MARYLAND HEALTH BENEFIT EXCHANGE

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September 29, 2022

Governor Larry J. Hogan Jr.
Governor's Office of Maryland
100 State Circle
Annapolis, Maryland
21401-1925

Senator Delores G. Kelley, Chair
Senate Finance Committee
Miller Senate Office Building, 3 East
11 Bladen Street
Annapolis, MD 21401

Delegate Joseline A. Peña-Melnyk, Chair
House Health and Government Operations Committee
Taylor House Office Building, Room 241
6 Bladen Street
Annapolis, MD 21401

Re: SB 632/Ch. 483, 2022 MSAR #14276 – Small Business and Nonprofit Health Insurance Subsidies Program – Workgroup Report

Dear Governor Hogan, Chair Kelley, and Chair Peña-Melnyk,

Pursuant to Senate Bill 632 of the 2022 Session of the Maryland General Assembly, the Maryland Health Benefit Exchange (MHBE) submits this report on the findings and recommendations of the Small Business and Nonprofit Health Insurance Subsidies Program.

If you have any questions regarding this report, please contact Johanna Fabian-Marks, Director of Policy and Plan Management at (443) 890-3518 or at johanna.fabian-marks@maryland.gov.

Sincerely,

Michele Eberle

Michele Eberle

Executive Director

cc: Sarah Albert, Department of Legislative Services (5 copies)

Legislative Report:

Small Business and Nonprofit Health Insurance Subsidies Program Workgroup

Maryland Health Benefit Exchange

September 29, 2022

Contents

Executive Summary 5

Background 6

History of the Small Group Market 7

Prior Small Business Subsidies in Maryland 7

ACA Small Business Health Options Program (SHOP) 8

Affordable Care Act Small Business Health Options Program (SHOP) Tax Credits in Maryland 9

SHOP Enrollment 10

Current Small Business Environment in Maryland 11

Individual and Small Group Market Data 15

Enrollment 15

Premiums 16

Individual Market Federal Premium Subsidies 17

Workgroup Overview 18

Summary of Meetings 19

Session 1 19

Session 2 19

Sessions 3 & 4 20

Session 5 27

Session 6 28

Findings and Considerations 29

Finding #1: Individual Market Coverage Very Affordable Due to Enhanced Federal Subsidies and State Reinsurance Program 29

Finding #2: Small Group Subsidy Cost Is Not Justified at This Time 30

Finding #3: Individual Market Subsidy for Small Employers Could Threaten Small Group Market Stability 31

Considerations if a Small Group Subsidy Is Implemented in the Future 31

Consideration #1: Simplicity Should Be Prioritized 31

Consideration #2: Subsidy Should Last as Long as Politically Feasible, Then Phase Out 31

Consideration #3: Employer Contribution Requirements Unpopular but Could Help Ensure Affordability of Employer Coverage 32

Recommendation 32

Conclusion 34

Appendix A: Workgroup Charter 35
Appendix B: Subsidy Cost Projections 38
Appendix C: Subsidy Phase-Out Designs 43
Appendix D: Preliminary Marketing and Outreach Plan 45
Appendix E: Written Comments from Members 48

Tables and Figures

Tables

Table 1: Health Insurance Partnership Enrollment and Costs: 2008 - 2015 7
Table 2: SHOP Enrollment, 2014 - 2022 9
Table 3: Maryland Businesses with 1-49 Employees by Industry Type, as Reported in 2019 Statistics of U.S. Businesses Data 12
Table 4: Uninsurance Rates by Firm Size Among People Ages 15-64 Who Worked During the Year, at State and National Level, as Reported in the 2021 ASEC Supplement to the CPS 14
Table 5: Average Marketwide Premium, Individual & Small Group Markets, 2016 - 2021 16
Table 6: Average Rate Change, Individual & Small Group Markets, 2016 - 2023 16
Table 7: Expected Contribution Towards Second Lowest Cost Silver Plan by Percent of Federal Poverty Line (2022 Guidelines for 2023 APTC Determinations) 17
Table 8: Workgroup Members 18
Table 9: Subsidy Design Options 24
Table 10: Subsidy Costs by Program Design Scenario 25
Table 11: Premium Cost of Bronze Plan for Family of Four, Small Group vs. Individual Market (PY 2022) 30
Table 12: Illustrative Small Business Outreach Annual Cost Estimate Breakdown 34

Figures

Figure 1: Maryland Private-Sector Businesses with 1-49 Employees by Employer Size, as Reported in the Third-Quarter 2021 MD Quarterly Census of Employment and Wages 11
Figure 2: Percent of businesses offering health insurance by number of employees 13
Figure 3: Individual and Small Group Enrollment, 2016 - 2022 15

Executive Summary

After exploring several subsidy designs, the Workgroup recommends that the State postpone implementation of a small business and nonprofit subsidy until after the expiration of enhanced premium tax credits in the individual market. These credits were extended by the Inflation Reduction Act in August 2022, nearly nine months after the Maryland General Assembly established this Workgroup, and are set to expire by 2026 if Congress does not extend them. With the enhanced premium tax credits, in combination with the State Reinsurance Program, individual market premiums are significantly discounted. Consequently, it is not cost-effective for the state to create a small group subsidy program in the current environment and doing so would risk creating adverse incentives that could result in low-income employees paying more for coverage in a small group plan than they would pay for individual market coverage.

Instead, the Workgroup recommends that the legislature ensure MHBE has funding sufficient to significantly expand marketing and outreach to small employers, including nonprofit organizations, and their employees. The outreach would involve education and training regarding existing coverage options and facilitate enrollment. The Workgroup also recommends that MHBE re-engage stakeholders to discuss the possibility of a small business premium subsidy by the summer of 2024 if it appears likely that the enhanced premium tax credits in the individual market will expire.

Background

This report responds to Senate Bill (SB) 632 of the 2022 Session of the Maryland General Assembly, which requires "the Maryland Health Benefit Exchange to convene a workgroup to study and make recommendations relating to the establishment of a Small Business and Nonprofit Health Insurance Subsidies Program to provide subsidies to small businesses and nonprofit employers and their employees for the purchase of health benefit plans."[1]

"The workgroup convened… shall study and make findings and recommendations regarding:

1) The health insurance coverage needs of small employers, nonprofit employers, and their employees;
2) Objectives and target metrics for the Program;
3) The optimal scope and design features of a Small Business and Nonprofit Health Insurance Subsidies Program, including:
    a) Whether subsidies under the Program should be available for the purchase of qualified health plans offered to small employers on the Exchange and the purchase of health benefit plans offered to small employers outside the Exchange;
    b) Subsidy eligibility and payment parameters for the Program;
    c) The administrative structure and infrastructure investments required for implementation of the Program, including any requirements for the Exchange, health insurance carriers, and any other entities involved in the implementation of the Program; and
    d) The duration of the Program;
4) The cost to administer the Program, including the cost to provide subsidies and operational costs; and
5) The sources and levels of funding needed to support the Program."[2]

[1] https://mgaleg.maryland.gov/mgawebsite/Legislation/Details/sb0632
[2] Ibid.

History of the Small Group Market

Maryland has a long history of protecting and encouraging a healthy, robust small group market. With Maryland's Health Insurance Reform Act of 1993, the state established many protections in the small group market that became required nationally with the later passage of the Affordable Care Act, such as requirements that insurers sell to all small businesses regardless of their employees' health status, prohibitions on excluding coverage for pre-existing conditions, and standards for benefits that had to be covered in small group plans.[3] When considering policy changes to further support the small group market, it is important to acknowledge that thanks to these reforms, Maryland's small group market has been stable, with modest annual rate increases and relatively steady enrollment, for decades. Maryland's market is also supported by an infrastructure of insurers, third party administrators, and producers, who provide administrative and educational support to small employers.

Prior Small Business Subsidies in Maryland

The Maryland Working Families and Small Business Health Coverage Act of 2007 created the Health Insurance Partnership, which provided subsidies to small businesses for purchasing health insurance. Only businesses who had not offered health insurance within the previous 12 months were eligible. The subsidies were available to businesses with two to nine employees[4] with low to moderate wages. Average annual wages of participants were around $28,500 in most years of the program. Program costs during the peak of the program ranged from $2 to $3 million per year (see Table 1).

Table 1: Health Insurance Partnership Enrollment and Costs: 2008 - 2015[5]

	Dec 2008	Dec 2009	Dec 2010	Dec 2011	Dec 2012	Dec 2013	Dec 2014	Dec 2015
Number of Participating Employers	79	221	315	370	425	423	70	18
Number of Participating Employees	246	646	892	1,066	1,171	1,205	184	42

[3] "Staff Report to the Maryland Health Care Commission: Maryland's Small Group Health Insurance Market - Summary of Carrier Experience for the Calendar Year Ended December 31, 2001," *Maryland State Archives,* June 21, 2002, https://msa.maryland.gov/megafile/msa/speccol/sc5300/sc5339/000113/000000/000355/unrestricted/20040714e.pdf.

[4] An eligible employee would be "an individual who is not a temporary, seasonal, or substitute employee and works 30 hours or more per week. Owners and partners working at least 30 hours per week count as eligible employees, as do independent contractors who work at least 30 hours per week if the employer chooses to insure them." Maryland Health Care Commission. (2016, January 1). *Health Insurance Partnership Final Report.* http://dlslibrary.state.md.us/publications/Exec/DHMH/MHCC/IN15-12A-05%281%29_2016.pdf.

[5] Ibid.

	Dec 2008	Dec 2009	Dec 2010	Dec 2011	Dec 2012	Dec 2013	Dec 2014	Dec 2015
Number of Covered Individuals	404	1,050	1,468	1,805	1,932	1,951	318	74
Average Annual Premium Subsidy per Covered Individual	$1,135	$1,232	$1,452	$1,397	$1,482	$1,484	$1,467	$1,723
Total Annual Subsidy for existing participants	**$458,534**	**$1,293,484**	**$2,138,086**	**$2,521,270**	**$2,863,097**	**$2,894,322**	**$466,551**	**$127,498**

The Health Insurance Partnership Program was phased out with the enactment of the Small Business Health Options Program (SHOP) under the Affordable Care Act (ACA). Like SHOP, the number of employers and covered lives under the Partnership remained low, with a range of 221 to 423 participating employers and 1,050 to 1,951 covered lives between 2009 and 2013.[6]

ACA Small Business Health Options Program (SHOP)

The ACA, enacted in 2010, required each state to establish a Small Business Health Options Program to "make it easier for employers to compare health plans, and to give their employees choice in coverage at an affordable price."[7] Currently, states are required to certify small group plans submitted by insurers as "qualified health plans," determine whether an employer meets eligibility requirements to purchase a qualified health plan, and assist qualified employers in facilitating the enrollment of their employees in qualified health plans. States are not required to offer a comprehensive small group plan shopping and enrollment platform (as they are required to do in the individual market).[8] Most states allow insurers to sell small group plans that are not qualified health plans in addition to small group qualified health plans.

MHBE's methods for facilitating SHOP enrollment have changed over time. In 2014, MHBE administered a "direct enrollment" process solely for the employer choice model. In this process, the Exchange determined employer eligibility to participate in the SHOP program, and then reported enrollment

[6] Maryland Health Care Commission. (2016, January 1). *Health Insurance Partnership Final Report*.
[7] Haase, L., Chase, D., and Gaudette, T. (2017, July). Talking SHOP: Revisiting the Small-business Marketplaces in California and Colorado. *The Commonwealth Fund.* Retrieved from: https://www.commonwealthfund.org/publications/fund-reports/2017/jul/talking-shop-revisiting-small-business-marketplaces-california.
[8] HHS Notice of Benefit and Payment Parameters for 2019, 83 Fed. Reg. 16930 (April 17, 2018) (to be codified at 45 CFR parts 147, 153, 154, 155, 156,157, 158).

information to CMS and the IRS. Producers worked directly with carriers and third-party administrators (TPAs) to sell SHOP-certified plans to employers.

In 2015, MHBE continued the direct enrollment process for Employer Choice plans. MHBE contracted with three TPAs to administer the Employee Choice model.

