MHBE Individual Subsidy Work Group

October 15, 2020

MHBE Policy Department

MARYLAND HEALTH BENEFIT EXCHANGE

Agenda

10:00AM-10:05AM
Welcome/Agenda/Update on Co-Chair and Charter Vote

10:05AM-10:30AM
California State Subsidy

10:30AM-10:40AM
Reinsurance background

10:40AM-10:55AM
Affordability in Healthcare and Frameworks for Evaluating Subsidy Designs

10:55AM-11:00AM
Public Comment

Co-Chair/Charter Vote

Co-Chair and Charter Votes

- 10 out of 11 members voted on the charter. All 10 voted to ratify it as presented.
- 10 out of 11 members voted on the co-chairs. 9 out of 11 members voted to confirm Beth and Ken as the co-chairs.
- The charter is ratified, and Beth and Ken will co-chair the workgroup.

California State Subsidy

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BACKGROUND

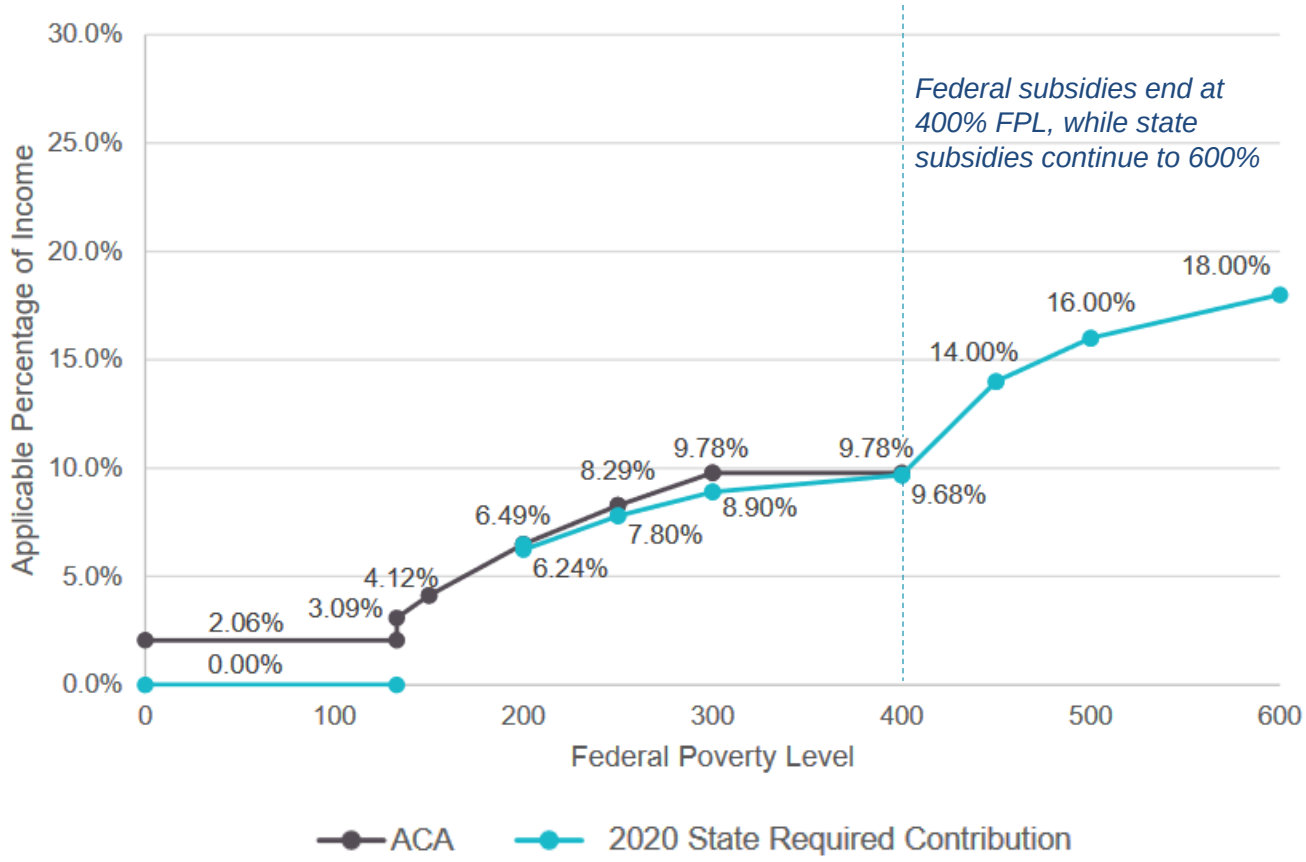
In 2020, California implemented a three-year state advanced premium subsidy and implemented a state mandate penalty. The new state subsidies followed the framework set by the Affordable Care Act and provided more support to those consumers who earn under 400% of the Federal Poverty Level (FPL), and new support to between 400% and 600% of FPL.

