maryland health connection

Affordability Work Group

Meeting 4
April 19, 2019

A service of Maryland Health Benefit Exchange

Agenda

- Welcome
- Guest Speaker: Cheryl Parcham, Director of Access Initiatives, Families USA
- Q & A
- Guest Speaker: Stan Dorn, Director of the National Center for Coverage Innovation and Senior Fellow, Families USA
- Q & A
- Guest Speaker: Linda Blumberg, Institute Fellow, Urban Institute
- Q & A
- Work Group Recommendations Draft
- Public Comment
- Adjournment

Cheryl Parcham
Families USA
Director of Access Initiatives

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Why Standardized Plans?

Presentation to Maryland Exchange
Cheryl Fish-Parcham, Director of Access Initiatives
April 19, 2019

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Families USA's Prior Research

"Federal Standardized Health Insurance Plans Could Help Improve Access to Care Without Raising Premiums" (2016 study with Milliman)

- The federal standardized silver plans would have premiums that are comparable to current silver marketplace plans that cover little to no services before the deductible.
- Offering these standardized plans could improve access to outpatient care without driving up premiums

"Designing Silver Plans With Affordable Out-of-Pocket Costs" (2014)

"Non-Group Health Insurance: Many Insured Americans with High Out-of-Pocket Costs Forgo Needed Care" (2015): ¼ with year round coverage went without needed care

"Improve the Display of Plan Information on Marketplace Websites to Help Enrollment" (2016)

- Assisters/consumers need info on pre-deducible service and out-of-pocket drug costs

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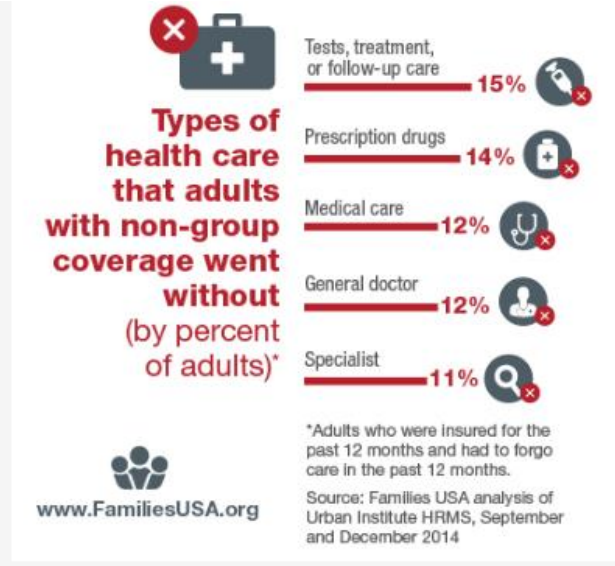
Sources

Consumers go without needed care if they can't afford up-front costs

In 2014, in the nongroup market, 22% of adults with incomes below 250% of poverty had deductibles of $3000 or more; nearly 30% of adults with incomes 250-400% of poverty had deductibles of $3000 or more per person. Adults in high deductible plans were more likely than those with deductibles below $1500 to report going without care because they couldn't afford it.



Sources

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Consumer needs vary, but for some, up-front cost is key

- Very sick consumers will spend through a deductible anyway; they may care more about out-of-pocket maximums
- Consumers with savings may want HSA compatible plans – and states with standardized plans do allow this as an option
- **But consumers also want to know that for the premiums they pay, they will in fact have access to health services – and for many, deductibles either pose an insurmountable barrier, or make plans unattractive.**
- Families USA's 2016 national survey of assisters showed problems finding pre-deductible services:
  - Half of assisters knew of some plans that offered pre-deductible services beyond primary care
  - 74% said pre-deductible services were always or often important to consumers' plan churches
  - Only 40% of assisters said they could determine which plans in their area offered pre-deductible services in addition to preventive care.

Sources

Why Standardized Plans: Some States' Perspectives

- Assure availability of pre-deductible services: Improve access
- Ease consumers' task of comparing plans
- Predictability – consumers know what they are getting (WA's consideration)
- Active purchaser: plans compete based on price (MA)
- Can shape products to suit consumer needs statewide (OR)
- Simplicity (VT). (Small population, two issuers, stable market.)

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Sources

Examples of Pre-Deductible Services In Some 2019 Silver Standard Plans

Is this service pre-deductible?	DC	CA	MA (high-silver)	VT
Outpatient primary care/mental health	Yes	Yes	Yes	Yes
Outpatient specialty	Yes	Yes	Yes	Yes
Drugs: generic	Yes	No	Yes	Yes
Drugs: preferred	No	No	Yes	No
Inpatient	No	No	No	No
Outpatient surgery	Yes	Yes	No	No
Labs	No	Yes	No	
Emergency Dept	No	Yes	No	Urgent care
Individual deductible	$3500	$2500	$2000	$2800
Separate drug deductible?	$250	$200	No	$300

Sources

How does enrollment in standard and non-standard plans compare? Some examples

- No clear preference (MA);
- Consistently, about 68% choose standard (NY);
- Standard enrollment consistently higher by substantial margin (VT)

Sources

How have states altered standard plans over time?

- All states make minor changes to accommodate changes in the AV calculator
- Some states require silver plans to be at highest possible AV level; this can result in more pre-deductible services and maximize the price of a “benchmark” plan that becomes the basis for premium tax credits.
- Some states have assured a high AV value bronze plan, either on or off-exchange, for unsubsidized consumers affected by silver loading. They may also require a low AV gold plan.
- MA required a broad network plan, and an optional alternate network plan prior to ACA. They later allowed issuers to offer non-standard plans in addition. AV requirements altered its offerings. In 2016, MA reduced the number of allowable non-standard plans to simplify shopping. They have added requirements regarding pediatric dental and opioid treatment and considered VBID. In 2018, they urged non-subsidized consumers to use off-exchange plans due to silver loading, and required a “low-AV gold” and a “high AV bronze” offering
- CT requires standard to be the issuers *lowest* price silver. Began offering an additional low AV silver in 2019, targeted at unsubsidized enrollees, that is not required to be priced low. Considered requiring a tiered network plan, but hasn’t.
- VT has a statutory restriction on maximum out-of-pocket pharmacy costs, but waived that for one bronze plan to bring down cost-sharing.

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Sources

QUESTIONS?

cparcham@familiesusa.org

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Q & A

Stan Dorn
Families USA
Director of the National Center for Coverage Innovation and Senior Fellow

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Affordability in Maryland's Individual Market

Stan Dorn, senior fellow and director of the National Center for Coverage Innovation

Maryland Health Benefit Exchange
Affordability Work Group
April 19, 2019

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Presentation overview

Who has affordability problems?

What are these problems' major causes?

What policy solutions deserve consideration?

