Stabilizing the Individual Health Insurance Market

Presentation to the
House Workgroup

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State of the Market

- About 250,000 Marylanders participate in the individual market
  - About 154,000 enrolled through the Maryland Health Benefit Exchange (MHBE) for calendar 2018, down slightly from the prior year
  - About 80% of exchange enrollees in January 2018 (almost half of individual market participants) qualify for federal tax credit
  - $64 million in federal tax credits received for month of January
  - Credit available for incomes up to 400% of federal poverty guidelines (FPG) ($48,560 for an individual and $100,400 for a family of four)
- 55% enrolled with CareFirst and 45% with Kaiser Permanente
- Participants select from platinum, gold, silver, bronze, and catastrophic plans

Maryland Health Benefit Exchange Initial Enrollment

	Calendar 2017	Calendar 2018
Enrolled	157,637*	153,571
Qualify for Tax Credit	94,858	121,400
% Tax Credit**	60%	79%
Value of January Credits	$30,000,000	$64,000,000

*Only 134,434 remained enrolled by March 2017.
**About 70% who stay in typically qualify.

Calendar 2018 Rates

- Rates initially approved for on-exchange silver plans increased by 31% (CareFirst Blue Choice health maintenance organization(HMO)), 22.7% (Kaiser HMO), 52% (CareFirst preferred provider organizations)
- Rate increases for other metal levels were similar
- Elimination of federal cost-sharing reduction (CSR) payments in October 2017 resulted in amended rates
- Amended rates added 21 to 27 percentage points to the originally approved rate increases for on-exchange silver plans
- CSR adjustments did not impact other rates

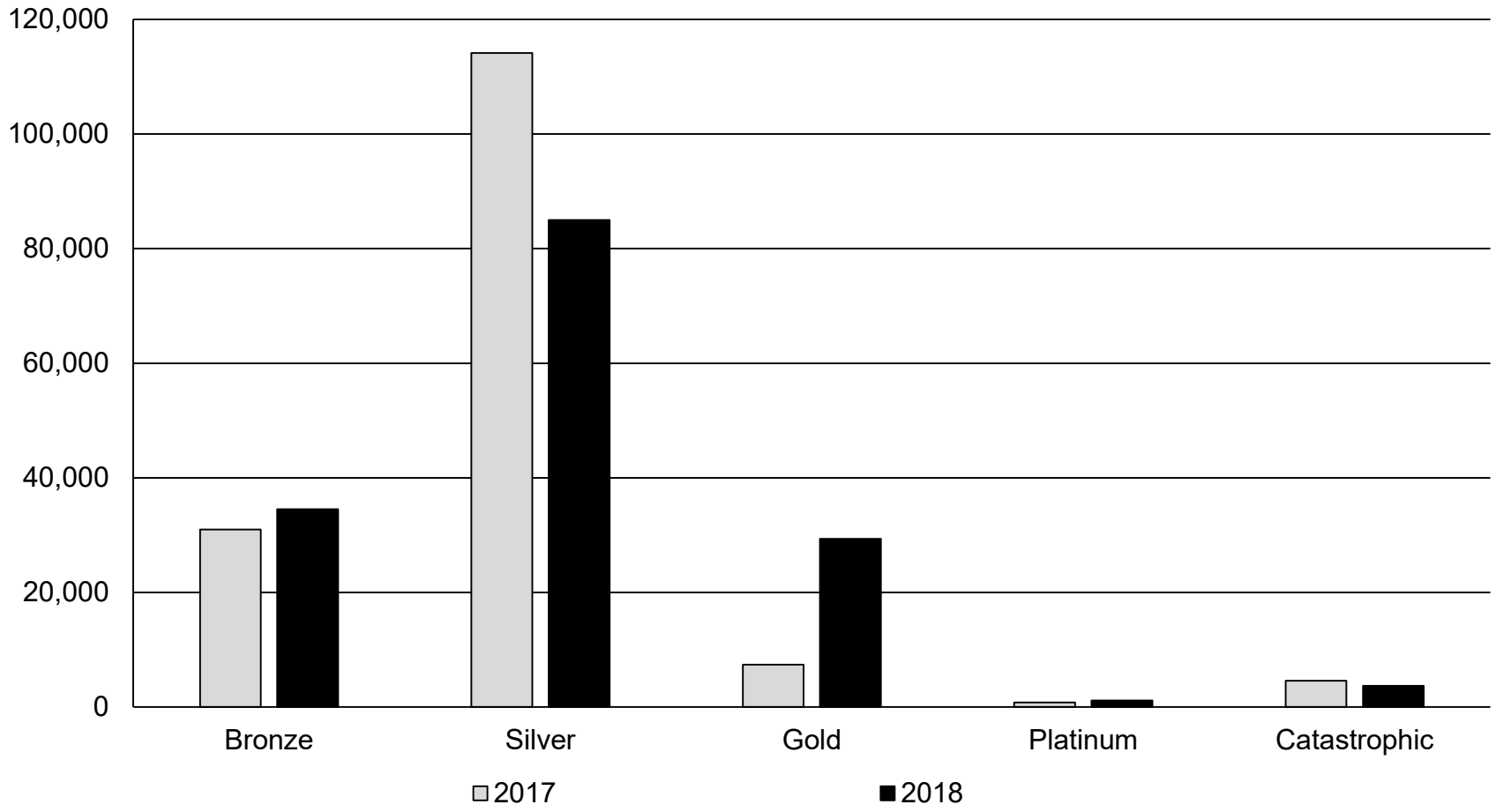
Calendar 2018 Rates (Cont.)

