

Chapter 1. Introduction

The Maryland Health Insurance Coverage Protection Commission

Both in response to and in anticipation of efforts at the federal level to repeal and replace the ACA, Chapter 17 of 2017 (**Appendix 1**) established the Maryland Health Insurance Coverage Protection Commission. Section 2 of Chapters 37 and 38 of 2018 altered the membership and charge of the commission (**Appendix 2**). Chapters 417 and 418 of 2019 required the commission to establish a workgroup and extended the termination date of the commission (**Appendix 3**) and Chapters 597 and 598 further changed the charge of the commission (**Appendix 4**).

The commission was established to (1) monitor potential and actual federal changes to the ACA, Medicaid, Maryland Children's Health Program (MCHP), Medicare, and the Maryland All-payer Model; (2) assess the impact of such changes; and (3) provide recommendations for State and local action to protect access to affordable health coverage. The commission will terminate on June 30, 2023.

The commission consists of (1) three members of the Senate; (2) three members of the House of Delegates; (3) the Secretary of Health (or designee); (4) the Maryland Insurance Commissioner (or designee); (5) the Attorney General (or designee); (6) one representative of the Maryland Hospital Association; (7) one representative of a managed care organization; (8) one consumer; (9) one representative of a health insurance carrier; (10) one representative who is an employer; (11) one representative of the nursing home industry; (12) one representative of the Maryland State Medical Society, also known as MedChi; (13) one representative of behavioral health care providers; (14) two members of the public; and (15) one representative of a group model health maintenance organization that participates in the individual market.

The duties of the commission encompass a requirement for a study that includes (1) an assessment of the current and potential adverse effects of the loss of health coverage on the residents, public health, and economy of the State resulting from changes to the ACA, Medicaid, MCHP, Medicare, or the Maryland All-payer Model; (2) an estimate of the costs of such adverse effects and the resulting loss of health coverage; (3) an examination of measures that may prevent or mitigate such adverse effects and the resulting loss of health coverage; and (4) recommendations for laws that may be warranted to minimize such adverse effects and assist residents in obtaining and maintaining affordable health coverage. The commission may hold public meetings across the State to carry out its duties and convene workgroups to solicit input from stakeholders.

More specifically, the commission is required to study and make recommendations for individual and group health insurance market stability, including:

- the components of one or more Section 1332 waivers;

- whether to pursue a standard plan design that limits cost sharing;
- whether to merge the individual and small group health insurance markets for rating purposes;
- whether to pursue a basic health program;
- whether to pursue a Medicaid buy-in program for the individual market;
- whether to provide subsidies that supplement premium tax credits or CSRs;
- whether to adopt a State-based individual health insurance mandate and how to use payments collected from individuals who do not maintain minimum essential coverage, including use of the payments to assist individuals in purchasing health insurance; and
- whether the State Reinsurance Program should be extended after calendar year 2023 and, if so, how it will be funded.

Chapters 417 and 418 of the Acts of 2019 created the Health Insurance Consumer Protections Workgroup. The purpose of the workgroup was to “carry out the finding and declaration of the General Assembly that it is in the public interest to ensure that the health care protections established by the federal Patient Protection and Affordable Care Act (ACA) continue to protect Maryland residents in light of continued threats to the ACA.” The findings and recommendations of the workgroup can be found in **(Appendix 5)**.

By December 31 each year, the commission must submit a report on its findings and recommendations to the General Assembly and the Governor. This report is the third annual report of the commission.

State Actions to Stabilize the Individual Health Insurance Market

State Reinsurance Program

In response to recommendations by the commission, emergency legislation was enacted to adopt measures to stabilize Maryland’s individual market. Chapters 6 and 7 of 2018 required MHBE to submit an application for a State Innovation Waiver under Section 1332 of the ACA to establish a State reinsurance program and seek federal pass-through funding (federal funding that would have been provided to Maryland residents in the form of APTC in the absence of the program). In August 2018, the federal government approved the waiver, which is valid through 2023. The program, which began January 1, 2019, provides reimbursement to carriers in the individual market that incur certain total annual claims costs on a per individual basis. Carriers

are reimbursed for 80% of claims between \$20,000 and \$250,000. Payments to carriers will be made after the plan year ends, and all costs have been recorded and reconciled.

