Report of the Maryland Health Insurance Coverage Protection Commission

Annapolis, Maryland
December 2020

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THE MARYLAND GENERAL ASSEMBLY
ANNAPOLIS, MARYLAND 21401-1991

December 31, 2020

The Honorable Bill Ferguson
President of the Senate
H-107 State House
Annapolis, Maryland 21401-1991

The Honorable Adrienne A. Jones
Speaker of the House of Delegates
101 State House
Annapolis, Maryland 21401-1991

Dear President Ferguson and Speaker Jones:

The Maryland Health Insurance Coverage Protection Commission respectfully submits its fourth annual report containing a summary of the commission's activities during the 2020 interim.

This has been an unprecedented year due to the global COVID-19 pandemic, which has resulted in significant morbidity and mortality, as well as substantial job loss and associated loss of employer-sponsored health insurance both nationally and in Maryland. During the 2020 interim, the commission held two meetings, which included presentations on Maryland's State Reinsurance Program, how other states fund their share of reinsurance programs, options for connecting unemployed individuals with health insurance coverage, proposals for a State-based individual market subsidy, and the impact of COVID-19 on enrollment in the Maryland Health Benefit Exchange.

We wish to thank the commission members, the commission staff, and the many individuals who briefed the commission for their support of the commission's work.

Sincerely,

Brian J. Feldman

Senator Brian J. Feldman
Senate Chair

Joseline A. Peña-Melnyk

Delegate Joseline A. Peña-Melnyk
House Chair

BJF:JAP/LJS:JBC/kkh

Enclosure

Maryland Health Insurance Coverage Protection Commission
2020 Membership

Senator Brian J. Feldman, Senate Chair
Delegate Joseline A. Peña-Melnyk, House Chair

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Chris West

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Chapter 1. Introduction

The Maryland Health Insurance Coverage Protection Commission

Both in response to and in anticipation of efforts at the federal level to repeal and replace the Patient Protection and Affordable Care Act (ACA), Chapter 17 of 2017 (**Appendix 1**) established the Maryland Health Insurance Coverage Protection Commission. Section 2 of Chapters 37 and 38 of 2018 altered the membership and charge of the commission (**Appendix 2**). Chapters 417 and 418 of 2019 required the commission to establish a workgroup and extended the termination date of the commission (**Appendix 3**), and Chapters 597 and 598 of 2019 further altered the commission's charge (**Appendix 4**).

The commission was established to (1) monitor potential and actual federal changes to the ACA, Medicaid, the Maryland Children's Health Program (MCHP), Medicare, and the Maryland All-payer Model; (2) assess the impact of such changes; and (3) provide recommendations for State and local action to protect access to affordable health coverage. The commission will terminate on June 30, 2023.

The commission consists of (1) three members of the Senate; (2) three members of the House of Delegates; (3) the Secretary of Health (or designee); (4) the Maryland Insurance Commissioner (or designee); (5) the Attorney General (or designee); (6) one representative of the Maryland Hospital Association; (7) one representative of a managed care organization; (8) one consumer; (9) one representative of a health insurance carrier; (10) one representative who is an employer; (11) one representative of the nursing home industry; (12) one representative of the Maryland State Medical Society, also known as MedChi; (13) one representative of behavioral health care providers; (14) two members of the public; and (15) one representative of a group model health maintenance organization that participates in the individual market.

The duties of the commission encompass a requirement for a study that includes (1) an assessment of the current and potential adverse effects of the loss of health coverage on the residents, public health, and the economy of the State resulting from changes to the ACA, Medicaid, MCHP, Medicare, or the Maryland All-payer Model; (2) an estimate of the costs of such adverse effects and the resulting loss of health coverage; (3) an examination of measures that may prevent or mitigate such adverse effects and the resulting loss of health coverage; and (4) recommendations for laws that may be warranted to minimize such adverse effects and assist residents in obtaining and maintaining affordable health coverage. The commission may hold public meetings across the State to carry out its duties and convene workgroups to solicit input from stakeholders.

More specifically, the commission is required to study and make recommendations for individual and group health insurance market stability, including:

- the need for and components of one or more Section 1332 waivers;

- whether to pursue a standard plan design that limits cost-sharing;
- whether to merge the individual and small group health insurance markets for rating purposes;
- whether to pursue a basic health program;
- whether to pursue a Medicaid buy-in program for the individual market;
- whether to provide subsidies that supplement premium tax credits or cost-sharing reductions;
- whether to adopt a State-based individual health insurance mandate, and how to use payments collected from individuals who do not maintain minimum essential coverage including use of the payments to assist individuals in purchasing health insurance; and
- whether the State Reinsurance Program should be extended after calendar 2023 and, if so, how it will be funded.

By December 31 each year, the commission must submit a report on its findings and recommendations to the General Assembly and the Governor. This report is the fourth annual report of the commission.

State Actions to Stabilize the Individual Health Insurance Market

In response to recommendations by the commission, emergency legislation was enacted to adopt measures to stabilize Maryland's individual market.

State Reinsurance Program

Chapters 6 and 7 of 2018 required the Maryland Health Benefit Exchange (MHBE) to submit an application for a State Innovation Waiver under Section 1332 of the ACA to establish a State reinsurance program and seek federal pass-through funding (federal funding that would have been provided to Maryland residents in the form of federal tax credits in the absence of the program). In August 2018, the federal government approved the waiver, which is valid through 2023. The program, which began on January 1, 2019, provides reimbursement to carriers in the individual market that incur certain total annual claims cost on a per individual basis. Carriers are reimbursed for 80% of claims between $20,000 and $250,000. Payments to carriers are made after the plan year ends and all costs have been recorded and reconciled.

