MARYLAND'S SMALL GROUP HEALTH INSURANCE MARKET

SUMMARY OF CARRIER EXPERIENCE

FOR THE CALENDAR YEAR ENDED

December 31, 2001

Staff Report to the
Maryland Health Care Commission

June 21, 2002

Introduction

Pursuant to Maryland's Health Insurance Reform Act of 1993, the Health Care Access and Cost Commission (HCACC), now known as the Maryland Health Care Commission (MHCC), was responsible for developing a Comprehensive Standard Health Benefit Plan (CSHBP) as the only product that insurance carriers could sell to small employers in Maryland. The original legislation defined "small employer" as an employer with at least two but no more than fifty eligible employees. Subsequently, the General Assembly expanded the definition of small employer to include certain "groups of one," effective July 1, 1996. The CSHBP must be offered on a guaranteed issue, guaranteed renewal basis, without pre-existing condition limitations, and with rates based on adjusted community rating. The CSHBP is open to small employers all year, and to groups of one, including bona fide self-employed individuals, during defined open enrollment periods. Currently, open enrollment is June and December; however, 2002 legislation will reduce open enrollment to one month per year (Chapter 284 of 2002 [HB 1427]).

The Health Insurance Reform Act of 1993 established: (1) a benefit "floor" as the actuarial equivalent of the benefits provided by a federally qualified HMO; and (2) an income affordability "cap" on the average rate of the plan as 12 percent of Maryland's average annual wage. The Commission is responsible for measuring the average cost of the standard benefit plan to determine if the average premium is at or under the cap and, should the cap be exceeded, the MHCC must adjust the benefits or the cost sharing arrangements in the CSHBP so that the cap would not be exceeded in the future. The Commission also must monitor the number of lives covered and the number of small employers purchasing the benefit plan. Should these numbers decrease significantly in any given year, the MHCC must carefully consider all of the components of the CSHBP to determine if it is meeting the needs of small employers and their employees that the initial legislation was intended to benefit.

In order to fulfill the monitoring obligations of the Health Insurance Reform Act of 1993, the HCACC, now the MHCC, established regulations requiring small group insurance carriers to report certain financial data such as: the number of employer groups insured; the number of lives covered; the number of policies written; member months; written and earned premium; claims incurred; administrative expenses; and loss ratios. These data were collected voluntarily from insurance carriers for calendar years 1993 and 1994. However, the data were determined to be incomplete and unreliable for analysis of insurance reforms that began on July 1, 1994. With the promulgation of regulations mandating the collection of the survey data for calendar year 1995 (the first full year of implementation), and calendar years 1996 through 2001, meaningful analyses of the progress of the health insurance reforms have been established.

It should be noted that it has always been the expectation of the Maryland legislature that the measure of the cost of the CSHBP in relation to the affordability cap exclude the cost of riders since the law contains separate, specific provisions for the purchase of riders to enhance the basic benefit plan. Since the first full year requiring carriers to submit annual financial surveys on their small group business to the MHCC, carriers were reminded that the financial reporting for the

CSHBP was to exclude the premium and medical costs related to riders. For several years, the ratio to the affordability cap had a reasonable "cushion" and the impact of riders, if any, was relatively insignificant. As medical cost inflation, and its impact on premium, significantly exceeded wage inflation, this cushion seriously narrowed, causing the MHCC to increase the out-of-pocket costs to the beneficiaries in an effort to continue to meet the legislative requirements on maintaining the affordability cap. (It should be noted that any changes to the CSHBP that the MHCC makes affect the costs two years into the future).

In Spring 2000, during deliberations on changes to the benefit plan, stakeholders testified that the Commission should take steps to assure that carriers report the financial data related to the CSHBP base plan only, and exclude data on riders. Without this separate reporting, the Commission could increase a deductible (e.g., raise the pharmacy deductible from $150 to $250 per person), and experience no impact on the calculation of the relationship of premium to the affordability cap, since carriers sell riders to reduce that deductible and include the related premium costs in their financial surveys. Moreover, with premiums increasing in general, the need for precision in estimating the actual cost of the CSHBP is greater.

Throughout the study required by HB 649, *"Health Insurance – Small Group Market – Eligibility Requirements," (2000)*, and in meetings with various stakeholders and interested parties in the small group market, carriers indicated that their business software systems do not generate the separation of rider data from CSHBP premiums. Moreover, carriers claimed that little, if any, ongoing business reasons exist to justify the significant expense to implement the appropriate software upgrades to allow for separate reporting between the base plan and riders. As an alternative, carriers provided Commission staff with two methodologies to assist carriers in the calculation of the impact of riders on premium. Commission staff, along with the Maryland Insurance Administration (MIA) staff and the MHCC's consulting actuary, reviewed both algorithms. After some modifications, Commission staff distributed both methodologies to the participating carriers to use in completing their financial surveys for year ending December 31, 2000. Carriers were asked to follow the same procedures in compiling the calendar year 2001 data.

Through the use of these revised reporting methodologies, Commission staff now can measure and exclude the impact of riders from the premium in the small group market. This report includes a narrative summary of the historical carrier experience in the small group market, using the "old" methodology, where riders were not systematically separated from premiums, as well as the information on CSHBP premiums without riders calculated by the "new" methodology for 2000 and 2001. The report also compares CSHBP financial data for the two most recent years of financial data collection (calendar years 2000 and 2001), and the base year (calendar year 1995).

Monitoring the Income Affordability Cap

The Maryland Department of Labor, Licensing, and Regulation ("DLLR"), Office of Labor Market Analysis and Information calculates Maryland's average wage quarterly. DLLR's final

figures for CY 2001 should be available by late August 2002. Based on its preliminary third quarter 2001 data, DLLR provided the Commission with an estimate of the 2001 average wage. Table 1-A uses this estimate of the 2001 average wage to calculate the historical 12 percent cap. Charts 1 and 2 also show the cost of the CSHBP in relation to the 12 percent cap.

The average rate of the CSHBP is established through a formula recommended by the Commission's consulting actuaries. The recommended formula calculates the "average cost per employee." The average cost per employee is the annualized result of multiplying the average premium earned per member month by the average number of covered lives per contract.

Table 1-A: **Old Method for Calculating the Affordability Cap – *Average Wage and Average Cost, Including Riders***

	12/31/01	12/31/00	Increase <Decrease>
Maryland Average Wage	$38,329	$36,380	$1,949
12 Percent of Wage	$4,599	$4,366	$233
% Increase/year	5.36%	5.54%	(0.18%)
Avg. Cost per Employee	$4,387	$3,925	$462
% Increase/year (Decrease)	11.78%	7.59%	4.19%
% of Cap	95.37%	89.90%	5.47%

Table 1-B: **Historical Data on the Affordability Cap – Old Method, *Including Riders***

	12/31/95	12/31/00	12/31/01
Maryland Average Wage	$29,120	$36,380	$38,329
12 Percent of Wage	$3,494	$4,366	$4,599
% Increase/year	2.55%	5.54%	5.36%
Avg. Cost per Employee	$2,923	$3,925	$4,387
% Increase/year (Decrease)	(7.03%)	7.59%	11.78%
% of Cap	83.66%	89.90%	95.37%

Table 1-C: **Impact of Riders on the Average Cost of the CSHBP**

	12/31/01		12/31/00		% Increase, 2000 to 2001	
	Old Method (with riders)	*New Method (without riders)*	*Old Method (with riders)*	*New Method (without riders)*	*With Riders*	*Without Riders*
Average Cost per Employee	$4,387	$3,565	$3,925	$3,244	11.78%	9.90%
Ratio of Total Premium to Cap	95.37%	77.52%	89.90%	74.32%	6.08%	4.28%
Estimated Average Cost per Employee for Riders	$822		$681		20.70%	
Estimated % Increase to Average Cost due to Riders	23.06%		20.99%		9.86%	
Riders as a % of Total Employee Cost	18.74%		17.35%		8.01%	

Comments: Base CSHBP without Riders – "New" Method

- Calendar year 2000 was the first evaluation period with an analysis of the cost of the base CSHBP only, using MHCC specified methodologies to exclude the cost of riders that enhance benefits. As noted earlier in this report, the legislature intended the annual surveys to exclude the cost of riders that employers may have purchased, at increased premiums, to improve the CSHBP. Riders might either lower out-of-pocket costs or add health benefits for the group as a whole. As Table 1-C indicates, riders added an estimated $680 (21%) to the average cost of the base plan in CY 2000, and about $822 (23%) in 2001.

- In 2001, the average ratio of the base plan only to total premium was 81.26%. This means that riders made up 18.74% of total premium. In 2000, these ratios were 82.65% and 17.35%, respectively.

- Carriers advised Commission staff that employers purchase riders for their employees' benefit package primarily for two reasons: (1) to reduce the out-of-pocket costs for prescription drugs (i.e., to eliminate the $150 deductible per person and lower copayments); and (2) to lower the deductibles in the PPO and POS delivery systems.

- A prescription drug rider is the most prevalent and expensive rider.

- When considering that the estimated cost of the CSHBP base plan ($3,565) is at 77.50% of the affordability cap, it is important to remember that the substantial deductibles and copayments add to out-of-pocket costs in all six delivery systems.

CSHBP with Riders – "Old" Method – Historical Comparison

With data for two consecutive years of estimating the impact of riders, a comparison can now be shown for 2000 and 2001. However, the following historical analysis on the overall cost of the CSHBP is based on costs that may have included riders.

