Market Stability Workgroup

Date of Meeting: October 8, 2019
Meeting Time: 1:00 pm
Meeting Location: United Way of Rhode Island
50 Valley St., Providence RI 02909

Workgroup Members Present: Co-Chair Marie Ganim, Co-Chair Lindsay Lang, Mike Ayotte, Steve Boyle, Sarah Bratko, Al Charbonneau, Dave Chenevert, Ralph Coppola, Erin Donovan-Boyle, Shamus Durac, Dr. Peter Hollman, Dr. John Luo, Joyce Therrien, Scott Mathieu, Elizabeth McClaine, Jamie Moran, Susan Storti, Melissa Travis, Larry Warner

Workgroup Members Absent: Marc Backon, Marcela Betancur, John Marcantonio,

Minutes

I. **Meeting was called to order** at 1:03 pm by Commissioner Ganim. Commissioner Ganim asked for any comments on the minutes, there were none and the minutes were approved.

a. Commissioner Ganim reviewed the agenda for the meeting and recapped highlights from the previous meeting:
   1. **Guiding Principles** - Refine the guiding principles to reflect the views of the group and ensure they accurately capture the need of the small group market.
   2. **Employee Survey** - Funding has been identified for the employee survey from an outside source and will be announced when the contract is signed. The funding is less than anticipated and will need the groups assistance in pushing the survey and response rate forward.
   3. **SHOP Evaluation** – Look further into the impact and role of SHOP in Rhode Island. What is the potential of SHOP in Rhode Island?
   4. **Inclusion of age in analysis** - Looking at age group specific impacts when making decisions. Identify how Medicare factors in.
   5. **Small group market decline** - Look at reasons for the decline in the small group market. There has been a decline over the last thirteen years and what is the reason of that.
   6. **Future oriented** - Consider anticipated future changes that may impact the small group market. What are the challenges and opportunities?
   7. **Policy options** - Consider specific policy options, for example with Medicare, allow small group members to join Medicare plan and dependents on employer plan. Expand or merge small group market.
      i. Al Charbonneau asked for more information on the employee survey.
      ii. Deb Faulkner responded that we are currently looking at what has been done at the national level, specifically the Kaiser Family Foundation's 2019 Employer Health Benefits Survey. The goal will be to select a vendor that is

familiar with the survey or similar tools and can leverage existing knowledge for the survey.

b. Commissioner Ganim reviewed changes made to the guiding principles at the previous meeting:
    1. Maintain market options that are attractive to small group market participants (businesses, carriers and employees);
    2. Keep costs stable and affordable by addressing cost drivers and balanced risk pools;
    3. Maximize the value of insurance coverage for all small businesses.

Commissioner Ganim asked if there were any additional changes that should be considered. Shamus Durac emphasized the importance of considering not just the businesses but the employees and dependents as well. With no additional comments, Commissioner Ganim asked the group to confirm the guiding principles. The group confirmed.

II. Small Group Market Trends

a. Commissioner Ganim transitioned the meeting over to Deb Faulkner. Deb began her presentation stating the importance of understanding what the data tells us about the current small group market to identify what the actual problems are and how to solve them. Deb reviewed the topics for the presentation:
    1. Small Group Insurance Market Stability: Moderate to Precarious
    2. Observed Small Group Insurance Trends: Premiums and Enrollment
    3. Sources of Enrollment Decline: Fewer Employers Offering
    4. Why is Offer Rate Declining among Small Businesses?
    5. Next Steps: Initial policy options to consider (starting list of ideas)

Deb presented what factors are impacting the market and how:

1. Premiums – average annual premium increase during 2017-2020: 4.9%; small group premium increases are less than or similar to other markets; premiums and trends are consistent with (or below) national/regional averages
2. Enrollment – enrollment declines are substantial; small risk pool increases concerns about volatility; though declines pre-dated the ACA, trends have gotten slightly worse
3. Choice – four carriers in RI's small group market; one dominant carrier with 80% market share; variety of plan/benefit structure options available
4. Carrier Stability - RI's commercial carriers all experienced positive (though narrow) net margins in 2018: there were mixed financial performance trends by carrier
    i. Scott Mathieu asked as the Small Group population gets smaller does the Medicaid population get larger?
    ii. Deb answered that we are looking at the population post ACA, and yes, the Medicaid population did increase but the Medicaid population increased

across all segments not just the small group market. More specifically we are seeing the decline in offer rate, not take up. If there was a decline in employee take up then we could consider Medicaid being a driver, but it is not.

