# Report on the Impact of the State Reinsurance Program

PUBLIC EXPOSURE DRAFT

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**Maryland Insurance Administration**
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**Commissioner**

**In consultation with**

**The Maryland Health Benefit Exchange**
**and**
**The Maryland Health Care Commission**

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# I. INTRODUCTION

House Bill 413/Senate Bill 395, enacted in the 2022 Session of the Maryland General Assembly, directs the Maryland Insurance Administration (the "Insurance Administration"), in consultation with the Maryland Health Benefit Exchange (MHBE) and the Maryland Health Care Commission (MHCC), to report to the Governor and the General Assembly on the impact of the State Reinsurance Program. In developing the report, the Insurance Administration is required to:

- consider whether the level of funding is appropriate, taking into account future population growth and projected premium growth;

- consider whether the assessment established under Md. Code Ann., Ins. § 6–102.1 (20xx)[1] is appropriately apportioned among the carriers; should be broadened to include other business sectors; and should be supplemented with General Funds;

- consider what market reforms are needed to provide affordable health coverage in the individual market, including continuation of the Program past 2026; providing State-based premium subsidies; and expanding eligibility for the Maryland Medical Assistance Program; and

- evaluate the design of the Program, including whether the program parameters established under § 31–117 of the Insurance Article are appropriate in light of other individual market reforms at the State and federal level, including the Young Adult Subsidies Program; the Easy Enrollment Health Insurance Program; a special or other enrollment period opened under § 31–108 of the Insurance Article; and premium subsidies available under the American Rescue Plan Act or any other federal law."[2]

# II. EXECUTIVE SUMMARY

For the reasons discussed in detail below, this Report concludes:

**1. No changes should be made to the design, parameters, state funding mechanisms, sources, or amount for the State Reinsurance Program.** The State Reinsurance Program (SRP) has been very successful and has done precisely what it was designed to do. It resulted in the reduction of rates in the individual health insurance market by 32% in three years and, since then, has kept rate increases at, or under, claim trends. Enrollment in the individual market rebounded and has continued to increase and Maryland's uninsured rates have continued to decrease. As a result of the implementation and prudent management of the SRP, Maryland's unsubsidized rates for comprehensive, quality health insurance in the individual market are now consistently among the lowest in the nation. The people who benefit the most from this are people who receive little or no premium subsidies.

Modeling supports the conclusion that the amount generated by the current 1% assessment is a stable funding source that is likely sufficient to carry the SRP through the end of the current 1332 Waiver (2028), even if enhanced federal subsidies authorized under the American Rescue Plan Act of 2021 (ARPA), as extended by the Inflation Reduction Act (IRA), sunset in 2025 – assuming that SRP Funds are dedicated to reinsurance costs and are not used for other purposes.

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[1] All citations in this Report are to the Insurance Article unless otherwise stated.

[2] 2022 MD Laws Ch. 59

The current funding source is stable and is already fully accounted for in the charges of all entities who pay the assessment and, thus, its continuation creates no additional cost or stress on rates or costs and does not require the diversion of funds from other sources or the imposition of new obligations. Consequently, this Report concludes that there is no reason to change the source, amount, or allocation of state funding for the SRP. However, if the ARPA enhanced subsidies terminate in 2025, there will not be sufficient funding to maintain the SRP at its current size through a third 1332 Waiver period. That will require policymakers to determine whether to alter the parameters of the SRP; alter the state funding source, amount and allocation; or a combination of both.

**2. This Report recommends consideration of four state-based market reform subsidy programs that could further improve the affordability of health insurance and health insurance benefits for people that live in our state.** Specifically, this Report describes and estimates the annual costs and potential positive impact of: continuation of the Young Adult Subsidy Program; adoption of a general state-based premium subsidy program not determined by age; adoption of a state-based cost-sharing subsidy program; and adoption of state-based premium subsidies for some or all undocumented persons, analyzed by age group. The state currently sponsors and funds a premium subsidy program that is targeted at young adults. This Report identifies adjustments that should be made to the Young Adult Subsidy Program to assure that it is more equitable and not regressive in its application, and models additional programs that would establish a premium subsidy for older qualifying adults and/or undocumented persons. Separately, the Report considers the costs and potential impact of subsidizing cost-sharing to improve the affordability of the benefits for individuals who have high deductibles or cost-sharing obligations that can be a barrier to their ability and willingness to access those benefits.

In determining whether, and to what extent, to adopt/continue and fund any of the state-based subsidy programs discussed in this Report, consideration also must be given to the need to address the impact of changes in the current levels of federal premium subsidies that are scheduled to sunset at the end of 2025. Under ARPA, as extended by the IRA, the federal government broadened the scope of individuals and families entitled to receive premium subsidies and provided greater subsidies for individuals and families at very low income levels who do not qualify for Medicaid. These enhanced subsidies resulted in significant increases in enrollment in health plans nationwide. The enhanced subsidies will expire at the end of calendar year 2025, absent action by Congress. If Congress allows the enhanced subsidies to sunset, subsidies for middle income enrollees will terminate and the amount of subsidies for those that remain eligible will be reduced. Consequently, some Marylanders could see their annual premium increase by as much as 40%. If this premium shock occurs, enrollment will be impacted and it is likely that the enrollees leaving the market will be the healthiest and youngest. It is important, therefore, that the state have a plan to buffer the sudden and wholesale elimination of the enhanced subsidies in order to protect and maintain stability in the state-based premium subsidy to offset some or all of the reduction in federal support in an effort to maintain enrollment for impacted individuals. The scope and size of that plan will necessarily impact (and inform) the creation and funding of other market reform programs.

Modeling supports the conclusion that the SRP will likely have sufficient funding to continue to contribute a minimal amount (such as $20 million) annually to support or pilot state-based market reforms subsidy programs, as has been the case with the Young Adult Subsidy. While it may appear as though there are significant sums that are estimated as the SRP Fund balance year over year and at the end of the current 1332 Waiver period (2028), in reality, and as discussed below, those amounts are not excess and should not be diverted. This Report strongly recommends that the SRP Fund not be viewed as a source of revenue for state-based market reform subsidy programs. Fund for state-based market reform programs and subsidies

that the General Assembly elects to continue, expand, or establish should be separately secured from one or more of the funding sources utilized by other states and discussed within the Report.

The Report estimates the costs associated with the state-based subsidy programs described in the Report. However, the Workgroup will be able to better model costs, the impact of assessments/funding mechanisms, and the potential positive outcomes of programs as the members of the General Assembly identify the specific programs and the scope, and/or combination of programs that the members believe are most likely to improve the affordability of quality health insurance in the individual market, as well as those funding sources that they wish to consider. As noted, contingency planning for the sunset of ARPA enhanced subsidies to avoid shock to the individual health insurance market should be considered when evaluating state-based subsidy programs.

## III. BACKGROUND AND LEGISLATIVE HISTORY

The State Reinsurance Program (SRP) was authorized by bi-partisan emergency legislation enacted by the Maryland General Assembly during the 2018 legislative session in order to stabilize rates in the State's individual health insurance market. Rates in that market had begun to spiral after the 2014 implementation of the Patient Protection and Affordable Care Act[3] (the "ACA"), amended by the Health and Education Reconciliation Act.[4] By 2018, enrollment of healthy individuals was dropping and, as a result, year over year rate increases for silver plans were as much as 50%.[5] The State Innovation Waiver authorized under Section 1332 of the ACA offered states the opportunity to use federal pass-through funding to address insurance market issues and improve access to quality health insurance.

As modeled by the Insurance Administration, MHBE, and the Department of Health, a reinsurance program funded in large part by federal pass-through funding was projected to reduce rates in the individual health insurance market by 30% over a three-year period and, thereafter, align rate changes with cost trends. Consequently, House Bill 1795 (Ch. X, Acts of 2018), which was signed into law by Gov. Larry Hogan on April 5, 2018, directed MHBE to submit a Section 1332 Waiver to the U.S. Secretaries of Health and Human Services (HHS) and the Treasury to establish the SRP. In that same Session, the General Assembly also enacted Senate Bill 387 (Ch. 37, Acts of 2018), which provided for an assessment on certain health plans to be collected in 2019 to help fund the SRP. *See* § 6-102.1. Section 9010 of the ACA created a federal health insurance provider fee ("9010 fee") for covered 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%.[6] 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 in order to provide a bridge for stability in the individual market.

On May 18, 2018, the MHBE submitted an application to HHS to waive §1312(c)(1) of the ACA for a period of five years to implement the SRP. The waiver proposed to cover plan years 2019 through 2023 and allow Maryland to include expected state reinsurance payments when establishing the market wide index rate, decreasing premiums and federal payments of advance premium tax credits (APTCs). The

[3] 2010. Mar 23, The Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119.
[4] 2010. Mar 30, Health Care Education and Reconciliation Act, Pub. L. No. 111-152, 124 Stat. 1029.
[5] The circumstances that resulted in those extraordinary rate increases are discussed in Section 7(A) of this Report.
[6] 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/

savings in federal payments of APTCs as a result of the SRP are then passed on to the state (referred to as pass-through payments), which are used to help fund the SRP.

MHBE proposed that the SRP would operate as a traditional, claims-based reinsurance program that reimburses qualifying health insurers for a percentage of an enrollee's claims between an attachment point and cap. The parameters of the SRP would be established annually by the MHBE Board of Trustees. On August 22, 2018, the Centers for Medicare and Medicaid Services (CMS), on behalf of HHS and the Department of the Treasury, approved Maryland's State Innovation waiver for a period of January 1, 2019 through December 31, 2023.[7]

During the 2019 Session, House Bill 258/Senate Bill 239 (Ch. 597, Acts of 2019) established a state-based health insurance provider assessment of 1% to contribute to funding for the SRP through 2023. In 2020, the U.S. Congress enacted the Further Consolidated Appropriations Act, which repealed the federal 9010 fee for calendar years beginning after December 31, 2020. Consequently, the General Assembly passed a technical correction to the applicability of the assessment (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 Maryland's assessment to the now repealed 9010 fee and to ensure that the 1% state-based health insurance provider assessment continued to apply as intended.

During the 2022 Session, House Bill 413/Senate Bill 395 (Ch. 59, Acts of 2022) extended the 1% health insurance provider assessment through calendar year 2028, in order to facilitate the state's application to the federal government to extend the SRP for a second 5-year waiver period, through 2028, and to provide state reinsurance funds to support the SRP during that time. On March 30, 2023, MHBE submitted an application to CMS and the Department of Treasury to extend the 1332 State Innovation Waiver authorizing the SRP for an additional five-year period, through December 31, 2028. The application was approved on June 28, 2023.

As noted above, the legislation also tasked the Insurance Administration, in consultation with the MHBE and the MHCC, with submitting a report to the General Assembly by December 1, 2023, on the impact of the SRP, including the adequacy and appropriateness of the 1% assessment, the SRP's program design, and market reforms needed to provide affordable health coverage in the individual market.

## IV. INTERAGENCY WORKGROUP

### A. HB413 State Reinsurance Workgroup

An interagency workgroup (the "Workgroup") consisting of representatives from the Insurance Administration, MHBE, MHCC, and several divisions within the Maryland Department of Health (MDH) was convened in early 2023 to conduct the research and analysis necessary to prepare this Report.

Members of the Workgroup met regularly to review the latest reinsurance projections, data on the effectiveness and success of the program to date, and reinsurance programs of all other states operating reinsurance programs under 1332 waivers. In addition, the Workgroup compiled, reviewed and discussed information pertaining to potential market reforms in Maryland, including the latest 2021 uninsured data, other states' premium and cost sharing reduction subsidies, and the possibility of the state pursuing a Medicaid 1115 waiver as a source of funding for state subsidies. The Workgroup also compiled, reviewed

[7] https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/1332-STC-MD-Signed.pdf

and discussed information relating to additional market reforms being pursued in other states, such as merging the Individual and Small Group markets, implementing a Basic Health Plan, and implementing an Individual health insurance mandate with a tax penalty. Members of the Workgroup conducted extensive modeling, utilizing both the actuaries within the Insurance Administration and external consulting actuaries. The Workgroup also coordinated with other groups working on reports to the General Assembly related to health financing, such as the Health Care and Dental Coverage for Undocumented Immigrants Report, to assure consistency in modeling assumptions and data.

## B. Summary of Public Stakeholder Meetings

The Workgroup invited input and comment from public stakeholders throughout its development of the Report. The Workgroup held five public meeting between May and December of 2023. A brief description of each Meeting is described below. More detailed information, including the full agenda, presentation slides and materials, meeting recordings, and written public comments may be accessed at https://insurance.maryland.gov/Consumer/Pages/workgroups.aspx.

### 1. May 11, 2023 Public Stakeholder Meeting

The first public stakeholder meeting was held on Thursday, May 11, 2023. During this first meeting, the Insurance Administration provided a comprehensive overview of the SRP to date, including impacts on enrollment and premiums, and funding projections through 2028. The Insurance Administration also provided an overview of Maryland's current uninsured landscape using the most recently available 2021 data, with rates broken down by age and income. The Insurance Administration then presented detailed information on the 15 other states with SRPs, including comparisons of the states' program parameters, as well associated costs and federal-pass-through attributable to each state's SRP. The Insurance Administration continued by presenting an overview of how Maryland's SRP interacts with federal premium subsidies and the Maryland Young Adult Subsidy, in regard to the program's impact on premiums. The presentations concluded by reviewing a list of initial discussion items for the workgroup's consideration around potential adjustments to the SRP's parameters, size, and design.

Stakeholders were in general agreement that the claims-based structure of the MD SRP and unique use of a dampening factor to adjust for interaction between reinsurance and risk adjustment should be maintained. Some stakeholders advocated for leaving the Maryland parameters at their current level, which is the most generous of all state reinsurance programs. Other stakeholders expressed a desire to modify the program parameters to make the program less generous and more similar to other states. Several stakeholders expressed an interest in adding financial incentives for care management and/or quality/performance metrics to the SRP.

### 2. May 25, 2023 Public Stakeholder Meeting

The second public stakeholder meeting was held on Thursday, May 25, 2023. The second meeting focused on additional market reforms that could be beneficial in addition to, and complement, the reinsurance program. Brad Boban, Chief Actuary at the Insurance Administration, began by presenting Maryland uninsured data broken down by age, poverty level, race and ethnicity, and citizenship to show which groups may be experiencing barriers to coverage despite existing federal and state market reforms. Mr. Boban presented potential additional market reforms including state premium subsidies, both for those already receiving federal APTC and a state subsidy for undocumented immigrants who are ineligible for federal APTC; cost-sharing reduction (CSR) subsidies; extended enrollment opportunities such as new

Special Enrollment Periods (SEPs); a state individual mandate and tax penalty; a merging of the individual and small group markets; a Basic Health Plan for the population with incomes between 138 and 200% of the federal poverty level (FPL); and expanding Maryland Medicaid up to 200% of FPL. Mr. Boban compared these potential reforms based on what federal waivers or authority they would require, the impact on reinsurance costs, administrative complexity, ability to be reversed, impact on APTC, impact on average morbidity, impact on the size of the risk pool, and cost to the state. He also discussed other states' market reforms, which are reviewed in more detail later in this report.

Commissioner Birrane, Mr. Boban, and Ms. Fabian-Marks then facilitated a discussion intended to inform actuarial modeling of potential subsidy programs to be presented to the group at the next stakeholder meeting. There was a general consensus that the structure of any supplemental state subsidies in the future should be simplified to a PMPM subsidy structure, which would be easier to implement, and, unlike the current structure, would not be regressive. Stakeholders agreed that subsidies for those who would be otherwise eligible except for their immigration status should be modeled assuming the state would subsidize a portion equal to the federal subsidy for those who are eligible. Stakeholders agreed that there was interest in seeing the impact of expanding Medicaid or creating a BHP for individuals below 200% FPL, including the impact on the Individual marketplace and the SRP.

**3. August 8, 2023 Public Stakeholder Meeting**

The third public stakeholder meeting was held on Tuesday, August 8, 2023. During this meeting, Mr. Boban began by presenting funding mechanisms used by other states with reinsurance programs. He then presented actuarial modeling results of possible changes to the SRP payment parameters based on feedback from first two meetings. In addition, he shared modeling of the potential state costs of a subsidy program for Marylanders who would be eligible to enroll in individual coverage if not for their immigration status, as well as the potential costs of a state supplemental subsidy program and a state cost-sharing reduction subsidy for those eligible for federal subsidies. Mr. Boban then presented the impact of expanding Medicaid to 200% FPL or creating a BHP, which in general would increase costs to the state and increase costs for some who remain in the individual market.

Stakeholders discussed various funding mechanisms. Multiple stakeholders advocated that the current premium assessment to fund reinsurance not be raised to fund additional programs; other stakeholders were open to the idea but cautioned that the impact on the other group fully insured markets should be considered. Several stakeholders advocated the consideration of funding mechanisms not being currently pursued by other states to fund Individual market initiatives, such as tobacco taxes, alcohol taxes, or carbon taxes. The possibility of receiving funding via a Medicaid 1115 waiver was of interest to multiple stakeholders.

**4. September 14, 2023 Public Stakeholder Meeting**

The fourth public stakeholder meeting was held on Thursday, September 14, 2023 and continued the discussion of the actuarial projections that were presented in Meeting 3.

**5. December 6, 2023 Public Stakeholder Meeting**

The fifth and final public stakeholder meeting was held on Wednesday, December 6, 2023 to discuss the draft of this Report exposed for public review and comment on December 2, 2023. During that meeting, the Workgroup provided a short summary of the key findings in the Report and [to be addressed following 12/6 meeting].

# V. ANALYSIS

## A. Evaluation of the Maryland State Reinsurance Program Design

*HB413 requires that the Report "evaluate the design of the Program, including whether the program parameters established under § 31–117 of the Insurance Article are appropriate in light of other individual market reforms at the State and federal level, including: the Young Adult Subsidies Program; the Easy Enrollment Health Insurance Program; a special or other enrollment period opened under § 31–108 of the Insurance Article; and premium subsidies available under the American Rescue Plan Act or any other federal law."*

### 1. Comparison of the Maryland SRP Program Design with Other States

To evaluate the design of the Maryland SRP, the Workgroup first reviewed the design of 1332 Waiver reinsurance programs adopted by other states and compared those designs parameters with the design parameters set by the MHBE Board as authorized under § 31–117, including a comparison of the size and impact of those programs in their respective states.

As of the date of this Report, there are were 16 states[8] with approved reinsurance programs. Of those states, 15 (including Maryland) have adopted claims-based reinsurance program; while one state, Alaska, has adopted a conditions-based reinsurance program. The key features of each types of programs are:

- Conditions-based: This type of program identifies enrollees with specified medical conditions and allows the plan to cede 100% of claims for those enrollees to the reinsurance program. In Alaska, the program identifies 34 covered conditions, including severe COVID-19 cases. The program covers the cost of *all* medical and drug claims for any enrollee who has a claim during the year who has one of the 34 specified diagnoses.

  - The benefit of a conditions-based reinsurance program is that it completely removes high risk claimants from the risk pool, leaving carriers with a significantly lower-morbidity pool on which rates can be based.

  - The challenges of a conditions-based reinsurance program are:
    - The program provides coverage for 100% of the claims for ceded enrollees, meaning that the state bears 100% of the risk that these enrollees' claims come in even higher than expected.
    - There is no incentive for carriers to control costs for reinsured members with covered conditions, because they bear 0% of the risk.
    - Such programs are more administratively complex and expensive to administer.

- Claims-based: This type of program reimburses the health plan for claims paid in excess of a certin amount (the attachment point) on behalf of any insured attributable to the plan year, regardless of the condition(s) that resulted in the claims. If an insured's total claims are less than the attachment point, no reimbursement is provided to the insurer under the reinsurance program. If an insured's

[8] Alaska, Colorado, Delaware, Georgia, Maine, Maryland, Minnesota, Montana, New Hampshire, New Jersey, North Dakota, Oregon, Pennsylvania, Rhode Island, Virginia, Wisconsin

total claims are in excess of the attachment point, the program provides reimbursement for a certain percentage of the amount by which the claims exceed the attachment point (called the coinsurance rate), up to a chosen reinsurance cap. Under a claims-based model, the reimbursement amount is calculated as (the total claim amount minus the attachment point) multiplied by the coinsurance rate, with the maximum reimbursement for an insured being calculated as (cap minus the attachment point) multiplied by the coinsurance rate.

Two states (GA and CO) vary parameters by geographic region, setting higher coinsurance rates in targeted regions. Maryland is the only state that makes an adjustment to account for the interaction between the SRP and the federal risk adjustment program, via a "dampening factor," as discussed below.

- The benefits of a claims-based reinsurance program are:
  - The program provides reimbursement on a coinsurance basis and subject to a cap. This incentivizes carriers to control costs for high-cost members, as they share a portion of the costs between the attachment point and the cap, and they still bear 100% of the risk over the cap.
  - The program is easier to administer than a conditions-based program.
- The challenge of a claims-based reinsurance program is that the reinsurance costs for a given set of parameters increases faster than claims trend, because of "deductible leveraging" and also rises faster than federal pass-through funding. Therefore, the parameters must be adjusted periodically to manage state costs; otherwise, if parameters remain fixed, over time the state will cover an increasing share of total claims in the market.

While most state reinsurance programs are claims-based, there are variations among plans with respect to the program parameters set by the state. Those choices impact the size of the program and the degree of impact that it has on rates in the state.

Maryland's SRP is a traditional, claims-based reinsurance program that provides reinsurance for the entire individual ACA health insurance market. Like other claim-based reinsurance programs, the Maryland SRP design includes three of the parameters used by other state reinsurance programs: an attachment point, a co-insurance rate, and a cap. Since the program's inception in 2019, with the exception of plan year 2023, Maryland's reinsurance parameters have been set at a $20,000 attachment point, 80% coinsurance rate, and $250,000 cap. For plan year 2022, approximately 7% of Maryland insureds had total claims that exceeded the $20,000 attachment point, resulting in payments of $484,920,457 from the Reinsurance Fund for the 2022 plan year.

The Maryland SRP is unique, however, in that § 31–117 authorizes the MHBE Board to apply a fourth SRP parameter, a market-level dampening factor provided by the Maryland Insurance Commissioner, if the Board deems it necessary. The dampening factor adjusts payments to an insurer from the SRP to account for the interaction between the SRP and the federal risk adjustment program, a feature of the ACA under which the federal government transfers payments from carriers with relatively low-risk enrollees to carriers with higher-risk enrollees to reduce the incentive for carriers to avoid high-risk enrollees. Because both programs cover some of the same high-risk, high-cost individuals, there is potential that some insurer claims will be covered by both programs. Absent the dampening factor, this interaction of the reinsurance and risk adjustment programs could inappropriately disrupt the individual market, potentially resulting in carriers receiving funding for high risk members through the two programs that

exceeds the members' total claims. The Board has determined a dampening factor necessary for every year of the SRP so far. To date, the dampening has ranged between .760 and .840.

For plan year 2023, at the recommendation of the Insurance Administration, the attachment point was lowered to $18,500 by the MHBE Board, with other parameters remaining unchanged. This action was taken because of larger claim trend increases in 2022 and the uncertainty of whether the enhanced federal premium tax credits under the American Rescues Plan Act (ARPA) would be extended, and the potential for additional, double digit rate increases in the individual market if the subsidies were not extended. After the 2023 rates were approved, the Inflation Reduction Act (IRA) extended the enhanced federal premium tax credits through the end of 2025. For 2024, the MHBE Board returned the attachment point to $20,000. Under the newly approved 1332 Waiver, the attachment point is will be increased by $1,000 per year, until reaching an attachment point of $24,000 in 2028. This increase in attachment point is necessary in order to slow the growth of SRP costs in future years, and ensure that the current funding mechanism of the 1.0% assessment remains sufficient.

Charts 5.1, 5.2 and 5.3 below compare the 2022 parameters for the fourteen states with a claims-based reinsurance program in 2022, including Maryland. The average attachment point in 2022 was $51,500 (range of $20,000 - $100,000), the average coinsurance rate was 63% (range of 40% - $100%) and the average reinsurance cap was $360,000 (range of $65,000 - $1M). Maryland's parameters for attachment point and coinsurance rate are significantly more generous than average, and Maryland's reinsurance cap is slightly lower than average.