The reinsurance program is funded by a combination of assessment revenues and federal pass-through funds. Originally, the revenues came from a 2.75% assessment on specified health insurance carriers to recoup the aggregate amount of the health insurance provider fee that would have been assessed under the ACA for calendar 2019 but was temporarily suspended for that year by action at the federal level. Chapters 597 and 598 extended the assessment through 2023 to provide additional funding for the program; however, for calendar 2020 through 2023, the assessment will be 1.0%.

When the program was established, MHBE initially overestimated the amount of total funding required. Since that time, federal pass-through funding has been greater than anticipated and, based on updated actuarial assumptions and actual experience, program expenditures have been lower than forecast. For example, for calendar 2019, estimated costs were $462 million, but final actual costs were $353 million. Thus, even with the potential impact of COVID-19 on enrollment and expenditures, available funding from the assessment will likely last longer than anticipated or may be available to fund other activities to further stabilize the individual market.

For calendar 2019, individual market premium rates approved by the Maryland Insurance Administration (MIA), reflecting the anticipated impact of the reinsurance program, declined by 13.2% overall. For calendar 2020 and 2021, approved rates fell an additional 10.3% and 11.9%, respectively. As a result of the success of the reinsurance program, a third carrier, UnitedHealthcare, will join CareFirst BlueCross BlueShield and Kaiser Permanente in the individual exchange in calendar 2021. However, although premiums have decreased for the third year in a row, they remain high with average premiums costing 10% of the median income for a household of four. Deductibles and out-of-pocket (OOP) expenses for calendar 2021 remain the same as calendar 2020 but range from $4,000 to $7,900 for bronze plans, $2,250 to $6,000 for silver plans (the most commonly purchased plan), and $0 to $1,750 for gold plans. Affordability is particularly an issue for individuals who do not receive a federal advanced premium tax credit (APTC).

Maryland Health Benefit Exchange Affordability Workgroup

To address these issues, MHBE established an affordability workgroup to develop recommendations to reduce OOP costs and maximize affordability. The workgroup found that the reinsurance program has helped stabilize the individual market and provide insurance to individuals with chronic illnesses that would not otherwise be able to obtain insurance. The workgroup also found that young adults aged 19 to 34 represent the largest group of the remaining uninsured. Thus, the workgroup recommended continuing the reinsurance program and considering a young adult subsidy, which may require Maryland to apply for another federal waiver. Chapters 104 and 105 of 2020 required MHBE to study an individual subsidy program and report to the General Assembly by December 1, 2020.

Maryland Easy Enrollment Health Insurance Program

In an effort to reach the remaining uninsured and streamline the process for enrolling in coverage, Chapters 423 and 424 of 2019 established the Maryland Easy Enrollment Health Insurance Program to facilitate health insurance enrollment for uninsured Marylanders. The program allows an uninsured individual to elect on their State income tax return to authorize the Comptroller to share information with MHBE in order to determine the individual's eligibility for insurance affordability programs. MHBE assists in enrolling these individuals in Medicaid or health insurance.

The Comptroller's Office, MHBE, the Maryland Department of Health (MDH), and other stakeholders collaborated to operationalize the program for the 2019 tax filing season. For phase I of the program, limited data fields were added to the State income tax return to allow tax filers to indicate whether any members of their household were uninsured and whether they authorized the Comptroller to share relevant information with MHBE. The Comptroller's Office sent data for applicable tax filers to MHBE, and MHBE notified eligible tax filers that they may enroll in coverage through a special enrollment period (SEP). MHBE, the Comptroller's Office, and MDH are targeting launch of phase II of the program in early 2022, for tax year 2021, with the goal of simplifying the enrollment process for interested individuals.

Overall, of the 60,645 individuals on tax year 2019 returns who expressed interest in health care coverage, 53,146 were determined eligible for the Easy Enrollment SEP, meaning that they had a Maryland address and were not already enrolled in Medicaid or a qualified health plan (QHP). Of those 53,146 eligible individuals, 9,131 (17.2%) applied for coverage, and 4,015 (7.6%) enrolled. The majority (75.9%) of individuals who enrolled were eligible for Medicaid coverage. Of those enrolling in QHPs, 87.0% were eligible for financial assistance. Individuals residing in Anne Arundel, Baltimore, Montgomery, and Prince George's, counties and Baltimore City accounted for almost 70% of all enrollments. Individuals aged 18 to 34 accounted for 38.4% of all enrollments.

The Impact of COVID-19

On March 5, 2020, the Governor declared a State of Emergency and the existence of a catastrophic health emergency to deploy resources and implement the emergency powers of the Governor to control and prevent the spread of COVID-19. Emergency legislation, Chapters 13 and 14 of 2020 (the COVID-19 Public Health Emergency Protection Act) authorized the Governor, for the duration of the emergency, to take actions relating to health insurance, Medicaid, retailer profits, employer actions, and personnel at State health care facilities as a result of the State of Emergency and catastrophic health emergency relating to COVID-19. More specifically, the Acts authorized the Governor to (1) facilitate access to health care and the provision of that care and (2) mitigate costs to individuals for COVID-19 diagnosis and treatment, including by prohibiting cost-sharing by health insurance carriers for COVID-19 testing, ordering MDH to cover the cost of testing if not paid for by a carrier or another third party, and requiring carriers to cover a

COVID-19 immunization (if and when available) without cost-sharing. The Acts also authorized the Governor to establish or waive telehealth protocols and order MDH to reimburse certain Medicaid telehealth services for COVID-19 patients. Additionally, the Acts authorized the development and implementation of orders to minimize disruption in enrollment in health insurance and Medicaid and to facilitate reimbursement for services relating to COVID-19.