In 2016, MHBE contracted with one TPA to administer both Employer and Employee Choice models.

By 2019, MHBE had returned to the direct enrollment process for both Employer and Employee choice models, and in 2020 began developing the Maryland Health Connection for Small Business portal.

Table 2: SHOP Enrollment, 2014 - 2022

	2014	2015	2016	2017	2018	2019	2020	2021	2022*
Employers	43	88	113	107	148	152	156	121	117
Covered Lives	263	604	735	588	853	821	878	649	645

*Data available as of August 31, 2022.

Affordable Care Act Small Business Health Options Program (SHOP) Tax Credits in Maryland

The ACA does not require small businesses to offer health insurance coverage. Instead, it created the SHOP tax credit intended to incentivize small businesses to offer coverage for their employees. Maryland does not mandate small businesses to contribute towards their employee's premiums, but SHOP tax credit eligibility requires a contribution.

Small businesses in Maryland applying for a qualified small group health plan can use the Maryland Health Connection for Small Business website to apply for eligibility for a tax credit, find a SHOP authorized producer to assist with comparing quotes, and select an employer-sponsored plan to offer their employees.

Maryland small businesses and tax-exempt organizations may qualify for the Small Business Health Care Tax Credit if they:

- Buy group health insurance coverage through Maryland Health Connection for Small Business.
- Have fewer than 25 full-time equivalent (FTE) employees.
- Pay an average annual salary of less than $56,000 (adjusted for inflation).
- Contribute at least 50 percent toward employee-only health insurance premiums.[9]

Beginning in 2014, the maximum credit is 50 percent (35 percent for tax-exempt organizations) of the employer's premium payments.[10] The tax credit is only available for two consecutive years.

[9] ACA §1421; 26 USC § 45R(d)(1).
[10] ACA §1421; 26 USC § 45R(b).

SHOP Enrollment

To date, SHOP enrollment in Maryland and other states has remained low. As of April 30, 2022, there were 121 active groups in Maryland with 651 covered lives (there were about 260,000 covered lives in the small group market overall in 2022, On- and Off-Exchange).[11] Nationally, as of January 2017, 27,205 groups with 232,698 covered lives were enrolled in SHOP marketplaces.[12] This is significantly less than the Congressional Budget Office's estimate that four million people would enroll in SHOP coverage by 2017 nationwide.[13] Some factors related to low SHOP enrollment in Maryland as well as nationally include:

- A robust small group market existed prior to the introduction of SHOP.
- Originally, many states were prioritizing staff time and resources for the individual market over SHOP.[14]
- Many businesses were either not aware of the tax credit incentives or had salaries too high to qualify for impactful benefit.[15] The phase-out and limited/two-year availability of the tax credit, as well as the paperwork burden, were also barriers.[16]
- In the 2019 Benefit and Payment Parameter rule, CMS effectively ended the federal SHOP exchange.[17]
- The credit starts to decline with more than 10 employees and as average income over $27,000 increases.
- Now, firms may browse and compare plan options on Maryland Health Connection for Small Business, or on HealthCare.gov in states that don't operate their own SHOP, but they must enroll through either a SHOP-registered producer or directly with an insurer.[18]

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[11] Source: MHBE;
"Market Share and Enrollment of Largest Three Insurers – Small Group Market," *Kaiser Family Foundation,* https://www.kff.org/other/state-indicator/market-share-and-enrollment-of-largest-three-insurers-small-group-market/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

[12] Congressional Research Service. (2021, February 16). Overview of Health Insurance Exchanges. Retrieved from https://sgp.fas.org/crs/misc/R44065.pdf

[13] CMS. (May 15, 2017). *The Future of SHOP.* Retrieved from: https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/The-Future-of-the-SHOP-CMS-Intends-to-Allow-Small-Businesses-in-SHOPs-Using-HealthCaregov-More-Flexibility-when-Enrolling-in-Healthcare-Coverage.pdf.

[14] Haase et al 2015.

[15] Haase et al 2017.

[16] Blumberg, L. and Rifkin, S. (2014, August). Early 2014 Stakeholder Experiences with Small-Business Marketplaces in Eight States. *The Urban Institute.* Retrieved from: https://www.urban.org/sites/default/files/publication/22851/413204-Early-Stakeholder-Experiences-with-Small-Business-Marketplaces-in-Eight-States.PDF

[17] HHS Notice of Benefit and Payment Parameters for 2019, 83 Fed. Reg. 16930 (April 17, 2018) (to be codified at 45 CFR parts 147, 153, 154, 155, 156,157, 158).

[18] CMS. (2021, October 25). Marketplace 2022 Open Enrollment Fact Sheet. Retrieved from: https://www.cms.gov/newsroom/fact-sheets/marketplace-2022-open-enrollment-fact-sheet

- Insurer participation—and, consequently, plan availability—has been limited nationally. In over half of states, no insurers were offering SHOP plans as of plan year 2020.[19]

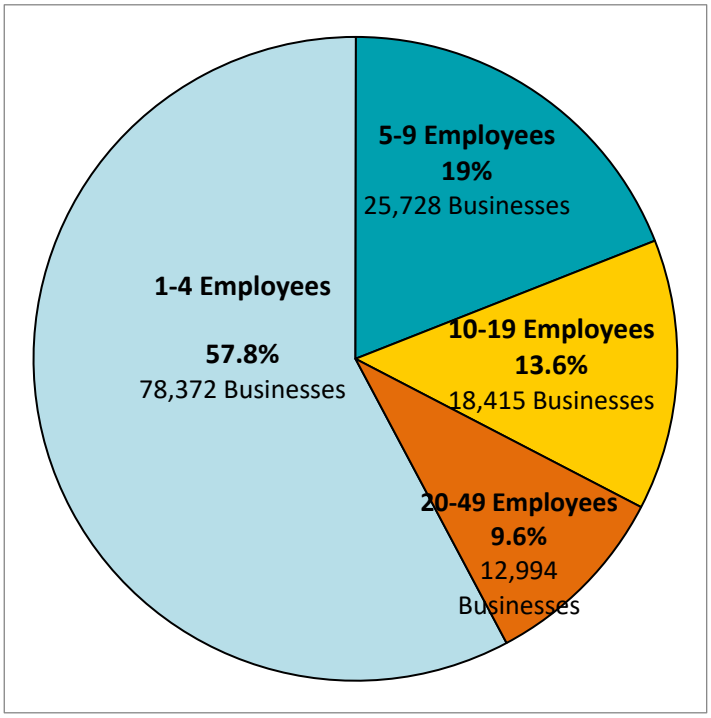
Current Small Business Environment in Maryland

Maryland defines a small business as one with between 1 and 50 employees.[20] As of the third quarter of 2021, there were an estimated 135,509 Maryland private-sector businesses operating with 1-49 employees. These businesses represent 77.4 percent of all private-sector businesses in the state.[21]

Figure 1[22] presents the number of private-sector businesses in the state with between 1 and 49 employees by employer size. Nearly 60 percent of these small businesses have between 1-4 employees.

Table 3 presents the industry types of Maryland businesses with 1-49 employees, as reported in the Census' 2019 Statistics on U.S. Businesses data. The category with the most small businesses was "Professional, Scientific, and Technical Services", followed by "Construction," then by "Other Services (except Public Administration)," then "Health Care and Social Assistance."[23]

Figure 1: Maryland Private-Sector Businesses with 1-49 Employees by Employer Size, as Reported in the Third-Quarter 2021 MD Quarterly Census of Employment and Wages



[19] Congressional Research Service. (2021, February 16). Overview of Health Insurance Exchanges. Retrieved from https://sgp.fas.org/crs/misc/R44065.pdf

[20] ACA §1304; 42 USC § 18024(b)(2); MD Code Ann., Ins. Art. §31–101(aa).

[21] Maryland Department of Labor. (2021). Maryland Quarterly Census of Employment and Wages: Employment and Wages by Size of Reporting Unit. Retrieved from http://www.dllr.maryland.gov/lmi/emppay/tab2md32021.shtml
Note: because of the size categories used by this reporting tool, businesses with exactly 50 employees are excluded from these estimates.

[22] Maryland Department of Labor. (2021). Maryland Quarterly Census of Employment and Wages: Employment and Wages by Size of Reporting Unit. Retrieved from http://www.dllr.maryland.gov/lmi/emppay/tab2md32021.shtml

[23] US Census Bureau. (2019). Statistics of US Businesses (SUSB) U.S. & States Data by NAICS with Detailed Employment Sizes. Retrieved from https://www.census.gov/data/tables/2019/econ/susb/2019-susb-annual.html

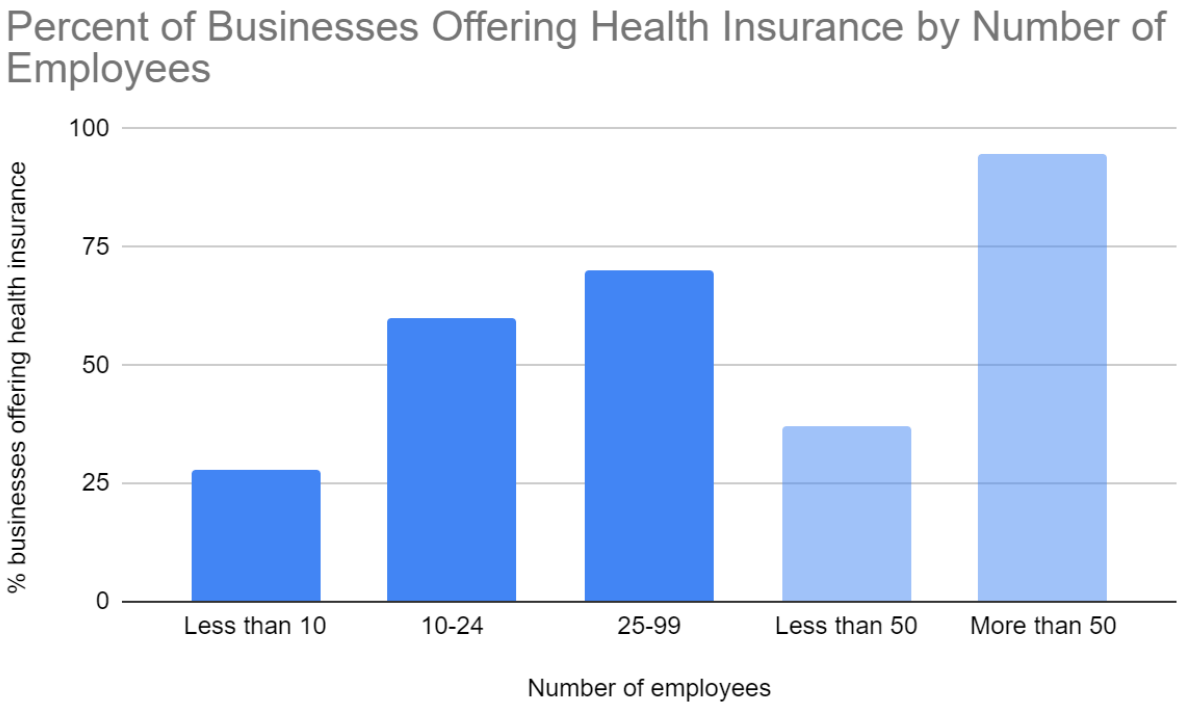
Table 3: Maryland Businesses with 1-49 Employees by Industry Type, as Reported in 2019 Statistics of U.S. Businesses Data[24]

Industry Type	Percent of Businesses
Professional, Scientific, and Technical Services	16.94%
Construction	13.22%
Other Services (except Public Administration) **includes Nonprofit Organizations*	12.25%
Health Care and Social Assistance	11.40%
Retail Trade	9.82%
Accommodation and Food Services	8.57%
Administrative and Support and Waste Management and Remediation Services	6.43%
Real Estate and Rental and Leasing	4.47%
Finance and Insurance	3.45%
Wholesale Trade	3.43%
Transportation and Warehousing	2.62%
Manufacturing	2.25%
Arts, Entertainment, and Recreation	1.79%
Educational Services	1.76%
Information	1.07%
Agriculture, Forestry, Fishing and Hunting	0.18%
Industries not classified	0.18%
Management of Companies and Enterprises	0.11%
Utilities	0.04%
Mining, Quarrying, and Oil and Gas Extraction	0.02%
Total	**100%**

