750 EAST PRATT STREET, 6TH FLOOR
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MARYLAND HEALTH BENEFIT EXCHANGE

December 1, 2020

The Honorable Delores G. Kelley
Chairwoman
Senate Finance Committee
Miller Senate Office Building, 3 West
11 Bladen Street
Annapolis, MD 21401

The Honorable Shane E. Pendergrass
Chairwoman
Health and Government Operations Committee
House Office Building, Room 241
6 Bladen Street
Annapolis, MD 21401

Re: Report Required by SB124/HB196 (Chapter 104 of the Acts of 2020) State-based Individual Market Health Insurance Subsidies

Dear Chairwoman Kelley and Chairwoman Pendergrass:

Pursuant to by SB124/HB196 (Chapter 104 of the Acts of 2020) – Maryland Health Benefit Exchange – Assessment Applicability and State-Based Individual Market Health Insurance Subsidies, the Maryland Health Benefit Exchange would like to submit this report in accordance with § 2–1257 of the State Government Article on establishing a State-based individual market health insurance subsidy program.

This report contains information on a potential State-based subsidy program in the State of Maryland, including the population that would be the intended target of the program, the effect of the program on the individual market, and the potential impact on the State Reinsurance Program.

If you have any questions regarding this report, please contact Johanna Fabian-Marks, Director of Policy and Plan Management at (443) 890-3518 or at johanna.fabian-marks@maryland.gov

Sincerely,

Michele Eberle
Executive Director

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Report on Establishing State-Based Individual Market Health Insurance Subsidies

Maryland Health Benefit Exchange

December 1, 2020

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Executive Summary

Over the last several years, Maryland has taken significant steps to stabilize the individual market, including through implementation of the State Reinsurance Program, a partnership with the federal government that has reduced 2021 individual market premiums by 31.5% compared to 2018, and the Easy Enrollment Program, a first-in-the-nation program that allows uninsured Marylanders to enroll in coverage by checking a box on their taxes and which led to more than 4,000 enrollments in 2020.

Despite these successes, Maryland's uninsured rate has held steady at about 6%.Prior to the impact of the pandemic, Maryland's uninsured rate was estimated by the Census Bureau at 6.1% in 2017, and 6% in 2018 and 2019.[1] While Maryland was one of only a handful of states that didn't see increases in uninsured rates during that period, the rapid pace of improvement made soon after the Affordable Care Act was slowing.

In Senate Bill 124 / House Bill 196 of 2020 (SB124/HB196), the General Assembly directed the Maryland Health Benefit Exchange (MHBE) to submit a report on the potential design, implementation, and effects of establishing state-based individual market health insurance subsidies in Maryland. Due to the design of federal premium subsidies, the reinsurance program does not significantly reduce premiums for households below 300% of the Federal Poverty Limit (FPL), and has a limited impact on households between 300-400% FPL. Consequently, it is predominantly higher income households that pay the full cost of their premiums who have felt the benefit of the reinsurance program. Increasing Maryland's reinsurance program would not be an effective way of reducing premiums for individuals at these FPL levels, and could not be done in a way to target particular groups, such as young adults. In contrast, an individual subsidy program would allow the state to strategically reduce premiums for targeted populations.

MHBE identified two potential target groups for a state subsidy, young adults earning less than 400% FPL, and households at 400-600% FPL. MHBE, in consultation with the Maryland Insurance Administration (MIA), identified eight potential designs for a young adult subsidy and three potential designs for a subsidy for households at 400-600% FPL. The subsidy designs were selected to span a range of levels of generosity, impact, and cost to the state, in order to provide a broad set of options for stakeholders and the General Assembly to consider. MHBE worked with the actuarial firm Lewis & Ellis to model the impact of each subsidy design. In order to gather public feedback, MHBE published Lewis & Ellis's report for public comment, discussed it with the MHBE Standing Advisory Committee, and convened an Individual Subsidy Work Group to discuss the report.

The modeling demonstrates that a young adult subsidy at a range of total costs could meaningfully reduce the uninsured rate in the target population, further stabilize the risk pool, and reduce premiums for all enrollees. In addition, as the coronavirus public health emergency shines a light on the health and healthcare inequities in our country, a young adult subsidy offers an opportunity to increase health coverage among currently uninsured young adults, who

[1] Katherine Keisler-Starkey and Lisa N. Bunch U.S. Census Bureau Current Population Reports, P60-271, Health Insurance Coverage in the United States: 2019, U.S. Government Publishing Office, Washington, DC, 2020. https://www.census.gov/library/publications/2020/demo/p60-271.html

are disproportionately likely to be Hispanic and Black. For these reasons, the Individual Subsidy Work Group recommended implementing an individual subsidy targeted at young adults below 400% FPL.

There are approximately 156,000 adults in Maryland who are uninsured, legally present, and earn too much to qualify for Medicaid. Of that group, young adults ages 18-34 constitute the largest group by age, at approximately 67,000 individuals (43%), approximately 40,800 of whom are below 400% FPL. The young adult subsidies modeled ranged from a version at the low end of estimated costs that is projected to increase enrollment by 5,400 young adults at a cost of $18M (possibly offset by $2M in federal pass-through funding) and reduce marketwide average premiums by 1%, to the most generous version modeled, which is projected to increase enrollment by 20,900 young adults, cost $64M (possibly offset by $12M in federal pass-through funding), and reduce marketwide average premiums by 3.5%. This demonstrates that there are a range of options for a young adult subsidy, any of which could have a meaningful impact to young adults and the market overall.

The subsidy designs modeled for individuals at 400-600% FPL, although not explicitly intended to do so, would benefit older adults more than young adults. Individuals in this income range are not eligible for federal subsidies to reduce their premiums and must pay the full cost themselves. Because federal subsidies end at 400% FPL, the net premium of an individual age 55-64 earning 400-600% FPL can jump up 87% compared to an individual earning 300-400% FPL, or 177% for a couple in that age group. Despite the fact that these older adults can face significant cost burdens for health insurance, they represent a relatively small percentage (15%) of the non-Medicaid eligible, legally present uninsured population, possibly due to the fact that they are more likely than younger adults to be insured through an employer and if not, are more likely to see the value in health insurance and buy it despite the cost.

The 400-600% FPL subsidies modeled ranged from a version projected to increase enrollment by 2,300 individuals at a cost of $17M (possibly offset by $3M in federal pass-through funding) and reduce marketwide average premiums by .1%, to a version projected to increase enrollment by 8,900 individuals, cost $69M (possibly offset by $10M in federal pass-through funding), and reduce marketwide average premiums by .5%. Although the Individual Subsidy Work Group expressed concern over the affordability of coverage for individuals in the 400-600% FPL range, the group recommended prioritizing young adults as the target population for a state subsidy due to the greater expected impact on increased enrollment, lower cost relative to increased enrollment, and more significant benefit to the risk pool. The work group recommended that MHBE consider expanding the state subsidy to individuals in the 400-600% FPL group as a second target population in the future, after gaining experience with the cost and impact of a state subsidy for young adults.

Because federal funding is projected to cover the entire cost of the state reinsurance program, the modeling projects that Maryland could use a portion of the state funding collected under the health insurance provider fee, which is currently dedicated to supporting the reinsurance program, to fund any one of the state subsidy designs without impacting the ability of the reinsurance program to continue to function as intended. The most expensive subsidy design is estimated to cost about $50 million less per year than annual funding under the health insurance provider fee (which is estimated at $112 to $125 million per year).

Additionally, if MHBE were authorized to implement a state subsidy, it would make sense to pursue amendment of Maryland's current ACA section 1332 waiver for the reinsurance program, in order to enable MHBE to put surplus federal pass-through funding towards the subsidy program. Surplus federal funding alone, without impacting the reinsurance program, could be sufficient to finance a subsidy program for 3-7 years depending on the subsidy designs implemented. However, use of federal pass-through funding would require federal approval, and no other state has received a 1332 waiver for a state subsidy program so the likelihood of federal approval is not yet known.

MHBE expects that if the legislature authorizes MHBE to implement a state subsidy, the MHBE Board would ultimately determine the appropriate allocation of available funding for reinsurance and state subsidies to maximize enrollment and affordability in the individual market. Given the success of the reinsurance program at stabilizing the individual market, it will be a priority to ensure that any additional programs to improve enrollment and affordability do not jeopardize the sustainability of the reinsurance program. It is important to note that the health insurance provider fee, like the reinsurance program, is only authorized through 2023. Therefore, if considering implementation of a state subsidy funded through the fee, it will also be important for the legislature to consider the future of both the reinsurance program and the fee.

Given the novel nature of a state subsidy program, the legislature may want to consider a pilot program to allow MHBE to gather enough credible data to refine longer-term projections of program costs. A pilot of two to three years would provide sufficient data and would make sense if the state does not pursue a waiver amendment to gain federal pass-through funding, as existing state funds accrued through 2023 would be sufficient to finance a pilot of this duration regardless of whether the health insurance provider fee is continued beyond 2023. If a waiver amendment to secure federal pass-through funding is pursued and approved, and the reinsurance program is renewed for a second 5-year period (2024-2028), it may make sense to consider extending a pilot through the end of the second waiver period. However, given present uncertainty over the continuation of the reinsurance program, a pilot program could be launched with an initial planned duration of two to three years and could later be extended if the reinsurance program were extended.

The work of the Maryland Governor and General Assembly have made Maryland a national leader in innovative health policy. A state-based subsidy for young adults would be another national first. MHBE welcomes the opportunity to continue to provide information to the General Assembly as it evaluates this idea.

1. Introduction

During the 2020 session, the General Assembly passed SB124/HB196, Maryland Health Benefit Exchange – Assessment Applicability and State-Based Individual Market Health Insurance Subsidies, which requires the MHBE to submit a report to the Senate Finance Committee and the House Health and Government Operations Committee on the potential design, implementation, and effects of establishing state-based individual market health insurance subsidies in Maryland. The full list of topics that the legislation specified for inclusion in this report can be found in Appendix 1.

Following implementation of the State Reinsurance Program (reinsurance program) in 2019, individual market premiums are down, enrollment through Maryland Health Connection is up, and a new carrier, UnitedHealthcare is entering the individual market for 2021. Although the reinsurance program has done an excellent job of stabilizing the individual market, Maryland's uninsured rate has held steady at about 6%. An individual subsidy program offers the opportunity to strategically target additional assistance to groups that are disproportionately uninsured or that face an inequitable level of cost relative to their situation due to how federal health insurance subsidies are designed.

A possible source of funding for subsidies is the state funding currently designated solely to support the Reinsurance Program. Federal funding was sufficient to cover the cost of the Reinsurance Program in 2019 and that is projected to continue for the remaining years of the program. Although the federal government requires that Maryland "must ensure sufficient funds, on an annual or other appropriate basis, for the reinsurance program to operate" as described in the 1332 waiver application, the federal government does not limit the state's use of state funding that exceeds that necessary to support the reinsurance program.[2]

MHBE worked with Lewis & Ellis Actuarial Consultants, in consultation with the Maryland Insurance Administration (MIA), to model the design and impact of potential state subsidies on the reinsurance program and the market overall. Lewis & Ellis produced a report detailing their evaluation, which MHBE published for public comment. In the fall of 2020, MHBE also formed a work group to gather feedback on Lewis & Ellis's modeling. The input received through the public comment period and work group has been used to inform this report.

2. State-based Individual Market Health Insurance Subsidies in Other States

Three states currently have state-based individual market subsidy programs: Massachusetts, California, and Vermont. None of these states have reinsurance programs. Colorado and New Jersey do have reinsurance programs and passed legislation in 2020 to establish state-based subsidies but are still in the process of designing their programs and have not yet implemented

[2] Maryland 1332 Waiver Approval and Standard Terms and Conditions. August 22, 2018. https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/1332-STC-MD-Signed.pdf

them. In addition, Massachusetts and California presented their state subsidy programs to the Individual Subsidy Work Group convened by MHBE and more information on their programs may be found on the MHBE website.[3]

A. Massachusetts

Massachusetts is a national leader in health reform, having implemented a suite of reforms in the mid-2000s that served as precursor to the federal reforms under the Affordable Care Act. In addition to a number of other reforms that Massachusetts has implemented, the Commonwealth operates the ConnectorCare Program, a state program that generously subsidizes both premiums and out-of-pocket costs for individuals earning less than 300% FPL. The ConnectorCare Program has helped to drive Massachusetts uninsured rate down to the lowest in the nation, at approximately 3%.[4] The program predates the ACA and Massachusetts adapted it to supplement the federal subsidies available through the ACA. Massachusetts does not have a reinsurance program.

B. California

In 2020, California implemented a state subsidy program and individual mandate penalty. The state subsidy program predominantly targets funding towards individuals making 400% to 600% FPL, who are ineligible for federal subsidies. Because the subsidy program was implemented this year and there have been several confounding factors, including simultaneous implementation of a state individual mandate to buy insurance and the COVID-19 pandemic, California has not yet been able to evaluate the impact of the subsidy program. California does not have a reinsurance program.

C. Vermont

Vermont has a state subsidy program that reduces the maximum premium contributions that enrollees must make to a benchmark exchange plan by an additional 1.5 percent. This has helped Vermont achieve the fourth lowest uninsured rate in the country at 4.5%.[5] Like the other states discussed here, Vermont has also implemented other reforms, including an individual mandate and a merger of their individual and small group market. Vermont does not have a reinsurance program.

D. Comparison

Massachusetts and Vermont both target households under 300% FPL, whereas California predominately targets households at 400-600% FPL. Table 1 provides a comparison of summary information on the state programs. Although it is difficult to tease out the impact of the subsidy program from the other reforms that these states have implemented, Massachusetts

[3] October 15, 2020 and October 22, 2020 MHBE Individual Market Subsidy Work Group Presentations. https://www.marylandhbe.com/policy-legislation/work-groups/individual-subsidy-work-group/

[4] Katherine Keisler-Starkey and Lisa N. Bunch U.S. Census Bureau Current Population Reports, P60-271, Health Insurance Coverage in the United States: 2019, U.S. Government Publishing Office, Washington, DC, 2020. https://www.census.gov/library/publications/2020/demo/p60-271.html

[5] Katherine Keisler-Starkey and Lisa N. Bunch U.S. Census Bureau Current Population Reports, P60-271, Health Insurance Coverage in the United States: 2019, U.S. Government Publishing Office, Washington, DC, 2020. https://www.census.gov/library/publications/2020/demo/p60-271.html

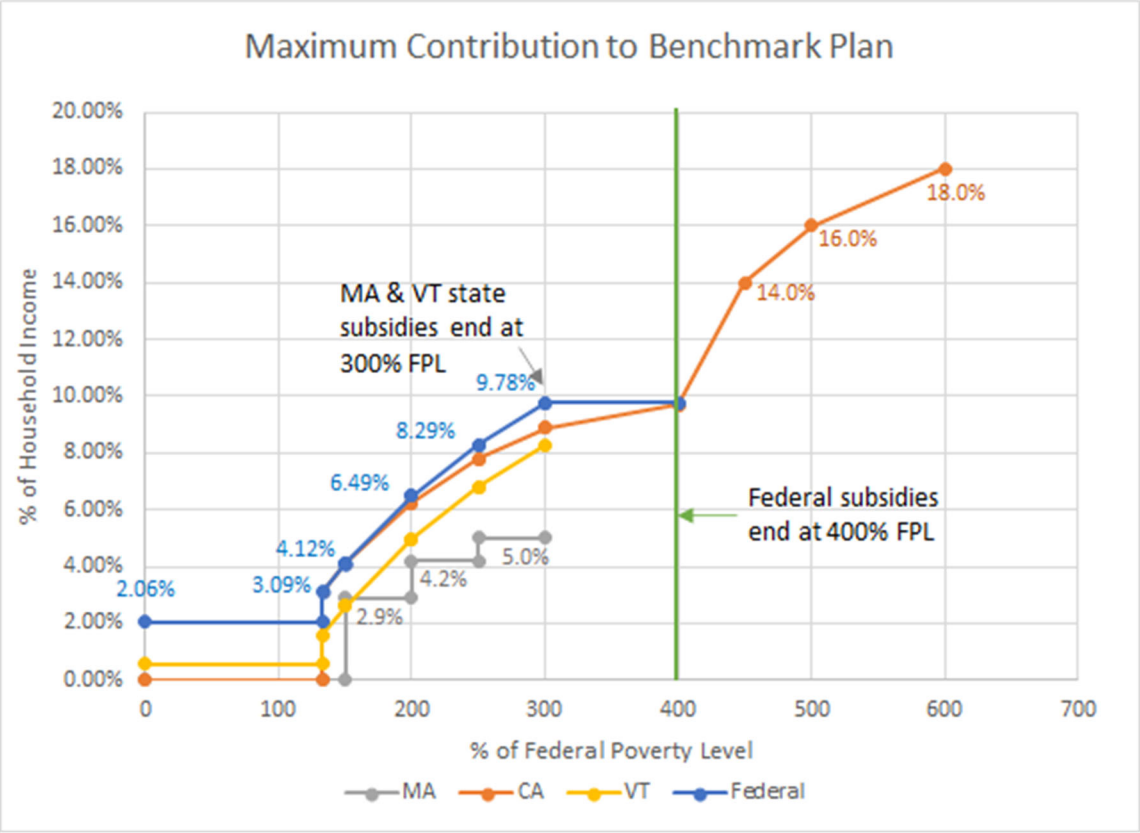
and Vermont have among the lowest uninsured rates in the nation. California just implemented its subsidy program in 2020, so it is too early to determine its effect.

Table 1. Summary Information on Existing State Individual Market Subsidy Programs

	Target Population	Subsidy Design	Impact	Reinsurance Program?
Mass.	Under 300% FPL	Sets premiums for 5 standard plans according to FPL. Also reduces cost-sharing	Lowest uninsured rate in the country at 3% *(MA has also implemented other reforms that may contribute to this, including an individual mandate, merged individual and small group markets)*	No
California	Mainly targeted at households 400-600% FPL	Modeled on federal APTC design	New program, difficult to untangle from impact of individual mandate implemented at the same time	No
Vermont	Under 300% FPL	Modeled on federal APTC design	4th lowest uninsured rate in the country at 4.5%. *(VT has also implemented other reforms that may contribute to this, including an individual mandate, merged individual and small group markets)*	No

Both California and Vermont closely modeled their subsidy designs on the federal subsidy program, whereas Massachusetts's subsidies decrease in a stepwise fashion rather than a smooth curve as income increases. Figure 1 compares the maximum contribution towards a benchmark premium by FPL in each state with the federal subsidy design. As the graph shows, California's design reduces the household contribution to 0% for individuals under 138% FPL, is slightly more generous than federal subsidies up to 400% FPL, and then continues on up to 600% FPL. Vermont's program mirrors the federal curve, but is 1.5% below it until it ends at 300% FPL, above which point Vermont residents would only qualify for federal subsidies. Massachusetts subsidy design is the most generous, with 0% contribution for households up to 150% FPL, then a stair step increase in contribution until the program ends at 300% FPL, above which point, like Vermont, Massachusetts residents would only qualify for federal subsidies.

Figure 1. Maximum Contribution Towards Benchmark Plan Premium for Existing State Individual Market Subsidy Programs Compared to Federal Subsidies



3. Reinsurance Program

The legislature has expressed interest in understanding the impact that funding for a state-based individual market health insurance subsidy program would have on the availability of funds for the existing reinsurance program in the individual market. In addition, the legislature requested comment on the appropriate allocation of available funding for reinsurance and State–based individual market health insurance subsidies to maximize enrollment and affordability in the individual market. In order to inform discussion of these issues, this section presents information on the background, funding and limitations of the reinsurance program.

A. Background

Prior to implementation of the reinsurance program in 2019, average rates in the individual market had increased by double digits annually from 2015 through 2018. As rates rose, enrollment in private coverage through Maryland Health Connection declined in 2017 and 2018 by 3.1% and 2.6%, respectively. Responding to these trends, Governor Hogan and the Maryland General Assembly took action in 2018 to create the reinsurance program to mitigate the premium impact of high cost enrollees in the individual market.[6] The reinsurance program

[6] 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 Gov. Larry Hogan on April 5, 2018.

has successfully stabilized and reduced premiums in the individual market. Compared to 2018, the year before the reinsurance program took effect, 2021 premiums are down an average of 31.5% and October 2020 enrollment is up 22% compared to October 2018 enrollment.[7] In addition, data from the Maryland Health Care Commission shows that following implementation of the reinsurance program, the individual market also added healthier enrollees. That reduced the "illness burden," which in turn led to slower growth in spending on health services -- an increase of 3% in 2019 vs. 8% in 2018.[8]

The reinsurance program operates under an Affordable Care Act Section 1332 State Innovation Waiver approved by the federal government. Reinsurance reduces premiums in the individual market by covering a portion of insurers' claims. Lower premiums mean that the federal government's costs to subsidize insurance for individual market enrollees under 400% FPL are also lower. Under the terms of the waiver, the federal government passes those savings on to MHBE to spend on the reinsurance program.

B. Funding

Senate Bill 387, Health Insurance – Individual Market Stabilization (Maryland Health Care Access Act of 2018) (SB 387) established a health plan assessment to be collected in 2019 to help fund the reinsurance program. Section 9010 of the Affordable Care Act (ACA) created a federal health insurance provider fee ("9010 fee") for certain entities engaged in the business of providing health insurance. The 9010 fee was based on the entity's net premiums for the year and was estimated at about 2.75% to 3%.[9] The federal spending bill enacted in January 2018 suspended the collection of this federal fee for 2019. SB 387 applied a 2.75 percent assessment on certain health insurance plans and Medicaid managed care organizations that are regulated by the state and allowed the state to collect certain funds that the federal government would have collected under Section 9010.

During the 2019 Session, House Bill 258/Senate Bill 239 – Health Insurance – Individual Market Stabilization – Provider Fee was passed to assess a state-based health insurance provider fee of 1% to fund the State Reinsurance Program through 2023. In 2020, the U.S. Congress enacted the Further Consolidated Appropriations Act, which repealed the 9010 fee for calendar years beginning after December 31, 2020. Consequently, the General Assembly passed a technical correction to the applicability of the fee (Senate Bill 124 of 2020, Maryland Health Benefit Exchange – Assessment Applicability and State–Based Individual Market Health Insurance Subsidies) to remove the language from House Bill 258/Senate Bill 239 that attached

[7] In 2019, the first year of the reinsurance program, on-exchange enrollment as of the end of open enrollment increased by 2.2%. The significant enrollment growth in 2020 is due in large part to two new special enrollment periods, Easy Enrollment and Covid-19, but lower premiums have also made health insurance more affordable. MHBE enrollment data is available https://www.marylandhbe.com/news-and-resources/reportsdata/

[8] Maryland Health Care Commission. "An Early Update on Privately Insured Spending in Maryland's Individual Market, 2019." November 16, 2019. https://www.marylandhbe.com/wp-content/uploads/2020/11/2019_PI_Ind_Mkt_Presentation_MHBE.pdf

[9] Levitis, Jason. Considerations for a State Health Insurer Fee Following Repeal of the Federal 9010 Fee. State Health and Value Strategies. Jan 30, 2020. https://www.shvs.org/considerations-for-a-state-health-insurer-fee-following-repeal-of-the-federal-9010-fee/

Maryland's assessment to the now repealed 9010 fee and to ensure that the state-based health insurance provider fee continued to apply as intended.