MIA has adopted several sets of emergency regulations and bulletins related to the pandemic, including requiring carriers to (1) waive any cost-sharing for any visit to diagnose or test for COVID-19, regardless of the setting of the testing; (2) waive any cost-sharing for laboratory fees to diagnose or test for COVID-19; (3) waive any cost-sharing for vaccination for COVID-19, when a vaccine becomes available; (4) evaluate a request to use an out-of-network provider to perform diagnostic testing of COVID-19; and (5) consider an adverse decision on a request for coverage of diagnostic services for COVID-19 an emergency case for which an expedited grievance procedure is required. The emergency regulations do not apply to Medicare supplement policies. Additionally, the Insurance Commissioner has issued bulletins prohibiting the cancellation or nonrenewal of individual health policies for nonpayment of a premium as part of the State's overall response to COVID-19.

In an effort to prioritize health and safety, MHBE opened a new Coronavirus SEP, running from March 16, 2020, through December 15, 2020, for any uninsured Marylander to apply for coverage. As of December 6, 2020, 97,759 individuals have enrolled in coverage through the SEP. Of these enrollees, 67% qualified for Medicaid, 23% enrolled in a QHP with an APTC, and 10% enrolled in a QHP without assistance.

Update on Legal Challenges to the ACA

In *Texas v. United States*, 20 states filed suit in the U.S. District Court, Northern District of Texas arguing that the ACA, as amended by the Tax Cuts and Jobs Act of 2017 (which eliminated the tax penalty of the individual mandate), is no longer constitutional without a tax penalty. In December 2018, Judge Reed C. O'Connor ruled in favor of the plaintiffs, concluding that the mandate is no longer permissible under Congress's taxing power and is thus unconstitutional. The judge found the individual mandate to be "essential" to and inseverable from the ACA and declared the entire law invalid. On appeal, the Fifth Circuit Court of Appeals affirmed the District Court opinion that Congress does not have constitutional authority to enforce the mandate. However, the circuit court did not affirm the District Court's determination that the individual mandate is not severable. Instead, the circuit court remanded the severability issue to the District Court. The Supreme Court heard oral arguments in the case, now known as *California v. Texas*, on November 10, 2020. Issues before the Supreme Court include (1) whether Texas and the individual plaintiffs have standing; (2) if so, whether the individual mandate is unconstitutional; (3) if unconstitutional, whether the rest of the ACA can survive; and (4) if the entire ACA is held invalid, whether the entire law should be unenforceable nationwide or whether it should be unenforceable only to the extent that provisions injure individual plaintiffs. The Supreme Court is expected to deliver its decision in spring 2021.

An October 2020 Urban Institute report estimated that, should the ACA be overturned, an additional 21.1 million people will become uninsured nationally. Medicaid and Children's Health Insurance Program coverage will decline by 15.5 million, 9.3 million people will lose income-related subsidies such as the APTC and cost-sharing reductions, the number of individuals with private nongroup insurance will decline by 27%, and federal spending on health care will fall by $152 billion per year in 2022. Furthermore, available private nongroup coverage will likely cover fewer benefits, require more OOP spending, and be less accessible to people with current or past health problems because of the elimination of guaranteed issue and modified community rating rules. In Maryland, an estimated 395,000 people will become uninsured (an increase of 95%), Maryland will lose an estimated $3.7 billion in federal funding for marketplace subsidies, Medicaid and MCHP, and health care spending by public and private insurers and households is estimated to decline by $3.3 billion.

To protect against the possibility that the ACA might be overturned, Chapters 620 and 621 of 2020 established nondiscrimination provisions and codified the consumer protection provisions of the ACA, including protections for individuals with preexisting conditions, which were previously only specified in Maryland law through cross-references. The Acts generally apply to any health benefit plan offered in the small group, individual, or large group markets with specified exceptions for grandfathered plans. Although the Acts will give Marylanders the option to retain coverage without the substantial federal subsidies provided under the ACA, many Marylanders could find insurance unaffordable.

Chapter 2. Work of the Commission

Agenda and Presentations

During the course of the 2020 interim, the Maryland Health Insurance Coverage Protection Commission held two virtual meetings that were live streamed to the public. Below is a summary of information as it was presented to the commission at the commission meetings. Accordingly, there may be some variation in figures referenced by presenters due to their drawing upon differing sources of information for their presentations. The views expressed by the presenters do not necessarily reflect the views of the commission or its members.

September Meeting

On September 14, 2020, during its first meeting, the commission received an update on the State Reinsurance Program, a presentation on how other states fund their share of reinsurance programs, and options for linking laid-off workers with health insurance.

State Reinsurance Program

Ms. Michele Eberle and Ms. Johanna Fabian-Marks, the Executive Director of the Maryland Health Benefit Exchange (MHBE) and the Director of Policy and Plan Management for MHBE, respectively, updated the commission on the State Reinsurance Program. As a result of the program, average premium rates have returned to pre-2018 levels, with monthly premiums decreasing an average of 10% for 2020 and 13% for 2019. Lower premiums have contributed to increased enrollment in the individual market, allowed enrollees to upgrade to higher value plans with lower cost-sharing, and led to UnitedHealthcare announcing that it would rejoin the individual market for plan year 2021.

