MHBE Individual Subsidy Work Group Meeting

October 22, 2020
10AM-11AM
Location: Google Meets

Members Present:
Allison Mangiaracino
Jon Levine
Ken Brannan
Matt Celentano
Joshua Morris
Beth Sammis
Robert Metz
Stephanie Klapper
Jacqueline Roche
Salliann Alborn
Brad Boban
Jay Hutchins

Others in attendance:
Michele Eberle
Elvina Morris
Johanna Fabian-Marks
Varun Palle
Jessica Grau
Gregory Derwart
Maria Dawley
Allison Taylor
Marissa Woltman

Welcome/Agenda/Approve Minutes

Ken welcomed everyone to the meeting. Beth explained that MHBE staff refocused the agenda so that the group would only be discussing policy items related to the subsidy design and not implementation issues.

The minutes from the last two meetings were approved.

Massachusetts State Subsidy Design

Marissa Woltman gave some background on the Massachusetts Health Connector. She explained that through the ConnectorCare Program individuals can be eligible if they meet the same eligibility criteria required by the ACA to receive Marketplace coverage and subsidies, but only if their incomes are up to 300% FPL. For an applicant to be eligible for any individual/family QHP through the Health Connector, they must be a lawfully-present resident of Massachusetts and not be incarcerated
In addition, they must meet the same eligibility requirements as those required to receive federal APTCs.

An applicant must be ineligible for other types of Minimum Essential Coverage (MEC), such as Medicaid, Medicare, Peace Corps, TRICARE, or Veterans Affairs coverage, and not be already enrolled in or eligible for affordable, minimum-value employer-sponsored Insurance (ESI). They must also have a Modified Adjusted Gross Income (MAGI) for the household up to 300% FPL.

As with APTC eligibility, immigrants who are lawfully present but do not qualify for Medicaid are eligible for ConnectorCare with incomes under 100% FPL. American Indians/Alaska Natives (AI/AN) with incomes up to 300% FPL are eligible for ConnectorCare with zero cost-sharing; non-AI/AN individual's pay cost-sharing according to their FPL

After reviewing a number of methodologies in 2006, the Board ultimately set affordability standards for higher income individuals based on a blend of premiums for employer-sponsored and non-group coverage, set standards based on Medicaid eligibility for the lowest income individuals, and then progressively bridged the gap between for others under 300% of the Federal Poverty Level.

The Health Connector's programmatic budget, which is largely comprised of State Premium Wrap and State Cost-Sharing Reduction subsidies, is funded by the state via the Commonwealth Care Trust Fund (CCTF). The CCTF collects revenue from a portion of the cigarette taxes, state individual mandate penalties, and employer assessments. In addition, state premium and cost-sharing expenditures are supplemented by federal "matching funds" available through the 1115 waiver
The Health Connector's administrative budget includes costs associated with administering all programs, as well as overhead and other contractual expenses. A portion of the administrative budget comes from CCTF, but another portion comes from the administrative fees assessed on the premium for all products sold through the Health Connector.

As of March 2020, ConnectorCare comprises 62% of all individual market enrollees in the state and 28% of enrollees in the state's merged individual and small group market. Competition in the ConnectorCare program makes lower-cost plans available to unsubsidized individuals and small businesses. Risk, age, and network differences lead ConnectorCare enrollees to have lower costs than other merged market enrollees,

Working on facing some key challenges, including continued non-payment of federal CSRs, and also aware that silver loading hurts the unsubsidized consumers. Also some issues with trade-offs related to cost and network breadth.

Rob – Question the CSR supplemental subsidy, about your experience with Silver Loading. Since Silver Loading, the price of Silver plans has gone up. Have you seen a lot of people buying at the Gold level or because of the supplemental subsidies, people are still buying at the Silver level? And have you put any thought into adding CSR subsidies on any other levels to avoid interactions with Silver loading?

Answer – If you become eligible for ConnectorCare, you only see the ConnectorCare plans for those enhanced Silver plans, so you do not actually have a pathway to take those APTCs and buy up to Gold. And even among the APTC population, most people buy up to bronze. Because of the competition on the Silver network, Massachusetts has some of the lowest APTC amounts, so they tend to not cover up to Gold.

Beth – What is the actual budget for the programs? How much does the state dedicate to the premium subsidy and the cost sharing subsidy programs separately?
Answer – Will get back to you on the numbers.

Ken – What was the motivation behind the merging of the markets?
Answer – Done as part of the 2006 reforms. Because the individual market was so small and included a lot of high cost, sick individuals and so there was an understanding that with relatively low premium increases on small groups we could affect large premium reductions for non-group purchases. Currently have a merged market advisory council underway to study the high premiums in the small group market.

Beth - One of our members had a comment about the higher number of individuals on the Massachusetts Exchange than Maryland does. But maybe when you're giving us the numbers of those who qualified for premium Cost-sharing reductions, you could also give us the number of individuals who qualified for subsidies from the State, so we can get a cost of per member per month.
Answer – On-exchange, the small group enrollment is only around 8,000 members, and the ConnectorCare membership is around 210,000 members, and they're all receiving premium and cost-sharing subsidies.

Allison – Is there a way to tease out the impact of the subsidy on coverage?
Answer – Because so many reforms were implemented at one time, it was hard to see the results of the individual reforms. It seems that maybe the individual mandate was a little bit less impactful than the subsidy reform. Massachusetts has been stuck at 97% coverage for a while, so we are looking at different studies to see the true impact of the ConnectorCare program.

