STATE OF MARYLAND
OFFICE OF THE GOVERNOR

LARRY HOGAN
GOVERNOR

May 18, 2018

The Hon. Alex M. Azar, Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

The Hon. Steven T. Mnuchin, Secretary
U.S. Department of the Treasury
1500 Pennsylvania Avenue, NW
Washington, DC 20220

Dear Secretary Azar and Secretary Mnuchin:

The State of Maryland respectfully asks for your assistance in creating a solution to the increasingly destabilized individual health insurance market in our state by approving our application for a Section 1332 State Innovation Waiver. As detailed in this application, Maryland is requesting that Section 1312(c)(1) of the Affordable Care Act (ACA) be waived for a period of five years beginning in the 2019 plan year to implement a state reinsurance program. This waiver will not affect any other provision of the ACA and adheres to the general guardrails established by Section 1332.

Without significant assistance, for example, in the form of a sizeable reinsurance program, a key part of the State's recent success in reducing the rate of uninsured Marylanders may be seriously compromised. Maryland has one of the best healthcare delivery systems in the country, and only six percent of our citizens do not have health insurance. However, we have experienced a significant contraction in the number of carriers offering policies in our individual health insurance market. From its peak in benefit years 2015 and 2016, the number of carriers offering plans on the state insurance exchange has decreased from five to two. Since the implementation of the Affordable Care Act, rates on the individual market in Maryland have risen by an outrageous and unsustainable 166 percent, and are set to increase by over 200 percent without action. Unless decisive and corrective action is taken, we anticipate that these rates will continue to rise to unaffordable levels for the approximately 250,000 Marylanders who rely on this form of access to health care.

STATE HOUSE, ANNAPOLIS, MARYLAND 21401
(410) 974-3901 1-800-811-8336
TTY USERS CALL VIA MD RELAY

As demonstrated in the comprehensive analysis attached in the application, we believe your assistance at the federal level, including federal pass-through funds, will allow more predictability in the health insurance market and allow Maryland's State Reinsurance Program to lower premium rates market-wide. Ensuring that health care is as accessible and affordable as possible for our citizens is a goal I am confident that we share. Combined with State resources, your expedited approval and federal contribution would assist us in stabilizing the individual market so that we can preserve our recent gains in health care delivery and deliver system-wide health savings.

Thank you for your consideration.

Sincerely,

Larry Hogan
Governor

cc: Seema Verma, Administrator, Centers for Medicare and Medicaid Services

Congress of the United States

Washington, DC 20510

May 17, 2018

The Honorable Steven Mnuchin
Secretary of the Treasury
Department of the Treasury
1500 Pennsylvania Avenue, NW
Washington, DC 20220

The Honorable Alex Azar
Secretary of Health and Human Services
Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Secretary Mnuchin and Secretary Azar,

We write to request that the U.S. Department of the Treasury and the U.S. Department of Health and Human Services grant Maryland's application for a Section 1332 State Innovation Waiver as soon as possible. We urge that this process include careful and thorough consideration of key stakeholder's input such as the Maryland Medical Society.

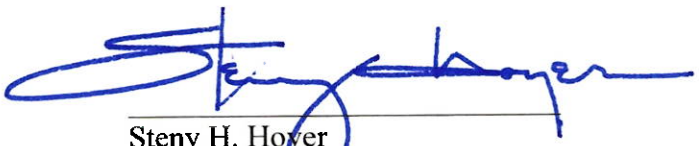
Earlier this year, the Maryland General Assembly voted to establish a state-based reinsurance program, the Maryland State Reinsurance Program. The Governor and both Democratic and Republican leaders strongly support this effort to address premium costs and access to affordable healthcare in our state. The Maryland Insurance Administration estimates that the State Reinsurance Program would lower premium rates market-wide by as much as 30 percent and would lead to a reduction in federal payments of advance premium tax credits. By contrast, without federal approval, rates for many individual market plans could increase substantially.

The matter is urgent because the Maryland Insurance Administration must finalize the approval of the individual market rates by September 1, 2018. Accordingly, on behalf of our constituents, we urge you to complete your consideration of Maryland's waiver application as soon as possible.

Sincerely,

Benjamin L. Cardin
United States Senator

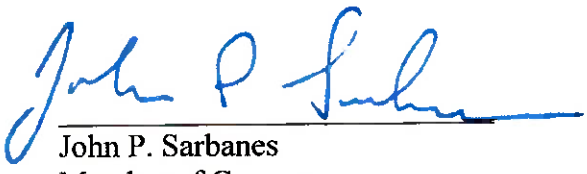
Chris Van Hollen
United States Senator



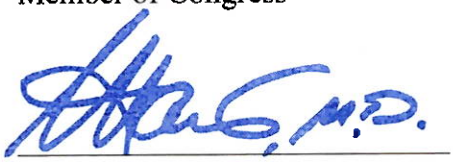
Steny H. Hoyer
Member of Congress

Elijah E. Cummings
Member of Congress

C.A. Dutch Ruppersberger
Member of Congress



John P. Sarbanes
Member of Congress



Andy Harris, M.D.
Member of Congress

John K. Delaney
Member of Congress

Jamie Raskin
Member of Congress

Anthony G. Brown
Member of Congress

Maryland 1332 State Innovation Waiver Application to Establish a State Reinsurance Program

Maryland Health Benefit Exchange
May 31, 2018

Table of Contents

Executive Overview

Waiver Request

On behalf of the state of Maryland, the Maryland Health Benefit Exchange (MHBE) respectfully submits this 1332 state innovation waiver application to the United States Department of the Treasury and the United States Department of Health and Human Services. Maryland is requesting to waive Section 1312(c)(1) of the Affordable Care Act (ACA) for a period of five years to implement a state reinsurance program. The waiver would cover plan years 2019 through 2023. The waiver would allow Maryland to include expected state reinsurance payments when establishing the market wide index rate, which will decrease premiums and federal payment of advance premium tax credits (APTCs). The waiver will not affect any other ACA provisions.

Rationale and Goals of the Reinsurance Program

While Maryland has made great strides in improving access to health care coverage, its non-group health insurance market is experiencing some challenges that are jeopardizing affordability and viability. Over recent years, a number of carriers have exited the non-group health insurance market, creating less competition in the market and leaving fewer choices for consumers. Only two carriers remain, and only one offers coverage statewide. At the same time, premiums have risen dramatically and are expected to continue to increase without further stabilization efforts. The proposed reinsurance program would help stabilize the market by offsetting the rate impact of high cost claims.

Impact and Operation of the Reinsurance Program

House Bill 1795 was signed into law on April 5, 2018, establishing the Maryland reinsurance program, which will be operated by the MHBE. Total program costs for 2019 are expected to be approximately $462 million. House Bill 1782, signed into law on April 10, 2018, creates a 2.75 percent assessment on certain health insurance plans and state regulated Medicaid managed care organizations to help fund the reinsurance program; the assessment fee is estimated to collect $365 million in 2019. Through this waiver application, Maryland is seeking federal pass-through funding through net APTC savings to fund the remainder of the program costs.

The reinsurance program will operate as a traditional, claims-based reinsurance program that will reimburse qualifying health insurers for a percentage of an enrollee’s claims between an attachment point and cap. Maryland is proposing a cap of $250,000 and a coinsurance rate of 80 percent for the 2019 plan year. The attachment point will be determined after further analyses and in consultation with stakeholders. The MHBE will establish the payment parameters each year. It is estimated that the reinsurance program will reduce average premiums by approximately 30 percent in 2019 from what they would be absent the waiver. Operationally, the MHBE can administer the program with existing resources if the federal government is able to accommodate certain modifications to the existing EDGE server infrastructure, thereby leveraging existing resources and reducing downstream administrative burden. If such federal flexibility is not available, the MHBE can administer the program with additional resources

costing $434,000 in fiscal year 2019. These potential approaches are detailed in *Section VI. Additional Information* under *Administrative Burden.*

Compliance with Section 1332

Waiver of Section 1312(c)(1) will not affect the comprehensiveness of coverage in Maryland's insurance markets. The reinsurance program will reduce premiums by approximately 30 percent in 2019 from what they would be absent the waiver, making insurance more affordable. In turn, enrollment in the non-group market is expected to increase by 5.8 percent in 2019. The decreased premiums will decrease federal spending on APTCs. The actuarial analysis estimates that federal savings will be $304 million, $319 million, and $157 million in 2019, 2020, and 2021, respectively.

I. Maryland 1332 Waiver Request

Since the enactment of the Affordable Care Act (ACA), the state of Maryland has made great strides in improving access to health care coverage, with the uninsured rate decreasing from 10.2 percent in 2013 to 6.1 percent in 2016.[1] As of February 1, 2018, 145,109 residents were enrolled in qualified health plans (QHPs) offered through the Maryland Health Benefit Exchange (MHBE), and over 315,000 were enrolled in the ACA Medicaid expansion. With these coverage expansions, hospital uncompensated care has also decreased from 7.2 percent of gross patient revenue in state fiscal year 2013 to 4.6 percent in 2016. This in turn reduced the all-payer costs for uncompensated care built into hospital rates under Maryland's hospital rate-setting system.[2][3]

Prior to the ACA, Maryland's non-group health insurance market was underwritten, meaning that insurance carriers could deny coverage to individuals based on health status. At that time, the state operated a high-risk pool—the Maryland Health Insurance Program—that offered coverage to certain individuals who could not otherwise qualify for non-group market coverage due to pre-existing health conditions. With the ACA reforms, this program was phased out, and participants could transition into QHPs. To mitigate the premium impact of the uncertainty of the health status of new entrants into the non-group market and the transition of high-risk pool enrollees, the ACA created several premium stabilization programs, including the:

- Permanent risk adjustment program
- Temporary risk corridors program
- Temporary reinsurance program

Both of the temporary programs have expired under the terms of the ACA. Maryland also supplemented the federal transitional reinsurance program for plan years 2015 and 2016 by increasing the coinsurance rate. Despite these initial premium stabilization programs, Maryland's non-group health insurance market—as in other states— is experiencing some challenges that are jeopardizing its affordability and viability.

Over the past several years, a number of carriers have exited the non-group health insurance market, creating less competition in the market and leaving fewer choices for consumers. Carrier participation decreased from a high of five in the 2015 and 2016 plan years to only two in 2018. Of the two remaining carriers, only one is statewide, and 13 of Maryland's 24 counties have only one carrier. At the same time, premiums have risen dramatically. Average rates increased by as much as 53.6 percent between 2017 and 2018 alone.[4] Without further stabilization efforts,

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[1] U.S. Census Bureau. Current Population Survey. Retrieved from https://www.census.gov/data/tables/time-series/demo/health-insurance/historical-series/hic.html

[2] Maryland Health Services Cost Review Commission (2016, October). *Report to the Governor: Fiscal Year 2016* Retrieved from http://www.hscrc.state.md.us/Documents/pdr/ar/Gov-Report-FY2016-102516.pdf.

[3] Maryland Health Services Cost Review Commission. (2017, April 12). *Disclosure of Hospital Financial and Statistical Data: Fiscal Year 2016*. Retrieved from http://www.hscrc.state.md.us/Documents/pdr/ar/HSCRC-Disclosure-Report-FY-2016.pdf.

[4] Maryland Insurance Administration. (2017, October 25). *Maryland Insurance Administration Approves Amended 2018 Premium Rates for Silver On-Exchange Plans Sold in the Individual Market*. Retrieved from http://www.mdinsurance.state.md.us/Pages/newscenter/NewsDetails.aspx?NR=2017172

premiums are expected to continue to increase at an unsustainable rate, raising concerns about the future viability of the market, a loss of access to coverage for consumers, and potential downstream implications for Maryland's hospital all-payer model.