The 1% state-based health insurance provider fee is estimated to collect approximately $112 million to $125 million per year, as shown in Table 2. Under state law, funding from the fee is placed in the Maryland Health Benefit Exchange Fund, a special, nonlapsing fund and "may be used only for the purposes of funding the State Reinsurance Program."[10]

The federal terms and conditions of the State Innovation Waiver state that "the MHBE must ensure sufficient funds, on an annual or other appropriate basis, for the reinsurance program to operate as described in the MHBE's waiver application". The 2019 and 2020-2023 health insurance provider fee ensures that Maryland has consistent funding to support the reinsurance program and allows Maryland to access the federal pass-through funding that undergirds the reinsurance program.

In addition to the state funding, MHBE receives federal "pass-through" funding in the amount that the federal government projects it saves as a result of the reinsurance program. The federal government calculates the pass-through amount in the spring of each year, for the current year. Current estimates project that federal funding will exceed the cost of the reinsurance program and that it will not be necessary to draw down state funding through 2023; however, circumstances that would increase the reinsurance program cost or reduce federal funding, and therefore require use of state funding, are possible. Any unspent federal funding must be rolled forward to support the reinsurance program in future years.

Table 2. Health Insurance Provider Fee, Federal Funding, and Reinsurance Program Cost, 2019-2023

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

Source: Estimated reinsurance program cost and federal funding are Lewis & Ellis projections (see Appendix 2); the Premiums Assessment estimates are MIA estimates as of July 9, 2020. Note 2020 Federal Funding is actual funding, not an estimate.
*2020 Federal Funding and Premium Assessment are actual numbers; the 2020 Reinsurance Program Cost is an estimate.
**Projected 2021-2023 federal funding is likely to be approximately $20-$40 million lower than shown each year due to the impact of UnitedHealthcare's entry into the individual market.

C. Limitations

Although the Reinsurance Program has achieved its goals of stabilizing the individual market and significantly reducing premiums, it is important to understand that the benefits of the reinsurance program primarily accrue to households earning more than 300% FPL and particularly to households earning more than 400% FPL (about $51,000 for an individual or

[10] MD Code, Insurance, § 31-107 and § 6-102.1.

$105,000 for a family of four). Households over 400% FPL earn too much to qualify for federal premium subsidies and must therefore pay the full cost of their insurance.

Under the Affordable Care Act, a household with an income less than 300 percent of the FPL pays a maximum amount of approximately 2 to 8 percent of household income towards a benchmark plan premium. Households between 300 and 400 percent of the FPL pay a maximum amount of approximately 10 percent of their household income towards a benchmark plan premium, and households over 400 percent of the FPL pay the full cost. Table 3 outlines the percentage of income paid by a household within the specified FPL tier; as FPL increases within the tier, the percentage increases on a sliding scale in a linear manner, from the initial percentage to the final percentage. For individuals in households under 400 percent of the FPL, a federal subsidy makes up the difference between the individual's payment and the full cost of the benchmark plan.[11]

Table 3. Maximum Contribution to Benchmark Plan Premium under Federal Subsidy Design, 2021

Household income as percent of FPL	Federal Maximum Contribution to Benchmark Plan	
	Initial percentage	Final percentage
< 133%	2.07%	2.07%
133% to <150%	3.10%	4.14%
150% to <200%	4.14%	6.52%
200% to <250%	6.52%	8.33%
250% to <300%	8.33%	9.83%
300% to 400%	9.83%	9.83%
>400%	no limit	no limit

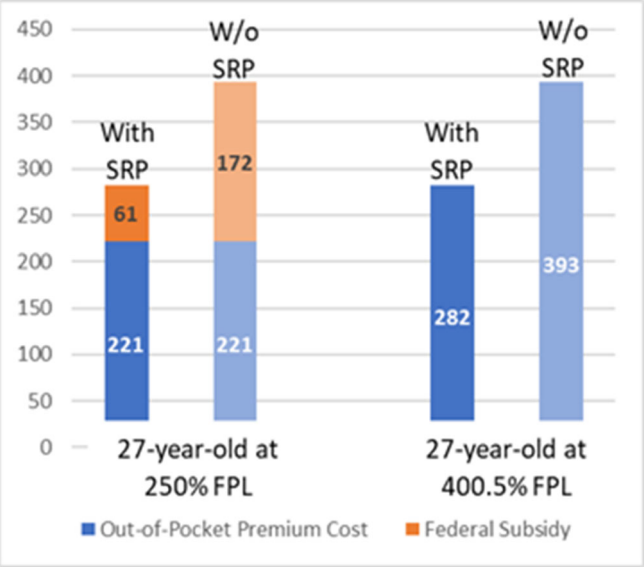
Because of the way this federal subsidy structure works, reductions in premiums resulting from the reinsurance program are not typically felt by individuals at lower FPLs. As a result, the reinsurance program is not an effective way to reduce premiums for individuals at lower FPLs, or to target subsidies towards specific populations such as young adults. For example, a 27-year-old in Baltimore City with an income of $31,900 (250% FPL) is expected to pay about 8 percent of their income, or $221 per month, towards the benchmark plan. In 2021, that benchmark plan will cost $282, so the individual would pay their $221 contribution and a federal subsidy of $61 would make up the difference. Without the reinsurance program, we estimate that the benchmark plan would have cost about $393 per month, so the individual would still have paid $221, but would have gotten a larger federal subsidy.[12] But in either case, with or without the reinsurance program, this individual pays $221 per month; they do not see a reduction in their premium payment as a result of the reinsurance program. In contrast, a 27-year-old with an income of $51,100 (400.5% FPL) would not qualify for a federal subsidy and

[11] An individual can choose to pay less in premium by applying their subsidy to a lower-premium plan, or can choose to pay more in premium by applying their subsidy to a higher-premium plan.

[12] 2021 estimated benchmark plan premiums provided to MHBE by MIA based on carrier filings.

saves about $111 on the benchmark plan due to the lower premium brought about by the reinsurance program. These scenarios are illustrated in Figure 2.

Figure 2. Comparison of 2021 Benchmark Plan Monthly Out-of-Pocket Premium Cost for 27-Year-Old in Baltimore City at 250% and 400.5% FPL, With and Without the State Reinsurance Program (SRP)



4. Remaining Uninsured in Maryland and Potential Target Populations for Individual Market State Subsidy

Although the reinsurance program stabilized the individual market, Marylanders continue to voice concern over costs, including rising deductibles and out-of-pocket-costs, and limited plan options. Furthermore, as shared by the Executive Director of the Maryland Health Services Cost Review Commission in a presentation to the MHBE Board, after being nearly halved during the first years following implementation of the Affordable Care Act, the value of uncompensated care impacting hospitals began rising in recent years.[13] This is one indicator that people with health insurance are struggling to pay their out-of-pocket costs. To discuss how to address these issues, the MHBE convened an Affordability Work group in 2019 to study affordability issues, including how to reduce out-of-pocket costs, maximize APTC for subsidized consumers, and maximize affordability for unsubsidized consumers.

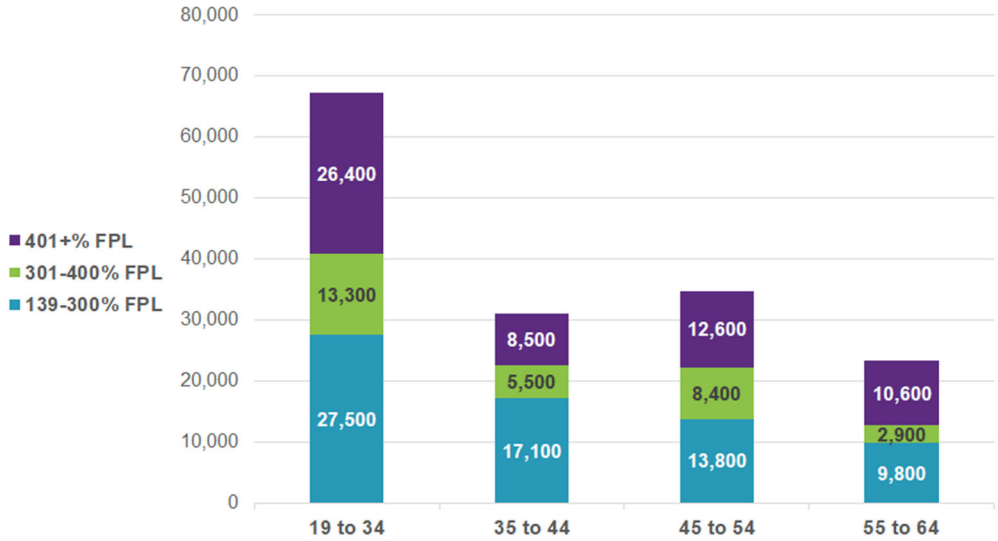
A. Remaining Uninsured in Maryland

Prior to COVID-19, an estimated 357,000 Marylanders lacked insurance. This report is based on the pre-Covid data that was available, but the impact of COVID-19 on the economy and the health risks posed by the virus underscore the importance of ensuring an affordable, accessible

[13] November 16, 2020 MHBE Board Meeting. Materials available at https://www.marylandhbe.com/about-us/board/board-minutes/2020-board-meeting-documents/

individual health insurance market to serve Marylanders without job-based coverage.[14] Of that group, about 156,000 are adults who are over-income for Medicaid and lawfully present.[15] The Affordability Work Group reviewed data on this population broken down by age and income to better understand which subgroups are most likely to be uninsured. As shown in Figure 3, the remaining non-Medicaid-eligible, lawfully present adult uninsured population is skewed toward the younger age groups, with the 19 to 34 age category accounting for approximately 43% (67,200 individuals). With respect to eligibility for financial assistance programs, approximately 60% (19 – 34 age category) to 72% (35 – 44 age category) of the uninsured across age groups have incomes below 400% FPL and could be eligible for federal subsidies.

Figure 3. Distribution of uninsured Maryland adults with incomes too high for expanded Medicaid coverage, limited to lawfully present residents, by age and income as a percentage of FPL: 2018[14]



In part, young adults' higher propensity to be uninsured may reflect a rational evaluation that the cost of insurance exceeds the benefit they are likely to receive. The ACA created a 3:1 age curve, where older adults pay at most three times the rate of young adults. The actual claim cost relativity between these age groups is closer to 5:1 or 6:1, so due to the restricted age curve, young adults on average pay more than their actual costs and subsidize older adults.[16]

MHBE further analyzed census data on young adults to better understand insured status by race and ethnicity, as shown in Figures 4 and 5.[17] The data shows that, of non-Medicaid eligible, lawfully present young adults, Hispanic and Black young adults are the most likely to be

[14] U.S. Census Bureau. Table HI-05_ACS. Health Insurance Coverage Status and Type of Coverage by State and Age for All Persons: 2019. American Community Survey Tables for Health Insurance Coverage. https://www.census.gov/data/tables/time-series/demo/health-insurance/acs-hi.html.

[15] Analysis by Families USA National Center for Coverage Innovation of 2018 data from the American Community Survey. PUMS USA, University of Minnesota, www.ipums.org. Note: ACS data do not include immigration status. These estimates impute immigration status based generally on previous Urban Institute results.

[16] Fontana, Joanne, Thomas Murawski, and Sean Hilton. "Impact of Changing ACA Age Rating Structure." Milliman Research Report. January 31, 2017. https://www.aarp.org/content/dam/aarp/ppi/2017-01/Milliman%20ACA%20Age%20Bands_2.7.17.pdf

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

uninsured, with uninsured rates of 16% and 9% respectively, approximately two to three times the uninsured rate for white young adults (5%). In absolute numbers, the three largest groups of uninsured young adults are Black, white, and Hispanic, accounting for approximately 36,700, 29,000, and 19,300 young adults, respectively.

Both the Affordability Work Group and the Individual Subsidy Work Group concluded that, because young adults are the largest group of uninsured, and increased participation of young adults in the individual market is critical for an improved risk pool and long term market sustainability, young adults should be a target population for intervention.[18]

Figure 4. Number of Uninsured, Lawfully Present Young Adults by Race/Ethnicity

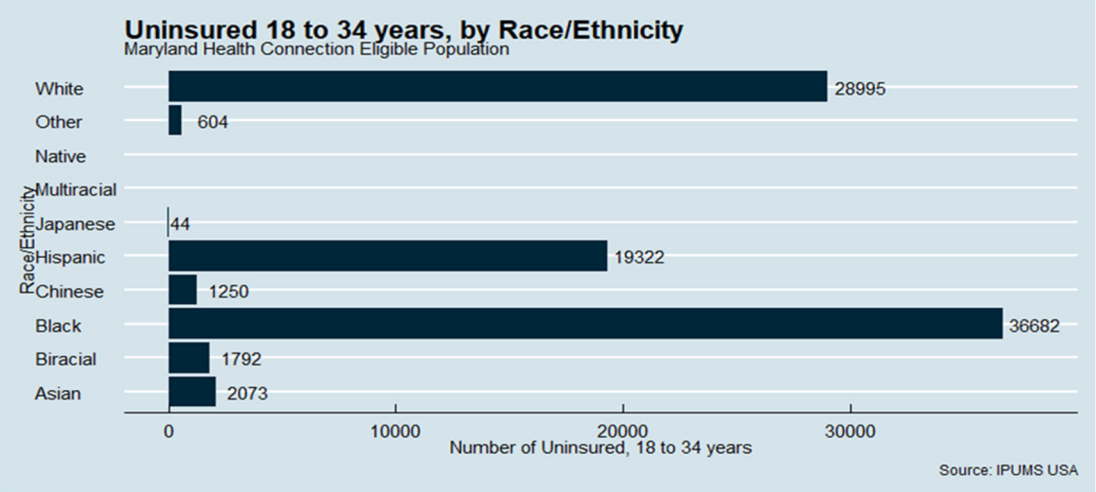
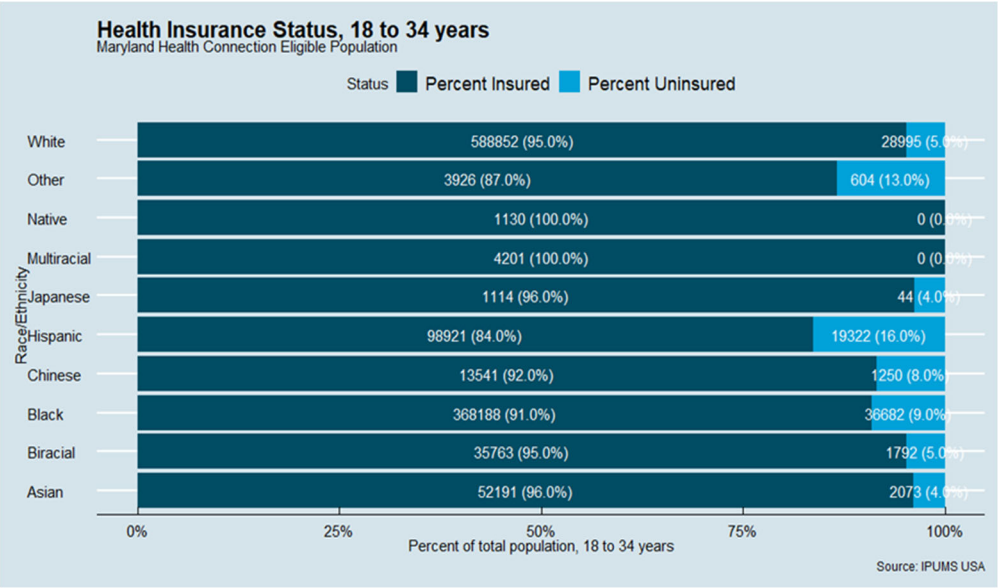


Figure 5. Percent of Uninsured, Lawfully Present Young Adults by Race/Ethnicity



[18] The Affordability Work Group's final report is available at https://www.marylandhbe.com/policy-legislation/work-groups/affordability-work-group/.

B. Effect of the Maryland Easy Enrollment Program on the Uninsured Rate and Risk Pool

In an effort to reach the remaining uninsured and streamline the process for enrolling in coverage, the Maryland General Assembly passed legislation establishing the Maryland Easy Enrollment Health Insurance Program (Easy Enrollment Program) in 2019. This legislation creates a first-in-the-nation voluntary enrollment pathway for uninsured tax-filers through a partnership between the Maryland Health Benefit Exchange (MHBE), the Comptroller's Office, and the Maryland Department of Health (MDH).[19]

The Comptroller's office, MHBE, MDH, and other stakeholders collaborated to quickly operationalize the program for the 2019 tax filing season. For phase I of the program, limited data fields were added to the state tax return to allow tax filers to indicate whether any members of their household were uninsured and whether they authorized the Comptroller to share relevant information with the MHBE. The Comptroller's office sent data for applicable tax filers to the MHBE, and the MHBE notified eligible tax filers that they may enroll in coverage through a special enrollment period (SEP). MHBE, the Comptroller's office, and MDH are targeting the launch of phase II of the program in early 2022, for tax year 2021, with the goal of simplifying the enrollment process for interested individuals.

The results to date demonstrate that the Easy Enrollment Program's simple intervention shows great promise in reaching the uninsured, particularly individuals who are eligible for Medicaid and young adults. More than 53,000 individuals used the Easy Enrollment Program to express interest in enrolling in health care coverage and were determined eligible for the SEP. Of that number, more than 9,000 (17.2 percent) applied for coverage, and more than 4,000 (7.6 percent) enrolled. About 76% of enrollees gained Medicaid coverage, indicating a lack of knowledge of the availability of free healthcare through Medicaid. The remaining 24% enrolled in private plans, and about 40% of these private plan enrollees were young adults ages 18-34. The Easy Enrollment Program also demonstrated success at reaching uninsured Black Marylanders, who accounted for 29.4% of total enrollees

The Easy Enrollment Program's conversion rate of 7.6% who were determined eligible for the SEP and ultimately enrolled compares favorably with the most recent similar experiment available, in which the Internal Revenue Service (IRS) sent letters in 2016 to a random set of taxpayers who had recently paid a tax penalty for not having maintained health insurance, encouraging them to enroll in coverage.[20] Among those who received the IRS letter, about 1.2% more enrolled in coverage compared to a control group who did not receive the letter.[21]

Even as the COVID-19 pandemic has underlined the importance of health care coverage, it presents some challenges to measuring the impact of the Easy Enrollment Program in its first year. In response to the public health emergency, the MHBE opened a Coronavirus Special

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[19] More information on year one implementation and results of the Easy Enrollment Program is available in the Joint Chairmen's Report - Impact of Maryland Easy Enrollment Health Insurance Program submitted October 15, 2020. Available at https://www.marylandhbe.com/news-and-resources/reportsdata/.

[20] Goldin, Jacob, Ithai Z. Lurie, and Janet McCubbin, "Health Insurance and Mortality: Experimental Evidence from Taxpayer Outreach," NBER, working paper, 2019, available at https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3496282

[21] See Table 2 of Goldin, Lurie, and McCubbin (2019).

Enrollment Period March 16 through December 15 for any uninsured Marylander to apply for coverage on Maryland Health Connection. This led more than 90,000 people to enroll in Medicaid and QHPs as of November 15. However, this SEP also overlapped with, and overshadowed, the availability of the SEP under the Easy Enrollment Program. As a result of the Coronavirus SEP combined with the extension of the tax filing deadline from April 15 to July 15, individuals who might have used Easy Enrollment to gain coverage in a normal year may have enrolled via the Coronavirus SEP this year instead. The MHBE is pleased that uninsured individuals are enrolling in coverage regardless of which SEP they use, but caution that these circumstances may make it more difficult to draw conclusions about the Easy Enrollment Program this year.

Although this first year of the Easy Enrollment Program demonstrated the program's ability to reach uninsured Marylanders, and merits continuation and further development, the overall effect of year one of the program on the uninsured rate and risk pool is likely to be small. Enrolling approximately 4,000 individuals would reduce the Maryland uninsured rate by less than 0.1%, and the approximately 1,000 individuals who enrolled in private plans represent a .6% increase in Exchange enrollment. In these early results, we did see that the Easy Enrollment Program was significantly more effective at enrolling individuals in Medicaid than in QHPs. This may be due to the fact that Medicaid coverage is free whereas individuals may judge the premiums they would be required to pay for a private plan to be unaffordable. Subsidies to reduce the cost of private coverage for targeted populations could yield higher uptake in enrollment through the Easy Enrollment Program.

C. Potential Target Populations for State Subsidy

MHBE identified two potential target populations for state subsidies: young adults and households at 400%-600% FPL. As discussed in section 4.A, the Affordability Work Group identified young adults as a target population for a potential state subsidy for several reasons. Young adults are the largest group, by age, of uninsured lawfully-present adults ineligible for Medicaid, and account for approximately 43% (67,200) of that remaining uninsured population. Not only are young adults more likely to be uninsured, they also tend to be healthy. Young adults 18-24 in Maryland have claims about 50% lower than the average of the individual market pool, and ages 25-34 have claims about 22% lower than average.[22] Therefore, bringing young adults into the individual market has the potential to improve the risk pool and reduce premiums for all individual market enrollees.

In 2019, MHBE commissioned a survey of currently or recently uninsured Maryland residents ages 18-34 and heard from these young adults that they value health insurance, but struggle to afford it. About 7 in 10 said that they would like to have health insurance (and this is before the coronavirus public health emergency), but 76% of those without insurance said health care and health insurance are difficult to afford.[23] This finding was echoed in a broader survey of the uninsured at all ages that MHBE commissioned in 2020, in which 76% of those currently

[22] Lewis & Ellis analysis for MHBE of individual market insurers' 2019 EDGE server claims data.

[23] MHBE 2019 Young Adult Marketing Survey, Sept 24 – Oct 11, 2019. Summary available at https://www.marylandhbe.com/wp-content/uploads/2020/02/6.-OE7-Marketing-and-Outreach-Report_Board-021820.pdf

uninsured said that they lacked insurance because they couldn't afford it or didn't believe they could qualify for affordable health insurance.[24]

MHBE identified the second potential target population, households at 400-600% FPL, as a result of the Affordability Workgroup's discussion and through conversations with the MIA regarding the "subsidy cliff" for individuals above 400% FPL. Federal subsidies cap the maximum cost of premiums for a benchmark health insurance plan at about 10% of income for households below 400% FPL, but individuals above that threshold must pay the full cost. This leads to a scenario in which some individuals who are only slightly above 400% FPL must pay a substantially higher percentage of their income than those earning slightly less who are eligible for federal subsidies. This primarily impacts middle-income older adults, and can result in a substantial burden to them.