- Federal tax credits are available to enrollees in on-exchange silver plans with incomes below 400% FPG, largely holding these individuals harmless from premium increases

- Must enroll in on-exchange silver plan to benefit from discounts

- Large increase in rates for silver plans led to migration to gold plans

Enrollment by Metal Level



Calendar 2018 Monthly Rate Examples

40-year-old

	Kaiser Permanente	Care First Blue Choice
Bronze	$314	$387
Silver	373	465
Gold	449	516

60-year-old

	Kaiser Permanente	Care First Blue Choice
Bronze	$668	$822
Silver	793	988
Gold	954	1,096

Options

- Reinsurance
- Section 1332 waiver
- Individual mandate
- Combine individual and small group markets
- Recreate high-risk pool
- Premium subsidies
- Basic health plan
- Single payer
- Medicaid buy-in

Reinsurance

- Federal and State funds were available for reinsurance for exchange plans in calendar 2014 through 2016
  - Payouts for calendar 2016 totaled $77 million
  - Ending reinsurance contributed to premium rate increase in calendar 2017
- Attachment point can be adjusted based on available funds
- Funding source would need to be identified
- The Department of Legislative Services (DLS) has retained an actuary to assist with analysis of impact of reinsurance on premiums

Section 1332 Waiver

- Could seek a federal Section 1332 waiver to waive one of several Affordable Care Act (ACA) standards (could develop one standard plan or repurpose federal tax credit funding)
- Application process is robust – must provide significant data, actuarial analyses, detailed budget plan, and timeline
- Requires enactment of legislation authorizing waiver for specific purposes
- Submission and approval before calendar 2019 rates are set is unlikely
- Potential long-term solution

Section 1332 Waiver (Cont.)

- Four states (Alaska, Hawaii, Minnesota, and Oregon) have approved waivers, mostly to use tax credit funding for reinsurance
  - Massachusetts – Premium Stabilization Fund to replace CSR payments
  - Vermont – wavier of Small Business Health Options Progam rules
- Two states have pending waiver applications
- Three states submitted but subsequently withdrew waivers

Section 1332 Waiver (Cont.)

- Alaska reinsurance program
  - Reinsure individuals with 1 of 33 high-cost conditions
  - Anticipate 20% reduction in premiums in 2018
  - Funding from $48 million in federal tax credit funds and $11 million in state funds
- Minnesota reinsurance program
  - For calendar 2018, attachment point of $50,000, $250,000 cap, 80% coinsurance
  - Estimated total reinsurance subsidies of $294 to $308 million in 2018
  - State will pay about 50%
- Oregon reinsurance program
  - For calendar 2018, cap of $1 million, 50% coinsurance, attachment point based on available funding
  - In 2018, Oregon will use $90 million in available fund balance, about $90 million from a 0.3% premium assessment (approved by voter referendum), and about $30 million in federal tax credit funds

Individual Mandate

- Individual mandate requires individuals who can afford insurance to buy it or pay the individual shared responsibility payment (penalty)
- More than 94,000 Maryland tax returns were subject to the federal penalty in tax year 2015
- Total penalties paid by Marylanders were $44.5 million
- 78% of returns paying penalty had an adjusted gross income (AGI) below $50,000; 96% had an AGI below $100,000
- Calendar 2017 penalty is the greater of (1) $695/adult and $347.50/child up to a maximum of $2,085 or (2) 2.5% of AGI
- Federal tax legislation zeroed out the penalty effective tax year 2019
- National estimates of the impact of this change range from enrollment drops of 5% to 15% in calendar 2019

Individual Mandate (Cont.)

