Individual Subsidy Work Group Report
Recommendations regarding a state-based subsidy program in Maryland

MHBE Policy and Plan Management
November 16, 2020

Background

During the 2020 session, the General Assembly passed Senate Bill 124, Maryland Health Benefit Exchange – Assessment Applicability and State–Based Individual Market Health Insurance Subsidies, which requires the Maryland Health Benefit Exchange (MHBE) to submit a report to the Senate Finance Committee and the House Health and Government Operations Committee on the potential design, implementation, and effects of establishing State-based individual market health insurance subsidies in Maryland, as well as an analysis of the appropriate allocation of available funding between subsidies and reinsurance.

MHBE worked with Lewis & Ellis Actuarial Consultants (Lewis & Ellis), in consultation with the Maryland Insurance Administration (MIA), to model the design and impact of potential state subsidies on the reinsurance program and two target populations identified by the Affordability Work Group – young adults, and individuals at 400%-600% of the federal poverty level (FPL). Lewis & Ellis produced a report detailing their evaluation, which MHBE published for public comment.

To garner additional feedback from stakeholders on the proposed subsidy designs, MHBE formed a work group. The work group met virtually, from October 7-November 12, 2020 on a weekly basis. The agenda, presentations, and minutes for each work group meeting are available on the MHBE website at: https://www.marylandhbe.com/policy-legislation/work-groups/individual-subsidy-work-group/

Individual Subsidy Work Group Membership

The work group consisted of 11 stakeholders, including two carriers participating in the Individual marketplace, consumer advocates, representatives from the provider community, and an insurance broker. To provide additional subject matter expertise, MHBE sought additional support from the MIA.

Table 1. Individual Subsidy Work Group Members

Name	Organization
Salliann Alborn	Maryland Community Health System
Kenneth Brannan*	Maryland Special Olympics
Matthew Celentano	League of Life and Health Insurers of Maryland
Jay Hutchins	Planned Parenthood of Maryland
Stephanie Klapper	Maryland Citizens' Health Initiative
Jon Levine	Viking Benefit Solutions
Allison Mangiaracino	Kaiser Permanente

Robert Metz	CareFirst
Joshua Morris	HealthCare Access Maryland
Jacqueline Roche	Independent consumer advocate
Beth Sammis*	Independent consumer advocate
Additional Staff	
Name	**Organization**
Bradley Boban	Maryland Insurance Administration

*Co-Chairs of the Work Group

Summary of Work Group Discussions – Background Topics

A. Uninsured Population in Maryland

The work group received background information on the status of the individual marketplace and the State Reinsurance Program (SRP), which is authorized under a federal section 1332 State Innovation Waiver, to assist in contextualizing the target population of a state-based subsidy design. Prior to the implementation of the SRP, premiums in the individual market were skyrocketing and membership was falling. In particular, enrollees who earned too much to be eligible for federal subsidies were struggling with affordability issues.

The SRP succeeded in stabilizing the individual market. As of the end of open enrollment for 2020, Maryland's total individual market enrollment – including plans obtained off-exchange directly from carriers – was 215,484, up 1% from a year earlier.

As shown in Figure 1, young adults (18-34) remain the largest cohort of the insured, accounting for approximately 43% (67,000 individuals).[1] The majority of uninsured young adults have annual incomes less than 400% of the federal poverty level (FPL).

One common explanation for the high percentage of uninsured young adults is that this group is more price-sensitive when considering health insurance because they are healthy "young invincibles". During workgroup discussions, the rating rules were identified as an important impediment to a higher take-up rate for young adults, and it was noted that the reinsurance program does not reduce premiums for lower and middle income young adults.

Under the Affordable Care Act (ACA), the difference between the highest and lowest premium based on age can be no greater than 3:1. Prior to the ACA, it was not uncommon to see premium differences based on age of 10:1. This means young adults are heavily subsidizing older adults, paying much more for health insurance than their contribution to claims costs. The workgroup identified this as an inequity in the individual market that a state subsidy program should address.

While the SRP has significantly lowered rates – by 30% since 2018 – it only reduces net premiums for individuals who do not receive APTC and has no impact on net premiums for those who receive APTC. The workgroup identified this as another inequity in the current individual market that a state subsidy program should address.

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[1] Analysis by the Families USA National Center for Coverage Innovation 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.

