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MARYLAND HEALTH BENEFIT EXCHANGE

November 1, 2021

The Honorable Guy Guzzone
Chairman
Senate Budget and Taxation Committee
Miller Senate Office Building, 3 West
11 Bladen Street
Annapolis, MD 21401

The Honorable Maggie McIntosh
Chairwoman
House Appropriations Committee
House Office Building, Room 121
6 Bladen Street
Annapolis, MD 21401

Re: Joint Chairmen's Report – Reinsurance Program Costs and Forecast

Dear Chairman Guzzone and Chairwoman McIntosh:

Pursuant to page 44 of the Joint Chairmen's Report for the 2021 Session, the Maryland Health Benefit Exchange (MHBE) submits this report on options for health coverage and cost sharing for individuals not eligible for existing programs, specifically for Marylanders who are uninsured or underinsured but are unable to enroll in Medicaid or Qualified Health Plans and are not eligible for the Advanced Premium Tax Credit.

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

Joint Chairmen's Report:

Report on Costs, Feasibility, and a Review of Activity in Other States to Serve Individuals Ineligible for Medicaid or Qualified Health Plans with Advanced Premium Tax Credits

Maryland Health Benefit Exchange

November 1, 2021

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I. Introduction

The 2021 Joint Chairmen's Report on the Fiscal 2022 State Operating Budget (HB 588) and the State Capital Budget (HB 590) and Related Recommendations[1] requests that the Maryland Health Benefit Exchange (MHBE) review options for increasing affordable coverage to improve health equity for individuals who are ineligible to enroll in Medicaid and qualified health plans (QHPs) and to make recommendations on options for health coverage and cost sharing. Specifically, the Committees requested that MHBE report on "costs, feasibility, and a review of activity in other states to serve this population."

Under federal rules, the largest population of non-incarcerated Maryland residents who are ineligible for Medicaid or QHP coverage are undocumented immigrants. Undocumented immigrants are foreign-born individuals residing in the United States without authorization, including those who entered the country without authorization and those who entered the country lawfully and stayed after their visa or status expired.[2] In 2018, there were an estimated 22 million noncitizens in the U.S.; 40 percent of non-citizens were undocumented immigrants.[3] Lawfully present immigrants are noncitizens who are lawfully residing in the U.S., and this group includes legal permanent residents, refugees, asylees, and other individuals who are authorized to live in the U.S. either temporarily or permanently. There are an estimated 244,700 undocumented immigrants residing in Maryland, approximately 115,900 of whom are estimated to be uninsured.[4]

In addition to undocumented individuals, individuals with a family member whose employer offers affordable self-only coverage (as determined by federal regulation) but not affordable family coverage are ineligible for exchange subsidies and may have difficulty affording health coverage. These individuals are referred to as falling within the "family glitch" in the Affordable Care Act. A study by the Kaiser Family Foundation (KFF) estimated that 5.1 million people fall into the family glitch, 9 percent of whom are uninsured. In Maryland, an estimated 83,000 people fall into the family glitch.[5] Applying KFF's estimated national rate of 9 percent uninsured in this population to the Maryland-specific estimate of 83,000 people impacted yields an estimated 7,470 uninsured individuals experiencing the family glitch in Maryland.

This report reviews relevant federal regulations, existing programs serving undocumented immigrants in Maryland, and options used or considered by other states to cover the undocumented and individuals falling within the family glitch, referred to collectively as "ineligible individuals" throughout this report.

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[1] "Report on the Fiscal Year 2022 State Operating Budget (HB 588) and the State Capital Budget (HB 590) and Related Recommendations (Joint Chairmen's Report)," Senate Budget and Taxation Committee and House Appropriations Committee, General Assembly of Maryland, April 30, 2021, https://mgaleg.maryland.gov/Pubs/BudgetFiscal/2021rs-budget-docs-jcr.pdf.

[2] "Health Coverage of Immigrants," *Kaiser Family Foundation,* July 15, 2021, https://www.kff.org/racial-equity-and-health-policy/fact-sheet/health-coverage-of-immigrants/#footnote-454226-4.

[3] Ibid.

[4] Source: MHBE analysis of American Community Survey data

[5] Cynthia Cox, Krutika Amin, Gary Claxton, Daniel McDermott, "The ACA Family Glitch and Affordability of Employer Coverage," *Kaiser Family Foundation,* April 7, 2021, https://www.kff.org/health-reform/issue-brief/the-aca-family-glitch-and-affordability-of-employer-coverage/.

II. Federal Regulations Affecting Coverage for Ineligible Individuals

A. Medicaid and QHP Eligibility – Citizenship Requirements

Generally, Medicaid eligibility is limited to U.S. citizens and lawfully present non-citizens.[6] Though lawfully present immigrants must have a "qualified"[7] status to be eligible for Medicaid, many legal permanent residents must wait five years after achieving qualified status before they are eligible to enroll. Some immigrants such as refugees and asylees, as well as lawfully present pregnant women and children under age 21, do not have to wait five years to be eligible for Medicaid.[8] Similarly, under federal regulations, only U.S. citizens or lawfully present non-citizens are eligible to enroll in a QHP and receive premium tax credits.[9] However, lawfully present immigrants with incomes below 100% of the federal poverty level (FPL) may receive subsidies if they are ineligible for Medicaid due to their immigration status. This includes lawfully present immigrants who are in the five-year waiting period or do not have "qualified status."

Individuals who are otherwise eligible for Medicaid except for their immigration status may be eligible for limited emergency services paid by Medicaid. Medicaid may pay for services to treat an emergency medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in: placing the individual's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.[10] Since 2002 states have had the option to provide prenatal care to women regardless of immigration status.[11] States also have the option to expand emergency Medicaid coverage through a Medicaid disaster relief state plan amendment to include COVID-19 testing and treatment during the state of public health emergency.[12] The duration and scope of COVID-19-related emergency Medicaid coverage varies depending on the state.

B. Public Charge Rule

In August 2019, the Trump Administration issued a final rule changing the "public charge" policies.[13] Under previous policy, the Department of Homeland Security (DHS) could deny entry to the U.S. or adjust the legal permanent resident status of someone considered to be a public charge. The 2019 rule expanded the definition of public charge to include health, nutrition, and housing programs in the public charge determinations, including Medicaid for non-pregnant adults. It also identified additional negative factors that will increase the likelihood of an individual becoming a public charge, including having an

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[6] 42 CFR § 435.406.

[7] Qualified non-citizens include lawful permanent residents, asylees, refugees, Cuban/Haitian entrants, individuals paroled into the U.S. for at least one year, battered non-citizens, victims of trafficking, individuals granted withholding of deportation, members of a federally recognized Indian tribe or American Indian born in Canada, and citizens of the Marshall Islands, Micronesia, and Palau who are living in the US.

[8] "Health Coverage of Immigrants" 2021; Social Security Act §1903(v)(4)

[9] 45 CFR § 155.305(a); 45 CFR § 1.36B-2(a)(4).

[10] 42 CFR § 440.255(b)(1);(c).

[11] 42 CFR § 440.255(b)(2).

[12] "Unauthorized Immigrants' Eligibility for COVID-19 Relief Benefits: In Brief," *Congressional Research Service,* May 7, 2020, https://crsreports.congress.gov/product/pdf/R/R46339.

[13] 84 Fed. Reg. 41,292, "Inadmissibility on Public Charge Grounds," August 14, 2019, https://www.federalregister.gov/documents/2019/08/14/2019-17142/inadmissibility-on-public-charge-grounds (to be codified at 8 CFR Parts 103, 212, 213, 214, 245 and 248).

income below 125 percent of the FPL. On April 12, 2021, however, DHS issued a letter to interagency partners to notify them that the 2019 public charge rule is no longer in effect, stating "DHS will not consider a person's receipt of Medicaid (except for Medicaid for long-term institutionalization), public housing, or SNAP benefits as part of the public charge inadmissibility determination. In addition, medical treatment or preventive services for COVID-19, including vaccinations, will not be considered for public charge purposes."[14] Subsequently, DHS published a final rule on March 15, 2021, withdrawing the public charge rule.[15] Research has shown that the 2019 public charge rule has impacted immigrants' decisions to apply for need based programs. A 2020 survey of immigrant families living in the US with children under 19 found that 28.8 percent of low-income immigrant families with children reported that they avoided one or more noncash public benefits or other help with basic needs because of concerns about legal permanent resident status or other immigration-related reasons.[16]

C. Family Glitch

Under the ACA, subsidies for health insurance purchased through the exchange are only available to individuals who cannot get coverage through a public program or their employer.[17] There is an exception for people whose employer-sponsored insurance is considered unaffordable or of insufficient value. People can qualify for exchange subsidies if their employer requires them to spend more than 9.83 percent of their household income on the company's health plan premium. Currently, this affordability test is based on the cost of the employee's self-only coverage, not the premium needed to cover dependents. Therefore, an employee and their family members may be ineligible for financial assistance through the exchange, even if the cost of adding dependents exceeds 9.83 percent of the family's income. This definition of "affordable" employer coverage is now known as the "family glitch." It is important to note that the Maryland Children's Health Program, which is available to uninsured children under age 19 with a household income at or below 322 percent of the federal poverty level, may mitigate the impact of the family glitch by offering affordable coverage to children of families in this situation.

In January 2021, President Biden issued an *Executive Order on Strengthening Medicaid and the Affordable Care Act,*[18] which references improving the affordability of coverage or financial assistance, including for dependents. Many experts believe that a fix to the family glitch may emerge from this order.

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[14] Tracy Renaud, "Public Charge Letter to Interagency Partners," *US Department of Homeland Security,* April 12, 2021, https://www.uscis.gov/sites/default/files/document/notices/SOPDD-Letter-to-USCIS-Interagency-Partners-on-Public-Charge.pdf.

[15] Inadmissibility on Public Charge Grounds; Implementation of Vacatur, 86 FR 14221, March 15, 2021. https://www.federalregister.gov/documents/2021/03/15/2021-05357/inadmissibility-on-public-charge-grounds-implementation-of-vacatur

[16] Jennifer M. Haley, Genevieve M. Kenney, Hamutal Bernstein, and Dulce Gonzalez, "Many Immigrant Families with Children Continued to Avoid Public Benefits in 2020, Despite Facing Hardships," *Urban Institute*, May 2021, https://www.urban.org/sites/default/files/publication/104279/many-immigrant-families-with-children-continued-avoiding-benefits-despite-hardships_0.pdf.

[17] Cox et al, 2021.

[18] "Executive Order on Strengthening Medicaid and the Affordable Care Act," *The White House,* January 28, 2021, https://www.whitehouse.gov/briefing-room/presidential-actions/2021/01/28/executive-order-on-strengthening-medicaid-and-the-affordable-care-act/.

III. Existing Resources in Maryland for Ineligible Individuals

Although they are ineligible for full Medicaid or QHP coverage, there are several resources for discounted healthcare services for ineligible individuals in Maryland.

A. Emergency Medicaid Coverage

The Maryland Medicaid program covers emergency medical services for undocumented immigrants who are otherwise technically and financially eligible for Medicaid, except for the citizenship requirement.[19] Coverage is limited to services that are "for the treatment of an emergency medical condition that, after a sudden onset, manifests itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention can reasonably be expected to result in:

(1) Placing the individual's health in serious jeopardy;

(2) Serious impairment to bodily functions; or

(3) Serious dysfunction of any bodily organ or part."

Coverage includes labor and delivery services, but does not include organ transplants or routine prenatal or postpartum care. Coverage extends from when the individual enters the hospital to receive the emergency medical services until the individual's emergency medical condition is stabilized. In calendar year (CY) 2020, this program served 14,675 individuals.[20]

B. EMTALA

The Emergency Medical Treatment and Active Labor Act (EMTALA) generally requires Medicare participating hospitals with emergency departments to provide an appropriate medical screening examination and stabilization care without regard for a patient's ability to pay.[21] The hospital may not inquire about a patient's ability to pay or immigration status until the patient is stabilized, meaning that no material deterioration of the emergency condition is likely to result from a discharge or transfer. Therefore, many hospitals are legally required to provide emergency care to undocumented immigrants. This obligation extends to individuals who seek care at the emergency department for suspected COVID-19.[22]

C. Hospital Financial Assistance Policies

Individuals with low income are eligible for financial assistance for medically necessary hospital services. Maryland law requires hospitals to provide free or reduced cost care as part of their financial assistance policies.[23] Hospitals are not allowed to use a patient's citizenship or immigration status as an eligibility requirement for financial assistance.[24]

- Maryland law and Maryland Health Services Cost Review Commission (HSCRC) regulations require hospitals to provide free, medically necessary care to individuals with family income at or below 200 percent of the FPL.[25]

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[19] COMAR 10.09.24.05-2.

