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BALTIMORE, MD 21202
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MARYLAND HEALTH BENEFIT EXCHANGE

February 5, 2020

The Honorable Delores G. Kelly
Senate Finance Committee
3 East Miller Senate Office Building
Annapolis, MD 21401

Re: Letter of Support — Senate Bill 124 —Maryland Health Benefit Exchange — Establishment of a State-Based Health Insurance Subsidies Program

Dear Chair Kelly,

The Maryland Health Benefit Exchange (MHBE) respectfully submits this letter of support on Senate Bill (SB) 124 – Maryland Health Benefit Exchange—Establishment of a State-Based Health Insurance Subsidies Program. SB 124 would require MHBE to establish and implement a State-Based Health Insurance Subsidies Program to provide a means for individuals to reduce the amount they pay for health benefit plans in the Individual Health Insurance Marketplace.

In 2018, Maryland established the State Reinsurance Program (SRP), under a State Innovation Waiver to increase premium affordability and foster stability in the individual market. As a result, 2020 premiums in the individual market, on average, fell by more than 22% compared to 2018 premiums.[1] Maryland has also experienced a reduction in the uninsured rate to 6%, the lowest rate ever in the state.

Although the SRP provided immediate relief through lower premiums, Marylanders continued to voice concern over health care affordability. In response, MHBE established the Affordability Work Group to provide the Board of Trustees with recommendations on policy solutions that would:

- Reduce out-of-pocket cost
- Maximize Advanced Premium Tax Credits (APTC) for subsidized consumers
- Maximize affordability for unsubsidized consumers.

The Work Group was presented with information on sub-populations where affordability issues may be concentrated. Data collected from Families USA shows that younger age groups (18-34) represent approximately 50% of the remaining uninsured population (Chart 1. Uninsured, non-elderly Maryland adults stratified by income category (by federal poverty level) and age group). In addition, 70% of this uninsured age group is also eligible for APTC. Given this group' high degree of price sensitivity and low risk aversion, the Work Group determined that additional premium support may maximize market participation.

1 https://insurance.maryland.gov/Pages/newscenter/NewsDetails.aspx?NR=2019236

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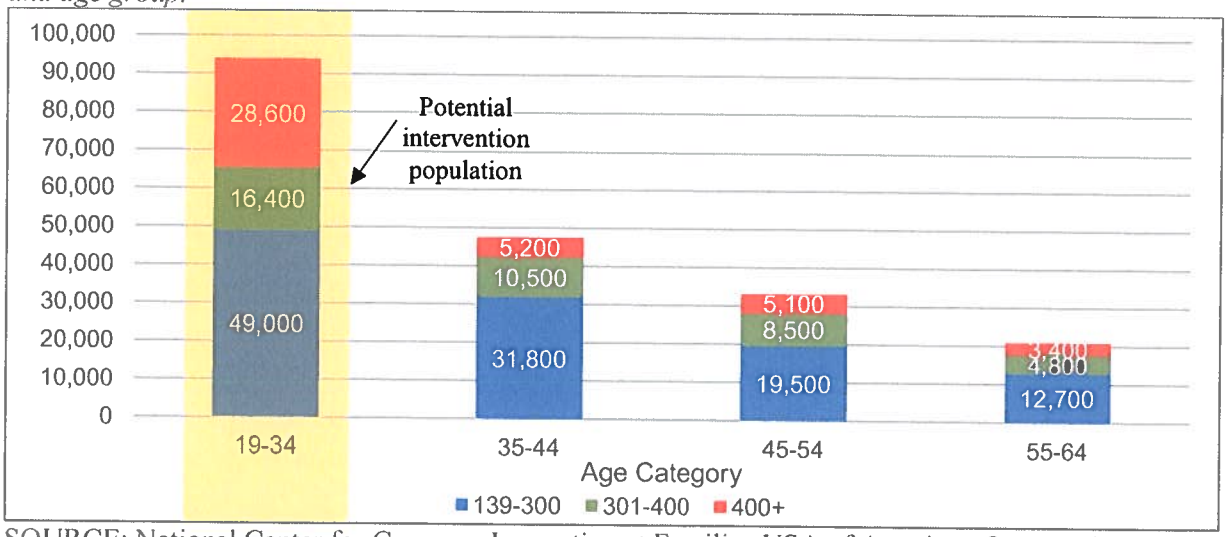
Chart 1. Uninsured, non-elderly Maryland adults stratified by income category (by federal poverty level) and age group.



SOURCE: National Center for Coverage Innovation at Families USA of American Community Survey data. (Families USA 2019)

A targeted state subsidy for young adults would have the additive effect of improving the risk pool, thereby lowering premiums for higher income individuals who are ineligible for APTC and would limit the utilization of State resources when compared with a broader benefit. In addition, when coupled with other initiatives such as the Maryland Easy Enrollment Health Insurance Program, subsidies to support this target group could have substantial enrollment impact. Additional information can be found in the Affordability Work Group Report attached to this letter.

SB 124 provides flexibility to establish program parameters, as well as to allocate funding between the SRP and the subsidies program, in a manner that maximizes the long–term affordability of health plans in the individual market. Further evaluation of a State-Based Health Insurance Subsidies Program was performed by Lewis and Ellis Actuaries and Consultants. The net premium, as well as the estimated uptake in enrollment was modeled in relation to the impacts on the SRP. Lewis and Ellis's early projections estimate that a young adult subsidy would yield an increase in enrollment of 7,000-14,700 individuals in the individual market, with enrollment phased in from 2021-2023, as well as a reduction in market-wide premiums ranging from 1%-2%. Premiums for young adults only may be reduced by 60% with the additional subsidy. Further information can be found in the attached Lewis and Ellis report. In addition, as a result of higher than expected federal pass-through funding to date under the SRP waiver, less state funding than originally anticipated may be required to support the SRP. SB 124 provides an opportunity to optimize the use of state funds to help reduce premiums and encourage market participation to further stabilize the marketplace

While the SRP has resulted in improvements to the marketplace, the experience of the most recent open enrollment period demonstrates that we need to take additional steps to address affordability issues and continue to reduce the rate of the uninsured. Against a national trend of declining enrollment in the individual market, MHBE enrollment increased by 1%, or nearly 2,000 people, for the 2020 plan year. However, approximately 400,000 people remain uninsured. In order to reduce the overall uninsured rate in Maryland by 1%, approximately 60,000 people would need to gain coverage.

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Further action to improve affordability and encourage the remaining uninsured to enroll in coverage, such as a state subsidy program, will be needed to make significant coverage gains.

MHBE staff can be made available to provide additional technical assistance on the implications of SB 124. For further discussions or questions please contact Johanna Fabian-Marks, Director of Policy and Plan Management at johanna.fabian-marks@maryland.gov.

Sincerely,

Michele Eberle

Michele Eberle
Executive Director

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MARYLAND HEALTH BENEFIT EXCHANGE

Appendix

I. Affordability Work Group Report
II. Lewis and Ellis: Actuarial Support Services for the Maryland State Innovation Waiver—Analysis of Young Adult, Federal Poverty Level Extension, and Small Group Subsidies

MARYLAND HEALTHBENEFIT EXCHANGE

Affordability Work Group Report

Recommendations to strengthen the individual market in Maryland

MHBE Policy and Plan Management
August 1, 2019

Background

In 2018, Maryland received a State Innovation Waiver (under Section 1332 of the Patient Protection and Affordable Care Act) to establish a State Reinsurance Program (SRP) that would offset rate increases in the individual market by 30 percent.[1] As a result, premiums in the individual market, on average fell by 13.2% in 2019.[2] A more favorable premium environment, coupled with a strategic investment in marketing, fostered enrollment growth in the individual market that was 24% above original projections.[3]

Although the State Reinsurance Program provided immediate relief through lower premiums, Marylanders continued to voice concern over rising deductibles, out-of-pocket costs, and limited plan options. MHBE summarized these concerns, with discussion, in the *Draft 2020 Annual Letter to Issuers Seeking to Participate in Maryland Health Connection.*[4] In response, MHBE proposed several policy proposals that sought to address these issues, including 1) the implementation of a standardized plan design; 2) create a requirement for issuers to offer additional product options; and 3) the establishment of a petition process to add Essential Community Providers.

In the *2020 Letter to Issuers Seeking to Participate in Maryland Health Connection* (2020 Issuer Letter) MHBE finalized two proposals that sought to address affordability in Maryland Health Connection plans:

1. Establishment of an Affordability Work Group that would provide the Board of Trustees with recommendations on policy solutions that would:

    - Reduce out-of-pocket costs
    - Maximize APTC for subsidized consumers
    - Maximize affordability for unsubsidized consumers

[1] https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/1332-STC-MD-Signed.pdf
[2] https://insurance.maryland.gov/Pages/newscenter/NewsDetails.aspx?NR=2018201
[3] https://www.marylandhbe.com/wp-content/uploads/2018/12/12.17.18_PressRelease.pdf
[4] Insert Draft Letter URL here

2. A requirement for issuers to offer *Value* qualified health plans at the bronze, silver, and gold metal levels, with certain criteria to establish deductible ceilings and require certain services be covered before deductible.[5]

The Affordability Work Group began meeting on March 1, 2019 and ceased business on June 14, 2019. This document provides a summary of this business and presents the Work Group's recommendations.

Affordability Work Group Membership
Work Group members represented stakeholders with diverse perspectives and subject matter expertise to inform the business of the Work Group. To provide additional subject matter expertise from a regulatory, statutory, and policy perspective MHBE sought additional support from the Maryland Insurance Administration.

Table 1. Affordability Work Group Membership

Name	Organization	Role
Ken Brannan	Special Olympics Maryland	Co-Chair
Stephanie Klapper	Maryland Citizens' Health Initiative	Member
Robert Metz	CareFirst	Member
Maansi Raswant	Maryland Hospital Association	Member
Kim Rucker	Kaiser Permanente	Member
Beth Sammis	Consumer Health First	Co-Chair
Brad Boban	Maryland Insurance Administration	Support
Joseph Fitzpatrick	Maryland Insurance Administration	Support

Affordability Work Group Business
The business of the Work Group – including meeting minutes, presentations, and background information — may be found in the Appendix of this document. The Appendix is organized by meeting date and includes all of the information supporting the business conducted during each session.

Summary of Work Group business

The Affordability Work Group was provided data on Maryland's individual market that contextualized potential drivers for premiums and out-of-pocket costs, including:

- Chronic disease burden

[5] https://www.marylandhbe.com/wp-content/uploads/2019/02/Final-2020-Letter-to-Issuers-Seeking-to-Participate-in-Maryland-Health-Connection.pdf

- Utilization and per member per month for service categories
- Enrollment mix and plan selection
- Unit cost information and performance against other states

The Work Group also received information on affordability from an out-of-pocket cost at the point of service perspective. Drawing from this information, the Work Group noted the critical role of diverse plan design in market participation. Given the absence of an individual mandate where market participation is voluntary, it was also noted that plan cost sharing design could encourage or discourage enrollment based on the plan's perceived value to the consumer.

Presentations from Covered California and Families USA provided insights into the tradeoffs of standardized plan designs. States that have implemented standard plans to achieve specific goals may – depending on the degree of flexibility in offering other plan designs – limit issuer product innovation, create inequities for certain consumers with specific medical needs, and discourage participation from consumers whose specific needs may not be met by the prescribed plan design.[6]

A presentation from Chris Koller, Former Rhode Island Health Insurance Commissioner, provided an example of how RI promoted increased primary care spend through the use of regulatory authority without increasing consumer premiums. MHBE staff noted that given the Total Cost of Care Waiver and the population health metrics against which State performance will be measured, Rhode Island's experience may serve as an example of how coordinated regulatory policy can foster an environment for health system transformation.

Presentations from Families USA and the Urban Institute provided the Work Group with information on sub-populations where affordability issues may be concentrated (even with financial assistance) and potential policy solutions to help resolve them. While some of these solutions extended past the scope of MHBE's existing authority, the Work Group noted that it is still important to consider which solutions should be investigated further by other policy making bodies, i.e. the Health Insurance Coverage Protection Commission.

In the final sessions the Work Group established the following:

1. An analytical framework to inform the Work Groups recommendations.
2. Sub-populations for policy intervention.
3. Recommendations to strengthen the individual market.

The remaining sections of this document provide additional detail.

