STATE OF MARYLAND

TASK FORCE REPORT TO THE GOVERNOR AND THE GENERAL ASSEMBLY

ON

COOPERATIVE PURCHASING FOR HEALTH INSURANCE

AS REQUIRED BY CHAPTER 307, LAWS OF 2018, AMENDED BY CHAPTER 110, LAWS OF 2019

Board of Public Works Procurement Advisor Gabriel Gnall, Chair

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TABLE OF CONTENTS

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EXECUTIVE SUMMARY

All 50 states provide health insurance coverage for their employees, with the amounts of coverage, the eligible enrollees, and the state and individual paid portions varying from state to state.[1] Maryland currently offers several medical plans for eligible employees, dependents, and retirees including Preferred Provider Organization (PPO) plans from two health insurance carriers, Exclusive Provider Organization (EPO) plans from two health insurance carriers, an Integrated Health Model (IHM) plan, a Dental Preferred Provider Organization (DPPO) plan, a Dental Health Maintenance Organization (DHMO) plan, as well as a prescription drug plan. The amounts the State subsidizes for these plans varies by category of employee or retiree.[2]

Historically, the Department of Budget and Management's (DBM) Employee Benefits Division (EBD) has set the benefits design for each plan and the Department's Procurement division has competitively procured contracts with the insurance carriers, with EBD staff serving as proposal evaluators, and with the assistance of DBM's contracted actuarial consultants as subject matter experts (currently The Segal Group, Inc.). With the recent changes to State procurement organization, effective October 1, 2019 the Department of General Services is now responsible for services procurements, including future health benefits procurements.[3]

Pooling public employee health benefit programs has been proposed as a concept with the goals of cost containment and increased efficiencies. Smaller entities may not have the ability to negotiate lower health care premiums and may end up paying higher administrative costs per participant in comparison to larger entities.[4] Taking the position that the combined resources and purchasing power of several governmental entities will result in greater cost savings through economies of scale, the legislative sponsor of Chapter 307, Laws of 2018, asserts that administrative costs would be lowered with millions of dollars saved.[5]

With the goal to "pool public employee health care purchasing by the State, counties, municipal corporations, and county boards to maximize value while maintaining a broad package of benefits and reasonable premiums," the Task Force to Study Cooperative Purchasing for Health Insurance was created and required to report its findings and recommendations to the Governor and General Assembly on or before January 1, 2020.[6]

When making its recommendations, the Task Force considered: 1) current options available to local governmental entities as well as nonprofit organizations; 2) how several other state governments and local consortiums have proceeded in pooling healthcare purchasing; and 3) the potential impacts to the State by allowing other governmental entities or nonprofit organizations to join the State's plan.

[1] http://www.ncsl.org/research/health/state-employee-health-benefits-ncsl.aspx
[2] https://dbm.maryland.gov/benefits/Documents/2020%20Health%20Benefits%20Guide.pdf
[3] http://mgaleg.maryland.gov/mgawebsite/Legislation/Details/hb1021/?ys=2017rs
[4] http://www.ncsl.org/documents/health/IntroandBriefsCC-16.pdf
[5] https://www.baltimoresun.com/opinion/op-ed/bs-ed-20190507-story.html
[6] http://mgaleg.maryland.gov/2018RS/chapters_noln/Ch_307_hb1400E.pdf

The Task Force makes the following recommendations within two subgroups, Local Governmental Entities and Nonprofit Organizations, with more detail provided later in the Report:

Local Governmental Entities

- Increase outreach to local governmental entities that are allowed to join the State's plan and provide information regarding the benefits and costs of the State's plan.

- Determine how participating local governmental entities would fall within the structure of the State's plan, how retirees can be included, and how sub-accounts would need to be configured with insurance carriers.

- Analyze the potential costs to the State and cost savings to local government entities by the State assuming or sharing the administrative burden for any local governmental entities that join the State's plan.

- Share claims experience information with local governmental entities that join the State's plan and evaluate imposing a penalty for exiting the State plan to lessen the risk of adverse selection.

