MARYLAND HEALTH BENEFIT EXCHANGE

Maryland 1332 State Innovation Waiver Amendment Request

Prepared by the Maryland Health Benefit Exchange
July 15, 2024

Contents

Section 1: Description of Request

A. Background

The State of Maryland, through the Maryland Health Benefit Exchange (MHBE) requests approval to amend its Waiver under Section 1332 of the Patient Protection and Affordable Care Act ("section 1332 waiver") from the Centers for Medicare and Medicaid Services (CMS) in the Department of Health and Human Services, and the Department of the Treasury ("the Departments").

Maryland currently has an approved section 1332 waiver that waives section 1312(c)(1) of the Affordable Care Act (ACA) to facilitate Maryland's State Reinsurance Program. The original waiver period was five years, beginning January 1, 2019 and ending December 31, 2023. On March 30, 2023, Maryland applied to extend its section 1332 waiver for an additional five-year period, through December 31, 2028. The Departments approved the extension request on June 28, 2023. See Appendix A for the extension application and approval letter.

During its 2024 Legislative session, the Maryland General Assembly passed the Access to Care Act (SB705/HB728), directing MHBE to apply for a waiver amendment to allow all Maryland residents to enroll in private plans on-Exchange, regardless of immigration status. See Appendix B for the bill text.

In a letter to the Departments submitted May 3, 2024, MHBE expressed its intent to submit an application seeking approval of a section 1332 waiver amendment that would waive section 1312(f)(3)[1] of the Affordable Care Act (ACA) to the extent it would otherwise prohibit enrollment of residents in Qualified Health Plans (QHPs or "private plans") and Qualified Dental Plans through MHBE, thereby allowing all qualified Maryland residents to enroll in private plans on-Exchange, regardless of immigration status. The Departments confirmed on June 4, 2024 that the application would be reviewed as a waiver amendment application.

MHBE requests to waive section 1312(f)(3) for the period January 1, 2026 through December 21, 2028, consistent with the currently approved term of Maryland's existing 1332 waiver. MHBE anticipates launching the new eligibility rules by November 1, 2025 for enrollment in 2026 plans. The waiver amendment is expected to meet all statutory guardrails.

B. Rationale for the Waiver Amendment Request

In the last ten years, Maryland's uninsured rate has fallen in half and stands at about six percent. 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

[1] https://housedocs.house.gov/energycommerce/ppacacon.pdf (page 101)

Program which has reduced individual market premiums by more than 20 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 or unemployment claim, and instituting state-funded premium assistance for young adults.

Despite Maryland's efforts to reduce the uninsured rate, an estimated 112,400 Marylanders are uninsured and ineligible for on-Exchange coverage due to immigration status. This comprises about 30 percent of Maryland's uninsured population.[2] Allowing these residents to enroll in private plans on-Exchange through this waiver amendment is an important next step towards reducing Maryland's uninsured rate and could have net positive impacts, including improving the overall health of the State's population and decreasing the cost of uncompensated care. In fiscal year 2021 Maryland hospitals provided over $780 million in uncompensated care, with some hospitals paying upward of 10 percent of their total allocated budget towards uncompensated care.[3]

Currently, individuals ineligible to enroll on-Exchange due to their immigration status are able to purchase full-price health plans off-Exchange. If MHBE's request to waive section 1312(f)(3) of the ACA is approved, these individuals would be able to enroll in full-price private plans on-Exchange. Although the Access to Care Act does not allocate state funds to subsidize the cost of coverage for these individuals, allowing enrollment regardless of immigration status could promote health equity by enabling access to many other benefits available through the Exchange.

First, the Exchange offers a simplified shopping experience that allows consumers to compare plans from all individual market insurers in one place. Consumers can easily compare plan costs, check if plans include their providers and prescription drugs, and use tools available to estimate total health care costs in order to help find the right plan tailored to their needs.

The Exchange also provides extensive consumer support through its Call Center, which provides consumer support 6 days a week in more than 200 languages, and in-person assistance through the Navigator Program and authorized brokers.

Lastly, allowing enrollment regardless of immigration status would allow mixed-status families to enroll in the same plan through the Exchange, which would provide continuity of coverage and care coordination, save families money by allowing individuals in the family to share a single plan deductible and out-of-pocket maximum, and reduce the burden of managing multiple plans.

C. Provision(s) of the Law that the State Seeks to Waive

MHBE seeks to waive Section 1312(f)(3) of the ACA (42 USC §18032 (f)(3)). This section prohibits persons that are not United States citizens, United States nationals, or aliens lawfully present in the United State from being deemed a qualified individual for the purpose of

[2]Source: MHBE analysis of American Community Survey data
[3] Health Services Cost Review Commission (HSCRC): Rate Year 2023 Uncompensated Care Report (June 2022).

qualifying for coverage in a qualified health plan offered on the exchange. MHBE is seeking a complete waiver of this subsection in order to deem any individual, regardless of immigration status, a qualified individual for the purpose of enrolling in a Qualified Health Plan (QHP) or Qualified Dental Plan (QDP), offered through Maryland Health Connection. Through this waiver, MHBE intends that 45 CFR §155.305 (a)(1) would not be used as an eligibility requirement for enrollment in a QHP or QDP through Maryland Health Connection. The other requirements of 45 CFR §155.305 (a) would apply to eligibility determinations.

Section 2: Public Notice and Comment Process

MHBE held a 30-day public comment period, from June 10, 2024 to July 9, 2024, following posting of a draft of this application to the MHBE website on June 10, 2024. MHBE held two public hearings on the amendment request, on June 18, 2024 and July 3, 2024. The dates, times, and locations of the public hearings were published on the MHBE website on May 10, 2024. The public was directed to submit comments to mhbe.publiccomments@maryland.gov.

During each public hearing, MHBE staff presented background on Maryland's 1332 Waiver including context about the State Reinsurance Program before presenting each section of the draft amendment request application and finally a timeline of the amendment request process. Then the public was invited to make comments. The presentation and minutes from the meetings can be found in Appendix D and E, respectively.

Seven commenters, representing ten different organizations (some commenters represented more than one organization), commented in support of the amendment request during public hearings. The represented organizations were Maryland Health Care for All, Maryland Community Health System, Maryland Assembly of School-Based Health Centers, the American College of Nurse Midwives, the Maryland Academy of Physician Assistants, Maryland Occupational Therapy Association, Maryland Dental Action Coalition, NAACP of Maryland, CASA, and Catholic Charities of Baltimore. Transcriptions of these oral comments can be found in Appendix E: Public Hearing Minutes.

MHBE received fifteen written comments in support of the amendment request, from La Clínica del Pueblo, ACLU of Maryland, Maryland Health Care for All, American Cancer Society Cancer Action Network, Maryland Academy of Physician Assistants, Jews United for Justice, American College of Nurse Midwives, Maryland Dental Action Coalition, Maryland Occupational Therapy Association, CareFirst BlueCross BlueShield, CASA, American Lung Association and partner organizations and three members of the public. These comments can be found in Appendix F: Public Comments.

MHBE did not receive any oral or written comments in opposition to the amendment request.

Section 3: Evidence of Sufficient Authority Under State Law

During the 2018 legislative session, the Maryland General Assembly passed House Bill 1795 – Establishment of a State Reinsurance Program (HB 1795), which was signed into law by then-Governor Larry Hogan, on April 5, 2018. HB 1795 was an emergency measure that directed the Maryland Health Benefit Exchange to submit a Section 1332 State Innovation Waiver to HHS and the Treasury to establish a State Reinsurance Program.

During its 2024 Legislative session, the Maryland General Assembly passed the Access to Care Act (SB705/HB728), which was then signed into law by Governor Wes Moore on May 16, 2024.[4] The Access to Care Act directs MHBE to apply for an amendment to Maryland's existing 1332 waiver to allow all Maryland residents to enroll in private plans on-Exchange, regardless of immigration status.

In addition to various clarifying technical amendments to the MD Insurance Code, the Access to Care Act adds two sections to the MD Insurance Code:

- § 31–123, to direct MHBE to submit a state innovation waiver application amendment under § 1332 of the ACA to establish a Qualified Resident Enrollment Program; and
- § 31–124, to direct MHBE to implement a Qualified Resident Enrollment Program to facilitate the enrollment of qualified residents in qualified plans, contingent on approval from the Departments of a Section 1332 waiver amendment.

[4] https://mgaleg.maryland.gov/mgawebsite/Legislation/Details/sb0705

Section 4: Implementation Plan

December 2024	Receive approval of 1332 waiver amendment request
March - August 2025	Design and finalize system changes - March: Exchange begins designing system changes - Summer 2025: Finalize system updates and complete testing in advance of fall OE activities, to support waiver implementation for OE 2026
November 2025	OE 2026 begins; waiver population eligible to purchase QHPs
January 2026	OE ends Jan 15; QHP coverage begins for waiver population

Section 5: Impact on Section 1332 Guardrails

Please see Appendix C for the actuarial analysis demonstrating that the amended waiver would continue to meet the statutory guardrails.

A. Comprehensiveness

This request does not include any changes to Essential Health Benefits (EHBs) and so benefit coverage under the amended waiver will be as comprehensive as it would be without the amended waiver.

B. Affordability

The actuarial analysis shows that the waiver amendment would not change enrollees' out-of-pocket costs or raise premiums, therefore satisfying the affordability requirement. Based on limited claims data, research on the demographics and healthcare spending of individuals who are otherwise eligible for QHPs but for their immigration status, and other states' experiences, the amended waiver is expected to immaterially reduce overall premiums.

C. Coverage

The amended waiver will not impact the coverage of individuals who would be eligible regardless of whether the waiver amendment is in place, and therefore any new enrollments due to the waiver will lead to an increase in coverage, satisfying the coverage requirement.

D. Federal Deficit

Because the amended waiver is expected to lower overall premiums, the federal APTC liability would be reduced, lowering the federal deficit and meeting the requirement.

Section 6: Estimated Impact on Passthrough Funding

MHBE's actuarial consultants project that the impact of the waiver amendment on market morbidity is expected to reduce overall premiums immaterially. Research indicates that the population who would be eligible for QHP but for their immigration status are healthier and spend less on health care than the general population, controlling for age and other factors. Further, the population in Maryland who would be eligible for QHP but for their immigration status is younger than the population in the state's individual market overall. The actuarial analysis anticipates only a limited impact from anti-selection and pent-up demand due to the prior availability of off-Exchange plans for the population who would be eligible for QHP but for their immigration status. Based on these factors, premiums are expected to reduce immaterially. Although lower premiums reduce the federal APTC liability, MHBE is not requesting federal passthrough funding as a result of this waiver amendment.

Please see the actuarial analysis in Appendix C for a detailed analysis.

Although the state does not currently project a material decrease on individual market premiums attributable to the newly enrolled OEI population that would yield additional PTC savings, the state will continue to assess the amended state waiver plan's (reinsurance program and on-Exchange OEI population) impact on the market during the waiver amendment period. Additionally, the state requests that if the Departments determine that pass-through funding is warranted based on the Departments' analysis of data gathered from the state's reporting and more detailed data requested thereafter, pass-through funding reporting for this amended provision would begin. If this determination is made, starting with the relevant plan year and for each plan year thereafter during the waiver period, by September 15 of the preceding year or once a state has finalized rates for the applicable plan year, whichever is later, the state will provide information that the Departments deem necessary to precisely calculate the state's pass-through funding, and the Departments will specify in Maryland's Specific Terms and Conditions (STCs) the conditions applicable to the state's use of such funding.

Appendix A: Maryland's 1332 Waiver Amendment Request Letter of Intent and Response Letter

MARYLAND HEALTH BENEFIT EXCHANGE

750 E. Pratt St., 6th floor
Baltimore, MD 21202
marylandhbe.com

May 3, 2024

The Honorable Xavier Becerra, Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, D.C., 20201

The Honorable Janet Yellen, Secretary
U.S. Department of the Treasury
1500 Pennsylvania Avenue, NW
Washington, D.C., 20220

Dear Secretary Becerra and Secretary Yellen,

The State of Maryland, through the Maryland Health Benefit Exchange (MHBE), intends to submit an application for an amendment to its Waiver under Section 1332 of the Patient Protection and Affordable Care Act ("section 1332 waiver") to the Centers for Medicare and Medicaid Services (CMS) in the Department of Health and Human Services, and the Department of the Treasury ("the Departments") on July 15, 2024. Through this application, MHBE will seek to waive section 1312(f)(3) of the Affordable Care Act (ACA) to the extent it would otherwise prohibit enrollment of residents in Qualified Health Plans (QHPs or "private plans") and Qualified Dental Plans through MHBE, thereby allowing all qualified Maryland residents to enroll in private plans on-Exchange, regardless of immigration status. MHBE intends to request to waive section 1312(f)(3) for the period January 1, 2026 through December 21, 2028.

Maryland currently has an approved section 1332 waiver that waives section 1312(c)(1) of the Affordable Care Act (ACA) to facilitate Maryland's State Reinsurance Program. The original waiver period was five years, beginning January 1, 2019 and ending December 31, 2023. On March 30, 2023, Maryland applied to extend its section 1332 waiver for an additional five-year period, through December 31, 2028. The Departments approved the extension request on June 28, 2023.

During its 2024 Legislative session, the Maryland General Assembly passed the Access to Care Act (SB705/HB728), directing MHBE to apply for a waiver amendment to allow all Maryland residents to enroll in private plans on-Exchange, regardless of immigration status.

An estimated 112,400 Marylanders are uninsured and ineligible for coverage due to immigration status. This comprises about 30% of Maryland's uninsured population.[1] Currently, individuals

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

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ineligible to enroll on-Exchange due to their immigration status are able to purchase full-price health plans off-Exchange. If the waiver amendment is approved, these individuals would be able to enroll in full-price private plans on-Exchange. Although the Access to Care Act does not allocate funds to subsidize the cost of coverage for these individuals, allowing enrollment regardless of immigration status would enable access to many other benefits available through the Exchange, including:

- A simplified shopping experience that allows consumers to compare plans from all individual market insurers in one place. Consumers can easily compare plan costs, check if plans include their providers and prescription drugs, and use tools available to estimate total health care costs in order to help find the right plan tailored to their needs;
- Extensive consumer support through our Call Center, which provides consumer support 6 days a week in more than 200 languages, and in-person assistance through the Navigator Program and authorized brokers;
- The ability for mixed-status families to enroll in the same plan through the Exchange, which would provide continuity of coverage and care coordination, save families money by allowing individuals in the family to share a single plan deductible and out-of-pocket maximum, and reduce the burden of managing multiple plans.

MHBE does not anticipate requesting additional federal pass-through funding as a result of this amendment.

If the waiver amendment is approved, MHBE anticipates the new eligibility rules to be effective by the start of Open Enrollment for Plan Year 2026 coverage (by November 1, 2025). MHBE's desired timeline for the application process is as follows:

6/3/2024:	The Departments respond to letter of intent.
6/10/2024:	Application published on MHBE website; 30-day state public comment period; MHBE to hold two public hearings between 6/10/2024 - 7/9/2024.
7/9/2024:	Public comment period ends.
7/15/2024:	MHBE submits waiver amendment application to the Departments.
8/29/2024:	The Departments determine that the application is complete**.** 30-day Federal public comment period begins.
9/30/2024:	30-day Federal public comment period ends.
12/31/2024:	The Departments approve the waiver amendment.
11/1/2025:	Open Enrollment for Plan Year 2026 begins.
1/1/2026:	Coverage begins for Plan Year 2026; qualified residents eligible to enroll in QHPs on-Exchange, regardless of immigration status.

These dates are subject to change if substantial revisions to the draft application are required in response to the Departments' response to this LOI or in response to public comment. MHBE acknowledges that the Departments may take up to 180 days to approve a waiver amendment

MARYLAND HEALTH BENEFIT EXCHANGE

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request but is prepared to work closely with the Departments so that the request, if possible, might be reviewed and approved more quickly, ideally by the end of 2024.

Thank you for your consideration. MHBE looks forward to working with the Departments through the waiver amendment process.

Sincerely,

Michele Eberle
Executive Director

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Consumer Information and Insurance Oversight
200 Independence Avenue SW
Washington, DC 20201

June 4, 2024

VIA ELECTRONIC MAIL: michele.eberle@maryland.gov
Michele Eberle
Executive Director
Maryland Health Benefit Exchange
750 E. Pratt St., 6th Floor
Baltimore, MD 21202

Dear Director Eberle:

Thank you for your May 3, 2024, letter of intent (LOI) to apply for an amendment to Maryland's State Innovation Waiver (section 1332 waiver) under Section 1332 of the Affordable Care Act (ACA). I am sending this letter from the Center for Consumer Information and Insurance Oversight (CCIIO) within the Centers for Medicare & Medicaid Services (CMS) under the Department of Health and Human Services (HHS), as well as on behalf of the Department of the Treasury (collectively, the Departments).

The Departments acknowledge that the state informed the Departments of the state's intent to apply for an amendment to the waiver at least fifteen months prior to the waiver amendment's proposed implementation date. The Departments confirm that the state's anticipated section 1332 waiver amendment application, as described below, may be submitted and will be reviewed as a waiver amendment request. The requirements for the state's waiver amendment application are enclosed with this letter. If the amendment is approved, the Departments may determine that the waiver amendment will be subject to additional or revised requirements, which will be provided in the amendment specific terms and conditions (STCs).

The state's currently approved waiver extension of the ACA requirement for the single risk pool contained in ACA section 1312(c)(1) allows the state to operate a state-based reinsurance program for the individual health insurance market from January 1, 2024, through December 31, 2028. As described in the May 3, 2024, LOI, the state seeks to amend its currently approved section 1332 waiver extension to also waive section 1312(f)(3) of the ACA to the extent it would otherwise prohibit enrollment of residents in Qualified Health Plans and Qualified Dental Plans through the Maryland Health Benefit Exchange (MHBE), thereby allowing all qualified Maryland residents to enroll in such plans on-Exchange, regardless of immigration status, from plan years 2026 through 2028.

A waiver amendment is a change to the existing waiver plan that is not otherwise allowable under the state's STCs, or that the Departments determine could impact any of the section 1332 statutory guardrails or program design for an approved waiver. Such changes include, but are not

limited to, changes to eligibility, coverage, benefits, premiums, out-of-pocket spending, and cost sharing. Given that the state will need to waive an additional statutory provision(s) in order to implement its proposed change in eligibility, the Departments have determined that this is a substantive change in program design and is not otherwise allowable under the state's existing STCs. As such, the Departments confirm that the state may proceed with submitting an application for a waiver amendment if the state wishes to pursue making this change.

The enclosed document further outlines the application requirements for the state's waiver amendment. The state is encouraged to engage with the Departments, as the required information and process may vary based on the complexity of the proposed change. Once the Departments receive the state's waiver amendment application, the Departments will conduct a preliminary review to determine if the application is complete and, if necessary, will identify the elements that are missing from the application by written notice. Please note, the state is not authorized to implement any aspect of the proposed waiver amendment without written approval by the Departments. This letter does not constitute any pre-determination or intent to approve the state's proposed amendment application.

Please send your acknowledgement of this letter and any communications and questions regarding program matters or official correspondence concerning the waiver to stateinnovationwaivers@cms.hhs.gov.

We look forward to working with you and your staff. Please do not hesitate to contact us if you have any questions.

Sincerely,

Jeff Wu
Acting Director, Center for Consumer Information & Insurance Oversight (CCIIO)
Centers for Medicare & Medicaid Services (CMS)

CC: Aviva Aron-Dine, Acting Assistant Secretary, Tax Policy, U.S. Department of the Treasury
The Honorable Wes Moore, Governor, State of Maryland
Kathleen A. Birrane, Commissioner, Maryland Insurance Administration
Johanna Fabian-Marks, Director, Policy and Plan Management, MHBE
Tony Armiger, Chief Financial Officer, MHBE

Enclosure

Specific Requirements for Maryland's Waiver Amendment Application

The Departments will review Maryland's waiver amendment application and make a preliminary determination as to whether it is complete within 45 days after it is submitted to stateinnovationwaivers@cms.hhs.gov. After determining that the application is complete, the application will be made public through the HHS website, and a 30-day federal public comment period will commence while the application is under review. A final decision regarding the waiver will be issued no later than 180 days after the preliminary determination of a complete application. If the Departments determine that the application is not complete, the Departments will send the state a written notice of the elements missing from the application. The state's waiver amendment application must include the following:

(1) A detailed description of the amendment request, including:
   a. The desired time period for the amendment request;
   b. A description of the changes to the waiver plan, including whether the state seeks to waive any new provisions and the rationale for the waiver;
   c. The impact on the guardrails;
   d. An updated implementation timeline;
   e. Any activities at the state level that are outside of the waiver, but that impact the baseline; and
   f. Sufficient supporting documentation.

(2) An explanation and evidence that the state has conducted the state public notice process specified for new applications at 31 C.F.R. § 33.112 and 45 C.F.R. § 155.1312, which includes:
   a. For a state with one or more Federally-recognized Indian tribes within its borders, providing a separate process for meaningful consultation with such tribes, and providing written evidence of the state's compliance with this requirement;
   b. Publicly posting the submitted LOI on the state's website in order to ensure that the public is aware that the state is contemplating a waiver amendment request;
   c. Providing a public notice and comment period of no less than 30 days that includes a comprehensive description of the waiver amendment application; information about where the application is available for public review; and where the written comments may be submitted;
   d. Publishing the date, time, and location of the public hearings that will be convened by the state to seek public input on the waiver amendment application in a prominent location on the state's public website. The state may use its annual public forum for the dual purpose of seeking public input on a waiver amendment application;
   e. Providing a description of issues raised and comments received during the entire public notice and comment period, and how the state considered comments when developing the waiver amendment application; and

f. Publicly posting the waiver amendment application on the state's website upon its submission of the waiver amendment application to the Departments.

(3) Evidence of sufficient authority under state law(s) in order to meet the ACA section 1332(b)(2)(A) requirement for purposes of pursuing the requested amendment(s);

(4) An updated actuarial and/or economic analysis demonstrating how the proposed amended waiver will meet section 1332 statutory guardrails. Such analysis must separately identify, in the "with-waiver" scenario, the impact of the requested amendment on the statutory guardrails. Such analysis must include a "with-waiver" and "without-waiver" status on both a summary and detailed level through the proposed approval period using data from recent experience, as well as a summary of and detailed projections of the change in the "with-waiver" scenario attributable to the waiver amendment;

a. For all waiver proposals, the state should use a baseline in which there is no state waiver plan in effect, and should compare premiums, comprehensiveness, and coverage under the baseline for each year to those projected under both the currently approved waiver and the proposed, amended waiver (to allow the Departments to separately evaluate the impact of the amendment on the existing 'with-waiver' scenario). For waivers that impact the individual market, data used to produce these projections might include overall premiums (e.g., for analysis of affordability) and Second Lowest Cost Silver Plan (SLCSP) premiums (e.g., for analysis of deficit neutrality).

i. A projection of the following items separately under the 'without-waiver' scenario, the currently approved 'with-waiver' scenario, and the amended 'with-waiver' scenario:[1]

A. Number of non-group market enrollees by income as a share of the Federal Poverty Level (FPL) (0% to 99%, ≥100% to ≤150%, >150% to ≤200%, >200% to ≤250%, >250% to ≤300%, >300% to ≤400%, and greater than 400% of FPL),[2] by PTC-eligibility, and by metal level. For those projected to newly enroll in Exchange coverage under the waiver, please also provide the number of enrollees by without-waiver coverage type (uninsured, employer-sponsored, other non-group, etc.);

[1] Specifically, the without-waiver scenario refers to the baseline, the currently approved with-waiver scenario refers to the reinsurance-only scenario, and the amended with-waiver scenario refers to a combined reinsurance and amendment scenario.

[2] To the extent different income cuts are more appropriate in the context of a specific waiver, the state may use those income cuts instead.

B. Overall average non-group market premium rate (i.e., total individual market premiums divided by total member months of all enrollees);

C. SLCSP rate for a representative consumer (e.g., a 21-year old nonsmoker), by rating area and issuer-specific service area. The state needs to identify where issuers have service areas that are smaller than rating areas;

D. The state's age rating curve (or a statement that the federal default is used); and

E. Aggregate non-group market premiums and PTC.

ii. Documentation of all assumptions and methodology used to develop the projections and growth of health care spending.

(5) An explanation of the expected impact, if any, of the proposed amendment on pass-through funding, as well as any new proposed uses for pass-through funding; and

(6) The Departments may request additional information and/or analysis in order to evaluate and reach a decision on the proposed amendment.

Appendix B: Maryland Senate Bill 705/House Bill 728 (Access to Care Act)

Chapter 841

(Senate Bill 705)

AN ACT concerning

Health Insurance – Qualified Resident Enrollment Program
(Access to Care Act)

FOR the purpose of requiring the Maryland Health Benefit Exchange to establish and implement the Qualified Resident Enrollment Program to facilitate the enrollment of qualified residents in qualified plans; providing that the operation and administration of the Program may include functions delegated by the Maryland Exchange to a third party; providing that the implementation of the Program is contingent on approval of a certain waiver application amendment; and generally relating to the Qualified Resident Enrollment Program.