[24] US Census Bureau. (2019). Statistics of US Businesses (SUSB) U.S. & States Data by NAICS with Detailed Employment Sizes. Retrieved from https://www.census.gov/data/tables/2019/econ/susb/2019-susb-annual.html

Small businesses in Maryland offer health insurance to their employees at persistently low rates. Just 28 percent of employers with less than 10 employees in the state reported offering their employees health insurance in 2020, compared to 60 percent of Maryland businesses employing 10 to 24 people and 94.7 percent of Maryland businesses employing 50 or more people.[25]

Figure 2: Percent of businesses offering health insurance by number of employees[26]



At small businesses in Maryland that do offer health insurance, however, take-up rates are similar to larger businesses: 67.7 percent of eligible employees at Maryland small businesses that offer health insurance are enrolled in health insurance, while the percentage for Maryland businesses with 50 or

[25] Agency for Healthcare Research and Quality. (2020). Center for Financing, Access and Cost Trends: 2020 Medical Expenditure Panel Survey - Insurance Component. Retrieved from https://meps.ahrq.gov/data_stats/summ_tables/insr/state/series_2/2020/tiia2.pdf
Note: while several national surveys experienced sharp drops in their response rates in 2020 due to the COVID-19 pandemic, the Insurance Component of the Medical Expenditure Panel Survey (MEPS-IC) experienced only a minimal decline in responses. As such, in 2020, the survey retained a sufficient sample to support state-level estimates like those included here. This data includes sole proprietors in the definition of businesses with "1" employee, although such businesses are not eligible for small group coverage in Maryland.

[26] Agency for Healthcare Research and Quality. (2020). Center for Financing, Access and Cost Trends: 2020 Medical Expenditure Panel Survey - Insurance Component tiia2.pdf (ahrq.gov).
Note: This dataset does not offer a breakdown for 26-50 employees or 51-99 employees. It only specifies the categories illustrated in the figure.

more employees is 67.3 percent. The numbers are slightly higher when narrowed to include only eligible full-time employees: for Maryland businesses who offer health insurance and employ less than 50 people, 69.5 percent of eligible full-time employees are enrolled, while 69.2 percent of eligible full-time employees at larger Maryland businesses offering health insurance are enrolled.[27]

Table 4 shows the health insurance coverage rates for small and large firms both for Maryland and at the national level among people ages 15-64 years who worked during the year, as reported in the 2021 Annual Social and Economic Supplement to the Current Population Survey. Maryland participation rates are better than the national average for both small and large employee groups. Note that the definitions of small and large firms are different in this table due to how the employer size variable was categorized in the data. In Maryland, 16.91 percent of employees in businesses with less than 100 employees were uninsured, compared with just four percent of workers at larger businesses. National data followed a similar pattern, with an uninsured rate among small business employees that was more than twice as high as the rate for employees of larger businesses.[28]

Table 4: Uninsurance Rates by Firm Size Among People Ages 15-64 Who Worked During the Year, at State and National Level, as Reported in the 2021 ASEC Supplement to the CPS[29]

Maryland			
Firm Size	**Respondents**	**# Uninsured**	**% Uninsured**
Small (<100 employees)	278	47	16.91%
Large (100 or more employees)	650	26	4.00%
United States			
Firm Size	**Respondents**	**# Uninsured**	**% Uninsured**
Small (<100 employees)	24,268	5,440	22.42%
Large (100 or more employees)	42,493	3,398	8.00%

[27] Agency for Healthcare Research and Quality. (2020). Center for Financing, Access and Cost Trends: 2020 Medical Expenditure Panel Survey - Insurance Component. Retrieved from https://meps.ahrq.gov/data_stats/summ_tables/insr/state/series_2/2020/ic20_iia_f.pdf

[28] US Census Bureau. (2021). Annual Social and Economic Supplement. Retrieved from https://www.census.gov/data/datasets/time-series/demo/cps/cps-asec.html

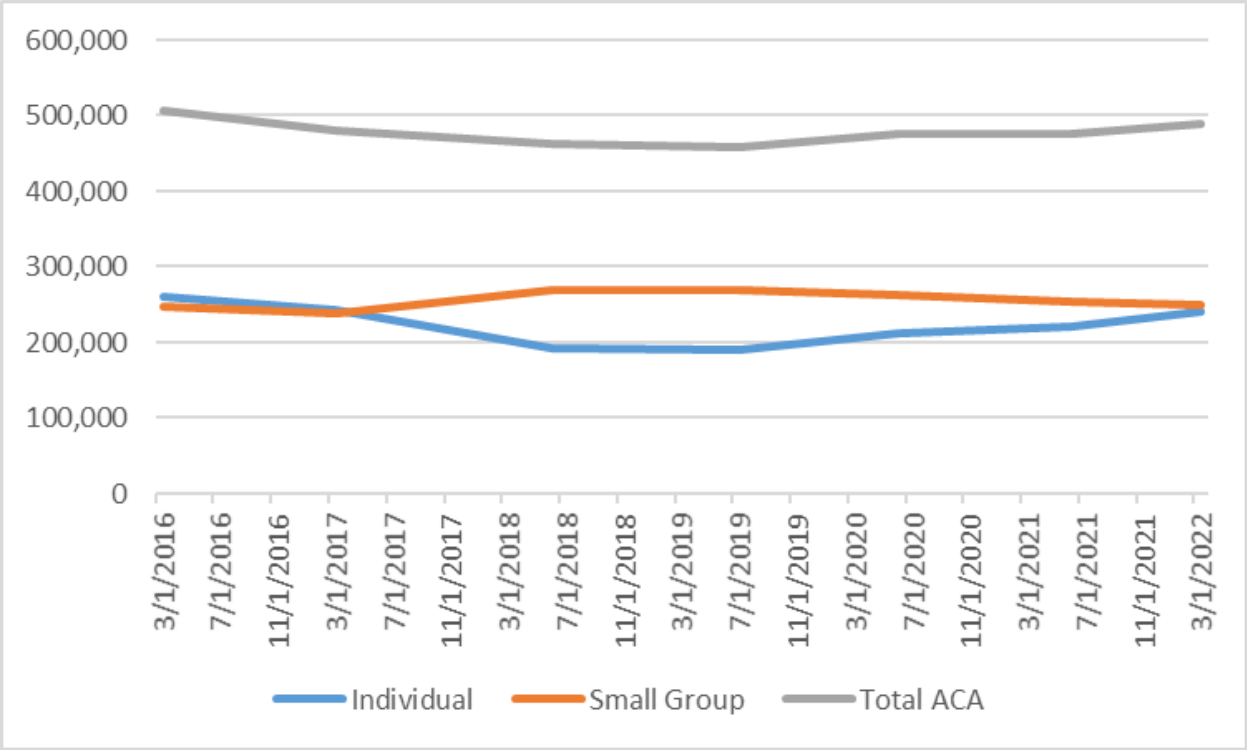
[29] US Census Bureau. (2021). Annual Social and Economic Supplement. Retrieved from https://www.census.gov/data/datasets/time-series/demo/cps/cps-asec.html

Individual and Small Group Market Data

Enrollment

Between July 2019 and March 2022, individual enrollment (on- and off-Exchange combined) grew by 51,000 lives (27 percent) and small group enrollment fell by 20,000 lives (8 percent). Overall, total ACA enrollment (all individual market plus small group market enrollment) grew by 30,000 lives, or 7 percent.[30]

Figure 3: Individual and Small Group Enrollment, 2016 - 2022



[30] MIA data.

Premiums

Rate Changes

Individual rates increased significantly until 2018, declined significantly from 2019-2021 due to the reinsurance program, then grew modestly in 2022.

Small group rates increased modestly each year between 2016 and 2022.

Premium Comparison

Individual market average premiums have fluctuated over time, starting out lower than small group premiums in 2016, then substantially exceeding the small group average by 2019, and by 2021 were about 18 percent below the small group average.[31]

Table 6: Average Rate Change, Individual & Small Group Markets, 2016 - 2023

Year	Average Rate Change	
	Individual	Small Group
2016	20.5%	-1.8%
2017	25.2%	3.3%
2018	33.1%*	1.9%
2019	-13.2%	5.0%
2020	-10.3%	3.0%
2021	-11.9%	2.3%
2022	2.1%	5.0%
2023	6.6%	7.6%

*Prior to CSR loading, representative of average unsubsidized increase

Table 5: Average Marketwide Premium, Individual & Small Group Markets, 2016 - 2021

Average Marketwide Premium			
	Ind	SG	SG vs Ind
2016	$325.33	$417.81	28.4%
2017	$400.46	$416.36	4.0%
2018	$592.62	$444.75	-25.0%
2019	$529.41	$456.90	-13.7%
2020	$470.99	$472.87	0.4%
2021	$417.75	$492.72	17.9%

[31] MIA data. This comparison does not control for differences in average age, location, or actuarial value.

Individual Market Federal Premium Subsidies

The American Rescue Plan Act increased federal Advance Premium Tax Credits (APTC) and eliminated the income cap on subsidy eligibility. The Inflation Reduction Act extended these subsidies through 2025.[32,33]

Table 7: Expected Contribution Towards Second Lowest Cost Silver Plan by Percent of Federal Poverty Line (2022 Guidelines for 2023 APTC Determinations)

Percentage of FPL	Max Expected Contribution Towards 2nd Lowest Cost Silver Plan	Household of 1		Household of 4	
		Income at % FPL	Expected Monthly Contribution	Income at % FPL	Expected Monthly Contribution
<150	0.00%	$20,385	$0.00	$41,625	$0.00
200	2.00%	$27,180	$45.30	$55,500	$92.50
250	4.00%	$33,975	$113.25	$69,375	$231.25
300	6.00%	$40,770	$203.85	$83,250	$416.25
>400	8.50%	$54,360	$385.05	$111,000	$786.25

Individuals are ineligible for APTC if they have an affordable offer of Minimum Essential Coverage[34] from their employer.[35] Affordability is defined by the Internal Revenue Service (IRS) each year.[36] On July 25, 2022, the IRS issued the 2023 affordability threshold—used to determine if an employer's lowest-premium health plan meets the Affordable Care Act's (ACA's) affordability requirement. The affordability threshold will be 9.12 percent of an employee's "household income," down from the 2022 limit of 9.61 percent.[33] Therefore, in 2023, if an employer offers coverage that costs less than 9.12 percent of a worker's household income, the worker is ineligible for APTCs in the individual market.

Since the inception of the ACA, APTC eligibility has been determined by the cost of the employer offer of coverage for the employee, not for family coverage. For example, a worker may be offered employer coverage that is below the affordability threshold for their own coverage but exceeds the affordability threshold when dependents are added to the plan. In these situations, the family is not eligible for APTC. This is referred to as the "family glitch." In April 2022, the IRS released a proposed rule to fix the family glitch and extend APTC eligibility to family members of employees with an employer offer that is only

[32] "Statements by CMS Leadership on President Biden Signing Inflation Reduction Act into Law," *CMS Newsroom*, https://www.cms.gov/newsroom/press-releases/statements-cms-leadership-president-biden-signing-inflation-reduction-act-law.

[33] "Key Facts: Premium Tax Credit," Health Reform Beyond the Basics, August 2022, healthreformbeyondthebasics.org/premium-tax-credits-answers-to-frequently-asked-questions/

[34] Minimum Essential Coverage is coverage that meets ACA requirements. More details at https://www.healthcare.gov/glossary/minimum-essential-coverage/.