iii. Al Charbonneau asked if it was possible that the decline be related to sole proprietors electing to purchase health coverage in the individual market?

iv. Deb responded that it could be possible. We are not looking at an issue of uninsured, what we have is problem in declining size of the small employer pool. Specifically, because the pool is community rated, it is a problem if it is the healthy individuals that are leaving, and this is something we need to determine.

v. Scott Mathieu stated he would argue that we should focus on driving for outcomes versus solving for problems.

vi. Deb responded that it comes back to the principles and the group needs to be careful not to solve problems that create others.

vii. Ralph Coppola added that we need to keep in mind that the rate of the insured has increased but the people are still leaving the small group market. Specifically identifying where they are in the system.

viii. Melissa Travis added that whether real or perceived, employers are feeling premiums are high and we are seeing them go outside of the small group market to find better options.

ix. Deb agreed with Melissa's statement, adding that even though the data demonstrates stable premiums, that is not the perception of small businesses.

Deb continued to review premium trends across New England and nationally, identifying that RI premiums are comparable to other markets. Using just average premiums, RI premiums look high, but when adjusted for age, risk score and actuarial value, RI premiums are significantly lower than other states in New England and nationally.

Deb reviewed the trends in RI's small group market. Identifying not only a shift in carrier market share, but also a decline in the number of covered lives. Deb also highlighted that while the pool of insured individuals in RI has grown, small group has gone from 13% of the overall insured pool to 9%. However, within the small group pool there has been an increase is the use of full choice. Through the full choice model, the employer is able to select a bench mark plan and employees can then choose a plan that meets their health care needs. This allows the employer to contribute a fixed amount, while giving the employee choice.

Next, Deb explained who is leaving the small group market and where they are going impacts community rating and premiums for the remaining individuals in the small group market. With community rating, the overall medical expenses of the group are estimated based on the profile of a geographic region (RI) and each member pays the same amount. Therefore, a business with

young, healthy individuals would pay the same premiums as a business with employees who have more significant health care needs. If the businesses with the healthier employees leave the marketplace, premium rates increase for those remaining due to a less healthy community pool.

Deb transitioned next to describing the four areas where employees of small business fall into regards to access to health care within their company:

1. Business does not offer health coverage
2. Business offers coverage, but the employee is not eligible (ie temporary or part time)
3. Business offers coverage, but the employee does not take it
4. Business offers coverage, and the employee is enrolled

According to the AHRQ MEPS Rhode Island Small Group Data, there has been a significant decline from 2015 to 2018 in the number of businesses offering coverage, impacting +15k individuals, or 10% decrease in the number of employees reporting their employer offers health insurance. During this time period there was growth in the number of employees working for small group employers and you would expect an uptick in the number of enrolled individuals which did not happen. This may suggest that small businesses are looking for areas to cut costs and health care if one of those areas.

i. Erin Donovan-Boyle asked if there is information on what businesses this reflects, are they new companies in the last three years?
ii. Deb stated that it is possible that the change is reflective of the birth and death of companies opposed to employers choosing not to offer coverage or to flip back and forth.
iii. Sara Bratko asked if that percentage is based on the actual employer or total employees in the state? With the introduction of the ACA, more and more hospitality businesses are no longer offering coverage to part time employees or employees they are not legally required too.
iv. Deb responded the percentage is based on the total number of employees that work for the organization. She added that if the issue was eligibility, we would expect to see a decline in the number of employees eligible or electing to enroll which don't. This also gets to the question about decline being related to employees choosing to enroll in Medicaid, the data does not decrease in the number of employees that are eligible but are electing to not enroll. In small group we are seeing the biggest issue is offer rate.

