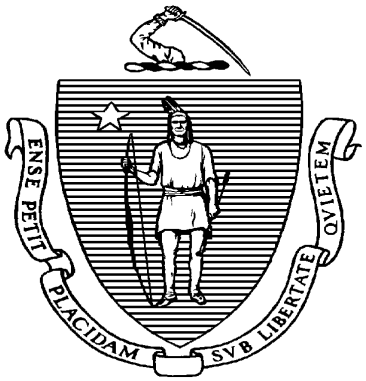
REPORT OF THE
MERGED MARKET ADVISORY COUNCIL

Pursuant to Executive Order Number 589



GARY D. ANDERSON
COMMISSIONER OF INSURANCE
COUNCIL CHAIR

Acknowledgments

Merged Market Advisory Council members met and conducted their work throughout the challenges that the COVID-19 health crisis presented during 2020. Members patiently adjusted to meeting and conducting sessions virtually as they methodically evaluated the features of the merged market and evaluated options to stabilize the market and the premiums available to merged market individuals and small employers.

Bela Gorman of Gorman Actuarial, Inc. coordinated the team that conducted a comprehensive study of Massachusetts' merged health insurance market for the Merged Market Advisory Council and responded to members' requests for detailed information. The work of Bela's team provided the necessary actuarial background and analysis for the members to understand the market and evaluate options.

Kevin Beagan and Jacqueline Horigan of the Division of Insurance, "Division", and Audrey Gasteier of Commonwealth Health Insurance Connector Authority, "Health Connector", respectively, and Gorman Actuarial coordinated the efforts of their staffs to assist the Merged Market Advisory Council to conduct its sessions and to develop the final report.

Table of Contents

Appendices

INTRODUCTION

Executive Summary

Since 2007, Massachusetts has maintained a merged market, a unique market structure that combines the nongroup and small group markets. Massachusetts is joined by only one other state and one territory, Vermont and the District of Columbia, that have merged markets. On October 18, 2019, Governor Baker formed the Merged Market Advisory Council through Executive Order 589 to examine the merged market for individual and small employer health coverage, analyze the factors underlying the cost of health coverage, and evaluate options to stabilize the market and cost of health coverage. The Council is comprised of 13 members, chaired by Commissioner of Insurance, and includes leaders, experts and stakeholders with experience in and knowledge of the health insurance industry, including carriers, brokers, actuaries, and individual purchaser representatives, as well as persons representing the business community, including representatives of employers and small businesses.

The report provides, for the first time since the merger of the individual and small group markets, a data-driven status report on the health of the merged market and options for policymakers to consider in the aim to control costs, while not sacrificing access and quality care.

Key Take-Aways

Health care premiums have risen more quickly than the rate of inflation and benchmark.

Despite the passage of health care cost containment legislation in 2010 and 2012, small employer and individual premium increases have continued at levels that are beyond general inflation as measured by the consumer price index (CPI) and the health care benchmark levels set by the Health Policy Commission. While the benchmark is intended to restrain provider unit cost changes, premiums also rise due to factors such as increased utilization of higher-cost providers, procedures, prescription drugs.

Consumers are not aware of their health care and coverage options.

Making health choices has become more complex with the array of available health care services and health benefit arrangements. Despite laws enacted to improve the transparency of health costs and efforts to disclose plan features, more can be done to simplify choices, educate consumers and assist them in understanding the financial impact of choices, especially of higher-cost providers or procedures than may be medically necessary for care.

The composition of the merged market has changed since the individual and small group markets were first merged in 2007.

Since the markets were first merged in 2007, as part of Chapter 58 of the Acts of 2006, the individual market has grown significantly, largely as a result of the federal Affordable Care Act, ACA, moving

the Commonwealth Care program into the merged market, where it became known as ConnectorCare. Over the same period of time, the small group market has declined for a variety of reasons. Other changes in the broader economic landscape, such as the rise of the 'gig economy', multiple recessions, and most recently the economic impact of the COVID-19 pandemic, may have played a role in small group membership decreases.

Lower-cost health coverage products are available in the Massachusetts merged market, but consumers, particularly small businesses, have historically tended to enroll in broad network plans versus plans with narrow networks but lower premiums.

The majority of small business enrollment tends to congregate in higher-cost products that offer an "all-inclusive" provider network, despite lower-cost options being available to them. Council members representing the small business community cited the need to compete with the benefits offered by large employers as a driving factor behind this choice. In recent years, however, small group market enrollment in lower-cost options that use a more limited provider network has begun to increase. This shift in behavior signals an opportunity to increase awareness among small businesses of the diversity of products and price-points available in the merged market.

Underlying price growth and patient choice of high-cost providers are driving premiums higher.

As noted previously above, premium increases have continued at levels that are beyond general inflation. These premium increases are necessitated in part by underlying price growth and patient choice of high-cost providers. The health costs of those persons who choose to use higher-cost providers are being subsidized by those persons who choose lower-cost providers. Many Council members advocated better education and outreach to increase price transparency information that is available to patients and providers as a means to slow the rise of premiums.

ConnectorCare and the small group market have comparable risk profiles, overall, while the non-ConnectorCare individual market has a worse risk profile.

As a result of these varied risk profiles, ConnectorCare individuals and small business enrollees are cross-subsidizing the non-ConnectorCare individual market. This is not the only "subsidy" in the merged market. For example, younger people cross-subsidize older people, enrollees in narrower network products cross-subsidize enrollees in broader network products via risk adjustment, and portions of the individual market's premiums are partially subsidized by federal tax dollars.

The risk adjustment program results in individuals in ConnectorCare generally cross-subsidizing enrollees of the higher-cost, broader-network carriers that tend to have mostly small group enrollees and higher-risk individual enrollees.

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 higher-risk

individual market enrollees of broader network carriers and enrollees, which also tend to be the carriers with the greatest share of the small group market.

Separating the small group and individual risk pools would achieve a one-time reduction in small group rates, and a one-time increase in individual market rates, but both risk pools would continue to grow with medical trend.

When the markets first merged and there was a different distribution of individuals and small employers, an actuarial study projected that average individual rates would decrease by 15% and average small group rates would increase by 1 to 1.5%. Demerging the markets at this time would result in a one-time average increase of 4 to 6% to the individual market. The estimated cost in annually recurring funding for every 1% reduction for reinsurance applied just to the individual market is estimated to cost between $15.7 and $23.5 million in a demerged market. Under a demerger, a one-time average decrease of 2 to 4% is estimated for the small group market that has a "compounding" effect on future premiums by resetting the base premium, separate and apart from medical trend. However, it bears noting that the impact on premium rates will vary across carriers and enrollees.

The establishment of a reinsurance program in the merged market could lower premiums, but would require funding from state revenue or other sources.

A state-level reinsurance program to subsidize the premiums of a small segment of the state's health insurance market would require investment of approximately $47 million in annually recurring funding for every 1% reduction in merged market premiums. This funding could come from state resources or other cross-market assessments from other sectors of the health coverage landscape outside of the merged market e.g., large group, self- and fully-insured coverage.

Federal pass-through monies that some states have used via ACA Section 1332 Waivers for state-level reinsurance programs do not appear to offer material financial support for Massachusetts.

Due to the unique features of the Massachusetts market, including the fact that Massachusetts draws down relatively low levels of federal premium tax credits per recipient, Massachusetts is likely to receive somewhat limited federal pass-through funding to support a state-based reinsurance program and only if the market remains merged. However, state agencies should continue to monitor any changes that may affect the availability of federal financial support for a state reinsurance program.

Alternative coverage arrangements sometimes marketed outside of the state-regulated merged market to individuals and/or small groups (*e.g.,* professional employer organizations, self-funded plans, health sharing ministries) do not appear to have materially affected the market, however there is anecdotal evidence of growth toward their adoption. Such options bear monitoring to track potential impact on the market and to ensure consumer awareness.

To date, there is no evidence that off-market product offerings have materially affected the merged market's composition or stability, but such trends bear monitoring. State rules governing marketing and disclosures could be revisited to ensure consumers are informed of how such products differ from merged market coverage, and state actions could be taken to collect more robust information regarding the enrollment in such products. The growth in recent years in adoption of such arrangements as alternatives to coverage offered through the merged market bear monitoring, as it could lead to more small employers and individuals exiting the merged market.

Merged Market Advisory Council

Mandate

Under Executive Order 589, issued on October 18, 2019, the Governor established a Merged Market Advisory Council "to advise the Governor and Lieutenant Governor regarding the merged market for insured health coverage that is regulated under M.G.L. c. 176J and to propose recommendations to ensure the long-term stability of coverage for individuals and small employers in the merged market and the affordability of insured health benefit plan products offered therein."

In completing its work, the Council was directed to "prepare a report that summarizes the status of the merged market based on an independent actuarial analysis and that makes recommendations for improved market functioning, including any policy and legislative changes that the Council recommends to ensure affordability and stability of coverage for small businesses and individuals."

"The Council shall oversee an independent actuarial analysis of the merged market to inform its work and its final recommendations. In formulating the recommendations, the Council shall consider and address:

1. The general stability of the merged market risk pool;
2. Trends and dynamics related to the composition of the merged market risk pool and its impact on premiums and affordability for small businesses and individuals;
3. Drivers and growth of health care costs and premiums in the merged market;
4. The impact to the merged market from: i) the presence or extent of any cross-subsidization between the non-group and small group market segments; ii) federal risk adjustment; and iii) coverage options for small-employers including, but not limited to, association health

plans, multiple employer welfare arrangements, professional employer organizations, individual coverage health reimbursement arrangements and self-insurance;

5. Policy or market dynamics that threaten the stability of the overall market for small group and individual coverage, or are forecasted to do so;

6. Strategies to strengthen and promote affordability for the small group market, including but not limited to, whether federal waivers should be sought to permit flexibility in the application of merged market rules; and

7. Other opportunities to improve the functioning of the merged market including, but not limited to, the establishment of a reinsurance program; provided, however, that the Council must consider the impact of such strategies on both the non-group and small group market segments and potential state and federal costs and funding sources."

Members of the Council

The following individuals were appointed to the Council:

Gary D. Anderson	Chair, Commissioner, Division of Insurance
Louis Gutierrez	Exec Director, Massachusetts Health Connector
Marylou Sudders	Secretary of Health and Human Services
Michael Caljouw	Blue Cross & Blue Shield, Health Insurance Carrier representative
Lora Pellegrini	Mass Assn of Health Plans, Health Insurance Carrier representative
Mark Gaunya	Health Insurance Broker representative
Rosemarie Lopes	Insurance Broker representative
Rina Vertes	Health Insurance Industry Actuary representative
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

Meetings

The MMAC met in open sessions that took place on the following dates:

- January 8, 2020;
- February 5, 2020;
- March 11, 2020;
- April 2, 2020;
- May 20, 2020;
- June 17, 2020;
- September 10, 2020;
- September 23, 2020;
- October 4, 2020;
- October 23, 2020;
- November 4, 2020;
- November 17, 2020;
- December 2, 2020;
- January 26, 2021;
- February 26, 2021; and
- March 16, 2021.

The Division and the Health Connector coordinated public sessions for interested parties to express their thoughts about the merged market on the following dates:

- January 29, 2020 at the office of the City Council in Lowell, Massachusetts;
- February 5, 2020 at the UMass Law School in Dartmouth, Massachusetts; and
- February 26, 2020; at the UMass Medical Center in Worcester, Massachusetts; and
- March 5, 2020 at Hearing Room 1-E, Division of Insurance, Boston, Massachusetts.

The final version of this report was approved by Council members on January 18, 2022.

BACKGROUND

This section reviews:

- *The evolution of health coverage in the U.S. and in Massachusetts*
- *Drivers of health care costs and premium growth*
- *Background on the Massachusetts merged market including membership and product availability*

Evolution of Health Coverage in the U.S. and in Massachusetts

Society has long valued access to those who could heal or cure ailments so that individuals can return to and maintain healthy, active, and productive lives. As scientific knowledge and training became more standardized, practitioners enhanced their skills and new treatments and prescriptions were developed, and patients were cured from previously untreatable illnesses. These new treatments were available to those who could afford to pay for them. For everyone else, they lived in dread that they would fall ill and could not locate or afford needed treatment. Unlike most other countries, which developed national health systems, in the United States created a private market with insurance companies during the early to mid-twentieth century initially offered individuals policies that would pay for certain limited hospital or surgical expenses provided the individual satisfied the company's medical review. If not, coverage might be denied or limited by pre-existing condition limitations.

The Rise of Employer-Sponsored Coverage and Managed Care Organizations

A confluence of two events in the 1940s led the US to tether health insurance to employment. During World War II, as industry competed for workers in the midst of a labor shortage, economists feared that business would raise salaries to compete for workers and that inflation would spiral out of control. To prevent this, the federal government imposed a wage freeze that prohibited employers from raising pay to attract workers. With wages frozen, employers began to use benefits, in particular employer-sponsored health insurance, to compete for labor. Employment-based health coverage was much more attractive than buying individual coverage because all employees could join the health plan without any medical underwriting and employees contributed only a portion of the premium (although many employers fully covered the cost of health insurance).

In 1943, the Internal Revenue Service established policy that the cost of employment-based health insurance should be exempt from federal income and payroll taxes. This made it far less expensive to obtain health insurance through a job than by any other means. Today, the single largest tax expenditure benefit for employers and employees in the United States is for employer-sponsored health insurance. As the employment-based health insurance system flourished, government stepped in to address gaps in coverage by creating Medicare and Medicaid for the non-working elderly and poor, by enacting laws to require certain benefits be included in every insured plan, and by promoting cost containment efforts to address rapid increases in health care costs and

premiums. Health Maintenance Organizations, "HMOs", arose with federal government support in the 1970s and 1980s that offer health services through limited networks of providers who agreed to follow the HMO's administrative processes and accepted discounted levels of reimbursement.

In the Massachusetts market, HMO plans dominated health coverage as Boston and Worcester-based HMOs developed statewide networks, and Blue Cross and insurance companies developed their own HMO subsidiaries. In 2020, there were 12 insurance carrier groups[1] actively marketing products in Massachusetts' insured health markets, with the vast majority of coverage issued through HMOs and related managed care plans. The following chart displays the distribution of coverage among the major carriers in the Massachusetts market in 2018.

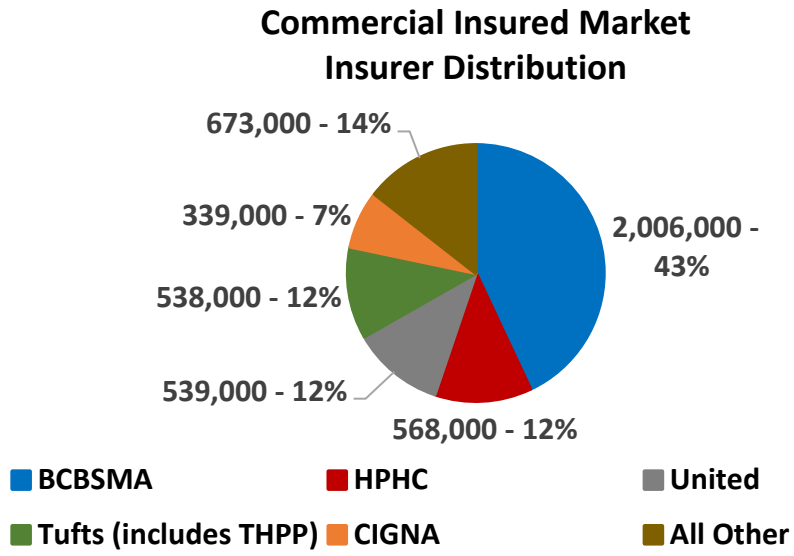


Figure 2: 2018 Average Membership by Carrier – Total Insured Market (Fully and Self-Insured)
Source: CHIA 2019 Annual Report Coverage Dataset

[1] **Aetna -** Aetna Health Inc., Aetna Health Insurance Company, Aetna Life Insurance Company
AllWays - AllWays Health Partners, Inc. and AllWays Health Insurance Company
BMC - Boston Medical Center Health Plan, Inc.
BCBSMA - Blue Cross and Blue Shield of MA, Inc. and Blue Cross and Blue Shield of MA, HMO Blue, Inc.
CIGNA - CIGNA Health and Life Insurance Company and Connecticut General
ConnectiCare - ConnectiCare of Massachusetts, Inc.
Fallon - Fallon Community Health Plan, Inc. and Fallon Health and Life Assurance Company
HNE - Health New England, Inc. and Health New England Insurance Company
HPHC - Harvard Pilgrim Health Care, Inc. and HPHC Insurance Company, Inc. and Health Plans Inc.
Tufts - Tufts Associated Health Maintenance Organization, Inc. and Tufts Insurance Company
Tufts Direct - Tufts Health Public Plans, Inc.
United - United HealthCare Insurance Company

Evolution of Small Group and Individual Markets

In the 1980s, despite the growth in health coverage options, small employers and individuals did not have the same access to affordable health coverage as large employers. Unlike large employers who leverage the law of large numbers, relatively stable workforces, and a large employment base to spread risk, carrier actuaries and underwriters have more difficulty predicting costs for small employers and individuals because their claims experience is more volatile on a year-to-year basis. Carriers were unwilling to underwrite coverage for these markets unless they could limit their exposure with pre-existing condition limitations or charge higher premiums based on the risk profile of the group or individual.

In Massachusetts during the 1990s, statutory reforms created rules that required carriers offering coverage to small employers and individuals to make coverage available to all eligible applicants, to limit pre-existing condition exclusions, and to base premiums on the collective experience of all eligible applicants. Several carriers that previously underwrote coverage chose to leave the market, but over 10 carriers have remained to offer options for coverage to small employers with up to 50 employees and to individuals.

In 2006, as part of a comprehensive state health reform bill known as Chapter 58 of the Acts of 2006[2], Massachusetts took the following steps to expand the availability and affordability of health coverage:

- Required adult residents under a new 'individual mandate' to have adequate health coverage or be subject to an annual assessment when filing their Massachusetts income tax;
- Combined the previously separate small employer and individual insurance markets into a single merged market so that premiums charged to individuals and small employer groups would be based on the collective experience of all eligible small employers and individuals and state rating factors, specifically for group size, industry and participation rate, were in place to mitigate the cross subsidies between constituencies within the new merged market configuration;
- Required employers to help support the expansion of health coverage (e.g., the Fair Share Contribution, the Free Rider Surcharge, and Section 125 Plan requirements, all of which were later sunsetted);
- Established an 88% Medical Loss Ratio requirement for the merged market;
- Created the Health Connector [3] to develop a marketplace for individuals and small employers to facilitate shopping for health coverage; and

[2] Chapter 58 of the Acts of 2006.
[3] The Commonwealth Health Insurance Connector Authority was created under M.G.L. c. 176Q.

- Established through the Health Connector a new health coverage program, called CommonwealthCare[4], with premiums subsidized based on an individual's income level up to 300% of the federal poverty level.

With these reforms, the Commonwealth's health coverage rate rose from 87% to 94% between 2006 and 2010.[5]

In 2010, the Legislature authorized Small Group Health Insurance Cooperatives to operate within the merged market. These cooperatives increased choices for employers and employees as well as effective financial incentives for subscribers to be healthier and more educated consumers of health care services.

Despite these advances, there was increased concern about the rising cost of all types of health coverage, but especially in the merged market where small employers and individuals were especially sensitive to premium increases. Laws passed in 2008 and 2010 required the Division of Insurance, "DOI", and other state agencies to address increasing health care costs to make coverage affordable. Among the changes, statewide carriers were required to offer lower-cost limited or tiered network products, premium discounts were provided to employers enrolling in group purchasing cooperatives, and the DOI initiated processes to review carriers' merged market rate requests. An additional law, Chapter 224 of the Acts of 2012, made further changes to require that there be health care price transparency for both carriers and providers. In addition, a new state agency, the Health Policy Commission, was charged to develop a health care cost benchmark as a target growth rate for health care costs.

The federal ACA was signed into law in 2010 and key provisions were implemented on January 1, 2014, designed to extend many of Massachusetts' 2006 health reform protections across the country. With implementation of the ACA in Massachusetts in 2014, many of Massachusetts' protections continued, but some significant changes were required, including:

- The CommonwealthCare program was incorporated into the merged market (and renamed ConnectorCare), greatly expanding the number of individuals obtaining coverage in the merged market;
- Small employer and individual market products were required to meet prescribed actuarial values that can impact plan design and cost-sharing;
- Carriers were required to meet certain Medical Loss Ratio (MLR) standards – 85% for large group and 80% for small group - or otherwise issue rebates to enrollees, in addition to more stringent state MLR standards;

[4] CommonwealthCare was initially a separate risk pool and was not part of the newly merged individual and small group market.

[5] https://www.umassmed.edu/contentassets/6396d1f75cd34b35b2e9657d86cc6946/inquiryjrnl_49.042.pdf.

- Employer premium discounts for purchasing cooperatives, and the industry, group size, and participation rating factors, integral features of the 2007 decision to merge the market and mitigate the cross-subsidy between individual and small employer premiums, were eliminated in order to comply with ACA community rating requirements that limited the use of rating factors beyond age, geography, family composition and tobacco usage[6];
- New federal risk transfer programs were created to account for differences in carriers' enrollment of persons with higher than average medical claims:
    - Temporary reinsurance and risk corridor programs were established to reimburse carriers for the cost of medical claims exceeding certain thresholds; and
    - A permanent risk adjustment program was established to annually redistribute funds among merged market carriers based on the relative health risk of carriers in the market.

Drivers of Health Care Costs and Premium Growth

Despite the Commonwealth's high rate of health coverage, challenges remain in controlling the cost of health care and coverage. Understanding the drivers of health care costs and premium growth is central to addressing merged market stability and improving affordability.

Between 2016 and 2018, health insurance premiums and cost-sharing in Massachusetts increased roughly twice as fast as wages/salaries and the rate of inflation (CPI), causing many residents with private health insurance to contribute an increasing share of their income toward health care.[7]

Affordability challenges due to growing health care costs disproportionately impact vulnerable communities already facing continued health equity challenges and health outcome disparities. The Massachusetts Department of Public Health's State Health Assessment details the persistent disparities in health outcomes among low-income communities, people of color, LGBTQ+ individuals, and other populations.[8]

The Massachusetts Health Policy Commission's 2019 Annual Health Care Cost Trends Report examined market dynamics and spending drivers in hospital inpatient and hospital outpatient services, which are two of the fastest health care spending categories from 2017 to 2018 and

[6] Although the ACA eliminated small group rating factors other than the use of a group's age, geographic location, family composition, tobacco usage, and plan benefits, Massachusetts has operated under a federal ACA Section 1321e waiver that allows for the reduced use of other factors during a transitional period as it comes fully into ACA rating compliance. This waiver is slated to expire at the end of CY 2021.

[7] The Massachusetts Health Policy Commission. 2019 Annual Health Care Cost Trends Report. (February 2020).

[8] The Massachusetts Department of Public Health. 2017 Massachusetts State Health Assessment. (October 2017). https://www.mass.gov/service-details/2017-state-health-assessment

together account for over 40% of all health care spending in Massachusetts.[9] While inpatient hospital stays are holding steady or decreasing, hospital inpatient spending has continued to grow among commercially-insured patients. Spending per inpatient stay grew 5.2% annually between 2013 and 2018 (from $14,500 to $18,700).[10] Hospital outpatient spending accounts for 60% of hospital spending for commercially-insured residents, with outpatient surgery accounting for more than a third of total hospital outpatient spending. Spending in this subcategory grew 11% from 2015 to 2017.[11] The report also noted pharmacy spending as a significant cost driver, with gross pharmacy spending growing at 5.8% in 2018 and 5.4% in 2017, and net spending growing at 3.6% and 3.7% respectively.[12]

There are many reasons that overall health care costs are increasing in Massachusetts, including that individuals receive more expensive health treatments and care from higher-cost providers and the increased cost of pharmaceuticals including brand-name and specialty drugs. Although this report will concentrate on merged market issues, there are factors outside of the merged market that are responsible for the rising cost of health care premiums. Trends in Massachusetts health care spending and impacts on premium growth have been extensively documented by the Health Policy Commission, "HPC", and the Center for Health Information and Analysis, "CHIA". For in-depth information on rising health care costs, key drivers of cost growth, and proposed strategies to address cost challenges in Massachusetts, please see:

- The Massachusetts Health Policy Commission's 2019 Annual Health Care Cost Trends Report; and
- The Center for Health Information and Analysis' 2019 Annual Report.

Background on the Massachusetts Merged Market

Merged Market Factors Impacting Premiums

Health insurance premiums are based on each carrier's projected claims costs and provider network contracts for the upcoming period or plan year. These dynamics are separate from the CPI. The stability of the insurance market relies on insurance carriers being financially responsible and able to pay for the cost of covered services and provider and carriers negotiating reasonable rates of reimbursement. When carriers develop premiums, each carrier's actuaries develop their market premiums by examining the following:

- historic claims payments;
- negotiated rates of payments with network providers;

[9] The Massachusetts Health Policy Commission. 2019 Annual Health Care Cost Trends Report. (February 2020).
[10] The Massachusetts Health Policy Commission. 2019 Annual Health Care Cost Trends Report (February 2020).
[11] MA Health Policy Commission. 2019 Annual Health Care Cost Trends Report (February 2020).
[12] MA Health Policy Commission. 2019 Annual Health Care Cost Trends Report (February 2020).

- changes to the health care delivery system with consolidation of provider organizations which has led to higher payment rates for previously lower-paid providers;
- shifts in utilization from lower-paid community providers to higher-paid providers;
- new health care technologies and services that are expected to impact future claims;
- new statutorily required health benefit mandates;
- emerging health care policy to evaluate the carrier's future projected costs;
- overall economic climate;
- trends in health care utilization;
- projected federal risk adjustment transfers;
- administrative expenses; and
- a limited "contribution-to-surplus" to protect against potential losses in future years.

In the merged market, carriers are required to spend 88 %[13] of every premium dollar toward claims expenses, and there are limits on their ability to increase administrative expenses or contributions-to-surplus. Year-to-year premium increases are tied to carriers' projected claims costs. If an individual carrier has a broad provider network and attracts a disproportionate share of higher-utilizing members and higher proportion of members using higher-paid providers, its costs may increase at a faster rate than other carriers. The MLR is a percentage applied to health care trends rather than a fixed dollar amount tied to annual CPI adjustments.

The federal risk adjustment program redistributes funds from insurers with lower-risk members to insurers with higher-risk members to account for risk distribution across the market and shifts in high utilizing members. However, this program does not work perfectly and has resulted in large transfers of money between carriers. Furthermore, as populations shift among carriers, carriers' premiums sometimes can be disproportionately impacted. While this movement is an important factor in any one carrier's sudden shift in premiums, it is not the major factor in increasing premiums.

While the ACA limits the types of rating factors that can be used, CMS has for several years approved Massachusetts waiver requests to allow a slower phasing-out of state-based rating factors not permitted under the ACA. Massachusetts lawmakers had previously utilized such factors as a mechanism to address the potentially negative impacts of a newly merged risk pool. Several factors have been phased out completely and the federal government continues to indicate its statutory inability to indefinitely permit the use of non-ACA-compliant rating factors. In 2021, two such state factors remain in use in the Massachusetts market - Group Purchasing Cooperatives and group size factors. The cooperative factor allows for a 3% discount for certain small groups and the group size factor is currently applied at one-third of its total value. The use of these factors has historically allowed premium impacts to be moderated for specific participants within the merged market.

[13] This is a higher standard than the 80% level required under the ACA.

Merged Market Tools to Control Rate Increases

The DOI uses all tools at its disposal to ensure that premiums reflect sound actuarial assumptions and to protect against unreasonable premium increases. Since 2010, DOI staff and actuarial consultants have reviewed carrier rate filings and challenged carrier assumptions in an effort to mitigate the level of carrier rate increases. Further, state laws require merged market carriers to spend 88 % of every premium dollar toward claims expenses. If a carrier spends less than 88% of premiums on claims expenses, then it is required to pay members back in the form of MLR rebates.[14]

Despite these efforts, carrier premiums have continued to increase, not only for merged market employers and individuals, but also across all market segments due to the growth in health care prices, as well as increased utilization of higher-cost providers, procedures and prescription drugs. Such increases are especially difficult for small groups and individuals who need to find ways to pay for the increased premiums in lieu of other needed things.

Characteristics of the Massachusetts Merged Market

Membership and Product Availability in the Merged Market

Overall, the merged market is relatively large and has a stable enrollment, with approximately 761,000 members in 2018. With ten carriers offering coverage, the merged market provides individuals and small employers with a wide range of products. The availability of products varies based on the distribution channel, with some carriers offering a subset of their products to individuals and the smallest employers (five or fewer employees). In general, however, all products must be made available to the market. The inclusion of ConnectorCare members in late 2014, the number of individuals in the merged market grew significantly. As of 2018, individuals comprised roughly 40% of the market (307,000 lives) and small group members accounted for 60% or 454,000 lives.

Merged Market Membership

In 2018, approximately 4.7 million residents obtained health coverage through the private health coverage market available to employers and individuals. 761,000 residents (16% of the private market) obtained coverage through the merged market (fully insured individual and small group). Within that total, as noted in the chart below, 307,000 obtained coverage on an individual basis and 454,000 obtained coverage through small employers.[15]

[14] KFF. 2020 Medical Loss Ratio Rebates (April 2020). https://www.kff.org/private-insurance/issue-brief/data-note-2020-medical-loss-ratio-rebates/

[15] Some carriers report sole proprietors as "individuals" while others categorize them as "small groups."

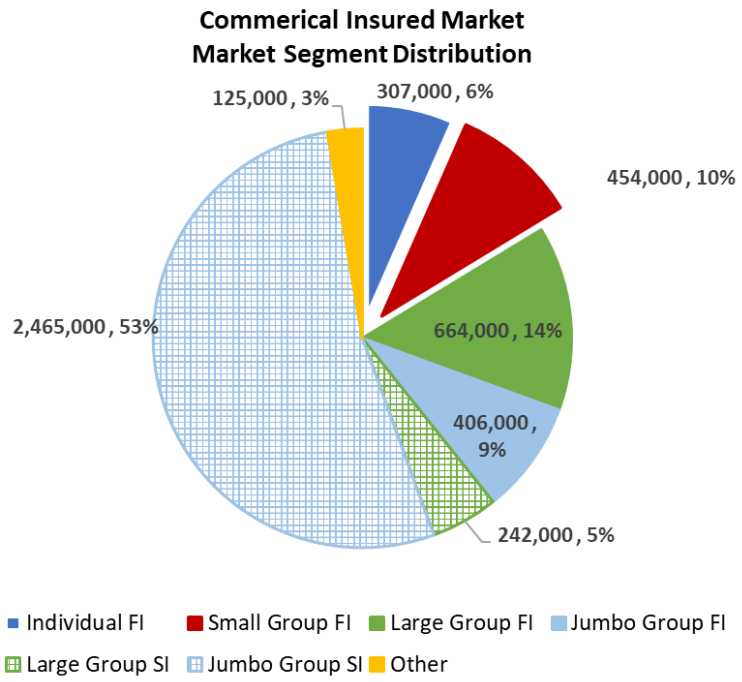


Figure 5: Average 2018 Membership
Source: CHIA 2019 Annual Report Coverage Dataset

As noted previously, the 761,000 members have a right to obtain and renew coverage from all the companies offering coverage within the merged market. Premiums are based on overall merged market claims experience that can only vary according to strict rating rules identified in state and federal laws. Although there may be limited exceptions to these rules,[16] each eligible individual and small group has access to plans available in the market.

It is important to understand the makeup of the subsectors of both the individual and small group markets. Roughly two-thirds of the individual market, 204,000 people, obtain federally subsidized health coverage through the Health Connector, with 190,000 covered through the ConnectorCare program. The remaining 103,000 individuals pay the full premium for individual coverage. The small

[16] Special M.G.L. c. 176J guarantee issue protections exist for: eligible individuals who reside in Massachusetts and eligible small employers that are located in Massachusetts with up to 50 eligible employees, with at least 50% of employees working in Massachusetts, with at least 75% of eligible employees choosing coverage (count excludes those with coverage through spouse but includes special count of part-time/seasonal/temp employees). Exception under existing law/regulation: HMOs are permitted to restrict eligible small employers with between 1 and 5 eligible employees to obtaining coverage through intermediaries. Since intermediaries do not offer all available products, groups with between 1 and 5 eligible employees are only able to obtain those HMO products that are being offered by an intermediary.

group population includes self-employed individuals,[17] employers with 2 to 5 employees, and employers with 6 to 50 employees. Pursuant to federal rules established by the ACA, in an unmerged market, self-employed individuals are eligible only for coverage in individual health markets; if the merged market were demerged, self-employed individuals would be required to obtain coverage in the individual market.

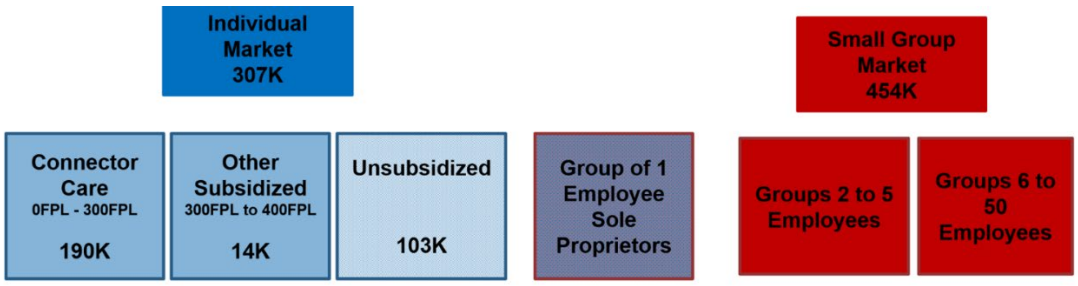


Figure 6: Average 2018 Membership
Source: CHIA 2019 Annual Report Coverage Dataset

Since 2014, the individual market has experienced steady growth, while the small group market has declined. The merged market in total has experienced small fluctuations over the past few years. From 2017 to 2019, individual membership increased by an estimated 12% and small group membership declined by approximately 8%.

[17] As noted previously, some carriers include sole proprietors under "individuals" and other categorize them as "small groups."

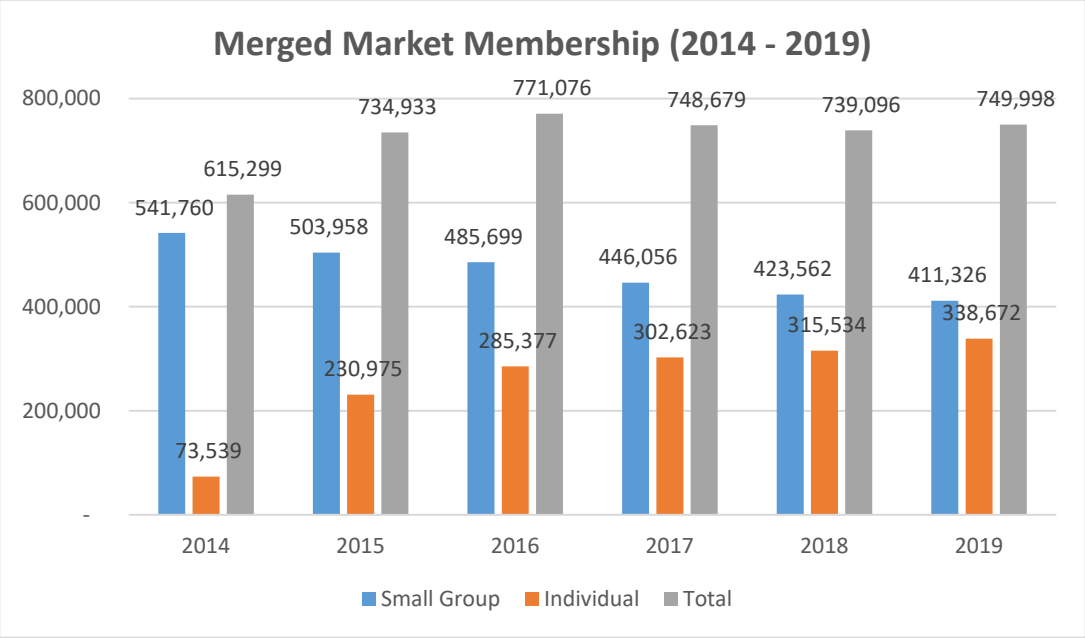


Figure 7: Merged Market Membership – 2014 – 2019
Source: 2014 to 2019 DOI Annual Merged Market Membership Reports[18]

Although there is no single reason for the decline in small group membership, the following factors have contributed to the decrease:

- More self-employed individuals are being counted as individuals as a result of the ACA definition change that occurred in 2014, making the small group count appear smaller and the individual market count look larger;
- Some small employers are seeking coverage outside of the state's merged market; and
- Some small employers have dropped coverage.[19]

Despite these changes to small group membership numbers, the total market remains sufficiently large, allowing risk to be spread across a broad spectrum of individuals and small employers.

When the merged market reforms were originally put in place, the number of individuals was relatively modest compared to the number of small group members. In 2007, there were approximately 46,000 individuals and 796,000 small group members. At the end of 2019, the merged market consisted of 339,000 individuals and 411,000 small group members.

[18] Data in this chart represents membership at a point in time.

[19] Sommers BD, Shepard M, Hempstead K. Why Did Employer Coverage Fall In Massachusetts After The ACA? Potential Consequences of a Changing Employer Mandate. Health Affairs (Millwood) (July 2018); 37(7):1144-1152. doi:10.1377/hlthaff.2018.0220. PMID: 29985692.

A significant jump in the number of individuals occurred in 2015 when the ConnectorCare program was added to the merged market. The chart below shows the change in the composition of the merged market since inception in 2007.

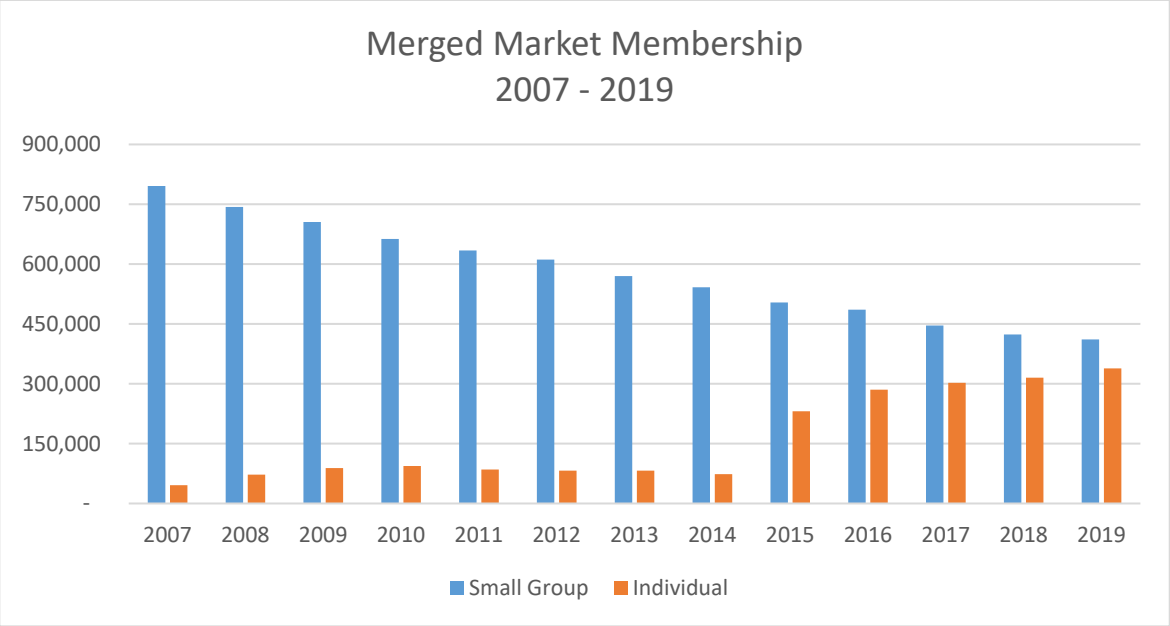


Figure 8: Merged Market Membership History – 2007 – 2019
Source: DOI Annual Merged Market Membership Reports

Availability of Products in the Merged Market

Unlike many states that have only one or two carriers offering guaranteed issue coverage to individuals and small employers, in 2020, Massachusetts had ten insurers[20] that offered health insurance in the merged market. The following table identifies the companies and number of product choices offered in 2020 in the merged market.

Insurer	Number of Merged Market Products
AllWays Health Partners	56
Boston Medical Center HP	7
Blue Cross/Blue Shield of MA	41
ConnectiCare of MA	5
Fallon Comm Health Plan	21
Health New England	30

[20] Three insurers – Fallon, Tufts, and Harvard Pilgrim – offer coverage in the merged market under more than one insurance license.

Harvard Pilgrim Health Care	34
Tufts Health Public Plans	8
Tufts Assoc HMO	42
United HealthCare	12
Total	**256**

Figure 9: Number of Products Offered by Insurer in Massachusetts Merged Market
Sources: Health Connector, HSA Insurance, Carrier Marketing Materials[21]

Although there have been changes in the number of insurers offering merged market coverage over the past decade, turnover has been fairly limited. All but two members have been in the merged market and/or Commonwealth Care since 2007.[22] Minuteman Health Plan, Inc. and CeltiCare of Massachusetts, Inc. both exited the market in 2018.

Insurers offer coverage through several distribution channels, including the Health Connector, producers (agents/brokers), intermediaries, and direct sales through carriers. The following tables illustrate products marketed to small employers and individuals through the primary distribution channels in 2020. For some carriers, the availability of products varies based on the distribution channel, with individuals and employers with five or fewer employees routinely offered a subset of products.