Table 4 shows the impact of the subsidy cliff for various age groups and household sizes, comparing a contract holder's net premium (after federal subsidies) at 300-400% of FPL vs premiums at 400-600% of FPL. As the table shows, an older individual or older couple feels the impact of the subsidy cliff more than younger adults. For example, the net premium of an individual age 55-64 earning 400-600% FPL can be 87% higher than an individual earning 300-400% FPL, or 177% higher for a couple in that age group. In contrast, because younger individuals' premiums are lower and already likely to be less than 10% of their income, younger individuals have a smoother transition from below 400% to above 400% FPL without, or with a smaller, cliff.

Table 4. Illustrative Comparison of Net Premiums, Highlighting the Net Premium (NP) Change at the "Subsidy Cliff"

Contract Type	FPL Range	Age Band				
		18-25	26-34	35-44	45-54	55-64
Individual	300-400%	$3,060	$3,540	$4,030	$4,440	$4,440
	400-600%	$3,060	$3,540	$4,030	$5,520	$8,300
	NP Change	0%	0%	0%	24%	87%
2 Person	300-400%	$6,000	$6,000	$6,000	$6,000	$6,000
	400-600%	$6,130	$7,070	$8,050	$11,040	$16,600
	NP Change	2%	18%	34%	84%	177%

[24] MHC Strategic Messaging Survey, July 21 –Aug 11, 2020. Summary available at https://www.marylandhbe.com/wp-content/uploads/2020/09/MHBE_2020-Strategic-Messaging-Survey_-Board-Report-09.21.20.pdf

5. Individual Market State Subsidies: Designs and Modeling

MHBE, in consultation with MIA, identified several potential subsidy designs for the target populations. The actuarial firm Lewis & Ellis modeled the potential impact of the identified designs. In total, Lewis & Ellis modeled eight potential subsidy designs targeted at young adults, and three potential designs targeted at households at 400-600% FPL. Lewis & Ellis's full report is attached in Appendix 2, and a summary follows.

It is important to note that, because these estimates are based on predicted consumer behavior, there is uncertainty in the projected impacts of these subsidy designs, including projected enrollment, the degree to which enrollment is projected to improve the health of the overall individual market risk pool, and projected overall cost. Actual enrollment increase and cost could be lower if a subsidy proves to be less influential in encouraging enrollment; on the other hand, actual enrollment and cost could be higher if the subsidy is more impactful than projected.

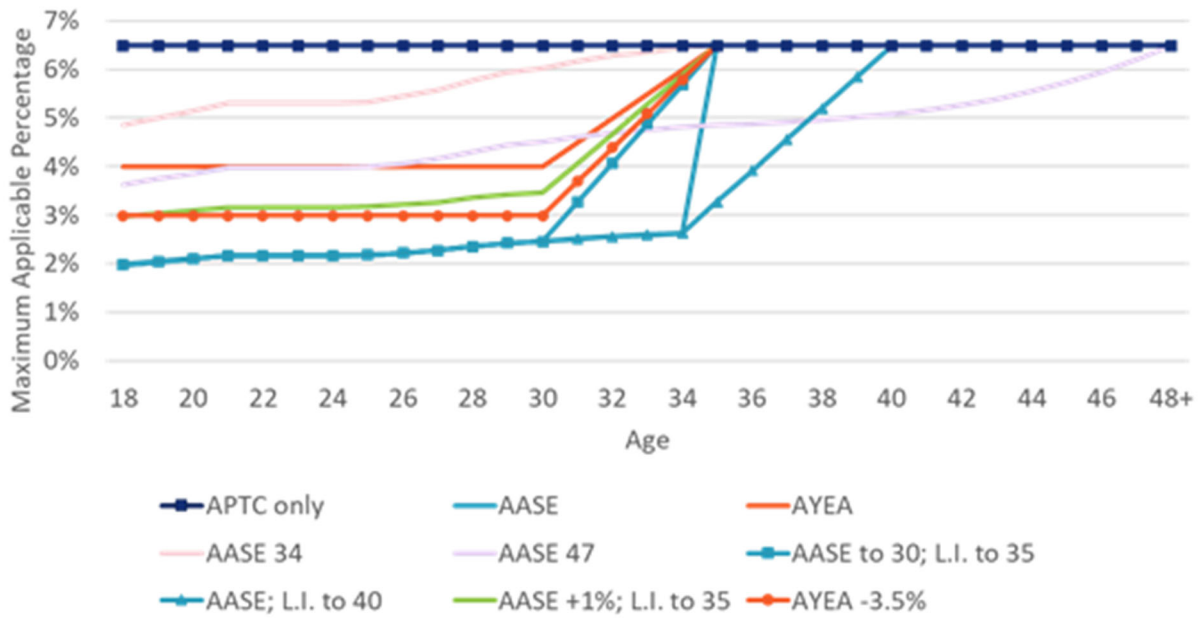
A. Young Adult Subsidy

All of the young adult subsidy designs would limit eligibility to those below 400% FPL, in line with eligibility limits for the federal subsidy.

In order to understand the subsidy designs that were modeled, it is important to understand how the federal subsidy works. As described in section 3.C and Table 3, under the Affordable Care Act, a household with an income less than 400 percent of the FPL pays a maximum amount of approximately 2 to 10 percent of household income towards a benchmark plan. A federal subsidy makes up the difference between the individual's payment and the full cost of the benchmark plan.

The young adult subsidies build on the federal design. Each subsidy reduces the maximum percent of income that a young adult would pay towards the benchmark plan, with the state subsidy used to make up the difference between the new reduced percent of income paid towards premium and the amount the individual would owe if they were only receiving the federal subsidy. Figure 6 provides an illustration of the subsidy designs that Lewis & Ellis modeled for an individual at 200% FPL at various ages. The dark blue line at the top indicates the percentage of income, about 6.5%, that an individual at this FPL would pay towards benchmark plan premiums under federal standards.

Figure 6. Maximum Applicable Percentage by Subsidy and Age at 200% of the FPL



The subsidy designs depicted below the dark blue line demonstrate the reduced percentages of income that individuals would pay under the various young adult subsidy designs. As shown in the graph, the subsidy designs range in generosity from a design that offers a relatively minimal subsidy compared to the federal subsidy and phases out completely at age 35 (Age Adjustment Subsidy Enhancement [AASE] 34) to a design that significantly reduces costs for young adults ages 18-34 and phases out from ages 35 to 40 (AASE; L.I to 40). The rest of the designs fall in between these two in terms of generosity. All phase out gradually between ages 30 and 35 with the exception of: 1) the AASE, which results in a cliff whereby a subsidy recipient would jump abruptly from receiving a significant state subsidy at age 34 to no state subsidy at age 35: and 2) the AASE 47, which phases out gradually until it completely ends at age 48.

Table 5 summarizes key data on the projected impact of these subsidies. The subsidy designs are listed in order of lowest to highest increase in enrollment in the targeted age group (column C), with data in the first row presenting a comparative baseline scenario in which the state continues the reinsurance program, but does not implement a state subsidy. Lewis & Ellis assumed in their modeling that the subsidy would be implemented in 2022, and that enrollment would gradually increase as young adults became increasingly aware of the subsidy, with the full impact on enrollment realized in 2024. This reflects recent experience in the individual market; the ACA subsidies took effect in 2014, but it took several years for the public to become aware of the subsidies and for enrollment to increase accordingly.

Column A presents the expected enrollment in the target age ranges in 2021 prior to implementation of the subsidy (43%) and column B presents the expected enrollment in 2024, after the subsidy has had its full effect on enrollment. Impacts range from a 0% increase to a 17% increase in the insured rate in the target population, which corresponds to increased enrollment ranging from 500 to 20,900. SB124 requested information on whether state-based individual market health insurance subsidies alone would encourage more young adults to enroll in the individual market and whether cost–sharing reductions will be necessary; this modeling

demonstrates that subsidies alone are expected to encourage more young adults to enroll in the individual market, and that cost-sharing reductions in addition to a premium subsidy are not expected to be necessary to encourage enrollment.

Table 5. Key Information on the Projected Effect, Cost, and Efficiency of Young Adult Subsidy Designs

		A	B	C	D	E	F	G	H	I	J	K
Scenario	Age	2021 % enrolled of eligible	2024 % enrolled of eligible	2024 Increase in Enrollment	2024 Gross Premium PCPY	2024 Net Premium PCPY	2024 State Subsidy PCPY	2024 Cost	2022 Possible Federal Pass-Through	2022 Change in Morbidity – Impact to Premiums (all)	% Subsidy Recipients who are New Enrollees by 2024	2024 Cost per New Member
Baseline (Reinsurance)	18-34	43%	43%	-	$5,003	$2,283	$0	-	-	-	-	-
AASE 34	18-34	43%	43%	500	$4,995	$2,056	$243	$6M	$400K	-0.10%	2%	$12,054
AYEA	18-34	43%	49%	5,400	$4,992	$1,691	$642	$18M	$2M	-1.00%	15%	$3,316
AYEA -3.5%	18-34	43%	52%	8,900	$4,988	$1,459	$928	$27M	$4M	-1.60%	22%	$3,078
AASE 47	18-47	43%	50%	9,300	$5,438	$1,758	$706	$30M	$5M	-1.60%	16%	$3,271
AASE +1%; LI to 35	18-34	43%	55%	11,700	$4,937	$1,474	$1,080	$32M	$8M	-2.00%	27%	$2,786
AASE 30; LI to 35	18-34	43%	58%	14,400	$4,915	$1,177	$1,384	$44M	$9M	-2.50%	32%	$3,066
AASE	18-34	43%	60%	15,900	$4,887	$963	$1,607	$53M	$10M	-2.70%	34%	$3,322
AASE; LI to 40	18-39	43%	58%	20,900	$5,255	$1,244	$1,326	$64M	$12M	-3.50%	30%	$3,066

Columns D through F present information on how the subsidy designs would impact average annual premium costs in the target populations. Column D shows the average gross premium per contractholder per year (PCPY) - that is, premium before application of state or federal subsidies - for the target population in 2024. The 2024 average gross premiums vary slightly because each subsidy is expected to result in an enrolled group with a slightly different mix of ages, but all of the average gross premiums are close to $5,000 PCPY, or about $417 per month. Column E shows the average net premium PCPY - that is, premium after application of state or federal subsidies - for the target population in 2024. Average net premiums range from about $1,000 to $2,000 PCPY, or $83 to $167 per month. The average reduction in net premium attributable to the state subsidy is shown in column F, and ranges from about $240 to $1,600 PCPY, or $20 to $133 per month.

Columns G and H present information on the projected cost of the program, and potential offsetting federal funding. Column G provides total cost estimates for the program in 2024, when the impact on enrollment is projected to have fully phased in. Total cost estimates range from $6 million to $64 million annually. (Cost for years 2022 and 2023 are projected to be less.) Lewis & Ellis estimate that implementing a state subsidy program would result in reduced costs to the federal government as a result of decreases in premiums due to healthier people entering the risk poll and reducing morbidity. If MHBE were to receive federal approval of a 1332 State Innovation Waiver to recoup these federal savings, Lewis & Ellis estimates that could yield $400,000 to $12 million dollars to offset state spending, as shown in column H.

Columns I through K present information on the projected impact to average premiums resulting from the subsidy, and on two measures of the efficiency of the subsidy designs. As shown in column I, the new young enrollees brought into the market are expected to improve the health of the overall individual market risk pool and reduce average premiums for all enrollees by .1% to 3.5% depending on the subsidy design. Column J provides information on the first measure of each subsidy's efficiency, the percent of subsidy recipients who are new enrollees by 2024. One of the primary goals of the young adult subsidy is to encourage currently uninsured young adults to enroll. One way of looking at the effectiveness of a subsidy in achieving that goal is by

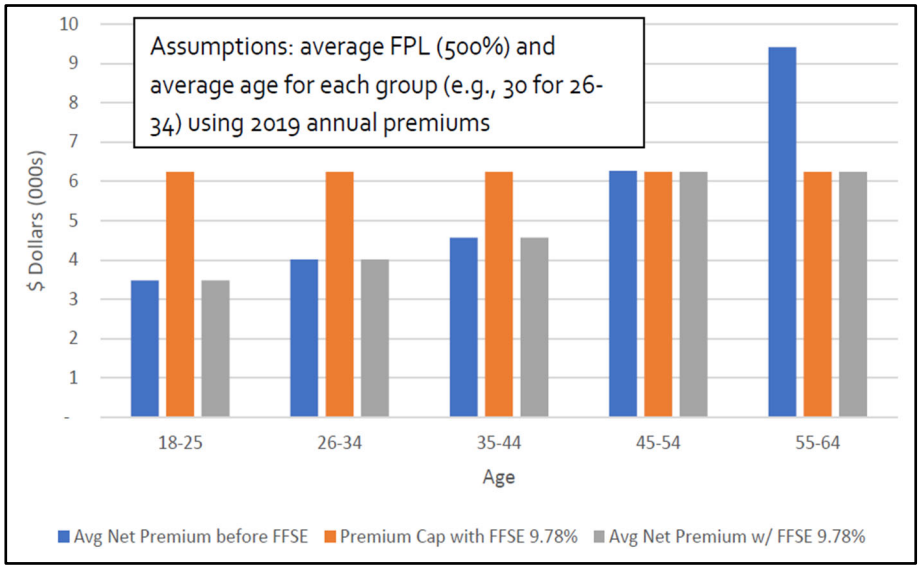
estimating the percent of subsidy recipients who are new enrollees brought into the market by the subsidy, as opposed to people who would have been enrolled regardless of the subsidy. As column J shows, the percent of subsidy recipients who would be new enrollees by 2024 ranges from 2% to 34%. Finally, column K presents the second measure of efficiency calculated by Lewis & Ellis, the cost of the program per new enrollee in 2024. This is calculated by dividing the program cost in column G by the increase in enrollment in column C, and yields about $2,800 to $3,300 per enrollee, with one outlier at about $12,000.

B. 400-600% FPL Subsidy

Similar to the young adult subsidies, the 400-600% FPL subsidy designs also build on the federal subsidy design. As previously mentioned, federal subsidies are not available for those above 400% FPL; just under that cap, federal subsidies limit premiums for a benchmark plan to a maximum of 9.78% of household income. MHBE modeled three simple versions of a subsidy for households at 400-600% FPL that would cap the percent of income that households would pay for a benchmark plan at 9.78% (matching the federal cap applicable to those just under 400% FPL), 12.5%, and 15%.

Lewis & Ellis's modeling revealed that this would primarily benefit older individuals, because premiums for younger individuals are typically below these caps already. Figure 7 provides an example showing that average premiums for individuals at 500% FPL (in blue) fall below the 9.78% threshold (in orange) for each age group except 55-64. However, it is important to note that when considering families rather than individuals, the picture becomes more complicated. As seen in Table 4 earlier, families at lower income thresholds can have premiums that exceed these caps, and therefore some benefit under these subsidy designs would also accrue to families in younger age ranges.

Figure 7. Illustrative Comparison of 400-600% FPL Subsidy Impact by Age for Individuals between 400-600% FPL using 2019 Annual Net Premiums and a Premium Cap of 9.78%



*FFSE in the figure above refers "400%+ FPL Subsidy Extension", the name Lewis & Ellis gave to the 400-600% FPL subsidy

Table 6 summarizes key data on the projected impact of these subsidies. As with the young adult subsidies, Lewis & Ellis assumed in their modeling that a subsidy would be implemented in 2022, and that the impact would gradually increase over three years as Marylanders became increasingly aware of the subsidy.

Table 6. Key Information on the Projected Effect, Cost, and Efficiency of 400-600% FPL Subsidy Designs

Scenario	Age	2021 % enrolled of eligible	2024 % enrolled of eligible	2024 Increase in Enrollment	2024 Gross Premium PCPY	2024 Net Premium PCPY	2024 State Subsidy PCPY	2024 Cost	2022 Possible Federal Pass-Through	2022 Change in Morbidity – Impact to Premiums (all)	% Subsidy Recipients who are New Enrollees by 2024	2024 Cost per New Member
Subsidies for Individuals 400-600% FPL												
FFSE 9.78%	18-64	53%	60%	8,900	$7,383	$5,926	$1,457	$69M	$10M	-0.50%	15%	$7,708
FFSE 12.5%	18-64		56%	3,900	$7,307	$6,575	$732	$32M	$4M	-0.20%	7%	$8,318
FFSE 15%	18-64		55%	2,300	$7,227	$6,827	$400	$17M	$3M	-0.10%	4%	$7,459

Column A presents the expected enrollment in the target FPL ranges in 2021 prior to implementation of the subsidy (53%) and column B presents the expected enrollment in 2024, after the subsidy has had its full effect on enrollment. Impacts range from a 2% increase to a 7% increase in the insured rate in the target population, which corresponds to increased enrollment ranging from 2,300 to 8,900 in the target population.

Columns D through F present information on how the subsidy designs would impact average annual premium costs in the target populations. Column D shows the average gross premium PCPY for the target population in 2024. All of the average gross premiums are close to $7,300 PCPY, or about $608 per month. Column E shows the average net premium PCPY - that is, premium after application of state subsidies - for the target population in 2024. Average net premiums range from about $5,900 to $6,800 PCPY, or $492 to $567 per month. The average reduction in net premium attributable to the state subsidy is shown in column F, and ranges from about $400 to $1,457 PCPY, or $33 to $121 per month.

Columns G and H present information on the projected cost of the program, and potential offsetting federal funding in 2024. Total cost estimates range from $17 million to $69 million annually. (Cost for years 2022 and 2023 are projected to be less.) Lewis & Ellis estimate that implementing a state subsidy program would result in reduced costs to the federal government as a result of decreases in premiums due to healthier people entering the risk poll and reducing morbidity. If MHBE were to receive federal approval of a 1332 State Innovation Waiver to recoup these federal savings, Lewis & Ellis estimates that could yield $3-$10 million dollars to offset state spending, as shown in column H.

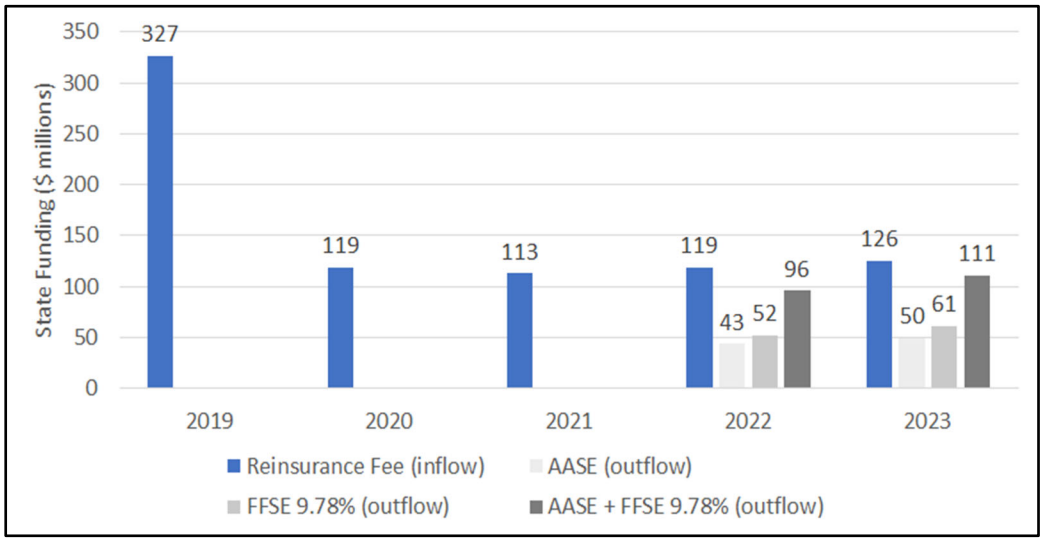
Columns I through K present information on the projected impact to average premiums resulting from the subsidy, and on two measures of the efficiency of the subsidy designs. As shown in column I, the enrollees brought into the market are expected to modestly improve the health of the overall individual market risk pool and reduce average premiums for all enrollees by .1% to .5% depending on the subsidy design. Columns J and K provide information on measures of each subsidy's efficiency: by 2024, the percent of subsidy recipients who would be new enrollees by 2024 ranges from 4% to 15% and the cost of the program per new enrollee is estimated at approximately $7,500 to $8,300. These efficiency measures focus on enrollment gain, but it is important to note that the goal of a 400%-600% subsidy would not only be to increase enrollment, but also to provide relief to current enrollees burdened with high premiums.

C. Impact on the Reinsurance Program

Funding a state subsidy using the state reinsurance fund is not projected to impact the availability of funds for reinsurance during the remainder of the waiver period, due to projections that federal funding will be sufficient to fully fund the program.

Because the state reinsurance funding has not been needed to fund the reinsurance program, there is significant state funding available to pay for a complimentary market stabilization initiative such as a state subsidy program. Lewis & Ellis projects that the annual funding expected from the health insurance provider fee would be sufficient to cover any single subsidy design that they modeled in 2022 and 2023, and could even be used to cover the second most expensive young adult subsidy and most expensive 400-600% FPL subsidy, as shown in Figure 8.

Figure 8. State Funding Inflow and Possible Outflows through 2023



Given the projected surplus federal funding for the reinsurance program, Maryland could also pursue an amendment to its current State Innovation Waiver under § 1332 of the Affordable Care Act to enable the state to access both (1) existing surplus federal funding from the reinsurance program and (2) additional federal pass-through generated by a state subsidy. The approximately $500-$600 million in surplus funding projected under the reinsurance waiver for the 2019-2023 period could fund a young adult subsidy for six to seven years or a young adult and a 400-600% FPL subsidy for three to four years. Use of federal funding does depend on several variable: using federal funding during the current waiver period would depend on federal approval of a waiver amendment, and use of federal pass-through past 2023 would depend on whether Maryland continues the reinsurance program and receives federal approval to roll surplus funding over into a second waiver period. However, even without federal pass-through funding, state funding under the health insurance provider fee is projected to be sufficient to cover the cost of a state subsidy program.

Implementation of any of the subsidy designs described in this report is not expected to significantly alter the reinsurance program, as the total change in the enrollment is at most 20,900 by 2024 for one subsidy (and 29,800 with two subsidies), which is approximately 13% of

the individual market. Maryland would not be required to amend its current 1332 waiver or request an additional waiver in order to implement a state subsidy program. However, as previously noted, amending the state's existing waiver would allow it to tap federal pass-through funding to finance a subsidy program.