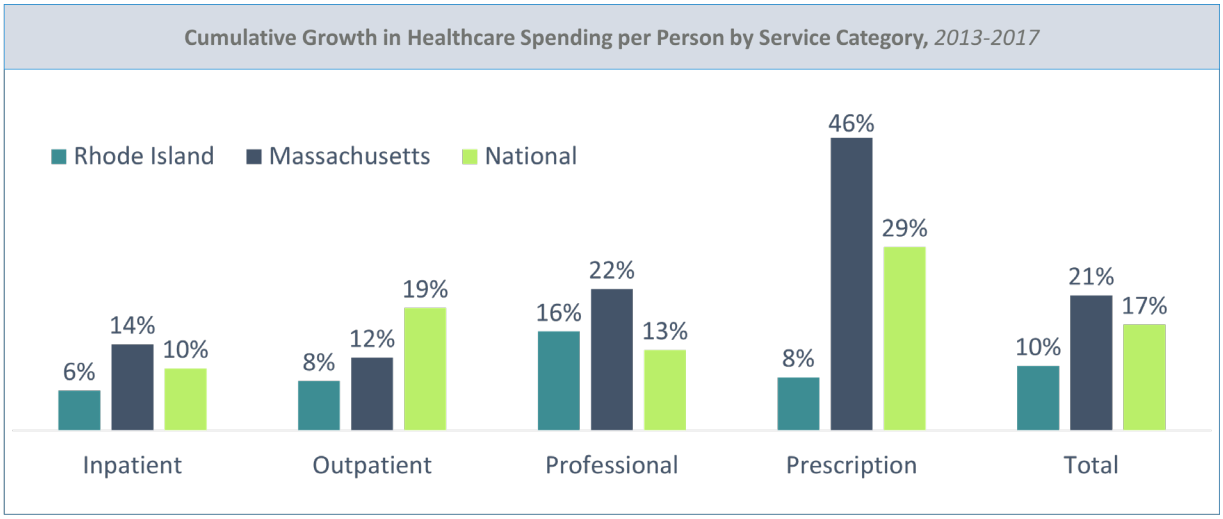
Next Deb reviewed the results from the 2019 Commonwealth Fund Study of Small Business Owners. The survey identified that cost is of significant concern and many small businesses have looked at how to reduce the cost of providing health insurance:

1. **Health care cost is a major problem for small employers**
    a. Biggest challenges facing your business: (#1) the cost of providing health coverage to employees; and (#2) attracting new customers
    b. Almost half (44%) said health care costs were a "major problem" for their business
    c. Two-thirds (69%) said the problem is getting worse
    d. Concern with health care costs looms larger the smaller the business
2. **Small-business owners have taken steps to lower their own health care costs**

a. Over half say they have made recent coverage adjustments to decrease costs:
b. About half (48%) increased deductibles or cost sharing
c. Over one-fourth (27-29%) negotiated for lower rates or changed carriers
d. About one-fourth (25%) increased employee premium share
e. 16% Reduced or eliminated dependent coverage
f. Fewer (one-third) have considered discontinuing coverage for their employees

The survey also identified through the informant interviews a mixed assessment of the role brokers play. Some employers raised concerns about brokers' priorities and the potential need for solutions that ensure they put their client's financial interests first.

The next topic presented was looking at cost drivers in the RI health insurance market. Deb pointed out that the cumulative growth from 2013-2017 for RI was 10% but far less than other states and nationally. Based on this data it could be argued that health care cost is not what is driving increase in premiums.



NOTE: Data for all Employer Sponsored Insurance, not just small group.

i. Al Charbonneau stated that given that we only purchase in this market, the national experience is irrelevant. We should look at what we are buying, the theme in the hospital is transition from inpatient to outpatient, but the dollars have not followed where health care is moving, and it hits premium. The MEPS data shows that RI premiums are not as high as other areas but our rate of deductibles are increasing significantly, which might indicate that our premiums are not actually that great.
ii. Deb responded that is an important consideration and that the more recent trends are offset by the shifting of cost.
iii. John Simmons echoed Al's concerns about comparing RI's experience to other states
iv. Ralph Coppola asked if you could say that we get more value for what we pay?
v. Al Charbonneau stated you could also argue that what we are paying in family premiums is taking a larger part of family incomes because premiums are higher in proportion to family income compared to states like Massachusetts.

vi. Ralph Coppola added that the flip side of that is not having coverage and ultimately paying more out of family income not towards premiums, healthcare bills are one of the leading causes of bankruptcy in the country.
vii. Jamie Moran added if we are looking at small employers and they are competing against others across the country, and competitors overhead cost is 5% less than in RI, they are going to be more competitive. As a RI business, my cost of goods is higher if my second biggest line item of health care is higher.