MA Small Group Market Product Offerings by Distribution Channel – 2020

Insurer	Health Connector	Intermediary (1 to 5 EEs)	Direct from Carrier or from Broker
AllWays	7	20	56
BMCHP	7	2	2
BCBS-MA	7	N/A	41
ConnectiCare	N/A	N/A	5
Fallon	15	14	21
Health NE	7	30	30
HPHC	7	19	34
Tufts Health Public Plans	7	8	8
Tufts Health Plan	6	13	42
United HealthCare	6	N/A	12
Total	**69**	**106**	**251**

Figure 10: Products Offered to Small Employers by Distribution Channel
Sources: Health Connector, HSA Insurance, and Carrier Marketing Materials

[21] Tufts and Harvard Pilgrim formally merged at the beginning of 2021, but there has not been a change to the products that each company is offering in the market. Fallon has announced its intent to reduce the number of products offered in the merged market and will only concentrate on those products offered on the Health Connector that will also be available to individuals and small employers outside the Health Connector.

[22] BMCHP and Tufts Health Public Plans initially limited participation to the CommonwealthCare program and did not offer coverage in the merged market.

MA Individual Market Product Offerings by Distribution Channel – 2020

Insurer	Health Connector		Intermediary	Direct or from Broker
	ConnectorCare	Other		
AllWays	1	5	4	4
BMCHP	1	5	2	2
BCBS-MA	N/A	6	N/A	5
ConnectiCare	N/A	N/A	N/A	5
Fallon	1	13	14	14
Health NE	1	5	30	30
HPHC	N/A	5	5	34
Tufts Public Plans	1	7	9	9
Tufts Health Plan	N/A	5	4	4
United HealthCare	N/A	5	N/A	5
Total	**5**	**56**	**68**	**112**

Figure 5: Products Offered to Individuals by Distribution Channel
Sources: Health Connector, HSA Insurance, Carrier Marketing Materials

Under state law, all products must be "made available" to all eligible small groups and eligible individuals, but the law does not require carriers to market all products to all market segments. A bill filed by Governor Baker would require that carriers openly market all products to all equally, and present all products on carrier websites.[23] Even though each market generally has an adequate number of carriers and products available, if the Governor's proposal were enacted, it would further expand the number and types of products marketed and made available to all merged market members.

[23] An Act to Improve Health Care by Investing in Value, H.4134, 191st General Court of the Commonwealth of Massachusetts. (2019).

PART A: MERGED MARKET ANALYSIS

This section reviews:

- *An actuarial analysis of the merged market to understand and quantify risk profiles, claims costs, and factors impacting the cost of coverage*
- *An assessment of non-merged market coverage options existing today and their impact on the merged market*
- *A review of existing policies (such as risk adjustment and the federal Section 1332 State Innovation Waiver) that present challenges and opportunities for market stability*

Merged Market Actuarial Analysis

The actuarial analysis consisted of two phases. The first phase focused on baseline analytics and the second phase included modeling various policy options. For the first phase, Gorman Actuarial, "GA", examined the composition of the merged market to better understand and quantify the relative risk profile and claims costs of the market, including a review of subpopulations within the market and factors that affect the cost of coverage. These subpopulations include the following:

- ConnectorCare members, consisting of individuals with family income up to 300% of the federal poverty level (FPL) who obtain subsidized health insurance through the Health Connector;
- Non-ConnectorCare individuals who obtain unsubsidized coverage through the Health Connector or directly from a health insurance carrier; and
- Employees and dependents of small employers who obtain coverage through the Health Connector or directly from a health insurance carrier.

Using data provided by the federal government to the insurers, the analysis also included an assessment of the relative risk profile of the subpopulations. Unfortunately, data was not available to align exactly with the three subpopulations. Instead, data was summarized into three groups and inferences were made about the three subpopulations. These three groups are:

- ConnectorCare Insurers Individual Market: Individual market enrollees of health insurers who participate in the ConnectorCare market. Approximately 70% of this population is enrolled in ConnectorCare. An analysis of this group led to observations and conclusions about ConnectorCare members.
- Non-ConnectorCare Insurers Individual Market: 100% of this population do not receive state premium subsidies, although federal APTC premium subsidies for individuals above 300% FPL are available. An analysis of this group led to observations and conclusions about all Non-ConnectorCare individuals

- Small group market: Employees and dependents that obtain health insurance through an employer with 50 or fewer employees. An analysis of this group led to observations and conclusions about the small group market.

Trends and Dynamics of the Merged Market Risk Pool

Provider Networks and Purchasing Patterns

The Health Connector offers an array of Qualified Health Plans, "QHPs", on its product shelf that represents a subset of products available to individuals and small employers outside the Health Connector. Although the Health Connector makes available a range of products,[24] the majority of persons covered through the Health Connector receive premium and cost-sharing subsidies (i.e., enrolled in ConnectorCare), and most ConnectorCare members are enrolled in products offered by Tufts Health Public Plans, "THPP", and Boston Medical Center HealthNet Plan, "BMCHP".

These carriers offer the lowest-priced products in the market for three main reasons: their provider networks exclude the state's highest-paid health care systems; their provider contracting strategies and reimbursement levels are generally lower than other carriers in the market for the same providers; and members covered by THPP and BMCHP are lower utilizers of health care services than members covered by other carriers.

There are two distinct types of carriers in the merged market: those that only offer limited network HMOs and those that offer products that include a broad provider network.[25] Carriers that exclusively use a limited provider network, BMCHP and THPP, offer HMO plans with the lowest premiums in the market. As shown below, premiums for insurers with a broader network are approximately 50% higher than premiums for insurers with limited networks. While enrollment in these plans is increasing in the individual market, with approximately 40% of the unsubsidized individual market enrolled in BMCHP and THPP, the take-up is considerably less in the small group market, with only 3% of the market enrolled in products offered by these two carriers. As stated earlier, employers offer health insurance benefits to attract and retain their employees. Carrier brand and network access are highly regarded in these decisions. There may be a variety of reasons for this behavior, such as employers not wanting employees to have limited options of providers.

[24] Carriers with over 5,000 lives in the Massachusetts merged market are required to bid to participate on the Health Connector.

[25] State law (Section 11 of M.G.L. c. 176J) requires merged market carriers with at least 5,000 covered lives to offer a limited or tiered network product with premiums that are at least 14% lower than a comparable broad network plan. (https://malegislature.gov/Laws/GeneralLaws/PartI/TitleXXII/Chapter176J/Section11). However, only BMCHP and THPP offer limited network plans exclusively and do not offer broad network products or products that allow individuals to obtain services outside of the provider network (i.e., PPO products).

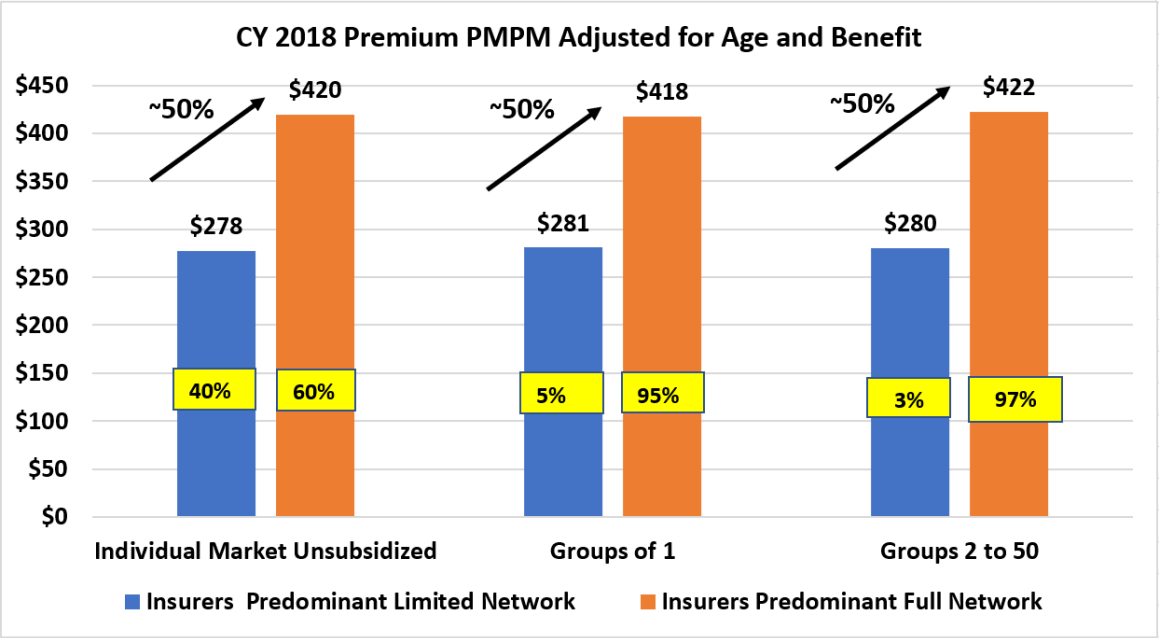


Figure 9: 2018 Premium PMPM[26]
Source: CHIA 2019 Annual Report

As illustrated in the chart below, the 2018 merged market allowed claims[27] per member per month, "PMPM", for BMCHP and THPP were substantially lower than the allowed claims PMPM for carriers in the market that includes both high and low-cost providers in their networks.

[26] CY Premium PMPMs were adjusted for average age factor and benefit differences using actuarial accepted methodologies. The premium was not adjusted for differences in renewal distribution.

[27] Reimbursement amount allowed under the carriers' contracts with providers.

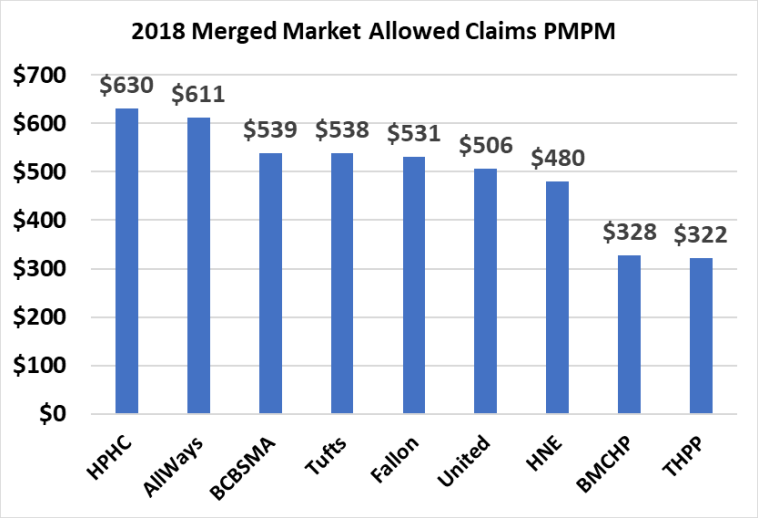


Figure 9: 2018 Allowed Claims PMPM
Source: CHIA 2019 Annual Report Coverage Dataset

The variation in allowed claims PMPM is more pronounced for individual market members as seen in the charts below, where the average allowed claims PMPM for non-ConnectorCare broad network carriers is over $500 per person more than the average allowed claims PMPM for the limited network carriers.

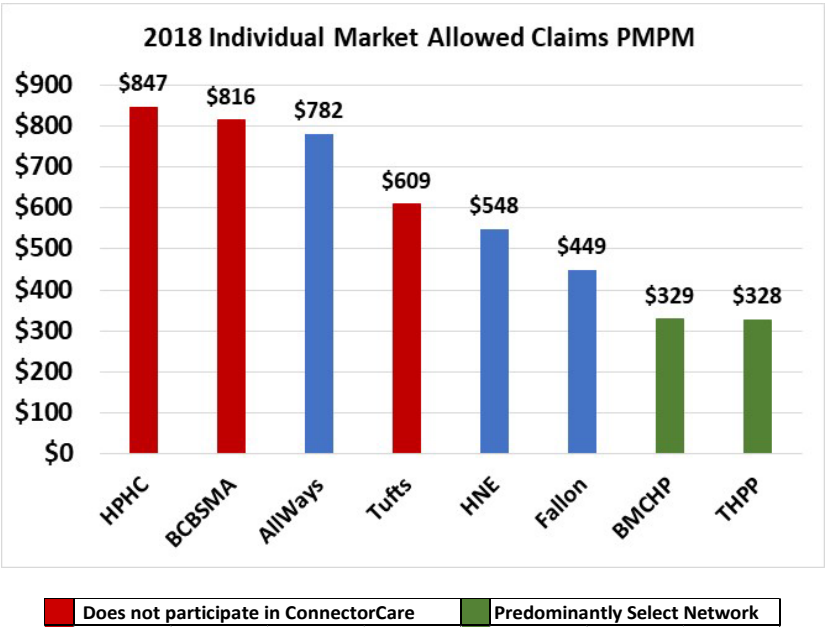


Figure 10: 2018 Individual Market Allowed Claims PMPM
Source: CHIA 2019 Annual Report Coverage Dataset

This variation in average allowed claims PMPM between limited network HMOs and broad network HMOs also exists in the small group market, but the variation is less pronounced. In addition, as noted previously, small group market membership in limited network products is significantly lower than individual market membership. Approximately 96% of small group members are enrolled in broad network products.

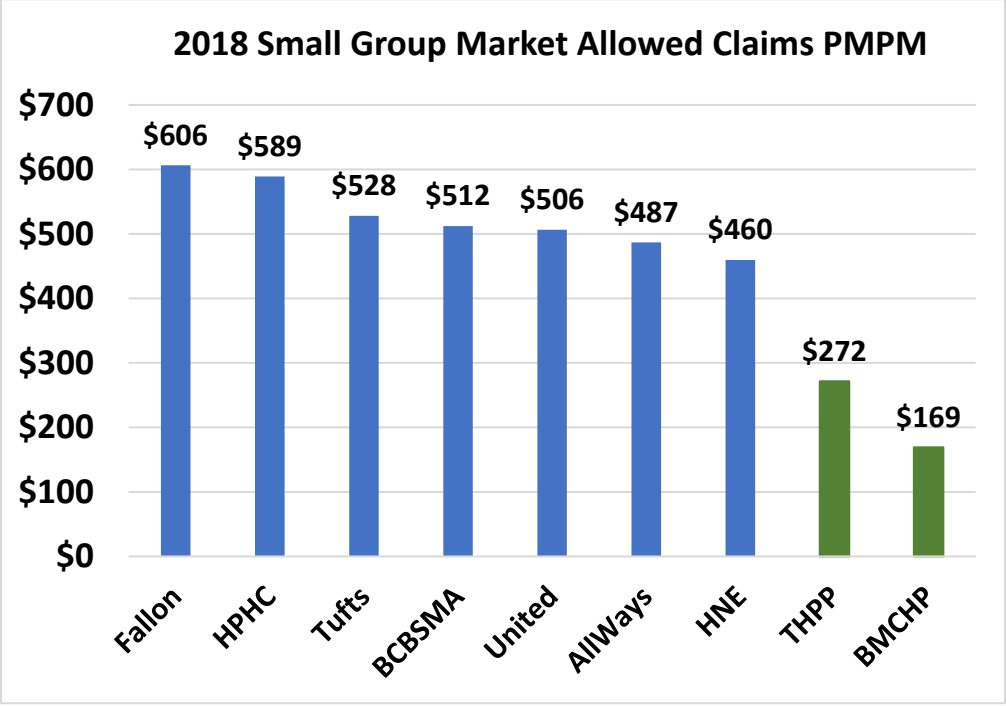


Figure 11: 2018 Small Group Market Allowed Claims PMPM
Source: CHIA 2019 Annual Report Coverage Dataset[28]

It stands to reason that employee retention and flexibility may be key reasons that many employers do not generally choose limited network products. Eight years ago, small business health insurance cooperatives began offering their members defined contribution options, providing each small business multiple options for their employees to select based upon their own family circumstances and provider preferences. Given the freedom of choice, more employees will choose the plan that best suits their families based on both cost and provider availability needs. The Health Connector established Health Connector for Business in 2018, which allows all small employers in

[28] BMCHP has very little small group membership and therefore the allowed claims reported do not represent an actuarially-credible population.

Massachusetts to offer their employees the ability to choose a plan from all of the market's carriers with a 15% discount on premiums through wellness incentives.

In both the individual and small group submarkets, the utilization of health care services and average allowed claims costs are appreciably lower for limited network HMOs. The premiums that these limited network plans charge are significantly lower than those charged for broad network products and are primarily driven by the exclusion of higher-cost health systems from their networks, lower provider reimbursement rates and innovative contracting strategies for the same providers, lower health care utilization by covered members, and lower administrative fees.

Individuals eligible for subsidized coverage on the Health Connector predominantly buy limited network HMO products from THPP and BMCHP. The chart below shows that most ConnectorCare[29] members who receive state and federal subsidies choose THPP and BMCHP. Individuals between 300% FPL and 400% FPL, who may be eligible for federal, but not state, subsidies, demonstrate similar shopping behavior.

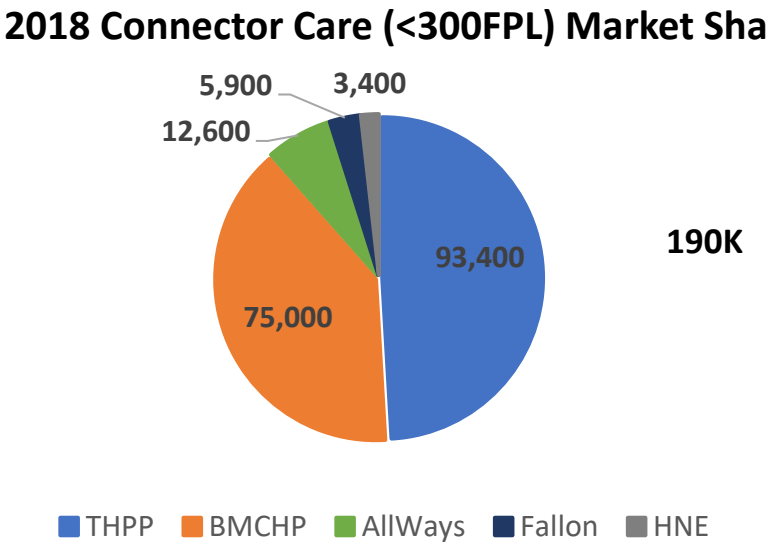


Figure 12: 2018 Average ConnectorCare Membership
Source: CHIA 2019 Annual Report Coverage Dataset

Unsubsidized individuals and small employers are less likely to purchase limited network HMOs than the ConnectorCare population. 89% of ConnectorCare members are enrolled in limited network HMO plans, while 40% of unsubsidized individuals and only 4% of small group members

[29] Households with income at 300% of FPL or lower may be eligible for the Health Connector's ConnectorCare program. FPL also determines eligibility for a household's ConnectorCare "Plan Type". Through state and federal subsidies, ConnectorCare guarantees eligible individuals monthly premiums as low as: $0 per month for Plan Type 1 and 2A, $46 per month for Plan Type 2B, $89 per month for Plan Type 3A, and $133 per month for Plan Type 3B.

are enrolled in limited network HMO plans.[30] The exact reasons that unsubsidized individuals and small employers are not purchasing limited network HMO products is unclear, but could include buyer preference for a broader network with more choice for employers and employees offering plans with a broader network to be more competitive in the job market, the need to maintain continuity of care with certain providers only available in a broader network, availability of network providers within a certain geographical area or lack of awareness or understanding regarding limited network HMO products with lower premiums. While choosing limited or tiered network products could result in savings, enrollees would require significant education regarding how these products impact provider access. In most cases, these consumers are buying broad HMO network products that are associated with higher premiums rather than limited network HMO products even though these limited network products may be suited to their particular needs.

While unsubsidized individuals are generally more likely to purchase broad network HMO products, unsubsidized individuals who purchase coverage on-Exchange through the Health Connector are more likely to purchase a limited network HMO plan than unsubsidized individuals purchasing coverage outside of the Health Connector as the Connector displays a broad selection of standardized plans.[31]

This trend is also true for small groups. Small groups purchasing coverage through Health Connector for Business are far more likely to choose a limited network HMO product compared to small groups shopping off-Exchange (See Appendix C for additional membership breakdown by sub-market). The defined contribution model employed by the Health Connector is not offered by carriers in the market off-Health Connector where carrier rules limit small groups to one carrier choice and in most cases, just one plan design for all employees.

Utilization Rates and Risk Profiles

Using the three submarkets noted above (ConnectorCare individuals, non-ConnectorCare individuals, and small groups), GA stratified these submarkets based on health care claims incurred by members in 2018. Five categories of members based on allowed claims were identified: (1) members with no claims reported; (2) claims up to $5,000: (3) claims between $5,001 and $50,000; (4) claims between $50,001 and $250,000; and (5) claims exceeding $250,000.

The ConnectorCare submarket had the lowest proportion of members, 12%, with claims over $5,000 while the percentages for small employers and non-ConnectorCare individuals were 16% and 18%, respectively. Approximately 23% of persons covered through the ConnectorCare program did not have any medical claims in 2018, compared to 14% of small employers' members and 19%

[30] CHIA 2019 Annual Report Coverage Dataset; THPP and BMCHP considered limited network HMOs although Fallon Community Care and Direct Care are also limited network products but not included due to membership size.

[31] The Health Connector promotes all of its products – limited-network and full-network – equally on its product shelves. Off-Health Connector, carriers are required to make all products available, but may not market every product equally so that individuals may not be aware of lower-cost limited network options.

of non-ConnectorCare individuals. It is unclear whether these trends are due to ConnectorCare being a healthier population, Connector Care individuals are utilizing lower-cost providers, whether providers are agreeing to reduced reimbursement when treating ConnectorCare individuals or whether it indicates that the ConnectorCare population is not accessing health care services for other reasons.

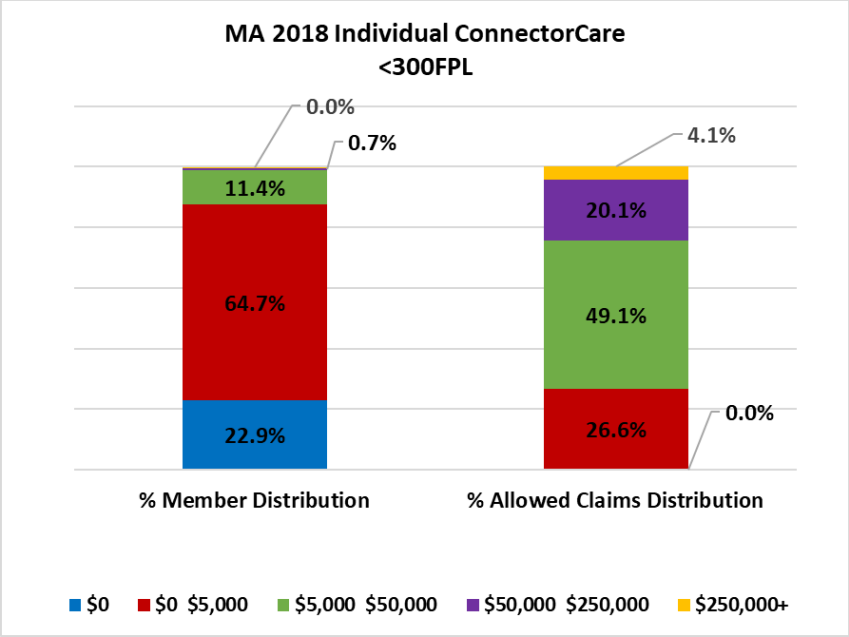


Figure 18: Distribution of Allowed Claims for ConnectorCare Members
Source: Data provided by insurers through DOI special examination and analyzed by Gorman Actuarial

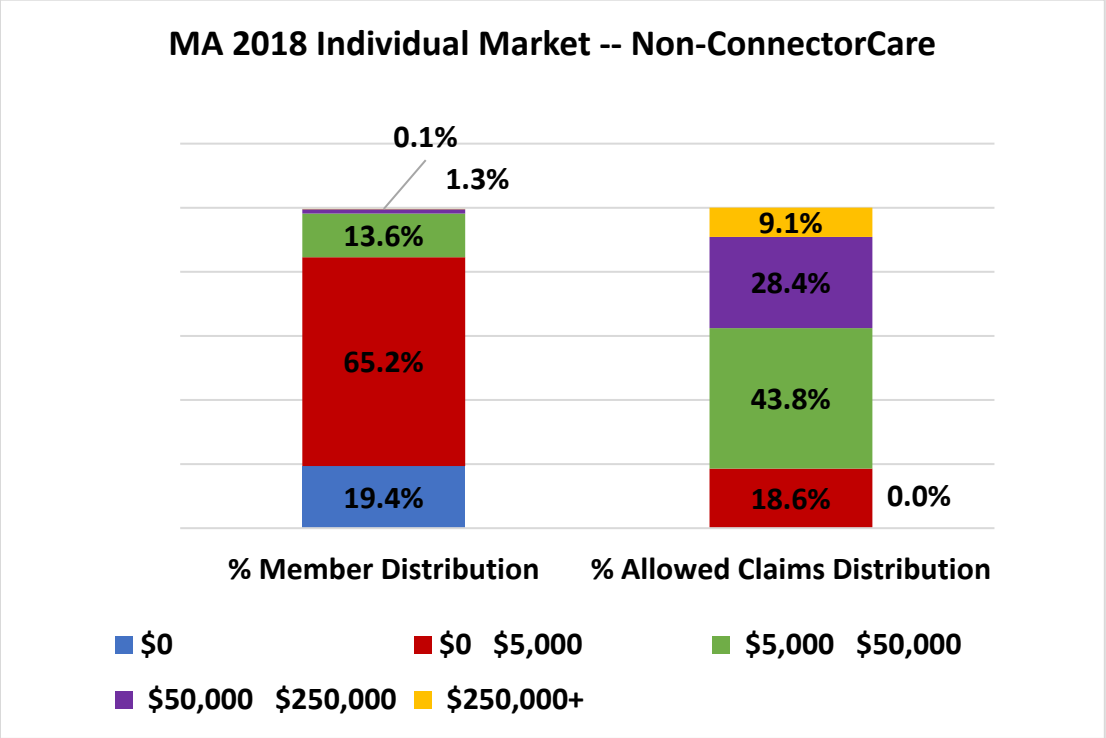


Figure 19: Distribution of Allowed Claims for Non-ConnectorCare Members
Source: Data provided by insurers through DOI special examination and analyzed by Gorman Actuarial

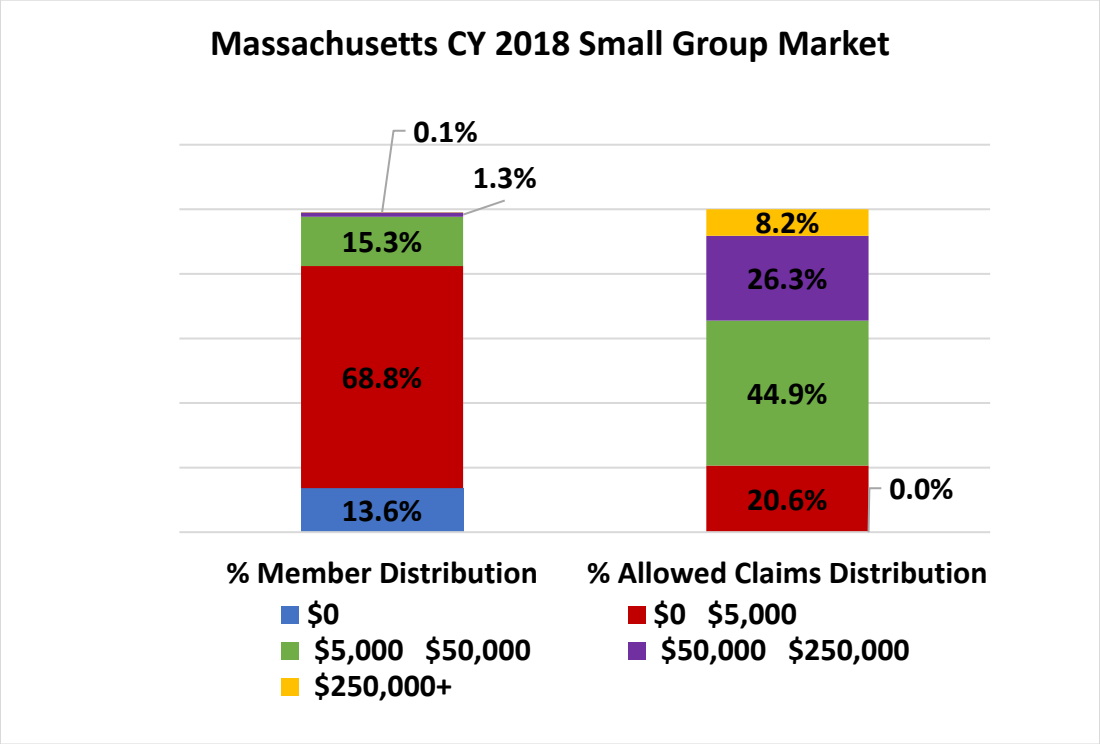


Figure 20: Distribution of Allowed Claims for Small Group Market Members
Source: Data provided by insurers through DOI special examination and analyzed by Gorman Actuarial

GA examined the underlying health of the submarkets to determine their relative health risk. Using risk adjustment reports provided by CMS, GA aggregated risk scores across insurers. As shown below, the risk score for carriers who concentrate on the ConnectorCare market[32] is comparable to the risk score for small groups. The risk scores for non-ConnectorCare individual market members were over 30% higher than the risk scores for ConnectorCare members and small employers. Coupled with the allowed claims PMPM analysis shown in Figures 9 through 11, these findings suggest that the highest utilizers, those with the highest risk scores and who tend to use the higher-paid providers, are individuals purchasing coverage from non-ConnectorCare carriers.

[32] ConnectorCare carriers include AllWays Health Partners, BMC HealthNet Plan, Fallon Community Health Plan, Health New England, and Tufts Health Public Plans. 72% of these insurers' individual market members are covered through the ConnectorCare program.

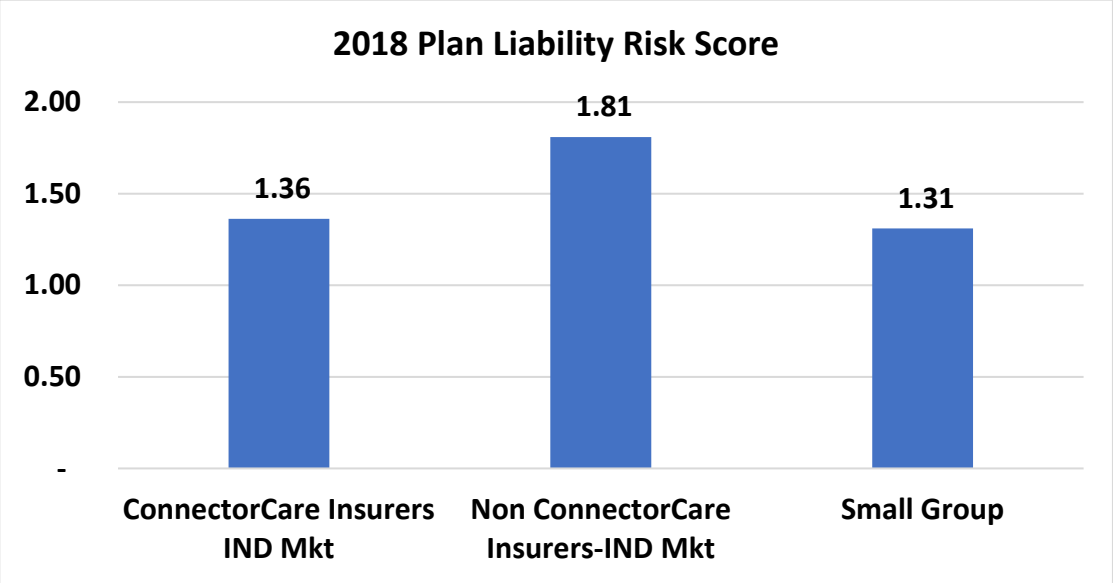


Figure 21: 2018 Plan Liability Risk Score for Merged Market Submarkets
Source: 2018 Federal risk adjustment reports.

Key Takeaways from Merged Market Actuarial Analysis

Premiums charged by carriers that only offer limited network HMO plans are significantly lower than premiums for carriers that utilize broad provider networks, where access is the trade-off for price. If unsubsidized individuals, groups of one, or groups of 2 to 50 chose a limited network product, there could be significant premium savings for members and employers. This is another example of the need for greater efforts to improve consumer literacy in regard to health care and health coverage.

Two carriers, BMCHP and THPP, that do not include higher-paid health care systems in their provider networks currently have average allowed claims PMPM that are significantly lower than the average allowed claims PMPM of all other carriers in the merged market.

89% of ConnectorCare members are enrolled in limited network HMO plans, while 40% of unsubsidized individuals and 4% of small group members are enrolled in limited network HMO plans.[33] As stated earlier, employers offer health insurance benefits to attract and retain their employees. Carrier brand and network access are highly regarded in those decisions.

[33] CHIA 2019 Annual Report Coverage Dataset; THPP and BMCHP considered limited network HMOs although Fallon Community Care and Direct Care are also limited network products but not included due to membership size.

- Based on 2018 data, risk scores for individual market non-ConnectorCare insurers are over 30% higher than the risk scores for individual market ConnectorCare insurers and small employers.

- The highest utilizers with the highest risk scores are individuals purchasing coverage from non-ConnectorCare insurers.

Impact of Non-Merged Market Coverage Options on the Merged Market

Massachusetts created a guarantee-issue merged market so that the only insured products offered to eligible individuals and small employers would be guarantee-issue (i.e., available to all), comply with rating rules such as modified community rating, and include consumer protections, all of which are codified in M.G.L. c. 176J and further defined through DOI regulations and bulletins. The merged market rules also require insurers to establish a single risk pool, which forms the basis on which premiums are set.

Recently, several alternative coverage arrangements have emerged that could impact the merged market's single risk pool. These new options have created a pathway for employers, and individuals, to move away from the guarantee-issue market. Conversely, some have expressed support for new options to be available on the market to increase competition and offer individuals and small businesses additional coverage options.

The Council explored the types of alternative individual and group products that exist outside of the merged market today and their effect on the market. Part of this exploration included hearing directly from several non-merged market product industry representatives.

Individual Options

Limited Benefit Products

While traditional health insurance products pay for the costs of covered health treatment expenses, limited benefit products offer supplemental benefits in the event an insured is hospitalized or suffers from a specified critical illness (e.g., cancer, accident, hospital indemnity insurance). These products provide a fixed payment to the “insured” per day or a lump sum to pay for incidental costs such as copayments or travel expenses. Carriers are required to make consumers aware that these products do not meet traditional health insurance standards, but consumers have been confused by websites and marketing tools that promote "affordable health coverage" options. Additionally, these products do not satisfy Massachusetts’ mandate for minimum creditable coverage, “MCC”.

Discount Plans

Although more prevalent for dental or prescription drug benefits, certain organizations market "medical" discount plans, which represent that members can receive discounts off charges by paying a monthly fee and receiving services from plan providers. These arrangements are not insurance products and do not directly pay any providers for health care services. Furthermore, these products do not satisfy Massachusetts' mandate for MCC.

Individual Coverage Health Reimbursement Arrangements (ICHRAs)

Recent tax rules created new ways that employers can contribute into financial accounts that can be used by employees to pay for individual health coverage. ICHRAs permit employees that purchase individual health coverage to submit a request for reimbursement for the cost of health insurance premiums, and the reimbursement from the employer is not counted as income for tax purposes, thereby lowering the effective cost of health insurance for the individual.

If an employer that had not previously provided group health insurance makes an ICHRA available, these arrangements could expand the number of people covered in the merged market. In some cases, for example, for an employer that has never offered the benefit to part-time workers, this approach could increase the number of lives covered in the individual market further spreading the risk and lowering premiums. In other cases, where an employer that previously provided a group health plan switches to an ICHRA, it could reduce the number covered if some of those covered under the employer plan decline to purchase an individual health policy and this could increase the risk pool's collective morbidity with impacts on premiums for those remaining in the merged market.

Health Sharing Ministry Plans

Health sharing ministry plans are non-insurance programs originally developed for members of certain religious groups in which members agree to collectively pay for each other's health treatment costs. Unlike insurance arrangements where monthly premiums are forwarded to an insurance company, health sharing ministry members contribute regular fees to the sharing ministry and make special contributions when the sharing ministry identifies health needs of members. There is no guarantee that a member's medical costs will be covered by the arrangement, and certain services (e.g., substance abuse, family planning) are often not eligible for reimbursement. Although the Health Connector recently revised its MCC regulations (which set standards for coverage that can be used to satisfy the state's individual mandate) to add new requirements for these types of plans to be deemed to satisfy basic coverage requirements, consumers will need education to clearly understand how the products work.

Impact on the Merged Market

For many of these options, plan sponsors are required to make consumers aware that these products do not meet traditional health insurance standards, but consumers have been confused by some websites and by some marketing tools that promote affordable health coverage options. At present, because our health plan benefits are comprehensive, there is a limited market for any of these products in Massachusetts, and they do not currently draw significant numbers of persons from the merged market. It will be important to monitor market conditions actively to be aware of any changing enrollment trends.

Group Options

Self-funded plans for small employers

In a partially self-funded arrangement, an employer (i.e., plan sponsor) is responsible for paying the cost of claims, administration and reinsurance, excluding member cost-sharing. In many cases, the plan sponsor contracts with an insurance carrier or Third-Party Administrator, “TPA”, under an administrative services only, “ASO”, arrangement to administer the benefits, adjudicate claims, contract with a provider network, and provide member services.

When employers elect to partially self-fund employee health benefits, they mitigate the risk of paying for all claims, including catastrophic health claims through the use of reinsurance. Many large employers may choose to self-fund so that their health premiums are based on their own health claim costs. These employers can choose the benefits to offer their employees, manage their claims, invest in the wellness of their members, incentivize employees to take certain wellness steps and save money on administrative costs. These large employers spread the risk of catastrophic claims across all of their employees, and the number of employees and dependents covered under the employer's plan is large enough to effectively spread the cost of these high-cost claims. However, many employers that self-fund their health insurance purchase stop-loss coverage or reinsurance from an insurer to pay for the cost of individual or aggregate claims that exceed a certain threshold.

Since federal ERISA provisions do not require an employer to be of a certain size to self-fund health benefits, certain organizations are marketing products to small employers to administer self-funded plans combined with the purchase of stop-loss coverage. Under these arrangements, small employers need to be aware of the potential downside exposure they may face for costs not covered under their stop-loss policy. Consumer protections and required benefits associated with the merged market may not be present in self-insurance arrangements. In addition, if a small group experiences medical claims that exceed expectations or a member is diagnosed with a high-cost condition, the self-funding stop-loss arrangement may no longer be financially viable. At that point, the group may choose to return to the merged market, with its guarantee-issue, community rating, and consumer protections. This cycle of individuals and groups coming back to the merged market

only when they have material and costly health care needs could result in increasing costs in the merged market.

Association Health Plans (AHPs) and Multiple Employer Welfare Arrangements (MEWAs)

Prior to 1996, Massachusetts law exempted AHPs from the requirements of the small group market. This blanket exemption was statutorily removed in 1996. AHPs that include small employers are required to comply with the state's small group market rules, except for the Massachusetts Bankers Association who were granted an exemption under a different law.[34] When ACA rules were initially developed, they paralleled Massachusetts requirements that coverage offered to small employers who were part of associations or a MEWA was subject to guarantee-issue, community rating, and all other small group rating rules.

Subsequent federal guidance issued in 2018 broadly defined the term employer to include the bonafide associations to which small employers may belong. With this change, some associations whose aggregate employer members covered more than 50 employees could qualify to buy large group products outside the rules of the merged market. Despite the federal change, existing state law is not in alignment with the bonafide association rules and requires that Massachusetts small groups that are part of an AHP obtain coverage and establish rates pursuant to Massachusetts merged market rating and benefits rules. Federal rules deferred to state standards where state rules were more stringent and Massachusetts retains the option to change its rules. Key parts of the 2018 AHP rule were vacated by a federal court in 2019,[35] and are currently under review by the new administration.[36]

Professional Employer Organizations

When small employers contract with Professional Employer Organizations, “PEO”, the employer and the PEO agree to co-employ staff. The PEO handles certain human resource functions, and coordinates employee health benefit plans on behalf of participating employers. Because PEOs contract for health benefits across all employers, carriers have offered the PEOs large group products that are not subject to the rules of the merged market but are subject to other insurance rules. If the PEO is headquartered and purchases coverage from an insurer domiciled in another state, the co-employed employees’ coverage is not subject to Massachusetts regulations, only the ACA and state regulations where the PEO is headquartered.

[34] See Section 78 of Chapter 153 of the Acts of 1992.

[35] Court Invalidates Rule on Association Health Plans | Health Affairs, March 29, 2019.

[36] Executive Order on Strengthening Medicaid and the Affordable Care Act | The White House, January 28, 2021.

Impact on the Merged Market

Alternative group options have become more prevalent as options for some small employers in other states, [37] but a limited number of small employers have accessed these options in Massachusetts. Some other states, such as Maine and Rhode Island, promulgated regulations in order to limit enrollment in any alternatives outside their states' markets. While there are considerable cost challenges for small businesses and their workforce, most continue to rely on the coverage options available in the merged market.

Analysis of Potentially Demerging the Nongroup and Small Group Markets

Prior to the merger of the individual and small employer markets in 2007, there were 66,000 persons covered in the individual market and 700,000 persons covered in the small group market. In December 2006, GA estimated that merging these markets would decrease average individual health care premiums by 15% and increase average small employer premiums by 1 to 1.5%.[38] Since 2007, only Vermont and the District of Columbia have elected to merge their individual and small group rating pools.

