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GARY D. ANDERSON
COMMISSIONER OF INSURANCE

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. The 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:
Rachel Davison, General Counsel 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 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 are currently available on this topic and said he has a sense that this issue has been examined and there are 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 are taking on risks, but that does not mean that they will have lower costs. These employers may leave for 12 months, but then they can return if they have a bad year, and thus Mr. Hurst is not necessarily of 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 created by 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".**