Matt – Who are the remaining uninsured?
Answer – There are pockets of undocumented people, and those who qualify for Medicaid and have not enrolled. Half of the population are chronically uninsured, and then the other half are in transition between insurance coverage.

Jacqueline – The two plans that have exited the market, did they exit the areas that are at risk of having no plans available and what were the reasons they left?
Answer – One carrier was not financially viable under the ACA. The other carrier had a small network and could not get competitive rates.

Michele – For the carriers that are in the ConnectorCare program, are you doing active purchasing, and what are the requirements?
Answer – Voluntary participation. The carriers that do participate mostly also participate in the Medicaid program and have experience with dealing with lower income populations. During plan certification, all carriers are applying for the program, but can opt out. The premium differential between the carriers that participate and those that do not is quite large, and would not represent meaningful choice.

Sallly – What is the level of churn between the Medicaid and?
Answer – 1/3 of new members are coming from Medicaid and 1/3 of Medicaid are churning off. Expanded CHIP eligibility, which creates several mixed households. There has been a lot of churn. Individuals who are on Medicaid and fail to renew, end up moving to unsubsidized programs, and often won't enroll and will go back to Medicaid. So we're looking to reduce that unnecessary churn for administrative reasons.

Jon – Has any state considered automatic enrollment with an opt-out option
Answer – Used to do automatic enrollment but stopped in 2009 for budgetary reasons. Still interested in automatic enrollment but concerned about the tax implications. But we are looking for ways to streamline the process, particularly for those coming out of Medicaid.

Michele – Are the individual subsidies only available for those who participate in ConnectorCare
Answer – Yes you must enroll in ConnectorCare. For people above 300% FPL they can use their APTCs, but if you are ConnectorCare elgibile you need to enroll in ConnectorCare to take advantage of the program.

Joshua – Could you talk more about your outreach and marketing efforts?
Answer – Its important to get the word out, especially hurdling the perceived barrier that they can't afford insurance. And we've partnered with Archipelago Strategies group to get the word out to hard to reach populations.

Brad – What programs are available for those over 300% that don't meet the State's definition of affordability?
Answer – If someone is over 300% and they don't have an employer sponsored plan, and they don't have a private market plan available to them under that dollar amount. they don't have to pay the penalty. Most people over 300% are enrolling in coverage, so we usually don't have to use that affordability standard. The low benchmark plan usually results in a zero-dollar APTC for many individuals. But that would play into their determination about paying the penalty.

Revised Work Group Agenda

The agenda was revised slightly to accommodate the short timeline. No members of the group voiced any concerns over the revised schedule.

Comparison of CA and MA and Workgroup Discussion

Johanna reviewed the differences between the programs, and then compared the federal contributions between the states.

Beth – Interesting that neither State the group spoke to has a reinsurance program, so that may indicate that the subsidy design may not be useful to Maryland. It does not sound practical for us to have a separate program since we have the reinsurance program. We need the subsidies to get the uninsured rate down.

Sally – Both states programs seem complex from both the consumer perspective and operational perspective. It would be nice to develop a simple program that appeals to the consumer.

Jackie – the thing to remember with the Massachusetts program, is that they have been building the program for years with federal funding programs.

Matt – I would like to hear from Lewis and Ellis why they think we should be pursuing an individual subsidy program when we have everything already set up through the Reinsurance program?

Beth – The Reinsurance program does not fix all the problems with the ACA, including that the old are subsidized by the young and those who have claims costs are being subsidizied by the reinsurance program. So those over 400% FPL are being subsidized at a greater extent. So we should be committed to bring down the uninsured, and we can build on both programs, and the inequities in the subsidies.

Brad - The reinsurance program can only bring down the unsubsidized rates. It is not actuarial possible to do it via the reinsurance program. The reinsurance program has reduced APTC. So, the under 300% population can only be targeted through a subsidy program.

Matt – We should be careful, and two models may not be enough information to decide what to do with the Individual marketplace.

Beth – Are we concerned with the over 400% or the under 400%, and personally the over 400% seem to have already benefited from the reinsurance program.

Rob – We should keep in mind that the legislature asked us to have a broad discussion about what to do with the Reinsurance money in relation to the program, and not just if we should create a subsidy program.

Matt – We should be having a broader discussion about how to address the uninsured, and we should not be rushed into options when the reinsurance program has not been around for that long.

Rob – I think we should just be clear that the group did not look at all the outside options.

There was some discussion about the focus of the work group in relation to altering the reinsurance program in lieu of just discussing a subsidy program.

Beth – Did L&E model a scenario where the program just remained as is?
Answer – They projected 3 or 4 years out with and without the subsidies and just reinsurance. But we do not have modeling of what a more generous reinsurance program would look like.

Brad – Lewis and Ellis did compute how much you need to spend for each member, and if you expanded the program, it would be very expensive. Since we are already the most generous program in the market, it would be hard to expand the program.

Rob – The reinsurance program does not cost the State money right now, but the subsidy program would, so it should just be clear in the report that the group did not consider other options except for a subsidy program.

Stephanie – Did the affordability work group recommended that subsidies would be the best way to address the remaining uninsured?

Brad –The affordability group saw that a large remaining of the uninsured were under 400% FPL and not opting to take APTC and under 35 years old, so a subsidy program would be a good way to target that group.

Joshua – Are we considering things that fall outside of the State subsidy program?
Answer – The charge for the group is just to evaluate the modeling that L&E has done, but if there are other recommendations, then that is fine as well.

Beth – To reiterate, we recommended to the staff that the operations and implementation piece be removed from these discussions to save time for policy discussions in the work group.

Adjournment

The meeting was adjourned at 11:13AM.