State regulations require MHBE to estimate parameters for the program (including attachment point, coinsurance rate, and cap) by April 1 of the calendar year immediately before the applicable plan year and finalize the parameters by December 31. For the first three years of the program, the parameters have remained the same with carriers being reimbursed for 80% of claims between $20,000 and $250,000. Maryland's reinsurance program is unique in its application of a dampening factor, which accounts for the interaction of the program and the federal risk adjustment program (a market stabilization program that moves money from lower risk carriers to higher risk carriers to help balance premiums). The dampening factor, which has decreased from 0.8 in 2019 to 0.760 in 2021, is intended to ensure that a carrier does not receive double payments under both programs.

For 2019, the program cost a total of just under $353 million below original estimates, which caused MHBE's actuaries to reduce future estimated costs for 2020 through 2023. Costs are

projected to grow to $478 million in total funds by 2023. Federal funding for the program was $373 million in 2019 and $447 million in 2020. MHBE anticipates receiving more federal funding than the actual cost of the program, which is fairly unique nationally. The program is estimated to result in a reduction in individual market premiums of 25.7% in 2020 and 29.1% in 2023. Enrollment growth is anticipated to continue to grow in 2021 to an estimated 224,909 enrollees.

State regulations require all carriers participating in the program to submit an annual report describing carrier activities to manage the costs and utilization of enrollees whose claims are reimbursed under the program. Carrier reports will collect targeted information on diabetes, behavioral health, asthma, and pregnancy/childbirth as well as information on common diagnoses among enrollees whose claims were reimbursed under the program. Reports on 2019 data were due October 30, 2020.

Funding States' Share of Reinsurance Programs

Ms. Jennifer B. Chasse, Principal Policy Analyst with the Department of Legislative Services, provided a presentation on the funding of states' share of reinsurance programs. As of September 2020, 14 states had approved reinsurance programs, including newly approved programs in New Hampshire and Pennsylvania, which will begin in 2021. There is great variation among the size and scope of programs as well as the annual cost, which ranges from $14.7 million in Rhode Island to $377.8 million in Maryland (the largest program). Costs differ based on numerous factors, including enrollment, attachment point, cap, coinsurance percentage, the amount of federal pass-through funding, and the risk pool being insured in each state's individual marketplace.

All state reinsurance program are designed to use a combination of state funding and federal pass-through funding. Even if federal funding exceeds the cost of the program from year-to-year, the state must have a designated source of funding for the program. The most common state funding sources are insurer assessments (nine states), general fund appropriations (four states), former high-risk pool/special fund transfers (two states), state individual mandate penalty revenues (two states), and savings from switching from a federal exchange to a state-based exchange (two states).

Linking Laid-off Workers with Health Insurance

Millions of Americans lost employment due to the COVID-19 pandemic. According to the Commonwealth Fund, as of June 2020, 7.7 million Americans lost jobs with employer-sponsored insurance (ESI) as a result of the pandemic. Experts project that unemployment and the number of uninsured will continue to rise as job losses become permanent and temporary policies such as grace periods granted to those unable to pay their monthly insurance premiums expire.

Mr. Stan Dorn, Director of the National Center for Coverage Innovation at Families USA, provided a presentation on options for Maryland to provide health insurance to laid-off workers

and their families. Mr. Dorn presented Census Bureau data (as of July 2020) that showed that one-third (33%) of all uninsured adults were receiving unemployment insurance (UI) and that 81% lived in a household that experienced reduced employment income since mid-March 2020. The majority of uninsured adults were people of color, the vast majority did not have a college degree, and most were earning less than $50,000 per year even prior to the COVID-19 pandemic.

Mr. Dorn described that the United States has had limited past success in enrolling laid-off workers in health insurance, likely due to the trauma of job loss, and the need for individuals to meet survival needs such as food and rent. However, there has been some success. Federal health coverage tax credits for trade-displaced workers initially did not have a significant effect (reaching only 10% to 20% of eligible individuals), but in areas where unions and state agencies completed paperwork on behalf of enrollees and proactively worked to solve problems, coverage rates increased to more than 50%. In 2020, Kentucky's UI agency gave the state's Medicaid agency contact information for UI claimants. The Medicaid agency then sent emails to claimants and invited them to complete a simple application form. When claimants opened the email without completing the application form, the agency called the claimant and helped them fill out the form over the telephone. Under this initiative, more than 130,000 adults gained Medicaid coverage in Kentucky from March to June 2020, a larger increase than any other state.

Mr. Dorn described several options for Maryland to pursue that would link laid-off workers with health insurance. First, Maryland could pursue a similar approach to Kentucky (proactive individual contact), which can be done quickly with little effort from UI, but with high health administrative costs (federal COVID relief funds may be used or a federal Medicaid administrative match of up to 75%). Second, Maryland could use an approach similar to the Easy Enrollment program, a check box on the UI form with simple income attestation and household information to start Medicaid eligibility. This information could be collected on the follow-up UI form. This would require some administrative costs and there would be more work for the Maryland Department of Labor (MDL) (*i.e.*, modifying forms, data interface). Third, Maryland could present health enrollment options while UI claimants are on hold on the telephone (*i.e.*, push a button to be connected to someone who can enroll you in health insurance). California uses an off-the-shelf software program called On Demand, billed as the "Uber for health insurance," which follows up with individuals who express interest in enrolling. Finally, Maryland could provide information about how to access health insurance to UI claimants. This could be done quickly with low health administrative costs and little effort from UI but is potentially less effective. Mr. Dorn noted that, unfortunately, information alone is often not enough and people who have lost their job often need help signing up for coverage.

