To: MassAHU
From: Shelley Kaleita
Re: January 26th, 2021, Merged Market Advisory Council Meeting
Date: January 27th, 2021

Attendees
Gary Anderson | Commissioner of Insurance, Chair
Louis Gutierrez | Executive Director, Health Connector
Michael Caljouw | Health Insurance Carrier
Mark Gaunya | Health Insurance Broker, MassAHU Member
Rosemarie Lopes | Health Insurance Broker, MassAHU Member
Rina Vertes | Health Insurance Actuary
Amy Rosenthal | Health Insurance Individual Purchaser
Patricia Begrowicz | Business Community Employer
Joshua Archambault | Health Insurance/Business Community
Jon Hurst | Health Insurance/Business Community
Lauren Peters | Department of Health and Human Services
Kevin Beagan | Deputy Commissioner, Mass DOI
Lora M. Pellegrini | Mass Association of Health Plans
Wendy Hudson | Business Community Small Business

Overview
On Tuesday, January 27th, from 2-3:30pm, the merged market advisory council convened via phone. The council discussed December membership changes, an update on the rate review process, reviewed previous meeting minutes and heard an executive summary presentation regarding the key findings and consensus of the council. Gary Anderson noted they are going to hold another meeting sometime in late February, and then again in early March, to review the reports and recommendations. Council members have until Friday, February 5th, to send their recommendations to Gary to distribute to the council.

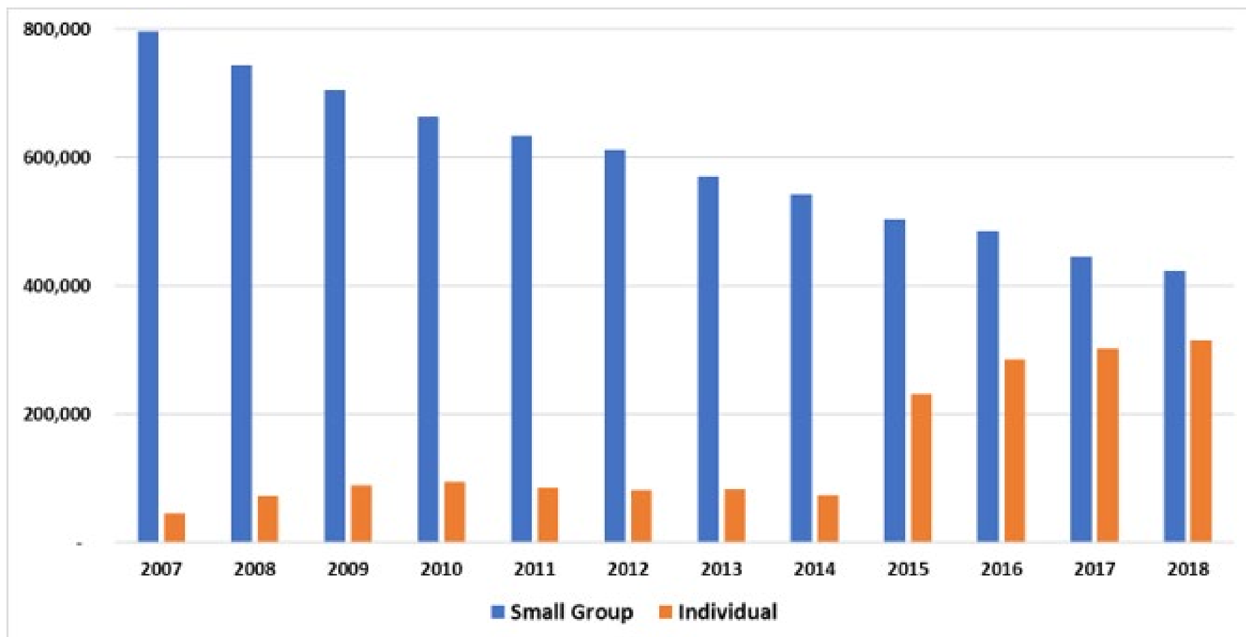
Gary Anderson began by reviewing the two previous meetings minutes for both the November 17th, and December 2nd. There were no comments made regarding the November 17th meeting, and the council moved to approve the minutes. Council members wanted more time to review and edit the December 2nd meeting minutes, which will be recirculated and approved at the next meeting.