Deb continued the presentation to review what options are available out the small group market, which removes them from the community rated group. In these scenarios the employer is rated on their own experience not all of those in the group. We are starting to see more of the following

1.) Stop loss/Self Insured Plans
    a. Employer at risk for employees' healthcare costs; stop loss protects against catastrophic losses
    b. Recent growth limited by OHIC underwriting restrictions as of July 2019
    c. Employer only pays the claims as they happen
    d. These are great for healthy groups immediately, but what happens if an employee gets sick
    e. Risky and detrimental to those left behind
2.) Professional Employer Organizations (PEOs)
    a. Outsourced solution for HR, payroll, benefits, workers' comp, and compliance
    b. Typically offered by payroll companies; anecdotal evidence that this option is growing
3.) Association Health Plans (AHPs)
    a. Group health plans offered by business/professional associations to members' employees
    b. Limited by state law, exemption for Builders
4.) Health Reimbursement Accounts (HRAs): New option in 2020
    Tax-advantaged employer-funded plan to reimburse employees for individual market premiums
    i. John Simmons asked if there is data available on the numbers for PEOs or stop loss firms in Rhode Island?
    ii. Deb responded that we have them for stop loss not PEOs
    iii. John Simmons asked if the benefits for plans in the small group market are the same for stop loss plans and PEOs?
    iv. Deb stated that the plan benefits are not the same, specifically there are no protections regarding essential health benefits. Deb also added that there has been a really big shift in the number of part time employees, increasing by 9,000 over time, in addition to variation within industries.

v. Jamie Moran asked if we see an increase in part time and decrease in full time, is there a chance of double counting an employee that works at two employers part time (I used to work full time at one employer, hours cut back and now I work part time at two employers).
vi. Deb responded that the data set does not allow us to parse out if an employee is employed in multiple part time positions.
vii. Melissa Travis asked if any of this driven by employers limiting hours at 30 hours to not have to offer coverage?
viii. Deb responded that if there were fewer people eligible this would be evident in the data and that is not what it shows. The number of eligible employees has remained stable, the issue is offer rate.
ix. Melissa Travis asked is it possible that new jobs are created with the intention of them to be part time?
x. Deb responded that it is definitely possible that employers are intentionally creating part time positions to avoid having to offer health insurance.
xi. Jamie Moran commented that it is important to understand if there is a difference in the definition of full time employee in the large group vs small and if this makes a difference. Prior to the ACA full time employee had a different meaning to post ACA where full time equivalent had a different meaning. And with the distinction of the large and small groups with the ACA did we see a shift in the make up of the business that remained as small group?
xii. Deb responded that in an effort to minimize the impact of the ACA on the data, data only from 2015 onward was used. There was a lot of noise between 2013 and 2015 prior to the start of the ACA.
xiii. Steve Boyle stated that some employers are intentionally keeping employee count below 50 by filling jobs as part time and the ACA changes continue to drive how they staff their organization.
xiv. Erin Donovan-Boyle stated it would be interesting to see in regard to PEOs what the reporting requirements are from state to state. RI is consistently ranked 50th in business friendliness because of extensive reporting requirements. If PEO reporting requirement are less are they encouraging businesses to join PEOs?
xv. Deb responded that this is something we can try to gather information on through the employee survey.

III. Discussion

a. Completing the presentation portion of the meeting Deb opened the floor for comment, prompting the group by asking if we identified the issues clearly enough to start a discussion on how to solve the problem? Are there specific concerns we want to address?