The conventional wisdom about who has trouble affording health care and coverage

- People in the individual market are basically OK if they qualify for federal premium tax credits (PTCs). Who are they?
  - Incomes above Medicaid levels and at or below 400 percent of the federal poverty level (FPL)—roughly $50,000 for an individual and $100,000 for a family of four.
  - No offer of employer-based insurance (ESI) that the ACA classifies as affordable.
  - U.S. citizens or lawfully present non-citizens.
- The people who are really suffering receive no help at all. They are generally above 400 percent of FPL and must buy insurance on their own.

A 60-year old, single adult buys a benchmark plan in Bethesda

At 399% FPL	At 401% FPL
• Monthly income: $4,153 • Consumer cost for benchmark plan: $398	• Monthly income: $4,174 • Consumer cost for benchmark plan: $1,016

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The truth is more nuanced

People who qualify for PTCs

- Many experience serious affordability problems

People who do not qualify for PTCs

- Some experience serious affordability problems, especially those with incomes just above 400% FPL
- The majority of individual-market participants with incomes too high for PTCs face relatively modest affordability challenges

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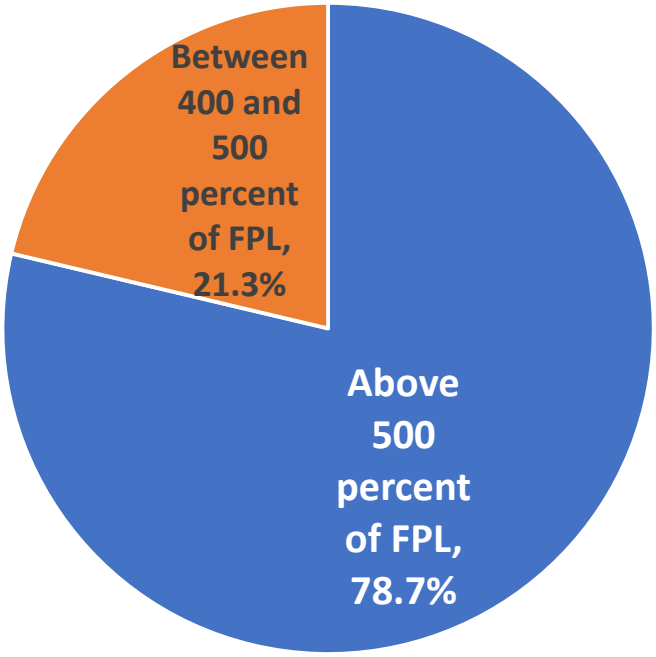
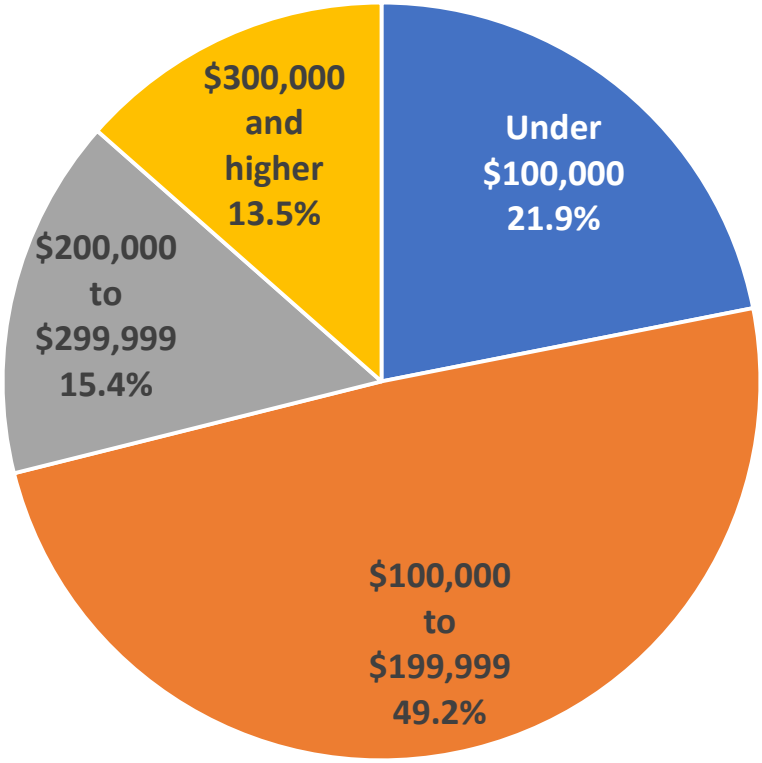
Most individually-insured Maryland residents with incomes too high for PTCs are relatively affluent

Individually-insured Maryland residents above 400% FPL, income by FPL (2017)



Individually-insured Maryland residents above 400% FPL, income by dollars (2017)



Source: NCCI/Families USA analysis of 2017 American Community Survey (ACS) data

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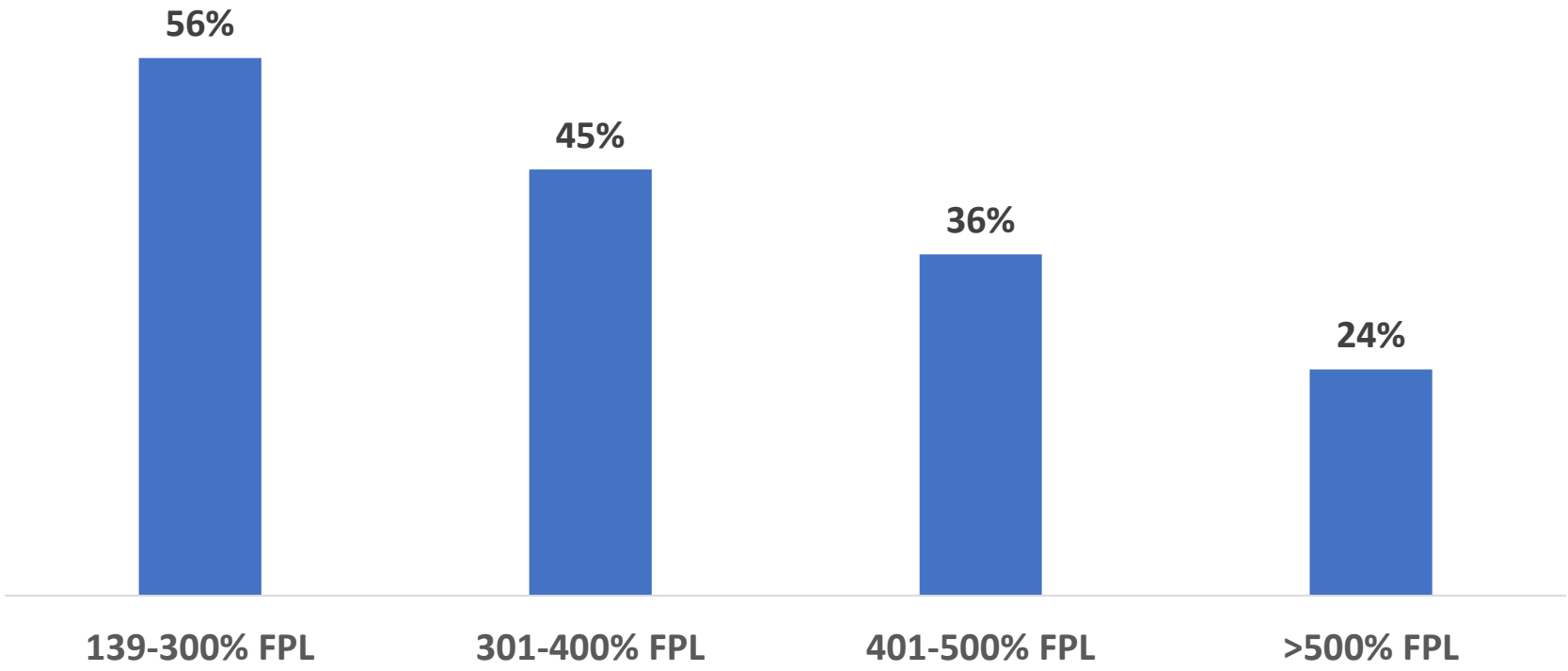
Despite PTCs, lower-income Marylanders are more likely to be uninsured