# Comparison of Parameters: Attachment Point

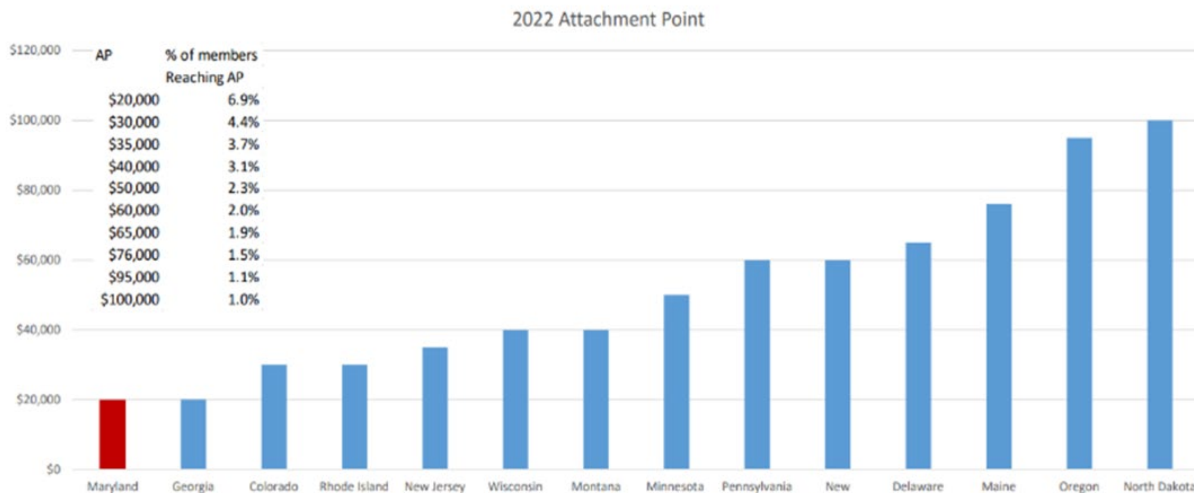


Figure 5.1: State Comparison of Attachment Points, 2022//

# Comparison of Parameters: Coinsurance

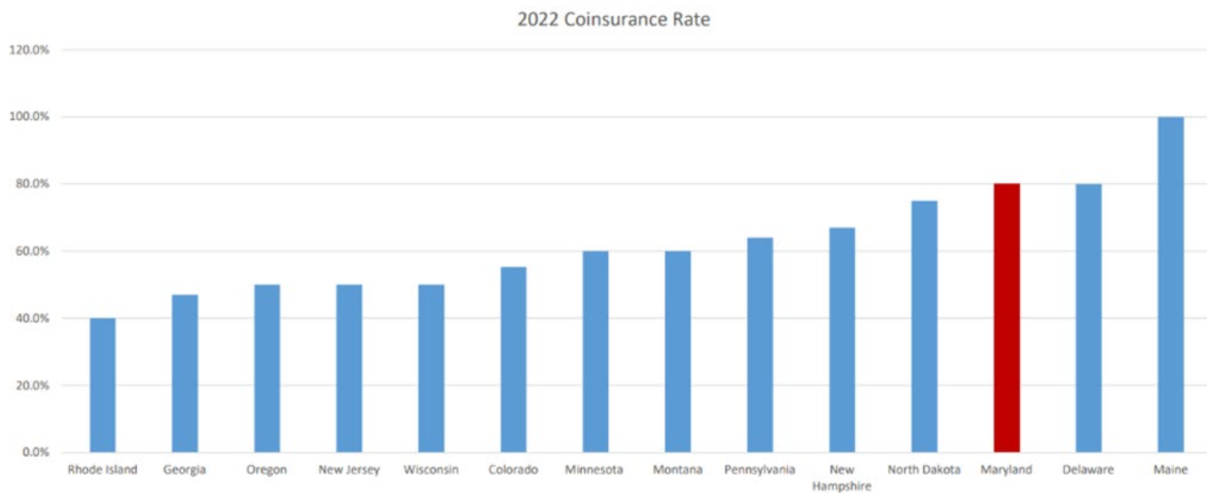


Figure 5.2: State Comparison of Coinsurance Rates, 2022

# Comparison of Parameters: Cap

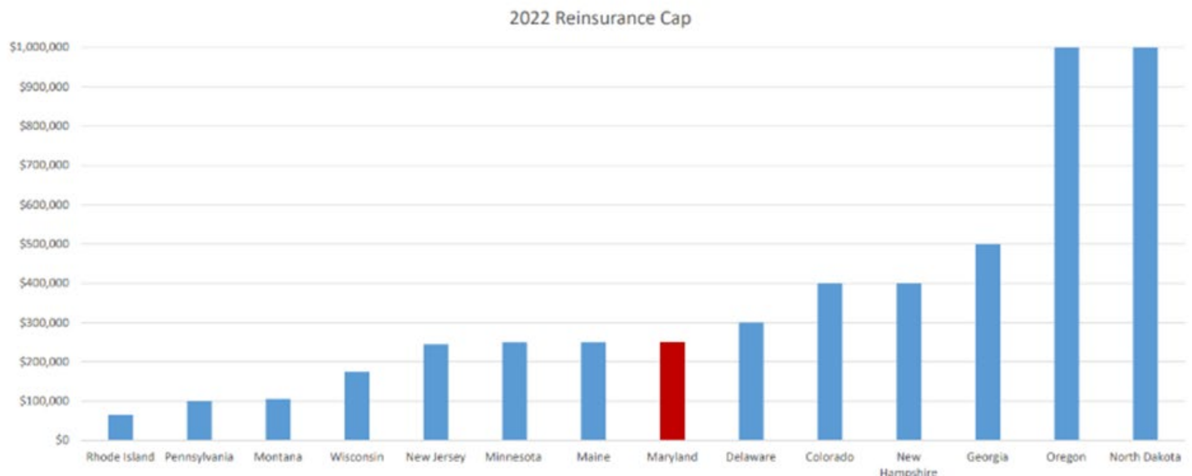


Figure 5.3: State Comparison of Reinsurance Caps, 2022

Reinsurance programs established under a 1332 Waiver are designed to generate federal funding that is used to fund the reinsurance program. If a state's 1332 Waiver is projected to reduce federal costs, those savings are "passed through" to the state under the 1332 Waiver. Reinsurance programs reduce federal costs by reducing carriers' claims costs, which in turn reduces premiums, and, therefore, reduces the amount the federal government must spend on APTCs to subsidize the premium of qualified enrollees.

Among states with a claims-based reinsurance program, in 2021, on a per-member per-month (PMPM) basis, Maryland's program cost was the largest in the nation, while simultaneously generating the largest pass-through amount on a PMPM basis. In 2021, Alaska's program both cost more on a PMPM basis than Maryland's and generated larger levels of pass-through funding on a PMPM basis, but as indicated previously, Alaska's program is a conditions-based program that cedes 100% of claims of

enrollees with certain conditions to the reinsurance program. Comparisons of Maryland's SRP costs and pass-through generated and those of other states are shown in charts 5.4 and 5.5 below.

## PMPM Reinsurance Cost Comparison

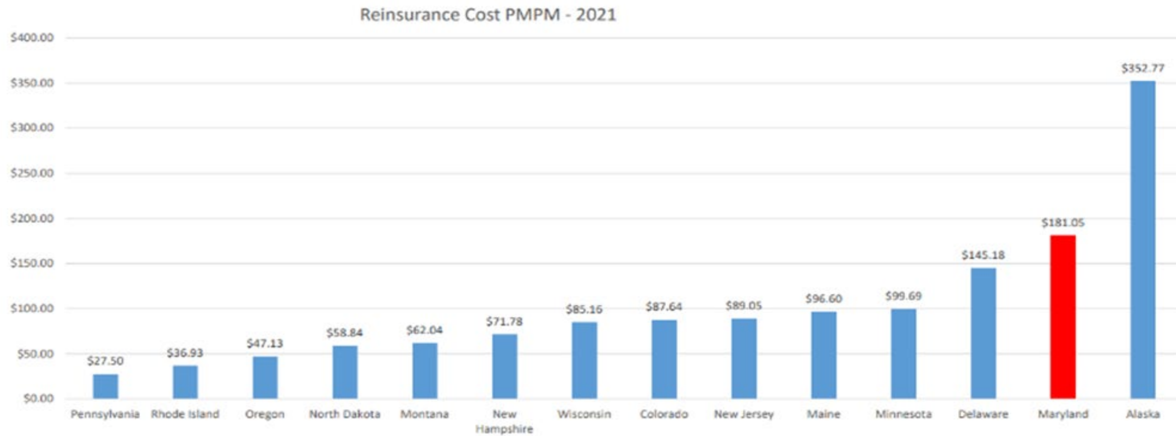

Figure 5.4: Cost Comparison of Per Member Per Month (PMPM) Reinsurance Cost by State, 2021.

## PMPM Federal Pass-through Comparison

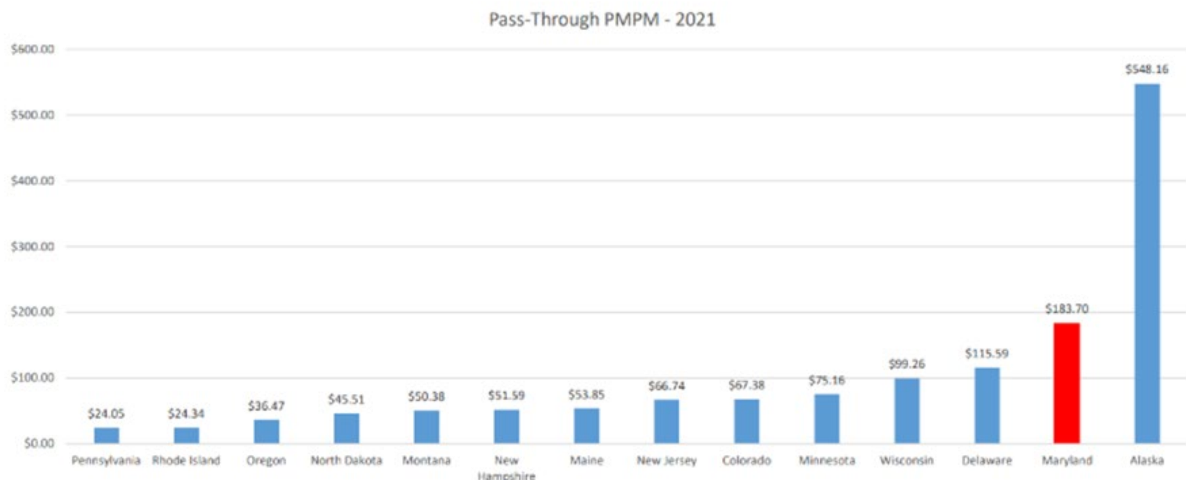

Figure 5.5: Comparison of Per Member Per Month (PMPM) Federal Pass-Through Generated by State, 2021.

After considering reinsurance program design in other states, it is the view of the Workgroup that the design of the Maryland SRP is appropriate and should not be changed. Moving to a conditions-based program would not be in the economic interest of the state. While a conditions-based reinsurance program like Alaska has the potential to have an even larger impact, it also shifts significant risk from the commercial market to the state and is significantly more complex to administer.

Further, as discussed in more detail below, the SRP parameters currently in place have been extremely effective in achieving the goal of stabilizing the individual marketplace. Overall payment parameters are established in state statute and regulation, and the specific level of each parameter is

determined by the MHBE Board in accordance with state law. Parameters are annually proposed by the MHBE Board in a public meeting, public comment is accepted, and parameters are finalized by the Board in a subsequent public meeting. When set, payment parameters are applied equally to subject carriers in the state.

### 2. Consideration of the Maryland SRP Design in Light of Other Individual Market Reforms at the State and Federal Level.

HB413 directs the Insurance Administration to assess whether the Maryland SRP design is appropriate in light of market reforms that exist at the State and federal level.

#### a. Maryland's State-Based Market Reform Programs

The state-based market reforms adopted by Maryland are: the Young Adult Health Insurance Subsidies Pilot Program; the Easy Enrollment Health Insurance Program; and Special Enrollment Periods. Each of these programs leverages the success of the SRP and has a positive, incremental impact on the stability and size of Maryland's individual health insurance market. However, none of the programs has an impact that would justify a change in the design of the Maryland SRP.

The Young Adult Health Insurance Subsidies Pilot Program was implemented in the 2022 plan year and is currently authorized through the end of 2025.[9] This program provides young adults who are already eligible for federal subsidies with additional state subsidies to further reduce their premiums. In 2022 and 2023 state subsidies were available up to age 34; for 2024 eligibility is extended up to age 37. The program is currently authorized to provide up to $20 million in premium subsidies to qualified young adults. Subsidies did not reach the program maximum in 2022 and, under current projections, are unlikely to reach the cap in 2023.

The Easy Enrollment Health Insurance Program permits a Marylander to check a box on their tax return indicating that they, their spouse, or children are uninsured and allowing information from the tax return to be shared with MHBE. This triggers a special enrollment period after they file their taxes. Using the information supplied, MHBE sends a notice to the consumer advising whether they are eligible for free/low cost health insurance and explaining how they can apply. This program has also been extended to Marylanders filing Unemployment Insurance Benefit claims.

Importantly, the MHBE Board took the initiative, consistent with federal guidelines, to create and extend a COVID-related special enrollment period (COVID SEP) to reduce barriers to obtaining coverage during the pandemic, so that uninsured Marylanders could purchase health insurance immediately and without waiting for a standard qualifying event.

These programs have interacted with the SRP in a synergistic manner to support enrollment. Reinsurance keeps unsubsidized rates affordable for those who earn too much for federal and state subsidies, so the number of new enrollees under Easy Enrollment and the COVID SEP were higher than they would have been absent the rate reducing impact of the SRP. While the new entrants that the state programs attract do add costs to the SRP, they also result in greater federal pass-throughs for the portion of the pool that is eligible for federal premium tax subsidies. In general, the state initiatives have targeted younger and healthier populations, because they are more likely to be uninsured. For this population, the additional extra pass-throughs have modestly exceeded reinsurance costs.

[9] Further analysis of this Program is discussed in Section VII.

Although the reduced net reinsurance costs are not nearly enough to pay for the total young adult subsidies themselves, Maryland's experience demonstrates that the presence of state programs that help bring in low-income residents can help improve the stability and long-term solvency prospects of the reinsurance program. However, none of these programs have an impact on enrollment that is sufficiently distinct from the impact of the SRP such that the existence of that program warrants any adjustment to the design of the SRP itself.

**b. Federal Programs**

While the Maryland state-based market reforms discussed above have had positive, but incremental, additional impact on enrollment in the individual health insurance market, the enhanced federal premium tax credits and cost-sharing subsidies available under ARPA are of a significantly higher magnitude and have been a significant driver of large enrollment increases nationwide, including Maryland. ARPA was designed to encourage people to buy individual health insurance during the Covid-19 pandemic by temporarily increasing the size and scope of premium tax credits, including eliminating the upper income limit for subsidy eligibility for individual health insurance plans purchased through an ACA marketplace. The enhanced subsidies increased the amount of financial help available to those already eligible and also provided subsidies to middle-income people by temporarily eliminated the "subsidy cliff." Under ARPA, no one purchasing coverage through a marketplace was required to pay more than 8.5% of their household income (an ACA-specific calculation) for the benchmark plan. And, people with lower incomes paid a smaller-than-normal percentage of their income for the benchmark plan – as low as $0 for people with income that doesn't exceed 150% of the poverty level. The Inflation Reduction Act, enacted in 2023, extended these enhanced subsidies through the end of calendar year 2025.

If the federal government allows the enhanced subsidies to expire and returns to pre-ARPA subsidy levels (including the removal of subsidies for middle-income people), modeling shows that, on average, the post-subsidy premium for those who have been receiving the enhanced premium tax credits will increase by 40% and it is expected that there will be significant enrollment losses.[10] It is likely that those enrollment losses will be disproportionately higher among healthier and younger enrollees and, thus, the morbidity of the pool would be expected to jump significantly, necessitating large double digit increases for the unsubsidized portion of the pool. This is reminiscent of the spiral that lead to the establishment of the SRP in 2018 as a means of stabilizing rates and increasing enrollment in the face of increased premiums and the loss of health and young enrollees. While the SRP accomplished its objective and brought stability and increased enrollment to the individual health insurance market, the significantly larger increases in enrollment during and following the COVID-19 pandemic have been driven primarily by the enhanced subsidies. The loss of those enhanced federal subsidies, absent state action, could disrupt the individual market and warrant separate consideration in the discussion of state-based subsidies (and the funding thereof) that follows in Section VII.

In addition, the higher premium tax credits provided under ARPA has also resulted in the receipt of higher pass-through amounts under Maryland's 1332 Waiver, enhancing the amount of federal funding for the SRP. Thus, the question of whether ARPA-level subsidies are extended has a significant impact on the long-term sufficiency of the amount collected by the state through the current 1% assessment. As shown

[10] https://www.kff.org/policy-watch/how-marketplace-costs-premiums-will-change-if-rescue-plan-subsidies-expire/

in Table 5.6 below[11], if ARPA is extended indefinitely, it is projected that on an ongoing basis the 1% state assessment will generate slightly more than the state share of reinsurance costs. This would sustain the SRP on an ongoing basis and allow the surplus in the SRP Fund to grow slightly each year that projections come in as expected. The surplus, at the end of 2028 would be the equivalent of approximately one year of reinsurance payments.

However, if ARPA ends in 2025, projections indicate that starting in 2026 the 1% state assessment would bring in less than the estimated state portion of reinsurance costs. Because the second waiver period is starting with a healthy $487M surplus from the first waiver period, the state would be able to cover the deficiency during the approved 5-year waiver. But, by 2028, the end of the second waiver period, projections indicate that the surplus would decline to $335M, almost $350M lower than the $678M surplus expected if ARPA-level subsidies are extended. This balance would be less than one-half of one year's projected reinsurance costs.

| ARPA Subsidies Continue Indefinitely | | | | | | |
|---|---|---|---|---|---|---|
| | 2024 | 2025 | 2026 | 2027 | 2028 | 2029 |
| **Program OutFlows** | | | | | | |
| Reinsurance Payments | $ 578,707,379 | $ 601,967,701 | $ 626,329,368 | $ 651,995,870 | $ 678,786,213 | $ 706,857,015 |
| Other Program OutFlows* | $ 35,000,000 | $ 35,000,000 | | | | |
| **Program Inflows** | | | | | | |
| State Reinsurance Fee Funding | $ 140,220,705 | $ 145,128,430 | $ 150,207,925 | $ 155,465,202 | $ 160,906,484 | $ 166,538,211 |
| Estimated Federal Pass Through | $ 474,246,276 | $ 499,916,753 | $ 525,801,760 | $ 558,837,384 | $ 588,315,377 | $ 619,473,003 |
| **Program Net Cash Flow** | | | | | | |
| Funding Available | **$ 487,765,370** | **$ 495,842,851** | **$ 545,523,169** | **$ 607,829,885** | **$ 678,265,533** | **$ 757,419,732** |
| **ARPA Subsidies Expire After 2025** | | | | | | |
| | 2024 | 2025 | 2026 | 2027 | 2028 | 2029 |
| **Program OutFlows** | | | | | | |
| Reinsurance Payments | $ 578,707,379 | $ 601,967,701 | $ 619,451,631 | $ 644,803,766 | $ 671,255,863 | $ 698,964,490 |
| Other Program OutFlows* | $ 35,000,000 | $ 35,000,000 | | | | |
| **Program Inflows** | | | | | | |
| State Reinsurance Fee Funding | $ 140,220,705 | $ 145,128,430 | $ 150,207,925 | $ 155,465,202 | $ 160,906,484 | $ 166,538,211 |
| Estimated Federal Pass Through | $ 474,246,276 | $ 499,916,753 | $ 416,900,813 | $ 436,061,855 | $ 455,631,394 | $ 476,178,949 |
| **Program Net Cash Flow** | | | | | | |
| Funding Available | **$ 487,765,370** | **$ 495,842,851** | **$ 443,499,958** | **$ 390,223,250** | **$ 335,505,265** | **$ 279,257,935** |

*Funding for the Young Adult Subsidy Program ($20M) and Health Equity Grants ($15M).

Table 5.6: Fund balance of the SRP if the American Rescue Plan Act (ARPA) subsidies continue indefinitely versus expiring after 2025.

Regardless of whether ARPA is extended, the SRP is projected to be solvent at the end of the second waiver period in 2028. As indicated previously, for plan years 2025-2028, the attachment point was modeled to increase by $1,000 annually. With these scheduled increases in attachment point, even if ARPA expires, assuming continuation of the current 1.0% assessment, the program is projected to be solvent at the end of the second waiver period in 2028, and the size of the program appears to remain sufficient through 2028. These projections are based on current law and assume there will be no SRP Funds used for other purposes, including the Young Adult Subsidy pilot, in 2026 or beyond. To the extent that funds are redirected from the SRP Fund for other purposes in 2026-2028, this will reduce the projected surplus position.

[11] All modeling and projections completed for this Report have taken into account future projected premium growth (5.0% per year, based on historical averages) and future population growth of both the state population in general and of the individual market specifically.

### 3. Conclusion: The Design of the Maryland SRP is Appropriate at This Time.

It is the conclusion of the Workgroup that the Maryland SRP design has been successful and should not be changed at this time. Because of the SRP, as implemented and managed, Maryland residents have the lowest unsubsidized bronze and gold premiums in the nation since 2021, and the third lowest unsubsidized silver plans. While the cost of the Maryland program is higher than other states, it is offset by higher federal pass-throughs. In the first 5-year waiver, the 1332 Waiver generated $9 of federal pass-through for every $1 of state spending. For the second 5-year waiver period, it is projected that $3 of federal pass-throughs will be generated for every $1 of state spending.[12] The $1,000 per year annual increase to the attachment point modeled in the approved waiver is intended to address this change and to help keep the growth in reinsurance costs at a level that is in line with expected funding for the SRP.

The parameters identified in § 31-117 provide the right levers to balance the operation of the SRP so as to achieve its objectives in providing a robust and stabile individual health insurance market offering high quality health benefits plans that are among the most affordable in the nation. A core strength of the SRP design is that if market conditions change unexpectedly in the future, changes can be made to the program's parameters. If future projections show solvency concerns emerging, or if the state wishes to divert reinsurance funding to other initiatives, the flexibility exists to reduce the size of the program by increasing the attachment point. Similarly, there is flexibility to increase the size of the program (by reducing or freezing the attachment point) if filed rate requests are large and are projected to cause market disruption, or if there is political uncertainty at the federal level. The MHBE Board, working cooperatively with the Insurance Administration, has used those levers to manage the SRP Fund responsibly, making adjustments when and as needed to protect the market and its participants.

