Maryland Health Insurance Coverage Protection Commission

Senator Brian J. Feldman and Delegate Joseline A. Peña-Melnyk, Co-Chairs

Monday, September 14, 2020, 2:00 p.m.
Virtual

Agenda

I. Update on the State Reinsurance Program

- Michele Eberle, Executive Director, Maryland Health Benefit Exchange
- Johanna Fabian-Marks, Director of Policy and Plan Management, Maryland Health Benefit Exchange

II. Presentation on Funding States' Share of Reinsurance Programs

- Jennifer Chasse, Principal Analyst, Department of Legislative Services

III. Connecting the Easy Health Insurance Enrollment Program and the Unemployment Insurance Program

- Stan Dorn, Senior Fellow, Families USA
- Michael Harrison, Policy Director, Maryland Department of Labor
- Michele Eberle, Executive Director, Maryland Health Benefit Exchange
- Johanna Fabian-Marks, Director of Policy and Plan Management, Maryland Health Benefit Exchange

IV. Closing Remarks

Future Meeting Date

December 8, 2020

State Reinsurance Program Update

Michele Eberle, Executive Director
Johanna Fabian-Marks, Director of Policy & Plan Management
Maryland Health Benefit Exchange

September 14, 2020

MARYLAND HEALTHBENEFIT EXCHANGE

Agenda

- Introduction
- 1332 Waiver Presentation
  - Performance for Plan Year 2020
  - Reinsurance Parameters, 2019-2021
  - Actual and Projected Costs and Funding, 2019-2023
  - Carrier Accountability Reports
  - 2020 Timeline

Background: How does the federal 1332 waiver work?

- Reinsurance reduces premiums in the individual market by covering a portion of insurer's claims
- Lower premiums mean that the federal government's costs to subsidize insurance for low- and middle-income people are also lower
- The federal government passes those savings ("federal pass-through funding") to MHBE to spend on the reinsurance program

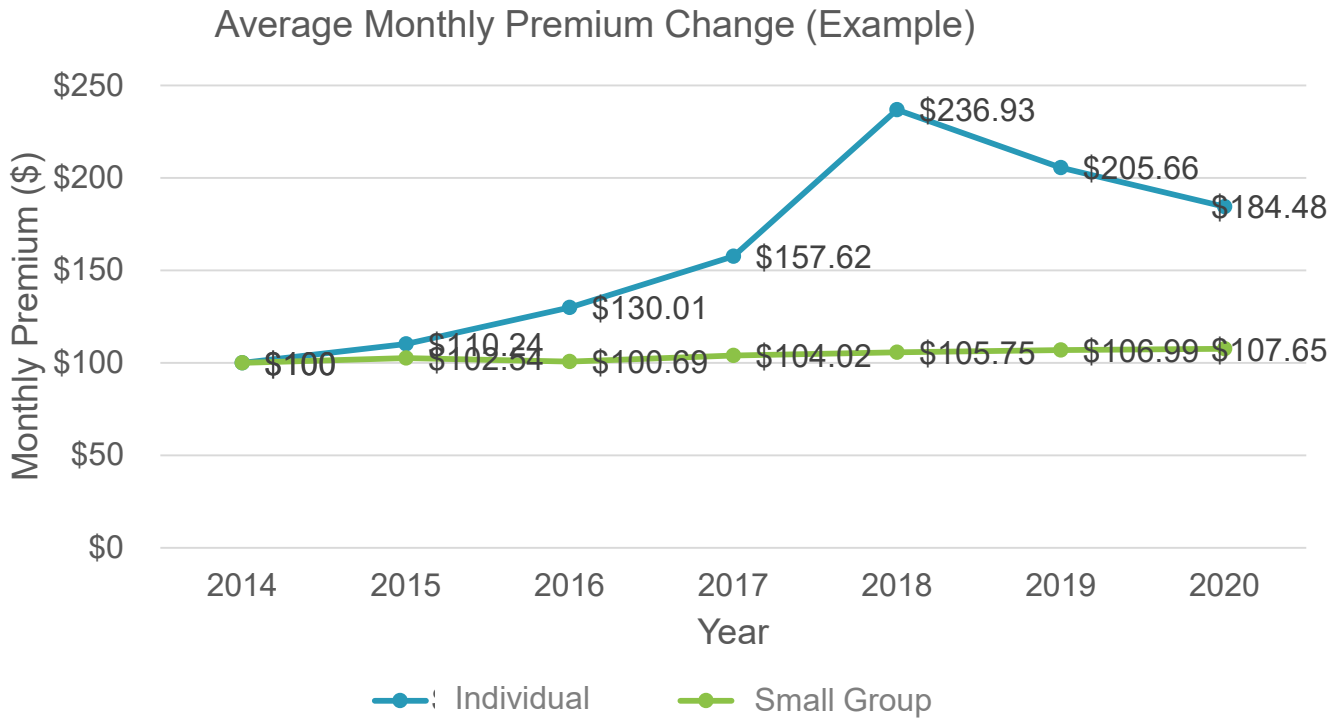
Maryland State Reinsurance Program (SRP) Performance for Plan Year 2020

Premiums Continued to Fall

Monthly premiums were lowered by an average of 10% for 2020, on top of a 13% decrease for 2019, returning average rates to below 2018 levels.

Plan Year	Individual Premium Change
2014	n/a
2015	10%
2016	18%
2017	21%
2018	50%*
2019	-13%
2020	-10%

Average (%) Premium Increases Individual & Small Group (Example)



*This reflects increases to on-exchange silver plan premiums to adjust for the fact that the federal government stopped making cost-sharing reduction payments. Absent this adjustment, the average premium change would have been 28%. The additional increase is largely born by higher APTCs from the federal government rather than paid directly by consumers.