Figure 1. Distribution of Uninsured Maryland Adults by Age and Income as a Percentage of FPL, 2018
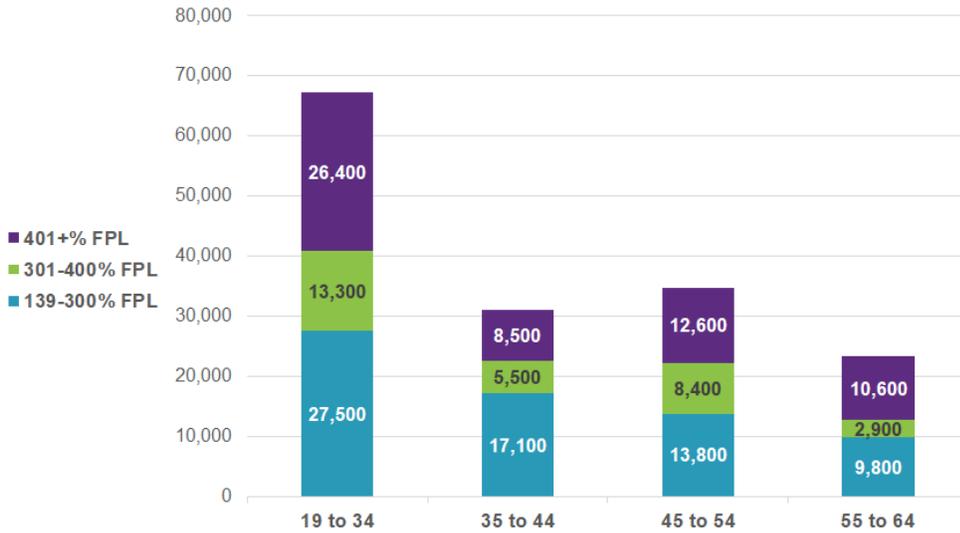

Figure 2 shows the number of uninsured by race and ethnicity. Of uninsured young adults 18-34 in the state of Maryland, over 40% are African American (36,682),[2] a community that historically has dealt with fewer opportunities for economic mobility and fewer chances to build generational wealth. The work group identified this as the final inequity in the current individual market that a state subsidy program should address. The work group expressed particular concern about this inequity as COVID-19 has exacerbated existing health disparities.

Figure 2. Uninsured, Lawfully Present Young Adults in Maryland by Race/Ethnicity, 2018

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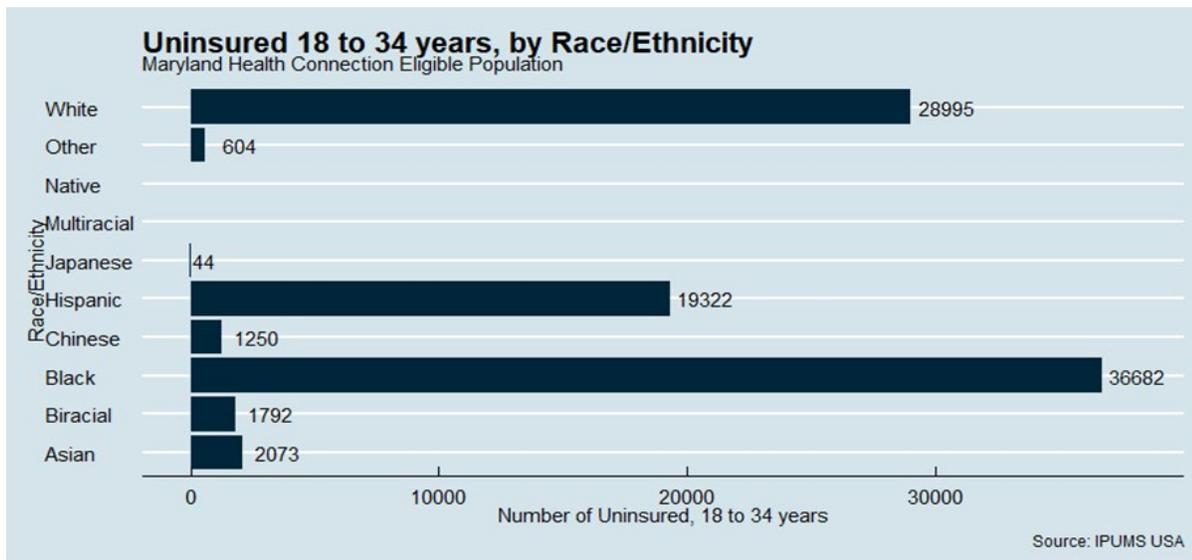
[2] MHBE analysis of 2018 American Community Survey Microdata from IPUMS (usa.ipums.org), all FPL levels.