- If participation by local governmental entities in the State's plan is not increased after outreach efforts are performed, consider establishment of a governing body or joint healthcare committee that would allow local governmental entities to have representation and substantive input into the plan design and procurement evaluation processes for the State's health plan.[7]

- Increase awareness of other options available to local government entities besides the State's plan, including the Local Government Insurance Trust, the Eastern Shore of Maryland Educational Consortium Health Insurance Alliance, and any other county, school board, or regional cooperative purchasing arrangements.

- Encourage local entities to combine resources and perform their own intergovernmental cooperative procurements.

Nonprofit Organizations

- Encourage enabling legislation to support nonprofits in combining resources to form a pool of nonprofits to cooperatively purchase health benefits.

- Research other states that allow nonprofit organizations to join those states' health plans and determine how those other states remain in compliance with Internal Revenue Service (IRS) rules governing each state's governmental plan status.

[7] The Department of Budget and Management did not concur with this recommendation.

I. Background and Scope of the Report

Chapter 307 of the Laws of 2018 established the Task Force to Study Cooperative Purchasing for Health Insurance. Chapter 110 of the Laws of 2019 removed the Maryland Insurance Commissioner from the list of Task Force members and removed the Maryland Insurance Administration as one of two agencies initially responsible for staffing the Task Force. The Department of Budget and Management was the remaining agency assigned to staff the Task Force.

The Task Force was required to:

(1) study models of cooperative purchasing of health insurance;
(2) recommend the health insurance benefit options that should be offered to:
    a. nonprofit organizations that qualify and elect to participate in the State health plan;
    b. county, municipal corporation, and county board employees;
    c. a surviving spouse, child, or dependent parent of a county, municipal corporation, or county board employee who died while employed by the State; and
    d. a retired county, municipal corporation, or county board employee;
(3) recommend ways to:
    a. minimize and combine administrative costs; and
    b. transition the State, counties, municipal corporations, and county boards to new plans, as applicable, without adversely affecting the health benefits of any employee;
(4) recommend whether the State should limit the number of nonprofit organizations that may participate in the State health plan; and
(5) make any other recommendations to control health costs and offer a variety of health benefit plan choices.[8]

The Task Force convened on four dates: August 29, September 30, October 21, and November 7, 2019. DBM's health care consultants, the Segal Group, provided presentations on various topics at each of the meetings and provided further information upon request from the Task Force members. Task Force members attended the meetings and participated in discussions, with the exception of the representative for the Maryland Municipal League who was never appointed.

The group's deliberations resulted in this Report which responds to the Task Force's charges and makes recommendations regarding cooperative purchasing for health insurance.

[8] http://mgaleg.maryland.gov/2018RS/chapters_noln/Ch_307_hb1400E.pdf

II. Which entities may be eligible to join the State's plan?

In addition to eligible State employees, spouses, dependents, and retirees, under current law an employee of a county, municipal corporation, or county board may enroll and participate in the health insurance benefit options established under the State Employee and Retiree Health and Welfare Benefits Program, subject to any additional authorization required under the terms and conditions of the employee's employment.[9] A "county board" means the board of education of a county and includes the Baltimore City Board of School Commissioners.[10]

Similarly, employees of the Tri-County Council for Southern Maryland, the Tri-County Council for Western Maryland, the Tri-County Council for the Lower Eastern Shore of Maryland, and the Mid-Shore Regional Council may enroll and participate in the State's benefits program with the approval of the employee's council.[11] Employees of the Southern Maryland Regional Library, the Eastern Shore Regional Library, and the Western Maryland Regional Library may enroll and participate in the State's benefits program with the approval of the employee's library. The Maryland Small Business Retirement Savings Board may enroll and participate in the State's benefits program, subject to the DBM Secretary's discretion to ensure that the participation of the Board does not impede, undermine, or conflict with the program's compliance obligations or governmental and cafeteria plan status.[12] Certain qualifying entities would generally participate as "satellite organizations," which is any organization or entity whose employees are eligible to participate in the State Employee and Retiree Health and Welfare Benefits Program as a separate account.[13]