Kevin Beagan then moved to discuss the December membership changes. He explained they collect membership on a monthly basis from the health plans, so they can be aware of changes going on in the market and have collected this information since March 2020. When comparing December 2020 to November 2020, there are 6,509 fewer individuals with covered membership through the health plans, and a decline of 9,977 in ASO business. This was offset by 1,680 new persons covered in small groups, 4,649 new persons covered under large group accounts and 6,030 covered under governmental account membership and in total, there were about 4,127 fewer covered members under all the accounts reported by the carriers in December 2020. When comparing commercial and governmental programs from March 2020 to December 2020, the total commercial coverage decreased by a total 112,881 members, governmental programs increased by 86,756, but the net result is that the total number of individuals covered as of December 2020 to March, is lower, but governmental programs have stepped in to make the numbers less dramatic. They will continue to monitor this going forward, and there is always the possibility that the economy could get worse in 2021.

Kevin Beagan then moved to bring to the attention of the council where they are in the current rate review process. During the Fall, Kevin made the council aware of certain concerns they had with conducting the rate review for January 2021. They are now in the midst of reviewing rates that will be effective in April 2021. Kevin noted that these came in January 4th, and they are still amid reviewing, and normally they look through filings and try to put them on file no later than February 15th. They had one rate filing that came in that they acknowledged was higher than they expected and thought it was necessary to call a hearing, in order for the company to present all the reasons the rate was higher. The notice is regarding a hearing that will commence on Thursday, February 4th, at 11am, and is one that they will allow for public comment, but is intended to have the company respond to the disapproval of reasons the division identified that apply to the rate filing. This is something that the DOI would like the company to put on record all the reasons that it needs the increase it wanted and that the rate increase was in the double digits, so it was necessary to take this step. Kevin emphasized that this is being handled in an expedited manner for the good of the market and there needs to be some way to identify how to proceed with this company, so that those small groups who are going through April open enrollment are aware of the products and rates that this company may have for the market. The DOI thought the rate increase was beyond a level that they could proceed with and felt it was necessary to hold a hearing.

Gary Anderson then moved to the presentation. He explained that the purpose of today is to take what they have learned over the course of 2020, and to level it with a base set of facts, findings and the discussions the council has had. He outlined the work they were tasked with through the executive order and noted that some things they have talked about fell outside the scope of the council. They agreed it was important to note in the report that there is a desire that certain

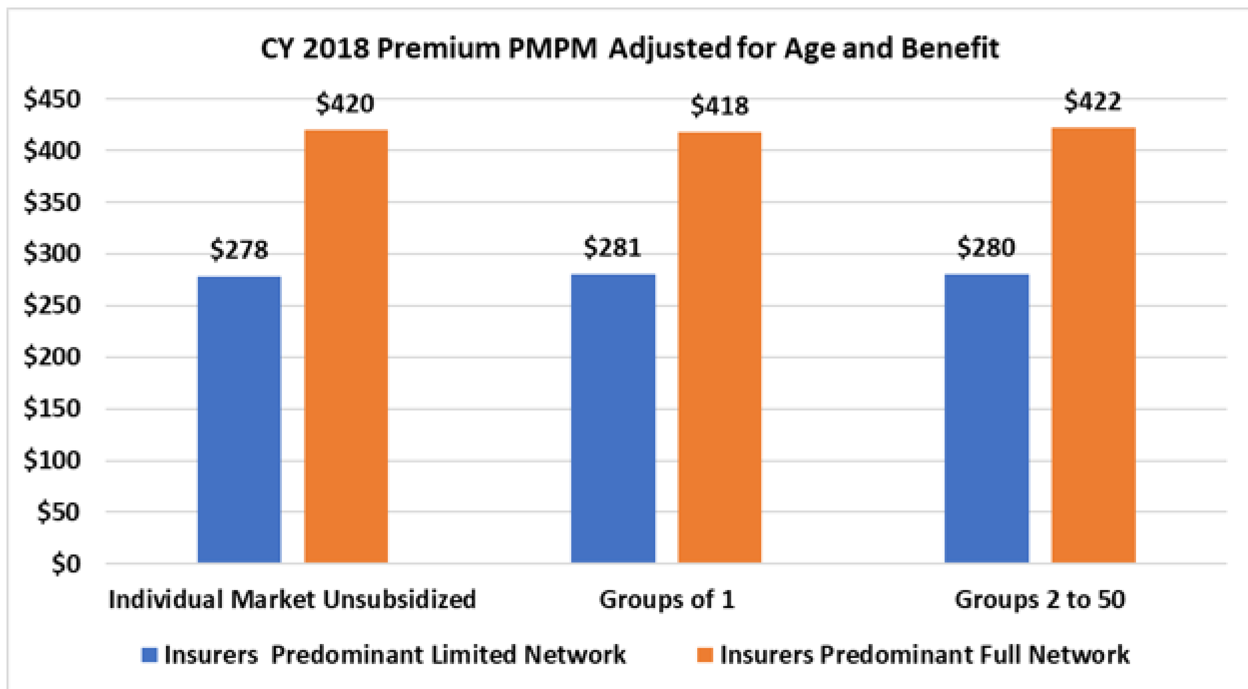
members have raised these issues, but they should be considered outside the executive order for policymakers. They have received suggestions from some of their members, and after today's meeting they will circulate those comments and any additional comments which they plan to discuss at the next meeting. They are planning to hold meetings the week of February 22nd, and then again in the second week of March.