Mr. Michael Harrison, Policy Director at MDL, responded to Mr. Dorn's presentation. Mr. Harrison noted that UI is 100% federally funded program using a tax paid by employers, which requires Maryland UI to strictly abide by federal laws. Thus, no federal funds may be used to promote a State program, which limits options for supporting direct linkage to MHBE. MDL can provide links on its website and is happy to look into options.

Ms. Eberle commented that MHBE has an excellent relationship with MDL and has been working with them to get information about coverage options to UI claimants even prior to the COVID-19 pandemic. Ms. Eberle remarked that the agencies should continue to work together to pursue options to ensure all Marylanders have access to coverage.

Additional Information on Linking Unemployment Insurance Claimants with Health Insurance

According to the National Academy of State Health Policy, at least four other states have taken action to connect recently unemployed individuals who have lost ESI with coverage. New Jersey has coordinated with its Department of Labor to include a link to the exchange website within the Department of Labor's consumer portal so that individuals are reminded of their health coverage options when they check the status of their unemployment claims. Colorado has purchased targeted advertisements to reach those who search for Consolidated Omnibus Budget Reconciliation Act so that consumers can compare cost and coverage options across programs. The Washington Health Benefit Exchange is telling consumers, "Filing for unemployment benefits? Visit the exchange to stay covered" to remind them to seek a new form of coverage after losing their ESI. Nevada includes informational pamphlets about open enrollment in direct mailers sent to individuals who have filed for unemployment. In addition, the state's Department of Unemployment will share open enrollment information on its social media and web pages.

On October 16, 2020, the Maryland Attorney General's COVID-19 Access to Justice Task Force sent correspondence to the Maryland Secretary of Labor, the Secretary of Health, and the Executive Director of MHBE requesting:

> a robust, three-step response to help the recently unemployed obtain healthcare coverage: First, building on Maryland's early success with the Easy Enrollment Program, the Department should, as quickly as possible, incorporate a health insurance check box into applications for unemployment insurance. A mandatory question on the application should seek the applicant's response to whether the applicant wants information from their unemployment application shared with the Maryland Health Benefit Exchange assistance in obtaining free or low-cost health insurance. The Department would then share that information with MHBE, which would follow up with the applicant. Second, ensure that MHBE has the resources to follow up and provide individual assistance to laid-off workers and their families by proactively reaching out, filling out paperwork, and walking them through the process. Third, launch a robust communications campaign, starting immediately and continuing until the economy recovers, that informs the public about the availability of free or low-cost health insurance for people who lose their jobs or experience income loss. The campaign should direct them to visit the Maryland Health Connection website for further information about how to obtain free or low-cost health insurance.

December Meeting

On December 8, 2020, during its second virtual meeting, the commission received a briefing on MHBE's State-based Individual Market Subsidy Program Report and the impact of COVID-19 on enrollment in the exchange, before engaging in a discussion on potential recommendations.

State-based Individual Market Subsidy Program Report

Ms. Eberle and Ms. Fabian-Marks presented MHBE's State-based Individual Market Subsidy Program Report.

Chapters 104 and 105 of 2020 required MHBE to submit a report to the Senate Finance and House Health and Government Operations committees on the potential design, implementation, and effects of establishing State-based, individual market health insurance subsidies in Maryland as well as an analysis of the appropriate allocation of available funding between subsidies and reinsurance. MHBE worked with Lewis & Ellis Actuarial Consultants, in consultation with the Maryland Insurance Administration, to model the design and impact of State subsidies on the populations targeted, the individual market overall, and the reinsurance program. Lewis & Ellis produced a report detailing their evaluation, which MHBE published for public comment in October 2020. To gather additional feedback on the proposed subsidy designs, MHBE formed an individual subsidy workgroup that met virtually on a weekly basis from October 7, 2020 to November 12, 2020. On December 1, 2020, MHBE submitted the required report, which incorporates the Lewis & Ellis analysis, public comments, and the workgroup report.

Ms. Fabian-Marks described how the State Reinsurance Program has successfully reduced premiums in the individual exchange. Monthly premiums are down an average of 11.9% for 2021 and more than 30% compared to 2018. In 2021, Maryland's lowest cost plans will be about 20% to 30% below U.S. averages, depending on metal level. However, Ms. Fabian-Marks noted that the benefits of the reinsurance program are primarily felt by households earning more than 300% of the federal poverty level (FPL), and particularly households earning more than 400% FPL (about $51,000 for an individual or $105,000 for a family of four) that earn too much to qualify for federal advanced premium tax credits (APTC). Because of the way that the federal subsidy structure works, reductions in premiums resulting from the reinsurance program are not typically felt by individuals at lower incomes. As a result, the reinsurance program is not an effective way to reduce premiums for individuals at lower incomes or to target subsidies toward specific populations, such as young adults.

Ms. Fabian-Marks described Maryland's remaining uninsured population (pre-COVID-19) as comprising about 156,000 uninsured adults who do not qualify for Medicaid and are lawfully present. This represents the target population for a potential State-based subsidy. Of this group, young adults are most likely to be uninsured (67,200; 43% of total). A majority of the uninsured

also have incomes below 400% FPL. Two potential target populations for a State-based subsidy are young adults and households with incomes between 400% and 600% FPL.