B. State Reinsurance Program

The work group was informed that federal pass-through funding for the SRP has been sufficient to cover the total cost of the program in 2019. Federal funds are also projected to be sufficient to cover the cost of the program through 2023, the duration of the period for which the SRP currently has federal approval. Table 2 presents cost and funding information for the reinsurance program through 2023.

During the 2019 session, the health insurance provider fee was implemented under House Bill 258/Senate Bill 239 – Health Insurance – Individual Market Stabilization – Provider Fee, after the U.S. Congress repealed the 9010 fee for calendar years beginning after December 31, 2020. The health insurance provider fee provides state funding to support the reinsurance program. Because federal funding is projected to exceed the cost of the reinsurance program, this leaves state funds raised by the health insurance provider fee available for other market stabilization initiatives, such as a state-based subsidy program. Some work group members representing health insurance carriers noted that they would like to have an additional public discussion of reducing this fee to lower premiums for all insured Marylanders by 1% and/or of changing the SRP program parameters. Carriers noted that SB 124 requested input on the appropriate allocation of funding between subsidies and reinsurance. Other work group members suggested such an analysis was outside the scope of work, emphasizing that the state has an unique opportunity to use this funding to further decrease the number of uninsured Marylanders (thereby further stabilizing the individual market) and the inequities identified in the previous section that impact take-up rates in the individual market without destabilizing any other insurance markets. The members ultimately decided to continue discussions for how best to design a state subsidy program under the assumption that the SRP program parameters and state and federal funding would stay as currently designed/projected. The workgroup did not undertake an analysis of the appropriate allocation of funding between subsidies and reinsurance.

Table 2. Actual and Projected Cost, Funding, and Impact of the Reinsurance Program, 2019-2023

	2019 Act.	2020 Est.	2021 Est.	2022 Est.	2023 Est.
Reinsurance Cost	$352,798,597	$377,828,828	$416,782,404	$447,975,589	$478,434,269
Federal Funding	$373,395,635	$447,277,359	$567,748,703	$628,614,048	$684,842,457
State Funding	**$326,889,258**	**$118,517,416**	**$112,591,545**	**$118,896,671**	**$125,554,885**

C. Individual Market State Subsidies in Other States

The group heard from two states with established subsidy programs, Massachusetts and California, to compare program designs, target populations, impact on improving the uninsured rate, and funding sources.

California implemented a three-year state premium subsidy and in conjunction, a state mandate penalty. The new state subsidy follows the framework set by the ACA and provided more support to those consumers who earn under 400% of FPL, and new support to between 400% and 600% of FPL.

In Massachusetts, individuals are eligible for the state subsidy program, known as ConnectorCare, if they meet the same eligibility criteria required by the ACA to receive Marketplace coverage and subsidies, but only if their incomes are below 300% FPL.

The group compared and discussed both state programs, agreeing that both programs seemed complex from a consumer perspective as well as an operational perspective. It was also noted that neither state had a reinsurance program, and therefore neither design is exactly relevant when considering how best to design a state subsidy program for Maryland to address the three specific inequities in our individual health insurance market.

Summary of Work Group Discussions - Lewis and Ellis Report

A. Initial Lewis & Ellis Modeling

Lewis and Ellis modeled four potential subsidy designs targeted at young adults, and three potential designs targeted at households at 400-600% FPL for the work group to review.

As previously shown in Figure 1, young adults remain the largest uninsured cohort in the State. In addition, under the Affordable Care Act (ACA), young adults subsidize the premiums of older adults due to the 3:1 premium age curve. Lewis and Ellis modeled subsidy designs that attempt to mitigate these issues with four different approaches:

1. Age Adjustment Subsidy Enhancement (AASE)
2. Advancing Youth Enrollment Act (AYEA)
3. AASE Cliffless to 34 (AASE 34)
4. AASE Cliffless to 47 (AASE 47)

These scenarios would be applicable to 18 to 34-year-olds (the last approach applies to 18 to 47-year-olds) below 400% FPL.

In addition, Lewis and Ellis was asked to model subsidy programs to target individuals whose incomes make them ineligible for federal premium subsidies under the ACA. Federal subsidies cap the maximum premium cost of a benchmark health insurance plan at about 10% of income for households below 400% FPL, but individuals above that threshold must pay the full cost. This leads to a scenario in which some individuals who are only slightly above 400% FPL must pay a substantially higher percentage of their income than those earning slightly less who are eligible for federal subsidies, as shown in Table 3. This primarily impacts middle-income older adults and can result in a substantial burden.

