider all enrollees in the insurer's individual and small group plans, inside and outside the exchange, to be members of a single risk pool.[4]
- Insurers must establish an index rate for the single risk pool based on the total combined claims costs for providing essential health benefits (EHBs) within that risk pool.[5] The index rate must be adjusted on a market-wide basis for the state, based on the total

[1] Section 7, Chapter 152, 2012 Laws of Maryland.
[2] 42 USC § 18032(c)(3).
[3] 45 CFR § 156.80(c).
[4] 42 USC § 18032(c).
[5] 45 CFR § 156.80(d)(1).

expected market-wide payments and charges under the risk adjustment and reinsurance programs, and exchange user fees.[6]

- Insurers may vary premium rates for a specific plan from its market-wide index rate based on certain actuarially justified plan-specific factors, such as benefits in addition to EHBs, administrative costs, the plan's provider network, delivery system characteristics, and utilization management practices.[7]
- Insurers may only establish index rates and make market-wide or plan-level adjustments on an annual basis.[8] In contrast, insurers in unmerged small group markets may establish index rates and make adjustments on a quarterly basis.[9]
- Insurers must offer coverage on a calendar year basis, with policy years ending on December 31.[10] In contrast, plan years in unmerged small group markets may operate on a non-calendar year basis.
- In states that merge their individual and small group markets, qualified employees of a small business may enroll in any qualified health plan (QHP) and are not limited to a QHP in the small group market.[11]

The U.S. Department of Health and Human Services (HHS) provided further explanation of the single risk pool for merged markets in the preamble to a final rule issued in 2013.[12] The purpose of a single risk pool is to prevent insurers from separating enrollees into different rating pools based on their health status; therefore, plan-specific adjustments to the market-wide index rate must not reflect differences in health status.[13] If a state merges its individual and small group markets, rating areas will apply uniformly to both markets in the state.[14] Insurers must calculate the market-wide index rate and plan-specific adjustments based on the merged market.[15] In a merged market, the pooled reinsurance adjustment is based only on the portion of the insurer's individual market business that is eligible for reinsurance payments.[16]

III. Maryland Landscape: Comparison of Individual and Small Group Markets

Prior to the ACA, Maryland implemented a number of reforms in the small group health insurance market in the 1990s, including the guaranteed issue of coverage; development of a required set of benefits, referred to as the Comprehensive Standard Health Benefit Plan; and community rating. In contrast, the individual market in Maryland was underwritten prior to the ACA. Like most other states, Maryland currently maintains separate individual and small group

[6] *Id.*
[7] 45 CFR § 156.80(d)(2).
[8] 45 CFR § 156.80(d)(3)(i).
[9] 45 CFR § 156.80(d)(3)(ii).
[10] 45 CFR §147.104(f).
[11] 45 CFR § 155.705(b)(7);(8).
[12] Patient Protection and Affordable Care Act; Health Insurance Market Rules, 78 Fed. Reg. 13,406 (Feb. 27, 2013), to be codified at 45 CFR pts. 144, 147, 150, 154, and 156.
[13] *Id* at 13,422.
[14] *Id* at 13,411.
[15] *Id* at 13,423.
[16] *Id.*

markets. This section of the report provides an overview of the differences between these two markets.

Market Size

Table 1 displays the number of enrollees in each market as of 2015 and 2016, according to the Maryland Insurance Administration (MIA). Market sizes were similar in each year, with the share in the individual market increasing slightly in 2016.

Table 1. Enrollment in Maryland's Individual and Small Group Health Insurance Markets, 2015 and 2016

Market	2015[1] Enrollment	2015 Percentage	2016[2] Enrollment	2016 Percentage
Individual	232,586	47.9%	263,140	51.6%
Small Group	253,131	52.1%	246,814	48.4%
Total	**485,717**	**100%**	**509,954**	**100%**

[1]Data as of April 30, 2015
[2]Data as of March 31, 2016

Carrier Participation

Not all carriers participate in both markets. Table 2 presents the carriers that participate in each market for the 2017 plan year. Aetna and UnitedHealthcare participate in the small group market only, and Cigna participates in the individual market only. All other carriers participate in both markets.

