INSURANCE ADMINISTRATION

Final Report on the Use of Medical Stop-Loss Insurance in Self-Funded Employer Health Plans in Maryland

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Commissioner

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FINAL REPORT ON THE USE OF MEDICAL STOP-LOSS INSURANCE IN SELF-FUNDED EMPLOYER HEATLH PLANS IN MARYLAND

Executive Summary

During the 2015 Regular Session, the Maryland General Assembly enacted House Bill 552, Chapter 494 ("Chapter 494"),[1] entitled Health Insurance-Medical Stop-Loss Insurance-Small Employers. Chapter 494 requires the Maryland Insurance Administration ("MIA") to conduct a study of the use of medical stop-loss insurance ("MSLI") in self-funded employer health plans in the State and report to the Senate Finance Committee and the House Health and Government Operations Committee ("Committees") on its findings and recommendations.[2] Specifically, Chapter 494 requires the MIA to submit an interim report, which was previously submitted,[3] and to submit a final report. This final report summarizes the MIA's findings and recommendations on the use of medical stop-loss insurance in self-funded employer health plans in the State ("Report"). In order to complete this Report, the MIA solicited information from stakeholders, conducted a survey of industry, researched other state laws, and reviewed relevant literature.

Maryland has the third highest specific attachment point compared to other states and the District of Columbia. Its aggregate attachment point, however, is comparable to other states. Research revealed that medical cost inflation and deductible erosion will continue to be an issue affecting MSLI premium rates. According to the MIA's study, in order to encourage small employers to continue to offer affordable and meaningful group health insurance to their employees, employers must have options at various price points. Further, an employer's decision to exit the fully-insured market in favor of self-insurance is complex, as is its decision to procure MSLI. Finally, without certain MSLI-related consumer protection laws, employers may be subjected to higher premium rates for certain individual high-cost employee claimants.

The MIA recommends that Maryland:

- maintain its current statutory attachment points;
- continue to monitor the effects of medical cost inflation;
- maintain its current disclosure requirements; and
- maintain its current consumer protections.

The MIA intends to continue to provide open-forum informational meetings for stakeholders on the topic of MSLI policies. The MSLI policy is one of the most crucial elements of a self-insured plan and the MIA is committed to ensuring that employers remain fully informed of the risks and rewards and consumers remain fully protected.

[1] *See*, Exhibit 1.
[2] Effective January 1, 2016, Employers with 51-100 employees were defined as small employers under the Affordable Care Act ("ACA"). The Protecting Affordable Coverage for Employees Act ("PACE Act"), enacted on October 7, 2015, however, accorded states the option of expanding the definition of a small employer. The definition of a small employer in Maryland did not change and is defined, among other things, as an employer that employs not more than 50 employees.
[3] *See*, Exhibit 2 and http://insurance.maryland.gov/Consumer/Appeals%20and%20Grievances%20Reports/2016-Interim-Medical-Stop-Loss-Report.pdf

I. Introduction

During the 2015 Regular Session, the Maryland General Assembly enacted House Bill 552, Chapter 494 ("Chapter 494"). Chapter 494, Health Insurance-Medical Stop-Loss Insurance-Small Employers, required the Maryland Insurance Administration ("MIA") to conduct a study comprised of 12 tasks on the use of medical stop-loss insurance ("MSLI") by self-funded employer health plans in the State. Further, Chapter 494 required the MIA to report its findings and recommendations to the Senate Finance Committee and the House Health and Government Operations Committee. Specifically, Chapter 494 required the MIA to submit an interim report, which was previously submitted and to submit a final report. This final report summarizes the MIA's findings and recommendations on the use of MSLI in self-funded employer health plans in the State ("Report").

Defining a Small Employer in Maryland

At the time Chapter 494 was enacted, there was an urgency to collect certain information concerning employers with 51-100 employees. This was based on the fact that effective January 1, 2016, the Affordable Care Act ("ACA") would define an employer having 2 to 100 employees as a small employer. As a result of the Protecting Affordable Coverage for Employees Act ("PACE Act"), enacted on October 7, 2015, however, states were given the option to expand the definition of a small employer. The definition of a small employer in Maryland remains the same. Had Maryland determined to expand the definition, however, the issue was whether these affected employers would exit the insured market and become self-insured and purchase MSLI. The definition of a small employer in Maryland did not change and is defined, among other things, as an employer that employs not more than 50 employees.

Medical Stop-Loss Insurance

MSLI is defined under Maryland law as "insurance, other than reinsurance, that is purchased by a person, other than a carrier or health care provider, to protect the person against catastrophic, excess, or unexpected losses incurred by that person's obligations to third parties under the terms of a health benefit plan." (Md. Code Ann., Ins. § 15-129.) MSLI indemnifies an employer that has chosen to self-fund the health benefit plan offered to its employees once health care expenses reach a certain dollar amount. At a certain dollar amount, called an "attachment point", the employer is no longer responsible for paying its employees' health care expenses. Rather, the MSLI carrier assumes responsibility for payment once the attachment point is reached. There are two attachment points: a specific attachment point and an aggregate attachment point. The specific MSLI attachment point is defined as the dollar amount over which the employer-policyholder is reimbursed in the event one employee generates medical claims in excess of the specified dollar amount during the contract period. An aggregate MSLI attachment point is an employer-policyholder's overall dollar limit of claim liability during the policy's term.

A History of Medical Stop-Loss Insurance in Maryland

The regulation of MSLI policies in Maryland began as a result of complaints received by the MIA shortly after the enactment of the 1993 Maryland Health Insurance Reform Act ("Reform Act"), known generally as "Small Group Reform." Prior to this time, rates charged to different small employers varied based on the experience of the group. As a result, many small businesses were unable to procure insurance. Small Group Reform established requirements for employers with 2 to 50 employees including guaranteed issue, guaranteed renewability, modified community rating, and a standard benefit package.

Thereafter, the MIA received complaints alleging that some insurers were selling MSLI policies with very low specific attachment points. At that time, it was the MIA's position that policies with low attachment points were being used as a substitute for health insurance. In order to protect consumers, reduce unfair competition in the insurance market, and implement the public policies expressed in Small Group Reform, the MIA promulgated Code of Maryland Regulations ("COMAR") 09.31.02 requiring specific and aggregate attachment points of $10,000 and 115% of the expected claims for all participants, respectively. According to the regulation, an MSLI policy need not contain both types of attachment points, but the attachment point which it does contain must meet the minimum requirements of the regulation. Further, an MISL policy which did not satisfy the minimum requirements of the regulation was deemed a standard health insurance policy, required by Maryland law to provide the benefits required by the comprehensive standard health benefit plan established by the Reform Act.

The regulation was challenged and the Fourth Circuit held that the regulation was preempted by the Employee Retirement Income Security Act of 1974 ("ERISA"), a federal statute regulating private employee benefit plans. According to the Court, by deeming an MSLI policy with attachment points at levels inconsistent with the requirements of the regulation as a standard health insurance policy, the regulation specifically intended to affect an employee benefit plan, could not be "saved," and was preempted by ERISA. The Fourth Circuit also stated, however, "[t]his is not to say that Maryland may not regulate stop-loss insurance policies. Such regulation is clearly reserved to the states." *AMS Inc. v. Bartlett*, 111 F.3d 358, 365 (4th Cir. 1997).

In 1999, House Bill 1086 (Chapter 683, Acts of 1999) was enacted and provided that an insurer may not issue, deliver, or offer a policy or contract of stop-loss insurance if the policy had a specific attachment point of less than $10,000 or an aggregate attachment point of less than 115% of expected claims.[4] In 2008 the MIA sponsored House Bill 272 - Medical Stop-Loss Insurance. In the MIA's written testimony before the Senate Finance Committee, the MIA testified that it had received 11 complaints from employers and employees regarding the failure of a non-admitted medical stop-loss insurer to reimburse claims. Since the carrier was non-admitted, the MIA's only recourse was to refer the matter to the U.S. Department of Labor.[5] House Bill 272 (Chapter 264, Acts of 2008) addressed this issue by replacing the definition of "stop-loss insurance" with "medical stop-loss insurance" and prohibiting the sale of an MSLI policy by an unauthorized carrier.[6]

In 2015, House Bill 552, as initially proposed, increased the specific attachment point from $10,000 to $40,000 and raised the aggregate attachment point from 115% to 125% of expected claims for MSLI. During her testimony,[7] the bill's sponsor stated that House Bill 552 was in response to the ACA's redefinition of a small employer from one that employed 2-50 employees to one that employed 2-100 employees, effective January 1, 2016, and its possible adverse effect on the small group market. Effective January 1, 2016, Employers with 51-100 employees would have been redefined as small employers under the ACA. The Protecting Affordable Coverage for Employees Act ("PACE Act"), enacted on October 7, 2015, however, amended the ACA and accorded states the option of expanding the definition of a small employer. The definition of a small employer in Maryland remained the same.

[4] *See*, http://mgaleg.maryland.gov/1999rs/bills/hb/hb1086e.pdf for a copy of HB 1086.
[5] *Medical Stop-Loss Insurance, Hearing on House Bill 272 before the Senate Finance Committee* , 2008 Leg., 425th Sess. (Md. 2008) (written testimony of the Maryland Insurance Administration).
[6] *See* http://mgaleg.maryland.gov/2008rs/chapters_noln/Ch_264_hb0272T.pdf
[7] *See*, http://mgahouse.maryland.gov/mga/play/fb0f72861c3b4dd1beb2cd358209e937/?catalog/03e481c7-8a42-4438-a7da-93ff74bdaa4c&playfrom=13896132

As enacted, House Bill 552 (Chapter 494, Acts of 2015) changed the specific attachment point for MSLI to $22,500 and the aggregate attachment point to 120%, effective June 1, 2015. The attachment points required in Chapter 494 do not apply to MSLI policies issued before June 1, 2015 as long as the policy maintains a specific attachment point of $10,000 and an aggregate attachment point of 115% of expected claims. In addition, Chapter 494 established certain protections and prohibitions for MSLI policies issued to a small employer group and required the MIA to conduct this study and issue this Report. Chapter 494 took effect June 1, 2015 and sunsets on June 30, 2018.

II. Chapter 494

In response to the 12 tasks the MIA was asked to study under Chapter 494, which are listed below, the agency researched and analyzed baseline data, including sample data, reviewed other state data and secondary resources, and solicited written and verbal feedback from interested parties.

(1) Health Benefit Plans
   (i) The types and costs of health benefit plans, including self-insured plans, offered in the State by employers with 2 to 50 employees and employers with 51 to 100 employees;
   (ii) For self-insured plans, the individual and aggregate attachment points of medical stop-loss insurance purchased;
   (iii) The number of plan designs and carriers available in the small employer market, including market share by carrier, and the number of plan designs and carriers available in the market for health benefit plans utilizing medical stop-loss insurance, including market share by medical stop-loss carrier;

(2) Contiguous State Plan Comparison: An overview of the employer health plan market in contiguous states, including the percentage of fully insured employer health plans and self-insured employer health plans utilizing medical stop-loss insurance;

(3) Large Employer Estimate: An estimate of the number of employers with 51 to 100 employees whose health benefits plans would change from the large group to the small group market in 2016, as a result of the change in the size of the small group market required by the federal Affordable Care Act;

(4) Legal Requirements: An analysis of statutory and regulatory requirements for medical stop-loss insurance in other states and the experience of states the requirements of which are different from those in Maryland;

(5) NAIC[8] Recommendations: A review of any guidance, recommendations, or model legislation regarding medical stop-loss insurance by the National Association of Insurance Commissioners or other groups;

(6) Incentives and Disincentives: Identification of any incentives and disincentives beginning in 2016, associated with the purchase of health insurance in the small group market compared to self-insurance with the purchase of medical stop-loss insurance, for both employers with 2 to 50 employees and employers with 51 to 100 employees;

[8] National Association of Insurance Commissioners.

(7) Comparison Risk Profile: A comparison of the risk profile of small employers that self-insure and the risk profile of small employers that purchase health insurance in the small group market;

(8) Impact on Small Group Market: An assessment of the impact on the stability and viability of the small group market, including the possibility of adverse selection and higher premiums, resulting from employers:

a. Choosing to self-insure instead of purchasing health insurance in the small group market; and
b. After self-insuring, switching to small group market;

(9) Maryland Health Benefit Exchange: An assessment of any impact on the Maryland Health Benefit Exchange of small employers choosing to drop coverage for their employees;

(10) Attachment Points: An assessment of different attachment points for medical stop-loss insurance, the effect that medical inflation could have on the attachment points in statute, and the desirability of maintaining or adjusting the current statutory levels;

(11) Consumer Protections: An assessment of the consumer protections in medical stop-loss insurance policies and contracts and the desirability of maintaining or adjusting the current statutory consumer protections; and

(12) Impact on Local Governments and Small Employers: An assessment of the impact on local governments and small employers of any changes to the attachment points or consumer protections in medical stop-loss insurance policies and contracts.

III. MIA Study

Overall Methodology

The MIA solicited information from numerous stakeholders including carriers offering fully-insured plans and those offering MSLI in Maryland, employers utilizing fully-insured health plans, employers utilizing self-funded plans in conjunction with stop-loss insurance, insurance producers, third party administrators, consumers and consumer advocates, the Office of the Attorney General, members of the Maryland Association of Counties, the Maryland Municipal League, and the Maryland Association of Bankers. As required by the study, the MIA held a public informational hearing on the topic of MSLI and invited stakeholders and other interested parties to attend and provide written comments.[9] In addition to the September 28, 2015, MSLI public meeting, the MIA held eight town hall meetings throughout the State during the summer of 2015 inviting all interested parties to provide written and verbal comments on the health insurance market in Maryland, including changes to MSLI.

[9] *See*, http://insurance.maryland.gov/Documents/newscenter/legislativeinformation/Medical-Stop-Loss-Hearing-Transcript.pdf for a copy of the transcript of the public hearing
See, http://insurance.maryland.gov/Documents/newscenter/legislativeinformation/Medical-Stop-Loss-Hearing-Comments.pdf for the written comments.

Methodology and Findings by Task:

Task (1)(i)
An analysis of baseline data, including sample data, where appropriate:
(i) on the types and costs of health benefit plans, including self-insured plans, offered in the State by employers with 2 to 50 employees and employers with 51 to 100 employee.[10]

The Insurance Commissioner is authorized under Maryland law to regulate a MSLI carrier and policy, but is not authorized to regulate an employer's self-funded health benefit plan. Unlike the fully-insured market, the Commissioner cannot require an employer to submit its self-funded health plan contract and rates for review. As a result, the MIA was unable to collect information on the types and costs of self-funded health benefit plans and the number of plan designs available within the self-funded health plan market. Therefore, the MIA requested certain information directly from the MSLI carriers through a data call and survey letter ("Data Call and Survey Letter"). [11]

The Survey requested information for policies issued between June 1, 2014 and May 31, 2015, and was mailed to 69 carriers that have MSLI products approved in the State. Specifically, the Survey requested information regarding minimum group size, number of MSLI policies issued, specific and aggregate attachment points, number of covered lives, number of plan designs, and total annual premiums. The MIA also asked the MSLI carriers to provide specific information regarding medical underwriting and the types of documentations carriers require employers to complete. The number of plan designs available by carriers is considered to be the standard set of benefits or coverages.

The top ten MSLI carriers, by number of MSLI policies issued during the Survey period, were also asked to provide quotes for an MSLI policy if they offered the type of self-funded benefit plan described which included medical stop-loss coverage.[12] In order to compare the cost of an MSLI policy in the small group self-insured market, the MIA created two sample small employers to be used by each MSLI carrier in its pricing model. The MIA requested that each MSLI carrier provide eight different quotes based on two different Standard Industry Codes ("SIC") and four different geographic areas.[13] The sample data included employer zip code, SIC code, employee age, number of dependents, and dependent ages. The MIA requested pricing based on specific attachment point of $10,000 and an aggregate attachment point of 115%[14] of expected claims as well as pricing based on a specific attachment point of $22,500 and an aggregate attachment point of 120% of expected claims.

The design of the plan was based on the CareFirst BlueChoice HMO HRA/HSA $1500 plan, the largest plan in the small group market based on enrollees in the first quarter of 2014 in Maryland. The request for quoting in the self-insured marketplace was mailed to carriers who offer MSLI to small group employers.

[10] Since the definition of a small employer did not change, the MIA did not survey employers with 51 to 100 employees. See Bulletin 15-27 dated October 8, 2015.
[11] *See*, Exhibit 3.
[12] *See*, Exhibit 4.
[13] The two SIC codes were business consulting and contracting-roofing. The four different geographic areas in Maryland were Baltimore City, Salisbury, Hagerstown, and Silver Spring.
[14] Chapter 494 provides that a policy or contract of medical stop-loss insurance issued or delivered before June 1, 2015 may maintain specific attachment points of no less than $10,000 and an aggregate attachment point of no less than 115%. Policies issued or offered after June 1, 2015 are subject to the higher attachment points of $22,500 and 120%.

Scenario 1: Specific stop-loss $10,000 and aggregate factor of 115% of expected claims (Effective date-5/1/2016)	**Scenario 2:** Specific stop-loss of $22,500 and aggregate factor of 120% of expected claims (Effective date- 5/1/2016)
1. SIC: 8748 Business consulting GEOGRAPHIC AREA: Baltimore City, 21215	2. SIC: 8748 Business Consulting GEOGRAPHIC AREA: Baltimore City, 21215
3. SIC: 8748 Business Consulting GEOGRAPHIC AREA Salisbury, 21801	4. SIC: 8748 Business Consulting GEOGRAPHIC AREA: Salisbury, 21801
5. SIC: 1761 Contracting-Roofing GEOGRAPHIC AREA: Hagerstown, 21740	6. SIC: 1761 Contracting-Roofing GEOGRAPHIC AREA: Hagerstown, 21740
7. SIC: 1761 Contracting-Roofing GEOGRAPHIC AREA: Silver Spring, 20909	8. SIC: 1761 Contracting-Roofing GEOGRAPHIC AREA: Silver Spring, 20909

Of the carriers surveyed, only one carrier was able to provide the MIA with pricing quotes for all eight scenarios. The other nine carriers reported that they were unable to provide the pricing information for the specifications outlined because they did not currently sell a similar plan and therefore did not have pricing available. The pricing information for the one MSLI carrier that responded shows a consistent pattern across each scenario for that company's quotes. The monthly premium for each insured decreased as the specific attachment point increased from $10,000 to $22,500. On the other hand, the monthly premium for each insured increased as aggregate attachment points increased from 115% to 120% of expected claims per employee per month. This is consistent throughout all eight scenarios regardless of SIC codes or geographic areas.

While not specifically requested, the MIA also surveyed MSLI carriers to determine how many MSLI policies had been issued to self-funded small employers and large employers between June 1, 2014 and May 31, 2015. There were 378 MSLI policies issued to self-funded employers having 2-50 workers, accounting for 39.92% of the self-funded market. There were 140 MSLI policies issued to self-funded employer groups with 51-100 workers, accounting for 14.78% of the market. Finally, there were 429 MSLI policies issued to self-funded employer groups with more than 101 employees, accounting for the remaining 45.30% of the market.