[35] 26 U.S. Code § 36B - Refundable credit for coverage under a qualified health plan

[36] Miller, Steven, "IRS Sets 2023 Health Plan Premium Affordability Threshold at 9.12% of Pay," *SHRM,* August 5, 2022, https://www.shrm.org/resourcesandtools/hr-topics/benefits/pages/irs-sets-2023-health-plan-premium-affordability-threshold.aspx#:~:text=The%20IRS%20announced%20that,2022%20limit%20of%209.61%20percent.

affordable for self-only coverage.[37] The IRS had not yet finalized this rule as of the writing of this report, but the change is anticipated to go into effect for Plan Year 2023. This change would enable employers to offer affordable employee-only coverage without impacting family members' APTC eligibility. MHBE projects that an estimated 12,000 Marylanders who become eligible for APTC as a result of the family glitch fix would newly enroll in individual market coverage in 2023.[38]

Workgroup Overview

Please see Appendix A for the workgroup charter, which details the roles MHBE sought to fill among the workgroup membership.

Table 8: Workgroup Members

Name	Affiliation	Role
Glenn Arrington	Group Benefit Strategies	Small group insurance producer
Neil Bergsman	MD Nonprofits	Non-profit community
David Brock	Aetna	Small group insurer
Dana Davenport	Association of Community Services of Howard County	Non-profit employee
Janet Ennis	Maryland Health Care Commission	State agency
Jon Frank	Insurance Advisor	**Co-Chair**; small group producer
Bruce Fulton	Neighbor Ride	Non-profit employer
Amber Hyde	All About Benefits, LLC	Small group insurance producer
Stephanie Klapper	Maryland Citizens' Health Initiative	Consumer advocate
Mark Kleinschmidt	Anne Arundel County Chamber of Commerce	Chamber of Commerce
Jamal Lee	Breasia Productions	Small business owner/employer

[37] "Biden Administration Proposes to Fix the Family Glitch," *Health Affairs,* April 6, 2022, https://www.healthaffairs.org/do/10.1377/forefront.20220405.571745/.
[38] Lewis & Ellis Actuaries & Consultants, "2023 Analysis for the State Reinsurance Program," July 7, 2022, https://www.marylandhbe.com/wp-content/uploads/2022/08/4c.-MHBE-2023-SRP-Report-Final-20220707.pdf.

Lane Levine	A Friendly Bread	Small business owner/employer
Allison Mangiaracino	Kaiser Permanente	Small group insurer
Robert Morrow	UnitedHealthcare	Small group insurer
Henry Nwokoma	Maryland Insurance Administration	State agency
Trina Palmore	Solomon's Financial Group	Small group insurance producer
Deb Rivkin	CareFirst	Small group insurer
Sandy Walters	Kelly Benefits	Third-party administrator (TPA)
Rick Weldon	Frederick County Chamber of Commerce	**Co-Chair**; Chamber of Commerce

Summary of Meetings

The Workgroup met six times between July and September. Meeting recordings and minutes are available at https://www.marylandhbe.com/policy/work-groups/small-business-and-nonprofit-health-insurance-subsidies-program-workgroup/.

Session 1

MHBE staff presented on the history of the small group market (see background above). Members asked for more granular data on small employer health insurance offerings and the uninsured employee population, to the extent possible.

Session 2

After consulting with MHBE and Hilltop data experts, it was determined that it would not be possible to estimate the specific characteristics of uninsured people who work for small businesses based on available data. However, MHBE provided data on the uninsured in the state: as of April 2021, 357,000 Marylanders were uninsured, 258,000 of whom were eligible to enroll on Maryland Health Connection. Maryland Nonprofits shared a dashboard with data on nonprofits in the state. MHBE staff also presented data comparing individual and small group enrollment, premiums, rate changes, and federal subsidies over time (see background above).

MHBE staff summarized the possible goals for discussion.

A. Reduce cost of offering insurance for interested businesses (even if they are already offering insurance), or:

B. Reduce the number of uninsured individuals
    i. by increasing the number of small businesses that offer small group plans, or
    ii. by increasing the number of small businesses that connect their employees to individual market coverage.

Some members expressed a desire to attempt both goals. Others observed that option B(ii), a program that reduces the number of uninsured individuals by helping small businesses connect their employees to individual coverage, makes the most sense. This is because a small group subsidy would have to be very rich to compete with the value of individual coverage and therefore would be costly to implement, both for the state and small businesses. One member likewise observed that option A is more of an economic development goal and could be costly to implement, whereas reducing the number of the uninsured is part of MHBE's mission and an important goal for the state.

There was speculation as to whether the legislative intent was primarily to assist businesses, or primarily to reduce the uninsured rate, because a (most likely modest) subsidy program will likely not be able to achieve both goals. The group acknowledged the importance of education and outreach to small employers to make them aware of options through the individual market and of any program that comes out of the workgroup's recommendations.

The group raised concerns about the ease of navigation for employers, and the level and longevity of any funding secured for a subsidy program. Many bills include a sunset date for the appropriation, and this one likely would as well. The group debated the tradeoffs around political feasibility, sustainability, and evaluation. One debated and ultimately unpopular idea was to build a phase-out mechanism into the program so that employers are eligible for less subsidy as they grow.

There was also discussion around carriers not accepting individual insurance as an acceptable waiver for participation requirement. Carriers have 60 - 75 percent participation requirements for small businesses in the current small business insurance market.

Sessions 3 & 4

Around the time of the third session, the workgroup members submitted survey responses to share their opinions about the potential subsidy program design. MHBE staff used this feedback to draft possible program designs, including eligibility parameters, for the workgroup's discussion.

The proposed eligibility parameters are below, along with the group's commentary.

Employers with 2-9 employees

Most members supported the focus on employers with 2 to 9 employees, while one member felt that employers with 2 to 50 employees should be the target because the other qualifiers will functionally narrow the population to mostly businesses with 2 to 9 employees.

No health insurance offered within the last 12 months

Many members raised the concern that this parameter unfairly penalizes employers who did offer benefits within the last 12 months.

Less than 60 months in operation or years in business (0-2 years or 0-4 years)

Most members agreed that newer employers should be targeted.

Require employers to contribute a minimum 50 percent towards premium—yes or no?

Most members who spoke during the meeting felt that this requirement would be a deterrent to participation for small employers. However, the results of the survey showed that members are evenly split in their opinions on this provision. Some members suggested a required contribution of some percentage lower than 50 percent.

Revenue requirements (between $ and $)

No significant discussion on this suggestion.

Employee income requirements (less than $50,000)

Some members felt that this parameter would be difficult to implement because employers are not necessarily aware of their employees' *household* incomes. Others felt it was a good way to allocate subsidy dollars. One member mentioned that in the Maryland Partnership Program, eligibility was based on average employee salary rather than each income having to be below the limit.

In general, members felt that too many eligibility parameters would deter small employers from taking advantage of the program. Furthermore, as one member pointed out and others agreed, there would be challenges to the administration of this program because the data required to determine eligibility is not currently being collected. This member pointed out that the flat rate or flat per member per month reductions used in other states are less complicated.

One member suggested that the parameters of the pre-ACA Maryland Partnership Program were simple enough for employers to navigate and should be emulated in a new subsidy program: group size and income, with no required employer contribution.

MHBE staff also presented three preliminary subsidy design options (see Table 9). The workgroup's feedback on this first round of options is summarized in the "Findings and Considerations" section.

<u>Option 1: Traditional small group plan subsidy</u>

- Subsidy set at some percent of premium for employee (could include employee's family)
  - Could vary based on size or income (e.g., larger subsidy for small businesses)
  - Could be claimed monthly or quarterly

    - Subsidy period could be limited (e.g., 12 or 24 consecutive months)
    - *Lewis & Ellis eventually modeled 10 percent for all small employers or 20 percent for employers with less than 10 employees who had not offered coverage within the previous 12 months*
- Employer determined eligible through an application established by MHBE and administered by MHBE and/or Third-Party Administrator
- Upon determination of eligibility, the employer sets up employer sponsored plan(s). Employer could pass on all or some of the subsidy to the employees
- Employer can apply during Open Enrollment season (Nov 15 to Dec 15) to waive participation rules or any month (under existing small business guidelines)
- Subsidy applied directly to monthly invoice

Advantages:

- Employer gets financial assistance
- Employees gets perks with small group plans (wellness program incentives) that are not a feature of individual market plans
- There is a broader selection of plans in the small group market than in the individual market, potentially enabling employers to better find a plan that fits their needs
- Employers view the ability to offer a health insurance benefit as a good employment practice, and as beneficial in recruitment and retention

Disadvantages:

- Employee choices limited to those selected by the employer
- Employees lose Advance Premium Tax Credits (APTCs) and Cost-Sharing Reductions (CSRs) if they are offered an employer plan deemed affordable by the IRS (<9.12 percent of income in 2023)

<u>Option 2: Individual Coverage Premium Subsidy</u>

- Employer determined eligible through an application established and administered by MHBE
- Upon determination of eligibility, employer/employees are given a way to identify themselves (e.g. unique code) as eligible for subsidy when enrolling through MHC
- Employers would encourage employees to check eligibility for APTCs and additional subsidies
- A producer or the employer would assist employees with selecting an individual insurance plan, and employees would enter the unique employer code
- The subsidy could potentially be considered taxable income, so employee would need to reconcile when filing taxes
- MHBE would establish a new Special Enrollment Period for new hires of small employers

Advantages:

- No impact on employee eligibility for APTCs and CSRs
- Fewer state dollars required to cover more uninsured individuals
- Reduced premium cost to employees compared with traditional small group plans

Disadvantages:

- Employers bear compliance responsibilities
- Tax implications for the employee
- Employee does not receive the perks of traditional group plans

Option 3: Subsidized Individual Coverage Health Reimbursement Arrangement (ICHRA) Plans

- Similar to Option 1, with subsidy set at a dollar amount or a percentage of the employee's premium or their family's premium
- Eligibility determined through an application provided by MHBE or a TPA
- Eligible employers set up employer-sponsored Health Reimbursement Arrangement (HRA) plan
- Employers may set up a plan during any month of the year, not just during Open Enrollment. New offer of an ICHRA opens a Special Enrollment Period (SEP), allowing employees to enroll in individual coverage at any time.

Advantages:

- Employer contribution amounts can vary by different classes of employees
- Costs are lower than small group rates
- Flexibility for employers
- Employees control plan selections

Disadvantages:

- Employees lose eligibility for APTCs and CSRs if they are offered "affordable" employer coverage
- Not available to self-employed individuals
- There is a more limited selection of plans in the individual market than in the small group market
- More education and marketing efforts are necessary to encourage take-up by small businesses

The group was critical of Options 1 and 2. Option 3 was widely considered too complex to be practical. Detailed feedback is available in the next section ("Findings and Considerations") of this report.

Based on workgroup feedback, MHBE tasked contracted actuaries Lewis & Ellis with examining the costs of a traditional small group subsidy versus an individual market subsidy for workers at small employers. The ICHRA design was not modeled due to workgroup feedback about its complexity.

Table 9: Subsidy Design Options

	Traditional Small Group (Option 1)	Individual Market Subsidy (Option 2)	ICHRA (Option 3)
Plan design	Group plan(s) chosen by employer	Employees shop for individual plans with APTC and Additional State Subsidy	Employees shop for individual plans using employer + subsidy contribution
APTC	If plan is deemed affordable by the IRS (<9.12% of household income in 2023), employee does not qualify for APTC	If they qualify for APTC, employees can keep APTC	If plan is affordable, employee does not qualify for APTC
Premium cost	Higher premiums than individual plans; more selection	Lower premiums than small group plans; limited selection	Lower premiums than small group plans; limited selection
Employer Contribution	Employer's choice/discretion; tax deductible business expense. Employee contribution tax free under Section 125	No tax-advantaged way for employers to contribute. Employees may owe taxes on additional subsidy.	State could set contribution requirement
On/Off exchange	On- and Off-Exchange	On-Exchange	ICHRAs are available on/off exchange
SHOP Tax-credit	Available	Not available	Not available
Target program start date	January 1, 2024	January 1, 2024	January 1, 2024
Plan year start	1st of any month. Especially beneficial 11/15-12/15	Open Enrollment. Could establish SEP for employees newly eligible for subsidy.	Available Special Enrollment Period (SEP) by offering ICHRA plans

Simplicity	• Follows existing small group protocols in place with insurers. • Employer maintains plan eligibility & compliance	• Carriers, TPAs & small businesses have concerns but can implement this option. • Employer maintains plan eligibility & compliance	• Complex

Lewis & Ellis modeled program costs for options 1 and 2 under multiple eligibility scenarios based on workgroup feedback: employers with 1-49 employees (excluding sole proprietorships) and employers with 1-9 employees that did not offer a small group health plan within the last 12 months. Detailed projections are available in Appendix B.