The 2006 estimates were based on rating rules in effect at the time, one of which, group size adjustment factor, allowed insurers to surcharge "groups of one" as much as ~15%. That is, for the same health plan, premiums charged to individuals could be 15% higher than premiums charged to small groups. This group size adjustment factor, which was an integral element of the merger of the nongroup and small group markets, is preempted by federal ACA rules and is currently being phased out.[39]

In 2019, there were 338,000 individuals and 411,000 small group members in the merged market. As previously noted, the number of small employer members has steadily declined at the same time the number of individuals has increased.

While there are governmental funds to subsidize the health coverage of certain individuals, and to a less extent small employer premiums, many employers, particularly in a difficult economy, are looking for more affordable options. Some MMAC members questioned whether the state should re-establish separate risk pools for individuals (subsidized and unsubsidized) and small employers

---

[37] https://www.commonwealthfund.org/publications/issue-briefs/2018/oct/health-small-group-insurance-market; and https://www.commonwealthfund.org/blog/2020/countering-threats-small-business-health-insurance-market.

[38] In a follow-up study conducted by Oliver Wyman Actuarial Consulting in August 2010 – "Analysis of Individual Health Coverage in Massachusetts Before and After the July 1, 2007 Merger of the Small Group and Nongroup Health Insurance Markets", consultants calculated that average small group premiums increased by 2.6% because of the merger with the nongroup market.

[39] The group size adjustment partially reflected the differential administrative costs of medium size groups compared to those of groups of one and individuals. One member expressed that the elimination of this factor is detrimental to small groups within a merged market.

(i.e., demerge the market). Some noted this may be worth pursuing with a reinsurance program to hold the individual market harmless.

GA performed a comprehensive review of the elements of the merged market, analyzing the characteristics of the risk pools, claims payments, risk adjustment transfers, and the requirement that under separate rating pools the ACA requires self-employed individuals to obtain coverage in the individual market.

Based on this analysis, GA found that, on average, outside of health care trend, there would be a one-time increase of 4 to 6% in average individual market rates and a one-time decrease of 2 to4% in small group market rates[40]. While the analysis found average rates would increase 4 to 6% in the individual market and decrease 2 to 4% in the small group market, the impact to each carrier would vary.

This would not mean that overall rates would increase or decrease by these amounts, but that rates would be reset going forward. For example, if health cost trends are 8%, the individual market would experience a 12% to 14% rate increase and the small group market would experience a 4% to 6% rate increase.

GA also modeled the impact of applying separate risk adjustment programs to each market segment. The results indicate that demerging the markets would significantly widen the distributions within the individual market. Payments from insurers that are payers in the merged market would increase significantly and receipts for insurers that are recipients will increase.

GA further analyzed whether federal or state reinsurance funds would be more effective under a demerged or merged market. The state or some other funding source would need to provide $94 million annually to eliminate the projected increase of 4 to 6% in individual market rates under a demerged market. As noted above, GA estimated that federal funding was uncertain and the $94 million would likely need to be provided primarily through state revenues or some other funding source.

If the state wished to raise the $94 million annually that GA estimated in the previous paragraph, GA estimated that $10 million to $24 million of federal funding may be available through a Section 1332 Waiver pass-through. However, the state would still need to annually invest $70 million to $84 million to fund the reinsurance program. This combined funding would reduce premiums in the first year of the program for individuals and small group enrollees in the merged market by an average 2 to 3%.

It was GA's professional opinion that, under a demerged market, there may be fewer health plan options available in each of the markets as carriers restructured their plan portfolios for each

[40] Even though this would be a one-time demerger change, it should be noted that the base premium would be adjusted. This is not expected to impact future premium increases due to cost trends, but since the base would be changed, this would have a "compounding" impact on future premiums.

market segment. Other market disruptions could also occur, such as insurers choosing to participate in one or the other market, but not both.

Discussion

During the meetings, questions were raised by some Council members about why small businesses should be subsidizing the cost of some of the individual market's health costs. The actuarial analysis only looked at the average premium impact to individuals and small employers if there was a demerger, and how small groups and/or nongroup enrollees' experiences would vary. The question of "why" is one for policymakers to consider based on the data provided by this Council and whether changes to the merged market call for a re-consideration.

Despite the growth in the number of individual members in the merged market relative to the number of small employer members, demerging the markets offers a one-time reduction in premiums that would impact the level of future premiums. This is due to the costs of the highest risk individuals within the individual market being subsidized by both the small group market and a large portion of the ConnectorCare individual market. This has been highlighted through claims costs analyses, risk score analysis, and risk adjustment payments and receipts.

GA's analyses highlighted that under a merged market, if the state wishes to pursue modified risk adjustment distributions, like New York has) the small group market will be negatively impacted. This is due to the fact that BCBS of Massachusetts and HPHC, which cover a majority of the small group market, are presently receivers of risk adjustment funds, meaning their premiums are lower than they would otherwise be absent full risk adjustment transfers.

MMAC members acknowledged that individuals and small employers have access to the full complement of products and if the markets were demerged, there could be a reduction in available options if carriers were allowed to choose to be in only one of the resulting markets. It was noted that limited network HMO products are currently available but the take-up rate among small employers is fairly limited. If products such as these were no longer available for small employers following a demerger, it could reduce the number of available product options, particularly lower-cost ones, for small employers.

Some Council members have pointed out that federal policy is undergoing significant changes as of the drafting of this report. Recent developments like the temporary expansion of premium subsidies for the individual market may, if made permanent, warrant additional consideration as Massachusetts continues to evaluate the most logical market structure going forward.

Existing Policies that Create Challenges and Opportunities for Market Stability

Federal Risk Transfer Programs

The ACA required CMS to develop and implement three risk mitigation programs designed to protect insurers that enroll higher than average risk: Reinsurance, Risk Corridors, and Risk Adjustment. These programs were established to ease the transition for insurers in individual and small group markets that, prior to enactment of the ACA, were permitted to deny coverage or increase rates charged to applicants with pre-existing conditions. Pursuant to the ACA, individual and small group markets are guarantee-issue and rating rules prohibit insurers from medically underwriting or charging higher premiums to enrollees based on their health status or denying coverage to enrollees with pre-existing conditions.[41]

Two programs – Reinsurance and Risk Corridors – were temporary. Under these programs, federal funds were provided to carriers that experienced higher than expected claims costs. Both programs were in effect from CY 2014 through CY 2016.

The third, Risk Adjustment, is a permanent program that redistributes moneys from carriers whose members have lower than average health care utilization to carriers whose members have higher than average health care utilization. For each state, this is a zero-sum transfer between carriers, with no federal or state funding. CMS uses historical utilization of health care services to estimate the health risk profile of each carrier, relative to the overall health risk profile of the market in each state. The goal of the program is to discourage carriers from “cherry-picking” or avoiding enrollees with certain health conditions or higher health care needs, as well as compensating carriers whose enrollees are higher-risk or higher-cost than the market average.

CMS collects data from carriers on their claims experience in a calendar year to calculate risk scores for each carrier in a given state market and determine financial transfers from carriers with lower than average risk profiles to carriers with higher than average risk profiles based on the prior year's claims experience in each state market. These transfers are typically finalized in July of the following year, so that transfers applicable to calendar year 2019 are finalized in July 2020. Although the risk adjustment model used by CMS is subject to public review, the risk score for any one carrier is difficult to predict because carriers are not aware of any other carriers’ claims experience, and risk adjustment is based on each carrier’s claims experience compared to the market-wide average.

The program is intended to allocate monies among carriers based on the relative risk of persons enrolled. As noted in the following table, there has been significant volatility in payments from one year to the next. In 2017, Massachusetts transitioned from a state-run Risk Adjustment program to

[41] As noted earlier, Massachusetts established a guarantee-issue individual and small group market in the 1990s and medical underwriting is not permitted.

the federal Risk Adjustment program. This change in methodology likely impacted the transfer of payments among carriers.

Risk Adjustment Transfers - PY 2014 - PY 2019						
Carrier	PY 2019[1]	PY 2018[2]	PY 2017[2]	PY 2016[3]	PY 2015[3]	PY 2014[4]
AllWays	$50,979,924	$55,007,378	$56,321,259	$54,771,043	$5,353,042	($27,858,047)
BCBSMA	$47,533,655	$12,500,608	$4,057,603	$33,826,090	$81,741,193	$50,714,401
BMC	($16,745,783)	($37,948,809)	($35,993,129)	($18,139,498)	($18,620,484)	($5,152,402)
Celticare		$0	$199,701	($1,880,633)	($2,366,108)	($481,601)
Connecticare	$552,385	$527,550	$664,697	($306,568)	($249,965)	($1,246,444)
Fallon	$4,089,551	$1,236,839	$4,440,346	$369,941	($3,890,227)	($11,107,357)
Health NE	($4,341,170)	($3,348,914)	($423,603)	($6,552,130)	($3,206,399)	($2,692,451)
Harvard Pilgrim	$18,011,718	$33,116,998	$28,012,262	($16,497,354)	($10,852,737)	($2,182,465)
Minuteman		$0	($10,888,138)	($9,619,224)	($5,976,150)	($2,857,045)
Tufts	($1,498,533)	$5,187,094	$16,623,471	$21,203,852	($1,277,729)	$8,201,309
Tufts Public	($89,438,269)	($62,005,322)	($61,974,969)	($55,423,070)	($39,440,273)	($3,696,957)
United	($9,143,478)	($4,273,421)	($1,115,078)	($1,752,449)	($1,214,162)	($1,640,940)

Notes:
1 - From CMS Report released July 2020
2 - From Carriers' TPIR Reports for PY 2017 and PY 2018 (Celticare and Minuteman info pulled from CMS RA report for PY 2017)
3 - From Funds Transfer Summary Reports for Non-Catastrophic Plans
4 - Funds Transfer Summary - Reissued October 2015

Figure 25: Risk Adjustment Transfers
Sources: CMS and Health Connector

Some carriers have raised concerns about the federal Risk Adjustment program's methodology, the difficulty predicting transfer amounts, and the challenges in accurately accounting for risk adjustment transfers when developing premium rates. As a result, some carriers have argued for the need to build in conservatism in rate development to account for their receiving less in risk adjustment transfers than expected or paying more in risk adjustment transfers than expected. As shown in the graphic below, premiums are set two years in advance of the actual risk adjustment transfers. For example, at the time CY 2021 premiums are finalized (July / August of 2020) for coverage effective January 1, 2021, insurers only have risk adjustment results for CY 2019. Insurers will not receive risk adjustment results for 2021 until July 2022.

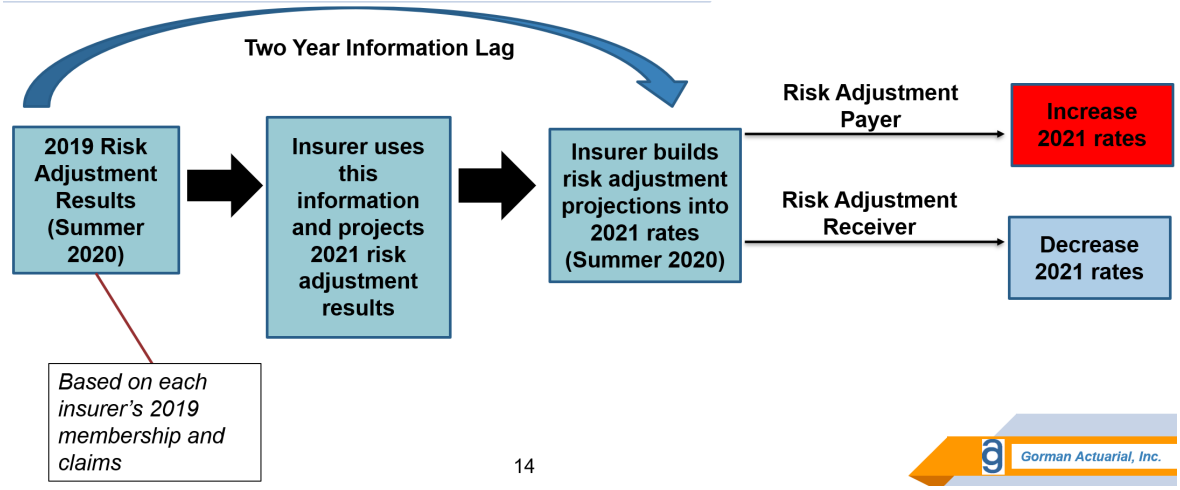


Figure 26: Risk Adjustment Timeline
Source: Gorman Actuarial

In order to address some states' concerns about the Risk Adjustment program, beginning in 2020, CMS provided states with an option to request a reduction in risk adjustment transfers of up to 50% in order to reduce the variability of payments and the impact that transfers can have on premiums. This is the only flexibility currently allowed in the risk adjustment transfer program. Only New York has pursued this option to date.[42]

Federal Innovation Waiver: Applying for Federal Funding Under Section 1332

Under the ACA, states are permitted to apply under a Section 1332 Waiver for flexibility in the administration of a specific subset of ACA rules to qualify for federal pass-through funds; however, the state's proposed changes must meet defined "guardrails" ensuring equal coverage, affordability, and consumer protections. In addition, state plans under a Section 1332 Waiver must not increase the federal deficit. States looking to implement such waivers establish state-specific programs and apply for federal funds that may be used to lower premiums. In recent years, many states have used Section 1332 Waivers to establish state-based reinsurance programs, using a state investment to lower premiums and then recouping the savings from the federal government in the form of lower ACA premium tax credit expenditures in the individual market to further invest in the reinsurance program, thereby further reducing premiums.

States that apply for such waivers need to develop a comprehensive application that demonstrates how a state's innovative strategies would save federal government payments towards premium tax

[42] The ACA allows states to establish a state-based risk adjustment program, subject to CMS review and approvals. From 2014 to 2016, Massachusetts operated a state-based risk adjustment program, but chose to terminate that program and join the federal risk adjustment program in 2017.

credits. If approved, these federal savings can then be used to support state programs that make coverage more affordable, increase the number of residents with health insurance, and do not compromise the quality of coverage.

GA presented information to the MMAC on actions other states have taken to implement or consider implementing a state reinsurance program to fund the expenses of high-cost medical claims and reduce premiums. The table in the appendix summarizes the state-based reinsurance programs currently approved by CMS.

Reinsurance is a risk transfer mechanism and can be administered “behind the scenes” so that it does not impact the consumer. Reinsurance programs can be designed using a prospective or retrospective model. Under a prospective reinsurance model, which Massachusetts had in place between 1996 and 2007, enrollees are identified as high risk prior to the start of the plan year and an insurance carrier cedes the high-risk individual to the reinsurance program. Recently, Alaska and Maine have established prospective reinsurance programs for their individual markets. The cost of health care services for individuals ceded to the reinsurance program is funded by state resources, federal Section 1332 funds, premiums charged to ceding carriers, and/or assessments on other carriers.

A retrospective reinsurance model identifies high-cost members after the plan year and carriers are reimbursed for all or a portion of medical expenses beyond a threshold amount (i.e., attachment point). Under both a prospective and retrospective model, reinsurance payments could be funded through a federal Section 1332 Waiver and state investments, such as an assessment on other carriers, individual mandate tax penalties, or state general funds.

GA and Health Connector staff analyzed applications submitted by other states and the parameters of the federal ACA Section 1332 Waiver program and found that federal funds for a reinsurance program in Massachusetts are likely to be limited. Further, if Massachusetts were to demerge its markets and then apply for a reinsurance waiver, there would likely not be funding available since it would increase, rather than decrease, federal expenditures via premium tax credits. Further, according to GA’s analysis, under a merged market scenario, if Massachusetts invested $70M to $84M annually into a reinsurance program, federal savings in the form of lower advance premium tax credits (APTC) would be between $10M and $24M. The combination of state and federal funds might then be used for a merged market reinsurance program. This merged market reinsurance program could result in an average 2% to 3% reduction in premiums in both the individual and small group market, with varied impact depending on the enrollee.

Funding from the federal government through a Section 1332 Waiver is based on the amount of federal APTC funds that are "saved" by reducing premiums for the second lowest-cost silver level plan. In Massachusetts, the second lowest-cost silver-level plan is among the lowest in the country, and therefore federal savings from the introduction of a reinsurance program would be relatively modest. As a result, federal funding through a Section 1332 Waiver would be lower than the amounts other states have been able to secure through their waivers.

PART B: POLICY OPTIONS

The MMAC looked to address both the underlying health care cost and trend issues driving premium rates as well as the insurance rules specific to the merged market.

This section reviews the policy options discussed by the MMAC to address:

- *The long-term stability of coverage for individual and small employers in the merged market*
- *The affordability of insured health benefit plan products offered in the merged market*

Splitting the Merged Market (Demerger)

Because the defining characteristic of the merged market is the combination of the individual and small group markets, the MMAC discussed the option of splitting the merged market into two separate risk pools – an individual market and a small group market. The data presented to the MMAC by GA made it clear that the merged market looks different today than it did when Chapter 58 of the Acts of 2006 was enacted, becoming the first state in the nation to combine the separate small employer and individual insurance markets into a single risk market.

Composition of the Market

While the overall membership in the merged market has remained relatively stable since the merger, the composition of the merged market has changed markedly. For example, in 2007, when the merged market reforms were originally put in place, there were approximately 46,000 individuals and 796,000 small group members.[43] Over time, the number of individuals in the merged market has increased, while the number of small group members has steadily declined. At the end of 2019, the merged market consisted of 339,000 individuals and 411,000 small group members. The addition of ConnectorCare members to the merged market in late 2014 caused the number of individuals in the merged market to grow significantly. Today, the merged market is approximately 45% individuals[44] and 55% members from small employer groups.[45]

There are a number of reasons for the decline in small group membership in the merged market, such as small employers seeking coverage outside of the state's merged market[46] or choosing not

[43] Aggregating the numbers, individuals represented a little more than 5% of the overall to-be-merged market and small group members presented a little less than 95% of the overall to-be-merged market. There was also a separate CommonwealthCare Program at the time that provided subsidies non-insurance coverage for income-eligible persons.

[44] Roughly two-thirds of the individuals in the merged market obtain federally subsidized health coverage through the Health Connector, and one-third of the individuals in the merged market pay the full premium for health insurance.

[45] The small group population includes self-employed individuals (i.e., groups of one), as well as employers with between two and fifty employees.

[46] Although the take-up appears limited at this time, the MMAC heard presentations within its meetings that certain small employers are obtaining coverage from Professional Employer Organizations or self-funding their employee health benefits and purchasing stop-loss coverage.

to offer health insurance through employer-sponsored plans for economic reasons. The rising cost of health insurance likely contributes to small employers exploring coverage options outside the merged market.[47,48] Between 2016 and 2018, premiums and cost-sharing for all fully-insured private commercial health plans in Massachusetts increased roughly twice as fast as wages/salaries and the rate of general inflation (CPI).[49]

Premium Impact from Splitting Individual and Small Group Markets

In the merged market, premiums charged to individuals and small employer groups are based on the collective experience of all eligible small employers and individuals and may only vary according to strict rating rules identified in state and federal laws. Splitting the risk pools for the individual and small group markets would allow premiums for small groups to be based on the claims experience of small employers and premiums for individuals to be based on the experience of individuals.

If the risk pools for individuals and small employers were split, actuarial modeling shows that in the first year there would be a one-time reduction in premiums for the small group market in the range of 2 to 4% and an initial one-time increase in premiums for the individual market of 4 to 6%. When the markets were merged in 2007, it was predicted that the cost of health insurance for individuals would be subsidized by small employers. The data reviewed by the MMAC showed, however, that it is the highest risk individuals within the individual market that are being subsidized by both the small group market and a large portion of the ConnectorCare individual subsidized market.[50]

Reinsurance

Based on the experience of other states with standalone individual markets, some members of the MMAC suggested that adding a reinsurance program could hold individuals harmless in a market with separate risk pools to mitigate against individual premium increases resulting from a de-merger. GA estimated that $94 million would be needed annually (based on current data) to eliminate the projected increase of 4 to 6% in individual premiums if the merged market were split into separate risk pools. Other states have used Section 1332 of the ACA to establish state-based

[47] Certain federal ACA requirements have also had an impact on the Massachusetts market and the cost of health insurance, including the phasing out of state-specific rating factors intended to mitigate the impact of the merger on small businesses, and creating a federal risk adjustment program to redistribute funds among carriers based on their relative health risk and temporary reinsurance and risk corridor programs to reimburse carriers for the cost of medical claims exceeding certain thresholds.

[48] In 2006, there were over 93,000 small employer groups – including groups of 1 - covering approximately 820,000 small group members; in 2019, there were 12, there were over 37,000 small employer groups covering approximately 371,000 small group members

[49] Center for Health Insurance and Analysis, Performance of the Massachusetts Health Care System. October 2019 Annual Report, p.71.

[50] The 2007 analysis did not include the subsidized population or risk adjustment which impacted the merged market as the federal ACA was implemented beginning in 2014.

reinsurance programs and leverage federal pass-through funding (i.e., savings to the federal government for lower ACA premium tax credit expenditures) to lower premiums for their individual markets.

Federal pass-through funding would be based on the amount of APTC funds that the federal government "saves" by reducing premiums for the state's second lowest cost silver level plan. However, if the merged market were split into separate risk pools for individuals and small groups, GA projects that premiums for individuals would be subject to an increase in the first year separate from increases resulting from medical trend. With an increase in premiums, the potential for federal funding through a Section 1332 Waiver under current guidance is unlikely because state policy would be increasing federal outlay for APTCs rather than generating savings. Absent federal funding to hold individuals harmless from premium increases associated with a demerger, any reinsurance program would need to be funded by resources and/or assessments within the Commonwealth. However, MMAC members agreed that state agencies should continue to monitor any changes that may affect the availability of federal financial support for a state reinsurance program.

Other Impacts

Splitting the risk pools would have other consequences aside from the direct premium impact. Pursuant to federal rules established by the ACA, self-employed individuals, sole proprietors, would be required to obtain coverage in the individual market, whereas they are currently obtaining coverage as small employer groups of 1, and the federal Risk Adjustment program would apply to the individual market and the small group market separately. Based on GA's modeling of separate risk adjustment programs for each market segment, splitting the individual and small group markets would significantly widen the distributions within the individual market such that payments from carriers that have historically been risk adjustment payers in the merged market would increase significantly to carriers that have historically been recipients. In addition, a demerger could increase both state and federal costs as APTCs and ConnectorCare subsidies increase to cover the higher underlying premium subsidies for individuals in an individual market.

Unlike many states that have only one or two carriers offering guaranteed issue coverage to individuals and small employers, Massachusetts has a stable market of thirteen carriers[51] offering

[51]

AllWays Health Partners, Inc.	Health New England, Inc.
Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc.	HPHC Insurance Company, Inc.
Boston Medical Center Health Plan, Inc.	Tufts Associated Health Maintenance Organization, Inc.
ConnectiCare of Massachusetts, Inc.	Tufts Health Public Plans, Inc.
Fallon Community Health Plan, Inc.	Tufts Insurance Company
Fallon Health & Life Assurance Company	UnitedHealthcare Insurance Company
Harvard Pilgrim Health Care, Inc.	

health insurance in the merged market. Those carriers collectively offer hundreds of products to the merged market through different marketing and distribution channels.

Even with a reinsurance program to hold harmless individuals from the projected premium increases that would result from splitting the individual and small group risk pools, there was not consensus among the members of the MMAC to recommend a demerger at this time. Small business representatives were more supportive of the idea, while consumer groups and insurer representatives were less so given the projected disruption and impact on individuals. Despite the changes in the composition of the merged market, the total market remains sufficiently large to allow risk to be spread across a broad spectrum of individuals and small employers.

Use of State-Specific Rating Factors

In the absence of consensus on splitting the risk pools, the MMAC explored whether there are other options to mitigate the rising cost of health insurance, particularly for small employers, who may have a competitive disadvantage in Massachusetts compared with other states. Since the merger in 2007, the landscape of the merged market has been affected by federal reforms, such as the implementation of the ACA, as well as evolving state policies.

Massachusetts-Specific Rating Factors

Prior to the ACA, and to help mitigate the anticipated increase in premiums to small employers that were projected to occur with the merger of the two separate risk pools in 2007, Massachusetts employed a number of rating factors. For example, carriers were permitted to develop a group purchasing cooperative rating factor that would discount the premiums on behalf of savings associated with wellness initiatives developed for plan members. However, the ACA eliminated small group rating factors other than the use of a group's age, geographic location, family composition, tobacco usage, and plan benefits.

Under the ACA, small employer premium discounts for group purchasing cooperatives, industry, and group size were required to be phased out to comply with community rating requirements. Through 2021, however, Massachusetts has been given transitional allowance by the federal government to retain the group purchasing cooperative rating factor and one-third of the magnitude of the original group size factor under ACA Section 1321(e).[52] This provision affords transitional authority to states that had state-based exchanges predating the ACA (such as the Health Connector) additional time to come into compliance with the ACA if approved by CMS.

[52] Massachusetts submitted an ACA Section 1321e request to continue to permit the use of the group purchasing cooperative rating factor for 2022 and the request was not granted.

Federal Waivers

Some members of the MMAC have proposed seeking a waiver from the federal government under Section 1332 of the ACA to continue using state-specific rating factors on a long-term basis, however, it was explained that rating factors are not permitted to be waived under Section 1332. While there is a request pending regarding use of the cooperative rating factor for 2022, further allowances are unlikely under Section 1321(e) transitional use of rating factors based on the conditions placed on the last extension by CMS. Federal officials have repeatedly reiterated that the ACA requires all states to comply with community rating rules, and that the Section 1321(e) transitional permission has been intended to allow Massachusetts extra time to come into compliance in a phased fashion and cannot be granted indefinitely. CMS's rating extension letter for 2021 included the closing statement, "…CMS will be approving no further requests for extension of these non-compliant rating factors."[53]

On June 28, 2021, CMS responded to Massachusetts' most recent request for an extension. In part, the communication reads:

> "The transition period was originally granted in 2013 to the Commonwealth of Massachusetts (Commonwealth) regarding the use of small group rating factors permitted under state law, which are not permitted under the Affordable Care Act (ACA). The Centers for Medicare & Medicaid Services (CMS) has modified the allowed transition period several times. On June 26, 2020, the Commonwealth was granted an extension for one additional year to allow the use of two specific small group rating factors, specifically the cooperative factor and the group size factor, with a final date for full compliance of January 1, 2022. Your recent letter requests an additional extension for the cooperative rating factor in the small group market. As we have previously indicated, to strike a balance between providing transition relief consistent with section 1321(e) of the ACA and promoting fair premiums, as contemplated by section 2701 of the Public Health Service Act, the transition period in the Commonwealth must be limited. The transition period previously granted by CMS to the Commonwealth has been sufficient and thus an additional extension will not be approved. Accordingly, all small group plans must come into full compliance with the applicable provisions of the ACA beginning with plan years starting on or after January 1, 2022."

Carriers in the merged market and other stakeholders were subsequently notified that the cooperative factor and the group size factor extension requests were denied by CMS.

Some members of the MMAC also suggested that Massachusetts could change the state age rating band from to 2:1 to 3:1. The ACA permits age rating bands that are higher than are currently used in Massachusetts. Other states have implemented 3:1 age rating bands, meaning the oldest

[53] June 26, 2020 Letter to Louis Gutierrez from CMS Deputy Director Randy Pate.

individuals pay no more than three times the premiums paid by the youngest individuals. There was not consensus among the MMAC about changing the age rating band because of concerns that doing so would increase premiums for older individuals in the merged market without a corresponding benefit to the market as a whole. More analysis would need to be done before recommending changes to the age rating bands.

Reinsurance for the Merged Market

The MMAC also discussed the possibility of creating a state-based reinsurance program to lower premiums in the existing merged market for both individuals and small employers. There was not consensus among the members of the MMAC to recommend a state-based reinsurance program in Massachusetts. The MMAC members agreed that before implementing a merged market reinsurance program, additional consideration would need to be given to its design and possible funding sources. For example, Massachusetts could conduct an analysis of high-cost claims experience in the merged market and the potential impact of a state reinsurance program on merged market enrollees depending on varying program parameters and funding mechanisms. The framework for a reinsurance program would need to identify the cost thresholds for attachment points, populations (morbidity relativities), or conditions that could be targeted, and the level of funding needed annually to subsidize high-cost claims.

Impact of Reinsurance

GA discussed the differences between a retrospective model (identifying high-cost members after the plan year and reimbursing carriers either all or a portion of medical expenses beyond an attachment point) and a prospective model (identifying high risk members prior to the start of the plan year and ceding them to the reinsurance program) that could be employed depending on the objectives to be achieved for the merged market and the funding structure. Some MMAC members expressed support for a reinsurance program designed carefully to account for the higher health risk of certain populations without rewarding the use of high-cost providers. Other members opposed it out of concern for the administrative burden and complexity it adds for carriers when designing products and premiums for the merged market.

GA presented information showing that spending approximately $94 million would produce a 2% to 3% reduction in premiums across the Massachusetts merged market. The $94 million is coincidentally the same amount that would have been required to hold individuals harmless if the markets were demerged, while in this case, the same funding would produce premium savings across the market for both individuals and small employers. The funding for such a state-based reinsurance program would likely have to come from multiple sources given the amount required

to yield a benefit.[54] As further described below, GA estimates that $10 million to $24 million of federal pass-through funding may be available through a Section 1332 Waiver depending on the program parameters which would need to ensure that APTC costs were not increased for the federal government, while spending an additional $70 million to $84 million annually would be needed to fully realize the estimated savings for the merged market. There was not consensus among the members of the MMAC to recommend reinsurance just for the merged market.

Funding for Reinsurance

Other states using Section 1332 Waivers for reinsurance programs have been able to leverage federal pass-through funding from APTC "savings" generated through lower premiums for the state's second lowest cost silver level plan to help fund state reinsurance programs. In Massachusetts, the average second lowest cost silver level plan is among the lowest in the country. For that reason, federal savings from the introduction of a reinsurance program in the Massachusetts merged market would be much lower than the amounts other states have been able to secure through their Section 1332 Waivers for reinsurance. GA also noted that because only a subset of the merged market generates savings, the individuals eligible for federal subsidies, the value of a Section 1332 Waiver for Massachusetts is further decreased by the savings being spread across the entire merged market.

Due to these unique features of the Massachusetts market, GA concluded that a Section 1332 Waiver would generate only a portion of the funding necessary, $10 to $24 million, to support a state-based reinsurance program on a merged market and another $70 million to $84 million would be needed to spread meaningful subsidies across the entire market.

The additional funding needed for a reinsurance program could come from an assessment on fully insured and self-insured large group markets, individual mandate tax penalties, or state general funds. GA calculated that an assessment of $2.40 PMPM across the entire fully insured and self-insured large group markets would generate the needed funds and produce a 0.5% increase in premiums for the large group and jumbo markets. More broadly, for every 1% increase in premiums in the large group and jumbo markets, there is approximately a 4% to 6% decrease in premiums in the merged market. Recognizing that such an assessment on fully insured or self-insured large group markets would increase costs for these segments, there was not consensus about a recommended funding mechanism.

Some MMAC members felt that a reinsurance program for the merged market could further complicate an already complex system by introducing further instability into the development of

[54] GA modeled a state-based reinsurance program using an investment of $94 million based on that amount being needed to offset the projected 4% to 6% premium increase for individuals if the merged market were split into separate risk pools for the non-group and small group markets. In comparison, the same $94 million would reduce the premiums for the merged market by 2% to 3%. Under a demerged market scenario, the potential for any federal funds is unlikely.

premiums. It was noted by these members that carrier rate-making has been complicated by the federal Risk Adjustment program, requiring assumptions about membership, utilization and unit cost trends and that carriers devote significant time to predicting the impact of it. The impact of a reinsurance program on a particular enrollee's premiums would vary depending on a health plan's distinct insured populations, product designs, and provider networks. There was a concern from these members about additional uncertainty with the creation of a reinsurance program because it could destabilize an individual carrier's participation in the market. Carrier representatives were also concerned about the costs associated with the state administration of a reinsurance program and its ability to regularly analyze and calibrate the appropriate reinsurance thresholds. There was also previously a federal reinsurance program created by the ACA that utilized a similar fee structure, and many other states currently operate reinsurance programs in their individual markets.

Innovating the Health Insurance Market

The MMAC considered a number of other options to reduce the cost of health insurance within the merged market, including modifying existing rules for certain products, encouraging the purchase and design of less expensive products, and developing pilot programs to test the viability of new products or different approaches to coverage. In reviewing the existing health insurance landscape, MMAC members learned about purchasing patterns and explored why some product designs have not been as successful as might have been expected when incorporated into the statutory framework.

Promoting Limited and Tiered Network Products

MMAC members discussed existing options, such as limited network or tiered network products. Massachusetts law requires carriers in the merged market with at least 5,000 covered lives to offer a limited or tiered network product with premiums that are at least 14% lower than a comparable broad network plan. While all carriers do offer such plans, there is limited take-up of these plans. The members discussed various approaches to increase the uptake and availability of these products including the recommendation to alter the provider "opt-out" rule for participation in tiered networks. Such changes would better position carriers to experiment with plan designs and cost-efficient products that reward high-value, low-cost care settings. Conversely, one MMAC member suggested that the existing exemptions for offering limited network plans should be expanded to carriers that already achieve reduced premiums. The examples provided would exempt carriers who have a majority of members enrolled in subsidized coverage or narrower networks where an additional premium reduction is not possible to achieve the 14% differential. To encourage increased availability of limited networks among carriers that do not have a majority of members enrolled in subsidized coverage, some MMAC members suggested a pilot in which provider reimbursement rates in those plans be set based on a percentage of the Medicare rate of

reimbursement to help achieve the lower price point. Such pilots would need to have a set provider reimbursement rate, since this will drive premium advantages more than any other factor.

Several members noted that membership in limited network products by small groups is significantly lower than for individuals, suggesting that small employers prefer broader network products. Some MMAC members suggested that limited network plans could be made more attractive to small employers if they were designed to guarantee access to out-of-network providers when medically necessary due to a need for specialized care. MMAC members also suggested that limited network plans would be more appealing to small employers if carriers were allowed to develop products that rely on network adequacy standards on a regional basis, targeting providers in the area where employees live and work. Another option that garnered significant support from MMAC members was to increase small group participation in limited network plans by allowing small employers to offer limited network plans with a defined contribution for employees that want a broader network, thus empowering employees with choices, while not forcing the employer to offer only a "one size fits all" solution for the workforce. It was also further noted that such narrow network options, standing alongside broader network products (in PPO for example) create market dynamics that lead to anti-selection, disadvantaging the entire merged market risk pool.

Some MMAC members raised concerns that limited and tiered networks add complexity to an already complex system for consumers and small employers. These products also put the onus on consumers and small employers to navigate potential additional barriers to accessing care, and could raise issues of care continuity and provider access. While choosing limited or tiered network products could result in savings, enrollees would require additional education both at the time of plan selection as well as once enrolled.

Products with Incentives to Shop for Health Care Services

MMAC members also suggested innovative benefit designs to create more affordable plan and coverage options in the merged market. One suggestion was for the development of plans with reference-based pricing or direct provider contracting flexibility. It was similarly suggested that limited network plans or direct contract arrangements could be designed to reimburse claims under those plans as a percentage of an existing benchmark, such as the Medicare rate of reimbursement or some other market-based benchmark. One member noted that the option of limiting provider reimbursements at a set level (e.g., based on a certain percentage of Medicare) would provide lower premiums and simultaneously drive utilization to value-oriented providers such as community hospitals. This approach would also address the challenges such providers consistently raise related to payer mix and low rates of reimbursement. Some MMAC members raised concerns regarding the potential for reference-based pricing to limit provider access for low-income individuals and employees.

The MMAC also discussed designing products that would incentivize consumers to shop when needing medical services. For example, a plan could reward members for receiving care from lower-

cost providers and use federal guidelines that establish transparency requirements for approximately 500 services. Greater transparency would enable members to compare quality and prices for those services and make informed decisions about using their health insurance. Another example that saw consensus was following a model developed in Maine that gives members in-network credit for using out-of-network providers that are higher quality and less expensive.

Marketing All Products and Wellness Options

GA presented information about distribution channels and how different products may be available to subsets of the merged market. Some MMAC members suggested that every carrier should market their products, especially limited network plans, to the entire market, individuals and small groups, and through all channels both on and off the Health Connector. Other MMAC members opposed that idea as being overly intrusive to the private market. Some MMAC members advocated for a free market approach with product offerings, pricing and compensation being the same across all distribution channels. They were in favor of plan pricing being based on actuarial results and market competition, with few state mechanisms to deviate from those results.

Some MMAC members also noted that significant discounts for wellness programs are only available for products offered through the Health Connector and such wellness incentives should be made available for products offered off the Health Connector as well. However, one MMAC member opposed expanding the Health Connector wellness rebates, noting that carriers have wellness program rebates that are available to small employers outside the Health Connector which they use to compete for business.

Investigating Innovative Benefit Designs

It was also suggested that Massachusetts could coordinate with the federal government on other initiatives that might result in lower-cost product options. For example, alternatives to the essential health benefit benchmark plan or limited-time waivers from the actuarial value requirements could encourage the introduction of new options to the market. Alternatively, Massachusetts could suspend or terminate any requirements that are inconsistent with federal rules under the ACA rules, such as medical loss ratio and MMC requirements, to reduce confusion, administrative costs, and compliance concerns for employers that result from differences between the two regulatory frameworks. However, some MMAC members expressed concerns that such benefit design changes could have unintended consequences, such as weakening consumer protections and leading to benefits and coverage erosion.

Exploring Changes to Federal Risk Adjustment

In connection with the MMAC's review of the federal risk adjustment program, a program that redistributes funds from carriers with lower-risk members to carriers with higher-risk members to account for the distribution of risk across the market and shifts in high utilizing members, GA noted that the federal program is imperfect and premiums can be disproportionately impacted as

members shift between carriers. This volatility, while not solely responsible for increasing premiums, does not foster stability in the market.

The analysis that GA presented to the MMAC highlighted that in a merged market, if the state wishes to modify the federal Risk Adjustment program, as has been done in New York, the small group segment of the merged market is likely to be negatively impacted. The carriers in the merged market that cover a majority of the small groups have generally been recipients of risk adjustment transfers, which suppresses premiums compared to what they would be in the absence of risk adjustment in accordance with the current federal methodology. Instead of modifying the current program, one MMAC member suggested a state-funded study of the federal risk adjustment methodology and its effect on health insurance premiums. However, there was recognition that the methodology is determined by the federal government and the state is unable to make changes to the methodology, other than as noted above. The member suggesting the state-funded study further suggested that findings of a state report could be shared with CMS in hopes of the granting of additional state flexibility or adjustments to the federal methodology.

Developing Pilot Programs

Considering the charge of the MMAC, Commissioner Anderson suggested that pilot programs might be a way to test certain hypotheses about the cost of health insurance initiatives without destabilizing the market in the Commonwealth. For example, there has been speculation that if similar small groups were to band together to leverage their market-buying power, they would be able to innovate on plan development and offerings, allowing them to purchase comparable coverage at a lower cost, more in line with what large groups pay. With group purchasing cooperatives, Massachusetts has a ready-made test subject. Legislative changes could be pursued to allow certified group purchasing cooperatives to be treated as a large group for purposes of health insurance. These cooperatives would be extracted from the merged market risk pool, eliminating the constraints of the merged market rating rules and mandated benefit requirements. Further, because of their limited membership, there would be minimal impact to the merged market. Such a pilot program could be time-limited, with the Division producing a report on the results of the group purchasing cooperatives' experience and how their premiums compared with merged market premiums.

Enhanced Disclosures, Education and Transparency

As health insurance becomes more complex, with more plan options and different types of products, MMAC members agreed that we need to closely monitor the market, amplify educational efforts, and enhance transparency. MMAC members heard that insurance purchasers would benefit from more robust disclosures about their coverage options and more education about the value of limited network products and the costs of health care through more robust transparency tools.

Alternate Health Programs

The MMAC reviewed and considered the effect of alternate health arrangements that are marketed outside of the state-regulated merged market, including professional employer organizations, self-funded plans and health sharing ministries. Although there was no evidence that these off-market product offerings have materially affected the merged market, there was consensus that they warrant continued monitoring to ensure consumer awareness about how they differ from merged market coverage.

In addition to monitoring the proliferation and uptake of such products, MMAC members suggested that the state review the rules governing health plan marketing and disclosures to identify opportunities to strengthen consumer protections relative to such coverage. Specifically, to ensure that consumers are adequately informed about what they are purchasing and how an alternative health arrangement might not afford the same benefits as a merged market product. Members agreed that stronger and clearer disclosures could help protect consumers from unanticipated medical expenses.

Improved Education and Transparency of Health Costs

There was general support for increasing educational efforts to improve health care and health insurance literacy. For example, outreach efforts in schools, workplaces and senior settings would help educate consumers and enable them to better understand how their choice of health care setting impacts what they pay for health care and insurance. MMAC members agreed that it is important to promote the efficient and effective use of health care services in Massachusetts by ensuring that consumers understand the cost of care, particularly as plan deductibles and cost-sharing rise.

It was also suggested that information about the cost of obtaining health care from different providers and different care settings might influence out of pocket costs and how health insurance is utilized. The MMAC discussed that information should be available from providers and carriers before plan members choose to obtain care from a particular provider or facility, as well as at the time the members receive the health care services.