- Based on DLLR's estimate of Maryland's average annual wage, the cost of the CSHBP for calendar year 2001 met the statutory requirement of remaining less than 12 percent of the average annual wage. This is the case in both the old method calculation (with riders), at 95.37%, and the new method (without riders), at 77.52%.

- In 2001, the increase in the average cost per employee of the CSHBP (11.78%) was more than the increase in the average annual wage (5.36%). This is the fourth consecutive year where the increase in the cost of the benefit plan exceeded the wage increase. The 11.78% increase in the average cost per employee in 2001 was significantly higher than the increase in 2000, which was 7.59%.

- From the initial measurement (as of 12/31/94) through 12/31/97, the average premium, as a percentage of the 12-percent affordability cap, consistently decreased, from 92.28% in 1994 to 81.72% in 1997. Several factors contributed to this decline: wages increased more rapidly than average costs; overall medical inflation remained relatively stable; and enrollment shifted from higher cost delivery systems (indemnity and PPO) to more affordable POS and HMO plans. Then, in 1998, the premium, as a percentage of the cap, increased about one percent. By 1999, the average premium, as a percentage of the cap, increased more than five percent. Carriers increased premiums to compensate for medical inflation and to improve their loss ratios. The peaking of the medical underwriting cycle also may have contributed to this increase. In 2000, premium, as a percentage of average annual wage, increased again by 1.38%. Then, in 2001, the average premium, as a percentage of the cap increased another 5.47%. However, income also increased by more than 5 percent.

- During the CY 1999 annual review of the CSHBP, the Commission, acting on the projections made by its consulting actuary and other health care analysts, recognized the need to make adjustments to the benefit plan so that the affordability cap would not be exceeded in the near future. At that time, only data using the old method (including riders) were available. Effective July 1, 2001, the Commission increased virtually all out-of-pocket costs, copayments, and deductibles. The estimated impact of these changes was approximately an 8.4% decrease in premium. Since the bulk of policy renewals occur in the first six months of each calendar year, the actual impact of these increased out-of-pocket costs has not been incurred.

Tables 2-A and 2-B show the average cost per delivery system over time. Tables 2-C and 2-D (and Chart 3) show the average premium as a percentage of the income affordability cap.

Table 2-A: Average Cost per Employee, by Delivery System, *Including Riders*

	2001		2000		Increase	
	Avg. Cost	% of Cap	Avg. Cost	% of Cap	Average Cost	
					Amount	%
CSHBP	**$4,387**	**95.37%**	**$3,925**	**89.90%**	**$462**	**11.78%**
Indemnity	5,487	119.31	7,127	163.24	(1,640)	(23.01)
PPO	4,707	102.35	4,376	100.23	331	7.56
POS	4,191	91.13	3,820	87.49	371	9.71
TPOS	4,225	91.87	3,755	86.01	470	12.52
HMO	4,161	90.48	3,600	82.46	561	15.58

Table 2-B: Average Cost per Employee, by Delivery System, *Including Riders*: 1995, and 2000 v. 2001

	1995	2000	2001	Amount of Change, 2000 v. 2001
	Average Cost	*Average Cost, **including** Riders*	*Average Cost, **including** Riders*	
CSHBP	**$2,923**	**$3,925**	**$4,387**	**$462**
Indemnity	3,615	7,127	5,487	(1,640)
PPO	3,034	4,376	4,707	331
POS	2,814	3,820	4,191	371
TPOS	-	3,755	4,225	470
HMO	2,738	3,600	4,161	561

Table 2-C: Average Cost as a % of the Cap, by Delivery System, *Including Riders*: 1995, and 2000 v. 2001

	1995	2000	2001
	% of Cap	*% of Cap, **including** Riders*	*% of Cap, **including** Riders*
CSHBP	**83.66%**	**89.90%**	**95.37%**
Indemnity	103.46	163.24	119.31
PPO	86.83	100.23	102.35
POS	80.54	87.49	91.13
TPOS	-	86.01	91.87
HMO	78.36	82.46	90.48

Table 2-D: Average Cost as a % of the Cap, by Delivery System, *Excluding Riders*

	2001		2000		Change in Average Cost	
	Avg. Cost	% Cap	Avg. Cost	% of Cap	Amount	%
CSHBP	**$3,565**	**77.52%**	**$3,244**	**74.30%**	**$321**	**9.89%**
Indemnity	4,876	106.02	6,951	159.21	(2,075)	(29.85)
PPO	3,392	73.76	3,166	72.51	226	7.14
POS	3,346	72.75	3,168	72.56	178	5.62
TPOS	3,706	80.58	3,406	78.01	300	8.81
HMO	3,763	81.82	3,261	74.69	502	15.39

Comments

- The CSHBP permits six delivery systems: Indemnity, PPO, POS, TPOS, HMO, and PPO/MSA. The triple option point-of-service (TPOS), added as of July 1, 1996, initially enrolls the individual in a HMO plan but, at the time of service, the individual may seek service in the HMO's closed panel, elsewhere in the network or outside the network, with increasing levels of financial obligation on the part of the enrollee. The PPO offered in conjunction with a medical savings account (PPO/MSA) was added as of July 1, 1998. With this option, the individual assumes the financial risk for a high deductible, but is required to fund a portion of the risk in a tax preferred medical savings account. Since 1998, only one carrier marketed the PPO/MSA product. In 2001, this same carrier covered one employer group. Because of this limited sales activity, the financial data on the PPO/MSA delivery system is nominal and, therefore, has been excluded consistently from the financial reports.

- Outward migration from higher cost delivery systems (indemnity and PPO) to lower cost delivery systems (POS and HMO) assisted in keeping the overall average cost of

the CSHBP affordable through 1998. As depicted in Table 3-A, the total number of covered lives in the small group market decreased almost 3 percent in 2001, particularly in the TPOS and HMO delivery systems. This decline was offset by in increase of almost 9 percent in the PPO delivery system. This declining enrollment in lower cost managed care plans may have contributed to the overall increase in the average cost of the CSHBP.

- The average cost of the CSHBP (with riders) increased another 11.78% in 2001 (See Chart 4). Although significant, it should be noted that this 11.78% increase is comparable to the consulting actuary's projected increase of 11.4%. It is also important to note that without riders, the average cost of the standard plan increased by 9.89%, compared to the consulting actuary's projected increase of 5 percent.

- This 11.78 % increase in the average cost of the CSHBP in 2001 is similar to increases on the national level as well. This increase is equal to or less than increases observed in other states and in both small and large group markets. Sources attribute these increases to the shift to less restrictive and therefore more expensive delivery systems, rising corporate profits, a tighter labor market, and increased health care spending, particularly in prescription drug benefits.

- The indemnity delivery system continues to downsize and remains the most expensive, at $5,487 per employee. Indemnity plans continue to exceed the affordability cap, with premiums at 119.31% of the cap. Because of the small enrollment numbers, the averages change significantly from year to year.

- Table 2-C indicates, under the old method (with riders), average premiums across all delivery systems is at 95.37% of the cap, with average premiums for each delivery system ranging from 119.31% for the indemnity product to 90.48% of the cap for HMO plans. As depicted in Table 2-D, under the new method (without riders), average premiums for indemnity products still exceed the cap, at 106.02%. However, both the PPO and POS plans, rather than the HMO product, show the greatest distance from the affordability cap, because these delivery systems have more out-of-pocket cost sharing.

Covered Lives

The participating carriers report to the Commission the number of lives covered in the small group market, which includes employees and their dependents, within each delivery system.

Table 3-A: **Covered Lives, 2000 v. 2001**

	2001	2000	Increase <Decrease>	
			Amount	%
CSHBP	**455,762**	**468,687**	**<12,925>**	**<2.76%>**
Indemnity	307	701	<394>	<56.21%>
PPO	190,289	174,954	15,335	8.77%
POS	47,382	53,527	<6,145>	<11.48%>
TPOS	22,520	33,267	<10,747>	<32.31%>
HMO	195,264	206,238	<10,974>	<5.32%>

Table 3-B: **Covered Lives: 1995, and 2000 v. 2001**

	1995	2000	2001
CSHBP	**402,411**	**468,687**	**455,762**
Indemnity	19,982	701	307
PPO	177,258	174,954	190,289
POS	20,018	53,527	47,382
TPOS	-	33,267	22,520
HMO	185,153	206,238	195,264

Comments

- After four years of favorable growth in the small group market, the total number of covered lives declined 2.63%, from 1998 to 1999, then decreased another 1.66% in 2000, and another 2.76%, or 12,925 lives in 2001. Part of this decline may be explained by a change in the statutory definition of small employer that took effect July 1, 2000 which excluded employers with more than 50 actual full-time employees from participating in the small group market. Previously, employers with more than 50 employees were eligible to participate in the small group market under certain circumstances. The elimination of these "larger" small employer groups may have had some impact on the number of covered lives.

- The two most popular delivery systems remain the HMO and PPO products. This pattern has been consistent over the seven-year evaluation period.

- With HMOs and related managed care options continuing to encounter criticism in the media, and beneficiaries preferring more flexibility in health care coverage, HMO enrollment experienced another 5.32% decrease of 10,974 covered lives, from 206,238 in 2000 to 195,264 in 2001 (See Chart 5).