Therefore, Maryland is requesting to waive Section 1312(c)(1) of the ACA to implement a state reinsurance program. Section 1312(c)(1) states that a "health insurance issuer shall consider all enrollees in all health plans (other than grandfathered health plans) offered by such issuer in the non-group market, including those enrollees who do not enroll in such plans through the Exchange, to be members of a single risk pool." The waiver would allow Maryland to include expected state reinsurance payments when establishing the market wide index rate. A lower index rate would in turn decrease premiums and decrease the premium subsidy amount that the federal government would have paid for eligible consumers. Maryland is requesting a five-year waiver for plan years 2019 through 2023 to implement a state-operated reinsurance program to stabilize the non-group market by making premiums more affordable.

Table 1 below summarizes the potential impact of the waiver program on premiums, enrollment, and net federal savings in 2019, as estimated by the Wakely Consulting Group. It is estimated that the program will reduce average premiums by 30 percent from what they would be absent the waiver, increase non-group market enrollment by 5.8 percent, and generate $304 million in federal savings.

Table 1. Potential Impact of the Maryland Reinsurance Waiver on 2019 Premiums, Enrollment, and Federal Deficit

	Premium Impact	Non-Group Enrollment	Federal Savings
Effects of Reinsurance	-30.0%	+5.8%	$304 million

II. Compliance with Section 1332 Guardrails

The actuarial analysis estimated that the proposed waiver program meets all four of the required Section 1332 guardrails in 2019, as well as each subsequent year of the required 10-year window. See Attachment 5 for the full analyses.

Comprehensive Coverage Requirement (1332(b)(1)(A))

The first guardrail for 1332 waivers is that health care benefits must be at least as comprehensive as they would have been without the waiver. The proposed program will have no impact on covered benefits and will not change the essential health benefit benchmark plan or actuarial value requirements. All ACA-compliant plans in the state are required to provide essential health benefits.[5] The program will have no impact on the scope of benefits in other health insurance markets in the state.

[5] Ins. Art. § 31-115(b)(1), Ann. Code of MD.

Affordability Requirement (1332(b)(1)(B))

The second guardrail is that health care coverage must be as least as affordable as it would have been without the waiver. The proposed program will decrease average premiums by an estimated 30 percent in 2019 from what they would be absent the waiver, and premiums will be lower than or equal to what they otherwise would have been during each subsequent year of the waiver. Cost sharing protections against excessive out-of-pocket spending will remain the same and within federal requirements, so the waiver will not have an impact on affordability in terms of cost sharing. The waiver will not affect cost sharing or the affordability of minimum essential coverage obtained through other means, such as Medicaid, the Children's Health Insurance Program (CHIP), small or large group market insurance, or other types of coverage. Employer contributions and employee wages are not expected to be affected by the waiver. The waiver will not affect the calculation of small business tax credits offered under the Small Business Health Options (SHOP) program.

Scope of Coverage Requirement (1332(b)(1)(C))

The third guardrail is that the state must cover at least a comparable number of people as it would have covered without the waiver. As noted above, the proposed program will reduce average non-group market premiums in 2019. This lower cost will in turn allow a greater number of consumers to newly purchase or maintain coverage in the non-group market than without the waiver. Enrollment is expected to increase by approximately 5.8 percent in 2019. In subsequent years, enrollment is projected to be greater than or equal to what it would have been absent the waiver. Those who obtain minimum essential coverage through other means, such as Medicaid, CHIP, small or large group market insurance, or other types of coverage, will have the same access to coverage.

Federal Deficit Requirement (1332(b)(1)(D))

The fourth guardrail is that the waiver program cannot increase the federal deficit. The proposed reinsurance program will reduce non-group market premiums in Maryland in 2019, including premiums for the second lowest cost silver plan. As the federal advanced premium tax credit (APTC) is based on the second lowest cost silver plan, the federal government will pay less for APTCs in Maryland than it would have paid without the waiver. The actuarial analysis estimates that the aggregate amount of APTCs will be less than or equal to what the federal government would have paid absent the waiver for each year of the required 10-year budget window. Federal savings are estimated to be $304 million, $319 million, and $157 million in 2019, 2020, and 2021, respectively.

III. Description of the 1332 Waiver Proposal

Enabling Legislation

The Maryland General Assembly passed two bills during the 2018 legislative session related to the establishment of the reinsurance program (see Attachment 1 for full copies of the enabling legislation). The Maryland General Assembly passed HB 1795, *Maryland Health Benefit Exchange-Establishment of a Reinsurance Program*, on March 26, 2018, and Governor Larry

Hogan signed the legislation on April 5, 2018. The bill directs the MHBE, in consultation with the Maryland Insurance Administration (MIA), to establish a state reinsurance program for carriers that offer non-group market health insurance coverage in Maryland. The goal of the program is to mitigate the impact of high-risk individuals on premium rates in the non-group market. The bill authorizes the MHBE to develop payment parameters for the reinsurance program beginning with the 2019 plan year, including the attachment point, coinsurance rate, and reinsurance cap. The bill authorizes funds for the program from (1) federal pass-through funds under an approved 1332 waiver, (2) any funds designated by the federal government to provide reinsurance to non-group market carriers, and (3) any funds designated by the state. Finally, the bill requires the MHBE to apply for a federal 1332 waiver to carry out the program, and implementation is contingent upon federal approval of this waiver. The bill grants the MHBE the authority to adopt regulations to implement the program. On April 16, 2018, the MHBE Board of Trustees voted to approve a state reinsurance program for 2019 with an attachment point that will be determined based on funding availability and consideration of stakeholder feedback, a coinsurance rate of 80 percent, and a cap of $250,000. See Attachment 2 for the accompanying MHBE Board Resolution.

The second bill, HB 1782, *Health Insurance – Individual Market Stabilization (Maryland Health Care Access Act of 2018)*, was passed on April 5, 2018 and signed by Governor Hogan on April 10, 2018. It creates a health plan assessment for the 2019 plan year to help fund the reinsurance program. Section 9010 of the ACA created a federal health insurance provider fee for covered entities engaged in the business of providing health insurance. The fee is based on the entity's net premiums for the year and was intended to help fund exchanges. The federal spending bill enacted in January 2018 suspended the collection of this federal fee for 2019.[6] HB 1782 applies a 2.75 percent assessment on certain health insurance plans and Medicaid managed care organizations that are regulated by the state, and essentially allows the state to collect certain funds that the federal government would have collected under Section 9010.

Program Features

Maryland is proposing to use a traditional, claims-based reinsurance program that would help pay claims associated with high-cost participants. The program will reimburse non-group market carriers for a percentage of the costs (coinsurance rate) for participants with annual claims costs exceeding a specified threshold (attachment point) and up to specified ceiling (reinsurance cap). Based on estimated funding and costs of the program, Maryland is proposing a reinsurance program with a cap of $250,000 and a coinsurance rate of 80 percent for the 2019 plan year. The attachment point will be determined after further analyses and in consultation with stakeholders. This will allow active stakeholder engagement and reflect the latest data available so that estimated reinsurance payments match the funding available. If the 2019 experience is more expensive than predicted, the MHBE may adjust these payment parameters. On the other hand, if the 2019 experience is less expensive than predicted, the MHBE may reserve the funds for future years. The program's authorizing legislation grants the MHBE the authority to establish the payment parameters each year.

[6] H.R. 195, 115th Cong. § 4003 (2017) (enacted).

Funding Mechanism

Total program costs for 2019 are expected to be about $462 million. Through this waiver application, Maryland requests federal pass-through funding through net APTC savings. The remaining program costs will be funded through the state health insurance assessment described above, which is estimated to collect $365 million.

IV. Waiver Implementation Timeline

The MHBE will implement and operate the reinsurance program. The MHBE will receive the federal pass-through and state funds, collect and review reinsurance claims from carriers (should EDGE server modifications not be feasible), and make payments to carriers for eligible claims. The MHBE already has experience with this process, as it implemented a state supplemental reinsurance program that wrapped around the federal transitional reinsurance program for the 2015 and 2016 plan years. The MHBE proposes the following draft implementation timeline for the initial years of the program. The MHBE respectfully requests a federal approval date of no later than August 22, 2018, in order for the state to approve final rates, certify QHPs, and load this information to the Maryland Health Connection website in time for renewal operations and open enrollment for the 2019 plan year.

Table 2. Draft Implementation Timeline

Date	Milestone
March 1, 2018	Non-group market carrier form filing deadline with the MIA for the 2019 plan year.
April 5, 2018	Reinsurance program is signed into law.
April 16, 2018	MHBE Board votes on parameters for the waiver application.
April 20, 2018	Waiver application is released for public comment. Although there are no federally-recognized tribes in the state, state-recognized tribes are encouraged to participate.
April 26, 2018	Public hearing is held on the Eastern Shore.
May 1, 2018	Non-group market carrier rate filing deadline with the MIA for the 2019 plan year.
May 3, 2018	Public hearing is held in Central Maryland.
May 7, 2018	Public hearing is held in Western Maryland.
May 10, 2018	Public hearing is held in Southern Maryland.
May 20, 2018	State public comment period closes.
May 21, 2018	MHBE Board votes to incorporate public comment feedback into waiver application.
May 31, 2018	Incorporate public comment and submit waiver application to the federal government.
July 16, 2018	Application deemed complete by the federal government. Federal approval and public comment period begins.
July 2018	MHBE begins state regulations promulgation process.
August 16, 2018	Federal 30-day comment period closes.
August 22, 2018	Desired federal approval date.
September 1, 2018	MIA approves rates for the 2019 plan year.
September 1, 2018	Reinsurance program payment parameters for the 2019 plan year will be finalized.
October 1, 2018	MHBE certifies QHPs for the 2019 plan year.
November 1, 2018	Open enrollment begins.
January 1, 2019	State regulations to operate the program become effective.

Date	Milestone
March 1, 2019	Non-group market carrier form filing deadline with the MIA for the 2020 plan year.
March 15, 2019	Premium assessment collection by the MIA.
April 15, 2019	MHBE submits quarterly report to the federal government.
May 1, 2019	Non-group market carrier rate filing deadline with the MIA for the 2020 plan year.
June 2019	MHBE holds required 6-month public forum.
July 1, 2019	Reinsurance program payment parameters for the 2020 plan year will be finalized.
July 15, 2019	MHBE submits quarterly report to the federal government.
August 2019	MIA approves rates for the 2020 plan year.
October 1, 2019	MHBE certifies QHPs for the 2020 plan year.
October 15, 2019	MHBE submits quarterly report to the federal government.
December 31, 2019	Premium assessment funds transferred to Maryland Health Benefit Exchange no later than the indicated date.
January 15, 2020	MHBE submits quarterly report to the federal government.
March 1, 2020	Non-group market carrier form filing deadline with the MIA for the 2021 plan year.
April 1, 2020	MHBE submits first annual report to the federal government.
April 15, 2020	MHBE submits quarterly report to the federal government.
May 1, 2020	Non-group market carrier rate filing deadline with the MIA for the 2021 plan year. Carriers submit 2019 claims to MHBE for reimbursement.
June 2020	MHBE holds required annual public forum.
July 1, 2020	Reinsurance program payment parameters for the 2021 plan year will be finalized.
July 15, 2020	MHBE submits quarterly report to the federal government.
August 2020	MIA approves rates for the 2021 plan year.
October 1, 2020	MHBE certifies QHPs for the 2021 plan year.
October 15, 2020	MHBE submits quarterly report to the federal government.
December 31, 2020	MHBE reimburses carriers for eligible 2019 claims.