Kevin explained they thought it was useful to remind everyone what they have talked about since the start of the merged market advisory council. This was a chart from the beginning of the MMAC that they wanted to highlight, to show how things have changed since 2007. Since the individual and small employer markets were first merged in 2007, the individual market has grown significantly, whereas the small group market has declined for a variety of reasons. The composition of the merged market has changed since the individual and small group markets were first merged in 2007, as a part of Chapter 58 of the Acts of 2006. At that time, enrollment in the individual market was considerably smaller than enrollment in the small group market. Individual enrollment grew significantly in 2014, which was largely as a result of the ACA moving the Commonwealth Care program into the merged market, where it became known as ConnectorCare. From 2015 forward, the ConnectorCare population has continued to grow. The number of small employer members has declined for a variety of reasons, including the rise of the 'gig economy', multiple recessions, availability of alternative programs, and other factors. This shows today the individual market is growing compared to the small group market.

Audrey Gasteier explained that there are three distinct populations in the merged market: Small employers, ConnectorCare individuals and the Non-ConnectorCare individuals. She explained in a merged market, a carrier's premiums reflect the collective claims cost of all individuals and small employers. Actuarially, ConnectorCare individuals and small employer members have

similar health risk scores, while those of non-ConnectorCare individuals have much higher risk scores. This means that ConnectorCare enrollees and small employers cross-subsidize the cost of non-ConnectorCare individuals' health expenses. This is not the only "cross-subsidy" in the merged market–for example, younger people cross-subsidize older people and enrollees in narrower network products cross-subsidize those in broader network products via risk adjustment.



Kevin Beagan noted they thought it was important to highlight that low-cost health coverage products are readily available in the Massachusetts merged market, but many unsubsidized individuals and small employers have opted for higher-premium, broad network products over lower-premium, narrow network products. Pictured above shows that limited network products in blue are approximately 50% less than for broad network plans shown in orange. They found the majority of small business market enrollment tends to congregate in higher-cost carriers, despite other lower-cost options being available to them. This highlights an opportunity for improved awareness among small businesses of the diversity of products and price-points available in the market, including flexible purchasing options through Health Connector for Business that are unique in the market and became newly available in 2018, but for which broad market awareness remains low.

Audrey Gasteier explained that part of the analysis they looked at over the past year was a de-merger. This showed that de-merging the markets would result in a one time average increase of 4 to 6 percent for the individual market, and a one time average decrease of 2 to 4 percent for the small group market, separate and apart from annual rate increase cost trends. In a de-merged market, a state-based reinsurance program could mitigate premium increases for individuals with

sufficient funding; conversely, MA is unlikely to qualify for a federally supported reinsurance program through a 1332 waiver that would mitigate individual rate increases in a meaningful way. De-merging the individual and small group risk pools will achieve a very modest one time reduction in small group rate growth (apart from trend), but will not materially impact future rate increases.