[20] The Maryland Medicaid DataPort, The Hilltop Institute at UMBC, as of April 2021.

[21] 42 U.S.C. § 1395dd.

[22] Congressional Research Service 2020.

[23] MD. CODE. ANN., Health-Gen. § 19-214.1; COMAR 10.37.10.26.

[24] MD. CODE. ANN., Health-Gen. § 19-214.1(i)(1).

[25] MD. CODE. ANN., Health-Gen. § 19-214.1(b)(2)(i); COMAR 10.37.10.26(A-2)(2)(a)(i).

- Hospitals must provide reduced-cost, medically necessary care to patients with family income between 200 and 300 percent of the FPL.[26]
- Hospitals must provide reduced-cost, medically necessary care to patients with family income below 500 percent of the FPL who have a financial hardship, which is referred to as the financial hardship policy.[27] In order to qualify as having a financial hardship, the medical debt incurred by a family over a 12-month period must exceed 25 percent of the family's income.[28]

The thresholds described above represent a minimum, and some hospitals have more generous policies.

D. Federally Qualified Health Centers

Federally Qualified Health Centers (FQHC) are community-based health care providers that provide primary care services in underserved areas.[29] They receive funding from the Health Resource Health Center Administration (HRSA) Health Center Program and must meet a strict set of requirements including providing services regardless of patients' ability to pay and charging for services on a sliding fee scale. Generally, FQHCs focus on providing services to underserved and vulnerable populations and some FQHCs focus on special populations such as individuals and families experiencing homelessness, migratory and seasonal agricultural workers, and residents of public housing.[30]

IV. Review of Activity in Other States to Provide Coverage and Subsidies to Ineligible Individuals

A review of state initiatives to date revealed three options for providing health insurance coverage and/or subsidies to ineligible individuals: applying for a Section 1332 waiver to offer coverage through the exchange, using state-only Medicaid funds, and implementing a state public option/Medicaid buy-in program.

A. Section 1332 Waiver to Cover Undocumented Individuals through the Exchange

Section 1332 of the Affordable Care Act (ACA) grants states significant flexibility in experimenting with alternative methods of providing coverage. Under a section 1332 waiver, states are permitted to waive certain provisions of the ACA provided they demonstrate that the 1332 waiver arrangement would provide coverage that 1) is at least as comprehensive, 2) affordable, 3) covers at least a comparable number of individuals, and 4) has no adverse impact on the federal budget.[31] States must follow a formal public process in submitting their application for federal approval, and actuarial analysis is required to show how the plan meets the above guardrails.[32]

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[26] COMAR 10.37.10.26(A-2)(2)(a)(ii).

[27] COMAR 10.37.10.26(A-2)(3).

[28] COMAR 10.37.10.26(A-2)(1)(b)(i).

[29] "Federally Qualified Health Centers," *Health Resources & Services Administration,* May 2018, https://www.hrsa.gov/opa/eligibility-and-registration/health-centers/fqhc/index.html.

[30] "What is a Health Center?" *Bureau of Primary Health Care, Health Resources & Services Administration,* August 2021, https://bphc.hrsa.gov/about/what-is-a-health-center/index.html.

[31] "Tracking Section 1332 State Innovation Waivers," *Kaiser Family Foundation,* November 1, 2020, https://www.kff.org/health-reform/fact-sheet/tracking-section-1332-state-innovation-waivers/.

[32] "State Roles Using 1332 Health Waivers," *National Conference of State Legislators,* July 1, 2021, https://www.ncsl.org/research/health/state-roles-using-1332-health-waivers.aspx.

No states to date have an approved 1332 waiver to cover undocumented immigrants. Nearly all 1332 waivers in place are in relation to state reinsurance programs. California previously submitted a 1332 waiver application that would allow undocumented individuals to purchase coverage through the state exchange without subsidies, due to state funding constraints.[33] Technically, the coverage offered to undocumented individuals would have been a non-qualified health plan (QHP). However, the authorizing state law set forth that carriers offering QHPs in the exchange would also be required to offer non-QHPs to the waiver population that would be identical to QHP coverage in terms of benefits, provider networks, and cost sharing structure.[34] Covered California estimated low uptake of the waiver because of the lack of subsidies, but noted that allowing all members of mixed status families to apply for coverage in one place would streamline the enrollment process.[35] The 1332 waiver application was eventually withdrawn, and it should also be noted that purchasing coverage without the benefit of subsidies would be prohibitively expensive for many.

B. State-Only Medicaid Funds to Cover Targeted Populations

Several states have expanded their Medicaid/CHIP programs to cover narrowly targeted sub-populations of undocumented immigrants, using state-only funds. As noted above, federal Medicaid rules prohibit federal funding of undocumented immigrants.

Eight jurisdictions—California, Connecticut, D.C., Illinois, Massachusetts, New York, Oregon, and Washington—provide coverage (or soon will provide coverage[36]) to children who meet income eligibility requirements, regardless of immigration status.[37]

Table 1. Summary of State-Only Medicaid/CHIP-Like Programs Covering Undocumented Children

State	Income Limit and Premiums (if applicable)	Eligibility	Benefits	Notes
CA	Same income limit for all children – no more than 266% FPL Above 160% FPL, premium applies	Other than premium for >160% FPL, same for all children	Full-scope	

[33] "Health Coverage and Care for Undocumented Immigrants: An Update," *Public Policy Institute of California,* June 2021, https://www.ppic.org/publication/health-coverage-and-care-for-undocumented-immigrants/.

[34] "Section 1332 State Innovation Waiver Application," *Covered California,* September 30, 2016, https://hbex.coveredca.com/stakeholders/Covered%20California%201332%20Waiver/Covered%20California%201332%20Application_Finalcombined_093016.pdf.

[35] "Analysis and Report on California's of Section 1332 State Innovation Waiver Proposals," *Covered California*, April 7, 2016, https://www.hbex.ca.gov/stakeholders/Covered%20California%201332%20Waiver/1332_wavier_options_analysis_04-07-16_FINAL.pdf.

[36] Jenna Carlesso, "Proposal opening HUSKY to undocumented children in CT wins final approval," *CT Mirror,* June 9, 2021, https://ctmirror.org/2021/06/09/proposal-opening-husky-to-undocumented-children-in-connecticut-wins-final-approval/.

[37] Samantha Artiga and Maria Diaz, "Health Coverage and Care of Undocumented Immigrants," *Kaiser Family Foundation,* July 15, 2019, https://www.kff.org/racial-equity-and-health-policy/issue-brief/health-coverage-and-care-of-undocumented-immigrants/.

State	Income Limit and Premiums (if applicable)	Eligibility	Benefits	Notes
DC	Up to 200% FPL (different threshold than kids in traditional Medicaid)	Under the age of 21	Same covered services[38]	
IL	Same income limit for all children 4 tiers with associated premiums/cost sharing	Other than premiums/cost sharing, same for all children (18 or younger)	Full-scope	
MA	MassHealth Limited: Infants ≤200% FPL; Ages 1-20 ≤150% FPL[39] CMSP: premiums above 200% FPL	Undocumented only eligible for 1) MassHealth Limited, 2) Children's Medical Security Plan (CMSP),[40] or 3) Health Safety Net (only reimburses hospitals and community health centers).	MassHealth Limited: Covers emergency services only CMSP: Reduced benefits	
NY	No cost up to 160% FPL; Premiums up to 400% FPL; Above 400% eligible at full price[41]	18 or younger, no other coverage	Same covered services	Approximately 71,000 undocumented children enrolled
OR	Same for all children – up to 305% FPL[42]	Same for all children (18 or younger)	Full-scope	Estimated to cover 15,000 undocumented kids.[43]
WA	Same for all children – no cost up to 210% FPL, w/ premiums up to 312% FPL	Same for all children (18 or younger)	Full-scope[44]	

[38] "Immigrant Children's Program," *Washington D.C. Department of Health Care Finance,* https://dhcf.dc.gov/service/immigrant-childrens-program, accessed October 18, 2021.

[39] "Understanding Non-citizens' Eligibility for Health Coverage from MassHealth and the Health Connector," *Massachusetts Law Reform Institute*, May 2020, https://www.masslegalservices.org/system/files/library/Understanding%20eligibility%20of%20non-citizens%202020.pdf

[40] 130 Code Mass. Regs. 504.003, https://www.mass.gov/doc/130-cmr-504000-masshealth-citizenship-and-immigration-1/download, accessed October 18, 2021.

[41] "Child Health Plus Yearly Income Eligibility and Monthly Premiums," *NY State of Health,* April 2021, https://www1.nyc.gov/assets/ochia/downloads/pdf/child_health_plus.pdf.

[42] "OHP Covers Me!" *Oregon Health Authority,* https://www.oregon.gov/oha/HSD/OHP/Pages/OHPcoversme.aspx.

[43] https://www.oregon.gov/oha/HSD/OHP/Documents/SB%20558%20Frequently%20Asked%20Questions.pdf, accessed October 18, 2021.

[44] "Eligibility Overview: Washington Apple Health (Medicaid) Programs," *Washington State Health Care Authority,* April 2021, https://www.hca.wa.gov/assets/free-or-low-cost/22-315.pdf.

Three jurisdictions—California, Illinois, and Washington. D.C.—have programs covering adults. California has extended Medicaid coverage to young adults aged 19-25 who are undocumented.[45] Shortly after instituting the coverage, California estimated that approximately 105,000 undocumented young adults could be covered, with a general fund cost of $260 million – around $2,500 per person.[46]

Illinois has recently expanded Medicaid-like coverage to seniors (those at least 65 years old) who meet income eligibility requirements, regardless of immigration status.[47] Not all program beneficiaries will be undocumented, as certain legal immigrants are not eligible for Medicaid (e.g., legal permanent residents subject to the five-year bar). Services are provided with no premiums or co-pays. The program is expected to cover between 4,200 and 4,600 seniors initially, costing around $46 million to $50 million per year.[48]

DC Healthcare Alliance is a program available to adults aged 21 and older with 1) income below 200 percent FPL, 2) assets below $4,000 for an individual, and 3) no other source of coverage.[49] Notably, it does not cover mental/behavioral health services. Additionally, the program only covers services delivered at providers within an MCO's network. Individuals do not face co-payments; additionally, they do not face premiums.

C. Public Option

In recent years, states have explored various proposals to create health plans – "public options" - to offer consumers an affordable alternative to existing fully private plans offered in the individual market. The term "public option" has traditionally referred to publicly funded plans (that is, the state government would bear the financial risk of covering health costs) that may be government-administered or may rely on private entities to provide some administrative functions. In recent efforts, however, "public option" has been used to describe privately funded plans (that is, private health insurance bears the financial risk) established pursuant to a state law and subject to certain stricter requirements intended to improve value, reduce costs, and advance other state goals.[50] Public option proposals may leverage existing Medicaid infrastructure and are sometimes also referred to as

[45] "Young Adult Expansion," *Washington State Department of Health Care Services,* September 15, 2021, https://www.dhcs.ca.gov/services/medi-cal/eligibility/Pages/youngadultexp.aspx.

[46] "Full-Scope Expansion for Seniors Regardless of Immigration Status," *California Legislative Analyst's Office,* February 14, 2020, https://lao.ca.gov/Publications/Report/4161#Full.2011Scope_Expansion_for_Seniors_Regardless_of_Immigration_Status.

[47] "Illinois Health Benefits for Immigrants 65 Years or Older," *Illinois Department of Healthcare and Family Services,* December 1, 2020, https://www.illinois.gov/hfs/SiteCollectionDocuments/65+BrochureForPotentialApplicants12012020EnglishFinal.pdf.