BY repealing and reenacting, without amendments,
Article – Insurance
Section 31–101(a) and 31–108(a)
Annotated Code of Maryland
(2017 Replacement Volume and 2023 Supplement)

BY adding to
Article – Insurance
Section 31–101(u–1), 31–123, and 31–124
Annotated Code of Maryland
(2017 Replacement Volume and 2023 Supplement)

BY repealing and reenacting, with amendments,
Article – Insurance
Section 31–107, 31–108(b)(1), and 31–115(b)(7)
Annotated Code of Maryland
(2017 Replacement Volume and 2023 Supplement)

SECTION 1. BE IT ENACTED BY THE GENERAL ASSEMBLY OF MARYLAND, That the Laws of Maryland read as follows:

Article – Insurance

31–101.

(a) In this subtitle the following words have the meanings indicated.

(U–1) "QUALIFIED RESIDENT" MEANS AN INDIVIDUAL, INCLUDING A MINOR, REGARDLESS OF IMMIGRATION STATUS, WHO AT THE TIME OF ENROLLMENT:

(1) IS SEEKING TO ENROLL IN A QUALIFIED PLAN OFFERED TO INDIVIDUALS THROUGH THE EXCHANGE;

(2) RESIDES IN THE STATE;

(3) IS NOT INCARCERATED, OTHER THAN INCARCERATION PENDING DISPOSITION OF CHARGES; AND

(4) IS NOT ELIGIBLE FOR THE FEDERAL PREMIUM TAX CREDIT, THE MARYLAND MEDICAL ASSISTANCE PROGRAM, MEDICARE, THE MARYLAND CHILDREN'S HEALTH PLAN, OR EMPLOYER–SPONSORED MINIMUM ESSENTIAL COVERAGE.

31–107.

(a) There is a Maryland Health Benefit Exchange Fund.

(b) (1) The purpose of the Fund is to:

(i) provide funding for the operation and administration of the Exchange in carrying out the purposes of the Exchange under this subtitle;

(ii) provide funding for the establishment and operation of the State Reinsurance Program authorized under this subtitle;

(iii) provide funding for the Medical Assistance Program and the Senior Prescription Drug Assistance Program;

(iv) provide funding for the establishment and operation of Health Equity Resource Communities under Title 20, Subtitle 14 of the Health – General Article; and

(v) provide funding for the establishment and operation of the State–Based Young Adult Health Insurance Subsidies Pilot Program authorized under this subtitle.

(2) The operation and administration of the Exchange, the State Reinsurance Program, **[**and**]** the State–Based Young Adult Health Insurance Subsidies Pilot Program**, AND THE QUALIFIED RESIDENT ENROLLMENT PROGRAM** may include functions delegated by the Exchange to a third party under law or by contract.

(c) The Exchange shall administer the Fund.

(d) (1) The Fund is a special, nonlapsing fund that is not subject to § 7–302 of the State Finance and Procurement Article.

(2) The State Treasurer shall hold the Fund separately, and the Comptroller shall account for the Fund.

(e) The Fund consists of:

(1) any user fees or other assessments collected by the Exchange;

(2) all revenue deposited into the Fund that is received from the distribution of the premium tax under § 6–103.2 of this article;

(3) income from investments made on behalf of the Fund;

(4) interest on deposits or investments of money in the Fund;

(5) money collected by the Board as a result of legal or other actions taken by the Board on behalf of the Exchange or the Fund;

(6) money donated to the Fund;

(7) money awarded to the Fund through grants;

(8) any pass–through funds received from the federal government under a waiver approved under § 1332 of the Affordable Care Act;

(9) any funds designated by the federal government to provide reinsurance to carriers that offer individual health benefit plans in the State;

(10) any funds designated by the State to provide reinsurance to carriers that offer individual health benefit plans in the State;

(11) any funds designated by the State to provide State–based health insurance subsidies to young adults in the State;

(12) any federal funds received in accordance with § 31–121 of this subtitle for the administration of small business tax credits; and

(13) any other money from any other source accepted for the benefit of the Fund.

(f) (1) The Fund may be used only:

(i) 1. for the operation and administration of the Exchange in carrying out the purposes authorized under this subtitle;

2. for the establishment and operation of the State Reinsurance Program; and

3. for appropriations to the Health Equity Resource Community Reserve Fund under § 20–1407 of the Health – General Article;

(ii) in fiscal years 2021 and 2022, for the Medical Assistance Program within the Medical Care Programs Administration of the Maryland Department of Health;

(iii) in fiscal year 2022, for the Senior Prescription Drug Assistance Program established under Title 15, Subtitle 10 of the Health – General Article; and

(iv) for the establishment and operation of the State–Based Young Adult Health Insurance Subsidies Pilot Program.

(2) In each of fiscal years 2023 through 2025, the Governor shall:

(i) transfer $15,000,000 to the Health Equity Resource Community Reserve Fund; and

(ii) include the funds transferred in accordance with item (i) of this paragraph in the annual budget bill as an appropriation to the Health Equity Resource Community Reserve Fund under § 20–1407 of the Health – General Article.

(g) (1) The Board shall maintain separate accounts within the Fund for Exchange operations, for the State Reinsurance Program, and for the State–Based Young Adult Health Insurance Subsidies Pilot Program.

(2) Accounts within the Fund shall contain the money that is intended to support the purpose for which each account is designated.

(3) Funds received from the distribution of the premium tax under § 6–103.2 of this article shall be placed in the account for Exchange operations and may be used only for the purpose of funding the operation and administration of the Exchange.

(4) The following funds may be used only for the purposes of funding the State Reinsurance Program:

(i) any pass–through funds received from the federal government under a waiver approved under § 1332 of the Affordable Care Act to provide reinsurance to carriers that offer individual health benefit plans in the State;

(ii) any funds designated by the federal government to provide reinsurance to carriers that offer individual health benefit plans in the State;

(iii) any funds designated by the State to provide reinsurance to carriers that offer individual health benefit plans in the State; and

(iv) except as provided in subsection (f) of this section, funds received from the distribution of the assessment under § 6–102.1 of this article.

(h) (1) Expenditures from the Fund for the purposes authorized by this subtitle may be made only:

(i) with an appropriation from the Fund approved by the General Assembly in the State budget; or

(ii) by the budget amendment procedure provided for in Title 7, Subtitle 2 of the State Finance and Procurement Article.

(2) Notwithstanding § 7–304 of the State Finance and Procurement Article, if the amount of the distribution from the premium tax under § 6–103.2 of this article exceeds in any State fiscal year the actual expenditures incurred for the operation and administration of the Exchange, funds in the Exchange operations account from the premium tax that remain unspent at the end of the State fiscal year shall revert to the General Fund of the State.

(3) If operating expenses of the Exchange may be charged to either State or non–State fund sources, the non–State funds shall be charged before State funds are charged.

(i) (1) The State Treasurer shall invest the money of the Fund in the same manner as other State money may be invested.

(2) Any investment earnings of the Fund shall be credited to the Fund.

(3) Except as provided in subsection (h)(2) of this section, no part of the Fund may revert or be credited to the General Fund or any special fund of the State.

(j) A debt or an obligation of the Fund is not a debt of the State or a pledge of credit of the State.

31–108.

(a) On or before January 1, 2014, the functions and operations of the Exchange shall include at a minimum all functions required by § 1311(d)(4) of the Affordable Care Act.

(b) In compliance with § 1311(d)(4) of the Affordable Care Act, the Exchange shall:

(1) make qualified plans available to qualified individuals**, QUALIFIED RESIDENTS,** and qualified employers;

31–115.

(b) To be certified as a qualified health plan, a health benefit plan shall:

(7) be in the interest of qualified individuals**, QUALIFIED RESIDENTS,** and qualified employers, as determined by the Exchange;

31–123.

(A) ON OR BEFORE JULY 1, 2025, THE EXCHANGE, IN CONSULTATION WITH THE COMMISSIONER AND AS APPROVED BY THE BOARD, SHALL SUBMIT A STATE INNOVATION WAIVER APPLICATION AMENDMENT UNDER § 1332 OF THE AFFORDABLE CARE ACT TO ESTABLISH A QUALIFIED RESIDENT ENROLLMENT PROGRAM AND, IF AVAILABLE, SEEK FEDERAL PASS–THROUGH FUNDING RESULTING FROM THE IMPLEMENTATION OF A QUALIFIED RESIDENT ENROLLMENT PROGRAM.

(B) ON OR BEFORE DECEMBER 31, 2025, THE COMMISSIONER MAY WAIVE ANY NOTIFICATION OR OTHER REQUIREMENTS THAT APPLY TO A CARRIER UNDER THIS ARTICLE IN CALENDAR YEAR 2025 DUE TO THE IMPLEMENTATION OF A WAIVER APPROVED UNDER § 1332 OF THE AFFORDABLE CARE ACT.

31–124.

(A) THE EXCHANGE, IN CONSULTATION WITH THE COMMISSIONER AND AS APPROVED BY THE BOARD, SHALL ESTABLISH AND IMPLEMENT A QUALIFIED RESIDENT ENROLLMENT PROGRAM:

(1) TO FACILITATE THE ENROLLMENT OF QUALIFIED RESIDENTS IN QUALIFIED PLANS;

(2) THAT, AS NECESSARY, MEETS THE REQUIREMENTS OF A WAIVER APPROVED UNDER § 1332 OF THE AFFORDABLE CARE ACT; AND

(3) THAT IS CONSISTENT WITH FEDERAL AND STATE LAW.

(B) THE QUALIFIED RESIDENT ENROLLMENT PROGRAM SHALL ~~BE DESIGNED TO MAKE INDIVIDUAL MARKET INSURANCE COVERAGE OFFERED THROUGH THE EXCHANGE AVAILABLE TO QUALIFIED RESIDENTS~~ ALLOW QUALIFIED RESIDENTS TO PURCHASE QUALIFIED PLANS ON THE INDIVIDUAL EXCHANGE.

(C) (1) THE IMPLEMENTATION OF THE QUALIFIED RESIDENT ENROLLMENT PROGRAM SHALL BE CONTINGENT ON APPROVAL FROM THE U.S. SECRETARY OF HEALTH AND HUMAN SERVICES AND THE U.S. SECRETARY OF THE TREASURY OF A STATE INNOVATION WAIVER APPLICATION AMENDMENT UNDER § 1332 OF THE AFFORDABLE CARE ACT.

(2) WITHIN 6 MONTHS BEFORE A FISCAL YEAR IN WHICH THE EXCHANGE IMPLEMENTS THE QUALIFIED RESIDENT ENROLLMENT PROGRAM, THE EXCHANGE SHALL SUBMIT A REPORT TO THE GENERAL ASSEMBLY, IN ACCORDANCE WITH § 2–1257 OF THE STATE GOVERNMENT ARTICLE, ON ITS PLAN TO IMPLEMENT THE PROGRAM, INCLUDING:

(I) THE AMOUNT AND SOURCE OF THE FUNDING FOR THE PROGRAM;

(II) THE PARAMETERS OF THE PROGRAM;

(III) THE NUMBER OF INDIVIDUALS ANTICIPATED TO ~~BE ASSISTED THROUGH~~ PARTICIPATE IN THE PROGRAM; ~~AND~~

(IV) THE AMOUNT OF PREMIUMS ANTICIPATED TO BE PAID BY PARTICIPANTS UNDER THE PROGRAM; AND

~~(IV)~~ (V) IF THE ~~EXCHANGE IS AUTHORIZED TO PROVIDE SUBSIDIES~~ GENERAL ASSEMBLY AUTHORIZES FUNDING TO SUBSIDIZE PREMIUMS UNDER THE PROGRAM, THE PARAMETERS OF THE SUBSIDIES.

(D) ON OR BEFORE JANUARY 1, 2026, THE EXCHANGE SHALL ADOPT REGULATIONS TO CARRY OUT THIS SECTION.

SECTION 2. AND BE IT FURTHER ENACTED, That this Act shall take effect October 1, 2024.

Approved by the Governor, May 16, 2024.

Appendix C: Actuarial Analysis

LEWIS & ELLIS
Actuaries and Consultants

Actuarial and Economic Analysis for Maryland's 1332 Waiver Amendment

MARYLAND HEALTH BENEFIT EXCHANGE

STATE OF MARYLAND

JOSH HAMMERQUIST, FSA, MAAA
Vice President & Principal

JASON DOHERTY, ASA, MAAA
Consulting Actuary

DAVE DILLON, FSA, MAAA, MS
Senior Vice President & Principal

Submitted on:
August 13, 2024

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INTRODUCTION

The State of Maryland is submitting a Section 1332 Waiver amendment application ("Amendment") to allow individuals who are otherwise eligible for Qualified Health Plans (QHPs) except for their immigration status (otherwise eligible individuals ("OEI")) to enroll in Individual market QHPs on the state's exchange. The goal of the Amendment is to improve health coverage and outcomes for those with limited access to care. The Amendment is expected to be implemented for the 2026 policy year.

Lewis and Ellis, LLC (L&E) has prepared this report for the Maryland Health Benefit Exchange ("MHBE"), the Maryland Insurance Administration ("MIA"), and the Department of Health and Human Services ("HHS") to meet the requirements of 45 CFR 155.1308(f)(4)(i)-(iii) and to analyze the impact of the Amendment.

Under current federal law, OEI are not allowed to enroll in Individual health insurance offered on an exchange. As a result, OEI without employer-sponsored insurance often have no other source of health coverage. In 2021, there were approximately 113,000 uninsured OEI in Maryland. The Amendment would allow these individuals access to unsubsidized QHP coverage on the state's marketplace.

Pursuant to federal law, Section 1332 waivers must comply with four requirements:

- Provide coverage that is at least as comprehensive as the coverage provided without the waiver.
- Provide coverage and cost-sharing protections against excessive out-of-pocket spending that are at least as affordable as without the waiver.
- Provide coverage to at least a comparable number of residents as without the waiver.
- Not increase the federal deficit[1].

Maryland's current waiver and the Amendment are both expected to meet the four compliance requirements.

The Amendment's implementation is expected to improve market morbidity and lower market premiums, albeit immaterially. At the time of this report, no federal pass-through is being requested as part of the Amendment, however, the state will monitor the Amendment's impact and may do so in the future if analysis shows it is warranted.

[1]https://www.cms.gov/cciio/programs-and-initiatives/state-innovation-waivers/section_1332_state_innovation_waivers-

WAIVER ANALYSIS

The following sections detail the processes for ensuring compliance with the four Section 1332 Waiver requirements, along with a comprehensive actuarial and economic analysis.

At the time of this report, there is uncertainty if the enhanced APTC subsidies introduced by the American Rescue Plan Act and extended by the Inflation Reduction Act will be extended beyond their current 2025 expiration. L&E has assumed these subsidies will expire as currently written into law. Their continuation or expiration is expected to have a limited enrollment impact for OEI and no impact to the four guardrails.

Maryland's current 1332 waiver is for the state-based reinsurance program. The waiver is set to expire at the end of 2028. Due to the success of the waiver, this analysis assumes it will be renewed for an additional period of five years beginning in 2029.

COMPREHENSIVENESS

The comprehensive requirement requires the waiver to have benefit coverage that is at least as comprehensive for residents of the State as coverage absent the waiver. This requirement was satisfied since the Amendment does not include any changes to Essential Health Benefits ("EHBs").

AFFORDABILITY

The affordability requirement states that coverage under the waiver must be at least as affordable for State residents absent the waiver. The Amendment does not change enrollees' out-of-pocket costs, so we will demonstrate that the premiums will not increase for the affordability requirement to be satisfied.

The Amendment's impact on market morbidity is expected to immaterially reduce overall premiums. Although other states have implemented similar 1332 waivers to allow OEI access to their exchanges, there is currently limited data on their Individual market claim utilization patterns and the corresponding morbidity outcomes. As a result, L&E relied on research that analyzed OEI and healthcare spending.

L&E projects that uninsured[2] OEI who enroll will generally be healthier than the average current enrollee in the Individual market. Research shows that OEI tend to be healthier due to the "Health Immigrant Effect" or "Immigrant Paradox"[3]. Two other studies also found that OEI were anywhere from 25%[4] to at least 60%[5] healthier than those with recognized citizenship status, controlling for age and other factors. Additionally, the state of Washington recently applied for a similar OEI waiver. Washington assumed the relative morbidity of their enrolling population to range from 0.64 to 0.85. L&E selected a 0.75 relative health status factor based on

[2] L&E assumed no currently insured OEI would switch coverage to purchase an unsubsidized QHP plan.
[3] Understanding the Healthy Immigrant Effect in the Context of Mental Health Challenges: A Systematic Critical Review - PMC (nih.gov)
[4] Expanding Insurance Coverage to Undocumented Immigrants in Connecticut | RAND
[5] Medical expenditures among immigrant and nonimmigrant groups in the United States: findings from the Medical Expenditures Panel Survey (2000-2008) - PubMed (nih.gov)

the previously referenced RAND study to reflect the OEI's lower acuity before age and enrollment choices are considered.

The Maryland OEI population is younger than those enrolled in the 2024 Maryland Individual market[6]. Generally, medical claim costs increase as individuals age. As a result, OEI are expected to have lower claim costs due to being younger, all else equal. Exhibit 1 below shows the expected relative morbidity based on age distribution differences using the federal age curve.

Exhibit 1 – Age Distribution of Maryland's 2024 Individual Market and Uninsured OEI Population

Age Band	Average Age Curve Factor	2024 Individual Maryland Market	2021 Maryland Uninsured OEI[7]	Ratio
0-17	0.78	6%	5%	
18-25	0.98	11%	14%	
26-34	1.13	19%	19%	
35-44	1.29	18%	31%	
45-54	1.76	18%	16%	
55-64	2.65	24%	11%	
65+	3	5%	3%	
Average Age		42	39	
Average Age Curve Factor		**1.69**	**1.47**	**0.87**

The average age of a population does not necessarily correspond to the average age of those purchasing insurance. Older individuals are more likely to buy insurance because they often have higher health care needs. As expected, Maryland's Individual market also exhibits this trend. Consequently, the relative age factor was adjusted upward to reflect Maryland's higher average age of insurance purchasers compared to the general population. The resulting adjusted age factor is 0.94.[8]

L&E acknowledges that various factors, including health status, influence the decision to purchase coverage. It's important to note that OEI have always had the option to buy the same Individual market coverage off-exchange and demonstrate similar patterns of anti-selection, as the premiums for on-exchange plans are identical to those off-exchange. Therefore, while L&E anticipates some degree of anti-selection and pent-up demand driven by increased awareness, L&E expects these effects to be limited because these plans have been continuously available off-exchange at the same or lower costs.[9]. L&E estimates the selection load, controlling for age to be 1.20.

[6] On-exchange enrollment only, through February 2024; detailed off-exchange enrollment is not available.
[7] Excludes the estimated number of Deferred Action for Childhood Arrival recipients becoming eligible for APTC in 2024.
[8] The average age of those insured on the Maryland Exchange is 3 years older than the general population in Maryland.
[9] Off-exchange silver plans have lower premiums than on-exchange silver plans.

Exhibit 2 below shows the relative morbidity buildup. The factors are multiplied to determine the final relative morbidity load.

Exhibit 2 – Amendment Population Relative Morbidity Buildup

Morbidity Measure	Factor
Age	0.94
Relative Health Status[10]	0.75
Selection	1.20
Relative Morbidity	**0.85**

Exhibit 3 below shows the expected enrollment and morbidity impact on premiums. The enrollment estimates are discussed in more detail in the following section and represent unique enrollment.

Exhibit 3 – Amendment Relative Morbidity and Premium Impact

	2026	2027	2028	2029	2030
Amendment Enrollment	244	306	356	389	402
Relative Morbidity	0.85	0.85	0.85	0.85	0.85
Non-Amendment Enrollment	243,671	244,680	245,740	246,808	247,885
Morbidity Impact to Premiums	**0.9998**	**0.9998**	**0.9998**	**0.9998**	**0.9998**

Since the waiver did not mandate any changes to out-of-pocket costs, the lower morbidity and resulting premium reduction achieved satisfy the affordability requirement.

COVERAGE

The coverage requirement states that the waiver must extend coverage to at least a comparable number of State residents absent the waiver. The waiver does not impact the coverage of individuals/those who would be eligible regardless of whether section 1312(f)(3) of the Affordable Care Act is waived, except for a minor reduction in premiums. Consequently, any new enrollments due to the waiver will lead to an increase in coverage.

OEI who enroll due to the Amendment will still be ineligible for any federal premium or Cost Sharing Reduction (CSR) subsidies and they must bear the full premium and cost sharing for their chosen plan. OEI also have a lower median income than individuals/those who would be eligible regardless of whether section 1312(f)(3) of the Affordable Care Act is waived[11]. As a result, the full premium and cost sharing requirement is likely to present an affordability challenge for many individuals. This population may be reluctant to engage with

[10] The age factor applied is not double counted with the health status factor as it was developed controlling for age.
[11] https://www.pewresearch.org/race-and-ethnicity/2009/04/14/a-portrait-of-unauthorized-immigrants-in-the-united-states/

government services due to their citizenship status and unfamiliarity with the health insurance marketplace. As a result, L&E anticipates that enrollment will be modest and is expected to occur gradually over several years.

To estimate enrollment, L&E reviewed Washington's waiver's enrollment which allowed OEI to enroll on the exchange and provided a state premium subsidy for those under 250% of the federal poverty limit (FPL). A comparison to those under 250% FPL receiving the state subsidy is inappropriate due to the significant difference in net premium between the Washington and Maryland waivers. However, unsubsidized individuals above 250% FPL in Washington have more comparable net premiums to those in Maryland[12]. L&E relied on this cohort's enrollment to validate the estimated Amendment enrollment for those above 250% FPL.

During the 2024 Open Enrollment period, which was the first period Washington's waiver went into effect, 273[13] OEI over 250% FPL enrolled. The total OEI population in Washington is comparable to Maryland's[14], therefore, L&E expects a similar magnitude of enrollment as a result of the Amendment. The exhibit below shows the expected enrollment above 250% FPL by income.

Exhibit 4 – Estimated 2026 Amendment Enrollment Greater Than 250% FPL

FPL Bucket	Estimated Enrollment	Uptake Percentage
250%-300%	61	0.59%
301%-400%	104	0.64%
401%+	94	0.84%
Total	**259**	**0.73%**

Enrollment in Maryland for the under 250% FPL cohort is expected to be much lower than Washington's enrollment due to its subsidy and resulting lower net premiums. L&E assumed a significant enrollment decline for this cohort compared to those above 250% since premium and cost sharing increase as a percentage of income.

[12] The 2024 second lowest cost silver plan in Maryland is 15% lower than Washington's.
[13] 118 individuals did not report income during their enrollment. L&E assumed this cohort's income was above 250% since they voluntarily chose not to apply for a subsidy.
[14] 12.12.2022 Washington Health Benefit Exchange Waiver 1332 Information.pdf (wahbexchange.org)

Exhibit 5 – Estimated 2026 Amendment Enrollment[15]

FPL Bucket	Estimated Enrollment	Uptake Percentage
0-138%	4	0.01%
139% - 150%	2	0.03%
151%-200%	8	0.05%
201%-250%	20	0.15%
250%+	259	0.73%
Total	**292**	**0.27%**

FEDERAL DEFICIT

The final requirement is that the implementation cost must not increase the federal deficit. Those enrolling due to the waiver will not be eligible for Advanced Premium Tax Credits or CSRs. As discussed in the Affordability section above, the relative morbidity of the enrolling population is expected to lower overall premiums. Lower market premiums reduce the federal APTC liability, lowering the federal deficit and meeting the requirement.

With the Amendment, Maryland's 1332 waiver would contain two components: the original reinsurance provision and the new on-exchange OEI population provision.

Exhibit 6 – Savings Components of Maryland's Current and Proposed Waiver/Amendment

Component	2026	2027	2028	2029	2030
Reinsurance	-33.60%	-33.39%	-33.19%	-33.00%	-32.82%
OEI	-0.02%	-0.02%	-0.02%	-0.02%	-0.02%

The data demonstrates that the reinsurance effect is the primary source of savings from the waiver. Consequently, the assumptions regarding morbidity and enrollment for the OEI population have a negligible impact on the overall savings produced by the waiver. Thus, both the existing waiver and the proposed amendment are expected to consistently result in federal savings.

RESULTS

Exhibits 7 and 8 show the projected enrollment[16], premiums, and APTCs for three scenarios: the first scenario where neither the reinsurance program nor the Amendment are active, the second scenario with the reinsurance program but without the Amendment, and the third scenario where both the reinsurance program and the Amendment are implemented.

[15] The enrollment estimates were scaled down to exclude the estimated number of Deferred Action for Childhood Arrival recipients becoming eligible for APTC in 2024.

[16] The unique enrollment values discussed in the Coverage section were converted to expected average enrollment as shown in Exhibit 3.