Task (1)(ii)
An analysis of baseline data, including sample data, where appropriate;
(ii) for self-insured plans, the individual and aggregate attachment points of medical stop-loss insurance purchased;

As previously stated, there were 378 MSLI policies issued to self-funded employers having 2-50 workers, accounting for 39.92% of the self-funded market. Both specific and aggregate attachment points are illustrated below. The specific attachment points ranged from $10,000 to $125,000 and the aggregate attachment points ranged from 115% to 150%.

Small Group Employers (2-50 Employees)

Specific Attachment Point Range for 2 to 50 Employees	Aggregate Attachment Point Range
$15,000	125%
$25,000	125%
$15,000 - $55,000	115%-125%
$30,000.00	115%
$10,000 - $20,000	125%
$15,000 - $50,000	115%
$45,000 - $80,000	125%
$45,000	125%
$100,000	125%
$25,000	115%-125%
$30,000 - $125,000	125%
$35,000	120%
$45,000	125%
$10,000 - $25,000	115%
$50,000 - $60,000	N/A
$10,000 - $30,000	125%
$10,000 - $50,000	120%-150%
$20,000 - $60,000	N/A

Large Group Employers (51-100 employees):

Of the 69 MSLI carriers surveyed, 14.78% (140 policies) of the total MSLI policies issued or renewed during the period were issued in the large group employer market. The specific and aggregate attachment points are illustrated below. The specific attachment points ranged from $15,000 to $500,000 while the aggregate attachment points ranged from 115% to 125%.

Specific Attachment Point Range for 51 to 100 Employees	Aggregate Attachment Point Range
$15,000	125%
$75,000	125%
$50,000	125%
$45,000	125%
$20,000 - $175,000	115%-125%
$25,000 - $50,000	125%
N/A	115%
$30,000 - $85,000	120-130%
$60,000 - $125,000	125%
$50,000	125%
$30,000 - $70,000	120%-125%
$35,000 - $60,000	120%-125%
$40,000 - $65,000	125%
$150,000 - $500,000	N/A
$40,000 - $65,000	125%
$30,000-$50,000	125%
$20,000.00	125%
$25,000 - $125,000	N/A
$55,000	125%

Task (1)(iii)
An analysis of baseline data, including sample data, where appropriate:
(iii) the number of plan designs and carriers available in the small employer market, including market share by carrier, and the number of plan designs and carriers available in the market for health benefit plans utilizing medical stop-loss insurance, including market share by medical stop-loss carriers.

Thirty-nine percent of the MSLI carriers surveyed offer unlimited plan design. Other companies responded that they offer various plan designs. One company reported that it does not negotiate on an employer by employer basis, but that employers may choose from a standard set of benefits and plan designs.

Plan Designs in Small Group Employer Markets

Plan Designs available	Total number of Plan Designs	Availability in the Small Group Employer Market
Unlimited	27	13
1	2	2
3	1	1
136	1	1
Employers can pick from a standard set of benefits. Plan designs are not negotiated on an employer by employer basis.	1	1
A number of optional plan design features that an employer can choose from in order to create their self-funded plan is available. The plan design is done on an employer by employer basis, but company would not consider assistance with an unlimited number of plan designs. The distinct potential plans an employer may ultimately choose exceeds 100,000.	1	1

The pricing information and pricing received from the MSLI carriers is anecdotal. Task one does not require a pricing comparison. Any attempt to compare pricing in the small group self-insured market versus the fully-insured market based on sample scenarios is not reliable. A more reliable methodology would require actual claims experience, pricing from third-party administrators ("TPAs"), and other components that make up the cost of self-insuring.

Market Share By Carrier For the Self-Insured Market Based on the number of MSLI Policies Issued during the Survey Period:

Carrier's Name	Total Market Share
Ace American Insurance Company	0.21%
Aetna Life Insurance Company	2.85%
All Savers Insurance Company	6.44%
Amalgamated Life Insurance Company	0.11%
American Alternative Insurance Corporation	0.63%
American Fidelity Assurance Company	0.53%
Arch Insurance Company	0.11%
Berkley Life and Health Insurance Company	0.32%
CareFirst of Maryland, Inc.	5.28%
Cigna Health and Life Insurance Company	20.80%
Coventry Health and Life Insurance Company	0.21%
Everest Reinsurance Company	0.32%
Fidelity Security Life Insurance Company	6.76%
Gerber Life Insurance Company	1.69%
Group Hospitalization and Medical Services, Inc.	0.74%
HCC Life Insurance Company	4.44%
HM Life Insurance Company	3.70%
National Health Insurance Company	0.11%
Nationwide Life Insurance Company	0.42%
Pan-American Life Insurance Company	0.32%
Reliance Standard Life Insurance Company	0.32%
ReliaStar Life Insurance Company	2.53%
Standard Security Life Insurance Company of New York	2.96%
Sun Life Assurance Company of Canada	4.12%
Symetra Life Insurance Company	5.07%
The Union Labor Life Insurance Company	1.06%
Time Insurance Company	4.44%
Transamerica Life Insurance Company	1.48%
Transamerica Premier Life Insurance Company	2.22%
Trustmark Life Insurance Company	11.40%
Unimerica Insurance Company	4.96%
United HealthCare Insurance Company	3.27%
Zurich American Insurance Company	0.21%
33 companies	**100%**

Market Share By Carrier For the Small Group Fully-Insured Market:

Carriers in the small group market	Market Share
Aetna Health Inc.	2%
Aetna Life Insurance Co.	3%
CareFirst BlueChoice Inc.	59%
CareFirst of Maryland Inc.	2%
Evergreen Health Cooperative	10%
Group Hospitalization and Medical Services Inc. (A CareFirst Company)	7%
Kaiser Foundation of Health Plan of the Mid-Atlantic States Inc.	3%
MAMSI Life and Health Insurance Co. (A UnitedHealthCare Company)	5%
Optimum Choice (A UnitedHealthCare Company)	3%
UnitedHealthCare Insurance Co.	5%
UnitedHealthCare of the Mid-Atlantic	1%
	100%

Task (2):
An overview of the employer health plan market in contiguous states, including the percentage of fully insured employer health plans and self-insured employer health plans utilizing medical stop-loss insurance.

The MIA contacted Delaware, Pennsylvania, Virginia, West Virginia, and DC. Virginia, Pennsylvania, and DC each reported that it did not collect this information. Delaware and West Virginia did not respond.

Task (3):
An estimate of the number of employers with 51 to 100 employees whose health benefits plans would change from the large group to the small group market in 2016, as a result of the change in the size of the small group market required by the federal Affordable Care Act.

During its 2016 ACA rate review, the MIA surveyed carriers in the State's fully-insured market requesting information from those employers having 51 to 100 employees. In 2015 there were 1,556 employers with 51-100 employees. As previously discussed, the definition of small employer in Maryland remained the same. Therefore, these 1,556 employers are still considered large employers in the State.

Task (4):
An analysis of statutory and regulatory requirements for medical stop-loss insurance in other states and the experience of states the requirements of which are different from those in Maryland.

An analysis was conducted of state requirements for the following categories of consumer protection provisions in existing medical stop-loss legislation:

- Minimum policy standards
- Risk transfer
- Disclosure
- Rate review

The NAIC's "Stop-Loss Coverage Chart" from the Compendium of State Laws on Insurance Topics, which was last updated in May 2015, provided a multi-jurisdiction analysis of state stop-loss laws. Twelve states and two territories, Puerto Rico and the Virgin Islands, have no stop-loss laws. The stop-loss laws of thirty-two states remain the same since the 2015 NAIC survey was completed. Some states, however, had enacted consumer protection requirements that were not identified in the 2015 NAIC chart. The updated findings reflect changes from May 2015 to May 2016. Alabama was not included in the NAIC survey.

Since the NAIC's 2015 update, there were six states plus DC that made changes to their medical stop-loss legislation regarding consumer protection. All increased an attachment point and now require a disclosure. Two states now specifically prohibit lasering.[15] For example,

- California increased its individual attachment point to $40,000;
- Colorado increased its individual attachment point to no lower than $20,000, prohibited lasering, required an actuarial certification on an annual basis, and required multiple written disclosures from the MSLI carrier to the employer;
- The District of Columbia enacted legislation establishing a $40,000 individual attachment point and a 120 percent aggregate attachment point, prohibited lasering and midyear cancellations and non-renewals except for non-payment or insolvency, and required a minimum 30-day cancellation and non-renewal notice from the MSLI carrier;
- Maryland enacted legislation increasing the specific attachment point to $22,500 and the aggregate attachment point to 120% (although pre-June 1, 2015 policies may be grandfathered in at the lower attachment points) and required MSLI carriers to provide small employers with a completed disclosure form as specified by the Code of Maryland Regulations 31.10.43.03.
- Missouri reserves the right to an actuarial analysis;
- New Jersey's individual attachment point increased to a minimum of $25,000 while its aggregate attachment point remained unchanged; and
- Tennessee reduced its specific attachment point to $10,000 and its aggregate attachment point changed to 120%.

Task (5):
A review of any guidance, recommendations, or model legislation regarding medical stop-loss insurance by the National Association of Insurance Commissioners or other groups.

The MIA reviewed various sources[16] including the NAIC's "*Stop Loss Insurance, Self-Funding, and the ACA"* ("NAIC White Paper") which was adopted in 2015. The 2015 NAIC White Paper is the most recent comprehensive review of stop-loss insurance regulation. It calls attention to the provisions and regulations that vary by state for MSLI policies.

[15] If an employee is a known risk, an MSLI carrier may require an employer to accept a higher attachment point for that employee because he or she is expected to exceed the attachment point set for the rest of the members of the group. This practice is known as "lasering."
[16] *See*, Exhibit 5.

While self-insuring permits an employer to pre-determine the amount of risk it is able to assume and at what dollar amount it should transfer that risk to the MSLI carrier, there are a number of other factors that must be taken into consideration. For example, the variations among policies, gaps in coverage, and regulations. These factors lead many employers with a self-funded health benefit plan to contract with a TPA to administer medical and prescription claims for employees, to utilize the TPA's network, and to include stop loss insurance.

Task (6):
Identification of any incentives and disincentives beginning in 2016, associated with the purchase of health insurance in the small group market compared to self-insurance with the purchase of medical stop-loss insurance, for both employers with 2 to 50 employees and employers with 51 to 100 employees.

As previously discussed, the definition of a small employer in Maryland did not change as a result of the PACE Act, and is defined, among other things, as a group of not more than 50 employees. Therefore, the MIA's identification of incentives and disincentives associated with the purchase of health insurance in the small group market compared to self-insuring with the purchase of MSLI focuses only on employers having 2 to 50 employees.

Purchasing a small group health benefit plan may be less costly, administratively less burdensome, and more beneficial for both employers and employees. Providing a fully-insured small group health benefit plan may entitle certain eligible employers to a small employer health care insurance tax credit and a medical loss ratio rebate. Moreover, a fully-insured small group health benefit plan contains the essential health benefits and the protections afforded under the ACA. Finally, the insurer, not the small employer, assumes the financial risk and administrative responsibility for providing those benefits.

Rates for the fully-insured small group market, however, increased 3.3 percent overall in Maryland for 2017, leading some small employers to question whether the time has come to exit the fully-insured market in favor of sponsoring a self-insured health benefit plan for their employees. Employers who sponsor self-insured health benefit plans for their employees assume the risk of claims directly and are responsible for managing the claims payments. These employers typically contract with a TPA to outsource the administration of the benefit plan and with an MSLI carrier to discharge the financial liability at a pre-determined attachment point. The higher attachment points permitted by Chapter 494, as of June, 2015, increase an employer's share of the risk. Predicting future risk and liability is typically accomplished by observing historical performance. Absent historical performance and sound assumptions, a small employer choosing to self-insure could experience claim fluctuation and unexpected costs up to and beyond the attachment points possibly leading to an increase in future MSLI premium rates.

On the other hand, self-insured plans are not subject to the ACA's essential health benefit requirements leading to more flexibility in benefit design, and are not subject to the risk adjustment and risk pooling requirements. Self-funded benefit plans are exempt from state insurance regulation and are not subject to the Maryland mandated benefits. Self-funded plans are, however, subject to federal regulation under ERISA, the Health Insurance Portability and Accountability Act, and the ACA. Self-funded plans often have very few minimum coverage requirements and plans are not subject to rate regulation.

Task (7):
A comparison of the risk profile of small employers that self-insure and the risk profile of small employers that purchase health insurance in the small group market.

It was determined that a comparison of the risk profile of small employers that self-insure and the risk profile of small employers that purchase health insurance in the small group market would entail an disproportionate expenditure of resources at the MIA in the time allotted. To do so would require the acquisition and analysis of health plan documents, claims data, and additional information from TPAs.

Task (8):
An assessment of the impact on the stability and viability of the small group market, including the possibility of adverse selection and higher premiums, resulting from employers (i) choosing to self-insure instead of purchasing health insurance in the small group market; (ii) after self-insuring, switching to the small group market.

The NAIC White Paper provides a comprehensive assessment of the impact of stop-loss insurance on the stability and viability of the small group market, including the possibility of adverse selection and higher premiums, resulting from employers attempting to self-insure and then subsequently switching to the small group market. When Chapter 494 was enacted, there was concern that large employers with 51-100 employees with good claims experience, once redefined as small employers, would either choose to sponsor a self-insured health benefit plan for its employees or terminate its self-insured health benefit plan due to high claims experience and enter the small group market. Since Maryland employers with 51-100 employees will continue to be considered large employers, it does not appear that the market will experience an impactful movement by "small" employers which would result in adverse selection that would affect the stability and viability of Maryland's small group market.

Task (9):
An assessment of any impact on the Maryland Health Benefit Exchange of small employers choosing to drop coverage for their employees.

Neither the MIA nor the MHBE routinely collects data regarding whether applicants had prior coverage, whether their last coverage was group coverage, or whether they lost coverage due to an employer dropping coverage. In light of this lack of information, the MIA developed another data call and survey letter[17] to collect information from carriers participating in the Maryland small group market in 2015. Although a subsequent data call letter was anticipated, it was not issued in 2016 because, as previously discussed, the definition of a small employer in Maryland did not change.

The MIA asked whether a carrier collected data regarding the reason why a small employer terminated their health benefit plans with the carrier. Only three carriers, representing 9.7 percent of the Maryland small group market, of the 13 carriers participating in the Maryland small group market in 2015 collected this data. One carrier reported that 605 employers terminated their fully-insured health benefit plan coverage between December 30, 2014 and July 1, 2015. Of these 605 terminating employers, 496 moved their coverage to a different carrier, while 109 dropped coverage for their employees. A second carrier reported that 37 employers terminated their health benefit plan coverage between December 30, 2014 and July 1, 2015. Of these 37 terminating employers, 10 moved their coverage to a different carrier, 12 dropped coverage for their employees, and 15 were unknown. The third carrier reported that 54

[17] *See*, Exhibit 6.

employers terminated their health benefit plan coverage between December 30, 2014 and July 1, 2015. Of these 54 terminating employers, 20 moved their coverage to a different carrier, two dropped coverage for their employees, and 32 dropped their coverage for a number of reasons. Of the 32 that dropped coverage, two are no longer in business, 14 employers failed to pay premiums, 12 employers changed to a different market segment, and four employers had no remaining members.

None of the carriers tracked data regarding whether the employees who lost coverage purchased individual coverage via the MHBE. Employees losing coverage have the option of purchasing directly from a carrier in the individual market, enrolling under a spouse's group coverage, or not purchasing coverage. The data provided indicated that the majority of employers did not drop coverage for their employees, but rather changed carriers. The three carriers that provided data in response to the survey, however, did not represent the majority of the Maryland small group market. Therefore, one cannot assume that the data described above is representative of the Maryland small group market. As previously discussed, Maryland employers employing 51-100 employees will continue to be defined as large employers. Therefore, there does not appear to be any evidence that the MHBE will experience a major shift in enrollees due to small employers terminating their fully-insured employer sponsored health benefit plans.

Task (10):
An assessment of different attachment points for medical stop-loss insurance, the effect that medical inflation could have on the attachment points in statute, and the desirability of maintaining or adjusting the current statutory levels.

Attachment Points

The MIA compared Maryland's specific attachment point to 27 states and DC and determined that Maryland's specific attachment point is higher than average. Generally, specific attachment points ranged from $10,000 to $40,000. Maryland has the third highest specific attachment point at $22,500. Only California, New Jersey, and DC are higher. Nine states have specific attachment points at $20,000. The remaining nine states have specific attachment points at $10,000. Some state laws do not include a specific attachment point and instead require that an actuary calculate these dollar amounts annually.[18]

There is more consistency among states regarding aggregate attachment points. Maryland and 17 other states plus DC have aggregate attachment points of 120% of anticipated claims, while six states have aggregate attachment points of 125%, and one state has an aggregate attachment point of 85% of anticipated claims. The remaining three states have established various stipulations that must be satisfied to determine the authorized attachment point.

Medical Inflation

As previously discussed, MSLI policies have two different attachment points, also known as deductibles: a specific attachment point and an aggregate attachment point. MSLI premium rates vary, among other things, by the dollar amount of the attachment points. During the past 16 years, employer-sponsored health benefit plan insurance premium rates increased by as much as 203%. A review of the medical inflation-related literature indicates that medical inflation rates continue to increase by double digits, exceeding the general inflation rate. The MIA consulted several medical inflation-related sources.[19] Medical inflation rates are driven by increases in hospital and specialty drug costs and other

[18] *See*, Exhibit 7.
[19] *See*, Exhibit 8.

factors influencing healthcare costs including taxes, increasing regulations, and lawsuits. These factors affect MSLI premium rates and lead to "deductible erosion" as illustrated in the following example.

> If we assume a $100,000 specific attachment point and a $120,000 claim, the resulting reimbursement is $20,000. If the specific attachment point remains at $100,000 and the medical inflation rate for the following year is 12%, then the same claim would be $134,400. As a result, the MSLI policy reimbursement would increase to $34,400 which is a 72% increase. Therefore the 12% increase in the medical inflation rate results in a 72% increase in the MSLI payment.

Medical inflation is one factor that causes MSLI premium rates to increase more rapidly than the general inflation rate. Raising the self-insured employer's deductible or attachment point may be more cost effective for the employer than maintaining the same attachment point and paying an increased MSLI premium rate that exceeds the medical inflation cost. Medical inflation is anticipated to continually increase resulting in higher claim payments by MSLI carriers and higher premium rates.