[48] Giles Bruce, "Illinois is First int he Nation to Extend Health Coverage to Undocumented Seniors," *Kaiser Health News,* January 7, 2021, https://khn.org/news/article/illinois-is-first-in-the-nation-to-extend-health-coverage-to-undocumented-seniors/ ; "Coverage for Immigrant Seniors," *Illinois Department of Healthcare and Family Services,* https://www.illinois.gov/hfs/Pages/CoverageForImmigrantSeniors.aspx, accessed October 18, 2021.

[49] "DC Healthcare Alliance and Cover All DC," *DC Health Link,* https://dchealthlink.com/node/2478, accessed October 18, 2021.

[50] Christine Monahan, "State Public Option-Style Laws: What Policymakers Need to Know," *The Commonwealth Fund,* July 23, 2021, https://www.commonwealthfund.org/blog/2021/state-public-option-style-laws-what-policymakers-need-know.

"Medicaid buy-in" programs. In this report, the more broadly applicable term "public option" will be used.

A state public option has the potential to offer coverage that is lower in cost than existing individual market coverage and may allow flexibility in offering coverage to ineligible individuals. However, if a public option relies on an exchange to offer coverage, a 1332 waiver may be necessary to deal with the federal prohibition on enrolling undocumented individuals through an exchange. Potential sources of cost savings in a public option include administrative efficiencies, state rate setting to reduce provider payments compared to commercial rates, increased competition, improvement to the individual market risk pool, or capture and reinvestment of federal savings through a 1332 waiver. However, early experience in other states has demonstrated the challenges of achieving significant savings through public options. Hospital rate setting is one of the significant sources of savings targeted in state public options to date, but this is less relevant in Maryland given the state's existing hospital rate setting and global budget framework. Even with potential savings from a public option, coverage is likely to be unaffordable for lower-income ineligible individuals absent a state subsidy to improve affordability.

Three states, Washington, Colorado, and Nevada, are in the early stages of implementing public options, all of which generally fall into the category of private plans subject to additional state requirements. Washington has not made its public option available to ineligible individuals but is exploring expanding eligibility and providing a state subsidy to them effective 2024. Colorado is implementing a public option separately from, but concurrently with, an initiative to offer QHPs and state subsidies to ineligible individuals. Nevada's public option would be available to undocumented individuals enrolling off-exchange but not on-exchange and would be available to individuals in the family glitch both on and off exchange. A fourth state, New Mexico, has not established a public option but has established a recent state subsidy program and is studying expanding the program to ineligible individuals. Additional details on each state's initiatives are provided in the following sections.

Washington State

Washington state became the first state to enact a public option, "Cascade Care" with the passage of SB 5526 in May 2019.[51] The law requires the state to contract with private insurers to offer bronze, silver, and gold plans on the state's exchange, but does not require private insurers or providers to participate in Cascade Care. The private insurers bear the financial risk and are responsible for marketing the plans. The law attempts to control costs by requiring the state-procured plans to cap payment for health care services at 160 percent of Medicare rates. The Cascade Care plans are also required to meet additional quality and value requirements.

Cascade Care launched in 2021 with modest impact. The state-procured plans are available in 19 of Washington's 39 counties, enrolled less than 2,000 people, and had average premiums about 4 percent

[51] "Bill Information: SB 5526 - 2019-2020," *Washington State Legislature,* https://app.leg.wa.gov/billsummary?BillNumber=5526&Chamber=Senate&Year=2019, accessed October 18, 2021.

higher compared to 2020 averages, compared to an average market wide 2021 rate change of a 2.4 percent decrease.[52,53]

Washington enacted additional legislation, SB 5377, in 2021 to address perceived shortfalls of the program.[54] Starting in 2022, state-licensed hospitals that receive payments from the state public employee benefits plan or Medicaid contract and are in a county without a public option plan must accept an offer to contract with at least one public option plan. SB 5377 also established a state premium subsidy beginning in 2023 for individuals up to 250 percent of the FPL, subject to state appropriations, with an initial $50 million appropriation in the state's biennial budget.[55] The budget further directs the state exchange to "explore opportunities to facilitate enrollment of Washington residents who do not qualify for emergency Medicaid or federal affordability programs in a state-funded program no later than plan year 2024."[56] This population would include undocumented individuals and those subject to the family glitch. The budget also authorizes the exchange to apply for a 1332 waiver as necessary to support the program.

Colorado

In 2020 Colorado passed SB 215 which established a health insurance affordability enterprise to make insurance coverage more affordable through a reinsurance program, support for the premium tax credit eligible population, and qualified individual subsidy payments.[57] This program is funded through fees on certain health insurers and a special hospital assessment. Qualified individual subsidy payments will be available starting in 2023 to Colorado residents who have a household income below 300 percent of the FPL and are not eligible for the premium tax credit, Medicaid, Medicare, or CHIP, regardless of immigration status. Qualified individuals may purchase a subsidized individual health plan through the Colorado exchange. Colorado is currently in the process of designing this program.

As of summer 2021, Colorado is still working through the details of subsidy design. They have established a partner organization in the form of a public benefit corporation to administer the program and determine eligibility. Between the undocumented and "family glitch" populations, they anticipate a potentially eligible population of about 100,000 individuals.[58] Due to limited funding (estimated at approximately $120 million over three years), the public benefit corporation authorized modeling to

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[52] Rachel Schwab, "A Fixer Upper: Washington State Enacts Legislation to Boost its Public Option," *Georgetown University Center on Health Insurance Reforms,* June 24, 2021, http://chirblog.org/fixer-upper-washington-state-enacts-legislation-boost-public-option/.

[53] "Special Exchange Board Meeting: 2021 Plan Certification," *Washington Health Benefit Exchange,* September 24, 2020, https://www.hca.wa.gov/assets/program/cascade-care-2021-plan-certification-presentation.pdf.

[54] "Bill Information: SB 5377 - 2021-22," *Washington State Legislature,* https://app.leg.wa.gov/billsummary?BillNumber=5377&Year=2021&Initiative=false, accessed October 18, 2021.

[55] "Certification of Enrollment: Engrossed Substitute Senate Bill 5092," *State of Washington,* May 19, 2021, http://lawfilesext.leg.wa.gov/biennium/2021-22/Pdf/Bills/Session%20Laws/Senate/5092-S.SL.pdf?q=20210615200214.

[56] Ibid.

[57] 2020 Colo. Sess. Laws Ch. 201.

[58] "Health Insurance Affordability Board Presentation," *Colorado Health Insurance Affordability Enterprise,* April 23, 2021, https://drive.google.com/file/d/1HkfkwDXDrCc_d9X_P3LK6on8PpYkE7PW/view?usp=sharing.

consider limiting the subsidy to individuals below 150 or 200 percent of the FPL.[59,60] The state does not anticipate issues with attracting carriers, as the conventional wisdom is that the targeted population is relatively healthy. Finally, while they do not require a 1332 waiver to establish the program, they would need one to re-invest any resulting federal savings back into the underlying state fund.

In 2021, Colorado passed legislation to establish a public option beginning in 2023, under which carriers in the individual and small group market are required to offer standardized bronze, silver, and gold public option plans on and off-exchange.[61] Insurers must reduce public option premiums by 15 percent over 5 years, compared to average premiums prior to the implementation of the public option. If they are unable to do so, the Insurance Commissioner may set hospital and provider reimbursement rates, subject to certain limits, in order to achieve the targeted premium reductions.

Nevada

Nevada's legislature passed a Medicaid buy-in plan in 2017, but it was subsequently vetoed by the governor.[62] In April 2021, another bill was introduced (SB 420) to require the state Medicaid agency, Exchange, and Insurance Department to work together to establish a public option health benefit plan effective 2026. This bill passed in the legislature and was approved by the Governor on June 9, 2021. SB 420 requires each Medicaid managed care organization to submit a bid to offer a silver and gold-level public option QHP on the individual market that would be sold on and off the state's health insurance exchange, and authorizes state officials to select the winning bid(s) through a competitive process. Public option premiums are required to be at least 5 percent lower than a benchmark premium in the individual market, and annual premium cost growth for public option plans is limited. To keep prices down, public option plans' aggregate provider reimbursements must be equivalent to or less than Medicare rates. To assure provider participation, the bill requires every provider that participates in Medicaid, the state employee health plan, or provides care to injured workers who receive workers compensation to participate in at least one provider network established in the public option, although the legislation grants state officials discretion to waive this requirement. As previously mentioned, the public would be available to undocumented individuals enrolling off-exchange but not on-exchange and would be available to individuals in the family glitch both on and off exchange. However, without an accompanying state subsidy, coverage is likely to be difficult to afford for many individuals ineligible for federal subsidies.

New Mexico

Similarly, a bill was introduced in New Mexico in 2019 (HB 416) that would create a Medicaid buy-in program to provide a low-cost, high-quality health insurance option to residents who are not eligible for Medicaid, Medicare, or premium tax credits. The bill stated that the Medicaid buy-in plan would be available to residents irrespective of immigration status. This program would establish an affordability

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[59] "Health Insurance Affordability Board Presentation," *Colorado Health Insurance Affordability Enterprise,* June 18, 2021, https://drive.google.com/file/d/1qrhBNyPVtrg-R8rR09vIgv4H9ngrp4io/view?usp=sharing.

[60] "Colorado Health Insurance Affordability Board Draft Meeting Minutes," *Colorado Health Insurance Affordability Enterprise,* https://drive.google.com/file/d/1_VjDMUH-PXjticR5vpwAgU_QROfNm48u/view?usp=sharing.

[61] "HB21-1232: Standardized Health Benefit Plan Colorado Option," *Colorado General Assembly,* https://leg.colorado.gov/bills/hb21-1232, accessed October 18, 2021.

[62] Megan Messerly, "Four years after passing Medicaid buy-in, lawmakers to consider new public option proposal," *The Nevada Independent,* April 27, 2021, https://thenevadaindependent.com/article/four-years-after-passing-medicaid-buy-in-lawmakers-to-consider-public-option-proposal.

scale for premiums and other cost-sharing fees and at a minimum provide financial assistance to residents with incomes below 200 percent of the FPL with the option of expanding financial assistance to include residents with incomes above 400 percent of the FPL. The plans offered by the Medicaid buy-in program would need to cover the essential health benefits required by the ACA. This bill was not passed. A study by Manatt found that this program could enroll up to 16,000 people, and premiums would be 15 to 28 percent lower than plans sold on the individual market.[63]

In 2021, New Mexico passed a bill (SB317) that would use a health insurance premium surtax to establish a Health Care Affordability Fund to reduce premiums and cost sharing for residents who purchase insurance through the exchange and fund initiatives for uninsured residents. It was estimated that the insurance surtax will bring in $115 million in revenue and this program could expand coverage to 23,000 uninsured residents.[64] The bill tasks the Insurance Superintendent with submitting a plan to the legislature by June 30, 2022 to extend coverage beginning July 1, 2023 to ineligible individuals, and specifies that the plan should be designed to achieve premiums and out-of-pocket costs that are as close as possible as those available to individuals eligible for federal subsidies.

IV. Evaluation of Coverage Options in Maryland

The following section provides high-level implementation considerations for three options to offer coverage to ineligible individuals: through the exchange in conjunction with a state subsidy program; specifically for undocumented individuals, through a state-only Medicaid program; and through a public option. These options are not mutually exclusive. For example, certain target populations could be offered coverage through a state-only Medicaid program, while the remainder of the ineligible population could be offered coverage through the Exchange with a state subsidy. In addition to implementation considerations, more detailed information, including a potential implementation timeline, and estimated cost, enrollment, and impact on the uninsured population is provided for the option of covering ineligible individuals through the exchange in conjunction with a state subsidy program.

A. Coverage through the Exchange Using a Section 1332 Waiver with a State Subsidy Program

Under this scenario, MHBE would pursue a two-part strategy to provide affordable coverage to ineligible individuals. To permit undocumented individuals to enroll directly into a QHP through Maryland Health Connection, MHBE would develop a 1332 waiver to waive the federal requirement that access to QHPs is limited to lawful residents.[65] In addition, MHBE would develop and implement a state subsidy program for ineligible individuals that would provide state-funded premium and cost-sharing assistance on par with that provided to individuals who are eligible for federal subsidies. This approach would leverage the existing Exchange regulatory framework and plan offerings to provide a single streamlined enrollment experience for all individuals to obtain coverage and access federal and/or state subsidies.