MARYLAND HEALTHBENEFIT EXCHANGE

Estimated Effect of the Reinsurance Program on 2020 Premiums

Rate Impact of the Reinsurance Program by carrier.*

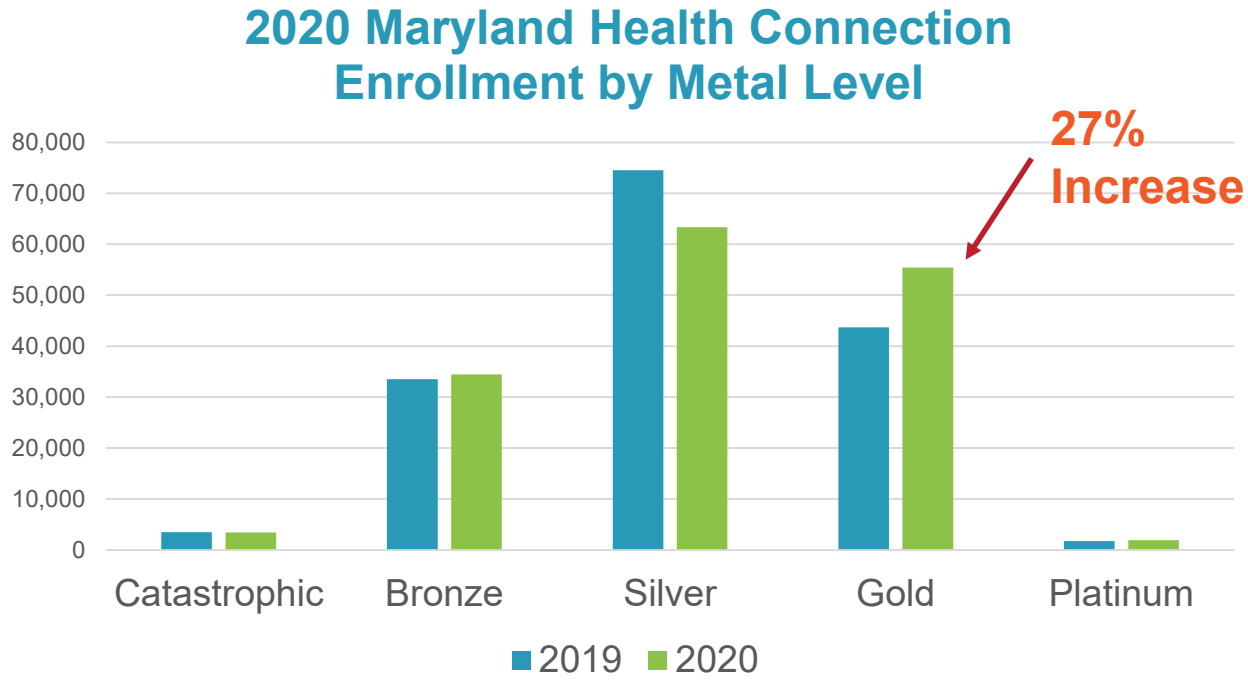
Carrier (Network)	Enrollment (on/off MHC)	2020 Rate Change (w/o Reinsurance)	2020 Rate Change (w/ Reinsurance)
CareFirst (HMO)	130,642	11.8%	-14.7%
CareFirst (PPO)	11,665	65.3%	-1.4%
Kaiser Permanente (HMO)	64,792	23.8%	-5.0%
Total	207,099	19.6%	-10.3%

*Data as of 4/30/20 provided by the MIA

Enrollees Chose Higher-Value Plans

With lower premiums, enrollees on Maryland Health Connection were able to upgrade to higher-value plans with lower cost-sharing.

Metal Level	2019 Total	2020 Total	% Change
Platinum	1,736	1,955	13%
Gold	**43,675**	**55,421**	**27%**
Silver	74,536	63,364	-15%
Bronze	33,529	34,445	3%
Catastrophic	3,487	3,415	-2%



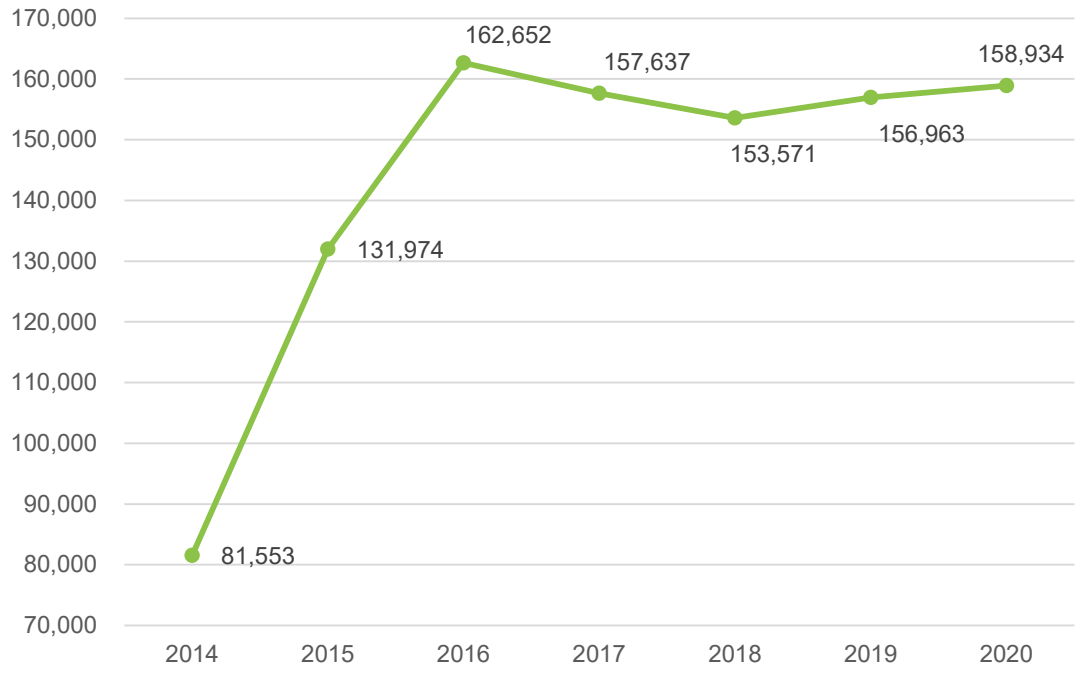
Enrollment data as of the end of open enrollment for 2020: Dec. 15, 2019.