Exhibit 7 – 2026 – 2030 Actuarial Analysis of Waiver/Amendment vs No Waiver

	2026	2027	2028	2029	2030
Baseline Scenario - No Reinsurance/No OEI					
Total Enrollment	229,051	229,999	230,996	232,000	233,011
PTC Enrollment	146,877	147,495	148,134	148,802	149,618
Increase in SLCSP Premium without Reinsurance	48.9%	48.4%	47.9%	47.5%	47.0%
Premium PMPM	$828.05	$875.67	$924.93	$976.99	$1,032.09
Total Premiums	$2,276,338,092	$2,417,666,599	$2,565,315,976	$2,722,139,155	$2,888,944,407
Total APTCs	$1,211,779,346	$1,282,224,073	$1,354,906,284	$1,431,530,388	$1,512,523,273
After Reinsurance - With Reinsurance/No OEI					
Premium PMPM	$549.92	$583.47	$618.31	$655.16	$694.13
Total Enrollment	243,671	244,680	245,740	246,808	247,885
PTC Enrollment	143,957	144,623	145,249	146,052	147,849
Total Premiums	$1,608,001,115	$1,713,150,227	$1,823,328,166	$1,940,391,346	$2,064,781,654
Total APTCs	$739,202,468	$787,938,728	$838,448,226	$891,792,450	$948,177,321
Estimated Federal Savings	$467,851,109	$489,342,492	$511,293,478	$534,340,558	$558,702,492
After Reinsurance - With Reinsurance and OEI					
Premium PMPM	$549.84	$583.35	$618.17	$655.00	$693.96
Total Enrollment	243,915	244,986	246,096	247,197	248,286
PTC Enrollment	143,957	144,623	145,249	146,052	147,849
Total Premiums	$1,609,359,261	$1,714,961,336	$1,825,561,217	$1,942,979,132	$2,067,611,438
Total APTCs	$739,054,783	$787,587,756	$837,839,996	$890,877,287	$946,909,439
Estimated Federal Savings	$467,997,317	$489,689,954	$511,895,626	$535,246,570	$559,957,695

Exhibit 8 - 2031 – 2035 Actuarial Analysis of Waiver/Amendment vs No Waiver

	2031	2032	2033	2034	2035
Baseline Scenario - No Reinsurance/No OEI					
Total Enrollment	$233,976	234,990	236,011	237,040	238,074
PTC Enrollment	$150,248	148,756	149,427	150,247	151,071
Increase in SLCSP Premium without Reinsurance	46.6%	46.2%	45.8%	45.4%	45.0%
Premium PMPM	$1,091.44	$1,152.85	$1,217.73	$1,286.42	$1,358.98
Total Premiums	$3,064,461,210	$3,250,885,972	$3,448,782,011	$3,659,200,852	$3,882,457,873
Total APTCs	$1,600,451,236	$1,691,171,990	$1,786,812,950	$1,887,906,952	$1,994,720,633
After Reinsurance - With Reinsurance/No OEI					
Premium PMPM	$736.45	$780.42	$826.92	$876.10	$928.22
Total Enrollment	248,911	249,989	251,076	252,171	253,270
PTC Enrollment	148,533	149,176	150,000	151,846	153,714
Total Premiums	$2,199,729,838	$2,341,145,282	$2,491,420,780	$2,651,134,601	$2,821,086,786
Total APTCs	$1,010,691,475	$1,075,480,166	$1,143,904,970	$1,216,230,021	$1,293,127,928
Estimated Federal Savings	$584,367,257	$610,580,876	$638,103,439	$667,196,184	$697,615,340
After Reinsurance - With Reinsurance and OEI					
Premium PMPM	$736.26	$780.21	$826.69	$875.86	$927.96
Total Enrollment	249,325	250,416	251,515	252,622	253,735
PTC Enrollment	148,533	149,176	150,000	151,846	153,714
Total Premiums	$2,202,825,573	$2,344,524,833	$2,495,106,605	$2,655,150,826	$2,825,459,676
Total APTCs	$1,009,092,015	$1,073,477,391	$1,141,431,097	$1,213,221,951	$1,289,528,125
Estimated Federal Savings	$585,950,723	$612,563,623	$640,552,573	$670,174,172	$701,179,145

Exhibits 9, 10, and 11 show the estimated first year enrollment[17] by FPL, APTC eligibility, and metal level for the three scenarios. L&E's reinsurance modeling does not separately project metal level enrollment, therefore, a metal level the distribution was estimated using 2024 Open Enrollment data from the 2024 Marketplace Open Enrollment Period Public Use Files. Future years' enrollment distributions are expected to be similar to those in the exhibits below.

[17] Enrollment values represent average, not unique enrollment.

Exhibit 9 – Expected Enrollment by FPL, APTC Eligibility, and Metal Level with Reinsurance and Amendment

	0-100%	100-150%	150-200%	200-250%	250-300%	300-400%	No APTC
Bronze	6,304	3,825	11,310	7,053	3,253	3,274	24,316
Silver	6,892	4,181	12,364	7,710	3,556	3,580	26,582
Gold	12,720	7,717	22,820	14,230	6,563	6,607	49,061

Exhibit 10 – Expected Enrollment by FPL, APTC Eligibility, and Metal Level with Reinsurance and No Amendment

	0-100%	100-150%	150-200%	200-250%	250-300%	300-400%	No APTC
Bronze	6,304	3,825	11,310	7,053	3,253	3,274	24,256
Silver	6,892	4,181	12,364	7,710	3,556	3,580	26,517
Gold	12,720	7,717	22,820	14,230	6,563	6,607	48,941

Exhibit 11 – Expected Enrollment by FPL, APTC Eligibility, and Metal Level No Reinsurance and No Amendment

	0-100%	100-150%	150-200%	200-250%	250-300%	300-400%	No APTC
Bronze	6,304	3,825	11,310	7,053	3,296	3,942	19,989
Silver	6,892	4,181	12,364	7,710	3,603	4,309	21,852
Gold	12,720	7,717	22,820	14,230	6,650	7,953	40,332

APPENDICES

APPENDIX A: PROJECTED SECOND LOWEST COST SILVER PLAN

Exhibits 12-15 below show the estimated premium for the second lowest cost silver plan for a 21-year-old in Maryland for the three Waiver/Amendment scenarios by rating area. The premium was estimated using filed 2025 premiums at the time of this report, trended 5% annually. The premium does not vary by rating area.

Exhibit 12 – Projected Benchmark Premium Rating Area 1

Scenario	2026	2027	2028	2029	2030
With Reinsurance/Amendment	$303.66	$318.83	$334.77	$351.50	$369.07
With Reinsurance/No Amendment	$303.71	$318.90	$334.84	$351.58	$369.16
No Reinsurance/No Amendment	$452.23	$473.29	$495.35	$518.48	$542.71

Exhibit 13 – Projected Benchmark Premium Rating Area 2

Scenario	2026	2027	2028	2029	2030
With Reinsurance/Amendment	$303.66	$318.83	$334.77	$351.50	$369.07
With Reinsurance/No Amendment	$303.71	$318.90	$334.84	$351.58	$369.16
No Reinsurance/No Amendment	$452.23	$473.29	$495.35	$518.48	$542.71

Exhibit 14 – Projected Benchmark Premium Rating Area 3

Scenario	2026	2027	2028	2029	2030
With Reinsurance/Amendment	$303.66	$318.83	$334.77	$351.50	$369.07
With Reinsurance/No Amendment	$303.71	$318.90	$334.84	$351.58	$369.16
No Reinsurance/No Amendment	$452.23	$473.29	$495.35	$518.48	$542.71

Exhibit 15 – Projected Benchmark Premium Rating Area 4

Scenario	2026	2027	2028	2029	2030
With Reinsurance/Amendment	$303.66	$318.83	$334.77	$351.50	$369.07
With Reinsurance/No Amendment	$303.71	$318.90	$334.84	$351.58	$369.16
No Reinsurance/No Amendment	$452.23	$473.29	$495.35	$518.48	$542.71

APPENDIX B: CAVEATS

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 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 these have inherent uncertainty. Therefore, actual enrollment could vary significantly.
- Political and Health Policy Uncertainty.
  - Future federal or state actions could dramatically change future premiums and enrollment.

This report has been prepared for Maryland Health Benefit Exchange, the Maryland Insurance Administration, and the Department of Health and Human Services in relation to the analysis of Maryland's 1332 Waiver. 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.

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 August 13, 2024. The date (a.k.a. "latest information date") through which data or other information has been considered in performing this analysis is July 2, 2024.

DISCLOSURES IN ACTUARIAL REPORTS

- The contents of this report are intended for the use of the Maryland Health Benefit Exchange, the Maryland Insurance Administration, and the Department of Health and Human Services. 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 LLC is financially and organizationally independent from the companies that participate in the Maryland Individual market. L&E 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 Department of Health and Human Services with analysis of Maryland's 1332 Waiver extension.
- 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 other 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.

Appendix D: Public Hearing Presentation

1332 Waiver Amendment Application Public Hearing

June 18, 2024 & July 3, 2024

MHBE Policy Department

MARYLAND HEALTHBENEFIT EXCHANGE

This meeting will be recorded

Public Hearing Agenda

- Introduction
- Reinsurance Program Overview
- 1332 Waiver Amendment Application Overview
- Public Testimony Period

*Note: If you wish to testify during the public comment period, please sign up on the Google Form in the comment section

State Reinsurance Program Overview

History

- **2014: ACA market reforms** went into effect, including no pre-existing condition exclusions, rates not based on health status
- **2014-2018: Individual market rates increased** by double digits each year; enrollment declined significantly
- **2019: Reinsurance program implemented** to stabilize the individual market
- **2019-2024:** Rates **down more than 20%** compared to 2018; enrollment rebounded

Plan Year	Avg. Individual Premium Change
2015	10%
2016	18%
2017	21%
2018	28%
Reinsurance Starts	
2019	**-13%**
2020	**-10%**
2021	**-12%**
2022	**2.1%**
2023	**6.6%**
2024	**4.7%**

MARYLAND HEALTHBENEFIT EXCHANGE

How Does Reinsurance Work?

- Reinsurance reimburses insurers for a portion of their claims costs. Lower costs allow carriers to charge lower premiums.
- The MHBE Board sets the parameters for the reinsurance program.

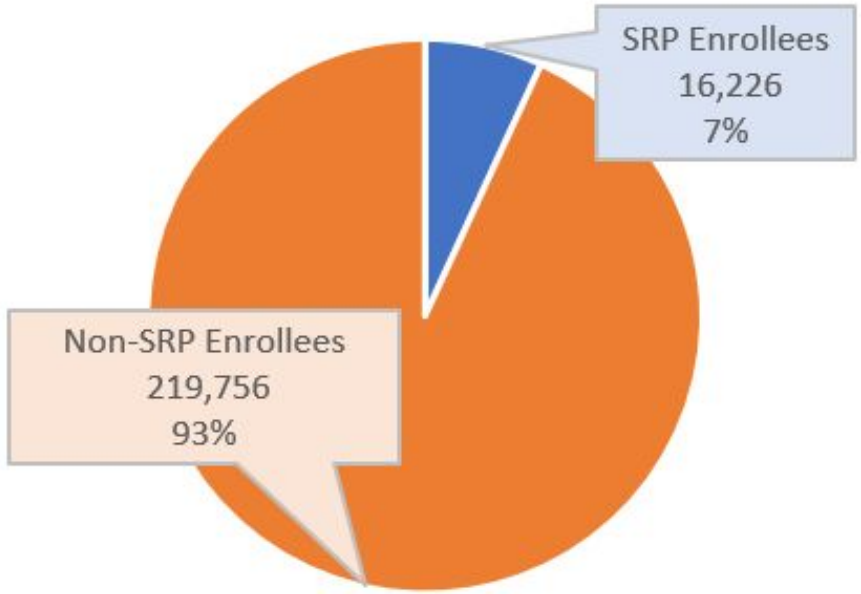
Parameters	2019 - 2022	2023	2024	Estimated 2025
Attachment Point	$20,000	$18,500	$20,000	$21,000
Coinsurance Rate	80%	80%	80%	80%
Cap	$250,000	$250,000	$250,000	$250,000
Dampening Factor	.760 - .805	.840	.850	Yes

2023 Reinsurance Results – Cost, Funding, Enrollment

2023 Program Cost and Federal Funding

	Summer 2023 Projection (L&E)	2023 Actuals
Cost	$544M	**$566M**
Federal Funding	n/a	**$473M**

2023 Total Average Individual Market Enrollment

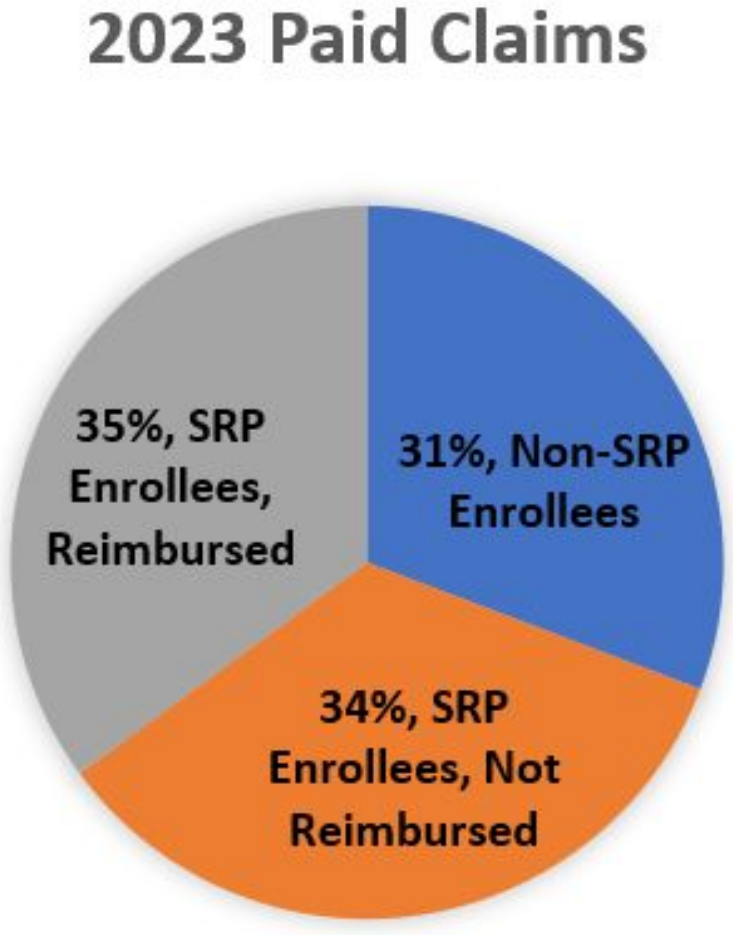


Enrollment calculated by MHBE using member months in CMS SRIS file

MARYLAND HEALTHBENEFIT EXCHANGE

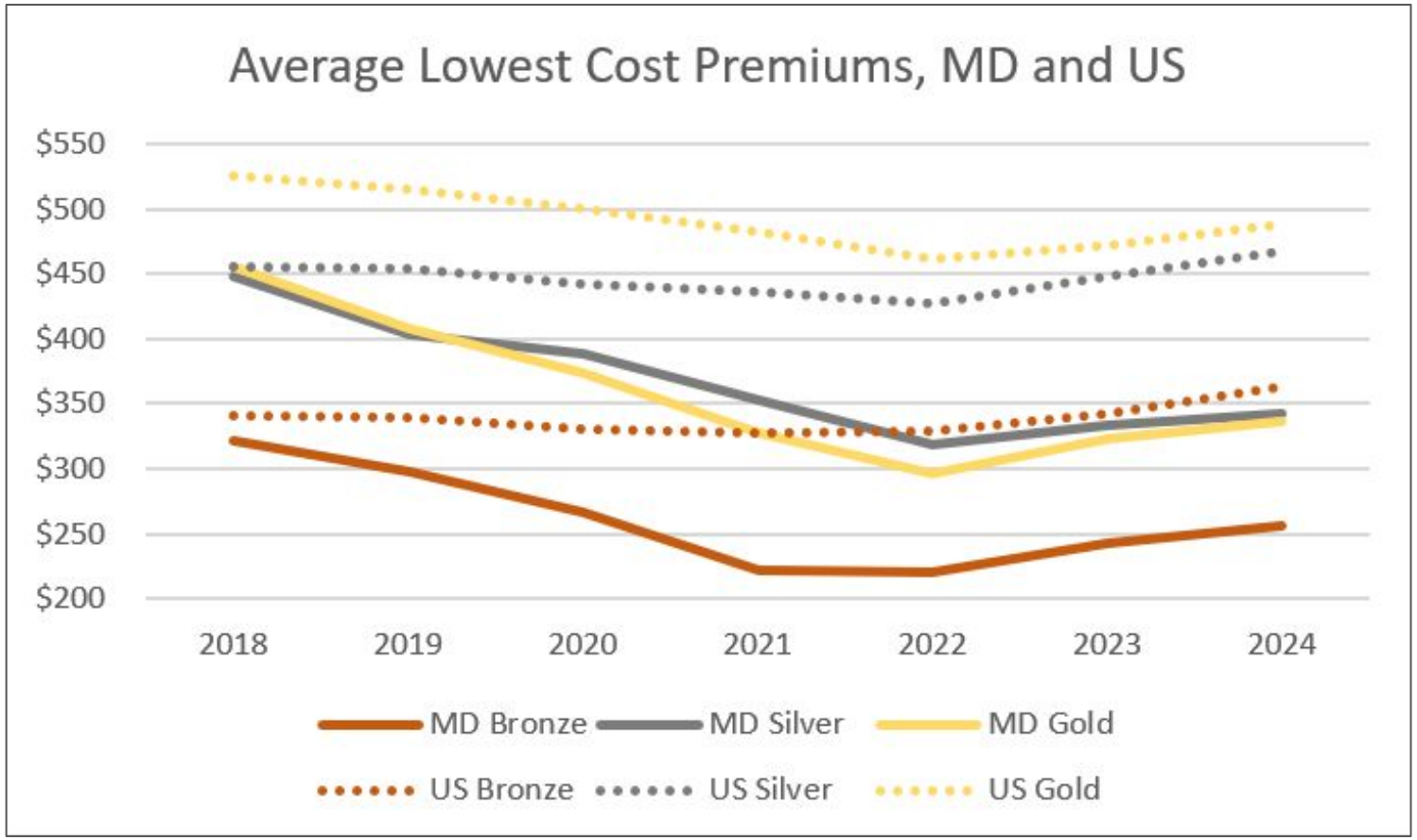
2023 Reinsurance Results – Paid Claims Breakdown

- Total paid claims in 2023 were about $1.62B
- The 93% of enrollees who did not qualify for SRP payments accounted for 31% of paid claims
- The 7% of enrollees who qualified for SRP payments accounted for 69% of paid claims
  - The SRP reimbursed about half of these claims, accounting for 35% of total paid claims
  - Issuers covered the other half, accounting for 34% of total paid claims



Reinsurance Program Impact: Premiums Successfully Reduced

- Premiums are down more than 20% compared to 2018.
- Maryland's lowest cost plans are about 25-30% below US averages



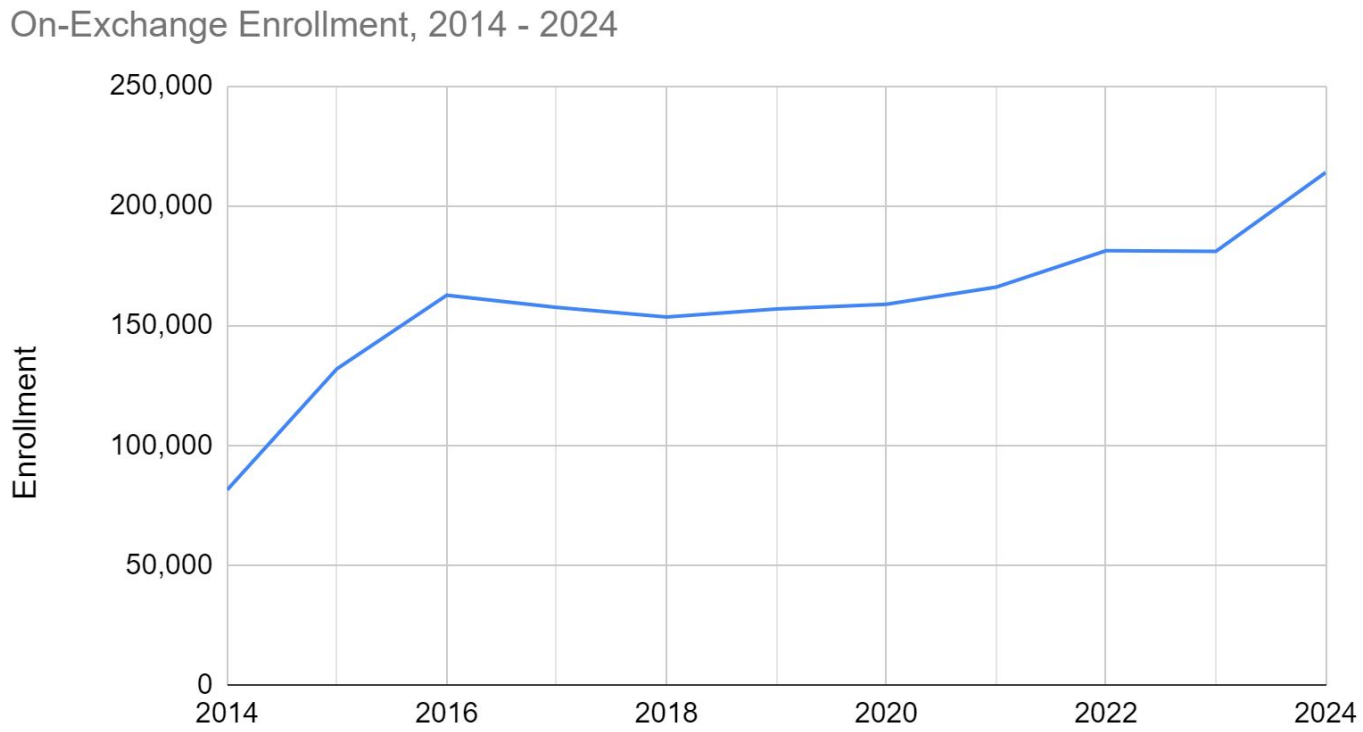
Data source: Kaiser Family Foundation:
https://www.kff.org/health-reform/state-indicator/average-marketplace-premiums-by-metal-tier

MARYLAND HEALTHBENEFIT EXCHANGE

Enrollment Continues to Rise

Between 2019 and 2024:

- On-Exchange enrollment is up 36%
- Total individual market enrollment (on- and off-Exchange) is up 32.8%

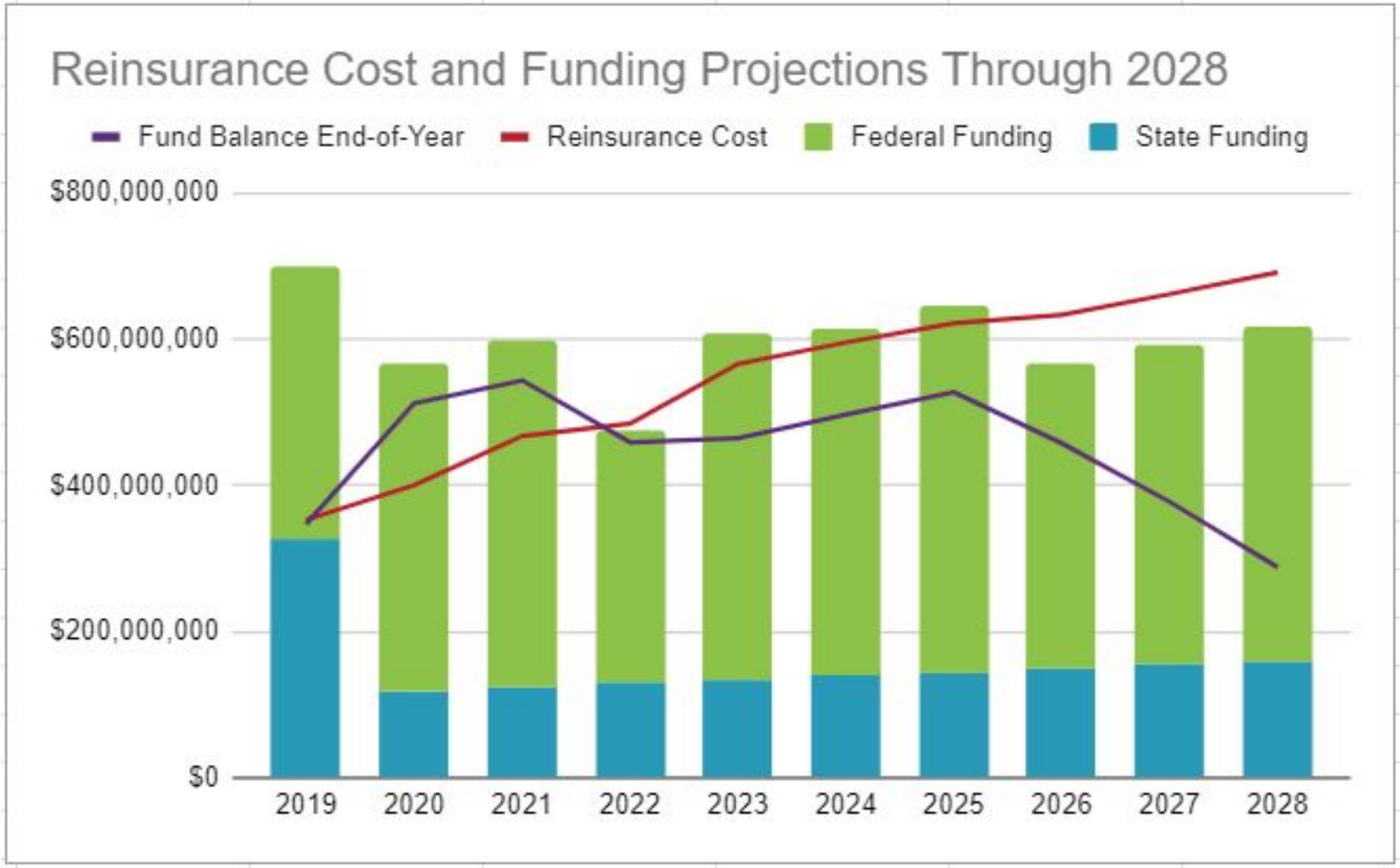


MARYLAND HEALTHBENEFIT EXCHANGE

Reinsurance Funding

- **Reinsurance is funded with state and federal dollars**
- State funding comes from the **state health insurance provider fee**, a state assessment on health insurance premiums that replaced a 2.75% federal assessment suspended in 2019 and repealed in 2020
  - 2019: 2.75% state assessment
  - **2020-2028: 1% state assessment**
- **Federal funding** comes from our “1332 waiver” from the federal government
  - The federal government subsidizes individual market premiums so that enrollees’ premium costs are capped at 0-8.5% of income for a benchmark plan
  - ACA Section 1332 allows states to waive certain ACA provisions; if the waiver reduces federal costs to subsidize premiums, those savings are passed to the state
  - By reducing premium costs through reinsurance, we reduce federal subsidies and recoup “pass-through” savings under the waiver

July 2024 SRP Funding Projections with 2025 Attachment Point of $21,000



- Projections assume attachment point increases by $1000 annually starting in 2025; enhanced federal subsidies end in 2025.
- Reflected in end-of-year balance, but not otherwise shown: $219M removed from state SRP fund for other programs across FY21-25, and est. $68M for Young Adult Subsidy across FY22-26.