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[63] Chiquita Brooks-LaSure, April Grady, Ashley Traube, and Patricia Boozang, "Quantitative Evaluation of a Targeted Medicaid Buy-In for New Mexico," *Manatt Health,* January 2019, https://www.manatt.com/Manatt/media/Documents/Articles/Final-New-Mexico-Buy-In-Phase-2-Paper-1-25.pdf.

[64] "Legislative Session Closes: House Democrats Achieve Landmark Policy Goals in Unprecedented Session," *Los Alamos Reporter,* March 20, 2021, https://losalamosreporter.com/2021/03/20/legislative-session-closes-house-democrats-achieve-landmark-policy-goals-in-unprecedented-session/.

[65] The waived provision would be 42 U.S. Code § 18032(f)(3).

1. Implementation Considerations

Section 1332 Waiver

As previously mentioned, a section 1332 waiver would allow undocumented individuals to enroll in QHPs through the Exchange and enable the state to recoup any federal savings resulting from this initiative to invest in supporting the program. To apply for a 1332 waiver, MHBE would need legislative authorization and the application would be subject to review and approval by the federal government and would have to be renewed every five years. As previously noted, no other state has received a similar 1332 waiver, so there is uncertainty as to whether such a waiver application would be approved. MHBE has had preliminary conversations with the federal government regarding the details of a potential 1332 waiver for this scenario.

State Subsidy Program

It would have to be determined whether state premium assistance would be offered as a state tax credit, similar to APTC, that would require reconciliation at the end of the year, or whether it would be offered as a simple subsidy that did not require reconciliation, similar to existing state premium subsidy programs in states such as Massachusetts, Vermont, and New Jersey, and the young adult subsidy pilot program in Maryland. A tax credit structure would involve additional administrative complexity and likely take additional time to implement. For the purposes of this analysis, a subsidy that does not require reconciliation was assumed.

Additionally, it would have to be determined whether cost sharing subsidies would be administered through an estimated advance payment and reconciliation process with insurers, similar to how the federal government administered cost sharing subsidies prior to 2018, or by allowing insurers to price the added cost of providing cost sharing subsidies into silver plans, as has been the practice since 2018. The latter option would be significantly simpler to administer.

Lastly, it is worthwhile to note that Medicaid currently covers emergency costs for undocumented individuals, for which the state receives some federal funding. This analysis assumes that claims for undocumented individuals enrolled through the Exchange would be fully covered through their Exchange plan. However, the state may want to investigate whether it would be possible, and if so, a better use of state resources, for these individuals to continue to receive coverage of emergency services through Medicaid while being otherwise enrolled in coverage through the Exchange.

2. Potential Implementation Timeline

CMS requires states undergo a comprehensive development and submission 1332 waiver process that includes actuarial analysis and stakeholder engagement/notice and public comment periods. Under the federally prescribed timeline, a state must first post a draft waiver for a minimum 30-day public comment period. Upon receipt of a waiver, the federal government must determine whether the application is complete within 45 days. Following the completeness determination, the federal government must issue a final decision within 180 days. Assuming the federal government determines the initially submitted application complete, and takes the maximum amount of time for review, final approval or denial could take as long as 7.5 months from the date of submission.

Given the time required to prepare and receive approval of a 1332 waiver as well as implementation complexity, MHBE would recommend targeting implementation no sooner than approximately 18 months after enactment of legislation directing MHBE to implement such a program.

3. Estimated Enrollment, Cost, and Impact on the Uninsured Rate

General Assumptions

We assumed implementation of a state subsidy for all ineligible individuals that mirrors the subsidies and cost-sharing provided by the federal government to current exchange enrollees. However, a state subsidy could be more or less generous, or targeted to a narrower set of individuals such as those within a certain income bracket or age range. The analysis below breaks out the estimated cost to cover several potential subpopulations.

The American Rescue Plan Act enhanced federal premium subsidies for 2021 and 2022. According to news reports, Congressional leadership is planning to propose an extension of the enhanced subsidies past 2022, but under current law they will expire at the end of 2022. Consequently, cost estimates are provided for both a scenario in which the state subsidy program is designed to mimic the enhanced subsidies, as well as a scenario in which it is designed to mimic the pre-2021 federal subsidies.

For the family glitch population, we assumed that the enrollee with the offer of affordable employer coverage would not be eligible for the state subsidy; only the household members would be eligible. We further assumed that if any household member is eligible for Medicaid or MCHP, they are not eligible for the state subsidy.

We also assumed that ineligible enrollees, like current exchange enrollees, would be ineligible for a subsidy if they have an offer of affordable employer coverage, using the federal definition for that term.

Enrollment Assumptions

Our analysis assumed a 30 percent participation rate among undocumented immigrants. This assumption is based on participation in other states' programs to offer low-cost healthcare services to undocumented immigrants and under-resourced individuals.

Program uptake among the family glitch population is more complex: the rate of eligible individuals switching from employer-sponsored insurance (ESI) to a subsidized marketplace plan likely depends on how much they might save, based on their income. We expect that 95 percent of individuals with incomes below 200 percent of the FPL, one third of those between 200-250 percent of the FPL, and five percent of those with incomes between 250-400 percent of the FPL would switch health plans due to the program. Of those already enrolled in unsubsidized marketplace plans, we expect that 100 percent would accept any offered subsidies.

We also assume that it will take about three years to reach full enrollment: 60 percent of enrollment would be achieved in year one, 90 percent in year two, and 100 percent in year three.

Estimated Cost

Similar to federal standards, the modeling assumes state premium subsidy eligibility for individuals up to 400 percent of the FPL and state cost-sharing subsidy eligibility for those up to 250 percent of the FPL.

These scenarios use pre-American Rescue Plan Act (ARPA) income limits in accordance with current law, under which the ARPA enhanced subsidies expire at the end of 2022.

Projections which assume that ARPA subsidies will be extended can be found on pages 15-17 of the Appendix, along with the detailed projections which support the information presented below.[66]

Three scenarios were modeled in order to provide a range of estimated costs and impacts. Under the first scenario, the full population of individuals meeting the income thresholds would be eligible for the state subsidy. In the second scenario, only children and young adults meeting the income thresholds and who are also age 0-34 would be eligible for the state subsidy. In the third scenario, income eligibility is reduced to those up to 200 percent of the FPL. The cost of these scenarios is further described below and in Table 2.

Full Population. In a scenario that mimics traditional APTC eligibility for the full population of ineligible individuals, the approximate net cost to the state would be $90,249,068 in the first year (2024). This net cost factors in $14,812,663 in pass-through savings from the federal government, subtracted from a gross cost of $105,061,731. In years two (2025) through five (2028) of a hypothetical waiver, the annual net cost to the state would be about $145.0, $165.4, $176.1, and $189.5 million, respectively. Average annual cost per enrollee is estimated at $3,600 in 2024, increasing approximately 3-5 percent each year thereafter.

Eligibility Limited to Young Adults and Children. A scenario limiting eligibility to those 34 years old and younger would cost the state $23,885,007 in year one; federal pass-through in year one is projected to be $15,393,297 and is subtracted from a gross cost of $39,278,304 to reach the net figure. Costs and pass-through would increase annually for net costs of $39.4, $46.3, $49.1, and $53.4 million in years two through five, respectively. Average annual cost per enrollee is estimated at $1,700 in 2024, increasing approximately 3-5 percent each year thereafter.

Eligibility Limited to <200% FPL. With eligibility limited to those with incomes under 200 percent of the federal poverty line, the state's net cost would be $72,886,667 in year one after factoring in a federal pass-through amount of $11,695,007. Annual net costs to the state would be approximately $115.9, $129.4, $138.1, $147.3 million in years two through five of the program, respectively. Average annual cost per enrollee is estimated at $4,200 in 2024, increasing approximately 3-5 percent each year thereafter.

[66] If ARPA subsidies are extended, our estimates differ from what is presented below. In the full population and young adult eligibility scenarios, enrollment would be higher, and the market would see a bigger reduction in premiums, though the cost to the state as well as federal pass-through amounts would be higher. If eligibility were limited to those with incomes below 200 percent FPL, the same would be true except that premium impacts would not change.

Table 2: Cost and Impact by Eligibility Scenario of Potential State Subsidy Program for Ineligible Individuals

Eligibility Scenario	Year				
Full population	**2024**	**2025**	**2026**	**2027**	**2028**
Enrollment	29,413	45,077	50,342	51,380	52,541
Gross cost	$105,061,731	$167,460,606	$192,601,978	$206,682,398	$222,253,490
Fed. pass-through	$14,812,663	$22,473,808	$27,188,740	$30,508,782	$32,731,635
Net cost to state	**$90,249,068**	**$144,986,797**	**$165,413,238**	**$176,173,616**	**$189,521,964**
Premium impact	-2.3%	-3.3%	-3.8%	-3.8%	-3.9%
Limited: young adults	**2024**	**2025**	**2026**	**2027**	**2028**
Enrollment	14,222	21,797	24,722	24,651	24,756
Gross cost	$39,278,304	$63,364,323	$75,724,575	$80,103,364	$86,161,230
Fed. pass-through	$15,393,297	$23,964,856	$29,429,203	$31,005,914	$32,809,905
Net cost to state	**$23,885,007**	**$39,399,467**	**$46,295,372**	**$49,097,450**	**$53,351,325**
Premium impact	-2.3%	-3.4%	-3.9%	-4.0%	-4.0%
Limited: <200% FPL	**2024**	**2025**	**2026**	**2027**	**2028**
Enrollment	20,050	30,640	33,910	34,572	35,250
Gross cost	$84,581,674	$134,033,759	$152,080,969	$162,384,112	$173,274,570
Fed. pass-through	$11,695,007	$18,168,344	$22,655,119	$24,256,221	$25,992,875
Net cost to state	**$72,886,667**	**$115,865,415**	**$129,425,850**	**$138,127,890**	**$147,281,694**
Premium impact	-1.7%	-2.6%	-3.0%	-3.1%	-3.1%

The projected costs do not include MHBE's administrative costs or staffing to launch and run the described coverage program. These would be estimated if legislation to establish such a program were proposed. However, the great majority of state costs are expected to come from the state subsidy; as such, MHBE determined that state subsidy costs were the most important projected cost information to provide for consideration.

Impact on Individual Market

The full population eligibility scenario is projected to result in the enrollment of approximately 29,000 - 52,000 individuals in each year of the waiver and is projected to reduce overall individual market premiums by 3.9 percent by 2028, because of the morbidity impact of adding new, generally healthy entrants to the risk pool.

The limited eligibility scenario for children and young adults under 35 is projected to result in the enrollment of about 14,000 - 25,000 individuals in each year of the waiver period and to reduce overall individual market premiums by 4 percent by 2028.

With eligibility capped at 200 percent of the federal poverty line, the program is projected to result in the enrollment of about 20,000 - 35,000 individuals each year and to reduce overall individual market premiums by 3.1 percent by 2028.

Impact on Uninsured Rate

We estimate that the full population eligibility scenario would result in a 0.6 percentage point reduction in the uninsured rate, to 5.4 percent from the current rate of 6.0 percent.

B. Coverage through a State-Only Medicaid Program

As previously discussed, legally present individuals in the family glitch are already eligible for coverage through Medicaid if they otherwise meet eligibility requirements such as income limits. Undocumented individuals are only eligible for emergency services through Medicaid, if they are otherwise technically and financially eligible for Medicaid, except for the citizenship requirement. Federal funds may not be used to provide non-emergency coverage to undocumented individuals, so any expansion of coverage to this population would have to be funded with state-only dollars. MHBE engaged in high-level conversations with the Maryland Department of Health to identify key issues that would need to be considered related to any such an expansion of coverage, summarized in Table 3. Decisions in each of these areas would guide implementation estimates related to cost and timeline.