MARYLAND HEALTHBENEFIT EXCHANGE

Enrollment Continued to Rise

- As of the end of open enrollment for 2020, Maryland's total individual market enrollment, including plans obtained directly from carriers, was 215,484 – up 1 percent from 212,149 a year earlier.
  - As of the end of June, total individual market enrollment is up 11.6% year-over-year.
- Individual market exchange enrollment was at a four-year high as of the end of open enrollment.
  - As of the end of August, Exchange enrollment is up 16.8% year-over-year.

Individual Market Exchange Enrollment[2]



1. Health Insurance Exchanges 2020 Open Enrollment Report Centers for Medicare and Medicaid Services, April 1, 2020
2. Enrollment data as of the end of open enrollment preceding each plan year

MARYLAND HEALTHBENEFIT EXCHANGE

Estimated Effect of the Reinsurance Program on 2020 Enrollment

Without the reinsurance program, individual market enrollment would have been an estimated 10 percent lower.

Scenario	Subsidized Enrollment	Unsubsidized Enrollment	Total Enrollment
2020 Estimate w/o Reinsurance	111,401	61,983	173,384
2020 Estimate w/ Reinsurance	111,401	81,568	192,969
Difference w/o Reinsurance	-	-24%	-10%
Actual 2020 Enrollment (as of end of open enrollment)	124,541	90,943	215,484

MARYLAND HEALTHBENEFIT EXCHANGE

A New Carrier Announced It's Entering the Market

- In May 2020, United Healthcare announced that it is rejoining the individual market and will be offering plans on Maryland Health Connection for plan year 2021.
- 2021 will be the first year with an increase in the number of individual market carriers since 2015.

Benefit Year	2014	2015	2016	2017	2018	2019	2020	2021
Participating carriers (#)	4	5	5	3	2	2	2	3*

* Pending approval of plan and rate filings by the Maryland Insurance Administration

MARYLAND HEALTHBENEFIT EXCHANGE

State Reinsurance Parameters, 2019-2021

SRP Parameters, 2019-2021

State regulations require the MHBE Board to:

- set estimated state reinsurance program parameters by April 1 of the calendar year proceeding the applicable plan year, and
- finalize parameters by December 31 of the calendar year proceeding the applicable plan year

Parameters	2019	2020	2021
Attachment Point:	$20,000	$20,000	$20,000
Coinsurance Rate:	80%	80%	80%
Cap:	$250,000	$250,000	$250,000
Dampening Factor	.8	.785	.760

Actual and Projected Costs and Funding, 2019-2023

Actual and Projected Cost, Funding, and Impact of the Reinsurance Program, 2019-2023

	2019 Act.	2020 Est.*	2021 Est.	2022 Est.	2023 Est.
Reinsurance Cost	$352,798,597	$377,828,828	$416,782,404	$447,975,589	$478,434,269
Federal Funding	$373,395,635	$447,277,359	$567,748,703	$628,614,048	$684,842,457
State Funding	$326,889,258	$118,517,416	$112,591,545	$118,896,671	$125,554,885
Reduction in Premiums (Reinsurance Funding)	-27.3%	-25.7%	-28.1%	-28.6%	-29.1%
Total Premium PMPM	$535	$494	$424	$443	$461
Total Enrollment	191,820	207,160	224,909	226,017	227,132

*2020 Federal Funding is actual funding, not an estimate.

SRP Spending and Funding Details, 2019

Description	Value	Notes
Federal funding spent on individual claims payment to issuers	$352,798,597.39	
CareFirst BlueChoice, Inc.	$206,560,535.36	
CareFirst of Maryland, Inc.	$34,650,600.84	
GHMSI	$26,023,597.56	
Kaiser Foundation Health Plan, Mid-Atlantic, Inc.	$85,563,863.63	
Federal funding spent on operation of the SRP	$347,218.75	$266,500 on EDGE Server and $80,718.75 on actuarial support services
Any unspent balance of Federal funding for the reporting year	$20,249,818.86	
Amount of State funding contribution to fully fund the SRP	$0	No state funding was necessary for plan year 2019, as federal funding was sufficient to cover the cost of the program

Carrier Accountability Reports

Carrier Accountability Reports

- State regulations at COMAR 14.35.17.03(C) require all carriers participating in the SRP to submit an annual report describing carrier activities to manage the costs and utilization of enrollees whose claims were reimbursed under the SRP
  - The report should also include efforts to contain costs so enrollees do not exceed the threshold
- This report will collect targeted information on diabetes, behavioral health, asthma, and pregnancy/childbirth, as well as information on the most common diagnoses among enrollees whose claims were reimbursed under the SRP
  - These conditions align with existing state population health goals and will provide more information on opportunities to improve health and reduce costs
- Reports on the first year of the SRP are due October 30, 2020.