	2019 Risk Adjustment Dollars	Individual Market Distribution	Small Group Market Distribution
BMCHP/THPP	-$106,184,051	93%	7%
All Other Insurers	$106,184,051	25%	75%

Kevin Beagan then explained they wanted to discuss findings about the impact of alternative products and federal/state programs. He noted they spent a lot of time discussing risk adjustment and that risk adjustment was intended to be a level setter across carriers in the market, to allow for sharing of higher risk profiles with those that have lower risk profiles. Looking at our market, carriers with predominant coverage in the ConnectorCare program have attracted individuals with lower risk profiles, comparable to those in the small group segment. The risk adjustment program results in individuals in the ConnectorCare program generally cross-subsidizing enrollees of the higher-cost, broader-network carriers that tend to have mostly small group enrollees and higher-risk individual enrollees. The chart pictured above shows the two ConnectorCare predominant carriers BMCHP and THPP have 93% of the market. In 2019, they transferred $106 million dollars to all insurers in the market and all other insurers did have some individuals, but other membership were 75% small employers. This effectively means that monies from the ConnectorCare program (a combination of premium contributions from low-to-moderate-income residents and state and federal public monies) are cross-subsidizing the carriers that predominantly enroll the small group market and higher-risk individual market enrollees. Kevin highlighted that this means there is cross subsidization coming about because of risk adjustment and with this in the merged market, it actually does benefit certain small employers and individuals covered outside BMCHP/THPP.

Kevin noted they wanted to look to alternative products such as PEOs, health sharing ministries, self-funding/stop-loss products that are marketed to individuals and/or small groups. As of now, they do not yet appear to have materially affected the merged market, but warrant continued monitoring. There is no evidence that off-market products have materially affected merged

market stability. The low-uptake of these alternative products is likely due to the fact that the Massachusetts merged market features many carriers with a robust product shelf. New rules may be needed for marketing and disclosures to ensure consumers understand how such products differ from merged market coverage. The Division of Insurance and the Health Connector should continue monitoring these products to evaluate their impact on the Massachusetts merged market.

Audrey Gasteier then discussed the 1332 waiver, noting that a federally sponsored state reinsurance program through a 1332 waiver is likely not a viable solution for the MA merged market. She noted many MMAC members are aware that other states have used this as a tool to draw down federal funds to support a reinsurance program. She emphasized it is unlikely that Massachusetts will qualify for meaningful federal pass-through funds to lower premiums via waiver-based reinsurance due to unique features of the Massachusetts market, including: ACA 1332 reinsurance waiver funding is derived from reductions in federal premium tax credits. This results from some features of the MA merged market. Most notably, we draw extremely low levels of APTC already, due to low-cost products in ConnectorCare, Massachusetts draws down low levels of federal premium tax credits. In 2020, we were the third lowest state in terms of our benchmark plan, the second lowest silver plan in the market, which is how APTC is calculated. The merged market is large, resulting in the need to spread the federal money over a larger population, minimizing impact. Section 1332 waiver funds for reinsurance available under a de-merged scenario are unlikely, as such a policy would increase federal premium tax credits. The Health Connector and the Division of Insurance should monitor possible changes in reinsurance waiver policy that may affect the availability of federal support.

Kevin Beagan then reviewed the discussion and information by Bela regarding creating a state based reinsurance program. Creating a state-based reinsurance program could lower merged market premiums, but would require significant funding from state tax revenue or other sources to have a meaningful impact. The projection shows, for every 1% reduction in annual premiums, a state-based reinsurance program would need $47M in annual funding. Potential funding sources include state tax revenues/general appropriations, assessments from large group self- and fully insured coverage. The Division of Insurance and the Health Connector should monitor federal changes that may encourage or finance reinsurance programs.