D. Public Engagement

I. Affordability Work Group and Public Comment on Lewis & Ellis Report

The MHBE's work developing and evaluating potential individual market state subsidies has benefited from and been informed by the input of stakeholders and the public. As described in section 4, MHBE convened a work group in 2019 that was tasked with providing the MHBE Board with recommendations on policy solutions to make coverage more affordable for Marylanders. One of the recommendations that group made was to consider implementing a state subsidy for young adults.

Following that recommendation and the passage of SB124/HB196, MHBE worked with MIA and Lewis & Ellis to model four subsidy designs targeted at young adults, as well as three subsidy designs targeted at individuals at 400-600% FPL. Lewis & Ellis produced a report of their results, which MHBE published for a 30-day public comment period on October 2. The public comments are included in Appendix 3. MHBE also reviewed and discussed Lewis & Ellis's analysis with the MHBE Standing Advisory Committee.

II. Individual Subsidy Work Group

In addition, MHBE convened a work group that included representatives from each individual market insurance carrier and the broker, navigator, advocacy, and provider communities. The work group received background information on the status of the individual market in Maryland and on the reinsurance program. The group also heard from two states with established subsidy programs, Massachusetts and California. After discussing this background information, the group walked through the Lewis and Ellis report and agreed on a framework for analyzing the subsidy designs, as shown in Table 7.

Table 7. Framework for Evaluating Subsidy Designs

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

Members of the work group were drawn to the most generous young adult subsidy modeled at the time, the AASE, because it targeted individuals who would improve the risk pool, bring in the most uninsured, and be the most cost effective - but concern was raised regarding the fact that the model had a cliff that would results in a sharp jump in premiums for individuals turning age 35.

The Individual Subsidy Work Group also discussed several ways in which a subsidy for young adults under 400% FPL could improve equity in health insurance: by targeting uninsured young adults, who are more likely to be Black or Hispanic; by targeting young adults under 400% FPL, who are less likely to have benefited from premium reductions as a result of the reinsurance program; and by offsetting the impact of the 3:1 age curve under the ACA, which results in younger enrollees subsidizing older enrollees.

As a result of the work group's feedback, MHBE and MIA identified four additional young adult subsidy designs that aimed to have the impact of the AASE design but phased out gradually without a cliff. The work group was pleased with the additional options and, with 10 of 11 members present, ultimately voted to submit seven recommendations to MHBE to be considered if the legislature authorizes MHBE to implement an individual market subsidy, as shown in Table 8. These recommendations assume a "steady state" in which the reinsurance waiver, federal reinsurance pass-through funding, and the state reinsurance fee continue. The full report of the work group is attached in Appendix 4.

Table 8. MHBE Individual Subsidy Work Group Recommendations

The Individual Subsidy Work Group recommends that:	Vote
1. MHBE use the considerations listed in the framework (*see Table 7)* when evaluating subsidy design	Yes: 10 No: 0
2. MHBE target subsidies at young adults, with subsidies phasing out to age 40	Yes: 10 No: 0
3. MHBE target subsidies at young adults up to 400% FPL	Yes: 10 No: 0
4. Of the subsidy designs the group was presented with, the AASE LI-40 best met the framework goals	Yes: 8 No: 0 Abstained: 2
5. MHBE later explore a subsidy targeting those 400-600% FPL	Yes: 10 No: 0
6. MHBE later explore including young adults with FPL 400-600% in the subsidy design	Yes: 10 No: 0
7. When considering the effectiveness of the subsidy program, MHBE evaluate how well the program reduces racial inequities	Yes: 10 No: 0

E. Staffing and Infrastructure

MHBE assumes that the subsidy program would be run by MHBE, and would operate similarly to the current federal subsidy program. To implement changes to the HBX system to calculate subsidies, MHBE anticipates initial costs at around $814,000. This would include system changes, as well as development hours and testing. For ongoing maintenance, MHBE anticipates additional costs of $271,000 per year. At this time, MHBE does not anticipate additional staffing needs. If legislation is proposed to establish a subsidy program, MHBE will provide a fiscal note with a more detailed fiscal analysis pertaining to the specifics of the proposal.

6. Conclusion

The subsidy designs modeled demonstrate that a young adult subsidy at a range of total costs could have a meaningful impact on reducing the uninsured rate in the target population, further stabilize the risk pool, and reduce premiums for all enrollees. For these reasons, implementing an individual subsidy targeted at young adults below 400% FPL was recommended by both work groups convened by MHBE to consider this topic, the Affordability Work Group in 2019 and the Individual Subsidy Work Group in 2020.

Although the Affordability Work Group and Individual Subsidy Work Group both expressed concern regarding the affordability of coverage for individuals in the 400-600% FPL range, both recommended prioritizing young adults as the target population for a state subsidy due to the greater expected impact on increased enrollment, lower cost, and more significant benefit to the risk pool. The Individual Subsidy Work Group recommended that MHBE consider expanding the state subsidy to individuals in the 400-600% FPL group as a second target population, after gaining a few years of experience with the cost and impact of a state subsidy for young adults.

Implementing any one of the state subsidies is not projected to impact the ability of the reinsurance program to continue to function as envisioned, because federal funding is projected to cover the entire cost of the reinsurance program. Annual funding under the health insurance provider fee is projected to exceed the cost of any one of the state subsidy designs and so could be used to support a state subsidy. In addition, federal funding under the current 1332 waiver for the reinsurance program is projected to exceed the cost of the reinsurance program; therefore, if MHBE is authorized to implement a state subsidy, it would be prudent to pursue amendment of the existing waiver to enable MHBE to put surplus federal pass-through funding towards the subsidy program. If MHBE were to receive federal approval, surplus federal funding alone, without impacting the reinsurance program, could be sufficient to finance a subsidy program for 3-7 years depending on the subsidy designs implemented. However, no other state has received a 1332 waiver for a state subsidy program so the likelihood of federal approval is not yet known.

MHBE expects that if authorized to implement a state subsidy, the MHBE Board would ultimately determine the appropriate allocation of available funding for reinsurance and state subsidies to maximize enrollment and affordability in the individual market. Given the reinsurance program's success at stabilizing the individual market, ensuring its ongoing viability will be a priority. It is important to note that the health insurance provider fee, like the reinsurance program, is only authorized through 2023. Therefore, if considering implementation

of a state subsidy funded through the fee, it will also be important for the legislature to consider the future of both the reinsurance program and the fee. The federal government is developing but has not yet released guidance on the process and timeline to extend an existing 1332 waiver. It would be logical to assume that an application to extend the waiver would need to be submitted at least a year prior to the end of the current waiver period in order to allow time for federal review and provide certainty to insurers as they work to finalize their rates for 2024.

Given the novel nature of a state subsidy program, the legislature may want to consider a pilot program to allow MHBE to gather enough credible data to refine longer-term projections of program costs. A pilot of two to three years would provide sufficient data and would make sense if the state does not pursue a waiver amendment to gain federal pass-through funding, as existing state funds accrued through 2023 would be sufficient to finance a program of this duration even in the absence of a continuation of the health insurance provider fee beyond 2023. If a waiver amendment to secure federal pass-through funding is pursued and approved, and the reinsurance program is renewed for a second 5-year period (2024-2028), it may make sense to consider extending a pilot through the end of the second waiver period. However, given present uncertainty over the continuation of the reinsurance program, a pilot program could be launched with an initial planned duration of two to three years and could later be extended if the reinsurance program were extended.

Through the reinsurance program, the Easy Enrollment Program, and numerous other efforts to improve the affordability and quality of health care, the actions of the Maryland Governor and General Assembly have put Maryland at the forefront of health policy innovation. MHBE welcomes the opportunity to continue to work with the General Assembly as it explores opportunities to build on these efforts.

Appendix 1. SB 124 / HB 196, Section 2

AND BE IT FURTHER ENACTED, That, on or before December 1, 15 2020, the Maryland Health Benefit Exchange shall report to the Senate Finance Committee and the House Health and Government Operations Committee, in accordance with § 2–1257 of the State Government Article, on the following as it relates to establishing State–based individual market health insurance subsidies in the State:

1) experiences of state-based individual market subsidies in other states, particularly those with a reinsurance program;
2) the effect the Easy Enrollment Program has had on the uninsured rate and risk pool in the individual market;
3) the population that would be the intended target of the State–based individual market health insurance subsidies, including age and income level;
4) the number of individuals currently enrolled in the individual market who would be eligible for State-based subsidies;
5) if young adults would be the intended target of the State–based individual market subsidies, whether State-based subsidies alone will encourage more young adults to enroll in the individual market and whether cost–sharing reductions will be necessary;
6) the average amount of individual market subsidies needed for a State–based subsidy program to effectively cover more individuals and lower the risk of the individual market pool;
7) the amount of State–based individual market subsidy funding necessary to reduce rates in the individual market by 1% and 5%;
8) an estimate of the impact that funding for State–based individual market subsidies will have on the availability of funds for reinsurance in the individual market, using the actual State liability for the State Reinsurance Program for the 2019 benefit year;
9) the appropriate allocation of available funding for reinsurance and State–based individual market subsidies that will maximize enrollment and affordability in the individual market;
10) the staffing and infrastructure needs to administer a State–based individual market subsidy program; and
11) the impact additional State–based individual market subsidies will have on federal subsidies and whether the State will need to amend its current State Innovation Waiver under § 1332 of the Affordable Care Act or request an additional waiver.

Appendix 2. Lewis & Ellis Report

LEWIS & ELLIS
Actuaries and Consultants

Actuarial Support Services for the Maryland State Innovation Waiver

Analysis of Updated Young Adult and Federal Poverty Level Extension Subsidies

MARYLAND HEALTH BENEFIT EXCHANGE

STATE OF MARYLAND

JOSH HAMMERQUIST, FSA, MAAA
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MICHAEL LIN, FSA, MAAA
Vice President & Consulting Actuary

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

Submitted on:
November 19, 2020

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INTRODUCTION

In 2019, the Maryland Health Benefit Exchange ("MHBE") engaged Lewis & Ellis ("L&E") to analyze the potential impact of subsidies on the individual and small group markets. In this report, L&E has been asked to update its analysis for these subsidies, which now focus solely on the individual market. If implemented, the subsidies could be funded by using state funding from the existing State Reinsurance Program ("SRP") Section 1332 waiver. Since 2019, federal pass through funding has been sufficient to cover all reinsurance program cost and Maryland has not had to utilize state funding to reimburse high dollar claims in the SRP.

The 2019 subsidy proposals were borne from recommendations from the 2019 Affordability Work Group and SHOP Advisory Committee. The goal of the proposals was to maximize participation in the individual market, improve the risk pool's morbidity, and increase affordability for all individual market participants.

Through discussions with the MHBE and the Maryland Insurance Administration ("MIA"), this report has been revised to analyze two different subsidy strategies. The first strategy, which includes four different approaches, focuses on young adults between the ages of 18 and 34[1]. These methods focus on young adults because this population has historically not purchased health insurance at the same rate as older adults.

The second strategy, which includes two different methods, focuses on all adults with incomes between 400% and 600% of the Federal Poverty Line ("FPL"). These methods target individuals whose incomes are in the "subsidy cliff". Under the Affordable Care Act (ACA), individuals with incomes greater than 400% of FPL are not eligible for premium tax credits. These subsidies extend the maximum applicable percentage to 600% FPL.

The purpose of the report is to provide L&E's analysis to inform MHBE stakeholders for the 2021 legislative session with the goal of assessing and analyzing the impact of additional stabilization measures for the individual market in Maryland and making coverage more affordable for members with incomes below 600% of FPL.

[1] One of the proposed methods, AASE 47, is applicable to adults ages 18 to 47.

INDIVIDUAL MARKET SUBSIDIES

L&E modeled two strategies to potentially maximize participation in Maryland's individual market and to increase affordability for all individual market participants.

The first strategy is designed to directly bring more young, uninsured individuals into the individual market. The second strategy is designed to support adults with incomes just above the ACA's 400% FPL cutoff to qualify for subsidies.

YOUNG ADULTS SUBSIDY BACKGROUND

The first group of subsidy approaches is the Young Adults Subsidies. To be eligible for the Young Adults Subsidy, an individual would need to be between the ages of 18 and 34[2] with an income below 400% of the FPL. This subsidy strategy has four different proposed structures which would reduce the premium paid by Young Adults depending on their income as a percentage of FPL. Graph 1 on page 4 illustrates the applicable percentage changes by age at 200% of the FPL for all four YA subsidies.

YOUNG ADULT SUBSIDY 1: AGE ADJUSTMENT SUBSIDY ENHANCEMENT

The first Young Adults Subsidy structure is the Age Adjustment Subsidy Enhancement ("AASE"). Providing the AASE to Young Adults would result in a net premium (for the second lowest cost silver plan) that better reflects the underlying actuarial risk of the cohort.

The ACA created a 3:1 age curve, where older adults pay at most three times the rate of Young Adults. Due to the age curve, Young Adults tend to subsidize older adults since the actual claim cost relativity between these age groups is more than 3:1. AASE attempts to impact Young Adults in a manner which better reflects the actual claims relativity. The approach is based on the following equation derived by Gabriel McGlamery of Florida Blue.

$$ACA\ Applicable\ Percentage\ * \left(\frac{Enrollment\ Group's\ Avg.\ Age\ Rate}{3}\right) = New\ YA\ AP$$

Currently, individuals of any age with an income equal to 200% of FPL pay a maximum of 6.5% of their 2020 income towards health insurance premiums. This is based on the 2020 Applicable Percentage Table released by the federal Internal Revenue Service (IRS)[3].

Under the AASE, an individual between the ages of 18-25 at 200% of FPL would see their applicable percentage reduced from 6.5% to 2.1%[4]. This premium reduction would be subsidized by the State. The maximum cost of the program per eligible individual would be the difference between 6.5% and 2.1% multiplied by the individual's income.

[2]One of the four proposed state subsidies subsidizes younger adults up to age 47, which is approximately the median age in the Maryland individual market. Otherwise, the other three subsidize individuals between 18 and 34.
[3]https://www.irs.gov/pub/irs-drop/rp-19-29.pdf
[4]Assuming the 18-25 group's age rate is 0.98 based on ACA rating curves from CMS (https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-Guidance-Regarding-Age-Curves-and-State-Reporting-12-16-16.pdf)

It should be noted that in some cases, the premium as a percentage of income for the second lowest cost silver plan would be lower than the applicable percentage. That is, there would be cases where the gross premium is less than the income cap and the resultant federal subsidy would be $0. In this scenario, the cost of the AASE program would be lower, and the cost would be the difference between the actual premium and 2.1% of income.

Table 7 (in the Supporting Tables section) shows the applicable percentage changes for the AASE.

YOUNG ADULT SUBSIDY 2: ADVANCING YOUTH ENROLLMENT ACT

The second Young Adults Subsidy structure is the Advancing Youth Enrollment Act ("AYEA"). Providing the AYEA to Young Adults would reduce the total applicable percentage for the second lowest cost silver plan by 2.5 percentage points when a Young Adult is between 18 and 30 years old. The 2.5 percentage points is reduced by 0.5 percentage points for each incremental year after age 30 until the adjustment terminates at age 35.

Currently, individuals of any age with incomes at 200% of FPL will have a 2020 applicable percentage of 6.5%[5].

Under the AYEA, an individual between the ages of 18-25 at 200% of FPL would see his or her applicable percentage reduced from 6.5% to 4.0%[6]. The premium reduction would be subsidized by the State. The maximum cost of the program per eligible individual would be the difference between 6.5% and 4.0% multiplied by the individual's income.

Table 8 (in the Supporting Tables section) shows the applicable percentage changes for AYEA.

YOUNG ADULT SUBSIDY 3: AGE ADJUSTMENT SUBSIDY ENHANCEMENT CLIFFLESS TO 34

The third Young Adults Subsidy is the Age Adjustment Subsidy Enhancement Cliffless to 34 ("AASE 34"). AASE 34 is a modification to the AASE subsidy. Formulaically, the new AASE applicable percentage formula is modified such that the denominator is the age curve factor for a 35 year-old (1.222) rather than 3. This modification would keep the net premiums the same for all ages greater than 34, but it would help smooth out the net premium for young adults.

Table 9 (in the Supporting Tables section) shows the applicable percentage changes for AASE 34.

YOUNG ADULT SUBSIDY 4: AGE ADJUSTMENT SUBSIDY ENHANCEMENT CLIFFLESS TO 47

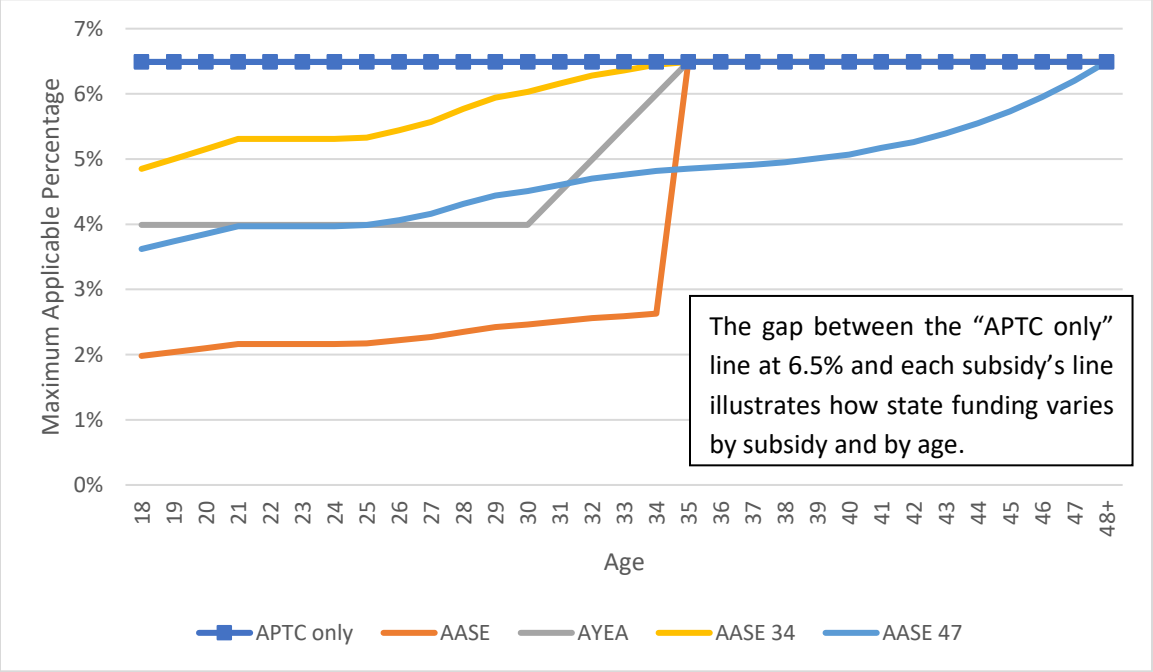
The final Young Adults Subsidy is the Age Adjustment Subsidy Enhancement Cliffless to 47 ("AASE 47"). In this modified AASE approach, the applicable percentage formula uses the age curve factor for a 48 year-old (1.635) in the denominator. The age 48 is chosen in this scenario because 48 is the average age in the Individual market. AASE 47 provides premium subsidies to

[5] https://www.irs.gov/pub/irs-drop/rp-19-29.pdf
[6] A reduction of 2.5% from the original applicable percentage

Young adults, similar to the first three Young Adult subsidies; however, AASE removes the "subsidy cliff" at age 35 by smoothing the phase out of the subsidy up to the average age in the Individual market. In other words, the first three Young Adults subsidies do not financially benefit the middle-aged adults (35 to 47), while AASE 47 does. This method does not impact the net premium for adults older than 47.

Table 10 (in the Supporting Tables section) shows the applicable percentage changes for AASE 47. Graph 1 illustrates the applicable percentage changes by age at 200% of the FPL for all four YA subsidies.

Graph 1: Maximum Applicable Percentage by Subsidy and Age at 200% of the FPL



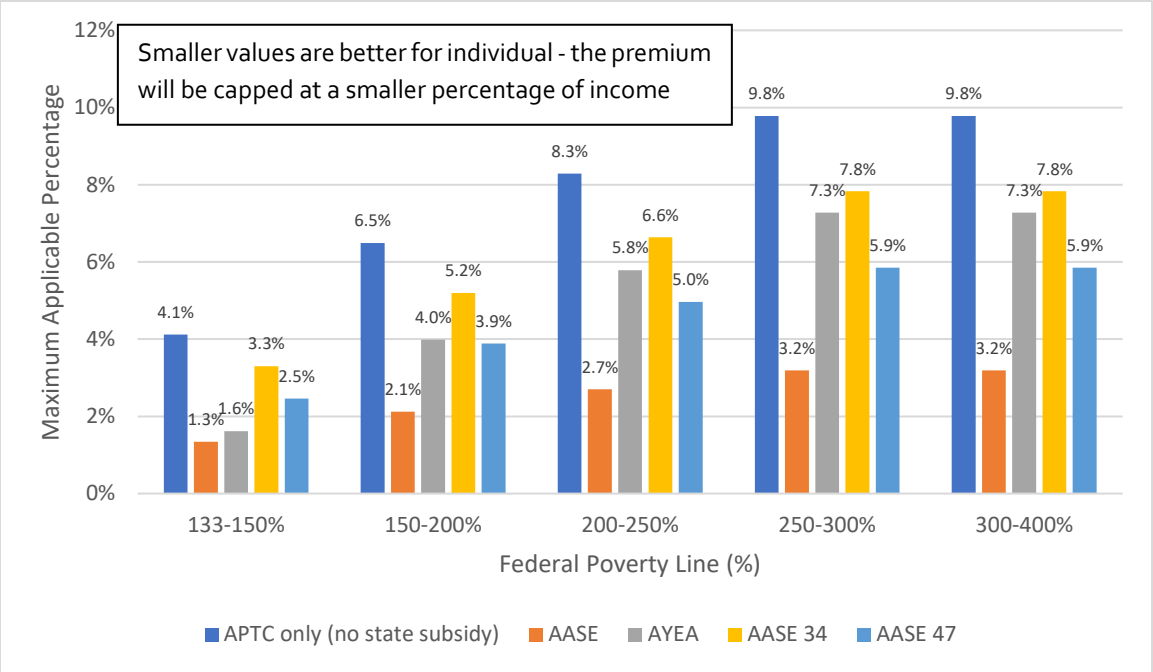
YOUNG ADULTS SUBSIDY COMPARISON

The AASE provides the highest levels of benefits versus the AYEA, AASE 34, and AASE 47 approaches by capping the percentage of income spent on premiums at a lower percentage of income. Therefore, the AASE would require the greatest amount of state funding.