- The declining enrollment in indemnity plans continued through calendar year 2001. With only five carriers having open contracts in this delivery system, it appears that these carriers are simply renewing existing indemnity accounts and enrolling new business in other delivery systems.

- The increased enrollment in the PPO delivery system of 15,335 lives was not sufficient to offset the decreases in covered lives in all the other delivery systems.

- Enrollment in the POS delivery system increased significantly from 1997 to1998 with continued growth in 1999. In 2000, enrollment declined 27.53%, and in 2001, enrollment decreased another 11.48%, or 6,145 lives. This reduction in covered lives appears to be the result of one prominent carrier converting its POS business to its PPO business. The PPO delivery system offers enrollees more flexibility than a POS product and closely resembles an indemnity plan.

- The TPOS is a unique product that allows a beneficiary to select a provider at the time of service from three delivery systems (indemnity, PPO, or HMO). The decrease in 2001 in TPOS enrollment can be attributed to one major carrier purchasing the sole TPOS carrier in 2000, but apparently establishing priorities other than the marketing of this product.

- Although overall enrollment has declined, Table 8-A indicates that the average covered lives per policy increased slightly in 2001, (by 0.021).

- Using the estimated figures from Table 9 of this report, the number of dependents covered under a family policy in 2001 equates to approximately 2.59 dependents per policy. This figure is up slightly from the 2000 calculation of 2.57 lives.

- Although declining enrollment indicates that steps may need to be taken to make the CSHBP more affordable for individuals and families, it should be noted that overall enrollment has increased from 402,411 covered lives in 1995 to 455,762 covered lives in 2001, or a 13.26% increase in covered lives since the inception of the standard benefit plan.

Employer Groups

One of the main objectives of small group market reform and the development of a standard benefit plan was to make affordable comprehensive health insurance coverage available to small employers in Maryland, and to eliminate negative insurance practices intended to avert risk. Choice of delivery systems and price competition also were desirable goals. A significant measure of the success of small group market reform is the number of employer groups established in the market (See Chart 6).

As a result of the staff's review of the surveys submitted by carriers for calendar year 2001, several carriers notified Commission staff that their 2000 filings were in error, specifically regarding the number of employer groups reported to both the MHCC and the MIA. Table 4-A reflects the data as originally reported to the Commission (in the staff report dated June 21, 2001) for calendar year 2000 and the corrected information for 2000. The carriers indicated that the other data elements reported were correct as originally filed. Therefore, the costs of the CSHBP and their relationship to the affordability cap were not affected by the incorrect filings.

When HCACC promulgated the regulations to collect the data necessary for fulfilling its mandate to monitor the CSHBP, one of the objectives was to identify data items that were readily available to the participating carriers, so as not to place any additional regulatory burden on the carriers, while permitting staff to adequately monitor the benefit plan. These data items include: the number of employer groups insured; the number of lives covered; member months; number of certificates outstanding, (i.e., number of employees covered); and related premium and expenses. The data elements were reviewed with various members of the carrier community and the MIA. Only one item, member months, was debated since indemnity carriers basically do not use this item in their daily business, while managed care companies use this statistic regularly. Staff then provided an alternative calculation to estimate member months for those carriers that do not typically collect this information.

Since the HCACC, and now the MHCC, did not have the statutory responsibility or the funding to audit carrier data, Commission staff was limited to relying on the data as filed. Since the first year of reporting, staff issued instructions requesting carriers to report cost information based on the CSHBP only. However, it was discovered that from 1995 through 1999, carriers were reporting the cost including riders, therefore, misleadingly reflecting premiums higher than should have been reported for only the base plan. In the 2000 reporting year, Commission staff established a process to allow carriers to estimate the impact of riders on the overall cost of the CSHBP. This same process, plus the auditing of carrier submissions, is now in place. Beginning with this report on the 2001 data, the MHCC has funded an independent audit of carrier submission to reduce reporting errors, verify mechanisms for reporting and improve the accuracy of the financial survey database as a planning tool for the future. In this review, the financial submissions of the three most prominent carriers reflecting 88 percent of the small group market were audited.

Table 4-A includes the original comparison of employer groups for 1999 and 2000, as well as an updated comparison using the corrected data. Tables 4-B and 4-C compare the corrected calendar year 2000 data to the data as submitted by carriers for calendar year 2001. **The analyses that follow are based on the corrected data.**

Table 4-A: **Employer Groups, 2000 v. 1999, *as reported, 12/31/00***

	12/31/00	12/31/99	Increase <Decrease>	
			Amount	%
CSHBP	**64,835**	**58,495**	**6,340**	**10.84%**
Indemnity	97	644	<547>	<84.94%>
PPO	26,348	19,555	6,793	34.74%
POS	12,862	10,502	2,360	22.47%
TPOS	3,590	3,042	548	18.01%
HMO	21,938	24,752	<2,814>	<11.37%>
Employer Groups, 2000 v. 1999, *as corrected, 12/31/01*				
CSHBP	**53,432**	**58,495**	**<5,063>**	**<8.66%>**
Indemnity	97	644	<547>	<84.94%>
PPO	20,307	19,555	752	3.85%
POS	7,500	10,502	<3,002>	<28.59%>
TPOS	3,590	3,042	548	18.01%
HMO	21,938	24,752	<2,814>	<11.37%>

Table 4-B: **Employer Groups: 2001 v. 2000**

		Corrected	Increase <Decrease>	
	12/31/01	12/31/00	Amount	%
CSHBP	**52,237**	**53,432**	**<1,195>**	**<2.24%>**
Indemnity	43	97	<54>	<55.67%>
PPO	21,986	20,307	1,679	8.27%
POS	6,922	7,500	<578>	<7.71%>
TPOS	2,585	3,590	<1,005>	<27.99%>
HMO	20,701	21,938	<1,237>	<5.64%>

Table 4-C: **Employer Groups: 1995, and 2000 v. 2001**

	1995	Corrected 2000	2001
CSHBP	**43,595**	**53,432**	**52,237**
Indemnity	3,653	97	43
PPO	19,368	20,307	21,986
POS	1,511	7,500	6,922
TPOS	-	3,590	2,585
HMO	19,063	21,938	20,701

Comments

- From 1995 through 1999, the number of employer groups consistently increased, from 43,595 to 58,495, or 34.18%). During 2000, the CSHBP lost 5,063 employer groups (8.66%). This decline continued in 2001, with the loss of an additional 1,195 groups (2.24%). This trend seems to be consistent with what is occurring nationally, with small employers simply unable to afford the significant inflation in healthcare costs and health insurance premiums.

- Another factor negatively impacting the number of employer groups in the CSHBP is the action by a major participating carrier of ceasing its HMO participation in the small group market and its controversial decision to transfer this business into new product lines.

- About one-third of the employer group decrease between 1999 and 2000 is attributable to one major carrier. That same carrier had a decrease in employer groups between 2000 and 2001 that was greater than the losses of the entire small group market – only increases by other carriers lessened the impact of this one carrier's loss.

- Based on DLLR's report, *"Employment and Payrolls, Third Quarter 2001,"* the total number of small employers (with one to 49 employees) was estimated at more than 114,500. Therefore, more than 45% of the small employers in Maryland are offering group benefit plans to their employees.[1] This figure has increased from 40% in 1995.

- The number of employers purchasing an HMO for their employees continued to decline for the third consecutive year, by 5.64% in 2001, as compared to 11.37% in 2000 and 5.11% in 1999. This may be an indication that employers are opting for less restrictive products for their employees, albeit at a higher cost when riders are included to "buy down" copayments and deductibles. This too follows national trends, where HMO plans are losing enrollment to PPO products.

- The PPO delivery system has stemmed its losses over past years to less costly products, and now has the most employer groups of any delivery system.

[1] It should be noted that DLLR calculates the number of employer groups based on "reporting units," which they define as the actual number of establishments per employer. An employer may have more than one reporting unit; however, most employers have only one reporting unit. Other data sources, such as MEPS-IC (Medical Expenditure Panel Survey – Insurance Component) simply count each small business. This difference would tend to make the number of DLLR's reporting units greater than the number of employer groups reported by MEPS. Therefore, the estimated 45% of small employers offering group coverage in Maryland in 2001, based on DLLR's reporting units, may be understated.

Percentage of Carriers' Premium Expended on Medical Care

Insurance carriers measure the viability of a product by developing the percentage of the premium expended on medical care (referred to in this report as the loss ratio). A loss ratio of 75 percent is defined as follows: for every dollar a carrier receives in premiums, 75 cents is spent on medical care. In the small group market, and for other group health insurance products as well, the Maryland Insurance Commissioner may require a carrier to reduce its rates if the carrier's loss ratio falls below 75 percent.

Tables 5-A, 5-B, and 5-C, (and Chart 7) show comparisons of the CSHBP's loss ratios by delivery system.