Audrey Gasteier expressed they wanted to capture the discussions around underlying healthcare cost drivers and the underlying medical and prescription drug trends that are key drivers of rising premiums that are challenging small businesses, individuals and all other market segments. They wanted to note here the council’s ongoing interest in supporting the work outside the MMAC entities they are charged with, that can help the merged market. Rising healthcare costs have resulted in premium increases across all market segments; unsubsidized individuals and small employers feel particularly burdened because they bear the full effect of such increases. Health

premiums are increasing across all market segments (e.g., merged market, large group, and government programs.) Premium cost pressures are caused by the increasing unit costs of health services and by increasing utilization of higher cost services. Under most product designs offered in the merged market, consumers have limited restrictions on providers and many services are delivered in higher-costing provider settings, which increases the overall cost of healthcare and health premiums. Although many individual premiums are subsidized via the state's ConnectorCare program, small employers (and unsubsidized individual purchasers) feel the full effect of rising health care premiums and are looking for ways to reduce these costs. Council members expressed the ongoing importance for continued pursuit (outside of the MMAC) of statewide cost containment strategies to address the underlying medical trend and provider prices, which remain the primary driver of premium growth across market segments and for the MMAC to look for strategies to address cost pressures specific to the merged market.

Observation
De-merging the individual and small group risk pools will achieve a very modest one-time reduction in small group rate growth (apart from trend), but will not materially impact future rate increases.
A federally-sponsored state reinsurance program through a 1332 waiver is likely not a viable solution for the MA merged market.
Creating a state-based reinsurance program could lower merged market premiums, but would require significant funding from state tax revenue or other sources to have a meaningful impact.
Alternative products (e.g., PEOs, health sharing ministries, self-funding/stop-loss products) marketed to individuals and/or small groups do not yet appear to have materially affected the merged market but warrant continued monitoring.
Rising healthcare costs have resulted in premium increases across all market segments; unsubsidized individuals and small employers feel particularly burdened because they bear the full effect of such increases. There is a need for more understandable and affordable product designs.
Low-cost health coverage products are readily available in the Massachusetts merged market, but many unsubsidized individuals and small employers have opted for higher-premium, broad network products over lower-premium, narrow network products.

Kevin emphasized he wants to ensure all council members' recommendations and observations are included in the report. He noted that there are strategies to address each of the observations pictured above, and members have come forward with strategies that they want to make sure everyone can go through before the next meeting. They think it is useful for all council members to put down strategies that can be talked about in the upcoming meeting, and today's presentation was supposed to help discuss the observations and hopefully find some consensus on. He noted that Josh and Mark submitted recommendations that were circulated to the group and they will talk in depth next time about each recommendation. They want to recirculate all ideas to put on

the table, and they know there are other ideas members may want to contribute. If there are any ideas, members want to circulate, to send this to him between now and next Friday, February 5th. They will use the meeting in late February to discuss all the ideas. Gary Anderson expressed that with the strategies they do approach, that they do this with eyes wide open, based on facts and the actuarial aspect of this provided the best data that could be available for the MMAC. The purpose of today was to give members the slides that give a basis of the report and that they need to digest the conversation and circle back to this at the next meeting. They then moved to adjourn the meeting.

Questions/Comments

Membership Changes

- Amy Rosenthal commented that she again would like to officially go on record acknowledging the important role that MassHealth plays in the Commonwealth and remaining strong, and she feels it is important to go on record each time the governmental account numbers increase.

Rate Review Process

- Amy Rosenthal asked if there will be any additional information available before the hearing
  - Kevin responded that there is information in the hearing notice and to contact the docket clerk, who can make information available specifically about the reasons for disapproval, the content of the hearing and what the rate filing includes. The company is expected to submit material by the end of this week that will respond to the DOI noted reasons for disapproval.

- Jon Hurst asked regarding the rate increase as of January 1st, it was a 7.1% increase and if they have the average for April
  - Kevin responded they are still going through the numbers right now, so there is a good deal of work they still need to do with other companies in the market. One company filed for a double digit rate increase and that they expressed concern with last time they had a discussion and that perhaps there may be special features of this one company that may need to be brought up in the hearing process. He noted that there is still a lot of back and forth between companies he needs to do before giving him an average number at this point.

- Michael Caljouw commented to give context to the timeline. It is generally mid February when the DOI expects to get to that position, if history holds relative to the average rate filing approval
  - Kevin responded they are still trying to work to make sure all filings are available for small groups to make choices by February. Regarding the company they are

holding a hearing for, they are trying to do as expeditiously and comprehensively as possible, and are hoping to identify if this can be settled by this time and are trying not to cause any disruption in the market.