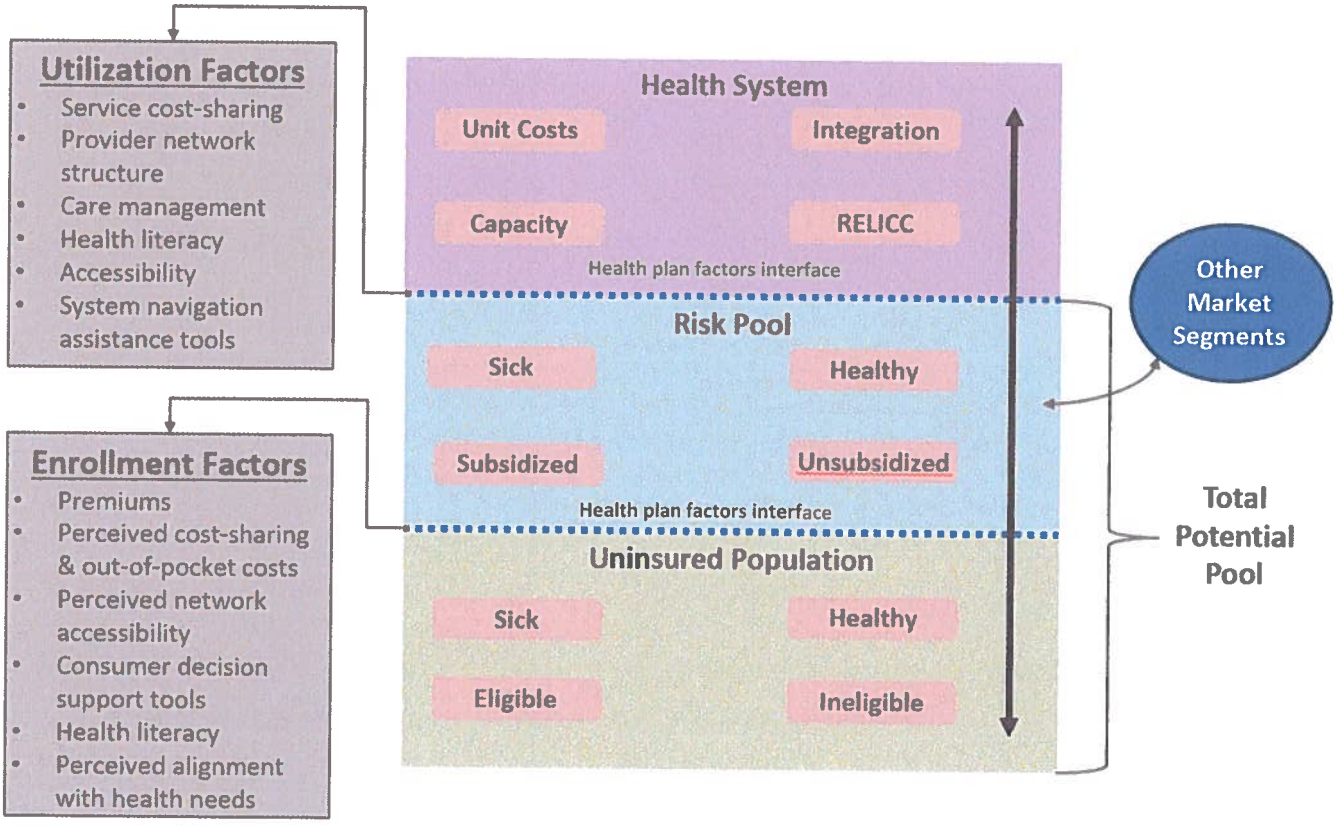
[6]Such specific goals include ensuring access to a minimum level of before deductible services, creating stability for consumers in expected out of pocket costs from year to year, creating an additional plan option, etc.

1. Analytical framework: Factors of health coverage that affect market participation and health system interaction.

Figure 1 provides an analytical framework for health coverage factors that affect enrollment take-up and health care utilization. The framework is drawn from the perspective of the uninsured population as they join the risk pool and interact with the health system. The dotted lines bordering the *Uninsured Population/Risk Pool* and *Risk Pool/Health System* represent the decision to enroll in coverage or utilize health care. Important sub-groups of the uninsured/risk pool populations have also been identified, as well as health system features that influence utilization.

Work Group members considered how policy recommendations that seek to affect health coverage factors would impact these sub-groups. Additionally, Work Group members considered the potential intersectionalities across sub-groups. For example, while reinsurance programs reduce premiums for those ineligible for financial assistance, the likelihood of an uninsured ineligible individual to enroll in coverage is usually dependent on whether the individual is sick or healthy (i.e., sick vs. healthy differences in price sensitivity). Therefore, while lower premiums increase coverage uptake for this population, it is important to consider 1) the cost of premiums after the reduction, and 2) whether the marginal enrollment, as a result of the premium reductions is healthier than, or of similar morbidity to, the existing risk pool. Work Group members noted that such an analysis is important when evaluating the long term impact of a policy on the risk pool and downstream self-sustained market stability.

Figure 1. Factors of health coverage that affect market participation and health system interaction.



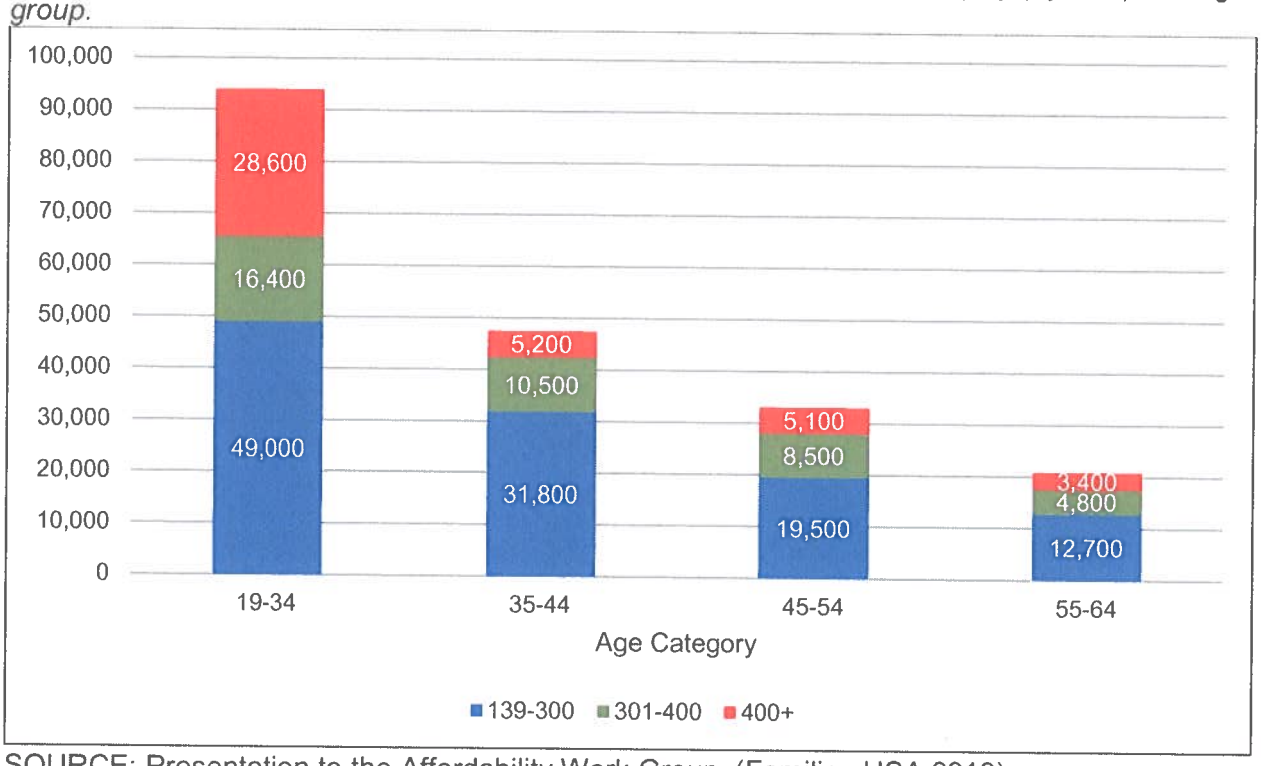
2. Determining populations for policy intervention.

To assist the Work Group in selecting populations for policy intervention, MHBE synthesized data on the remaining uninsured population (Maryland-specific) and chronic disease prevalence in the individual market into three charts below.[7,8]

Remaining uninsured in Maryland

Chart 1 provides additional information on the remaining QHP-eligible, uninsured population in Maryland (income strata that would be eligible for Medicaid have been removed), with stratification by age and income (by federal poverty level, FPL). The remaining uninsured population is skewed toward the younger age groups as the 19 – 34 age category accounts for approximately 50% (94,000) of the remaining uninsured population. With respect to eligibility for financial assistance programs, approximately 70% (19 – 34 age category) to 89% (35 – 44 age category) of the uninsured across age groups could be eligible for tax credits.

Chart 1. Uninsured, non-elderly Maryland adults stratified by income category (by FPL) and age group.



SOURCE: Presentation to the Affordability Work Group. (Families USA 2019)

The above 400% of FPL population for the 18 – 34 age category is the largest in magnitude and proportion across the age categories. The Work Group determined that this is likely attributed to the low propensity of young, healthy adults to enroll in health coverage. Additionally, it was noted that a long-term solution to ensuring affordability in the individual market requires the increased participation of the 18 – 34 age category to improve the composition of the risk-pool.

[7] https://www.marylandhbe.com/wp-content/uploads/2019/04/Affordability%20Work%20Group%20Presentation%204.19.19.pdf
[8] https://www.marylandhbe.com/wp-content/uploads/2019/05/May-31-presentation.pdf

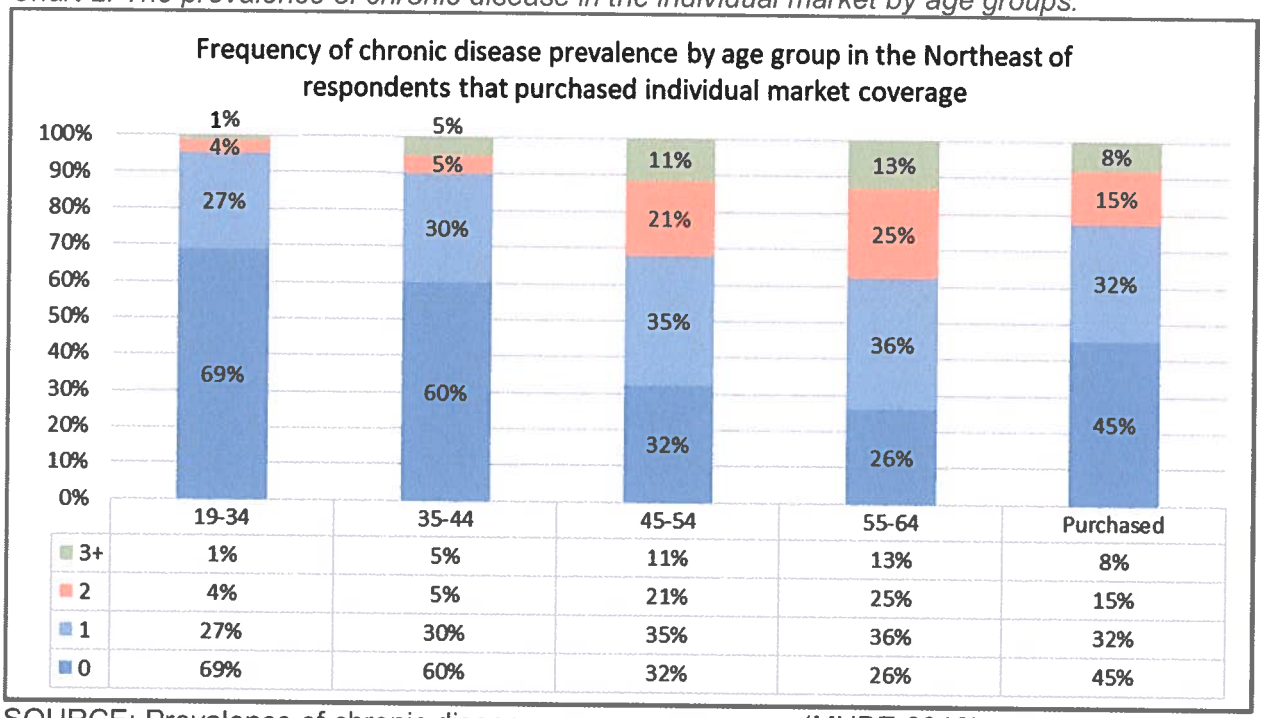
Further, the Work Group discussed that while the full implementation of the Maryland Easy Enrollment Health Insurance Program should work to reduce the proportion of the uninsured that is eligible for financial assistance, the degree of take-up may not be even, as risk aversion and the propensity to enroll in health coverage is likely to vary, across age groups.

Chronic disease prevalence in the individual market

Chart 2 provides insight on the prevalence of chronic disease in the individual market with data provided by the 2017 National Health Interview Survey. Given Maryland's individual market risk pool, it was important for the Work Group to consider this population's specific affordability concerns (ex. prescription drugs, etc.). While Chart 2 is not specific to Maryland, it speaks to the chronic disease burden in the individual market generally.