The reinsurance program is funded by a combination of assessment revenues and federal pass-through funds. Revenues come from a 2.75% assessment on specified health insurance carriers to recoup the aggregate amount of the health insurance provider fee that would have been assessed under ACA for calendar 2019 but was temporarily suspended for that year by action at the federal level. Chapters 597 and 598 of 2019 extended the assessment through 2023 to provide additional funding for the program; however, for calendar 2020 through 2023, the assessment will be 1.0%.

When the reinsurance program was established, MHBE estimated that total funding would be \$1.1 billion for calendar 2019 through 2021, including \$365 million in State funds from the one-time assessment and \$730 million in federal pass-through funds. MHBE advises that program costs are now estimated to be less than anticipated. For calendar 2019, estimated costs of \$462 million have been revised to \$370 million, though final costs will not be determined until all 2019 claims are accrued. For calendar 2020, estimated costs of \$459 million are now anticipated to be \$400 million. These revised estimates suggest that funding will last longer than initially anticipated or may be available to fund other activities to further stabilize the individual market.

For calendar 2019, individual market premium rates approved by the Maryland Insurance Administration (MIA), reflecting the anticipated impact of the reinsurance program, declined by an overall 13.2%. For calendar 2020, approved rates fell an additional 10.3%. Although premiums have decreased for the second year in a row, they remain high, and deductibles and out-of-pocket (OOP) expenses continue to increase. In calendar 2020, deductibles will range from \$4,000 to \$7,900 for bronze plans, \$2,250 to \$6,000 for silver plans (the most commonly purchased plan), and \$0 to \$1,750 for gold plans. Affordability is particularly an issue for individuals who do not receive an APTC. To address these issues, MIA conducted a report on health insurance cost-sharing trends and MHBE established a workgroup to study affordability of health care in Maryland.

Maryland Easy Enrollment Health Insurance Program

Following presentations made to the commission in 2018, Chapters 423 and 424 of 2019 established the Maryland Easy Enrollment Health Insurance Program to facilitate health insurance enrollment for uninsured Marylanders. The program allows an uninsured individual to elect on their State income tax return to authorize the Comptroller to share information with MHBE in order to determine the individual's eligibility for insurance affordability programs. MHBE will assist in enrolling uninsured individuals in Medicaid or subsidized or unsubsidized health insurance. The program is anticipated to begin with the filing of tax year 2019 State income tax returns in early 2020.

Chapter 2. Work of the Commission

Agenda and Presentations

During the course of the 2019 interim, the Maryland Health Insurance Coverage Protection Commission held three meetings. Below is a summary of information as it was presented to the commission at the commission meetings. Accordingly, there may be some variation in figures referenced by presenters due to their drawing upon differing sources of information for their presentations. The views expressed by the presenters do not necessarily reflect the views of the commission or its members.

August 21, 2019 Meeting

During its first meeting, the Commission received briefings on the Maryland Easy Enrollment Health Insurance Program, the Health Insurance Consumer Protections Workgroup, and pre-existing condition protections implemented in other states. The Commission also reviewed and discussed options to stabilize the individual market that were presented to the Commission in 2017 and 2018.

Maryland Easy Enrollment Health Insurance Program

During the 2019 session, the General Assembly passed legislation establishing the Maryland Easy Enrollment Health Insurance Program, to allow an uninsured individual to elect on their State income tax return to authorize the Office of the Comptroller to share information with the Maryland Health Benefit Exchange (MHBE) in order to determine the individual's eligibility for insurance affordability programs.