V. Actuarial and Economic Analysis

The State of Maryland Department of Legislative Services (DLS), through Bolton Partners, retained the Wakely Consulting Group, LLC (Wakely). Through a Memorandum of Understanding with DLS, the MHBE has engaged with Wakely to address the actuarial analysis, actuarial certifications, economic analysis, data, and assumptions requirements for a 1332 waiver. Wakely collected 2016, 2017, and emerging 2018 data directly from Maryland insurers to develop the base data for the analyses. See Attachment 5 for Wakely's full report.

VI. Additional Information

Administrative Burden

This waiver program may pose a minor administrative burden to the federal government and to the state. Within the federal government, staff from the Department of the Treasury and the Centers for Medicare & Medicaid Services (CMS) will have the increased burden of:

- Reviewing and approving the waiver application
- Determining and transferring pass-through funds to the state
- Reviewing state reports, including the required quarterly and annual reports
- Periodically evaluating the program
- Reviewing any documented complaints related to the waiver that may arise
- Modifying the EDGE server infrastructure to leverage for the program

The waiver will not affect the calculation or payment of APTCs.

Within Maryland, the waiver program will have no administrative impact on employers or consumers, and consumers will continue to shop for and purchase plans through the same vehicles as available now. The program will have a small administrative impact on non-group market insurance carriers in terms of identifying and submitting documentation of reinsurance claims for reimbursement. These carriers, however, have previously implemented these processes under the federal transitional and Maryland supplemental reinsurance programs, and the financial benefit of reinsurance payments will far outweigh these administrative costs.

To implement a program with the greatest administrative efficiency, the MHBE respectfully requests consideration on whether the existing EDGE server infrastructure, utilized in the administration of the risk adjustment program and transitional reinsurance program, may be leveraged to implement the State Reinsurance Program with modifications. The MHBE has received feedback from the issuers participating in the non-group market that leveraging the EDGE server would increase program efficiency and reduce downstream administrative burden. Should the request to leverage the EDGE server be approved, the implementation, and ongoing, costs of modifications to the EDGE server may be drawn from the total pass-through funding amount received from waiver approval. If approved, the MHBE will supply the necessary reinsurance parameters to the federal government annually, through written communication, on a timeline to be determined with federal partners.

Alternatively, if the primary method should not be available, the waiver program will have a minor impact on state agency burden. The MHBE will be responsible for administering the program, including administering funds, reviewing and collecting claims information from carriers, paying carriers for eligible claims, ongoing program monitoring, and complying with federal reporting and public comment requirements. The MHBE previously administered a state supplemental reinsurance program for the 2015 and 2016 plan years and can leverage and build upon these pre-existing resources. The MHBE anticipates some additional staff costs for administering the program, including hiring a program manager and IT consultant time. These costs are estimated to be approximately $434,000 in state fiscal year 2019, $582,000 in 2020, and $599,000 in 2021.The MIA may also have minor increased burden related to reviewing and

approving carrier rate filings and state health insurance premium tax collection, but this can be absorbed by current staff resources.

Impact on Other ACA Provisions

The program will have no impact on other provisions of the ACA.

Impact on Access to Out-of-State Services

Maryland shares borders with Virginia; West Virginia; Washington, D.C.; Pennsylvania; and Delaware. Of the two carriers in Maryland's non-group insurance market, one offers coverage statewide, and the other offers coverage in 11 of 24 counties. Both carriers' networks contain providers in border states. This waiver will not affect provider networks or access to services out-of-state.

Compliance, Fraud, Waste, and Abuse

The MIA is responsible for regulating and monitoring the solvency of non-group market insurance carriers and performing market conduct analysis, examinations, and investigations. The MHBE is responsible for certifying non-group market QHPs for participation on the exchange. The MIA and MHBE will continue these existing processes under the waiver program.

The MHBE has a robust compliance program and will administer the reinsurance program in accordance with its existing compliance and auditing procedures. The Maryland Office of Legislative Audits conducts a financial audit of the MHBE every three years, and per ACA requirements, the MHBE contracts with an independent, external auditor each year to audit financial and program activities. As a state-based exchange, the MHBE is also subject to audits by the U.S. Government Accountability Office, CMS, and the Internal Revenue Service. The MHBE also maintains internal and external stakeholder hotlines for reporting of fraud, waste, and abuse concerns.

The federal government is responsible for calculating the savings resulting from this waiver and for ensuring that this waiver does not increase federal spending.

VII. State Reporting Requirements and Targets

The MHBE will comply with the quarterly and annual waiver reporting requirements as defined in 45 CFR §155.1324. States must submit quarterly reports in accordance with the terms and conditions specified in the waiver. These reports must include, but are not limited to reports of any ongoing operational challenges and plans for/results of associated corrective actions. Unless otherwise specified in the waiver approval, the MHBE will submit its first quarterly report in April 2019. While there is no change to the provision of the ten Essential Health Benefits under this waiver application, Maryland will report on any modifcations from federal or state law on an annual basis.

States must also submit an annual report that documents the following:

- The progress of the waiver

- Data on compliance with the four Section 1332 guardrails, similar to the data presented in Attachment 5
- A summary of the required annual post-award public forum, including all public comments received on the progress of the waiver and action taken in response to such concerns or comments
- Other information as required by the terms and conditions of the waiver
- The premium for the second lowest cost silver plan under the waiver and an estimate of what the premium would have been without the waiver for a representative consumer in each rating area

The annual report is due no later than 90 days after the end of each waiver year, or as otherwise specified in the terms and conditions. The MHBE will submit its first annual report by April 1, 2020, unless otherwise specified. The MHBE is committed to ensuring that the quarterly and annual reports will conform to the measures and formats to be specified by CMS.

VIII. Public Comments and Tribal Consultations

Public Comments

The MHBE opened the 30-day public comment process for this waiver application on April 20, 2018, by posting notice of the opportunity to comment on the agency's website at marylandhbe.com/policy-legislation/public-comment/1332-waiver. In addition, the MHBE sent out a press release and an email notification to its stakeholder distribution list, which includes over 200,000 email addresses for Maryland Health Connection enrollees who opted in to receive messaging; individuals who opted in to receive messaging through MarylandHealthConnection.gov and MarylandHBE.com; contact lists of community stakeholders, including faith-based organizations, application counselor sponsoring entities, consumer assistance organizations, producers, SHOP stakeholders, plan management stakeholders, and other community and individual stakeholders; members of the media; Maryland elected officials; MHBE Board members; state executive leadership; and MHBE staff members.

The public comment period closed on May 20, 2018. The MHBE received a total of 21 written comments from a variety of stakeholders, including consumers, professional/trade organizations, insurance carriers, advocacy organizations, and a legislator. The press release, email notification and public comments are included as Attachment 3.

Public Hearings

The MHBE conducted four public hearings across the state to obtain stakeholder input:

1. On the Eastern Shore, the MHBE conducted a public hearing on April 26, 2018 in the Chesapeake Room at the Talbot County Department of Parks and Recreation located at 10028 Ocean Gateway, Easton, MD 21601.

2. Within central Maryland, the MHBE conducted a public hearing on May 3, 2018 in the Training Room at the Maryland Health Benefit Exchange, located at 750 E Pratt Street in Baltimore, Maryland 21202.

3. Within Western Maryland, the MHBE conducted a public hearing on May 7, 2018, at the Frederick County Health Department, located at 350 Montevue Ln., Frederick, MD 21702.

4. Within Southern Maryland, the MHBE conducted a public hearing on May 10, 2018 at the Charles County Health Department, located at 4545 Crain Highway, White Plains, MD 20695.

During each hearing, the MHBE provided an overview of the proposed waiver program and public comment process and then opened the meeting to questions from the public, followed by an opportunity for members of the public to offer testimony. All attendees were encouraged to ask questions and to voice their opinions. A total of 67 members of the public attended the four hearings, and 11 members entered testimony into the public record. Audio recordings of each meeting are available at marylandhbe.com/policy-legislation/public-comment/1332-waiver. See Attachment 4 for the details of each hearing.

Summary of Public Comments

During the four public hearings, stakeholders asked a number of questions about the proposed reinsurance program. Frequently asked question included:

- Will the waiver impact out-of-pocket costs?
- Will the waiver impact consumer choices?
- How much will the waiver lower premiums?
- If the waiver is a short-term premium stabilization plan, what is the long-term plan?
- What will happen if the waiver is not approved?

Stakeholders also offered verbal testimony during the hearings and submitted written comments to the MHBE, which included the following themes:

- **Support of the state initiative to stabilize the non-group market.** All written comments and verbal testimony expressed universal support to establish the reinsurance program.
- **Equal impact on consumers.** Several stakeholder groups, including one of the two carriers in the non-group market, the state's medical society, a consumer advocacy organization, and other local professional organizations, requested that the program be structured in such a way that premium relief is experienced by as many consumers as possible. These stakeholders cautioned that a reinsurance program with payments that favor issuers with less managed provider networks and utilization controls might be viewed as a disincentive for new market entrants. Further, the respondents cautioned that

unequal premium relief might be perceived by Marylanders as "unfair" if not equitably experienced as a "market-wide" impact.

- **Coordination with the federal risk adjustment program.** Many stakeholders, an issuer, consumer advocates, the state medical society, a Maryland state senator, and other advocacy groups, expressed concern on potential issuer payments under the state reinsurance program and the federal risk adjustment program that would be duplicative of the same risk. The respondents cautioned that this could result in market distortions that would change profitability from low-risk members to high-risk members, whose claims might receive duplicate payments under both programs. The respondents expressed concern that this would create a disincentive to broaden the risk pool to attract healthier consumers.

  The other of the two issuers in the non-group market cautioned against such an approach stating that, at the federal level, the programs were intended to address different issues. While the risk adjustment program is intended to equalize the risk burden borne by any single issuer, the reinsurance program was designed to mitigate the costs of a "very small percentage of high cost enrollees in order to reduce premiums for all." This issuer also cautioned that any action to coordinate payments between risk adjustment and reinsurance might affect approval of the 1332 waiver application.

  Both issuers have requested an actuarial study to determine the degree of overlap between the two programs, if any.

- **Amend 1332 Waiver Application Language.** An issuer, the state medical society, and the state hospital association requested that the 1332 waiver application include their concerns regarding duplicative risk adjustment and reinsurance payments and incentives to manage the care of high-risk enrollees. While these respondents did not suggest that the specific methodology be included in the application, they requested that the state indicate its intent to account for duplicative payments in the final application.

- **Establishing a reinsuring program that will attract new entrants.** An issuer, the state medical society, and a consumer advocacy organization expressed that the reinsurance program could be leveraged to create a market environment that is favorable for new entrants. They cautioned that the program should not be constructed in a manner that would support certain care delivery models over others. Specifically, "the design of Maryland's reinsurance program [should] not unintentionally competitively disadvantage [an issuer] or other carrier" (a consumer advocacy organization).

- **Incentives for utilization/care management and quality improvement.** The state hospital association, an issuer, the state medical society, a consumer advocacy organization, and a Maryland state legislator expressed that the reinsurance program should be explored as a tool to increase quality and reward effective utilization/care management. Additionally, the respondents suggested that the program could be used to further the goals of other state initiatives, such as the hospital All-Payer Model and the state's Medicare waiver.

- **Reduction in out-of-pocket costs**. Although not specific to the 1332 waiver application, many stakeholders including consumers, the state medical society, and the state hospital association, expressed that the state should seek to reduce out-of-pocket costs.

Consumers frequently noted that, while reduced premiums would help, they would not reduce out-of-pocket costs paid at the point of service. Consumers frequently described high deductibles as a barrier to care, and that even with premium relief, the value of having health insurance coverage is being able to defray costs when you need to access services.