For any local government entity that does enroll and participate in the State's benefits program, the governing body of the local government entity shall (1) pay to the State the total costs resulting from the participation of its employees in the Program; and (2) determine the extent to which the local government entity will subsidize participation by its employees in the program.[14]

In addition, qualifying nonprofit organizations and their employees may be permitted to enroll and participate in the State's benefits program as satellite organizations. A "qualifying nonprofit organization" is an organization that:

(1) (i) receives State funds from the Maryland Department of Health that cover more than one-third of the organization's operating expenses; and
    (ii) is: 1. described in § 501(c)(3) of the Internal Revenue Code; and
    2. exempt from income tax under § 501(a) of the Internal Revenue Code;
(2) is the Legal Aid Bureau, Inc.;
(3) is a corporation, a limited liability company, or any other entity that is wholly owned by the Legal Aid Bureau, Inc.; or

[9] State Personnel and Pensions Article (SPP), § 2-513(a)(1), Annotated Code of Maryland
[10] SPP § 2-501(b)
[11] SPP § 2-515
[12] SPP § 2-515.2
[13] SPP § 2-501(d)
[14] SPP § 2-513(b)

(4) is the Maryland Crime Victims' Resource Center. [15]

The Secretary of DBM adopts regulations for the enrollment and participation of employees of a qualifying nonprofit organization to participate in the State's benefits program as a satellite organization.

According to State law, the participation of a satellite organization in the State's benefits program may not impede, undermine, or conflict with the program's compliance obligations or governmental and cafeteria plan status, as defined in 26 U.S.C. § 125.[16] This particular restriction will be discussed in more detail below in the discussion and recommendations regarding nonprofit organizations.

III. What information is available to other entities on the State's plan?

DBM's Employee Benefits Division (EBD) manages the State Employee and Retiree Health and Welfare Benefits Program. EBD provides information on the State's health benefits plans via its website, including benefits guides with the available options for employees, details of the plan designs, the wellness program, as well as enrollment materials. In addition, information is provided regarding the annual employee and retiree rates and State subsidies, as well as forms for satellite organization employees.[17]

Currently the State health plan includes approximately 67,000 active employees (153,000 members including spouses and dependents), 15,000 pre-Medicare retirees (23,000 members), and 35,000 Medicare retiree contracts (50,000 members), with a total of 226,000 members including employees, retirees, spouses and dependents.

IV. What are some considerations regarding the addition of retirees?

Each governmental entity that provides retirement health care benefits typically has its own structure for how retirees contribute to receive benefits and how retirees are determined to be eligible (usually based on length of service). Generally, State retirees may enroll and participate in the State's health benefit options if the retiree retired directly from State service with at least five years of creditable services, ended State service with at least ten years of creditable service and within five years before the age at which a vested retirement allowance normally would begin, or ended State service with at least 16 years of creditable service. Members hired on or after July 1, 2011 are required to have completed at least 25 years of creditable service, have retired directly from State service with at least ten years of creditable service, or ended State service with at least ten years of creditable service and within five years before the age at which a vested retirement allowance would normally begin.

Currently retirees of satellite organizations are not allowed to participate in the State's health program unless specifically authorized by statute. This general restriction is an obstacle for some entities to participate since the provision of retiree health care would need to be provided

[15] SPP § 2-512(a)
[16] SPP § 2-512(d)
[17] https://dbm.maryland.gov/benefits/pages/default.aspx

through another contract, or the entity would need to decide not to provide retiree health coverage. Allowing retirees from satellite organizations to join the State's health program would add to the Other Postemployment Benefits (OPEB) liability from an accounting perspective; future claims liability must be recorded but contributions (unless paid by retirees) can only be recorded as they are received. As of June 30, 2019, the State's net OPEB liability was $14.3 billion, with a funded ratio of 2.4%.[18] Any change to this status would have a material negative impact to the State.

