Minutes of the
Merged Market Advisory Council (Council or MMAC) Meeting of October 23, 2020
Approved by Council at the Meeting Held on November 4, 2020.
Motion of Council Member Michael Caljouw and Seconded by Council Member Mark Gaunya
The Motion Passed by a Unanimous Vote of the Council Members Present.
Held via video conference

Members Participating by video conference or by phone:
Gary D. Anderson, Chairman, Commissioner Division of Insurance
Louis Gutierrez, Exec Director, Massachusetts Health Connector
Lauren Peters, designee of Marylou Sudders, Secretary of Health and Human Services
Michael Caljouw, Blue Cross & Blue Shield, Health Insurance Carrier representative
Lora Pellegrini, Massachusetts Association of Health Plans, Health Insurance Carrier representative
Mark Gaunya, Health Insurance Broker representative
Rosemarie Lopes, Insurance Broker representative
Rina Vertes, Health Insurance Industry Actuary
Amy Rosenthal, Small Group/Individual Health Insurance Purchaser representative
Patricia Begrowicz, Small Group/Individual Employer representative
Jon Hurst, Health Insurance Business Community representative
Joshua Archambault, Health Insurance Business Community representative
Wendy Hudson, Small Group/Individual Employer representative

Attending to the Council:
Kevin P. Beagan, Deputy Commissioner, Health Care Access Bureau, Division of Insurance
Michael D. Powers, Counsel to the Commissioner Division of Insurance
Jackie Horigan, Director Consumer Services Section Division of Insurance

Call to Order
Chairman Gary D. Anderson called the meeting to order at 12:31 PM.
Ms. Horigan called a roll of the Council Members and reported a quorum was present.

Membership
Mr. Beagan noted that HMO-reported membership for September 2020 was very similar to that of August 2020. There were further declines in commercial membership – 3,595 in small group; 13,524 in large group; and 6,933 in ASO (Administrative Services Only self-funded business) – offset by increases in governmental (16,509) accounts. In comparing April 2020 to September 2020 membership, commercial coverage – including ASO – has decreased by 80,199 (1.7%) but governmental programs increased by 66,196 to fill the gap.

Mr. Beagan reiterated that the Division will continue to monitor this information but that concerns about a dramatic drop in coverage have so far not materialized.

Ms. Rosenthal noted the work of the Executive Office of Health and Human Services (HHS) and

that a strong MassHealth program is critical to the Commonwealth's residents. Commissioner Anderson likewise appreciated the work of his colleagues at HHS.

Minutes
Chairman Anderson asked the group to review the minutes from the October 7, 2020 meeting, which had been shared in advance of the meeting, and vote on approval. Mr. Gaunya, Mr. Archambault, and Mr. Caljouw offered edits to the minutes as drafted. Mr. Hurst made a motion to accept the minutes as drafted and Mr. Gaunya seconded the motion. The minutes were unanimously approved as amended.

Presentation by Gorman Actuarial
Mr. Beagan stated that the Council has previously discussed products available within the Merged Market and programs available outside the Merged Market. He noted that today the Council would be discussing possible different techniques to ensure fair risk distribution.

Reinsurance:
Ms. Gorman presented a powerpoint presentation that concentrated on risk distribution. She indicated that insurance is designed to spread the risk of claims over all covered persons. In general for health insurance, 80% of costs are incurred by 20% of members. Within one insurer, premiums are set based on projected expenses of the entire pool and the members with high costs are subsidized by members with low costs.
In order to have a fair distribution of costs across insurers which can stabilize health coverage in the merged market, all the carriers are subject to the same guarantee issue, product offering and rating factor requirements. It is still possible that a carrier may get an unfair share of high-cost utilizers compared to other carriers and this could lead to instability in the market. When looking across the entire market, it is important to look at strategies that monitor and fairly distribute the risk of high-utilizing persons efficiently.

Ms. Gorman highlighted one slide that presented the risk scores – based on federal calculations – showing individual market enrollees for insurers that participate in the ConnectorCare market and small group members have comparable risk scores but those individual market enrollees for insurers that do not participate in ConnectorCare are significantly higher than those of the other two. This suggests that Non ConnectorCare enrollees within the individual market have the highest scores and are most likely to have higher than average claim costs. The carrier that gets more than their share of these individuals will have an unfair share of the risk and strategies to distribute this risk are intended to stabilize the market.

Ms. Gorman then explained how prospective and retrospective reinsurance programs have been set up to reimburse insurance carriers for enrolling individuals who have higher than average risk or health care costs. Mr. Gaunya noted that reinsurance is already done in fully insured health contracts and carriers secure reinsurance on their own. Mr. Gaunya stated that reinsurance costs are baked into the premiums the carriers are charging. Mr. Beagan noted that carriers all purchase reinsurance in their book of business. Mr. Caljouw stated that this is why funding is important and outside funding (federal funding) is necessary.