Heather Forsyth, Director of Consumer Assistance at the Maryland Health Benefit Exchange, advised the Commission that the Program will be available in part for the 2019 tax year. In discussions with the Office of the Comptroller, the Exchange determined that it was not administratively feasible to roll the entire program out this year; however, the agencies will implement as much as possible. In Phase 1 of implementation (available for tax year 2019), the system will provide preliminary eligibility determinations. The system will generate a personalized notice to everyone who checks the box on the tax form. The notice will include information about the individual's likely eligibility status and advise the individual about how to get help through the Exchange. The Exchange is also preparing training materials for their consumer assistance workers, and has privacy protections in place.

There will be a 30-day "Tax Time" special enrollment period for individuals enrolling in private insurance. The special enrollment period will begin when an individual receives their notice of eligibility. The notice will include the date on which the individual's special enrollment period will end. The Exchange also noted that individuals can enroll in Medicaid year-round, so no special enrollment period is needed for individuals who seek Medicaid or MCHIP enrollment.

The Exchange advised the Commission that they will be collecting data on 1) the number of consumers who check the checkoff box; 2) the number of consumers who follow up with the Exchange; and 3) the number who enroll in health insurance. This data will be made available to the General Assembly.

Deborah Gorman, Deputy Director of the Revenue Administration Division at the Office of the Comptroller, provided a draft copy of the Easy Enrollment tax forms. Individuals will use the checkoff boxes on Maryland Form 502 to indicate whether they have insurance and if not, whether they authorize the Comptroller to share information from their tax return with the Exchange. Individuals may use Maryland Form 502B to provide information about dependents. Ms. Gorman also indicated that the Exchange has set up a landing page, linked from the tax instructions, where individuals can get more information about health insurance options.

Jessica Grau, Health Policy Analyst at the Maryland Health Benefit Exchange, provided an update on the Maryland Easy Enrollment Workgroup. The workgroup is comprised of 22 members, chosen from 55 applicants. Ms. Grau also announced that the workgroup's first meeting would be held in September.

Health Insurance Consumer Protections Workgroup

Delegate Pena–Melnyk provided an update on the Health Insurance Consumer Protections Workgroup. This workgroup was created by Chapters 417 and 418 (HB 697 and SB 868) of 2019. The purpose of the workgroup was to “carry out the finding and declaration of the General Assembly that it is in the public interest to ensure that the health care protections established by the federal Patient Protection and Affordable Care Act (ACA) continue to protect Maryland residents in light of continued threats to the ACA.”

The workgroup is comprised of members of the Commission and held an organizational meeting in late July. The group will meet four times during the interim to review HB 697 and SB 868 of 2019, as introduced, and make recommendations for legislation that would codify the ACA's consumer protections in Maryland law. Meetings will be open to the public, and video recordings of the meetings will be published on the DLS website. The workgroup will provide its report to the Commission at the December 17 meeting.

Pre-existing Condition Protections in Other States

Dania Palanker, Assistant Research Professor at the Center on Health Insurance Reforms at Georgetown University's Health Policy Institute, provided an update on the *Texas v. United States* ACA litigation. In December 2018, a District Court Judge from the Northern District of Texas ruled that the entire Affordable Care Act was unconstitutional, since Congress had acted to set the penalty for failing to purchase health insurance to \$0. Without a penalty, the judge ruled, the individual mandate was no longer a valid exercise of Congress' power to tax.

The case was appealed to the 5th Circuit Court of Appeals, which heard oral arguments in July. The oral arguments were organized around three topics: 1) whether the parties have

standing; 2) whether the ACA was unconstitutional without the mandate; and 3) whether any part of the ACA is severable.

Ms. Palanker observed that the case will likely turn on the third item – whether or not any part of the ACA is severable. The court is likely to find that the parties have standing to sue. Furthermore, she noted that two of the judges seemed to think that the individual mandate was unconstitutional without the tax penalty. Therefore, the question about severability will be of high importance. If the entire ACA is unconstitutional, then the premium tax credits and the Medicaid expansion would also go away. The court is expected to reach a decision before the end of the year, and the case will likely be appealed to the Supreme Court.