Among non-elderly adults in Maryland without employer-sponsored insurance, the percentage who are uninsured, by income: 2017



Source: NCCI/Families USA analysis of 2017 ACS data. *Note*: data display is limited to uninsured consumers and those reporting coverage in the individual market. ACS data do not identify people ineligible for PTCs because of immigration status or ESI offers. ACS respondents sometime mischaracterize their coverage.

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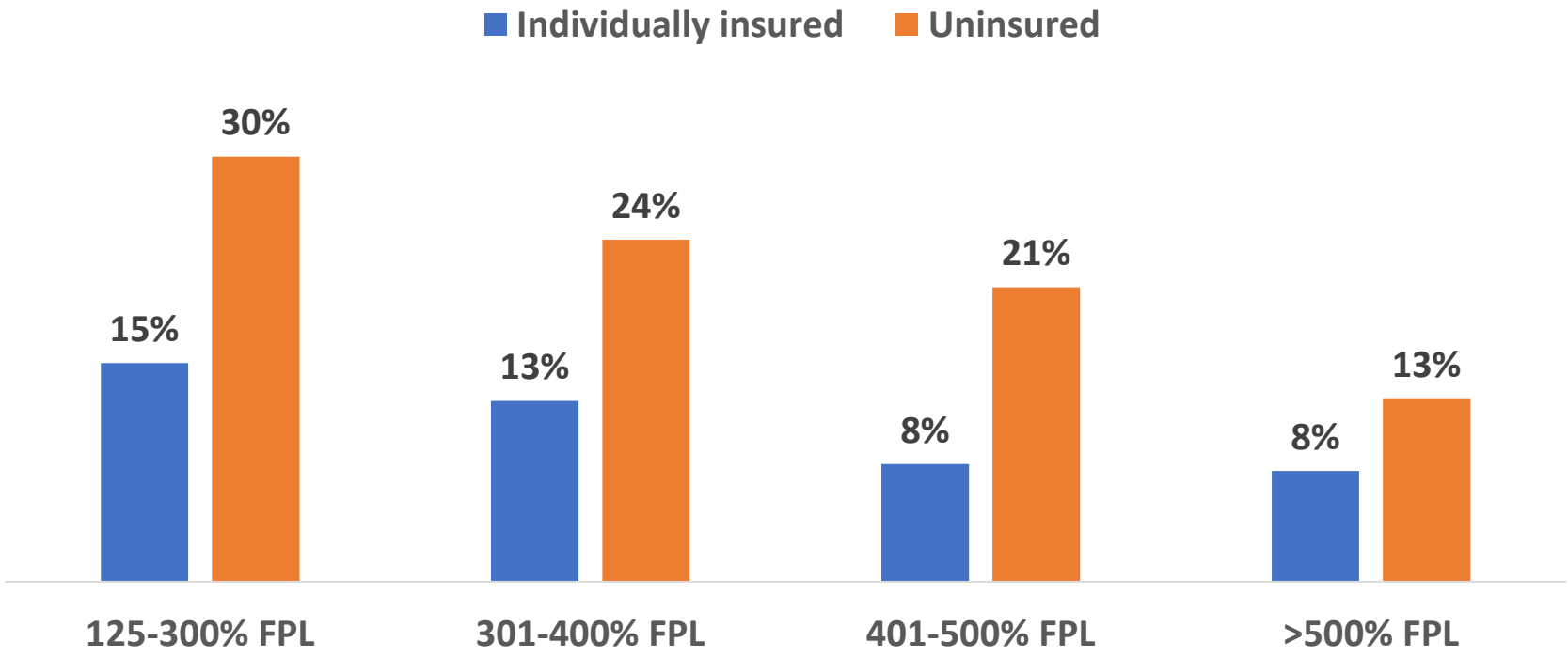
Problems with unaffordable bills are most common for the uninsured and for lower-income people

The percentage of non-elderly U.S. residents unable to pay medical bills or having trouble paying medical bills, by income and insurance status: 2017



Source: NCCI/Families USA analysis of 2017 National Health Interview Survey (NHIS) data. ACS data do not identify people ineligible for PTCs because of immigration status or ESI offers.