Appendices

Appendix 1: 2020 Timeline

Timing	Action
July 20, 2020	MHBE Board finalizes 2021 SRP parameters and recommendation for dampening factor
September 2020	MIA approves 2021 rates
September 2020	Issuers receive SRP payments for 2019 claims experience
September 30, 2020	Report due to the legislature outlining program costs for 2019 and plans for provider assessment fee
October 30, 2020	2019 Carrier Accountability Reports due to MHBE
December 1, 2020	Report due to the legislature on potential implementation and effect of an individual market subsidy program, including potential effect on the SRP

Appendix 2: Summary Data, 2014-2020

Benefit Year	Participating carriers (#)	QHPs Offered (#)	Exchange Enrollment	Subsidized/ Unsubsidized (%)	Premium Change (%)	Rate Justification
2014	4	45	81,553	80/20	-	-
2015	5	53	131,974	70/30	10%	Sicker/Older Pool | MHIP Migration | Increased unit cost of care | Increased utilization | Health Insurer Fee
2016	5	53	162,652	70/30	18%	Actual claims experience higher than 2015 rates | Pent-up demand in formerly uninsured entrants | Risk Adjustment payments | Increased cost and utilization trends | Reduction in reinsurance payments
2017	3	23	157,637	78/22	21%	Increased unit cost of care, claims, morbidity of pool | Cessation of the reinsurance program
2018	2	21	153,571	79/21	50%*	New members entering risk pool | Current members terminating coverage | Increased churn and trend | Loss of CSR | Individual mandate enforcement not included in rate
2019	2	20	156,963	77/23	-13%	Introduction of the State Reinsurance Program | Medical inflation | Removal of the Individual Mandate
2020	2	23	158,934	76/24	-10%	Ongoing effectiveness of reinsurance program | Trend

Sources: MHBE Annual Reports, MHBE Plan Management, MIA Rate Decisions, Carrier Rate Justifications. Enrollment data as of the end of open enrollment preceding each benefit year
*This reflects increases to on-exchange silver plan premiums to adjust for the fact that the federal government stopped making cost-sharing reduction payments. Absent this adjustment, the average premium change would have been 28%. The additional increase is largely born by higher APTCs from the federal government rather than paid directly by consumers.

Funding States' Share of Reinsurance Programs

Presentation to the
Maryland Health Insurance Coverage Protection Commission

Department of Legislative Services
Office of Policy Analysis
Annapolis, Maryland

September 14, 2020

Cost Variation in State Reinsurance Programs

- To date, 14 states have approved reinsurance programs
- The annual cost of each program varies significantly (from $14.7 million in Rhode Island to $377.8 million in Maryland)
- Costs differ based on numerous factors, including:
  - Enrollment (17,700 in Alaska to 330,000 in Pennsylvania)
  - Attachment point ($20,000 in Maryland to $100,000 in North Dakota)
  - Cap ($77,000 in Pennsylvania to $1.0 million in North Dakota and Oregon)
  - Coinsurance rate (50% in Oregon, Rhode Island, and Wisconsin to 90% in Maine and Pennsylvania)
  - Available federal pass-through funding ($5.2 million in Rhode Island to $447.3 million in Maryland)

Summary of State Reinsurance Programs

State	Enrollment	Attachment Point	Cap	Coinsurance	2020 Cost	State Share	Federal Pass-through	2020 Premium Reduction
Alaska	17,700	Condition-specific reinsurance			$69.0 million	N/A	$69.0 million	37.1%
Colorado	166,900	$30,000	$400,000	Variable	$250.0 million	$80.5 million	$169.5 million	22.4%
Delaware	24,000	$65,000	$215,000	75%	$26.9 million	$5.2 million	$21.7 million	13.8%
Maine	62,000	$65,000	$95,000	90%	$81.8 million	$55.8 million	$26.0 million	7.2%
Maryland	***156,600***	***$20,000***	***$250,000***	***80%***	***$377.8 million***	***N/A***	***$447.3 million***	***35.8%***
Minnesota	110,000	$50,000	$250,000	80%	$169.0 million	$83.0 million	$86.0 million	21.3%
Montana	43,800	$40,000	$101,750	60%	$34.5 million	$12.0 million	$22.5 million	8.9%

Summary of State Reinsurance Programs (Cont.)

State	Enrollment	Attachment Point	Cap	Coinsurance	2020 Cost	State Share	Federal Pass-through	2020 Premium Reduction
New Hampshire	41,800	$60,000	$400,000	74%	$46.0 million*	$13.0 million*	$33.0 million*	N/A
New Jersey	247,500	$40,000	$215,000	60%	$320.0 million	$130.0 million	$190.0 million	16.9%
North Dakota	21,700	$100,000	$1.0 million	75%	$47.0 million	$25.5 million	$21.5 million	20.0%
Oregon	145,300	$90,000	$1.0 million	50%	$101.8 million	$47.4 million	$54.4 million	8.0%
Pennsylvania	330,000	$47,000	$77,000	90%	$139.3 million*	$44.2 million*	$95.1 million*	N/A
Rhode Island	34,600	$40,000	$97,000	50%	$14.7 million	$9.5 million	$5.2 million	3.8%
Wisconsin	195,500	$40,000	$175,000	50%	$200.0 million	$58.0 million	$142.0 million	11.0%

Note: New Hampshire and Pennsylvania will implement their reinsurance programs in 2021.