Option 1A, a 10 percent reduction in small group premiums for all employers with 1-49 employees, is estimated to have a per member per month (PMPM) subsidy cost of $60, covering 292,671 individuals for an overall subsidy cost to the State of $174,464,709.

Option 1B, a 10 percent reduction in individual market premiums for employees of small employers, is estimated to have a PMPM subsidy cost of $38, cover 135,656 individuals, and cost the State a total of $51,182,920. A significant portion of the subsidy in this scenario is expected to go to consumers who are already enrolled in the individual market.

Option 2A, a 20 percent reduction in small group premiums for employers with 1-9 employees who did not offer a small group plan within the previous 12 months, is projected to have a PMPM cost of $111, participation from 25,775 individuals, and total cost to the State of $28,708,173. This employer cohort is expected to select lower-value small group plans based on what they can afford.

Option 2B, a 10 percent reduction in post-APTC individual market premiums for employees of employers with 1-9 employees who did not offer small group plans in the previous 12 months, has a projected PMPM cost of $37, participation of 68,161, and a total cost to the State of $25,717,643. This option would likely not reach many of the currently uninsured.

Table 10: Subsidy Costs by Program Design Scenario

Scenario	Subsidy %	Employee Uptake	Subsidy Cost PMPM	Uninsured Impact	Total Cost
1A: All small groups, *small group subsidy*	10%	292,671	$60	26,567	$174 million
1B: All small groups, *individual market subsidy*	10%	135,656	$38	10,697	$51 million
2A: 1-9 employees, no offer of coverage within past 12 months, *small group subsidy*	20%	25,775	$110	11,598	$29 million
2B: 1-9 employees, no offer of coverage within past 12 months, *individual market subsidy*	10%	68,161	$38	6,704	$26 million

Lewis & Ellis also presented year-over-year costs for possible phase-out designs that gradually reduce the subsidy amount over a two-year or four-year period for select subsidy scenarios. Detailed designs and cost projections for the phase-out options may be found in Appendix C. The projections were presented in response to members' desire for a phase-out design instead of a sudden termination of the subsidy if its duration must be limited. When presented with the phase-out designs, members expressed that any limit on subsidy duration would disincentivize participation and expressed a preference for a permanent subsidy.

After seeing the cost projections, many workgroup members expressed that none of the subsidy options make sense for Maryland right now, especially due to the generosity of the enhanced premium tax credits for individual market coverage that have been renewed for three additional years, through the end of 2025.

The Workgroup did not favor the individual market subsidy design, with members saying that it would be too complex to implement and does not align with the intent of Senate Bill 632. However, they acknowledged that the small group subsidy would also be disadvantageous: it would be expensive to the State and have a limited impact on small group enrollment; further, increased small group enrollment may not be a desirable goal given the current federal subsidy environment in the individual market. The

Workgroup also acknowledged that new offers of employer coverage could hurt low-income workers, who become ineligible for APTCs and CSRs if they have an offer of "affordable" employer coverage.

Several members agreed that perhaps small employers who do not offer small group plans should receive an incentive payment for each employee who signs up for coverage in the individual market.

Many group members felt that a 10 percent subsidy is too small to be an effective incentive. A small business owner on the workgroup shared that, if he did not already offer coverage, a 10 percent subsidy would not be enough to convince him to offer coverage. Producers in the group agreed that marketing such a small subsidy would cost them time and money that would not be worthwhile.

This session had 15 out of 19 Workgroup members present. Five cast a vote for one of the four sub-options modeled by Lewis & Ellis. Two votes were for option 1A: 10 percent subsidy for all small employers. Two votes were for option 1B: 10 percent subsidy on the individual market for employees of small employers. One vote was for option 2A: 20 percent subsidy for small groups with 1-9 employees and no offer of coverage within the previous 12 months.
For varying reasons, the other members chose to vote "no" on all 4 options at this time. After discussion of the ballot structure, it was agreed that a no vote had to be accomplished by abstaining/not submitting a vote on the 4 options presented. Of those who abstained, some wanted an extension for the report deadline to identify a funding source for the program and a subsidy program timeline beyond two to four years; some wanted the actuaries to model other options, like the impact of a minimum required employer contribution versus no required employer contribution; and some simply were not in favor of a subsidy for the small group market.

The workgroup seemed to be forming a consensus that they could not recommend any of these options given the current federal subsidy environment in the individual market. Instead, funds should go towards the marketing of existing options, including small group plans for employers who can afford offerings that compete with current individual market prices and value, and individual market plans for employees of employers who cannot afford to offer small group plans. When (or if) the enhanced APTCs expire in 2026, the considerations developed by this workgroup can be used to develop a subsidy proposal.

Session 5

In session five, MHBE staff presented on a potential marketing and outreach design. This plan was designed to raise awareness of existing enrollment options and proposed additional ways to reach small employers and their employees by cultivating partnerships and providing workshop training. MHBE asked members of the workgroup for feedback on the proposed outreach presentation as well as the draft of the final report, which had been provided in advance of the meeting.

One small business owner wanted to discuss the idea to set aside subsidy funds to provide financial incentives for employers to help their employees sign up for individual coverage. The requested $2-$4 million could be used either to reward employers for each employee who signs up for insurance and/or to cover expenses related to holding information sessions and signup events at the workplace. Expenses could include food for attendees or compensation to the employer for lost productivity during the

event. The workgroup discussed that there may be legal or administrative challenges to implementing such a program. One workgroup member suggested that commissions paid by health insurers to producers may be sufficient incentive to get producers to reach out to and assist employers, but that the state could support producers by developing and providing the curriculum they would use in discussions with employers and employees, and possibly by providing funding for food for attendees.

If legal or administrative challenges prevent provision of financial incentives to employers, the workgroup discussed creating a program to recognize employers who hold such events by awarding them a certification or badge to display on their business front, website, or marketing materials. The badge could say something like "health-insurance friendly company." Many members of the workgroup supported this option.

MHBE is reviewing legal considerations related to providing financial incentives to employers for access to their employees, but due to the timeframe to finalize this report, is not able to provide more information on that possibility in this report. MHBE also notes that there may be administrative challenges to identifying the small business eligible to receive a certification or badge but supports the intent of this idea and intends to discuss it further with stakeholders.

A producer in the workgroup reiterated that any future subsidy should include all small groups with 2-50 employees. This member also cautioned against making small employers think that small group plans they already have are not good enough, and that the benefits of each type of plan (on-Exchange, off-Exchange, or individual market) be fully represented. Lastly, he emphasized that the marketing and outreach campaign should include producers and be careful not to supersede their role.

Session 6

MHBE presented the written comments and feedback from members. In addition to the suggested clarifications and technical edits to the report that MHBE staff presented, one member suggested that the report should mention the proposed federal fix to the "family glitch" and the group agreed to add that to the edits that staff presented. In addition, one member suggested amending the requested figure of $3 million allocated to marketing and outreach to $2 to $4 million in order to make the recommendation more flexible. The group discussed this proposal and agreed to amend the recommended amount to $2 to $4 million in order to achieve a unanimous vote.

Members were asked to vote Yes or No on the following items:

1) Recommendations: The legislature should ensure MHBE has sufficient funding to significantly expand marketing and outreach to small employers and their employees to provide education regarding, and facilitate enrollment in, existing coverage options. Also, MHBE should re-engage stakeholders to discuss the possibility of a small business & nonprofit premium subsidy in the future, if it appears likely that the enhanced premium tax credits in the individual market will expire.

2) Approve the final report document with the clarifications and technical edits.

3) Recommend that MHBE follow-up with a letter to the legislature to address the legal and administrative challenges for the proposed financial incentives to employer for hosting educational and enrollment events.

Fourteen out of 19 members were present; all fourteen voted Yes to approve all three items. Members who were absent and unable to participate in the voting were contacted by email to provide their votes in writing to MHBE.

Rachel Clark, sitting in for Aetna's David Brock, abstained from voting and provided this statement: "Aetna prefers to abstain from voting given the focus of the workgroup has shifted from recommending a specific program. As a neutral carrier, we would not take a position regarding fiscal expenditures to taxpayers. That input is best left to the key stakeholders in the small business broker and employer community."

Mark Kleinschmidt, Deb Rivkin, Jamal Lee, and Rick Weldon provided their votes in writing; all four voted yes on all three items. As a result, the report was unanimously approved by the 18 members who voted; one member abstained.

Findings and Considerations

Finding #1: Individual Market Coverage Very Affordable Due to Enhanced Federal Subsidies and State Reinsurance Program

The Inflation Reduction Act extends enhanced APTCs for individual market plans through the end of 2025, making it challenging for small group plans to be competitive from a premium standpoint without significant subsidization, either through an employer contribution or a potential state subsidy.

As a result, producers anticipate encouraging employer clients who are not able to provide a significant contribution towards premium to forgo offering employer coverage and instead direct employees to individual market coverage through Maryland Health Connection. Employers could disadvantage their employees by offering them small group insurance, because workers with an offer of employer coverage may lose eligibility for APTCs and Cost Sharing Reductions (CSRs) and ultimately have to pay more for coverage through their employer.

Illustrative Example

For a family of four,[39] the 2022 premium for a Bronze small group plan is $1,214 per month. This plan would have a deductible of $6,200 per individual or $12,400 for the family. If there were a small group subsidy of 20 percent, the premium would be $971 per month. If the employer contributed 50 percent, the employee and employer would each pay $486 in monthly premiums for this plan.

With a household income of $85,000, or just over 300 percent of the federal poverty line (FPL), the same family would pay $271 per month in premiums after application of APTC for a comparable Bronze plan on the individual market (3.8 percent of their annual household income). They would receive $316 in

[39] Two adults aged 49 and 43; two children aged 15 and 17.

monthly APTC, assuming their employer does not offer an "affordable" small group plan.[40] Their children would be eligible for the Children's Health Insurance Plan (CHIP).[41]

With a household income of $65,000, or just over 250 percent of FPL, the family would pay $15 per month in premiums for a Bronze plan on the individual market for the adults (0.28 percent of annual household income), and the children would be covered by CHIP.

Table 11: Premium Cost of Bronze Plan for Family of Four, Small Group vs. Individual Market (PY 2022)

	Monthly Premium	Reduction Amount	Employer Premium Contribution	**Monthly Premium for Family**	**Percent of Annual Household Income**
Small Group: Employer-Sponsored Plan with 50% Employer Contribution	$1,214	20% hypothetical state subsidy	$485	**$485**	**N/A**
Individual Market: Annual household income of $85,000	$587	$316 APTC	N/A	**$271.30**	**3.8%**
Individual Market: Annual household income of $65,000	$587	$572 APTC	N/A	**$15.30**	**0.28%**

Finding #2: Small Group Subsidy Cost Is Not Justified at This Time

Depending on eligibility parameters, a subsidy program could cost anywhere between $25 million and $175 million (see Table 10 for details). This cost could be justified if it provided a significant benefit to small employers and employees, but as the previous example and the actuarial modeling indicate, given the affordability of individual market coverage in the current environment, such an investment does not appear to be the best use of state funds at this time.

[40] $587 - $316 = $271. If the children were not eligible for CHIP, their premiums would cost $53/month each for a total family monthly premium of $377.30. An employer plan is considered affordable if the employee self-only coverage costs less than 9.12% of household income.