Table 3. Key Considerations Related to Providing Coverage through a State-Only Medicaid Program

Target population	The state would need to identify which populations would be eligible for coverage. Coverage could be targeted to specific populations, such as children, young adults, or older adults, at current income thresholds applied to the general population, or at lower income thresholds - both routes have been used by states described in section IV.B. Alternatively, coverage could be made available to all individuals regardless of citizenship status who meet existing income guidelines, or at an income threshold lower than that applied to the general population. A larger target population would likely drive a higher state cost.
Coverage mechanism	The state would have to determine whether to provide coverage through Medicaid Managed Care Organizations (MCOs) or through the Fee-for-Service (FFS) program. Most Medicaid enrollees are enrolled in MCOs; however, specialized programs such as the current Emergency Medical Assistance program are typically delivered through FFS.
Benefits	The state would need to decide whether to offer this population the full Medicaid benefit package available to currently eligible individuals (full Medicaid physical and behavioral health and long term care benefits) or a subset of benefits that perhaps more closely aligns with benefits available in the commercial market.
Enrollment mechanism	The state would have to determine whether the target population would enroll through Maryland Health Connection, as is done by most Medicaid enrollees currently, or through a mechanism outside of MHC, such as through an application process administered by local partners.
Coordination with existing programs	The state would have to determine if and how expanded coverage would coordinate with existing Emergency Medical Assistance currently provided through Medicaid.

C. Coverage through a Public Option

Coverage for ineligible individuals through a public option could take many forms. As with coverage through a State-Only Medicaid Program, a number of key questions, summarized in table 4, would need to be addressed in order to provide implementation estimates related to cost and timeline. Given the significant breadth of options for shaping a public option, this report presents these items for consideration rather than evaluating any one combination of options. In addition, MHBE understands that the Health Insurance Coverage Protection Commission is considering procuring an actuarial study of a potential Medicaid buy-in, which would be one form of a public option, and did not want to duplicate efforts.

Table 4. Key Considerations Related to Providing Coverage through a Public Option

Form of public option	The state would need to decide what form of public option to pursue. Options include private qualified health plans offered through the Exchange, but subject to additional regulation related to cost and/or quality; private non-qualified health plans contracted by the state to offer coverage; and a state-run plan in which the state bears the financial risk and charges/subsidizes enrollee premiums.
Target population	The state would have to determine who would be eligible to purchase coverage through the public option. Options included opening eligibility to all Marylanders, only those Marylanders without an offer of affordable employer-sponsored health insurance, or only individuals ineligible for coverage through Medicaid or for APTCs. Depending on the eligible population, the impact on the individual and group markets and on Medicaid would need to be evaluated.
Insurer and provider participation	Early experience from other states indicates that careful consideration must be given to how to attain participation from providers and, if private insurers are part of the public option scheme, from private insurers. Options range from simple encouragement from the state to participate to tying participation in other state programs, such as the state employee health benefits plan or Medicaid, to participation in the public option.
Implementation leads	The state would need to decide which agency or agencies would be responsible for leading implementation of a public option.
Premium savings	The mechanism for and level of anticipated premium savings would have to be evaluated. To date, savings in other states' public options have generally been anticipated through lower hospital costs. Given Maryland's unique hospital financing system, that may not be a significant source of savings.
Benefits	The benefit package available through the public option would have to be determined.
Enrollment mechanism	The state would have to determine whether the target population would enroll through Maryland Health Connection, or through a mechanism outside of MHC, such as through an application process administered by local partners.
Coordination with existing programs	The state would have to determine if and how expanded coverage would coordinate with other coverage programs such as Medicaid, MCHP, and private coverage offered through Maryland Health Connection.

V. Conclusion

In the last ten years, Maryland's uninsured rate has fallen in half and stands at about 6 percent as of 2019. Maryland has been a national leader in working to reduce the uninsured rate, including by implementing a state-based health insurance marketplace, launching the State Reinsurance Program which has reduced individual market premiums by more than 30 percent since 2019, enacting the Easy Enrollment Program to allow uninsured individuals to get connected to health coverage by checking a box on their state tax return, and instituting state premium assistance for young adults starting in 2022. However, as of 2019 approximately 357,000 individuals remain uninsured in Maryland, approximately 35 percent of whom are either ineligible for coverage through state programs due to immigration status or ineligible for federal financial assistance with health insurance premiums due to the federal family glitch.

This report presents information on existing resources for discounted healthcare services for these ineligible individuals in Maryland, describes actions other states are taking or exploring to provide coverage to similarly situated individuals in their states, and presents information on options that Maryland could consider to provide coverage to these ineligible individuals. The greatest level of detail is provided on the option of covering ineligible individuals through the Maryland Health Benefit Exchange using a combination of a federal 1332 waiver and a state-based premium and cost-sharing subsidy program that aligns with the federal subsidy program. Approximately 160,000 individuals would be eligible for such a program and an estimated 50,000 would choose to enroll in coverage, at a cost to the state of approximately $190 to $222 million, or $165 to $190 million if the state were able to receive federal pass-through funding to offset the cost of the program.[67] This would bring down the state's uninsured rate by approximately 0.6 percentage points, to approximately 5.4 percent.

To explore the potential costs of targeting a subset of the full population, options to limit subsidies to individuals at or below 200 percent of the federal poverty level, or to children and young adults up to age 34 were also modeled. Under the 200 percent FPL or below scenario, approximately 90,000 individuals would be eligible for a state subsidy and an estimated 35,000 would choose to enroll, at a cost to the state of approximately $150 to $170 million, or $130 to $150 million if the state were able to receive federal pass-through funding to offset the cost of the program. Under the child and young adult eligibility scenario, approximately 70,000 individuals would be eligible for a state subsidy and an estimated 25,000 would choose to enroll, at a cost to the state of approximately $75 to $85 million, or $46 to $53 million if the state were able to receive offsetting federal pass-through funding.

In addition to the option of providing coverage through the Exchange using a federal 1332 waiver and a state-based subsidy program, this report summarizes key considerations relating to providing coverage through Medicaid using state-only funds and to providing coverage through a public option. Due to the complexity of those coverage options, the variety of forms they could take, and the importance of involving additional state agencies as lead or key partners in their implementation, this report does not provide enrollment or cost projections for these options.

[67] The figures cited here do not assume that the enhanced federal subsidies under the American Rescue Plan Act (ARPA) are in place during program implementation. Additional modeling that reflects the ARPA subsidies is available in the Appendix.

Appendix: Actuarial Report

LEWIS & ELLIS
Actuaries and Consultants

Undocumented and Family Glitch Subsidy Cost Projections

MARYLAND HEALTH BENEFIT EXCHANGE

STATE OF MARYLAND

JOSH HAMMERQUIST, FSA, MAAA
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Submitted on:
October 27, 2021

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EXECUTIVE SUMMARY

The Maryland Health Benefit Exchange (MHBE) engaged Lewis & Ellis (L&E) to estimate the potential impact of subsidies for individuals ineligible for coverage and/or Advanced Premium Tax Credits (APTC) through Maryland Health Connection via a Section 1332 waiver under the Affordable Care Act (ACA). The affected populations were identified as undocumented immigrants and families falling into the "family glitch". If implemented, the program would provide state premium and cost sharing subsidies to fund individual market health premiums and cover out of pocket costs for qualified enrollees.

Dependents fall into the family glitch if: (1) their income is between 138% and 400%[1] of the Federal Poverty Level (FPL), (2) one family member has an employer offer of single coverage deemed to be affordable which is defined as being less than 9.83 percent[2] of family income, and (3) the cost of providing coverage to the whole family is greater than 9.83 percent of income. The offer of "affordable" single coverage to one adult means the entire family is ineligible for ACA subsidies, even if the family coverage is unaffordable.

Under current law, undocumented immigrants are not allowed to participate in the healthcare exchanges established by the ACA or in state programs such as Medicaid. As a result, the only sources of healthcare coverage for these individuals are through their employers (if offered), the individual marketplace outside of an exchange (which is often unaffordable), or through a state program such as the one being modeled[3].

State premium subsidy costs for potential enrollees were modeled using current 2021 ACA eligibility guidelines for APTC[4]. An additional scenario was also modeled using the expanded subsidies made available with the passing of the American Rescue Plan Act (ARPA). This scenario assumes that the expanded subsidies are extended beyond 2022. In the family glitch population, state premium subsidies would only be available to eligible dependents as part of the Waiver program. The family member with the offer of coverage deemed affordable would not be eligible for subsidies.

L&E estimates the average per member per year (PMPY) cost of offering subsidies to the study population to be approximately $3,600 in 2024, increasing approximately 5% per year over the life of the program. Cost increases are mainly a function of year-over-year projected individual market premium growth.

[1] ARPA extends APTC subsidies to families with incomes exceeding 400% FPL. L&E modeled one scenario that extended ARPA indefinitely, so families with incomes exceeding 400% FPL are eligible for the proposed subsidy.
[2] ARPA reduces the 9.83 percent to 8.50 percent of income.
[3] https://www.kff.org/racial-equity-and-health-policy/issue-brief/health-coverage-and-care-of-undocumented-immigrants/
[4] http://www.healthreformbeyondthebasics.org/wp-content/uploads/2020/08/REFERENCE-GUIDE_Yearly-Guideline-and-Thresholds_CoverageYear2021-2.pdf

There is significant uncertainty regarding how these populations will engage with the program when offered subsidies. Consumer interest will depend heavily on outreach and marketing to potential enrollees. L&E estimates approximately 32% of those offered subsidies will participate in the program after it is fully phased in.

The proposed subsidies are expected to attract relatively healthy members to the individual market, which would decrease morbidity and reduce the average individual market premiums. This premium reduction decreases the federal government's APTC costs. In turn, these costs may be eligible for pass through funding to the State through a 1332 waiver, which would potentially offset a portion of the program cost.

ASSUMPTIONS

POPULATION GROWTH ASSUMPTIONS

The undocumented population was assumed to grow by 2.8% per year based on historical growth rates from the American Immigration Council[5].

Limited data is available regarding the year-over-year growth rate of the family glitch population. Therefore, L&E assumed this population would grow at the 0.7% average historical growth rate of the Maryland population[6].

MARKET ASSUMPTIONS

The proposed subsidy costs are a function of the second lowest cost silver plan. In 2019 Maryland implemented the State Reinsurance Premium (SRP)[7] which significantly lowered individual market premiums. Beginning in 2022, the MHBE is offering a Young Adult subsidy for two years to further expand coverage to Marylanders. The inclusion of additional younger, relatively healthier members into the market is further expected to reduce premiums.

L&E modeled the estimated impact of these programs as part of the SRP analysis and developed premium, enrollment, and demographic projections. The assumptions in Exhibit 1 were used for this analysis.

Exhibit 1 – 2024-2028 Maryland Individual Market Projections

	2024	2025	2026	2027	2028
Market Enrollment	224,983	226,093	227,209	228,331	229,459
APTC Eligible	132,980	134,270	134,933	136,270	136,943
Gross Premiums PMPM - APTC	$561	$589	$619	$650	$682
Gross Premiums PMPM - non -APTC	$442	$464	$487	$512	$537
Benchmark Premium PMPM	$337	$353	$371	$390	$409
Average Age - APTC	1.71	1.71	1.71	1.71	1.71
100% FPL	13,519	13,740	13,963	14,191	14,422

[5] https://www.americanimmigrationcouncil.org/research/immigrants-in-maryland
[6] https://msa.maryland.gov/msa/mdmanual/01glance/html/pop.html
[7] 2022 Analysis for the State Reinsurance Program

OTHER ASSUMPTIONS

If implemented, the program is not expected to start before 2024. Therefore, no impact due to COVID-19 was considered as part of the analysis.

METHODOLOGY

DATA SOURCES

To model the family glitch population, L&E relied on the Kaiser Family Foundation study, *The ACA Family Glitch and Affordability of Employer Coverage*, which utilized 2019 census data to estimate total family glitch members by state, and demographic characteristics, including FPL, age, and type of insurance coverage. Maryland individual market data was used to estimate the age band distribution by FPL because the KFF study data did not include this level of detail. Additional adjustments were made to account for family glitch adults under 138% FPL and family glitch children under 322% FPL not being eligible for subsidies due to eligibility for Medicaid/CHIP. The following table shows the expected age and FPL breakout of the family glitch population in 2024.