> *Task (11):*
> *An assessment of the consumer protections in medical stop-loss insurance policies and contracts and the desirability of maintaining or adjusting the current statutory consumer protections.*

In addition to reviewing the NAIC White Paper, the MIA conducted a review of each state's consumer protections added in the past two years.[20] The NAIC White Paper specifically addressed regulatory options to protect policyholders, consumers, and health care providers. Some of the options suggested by the NAIC included minimum policy standards, risk transfer, disclosure, and rate review. In their minimum policy standards, 25 states include consumer protection provisions regarding lasering, licensing, or various other policy provisions. Sixteen states require certain disclosures which predominantly cover the cancellation of a policy. Six states include provisions concerning risk transfer, and two states include provisions concerning rate review. The states with the most consumer protections recently added are Utah, (6), Colorado (4), New York (3) , South Carolina (3), Pennsylvania (3) and Maryland (2).

Minimum policy standards are suggested as an option to protect employers and to ensure consistency among MSLI policies. One of the key minimum standards suggested is a prohibition on "lasering". "Lasering" is defined by the NAIC as "assigning different attachment points or deductibles, or denying coverage altogether, for an employee or dependent based on the health status of the individual." Other minimum policy standards suggested are provisions regarding mid-term rate increases and the payment of claims.

Maryland Consumer Protections

Chapter 494 prohibits "lasering", requires guaranteed rates for at least 12 months without adjustment, and requires MSLI carriers to pay stop-loss claims which are incurred during the policy period and which are submitted within 12 months after the expiration date of the policy. Chapter 494 also requires the MSLI carrier to provide a disclosure, in a form approved by the Commissioner, to the small employer prior to entering into the contract. The disclosure includes the total cost of the MSLI policy, the dates on which the policy takes effect and terminates, the provisions for renewing the policy, the aggregate and

[20] *See*, Exhibit 9.

specific attachment points, and any limitations on coverage. *See*, COMAR 31.10.43, effective January 1, 2016.

In Maryland, MSLI carriers must obtain the Commissioner's approval prior to utilizing a premium rate. During the rate review process the MIA reviews whether the premium is reasonable in relation to the benefits being offered. The MIA reviews the actuarial assumptions and methods used by the insurer to ensure adequacy of these assumptions. Furthermore, for all MSLI premium rate filings, the MIA requires that the filing be signed by an actuary meeting the minimum qualification standards of the Society of Actuaries, attesting that the information contained in the premium rate filing is accurate and complies with Actuarial Standards of Practice Number 8.[21]

Task (12):
An assessment of the impact on local governments and small employers of any changes to the attachment points or consumer protections in medical stop-loss insurance policies and contracts.

The MIA gathered feedback from local government organizations and small employers during the information session in September, 2015 and through written correspondence submitted to the MIA. For policies issued after June 1, 2015, Chapter 494 increased the specific attachment point from $10,000 to $22,500 and the aggregate attachment point from 115% to 120%. Since the new attachment points have been in effect for just over one year and policies issued prior to June 1, 2015 are not affected, there is little tangible evidence available on the impact of these new attachment points on local governments and small employers, the definition of which remains the same in Maryland. Notwithstanding this, the MIA reviewed the feedback from local government organizations and small employers and determined that both groups generally appreciate the complexity and risks associated with designing, pricing, offering, and administering an employer-sponsored health benefit plan. Despite this complexity, most believe that it is a viable tool, in some cases the only cost-effective tool available to them, if they want to offer health insurance to their employees.

Information Session Feedback: Testimony

Below is a representative sample of the testimony received:

- "Self-funding has a vast number of advantages and complexities…but the reality is, it is still a viable tool to help more people get coverage and have a net return of greater people covered."
- "It's far more complex than everybody thinks. People aren't going to flock to it without understanding the pieces and the components. Self-funded is built with administrative costs, managed care, network leasing, pharmaceutical benefits arrangements, all pretty much separate and apart from the stop-loss piece itself.
- "With self-funding, we can affordably keep offering benefits to our company."
- "One of the things I use in a selling point when I'm trying to sell my company to a candidate who's got many other options in insurance."
- "From the local government perspective, the dollars that we can save on health insurance go directly back to their taxpayers."
- "I think at this point, anyway, we haven't seen anything that indicates further changes are needed, and we hope that will be one of the results of the study."

[21] Regulatory filings for health plan entities.

- "The more risk we force upon them (small employers), the more likely they are to then bail out and go back to the fully insured market and create anti-selection. So the higher the risk we impose upon employers, the more we corrupt the system ourselves."
- "Obviously, one of the reasons we went to the self-insurance was due to the cost."

Written feedback:

Nineteen small employers and organizations provided written comments on MSLI. Comments included the benefits of MSLI, how it helps competition, and the recommendation that Maryland maintain the law as is.

Specific quotes included the following:

- "We like using the self-funded plan in conjunction with stop-loss insurance because it is more affordable and allows us to educate our employees on making intelligent medical choices."
- "We must compete for our business across the country, so it is imperative that we are able to not only control our costs but also manage our liabilities."
- "Employers need to have this protection at risk levels they can tolerate."
- "Although I don't know what changes you may be considering, please don't make it more difficult or expensive for our company to keep our health plan."
- "Allows the employees and us, the employers, to play an active role in controlling medical and health insurance premium costs."
- "Financial protection of stop-loss allows us to provide health benefits."
- "Nevertheless, self-funding remains an important option for employers who decide to accept the risk. As a matter of policy, we do not believe that state law should hinder their ability to do so. The fear that self-funding will result in significant adverse selection and therefore significant damage to the fully insured market, is simply unsupported by the facts."
- "Quite simply, we believe that they should have as many choices as possible. We applaud the efforts of the Maryland Insurance Administration in conducting this study. We strongly encourage you, however, to resist any further changes to Maryland law on the subject of stop-loss insurance."

IV. Conclusion

House Bill 552 was initially proposed in response to an anticipated change to the ACA wherein a small employer was defined as an employer employing 2-100 workers, effective January 1, 2016. The PACE Act amended this provision to give states the option to expand the definition of a small employer. In Maryland, a small employer is defined as, among other things, an employer employing not more than 50 workers. Chapter 494 required the MIA to conduct a study of the use of MSLI in self-funded employer health plans in the State.

The MIA's study found that small employers choosing to self-insure do so in order to offer employees a cost-effective alternative to traditional insurance. Employers appreciate the complexity of the decision to exit the fully-insured market in favor of self-insuring. Employers who determine to self-insure rely on the availability of an affordable medical stop-loss insurance product. Given the complexity of the decision, the disclosures required under Chapter 494 are beneficial and should be maintained under the law. Similarly, the consumer protections recently enacted should be maintained under the law.

The escalation of the attachment points, effective for policies issued after June 1, 2015, will increase the cost of self-insuring, but the study did not investigate whether and to what extent these

increases may reduce or otherwise stabilize MSLI premium rates. Based on stakeholder comments and the comparison to other states, however, it is recommended that the current statutory levels be maintained.

APPENDIX

EXHIBIT 1

Chapter 494

(House Bill 552)

AN ACT concerning

Health Insurance – Medical Stop–Loss Insurance – Small Employers

FOR the purpose of altering, with ~~a certain exception~~ certain exceptions, certain attachment points above which a medical stop–loss insurer assumes certain liability for losses incurred by an insured; applying the altered attachment points to renewal of a policy or contract of medical stop–loss insurance; prohibiting a medical stop–loss insurer, for a certain policy or contract, from taking certain actions; requiring a medical stop–loss insurer, for a certain policy or contract, to guarantee certain rates, pay certain claims within a certain period, and disclose certain information to a small employer; ~~requiring a medical stop–loss insurer, on or before a certain date each year, to file a certain actuarial certification with the Maryland Insurance Commissioner;~~ requiring the Maryland Insurance Administration to conduct a study of the use of medical stop–loss insurance in self–funded employer health plans; requiring the Administration to solicit information from stakeholders, including certain persons, and hold certain hearings; requiring the study to include certain matters; requiring the Administration to submit certain reports to the Governor and certain legislative committees on or before certain dates; providing for the application of this Act; providing for the termination of this Act; defining a certain term; making ~~a certain conforming change~~ certain conforming changes; and generally relating to medical stop–loss insurance.

BY repealing and reenacting, with amendments,
Article – Insurance
Section 15–129
Annotated Code of Maryland
(2011 Replacement Volume and 2014 Supplement)

SECTION 1. BE IT ENACTED BY THE GENERAL ASSEMBLY OF MARYLAND, That the Laws of Maryland read as follows:

Article – Insurance

15–129.

(a) (1) In this section the following words have the meanings indicated.

(2) "Aggregate attachment point" means the percentage of expected claims in a policy year above which the medical stop–loss insurer assumes all or part of the liability for losses incurred by the insured.

(3) "Carrier" means:

(i) an insurer; or

(ii) a nonprofit health service plan.

(4) "Expected claims" means the amount of claims that, in the absence of medical stop–loss insurance, are projected to be incurred by the insured using reasonable and accepted actuarial principles.

(5) "Medical stop–loss insurance" means insurance, other than reinsurance, that is purchased by a person, other than a carrier or a health care provider, to protect the person against catastrophic, excess, or unexpected losses incurred by that person's obligations to third parties under the terms of a health benefit plan.

(6) "Medical stop–loss insurer" means a carrier that is authorized to sell, issue, and deliver policies of medical stop–loss insurance in the State.

(7) "SMALL EMPLOYER" HAS THE MEANING STATED IN § 31–101 OF THIS ARTICLE.

[(7)**] (8)** "Specific attachment point" means the dollar amount in losses attributable to a single individual in a policy year beyond which the medical stop–loss insurer assumes all or part of the liability for losses incurred by the insured.

(b) **[**This**] SUBJECT TO SUBSECTION (D)(2) OF THIS SECTION, THIS** section applies to each medical stop–loss insurer and each medical stop–loss insurance policy or contract that is delivered or issued for delivery in the State.

(c) Medical stop–loss insurance may only be sold, issued, or delivered in the State by a carrier that holds a certificate of authority issued by the Commissioner that authorizes the carrier to engage in the business of health insurance or to act as a nonprofit health service plan.

(d) **(1) [**A**] EXCEPT AS PROVIDED IN PARAGRAPH (2) OF THIS SUBSECTION, A** medical stop–loss insurer may not issue, **RENEW,** deliver, or offer a policy or contract of medical stop–loss insurance, if the policy **OR CONTRACT** has:

[(1)**] (I)** a specific attachment point of less than **[**$10,000**] ~~$40,000~~ $22,500**; or

[(2)**] (II)** an aggregate attachment point of less than **[**115%**] ~~125%~~ 120%** of expected claims.

(2) THIS SUBSECTION DOES NOT APPLY TO:

(I) A POLICY OR CONTRACT OF MEDICAL STOP–LOSS INSURANCE ISSUED OR DELIVERED BEFORE ~~JANUARY~~ JUNE 1, 2015, IF THE POLICY OR CONTRACT MAINTAINS:

1. A SPECIFIC ATTACHMENT POINT OF NO LESS THAN $10,000; AND

2. AN AGGREGATE ATTACHMENT POINT OF NO LESS THAN 115% OF EXPECTED CLAIMS; ~~OR~~

(II) A RENEWAL OF A POLICY OR CONTRACT DESCRIBED IN ITEM (I) OF THIS PARAGRAPH; OR

(III) A POLICY OR CONTRACT OF MEDICAL STOP–LOSS INSURANCE ISSUED OR DELIVERED ON OR AFTER JUNE 1, 2015, IF THE POLICY OR CONTRACT:

1. IS ISSUED OR DELIVERED TO AN EMPLOYER THAT ON MAY 31, 2015, HELD A POLICY OR CONTRACT OF MEDICAL STOP–LOSS INSURANCE WITH:

A. A SPECIFIC ATTACHMENT POINT OF NOT LESS THAN $10,000; AND

B. AN AGGREGATE ATTACHMENT POINT OF NOT LESS THAN 115% OF EXPECTED CLAIMS; AND

2. MAINTAINS:

A. A SPECIFIC ATTACHMENT POINT OF NOT LESS THAN $10,000; AND

B. AN AGGREGATE ATTACHMENT POINT OF NOT LESS THAN 115% OF EXPECTED CLAIMS.

(E) FOR A STOP–LOSS INSURANCE POLICY OR CONTRACT ISSUED TO A SMALL EMPLOYER, A MEDICAL STOP–LOSS INSURER MAY NOT:

~~(1) INCREASE COST SHARING OR DECREASE OR REMOVE STOP–LOSS COVERAGE FOR A SPECIFIC INDIVIDUAL WITHIN A SMALL EMPLOYER'S HEALTH BENEFIT PLAN; OR~~

(1) (I) IMPOSE HIGHER COST SHARING FOR A SPECIFIC INDIVIDUAL WITHIN A SMALL EMPLOYER'S HEALTH BENEFIT PLAN THAN IS

REQUIRED FOR OTHER INDIVIDUALS WITHIN THE SMALL EMPLOYER'S HEALTH BENEFIT PLAN; OR

(II) DECREASE OR REMOVE STOP–LOSS COVERAGE FOR A SPECIFIC INDIVIDUAL WITHIN A SMALL EMPLOYER'S HEALTH BENEFIT PLAN; OR

(2) EXCLUDE ANY EMPLOYEE OR DEPENDENT FROM A POLICY OR CONTRACT ON THE BASIS OF AN ACTUAL OR EXPECTED HEALTH STATUS–RELATED FACTOR OR CONDITION, INCLUDING:

(I) PHYSICAL OR ~~MENTAL ILLNESS~~ BEHAVIORAL HEALTH, INCLUDING MENTAL ILLNESS OR SUBSTANCE USE DISORDER;

(II) CLAIMS EXPERIENCE;

(III) MEDICAL HISTORY;

(IV) RECEIPT OF HEALTH CARE;

(V) GENETIC INFORMATION;

(VI) DISABILITY;

(VII) EVIDENCE OF INSURABILITY, INCLUDING CONDITIONS ARISING OUT OF ACTS OF DOMESTIC VIOLENCE AGAINST AN EMPLOYEE OR DEPENDENT; OR

(VIII) ANY OTHER HEALTH STATUS–RELATED FACTOR AS DETERMINED BY THE COMMISSIONER.

(F) FOR A STOP–LOSS INSURANCE POLICY OR CONTRACT ISSUED TO A SMALL EMPLOYER, A MEDICAL STOP–LOSS INSURER SHALL:

(1) GUARANTEE RATES FOR AT LEAST 12 MONTHS, WITHOUT ADJUSTMENT, UNLESS THERE IS A CHANGE IN:

(I) THE BENEFITS PROVIDED UNDER THE SMALL EMPLOYER'S HEALTH BENEFIT PLAN DURING THE POLICY OR CONTRACT PERIOD;

(II) THE OWNERSHIP AND CONTROL OF THE SMALL EMPLOYER; OR

(III) THE NUMBER OF COVERED LIVES BY A SIGNIFICANT PERCENTAGE RESULTING FROM AN EVENT SUCH AS AN ACQUISITION OR A DIVESTITURE;

(2) PAY STOP–LOSS CLAIMS INCURRED DURING THE POLICY OR CONTRACT PERIOD AND SUBMITTED WITHIN 12 MONTHS AFTER THE EXPIRATION DATE OF THE POLICY OR CONTRACT; AND

(3) DISCLOSE TO THE SMALL EMPLOYER, IN A FORM AND MANNER APPROVED BY THE COMMISSIONER AND BEFORE ENTERING INTO A POLICY OR CONTRACT FOR MEDICAL STOP–LOSS INSURANCE:

(I) THE TOTAL COSTS OF THE POLICY OR CONTRACT;

(II) 1. THE DATES ON WHICH THE POLICY OR CONTRACT TAKES EFFECT AND TERMINATES; AND

2. PROVISIONS FOR RENEWING THE POLICY OR CONTRACT;

(III) THE AGGREGATE ATTACHMENT POINT AND THE SPECIFIC ATTACHMENT POINT FOR THE POLICY OR CONTRACT; AND

(IV) ANY LIMITATIONS ON COVERAGE.

[(e)**] (G)** A medical stop–loss insurer who offers or issues a medical stop–loss insurance policy **OR CONTRACT** that does not meet the requirements of this section shall be subject to the sanctions set forth in § 4–113 of this article for authorized insurers and § 4–212 of this article for unauthorized insurers.

(H) ~~ON OR BEFORE APRIL 1 OF EACH YEAR, A MEDICAL STOP–LOSS INSURER SHALL FILE WITH THE COMMISSIONER, IN A FORM AND MANNER APPROVED BY THE COMMISSIONER, AN ACTUARIAL CERTIFICATION THAT THE INSURER IS IN COMPLIANCE WITH THE MINIMUM ATTACHMENT POINTS SPECIFIED IN THIS SECTION.~~

~~[(f)] (I)~~ Nothing in this section shall be construed as:

(1) imposing any requirement or duty on any person other than a carrier; or

(2) treating any medical stop–loss insurance policy as a policy of individual, group, or blanket health insurance covering the participants in the underlying health benefit plan.

SECTION 2. AND BE IT FURTHER ENACTED, That:

(a) The Maryland Insurance Administration shall conduct a study of the use of medical stop–loss insurance in self–funded employer health plans.

(b) As part of the study, the Administration shall:

(1) solicit information from stakeholders; and

(2) hold informational hearings, as appropriate.

(c) The stakeholders from whom the Administration shall solicit information shall include:

(1) carriers offering fully insured health plans in the State;

(2) carriers offering medical stop–loss insurance in the State;

(3) employers utilizing fully insured health plans;

(4) employers utilizing self–funded health plans in conjunction with medical stop–loss insurance;

(5) insurance producers;

(6) third party administrators;

(7) consumers;

(8) the Office of the Attorney General;

(9) Maryland counties and municipalities; and

(10) the Maryland Bankers Association.

(d) The study shall include:

(1) an analysis of baseline data, including sample data, where appropriate, on:

(i) the types and costs of health benefit plans, including self–insured plans, offered in the State by employers with 2 to 50 employees and employers with 51 to 100 employees;

(ii) for self–insured plans, the individual and aggregate attachment points of medical stop–loss insurance purchased; and

(iii) the number of plan designs and carriers available in the small employer market, including market share by carrier, and the number of plan designs and carriers available in the market for health benefit plans utilizing medical stop–loss insurance, including market share by medical stop–loss carrier;

(2) an overview of the employer health plan market in contiguous states, including the percentage of fully insured employer health plans and self–insured employer health plans utilizing medical stop–loss insurance;

(3) an estimate of the number of employers with 51 to 100 employees whose health benefits plans would change from the large group to the small group market in 2016, as a result of the change in the size of the small group market required by the federal Affordable Care Act;

(4) an analysis of statutory and regulatory requirements for medical stop–loss insurance in other states and the experience of states the requirements of which are different from those in Maryland;

(5) a review of any guidance, recommendations, or model legislation regarding medical stop–loss insurance by the National Association of Insurance Commissioners or other groups;

(6) identification of any incentives and disincentives beginning in 2016, associated with the purchase of health insurance in the small group market compared to self–insurance with the purchase of medical stop–loss insurance, for both employers with 2 to 50 employees and employers with 51 to 100 employees;

(7) a comparison of the risk profile of small employers that self–insure and the risk profile of small employers that purchase health insurance in the small group market;

(8) an assessment of the impact on the stability and viability of the small group market, including the possibility of adverse selection and higher premiums, resulting from employers:

(i) choosing to self–insure instead of purchasing health insurance in the small group market; and

(ii) after self–insuring, switching to the small group market;

(9) an assessment of any impact on the Maryland Health Benefit Exchange of small employers choosing to drop coverage for their employees;

(10) an assessment of different attachment points for medical stop–loss insurance, the effect that medical inflation could have on the attachment points in statute, and the desirability of maintaining or adjusting the current statutory levels;

(11) an assessment of the consumer protections in medical stop–loss insurance policies and contracts and the desirability of maintaining or adjusting the current statutory consumer protections; and

(12) an assessment of the impact on local governments and small employers of any changes to the attachment points or consumer protections in medical stop–loss insurance policies and contracts.