The Work Group noted that the data reaffirmed commonly held assumptions around the relationship of chronic disease and age – as an individual ages, the prevalence of one or more chronic diseases increases. The prevalence of more than one chronic disease is higher in the 45 – 54 and 55 – 64 age categories (68% and 74%, respectively) than in the 35 – 44 age category (40%). Additionally, the proportion of respondents with two or more chronic diseases increases as a share of total chronic disease prevalence in older age categories (i.e. compounding morbidity). For example, 25% of respondents with chronic diseases aged 35 – 44 have two or more diseases (40% have chronic diseases, 10% have two or more chronic diseases, 25% of total with chronic disease). For respondents in the 45 – 54 and 55 – 64 age categories this proportion increases to 47% and 51%, respectively. Additional information on this analysis may be view in the Appendix under *Chronic Disease Prevalence Across Age-Groups.*

Chart 2. The prevalence of chronic disease in the individual market by age groups.



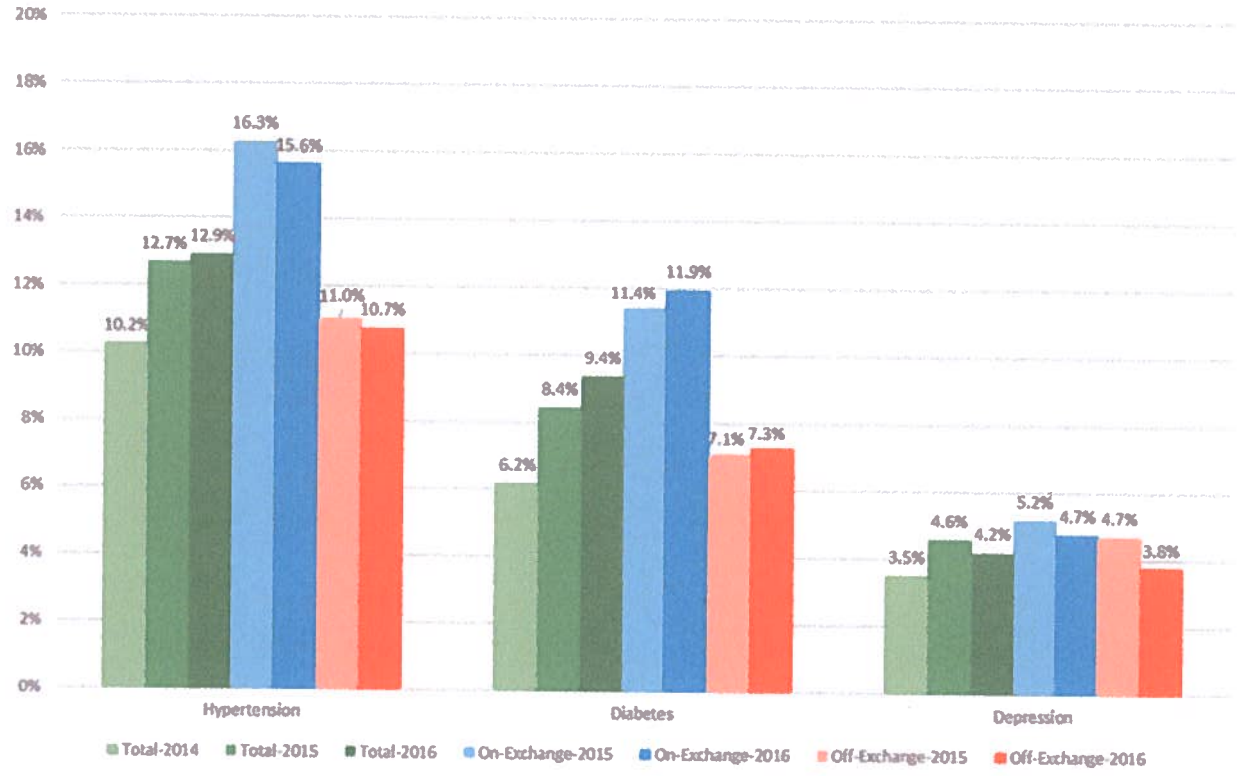
SOURCE: Prevalence of chronic disease across age groups. (MHBE 2019)

Work Group members noted the importance of effective chronic disease management programs in the individual market given the market's unique historic role as the coverage of last resort –

particularly with older populations that have manifested chronic diseases (i.e., this population has a high propensity to purchase health coverage). Additionally, the Work Group noted that it would be important to measure the interaction of the State Reinsurance Program with the claims of individuals with chronic diseases. For example, while only 5 – 6% of the individual market has a claims burden that is eligible for payment under the SRP, a larger population of enrollees in the individual market have chronic diseases whose claims do not meet the threshold. Work Group members discussed that it will be important to analyze claims data to determine which chronic diseases are drivers of claims under the SRP.

MHBE also provided the Work Group with data from the Maryland Health Care Commission (MHCC 2018) (Chart 3) on the prevalence of chronic disease in Maryland's individual market. Chart 3 provides insight on the prevalence of select chronic diseases (hypertension, diabetes, and depression) in the individual market (2014 – 2016) and breakouts for on- and off-Exchange enrollees for 2015 and 2016.

Chart 3. Total (ACA-Compliant & Noncompliant Plans, 2014 - 2016), and On-Exchange vs. Off-Exchange (ACA-Compliant Plans Only): Prevalence of Select Chronic Conditions, Individual Market, 2015 t0 2016.



Notes: (i) On v. off-Exchange data splits were not available in the MCDB until 2015.
(ii) Total includes both grandfathered and non-grandfathered plans.

SOURCE: Privately Insured Spending in Maryland's Individual Market, 2016. (MHCC 2018)

For *Total* individual market enrollment, the prevalence of enrollees with hypertension and diabetes grew each year from 2014 – 2016 (10.2% to 12.9% and 6.2% to 9.4%, respectively).[9] For ACA-compliant plans, the prevalence of both hypertension and diabetes was greater among on-Exchange members than among off-Exchange members in 2016 (15.6% vs. 10.7% for hypertension; 11.9% vs. 7.3% for diabetes).[10]

Selection of intervention populations

These charts, combined with the information received on drivers for unaffordability in the individual market (i.e., health of the risk pool, chronic disease concentration, trend/utilization, out-of-pocket costs, etc.), helped the Work Group identify sub-populations that should be focused on for policy intervention.

The Work Group noted that policy interventions to strengthen the individual market should 1) work to improve the risk pool by encouraging healthier risk to enroll; and 2) better manage the existing risk in the risk pool to improve health outcomes, encourage health system alignment, and support sustainability of the State Reinsurance Program.

Intervention Population #1: Young Adults (18 – 34)

Work Group members determined that Young Adults (18 – 34) should be focused on as an intervention population. Additionally, because the likelihood of a young adult enrolling in health coverage changes with their eligibility status for financial assistance and, if ineligible, the cost of health coverage relative to their income, consideration should be made for income. Work Group members also noted that 1) young adult women experience a higher need for health services and are more likely to enroll in coverage when uninsured; and 2) young adults have a large unmet need for behavioral health therapies, and therefore the need for health services should also be considered a factor.

Table 1. Young Adults (18 – 34)

Factor	Sub-populations
Income	1. Eligible for financial assistance (139% – 400% of FPL) 2. Ineligible for financial assistance (400+% FPL)
Need for health services	1. Women 2. Young Adults with Substance Use Disorder/Behavioral Health needs

Work Group members determined that policy interventions should seek to increase Young Adult participation in the risk pool by making individual market coverage more attractive/responsive to their needs

Intervention Population #2: Individuals with Chronic Diseases

Given the existing prevalence of chronic disease in the individual market and its effect on the risk pool, Work Group members determined that individuals with chronic diseases should be focused on as an intervention population. Furthermore, improvement in population health

[9] The Total category includes data for both ACA-compliant & ACA-noncompliant plans.

[10] It important to note that lower income populations have a higher prevalence of chronic disease than the general population. Given that the on-Exchange market offers income-based financial assistance to purchase health coverage such differences in chronic disease prevalence is not unexpected.

metrics/health outcomes for members with chronic diseases align with state-wide initiatives under the Total Cost of Care Waiver.

Recommendations to strengthen the individual market.

The Work Group's recommendations for the intervention populations are presented on the subsequent pages in Tables 3 & 4. The recommendations are comprehensive in scope and span from targeted investments in marketing to structural changes to the individual market. This section summarizes several recommendations and provides additional insights.

Value plans[11]
The Work Group members agreed that the Value plans will be an important additional option for consumers seeking lower deductibles and increased access to before-deductible services. To support this new initiative, Work Group members recommend a targeted marketing investment to inform consumers of the Value plans, specifically Young Adults for Value Bronze.

Given that Value plan outcomes are not yet available, the Work Group does not recommend specific modifications at this time. However, the Work Group does recommend that MHBE monitor the impact of Value plans (in terms of deductible relief from current enrollment) and enrollment outcomes (e.g., Young Adult enrollment in Value Bronze plans).

For potential future modifications to the Value plan requirement, the Work Group recommends that MHBE analyze the impact of replacing, or conjoining, the current Value Plan requirement that generic drugs be covered before deductible with a separate prescription drug and medical deductible. The Work Group members noted that these changes could increase plan Actuarial Value (i.e., generosity) above federal requirements, or affect the cost-sharing and utilization of other benefit categories to adjust.

State-subsidy for Young Adults[12]
The Work Group members agreed that increased participation of Young Adults in the individual market is critical for an improved risk pool and long term market sustainability. To achieve this, the Work Group recommends that the State commission a study for a State-subsidy for Young Adults. Data shows that this group represents approximately 50% of the remaining uninsured population, and given this group' high degree of price sensitivity and low risk aversion, additional premium supports – in the absence of a mandate – could maximize market participation.

Additionally, the Work Group recommends that the study consider the State-subsidy in conjunction with a State Innovation Waiver to access federal pass through funds (in a similar manner as the State Reinsurance Program), to determine if it would be advantageous. Importantly, the Work Group recommends that the waiver should not modify the existing federal tax credit structure and consider the potential for interaction with the State Reinsurance Program. The Work Group also recommended that the study should contemplate several funding source scenarios.

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[11] See the Appendix for a full description of the 2020 Value plan requirement.

[12] It is important to note that new State Relief and Empowerment Waiver Guidance provides alternative subsidy structures as an option for future waivers.

It is important to note that the Work Group considered a broader State-subsidy for those eligible for financial assistance (under 400% FPL), as well as those ineligible for financial assistance (above 400% FPL). Further, the Work Group was also mindful of 1) the resources that could be available to the State to fund such initiatives; 2) the potential downstream impact to the risk pool; and 3) other policy initiatives (i.e., the Maryland Easy Enrollment Health Insurance Program, MEEHP) occurring in parallel.

Given these considerations the Work Group determined that a targeted State-subsidy for Young Adults would have the additive effect of improving the risk pool (lowering premiums for the above 400% FPL), would limit the utilization of State resources (when compared with a broader benefit), and, when coupled with the MEEHP, could have substantial enrollment impact.

State Reinsurance Program

Work Group members recommended the continual operation of the State Reinsurance Program (SRP). They noted that the SRP provides important premium stability for Marylanders who are ineligible for financial assistance due to income. Further, given the positive impact the SRP yielded in the first year, Work Group members note the importance of maintaining and building on those gains.

With respect to the recommended intervention populations, the SRP provides critical premium stability for individuals with chronic diseases who otherwise may not have access to continuous, more affordable coverage (given prior year's premium increases). The Work Group also noted that the SRP provides benefit to Young Adults who are ineligible for financial assistance due to income, with acknowledgement that the magnitude of the premium relief is smaller for Young Adults than it is for older members.[13]

Work Group members noted the importance of the sustainability of the State Reinsurance Program and recommend that MHBE closely monitor the claims experience under the SRP for disease-specific trends/opportunities to increase program integrity.

Chronic Disease Management Programs

The Work Group recommends that MHBE and issuers seek increased participation in these programs through marketing and health literacy efforts. Specifically for chronic diseases that have high prevalence in the individual market (hypertension, diabetes, and depression) and are drivers of claims to the SRP.

Additionally, Work Group members recommend state-wide coordination of chronic disease management programs and measurements across markets & programs (Medicare & Medicaid) to assist in the implementation and monitoring of the Total Cost of Care Waiver. These coordination efforts should also include diabetes prevention programs.

Other recommendations

The Work Group also provided recommendations on how to improve coordination across Maryland agencies with regulatory authority over health services delivery, cost, and coverage.