- **Expansion of public programs.** Although not specific to the 1332 waiver application, four respondents (two consumers, a consumer advocacy organization, and a policy advocacy organization) expressed support for the expansion of public programs as a long-term solution for non-group market stability. While this support was expressed through different recommendations, they all follow a common theme of the desire to expand the role of public programs in reducing the cost of care, either through the creation of public option through a Medicaid Buy-in program (a consumer advocacy organization), a single-payer system (a policy advocacy organization), an expansion of the existing subsidy structure (consumer), or a more active role in reducing out-of-pocket costs at the point of service (consumer).
- **Participation in CRISP (Maryland's Health Information Exchange).** Although not specific to the 1332 waiver application, the state's medical society recommended that the reinsurance program should require robust issuer participation in CRISP.
- **Stand-Alone Dental Plans (SADPs).** Although not specific to the 1332 waiver application, the Alliance of Dental Plans, while in support of the waiver, acknowledged that they would not directly benefit from the program. They requested that the state explore potential mechanisms for how the reinsurance program could benefit SADPs.

Response to Public Comments

In testimony before the MHBE Board of Trustees and public hearings, stakeholders requested that the MHBE take action on the potential duplicative payment transfers issuers might receive from the risk adjustment and reinsurance programs. Both issuers participating in the non-group market have advocated that the MHBE commission the Wakely Consulting Group to investigate, and forecast, the magnitude of duplicative payments that would occur, if any, under the State Reinsurance Program.

In response to these public comments, the MHBE has commissioned additional actuarial analyses to determine the potential for duplicate payments under the proposed state reinsurance program and the federal risk adjustment program. The actuarial report is expected on June 30, 2018. MHBE will share the results of the completed study with application reviewers upon completion. Further, on May 21, 2018, the MHBE Board of Trustees voted to consider regulatory action based on the results of this study. The Board also voted to explore the inclusion of financial incentives in the State Reinsurance Program for issuers to manage high risk and high cost enrollees after active engagement with stakeholders in the regulatory process. See Attachment 2 for the accompanying Board Resolution.

Attachments

1. Enabling Legislation
2. MHBE Board Resolutions
3. Public Comment
4. Public Hearing Process
5. Actuarial and Economic Analysis

Attachment 1. Enabling Legislation

- For HB 1795, Maryland Health Benefit Exchange-Establishment of a Reinsurance Program, see http://mgaleg.maryland.gov/2018RS/chapters_noln/Ch_6_hb1795T.pdf
- For HB 1782, Health Insurance-Individual Market Stabilization (Maryland Health Care Access Act of 2018), see http://mgaleg.maryland.gov/2018RS/chapters_noln/Ch_37_hb1782E.pdf

Chapter 6

(House Bill 1795)

AN ACT concerning

Maryland Health Benefit Exchange – Establishment of a Reinsurance Program

FOR the purpose of repealing the requirement that the Maryland Health Benefit Exchange implement or oversee the implementation of state–specific requirements for transitional reinsurance and risk adjustment under the Affordable Care Act; repealing the prohibition on the Exchange's assuming responsibility for the program corridors for health benefit plans in certain exchanges established under certain provisions of the Affordable Care Act; repealing the requirement that the Exchange operate or oversee the operation of a transitional reinsurance program in accordance with certain regulations for certain coverage years; repealing the requirement that the Exchange operate or oversee the operation of a certain risk adjustment program; repealing the requirement that the Exchange, beginning in a certain year, strongly consider using a certain model for a certain purpose; altering the purposes of the Maryland Health Benefit Exchange Fund; altering the contents of the ~~Maryland Health Benefit Exchange~~ Fund; providing that certain funds may be used only for the purposes of the State Reinsurance Program; requiring, rather than authorizing, the Exchange, in consultation with the Maryland Insurance Commission and as approved by the Maryland Health Benefit Exchange Board, to establish and implement a State Reinsurance Program to provide reinsurance to certain carriers and that meets certain requirements and is consistent with certain laws; requiring that the Program be designed to mitigate the impact of certain individuals on certain rates; requiring the Exchange, in consultation with the Commissioner and as approved by the Board and based on available funds, to establish certain parameters for reinsurance in certain years; authorizing the Exchange, in consultation with the Commissioner and as approved by the Board, to alter the parameters under certain circumstances; providing that, beginning on a certain date, funding for reinsurance in the individual health insurance market through the Program may be made ~~from certain sources~~ by using certain funds; requiring that~~, beginning on a certain date and under certain circumstances, certain State funding~~ the implementation of the Program for the reinsurance of the individual market ~~through the Program~~ be contingent on the ~~Centers for Medicare and Medicaid Services'~~ U.S. Secretary of Health and Human Services and the U.S. Secretary of the Treasury approving a waiver application under a certain provision of federal law; requiring the Exchange to adopt certain regulations on or before a certain date; ~~authorizing~~ requiring the Exchange ~~and the Maryland Insurance~~, in consultation with the Commissioner and as approved by the Board, to submit a waiver and seek certain funding under certain provisions of federal law as soon as practicable but not later than a certain date; authorizing, on or before a certain date, the Commissioner to waive certain statutory requirements under certain circumstances; making this Act an emergency measure; and generally relating to the establishment of a reinsurance program by the Maryland Health Benefit Exchange.

BY repealing
Article – Insurance
Section 31–117
Annotated Code of Maryland
(2017 Replacement Volume)

BY repealing and reenacting, with amendments,
Article – Insurance
Section 31–107
Annotated Code of Maryland
(2017 Replacement Volume)

BY adding to
Article – Insurance
Section 31–117 and 31–117.1
Annotated Code of Maryland
(2017 Replacement Volume)

SECTION 1. BE IT ENACTED BY THE GENERAL ASSEMBLY OF MARYLAND, That Section(s) 31–117 of Article – Insurance of the Annotated Code of Maryland be repealed.

SECTION 2. AND BE IT FURTHER ENACTED, That the Laws of Maryland read as follows:

Article – Insurance

31–107.

(a) There is a Maryland Health Benefit Exchange Fund.

(b) (1) The purpose of the Fund is to:

(i) provide funding for the operation and administration of the Exchange in carrying out the purposes of the Exchange under this title; and

(ii) provide funding for the establishment and operation of the State Reinsurance Program authorized under ~~§ 31–117 of~~ this title.

(2) The operation and administration of the Exchange and the State Reinsurance Program may include functions delegated by the Exchange to a third party under law or by contract.

(c) The Exchange shall administer the Fund.

(d) (1) The Fund is a special, nonlapsing fund that is not subject to § 7–302 of the State Finance and Procurement Article.

(2) The State Treasurer shall hold the Fund separately, and the Comptroller shall account for the Fund.

(e) The Fund consists of:

(1) any user fees or other assessments collected by the Exchange;

(2) all revenue deposited into the Fund that is received from the distribution of the premium tax under § 6–103.2 of this article;

[(3) all revenue transferred to the Fund before July 1, 2016, from the Maryland Health Insurance Plan Fund;**]**

[(4)**] (3)** income from investments made on behalf of the Fund;

[(5)**] (4)** interest on deposits or investments of money in the Fund;

[(6)**] (5)** money collected by the Board as a result of legal or other actions taken by the Board on behalf of the Exchange or the Fund;

[(7)**] (6)** money donated to the Fund;

[(8)**] (7)** money awarded to the Fund through grants; **[**and**]**

(8) ANY PASS–THROUGH FUNDS RECEIVED FROM THE FEDERAL GOVERNMENT UNDER A WAIVER APPROVED UNDER § 1332 OF THE AFFORDABLE CARE ACT;

(9) ANY FUNDS DESIGNATED BY THE FEDERAL GOVERNMENT TO PROVIDE REINSURANCE TO CARRIERS THAT OFFER INDIVIDUAL HEALTH BENEFIT PLANS IN THE STATE;

(10) ANY FUNDS DESIGNATED BY THE STATE TO PROVIDE REINSURANCE TO CARRIERS THAT OFFER INDIVIDUAL HEALTH BENEFIT PLANS IN THE STATE; AND

[(9)**] (11)** any other money from any other source accepted for the benefit of the Fund.

(f) The Fund may be used only:

(1) for the operation and administration of the Exchange in carrying out the purposes authorized under this title; and

(2) for the establishment and operation of the State Reinsurance Program **[**authorized under § 31–117 of this title**]**.

(g) (1) The Board shall maintain separate accounts within the Fund for Exchange operations and for the State Reinsurance Program.

(2) Accounts within the Fund shall contain the money that is intended to support the purpose for which each account is designated.

(3) Funds received from the distribution of the premium tax under § 6–103.2 of this article shall be placed in the account for Exchange operations and may be used only for the purpose of funding the operation and administration of the Exchange.

[(4) Funds transferred from the Maryland Health Insurance Plan Fund before July 1, 2016, shall be placed in the account for the State Reinsurance Program and may be used only for the purpose of funding the State Reinsurance Program.**]**

(4) THE FOLLOWING FUNDS MAY BE USED ONLY FOR THE PURPOSES OF FUNDING THE STATE REINSURANCE PROGRAM:

(I) ANY PASS–THROUGH FUNDS RECEIVED FROM THE FEDERAL GOVERNMENT UNDER A WAIVER APPROVED UNDER § 1332 OF THE AFFORDABLE CARE ACT;

(II) ANY FUNDS DESIGNATED BY THE FEDERAL GOVERNMENT TO PROVIDE REINSURANCE TO CARRIERS THAT OFFER INDIVIDUAL HEALTH BENEFIT PLANS IN THE STATE; AND

(III) ANY FUNDS DESIGNATED BY THE STATE TO PROVIDE REINSURANCE TO CARRIERS THAT OFFER INDIVIDUAL HEALTH BENEFIT PLANS IN THE STATE.

(h) (1) Expenditures from the Fund for the purposes authorized by this subtitle may be made only:

(i) with an appropriation from the Fund approved by the General Assembly in the State budget; or

(ii) by the budget amendment procedure provided for in Title 7, Subtitle 2 of the State Finance and Procurement Article.

(2) Notwithstanding § 7–304 of the State Finance and Procurement Article, if the amount of the distribution from the premium tax under § 6–103.2 of this article exceeds in any State fiscal year the actual expenditures incurred for the operation and administration of the Exchange, funds in the Exchange operations account from the premium tax that remain unspent at the end of the State fiscal year shall revert to the General Fund of the State.

(3) If operating expenses of the Exchange may be charged to either State or non–State fund sources, the non–State funds shall be charged before State funds are charged.

(i) (1) The State Treasurer shall invest the money of the Fund in the same manner as other State money may be invested.

(2) Any investment earnings of the Fund shall be credited to the Fund.

(3) Except as provided in subsection (h)(2) of this section, no part of the Fund may revert or be credited to the General Fund or any special fund of the State.

(j) A debt or an obligation of the Fund is not a debt of the State or a pledge of credit of the State.

31–117.

(A) THE EXCHANGE, IN CONSULTATION WITH THE COMMISSIONER AND AS APPROVED BY THE BOARD, SHALL ESTABLISH AND IMPLEMENT A STATE REINSURANCE PROGRAM:

(1) TO PROVIDE REINSURANCE TO CARRIERS THAT OFFER INDIVIDUAL HEALTH BENEFIT PLANS IN THE STATE;

(2) THAT MEETS THE REQUIREMENTS OF A WAIVER APPROVED UNDER § 1332 OF THE AFFORDABLE CARE ACT; AND

(3) THAT IS CONSISTENT WITH STATE AND FEDERAL LAW.

(B) THE STATE REINSURANCE PROGRAM SHALL BE DESIGNED TO MITIGATE THE IMPACT OF HIGH–RISK INDIVIDUALS ON RATES IN THE INDIVIDUAL INSURANCE MARKET INSIDE AND OUTSIDE THE EXCHANGE.