While the Workgroup has concluded that no adjustments to the Maryland SRP design should be made at this time, it is important to note that if ARPA-level subsidies expire at the end of 2025, further consideration will need to be given to the size and parameters of the SRP in the long-fun. While the SRP will remain solvent through 2028, it is not projected to remain so under the current parameters for a third five-year waiver period. Given that, additional analysis should be conducted if and when it is clear that ARPA-level subsidies will expire in order to determine how the State should address the impact of the reductions in federal funding each year. For example, the parameters of the SRP could be changed to reduce reinsurance costs (by increasing the attachment point, reducing the coinsurance rate, etc.), so that the amount generated by pass-throughs and the annual assessment is enough to cover program costs. Alternatively, state funding for the SRP could be increased, either by increasing the existing assessment rate or finding an additional source of funding, in order to maintain the size of the SRP. The impact of

[12] Federal pass-through dollars reflect the difference between the amount the federal government would have paid to subsidize eligible enrollees without the waiver and the amount they are paying for those subsidies with the waiver in place. When making that calculation, the federal government uses the state's second lowest cost silver plan as the benchmark. At the time the waiver became effective, Maryland had only two insurers willing to offer health insurance in the individual market and only one that was issuing coverage in all Maryland counties. At that time, the second lowest cost silver plan was actually the CareFirst PPO plan in most counties. Because of the high cost of that product, the premium decreases resulting from the implementation of the SRP, resulted in a very large subsidy savings for the federal government, which were passed through to Maryland, at the 9 – 1 ratio noted. However, a third carrier entered the market in 2021 and began writing in all Maryland counties in 2022. Because that carrier offered silver plans, the federal benchmark for calculating pass throughs shifted over those two years from the CareFirst PPO plan to a United Silver plan, resulting in a reduction in federal savings and, consequently, a reduction in pass through amounts. The current 3 – 1 projections reflect that shift. It should also be noted that the amounts that Maryland is receiving currently in federal pass throughs is more typical of what other states receive.

reductions in federal funding for the SRP if ARPA-level subsidies are not continued is complicated by the impact of reductions in federal subsidies for enrollees. Modeling must consider both, as both will impact rates and enrollment.[13]

## VI. REINSURANCE PROGRAM FUNDING: SOURCES, LEVELS AND APPORTIONMENT

*HB413 requires that the Report "include options for obtaining sustainable funding sources to support stability in the individual market."*

*HB413 requires consideration of "whether the level of funding is appropriate, taking into account further population growth and projected premium growth," as well as "whether the assessment established under § 6–102.1 of the Insurance Article is appropriately apportioned among the carriers; should be broadened to include other business sectors; and should be supplemented with the General Funds"*

Because funding sources, levels, and apportionment are interrelated, the Workgroup considered these issues together. For the reasons discussed below, the Workgroup concludes that no change should be made at this time to the source, amount, or apportionment of state funding for the Maryland SRP for the 2024 – 2028 1332 Waiver period. The current assessment is projected to generate an average of $150 million per year during the five-year 1332 Waiver period beginning in 2024. The current 1% assessment is sufficient to fund the SRP throughout Maryland's second five-year 1332 Waiver period, if SRP Funds are not diverted to other programs – including the market reform programs discussed in Section VII of this Report. In addition, the assessment is accounted for within current rates and its continuation at the current level has no impact on rates or any other revenue source.

However, if ARPA's enhanced subsidies are not extended beyond the end of 2025, the amount of state funding for the SRP may need to be revisited to assure continuation of the SRP for a third five-year waiver period. If funding amounts are reconsidered, funding sources and apportionment are appropriately considered at that time.

### A. Funding Sources

State reinsurance programs are funded through a variety of sources that include: an annual assessment on premium earned by issuers of health coverage plans; allocation of a part of the state's general premium taxes on insurers; annual appropriations from the state's general funds; and penalties or shared responsibility payments from state individual mandates. States typically use one to two of these sources to fund their reinsurance programs.[14]

#### 1. Health insurance premium assessments

As noted above, legislation enacted in 2018, imposed a 2.75 percent assessment on certain health insurance plans and Medicaid managed care organizations regulated by the state to provide bridge funding for the SRP in 2019. The funds directed to the SRP were funds that would have been paid to the federal government under Section 9010 of the ACA, but for the suspension of the federal assessment by the federal government that year. In 2019, the assessment was reduced to 1% for subsequent years.

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[13] For purposes of this Report, this modeling was not performed.

[14] Centers for Medicare and Medicaid Services. CCIIO Data Brief Series: State Innovation Waivers: State-Based Reinsurance Programs. August 2021. https://www.cms.gov/cciio/programs-and-initiatives/state-innovation-waivers/downloads/1332-data-brief-aug2021.pdf

Like Maryland, most states fund their state reinsurance program through assessments imposed on issuers of the premium earned by health insurance issuers. In 2022, the states that took this approach included Colorado, Delaware, New Hampshire, New Jersey, Maine, Montana, Oregon, and Pennsylvania. New Hampshire and Maine use a different methodology, but the total amount collected per policy is less than the amount collected in Maryland. Table 6.1 lists the assessment amount imposed by those states. Most states assess a percentage of premium.

| **STATE** | **2022 Reinsurance Assessment Rate** |
|---|---|
| Pennsylvania | 3% (only for issuers participating in the individual market) |
| Delaware | 2.75% |
| New Jersey | 2.5% |
| Oregon | 2.0% |
| Montana | 1.2% |
| Colorado | 1.15% for nonprofit insurers and 2.10% for for-profit insurers |
| Maryland | 1.0% |
| New Hampshire | 0.6% of previous year's second lowest cost silver plan |
| Maine | $4 per member per month |

Table 6.1: State 1332 Health Insurer Assessments

Most states that rely on premium assessments limit the assessment to fully-insured health insurance in their state. Oregon is an outlier in that it expanded the application of its two percent assessment to self-funded employee health plans sponsored by state and local governments, which is the only segment of the self-insured market over which state lawmakers have authority under ERISA. *See* 29 USC §1003(b)(1).

### 2. State premium taxes

In 2022, two states, Alaska and North Dakota, funded their reinsurance programs with funds generated through their state's general premium tax.[15] Neither state altered the premium tax rate in the state to accommodate reinsurance plan funding. Rather, each state made the policy decision to allocate a portion of the premium tax collected in the state to funding the reinsurance program as opposed to other programs or expenses.

In 2022, the Insurance Administration collected approximately $633,714,563 in premium tax. The amounts collected are paid to the General Fund for the benefit of the State, except for those amounts that are statutorily directed to specific uses. *See, e.g.* Section 6-103.2 of the Insurance Article, enacted in 2013. Section 6-105.3 of the Insurance Article, effective October 1, 2022, provides that a stand-alone dental plan carrier or stand-alone vision plan carrier that is subject to the Health Insurance Provider Fee imposed under § 6–102.1 in calendar year 2024 and each calendar year thereafter is exempt from the Health Care Regulatory Assessment under § 2–112.2 of this Article and the Annual Assessment Fee under § 2–502 of this Article for each year in which the Health Insurance Provider Fee is paid.

[15] North Dakota's health insurance assessment is 100% deductible from the state's premium tax, so it is functionally a premium tax. HB413 provided a similar credit to stand-alone dental and vision plans that pay the 1% premium assessment.

**3. General Funds**

In 2023, four states, Wisconsin, Georgia, and Minnesota, and Virginia, funded their reinsurance programs through annual appropriations from the state's general funds. New Jersey also authorizes the use of general funds if other designated sources are not sufficient to fund its reinsurance program.

Programs funded solely by general funds face budget uncertainty. In general, budget shortfalls are correlated with recessions, which tend to see loss of employer sponsored coverage and increased need for individual market programs. This means that program costs are likely to increase at the same time that the state budget is constrained. Additionally, by funding the program with an assessment each year, there is political uncertainty regarding allocation of general funds for program funding. If general funds allocated to fund the program are insufficient in a given year, this could result in large rate increases and market disruption.

This was most recently seen in Virginia. CMS approved Virginia's 1332 Waiver, which established a reinsurance program that is funded by general funds. Virginia's new reinsurance program had bipartisan support and successfully reduced average premiums by 17.3% compared to a scenario without reinsurance in 2023.[16] Nonetheless, no money was initially allocated in the budget for the reinsurance plan for plan year 2024. Had the program gone unfunded, rates would have spiked by 28% for plan year 2024.[17] Virginia lawmakers finally included reinsurance funding in a budget bill passed during a special session in September of 2023.[18] Carriers then resubmitted new, lower 2024 rates to account for the effect of a funded reinsurance program. The final 2024 average rate approval for Virginia's individual market plans was 0%.

Reinsurance programs are intended to bring stability to insurance markets. Relying on general funds does not ensure the stable funding that a reinsurance program needs for insurers to price confident assumptions of reimbursement into future rates. Funding uncertainty may also generate headlines regarding price increases and lead to consumer confusion that can reduce consumer confidence.

**4. Individual Mandate Penalty Payments**

As of 2022, two states, New Jersey and Rhode Island, funded their programs with penalty payments collected from those who do not comply with state individual mandates. If funding through penalty payments is not sufficient, New Jersey may also use general funds to support their program.

**5. Colorado**

Under Colorado's current 1332 Waiver, Colorado collects funds from a health insurance premium assessment, a temporary two-year hospital assessment, premium tax revenue, and general funds. The funds are then allocated across multiple affordability programs, including the reinsurance program and state premium assistance programs. Documentation from the state for 2021 reinsurance program year (which

[16] "Commonwealth Health Reinsurance Program," *Virginia State Corporation Commission,* https://scc.virginia.gov/pages/Reinsurance-Program.

[17] "Some 'Obamacare' plans could see big rate hikes after lawmakers fail to agree on reinsurance program," *AP News,* August 10, 2023, https://apnews.com/article/virginia-health-insurance-rates-obamacare-marketplace-youngkin-3cda7f0571e926e58b7bf1ed65230906.

[18] "Virginia lawmakers pass long-overdue budget bill with tax rebates, extra aid for schools," *AP News,* September 6, 2023, https://apnews.com/article/virginia-general-assembly-youngkin-budget-091b2fba598d03af7d39ff4fac66721b.

was under the state's initial five-year 1332 Waiver, states that state funding for that year was drawn from the health insurance premium assessment and state premium tax.[19]

#### 6. Stakeholder suggestions

Stakeholders have suggested alternative sources of funding for the SRP. Those suggestions include revenue from existing or increased tobacco, alcohol, and sugar-sweetened beverage taxes, as well as taxing the 100 largest historical emitters of carbon dioxide. These approaches are not used by any other states to fund their reinsurance programs.

One stakeholder group also commented in support of hospitals contributing to reinsurance funding. Colorado is the only state that uses a hospital assessment as part of their 1332 waiver funding mechanism; however, that assessment is temporary and it appears that funding collected was ultimately used to fund other affordability programs.

### B. Funding Amounts and Allocation

Maryland's 1% health insurance premium assessment is a stable source of funding for the reinsurance program. The 1% assessment does not appear to be deterring enrollment, which has grown 21% in the individual market since the reinsurance program launched, from 190,000 in July 2019 to almost 229,000 in June 2023. In addition, the agencies contributing to this report are not aware of any evidence that demonstrates the fee has negatively impacted enrollment in the small or large group fully insured markets in Maryland.

The state premium assessment replaced a federal health insurance premium assessment of approximately 2.75%, which the federal government suspended in 2019 and ultimately eliminated. Maryland's initial premium assessment of 2.75% allowed the state to collect the funding that was previously collected by the federal government. The rate was then reduced to 1% and that amount is sufficient to fund the SRP and has been fully accounted for within existing rates.

The assessment is apportioned appropriately among carriers. While the SRP directly supports the individual health insurance market, assessments are collected from all health plan issuers in the state, HMOs, MCOs, and stand-alone dental and vision plans. The Workgroup believes that this an appropriate allocation of responsibility among the health coverage industry operating in the state. The individual market is a particularly critical market, because it is the option of last resort for people who do not qualify for health coverage in any other market. Furthermore, the ability of individuals who are between jobs, or shifting out of Medicaid, or who have aged out of a parent's plan to obtain good health insurance serves the interests of all markets in assuring that health care continues and that individuals returning to employment or to a governmental plan do not present extraordinary pent-up risk. In addition, the 1% rate is accounted for in current cost for all of the entities on whom it is imposed and its continuation imposes no additional costs or burdens on those entities.

In addition to considering whether the assessment is appropriately apportioned among carriers, the workgroup was charged with considering whether the assessment "should be broadened to include other business sectors; and should be supplemented with the General Funds." To inform consideration of these questions, we examined other states' reinsurance funding mechanisms as of 2022, as described in the

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[19] For more information, see Colorado Senate Bill 20-215, available here: https://leg.colorado.gov/sites/default/files/2020a_215_signed.pdf. Information on state funding specifically used for Colorado's reinsurance program in 2021 is available here: https://drive.google.com/file/d/16x03F6x5at-IEcNbaoM-cX6b_lMza483/view

previous section. It is notable that the majority of states fund their programs using the same type of health insurance premium assessment used in Maryland.

Currently, only one state,[20] Colorado, incorporates an assessment on another business sector. As noted in the previous section, Colorado has a uniquely complex funding and allocation process for their insurance affordability programs. The state gathers a combination of funds from a health insurance premium assessment, a temporary two-year hospital assessment, premium tax revenue, and general funds. The funding is then allocated across multiple affordability programs, including reinsurance and a state premium assistance program. Although a two-year hospital assessment is part of this revenue stream, it appears that for the 2021 plan year, the most recent year for which payment data was publicly available, state funding specifically for the reinsurance program was drawn only from the health insurance premium assessment and state premium tax. Implementing a hospital assessment in Maryland would be challenging due to Maryland's Total Cost of Care (TCOC) Model. The TCOC Model is intended to constrain hospital costs, and adding a hospital assessment could jeopardize Maryland's ability to meet the TCOC goals in its agreement with the federal government.

One other state, Oregon, expanded their health insurance premium assessment beyond fully insured plans and imposes a premium assessment on state and local government self-insured public employee plans.

### C. Conclusion

Given the success, simplicity, and stability of Maryland's reinsurance funding mechanism, we recommend that Maryland continue to use a premium assessment to fund reinsurance, and do not recommend broadening the assessment to other business sectors or turning to state general funds to supplement funding.

Based upon the projections, it appears that the current 1.0% assessment is adequate, and given the considerations discussed above, it is recommended that no changes to the assessment amount or funding source are necessary at this time.

## VII. MARKET REFORMS

*HB413 requires consideration of "what market reforms are needed to provide affordable health coverage in the individual market, including: continuation of the Program past 2026; providing state-based premium subsidies; and expanding eligibility for the Maryland Medical Assistance Program."*

### A. Continuation of the Program Past 2026

CMS extended Maryland 1332 Waiver and the continuation of the SRP through the end of 2028. As discussed below, the SRP has stabilized the individual market, reduced premium, and led to increased enrollment in the individual market. Because of the SRP, Maryland's unsubsidized premium rates are among the very lowest in the nation. Importantly, the SRP is designed to provide flexibility to adjust program parameters and the size and cost of the Program when necessary. For example, should federal pass through amounts decrease, the state's options include adjustments to the SRP to address that change. Given the success and the flexibility of the SRP, the Workgroup strongly recommends that the SRP be

[20] Minnesota had previously funded the state portion of its section 1332 state-based reinsurance waiver, in part, through an assessment levied on hospitals and other providers. However, that assessment is no longer being levied: https://www.cms.gov/cciio/programs-and-initiatives/state-innovation-waivers/downloads/1332-data-brief-aug2021.pdf

continued indefinitely and that the state seek a continuation of the current 1332 Waiver in advance of its 2028 expiration.

| Benefit Year | Year over Year Premium Change (%) | Cumulative Premium Change (%) |
|---|---|---|
| 2014 | N/A | |
| 2015 | 10% | |
| 2016 | 18% | |
| 2017 | 21% | |
| 2018 | 28% | |
| Reinsurance Starts | | |
| 2019 | -13.2% | -13.2% |
| 2020 | -10.3% | -22.1% |
| 2021 | -11.9% | -31.4% |
| 2022 | 2.1% | -30.0% |
| 2023 | 6.6% | -25.3% |
| 2024 | 4.7% | -21.8% |

Table 7.1: Premium Rate Changes Year over Year 2015 through 2024, and Cumulative Premium Changes after Reinsurance Starts.

As seen in Table 7.1, rates in the individual market are approximately 22% lower than they were in 2018, the year before the SRP started. Additionally, total individual market enrollment has increased by approximately 20% since the start of the SRP.

The SRP is functioning as intended. The initial goal was to decrease individual health insurance rates by approximately 30% over the first three years of the program. The SRP exceeded that goal by achieving a cumulative average rate decrease of 31.4% over the first three years. After the first three years, the SRP was intended to keep average rate increases in line with increases in cost trends. Again, the SRP has exceeded this goal, with an average annualized increase of 4.5%, even though cost trends have been higher.

If the SRP were allowed to sunset, there would be severe ramifications for the individual market. The impact is best understood in the context of the rate crises that lead to the establishment of the SRP through emergency legislation in the 2018 Session.

Prior to implementation of the SRP, average double digit rate increases were approved for the individual market each year from 2015 through 2018, with increases as high as 50% looming for the 2019 plan year. That is because, while market reform measures (like guarantee issue) had been present in the Maryland small group market for decades, that was not true of the individual market. Prior to the passage of the ACA, insurers were permitted to underwrite individual health insurance applicants and coverage could be denied, limited and/or rated based on pre-existing conditions. Individuals who could not pass medical underwriting could obtain coverage through the Maryland Health Insurance Program (MHIP), a state-funded high risk pool, that was required to insure those who were otherwise unable to obtain health insurance. As a result, average claims in the individual market were far below the average claims in the small group market, and resulted in affordable premiums for those able to pass underwriting and obtain individual coverage.

When the ACA became fully effective in 2014, underwriting and rating based upon health status were no longer permitted in the individual market, plans had to be offered on guaranteed issue basis, and modified community rating was required. These market reforms already existing for Maryland's small group, which did not experience any significant rating impacts as a result of the implementation of the

ACA. However, the implementation of these reforms had a profound and drastic impact on the Maryland's individual market.

MHIP no longer existed to absorb the highest risk applicants. The influx of individuals previously denied access to the individual market caused the average claims level of the individual pool to drastically increase; morbidity in the individual market more than doubled over the first 5 years of the ACA. That drastic increase in claims drove increases in rates, which drove reductions in enrollment by younger healthier people, which drove increases in rates to offset the drop in premium from low claim enrollees – which created the "death spiral" that necessitated the creation of the reinsurance program as a means of effectively removing a layer of claims from rates by allowing carriers to recoup those costs through a pool funded by federal and state dollars.

If that mechanism (the SRP) were removed, rates would begin to spiral again. To illustrate, the total cost of providing coverage for mandated essential health benefits under the ACA is higher in the individual market than the small group market. These costs are reflected in the "index rate," which is defined as the total cost of providing coverage for the mandated essential health benefits under the ACA. In 2022, the index rate in the individual market was $623 per member per month (PMPM), while the index rate in the small group market was $502 PMPM. The index rate in the individual market has consistently been significantly higher than that of the small group market, ranging from 33% higher in 2020 to 24% higher in 2022. While the SRP is having a positive impact, even with the SRP in place, in 2022, the PMPM cost of coverage in the individual market was approximately 24% higher than in the small group market.

The higher claims in the individual market result from fewer healthy members enrolling in the individual market than the small group market. The cost to the enrollee is a significant factor in the enrollment. Absent subsidies, enrollees in the individual market pay 100% of the policy premium. However, small group market premium is often subsidized significantly by the employer. According to the 2023 Kaiser Family Foundation employer health benefits survey[21], employers on average subsidize 75% of monthly healthcare costs for their employees. This subsidization lowers the monthly premium that a member pays in the small group market to an affordable level. In the individual market, unsubsidized members are expected to pay the full premium without any financial assistance.

Without the SRP in place, premiums for unsubsidized members would not be affordable even if various state and federal initiatives were able to improve the health status of the individual pool and bring the individual index rate in line with the small group index rate. While Marylanders who receive federal subsidies are shielded from large increases, the approximately 43% of the market who purchase full price unsubsidized coverage would experience the full magnitude of these levels of increase. The majority would be forced to reduce their benefits to offset the premium increase (gold is the current most popular level; bronze was the most popular metal level in 2018); and a meaningful portion of the pool would be expected to drop coverage. The portion of the pool that lapses would be healthier members with low claims, and there is a large risk that an anti-selection spiral would resume. This would lead to significant rate increases as was observed in 2015-2018, eliminating years of progress made to achieve a stable Individual market that offers affordable healthcare options to the majority of state residents. As Marylanders priced out of the Individual marketplace go uninsured, uncompensated care costs would increase, which is built into hospital rates by the HSCRC and leads to higher spending for all payers. Virginia offered a recent real-life example of this dynamic when carriers initially filed substantial, double digit 2024 individual rate increases when they believed their reinsurance program would not be funded.

[21] https://www.kff.org/health-costs/report/2023-employer-health-benefits-survey/

There is a fundamental need for the SRP. The health of the individual market depends on its continuation.

## B. State-Based Subsidies

### 1. Uninsured Rate Data by Cohort

In considering the market place reforms and subsidies that are needed to improve access to affordable care for all Marylanders, the Workgroup considered current information on uninsured rates across cohorts that was developed by the State Health Access Data Assistance Center (SHADAC). To assist in the analysis and assessment of the effectiveness of existing federal and state market reforms and identifying priority groups for potential future reforms, the SHADAC analyzed data from the two most recent U.S. Census American Community Surveys.[22] A summary of uninsured rates by cohort in 2019 and 2021 is provided in Table 7.2, below.

Source: SHADAC (US Census American Community Survey)

| Uninsured | 2019 | 2021 | Change (2021 - 2019) |
|---|---|---|---|
| Maryland Total | 6.0% | 6.1% | 0.1% |
| | | | |
| Age | | | |
| 0-18 | 3.2% | 4.5% | 1.3% |
| 19-64 | 8.2% | 8.1% | -0.1% |
| 19-25 | 9.2% | 9.2% | 0.0% |
| 26-34 | 12.0% | 10.4% | -1.6% |
| 35-54 | 7.8% | 8.0% | 0.3% |
| 55-64 | 5.0% | 5.3% | 0.3% |
| 65+ | 0.9% | 0.8% | 0.0% |
| Race/Ethnicity | | | |
| Hispanic | 20.2% | 20.5% | 0.3% |
| Asian, NH | 5.8% | 5.8% | -0.1% |
| Black, NH | 5.6% | 5.7% | 0.1% |
| Other race/multiple races | 5.2% | 5.6% | 0.5% |
| White, NH | 3.0% | 3.0% | 0.0% |
| Poverty Level | | | |
| 0-138% FPG | 11.4% | 12.2% | 0.8% |
| 139-250% FPG | 9.6% | 9.9% | 0.4% |
| 251-400% FPG | 6.5% | 6.2% | -0.4% |
| 401%+ FPG | 2.0% | 2.2% | 0.2% |
| Citizenship | | | |
| Not a U.S. Citizen | 32.0% | 31.9% | -0.1% |
| U.S. Citizen | 3.8% | 4.1% | 0.3% |

Table 7.2: Uninsured Rates by Age, Race/Ethnicity, Poverty Level, and Citizenship.

The data presented in Table 7.2 shows that the uninsured rate among Marylanders who are U.S. citizens is 4.1%, which includes those who are being assisted by federal APTC and CSR subsidies and by state Young Adult subsidies. The uninsured rates differ significantly, however, among cohorts and is the highest among non-US citizens, Hispanic people, and young adults in the 26 – 34 age range. It will be important to keep this data in mind in considering which populations to target for subsidies in order to encourage them to obtain health insurance. Enabling healthy people to obtain and use health insurance improves the health of the pool and keeps rates in check. And enabling all people to obtain and use health insurance rather than emergency services for which they cannot pay reduces the uncompensated care costs that are ultimately born by all Marylanders, including increasing hospital rates.

[22] https://www.shadac.org/sites/default/files/publications/1_year_ACS/ACS_19-21_MD.pdf

### 2. Overview of Federal ACA Subsidies

The ACA created two federal income-based subsidy programs for qualifying Marketplace enrollees, which provide both premium assistance through APTC, as well as assistance for out-of-pocket costs through CSRs. Both are available to Maryland residents who are U.S. citizens or have a legal immigration status; including those who are in their five-year waiting period to be eligible for Medicaid.

APTC reduces the enrollee's monthly premium payments by providing advance tax credits based on an enrollee's estimated income. The amount of the tax credit is computed as the amount needed to bring the cost of the "benchmark" second lowest cost silver plan down to an expected contribution level, which varies according to household income as a percentage of the FPL. Note that if the unsubsidized premium is lower than the expected contribution, no APTC is given. APTC can be used to purchase any plan on the marketplace except Catastrophic plans, and can only be applied to the EHB portion of premiums. ARPA enhanced APTC by reducing the amount an individual is expected to contribute towards the benchmark plan, and eliminated the income eligibility cap for the years 2021 and 2022.[23] The IRA extended these changes through the end of 2025.

| **FPL** | **2023 Expected Contribution (EC) as a percent of Household Income (Federal Reference Amounts)** | |
|---|---|---|
| | **Amount under Original ACA** (if ARPA were not in effect) | **Current Amount under ARPA** |
| **138%** | 3.10% | **0.00%** |
| **150%** | 3.84% | **0.00%** |
| **200%** | 6.05% | **2.00%** |
| **250%** | 7.73% | **4.00%** |
| **300%** | 9.12% | **6.00%** |
| **350%** | 9.12% | **7.25%** |
| **400%** | 9.12% | **8.50%** |
| **450%** | No limit | **8.50%** |
| **500%** | No limit | **8.50%** |
| **600%** | No limit | **8.50%** |

Table 7.3: Comparison of 2023 expected contributions as a percent of household income, with and without changes due to ARPA. The expected contribution is interpolated for FPLs between 150% and 400% FPL.