(e) (1) On or before December 1, 2015, the Administration shall submit an interim report of its findings and recommendations to the Governor and, in accordance with § 2–1246 of the State Government Article, the Senate Finance Committee and the House Health and Government Operations Committee.

(2) On or before October 1, 2016, the Administration shall submit a final report of its findings and recommendations to the Governor and, in accordance with § 2–1246 of the State Government Article, the Senate Finance Committee and the House Health and Government Operations Committee.

SECTION ~~2.~~ 3. AND BE IT FURTHER ENACTED, That this Act shall apply to all medical stop–loss insurance policies and contracts issued, delivered, or renewed in the State on or after June 1, 2015.

SECTION ~~3.~~ 4. AND BE IT FURTHER ENACTED, That this Act shall take effect June 1, 2015. It shall remain effective for a period of 3 years and 1 month and, at the end of June 30, 2018, with no further action required by the General Assembly, this Act shall be abrogated and of no further force and effect.

Enacted under Article II, § 17(c) of the Maryland Constitution, May 30, 2015.

EXHIBIT 2

Exhibit 2:

Interim Report on the Use of Medical Stop-Loss Insurance in Self-Funded Employer Health Plans in Maryland
MSAR #10495

December, 2015

For more information concerning this document, please contact:

Nancy Egan
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INTERIM REPORT ON THE USE OF MEDICAL STOP-LOSS INSURANCE IN SELF-FUNDED EMPLOYER HEATLH PLANS IN MARYLAND

I. Introduction

During the 2015 Regular Session, the Maryland General Assembly passed House Bill 552, Chapter 494,[1] (referred to herein as "Chapter 494") concerning Health Insurance-Medical Stop-Loss Insurance-Small Employers. Chapter 494 requires the Maryland Insurance Administration ("MIA") to conduct a study of the use of medical stop-loss insurance in self-funded employer health plans in the State and report to the Senate Finance Committee and the House Health and Government Operations Committee (referred to collectively herein as the "Committees") on its findings and recommendations. Specifically Chapter 494 requires the MIA to submit an interim report on or before December 1, 2015, and a final report on or before October 1, 2016.

This document constitutes the required interim report that is due and provides the Committees a brief summary of the MIA's progress in conducting the required study. Information presented in this interim report is subject to revision after additional information is obtained and further analysis is performed.

II. Medical Stop-Loss and Self-Funding Background

An employer has two options when choosing how to provide health benefit plans to their employees. The first is a "fully insured" plan in which the employer buys a group health insurance policy from a licensed insurer who has the responsibility of providing those benefits that are defined in the plan's policy. The second is a "self-funded" plan in which the employer is responsible for providing the benefits and defining the benefits of the plan. Medical stop-loss insurance indemnifies the sponsor (employer) of a self-funded health plan against benefit payments that the plan is required to pay in excess of a certain agreed amount, known as the "attachment point." AMS, Inc. v. Bartlett, 111 F.3d 358, 361 (4th Cir. 1997). Stop-loss insurance is a "third-party" line of coverage. This means the claimant who has suffered the loss is not insured under the policy. This is fundamental distinction between stop-loss insurance and group health insurance. Stop-loss is sometimes referred to as a form of reinsurance, but a significant difference between stop-loss insurance and reinsurance is the nature of the entity purchasing the coverage. Reinsurance covers a licensed carrier for its obligation under insurance policies, while stop-loss insurance covers a self-funded employer for its obligations under a health benefit plan.

Medical stop-loss insurance is defined in Maryland law as "insurance, other than reinsurance, that is purchased by a person, other than a carrier or health care provider, to protect the person against catastrophic, excess, or unexpected losses incurred by that person's obligations to third parties under the terms of a health benefit plan.[2]

A medical stop-loss insurance policy usually consists of two components; a specific stop-loss attachment point and an aggregate stop-loss attachment point. The specific attachment point is the threshold over which the policyholder is reimbursed in the event that a single individual generates medical claims over the specified amount during the contract period. Contract periods are typically twelve months.[3] An aggregate stop-loss attachment point is the threshold that reimburses the policyholder in the event that total medical expenditures exceed a pre-determined amount (the "aggregate attachment point").[4] The two components of the policy provide protection to the policyholder against the risk of a single individual with a high dollar claim or against high utilization claim expenses by all individuals covered under the underlying health plan.

Most medical stop-loss policies are issued to employers who self-fund a health plan for their employees. There are a number of different factors to influence an employer's decision to self-fund a health plan. These factors include differences in the way self-funded and fully insured employer health plans are regulated, the amount of financial risk associated with self-funding versus fully insured health plans, and the prices employers are charged for administrative services when they choose to self-fund the health plan.

When an employer decides to self-fund rather than purchase a fully insured plan from an insurance company the employer is taking on the responsibility and risk instead of the insurance company. Self-funding employers

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[1] A copy of Chapter 494 appears in Appendix 1.
[2] Md. Code Ann., Ins. §15-129.
[3] Milliman *NAIC Report, Statistical Modeling and Analysis of Stop-Loss Insurance for Use in NAIC Model Act,* May 24, 2012.
[4] *Id.*

decide what benefits to offer, are responsible for paying medical claims for their employees and the employees' families, and assume all of the risk for the health plan. Employers can purchase a medical stop-loss insurance policy to help mitigate the risk of self-funding the expense of certain types of claims. These claims can include high dollar but low frequency claims of a single individual covered under the underlying health plan or low dollar claims at an unusually high frequency based on the claims of all the individuals covered under the underlying health plan. Employers who purchase medical stop-loss insurance policies remain responsible if the medical stop-loss insurer fails to preform, denies a claim, if there are gaps in coverage, or if there are conflicts or inconsistencies between the medical stop-loss policy and the employer's obligations under the self-funded health plan[5]. The employer must also make decisions about how much risk to insure with a stop-loss policy, the selection of a medical stop-loss insurer, and the determination of the benefits to be covered by the self-funded plan.

Most employers with self-funded plans hire third-party administrations ("TPAs") to administer their plans. Employers hire TPAs who can offer a number of services to the employer. The services include helping the employer design the benefit package, estimate the cost associated with the entire program, ensure the health plan complies with federal law and notice requirements, provide cost management service, and provide claim management services to help the employer with enrollment issues and medical claim processing.[6]

III. Medical Stop-Loss Insurance in Maryland

The regulation of medical stop-loss policies in Maryland began as a result of complaints received by the MIA shortly after the passage of the Maryland Health Insurance Reform Act in 1993, known generally as "Small Group Reform." Before the General Assembly passed small group reform, the small group market was dysfunctional. Rates charged to different small employers varied based on the experience of the group, and as a result, many small businesses could not get insurance at all. Small Group Reform established requirements for groups from 2-50 employees including guaranteed issue, guaranteed renewability, modified community rating and a standard benefit package. Many of the benefits we now see nationally as a result of the Affordable Care Act ("ACA") were included in the Maryland Health Insurance Reform Act of 1993.

In an attempt to avoid some of the requirements of Small Group Reform, the MIA received a number of complaints that some insurers were selling stop-loss policies with very low specific attachment points. It was the view of the MIA at the time that with such low attachment points, there was no meaningful self-insurance or risk retention by the purchaser and that the stop-loss policy was being used as a substitute for health insurance.

In order to protect consumers, reduce unfair competition in the insurance market and implement the public policies expressed in Small Group Reform, the MIA sought to adopt a regulation to address the issue. The regulation was challenged and the Fourth Circuit found that it was preempted by ERISA because the regulation stated that any medical stop-loss insurance policy with a specific attachment point below $10,000 did not comply with the regulation and would be deemed to be a group health insurance policy. In the court's view, by deeming the medical stop-loss policies that attached at levels inconsistent with the regulation as direct policies of group health insurance, the State impinged on the solvency and financial planning choices which ERISA vests solely in ERISA plans.[7] The Fourth Circuit, however, was careful to state that "[t]his is not to say that Maryland may not regulate stop-loss insurance policies. Such regulation is clearly reserved to the states." *AMS Inc. v. Bartlett*, 111 F.3d 358, 365 (4th Cir. 1997).

In 1999, the MIA approached the General Assembly with legislation designed to address the concerns at which the regulation had been aimed, but also in keeping with the holding of the Fourth Circuit. Clearly mindful of the elements of the regulation that had resulted in the conclusion that the regulation was preempted, §15-129 of the

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[5] *Stop Loss Insurance, Self-Funding and the ACA, White Paper, NAIC, 2015* http://www.naic.org/documents/committees_b_erisa_exposure_150324_stop_loss_white_paper_clean.pdf.

[6] *Id.*

[7] The Employee Retirement Income Security Act of 1974 ("ERISA") is a comprehensive federal statute regulating private employee benefit plans, including plans maintained for the purpose of providing medical or other health benefits for employees. To assure national uniformity of federal law, ERISA broadly preempts state law and assures that federal regulation will be exclusive. Section 514(a) provides that ERISA "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan" as defined by ERISA. While ERISA broadly pre-empts state laws that relate to employee benefit plans, that pre-emption is substantially qualified by an "insurance saving clause," which broadly states that nothing in ERISA "shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities." *Metropolitan Life Ins. Co. v. Mass.*, 471 U.S. 724, 733 (1985).

Insurance Article required, when initially passed, that stop-loss insurance policies issued in the State have certain minimum attachment points, but, the statute is clear that stop-loss policies are not direct policies of group health insurance. Md. Code Ann. Ins. §15-129 (e)[8] House Bill 1086 (Chapter 683, Acts of 1999) passed and provided that an insurer may not issue, deliver, or offer a policy or contract of stop-loss insurance, if the policy has a specific attachment point of less than $10,000 or an aggregate attachment point of less than 115% of expected claims.[9]

In 2008 the MIA sponsored House Bill 272- Medical Stop-Loss Insurance. In the MIA's written testimony before the Senate Finance Committee, the MIA provided that it had received 11 complaints from employers and employees regarding the failure of a non-admitted medical stop-loss insurer to reimburse claims. Since the carrier was non-admitted, the MIA's only recourse was to refer the employers to the U.S. Department of Labor.[10] House Bill 272 (Chapter 264, Acts of 2008) addressed this issue by replacing the definition of "stop-loss insurance" with "medical stop-loss insurance" and prohibiting the sale of medical stop-loss insurance by unauthorized carriers.[11]

House Bill 552 of 2015, as first introduced, would have increased the specific attachment point from $10,000 to $40,000 and raised the aggregate attachment point from 115% to 125% of expected claims for medical stop-loss insurance. In her oral testimony in front of the House and Government Operations Committee on March 4, 2015, the bill sponsor, Delegate Pendergrass, stated that bill was in response to the ACA changing the definition of small employer from 2-50 employees to 2-100 employees effective January 1, 2016 and its possible adverse effect on the small group market.[12] In its final version, House Bill 552 (Chapter 494, Acts of 2015), changes the specific attachment point for medical stop-loss insurance to $22,500 and the aggregate attachment point to 120% effective June 1, 2015. Chapter 494 provides that the provisions of the law do not apply to medical stop-loss insurance contracts issued before June 1, 2015 as long as the policy or contract maintains a specific attachment point of $10,000 and an aggregate attachment point of 115% of expected claims. In addition, Chapter 494 establishes certain protections and prohibitions for medical stop-loss insurance issued to a small employer and provides for the MIA to conduct a study. Chapter 494 took effect June 1, 2015 and terminates on June 30, 2018.

Since the enactment of Chapter 494, federal law has changed. The federal law, entitled Public Law 114-60 Protecting Affordable Coverage for Employees Act[13] ("PACE Act") revises the definition of small employer under health insurance market provisions by amending the Patient Protection and Affordable Care Act (42 U.S.C. 18024(b)) and the Public Health Service Act (42 U.S.C. 300gg-91(e)). The PACE Act will keep the definition of small employer at 50 employees for the foreseeable future, unless a state requires the small employer definition to be expanded to 100 employees.

IV. Requirements of the MIA's Study

Chapter 494 requires the MIA to perform an analysis of baseline data, including sample data, where appropriate, on:

(1) (i) The types and costs of health benefit plans, including self-insured plans, offered in the State by employers with 2 to 50 employees and employers with 51 to 100 employees;

(ii) For self-insured plans, the individual and aggregate attachment points of medical stop-loss insurance purchased; and

(iii) The number of plan designs and carriers available in the small employer market, including market share by carrier, and the number of plan designs and carriers available in the market for health benefit plans utilizing medical stop-loss insurance, including market share by medical stop-loss carrier;

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[8] While not a direct form of group health insurance, it is a form of health insurance because it "appertains" to the indemnification of human beings against bodily injury and other perils identified in the definition of health insurance. *See* Md. Code Ann. Ins. Art. § 1-101(s).

[9] *See* http://mgaleg.maryland.gov/1999rs/bills/hb/hb1086e.pdf for a copy of HB 1086.

[10] *Medical Stop-Loss Insurance, Hearing on House Bill 272 before the Senate Finance Committee* , 2008 Leg., 425th Sess. (Md. 2008) (written testimony of the Maryland Insurance Administration).

[11] *See* http://mgaleg.maryland.gov/2008rs/chapters_noln/Ch_264_hb0272T.pdf.

[12] To listen to all of the testimony go to http://mgahouse.maryland.gov/mga/play/fb0f72861c3b4dd1beb2cd358209e937/?catalog/03e481c7-8a42-4438-a7da-93ff74bdaa4c&playfrom=13896132.

[13] A copy of H.R. 1624- Protecting Affordable Coverage for Employees Act appears in Appendix 2.

(2) An overview of the employer health plan market in contiguous states, including the percentage of fully insured employer health plans and self-insured employer health plans utilizing medical stop-loss insurance;

(3) An estimate of the number of employers with 51 to 100 employees whose health benefits plans would change from the large group to the small group market in 2016, as a result of the change in the size of the small group market required by the federal Affordable Care Act;

(4) An analysis of statutory and regulatory requirements for medical stop-loss insurance in other states and the experience of states the requirements of which are different from those in Maryland;

(5) A review of any guidance, recommendations, or model legislation regarding medical stop-loss insurance by the National Association of Insurance Commissioners or other groups;

(6) Identification of any incentives and disincentives beginning in 2016, associated with the purchase of health insurance in the small group market compared to self-insurance with the purchase of medical stop-loss insurance, for both employers with 2 to 50 employees and employers with 51 to 100 employees;

(7) A comparison of the risk profile of small employers that self-insure and the risk profile of small employers that purchase health insurance in the small group market;

(8) An assessment of the impact on the stability and viability of the small group market, including the possibility of adverse selection and higher premiums, resulting from employers:

(ii) Choosing to self-insure instead of purchasing health insurance in the small group market; and

(iii) After self-insuring, switching to small group market;

(9) An assessment of any impact on the Maryland Health Benefit Exchange of small employers choosing to drop coverage for their employees;

(10) An assessment of different attachment points for medical stop-loss insurance, the effect that medical inflation could have on the attachment points in statute, and the desirability of maintaining or adjusting the current statutory levels;

(11) An assessment of the consumer protections in medical stop-loss insurance policies and contracts and the desirability of maintaining or adjusting the current statutory consumer protections; and

(12) An assessment of the impact on local governments and small employers of any changes to the attachment points or consumer protections in medical stop-loss insurance policies and contracts.

V. Methodology

As part of the medical stop-loss study, the MIA is required to solicit information from the following stakeholders: 1) carriers offering fully-insured plans in Maryland; 2) carriers offering medical stop-loss insurance in Maryland; 3) employers utilizing fully-insured health plans; 4) employers utilizing self-funded plans in conjunction with stop-loss insurance; 5) insurance producers; 6) third party administrators; 7) consumers; 8) the Office of the Attorney General; 9) Maryland counties and municipalities; and 10) the Maryland Bankers Association. To complete this multi-faceted analysis, the MIA: 1) developed a survey; 2) developed two data call letters;[14] 3) is working with the National Association of Insurance Commissioners ("NAIC") and other state Insurance Departments to gather information relevant to how medical stop-loss insurance is regulated in other states and jurisdictions; 4) is working with the insurance producer community to develop sample data sets for quoting in the self-insured market; 5) held an informational public hearing; 6) provided a platform for comments by conducting eight town hall meetings around the state; and 7) has actively solicited information from stakeholders through meetings, conference calls, and stakeholder written comments.

[14] See Task One and Task Nine for further information.

As part of the outreach to consumers, employers and insurance producers, the MIA conducted eight town hall meetings over the summer of 2015 in various locations across the state from western Maryland to the Eastern Shore[15]. Insurance Commissioner Redmer invited interested parties to provide opinions, questions and concerns about the recent changes to the health insurance market including changes to medical stop-loss insurance. In addition, the MIA has been actively communicating with the Maryland Association of Bankers ("MBA") and the National Federation of Independent Businesses while also working closely with the Maryland Municipal League ("MML") and Maryland Association of Counties ("MACo") in order to gather information on how changes would affect the business community, local governments and consumers. The MIA remains in communication with these key stakeholders, and others as appropriate, while engaging them on the issues at hand.

As required by the study, the MIA held a public informational hearing on the topic of medical stop-loss insurance where stakeholders were invited to attend and provide written comments about the components of the medical stop-loss study. The public informational hearing was held on Monday, September 28, 2015 with various stakeholders providing oral comments.[16] Stakeholders were encouraged to provide written comments. Among the stakeholders who provided written and oral comments were small business owners, MACo members, MML members, MBA, producers and consumer advocates.[17]

VI. Chapter 494 Analysis Progress Report

Analysis Task (1): *An analysis of baseline data, including sample data, where appropriate; (i) on the types and costs of health benefit plans, including self-insured plans, offered in the State by employers with 2 to 50 employees and employers with 51 to 100 employees;*
(ii) for self-insured plans, the individual and aggregate attachment points of medical stop-loss insurance purchased; and
(iii) the number of plan designs and carriers available in the small employer market, including market share by carrier, and the number of plan designs and carriers available in the market for health benefit plans utilizing medical stop-loss insurance, including market share by medical stop-loss carriers.