Emily Curran, Research Fellow at the Center on Health Insurance Reforms at Georgetown University's Health Policy Institute, provided an overview of what other states have done to protect consumers in light of the uncertainty around the Affordable Care Act. A number of states have “baked in” some of the ACA's consumer protections by codifying those provisions into their states' laws. Some states (CT, HI, MD, MA, MN, OR, VT) implemented early market reforms in 2014 by establishing a state-based marketplace and expanding their Medicaid programs. By 2018, 14 states adopted community rating provisions, 9 states adopted guaranteed issue, and 10 states adopted prohibitions on pre-existing condition exclusions.

Other states have taken different approaches. In two states – New Jersey and Rhode Island – the Governor has issued an executive order directing agencies to uphold the ACA's principles. Maine has issued bulletins clarifying state law on dependent coverage, the medical loss ratio, annual and lifetime limits, and essential health benefits, along with other provisions. North Dakota, like Maryland, has created workgroup to study consumer protections and make recommendations to the General Assembly.

Options to Stabilize the Individual Market as Presented to the Commission in 2017 and 2018

During the 2017 and 2018 interims, the Commission received presentations on options to stabilize the individual market. These include 1) merging the individual and small group markets; 2) pursuing a standardized benefit design; and 3) developing a basic health program. Delegate Pena-Melnyk provided a recap of each of those three options and opened the floor for discussion. The purpose of the conversation was to determine whether the Commission wanted to continue pursuing any of those options, or alternatively, to table discussions for now.

Merging the Individual and Small Group Markets

The ACA provides states with the option of merging their individual and small group health insurance markets. This would result in a single risk pool and a single index rate for the total combined claims costs for providing essential health benefits within that risk pool.

Under the direction of the General Assembly in 2011, MHBE convened advisory committees and worked with several consultants to conduct studies to help MHBE develop a number of initial policies required for MHBE's establishment and operations. One of these

considerations what whether the individual and small group markets should be merged. Based on the work of the advisory committees, the MHBE Board of Trustees recommended against merging markets for several reasons:

- Maryland’s small group market was twice as large as the individual market;
- Concern that combining the risk pools would drive up costs in the small group market;
- Concern that rising costs would drive more small groups to self-insure; and
- Not all carriers participated in both markets.

MHBE revisited this recommendation in 2016 and 2018, and in both instances continued to recommend against.

During the 2018 interim, Wakely Consulting Group provided the Commission with an analysis of merging markets in Maryland. Wakely laid out four policy options that Maryland should consider if the State wants to move forward with a merger. Wakely also noted that merging the markets would lessen the effect of the State reinsurance program. Wakely recommended that if Maryland decided to pursue a merger, it should wait until after the reinsurance program ends.

Delegate Pena–Melnyk opened the floor for discussions. The Commission did not take a formal vote, but members indicated their preference was to table this discussion for the foreseeable future.

Standardized Benefit Design

Standardized benefit designs are health benefit plans with benefits and cost sharing set by a non-carrier entity with the intent of assisting consumers in comparing plans “apples-to-apples” across the carriers that offer them. A standardized benefit design workgroup was convened in 2017, and MHBE reported to the Commission on the findings of that workgroup during the 2018 interim. The workgroup did not reach consensus on whether plans should be standardized in the individual market.

In 2018, Commissioners raised questions about the extent to which a standardized benefit design would benefit Maryland consumers, particularly given that there are only two carriers that participate in the individual market that have significantly different models of coverage. It is unclear how a standardized benefit design would assist consumers in choosing between such fundamentally different plans. It is also unclear how standardized benefit design would affect deductibles and premiums.

Delegate Pena–Melnyk opened the floor for further comment. The Commission did not take a formal vote, but members indicated their preference was to table this discussion for the foreseeable future.