CSRs are the second form of federal subsidies. CSRs reduce out-of-pocket costs, including deductibles, copays, and coinsurance for qualified enrollees. Under the ACA, plans are classified by metal levels with corresponding actuarial values (AVs), which is the measure of the share of health care claims costs (excluding premiums) that an insurer pays, on average, compared to an enrollee in a plan year. Plans are classified as Bronze, with an AV of about 60 percent; Silver, with an AV of about 70 percent; Gold, with an AV of about 80 percent; and Platinum, with an AV of about 90 percent.[24] Eligible consumers must enroll in a Silver plan to access CSRs.[25] Consumers with a household income below 150% FPL are eligible for CSRs that increase the value of a Silver plan to 94% AV; those with household incomes between 150%

[23] Pre-ARPA APTC eligibility was capped at incomes at or below 400 percent of the federal poverty level (FPL)

[24] Exact ranges for permissible AVs for each metal level are determined by CMS and were last updated in 2023: https://www.cms.gov/newsroom/fact-sheets/hhs-notice-benefit-and-payment-parameters-2023-final-rule-fact-sheet.

[25] American Indian CSR plans are available at all metal levels.

and 200% FPL are eligible for CSRs that increase the value of a Silver plan to 87% AV; and those with household incomes between 200% and 250% FPL are eligible for CSRs that increase the value of a Silver plan to 73% AV.

In the early years of the ACA, the CSR subsidies were funded by the federal government, so that the reduction of cost-sharing for low-income members would not impact silver premiums. This meant that bronze premiums were cheaper than silver premiums, which were cheaper than gold premiums, as would be expected based on AVs. However, in 2018 the federal government ceased funding CSRs, and in order to ensure that rates were adequate it was necessary for the Insurance Administration to require all carriers to "CSR-load" the on-exchange silver premiums to reflect the costs associated with the required reduction of cost-sharing. Because the majority of on-exchange silver members are in 87% or 94% CSR plans, the average AV of a silver plan when accounting for CSRs is higher than gold's 80%, and therefore silver premiums are also higher than gold.

The side effect of the federal CSR defunding and the CSR-loading is that APTCs are significantly higher than they would be if CSRs were funded. This has benefitted Maryland consumers who are able to use the higher APTCs to buy gold plans. It has also benefited the federal funding of the 1332 waiver since pass-throughs are based on a CSR-loaded silver premium. If at some point in the future the federal government allocates money to fund CSRs again, there would be a significant impact on all results modeled in this report. That impact has not been quantified and would require additional analyses.

### 3. Overview of States that Provide Additional Subsidies Through State-Funded Programs

In addition to the federal ACA subsidies, a number of states have implemented state-funded subsidy programs to further reduce low-income enrollees' costs. An overview of these programs is set forth below.[26]

#### a. Synopsis of State-Funded Subsidy Program Parameters

Maryland currently operates a state-funded premium subsidy program for young adults, which provides additional premium assistance to young adults up to 400% FPL and between age 18-34.ʾ Age eligibility for the Maryland young adult subsidy was expanded up to age 37 beginning in 2024.The subsidy is currently structured to lower a young adult's expected contribution as a percent of income by up to 2.5%, with the constraint that 0% is the minimum expected contribution.

In addition to Maryland, seven states have implemented additional state-funded premium assistance: California (CA), Connecticut (CT), Massachusetts (MA), New Jersey (NJ), New Mexico (NM), Vermont (VT), and Washington (WA).[27] Two of these state programs pre-date the ACA subsidies (MA and VT) while others have been implemented within the last few years. The programs vary in generosity, both in income-based eligibility parameters and subsidy amount available to enrollees, as well as

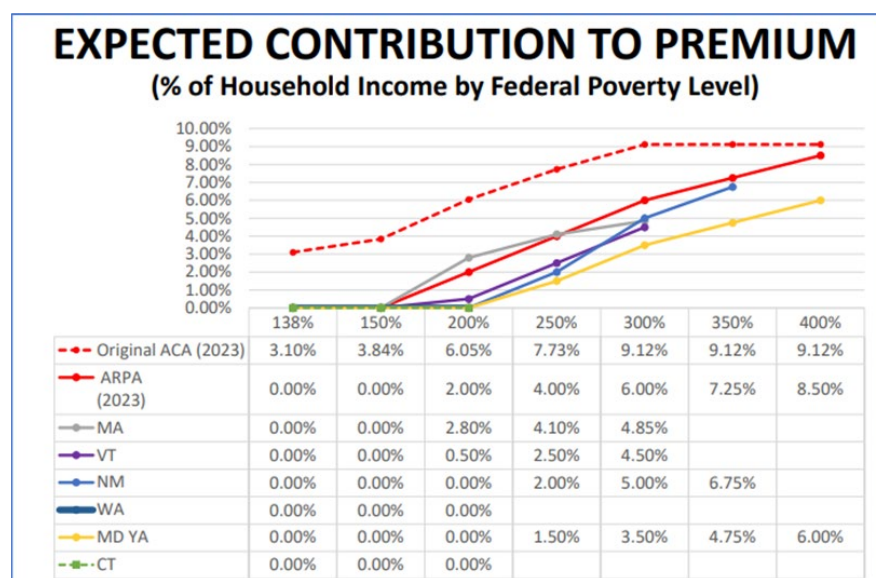
[26] This overview does not include information on Basic Health Programs, which are operated in Minnesota and New York. Basic Health Programs are a state option under the ACA that can be used to reduce costs for low-income consumers between 138% and 200% FPL. However, they differ in fundamental ways from a state subsidy program that builds on federal APTC and CSRs. Basic Health Programs generate federal funding by leveraging savings between Medicaid-level reimbursement rates and commercial reimbursement rates. Because of Maryland's unique Total Cost of Care model, under which hospital rates are set for all payers with a very narrow public-private payer differential compared to other states, it is unlikely that a Basic Health Plan could be financially feasible in Maryland.

[27] California implemented state premium subsidies in 2020, but suspended the program in 2021 after the introduction of enhanced federal ARPA subsidies which exceeded the generosity of the state subsidies.

mechanisms used to generate funding for the programs. Maryland is the only state that restricts its premium subsidy program by age.

Four states (CT, MA, NM, and VT) have a structure similar to the current Maryland Young Adult Subsidy in which they reduce an individual's federal expected contribution towards the benchmark plan by a given percentage of income, and use the state subsidy to cover the difference. Two states (NJ and WA) provide additional state premium subsidies as a flat per member per month (PMPM) dollar amount. In addition, California implemented an APTC-like premium subsidy in 2020, but largely suspended it in 2021 when federal ARPA subsidies were implemented.

Figure 7.4 shows the expected contribution for individuals in each state with APTC-like state premium assistance, including Maryland, compared to both original ACA and ARPA enhanced federal APTC. As the table demonstrates, Maryland offers the most generous premium subsidy, but limits the subsidy to young adults; the other states shown make their subsidies available regardless of age.




| | 138% | 150% | 200% | 250% | 300% | 350% | 400% |
|---|---|---|---|---|---|---|---|
| Original ACA (2023) | 3.10% | 3.84% | 6.05% | 7.73% | 9.12% | 9.12% | 9.12% |
| ARPA (2023) | 0.00% | 0.00% | 2.00% | 4.00% | 6.00% | 7.25% | 8.50% |
| MA | 0.00% | 0.00% | 2.80% | 4.10% | 4.85% | | |
| VT | 0.00% | 0.00% | 0.50% | 2.50% | 4.50% | | |
| NM | 0.00% | 0.00% | 0.00% | 2.00% | 5.00% | 6.75% | |
| WA | 0.00% | 0.00% | 0.00% | | | | |
| MD YA | 0.00% | 0.00% | 0.00% | 1.50% | 3.50% | 4.75% | 6.00% |
| CT | 0.00% | 0.00% | 0.00% | | | | |

Figure 7.4: Expected contribution for individuals in states with additional premium assistance, compared to both federal expected contribution levels with and without ARPA

Five states (CO, CT, MA, NM, VT) currently have state-funded CSR programs to supplement federal CSRs. Colorado provides only additional CSRs, while the other four states provide both state-funded CSR and state premium assistance. In addition, California is implementing a state-funded CSR program in 2024.

Most states provide more targeted subsidies to eligible enrollees under the 300% FPL range (CA, MA, VT, WA, CT). Connecticut's premium and cost-sharing subsidy program has the lowest income threshold, capping eligibility at 175% FPL, but reduces premiums and cost sharing to $0 for all eligible enrollees. New Jersey's program has the highest income limit, with individuals up to 600% FPL eligible for more modest additional state premium assistance. Massachusetts's premium subsidy provides moderate additional assistance beyond ARPA-enhanced APTC, however the state seems to provide the most generous state CSR subsidy available to a higher income threshold.

For the majority of states, the state subsidies have been in place for too short of a time to yield useful data. The exception is MA and VT, where data does show that state reforms have been extremely effective. Since the ACA began, these two states have been amongst the lowest uninsured rates in the

country. For 2021, MA has the lowest uninsured rate of 2.4% and VT has the second lowest of 3.9%; compared to MD’s 6.1%. However; both of these states implemented complex and comprehensive market reforms that included the merger of individual and small group markets, individual and small group mandates to purchase insurance, and the simultaneous availability of both premium and cost-sharing subsidies. Until there has been enough time for the newer states that are providing subsidies in a more typical unmerged markets, it is difficult to estimate how much of the success in MA/VT is due to subsidies, other reforms, or the synergy between the two.

Table 7.5 provides a general overview of state funded subsidy program parameters by state.

| Summary of State-Funded Marketplace Subsidy Programs by State | | |
|---|---|---|
| **State** | **Subsidy Type and Eligibility** | **Parameters** |
| **California**[28, 29, 30] (premium subsidy program suspended since 2021) | **Premium:**<br>APTC eligible consumers up to 600% FPL<br><br>**Cost-Sharing:**<br>APTC eligible consumers up to 250% FPL, starting in 2024 | *2021 Parameters:<br>● <138% FPL : 0% contribution<br>● 138-400% FPL: Modest reduction<br>● 400-600% FPL: Caps contributions between 9.68-18%<br><br>Cost-sharing subsidies<br>● <150% FPL: increases silver CSR AV slightly compared to federal standard of 94%<br>● 150-200% FPL: increases silver CSR AV to ~90% (compared to federal standard of 84%)<br>● 200-250% FPL: increases silver CSR AV to ~80% (compared to federal standard of 73%) |
| **Massachusetts**[31] | **Premium:**<br>APTC eligible consumers up to 300% FPL<br><br>**Cost-Sharing:**<br>Same as premium eligibility | Additional premium subsidies that further reduce expected contribution (EC) below federal levels, by FPL:<br>● 0-150% FPL: 0% (vs 0-2% federal EC)<br>● 150-200% FPL: 2.8% (vs 0-2% federal EC)<br>● 200-250 FPL: 4.1% (vs 0-2% federal EC)<br>● 250-300% FPL: 4.85% (vs 0-2% federal EC)<br><br>Cost sharing increases AV value of plans to between 92% and 99.6% |
| **Vermont**[32, 33] | **Premium:**<br>APTC eligible consumers up to 300% FPL<br><br>**Cost-Sharing:**<br>APTC eligible consumers between 200-300% FPL | Premium assistance reduces expected contribution by an additional 1.5% of household income, from (pre-ARPA) ACA standards.<br><br>Cost sharing further reduces co-payments, co-insurance, & deductibles.<br>● 200-250% FPL: increases silver CSR AV to 77% (compared to federal standard of 73%)<br>● 250-300% FPL: Eligible for silver CSR AV of 73% (federal cutoff for CSR eligibility is 250% FPL) |
| **New Mexico**[34] | **Premium:**<br>APTC eligible consumers up to 400% FPL<br><br>**Cost Sharing**:<br>APTC eligible consumers | Additional premium subsidies - expected contributions by FPL:<br>● <200%: 0% (vs 0-2% federal EC)<br>● 200-250%: 0-2% (vs 2-4% federal EC)<br>● 250-300%: 2-5% (vs 4-6% federal EC)<br>● 300-400%: 5-8.5% (vs 6-8.5% federal EC) |

[28] https://hbex.coveredca.com/toolkit/pdfs/CA_Premium_Subsidy_vs_CA_Premium_Credit.pdf
[29] MHBE Individual Subsidy Workgroup, 10/15/2022 Presentation
[30] https://www.coveredca.com/newsroom/news-releases/2023/07/20/covered-california-to-launch-state-enhanced-cost-sharing-reduction-program/
[31] MHBE Individual Subsidy Workgroup, 10/22/2022 Presentation
[32] https://dvha.vermont.gov/sites/dvha/files/doc_library/Health%20Program%20Eligibility%20Tables.pdf
[33] https://info.healthconnect.vermont.gov/sites/vhc/files/doc_library/2023%20Eligibility%20APTC%20Threshold.pdf
[34] https://a.storyblok.com/f/132761/x/7512ccd5ca/health-insurance-marketplace-affordability-program_policies-and-examples_221014.pdf

| | | |
|---|---|---|
| | up to 300% FPL | • >400%: no state subsidy<br><br>Cost sharing increases AV plan values to 85% up to 99% based on income |
| **Connecticut**[35] | **Premium:**<br>APTC eligible consumers under age 65 with income below 175% FPL<br><br>**Cost-Sharing:**<br>Same as premium eligibility | Plans have $0 premiums and no cost-sharing for all qualifying consumers.<br>• After eligible consumer enrolls in silver plan and accepts all available federal subsidies, CT fully subsidizes remaining consumer costs: $0 premiums, no deductibles, no copays/coinsurance |
| **New Jersey**[36] | **Premium:**<br>APTC eligible consumers up to 600% FPL | Additional premium subsidies as a **flat per member per month (PMPM)** amount based on income.[37]<br>• 138-150% FPL: up to $40/month<br>• 150-200% FPL: up to $50/month<br>• 200-400% FPL: up to $100/month<br>• 400-600% FPL: up to $50/month<br><br>PMPM amounts based on NJ cost estimate tool for 2023 plans. |
| **Washington**[38] | Premium:<br>APTC eligible consumers up to 250% FPL | Additional premium subsidies as a **flat per member per month (PMPM)** amount based on income (up to $155 PMPM).<br><br>Most eligible consumers will have a reduced net monthly premium of $5 or less |
| **Colorado**[39] | **Cost Sharing:**<br>APTC eligible consumer between 150-200% FPL | Increases CSR level to 94% (compared to federal standard of 87% for this income bracket) |

Table 7.5: Summary of State-Funded Marketplace Subsidy Programs by State

[35] https://access-health-ct.helpjuice.com/en_US/covered-connecticut-program
[36] https://nj.gov/getcoverednj/financialhelp/premiums/
[37] Limited information is publicly available for New Jersey's subsidy parameters. PMPM estimates by FPL are based on their Marketplace's cost estimate tool for 2023 plans: https://enroll.getcovered.nj.gov/hix/preeligibility#/
[38] https://www.wahbexchange.org/about-the-exchange/what-is-the-exchange/cascade-care/cascade-care-savings/
[39] https://content.naic.org/sites/default/files/national_meeting/Colorado%27s%201332%20Waiver%20Amendment_NAIC.pdf

### c. Funding for State Subsidies

States utilize a variety of mechanisms to provide sustainable funding sources for their state subsidy programs, both through generating additional state revenue and by taking advantage of federal dollars through federal waiver programs.

Some states simply designate funds from their state general fund towards these programs each fiscal year. However, most states generate additional state revenue that finances either part or the entirety of the costs of additional premium and cost sharing subsidies, most commonly via state premium taxes or assessments on certain health plans. Massachusetts notably has multiple state funding sources which contribute to their robust subsidy program, including revenue from their state individual mandate penalties, a portion of the state cigarette tax, as well as a state employer assessment on the first $15,000 of each employee's wages.

A few states make use of federal waiver programs to generate federal dollars to fund their subsidy programs, in addition to state dollars. New Jersey uses federal pass-through revenue from their Section 1332 waiver to supplement costs for their state premium subsidy program. The Massachusetts, Vermont, and most recently Connecticut state subsidy programs all operate with supplemental federal financial participation (FFP) dollars from Medicaid 1115 waivers that match a portion of these states' spending on additional premium and cost-sharing subsidies.

| Summary of Funding Mechanisms for Marketplace Subsidy Programs by State | |
|---|---|
| **State** | **Funding** |
| **California (2020)**[40] | State funds: Appropriations from the state general fund ($304 million in 2020) |
| **Massachusetts**[41] | State funds: A portion of the state cigarette tax, individual mandate penalties, and employer assessment<br><br>Federal funds: Federal match under state's Section 1115 waiver |
| **Vermont**[42] | State funds: 1% tax on all health insurance claims paid by health insurers<br><br>Federal funds: Federal match under state's Section 1115 waiver |
| **New Mexico**[43] | State funds: Increased premium assessment from 1% to 3.75% (beginning January 2022). Estimated to generate around $165 million annually. |
| **Connecticut**[44, 45] | State funds: Appropriations from the state general fund<br><br>Federal funds: Federal match under state's Section 1115 waiver |
| **New Jersey**[46] | State funds: 2.5% premium tax<br><br>Federal funds: Federal pass-through under state's Section 1332 waiver |
| **Washington**[47] | State funds: Appropriations from the state general fund ($50 million in FY2021) |
| **Colorado**[48] | State funds: Premium assessment and special assessment on Colorado hospitals (2022 and 2023 only), part of state premium tax<br><br>Federal funds: Federal pass-through under state's Section 1332 waiver |

Table 7.6: Summary of Funding Mechanisms for State-Funded Marketplace Subsidy Programs by State

#### d. 1115 Waiver Funding for State Premium Subsidies

Medicaid 1115 Demonstration Waivers allow states to waive certain provisions of the Medicaid law and receive additional flexibility to design and improve their programs. The waiver authority's broadly defined purpose provides states the opportunity to receive FFP funds for demonstration proposals that CMS determines are likely to assist in promoting the objectives of the Medicaid statute. Proposals under a 1115

[40] https://lao.ca.gov/Publications/Report/4681
[41] https://www.mahealthconnector.org/wp-content/uploads/MA-Cost-Sharing-Subsidies-in-ConnectorCare-Brief-083021.pdf
[42] Department of Vermont Health Access - Annual Report for State Fiscal Year 2021 (page 101)
[43] https://www.nmlegis.gov/handouts/ALFC%20092121%20Item%2022%20OSI.pdf
[44] Connecticut Office of Health Strategy FY 23 budget
[45] CMS Approval letter 12/15/22 - CT 1115 Waiver
[46] https://pub.njleg.state.nj.us/publications/budget/governors-budget/2023/DOBI_analysis_2023.pdf
[47] https://www.hca.wa.gov/assets/hbe-cascade-care-savings-announcement.pdf
[48] Evaluation of the Colorado Health Insurance Affordability Enterprise FY 2022/23

waiver must be "budget neutral," meaning the demonstration does not result in federal Medicaid costs that are greater than likely Medicaid costs to the federal government absent the demonstration. Massachusetts was the first state to receive approval from CMS to receive FFP under their 1115 waiver to provide funding for state Marketplace subsidies for QHP enrollees.[49] Vermont and Connecticut have since received approval for similar use of FFP funds under their 1115 waivers. At present, this is the only funding mechanism the Workgroup is aware of to receive federal funding specifically for state marketplace subsidy programs.

Connecticut recently received approval for an 1115 waiver beginning December 15th, 2022 for a five year waiver period. The waiver enables the state to implement their "Covered Connecticut" program which provides $0 premium/$0 cost-sharing plans to eligible enrollees under age 65 with income between 138% and 175% FPL, with plan benefits comparable to those under Connecticut Medicaid.[50] The Connecticut legislature had considered two options for expanding access to affordable health insurance for low-income individuals who earn too much to qualify for Medicaid but not enough to afford private Marketplace coverage: 1) expanding Medicaid eligibility from 138% to 175% FPL (no federal waiver required) or 2) establish a state-funded subsidy program for Marketplace enrollees up to 175% FPL, using an 1115 waiver to receive FFP for the program. Their rationale for ultimately choosing the waiver route was that pairing current federal Marketplace subsidies with FFP from the 1115 waiver to provide additional state subsidies for this population would provide affordable health insurance coverage to more people with the same amount of state funds than by expanding Medicaid.

The potential risk associated with the 1115 waiver approach is the financial liability to the state for ensuring "budget neutrality" of a demonstration program. Due to the nature of this type of demonstration, the covered population under the waiver is considered "hypothetical" by CMS. As a result, there are inherent challenges with evaluating the demonstration due to the lack of a comparable population. Total state subsidy costs are subject to a hypothetical budget neutrality test, which subjects hypothetical expenditures to predetermined limits approved by CMS as a part of this demonstration approval. If the state's actual spending exceeds the agreed-upon expenditure limit, the state may be liable to offset excess spending with state funds or pay funds back to CMS.

It should be noted that no state is simultaneously receiving federal pass-through funding from a 1332 waiver and also receiving federal funding to fund Individual marketplace subsidies through an 1115 waiver. It is uncertain exactly how the two programs would interact. Federal 1115 waivers are even more complex than 1332 waivers and Maryland already has an existing 1115 waiver into which any new demonstration waiver would need to be incorporated. If the state wishes to pursue the possibility of modifying its 1115 waiver to fund a state subsidy and CSR program, a separate analysis should be performed by MDH and MHBE on the feasibility, potential benefits, and potential risks.

### 3. Evaluation of Maryland State-Funded Premium Subsidy Options

Four different scenarios were modeled for a supplemental state premium subsidy (SSPS) funded by the State in plan year 2026. The modeling used a flat PMPM framework, where all eligible enrollees would receive a fixed monthly subsidy amount to cover all or a portion of an eligible enrollee's net premium after federal APTC are applied. Upon consideration, the workgroup concluded that a fixed PMPM amount structure would more equitable than the APTC-like structure used by most other states because it is innately progressive: a fixed subsidy amount covers a larger percentage of the residual premium for qualifying low-

[49] https://www.mahealthconnector.org/wp-content/uploads/MA-Cost-Sharing-Subsidies-in-ConnectorCare-Brief-083021.pdf
[50] https://www.medicaid.gov/sites/default/files/2022-04/covered-ct-appl-with-cvr-ltr-pa.pdf

income enrollees, compared to qualifying enrollees at higher incomes. Lower income enrollees are more likely to be uninsured, so a flat PMPM subsidy design may more effectively target funding to reduce uninsured rates.

Contracted actuarial firm Lewis & Ellis (L&E) modeled four subsidy scenarios at $40, $75, $100, and $125 PMPM and included additional modeling parameters described below.

- Only those receiving a non-zero amount of APTC would be eligible to receive the SSPS.
- The SSPS amount received would be the lesser of the SSPS and the amount needed to reduce an enrollee's net premium for the benchmark silver plan to $0. For example, an individual with a $60 monthly net premium after receiving APTC for the benchmark plan would receive the total amount in the $40 scenario but only $60 in the $75 scenario.
- Maryland's Young Adult Subsidy Program would be phased out and replaced by the SSPS.

Table 7.7 shows the total costs to the state for each scenario. The cost estimates do not assume any new enrollment due to the subsidy's implementation.

| $40 PMPM Subsidy | $75 PMPM Subsidy | $100 PMPM Subsidy | $125 PMPM Subsidy |
|---|---|---|---|
| $55,459,728 | $102,771,347 | $132,732,185 | $159,023,586 |

Table 7.7: 2026 Supplemental State Subsidy Cost for Existing Individual Market Enrollees

The reduction in net premiums from the introduction of an SSPS is expected to increase individual market enrollment both by attracting new enrollees who are uninsured and by lowering lapse rates for existing enrollees.