While the legislation identified the amount of funding available for the new program and the share of the funding that is meant to go to those above and below 400% of FPL, the legislation delegated authority to Covered California's Board to set the exact eligibility requirements for the new subsidies.

For the 2020 program year, Covered California adopted a program design regulation that included key program design elements, including the eligibility definitions for the program, the "required contribution" curve that determines the benefit amounts under the program, and the caps on reconciliation of state subsidies upon filing of final tax returns with the California Franchise Tax Board.

STATE SUBSIDIES FOLLOW ACA IN LIMITING PREMIUMS AS A SHARE OF INCOME

Figure 1: Required Contribution for Benchmark Silver Plan as a Percentage of Income Under ACA and California State Subsidy Program



Under the ACA, financial assistance is provided to limit the share of income a consumer must spend on premiums for the benchmark second-lowest silver plan (grey line). For example, the ACA caps premiums for a consumer earning 300% of FPL to 9.78% of income.

California's new state subsidies offer new help to two groups (blue line):

1) Many consumers below 400% of FPL see their required contribution reduced (for example, the consumer at 300% of FPL will receive a state credit to reduce the share of income spent on premiums from 9.78% to 8.90% of income.

2) For consumers from 400 to 600% of FPL, which saw no financial protection under the ACA, new state caps limit premiums to the percentages shown in Figure 3, so that a consumer at 450% of FPL spends no more than 14% of their income on premiums.

STATE SUBSIDY PROGRAM METRICS

- With the enrollment experience from 2020, we estimate that if maintained through 2022, this program design would have a cumulative cost of $938 million.
- Note that we still anticipate enrollment growth in the 400 to 600% FPL group that are receiving state subsidies for 2021.

Total Program Cost Over 3 Year

2020	$217M
2021	$349M
2022	$372M
Grand Total	$938M

Key Program Metrics for 2021

	2021
State Subsidy $ (aggregate)	$349M
State Subsidy $ (% of spend to over 400 FPL)	72%
Enrollees	1,502,271
Enrollees between 400 and 600% FPL	98,984
Enrollees Receiving State Subsidy (400 to 600% FPL)	57,720
Share of Enrollees in 400 to 600% FPL Receiving >$0	45%
State Subsidy $ (avg PMPM) - receiving only	$47
State Subsidy $ (avg PMPM, 400-600% receiving only)	$362
State Subsidy $ (avg PMPM, 200-400% receiving only)	$14

Reinsurance Background

State Reinsurance Program (SRP) History

- The individual market faced significant premium increases in 2016-2018 (>18% each year) and declining enrollment.
- In 2018, the General Assembly passed, and the Governor signed:
  - HB 1795 to establish the SRP and require MHBE to apply for a State Innovation Waiver under section 1332 of the ACA to receive federal funds to defray the cost of the program
  - SB 387 to place a 2.75% assessment on carriers to recoup the aggregate amount of the health insurance provider fee that was previously assessed under Section 9010 of the ACA. The Tax Cuts and Jobs Act of 2017 waived this fee for 2018.
- MHBE applied for a 1332 waiver to implement a reinsurance program to reduce premiums by approximately 30% compared to what they would be absent the waiver. CMS approved the application in August 2018.
- In 2019, HB 258/SB 239 was passed to assess a 1% fee to fund the SRP from 2020-2023. In 2020, the U.S. Congress enacted the Further Consolidated Appropriations Act, which repealed the 9010 fee for calendar years beginning after December 31, 2020.