Basic Health Program

Section 1331 of the Affordable Care Act gives states the option of creating a Basic Health Program, a health benefits coverage program for low-income residents who would otherwise be eligible to purchase coverage through MHBE. The Basic Health Program gives states the ability to provide more affordable coverage for these low-income residents and improve continuity of care for people whose income fluctuates above and below Medicaid and Children's Health Insurance Program (CHIP) levels.

Through the Basic Health Program, states can provide coverage to individuals who are citizens or lawfully present non-citizens, who do not qualify for Medicaid, CHIP, or other minimum essential coverage and have income between 133 percent and 200 percent of the federal poverty level (FPL). People who are lawfully present non-citizens who have income that does not exceed 133 percent of FPL but who are unable to qualify for Medicaid due to such non-citizen status, are also eligible to enroll.

Two states (New York and Minnesota) currently offer basic health plans; however both states are confronting funding shortages for their programs with the federal government's decision to stop paying cost-sharing reductions.

The Commission did not take a formal vote, but members indicated their preference was to table this discussion for the foreseeable future.

October 15, 2019 Meeting

During its second meeting, the commission received briefings on the Maryland Insurance Administration's [Report on Cost-Sharing Trends in Health Insurance](#), the Maryland Health Benefit Exchange's Affordability Work Group [report](#), Medicaid buy-in programs, and health insurance coverage reforms in Massachusetts.

Trends in Health Insurance

The 2019 *Joint Chairmen's Report* requested that the Maryland Insurance Administration (MIA) produce an informational report on the trends and changes of health insurance benefit design and actuarial value between 2013 and 2018, and the impact of these changes on utilization trends. MIA found that the average actuarial value (the percent of allowed essential health benefits that are paid by the carriers) of plans in the individual and small group markets increased between 2016 and 2018. The average medical deductible decrease slightly between 2013 and 2015, and increased steadily between 2016 and 2018, to \$4,168 in 2018. The impact of these cost-sharing changes on claims utilization has been a slight upward pressure for all years except for 2016, which saw a moderate downward trend. The average drug deductible has gradually declined since 2016 to \$2,113 in 2018. The average out-of-pocket (OOP) maximum increased for all years through 2018 to \$6,938 and is approaching the maximum allowable for OOP expenses under federal regulations.

Affordability Workgroup

The Maryland Health Benefit Exchange (MHBE) discussed the affordability landscape for plans that will be offered on the exchange in calendar 2020. In general, premium decreases are the greatest for bronze and gold plans, in part due to reinsurance program funding. While calendar 2020 premiums decreased by 10.3%, affordability issues remain, particularly for those who do not receive financial assistance and for households with older individuals. Notably, of the remaining uninsured who are eligible to purchase a qualified health plan (QHP) in the exchange, 29% are ineligible for financial assistance (*e.g.*, the household has income greater than 400% of federal poverty guidelines).

MHBE established an Affordability Work Group under 2020 plan certifications standards to develop recommendations to reduce OOP costs and maximize affordability for both subsidized and unsubsidized consumers. The work group found that Maryland's reinsurance program has helped to stabilize the individual market and provide insurance to individuals with chronic illnesses that would not otherwise be able to obtain insurance. The work group also considered who are the remaining uninsured in Maryland and found that the largest group is young adults ages 19 to 34 (94,000), of which nearly 70% are eligible for financial assistance. The work group recommended continuing the reinsurance program and considering a young adult subsidy, which would improve the individual market risk pool by adding individuals who are healthier than average and lowering costs for all. If a subsidy is implemented under a State Innovation (Section 1332) Waiver, Maryland may be able to receive federal pass-through funding. The work group noted that a study should be performed to determine whether it would be more advantageous to pair a young adult subsidy with or without a waiver.

MHBE has also required carriers to offer value plans in the individual exchange for calendar 2020. Value plans will cap deductibles at \$2,500 for silver plans and \$1,000 for gold plans and are designed to give consumers greater access to primary care, mental health care, and generic drugs before their deductibles apply.