i. Jamie Moran commented that in regards to stop loss, it is a really difficult decision for an employer to not consider the stop loss plan when it can be substantially less expensive for them.
ii. Deb responded that this can be tricky for businesses depending on if they have a good or bad year and the stop loss plan can adjust accordingly. The thing for businesses is, they can always leave and come back to the small group market.
iii. Ralph Coppola asked if you can penalize a business if they leave as a good risk and come back as a bad one? If they are now adversely impacting the group can we penalize them.
iv. Erin Donovan-Boyle commented that it is not about risk as it is a community rating, even if they are unhealthy they will still be paying more than when they left.
v. Jim Delisle added if that group is a bad risk when they leave the pool, that risk should improve the remaining pool. If they leave and come back it should not make the pool any worse than it was previously.
vi. Deb commented that her assumption would be that the self-insured option would be most appealing to a group that is lower risk. The vast majority of groups that are going to leave are going to be the ones that look at their employees and determine it is worth it to leave.
vii. Steve Boyle commented that sometimes when we are looking at this we talk about risk pools but we need to keep the business in mind, that if we take away these other options we need to offer something else that can entice them to keep coverage for their employees. At the end of the day the company's bottom line is important.
viii. Deb posed the question what could we do to make it an even opportunity for the healthy and sick groups?
ix. Commissioner Ganim commented that some of the technical experts that we reached out to will be providing some insight as to what has been done in other states.
x. Ralph asked what was the thought process of the ACA to encourage to rate small groups this way?
xi. Deb responded that the ACA did not encourage small groups to leave but was designed to encourage them to stay. What has happened since then is the community rated pool requirements have become stricter. The thought behind the community rated pool is that it would be an asset to small businesses and help keep costs manageable.
xii. Ralph stated prior to the ACA many insurance brokers tried to put small businesses in to the self-funded market and if they were smaller than three hundred employees it was a disaster. Now something has changed since the ACA that has changed that paradigm.
xiii. Deb asked why are stop loss policies being sold to small groups more over time than previously? I don't think it is an ACA issue, but it is increasing over time and the question is why?
xiv. Jamie Moran respond that it could be a regional thing, previously they were not popular but over time have become more attractive to avoid taxes, and save money with benefits.
xv. Scott Mathieu added that there is a market for the plans because they are meeting what the consumer is looking for and affordable for small businesses.
xvi. Dave Chenervert commented that as business person, his priority is providing good, quality health coverage for the lowest cost. It is concerning what we are not focusing on cost more when business is driving 80% of the cost in RI. With one company having this much of the market, competition is lost.

xvii. John Simmons asked if in the approval of the OHIC rates, are they actuarially sound?
xviii. Commissioner Ganim confirmed that rate approval is contingent upon plan actuarial submissions that are reviewed by OHIC actuarial experts.
xix. Scott Mathieu added that for many insurers risk and risk adjustment is something that can drive cost in one direction or another.
xx. Jim Delisle added that the more volatile the risk pool, the greater the impact of risk adjustment can have on premiums.
xxi. Al Charbonneau commented that we should also look at all of the various taxes, fees, and assessment that are imbedded into the premiums and is there an opportunity to assess theses.

Wrapping up the discussion, Deb recapped what was heard in the last meeting regarding potential interventions or strategies to explore:

1. Full use of SHOP to lower employee costs
2. Merge markets (Ind/Small Group or <100)* potentially with HRA
3. Regulatory actions as needed to address purchasing policies
4. -e.g., stop loss/self insurance, PEOs, AHPs, HRAs, etc.
5. Small Group rate regulation or plan design to lower cost – e.g., limited/tiered networks or alternative provider payment methods
6. Targeted employer incentives for coverage
7. Reinsurance or subsidy program

Deb explained that a reinsurance or subsidy program would be a proactive strategy that could be used to mitigate a substantial increase in rates due to shifts in risk. This could help control for one carrier not ending up with the lion's share of the risk. This would be a volatility protection.

i. Dr. Peter Holman added that if we explore merging markets it will be important to not only discuss strategy but also to articulate potential impact. Specifically, it should be addressed if we merge the markets, how will we transition the people currently in the market today.
ii. Jamie Moran asked how realistic is it for us to pull out taxes that go into the general fund that do not go towards anything related to health or dental costs?
iii. Deb responded that we have to demonstrate that taxes are driving that employer offer rate down and increasing the risk pool. If we can demonstrate this, we can bring issues to the legislature.
iv. Al Charbonneau stated it seems like we should provide a list of what is actionable, and with respect to legislature more and more providers are going to the legislature for relief. We should at least be able to make a case to the legislature that at a minimum they should have experts at the table in decision making about healthcare.
v. Ralph Coppola asked if there was any way to increase premium taxes on the self-insured groups.
vi. Deb responded that putting restrictions around self-insured is hard because it is not a local state issue but a national one. It is something we should add to the list and explore if there is anything that can be done about it.

Deb asked if there were any additional thoughts from the group, there was none.

IV. Public Comment

Commissioner Ganim asked for any public comment, there was none.

V. Adjourn

Lindsay Lang adjourned the meeting at 2:45pm.