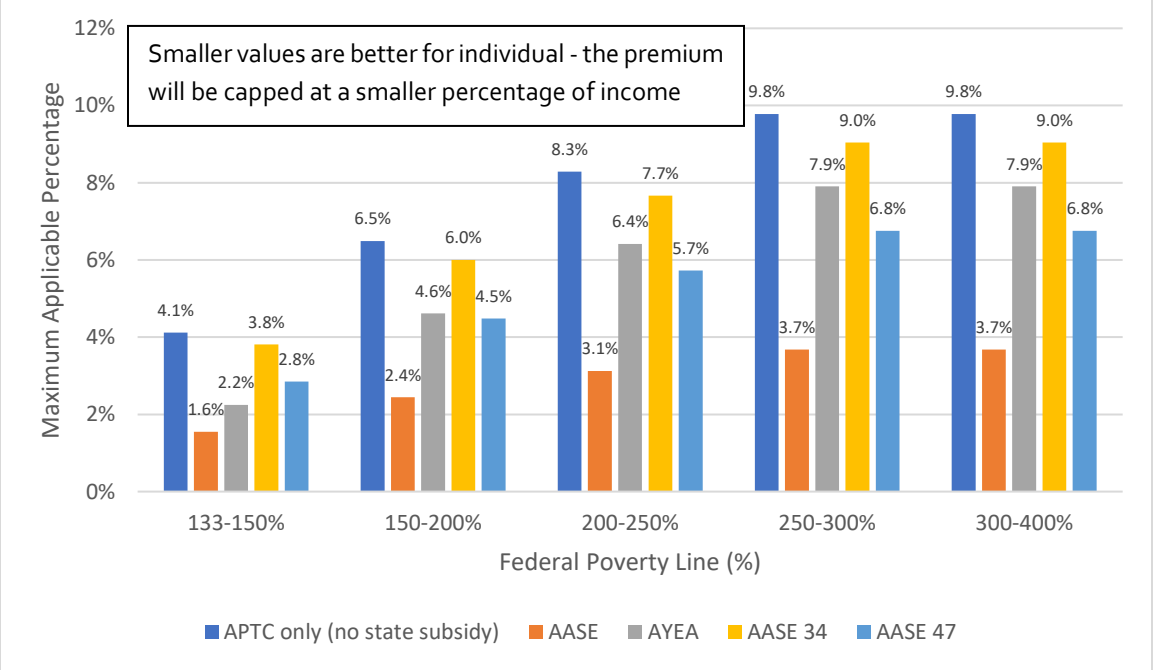
Graph 2 compares the changes to the applicable percentage for all four Young Adult Subsidies for adults aged 18-25 at various income levels. Graphs 3, 4, and 5 show the same comparison for adults 26-34, 35-44, and 45-47, respectively.

The order of the methods by the greatest benefit richness, and correspondingly the largest required funding is: AASE, AASE 47, AYEA, and AASE 34. The three "AASE" subsidies can be compared mathematically – AASE uses a denominator of 3, AASE 47 uses 1.635, and AASE 34 uses 1.222. The smaller the denominator, the greater income cap percentage, which leads to the individual paying a greater share of premiums.

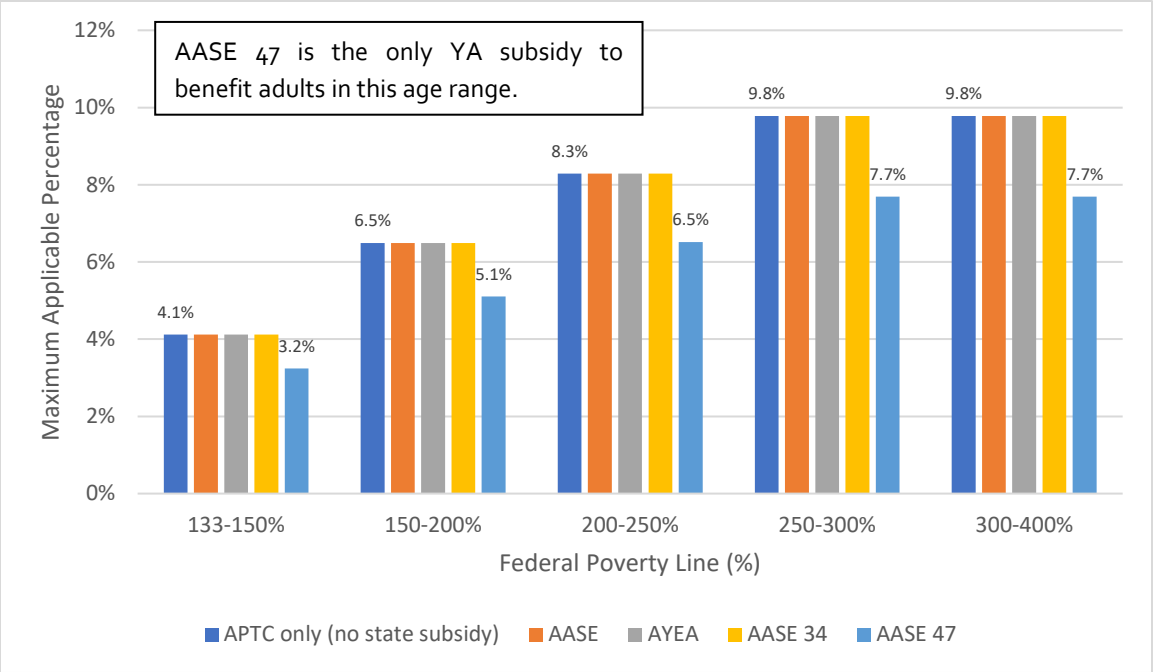
Graph 2: Comparison of Young Adult Caps on Premium as % of Income for Ages 18-25



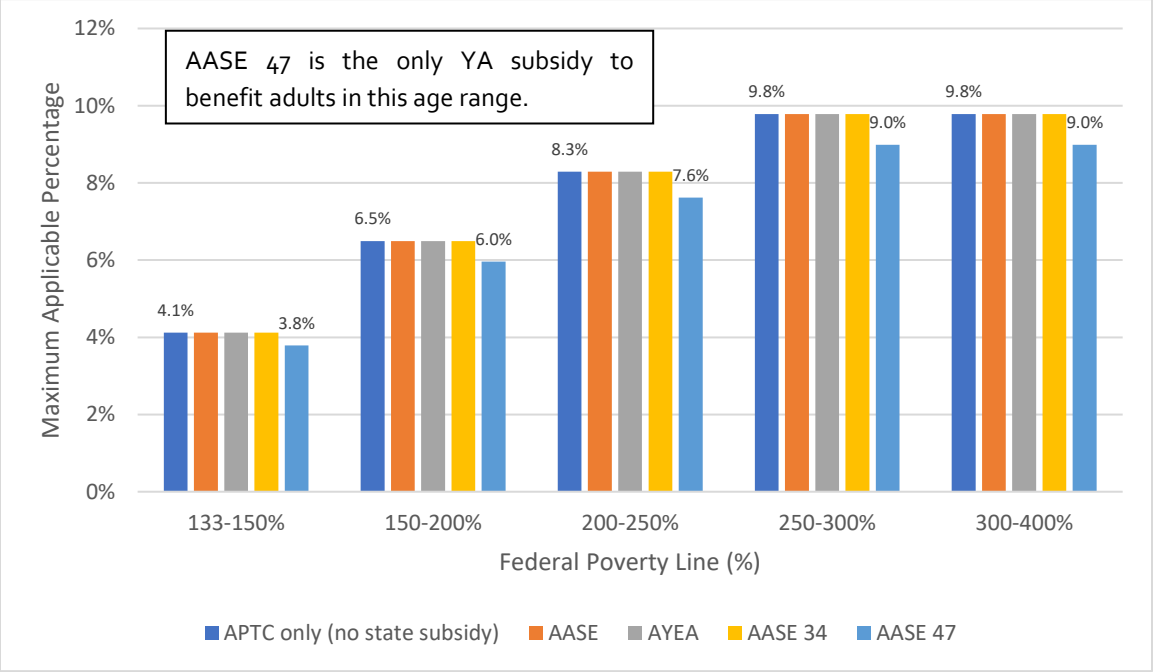
Graph 3: Comparison of Young Adult Caps on Premium as % of Income for Ages 26-34



Graph 4: Comparison of Young Adult Caps on Premium as % of Income for Ages 35-44



Graph 5: Comparison of Young Adult Caps on Premium as % of Income for Ages 45-47



400%+ FPL SUBSIDY EXTENSION BACKGROUND

The second group of subsidy strategies[7] would support individuals with incomes greater than 400% of the FPL, an area commonly known as the "subsidy cliff." The ACA provides premium assistance to individuals with incomes less than 400% of FPL. Once an individual's income rises above 400% FPL, the individual is no longer eligible for premium assistance. In other words, these individuals are required to pay the full premium charged by carriers with no federal support to obtain health insurance coverage.

The 400%+ FPL Subsidy Extension ("FFSE") would allow individuals and households with incomes between 400% and 600% FPL to obtain premium subsidies funded by the State. FFSE would extend the maximum applicable percentage to 600% FPL. In other words, the maximum applicable percentage for an individual at 400% FPL is applied to all individuals between 400% and 600% of the FPL under FFSE. The maximum applicable percentages reviewed are: 9.78%, 12.5% and 15%.

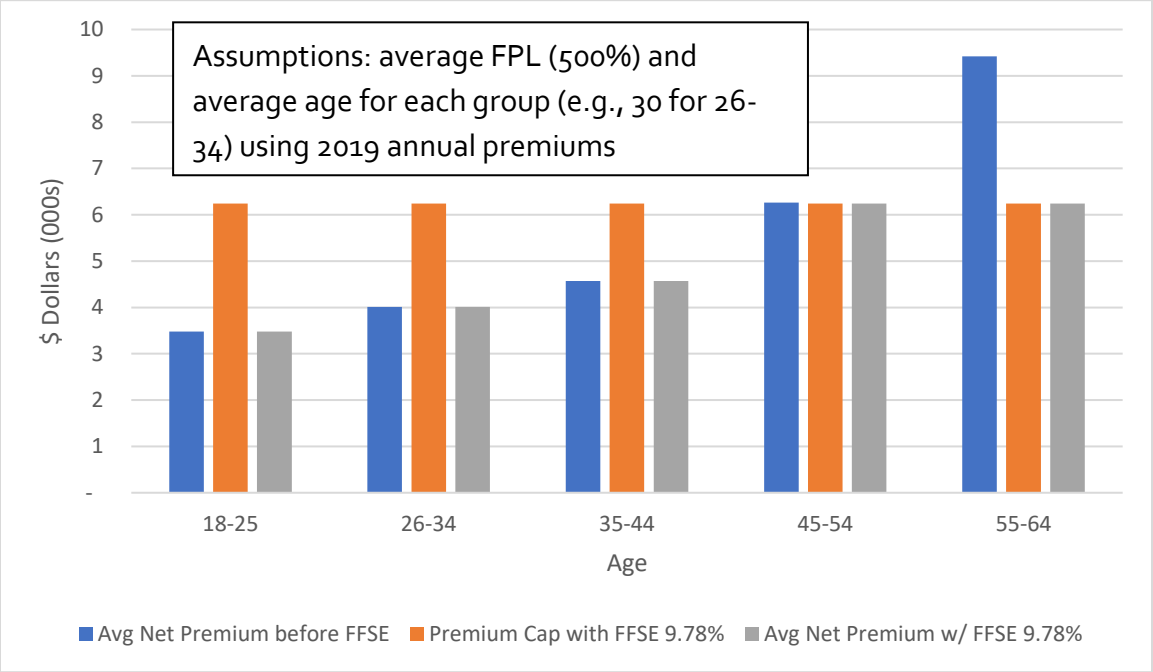
Table 11 (in the Supporting Tables section) shows the applicable percentage changes for FFSE.

Graph 6 demonstrates that the implementation of FFSE would be expected to impact Individual older adults more positively than Individual Younger Adults[8]. This result is due to Individual Younger Adults (e.g., 18-34) having premiums that are below the premium cap (i.e., maximum premium paid as a percentage of income) based on the subsidy and would not be materially impacted by the FPL extension. Younger Adults enrolled with a spouse, child, or in a family plan may benefit from the FFSE, but based on the subsidy structure and the premium levels, older adults in multi-person plans will receive a higher benefit. As the maximum applicable percentage increases from 9.78% to 15%, fewer adults are helped by the FFSE.

[7] This is the second subsidy strategy reviewed. To clarify, Young Adult subsidy is the first approach with four versions (AASE, AYEA, AASE 34, etc.), while the 400+ FPL Subsidy is the second approach.

[8] This statement focuses on the impact of FFSE on members who enroll as individuals. Younger Adults (e.g., 18-34) would only receive FFSE when they are in a plan with their spouse and/or family, due to the way FPL and premium caps are calculated based on the number of people in a household. Thus, the statement is not suggesting Younger Adults would never qualify for FFSE, but rather Younger Adults in individual plans would not receive the FFSE subsidy.

Graph 6: Illustrative Comparison of 400%+ FPL Subsidy Extension (FFSE) Impact by Age for Individuals[9] between 400-600% FPL using 2019 Annual Net Premiums



[9] This graph illustrates the impact of FFSE on members who enroll as individuals. Younger Adults (e.g., 18-34) would only receive FFSE when they are in a plan with their spouse and/or family, due to the way FPL and premium caps are calculated based on the number of people in a household. Thus, the graph is not suggesting Younger Adults would never qualify for FFSE, but rather Younger Adults in individual plans would not receive the FFSE subsidy.

SCENARIOS FOR MODELING

To model the impact of the two subsidy strategies: 1) Young Adults and 2) 400%+ FPL, L&E has modeled seven different scenarios. These seven scenarios would be integrated with the State Reinsurance Program which began in August 2019. That is, L&E's subsidy modeling assumes that the SRP is active in all years, until reinsurance funding is exhausted.

The seven scenarios are:

1. Reinsurance + Young Adult Subsidy 1 (Age Adjustment Subsidy Enhancement)
2. Reinsurance + Young Adult Subsidy 2 (Advancing Youth Enrollment Act)
3. Reinsurance + Young Adult Subsidy 3 (Age Adjustment Subsidy Enhancement Cliffless to 34)
4. Reinsurance + Young Adult Subsidy 4 (Age Adjustment Subsidy Enhancement Cliffless to 47)
5. Reinsurance + 400%+ FPL Subsidy Extension at 9.78% Cap
6. Reinsurance + 400%+ FPL Subsidy Extension at 12.5% Cap
7. Reinsurance + 400%+ FPL Subsidy Extension at 15% Cap

Since the Young Adult and FFSE subsidies target different segments of the population, L&E did not model the interaction of the subsidies together. An approximation that can be used is to sum two of the scenarios together, one Young Adult and one FFSE subsidy, to estimate the total impact.

MODELING METHODOLOGY

The steps in projecting the impact of the Young Adults and 400%+ FPL Extension Subsidies for the 2021 individual market are as follows:

1) **Setting a baseline for 2019 and 2020 enrollment** – To understand the full impact of the subsidies, L&E collected and used data from the MHBE, participating insurers, and CMS regarding enrollment levels, the uninsured population, and individual market morbidity levels by age and income.

2) **Understanding the impact of subsidies on net premiums** – To help stabilize the individual market, the two proposed subsidies target specific ages and income levels. The discussion previously highlights how net premiums for Young Adults between ages 18 and 34[10] and individuals between 400%-600% of FPL will be reduced based on the proposed subsidy structures.

3) **Estimating the uptake in enrollment** – Once the impact on net premium (step 2) was understood, L&E modeled the increase in enrollment due to the presence of the subsidies. The uptake assumption was based on a regression analysis[11] of eligible market insured rates compared to the net premium as a percentage of income[12], as well as the change in net premium from a scenario when the subsidies did not exist.

   Additionally, enrollment changes were phased in over a three-year period like the 2014-2016 enrollment experience of the individual market (i.e., when the subsidies are announced, it is assumed that not everyone will know or sign up for coverage immediately).

4) **Understanding the impact on reinsurance payments** – Once the increased enrollment and the expected morbidity were modeled, the claims from these additional enrollees were input in the previous State Reinsurance Program model to calculate the impact to the SRP.

5) **Calculating the subsidies needed and premium tax credit changes** – After projecting claims and calculating premiums, the cost of the subsidies was estimated. Changes to the premium tax credits paid by the federal government resulting from increases in enrollment and reduced morbidity were also modeled.

[10] As previously noted, one of the "Young Adults" subsidies extends State support up to age 47.
[11] The regression analysis was performed separately for each of the five age groups: 18-25, 26-34, 35-44, 45-54, and 55-64.
[12] The February 19, 2020 report compared the eligible market insured rates to the maximum percentage of income that individuals are required to spend before APTCs/subsidies are paid. The MHBE provided more granular enrollment data for this report, facilitating the switch to net income, which is a more accurate measure of the purchasing decisions that the uninsured will face with the implementation of the new subsidies.

6) **Comparing results of each scenario to prior projections and to other scenarios** – To inform the MHBE and state legislators of the subsidies' impact, the results of each scenario are summarized.

RESULTS

L&E projects the Young Adult Subsidies will increase enrollment by approximately 500 to 15,900 individuals, which varies by scenario as seen in Table 1. Note, these numbers are reported in the aggregate, as the projected enrollment is phased in from 2022 to 2024. The best-estimate figures (enrollment, subsidy levels, etc.) in this report are calculated assuming that the uninured levels in Maryland will return to pre-COVID-19 levels by 2022[13].

Of the four Young Adults Subsidies, the AASE reduces premiums for Young Adults the most, followed by AASE 47, AYEA, and AASE 34. AYEA does not reduce premiums for higher income Young Adults (e.g., >200% FPL) and older Young Adults (closer to 34) as much as AASE and AASE 47.

The 400%+ FPL Extension Subsidy is expected to increase enrollment by up to 8,900 individuals by 2024, depending on the income cap used for individuals with incomes between 400% and 600% FPL. The impact of FFSE is smaller than the Young Adult subsidies. FFSE caps the amount of premiums that individuals between 400%-600% FPL pay. Older adults (e.g., >45) are more likely to have premium rates that exceed the cap. Therefore, these older adults would be helped by the FFSE more than younger adults since premium that exceeds the cap would be paid through the subsidy.

Table 1: Comparison of 3-Year Enrollment Impact by Scenario

Scenario	AASE	AYEA	AASE 34	AASE 47[14]	FFSE 9.78%	FFSE 12.5%	FFSE 15%
2022-2024 Increase in Enrollment	15,900	5,400	500	9,300	8,900	3,900	2,300

Table 2 summarizes the impact each subsidy has on its targeted population.

AASE and AASE 47 provide a higher subsidy for Young Adults greater than 200% of the FPL than AYEA and AASE 34, which makes AASE and AASE 47 more effective in enrolling Young Adults than AYEA or AASE 34.

To further look at the ineffectiveness of AASE 34, Graphs 2-3 presented earlier in this report illustrate that the AASE 34 does not substantially change the net premium for young adults. The AASE 34 maximum applicable percentage (yellow bar) in each graph is not significantly lower than the scenario without a state subsidy. Additionally, Table 2 below in the "2024 Subsidy

[13]The uninsured population assumption is based on the latest uninsured estimates from Families USA from 2018. Please see the Sustained Uninsured section in the Results section of the report for the impact if the uninsured rate does not improve by 2022.

[14] Includes adults 35-47, which is not included in the first three Young Adult subsidies.

PCPY" column also shows a much smaller subsidy for AASE 34 when compared to the other Young Adults subsidies.

As mentioned before, FFSE provides subsidies for older adults. Due to the structure of the subsidy, Young Adults at 400-600% of FPL will not be as likely to receive a subsidy[15].

Table 2: Comparison of Subsidy Impact by Age and Income for Young Adult and 400%+ Subsidies

Scenario	Age	FPL Range	2021 % enrolled of eligible[16]	2024[17] % enrolled of eligible	2024 Gross Premium PCPY[18]	2024 Net Premium PCPY	2024 Subsidy PCPY
Reinsurance Only	18-34	133-200%	56%	56%	$4,809	$1,231	$0
	18-34	200-300%	43%	43%	$4,968	$2,904	$0
	18-34	300-400%	22%	22%	$6,084	$5,138	$0
	18-34	**133-400%**	**43%**	**43%**	**$5,003**	**$2,283**	**$0**
AASE	18-34	133-200%	56%	66%	$4,597	$444	$791
	18-34	200-300%	43%	59%	$4,796	$1,075	$1,906
	18-34	300-400%	22%	52%	$5,824	$2,026	$3,002
	18-34	**133-400%**	**43%**	**60%**	**$4,887**	**$963**	**$1,607**
AYEA	18-34	133-200%	56%	63%	$4,720	$710	$518
	18-34	200-300%	43%	47%	$4,907	$2,167	$757
	18-34	300-400%	22%	29%	$6,577	$4,630	$822
	18-34	**133-400%**	**43%**	**49%**	**$4,992**	**$1,691**	**$642**
AASE 34	18-34	133-200%	56%	56%	$4,781	$1,084	$144
	18-34	200-300%	43%	43%	$4,937	$2,570	$327
	18-34	300-400%	22%	24%	$6,214	$4,817	$409
	18-34	**133-400%**	**43%**	**43%**	**$4,995**	**$2,056**	**$243**
AASE 47	18-47[19]	133-200%	56%	59%	$5,126	$871	$369
	18-47	200-300%	42%	49%	$5,301	$2,110	$891
	18-47	300-400%	25%	35%	$7,154	$4,179	$1,463
	18-47	**133-400%**	**43%**	**50%**	**$5,438**	**$1,758**	**$706**
400%+: FFSE 9.78%	18-34	400-600%	49%	49%	$4,384	$4,364	$20
	35-44	400-600%	61%	64%	$6,001	$5,669	$332
	45-54	400-600%	50%	60%	$9,126	$7,386	$1,740
	55-64	400-600%	57%	80%	$11,218	$7,281	$3,936
	18-64	**400-600%**	**53%**	**60%**	**$7,383**	**$5,926**	**$1,457**
400%+: FFSE 12.5%	18-34	400-600%	49%	49%	$4,430	$4,430	$0
	35-44	400-600%	61%	61%	$5,925	$5,925	$0
	45-54	400-600%	50%	56%	$9,054	$8,183	$870
	55-64	400-600%	57%	67%	$11,932	$9,496	$2,436
	18-64	**400-600%**	**53%**	**56%**	**$7,307**	**$6,575**	**$732**
400%+: FFSE 15%	18-34	400-600%	49%	49%	$4,448	$4,448	$0
	35-44	400-600%	61%	61%	$5,949	$5,949	$0
	45-54	400-600%	50%	52%	$8,755	$8,450	$305
	55-64	400-600%	57%	64%	$11,980	$10,482	$1,498
	18-64	**400-600%**	**53%**	**55%**	**$7,227**	**$6,827**	**$400**

[15] This is a generalization for Young Adults in Individual (1-person) plans.
[16] Eligible individuals exclude anyone with insurance provided by their employer.
[17] All 2024 figures are modeled with subsidy included, unless otherwise noted.
[18] PCPY = per contract holder per year (some contracts may be individual, 2 persons, or family)
[19] Using 18-44 figures as an approximation for 18-47 figures. For modeling purposes, age bands are 18-25, 26-34, 35-44 and 45-54. The subsidies for adults aged 45-47 under the AASE47 are low and the impact on enrollment is immaterial.