(C) (1) BASED ON AVAILABLE FUNDS, THE EXCHANGE, IN CONSULTATION WITH THE COMMISSIONER AND AS APPROVED BY THE BOARD, SHALL ESTABLISH REINSURANCE PAYMENT PARAMETERS FOR CALENDAR YEAR 2019 AND EACH SUBSEQUENT CALENDAR YEAR THAT INCLUDE:

(I) AN ATTACHMENT POINT;

(II) A COINSURANCE RATE; AND

(III) A COINSURANCE CAP.

(2) THE EXCHANGE, IN CONSULTATION WITH THE COMMISSIONER AND AS APPROVED BY THE BOARD, MAY ALTER THE PARAMETERS ESTABLISHED IN ACCORDANCE WITH PARAGRAPH (1) OF THIS SUBSECTION AS NECESSARY TO SECURE FEDERAL APPROVAL FOR A WAIVER SUBMITTED IN ACCORDANCE WITH § 31–117.1(A) OF THIS TITLE.

~~(C)~~ (D) BEGINNING JANUARY 1, 2019, FUNDING FOR REINSURANCE IN THE INDIVIDUAL MARKET THROUGH THE STATE REINSURANCE PROGRAM MAY BE MADE ~~FROM~~ BY USING:

~~(1) ANY AVAILABLE STATE FUNDING SOURCE; AND~~

~~(2) ANY AVAILABLE FEDERAL FUNDING SOURCE.~~

(1) ANY PASS–THROUGH FUNDS RECEIVED FROM THE FEDERAL GOVERNMENT UNDER A WAIVER APPROVED UNDER § 1332 OF THE AFFORDABLE CARE ACT;

(2) ANY FUNDS DESIGNATED BY THE FEDERAL GOVERNMENT TO PROVIDE REINSURANCE TO CARRIERS THAT OFFER INDIVIDUAL HEALTH BENEFIT PLANS IN THE STATE; AND

(3) ANY FUNDS DESIGNATED BY THE STATE TO PROVIDE REINSURANCE TO CARRIERS THAT OFFER INDIVIDUAL HEALTH BENEFIT PLANS IN THE STATE.

~~(D)~~ (E) ~~BEGINNING JANUARY 1, 2019, IF REQUIRED UNDER THE TERMS AND CONDITIONS OF RECEIVING FEDERAL FUNDS, STATE FUNDING~~ THE IMPLEMENTATION OF A STATE REINSURANCE PROGRAM FOR REINSURANCE IN THE INDIVIDUAL MARKET ~~THROUGH THE STATE REINSURANCE PROGRAM~~ SHALL BE CONTINGENT ON ~~THE CENTERS FOR MEDICARE AND MEDICAID SERVICES' APPROVING A WAIVER~~ APPROVAL FROM THE U.S. SECRETARY OF HEALTH AND HUMAN SERVICES AND THE U.S. SECRETARY OF THE TREASURY OF A STATE INNOVATION WAIVER APPLICATION UNDER § 1332 OF THE AFFORDABLE CARE ACT.

~~(E)~~ (F) ~~THE~~ ON OR BEFORE JANUARY 1, 2019, THE EXCHANGE SHALL ADOPT REGULATIONS IMPLEMENTING THE PROVISIONS OF THIS SECTION.

31–117.1.

(A) ~~THE~~ AS SOON AS PRACTICABLE BUT NOT LATER THAN JULY 1, 2018, THE EXCHANGE ~~AND THE COMMISSIONER MAY~~, IN CONSULTATION WITH THE COMMISSIONER AND AS APPROVED BY THE BOARD, SHALL SUBMIT A ~~WAIVER~~ STATE INNOVATION WAIVER APPLICATION UNDER § 1332 OF THE AFFORDABLE CARE ACT TO ESTABLISH A PROGRAM FOR REINSURANCE AND SEEK FEDERAL PASS–THROUGH FUNDING ~~UNDER § 26B OF THE INTERNAL REVENUE CODE AND § 1402 OF THE AFFORDABLE CARE ACT~~.

(B) ON OR BEFORE DECEMBER 31, 2018, THE COMMISSIONER MAY WAIVE ANY NOTIFICATION OR OTHER REQUIREMENTS THAT APPLY TO A CARRIER UNDER THIS ARTICLE IN CALENDAR YEAR 2018 DUE TO THE IMPLEMENTATION OF A WAIVER APPROVED UNDER § 1332 OF THE AFFORDABLE CARE ACT.

SECTION 3. AND BE IT FURTHER ENACTED, That this Act is an emergency measure, is necessary for the immediate preservation of the public health or safety, has been passed by a yea and nay vote supported by three–fifths of all the members elected to each of the two Houses of the General Assembly, and shall take effect from the date it is enacted.

Approved by the Governor, April 5, 2018.

Chapter 37

(House Bill 1782)

AN ACT concerning

Health Insurance – ~~Health Care Access Program – Establishment~~ Individual Market Stabilization
(Maryland Health Care Access Act of 2018)

FOR the purpose of ~~requiring the State Health Services Cost Review Commission, for a certain fiscal year, to assess on each hospital a certain fee for a certain purpose; prohibiting the State Health Services Cost Review Commission from raising certain hospital rates as part of a certain update factor to offset the fee; prohibiting the fee from exceeding a certain percentage of certain revenue; requiring each hospital to remit the fee to the Maryland Health Benefit Exchange Fund; requiring a carrier to pay a certain assessment on certain premiums under certain circumstances beginning on a certain date; requiring the assessment to be in addition to certain taxes and certain penalties or actions; requiring certain health insurers, nonprofit health service plans, health maintenance organizations, and managed care organizations to pay, in a certain calendar year, a certain additional assessment for a certain purpose; providing for the distribution of the assessments; altering the purpose, contents, and authorized use of the Maryland Health Benefit Exchange Fund; requiring that certain funds be used in a certain manner; repealing the requirement that the Maryland Health Benefit Exchange implement or oversee the implementation of state–specific requirements for transitional reinsurance and risk adjustment under the Affordable Care Act; repealing the authority of the Exchange to establish a State Reinsurance Program; requiring the Exchange to establish a Health Care Access Program to provide reinsurance to certain carriers; requiring that the Program be designed to mitigate the impact of certain individuals on certain rates; providing that, beginning on a certain date, funding for reinsurance in the individual health insurance market through the Program may be made from certain sources; requiring that, beginning on a certain date and under certain circumstances, certain State funding for the reinsurance of the individual market through the Program be contingent on the Centers for Medicare and Medicaid Services approving a waiver under a certain provision of federal law; requiring the Exchange to adopt certain regulations on or before a certain date; authorizing the Exchange and the Maryland Insurance Commissioner to submit a waiver under a certain provision of federal law in accordance with the recommendations of the Maryland Health Insurance Coverage Protection Commission; authorizing, on or before a certain date, the Commissioner to waive certain statutory requirements under certain circumstances; requiring, beginning on a certain date, an individual to maintain certain coverage for certain individuals; requiring that an individual pay a certain penalty under certain circumstances; requiring that the penalty be in addition to a certain State income tax and included with a certain income tax return; requiring that certain individuals be jointly liable for the penalty under certain circumstances; establishing the amount of the penalty; exempting an individual who qualifies for a~~

~~certain exemption under federal law from being assessed the penalty; requiring an individual to indicate certain information on a certain income tax return; requiring the Comptroller to distribute certain revenues from the penalty to a certain fund for certain purposes; defining certain terms; repealing certain provisions of law rendered obsolete by certain provisions of this Act; requiring the Maryland Health Insurance Coverage Protection Commission to study and make recommendations for individual and group market stability; requiring the Maryland Health Insurance Coverage Protection Commission to engage an independent actuarial firm to assist in its study; requiring the Maryland Health Insurance Coverage Protection Commission, on or before a certain date, to report certain findings and recommendations to the Governor and the General Assembly~~ requiring certain ~~health~~ insurers, nonprofit health service plans, health maintenance organizations, ~~and~~ *dental plan organizations, fraternal benefit organizations,* managed care organizations, *and certain other persons* to be subject to a certain assessment in a certain year; establishing the purpose and providing for the distribution of the assessment; establishing that certain provisions of law that apply to certain small employer health benefit plans apply to health benefit plans offered by certain entities; altering the definition of "short–term limited duration insurance" as it relates to certain provisions of law governing individual health benefit plans; altering the membership of the Maryland Health Insurance Coverage Protection Commission; requiring the Commission to study and make recommendations for individual and group health insurance market stability; requiring the Commission to engage an independent actuarial firm to assist in a certain study; requiring the Commission to include its findings and recommendations from a certain study in a certain report; making this Act an emergency measure; and generally relating to health insurance.

~~BY repealing and reenacting, with amendments,~~
~~Article – Health – General~~
~~Section 19–214(d)~~
~~Annotated Code of Maryland~~
~~(2015 Replacement Volume and 2017 Supplement)~~

BY adding to
Article – Insurance
Section 6–102.1~~, 6–102.2, 31–117, and 31–117.1~~
Annotated Code of Maryland
(2017 Replacement Volume)

BY repealing and reenacting, with amendments,
Article – Insurance
Section ~~31–107~~ 15–1202 and 15–1301(s)
Annotated Code of Maryland
(2017 Replacement Volume)

~~BY repealing~~

~~Article – Insurance~~
~~Section 31–117~~
~~Annotated Code of Maryland~~
~~(2017 Replacement Volume)~~

~~BY adding to~~
~~Article – Tax – General~~
~~Section 10–102.2~~
~~Annotated Code of Maryland~~
~~(2016 Replacement Volume and 2017 Supplement)~~

BY repealing and reenacting, without amendments,
Chapter 17 of the Acts of the General Assembly of 2017
Section 1(b) and (g)

BY repealing and reenacting, with amendments,
Chapter 17 of the Acts of the General Assembly of 2017
Section 1(c)(6)(viii) and (ix), (h), and (i)

BY adding to
Chapter 17 of the Acts of the General Assembly of 2017
Section 1(c)(6)(x) and ~~(xi) and~~ (h)

SECTION 1. BE IT ENACTED BY THE GENERAL ASSEMBLY OF MARYLAND, That the Laws of Maryland read as follows:

~~Article – Health – General~~

~~19–214.~~

~~(d) (1) Each year, the Commission shall assess a uniform, broad–based, and reasonable amount in hospital rates to reflect the aggregate reduction in hospital uncompensated care realized from the expansion of health care coverage under Chapter 7 of the Acts of the 2007 Special Session of the General Assembly.~~

~~(2) (i) 1. The Commission shall ensure that the assessment amount equals 1.25% of projected regulated net patient revenue.~~

~~2. Each hospital shall remit its assessment amount to the Health Care Coverage Fund established under § 15–701 of this article.~~

~~(ii) Any savings realized in averted uncompensated care as a result of the expansion of health care coverage under Chapter 7 of the Acts of the 2007 Special Session of the General Assembly that are not subject to the assessment under paragraph (1) of this subsection shall be shared among purchasers of hospital services in a manner that the Commission determines is most equitable.~~

~~(3) (i) Funds generated from the assessment under this subsection may be used only to supplement coverage under the Medical Assistance Program beyond the eligibility requirements in existence on January 1, 2008.~~

~~(ii) Any funds remaining after the expenditure of funds under subparagraph (i) of this paragraph has been made may be used for the general operations of the Medicaid program.~~

~~(4) (I) IN ADDITION TO THE RATES IMPOSED UNDER PARAGRAPH (1) OF THIS SUBSECTION AND SUBJECT TO SUBPARAGRAPHS (II) AND (III) OF THIS PARAGRAPH, FOR FISCAL YEAR 2019, THE COMMISSION SHALL ASSESS A UNIFORM, BROAD–BASED AND REASONABLE FEE ON EACH HOSPITAL FOR THE PURPOSE OF SUPPORTING THE HEALTH CARE ACCESS PROGRAM ESTABLISHED UNDER § 31–117 OF THE INSURANCE ARTICLE.~~

~~(II) THE COMMISSION MAY NOT RAISE HOSPITAL RATES AS PART OF THE ANNUAL UPDATE FACTOR FOR FISCAL YEAR 2019 TO OFFSET THE FEE ASSESSED UNDER SUBPARAGRAPH (I) OF THIS PARAGRAPH.~~

~~(III) THE FEE ASSESSED UNDER SUBPARAGRAPH (I) OF THIS PARAGRAPH MAY NOT EXCEED 0.5% OF EACH HOSPITAL'S NET PATIENT REVENUE.~~

~~(IV) EACH HOSPITAL SHALL REMIT THE FEE ASSESSED UNDER SUBPARAGRAPH (I) OF THIS PARAGRAPH TO THE MARYLAND HEALTH BENEFIT EXCHANGE FUND ESTABLISHED UNDER § 31–107 OF THE INSURANCE ARTICLE.~~

Article – Insurance

6–102.1.