* Estimated 2021 figures

Funding State Reinsurance Programs

- All state reinsurance programs are designed to use a combination of federal pass-through funding and state funding
- State funding sources include:
  - Insurer assessments
  - State general fund appropriations
  - Former high-risk pool/special funds
  - State individual mandate penalties
  - Savings from switching to a state-based exchange
  - Other approaches such as a special assessment fee on hospitals, redirected insurance premium tax revenues, and premiums from policies ceded to the program

Insurer Assessments

- Nine states fund (or partially fund) their reinsurance programs through insurer assessments (Alaska, Colorado, Delaware, Maine, Maryland, Montana, New Hampshire, North Dakota, and Oregon)
- Assessments reflect either a percentage of premiums (1.0% to 2.75%) or a per member per month charge ($2.00 to $4.00)
- Assessments may be applied to some or all insurance markets with specified exceptions

Insurer Assessments (Cont.)

- **Alaska:** $55 million from an existing assessment on all insurers (including home and auto) redirected from the state's general fund to cover the state's share of the program for all five years
- **Colorado:** A portion of funding comes from a premium assessment (1.15% assessment on nonprofit carriers, 2.1% on for-profit carriers)
- **Delaware:** All state funding comes from a health insurer fee (2.75% in years where such a fee is not collected at the federal level or 1.0% in years where such a fee is collected at the federal level)

Insurer Assessments (Cont.)

- **Maine:** A portion of state costs come from an assessment of $4.00 per member per month (PMPM) for all health insurance markets (excluding state and federal employees); additional optional assessment of up to $2.00 PMPM to cover any net losses or deficit
- **Maryland:** State share funded with a 1.0% (formerly 2.75%) state health insurer assessment
- **Montana:** Predominately funded with a 1.2% annual assessment on major medical insurance premiums (excluding self-funded group plans)

Insurer Assessments (Cont.)

- **New Hampshire:** Program will be funded solely by an assessment tied to the state's prior year's benchmark plan (about $2.43 PMPM)

- **North Dakota:** Program funded solely by an unspecified assessment on premiums written in the group market; assessment is tax deductible, resulting in reduced state tax revenues

- **Oregon:** Predominately funded with a 1.5% assessment on fully-insured commercial major medical premiums

General Fund Appropriations

- Four states use state general fund appropriations to fund or partially fund their reinsurance programs
  - **Minnesota:** State share includes general fund contribution as needed
  - **New Jersey:** State share includes an annual general fund appropriation
  - **Rhode Island:** State share includes a general fund appropriation for the Health Insurance Market Integrity Fund
  - **Wisconsin:** Full state share comes from state "general purpose revenue" appropriated for the Wisconsin Healthcare Stability Plan through a "sum sufficient" appropriation"

High-risk Pool/Other Special Funds

- Two states fund a portion of their reinsurance programs with funds from former high-risk pools and other special funds
  - **Minnesota:** Along with general funds, state share comes from funding remaining from its former high-risk pool and funds from the State Healthcare Access Fund (which includes a 2% provider tax on hospitals and other providers)
  - **Oregon:** In addition to an insurer assessment, state used one-time-only transfers, including excess balance from the Oregon Health Insurance Exchange and the remaining balance of the Oregon Medical Insurance Pool Account

State Individual Mandate Penalties

- Two states fund a portion of their reinsurance programs with revenues from penalties from recently enacted state individual mandates
  - **New Jersey:** In addition to an annual general fund appropriation, state share comes from shared responsibility payments (estimated revenues of $90 million to $100 million annually)
  - **Rhode Island:** State share will be predominately funded by penalties from the state individual mandate, which took effect in 2020

Savings from Switching to State-based Exchange

- As of 2020, 32 states have a federally-facilitated exchange (FFE), 6 have a state-based exchange on the federal platform (SBE-FP), and 13 have a state-based exchange (SBE)
- SBE-FP states pay a user fee of 2.5% to 3% of premiums to use the federal platform (including information technology, call center, and eligibility/enrollment functions)
- Two SBE-FP states plan to leave the federal platform in 2020, which will generate net savings due to the lesser cost of running an SBE compared with federal user fees
  - **New Jersey:** Anticipates net savings of $35.4 million annually; funds not necessarily used for reinsurance but to provide additional state subsidies for individuals/families with incomes up to 400% of federal poverty guidelines beginning in 2021
  - **Pennsylvania:** State share will come from estimated net savings of $50.0 million annually

Other Funding Mechanisms

- Other less common funding mechanisms are used in a few states
  - **Colorado:** In addition to an insurer assessment, state funding includes a temporary special assessment fee on hospitals ($40 million) and redirected insurance premium tax revenues ($15 million in 2020, and the sole source of funding for the program beginning in fiscal 2024)
  - **Maine:** In addition to insurer assessments, state funding comes from reinsurance premiums paid by insurers (90% of enrollee premiums) for all policies ceded to the program (mandatory for certain high-risk individuals, otherwise discretionary)

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THE VOICE FOR HEALTH CARE CONSUMERS

Providing Health Insurance to Laid-Off Workers and Their Families: Options for Maryland

Stan Dorn, Director of National Center for Coverage Innovation at Families USA
Maryland Health Insurance Coverage Protection Commission
September 14, 2020