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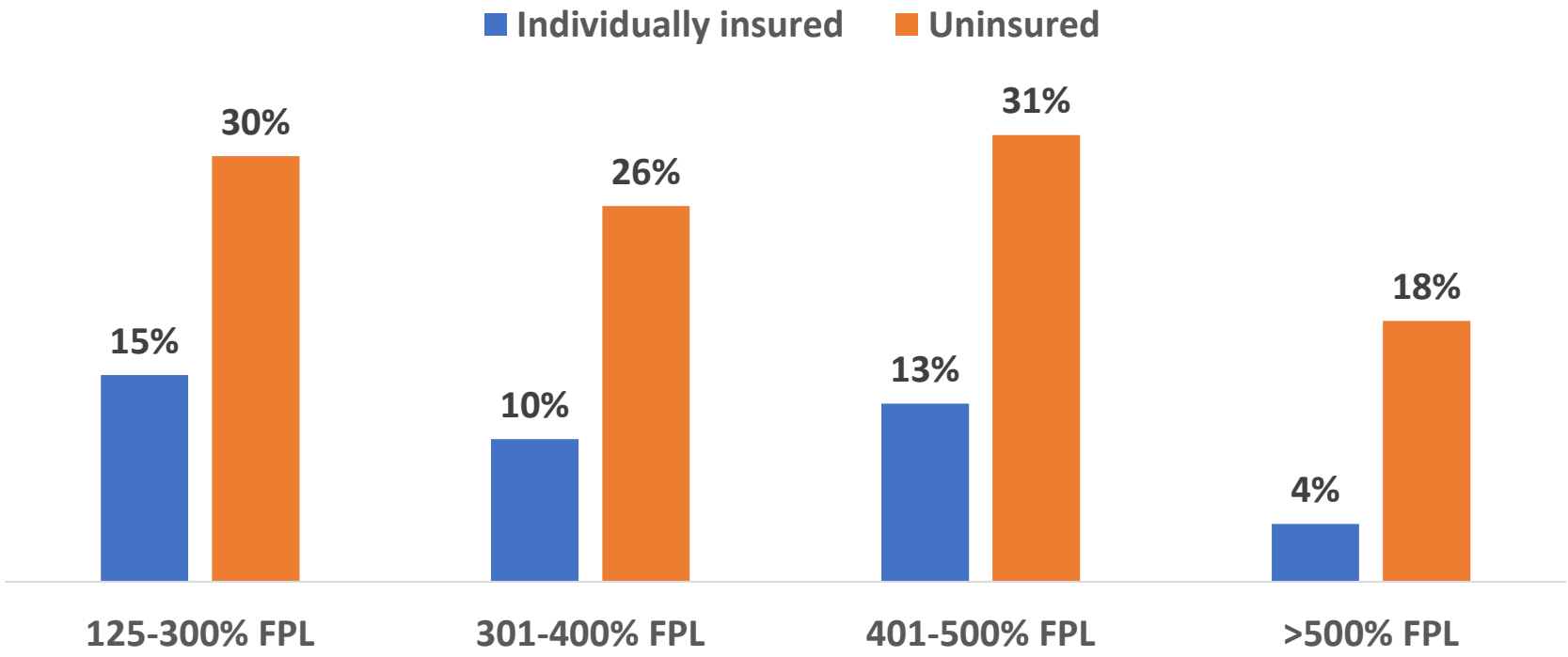
Except for the highest-income people, many people go without necessary care because of cost – especially the uninsured

The percentage of non-elderly U.S. residents who needed but could not afford medical care or prescription drugs during the past 12 months,, by income and insurance status: 2017



Source: NCCI/Families USA analysis of 2017 NHIS data. NHIS data do not identify people ineligible for PTCs because of immigration status or ESI offers.

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Presentation overview

Who has affordability problems?

What are these problems' major causes?

1. **Low- to moderate-income people**
2. **Higher-income people**

What policy solutions deserve consideration?

Financial assistance for low- and moderate-income people is greater under earlier successful programs than under the ACA

	150% FPL		200% FPL		250% FPL		300% FPL	
	Premiums	AV and deductible	Premiums	AV and deductible	Premiums	AV and deductible	Premiums	AV and deductible
MA law	$0	95%, $0	$44	95%, $0	$85	92%, $0	$126	92%, $0
Median CHIP state	$0	99%, $0	$0	99%, $0	$29	99%, $0	$35	99%, $0
ACA	$63	94%, $255	$132	87%, $809	$211	73%, $2,904	$299	70%, $3,609

Sources: Gasteier, Massachusetts Health Connector, 2018; Brooks et al., Georgetown Center for Children and Families, 2019; Rae et al., Kaiser Family Foundation 2017; Whitener et al., Georgetown Center for Children and Families 2016.
Note: AV=actuarial value, or the average percentage of covered health care costs paid by the insurer for a standardized population. Estimates for MA, CHIP premiums, and ACA premiums and AV are for 2019. Estimates for CHIP actuarial value are for 2016. ACA deductibles are averages for 2017.

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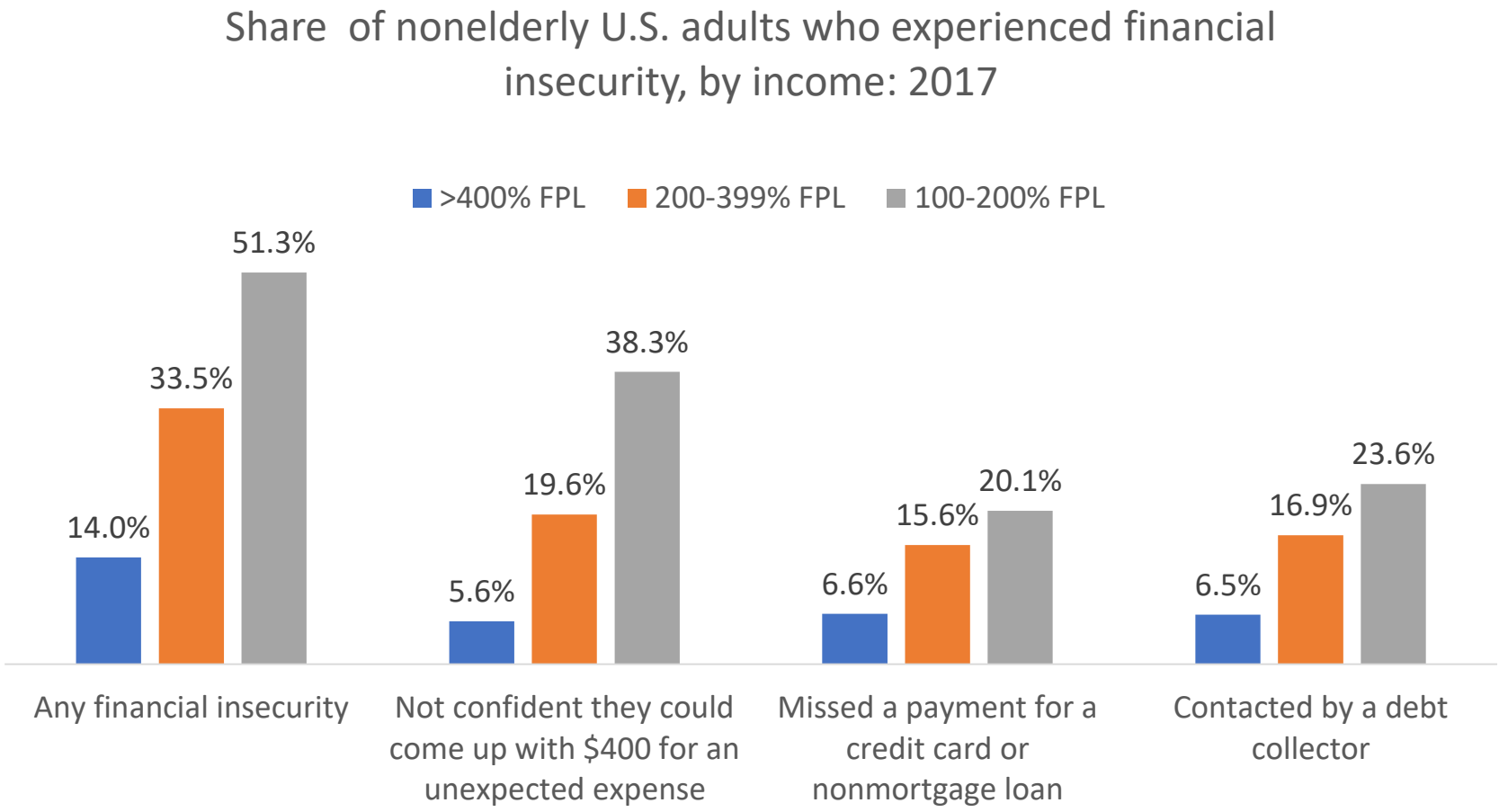
PTC-eligible consumers often experience financial distress