Table 7.8 shows the estimated enrollment changes due to uptake from the previously uninsured population as well as new enrollment due to a reduction in lapses because of lower premiums.

| Cohort | $40 PMPM Subsidy | $75 PMPM Subsidy | $100 PMPM Subsidy | $125 PMPM Subsidy |
|---|---|---|---|---|
| New Enrollment – Uninsured | 7,892 | 13,005 | 17,867 | 19,208 |
| New Enrollment – Lapse Reduction | 2,013 | 3,101 | 3,671 | 4,128 |
| **Total** | **9,905** | **16,106** | **21,538** | **23,335** |

Table 7.8: 2026 Enrollment Impact of SSPS

In addition to the subsidy cost, the State must also cover the cost of any new enrollee's reinsurance claims through the SRP. The uninsured cohort purchasing coverage is projected to be healthier relative to the market average because of their previous decision to forgo coverage. As a result, the expected reinsurance claims per member per year (PMPY) for new enrollees are projected to be much lower than the market average. New enrollees also generate reinsurance pass-through funding due to being covered by the SRP and receiving APTC. The modeling projected that new enrollees will generate more pass-through funding than the cost of providing the program benefits to the new enrollees. Based on these projections, the modeling estimated that without SSPS implementation, 2026 pass-through funding would cover 84% of SRP costs, and with SSPS implementation, new enrollees would generate pass-through funding equivalent to 122% to 154% of their SSPS costs (both premium subsidy and reinsurance costs). Table 7.9

below outlines these estimates for the total number of new enrollees (outlined in Table 7.8) resulting from SSPS implementation.

| | $40 PMPM Subsidy | $75 PMPM Subsidy | $100 PMPM Subsidy | $125 PMPM Subsidy |
|---|---|---|---|---|
| Program Costs PMPY | $1,764 | $1,889 | $2,116 | $2,144 |
| Pass-through PMPY | $2,717 | $2,621 | $2,699 | $2,619 |
| Pass-through % of Costs | 154% | 139% | 128% | 122% |

Table 7.9: 2026 Pass-through costs for the total estimated new enrollees outlined in table 7.7

Table 7.10 shows the total costs of the program for existing and new enrollees. Although the cost of new enrollment is projected to be offset by the reinsurance pass-through generated by their enrollment, the cost of subsidies for existing enrollees is significantly more than the amount offset, resulting in a total state cost of between $46M and $148M depending on the generosity of the subsidy.

| | $40 PMPM Subsidy | $75 PMPM Subsidy | $100 PMPM Subsidy | $125 PMPM Subsidy |
|---|---|---|---|---|
| Existing Enrollee Cost | $55,459,728 | $102,771,347 | $132,732,185 | $159,023,586 |
| New Enrollee Cost | ($9,444,933) | ($11,788,316) | ($12,558,939) | ($11,085,443) |
| **Total Cost** | **$46,014,795** | **$90,983,031** | **$120,173,246** | **$147,938,143** |

Table 7.10: 2026 Total SSPS Cost

**Evaluation of Maryland State-Funded Cost Sharing Reduction Subsidy Options**

The ACA currently provides for CSRs for enrollees with incomes under 250% FPL. Enrollees with an income less than or equal to 150% FPL who are ineligible for Medicaid, are eligible for CSR 94 plans (silver plan with 94% AV), those with an income greater than 150% and less than or equal to 200% FPL are eligible for CSR 87 plans (silver plan with 87% AV), and those with an income greater than 200% and less than or equal to 250% of FPL are eligible for CSR 73 plans (silver plan with 73% AV). These AVs are achieved by reducing the out-of-pocket costs (copays, deductibles and annual maximum) that an eligible insured is responsible for, as compared with the standard version of the silver plan. The table below outlines cost-sharing for the standard plans in 2024, which must be offered by all carriers. Note that medical and drug services have separate deductibles and out-of-pocket maximums. The combined individual out-of-pocket maximum is limited by federal regulation to: $9,450 for non-CSR plans; $7,550 for the 73% CSR plan; and $3,150 for the 87% and 94% CSR plans.

## Understanding Value Plan Costs 2024

Blue text means this is the amount you will pay for the service, even if you have not met your deductible.

| Coverage Category | Gold | Enhanced Silver 94 | Enhanced Silver 87 | Enhanced Silver 73 | Silver | Bronze |
|---|---|---|---|---|---|---|
| Average percent insurance company will cover annually | 81% | 94% | 87% | 73% | 71% | 64% |
| You are eligible for enhanced Silver plan if your annual household income for one person is: | | $20,121 – $21,870 | $21,871 – $29,160 | $29,161 – $36,450 | | |
| Preventive Care | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** |
| Routine Diabetes Care[1] | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** |
| Primary Care Visit | **$10** | **$2** | **$10** | **$35** | **$35** | **$35** |
| Urgent Care Visit | **$40** | **$15** | **$30** | **$75** | **$75** | **$75** |
| Specialist Visit | **$30** | **$15** | **$30** | **$90** | **$90** | **$90** |
| Emergency Room Services | $350 | **$75** | $150 | $500 | $500 | n/a |
| Mental Health and Substance Use Disorder Office Visits | **$10** | **$2** | **$10** | **$35** | **$35** | **$35** |
| Imaging | $400 | **$125** | $350 | $600 | $600 | n/a |
| Laboratory Tests | **$25** | **$5** | **$25** | **$80** | **$80** | **$80** |
| X-rays and Diagnostics | **$50** | **$20** | **$50** | **$150** | **$150** | **$150** |
| Generic Drugs[2] | **$10** | **$0** | **$5** | **$25** | **$25** | **$25** |
| Preferred Brand Drugs | **$30** | **$5** | $25 | $75 | $75 | n/a |
| Non-Preferred Brand Drugs | $60 | **$15** | $50 | $80 | $80 | n/a |
| Specialty Drugs | $75 | **$25** | $60 | $100 | $100 | n/a |
| Medical Deductible Individual<br>Medical Deductible Family[3] | $1,000<br>$2,000 | $0<br>$0 | $1,000<br>$2,000 | $4,500<br>$9,000 | $4,500<br>$9,000 | $9,450<br>$18,900 |
| Drug Deductible Individual<br>Drug Deductible Family[3] | $150<br>$300 | $0<br>$0 | $150<br>$300 | $750<br>$1,500 | $750<br>$1,500 | n/a |
| Annual Medical Out-of-Pocket Maximum Individual<br>Annual Medical Out-of-Pocket Maximum Family[3] | $6,750<br>$13,500 | $1,750<br>$3,500 | $2,500<br>$5,000 | $6,050<br>$12,100 | $7,600<br>$15,200 | $9,450<br>$18,900 |
| Annual Drug Out-of-Pocket Maximum Individual<br>Annual Drug Out-of-Pocket Maximum Family[3] | $600<br>$1,200 | $250<br>$500 | $500<br>$1,000 | $1,500<br>$3,000 | $1,500<br>$3,000 | n/a |

[1] All Value Plans cover insulin, glucometers, test strips, and routine diabetic care for $0. For the full list of diabetic care benefits, visit MarylandHealthConnection.gov/value-plan

[2] Copays for prescription drugs may not exceed the retail price. For example, if generic Drug A has a retail price of $5, you will only pay $5, even if your plan's copay for generics is $10.

[3] Once the total family deductible or max out-of-pocket is met, this satisfies the deductible or max out-of-pocket for all family members.

Table 7.11: Standard Value Plan Designs for 2024*Current Cost Sharing Landscape in Maryland*

Because of the defunding of federal CSRs, which resulted in the requirement that on-Exchange silver premiums be CSR-loaded, and because of the relatively small CSR available in the 73% plan, policyholders who make 200% FPL or more can best minimize their combined out-of-pocket costs (premium and cost-sharing) by enrolling in a gold plan. Even though enrollees with incomes between 200%-250% FPL are eligible for a CSR 73% silver plan, they can still obtain lower cost-sharing for a nearly identical premium by enrolling in a gold plan, which has lower cost-shares than then CSR 73% plan. In the example plans modeled, as further described below, the gold plan is only $1.70 more per month than the CSR 73% silver plan and has a $200 lower annual maximum.

Tables 7.12 and 7.13 outline the worst-case scenario that an individual or family could face, in which the insured hits their annual maximum. Tables 7.14 and 7.15 show an additional scenario where the individual or family only hit their deductble. The tables assume a 40-year-old insured in the Baltimore region, as well as a family of four, ages 43, 40, 12 and 8, in the Baltimore region. For modeling purposes, the silver plan modeled was the 2024 second lowest cost silver plan (SLCSP), which was the UnitedHealthcare silver value plan. The gold plan modeled was UnitedHealthcare's gold value plan, and the midpoint income of each FPL range was used.

| SLCSP = UHC Silver Value Plan | | | | | | |
|---|---|---|---|---|---|---|
| Gold Plan = UHC Gold Value Plan | | | | | | |
| 40 Year Old Baltimore Region | | | | | | |
| 2024 Premiums/Cost-Sharing | | | | | | |
| **Household of One** | | | | | | |
| | | | | | Total | Total |
| | | | Annual | Plan | Prem + OOP | Prem + OOP Max |
| Range | Federal AV | Annual Earnings | Premium | MOOP | Max | % of Income |
| 100-150 | CSR 93% | $20,120 | $0 | $2,000 | $2,000 | 9.9% |
| 150-200 | CSR 87% | $25,515 | $255 | $3,000 | $3,255 | 12.8% |
| 200-250 | Gold 81% | $32,805 | $1,005 | $7,350 | $8,355 | 25.5% |
| 250-300 | Gold 81% | $40,095 | $2,026 | $7,350 | $9,376 | 23.4% |
| 300-350 | Gold 81% | $47,385 | $3,160 | $7,350 | $10,510 | 22.2% |
| 350-400 | Gold 81% | $54,675 | $4,170 | $7,350 | $11,520 | 21.1% |
| 400-450 | Gold 81% | $61,965 | $4,170 | $7,350 | $11,520 | 18.6% |
| 450-500 | Gold 81% | $69,255 | $4,170 | $7,350 | $11,520 | 16.6% |
| 500-550 | Gold 81% | $76,545 | $4,170 | $7,350 | $11,520 | 15.0% |
| 550-600 | Gold 81% | $83,835 | $4,170 | $7,350 | $11,520 | 13.7% |
| 600-650 | Gold 81% | $91,125 | $4,170 | $7,350 | $11,520 | 12.6% |
| 650-700 | Gold 81% | $98,415 | $4,170 | $7,350 | $11,520 | 11.7% |

7.12: Worst Case Total Premium Plus Cost Sharing for an Individual

| SLCSP = UHC Silver Value Plan | | | | | | |
|---|---|---|---|---|---|---|
| Gold Plan = UHC Gold Value Plan | | | | | | |
| Baltimore Region (Ages 43, 40, 12, 8) | | | | | | |
| 2024 Premiums/Cost-Sharing | | | | | | |
| **Family of 4** | | | | | | |
| | | | | | Total | Total |
| | | | Annual | Plan | Prem + OOP | Prem + OOP Max |
| Range | Federal AV | Annual Earnings | Premium | MOOP | Max | % of Income |
| 100-150 | CSR 93% | $41,400 | $0 | $4,000 | $4,000 | 9.7% |
| 150-200 | CSR 87% | $52,500 | $525 | $6,000 | $6,525 | 12.4% |
| 200-250 | Gold 81% | $67,500 | $2,093 | $14,700 | $16,793 | 24.9% |
| 250-300 | Gold 81% | $82,500 | $4,193 | $14,700 | $18,893 | 22.9% |
| 300-350 | Gold 81% | $97,500 | $6,527 | $14,700 | $21,227 | 21.8% |
| 350-400 | Gold 81% | $112,500 | $8,927 | $14,700 | $23,627 | 21.0% |
| 400-450 | Gold 81% | $127,500 | $10,905 | $14,700 | $25,605 | 20.1% |
| 450-500 | Gold 81% | $142,500 | $12,180 | $14,700 | $26,880 | 18.9% |
| 500-550 | Gold 81% | $157,500 | $13,455 | $14,700 | $28,155 | 17.9% |
| 550-600 | Gold 81% | $172,500 | $13,589 | $14,700 | $28,289 | 16.4% |
| 600-650 | Gold 81% | $187,500 | $13,589 | $14,700 | $28,289 | 15.1% |
| 650-700 | Gold 81% | $202,500 | $13,589 | $14,700 | $28,289 | 14.0% |

7.13: Worst Case Total Premium Plus Cost Sharing for a Family of Four

| SLCSP = UHC Silver Value Plan | | | | | | |
|---|---|---|---|---|---|---|
| Gold Plan = UHC Gold Value Plan | | | | | | |
| 40 Year Old Baltimore Region | | | | | | |
| 2024 Premiums/Cost-Sharing | | | | | | |
| **Household of One** | | | | | | |
| | | | | | | Total |
| | | | Annual | Plan | Total | Prem + Ded |
| Range | Federal AV | Annual Earnings | Premium | Deductible | Prem + Ded | % of Income |
| 100-150 | CSR 93% | $20,120 | $0 | $0 | $0 | 0.0% |
| 150-200 | CSR 87% | $25,515 | $255 | $1,150 | $1,405 | 5.5% |
| 200-250 | Gold 81% | $32,805 | $1,005 | $1,150 | $2,155 | 6.6% |
| 250-300 | Gold 81% | $40,095 | $2,026 | $1,150 | $3,176 | 7.9% |
| 300-350 | Gold 81% | $47,385 | $3,160 | $1,150 | $4,310 | 9.1% |
| 350-400 | Gold 81% | $54,675 | $4,170 | $1,150 | $5,320 | 9.7% |
| 400-450 | Gold 81% | $61,965 | $4,170 | $1,150 | $5,320 | 8.6% |
| 450-500 | Gold 81% | $69,255 | $4,170 | $1,150 | $5,320 | 7.7% |
| 500-550 | Gold 81% | $76,545 | $4,170 | $1,150 | $5,320 | 6.9% |
| 550-600 | Gold 81% | $83,835 | $4,170 | $1,150 | $5,320 | 6.3% |
| 600-650 | Gold 81% | $91,125 | $4,170 | $1,150 | $5,320 | 5.8% |
| 650-700 | Gold 81% | $98,415 | $4,170 | $1,150 | $5,320 | 5.4% |

7.14: Total Premium Plus Cost Sharing for an Individual Reaching Their Deductible

| SLCSP = UHC Silver Value Plan | | | | | | |
|---|---|---|---|---|---|---|
| Gold Plan = UHC Gold Value Plan | | | | | | |
| Baltimore Region (Ages 43, 40, 12, 8) | | | | | | |
| 2024 Premiums/Cost-Sharing | | | | | | |
| **Family of 4** | | | | | | |
| | | | | | | Total |
| | | | Annual | Plan | Total | Prem + Ded |
| Range | Federal AV | Annual Earnings | Premium | Deductible | Prem + Ded | % of Income |
| 100-150 | CSR 93% | $41,400 | $0 | $0 | $0 | 0.0% |
| 150-200 | CSR 87% | $52,500 | $525 | $2,300 | $2,825 | 5.4% |
| 200-250 | Gold 81% | $67,500 | $2,093 | $2,300 | $4,393 | 6.5% |
| 250-300 | Gold 81% | $82,500 | $4,193 | $2,300 | $6,493 | 7.9% |
| 300-350 | Gold 81% | $97,500 | $6,527 | $2,300 | $8,827 | 9.1% |
| 350-400 | Gold 81% | $112,500 | $8,927 | $2,300 | $11,227 | 10.0% |
| 400-450 | Gold 81% | $127,500 | $10,905 | $2,300 | $13,205 | 10.4% |
| 450-500 | Gold 81% | $142,500 | $12,180 | $2,300 | $14,480 | 10.2% |
| 500-550 | Gold 81% | $157,500 | $13,455 | $2,300 | $15,755 | 10.0% |
| 550-600 | Gold 81% | $172,500 | $13,589 | $2,300 | $15,889 | 9.2% |
| 600-650 | Gold 81% | $187,500 | $13,589 | $2,300 | $15,889 | 8.5% |
| 650-700 | Gold 81% | $202,500 | $13,589 | $2,300 | $15,889 | 7.8% |

7.15: Total Premium Plus Cost Sharing for a Family Reaching Their Deductible

As seen in Tables 7.12 and 7.13, and as highlighted, those in the 200%-300% FPL range have the highest potential out-of-pocket costs, as a percentage of annual income, in a year in which they reach their annual maximum, as compared with all other FPL ranges. An individual or family of four in the 200%-250% FPL income bracket which has a bad claims year and hits their plan maximum would spend approximately 25% of their annual income on health insurance costs, which is the largest out-of-pocket percentage for any income bracket.

Similarly, insureds between 250%-300% FPL have disproportionate out-of-pocket costs as compared with other income An individual or family of four in the 250-300% FPL range who hits the plan maximum would spend approximately 23% of their annual income on health insurance costs, which is the second largest out-of-pocket percentage, behind only the 200%-250% FPL income bracket.

This analysis demonstrates the potential barrier to accessible care due to the cost-sharing burden on moderate and low-income households. Higher income households of 400% FPL or more in general have total costs (premiums plus cost-sharing) that are affordable relative to their incomes. Other states have targeted incomes in the under 300% range for state-funded CSRs (SFCSRs), but this data suggests that the idea should be explored for those up to 400% FPL. Only a small number of possible SFCSRs have been modeled for this report to show examples of what program costs could be. If the state wishes to pursue SFCSRs, more detailed modeling is recommended, so that key decisions would need to be made about appropriate out-of-pocket maximums, deductibles, and AVs for various income ranges.

*State-Funded Cost Sharing Reduction Options Modeled*

L&E modeled two state funded cost sharing reduction (SFCSR) programs that would further reduce cost sharing for eligible enrollees in 2026.

**1) Silver SFCSRs**: The first program modeled would provide additional SFCSRs to individuals up to 200% FPL enrolled in the 87% and 94% AV silver plans who receive federal CSRs.

Because enrollment into the 87% and 94% CSR silver variants is restricted by income eligibility, no additional enrollment was assumed due to the silver SFCSR subsidy. It is estimated to cost between $7.24 and $7.42 PMPM to increase AV by 1% for these enrollees, for a total cost for existing enrollees of $1.4M to $2.6M for each 1% increase in AV (see table 7.16). Using these figures, if the state were to fully eliminate cost sharing for these existing enrollees, the cost is estimated at approximately $33.5M annually.

| Silver Only | 87% CSR | 94% CSR |
| --- | --- | --- |
| PMPM Buyup Cost per 1% AV | $7.42 | $7.24 |
| Projected 2026 Member Months | 187,257 | 356,215 |
| **Projected 2026 Annual Cost** | **$1,389,203** | **$2,580,298** |

Table 7.16: 2026 SFCSR Silver Cost Projections. Note: The small difference between the 87% and 94% CSR buyup cost PMPM is due to slight membership differences in those variants between plans.

**2) Gold SFCSRs**: The second program modeled would provide SFCSRs for enrollees with incomes between 200% and 300% FPL who purchase Gold plans. These individuals are not eligible for traditional 87% and 94% AV CSR Silver plans. Individuals between 200-300% FPL are currently eligible for minimal or no federal CSRs.

Like the Silver SFCSR assumptions, no additional enrollment was assumed because of the Gold SFCSR subsidy. The rationale for this assumption is that the benefits of CSRs are more difficult to

communicate since they are not realized until the enrollee starts incurring medical costs, unlike premium subsidies which have a clear, defined benefit that is realized every month when an enrollee pays premium. Additionally, while new enrollment from the cost-sharing subsidy is assumed insignificant, it is expected that existing enrollees in other metal levels will recognize the value of the gold SFCSR subsidy. Therefore, in addition to the number of existing enrollees in gold plans, the overall cost of the gold SFCSR subsidy is dependent on the number of enrollees switching coverage from other metal levels to gold plans.

Assuming no SFCSRs are in effect in 2026, average enrollment for enrollees between 200-300% FPL is projected to be approximately 2,900 in CSR Silver 73% plans, 24,600 in gold plans, and 13,200 in other metal levels (see Table 7.17).

| FPL Bucket | CSR Silver 73% | Gold | Other Metals |
|---|---|---|---|
| 200-250 | 35,154 | 176,240 | 72,428 |
| 250-300 | - | 119,449 | 85,634 |
| **Total** | **35,154** | **295,689** | **158,062** |

Table 7.17: Projected Pre-SFCSR Subsidy 2026 Enrollment (Member Months) by Metal Level for 200-300% FPL Enrollees

Because it's difficult to model consumer behavior due to CSR subsidy availability, three enrollment scenarios were modeled for the gold SFCSR subsidy:

- The baseline scenario assumes there is no shift into gold plans from other metal levels, and only those originally projected to enroll in gold plans before the subsidy's implementation (as shown in Table 7.17) receive the gold SFCSR.
- The second scenario assumes that 100% of the eligible enrollment in CSR silver 73% and other metal level plans will migrate to gold plans.
- The third scenario assumes that only 50% of eligible enrollment will migrate from other metal levels.

The modeling parameters for the gold SFCSR reduced cost sharing to levels comparable to those of a platinum plan by increasing the AV of gold plans by approximately 10%. The projected cost of each scenario is $28M if no eligible enrollees moved from other metal levels into gold plans, $37M if half of eligible enrollees not enrolled in gold shift into gold, and $46M if all enrollees between $200%-300% FPL enrolled in gold plans (see Table 7.18).

| Scenario | SFCSR Cost |
|---|---|
| Only Current Gold Enrollment | $27,842,659 |
| 100% Migration into Gold | $46,036,248 |
| 50% Migration into Gold | $36,939,453 |

Table 7.18: Projected SFCSR 2026 Cost for 200-300% FPL Enrollees

### x. Cost to Replace ARPA Subsidies in 2026

The enhanced federal subsidies initially implemented under ARPA are set to expire at the end of 2025. Beginning in 2026, enrollees receiving APTC in the individual market will see significant net premium increases due to reduced premium subsidies if Congress does not act to extend them. It is

projected to cost the state $149M to replace the lost ARPA subsidy funding in 2026, increasing to $166M in 2028 (see table 7.19).

| Year | APTC Shortfall |
|---|---|
| 2026 | $149,308,590 |
| 2027 | $157,280,504 |
| 2028 | $165,997,279 |

Table 7.19: Replacing ARPA Subsidies Cost

As noted above, the loss of the federally enhanced subsidies is anticipated to have a significant, negative impact on plan affordability and enrollment. The scope of persons eligible to receive subsidies will be reduced and the amount of subsidy available to eligible persons will also be reduced. At the same time, the dollars received as pass-throughs from the federal government will be reduced. In order to avoid the kind of premium shock that could have significant negative impacts on enrollment and the health of the individual market, the state will need to develop a contingency plan that considers the size of the SRP and the availability of state funds to provide subsidies that could buffer and phase in the impact of APTC losses. This Report does not attempt to model contingency options at this time.

**Expanding Eligibility for the Maryland Medical Assistance Program**

As directed, the Workgroup modeled the impacts of expanding the Maryland Medicaid Assistance Program. Expansion to adults with incomes below 200% of the federal poverty line (FPL) was assumed for modeling purposes. This approach would not require a 1332 waiver, but would likely require CMS approval in some form, such as a state plan amendment. In general, for the individual market, such an expansion would negatively impact average morbidity and decrease the size of the risk pool, the amount of APTC, and federal funding for the reinsurance program, resulting in the State becoming responsible for a much larger share of reinsurance costs than it would be otherwise. Such an expansion would require a significant administrative lift and would not be easily reversible.

If Maryland were to expand Medicaid for adults to 200% FPL, the state would lose federal dollars in the form of reduced APTC to the population with incomes <200% FPL. Potential impacts of Medicaid expansion were modeled for calendar year 2026, and assume that the enhanced APTC through ARPA is extended indefinitely. In this scenario for 2026, an estimated $421 million of APTC (55% of total APTC that would otherwise flow to state residents) would be lost if those with incomes <200% FPL were covered through Medicaid instead of private plans.

Other effects of removing individuals with incomes <200% FPL from the individual market include reduced reinsurance costs, but also reduced pass-through from the federal government to the State. Reinsurance costs would be projected to fall by 26%, from $579M to $428M. Pass-through funding would be projected to fall by an even larger share, 58%, leaving the State responsible for a greater portion of reinsurance funding. Removing the <200% FPL population from the individual market is projected to cause the pass-through amount to plummet to $198M; absent Medicaid expansion it is projected at $500 million in 2026. Subsequently, the state balance at the end of the waiver period is projected to fall from $336M to a deficit of $101M (Table 7.20).