Some MMAC members advocated for rules requiring providers to help consumers understand the cost of facility fees and the differential costs associated with receiving care from certain types of providers in different health care settings. A gap in price transparency could be filled by having all providers disclose the cash price for services coupled with education and promotion of access to this feature to the general public. In addition, a public awareness campaign could educate consumers that they can obtain pricing information for a health care service ahead of time and how to effectively comparison shop. Greater transparency and the ability to shop would highlight for consumers that community care options are of high quality and usually less expensive than other options. Some MMAC members noted that there is low utilization of transparency shopping tools for health care services. However, if these tools were used, some members believed that care

decisions could be influenced. These MMAC members support enhanced consumer education but were skeptical that such transparency efforts would result in significant shifts towards lower-cost providers, particularly in such a complicated health care system.

It was also suggested by one member that enforcement of the existing price and quality transparency rules be transferred to the Health Policy Commission, providing the HPC with additional authority to implement the provisions of Chapter 224 of the Acts of 2012; while other MMAC members noted that the Health Policy Commission's monitoring of the performance of individual payers and providers against the Commonwealth's health care cost growth benchmark through performance improvement plans has not resulted in meaningful cost containment across the market.

Other efforts to improve transparency could include making claims information collected through various channels more readily available. For example, CHIA could open the all-payer claims database and release all claims in a de-identified machine-readable format to the public to support claims-based population research initiatives, identify market inefficiencies, and improve the consumer education and shopping experience more engaging and helpful.

In addition, carriers and all providers could make machine-readable claim data available, beyond what is required under a new federal rule applicable to hospitals (Price Transparency Requirements for Hospitals to Make Standard Charges). Similarly, if small employers were given access to their historical claims data, including information not currently granted by any insurers such as medical loss ratios and information about large claims, it would help small employers to make informed decisions about their health benefit plan and allow them to more effectively invest in the health and wellbeing of their employees, especially when coupled with plan design changes to reward high-value/lower-cost care. A MMAC member raised privacy concerns about this level of information sharing and its potential impact on employees with high claims costs.

Improved Disclosure

Some MMAC members suggested better education for individuals and small employers about the value of limited network options. They also suggested having every carrier market limited network options to all individuals and small groups, including off-Health Connector. This would expand the availability of less expensive products and potentially raise awareness of them. However, it was noted that small employers often use broader network plans to attract and retain talent within Massachusetts.

There was consensus among the MMAC members to update the rules relating to disclosure and marketing materials, particularly with the increased availability of alternatives to merged market products, such as limited benefit products offering supplemental benefits, discount plans, and health sharing ministries. Stronger disclosures about what does not qualify as a health benefit plan in Massachusetts and the features that differentiate them from merged market products, as well as increased producer training, including education standards for self-funded plans and stop loss products, would help provide clearer information to the market. Should small employers enter into,

for example, self-funded and stop loss products, they should be fully aware of both any potential benefits and any potential downside risk. While there was not consensus about limiting the availability of alternative products or creating new rules for them at this time, MMAC members agreed that such products warrant continued monitoring relative to their impact on the market.

Revamping Health Insurance Rate Review

In conjunction with the work of the MMAC, the Division has been considering the health insurance rate review process that has been in place since 2010 and looking for opportunities to make the process more effective or efficient. Specifically, the Division has been conducting an internal review of the small group health insurance regulation, 211 CMR 66.00, which applies to the merged market, to identify potential amendments that could help support the long-term stability of coverage for individuals and small employers as well as the affordability of health benefit plans offered in the merged market.

One MMAC member suggested that making health insurance rate review more transparent could put downward pressure on premiums. Transparency could be achieved through public-facing information, made available through the Division's website, and a public comment period on proposed rate increases. This process could provide the justifications for proposed rates, as well as the reasons for approving final rates, including information about the underlying health care costs and efforts carriers are undertaking to ensure affordability. The MMAC member also suggested adding affordability standards to the framework for reviewing proposed rate increases. Massachusetts is the only state that conducts rate review on a quarterly basis. In order to accommodate these changes, the rate review process could be conducted less frequently. A few members expressed concerns that modifying the Division's rate review process could create delays in rate approval and unfairly politicize the rate process. Further, the same members indicated that setting an affordability standard without mechanisms to contain health care costs could lead to carriers having insufficient rates to cover claims costs.

The Division sees that its recent experience with the disapproval of a second quarter of 2021 rate increase filing, and the subsequent hearing, highlighted that the existing process should be reviewed to consider whether it would be more effective if revamped. Carriers in the merged market are required to spend 88% of every premium dollar on claims expenses and there are limits on their ability to increase administrative expenses or contributions-to-surplus, but the process should be examined to determine whether additional tools could help with the affordability of health insurance in Massachusetts.

Modifications could be considered to make relevant information more accessible to the public, better inform individuals and small employers about rate changes including useful information about health care cost drivers in our marketplace. Any modifications, however, should be made with a view toward preserving the vibrant health insurance market in the Commonwealth,

maintaining a strong competitive marketplace with a variety of products available at different price points to meet the needs of individuals and small employers.

Reducing Health Care Costs

Throughout the meetings of the MMAC, and even when there was not agreement about merged market policy options, there was a consistent theme that Massachusetts needs to reduce the overall cost of health care, as that is what drives premiums. To that end, the MMAC discussed a variety of ideas to apply downward pressure on health care costs in order to promote more affordable health benefit plans in Massachusetts, particularly for the merged market. Statewide cost containment strategies could help temper medical trend and provider prices that drive increasing premiums.

Health insurance premiums take into account, among other things, historic claims payments, negotiated rates of payments with network providers, new health care technologies and services that are expected to impact future claims, emerging health care policy to evaluate the carrier's future projected costs, and trends in health care utilization, all of which are affected by health care costs. Addressing high health care costs, such as payment variations, increasing unit costs of health services, increasing utilization of higher-cost services, along with prescription drug spending, could help moderate premium increases in the merged market and more broadly in the Commonwealth.

Benchmarks

A few MMAC members made suggestions relating to the role of the HPC for cost containment and to the health care cost benchmark that is intended to be linked to the state's overall economy. It was recommended that the HPC be afforded additional enforcement tools related to hospital pricing and total medical expense, particularly in light of the fact that total health care expenditures exceeded the statutory cost growth benchmark in 2018 and 2019.

One MMAC member suggested that the HPC's current authority be used and additional tools be extended to curtail the growth of provider groups and systems that significantly contribute to the state's health care cost growth year-over-year. The use of performance improvement plans by the HPC is one such tool that was particularly noted by several members. One MMAC member suggested that the HPC's authority be extended to require provider entities over a relative price of 1.3 or total medical expenses above the statewide average to make specific filings to the Commission to justify and substantiate the high cost. Other MMAC members suggested reducing the cost benchmark and increasing efforts to enforce adherence to it, contending that lowering the benchmark would better focus efforts to lower the underlying price of care thereby reducing the rate of growth. Looking at growth rates in unit prices as compared to the benchmark and cost sharing could also provide useful data.

Transparency

The HPC found that hospital inpatient and outpatient services were two of the fastest health care spending categories from 2017 to 2018 and together account for over 40% of all health care spending in Massachusetts. As such, a MMAC member suggested that the HPC's current authority be extended to curtail provider groups that have a significant and negative impact on the individual total medical. A MMAC member suggested making hospital costs more transparent during HPC annual cost trend hearings to display Hospital Total Medical Expenses and expanded alternative payment arrangements.

The HPC also found that prescription drug costs contribute to rising premiums. One MMAC member proposed applying the current prescription drug processes in place for MassHealth and via the HPC to the commercial health insurance market. Other MMAC members suggested requiring pharmaceutical companies to disclose their research, development, marketing, and manufacturing costs, as well as profits. Another MMAC member suggested more transparency around specialty drug costs relating to those drugs administered in a provider setting and seen as a contributor of health care spending.

Carrier-Provider Contracts

With respect to contracts between carriers and providers that contribute to rising health insurance premiums, a few ideas were offered. For example, some MMAC members suggested ending contracting practices that have the potential to be anti-competitive and anti-consumer. These practices include all-or-nothing clauses, exclusive contracting, gag clauses, and provider opt-out, which may result in stymieing product designs, escalating health care prices and providing lower-quality care.

One member also noted that M.G.L. c. 176O, §9A(a)(iv) prohibits a health plan from requiring a provider to participate in a new select network or tiered network plan without granting the provider the right to opt-out at least 60 days before the health plan submits it to the Division for approval. The 60-day opt-out provision presents a significant barrier to the development and introduction of a market-based tool intended to help employers engage their employees in accessing lower-cost providers. Which providers opt out of a new health plan product affects whether the product is available to all employers and consumers in the state or only those in certain regions, undercutting employers' efforts to engage their employees to utilize high-quality, efficient providers. As noted earlier in the report, legislation that would strike the opt-out provision from existing state statute could achieve cost savings and increase affordability in limited network products.

M.G.L. c. 176D, §3(4) was cited as prohibiting "most favored nations" contract provisions, also called pricing parity or price protection clauses, through which a dominant provider demands the "best price" and the carriers are not able to offer similar terms to other, competing providers.

Similarly, M.G.L. c. 176O, §9A was cited as precluding all-or-nothing clauses, but only for limited or tiered network plans. MMAC members noted that this arrangement allows "must have" providers to exert market power and demand higher rates of reimbursement. One MMAC member requested that carrier and providers be allowed to negotiate reasonable reimbursement for telehealth rather than having rates of reimbursement set by legislative action, and while Chapter 260 of the Acts of 2020, includes provisions regarding parity in the rates of reimbursement for certain in-network services obtained via telehealth compared with in-person, the new law is not prescriptive in how rates of reimbursement are set except for behavioral health.

New Services and Treatments

A few other provider-related suggestions were offered by MMAC members relating to the Determination of Need, "DoN", process and scope of practice. Some MMAC members suggested phasing-out or decreasing the DoN threshold could increase access to care for patients, increase competition, lower prices, and increase of the quality of care provided.

They also suggested that liberalizing practice limitations would allow providers to offer any health care service within the scope of their training and could increase access to care with lower costs. For example, maximizing flexibility for how pharmacists or pharmacy technicians can extend the health system by offering more services that they have training to provide or re-examining what well-trained physician assistants can do by default instead of having their supervising physician limit where and what they can practice. This could also mean limiting hospitals or physicians from charging doctor rates when the services are provided by another kind of provider. To implement more liberalized scope of practice rules, Massachusetts could consider creating a "sunset review" panel to consider scope of practice in the context of the most recent medical literature and restrict only those areas of practice where there is a compelling and conclusive reason to restrict licensed medical professionals from performing services and treatments.

One MMAC member highlighted the importance of carrier tools to address high health care costs, such as rising unit costs, increasing utilization of higher-cost services, and costs associated with advancements in health care like breakthrough treatments, genetic therapies, high-cost pharmaceuticals, and biologics. Specifically, this member noted the role of carrier utilization review processes, such as prior authorization to reduce unnecessary utilization. In addition, this member suggested that carriers could mitigate the pressure of higher premiums with flexibility in design of cost-sharing mechanisms that make members more aware of the cost of care as they pay higher out-of-pocket costs for care. Further, the MMAC member proposed establishing a moratorium on state-mandated benefits and prohibiting mandated treatment that is not evidence-based to help restrict the growth in health care costs and the corresponding increase in health insurance premiums. It was noted that state mandated benefits are not required to be covered by ERISA-exempt self-insured employer groups, thus contributing to premium differentials between large and small businesses.

Out-of-Network Costs

Another concern that MMAC members raised was related to the exorbitant costs associated with out-of-network health care services provided to insured members. One MMAC member suggested addressing PPO costs as a means to control overall health care system costs. PPOs in general have higher PMPM medical expenses compared to individual HMO members, which is attributable to PPO members seeking care out-of-state and out-of-network.

Other members suggested that consumers could be better protected from surprise medical bills if there were state-based default reimbursement rates for established out-of-network services. It should be noted that Section 71 of Chapter 260 of the Acts of 2020, tasks the Secretary of Health and Human Services, in consultation with the HPC, CHIA and the Division, with developing a report by September 1, 2021, with recommendations for establishing non-contracted, out-of-network rates of reimbursement for emergency and non-emergency health care in the Commonwealth. This report was filed on September 8, 2021 and recommended the institution of the median in-network rate as further defined in the report. Members noted that this is an important affordability issue, not just with regard to individual costs for a member but also the impact of these added costs to the system's overall affordability. The federal No Surprises Act legislation, which was signed into law on December 27, 2020, establishes a framework and will inform future state-based policies on this issue.

CONCLUSION

Closing Summary

This report summarizes the status of the Massachusetts merged market based on an independent actuarial analysis and examination of factors impacting merged market affordability and stability. Understanding the history of the merger and mitigation measures established for small business, key characteristics of the merged market today, how it has changed over time, impact of new state and federal laws, including the ACA, information about subpopulations within the market, and the projected impacts of certain actions will help inform merged market policy considerations.

Since Massachusetts became one of the only states to merge markets 2007[55], the individual market has grown significantly, the small group market has declined and overall the number of covered lives has remained stable. In general, most small group enrollment is concentrated in higher-cost products despite the availability of low-cost options in the merged market because employers use health insurance benefits to attract and retain employees, which helps them compete for labor. In addition, ConnectorCare and the small group market have similar risk profiles while the non-ConnectorCare individual market has a higher-risk profile.

While alternative arrangements outside of the merged market may attract some individuals and small businesses, these options have not led to a significant number of enrollees leaving the merged market or undermining its general stability. Yet, if health care affordability challenges persist for small groups and individuals, their appeal to some in the market may grow. In Massachusetts, risk adjustment results in individuals in the ConnectorCare program generally cross-subsidizing enrollees of the higher-paid, broader-network carriers that tend to have mostly small group enrollees and higher-risk individual enrollees. Considering this dynamic, the present flexibility CMS provides to states to reduce risk adjustment transfers up to 50% is unlikely to improve stability or affordability within the merged market, but may reduce volatility and conservatism built into premium pricing by the carriers.

Reinsurance, another potential risk mitigation mechanism, could provide premium reductions in the merged market with varying impacts depending on the amount invested in reinsurance and whether the market remained merged or demerged. GA's analysis found that if the market remained merged and Massachusetts invested annually into a reinsurance program, the state may be able to utilize a modest amount of federal pass-through funding through an ACA 1332 Waiver to reduce premiums. However, it is unlikely that any federal funds would be available for a reinsurance program in Massachusetts under a demerged scenario because of how low-cost the second lowest cost silver plan in Massachusetts is in most regions.

[55] Vermont and the District of Columbia subsequently merged their individual and small group markets.

The merged market and Massachusetts's approach to health coverage expansion has led to a high level of health coverage, but affordability challenges persist, especially for small businesses and some individual purchasers whose coverage is not subsidized. The MMAC discussed the major learnings from the refreshed merged market analyses conducted during 2020 and 2021, including the current state of the market and actuarial dynamics within the merged market and the projected impact of specific actions on the merged market. Findings from this analysis will help to guide future policy considerations and recommendations to improve merged market stability and affordability for individuals and small groups in Massachusetts.

Next Steps

This report is being shared with Governor Baker and members of his Administration for consideration in shaping short and long-term policies that impact individuals and small employers in Massachusetts. There is a consensus among some members of the MMAC that steps to promote the transparency of health care price and quality, improve health care and health coverage literacy, and help employers and consumers with the purchase of lower-cost products will ultimately lower the overall cost of health care. Other members pointed to the potential for unintended consequences of this approach, such as the impact on provider access. State efforts to mitigate and lower underlying health care costs remain an essential policy component of overall health care affordability and cost containment strategies for individual and small business purchasers in the merged market.

Small businesses are incubators of change, and the MMAC members believe that there should be careful consideration to permitting new health insurance product designs to be offered in pilot programs within the merged market provided that such pilot programs monitor the impact on enrollee access and ensure sufficient access to care by complying with existing consumer protections required of merged market products. If permitted, new lower-cost product designs, such as those that may include group purchasing power, consumer education and premium financial incentives, site of service programs or telehealth-first designs, could be developed with subsets of the overall small group market creating an environment of innovation that will allow the merged market to find solutions that work for individuals and employers. These innovations can be tested and redesigned before being offered to the entire market. Finally, to truly deal with affordability issues in the merged market, policymakers and legislators should aggressively work to rein in underlying health care costs identified in over two dozen state reports.

APPENDICES

APPENDIX A

Executive Order No. 589: Merged Market Advisory Council

DATE: 10/18/2019

ISSUER: Governor Charlie Baker

WHEREAS, the Commonwealth has a unique merged health insurance market structure, which blends individual and small group coverage segments with the intention of increasing and stabilizing its risk pool to provide greater access to affordable health insurance coverage;

WHEREAS, the Commonwealth has the lowest rate of uninsured residents in the nation;

WHEREAS, the number of covered lives in the small group market in the Commonwealth continues to decline;

WHEREAS, the cost of health care and health insurance coverage in the Commonwealth continues to grow and consume a significant portion of individuals' and small employers' budgets;

WHEREAS, the Commonwealth seeks to ensure that both individuals and small businesses have access to affordable health coverage;

WHEREAS, there is a need to understand how emerging federal policies may affect the Commonwealth's merged market;

WHEREAS, the merged market was implemented in the Commonwealth over a decade ago and the dynamics of the health insurance landscape continue to evolve, the state has the potential to benefit from an in-depth review of its practices with the objective of achieving better outcomes for all stakeholders;

WHEREAS, the Administration recognizes that input from a diverse set of stakeholders is necessary to assist it in its mission of ensuring that all residents have access to affordable health insurance coverage;

NOW, THEREFORE, I, Charles D. Baker, Governor of the Commonwealth of Massachusetts, by virtue of the authority vested in me by the Constitution, Part 2, c. 2, § I, Art. I, do hereby order as follows:

Section 1. The Massachusetts Merged Market Advisory Council is hereby established to advise the Governor and Lieutenant Governor regarding the merged market for insured health coverage that is regulated under M.G.L. c. 176J and to propose recommendations to ensure the long-term stability of coverage for individuals and small employers in the merged market and the affordability of insured health benefit plan products offered therein.

Section 2. The Council shall consist of up to 13 members. Up to 10 members shall be leaders, experts and other stakeholders drawn from outside of the Administration, and shall include persons with experience in and knowledge of the health insurance industry, including members representing the perspective of carriers, brokers, actuaries, and individual purchaser representatives, as well as persons representing the business community, including representatives of employers and small businesses. The Council shall also include the Commissioner of the Division of Insurance, who shall serve as chair, the Secretary of the Executive Office of Health and Human Services or her designee, and the Executive Director of the Commonwealth Health Insurance Connector Authority, all of whom shall serve as members of the Council ex officio. Each member shall be appointed by the Governor and serve at his pleasure, without compensation and in an advisory capacity.

Section 3. The Council's principal purposes shall be to prepare a report that summarizes the status of the merged market based on an independent actuarial analysis and that makes recommendations for improved market functioning, including any policy and legislative changes that the Council recommends to ensure affordability and stability of coverage for small businesses and individuals.

The Council shall oversee an independent actuarial analysis of the merged market to inform its work and its final recommendations. In formulating the recommendations, the Council shall consider and address:

1. The general stability of the merged market risk pool;
2. Trends and dynamics related to the composition of the merged market risk pool and its impact on premiums and affordability for small businesses and individuals;
3. Drivers of health care costs and premiums and growth of health care costs and premiums in the merged market;
4. The impact to the merged market from: i) the presence or extent of any cross-subsidization between the non-group and small group market segments; ii) the role of federal risk adjustment; and iii) the impact of emerging coverage options for small-employers including, but not limited to, association health plans, multiple employer welfare arrangements, professional employer organizations, individual coverage health reimbursement arrangements and self-insurance;
5. Policy or market dynamics that threaten the stability of the overall market for small group and individual coverage, or are forecasted to do so;
6. Strategies to strengthen and promote affordability for the small group market, including but not limited to, whether federal waivers should be sought to permit flexibility in the application of merged market rules; and
7. Other opportunities to improve the functioning of the merged market including, but not limited to, the establishment of a reinsurance program; provided, however, that the Council must consider the impact of such strategies on both the non-group and small group market segments and potential state and federal costs and funding sources.

Section 4. The Council shall be supported by staff from the Governor's Office, the Division of Insurance, the Executive Office of Health and Human Services, and the Commonwealth Health Insurance Connector

Authority. The Council also may utilize outside resources to conduct the independent actuarial analysis and other consulting services as necessary to support its recommendations.

Section 5. The Council may determine the procedures appropriate for conducting its proceedings. The Council is authorized to hold public meetings, fact-finding hearings, and other public forums to solicit feedback and request data from outside experts, policymakers, business organizations, carriers, consumers, advocates, and other interested persons. The Council shall consider information received from these sources in the development of its recommendations.

Section 6. The Council shall submit a final report with recommendations to the Governor not later than April 30, 2020.

Section 7. The Council shall terminate upon submission of the final report or six months after the signing of this order, whichever comes later.

Section 8. This Executive Order shall take effect upon execution and shall continue in effect until amended, superseded or revoked by subsequent Executive Order.

Given at the Executive Chamber in Boston this 18 day of October in the year of our Lord two thousand nineteen and of the Independence of the United States of America two hundred forty-three.

APPENDIX B

Legislative History of Massachusetts Merged Market for Health Insurance

Prior to the 1990s, insured health coverage was only available to most individuals or small employers if the applicant satisfied a health insurer's medical underwriting criteria. Even if accepted for coverage, rates could vary greatly based on the characteristics of an individual/group or based on past health claims costs. In Massachusetts, Blue Cross and Blue Shield of Massachusetts, Inc. was the only entity that was required to issue coverage to all applicants, as the statutory plan of last resort, however, this coverage was only available with a 3-year pre-existing condition exclusion. Many individuals and small groups were unable to buy or afford to buy coverage in Massachusetts.

In the 1990s, a number of states passed laws to make health coverage more stable and available for small employers so that carriers could only offer coverage to any eligible small employers as long as they offered the same coverage to all eligible small employer according to rate rules that restricted the variation of coverage across the market.

Stage One: 1991 Rules for Coverage Offered to Small Employers

When enacted, Chapter 495 of the Acts of 1991, "Chapter 495", created M.G.L. c. 176J, "Small Group Health Insurance", to standardize coverage available to small employers beginning April 1, 1992. In order to implement M.G.L. c. 176J, the Division promulgated 211 CMR 66.00, "Small Group Health Insurance".

Availability of Coverage

As was noted in M.G.L. c. 176J, § 2(a):

> "Except as otherwise provided, this chapter applies to all health benefit plans issued, made effective, delivered or renewed to any eligible small business after April 1, 1992, whether issued by a carrier, or through an intermediary. Nothing in his chapter shall be construed to require a carrier that does not issued health benefit plans subject to the chapter to issue health benefit plans subject to this chapter."

In effect, this statute requires that any carrier electing to offer any health benefit plans to any eligible small employer must offer the same health benefits plans to every other eligible small employer. Except under certain identified conditions,[56] carriers are not allowed to establish any limitations on

[56] According to M.G.L. c. 176J, § 4(b)(2)-(4),

"(b) A carrier shall not be required to issue a health benefit plan to an eligible individual or eligible small business if the carrier can demonstrate to the satisfaction of the commissioner that within the prior 12 months, (a) the eligible individual or eligible small business has repeatedly failed to pay on a timely basis the required health premiums; or, (b) the eligible individual or eligible small business has committed fraud, misrepresented whether or not a person is an eligible individual or eligible employee, or misrepresented other information necessary to determine the size of a group, the participation rate of a group,

any offered coverage being made available to any other eligible small employer[57] with between 1 and 25 employees without medical underwriting, also referred to as coverage being available on a guarantee issue basis. Carriers could establish waiting periods and pre-existing condition limitations but only according to the limits allowed by law.[58] Carriers are required, except under specific circumstances to make coverage guaranteed renewable for any small employer as long as the product was being renewed to any other carrier. Carriers are also required to provide coverage to every eligible

---

or the premium rate for a group; or (c) the eligible individual or eligible small business has failed to comply in a material manner with a health benefit plan provision, including for an eligible small business, compliance with carrier requirements regarding employer contributions to group premiums; or (d) the eligible individual voluntarily ceases coverage under a health benefit plan; provided that the carrier shall be required to credit the time such person was covered under prior creditable coverage provided by a carrier if the previous coverage was continuous to a date not more than 63 days prior to the date of the request for the new coverage. A carrier shall not be required to issue a health benefit plan to an eligible individual or eligible small business if the individual or small business fails to comply with the carrier's requests for information which the carrier deems necessary to verify the application for coverage under the health benefit plan.

(3) A carrier shall not be required to issue a health benefit plan to an eligible individual or eligible small business if the carrier can demonstrate to the satisfaction of the commissioner that:—

(i) the small business fails at the time of issuance or renewal to meet a participation requirement established under the definition of participation rate in section 1; or

(ii) acceptance of an application or applications would create for the carrier a condition of financial impairment, and the carrier makes such a demonstration to the same commissioner.

(4) Notwithstanding any other provision in this section, a carrier may deny an eligible individual or an eligible small business with 5 or fewer eligible employees enrollment in a health benefit plan unless the eligible individual or eligible small business enrolls through an intermediary or the connector. If an eligible individual or an eligible small business with 5 or fewer eligible employees elects to enroll through an intermediary or the connector, a carrier may not deny that eligible individual or eligible small business enrollment. The carrier shall implement such requirements consistently, treating all similarly situated eligible individuals and eligible small businesses in a similar manner.

[57] ''According to the original M.G.L. c. M.G.L. c. 176J, § 1, an Eligible small business'' or ''group'', is any sole proprietorship, firm, corporation, partnership or association actively engaged in business who, on at least fifty percent of its working days during the preceding year employed from among one to not more than fifty eligible employees, the majority of whom worked in the commonwealth; provided, however, that a health carrier may offer health insurance to a business of more than fifty employees in accordance with the provisions of this chapter. In determining the number of eligible employees, a business shall be considered to be 1 eligible small business or group if: (1) it is eligible to file a combined tax return for purpose of state taxation, or (2) its companies are affiliated companies through the same corporate parent. Except as otherwise specifically provided, provisions of this chapter which apply to an eligible small business shall continue to apply through the end of the rating period in which an eligible insured no longer meets the requirements of this definition

[58] According to M.G.L. c. 176J, § 4(c)(2)-(3),

"(2) A carrier shall not be required to renew the health benefit plan of an eligible individual or eligible small business if the individual or small business: (i) has not paid the required premiums; (ii) has committed fraud, misrepresented whether or not a person is an eligible individual or eligible employee, or misrepresented information necessary to determine the size of a group, the participation of a group, or the premium rate for a group; (iii) failed to comply in a material manner with health benefit plan provisions including, for employers, carrier requirements regarding employer contributions to group premiums; (iv) fails, at the time of renewal, to meet the participation requirements of the plan; (v) fails, at the time of renewal, to satisfy the definition of an eligible individual or eligible small business; or, (vi) in the case of a group, is not actively engaged in business.

(3) A carrier may refuse to renew enrollment for an eligible individual, eligible employee or eligible dependent if: (i) the eligible individual, eligible employee or eligible dependent has committed fraud, misrepresented whether or not he or she is an eligible individual, eligible employee or eligible dependent, or misrepresented information necessary to determine his eligibility for a health benefit plan or for specific health benefits; or (ii) the eligible individual, eligible employee or eligible dependent fails to comply in a material manner with health benefit plan provisions."

employee[59] within the eligible employer and to the eligible employee's eligible dependents[60] as noted in the original M.G.L. c. 176J, § 5(a), regardless of "actual or expected health condition."

There was an allowance built into the original M.G.L. c. 176J, § 2(b) that permitted association group policies[61] offered to qualified associations to be exempt from the provisions of M.G.L. c. 176J. Carriers writing products to qualified associations were not required to offer those products other than to members of the qualified associations.

If a carrier wishes to stop writing any specific product or all products to small employers, it was required to notify the Division and cease the offering on a uniform date.[62] If a carrier wished to cease renewing coverage, it was required to notify the Division and only start nonrenewing existing coverage according to rules established by regulation.[63]

Health Benefit Plan Benefits

The M.G.L. c. 176J under Chapter 495 did not establish benefit levels for products. Carriers were required to offer all available health benefit plans to eligible employers. The law clarified which benefit plans should be considered subject to this law and unless specifically identified as a benefit plan that

[59] According to M.G.L. c. 176J, § 1, an "eligible employee" is "an employee who: (1) works on a full-time basis with a normal work week of thirty or more hours, and includes an owner, a sole proprietor or a partner of a partnership; provided however, that such owner, sole proprietor or partner is included as an employee under a health care plan of an eligible small business but does not include an employee who works on a temporary or substitute basis, and (2) is hired to work for a period of not less than five months."

[60] According to M.G.L. c. 176J, § 1, an "eligible dependent" is "the spouse or child of an eligible person, subject to the applicable terms of the health benefit plan covering such employee."

[61] According to M.G.L. c. 176J, § 1, a "qualified group policy" is "a group policy that (1) is issued to an association or to a trust or maintained for the benefit of members of one or more associations, and (ii) issues or provides coverage to any of the following members of such association: employees thereof of employees of members or one or more of the preceding or all of any class or classes thereof. If employees are covered, such coverage be for the benefit of persons other than the employees; employer. A minimum of one hundred persons shall be eligible for coverage under the group policy as of its original issue date. The association shall have been organized and maintained in good faith for purposes other than that of obtaining insurance, as determined by the commissioner, shall have a constitution and by-laws or other governing documents analogous thereto and shall have been in active existence for at least one year."

[62] According to M.G.L. c. 176J, § 4(b)(1),

"a carrier may deny an eligible individual or eligible small group enrollment in a health benefit plan if the carrier certifies to the commissioner that the carrier intends to discontinue selling that health benefit plan to new eligible small businesses."

[63] According to 211 CMR 66.05(6):

"A Carrier that elects to nonrenew all of its Health Benefit Plans delivered or issued for delivery to Eligible Individuals and Eligible Small Businesses in Massachusetts: (a) must submit to the Commissioner, 30 days in advance of providing notice required under 211 CMR 66.05(6)(c) a statement certified by an officer of the Carrier that specifies:

1. The date by which it will nonrenew all of its Health Benefit Plans to all groups;
2. The reason(s) for the nonrenewal of all Health Benefit Plans;
3. The number of groups and individuals covered by the nonrenewed Health Benefit Plans, both in Massachusetts and in its total book of business; and
4. An acknowledgment that the Carrier is prohibited from writing new business in the individual and small group market in Massachusetts for a period of five years from the date of notice to the Commissioner.

is exempt from the law[64], carriers would be required to make the health benefit plan available to all eligible employers according to the requirements of the statute. For health benefit plans subject to M.G.L. c. 176J, they were permitted under M.G.L. c. 176J, § 6(a)[65] to offer coverage that did not include mandated benefits but only for those small businesses which did not provide health coverage to employees as of April 1, 1992.

Carriers were not permitted to establish waiting periods and pre-existing condition limitations except according to the limits allowed by law. Under Chapter 495, carriers were only permitted to apply clauses that limit coverage for a pre-existing condition for 6 months and only to conditions that manifested themselves during the 6 months immediately preceding coverage. Carriers were likewise not permitted to establish waiting periods that delayed coverage under a health plan for more than 6 months beyond the insured's coverage effective date. This was subsequently amended with changes made in 2006.

Premium Rating

Prior to Chapter 495, there were not any restrictions regarding the premium rates charged to eligible small groups and if carrier factored in a small group's past claims experience, rates could spike in a year following an unusual medical claim. With Chapter 495, any carrier wishing to participate in the small group health insurance market was expected to base its small group premium rates on the collective claims experience of the whole small group market. Carriers were permitted to vary premium rates by small employer but only based on actuarially developed factors based on the following unique characteristics of a group in comparison to other small groups: age and sex of eligible persons, number of eligible

[64] According to M.G.L. c. 176J, § 1,

" Health benefit plans shall not include: accident only, credit only, limited scope vision or dental benefits if offered separately; hospital indemnity insurance policies that provide a benefit to be paid to an insured or a dependent, including the spouse of an insured, on the basis of a hospitalization of the insured or a dependent, that are sold as a supplement and not as a substitute for a health benefit plan and that meet any requirements set by the commissioner by regulation; disability income insurance; coverage issued as a supplement to liability insurance; specified disease insurance that is purchased as a supplement and not as a substitute for a health plan and meets any requirements the commissioner by regulation may set; insurance arising out of a workers' compensation law or similar law; automobile medical payment insurance; insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in a liability insurance policy or equivalent self-insurance; long-term care if offered separately; coverage supplemental to the coverage provided under 10 U.S.C. 55 if offered as a separate insurance policy; travel insurance; or any policy subject to chapter 176K or any similar policies issued on a group basis, Medicare Advantage plans or Medicare Prescription drug plans. A health plan issued, renewed or delivered within or without the commonwealth to an individual who is enrolled in a qualifying student health insurance program under section 18 of chapter 15A shall not be considered a health plan for the purposes of this chapter and shall be governed by said chapter 15A."

[65] According to M.G.L. c. 176J, § 6(a),

"Notwithstanding any general or special law to the contrary, the commissioner may approve health insurance policies submitted to the division of insurance for the purpose of being provided to eligible individuals or eligible small businesses. These health insurance policies shall be subject to this chapter and may include networks that differ from those of a health plan's overall network. The commissioner shall adopt regulations regarding eligibility criteria. These eligibility criteria shall require that health insurance policies that exclude mandated benefits shall only be offered to small businesses which did not provide health insurance to its employees as of April 1, 1992. These eligibility criteria shall also provide that small businesses shall not have any health insurance policies that exclude mandated benefits for more than a 5–year period."

employees, rate that eligible employees have participated in the small group plan and industry of the group. Following a transition period in 1992 and 1993, carriers were expected to establish rating rules so that the premium charged to the lowest cost eligible group could not be more than two times the premium charged to the highest cost eligible group. Carriers were expected to submit annual actuarial certifications that all premiums charged to eligible small employers fell within the required 2-:1 rating band.

Stage Two: 1996 Rules for Coverage Offered to Small Employers/Individuals

When enacted, Chapter 297 of the Acts of 1996, "Chapter 297", amended M.G.L. c. 176J to further standardize coverage available to small employers beginning April 1, 1992. In order to implement the Chapter 297 amendments, the Division promulgated changes to 211 CMR 66.00.

Availability of Coverage

Chapter 297 made four major changes to the availability of coverage:

Expanded the size of the small group market;
Eliminated the blanket exemption for association health plans
Required the offering of "mini-COBRA" benefits; and
Created M.G.L. c. 176M to allow for guarantee issue products for individuals.

Expansion to small group market

Chapter 495 had created rules for coverage marketed to eligible employers with between 1 and 25 eligible employees, Chapter 297 changed M.G.L. c. 176J so that the rules would apply to coverage marketed to eligible employers with between 1 and 50 eligible employees. When implemented beginning August 15, 1996, carriers were required to ensure that all products previously made available to employer groups with between 1 and 25 eligible employees would be the only products that would be offered to groups with between 26 and 50 eligible employees. This expanded the array of products that would be available on a guarantee issue basis to groups with between 26 and 50 employees.

Elimination of the exemption for association health plans

Chapter 495 had created an exemption for association health plans allowing carriers to exclusively offer coverage to members of qualified associations without offering coverage to eligible employers not part of the qualified associations. Chapter 297 eliminated the association exemption. Carriers would be permitted to market coverage through associations, but the coverage was also required to be available to all other eligible small employers, and the products and rates offered through associations were fully subject to the benefit and rating rules of M.G.L. c. 176J.

Requirement to offer "mini-COBRA" benefits

Congress enacted the federal Consolidated Omnibus Budget Reconciliation Act (COBRA) in 1985 which, among other things, created continuation of coverage rights for persons in most employer-sponsored health benefit plans if they were separated from employment. With the enactment of COBRA, the eligible person was able to continue the benefits of the employer-sponsored health benefit plan for period of time dependent on the reason for separation from employment, as long as the affected individual paid the cost of the health benefit plan. Federal COBRA rights only applied to employers employing 20 or more individuals. Under Chapter 297, section 9 was added to M.G.L. c. 176J to require that health plans offer

right like the ones in federal COBRA rules to individuals who were employed in firms with between 2 and 19 employees.

Creation of Guarantee Issue Market for Individuals

Prior to Chapter 297, individuals wishing to obtain individual health coverage were required to apply for coverage from insurance companies. Blue Cross and Blue Shield of Massachusetts, Inc. was required under its authorizing statutes (M.G.L. c. 176A and M.G.L. 176B) to offer coverage to all Massachusetts residents, but would apply a 3-year pre-existing limitation to such coverage. All other companies would medically underwrite individual coverage and could deny coverage, apply exclusions or apply premium surcharges based on actual or projected claims for an individual.

Chapter 297 created M.G.L. c 176M, establishing a guaranteed issue market for individuals and required carriers with at least 5,000 lives in the small group market would be required to offer products on a guaranteed issue basis to all eligible individuals who resided in Massachusetts.

Health Plan Benefits for Small Groups

Expansion of Benefits to Association Plans and Groups with Between 26 and 50 Employees

The provisions of Chapter 495 now applied to a new group of employers, those in association health plans and employers with between 26 and 50 employees. Carriers were only permitted to apply clauses that limit coverage for a pre-existing condition for 6 months and only to conditions that manifested themselves during the 6 months immediately preceding coverage. Carriers were likewise not permitted to establish waiting periods that delayed coverage under a health plan for more than 6 months beyond the insured's coverage effective date.

Premium Rating

Chapter 297 prohibited carriers from using sex or gender in developing small group premiums. Otherwise, carriers were required to offer rates that were based on the collective claims experience of employers from both the 1-25 and the 26-50 employer groups. Carriers were given a 3-year transition period so that they could gradually reduce the variation of rates offered in the 26-50 market to the 2:1 rating rules that applies to the 1-25 market. There were also provisions in Chapter 297 that would require that the small group rating band be reduced to a 1.5:1 band as of 2000, but this was repealed by Chapter 61 of the Acts of 1999.

Stage Three: 2006 Rules to Merge Small Group and Nongroup Markets

Chapter 58 of the Acts of 2006, a comprehensive health reform law, was enacted in April 2006 and among other provisions, amended both M.G.L. c. 176J and M.G.L. c. 176J to merge the previously separate small group and nongroup markets beginning July 1, 2007.

Availability of Coverage

Chapter 297 changed M.G.L. c. 176J so that the rules would apply to coverage marketed to eligible individuals.[66] This expanded the array of products that would be available on a guarantee issue basis to all eligible individuals.

Premium Rating

Carriers were required to offer rates to the merged market that were based on the collective claims experience of individuals and employers with between 1 and 50 employees[67]. Carriers were given a 3-year transition period so that they could gradually reduce the variation of rates offered in the 26-50 market to the 2:1 rating rules that applies to the 1-25 market.

Creation of the Health Connector

The Commonwealth Health Insurance Connector Authority, "Health Connector", was created by statute under M.G.L. c. 176Q[68] to establish a health insurance marketplace to facilitate individuals and small employers purchase of health insurance from one central health exchange. The Health Connector was also empowered to coordinate a system to create and offer subsidized health coverage for individuals based on their level of income.

Stage Four A: 2010-2012 Rules to Encourage Cost Containment

When enacted, Chapter 288 of the Acts of 2010 modified M.G.L. c. 176J to do the following:

- Give the Division authority to review merged market premium rates and require health insurers to spend at least 90% of the premiums they collect on health care services for their members.
- Allow carriers to offer discounted merged market products to members of approved group purchasing cooperatives.
- Require carriers to offer a tiered or limited network product at substantial savings compared to full network plans.
- Modify the definition of "eligible individual" to restrict eligibility for individual coverage to those who did not already have coverage through employment.

Rate Review

M.G.L. c. 176J was amended to require that all merged market carriers submit quarterly rate filings at least 90 days and that all such filings would be reviewed by Division staff according to statutory standards.

---

[66] See https://malegislature.gov/Laws/GeneralLaws/PartI/TitleXXII/Chapter176J/Section4.

[67] According to M.G.L. c. 176J, $3(a)(1)(i)-(ii):

"For every health benefit plan issued or renewed to eligible individuals and eligible small groups, including a certificate issued to an eligible individual or eligible small group that evidences coverage under a policy or contract issued or renewed to a trust, association or other entity that is not a group health plan, a carrier shall develop a group base premium rate that is the same for eligible individuals and eligible small groups. In developing these merged market group base premium rates, carriers:

(i) with respect to the group base premium rate developed for eligible individuals and eligible small groups, a carrier shall consider all enrollees in those health plans, other than grandfathered health plans, offered by such carrier to be members of a merged individual and small group risk pool;

(ii) in calculating the premium to be charged to each eligible individual or eligible small group, a carrier shall develop a base premium and use only those rate adjustment factors identified in this section, inclusive, for all insured health benefit plans offered to eligible individuals and eligible small groups, respectively, with all other rating adjustments being prohibited;"

[68] See https://malegislature.gov/laws/generallaws/parti/titlexxii/chapter176q.

The Division was expected to complete reviews and decide whether to disapprove filings by no later than 45 days before the proposed effective date.[69] The statute was further amended so that if rates were

[69] SECTION 29. Said chapter 176J is hereby further amended by striking out section 6, as so appearing, and inserting in place thereof the following section:-

Section 6. (a) Notwithstanding any general or special law to the contrary, the commissioner may approve health insurance policies submitted to the division of insurance for the purpose of being provided to eligible individuals or eligible small businesses. These health insurance policies shall be subject to this chapter and may include networks that differ from those of a health plan's overall network. The commissioner shall adopt regulations regarding eligibility criteria. These eligibility criteria shall require that health insurance policies that exclude mandated benefits shall only be offered to small businesses which did not provide health insurance to its employees as of April 1, 1992. These eligibility criteria shall also provide that small businesses shall not have any health insurance policies that exclude mandated benefits for more than a 5-year period.