Source: Brown and Braga, Dec. 2019 (Urban Institute).

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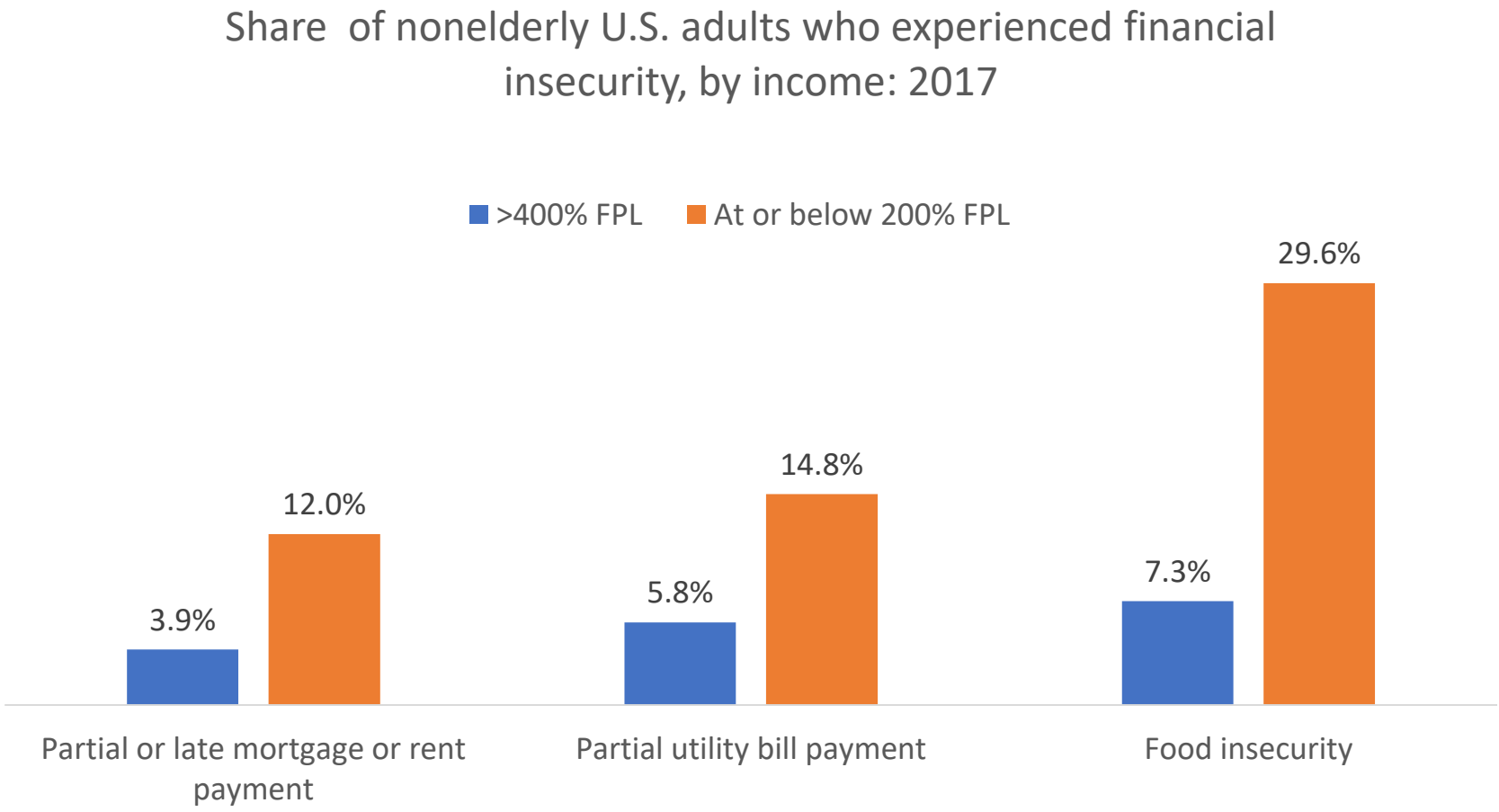
PTC-eligible consumers often experience financial distress, continued



Source: Scully and Gonzalez, November 2018 (Urban Institute).

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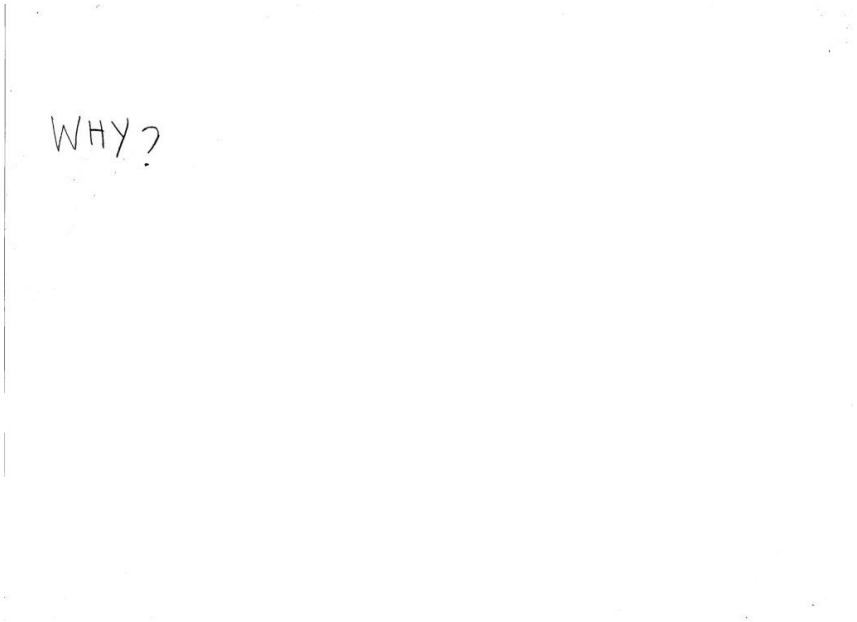
Why don’t the eligible uninsured enroll?