[41] Children in Maryland are eligible for CHIP (Medicaid) with family incomes of up to 322% of FPL, which is $89,355 for a family of four. From "Medicaid and CHIP Income Eligibility Limits for Children as a Percent of the Federal Poverty Level," *Kaiser Family Foundation,* January 1, 2022, https://www.kff.org/health-reform/state-indicator/medicaid-and-chip-income-eligibility-limits-for-children-as-a-percent-of-the-federal-poverty-level/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

Finding #3: Individual Market Subsidy for Small Employers Could Threaten Small Group Market Stability

If the State were to offer a subsidy on the individual market for employees of small employers who currently offer employer coverage, it could incentivize small employers who currently offer small group plans to stop offering them and shift employees to the individual market. This could drive down enrollment in the small group market, causing premiums to increase and destabilizing the market.

Considerations if a Small Group Subsidy Is Implemented in the Future

Consideration #1: Simplicity Should Be Prioritized

In general, the Workgroup agreed that the logistics of applying a premium reduction should be as simple as possible for employers, insurers, and producers so as to encourage uptake by employers. A small group subsidy, sent directly from the State to insurers and shown as a discount line item on employer invoices, was determined by the group to be the simplest way for employers to receive the subsidy.

The Workgroup identified administrative complexities that led to concerns with the idea of offering an individual market premium subsidy for employees of small employers. It would likely be difficult to determine and maintain updated eligibility information because employers would need to regularly verify individuals' employment. In addition, workgroup members felt that an individual market premium subsidy would not provide a clear benefit to employers.

The Workgroup recommends that any future small group subsidy should not be designed as a tax credit. Tax credits are administratively complicated and inconvenient if employers can only redeem them annually when filing taxes. In addition, tax credits are generally not usable by nonprofit employers, or else they need to be structured differently for nonprofits to take advantage of them, adding further to the complexity.

Third-Party Administrators (TPAs) could play a role in determining subsidy eligibility through an application process. The TPA representative on the workgroup shared that TPAs would be willing to engage in such a process.

Consideration #2: Subsidy Should Last as Long as Politically Feasible, Then Phase Out

If the subsidy must be time-limited, the workgroup recommends gradually reducing subsidy amounts over time in a phase-out process to help employers adjust. Some members felt that a limited-duration subsidy can give new businesses a temporary support as they grow the capacity to offer health insurance without a subsidy. However, other members pointed out that nonprofit organizations do not have a goal of financial growth like for-profit businesses do, and therefore preferred a permanent subsidy. Some workgroup members also contended that a temporary subsidy would discourage participation, citing the relative lack of popularity of two-year SHOP Tax Credits, and that the subsidy should be permanent.

Consideration #3: Employer Contribution Requirements Unpopular but Could Help Ensure Affordability of Employer Coverage

To qualify for the existing SHOP Tax Credit, employers must contribute 50 percent toward employees' small group plan premiums. Workgroup members cited this contribution requirement as a disincentive for small employers to participate in the program. In the small group market in general, there are no contribution requirements for an employer to offer a plan. However, a certain percentage of employee participation is required for an employer to offer a plan. The participation percentage, usually 60 – 75 percent, varies by carrier.

Some workgroup members felt that requiring employer contributions for subsidy eligibility would unfairly prevent employers who cannot afford to contribute from offering a small group plan. On the other hand, employers who cannot afford a meaningful contribution would likely do their employees a disservice by offering coverage, because doing so could make the employees and their families ineligible for subsidies in the individual market, leaving them to pay higher costs for a plan through their employer. In other words, if the cost of small group coverage is not sufficiently offset for the employee by an employer contribution – either alone or in combination with a state small group subsidy – employees may pay less if they enroll in an individual plan, the cost of which can be reduced by APTCs.

It is important to note that not every offer of employer coverage will make an employee ineligible for APTC in the individual market; if the employee would have to pay more than 9.12 percent of household income for the employer coverage, it is considered "unaffordable" under federal law and does not impact APTC eligibility. However, in comparison, currently in the individual market premium costs for a benchmark plan are capped at 8.5 percent of household income; the lowest-income individuals are expected to contribute 0 percent of household income. Consequently, when deciding whether to offer coverage, small employers must carefully weigh the cost of a small group plan for their employees against the likely cost for their employees in the individual market. Producers can help employers compare options and determine what makes the most sense for an employer and their employees.

Recommendation

After exploring several subsidy designs, the Workgroup recommends that the State postpone implementation of a small business and nonprofit subsidy until after the expiration of enhanced premium tax credits in the individual market, which were recently extended by the Inflation Reduction Act and are set to expire by 2026 if Congress does not extend them. With the enhanced premium tax credits, in combination with the State Reinsurance Program, individual market premiums are significantly discounted. Consequently, it is not cost-effective for the state to create a small group subsidy program in the current environment and doing so would risk creating adverse incentives that could result in low-income employees paying more for coverage in a small group plan than they would pay for individual market coverage.

Even with a subsidy, premium costs for small group plans are significantly more expensive than plans of the same level of generosity on the individual marketplace. To offer one example, with a 20 percent subsidy and 50 percent employer contribution, a family of four with an annual household income of $65,000 could pay $486 per month for an employer-sponsored Bronze plan. With no employer offer of coverage, the family would otherwise be eligible for a comparable plan at $15 per month in the individual market. It would cost the State $28.7 million to offer this 20 percent small group subsidy that would be ineffective at improving insurance affordability.

Rather than invest in a small group subsidy at this time, the Workgroup recommends that the General Assembly ensure that MHBE has sufficient funding to substantially increase marketing and outreach to small employers and their employees to educate them about current coverage options. The enhanced subsidies in the individual market are still relatively new and many small employers and employees may be unaware of the affordability of individual market coverage. Offering a traditional small group plan may still be the right choice for some employers, but through marketing and outreach by MHBE, ideally in collaboration with the producer community, the state can help to ensure that small employers and employees are educated about their coverage options and enroll in the option that is the best fit for them. Such a marketing and outreach program could both help to reduce the overall uninsured rate in the state and support Maryland small businesses by ensuring that their employees have the coverage they need to remain healthy and competitive.

The workgroup recommends allocating $2 to $4 million per year to MHBE to invest in training, marketing, and outreach to educate small employers and their employees on their health insurance options on- and off-Exchange for a minimum of three years. This would enable MHBE to engage directly with small businesses, nonprofit organizations, and authorized producers to develop key partnerships and relay important information through trusted messengers with existing communications channels that reach target audiences. Through these existing partners, MHBE would provide workshops, training and events targeted specifically to small employers and employees who are seeking health insurance, with a focus on those most likely to be uninsured. Outreach will include messaging directed to small employers through digital advertising, business news platforms, promotional flyers, and branded materials.

Table 12: Illustrative *Small Business Outreach Annual Cost Estimate Breakdown*

Campaign Element	Approximate Allocation
Planning and Market Research	$450,000
Outreach and Events	$350,000
Partnerships	$300,000
Advertising Creative Assets	$250,000
Media Buy	$1,000,000
Educational Materials, Including Printing	$500,000
Video Content	$200,000
Total	**$3,000,000**

After two years, the Workgroup suggests that MHBE report to the General Assembly on the impact of that investment so that the General Assembly can determine if it is beneficial to extend that investment for additional years. The Workgroup does not recommend that MHBE divert funding currently used for successful individual market marketing and outreach or otherwise divert existing funding for this initiative, but rather recommends that new funding be made available to MHBE for this effort.

In addition, the Workgroup recommends that MHBE re-engage stakeholders to discuss the possibility of a small business premium subsidy in the future, if it appears likely that the enhanced premium tax credits in the individual market will expire. Such a discussion should build on the efforts of this workgroup, including the considerations summarized above in the Findings and Considerations section.

Conclusion

A small group subsidy would be more appropriate if the enhanced federal subsidies expire, as they are currently scheduled to do in 2026. At this time, the state should invest in marketing and outreach to small employers and their employees to educate them about current coverage options on- and off-Exchange. A $2 to $4 million annual investment would enable a robust outreach initiative. Such an investment could be piloted for three years, with a report developed by MHBE after two years of implementation to describe the impact and inform future funding decisions.

Appendix A: Workgroup Charter

Small Business and Non-profit Health Insurance Subsidies Workgroup

Workgroup Charter

WORKGROUP RESPONSIBILITIES UNDER SB632

The Maryland Health Benefit Exchange shall convene a workgroup to study and make recommendations relating to the establishment of a Small Business and Nonprofit Health Insurance Subsidies Program to provide subsidies to small businesses and nonprofit employers and their employees for the purchase of health benefit plans.

The workgroup shall study and make findings and recommendations regarding:

(1) the health insurance coverage needs of small employers, nonprofit employers, and their employees
(2) objectives and target metrics for the Program
(3) the optimal scope and design features of a Small Business and Nonprofit Health Insurance Subsidies Program, including:
    a. whether subsidies under the Program should be available for the purchase of qualified health plans offered to small employers on the Exchange and the purchase of health benefit plans offered to small employers outside the Exchange
    b. subsidy eligibility and payment parameters for the Program
    c. the administrative structure and infrastructure investments required for implementation of the Program, including any requirements for the Exchange, health insurance carriers, and any other entities involved in the implementation of the Program; and
    d. the duration of the Program
(4) the cost to administer the Program, including the cost to provide subsidies and operational costs
(5) the sources and levels of funding needed to support the Program

On or before October 1, 2022, the Exchange shall submit a report to the Governor and, in accordance with § 2–1257 of the State Government Article, the Senate Finance Committee and the House Health and Government Operations Committee that includes the findings and recommendations of the workgroup required under this section.

WORKGROUP MEETINGS

The below sections contain information relevant to the business of the Workgroup meetings. All meetings of the Workgroup are open to the public.

Location, Time, and Notice

The work group will meet on the following dates:

- July 12, 2022
- July 26, 2022
- August 9, 2022
- August 23, 2022
- September 6, 2022
- September 20, 2022

Meetings will be held via Google Meets:
Video call link: https://meet.google.com/aab-msxq-srw
Or dial: (US) +1 252-881-0183 PIN: 269 220 987#

Reasonable notice of all meetings, stating the time and place, shall be given to each Member by mail or electronic mail. Reasonable notice of all meetings shall be provided to the public by posting on the MHBE website: https://www.marylandhbe.com/policy/work-groups/small-business-and-nonprofit-health-insurance-subsidies-program-workgroup/

Order of Business Generally, the agenda/order of business at meetings of the Workgroup shall be as follows:

(a) Calling the meeting to order
(b) Consideration and approval of minutes of previous Workgroup meeting
(c) Consideration of the topic/questions presented before the Workgroup
(d) Determination of recommendations from the general Workgroup body – including identification of consensus recommendations
(e) Public comments
(f) Adjournment

Quorum A simple majority of the Members shall constitute a quorum at any meeting for the conduct of the business of the Workgroup.

Voting Each Member shall be entitled to one vote. There shall be no voting by proxy. A quorum being present, a majority vote shall rule. Voting by mail or electronically is permitted, provided that the action to be voted upon and the results of the vote shall be fully set forth at a meeting and reflected in the minutes when required by the Open Meetings Act.

CO-CHAIRS

The members of the Workgroup shall elect two Co-chairs. Elected Co-chairs' terms shall last for the duration of the Workgroup term. In addition to presiding at meetings, Co-chairs shall take an active role in determining the recommendations from the general body, preside over vote counting for recommendations, and shall work with MHBE to determine actions items required of MHBE support resources.

MEMBERSHIP & MEMBER RESPONSIBILITIES

The below sections contain information relevant to membership and membership responsibilities of the Workgroup meetings. Members are expected to lend their expertise, in good faith, to meet the goals of the Workgroup. MHBE will make resources available to provide technical/administrative assistance to the Workgroup.

Membership The Workgroup consists of seventeen representatives in total with representation as follows:

(1) Four individuals affected by small group insurance to include the following:
    a. A small business owner/employer
    b. A small business employee
    c. A non-profit business owner/employer
    d. A non-profit business employee
(2) Four individuals representing insurers currently participating in the small group market
(3) Four licensed small group insurance producers representing different areas of the State
(4) Three individuals representing following organizations:
    a. Chamber of Commerce or other small business group
    b. Non-profit community
    c. Consumer Advocacy community
(5) Two representatives selected from persons who expresses interest in participating in the workgroup

The Maryland Health Benefit Exchange has sole discretion for final committee selection.