Waiver Amendment Application

Application Contents

Section 1: Description of Request
Section 2: Public Notice and Comment Process
Section 3: Evidence of Sufficient Authority Under State Law
Section 4: Implementation Plan
Section 5: Impact on Section 1332 Guardrails
- A. Comprehensiveness
- B. Affordability
- C. Coverage
- D. Federal Deficit

Section 6: Estimated Impact on Passthrough Funding
Appendix A: Maryland's 1332 Waiver Extension Request and Letter of Approval
Appendix B: Maryland Senate Bill 705/House Bill 728 (Access to Care Act)
Appendix C: Actuarial Analysis
Appendix D: Public Hearing Presentation
Appendix E: Public Hearing Minutes
Appendix F: Public Comments

1. Background & Description of Request (1/2)

- Maryland General Assembly passed Access to Care Act (SB705/HB728)
  - Directs MHBE to apply for waiver amendment to allow all residents to enroll on-Exchange, regardless of immigration status (waiver of section 1312(f)(3) of the Affordable Care Act)
- Maryland has an approved section 1332 waiver to facilitate the state reinsurance program through 2028
- MHBE requests to waive section 1312(f)(3) for the period January 1, 2026 through December 21, 2028. MHBE anticipates launching the new eligibility rules by November 1, 2025 for enrollment in 2026 plans.

1. Background & Description of Request (2/2)

- ~112,400 Marylanders are uninsured and ineligible for coverage due to immigration status (~30% of MD uninsured population)
- Currently, individuals ineligible to enroll on-Exchange due to their immigration status are able to purchase full-price health plans off-Exchange
- If waiver amendment is approved, these individuals would be able to enroll in full-price private plans on-Exchange
- Newly eligible individuals under the waiver amendment would not be eligible for Federal or state subsidies

1. Benefits of On-Exchange Enrollment

- Simplified shopping experience
  - Plan cost comparison
  - Tools that show whether plans include providers and prescription drugs
  - Total health care cost estimation
- Extensive consumer support
  - Call Center (more than 200 languages)
  - In-person assistance: Navigator Program and authorized brokers
- Streamlined enrollment in the same plan for mixed-status families
  - Continuity of coverage and care coordination
  - Allow families to share single plan deductible and out-of-pocket maximum
  - Reduce burden of managing multiple plans

2. Public Notice and Comment Period

- 30-day comment period: June 10 - July 9, 2024
- Two public hearings
  - June 18, 2024
  - July 3, 2024
- Notice of public hearings was posted on MHBE's website on May 10, 2024
- The public may also submit comments to mhbe.publiccomments@maryland.gov
- A summary of this and the second meeting will be added to the final submission of the application, as well as:
  - Presentations
  - Meeting minutes
  - Comments received

3. Evidence of Sufficient Authority Under State Law

- 2018 - Maryland General Assembly passed House Bill 1795 – Establishment of a State Reinsurance Program (HB 1795). Directed MHBE to submit a Section 1332 State Innovation Waiver to HHS and the Treasury to establish a State Reinsurance Program
- 2024 - MGA passed Access to Care Act (SB705/HB728), which directs MHBE to apply for an amendment to Maryland's existing 1332 waiver to allow all Maryland residents to enroll in private plans on-Exchange, regardless of immigration status, and
  - Clarifies technical amendments to the MD Insurance Code
  - Adds two sections to the MD Insurance Code:
    - § 31–123, to direct MHBE to submit a state innovation waiver application amendment under § 1332 of the ACA to establish a Qualified Resident Enrollment Program; and
    - § 31–124, to direct MHBE to implement a Qualified Resident Enrollment Program to facilitate the enrollment of qualified residents in qualified plans, contingent on approval from the Departments of a Section 1332 waiver amendment

4. Implementation Plan

- February 25, 2025 - last day for CMS to approve or deny request
- March to August 2025
  - Exchange begins designing system changes
  - Summer 2025 - Finalize system updates and complete testing in advance of fall OE activities, to support waiver implementation for OE 2026
- November 2025 - OE 2026 begins; waiver population eligible to purchase QHPs
- January 2026 - OE ends Jan 15; QHP coverage begins for waiver population

5. Impact on 1332 Guardrails

The amended waiver would continue to meet the statutory guardrails:

1332 Waiver Guardrail	**Estimated Waiver Impact**
Comprehensiveness: Provide coverage that is at least as comprehensive as the coverage provided without the waiver	Not requesting changes to Essential Health Benefits, so no impact
Affordability: Provide coverage and cost-sharing protections against excessive out-of-pocket spending that are at least as affordable as without the waiver	Amended waiver would not change enrollees' out-of-pocket costs or raise premiums
Coverage: Provide coverage to at least a comparable number of residents as without the waiver	Amended waiver would not impact coverage of individuals who were already eligible pre-amendment, and newly eligible enrollments will lead to increase in coverage
Federal Deficit: No increase to the federal deficit	Amendment expected to immaterially reduce premiums, reducing federal APTC liability and the federal deficit

6. Estimated Impact on Passthrough Funding

- Amendment is expected to immaterially reduce overall premiums
  - Research indicates that those eligible but for immigration status are healthier than the general population, controlling for age and other factors
  - Those eligible but for immigration status are younger than the Individual Market overall
- Limited impact from anti-selection and pent-up demand (prior off-Exchange availability)
- Although reduced premiums reduce federal APTC liability, MHBE is not requesting passthrough as a result of this waiver amendment

Timeline

Completed Activities for Amendment Request	
April/May	MHBE submitted letter of intent (LOI) after Board vote to authorize submission
6/4/2024	CMS responded to LOI allowing MHBE to apply for waiver amendment
Current/Remaining Activities for Amendment Request	
6/10 - 7/9/2024	Application published on MHBE website; 30-day state public comment period
6/18/2024	Public Hearing #1
7/3/2024	Public Hearing #2
7/15/2024	Board vote to submit application; submit application to federal government
7/16/2024	Sixth Annual Reinsurance Forum
8/29/2024	Federal government determines whether application is complete (up to 45 days)
8/29 - 9/30/2024	30-day Federal public comment period
2/25/2025	Last day for federal approval: federal government may take up to 180 days from determination of completeness to approve an application (MHBE has request a decision by the end of 2024)
11/1/2025	Open enrollment starts for plan year 2026; all qualified residents eligible to enroll
1/1/2026	Plan year 2026 coverage begins

Public Comment

Appendix E: Public Hearing Minutes

MHBE

Section 1332 Waiver Amendment Hearing 1

June 20, 2024
1:00 PM – 2:00 PM
Via Google Meets

Attendees:
Adam Zimmerman -MDInsurance-, Alexandra Allen, alexis Solis, Amelia Marcus -MHBE-, Becca Lane -MHBE-, Bradley Boban -MDInsurance-, Diana Gertsenshteyn, Jasmin Aramburu, Jenny Ozor, Ken Brannan, Larry Lewis, Leidi Garcia, Madelin Martinez, Michele Eberle -MHBE-, NaShona Kess, Nic Nemec, Nicholas Penders, Ninfa Amador, Philemon Kendzierski, Stephanie Klapper, Viviana Lozano, william reid

***

Becca Lane, Senior Health Policy Analyst at the Maryland Health Benefit Exchange (MHBE), led the presentation. She was joined by Michele Eberle, Executive Director of the MHBE; Amelia Marcus, Health Policy Analyst at the MHBE; and Brad Boban, Chief Actuary for the Maryland Insurance Administration (MIA). The slides that were shown are available in the presentation for this meeting.

Ms. Lane began her presentation with an overview of the State Reinsurance Program (SRP). She noted that the Affordable Care Act (ACA) went into effect in 2014, rates doubled between 2014-2018, and enrollment declined significantly. In 2019, the SRP was implemented in Maryland as way to stabilize the individual market. It was successful, bringing rates down 20% compared to before the SRP, and enrollment has rebounded. The SRP reimburses insurers for a portion of high claims costs, up until a certain capped amount. The parameters for the program, which are set annually by the MHBE Board of Trustees, include the attachment point beyond which claims are reimbursed, the coinsurance rate, the reimbursement cap, and the dampening factor, which is meant to account for the interaction between the SRP and the federal risk adjustment program.

There were $1.5 billion of total claims paid in 2022. The 94% of enrollees who did not qualify for the SRP accounted for 34% of total claims paid, while the 6% of enrollees who qualified for the SRP accounted for 66% of total claims paid, with the SRP paying about half of the claims cost and the other half covered by insurers.

For each metal level, premiums in Maryland are 25-30% lower (depending on the metal level) than the national average. Enrollment continues to increase, with on-exchange

enrollment up 36%, although Ms. Lane noted that some portion of the observed enrollment increases is likely due to other factors, such as the enhanced premium subsidies available through the American Rescue Plan Act.

Funding for the SRP comes from state dollars—a 1% state health insurance provider fee, which is assessed on premiums and itself replaces an old federal assessment—as well as federal funding from the 1332 waiver. The federal government caps consumers' expected contribution at a certain percentage of their income and covers the remainder using advance premium tax credits (APTCs). 1332 waivers allow Maryland to reduce the cost of federally subsidized premiums, and the resulting savings for the federal government are "passed through" to the state.

Ms. Lane then presented a slide breaking down the SRP's funding sources. She pointed out that the early years of the program were funded entirely through federal pass-through funds, with excess pass-through funds allowing Maryland to save for future years when annual revenues may be insufficient to cover the SRP's cost. 2022 was the first year that Maryland had to draw on these reserve funds. Ms. Lane noted that more up-to-date projections will be available later in July and will be presented at the Sixth Annual Reinsurance Forum on July 16, directing interested parties to visit the MHBE's website for details on the event.

Next, Ms. Lane described the contents of the application itself. She started with the first section, a description of the request. The Maryland General Assembly passed the Access to Care Act, which directs the MHBE to apply for an amendment to allow residents to enroll on-exchange regardless of immigration status, which would waive section 1312(f)(3) of the ACA. The MHBE's request is for the federal government to waive this portion of the ACA through the rest of the waiver period for Maryland's existing approved waiver, which lasts until 2028. The MHBE anticipates that the change will be effective by November 2025, in time for open enrollment for plan year (PY) 2026.

The next section of the application provides background on the waiver amendment. Around 112,000 Marylanders are uninsured and ineligible for coverage due to immigration status, making up around 30% of Maryland's overall uninsured population. This population is currently eligible to enroll in full-price plans off-exchange. If the waiver amendment passes, they will be newly eligible for on-exchange plans but will not be eligible for subsidies. Still, there are benefits to being able to enroll on-exchange, including a simplified shopping experience; extensive consumer support, with assistance available in over 200 languages; the ability to enroll in the same plan together for families, which will allow for cost savings in the form of sharing a deductible and an out-of-pocket maximum; and a reduction in the administrative burden of managing multiple plans.

The section of the application on the public notice and comment period explains that the 30-day public comment period ends on July 9. There will be two public hearings on the waiver amendment application, including this one—the second will take place on July 3, 2024— and notice of each of these hearings was posted 30 days in advance. The

public may submit comments to mhbe.publiccomments@maryland.gov. A summary of the two public hearings, any meeting materials, and any comments given will be added to the final submission of the application.

The next section of the application provides evidence that the MHBE has sufficient authority under state law to apply for this waiver amendment. It describes how, in 2018, the Maryland General Assembly passed House Bill 1795, directing the MHBE to submit a Section 1332 waiver to establish the SRP, and describes the Access to Care Act, passed in 2024.

Next, the application describes the implementation plan for the amendment. The MHBE hopes to receive approval for the request by December 2024, after which the MHBE will engage in design, testing, and finalization of system changes between March and August of 2025. The anticipated implementation date will be in November 2025, for open enrollment for 2026 plans, and coverage for the new population will begin in January 2026.

Ms. Lane then moved on to discussing the section of the application describing the waiver amendment's impact on the Section 1332 statutory guardrails. The waiver amendment would have no impact on comprehensiveness or affordability while increasing coverage. Additionally, it is expected to immaterially reduce premiums, reducing federal APTC liability and the federal deficit nominally.

Ms. Lane explained that the expected reduction of premiums is due to the healthier-than-average status of those who are eligible but for their immigration status. The fact that these individuals could already have purchased plans off-exchange means there will be little impact from anti-selection and pent-up demand. Although reductions in premiums and federal APTC liability are expected, MHBE is not requesting pass-through funding as a result of the waiver amendment.

Finally, Ms. Lane shared details on the timeline for the waiver amendment process. A second public hearing will take place on July 3, 2024. Then, the MHBE Board of Trustees will vote in mid-July on whether to submit the application to the federal government and will do so if the vote goes through. The Annual Reinsurance Forum will be held on July 16, 2024. By the end of August, the federal government will communicate whether the application is complete, after which they will hold their own 30-day public comment period. Finally, the federal government will deliberate, taking up to 180 days to make a decision on whether to approve the waiver amendment. This puts the deadline at around the end of February 2025, and the federal government may take that much time, but the MHBE has requested a decision by the end of calendar year 2024. Open enrollment for PY 2026 begins on November 1, 2026, and coverage begins on January 1, 2026.

Public Comment

Stephanie Klapper, Deputy Director of the Maryland Health Care for All Coalition, gave the following statement: "Stephanie Klapper for the Maryland Health Care for All

Coalition. We are made up of hundreds of faith, business, labor, community, and health care organizations from across the state, all working together toward access to quality affordable health care for all Marylanders. We wanted to take the opportunity to thank the Maryland General Assembly and Governor Moore for passing the Access to Care Act and signing it into law, to commend Maryland Health Benefit Exchange for this application draft, and to express our strong support that this is going to provide a simplified shopping experience for immigrants, advanced technology to identify plans that they didn't have access to before, extensive consumer reports, unique plan options, and the ability for multi-status families to apply for coverage together. We are just very excited about this. I wanted to thank you for your hard work towards it and for getting it up off the ground as soon as possible."

Leidi Garcia, Senior Manager for Navigational Health and Social Services at CASA, gave the following statement: "Good afternoon. My name is Leidi Garcia, and I'm the Senior Manager for Navigational Health and Social Services at CASA, Maryland's largest organization for immigrant and working-class families. Today, on behalf of over 155,000 members who have voiced that access to care is their most critical opportunity in improving their quality of life, I share comments supporting your most recent 1332 waiver application. Of the many social services programs we provide at CASA, this year alone, we assisted over 55,000 Maryland residents with vital health navigation services, including enrollment assistance for the Affordable Care Act. The population CASA serves are mainly uninsured and excluded from the formal health care system almost fully because of their immigration status. During my almost 10 years at CASA providing essential health and social services, 2023 had the biggest impact on my team. The Healthy Babies Equity Act expanded health coverage, allowing hundreds of families to get insured for the first time during a critical period in their lives. Although Maryland has made progress in prioritizing health equity, little has been done to address access to care for the nearly 5% of our population who are undocumented and uninsured, comprising about 30% of the uninsured population in Maryland. We appreciate the effective implementation of the Healthy Babies Equity Act, which has significantly improved the lives of over 6,000 babies and parents since its implementation last year. It is also a financially prudent way to ensure that both patients and our hospital systems are not strained by high medical use incurred by hospital stays for acute illness and that uncompensated care costs are managed. If this waiver is approved, Maryland will be in good company supporting and providing health care access to immigrant communities. Most recently, the Biden administration expanded the coverage of the Affordable Care Act to DACA recipients, individuals considered to be living and working lawfully within the United States who were denied coverage due to their immigration status. In 2022, Washington state also submitted a 1332 waiver to allow Washingtonians, regardless of immigration status, to access the state's health insurance marketplace. Across the country, state and local programs have also opened eligibility for purchasing health care regardless of immigration status. Within the Maryland General Assembly's leadership in the issue, particularly the Chair of the Finance Committee, the Health and Government Operations Committee, and the bill's sponsors, Delegate Cullison and Senator Hayes, who made the waiver application possible. We thank you in the past for expanding health care. Your support has ensured that Maryland gets closer to ending the inequality

of the health care space. We look forward to seeing health care expansion for immigrant communities through an approved 1332 waiver, which will permit individuals to purchase a product that could mean the difference between life and death."

NaShona Kess, Executive Director of the Maryland State Conference of the NAACP, gave the following statement: "Good afternoon. My name is NaShona Kess, and I'm the Executive Director of the Maryland State Conference of the NAACP. We express our support for the 1332 waiver to waive, in particular, section 1312(c)(1) of the Affordable Care Act. This waiver is essential for allowing immigrants to purchase health insurance through the health care exchange through comparable and competitive rates, a fundamental right that should be accessible to all Marylanders. Section 1332 waivers permit Maryland to implement innovative strategies for providing residents, including immigrants, with access to high-quality, affordable health insurance while retaining ACA protections. This waiver meets all statutory requirements, ensures comprehensive and affordable coverage, maintains or increases the amount of insured residents, and does not increase the federal deficit. Allowing immigrants access to the health care exchange benefits everyone: it provides comprehensive coverage, reduces emergency room reliance, and lowers uncompensated care costs. Immigrants would have access to the same qualified health plans as other residents, ensuring affordability and financial protection. Moreover, by expanding the pool, we stabilize premiums and reduce overall cost, promoting public health and economic strength. This waiver aligns with ACA's goal of health equity, creating a more just and inclusive society. The Maryland state conference of NAACP fully supports this waiver as a step towards health equity and justice for all residents of Maryland. It is time to ensure our immigrant neighbors have the same opportunities to live healthy, productive lives as everyone else."

Ms. Lane ended the hearing with a reminder that additional comments may be sent in writing to mhbe.publiccomments@maryland.gov.

MHBE

Section 1332 Waiver Amendment Hearing 2

July 3, 2024
1:00 PM – 2:00 PM
Via Google Meets

Becca Lane, Senior Health Policy Analyst at the Maryland Health Benefit Exchange (MHBE), led the presentation. She was joined by Michele Eberle, Executive Director of the MHBE; Amelia Marcus, Health Policy Analyst at the MHBE; Brad Boban, Chief Actuary for the Maryland Insurance Administration (MIA); and Adam Zimmerman, Senior Actuary at the MIA. The slides that were shown are available in the presentation for this meeting.

Ms. Lane began her presentation with an overview of the State Reinsurance Program (SRP). She noted that the Affordable Care Act (ACA) went into effect in 2014, rates doubled between 2014-2018, and enrollment declined significantly. In 2019, the SRP was implemented in Maryland, through a 1332 waiver, to stabilize the individual market. It was successful, bringing rates down 20% compared to before the SRP, and enrollment has rebounded. The SRP reimburses insurers for a portion of high claims costs, up until a certain capped amount. The parameters for the program, which are set annually by the MHBE Board of Trustees, include the attachment point beyond which claims are reimbursed, the coinsurance rate, the reimbursement cap, and the dampening factor, which is meant to account for the interaction between the SRP and the federal risk adjustment program.

The total amount paid by the SRP in 2023 was about $566 million, of which $473 million was funded through federal funding. About 7% of enrollees in the individual market in 2023 had claims reimbursed by the SRP, accounting for 69% of all paid claims in the market, while the 93% of enrollees who did not qualify for the SRP accounted for 31% of all paid claims. Overall paid claims in the individual market totaled about $1.6 billion in 2023.

For each metal level, premiums in Maryland are 25-30% lower (depending on the metal level) than the national average. Enrollment continues to increase, with on-exchange enrollment up 36% and total individual enrollment up almost 33%, although Ms. Lane noted that some portion of the observed enrollment increases is likely due to other factors, such as the enhanced premium subsidies available through the American Rescue Plan Act.

Funding for the SRP comes from state dollars—a 1% state health insurance provider fee, which is assessed on premiums and itself replaces an old federal assessment—as

well as federal funding from the 1332 waiver. The federal government caps consumers' expected contribution at 8.5% of their income and covers the remainder using advance premium tax credits (APTCs). 1332 waivers allow Maryland to reduce the cost of federally subsidized premiums, and the resulting savings for the federal government are "passed through" to the state.

Ms. Lane then presented a slide breaking down the SRP's funding sources. She pointed out that the early years of the program were funded entirely through federal pass-through funds, with excess pass-through funds allowing Maryland to save for future years when annual revenues may be insufficient to cover the SRP's cost. 2022 was the first year that Maryland had to draw on these reserve funds. The MHBE's projections show that the program will have about $228 million in 2028. Ms. Lane noted that those who are interested in learning more about the SRP can come to the Sixth Annual Reinsurance Forum on July 16, directing interested parties to visit the MHBE's website for details on the event.

Next, Ms. Lane described the contents of the application itself. She started with the first section, a description of the request. The Maryland General Assembly passed the Access to Care Act, which directs the MHBE to apply for a waiver amendment to allow residents to enroll on-exchange regardless of immigration status, which would waive section 1312(f)(3) of the ACA. The MHBE's request is for the federal government to waive this portion of the ACA through the rest of the waiver period for Maryland's existing approved waiver, which lasts until 2028. The MHBE anticipates that the change will be effective by November 2025, in time for open enrollment for plan year (PY) 2026.

The next section of the application provides background on the waiver amendment. Around 112,000 Marylanders are uninsured and ineligible for coverage due to immigration status, making up around 30% of Maryland's overall uninsured population. This population is currently eligible to enroll in full-price plans off-exchange. If the waiver amendment passes, they will be newly eligible for on-exchange plans but will not be eligible for subsidies. Still, there are benefits to being able to enroll on-exchange, including a simplified shopping experience; extensive consumer support, with assistance available in over 200 languages; and the ability to enroll in the same plan together for mixed-status families, which will allow for cost savings in the form of sharing a deductible and an out-of-pocket maximum, along with reducing the administrative burden of managing multiple plans.

The section of the application on the public notice and comment period explains that the 30-day public comment period ends on July 9. This meeting is the second of two public hearings on the waiver amendment application, and notice of each of these hearings was posted 30 days in advance. The public may submit comments to mhbe.publiccomments@maryland.gov, and many comments have been submitted. A summary of the two public hearings, any meeting materials, and any comments given will be added to the final submission of the application.

The next section of the application provides evidence that the MHBE has sufficient authority under state law to apply for this waiver amendment. It describes how, in 2018, the Maryland General Assembly passed House Bill 1795, directing the MHBE to submit a Section 1332 waiver to establish the SRP, and describes the Access to Care Act, passed in 2024.