Table 2. Carrier Participation in Maryland's Individual and Small Group Markets, 2017

Carrier	Individual Market	Small Group Market
Aetna Health Inc.		✓
Aetna Life Insurance Co.		✓
CareFirst BlueChoice Inc.	✓	✓
CareFirst of Maryland Inc.	✓	✓
Cigna Health and Life Insurance Co.	✓	
Evergreen Health Cooperative	✓	✓
Group Hospitalization and Medical Service Inc. (a CareFirst Co.)	✓	✓
Kaiser Foundation Health Plan of the Mid-Atlantic States Inc.	✓	✓
MAMSI Life and Health Insurance Co. (a UnitedHealthCare Co.)		✓
Optimum Choice (a UnitedHealthCare Co.)		✓
UnitedHealthCare Insurance Co.		✓
UnitedHealthCare of the Mid-Atlantic Inc.		✓

Benefits

Non-grandfathered individual and small group health insurance plans are required to cover EHBs in ten categories based on a state-selected benchmark plan.[17] In Maryland, the state benchmark plan is the one with the largest small group enrollment in any of the three largest small group insurance products.[18] Federal regulations required states to update their benchmark plans for 2017 and beyond based on plans that were sold in 2014. If the chosen benchmark plan does not include services required by the ACA, it must be supplemented.[19]

Maryland selected the CareFirst BlueChoice Health Maintenance Organization HRA/HSA $1,500 plan as the benchmark plan for 2017 (MIA, 2015). For the individual market, the benchmark plan includes the same EHBs as the small group market, with the exception of two additional benefits: in vitro fertilization and hair prosthesis (MIA, 2015).[20] The 2017 benchmark plan includes abortion coverage, but the abortion benefit may not apply to certain religious employer plans (MIA, n.d.). If the small group and individual markets are merged, the EHBs would have to be uniform for both markets.

Costs

Using data from the MIA, Table 3 compares the average premiums in each market for 2014 and 2015. These estimates are based on the average of each carrier's premium revenue divided by enrollment, and thus do not represent the average premium paid across all of the enrollees in the markets.

Table 3. Average Premiums in Maryland's Individual and Small Group Markets, 2014 and 2015

Market	2014	2015
Individual	$301	$361
Small Group	$409	$446

[17] 45 CFR §§ 147.150(a);156.100.
[18] MD. Code Ann., Ins. §31-116(c)(1)(i).
[19] MD. Code Ann., Ins. §31-116(d)(3).
[20] Maryland law requires the benchmark plan for individual health plan benefits to cover any benefits that were mandated before December 31, 2011.

Table 4 shows the average approved premium rate changes for small group health insurance plans offered in Maryland for 2015 through 2017. Competition and decades of reform in the state's small group market helped to keep rate changes modest each year (MIA, 2014). In 2016, the overall average small group market rate decreased by 1.8 percent. In 2017, these rates will increase by an average of 3.3 percent.

Table 4. Average Approved Rate Changes in the Maryland Small Group Market, 2015- 2017

Carrier	2015 Average Approved Rate Change[1]	2016 Average Approved Rate Change[2]	2017 Average Approved Rate Change[3]
Aetna Health Inc.	0.5%	5.3%	2.0%
Aetna Life Insurance Co.	0.5%	7.5%	2.0%
CareFirst BlueChoice Inc.	5.8%	-3.2%	3.4%
CareFirst of Maryland Inc.	4.7%	-16.9%	9.5%
Coventry Health and Life Insurance Co.	10.9%	N/A	N/A
Coventry Health Care of Delaware Inc.	8.5%	N/A	N/A
Evergreen Health Cooperative	0.0%	8.9%	9.8%
Group Hospitalization and Medical Service Inc. (a CareFirst Co.)	4.7%	-16.9%	9.5%
Kaiser Foundation Health Plan of the Mid-Atlantic States Inc.	7.8%	5.5%	-2.6%
MAMSI Life and Health Insurance Co. (a UnitedHealthCare Co.)	-2.6%	1.7%	-4.5%
Optimum Choice (a UnitedHealthCare Co.)	-2.6%	-2.9%	-4.5%
UnitedHealthCare Insurance Co.	-2.6%	1.7%	-4.5%
UnitedHealthCare of the Mid-Atlantic	-2.6%	1.7%	1.2%