Participation in Meetings Members will attend meetings via web conference. Members participating by such means shall count for quorum purposes, and their support for recommendations shall be included so long as their participation is included in attendance.

AMENDMENT OF CHARTER

The Workgroup members, in consultation with MHBE, may amend this Charter at any meeting, by an affirmative vote of a minimum of two thirds of Members.

Appendix B: Subsidy Cost Projections

Data	Source
Group demographics, uninsured rates, insurance uptake	The Hilltop Institute
Small group market premium rates	Maryland Insurance Agency
Gross and net Individual premium rates	L&E reinsurance modeling

1.A. 10% Small Business Premium Reduction – All Small Groups

Scenario 1- All small businesses in Maryland with and without a small group plan offering

- Option A - 10% reduction to small group premium
- 20% of firms who previously did not offer insurance coverage are projected to begin offering after the introduction of the subsidy
- Expected employee participation is 50% after new offer of coverage from their employer. Total new employee participation is 10% (20% x 50%)
- Premiums are based on 2022 and 2023 approved rate increases and 5% additional trend to 2024

MARYLAND HEALTHBENEFIT EXCHANGE

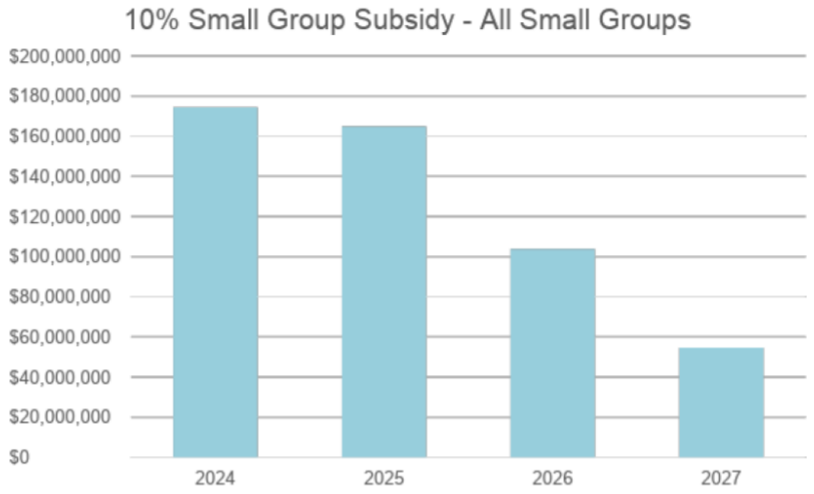
Cohort	Total Employees	Uptake
Currently In SG Market	248,328	100%
Offer of Employer Coverage and not Accepted	118,556	15%
No Employer Offer of Coverage	265,674	10%
Total	**632,558**	**292,671**

Projected 2024 SG Gross Premium PMPM	$598
SG Subsidy Percentage	10%
Post-Subsidy Premium PMPM	$538
Employer Contribution Rate	50%
Employee Net Premium PMPM	$239
Subsidy PMPM Cost	$60
Projected 2024 SG Subsidy Cost	**$174,464,709**

12

1.A. 10% Small Business Premium Reduction – All Small Groups (cont.)

- Subsidy cost scales with premium trend (assumed 5%)
- Employer participation expected to decline after two years due to expiration of tax credit
- Not feasible due to size of current small group market. One year cost in 2024 for just firms already participating in the small group market would be ~$150M.



MARYLAND HEALTHBENEFIT EXCHANGE

13

1.B. 10% Individual Market Premium Reduction – All Small Groups

Scenario 1- All small businesses in Maryland with and without a small group plan offering

- Option B - 10% reduction to Individual market premiums after APTC
- No expected enrollment from those currently participating in small group market
- 10% reduction will have limited impact on those who had an employer offer of insurance but declined coverage
- Significant number of those with no employer offer but with coverage elsewhere are expected to already be covered in the Individual market.
- Enrollment from uninsured projected to be low

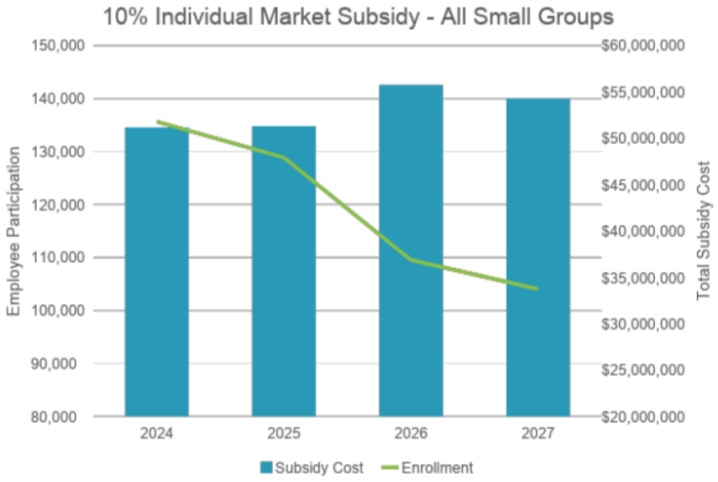
Cohort	Population	Uptake
In SG Market	248,328	0%
Offer of Employer Coverage and not Accepted	118,556	5%
No Employer Offer of Coverage	265,674	49%
Total	**632,558**	**135,656**

Premium Assumptions	2024
Average 2024 Ind Net Premium after APTC	$378
Subsidy Amount	10%
Net Premium with SG Subsidy	$340
Subsidy Cost to State PMPM	$38
Projected 2024 Ind. Market Subsidy Cost	**$51,182,920**

14

1.B. 10% Individual Market Premium Reduction – All Small Groups (cont.)

- Assumes average age of 45 and income 350% of federal poverty level
- Significant portion of the subsidy is projected to go to those currently covered in the Individual market. Enrollment from either uninsured or covered outside the Individual or Small Group market is projected to be low given the subsidy level.
- Projected to be healthier than average existing enrollee.



MARYLAND HEALTHBENEFIT EXCHANGE

15

2.A. 20% Small Business Premium Reduction – <10, No Offer

Scenario 2- Small businesses in Maryland with under 10 employees with no small group plan offering in the past 12 months.

- Option A - 20% reduction to small group premium
- 29% of firms who previously did not offer insurance coverage are projected to begin offering after the introduction of the subsidy
- Expected employee participation is 60% after new offer of coverage from their employer. Total new employee participation is 17% (29% x 60%)
- Plan selection for this cohort is expected to lean toward cheaper options

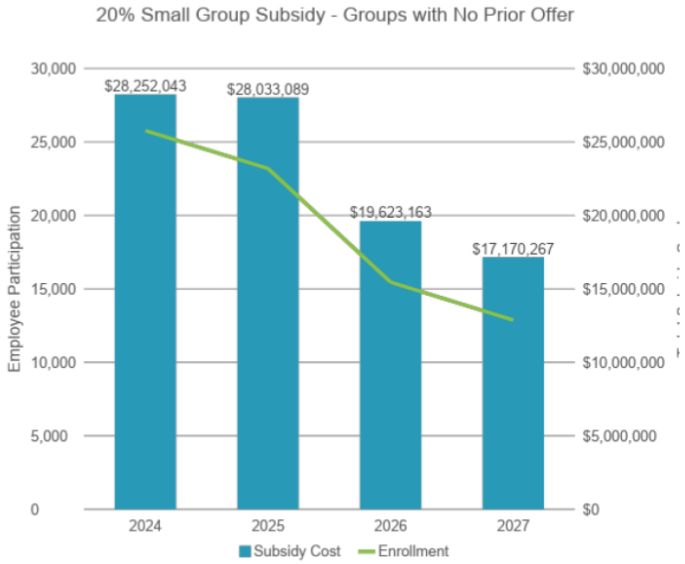
Eligibility Assumptions	2024
Number of MD employees in SGs of 1-9 Not Offered Coverage	148,986
Employer Uptake After Subsidy Introduction	29%
Employee Uptake From Participating Employers	60%
Employee Participation	**25,775**
Projected 2024 SG Gross Premium PMPM	$558
SG Subsidy Percentage	20%
Post-Subsidy Premium PMPM	$446
Employer Contribution Rate	50%
Employee Net Premium PMPM	$167
Subsidy PMPM Cost	$111
Projected 2024 SG Subsidy Cost	**$28,708,173**

MARYLAND HEALTHBENEFIT EXCHANGE

16

2.A. 20% Small Business Premium Reduction – <10, No Offer (cont.)

- Employer participation expected to decline after two years due to expiration of tax credit
- Normal lapsation expected to follow recent small group market trends



MARYLAND HEALTHBENEFIT EXCHANGE

17

2.B. 10% Individual Market Premium Reduction – <10, No Offer

Scenario 2- Small businesses in Maryland with under 10 employees with no small group plan offering in the past 12 months.

- Option B - 10% reduction to Individual market premiums after APTC
- MD uninsured rate for employees in groups less than 100 was 17% in 2021. Assumed uninsured rate of 45% for this cohort as the rate of offering insurance declines with group size.
- Enrollment from uninsured projected to be low
- Significant number of those who are not uninsured are expected to already be covered in the Individual market as they do not have an offer from an employer

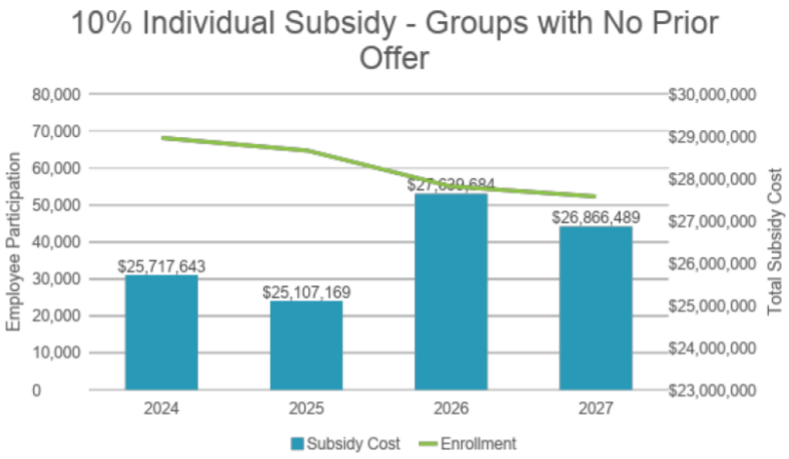
Cohort	Population	Uptake
Uninsured	67,044	10%
Other Insurance	81,942	75%
Total	**148,986**	**68,161**

Premium Assumptions	2024
Average 2024 Ind Net Premium after APTC	$378
Subsidy Discount	10%
Net Premium with SG Subsidy	$340
Subsidy Cost to State PMPM	$37
Projected 2024 Ind. Market Subsidy Cost	**$25,717,643**

18

2.B. 10% Individual Market Premium Reduction – <10, No Offer (cont.)

- Assumes average age of 45 and income 350% of federal poverty level
- New entrants are projected to be healthier than average existing enrollee.
- Expected increase to 2024 reinsurance costs is $2M



MARYLAND HEALTHBENEFIT EXCHANGE

Appendix C: Subsidy Phase-Out Designs

2-Year Phase-Out Plan: 20% SG Subsidy Reduction Program

- Scenario 2.A: <10, no offer

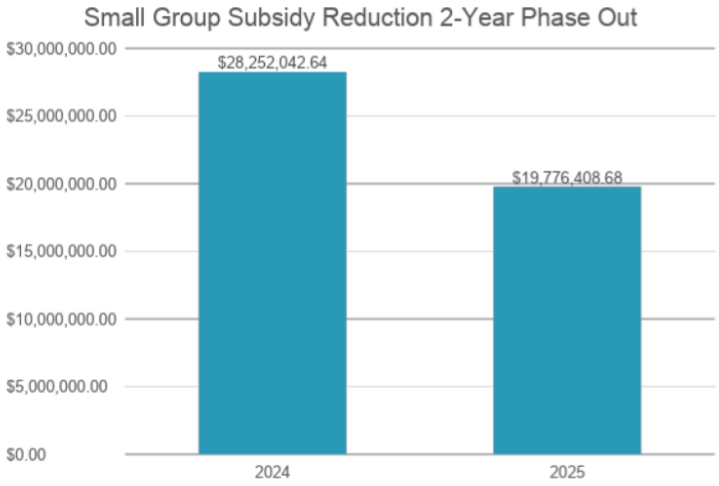
-30% annual subsidy reduction over a two-year span starting in 2024

-Total 2-year program **$48,028,121**

-Subsidy would need to decrease to 14% to meet 30% target.