# Reinsurance Projection w <200% Removed

Current 1332 projections (as of 7/7/23)
Updated ro remove <200% FPL Population

All figures in Millions

| | 2024 | 2025 | 2026 | 2027 | 2028 | 5-Year Total |
|---|---|---|---|---|---|---|
| Reinsurance Costs | $ (579) | $ (428) | $ (439) | $ (456) | $ (475) | $ (2,377) |
| YoY % Growth | 6% | -26% | 2% | 4% | 4% | |
| Federal Pass-Throughs | $ 474 | $ 198 | $ 137 | $ 145 | $ 154 | $ 1,107 |
| YoY % Change | 0% | -58% | -31% | 6% | 6% | |
| State Assessment | $ 140 | $ 145 | $ 150 | $ 155 | $ 161 | $ 752 |
| State share of Reinsurance | $ (104) | $ (230) | $ (302) | $ (312) | $ (321) | $ (1,270) |
| Other State Outflows | $ (35) | $ (35) | $ - | $ - | $ - | $ (70) |
| EOY Federal Fund Balance | $ - | $ - | $ - | $ - | $ - | |
| EOY State Fund Balance | $ 488 | $ 368 | $ 216 | $ 60 | **$ (101)** | |
| Average Enrollment | 229,834 | 231,098 | 231,576 | 232,536 | 233,545 | |
| | 4% | 1% | 0% | 0% | 0% | |

Table 7.20: Reinsurance projections updated to remove the population <200% FPL

Removing adults with incomes <200% FPL would also impact subsidies in the individual market. If the <200% FPL population, who receive the most generous CSRs, were removed from the individual market, the cost to provide CSRs would go down, which would reduce silver premiums and consequently APTC amounts (Table 7.21; for more background see discussion on page XX). This dynamic would limit consumers' ability to use APTC to afford plans that are more generous than the benchmark plan.

# Subsidized premium impact of <200% Removal

| **Illustrative Monthly Premum for Age 40** | | | | | |
|---|---|---|---|---|---|
| **Assume Optimum Choice will be benchmark (as in 2024)** | | | | | |
| **250% FPL** | | | | | |
| | | | | | |
| Current rates with high CSR loads on silver | | | | | |
| | | | | | |
| | Unsubsidized Premium | APTC | Post-Subsdy Premium | | |
| Benchmark | $352 | $239 | $113 | | |
| BlueChoice Bronze | $265 | $239 | $26 | | |
| BlueChoice Gold | $377 | $239 | $138 | | |
| | | | | | |
| Rates with low CSR load after <200% FPL removed | | | | | |
| | Unsubsidized Premium | APTC | Post-Subsdy Premium | % Impact | $ Impact |
| Benchmark | $287 | $174 | $113 | 0% | $0 |
| BlueChoice Bronze | $265 | $174 | $92 | 249% | $66 |
| BlueChoice Gold | $377 | $174 | $203 | 48% | $66 |

Table 7.21: Impact of removing <200% FPL population on subsidized premiums

The projected annual cost to cover adults above current Medicaid financial eligibility thresholds but below 200% FPL under Medicaid is approximately $420 million, with the State and federal governments each paying half of that cost (Table 7.22). This cost is in addition to the cost of losing federal funding in the form of pass-throughs and APTCs.

*These scenarios apply the lower and upper bounds, respectively, of the 95% confidence intervals for the estimated population of uninsured adults 20-64 years of age sourced from the 2021 American Community Survey sample for Maryland.

| | Projected Enrollment | Projected Annual Expenditure | State Share (50%) | Federal Share (50%) |
|---|---|---|---|---|
| **Best Estimates** | **73,650** | **$420,447,064** | **$210,223,532** | **$210,223,532** |
| Lower Bound of 95% CI* | 63,182 | $360,516,492 | $180,258,246 | $180,258,246 |
| Upper Bound of 95% CI* | 81,589 | $465,546,834 | $232,773,417 | $232,773,417 |

Table 7.22: Enrollment and expenditure projections for covering <200% FPL population

To summarize, expanding Medicaid eligibility to individuals <200% FPL in 2026 is projected to cost the state $210M in direct Medicaid costs, result in state residents forgoing $421M in APTC, and increase the state share of SRP costs by $437M over the next 5-year waiver period. Given this, the Workgroup does not believe that Medicaid expansion is a viable or economically efficient approach to improving access to affordable health plans.

### Health Coverage Options for Marylanders without a Legal Immigration Status who are Over the Medicaid Income Threshold

Under current law, Marylanders without a legal immigration status are not permitted to purchase ACA products on-exchange, and thus are not eligible for federal subsidies. Consequently, the only access to healthcare for this population is either through their employer (if it is offered), or off-exchange, where federal subsidies are not available. While the cost of individual coverage in Maryland remains among the lowest in the nation, unsubsidized coverage is often unaffordable for people whose incomes are below 400% FPL.

The SHADAC analysis of Census data shown in Table 7.2 shows that 31.9% of Marylanders who are not a U.S. citizen are uninsured. This figure includes undocumented persons and persons with legal immigration status. The Health Care and Dental Coverage for Undocumented Immigrants Report prepared by MDH and MHBE estimated that there are approximately 112,400 undocumented residents who are uninsured, accounting for approximately 30% of the currently number of uninsured Marylanders. Consistent with that report, the estimated number of undocumented and uninsured residents by age and FPL are shown in Table 7.23.

| FPL/AGE | 0-17 | 18-25 | 26-34 | 35-44 | 45-54 | 55-64 | 65+ |
|---|---|---|---|---|---|---|---|
| 0-133% | 5,167 | 6,895 | 10,750 | 10,750 | 3,769 | 3,769 | 489 |
| 133-150% | 660 | 665 | 665 | 3,238 | 1,123 | 1,123 | 100 |
| 150-200% | 1,942 | 2,862 | 2,862 | 5,410 | 2,692 | 2,692 | 343 |
| 200-250% | 1,942 | 1,540 | 1,540 | 3,463 | 2,864 | 2,864 | 758 |
| 250-300% | 1,942 | 2,069 | 2,069 | 3,575 | 1,818 | 1,818 | 375 |
| 300-400% | - | - | 2,029 | 5,798 | 2,477 | 2,477 | 387 |
| 400%+ | - | - | - | - | - | 1,979 | 1,484 |

Table 7.23: The number of Uninsured Undocumented Residents in a Percentage Range over the Federal Poverty Level (FPL).

Lewis and Ellis modeled the estimated costs of making subsidies available to undocumented individuals above Medicaid income thresholds. There are multiple components to the cost.

- The first component is the cost of a state premium subsidy.
  - The premium subsidy modeling assumes that the state will provide subsidies equal to the federal subsidies and that the federal subsidies will remain at current ARPA levels. This assumption was chosen, because the cost to the state would be higher if ARPA-level subsidies are extended and lower if they end in 2025 as currently scheduled, so this is the more conservative set of estimates. This is the opposite dynamic of the impact on state spending for the SRP.
  - Note that in all of the actuarial projections regarding subsidies, the per member per month cost of the subsidies are much firmer estimates with a fairly low level of uncertainty.
  - The enrollment take-up assumption has a much higher amount of uncertainty, which is why a range of plausible take-up assumptions have been modeled.
    - Enrollment uptake is contingent upon consumer outreach efforts, consumer willingness to interact with state programs, and the overall cost savings for each eligible enrollee.
    - While this program would offer premium savings to a population with limited options for health insurance coverage, it is still expected that a portion of the Marylanders who are not lawfully present might be hesitant to interact with a state-run program.
    - Three program uptake scenarios were modeled – a low scenario which assumed 10% enrollment uptake, a midpoint scenario that assumed 19% enrollment uptake and a high scenario that assumed 31% enrollment uptake.
    - These uptake assumptions were set to be consistent with the assumptions for the modeling for those under the Medicaid-income threshold. There is an expectation that uptake for the population over the Medicaid income threshold would be lower because of non-zero premiums after subsidies, with take-up declining as income increases and subsidies decrease.
- The second component of costs that was modeled is a state CSR subsidy.
  - Once again, the modeling assumed that the state would provide CSRs equal to the federal ones for those of eligible incomes <250% FPL.
  - Unlike the federal subsidy which has been unfunded since 2018 and must be built into on-exchange silver premiums, the state CSR subsidy must be funded to avoid an upward impact on federal subsidies, which would jeopardize the state's 1332 waiver. There are

three levels of CSRs which become more generous as income decreases. The estimated annual per person cost of the CSR component is summarized below.

| Plan Type | PMPY Cost |
|---|---|
| CSR Silver 94% AV | $2,086 |
| CSR Silver 87% AV | $1,478 |
| CSR Silver 73% AV | $261 |
| All Other Variants | $0 |

Table 7.24: The Per Member Per Year Cost across the Three Levels of State Cost-Sharing Reduction

- The third cost component which was modeled was the cost impact on the SRP.
  - Unlike new entrants who are eligible for federal subsidies and generate additional pass-through dollars which can partially or completely offset additional reinsurance costs, any new entrant into the individual market not eligible for federal subsidies because of lack of a lawful immigration status will generate additional reinsurance cost, but will not generate federal pass-through. This additional cost has been modeled according to age, since younger members are less likely to result in claims that qualify for reinsurance than older members.

| 0-17 | 18-25 | 26-34 | 35-44 | 45-54 | 55-64 | 65+ |
|---|---|---|---|---|---|---|
| $651 | $798 | $1,457 | $1,772 | $2,209 | $3,027 | $3,869 |

Table 7.25: Modeled additional costs for new entrants into the Individual market that are not eligible for federal subsidies by age.

The modeling shows that in 2026, the total costs for this population would range anywhere from $48.8M to $152.4M, with SRP costs increasing anywhere from $13.3 M to $40.7M, as shown in Table 7.26. Note that 2026 numbers are shown to be consistent with other subsidy modeling done for lawfully present Marylanders earlier in the report. The parallel SB 806 report shows estimated 2025 numbers. These can be found in the Appendix of the L&E report.

| Scenario | Projected Enrollment | CSR Costs | Premium Subsidy Costs | Reinsurance Costs | Dental Costs | Total Costs |
|---|---|---|---|---|---|---|
| **Low** | 6,643 | $5,526,770 | $29,940,130 | $13,331,878 | $0 | **$48,798,778** |
| **Midpoint** | 12,316 | $11,378,947 | $57,234,484 | $24,561,147 | $0 | **$93,174,578** |
| **High** | 20,464 | $17,933,247 | $93,753,399 | $40,771,839 | $0 | **$152,458,485** |

Table 7.26: Projected Total Costs in 2026 for Undocumented Maryland Citizens across Low, Medium, and High Enrollment Scenarios.

| Age Band | 0-18 | 18-25 | 26-34 | 35-44 | 45-54 | 55-64 | 65+ | All Ages |
|---|---|---|---|---|---|---|---|---|
| APTC Costs | $0 | $2,139,877 | $2,600,455 | $7,514,243 | $5,784,111 | $9,706,377 | $2,195,066 | $29,940,130 |
| CSR Costs | $0 | $759,612 | $759,612 | $2,071,700 | $910,993 | $910,993 | $113,861 | $5,526,770 |
| Reinsurance Costs | $0 | $637,230 | $1,370,344 | $3,974,775 | $2,526,622 | $3,760,531 | $1,062,376 | $13,331,878 |
| Dental Costs | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Total Costs** | **$0** | **$3,536,719** | **$4,730,411** | **$13,560,717** | **$9,221,726** | **$14,377,901** | **$3,371,304** | **$48,798,778** |
| Estimated Enrollment | 0 | 799 | 941 | 2,243 | 1,144 | 1,243 | 275 | 6,643 |
| **Estimated Total Costs PMPY** | **$0** | **$4,428** | **$5,028** | **$6,045** | **$8,064** | **$11,572** | **$12,276** | **$7,345** |

Table 7.27: Projected Total Costs in 2026 for Undocumented Maryland Citizens by age (Low Enrollment Scenario)

| Age Band | 0-18 | 18-25 | 26-34 | 35-44 | 45-54 | 55-64 | 65+ | All Ages |
|---|---|---|---|---|---|---|---|---|
| APTC Costs | $0 | $4,230,889 | $5,103,895 | $14,715,744 | $11,024,425 | $18,201,175 | $3,958,356 | $57,234,484 |
| CSR Costs | $0 | $1,567,343 | $1,567,343 | $4,272,821 | $1,870,256 | $1,870,256 | $230,926 | $11,378,947 |
| Reinsurance Costs | $0 | $1,228,501 | $2,538,545 | $7,379,115 | $4,671,564 | $6,878,446 | $1,864,977 | $24,561,147 |
| Dental Costs | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Total Costs** | **$0** | **$7,026,734** | **$9,209,784** | **$26,367,680** | **$17,566,245** | **$26,949,877** | **$6,054,258** | **$93,174,578** |
| Estimated Enrollment | 0 | 1,540 | 1,743 | 4,165 | 2,114 | 2,273 | 482 | 12,316 |
| **Estimated Total Costs PMPY** | **$0** | **$4,563** | **$5,285** | **$6,331** | **$8,308** | **$11,858** | **$12,559** | **$7,565** |

Table 7.28: Projected Total Costs in 2026 for Undocumented Maryland Citizens by age (Medium Enrollment Scenario)

| Age Band | 0-18 | 18-25 | 26-34 | 35-44 | 45-54 | 55-64 | 65+ | All Ages |
|---|---|---|---|---|---|---|---|---|
| APTC Costs | $0 | $6,852,824 | $8,293,472 | $23,797,887 | $18,229,648 | $30,093,840 | $6,485,727 | $93,753,399 |
| CSR Costs | $0 | $2,483,743 | $2,483,743 | $6,687,996 | $2,953,886 | $2,953,886 | $369,992 | $17,933,247 |
| Reinsurance Costs | $0 | $2,005,182 | $4,252,170 | $12,315,747 | $7,858,893 | $11,364,395 | $2,975,453 | $40,771,839 |
| Dental Costs | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Total Costs** | **$0** | **$11,341,749** | **$15,029,385** | **$42,801,630** | **$29,042,427** | **$44,412,122** | **$9,831,172** | **$152,458,485** |
| Estimated Enrollment | 0 | 2,513 | 2,919 | 6,951 | 3,557 | 3,755 | 769 | 20,464 |
| **Estimated Total Costs PMPY** | **$0** | **$4,513** | **$5,149** | **$6,158** | **$8,165** | **$11,828** | **$12,782** | **$7,450** |

Table 7.29: Projected Total Costs in 2026 for Undocumented Maryland Citizens by age (High Enrollment Scenario)

## VIII. CONCLUSION

[Conclusion will be included following December 6, 2023 Public Stakeholder meeting]

LEWIS & ELLIS
Actuaries and Consultants

# HB413 - Undocumented Immigrant Subsidy Cost Analysis

MARYLAND HEALTH BENEFIT EXCHANGE

STATE OF MARYLAND

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**Submitted on:**
November 17, 2023

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# EXECUTIVE SUMMARY

The Maryland Health Benefit Exchange (MHBE) and Maryland Insurance Administration (MIA) engaged Lewis & Ellis (L&E) to estimate the potential impact of various premium stabilization and market reforms in the Individual market as pursuant to House Bill 413 of 2022 and Senate Bill 806 of 2023. If implemented, the state would pay the costs to cover these individuals under the State Reinsurance Program (SRP) and provide premium, cost sharing reduction, and dental subsidies to eligible enrollees.

Under current law, undocumented immigrants are not allowed to participate in the healthcare exchanges established by the Affordable Care Act (ACA) and other federal healthcare programs available to them are limited. As a result, the primary sources of healthcare coverage for these individuals are through their employers (if offered), the individual marketplace outside of an exchange (which is often unaffordable), or through a state program such as the one being modeled[1].

The undocumented immigrant state subsidy costs were modeled using ACA eligibility guidelines for the Advanced Premium Tax Credits (APTC) and cost sharing reduction subsidies (CSRs). The dental subsidy was presumed to equal the lowest cost standalone dental plan offered in the marketplace. Reinsurance costs were modeled using trended 2022 Individual market claims that were adjusted for age differences.

There is significant uncertainty regarding how these populations will engage with the program when offered subsidies. Consumer interest will depend heavily on outreach and marketing to potential enrollees. Due to this uncertainty, L&E has modeled three scenarios: a low, midpoint, and high enrollment scenario.

Undocumented immigrants were split into two groups. One above and one below the Maryland income threshold for Medicaid eligibility. This grouping allows a direct comparison to the cost of providing coverage under Medicaid for income eligible enrollees.

For the midpoint scenario, L&E estimates the total cost of offering coverage to the Medicaid income eligible undocumented population to be $112.8M in 2026. For those above the Medicaid income threshold, the associated cost was estimated to be $93.2M. Costs are projected to grow at a rate of approximately 8% per year over the life of the program.

[1]https://www.kff.org/racial-equity-and-health-policy/issue-brief/health-coverage-and-care-of-undocumented-immigrants/

# ASSUMPTIONS

## PROGRAM ELIGIBILITY

If undocumented immigrants are allowed to purchase subsidized coverage through the Individual market, costs may include a state-funded premium, cost sharing reduction (if eligible), reinsurance, and a dental subsidy. Reinsurance costs must also be covered under the SRP, since undocumented immigrants will not be eligible for federal pass through savings. While the premium and CSR subsidy programs are designed to mirror the eligibility of ACA programs, the dental subsidy will only be available to individuals under the Medicaid income threshold.

## POPULATION ASSUMPTIONS

The undocumented immigrant population was assumed to grow by 2.8% per year based on historical growth rates from the American Immigration Council[2].

## MARKET ASSUMPTIONS

The proposed premium subsidy mirrors how APTC is applied, which means the subsidy is a function of the second lowest cost silver plan (referred to as the benchmark plan) for a given year. Exhibit 1 shows the estimated benchmark premiums, taking into account the SRP's estimated impact and other market factors expected to influence the premium.

**Exhibit 1 – 2025-2029 Maryland Benchmark Premiums[3]**

| 2025 | 2026 | 2027 | 2028 | 2029 |
|---|---|---|---|---|
| $361 | $380 | $399 | $419 | $440 |

## ENHANCED SUBSIDIES

At the time of this report, there is uncertainty whether the enhanced federal subsidies introduced with the American Rescue Plan Act (ARPA) and extended through 2025 by the Inflation Reduction Act (IRA) will be renewed beyond their 2025 expiration date. This report focuses on the scenario where the ARPA subsidies will continue indefinitely beyond 2025.

[2] https://www.americanimmigrationcouncil.org/research/immigrants-in-maryland
[3] Age 40 per member per month premiums.

Appendix A shows the cost and enrollment difference for 2026 assuming the subsidies are not extended.

## OTHER ASSUMPTIONS

If implemented, the earliest the program is expected to go into effect is the 2025 plan year. While 2025 is the first potential year of operation, 2026 is the baseline scenario modeled to allow for a direct comparison to the scenario in which ARPA expires in 2026, as currently written into law.

At the time of this report, The Hilltop Institute (Hilltop) is modeling the cost of Medicaid covering undocumented immigrants that meet the Maryland Medicaid income requirement in a parallel study. To compare the expected Medicaid costs versus Individual market costs, the modeling in this report was split between Medicaid-income eligible and non-Medicaid-income eligible cohorts.

# METHODOLOGY

## DATA SOURCES

Data on the uninsured, undocumented population was provided by Hilltop. The data was sourced from the 2021 U.S. Census Bureau's American Community Survey for Maryland.

## PROGRAM PARTICIPATION

Based on the income distribution provided and the estimated benchmark premiums, 86% of uninsured undocumented immigrants are projected to be eligible for the proposed program. Exhibit 2 shows the expected 2026 distribution of eligible individuals by age and FPL.

**Exhibit 2 – 2026 Projected Age and FPL Distribution of Eligible Undocumented Immigrants**

| FPL/AGE | 0-17 | 18-25 | 26-34 | 35-44 | 45-54 | 55-64 | 65+ |
|---|---|---|---|---|---|---|---|
| 0-133% | 5,167 | 6,895 | 10,750 | 10,750 | 3,769 | 3,769 | 489 |
| 133-150% | 660 | 665 | 665 | 3,238 | 1,123 | 1,123 | 100 |
| 150-200% | 1,942 | 2,862 | 2,862 | 5,410 | 2,692 | 2,692 | 343 |
| 200-250% | 1,942 | 1,540 | 1,540 | 3,463 | 2,864 | 2,864 | 758 |
| 250-300% | 1,942 | 2,069 | 2,069 | 3,575 | 1,818 | 1,818 | 375 |
| 300-400% | - | - | 2,029 | 5,798 | 2,477 | 2,477 | 387 |
| 400%+ | - | - | - | - | - | 1,979 | 1,484 |

The most significant variable affecting overall program costs is the participation rate of eligible enrollees. This variable is dependent on marketing efforts and outreach, consumers' willingness to interact with state and federal programs, and the cost savings for each eligible enrollee. While the program would offer significant savings to a population with traditionally limited options for health coverage, a portion of this population is expected to be hesitant to interact with a state-run program due to their citizenship status and their unfamiliarity with the health insurance marketplace.

As a result, modeling participation into this program has challenges. Three scenarios were modeled to account for the range of enrollment outcomes. The ranges selected for the Medicaid

income eligible population mirrored the uptake percentages modeled in Hilltop's corresponding Medicaid study.

**Exhibit 3 – Projected Uptake Scenarios for Eligible Undocumented Immigrants**

| Population | Low | Midpoint | High |
|---|---|---|---|
| Medicaid Income Eligible | 13% | 29% | 44% |
| Non-Medicaid Income Eligible | 10% | 19% | 31% |

Within each scenario, enrollment uptake was assumed to decline as FPL increased, subject to the assumed aggregate uptake percentage.

## PREMIUM SUBSIDY

Premium subsidies were modeled to mirror the ACA's APTC program, which limits the amount an individual or family must spend on premiums based on their income level.

**Exhibit 4– Maximum Premium Contribution as a Percentage of Income[4]**

| FPL | Average Contribution Percentage[5] |
|---|---|
| 0-133% | 0.00% |
| 133-150% | 0.00% |
| 150-200% | 1.00% |
| 200-250% | 3.00% |
| 250-300% | 5.00% |
| 300-400% | 7.25% |
| 400-600% | 8.50% |
| 600+% | 8.50% |

[4] Values shown are the average for each FPL bracket.
[5] https://www.irs.gov/pub/irs-drop/rp-21-23.pdf

## COST SHARING REDUCTION SUBSIDY

To improve affordability for low-income members, the ACA provides CSRs[6] for those eligible for APTC and under 250% FPL. Similar to the premium subsidy provision, state CSR subsidy eligibility would mirror current ACA provisions and would increase in richness as income declines. Costs by Actuarial Value level (a function of FPL) were based on Maryland-specific rate filing data. L&E assumed that 100% of enrollees eligible for CSR subsidies would use their premium subsidy to enroll in an applicable silver plan and therefore also receive the cost sharing reduction subsidy.

**Exhibit 5 – 2026 CSR Costs PMPY**

| Plan Type | PMPY Cost |
|---|---|
| CSR Silver 94% AV | $2,086 |
| CSR Silver 87% AV | $1,478 |
| CSR Silver 73% AV | $261 |
| All Other Variants | $0 |

CSR cost trends are assumed to align with the assumed 5% claims cost trend.

## DENTAL SUBSIDY

In addition to premium and CSR subsidies, a dental coverage subsidy was also modeled. It was assumed the state would provide a subsidy amount equal to the lowest cost standalone dental plan offered each year for Medicaid income eligible enrollees. Because dental premiums in Maryland have experienced low trends in recent years, it was assumed the lowest dental premium offered in the 2024 plan year would remain flat into 2026 and beyond. Exhibit 6 shows the expected dental subsidy PMPY by age band.

**Exhibit 6 – 2026 Dental Subsidy by Age Band PMPY**

| Age 0-18 | Age 19-29 | Age 30-45 | Age 46+ |
|---|---|---|---|
| $147 | $131 | $147 | $164 |

[6] Individuals under 250% FPL are eligible to enroll in a special silver plan variant that reduces deductibles, copays, and other cost sharing beyond a traditional 70% actuarial value silver plan. For example, an individual under 150% FPL is eligible for a 94% silver CSR variant that has an actuarial value of approximately 94%.