(b) Notwithstanding any general or special law to the contrary, the commissioner shall require carriers offering health benefit plans to eligible small businesses and eligible individuals to submit information as required by the commissioner, which shall include the current and projected medical loss ratio for plans the components of projected administrative expenses and financial information, including, but not limited to:

(i) underwriting, auditing, actuarial, financial analysis, treasury and investment expenses;

(ii) marketing and sales expenses, including, but not limited to, advertising, member relations, member enrollment and all expenses associated with producers, brokers and benefit consultants;

(iii) claims operations expenses, including, but not limited to, adjudication, appeals, settlements and expenses associated with paying claims;

(iv) medical administration expenses, including, but not limited to, disease management, utilization review and medical management;

(v) network operations expenses, including, but not limited to, contracting, hospital and physician relations and medical policy procedures;

(vi) charitable expenses, including, but not limited to, contributions to tax-exempt foundations and community benefits;

(vii) state premium taxes;

(viii) board, bureau and association fees;

(ix) depreciation; and

(x) miscellaneous expenses described in detail by expense, including any expense not included in clauses (i) to (ix), inclusive.

(c) Notwithstanding any general or special law to the contrary, the commissioner may require carriers offering small group health insurance plans, including carriers licensed under chapters 175, 176A, 176B or 176G, to file all changes to small group product base rates and to small group rating factors at least 90 days before their proposed effective date. The commissioner shall disapprove any proposed changes to base rates that are excessive, inadequate or unreasonable in relation to the benefits charged. The commissioner shall disapprove any change to small group rating factors that is discriminatory or not actuarially sound. Rate filing materials submitted for review by the division shall be deemed confidential and exempt from the definition of public records in clause Twenty-sixth of section 7 of chapter 4. The commissioner shall adopt regulations to carry out this section.

(d) For base rate changes filed under this section, if a carrier files a base rate whose administrative expense loading component, not including taxes and assessments, increases by more than the most recent calendar year's percentage increase in the New England medical CPI or if a carrier's reported contribution to surplus exceeds 1.9 per cent or if the aggregate medical loss ratio for all plans offered under this chapter is less than 88 per cent , such carrier's rate, in addition to being subject to all other provisions of this chapter, shall be presumptively disapproved as excessive by the commissioner as set forth in this subsection, with the exception of any carrier whose Risk Based Capital Ratio falls below 300% for the most recent four consecutive quarters. For such carriers the reported contribution to surplus may not exceed 2.5 per cent.

If, however, a carrier's base rates are presumptively disapproved for failure to meet only the aggregate medical loss ratio threshold of 88 per cent, the carrier's base rates shall nevertheless not be presumptively disapproved as excessive by the commissioner if the carrier's aggregate medical loss ratio for all plans offered under this chapter is not less than 1 per cent greater than the carrier's equivalent medical loss ratio was 12-months prior to the carrier's present rate filing.

If the annual aggregate medical loss ratio for all plans offered under this chapter is less than 88 per cent, or less than the medical loss ratio that was not presumptively disapproved by the commissioner for being in excess of 1% of the carrier's prior

year base rate, over the applicable 12-month period, the carrier shall refund the excess premium to its eligible individuals and eligible small groups. A carrier shall communicate within 30 days to all individuals and small groups that were covered under plans during the relevant 12-month period that such individuals and small groups qualify for a refund to be issued under this paragraph, which may take the form of either a refund on the premium for the applicable 12-month period, or if the individual or groups are still covered by the carrier, a credit on the premium for the subsequent 12-month period. The total of all refunds issued shall equal the amount of a carrier's earned premium that exceeds that amount necessary to achieve a medical loss ratio of 88 per cent, calculated using data reported by the carrier as prescribed under regulations promulgated by the commissioner. The commissioner may authorize a waiver or adjustment of this requirement only if it is determined that issuing refunds would result in financial impairment for the carrier.

(e) If a proposed base rate change has been presumptively disapproved:

(1) A carrier shall communicate to all employers and individuals covered under a small group product that the proposed increase has been presumptively disapproved and is subject to a hearing at the division of insurance.

(2) The commissioner shall conduct a public hearing and shall advertise it in newspapers in the cities of Boston, Brockton, Fall River, Pittsfield, Springfield, Worcester, New Bedford and Lowell, or shall notify such newspapers of the hearing.

(3) The attorney general may intervene in a public hearing or other proceeding under this subsection and may require additional information as the attorney general consider necessary to ensure compliance with this subsection.

The commissioner shall adopt regulations to specify the scheduling of the hearings required pursuant to this section.

(f) If the commissioner disapproves the rate submitted by a carrier the commissioner shall notify the carrier in writing no later than 45 days prior to the proposed effective date of the carrier's rate. The carrier may submit a request for hearing with the division of insurance within 10 days of such notice of disapproval. The division must schedule a hearing within 15 days of receipt. The commissioner shall issue a written decision within 30 days after the conclusion of the hearing. The carrier may not implement the disapproved rates, or changes at any time unless the commissioner reverses the disapproval after a hearing or unless a court vacates the commissioner's decision.

disapproved that the carrier would be required to notify insureds and continue rates that were in place prior to the filing.[70] The Division was also given greater authority to review rating factors used in setting individuals' and employers' premiums[71] and loss ratios were set at 90%.[72]

Limited and Tiered Network Health Plans

Carriers with more than 5,000 persons covered under merged market health plans were required to offer at least one limited or tiered network health plan that costs at least 12% less than the carriers' broadest network products.[73]

---

[70] SECTION 31. Said section 6 of said chapter 176J is hereby further amended by striking out clause (d), (e), and (f), as appearing in section 29, inserting in place thereof the following 2 subsections:-

(d) If a proposed base rate change has been disapproved:

(1) A carrier shall communicate to all employers and individuals covered under a small group product that the proposed increase has been presumptively disapproved and is subject to a hearing at the division of insurance.

(2) The commissioner shall conduct a public hearing and shall advertise it in newspapers in Boston, Brockton, Fall River, Pittsfield, Springfield, Worcester, New Bedford and Lowell, or shall notify such newspapers of the hearing.

(3) The attorney general may intervene in a public hearing or other proceeding under this subsection and may require additional information as the attorney general consider necessary to ensure compliance with this subsection.

(e) If the commissioner disapproves the rate submitted by a carrier the commissioner shall notify the carrier in writing no later than 45 days prior to the proposed effective date of the carrier's rate. The carrier may submit a request for hearing with the division of insurance within 10 days of such notice of disapproval. The division must schedule a hearing within 15 days of receipt. The commissioner shall issue a written decision within 30 days after the conclusion of the hearing. The carrier may not implement the disapproved rates, or changes at any time unless the commissioner reverses the disapproval after a hearing or unless a court vacates the commissioner's decision.

[71] SECTION 24. Subsection (a) of section 3 of said chapter 176J, as so appearing, is hereby amended by striking out clause (2) and inserting in place thereof the following clause:-

(2) A carrier may establish an age rate adjustment that applies to both eligible individuals and eligible small groups; provided, however, that the carrier applies the rate adjustment on a year-to-year basis for both eligible individuals and eligible small groups.

SECTION 25. Said section 3 of said chapter 176J, as so appearing, is hereby further amended by adding the following subsection:-

(f) The commissioner may conduct an examination of the rating factors used in the small group health insurance market in order to identify whether any expenses or factors inappropriately increase the cost in relation to the risks of the affected small group. The commissioner may adopt changes to the small group regulation each July 1 for rates effective each subsequent January 1 to modify the derivation of group base premium rates or of any factor used to develop individual group premiums.

[72] SECTION 30. Said section 6 of said chapter 176J, as appearing in section 29, is hereby further amended by striking out the figure "88", each time it appears, and inserting in place thereof the following figure:- 90.

[73] SECTION 32. Said chapter 176J is hereby amended by adding the following section:-

Section 11. (a) A carrier that offers a health benefit plan that: (i) provides or arranges for the delivery of health care services through a closed network of health care providers; and (ii) as of the close of any preceding calendar year, has a combined total of 5,000 or more eligible individuals, eligible employees and eligible dependents, who are enrolled in health benefit plans sold, issued, delivered, made effective or renewed to qualified small businesses or eligible individuals, shall offer to all eligible individuals and small businesses in at least 1 geographic area at least one plan with either a reduced or selective network of providers, or a plan in which providers are tiered and member cost sharing is based on the tier placement of the provider.

The base premium for the reduced or selective network, or tiered network plan shall be at least 12 per cent lower than the base premium of the carrier's most actuarially similar plan with the carrier's non-selective or non-tiered network of providers.

(b) A tiered network plan shall only include variations on member cost-sharing between provider tiers, which are reasonable in relation to the premium charged, as long as the carrier provides adequate access to covered services at lower patient cost sharing levels.
(c) The commissioner shall determine network adequacy for a tiered network plan based on the availability of sufficient network providers in the carrier's overall tiered network plan.
(d) The commissioner shall determine network adequacy for a select network plan based on the availability of sufficient network providers in the carrier's select network of providers.
(e) In determining network adequacy under this section the commissioner may consider factors including: the location of providers participating in the plan; employers or members that enroll in the plan; the range of services provided by providers in the plan; and any plan benefits that recognize and provide for extraordinary medical needs of members that may not be adequately dealt with by the providers within the plan network.
(f) Carriers may: (i) reclassify provider tiers; or (ii) determine provider participation in selective and tiered plans no more than once per calendar year; provided, however, that carriers may reclassify providers from a higher-cost tier to a lower cost tier or add new providers to its selective and tiered plans at any time. If the carrier reclassifies provider tiers or providers participating in a selective plan during the course of an account year, the carrier shall provide affected members of the account with information regarding the plan changes at least 30 days before the changes take effect. Carriers shall provide information on their websites about any tiered or selective plan, including, but not limited to, the providers participating in the plan, the selection criteria for those providers and if applicable, the tier in which each provider is classified.
(g) The division of insurance shall report annually on utilization trends of eligible employers and eligible individuals enrolled in plans offered under this section The report shall include the number of members enrolled by plan type, de-identified aggregate demographic, and geographic information on all members and the average direct premium claims incurred for selective and tiered network plans compared to non-selective and non-tiered plans.

SECTION 33. Said chapter 176J is hereby further amended by striking out section 11, as inserted by section 23, and inserting in place thereof the following section:-
Section 11. (a) A carrier that offers a health benefit plan that: (i) provides or arranges for the delivery of health care services through a closed network of health care providers; and (ii) as of the close of any preceding calendar year, has a combined total of 5,000 or more eligible individuals, eligible employees and eligible dependents, who are enrolled in health benefit plans sold, issued, delivered, made effective or renewed to qualified small businesses or eligible individuals, shall offer to all eligible individuals and small businesses in at least 1 geographic area at least 1 plan with either a reduced or selective network of providers or a plan in which providers are tiered and member cost sharing is based on the tier placement of the provider.

The base premium for the reduced or selective or tiered network plan shall be at least 12 per cent lower than the base premium of the carrier's most actuarially similar plan with the carrier's non-selective or non-tiered network of providers. The savings may be achieved by means including, but not limited to: (i) the exclusion of providers with similar or lower quality based on the standard quality measure set with higher health status adjusted total medical expenses or relative prices, as determined under section 6 of chapter 118G; or (ii) increased member cost-sharing for members who utilize providers for non-emergency services with similar or lower quality based on the standard quality measure set and with higher health status adjusted total medical expenses or relative prices, as determined under section 6 of chapter 118G.

(b) A tiered network plan shall only include variations in member cost-sharing between provider tiers which are reasonable in relation to the premium charged and ensure adequate access to covered services. Carriers shall tier providers based on quality performance as measured by the standard quality measure set and by cost performance as measured by health status adjusted total medical expenses and relative prices. Where applicable quality measures are not available, tiering may be based solely on health status adjusted total medical expenses or relative prices or both.
The commissioner shall promulgate regulations requiring the uniform reporting of tiering information, including, but not limited to requiring, at least 90 days before the proposed effective date of any tiered network plan or any modification in the tiering methodology for any existing tiered network plan, the reporting of a detailed description of the methodology used for tiering providers, including: the statistical basis for tiering; a list of providers to be tiered at each member cost-sharing level; a description of how the methodology and resulting tiers will be communicated to each network provider, eligible individuals and small groups; and a description of the appeals process a provider may pursue to challenge the assigned tier level.

Small Group Purchasing Cooperative

M.G.L. c. 176J was amended to permit the establishment of 6 small business group purchasing cooperatives[74] which could contract directly with carriers for discounted premiums on behalf of savings associated with wellness initiatives developed for plan members. The group purchasing cooperative would need to be approved by the Division for meeting wellness and other enrollment standards, to contract with qualified associations[75] not formed for the purpose of obtaining insurance composed of small employers.

Carriers were permitted to develop a group purchasing cooperative rating factor that would discount the premiums on behalf of savings associated with wellness[76] initiatives developed for plan members. A group purchasing cooperative would need to be approved by the Division for meeting wellness and other

(c) The commissioner shall determine network adequacy for a tiered network plan based on the availability of sufficient network providers in the carrier's overall network of providers.
(d) The commissioner shall determine network adequacy for a selective network plan based on the availability of sufficient network providers in the carrier's selective network.
(e) In determining network adequacy under this section the commissioner of insurance may take into consideration factors such as the location of providers participating in the plan and employers or members that enroll in the plan, the range of services provided by providers in the plan and plan benefits that recognize and provide for extraordinary medical needs of members that may not be adequately dealt with by the providers within the plan network.
(f) Carriers may: (i) reclassify provider tiers; and (ii) determine provider participation in selective and tiered plans no more than once per calendar year except that carriers may reclassify providers from a higher-cost tier to a lower cost tier or add providers to a selective network at any time. If the carrier reclassifies provider tiers or providers participating in a selective plan during the course of an account year, the carrier shall provide affected members of the account with information regarding the plan changes at least 30 days before the changes take effect. Carriers shall provide information on their websites about any tiered or selective plan, including but not limited to, the providers participating in the plan, the selection criteria for those providers and where applicable, the tier in which each provider is classified.
(g) The division of insurance shall report annually on utilization trends of eligible employers and eligible individuals enrolled in plans offered under this section. The report shall include the number of members enrolled by plan type, aggregate demographic, geographic information on all members and the average direct premium claims incurred, as defined in section 6, for selective and tiered network products compared to non-selective and non-tiered products.

[74] SECTION 22. Said section 1 of said chapter 176J, as so appearing, is hereby further amended by inserting after the definition of "Resident" the following definition:-
"Small business group purchasing cooperative", or "group purchasing cooperative", a Massachusetts nonprofit or not-for-profit corporation or association, approved as a qualified association by the commissioner under section 13, all the members of which are part of a qualified association which negotiates with 1 or more carriers for the issuance of health benefit plans that cover employees, and the employees' dependents, of the qualified association's members.

[75] SECTION 21. Said section 1 of chapter 176J, as so appearing, is hereby further amended by inserting after the definition of "Prototype plan" the following definition:-
"Qualified association", a Massachusetts nonprofit or not-for-profit corporation or other entity organized and maintained for the purposes of advancing the occupational, professional, trade or industry interests of its association members, other than that of obtaining health insurance, and that has been in active existence for at least 5 years, that comprises at least 100 association members and membership in which is generally available to potential association members of such occupation, profession, trade or industry without regard to the health condition or status of a prospective association member or the employees and dependents of a prospective association member.

[76] SECTION 23. Said section 1 of said chapter 176J, as so appearing, is hereby further amended by adding the following definition:-
"Wellness program", or "health management program", an organized system designed to improve the overall health of participants through activities that may include, but shall not be limited to, education, health risk assessment, lifestyle coaching, behavior modification and targeted disease management.

enrollment standards, to contract with qualified associations not formed for the purpose of obtaining insurance composed of small employers.

Tightening of Enrollment Rules

M.G.L. was further amended to tighten the rules for eligible individuals,[77] clarify annual open rules for individuals[78] and identify when small group plans could be discontinued from offer.[79]

Stage Four B: 2010-2012 Rules to Encourage Cost Containment

Chapter 359 of the Acts of 2010

This statute made technical corrections to Chapter 288 to clarify that certain parts of rates filings that describe provider rates of reimbursement or rating factors would be considered confidential,[80] to clarify

[77] SECTION 20. Section 1 of said chapter 176J, as so appearing, is hereby amended by striking out the definition of "Eligible individual" and inserting in place thereof the following definition:-
"Eligible individual", an individual who is a resident of the commonwealth and who is not seeking individual coverage to replace an employer-sponsored health plan for which the individual is eligible and which provides coverage that is at least actuarially equivalent to minimum creditable coverage.

[78] SECTION 27. Said subsection (a) of said section 4 of said chapter 176J is hereby further amended by striking out paragraph (3), as appearing in section 26, and inserting in place thereof the following paragraph:-
(3) A carrier shall enroll an eligible individual who does not meet the requirements of paragraph (2) into a health benefit plan during the mandatory annual open enrollment period for eligible individuals and their dependents. Each year, the open enrollment period shall begin on July 1 and end on August 15. A carrier shall only enroll an eligible individual who does not meet the requirements of paragraph (2) into a health benefit plan during the open enrollment period. All coverage shall become effective on the first day of the month following enrollment. The commissioner shall promulgate regulations for the open enrollment period permissible under this section. With respect to Trade Act/Health Coverage Tax Credit Eligible Persons, a carrier may impose a pre-existing condition exclusion or waiting period of no more than 6 months following the individual's effective date of coverage if the Trade Act/Health Coverage Tax Credit Eligible Person has had less than 3 months of continuous health coverage before becoming eligible for the health care tax credit; or a break in coverage of over 62 days immediately before the date of application for enrollment into the qualified health plan.

[79] SECTION 28. Subsection (b) of said section 4 of said chapter 176J, as appearing in the 2008 Official Edition, is hereby amended by striking out clause (1) and inserting in place thereof the following clause:
(1) Notwithstanding any other provision in this section, a carrier may deny an eligible individual or eligible small group enrollment in a health benefit plan if the carrier certifies to the commissioner that the carrier intends to discontinue selling that health benefit plan to new eligible individuals or eligible small businesses. A health benefit plan closed to new members may be cancelled and discontinued to all members upon the approval of the commissioner of insurance when such plan has been closed to enrollment for new individuals and small groups and the carrier has complied with the requirements of 42 U.S.C. Sec. 300gg-12; provided, however, that cancellation of the plan shall be effective on the individual or small group's next enrollment anniversary after such cancellation is approved by the commissioner of insurance. The commissioner may promulgate regulations prohibiting a carrier from using this paragraph to circumvent the intent of this chapter.

[80] SECTION 31A. The fourth sentence of subsection (c) of section 6 of chapter 176J of the General Laws, as amended by section 29 of chapter 288 of the acts of 2010, is hereby further amended by striking out the words "Rate filing materials submitted for review by the division shall be deemed confidential and exempt from the definition of public records in clause Twenty-sixth of section 7 of chapter 4" and inserting in place thereof the following words:- Any rates of reimbursement included in the rate filing materials submitted for review by the division shall be deemed confidential and exempt from the definition of public records in clause Twenty-sixth of section 7 of chapter 4. The commissioner shall adopt regulations to carry out this section.

that certain rate review standards would lead to presumptive disapprovals[81] and that group purchasing cooperatives would be limited to no more than 85,000 merged market members.[82]

Stage Four C: 2010-2012 Rules to Encourage Cost Containment

Chapter 224 of the Acts of 2012

This statute made changes to existing statutes to improve cost containment through transparency, innovation and efficiency. Insurance carriers were required to develop information for covered persons to understand the relative cost of care from differing providers, were encouraged to adopt alternative payment methodologies, and fostered the development of streamlined administrative processes to access care. This statute also created a new agency, the Health Policy Commission to monitor health care increases and to develop a health care cost benchmark linked to the state's overall economy and providers and payers were expected to hold costs below this benchmark.

Within the merged market, the statute was amended to permit carriers to offer a wellness program discount for groups qualifying for the discount,[83] modified the required loss ratio to be used for merged market accounts to be set reduced from 90 to 89% between April 1, 2014 and March 31, 2015 and at 88% thereafter,[84] allowed carriers to develop smart tiering products that would assign providers to tiers by services (e.g., a surgical unit in a hospital might be at a tier 2 level while a medical unit might be at a tier 1 level),[85] permit greater variability in the discounts available when coverage was obtained from group

[81] SECTION 31B. Clause (i) of subsection (d) of said section 6 of said chapter 176J, as appearing in section 31 of said chapter 288 is hereby amended by striking out the word "presumptively".

[82] SECTION 32. The second sentence of subsection (b) of section 12 of said chapter 176J, as appearing in section 34 of said chapter 288 is hereby amended by striking out the words ", for each approved group purchasing cooperative, in the aggregate, shall not exceed 85,0000" and inserting in place thereof the following words:- for all approved group purchasing cooperatives, in the aggregate, shall not exceed 85,000.

[83] SECTION 174. Subsection (a) of section 3 of chapter 176J, as appearing in the 2010 Official Edition, is hereby amended by striking out paragraph (5) and inserting in place thereof the following paragraph:-
(5) A carrier shall apply a wellness program rate discount that applies to both eligible individuals and eligible small groups who follow those wellness programs that have been approved by the commissioner. If a carrier establishes a wellness program rate discount every eligible insured following the wellness program shall be subject to the applicable wellness program rate discount. The division shall determine by regulation the criteria for qualifying for the rate discount. The criteria may require (i) a minimum participation in the programs by percentage, (ii) promoting healthy workplace habits, (iii) promoting health screenings, (iv) promoting health education and (v) any other criteria that the commissioner of insurance deems reasonable.

[84] SECTION 175. Section 6 of said chapter 176J, as amended by section 20 of chapter 142 of the acts of 2011, is hereby further amended by striking out the figure "90", each time it appears, and inserting in place thereof the following figure:- 89.
SECTION 176. Said section 6 of said chapter 176J, as so amended, is hereby further amended by striking out the figure "89", as inserted by section 175, and inserting in place thereof, in each instance, the following figure:- 88.

[85] SECTION 177. Said chapter 176J is hereby further amended by striking out section 11, as appearing in the 2010 Official Edition, and inserting in place thereof the following:-
Section 11. (a) A carrier that offers a health benefit plan that: (i) provides or arranges for the delivery of health care services through a closed network of health care providers; and (ii) as of the close of any preceding calendar year, has a combined total of 5,000 or more eligible individuals, eligible employees and eligible dependents, who are enrolled in health benefit

plans sold, issued, delivered, made effective or renewed to qualified small businesses or eligible individuals, shall offer to all eligible individuals and small businesses in at least 1 geographic area at least 1 plan with either:
(1) a reduced or selective network of providers;
(2) a smart tiering plan in which health services are tiered and member cost sharing is based on the tier placement of the services; or,
(3) a plan in which providers are tiered and member cost sharing is based on the tier placement of the provider.
The commissioner of insurance shall annually determine a base premium rate discount of at least 14 per cent for the reduced or selective or tiered network plan compared to the base premium of the carrier's most actuarially similar plan with the carrier's non-selective or non-tiered network of providers. The savings may be achieved by means including, but not limited to: (i) the exclusion of providers with similar or lower quality based on the standard quality measure set with higher health status adjusted total medical expenses or relative prices, as determined under section 10 of chapter 12C; or (ii) increased member cost-sharing for members who utilize providers for non-emergency services with similar or lower quality based on the standard quality measure set and with higher health status adjusted total medical expenses or relative prices, as determined under said section 10 of said chapter 12C.
The commissioner may apply waivers to the base premium rate discount determined by the commissioner under this section to carriers who receive 80 per cent or more of their incomes from government programs or which have service areas which do not include either Suffolk or Middlesex counties and who were first admitted to do business by the division of insurance on January 1, 1988, as health maintenance organizations under chapter 176G.
(b) A tiered network plan shall only include variations in member cost-sharing between provider tiers which are reasonable in relation to the premium charged and ensure adequate access to covered services. Carriers shall tier providers based on quality performance as measured by the standard quality measure set and by cost performance as measured by health status adjusted total medical expenses and relative prices. Where applicable quality measures are not available, tiering may be based solely on health status adjusted total medical expenses or relative prices or both. Smart tiering plans may take into account the number of services performed each year by the provider. For smart tiering plans, if a medically necessary and covered service is available at not more than 5 facilities in the state, as determined by the health policy commission, that service shall not be placed into the most expensive cost-sharing tier.
The commissioner shall promulgate regulations requiring the uniform reporting of tiering information, including, but not limited to, requiring at least 90 days before the proposed effective date of any tiered network plan or any modification in the tiering methodology for any existing tiered network plan, the reporting of a detailed description of the methodology used for tiering providers, including: the statistical basis for tiering; a list of providers to be tiered at each member cost-sharing level; a description of how the methodology and resulting tiers will be communicated to each network provider, eligible individuals and small groups; and a description of the appeals process a provider may pursue to challenge the assigned tier level.
(c) The commissioner shall determine network adequacy for a tiered network plan based on the availability of sufficient network providers in the carrier’s overall network of providers.
(d) The commissioner shall determine network adequacy for a selective network plan based on the availability of sufficient network providers in the carrier’s selective network.
(e) In determining network adequacy under this section the commissioner of insurance may take into consideration factors such as the location of providers participating in the plan and employers or members that enroll in the plan, the range of services provided by providers in the plan and plan benefits that recognize and provide for extraordinary medical needs of members that may not be adequately dealt with by the providers within the plan network.
(f) Carriers may: (i) reclassify provider tiers; and (ii) determine provider participation in selective and tiered plans not more than once per calendar year except that carriers may reclassify providers from a higher cost tier to a lower cost tier or add providers to a selective network at any time. If the carrier reclassifies provider tiers or providers participating in a selective plan during the course of an account year, the carrier shall provide affected members of the account with information regarding the plan changes at least 30 days before the changes take effect. Carriers shall provide information on their websites about any tiered or selective plan, including but not limited to, the providers participating in the plan, the selection criteria for those providers and where applicable, the tier in which each provider is classified.
(g) A smart tiering plan shall be a tiering product, which offers a cost-sharing differential based on services rather than facilities providing services. A service covered in a smart tiering plan may be reimbursed through bundled payments for acute and chronic diseases.

purchasing cooperatives, [86] and required that carriers assign primary care providers to coordinate a member's care.[87]

(h) The division of insurance shall review smart tiering plans in a manner consistent with other products offered in the commonwealth. The division of insurance may disapprove a smart tiering plan if it determines that the carrier differentiated cost-sharing obligations solely based on the provider. There shall be a rebuttable presumption that a plan has violated this subsection if the cost-sharing obligation for all services provided by a provider, including a health care facility, accountable care organization, patient centered medical home, or provider organization, is the same.

(i) The commissioner when reviewing smart tiering plans shall promote the following goals: (1) avoid creating consumer confusion; (2) minimize the administrative burdens on payers and providers in implementing smart tiering plans; and (3) allow patients to get their services in the proper locations.

(j) The division of insurance shall report annually specific findings and legislative recommendations, including the following: (1) the utilization trends of eligible employers and eligible individuals enrolled in plans offered under this section; (2) the extent to which tiered product offerings have reduced health care costs for patients and employers; (3) the effects that tiered product offerings have on patient education relating to health care costs and quality; (4) the effects that tiered product offerings have on patient utilization of local hospitals and the resulting impact on overall state health care costs, including the state's compliance with the health care cost growth benchmark established under section 9 of chapter 6D; (5) opportunities to incentivize tiered product offerings for both health systems and employers. The report shall also include the number of members enrolled by plan type, aggregate demographic, geographic information on all members and the average direct premium claims incurred, as defined in section 6, for selective and tiered network products compared to non-selective and non-tiered products. The report shall be submitted to clerks of the house of representatives and the senate, the senate and house committees on ways and means and the joint committee on health care financing.

[86] SECTION 179. Said section 12 of said chapter 176J, as so appearing, is hereby further amended by adding the following subsection:—

(h) Any rates offered by a carrier to a certified group purchasing cooperative under this section shall be based on those group base premium rates that apply to individuals and small employer groups enrolling outside the group purchasing cooperative but may differ based on:

(1) a benefit rate adjustment factor that would apply to the certified group purchasing cooperative product if its covered benefits are different than those that apply outside the certified group purchasing cooperative;

(2) a cooperative adjustment factor that would reflect the relative difference in the projected experience of the members projected to be enrolled in health benefit plans through the certified group purchasing cooperative relative to the projected experience of the members projected to be enrolled in health benefit plans outside the certified group purchasing cooperative; or

(3) any other rate adjustment factor resulting in a discount of up to 10 per cent. Any adjustment greater than 10 per cent shall require prior approval in writing from the commissioner.

[87] SECTION 180. Said chapter 176J is hereby further amended by adding the following 2 sections:-

Section 16. To the maximum extent possible, carriers shall attribute every member to a primary care provider. Members may change their primary care provider, provided that the member gives notice to the carrier.

Section 17. To the extent permissible under applicable state and federal privacy laws, every carrier shall disclose patient-level data to providers in their network solely for the purpose of carrying out treatment, coordinating care among providers and managing the care of their own patient panel; provided, that an individual provider shall only receive patient-level data related to patients treated by said provider. Patient-level data shall include, but not be limited to, health care service utilization, medical expenses, and demographics.

The division of insurance shall develop procedures and a standard format for disclosing such patient panel; provided, that an individual provider shall only receive patient-level data related to patients treated by said provider. Patient-level data shall include, but not be limited to, health care service utilization, medical expenses, and demographics. The division of insurance shall develop procedures and a standard format for disclosing such patient-level information. The division may require carriers to disclose such information through the all-payer claims database established under section 12 of chapter 12C if the division and the center for health information and analysis determine that the all-payer claims database is an efficient means to provide such information.

Carriers shall make available to any provider with whom they have entered into an alternative payment contract, the contracted prices of individual health care services within such payer's network for the purpose of referrals.

Stage Five: 2013 Rules to Implement

Federal ACA Provisions

Chapter 35 of the Acts of 2013

This statute was enacted to implement changes to Massachusetts insurance laws so that they would be consistent with requirements in the federal Patient Protection and Affordable Care Act of 2010, "ACA" as that law was scheduled to go into effect on January 1, 2014. Although the ACA was modeled on many features of Massachusetts' health coverage markets, certain changes were necessary to meet the standards of the ACA.

First, Massachusetts statutes were modified so that definitions[88] and process[89] used to define who were eligible for merged market coverage were consistent with federal law. Second, the method to develop

[88] SECTION 43. Section 1 of chapter 176J of the General Laws, is hereby amended by striking out the definition of "Eligible dependent", as so appearing, and inserting in place thereof the following definition:-
"Eligible dependent", the spouse or child of an eligible person, subject to the applicable terms of the health benefit plan covering such employee. The child of an eligible individual or eligible employee shall be considered an eligible dependent until the end of the child's twenty-sixth year of age.
SECTION 44. Said section 1 of said chapter 176J is hereby further amended by striking out the definition of "Eligible individual", as most recently amended by section 30 of chapter 118 of the acts of 2012, and inserting in place thereof the following definition:-
"Eligible individual", an individual who is a resident of the commonwealth.
SECTION 45. Said section 1 of said chapter 176J is hereby further amended by inserting after the definition of "Financial impairment", as appearing in the 2010 Official Edition, the following definition:-
"Grandfathered health plan", any group health plan or health insurance coverage to which 42 U.S.C. section 18011 applies.
SECTION 46. Said section 1 of said chapter 176J is hereby further amended by striking out the definition of "Pre-existing conditions provision", as so appearing.
SECTION 47. Said section 1 of said chapter 176J is hereby further amended by striking out the definition of "Waiting period", as so appearing.

[89] SECTION 49. Subsection (a) of section 4 of said chapter 176J, as most recently amended by section 8 of chapter 3 of the acts of 2013, is hereby further amended by striking out paragraph (2) and inserting in place thereof the following paragraph:-
(2) A carrier shall enroll eligible individuals, as defined by section 1, and eligible individuals, as defined in section 2741 of the Health Insurance Portability and Accountability Act of 1996, 42 U.S.C. section 300gg-41(b), into a health plan if those individuals request coverage within 63 days of termination of any prior creditable coverage. A carrier shall also enroll eligible individuals, as permitted under the Patient Protection and Affordable Care Act, Public Law 111-148, and any rules, regulations and guidances applicable thereto, as amended from time to time. A carrier shall enable any such eligible individual to renew coverage if that coverage is available to other eligible individuals. Coverage shall become effective in accordance with said Patient Protection and Affordable Care Act, and any rules, regulations and guidances applicable thereto, as amended from time to time, subject to reasonable verification of eligibility, and shall be effective through December 31 of that same year. Carriers shall notify any such eligible individuals that:
(i) coverage shall be in effect only through December 31 of the year of enrollment;
(ii) if any such eligible individual is in a health plan with a plan-year deductible or out-of-pocket maximum, an explanation of how that deductible or out-of-pocket maximum and premiums will be impacted for the period between the plan effective date and December 31 of the enrollment year; and
(iii) the next open enrollment period during which any such eligible individual shall have the opportunity to enroll in a health plan that will begin on January 1 of the following calendar year.
A carrier shall not impose a pre-existing condition exclusion or waiting period of any duration on a health plan.
SECTION 49A. Subsection (b) of section (4) of said chapter 176J, as appearing in the 2010 Official Edition, is hereby amended by adding the following paragraph:-

premiums was modified so that only federally permitted rating factors were allowed to be used in the merged market.[90]

(5) Notwithstanding any other provision in this section, with respect to a health benefit plan offered only through a public exchange that pursuant to federal law and regulation does not include pediatric dental benefits, a carrier may deny an eligible individual or eligible small business of any size enrollment in such health benefit plan unless the eligible individual or eligible small business enrolls through the connector. If an eligible individual or eligible small business elects to enroll through the connector, a carrier may not deny that eligible individual or eligible small business enrollment. The carrier shall implement such requirements consistently, treating all eligible individuals and eligible small business in a similar manner.
SECTION 50. Said chapter 176J is hereby further amended by striking out section 5, as so appearing, and inserting in place thereof the following section:-
Section 5. No policy shall exclude an eligible individual, eligible employee or eligible dependent on the basis of age, occupation, actual or expected health condition, claims experience, duration of coverage or medical condition.
SECTION 52. Section 9 of said chapter 176J, as so appearing, is hereby amended by striking out, in lines 64 and 65, the words "which does not contain any exclusion or limitation with respect to any preexisting condition of such beneficiary".

[90] SECTION 48. Said chapter 176J is hereby amended by striking out section 3, as amended by section 174 of chapter 224 of the acts of 2012, and inserting in place thereof the following section:-
Section 3. (a) (1) For every health benefit plan issued or renewed to eligible individuals and eligible small groups, including a certificate issued to an eligible individual or eligible small group that evidences coverage under a policy or contract issued or renewed to a trust, association or other entity that is not a group health plan, a carrier shall develop a group base premium rate that is the same for eligible individuals and eligible small groups. In developing these merged market group base premium rates, carriers:
(i) with respect to the group base premium rate developed for eligible individuals and eligible small groups, a carrier shall consider all enrollees in those health plans, other than grandfathered health plans, offered by such carrier to be members of a merged individual and small group risk pool;
(ii) in calculating the premium to be charged to each eligible individual or eligible small group, a carrier shall develop a base premium and use only those rate adjustment factors identified in this section, inclusive, for all insured health benefit plans offered to eligible individuals and eligible small groups, respectively, with all other rating adjustments being prohibited;
(iii) may offer any rate basis types, but rate basis types that are offered to any eligible individual or eligible small group shall be offered to every eligible individual or eligible small group for all coverage issued or renewed; provided, however, that if an eligible small group does not meet a carrier's minimum or participation contribution requirements, the carrier may separately rate each employee as an eligible individual, as set forth in clause (i);
(iv) shall apply the same rating factors when calculating premiums for eligible individuals as are used when calculating premiums for eligible small groups; and
(v) notwithstanding this section, all carriers offering any coverage to any eligible individual or eligible small group shall make that coverage available to every eligible individual and eligible small group.
(2) The commissioner shall annually file with the United States Department of Health and Human Services to establish a standard age rate adjustment factor table so that the ratio of the highest factor for adults over age 20 compared to the lowest factor for adults over age 20 shall not exceed a ratio of 2-to-1. A carrier that elects to apply standard age rate adjustment factors shall apply them based upon the covered person's age when the coverage period begins.
(3) The commissioner shall annually file with the United States Department of Health and Human Services to establish not more than 7 distinct regions of the state for the purposes of area rate adjustments. A carrier may establish an area rate adjustment for each distinct region, the value of which shall range from .8 to 1.2. If a carrier chooses to apply area rate adjustments, every eligible individual and eligible small group within each area shall be subject to the applicable area rate adjustment.
(4) A carrier shall establish a basis type rate adjustment factor for eligible individuals and eligible small groups which shall vary the rate only on the basis of whether the health benefit plan covers an individual or family. For purposes of this section, the total premium for family coverage must be determined by summing the premiums for each individual family member. With respect to family members under the age of 21, the premiums for not more than the 3 oldest covered children must be taken into account in determining the total family premium.

(5) The commissioner shall annually file with the United States Department of Health and Human Services to establish a standard tobacco use factor. A carrier may apply a tobacco use rate factor in a manner permitted under state and federal law that applies to both eligible small groups and eligible individuals; provided, however, that the carrier uses a certification of tobacco use process that has been approved by the commissioner to determine that eligible individuals and their eligible dependents or eligible small group employees and their eligible dependents have not used tobacco products within the past year.

(6) A carrier may establish a benefit level rate adjustment for all eligible individuals and eligible small groups that shall be expressed as a number. The number shall represent the relative actuarial value of the benefit level, including the health care delivery network, of the health benefit plan issued to that eligible individual or eligible small group as compared to the actuarial value of other health benefit plans within that class of business. If a carrier chooses to establish benefit level rate adjustments, every eligible individual and every eligible small group shall be subject to the applicable benefit level rate adjustment.

(7) A carrier shall not apply any rate adjustment factor to the group base premium rate, other than those set forth herein.

(b) (1) A carrier that, as of the close of any preceding calendar year, has a combined total of 5,000 or more eligible individuals, eligible employees and eligible dependents, who are enrolled in health benefit plans sold, issued, delivered, made effective or renewed to qualified small businesses or eligible individuals pursuant to its license under chapter 176G, shall be required annually to file a plan with the connector for its consideration, which meets the requirements for the connector seal of approval pursuant to section 10 of chapter 176Q; provided, however, that the plan shall be filed not later than October 1.

(2) A carrier that, as of the close of any preceding calendar year, has a combined total of 5,000 or more eligible individuals, eligible employees and eligible dependents, who are enrolled in health benefit plans sold, issued, delivered, made effective or renewed to qualified small businesses or eligible individuals pursuant to its authority under chapter 175, 176A or 176B, shall be required annually to file a plan with the connector for its consideration, which meets the requirements for the connector seal of approval pursuant to section 10 of chapter 176Q; provided, however, that the plan shall be filed not later than October 1.

(c) For the purposes of this section, no eligible individual, eligible employee, or eligible dependent shall be considered to be enrolled in a health benefit plan issued pursuant to a carrier's authority under chapter 175, 176A or 176B if the health benefit plan is sold, issued, delivered, made effective or renewed to said eligible employee or eligible dependent as a supplement to a health benefit plan subject to licensure under chapter 176G.

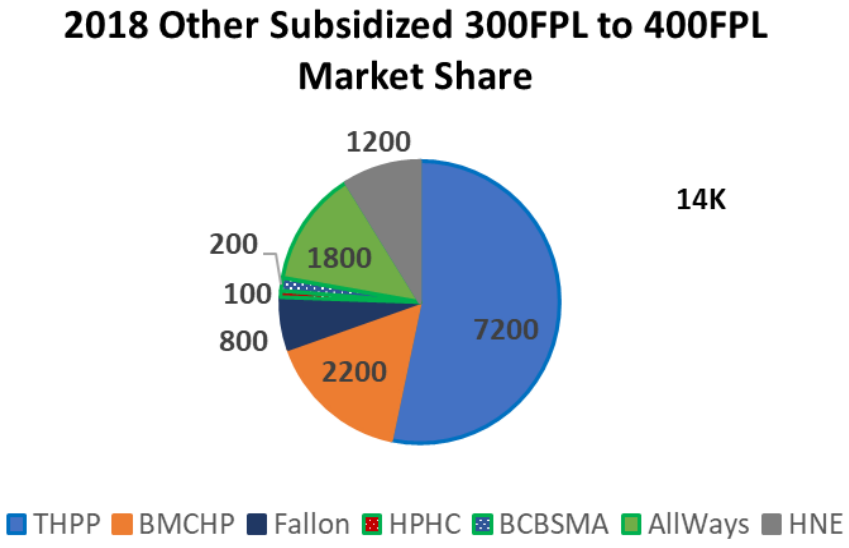
(d) The commissioner may conduct an examination with respect to the derivation of group base premium rates used to develop individual group premiums in order to identify whether any expenses inappropriately increase the cost in relation to the risks of the merged individual and small group health insurance market.

SECTION 51. Section 6 of said chapter 176J is hereby amended by striking out subsection (c), as so appearing, and inserting in place thereof the following subsection:-

(c) Notwithstanding any general or special law to the contrary, carriers offering small group health insurance plans, including carriers licensed under chapters 175, 176A, 176B or 176G, shall file small group product base rates and any changes to small group rating factors that are to be effective on January 1 of each year, on or before July 1 of the preceding year. The commissioner shall disapprove any proposed changes to base rates that are excessive, inadequate or unreasonable in relation to the benefits charged. The commissioner shall disapprove any change to small group rating factors that is discriminatory or not actuarially sound. Rates of reimbursement or rating factors included in the rate filing materials submitted for review by the division shall be deemed confidential and exempt from the definition of public records in clause Twenty-sixth of section 7 of chapter 4.