Next, the application describes the implementation plan for the amendment. The MHBE hopes to receive approval for the request by December 2024, but the Centers for Medicare & Medicaid Services have until February 25, 2025, to do so. After receiving their approval, MHBE will engage in design, testing, and finalization of system changes between March and August of 2025. The anticipated implementation date will be in November 2025, for open enrollment for 2026 plans, and coverage for the new population will begin in January 2026.

Ms. Lane then discussed the section of the application describing the waiver amendment's impact on the Section 1332 statutory guardrails. The waiver amendment would have no impact on comprehensiveness or affordability while increasing coverage. Additionally, it is expected to immaterially reduce premiums, reducing federal APTC liability and the federal deficit nominally.

Ms. Lane explained that the expected reduction of premiums is due to the healthier-than-average and younger-than-average statuses of those who are eligible but for their immigration status. The fact that these individuals could already have purchased plans off-exchange means there will be little impact from anti-selection and pent-up demand. Although reductions in premiums and federal APTC liability are expected, the MHBE is not requesting pass-through funding as a result of the waiver amendment.

The MHBE Board of Trustees will vote on Monday, July 15, on whether to submit the application to the federal government and will do so if the vote goes through. The Annual Reinsurance Forum will be held on July 16, 2024. By the end of August, the federal government will communicate whether the application is complete, after which they will hold their own 30-day public comment period. Finally, the federal government will deliberate, taking up to 180 days to make a decision on whether to approve the waiver amendment. This puts the deadline at around the end of February 2025, and the federal government may take that much time regardless of MHBE's request for a decision by the end of calendar year 2024. Open enrollment for PY 2026 begins on November 1, 2026, and coverage begins on January 1, 2026.

Public Comment

Salliann Alborn, Chief Executive Officer of Maryland Community Health System, shared the following comments on behalf of her organization: "Good afternoon. As many of you may know, Maryland Community Health System, which is a network of seven federally qualified health centers (FQHCs) with 55 locations across the state, supported House Bill 728, Senate Bill 705, enthusiastically, and we're delighted to be with you today to also offer our support for the waiver amendment. As we mentioned during the legislative session, there are about 225,000 undocumented people in Maryland, of which 71% of

them are employed. However, 55% of them are uninsured, and we feel this opportunity to purchase insurance coverage on the Maryland Health Benefit exchange at no cost to the state provides them an opportunity to have access to a full range of healthcare services, such as primary care, specialty care, hospitalization, ancillary services, etc. As many of you know, FQHCs see patients that are presented to us regardless of their ability to pay, and we have a sliding fee scale from zero to whatever the patient is capable of paying. However, our primary care services don't extend to being able to provide a more comprehensive package of services, such as hospitalization, x-ray, specialty care services, etc. We avail our patients of every service that we have available, but we provide primarily primary care. So, we feel that this is the right thing to do, and that was our support during the legislative session. That is our primary message during today's hearing. However, I do want to make the point that most of our sliding fee scale patients predominantly are uninsured, are also undocumented, and are on a sliding fee scale. They only pay about 10 or 20 percent of the total cost of the visit. And, for us, this results in an increasing level of uncompensated care. For our seven FQHCs alone, that, annually, is tens of millions of dollars. We make an enormous contribution in services to the Maryland health care system. And, frankly, whatever we can do to reduce that by giving people an opportunity to actually buy coverage and have coverage for their health care needs will help contain our growing uncompensated care costs and allow us to see other people who have no access whatsoever to buying coverage. So, with that, Maryland Community Health System urges support for this waiver amendment."

Robyn Elliott**,** Managing Partner with Public Policy Partners, shared the following comments on behalf of the Maryland Assembly of School-Based Health Centers, the American College of Nurse Midwives, and the Maryland Academy of Physician Assistants: "I'm here on behalf today of the Maryland Assembly of School-Based Health Centers, The American College of Nurse Midwives, and the Maryland Academy of Physician Assistants, really echoing Salli's comment. These organizations support this waiver and supported the legislation that led to the waiver request because it is the right thing to do to provide the opportunity to people to take control of their own lives and be able to use their own money to purchase insurance. I wanted to thank the Maryland Health Benefit Exchange. One of the reasons that this legislation and this waiver can work is all of the incredible work that the Exchange has done in creating a system that is consumer-friendly, and it's just absolutely amazing because Navigating the insurance world is not easy, and it's not easy for anyone and particularly challenging if English is not your first language, and we heard that over and over again as a theme during the legislative session, and I think it's really important also to raise at this point in the process. And the last thing I wanted to mention: very similar to what Salli said, that school-based health centers, there are 89 of them across the state, and they are in areas and schools which there are economic challenges, where there are high rates of uninsurance and people who are covered under Medicaid. These 89 school-based health centers really struggle with sustainability, and one of the primary reasons, just like the federally qualified health centers, is to serve everyone. And many of the students in these school-based health centers who don't have insurance do so because they themselves do not have documentation, or it may be they are of legal status

themselves, but one of their parents isn't, or a family member in their household isn't. So that really, I think, creates a hesitancy, potentially, about people enrolling in insurance, even if they legally could, and so creating an opportunity for really the whole household to gain coverage is just an incredible opportunity, and I really want to thank… there are a lot of people on this call who helped make it possible to get to this moment, and I want to thank the Exchange for all the work I know in putting together the waiver amendment and also navigating the federal process that I know we're just about to embark on. So, thank you."

Michael Paddy, Senior Governmental Affairs Associate with Public Policy Partners, shared the following comments on behalf of the Maryland Occupational Therapy Association and the Maryland Dental Action Coalition: "I'm here today on behalf of the Maryland Occupational Therapy Association (MOTA) and the Maryland Dental Action Coalition (MDAC). I just want to say, thanks for working with the Dental Action Coalition to make sure dental insurance isn't forgotten about when we talk about all the products that are offered on the exchange. Obviously, those standalone dental products are incredibly important to someone's health, and having access to that insurance is… [audio unclear due to temporary drop in quality of call and recording] … important. both MOTA and MDAC supported this legislation, and we're going to continue to support this process through the waiver. And I think Robyn said it best earlier, so I'll just leave my comments there."

Ms. Alborn shared the following additional comments: "I would just like, again, to comment and reinforce what Robyn Elliot said about obtaining coverage. We have a number of certified application counselors in our health centers and work with the undocumented uninsured population to try and get them coverage if we can, whether it's Medicaid or Medicare or some other form of coverage, if it's available, and I will tell you… and also having been in the insurance business myself for nearly 20 years… it is very, very difficult for people in general, and for people for which English is not their first language, to navigate the system and fill out the application. I've had a long experience with the exchange, as have the FQHCs, in referring people there, and I just echo what Robyn said about the process they have and the navigation support that they provide, which, certainly during the unwinding and in helping people we refer there, is really… whether it's language or how they describe products… it's a trusted source of insurance purchase coverage, and I just really wanted to re-emphasize that point because it is such a dominant issue when we're trying to work with our patients. Thank you for giving me that opportunity."

Madelin Martinez, Assistant Advocacy Director for Catholic Charities of Baltimore, shared the following statement on behalf of her organization: "Hello, everyone. My name is Madelin Martinez. I'm here on behalf of Catholic Charities of Baltimore. One of our programs, Esperanza Center, serves as a primary health care provider for about 1,500 undocumented immigrants here in the Baltimore region. Most of our patients come with non-emergent conditions. However, if they wouldn't have access to our clinic, the conditions were either go untreated, or they would end up in the emergency room, which would contribute to the ongoing cost of care in our state. During session, Catholic

Charities of Baltimore supported this bill because the passage of this bill would ensure that Maryland residents who are working and paying taxes can purchase insurance through Maryland Health Connection, and we are here to support the waiver as well, and to ensure that the provisions listed on the bill are included, and to ensure that the bill moves forward, so that in 2026, hopefully, we would have the opportunity to educate the people who come to Esperanza Center and the members we serve about the importance of enrolling and purchasing health care in Maryland. So, we're very thankful to the Maryland Health Benefit Exchange. We know this work started a long time ago, and it's so exciting to see it here at this point. And thank you for the opportunity to provide comment today."

Ms. Lane thanked the group for all the comments they provided and ended the hearing with a reminder that additional comments may be sent in writing to mhbe.publiccomments@maryland.gov.

Appendix F: Public Comments

Public Comments: Draft 1332 Waiver Amendment Application
By Stephanie Klapper, Deputy Director, Maryland Health Care for All! Coalition
July 2, 2024

Thank you for this opportunity to submit public comments on the draft 1332 waiver amendment application to allow Maryland residents, who do not have current legal residency status, to purchase health insurance through Maryland Health Connection. We thank the Maryland General Assembly, Governor Moore, and lead sponsors Sen. Antonio Hayes and Del. Bonnie Cullison for passing legislation requiring Maryland to submit this amendment request.

If approved by the federal government, this waiver amendment will have no cost to the state, and will help more Marylanders receive navigational support from Maryland Health Connection to compare insurance plans, including easier-to-compare Value Plans not available off-Exchange. This is a step toward ending healthcare disparities for immigrant communities in Maryland. It will ensure access to primary care, resulting in higher early detection rates and better long-term management of chronic diseases and serious illnesses. It will decrease the amount of costly emergency room visits and mortality rates. Often uninsured Marylanders have to wait until their health issues bring them to the emergency room, which increases hospital wait times and also increases uncompensated care. According to our hospitals, the State is spending between $120—170M per year in uncompensated care for emergency department services for Marylanders who do not have insurance. Uncompensated care drives up health insurance premiums for everyone.

When Marylanders can access coverage, they can access preventive care, which allows them to stay healthier and have fewer visits to the emergency room. We recently released a report showing that past health care expansion in Maryland reduced uncompensated care by at least $460 million, making coverage more affordable for everyone else. This waiver amendment will help ensure more Marylanders can purchase coverage, and will therefore also help stabilize premiums and improve hospital wait times for ALL Marylanders.

While the state has recently made historic gains in health insurance coverage, Black, Latino, and Asian American Marylanders remain disproportionately represented among the uninsured. Immigration status can be a significant barrier to coverage. Removing immigration status as a barrier to health coverage is a matter of health equity and will establish a more fair and just health benefit exchange.

On behalf of the hundreds of organizations that make up the Maryland Health Care for All! Coalition, we applaud this draft 1332 waiver amendment application and thank MHBE for its commitment to ensuring access to quality, affordable health care for all Marylanders.

2600 St. Paul Street Baltimore, MD 21218
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Phone (410)235-9000 Fax (410)235-9000

The Maryland Academy of Physician Assistants

mdapa

To: **Maryland Health Benefit Exchange (MHBE)**

Subject: **Support of MHBE's Draft 1332 Waiver Amendment, pursuant to SB 705/ HB 728 of 2024**

Date: **July 1, 2024**

The Maryland Academy of Physician Assistants (MdAPA) supports the 1332 waiver amendment request to allow individuals, regardless of legal residency status, to purchase their own insurance on the Maryland Health Benefit Exchange. Maryland has made great strides in reducing the number of uninsured individuals with implementation of the Affordable Care Act and other State coverage initiatives, such as the Reinsurance Program. However, there are a core group of people, about 6% of Marylanders, who do not have coverage.[i] Immigrants without legal residency status are among this 6%. The requested amendment to Maryland's 1332 waiver will open an additional pathway for this community to obtain insurance. For people who are not fluent in English, it is particularly difficult to navigate the process of purchasing insurance. If the waiver amendment is approved, more people can benefit from the Exchange's navigator and support system to purchase the best insurance option for their family.

If we can provide any additional information, please contact our governmental affairs representative, Robyn Elliott, at relliott@policypartners.net.

[i] https://www.marylandhbe.com/wp-content/uploads/2021/02/COVID_Uninsured_Analysis_Report.pdf

June 18, 2024
The Honorable Michelle Eberle, Secretary
Maryland Health Benefit Exchange
750 E. Pratt St. 6th floor
Baltimore MD, 21202

Public Comment IN SUPPORT of Maryland's Section 1332 Waiver Amendment Request
Maryland Health Benefit Exchange
June 18, 2024

Dear Secretary, Eberle,

My name is Suyanna Linhales Barker, and I hold the position of Chief Program Officer at La Clínica del Pueblo. La Clínica is a Federally Qualified Health Center (FQHC) providing comprehensive health and community services to primarily Latino immigrants in the Washington metropolitan region. Our roots trace back to 1983, when we were established in response to the influx of Central American refugees arriving in the District. As our community has expanded into Prince George's County, so have we; we now offer services in Maryland.

Today we operate a clinical site in Hyattsville, provide mental health services to unaccompanied minors at Northwestern High School, and provide a range of holistc primary care, community health education and linkage to care activities throughout Prince George's and Montgomery Counties.

As an organization steadfastly committed to promoting health equity, La Clínica del Pueblo wishes to express our favorable stance on The Maryland Health Benefit Exchange (MHBE) approval to amend its existing Section 1332 waiver under the Patient Protection and Affordable Care Act (ACA) from the Centers for Medicare and Medicaid Services (CMS) and the Department of the Treasury.

The successful approval of the 1332 waiver will enable the full implementation of the Access to Care Act (SB705/HB728), which was passed by the Maryland General Assembly in 2024. This act directs MHBE to seek an amendment to allow all Maryland residents, regardless of immigration status, to be eligible to purchase private health plans on the Exchange.

At La Clínica, we firmly believe that health is a fundamental human right and that it is nurtured not just within the confines of a clinic, but also within the environments in which we live, work, and play. We also recognize that achieving high-quality health outcomes

necessitates addressing the inequities in health access related to race, class, and immigration status. Over sixty percent of our patients in Maryland are uninsured and ineligible for health insurance, particularly impacting essential workers during the COVID-19 pandemic. These same patients are just a fraction of the 112,400 residents who do not have healthcare in the state.[1]

We strongly believe that the Access to Care Act (SB705/HB728) is a crucial measure toward achieving health equity in Maryland. The bill will allow consumers to receive adequate support in their native language and navigation support to select adequate plans in the insurance market. Most importantly, extending the opportunity to purchase insurance can ensure that many patients who receive services at La Clinica, other FQHC's and Primary Care providers are incentivized to get regular checkups and preventive screenings.

Primary care should serve as the cornerstone of healthcare delivery, offering preventive services, early disease detection, and management of chronic conditions. By investing in primary care, we prioritize patient-centered approaches that emphasize continuity of care, patient education, and holistic well-being. By opening the exchange to previously excluded populations, the bill will help increase the financial sustainability of primary care providers, improve health outcomes, mitigate healthcare costs, give consumers options of where to receive care and reduce costs. Ultimately, establishing the 1332 waiver can help the State save funds typically used for covering uncompensated care for emergency department services for uninsured residents.

The passing of the 1332 waiver aligns with Maryland values aimed at protecting life, promoting health and treating all people with dignity, respect and care. It is for all these compelling reasons that La Clinica Del Pueblo respectfully requests favorable consideration of the 1332 waiver.

Thank you for your consideration,
Suyanna Linhales Barker DrPH.

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

July 9, 2024

Michele Eberle
Executive Director
Maryland Health Benefit Exchange
750 E. Pratt St., 6th floor
Baltimore, MD 21202

Re: Maryland 1332 State Innovation Waiver Amendment Request

Dear Executive Director Eberle:

The American Cancer Society Cancer Action Network (ACS CAN) appreciates the opportunity to comment on the Maryland Health Benefit Exchange's (MHBE's) request to amend the state's 1332 State Innovation Waiver. ACS CAN is making cancer a top priority for public officials and candidates at the federal, state and local levels. ACS CAN empowers advocates across the country to make their voices heard and influence evidence-based public policy change as well as legislative and regulatory solutions that will reduce the cancer burden. As the American Cancer Society's nonprofit, nonpartisan advocacy affiliate, ACS CAN is critical to the fight for a world without cancer.

ACS CAN supports a robust marketplace from which consumers can choose a health plan that best meets their needs. Access to health care coverage is paramount for preventing, detecting and treating cancer. Research from the American Cancer Society has shown that uninsured Americans are less likely to get screened for cancer and thus are more likely to have their cancer diagnosed at an advanced stage when survival is less likely and the cost of care more expensive.[1] In the United States, more than 2 million people will be diagnosed with cancer this year – an estimated 36,410 in Maryland.[2] An additional 18 million people are living with a history of cancer – 275,420 in Maryland.[3] For these individuals access to affordable health insurance is a matter of life or death.

ACS CAN supported the Access to Care Act, signed into law on May 16, 2024, which directed the MHBE to apply for an amendment to Maryland's existing 1332 waiver to allow all Maryland residents to enroll in private plans on the Exchange, regardless of immigration status. Cancer impacts everyone; a critical factor for eliminating disparities and ensuring health equity is to guarantee that all individuals have access to affordable and quality coverage.

ACS CAN supports this request to amend the Maryland 1332 State Innovation Waiver, as it will provide everyone – regardless of immigration status – the opportunity to enroll in health insurance plans on the

[1] E Ward et al, "Association of Insurance with Cancer Care Utilization and Outcomes, *CA: A Cancer Journal for Clinicians* 58:1 (Jan./Feb. 2008), http://www.cancer.org/cancer/news/report-links-health-insurance-status-with-cancer-care.
[2] American Cancer Society. Cancer Facts & Figures: 2024. Atlanta: American Cancer Society, 2024.
[3] American Cancer Society. Cancer Treatment & Survivorship: Facts & Figures 2022-2024. Atlanta: American Cancer Society, 2022.

exchange, where these individuals will benefit from a simplified shopping experience, consumer support, and the patient protections established in the Affordable Care Act. Undocumented immigrants are at a high risk of being uninsured, reflecting this population's limited access to health coverage options.[4] As of 2023, half (50%) of likely undocumented immigrant adults and one in five (18%) lawfully present immigrant adults reported being uninsured compared to less than one in ten naturalized citizen (6%) and U.S.-born citizen (8%) adults.[5] We hope this change will increase the rate of insurance coverage among immigrant populations, as everyone should have a fair and just opportunity to prevent, detect, treat and survive cancer.

Conclusion

On behalf of the American Cancer Society Cancer Action Network, we thank you for the opportunity to comment on Maryland's 1332 State Innovation Waiver Amendment Request. We support this proposal, which will provide more individuals access to quality health insurance and cancer prevention, treatment and survivorship care. If you have any questions, please feel free to contact me at lance.kilpatrick@cancer.org

Sincerely,

Lance Kilpatrick
Maryland Government Relations Director
American Cancer Society Cancer Action Network

[4] KFF. Health Coverage and Care of Undocumented Immigrants. July 15, 2019. Health Coverage and Care of Undocumented Immigrants | KFF.

[5] KFF. Key Facts on Health Coverage of Immigrants. September 17, 2023. Key Facts on Health Coverage of Immigrants | KFF.

EMAILED PUBLIC COMMENTS ON 1332 WAIVER AMENDMENT REQUEST

As a primary care physician and Unitarian Universalist person of faith, I am writing in regard to the proposed Section 1332 Waiver Request to allow all Marylanders, including our undocumented immigrant neighbors, to apply for health care coverage under the Affordable Care Act.

Our state recently enacted HB728/SB705, the Access to Care Act.
The MHBE is required to request this waiver under this new law, and I urge you to do so promptly, because ensuring that all Marylanders, regardless of an immigration status, have access to affordable health care is the morally correct thing to do, the legal thing to do, and also will help keep healthcare cost lower for all Marylanders. waiver

Respectfully,

Kari Alperovitz-Bichell, MD, MPH
1936 Severn Grove Rd.
Annapolis, MD 21401

Dear Ladies and Gentlemen:

I wish to express my support for the waiver that will allow all Marylanders, including our undocumented immigrant neighbors, to apply for health care coverage under the Affordable Care Act.

I worked during the 9 years before my retirement with the Latinex community in Southeast Baltimore and realize the agony of parents' decisions about sick children--or themselves--needing care but not born in this country. It seems so unfair.

If they are able to purchase insurance, why should they be denied? They are working and contributing to our city and state and our economy. Ttheir health is as important as mine.

Thank you for your attention.

Sincerely,

Marilyn Carlisle
1238 Ramblewood Rd
Baltimore, MD 21239

I encourage MHBE to expeditiously submit the Section 1332 waiver request as required by the recent enactment of SB705/HB728 in the last legislative session to enable all Marylanders, regardless of their immigration status to apply to healthcare coverage under the Affordable Care Act. Ensuring that everyone in MD has access to health care makes our entire Maryland community healthier, reduces reliance on expensive emergency care and prevents unnecessary emergency care. Thank you.

James Caldiero

To Whom It May Concern,

The ACLU of Maryland supports MHBE's 1332 Waiver Amendment Application, to ensure that undocumented individuals and families in Maryland have access to the healthcare benefits provided by the Affordable Care Act. Please see our testimony (attached) for SB705 - Access to Care, which we submitted to the legislature during this year's session.

A large percentage of undocumented people living, working, and supporting their families in Maryland do not have health insurance. Without healthcare, those who have chronic health issues — and their loved ones — often struggle in their effort towards economic stability and accessing the vast array of opportunities that our state has to offer. A serious one-time illness or injury can also derail an individual's or family's path towards success. Access to Care will not only help individuals and families in need, it will also improve Maryland's overall economic well being.

Thank you for your work on this matter.

Sincerely,

Frank Patinella
Pronouns: He/Him/His

Senior Public Policy Advocate
American Civil Liberties Union of Maryland
3600 Clipper Mill Road, Suite 350
Baltimore, MD 21211
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Testimony for the Senate Finance Committee
SB 705 - Health Insurance - Qualified Resident Enrollment Program (Access to Care Act)
February 21, 2024

Written by: Elizabeth Chung, Executive Director of the Asian American Center of Frederick, Yewande Oladeinde, President of Nigerians in Frederick, and Frank Patinella, Senior Education Advocate for the ACLU of Maryland

FAVORABLE

The ACLU of Maryland, Asian American Center of Frederick (AACF), and Nigerians in Frederick support SB 705 - Health Insurance - Qualified Resident Enrollment Program (Access to Care Act), which seeks to address critical health disparities among undocumented individuals in Maryland. This bill would provide access to Maryland's Health Benefit Exchange program for individuals and families that meet the federal Affordable Care Act's (ACA) income eligibility criteria. The bill would require the state to apply for a waiver under the ACA to secure eligibility for undocumented individuals and families.

The Maryland legislature has made significant strides in expanding healthcare to residents throughout the state through a variety of programs over the past decade. Since the ACA passed, 28 million Marylanders have obtained affordable health insurance through the state's exchange. However, there are many people in Maryland — especially nearly 300,000 undocumented immigrants — who struggle to find resources for routine care due to the lack of access to healthcare insurance. Without this benefit, many undocumented immigrants have not had the option to receive regular monitoring and treatment for serious medical conditions.

Access to primary care and specialized services have been correlated with positive health outcomes.[1] Health insurance allows individuals to secure a regular source of care, which is critical for detecting and treating diseases, managing chronic illnesses, and overall preventive care. People without insurance oftentimes delay seeking care due to the high costs of paying out of pocket, which can eventually lead to costly emergency room visits and sometimes the outcomes are fatal.

For the past four years, AACF has been part of the Community Health Access Program (CHAP) with Kaiser Permanente (KP) to provide health insurance to thousands of Marylanders. For every person enrolled, there were approximately 2 people placed on the waiting list. Further, despite

[1] *Access to primary care*. Access to Primary Care - Healthy People 2030. (n.d.). Retrieved February 13, 2023, from https://health.gov/healthypeople/priority-areas/social-determinants-health/literature-summaries/access-primary-care

KP's generosity, there was still an access issue because many of AACF's clients in communities from western Maryland lacked adequate transportation to access health care services in counties where KP providers are located. SB 705 would largely remove this barrier by allowing hundreds of thousands of residents to access healthcare services in their local communities.

Nevertheless, the CHAP insurance provision continues to save lives. Of the thousands of people that AACF served, one older gentleman's story is particularly compelling. This man came to America from Bangladesh more than 20 years ago and was undocumented since his arrival. He worked as a cook and did not have money for health insurance. But he paid his taxes, volunteered to serve the community, and made great contributions to the community. AACF was able to help him access care through KP and he was able to have an operation on his hernia, which progressed to a debilitating condition for him. This operation allowed him to continue working and he was finally able to visit his grandchildren whom he had not yet met in his home country. The CHAP insurance saved his life. Unfortunately, there are many more people like him who need access to healthcare in our community and throughout our state.

Nigerians in Frederick has also collaborated with AACF in seeking healthcare resources for their constituents that do not have access to affordable healthcare. One woman who attended an AACF health fair revealed that her prescription medications had to be sent to her by her family in Nigeria. After being connected with services through the health fair, medical professionals learned quickly that she was at high risk of going into a hypertensive crisis due to her excessively high blood pressure. Every time she reflects on her experience, she is filled with gratitude and gives credit to AACF, Nigerians in Frederick, and the healthcare she received for saving her life.

Another case happened during the COVID pandemic, when there were lots of uncertainties about getting the vaccine and misinformation being spread among the Nigerian community about the need to have health insurance to pay for the vaccines or that the vaccine was a way for the government to track those in the country illegally. The health fair with AACF and the educational outreach efforts helped to alleviate their concerns.