-Soft landing for small businesses who took advantage of the subsidy program

-Connect Small Businesses with other available programs



MARYLAND HEALTHBENEFIT EXCHANGE

23

4-Year Phase-Out Plan: 20% SG Subsidy Reduction Program

- Scenario 2.A: <10, no offer

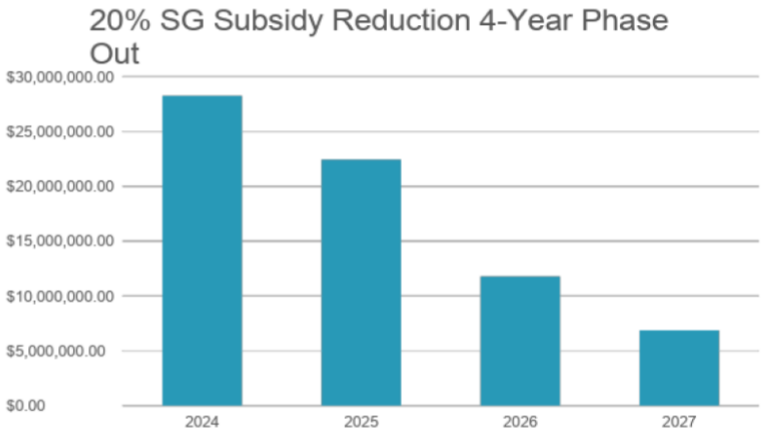
-Reduce subsidy amount by 4% per year

-Total 4-year program **$69,320,518**

-25% total cost reduction

-Soft landing for small businesses who took advantage of the subsidy program

-Connect Small Businesses with other available programs



MARYLAND HEALTHBENEFIT EXCHANGE

24

2-year Phase-Out Plan: 10% Individual State Subsidy Program

-Scenario 2.B: <10, no offer

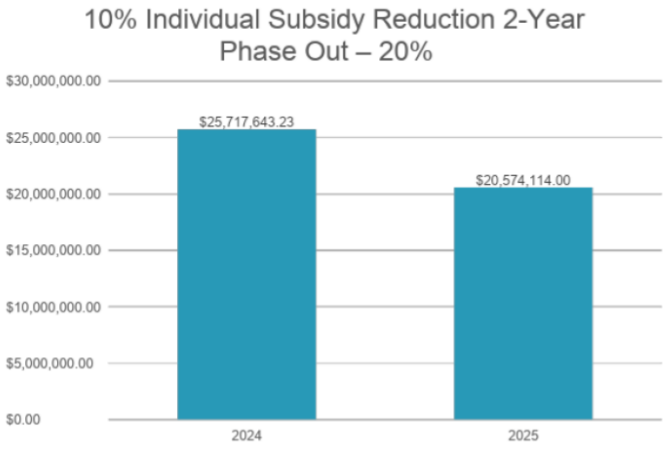
-20% subsidy budget reduction over a two year span starting in 2024

-Total 2 year program **$46,291,757**

-Subsidy would need to decrease to 8% to meet 20% target

-Soft landing for Small Businesses who take advantage of the subsidy program

-Connect Small Businesses with other available programs for their employees



MARYLAND HEALTHBENEFIT EXCHANGE

25

Appendix D: Preliminary Marketing and Outreach Plan

Marketing & Outreach: Maryland Health Connection for Small Business - Options for Consideration

The MHBE marketing team acknowledges the following elements to developing an effective and efficient outreach plan:

- Understanding the target audience: small businesses & non-profit organizations
- Proactive
- Community partnerships
- Engage in-person
- Responsive to audience needs

Planning and Market Research

In addition to overall campaign support, and depending on internal MHBE staffing and capacity, the MHBE marketing team recommends working with a campaign partner to help steer:

- **Strategy development** to align on campaign goals that funnel down to tactics on subsequent slides, target audiences based on state and third-party data, key performance indicators to measure success, and messaging
- **Market research** with eligible businesses to inform messaging, materials development, and outreach strategies

Outreach

Through partners and other paid opportunities, MHBE could reach small business owners through:

- **Events and conferences**, including booth space, sponsorship to raise awareness (e.g., as the named sponsor for the event Wi-Fi), advertising on-site, or communications to attendees
- **Direct mail** or similar distribution methods based on lists provided by partners or purchased from relevant organizations (e.g., employers with certain types of licenses)
- **Social media** to be posted by Maryland Health Connection or partners to promote relevant dates, educational information, etc., including a LinkedIn strategy
- **Earned media** through business- or trade-focused publications and media outlets

In addition, MHBE recommends developing a **broker engagement plan** to ensure collaboration and consistency.

Partnerships

By working directly with organizations that serve the small business community, MHBE can relay important information through trusted messengers with existing communications channels that reach our target audiences. MHBE recommends considering a multi-pronged approach to outreach to engage 20-30 organizations across Maryland (some examples below):

Advertising

Paid advertising allows an entity to reach relevant audiences more directly through third-party data. The MHBE marketing team recommends running advertising throughout the year or at least key flights when businesses tend to make benefits decisions (May-July, October-December). Options include:

- **Digital advertising** targeting employers, small business owners, entrepreneurs, etc. This would likely include:
    - Paid search (Google, Bing)
    - Facebook, Instagram, LinkedIn
    - Display and native advertising (i.e., an ad next to an article about small businesses)
    - Video
- **Business platforms**, such as Baltimore Business News, in print and digital
- **Maryland Nonprofit entities**

Educational Materials

New materials and collateral would support outreach efforts that speak directly to small business owners, nonprofits, and their employees. Materials could be distributed at events and through targeted partnerships. Potential new pieces include:

- **Fact sheets**
- **Branded folders** filled with relevant materials (this was a top request from brokers during stakeholder interviews conducted in 2018)
- **Giveaways** to draw potential customers to event booths/tables (such as thumb drives, water bottles, etc.)

In addition, the MHBE marketing team recommends making **website content updates** to ensure that all MHBE-owned websites (MHBE, MHC, MHC for Small Business) are aligned and feature updated messaging and resources.

Video Content

In addition to print materials, video content can help customers better understand their options through Maryland Health Connection for Small Business. Videos can be posted to YouTube or social media by MHC or partners. With health literacy in mind, videos could explain:

- **What is MHC for Small Business?** (With an emphasis on why someone should use it)
- **About the Small Business Tax Credits**
- **How to get help** (promoting producer and navigator support)
- **Testimonial** from existing customer

The MHBE marketing team recommends the production of video content to help the small business owner explain health coverage options to employees. For example, if employees need to use a portal to select their plans, a "how to" video could benefit an employer who may not otherwise have the resources or knowledge to explain the process.

Illustrative Budget Estimates

Campaign Elements	Approximate Allocation
Planning and Market Research	$450,000
Outreach and Events	$350,000
Partnerships	$300,000
Advertising Creative Assets	$250,000
Media Buy	$1,000,000
Educational Materials, Including Printing	$500,000
Video Content	$200,000
Total	**$3,000,000**

Appendix E: Written Comments from Members

Glenn Arrington, Group Benefit Strategies

Mr. Arrington suggested some corrections to the summary of meetings 3 and 4, which were incorporated in the final report, and noted that "From the onset of the work group my comments were if we are going to have a bill to support small group it should support all small groups 2-50."

Mr. Arrington also stated: "As far as a marketing support if a monetary value is awarded it should be for on exchange and off exchange as Deb pointed out in her email. My major concern is promoting small employers to think that the current small group plans they have may not be as good as the SHOP or MHBE individual plan options. So, if we market the SHOP and MHBE market we MUST make sure we promote the advantages of OFF exchange plans and that NOT all plans are on the SHOP and that IND MHBE plans may not be as advantageous with pharmacy benefits. I just had a group client leave a large group employer and she was very disappointed with the pharmacy benefit compared to the IND market on and off the exchange.

Additionally, we need to make sure the marketing efforts protect the producer and agents' current book of business. Meaning the marketing should state in bold letters and highlighted to make sure you contact your current agent and producer with these new marketing materials. We want to protect the current active accounts in small group and make sure If the marketing efforts do not just create "churn" to the SHOP and IND market. The marketing efforts should clearly state to check with your agent and producer since some of the products may differ from what you currently have in force.

Lastly, we need to make sure the marketing efforts include all active producers and agent to the events and active outreach. We do not want to make this seem as a State Agency program and make the producer feel a part of the marketing to bolster the support of the broker community with the outreach. And make sure the MD Chamber and other chambers forward the opportunities to all supporting brokers in there surrounding area. We do not want to create an assumption of an association plan or having navigators at the chambers. We all need to market the efforts to support the current active producers and make them feel a part of the effort to increase awareness to this marketing effort.

These are my comments and I agree that the small group subsidy is too premature with the Federal Subsidies that were approved to continue for 3 more years."

Neil Bergsman, MD Nonprofits

"The draft report is very clear, informative, and authoritative. I think it accurately reflects our meetings." In addition, Mr. Bergsman provided several small clarifications and additions which were incorporated into the final report.

Lane Levine, A Friendly Bread

"My only comment is that I am hoping we can talk more about the idea of financial incentives for employers to help their employees sign up for individual coverage. I see the comment is mentioned on page 26, but I'd like to suggest that part of the $3M being requested could be a reserve of money that is used for either 1) rewarding employers for how many of their employees sign up for insurance, or 2) covering expenses related to holding info-sessions or signup events at the workplace (expenses could be to cover lost productivity for the duration of the event, or for providing food for the event, etc."

Sandy Walters, Kelly Benefits

Mr. Walters suggested several clarifications that were incorporated into the final report. In addition, he noted that he agrees with the recommendations in the report except for the recommendation to invest in marketing and outreach to small employers as reflected in paragraphs 3-5 in the Recommendations section of the report, stating: "I do not feel it is wise to invest in marketing SHOP. The federal government has seen that this market is not the current focus of ACA. Also, Maryland has had a robust market in this area pre-ACA and continues to have a leading market for small groups. The percentage of participation is higher in Maryland than the national marketplace. Less than 1% of small groups in Maryland have chosen the SHOP over going to carriers direct or thru their broker."

Deborah Rivkin, CareFirst

Ms. Rivkin noted that she agreed with Mr. Walter's comments, adding "The one nuance to his comments is in the Recommendations, (paragraph 3 & 4), if there is going to be a marketing campaign done by the Exchange, that employers and employees should be informed about on and off exchange options, marketing should not be focused only on SHOP options."

Mark Kleinschmidt, Anne Arundel Chamber of Commerce

"I think the report puts forth a good overview of the discussions the group had over the last few weeks. I think it is wise to postpone the idea of implementing a subsidy when the federal credit is still available. The small business owner has limited time to deal with activities outside of the scope of their business. Health insurance, while vitally important, is one of those things.

Providing information to the small business owner about coverage options for individuals through the Exchange makes a lot of sense. It also has the best chance of moving the needle to get more people insured. It is not complicated for the employer, and it provides the employee with a low-cost option.

I would recommend placing the two paragraphs from the Executive Summary in the cover letter. This will maximize the chance that readers (legislators) will see it. Adding in something about the money for marketing in the cover letter would also be helpful. These funds should be obtained in the upcoming session, and this should be the focus of the group moving forward while we continue to monitor the changing health insurance marketplace."