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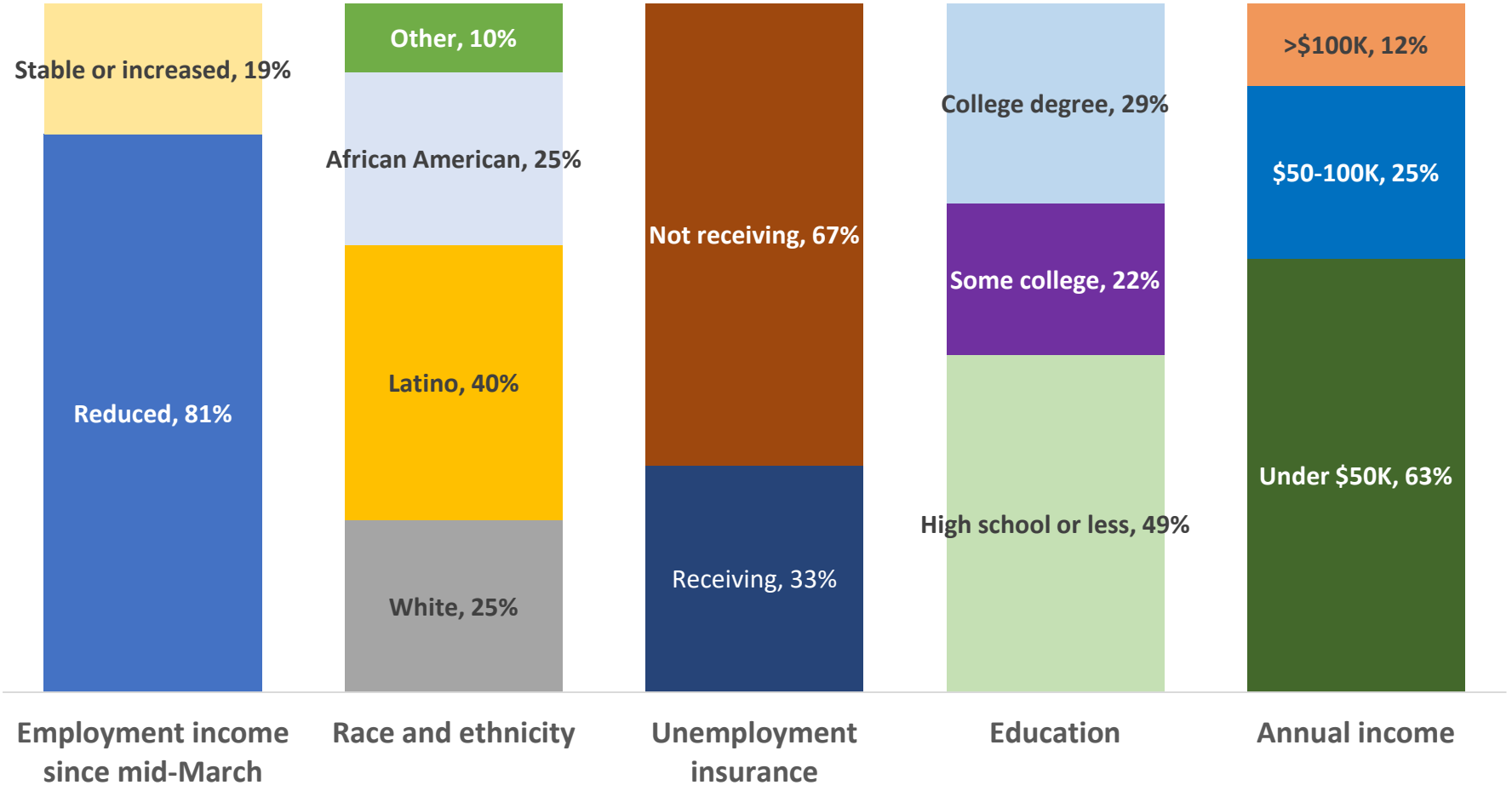
Approximate characteristics of uninsured adults in Maryland, July 2020



Source: National Center for Coverage Innovation at Families USA analysis of Household Pulse Survey (HPC) data for July 2 – July 21, 2020. *Note:* Total number of adults HPC estimated as uninsured was 290,000. Estimates are approximate because of small sample size.

Limited past success enrolling laid-off workers into health coverage

Health coverage tax credit (HCTC) (2002):

13-21% take-up

COBRA subsidies (2009):

No statistically significant coverage impact

ACA:

Less than 15% use of SEP for people losing employer coverage

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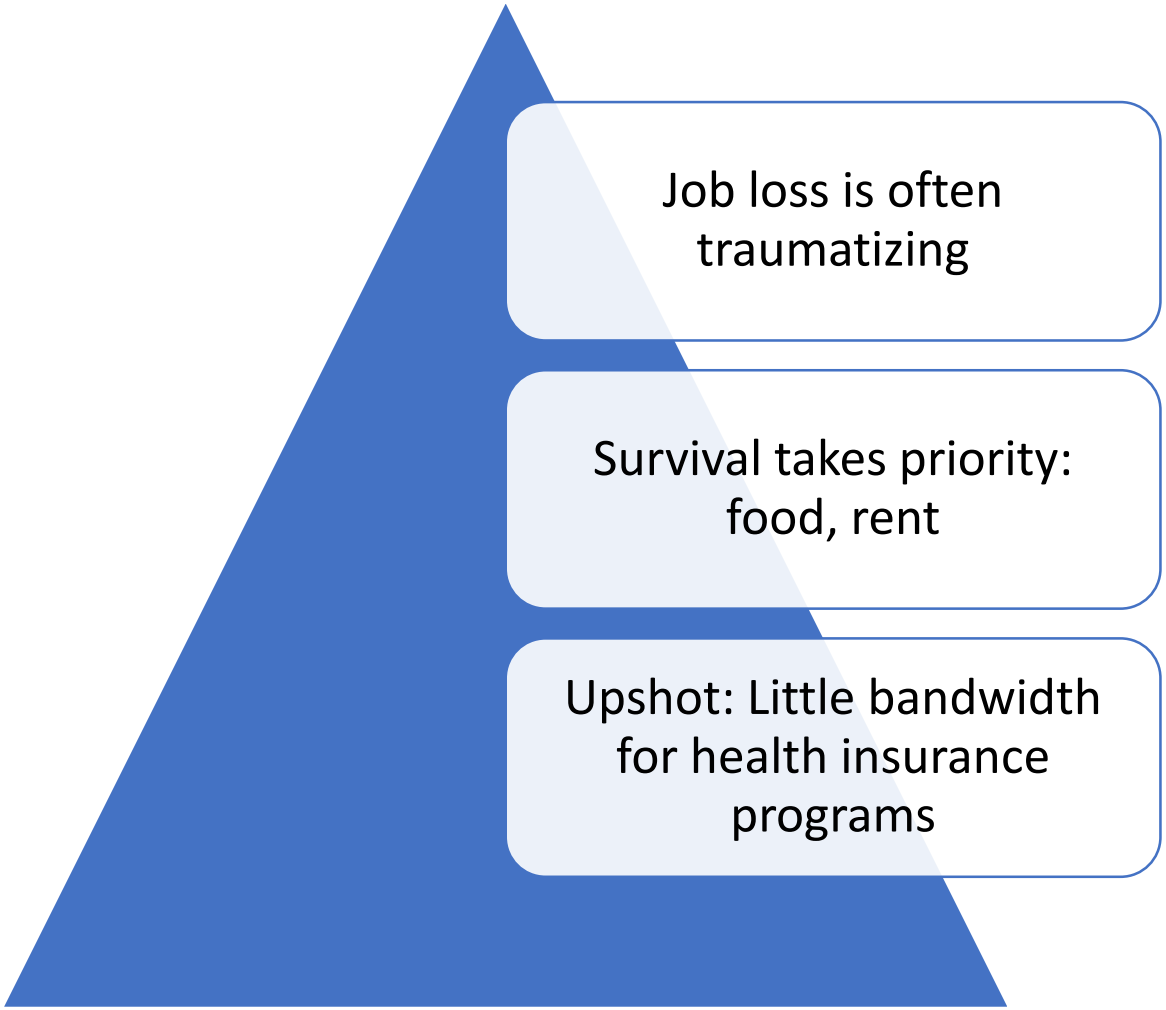
Why?