Another perspective to consider is the efficiency of the subsidy to attract new enrollees. This report looks at efficiency in two ways.

First, the number of new enrollees that each subsidy introduces into the Individual Market relative to the number of individuals who will receive the subsidy. Table 3 shows the percentage of enrollees who receive the subsidy that will be new enrollees.

Table 3: Comparison of Percentage of Subsidy Recipients who will be New Enrollee

Subsidy	% of subsidy recipients who will be a new enrollee by 2024
AASE	34% of individuals, ages 18-34 at 133-400% FPL
AYEA	15% of individuals, ages 18-34 at 133-400% FPL
AASE 34	2% of individuals, ages 18-34 at 133-400% FPL
AASE 47	16% of individuals, ages 18-47 at 133-400% FPL
FFSE 9.78%	15% of individuals, ages 18-64 between 400-600% FPL
FFSE 12.5%	7% of individuals, ages 18-64 between 400-600% FPL
FFSE 15%	4% of individuals, ages 18-64 between 400-600% FPL

The second method of assessing efficiency is the cost of the subsidy per new enrollee, which is shown in Table 4.

Table 4: Comparison of Subsidy Cost per New Enrollee

	2022			2023			2024		
	Cost	New Members[20]	Cost per New Member	Cost	New Members	Cost per New Member	Cost	New Members	Cost per New Member
AASE	$43,336,496	9,535	$4,545	$49,634,014	14,302	$3,470	$52,790,201	15,891	$3,322
AYEA	$16,124,993	3,250	$4,962	$17,234,720	4,875	$3,536	$17,963,187	5,416	$3,316
AASE 34	$5,603,824	296	$18,942	$5,802,269	444	$13,075	$5,943,339	493	$12,054
AASE 47	$26,727,083	5,572	$4,797	$28,992,306	8,358	$3,469	$30,379,636	9,287	$3,271
FFSE 9.78%	$52,430,263	5,333	$9,832	$61,256,115	7,999	$7,658	$68,511,685	8,888	$7,708
FFSE 12.5%	$22,279,648	2,337	$9,531	$27,589,157	3,506	$7,869	$32,403,843	3,896	$8,318
FFSE 15%	$12,350,820	1,388	$8,897	$14,980,882	2,082	$7,194	$17,258,101	2,314	$7,459

The subsidies will not significantly alter the reinsurance program, as the total change in enrollment is at most 15,900 individuals by 2024 for one subsidy (and, 24,800 with two subsidies[21]), which is approximately 10%[22] of the individual market.

[20] This column shows the cumulative new members each year that were not enrolled prior to the state subsidies being introduced in 2022.

[21] This is an approximation by summing the modeling of two scenarios (the greatest enrollment YA subsidy scenario with the greatest enrollment FFSE).

[22] 2021 projected enrollment is approximately 225,000.

Premium Rate Reduction Estimates

The Young Adult subsidies are anticipated to reduce rates by up to 3.5%[23] compared to the current market with a projected state cost up to $43 million. The FFSE subsidies are anticipated to reduce rates by up to 0.7% with a projected state cost up to $52 million.

L&E modeled revisions of two methods to estimate the funding required to reduce rates by 1.0% and 5.0%. Revisions to two Young Adult subsidies were modified since the Young Adult subsidies are generally more efficient than FFSE in enrolling new members. The Young Adult subsidies modified were the AYEA (modified from a 1.2% premium reduction to a 1.0% reduction) and the AASE (modified from a 3.5% premium reduction to a 5.0% rate reduction).

For AYEA, the subsidy was modified by removing the subsidy for Young Adults from 30-34, such that the premium reduction reached the target 1.0%. For AASE, the subsidy was modified by increasing the denominator of 3 used in calculating the YA subsidy to approximately 7[24], so the premium reduction reached the target 5.0%.

Table 4b below shows the updated 2022 cost and enrollment under the modified scenarios. For the AASE, 2022 costs are expected to increase from $43M to $62M, while the AYEA costs are expected to decrease from $16M to $13M.

Table 4b: Comparison of Subsidy Cost per New Enrollee

Scenario	2022 – Best Estimate					2022 – Modified Target		
	Cost	New Members	Cost per New Member	Projected Premium Reduction	Target Premium Reduction	Cost	New Members	Cost per New Member
AASE	$43,336,496	9,535	$4,545	3.5%	5.0%	$61,931,243	12,272	$5,047
AYEA	$16,124,993	3,250	$4,962	1.2%	1.0%	$12,667,143	2,030	$6,240

State Funding

The State will need $6 to $43 million in 2022 to pay for the Young Adults subsidies, and/or $12 to $52 million to pay for the 400%-600% FPL subsidy. Through discussions with MHBE and MIA, the funding for the subsidies may come through excess state funds available under the State Reinsurance Program.

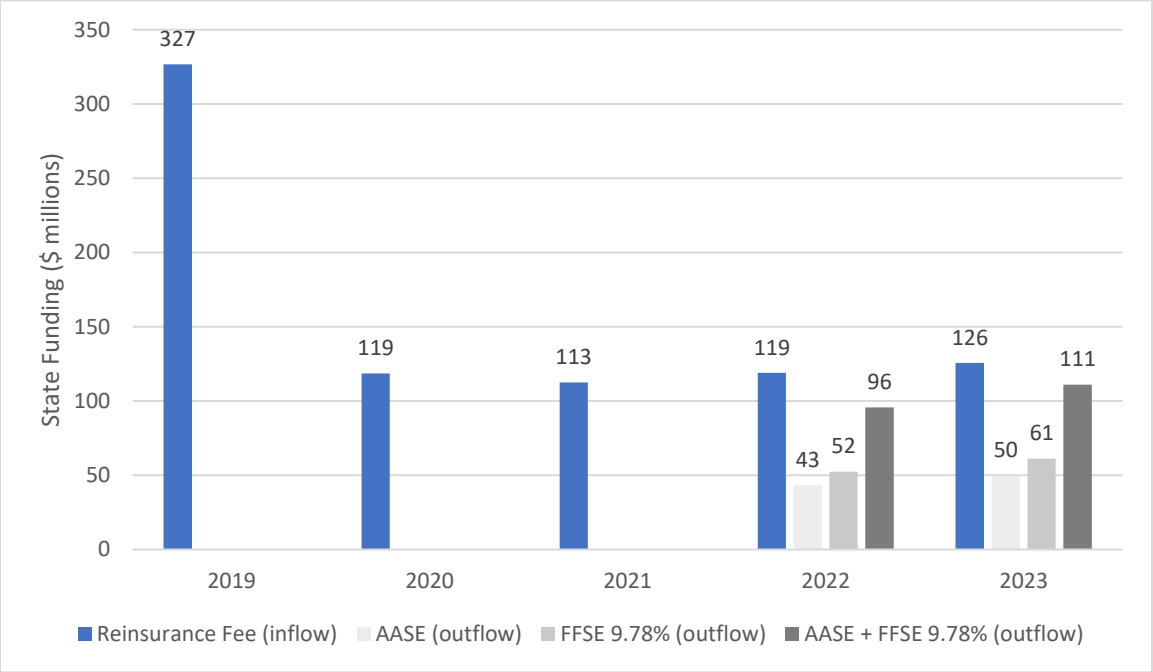
Graph 7 shows the potential state funding available through the reinsurance fee assessment and the state funding required to support the most expensive Young Adult and FFSE subsidies. The

[23] See the change in "Total Non-Group Premium PMPM" in Table 6 from the "Reinsurance" scenario.
[24] The standard AASE's subsidy is double the net premium for an individual which is shown in Table 2. Therefore, significant changes to this method are required to achieve the target of 5.0% premium reduction, since after APTC, the standard subsidy is already paying for 2/3rds of the premium.

state has received a reinsurance fee assessment[25] from insurance carriers to be used for the State Reinsurance Program; however, federal pass through funding through a 1332 Waiver has been able to cover all of the reinsured claims since the program began. In other words, no state reinsurance funding has been used for the reinsurance program.

The projected state funding required for three scenarios are shown in Graph 7: AASE, FFSE 9.78%, and a combined AASE + FFSE 9.78%. Since the subsidies will not begin until 2022 and the reinsurance program has continued to rely exclusively on federal pass through savings, there is significant state funding available[26] to pay for market stabilization measures, such as the Young Adult and/or FFSE subsidies. In the first two years of the subsidy program, the state's reinsurance fee[27] collected for the specific year is expected to exceed the cost of the subsidy program (e.g., $119 million inflow in 2022 from the reinsurance fee versus $96 million cost outflow expected for the AASE + FFSE 9.78%).

Graph 7: State Funding Inflow and Outflows through 2023



The reinsurance program is expected to run out of funding a year earlier in 2024 if one or two subsidies are utilized. A standalone reinsurance program without any state subsidy is expected to exhaust state funding in 2025. L&E's modelling assumes that any excess federal pass through funding at the end of the current 1332 Waiver in 2023 cannot be rolled forward to pay for

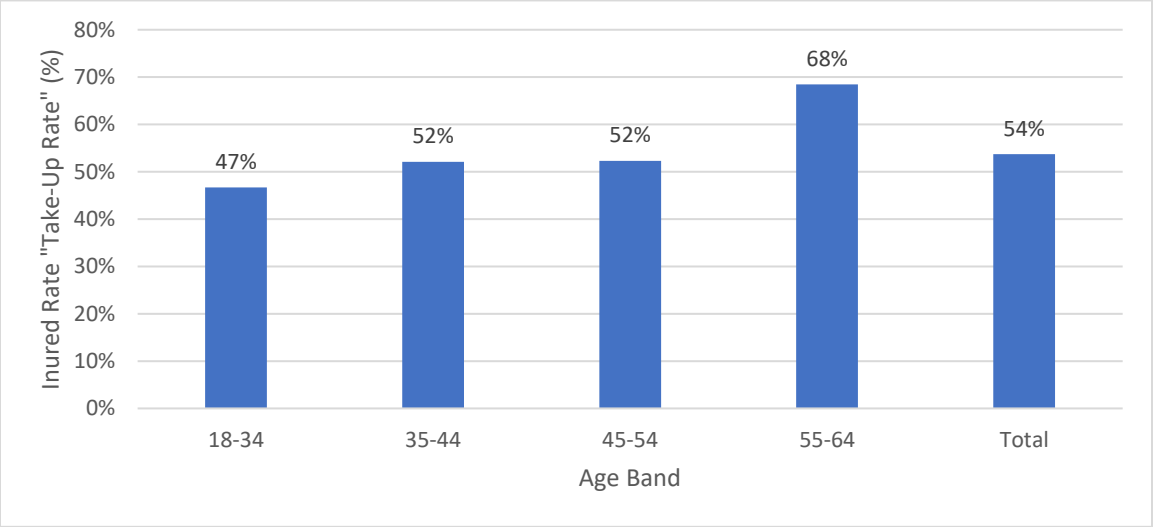
[25] State reinsurance fee (inflows) estimates are provided by the MIA.
[26] The reinsurance fee has not been used because the federal pass through savings has covered the cost of the SRP. This report assumes that excess federal pass through savings from the SRP cannot be used to fund the subsidies.
[27] The reinsurance fee is set to expire at the end of 2023. Discussions with the MHBE and MIA have indicated that the fee may be renewed after 2023, though the analysis throughout this report has assumed that the fee will expire at the end of 2023.

reinsured claims in 2024 and beyond, which will require the State to utilize state reinsurance funding for both the reinsurance and subsidy programs.

Final Considerations

Young Adults pay a greater share of their contribution to claims[28] through the premiums paid with the 3:1 age curve required by the Affordable Care Act. While the State Reinsurance Program has helped to reduce overall premiums in the market for all enrollees, Young Adults are insured at rates that still are below that of middle age and older adults. The Young Adult subsidies supplementing the SRP will reduce the cost of insurance for Young Adults further, helping the overall morbidity level in the market, and thus, reducing premiums for all enrollees. Graph 8 shows the projected 2021 insured rates by age band.

Graph 8: Projected 2021 Insured Rates ("Take-up Rates") by Age Band



The FFSE subsidies focus on making insurance more affordable for individuals at 400%-600% of the FPL. As seen in Tables 3 and 4, FFSE subsidies are not as effective in enrolling new members compared to YA subsidies, because individuals between 400-600% are currently enrolled at higher rates than Young Adults. Table 5 below illustrates the impact of the "subsidy cliff", showing the net premiums for different contract sizes (e.g., Individual, 2 Person, etc.) at 300-400% of the FPL and 400-600% of the FPL. There is a significant jump in net premiums for older adults and adults who enroll with family members, as these individuals better qualify for APTCs (i.e., these individuals tend to have premiums that exceed the maximum premium paid as a percentage of income).

[28] Studies indicate that the relativity of claims between a young adult (age 21) and an older adult (age 64) is greater than 1:3, which is the premium relativity under the ACA. For example: https://theactuarymagazine.org/the-old-and-the-beautiful/

Table 5: Illustrative Comparison of Net Premiums under Current Reinsurance Program (No Subsidy), Highlighting the Net Premium (NP) Change at the "Subsidy Cliff"

Contract Type	FPL Range	Age Band				
		18-25	26-34	35-44	45-54	55-64
Individual	300-400%	$3,060	$3,540	$4,030	$4,440	$4,440
	400-600%	$3,060	$3,540	$4,030	$5,520	$8,300
	NP Change[29]	*0%*	*0%*	*0%*	*24%*	*87%*
2 Person	300-400%	$6,000	$6,000	$6,000	$6,000	$6,000
	400-600%	$6,130	$7,070	$8,050	$11,040	$16,600
	NP Change	*2%*	*18%*	*34%*	*84%*	*177%*
Family	300-400%	$8,530	$8,530	$8,530	$8,530	$8,530
	400-600%	$11,340	$13,090	$14,900	$20,420	$30,700
	NP Change	*33%*	*53%*	*75%*	*139%*	*260%*

Table 6 on the following page summarizes the 2022 results of the modeling.

[29] Calculated as the incremental increase for a contract holder moving from 300-400% of the FPL to 400-600%, assuming the same age and contract type.

Table 6: Summary of Impact by Scenario for 2022

Field	Baseline	Reinsurance (RI)	RI + AASE	RI + AYEA	RI + AASE 34	RI + AASE 47	RI + FFSE 9.78%	RI + FFSE 12.5%	RI + FFSE 15%
Total Non-Group Enrollment	184,054	226,017	233,444	228,548	226,248	230,357	230,175	227,840	227,100
APTC Enrollment	134,346	134,346	141,773	136,878	134,577	138,686	134,346	134,346	134,346
APTC + YA Subsidy Enrollment	0	0	45,077	39,948	36,233	91,119	0	0	0
400+ Extension Enrollment	0	0	0	0	0	0	24,818	16,697	8,459
Total Non-Group Premium PMPM	$803	$447	$431	$442	$447	$438	$444	$446	$446
APTC (Gross/ Net) Premium PMPM	$883/$124	$480/$123	$458/$101	$472/$114	$479/$120	$467/$109	$473/$123	$477/$123	$478/$123
APTC + YA Subsidy (Gross/Net) Premium PMPM	-	-	$284/$48	$289/$84	$291/$96	$356/$95	-	-	-
400+ Extension (Gross/Net) Premium PMPM	-	-	-	-	-	-	$572/$396	$645/$534	$608/$486
Total Premiums	$1,772,967,310	$1,212,602,090	$1,208,094,775	$1,210,855,520	$1,212,386,325	$1,210,372,611	$1,226,244,643	$1,218,807,627	$1,216,773,196
Total APTCs[30]	$1,223,703,065	$575,034,083	$564,614,100	$572,643,316	$574,601,391	$569,674,172	$564,883,656	$570,539,312	$572,355,981
Total YA Subsidy	-	-	$43,336,496	$16,124,993	$5,603,824	$26,727,083	$0	$0	$0
Total 400-600 Subsidy	-	-	$0	$0	$0	$0	$52,430,263	$22,279,648	$12,350,820
Reinsurance Funding	-	$447,975,589	$448,108,062	$448,020,740	$448,077,886	$448,053,003	$448,330,383	$448,131,103	$448,067,947
RI Reduction in Premiums	-	-28.5%	-28.6%	-28.6%	-28.6%	-28.6%	-28.6%	-28.6%	-28.6%
RI Assessment	-	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%
Reduction in Premiums (Improved Morbidity)	-	-22.8%	-25.5%	-23.8%	-22.9%	-24.4%	-23.3%	-23.0%	-22.9%
Estimated APTC Savings[31]	-	$648,668,982	$659,088,965	$651,059,749	$649,101,674	$654,028,893	$658,819,408	$653,163,753	$651,347,084
Estimated Net Federal Savings	-	$622,915,321	$632,921,607	$625,211,169	$623,330,835	$628,062,431	$632,662,753	$627,231,640	$625,487,096
Estimated Pass Through (RI-only)	-	139%	141%	140%	139%	140%	141%	140%	140%
Total State Funds (RI- only)	-	$118,896,671	$118,896,671	$118,896,671	$118,896,671	$118,896,671	$118,896,671	$118,896,671	$118,896,671

[30] In the reinsurance modeling performed previously, enrollment by age and income was not provided in the data. A simplified methodology of calculating APTCs was used looking at historical ratios of gross and net premiums to APTCs. In this modeling, enrollment by age and income was provided and used. Correspondingly, APTCs were estimated through using the gross premiums, age curves and subsidy structures.

[31] Based on the changes to APTC calculations (in the previous footnote), the APTC savings were updated.

Comparison to Prior Reports

Table 1c compares the current enrollment projections to those in the February 19, 2020 report – note, several of the subsidies were not analyzed in the prior report ("N/A" in the table below).

Table 1c: Comparison of 3-Year Enrollment Impact by Scenario

Scenario	AASE	AYEA	AASE 34	AASE 47[32]	FFSE 9.78%	FFSE 12.5%	FFSE 15%
Current 2022-2024 Increase in Enrollment	15,900	5,400	500	9,300	8,900	3,900	2,300
Prior 2021-2023 Increase in Enrollment	15,000	7,400	N/A	N/A	2,800	N/A	N/A

There are several reasons driving changes to the above enrollment projections:

1. **Underlying data changes** – MHBE provided more granular enrollment data, especially enrollment by contract size (i.e., the number of enrolled members by contract holder), which impacts premium, APTC, and subsidy calculations. Previously, L&E made assumptions based on carrier filings to estimate the number of enrollees in age and income groupings by single, 2-person, and family tiers. The contract holder breakdown across all age and income groupings were assumed to be the same. With the updated data, this assumption is no longer needed.

   Second, the uninsured population was updated based on more current data. A previous data set provided by Families USA showed 195,500 uninsured adults in Maryland. An updated data set used in this analysis showed 156,400 uninsured adults. There were sizeable changes in the age and income breakdown of the uninsured. For example, the estimated number of uninsured adults above 400%+ FPL increased from 42,300 to 58,100 and the uninsured adults from ages 19-34 dropped from 94,000 to 67,200.

2. **Subsidy uptake methodology refinement** – Through reviewing the past analysis, L&E refined the methodology used to project the number of uninsured that would take up coverage due to a Young Adult or an FFSE subsidy. Previously, a single regression across young and middle-aged adults was used based on comparing the enrollment rate to the maximum percentage of income that individuals are required to spend before the subsidies was used. In this updated report, L&E modified the approach to include a set of regressions, one for each age band (e.g. 18-25, 26-34, etc.) that compared the enrollment rate to the net premium as a percentage of income. L&E believes this methodology is more in-line with

[32] Includes adults 35-47, which is not included in the first three Young Adult subsidies.

actual human behavior in two ways: a) consumers make a decision off the net premium they will pay, not based on an income cap; and b) consumer behavior varies across ages. The updated regressions showed that younger adults (e.g., 18-25) were more price sensitive than older adults (e.g., 55-64). In other words, decreasing net premiums for younger adults leads to a larger increase in the enrollment of younger adults than a similar decrease in net premiums for older adults.

Sustained Uninsured Rates

The best estimate modelling used in this report assumes Maryland's uninsured rate returns to pre-COVID-19 levels starting in 2022, the first year the subsidies would be available. Note, there are publicly available reports that have differing perspectives on COVID-19's impact on the uninsured rates. One report (Families USA) has estimated up to 75,000[33] adults have become uninsured in Maryland, while another (Commonwealth Fund) suggests that the uninsured rate is not significantly different[34] as a result of COVID-19.

The following analysis assumes that COVID-19 will have a significant impact on Maryland's uninsured rates, that is, similar to the Families USA report. This analysis provides the MHBE and MIA a "worst-case uninsured" perspective. The MHBE and MIA may want to revisit this analysis as additional uninsured data becomes available.

If the impact of COVID-19 continues to linger into 2022 and beyond, the subsidy enrollment and costs are expected to be higher (i.e., more uninsured, more people available to take up coverage).

In the best estimate scenario, there are approximately 156,400[35] uninsured adults under age 65 that could take up coverage in the Individual market. Families USA estimated approximately 75,000[36] adults under the age of 65 would lose healthcare coverage due to the pandemic. Of these, approximately 18,000[37] have taken up coverage during Special Enrollment Period for COVID-19 and Easy Enrollment. Additionally, approximately 23% and 28%[38] of the 75,000 are unlawfully present and estimated to be eligible for Medicaid, respectively, and thus assumed to be excluded from potential enrollment in the Individual market. After these adjustments, there is approximately 19,000 more uninsured adults that could take up coverage in the Individual market under a sustained uninsured scenario than in the best estimate scenario.

[33] Based on 2020 analysis from Families USA: https://familiesusa.org/wp-content/uploads/2020/07/COV-254_Coverage-Loss_Report_7-17-20.pdf
[34] Based on a 2020 survey conducted by Commonwealth Fund: https://www.commonwealthfund.org/publications/issue-briefs/2020/aug/looming-crisis-health-coverage-2020-biennial
[35] Based on 2018 data from Families USA; assuming that uninsured levels return to pre-COVID-19 levels
[36] Based on 2020 analysis from Families USA: https://familiesusa.org/wp-content/uploads/2020/07/COV-254_Coverage-Loss_Report_7-17-20.pdf
[37] Based on 2020 data from MHBE
[38] Based on 2018 data from Families USA from the 2020 analysis: https://familiesusa.org/wp-content/uploads/2020/07/COV-254_Coverage-Loss_Report_7-17-20.pdf

Table 1d shows the estimated increase in enrollment under each subsidy approach by 2024 for the best-estimate (as discussed previously) and a "Sustained Uninsured". Table 4d compares the cost of enrolling new members for 2022 between the best-estimate and sustained uninsured scenarios. The proposed subsidies will have a greater impact on enrollment under the sustained uninsured rate scenario, and therefore the cost for the subsidies will be higher.