~~(A) (1) IN THIS SECTION THE FOLLOWING WORDS HAVE THE MEANINGS INDICATED.~~

~~(2) "CARRIER" HAS THE MEANING STATED IN § 15–1201 OF THIS ARTICLE.~~

~~(3) "HEALTH BENEFIT PLAN" HAS THE MEANING STATED IN § 15–1201 OF THIS ARTICLE.~~

~~(B) (1) BEGINNING JANUARY 1, 2019, A CARRIER SHALL PAY AN ASSESSMENT OF 3% ON THE CARRIER'S NEW AND RENEWAL GROSS DIRECT PREMIUMS IF THE CARRIER FAILS TO OFFER INDIVIDUAL HEALTH BENEFIT PLANS IN THE STATE IN ACCORDANCE WITH TITLE 15, SUBTITLE 13 OF THIS ARTICLE.~~

~~(2) THE ASSESSMENT PAYABLE BY A CARRIER UNDER THIS SECTION SHALL BE BASED ON THE CARRIER'S PREMIUMS IN ANY MARKET SEGMENT:~~

~~(I) ALLOCABLE TO THE STATE; AND~~

~~(II) WRITTEN DURING THE IMMEDIATELY PRECEDING CALENDAR YEAR.~~

~~(C) NOTWITHSTANDING § 2–114 OF THIS ARTICLE, BEGINNING JANUARY 1, 2019, THE ASSESSMENT REQUIRED UNDER SUBSECTION (B) OF THIS SECTION SHALL BE DISTRIBUTED ANNUALLY TO THE MARYLAND HEALTH BENEFIT EXCHANGE FUND ESTABLISHED UNDER § 31–107 OF THIS ARTICLE FOR THE SOLE PURPOSE OF FUNDING THE OPERATION AND ADMINISTRATION OF THE HEALTH CARE ACCESS PROGRAM AUTHORIZED UNDER § 31–117 OF THIS ARTICLE.~~

~~(D) THE ASSESSMENT REQUIRED UNDER THIS SECTION SHALL BE IN ADDITION TO:~~

~~(1) TAXES OWED BY THE CARRIER UNDER ANY OTHER PROVISION OF LAW; AND~~

~~(2) ANY PENALTIES IMPOSED OR ACTIONS TAKEN BY THE COMMISSIONER IN RESPONSE TO THE CARRIER'S FAILURE TO COMPLY WITH THIS ARTICLE.~~

~~6–102.2.~~

(A) THIS SECTION APPLIES TO:

(1) ~~A HEALTH~~ *AN* INSURER, *A* NONPROFIT HEALTH SERVICE PLAN, ~~OR~~ *A* HEALTH MAINTENANCE ORGANIZATION*, A DENTAL PLAN ORGANIZATION, A FRATERNAL BENEFIT ORGANIZATION, AND ANY OTHER PERSON SUBJECT TO REGULATION BY THE STATE* THAT PROVIDES A ~~HEALTH BENEFIT PLAN~~ ~~REGULATED~~ *PRODUCT THAT:*

(I) IS SUBJECT TO THE FEE UNDER § 9010 OF THE AFFORDABLE CARE ACT; AND

***(II) MAY BE SUBJECT TO AN ASSESSMENT* BY THE STATE; AND**

(2) A MANAGED CARE ORGANIZATION AUTHORIZED UNDER TITLE 15, SUBTITLE 1 OF THE HEALTH – GENERAL ARTICLE.

(B) THE PURPOSE OF THIS SECTION IS TO RECOUP THE *AGGREGATE AMOUNT OF THE* HEALTH INSURANCE PROVIDER FEE THAT OTHERWISE WOULD HAVE BEEN ASSESSED UNDER § 9010 OF THE AFFORDABLE CARE ACT THAT IS ATTRIBUTABLE TO STATE HEALTH RISK FOR CALENDAR YEAR 2019 AS A BRIDGE TO STABILITY IN THE INDIVIDUAL HEALTH INSURANCE MARKET.

(C) (1) IN CALENDAR YEAR 2019, IN ADDITION TO THE AMOUNTS OTHERWISE DUE UNDER THIS SUBTITLE, AN ENTITY SUBJECT TO THIS SECTION SHALL BE SUBJECT TO AN ASSESSMENT OF 2.75% ON ALL AMOUNTS USED TO CALCULATE THE ENTITY'S PREMIUM TAX LIABILITY UNDER § 6–102 OF THIS SUBTITLE OR THE AMOUNT OF THE ENTITY'S PREMIUM TAX EXEMPTION VALUE FOR CALENDAR YEAR 2018.

(2) NOTWITHSTANDING § 2–114 OF THIS ARTICLE, THE ASSESSMENT REQUIRED UNDER THIS SECTION SHALL BE DISTRIBUTED BY THE COMMISSIONER TO THE MARYLAND HEALTH BENEFIT EXCHANGE FUND ESTABLISHED UNDER § 31–107 OF THIS ARTICLE.

15–1202.

(a) This subtitle applies only to a health benefit plan that:

(1) covers eligible employees of small employers in the State; and

(2) is issued or renewed on or after July 1, 1994, if:

(i) any part of the premium or benefits is paid by or on behalf of the small employer;

(ii) any eligible employee or dependent is reimbursed, through wage adjustments or otherwise, by or on behalf of the small employer for any part of the premium;

(iii) the health benefit plan is treated by the employer or any eligible employee or dependent as part of a plan or program under the United States Internal Revenue Code, 26 U.S.C. § 106, § 125, or § 162; or

(iv) the small employer allows eligible employees to pay for the health benefit plan through payroll deductions.

(b) A carrier is subject to the requirements of § 15–1403 of this title in connection with health benefit plans issued under this subtitle.

(C) THIS SUBTITLE APPLIES TO ANY HEALTH BENEFIT PLAN OFFERED BY AN ASSOCIATION, A PROFESSIONAL ~~EMPLOYEE~~ *EMPLOYER* ORGANIZATION, OR ANY

OTHER ENTITY, INCLUDING A PLAN ISSUED UNDER THE LAWS OF ANOTHER STATE, IF THE HEALTH BENEFIT PLAN COVERS ELIGIBLE EMPLOYEES OF ONE OR MORE SMALL EMPLOYERS AND MEETS THE REQUIREMENTS OF SUBSECTION (A) OF THIS SECTION.

15–1301.

(s) "Short–term limited duration insurance" **[**has the meaning stated in 45 C.F.R. § 144.103**] MEANS HEALTH INSURANCE COVERAGE PROVIDED UNDER A POLICY OR CONTRACT WITH A CARRIER AND THAT:**

(1) HAS A POLICY TERM THAT IS LESS THAN 3 MONTHS AFTER THE ORIGINAL EFFECTIVE DATE OF THE POLICY OR CONTRACT;

(2) MAY NOT BE EXTENDED OR RENEWED;

(3) APPLIES THE SAME UNDERWRITING STANDARDS TO ALL APPLICANTS REGARDLESS OF WHETHER THEY HAVE PREVIOUSLY BEEN COVERED BY SHORT–TERM LIMITED DURATION INSURANCE; AND

(4) CONTAINS THE NOTICE REQUIRED BY FEDERAL LAW PROMINENTLY DISPLAYED IN THE CONTRACT AND IN ANY APPLICATION MATERIALS PROVIDED IN CONNECTION WITH ENROLLMENT.

~~31–107.~~

~~(a) There is a Maryland Health Benefit Exchange Fund.~~

~~(b) (1) The purpose of the Fund is to:~~

~~(i) provide funding for the operation and administration of the Exchange in carrying out the purposes of the Exchange under this title; and~~

~~(ii) provide funding for the establishment and operation of the **[**State Reinsurance Program**] HEALTH CARE ACCESS PROGRAM** authorized under § 31–117 of this title.~~

~~(2) The operation and administration of the Exchange and the **[**State Reinsurance Program**] HEALTH CARE ACCESS PROGRAM** may include functions delegated by the Exchange to a third party under law or by contract.~~

~~(c) The Exchange shall administer the Fund.~~

~~(d) (1) The Fund is a special, nonlapsing fund that is not subject to § 7–302 of the State Finance and Procurement Article.~~

~~(2) The State Treasurer shall hold the Fund separately, and the Comptroller shall account for the Fund.~~

~~(e) The Fund consists of:~~

~~(1) any user fees or other assessments collected by the Exchange;~~

~~(2) all revenue deposited into the Fund that is received from the distribution of the premium tax under § 6–103.2 of this article;~~

~~(3) all revenue transferred to the Fund before July 1, 2016, from the Maryland Health Insurance Plan Fund;~~

~~(4) ASSESSMENTS COLLECTED BY THE COMMISSIONER UNDER §§ 6–102.1 AND 6–102.2 OF THIS ARTICLE;~~

~~(5) ASSESSMENTS REMITTED IN ACCORDANCE WITH § 19–214 OF THE HEALTH – GENERAL ARTICLE;~~

~~(6) PENALTIES COLLECTED BY THE COMPTROLLER UNDER § 10–102.2 OF THE TAX – GENERAL ARTICLE;~~

~~[~~~~(4)~~**] (7)** ~~income from investments made on behalf of the Fund;~~

~~[~~~~(5)~~**] (8)** ~~interest on deposits or investments of money in the Fund;~~

~~[~~~~(6)~~**] (9)** ~~money collected by the Board as a result of legal or other actions taken by the Board on behalf of the Exchange or the Fund;~~

~~[~~~~(7)~~**] (10)** ~~money donated to the Fund;~~

~~[~~~~(8)~~**] (11)** ~~money awarded to the Fund through grants; and~~

~~[~~~~(9)~~**] (12)** ~~any other money from any other source accepted for the benefit of the Fund.~~

~~(f) The Fund may be used only:~~

~~(1) for the operation and administration of the Exchange in carrying out the purposes authorized under this title; and~~

~~(2) for the establishment and operation of the~~ **~~[~~**~~State Reinsurance Program~~**~~] HEALTH CARE ACCESS PROGRAM~~** ~~authorized under § 31–117 of this title.~~

~~(g) (1) The Board shall maintain separate accounts within the Fund for Exchange operations and for the [State Reinsurance Program]~~ **HEALTH CARE ACCESS PROGRAM.**

~~(2) Accounts within the Fund shall contain the money that is intended to support the purpose for which each account is designated.~~

~~(3) Funds received from the distribution of the premium tax under § 6–103.2 of this article shall be placed in the account for Exchange operations and may be used only for the purpose of funding the operation and administration of the Exchange.~~