The immigrant community is one of the most vulnerable and underserved populations when it comes to healthcare access. Passing SB 705 would represent a big step forward to ensure that the basic human right of healthcare, regardless of immigration status, is more accessible for Maryland's immigrant communities.

<u>For the foregoing reasons, we urge this committee to give SB 705 a favorable report.</u>

Elizabeth Chung | Executive Director | Asian American Center of Frederick | echung@aacfmd.org
Yewande Oladeinde, Ph.D. | Nigerians in Frederick | info@associationofnigeriansinfrederick.com
Frank Patinella | Senior Education Advocate | ACLU of Maryland | patinella@aclu-md.org

Kimberly Y. Robinson
Vice President
State Government Affairs

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VIA ELECTRONIC TRANSMISSION

July 9, 2024

Michele Eberle
Executive Director
Maryland Health Benefit Exchange
750 East Pratt Street, 6th floor
Baltimore, MD 21202

RE: Maryland 1332 State Innovation Waiver Amendment Request

Dear Director Eberle:

On behalf of CareFirst BlueCross BlueShield (CareFirst), we appreciate the opportunity to comment on the Maryland Health Benefit Exchange's (MHBE) draft 1332 State Innovation Waiver (1332 Waiver) amendment application. Throughout our more than 80-year history, CareFirst has been on a continuous journey to improve the health of the communities we serve through innovation, advocacy, and investment in our communities. CareFirst believes ensuring equitable access to high quality, affordable healthcare services is essential to improving health outcomes. It is part of our mission to promote the integration of a healthcare system that meets the healthcare needs of all Marylanders. We proudly supported the Access to Care Act (Maryland House Bill 728/Senate Bill 705) and applaud the State of Maryland and MHBE for taking steps to establish a Qualified Resident Enrollment Program to allow all Maryland residents to enroll in private plans on-Exchange, regardless of immigration status.

CareFirst strongly believes all people, regardless of their race, ethnicity, or citizenship status, deserve access to quality and affordable healthcare. Undocumented immigrants likely experience adverse health outcomes directly related to their high risk of being uninsured. Often, they have limited access to employer-sponsored insurance and face eligibility restrictions preventing their ability to purchase individual health insurance plans offered through MHBE or to enroll in Medicare, Medicaid, or the Children's Health Insurance Program. It is well established that the timely use of healthcare services is associated with better health outcomes. Inadequate health insurance coverage is one of the largest barriers to healthcare access for reasons such as high out-of-pocket medical care costs, which lead to individuals delaying or forgoing much-needed medical care. Data illustrates that uninsured adults are less likely to receive preventive services for chronic conditions such as diabetes, cancer, and cardiovascular disease. Similarly, children without health insurance coverage are less likely to receive appropriate treatment for conditions such as asthma or critical preventive services such as dental care, immunizations, and well-child visits that track developmental milestones (Healthy People 2030). A Qualified Resident Enrollment Program will create a pathway for uninsured individuals who are currently

ineligible to enroll on-Exchange due to their immigration status to obtain health insurance, giving them access to free or low-cost preventive care and essential health benefits, access to a network of behavioral health providers and specialists to treat chronic conditions, and financial protection from unexpected, high medical costs.

After reaching a record low of 7.3 percent in 2023, the Congressional Budget Office (CBO) projects the nation's uninsured rate to climb to nearly 9 percent by 2034. This anticipated increase of people without health insurance will be partly attributable to a surge in immigration that began in 2021 (that the CBO projects will continue through 2026), as those newly arrived immigrants will be significantly less likely to have health insurance coverage than the overall population. Although uninsured people tend to utilize fewer healthcare resources compared to those with health insurance coverage, when those without health insurance seek medical attention and cannot afford the costs, the resulting unpaid expenses are considered uncompensated care. Under Maryland's Total Cost of Care model, the Health Services Cost Review Commission (HSCRC) sets rates for services provided by Maryland hospitals. Uncompensated care costs are factored into rate-setting, ultimately increasing the cost of care for all Marylanders. The Qualified Resident Program will help lower the uninsured rate in Maryland and have a direct downstream impact on the affordability of healthcare services in the state.

Expanding care to individuals of any immigration status is not a new concept to the state of Maryland. The Healthy Babies Equity Act, which became effective in July 2023, provides Medicaid coverage to non-citizen pregnant and postpartum individuals and their children (for up to one year) who would otherwise, besides their immigration status, be eligible for Medicaid or Maryland Children's Health Program. The Qualified Resident Enrollment Program would provide an avenue for continuity of coverage for undocumented Maryland residents, as they would have the option to purchase health insurance on Exchange when they are no longer eligible for the coverage provided through the Healthy Babies Equity Act, for example, thus giving more families the opportunity to avoid a gap in coverage. Other jurisdictions, such as the District of Columbia through the Alliance Program and the Immigrant Children's Program, have taken steps to expand access to care for individuals who are not eligible for Medicaid or Medicare due to their immigration status. Maryland has the opportunity to join the ranks of other jurisdictions that are decreasing the costs of uncompensated care and increasing access to coverage with a Qualified Resident Enrollment Program that will allow previously ineligible individuals, regardless of being pregnant or postpartum, to enroll in healthcare coverage.

Establishing a Qualified Resident Enrollment Program is an important piece of advancing a transformative healthcare experience for Maryland's undocumented residents. We are in full support of MHBE's submission of a 1332 Waiver amendment request to establish a Qualified Resident Program and look forward to partnering with MHBE to identify and secure a long-term, sustainable funding source to ensure the success and affordability of the Qualified Resident Enrollment Program.

Sincerely,

Kimberly Y. Robinson

Public Comments in SUPPORT of 1332 Waiver Amendment Request
(Pursuant to 2024 Access to Care Act SB705/HB588)
Maryland Health Benefit Exchange

June 24, 2024

Dear Ms. Eberle,

CASA is pleased to offer public comments in strong support of the Maryland Health Benefit Exchange's 1332 State Innovation Waiver Amendment Request. CASA is a national powerhouse organization building power and improving the quality of life in working-class: Black, Latino/a/e, Afro-descendent, Indigenous, and Immigrant communities.

With a membership of over 155,000 members, CASA creates change with its power-building model blending human services, community organizing, and advocacy to serve the full spectrum of the needs, dreams, and aspirations of members. For nearly forty years, CASA has employed grassroots community organizing to bring our communities closer together and fight for justice, while simultaneously providing much-needed services, helping to ensure that low-income immigrants can live rich and full lives.

CASA operates a robust Health and Human Services Department, where our offices work closely with thousands of Marylanders who are uninsured, the majority of whom are undocumented and live in mixed-status households. The CASA health team helps thousands of families, including children and pregnant individuals, navigate city, state, and federal health programs. Most recently, our health team in coordination with our state's Medicaid program, has answered the call to support newly eligible pregnant immigrant individuals to enroll in Medicaid. The recent expansion results from the Healthy Babies Equity Act a critical piece of legislation that seeks to expand immigrant healthcare and provide much-needed coverage to individuals during pregnancy. We were pleased to continue to support another piece of legislation that seeks to tackle our state's uninsured rate by removing barriers to access to care, the Access to Care Act.

The Access to Care Act 2024 HB 728/SB 705 addresses critical health disparities faced by the immigrant community in Maryland by expanding the Affordable Care Act to all Marylanders who meet the regular eligibility, regardless of their immigration status. As part of the Act MHBE is directed to submit a State Innovation Waiver. We applaud MHBE's swift waiver request application and fully support it. Despite the deep contributions to Maryland that

undocumented families have made to our state, there are over 250,000 immigrants who worked on the frontlines during the pandemic and who paid over $240 million in federal, state, and local taxes. Yet, Black and Brown residents continue to become sicker, are hospitalized at higher rates, and die younger as they are forced to face life-or-death situations due to being excluded from programs such as the Affordable Care Act. The Institute of Medicine[1] estimates that 18,000 Americans died in one year because they were uninsured. Access to healthcare affects an individual's health, well-being, and life expectancy. It can prevent diseases and disabilities, detect and treat illnesses, increase the quality of life, reduce the likelihood of premature death, and increase life expectancy.[2] At no fiscal burden to the state, meeting all federal statutory guardrails, this waiver request is instrumental in tackling the disproportionately high uninsured rate among immigrant Marylanders. The data is stark, ineligible immigrant Marylanders only make up 6% of the state's population but account for more than 30% of the uninsured in the state.

Opening access to the state's health insurance marketplace for all, regardless of immigration, will allow any Maryland to have hands-on support through the health insurance process. For many immigrant families navigating the private healthcare market without culturally competent assistance such as language assistance has been a barrier to getting insured. With certified authorized brokers, navigator programs, and extensive customer support in over 200 languages, immigrant families will have access to just the support they need to be well-informed consumers and insured individuals.

In addition to tackling the uninsured rate, this waiver request will also tackle child poverty and child health outcomes in Maryland. Studies show that children of immigrants are more likely to lack health insurance than children whose parents were born in the U.S. Furthermore children of color, particularly, Black and Latino children, fare comparably worse than their White peers with similar backgrounds.[3] With this new opportunity, immigrant parents will be able to compare coverage options and enroll in the same plans as their children leading to cost savings on premiums for families. Removing the immigration requirement will ensure that more people, regardless of their immigration status, get healthcare.

CASA's membership, unfortunately, is overflowing with stories of families who due to their lack of access to care have foregone routine preventative care, and ended up receiving the most expensive type of care there is, emergency room (ER) care. This trend is unsustainable not only for families, who face mounting medical debt but also for our hospital system, which grapples with unprecedentedly long ER wait times and expends millions on uncompensated care annually.

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[1] https://www.commonwealthfund.org/blog/2019/insurance-coverage-saves-lives
[2] https://www.healthypeople.gov/2020/leading-health-indicators/2020-lhi-topics/Access-to-Health-Services
[3] https://www.ncbi.nlm.nih.gov/books/NBK224446/

Access to primary care coverage is provided through a comprehensive system that includes doctors and specialists which only health insurance provides is critical to protecting the health of our communities and our medical system.

This waiver request aligns Maryland with its values of protecting life and treating all people with dignity, respect, and care while addressing one of the most significant healthcare disparities experienced by Marylanders of color. **For all of the reasons above, CASA offers these public comments in support of the 1332 State Innovation Waiver Amendment Request.**

Maryland Dental Action Coalition

10015 Old Columbia Road, Suite B-215
Columbia, Maryland 21046
www.mdac.us

To: **Maryland Health Benefit Exchange (MHBE)**

Subject: **Support of MHBE's Draft 1332 Waiver Amendment, pursuant to Senate Bill 705 / House Bill 728 of 2024**

Date: **July 1, 2024**

The Maryland Dental Action Coalition strongly supports the 1332 waiver amendment proposal to enable all individuals, regardless of legal status, to buy health insurance through the Maryland Health Benefit Exchange. Maryland has significantly reduced uninsured rates by implementing the Affordable Care Act, and through state initiatives like the Reinsurance Program. Yet, about 6% of Marylanders remain uninsured, including immigrants without legal status. CareQuest Institute for Oral Health, in partnership with MDAC, has been monitoring costs for emergency department visits for dental conditions that should have been treated earlier. In 2021, these emergency room visits cost $2.1 million for uninsured individuals. Some of these costs would have been avoided if more people could get dental coverage and had these dental issues managed by dental providers in an out-patient setting.

The proposed amendment to Maryland's 1332 waiver will create a new avenue for immigrants without legal status to obtain coverage. For those with limited English proficiency, navigating health insurance purchases is especially challenging. If approved, the waiver amendment would allow more people to benefit from the Exchange's navigator and support system, helping them choose the best health insurance option for their families. This change could make a significant difference in expanding healthcare access for all Maryland residents.

If we can provide any additional information, please contact Robyn Elliott at relliott@policypartners.net .

Optimal Oral Health for All Marylanders

AFFILIATE OF
AMERICAN COLLEGE of NURSE-MIDWIVES
With women, for a lifetime®

To: **Maryland Health Benefit Exchange (MHBE)**

Subject: **Support of MHBE's Draft 1332 Waiver Amendment, pursuant to SB 705/ HB 728 of 2024**

Date: **July 1, 2024**

The Maryland Affiliate of the American College of Nurse Midwives (ACNM) strongly supports MHBE's application to amend Maryland's 1332 to allow immigrants, regardless of legal residency status, to purchase qualified health plans. ACNM was a strong supporter of SB 705/HB 728, the Maryland legislation that established this pathway in 2024.

Maryland should take this step forward as it will allow us to improve health outcomes for pregnant and postpartum individuals as well as their newborns. The U.S. Department of Health and Human Services has set a goal to "increase the proportion of pregnant women who receive early and adequate prenatal care" in the Healthy People 2030 program[i]. Increasing the number of families who are insured is a critical strategy in ensuring access to care. If implemented, the State of Maryland would realize savings in health care, social, and educational systems. If we can improve the health outcomes of newborns and their families, we reduce the need for higher-intensity services.

If we can provide any additional information in supporting this waiver request, please contact Robyn Elliott at relliott@policypartners.net.

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[i] https://health.gov/healthypeople/objectives-and-data/browse-objectives/pregnancy-and-childbirth/increase-proportion-pregnant-women-who-receive-early-and-adequate-prenatal-care-mich-08

July 9, 2024

Matan Zeimer
Baltimore, MD 21218

JEWS UNITED FOR JUSTICE 25 YEARS
THINK JEWISHLY. ACT LOCALLY.

SUPPORT FOR 1332 WAIVER AMENDMENT

Health Insurance - Qualified Resident Enrollment Program (Access to Care Act)

TO: The Maryland Health Benefit Exchange (MHBE)

FROM: Matan Zeimer, Maryland Policy Director at Jews United for Justice (JUFJ)

My name is Matan Zeimer and I am submitting this public comment on the 1332 Waiver Amendment Application on behalf of Jews United for Justice (JUFJ). JUFJ organizes 6,000 Jews and allies from across the state in support of social, racial, and economic justice campaigns.

After years of advocacy alongside our partners, including CASA and the Healthcare for All Coalition, the Maryland General Assembly finally passed the Access to Care Act (ACA) during the 2024 legislative session. This legislation ensures that everyone in Maryland, regardless of immigration status, will be able to access healthcare coverage. By submitting a 1332 waiver as required by this legislation, MHBE will be advancing a significant achievement in the fight for both immigrant and health justice in Maryland and in turn improve equity and health outcomes in communities across the state. We know that increased access to primary care for all Marylanders, regardless of immigration status, will result in greater healthcare equity, decreased costs, and decreased burden on emergency departments.

The insistence that we behave with care, equity, and love toward the stranger is the most-repeated commandment in the entire Torah. As Jews and as human beings, we are obligated to make sure that those of us who were not born in our community are as safe, and as healthy, as those who were. This is why we've joined partners advocating for the expansion of healthcare access in Maryland and why we will continue to support these efforts moving forward.

On behalf of Jews United for Justice, I respectfully submit this public comment in favor of MHBE's draft 1332 Waiver Amendment Application.

July 9, 2024

Michele Eberle
Executive Director
Maryland Health Benefit Exchange
750 East Pratt St., 6th floor
Baltimore, MD 21202

Re: Maryland Section 1332 State Innovation Waiver Amendment Request

Dear Director Eberle:

Thank you for the opportunity to provide feedback on Maryland's Waiver Amendment Request.

The undersigned organizations represent millions of individuals facing serious, acute and chronic health conditions. We have a unique perspective on what individuals and families need to prevent disease, cure illness and manage chronic health conditions. The diversity of our organizations and the populations we serve enable us to draw upon a wealth of knowledge and expertise that is an invaluable resource regarding any decisions affecting the Affordable Care Act, the marketplace, and the people that they serve. We urge the state to make the best use of the recommendations, knowledge and experience our organizations offer here.

Our organizations are committed to ensuring that Maryland's healthcare programs provide quality and affordable healthcare coverage. We believe that Maryland's proposal to use a Section 1332 waiver to allow all Marylanders, regardless of immigration status, to enroll in marketplace coverage will advance these objectives. Once implemented, this waiver amendment is expected to provide access to comprehensive marketplace coverage to thousands of Marylanders while satisfying the federal guardrail protections governing waivers.

Our organizations support Maryland's efforts to improve health equity by making affordable coverage available to all Marylanders, regardless of immigration status. Waiving Section 1312(f)(3) of the Affordable Care Act will make it easier for more Marylanders to access the care they need. This will enable more families with mixed immigration status to enroll in coverage together, and for uninsured individuals with no other options for health coverage to enroll in coverage as well. Those who enroll in coverage due to this amendment will also have access to other benefits available through the marketplace, including language interpretation services.

At the same time, the state represents that the waiver will not affect comprehensiveness of benefits or costs for existing marketplace enrollees, satisfying federal statutory guardrails. We appreciate the commitment to preserving affordability and access to comprehensive coverage for the more than 200,000 current enrollees of the program.

While Maryland anticipates that this amendment will gradually increase enrollment, the cost of marketplace plans may still be a barrier to accessing coverage for this population. Our organizations urge Maryland to establish a state subsidy program for the population that this amendment would impact. Research consistently shows that higher cost-sharing is associated with decreased use of preventive services and medical care among low-income populations.[1] A subsidy program would improve affordability of care and drive coverage enrollment in Maryland, while also bolstering health equity. Nationally, 18% of lawfully present immigrants and half of undocumented immigrants report being uninsured, compared to 8% of US-born citizens, and this population is also more likely to report facing coverage barriers and skipping care.[2] By expanding financial assistance for marketplace plans, the state can raise enrollment among underserved populations, improving health equity and reducing disparities in Maryland.

Our organizations support this proposal to expand access to quality coverage in Maryland and encourage the state to consider implementing a subsidy program that would improve affordability of coverage. Thank you for the opportunity to provide comments.

Sincerely,

American Lung Association
Child Neurology Foundation
Hemophilia Federation of America
National Organization for Rare Disorders
National Patient Advocate Foundation
The AIDS Institute
The Leukemia & Lymphoma Society

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[1]Artiga, Samantha et al. The Effects of Premiums and Cost Sharing on Low-Income Populations: Updated Review of Research Findings. KFF. June 1, 2017. Available at: https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/.

[2] Key Facts on Health Coverage of Immigrants. KFF. September 1, 2023. Available at: https://www.kff.org/racial-equity-and-health-policy/fact-sheet/key-facts-on-health-coverage-of-immigrants/.

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The Effects of Premiums and Cost Sharing on Low-Income Populations: Updated Review of Research Findings

Samantha Artiga (https://www.kff.org/person/samantha-artiga/), **Petry Ubri, and Julia Zur**

Published: Jun 01, 2017

ISSUE BRIEF

Key Findings

Recently, there has been increased interest at the federal and state level to expand the use of premiums and cost sharing in Medicaid as a way to promote personal responsibility, prepare beneficiaries to transition to commercial and private insurance, and support consumers in making value-conscious health decisions. This brief reviews research from 65 papers published between 2000 and March 2017 on the effects of premiums and cost sharing on low-income populations in Medicaid and CHIP. This research has primarily focused on how premiums and cost sharing affect coverage and access to and use of care; some studies also have examined effects on safety net providers and state savings. The effects on individuals, providers, and state costs reflect varied implementation of premiums and cost sharing across states as well as differing premium and cost sharing amounts. Together, the research finds:

- **Premiums serve as a barrier to obtaining and maintaining Medicaid and CHIP coverage among low-income individuals.** These effects are largest among those with the lowest incomes, particularly among individuals with incomes below poverty. Some individuals losing Medicaid or CHIP coverage move to other coverage, but others become uninsured, especially those with lower incomes. Individuals who become uninsured face increased barriers to accessing care, greater unmet health needs, and increased financial burdens.
- **Even relatively small levels of cost sharing in the range of $1 to $5 are associated with reduced use of care, including necessary services.** Research also finds that cost sharing can result in unintended consequences, such as increased use of the emergency room, and that cost sharing negatively affects access to care and health outcomes. For example, studies find that increases in cost sharing are associated with increased rates of uncontrolled hypertension and hypercholesterolemia and reduced treatment for children with asthma. Additionally, research finds that cost sharing increases financial burdens for families, causing some to cut back on necessities or borrow money to pay for care.
- **State savings from premiums and cost sharing in Medicaid and CHIP are limited.** Research shows that potential revenue gains from premiums and cost sharing are offset by increased disenrollment; increased use of more expensive services, such as emergency room care; increased costs in other areas, such as resources for uninsured individuals; and administrative expenses. Studies also show that raising premiums and cost sharing in Medicaid and CHIP increases pressures on safety net providers, such as community health centers and hospitals.

Introduction

Recently, there has been increased interest at the federal and state level to expand the use of premiums and cost sharing in Medicaid. Current rules limit premiums and cost sharing in Medicaid to facilitate access to coverage and care for the low-income population served by the program, who have limited resources to spend on out-of-pocket costs. Proponents of increasing premiums and cost sharing in Medicaid indicate that doing so will promote personal responsibility, prepare beneficiaries to transition to commercial and private insurance, and support consumers in making value-conscious health decisions.[1] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-1)

This brief, which updates an earlier brief "*Premiums and Cost-Sharing in Medicaid: A Review of Research Findings* (https://www.kff.org/medicaid/issue-brief/premiums-and-cost-sharing-in-medicaid-a-review-of-research-findings/)," reviews research on the effects of premiums and cost sharing on low-income populations in Medicaid and CHIP. It draws on findings from 65 papers published between 2000 and March 2017, including peer-reviewed studies and freestanding reports, government reports, and white papers by research and policy organizations. This research has primarily focused on how premiums and cost sharing affect coverage and access to care; some studies also have examined effects on state savings. The effects on individuals, providers, and state costs reflect varied implementation of premiums and cost sharing across states as well as differing premium and cost sharing amounts.

Premiums and Cost Sharing in Medicaid and CHIP Today

Currently, states have options to charge premiums and cost sharing in Medicaid and CHIP that vary by income and eligibility group (Box 1). Reflecting these options, premiums and cost sharing in Medicaid and CHIP vary across states and groups. As of January 2017, 30 states charge premiums or enrollment fees and 25 states charge cost sharing for children in Medicaid or CHIP.[2] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-2) Most of these charges are limited to children in CHIP since the program covers children with higher family incomes than Medicaid and has different premium and cost sharing rules. States generally do not charge premiums for parents in Medicaid, but 39 states charge cost sharing for parents and 23 of the 32 states that implemented the Affordable Care Act (ACA) Medicaid expansion to low-income adults charge cost sharing for expansion adults.[3] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-3) Six states have waivers to charge premiums or monthly contributions for adults that are not otherwise allowed.[4] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-4)

Box 1: Medicaid and CHIP Premium and Cost Sharing Rules

Medicaid

- States may charge premiums for enrollees with incomes above 150% of the federal poverty level (FPL), including children and adults. Enrollees with incomes below 150% FPL may not be charged premiums.
- States may charge cost sharing up to maximums that vary by income (Table 1). States cannot charge cost sharing for emergency, family planning, pregnancy-related services, preventive services for children, or preventive services defined as essential health benefits in Alternative Benefit Plans in Medicaid. In addition, states generally cannot charge cost sharing to children enrolled through mandatory eligibility categories. The minimum eligibility standard for children is 133% FPL, although some states have higher minimums.
- Overall, premium and cost sharing amounts for family members enrolled in Medicaid may not exceed 5% of household income. This 5% cap is applied on a monthly or quarterly basis.

CHIP

- States have somewhat greater flexibility to charge premiums and cost sharing for children in CHIP, although there are limits on the amounts that states can charge, including an overall cap of 5% of household income.

Table 1: Maximum Allowable Cost Sharing Amounts in Medicaid by Income

	<100% FPL	100% – 150% FPL	>150% FPL
Outpatient Services	$4	10% of state cost	20% of state cost
Non-Emergency use of ER	$8	$8	No limit (subject to overall 5% of household income limit)
Prescription Drugs			
Preferred	$4	$4	$4
Non-Preferred	$8	$8	20% of state cost
Inpatient Services	$75 per stay	10% of state cost	20% of state cost

Notes: Some groups and services are exempt from cost sharing, including children enrolled in Medicaid through mandatory eligibility pathways, emergency services, family planning services, pregnancy related services, and preventive services for children. Maximum allowable amounts are as of FY2014. Beginning October 1, 2015, maximum allowable amounts increase annually by the percentage increase in the medical care component of the Consumer Price Index for All Urban Consumers (CPI-U).