From a cash perspective, satellite organization benefit payments will still add to the OPEB liability based on the current rate structure. There is a possibility that such benefit payments could be cost neutral under the following conditions: (1) Pre-Medicare retirees would need to be rated separately (currently rated together with actives); and (2) the State would need to charge satellite organizations premiums based on the actual cost of benefits. However, this would require substantial changes to the way that the plan is currently administered.

Finally, in terms of retiree healthcare benefits, current litigation surrounding the retiree prescription drug plan has the potential to alter provisions and costs of Medicare eligible retiree benefits for the State and retirees.

V. What options do other entities have to procure health insurance?

Local government entities have several options to procure health insurance. First, a single government entity can procure health insurance for just its own employees and retirees. With this approach, the government entity retains autonomy in plan design and procurement award decisions that impact only their risk pool of participants. As choice of health care benefits is a significant and very personal consideration for employees and retirees, a government entity may decide it is in the best interests of its employees and retirees to retain direct control over those benefit plans. Further, local jurisdictions note that their health benefit plans, which can be customized to meet the specific needs of each jurisdiction, are an effective tool in recruiting and retaining employees.

An alternative option is for like entities (ex. county school boards) to pool their resources and combine their participant pools into a larger pool. Depending on the combined size of the government entities, better pricing through economies of scale may be achieved by cooperative purchasing of health insurance. While some autonomy is given up when pooling with other entities, if all entities are of a similar type (ex. county; school board; within a geographic region; etc.), it is more likely that the risk pools of participants will be similar and a consensus on plan design and insurance carrier(s) more easily achieved.

One such pool is the Eastern Shore of Maryland Educational Consortium Health Insurance Alliance. From information provided during the Task Force meetings, the Consortium was founded in 1995 to allow for a larger risk pool to better manage premium costs for public school systems and their employees. Current participants include Kent, Caroline, Talbot, Dorchester,

[18] "Maryland State Employee and Retiree Health and Welfare Benefits Program Actuarial Valuation and Review of Other Postemployment Benefits (OPEB) Measured as of June 30, 2019 In Accordance with GASB Statements. No, 74 and No, 75" The Segal Group.

Somerset, Queen Anne's County schools and Queen Anne's County Government, and active and retired employees and their families are covered. The Consortium Board of Trustees makes procurement decisions and includes two trustees (one representing management; one representing employee unions) from each participating public school system and one trustee from each participating county government. Premium rates are different for each school system depending on their group claims experience, but each entity controls the subsidy percentage split for their participants. Each entity is able to review its claims data. Medical, vision, dental and prescription benefits are offered, and CareFirst has been the provider of choice because of its network of available physicians on the Eastern Shore. Prescription benefits are currently provided by Express Scripts. CareFirst administers an EPO, PPO and Blue Choice plan for the Consortium. Working with the same schedule of benefits has resulted in lower administrative fees over the years. The alliance also has greater flexibility of plan design and increased annual premium rate negotiation power compared to each entity being on its own. At the end of each year, a settlement is determined for each entity with surpluses being reserved or overages being assessed or reserved individually to each member school system.

Another option, the Local Government Insurance Trust (LGIT) is a nonprofit that provides joint self-insurance for towns, cities, and counties in Maryland. There are currently 190 participants with LGIT including 147 municipalities and 17 counties, with over 1,200 covered employees.[19] Most of the participants are small towns. The Benecon Group negotiates administrative fees and procures insurance carrier services on behalf of LGIT.[20] Each participating entity selects their plan design and coverage levels and pays a premium to LGIT based on plan design and group demographics. Any excess funds (premiums minus final claims) are returned to members with positive claims experience.