The Maryland Insurance Administration does not regulate employer self-funded health plans, which are often offered by an employer who purchases a medical stop-loss insurance policy. Medical stop-loss insurance policies function to limit significant risk to employers as a result of high dollar claims and high utilization claims that may arise. The MIA's regulatory oversight extends only to the medical stop-loss policies; it does not extend to the self-funded plan that covers the employees of the self-funded employer. In contrast, the MIA has jurisdiction over fully insured hea

lth benefit plans.

In the fully insured small group market, there are 13 carriers offering 330 small group medical plans on and off the Exchange for calendar year 2015. This includes HMO, PPO and POS product types with actuarial value metal levels of all four types, Platinum, Gold, Silver and Bronze.[18] Unlike the fully insured market, the MIA cannot require employers to submit self-funded health plan contracts and rates for review because of MIA's regulatory constraints. Therefore, the MIA does not have any information readily available on the types/costs of health benefit plans and number of plan designs available within the self-funded health plan market. As part of the MIA data call/survey the MIA is requesting this type of information from the medical stop-loss carriers (part of Task (1) (iii)). In addition, the MIA is currently gathering information regarding the market share by medical stop-loss carrier in 2015. The market share by carrier in the fully insured small employer market as of December 31, 2014 is as follows:

Market Share for the Fully Insured Small Group Market

[15] The eight town hall meetings were held in Salisbury, Easton, Rockville, Hagerstown, Hunt Valley, Waldorf, Annapolis and Baltimore.
[16] For a copy of the transcript of the public hearing, see: http://insurance.maryland.gov/Documents/newscenter/legislativeinformation/Medical-Stop-Loss-Hearing-Transcript.pdf.
[17] For a full list of the written comments, see: http://insurance.maryland.gov/Documents/newscenter/legislativeinformation/Medical-Stop-Loss-Hearing-Comments.pdf.
[18] A sample of approved 2015 monthly rates for the lowest-priced bronze, silver, gold and platinum plans from Maryland's four rating areas is attached in Appendix 3.

Name	Number of Covered Lives	Market Share by Covered Lives
Aetna Health Inc (PA Corporation)	3,836	1.20%
Aetna Health Ins Co	20	0.01%
Aetna Life Ins Co	9,776	3.05%
CareFirst BlueChoice Inc	159,164	49.68%
CareFirst of MD Inc	23,972	7.48%
Cigna Health & Life Ins Co	181	0.06%
Coventry Health & Life Ins Co	12,304	3.84%
Coventry Health Care of DE	13,424	4.19%
Evergreen Health Cooperative Inc	11,286	3.52%
Group Hospitalization & Medical Services	46,028	14.37%
Kaiser Foundation Health Plan	7,603	2.37%
Kaiser Permanente Ins Co	19	0.01%
Mamsi Life & Health Ins Co	9,458	2.95%
Mid West National Life Ins Co of TN	0	0.00%
Optimum Choice Inc	8,106	2.53%
UnitedHealthcare Ins Co	12,024	3.75%
United Healthcare Mid-Atlantic	3,206	1.00%
Total	320,407	100.00%

In addition, federal law has changed since this study was enacted. The new federal law, the PACE Act, will keep the definition of small employer at 50 employees for the foreseeable future, unless a state requires the small employer definition to be expanded to 100 employees. Based on this federal law, Maryland employers with 51-100 employees will continue to be classified as large employers, meaning there will not be a shift in the pricing for the small employer from large group to small group. Due to the recent change in federal law, the MIA suggests that addressing the areas of study in Task One dealing with pricing for employers with 51-100 employees in the marketplace is not relevant at this time.

In order to understand the dynamics of Maryland's medical stop-loss insurance market, the MIA developed a data call letter and survey to request information from the carriers providing medical stop-loss insurance in Maryland.[19] The data call letter/survey was sent to the medical stop-loss insurers and requested information for policies issued during the time period of June 1, 2014 through May 31, 2015. The letter was submitted to the 69 medical stop-loss carriers identified as selling medical stop-loss insurance in the State. The survey requested information regarding minimum group size, minimum attachment points written, and pricing of the product. The survey results will help provide an overview of the individual and aggregate attachment points for medical stop-loss insurance purchased for self-insured plans (Task (1) (ii)). Based on the survey response, the MIA will be able to determine the number of medical stop loss policies written in the 2-50, 51-100 and 100+ employee markets and minimum individual and aggregate attachment points for each market. The MIA also is asking medical stop-loss carriers to provide specific information regarding the number of plan designs available if they offer management services for the self-funded portion of the plan.

Additionally, the MIA reached out to the medical stop-loss carriers, as well as the insurance producer community, to help develop the parameters for quoting in the self-insured market. Working with these groups, the MIA developed two sample employers in the 2-50 market. Each medical stop-loss carrier will be asked to quote the two sample employer groups in four different zip codes that represent the four rating regions of Maryland. The

[19] A copy of the data call letter and survey appears in Appendix 4.

sample data includes employer zip code, SIC code,[20] employee age, number of dependents, and dependent ages. For the self-insured market, the MIA is requesting pricing based on an individual attachment point at $10,000 and aggregate at 115%[21] of expected claims as well as pricing based on an individual attachment point at $22,500 and aggregate 120% of expected claims. The baseline design of the plan is based on the CareFirst BlueChoice HMO HRA/HSA $1500 plan, the largest plan in the largest small group product by enrollment in the first quarter of 2014 in Maryland. The request for quoting in the self-insured marketplace will be sent to only those medical stop loss carriers who operate in the 2-50 market.

However, any information and pricing received from the medical stop-loss carriers will be merely anecdotal. Task One does not require any comparison of pricing. Any attempt to compare pricing in the small group self-insured market versus the fully insured marketplace would not be practical and would require actual claims experience, pricing from TPAs, and other components that make up the cost of self-insuring.

Analysis Task (2): *An overview of the employer health plan market in contiguous states, including the percentage of fully insured employer health plans and self-insured employer health plans utilizing medical stop-loss insurance.*

The MIA has initiated research regarding the percentage of fully insured employer health plans and self-insured employer health plans utilizing medical stop-loss insurance in contiguous states. The MIA is consulting the NAIC's "Stop Loss Coverage Chart" from the *Compendium of State Laws on Insurance Topics* (last updated May 2015). Staff will directly consult contiguous states to acquire information as necessary for the final report.

Analysis Task (3): *An estimate of the number of employers with 51 to 100 employees whose health benefits plans would change from the large group to the small group market in 2016, as a result of the change in the size of the small group market required by the federal Affordable Care Act.*

The MIA surveyed carriers in Maryland's fully insured group market on the number of employers with 51 to 100 employees during its 2016 ACA rate review process, the survey showed there were 1,556 employer groups with 51-100 employees in 2015. Since the enactment of Chapter 494, federal law has changed. The new federal law, the PACE Act, revises the definition of small employer under the health insurance market provisions by amending the Patient Protection and Affordable Care Act (42 U.S.C. 18024(b)) and the Public Health Service Act (42 U.S.C. 300gg-91(e)). The PACE Act will keep the definition of small employer at 50 employees for the foreseeable future, unless a state requires the small employer definition to be expanded to 100 employees. Since the PACE Act retained the definition of small group at 50 employees, there will not be any shift of employers from large group to small group as employers with 51-100 employees will continue to be considered large employers.

Analysis Task (4): *An analysis of statutory and regulatory requirements for medical stop-loss insurance in other states and the experience of states the requirements of which are different from those in Maryland.*

The MIA has initiated research regarding the statutory and regulatory requirements for medical stop-loss insurance in other states and the experience of states in which the requirements are different from those in Maryland. The MIA will rely heavily on the NAIC's "Stop Loss Coverage Chart" from the *Compendium of State Laws on Insurance Topics* (last updated May 2015), which provides a multi-jurisdiction analysis of state stop loss laws, in the final report.

Analysis Task (5): *A review of any guidance, recommendations, or model legislation regarding medical stop-loss insurance by the National Association of Insurance Commissioners or other groups.*

The NAIC adopted the Stop Loss Insurance Model Act (#92) in 1995. Based on a 1994 actuarial study by Coopers and Lybrand, Section 3 of the model set the following minimum attachment points, giving the Commissioner the authority to adjust them for inflation:

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[20] Standard Industrial Classification ("SIC") codes are four-digit numerical codes assigned by the U.S. government to business establishments to identify the primary business of the establishment. The first two digits of the code identify the major industry group, the third digit identifies the industry group, and the fourth digit identifies the industry.

[21] Chapter 494 provides that a policy or contract of medical stop-loss insurance issued or delivered before June 1, 2015 may maintain specific attachment points of no less than $10,000 and an aggregate attachment point of no less than 115%. Policies issued or offered after June 1, 2015 are subject to the higher attachment points of $22,500/120%.

A. (1) An insurer shall not issue a stop loss insurance policy that:

(a) Has an annual attachment point for claims incurred per individual which is lower than $20,000;

(b) Has an annual aggregate attachment point, for groups of fifty (50) or fewer, that is lower than the greater of:

(i) $4,000 times the number of group members;
(ii) 120 percent of expected claims; or
(iii) $20,000;

(c) Has an annual aggregate attachment point for groups of fifty-one (51) or more that is lower than 110 percent of expected claims; or

(d) Provides direct coverage of health care expenses of an individual.

In the fall of 2011, a 2012 charge was adopted for the ERISA (B) Working Group of the NAIC Regulatory Framework (B) Task Force to update the stop loss model act to account for medical inflation. A new study was commissioned utilizing current data in order to update the attachment points. The Milliman Group was chosen to do the study, and on May 24, 2012, they issued their report entitled: *Milliman NAIC Report: Statistical Modeling and Analysis of Stop Loss Insurance for Use in the NAIC Model Act.* Based on the Milliman Report, guideline amendments to the model act were drafted that included raising the annual attachment point for all groups to $60,000 and raising the aggregate attachment point for groups of 50 or less to the lower than the greater of (i) 15,000 times the number of group members; (ii) 130 percent of expected claims; or (iii) $60,000.[22] The motion to adopt the guideline amendments failed at the 2012 Fall National Meeting.

From 2013 to 2015, the ERISA (B) Working Group continued its study of the stop-loss issue by composing a comprehensive white paper on this subject. The NAIC White Paper entitled "*Stop Loss Insurance, Self-Funding and the ACA"* was adopted at the Executive/Plenary session of the NAIC on August 18, 2015.

The MIA will consider the NAIC Model Law on stop-loss insurance and the NAIC's recently published white paper as part of its research for this study. The following resources may also be consulted:

- "Statistical Modeling and Analysis of Stop- Loss Insurance for Use in NAIC Model Act." Milliman, Inc. Prepared for the NAIC, May 24, 2012.
- Modeling Employer Self-Insurance Decisions After the Affordable Care Act. Published in: HSR, Health Services Research, v. 48, no. 2, part. 2, Apr. 2013, p. 850-865.
- Research conducted by the Kaiser Family Foundation (www.kff.org).
- Any resources from the National Academy for State Health Policy concerning guidance, recommendations, or model legislation regarding medial stop-loss insurance.

Analysis Task (6): *Identification of any incentives and disincentives beginning in 2016, associated with the purchase of health insurance in the small group market compared to self-insurance with the purchase of medical stop-loss insurance, for both employers with 2 to 50 employees and employers with 51 to 100 employees.*

Since the enactment of Chapter 494, federal law has changed. The new federal law, the PACE Act, revises the definition of small employer under the health insurance market provisions by amending the Patient Protection and Affordable Care Act (42 U.S.C. 18024(b)) and the Public Health Service Act (42 U.S.C. 300gg-91(e)). The PACE Act will keep the definition of small employer at 50 employees for the foreseeable future, unless a state requires the small employer definition to be expanded to 100 employees. One reason this task was created was due to the concern that employers with 51-100 employees, who were considered large employers, would be considered small employers in 2016, and may decide to self-insure rather than participate in the small group market. Since Maryland employers with 51-100 employees will continue to be considered large employers, there does not appear to be a reason to assume that there will be a major shift in Maryland of employers in the 51-100 market into the self-insured market. In fact with the higher attachment points required by Chapter 494, as of June 1, 2015, the portion of risk that must be assumed by the employer with 51-100 employees for the payment of claims under a medical stop-loss insurance policy has risen and may act as a disincentive for those employers in 2016.

[22] *Guideline Revisions to Stop Loss Insurance Model Act (#92), July 2, 2012 Draft.*

Since the PACE Act retained the definition of small group at 50 employees, the incentive and disincentives below focus only on employers with 2 to 50 employees. In 2016, small employers with significant health insurance premium increases could reduce operational expenses by exploring the possibility of self-insurance, reviewing their fully-insured plans for possible savings options such as changing deductibles or disbanding their group and advising their employees to seek coverage elsewhere including entering into the individual market.

Some of the incentives for a small employer in 2016 to purchase a health plan in the small group market is the policy defines the plan's benefits and the insurer assumes responsibility for providing those benefits.[23] Additionally the policy contains the protections of the ACA including the provisions of the essential health benefits. Employers also may have an easier time with budgeting and cash flow since their premiums are fixed and employers know what they will be paying every month.[24] Finally, employers may want to purchase coverage, as opposed to not offering any coverage, to retain employees.

A small employer considering self-funding the employees' health plan in conjunction with the purchase of medical stop-loss insurance should understand that the employer assumes all of the risk that comes with self-funding a health plan, including the risk of high dollar claims and high utilization claims, and the financial responsibility if the medical stop-loss insurer fails to perform in any way.[25] The price and contract of a medical stop-loss policy can drastically change from year to year because medical stop-loss policies are written based on claim experience. An additional disincentive for self-funded plans is that the employer must pay claims as they are incurred and the timing of those claims is beyond the control of the employer. This can result in unpredictable cash flow. Additionally, with the higher attachment points required by Chapter 494, as of June 1, 2015, the portion of risk that must be assumed by the employer with 2-50 employees for the payment of claims under a stop-loss insurance policy has risen and acts as a disincentive for those employers in 2016. When attachment points rise, there is greater financial risk for the employer.

However, some of the incentives for a small employer who self-funds the employees' health plan are that the employer's benefit plans are exempt from state insurance regulation. Self-funded plans are subject to federal regulation under ERISA, HIPAA and the ACA.[26] Self-funded plans often have very few minimum coverage requirements and plans cannot be subject to rate regulation because they have no rates.[27] Small employers who offer self-funded health plans to their employees in conjunction with medical stop-loss insurance are able to define the benefits for their plan for their employees and are not subject to Maryland mandated benefits.

Another option that small employers may consider in 2016 and going forward is disbanding their group health plan as a cost-saving measure and advising their employees to seek coverage elsewhere including entering into the individual market. However, as shown in the Maryland rate charts below, the small group market health insurance rates overall will decrease by 1.8% in 2016 including a 3.2% rate decrease by the carrier representing 57% of the small group market. These declines in the small group market can be attributed to increased competition and two decades of reform in the State's small group market.

2016 Rates

Carriers in the individual market	Average Rate Change approved	Market Share
All Savers Insurance (A UnitedHealthCare Company)	-3.2%	0%
CareFirst BlueChoice Inc.	19.8%	72%

[23] *Stop Loss Insurance, Self-Funding and the ACA, White Paper, NAIC, 2015*. http://www.naic.org/documents/committees_b_erisa_exposure_150324_stop_loss_white_paper_clean.pdf.

[24] *Employer Self-Insurance Decisions and the Implications of the Patient Protection and Affordable Care Act as Modified by the Health Care and Education Reconciliation Act of 2010 (ACA),* Technical Report, RAND Health, 2011: http://www.rand.org/content/dam/rand/pubs/technical_reports/2011/RAND_TR971.pdf .

[25] *Stop Loss Insurance, Self-Funding and the ACA, White Paper, NAIC, 2015*. http://www.naic.org/documents/committees_b_erisa_exposure_150324_stop_loss_white_paper_clean.pdf.

[26] Employer Self-Insurance Decisions and the Implications of the Patient Protection and Affordable Care Act as Modified by the Health Care and Education Reconciliation Act of 2010 (ACA), Technical Report, RAND Health, 2011: http://www.rand.org/content/dam/rand/pubs/technical_reports/2011/RAND_TR971.pdf.

[27] *Stop Loss Insurance, Self-Funding and the ACA, White Paper, NAIC, 2015* http://www.naic.org/documents/committees_b_erisa_exposure_150324_stop_loss_white_paper_clean.pdf.

CareFirst of Maryland Inc.	26.0%	14%
Cigna Health and Life Insurance Co.	-3.3%	0%
Evergreen Health Cooperative	9.5%	1%
Group Hospitalization and Medical Services Inc. (A CareFirst Company)	26.0%	9%
Kaiser Foundation Health Plan of the Mid-Atlantic States	10.0%	3%
UnitedHealthCare of the Mid-Atlantic Inc.	-0.5%	1%
Total	20.5%	100%

Carriers in the small group market	**Average Rate Change approved**	**Market Share**
Aetna Health Inc.	5.3%	6%
Aetna Life Insurance Co.	7.5%	7%
CareFirst BlueChoice Inc.	-3.2%	57%
CareFirst of Maryland Inc.	-16.9%	2%
Evergreen Health Cooperative	8.9%	5%
Group Hospitalization and Medical Services Inc. (A CareFirst Company)	-16.9%	7%
Kaiser Foundation of Health Plan of the Mid-Atlantic States Inc.	5.5%	3%
MAMSI Life and Health Insurance Co. (A UnitedHealthCare Company)	1.7%	4%
Optimum Choice (A UnitedHealthCare Company)	-2.9%	3%
UnitedHealthCare Insurance Co.	1.7%	4%
UnitedHealthCare of the Mid-Atlantic	1.7%	1%
Total	-1.8%	100%

At the same time individual market rates will increase 20.5% overall in 2016 including a 19.8% increase by the carrier representing 72% of the individual market. In the individual market health insurers have sought rate adjustments in response to significant changes in regulation and market dynamics over the past two years. Individual rates are moving more closely in-line with small group rates. This makes sense because the individual market is now being offered under the same set of rules that have applied to the small group market over the past 20 years in Maryland including guaranteed issue; community rating; and comprehensive benefits. While the option of disbanding their group as a cost-saving measure may seem attractive to the small employer, rate convergence will continue between individual and small group rates and likely result in individual rates that are very close to those of the small group market, if not higher. In addition, some small employers may be hesitant to stop offering health coverage to their employees for fear of losing employees to other employers who do offer health coverage.

Analysis Task (7): *A comparison of the risk profile of small employers that self-insure and the risk profile of small employers that purchase health insurance in the small group market.*

To compare the risk profile of small employers that self-insure and the risk profile of small employers that purchase health insurance in the small group market the MIA would need to acquire health plan documents, claim data and additional information from the TPAs. Gathering this information would be difficult and impractical. In addition, at the time of the passage of Chapter 494, there was an urgency to collect this information for employers in the 51-100 market who, effective January 1, 2016, were to be redefined as small employers. Those employers with 51-100 employees would then have been subject to possible higher rates moving from experience rating to modified community rating and may have considered self-insuring as a possible option. With the passage of the PACE Act, there no longer seems to be a need to collect this information.