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[13] Reinsurance programs modify the market index rate, which serves as the base for all premiums. Because this market index rate is further modified by age with a factor ranging from one (for 21 years old) to three (for 64+ years old) to reach the final premium, the magnitude of premium relief is greatest for older members. For example, a 21 year old in Baltimore City, who was enrolled in the second lowest cost silver plan, in 2018 saved nearly $125 for their plan in 2019 while a 64 year old saved $375, thrice the magnitude.

The Work Group recommends that the agencies establish a shared database of contacts and programs across agencies with the goal to:

1. Share data, learnings, and how learnings could be leveraged by each agency.
2. Prevent duplicative efforts.

The Work Group also recommends that MHBE host forums for agencies to coordinate on issues that pertain to affordability, population health, etc. including stakeholder participation and engagement. Topics that were specifically noted were – the MD Primary Care Program and coordination of agency action to address diabetes.

Opportunity for comment and next steps.

MHBE welcomes public comment on this document. MHBE will receive comments from the date of publication to August 31, 2019. MHBE will present these recommendation to the MHBE Board of Trustees at the September 16, 2019 session.

Comments may be submitted to: mhbe.publiccomments@maryland.gov

Table 3. Intervention Population #1: Young Adults (18-34)

Sub-Group	Near Term	Long Term
General *Women* *Young Adults with Substance Use Disorder/Behavioral Health needs*	1. Marketing investment focused on Young Adults 2. Value Plans: a. Evaluate the outcomes of the Value Plans b. Marketing investment in Value Plans 3. Consumer Decision Support Tools: a. Development of an Out-of-Pocket Cost Calculator b. Development of a plan shopping experience optimized to display service categories customized by the user, or automatically, by age 4. Development of a health literacy program focused on Young Adults 5. Successful implementation of the Maryland Easy Enrollment Health Insurance Program	1. Continued marketing investment focused on Young Adults
139% - 400 % FPL Eligible for financial assistance	1. A marketing investment focused on Young Adults 2. The State should commission a study on a supplemental premium subsidy for Young Adults that does not modify the existing federal tax credit structure. The study should: a. Analyze potential interaction with the State Reinsurance Program, and federal pass through, for the following scenarios: i. Supplemental premium subsidy w/ an independent funding source ii. Supplemental premium subsidy w/ funding carved-out from the existing premium assessment under Md. INSURANCE Code Ann. § 6-102.1	1. Establishment of a state-based supplemental premium subsidy for Young Adults: a. Utilizing only state funds or, b. Utilizing state & federal pass-through funds under a 1332 waiver.

Sub-Group	Near Term	Long Term
	iii. Supplemental premium subsidy under i & ii seeking federal pass through under a 1332 waiver b. Estimate required funding amount & identify potential funding sources c. Project impact of the subsidy on the individual market for a five- and ten-year time horizon d. Be updated at a later time to account for the implementation of other policies, i.e. the Maryland Easy Enrollment Health Insurance Program	
400+% FPL Ineligible for financial assistance	1. Continuation of the State Reinsurance Program	1. Continuation of the State Reinsurance Program 2. Establishment of a state-based supplemental premium subsidy for Young Adults: a. Utilizing only state funds or, b. Utilizing state & federal pass-through funds under a 1332 waiver.

Table 4. Intervention Population #2: Individuals with Chronic Diseases

Sub-Group	Near Term	Long Term
General	1. Value Plans a. Evaluate the outcomes of the Value Plans b. Study separate medical & drug deductibles and/or generic drugs before deductible i. Requirement within Actuarial Value ranges (+2/-4) ii. Impact on the utilization and cost-sharing of other benefit categories 2. Chronic Disease Management Programs a. Increase participation in these programs through education/health literacy b. Analysis of State Reinsurance Program claims for conditions that are drivers of claims to the SRP and the prevalence of those conditions c. Promotion of those with diabetes, hypertension, and depression into Care Management Programs d. State-wide coordination of chronic disease management programs and measurements across markets & programs (Medicare & Medicaid) including diabetes prevention programs 3. Consumer Decision Support Tools a. Plan shopping experience that is responsive to consumer's unique service category needs b. Prescription Drug Search that relays cost sharing, limitations/ exclusions, prior authorizations, and consumer protections for formulary changes	1. Continuation of the State Reinsurance Program

Sub-Group	Near Term	Long Term
	4. Provider Networks a. Expansion of care coordination for those with chronic diseases b. Expand capacity through telemedicine services c. Improve health literacy for the newly insured with provider selection	

APPENDIX

1. Excerpt from the 2020 Issuer Letter – 2020 Value Plan Requirement
2. Prevalence of chronic disease across age groups
3. Meeting #1 – February 15, 2019
    a. Welcome Webinar Materials
4. Meeting #2 – March 1, 2019
    a. Agenda
    b. Preferred Provider Organization Analysis
    c. Presentation
    d. Covered California - *Key Ingredients to Creating a Viable Individual Market That Works for Consumers*
5. Meeting #3 – March 15, 2019
    a. Agenda
    b. Presentation
    c. Minutes
6. Meeting #4 – April 5, 2019
    a. Agenda
    b. Presentation
    c. Minutes
7. Meeting #6 – April 19, 2019
    a. Agenda
    b. Presentation
    c. Minutes
8. Meeting #7 – May 31, 2019
    a. Agenda
    b. Presentation
    c. Minutes
9. Meeting #8 – June 14, 2019
    a. Agenda
    b. Presentation
    c. Minutes

Excerpt from the 2020 Issuer Letter – 2020 Value Plan Requirement

Table 4-B-1. 2020 Qualified Plan Certification Standard – Out-of-pocket Costs.

"Value" plans	
1.	Standard plans are deferred for 2020 and will be included for evaluation in the 2019 Affordability Work Group with potential adoption in 2021.
2.	Issuers must offer at least one bronze plan, called a "Value" plan, with certain number of certain services available before deductible.
3.	Issuers must offer at least one, non-HSA silver "Value" plan with certain services before a certain deductible.
4.	Issuers must offer at least one, non-HSA gold "Value" plan with certain services before a certain deductible

a. "Value" plans.

In response to public feedback on the increasing consumer cost-sharing and rising out-of-pocket costs in QHPs offered through Maryland Health Connection (see *Draft 2020 Letter to Issuers Seeking to Participate in Maryland Health Connection*), MHBE will require that issuers offer "Value" plans, that meet certain cost sharing and branding requirements, at the bronze, silver, and gold coverage metal levels. It should be noted that MHBE seeks to implement the standard through a phased approach. Additionally, the standard will be further developed through the 2019 Affordability Work Group as a starting point for addressing affordability issues. Table 4-B-2 below details specific QHP requirements for the 2020 plan year.

Table 4-B-2. "Value" plan offering requirements for the 2020 plan year.

Requirements	Bronze	Silver	Gold
Minimum offering	Issuer must offer at least 1 "Value" plan.	Issuer must offer at least 1 "Value" plan.	Issuer must offer at least 1 "Value" plan.
Branding	Required for 2020.	Optional.	Optional.
Deductible ceiling	No requirement. Lower deductibles are encouraged.	$2500 or less.	$1000 or less.
Set Office Visits Before Deductible	Issuer may allocate no less than three office visits across the following settings: • Primary Care Visit (not including preventive care) • Urgent Care Visit • Specialist Visit	No requirement.	No requirement.
Services Before Deductible	See 'Office Visits Before Deductible' above.	The following services must be offered as copays before deductible: • Primary Care Visit	The following services must be offered as copays before deductible: • Primary Care Visit

Requirements	Bronze	Silver	Gold
		• Urgent Care Visit • Specialist Care Visit • Laboratory Tests • X-rays and Diagnostics • Imaging	• Urgent Care Visit • Specialist Care Visit • Laboratory Tests • X-rays and Diagnostics • Imaging • Generic Drugs
Encouraged Services Before Deductible		The following services are strongly encouraged to be offered as copays before deductible: • Generic Drugs	
Limitations & Exceptions	No requirement.	No requirement.	No requirement.
Facility Fees	No requirement.	No requirement.	No requirement.

b. Value Bronze Plan office visits requirement.

Under the "Value" Bronze three office visits requirement issuers may allocate, at minimum, any three office visits across the Primary, Urgent, and Specialist Care Visits. Issuers are encouraged to allow maximum consumer flexibility to the extent possible under existing technical/operational limitations. To incentivize appropriate utilization of lower cost sites of care MHBE strongly recommends the inclusion of at least one urgent care visit in the selected allocation. It

The 2019 Affordability Work Group will consider avenues to maximize the consumer flexibility of the three office visit requirement. To support innovation in this space, MHBE will gather the relevant expertise from other states/issuers that have offered, and priced for, flexible cost-sharing/utilization design under existing federal actuarial value and reporting requirements.

c. Branding requirements.

For the 2020 plan year, MHBE will require "Value" branding for bronze QHPs. Branding for the other metal levels will be explored after consultation with the 2019 Affordability Work Group. Given the expected contrast between currently offered bronze QHPs and the "Value" bronze QHPs, MHBE believes the additional branding will be helpful to consumers in identifying the distinction between bronze QHPs.

d. Issuer offering requirement.

For the 2020 plan year, MHBE clarifies that "Value" plan offering requirements will be applied at the branded, holding company level. To maximize impact and reduce administrative burden, it is recommended that branded holding companies offering plans with multiple product types, offer "Value" plans in the product with the greatest share of the holding company's enrollment and span of service area. MHBE recommends that holding companies offer "Value" plans under HMO product lines.

e. Other QHP offerings.

MHBE understands that "Value" plan requirements will increase QHP actuarial value and potentially premiums. "Value" plans are intended to supply consumers with alternative options that provide minimum expectations of the services that will be offered before deductible. MHBE encourages issuers to offer additional QHPs with lower actuarial value to support premium affordability for unsubsidized consumers and provide distinct options within each metal level.

MHBE also encourages issuers to consider the entirety of their product portfolios as they pertain to consumer access to premium tax credits within their respective service areas.

f. Mapping cost-sharing with services provided.

MHBE expects that issuers use the same service to cost-sharing mapping utilized when completing Plan and Benefits Templates and Summary of Benefits and Coverage.

g. Services before deductible deferred for 2020.

MHBE will defer before deductible/cost sharing requirements for preferred brand, non-brand, and specialty drugs until prescription drugs are deliberated by the 2019 Affordability Work Group. MHBE will also defer Emergency Room Visit deductible requirements for the 2020 plan year.

h. *About Doctors in This Plan (PDF).*

Currently issuers may supply MHBE with additional provider network information via the *About Doctors in This Plan (PDF).* MHBE will amend this option to allow issuers to supply additional information about their QHP offerings that may not be detailed, or described, through the Summary of Benefits and Coverage standard format. While issuers must still supply additional descriptive information about their provider networks, they may also provide:

- Information on their chronic disease management/cost-sharing programs
- Information on wellness/incentive programs
- Information on telemedicine services
- Other information

The URL will be retitled to reflect the change in provided information.

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Prevalence of chronic disease across age groups

Chronic Disease Prevalence Across Age-Groups

Background. MHBE utilized data from the 2017 National Health Interview Survey[14] (NHIS) to determine chronic disease burden across age-groups and specifically for individuals who sought, and then purchased, coverage in the individual market either directly from issuers or through the Marketplace. Additionally, the analysis seeks to provide insight on the experience of respondents who purchased individual market coverage on whether it was difficult to find affordable coverage and/or coverage that met their specific need.

The purpose of the analysis is to provide members of the 2019 Affordability Work Group with additional information on 1) the prevalence of chronic disease across age groups (n = 3003), 2) among those with interest in individual market coverage (n = 364), and 3) among those who purchased individual market coverage (n = 277). It is important to note that the data is specific to the Northeast region as the NHIS does not report state-specific geographic data.

MHBE did not perform statistical significance analysis for this white paper. The discussion of the findings is to provide members of the Affordability work group with additional insights on the distribution of chronic disease within the individual market population, contrast this allocation with the sample population, and detail the experience of finding appropriate coverage within individual market participants.

Source information. The source data for this analysis is the 2017 National Health Interview Survey, a comprehensive annual survey performed by the National Center for Health Statistics. The NHIS collects information on medical conditions, health insurance coverage, doctor's office visits, and physical activity/other health behaviors. Historically, the survey has been used to track "health status, health care access, and progress toward achieving national health objectives."

Methods. MHBE utilized the 2017 NHIS Sample Adult file as the base data for this analysis. The file contains survey data from 26,742 respondents to the NHIS. Of this sample 4348 respondents indicated they were from the Northeast region and 3003 respondents reported an age between 18 and 64 years old. Survey data for those older than 65 years old were excluded.

To determine whether a respondent took interest in, and purchased, coverage in the individual market MHBE considered answers of "yes" to the questions in Table 1.

