HB 413: Public Stakeholder Meeting #3: Funding Mechanisms for 1332 waivers

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Maryland Insurance Administration

Brad Boban, Chief Actuary

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INSURANCE ADMINISTRATION

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Summary of 1332 Funding Mechanism as of 2022

- 8 states fund their program through health insurance premium assessments.
  - Oregon, Maine, Maryland, Delaware, Montana, Pennsylvania, New Hampshire, New Jersey
- 2 states funds their program through the state's premium tax.
  - Alaska and North Dakota* (health assessment that is 100% deductible from premium tax)
- 3 states fund their program through General Funds.
  - Wisconsin, Georgia, and Minnesota
- 2 states fund their program from penalties and shared responsibility payments from the state's individual mandate.
  - New Jersey and Rhode Island
- Colorado uses a multi-funding approach: health insurance premium assessment, 2-year hospital assessment, portion of state's premium tax revenue, and general funds.

Summary of State Assessments

- Pennsylvania = 3.0% (only for issuers participating in market)
- Delaware = 2.75%
- New Jersey = 2.5%
- Oregon = 2.0%
- Montana = 1.2%
- Maryland = 1.0%
- New Hampshire = 0.6% of previous year's SLCSP
- Maine = $4 PMPM
- Colorado = TBD

Newly approved 2023 Waivers

- Colorado received an amendment approval for 2023 that contains a variety of funding mechanisms:
  - Premium assessment at a rate still TBD
  - Temporary 2-year assessment on hospitals and other medical providers. Rate TBD
  - Ability to divert state premium taxes into reinsurance fund. Amount TBD
  - Use of general funds only for the administrative portion of the program
- Oregon has expanded their 2% assessment to include self-insured public employees (state or local governments). “Premium equivalents” are defined as claims + admin.

Magnitude of Maryland Assessment

- Current 1.0% assessment projected to bring in $752M over the 5-year waiver extension, an average of slightly over $150M a year.
- Increasing to 1.2% would be expected to generate an extra $30M per year, for a total of $180M annually.
- Increasing to 2.0% would bring in $300M annually
- Increasing to 2.5% would bring in $375M annually
- Increasing to 2.75% would bring in $412M annually

State Premium Taxes?

- AK is solely funded from the state premium tax
- ND technically has a health premium assessment, but allows carriers to deduct it from premium tax, so effectively is funded from the base premium tax.
- CO is partially funded; general funds may only be used for administration of program.
- Can/should a portion of the state's 2% premium tax be earmarked for the 1332 waiver?
- Appropriate for non-health lines of business to be forced to pay for healthcare initiatives?

General Funds

- Drawback of general funds is state budget uncertainty.
  - Budget shortfalls can be correlated with recessions, which tend to see loss of employer sponsored coverage and increased need for Individual market programs; meaning that programs costs are likely to swell at same time funding is constrained.
- An approach like CO, where general funds are supplemental to the annual health premium assessment, would be recommended if this option were to be pursued.

Individual Mandate?

- Tax data from when Individual mandate was in effect showed the mandate was very regressive, with a large number of low income households (who would be eligible for premium tax credits), paying the penalty.
- No evidence that the individual mandate was effective at incentivizing people to buy coverage; nationwide there were no significant enrollment drops when the mandate was repealed.

Hospital Assessment?

- Maryland's unique Total Cost of Care model gives any hospital assessment additional considerations that Colorado did not have.
- With the requirement to keep growth of costs below the national level, adding an additional assessment will be counteractive to the fundamental goal of the TCOC model.

Funding outside of a 1332 waiver

- An additional potential source of funding for subsidies is a Medicaid 1115 waiver
- State would submit a 1115 waiver stating that we were planning to expand Medicaid to a certain threshold, like 200%. But instead are going to create state premium/cost-share subsidies and keep those members in the Individual QHP risk pool.
- The 1115 waiver will have an actuarial analysis computing how much money we're saving the federal government by not expanding Medicaid, and that savings can be passed on to the state.

Funding outside of a 1332 waiver

- Multiple states have obtained funding for their subsidies this way (CT, VT, MA)
- BUT, no state has both a 1332 waiver and this type of 1115 waiver
- Each waiver would be independently evaluated, but actuarial analyses would need to be done in a certain “stacking order”
- Unclear whether a state can get savings for the 138-200% population BOTH from a 1115 waiver (for saving the feds on Medicaid) and from a 1332 waiver (for saving the feds on APTC).
- So there may be a reduction in 1332 pass-throughs if 1115 funding is pursued. The net result may still be a gain in total funding (if the per person savings for Medicaid is greater that the per person APTC savings)

Thank You!

Written comments on items discussed today may be submitted to:
jamie.sexton@maryland.gov
by Friday, August 25, 2023

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THANK YOU FOR ATTENDING

Contact Information:

Maryland Insurance Administration

800-492-6116 | 410-468-2000 | 800-735-2258 (TTY)

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