Table 5-A: Loss Ratios by Delivery System, *Including Riders*: 2000 v. 2001

	12/31/01	12/31/00	Increase <Decrease>
CSHBP	**78.66%**	**81.78%**	**<3.12%>**
Indemnity	80.80	103.23	<22.43%>
PPO	78.46	78.77	<0.31%>
POS	75.48	75.67	<0.19%>
TPOS	75.38	92.91	<17.53%>
HMO	80.18	84.43	<4.25%>

Table 5-B: Loss Ratios by Delivery System, *Including Riders*: 1995, and 2000 v. 2001

	1995	2000	2001
CSHBP	**82.97%**	**81.78%**	**78.66%**
Indemnity	78.77	103.23	80.80
PPO	81.43	78.77	78.46
POS	77.68	75.67	75.48
TPOS	-	92.91	75.38
HMO	85.52	84.43	80.18

Table 5-C: Loss Ratios by Delivery System, *Excluding Riders*: 2000 v. 2001

	12/31/01	12/31/00	Increase <Decrease>
CSHBP	**78.72%**	**81.79%**	**<3.07%>**
Indemnity	77.52	103.13	<25.61%>
PPO	78.26	78.72	<0.46%>
POS	75.48	75.68	<0.20%>
TPOS	75.38	92.91	<17.53%>
HMO	80.28	84.48	<4.20%>

Comments

- Average premiums (i.e., cost per employee) rose 11.78% from 2000 to 2001, and resulted in a 3.12% decrease in the overall medical loss ratio. This signifies that carriers allocated more premium dollars to administrative expenses and profit, and less premium dollars to medical claims payments.

- The loss ratios for all five delivery systems, with and without riders, decreased in 2001. Each loss ratio was at or below 80 percent, implying that the small group insurance market should remain a viable and profitable market for carriers.

- The loss ratios for indemnity plans have been extremely volatile, due to the virtual elimination of this delivery system from the small group market. This situation appears to follow national trends.

- The loss ratios for the HMO delivery system continue to decrease, from a high point of 92.39% (in 1996) to 80.18% in 2001. HMO loss ratios consistently are one of the highest among delivery systems, reflecting the intense competition among HMOs.

- Since entering the small group market in 1997, the carrier that exclusively markets the TPOS delivery system has experienced significant financial problems, along with several ownership changes. As a result, its volume of business (both covered lives and number of employer groups) has varied from year to year. Similarly, the TPOS loss ratios also have been very erratic, ranging from 138.61% in 1997 to 75.38% in 2001. The MIA has advised Commission staff that the overall financial status of this TPOS carrier improved in 2001.

Participating Carriers

This analysis of carriers participating in the small group market is based on information included in the financial surveys submitted to the Commission indicating the number of covered lives within each delivery system. Several carriers have approved contracts with the MIA to sell the CSHBP; however, for various reasons, they are not marketing this product and cover no lives. These carriers are not reflected in this report.

Table 6-A: Number of Carriers, by Delivery System, with Covered Lives, 2000 v. 2001

Delivery System	12/31/01	12/31/00	Increase <Decrease>
Indemnity	3	6	<3>
PPO	10	12	<2>
POS	2	2	-
TPOS	1	1	-
HMO	8	9	<1>
PPO/MSA	1	1	-
Total Number of Carriers [2]	14	18	<4>

Table 6-B: No. of Carriers by Delivery System with Covered Lives: 1995, and 2000 v. 2001

Delivery System	1995	2000	2001
Indemnity	23	6	3
PPO	24	12	10
POS	7	2	2
TPOS	-	1	1
HMO	18	9	8
PPO/MSA	-	1	1
Total Number of Carriers	37	18	14

[2] Total number of carriers is less than the sum in each year because some carriers are in multiple delivery systems.

Comments

- In spite of continued reduction of participating carriers in the small group market, employers still have a variety of choices within a delivery system, except for indemnity plans.

- The decrease by four in the total number of participating carriers is a result of three indemnity and PPO carriers finalizing their business in the small group market and one HMO going out of business entirely in 2001 (See Chart 8).

- Twelve of the 14 participating carriers in the small group insurance market offer coverage in all four geographic areas of the state.

Prominent Carriers

To ascertain who are the prominent carriers in the small group market, carriers that insured approximately 5 percent of the total lives or 10 percent of the lives in any one particular delivery system were identified. This analysis is based on a consistent 12 carriers, defined historically, even though some carriers, (particularly indemnity carriers) are no longer in the market.

Table 7-A: Prominent Carriers, by Delivery System, 2000 v. 2001

Delivery System	% of Business in 2001	% of Business in 2000	Increase <Decrease>
Indemnity	83.71%	92.01%	<8.30%>
PPO	93.69%	93.13%	0.56%
POS	100.00%	100.00%	-
TPOS	100.00%	100.00%	-
HMO	87.18%	91.47%	<4.29%>
Total	**91.86%**	**93.69%**	**<1.83%>**

Table 7-B: Prominent Carriers: 1995, and 2000 v. 2001

Delivery System	% of Business in 1995	% of Business in 2000	% of Business in 2001
Indemnity	73.14%	92.01%	83.71%
PPO	93.67%	93.13%	93.69%
POS	72.00%	100.00%	100.00%
TPOS	-	100.00%	100.00%
HMO	79.75%	91.47%	87.18%
Total	**80.27%**	**93.69%**	**91.86%**

Comments

- Prominent carriers slightly decreased their dominance in coverage in the small group market, from 93.69% of the business in 2000 to 91.86% of the business in 2001. This decrease is a result of the overall decrease in the number of covered lives for one prominent carrier across all delivery systems (See Chart 9).

- Two major carriers increased their combined share of the small group market, to more than 80% in 2001, compared to their 70% share of the market in 2000.

Average Covered Lives per Policy

The formula to calculate the average cost of the CSHBP, that was recommended by consulting actuaries and approved by the original Commission, is sensitive to the number of covered lives per policy (or the contract between the carrier and the employee). As the MHCC continues to regulate changes to the plan, the impact on the affordability of dependent coverage is of concern.

Table 8 (and Chart 10) displays the average number of covered lives per policy by delivery system.

Table 8-A: Average Covered Lives per Policy, by Delivery System, 2000 v. 2001

	2001	2000	Increase <Decrease>
CSHBP	**1.824**	**1.803**	**0.021**
Indemnity	1.943	1.744	0.199
PPO	1.867	1.863	0.004
POS	1.782	1.848	<0.066>
TPOS	1.913	1.954	<0.041>
HMO	1.785	1.722	0.063

Table 8-B: Average Covered Lives per Policy, by Delivery System: 1995, and 2000 v. 2001

	1995	2000	2001
CSHBP	**1.751**	**1.803**	**1.824**
Indemnity	1.522	1.744	1.943
PPO	1.721	1.863	1.867
POS	1.832	1.848	1.782
TPOS	-	1.954	1.913
HMO	1.801	1.722	1.785

Comments

- Table 8 reveals that the average covered lives per policy increased from 1.803 in 2000 to 1.824 in 2001, the first increase since 1997.

- Using 2001's total number of policies as a basis (i.e., 249,813), the 0.021 increase between 2000 and 2001 in average covered lives represents 5,246 lives.

- With the exception of indemnity plans, which have experienced wide variations due to such small enrollment, the TPOS delivery system continues to insure the highest average number of covered lives per policy of all delivery systems.

Estimated Number of Covered Lives by Family Composition

Table 9 estimates the number of covered lives by family composition. As mentioned earlier in this report, the number of dependents covered under a family policy in 2001 equates to approximately 2.59 dependents per policy, up slightly from 2.57 in 2000.

Table 9: Estimated No. of Covered Lives by Family Composition, 1995, and 2000 v. 2001

Type of Policy	*1995*	*2000*	*2001*
Employee(s):			
Individual	135,175	153,497	146,329
Employee + 1	36,506	41,278	39,040
Family	58,184	65,193	64,444
Total	**229,865**	**259,968**	**249,813**
Dependent(s):			
Individual	-	-	-
Employee + 1	36,506	41,278	39,040
Family	135,740	167,441	166,909
Total	**172,246**	**208,719**	**205,949**
Total Covered Lives	**402,111**	**468,687**	**455,762**

Comments

- Table 9 indicates that, since 1995, employee coverage in the small group insurance market has increased about 19,948 (from 229,865 in 1995 to 249,813 in 2001). However, this number has declined from its peak of 265,819 in 1998.

- Similarly, since 1995, dependent coverage in the small group insurance market has increased about 33,703 (from 172,246 in 1995 to 205,949 in 2001). This figure also has decreased from its peak of 223,654 in 1998.

- Table 8-A indicates that the increase in the average covered lives per policy of 0.021 represents an estimated increase of 5,246 lives, implying that, overall, there are fewer employees being covered but, of those covered employees, there are more dependents.

- Because the number of covered employees declined by 3.91% between 2000 and 2001, but the number of covered dependents only declined by 1.33%, over the same time period, the average covered lives per policy increased (by 0.021).

How Does Maryland's Small Group Market Compare to Similar Markets in Other States?

During the 2001 legislative session, the General Assembly passed HB 695, *"Health Insurance – Study of Maryland's Small Group Market,"* requiring the Commission to contract with an independent consultant to conduct a study comparing Maryland's small group health insurance market reform law to other states, based on a comparative analysis of benefits and rating factors. In September 2001, Health Management Associates (HMA) was selected to conduct this study, with Elliot K. Wicks, Ph.D. as the Project Director.

Dr. Wicks completed the study entitled, "*Assessment of the Performance of Small-Group Health Insurance Market Reforms in Maryland"* on February 19, 2002, and presented his findings to both the House Economic Matters Committee and the Senate Finance Committee during the 2002 legislative session.