Table 1. Interest in the individual market and associated questions.[15]

Scenario	NHIS Questions
1. Interest in individual market coverage (Interest)	[AINDINS2] DURING THE PAST 3 YEARS, did you try to purchase health insurance directly, that is, not through any employer, union, or government program? Please include insurance you tried to purchase through Healthcare.gov or the [Fill1: Health Insurance Marketplace/Fill2: Health Insurance Marketplace, such as (fill: state exchange name)]. [AEXCHNG] Have you looked into purchasing health insurance coverage through the [Fill: Health Insurance Marketplace/Health Insurance Marketplace, such as {fill: state exchange name}?
2. Purchased individual market coverage (Purchased)	[AINDPRCH] Was a plan purchased?

MHBE bucketed the age variable into the categories listed in Table 2. The shaded frequency columns apply to the Scenario to their right. It is important to note that the category sizes/cut-offs are arbitrary and have been selected for

[14] https://www.cdc.gov/nchs/nhis/index.htm
[15] ftp://ftp.cdc.gov/pub/Health_Statistics/NCHS/Dataset_Documentation/NHIS/2017/samadult_layout.pdf

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the convenience of the Affordability Work Group, matching the age categories presented in other analyses.

Table 2. Modified Adult Sample file age group frequencies.

Categories (yrs.)	Interest	(%)	Purchased	(%)	Sample	(%)
19 – 34	114	31.3%	83	30%	972	32.4%
35 – 44	58	15.9%	40	14.4%	517	17.2%
45 – 54	82	22.5%	62	22.4%	717	23.9%
55 – 64	110	30.2%	92	33.2%	797	26.5%
Total	364	100%	277	100%	3003	100%

To determine whether a respondent had one or more of six chronic conditions MHBE utilized the same criteria established by the NCHS in their 2009 report *Percent of U.S. Adults 55 and Over with Chronic Conditions.*[16] Respondents who answered "yes" to the questions in Table A (See Appendix) were considered as having the chronic disease associated with the question. Then, MHBE stratified the sample population by respondents who purchased individual market coverage.

To provide insight on the difficulty of finding individual market coverage that was affordable or met the respondent's specific needs MHBE counted respondents that answered "Somewhat difficult" or "Difficult" to the questions in Table B (See Appendix).

Chronic disease prevalence. Figure 1 depicts the prevalence of chronic disease by respondent age category. The data reaffirm commonly held associations of chronic disease and age as the prevalence of one or more chronic diseases increases in older age categories. Notably, the prevalence of more than one chronic disease is higher in the 45 – 54 & 55 – 64 age categories (68% and 74%, respectively) than in the 35 – 44 age category (40%). Additionally, the proportion of respondents with two or more chronic diseases increases as a share of total chronic disease prevalence in older age categories. For example, 25% of respondents with chronic diseases age 35 – 44 have two or more diseases. For respondents in the 45 – 54 and 55 – 64 age categories this proportion increases to 47% and 51%, respectively.

Figure 1.

[16] https://www.cdc.gov/nchs/data/health_policy/adult_chronic_conditions.pdf

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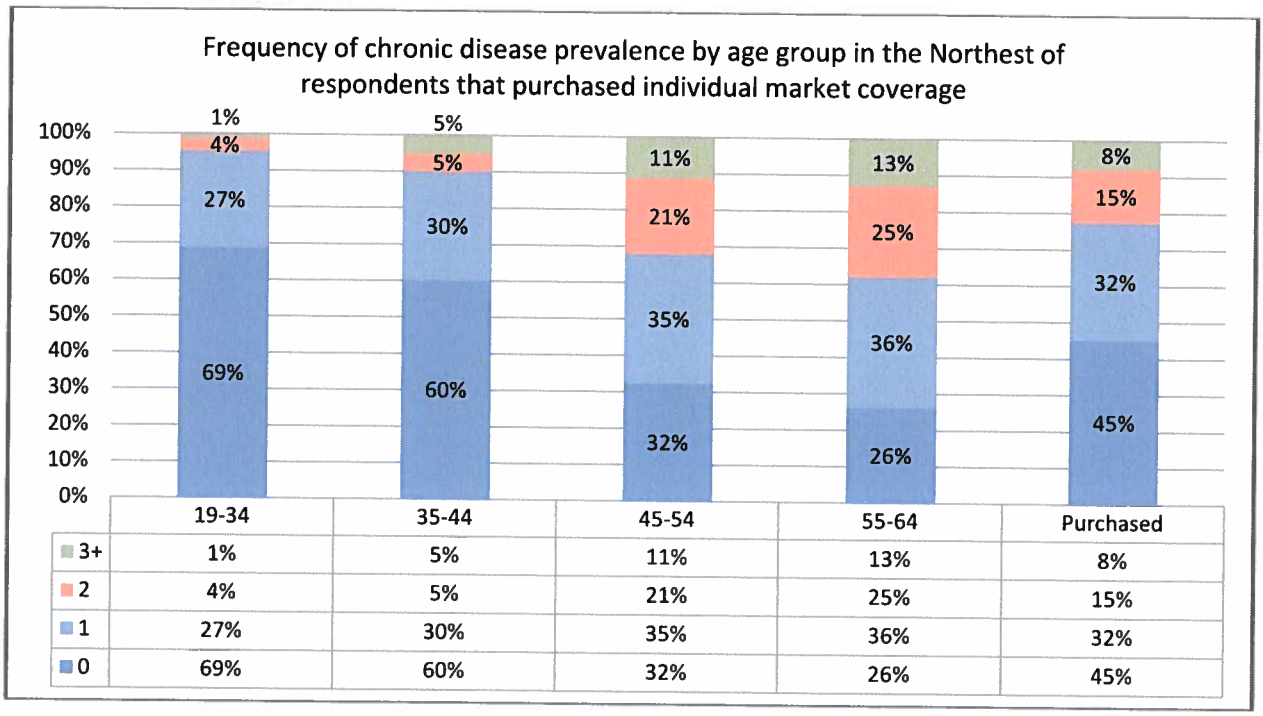

	19-34	35-44	45-54	55-64	Purchased
3+	1%	5%	11%	13%	8%
2	4%	5%	21%	25%	15%
1	27%	30%	35%	36%	32%
0	69%	60%	32%	26%	45%

Table 3 displays the relative prevalence of chronic disease between respondents who purchased individual market coverage (purchased) and the sample population across the age categories. The goal of this comparison was to gather additional insight on whether the purchased population has greater prevalence of one or more chronic diseases than the sample population. The data in Table 3 can be best understood as a metric for comparing the prevalence of chronic disease in the purchased population with the prevalence of chronic disease in the sample population. As an example, a 0% in this analysis would mean that the purchased population has an equal prevalence of chronic disease as the sample population.

Comparing the purchased and sample populations in the aggregate (the bottom right cell of Table 3), the purchased population has a prevalence of chronic disease that is 11% higher than the prevalence of chronic disease in the sample population. Further, when comparing across each chronic disease category (1, 2, and 3+) the purchased population has a higher prevalence of chronic disease than the sample population (9%, 13%, and 16%, respectively).

It is important to contextualize the insights from Table 3 with the age category distribution in Table 2. There is a notable difference between the proportion of the sample and purchased populations in the 55 – 64 age category (26.5% and 33.2%, respectively). Interestingly, when chronic disease prevalence is compared for this age category the purchased population has only 1% higher prevalence of chronic disease than the sample population. If the 55 – 64 age category is overrepresented in the individual market then, from a chronic disease perspective, this category is not disproportionately sicker than the sample population.

Unlike the 55 – 64 age category there appears to be an inverse association with the 45 – 54 age category. While there is a small difference in the representation of this age category between the purchased and sample population (22.4% and 23.9%, respectively), this category has the greatest difference in chronic disease prevalence at 21%.

This initial analysis can inform future research on what the drivers are for individual market participation across age categories. For example it is possible that the previously uninsured may be motivated to enroll in individual market coverage when chronic diseases begin to manifest. Enrollment into coverage by this group, those with emergent symptoms of chronic disease, may drive the differential in chronic disease prevalence for the 45 – 54 age category. This hypothesis may support the 1% difference in chronic disease prevalence in the 55 – 64 age category as chronic diseases that manifested when these respondents were younger already induced this group into maintaining consistent coverage since. When coupled with the additional participation of those 55 – 64 without chronic diseases

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because of increased risk aversion with age, it could be that chronic disease prevalence for this age category could be the same as that of the sample population. This hypothesis may be further supported by this age group having the lowest national uninsured rate across the age bins at 7.9% and the lowest share of the national uninsured population at 12%.[17]

Table 3. Relative prevalence of chronic disease between respondents who purchased individual market coverage and the sample population.

	Diagnosed Chronic Diseases				
Age	**0**	**1**	**2**	**3+**	**Total Chronic**
19-34	-1%	8%	-18%	-22%	3%
35-44	-1%	8%	-45%	85%	1%
45-54	-27%	9%	47%	23%	21%
55-64	-3%	5%	0%	-6%	1%
Purchased/ Sample	-11%	9%	13%	16%	11%

Chronic/non-chronic disease respondent experience. Table 4 provides insight into the association between chronic disease diagnosis and purchasing individual market coverage. For the purchased population, the odds of purchasing individual market coverage is 1.29 higher with a diagnosis of chronic disease compared to no chronic disease diagnosis.

Table 4. Purchasing outcomes of respondents who were interested in purchasing individual market coverage and diagnosis of chronic disease.

n = 364	**Purchased individual market coverage?**		
Chronic Disease	**Yes**	**No**	**Total Interested Pop.**
1-4	42%	12%	54%
0	34%	12%	46%
Total	76%	24%	100%
Odds-Ratio (Chronic vs. No Disease)	1.29		

To provide additional insight into the difficulty of finding coverage that was affordable/met respondent need MHBE considered responses of "Very Difficult" and "Somewhat Difficult" as difficult for the questions in Table B (see Appendix). 57% of respondents who purchased individual market coverage had difficulty in finding coverage that was affordable. Inversely, 58% of these respondents had no difficulty finding coverage that met their specific needs. Further, it was determined that the odds of difficulty in finding an affordable plan is 9.8 higher for respondents who indicated difficulty in finding a plan that met their needs compared with respondents who experienced no difficulty finding a plan that met their needs. It is important to note that these questions may interact as "affordability" is likely an important need for the non-chronic disease population when purchasing coverage.

Table 5. Respondents without chronic disease who purchased individual market plans and their difficulty in finding a plan that was affordable and/or the type of coverage the respondent needed.

n = 125	**Difficulty - Affordable**		
Difficulty – Meets Needs	**Yes**	**No**	**Total**

[17] https://www.kff.org/uninsured/fact-sheet/key-facts-about-the-uninsured-population/

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n = 125	Difficulty - Affordable		
Yes	35%	6%	42%
No	22%	37%	58%
Total	57%	43%	100%
Odds-Ratio (Chronic vs. No Disease)	9.8		

For Table 6 MHBE performed the same analysis in Table 5 for respondents who have chronic diseases and purchased individual market coverage. The odds of having difficulty finding an affordable plan is 18.2 higher for respondents who also indicated difficulty in finding a plan that met their needs compared with respondents who experienced no difficulty in finding a plan that met their need. As with respondents without chronic disease it is likely that these two questions interact, but in a different manner. For those with chronic disease, affordability issues often compound with plan-specific attributes like benefits, cost-sharing, provider networks, and access to chronic disease/wellness programs.

Table 6. Respondents with chronic disease purchased individual market plans and their difficulty in finding a plan that was affordable and/or the type of coverage the respondent needed.

n = 152	Difficulty - Affordable		
Difficulty – Meets Needs	**Yes**	**No**	**Total**
Yes	40%	10%	50%
No	9%	41%	50%
Total	49%	51%	100%
Odds-Ratio (Chronic vs. No Disease)	18.2		

Discussion. Difficulty finding affordable coverage is an issue for those with, and without, chronic disease. Affordability also interacts with difficulty in finding a plan that meets their, albeit different, needs. When considering options to address affordability issues in the individual market it is important to think through how interventions in plan design can help meet the coverage needs of these disparate populations. For those without chronic diseases it will be important to consider plan features that encourage market participation and appropriate utilization while balancing premium pressures. For those with chronic disease it will be important to consider plan features that encourage maintenance, reduce out-of-pocket costs for prescription drugs, and include benefits that can improve health outcomes and health system savings.