[1] Commissioner Approves Small Group Health Premium Rates. Retrieved from http://insurance.maryland.gov/Pages/newscenter/NewsDetails.aspx?NR=201439

[2] The Maryland insurance Administration Approves Premium Rates for 2016 Small Group and Individual Markets. Retrieved from http://insurance.maryland.gov/Pages/newscenter/NewsDetails.aspx?NR=20155

[3] The Maryland insurance Administration Approves Premium Rates for 2017 Small Group and Individual Markets. Retrieved from http://insurance.maryland.gov/Pages/newscenter/NewsDetails.aspx?NR=2016108

In contrast, the individual market has experienced greater rate increases. Table 5 shows the average approved premium rate changes for individual health insurance plans offered in Maryland for 2015 through 2017. In 2015, two new companies entered the individual market: Cigna Health and Life Insurance Company and UnitedHealthCare of the Mid-Atlantic Inc. However, UnitedHealthCare is exiting the individual market beginning with the 2017 plan year. In 2016, average health insurance rates increased, and they will increase again in 2017 by an average of 25.2 percent.

Table 5. Average Approved Rate Changes in Maryland's Individual Market, 2015-2017

Carrier	2015 Average Approved Rate Change[1]	2016 Average Approved Rate Change[2]	2017 Average Approved Rate Change[3]
All Savers Insurance (a UnitedHealthCare Co.)	-6.7	-3.2	N/A
CareFirst BlueChoice Inc.	9.8%	19.8%	23.7%
CareFirst of Maryland Inc.	16.2%	26.0%	31.4%
Cigna Health and Life Insurance Co.	First year in market	-3.3%	29.8%
Evergreen Health Cooperative	-10.3%	9.5%	20.3%
Group Hospitalization and Medical Services Inc. (a CareFirst Co.)	16.2%	26.0%	31.4%
Kaiser Foundation Health Plan of the Mid-Atlantic States Inc.	-14.1%	10.0%	26.6%
UnitedHealthCare of the Mid-Atlantic Inc.	First year in market	-0.5%	N/A

[1] Commissioner Approves Premium Rates for 2015 Individual Market. Retrieved from http://insurance.maryland.gov/Pages/newscenter/NewsDetails.aspx?NR=201441
[2] The Maryland insurance Administration Approves Premium Rates for 2016 Small Group and Individual Markets. Retrieved from http://insurance.maryland.gov/Pages/newscenter/NewsDetails.aspx?NR=20155
[3] The Maryland insurance Administration Approves Premium Rates for 2017 Small Group and Individual Markets. Retrieved from http://insurance.maryland.gov/Pages/newscenter/NewsDetails.aspx?NR=2016108

The ACA requires health insurers in the individual and small group markets to spend at least 80 percent of the premiums they receive on health care services and activities to improve health care quality.[21] The calculation of this percentage of annual premiums is known as the medical loss ratio (MLR).[22] If the MLR falls below 80 percent, the carrier must calculate the difference and rebate the amount to the insured parties. The MLR is affected by the insurers' costs for administration, overhead, and marketing, which may vary between the policies offered to individuals and small groups. According to data from the MIA, individual market plans had a considerably higher MLR compared with small group market plans in both 2014 and 2015. In

[21] 45 CFR § 158.210(b);(c).
[22] 45 CFR §158.101(b).

most cases, the individual market MLR exceeded 100 percent, meaning that medical expenditures were higher than premium revenues.

Rate Review Process

The MIA reviews and approves the rates for fully insured plans in the state, including the individual and small group markets. Carriers are required to submit both forms and rates each year, and the MIA issues a bulletin with the deadlines for submission. Currently, the MIA has separate forms and filing deadlines for each market. For example, individual market forms for the 2017 plan year were due to the MIA on March 1, 2016, and the rates were due on May 2, 2016 (MIA, 2015). For the small group market, forms were due on April 1, 2016, and rates were due on May 2, 2016 (MIA, 2015).