Presentation

- Michael Caljouw commented that if this becomes a slide deck available for public consumption at some point that he thinks they should note, they are closely monitoring the COVID-19 conditions for both the individual and small group markets.
    - Kevin replied they hope this deck can be information they can agree to, and it might be a part of the final MMAC report. Today, they just want to show the facts from the past year.

- Amy Rosenthal commented that it's important to note in the Non-ConnectorCare individuals population that this group comprises different people. Some folks are just right over the income line where they would get subsidies, and others are folks who are financially well off.
- Mark Gaunya commented regarding the demerger analysis, that although this is a one time savings opportunity, this has a compounding effect. It is fair to say that it is one time, but it resets the slope and they should make that point.
- Jon Hurst agreed with Mark and added it would be fair to add a historical basis of what they saw with the difference in small group and individual when they first merged and what the impact was.
- Joshua Archambault commented Bela ran numbers on what the cost of reinsurance would be to hold the market harmless and that might be helpful context to include in the demerger
    - Kevin replied that they have this in a later slide, but they will consider adding that to the demerger slide.

- Michael Caljouw commented regarding the DOI and health connector monitoring alternative products in the market, that they should think through the reporting requirements relative to those products and the state's role in getting the correct information about this because they need the information to understand the prevalence of the products as they occur.
- Jon Hurst commented he did not see any discussion in the slides about rating factors and when we merged the two risk pools together, this was a part of the deal to mitigate the impact on small businesses and to keep small businesses coverage intact, as they have grown through several years of losing the mitigation. Whether it is a 1332, or another vehicle to be waived and acknowledging MA is an outlier, it seems there should be acknowledgement about how this is a problem because it is two strikes against businesses.

- Louis Gutierrez commented that the dilemma they face on the rating factors is that to his understanding, they cannot use the 1332 and were told definitively this past year by CMS, not to come back on those rating factors, but they are a factor in the changes in the market over time, so he has no objection to this being noted.
- Mark Gaunya looked to clarify what Audrey was saying and noted, that essentially that APTC arbitraged is funding reinsurance programs and because MA is the third lowest, we are not able to take advantage of that financing
    - Audrey replied that this is correct and there is not much further down MA can go, but Mark is correctly characterizing what she is saying
    - Kevin noted that to Jon's point, they can add a slide to point out the difficulties regarding ACA implementation and rating factors.

- Amy Rosenthal commented it seems that the Biden administration could potentially revisit and waive what was described, and they should monitor this for any opportunity.
- Joshua Archambault commented he wants to make sure that it is clear in the slide and inquired if the reinsurance program is just for the individual market post demerger, or if this is across the entire merged market because this is an important distinction about how many dollars need to be administered to buy down premiums 1%
    - Kevin commented that his recollection is that it was shown for both the merged and also de-merged market and that it was relatively the same.
    - Bela commented that the slide shown talks about the merged market and the $47 million investment would reduce premiums in the merged market 1%. When demerging, the individual market rates go up 4-6%, and if we infuse $47 million into that market it would be cut in half, so rates would go up 2-3%. The other option is to invest $94 million into the individual market to eliminate any increase from demerging
    - Kevin asked if it would be fair to say that for every 2% reduction in annual premiums for the individual market, that it would need $47 million.
    - Bela responded yes

- Michael Caljouw commented it was important to note, under the MMAC interest, underscoring the importance of cost containment strategies that are embraced by partners in government. This is an incredibly important aspect to the recommendation coming from the MMAC.
- Rina Vertes commented she would like to see the slide about rising healthcare costs as the first slide, and everything else is because this is such a big deal, and here is everything else we can do in a more focused manner on the merged market and in the meantime these are the other solutions. She would hate to see this council author a report that costs are high and they have a bunch of solutions, but it is always the last thought.