SB 124 – Background and Reinsurance Implications

- SB 124 / HB 196 initially directed the MHBE Board to “allocate the funds collected under this section between the state reinsurance program and the state–based health insurance subsidies program in a manner that maximizes the long–term affordability of health plans in the individual market.”
- SB 124 was modified to instead require MHBE submit a report, due 12/1, on the potential design, impact, and implementation of a state subsidy program. Among other items, SB 124 requires MHBE to comment on the following in the report:
  - Estimate of the impact that funding for State-based individual market subsidies will have on the availability of funds for reinsurance in the individual market, using actual State liability for the State Reinsurance Program for the 2019 benefit year
  - Appropriate allocation of available funding for reinsurance and State-based individual market subsidies that will maximize enrollment and affordability in the individual market

MD 1332 Waiver Terms & Conditions – Key Provisions

- **Legislation Authorizing and Appropriating Funds to the reinsurance program**. The MHBE must ensure sufficient funds, on an annual or other appropriate basis, for the reinsurance program to operate as described in the MHBE's waiver application.
- **Pass-through Funding**. The MHBE will be entitled to funding based on the amount of premium tax credits that would have been provided to individuals in the State of Maryland absent the waiver, but that will not be provided under the waiver.
- The MHBE agrees to use the full amount of pass-through funding for purposes of implementing the MHBE's plan as approved by the Departments, including implementing the reinsurance program for 2019 and future years.
- To the extent pass-through funding exceeds the amount necessary for program, remaining funds must be carried forward and used for purposes of implementing the MHBE's plan under the waiver, such as making reinsurance payments in the next calendar year.

SRP Parameters, 2019-2021

State regulations require the MHBE Board to:

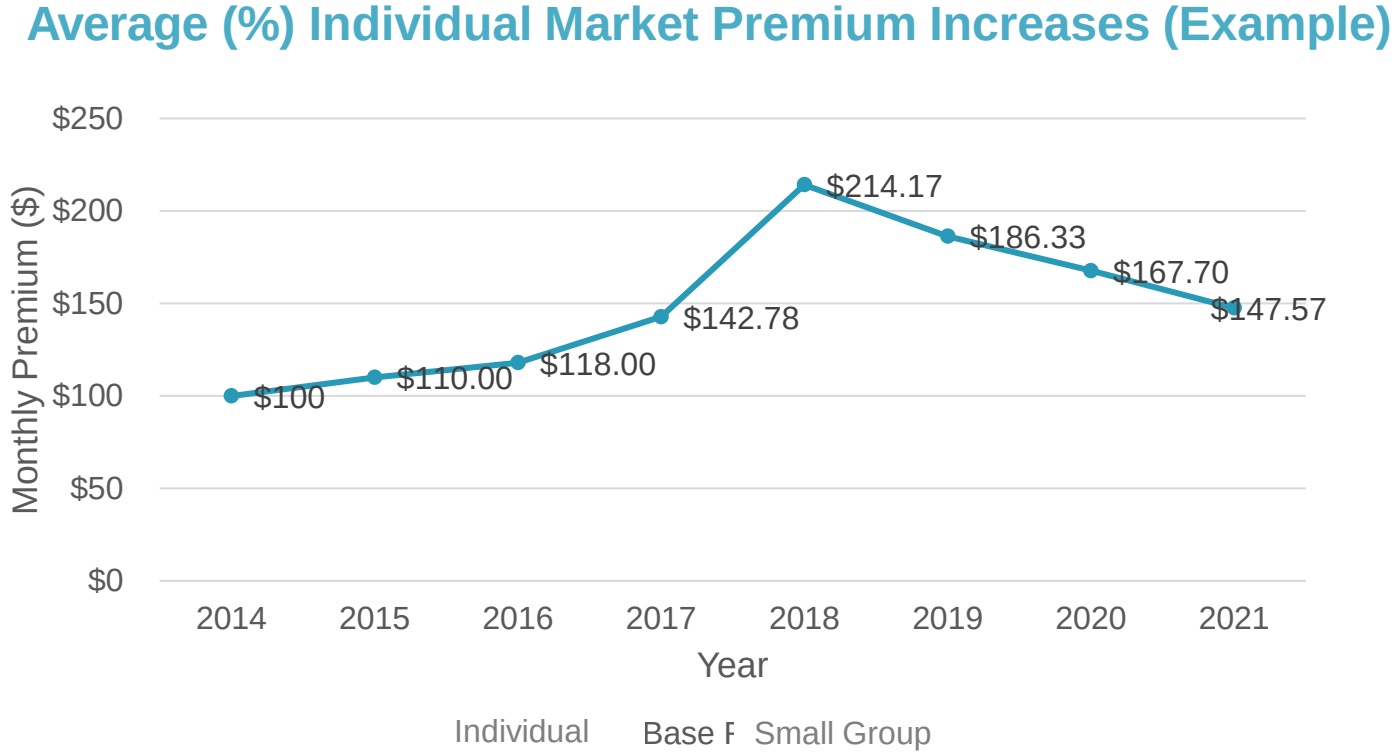
- set estimated state reinsurance program parameters by April 1 of the calendar year proceeding the applicable plan year, and
- finalize parameters by December 31 of the calendar year proceeding the applicable plan year