Effects of Premiums (Table 1 (https://www.kff.org/report-section/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings-table-1/))

A large body of research shows that premiums can serve as a barrier to obtaining and maintaining Medicaid and CHIP coverage among low-income individuals. Studies show that premiums in Medicaid and CHIP lead to a reduction in coverage among both children and adults.[5] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-5),[6] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-6),[7] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-7),[8] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-8),[9] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-9),[10] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-10) Numerous studies find that premiums increase disenrollment from Medicaid and CHIP among adults and children, shorten lengths of Medicaid and CHIP enrollment, and deter eligible adults and children from enrolling in Medicaid and CHIP.[11] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-11),[12] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-12),[13] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-13),[14] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-14),[15] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-15),[16] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-16),[17] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-17),[18] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-18),[19] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-

findings/view/footnotes/#footnote-220856-19)[20](https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-20)[21](https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-21)[22](https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-22)[23](https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-23)[24](https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-24)[25](https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-25)[26](https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-26)[27](https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-27)[28](https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-28)[29](https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-29)[30](https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-30)[31](https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-31)[32](https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-32)[33](https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-33)[34](https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-34)[35](https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-35)[36](https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-36)[37](https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-37)[38](https://www.kff.org/medicaid/issue-brief/the-effects-of-

premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-38)’[39] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-39)

Although some individuals who disenroll from Medicaid or CHIP following premium increases move to other sources of coverage, others become uninsured and face negative effects on their access to care and financial security. Those with lower incomes and those without a worker in the family are more likely to become uninsured compared to those with relatively higher incomes or with a worker in the family, reflecting less availability of employer coverage.[40] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-40)’[41] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-41)’[42] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-42)’[43] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-43)’[44] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-44)’[45] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-45)’[46] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-46)’[47] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-47)’[48] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-48)’[49] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-49) Studies also show that those who become uninsured following premium increases face increased barriers to accessing care, have greater unmet health needs, and face increased financial burdens.[50] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-50)’[51] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-51)’[52] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-52) ’[53] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-

populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-53)',[54] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-54) Several studies suggest that these negative effects on health care are largest among individuals with greater health care needs.[55] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-55)',[56] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-56)

Premium effects are largest for those with the lowest incomes, particularly among those with incomes below poverty. Given that most states limit premium charges to children in CHIP, most studies of premium effects have focused on children in CHIP, who generally have incomes above 100% or 150% of the federal poverty level. A range of these studies show that premium effects are larger among children at the lower end of this income range, who have greater disenrollment and increased likelihood of becoming uninsured.[57] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-57)',[58] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-58)',[59] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-59)',[60] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-60)',[61] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-61)',[62] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-62)',[63] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-63)',[64] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-64)',[65] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-65) Reflecting the more limited use of premiums among Medicaid enrollees with incomes below poverty, fewer studies have focused on this population. However, studies that have focused on poor Medicaid enrollees found substantial negative effects on enrollment from premiums.[66] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-66)',[67] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-

populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-67),[68] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-68),[69] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-69) For example, in Oregon, nearly half of adults disenrolled from Medicaid after a premium increase with a maximum premium amount of $20, with many becoming uninsured and facing barriers to accessing care, unmet health needs, and increased financial burdens.[70] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-70),[71] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-71),[72] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-72) Similarly, a more recent study of the Healthy Indiana Plan waiver program for Medicaid expansion adults with incomes below 138% FPL, which requires premiums that range from $1-$100 to enroll in a more comprehensive plan, found that 55% of eligible individuals either did not make their initial payment or missed a payment.[73] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-73) Research also finds that premium effects may vary by other factors beyond income. For example, one study finds larger effects of premiums among families without an offer of employer-sponsored coverage.[74] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-74) Some research also suggests that increases in Medicaid and CHIP premiums may have larger effects on coverage for children of color and among children whose families have lower levels of educational attainment.[75] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-75),[76] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-76),[77] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-77)

Research finds varying implications of premiums for individuals with significant health needs. Overall, individuals with greater health needs are less likely to disenroll from Medicaid or CHIP coverage and are more likely to have longer periods of Medicaid or CHIP coverage compared to those with fewer health needs.[78] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-78),[79] (https://www.kff.org/medicaid/issue-brief/the-effects-of-

premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-79)',[80] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-80)',[81] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-81) However, findings vary regarding how individuals with health needs respond to premium increases. Some studies show that individuals with greater health needs are less sensitive to premium increases compared to those with fewer health needs, reflecting their increased need for services.[82] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-82)',[83] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-83) These findings suggest that individuals with greater health needs are more likely than those with less significant health needs to remain enrolled following premium increases, but then face increased financial burdens to maintain their coverage. Other studies find that children with increased health needs are as likely or more likely than those with fewer health needs to disenroll from coverage following premium increases, suggesting premiums may lead to children going without coverage despite ongoing health needs.[84] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-84)',[85] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-85)

Effects of Cost Sharing (Table 2 (https://www.kff.org/report-section/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings-table-2/))

A wide range of studies find that even relatively small levels of cost sharing, in the range of $1 to $5, are associated with reduced use of care, including necessary services. The RAND health insurance experiment (HIE), conducted in the 1970s and still considered the seminal study on the effects of cost sharing on individual behavior, shows a reduction in use of services after cost sharing increased, regardless of income.[86] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-86) Since then, a growing body of research has found that cost sharing is associated with reduced utilization of services,[87] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-87) including vaccinations,[88] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-88) prescription drugs,[89] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-

sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-89)',[90] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-90)',[91] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-91)',[92] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-92) mental health visits,[93] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-93) preventive and primary care,[94] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-94)',[95] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-95)',[96] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-96)',[97] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-97)',[98] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-98) and inpatient and outpatient care,[99] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-99)',[100] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-100) and decreased adherence to medications.[101] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-101)',[102] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-102)',[103] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-103) In many of these studies, copayment increases as small as $1-$5 can effect use of care. Some studies find that lower-income individuals are more likely to reduce their use of services, including essential services, than higher-income individuals.[104] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-104)',[105] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-105) Research also suggests that copayments can result in unintended consequences, such as increased use of other costlier services like the emergency room.[106] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-

on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-106) Two studies have found that copayments do not negatively affect utilization.[107] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-107),[108] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-108) In one case, the authors suggest that increases in provider reimbursement may have negated effects of the copayment increases, particularly if not all copayments were being collected by providers at the point of care.[109] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-109)

Research points to varying effects of cost sharing for people with significant health needs. Some studies find that utilization among individuals with chronic conditions or significant health needs is less sensitive to copayments compared to those with fewer health needs. As such, these individuals face increased cost burdens associated with accessing care because of copayment increases.[110] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-110),[111] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-111) Other research finds that even relatively small copayments can reduce utilization among individuals with significant health needs.[112] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-112),[113] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-113),[114] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-114)

Numerous studies find that cost sharing has negative effects on individuals' ability to access needed care and health outcomes and increases financial burdens for families.[115] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-115),[116] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-116),[117] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-117),[118] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-118),[119] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-

populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-119)',[120] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-120)',[121] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-121)',[122] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-122) For example, studies have found that increases in cost sharing are associated with increased rates of uncontrolled hypertension and hypercholesterolemia[123] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-123) and reduced treatment for children with asthma.[124] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-124) Increases in cost sharing also increase financial burdens for families, causing some to cut back on necessities or borrow money to pay for care. In particular, small copayments can add up quickly when an individual needs ongoing care or multiple medications.[125] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-125)',[126] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-126)

Findings on how cost sharing affects non-emergent use of the emergency room are limited. One study found that these copayments reduce non-urgent visits.[127] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-127) Other studies find that these copayments do not affect use of the emergency room.[128] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-128)',[129] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-129)

Effects on State Budgets and Providers (Table 3 (https://www.kff.org/report-section/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings-table-3/))

Research suggests that state savings from premiums and cost sharing in Medicaid and CHIP are limited. Studies find that potential increases in revenue from premium and cost sharing are offset by increased disenrollment; increased use of more expensive services, such as emergency room care; increased costs in other areas, such as resources for

uninsured individuals; and administrative expenses.[130](https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-130),[131](https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-131),[132](https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-132),[133](https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-133),[134](https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-134),[135](https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-135),[136](https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-136) One state study found increased revenues from premiums without significant effects on enrollment, but authors note a range of program-specific factors that may have contributed to this finding, including it being limited to a Medicaid-buy in program for individuals with disabilities with incomes above 150% FPL who may be less price-sensitive to the increase and the state implementing administrative processes designed to minimize disenrollment.[137](https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-137)

Studies also show that increases in premiums and cost sharing in Medicaid and CHIP can increase pressures on safety net providers, such as community health centers and hospitals. Several studies show that coverage losses following premium increases lead to increases in the share of uninsured patients seen by providers[138](https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-138),[139](https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-139),[140](https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-140) and increased emergency department use by uninsured individuals.[141](https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-141),[142](https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-142) One study also found that increases in copayments led to community health centers having to divert resources for medications for uninsured

individuals to help people who could not afford copayments and that copayments increased the rate of "no shows" for appointments at community health centers.[143] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-143)

Conclusion

Recently, there has been increased interest at the federal and state levels to expand the use of premiums and cost sharing in Medicaid as a way to promote personal responsibility, prepare beneficiaries to transition to commercial and private insurance, and support consumers in making value-conscious health decisions. Current rules limit premiums and cost sharing in Medicaid to facilitate access to coverage and care for the low-income population served by the program, who have limited resources to spend on out-of-pocket costs. This review of a wide body of research provides insight into the potential effects of increasing premiums and cost sharing for Medicaid enrollees. It shows that premiums serve as a barrier to obtaining and maintaining coverage for low-income individuals, particularly those with the most limited incomes, and that even relatively small levels of cost sharing reduce utilization of services. As such, increases in premiums and cost sharing result in increased barriers to coverage and care, greater unmet health needs, and increased financial burdens for families. Further, the research suggests that state savings from premiums and cost sharing in Medicaid and CHIP are limited and that increases in premiums and cost sharing in Medicaid and CHIP can increase pressures on safety-net providers.

STUDY TABLES (HTTPS://WWW.KFF.ORG/REPORT-SECTION/THE-EFFECTS-OF-PREMIUMS-AND-COST-SHARING-ON-LOW-INCOME-POPULATIONS-UPDATED-REVIEW-OF-RESEARCH-FINDINGS-STUDY-TABLES/) ›

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Key Facts on Health Coverage of Immigrants

Published: Sep 17, 2023

Note: This content was updated on June 26, 2024 to include updated information about state coverage for immigrants.

Summary

As of 2022, there were 45.5 million immigrants residing in the U.S., including 21.2 million noncitizen immigrants and 24.2 million naturalized citizens, who each accounted for about 7% of the total population.[1] Noncitizens include lawfully present and undocumented immigrants. Many individuals live in mixed immigration status families that may include lawfully present immigrants, undocumented immigrants, and/or citizens. One in four children has an immigrant parent, including over one in ten (12%) who are citizen children with at least one noncitizen parent.[2] This fact sheet provides an overview of health coverage for immigrants based on data from The 2023 KFF/LA Times Survey of Immigrants (https://www.kff.org/racial-equity-and-health-policy/issue-brief/health-and-health-care-experiences-of-immigrants-the-2023-kff-la-times-survey-of-immigrants), the largest nationally representative survey focused on immigrants.

As of 2023, half (50%) of likely undocumented immigrant adults and one in five (18%) lawfully present immigrant adults report being uninsured compared to less than one in ten naturalized citizen (6%) and U.S.-born citizen (8%) adults.[3] Noncitizen immigrants are more likely to be uninsured than citizens because they have more limited access to private coverage due to working in jobs (https://www.kff.org/racial-equity-and-health-policy/issue-brief/employment-among-immigrants-and-implications-for-health-and-health-care/) that are less likely to provide health benefits and they face eligibility restrictions for federally funded coverage options, including Medicaid, the Children's Health Insurance Program (CHIP), Affordable Care Act (ACA) Marketplace coverage, and Medicare. Those who are eligible for coverage also face

a range of enrollment barriers including fear, confusion about eligibility rules, and language and literacy challenges. Reflecting their higher uninsured rate, noncitizen immigrants are more likely than citizens to report barriers to accessing health (https://www.kff.org/racial-equity-and-health-policy/issue-brief/health-and-health-care-experiences-of-immigrants-the-2023-kff-la-times-survey-of-immigrants) care and skipping or postponing care. Immigrants have lower health care expenditures (http://www.pnhp.org/docs/ImmigrationStudy_IJHS2018.pdf) than their U.S.-born counterparts given their more limited access and use.

Some states have expanded access to health coverage for immigrants. At the federal level, legislation (https://www.congress.gov/bill/118th-congress/senate-bill/2646?s=5&r=5) has been proposed that would expand eligibility for health coverage for immigrants, though it faces no clear path to passage in Congress. At the state level, there has been continued take up of state options to expand Medicaid and CHIP coverage for lawfully present immigrant children and pregnant people, and a small but growing number of states have expanded fully state-funded coverage to certain groups of low-income people regardless of immigration status. However, many immigrants, particularly those who are undocumented, remain ineligible for coverage options.

Many immigrants remain fearful of accessing assistance programs, including health coverage. The Biden Administration reversed prior Trump Administration changes to public charge rules (https://www.kff.org/racial-equity-and-health-policy/issue-brief/2022-changes-to-the-public-charge-inadmissibility-rule-and-the-implications-for-health-care/), which may help reduce fears among immigrant families about participating in non-cash assistance programs, including Medicaid and CHIP. It also increased funding (https://www.kff.org/private-insurance/issue-brief/navigator-funding-restored-in-federal-marketplace-states-for-2022/) for Navigator programs that provide enrollment assistance to individuals, which is particularly important for helping immigrant families enroll in coverage. However, as of 2023, nearly three-quarters (https://www.kff.org/racial-equity-and-health-policy/issue-brief/health-and-health-care-experiences-of-immigrants-the-2023-kff-la-times-survey-of-immigrants) of immigrant adults, including nine in ten of those who are likely undocumented, report uncertainty about how use of non-cash assistance programs may impact immigration status or incorrectly believe use may reduce the chances of getting a green card in the future. About a quarter (27%) of likely undocumented immigrants and nearly one in ten (8%) lawfully present immigrants say they avoided applying for food, housing, or health care assistance in the past year due to immigration-related fears.

Overview of Immigrants

Based on federal survey data, as of 2022, there were 45.5 million immigrants residing in the U.S., including 21.2 million noncitizens and 24.2 million naturalized citizens, who each accounted for about 7% of the total population (Figure 1).[4] About six in ten noncitizens were lawfully present immigrants, such as lawful permanent residents (green card holders) and those with a valid work or student visa, while the remaining four in ten

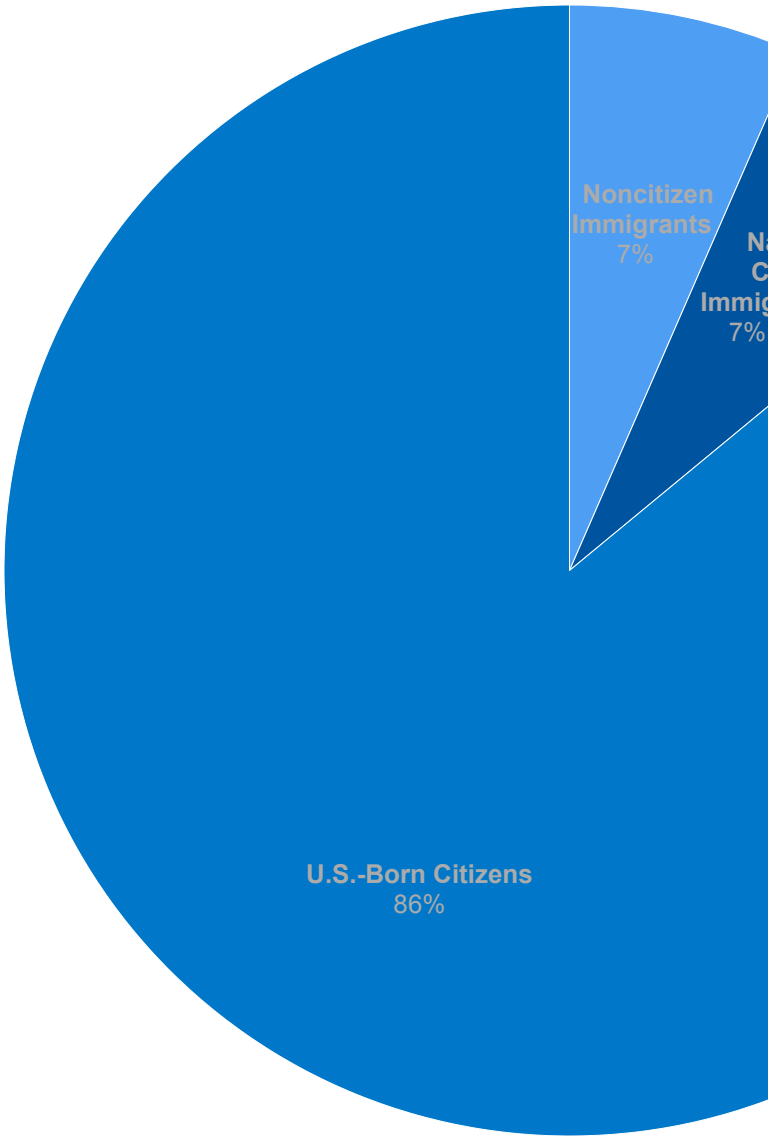
were undocumented immigrants, who may include individuals who entered the country without authorization and individuals who entered the country lawfully and stayed after their visa or status expired.[5] Many individuals live in mixed immigration status families that may include lawfully present immigrants, undocumented immigrants, and/or citizens. A total of 19 million or one in four children living in the U.S. had an immigrant parent as of 2022, and the majority of these children were citizens (Figure 1).[6] About 8.6 million or 12% were citizen children with at least one noncitizen parent.

Figure 1

Immigrants as a Share of the Total U.S. Population, 2022

Total U.S. Population: 324.5 Million

Total U.S. Population | Total Children



NOTE: Totals may not sum to 100% due to rounding.
SOURCE: KFF analysis of 2022 American Community Survey (ACS) 1-yr estimates. • PNG

Uninsured Rates by Immigration Status

The 2023 KFF/LA Times Survey of Immigrants (https://www.kff.org/racial-equity-and-health-policy/issue-brief/health-and-health-care-experiences-of-immigrants-the-2023-kff-la-times-survey-of-immigrants), the largest nationally representative survey focused on immigrants, provides data on health coverage of immigrant adults and experiences accessing health care, including by immigration status.

Although the majority of uninsured people (https://www.kff.org/uninsured/report/the-uninsured-and-the-aca-a-primer-key-facts-about-health-insurance-and-the-uninsured-amidst-changes-to-the-affordable-care-act/) **are citizens, noncitizen immigrants, particularly likely undocumented immigrants, are significantly more likely to report being uninsured than citizens.** As of 2023, half (50%) of likely undocumented immigrants and one in five (18%) lawfully present immigrants say they are uninsured compared to 6% of naturalized citizens and 8% of U.S.-born citizens (Figure 2).[7]

Figure 2

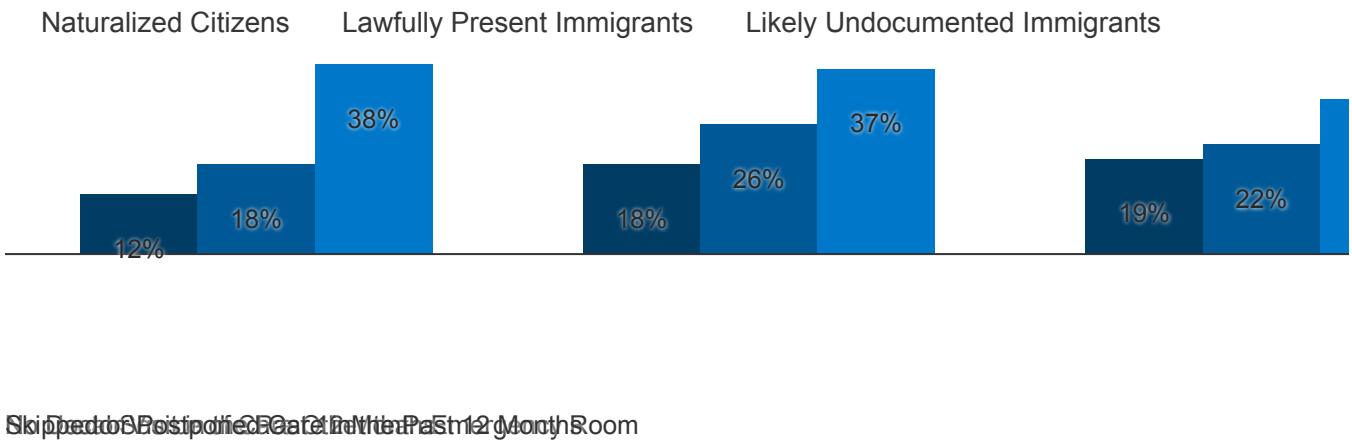
Uninsured Rates among U.S. Adults by Citizenship and Immigra

NOTE: Difference in uninsured rates between lawfully present immigrants, likely undocumented immigrants, and U.S.-born citizens are st
SOURCE: KFF/LA Times Survey of Immigrants (April 10 - June 12, 2023) and KFF/LA Times Survey of Immigrants: U.S.-Born Adult Compa

Reflecting their higher uninsured rates, noncitizen immigrants, especially those who are likely undocumented, are more likely than citizens to report barriers to accessing health care and skipping or postponing care. Research shows that having insurance makes a difference in whether and when people access needed care. Those who are uninsured often delay (https://www.kff.org/report-section/the-uninsured-and-the-aca-a-primer-key-facts-about-health-insurance-and-the-uninsured-amidst-changes-to-the-affordable-care-act-how-does-lack-of-insurance-affect-access-to-care/) or go without needed care, which can lead to worse health outcomes over the long-term that may ultimately be more complex and expensive to treat**.** Overall, likely undocumented immigrants are more likely than lawfully present immigrants and naturalized citizens to report not having a usual source of care other than an emergency room, not having a doctor's visit in the past 12 months, and skipping or postponing care in the past 12 months (Figure 3).[8] Lawfully present immigrants also are more likely than naturalized citizens to say they have not had a doctor's visit in the past 12 months.

Figure 3

Health Care Access and Use among Immigrant Adults by Immig



Skipped Doctor's Postponed Care Unmet Need Past 12 Months Room

NOTE: All differences between likely undocumented immigrants and lawfully present immigrants/naturalized citizens are statistically signific
present immigrants and naturalized citizens also is statistically significant at p<0.05.
SOURCE: KFF/LA Times Survey of Immigrants (April 10 - June 12, 2023) • PNG

Research also shows that immigrants have lower (http://www.pnhp.org/docs/ImmigrationStudy_IJHS2018.pdf) **health care expenditures than their U.S.-born counterparts as a result of lower health care access and use, although their out-of-pocket payments tend to be higher due to higher uninsured rates.** Recent research further finds that, because immigrants, especially undocumented immigrants, have lower health care use despite contributing billions of dollars in insurance premiums and taxes, they help subsidize (https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2798221) the U.S. health care system and offset the costs of care incurred by U.S.-born citizens.

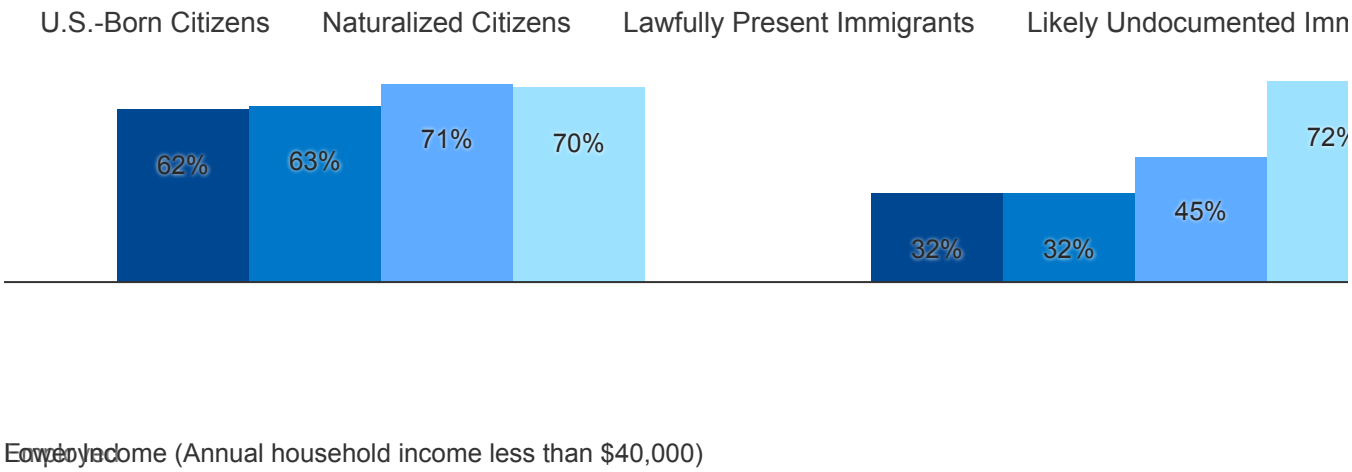
Access to Health Coverage Among Immigrants

Private Coverage

Despite high rates of employment, noncitizen immigrants have limited access to employer-sponsored coverage. Although most noncitizen immigrant adults say they are employed, they are significantly more likely than citizens to report being lower income (household income less than $40,000) (Figure 4).[9] This pattern reflects disproportionate employment of noncitizen immigrants in low-wage jobs and industries (https://www.kff.org/racial-equity-and-health-policy/issue-brief/employment-among-immigrants-and-implications-for-health-and-health-care/) that are less likely to offer employer-sponsored coverage. Given their lower incomes, noncitizen immigrants also face challenges affording employer-sponsored coverage when it is available or through the individual market.