Ms. Gorman discussed prospective models that were used in some jurisdictions, including in Massachusetts between 1992 and 2007. Mr. Beagan explained how under the Massachusetts reinsurance program, an insurance company would collect information at enrollment to determine whether an enrollee was risk of high claims and decided whether or not to cede the risk of that one individual to the reinsurance pool. All the companies in the market were responsible for the costs of that individual if they fell outside certain threshold. At the end of a reporting period, carriers were assessed to fund the losses. Mr. Hurst asked if there were assessments on self-funded plans or on providers. Mr. Beagan replied the assessment was on fully insured plans.

Ms. Gorman then described retrospective reinsurance such as the transitional reinsurance program established by CMS for the 3-year period from 2014-2016 when the ACA was implemented. Under these programs, claims are collected from each carrier and CMS evaluates how much insurers receive based on the program design.

Mr. Archambault inquired whether prospective reinsurance programs are efficient since insurance dollars are only being spread to those ceded, i.e., there is incentive to target high risk, whereas with retrospective reinsurance programs there is less incentive to manage high costs over the long term. Mr. Caljouw and Mr. Beagan stressed that under either prospective or retrospective reinsurance, carriers would treat the consumer the same; there is merely a difference between how the carrier, under prospective reinsurance, chooses individuals to cede to the reinsurance program.

Ms. Vertes asked whether the retrospective model pays more to carriers when consumers go to the most expensive facilities. Ms. Gorman said that the highest costs are often incurred by sicker people who are being treated by the most expensive providers. Ms. Vertes said the best care is not always at the most expensive facility.

Risk Adjustment:
Ms. Gorman then described the federal risk adjustment system that evolved out of the federal ACA. Mr. Caljouw stressed that the Council needed to acknowledge that risk adjustment is a federal requirement that cannot be changed.

Ms. Pellegrini noted that reports indicate wide volatility, but carriers don't think that there is that much membership volatility and are looking for explanations in swings. Ms. Gorman said that there are membership shifts but to study it would be outside of the scope of the Council. Ms. Pellegrini disagreed, saying a study would be within scope.

Mr. Gutierrez noted that Massachusetts attempted to change risk adjustment in 2015 and was slapped down by the federal government. Ms. Vertes noted that while she doesn't like risk adjustment because it is destabilizing to the market, it is most likely an area that cannot be changed, and since risk adjustment doesn't bring overall merged market costs down rather it redistributes cost, it shouldn't be the Council's focus.

Ms. Gorman indicated that she wanted to explain how risk adjustment works as well as the limited flexibility offered under recent federal rules. She also pointed out how the current risk adjustment moves significant funds from a few primarily ConnectorCare carriers to the remaining carriers and

helps subsidize the cost of Non-ConnectorCare enrollees and small group premiums. Mr. Gutierrez said that there is heavy cross subsidization into the small group market.

In response to the comments about cross subsidization and the impact of eliminating that cross subsidization, Ms. Vertes replied risk adjustment is most likely not having that big of an impact on small group premiums, and Mr. Gaunya did not feel that risk adjustment is the driving reason for high costs. Chairman Anderson noted that it is a significant component of the market and while the Council may not be able to do anything about risk adjustment, it's important to take note of its impact.

Ms. Pellegrini said that, because of risk adjustment, carriers with ConnectorCare plans are getting penalized. Ms. Gorman indicated that reducing the level of risk adjustment – as allowed under recent federal rules – may negatively impact small group rates. She instead suggested that risk adjustment continue to be carefully and regularly monitored to see whether changes may be considered in the future. There seemed to be agreement among the members.

Conclusion

Commissioner Anderson thanked the Council Members for their participation and noted the discussion was excellent, stating that the Council could not fulfill the requirement set forth by the Governor without holding honest conversations about health insurance in Massachusetts. He appreciated all the thoughts raised today and wants to find enough time for everyone to express their opinions.

He stated that the November meetings of the Council will be virtually held on the same Teams platform on Wednesday, November 4, 2020 from 2:00-3:30 and Tuesday, November 17, 2020. Chairman Anderson called for a motion to adjourn. Mr. Gaunya made the motion, and it was seconded by Ms. Rosenthal. The motion passed by a unanimous vote of the Council Members, with Chairman Anderson abstaining.

Whereupon, the Council's business was concluded.

These minutes are exempt from the requirements of M.G.L. c. 30A, § 22(a) based on the definition of a "public body" as defined under c. 30A, § 18.

List of Documents provided at the Council meeting:

1. **Draft minutes of the October 7, 2020 Council meeting.**
2. **Proposed workflow of meeting.**
3. **Gorman Actuarial Presentation on Risk Adjustment and Reinsurance**
4. **Aggregate HMO membership in Massachusetts health plans as of September 30, 2020.**