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

The SRP Has Successfully Reduced Premiums

2021 premiums have decreased more than 30% compared to 2018 premiums, returning average rates to below 2018 levels.

Plan Year	Individual Premium Change
2014	n/a
2015	10%
2016	18%
2017	21%
2018	50%*
2019	-13%
2020	-10%
2021	-12%



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

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2019 Reinsurance Results – Program Cost

- The total cost of the 2019 reinsurance program was about $353M, about $17M below projections
- The federal pass-through funding received for 2019 will be sufficient to cover the full cost of the program for that year
- Per the terms of the waiver, any unspent federal funding must be rolled forward to be used for the reinsurance program in future years

	Spring 2018 Projection (Wakely)	Fall 2019 Projection (L&E)	2019 Actuals
Total Cost	$462M	$370M	$353M
Federal Funding	$304M	$373M	$373M

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

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

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

SRP Spending and Funding Details, 2019

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

Affordability in Healthcare and Framework for Evaluating Subsidy Design

Defining Affordability: No Accepted Standard[1]

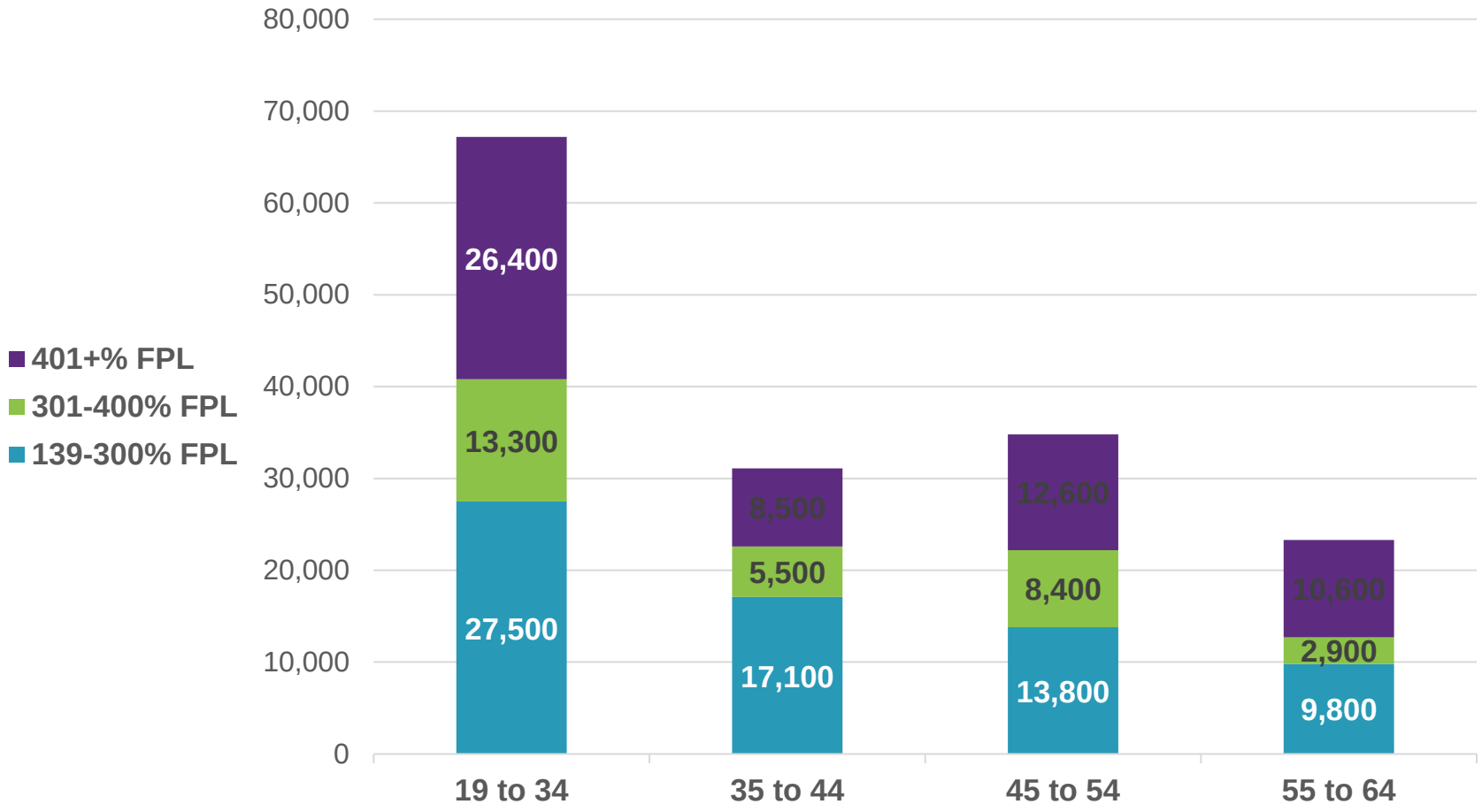
- There is no widely accepted standard for affordability in healthcare.
- In one study, 18 experts could not reach consensus on how to factor in deductibles, children, debt, savings, and many other considerations in order to judge whether health coverage was affordable in different situation. The median affordability cutoff for insurance, in these experts' opinions, was slightly lower than ACA standards.[2]
- In a study of 6,000 people, respondents felt that households could afford to spend about 5% of income on health insurance, regardless of income.[3]