IV. Experiences in Other States

Only Washington, D.C., and two states—Massachusetts and Vermont—have merged their individual and small group markets to varying degrees of conformity with federal regulations. Studies and public forums in other states, such as New York, Colorado, New Jersey, California, and Indiana, resulted in decisions against merging markets or to take time to gather more data on the potential impact on rates. Key considerations included:

- Advantages of a merged market may include (Colorado Health Benefit Exchange, 2012):
    - It may be cost effective to combine functions of the certification and rating of QHPs.
    - A larger risk pool may attract new insurers to enter the market.
- Disadvantages of a merged market may include (United Hospital Fund, 2011; Colorado Health Benefit Exchange, 2012):
    - There are differences between the markets in premium collection, billing, enrollment, and services.
    - Merging risk pools may create additional uncertainty for premium rating.
    - There would be an initial administrative cost to insurers.
    - It is difficult to predict the net effect of the risk pool if the markets were combined.
    - Merging risk pools may discourage insurers that do not want to offer coverage in both markets.

In New Jersey, analysts noted that arguments for combining the markets, such as achieving economies of scale and attracting greater health plan competition, may not apply in that state because the markets already appear large enough to make them viable marketplaces and are already served by the same carriers. In a policy brief written by the Center for State Health Policy at Rutgers, authors found that the composition of markets in New Jersey suggested that a merger would not reduce premiums for non-group enrollees and could even lead to higher rates for individuals (Rutgers Center for State Health Policy, 2011).

Massachusetts

Massachusetts enacted legislation in 2006 to merge its small group and individual health insurance markets as part of the state's pre-ACA health care reform efforts.[23] The law combined risk pools and unified plan offerings. Although rates in the merged market in Massachusetts increased by 2.6 percent for small businesses after the merger, state officials maintain that coverage for Massachusetts' residents has become more affordable overall (Massachusetts Health Connector, 2016).

Massachusetts' merged market, however, does not meet the ACA federal definition in the following ways: its small businesses are not required to renew coverage on a calendar year basis, carriers may update their small group rates quarterly, and small groups may use rating factors that differ from those identified in the ACA (Massachusetts Health Connector, 2016). In 2013, the federal government granted Massachusetts a transition period—until January 1, 2018—to align its merged market with the federal definition. However, Massachusetts is satisfied with its current merged market and is concerned that conforming to the federal definition will have adverse consequences. These concerns include (Massachusetts Health Connector, 2016):

- Transitioning to the ACA rating factors could increase premiums for small group enrollees as much as 30 percent.
- Transitioning to a calendar year plan year could cause disruptions in coverage and additional cost sharing to more than half a million enrollees.
- Transitioning to annual rating could increase premiums and lead to market volatility.
- These changes could cause small employers to withdraw from the market.

To address these concerns, the state applied for a Section 1332 waiver from the federal government that would allow the market to continue operating as it currently is without fully transitioning to the federally-defined merged market (Massachusetts Health Connector, 2016). To date, this waiver has not yet been approved.

Vermont

Vermont merged its individual and small group health insurance markets in 2014; plans and rates are identical for individuals and small businesses (Department of Vermont Health Access, 2016). Vermont's merged market is unique in that the state has only two carriers that offer coverage in the individual and small group markets, and the merged market is very small, covering approximately 75,000 individuals (Department of Vermont Health Access, 2016). Vermont's merged market is not fully ACA-compliant because the state never created an online portal for small businesses to purchase insurance; instead employers enroll directly with carriers (Department of Vermont Health Access, 2016). The federal government granted states flexibility to transition to direct enrollment by 2017. Concerned that transitioning to an online portal would cause disruption, Vermont officials submitted a proposal in March 2016 for a Section 1332

[23] 2006 Mass. Acts Ch. 58.

waiver that would allow small businesses to continue to purchase coverage directly from carriers (Department of Vermont Health Access, 2016). To date, this waiver has not yet been approved.