## REINSURANCE COSTS

In addition to the previously modeled subsidy amounts, newly enrolled undocumented immigrants were assumed to be covered by the State Reinsurance Program. Therefore, claims by these members within the parameters of the SRP would be the state's liability and must be included in the total cost of the program.

To model the expected costs, L&E trended total 2022 Individual claims to 2026 by 5% annually. Because reinsurance claims vary significantly by age, claims were scaled by using a Maryland-specific age curve. The 2026 reinsurance parameters expected to be in place[7] were then applied. Exhibit 7 shows the expected 2026 reinsurance liability by age band.

**Exhibit 7 – 2026 SRP Costs by Age Band PMPY**

| 0-17 | 18-25 | 26-34 | 35-44 | 45-54 | 55-64 | 65+ |
|---|---|---|---|---|---|---|
| $651 | $798 | $1,457 | $1,772 | $2,209 | $3,027 | $3,869 |

[7] While not finalized, the expected attachment point, coinsurance percentage, and maximum cap are projected to be $22,000, 80%, and $250,000 respectively.

# RESULTS

Exhibit 8 below shows the cost estimates for the undocumented population who would qualify for Medicaid.

**Exhibit 8 – 2026 Undocumented Immigrant Costs – Medicaid Income Eligible**

| Scenario | Projected Enrollment | CSR Costs | Premium Subsidy Costs | Reinsurance Costs | Dental Costs | Total Costs |
|---|---|---|---|---|---|---|
| **Low** | 6,373 | $12,910,345 | $29,058,075 | $9,658,264 | $929,994 | **$52,556,678** |
| **Midpoint** | 13,845 | $27,626,855 | $62,356,261 | $20,791,825 | $2,020,584 | **$112,795,526** |
| **High** | 20,939 | $41,892,023 | $94,459,263 | $31,489,065 | $3,055,783 | **$170,896,134** |

Exhibit 9 below estimates the costs for undocumented immigrants that are ineligible for Medicaid.

**Exhibit 9 – 2026 Undocumented Immigrant Costs – Medicaid non-Income Eligible**

| Scenario | Projected Enrollment | CSR Costs | Premium Subsidy Costs | Reinsurance Costs | Dental Costs | Total Costs |
|---|---|---|---|---|---|---|
| **Low** | 6,643 | $5,526,770 | $29,940,130 | $13,331,878 | $0 | **$48,798,778** |
| **Midpoint** | 12,316 | $11,378,947 | $57,234,484 | $24,561,147 | $0 | **$93,174,578** |
| **High** | 20,464 | $17,933,247 | $93,753,399 | $40,771,839 | $0 | **$152,458,485** |

# APPENDICES

## APPENDIX A: ENHANCED ARPA SUBSIDY EXPIRATION

The following exhibits show the estimated 2026 costs in the event that ARPA's enhanced subsidies are not extended beyond 2025. Due to lower premium subsidies and resulting higher net premiums for all eligible enrollees, the uptake assumptions were lowered to account for the lower program richness.

**Exhibit 10 – 2026 Undocumented Immigrant Costs –
Medicaid Income Eligible No ARPA Subsidies**

| Scenario | Projected Enrollment | CSR Costs | Premium Subsidy Costs | Reinsurance Costs | Dental Costs | Total Costs |
|---|---|---|---|---|---|---|
| **Low** | 5,270 | $10,702,581 | $22,646,004 | $8,433,166 | $768,984 | **$42,550,736** |
| **Midpoint** | 11,751 | $23,944,970 | $50,820,699 | $18,902,130 | $1,714,621 | **$95,382,420** |
| **High** | 18,705 | $38,136,390 | $80,936,651 | $30,097,074 | $2,729,333 | **$151,899,448** |

**Exhibit 11 – 2026 Undocumented Immigrant Costs –
Medicaid non-Income Eligible No ARPA Subsidies**

| Scenario | Projected Enrollment | CSR Costs | Premium Subsidy Costs | Reinsurance Costs | Dental Costs | Total Costs |
|---|---|---|---|---|---|---|
| **Low** | 4,351 | $4,493,887 | $16,577,274 | $9,259,602 | $0 | **$30,330,763** |
| **Midpoint** | 8,287 | $9,098,027 | $32,122,528 | $17,483,447 | $0 | **$58,704,002** |
| **High** | 12,717 | $13,371,406 | $48,936,289 | $26,977,665 | $0 | **$89,285,359** |

## APPENDIX B: MEDICAID INCOME-ELIGIBLE PROGRAM COSTS BY AGE

The following exhibits show the estimated costs for the 2026 Medicaid income-eligible persons by age for the low, midpoint, and high scenarios.

**Exhibit 12 – 2026 Medicaid Income Eligible Program Costs – Low Uptake Scenario**

| | Children (0-19) | Adults Under 65 (20-64) | Adults 65+ | All Ages |
|---|---|---|---|---|
| Premium Subsidy Cost | $3,223,656 | $25,075,544 | $758,876 | $29,058,075 |
| CSR Cost | $2,159,303 | $10,603,100 | $147,943 | $12,910,345 |
| Reinsurance Cost | $794,128 | $8,589,792 | $274,344 | $9,658,264 |
| Dental Cost | $179,330 | $739,033 | $11,631 | $929,994 |
| **Total Cost** | **$6,356,417** | **$45,007,469** | **$1,192,793** | **$52,556,678** |
| Estimated Enrollment | 1,220 | 5,083 | 71 | 6,373 |
| **Estimated Total Costs PMPY** | **$5,212** | **$8,855** | **$16,820** | **$8,247** |

**Exhibit 13 – 2026 Medicaid Income Eligible Program Costs – Midpoint Uptake Scenario**

| | Children (0-19) | Adults Under 65 (20-64) | Adults 65+ | All Ages |
|---|---|---|---|---|
| Premium Subsidy Cost | $7,124,054 | $53,609,783 | $1,622,424 | $62,356,261 |
| CSR Cost | $4,641,868 | $22,668,696 | $316,291 | $27,626,855 |
| Reinsurance Cost | $1,840,915 | $18,364,383 | $586,528 | $20,791,825 |
| Dental Cost | $415,715 | $1,580,002 | $24,867 | $2,020,584 |
| **Total Cost** | **$14,022,553** | **$96,222,864** | **$2,550,109** | **$112,795,526** |
| Estimated Enrollment | 2,827 | 10,866 | 152 | 13,845 |
| **Estimated Total Costs PMPY** | **$4,960** | **$8,855** | **$16,820** | **$8,147** |

**Exhibit 14 – 2026 Medicaid Income Eligible Program Costs – High Uptake Scenario**

| | Children (0-19) | Adults Under 65 (20-64) | Adults 65+ | All Ages |
|---|---|---|---|---|
| Premium Subsidy Cost | $10,720,111 | $81,279,349 | $2,459,804 | $94,459,263 |
| CSR Cost | $7,043,816 | $34,368,668 | $479,538 | $41,892,023 |
| Reinsurance Cost | $2,757,040 | $27,842,774 | $889,252 | $31,489,065 |
| Dental Cost | $622,595 | $2,395,487 | $37,701 | $3,055,783 |
| **Total Cost** | **$21,143,561** | **$145,886,278** | **$3,866,295** | **$170,896,134** |
| Estimated Enrollment | 4,234 | 16,475 | 230 | 20,939 |
| **Estimated Total Costs PMPY** | **$4,994** | **$8,855** | **$16,820** | **$8,162** |

## APPENDIX C: NON-MEDICAID INCOME-ELIGIBLE PROGRAM COSTS BY AGE

The following exhibits show the estimated costs for the 2026 non-Medicaid income-eligible persons by age for the low, midpoint, and high scenarios.

**Exhibit 15 – 2026 non-Medicaid Income Eligible Program Costs – Low Uptake Scenario**

| Age Band | 0-18 | 18-25 | 26-34 | 35-44 | 45-54 | 55-64 | 65+ | All Ages |
|---|---|---|---|---|---|---|---|---|
| APTC Costs | $0 | $2,139,877 | $2,600,455 | $7,514,243 | $5,784,111 | $9,706,377 | $2,195,066 | $29,940,130 |
| CSR Costs | $0 | $759,612 | $759,612 | $2,071,700 | $910,993 | $910,993 | $113,861 | $5,526,770 |
| Reinsurance Costs | $0 | $637,230 | $1,370,344 | $3,974,775 | $2,526,622 | $3,760,531 | $1,062,376 | $13,331,878 |
| Dental Costs | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Total Costs** | **$0** | **$3,536,719** | **$4,730,411** | **$13,560,717** | **$9,221,726** | **$14,377,901** | **$3,371,304** | **$48,798,778** |
| Estimated Enrollment | 0 | 799 | 941 | 2,243 | 1,144 | 1,243 | 275 | 6,643 |
| **Estimated Total Costs PMPY** | **$0** | **$4,428** | **$5,028** | **$6,045** | **$8,064** | **$11,572** | **$12,276** | **$7,345** |

**Exhibit 16 – 2026 non-Medicaid Income Eligible Program Costs – Midpoint Uptake Scenario**

| Age Band | 0-18 | 18-25 | 26-34 | 35-44 | 45-54 | 55-64 | 65+ | All Ages |
|---|---|---|---|---|---|---|---|---|
| APTC Costs | $0 | $4,230,889 | $5,103,895 | $14,715,744 | $11,024,425 | $18,201,175 | $3,958,356 | $57,234,484 |
| CSR Costs | $0 | $1,567,343 | $1,567,343 | $4,272,821 | $1,870,256 | $1,870,256 | $230,926 | $11,378,947 |
| Reinsurance Costs | $0 | $1,228,501 | $2,538,545 | $7,379,115 | $4,671,564 | $6,878,446 | $1,864,977 | $24,561,147 |
| Dental Costs | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Total Costs** | **$0** | **$7,026,734** | **$9,209,784** | **$26,367,680** | **$17,566,245** | **$26,949,877** | **$6,054,258** | **$93,174,578** |
| Estimated Enrollment | 0 | 1,540 | 1,743 | 4,165 | 2,114 | 2,273 | 482 | 12,316 |
| **Estimated Total Costs PMPY** | **$0** | **$4,563** | **$5,285** | **$6,331** | **$8,308** | **$11,858** | **$12,559** | **$7,565** |

**Exhibit 17 – 2026 non-Medicaid Income Eligible Program Costs – High Uptake Scenario**

| Age Band | 0-18 | 18-25 | 26-34 | 35-44 | 45-54 | 55-64 | 65+ | All Ages |
|---|---|---|---|---|---|---|---|---|
| APTC Costs | $0 | $6,852,824 | $8,293,472 | $23,797,887 | $18,229,648 | $30,093,840 | $6,485,727 | $93,753,399 |
| CSR Costs | $0 | $2,483,743 | $2,483,743 | $6,687,996 | $2,953,886 | $2,953,886 | $369,992 | $17,933,247 |
| Reinsurance Costs | $0 | $2,005,182 | $4,252,170 | $12,315,747 | $7,858,893 | $11,364,395 | $2,975,453 | $40,771,839 |
| Dental Costs | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Total Costs** | **$0** | **$11,341,749** | **$15,029,385** | **$42,801,630** | **$29,042,427** | **$44,412,122** | **$9,831,172** | **$152,458,485** |
| Estimated Enrollment | 0 | 2,513 | 2,919 | 6,951 | 3,557 | 3,755 | 769 | 20,464 |
| **Estimated Total Costs PMPY** | **$0** | **$4,513** | **$5,149** | **$6,158** | **$8,165** | **$11,828** | **$12,782** | **$7,450** |

## APPENDIX D: 2025-2029 PROGRAM COSTS

The following exhibits show the estimated costs for 2025 through 2029 for the low, midpoint, and high scenarios.

**Exhibit 18 –2025-2029 Medicaid Income Eligible Program Costs**

| Scenario/Year | Low | Midpoint | High |
|---|---|---|---|
| 2025 | $47,870,219 | $102,701,898 | $155,610,752 |
| 2026 | $52,556,678 | $112,795,526 | $170,896,134 |
| 2027 | $56,611,231 | $121,509,923 | $184,097,163 |
| 2028 | $60,934,554 | $130,802,292 | $198,173,702 |
| 2029 | $65,592,490 | $140,814,646 | $213,340,765 |

**Exhibit 19 –2025-2029 Non-Medicaid Income Eligible Program Costs**

| Scenario/Year | Low | Midpoint | High |
|---|---|---|---|
| 2025 | $45,728,657 | $87,395,544 | $142,947,298 |
| 2026 | $48,798,778 | $93,174,578 | $152,458,485 |
| 2027 | $52,289,550 | $99,676,451 | $163,011,544 |
| 2028 | $55,770,319 | $106,214,962 | $173,756,878 |
| 2029 | $59,638,540 | $113,418,731 | $185,663,464 |

## APPENDIX E: CAVEATS & LIMITATIONS

The guidance provided in this report is based on evaluating a specific set of assumptions and should be used to evaluate a range of potential outcomes. Actual experience will deviate from the projections evaluated.

L&E performed reasonability tests on the data used; however, L&E did not perform a detailed audit of the data. To the extent that the information provided was incomplete or inaccurate, the results in this report may be incomplete or inaccurate.

L&E made several assumptions in performing the analysis. Several of these assumptions are subject to material uncertainty and it is expected that actual results could materially differ from the projections.

Examples of uncertainty inherent in the assumptions include, but are not limited to:

- Data Limitations.
  - L&E relied on the data submitted from Hilltop, Maryland insurers, and 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 premium changes have 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 2025 and beyond.

This report has been prepared for the MHBE for discussion purposes in relation to the possible implementation of subsidies for the undocumented population. 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.

The responsible actuaries for this report are members of the American Academy of Actuaries and meet the qualification standards for performing this analysis. The guidance and analysis

expressed in this report are those of the authors only and do not necessarily represent the opinions of other L&E consultants.

The authors of this report are not attorneys and are not qualified to give legal advice. Users of this report should consult legal counsel for interpreting proposed legislation and/or state laws.

## APPENDIX F: DISCLOSURES

The Actuarial Standards Board (ASB), vested by the U.S.-based actuarial organizations[8], 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[9], to observe the ASOPs of the ASB when practicing in the United States. ASOP 41 provides guidance to actuaries with respect to actuarial communications and requires certain disclosures which are contained in the following.

### IDENTIFICATION OF THE RESPONSIBLE ACTUARIES

The responsible actuaries are:

- Josh Hammerquist, FSA, MAAA, Vice President & Principal
- Jason Doherty, ASA, MAAA, Consulting Actuary
- Dave Dillon, FSA, MAAA, MS, Senior Vice President & Principal

The actuaries are available to provide supplementary information and explanation.

### IDENTIFICATION OF ACTUARIAL DOCUMENTS

The date of this document is November 17, 2023. The date (a.k.a. "latest information date") through which data or other information has been considered in performing this analysis is November 9, 2023.

### DISCLOSURES IN ACTUARIAL REPORTS

- The contents of this report are intended for the use of the MHBE. 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 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 the financial impact of offering subsidies to undocumented immigrants in Maryland.
- The responsible actuaries identified above are qualified as specified in the Qualification Standards of the American Academy of Actuaries.
- Lewis & Ellis has reviewed the data provided for reasonableness but has not audited it. L&E nor the responsible actuaries assume responsibility for items that may have a material impact on the analysis. To the extent that there are material inaccuracies in,

[8] 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.
[9] These organizations adopted identical Codes of Professional Conduct effective January 1, 2001.

misrepresentations in, or lack of adequate disclosure by the data, the results may be accordingly affected.

- L&E is not aware of any 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.

LEWIS & ELLIS
Actuaries and Consultants

# Maryland HB 413 Cost Analysis

## MARYLAND HEALTH BENEFIT EXCHANGE

## STATE OF MARYLAND


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**Submitted on:**
November 17, 2023

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# EXECUTIVE SUMMARY

The Maryland Health Benefit Exchange (MHBE) and the Maryland Insurance Administration (MIA) engaged Lewis & Ellis (L&E) to estimate the potential impact of various Individual market premium stabilization and market reforms as outlined in House Bill 413, which was passed into law in 2022. These reforms modify the State Reinsurance Program's (SRP) parameters, provides Individual market coverage for undocumented immigrants[1], and provides supplemental state premium and cost sharing reduction subsidies.

The reforms in this report were all modeled individually. Any potential interaction between the programs were not modeled.

A significant portion of SRP funding is based on the federal pass-through program which shares Advanced Premium Tax Credits (APTC) savings with the state resulting from lower premiums because of SRP. Since the American Rescue Plan Act's (ARPA) enhanced subsidies increase the APTC per member per year (PMPY), there is more pass-through funding available for the SRP. As a result, the continuation of ARPA beyond its current 2025 expiration date is an important factor for SRP funding and solvency. If the ARPA subsidies expire in 2025, L&E estimates a reduction of approximately $500M in pass-through funding for the time period 2026-2029.

Additionally, if the enhanced federal subsidies expire in 2025, L&E estimates that Maryland's cost to return subsidy amounts in 2026 to enhanced ARPA levels via a state subsidy would be approximately $149M, or $945 per member per year (PMPY).

A supplemental state premium subsidy was modeled where APTC eligible enrollees would receive an additional fixed per member per month (PMPM) subsidy. L&E estimates that a $40 PMPM premium subsidy would cost approximately $46M in 2026. The supplemental subsidy is projected to drive additional enrollment into the Individual market through new enrollment from those uninsured and lower lapse rates from existing enrollees.

For assessment purposes, a hypothetical scenario was modeled where the Medicaid income threshold was raised from 138% of the Federal Poverty Level (FPL) to 200%. This modification would be expected to remove a large portion of the healthier than average enrollment from the Individual market and would be expected to significantly raise net premiums for those remaining in the Individual market. Furthermore, SRP net costs would be expected to rise substantially due to the loss of pass-through dollars. This loss of pass-through dollars would likely threaten SRP's solvency.

[1] The analysis for modeling costs for undocumented immigrants was done in a separate L&E reported titled HB413 – Undocumented Immigrant Subsidy Cost Analysis

# ASSUMPTIONS

## POPULATION ASSUMPTIONS

The baseline scenario was modeled using the following assumptions for the expected population in the Individual market before the introduction of any subsidies or other market changes modeled.

- A base population growth factor of 0.5% annually.
- Estimated new enrollment is included from the Young Adult Subsidy Program, fixing the "Family Glitch", and Medicaid redeterminations.

## MARKET ASSUMPTIONS

Overall claims and benchmark premium[2] trend is assumed to be 5% for all scenarios modeled.

## OTHER ASSUMPTIONS

All scenarios are assumed to be independent of each other. In other words, only one market reform outlined in each section is in effect simultaneously. The potential interaction between multiple scenarios is beyond the scope of this report.

Unless the scenario was modeled before 2026 or explicitly stated otherwise, this report focuses on the scenario where ARPA subsidies have been extended indefinitely beyond their current expiration date of 2025.

[2] The benchmark plan is the second lowest cost silver on-exchange plan in each area and is used to determine the amount of APTC for eligible enrollees.

# METHODOLOGY

## DATA SOURCES

Data on the uninsured, lawfully present population (by age and federal poverty limit (FPL)) was provided by MHBE. The data was sourced from the 2021 U.S. Census Bureau's American Community Survey for Maryland.

## 1: ALTERNATE STATE REINSURANCE PROGRAM PARAMETERS

Under the SRP, Maryland has flexibility in varying the reinsurance parameters (i.e., the attachment point, coinsurance, and maximums) to target anticipated premium rate reductions. Table 1 below shows parameters for a base scenario (the SRP parameters expected to be in place in 2025) as well as 11 alternate reinsurance parameter combinations. For each scenario, the expected percentage of claims covered is provided.

Scenarios 1-4 show different parameter combinations which cover approximately the same 33.6% of expected claims as the base scenario. Scenarios 5 and 6 model whether 33.6% of claims can be covered with a $20,500 attachment point and 60% and 50% coinsurance amounts, respectively. However, even without a benefit maximum, the percentage of claims covered cannot reach the 33.6% target. Scenarios 8-11 model the expected percentage of claims covered with 80% coinsurance, a $250,000 maximum, and varying attachment points.

**Table 1 – Reinsurance Parameters 2025**

| Scenario | Attachment Point | Coinsurance | Maximum | Percentage Of Claims Covered |
|---|---|---|---|---|
| Base | $21,000 | 80% | $250,000 | 33.6% |
| 1 | $25,700 | 80% | $500,000 | 33.6% |
| 2 | $27,758 | 80% | $1,000,000 | 33.6% |
| 3 | $34,946 | 90% | $1,000,000 | 33.6% |
| 4 | $20,500 | 70% | $1,000,000 | 33.6% |
| 5 | $20,500 | 60% | Not feasible | 29.1% |
| 6 | $20,500 | 50% | Not feasible | 24.2% |
| 7 | $40,000 | 80% | $250,000 | 22.9% |
| 8 | $25,000 | 80% | $250,000 | 30.5% |
| 9 | $30,000 | 80% | $250,000 | 27.6% |
| 10 | $50,000 | 80% | $250,000 | 19.4% |
| 11 | $60,000 | 80% | $250,000 | 16.6% |

## 2: STATE REINSURANCE PROGRAM – ARPA CONTINUES INDEFINITELY

A significant driver of SRP solvency is the amount of federal pass-through dollars received due to the federal government's realized APTC savings from lower premiums. In the first four years the SRP has been in effect, pass-through funding has covered between 71%-106% of program costs. Since ARPA's enhanced subsidies increase the APTC PMPY amount, and thus increase pass-through received, the continuation or expiration of ARPA has a significant impact on SRP funding and solvency.

Table 2 below shows the differences in funding available between two scenarios where ARPA expires at the end of 2025 and where ARPA is extended indefinitely.

**Table 2 – SRP Funding Scenarios**

| ARPA Subsidies Continue Indefinitely | | | | | | |
|---|---|---|---|---|---|---|
| | *2024* | *2025* | *2026* | *2027* | *2028* | *2029* |
| **Program OutFlows** | | | | | | |
| Reinsurance Payments | $ 578,707,379 | $ 601,967,701 | $ 626,329,368 | $ 651,995,870 | $ 678,786,213 | $ 706,857,015 |
| Other Program OutFlows* | $ 35,000,000 | $ 35,000,000 | | | | |
| **Program Inflows** | | | | | | |
| State Reinsurance Fee Funding | $ 140,220,705 | $ 145,128,430 | $ 150,207,925 | $ 155,465,202 | $ 160,906,484 | $ 166,538,211 |
| Estimated Federal Pass Through | $ 474,246,276 | $ 499,916,753 | $ 525,801,760 | $ 558,837,384 | $ 588,315,377 | $ 619,473,003 |
| **Program Net Cash Flow** | | | | | | |
| Funding Available | **$ 487,765,370** | **$ 495,842,851** | **$ 545,523,169** | **$ 607,829,885** | **$ 678,265,533** | **$ 757,419,732** |
| **ARPA Subsidies Expire After 2025** | | | | | | |
| | *2024* | *2025* | *2026* | *2027* | *2028* | *2029* |
| **Program OutFlows** | | | | | | |
| Reinsurance Payments | $ 578,707,379 | $ 601,967,701 | $ 619,451,631 | $ 644,803,766 | $ 671,255,863 | $ 698,964,490 |
| Other Program OutFlows* | $ 35,000,000 | $ 35,000,000 | | | | |
| **Program Inflows** | | | | | | |
| State Reinsurance Fee Funding | $ 140,220,705 | $ 145,128,430 | $ 150,207,925 | $ 155,465,202 | $ 160,906,484 | $ 166,538,211 |
| Estimated Federal Pass Through | $ 474,246,276 | $ 499,916,753 | $ 416,900,813 | $ 436,061,855 | $ 455,631,394 | $ 476,178,949 |
| **Program Net Cash Flow** | | | | | | |
| Funding Available | **$ 487,765,370** | **$ 495,842,851** | **$ 443,499,958** | **$ 390,223,250** | **$ 335,505,265** | **$ 279,257,935** |

*Funding for the Young Adult Subsidy Program ($20M) and Health Equity Grants ($15M).