- Several states, including Maryland, considering establishing their own individual mandate
- Massachusetts has had an individual mandate since 2006
  - About 50,000 people pay penalty annually
  - Penalty varies by age and income but is typically 50% of the least costly plan
  - For 2017, penalty ranged from $252 to $1,152
- State individual mandate could encourage younger healthier consumers to maintain coverage
- Penalty revenue could be used for “down payment” for coverage or for other stabilization efforts
- Earliest revenue could be collected is April 2020 (for tax year 2019)

Combine Individual and Small Group Markets

- About 255,000 enrolled in small group market
- Rates rose 1.7% for calendar 2018
- Rates for small group are similar to (but still quite a bit lower) but more stable than individual market
- Expanding number of covered lives would spread risk and slow growth of rates for individual market but might generate significant increase in rates for current small group market participants

Recreate High-risk Pool

- Maryland had a high-risk pool from 2003 through 2014
- The Maryland Health Insurance Program provided insurance for individuals with certain qualifying conditions or who did not have access to insurance
- Members paid a premium based on age, subscriber type, and benefit plan, with discounted premiums for those with incomes below 300% FPG
- Funded through premiums and 1% assessment on hospital rates
- In fiscal 2013 (last full year of program), premium revenues of $102.5 million, hospital assessment revenue ($121.9 million), and limited federal grants ($19.8 million)

Recreate High Risk Pool (Cont.)

- A very small share of market is driving the exceptional costs
- Incentivizing these patients to enroll in a heavily subsidized high-risk pool could stabilize the rest of the individual market and even reduce existing rates
- Not a viable one-year solution but a potential long-term strategy for stabilizing market

Premium Subsidies

- The State could offer additional premium subsidies as a way to reduce premium cost and encourage enrollment

- Given current Advanced Premium Tax Credit (APTC) structure, additional premium assistance would have to be targeted at higher income levels

- While premium subsidies would assist in defraying costs to the individual in the short term, they would be costly to maintain in the long term and do not address the drivers of premium growth

Basic Health Plan

- A basic health plan is an option under the ACA for individuals up to 200% FPL who would otherwise qualify for insurance through MHBE

- Federal government provides 95% of the funding these enrollees would have received in subsidies through MHBE

- Federal approval is required

- In the short term, it is unclear what the impact of removing individuals with incomes up to 200% FPL would have on the overall risk level of the individual pool. For individuals at that income level, APTCs already significantly reduce premium costs

Basic Health Plan (Cont.)

- Two states currently offer basic health plans: New York and Minnesota

- Both states are confronting funding shortages for their programs with the federal government decision to stop paying cost-sharing reductions

Single Payer

- Single-payer options have been proposed in numerous states, but none has been implemented
- Vermont's single-payer proposal was ultimately undone by the potential cost
- While single-payer implementation at the State level may or may not be a viable option, it is not something that can be done quickly or easily

Medicaid Buy-in

- Different approaches including
  - Introducing a Medicaid plan as a public option on MHBE (*e.g.*, 2017 legislation passed in Nevada and vetoed by the Governor)
  - Allowing individuals not currently eligible for Medicaid to buy into the program
- Any approach that includes subsidies would likely involve the need for a 1332 or 1115 waiver

Potential Sources of Funding

- Assessment on insurers that do not participate in exchange
- Health insurer fee on all insurers for calendar 2019
  - Congress has suspended federal health insurer fee for calendar 2019
  - Federal fee is in place for calendar 2018 and resumes in calendar 2020
  - Potential State revenue in calendar 2019 estimated at around $250 million

Potential Sources of Funding (Cont.)

- State level individual mandate (no revenue until calendar 2020)

- Hospital assessment

  – In the fiscal 2019 budget plan, current Medicaid hospital assessment declines by $25 million in fiscal 2019 and another $45 million in fiscal 2020

  – Instead of reducing assessment, these amounts could fund reinsurance and help reduce uncompensated care in hospitals

Conclusions

- CareFirst has indicated that its calendar 2019 rate increases could be as high as calendar 2018

- DLS has contracted with Wakely Consulting for actuarial analysis regarding reinsurance options to quantify the size of the problem for calendar 2019 and the cost of a meaningful solution. Analysis expected to be complete in mid-March

- Proposed calendar 2019 rates need to be filed by May 2018. To the extent that carriers can take them into account in developing rates, actions taken during the current session could meaningfully influence those rates

Conclusions (cont.)

- In the short-term, actions that the State has recent experience administering, for example reinsurance, may be easier to implement and easier for insurers to factor into their rates

- Long-term stability in the individual market will require other actions, ongoing funding sources, or a combination of both. Actions requiring a 1332 waiver need authorizing legislation this session, even though a waiver is unlikely to impact calendar 2019 rates. The legislature and administration need to agree on the approach to be taken in such a waiver

- Federal government remains a wild card