Analysis Task (8): *An assessment of the impact on the stability and viability of the small group market, including the possibility of adverse selection and higher premiums, resulting from employers*

(i) choosing to self-insure instead of purchasing health insurance in the small group market;

(ii) after self-insuring, switching to the small group market.

Small employers are very aware of the cost of health insurance for their employees and tend to search for less expensive options. Some shop their plans in the insured market each year. Other employers may choose to self-fund health plans for their employees, if they believe that their group is healthier than the average group. The

employers that choose to self-fund instead of purchasing health insurance in the small group market can create adverse selection by leaving the older, sicker, and higher risk groups for the small group market. Additionally, another factor that may contribute to adverse selection is the possibility that small employers, after self-insuring and experiencing high claims, switch back to the small group market. This concern is based on the differing underwriting standards between the two markets. Since small group market laws require modified community rating for the insured market and the self-funded market is based on an individual employer's risk profile, it is assumed that self-funded plans will be attractive to low-risk groups; conversely, high-risk groups are expected to see better rates in the modified community-rated environment of a fully-insured plan.

Maryland enacted small group reform in 1994 including guaranteed issue, guaranteed renewability, modified community rating and a standard benefit package. Many of the benefits we now see nationally as a result of the Affordable Care Act ("ACA") were included in the Maryland Health Insurance Reform Act of 1993. Since that time, small employers in Maryland have been able to either purchase health insurance in the small group market or chose to self-insure or switch back into the fully insured market after experiencing high claims. Effective January 1, 2016, under the ACA, the definition of "small group" would have expanded from an employer with 2-50 employees to an employer with 2-100 employees subjecting those employers with 51-100 employees to the small group rating rules. Employers with 51-100 employees would no longer be rated based on the experience of the employer's group, but on the modified community rating.

The NAIC White Paper, "*Stop Loss Insurance, Self-Funding, and the ACA,"*[28] provides a comprehensive assessment of the impact of stop-loss insurance on the stability and viability of the small group market, including the possibility of adverse selection and higher premiums, resulting from employers attempting to self-insure and then subsequently switching to the small group market.

When Chapter 494 passed there was concern that the employers with 51-100 employees with good claims experience would choose to self-insure or switch from self-insuring due to high claim experience to the small group market. Federal law has changed since this study was enacted. The new federal law, the PACE Act, will keep the definition of small employer at 50 employees for the foreseeable future, unless a state requires the small employer definition to be expanded to 100 employees. Since Maryland employers with 51-100 employees will continue to be considered large employers, it does not appear there will be any impactful movement by small employers which would result in adverse selection that would affect the stability and viability of the small group market.

Analysis Task (9): *An assessment of any impact on the Maryland Health Benefit Exchange of small employers choosing to drop coverage for their employees.*

Analysis Task 9 of the report is focused on whether there is an impact on the Maryland Health Benefit Exchange ('MHBE") when small employers drop coverage for their employees. Neither the MIA nor the MHBE collects this type of data. The MHBE does not ask applicants whether they had prior coverage, whether their last coverage was group coverage, or whether they lost coverage due to an employer dropping coverage.

As a result, the MIA developed a data call letter [29] to be sent to the carriers participating in the Maryland small group market in 2015. A second data call letter will be sent in 2016 to the carriers participating in the Maryland small group market. In the letter, the MIA asked whether any of the carriers collected data regarding the reasons why small employers dropped their health benefit plans with the carriers. Only three carriers of the 13 carriers participating in the Maryland small group market in 2015 collected this data. The three carriers that collected this data represent 9.7% of the Maryland small employer market.

One carrier reported that 605 employers terminated their health benefit plan coverage between December 30, 2014 and July 1, 2015. Of these 605 terminating employers, 496 moved their coverage to a different carrier, while 109 dropped coverage for their employees.

A second carrier reported that 37 employers terminated their health benefit plan coverage between December 30, 2014 and July 1, 2015. Of these 37 terminating employers, 10 moved their coverage to a different carrier, 12 dropped coverage for their employees, and 15 were unknown.

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[28] *Stop Loss Insurance, Self-Funding and the ACA, White Paper, NAIC, 2015*, Appendix A. http://www.naic.org/documents/committees_b_erisa_exposure_150324_stop_loss_white_paper_clean.pdf.

[29] A copy of the data call letter to carriers appears in Appendix 5.

The third carrier reported that 54 employers terminated their health benefit plan coverage between December 30, 2014 and July 1, 2015. Of these 54 terminating employers, 20 moved their coverage to a different carrier, two dropped coverage for their employees, and 32 dropped their coverage for a number of reasons including the employer was no longer in business (2), nonpayment of premium (14), change to a different market segment (12), and no remaining members (4).

None of the carriers tracked if the employees losing coverage ended up applying for coverage with the MHBE. Employees losing coverage have the option of purchasing directly from a carrier in the individual market, enrolling under a spouse's group coverage, purchasing through the MHBE, or not purchasing coverage. For employees who have higher incomes (over 400% of the federal poverty line), there would be no advantage to purchasing new coverage through the MHBE, as the reason for purchasing through the MHBE is to avail oneself of premium tax credits, and these higher income employees would not qualify for the premium tax credits.

The data provided indicated that employers were not dropping coverage for their employees, but instead changing carriers when they terminated their prior coverage. The 3 carriers that provided data in response to the survey did not represent the majority of the Maryland small group market. Therefore, we cannot assume that the data described above would apply to the entire small group market.

One reason this study was created was due to the concern that employers with 51-100 employees, who were considered large employers, would be considered small employers in 2016, and may decide to drop coverage rather than participate in the small group market. Federal law has changed since the bill requiring this study was enacted. The new federal law, the PACE Act, will keep the definition of small employer at 50 employees for the foreseeable future, unless a State requires the small employer definition to be expanded to 100 employees. Since Maryland employers with 51-100 employees will continue to be considered large employers, there does not appear to be a reason to assume that there will be a major shift in Maryland employers dropping coverage in the future. Therefore, there does not appear to be any evidence that there will be a major impact on the MHBE due to small employers dropping coverage for their employees.

Analysis Task (10): *An assessment of different attachment points for medical stop-loss insurance, the effect that medical inflation could have on the attachment points in statute, and the desirability of maintaining or adjusting the current statutory levels.*

Medical stop-loss insurance policies have two different attachment points: a specific attachment point and an aggregate attachment point. Stop-loss premiums vary by the levels of attachment points, among other things. For example, if the attachment point is higher, the stop-loss premium would be lower.[30]

Medical inflation is a potential factor that could impact stop-loss rates. A high medical inflation rate could cause costs for specific stop-loss coverage to increase at rates higher than the general inflation rate. Also, a company may have paid claims that came close to the attachment point, but did not reach it. With medical inflation, this would cause the claim to go over the attachment point. Therefore, a stop-loss carrier would have to cover a claim it would not have covered in the previous year. This type of event is known as "deductible erosion" in the industry. Maintaining the current statutory levels would mean business as usual in the industry. Small group employers who self-insure their health benefit plans could continue to enjoy the low attachment points for both specific and aggregate stop-loss, which would continue making self-insured health benefit plans affordable, but raising the cost of the medical stop-loss insurance, as more claims would be paid under a medical stop-loss policy with lower attachment points. Adjusting the current statutory levels to a higher point could steer some small group employers away from the self-insured health insurance market. These employer groups may move into the fully insured market or may decide to drop their coverage if the fully insured premium is not affordable.

The MIA is currently reviewing the Milliman *NAIC Report: Statistical Modeling and Analysis of Stop Loss Insurance for Use in the NAIC Model Act* prepared for the NAIC, May 24, 2012 and any regulatory or legislative activity in other states addressing medical inflation and medical stop-loss attachment points and will summarize the findings in the final report.

Analysis Task (11): *An assessment of the consumer protections in medical stop-loss insurance policies and contracts and the desirability of maintaining or adjusting the current statutory consumer protections.*

[30] Appendix 6 is a sample stop-loss base premium rate by specific attachment points from a carrier with the largest stop-loss market share. Appendix 7 is a sample of aggregate stop-loss rates by attachment points and group size.

The NAIC in its *Stop Loss Insurance, Self-Funded and the ACA, White Paper, NAIC, 2015* specifically addressed regulatory options to protect policyholders, consumers, and health care providers. Some of the options suggested by the NAIC included 1) minimum policy standards; 2) risk transfer; 3) disclosure; and 4) rate review.

Minimum policy standards are suggested as an option to protect employers and to ensure a level playing field for all insurers. One of the key minimum standards suggested is to address the issue of "lasering". "Lasering" is defined by the NAIC as "assigning different attachment points or deductibles, or denying coverage altogether, for an employee or dependent based on the health status of the individual."[31] Other minimum policy standards suggested to be included for employers were provisions regarding mid-term rate increases and payment of claims.

Chapter 494 has included certain statutory consumer protections for small employers who utilize medical stop-loss insurance. Chapter 494 adds protection against "lasering" within the contract and provides additional protections for the employer regarding rates and payment of claims. Specifically, §15-129(e) of Chapter 494 addresses "lasering" by prohibiting: 1) imposing higher cost sharing for a specific individual within a small employer's health benefit plan than required for other individuals within the small employer's health benefit plan; 2) decreasing or removing stop-loss coverage for a specific individual within a small employer's health benefit plan; or 3) excluding any employee or dependent from a policy or contract on the basis of an actual or expected health status–related factor or condition, including physical or behavioral health, including mental illness or substance use disorder; claims experience; medical history; receipt of health care; genetic information; disability; and any evidence of insurability, including conditions arising out of acts of domestic violence against an employee or dependent. Additionally, §15-129 (f) of Chapter 494 provides protection for the employer regarding rates and payment of claims by requiring guaranteed rates for at least 12 months, without adjustment, and paying stop-loss claims incurred during the policy or contract period and submitted within 12 months after the expiration date of the policy or contract.

For risk transfer, the NAIC Stop loss Model Act (#92) adopted in 1995, sets minimum standards for attachment points, which the NAIC suggests states review to determine whether they are appropriate to market conditions in their state. Those attachment point standards for small group are $20,000 for a specific attachment point and for an annual aggregate attachment point that is lower than the greater of: (i) $4,000 times the number of group members; (ii) 120 percent of expected claims; or (iii) $20,000. Maryland passed legislation in 1999 with attachment points lower than the NAIC model. Until the passage of Chapter 494, an insurer could not issue, deliver, or offer a policy or contract of stop-loss insurance, if the policy has a specific attachment point of less than $10,000 or an aggregate attachment point of less than 115% of expected claims. This applied to all policies of medical stop-loss insurance regardless of the size of the employer. Chapter 494 raises the specific attachment point for medical stop-loss insurance to $22,500 and the aggregate attachment point to 120%, effective June 1, 2015.

The NAIC also suggested that state regulators consider some type of disclosure to the small employer. A small employer is unlikely to have dedicated staff who are trained in understanding the differences between a fully insured plan and that of a self-insured plan. Stop-loss insurance products are exempt from certain requirements under state or federal health insurance law, including the ACA, and include certain financial risks. Small employers may benefit from education on the risk they are assuming in self-funding a health plan, as well as protections that they should be looking for when they shop for a medical stop-loss insurance policy. NAIC suggestions include that any disclosure developed include uniform key terms and definitions, ensure stop-loss policy purchasers receive and understand all necessary information and specific contract terms be disclosed as well. Chapter 494 has included a disclosure requirement be given to the small employer, in a form and manner approved by the Commissioner and before entering into a policy or contract for medical stop–loss insurance. The disclosure is required to include the total costs of the policy or contract; the dates on which the policy or contract takes effect and terminates; the provisions for renewing the policy or contract; the aggregate attachment point and the specific attachment point for the policy or contract; and any limitations on coverage. The MIA adopted such a disclosure by regulation. *See* COMAR 31.10.43, which becomes effective January 1, 2016.

An additional NAIC suggestion for those states that perform rate review of medical stop-loss premium rates, is to consider whether the premiums are reasonable in relation to the benefits conferred, whether the premium is allowed to vary based on the claims submitted by the employer, and for those employers without credible experience, to examine how the insurer calculates "expected" claims when determining compliance with minimum

[31] *Stop-Loss Insurance, Self-Funded and the ACA, White Paper, NAIC, 2015*.

aggregate attachment point requirements. In Maryland, insurers are required to obtain the approval of the Maryland Insurance Administration prior to use of a medical stop-loss premium rate. During the rate review process, the MIA reviews whether the premium is reasonable in relation to the benefits being offered. The MIA reviews the actuarial assumptions and methods used by the insurer to ensure adequacy of these assumptions. Furthermore, for all medical stop-loss premium rate filings, the MIA requires that the filing be signed by an actuary meeting the minimum qualification standards of the Society of Actuaries, attesting that the information contained in the premium rate filing is accurate and complies with Actuarial Standards of Practice Number 8.

At the time of filing this interim report, the MIA has received only one written comment on consumer protection, which the MIA is reviewing.[32] Additionally, the MIA is continuing to review recommendations for consumer protection suggested by the NAIC and interested parties while also monitoring and assessing how other states address regulatory options to provide consumer protections.

Analysis Task (12): *An assessment of the impact on local governments and small employers of any changes to the attachment points or consumer protections in medical stop-loss insurance policies and contracts.*

The MIA is currently working with the small employer community as well as the Maryland Association of Counties ("MACo") and the Maryland Municipal League ("MML") to provide feedback on the impact of the changes to the attachment points as well as the new consumer protections that were implemented by Chapter 494.

The MIA held a Public Informational Hearing on Medical Stop-Loss Insurance on September 28, 2015 to gather public opinion on the recent changes to the State stop-loss laws. MACo and MML provided written testimony voicing the organizations' concern for the Maryland Local Government Health Cooperative ("Cooperative").[33] The Cooperative is an insurance pool whose membership is limited to Maryland's counties, incorporated cities, and towns, and was established to allow public entities to more efficiently finance their employee health benefits through self-funding. The Cooperative was formed in 2010 and currently has 19 local government members. For small counties and municipalities of all sizes, the Cooperative provides an opportunity to maintain relatively high benefit offerings for their employees through self-insurance, an option that would be unavailable to them acting alone. Through the Cooperative, counties and municipalities come together and support each other by sharing in both the risks and benefits of self-insurance. According to MACo and MML, these local governments avoid unexpected and cost-prohibitive premium increases from year-to-year. In turn, any savings are passed on to both taxpayers and employees.

Both MACo and MML are working to provide the MIA with additional information regarding the current self-insured market and the impact of changes to the State medical stop-loss law on local governments. Specifically, MACo is currently collecting information relative to medical stop-loss carriers and the specific and aggregate attachment points for the counties that self-insure. MML is conducting a survey of its membership based on the study language in Chapter 494 and will compile that information. Benecon Group, Inc., the actuary for the Cooperative who specializes in developing and managing municipal health insurance cooperatives, including counties, school districts, townships, boroughs and other local government units is compiling information regarding the specific financial impact of the changes to the attachments point on the local governments.

Additionally, the medical stop-loss public hearing and the town hall meetings that were conducted by the MIA during the summer provided a forum for small employers to provide feedback about the impact of the changes made by Chapter 494. As of the date of the interim report, the MIA has not received any comments from either the local governments or small employers reacting negatively to the consumer protections included in Chapter 494. The MIA will continue to work with both local governments and small employers to gather information for the final report.

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[32] The Maryland Women's Coalition for Health Care Reform requested several areas to be addressed including prohibition of early termination or rescission other than for fraud or intentional misrepresentation, requiring a carrier to honor any claim which the employer is legally obligated to pay, stronger disclosure requirements, and transparency relating to the collection and use of individualized demographic and health data with an opt-in requirement for individuals. For a copy of the Maryland Women's Coalition for Health Care Reform's written comments see: http://insurance.maryland.gov/Documents/newscenter/legislativeinformation/Medical-Stop-Loss-Hearing-Comments.pdf.

[33] A full copy of MACo's and MML's written comments in response to the MIA's Public Informational Hearing on Medical Stop-Loss Insurance held on September 28, 2015 can be found at: http://insurance.maryland.gov/Documents/newscenter/legislativeinformation/Medical-Stop-Loss-Hearing-Comments.pdf .

VII. Conclusion

Since tasked with the study, the MIA has made significant progress in the research needed to respond to the Maryland General Assembly's request for the use of medical stop-loss insurance in self-funded employer health plans in Maryland. As summarized in this interim report, a majority of tasks have been addressed and substantial information has been developed. The MIA's work plan is tailored to the list of mandated tasks and a considerable continuing effort is necessary to satisfy the requirements of Chapter 494. Consequently, at this time, it is too early to draw meaningful conclusions based on the research completed or make any specific recommendations to the Committees. However, at the time of the passage of Chapter 494, there was an urgency to collect certain information for employers in the 51-100 market who, effective January 1, 2016, were to be redefined as small employers. Those employers with 51-100 employees would then have been subject to possible higher rates moving from experience rating to modified community rating and may have considered self-insuring as a possible option. Certain tasks, Task One (certain parts), Task Three, Task Six, Task Seven, Task Eight and Task Nine were designed to address the issue of the change of small group definition effective January 1, 2016 and its effect on the viability of the small group market. With the passage of the PACE Act keeping the definition of small employer at 50 employees for the foreseeable future, the need to collect that information no longer seems urgent or necessary. The MIA requests that certain requirements of this study be analyzed in light of the change in the federal law and the MIA be given direction on the remainder of study requirements. The MIA will be submitting its final report of findings and recommendations to the Committees on October 1, 2016.

EXHIBIT 3

Exhibit 3: Task #1 Data Call Letter and Survey

SENT VIA ELECTRONIC MAIL: [CONTACT EMAIL]

September XX, 2015

[NAME]
[COMPANY ADDRESS]

RE: **Data Call Letter – Medical Stop Loss Insurance**
Response Due by October XX, 2015

The Maryland Insurance Administration ("Administration") is required by legislation passed in the 2015 General Assembly[34] to conduct a study regarding medical stop loss insurance. Pursuant to Maryland Code Annotated, Insurance, §§2-205 and 2-209(g), and COMAR 31.04.20, the Administration has initiated a market conduct analysis ("analysis") to collect information needed for the study.

To conduct the analysis, the Administration requires that you fill out the attached spreadsheet with information on every medical stop loss policy issued or renewed by your company in the State of Maryland between June 1, 2014 and May 31, 2015 and answer the two questions posed below. Your response is due no later than September XX, 2015. Based on your company's response, you may be asked to respond to further Interrogatories and/or Requests for Production of Documents. If you have not issued or renewed any medical stop loss policies during the period of June 1, 2014 and May 31, 2015, please note that in your response. In this case, you are not required to complete the attached spreadsheet.

Questions

1. Does your company have a threshold for minimum number of employees in order to issue or renew a medical stop loss policy? If so, what was the minimum number of employees required for medical stop loss policies issued or renewed in Maryland between June 1, 2014 and May 31, 2015?