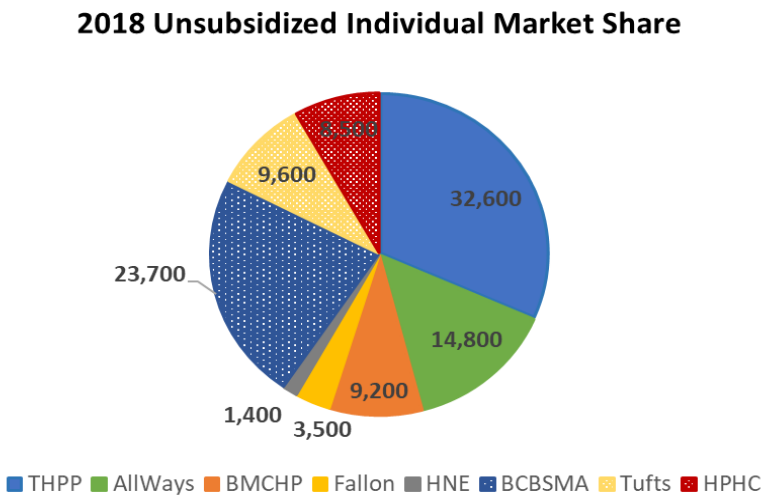
APPENDIX C

Shopping Behavior of Sub-Markets Based on 2018 Membership

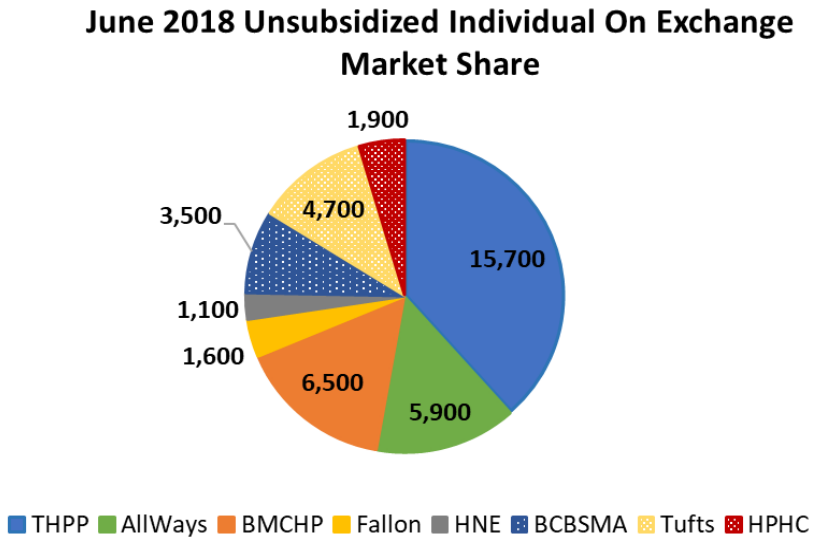


2018 Average Other Subsidized Membership
Source: CHIA 2019 Annual Report Coverage Dataset and Connector Data[91]

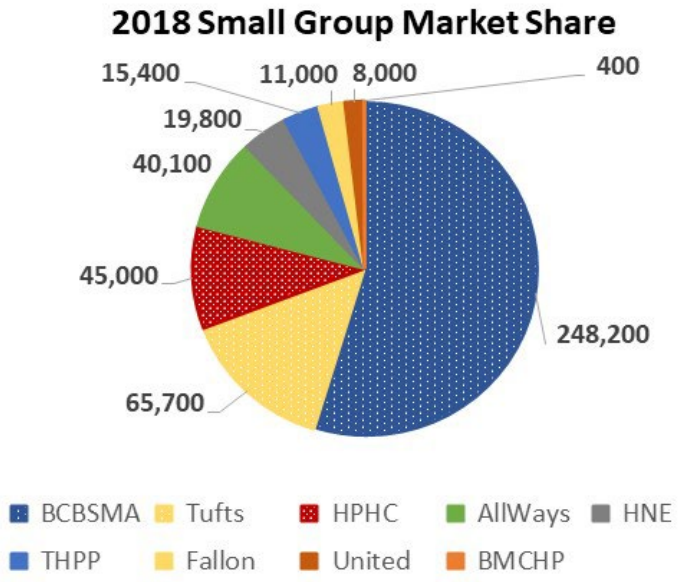
[91] Some insurers are unable to report the 300 to 400FPL population accurately to CHIA. CHIA reported numbers were adjusted using data from the Connector.



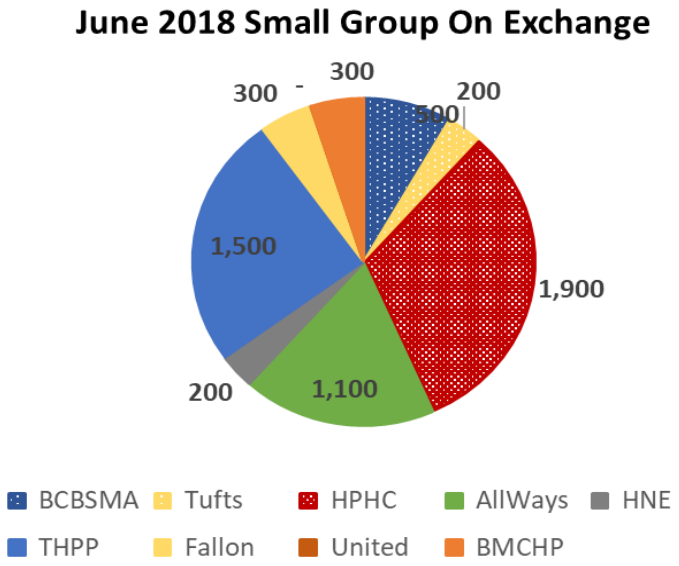
2018 Average Unsubsidized Individual Market Membership
Source: CHIA 2019 Annual Report Coverage Dataset



Source: Health Connector



2018 Average Small Group Membership
Source: CHIA 2019 Annual Report Coverage Dataset



June 2018 Connector Small Group Membership

Appendix D

Actuarial Qualifications: Limitations and Data Reliance

Gorman Actuarial, "GA" provided actuarial analyses and modeling results for use by the Massachusetts Merged Market Advisory Council. While GA understands that analyses may be distributed to third parties, GA assumes no duty or liability to any third parties who receive the information herein.

Users of these results must possess a reasonable level of expertise and understanding of health care, health insurance markets and financial modeling so as not to misinterpret the information presented. The analyses addresses certain provisions of the Affordable Care Act, but is not intended to act as an official or comprehensive interpretation of the legislation itself.

Analyses and modeling results presented in this report was based on data provided by the MA DOI, insurers in the Massachusetts health insurance markets, the Health Connector, and other public sources. GA has not audited this information for accuracy. GA has performed a limited review of the data for reasonableness and consistency. If the underlying data are inaccurate or incomplete, the results of this analysis may likewise be inaccurate or incomplete.

The results presented in this report are estimates based on complex actuarial models. Differences between our estimates and actual amounts depend on the extent to which future experience conforms to the assumptions made for this analysis. Actual experience will most likely not conform exactly to the assumptions used in this analysis. Actual results will differ from projected results to the extent that actual experience deviates from expected experience. **Given the many unknowns, has not accounted for changes that may occur in these markets due to the impact of COVID-19.**

The report contains statements that attempt to provide some prospective context to current or past trends. These statements are based on the understanding of the existing and proposed regulatory environment as of February 2021. If subsequent changes are made, these statements may not appropriately represent the expected future state.

Qualifications

The actuarial analyses shown in this report was conducted by Bela Gorman and peer reviewed by Jenn Smagula, both of whom are members of the American Academy of Actuaries and Fellows of the Society of Actuaries. They both meet the qualification standards for performing the actuarial analyses presented in this report.

Appendix E

Glossary of Terms

- **Allowed Claims PMPM**: Total claims amount paid to providers for health care services provided to members inclusive of member cost sharing and the portion paid by the carrier divided by the sum of members covered in each of the months for the reported period.
- **Community Rating**: Under state and federal laws, community rating, or "modified community rating" refers to a requirement wherein carriers cannot charge different premiums for different subscribers based on any characteristics other than those permitted under law (e.g., per the ACA: age, geography, tobacco usage). These requirements (along with guaranteed issue) are the policies frequently referred to as "protections for pre-existing conditions" since they protect individuals and small businesses from being charged more for current or prior health conditions, or perceived health risk.
- **Guaranteed Issue**: Under state and federal laws, guaranteed issue refers to the requirement that carriers offer coverage to anyone who seeks it, meaning they cannot turn a potential subscriber (individual or group) away for health conditions or perceived health risk.
  HMO: A Health Maintenance Organization or "HMO" is an entity licensed by the Division of Insurance (DOI) under the provisions of M.G.L. c. 176G. In an HMO plan, non-emergency care is covered only when it is provided or arranged by a network provider. An HMO's network of providers is located within the HMO's "service area".
- **Individual Market**: The fully insured health insurance market for individuals and families who purchase their own health coverage (not through an employer). This market comprises both individuals and families who qualify for state and/or federal subsidies, as well as those who do not. This market receives no preferable tax treatment for their purchase of health coverage, unlike the employer-sponsored insurance market, which allows both the employer and employee to use pre-tax income towards health care premiums.
- **Merged Market**: Massachusetts maintains a shared "merged" risk pool for the individual and small group market.
- **PPO:** In a Preferred Provider Organization or "PPO"", the plan covers medically necessary care from any health care provider, but usually pays more for services provided within the network. The PPO plan provides a subset of licensed providers from which the PPO's members can choose to seek care without receiving permission from a primary care physician or other clinician.
- **Small Group Market**: The fully insured health insurance market for employers with fewer than 50 eligible employees. These employers are subject to state and ACA rules regarding small group coverage from a rating and benefits perspective.

Appendix F

Meeting Minutes of the Merged Market Advisory Council

Meetings

The MMAC met in open sessions that took place on the following dates:

- January 8, 2020;
- February 5, 2020;
- March 11, 2020;
- April 2, 2020;
- May 20, 2020;
- June 17, 2020;
- September 10, 2020;
- September 23, 2020;
- October 4, 2020;
- October 23, 2020;
- November 4, 2020;
- November 17, 2020;
- December 2, 2020;
- January 26, 2021
- February 26, 2021; and
- March 16, 2021.

Minutes of Meeting of the Merged Market Advisory Council (Council) held on Wednesday,January 22, 2020 and Approved by the Council on Wednesday, February 5, 2020;

Motion of Council Member Michael Caljouw and Seconded by Council Member Jon Hurst. The Motion Passed by a Unanimous Vote of the Council Members Present.

January 22, 2020, Minutes of the Council Meeting
Held at 1000 Washington Street, Boston, Massachusetts.

Members Present:
Gary D. Anderson, Chairman, Commissioner, Division of Insurance
Marylou Sudders, Secretary of Health and Human Services
Louis Gutierrez, Executive Director Health Connector
Michael Caljouw, Blue Cross & Blue Shield, Health Insurance Carrier representative
Lora Pellegrini, Executive Director 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
Joshua Archambault, Health Insurance Business Community representative
Jon Hurst, Health Insurance Business Community representative

Participating by Telephone:
Wendy Hudson, Small Group/Individual Employer representative

Attending to the Council:
Michael D. Powers, Counsel to the Commissioner, Division of Insurance
Jackie Horigan, Director Consumer Services Section, Division of Insurance

Call to Order:
Chairman Gary Anderson called the meeting to order.

Chairman Anderson welcomed the members of the Merged Market Advisory Council (sometimes referred to hereinafter as the "Council") and thanked them for their willingness to serve at the request of Governor Baker and on such short notice. Chairman Anderson asserted that he looked forward to hearing the input and expertise that the Members of the Council had to offer, and he was eager to begin the work of the Council and informed the Members that there were several Principles that should guide the deliberations:

- All options should be considered, but not driven by any single entity or point of view.
- We consider both the short-term and the long-term impacts of all options.
- We base our deliberations on data-driven and actuarial analyses.
- We make recommendations that look to improve the vibrancy/stability of the market.

Commissioner Anderson then introduced Kevin Beagan, Deputy Commissioner of the Health Care Access Bureau.

Deputy Commissioner Beagan stated that it would be useful to begin these proceedings for each Council Member to learn about each other and requested the Members introduce themselves starting with Secretary Sudders.

Secretary Sudders introduced herself, informed the Members of the Council that her Secretariat had been engaged in issues covering the Merged Small Group/Individual insurance health market (hereinafter "Merged Market") for many years, played a very large role in them, and shelooked forward to participating in the Council's deliberations.

Patricia Begrowicz, Small Group/Individual Employer representative, introduced herself and stated that she had about 150 employees and she represented health care consumers because she purchased health insurance for her workforce.

Amy Rosenthal, Small Group/Individual health insurance purchaser representative, introduced herself and informed the Members that she was the Chief Executive Officer for Health Care for All. Her organization receives about 20,000 calls from consumers each year and she hears from consumers about their concerns on issues affecting health care in Massachusetts.

Michael Caljouw introduced himself by informing the Members that he was with Blue Cross and Blue Shield of Massachusetts and is Vice-President for Public, Government, and Regulatory Affairs and that they insure about 2.8 million lives in the Commonwealth.

Joshua Archambault, Health Insurance Business Community representative, stated that he had been following the discussions surrounding the health care Merged Market for years and he looked forward to the upcoming discussions.

Rosemarie Lopes, Insurance Broker representative, stated that she too was looking forward tothe discussions.

Rina Vertes, Health Insurance Industry Actuary, informed the Members of the Council that she was also acting member of the Massachusetts Health Connector, and she has been interested in health insurance issues for many years.

Mark Gaunya, Health Insurance Broker representative, informed the Council that he was the co-owner of an employee benefits firm, an advisor to large employers for health insurance and other employee benefits and was passionate about making health insurance easier and more affordable for everyone.

Lora Pellegrini, Executive Director Massachusetts Association of Health Plans, and is a Health Insurance Carrier representative, informed the Council that she was very engage with how we can make health insurance more affordable for the citizens of Massachusetts.

Jon Hurst, Health Insurance Business Community representative, informed the Members of the Council that his group has 4,000 members 99% are small businesses mostly mom and pop organizations, and restaurants.

Wendy Hudson, Small Group/Individual Employer representative, introduced herself over the telephone and informed the Council she was on Nantucket, was unable to postpone her business meeting, and, therefore, had to do the meeting by telephone conference. She informed the Council that she was the owner of two small businesses-- a craft brewery and book stores. She looked forward to participating in the Council's deliberations, learning in depth about the issues, and was looking to have affordable health insurance coverage for her employees.

Commissioner Anderson informed the Council that he too was looking toward the upcoming meetings as a learning experience about the health care insurance issues affecting the consumers of Massachusetts and requested Jackie Horigan, Director of Consumer Services Section of the Division of Insurance who was handling the communication system for the meeting, to post the proposed schedule for upcoming Council meetings and public listening sessions.

Lora Pellegrini queried whether she could have a stand-in or substitute attend meetings on her behalf when she was unavailable because of a conflict in her schedule. Deputy Commissioner Beagan indicated that such an arrangement could be allowed, but asserted that any such substitute would not be allowed to vote. Mr. Beagan noted that remote participation was allowed by conferencing by telephone as Wendy Hudson was doing during the meeting.

Mr. Beagan noted that the proposed schedule provided dates for both Council meetings and for public sessions as the Commissioner thought it would be productive to have optional meetings for public sessions, meaning Council Members were not required to attend but could attend at their discretion, to allow interested members of the general public an opportunity to express their opinions about health care issues in the Commonwealth. The first such session was scheduled for Lowell on January 29, 2020.

Secretary Sudders suggested that it would be better to look at the merged market by segmenting the small business entities into different groups such as individuals to 25 persons and 25-50 persons.

Chairman Anderson agreed.

Lora Pellegrini pointed out that we need to address "Risk Reduction" in the merged market.

Deputy Commissioner Beagan responded that the Division has looked at Risk Reduction withour actuaries and they will provide a presentation on the issue.

Jon Hurst asked if the Council Members would be sworn-in as indicated in the letters that the Members received from Governor Baker.

Secretary Sudders volunteered that she had someone working in her office that periodically swore-in various members of different committees that come under the Office of the Secretariat of Health and Human Services and said that she could make the person available for the next meeting of the Council.

Deputy Commissioner Beagan informed the Council that Gorman Actuarial, Inc. was retained and Bela Gorman was in attendance to provide an overview of their services.

Bela Gorman introduced herself and said she came to discuss the scope of the project. She informed the Council that she has been analyzing the merged health care insurance market for many years and is very interested in the outcome of the Council's work. The work was already in progress, she has been collecting some baseline public data from Massachusetts agencies, and noted that Massachusetts is number one in the United States for collecting data for the merged market. When she was notified that her company was selected as the actuary for the Council, she began collecting data from the health insurance industry to put together with the public data.

Ms. Gorman informed the Council that she was creating algorithms to look at risk profile of the Merged Market, also reviewing Network differences, Plan Design differences, different group subsidizing, PPOs, how new products impact the Merged Market, and the impacts of small groups leaving the Merged Market. She also will look at other states such as New York, develop models to present policy questions, and she projected that these studies would take from three to six months to complete.

Deputy Commissioner Beagan asked Ms. Gorman to elaborate on her data collection.

Ms. Gorman replied that she began collecting the data on November 23, 2019, and would finish collecting the data next week with a follow-up to check the data that was collected.

Mr. Caljouw asked whether the manner in which the meetings were scheduled would begin by discussing the data first?

Chairman Anderson responded yes.

Mr. Archambault asked Ms. Gorman whether the goal to be reached at the end of the process would be to establish certain models for emerging trends in the Merged Market.

Ms. Gorman replied that at this time she was not able to answer the question, she needed to review the data and the models that would be created.

Mr. Gaunya suggested the Council consider any policy changes through the lens of the ACA, ERISA and Massachusetts state law and only focus attention on policies we can legally consider.

Ms. Gorman responded that there were several major changes in Federal laws restricting the states' ability to make policies, beginning in 2006 and through 2014, and thereafter, big changes came from the Federal government.

Deputy Commissioner Beagan informed the Council Members that he and the staff at the Division of Insurance would be meeting with Ms. Gorman and going over the issues and then provided a presentation of a 33 page of slides entitled "Massachusetts Health Coverage & Market Share" which is posted on the Merged Market Council's website which can be found at the following link: **Merged Market Introduction Presentation**

At the conclusion of the presentation, Deputy Commissioner Beagan stated that if any Council Member was associated with a person interested in offering assistance such assistance would be greatly appreciated and the Council Member should provide the contact information to Mr. Beagan.

Adjournment of Meeting:
Commissioner Anderson closed the meeting by thanking everyone for participating and the meeting was adjourned by a consensus of the Council Members.

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. **Slide presentation "Massachusetts Health Coverage & Market Share."**
2. **Slide presentation "History of Massachusetts' Merged Small Group/Individual InsuredHealth Market."**

Minutes of Meeting of the Merged Market Advisory Council (Council) held on Wednesday, February 5, 2020 and Approved by the Council on Thursday, March 5, 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.

February 5, 2020, Minutes of the Council Meeting
Held at 1000 Washington Street, Boston, Massachusetts.

Members Present:
Gary D. Anderson, Chairman, Commissioner, Division of Insurance
Lauren Peters, designee of Marylou Sudders, Secretary of Health and Human ServicesLouis Gutierrez, Executive Director the Massachusetts Health Connector
Michael Caljouw, Blue Cross & Blue Shield, Health Insurance Carrier representative
Elizabeth Murphy, designee of Lora Pellegrini, Executive Director 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
Wendy Hudson, Small Group/Individual Employer representative
Joshua Archambault, Health Insurance Business Community representative
Jon Hurst, President of the Retailers Association of Massachusetts, Health Insurance Business Community representative

Participating by Telephone:
Lora Pellegrini, Executive Director Massachusetts Association of Health Plans. Prior to the meeting Council Member Pellegrini contacted Kevin Beagan, Deputy Commissioner of the Health Care Access Bureau of the Division of Insurance, and informed him that she would be sending Elizabeth Murphy and would be calling in by telephone one hour after the meeting began, at 2:30PM to listen in to the remaining portion of the meeting.

Attending to the Council:
Michael D. Powers, Counsel to the Commissioner, Division of Insurance
Jackie Horigan, Director Consumer Services Section, Division of Insurance
Audrey Gasteier, Massachusetts Health Connector
Emily Brice, Massachusetts Health Connector

Call to Order:
Chairman Gary Anderson called the meeting to order. Chairman Anderson announced that Marylou Sudders, Secretary of Health and Human Services, had a previous commitment that she was unable to postpone and sent Lauren Peters to attend the meeting on her behalf.

Chairman Anderson welcomed Gabe Cohen, from the office of the Secretary of Health and Human Services, to administer the oath of office and swear-in the members of the Merged Market Advisory Council (hereinafter sometimes referred to as the "Council"). Mr. Cohen handed out a piece of paper containing the oath of office to all the Members of the Council present, asked them to stand, raise their right hands, and repeat the oath of office after him, which included: (1) solemnly swearing and affirming faith and allegiance to the Commonwealth; swearing and affirming support of the Massachusetts Constitution and to faithfully and impartially performing all of their duties as a Member of the Council; (3) and supporting the Constitution of the United States. All the Members of the Council who were present at the meeting repeated the oath of office as administered and were duly sworn-in.

Chairman Anderson called for a review of the minutes of the meeting held on January 22, 2020. The Members of the Council reviewed the draft minutes and Council Member Wendy Hudson pointed out that she found one issue that should be changed in the draft minutes which was: the minutes reported that she was teleconferencing from Martha's Vineyard during the January 22 meeting and in fact she was calling from Nantucket. Chairman Anderson called for a motion to approve the minutes as amended, a motion was made by Council Member Michael Caljouw, of Blue Cross & Blue Shield, the motion was seconded by Council Member Jon Hurst, President of Retailers Association of Massachusetts, and the motion passed unanimously with Chairman Anderson abstaining.

Deputy Commissioner Beagan went through the upcoming schedule for the regularly scheduled meetings for the Council, and went through the proposed schedule for the public meetings to gather public input from interested parties. Deputy Commissioner Beagan passed out minutes to the Members of the Council of the public meeting that was held on January 31, 2020, at the Division of Insurance located at 1000 Washington Street, Boston, Massachusetts. A Member of the Council asked Deputy Commissioner Beagan if the Council would accept written statements from interested parties and Mr. Beagan responded in the affirmative, stating that any written statements should be sent to: MergedMarket@Mass.Gov.

Deputy Commissioner Beagan next introduced Bela Gorman, principal of Gorman Actuarial, Inc. to provide a presentation created for the individual/small group health insurance markets entitled "Health Insurance Premium Rates," dated February 5, 2020. Ms. Gorman introduced herself and said she has been collecting some baseline public data from Massachusetts state agencies, and comparing it to private data. Ms. Gorman explained that the power point presentation she created was to go over some fundamental concepts underlining the Merged Market which would create a basis for understanding future presentations. The handout consisted of 43 slides that were projected on a large screen while Ms. Gorman went through each slide, at various points providing additional background information, and entertaining questions and comments from various Members of the Council.

At the conclusion of Ms. Gorman's presentation, Council Member Jon Hurst, Executive Director of the Retailers Association of Massachusetts, provided a handout entitled "Retailers Association of Massachusetts Annual Health Insurance Increases."

Louis Gutierrez, Executive Director Health Connector, noted that the Council during its deliberations should focus on the impact the individual market is having on the small group market and determine whether the individual market may be subsidizing the small group market.

Adjournment of Meeting:
Commissioner Anderson called for a motion to adjourn the meeting, the motion was made by Council Member Mark Gaunya and seconded by Council Member Amy Rosenthal, the motion passed by a unanimous vote of those in attendance with Chairman Anderson abstaining.

Chairman Anderson concluded the meeting by thanking everyone for their participation.

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. **Slide presentation "Health Insurance Premium Rates" dated February 5, 2020 created by Gorman Actuarial Inc.**
2. **Minutes of the public meeting held on January 31, 2020 at 1000 Washington Street,Boston, Massachusetts.**
3. **"Retailers Association of Massachusetts Annual Health Insurance Increases."**

Minutes of Meeting of the Merged Market Advisory Council (Council) held on Thursday, March 5, 2020 and Approved by the Council at the Meeting Held on Wednesday, March 11, 2020;

Motion of Council Member Michael Caljouw and Seconded by Council MemberRosemarie Lopes. The Motion Passed by a Unanimous Vote of the Council Members Present with Secretary Sudders' Designee, Lauren Peters, Abstaining.

March 5, 2020, Minutes of the Council Meeting
Held at 1000 Washington Street, Boston, Massachusetts.

Members Present:
Gary D. Anderson, Chairman, Commissioner, Division of Insurance
Louis Gutierrez, Executive Director the Massachusetts Health Connector
Michael Caljouw, Blue Cross & Blue Shield, Health Insurance Carrier representative
Lora Pellegrini, Executive Director 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
Wendy Hudson, Small Group/Individual Employer representative
Joshua Archambault, Health Insurance Business Community representative
Jon Hurst, President of the Retailers Association of Massachusetts, Health Insurance Business Community representative

Attending to the Council:
Michael D. Powers, Counsel to the Commissioner, Division of Insurance
Jackie Horigan, Director Consumer Services Section, Division of Insurance
Audrey Gasteier, Massachusetts Health Connector
Emily Brice, Massachusetts Health Connector

Call to Order:
Chairman Gary Anderson called the meeting to order. Chairman Anderson announced that Marylou Sudders, Secretary of Health and Human Services, had a previous commitment that she was unable to postpone and could not attend the meeting.

Chairman Anderson called for a review of the minutes of the meeting held on March 5, 2020. The Members of the Council reviewed the draft minutes and Council Member Michael Caljouw made the motion to approve the minutes, the motion was seconded by Council Member Mark Gaunya, and the motion passed unanimously with Chairman Anderson abstaining.

Chairman Anderson turned over the next segment to Kevin Beagan, Deputy Commissioner for the Health Care Access Bureau of the Division of Insurance, to discuss a recent issue raised about an agreement between Harvard Pilgrim Health Care, Inc. (hereinafter "HPHC") and Massachusetts Biotechnology Council (hereinafter "MassBio").

Deputy Commissioner Beagan asserted that there were questions raised about HPHC marketing Association Health Plans to MassBio and he was in contact with representatives from HPHC and in fact received a letter from HPHC explaining the relationship. HPHC entered into a marketing relationship with MassBio to promote certain plan designs as part of its "Edge Benefits" to its large employer group member companies or those companies with over 50 employees.

Applicable members will be able to choose HPHC for their health insurance needs. Each current large employer group member of MassBio will be individually rated. In reviewing its joint marketing materials with MassBio, HPHC ensured that there was no discussion of small groups within the description of the HPHC health coverage offered to MassBio's member companies. Mr. Beagan asserted that representatives from HPHC informed him that it is not engaged in marketing Association Health Plans and does not intend to. HPHC sent a confirmatory letter about these matters to Commissioner Anderson dated March 3, 2020.

Quarter-2 2020 Rates:

Deputy Commissioner Beagan informed the Members of the Council that the Division of Insurance completed its Quarterly Rate Review of health insurance premiums and the January submission of projected rates disclose the following:

- Average is expected to go up by 7.9% for those renewing April 1 and June 30
- Companies filed rates at the beginning of January and DOI staff and its consulting actuaries worked closely with companies to get them to lower rates
- DOI is not happy with rate changes; this is one of the most difficult tasks of the Division
- DOI is closely looking at costs and claims development; there is a mix of high cost services and prescription drugs
- DOI is offering to have supplemental meeting with members of the Council to go overrates and the DOI review process
- This is not only a small group issue and there is a similar impact in the large group market

Commissioner Anderson and Deputy Commissioner Beagan offered to schedule a one-hour webinar the next two meetings of the Council. Council Member Lora Pellegrini stated this would be helpful and with some confusion about cost benchmarks, a webinar would help inclarifying the issues.

Deputy Commissioner Beagan offered to distribute a "doodle poll" to begin the conversation. Council Member Mark Gaunya questioned whether it would be appropriate for insurance carriers to be involved in that conversation and Commissioner Anderson responded that carriers should

weigh-in if they felt the need to do so. Council Member Michael Caljouw, of Blue Cross & Blue Shield, observed that he engaged in frequent conversations with Council Member Jon Hurst, President of Retailers Association of Massachusetts, and Mr. Caljouw stated he would be happy to participate.

Review of Public Meetings Held by the Council:

Deputy Commissioner Beagan informed the Council that the public meeting held in Dartmouth, Massachusetts in February was attended by some representatives of small businesses and there were concerns relayed about availability, level of deductibles, the good and bad features of limited and tiered products, and group purchasing cooperatives along with discussions of what people are buying and problems that they are having. Council Member Rosemarie Lopes asserted that is good to have public sessions in other locations. Deputy Commissioner Beagan observed that he would have liked to have better representation from small businesses at the public sessions. Commissioner Anderson declared that we should redouble our efforts to get theword out.

Deputy Commissioner Beagan stated that the next public session of the Council would be held in Springfield on March 18, 2020, and reminded everyone about the Council's email address for the public to submit comments to/at: MergedMarket@mass.gov

Presentation by Gorman Actuarial Inc.:

Commissioner Anderson next introduced Bela Gorman, principal of Gorman Actuarial, Inc. to provide a presentation created for the individual/small group health insurance markets (hereinafter "Merged Market") entitled, "Merged Market Advisory Council," dated March 5, 2020. Ms. Gorman introduced herself and explained that the power point presentation she created for this meeting of the Council was to continue building on some fundamental concepts underlining the Merged Market. The handout consisted of 29 slides with 3 topics: (1) Risk Adjustment Recap; (2) Group Size Adjustment; and (3) Baseline Analytics. The presentation was projected on a large screen while Ms. Gorman went through each slide, at various points providing additional background information, and entertained questions and comments from various Members of the Council.

Discussion about Employer Offered Individual Coverage Health Reimbursement Accounts (hereinafter "ICHRAs"):

At the conclusion of Ms. Gorman's presentation Deputy Commissioner Began announced the next segment of the Council's meeting and introduced Jeff Rich of HSA Insurance, a private exchange, and Bill Stewart of Benefit Strategies, LLC to talk about the new federal rules permitting Individual Contributory Health Care Reimbursement Accounts (ICHRAs) whereby an employer would pay employees to purchase individual health coverage.

Mr. Rich explained that his company offers individual health insurance coverage through approximately 800 insurance brokers. There are mixed feelings of the brokers that he transacts business with: 1/3 are very interested in the product; 1/3 don't care; and 1/3 think the product is

terrible. Mr. Rich elaborated that the concept involves a platform of products, an administrator, and a broker. Since January there has been an uptick in sales, there is interest in these products because they are a means for employers to save money and a company's employees become real consumers who choose the products responsive to an employee's needs.

Mr. Stewart observed that the ICHRA idea was intended to strengthen the non-group market so that an estimated 11 million people could transfer from the group market and obtain coverage in the non-group market. The federal rules established guardrails placed to limit potential bad risk dumping and cherry picking. The rules would restrict the number of employee classes and prescribe classes assigned to ICHRAs require a minimum of 10 people. Mr. Stewart's company acts as the program administrator and takes the burden of administering health products from the backs of employers. ICHRAs allow the option of moving some of the risk in a large group into a separate category and subsidize them, thereby decreasing costs.

Mr. Stewart stated that ICHRAs may not be attractive in Massachusetts at this time. Currently there is a scarcity of talent in a very tight labor market and the concept of an employer offering an ICHRA might not be received well by employees because they are seeking the traditional all-inclusive group health insurance coverage and benefits plans. Massachusetts is also different than other states because its Merged Market for non-group and small groups makes individual coverage more affordable than it may be in other states.

Mr. Rich opined that ICHRAs offer another option for employers with high quality plans for individuals. Council Member Mark Gaunya queried whether there was an interest by groups of under 50 employees and Mr. Rich responded that the majority of interest was in large groups.

Council Member Rina Vertes opined that ICHRAs were a better option for some employers because it out-sources the burden on employees to do the shopping for their health product and Ms. Vertes found it surprising that more employers aren't interested in offloading administrative responsibilities. Mr. Rich responded that this was one of the main reasons for employers choosing ICHRAs.

Council Member Mark Gaunya stated that this concept is early for Massachusetts with apparently few competitors doing business at this stage. Mr. Gaunya asked Mr. Rich about the number of parties marketing ICHRAs at this time and Mr. Rich indicated there were few. Council Member Gaunya then asked whether there was a way to keep track of the use of ICHRAs in Massachusetts and Deputy Commissioner Beagan answered there was not a current way to keep track of this.

Council Member Joshua Archambault asked if there was an interest by seasonal employers and Mr. Stewart responded that there was. Mr. Stewart recounted that he recently was approached by a Maine ski resort company that wanted to provide some health insurance coverage to the company's ski pros and wanted to provide some tax-free money to help pay for some of their medical coverage. Mr. Stewart informed the ski company that they could provide such coverage

through an ICHRA, but could not restrict the offer to the ski pros but had to offer it to all of the seasonal employees working at the resort such as the ticket takers and ski-lift operators.

Deputy Commissioner Beagan thanked Mr. Rich and Mr. Stewart for taking time to appearbefore the Council and moved onto the next item on the agenda.

Discussion of Limited Supplemental Health Plans:

Deputy Commissioner Beagan next introduced Jenny Erickson, Senior Vice-President and General Counsel for Life Insurance Association of Massachusetts (LIAM) and Edward "Ed" Donahue Second Vice-President and Reginal Director of Aflac Inc.

Ms. Erickson informed the Council these supplemental health plans are not traditional health insurance products and not part of the Merged Market. She was present to talk about two types: hospital indemnity coverage that makes payments to an insured to indemnify for hospital costs not covered by health insurance and specified disease coverage that indemnifies for costs incurred as the result of diseases.

Hospital Indemnity Insurance provides benefits to be paid to an insured or a dependent, including the spouse of an insured, on the basis of hospitalization of the insured or a dependent. It is intended to cover gaps not covered by health insurance including co-payments or coinsurance deductibles, travel or overnight stays at hotels for families, and income replacement and transportation costs including those costs not covered for ambulances. Hospital indemnity coverage has a fixed dollar cap. Depending on the policy the cap may increase based on the severity of an event such as being placed in a cardiac care facility or Intensive Care treatment. Hospital indemnity coverage is sold as a supplement and not as a replacement for health benefit plans. Individual hospital indemnity plans must meet the requirements set by Massachusetts state law and the Commissioner of the Division of Insurance by regulation. These products comply with M.G.L. c. 175 §§ 108 and 110, and 211 CMR 42.00 et seq.

Specified Disease Insurance provides benefits to be paid to an insured or dependent, including the spouse of an insured, if the insured or dependent comes down with a specified disease such as cancer or stroke. As with hospital indemnity insurance, it is intended to fill-in gaps not covered by traditional health insurance including copayments, coinsurance or deductibles, travel or overnight hotels for families, payment for groceries, and income replacement. Individual specified disease insurance products must meet the requirements set by the Massachusetts state law and the Commissioner of the Division of Insurance by regulation. These products comply with M.G.L. c. 175 §§ 108 and 110, and 211 CMR 146.00 et seq.

These products don't directly pay for healthcare but give policyholders money in-hand, are triggered by health events, and the policyholders choose how to use the money. These products are sold individually and through employers, the premiums are generally less than $500 per year and the average age of the purchaser is 50 years old and most insureds have underlying health insurance coverage.

Council Member Amy Rosenthal stated that her call center receives about 20,000 calls per year and a recent caller was upset because she purchased this type of coverage and did not receive any payments. Council Member Rosenthal went to the website, reviewed it, and she was confused about the provisions of the coverage the company was offering. She stated that it is easy to say consumers should do a better job of educating themselves, but marketing is often times confusing even to the sophisticated consumer and there needs to be a better job done making these products more easily understood.

Council Member Michael Caljouw observed that the Division of Insurance regulations are strong but there are some tweaks to think about; some carriers don't do a good job of explaining the supplemental nature of these products and he would support some amendments to the current regulations. He found that there have been abuses in companies marketing these products, but wished to make it clear that none of the people attending and participating at the Council meeting were engaged in such misconduct.

Deputy Commissioner Beagan observed that, if people leave the Merged Market and bought a hospital indemnity plan thinking it is health insurance they bought the wrong product, and they usually return to the health insurance coverage when they have an injury or health sickness to pay for their health care needs.

Discussion of Professional Employer Organizations ("PEOs"):

Deputy Commissioner Beagan next introduced Robert "Bob" Burbridge founder and owner of Genesis HR Solutions, Patricia "Patty" Hilger, specialist Genesis HR Solutions, and Daniel Harris, Regional Director of the National Association of Professional Employer Organizations "NAPEO" to talk about PEOs.

Bob Burbridge introduced himself by stating he is the owner of Genesis HR Solutions and started the company in 1991. He informed the members of the Council that a PEO offers comprehensive human resources solutions providing services to small and medium business, providing access to quality health insurance coverage, 401(k), dental, and life coverage. A PEO helps businesses focus on growing the business by providing a comprehensive suite of human resources functions and access to a Fortune 500 level of human resource benefits for small and medium size businesses. They cover the gamut of activates from payroll, risk management, labor relations, workers compensation, to health care coverage for employees along with navigating the alphabet soup of employment regulation such as FMLA, COBRA, and other compliance regimes.

The PEO allows smaller companies to have the feel of larger companies by providing the same services that larger companies can provide in-house. Many times they do not provide the cheaper option; health care is never offered on its own by PEOs and only with other services. The standard PEO is a co-employment relationship established by client services contractual

agreements and in Massachusetts there are statutory registration requirement and laws governing them.

Patty Hilger explained that a PEO is based on a client partnership model: a company outsources solution for HR resource management and the PEO acts in the role of the employer. Typically the clients/companies lack experienced HR staff. The PEOs bring value to businesses: HR functions (handle life cycle of employment and expertise in navigating employee issues); relief from the day-to-day administration of employees' services, and these types of burdensome tasks of being an employer; employee benefits; consolidation and integration of all of these services with single point of contact.

Council Member Lora Pellegrini asked how a PEO selects offerings for employers. Ms. Hilger responded that Genesis selects carriers and working with a broker determines what plans to offer. The PEO creates a large group because of its co-employment relationships and because itis acting in the capacity as the employer.

Daniel Harris informed the Council of some basic facts about PEOs. Currently there are 34,000 covered lives in Massachusetts; 78 PEOs; regulated since 2018; and based on survey of members, about half of PEOs offer health coverage; 30% of clients choose to sponsor their own plans.

Council Member Jon Hurst asked Mr. Harris why trade associations can't do the same as PEOs. His organization separates everything and breaks things out much like a chamber of commerce has separate entities for everything such as health insurance, workers compensation all are stand alone and it appears that a PEO is combining everything.

Bob Burbridge responded, the PEO acts in the shoes of the employer through a contractual agreement and they are the employer and have a fiduciary responsibility by law for any of the services that they are performing for a company. The PEOS are on the hook for payments of any premiums contracted for the employees working for a company. He indicated that Trade Associations direct employers to different companies to choose for themselves and they determine whether to take the service. If a member of a Trade Association takes a recommended service, the decision is between the company and the servicing company and the Trade Association is not obligated for any part of the transaction.

Council Member Lopes asked Mr. Burbridge how long does an average employer stay with the PEO. Mr. Burbridge replied that on average an employer stays with his PEO for 10-12 years. He said that the relationship is designed to be a long-term relationship.

Michael Caljouw asked what is the potential impact that PEOs and other product designs might have on risk in the Merged Market. Mr. Burbridge responded that groups that join PEOs are similar to other groups in the market. He said that Genesis usually offers employees richer benefits and more expensive types of coverage.

Deputy Commissioner Beagan asked whether other states treat the health coverage offered through a PEO entity as large group coverage. Mr. Harris answered that most states treat a PEO as a large group employer for purposes of health insurance coverage with the exception of the state of Maryland. In Maryland, PEO health coverage is considered to be part of the small group market. At this time, over 30 states have adopted NAPEO's model law which treats coverage issued through PEOs as large group coverage.

Council Member Michael Caljouw suggested that the Council should take a look at rating rules; e.g., the requirement for look-through for coops but not PEOs because of the co-employment relationship created between the PEO and employer. Mark Gaunya asserted that, PEOs are responsible for payment of taxes and premiums and there is a major difference between PEOs and Trade Associations. PEOs have fiduciary relationship because of co-employment contractual agreements that distinguishes them from Trade Associations.

Commissioner Anderson summarized the issue by stating that the reason we requested a presentation by those involved with PEOs is to determine why people are migrating out of the Merged Market. He thanked the presenters for appearing before the Council, and concluded that PEOs may be another reason for people migrating out of the Merged Market.

Adjournment:
Commissioner Anderson thanked the Council Members and the presenters for their participation, and stated that the next meeting of the Council will be on Wednesday, March 11, 2020 at the Division of Insurance, Room 1E, 1000 Washington Street, Boston. Chairman Anderson called for a motion to adjourn and Council Member Mark Gaunya made the motion, the motion was seconded by Council Member Jon Hurst and the motion passed by a unanimous vote of those in attendance 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. **Slide presentation "Merged Market Advisory Council" dated March 5, 2020 createdby Gorman Actuarial Inc.**
2. **Draft minutes of the public meeting held on February 5, 2020 at 1000 Washington Street, Boston, Massachusetts.**
3. **Letter dated March 3, 2020, from Patrick Cahill, Vice-President MassachusettsMarket, Harvard Pilgrim Health Care to Gary D. Anderson, Commissioner, Division of Insurance.**
4. **Handout entitled "HOSPITAL INDEMNITY INSURANCE".**

5. **Handout "3 WAYS SMALL BUSINESSES BENEFIT FROM USING A PEO."**
6. **Handout "Facts about Professional Employer Organizations (PEOs).**
7. **Summary of Public Information Session on Wednesday, February 12, 2020 at UMass Law School in Dartmouth, Mass.**
8. **2Q20 Average Rate Increases for Merged Market.**

Minutes of Meeting of the Merged Market Advisory Council (Council) held on Wednesday, March 11, 2020 and Approved by the Council at the Meeting Held on June 17, 2020; Motion of Council Member Joshua Archambault and Seconded by Council Member Rosemarie Lopes. Motion Passed by a Unanimous Vote of the Council Members Present.