Exhibit 2 – Estimated Family Glitch Population by Age and FPL

	0-133%	133-150%	150-200%	200-250%	250-300%	300-400%	400-600%	600+%
0-18	-	-	-	-	-	3,576	11,907	4,220
18-25	-	741	1,099	830	377	472	340	181
26-34	-	1,822	3,046	2,855	1,655	2,861	3,227	1,310
35-44	-	1,250	1,777	1,516	868	1,568	1,868	679
45-54	-	1,251	1,857	1,719	1,157	2,340	1,917	582
55-64	-	1,972	3,306	3,459	2,699	6,493	2,766	798
65+	-	116	166	109	64	113	24	44

For the undocumented population, L&E used population estimates by family status, age, FPL, and insured status provided by the MHBE. Nearly all insured undocumented individuals were covered through Employer Sponsored Insurance (ESI). Based on discussions with the MHBE, L&E assumed most of the insured undocumented individuals have Minimum Value plans from their employers and therefore are ineligible for subsidies. For the small number of insured individuals who would be eligible, L&E assumed the number switching health coverage would be immaterial due to the low perceived benefit of switching and hesitancy to interact with state and federal programs. Therefore, no insured undocumented individuals were included in the analysis.

PREMIUM SUBSIDY

Premium subsidies were modeled to mirror the ACA's APTC program, which limits the amount an individual or family is required to spend on premiums based on their level of income. Premium subsidies for eligible enrollees were calculated for two scenarios, utilizing market assumptions

from Exhibit 1. In the first scenario, subsidy amounts were based on 2021 ACA APTC eligibility[8] income guidelines, prior to the passing of ARPA. In this scenario, approximately 75% of the total family glitch and undocumented population are eligible for premium subsidies.

The second scenario modeled the expanded subsidies made available through ARPA, which provides richer subsidy amounts for those who already qualify under current ACA provisions and expands subsidies to those previously ineligible because their incomes exceed 400% FPL. As a result of the expanded eligibility, approximately 90% of the population is estimated to be eligible to receive premium subsidies. Cost projections under the ARPA scenario can be found in Appendix A.

Exhibit 3– Maximum Premium Contribution as a Percentage of Income[9]

FPL	Pre-ARPA APTC	ARPA[10]
0-133%	2.07%	0.00%
133-150%	3.62%	0.00%
150-200%	5.33%	1.00%
200-250%	7.43%	3.00%
250-300%	9.08%	5.00%
300-400%	9.83%	7.25%
400-600%	N/A	8.50%
600+%	N/A	8.50%

PROGRAM PARTICIPATION

The most significant variable for estimating overall program costs is the participation rate of eligible enrollees, which is dependent on marketing efforts and outreach, consumers' willingness to interact with state and federal programs, and the cost savings for each eligible enrollee.

UNDOCUMENTED POPULATION

L&E expects this population to be hesitant to interact with a state-run program due to their citizenship status and their unfamiliarity with the health insurance marketplace. On the other hand, the potential savings from acquiring full insurance coverage could encourage portions of this population to participate in the program.

[8] Adults under 138% and children under 322% FPL are generally not eligible for APTC in Maryland due to Medicaid eligibility. Premium subsidies under the proposed program would be available for these FPLs for undocumented immigrants as they are ineligible for Medicaid regardless of income due to citizenship status

[9] Values shown are average for the given FPL bracket

[10] https://www.irs.gov/pub/irs-drop/rp-21-23.pdf

To estimate the potential enrollment from the undocumented population, L&E reviewed other states' programs where low-cost healthcare services were offered to undocumented immigrants and under-resourced individuals. The participation rates for these programs were approximately 25% to 35% of the undocumented uninsured populations. However, it should be noted that many of these programs offer community-based healthcare programs rather than traditional health insurance.

A New York program, NYC Care[11], currently offers healthcare to undocumented immigrants who do not qualify or cannot afford health insurance. NYC Care connects patients to care in participating hospitals and pharmacies and members pay income-based costs for services and receive a membership card similar to traditional insurance plans.

L&E used NYC Care's participation rate as a benchmark for the Maryland program. NYC Care saw program participation of approximately 25% of undocumented immigrants in 2019. However, the Maryland program is different because enrollment is limited to open enrollment periods, so enrollees must proactively enroll before needing medical care. Due to Maryland's enrollment requirement, L&E assumed that 30% of undocumented uninsured individuals would participate.

FAMILY GLITCH POPULATION

Unlike the undocumented population, the majority of those in the family glitch population have existing health insurance coverage. Most have ESI through a family member's employer plan for which they are spending more than 9.83% of total family income. A small number are buying unsubsidized Marketplace plans.

Exhibit 4 – Insurance Status of Dependents in the Family Glitch[12]

Coverage Status	Percentage of Population
Employer Sponsored	85%
Unsubsidized Marketplace Plan	6%
Uninsured	9%

L&E modeled each population in the table above separately to estimate enrollment.

Since individuals with ESI already have insurance coverage, their participation in the proposed program depends on the magnitude of premium savings[13]. To estimate an expected willingness to switch coverage, L&E compared the expected premium as a percentage of income assuming

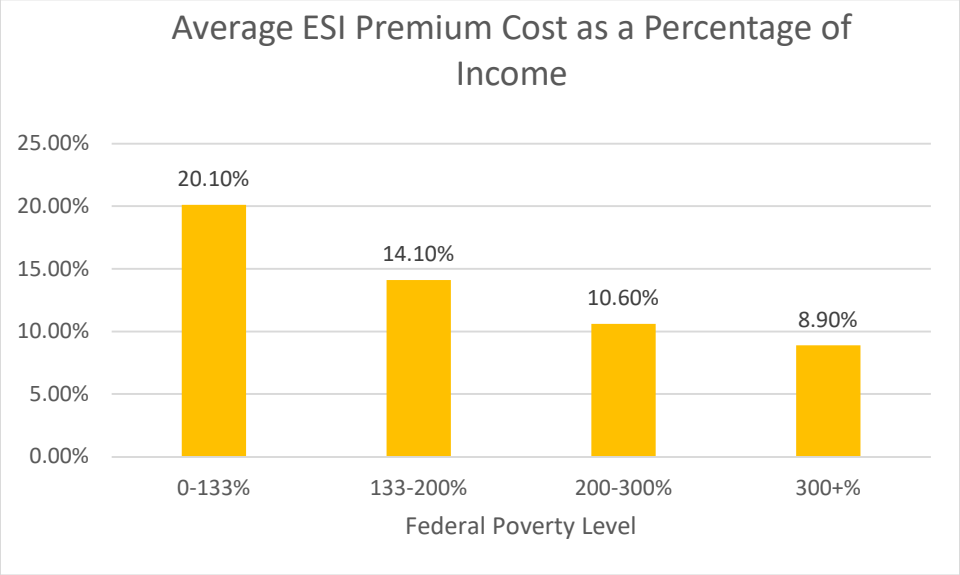
[11] https://www.nyccare.nyc/

[12] https://www.kff.org/report-section/the-aca-family-glitch-and-affordability-of-employer-coverage-issue-brief/

[13] In addition to premiums, expected cost sharing amounts such as deductibles, copays etc. also influence this decision. Due to the variation in ESI benefit richness and many enrollees being eligible for CSR subsidies, only premium differences were considered.

an individual was eligible for premium subsidies versus their current average premium as a percentage of income to receive their ESI. An elasticity model was used to determine the likelihood of an individual changing coverage based on the estimated premium savings.

Exhibit 5 – Average ESI Premium as Percentage of Income by FPL[14]



Unsurprisingly, those with lower incomes pay a higher percentage of their total income toward premiums. Since Marketplace premiums decline as income levels decrease, those with the lowest incomes are likely to experience the largest savings. Savings would decrease as income rises. Those with FPLs under 200% are expected to experience significant savings, with many saving more than 30% of total premium. Expected program enrollment for these individuals was 95% of eligible enrollees. Those between 200% and 250% FPL will see modest savings. Because of expected hesitancy to switch health plans, only approximately a third of these enrollees were modeled to drop their ESI coverage in favor of entering the proposed program. Persons between 250% to 400% FPL experienced limited to no premium savings. Approximately 5% of those in this population are expected to join the program.

6% of individuals in the family glitch population are currently buying unsubsidized plans. L&E assumed 100% of eligible enrollees would accept the subsidies offered.

Approximately 9% of dependents in the family glitch population do not have insurance coverage. To model the participation for these enrollees, L&E utilized an uninsured uptake regression model previously used for the SRP modeling to project uninsured enrollment into the individual market. The regression model uses a potential enrollee's age and estimated net premium as a percentage of income to estimate the likelihood of purchasing a Marketplace plan.

[14] Source: Exhibit 2 "Premiums as a percentage of income for people with unaffordable family coverage who are ineligible for tax credits because of an affordable single coverage offer, by alternative affordability tests" https://www.healthaffairs.org/doi/10.1377/hlthaff.2015.1491

PHASE-IN

New programs often take time to reach maturity on an operational level and due to the time it takes eligible enrollees to learn about a new program. Therefore, an adjustment was applied to phase-in enrollment over the first three years of the program. L&E assumed 60% of ultimate enrollment levels will be reached in year 1, 90% in year 2, and 100% in the third operational year.

COST SHARING REDUCTION SUBSIDY

To further reduce costs and improve access of care to enrollees, the MHBE requested that the impact of cost sharing reduction subsidies be considered as part of the program to cover out-of-pocket costs for qualified enrollees. Subsidy eligibility would mirror current ACA provisions, which are available to enrollees under 250% FPL, increasing in richness as income declines. Costs by Actuarial Value level (a function of FPL) were based on Maryland-specific rate filing data. Based on discussions with the MHBE, L&E assumed 100% of enrollees eligible for cost sharing reduction subsidies would use their premium subsidy to enroll in an applicable silver plan and therefore receive the cost sharing reduction subsidy.

Exhibit 6 – CSR Eligibility and PMPM Costs by FPL

FPL Min	Max	Plan Type	PMPM Cost
0%	133%	CSR Silver 94% AV	$57.75
133%	150%	CSR Silver 94% AV	$57.75
150%	200%	CSR Silver 87% AV	$43.17
200%	250%	CSR Silver 73% AV	$18.08
250%	Max	N/A	$0.00

MORBIDITY IMPACT ON PREMIUMS

The proposed subsidies are expected to attract relatively healthier enrollees to the individual market. The inclusion of a relatively healthier population reduces the average morbidity and the overall premium levels, thus lowering the federal government's cost of providing APTC to existing Marketplace enrollees. Therefore, Maryland may be able to apply for a 1332 waiver to capture these saving as pass-through payments, thus lowering the net cost of providing the subsidies.

Except for the small portion of family glitch individuals participating in the Marketplace through unsubsidized plans, there is limited information regarding the health status of the study population. Risk score information is not available for uninsured individuals or the portion of the

family glitch population with ESI coverage. These two groups make up the majority of the population being modeled.

Age is the only available variable which provides insight into the expected health costs for the eligible enrollees. Therefore, L&E used the average ages of each population to model the eligible enrollees' morbidity level relative to the individual market.

For all scenarios modeled, the new population is projected to be younger, and therefore healthier than the existing individual market. The estimated average age in 2024 for an existing Individual Marketplace enrollee receiving APTC is 49, with the eligible undocumented and family glitch populations projected to be 41 and 46 years respectively.

IMPACT ON UNINSURED RATE

L&E modeled the impact the proposed program would have on Maryland's uninsured rate. MHBE currently estimates the uninsured rate to be approximately 6.0%. Under the Full Population scenario, L&E estimates approximately 35,000 individuals would gain coverage after the program is fully phased in. This results in the uninsured rate decreasing approximately 0.6% down to 5.4%,

RESULTS[16]

FULL POPULATION

In this scenario, all individuals, excluding those eligible for Medicaid or CHIP, between 0% to 400% FPL are eligible for premium subsidies and those between 0% to 250% PFL are eligible for cost sharing reduction subsidies.