## 3: SUPPLEMENTAL STATE PREMIUM SUBSIDY

To further improve affordability in the Individual market, a supplemental state premium subsidy (SSPS) funded by the State was modeled for 2026. Eligible enrollees would receive a fixed amount for each month they are enrolled. Four PMPM subsidy scenarios were modeled: $40, $75, $100, and $125. The SSPS would be in addition to any APTC received and would have the following limitations:

- Only those receiving a non-zero amount of APTC would be eligible to receive the SSPS.

- The SSPS amount received would be the minimum of the SSPS and the amount needed to reduce an enrollee's net premium for the benchmark silver plan to $0[3]. For example, an individual with a $60 monthly net premium after receiving APTC for the benchmark plan would receive the total amount in the $40 scenario but only $60 in the $75 scenario.
- It is assumed Maryland's Young Adult Subsidy Program, which began in 2022, would be phased out and replaced by the SSPS.

Table 3 shows the total SSPS cost for Individual market enrollees for each scenario. The cost estimates do not assume any new enrollment due to the subsidy's implementation.

**Table 3 – 2026 Supplemental State Subsidy – Existing Individual Market Enrollees**

| $40 PMPM Subsidy | $75 PMPM Subsidy | $100 PMPM Subsidy | $125 PMPM Subsidy |
|---|---|---|---|
| $55,459,728 | $102,771,347 | $132,732,185 | $159,023,586 |

The reduction in net premiums due to the introduction of the SSPS is expected to increase Individual market enrollment in two ways. First, new enrollment from the uninsured population who would choose to enroll in coverage because of the lower cost and marketing efforts for the program. Second, the subsidy is expected to lower lapse rates for existing enrollees due to the reduced premium.

To model enrollment increases from the uninsured population, L&E used an elasticity model to estimate the impact for various age groups based on a member's net premium as a percentage of income. The model was informed by an analysis of ARPA and the Young Adult Subsidy Program's impact on enrollment given the magnitude of their reduction to net premiums, and experience with similar programs. Predicting consumer behavior has challenges, therefore three enrollment scenarios were modeled for the uninsured population taking coverage.

L&E analyzed 2022 Individual market lapse rates by categorizing APTC eligible enrollees by their net premiums. Unsurprisingly, lapse rates decrease as an enrollee's net premium decreases. The 2022 lapse rates were segmented by net premium and applied to the projected 2026 premiums net of the SSPS to determine the overall reduction to lapse rates.

[3] Under ARPA, those under 150% FPL have a required contribution amount of 0% for the benchmark plan and thus a 0$ net premium. As a result, they would not be eligible for any amount of SSPS.

Table 4 shows the estimated enrollment changes due to uptake form the previously uninsured population for the three scenarios as well as new enrollment[4] due to a reduction in lapses because of lower premiums.

**Table 4 – 2026 Enrollment Impact of SSPS**

| Cohort | $40 PMPM Subsidy | $75 PMPM Subsidy | $100 PMPM Subsidy | $125 PMPM Subsidy |
|---|---|---|---|---|
| New Enrollment – Lapse Reduction | 2,013 | 3,101 | 3,671 | 4,128 |
| New Uninsured Enrollment – Low Scenario | 3,734 | 5,915 | 8,012 | 8,230 |
| New Uninsured Enrollment – Midpoint Scenario | 6,519 | 8,725 | 11,508 | 11,726 |
| New Uninsured Enrollment – High Scenario | 8,841 | 11,730 | 15,874 | 15,982 |

In addition to the subsidy cost, the State must also cover the cost of any new enrollee's reinsurance claims. The uninsured cohort purchasing coverage is projected to be healthier relative than the market average because of their previous decision to forgo coverage. As a result, the expected reinsurance claims PMPY for new enrollees are projected to be much lower than the market average. The assumed morbidity improvement was also applied to the additional enrollment based on lower lapse rates.

New enrollees also generate pass-through funding due to being covered by the SRP and by receiving APTC. Before SSPS implementation, L&E projects 2026 pass-through funding will cover 84% of SRP costs. L&E estimates new enrollees will have 107% to 145% of SSPS costs (both premium subsidy and reinsurance costs) for the mid-point scenario covered by pass-through funding due to the following:

1. Uninsured uptake into the program skews younger than the current Individual market which results in lower reinsurance costs PMPY. Additionally, reinsurance costs were scaled down to account for this population previously foregoing insurance coverage and now choosing to acquire it due to reduced cost. As a result, new enrollment is projected to have reinsurance costs lower than the expected 2026 market average.

[4] Future references to "new enrollment" will refer to new enrollment from the uninsured plus the additional enrollment from those no longer expected to lapse as a result of the subsidy. Each new enrollment does not represent each unique enrollee but rather 12 months of coverage since the average enrollee is not enrolled for an average of 12 months per year.

2. Younger individuals receive less APTC due to lower age adjusted premiums, resulting in less pass-through funding PMPY. However, the reduction in reinsurance costs is larger for these enrollees than the reduction in pass-through funding.

Therefore, new enrollees, in aggregate, generate more pass-through funding than the cost of providing the program benefits to the new enrollees[5].

**Table 5 – 2026 Pass-through Costs – Midpoint Scenario**

| | $40 PMPM Subsidy | $75 PMPM Subsidy | $100 PMPM Subsidy | $125 PMPM Subsidy |
|---|---|---|---|---|
| Program Costs PMPY | $1,880 | $2,194 | $2,432 | $2,546 |
| Pass-through PMPY | $2,723 | $2,702 | $2,695 | $2,731 |
| Pass-through % of Costs | 145% | 123% | 111% | 107% |

Table 6 below shows the total costs of the program for existing and new enrollees for the midpoint scenario. Appendix A shows a detailed breakout of the costs for all three scenarios.

**Table 6 – 2026 Total SSPS Cost – Midpoint Scenario**

| | $40 PMPM Subsidy | $75 PMPM Subsidy | $100 PMPM Subsidy | $125 PMPM Subsidy |
|---|---|---|---|---|
| Existing Enrollee Cost | $55,459,728 | $102,771,347 | $132,732,185 | $159,023,586 |
| New Enrollee Cost | ($7,189,678) | ($6,007,348) | ($3,993,147) | ($2,931,224) |
| **Total Cost** | **$48,270,050** | **$96,763,999** | **$128,739,038** | **$156,092,362** |

## 4: SUPPLEMENTAL STATE SUBSIDY – REPLACE ARPA

At the time of this report, APRA is set to expire at the end of 2025. Beginning in 2026, enrollees receiving APTC in the Individual market will see significant net premium increases due to reduced premium subsidies. Morbidity is expected to worsen due to lapses from healthy enrollees[6]. This would be expected to raise gross and net premiums for unsubsidized enrollees. L&E has modeled the State's cost if the lost subsidies beyond 2025 were re-instated.

Table 7 shows the projected APTC shortfall amounts and resulting cost to the State for 2026 through 2028.

[5] The savings from new enrollees only partially offsets the cost of providing the subsidy to existing enrollees.
[6] If implemented, Maryland may be able to apply for a 1332 Waiver to capture the APTC savings from improved morbidity. However, this analysis is beyond the scope of this report.

**Table 7 – Replacing ARPA Subsidies Cost**

| Year | APTC Shortfall |
|---|---|
| 2026 | $149,308,590 |
| 2027 | $157,280,504 |
| 2028 | $165,997,279 |

## 5: COST SHARING REDUCTION SUBSIDIES

While premium subsidies help enrollees reduce their monthly payments for insurance coverage, enrollees still incur significant out-of-pocket costs due to copays, deductibles, and coinsurance. To improve affordability for low-income members, the ACA provides Cost Sharing Reduction subsidies (CSRs) for those with incomes under 250% FPL.

Two additional CSR programs were modeled that would further reduce cost sharing for eligible enrollees in 2026. The first program provides additional state-funded cost-sharing reductions (SFCSRs) to individuals enrolled in the 87% and 94% variant silver plans who receive CSRs through the ACA. The second program provides SFCSRs for persons with FPLs between 200% and 300% and who have purchased gold plans. That is, persons not eligible for traditional 87% and 94% AV CSR silver plans[7].

**Silver SFCSRs**

To model the cost of the silver SFCSRs, L&E calculated the projected 2024 average allowed cost[8] for silver plans as reported by Maryland insurers in their rate filings. This amount was trended 5% annually to a 2026 implementation date. The cost to increase an enrollee's AV by 1% (i.e., from 87% CSR to 88%) is 1% times the average silver allowed amount.

Projected enrollment was derived from actual 2023 enrollment by CSR variant which was trended forward to 2026 and also increased to account for Medicaid redeterminations. Table 8 below shows the projected enrollment, assuming no new enrollment as a direct result of the subsidy, and the PMPM cost needed to reduce enrollee cost sharing in the 87% and 94% silver variants for each 1% of AV[9].

[7] Those between 200% and 250% FPL are eligible for CSRs via the 73% CSR silver variant. However, given the premium relationships in Maryland as the result of silver loading, gold plans are generally cheaper and have reduced cost sharing compared to the 73% silver variant making them a more attractive choice for the majority of enrollees in this cohort.

[8] Weighted by enrollment.

[9] Costs are proportional per 1% increase in AV (i.e., a 3% buyup to 90% AV would be $7.42 x 3 = $22.26 PMPM).

**Table 8 – 2026 SFCSR Silver Cost Projections[10]**

| Silver Only | 87% CSR | 94% CSR |
|---|---|---|
| PMPM Buyup Cost per 1% AV | $7.42 | $7.24 |
| Projected 2026 Member Months | 187,257 | 356,215 |
| **Projected 2026 Annual Cost** | **$1,389,203** | **$2,580,298** |

Table 9 below shows two enrollment scenarios and the resulting program savings due to new enrollees joining the market. In these scenarios all enrollees in the 87% and 94% CSR variants have their AVs increased by four points. Like the SSPS, those joining because of the SFCSR are projected to be healthier than average and therefore generate more pass-through than the cost of their program benefits.

**Table 9 – 2026 SFCSR Silver 4% AV Buyup Projections - New Enrollment Scenarios**

| Silver Only | Scenario 1 | Scenario 2 |
|---|---|---|
| Existing Enrollee Cost – 4% AV Buyup | $15,878,007 | $15,878,007 |
| New Enrollment | 2,000 | 4,000 |
| New Enrollment Subsidy Costs PMPY – 4% AV Buyup | $352 | $352 |
| New Enrollment Reinsurance Costs PMPY | $1,462 | $1,462 |
| New Enrollment Pass-through PMPY | ($2,846) | ($2,846) |
| Total New Enrollee Cost | ($2,064,786) | ($4,129,573) |
| **Total Cost** | **$13,813,221** | **$11,748,434** |

**Gold SFCSRs**

Similar to the silver SFCSR approach, a gold SFCSR program would reduce enrollee cost sharing for eligible enrollees (200-300% FPL and APTC eligible) in gold plans by lowering deductibles, coinsurance, and copays. The goal of the gold SFCSR would be to reduce cost sharing to levels comparable to those of a platinum plan. In other words, the gold SFCSR program would increase the AV of gold plans by approximately 10%[11]. Like the silver SFCSRs, the projected PMPM cost was determined by taking the projected 2024 weighted average allowed amount for gold plans trending forward to 2026, multiplied by the 10% AV buyup. This cost is an estimated $94.16 PMPM.

[10] The small difference between the 87% and 94% CSR buyup cost PMPM is due to slight membership differences in those variants between plans.

[11] While AVs can vary within metal levels, for simplicity it was assumed the average difference would mirror the 10% relationship (90%-80%) between gold in platinum as reflected in the ACA risk adjustment transfer formula.

While a $94 premium subsidy may generate new enrollment into the Individual market, it's not clear the impact that a gold SFCSR will have. Premium subsidies have a clear, defined benefit that is realized every month when an enrollee pays premium. A CSR subsidy is more difficult to communicate since any consumer benefit is not realized until the enrollee starts incurring medical costs. Healthy members with very low claim levels may see little to no benefit from the SFCSR. Additionally, unlike premium subsidies, there is limited historical data showing the impact of CSR costs on enrollment.

Like new enrollees from the SSPS and the silver SFCSR, those expected to join due to the implementation of the gold SFCSR are projected to be healthier than average, generating more pass-through dollars than reinsurance costs incurred. However, unlike the silver SFCSR, these enrollees are expected to have program costs roughly equal to pass-through due to the higher PMPY subsidy cost associated with the gold SFCSR than the silver. As a result of this revenue neutrality, new enrollment is not expected to have a material impact on total costs.

While new enrollment costs from the subsidy may be immaterial, it is expected that more knowledgeable, existing Individual market enrollees in other metal levels will recognize the value of the SFCSR subsidy. This value would be recognized through marketing efforts or by comparing plans during open enrollment. Therefore, in addition to the number of existing enrollees in gold plans, the overall cost of the SFCSR subsidy is dependent on the number of enrollees switching coverage from other metal levels to gold plans. Table 10 below shows projected enrollment for the eligible cohort, assuming the SFCSR subsidy is not in effect.

**Table 10 – Projected Pre-SFCSR Subsidy 2026 Enrollment (Member Months) by Metal Level - 200-300% FPL Enrollees**

| FPL Bucket | CSR Silver 73% | Gold | Other Metals |
|---|---|---|---|
| 200-250 | 35,154 | 176,240 | 72,428 |
| 250-300 | - | 119,449 | 85,634 |
| **Total** | **35,154** | **295,689** | **158,062** |

Approximately 40% of enrollment is projected to be in other metal levels before the impact of a gold SFCSR. As described above, modeling consumer behavior due to CSR subsidy availability has challenges. Therefore, L&E modeled three enrollment scenarios for the gold SFCSR subsidy.

The baseline scenario assumes there is no shift into gold plans from other metal levels, and only those originally projected to enroll in gold plans before the subsidy's implementation (as shown in Table 6) receive the SFCSR.

The second scenario also assumes that 100% of the eligible enrollment in CSR silver 73% and other metal level plans[12] will migrate to gold plans.

The third scenario assumes that only 50% of eligible enrollment will migrate from other metal levels. Table 11 shows the projected cost for each of the three enrollment scenarios.

**Table 11 – Projected 2026 Gold to Platinum CSR Costs - 200-300% FPL Enrollees**

| Scenario | SFCSR Cost |
|---|---|
| Only Current Gold Enrollment | $27,842,659 |
| 100% Migration into Gold | $46,036,248 |
| 50% Migration into Gold | $36,939,453 |

## 6: REMOVING INDIVIDUALS UNDER 200% FPL

An alternative scenario was modeled where the income threshold for Medicaid in Maryland was expanded from 138% FPL to 200% FPL. L&E modeled the impact of removing individuals under 200% FPL from the Individual market in 2025. This change would have a significant negative impact on the Individual market and would put substantial stress on the solvency of the SRP.

**Impact on Enrollment and Affordability**

The first result of the loss of these members would be a substantial increase in net premiums for all remaining enrollees receiving APTC. APTC amounts are indexed to income levels and the benchmark silver plan. Higher benchmark premiums result in larger APTC amounts for eligible enrollees, all else being equal. Due to CSR defunding in 2017, silver premiums in Maryland now contain a "CSR load". In addition to funding the expected CSR costs, the CSR load has a secondary benefit of raising silver premiums, including the benchmark plan. As a result, all APTC-eligible enrollees enjoy the benefit of higher subsidy amounts, increasing buying power and lowering their net premiums.

Individuals under 200% FPL are primarily in CSR silver plans. Their removal from the Individual market would substantially lower the CSR load. Silver premiums, including the benchmark plan, would experience significant rate decreases. As a result of a lower benchmark plan premium, APTC amounts would be reduced by a similar amount.

Since other metal levels are not affected by CSR loading, their premiums are not directly impacted by the removal of these enrollees. Without a corresponding drop in non-silver

[12] At the time of this report, no insurers in Maryland offer platinum plans. Therefore, all other enrollment from non-CSR 73% plans would be from bronze members.

premiums, a reduction in the benchmark plan premium results in higher net premiums for all other metal tiers.

Faced with higher net premiums due to less APTC availability, it is expected that a portion of healthier than average APTC-eligible individuals would lapse coverage. Due to the ACA single risk pool requirements, the loss of these healthier members would raise overall market morbidity. As a result, premiums for all metal tiers would increase uniformly.

Unsubsidized enrollees must pay the full cost of premium increases. Like APTC-eligible enrollees described above, lapses from healthy unsubsidized enrollees would be expected. This circular process of higher premiums and the resulting loss of healthy members could continue in future years without intervention.

**Impact on SRP Solvency**

The enrollment losses and premium changes described would reduce SRP solvency due to the following:

- Lower silver loads reduce benchmark premiums which reduces PMPY pass-through funding.
- Since APTC amounts increase as income decreases, more PMPY pass-through funding is derived by individuals under 200% FPL compared to those above 200% FPL. Therefore, the removal of the under 200% FPL population from the market reduces the average pass-through PMPY amount while not reducing the average reinsurance costs PMPY.
- Healthy enrollees have fewer reinsurance costs. It is likely that the majority of healthy members lapsing will have claims less than the SRP attachment point and thus would not trigger reinsurance payments. APTC-eligible enrollees with no reinsurance claims increase the available SRP funding due to generating pass-through dollars with no associated costs. Therefore, the loss of these enrollees will decrease SRP funding.

As a result, removing individuals under 200% FPL from the Individual market is expected to substantially increase SRP's required state funding. Assuming the ARPA subsidies expire in 2025, the combined impact would result in SRP becoming insolvent beginning in 2028.

# APPENDICES

## APPENDIX A: SSPS 2026 COSTS BY AGE AND FPL

The tables below show the 2026 SSPS costs by age and FPL[13] for the midpoint scenario for the four PMPM subsidy amounts modeled.

**Table 12 - $40 PMPM SSPS – Midpoint Scenario**

| Age/FPL | 0-18 | 18-25 | 26-34 | 35-44 | 45-54 | 55-64 | 65+ |
|---|---|---|---|---|---|---|---|
| 0%-138% | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| 138%-150% | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| 150%-200% | $248,965 | $1,806,977 | $2,971,621 | $3,321,284 | $3,828,756 | $4,780,590 | $309,494 |
| 200%-250% | $190,579 | $1,195,473 | $2,248,902 | $2,103,759 | $2,612,724 | $3,796,923 | $172,397 |
| 250%-300% | $220,482 | $620,522 | $1,098,761 | $1,009,506 | $1,505,872 | $2,413,492 | $84,091 |
| 300%-400% | $988,943 | $564,317 | $1,021,890 | $1,075,123 | $1,650,149 | $3,048,097 | $57,263 |
| 400%+ | $0 | $901 | $921 | $19,933 | $19,544 | $2,951,711 | $330,088 |

**Table 13 - $75 PMPM SSPS – Midpoint Scenario**

| Age/FPL | 0-18 | 18-25 | 26-34 | 35-44 | 45-54 | 55-64 | 65+ |
|---|---|---|---|---|---|---|---|
| 0%-138% | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| 138%-150% | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| 150%-200% | $488,485 | $3,545,409 | $5,830,516 | $6,516,577 | $7,512,272 | $9,379,832 | $607,247 |
| 200%-250% | $386,561 | $2,424,839 | $4,561,563 | $4,267,161 | $5,299,521 | $7,701,491 | $349,681 |
| 250%-300% | $447,215 | $1,258,636 | $2,228,672 | $2,047,631 | $3,054,436 | $4,895,408 | $170,567 |
| 300%-400% | $2,005,922 | $1,144,633 | $2,072,752 | $2,180,726 | $3,347,081 | $6,182,609 | $116,149 |
| 400%+ | $0 | $1,828 | $1,868 | $40,431 | $39,642 | $5,987,104 | $669,535 |

[13] Individuals under 150% FPL are not eligible for a SSPS due to their net premium being $0 with the enhanced ARPA subsides.

**Table 14 - $100 PMPM SSPS – Midpoint Scenario**

| Age/FPL | 0-18 | 18-25 | 26-34 | 35-44 | 45-54 | 55-64 | 65+ |
|---|---|---|---|---|---|---|---|
| 0%-138% | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| 138%-150% | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| 150%-200% | $652,676 | $4,737,107 | $7,790,294 | $8,706,957 | $10,037,329 | $12,532,622 | $811,357 |
| 200%-250% | $523,687 | $3,114,853 | $5,521,985 | $5,423,396 | $6,785,784 | $9,610,470 | $444,418 |
| 250%-300% | $614,253 | $1,728,745 | $3,061,098 | $2,812,436 | $4,195,290 | $6,723,879 | $234,275 |
| 300%-400% | $2,755,149 | $1,572,161 | $2,846,940 | $2,995,244 | $4,597,240 | $8,491,859 | $159,532 |
| 400%+ | $0 | $2,511 | $2,566 | $55,533 | $54,448 | $8,223,332 | $919,611 |

**Table 15 - $125 PMPM SSPS – Midpoint Scenario**

| Age/FPL | 0-18 | 18-25 | 26-34 | 35-44 | 45-54 | 55-64 | 65+ |
|---|---|---|---|---|---|---|---|
| 0%-138% | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| 138%-150% | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| 150%-200% | $803,204 | $5,829,631 | $9,586,979 | $10,715,053 | $12,352,250 | $15,423,035 | $998,482 |
| 200%-250% | $641,963 | $3,579,161 | $5,805,712 | $5,978,697 | $7,599,096 | $10,450,045 | $489,891 |
| 250%-300% | $777,040 | $2,186,891 | $3,872,339 | $3,557,778 | $5,307,110 | $8,505,816 | $296,361 |
| 300%-400% | $3,485,308 | $1,988,810 | $3,601,425 | $3,789,032 | $5,815,583 | $10,742,340 | $201,811 |
| 400%+ | $0 | $3,176 | $3,246 | $70,250 | $68,878 | $10,402,648 | $1,163,323 |

## APPENDIX B: CAVEATS & LIMITATIONS

The guidance provided in this report is based on evaluating a specific set of assumptions and should be used to evaluate a range of potential outcomes. Actual experience will deviate from the projections evaluated.

L&E performed reasonability tests on the data used; however, L&E did not perform a detailed audit of the data. To the extent that the information provided was incomplete or inaccurate, the results in this report may be incomplete or inaccurate.

L&E made several assumptions in performing the analysis. Several of these assumptions are subject to material uncertainty and it is expected that actual results could materially differ from the projections.

Examples of uncertainty inherent in the assumptions include, but are not limited to:

- Data Limitations.
    - L&E relied on the data submitted from Hilltop 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 premium changes have 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 2025 and beyond.

This report has been prepared for the MHBE for discussion purposes in relation to the possible implementation of premium stabilization and market reforms. 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.

The responsible actuaries for this report are members of the American Academy of Actuaries and meet the qualification standards for performing this analysis. The guidance and analysis expressed in this report are those of the authors only and do not necessarily represent the opinions of other L&E consultants.

The authors of this report are not attorneys and are not qualified to give legal advice. Users of this report should consult legal counsel for interpreting proposed legislation and/or state laws.

# APPENDIX C: DISCLOSURES

The Actuarial Standards Board (ASB), vested by the U.S.-based actuarial organizations[14], 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[15], to observe the ASOPs of the ASB when practicing in the United States. ASOP 41 provides guidance to actuaries with respect to actuarial communications and requires certain disclosures which are contained in the following.

## IDENTIFICATION OF THE RESPONSIBLE ACTUARIES

The responsible actuaries are:
- Josh Hammerquist, FSA, MAAA, Vice President & Principal
- Jason Doherty, ASA, MAAA, Consulting Actuary
- Dave Dillon, FSA, MAAA, MS, Senior Vice President & Principal

The actuaries are available to provide supplementary information and explanation.

## IDENTIFICATION OF ACTUARIAL DOCUMENTS

The date of this document is November 17, 2023.The date (a.k.a. "latest information date") through which data or other information has been considered in performing this analysis is November 9, 2023.

## 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 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 the financial impact of various premium stabilization and market reform programs as outlined in HB413.
- The responsible actuaries identified above are qualified as specified in the Qualification Standards of the American Academy of Actuaries.
- Lewis & Ellis has reviewed the data provided for reasonableness but has not audited it. L&E nor the responsible actuaries assume responsibility for items that may have a

[14] 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.
[15] These organizations adopted identical Codes of Professional Conduct effective January 1, 2001.

material impact on the analysis. To the extent that there are material inaccuracies in, misrepresentations in, or lack of adequate disclosure by the data, the results may be accordingly affected.

- L&E is not aware of any 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.