March 11, 2020, Minutes of the Council Meeting
Held Telephonically

Members Present:
Gary D. Anderson, Chairman, Commissioner, Division of Insurance
Louis Gutierrez, Executive Director the 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, Executive Director 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
Wendy Hudson, Small Group/Individual Employer representative
Joshua Archambault, Health Insurance Business Community representative
Jon Hurst, President of the Retailers Association of Massachusetts, Health Insurance Business Community representative

Participating by Telephone:
Governor Charles Baker issued a Declaration of a State of Emergency on March 10, 2020 (State of Emergency), directing Executive Branch agencies to either cancel large meetings or hold them virtually because of the Coronavirus pandemic ("COVID-19") and Kevin Beagan, Deputy Commissioner for the Division of Insurance Health Care Access Bureau, notified the Members of the Council that the Merged Market Advisory Council Meeting would be held by teleconference and provided a call-in conference number for the meeting.

Attending to the Council:
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 1:05PM. Chairman Anderson announced that Marylou Sudders, Secretary of Health and Human Services, had a previous commitment, she was unable to postpone it, could not attend the meeting, and her designee Lauren Peters would be participating.

Chairman Anderson called a roll of the Council Members participating by teleconference and each member identified herself or himself, including Secretary Sudders' designee Lauren Peters. Chairman Anderson announced that Council Member Joshua Archambault would be joining the teleconference at 2:00PM and, thereafter, Mr. Archambault joined the meeting at that time.

The Members of the Council reviewed the draft minutes, and Council Member Michael Caljouw made the motion to approve the minutes, the motion was seconded by Council Member Rosemarie Lopes, and the motion passed unanimously with Chairman Anderson and Council Member (Designee) Peters abstaining.

Chairman Anderson turned over the next segment of the meeting to Kevin Beagan, Deputy Commissioner for the Health Care Access Bureau of the Division of Insurance, and Mr. Beagan indicated that the last public session was scheduled for Springfield, but because of the State of Emergency, Mr. Beagan cancelled it and will attempt to have some session in the Western part of the state by virtual conferencing or otherwise.

Presentation by Gorman Actuarial Inc.:

Commissioner Anderson next introduced Bela Gorman, principal of Gorman Actuarial, Inc., to provide a third presentation to the Council, analyzing aspects of the individual/small group health insurance markets (hereinafter "Merged Market") entitled, "Merged Market Advisory Council, dated March 11, 2020." Ms. Gorman introduced herself and explained that the PowerPoint presentation she created for the current meeting of the Council was a follow-up from the presentation presented on March 5, 2020, which provided a lot of analytics with respect to the Merged Market.

Ms. Gorman referred the Council Members to Slide-4 of her presentation and noted groups that leave the Merged Market usually have a healthier profile, whereas the groups that remain have a higher risk profile. This change usually increases the pressure to raise premium rates. Ms. Gorman stated that smaller employer groups know the health of their employees, and if there are employees in their group who have high health risks, they will react in a risk averse manner and will not move out of the Merged Market, whereas the trend is that those employers with healthier employees will look to move out.

Council Member Jon Hurst asked whether instead one could say that an employer that opts to leave is one that just competently manages its medical claims.

Council Member Rina Vertes responded that small group employers move all the time, and moving out of the Merged Market does not necessarily mean that the groups have healthier employees but are instead groups looking for a more affordable solution. Council Member Michael Caljouw suggested that it may be helpful to provide data analytics that arecurrently available on this topic and said he has a sense that this issue has been examined and thereare studies that can be circulated on the topic.

He noted that there should be a root discussion about the behavior of group entities, but that it may also be useful to study the impacts that the new opportunities may have to the marketplace over time.

Council Member Lora Pellegrini stated that the state of Maine has experience with healthy risks leaving the small group market to move to self-insure with stop-loss coverage. She suggested that the Council review what the experience has been in Maine and determine what the impact was on Maine's small group market. Ms. Pellegrini said that a similar situation is happening in Rhode Island. She noted that some of these options are still fairly new, and there is not a lot of experience regarding these new products entering the market.

Ms. Gorman directed the Members of the Council to Slide-5 of the presentation and stated that last week the Council heard about Individual Coverage Health Reimbursement Accounts (hereinafter "ICHRAs"). Ms. Gorman said that ICHRAs seem to be a way for small groups to save money and shop around. At this time, it is unclear what impact ICHRAs have on the Merged Market, and this type of product offering might increase the overall enrollment in the Merged Market.

Jon Hurst pointed out that there is one particular aspect that is not reflected: the added reform of the Employer Medical Assistance Contribution (hereinafter "EMAC") and MassHealth. At the time EMAC was implemented, insurers felt it would affect small group premiums. Mr. Hurst felt that there may be a resulting impact on the Merged Market if there is a migration into ConnectorCare.

Council Member Louis Gutierrez noted that there has been a migration into ConnectorCare, and ConnectorCare by far has the lowest impact on increases to the Merged Market. Mr. Gutierrez asserted that providers will differ as to the rates they will extend to ConnectorCare membership, and the rates are the real figures.

Ms. Gorman moved on to Slide-6 of her presentation, stating that it was a modeling exercise as to what can happen to the Merged Market as small groups leave. Ms. Gorman noted the review should look over a 5-year period, because small groups leave the Merged Market gradually over time. Slide-6 illustrates what would happen to the overall market as small groups leave. The assumption is groups leaving the Merged Market are healthier than the groups that stayed behind. According to the presentation, Ms. Gorman indicated that on average those groups leaving the merged market are 10% healthier than those that stay behind in the small group market. If such a trend were to continue whereby healthier groups continue to migrate every year, less healthy people will remain in the Merged Market.

Council Member Jon Hurst asked the other MMAC members to consider whether the groups leaving consisted of healthier individuals, or whether they were just better consumers who shopped around for better options?

Council Member Mark Gaunya stated he thought that unless a review was conducted based upon individual risk scores, it's not feasible to determine whether groups who leave the small group market are or are not healthier. Council Member Hurst responded that these small group employers who decide to self-insure aretaking on risks, but that does not mean that they will have lower costs. These employers may leavefor 12 months, but then they can return if they have a bad year, and thus

Mr. Hurst is not necessarilyof the opinion that every employer who leaves the Merged Market has a healthier group.

Council Member Vertes agreed and stated that the fact that small group employers are migrating out of the Merged Market does not mean the ones leaving are healthier groups. There could be some adverse selection going on whereby they are bouncing in and out of the Merged Market, and she concluded that that helps no one.

Ms. Gorman directed the Council Members to Slide-8, indicating that in 2018 22% of ConnectorCare members did not use services, the highest percentage for any group in the presentation. The analysis indicates that members in the ConnectorCare plans use less services and less costs than the non-ConnectorCare plans.

Council Member Gaunya noted that, when a group has a narrow network that precludes members from using providers connected with academic health centers, then the costs of care in many cases are lower.

Ms. Gorman noted that the average cost per claimant is not that different between services provided through ConnectorCare plans and those provided through non-ConnectorCare plans.

Council Member Gaunya responded that ConnectorCare members do not have access to higher costing providers because they are offered limited network plans.

Ms. Gorman directed the Council Members to Slide-8 where it indicates that 23% [22.9%] of ConnectorCare members don't use medical services; whereas 19% [19.4%] of the non-ConnectorCare members do not medical services. Therefore, there is a higher percentage of members using medical services in non-ConnectorCare plans.

Deputy Commissioner Beagan noted that Slide-8 is based on people who do not file claims. What this data shows is that there are differences in the distribution of the risk.

Council Member Gutierrez made one point of clarification regarding the use of the word "healthier." He observed that the people who are members of ConnectorCare plans are at or below 300% below the poverty level and are a highly stressed portion of the population that may not generally be familiar with how to use health care services. Therefore, the ConnectorCare members are not necessarily healthier and consequently a lower risk for that reason, but instead their lower costs be based on less utilization of medical services. Mr. Gutierrez suggested that we replace our discussion about whether groups are or are not healthier with one about whether groups are or are not higher than average utilizers of health care.

Council Member Hudson agreed and stated that she has found that the communities participating in ConnectorCare, with which she is familiar from her work on Nantucket, are not utilizing medical services. She believes it is more of a health care access issue.

Council Member Vertes concurred. She noted that just because a person does not access health care does not mean that the person does not need the care.

Ms. Gorman directed the Members of the Council to Slide-10. Risk scores alone cannot tell the story for those carriers that participate in ConnectorCare since they are based on the claims filed on behalf of the ConnectorCare population. If the risk scores are low, this may create an assumption that ConnectorCare members are not high risks. This may not be accurate based solely on medical claims filed, because ConnectorCare covered persons may not be accessing health care services even though they are sick. Slide-11 indicates that the lowest utilizers of care are in ConnectorCare plans, the highest use is the small group non-ConnectorCare segment, and it appears that groups of 1 have the highest risk profile.

Commissioner Anderson observed that each of the carriers has its own risk pool, and he asked Council Member Gutierrez to provide some background about efforts to continue the federally granted flexibility to use Massachusetts-specific rating factors. Mr. Gutierrez responded that we need to thread a needle when we request a continuance to the current transitional rating factors going into 2021. If the Connector elects to file for the continued flexibility, it needs to submit supporting analysis for the request for two rating factors (group size and cooperative) to continue for another year.

Mr. Gutierrez indicated that the Connector will consider any input from members of the Council relative to the submission of a request to the U.S. Dept. of HHS for continued authority, under ACA Section 1321(e), for the Commonwealth to use two Merged Market rating factors (the group size factor and the cooperative discount), in the interest of continued Merged Market stability. He presumed that it must be actuarially based, and considering any of the material submitted by Council Members would be helpful, along with some of the material that Bela Gorman submitted. Commissioner Anderson urged Council Members to share additional thoughts or information directly with the Connector and asked that the MMAC members listen for the remainder of the meeting to information presented by representatives from certain health industries.

Sharing Ministries:

Deputy Commissioner Beagan introduced Dave Sterritt and Brad Nail, and turned the discussion to Mr. Nail, of Catholic Solidarity Health. Mr. Nail informed the Council Members that Catholic Solidarity Health's sharing ministry is three elements: (1) contents; (2) costs; (3); and community. His organization publishes and distributes a monthly publication to its group of committed Christians, who have offered to contribute a specific amount of money each month towards the group's medical costs. The payments are submitted to pay for the shared medical costs of all the members.

The organization, in turn, works to reduce the costs of medical bills by negotiating with providers based on a referenced-based pricing model, focusing on what Medicaid would pay. Using this, they work towards getting medical providers' prices reduced by a good percentage.

Mr. Nail indicated that his organization's membership pays about $540 per month and are responsible for paying the first part of their own medical costs up to $2,200. Mr. Nail indicated that CSH examines bills carefully and negotiates with providers. Recently they had a multi-million dollar medical bill negotiated down to $600,000.

Stewart Lark, General Counsel for the Christian Healthcare Ministries (CHM), stated that they have about 400,000 members with over 600 members in Massachusetts. His health care ministry does not have insurance contracts with its members. Instead faith-based communities rely on the faith of the other members paying their share of the members' health care costs.

Mr. Lark then discussed legislation drafted by the National Council of Insurance Legislators ("NCOIL") called the "Health Care Sharing Ministry Registration Model Act" which would regulate ministries. This bill has been filed in 30 states including Massachusetts. Mr. Lark indicated that Massachusetts should adopt a statute or regulation concerning the operation of health care sharing ministries in order to establish standards that would apply to all ministries.

Among the features of the model, health care ministry sharing members would be required to provide information to all applicants and have them sign acknowledgements that they are individually responsible for payment of medical bills. The bill would also give enforcement authority to state officials, such as insurance commissioners. Joel Noble, Director of Public Policy of Samaritan Ministries International, stated that he worked with the Connector and had a long history in Massachusetts. He asserted that his organization was not engaged in providing insurance, was very open and transparent. He said that it is in everyone's interest to engage in best practices, and they have a website on how Health Care Ministries should act.

Council Member Amy Rosenthal asked about the multi-million dollar medical bill that was negotiated down to $600,000 and what happens when the ministry is not able to negotiate the medical bills down.

Mr. Nail responded that, if the medical bills are not covered by the reserve funds, they adjust membership contributions up or down as claims come in. If a member has concerns about payments of medical bills, they have a process which allows members to resolve disputes about the payment of medical bills amongst themselves. In the event that the sharing ministry can't resolve the complaint internally, they have an arbitration process. Mr. Nail indicated that Members also voluntarily decide to increase their contributions to help any family pay their medical bills. Ministries usually will only help with claims of up to $1 million per member per year, and he has found there has not been a problem with claims exceeding that limit. A consumer or member can appeal to a board comprised of members, and their decision is binding; they have only used it 3 times in the last 25 years.

Council Member Gaunya wondered how the ministry was able to live within the $1 million limit when there has been an 80% increase in catastrophic medical claims over the last five years.

Mr. Nail agreed that cost increases can cause great pressure. The ministry works to keep claim costs below that price, and there are some Catholic doctors who are helping out by accepting 80% less than what Medicare will pay. There are also lists of other providers and pharmacies that are willing to work with the ministry. In one case, the ministry was notified that a single mother with two kids needed a drug that cost $10,000 per month; after being contacted by the ministry, the pharmaceutical company wrote the bill off.

Self-Funded:

Deputy Commissioner Beagan introduced Eric Swain from United Healthcare and Trey Swacker from Aetna Insurance Company to begin a discussion about self-funded/stop-loss plans for small groups.

Trey Swacker is the manager for Aetna's small-group self-funded stop-loss products. These are level-funded products that Aetna administers for employers engaged in pre-funding the potential medical bills for their employees. The employers are liable for the payment of medical claims, and Aetna provides stop-loss protection for any member who has claims of over $30,000.00. Members with claims exceeding $30,000.00 will be covered by a specific stop-loss insurance policy.

Aetna charges the group administrative fees, and there is a charge for the stop-loss coverage. If a group decides to stop being covered through Aetna, Aetna will cover any run-out when the group leaves them. At the end of the year, if claims are less than projected, Aetna will give back to the group the unused amounts collected from the employer. The self-funded plans cover full medical benefits, including virtually all of the basic medical benefits and pharmacy benefits in the bronze category. Aetna sells only to groups sized 25-50 or 5-24 employees. Aetna also requires that employers purchase run-out protection.

Council Member Gaunya asked Mr. Swacker to discuss the mechanics of self-funded arrangements. When talking about partially self-insured business, Mr. Gaunya indicated that there is a major question about whether the groups are healthy and this, in turn, speaks to any one group's suitability.

Mr. Swacker replied that price is important and it is the reason that groups sign up with Aetna. Being self-funded, employers encourage their employees to engage in living healthier life styles, in an effort to keep health costs down. The employer understands the total risks up front.

Council Member Gaunya indicated that this educates the employer so that the employer can best judge how they will finance their employee's health care costs.

Mr. Swain indicated that there is a fully insured market and it works for those who want the protection of full health insurance. This other self-funded market instead lets small employers control their own health care costs while having adequate protection from unexpected losses through stop-loss coverage. These plans are subject to all ERISA requirements, which are different from what may be required by the ACA. Self-funded products are not required to follow all of the mandates of state laws and the ACA.

Mr. Swain indicated that his company began to offer its self-funded/stop-loss product in 2016, and the vast majority of companies that bought the product were in the Merged Market. At this time, this product represents less than 3% of Aetna's sales in Massachusetts in a given year.

Mr. Swacker indicated that Aetna won't sell to groups with fewer than 5 members. Aetna has found it is not possible to assess risk properly when a group has fewer 5 members.
Ms. Maggie Lord from Aetna stated that there are some states that have looked at stop-loss and limited the size of groups to which stop-loss can be made available. For instance, the state of Maine requires that all carriers offering stop-loss coverage must have run-out periods, and limits the sale of level funded stop-loss products when the group has fewer than 10 eligible group members. The state of Rhode Island has not limited stop-loss coverage by the size of a group but has restricted the use of employee health status in identifying eligibility for stop-loss coverage. Around the country there has been some "noise," and New York banned offering self-funded products to small groups.

Council Member Archambault asked the reasons businesses why are leaving the Merged Market and buying the Aetna self-funded/stop-loss option.

Mr. Swain replied that costs are the driving factor.

Association Health Plans:
Deputy Commissioner Beagan introduced Chris DeLorey of Marsh and McLennan to help inform Council Members about bonafide Association Health Plans (AHPs).

Mr. DeLorey advised that one must consider the ACA's requirements and what would constitute a bonafide group when exploring exceptions for AHPs in Massachusetts. Because AHPs are required to operate only to meet the interests of plan members, higher cost-structured groups may be attracted to AHPs since they are designed to meet the needs of the group members.

During the presentation, Attorney Chris Condeluci introduced himself by phone and stated that indicated that AHPs are not a new concept, and many have been around a long time. The ACA did impose new rules and beefed up state laws to keep out unscrupulous actors. The Obama administration issued guidance that an AHP is to be treated as a large group plan and the AHP is able to treat the risk pool as the AHP's own. Under this type of coverage many argued that they would be offering skinny plans or self-funded, but Mr. Condeluci indicated that this has not been the case.

Chris DeLorey had been engaged in working on behalf of groups of franchisees in Massachusetts, which has grown from 1000 to 15,000 franchise employees in the warehouse and hourly staff as well. Mr. DeLorey has noticed a lot of employees coming off of state-subsidized care when joining the AHP that he follows. The average age of the franchise population is not young.

One of the groups being considered as an AHP is ACE Hardware. Corporate employees have formed together to create one large group of 5,000 lives across independent franchisees. Mr.

DeLorey could see placing all the ACE Hardware franchisees into one large group, and this would be advantageous to them. Some want to stay in the Merged Market, but most of the franchisees want to go to a large group plan. Mr. DeLorey provided an anecdotal case of a franchise on the Cape Cod, where it would not be cost effective to join a large group because the franchisee has a sick member, so for that franchise it is better to remain within the protections of the Merged Market.

Mr. DeLorey asserted that AHPs are just like what the state municipal associations offer their members, which is the ability to band together for insurance and other group benefits.

Adjournment:

Commissioner Anderson thanked the Council Members and the presenters for their participation, and stated that the next meeting of the Council would be on Thursday, March 26, 2020 and would be held by teleconference. Chairman Anderson called for a motion to adjourn, Council Member Gaunya made the motion, the motion was seconded by Council Member Rosenthal, and 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. **Slide presentation "Merged Market Advisory Council" dated March 11, 2020 createdby Gorman Actuarial Inc.**
2. **Draft minutes of the public meeting held on March 5, 2020 at 1000 Washington Street, Boston, Massachusetts.**

Handouts:

1. **Model Healthcare Sharing Ministry Registration Act Massachusetts**
2. **Model Healthcare Sharing Act, National Council of Insurance Legislators (NCOIL)**
3. **Health Care Sharing Ministry Registration Model Act**
4. **Samaritan Ministries "What is a health care sharing ministry?"**
5. **Samaritan Ministries "Best Practices".**

Minutes of Meeting of the Merged Market Advisory Council (Council) held on Wednesday,May 20, 2020 and Approved by Council on Thursday, September 10, 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.

May 20, 2020, Minutes of the Council Meeting
Held Telephonically

Members Participating by Telephone:
Gary D. Anderson, Chairman, Commissioner, Division of Insurance
Louis Gutierrez, Executive 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
Wendy Hudson, Small Group/Individual Employer representative
Joshua Archambault, Health Insurance Business Community representative
Jon Hurst, Health Insurance Business Community representative

Attending to the Council:
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 1:08PM.
Chairman Anderson called a roll of the Council Members participating by teleconference and the members identified themselves, including Secretary Sudders' designee Lauren Peters.

Chairman Anderson informed the members of the Council that the draft minutes of the meeting held on March 11, 2020 had been provided to all the members of the Council. Chairman Andersonasked the group to review the draft minutes for approval at the next meeting.

Update on DOI Actions relating to COVID-19:
Chairman Anderson informed the members of the Council that the Division of Insurance (DOI) has issued 16 bulletins since March to provide guidance to carriers and consumers and that, of those, roughly ten (10) are health-related. Chairman Anderson explained that the guiding principleof these bulletins has been removal of barriers for testing and treatment for COVID-

19 and ensuring access to healthcare for all Massachusetts residents. Bulletins issued by the DOI are all posted to the DOI's public website.

Chairman Anderson turned over the next segment of the meeting to Kevin Beagan, Deputy Commissioner for the DOI's Health Care Access Bureau. Mr. Beagan stated that it is an understatement to say that COVID-19 has had an impact on the insurance market. Changes are happening quickly.

Mr. Beagan explained that the DOI is collecting monthly membership information, from health carriers to understand the changes to the market as they happen. This information will be collectedon the 15th of each month for the preceding month, starting with reporting in May for February, March and April. Mr. Beagan noted that changes so far are relatively flat, which indicates that many of the Division's bulletins, including Bulletin 2020-05, probably have helped enable April membership to stay similar to that of March. Mr. Beagan stated that we could expect May and June to change as certain short-term solutions may turn into longer term problems. The Division needs to collect this information to understand the general health of companies in the market and give policyholders and policymakers information.

Presentation by Gorman Actuarial Inc.:

Commissioner Anderson next introduced Bela Gorman, principal of Gorman Actuarial, Inc. to give an update to the Council. Ms. Gorman explained that her group did a data call in the fall of 2019 for CY2018, and with all the changes to the market that she thinks it important to collect 2019 data and other information that help in understanding the evolving composition of the market.Ms. Gorman noted that her team has developed models looking into a number of scenarios, including changes to the market if the Merged Market were separated; and what would happen with the development of a reinsurance model, but all the modeled information will change with the evolving market. She indicated that the Merged Market is going to look very different, and itwould make sense to understand the size and composition of market post-COVID-19 and incorporate these learnings into the modeling we have done.

Mr. Beagan stated that the members of the Council would be kept aware of dynamic changes to the market.

Chairman Anderson asked if any members of the Council had questions.

Mr. Caljouw suggested letting market dynamics settle out, but not for too long, and then selectingthe best period of time for a snapshot of membership.

Mr. Beagan acknowledged this concern, reminding the group that it is part of the reason why the Chairman would like the Council to meet regularly and go over this information as it becomes available.

Mr. Hurst noted that telemedicine is up and utilization is way down and asked that attention be paid to any profits that the hospitals are making while small businesses continue to pay premiumsfor coverage they are not using.

Mr. Gaunya observed that he has heard that there has been 25-65% reduction in medical claim utilization, that Massachusetts residents are not having elective procedures, and telehealth is booming. He indicated that with all these changes, we need to understand how it affects the market. The fully insured market is going to be a challenging environment because of pressure onhealth plans to reimburse providers for lost revenue.

Mr. Archambault asked, with regard to aggregate membership data, if the data could include historical membership numbers and break apart Medicare and Medicaid numbers.

Update from Massachusetts Health Connector:

Mr. Gutierrez informed the Council that the Health Connector submitted a letter to federal CMS requesting an extension of the cooperative and small group rating factors currently in use to still be available for use in 2021. Mr. Gutierrez stated that he should have an update for the Council inJune.

Consideration of a Recommendation regarding 211 CMR 40.00- Marketing of Insured Health Plans

Chairman Anderson suggested that the Council consider supporting the DOI revising 211 CMR 40.00 to update requirements concerning marketing and disclosure of health plans to address illegal health plans, confusion about coverage for limited benefit plans, and confusion about Sharing Ministry Plans.

The Chairman called for a motion to approve the Council recommending that the DOI draft revisions to 211 CMR 40.00. Council Member Rosenthal made a motion, the motion was secondedby Council Member Gaunya, and the motion passed by a unanimous vote of the Council, with Chairman Anderson abstaining and with Council Members Caljouw[i], Lopes and Hudson not voting. Mr. Caljouw later emailed and reported he had gotten disconnected from the call and asked that his "yes" vote be recorded.

Adjournment:

Commissioner Anderson thanked the Council Members and the presenters for their participation, and stated that the next meeting of the Council will be on Wednesday, June 17, 2020 and would be held by teleconference. Chairman Anderson called for a motion to adjourn. Council Member Gaunya made the motion, the motion was seconded by Council Member Archambault, and the motion passed by a unanimous vote of the Council Members, with Chairman Anderson abstaining.

[i] Mr. Caljouw lost his video connection prior to the actual vote and was therefore not present for the vote. He did concurrently send an e-mail that indicated that he voted for the motion.

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 definitionof a "public body" as defined under c. 30A, § 18.

List of Documents provided at the Council meeting:

1. **List of DOI Actions taken since the start of COVID-19 public health crisis.**
2. **Aggregate membership in Massachusetts health plans as of April 30, 2020.**
3. **Draft minutes of the Council meeting held via telephone on March 11, 2020.**

Minutes of Meeting of the Merged Market Advisory Council (Council) held on Wednesday, June 17, 2020 and Approved by the Council on Thursday, September 10, 2020.

Motion of Council Member Amy Rosenthal and Seconded by Council Member Rosemarie Lopes. The Motion Passed by a Unanimous Vote of the Council Members Present.

June 17, 2020, Minutes of the Council Meeting
Held Telephonically

Members Participating by Telephone:
Gary D. Anderson, Chairman, Commissioner, Division of Insurance
Louis Gutierrez, Executive 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, Executive Director, Massachusetts Association of Health Plans, Health Insurance Carrier 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
Joshua Archambault, Health Insurance Business Community representative
Jon Hurst, President of the Retailers Association of Massachusetts, Health Insurance Business Community representative

Not Participating:
Wendy Hudson, Small Group/Individual Employer representative
Mark Gaunya, Health Insurance Broker representative

Attending to the Council:
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 1:00PM. Chairman Anderson called a roll of the Council Members participating by teleconference and themembers or designees identified themselves.

Chairman Anderson explained that as a result of the COVID-19 public health crisis, the Council meetings could not be held as originally scheduled. The work of the Council is important, and in order to keep progress moving, monthly meetings have also been scheduled for July and August, with an intent to resume bi-weekly meetings in September in order to complete Council work. The Council members reviewed the draft minutes from the March 11, 2020 meeting, and Council Member Joshua Archambault made the motion to approve the minutes, the motion was seconded

by Council Member Rosemarie Lopes, and the motion passed unanimously with Chairman Anderson and Council Member (Designee) Peters abstaining.

Chairman Anderson also informed the members of the Council that the draft minutes of the meeting held May 20, 2020 had been provided to all the members of the Council. Chairman Anderson asked the group to review the draft minutes for approval at the next meeting. Mr. Caljouw suggested a revision to the minutes regarding the Division's bulletins and membership. Kevin Beagan, Deputy Commissioner for the Health Care Access Bureau of the Division of Insurance, said he would revise and send to the group before the next meeting.

Presentation about May End Membership

Mr. Beagan said that the Division has reviewed membership levels for May 2020 and is encouraged that the carriers have not seen a significant drop in membership. He said that employer group membership did drop by approximately 20,000 persons, but with an increase of about 15,000 in government programs, the total number with health coverage only dropped by 5,000 in total.

Mr. Beagan explained that the Division expected much lower numbers because of the high rateof unemployment, so it was a relief to see the numbers have not significantly dropped. Mr. Beagan reminded the Council that the companies report their membership levels on the 15th of each month for the preceding month, and the Division will share June membership levels with the Council when received. Mr. Beagan also explained that the Division is working with companies to expand the reporting to include both small and large group numbers, as well as government accounts.

Council member Pellegrini said that it is great that we have such little drop in membership, but surprising. She asked if the Administration is tracking employers who furloughed employees and maintained their benefits but are now letting those employees go as the economy gets worse. She also asked if the Administration is tracking the impact of those individuals receiving health care benefits via COBRA.

Mr. Beagan explained that we are looking at summary information that can be reported quickly, but that the Division, as well as the Center for Health Information and Analysis (CHIA), will be collecting more in-depth information.

Presentation about Suggested Changes to 211 CMR 40.00

Deputy Commissioner Beagan said that the Council discussed at the last meeting that the DOI should revisit 211 CMR 40.00 ("Marketing of Insured Health Plans") to set up new safeguards so individuals understand the coverage they are buying and avoid choosing options outside the merged market, and then return to the merged market when they realize that the options chosen do not give the coverage they need.

Mr. Beagan presented draft materials and explained that the draft would require new disclosures so that covered persons would be much more aware when an option is for fully insured health coverage and when an option is for limited health coverage. Mr. Beagan reminded the Council that the MMAC does not need to vote on what ends up in the final regulation, but the Division would welcome any ideas that MMAC members may have. Ultimately, the Division will need tofollow the standard M.G.L. c. 30A approval process when proposing final changes, which will go through a formal hearing.

Council member Rosenthal said she is appreciative of efforts to make sure people understand what they are buying and understand when a plan is a limited health plan. Ms. Rosenthal indicated that she would like to review the regulation with her helpline counselors and share suggested revisions at a later time.

Mr. Caljouw said that he is supportive of the changes generally, but wants to be sure that any changes to this regulation are consistent with 211 CMR 152.00 and the existing requirementswith regard to notices about benefits.

Presentation about Sharing Ministries:

The discussion then turned to the NCOIL (National Council of Insurance Legislators) sharing ministries model.

Chairman Anderson explained that the Council is not being asked to endorse the model but instead to consider whether there should be any regulation of sharing ministries. Chairman Anderson also explained that the Council should consider any potential overlap with the Massachusetts Health Connector's regulation for minimum creditable coverage (MCC). The Chairman asked Audrey Gasteier from the Health Connector, who was also on the call, to explain that regulation.

Ms. Gasteier said that the Connector's Board of Directors voted last year to address sharing ministries within its regulations to identify when persons with membership in sharing ministries would be considered to satisfy Minimum Creditable Coverage (MCC). She indicated that she would look into the issue in more detail and see whether it may be helpful for there to be new processes, as suggested by NCOIL, which would regulate the activities of sharing ministries in Massachusetts.

Council member Archambault said that he is concerned about spending time and resources on issues such as sharing ministries when the total number of persons enrolled in these options are minor compared to other options that are a larger part of the market. Chairman Anderson said that it is a small piece of the market, but we are looking at all options because we do not know what impact the pandemic is going to have on the market.

Council member Pellegrini said that she has been talking to a lot of small business owners, many of whom got loans to help bridge financial gaps, but that money is running out. She hopes that

more information from economic experts over the next month or two can help shed light on the impact of COVID-19.

Council member Hurst said COVID-19 has sidetracked the Council from discussing substantial real long term reforms, and would like to put a spotlight back on rating factors. He asked whether CMS/HHS has responded to the Connector's request for continued authority, under ACA Section 1321e, for the Commonwealth to use two merged market rating factors (the group size factor and the cooperative utilization factor (a topic discussed at previous MMAC meetings).

Council member Gutierrez said that the Connector did reach out to get an update on the status, and while not final, the Connector received favorable signals that it is in final stages of approval. Council member Rosenthal agreed that the Council should keep an eye on both the numbers and do work on sharing ministries. She said that while it is not a large part of the market, this issue is important for individuals and families who discover that they don't actually have the health coverage that they thought they purchased.

Council member Vertes said she is baffled that there has not been more erosion in employer sponsored coverage and uptick in government sponsored coverage. She said she is likewise afraid that the Council is losing focus of the core issue, which is the cost of health care and the burden it places on individual, small businesses, and the government. She said that in NY payers are asking for rate increases north of 11%, and she is very concerned about the rates carriers will be filing in the next few weeks. Mr. Hurst agreed with that sentiment and said that the rates should reflect the drop in utilization.

Mr. Caljouw suggested that for the July or August meeting, Gorman Actuarial could model the impact of any legislative changes that might occur through next 6 weeks that might impact the market and that a segment of these Council meetings should be dedicated to reviewing that modeling.

Mr. Anderson said that the Council members' comments present a snapshot of the many challenges the Council is facing. When the full meetings resume in September, the plan is to have more updates from Gorman Actuarial.

Adjournment:

Commissioner Anderson thanked the Council Members for their participation, and reminded Council members that the purpose of these monthly meetings is to maintain the momentum the Council created pre-crisis and address some lower priority items that will still benefit Massachusetts residents. Chairman Anderson called for a motion to adjourn, Council Member Hurst made the motion, the motion was seconded by Council Member Archambault, and 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 to the Council before the meeting:

1. **Draft amendments to 211 CMR 40.00**
2. **Draft minutes of the public meeting held on March 11, 2020 at 1000 WashingtonStreet, Boston, Massachusetts.**
3. **Draft minutes of the public meeting held on May 20, 2020 via telephone.**
4. **NCOIL HCSM Model draft**

Minutes of the Merged Market Advisory Council (Council or MMAC) Meeting of September 23, 2020 Approved by Council at the Meeting Held on October 7, 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
Audrey Gasteier, designee of Louis Gutierrez, Executive 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 2:04 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 August 2020 was very similar to that of July 2020. There were further declines in commercial membership – 1,614 in small group; 16,791 in large group; and 2,764 in ASO (Administrative Services Only self-funded business) – offset by increases in individual (5,686) and governmental (19,713) accounts.

In comparing April 2020 to August 2020 membership, commercial coverage – including ASO – has decreased by 56,147 (1.2%) but governmental programs increased by 49,687 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 acknowledged the work of the Executive Office of Health and Human Services during the COVID-19 crisis and stated the importance to keep MassHealth strong because consumers never know when they may need to go on it.

Minutes

Chairman Anderson asked the group to review the minutes from the September 10, 2020 meeting, which had been shared in advance of the meeting, and vote on approval. Mr. Gaunya made a motion to accept the minutes as drafted and Ms. Lopes seconded the motion. The minutes were unanimously approved with no discussion.

Discussion of Policy Options:

Chairman Anderson asked Mr. Beagan to lead a scheduled discussion of policy options.

Addressing Rising Health Care Costs

Mr. Beagan noted that a few members wished the Council to talk about rising health care costs – even if outside the scope of the Council - and consider whether more work was needed to stem health care cost pressures. Mr. Beagan highlighted items within the Governor's 2019 Health Reform Bill that would stress increasing investments in primary care and addressing facility fees and drug prescription costs. He asked if MMAC members had thoughts about cost control.

Mr. Hurst noted that the recently announced average rate change of 7.9% increase for 1Q21 merged market premium rates is high and noted that consumers need to know why it costs so muchand what these costs were getting them, especially with rising deductibles and copays. Ms. Vertesagreed the rate increase is eye-catching and noted there continues to be a wide variation in healthcare practitioner payment rates (unit cost) that leads to higher costs. Ms. Vertes explained that doctors and hospitals have different rates for a standard set of services, such as an appendectomy or MRI which may cost $1,000 in one place and $4,000 elsewhere. Ms. Vertes encouraged the Council to foster ideas where patients are aware of the differences. Mr. Gaunya noted that the most expensive facility is not necessarily the best and quality is often comparable.

Mr. Gaunya noted that unit costs are a challenge and suggested that price transparency requirements established in Chapter 224[1]should be better publicized and patients should know that they can ask for the price of services. Mr. Hurst and Mr. Caljouw added that transparency means little if it has no effect on premiums.

Ms. Peters noted the coverage that businesses choose impacts what they pay since carrier premiums can vary significantly. Consumers should pay attention to not only what provider to goto, but also what carrier offers the best products for them. Mr. Caljouw noted that there should befurther thought to reward consumers for making smart choices about where to get care and suggested that tiered and limited network products encouraged the patients' use of lower cost care.

[1] Chapter 224 of the Acts of 2012, "An Act Improving the Quality of Health Care and Reducing Costs Through IncreasedTransparency, Efficiency and Innovation."

Ms. Pellegrini and Ms. Rosenthal thought the Council should support efforts by HPC, CHIA, andothers studying underlying costs, such as prescription drug costs that affect all health plan costs. Mr. Archambault thought that there should also be studies looking at providers' scope of practiceand whether more care could be provided by less expensive providers.

Equalizing how Carriers Offer Products across Submarkets

Mr. Beagan presented a slide deck[2] (attached) about products offered in the Merged Market. By law, all must be made available to all eligible individuals and small employers, but carriers do notactively market all products in all submarkets. Among the points noted in the slide deck:

- only a handful of carriers offer ConnectorCare products;
- two ConnectorCare carriers do not offer preferred provider plans and individual preferredprovider plan membership is concentrated in just a few carriers;
- not every carrier offers both a tiered or a limited network product.

Mr. Beagan indicated that the Governor's Health Reform bill proposed changes to the statute thatwould require that every product be identified on carrier websites and marketed to all merged market members and there appeared to be Council support for these provisions. Mr. Beagan askedif Council members had thoughts whether products be offered by every carrier in every submarket.

ConnectorCare Products

Ms. Gasteier asked if every carrier should be added to the ConnectorCare offerings. Mr. Caljouw noted that the products not in ConnectorCare cost more than the most popular ConnectorCare products and adding choice would not necessarily reduce cost. Ms. Rosenthal noted that the Connector should have a sufficient amount of choices to make sure consumers can afford a level of care, and it doesn't make sense to offer plans on the Connector just for the sake of offering themif consumers cannot afford them.

Ms. Pellegrini felt that the market should decide who participates in ConnectorCare and Mr. Gaunya added that it would not be optimal for rules to dictate where carriers compete exceptto require that products offered on the Connector also be available off-Connector.

Preferred Provider Plans

Ms. Vertes did not think there was a need to require every carrier to offer a preferred provider plansince every HMO plan already offers generous networks with access to care. She felt that peopleonly purchase preferred provider plans because they don't want to go through the process of gettinga referral. She thought that equalizing the offer of these plans would not improve the market and the problem remains that unit costs are driven by the robustness of existing provider networks.

[2] Developed by Bob Carey as part of the work conducted by Gorman Actuarial.

Limited Network/Tiered Network Products

Ms. Pellegrini indicated that state law requires almost every carrier to offer either a tiered or limitednetwork product that costs 14% less than a full network product. Ms. Peters suggested that the drafters required the 14% differential to incentivize employers/consumers to buy those plans and asked what could be done to incentivize employers to buy these products. Mr. Hurst noted that the cost differential should be at least 25% to get employers to buy these plans.

Ms. Pellegrini indicated there continues to be problems with developing these products because of statutory provisions that allow providers a 60-day right to opt-out of a product. This prevents the development of meaningful tiered products with greater premium differentials or cost-sharing differential between tiers. Mr. Gaunya said that what is most important to employers/consumers is: 1) whether their doctor is in the network and 2) whether their hospital is in the network. Mr. Hurst noted that no employer is going to make their employee go to a plan where the employee's doctor is not part of the network. He felt limited network products should be an option but not a mandate.

Ms. Lopes noted that tiered products have picked up speed with her clients because business owners don't want to lose choice. Ms. Vertes stated that tiered networks have potential to addresssome of the cost concerns, but the current design of tiered networks don't provide enough financialdifferentiation for consumers to choose between providers in one tier versus another.Ms. Rosenthal noted that her organization receives thousands of calls about tiered networkproducts because they are confusing, and it is challenging to educate the public about them.

Ms. Vertes stated that there should be more reference-based pricing where the consumer pays a provider's cost beyond what is a reasonable amount. If the agreed amount is $1,000 and the provider charges up to that rate, the plan pays the whole amount; however, if the provider charges more, then the consumer is responsible for the rest.

Mr. Caljouw stated that the current statute allows for smart tiering/smart network and that there was room for more of these products to be developed to address cost and choice.

Regional Network Products

Mr. Beagan indicated that certain members suggested a need for regional network options to encourage members to seek care locally. Ms. Begrowicz reminded the Council that her area couldbenefit from such plans and tiered networks aren't available in Western MA. Mr. Caljouw said carriers have had difficulty developing such plans based on negotiations with providers. Ms. Pellegrini thought carriers would address this as their systems allowed.

Conclusion:

Mr. Beagan noted that in the next meeting, the Council would discuss alternate options like PEOs. He also identified that the November meetings would be on November 4 and 17.

Commissioner Anderson thanked the Council Members and the presenters for their participation, and reiterated that it is very important that every member of the Council is heard and that the Council can work toward a consensus. He stated that the next meeting of the Council will be on Wednesday, October 7, 2020 at 2 P.M. and that the meeting would be held virtually using the sameTeams platform. Chairman Anderson called for a motion to adjourn. Mr. Gaunya made the motion,and it was seconded by Mr. Hurst. 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 definitionof a "public body" as defined under c. 30A, § 18.

List of Documents provided at the Council meeting:

1. **Draft minutes of the September 10, 2020 Council meeting that were approved at theSeptember 23, 2020 meeting.**
2. **Aggregate HMO membership in Massachusetts health plans as of August 30, 2020.**
3. **Merged Market Products Presentation.**
4. **Proposed workflow of meeting.**

Minutes of the Merged Market Advisory Council (Council or MMAC) Meeting of October 7, 2020Approved by Council at the Meeting Held on October 23, 2020. Motion of Council Member Jon Hurst 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, Executive 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 2:01 PM.
Ms. Horigan called a roll of the Council Members and reported a quorum was present.