The Affordable Care Act (ACA) established the Consumer Operated and Oriented Plan (Co-op) Program. Co-ops are private, nonprofit, state-licensed health insurance carriers designed to offer competitive health plans in the individual and small group markets. Co-ops are structured to keep costs low through collective purchasing, a patient-centered medical home, and an emphasis on preventive care. However, as federal funding has been significantly cut for these programs, co-ops have declined from 23 in 2013 to just four in five states (Idaho/Montana, Maine, New Mexico, and Wisconsin). While co-ops had enrolled over 1 million people in 2015, that number is now down to approximately 150,000.[21]

The Maryland Health Connection, through the Maryland Health Benefit Exchange, allows individuals to purchase health plans available in the State.[22] With the Small Business Health Options Program (SHOP), small businesses and nonprofit organizations may enroll to qualify for a health care tax credit based on the average salary and number of employees. There is a choice in coverage with providers and plans, and organizations have flexibility in how to contribute to employer premiums. In order to qualify under the SHOP program, the entity's principal business

[19] https://www.lgit.org/
[20] https://benecon.com/
[21] https://www.healthinsurance.org/obamacare/co-op-health-plans-put-patients-interests-first/
[22] https://www.marylandhealthconnection.gov/

address must be in Maryland, the entity must employ 50 or fewer full-time equivalent (FTE) employees, and the entity must offer coverage to all full-time employees.[23]

As noted above, it is currently possible for local government entities to enroll and participate in the State's benefits plan. A recent list of State satellite organizations provided by DBM details approximately 60 entities, including towns, cities, and other local government entities. However, noticeably absent are large counties and municipalities that are typically self-insured.

VI. How are other states cooperatively purchasing health insurance?

The Segal Group provided information on how several other states are cooperatively purchasing health insurance with emphasis on Connecticut, New Jersey, and Utah.

Connecticut

Connecticut started its Connecticut Partnership Plan in 2012 as a pool for entities to join separately from the state's employee health insurance pool. Entities that joined received the same benefits offered to state employees with pricing dependent on each group applying for coverage. Only nine entities joined the plan in the first three years of its existence and the plan eventually suffered from adverse selection – an imbalance of high-risk, sick policyholders to healthy policyholders. This led to higher health insurance premiums for participants and discouraged new local government agencies with better claims experience from joining the plan.

In 2016 Connecticut modified the program to make it easier and more cost effective for local municipalities to join the pool, resulting in the Connecticut Partnership Plan 2.0. This second iteration of the plan was administered by a separate, dedicated service team and was a voluntary program that allowed cities, towns, schools, boards of education, quasi-public agencies, and public libraries to join. Nonprofit organizations are not eligible to join the Connecticut plan.

The most significant difference in the second iteration of the program is that all groups that join the partnership pay the same rates as the state; claims experience is pooled together with the state, allowing for a more stable pool and reduced risk of adverse selection. Approximately 30 groups have joined since July 1, 2016 and there are currently over 120,000 members in the state pool. Entities must join as a unit (i.e. an entire town, city, etc.) and must participate in the program for three years, with penalties to the entity if they leave the pool earlier. Active employees, early retirees, and Medicare retirees are eligible to join, and all entities have the same plan design and insurance carriers.

New Jersey

New Jersey provides separate pools for the State Health Benefits Program and the School Employees' Health Benefits Program. The State Program covers over 200,000 state employees and 70% of local government employees. All public entities are eligible to join the State Program after creating a resolution to do so. Nonprofit organizations are currently not allowed to join the New Jersey state program. All entities use the same plan design, but the state and local

[23] https://www.marylandhbe.com/

government claims experience pools are completely separate. While local entities may join the State Program, they do not have a role in the procurement process – all procurement decisions are handled by the state procurement team. Local government entities in the program receive claims experience every year, meaning that the pool is more likely to be subject to adverse selection. Additionally, while certain entities have had to pay back premiums when exiting the pool, other entities have been allowed to waive the provisions requiring payments of premiums for early exit. This structure has further contributed to entities leaving the pool.

The School Program covers about 30% of school districts in the state. The procurement process for the School Program is combined with the State Program. Benefits are determined primarily by bargaining units (i.e. teachers' unions) and benefit plans are rich in their coverage. For this and other reasons, there has been some migration out of this program in the past few years. Currently, school employees are all in one risk pool but there has been discussion about breaking the pool into smaller divisions.