In the report, Dr. Wicks compared Maryland's small group market reforms and performance with six other states: Colorado, Delaware, Florida, New Jersey, North Carolina, and Virginia, with a comparison to the United States as a whole also. Dr. Wicks concluded that the benefits offered in Maryland's CSHBP are comparable to those offered in other states. Out-of-pocket costs tend to be higher, but mental health benefits and emergency room copayments are lower, and the prohibition of pre-existing condition limitations is more generous. He also concluded that, in terms of the benefits offered in the standard plan, it does not appear that any significant changes are necessary. However, one of the recommendations in his report was to redevelop the CSHBP entirely every five years, rather than adding benefits or modifying out-of-pocket costs during each annual review.

Research from this study also revealed that a large reduction in premium would need to occur before a significant number of small employers who are presently uninsured would purchase a group health plan for their employees. However, the research also concluded the corollary: that relatively large increases in premium that many small employers nationwide are currently experiencing is not necessarily resulting in small employers dropping their group health coverage.

As a result of these and other findings, Dr. Wicks developed five recommendations relating to the benefit structure and rating factors used in the CSHBP. Below is a brief description of each recommendation and the efforts Commission staff is taking to address the suggested changes.

1. *The MIA, in consultation with the MHCC, should develop a plan to more effectively market the rate guide to small employers purchasing the CSHBP.*

In January and July of each year, the MIA publishes a rate guide to assist small employers in selecting an insurance carrier. (It should be noted that the MIA publishes this document on a voluntary, not a mandatory basis). The rate guide includes the estimated annual rates for all six delivery systems, broken down into four geographic areas: the Baltimore metropolitan area; the Washington, D.C. metropolitan area; western Maryland; and eastern/southern Maryland, based on a hypothetical group of 10 employees. The rate guide also includes a list of carriers participating in the small group insurance market, including their addresses and telephone numbers. Dr. Wicks suggested that the rate guide be redesigned so that it is easier to understand, and more widely publicized so as to be more useful to small employers and consumers. Staff of both the MIA and the MHCC have discussed this recommendation and have agreed to work together to simplify the rate guide and market it more efficiently.

2. *The MIA, in conjunction with the MHCC, should develop a process to ensure that health insurers are informing small employers about the availability and costs of the CSHBP base plan only, including premium rates for the standard plan that are separate from the premium rates relating to riders.*

When the CSHBP was originally developed in 1993, the Standard Benefit Plan Task Force held meetings throughout the State to hear testimony from a diverse group of interested parties and stakeholders to conscientiously design a comprehensive benefit package, while maintaining costs within a statutorily set limit of 12 percent of Maryland's average annual wage. As required by law, participating carriers are required to market the standard base plan, but are allowed to sell riders that can enhance but not diminish the benefit package. MIA and MHCC staff are currently working on implementing the recommendation as suggested by Dr. Wicks.

3. *The MHCC should revisit the package of benefits and the cost sharing arrangements included in the CSHBP and redesign the standard plan, at least every five years.*

Presently, the Commission conducts an annual review of the CSHBP, starting with an analysis of the annual carrier financial surveys in June, followed by a public hearing in September to allow interested parties to present testimony on proposed changes to the standard plan, and concluding with the final report on proposed changes to the CSHBP in November, with the Commission

adopting any changes it deems necessary. Using this approach, incremental changes to the plan are addressed, based on the consulting actuary's projection of the overall cost of the CSHBP in relation to the 12 percent affordability cap. Commission staff will be working with the Commission to address Dr. Wicks's suggestion to revisit the entire benefit package at least every five years.

4. *The MHCC should not change its rating rules currently enforced in regulation.*

Commission staff agrees with this recommendation and will advise the Commission to take no action to alter the current rating rules in the CSHBP.

5. *The MHCC should change the current open enrollment policy offered to self-employed individuals in the small group insurance market from two times per year to one time per year.*

During the 2002 legislative session, the General Assembly passed HB 1427, *"Health Insurance – Small Group – Open Enrollment Period,"* incorporating Dr. Wicks's recommendation into the law. Effective October 1, 2002, only one open enrollment period per year will be offered to self-employed individuals in the CSHBP.