MHBE's 2019 Affordability Work Group recommended that a subsidy be targeted to young adults, which comprise the largest group of uninsured, lawfully present adults ineligible for Medicaid by age. Adding this population to the market could further stabilize the market and reduce premiums for all enrollees. In a 2019 survey, about 70% of uninsured Maryland young adults said that they would like to have health insurance, but 76% said that it is difficult to afford.

The second potential target population for a State-based subsidy, households with incomes between 400% and 600% FPL, was also discussed by the 2019 Affordability Work Group. The federal subsidy cliff at 400% FPL can result in a big jump in net premium for people just over 400% FPL. This primarily impacts middle-income, older adults. For example, a couple age 55 to 64 with a household income between 400% and 600% FPL can see their premium jump 177% compared to a couple of the same age with a household income between 300% and 400% FPL.

MHBE modeled multiple subsidy scenarios for both potential target populations. Regarding young adults, eight scenarios were modelled, resulting in estimated increases in enrollment of between 500 and 21,000 new participants to the market. On average, a State subsidy for young adults would reduce premiums for subsidized enrollees by between 12% and 60% compared to a federal APTC only (equating to $20 to $130 per month). The cost of young adult subsidies would range from $6 million to $64 million per year depending on the subsidy provided. Should the State receive a federal waiver, State costs could be offset by federal pass-through funding of between $400,000 and $12 million depending on the subsidy provided. Overall, individual market premiums could be reduced by between 0.10% and 3.5% by a young adult subsidy.

Regarding subsidies for individuals with household incomes between 400% and 600% FPL, three scenarios were modelled resulting in estimated increases in enrollment of between 2,300 and 8,900 new participants to the market. This is primarily because this type of subsidy largely impacts older adults who are already more likely to have insurance. On average, a State subsidy for individuals with incomes between 400% and 600% FPL would reduce premiums for subsidized enrollees by between 5% and 20% (equating to $33 to $121 per month). The cost of these subsidies would range from $17 million to $69 million, depending on the subsidy provided. Should the State receive a federal waiver, State costs could be offset by federal pass-through funding of between $3 million and $10 million, depending on the subsidy provided. Overall, individual market premiums could be reduced by between 0.10% and 0.5% by a subsidy for individuals with incomes between 400% and 600% FPL.

There are two potential funding sources for a State-based subsidy – federal pass-through funding and the State health insurance provider fee. Ms. Fabian-Marks notes that it would be ideal to use federal funding, but there is sufficient State funding available since the federal pass-through funding for reinsurance has exceeded costs.

MHBE's individual subsidy workgroup made a total of seven recommendations, including that (1) MHBE target subsidies at young adults, with subsidies phasing out to age 40; (2) MHBE target subsidies at young adults with incomes up to 400% FPL; (3) of the subsidy designs presented, the Age Adjustment Subsidy Enhancement; linear interpolation to age 40 (AASE; LI to 40) best met the framework goals; and (4) MHBE later explore a subsidy targeting those with incomes at 400% to 600% FPL and explore including young adults in the subsidy design. Subsidy design AASE; LI-40 would provide a subsidy to individuals age 18 to 39, is estimated to increase MHBE enrollment by 20,900 by 2024, and would cost $64 million in 2024. This cost could potentially be offset by up to $12 million in federal pass-through funding and could reduce individual market premiums for all by 3.5%,

Ms. Fabian-Marks described that a young adult subsidy could meaningfully reduce the uninsured rate among young adults, further stabilize the risk pool, and potentially reduce premiums for all enrollees. Implementing a State subsidy program is not projected to impact the reinsurance program. If MHBE is authorized to implement a State subsidy program, it would be prudent to pursue amendment of the existing reinsurance waiver to enable MHBE to put surplus federal pass-through funding toward the subsidy program. However, federal approval of such an amendment is uncertain. Given the novel nature of a State subsidy program, the legislature may want to consider a pilot program of approximately two to three years to allow MHBE to gather enough credible data to refine longer-term projections of program costs.

Impact of COVID-19 on Enrollment

Ms. Fabian-Marks also provided an update on the impact of COVID-19 on MHBE enrollment. MHBE launched a COVID-19 special enrollment period from March 15, 2020, through December 15, 2020. Any uninsured Marylander can enroll in coverage and does not need to have a qualifying event, such as moving or marriage. Through December 6, 2020, 97,759 individuals have enrolled (67% Medicaid, 23% qualified health plan (QHP) with an APTC, and 10% a QHP without assistance). Overall, as of October 31, 2020, MHBE QHP enrollment was up 18% year-over-year.

Chapter 3. Recommendations

Required Findings and Recommendations

In its 2020 annual report, the Maryland Health Insurance Coverage Protection Commission must make recommendations for individual and group health insurance market stability, including:

- the need for and components of one or more Section 1332 waivers;
- whether to pursue a standard plan design that limits cost-sharing;
- whether to merge the individual and small group health insurance markets for rating purposes;
- whether to pursue a basic health program;
- whether to pursue a Medicaid buy-in program for the individual market;
- whether to provide subsidies that supplement premium tax credits or cost-sharing reductions;
- whether to adopt a State-based individual health insurance mandate and how to use payments collected from individuals who do not maintain minimum essential coverage, including use of the payments to assist individuals in purchasing health insurance; and
- whether the State Reinsurance Program should be extended after calendar 2023 and, if so, how it will be funded.