Utah

Utah created a nonprofit trust in the 1970's within the Utah Retirement System called the Public Employers Health Plan (PEHP) that currently provides medical, dental, life, and long-term disability benefits to Utah state employees as well as the Local Governments Risk Pool (LGRP). The LGRP consists of more than 250 municipalities, counties, special districts and schools in a self-funded pool. Depending on group size, the PEHP offers up to six medical options and three network options (Advantage, Summit, and Preferred). The PEHP serves only the public sector and competes with other health plans offered in Utah (e.g. Aetna, BlueCross BlueShield, Cigna, Humana, UnitedHealthcare) by working directly with employers and through brokers. PEHP contracts with the MultiPlan network of providers and facilities to help reduce costs when participants receive care outside of Utah. The PEHP had over 162,000 medical plan members as of December 31, 2018.

The PEHP administers several distinct risk pools with rate setting policies varying by entity. There is the State Employee Risk Pool with tight restrictions on what entities can join - only state, independent state entities, applied technology colleges, and universities under a certain size are allowed to join. The Local Governments Risk Pool includes separately-rated entities and all groups are medically underwritten in accordance with general industry standards. There is a Local School Boards Association that is community-rated with limits on joining as well as a Medicare Supplemental Risk Pool that is age rated without underwriting. Finally, there are stand-alone single entity risk pools as well.

VII. What are some of the considerations regarding nonprofits?

Current State law limits participation of nonprofit organizations in the State's health plan.[24] As directed by Chapter 307 of the Laws of 2018, the Task Force considered participation by additional nonprofit organizations in the State's health plan. However, there is serious concern that expanding nonprofit participation in the State plan may put the State's governmental plan status at risk.

[24] SPP § 2-512(a)

Governmental Plan Status

A "governmental plan" is defined under the Employee Retirement Income Security Act of 1974 (ERISA)[25] as a "a plan established or maintained for its employees by the Government of the United States, by the government of any State or political subdivision thereof, or by any agency of instrumentality of any of the foregoing."[26] The Internal Revenue Code (IRC) includes a definition of "governmental plan" similar to that in ERISA.[27] The primary consideration regarding nonprofit organizations joining the State plan from the perspective of the State is ensuring that the State's governmental plan status is maintained.

As counties, municipal corporations, county boards and other political subdivisions are governmental entities, allowing those entities to join the State's plan does not affect the "governmental plan" status of the State's program. However, if the State were to allow more nonprofit organizations to join the State's plan, beyond those "qualified" nonprofit organizations currently delineated in statute, the State could be at risk of losing its governmental plan status. Losing that status could subject the State to additional reporting, disclosure, and fiduciary requirements. If governmental status were lost, the State plan could potentially be considered a Multiple Employer Welfare Arrangement (MEWA) and would need to comply with ERISA.

The U.S. Department of Labor (DOL) has issued advisory opinion letters on the subject of governmental plan status, including whether the participation of certain private, nonprofit employers would adversely affect a state's governmental plan status. While a DOL advisory concluded that "a *de minimis* number" of nonprofit organizations employees could participate in a state health plan without affecting that plan's status as a governmental plan under ERISA, "the Department did not establish a specific number of employees or percentage threshold that would constitute more than a *de minimis* number for this purpose." [28] The scope and applicability of DOL advisory letters is limited to the specific employer-inquiry and the DOL has not established a specific number or percentage threshold that would constitute more than a *de minimis* amount.

Representative for nonprofit organizations may assert that the demographics of nonprofit organization employees could benefit the State's risk pool. However, from an underwriting standpoint, because the number of nonprofits that could potentially join the State's plan is limited in order to not disrupt the State's governmental plan status, the effect of nonprofit enrollment would likely have very little impact on the pricing for the pool.

If additional nonprofit organizations were permitted to join the State's plan, those organizations would likely experience the same disadvantages that participating governmental entities may experience, including limited autonomy and ability to work with insurance vendors, more limited plan design selection, and the requirement to pay rates set by the State with little to no input. Alternatively, nonprofits may have other options to procure health insurance, similar to

[25] https://www.dol.gov/general/topic/health-plans/erisa
[26] https://www.law.cornell.edu/uscode/text/29/1002 The Employee Retirement Security Act of 1974 is a federal law that sets minimum standards for most voluntarily established retirement and health plans in private industry to provide protection for individuals in these plans.
[27] https://www.irs.gov/retirement-plans/governmental-plans-under-internal-revenue-code-section-401-a
[28] https://www.dol.gov/agencies/ebsa/employers-and-advisers/guidance/advisory-opinions/2012-01a

other government entities as noted in Section V. above. However, nonprofit organizations with more than 50 employees would currently not be eligible to take advantage of the Maryland Health Connection SHOP program.