Table 3. Illustrative Comparison of Net Premiums under Current Reinsurance Program (No Subsidy), Highlighting the Net Premium (NP) Change at the "Subsidy Cliff"

Contract Type	FPL Range	Age Band				
		18-25	26-34	35-44	45-54	55-64
Individual	300-400%	$3,060	$3,540	$4,030	$4,440	$4,440
	400-600%	$3,060	$3,540	$4,030	$5,520	$8,300
	NP Change	0%	0%	0%	24%	87%
2 Person	300-400%	$6,000	$6,000	$6,000	$6,000	$6,000
	400-600%	$6,130	$7,070	$8,050	$11,040	$16,600
	NP Change	2%	18%	34%	84%	177%
Family	300-400%	$8,530	$8,530	$8,530	$8,530	$8,530
	400-600%	$11,340	$13,090	$14,900	$20,420	30,700
	NP Change	33%	53%	75%	139%	260%

Lewis and Ellis modeled 3 different approaches to reducing the cost burden for households at 400-600% FPL:
1. 400%+ FPL Subsidy Extension 9.78%[1] (FFSE 9.78%)
2. 400%+ FPL Subsidy Extension 12.5% (FFSE 12.5%)
3. 400%+ FPL Subsidy Extension 15% (FFSE 15%)

These subsidy designs would be available to all age groups.

To fully understand the impact of the subsidy designs, Lewis and Ellis collected and used data from the MHBE, insurers, and the Centers for Medicare and Medicaid Services regarding enrollment levels, the uninsured population, and individual market morbidity levels by age and income. They then analyzed the impact (reduction) on net premiums for each proposed subsidy structure and modeled the increase in enrollment due to the subsidies. Once the increased enrollment and expected morbidity were modeled, the claims from these additional enrollees were input into the SRP model to calculate the impact on the program and the cost of the subsidies, as well as potential federal pass-through funding due to federal savings resulting from improved morbidity (See Appendix Table 1.) To receive federal pass-through savings, Maryland would need federal approval of a new section 1332 waiver, or approval of amendments to the current waiver.

When observing the results of the modeling, the work group noted that, of the four young adult subsidies, the AASE is projected to increase enrollment for young adults the most, followed by the AASE 47, AYEA, and AASE 34. Out of the subsidy designs targeted at 400%-600% FPL, only the FFSE 9.87% was only expected to increase enrollment by a significant percentage (up to 8,900 individuals) by 2024. Projected increases in 2024 enrollment under each of the subsidy designs in shown in Table 4.

Table 4. Comparison of 2024 Enrollment

Scenario	AASE	AYEA	AASE 34	AASE 47	FFSE 9.78%	FFSE 12.5%	FFSE 15%
2024 Increase in Enrollment	15,900	5,400	500	9,300	8,900	3,900	2,300
2024 Baseline Subsidy-Eligible Enrollment	31,300	31,300	31,300	49,000	62,700	62,700	62,700

The work group members also noted that the AASE would also have the lowest cost per new member, while bringing in the largest projected number of new members, as shown in Table 5.

Table 5. Efficiency of Subsidies using 2022 Projected Cost and Enrollment

Subsidy	Cost	New Members	Cost per New Member
AASE	$43,336,496	9,535	$4,545
AYEA	$16,124,993	3,250	$4,962
AASE 34	$5,603,824	296	$18,942
AASE 47	$26,727,083	5,572	$4,797
FFSE 9.78%	$52,430,263	5,333	$9,832
FFSE 12.5%	$22,279,648	2,337	$9,531
FFSE 15%	$12,350,820	1,388	$8,897

The work group generally agreed that subsidies targeted at young adults seemed to be the most beneficial option in terms of targeting individuals who would most improve the risk pool, bringing in the most uninsured, and being the most cost effective. However, the work group did express concern for individuals in the 400-600% FPL range, noting that there is a lack of equity inherent in the lack of federal premium subsidies for individuals over 400% that can result in individuals in this FPL range, particularly older individuals, facing significant premium affordability issues.

Although older individuals in this FPL range are a smaller group of the uninsured, that does not necessarily mean that they do not struggle to pay premiums; rather, due to their age and health risks, they may feel obligated to maintain insurance coverage.