The Need for and Components of Additional Section 1332 Waivers

Section 1332 of the federal Patient Protection and Affordable Care Act (ACA) permits a state to apply for a State Innovation Waiver (now also referred to as a State Relief and Empowerment Waiver) to pursue innovative strategies for providing their residents with access to high quality, affordable health insurance while retaining the basic protections of the ACA. Under such a waiver, states may waive specified ACA requirements while still providing access to quality health care that is at least as comprehensive and affordable and covers a comparable number of residents as would be covered absent a waiver, without increasing the federal deficit. A Section 1332 waiver may waive ACA standards including qualified health plan establishment, consumer choice and insurance competition, advanced premium tax credits (APTC), and cost-sharing reduction plans. Under a Section 1332 waiver, a state may receive federal funding

that would have been provided to the state in the form of APTCs or other federal funding in the absence of the state innovation for which the waiver is granted. The application process is robust, and a state must provide significant data, actuarial analyses and certifications, a detailed 10-year budget plan, analysis of the impact of the waiver on health insurance coverage, and a detailed implementation plan and timeline. Waivers can be approved for up to 5 years and can be renewed.

Chapters 6 and 7 of 2018 required the Maryland Health Benefit Exchange (MHBE) to submit an application for a Section 1332 waiver to establish a State Reinsurance Program and seek federal pass-through funding. The federal government approved the waiver in August 2018. The waiver is approved through 2023. Under the waiver, Maryland is able to use federal pass-through funds to provide additional funding for the program.

Maryland may need to apply for a new Section 1332 waiver or amend the waiver obtained for the reinsurance program to implement additional options to stabilize the individual market. For instance, if Maryland moves forward with establishing a State-based individual market subsidy program, a determination will need to be made as to whether implementation requires federal approval. In particular, if the State seeks federal funds to implement the program, a Section 1332 waiver will be required.

Tabled Options for Stabilizing the Individual Market

During the 2019 interim, the commission declined to further pursue three options for stabilizing the individual market: (1) merging the individual and small group markets; (2) establishing a standard plan; and (3) establishing a basic health program. The commission considered the recommendations of the MHBE Board of Trustees against merging the markets and the Wakely Consulting Group report, which noted that merging the markets would lessen the effect of the State Reinsurance Program. Based on the recommendations and report, the commission did not to pursue the option of merging the markets. MHBE established a standardized benefit design workgroup in 2017. Commissioners considered the findings of the workgroup and whether a standardized benefit design would benefit Maryland consumers with only two carriers in the individual market. The commission was uncertain how a standardized benefit design would affect deductibles and premiums in the individual market and did not request additional information on the option of establishing a standardized benefit design. Section 1331 of the ACA authorizes states to create a basic health program. Two states have offered basic health plans but have experienced funding shortages. The commission did not opt to pursue establishing a basic health program in Maryland at this time.

Additional Information Requested on Medicaid Buy-in

In its 2019 report, the commission requested additional information before making a recommendation on whether to establish a Medicaid buy-in option. There are several options to structure and finance Medicaid buy-in plans, and the commission suggested that a consultant could help determine what option would be most beneficial to Maryland consumers. Unfortunately,

budget constraints did not allow the commission to request a study. Should the fiscal 2021 budget allow, the commission would like to request a study on pursuing a Medicaid buy-in, similar to the studies conducted for Colorado and New Mexico in 2018.

Subsidies That Supplement Premium Tax Credits or Cost-sharing Reductions

At its December 2020 meeting, the commission received a presentation on MHBE's State-based Individual Market Subsidy Program Report. MHBE's individual subsidy workgroup recommended that MHBE target subsidies at young adults with incomes up to 400% of the federal poverty level, with subsidies phasing out to age 40. Such a subsidy is projected to reduce the uninsured rate among young adults, further stabilize the risk pool, and potentially reduce premiums for all enrollees.

MHBE suggested that the program could be funded with surplus funds in the MHBE Fund generated by the annual health insurance provider fee and federal pass-through funds. Surplus funds generated from the annual health insurance provider fee are projected to exceed the cost of the State-based individual market subsidy recommended by the workgroup. In addition, federal funding under the current Section 1332 waiver for the reinsurance program is projected to exceed the cost of the reinsurance program and could be sufficient to finance a subsidy program for three to seven years. State legislation is required to use any surplus funds that are earmarked in statute for the State Reinsurance Program and an amendment to the Section 1332 waiver for the reinsurance program is required to use the federal-pass through funds.

The health insurance provider fee and the reinsurance program are scheduled to terminate in 2023. As an alternative to implementing a permanent program for individual subsidies, the workgroup report recommended establishing a pilot program so that additional data can be collected to refine the long-term costs of the subsidy program and the State Reinsurance Program. The fees generated from the health insurer provider fee could support a pilot of two to three years, and the pilot program could provide sufficient data to pursue a waiver to gain federal pass-through funding for both the individual market subsidy program and the reinsurance program. Both programs could be renewed in 2023.

The commission supports the recommendations of the individual subsidy workgroup for MHBE to pursue a young adult subsidy. Further, the commission supports the establishment of the subsidy as a pilot program of two to three years, with MHBE reporting back to the General Assembly and the commission on the impact and long-term cost of such a subsidy. The commission cautions that funding for the reinsurance program should not be jeopardized as a result of funding individual subsidies. The reinsurance program has substantially reduced individual market premiums and stabilized the market, and the commission believes that its continuation is necessary to continue improving access to affordable healthcare.