VIII. Recommendations

After thorough review and discussion of several issues and challenges faced with the cooperative purchasing of health insurance, the Task Force makes the following recommendations:

Regarding Local Governmental Entities:

- **Increase outreach to local governmental entities that are allowed to join the State's plan and provide information regarding the benefits and costs of the State's plan.**
    - While local governmental entities are currently allowed to join the State's plan, very few such entities actually do so. Those entities that have joined are generally smaller towns and boards, and currently no counties or school boards participate in the State plan.
    - If the primary goal of pooling the procurement of health insurance is to lower costs by increasing economies of scale, then the State must attract larger government entities like county governments and boards of education to join the State's plan.
    - The State currently conducts some outreach to local government entities, including through groups like the Maryland Association of Counties (MACO). As an example, the State's pharmacy benefit manager (PBM), CVS Caremark, represented the State at the MACO conference in August 2019 and periodically sends emails to local jurisdictions about the State's pharmacy benefits program.
    - The State should increase outreach to local governmental entities and boards of education and provide information on the pricing and benefits options of the State's plan. With this information, local entities should weigh the potential costs and benefits in joining the State's plan versus continuing with their current health insurance system. Actuaries may need to be utilized to process an entity's claims data and provide a comparison between the local entity's current plan and the State's plan.

- **Determine how participating local governmental entities would fall within the structure of the State's plan, how retirees can be included, and how sub-accounts would need to be configured with insurance carriers.**
    - Current outside entities that have joined the State plan participate as satellite organizations. If additional, larger government entities like counties and school systems were to join the State's plan, the State would need to determine how those entities would fit into the State plan structure. Would they be satellite organizations as well? Would separate risk pools need to be created for like entities?

- The current law specifically allows for employees of other entities to join the State's plan. Whether and how to allow other entities' retirees to join the State's plan should be analyzed further.
- If additional entities were to join the State's plan, the State would need to discuss with its insurance carriers how those entities would be added. Would sub-accounts need to be created for different sized entities? Would administrative costs increase significantly?

- **Analyze the potential costs to the State and cost savings to local government entities by the State assuming or sharing the administrative burden for any local governmental entities that join the State's plan.**
  - While the current law states that local government entities are to pay to the State the total costs resulting from the participation of their employees in the State's plan, there may be unanticipated administrative burdens on the State if a significantly larger pool was created. The State should analyze hypothetical costs for the inclusion of different sized entities in the State's plan and how those costs would be passed onto the participating entities. Conversely, any potential cost savings to local government entities should be analyzed as well.
  - In addition, the potential costs to the State and other participating entities of entities leaving the State plan should be taken into account. Entry-exit rules would likely need to be established.

- **Share claims experience information with local governmental entities that join the State's plan and evaluate imposing a penalty for exiting the State plan to lessen the risk of adverse selection.**
  - Any local government entities that join the State plan will want to be able to review their claims experience and will also likely want to know how other participating entities affect the total risk pool. The State should share this information with the participating entities.
  - However, depending on the size of entities and how risk pools are structured, providing such claims experience information could lead to adverse selection where entities with more favorable claims experience leave, and entities with less favorable claims experience remain in the State plan.
  - To counter the risk of adverse selection, the implementation of an exit penalty on entities leaving the State plan should be considered. While an exit penalty would likely lessen the risk of adverse selection, it would not eliminate the possibility entirely.