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6/10/2002

MARYLAND HEALTH CARE COMMISSION

Maryland's Small Group Market

Summary of Carrier Experience

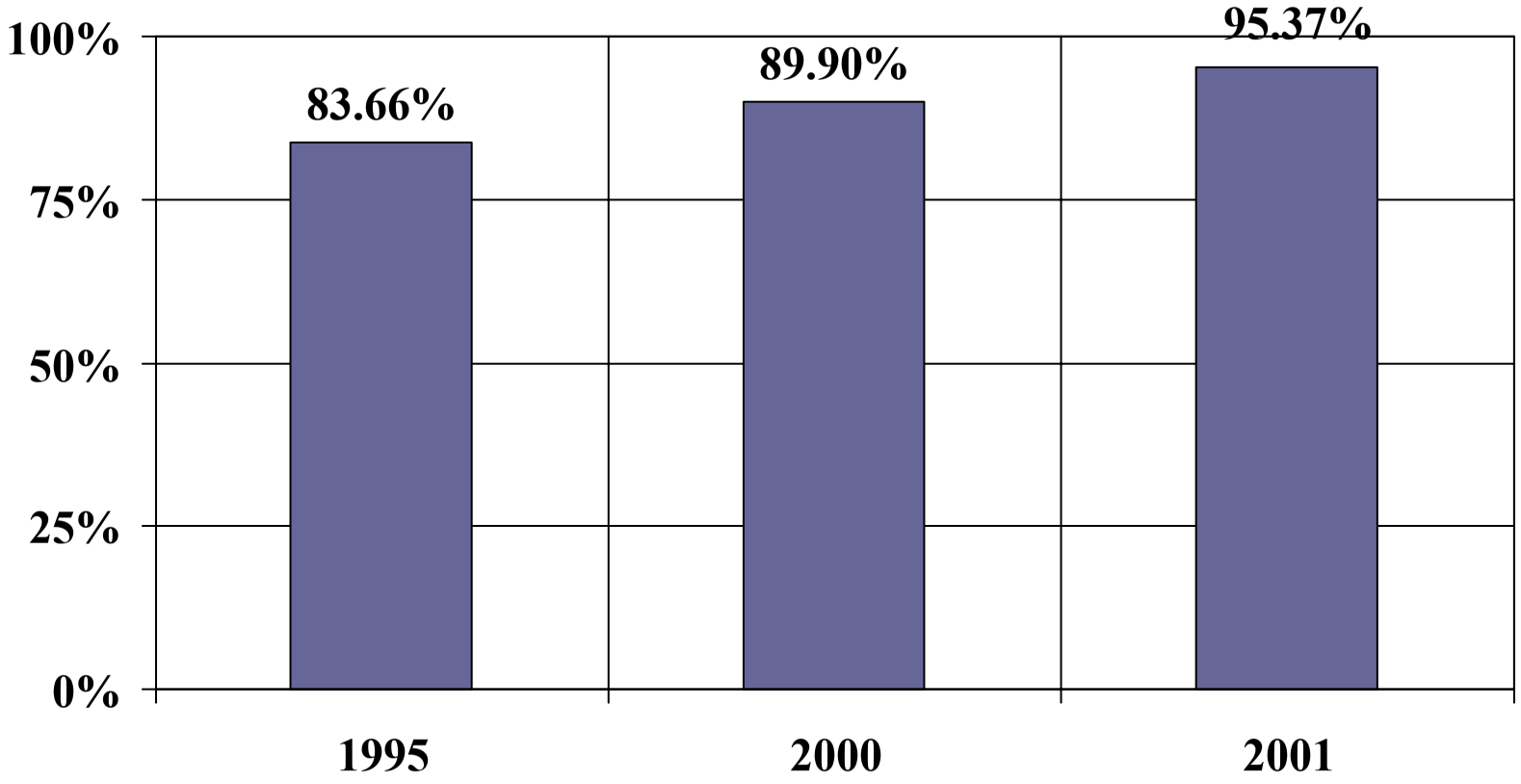
for the Calendar Year ended

December 31, 2001

June 21, 2002

Chart 1

Cost of the CSHBP (with riders) in Relation to 12% Cap 1995; 2000-2001



Cost of the CSHBP in Relation to 12% Cap with Riders vs. without Riders, 2001

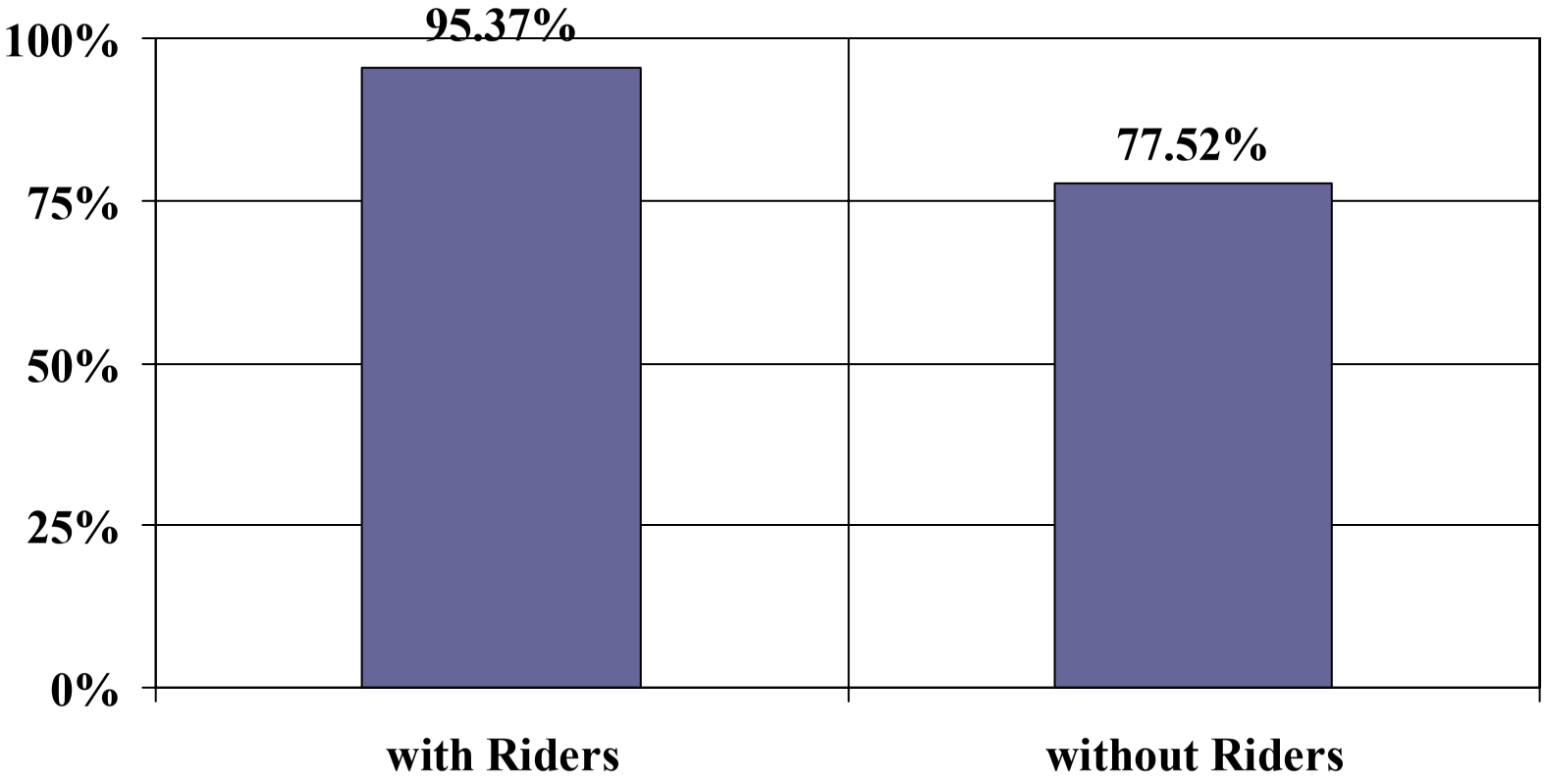
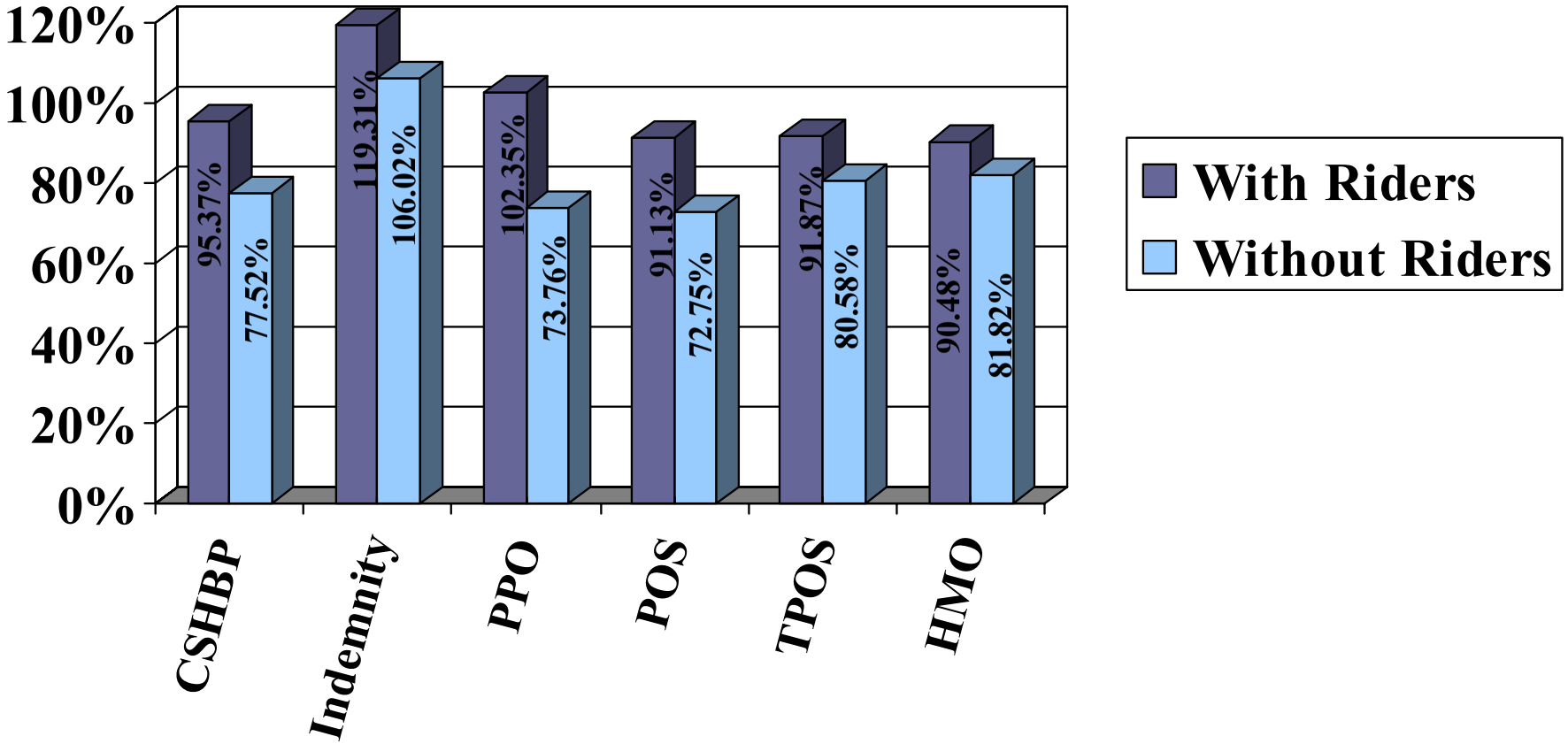


Chart 3

Cost of the CSHBP in Relation to 12% Cap with Riders vs. without Riders by Delivery System, 2001



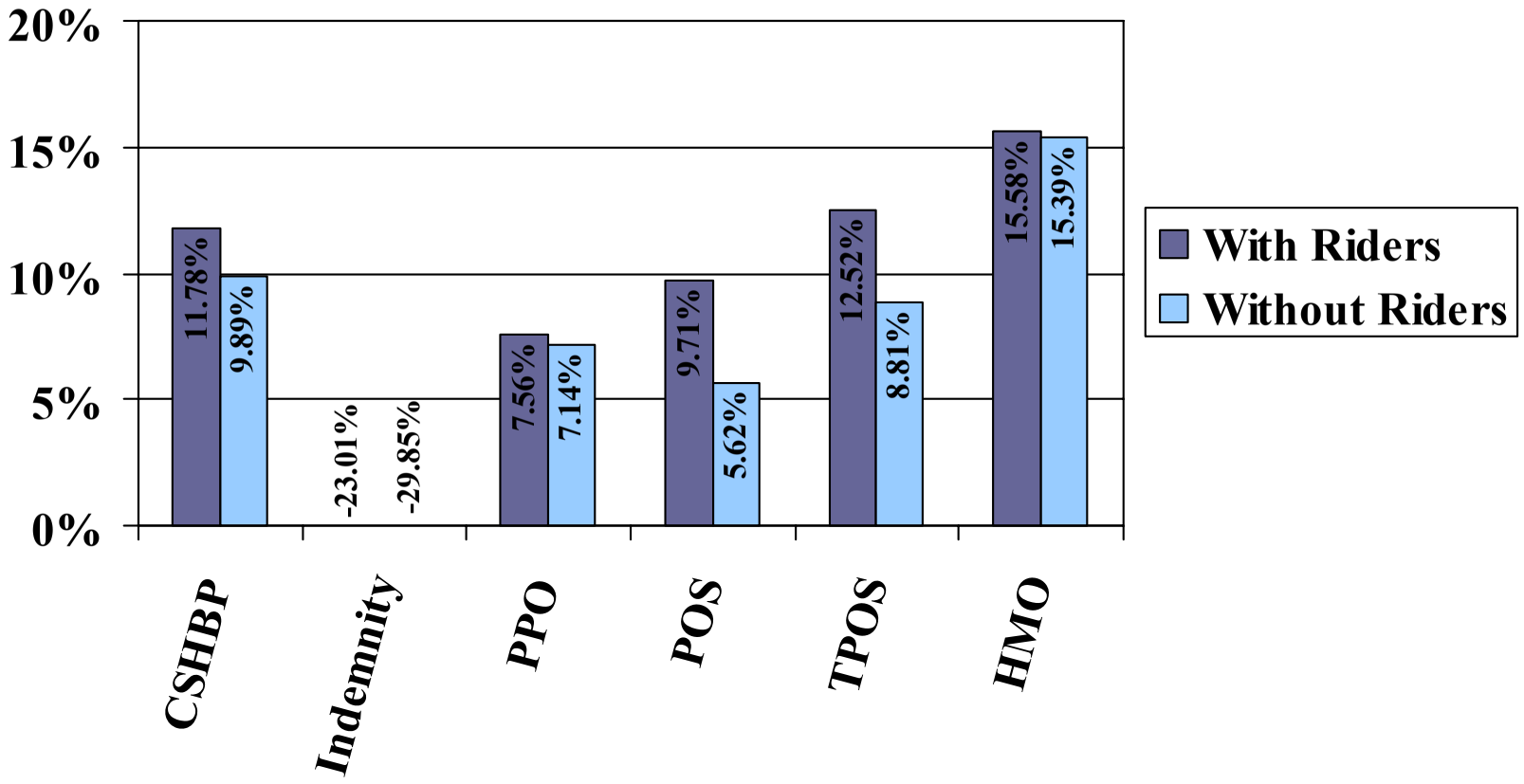
Source: MHCC's Summary of Carrier Experience