APPENDIX

Table A. Chronic diseases and associated questions.[18]

Chronic Disease	NHIS Questions
Diabetes	[DIBEV1] Have you EVER been told by a doctor or health professional that you have diabetes or sugar diabetes?
Cardiovascular Disease	[HYPEV] Have you EVER been told by a doctor or other health professional that you had... Hypertension, also called high blood pressure? [HYPDIFV] Were you told on two or more DIFFERENT visits that you had hypertension, also called high blood pressure? [CHDEV] Have you EVER been told by a doctor or other health professional that you had ... Coronary heart disease? [ANGEV] Have you EVER been told by a doctor or other health professional that you had ... Angina, also called angina pectoris? [MIEV] Have you EVER been told by a doctor or other health professional that you had ...A heart attack (also called myocardial infarction) [HRTEV] Have you EVER been told by a doctor or other health professional that you had ...Any kind of heart condition or heart disease (other than the ones I just asked about)? [STREV] Have you EVER been told by a doctor or other health professional that you had...A stroke?
Chronic Obstructive Pulmonary Disease (COPD)	[EPHEV} Have you EVER been told by a doctor or other health professional that you had...Emphysema? [CBRCHYR] During the PAST 12 MONTHS, have you been told by a doctor or other health professional that you had...chronic bronchitis?
Asthma	[AASMEV] Have you EVER been told by a doctor or other health professional that you had asthma? [AASTILL] Do you still have asthma?
Cancer	[CANEV] Have you EVER been told by a doctor or other health professional that you had...Cancer or a malignancy of any kind?
Arthritis	[ARTH1] Have you EVER been told by a doctor or other health professional that you have some form of arthritis, rheumatoid arthritis, gout, lupus, or fibromyalgia?

Table B. Questions associated with purchasing individual market coverage.

Coverage Attribute	NHIS Question
Met need	[AINDDIF1] How difficult was it to find a plan with the type of coverage you needed? Would you say…
Affordable	[AINDDIF2] How difficult was it to find a plan you could afford? Would you say…

[18] ftp://ftp.cdc.gov/pub/Health_Statistics/NCHS/Dataset_Documentation/NHIS/2017/samadult_layout.pdf

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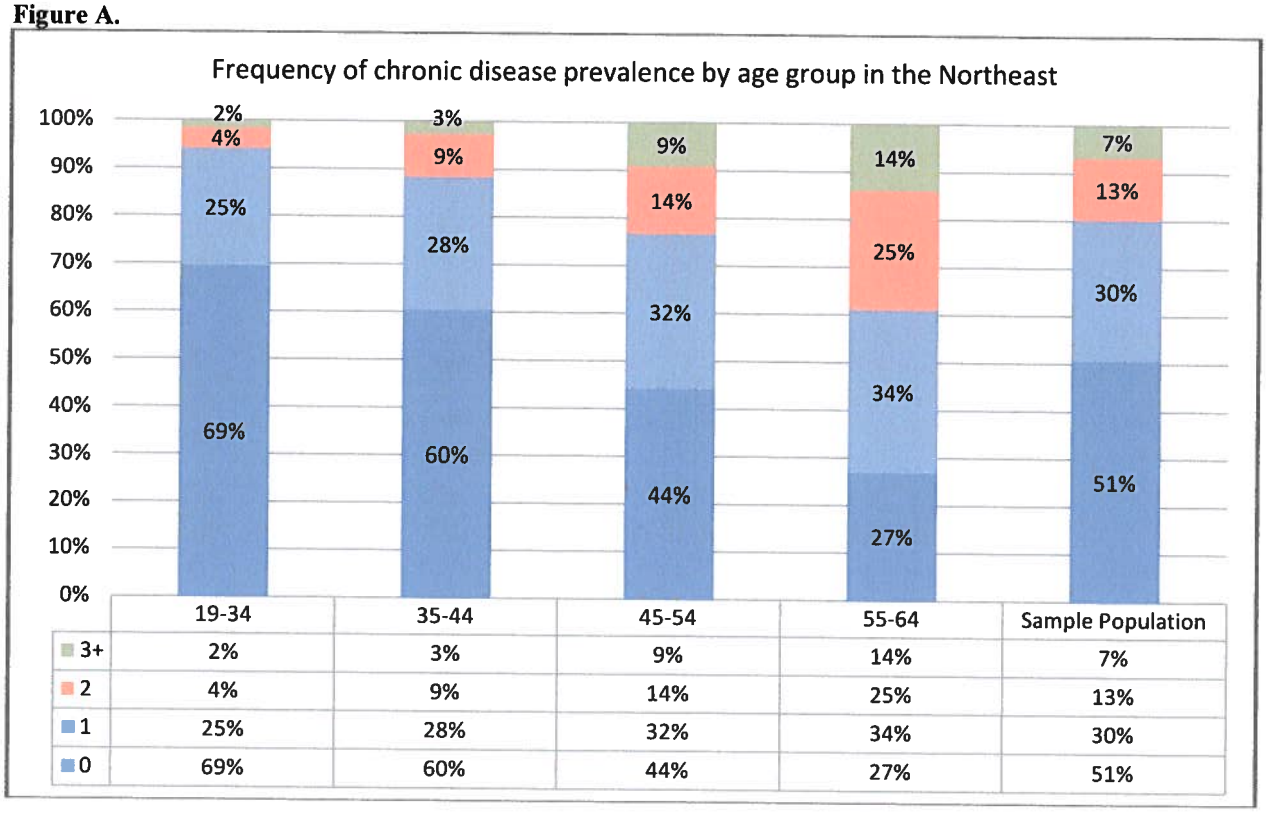
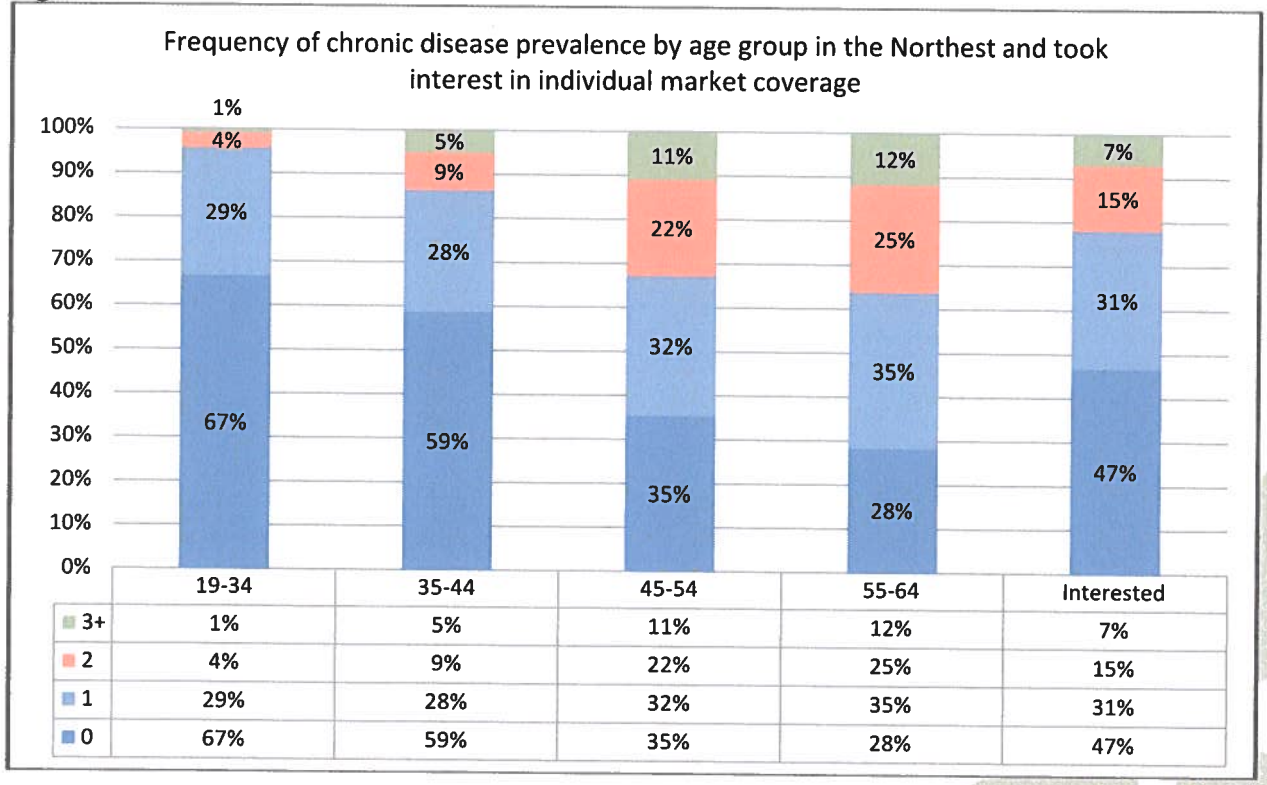
Figure A.



	19-34	35-44	45-54	55-64	Sample Population
3+	2%	3%	9%	14%	7%
2	4%	9%	14%	25%	13%
1	25%	28%	32%	34%	30%
0	69%	60%	44%	27%	51%

Figure B.



	19-34	35-44	45-54	55-64	Interested
3+	1%	5%	11%	12%	7%
2	4%	9%	22%	25%	15%
1	29%	28%	32%	35%	31%
0	67%	59%	35%	28%	47%

Meeting #1 – February 15, 2019

a. Welcome Webinar Materials

Meeting #2 – March 1, 2019

a. Agenda
b. Preferred Provider Organization Analysis
c. Presentation
d. Covered California - *Key Ingredients to Creating a Viable Individual Market That Works for Consumers*
e. Minutes

Meeting #3 – March 15, 2019

a. Agenda
b. Presentation
c. Minutes

Meeting #4 – April 5, 2019

a. Agenda
b. Presentation
c. Minutes

Meeting #6 – April 19, 2019

a. Agenda
b. Presentation
c. Minutes

Meeting #7 – May 31, 2019

a. Agenda
b. Presentation
c. Minutes

Meeting #8 – June 14, 2019

a. Agenda
b. Presentation
c. Minutes

LEWIS & ELLIS
Actuaries and Consultants

Actuarial Support Services for the Maryland State Innovation Waiver

Analysis of Young Adult, Federal Poverty Level Extension, and Small Group Subsidies

MARYLAND HEALTH BENEFIT EXCHANGE

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Submitted on:
February 3, 2020

Table of Contents

INTRODUCTION

In 2019, the Maryland Health Benefit Exchange ("MHBE") engaged Lewis & Ellis ("L&E") to analyze the potential impact of three subsidies on the individual and small group markets. If implemented, the subsidies would be supported through additional state funding and potentially a second Affordable Care Act ("ACA") Section 1332 waiver ("Waiver"). These proposals are borne from recommendations from the 2019 Affordability Work Group and SHOP Advisory Committee. The proposals seek to maximize participation in their respective markets, improve the risk pool and increase affordability for all individual market and small business participants.

The three subsidies encourage uninsured young adults and uninsured individuals between 400-600% to take up coverage in the individual market, as well as smaller employers (with fewer than 15 employees) not currently offering health insurance to do so in the small group market. The subsidies will provide financial support to individuals and small employers to reduce the individual's or employer's share of premiums paid for health insurance coverage by having the state pay for a portion of the premiums.

The first subsidy targets Young Adults between the ages of 18 and 34 whose incomes are less than 400% of FPL. There are two proposed subsidy structures for reducing the premiums Young Adults pay.

The second subsidy targets individuals whose incomes are in the "subsidy cliff", or 400-600% of FPL. Under the ACA, individuals with incomes greater than 400% of FPL are not eligible for premium tax credits. This subsidy extends the maximum applicable percentage to 600% FPL.

The third subsidy supports small employers with less than 15 employees. In addition to the Small Business Health Care Tax Credit from the ACA, Maryland would provide a subsidy of up to 50% of the Employer Contribution to eligible small employers, who have not offered health coverage to employees within the last-year and who contribute at least 50% of the total premium.

The purpose of the report is to provide L&E's analysis to inform MHBE stakeholders for the 2020 legislative session with the goal of assessing and analyzing the impact of 1) additional stabilization measures for the individual market and 2) methods to improve the small business environment in Maryland in potential preparing of future State Innovation Waiver applications.

INDIVIDUAL MARKET SUBSIDIES

All three subsidy approaches considered by the MHBE could affect enrollment in the individual market. The first two approaches are designed specifically to bring more uninsured individuals into the individual market, while the third approach is designed to encourage more small employers to offer health insurance coverage, which could shift enrollment from the individual market to the small group market. This section will primarily focus on the background, methodology and expected impact of the first two subsidies.

YOUNG ADULTS SUBSIDY BACKGROUND

The first of the subsidies is the Young Adults Subsidy. To be eligible for the Young Adults Subsidy, an individual would need to be between the ages of 18 and 34 with an income below 400% of the FPL. This subsidy strategy has two different proposed structures which would reduce the premium paid by Young Adults depending on their income as a percentage of FPL.

Young Adult Subsidy 1: Age Adjustment Subsidy Enhancement

The first Young Adults Subsidy structure is the Age Adjustment Subsidy Enhancement ("AASE"). Providing the AASE to Young Adults would result in a net premium (for the second lowest cost silver plan) that better reflects the underlying actuarial risk of the cohort. The ACA created a 3:1 age curve, where older adults pay at most three times the rate of Young Adults. Due to the age curve, Young Adults tend to subsidize older adults since the actual claims relativity is steeper than 3:1. AASE attempts to subsidize Young Adults in a manner which better reflects the actual claims relativity. The approach is based on the following equation derived by Gabriel McGlamery of Florida Blue.