- Many are unaware of
  - Available financial help
  - Health insurance exchanges
- Of those who shop on the exchange and do not enroll, the #1 reported reason for not buying insurance is perceived unaffordability of coverage

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Context for high premiums charged to consumers buying individual-market coverage without financial assistance

- U.S. health care is expensive. In Maryland, firms with 1,000 or more workers are charged average annual premiums of:
  - $7,020 for worker-only coverage
  - 19,805 for family coverage*
- BUT -- individual coverage is more expensive than comparable group coverage. In Maryland, average monthly premiums, adjusted for generosity of coverage, are:
  - $947 in the individual market
  - $623 in the small-group market**

*AHRQ, MEPS-IC 2017.

**NCCI/Families USA analysis of CCIIO, Interim Summary Report on Risk Adjustment for the 2018 Benefit Year, 2019

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Why are individual-market premiums high in Maryland?

Limited participation by young and healthy people

Average risk score in MD:

1.514 individual, 1.115 small-group*

Take-up rates for MD individual coverage:

Age 19-44: 46%

Age 45-54: 60%

Age 55-64: 73%**

Limited competition

Lowest-cost individual market coverage is 50% more expensive in parts of MD with only one carrier

National research shows that, where additional carriers compete, premiums decline

No Medicaid-based plans

Where Medicaid MCO plans are offered in markets with >1 plan, they are the lowest-price silver 70% of the time***

Three out of the four states with the lowest adjusted premiums in individual market have Medicaid MCO-based plans (RI, MA, AR – not DC)

*CCIIO 2019, op cit.

**NCCI/Families USA analysis of 2017 ACS data for adults above 138% FPL. Uninsured and individual-market enrollees are counted as eligible. Data do not identify people ineligible for PTCs because of immigration status or ESI offers.

***Hempstead et al., 2018 (Health Affairs blog)

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Presentation overview

Who has affordability problems?

What are these problems' major causes?

What policy solutions deserve consideration?

Don’t just focus on premiums! That leaves behind low-wage workers and middle-class families who qualify for PTCs. What the latter group pays is based on income, not premiums.

	Individually-insured Marylanders with incomes too high for PTCs	Uninsured and individually-insured Marylanders potentially eligible for PTCs
Average household income	$183,000	$61,000
Percentage African-American or Latino	30%	45%
Percentage with a college education	40%	21%

Source: NCCI/Families USA analysis of 2017 ACS data, excluding immigrants estimated to be ineligible for PTCs based on Urban Institute research results. Estimates of PTC eligibility did not consider ESI offers.

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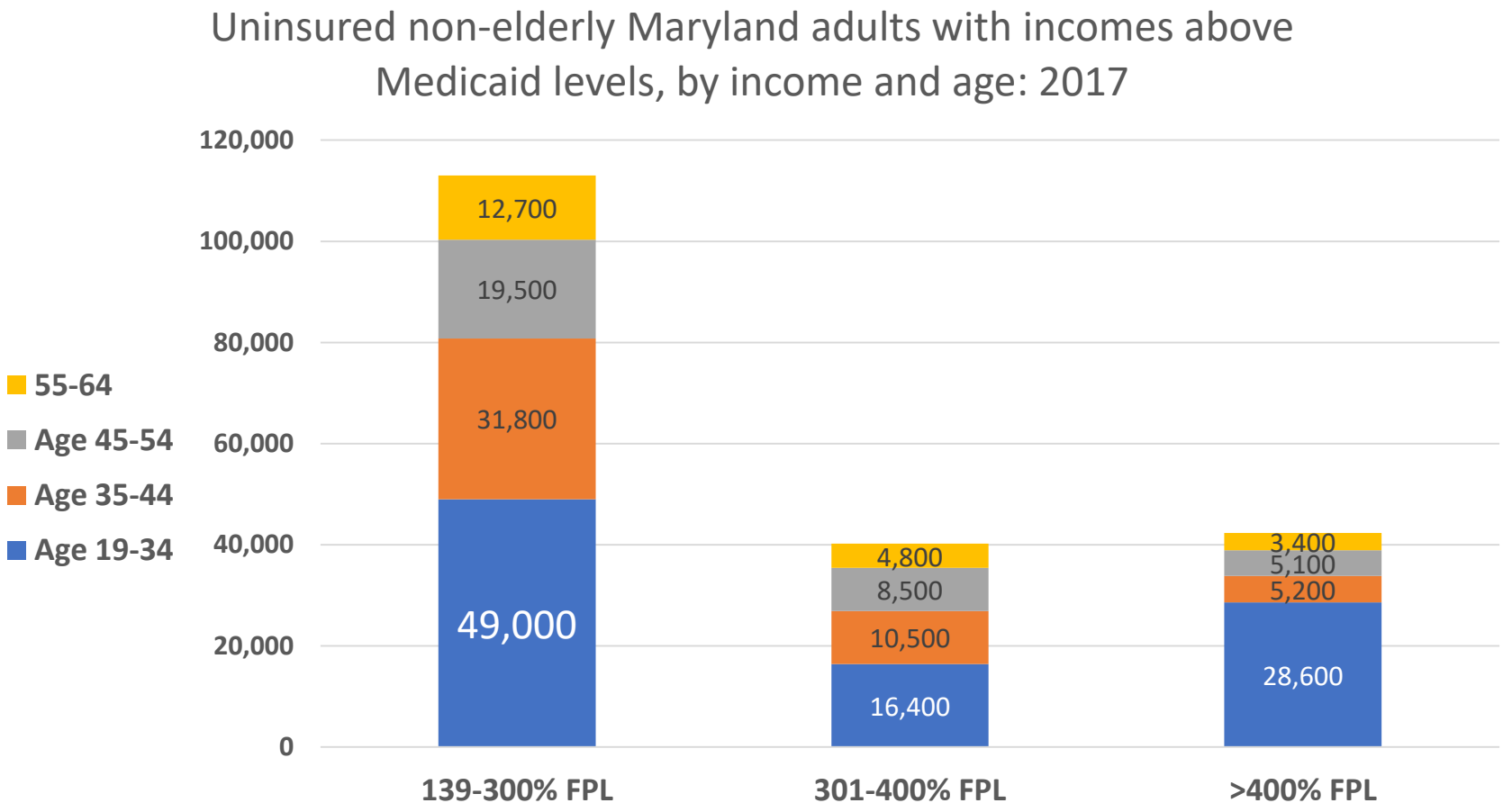
Enrolling uninsured, low- and moderate-income people ***both*** helps them ***and*** lowers premiums by improving the risk pool!