Defining Affordability: Approaches[1]

Approaches to thinking about affordability include:

- Budget-based definition: A household can afford to pay for health insurance if it would be left with enough income to meet its other minimum needs.
  - Connecticut is working to develop an affordability standard using this approach
  - Requires defining and measuring minimum needs
- Behavioral definition: If most people at a certain income level buy insurance, then it is affordable.
  - If 51% of people purchase coverage, does it mean that coverage is affordable for everyone at that income level, regardless of other circumstances?

Distribution of uninsured, Maryland adults with incomes too high for expanded Medicaid coverage, limited to citizens and lawfully present non-citizens, by age and income as a percentage of FPL: 2018



Source: Analysis by NCCI of 2018 data from the American Community Survey. PUMS USA, University of Minnesota, www.ipums.org. Note: ACS data do not include immigration status. These estimates impute immigration status based very generally on previous Urban Institute results.

Defining Affordability: ACA Standards

ACA standards (2021):

- Employer-sponsored insurance is considered affordable if the employee contribution for individual coverage is no more than 9.83% of household income
- Limits out-of-pocket costs (not including premiums) to $8,550 per individual and $17,100 per family for covered services
- Sets reduced premiums for individuals earning less than 400% of the federal poverty level

Defining Affordability: Federal and State Required Contribution Schedules

- Under the ACA, individuals ear… …L are required to contribute a percentage of their income to… …premium (second lowest cost silver plan) and federal tax credits a… …b…d contribution and the full premi…
- The federal required contribut… …0%
- California, Massachusetts, an… …re… required contribution at certain in… …vels.