Job loss is often traumatizing
Survival takes priority: food, rent
Upshot: Little bandwidth for health insurance programs

Success requires proactive, one-on-one consumer assistance

HCTC, 2005

- Unions and state agencies completed paperwork, proactively solved problems
- More than doubled coverage rates

Kentucky, 2020

- UI agency gave Medicaid agency contact information
- Medicaid agency sent emails, invited to complete simple form
- When people opened email w/o completing form, agency called, filled out form on the phone
- >130,000 adults gained Medicaid from March to June, a larger increase than any other state

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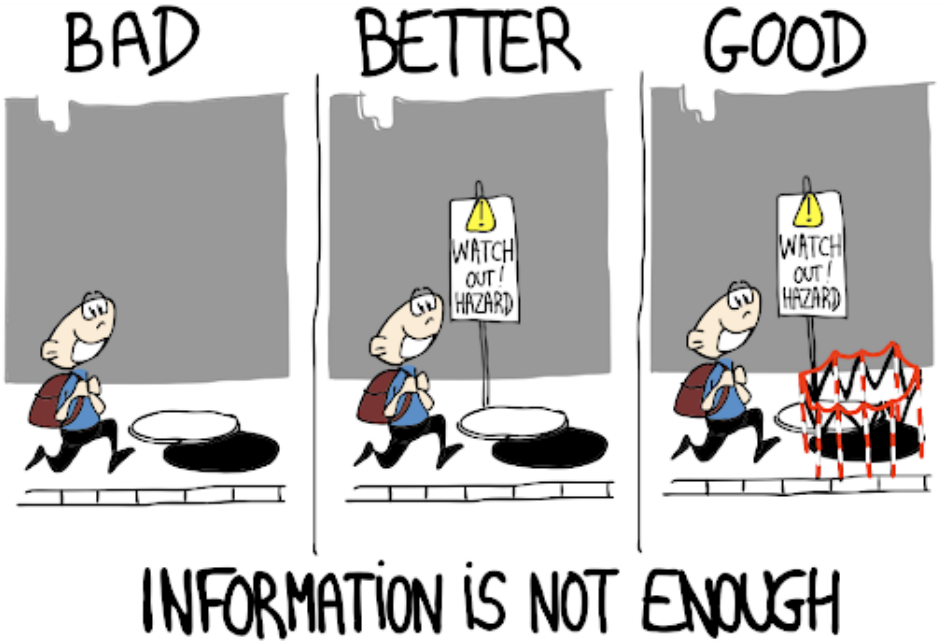
Options for Maryland

Basic approach	Advantages	Disadvantages	Variations
KY-style proactive individual contact	Effective. Can do quickly. Little effort from DOL.	Health administrative costs high.	Use federal COVID relief funds. Use brokers and agents. Claim federal Medicaid administrative match (50-75%).
EZ-enroll-style: Include check box, simple income attestation, in UI follow-up forms	Health administrative costs moderate. Potentially effective.	Some work from DOL. May take time to start.	Check box can request auto-enrollment, authorize exchange to obtain other relevant data.
Present health enrollment option while UI claimants are on hold	Potentially effective.	Some work from DOL. Health administrative costs > modest.	Use “on demand” call-back mechanism to reduce health administrative costs.
Provide information	Health administrative costs low. Can do quickly. Little DOL effort.	Potentially less effective.	Test different messages and communications vehicles. Invite UI claimant to provide contact information, followed by “on demand” call-back.