Exhibit 7 – 2024-2028 Program Projections Full Population

Full Population

	2024			2025			2026		
Enrollment	Undocumented	Family Glitch	**Total**	Undocumented	Family Glitch	**Total**	Undocumented	Family Glitch	**Total**
Eligible for Subsidy	107,273	45,189	**152,462**	110,518	45,496	**156,014**	113,670	45,805	**159,475**
Taking Subsidies	19,309	10,104	**29,413**	29,840	15,237	**45,077**	34,101	16,241	**50,342**
Phase In	60%	60%	**60%**	90%	90%	**90%**	100%	100%	**100%**
Uptake %	18%	22%	**19%**	27%	33%	**29%**	30%	35%	**32%**
Subsidy Costs									
Premium Subsidy	$59,478,461	$32,357,373	$91,835,834	$96,006,530	$51,230,106	$ 147,236,636	$115,516,232	$54,579,911	$ 170,096,143
Cost Sharing Subsidy	$8,333,245	$4,892,651	$13,225,897	$12,846,433	$7,377,537	$ 20,223,970	$14,669,564	$7,836,271	$ 22,505,835
Gross Cost to State	**$67,811,707**	**$37,250,024**	**$105,061,731**	**$108,852,963**	**$58,607,643**	**$167,460,606**	**$130,185,796**	**$62,416,182**	**$192,601,978**
Pass-through			$14,812,663			$22,473,808			$27,188,740
Net Cost to State			**$90,249,068**			**$144,986,797**			**$165,413,238**
Individual Market Impact									
Relative Morbidity of New Members			-19.5%			-19.7%			-20.9%
Morbidity Premium Impact			-2.3%			-3.3%			-3.8%

Full Population

	2027			2028		
Enrollment	Undocumented	Family Glitch	**Total**	Undocumented	Family Glitch	**Total**
Eligible for Subsidy	116,822	46,116	**162,938**	120,251	46,824	**167,075**
Taking Subsidies	35,047	16,334	**51,380**	36,075	16,466	**52,541**
Phase In	100%	100%	**100%**	100%	100%	**100%**
Uptake %	30%	35%	**32%**	30%	35%	**31%**
Subsidy Costs						
Premium Subsidy	$125,439,930	$58,285,767	$ 183,725,697	$136,476,969	$62,358,179	$ 198,835,148
Cost Sharing Subsidy	$15,076,285	$7,880,416	$ 22,956,701	$15,494,283	$7,924,060	$ 23,418,342
Gross Cost to State	**$140,516,215**	**$66,166,183**	**$206,682,398**	**$151,971,251**	**$70,282,239**	**$222,253,490**
Pass-through			$30,508,782			$32,731,526
Net Cost to State			**$176,173,616**			**$189,521,964**
Individual Market Impact						
Relative Morbidity of New Members			-20.9%			-21.0%
Morbidity Premium Impact			-3.8%			-3.9%

The average PMPY cost is approximately $3,600 in 2024 and is expected to increase 3-5% per year. Year-over-year cost increases are primarily driven by the expected premium increases outlined in Exhibit 1.

[16] Enrollment and cost values in Exhibits 7-9 are rounded to the nearest whole number

YOUNG ADULT/CHILDREN

An additional, lower cost scenario was modeled where only children and adults under age 35 are eligible for subsidies. L&E assumed that qualified enrollees from the family glitch population would not be eligible for the Young Adult subsidy because the Young Adult subsidy program is a pilot currently scheduled to end in 2023.

Exhibit 8 – 2024-2028 Ages 0-34 Only Program Projections

Children/Young Adult (0-34)

	2024			2025			2026		
Enrollment	Undocumented	Family Glitch	**Total**	Undocumented	Family Glitch	**Total**	Undocumented	Family Glitch	**Total**
Eligible for Subsidy	53,614	12,295	**65,909**	55,187	12,378	**67,565**	56,717	12,462	**69,179**
Taking Subsidies	9,651	4,571	**14,222**	14,900	6,896	**21,797**	17,015	7,707	**24,722**
Phase In	60%	60%	**60%**	90%	90%	**90%**	100%	100%	**100%**
Uptake %	18%	37%	**22%**	27%	56%	**32%**	30%	62%	**36%**
Subsidy Costs									
Premium Subsidy	$22,671,989	$9,824,901	$32,496,890	$37,119,070	$15,867,306	$ 52,986,377	$44,995,903	18,963,174	$ 63,959,077
Cost Sharing Subsidy	$4,446,758	$2,334,656	$ 6,781,414	$6,855,070	$3,522,877	$ 10,377,947	$7,827,923	3,937,575	$ 11,765,498
Gross Cost to State			**$39,278,304**			**$63,364,323**			**$75,724,575**
Pass-through			$15,393,297			$23,964,856			$29,429,203
Net Cost to State			**$23,885,007**			**$39,399,467**			**$46,295,372**
Individual Market Impact									
Relative Morbidity of New Members			-39.5%			-39.6%			-39.6%
Morbidity Premium Impact			-2.3%			-3.4%			-3.9%

Children/Young Adult (0-34)

	2027			2028		
Enrollment	Undocumented	Family Glitch	**Total**	Undocumented	Family Glitch	**Total**
Eligible for Subsidy	58,474	12,939	**71,413**	60,095	13,027	**73,122**
Taking Subsidies	17,542	7,109	**24,651**	18,029	6,728	**24,756**
Phase In	100%	100%	**100%**	100%	100%	**100%**
Uptake %	30%	55%	**35%**	30%	52%	**34%**
Subsidy Costs						
Premium Subsidy	$49,069,100	19,176,449	$ 68,245,549	$53,492,019	20,565,254	$ 74,057,272
Cost Sharing Subsidy	$8,044,956	3,812,859	$ 11,857,815	$8,268,006	3,835,951	$ 12,103,958
Gross Cost to State			**$80,103,364**			**$86,161,230**
Pass-through			$31,005,914			$32,809,905
Net Cost to State			**$49,097,450**			**$53,351,325**
Individual Market Impact						
Relative Morbidity of New Members			-39.8%			-39.8%
Morbidity Premium Impact			-4.0%			-4.0%

PMPY costs in this scenario start at $1,700 in 2024 and increase at a similar 3-5% yearly rate to the Full Population scenario.

200% FPL LIMIT

A third scenario was modeled where only individuals ineligible for Medicaid or CHIP with FPL less than or equal to 200% are eligible for subsidies. All individuals are eligible for both the premium and cost sharing subsidy.

Exhibit 9– 2024-2028 Capped at 200% FPL Program Projections

200% FPL and Under

	2024			2025			2026		
Enrollment	Undocumented	Family Glitch	**Total**	Undocumented	Family Glitch	**Total**	Undocumented	Family Glitch	**Total**
Eligible for Subsidy	67,227	18,780	**86,008**	69,091	18,908	**87,999**	71,007	19,036	**90,043**
Taking Subsidies	12,101	7,949	**20,050**	18,655	11,985	**30,640**	21,302	12,608	**33,910**
Phase In	60%	60%	**60%**	90%	90%	**90%**	100%	100%	**100%**
Uptake %	18%	42%	**23%**	27%	63%	**35%**	30%	66%	**38%**
Subsidy Costs									
Premium Subsidy	$44,173,391	$27,183,922	$71,357,313	$70,946,628	$42,865,460	$ 113,812,088	$85,022,910	$44,554,064	$ 129,576,974
Cost Sharing Subsidy	$8,333,245	$4,891,115	$13,224,360	$12,846,433	$7,375,237	$ 20,221,671	$14,669,564	$7,834,432	$ 22,503,995
Gross Cost to State	**$52,506,637**	**$32,075,037**	**$84,581,674**			**$134,033,759**			**$152,080,969**
Pass-through			$11,695,007			$18,168,344			$22,655,119
Net Cost to State			**$72,886,667**			**$115,865,415**			**$129,425,850**
Individual Market Impact									
Relative Morbidity of New Members			-20.3%			-21.4%			-23.2%
Morbidity Premium Impact			-1.7%			-2.6%			-3.0%

200% FPL and Under

	2027			2028		
Enrollment	Undocumented	Family Glitch	**Total**	Undocumented	Family Glitch	**Total**
Eligible for Subsidy	72,976	19,166	**92,141**	74,999	19,296	**94,295**
Taking Subsidies	21,893	12,679	**34,572**	22,500	12,750	**35,250**
Phase In	100%	100%	**100%**	100%	100%	**100%**
Uptake %	30%	66%	**38%**	30%	66%	**37%**
Subsidy Costs						
Premium Subsidy	$91,963,756	$47,466,132	$ 139,429,888	$99,460,938	$50,546,904	$ 150,007,842
Cost Sharing Subsidy	$15,076,285	$7,877,939	$ 22,954,224	$15,494,283	$7,772,446	$ 23,266,728
Gross Cost to State			**$162,384,112**			**$173,274,570**
Pass-through			$24,256,221			$25,992,875
Net Cost to State			**$138,127,890**			**$147,281,694**
Individual Market Impact						
Relative Morbidity of New Members			-23.3%			-23.3%
Morbidity Premium Impact			-3.1%			-3.1%

PMPY costs in this scenario begin at approximately $4,200.

MARKET STABILIZATION AND PASS-THROUGH

Projected pass-through dollars were calculated as the difference in total estimated APTC paid into the existing Individual market based on premium levels before and after the inclusion of the undocumented and family glitch populations.

Exhibit 10 – Estimated Pass-through Full Population

	2024	2025	2026	2027	2028
Initial APTC Paid	$520,026,257	$555,135,050	$592,349,371	$631,779,808	$673,578,597
APTC Paid with Morbidity Impact	$504,433,980	$531,478,410	$563,729,645	$599,665,300	$639,124,359
Pass-through	**$14,812,663**	**$22,473,808**	**$27,188,740**	**$30,508,782**	**$32,731,526**

Exhibit 11 – Estimated Pass-through Ages 0-34

	2024	2025	2026	2027	2028
Initial APTC Paid	$520,026,257	$555,135,050	$592,349,371	$631,779,808	$673,578,597
APTC Paid with Morbidity Impact	$503,822,786	$529,908,886	$561,371,263	$599,142,004	$639,041,856
Pass-through	**$15,393,297**	**$23,964,856**	**$29,429,203**	**$31,005,914**	**$32,809,905**

The total pass-through savings is expected to be similar in the age 0-34 scenario because the estimated morbidity impact per new enrollee is greater than the Full Population scenario due to the significant age difference, which offsets the lower enrollment.

Exhibit 12 – Estimated Pass-through 200% FPL Limit

	2024	2025	2026	2027	2028
Initial APTC Paid	$520,026,257	$555,135,050	$592,349,371	$631,779,808	$673,578,597
APTC Paid with Morbidity Impact	507,715,723	536,010,478	568,501,878	606,246,943	646,217,676
Pass-through	**$11,695,007**	**$18,168,344**	**$22,655,119**	**$24,256,221**	**$25,992,875**

APPENDICES

APPENDIX A: ARPA[17]

Under ARPA, subsidies are expanded to those previously ineligible (greater than 400% FPL) and expanded for those previously eligible via richer subsidies. The three previous scenarios for the proposed program were revised to assume ARPA subsidies would be extended through 2028.