CA eliminates costs for people below 138% FPL, slightly reduces costs for people 200-400% FPL, and adds caps for 400-600% FPL

…costs for …w 300% …e required … ranging … 7.4% of …me

VT reduces the req'd contribution by 1.5% for people below 300% FPL

Household income as percent of FPL	APTC Required Contributions		CA Req'd Contributions		MA Req'd Contributions	VT Req'd Contributions	
	Initial percentage	Final percentage	Initial percentage	Final percentage	Percentage	Initial percentage	Final percentage
< 138%	2.07%	2.07%	0.00%	0.00%	0.00%		
138% to <150%	3.10%	4.14%	same as ACA	same as ACA	0.00%	1.60%	2.64%
150% to <200%	4.14%	6.52%	same as ACA	same as ACA	2.90-4.30%	2.64%	5.02%
200% to <250%	6.52%	8.33%	6.24%	7.80%	4.20-6.20%	5.02%	6.83%
250% to <300%	8.33%	9.83%	7.80%	8.90%	5.00-7.40%	6.83%	8.33%
300% to 400%	9.83%	9.83%	8.90%	9.68%	same as ACA	same as ACA	same as ACA
400% to 450%	n/a	n/a	9.68%	14.00%	n/a	n/a	n/a
450% to 500%	n/a	n/a	14.00%	16.00%	n/a	n/a	n/a
500% to 600%	n/a	n/a	16.00%	18.00%	n/a	n/a	n/a

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Frameworks for Evaluating Subsidy Design: Affordability and Equity

1. Achievement of an affordability standard
   - Difficult because there are no clear benchmarks for affordability

2. Equitable distribution of costs and subsidies
   - Harmonize subsidy schedule so that similarly situated people are expected to pay similar costs.
   - Subsidy cliffs and steep subsidy curves can mean that a small increase in income can result in large increases in costs.
   - 3:1 age rating results in young adults subsidizing costs for older adults

Frameworks for Evaluating Subsidy Design: Total Cost and Reduction in Average Costs

3. Total cost relative to potential funding
   - Considerations:
     - State fee yielded about $327M in 2019, projected to yield about $110-$120M per year 2020-2023
     - State ability to meet its commitment to support the reinsurance program at a 30% reduction in premiums compared to the “without reinsurance” scenario
     - Possibility that state subsidy could be more or less effective at increasing enrollment than projected (higher or lower state cost)

4. Reduction in average costs
   - Does the subsidy improve the average morbidity of the risk pool, resulting in lower average costs for all enrollees?

Frameworks for Evaluating Subsidy Design: Change in Uninsured & Efficiency at Bringing in Targeted Enrollees

3. Effectiveness at reducing the uninsured rate in the target population

Baseline Scenario (SRP only)	2021 % enrolled of eligible
Ages 18-34	43%
400-600% FPL	53%

5. Percentage of subsidy recipients who will be new enrollees
   - The number of new enrollees that each subsidy brings into the individual market relative to the total number of people who will receive the subsidy

6. Cost per new enrollee
   - Divide the number of new enrollees by the total cost of the subsidy to calculate the “cost per new enrollee”

Discussion

- Would you suggest other ways of thinking about evaluating subsidy designs?

- Of the ways that we've discussed, which do you consider most important?

Citations

- [1] Slides 14 and 15 adapted from Weiner, Janet. (2020). Setting Standards for Affordable Health Care. *University of Pennsylvania, Leonard Davis Institute of Health Economics and United States of Care Issue Briefs*. Retrieved from https://repository.upenn.edu/ldi_issuebriefs/144
- [2] Muennig, P., Sampat, B., Tilipman, N., Brown, L.D., & Glied, S.A. (2011). We All Want It, But We Don't Know What It Is: Toward a Standard of Affordability for Health Insurance Premiums. *Journal of Health Politics, Policy and Law*, 36(5), 829-53.
- [3] Glied, S.A. & Muennig, P. (2018). Reforming Reform: Public Assessments of the Affordability of Health Insurance Policies. *SocArXiv Papers*. Retrieved from https://osf.io/preprints/socarxiv/8g4n6/

Remaining Meetings

Tentative Agenda for Remaining Meetings

Date	Agenda
Oct 19	Massachusetts State Subsidy Design
	L&E report – review and discuss
Oct 26	L&E report – continue discussion
	L&E report – vote on recommended subsidy designs
	Priorities/considerations for subsidy implementation (if time allows)
Nov 2	Discussion of potential implementation approaches and considerations
Nov 9	Discussion of potential implementation approaches and considerations
	Vote on recommendations related to implementation approaches and considerations

Public Comment