Source: NCCI/Families USA analysis of 2017 ACS data. *Note*: ACS data do not identify consumers who are ineligible for PTCs because of immigration status or employer coverage offers.

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Expediting enrollment

- Maryland Easy Enrollment Health Program (MEEHP)
  - Consumers can enroll in coverage by checking a box on their tax return asking the exchange to use their tax return information to determine their eligibility for free or low-cost insurance
  - Key implementation issues
    - Engagement of tax preparers -- $$$!
    - Automated interfaces between tax software/Comptroller and the exchange, with real-time eligibility determinations, as much as possible
    - **Highly** simplified plan choice
    - Tax return language that is very simple and encourages enrollment
- Exchange web interface
  - Standard strategy used in tech: vary web interface to conducted randomized, controlled trials (RCTs)
    - Impact: determines display strategies that increase enrollment
  - An example: reference pricing
    - "75% DISCOUNT! This insurance normally costs $400 a month. But if you buy now, you can get it for just $100 a month!"

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Learning from

- For the past three years, Massachusetts has had the country's second- or third-lowest-cost exchange coverage, despite having the country's second-highest-cost health care system
- Most important single factor: supplemental affordability aid
  - Allows broad participation by young and healthy consumers, improving the risk pool
  - Incentives for carriers to lower premiums
- Other policies
  - Operates a public program, with only Medicaid-MCO-based carriers serving recipients of supplemental affordability aid, inside a competitive health insurance market
  - All carriers with 5,000 covered lives must offer exchange plans
  - Individual and small-group markets are merged
  - Facilitating smart shopping with
    - Standardized plans
    - Decision-support and web display

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Conclusion

- Reinsurance incredibly effective in lowering premiums and leveraging federal dollars. However:
  - Treats symptoms, not the cause of high premiums in individual market
  - Effectively = across-the-board premium subsidy for people ineligible for PTCs
  - Most consumers who receive help do not need public assistance
- Strategies discussed here help people up and down the income scale
  - Enroll and lower costs for low-wage workers and middle-income families who qualify for PTCs
  - Improve risk pool and lower premiums charged to those who are ineligible for PTCs
  - Affordability together!
- Other strategies also warrant consideration
  - Extending premium subsidies to people just over 400% FPL
  - Focusing on provider charges

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Q & A

Linda Blumberg
Urban Institute
Institute Fellow

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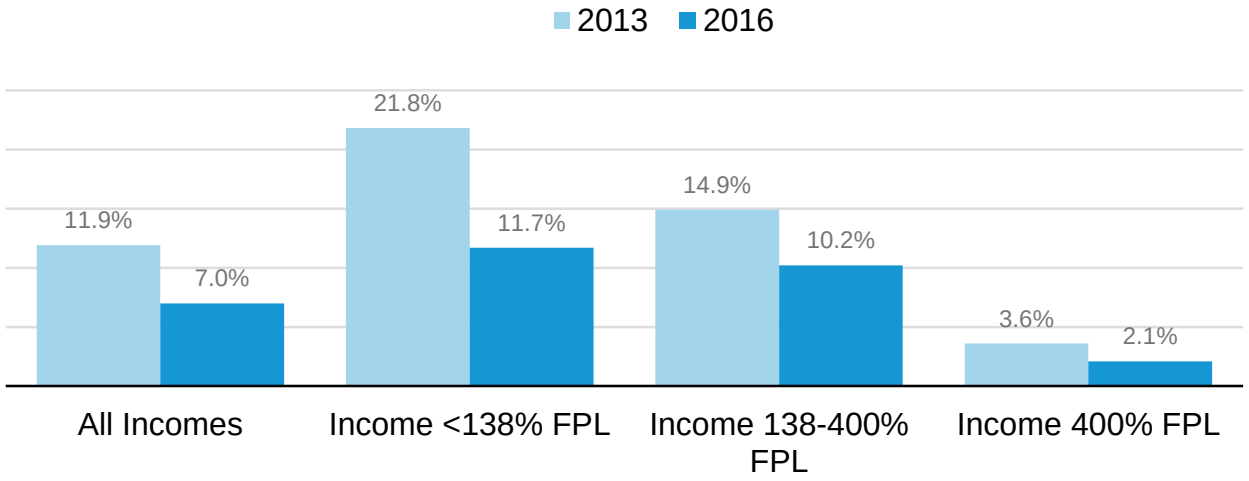
April 19, 2019

ACA Coverage: Affordability Concerns and Strategies to Address Them

Linda J. Blumberg, Ph.D.
Institute Fellow, Health Policy Center
Presentation to the Maryland Health Benefit Exchange Affordability Work Group

Changes in Maryland Uninsured
2013-2016



Source: Urban Institute analysis of American Survey data from 2013 and 2016 using the Integrated Public Use Microdata Series.

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Changes by Coverage Type

Maryland

Employer	decreased by	1.4%
Medicaid and CHIP	increased by	23.0%
Other Public	no significant change	
Private Nongroup	increased by	45.0%
Uninsured	**decreased by**	**41.2%**

National Uninsured	**decreased by**	**41.2%**
National Uninsured in Expansion States	**decreased by**	**50.3%**

Source: Urban Institute analysis of American Survey data from 2013 and 2016 using the Integrated Public Use Microdata Series.

Large Coverage Gains Under ACA, but…

- Still large numbers of uninsured people, 2016
  - 349,000 in Maryland
  - 26.5 million nationally
- Most frequently cited reason for being uninsured = affordability

Source: Urban Institute analysis of American Survey data from 2016 using the Integrated Public Use Microdata Series
Source: Kaiser Family Foundation

Affordability should take into account three components of the system

- Covered Benefits
- Premiums
- Out of Pocket Costs at Point of Service
- Absent Subsidies:
  - Low Premiums with high OOP costs and narrower benefits make access to care less affordable for the sick;
  - Higher premiums with low OOP costs and broad benefits increase costs for the healthy

Did the ACA go far enough on Affordability, 2019

	Premium as share of income	Premium plus deductible as share of income	Premium plus OOP maximum as share of income
150% FPL	4.2%	4.7%	16.2%
250% FPL	8.4%	13.8%	27.6%
350% FPL	9.9%	17.2%	23.6%
405% FPL	9.9%	16.3%	21.8%

OOP Costs & APTC Caps Tend to Increase over time

- As total spending per capita increases over time, even a fixed AV will lead to higher cost-sharing requirements
  - AV = avg reimbursed expenses/avg total expenses.
    - 70% AV = $7,000/$10,000 --- OOP on average = $3,000
    - 70% AV = $8,400/$12,000 --- OOP on average = $3,600
- Plus, the formula for APTC caps means that the percent of income caps will grow as health spending increases faster than general inflation.