District of Columbia

Washington, D.C. merged the risk pools of its individual and small group markets in 2014. The District was approved to use a hybrid approach to its merged market rather than fully comply with the ACA definition (DC Health Benefit Exchange Authority, 2016). Insurers must use a single risk pool for individual and small group claims in the development of the index rate, but all other aspects of rate development are separate for each market (DC Health Benefit Exchange Authority, 2016). Insurers are allowed to make quarterly adjustments to the index rate for the small group market instead of once per year and may offer different plans in the individual and small group markets (DC Health Benefit Exchange Authority, 2016).

V. Policy Options and Considerations

Under the legislative mandate for this report, the state has four policy options to consider:

1. Continue to maintain separate individual and small group health insurance markets.
2. Merge the individual and small group health insurance markets in compliance with all of the ACA requirements.
3. Merge some aspects of the individual and small group markets, but not in full compliance with the ACA requirements, by pursuing a 1332 waiver from the federal government, similar to Massachusetts and Vermont.
4. Defer a policy decision at this time and revisit the issue when further data are available, and the individual market is more stable.

The following factors should be considered when weighing these policy options:

- **Rate Impact –** Premiums in the small group market have been fairly stable, given the decades of experience with reform in the state, whereas premiums in the individual market are currently more volatile. Although merging markets may have the potential to decrease premiums for the individual market, the MHBE has insufficient data at this time to predict the actual rate impact.
- **Timing of Rate Adjustments –** Merged markets may establish index rates and make adjustments only once per year, whereas the small group market currently can do so quarterly.
- **Carrier Participation –** Not all carriers participate in both markets. For the 2017 plan year, Aetna and UnitedHealthcare are in the small group market only, and Cigna is in the individual market only. Merging would require these carriers to either participate in both markets, or completely withdraw from the market.
- **Essential Health Benefits –** There is a slight difference in the EHB between the individual and small group markets, with the individual market covering some

additional services. Merging markets would require the state to create a uniform EHB.

- **Plan Year –** The ACA requires individual and merged markets to offer coverage on a calendar year basis, whereas an unmerged small group market may operate on a non-calendar year basis. A number of small employers in Maryland currently renew their coverage in a month other than January. If these employers were required to transition to a calendar year plan, their employees could experience a gap in coverage during the transition year (between the month in which their non-calendar year plan ends and January). Enrollees in such plans may also face additional cost sharing during the transition year, as accruals to deductibles and out-of-pocket maximums would re-set with the January plan year.
- **Rate Review –** If the state merged its markets, the MIA would need to develop new rate filing forms and review the rates for both markets at the same time.
- **Risk Adjustment –** Merging markets may impact risk adjustment. Risk adjustment payment transfers are calculated by comparing to a baseline premium, which is the average premium in the state. Currently, these payments are calculated separately for the individual and small group markets in Maryland. If the state were to merge markets, the experience of the individual and small group markets would be combined, which could change the average premium in the state and in turn modify the risk adjustment payment amounts that carriers owe or receive. Merging markets may also change plans' average risk scores, which could affect which plans would owe or receive payments under the risk adjustment program.
- **Small Group Self-Insurance –** Self-insurance refers to plans for which the employer, rather than an insurer, assumes the risk for paying for covered services. If merging markets results in premium increases and/or additional administrative burden for the small group market, small businesses, particularly those with low-risk employees, may choose to self-insure. This situation could lead to premium increases in the fully-insured market. Premium increases and/or additional administrative burden can also cause small employers to completely drop coverage.
- **Experience of Other States –** Only Washington, D.C., and two other states have merged markets, and none of these states are fully ACA-compliant. The review did not identify any other states that are currently considering this policy option.
- **1332 Waiver Application –** Section 1332 of the ACA contains a mechanism that allows states to waive components of the regulations through a waiver. If Maryland were to pursue a 1332 waiver application to waive certain ACA requirements for merged markets, the state would need to submit several pieces of evidence to demonstrate that the state's plan does not alter the affordability and coverage protections of the ACA. The items that states must submit with a 1332 waiver application include, but are not limited to:
    - A ten-year budget plan demonstrating that the change is deficit-neutral to the federal government.
    - An actuarial analysis with certification to support the state's assertions that the waiver complies with the required components of the ACA.