2. Does your company offer a set number of plan designs for medical stop loss policies? If so, how many plan designs were offered between June 1, 2014 and May 31, 2015? (Please consider the definition of "plan design" to be a fixed combination of a specific attachment point and an aggregate attachment point. For example, if the only medical stop loss policies your company offers are those with a specific attachment point of $30,000 and an aggregate attachment point of 150% of expected claims, then you only offer one plan design. If the attachment points are negotiated on an employer by employer basis, then your company offers an unlimited number of plan designs.)

3. What type of documentation do you require employers to complete in order to perform medical underwriting? Do the documentation requirements vary according to the size of the employer?

Additionally, and in accordance with COMAR 31.04.20.05E, your company is required to certify the accuracy of all information provided to the Administration by submitting a "Certificate of

[34] House Bill 552, Chapter 494, Acts of 2015.

Compliance" signed by an officer of the company. This certificate of compliance must be signed and submitted regardless as to whether you have issued or renewed any medical stop loss policies during the period of June 1, 2014 and May 31, 2015. A copy of the Administration's standard Certificate of Compliance is included at the end of this data call letter.

Please provide your response to Joseph Fitzpatrick, Market Data Analyst, via e-mail to joseph.fitzpatrick@maryland.gov by close of business September XX, 2015. If you are unable to provide the above information by the deadline, please contact Nour Benchaaboun, Chief, Market Analysis at (410) 468-2222 or via e-mail at nour.benchaaboun@maryland.gov at least 5 days prior to September XX, 2015 (by September XX, 2015). Please be sure to provide detailed information as to why you are unable to provide the information requested. If your company has no data to report, or did not issue or renew any medical stop loss policies during the time period in question, please report that, in writing, along with a completed Certificate of Compliance.

MARYLAND INSURANCE ADMINISTRATION MARKET CONDUCT ACTION CERTIFICATE OF COMPLIANCE

Pursuant to Code of Maryland Regulations ("COMAR") 31.04.20.05 E, I _____ hereby certify to the best of my knowledge, information, and belief, that the information hereto submitted to the Maryland Insurance Administration ("Administration") represents a full, complete and truthful response to the Maryland Insurance Commissioner's ("Commissioner") request dated [DATE], for accounts, records, documents, data or other information needed for the Administration's analysis.

I further attest that I am an authorized officer/representative of the Company, that I have undertaken an adequate inquiry to provide this certification to the Commissioner, and am authorized to bind the Company to the responses provided.

Signature: _____

Print Name: _____

Company: _____

Title: _____

Date: _____

MEDICAL STOP LOSS SURVEY Spreadsheet

MSL Policies Issued/Renewed Between 6/1/2014 - 5/31/2015

Insurer's Name: _____
NAIC Number: _____
Group Code: _____
Insurer contact's Name: _____
Mailing Address: _____
Telephone Number: _____
E-mail Address: _____
Number of Plan Designs: _____
Threshold for Minimum Number of Employees: _____

Number	Policy Number	Employer Zip Code	Number of Covered Lives	Number of Covered Employees	Average Age of Employees	Specific Attachment Point	Aggregate Attachment Point	Total Annual Premium	SIC Code
1									
2									
3									
4									
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EXHIBIT 4

Exhibit 4: Task #1 (i) Data call letter (pricing)

SENT VIA ELECTRONIC MAIL: [CONTACT EMAIL]

May XX, 2016

[NAME]
[COMPANY ADDRESS]

RE: Sample Quotes – Medical Stop Loss Insurance
Response Due by June XX, 2016

The Maryland Insurance Administration ("Administration") is required by legislation passed in the 2015 General Assembly to conduct a study regarding medical stop loss insurance. Pursuant to Maryland Code Annotated, Insurance, §§2-205 and 2-209(g), and COMAR 31.04.20, the Administration has initiated a market conduct analysis ("analysis") to collect information needed for the study.

To conduct the analysis, the Administration requires that you answer the questions posed below and provide sample quotes based on the parameters provided. Your response is due no later than June 1, 2016. Based on your company's response, you may be asked to respond to further questions. If you do not offer the type of product explained below, please note that in your response.

Questions

1. Do you offer a suite of products which includes not only stop-loss coverage, but a complete program for administration, Rx, network leasing, managed care, billing and enrollment, etc. for a complete turnkey self-funded benefit plan? If the answer is 'no' then you may proceed to the required Certificate of Compliance.

2. If the answer to question one is "yes", we are seeking quotations and proposals from you based on quoting criteria and scenario information we have provided on the next page of this letter. We request a total of eight quotes- using two employer groups, two hypothetical criteria for each employer that vary by standard industry code and zip code, and two specific and aggregate stop loss criteria. Please provide the overall plan rate and a comprehensive proposal for your self-funded benefit program for each quote.

3. Does your standard turnkey plan omit any of the Essential Health Benefits required in the small group market? If so, which ones?

Quoting Criteria

Two employer groups are listed in Appendix A. For each employer group, we have created 2 hypothetical criteria which vary by standard industry codes and geographic areas. Therefore there are 4 total census demographics exhibits contained in Appendix A. You may assume that each group's main operation is a single location. Additionally, assume that all groups are currently in the fully insured market and no claim data is available.

We are seeking proposals to provide benefits as similar as possible to the State selected benchmark plan. The schedule of benefits for that plan as well as the cost sharing associated with the most popular benefit plan is provided in Appendix B.

Scenario #1: Specific stop-loss $10,000 and aggregate factor of 115% of expected claims
Effective date: 5/1/2016

Scenario #2: Specific stop-loss of $22,500 and aggregate factor of 120% of expected claims
Effective date: 5/1/2016

Additionally, and in accordance with COMAR 31.04.20.05E, your company is required to certify the accuracy of all information provided to the Administration by submitting a "Certificate of Compliance" signed by an officer of the company. This certificate of compliance must be signed and submitted regardless as to whether you issue the types of turnkey products described above. A copy of the Administration's standard Certificate of Compliance is included at the end of this data call letter.

Please provide your response to Tyler Robison, via e-mail to tyler.robison@maryland.gov by close of business June 1, 2016. If you are unable to provide the above information by the deadline, please contact Nour Benchaaboun, Chief, Market Analysis at (410) 468-2222 or via e-mail at nour.benchaaboun@maryland.gov at least 5 days prior to June 1, 2016. Please be sure to provide detailed information as to why you are unable to provide the information requested.

MARYLAND INSURANCE ADMINISTRATION MARKET CONDUCT ACTION CERTIFICATE OF COMPLIANCE

Pursuant to Code of Maryland Regulations ("COMAR") 31.04.20.05 E, I _____ hereby certify to the best of my knowledge, information, and belief, that the information hereto submitted to the Maryland Insurance Administration ("Administration") represents a full, complete and truthful response to the Maryland Insurance Commissioner's ("Commissioner") request dated May 1, 2016, for accounts, records, documents, data or other information needed for the Administration's analysis.

I further attest that I am an authorized officer/representative of the Company, that I have undertaken an adequate inquiry to provide this certification to the Commissioner, and am authorized to bind the Company to the responses provided.

Signature: _____

Print Name: _____

Company: _____

Title: _____

Date: _____

Appendix A: Task #1 i Quoting Criteria (Data call letter, May 2016)

Count	COVERAGE	PERSON_TYPE	GENDER	AGE
1	Employee Only	Employee	Female	29
2	Employee Only	Employee	Female	24
3	Employee Only	Employee	Male	37
4	Employee Only	Employee	Female	32
5	Employee Only	Employee	Female	35
6	Employee	Employee	Male	53
		Spouse	Female	50
		Child	Female	18
		Child	Female	22
7	Employee	Employee	Male	54
		Spouse	Female	55
8	Employee Only	Employee	Female	26
9	Employee	Employee	Female	29
		Spouse	Male	30
10	Employee Only	Employee	Male	30
11	Employee Only	Employee	Female	27
12	Employee	Employee	Male	53
		Spouse	Female	57
		Child	Female	19
		Child	Male	22
13	Employee Only	Employee	Male	51
14	Employee	Employee	Female	54
		Spouse	Male	58
		Child	Female	24
		Child	Female	17
15	Employee	Employee	Male	44
		Spouse	Female	38
		Child	Female	5
		Child	Male	9
16	Employee Only	Employee	Male	34
17	Employee Only	Employee	Female	28
18	Employee Only	Employee	Female	49
18	Employee	Employee	Male	36
		Spouse	Female	38
		Child	Female	1
		Child	Female	3
20	Employee Only	Employee	Female	23
21	Employee Only	Employee	Female	26
22	Employee	Employee	Female	62
		Spouse	Male	65
23	Employee Only	Employee	Female	64
24	Employee Only	Employee	Female	57
25	Employee	Employee	Male	43
		Spouse	Female	44
26	Employee	Employee	Male	49
		Spouse	Female	48
27	Employee Only	Employee	Female	30
28	Employee Only	Employee	Female	30
29	Employee Only	Employee	Female	33
30	Employee Only	Employee	Male	39
31	Employee	Employee	Female	40
		Spouse	Male	42
		Child	Male	6
		Child	Male	9
32	Employee Only	Employee	Female	29
33	Employee	Employee	Male	59

Business Consulting

SIC Code 8748

Avg age of Employees	40
Avg age of Group	36
21 Employees - Females	
13 Employees - Males	
Total # of Employees	34
Number of Covered Lives	58
ZipCode (Baltimore City)	21215

		Spouse	Female	56
34	Employee Only	Employee	Female	63

Count	COVERAGE	PERSON_TYPE	GENDER	AGE
1	Employee Only	Employee	Female	29
2	Employee Only	Employee	Female	24
3	Employee Only	Employee	Male	37
4	Employee Only	Employee	Female	32
5	Employee Only	Employee	Female	35
6	Employee	Employee	Male	53
		Spouse	Female	50
		Child	Female	18
		Child	Female	22
7	Employee	Employee	Male	54
		Spouse	Female	55
8	Employee Only	Employee	Female	26
9	Employee	Employee	Female	29
		Spouse	Male	30
10	Employee Only	Employee	Male	30
11	Employee Only	Employee	Female	27
12	Employee	Employee	Male	53
		Spouse	Female	57
		Child	Female	19
		Child	Male	22
13	Employee Only	Employee	Male	51
14	Employee	Employee	Female	54
		Spouse	Male	58
		Child	Female	24
		Child	Female	17
15	Employee	Employee	Male	44
		Spouse	Female	38
		Child	Female	5
		Child	Male	9
16	Employee Only	Employee	Male	34
17	Employee Only	Employee	Female	28
18	Employee Only	Employee	Female	49
18	Employee	Employee	Male	36
		Spouse	Female	38
		Child	Female	1
		Child	Female	3
20	Employee Only	Employee	Female	23
21	Employee Only	Employee	Female	26
22	Employee	Employee	Female	62
		Spouse	Male	65
23	Employee Only	Employee	Female	64
24	Employee Only	Employee	Female	57
25	Employee	Employee	Male	43
		Spouse	Female	44
26	Employee	Employee	Male	49
		Spouse	Female	48
27	Employee Only	Employee	Female	30
28	Employee Only	Employee	Female	30
29	Employee Only	Employee	Female	33
30	Employee Only	Employee	Male	39
31	Employee	Employee	Female	40
		Spouse	Male	42
		Child	Male	6
		Child	Male	9
32	Employee Only	Employee	Female	29
33	Employee	Employee	Male	59
		Spouse	Female	56
34	Employee Only	Employee	Female	63

Business Consulting

SIC Code 8748

Avg age of Employees	40
Avg age of Group	36
21 Employees - Females	
13 Employees - Males	
Total # of Employees	34
Number of Covered Lives	58
ZipCode (Salisbury)	21801

Count	EMPLOYEE	COVERAGE	GENDER	AGE
1	EMPLOYEE ONLY	Employee	M	**53**
2	EMPLOYEE and Spouse	Employee	M	**31**
		SPOUSE	F	**24**
3	EMPLOYEE and Child	Employee	F	**51**
		CHILD	F	**17**
4	EMPLOYEE ONLY	Employee	M	**43**
5	EMPLOYEE and Spouse	Employee	M	**57**
		SPOUSE	F	**48**
6	EMPLOYEE ONLY	Employee	M	**47**
7	EMPLOYEE ONLY	Employee	M	**22**
8	EMPLOYEE and Children	Employee	M	**44**
		CHILD	M	**18**
		CHILD	F	**10**
		CHILD	F	**19**
		CHILD	M	**16**
9	EMPLOYEE ONLY	Employee	M	**54**
10	EMPLOYEE and Family	Employee	M	**48**
		SPOUSE	F	**49**
		CHILD	F	**18**
		CHILD	F	**15**
11	EMPLOYEE ONLY	Employee	M	**23**
12	EMPLOYEE ONLY	Employee	M	**57**
13	EMPLOYEE ONLY	Employee	M	**38**
14	EMPLOYEE ONLY	Employee	M	**42**
15	EMPLOYEE ONLY	Employee	M	**54**
16	EMPLOYEE ONLY	Employee	M	**58**
17	EMPLOYEE ONLY	Employee	M	**42**
18	EMPLOYEE ONLY	Employee	M	**37**
19	EMPLOYEE and Child	Employee	M	**35**
		CHILD	F	**11**
20	EMPLOYEE ONLY	Employee	M	**36**
21	EMPLOYEE ONLY	Employee	M	**49**
22	EMPLOYEE ONLY	Employee	M	**54**
23	EMPLOYEE ONLY	Employee	M	**37**
24	EMPLOYEE ONLY	Employee	M	**51**
25	EMPLOYEE ONLY	Employee	M	**45**
26	EMPLOYEE ONLY	Employee	M	**49**
27	EMPLOYEE+FAMILY	Employee	M	**50**
		SPOUSE	F	**50**
		CHILD	M	**11**
28	EMPLOYEE ONLY	Employee	M	**54**
29	EMPLOYEE ONLY	Employee	M	**45**
30	EMPLOYEE and Child	Employee	M	**42**
		CHILD	F	**15**
		CHILD	M	**19**
31	EMPLOYEE ONLY	Employee	M	**38**
32	EMPLOYEE ONLY	Employee	M	**22**
33	EMPLOYEE ONLY	Employee	M	**37**
34	EMPLOYEE and Child	Employee	M	**42**
		CHILD	F	**20**
35	EMPLOYEE ONLY	Employee	M	**42**
36	EMPLOYEE and Spouse	Employee	M	**35**
		SPOUSE	F	**34**

Contracting - Roofing

SIC Code 1761

Avg Age employee	**43**
Avg Age Group	**37**
1 Female employee	
35 Male employees	
Total # of Employees	**36**
Number of Covered Lives	**53**
Zipcode (Hagerstown)	**21740**

Count	EMPLOYEE	COVERAGE	GENDER	AGE
1	EMPLOYEE ONLY	Employee	M	**53**
2	EMPLOYEE and Spouse	Employee	M	**31**
		SPOUSE	F	**24**
3	EMPLOYEE and Child	Employee	F	**51**
		CHILD	F	**17**
4	EMPLOYEE ONLY	Employee	M	**43**
5	EMPLOYEE and Spouse	Employee	M	**57**
		SPOUSE	F	**48**
6	EMPLOYEE ONLY	Employee	M	**47**
7	EMPLOYEE ONLY	Employee	M	**22**
8	EMPLOYEE and Children	Employee	M	**44**
		CHILD	M	**18**
		CHILD	F	**10**
		CHILD	F	**19**
		CHILD	M	**16**
9	EMPLOYEE ONLY	Employee	M	**54**
10	EMPLOYEE and Family	Employee	M	**48**
		SPOUSE	F	**49**
		CHILD	F	**18**
		CHILD	F	**15**
11	EMPLOYEE ONLY	Employee	M	**23**
12	EMPLOYEE ONLY	Employee	M	**57**
13	EMPLOYEE ONLY	Employee	M	**38**
14	EMPLOYEE ONLY	Employee	M	**42**
15	EMPLOYEE ONLY	Employee	M	**54**
16	EMPLOYEE ONLY	Employee	M	**58**
17	EMPLOYEE ONLY	Employee	M	**42**
18	EMPLOYEE ONLY	Employee	M	**37**
19	EMPLOYEE and Child	Employee	M	**35**
		CHILD	F	**11**
20	EMPLOYEE ONLY	Employee	M	**36**
21	EMPLOYEE ONLY	Employee	M	**49**
22	EMPLOYEE ONLY	Employee	M	**54**
23	EMPLOYEE ONLY	Employee	M	**37**
24	EMPLOYEE ONLY	Employee	M	**51**
25	EMPLOYEE ONLY	Employee	M	**45**
26	EMPLOYEE ONLY	Employee	M	**49**
27	EMPLOYEE+FAMILY	Employee	M	**50**
		SPOUSE	F	**50**
		CHILD	M	**11**
28	EMPLOYEE ONLY	Employee	M	**54**
29	EMPLOYEE ONLY	Employee	M	**45**
30	EMPLOYEE and Child	Employee	M	**42**
		CHILD	F	**15**
		CHILD	M	**19**
31	EMPLOYEE ONLY	Employee	M	**38**
32	EMPLOYEE ONLY	Employee	M	**22**
33	EMPLOYEE ONLY	Employee	M	**37**

Contracting - Roofing

SIC Code 1761

Avg Age of Employee **43**

Avg Age of Group **37**

1 Female employee

35 Male employees

Total # of Employees

Number of Covered Lives

Zipcode (Silver Spring)

34	EMPLOYEE and Child	Employee	M	**42**
		CHILD	F	**20**
35	EMPLOYEE ONLY	Employee	M	**42**
36	EMPLOYEE and Spouse	Employee	M	**35**
		SPOUSE	F	**34**

Appendix B: Task #1 (i) Quoting Criteria (data call letter, May 2016)

The cost sharing associated with the most popular benefit plan in the small group HMO are the following:

1. Rx benefit is $10/$45/$65/50% for Generic/Preferred Brand/Non-Preferred Brand/Specialty;
2. PCP Copay = $20;
3. Specialist Copay = $30;
4. ER Copay = $100;
5. I/P Copay = $250;
6. Coins = N/A;
7. Deductible = $1,500; and
8. Out of Pocket Max = $4,000.