- Mark Gaunya commented he agreed with Mike and Rina and wanted to say as a backdrop that they are often told healthcare price transparency doesn't work. He emphasized it is not a thing; it is a principle. He agrees with Rina that we should start at the front end of this and say that the way the market has been designed is because things have been done behind the scenes. By bringing this to the forefront and making things transparent, they can measure and improve. He also thinks because of the omnibus bill that was just passed regarding surprised medical billing, there is language that now codified in statute nationally, about price transparency and the state has an opportunity to take 224 and advance it even further, and to lead the country. He highlighted there are about 8 reports from the Attorney General outlining what the problem is, and that the MMAC needs to provide solutions to address that.
- Amy Rosenthal commented she appreciates the conversation, but she thinks that getting to underlying costs is a very long and challenging issue. To be frank, Healthcare For All has a pretty robust plan for the upcoming session to look at the underlying costs, and she welcomes commission members as there are real opportunities to get at these cost drivers. In the meantime, there are opportunities through the MMAC to provide immediate relief while simultaneously addressing the underlying costs.
- Lora M. Pellegrini commented that the work Amy is doing is important and that we need to hold all players in the healthcare sector accountable because for far too long the focus has been on the health plans. There needs to be a commitment to cost containment and to making all parties held accountable going forward. She thinks the surprise billing legislation and legislature, disappointed that they did not hit that home by setting an out of network rate and they did not feel it was the right time given what is happening in the provider community, which is fair, but for small business we need to redouble our efforts on cost containment.
- Rina Vertes commented words are important, and she wonders if there is a better way to phrase these observations.
- Joshua Archambault discussed that he and Mark, with insight from other members, created a list of recommendations divided into four buckets. They tried to think through what the spirit of the executive order is and issues raised in conversations and they came up with four buckets: trying to get to a level playing field, reducing costs, achieving cost reductions and plan design changes. In their document, they had 20 different policy proposals trying to put concrete things on the table. He thinks it is unrealistic to talk through all 20 and get every single person to agree on all 20 because some required details to be worked out, but at least directionally, these would be areas that the Governor, and listed agencies, take to reduce the cost of care.
- Mark Gaunya commented that he and Josh really collaborated before bringing anything forward and they will go back and revisit this before the next meeting since it is a preliminary draft.

- Michael Caljouw commented his observation about the observations, is more about the need for granularity in the discussion. It is great to have a principle discussion, but they need to have a tools discussion because there are some things that are already available for further embroidery under statutes that exist, and some that require the legislature. He wants them to think about the tools they have, versus the tools they need. There are two tasks ahead of them, alignment on the observations they are pursuing and once they get to the pursuit, they must look at the tools, whether this is a regulatory solution or a legislative solution, or a federal and state solution that requires back and forth. He emphasized they need to look at regulatory solutions in addition to legislative ones.
    - Mark Gaunya responded that is what they did when putting their chart together, what is the principle, what are the strategies and who are the parties to work with, so they have a similar mindset.

- Louis Gutierrez commented one of Amy's earlier comments struck him, and there have been strong presumptions about the ACA and it has been hanging on in terms of political landscape. He wonders in a time where small businesses have been devastated by the pandemic and there is renewed administration support for health coverage through the ACA, if there are any federal strategies assisting small businesses that may be revisited and that they can evaluate and consider and to include this in the list.
- Lauren Peters commented she wanted to stress the importance that we anchor observations in facts that there is general consensus on, and she wanted to echo Mike's thought that we include some level of granularity and detail.
- Jon Hurst commented he was thinking about something he said at the first meeting, that the former CEO of Harvard Pilgrim 15 years ago was very opposed to merging the markets and that was when Charlie Baker was CEO. In discussion in subsequent years, the impact of the ACA on our merged market place and Chapter 58, have been rather dramatic and one way was on small business and hitting a second strike on losing our rating factors aside from merged our markets. He emphasized we need to come to grips and come up with options and if members think demerging is an option, then they should vote and then have fallback options. Bottom line, we need to do something based on what is right for small businesses and what is viable public policy wise.
- Lora M. Pellegrini commented for the record, their plans are strongly opposed to a reinsurance program for the merged market if it includes an assessment on other lines of insurance business. They remain concerned about risk adjustment and adding this onto what is already a flawed mechanism in methodology and that they do not support this at the time, unless it is state money then they may consider it depending on the attachment points.