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

Currently, individuals of any age with an income equal to 200% of FPL pay a maximum of 6.5% of their income in 2020 towards health insurance premiums. This is based on the Applicable Percentage Table for 2020 released by the IRS[1].

Under the AASE, an individual between the ages of 18-25 at 200% of FPL would see their applicable percentage reduced from 6.5% to 2.1%[2] under AASE. The reduction in premiums would be subsidized by the State. The maximum cost of the program per individual would be the difference between 6.5% and 2.1% multiplied the individual's income.

It should be noted that in some cases, the premium as a percentage of income for the second lowest cost silver plan would be lower than the applicable percentage. That is, there would be cases where the gross premium is less than the income cap and the resultant federal subsidy

[1] https://www.irs.gov/pub/irs-drop/rp-19-29.pdf

[2] Assuming the 18-25 group's age rate is 0.98 based on ACA rating curves from CMS (https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-Guidance-Regarding-Age-Curves-and-State-Reporting-12-16-16.pdf)

would be $0. In this scenario, the cost of the AASE program would be lower and would be the difference between the actual premium and 2.1% of income.

Table 5 (in the Supporting Tables section) shows the applicable percentage changes for the AASE.

Young Adult Subsidy 2: Advancing Youth Enrollment Act

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

Currently, individuals of any age with incomes at 200% of FPL will have a 2020 applicable percentage of 6.5%[3].

Under the AYEA, an individual between the ages of 18-25 at 200% of FPL would see his or her applicable percentage reduced from 6.5% to 4.0%[4]. The reduction in premiums would be subsidized by the State. The maximum cost of the program per individual would be the difference between 6.5% and 4.0% multiplied by the individual's income.

Table 6 (in the Supporting Tables section) shows the applicable percentage changes for AYEA.

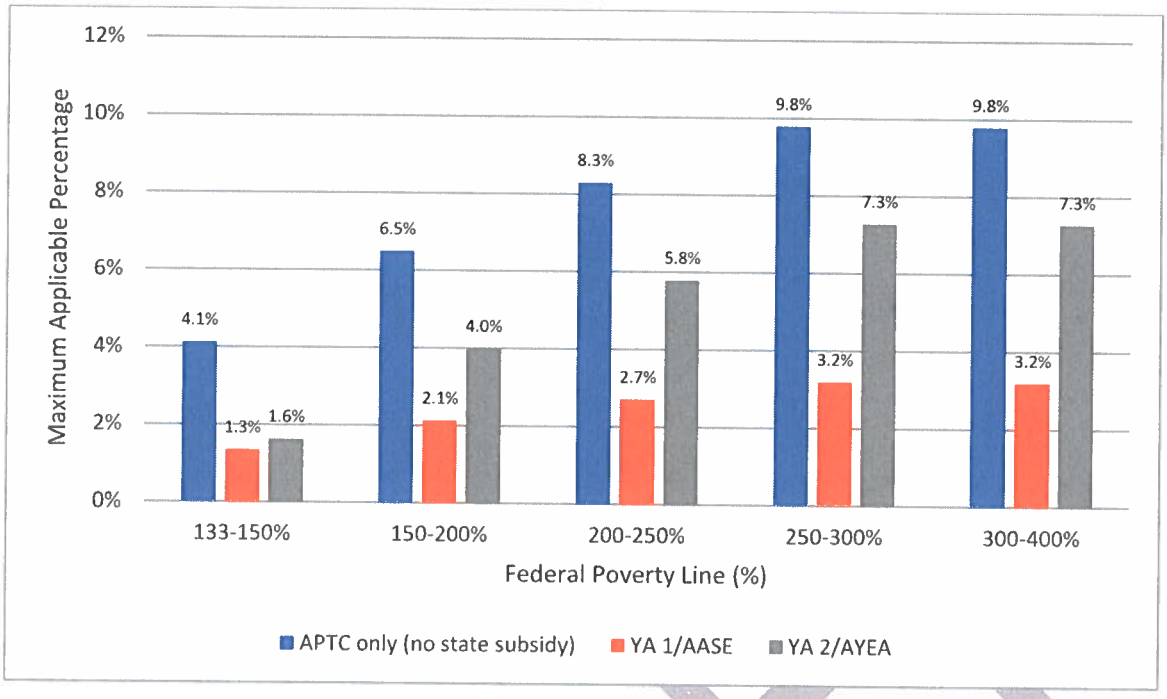
Young Adults Subsidy Comparison

The AASE provides higher levels of benefits versus the AYEA by capping the percentage of income spent on premiums at a lower percentage of income. Therefore, the AASE would require greater funding by the State to cover the higher level of benefits.

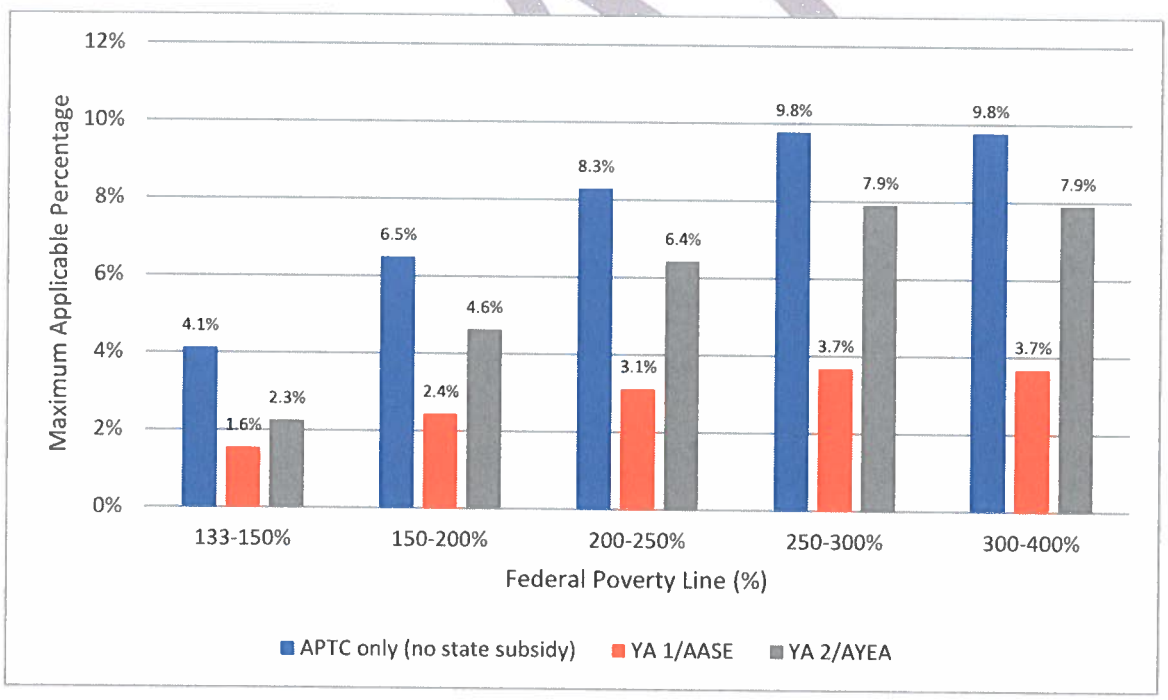
Graph 1 compares the changes to the applicable percentage for both the AASE and AYEA approaches for 18-25 year old adults. Graph 2 shows the same comparison for 26-34 year old adults.

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

Graph 1: Comparison of Young Adult Caps on Premium as % of Income for Ages 18-25



Graph 2: Comparison of Young Adult Caps on Premium as % of Income for Ages 26-34



400+ FPL Subsidy Extension Background

The second subsidy approach[5] would support individuals with incomes greater than 400% of the FPL; an area commonly known as the "subsidy cliff." The ACA provides premium assistance to individuals with incomes less than 400% of FPL. Once an individual's income rises above 400% of FPL, the individual is no longer eligible for premium assistance. In other words, these individuals are required to pay the full premium charged by carriers with no federal support to obtain health insurance coverage.

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

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

Graph 3 below demonstrates that the implementation of FFSE would be expected to positively impact Individual older adults, not Individual Younger Adults[6]. Individual Younger Adults (e.g., 18-34) have premiums that are below the premium cap (i.e., maximum premium paid as a percentage of income) based on the subsidy and would not be materially impacted by the FPL extension.

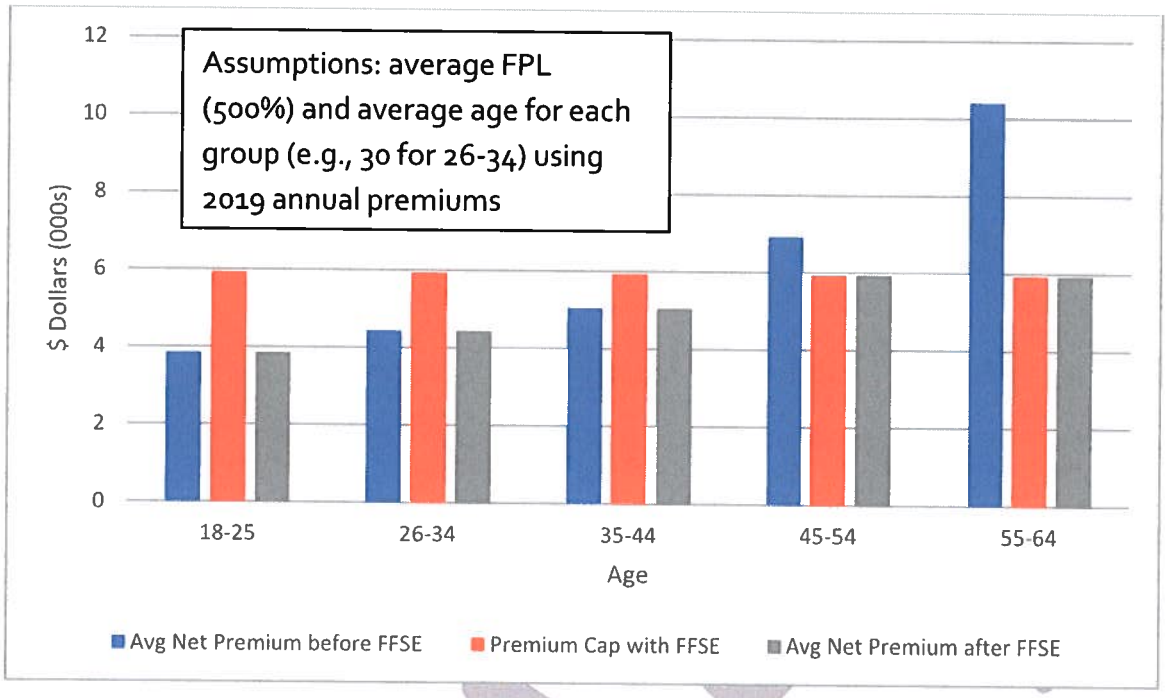
Current 2019 enrollment figures indicate 68% of eligible[7] adults 45-54 are enrolled and 82% of eligible adults 55-64 are already enrolled without any subsidy. Since FFSE would largely subsidize adults who are currently enrolled, the FFSE is not expected to be an effective method to maximize participation in the individual market.

[5] This is the second subsidy approach reviewed. To clarify, Young Adult subsidy is the first approach with two versions (AASE and AYEA), while the 400+ FPL Subsidy is the second approach.

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

[7] "Eligibles" means individuals who are eligible for enrolling in the Individual Market, excluding those who have coverage provided by their employers.

Graph 3: Illustrative Comparison of 400%+ FPL Subsidy Extension (FFSE) Impact by Age for Individuals[8] between 400-600% FPL using 2019 Annual Net Premiums



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

SCENARIOS FOR MODELING

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

The four scenarios are:

1. Reinsurance + Young Adult Subsidy 1 (Age Adjustment Subsidy Enhancement)
2. Reinsurance + Young Adult Subsidy 2 (Advancing Youth Enrollment Act)
3. Reinsurance + Young Adult Subsidy 1 (Age Adjustment Subsidy Enhancement) + 400%+ FPL Subsidy Extension
4. Reinsurance + Young Adult Subsidy 2 (Advancing Youth Enrollment Act) + 400%+ FPL Subsidy Extension

Additionally, all scenarios assume the small group subsidy will be in effect starting in 2021. The small group subsidy will incentivize new small employers to offer health insurance. The subsidy is expected to impact 5,000 individuals that are currently purchasing coverage in the individual market. The small group subsidy will be discussed in more detail later in the report.