Minutes
Chairman Anderson asked the group to review the minutes from the September 23, 2020 meeting, which had been shared in advance of the meeting, and vote on approval. Mr. Caljouw made a motion to accept the minutes as drafted and Mr. Gaunya seconded the motion. The minutes were unanimously approved, with Mr. Gutierrez abstaining.

Discussion of Non-merged Market Products
Chairman Anderson asked that the group consider using a proposed framework for policy evaluation. He suggested that when discussing the options that MMAC members consider both short-term and long-term impacts, that deliberations be based on data-driven and actuarial analyses where possible, and that recommendations be considered that will improve the vibrancy/stability of the market. He also suggested that MMAC members consider how options might

increase/decrease costs for small business, costs for individuals, stability in the market, access to coverage and consumer protections for merged market participants and state budgets or federal subsidies.

Commissioner then asked Mr. Beagan to lead a scheduled discussion of non-merged market products. Mr. Beagan reminded Council members that the Governor's Executive Order creating the Council required that the Council look at all facets of the merged market, including emerging coverage options which could impact how individuals and employers choose health plans.

Sharing Ministries

Mr. Gutierrez noted that the Connector understands the role sharing ministries were intended to have, however, entities are now heavily marketing plans that are not what they seem. Mr. Gutierrez noted that this has led to member confusion and demonstrated shortfalls. The Connector has taken steps in the past to help address sharing ministries. Ms. Rosenthal agreed that consumers are significantly confused about this option when they buy it. Ms. Pellegrini agreed with the Connector that there need to be appropriate consumer protections.

Mr. Archambault noted that that the Connector's regulation seems to address the needed marketing concerns and is hesitant to add more restrictions to what can be offered and seek a solution where a problem does not exist. Mr. Beagan said that the Division of Insurance has no plans to make sharing ministries look like traditional insurance products.

Mr. Hurst understood that the Governor's Order did identify that the MMAC should talk about options such as ministries but thought that this should not be the focus of the Council since rates are going up and small employers need options. Between the costs of UI and PFML, the Council should be looking at how to offer relief in health insurance costs.

[Microsoft Teams experienced a failure at this time and the meeting disconnected. All Council members signed back into the meeting and Commissioner Anderson confirmed all were present.]

Mr. Gaunya noted that he supports truth in advertising as well as creating flexibility in the marketplace. Ms. Lopes suggested that sharing ministries should provide more disclosure about who they are and what they are offering. Chairman Anderson noted that the Division of Insurance regulates insurance and even suggested that there be thought about the appropriate agency or agencies that should regulate these entities.

Professional Employer Organizations

Mr. Gaunya noted that PEOs provide more access to product choice and only Maryland requires PEOs be a part of small group insurance offerings. Still, he noted with PEO co-employment, the PEO serves as a co-fiduciary with the employer and collectively they (employer/PEO) are a large group. He also added, if small groups are able to offer high quality, affordable health insurance coverage for their employees, they will remain in the merged market instead of evaluating alternate solutions.

Mr. Beagan noted that PEOs are a small piece of the market and asked Council members for their thoughts on whether PEOs should be registered, or meet certain standards. Mr. Caljouw said that that it may be appropriate for PEOs to align with state rules. Mr. Gaunya said PEOs already follow ACA regulations for ALE's (Applicable Large Employers). Ms. Rosenthal was interested in keeping the market as stable as possible and that PEOs could splinter groups away from the merged market.

Mr. Archambault said some thought should be given to where the PEO is located and that MA should avoid driving small employers who don't want additional regulations elsewhere. Mr. Hurst said guardrails are fine but agreed that MA should be taking steps to fix its small group market so that small group health coverage stays in Massachusetts rather than join a PEO with coverage issued outside Massachusetts where the PEO is located.

Self-funded Plans with Stop Loss Coverage

Mr. Gaunya noted that small employers have additional control, flexibility and choice with this healthcare financing arrangement, where the coverage is partially self-funded. He noted several advantages including reducing health insurance premium taxes and administrative costs by choosing to partially self-fund and buying stop loss coverage to limit their financial exposure. He noted that employers who have the appropriate level of risk tolerance and suitability to take that risk choose this financing arrangement to give them greater flexibility and choice in access, plan design and actionable insight into their financial performance.

Mr. Caljouw disagreed and said that these products could adversely impact the market and it may be appropriate to consider regulatory guardrails to protect small businesses. Ms. Pellegrini noted that MAHP is neutral on this topic. Mr. Hurst suggested that Maine established guardrails and they have not appeared to be a barrier in that market.

Mr. Beagan asked if any oversight is needed or if stop loss only be available to groups of a certain size. Mr. Gaunya noted that he generally doesn't agree with restricting access to these solutions but did agree that not all small employers are suitable for this financing option. He thought that there needed to be better access to information so that employers understand the risk of self-funding and perhaps more knowledge oversight of brokers and consultants who advise small group clients to self-fund with better trained insurance professionals who are qualified to advise small groups who are considering a shift to a self-funded financing arrangement. Mr. Archambault agreed that there be better claims and price transparency for employers so that they are able to make better choices.

Association Health Plans/ Multiple Employer Welfare Arrangements

Mr. Beagan noted that our merged market law does not permit association health plans. Ms. Rosenthal said other states have had issues with AHPs but MA hasn't seen those issues because of our regulations do not permit AHPs.

Mr. Hurst stated that AHPs are a great model for like-minded small employers who are trying to control their costs and found that the group purchasing cooperative model worked until impacted by the ACA. Ms. Pellegrini said AHP supports protections that subject AHPs to group rules.

Mr. Caljouw noted from a Bela Gorman presentation that AHPs would have a material impact on the remainder of the market and stressed the need to consider costs and stability. Mr. Archambault felt that anti-discrimination rules in other states tend to allow both "good" and "bad" risk to move into AHPs so that they should not have a material impact on the market.

Mr. Gaunya stated the costs depend on the makeup of the risk pool and because of their broader appeal, AHP's could splinter the risk pool in the Merged Market and impact its stability. Mr. Caljouw doesn't see why state's regulatory treatment of AHPs is different than it was for group purchasing cooperatives and that merged market rules apply fairly across the market.

Ms. Begrowicz noted that as a small business owner she likes to have options and would not support taking away options.

Individual Health Coverage Reimbursements
Mr. Beagan asked about this as an option for flexibility and choice.

Mr. Archambault noted that federal HRA changes could put more healthy lives into the market and have a potentially positive impact on the individual market.

Conclusion:
Mr. Beagan noted that in the next meeting, the Council would discuss reinsurance and riskadjustment. He also noted that he would be sharing a draft report with members this month.

Mr. Caljouw thanked Mr. Beagan for providing summary documents in advance and suggested similar documents would be helpful for the topics planned for upcoming meetings.

Ms. Vertes asked if the general topic of additional products and tools to help address cost issues would be addressed at future meetings, and noted the importance of product flexibility in addition to managing the risk pool.

Commissioner Anderson thanked the Council Members for their participation. He stated that the next meeting of the Council will be on Friday, October 23, 2020 at 12:30 P.M. and that the meeting would be held virtually using the same Teams platform. Chairman Anderson called for a motion to adjourn. Mr. Gaunya made the motion, and it was seconded by Mr. Hurst. 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 September 23, 2020 Council meeting.**
2. **Proposed workflow of meeting.**
3. **Proposed workflow of future meetings**
4. **Summary documents of products discussed**

Minutes of the Merged Market Advisory Council (Council or MMAC) Meeting of November 17, 2020 Approved by Council at the Meeting Held on January 26, 2021.

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, Executive 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 3:32 PM.
Ms. Horigan called a roll of the Council Members and reported a quorum was present.

October 2020 Membership
Mr. Beagan noted that there were further reductions in membership in the individual and commercial markets (2,500 lives), and an increase in persons covered through government accounts (4,400 lives) in October. Overall, when comparing October with April 2014, there were over 23,000 fewer persons reported as covered but these may not be indicative of Massachusetts membership since the DOI numbers include persons living in other states who are covered in Massachusetts-issued groups.

Mr. Gaunya stated that the large groups are being impacted by the exhaustion of federal assistance, and employers are preparing for another economics slowdown as Massachusetts is seeing an

increase in cases. Ms. Rosenthal noted that more individuals, such as hotel employees, are getting laid off now and that there continue to be people in need of assistance. Undersecretary Peters asked Ms. Rosenthal if there has been an uptick in calls to her organization. Ms. Rosenthal noted that it comes in peaks and waves and generally the calls are from long-term insured individuals; individuals who recently lost coverage and don't know how to obtain coverage; and immigrant populations who were disenrolled. Mr. Beagan indicated that the DOI would continue to collect and report this information publicly to highlight sudden changes in membership.

Minutes
Chairman Anderson asked the group to review the minutes from the November 4, 2020 meeting. Ms. Vertes and Ms. Pellegrini offered edits to the minutes as drafted. Mr. Gaunya made a motion to accept the minutes as amended and Mr. Caljouw seconded the motion. The minutes, as amended were unanimously approved.

Presentation by Gorman Actuarial
Ms. Gorman explained that today's presentation is intended to further the previous session's discussion about federal section 1332 waivers and state reinsurance programs. Ms. Gorman described the federal section 1332 waiver process, how the federal government would assess federal section 1332 funds based on savings achieved by reducing federal subsidization of ConnectorCare costs. Ms. Gorman highlighted that Massachusetts' potential funds would be limited because federal savings would be low compared to those in other states due to the formula used. (The savings are based on the second lowest cost silver plan which is a limited network low-premium product in Massachusetts.)

Mr. Caljouw asked if Ms. Gorman's description of the federal savings calculation could change under a new Administration and could it be possible that savings could also be tied to other federal savings, including, for example, savings to Medicaid. Ms. Gorman said that the federal analysis was always based on the savings to tax credits, but that there might be room to explore this further in the near future. Ms. Peters said she would need to check with CMS.

Mr. Hurst asked whether demerging the market by itself could be used to justify the 1332 waiver, as it would save the federal government a lot of money. Ms. Gorman noted that there would need to see substantial proof that with a demerger people would migrate from the individual market to the small group, thereby saving the federals government money on tax credits, and there was no current data to show that would happen.

Ms. Gorman presented an analysis that showed that a demerger might result in a limited reduction in small group costs and there may need to be federal 1332 funds and funds from a state reinsurance mechanism to reduce the impact on individuals. She further presented an analysis that the same federal/state funds available in a merged market would bring down both individual and small employer premiums by approximately 2%, but that she thought that there would be more federal money available if the markets remained merged. While Ms. Gorman estimated that $94 million of federal/state money could reduce average premium by plan, it would vary by company

depending on how the reinsurance program is designed. Ms. Pellegrini stated that this seems like a lot of work for not a lot of relief.

Ms. Gorman said there are many ways to develop a reinsurance program and it could be designed to target the highest cost individuals; maximize federal funding; or put downward pressure on reimbursement), but cautioned policy goals cannot be met within one reinsurance program.

Mr. Beagan noted that what could be a good design for reinsurance today could need to change in the future. Ms. Gorman agreed, explaining that many states have taken advantage of the 1332 waiver and established a reinsurance program in their individual market. She noted that generally oversight is done by a separate board or commission, or within exchange or within the DOI, but that each year data is reviewed and reevaluated so the program can change.

Ms. Rosenthal and Ms. Vertes questioned whether individuals are high cost because they are sick and need care or because they go to high cost facilities. Mr. Caljouw stated that it is a little of both. Ms. Vertes indicated that reinsurance is not efficient when it rewards plans just because members get care from high-cost providers.

Ms. Rosenthal asked if plan design matters. Mr. Caljouw stated that a system could be created where attachment points could sift out people based on where they choose to get care. Commissioner Anderson thought that the group was suggesting that reinsurance be considered to spend based on people who are much sicker than normal rather than based on where people get care Ms. Vertes said that anything that parcels out the incremental costs associated with the same care being done at a higher cost provider would be good.

Ms. Pellegrini asked how this jives with risk adjustment and she doesn't see how this relieves small business. It brings a tiny amount of relief to individuals and a ton of administrative costs for plans. Ms. Gorman said putting a reinsurance program on top of the merged market would give small premium relief to the entire merged market. In terms of overlap between risk adjustment and reinsurance, risk adjustment redistributes dollars within each market, so there is no new money coming in to lower overall rates, whereas reinsurance is taking money from somewhere else and putting it into the market to lower rates. All states with the 1332 waiver have reinsurance program and risk adjustment working side by side.

Ms. Pellegrini said it seems like a lot of work and could be problematic among plans. Mr. noted he can understand Ms. Pellegrini's concerns but if we're able to infuse new money in without affecting the market, it would be new money that lowers premiums for everyone. Mr. Gaunya said he appreciates Ms. Pellegrini's perspective that the 2% isn't significant, but he would suggest that every dollar in efficiency is good. If we more efficiently manage risk, everyone wins. Ms. Rosenthal agreed.

Mr. Caljouw noted that the Council could present a set of principles to align around a reinsurance program, i.e. no state based assessments; rely on 1332 waiver that stayed away from premium tax

credits. He said if we're talking about free money that doesn't have a negative net impact, 2% premium relief is meaningful.

Mr. Hurst asked if there was a way to carve out the small group to help hold small group employers harmless on a reinsurance assessment. Ms. Vertes agreed that small employers have born the burden of that market for years and the goal should be to spread that burden across a broader base.

Ms. Vertes also indicated said she wants to make sure the Council's report has a section that acknowledges broader discussion and actions are needed on how to reduce costs of healthcare to all purchasers, not just small employers. Mr. Gaunya said this is why he previously noted Massachusetts' price transparency law and it should be promoted more to let consumers know they have a right to see price information. If we want to get at the cost of health insurance, we need to look at the cost of health care, half of the 7-8%trend is the price of care. He agreed that savings from a reinsurance program are only 2%, and while any saving is good, we need people more engaged in the quality and price of the healthcare they are receiving to have a more competitive marketplace.

Ms. Rosenthal agreed that the Council needs to think about affordability overall and while the numbers don't sound big, the presentation (by Ms. Gorman) shows a return that the Council should give consideration. Ms. Hudson agreed noting that small businesses need relief. She supported previous comments about the costs of healthcare.

Mr. Beagan noted that the Council has been looking for the ways to make the in the merged market more efficient but also agreed that the MMAC we should think about bringing down the curve for whole market, not just merged market. Mr. Gutierrez agreed that 2% savings is good and agreed the annual medical trend is impacted everyone.

Conclusion

Commissioner Anderson thanked the Council Members for their participation and engagement. He also thanked Bela Gorman for all her work on today's presentation. He again noted that the Governor's Order gave the Council certain directives, and while is the Council is tasked with performing an independent analysis of the merged market, part of that includes looking at drivers of health care costs which is not isolated to the merged market.

The Commissioner noted that the pandemic impacted the timeline of the Council but that he does not want the Council to feel pressured to hustle to get a report to the Governor and leave concerns unaddressed. He said if a second meeting in December is needed, the Council could meet twice so that everyone's comments are heard.

Mr. Beagan noted that the next meeting of the Council will be virtually held on the same Teams platform at some point in December, potentially December 2, and that he would be able to confirm the date shortly after speaking with a few Council members. Chairman Anderson called for a motion to adjourn. Mr. Hurst made the motion, and it was seconded by Mr. Gaunya. The motion passed by a unanimous vote of the Council Members, with Chairman Anderson abstaining.

Whereupon, the Council's business was concluded at 5:07 P.M. These minutes are exempt from 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 November 4, 2020 Council meeting.**
2. **Proposed workflow of meeting.**
3. **Gorman Actuarial Presentation on Reinsurance Programs and Funding**
4. **October 2020 Membership**

Minutes of the Merged Market Advisory Council (Council or MMAC) Meeting of December 2,2020 Approved by Council at the Meeting Held on February 26, 2021.

Motion of Council Member Rina Vertes and Seconded by Council Member Michael Caljouw. The Motion Passed by a Unanimous Vote of 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, Executive Director, Massachusetts Health Connector
Lauren Peters, designee of Marylou Sudders, Secretary of Health and Human ServicesMichael 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 2:01 PM.
Ms. Horigan called a roll of the Council Members and reported a quorum was present.

Minutes
Chairman Anderson noted that the draft meeting minutes from the November 17, 2020 meeting were still being finalized as the Division wanted to ensure everyone's comments were captured, and would be distributed to the Council for review upon competition. No vote on minutes occurred.

Commissioner Anderson noted that he intends to hold another meeting in January to enable the Division to consider the observations, suggestions, and recommendations offered by the Council and to prepare a final report to be discussed at that time.

Discussion by Council Members of Healthcare Cost Drivers

Mr. Beagan noted that the Council had discussed products offered in the market, the composition of the market, different product designs, different levels of subsidizations in the market and the issue of reinsurance and federal waivers, but he understood from the last meeting that MMAC members felt it was important to have a discussion about the factors driving health care costs and premiums. He showed a few slides to help the Council understand healthcare cost trends.

Mr. Beagan explained that the statutory Medical Loss Ratio for the merged market is 88%. He presented information from an HPC report that illustrated a breakdown of how different costs went up in the market from 2015 -2017. He noted that there are different reasons that costs are going up, including the introduction of new technology and new services, as well as increased utilization of services in high cost facilities. Mr. Beagan thought it would be useful to point these cost pressures out at outset of the meeting so that Council members would have an opportunity to come up with ideas about changing cost pressures.

Ms. Vertes thanked Mr. Beagan for enabling the Council to have this discussion. She agreed that focusing on the fact that 90% of premium is tied to medical cost is vital. She also noted that holding all stakeholders accountable is necessary, including consumers who choose to obtain care from high cost providers when they do not need to. Ms. Vertes suggested that careful thought should be given to reference based pricing models where consumers who choose to go to high-cost providers pay the difference between the provider's cost and the reference price. It is necessary to have products that allow consumers to understand the costs of care. Deductibles have not beeneffective, because when the deductible is met, the consumer does not have any incentive to understand the cost of choosing high-cost providers.

Mr. Gaunya brought up medical trend having three components: unit cost, utilization, and provider mix. Mr. Gaunya noted that 50% of the increasing costs can be tied to increases in the actual price of care people are receiving (trend), 35% can be tied to increases in overall utilization and 15% can be tied to patients going to higher cost facilities. Mr. Gaunya stressed that members have a right to know the price they are charged for the service that they get. Mr. Gaunya that there should be more time and energy used to increase awareness of the transparency law so that consumers know that they have a right to price and quality information. Last, he further recommended that there needs to be increased investment in primary care, telehealth and behavioral health services.

Mr. Caljouw noted that efforts to increase provider price transparency that are unrelated to product design and costs have failed and are likely to continue to fail. Mr. Caljouw noted that consumers need to know and also care about the price of health care services they choose (non-emergency services). He pointed out that there was a mandate in Chapter 224 that providers must provide price information to consumers but very few obtain or use this information. He thought the group should look at product design changes and creating product differentials based upon provider price, an idea that the Provider Price Commission studied and endorsed a few years ago. Finally he noted the Council should examine existing regulatory levers, including at the HPC, and how they should change so that agencies would be able to collect, analyze and report on hospital-based total medical expense (TME) information. Such information is released on health plans and medical groups, but not on hospitals or hospital systems. He said that BCBSMA is concerned that hospitals have

already started to seek to increase reimbursement (sometimes by double digits) for the near future and that will have direct impacts on consumer premiums. He noted that 90% of premiums is comprised of medical expenses and therefore any approach should focus on the 90%.

Mr. Hurst agreed with the previous comments. While transparency is important, it is not the only answer. The design of health plans should encourage individuals to use the transparency information. If someone with a high deductible health plan needs surgery and can choose to go to a high-cost or low-cost hospital, they are not impacted by the relative cost of the two hospitals if the cost is above the plan deductible. Once the deductible is satisfied, the cost does not matter to the consumer. Mr. Hurst thought that maybe reimbursements should be tied to a certain percentage of Medicare for certain parts of a risk pool.

Mr. Archambault agreed transparency is not a silver bullet but thought more should be done so that patients would learn more about pricing, including automatic disclosures from providers about estimated costs. He suggested that carriers do more to educate their patients, including encouraging they to shop around and save money. He agreed with the concept of referenced basedpricing and noted that it occurs more often in the public sector than in the private sector. He hopedthe report highlights the barriers to lower cost options (scope of practice reform, determination ofneed). Certificate of need does not lower prices. Telehealth should be allowed across state lines asit increases access and hopes the Legislature does not mandate payment parity with telehealth.

Undersecretary Peters didn't disagree with any of the stated comments but thought that this group was created to discuss issues unique to merged market, and urged that the final report highlight recommendations to address the dynamics in the merged market. One such dynamic as an example is around ConnectorCare that the premiums are lower and it's not because they're getting that cross subsidization from the small group but rather they are in narrower, limited tiered networks with providers that have lower costs. Ms. Peters thought the group should consider product designs that help consumers make wiser choices.

Ms. Pellegrini said it is hard to disentangle the cost of care from premium. Transparency is a piece of the puzzle and we need to encourage people to shop for providers but systems are also built to keep people within that system of care. She noted it will be hard to address a lot of what the Council is discussing during COVID and the stressors placed on our frontline providers. If we could reign in surprise billing that would help consumers save money. There are policy initiatives the Council can focus on in the report.

Ms. Vertes suggested the group think about the most popular ConnectorCare plans where the cost and premium are substantially cheaper than costs and premiums for other statewide network plans. She thought that the Council should recommend further education to promote that these are not inferior products and provide access to good health care. She also supports greater investment in primary care and less reliance on specialty care.

Ms. Rosenthal noted that the driving costs of healthcare have not been the topic of conversation for the majority of meetings. She supports looking at the Division's rate review process to get at the affordability of insured health products. While she supports transparency, she cautioned that

consumers don't necessarily understand how to shop around and she thought that Mr. Gaunya was correct about the need to have better tools to explain the relative costs of care.

Ms. Hudson brought up the pending Harvard/Tufts merger and asked about its potential impact to the market/consumers. Ms. Rosenthal indicated that she hoped that the merger would not cause any disruption and would be beneficial to consumers. Mr. Gaunya noted that he heard that the merger would produce a $100 million in administrative savings. Mr. Beagan asked Commissioner Anderson if he wanted to comment on the transaction and Commissioner Anderson noted that it would not be prudent to comment on the proposed transaction as it was still pending but noted that the hearing on the transaction is scheduled for December 3.

Commissioner Anderson said good points have been made and explained that building a base to understand what is going on in the market was essential and Ms. Gorman's presentations helped to look at this from an actuarial analysis.

Mr. Beagan noted that certain products offered through ConnectorCare do cost considerably less than other available products and that there could be more attention made to educate individuals and small groups that these are not inferior products is key. He recalled a "peace of mind" product offered by Fallon which offered a Worcester-centric network but offered access to Boston teaching hospitals when medically necessary. Individuals and small employers might be amenable to these products if they knew they could go to certain hospitals when needed.

Mr. Gaunya reinforced the notion of healthcare literacy and that people need to understand how their healthcare works and to debunk myths that what costs more is better care. Transparency might not be a magic elixir, but it is still important.

Ms. Lopes echoed Mr. Gaunya's thoughts about health literacy. She thought there needed to be much more work done by government and producers to convince people that providers who cost less do not provide inferior care. She and Mr. Gaunya said that government and producers need to help employers maximize their benefits, but it is difficult to convince them about this item.

Undersecretary Peters said we need to pair education with some sort of product redesign so that those wishing to see a high-cost provider will pay more to do so. Mr. Caljouw said there need to be incentives for consumers to shop wisely and referenced a GIC campaign that suspended premiums for 3 months if a consumer purchased a lower-cost tiered network product. Ms. Pellegrini cautioned about this idea because too many people signed up for these plans and reversed course because they did not understand what they were buying.

Mr. Hurst said in the early years of RAM's cooperative, the most popular plan was the Fallon Steward Network plan and it was so popular because the cooperative was involved in designing the product and it wasn't forced on employers. It is better to have a system where individuals and small employers can choose a plan that works for them. Ms. Rosenthal said that designing products with "skin in the game" only works for people who can afford the "skin" and cautioned the group to think about economic disparities. She noted that the MMAC should also remember to consider health equity as it thinks about recommendations, so they are win-win solutions.

Mr. Gutierrez said a tiered product is the best of both worlds. The overall theme of tying product design, "skin in the game" and consumer education –we have the mechanisms for all of this. Ms. Vertes said tiered network products with a 10% price differential are not enough for consumers to feel they are getting any value for giving something up and there need to be more aggressive designs. Ms. Pellegrini pointed out that there needs to be changes to existing law so that carriers have more latitude in designing products because existing law allows providers to "opt out" or products if they do not like product designs; this has made it extremely difficult to design more affordable options. Undersecretary Peters noted that there was language proposed bythe Governor is his pending bill that was intended to address this.

Conclusion

Commissioner Anderson thanked the Council Members for their participation and engagement. He again noted that the Governor's Order gave the Council certain directives, and while the Council is tasked with performing an independent analysis of the merged market, part of that includes looking at drivers of health care costs which is not isolated to the merged market. The Commissioner noted that the Council has been given the opportunity to analyze at the merged market and that the Council should take advantage of that and suggest meaningful options for the Governor to consider. Commissioner Anderson talked about developing pilot products where appropriate and even a legislative initiative to create a pilot program changing how a subset of small groups are rated (i.e., removing a small subset of the merged market and rating the subset outside merged market rules to see if the group receives more favorable rates outside these rules.)

Mr. Beagan noted that the next meeting of the Council will be virtually held on the same Teams platform at some point in January and that a doodle poll would be sent around to confirm member's availability. Chairman Anderson called for a motion to adjourn. Mr. Hurst made the motion, andit was seconded by Mr. Gaunya. The motion passed by a unanimous vote of the Council Members, with Chairman Anderson abstaining.

Whereupon, the Council's business was concluded at 3:31 P.M.

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. **Proposed workflow of meeting.**
2. **November 2020 membership numbers**

Minutes of the Merged Market Advisory Council (Council or MMAC) Meeting of January 26, 2021Approved by Council at the Meeting Held on March 16, 2021.

Motion of Council Member Mark Gaunya and Seconded by Council Member Lora Pellegrini. The Motion Passed by a (Unanimous) Vote of 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, Executive 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
Audrey Gasteier, Chief of Policy and Strategy for the Health Connector
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 2:01 PM.
Ms. Horigan called a roll of the Council Members and reported a quorum was present.

Minutes
Chairman Anderson asked for approval of the November 17, 2020 meeting minutes. A motion was made, seconded and the minutes were approved without discussion. Chairman Anderson announced that the December 2, 2020 minutes would be redistributed to the group so that members can review and propose edits and that the Council would plan to vote on those minutes at the next Council meeting.

December 2020 Membership
Mr. Beagan noted that comparing December 2020 to November 2020, there were 6,509 fewer individual members and a decline of 9,977 in ASO business that was offset by an increase of 1,680

in small group, 4,649 in large group and 6,030 in government membership. In total, the carriers reported 4,127 fewer covered under all their accounts at the end of December 2020.

In comparing commercial to governmental programs, commercial coverage – including ASO – decreased by 112,881 between April and November, but governmental programs have increased by 86,756 to fill in much of the gap.

Ms. Rosenthal asked to go on the record again in support of the importance of the Commonwealth's MassHealth program.

2nd Quarter Merged Market Rates

Mr. Beagan noted that the Division of Insurance is currently reviewing rate filings for 2Q (rates for health plans renewing April 1-June 30). Mr. Beagan informed the members that one carrier has filed for a double-digit rate increase and that the DOI will be holding a rate hearing on February 4, beginning at 11:00 in order for the company to respond to the reasons for the Division's disapproval.

Presentation on Key Findings and Consensus Themes

Chairman Anderson explained that the goal of today's meeting is to take what the Council has studied over the last year and to go over the base set of findings in relation to the Governor's Executive Order (EO). The Commissioner noted the ultimate report should note that certain members have raised issues that may outside of the scope of the EO but that they are likewise worth considering by policymakers. He also noted that Council members have begun submitting comments regarding what should be in the final report and those will be circulated amongst the group for discussion at the next meeting. He then asked Mr. Beagan and Ms. Gasteier to go over the presentation.

Mr. Beagan indicated that the presentation was to remind members of the key take-aways of the analysis performed by Gorman Actuarial. The market has changed a great deal since the 2007 merger of the individual and small business markets. The number of individuals in the merged market has grown especially with the federal ACA implementation as the subsidized CommonwealthCare program was brought into the merged market where it became the ConnectorCare program.

Ms. Gasteier described Gorman Actuarial analysis that the merged market is actuarially composed of 3 submarket segments: small employers; the individuals enrolled through ConnectorCare; and non-ConnectorCare individuals. Gorman indicated that small employer members and ConnectorCare have similar health risk scores and non-ConnectorCare individuals have much higher risk scores. Since rates are based on the pooled experience of all merged market members, this means that small employers and ConnectorCare individuals cross-subsidize the cost of non-ConnectorCare individuals' health premiums.

Mr. Beagan next discussed that lower-cost limited/tiered network products – that can be 50% less expensive than broad network products - are available to all merged market members. While the

vast majority of ConnectorCare members are enrolled in the lower cost products, most non-Connector individuals and small employers remain in higher-premium, broad network products. If small employers and non-ConnectorCare individuals were more aware of these options, there is much room for cost savings.
Ms. Gasteier discussed Gorman's analysis of de-merging the individual and small groups into separate risk pools. Gorman estimated that this would result in a one-time 4-6% increase in average individual premiums and a one-time 2-4% decrease in average small employer premiums, separate and apart from annual medical/prescription cost trend increases. Mr. Gaunya pointed out that while a demerger is being presented as a one-time savings opportunity, he suggested that it would have a compounding effect on future premiums for small employers.

Ms. Gasteier also noted that a Section 1332 waiver would not be a viable solution for Massachusetts because 1332 reinsurance waiver funding is derived from reductions in federal premium tax credits. Due to low-cost products in ConnectorCare, Massachusetts draws down low levels of federal premium tax credits (in 2020, MA was 3rd lowest state in terms of bench mark plan which is how APTC gets calculated). Gorman had pointed out that due to the nature of the Massachusetts merged market membership, there would be less federal money available from Section 1332 waivers if the market demerged than if it stayed merged.

Mr. Gaunya asked whether Massachusetts APTC funding created a situation where Massachusetts could not take advantage fully of federal funds. Ms. Gasteier said yes, there is not much lower we can go. Ms. Rosenthal noted that the Biden Administration could revisit this issue more broadlyand it is important to keep an eye on that. Ms. Gasteier did note that there continue to be changesat the federal level and the Connector will keep monitoring the evolving nature of federal Section1332 waivers.

Mr. Hurst asked why the presentation did not discuss seeking the continuation of Massachusetts' specific rating factors which were part of the original merger to mitigate the impact on small businesses. Mr. Gutierrez indicated that rating factors are not "1332-able" and that the Connector was told by CMS not to request another continuation of transitional rating factors.

Mr. Beagan discussed how risk adjustment impacts Massachusetts carriers and how it was intended under the ACA to be a level setter across the carriers, but has in fact caused rate volatility as carriers try to develop premium rates that consider future risk adjustment payments. In Massachusetts, ConnectorCare plans have attracted those with lower health risk scores and pay monies to those carriers who cover small employers and non-ConnectorCare individuals with higher risk scores.

Mr. Beagan discussed alternative programs, including PEOs, stop loss products and sharing ministries, which are being marketed to individuals and small groups. At this time, these alternative programs do not seem to have had an impact on coverage due to the robust offering of merged market products. However, additional new rules may be needed for marketing and disclosures so consumers know how these products differ from fully insured products. Mr. Caljouw noted that these programs should be subject to reporting requirements and the state should

take some role in producing information for consumers to fully understand the features of the products.

Next, Gorman had presented information about how a state-funded reinsurance program could impact the market. She indicated that such a reinsurance program would require significant funding from state tax revenue or assessing non-merged market plans. She estimated that for every1% reduction in annual premiums a state-based reinsurance program would need $47M in annual funding.

Ms. Gasteier next talked about underlying healthcare cost drivers and wanted to note the Council's ongoing interest 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. Mr. Caljouw stated that cost containment strategies by all interested parties is a very important recommendation coming out the Commission and it would be a missed opportunity if the Commission does not include that it in its final report. Ms. Vertes stated that she would like this to be the first slide of the presentation and that all of the other recommendations are fixes for the market in the immediate term.

Ms. Rosenthal appreciated hearing this conversation and that getting at underlying costs is a long-standing issue.

Mr. Beagan said we need to develop strategies moving forward to address the observations made thus far. He noted that Mr. Archambault and Mr. Gaunya have shared ideas and the Division is looking for consensus on all proposed strategies. Mr. Archambault discussed some of the proposals he and Mr. Gaunya developed, with input from other council members, and the ideas are lumped into 4 buckets: level playing field; reduce costs; achieve cost reductions building on Ch. 224; and plan design changes. Mr. Caljouw noted the need for granularity about specific tools to make changes. Undersecretary Peters stressed the importance of anchoring observations in facts and agreed with Mr. Caljouw that granularity and level of detail is needed.

Mr. Hurst noted that Governor Baker, prior to being the Governor, was a strong opponent of merging the market, and the impact of the ACA on the marketplace has been dramatic on small businesses and the Council needs to look at options — if some Council members think demerging is an option, it should be said and voted on, and have fallbacks if those ideas don't have consensus. We need to do something that is right for small businesses and viable public policy. Ms. Rosenthal raised concerns about demerging the market and noted that the EO asked for recommendations that ensure the long-term stability of coverage for individuals and small employers in the merged market. She said we should continue to explore a reinsurance program for the entire merged market and collect income data for non-Connector individual market. Ms. Pellegrini said for the record the MAHP plans are strongly opposed to a reinsurance program for the merged market if itincludes an assessment on other lines of insurance business. The MAHP plans do not think now isthe time to put assessments on any line of business. MAHP plans remain concerned about risk adjustment and adding to what is already a flawed mechanism.

Conclusion

Mr. Beagan said all ideas will be shared with the group and asked that members share ideas by the following Friday. Commissioner Anderson noted that no one expects the Council will agree on all ideas but that the Council can make solid, fact-based recommendations to the Governor.

Mr. Beagan noted that the next meeting of the Council will be virtually held on the same Teams platform the week of February 22 based on Council member's availability. Chairman Anderson called for a motion to adjourn. Mr. Gaunya made the motion, and it was seconded by Mr. Hurst. The motion passed by a unanimous vote of the Council Members, with Chairman Anderson abstaining.

Whereupon, the Council's business was concluded at 3:22 P.M. These minutes are exempt from 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 November 17, 2020 and December 2, 2020 Council meetings.**
2. **Division of Insurance/Massachusetts Health Connector Presentation on Key Findingsand Consensus Themes.**
3. **December 2020 Membership.**

Minutes of the Merged Market Advisory Council (Council or MMAC) Meeting of March 16, 2021 Approved by Council at the Meeting Held on January 18, 2022.

Motion of Council Member Mark Gaunya and Seconded by Council Member Lora Pellegrini. 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, Executive 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
Audrey Gasteier, Chief of Policy and Strategy for the Health Connector
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 2:02 PM.
Ms. Horigan called a roll of the Council Members and reported a quorum was present.

Commissioner Anderson thanked the group for making the time to meet. He noted that the Council has met a number of times and thanked members for their commitment to the Council, especially during the COVID-19 public health crisis. The Chair also thanked Bela Gorman and her team, and DOI and Connector staff for all of their hard work.

Minutes
Chairman Anderson asked for approval of the January 26, 2021 meeting minutes. A motion was made, seconded and the minutes were approved without discussion. Chairman Anderson announced that the February 26, 2021 minutes would be redistributed to the group so that members

can review and propose edits and that the Council would plan to vote on those minutes at the next Council meeting.

January 2021 Membership
Mr. Beagan next gave his regular update on HMO membership. He noted that there is a significant reduction in insured business and that the DOI had been checking the information to understand the reasons for the changes.

Overall, covered lives increased by 19,567, but there was shifting of membership. Large group membership declined by 7,836, but this is offset by a larger increase of 25,212 in ASO business. Mr. Beagan noted that this reflects that certain large employers switched from insured to ASO status on January 1. Merged market business decreased by almost 27,000.

These changes are partially due to a data error in one company's information reported since July 2020. If reported correctly, there would have been a gradual reduction in membership beginning in July. Government accounts also went up by almost 26,000 to absorb those members. Ms. Gasteier explained that people who normally shift between MassHealth and ConnectorCare coverage are staying in MassHealth due to COVID so during open enrollment flow into MassHealth was not offset by flow into ConnectorCare. Mr. Beagan noted than since the beginning of COVID 19, there are 45,000 fewer persons enrolled in the merged market; in the large group market there are about 68,000 fewer persons, while the government accounts have increased by 112,000 since April 2020.

Mr. Caljouw wanted to ensure that the report appropriately contextualized the data, and whether information from other economic periods would be incorporated to help the public understand when we may expect the market to settle. Mr. Beagan noted that this was not specifically addressed within the report but if information about how COVID-19 impacted the market, it would be wise to include that information. Mr. Gutierrez noted that the swing of covered lives in government accounts will flow back into the individual merged market. Mr. Hurst noted that it was interesting that the large group account decreased by as much as it did and whether rising costs of premium and PFML were factors. Mr. Gaunya said we are seeing more interest among middle market in exploring self-insured business as new technology allows for better risk assessment.

Chairman Anderson explained that DOI has been reporting the information in real-time to help the Council understand the market reactions to the pandemic but that this information would not be incorporated into the Council's report.

Finally, Mr. Beagan noted that DOI has been collecting information from carriers about utilization trends, not just membership, to see how utilization changed during COVID. He advised the Council that report would be available in about a month.

Discussion on Part A Report of the Merged Market Advisory Council
Chairman Anderson outlined the timeline relative to the Council's report.

- Council member comments on Part A document due March 23.

- DOI/Connector staff will review between March 23-31.
- Revised Part A document shared with Council on March 31, in addition to Part B.
- Council member "fatal flaw" comments on Part A due April 8, in addition to Council comments on Part B.
- DOI/Connector staff will review between April 8-20.
- Revised Part B document shared with Council April 20.
- Council member "fatal flaw" comments on Part B due April 28.
- DOI/Connector staff will review between April 28-May 6.
- Next MMAC meeting either May 6, 7, 10, 11 to review and adopt final report.

He then asked Mr. Beagan to go over Part A. Mr. Beagan read aloud the mandate of the Governor's Executive Order and noted that Part A summarizes the status of the merged market based on an independent market analysis, while Part B is intended to address recommendation for improved market functioning, including any policy and legislative changes that the Council recommends.

Mr. Beagan then went over various pages within the report, including slides on comparing the merged market in 2014 and 2019; comparisons of claims costs; the wide availability of products for purchase; and the general risk of the sub-populations within the merged market. Mr. Beagan noted that while members would be sending written comments, they could offer any first thoughts now.

Mr. Caljouw referred to the graphs about lower cost limited plans offered by THPP and BMC and noted that during discussion it was clear that small groups are not interested in buying those products and suggested additional context might be useful. Mr. Gaunya noted that there is no straight answer to why small groups don't buy lower cost limited plans but access to care and perception of these plans are factors. Mr. Caljouw also referred to (page 24) the sub-groups within the market. He pointed out that the language should be corrected to note that 100% don't receive state premium subsidies but that federal subsidies might exist.

Mr. Beagan then went over the key take-aways listed within the report and opened the floor to discussion of these items by the members. Ms. Vertes said it was important to add on page 4 that the market has cross subsidization in risk pools relating to use of providers who are paid more vs providers who are paid less. She noted on page 5, in relation to de-merging, the last sentence about "unintended consequences" is intended to scare people and doesn't belong in an executive summary. She also said that the idea of a one-time reduction is a permanent savings that goes into perpetuity and should be added for context for the average reader and the establishment of reinsurance talks about the cost to hold the entire merged market premium and the report should note what the cost would be to hold the individual market harmless (Bela noted that it is in the report and Mr. Beagan said it could be added to the executive summary).

Mr. Archambault wondered if underlying price should be its own takeaway. He also asked Ms. Gorman if demerging, waiting a year and then applying for a 1332 waiver, would the savings be

greater. Ms. Gorman said maybe, but it depends on what the federal government considers the baseline.

Mr. Hurst asked about rating factors and the history of the merged market and the impact on small employers. Mr. Beagan noted that the report does address those but can do so in greater detail (page 12-14).

Mr. Gaunya agreed that the 1x savings should note that it is "compounding." He also commented that the national health care literacy problem and 2012 transparency law should be incorporated into the executive summary. Finally, he noted that the report should include the difference between CPI vs medical inflation (trend).

Ms. Rosenthal agreed that the Council has spent a lot of time talking about underlying costs so adding that to key takeaways would be valuable, as well as adding information about pharmaceutical costs. She asked whether the report should note federal pass-through funding in the range of $10-24M because that it halfway to the $47M. Ms. Gorman reminded that $94M is needed to eliminate the impact of demerging and $47M for every 1% reduction, and that there is potential for pass-through funding under a merged market scenario, but that it would not be large.

Conclusion

Chairman Anderson thanked the members for their comments and reminded Council members to submit additional comments by March 23.

Mr. Beagan noted that the next meeting of the Council will be virtually held on the same Teams platform in May based on Council member's availability. Chairman Anderson called for a motion to adjourn. Mr. Caljouw made the motion, and it was seconded by Mr. Gaunya. The motion passed by a unanimous vote of the Council Members, with Chairman Anderson abstaining.

Whereupon, the Council's business was concluded at 3:17 P.M. These minutes are exempt from 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 January 26, 2021 Council meeting.**
2. **Part A Report of the Merged Market Advisory Council.**
3. **January 2021 Membership.**