Potential State-based Individual Health Insurance Mandate

The commission received several briefings on the impact of individual mandates and the implementation of individual responsibility fees at the federal and state levels. In the 2018 commission report, the commission found that a State-based individual mandate could take several forms. Maryland could adopt a mandate that mirrors the federal individual mandate as did New Jersey. Alternatively, the report found that Maryland could adopt a down payment plan in which the uninsured could elect to turn their penalty payment into a down payment to buy insurance.

In response to the commission's findings, Chapters 423 and 424 of 2019 established the Maryland Easy Enrollment Health Insurance Program. The Acts also require MHBE to establish a Maryland Easy Enrollment Health Insurance Program Advisory Workgroup to provide ongoing advice regarding implementation of the program. By December 31, 2022, the advisory workgroup must report to the General Assembly on (1) the effectiveness of the program; (2) recommendations as to whether implementing an individual responsibility amount or implementing automatic enrollment of individuals in a qualified health plan in the individual market is feasible and in the best interest of the State; and (3) if so, the dollar amount of the individual responsibility amount and whether the State should provide an individual the option of obtaining health insurance instead of paying the individual responsibility amount.

The commission therefore defers making a recommendation on whether to adopt a State-based individual health insurance mandate and how to use payments collected from individuals who do not maintain minimum essential coverage until the advisory workgroup has submitted its report in 2022.

State Reinsurance Program

The State Reinsurance Program, which began January 1, 2019, and is the largest reinsurance program in the nation, has been a successful tool for stabilizing Maryland's individual health insurance market. As a result of the program, average premium rates have returned to pre-2018 levels, with monthly premiums decreasing an average of 10% for 2020 and 13% for 2019. Lower premiums have contributed to increased enrollment in the individual market, allowed enrollees to upgrade to higher value plans with lower cost-sharing, and led to UnitedHealthcare announcing it would rejoin the individual market for plan year 2021. Program costs have come in below those initially estimated and federal pass-through funding has exceeded the actual costs of the program leading to a surplus of available funding. Enrollment growth is anticipated to continue to grow in 2021 to an estimated 224,909 enrollees.

The federal terms and conditions of the Section 1332 waiver for the program require MHBE "to ensure sufficient funds, on an annual or other appropriate basis, for the reinsurance program to operate as described in MHBE's waiver application." Chapters 37 and 38 of 2018 established a one-time State health plan assessment to be collected in 2019 to help fund the

reinsurance program. The State assessment was modeled on Section 9010 of the ACA, which imposed a federal assessment of approximate 2.75% on the premiums for specified entity's that provide health insurance and was suspended by the federal government in 2019. Subsequent to the approval of Maryland's Section 1332 waiver, the Section 9010 assessment was repealed for calendar years beginning after December 31, 2020. Meanwhile, Chapters 597 and 598 of 2019 extended the State assessment through 2023 and reduced it to 1%. The 1% assessment is estimated to collect approximately $112 million to $125 million per year and ensures that Maryland has consistent funding to support the reinsurance program and access to federal pass-through funding.

Based on the success of the program and its dependence on continued State funding, at this time, the commission supports the State Reinsurance Program because of its proven success and recommends that the program be extended past 2023. In light of the dependence of the program on State funding, a majority of the commissioners also support extending the duration of the assessment past 2023 at an amount sufficient to continue the program as it currently exists.

Additional Recommendations

Connecting Laid-off Workers with Health Coverage

As a result of the COVID-19 pandemic, millions of Americans lost employment. According to the Commonwealth Fund as of June 2020, 7.7 million Americans lost jobs with employer-sponsored insurance, and experts project that unemployment and the number of uninsured will continue to rise. There are many options for Maryland to pursue that would help link unemployed and laid-off workers with health care coverage. At its September 2020 meeting, the commission was briefed on options to link laid-off workers with health coverage. Options included (1) proactive contact of unemployment insurance (UI) claimants by MHBE based on information provided from the Maryland Department of Labor (MDL); (2) an approach similar to the Maryland Easy Enrollment Health Insurance Program in which a check box on the UI form would indicate whether the applicant wishes to be contacted by MHBE; (3) the automatic transfer by telephone or electronic link of UI claimants from MDL to MHBE for the purpose of possible enrollment in health insurance options; or (4) providing information about how to access health insurance to UI claimants.

In October 2020, the Maryland Attorney General's COVID-19 Access to Justice Task Force sent correspondence to MDL, the Maryland Department of Health, and MHBE requesting "a robust, three-step response to help the recently unemployed obtain healthcare coverage." As of the final commission meeting, the Attorney General had not received a response, although, MHBE indicated one is forthcoming.

Based on what is possible under federal law, the commission recommends that MHBE and MDL continue to work together to find a way to establish a means to connect unemployment insurance claimants with health insurance coverage options to ensure that individuals have support

in obtaining needed health insurance coverage. Although not specifically mentioned or endorsed during the discussion of commission recommendations at the December 8 meeting, some commissioners have expressed strong support for recommending that (1) MHBE and MDL, as soon as practicable and as allowed under federal law, create a checkbox on appropriate UI forms similar to the one used on individual tax forms for the Maryland Easy Enrollment Health Insurance Program (MEEHIP) and (2) the General Assembly enact legislation during the 2021 session requiring MHBE and MDL to establish a program similar to MEEHIP that utilizes a checkbox on appropriate UI forms to connect UI applicants to health insurance coverage.