Figure 4

Employment and Income Among U.S. Adults by Citizenship and



NOTE: Differences in employment and income as compared to citizens are statistically significant at p<0.05.
SOURCE: KFF/LA Times Survey of Immigrants (April 10 - June 12, 2023) and KFF/LA Times Survey of Immigrants: U.S. Born Adult Compa

Federally Funded Coverage

Lawfully present immigrants may qualify for Medicaid and CHIP but are subject to certain eligibility restrictions. In general, lawfully present immigrants must have a "qualified" immigration status to be eligible for Medicaid or CHIP, and many, including most lawful permanent residents or "green card" holders, must wait five years after obtaining qualified status before they may enroll. Some immigrants with qualified status, such as refugees and asylees, as well as citizens of Compact of Free Association (COFA) communities, do not have to wait five years before enrolling. Some immigrants, such as those with temporary protected status, are lawfully present but do not have a qualified status and are not eligible to enroll in Medicaid or CHIP regardless of their length of time in the country (Appendix A). For children and pregnant people, states can eliminate the five-year wait and extend coverage to lawfully present immigrants without a qualified status. As of March 2024, 37 states (https://www.kff.org/racial-equity-and-health-policy/issue-brief/state-health-coverage-for-immigrants-and-implications-for-health-coverage-and-care/) plus D.C. have taken up this option for children and 30 states plus D.C. have elected the option for pregnant individuals.

In December 2020, Congress restored Medicaid eligibility for citizens of COFA communities and in March 2024 (https://www.congress.gov/bill/118th-congress/house-bill/4366), eligibility was restored for additional federally funded programs including CHIP. The U.S. government has COFA agreements with the Republic of the Marshall Islands, the Federated States of Micronesia, and the Republic of Palau. Certain citizens of these nations can lawfully work, study, and reside in the U.S., but they had been excluded from federally funded Medicaid since 1996, under the Personal Responsibility and Work Opportunity

Reconciliation Act. As part of a COVID-relief package, Congress restored Medicaid eligibility for COFA citizens who meet other eligibility requirements for the program effective December 27, 2020. On March 9, 2024, Congress further extended eligibility for COFA citizens to newly include other federally funded programs such as CHIP, the Supplemental Nutrition Assistance Program (SNAP), and Temporary Assistance for Needy Families (TANF), among others.

A total of 22 states have also extended coverage to pregnant people regardless of immigration status through the CHIP From-Conception-to-End-of-Pregnancy (https://www.kff.org/report-section/medicaid-and-chip-eligibility-enrollment-and-renewal-policies-as-states-prepare-for-the-unwinding-of-the-pandemic-era-continuous-enrollment-provision-report/#MedicaidandCHIPEligibility) **(FCEP) option**. Colorado (https://leg.colorado.gov/bills/hb22-1289) plans to implement this coverage by January 2025. While other pregnancy-related coverage in Medicaid and CHIP requires 60 days of postpartum coverage, the CHIP FCEP option does not include this coverage. However, some states that took up this option provide postpartum coverage regardless of immigration status either through a CHIP state plan amendment or using state-only funding. Additionally, ten states (California, Connecticut, Illinois, Maine, Massachusetts, Minnesota, New York, Oregon, Rhode Island, and Washington) have used state funding or CHIP health services initiatives to extend postpartum coverage to 12 months to individuals regardless of immigration status to align with the Medicaid extension (https://www.kff.org/policy-watch/postpartum-coverage-extension-in-the-american-rescue-plan-act-of-2021/) established by the American Rescue Plan Act, and Maryland extends coverage (https://health.maryland.gov/mmcp/medicaid-mch-initiatives/Pages/healthybabies.aspx) for four months postpartum through its health services initiative.

Lawfully present immigrants can purchase coverage through the ACA Marketplaces and, like citizens, may receive tax credits to help pay for premiums and cost sharing that vary on a sliding scale based on income. Generally, these tax credits are available to people with incomes starting from 100% of the federal poverty level (FPL) who are not eligible for other affordable coverage. In addition, lawfully present immigrants with incomes below 100% FPL may receive tax credits if they are ineligible for Medicaid based on immigration status. This group includes lawfully present immigrants who are not eligible for Medicaid or CHIP because they are in the five-year waiting period or do not have a “qualified” status.

Lawfully present immigrants also can qualify for Medicare (https://www.kff.org/faqs/medicare-open-enrollment-faqs/can-immigrants-enroll-in-medicare/) **subject to certain restrictions.** Specifically, they must have sufficient work history to qualify for premium-free Medicare Part A. If they do not have sufficient work history, they may qualify if they are lawful permanent residents and have resided in the U.S. for five years immediately prior to enrolling in Medicare, although they must pay premiums to enroll in Part A.

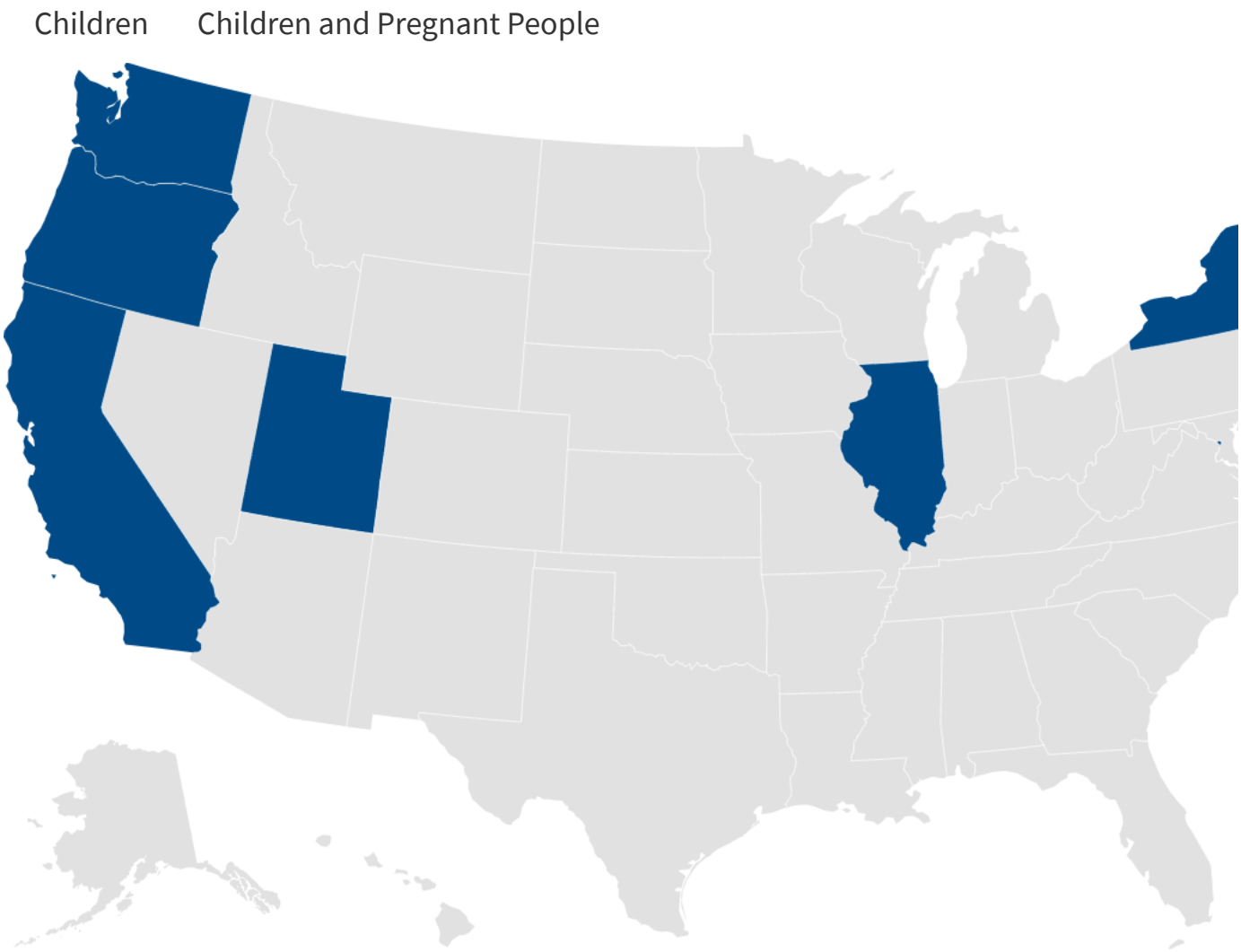
Undocumented immigrants are not eligible to enroll in federally funded coverage including Medicaid, CHIP, or Medicare or to purchase coverage through the ACA Marketplaces. Previously, individuals with Deferred Action for Childhood Arrivals (https://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO-12-002.pdf) (DACA) status were not considered lawfully present for purposes of health coverage eligibility and remained ineligible for these coverage options despite having a deferred action status, which otherwise qualified (https://www.healthcare.gov/immigrants/immigration-status/) for Marketplace coverage. On May 3, 2024, the Biden Administration published new regulations (https://public-inspection.federalregister.gov/2024-09661.pdf) that will change the definition of lawfully present to include DACA recipients for purposes of eligibility to purchase coverage through the ACA Marketplaces and to receive tax credits to help pay for premiums and cost sharing. The rule will become effective on November 1, 2024. Medicaid payments for emergency services may be made on behalf of individuals who are otherwise eligible for Medicaid but for their immigration status. These payments cover costs for emergency care for lawfully present immigrants who remain ineligible for Medicaid as well as for undocumented immigrants.

State Funded Coverage

As of June 2024, 12 states (https://www.kff.org/racial-equity-and-health-policy/issue-brief/state-health-coverage-for-immigrants-and-implications-for-health-coverage-and-care/) **plus D.C. provide comprehensive state-funded coverage for children regardless of immigration status (Figure 5)**. These states include California, Connecticut, Illinois, Maine, Massachusetts, New Jersey, New York, Oregon, Rhode Island, Utah, Vermont, Washington, and D.C. By 2025, Colorado (https://leg.colorado.gov/bills/hb22-1289) and Minnesota (https://www.house.mn.gov/hrd/pubs/mncare.pdf) plan to offer state-funded Medicaid-like coverage to income-eligible children regardless of immigration status. Additionally, two of these states (New Jersey and Vermont) also provide state-funded coverage to income-eligible pregnant people regardless of immigration status, with Vermont extending this coverage for 12 months postpartum.

Figure 5

State-Funded Coverage for Children and Pregnant People Regardless of



Note: In Connecticut, new enrollment of children regardless of immigration status is limited to those under age 13, and to age 19.

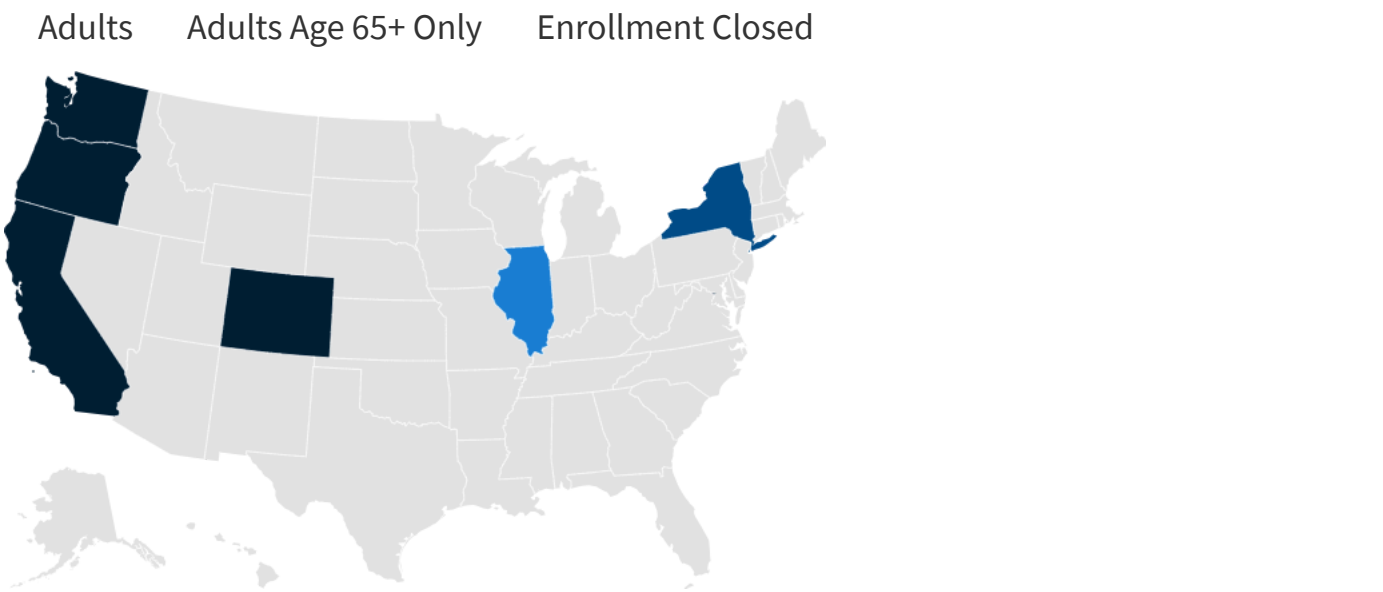
Source: KFF, "A Look at Medicaid and CHIP Eligibility, Enrollment, and Renewal Policies During the Unwinding of Contin

As of June 2024, six states (https://www.kff.org/racial-equity-and-health-policy/issue-brief/state-health-coverage-for-immigrants-and-implications-for-health-coverage-and-care/) **(California, Colorado, Illinois, New York, Oregon, Washington) plus D.C. have also expanded fully state-funded coverage to some income-eligible adults regardless of immigration status (Figure 6)**. Some additional states cover (https://files.kff.org/attachment/Table-3-Medicaid-and-CHIP-Eligibility-Enrollment-and-Renewal-Policies-as-States-Prepare-for-the-Unwinding-of-the-Pandemic-Era-Continuous-Enrollment-Provision.pdf) some income-eligible adults who are not otherwise eligible due to immigration status using state-only funds but limit coverage to specific groups, such as

lawfully present immigrants who are in the five-year waiting period for Medicaid coverage, or provide more limited benefits. Maryland and Minnesota have also indicated plans to extend coverage to adults.

Figure 6

State-Funded Coverage for Adults Regardless of Immigration Status as o



Note: Colorado and Washington provide state marketplace coverage regardless of immigration status. Illinois state-fun
funded coverage is limited to individuals ages 65 and older.

Source: KFF, "A Look at Medicaid and CHIP Eligibility, Enrollment, and Renewal Policies During the Unwinding of Contin

Data suggest that state coverage options for immigrants make a difference in their health coverage and health care access and use. The 2023 KFF/LA Times Survey of Immigrants (https://www.kff.org/racial-equity-and-health-policy/poll-finding/kff-la-times-survey-of-immigrants/) shows that immigrants residing in states with more expansive coverage (https://www.kff.org/racial-equity-and-health-policy/issue-brief/state-health-coverage-for-immigrants-and-implications-for-health-coverage-and-care/) policies for immigrants are less likely to be uninsured compared to their counterparts living in states with less expansive coverage policies. California's 2016 expansion to cover low-income children regardless of immigration status was associated with a 34% (https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2021.00096?

journalCode=hlthaff)decline in uninsurance rates. Similarly, a decline in uninsurance rates. Similarly, a study (https://publications.aap.org/pediatrics/article-abstract/150/3/e2022057034/189211/Insurance-and-Health-Care-Outcomes-in-Regions?autologincheck=redirected?nfToken=00000000-0000-0000-0000-000000000000) found that children who reside in states that have expanded coverage to all children regardless of immigration status were less likely to be uninsured, to forgo medical or dental care, and to go without a preventive health visit than children residing in states that have not expanded coverage. Other research has found that expanding Medicaid coverage to pregnant people regardless of immigration status was associated with higher rates of prenatal care and improved outcomes (https://www.nber.org/system/files/working_papers/w30299/w30299.pdf) including increases in average gestation length and birth weight among newborns, while more restrictive state coverage policies were associated with reduced postpartum care (https://jamanetwork.com/journals/jama/fullarticle/2807288) utilization. The cost of providing insurance to immigrant adults through Medicaid expansion was also found to be less than half (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10504616/) the per person cost of doing so for U.S-born adults. Recent estimates also suggest that the state-funded expansion to all immigrants regardless of status in California could reduce poverty (https://www.ppic.org/blog/californias-medi-cal-expansion-is-lowering-poverty-among-undocumented-immigrants/) among noncitizen immigrants and their families.

Enrollment Barriers

Among immigrants who are eligible for coverage, many remain uninsured because of a range of enrollment barriers, including fear, confusion about eligibility policies, difficulty navigating the enrollment process, and language and literacy challenges. Research (https://www.kff.org/racial-equity-and-health-policy/issue-brief/living-in-an-immigrant-family-in-america-how-fear-and-toxic-stress-are-affecting-daily-life-well-being-health/) suggests that changes to immigration policy made by the Trump Administration contributed to growing fears among immigrant families about enrolling themselves and/or their children in Medicaid and CHIP even if they were eligible. In particular, changes to the public charge policy (https://www.kff.org/racial-equity-and-health-policy/fact-sheet/public-charge-policies-for-immigrants-implications-for-health-coverage/) likely contributed to decreases in participation in Medicaid among immigrant families and their primarily U.S.-born children. The Biden Administration reversed many of these changes, including the changes to public charge policy, and has increased funding (https://www.kff.org/private-insurance/issue-brief/navigator-funding-restored-in-federal-marketplace-states-for-2022/) for Navigator programs that provide enrollment assistance to individuals, which is particularly important for helping immigrant families enroll in coverage. However, as of 2023, nearly three-quarters (https://www.kff.org/racial-equity-and-health-policy/issue-brief/health-and-health-care-experiences-of-immigrants-the-2023-kff-la-times-survey-of-immigrants) of immigrant adults, including nine in ten of those who are likely undocumented, report uncertainty or an incorrect understanding about how use of non-cash assistance programs may impact immigration status or incorrectly believe use may reduce the chances of getting a green card in the future. About a quarter (27%) of likely undocumented

immigrants and nearly one in ten (8%) lawfully present immigrants say they avoided applying for food, housing, or health care assistance in the past year due to immigration-related fears (https://www.kff.org/racial-equity-and-health-policy/issue-brief/health-and-health-care-experiences-of-immigrants-the-2023-kff-la-times-survey-of-immigrants).

Conclusion

Although the majority of immigrants are working, noncitizen immigrants, particularly those who are likely undocumented, have high uninsured rates due to more limited access to both public and private coverage. Federal legislation (https://www.congress.gov/bill/118th-congress/senate-bill/2646?s=5&r=5) has been proposed that would expand immigrant eligibility for health coverage, though there is no clear path to passage in Congress. In the absence of federal action, some states are filling gaps in access to coverage for immigrants. However, many remain ineligible for any coverage options, contributing to barriers to access and use of care. Those eligible for coverage also face an array of barriers (https://www.urban.org/sites/default/files/2022-11/Immigrant%20Families%20Faced%20Multiple%20Barriers%20to%20Safety%20Net%20Programs%20in%202021.pdf) to enrollment, including fear and confusion about eligibility. The Biden Administration has made changes to public charge (https://www.federalregister.gov/documents/2022/09/09/2022-18867/public-charge-ground-of-inadmissibility) policies that are intended to reduce fears of enrolling in health coverage and accessing care and increased funding for outreach and enrollment assistance, which may help eligible immigrant families enroll and stay enrolled in coverage. However, immigrants continue to have significant confusion around public charge (https://www.kff.org/racial-equity-and-health-policy/issue-brief/health-and-health-care-experiences-of-immigrants-the-2023-kff-la-times-survey-of-immigrants) rules highlighting the importance of outreach and enrollment assistance (https://www.kff.org/private-insurance/issue-brief/navigator-funding-restored-in-federal-marketplace-states-for-2022/), including community-led efforts, to rebuild trust and reduce fears among immigrant families about accessing health coverage and care.

Appendix A: Lawfully Present immigrants by Qualified Status

Qualified Immigrant Categories	Other Lawfully Present Immigrants
• Lawful permanent resident (LPR or green card holder) • Refugee • Asylee • Cuban/Haitian entrant • Paroled into the U.S. for at least one year • Conditional entrant granted before 1980 • Granted withholding of deportation • Battered noncitizen, spouse, child, or parent • Victims of trafficking and his/her spouse, child, sibling, or parent or individuals with pending application for a victim of trafficking visa • Member of a federally recognized Indian tribe or American Indian born in Canada • Citizens of the Marshall Islands, Micronesia, and Palau who are living in one of the U.S. states or territories (referred to as Compact of Free Association or COFA migrants)	• Granted Withholding of Deportation or Withholding of Removal, under the immigration laws or under the Convention against Torture (CAT) • Individual with Non-Immigrant Status, includes worker visas, student visas, U-visa, and other visas, and citizens of Micronesia, the Marshall Islands, and Palau • Temporary Protected Status (TPS) • Deferred Enforced Departure (DED) • Deferred Action Status • Lawful Temporary Resident • Administrative order staying removal issued by the Department of Homeland Security • Resident of American Samoa • Applicants for certain statuses • People with certain statuses who have employment authorization

Endnotes

1. KFF analysis of 2022 American Community Survey (ACS) 1-year Public Use Microdata Sample.

← Return to text (https://www.kff.org/racial-equity-and-health-policy/fact-sheet/key-facts-on-health-coverage-of-immigrants/#endnote_link_597741-1)

2. KFF analysis of 2022 American Community Survey (ACS) 1-year Public Use Microdata Sample.

← Return to text (https://www.kff.org/racial-equity-and-health-policy/fact-sheet/key-facts-on-health-coverage-of-immigrants/#endnote_link_597741-2)

3. KFF/LA Times Survey of Immigrants (April 10 – June 12, 2023).

← Return to text (https://www.kff.org/racial-equity-and-health-policy/fact-sheet/key-facts-on-health-coverage-of-immigrants/#endnote_link_597741-3)

4. Lawfully present immigrants are those who said they are not a U.S. citizen, but currently have a green card (lawful permanent status) or a valid work or student visa; likely undocumented immigrants are those who said they are not a U.S. citizen and do not currently have a green card (lawful permanent status) or a valid work or student visa. These immigrants are classified as “likely undocumented” since they have not affirmatively identified themselves as undocumented.KFF analysis of 2022 American Community Survey (ACS) 1-year Public Use Microdata Sample.

← Return to text (https://www.kff.org/racial-equity-and-health-policy/fact-sheet/key-facts-on-health-coverage-of-immigrants/#endnote_link_597741-4)

5. The estimate of the total number of noncitizens in the US is based on the 2022 American Community Survey (ACS) 1-year Public Use Microdata Sample (PUMS). The ACS data do not directly indicate whether an immigrant is lawfully present or not. We draw on the methods underlying the 2013 analysis by the State Health Access Data Assistance Center (SHADAC) and the recommendations made by Van Hook et. Al. [1](https://www.kff.org/medicaid/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid/view/footnotes/#footnote-508802-1), [2](https://www.kff.org/medicaid/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid/view/footnotes/#footnote-508802-2) This approach uses the Survey of Income and Program Participation (SIPP) to develop a model that predicts immigration status; it then applies the model to ACS, controlling to state-level estimates of total undocumented population from Pew Research Center. For more detail on the immigration imputation used in this analysis, see the Technical Appendix B (https://www.kff.org/report-section/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid-technical-appendix-b-immigration-status-imputation).

← Return to text (https://www.kff.org/racial-equity-and-health-policy/fact-sheet/key-facts-on-health-coverage-of-immigrants/#endnote_link_597741-5)

6. KFF analysis of 2022 American Community Survey (ACS) 1-year Public Use Microdata Sample.

← Return to text (https://www.kff.org/racial-equity-and-health-policy/fact-sheet/key-facts-on-health-coverage-of-immigrants/#endnote_link_597741-6)

7. KFF/LA Times Survey of Immigrants (April 10 – June 12, 2023).

← Return to text (https://www.kff.org/racial-equity-and-health-policy/fact-sheet/key-facts-on-health-coverage-of-immigrants/#endnote_link_597741-7)

8. KFF/LA Times Survey of Immigrants (April 10 – June 12, 2023).

← Return to text (https://www.kff.org/racial-equity-and-health-policy/fact-sheet/key-facts-on-health-coverage-of-immigrants/#endnote_link_597741-8)

9. KFF/LA Times Survey of Immigrants (April 10 – June 12, 2023).

← Return to text (https://www.kff.org/racial-equity-and-health-policy/fact-sheet/key-facts-on-health-coverage-of-immigrants/#endnote_link_597741-9)

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