Medicaid Buy-in Programs

Chiquita Brooks-LaSure, Managing Director of Manatt Health, discussed evolving public option/Medicaid buy-in models and associated considerations. Nationally, as of 2017, 30 million people remained uninsured, 34% of whom are eligible for Medicaid and 25% of whom are eligible for federal financial assistance in exchanges. Each state has specific market dynamics and health policy goals to consider when choosing affordability and cost-containment policies (*i.e.*, reducing premiums, reducing cost sharing, increasing access for the uninsured). Medicaid buy-in is generally defined as a state leveraging the government bargaining power in some way to offer a more affordable coverage option.

State options include off-market buy-ins (Medicaid-like coverage for consumers who are not eligible for Medicaid offered as an off-market, state-administered plan), on-market public options (a state-sponsored QHP on the exchange and often a "mirror plan" outside the exchange), and Basic Health Program buy-ins. Savings sources may include provider payment rates, administrative efficiencies, leveraging of purchasing power, and long-term savings through investments in population health and delivery systems. Financing can be self-sustaining (enrollee premiums), subsidized with state dollars, funded through federal pass-through funding under Section 1332 waivers, or a combination of the above.

Washington State enacted the nation's first public option legislation in 2019. The goal of the program is to increase affordability and choice for unsubsidized customers priced out of the state exchange. The Washington Health Care Authority (the state's Medicaid agency) will contract with one or more insurers to offer one or more state-sponsored plans on the state's exchange for calendar 2021. Plans will be subject to an aggregate cap of 160% of Medicare rates with specified exceptions. Plans are projected to reduce premiums by 5% to 10%. Of note, Washington has one of the lowest percentages of subsidized consumers in the nation (only 65% of enrollees receive subsidies).

In 2018, New Mexico considered four options for public options: (1) a targeted Medicaid buy-in; (2) a QHP public option; (3) the Basic Health Program; and (4) a Medicaid buy-in for all. New Mexico has a small marketplace population (82% of whom receive subsidies) and lower than average benchmark premiums. More than one-third (34%) of New Mexicans were enrolled in Medicaid in 2017 (the highest proportion in the country). After targeted Medicaid buy-in legislation did not pass, the state continues to weigh its options.

In 2019, Colorado enacted legislation to study a state option for health care coverage. According to the initial report, all state residents would be eligible and plans would be available both on and off-exchange through existing insurers. Savings are anticipated to be generated through an required 85% medical loss ratio (up from the current 80%), prescription drug rebates, and caps on facility reimbursement at 175% to 225% of Medicare rates. Any provider that offers insurance in either the individual or group market will be expected to offer the state option if they meet certain thresholds. Premiums are anticipated to decrease by between 9% and 18%. The state option would be self-funded, but the report recommends applying for a Section 1332 waiver to obtain federal pass-through funding.

Emerging themes among states to date is that specific state dynamics heavily influence design choices, provider responses depend on reimbursement rates and the option's targeted population, stakeholders will need to balance priorities, designs often impact subsidized and unsubsidized populations differently, and concerns about state risk and the effects on other populations. State options cannot solve all issues and may not be the simplest way to address high OOP costs or high premiums, nor may they change behavior among people who are currently eligible for other programs but do not enroll.

Key questions for Maryland to consider if they want to consider a public option are: (1) what problem(s) is Maryland trying to solve and is a buy-in an effective strategy?; (2) who remains uninsured and how will that influence policy design?; (3) what are the potential sources of cost savings?; (4) what existing infrastructure is the best fit for a public option?; (5) what are the potential impacts on other insurance markets?; (6) does the State require, or would it be beneficial to pursue, a Section 1332 waiver?; and (7) is Maryland positioned to implement a state option?

