MARYLAND Health Care FOR All

June 9, 2023

Dear Commissioner Birrane,

Thank you for the opportunity to provide comments to the State Reinsurance Workgroup, and for your leadership in pursuing access to quality, affordable health care for all Marylanders. Since the passage of the Affordable Care Act, Maryland has made great progress by cutting the number of uninsured in half. Now we must make further progress to go from 6% of Marylanders being uninsured to 0% uninsured.

We urge the workgroup to include in its report a recommendation to continue the successful young adult health subsidies program at its current level. In 2022 about 45,000 young Marylanders have used these subsidies to enroll in insurance coverage, including over 17,000 who were new to the marketplace, which is helping to stabilize the market for everyone. MHBE's new enrollees comprised of young adults increased from 4% to more than 24%. Young adults were more likely to pay their premiums and continue coverage. It is critical that this program continue to help young adults, many of whom have been able to access health coverage through Maryland Health Connection for the first time, while others already had coverage and were better able to afford their plans or upgrade to higher metal-level plans with lower cost-sharing. This program has also been reducing racial and ethnic coverage disparities within this age group. In 2022 young adult subsidy recipients were more likely to be Latino or Black than young adult enrollees ineligible for the subsidy. In 2023, Latino young adult enrollment grew 13%, more than any other population. We strongly disagree that Maryland should suspend any state subsidy programs until ARPA expires.

We also ask that the Workgroup recommend expanding the subsidy to additional ages. While young adults are the age group most likely to lack health coverage, adults aged 35-54 are the next most likely to lack health coverage as shared in the slides from the second workgroup meeting.

We strongly urge the workgroup to recommend that premium subsidies be made available to those ineligible due to immigration status. Over 115,000 uninsured Marylanders are ineligible for Medicaid and private insurance from Maryland Health Connection because of immigration status despite contributing millions of dollars in taxes every year. This has had the highest impact on Black and Latino residents, who have become sicker, hospitalized at higher rates, and die younger due to their exclusion from access to quality, affordable health care. For these subsidies it is critically important that undocumented Marylanders receive financial help at the same level as received by all other health plan purchasers on the Exchange so that they are able to afford to purchase the coverage. This may mean that more state funds are required in order to make up for a lack of federal applied premium tax credits for this population.

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We ask the workgroup to recommend creating supplemental state cost-sharing subsidies and lowering out of pocket maximums to be the most generous to consumers as possible, emulating Massachusetts's success. It is important that cost-sharing and out-of-pocket maximums are set at levels so that consumers can access care with their health coverage and also avoid becoming financially insolvent.

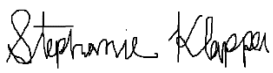
As Ms. Eberle noted at the first meeting of the workgroup, prescription drug costs are a significant driver of health insurance premiums. In order to make coverage affordable it is critical that we address the root causes for why costs are rising quickly in the first place. Maryland is fortunate to have the first-in-the-nation Prescription Drug Affordability Board which is nearly ready to release its plan to set upper payment limits for high-cost drugs for state and local governments. We urge the workgroup to express in its report support for the Prescription Drug Affordability Board going beyond this to gain the authority to set upper payment limits for high-cost drugs for ALL Marylanders.

As was discussed at the workgroup meetings, the subsidies and expansions outlined above will likely not be possible without additional funding sources. We believe that there are potential funding sources which also have independent public health benefits. For example, HB 915/SB 843 sponsored by Del. Fraser-Hidalgo and Sen. Kramer would have assessed the 100 largest historical emitters of carbon dioxide and allocated 20% of the proceeds to expand health care coverage. Other options could include tobacco, alcohol, or sugar sweetened beverage taxes, which in addition to raising revenue for health coverage would also improve public health. There is precedent for this—prior to the ACA Maryland expanded access to Medicaid for hundreds of thousands of Marylanders by increasing the tobacco tax. We believe that there are public health-based funding sources to be created that the public would support going toward expanding access to health coverage.

In response to other questions raised at the last meeting: We are long-time supporters of expanding Medicaid up to 200% of the federal poverty level. If Maryland were to reinstate an individual mandate, then we would recommend that the money collected be applicable as a down payment for the individual to enroll in health coverage as was proposed in the original text of SB 802/HB 814 in 2019 before it was amended to create the Easy Enrollment program and passed into law. We are interested in exploring extended enrollment opportunities. We have concerns about unintended consequences of merging the individual/small group markets.

Thank you for your leadership and consideration of these recommendations to ensure access to quality, affordable health care for all Marylanders.

Sincerely,



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