~~[(4) Funds transferred from the Maryland Health Insurance Plan Fund before July 1, 2016, shall be placed in the account for the State Reinsurance Program and may be used only for the purpose of funding the State Reinsurance Program.]~~

~~(4) THE FOLLOWING FUNDS MAY BE USED ONLY FOR THE PURPOSES OF THE HEALTH CARE ACCESS PROGRAM:~~

~~(I) ASSESSMENTS DISTRIBUTED TO THE FUND IN ACCORDANCE WITH §§ 6–102.1 AND 6–102.2 OF THIS ARTICLE;~~

~~(II) ASSESSMENTS REMITTED TO THE FUND IN ACCORDANCE WITH § 19–214 OF THE HEALTH – GENERAL ARTICLE;~~

~~(III) PENALTIES DISTRIBUTED TO THE FUND IN ACCORDANCE WITH § 10–102.2 OF THE TAX – GENERAL ARTICLE; AND~~

~~(IV) ANY FUNDS THAT THE STATE RECEIVES FROM THE FEDERAL GOVERNMENT UNDER ANY FEDERALLY SPONSORED OR DEVELOPED PROGRAM TO PROMOTE OR ENHANCE STABILITY IN THE INDIVIDUAL HEALTH INSURANCE MARKET.~~

~~(h) (1) Expenditures from the Fund for the purposes authorized by this subtitle may be made only:~~

~~(i) with an appropriation from the Fund approved by the General Assembly in the State budget; or~~

~~(ii) by the budget amendment procedure provided for in Title 7, Subtitle 2 of the State Finance and Procurement Article.~~

~~(2) Notwithstanding § 7–304 of the State Finance and Procurement Article, if the amount of the distribution from the premium tax under § 6–103.2 of this article exceeds in any State fiscal year the actual expenditures incurred for the operation and administration of the Exchange, funds in the Exchange operations account from the~~

~~premium tax that remain unspent at the end of the State fiscal year shall revert to the General Fund of the State.~~

~~(3) If operating expenses of the Exchange may be charged to either State or non–State fund sources, the non–State funds shall be charged before State funds are charged.~~

~~(i) (1) The State Treasurer shall invest the money of the Fund in the same manner as other State money may be invested.~~

~~(2) Any investment earnings of the Fund shall be credited to the Fund.~~

~~(3) Except as provided in subsection (h)(2) of this section, no part of the Fund may revert or be credited to the General Fund or any special fund of the State.~~

~~(j) A debt or an obligation of the Fund is not a debt of the State or a pledge of credit of the State.~~

~~[31–117.~~

~~(a) The Exchange, with the approval of the Commissioner, shall implement or oversee the implementation of the state–specific requirements of §§ 1341 and 1343 of the Affordable Care Act relating to transitional reinsurance and risk adjustment.~~

~~(b) The Exchange may not assume responsibility for the program corridors for health benefit plans in the Individual Exchange and the SHOP Exchange established under § 1342 of the Affordable Care Act.~~

~~(c) (1) In compliance with § 1341 of the Affordable Care Act, the Exchange, in consultation with the Maryland Health Care Commission and with the approval of the Commissioner, shall operate or oversee the operation of a transitional reinsurance program in accordance with regulations adopted by the Secretary for coverage years 2014 through 2016.~~

~~(2) As required by the Affordable Care Act and regulations adopted by the Secretary, the transitional reinsurance program shall be designed to protect carriers that offer individual health benefit plans inside and outside the Exchange against excessive health care expenses incurred by high–risk individuals.~~

~~(3) (i) The Exchange, in consultation with the Maryland Health Care Commission and with the approval of the Commissioner, may establish a State Reinsurance Program to take effect on or after January 1, 2014.~~

~~(ii) The purpose of the State Reinsurance Program is to mitigate the impact of high–risk individuals on rates in the individual insurance market inside and outside the Exchange.~~

~~(iii) The Exchange shall use funds transferred from the Maryland Health Insurance Plan Fund before July 1, 2016, to fund the State Reinsurance Program.~~

~~(d) (1) In compliance with § 1343 of the Affordable Care Act, the Exchange, with the approval of the Commissioner, shall operate or oversee the operation of a risk adjustment program designed to:~~

~~(i) reduce the incentive for carriers to manage their risk by seeking to enroll individuals with a lower than average health risk;~~

~~(ii) increase the incentive for carriers to enhance the quality and cost–effectiveness of their enrollees' health care services; and~~

~~(iii) require appropriate adjustments among all health benefit plans in the individual and small group markets inside and outside the Exchange to compensate for the enrollment of high–risk individuals.~~

~~(2) Beginning in 2014, the Exchange, with the approval of the Commissioner, shall strongly consider using the federal model adopted by the Secretary in the operation of the State's risk adjustment program.~~**]**

~~**31–117.**~~

~~**(A) THE EXCHANGE SHALL ESTABLISH A HEALTH CARE ACCESS PROGRAM TO PROVIDE REINSURANCE TO CARRIERS THAT OFFER INDIVIDUAL HEALTH BENEFIT PLANS IN THE STATE.**~~

~~**(B) THE HEALTH CARE ACCESS PROGRAM SHALL BE DESIGNED TO MITIGATE THE IMPACT OF HIGH–RISK INDIVIDUALS ON RATES IN THE INDIVIDUAL INSURANCE MARKET INSIDE AND OUTSIDE THE EXCHANGE.**~~

~~**(C) BEGINNING JANUARY 1, 2020, FUNDING FOR REINSURANCE IN THE INDIVIDUAL MARKET THROUGH THE HEALTH CARE ACCESS PROGRAM MAY BE MADE FROM:**~~

~~**(1) ANY AVAILABLE STATE FUNDING SOURCE; AND**~~

~~**(2) ANY AVAILABLE FEDERAL FUNDING SOURCE.**~~

~~**(D) BEGINNING JANUARY 1, 2020, IF REQUIRED UNDER THE TERMS AND CONDITIONS OF RECEIVING FEDERAL FUNDS, STATE FUNDING FOR REINSURANCE IN THE INDIVIDUAL MARKET THROUGH THE HEALTH CARE ACCESS PROGRAM SHALL BE CONTINGENT ON THE CENTERS FOR MEDICARE AND MEDICAID SERVICES APPROVING A WAIVER UNDER § 1332 OF THE AFFORDABLE CARE ACT.**~~

~~(E) THE EXCHANGE SHALL ADOPT REGULATIONS IMPLEMENTING THE PROVISIONS OF THIS SECTION.~~

~~31–117.1.~~

~~(A) THE EXCHANGE AND THE COMMISSIONER MAY SUBMIT A WAIVER UNDER § 1332 OF THE AFFORDABLE CARE ACT IN ACCORDANCE WITH THE RECOMMENDATIONS OF THE MARYLAND HEALTH INSURANCE COVERAGE PROTECTION COMMISSION ESTABLISHED UNDER CHAPTER 17 OF THE ACTS OF THE GENERAL ASSEMBLY OF 2017.~~

~~(B) ON OR BEFORE DECEMBER 31, 2019, THE COMMISSIONER MAY WAIVE ANY NOTIFICATION OR OTHER REQUIREMENTS THAT APPLY TO A CARRIER UNDER THIS ARTICLE IN CALENDAR YEAR 2019 DUE TO THE IMPLEMENTATION OF A WAIVER APPROVED UNDER § 1332 OF THE AFFORDABLE CARE ACT.~~

~~Article – Tax – General~~

~~10–102.2.~~

~~(A) THIS SECTION DOES NOT APPLY TO A NONRESIDENT, INCLUDING A NONRESIDENT SPOUSE AND A NONRESIDENT DEPENDENT.~~

~~(B) BEGINNING JANUARY 1, 2019, AN INDIVIDUAL SHALL MAINTAIN FOR THE INDIVIDUAL, AND FOR EACH DEPENDENT OF THE INDIVIDUAL, MINIMUM ESSENTIAL COVERAGE, AS DEFINED IN § 15–1301 OF THE INSURANCE ARTICLE.~~

~~(C) (1) SUBJECT TO PARAGRAPH (2) OF THIS SUBSECTION AND EXCEPT AS PROVIDED UNDER SUBSECTION (E) OF THIS SECTION, AN INDIVIDUAL SHALL PAY A PENALTY IN THE AMOUNT DETERMINED UNDER SUBSECTION (D) OF THIS SECTION IF THE INDIVIDUAL FAILS TO MAINTAIN THE COVERAGE REQUIRED UNDER SUBSECTION (B) OF THIS SECTION FOR 3 OR MORE MONTHS OF THE TAXABLE YEAR.~~

~~(2) ANY PENALTY IMPOSED UNDER THIS SUBSECTION FOR ANY MONTH IN WHICH AN INDIVIDUAL FAILS TO MAINTAIN THE COVERAGE REQUIRED UNDER SUBSECTION (B) OF THIS SECTION SHALL BE:~~

~~(I) IN ADDITION TO THE STATE INCOME TAX UNDER § 10–105(A) OF THIS SUBTITLE; AND~~

~~(II) INCLUDED WITH THE STATE INCOME TAX RETURN FOR THE INDIVIDUAL UNDER SUBTITLE 8 OF THIS TITLE FOR THE TAXABLE YEAR THAT~~

~~INCLUDES THE MONTHS IN WHICH COVERAGE WAS NOT MAINTAINED AS REQUIRED UNDER SUBSECTION (B) OF THIS SECTION.~~

~~(3) IF AN INDIVIDUAL WHO IS SUBJECT TO A PENALTY UNDER THIS SECTION FILES A JOINT STATE INCOME TAX RETURN UNDER § 10–807 OF THIS TITLE, THE INDIVIDUAL AND THE INDIVIDUAL'S SPOUSE SHALL BE JOINTLY LIABLE FOR THE PENALTY.~~

~~(D) THE AMOUNT OF THE PENALTY IMPOSED UNDER SUBSECTION (C) OF THIS SECTION SHALL BE EQUAL TO THE GREATER OF:~~

~~(1) 2.5% OF THE SUM OF THE INDIVIDUAL'S FEDERAL MODIFIED ADJUSTED GROSS INCOME, AS DEFINED IN 42 U.S.C. § 1395R, AND THE FEDERAL MODIFIED ADJUSTED GROSS INCOME OF ALL INDIVIDUALS CLAIMED ON THE INDIVIDUAL'S INCOME TAX RETURN; OR~~

~~(2) THE FOLLOWING FLAT RATES PER INDIVIDUAL, ADJUSTED ANNUALLY FOR INFLATION:~~

~~(I) $695 PER ADULT; AND~~

~~(II) $347.50 PER CHILD UNDER 18 YEARS OLD.~~

~~(E) AN INDIVIDUAL MAY NOT BE ASSESSED A PENALTY UNDER SUBSECTION (C) OF THIS SECTION IF THE INDIVIDUAL QUALIFIES FOR AN EXEMPTION UNDER 26 U.S.C. § 5000A(E).~~

~~(F) AN INDIVIDUAL SHALL INDICATE ON THE INCOME TAX RETURN FOR THE INDIVIDUAL, IN THE FORM REQUIRED BY THE COMPTROLLER, WHETHER MINIMUM ESSENTIAL COVERAGE WAS MAINTAINED AS REQUIRED UNDER SUBSECTION (B) OF THIS SECTION FOR:~~

~~(1) THE INDIVIDUAL;~~

~~(2) THE INDIVIDUAL'S SPOUSE IN THE CASE OF A MARRIED COUPLE; AND~~

~~(3) EACH DEPENDENT CHILD OF THE INDIVIDUAL, IF ANY.~~

~~(G) NOTWITHSTANDING § 2–609 OF THIS ARTICLE, AFTER DEDUCTING A REASONABLE AMOUNT FOR ADMINISTRATIVE COSTS, THE COMPTROLLER SHALL DISTRIBUTE THE REVENUES FROM THE PENALTY TO THE MARYLAND HEALTH BENEFIT EXCHANGE FUND FOR THE PURPOSES OF THE HEALTH CARE ACCESS PROGRAM ESTABLISHED UNDER § 31–117 OF THE INSURANCE ARTICLE.~~