Chart 4

Average Cost by Delivery System

Percentage of Increase, with riders vs. without riders

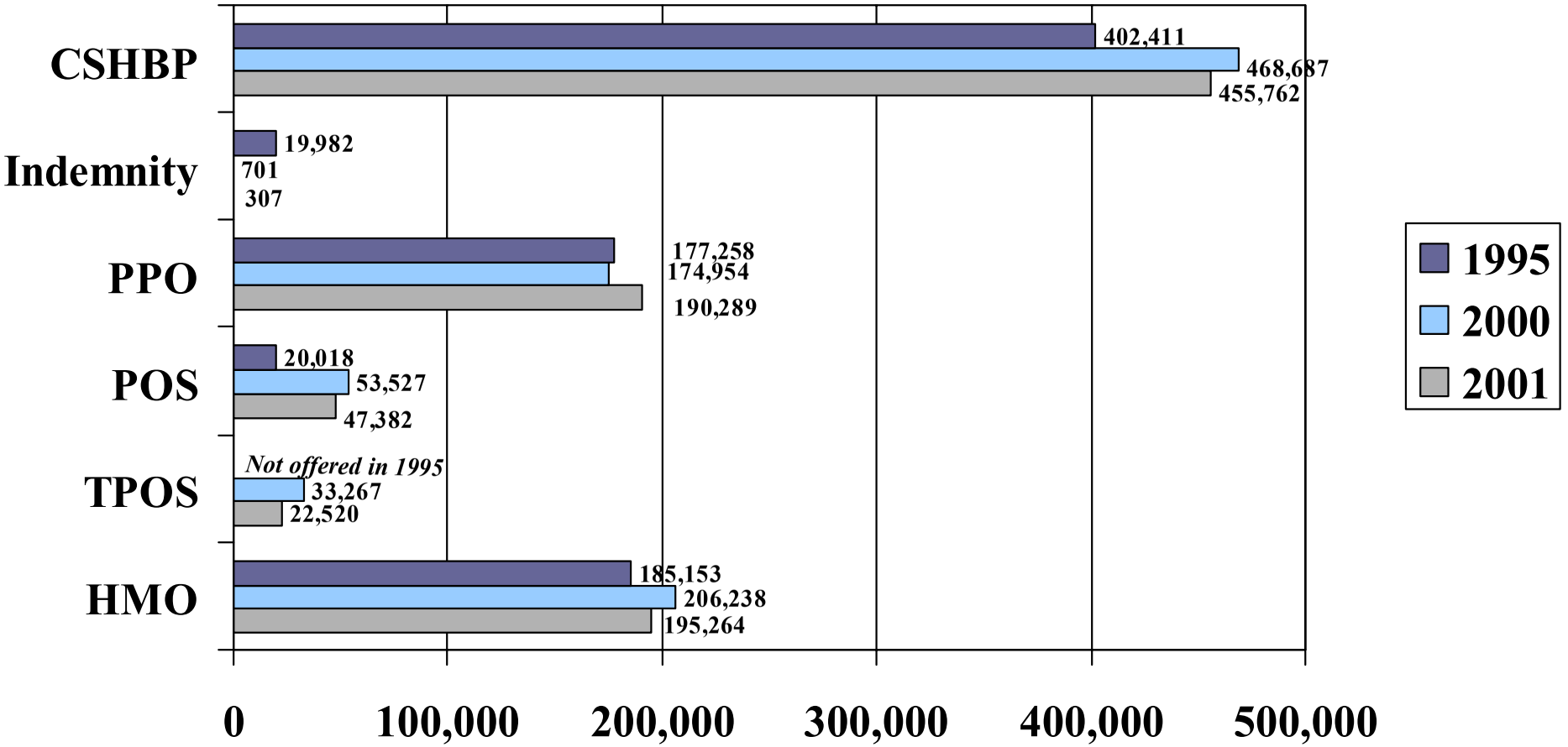
2000-2001



Source: MHCC's Summary of Carrier Experience

CSHBP Covered Lives By Delivery System 1995; 2000-2001

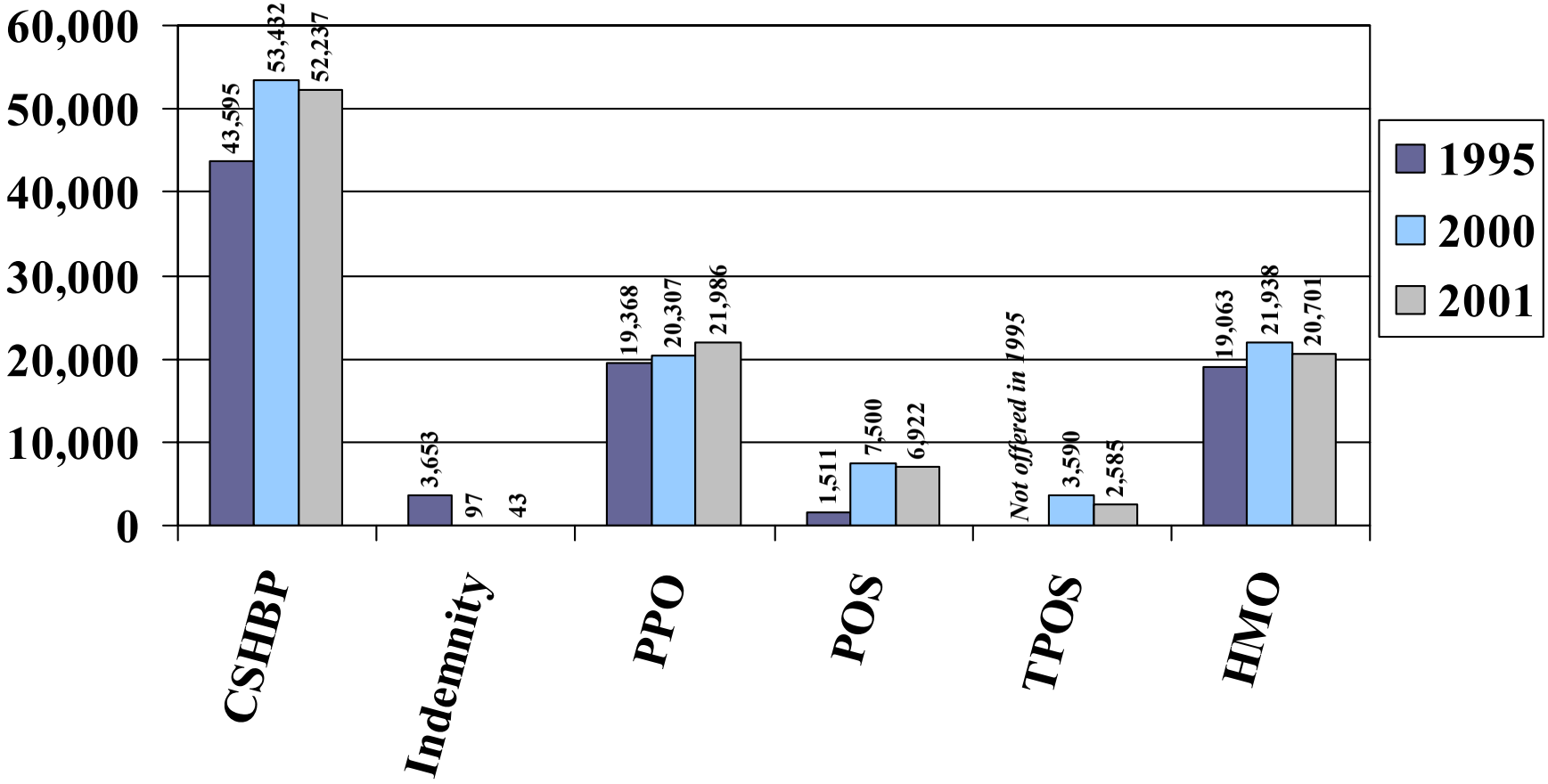
Chart 5



Source: MHCC's Summary of Carrier Experience

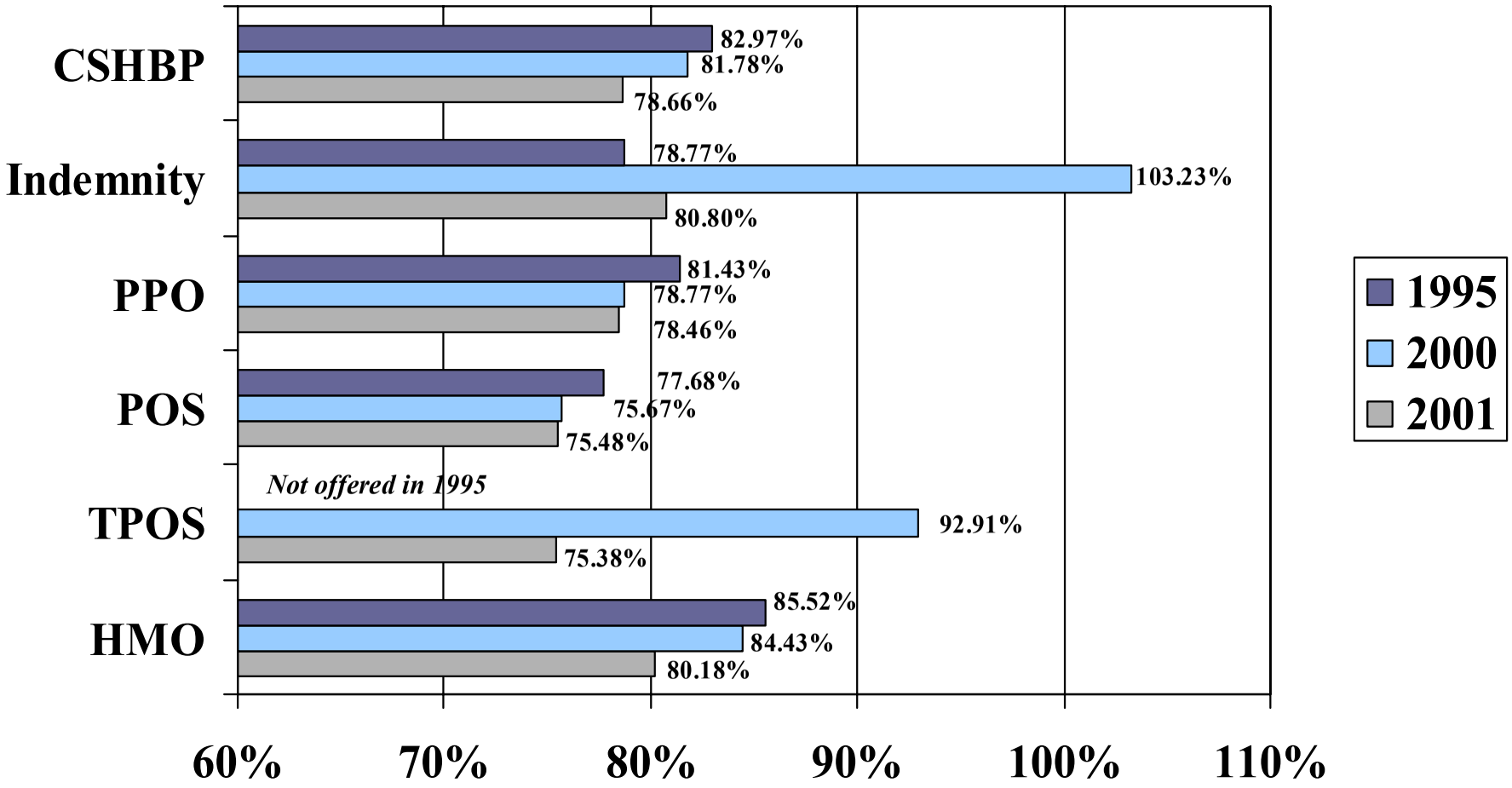
Chart 6

CSHBP Employer Groups
By Delivery System
1995; 2000-2001



Source: MHCC's Summary of Carrier Experience

Loss Ratio By Delivery System
1995; 2000-2001



Source: MHCC's Summary of Carrier Experience

Number of Carriers by Delivery System With Covered Lives, 1995;2000-2001

Delivery System	*1995*	*2000*	*2001*
Indemnity	23	6	3
PPO	24	12	10
POS	7	2	2
TPOS	-	1	1
HMO	18	9	8
PPO/MSA	-	1	1
Total # of Carriers	**37**	**18**	**14**

Source: MHCC's Summary of Carrier Experience

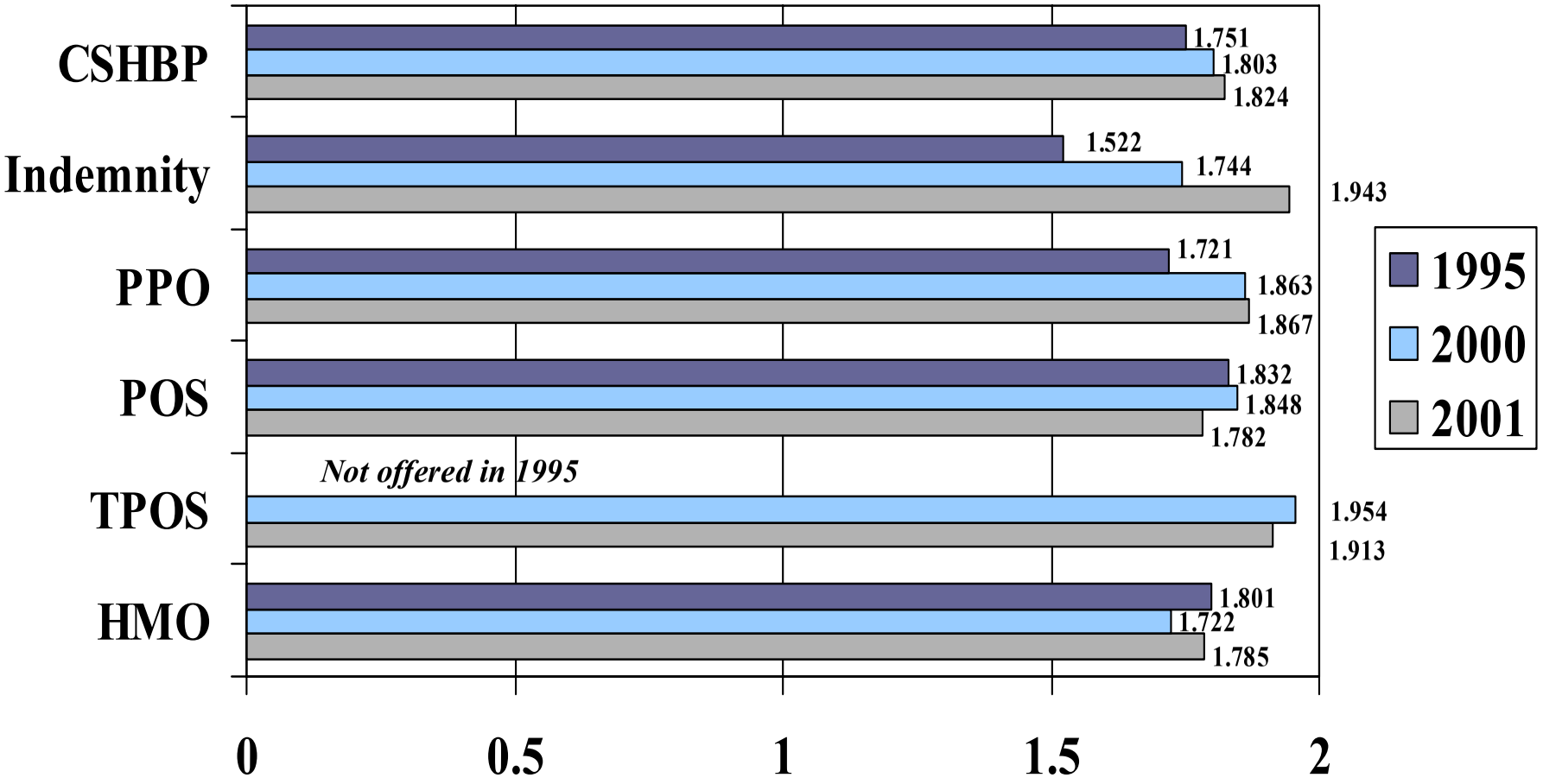
Prominent Carriers, 1995; 2000-2001

Delivery System	*% of Business in 1995*	*% of Business in 2000*	*% of Business in 2001*
Indemnity	73.14%	92.01%	83.71%
PPO	93.67%	93.13%	93.69%
POS	72.00%	100.00%	100.00%
TPOS	-	100.00%	100.00%
HMO	79.75%	91.47%	87.18%
Total	**80.27%**	**93.69%**	**91.86%**

Source: MHCC's Summary of Carrier Experience

Chart 10

Average Covered Lives per Policy by Delivery System 1995; 2000-2001



Source: MHCC's Summary of Carrier Experience

Conclusions

1) CSHBP premium is within affordability cap by either "old method" (with riders) or "new method" (without riders)
2) For the second consecutive year, riders constitute a substantial part of premium (18.74%) particularly for PPO and POS plans
3) Increases in CSHBP premium (11.78%) are comparable to increases in small and large group markets elsewhere
4) Decline in number of covered lives (2.76%), and number of employer groups (2.24%)
5) Still choice of carriers, but concentration of carriers is continuing