Health Insurance Coverage in Massachusetts

Antecedents to 2016 Reforms

Michael Miller, Director of Strategic Policy for Community Catalyst, discussed the unique dynamics that have made Massachusetts' robust health insurance coverage system possible. Several policy antecedents paved the way for larger reforms in 2006: (1) creation of an uncompensated care pool in 1980s (which made these costs transparent and later served as a financing tool for insurance premium subsidies); (2) small group insurance reform (open to groups as small as 1, which began to blur the differences between the small and individual markets); (3) nongroup insurance reform (adopted medical underwriting protections, preserved carrier participation by requiring sale of products in both the group and nongroup markets); and (4) Medicaid expansion in the 1990s. Several "environmental" factors also made reform possible: Massachusetts has had an iterative policymaking process, employers embrace "high road" economic development strategies, consumers embrace a pragmatic approach to policymaking, policymakers have looked for the "big tent," and the state has many consensus building institutions. This has resulted in a "better boat" and a "calmer sea" – more affordable coverage; lower premiums and cost-sharing; a bigger, more stable risk pool; high coverage rates; and alignment of financial and operational responsibilities. Three key takeaways from Massachusetts' experience have been: (1) affordability makes the world go around; (2) shared responsibility and trust building are key; (2) you don't – and maybe can't – do everything at once, thus an iterative approach is a good approach to building success.

Role of the Massachusetts Health Connector

Audrey Morse Gasteier, Chief of Policy and Strategy for the Massachusetts Health Connector, provided a presentation on health coverage expansion in Massachusetts. Massachusetts currently has the highest insurance rate of any state, the lowest average exchange premiums in the country, and the second lowest benchmark plan in the country. Three key features of the Connector help make this possible: (1) the state's unique "wrap program," ConnectorCare, which uses state-financed subsidies on top of ACA subsidies; (2) program dynamics in the unsubsidized market; and (3) the state's individual mandate.

ConnectorCare State Premium Wrap

Unique to Massachusetts, the Health Connector layers additional state subsidies on top of federal advanced premium tax credits (APTCs) for eligible individuals with incomes up to 300% FPG via the ConnectorCare program. Minnesota, New Hampshire, New York, and Vermont also have subsidy "wrap" programs, but ConnectorCare is particularly robust.

ConnectorCare selects plans from commercial carriers (including carriers that participate in Medicaid) and enrollees are part of the commercial "merged market" risk pool. ConnectorCare uses each selected carrier's lowest-cost silver plan as the base and enriches it with state premium and cost-sharing subsidies, in addition to federal APTCs, to create a selection of plans with low premiums and co-payments for eligible individuals. Enrollees are divided into five "plan types" based on income. Enrollees make per-member premium contributions based on their plan types, in base amounts ranging from \$0 to \$130/month (calendar 2020). Plans have modest co-payments, but no deductibles or coinsurance.

Funding comes from the Commonwealth Care Trust Fund (created to support affordability and coverage expansion), which obtains revenue from tobacco taxes, penalties paid by uninsured

individuals who do not meet the individual mandate, an assessments from the employer community. The state also receives federal matching funds for some of the population in the program through a Section 1115 waiver. The net cost to the State for the program is approximately \$165 million annually – about half to buy down premium costs and half to buy down cost-sharing. The program currently covers about 200,000 enrollees and has five carriers participating statewide.

Dynamics of Massachusetts' Unsubsidized Market and the State Individual Mandate

Converse to most states' experiences, Massachusetts has continued to see growth in its unsubsidized market. This is helped by competition in the Connector Care Program, which creates competitive dynamics between carriers. Massachusetts has also had an individual mandate since 2007, which has helped to keep the risk pool stable, stem against adverse selection, and keep coverage rates high. There are also cost-sharing ceilings and significant consumer protections inherent in the state's individual mandate.

Next Steps for Massachusetts

Amy F. Rosenthal, Executive Director of Massachusetts' Health Care For All, described the role of the organization in supporting insurance and enrollment issues and discussed next steps for Massachusetts. Future efforts will expand coverage to all residents, address prescription drug prices, address out-of-network and balance billing issues, think about social determinants of health, and work on integration of oral health, mental health parity, and pediatric mental health services.