- **If participation by local governmental entities in the State's plan is not increased after outreach efforts are performed, consider establishment of a governing body or joint healthcare committee that would allow local governmental entities to have representation and substantive input into the plan design and procurement evaluation processes for the State's health plan.**
  - A likely current impediment for local entities joining the State's plan is the local entities' lack of input in determining the State's plan design and selection of insurance carriers. Under current law and practice, DBM controls

plan design negotiations as well as the procurement and selection processes without direct involvement from any non-State local entities that may be permitted to join the State plan. If recommended outreach efforts do not result in increased participation by local entities, the majority of Task Force members recommend that local entities be allowed to include their representatives in the State's health plan design and procurement selection processes, with those representatives having substantive and meaningful input. Local entity representatives could potentially include representatives for employee groups, unions, retirees, and other stakeholders.

  - Several states have employee health plans with employee representatives on the managing body, whether it be a board of trustees, commission, or benefits committee. If the State were to pursue implementing such a body to allow local entity input into the State's health plan, the creation of a similar governing body or joint healthcare committee would likely require legislation.
  - DBM did not concur with this recommendation. DBM's Employee Benefits Division currently controls plan design negotiations, and with the recent changes to the State's procurement organization, the Department of General Services will be responsible for procuring future health benefits contracts. DBM does not believe it is the charge of the Task Force to get involved in the State's procurement process. The Secretary of DBM has broad authority for administration of the State Employee and Retiree Health and Welfare Benefits Program and to establish health insurance benefit options. It is the opinion of DBM that in meeting this fiduciary duty, DBM has provided a rich health benefits plan while controlling costs for State employees, and it is unclear what value would be added by creating a managing body in lieu of the current process that has delivered a comprehensive and affordable health plan for State employees.

- **Increase awareness of other options available to local government entities besides the State's plan, including the Local Government Insurance Trust, the Eastern Shore of Maryland Educational Consortium Health Insurance Alliance, and any other county, school board, or regional cooperative purchasing arrangements.**
  - In addition to the State's plan, local entities may not be aware of other cooperative purchasing options available to them. Presentations should be given on opportunities for cooperative purchasing of healthcare (as well as other services and commodities) at events such as MACO, Maryland Association of Boards of Education (MABE), and Association of School Business Officials (ASBO) conferences.

- **Encourage local entities to combine resources and perform their own intergovernmental cooperative procurements.**
  - While the Task Force's focus was on integration of local entities into the State's plan, some entities may prefer to combine their resources with like entities (ex. other counties; other school boards; entities within a shared geographic area) and pursue cooperative purchasing alliances to achieve reduced costs and greater efficiencies.

Regarding Nonprofit Organizations:

- **Encourage enabling legislation to support nonprofits in combining resources to form a pool of nonprofits to cooperatively purchase health benefits.**
    - From discussions in Task Force meetings, it has become apparent that nonprofits with more than 50 employees in particular are facing challenges with the costs of health care for their employees. These sized organizations are too large to take advantage of programs like the SHOP program through the Maryland Health Connection but are also too small to run their own benefit programs.
    - If a self-insured trust were able to be created, perhaps similar to LGIT but for just nonprofits, nonprofit organizations of varying sizes might be able to pool their resources to cooperatively purchase health benefits and lower the costs of health care for their employees.

- **Research other states that allow nonprofit organizations to join those states' health plans and determine how those other states remain in compliance with Internal Revenue Service (IRS) rules governing each state's governmental plan status.**
    - The issue of potentially allowing nonprofits into the State's plan while maintaining the State's governmental plan status was a sensitive topic throughout the Task Force meetings. There is the potential for significant risk to the State by allowing additional nonprofits to join the State's plan.
    - Delaware and Vermont have included a limited number of nonprofit organizations, including charter schools, in their state plans. Additional research into the inclusion of nonprofit organizations in other states' plans would be needed to determine the extent to which such inclusion would create additional risk to a state's governmental plan status.

IX. Conclusion

While there are some trade-offs to consider, pooling resources and procuring health care cooperatively may lead to cost savings and increased efficiencies for participants. If a significant portion of the Task Force recommendations are met, the State, local government entities, and nonprofit organizations could realize cost savings with more entities combining their purchasing power to benefit their employees.