MODELING METHODOLOGY

The steps in projecting the impact of the Young Adults and 400%+ FPL Extension Subsidies for the 2020 individual market are as follows:

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

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

3) **Estimating the uptake in enrollment** – Once the impact on net premium (step 2) was understood, L&E modeled the increase in enrollment due to the presence of the subsidies. The uptake was based on regression analysis of eligible market insured rates compared to the maximum income spent on healthcare premiums for Young Adults, as well as the change in net premium from a scenario when the subsidies did not exist.

   Additionally, enrollment was phased in over a three-year period similar to the 2014-2016 enrollment experience of the individual market (i.e., when the subsidies are announced, not everyone will know or sign up for coverage immediately).

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

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

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

RESULTS

L&E projects the subsidies will increase enrollment by 7,000 to 17,600 individuals, which varies by scenario. Note, these numbers are reported in the aggregate, as the enrollment is phased in from 2021 to 2023. Additionally, the small group subsidy modeling estimates that 5,000 lives will leave the individual market for the small group market in 2021.

Of the two Young Adults Subsidies, the Age Adjustment Subsidy Enhancement reduces premiums for Young Adults more than the Advancing Youth Enrollment Act. AYEA does not reduce premiums for higher income Young Adults (e.g., >200% FPL) and older Young Adults (closer to 34) as much as AASE. Overall, 7,700 more Young Adults are expected to enroll under AASE than AYEA (14,700 compared to 7,000 by 2023).

The 400%+ FPL Extension Subsidy is expected to increase enrollment by 2,900 individuals by 2023. The impact of FFSE is much smaller than the Young Adult subsidies. FFSE caps the amount of premiums that individuals between 400%-600% FPL pay; however, older adults (e.g., >45) have premium rates that are more likely to exceed the cap. Therefore, these older adults would be helped more by the FFSE than younger adults. Since these older adults are already insured at a high rate, FFSE's impact of net new enrollees is expected to be limited.

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

Scenario	YA1/AASE	YA2/AYEA	YA1/AASE + FFSE	YA2/AYEA + FFSE
2021-2023 Increase in Enrollment	14,700	7,000	17,600	9,900

Overall, Scenario 3 (AASE + FFSE) brings in the most members as seen in Table 1 above.

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

Looking at the enrollment rate, the AASE provides a higher subsidy for Young Adults greater than 200% of the FPL, which makes AASE more effective in enrolling Young Adults than AYEA.

As mentioned before, FFSE provides subsidies for older adults due to the structure of the subsidy and Young Adults at 400-600% of FPL will likely not receive a subsidy[9].

[9] This is a generalization for Young Adults in Individual (1-person) plans.

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

	Age	FPL Range	2019 % enrolled of eligible[10]	2023[11] % enrolled of eligible	2023 Gross Premium PCPY[12]	2023 Net Premium PCPY	2023 Subsidy PCPY
YA1: AASE	18-34	133-200%	41%	48%	8,327	415	263
	18-34	200-300%	26%	45%	8,300	1,008	434
	18-34	300-400%	17%	42%	8,263	1,699	522
YA2: AYEA	18-34	133-200%	41%	47%	8,365	664	178
	18-34	200-300%	26%	38%	8,283	2,030	179
	18-34	300-400%	17%	18%	9,198	3,936	200
400%+: FFSE	18-34	400-600%	34%	36%	8,682	6,947	1,736
	35-44	400-600%	66%	69%	10,174	6,946	3,228
	45-54	400-600%	68%	77%	13,934	6,943	6,991
	55-64	400-600%	82%	91%	20,745	6,913	13,832

Another perspective to consider is the efficiency of the subsidy to attract new enrollees. This report looks at efficiency in two ways. First, the number of new enrollees that each subsidy introduces into the Individual Market relative to the number of individuals who will receive the subsidy.

- Under AASE, 35% of Young Adults who will receive the subsidy (ages 18-34 at 133-400% FPL) will be new enrollees in 2023
- Under AYEA, 20% of Young Adults who will receive the subsidy (ages 18-34 at 133-400% FPL) will be new enrollees in 2023
- Under FFSE, 10% of adults who will receive the subsidy (primarily older adults at 400-600% FPL) will be new enrollees in 2023

The second method of assessing the efficiency of the subsidy approaches is the cost of the subsidy per new enrollee which is shown in Table 3.

Table 3: Comparison of Subsidy Cost per New Enrollee

	2021			2022			2023		
	Cost	New Members	Cost per New Member	Cost	New Members	Cost per New Member	Cost	New Members	Cost per New Member
YA1: AASE	$7,272,651	8,821	$824	$8,643,780	13,232	$653	$9,396,291	14,702	$639
YA2: AYEA	$3,179,805	4,214	$755	$3,531,380	6,321	$559	$3,763,761	7,024	$536
FFSE	$155,865,416	1,735	$89,852	$168,692,825	2,602	$64,831	$180,879,047	2,891	$62,563

[10] Eligible individuals exclude anyone with insurance provided by their employer.
[11] All 2023 figures are modeled with subsidy included, unless otherwise noted.
[12] PCPY = per contract holder per year (some contracts may be individual, 2 person, or family)

The subsidies will not significantly alter the reinsurance program, as the total change in enrollment is at most 17,600 individuals by 2023, which is less than 10% of the market. In all scenarios, the reinsurance program is still expected to run out of funding in 2025.

The State will require an additional $3 to $7 million in 2021 to pay for the Young Adults subsidies, and/or $156 million to pay for the 400%-600% FPL subsidy. The Young Adult subsidies will increase the Advanced Premium Tax Credits ("APTCs") in 2021, due to an increase in enrollment targeted at individuals who are eligible to receive federal subsidies; therefore, federal pass through funding would not be available in a second Section 1332 Waiver for these subsidies.

Table 4 on the next page summarizes the 2021 results of the modeling.

Table 4: Summary of Impact by Scenario for 2021

Field	Baseline	Reinsurance (RI)	RI + YA 1 (AASE)	RI + YA 2 (AYEA)	RI + YA 1 (AASE) + 400+ (FFSE)	RI + YA 2 (AYEA) + 400+ (FFSE)
Total Non-Group Enrollment	164,906	196,014	198,674	195,336	199,946	196,602
APTC Enrollment	116,655	118,496	123,818	119,210	123,818	119,210
APTC + YA Subsidy Enrollment	-	-	41,785	37,177	41,785	37,177
400+ Extension Enrollment	-	-	-	-	50,457	50,457
Total Non-Group Premium PMPM	$909	$583	$571	$577	$571	$576
APTC (Gross/ Net) Premium PMPM	$934/$89	$606/$89	$587/$70	$596/$78	$585/$70	$594/$78
APTC + YA Subsidy (Gross/Net) Premium PMPM	-	-	$370/$34	$371/$58	$369/$34	$370/$58
400+ Extension (Gross/Net) Premium PMPM	-	-	-	-	$547/$289	$548/$289
Total Premiums	$1,799,013,577	$1,370,274,433	$1,362,039,483	$1,353,389,477	$1,369,117,283	$1,359,765,201
Total APTCs[13]	$1,202,046,244	$734,497,450	$768,232,597	$740,967,352	$765,680,277	$738,026,868
Total YA Subsidy	-	-	$7,272,651	$3,179,805	$7,251,355	$3,168,846
Total 400-600 Subsidy	-	-	-	-	$155,865,416	$156,494,505
Reinsurance Funding		$427,167,413	$419,005,342	$419,005,342	$419,179,835	$419,103,678
RI Reduction in Premiums	-	-28.9%	-28.6%	-28.8%	-28.5%	-28.7%
RI Assessment	-	1.0%	1.0%	1.0%	1.0%	1.0%
Reduction in Premiums (Improved Morbidity)	-	-9.8%	-11.9%	-10.8%	-12.2%	-11.2%
Estimated APTC Savings[14]	-	$467,548,793	$441,086,298	$464,258,697	$443,617,322	$467,188,221
Estimated Net Federal Savings	-	$456,327,622	$430,500,227	$453,116,489	$432,970,506	$455,975,704
Estimated Pass Through (RI-only)	-	107%	103%	108%	103%	109%
Total State Funds (RI- only)	-	$52,893,994	$52,893,994	$52,893,994	$52,893,994	$52,893,994
Estimated Pass Through (RI + Subsidy)	-	$456,327,622	$430,500,227	$453,116,489	$432,970,506	$455,975,704
Total State Funds (RI + Subsidy)	-	$52,893,994	$60,166,645	$56,073,799	$216,010,765	$212,557,345

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

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

SUPPORT TABLES

Table 5: Age Adjustment Subsidy Enhancement, Applicable Percentage

AASE	Applicable Ages	Federal Poverty Line (FPL)		% of Income (Applicable Percentage)	
		Minimum	Maximum	Minimum	Maximum
Pre-subsidy; Post-subsidy for all non-Young Adults	All	0%	133%	0.00%	2.06%
	All	133%	150%	3.09%	4.12%
	All	150%	200%	4.12%	6.49%
	All	200%	250%	6.49%	8.29%
	All	250%	300%	8.29%	9.78%
	All	300%	400%	9.78%	9.78%
Post-subsidy for all Young-Adults	18-25	0%	133%	0.00%	0.67%
	18-25	133%	150%	1.01%	1.34%
	18-25	150%	200%	1.34%	2.12%
	18-25	200%	250%	2.12%	2.70%
	18-25	250%	300%	2.70%	3.19%
	18-25	300%	400%	3.19%	3.19%
	26-34	0%	133%	0.00%	0.78%
	26-34	133%	150%	1.16%	1.55%
	26-34	150%	200%	1.55%	2.44%
	26-34	200%	250%	2.44%	3.12%
	26-34	250%	300%	3.12%	3.68%
	26-34	300%	400%	3.68%	3.68%

Table 6: Advancing Youth Enrollment Act, Applicable Percentage

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

Table 7: 400%+ FPL Subsidy Extension, Applicable Percentage

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

APPENDICES

APPENDIX A: CAVEATS

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

L&E made several assumptions in performing the analysis. Several of these assumptions are subject to material uncertainty and it is not unexpected that actual results could materially differ from the projections. Examples of uncertainty inherent in the assumptions include, but are not limited to:

- Data Limitations.
  - L&E relied on the data submitted from all insurers for significant portions of this analysis. To the extent that the data is inaccurate, the analysis will be impacted.
- Enrollment Uncertainty.
  - Beyond changes to premiums and market wide programs, individual responses to these has inherent uncertainty. Therefore, actual enrollment could vary significantly.
- Political and Health Policy Uncertainty.
  - Future federal or state actions could dramatically change premiums and enrollment in 2020 and later years.

This report has been prepared for the MHBE for discussion purposes in relation to the Young Adult, 400%+ Extension, and Small Group Subsidies analysis. Any other use may not be appropriate. L&E understands that this report may be distributed to other parties; however, any user of this report must possess a certain level of expertise in actuarial science and/or health insurance so as not to misinterpret the data presented. Any distribution of this report should be made in its entirety. Any third party with access to this report acknowledges, as a condition of receipt, that L&E does not make any representations or warranties as to the accuracy or completeness of the material. Any third party with access to these materials cannot bring suit, claim, or action against L&E, under any theory of law, related in any way to this material.

APPENDIX B: DISCLOSURES

The Actuarial Standards Board (ASB), vested by the U.S.-based actuarial organizations[15], 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[16], 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
- Dave Dillon, FSA, MAAA, MS, Senior Vice President & Principal
- Kevin Ruggeberg, ASA, MAAA, Assistant Vice President & Consulting Actuary
- Michael Lin, FSA, MAAA, Vice President & Consulting Actuary

The actuaries are available to provide supplementary information and explanation.

IDENTIFICATION OF ACTUARIAL DOCUMENTS

The date of this document is February 3, 2020. The date (a.k.a. "latest information date") through which data or other information has been considered in performing this analysis is February 3, 2020.

DISCLOSURES IN ACTUARIAL REPORTS

- The contents of this report are intended for the use of the Maryland Health Benefit Exchange. Any third party with access to this report acknowledges, as a condition of receipt, that they cannot bring suit, claim, or action against L&E, under any theory of law, related in any way to this material.
- Lewis & Ellis Inc. is financially and organizationally independent from the companies that participate in the Maryland individual market. L&E is not aware of anything that would impair or seem to impair the objectivity of the work.
- The purpose of this report is to assist the MHBE with an analysis of proposed subsidy programs.
- The responsible actuaries identified above are qualified as specified in the Qualification Standards of the American Academy of Actuaries.

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

- Lewis & Ellis has reviewed the data provided for reasonableness but has not audited it. L&E nor the responsible actuary assumes responsibility for items that may have a material impact on the analysis. To the extent that there are material inaccuracies in, misrepresentations in, or lack of adequate disclosure by the data, the results may be accordingly affected.
- 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.