- Documentation of the approved state legislation granting the state authority to execute the proposed changes.
- An analysis of the effect the proposed changes will have on health insurance coverage.
- A plan and timeline for implementation (Centers for Medicare & Medicaid Services [CMS], n.d.).

The state must also conduct a public notice and hearing process. Submitting a 1332 waiver application requires significant resources. To date, approximately three 1332 waiver applications have been submitted to CMS, and no approvals have been granted.

VI. Stakeholder Input

The MHBE sought input on this report from its Standing Advisory Committee (SAC), the members of which represent carriers, providers, and consumer advocacy organizations. The MHBE gave the SAC the opportunity to provide verbal comments during the November 10, 2016, meeting, as well as written comments. During the November 10 meeting, the stakeholders generally agreed that the MHBE should defer a policy decision at this time and revisit the issue when more data are available. Comments from members included:

- Maryland's small group market is robust today, but merging the markets could lead to additional carriers leaving the state altogether. There was concern that the carriers currently participating in the small group market only would leave the state if they were required to participate in the individual market, a situation that could adversely impact consumers, particularly on the Eastern Shore.
- With the ACA-instituted changes to the individual market, including the removal of underwriting, the landscape remains unstable, making it difficult to assess the likely impact of merging the markets.
- The possibility of carriers leaving the individual market is a nationwide concern. It would be especially problematic in Maryland because one carrier has a large portion of the individual market membership.

Members suggested that the state use the all-payer claims database in the future to identify demographic and utilization characteristics of the two markets to inform a future decision. In addition to the discussion on November 10, one SAC member submitted written comments. These comments suggested further study using claims data. See Appendix I for the full text of these written comments.

VII. Recommendation

Based on the findings presented in this report, the MHBE recommends that the state defer a policy decision at this time and revisit the issue when further data are available, and the individual market is more stable. This policy option has strong support from stakeholders in the SAC and would minimize market disruption at this time. The MHBE suggests revisiting this policy decision in two years and reporting back to the Governor and General Assembly by December 1, 2018.

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Appendix I. SAC Member Written Comments

The MHBE received the following written comments from committee member Leni Preston, President of Consumer Health First.

Consumer Health First

Access - Quality - Equity

MEMORANDUM

TO: Board of Directors, Maryland Health Benefit Exchange
FROM: Leni Preston, President - leni@mdchcr.org or Cell: 301.351.9381
DATE: 14 November 2016
RE: Report on Merging the Individual and Small Group Health Insurance Markets

Consumer Health First appreciates the opportunity to serve as a consumer representative on the MHBE Standing Advisory Committee. It is in that capacity that we submit the following comments for your consideration. These relate to the report on the merging of the individual and small group markets to the Governor and General Assembly.

In doing so we understand that, with the outcome of the election, there are uncertainties that make it wise to postpone any firm action in this regard. That said, we believe that there may well be advantages for consumers were the two markets to be merged. These could include a more stable risk pool and thus lower prices. Given what we are now seeing with consumers being unable to afford their insurance we believe this is an issue that must be addressed.

However, we also believe that the **data provided in this report is insufficient to make a fully informed decision as it fails to review claim costs and to identify the drivers of these claim costs. Therefore, we recommend the following:**

- Identification of claim cost trends over a three to five year period rather than the two years used in the report in both the individual and small group markets.
- Based upon the assumption that the cost of claims drives premiums, it would be important to conduct a full analysis of the medical services and diagnoses driving health care claims in both the individual and small group markets using Maryland's All Payer Claims Database to determine the extent to which these markets are materially similar or different.
- Again using Maryland's All Payer Claims Database, identify the demographic characteristics of the individual and small group markets to determine if these are materially similar or different and assess the impact of these demographic characteristics (e.g., family size, average age) on the observed claim costs.

We believe that it is important that these **analyses be completed by December 2017. This would facilitate a** determination on the efficacy of merging the markets if many elements of the current rules governing the commercial health insurance market continue. Alternately, it would serve as a guide for Maryland's response to any changes implemented at the federal level as a means to ensure continued access to affordable, comprehensive coverage for Marylanders who depend on the individual and small group markets for their health insurance.

Again, we very much appreciate the opportunity to provide our perspective on this important issue.