Table 1d: Comparison of 3-Year Enrollment Impact by Scenario

Scenario	AASE	AYEA	AASE 34	AASE 47[39]	FFSE 9.78%	FFSE 12.5%	FFSE 15%
2022-2024 Increase in Enrollment (Best-Estimate)	15,900	5,400	500	9,300	8,900	3,900	2,300
2022-2024 Increase in Enrollment (Sustained Uninsured)	19,100	7,600	800	12,600	10,000	4,400	2,600

Table 4d: Comparison of Subsidy Cost per New Enrollee

Scenario	2022 – Best Estimate			2022 – Sustained Uninsured		
	Cost	New Members	Cost per New Member	Cost	New Members	Cost per New Member
AASE	$43,336,496	9,535	$4,545	$45,187,431	11,464	$3,942
AYEA	$16,124,993	3,250	$4,962	$16,628,225	4,577	$3,633
AASE 34	$5,603,824	296	$18,942	$5,660,784	459	$12,333
AASE 47	$26,727,083	5,572	$4,797	$27,586,521	7,563	$3,648
FFSE 9.78%	$52,430,263	5,333	$9,832	$53,326,400	5,993	$8,898
FFSE 12.5%	$22,279,648	2,337	$9,531	$22,673,114	2,627	$8,631
FFSE 15%	$12,350,820	1,388	$8,897	$12,563,929	1,560	$8,054

[39] Includes adults 35-47, which is not included in the first three Young Adult subsidies.

SUPPORT TABLES

Table 7: Age Adjustment Subsidy Enhancement, Applicable Percentage

AASE	Applicable Ages	Federal Poverty Line (FPL)		% of Income (Applicable Percentage)	
		Minimum	Maximum	Minimum	Maximum
Pre-subsidy; Post-subsidy for all non-Young Adults	All	0%	133%	2.06%	2.06%
	All	133%	150%	3.09%	4.12%
	All	150%	200%	4.12%	6.49%
	All	200%	250%	6.49%	8.29%
	All	250%	300%	8.29%	9.78%
	All	300%	400%	9.78%	9.78%
Post-subsidy for all Young-Adults	18-25	0%	133%	0.67%	0.67%
	18-25	133%	150%	1.01%	1.34%
	18-25	150%	200%	1.34%	2.12%
	18-25	200%	250%	2.12%	2.70%
	18-25	250%	300%	2.70%	3.19%
	18-25	300%	400%	3.19%	3.19%
	26-34	0%	133%	0.78%	0.78%
	26-34	133%	150%	1.16%	1.55%
	26-34	150%	200%	1.55%	2.44%
	26-34	200%	250%	2.44%	3.12%
	26-34	250%	300%	3.12%	3.68%
	26-34	300%	400%	3.68%	3.68%

Table 8: Advancing Youth Enrollment Act, Applicable Percentage

AYEA	Applicable Ages	Federal Poverty Line (FPL)		% of Income (Applicable Percentage)	
		Minimum	Maximum	Minimum	Maximum
Pre-subsidy; Post-subsidy for all non-Young Adults	All	0%	133%	2.06%	2.06%
	All	133%	150%	3.09%	4.12%
	All	150%	200%	4.12%	6.49%
	All	200%	250%	6.49%	8.29%
	All	250%	300%	8.29%	9.78%
	All	300%	400%	9.78%	9.78%
Post-subsidy for all Young-Adults	18-25	0%	133%	0.00%	0.00%
	18-25	133%	150%	0.59%	1.62%
	18-25	150%	200%	1.62%	3.99%
	18-25	200%	250%	3.99%	5.79%
	18-25	250%	300%	5.79%	7.28%
	18-25	300%	400%	7.28%	7.28%
	26-34	0%	133%	0.41%	0.41%
	26-34	133%	150%	1.22%	2.25%
	26-34	150%	200%	2.25%	4.62%
	26-34	200%	250%	4.62%	6.42%
	26-34	250%	300%	6.42%	7.91%
	26-34	300%	400%	7.91%	7.91%

Table 9: Age Adjustment Subsidy Enhancement Cliffless to 34, Applicable Percentage

AASE 34	Applicable Ages	Federal Poverty Line (FPL)		% of Income (Applicable Percentage)	
		Minimum	Maximum	Minimum	Maximum
Pre-subsidy; Post-subsidy for all non-Young Adults	All	0%	133%	2.06%	2.06%
	All	133%	150%	3.09%	4.12%
	All	150%	200%	4.12%	6.49%
	All	200%	250%	6.49%	8.29%
	All	250%	300%	8.29%	9.78%
	All	300%	400%	9.78%	9.78%
Post-subsidy for all Young-Adults	18-25	0%	133%	1.65%	1.65%
	18-25	133%	150%	2.47%	3.30%
	18-25	150%	200%	3.30%	5.20%
	18-25	200%	250%	5.20%	6.64%
	18-25	250%	300%	6.64%	7.83%
	18-25	300%	400%	7.83%	7.83%
	26-34	0%	133%	1.90%	1.90%
	26-34	133%	150%	2.86%	3.81%
	26-34	150%	200%	3.81%	6.00%
	26-34	200%	250%	6.00%	7.66%
	26-34	250%	300%	7.66%	9.04%
	26-34	300%	400%	9.04%	9.04%

Table 10: Age Adjustment Subsidy Enhancement Cliffless to 47, Applicable Percentage

AASE 47	Applicable Ages	Federal Poverty Line (FPL)		% of Income (Applicable Percentage)	
		Minimum	Maximum	Minimum	Maximum
Pre-subsidy; Post-subsidy for all non-Young Adults	All	0%	133%	2.06%	2.06%
	All	133%	150%	3.09%	4.12%
	All	150%	200%	4.12%	6.49%
	All	200%	250%	6.49%	8.29%
	All	250%	300%	8.29%	9.78%
	All	300%	400%	9.78%	9.78%
Post-subsidy for all Young-Adults	18-25	0%	133%	1.23%	1.23%
	18-25	133%	150%	1.85%	2.47%
	18-25	150%	200%	2.47%	3.88%
	18-25	200%	250%	3.88%	4.96%
	18-25	250%	300%	4.96%	5.85%
	18-25	300%	400%	5.85%	5.85%
	26-34	0%	133%	1.42%	1.42%
	26-34	133%	150%	2.13%	2.85%
	26-34	150%	200%	2.85%	4.48%
	26-34	200%	250%	4.48%	5.73%
	26-34	250%	300%	5.73%	6.76%
	26-34	300%	400%	6.76%	6.76%
	35-44	0%	133%	1.62%	1.62%
	35-44	133%	150%	2.43%	3.24%
	35-44	150%	200%	3.24%	5.10%
	35-44	200%	250%	5.10%	6.52%
	35-44	250%	300%	6.52%	7.69%
	35-44	300%	400%	7.69%	7.69%
	45-47	0%	133%	1.89%	1.89%
	45-47	133%	150%	2.84%	3.79%
	45-47	150%	200%	3.79%	5.96%
	45-47	200%	250%	5.96%	7.62%
	45-47	250%	300%	7.62%	8.99%
	45-47	300%	400%	8.99%	8.99%

Table 11: 400%+ FPL Subsidy Extension, Applicable Percentage

Scenario	Applicable Ages	Federal Poverty Line (FPL)		% of Income (Applicable Percentage)	
		Minimum	Maximum	Minimum	Maximum
Pre-subsidy for 400-600% FPL	All	400%	600%	n/a	n/a
Post-subsidy for 400-600% FPL 9.78%	All	400%	600%	9.78%	9.78%
Post-subsidy for 400-600% FPL 12.5%	All	400%	600%	12.50%	12.50%
Post-subsidy for 400-600% FPL 15%	All	400%	600%	15.00%	15.00%

APPENDICES

APPENDIX A: 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 not unexpected 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 and provided by the MHBE for significant portions of this analysis. To the extent that the data is inaccurate, the analysis will be impacted.
- Enrollment Uncertainty.
  - Beyond changes to premiums and market wide programs, consumer responses to these has inherent uncertainty. Therefore, actual enrollment could vary significantly.
- Political and Health Policy Uncertainty.
  - Future federal or state actions could dramatically change premiums and enrollment in 2021 and later years.
- Risk Adjustment Transfers.
  - Given historical enrollment changes in the Maryland market, estimates of risk adjustment transfers by cost category is highly uncertain.
- COVID-19 Pandemic
  - Claims data used in modeling is through May 2020 and likely does not reflect the full impact of the COVID-19 global pandemic.

This report has been prepared for the MHBE for discussion purposes in relation to the Young Adult and 400%+ Extension subsidies analysis. 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 B: DISCLOSURES

The Actuarial Standards Board (ASB), vested by the U.S.-based actuarial organizations[40], 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[41], 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 below.

IDENTIFICATION OF THE RESPONSIBLE ACTUARIES

The responsible actuaries are:

- Josh Hammerquist, FSA, MAAA, Vice President & Principal
- Michael Lin, FSA, MAAA, Vice President & 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 November 19, 2020. The date (a.k.a. "latest information date") through which data or other information has been considered in performing this analysis is September 21, 2020.

DISCLOSURES IN ACTUARIAL REPORTS

- The contents of this report are intended for the use of the Maryland Health Benefit Exchange. Any third party with access to this report acknowledges, as a condition of receipt, that they cannot bring suit, claim, or action against L&E, under any theory of law, related in any way to this material.
- Lewis & Ellis Inc. is 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 MHBE with an analysis of proposed subsidy programs.
- The responsible actuaries identified above are qualified as specified in the Qualification Standards of the American Academy of Actuaries.

[40] 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.
[41] These organizations adopted identical Codes of Professional Conduct effective January 1, 2001.

- Lewis & Ellis has reviewed the data provided for reasonableness but has not audited it. L&E nor the responsible actuary assumes responsibility for items that may have a 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.
- Besides the COVID-19 pandemic, 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 C: PRESENTATION TO THE INDIVIDUAL SUBSIDY WORK GROUP

LEWIS & ELLIS

1

Analysis of Young Adult and Federal Poverty Level Extension Subsidies

MARYLAND HEALTH BENEFIT EXCHANGE
OCTOBER 2020

Josh Hammerquist, FSA, MAAA
Michael Lin, FSA, MAAA
Dave Dillon, FSA, MAAA, MS

L&E

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Contents

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A Executive Summary

- Since 2019, Lewis & Ellis ("L&E") has supported the Maryland Health Benefit Exchange ("MHBE") to:
  - Review and analyze the 1332 Waiver / State Reinsurance Program, and
  - Evaluate the potential impact of subsidies on the individual and small group markets.
- In our most recent report, L&E has been asked to update the subsidy analysis for the individual market.
  - Funding available from the existing State Reinsurance Program ("SRP") Section 1332 waiver.
  - Federal pass through funding has been sufficient to cover all claims under the SRP.
- Through discussions with the MHBE and the Maryland Insurance Administration ("MIA"), the report has been revised to analyze two different subsidy strategies – Young Adults Subsidies and 400-600% FPL Subsidies.
- The purpose of this presentation is to inform the MHBE Individual Subsidy Workgroup of the proposed subsidies' impact on the individual market.

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B Subsidy Background

There are two subsidy strategies: Young Adult Subsidies and 400-600% FPL Subsidies

Young Adult Subsidies

Purpose: Make premiums more affordable for young adults (i.e., subsidizing) because this population subsidizes older adults and historically not purchased health insurance at the same rate as older adults.

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

Applicable Age Groups: 18-34 (last approach is 18-47)

Applicable Income Groups: 133% to 400% of FPL

400-600% FPL Subsidies

Purpose: Targets individuals whose incomes are in the "subsidy cliff"
- Under the Affordable Care Act (ACA), individuals with incomes greater than 400% of FPL are not eligible for premium tax credits.
- These subsidies extend the maximum applicable percentage to 600% FPL.

Proposed Approaches: 3
1. 400%+ FPL Subsidy Extension 9.78%[1] (FFSE 9.78%)
2. 400%+ FPL Subsidy Extension 12.5% (FFSE 12.5%)
3. 400%+ FPL Subsidy Extension 15% (FFSE 15%)

Applicable Age Groups: all

Applicable Income Groups: 400% to 600% of FPL

1 Without the FFSE, individuals between 400-600% of the FPL do not receive any support on premiums. With an FFSE, the maximum applicable percentage for an individual at 400% FPL is applied to all individuals between 400% and 600% of the FPL under FFSE. The maximum applicable percentages analyzed are: 9.78%, 12.5% and 15%.

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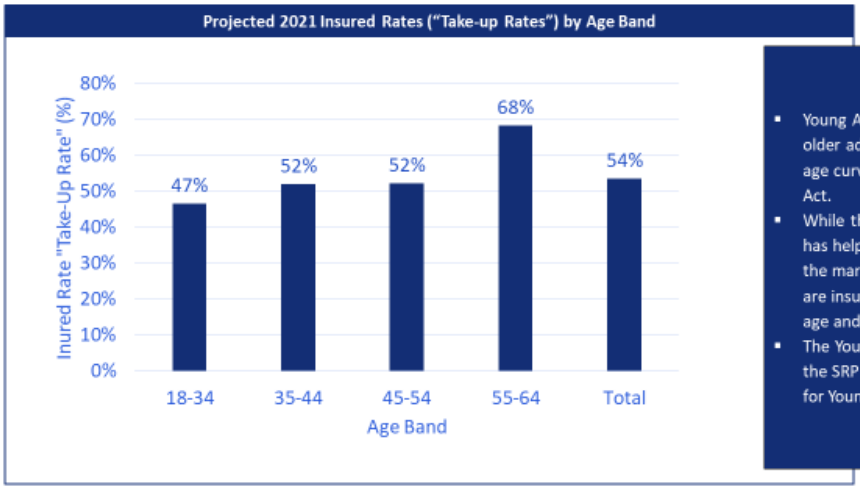
B Young Adult Subsidies



- Young Adults subsidize the premiums of older adults because of the 3:1 premium age curve required by the Affordable Care Act.
- While the State Reinsurance Program (SRP) has helped to reduce overall premiums in the market for all enrollees, Young Adults are insured at rates that are below middle age and older adults.
- The Young Adult subsidies supplementing the SRP will reduce the cost of insurance for Young Adults further.

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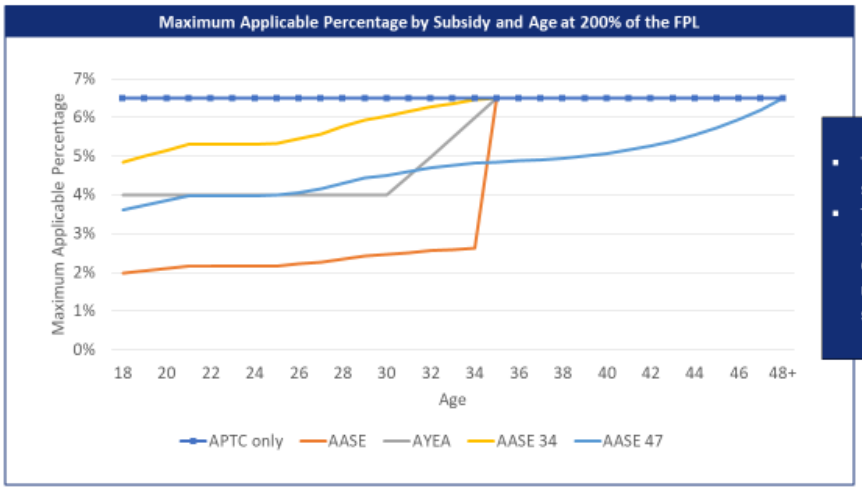
B Young Adult Subsidies



- This graph illustrates the impact of each subsidy by age.
- The graph focuses on an individual at 200% of the FPL – these lines will vary at other income levels, but generally the relativities between them remain the same.

B 400-600% FPL Subsidies

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

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

- The table shows the impact of the "subsidy cliff" at various age bands and contract sizes, comparing a contract holder's net premium, if he/she were at 300-400% of FPL vs 400-600% of FPL.
- An older individual or an individual enrolling with other family members feel the impact of the subsidy cliff more than a younger, individual adult.
- FFSEs goal is to reduce the net premium change for those right about the 400% FPL cut off to qualify for APTCs.

C Modeling Methodology

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

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D Results (Overall)

Comparison of 3-Year Enrollment, Insured Rates, Premiums and Subsidies by Scenario

Scenario	Age	FPL Range	2021 % enrolled of eligible[1]	2024 % enrolled of eligible[1]	2021 enrolled	2022-2024 Increase in Enrollment – Subsidy	2024 enrolled[2]	2024 Gross Premium PCPY	2024 Net Premium PCPY	2024 Subsidy PCPY
Reinsurance	18-34	133-400%	43%	43%	30,800	0	31,300	$5,003	$2,283	$0
AASE	18-34	133-400%	43%	60%	30,800	15,900	43,700	$4,887	$963	$1,607
AYEA	18-34	133-400%	43%	49%	30,800	5,400	35,500	$4,992	$1,691	$642
AASE 34	18-34	133-400%	43%	43%	30,800	500	31,600	$4,995	$2,056	$243
AASE 47	18-47	133-400%	43%	50%	48,400	9,300	56,300	$5,438	$1,758	$706
FFSE 9.78%	18-64	400-600%	53%	60%	52,400	8,900	60,100	$7,383	$5,926	$1,457
FFSE 12.5%	18-64	400-600%	53%	56%	52,400	3,900	56,200	$7,307	$6,575	$732
FFSE 15%	18-64	400-600%	53%	55%	52,400	2,300	55,000	$7,227	$6,827	$400

- Of the four Young Adults Subsidies, the AASE increases enrollment for Young Adults the most, followed by AASE 47, AYEA, and AASE 34.
- The FFSE is expected to increase enrollment by up to 8,900 individuals by 2024, depending on the income cap used for individuals with incomes between 400% and 600% FPL.
  - FFSE caps the amount of premiums that individuals between 400%-600% FPL pay. Older adults (e.g., >45) are more likely to have premium rates that exceed the cap and thus more likely to receive this subsidy.

1 This indicates the portion of people enrolled in the market as a percentage of the total market (including uninsured).
2 This is the projected 2024 enrollment. Note, this figure is not exactly equal to "2021 enrolled" + "2022-2024 Increase in Enrollment – Subsidy". There are two drivers: 1) increase in membership due to other reasons (e.g., population growth and reinsurance program) and 2) the "2022-2024 Increase in Enrollment – Subsidy" is total new unique members, whereas the "2024 enrolled" is average members.

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D Results (Efficiency of New Enrollees)

Efficiency of Subsidies on New Enrollees

Subsidy	% of subsidy recipients who will be a new enrollee by 2024
AASE	34% of individuals, ages 18-34 at 133-400% FPL
AYEA	15% of individuals, ages 18-34 at 133-400% FPL
AASE 34	2% of individuals, ages 18-34 at 133-400% FPL
AASE 47	16% of individuals, ages 18-47 at 133-400% FPL
FFSE 9.78%	15% of individuals, ages 18-64 between 400-600% FPL
FFSE 12.5%	7% of individuals, ages 18-64 between 400-600% FPL
FFSE 15%	4% of individuals, ages 18-64 between 400-600% FPL

	2022		
Subsidy	Cost	New Members	Cost per New Member
AASE	$43,336,496	9,535	$4,545
AYEA	$16,124,993	3,250	$4,962
AASE 34	$5,603,824	296	$18,942
AASE 47	$26,727,083	5,572	$4,797
FFSE 9.78%	$52,430,263	5,333	$9,832
FFSE 12.5%	$22,279,648	2,337	$9,531
FFSE 15%	$12,350,820	1,388	$8,897

We looked at efficiency in two ways:

1. First, the number of new enrollees that each subsidy introduces into the Individual Market relative to the number of individuals who will receive the subsidy
2. Second, the cost of the subsidy per new enrollee

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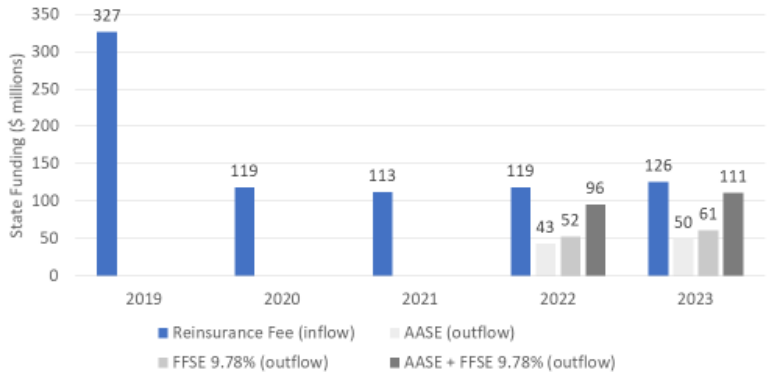
D Results (State Funding)

State Funding Inflow and Possible Outflows through 2023



- The state reinsurance funding has not been used for the reinsurance program, so there is significant state funding available to pay for market stabilization measures, such as the Young Adult and/or FFSE subsidies
- It is projected that the first two years of the subsidy program can be covered by the state's reinsurance fee alone
  - We have graphed three scenarios: most expensive Young Adult subsidy, most expensive FFSE, and the two combined.