B. Additional Modeling Request

A number of members of the group agreed that the AASE modeling option seemed to be the most attractive as measured by risk pool improvement, increased enrollment, and cost effectiveness, but concern was raised regarding the fact that the model had a cliff that would result in a sharp jump in premiums for individuals turning 35. The work group requested additional modeling to try to achieve an impact on the scale of the AASE, but without the cliff. MHBE consulted with MIA, and requested that Lewis & Ellis model four additional young adult subsidy designs:

Additional Request 1: A variation of AASE with no cliff. Model:
1) AASE formula through age 30, then linear interpolation from 31 through 35.
2) AASE formula through age 35, then linear interpolation from 36 to 40.

Additional Request 2: A variation midway between the AASE and AYEA
3) AASE formula with a new +1% term to shift the curve up, with the linear interpolation between 31 and 35 to have a grade-off instead of a cliff
4) AYEA formula altered to by -3.5% from the federal contribution.

Lewis & Ellis's results for all subsidy designs, including the four additional subsidy designs, are presented in Appendix Table 2.

After seeing the additional modeling results, the group was generally pleased with the way the new AASE LI-40 increased the number of new enrollees and reduced the morbidity impact to premiums even more than the original AASE. The new modeling also addressed the group's concerns related to the "subsidy cliff" and easing consumers into increased costs.

Some members of the work group were additionally concerned about the AASE LI-40's projected cost, since federal pass through, if approved by the federal government, would only cover a portion of the cost. However, MHBE staff noted that the way the modeling was done shows the pass-through estimates at a conservative level and they may be higher than predicted (again, assuming federal approval to recoup federal savings as pass-through funding).

Subsidy Design Evaluation and Recommendations

A. Subsidy Design Evaluation

When considering the designs, the work group determined that it would take into consideration the following framework:

Table 6. Framework for Evaluating Subsidy Designs

1. Equity	Equitable distribution of costs and subsidies
2. Effectiveness	A. Effectiveness at reducing the uninsured rate in the target population
	B. Percentage of subsidy recipients who will be new enrollees
	C. Cost per new enrollee
3. Total Cost	Total cost relative to potential funding
4. Impact on Risk Pool	Reduction in average costs for all enrollees due to improved morbidity
5. Affordability	An overarching goal of establishing a state subsidy should be to improve health insurance affordability

B. Work Group Recommendations

By the end of the work group meetings, a general consensus emerged for a state subsidy program to reduce inequities in the individual market based on age, income and race and ethnicity as both feasible and desirable particularly given the current circumstances of the COVID-19 pandemic under the assumption that the existing SRP surplus will continue to exist. Without access to affordable health insurance, many Marylanders may forego needed care to treat the short and long-term health effects of contracting COVID-19 as well as the indirect mental health effects of the pandemic. As a result, the work group respectfully submits the following recommendations for a state subsidy program for the General Assembly's and the MHBE's consideration:[3]

Recommendations	Vote
MHBE use the considerations listed in the framework when evaluating subsidy design	Yes: 10 No: 0
MHBE target subsidies at young adults, with subsidies phasing out to age 40	Yes: 10 No: 0
MHBE target subsidies at young adults up to 400%	Yes: 10 No: 0
Of the subsidy designs the group was presented with, the AASE LI-40 best met the framework goals	Yes: 8 No: 0 Abstained: 2
MHBE later explore a subsidy targeting those 400-600% FPL	Yes: 10 No: 0
MHBE later explore including young adults with FPL 400-600% in the subsidy design	Yes: 10 No: 0
When considering the effectiveness of the subsidy program, MHBE evaluate how well the program reduces racial inequities	Yes: 10 No: 0

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[3] One work group member was absent on the day the group considered recommendations. Two carrier representatives abstained from voting on the recommendation "Of the subsidy designs the group was presented with, the AASE L1-40 best met the framework goals" noting they needed additional time to evaluate this design.