Trump Administration proposed regulatory change percent of income cap adjustments

- Proposed regulatory changes, if implemented, would increase the APTC percent of income caps faster each year than they did before.
- HHS projects that the change would increase premiums by over $180 million nationwide in the first year, and decrease enrollment by 100,000 people.
- Formula was previously tied to average employer-sponsored insurance premium growth, now to both employer and nongroup coverage.

APTC Caps Since 2014,

% of Federal Poverty Level	Premium Cap, Maximum Percent of Income Payable towards Premium					
	2014	2015	2016	2017	2018	2019
Up to 138%	2	2.01	2.03	2.04	2.01	2.08
150%	3	3.02	3.05	3.06	3.02	3.11
200%	4	4.02	4.07	4.08	4.03	4.15
250%	6.3	6.34	6.41	6.43	6.34	6.54
300%	8.05	8.1	8.18	8.21	8.1	8.36
400%	9.5	9.56	9.66	9.69	9.56	9.86

Policy Options for Improving Affordability for Nongroup Consumers Ineligible for APTCs

- Public Option
- Capped Provider Payment Rates
- Individual mandate
- Reinsurance (Maryland has adopted)
- Global Budgets
  - Maryland's Global Budgets are a step, but don't include docs
    - What are the right levels?
    - Is there power to keep them there?

Strategies to Improve Affordability for the Subsidized

- Basic Health Plan (MN, NY)
- Enhance APTCs (MA, VT)
- Enhance Cost-Sharing Assistance (MA, VT)
- Eliminate indexing of APTC Caps
- Tie APTCs to gold level coverage
- Standard Benefit Plans that require some types of care before the deductible (CA) → mixed effects

Example of Alternative APTC & CSR Schedules

	Premium Tax Credit Schedule Household Premium Caps as Percent of Income		Cost-Sharing Reduction Schedule AV of Plan Provided to Eligible Enrollees (%)	
Income (% of FPL)	2019 ACA schedule: Pegged to silver (70% AV) premium, indexed	Proposed schedule: Pegged to gold (80% AV) premium, not indexed	2019 ACA schedule: Coverage provided in a silver plan	Proposed schedule: Coverage provided in a gold plan
100–138	2.08	0-1.0	94	94
138–150	3.11–4.15	1.0–2.0	94	94
150–200	4.15–6.54	2.0–4.0	87	90
200–250	6.54–8.36	4.0–6.0	73	85
250–300	8.39–9.86	6.0–7.0	70	85
300–400	9.86	7.0–8.5	70	80
≥ 400	NA	8.5	70	80

Source: Urban Institute analysis, Health Insurance Policy Simulation Model 2018. Reform simulated in 2020.

Notes: ACA = Affordable Care Act; AV = actuarial value; FPL = federal poverty level; NA = not applicable.

The ACA premium tax credit schedule can be found at https://www.irs.gov/pub/irs-drop/rp-18-34.pdf. Under the ACA, premium tax credits are indexed to change as a function of the increase in health care costs relative to general inflation. Our proposal would eliminate the indexing, keeping the the percent of income caps fixed.

Implications for Enrollee Portion of Premiums & OOP, 2020

	138% of FPL			250% of FPL			350% of FPL			450% of FPL		
	ACA (94% AV)	Scenario 3 (94% AV)	Difference	ACA (73% AV)	Scenario 3 (85% AV)	Difference	ACA (70% AV)	Scenario 3 (80% AV)	Difference	ACA (70% AV)	Scenario 3 (80% AV)	Difference
Enrollee portion of premiums												
Single Age												
25	$524	$169	-$356	$2,554	$1,833	-$721	$4,217	$3,315	-$902	$4,722	$4,674	-$47
45	$524	$169	-$356	$2,554	$1,833	-$721	$4,217	$3,315	-$902	$6,791	$4,674	$2,117
64	$524	$169	-$356	$2,554	$1,833	-$721	$4,217	$3,315	-$902	$14,108	$4,674	-$9,434
Family of four (two age 35, two children)	$1,085	$349	-$736	$5,281	$3,791	-$1,491	$8,721	$6,854	-$1,866	$18,689	$9,666	-$9,023
Out-of-pocket structure												
Single												
Deductible	$200	$200	$0	$2,650	$1,000	-$1,650	$3,150	$1,500	-$1,650	$3,150	$1,500	-$1,650
Out-of-pocket maximum	$700	$700	$0	$6,500	$2,700	-$3,800	$7,450	$7,200	-$250	$7,450	$7,200	-$250
Family												
Deductible	$400	$400	$0	$5,300	$2,000	-$3,300	$6,300	$3,000	-$3,300	$6,300	$3,000	-$3,300
Out-of-pocket maximum	$1,400	$1,400	$0	$13,000	$5,400	-$7,600	$14,900	$14,400	-$500	$14,900	$14,400	-$500

Implications of Incremental Reforms at Federal Level, 2020

- Scenario 1: Restore 2016 ACA policies (IM, CSRs, STLDs)
  - Uninsured: -2.2 million (-6.9%); MEC: +6.1 million
  - Federal Spending: -2.7%, -$11.4 billion
  - State Spending: +0.8%, +$1.5 billion
- Scenario 2: Scenario 1+Expand Medicaid in remaining states + limited autoenrollment
  - Uninsured: -7.1 million (-23.8%)
  - Federal Spending: +19.5%, +$79.5 billion
  - State Spending: -4.4%, -$8.9 billion

Implications of Incremental Reforms at Federal Level, 2020, cont'd

- Scenario 3: Scenario 2 + Improve marketplace financial assistance
  - Uninsured: -1.7 million (-7.6%)
  - Federal Spending: +12.9%, +$62.9 billion
  - State Spending: -0.1%, -$230 million
- Scenario 4: Scenario 3 + Reduce nongroup market premiums and OOP costs
  - Uninsured: -1.1 million (-5.3%)
  - Federal Spending: -2.1%, -$11.8 billion
  - State Spending: +0.2% +$420 million

Implications of all incremental reforms taken together compared to current law, 2020,

- Uninsured: -12.2 million (-37.9%)
- Minimum Essential Coverage: +16.1 million
- Federal Spending: +28.5%, +$119.2 billion
- State Spending: -3.6%, -$7.2 billion

Summary

- Coverage and affordability have improved markedly since 2013, but many remain uninsured and face high health care costs relative to income.
- An array of strategies for improving affordability and increasing coverage are available.
- Government costs vary with level of affordability.
- Even at generous funding levels, millions of uninsured will remain, including many in the undocumented population and others choosing not to enroll.

Q & A

Public Comment

Adjournment