Conclusion



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MARYLAND CITIZENS' HEALTH INITIATIVE
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April 8, 2020

Honorable Lawrence J. Hogan Jr.
100 State Circle
Annapolis, Maryland
21401-1925

CC: Secretary of Health Robert R. Neall
Secretary of Labor Tiffany Robinson
Maryland Health Benefit Exchange Executive Director Michele Eberle
Honorable Members of the COVID-19 Response Legislative Workgroup

Re: Health Coverage for Unemployed to Limit Toll of COVID-19

Dear Governor Hogan,

Thank you for your leadership during these unprecedented and challenging times, which is doing so much to limit the toll COVID-19 is taking on our state. As one important part of this work, Maryland is leading the nation in safeguarding access to quality, affordable health coverage, which promotes rapid detection and treatment of disease by helping people immediately seek care when they first feel ill. Maryland was one of the first states in the country to offer a COVID-19 special enrollment period, which has already led to 10,000 uninsured residents obtaining health insurance. That most recent step builds on the landmark and bipartisan Maryland Easy Enrollment Health Insurance Program you signed into law last year, which lets Marylanders start enrolling in health care by simply checking a box on their state income tax return. Tens of thousands of families have already checked the box, beginning their journey to health coverage.

Since the Affordable Care Act took effect, Maryland cut its uninsured rate in half. Unfortunately, massive layoffs triggered by the COVID-19 pandemic threaten this progress, as thousands of Marylanders lose the health insurance formerly provided by their employers. During this public health crisis, it is especially important that the maximum possible number of Marylanders retain health coverage. In addition to facilitating rapid detection and treatment of COVID-19 by reducing financial barriers to health care, insurance helps patients receive care in appropriate primary care settings, without burdening already overcrowded emergency rooms.

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The Maryland Citizens' Health Initiative urges you to ensure that Marylanders who lose employer-sponsored insurance through no fault of their own can immediately enroll in quality, affordable health insurance. This is not an easy task. Historically, people who lose a job are a very challenging population to reach. Often, they are simultaneously dealing with the emotional effects of job loss, applying for Unemployment Insurance (UI) and perhaps the Supplemental Nutrition Assistance Program for the first time, and looking for new employment. This leaves little bandwidth to learn about complicated health care programs and enroll.

In the past, health programs have reached this population only when state agencies or private organizations provided intensive, one-on-one assistance to newly unemployed families, explaining their health care options, completing paperwork for them, and trouble-shooting problems. Maryland now has an opportunity, once again, to point the way for the rest of the country by implementing a similar a program as recession takes hold. **To address this challenge, we ask you to create a robust three-step response to help the recently unemployed receive health coverage**:

- First, building on your administration's early success with the Easy Enrollment Program, the Maryland Department of Labor should, as quickly as possible, incorporate a health-insurance check-box into applications for UI. As far as we know, this should not require a statutory change. The question should be mandatory for the applicant to answer and ask whether the applicant wants their contact information and social security number shared with the Maryland Health Connection to help them obtain free or low-cost health insurance. The Department of Labor would then share that information with the Maryland Health Benefit Exchange, which would follow up.

- Second, ensure that the Maryland Health Benefit Exchange has the resources it needs to follow up and provide intensive, individual assistance that helps laid-off workers and their family by proactively reaching out, filling out paperwork, and walking them through the process. To cover the cost of additional navigators, hotline staff, and technological investments needed to reach laid-off workers, Maryland should use some of its resources provided under the federal $150-billion Coronavirus Relief Fund created by the CARES Act. We understand the Exchange could not begin to do this immediately but we know that with adequate resources they would do a great job on this as soon as practicable.

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- Third, launch a robust communications campaign that starts now, and continues until the economy recovers, that tells the public that, if they or a family member or friend loses their job or their income drops, they should immediately visit the Maryland Health Connection website to see if they qualify for free or low-cost health insurance. The campaign could potentially be funded through the Coronavirus Relief Fund, supplementing investments already made by the Maryland Health Connection.

The recommendations come from the National Center for Coverage Innovation at Families USA, based on research that we would be glad to share. These three steps will prevent unprecedented numbers of Marylanders from losing health insurance at a time when they need it more than ever, for their safety and for all of us.

Thank you for your leadership. I look forward to working with you on this important issue. As you continue to respond to this crisis, please know that the Maryland Citizens' Health Initiative is eager to continue to share your administration's information and resources with the Maryland Health Care for All! Coalition, comprised of hundreds of organizations across the state, all working toward quality, affordable health care for all Marylanders.

Sincerely,

Vincent DeMarco, President
Maryland Citizens' Health Initiative

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FOR IMMEDIATE RELEASE
April 8, 2020

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Maryland Citizens' Health Initiative Statement About Proposal to Use Unemployment Insurance Sign-Ups to Increase Health Insurance Enrollment

Maryland Citizens' Health Initiative President Vincent DeMarco released the following statement today:

"Maryland Citizens' Health Initiative today delivered a letter to Governor Larry Hogan asking the state to take an innovative step to help people without health insurance sign up for affordable care. This could happen by asking Marylanders applying for state unemployment insurance to check a box on the application indicating they are interested in also enrolling in health insurance. Checking the box would start a process connecting the applicant with free or affordable health insurance options.

"Unfortunately, tens of thousands of Marylanders are losing their jobs during the coronavirus crisis, and many of them will lose health insurance coverage as well. The state should act to make it easy for them to learn about their health insurance options and begin the enrollment process.

"This idea would build on the strong success of the Maryland Easy Enrollment Health Insurance Program, which allows people without insurance to start the enrollment process by simply checking a box on their tax returns. As of this week, more than 37,000 tax filers had checked the box and more than 1,800 had enrolled in an insurance plan. We urge all Marylanders to consider this option when filling out their tax forms before the new deadline of July 15.

"We applaud Governor Hogan, Michele Eberle, the executive director of the Maryland Health Benefit Exchange, and her team for taking smart and effective steps that are helping Marylanders get health insurance during this public health and economic emergency. We also thank Stan Dorn at Families USA, for helping conceive the plan to promote enrollment through the unemployment insurance process."

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