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D Results (2022 Full Summary)

Field	Baseline	Reinsurance (RI)	RI + AASE	RI + AYEA	RI + AASE 34	RI + AASE 47	RI + FFSE 9.78%	RI + FFSE 12.5%	RI + FFSE 15%
Total Non-Group Enrollment	184,054	226,017	233,444	228,548	226,248	230,357	230,175	227,840	227,100
APTC Enrollment	134,346	134,346	141,773	136,878	134,577	138,686	134,346	134,346	134,346
APTC + YA Subsidy Enrollment	0	0	45,077	39,948	36,233	91,119	0	0	0
400+ Extension Enrollment	0	0	0	0	0	0	24,818	16,697	8,459
Total Non-Group Premium PMPM	$803	$447	$431	$442	$447	$438	$444	$446	$446
APTC (Gross/ Net) Premium PMPM	$883/$124	$480/$123	$458/$101	$472/$114	$479/$120	$467/$109	$473/$123	$477/$123	$478/$123
APTC + YA Subsidy (Gross/Net) Premium PMPM	-	-	$284/$48	$289/$84	$291/$96	$356/$95	-	-	-
400+ Extension (Gross/Net) Premium PMPM	-	-	-	-	-	-	$572/$396	$645/$534	$608/$486
Total Premiums	$1,772,967,310	$1,212,602,090	$1,208,094,775	$1,210,855,520	$1,212,386,325	$1,210,372,611	$1,226,244,643	$1,218,807,627	$1,216,773,196
Total APTCs	$1,223,703,065	$575,034,083	$564,614,100	$572,643,316	$574,601,391	$569,674,172	$564,883,656	$570,539,312	$572,355,981
Total YA Subsidy	-	-	$43,336,496	$16,124,993	$5,603,824	$26,727,083	$0	$0	$0
Total 400-600 Subsidy	-	-	$0	$0	$0	$0	$52,430,263	$22,279,648	$12,350,820
Reinsurance Funding	-	$447,975,589	$448,108,062	$448,020,740	$448,077,886	$448,053,003	$448,330,383	$448,131,103	$448,067,947
RI Reduction in Premiums	-	-28.5%	-28.6%	-28.6%	-28.6%	-28.6%	-28.6%	-28.6%	-28.6%
RI Assessment	-	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%
Reduction in Premiums (Improved Morbidity)	-	-22.8%	-25.5%	-23.8%	-22.9%	-24.4%	-23.3%	-23.0%	-22.9%
Estimated APTC Savings	-	$648,668,982	$659,088,965	$651,059,749	$649,101,674	$654,028,893	$658,819,408	$653,163,753	$651,347,084
Estimated Net Federal Savings	-	$622,915,321	$632,921,607	$625,211,169	$623,330,835	$628,062,431	$632,662,753	$627,231,640	$625,487,096
Estimated Pass Through (RI-only)	-	139%	141%	140%	139%	140%	141%	140%	140%
Total State Funds (RI- only)	-	$118,896,671	$118,896,671	$118,896,671	$118,896,671	$118,896,671	$118,896,671	$118,896,671	$118,896,671

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D Results (Sustained Uninsured)

Comparison of 3-Year Enrollment, Insured Rates, Premiums and Subsidies by Scenario

Scenario	AASE	AYEA	AASE 34	AASE 47	FFSE 9.78%	FFSE 12.5%	FFSE 15%
2022-2024 Increase in Enrollment (Best-Estimate)	15,900	5,400	500	9,300	8,900	3,900	2,300
2022-2024 Increase in Enrollment (Sustained Uninsured)	19,100	7,600	800	12,600	10,000	4,400	2,600

Scenario	2022 – Best Estimate			2022 – Sustained Uninsured		
	Cost	New Members	Cost per New Member	Cost	New Members	Cost per New Member
AASE	$43,336,496	9,535	$4,545	$45,187,431	11,464	$3,942
AYEA	$16,124,993	3,250	$4,962	$16,628,225	4,577	$3,633
AASE 34	$5,603,824	296	$18,942	$5,660,784	459	$12,333
AASE 47	$26,727,083	5,572	$4,797	$27,586,521	7,563	$3,648
FFSE 9.78%	$52,430,263	5,333	$9,832	$53,326,400	5,993	$8,898
FFSE 12.5%	$22,279,648	2,337	$9,531	$22,673,114	2,627	$8,631
FFSE 15%	$12,350,820	1,388	$8,897	$12,563,929	1,560	$8,054

- There are publicly available reports that have differing perspectives on COVID-19's impact on the uninsured rates; one suggests a significant increase while another suggests minimal change.
- Our best estimate analysis assumed that the uninsured rate would return to pre-COVID-19 levels by 2022.
- To provide MHBE with a "worst case" uninsured scenario, we modelled a scenario assuming COVID-19 has indeed significantly increased the uninsured rates and the impact will be sustained through 2022.

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E Questions

APPENDIX D: ANALYSIS OF ADDITIONAL YOUNG ADULT SUBSIDIES

The MHBE and MIA proposed four additional Young Adult subsidies after the initial presentation. These subsidies addressed two goals: a) provided the workgroup a variation of AASE with no cliff and b) modeled something midway between the AASE and AYEA

For providing the workgroup a variation of AASE with no cliff, the two subsidies modeled were:

1) AASE formula through age 30, then linear interpolation from 31 through 35.
2) AASE formula through age 35, then linear interpolation from 36 to 40.

For modeling something midway between the AASE and AYEA, the two subsidies modeled were:

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

The results of this modeling were presented in a PowerPoint comparing the additional subsidies to the original subsidies.

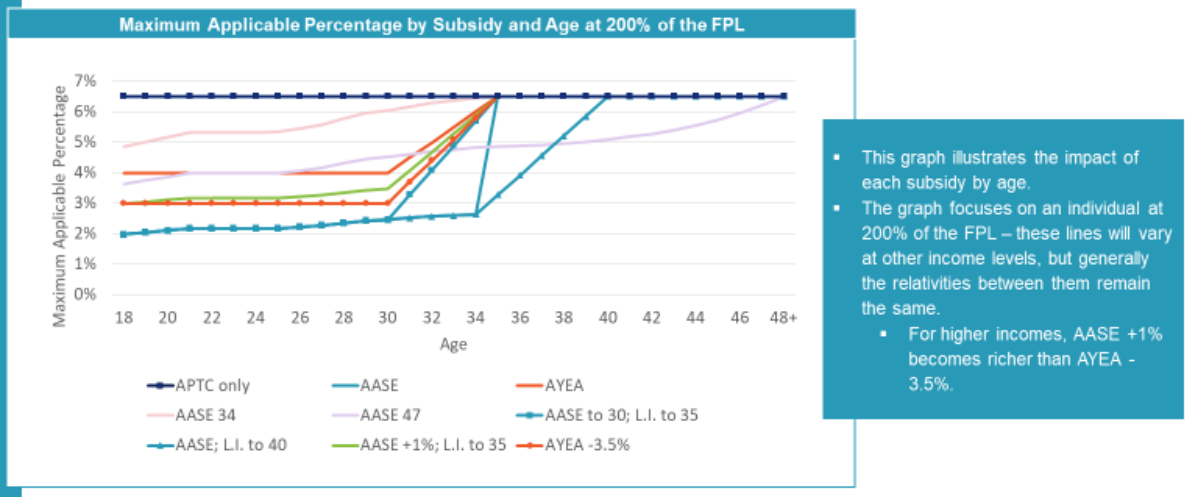
Overall Modeling Results & Discussion

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

MARYLAND HEALTHBENEFIT EXCHANGE

1

Young Adult Subsidy Structures



- This graph illustrates the impact of each subsidy by age.
- The graph focuses on an individual at 200% of the FPL – these lines will vary at other income levels, but generally the relativities between them remain the same.
  - For higher incomes, AASE +1% becomes richer than AYEA -3.5%.

MARYLAND HEALTHBENEFIT EXCHANGE

2

Appendix 3. Public Comments on Lewis & Ellis Report

KAISER PERMANENTE®

Mid-Atlantic Permanente Medical Group, P.C.
Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc
2101 East Jefferson Street
Rockville, Maryland 20852

October 30, 2020

Michele Eberle
Executive Director
Maryland Health Benefit Exchange
750 E. Pratt Street
Baltimore, MD 21202

Submitted electronically via: mhbe.publiccomments@maryland.gov

RE: Lewis & Ellis Analysis of Updated Young Adult and Federal Poverty Level Extension Subsidies

Dear Ms. Eberle:

Kaiser Permanente (KP) appreciates the opportunity to provide comments on the Lewis & Ellis Analysis of updated Young Adult and Federal Poverty Level Extension Subsidies submitted to the Maryland Health Benefit Exchange on September 21, 2020.

KP is the largest private integrated health care delivery system in the United States, delivering health care to over 12 million members in eight states and the District of Columbia. Kaiser Permanente of the Mid-Atlantic States, which operates in Maryland, provides and coordinates complete health care services for approximately 755,000 members. In Maryland, we deliver care to over 430,000 members.

Kaiser Permanente strongly supports state-funded subsidy enhancements, like those proposed in the Lewis and Ellis report, because they provide an immediate and direct benefit to consumers and can be targeted to those most in need. By contrast, funding through reinsurance programs flows indirectly through insurers, and its premium impact is spread across all consumers and all products. Subsidy enhancements are relatively simple for states to administer through existing tax methodologies and they can be implemented quickly because a Section 1332 waiver would likely not be required, particularly where the state expands the category of income-eligible subsidy recipients (e.g., from 400 to 600 percent of the Federal Poverty Level (FPL)).

In general, we support expanding the number of consumers eligible for income-based subsidies rather than increasing subsidy amounts for existing recipients and therefore support the strategy, analyzed by Lewis and Ellis, of focusing on all adults with incomes between 400 and 600 percent FPL. The current "subsidy cliff" is harmful to consumers and has a negative impact on small business owners and sole proprietors, who need affordability relief and assistance in maintaining comprehensive coverage. This approach also will not require federal approval, as it does not implicate existing federal subsidy structures.

Kaiser Permanente supports exploring the young adult subsidy approaches as well. We appreciate that young adults, ages 18 to 34, have not historically purchased health insurance at the same rate as adults and support policies that encourage this group to enter the market. We have no concerns with the analysis conducted by Lewis and Ellis and agree with the modeling showing the Age Adjustment Subsidy Enhancement may lead to the greatest increase in enrollment and have the greatest value.

As MHBE is aware, the reinsurance fee is set to expire in 2023. This presents a challenge either for the state subsidies that are the focus for this workgroup, or for the reinsurance program. However, it is no greater a challenge for state subsidies than for the MD reinsurance program and must be addressed to provide ongoing support for either program.

Thank you for the opportunity to comment. Please contact Allison Taylor at (202) 924-7496 or allison.w.taylor@kp.org or Bill Wehrle at (510) 268-4470 or Bill.S.Wehrle@kp.org with any questions.

Sincerely,

Bill Wehrle

Vice President, Health Insurance Exchanges
Kaiser Foundation Health Plan of Mid-Atlantic States, Inc.

HEALTH CARE for All
MARYLAND CITIZENS' HEALTH INITIATIVE
2600 ST. PAUL STREET BALTIMORE, MD 21218 P: (410)235-9000 F: (410)235-8963 WWW.HEALTHCAREFORALL.COM

November 2, 2020

Maryland Health Benefit Exchange
750 E Pratt St.
Baltimore, MD 21202

Dear MHBE,

Thank you for the opportunity to comment on the analysis completed by Lewis and Ellis Actuaries and Consultants to analyze the potential impact of subsidies on the individual market. As a health advocacy nonprofit organization, our mission is to advance policies toward quality, affordable health care for all Marylanders. Based on the analysis it is clear that a state individual subsidies program could make coverage more affordable and bring uninsured Marylanders into the individual market. Massachusetts already has a very successful state individual subsidy program which has helped them bring their uninsured rate down to 3%, while California and New Jersey are currently implementing their own individual state subsidy programs. Maryland should follow suit and create a state individual subsidy program.

We are open to examining various ways that such a program would be structured. Of the individual models considered in the analysis, we are particularly interested in further discussion of the Age Adjustment Subsidy Enhancement. Of all of the models it appears that this one would help the most uninsured people to enroll, and could also reduce overall premiums in the market by up to 3.8% by bringing more young and health people into the market. We are also interested in further discussion of the racial and ethnic equity implications of this model. There are higher percentages of uninsured Black and Latino Marylanders than white Marylanders aged 18-34, while at the same time the COVID-19 pandemic is hitting Black and Latino communities harder. In addition, though young adults may stay on their parents' employer sponsored insurance until they turn 26, during the pandemic Black unemployment rates are double white unemployment rates.

Thank you for the opportunity to submit this feedback on the analysis. I look forward to continuing to engage with staff and stakeholders as a member of the Individual Subsidy Workgroup.

Best regards,

Stephanie Klapper, MSW
Deputy Director, Maryland Citizens' Health Initiative Education Fund

Deborah Rivkin
Vice President
Government Affairs – Maryland

CareFirst BlueCross BlueShield
1501 S. Clinton Street, Suite 700
Baltimore, MD 21224-5744
Tel. 410-528-7054
Fax 410-528-7981

October 30, 2020

Johanna Fabian-Marks
Director, Policy and Plan Management
750 E. Pratt St.
Baltimore, MD 21202

Sent via email: mhbe.publiccomments@maryland.gov

Dear Ms. Fabian-Marks:

CareFirst BlueCross BlueShield (CareFirst) appreciates the opportunity to provide formal comments on the Lewis & Ellis (L&E) "Analysis of Updated Young Adult and Federal Poverty Level Extension Subsidies." CareFirst strongly supports Maryland's state-based reinsurance program as the driver of market stability and growing enrollment. CareFirst also supports additional efforts to stabilize Maryland's individual market and increase access to comprehensive, affordable healthcare.

Maryland's reinsurance program has been a significant success, stabilizing individual market rates to below 2018 levels, and growing enrollment each year the program has been in effect. The program is also extraordinarily cost effective for the state due the leveraging of significant federal funding to support the program. As the state considers a premium subsidy, it is critical to recognize that the reinsurance program is the key mechanism that provides stability to the individual market. A premium subsidy is not a replacement for the reinsurance program.

To the extent that there are additional state dollars available to support other market stabilization efforts, CareFirst also supports using these dollars for targeted subsidies in the individual market that would expand access and affordability. However, before commenting on the L&E analysis, we offer the following long-term questions for consideration on the state's reinsurance program as the MHBE reviews the analysis and recommendations:

- *Will the Federal government alter its funding methodology moving forward for Maryland?* Maryland is the only state currently operating a reinsurance program with Federal funding that exceeds the cost to the state. CMS may choose to alter its funding methodology specific to Maryland due to this issue. CareFirst expects the 2022 state-based reinsurance funding estimate, which will be provided by CMS in early 2021, to give initial insight into this question. It will be the first estimate CMS has provided with an understanding of the state commitments to the program. If CMS alters its funding methodology for Maryland, the existing state surplus may no longer exist or may be significantly reduced.

- *Will Maryland dedicate additional funds for a second state-based reinsurance waiver term?* Without a second waiver term for state-based reinsurance, individual rates will spike and the market will revert to its state in 2018. A second waiver term is necessary to ensure the long-term stability of the individual market. If additional state funds are not appropriated to a second waiver term, the existing state surplus funds will need to be used to fund a second term of the waiver for reinsurance.
- *Will there be any Federal changes to the Affordable Care Act (ACA)?* The potential for a new administration and Congress to modify the ACA could change the state's policy goals. Additionally, the United States Supreme Court will hear *California v. Texas* on November 10 and is expected to rule on the case in 2021. If portions of the ACA are ruled unconstitutional, Federal funding provided to Maryland under the ACA could be struck. The state surplus funds would be needed to support the reinsurance program.

With these questions and considerations in mind, we offer comments on the L&E analysis on options for state-based premium subsidies. L&E fundamentally reviewed two types of subsidies:

- *Young Adult Subsidies*: Currently, Marylanders who make below 400% of the Federal Poverty Level (FPL) receive Federal subsidies and pay the same premium regardless of their age. These subsidy designs would provide additional financial assistance to younger Marylanders who income is less than 400% FPL.
- *400%+ FPL Subsidies*: Currently, Marylanders whose income is more than 400% FPL do not receive a Federal subsidy. These subsidy designs would extend financial assistance to those who make between 400%-600% FPL.

If Maryland chooses to pursue a premium subsidy, CareFirst would support a design that targets young adults age 18-34 whose income is below 300% of the FPL[1] for several reasons:

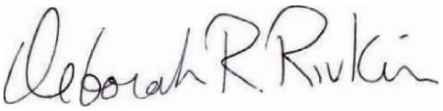
- *Young Adult Subsidies are More Efficient*: The L&E report estimates that young adult subsidies cost approximately half of the 400%+ FPL subsidies per new member enrolled, making them substantially more efficient.
- *Young Adult Subsidies Reduce Rates*: These subsidies will enroll more young, healthy individuals, which will reduce individual market rates more than the 400%+ FPL subsidies according to L&E. These rate reductions will increase affordability for all enrollees.
- *Young Adults 300-400% FPL Are Better Targeted By Reinsurance:* Individuals age 18-34 who make between 300-400% FPL do not receive Federal subsidies, so are directly impacted by the reinsurance program. Due to the significant leveraging of significant Federal funds, reinsurance is highly efficient. While L&E did not model variants focused exclusively on the <300% population, CareFirst believes financial assistance would be better focused on those who cannot be directly targeted by reinsurance.

In terms of timeline, CareFirst believes that a subsidy program would require 1.5 years to appropriately test and implement, so could not be operationalized before the 2023 benefit year.

[1] This most closely correlates with the Advancing Youth Enrollment Act (AYEA) subsidy outlined by L&E.

In conclusion, CareFirst continues to support a strong state-based reinsurance program as the most cost-effective way to increase affordability and enrollment in the individual market. To the extent there are additional state funds available, we would also support a premium subsidy targeted towards young adults age 18-34 whose income is below 300% FPL.
Thank you in advance for your consideration.

Sincerely,



Deborah R. Rivkin

Appendix 4. Individual Subsidy Work Group Report

750 EAST PRATT STREET, 6TH FLOOR
BALTIMORE, MD 21202
marylandhbe.com

MARYLAND HEALTH BENEFIT EXCHANGE

Individual Subsidy Work Group Report

Recommendations regarding a state-based subsidy program in Maryland

MHBE Policy and Plan Management
November 16, 2020

Background

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

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

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

Individual Subsidy Work Group Membership

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

Table 1. Individual Subsidy Work Group Members

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

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

*Co-Chairs of the Work Group

Summary of Work Group Discussions – Background Topics

A. Uninsured Population in Maryland

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

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

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

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

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

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

[1] Analysis by the Families USA National Center for Coverage Innovation of 2018 data from the American Community Survey. PUMS USA, University of Minnesota, www.ipums.org. Note: ACS data do not include immigration status. These estimates impute immigration status based very generally on previous Urban Institute results.

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

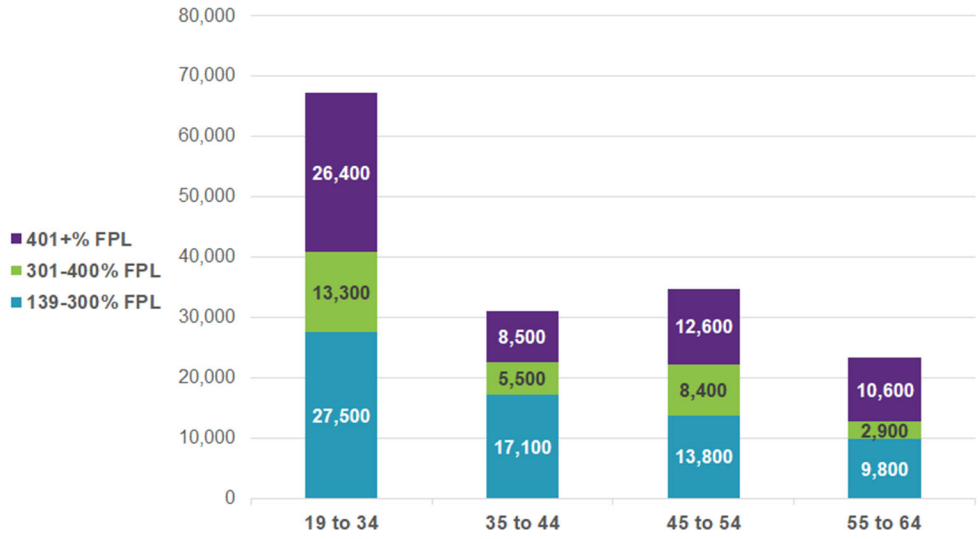
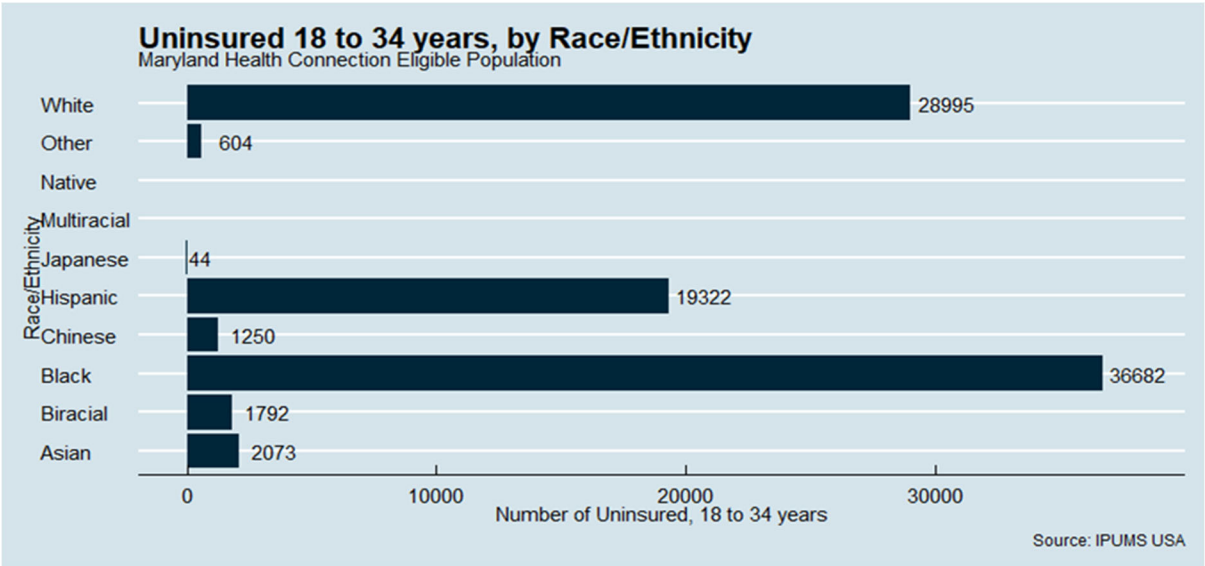


Figure 2 shows the number of uninsured by race and ethnicity. Of uninsured young adults 18-34 in the state of Maryland, over 40% are African American (36,682),[2] a community that historically has dealt with fewer opportunities for economic mobility and fewer chances to build generational wealth. The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

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



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

B. State Reinsurance Program

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

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

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

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

C. Individual Market State Subsidies in Other States

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

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

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

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

Summary of Work Group Discussions - Lewis and Ellis Report

A. Initial Lewis & Ellis Modeling

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

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

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

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

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

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

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

Lewis and Ellis modeled 3 different approaches to reducing the cost burden for households at 400-600% FPL:

1. 400%+ FPL Subsidy Extension 9.78%[1] (FFSE 9.78%)
2. 400%+ FPL Subsidy Extension 12.5% (FFSE 12.5%)
3. 400%+ FPL Subsidy Extension 15% (FFSE 15%)

These subsidy designs would be available to all age groups.

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

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

Table 4. Comparison of 2024 Enrollment

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

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

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

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

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

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

B. Additional Modeling Request

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

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

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

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

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

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

Subsidy Design Evaluation and Recommendations

A. Subsidy Design Evaluation

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

Table 6. Framework for Evaluating Subsidy Designs

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

B. Work Group Recommendations

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

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

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

Appendix

Work Group Member Comments on Draft Report

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

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

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

Table 2. Full Results of Lewis and Ellis Modeling

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