The essential health benefits for small group market shall include:

1. Except as specified in item 5 below, the benefits described in Regulations .03, .03-1 and .09 of COMAR 31.11.06.
2. Habilitative services for adults (those 19 and over) that are at least equal to the rehabilitative benefits described in COMAR 31.11.06.03 A (15).
3. Pediatric vision benefits for children up to age 19 in accordance with the FEP Blue Vision high plan. The FEP Blue Vision high plan benefits include the following benefits:
    a. One routine eye examination, including dilation if professionally indicated, each year;
    b. One pair of prescription eyeglass lenses each year
    c. One frame each year;
    d. In lieu of eyeglasses , one pair of contact lenses each year; and
    e. Low vision services, including one comprehensive low vision evaluation every 5 years, 4 follow-up visits in any 5-year period, and prescribed optical devices, such as high-power spectacles, magnifiers and telescopes.
4. Pediatric dental benefits for children up to age 19[1] in accordance with the Maryland Children's Health Insurance Plan dental benefit, which includes benefits for:

[1] 45 C.F.R. § 155.1065 allows the pediatric dental component of the Essential Health Benefits (EHB) to be offered through a stand-alone dental plan in an Exchange. If stand-alone dental plans are available in the Exchange, section 1302(b)(4)(F) of the Affordable Care Act permits Qualified Health Plans offered in the Exchange to exclude coverage of the pediatric dental component of the EHB.

a. Periodic screening in accordance with the periodicity schedule developed by the American Academy of Pediatric Dentistry; and
b. Treatment of all dental services determined to be medically necessary for problems identified during screening or diagnostic evaluations. Benefits include diagnostic services, preventative services, restorative services, endodontic services, periodontics services, removable prosthodontics, maxillofacial prosthetics, fixed prosthodontics, orthodontics for children with severe dysfunctional, handicapping malocclusion, and adjunctive general services.

5. Mental health and substance use benefits in accordance with the Government Employees Health Association, Inc. Benefit Plan, which includes:

a. Professional services by licensed professional mental health and substance use practitioners when acting within the scope of their license, such as psychiatrists, psychologists, clinical social workers, licensed professional counselors, or marriage and family therapists.

i. Diagnosis and treatment of psychiatric conditions, mental illness, or mental disorders. Services include:

A. Diagnostic evaluation;
B. Crisis intervention and stabilization for acute episodes;
C. Medication evaluation and management (pharmacotherapy);
D. Treatment and counseling (including individual or group therapy visits);
E. Diagnosis and treatment of alcoholism and drug abuse, including detoxification, treatment and counseling;
F. Professional charges for intensive outpatient treatment in a provider's office or other professional setting.

ii. Electroconvulsive therapy;

iii. Inpatient professional fees;

iv. Outpatient diagnostic tests provided and billed by a licensed mental health and substance abuse practitioner;

v. Outpatient diagnostic tests provided and billed by a laboratory, hospital or other covered facility;

vi. Psychological and neuropsychological testing necessary to determine the appropriate psychiatric treatment.

b. Inpatient hospital and inpatient residential treatment centers services, which includes:

i. Room and board, such as:

A. Ward, semi-private or intensive care accommodations (Private room is covered only if medically necessary. If private room is not medically necessary, the contract covers only the hospital's average charge for semiprivate accommodations.);
B. General nursing care;
C. Meals and special diets.

ii. Other facility services and supplies--Services provided by a hospital or residential treatment center (RTC).

c. Outpatient hospital-Services such as partial hospitalization or intensive day treatment programs.

d. Emergency room-Outpatient services and supplies billed by a hospital for emergency room treatment.

e. Permissible exclusions for the mental health and substance use benefit:

i. Services by pastoral or marital counselors;
ii. Therapy for sexual problems;
iii. Treatment for learning disabilities and intellectual disabilities;
iv. Telephone therapy;
v. Travel time to the member's home to conduct therapy;
vi. Services rendered or billed by schools, or halfway houses or members of their staffs;
vii. Marriage counseling;
viii. Services those are not medically necessary.

6. Wellness benefits, which include:

a. A health risk assessment that is completed by each individual on a voluntary basis; and
b. Written feedback to the individual who completes a health risk assessment, with recommendations for lowering risks identified in the completed health risk assessment.

7. Insulin pumps--The diabetes treatment, equipment and supplies benefit of COMAR 31.11.06.03A (29) and COMAR 31.11.06.03H is expanded to include insulin pumps.

8. Cardiac rehabilitation benefits for individuals who have been diagnosed with significant cardiac disease, or who have suffered a myocardial infarction, or have undergone invasive cardiac treatment immediately preceding referral for cardiac rehabilitation. Cardiac rehabilitation is a comprehensive program involving medical

evaluation, prescribed exercise, cardiac risk factor modification, education and counseling. Benefits include:

a. Continuous EKG telemetric monitoring during exercise, EKG rhythm strip with interpretation, physician's revision of exercise prescription, and follow up examination for physician to adjust medication or change regimen; and
b. Increased outpatient rehabilitation services (physical therapy, speech therapy and occupational therapy) for cardiac rehabilitation of 90 visits per therapy, per contract year.
c. Exclusions applicable to cardiac rehabilitation-

i. Services must be provided at a place of service equipped and approved to provide cardiac rehabilitation.
ii. Benefits will not be provided for maintenance programs. Maintenance programs consist of activities that preserve the individual's present level of function and prevent regression of that function. Maintenance begins when the therapeutic goals of a treatment plan have been achieved, or when no additional progress is apparent or expected to occur.

9. Solid organ transplants and other non-solid organ transplant procedures-The organ transplant benefit found in COMAR 31.11.06.03A (20) is expanded to include all medically necessary non-experimental/investigational solid organ transplant and other non-solid organ transplant procedures. Covered services include the cost of hotel lodging and air transportation for the recipient individual and a companion (or the recipient individual and two companions if the recipient individual is under the age of 18 years), to and from the site of the transplant.

10. Pulmonary rehabilitation benefits (one (1) program per lifetime) for individuals who have been diagnosed with significant pulmonary disease. Permissible limitations include:

a. Services must be provided at a place of service equipped and approved to provide pulmonary rehabilitation services;
b. Benefits will not be provided for maintenance programs. Maintenance programs consist of activities that preserve the individual's present level of function and prevent regression of that function. Maintenance begins when the therapeutic goals of a treatment plan have been achieved, or when no additional progress is apparent or expected to occur.

11. Professional nutritional counseling and medical nutrition therapy-The nutritional services benefit found in COMAR 31.11.06.03A(19) is expanded to include benefits for unlimited medically necessary nutritional counseling provided by a licensed dietician- nutritionist, physician, physician assistant or nurse practitioner for an individual at risk due to nutritional history, current dietary intake, medication use or chronic illness or condition. It also includes unlimited medical nutrition therapy provided by a licensed dietician-nutritionist, working in coordination with a primary care physician, to treat a chronic illness or condition.

12. Delivery of benefits through patient centered medical homes for individuals with chronic conditions, serious illnesses or complex health care needs who agree to participate in a patient centered medical home program. This includes associated costs for coordination of care, such as:

    a. Liaison services between the individual and the health care provider, nurse coordinator, and the care coordination team;
    b. Creation and supervision of a care plan;
    c. Education of the individual and family regarding the individual's disease, treatment compliance and self-care techniques; and
    d. Assistance with coordination of care, including arranging consultations with specialists and obtaining medically necessary supplies and services, including community resources.

13. While abortion coverage is a part of the benchmark plan, in accordance with §1303(b)(1)(A) of the Affordable Care Act, carriers will not be required to cover these services.

EXHIBIT 5

Exhibit 5: Task #5 Sources

SOURCES	DATE	Link
NAIC WHITE PAPER	2015	http://www.naic.org/documents/SLI_SF.pdf
MILLIMAN REPORT: Statistical Modeling and Analysis of Stop-loss Insurance for Use in NAIC Model Act.	2012	http://www.naic.org/documents/committees_b_erisa_millman_naic_final_report.pdf
HEALTH SERVICES RESEARCH. Modeling Employer Self-Insurance Decisions after the Affordable Care Act	2013	Abstract: http://www.hsr.org/hsr/abstract.jsp?aid=48588 82175
RAND HEALTH REPORT Employer Self-Insurance Decisions and the Implications of the Patient Protection and Affordable Care Act as Modified by the Health Care and Education Reconciliation Act of 2010	2011	http://www.rand.org/content/dam/rand/pubs/technical_reports/2011/RAND_TR971.pdf
J. KAISER FAMILY FOUNDATION. 2016 Employer Health Benefits Survey.	2016	http://kff.org/health-costs/report/2016-employer-health-benefits-survey/
EMPLOYEE BENEFIT RESEARCH INSTITUTE	2016	https://www.ebri.org/pdf/notespdf/EBRI_Notes_07-no7-July16.Self-Ins.pdf
SELF-INSURANCE INSTITUTE OF AMERICA		http://www.siia.org/i4a/pages/index.cfm?pageid=1

EXHIBIT 6

Exhibit 6: Task #9 Survey

September XX, 2015

Company Name
Company Address

Re: Data Call Letter—Small Employer Health Benefit Plans
Response Due by:

House Bill 552, Chapter 494, Acts of 2015 requires the Maryland Insurance Administration to conduct a study of many aspects of the impact of medical stop-loss insurance in Maryland. One issue that is required to be studied is the impact on the Maryland Health Benefit Exchange of small employers choosing to drop coverage for their employees.[35]

In order to study this issue, we are requesting a response to the following questions:

1. When a small employer terminates a health benefit plan with your company, does your company track if:

a. The small employer is moving coverage to a different carrier in the small group market?

☐ Yes ☐ No.

b. The small employer is dropping coverage for its employees overall?

☐ Yes ☐ No.

If the answers to 1.a. and 1.b. are *both* "No" STOP. Return this survey to the address at the bottom of this survey.

2. If the answer to either question 1.a. or question 1.b. is "Yes":

a. How many small employers terminated health benefit plan coverage with your company between December 31, 2014 and July 1, 2015? _____

b. How many of the small employers who terminated health benefit plan coverage with your company between December 31, 2014 and July 1, 2015 moved their coverage to a different carrier? _____

c. How many of the small employers who terminated health benefit plan coverage with your company between December 31, 2014 and July 1, 2015 dropped coverage for their employees overall? _____

Thank you for your response. Please return the survey to Mr. Nour Benchaaboun, Chief, Market Analysis, Compliance and Enforcement Unit, Maryland Insurance Administration, 200 St. Paul Place, Baltimore, MD 21202 or email to Nour.Benchaaboun@maryland.gov. by September XX, 2015.

[35] Section 2, Item (d)(9), House Bill 552, Chapter 494, Acts of 2015.

EXHIBIT 7

Exhibit 7: Task #10 Attachment Points

STATES AND DC	SORTED BY: SPECIFIC ATTACHMENT POINT	AGGREGATE ATTACHMENT POINT		STATE	SPECIFIC ATTACHMENT POINT	SORTED BY: AGGREGATE ATTACHMENT POINT
AK	$10,000	120%		UT	$10,000	85%
KS	$10,000	120%		MD	$22,500	120%
LA	$10,000	120% (=<50) but 110% (>50)		AK	$10,000	120%
NV	$10,000	120% (=<50) but 110% (>50)		AR	$20,000	120% (=<50) but 110% (>50)
OK	$10,000	120%		CA	$40,000	120%
OR	$10,000	120%		CO	$20,000	120%
PA	$10,000	$100,000 per year		CT	$20,000	120% (=<50) but 110% (>50)
UT	$10,000	85%		FL	$20,000	120% (=<50) but 110% (>50)
TN	$10,000	120%		RI	$20,000	120%
AR	$20,000	120% (=<50) but 110% (>50)		IA	Not greater than 5% of claims	120%
CO	$20,000	120%		KS	$10,000	120%
CT	$20,000	120% (=<50) but 110% (>50)		OK	$10,000	120%
FL	$20,000	120% (=<50) but 110% (>50)		OR	$10,000	120%
MO	$20,000	120%		MO	$20,000	120%
MN	$20,000	120% (=<50) but 110% (>50)		VT	$20,000	120% (=<50) but 110% (>50)
				TN	$10,000	120%
RI	$20,000	120%		LA	$10,000	120% (=<50) but 110% (>50)
VT	$20,000	120% (=<50) but 110% (>50)		MN	$20,000	120% (=<50) but 110% (>50)
MD	$22,5000	120%		NV	$10,000	120% (=<50) but 110% (>50)
NJ	$25,000	125%				
CA	$40,000	120%		DC	$40,000	120%
DC	$40,000	120%		IN	Calculated by an actuary annually	125%
WA	5% or $100,000	120%		NE	NA	125%
GA	Calculated by actuary annually	Calculated by actuary annually		NJ	$20,000	125%
IN	Calculated by actuary annually	125%		OH	Rolling number, no more than 5% of aggregate premium up to $1 million and 2.5% of premium above that amount	125%
TX	Calculated by actuary annually	125%		TX	Calculated by actuary annually	125%
NE	NA	125%		WA	5% or $100,000	125%
IA	Not greater than 5% of claims	120%		GA	Calculated by actuary annually	Calculated by actuary annually
ND	Pool retention per person $50,000	No more than 10% of annual premium		PA	$10,000	$100,000 per year
OH	Rolling number, no more than 5% of aggregate premium up to $1 million and 2.5% of premium above that amount	125%		ND	Pool retention per person $50,000 No more than 10% of aggregate premium	No more than 10% of annual premium

EXHIBIT 8

Exhibit 8: Task 10: Medical Inflation Articles

SOURCE	DATE	FINDING
CNBC http://www.cnbc.com/2015/05/22/medical-cost-inflation-highest-level-in-8-years.html	May 2015	Medical care index rose .7% in April, biggest increase since January 2007 Driven by reported hikes in hospital services Milliman projects a 6.3% growth health care cost for a family Price increase in specialty drugs
Cypress Benefits http://www.cypressbenefit.com/Cypress_Solution/03_10_10/Leveraged_Trend.pdf	March 2010	Stop-loss premium can go up more than the medical trend due to the leveraged trend (effect of first-dollar medical inflation on stop-loss reimbursements) Employer keeps liability fixed but there is a 12% annual trend in medical claims
PWC http://www.pwc.com/us/en/health-industries/health-research-institute/behind-the-numbers.html		2017 medical costs will continue to rise at the same rate as 2016 Signs point to larger increases in the future Medical costs still outpace general economic inflation Roughly half of employer health costs are from hospital inpatient and outpatient spending but prescription drug share is increasing
Forbes http://www.forbes.com/sites/mikepatton/2015/06/29/u-s-health-care-costs-rise-faster-than-inflation/#4ac4ac106ad2	June 2015	Prices rise when demand increases relative to supply, but other forces influence cost of healthcare too (additional taxes and increased regulations, lawsuits and medical malpractice) Increase in price of drugs, medical devices and hospital care but there is a 2.3% medical device tax in the ACA Root of problem is over-regulation and excessive taxation
Kaiser http://kff.org/infographic/visualizing-health-policy-recent-trends-in-employer-sponsored-health-insurance-premiums/	January 2016	Between 1999 and 2015, employer-sponsored health insurance premiums increased by 203 percent, outpacing both inflation and workers' earnings. However, growth of premiums for family coverage slowed toward the end of that time period, from an average of 11 percent a year between 1999 and 2005, to 5 percent between 2005 and 2015.

EXHIBIT 9

Exhibit 9: Task #11 Consumer Protections

CONSUMER PROTECTION	DETAILS	COUNT	STATE
MINIMAL POLICY STANDARDS		**25**	
	No lasering	**4**	**CO, OH, UT, NY**
	Must be licensed in state or authorized to transact business in accredited insurer/authorized in state	**4**	**IA, ME, MO, SC**
	Must be actuarially certified	**2**	**CO, UT**
	Policy forms must be submitted to director for approval	**1**	**MO**
	Carriers not permitted to increase rates during policy year	**1**	**NH**
	Policy must require that all claims be submitted within 90 days of being incurred and that must provide both a 12 month and 15 month claims incurred period at policy year-end	**1**	**TX**
	Contract terms/rates must be guaranteed for minimum 12 months	**1**	**UT**
	Individual attachment point is optional	**1**	**WA**
	For incurred basis stop loss, policy must state that bankruptcy or insolvency of the plan or employer does not relieve the stop loss carrier from paying claims. Plan insures and pays the employer/policyholder, not participants	**1**	**KS**
	Commissioner may set additional standards via rulemaking	**1**	**AR**
	All claims to be submitted within 90 days of being incurred and policy must provide 23 month claim incurred period and 15 month paid claims period for each policy year	**1**	**IN**
	No individual deductibles	**1**	**OH**
	Stop loss carriers must comply with all laws of the state that apply to the underlying health plan	**1**	**MN**
	Insolvency of plan or employer doesn't relieve carrier from obligation to pay claims. Carrier must be licensed in state as must producer. No risk pooling among multiple employer members.	**1**	**PA**
	MEWA must deposit a bond with the Commissioner for payment of claims if the MEWA becomes insolvent	**1**	**TN**
	Any administrator retained by MEWA must be a licensed TPA. MEWA must provide proof of a fidelity bond on TPA. All rates must be actuarially certified	**1**	**OK**
	Aggregate coverage must cover incurred, unpaid claim liability in the event of plan termination	**1**	**SC**
	Carrier in state must be licensed in state as must producer	**1**	**PA**
DISCLOSURES		**16**	
	CANCELLATION POLICY: **Carrier must give 180 day notice of cancellation or non-renewal** **Carrier must provide 60 day notice of cancellation or non-renewal to Commissioner** **Carrier must give 90 day notice to commissioner upon cancellation or renewal** **Carrier must give 30 day notice** **Can't be cancelled for minimum of one year, If purchase on paid loss basis, minimum 3 month reporting period after termination of policy** **Carrier may not terminate coverage unless it provides to insured and director minimum 30 day notice of intent to do so** **Policy must provide for at least 90 day notice to the superintendent and the MEWA of any cancellation or non-renewal** **Policy non-cancellable for minimum of 2 year term, must include provisions to cover incurred claims in event of plan insolvency/termination**	**10**	 **GA** **IN** **IA** **LA** **MI** **NE** **NM** **MO** **NY** **SC**

	No cancelling for claims experience Carrier can't cancel or modify terms without providing 30 days' notice, policy can't be canceled for minimum 2 years		
	Multiple disclosures required in writing to insured employer	**1**	**CO**
	Insurer must provide small employer with completed disclosure form as specified by COMAR	**1**	**MD**
	Certain disclosures required (premium, inception/termination dates, and attachment points.) Pre-existing condition waiting periods may be approved by the Superintendent to prevent "significant financial hardship" to the group	**1**	**NY**
	Disclosure requirements are uncommon	**1**	**SD**
	Carrier must provide certain disclosures to employer	**1**	**UT**
RISK TRANSFER		**6**	
	Bankruptcy of insolvency of employer or plan does not relieve carrier of obligations. Claims incurred during the policy period shall be covered if proof of payment by plan is given within 90 days of plan termination. Rates may not be adjusted during first 12 months.	**1**	**LA**
	Liability once ceded may not be directly or indirectly returned to a pool or member	**1**	**ND**
	Individual attachment point increased to no lower than $20,000	**1**	**CO**
	Specific attachment point of $22,500 and aggregate attachment point of 120%, pre 6/1/2015 policies grandfathered at lower rates	**1**	**MD**
	No risk pooling among multiple employee members	**1**	**PA**
	Individual attachment point to $25,000, aggregate unchanged, sunset on 9/28/2016	**1**	**NJ**
RATE REVIEWS		**2**	
	Must provide payment of incurred claims after coverage ends	**1**	**UT**
	Rates and forms must be filed for review	**1**	**UT**