Appendix

Work Group Member Comments on Draft Report

Section	Comment	Response
"During workgroup discussions, the rating rules were identified as an important impediment to a higher take-up rate for young adults, and it was noted that the reinsurance program does not reduce premiums for lower and middle income young adults."	"The term "middle income" is subjective – recommend being more specific" (*suggested replacing idle income with "less than 300% FPL"*)	There are circumstances where reinsurance may not help people at 300-400% FPL, so vaguer language was retained in the report.
"Some members of the work group were additionally concerned about the AASE LI-40's projected cost, since federal pass through, if approved by the federal government, would only cover a portion of the cost. However, MHBE staff noted that the way the modeling was done shows the pass-through estimates at a conservative level and they may be higher than predicted (again, assuming federal approval to recoup federal savings as pass-through funding)."	"I agree concern was raised about the total cost, but I think this section is confusing. Is this referring to pass-through for a subsidy program? If so, I think we need to introduce that concept in the report and explain no other state has yet applied for such a waiver so CMS has not opined on the pass-through amounts. More importantly, there would be implications for the existing 1332 reinsurance waiver, which need to be considered relative to the pass-through. L&E has estimated a $12M pass-through in 2022 compared to $628M in Federal funding for reinsurance in 2022. Given that the workgroup did not consider or discuss these complexities, I would recommend deleting this section."	This section is referring to potential federal pass-through for a subsidy program. To provide additional context in the report, information regarding potential pass-through, which was discussed with the workgroup as an aspect of Lewis & Ellis's modeling, was added to page 6 of the report.

Table 1. Lewis and Ellis Modeling Methodology for Proposed Subsidy Design

Step	Step detail
1. Setting a baseline for 2019 and 2020 enrollment	Collected and used data from the MHBE, participating insurers, and CMS regarding enrollment levels, the uninsured population, and individual market morbidity levels by age and income
2. Understanding the impact of subsidies on net premiums	Analyzed the impact (reduction) on net premiums for each proposed subsidy structure
3. Estimating the uptake in enrollment	Modeled the increase in enrollment due to the presence of the subsidies • Uptake assumption was based on a regression analysis of eligible market insured rates compared to the net premium as a percentage of income • Enrollment changes were phased in over a three-year period (similar to the 2014-2016 enrollment experience of the individual market).
4. Understanding the impact on reinsurance payments	Claims from these additional enrollees flowed through the previous State Reinsurance Program model to calculate the impact to the SRP
5. Calculating the subsidies needed and premium tax credit changes	Estimated the cost of the subsidies and changes to the premium tax credits paid by the federal government resulting from increases in enrollment

Table 2. Full Results of Lewis and Ellis Modeling

		A	B	C	D	E	F	G	H	I	J	K
Scenario	Age	2021 % enrolled of eligible	2024 % enrolled of eligible	2024 Increase in Enrollment	2024 Gross Premium PCPY	2024 Net Premium PCPY	2024 State Subsidy PCPY	2024 Cost	2022 Possible Federal Pass-Through	2022 Change in Morbidity – Impact to Premiums (all)	% Subsidy Recipients who are New Enrollees by 2024	2024 Cost per New Member
Reinsurance	18-34	43%	43%	-	$5,003	$2,283	$0	-	-	-	-	-
Subsidies for Young Adults under 400% FPL												
AASE	18-34	43%	60%	15,900	$4,887	$963	$1,607	$53M	$10M	-2.7%	34%	$3,322
AYEA	18-34		49%	5,400	$4,992	$1,691	$642	$18M	$2M	-1.0%	15%	$3,316
AASE 34	18-34		43%	500	$4,995	$2,056	$243	$6M	$400K	-0.1%	2%	$12,054
AASE 47	18-47	43%	50%	9,300	$5,438	$1,758	$706	$30M	$5M	-1.6%	16%	$3,271
Subsidies for Individuals 400-600% FPL												
FFSE 9.78%	18-64		60%	8,900	$7,383	$5,926	$1,457	$69M	$10M	-0.5%	15%	$7,708
FFSE 12.5%	18-64	53%	56%	3,900	$7,307	$6,575	$732	$32M	$4M	-0.2%	7%	$8,318
FFSE 15%	18-64		55%	2,300	$7,227	$6,827	$400	$17M	$3M	-0.1%	4%	$7,459
Variation of original AASE with no cliff (LI = linear interpolation)												
AASE 30; LI to 35	18-34	43%	58%	14,400	$4,915	$1,177	$1,384	$44M	$9M	-2.5%	32%	$3,066
AASE; LI to 40	18-39	43%	58%	20,900	$5,255	$1,244	$1,326	$64M	$12M	-3.5%	30%	$3,066
Variation between the original AASE and AYEA (LI = linear interpolation)												
AASE +1%; LI to 35	18-34	43%	55%	11,700	$4,937	$1,474	$1,080	$32M	$8M	-2.0%	27%	$2,786
AYEA -3.5%	18-34	43%	52%	8,900	$4,988	$1,459	$928	$27M	$4M	-1.6%	22%	$3,078