Exhibit 13– 2024-2028 Full Population Program Projections - ARPA

Full Population

	2024			2025			2026		
Enrollment	Undocumented	Family Glitch	**Total**	Undocumented	Family Glitch	**Total**	Undocumented	Family Glitch	**Total**
Eligible for Subsidy	120,157	52,941	**173,098**	125,472	53,300	**178,772**	128,950	53,662	**182,613**
Taking Subsidies	21,628	12,761	**34,389**	33,877	18,501	**52,378**	38,685	20,650	**59,335**
Phase In	60%	60%	**60%**	90%	90%	**90%**	100%	100%	**100%**
Uptake %	18%	24%	**20%**	27%	35%	**29%**	30%	38%	**32%**
Subsidy Costs									
Premium Subsidy	$70,418,522	$45,463,817	$ 115,882,339	$112,703,099	$66,705,872	$ 179,408,971	$134,869,767	$78,110,405	$ 212,980,172
Cost Sharing Subsidy	$8,333,245	$5,135,953	$ 13,469,198	$12,846,433	$7,386,481	$ 20,232,914	$14,669,564	$8,249,230	$ 22,918,794
Gross Cost to State	**$78,751,768**	**$50,599,770**	**$129,351,538**	**$125,549,532**	**$74,092,353**	**$199,641,885**	**$149,539,331**	**$86,359,635**	**$235,898,966**
Pass-through			$21,797,793			$34,780,058			$40,659,163
Net Cost to State			**$107,553,744**			**$164,861,828**			**$195,239,803**
Individual Market Impact									
Relative Morbidity of New Members			-18.9%			-19.6%			-19.7%
Morbidity Premium Impact			-3.3%			-4.9%			-5.4%

Full Population

	2027			2028		
Enrollment	Undocumented	Family Glitch	**Total**	Undocumented	Family Glitch	**Total**
Eligible for Subsidy	132,680	56,023	**188,703**	136,358	56,403	**192,762**
Taking Subsidies	39,804	19,696	**59,499**	40,908	18,189	**59,097**
Phase In	100%	100%	**100%**	100%	100%	**100%**
Uptake %	30%	35%	**32%**	30%	32%	**31%**
Subsidy Costs						
Premium Subsidy	$146,843,345	$75,851,960	$ 222,695,304	$159,384,741	$80,002,929	$ 239,387,670
Cost Sharing Subsidy	$15,076,285	$7,885,769	$ 22,962,054	$15,494,283	$7,929,762	$ 23,424,045
Gross Cost to State	**$161,919,629**	**$83,737,728**	**$245,657,358**	**$174,879,024**	**$87,932,691**	**$262,811,715**
Pass-through			$45,233,582			$47,160,101
Net Cost to State			**$200,423,776**			**$215,651,614**
Individual Market Impact						
Relative Morbidity of New Members			-20.9%			-21.0%
Morbidity Premium Impact			-5.7%			-5.6%

[17] Enrollment and cost values in Exhibits 13-15 are rounded to the nearest whole number

Exhibit 14 – 2024-2028 Ages 0-34 Only Program Projections - ARPA

Children/Young Adult (0-34)

	2024			2025			2026		
Enrollment	Undocumented	Family Glitch	**Total**	Undocumented	Family Glitch	**Total**	Undocumented	Family Glitch	**Total**
Eligible for Subsidy	57,916	15,599	**73,515**	61,505	15,705	**77,210**	63,211	15,812	**79,022**
Taking Subsidies	10,425	6,225	**16,650**	16,606	9,388	**25,994**	18,963	10,481	**29,444**
Phase In	60%	60%	**60%**	90%	90%	**90%**	100%	100%	**100%**
Uptake %	18%	40%	**23%**	27%	60%	**42%**	30%	66%	**47%**
Subsidy Costs									
Premium Subsidy	$26,380,527	$14,081,188	$ 40,461,715	$42,318,847	$22,210,722	$ 64,529,569	$50,873,996	$26,282,355	$ 77,156,350
Cost Sharing Subsidy	$4,446,758	$2,336,203	$ 6,782,962	$6,855,070	$3,526,479	$ 10,381,549	$7,827,923	$3,942,179	$ 11,770,102
Gross Cost to State			**$47,244,677**			**$74,911,118**			**$88,926,452**
Passthrough			$17,892,804			$28,495,683			$33,539,389
Net Cost to State			**$29,351,872**			**$46,415,435**			**$55,387,063**
Individual Market Impact									
Relative Morbidity of New Members			-38.8%			-38.9%			-38.9%
Morbidity Premium Impact			-2.7%			-4.0%			-4.5%

Children/Young Adult (0-34)

	2027			2028		
Enrollment	Undocumented	Family Glitch	**Total**	Undocumented	Family Glitch	**Total**
Eligible for Subsidy	64,963	15,919	**80,882**	67,802	16,027	**83,829**
Taking Subsidies	19,489	10,439	**29,928**	20,341	8,878	**29,219**
Phase In	100%	100%	**100%**	100%	100%	**100%**
Uptake %	30%	66%	**47%**	30%	55%	**46%**
Subsidy Costs						
Premium Subsidy	$55,322,564	$28,009,783	$ 83,332,346	$60,273,456	$29,249,049	$ 89,522,505
Cost Sharing Subsidy	$8,044,956	$3,965,696	$ 12,010,652	$8,268,006	$3,989,085	$ 12,257,091
Gross Cost to State			**$95,342,999**			**$101,779,596**
Passthrough			$35,780,809			$36,808,999
Net Cost to State			**$59,562,190**			**$64,970,597**
Individual Market Impact						
Relative Morbidity of New Members			-38.9%			-39.2%
Morbidity Premium Impact			-4.5%			-4.4%

Exhibit 15– 2024-2028 Under 201% FPL Only Program Projections - ARPA

Cap at 200% FPL

	2024			2025			2026		
Enrollment	Undocumented	Family Glitch	**Total**	Undocumented	Family Glitch	**Total**	Undocumented	Family Glitch	**Total**
Eligible for Subsidy	67,227	18,780	**86,008**	69,091	18,908	**87,999**	71,007	19,036	**90,043**
Taking Subsidies	12,101	7,949	**20,050**	18,655	11,984	**30,639**	21,302	12,608	**33,910**
Phase In	60%	60%	**60%**	90%	90%	**90%**	100%	100%	**100%**
Uptake %	18%	42%	**23%**	27%	63%	**35%**	30%	66%	**38%**
Subsidy Costs									
Premium Subsidy	$47,749,398	$43,497,966	$ 91,247,364	$76,624,775	$68,677,201	$ 145,301,976	$91,465,464	$73,857,805	$ 165,323,270
Cost Sharing Subsidy	$8,333,245	$4,890,898	$ 13,224,143	$12,846,433	$7,374,424	$ 20,220,858	$14,669,564	$7,834,433	$ 22,503,997
Gross Cost to State			**$104,471,507**			**$165,522,834**			**$187,827,266**
Passthrough			$11,695,282			$18,169,420			$22,655,119
Net Cost to State			**$92,776,226**			**$147,353,414**			**$165,172,147**
Individual Market Impact									
Relative Morbidity of New Members			-20.3%			-21.4%			-23.2%
Morbidity Premium Impact			-1.7%			-2.6%			-3.0%

Cap at 200% FPL

	2027			2028		
Enrollment	Undocumented	Family Glitch	**Total**	Undocumented	Family Glitch	**Total**
Eligible for Subsidy	72,976	19,166	**92,141**	74,999	19,296	**94,295**
Taking Subsidies	21,893	12,679	**34,572**	22,500	12,750	**35,250**
Phase In	100%	100%	**100%**	100%	100%	**100%**
Uptake %	30%	66%	**38%**	30%	66%	**37%**
Subsidy Costs						
Premium Subsidy	$98,692,707	$77,697,541	$ 176,390,248	$106,489,036	$80,311,717	$ 186,800,753
Cost Sharing Subsidy	$15,076,285	$7,877,941	$ 22,954,226	$15,494,283	$7,772,448	$ 23,266,730
Gross Cost to State			**$199,344,473**			**$210,067,484**
Passthrough			$24,256,222			$25,992,876
Net Cost to State			**$175,088,251**			**$184,074,608**
Individual Market Impact						
Relative Morbidity of New Members			-23.3%			-23.3%
Morbidity Premium Impact			-3.1%			-3.1%

APPENDIX B: CAVEATS & LIMITATIONS

The guidance provided in this report is based on evaluating a specific set of assumptions and should be used to evaluate a range of potential outcomes. Actual experience will deviate from the projections evaluated.

L&E performed reasonability tests on the data used; however, L&E did not perform a detailed audit of the data. To the extent that the information provided was incomplete or inaccurate, the results in this report may be incomplete or inaccurate.

L&E made several assumptions in performing the analysis. Several of these assumptions are subject to material uncertainty and it is expected that actual results could materially differ from the projections.

Examples of uncertainty inherent in the assumptions include, but are not limited to:

- Data Limitations.
  - L&E relied on the data submitted from the insurers to the MHBE for significant portions of this analysis. To the extent that the data is inaccurate, the analysis will be impacted.
- Enrollment Uncertainty.
  - Beyond changes to premiums and market wide programs, consumer responses to premium changes have inherent uncertainty. Therefore, actual enrollment could vary significantly.
- Political and Health Policy Uncertainty.
  - Future federal or state actions could dramatically change premiums and enrollment in 2024 and beyond.

This report has been prepared for the MHBE for discussion purposes in relation to the possible implementation of subsidies for the family glitch and undocumented population. Any other use may not be appropriate. L&E understands that this report may be distributed to other parties; however, any user of this report must possess a certain level of expertise in actuarial science and/or health insurance so as not to misinterpret the data presented. Any distribution of this report should be made in its entirety. Any third party with access to this report acknowledges, as a condition of receipt, that L&E does not make any representations or warranties as to the accuracy or completeness of the material. Any third party with access to these materials cannot bring suit, claim, or action against L&E, under any theory of law, related in any way to this material.

The responsible actuaries for this report are members of the American Academy of Actuaries and meet the qualification standards for performing this analysis. The guidance and analysis

expressed in this report are those of the authors only and do not necessarily represent the opinions of other L&E consultants.

The authors of this report are not attorneys and are not qualified to give legal advice. Users of this report should consult legal counsel for interpreting proposed legislation and/or state laws.

APPENDIX C: DISCLOSURES

The Actuarial Standards Board (ASB), vested by the U.S.-based actuarial organizations[18], promulgates Actuarial Standards of Practice (ASOPs) for use by actuaries when providing professional services in the United States.

Each of these organizations requires its members, through its Code of Professional Conduct[19], to observe the ASOPs of the ASB when practicing in the United States. ASOP 41 provides guidance to actuaries with respect to actuarial communications and requires certain disclosures which are contained in the following.

IDENTIFICATION OF THE RESPONSIBLE ACTUARIES

The responsible actuaries are:

- Josh Hammerquist, FSA, MAAA, Vice President & Principal
- Jason Doherty, ASA, MAAA, Consulting Actuary
- Dave Dillon, FSA, MAAA, MS, Senior Vice President & Principal

The actuaries are available to provide supplementary information and explanation.

IDENTIFICATION OF ACTUARIAL DOCUMENTS

The date of this document is October 27, 2021.The date (a.k.a. "latest information date") through which data or other information has been considered in performing this analysis is September 2, 2021

DISCLOSURES IN ACTUARIAL REPORTS

- The contents of this report are intended for the use of the Maryland Health Benefit Exchange. Any third party with access to this report acknowledges, as a condition of receipt, that they cannot bring suit, claim, or action against L&E, under any theory of law, related in any way to this material.
- Lewis & Ellis Inc. is not aware of anything that would impair or seem to impair the objectivity of the work.
- The purpose of this report is to assist the MHBE with the financial impact of offering subsidies to under and uninsured Marylanders.
- The responsible actuaries identified above are qualified as specified in the Qualification Standards of the American Academy of Actuaries.
- Lewis & Ellis has reviewed the data provided for reasonableness but has not audited it. L&E nor the responsible actuaries assume responsibility for items that may have a

[18] The American Academy of Actuaries (Academy), the American Society of Pension Professionals and Actuaries, the Casualty Actuarial Society, the Conoference of Consulting Actuaries, and the Society of Actuaries.
[19] These organizations adopted identical Codes of Professional Conduct effective January 1, 2001.

material impact on the analysis. To the extent that there are material inaccuracies in, misrepresentations in, or lack of adequate disclosure by the data, the results may be accordingly affected.

- L&E is not aware of any subsequent events that may have a material effect on the findings.

ACTUARIAL FINDINGS

The actuarial findings of the report can be found in the body of this report.

METHODS, PROCEDURES, ASSUMPTIONS, AND DATA

The methods, procedures, assumptions, and data used can be found in the body of this report.

ASSUMPTIONS OR METHODS PRESCRIBED BY LAW

This report was prepared as prescribed by applicable law, statutes, regulations, and other legally binding authority.

RESPONSIBILITY FOR ASSUMPTIONS AND METHODS

The actuaries do not disclaim responsibility for material assumptions or methods.

DEVIATION FROM THE GUIDANCE OF AN ASOP

The actuaries do not believe that material deviations from the guidance set forth in an applicable ASOP have been made.