~~SECTION 2. AND BE IT FURTHER ENACTED, That:~~

~~(a) (1) The Maryland Health Insurance Coverage Protection Commission, established under Chapter 17 of the Acts of the General Assembly of 2017, shall study and make recommendations for individual and group health insurance market stability, including:~~

~~(i) the components of a waiver under § 1332 of the Affordable Care Act to ensure market stability;~~

~~(ii) whether to pursue a standard plan design that limits cost sharing;~~

~~(iii) whether to merge the individual and small group health insurance markets in the State for rating purposes;~~

~~(iv) whether to pursue a Basic Health Program; and~~

~~(v) whether to pursue a Medicaid buy–in program for the individual market.~~

~~(2) The Maryland Health Insurance Coverage Protection Commission shall engage an independent actuarial firm to assist in its study under this subsection.~~

~~(b) On or before October 1, 2018, the Maryland Health Insurance Coverage Protection Commission shall issue a report on its findings and recommendations, including any legislative proposals, under subsection (a) of this section to the Governor and, in accordance with § 2–1246 of the State Government Article, the General Assembly.~~

~~SECTION 3. AND BE IT FURTHER ENACTED, That the Maryland Health Benefit Exchange shall adopt the regulations required under § 31–117 of the Insurance Article, as enacted by Section 1 of this Act, on or before January 1, 2019.~~

SECTION 2. AND BE IT FURTHER ENACTED, That the Laws of Maryland read as follows:

Chapter 17 of the Acts of 2017

SECTION 1. BE IT ENACTED BY THE GENERAL ASSEMBLY OF MARYLAND, That:

(b) There is a Maryland Health Insurance Coverage Protection Commission.

(c) The Commission consists of the following members:

(6) the following members:

(viii) one representative of behavioral health providers, appointed jointly by the President of the Senate and the Speaker of the House; **[**and**]**

(ix) two members of the public:

1. one of whom shall be appointed jointly by the President of the Senate and the Speaker of the House; and

2. one of whom shall be appointed by the Governor**;** ***AND***

(X) ONE REPRESENTATIVE OF A GROUP MODEL HEALTH MAINTENANCE ORGANIZATION THAT PARTICIPATES IN THE INDIVIDUAL MARKET, APPOINTED BY THE GOVERNOR~~; AND~~

~~(XI) ONE REPRESENTATIVE OF THE LEAGUE OF LIFE AND HEALTH INSURERS OF MARYLAND, TO BE APPOINTED JOINTLY BY THE PRESIDENT OF THE SENATE AND THE SPEAKER OF THE HOUSE~~.

(g) (1) The Commission shall:

(i) monitor potential and actual federal changes to the ACA, Medicaid, the Maryland Children's Health Program, Medicare, and the Maryland All–Payer Model;

(ii) assess the impact of potential and actual federal changes to the ACA, Medicaid, the Maryland Children's Health Program, Medicare, and the Maryland All–Payer Model; and

(iii) provide recommendations for State and local action to protect access of residents of the State to affordable health coverage.

(2) The duties of the Commission under paragraph (1) of this subsection shall include a study that includes:

(i) an assessment of the current and potential adverse effects of the loss of health coverage on the residents, public health, and economy of the State resulting from changes to the ACA, Medicaid, the Maryland Children's Health Program, Medicare, or the Maryland All–Payer Model;

(ii) an estimate of the costs to the State and State residents of adverse effects from changes to the ACA, Medicaid, the Maryland Children's Health Program, Medicare, or the Maryland All–Payer Model and the resulting loss of health coverage;

(iii) an examination of measures that may prevent or mitigate the adverse effects of changes to the ACA, Medicaid, the Maryland Children's Health Program, Medicare, or the Maryland All–Payer Model and the resulting loss of health coverage on the residents, public health, and economy of the State; and

(iv) recommendations for laws that:

1. may be warranted to minimize the adverse effects associated with changes to the ACA, Medicaid, the Maryland Children's Health Program, Medicare, or the Maryland All–Payer Model; and

2. will assist residents in obtaining and maintaining affordable health coverage.

(H) (1) THE COMMISSION SHALL STUDY AND MAKE RECOMMENDATIONS FOR INDIVIDUAL AND GROUP HEALTH INSURANCE MARKET STABILITY, INCLUDING:

(I) THE COMPONENTS OF ONE OR MORE WAIVERS UNDER § 1332 OF THE AFFORDABLE CARE ACT TO ENSURE MARKET STABILITY THAT MAY BE SUBMITTED BY THE STATE;

(II) WHETHER TO PURSUE A STANDARD PLAN DESIGN THAT LIMITS COST SHARING;

(III) WHETHER TO MERGE THE INDIVIDUAL AND SMALL GROUP HEALTH INSURANCE MARKETS IN THE STATE FOR RATING PURPOSES;

(IV) WHETHER TO PURSUE A BASIC HEALTH PROGRAM;

(V) WHETHER TO PURSUE A MEDICAID BUY–IN PROGRAM FOR THE INDIVIDUAL MARKET;

(VI) WHETHER TO PROVIDE SUBSIDIES THAT SUPPLEMENT PREMIUM TAX CREDITS OR COST–SHARING REDUCTIONS DESCRIBED IN § 1402(C) OF THE AFFORDABLE CARE ACT; AND

(VII) WHETHER TO ADOPT A STATE–BASED INDIVIDUAL HEALTH INSURANCE MANDATE AND HOW TO USE PAYMENTS COLLECTED FROM INDIVIDUALS WHO DO NOT MAINTAIN MINIMUM ESSENTIAL COVERAGE, INCLUDING USE OF THE PAYMENTS TO ASSIST INDIVIDUALS IN PURCHASING HEALTH INSURANCE.

(2) THE COMMISSION SHALL ENGAGE AN INDEPENDENT ACTUARIAL FIRM TO ASSIST IN ITS STUDY UNDER THIS SUBSECTION.

(3) THE COMMISSION SHALL INCLUDE ITS FINDINGS AND RECOMMENDATIONS FROM THE STUDY REQUIRED UNDER PARAGRAPH (1) OF THIS SUBSECTION IN THE ANNUAL REPORT SUBMITTED BY THE COMMISSION ON OR BEFORE DECEMBER 31, 2019, UNDER SUBSECTION (J) OF THIS SECTION.

[(h)**] (I)** The Commission may:

(1) hold public meetings across the State to carry out the duties of the Commission; and

(2) convene workgroups to solicit input from stakeholders.

[(i)**] (J)** On or before December 31 each year, the Commission shall submit a report on its findings and recommendations, including any legislative proposals, to the Governor and, in accordance with § 2–1246 of the State Government Article, the General Assembly.

SECTION ~~4.~~ 3. AND BE IT FURTHER ENACTED, That this Act is an emergency measure, is necessary for the immediate preservation of the public health or safety, has been passed by a yea and nay vote supported by three–fifths of all the members elected to each of the two Houses of the General Assembly, and shall take effect from the date it is enacted.

Approved by the Governor, April 10, 2018.

Attachment 2. MHBE Board Resolutions

750 EAST PRATT STREET, 6TH FLOOR
BALTIMORE, MD 21202
marylandhbe.com

MARYLAND HEALTH BENEFIT EXCHANGE

RESOLUTION OF THE MARYLAND HEALTH BENEFIT EXCHANGE BOARD OF TRUSTEES

SUBJECT: ON THE 2019 STATE REINSURANCE PROGRAM AND SUBMISSION OF A 1332 STATE INNOVATION WAIVER APPLICATION

WHEREAS, Maryland Health Connection is the state-based insurance marketplace for Maryland residents to explore and compare health coverage options, determine eligibility for tax subsidies and credits, and enroll in private health insurance plans on the individual market; and

WHEREAS, Maryland Health Connection connects eligible consumers with financial assistance to help make coverage more affordable; and

WHEREAS, Maryland Health Connection consumers who do not receive financial assistance must shoulder the full cost of health insurance premiums; and

WHEREAS, premiums in the individual market have risen to unsustainable levels for many Marylanders without financial assistance; and

WHEREAS, the Maryland Health Benefit Exchange (MHBE) is a public corporation and independent unit of Maryland state government, and is responsible for the operation of Maryland Health Connection; and

WHEREAS, the MHBE is required by House Bill 1795 (Maryland Health Benefit Exchange - Establishment of a Reinsurance Program) to submit a State Innovation Waiver to establish a State Reinsurance Program, under Section 1332 of the Affordable Care Act, to help stabilize premiums in the individual market; and

WHEREAS, the MHBE Board of Trustees must approve an attachment point, coinsurance rate, and cap for the State Reinsurance Program; and

WHEREAS, the MHBE Board of Trustees must approve an application for a State Innovation Waiver for the State Reinsurance Program,

NOW THEREFORE, BE IT RESOLVED THAT, the MHBE Board of Trustees approves of a State Reinsurance Program for 2019 with an attachment point that will be determined based on funding availability and stakeholder engagement, a coinsurance rate of 80%, and a cap of $250,000; and

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MARYLAND HEALTH BENEFIT EXCHANGE

BE IT FURTHER RESOLVED THAT, the MHBE Board of Trustees approves MHBE to submit a State Innovation Waiver application, to the U.S. Secretary of Health and Human Services and the U.S. Secretary of the Treasury, for a State Reinsurance Program not inconsistent with the parameters indicated within this resolution.

Robert R. Neall
Chair, Board of Trustees

May 25, 2018
DATE

Approved by the MHBE Board of Trustees on April 16, 2018.

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BALTIMORE, MD 21202
marylandhbe.com

MARYLAND HEALTH BENEFIT EXCHANGE

RESOLUTION OF THE MARYLAND HEALTH BENEFIT EXCHANGE BOARD OF TRUSTEES

SUBJECT: MARYLAND HEALTH BENEFIT EXCHANGE BOARD OF TRUSTEES ACTION ON PUBLIC COMMENT AND TESTIMONY ON THE 1332 STATE INNOVATION WAIVER APPLICATION

WHEREAS, the Maryland Health Benefit Exchange (MHBE) is a public corporation and independent unit of Maryland state government, and is responsible for the operation of Maryland Health Connection; and

WHEREAS, the MHBE, to help stabilize premiums in the individual market , is applying to the U.S. Secretaries of Health and Human Services and the Treasury for a State Innovation Waiver to to establish a State Reinsurance Program, under Section 1332 of the Affordable Care Act,; and

WHEREAS, the MHBE has consulted with the Maryland Commissioner of Insurance and held four public hearings across Maryland to receive testimony from the public and a public comment period of thirty days from April 20, 2018 to May 20, 2018 for the State Innovation Waiver Application; and

WHEREAS, the MHBE has received unanimous public comment and testimony in support of the goal of the State Innovation Waiver; and

WHEREAS, the MHBE has received testimony from a diverse set of stakeholders that State Reinsurance Program payments to issuers should not be duplicative with payments received under the existing Federal Risk Adjustment Program; and

WHEREAS, the MHBE has commissioned a study from Wakely Consulting Group on potential duplicative payments under both the State Reinsurance Program and the Federal Risk Adjustment Program, and

WHEREAS, the MHBE has received testimony from a diverse set of stakeholders that the State Reinsurance Program should include financial incentives for issuers who demonstrate effectiveness and efficiency in care management of high risk and high claims enrollees; and

WHEREAS, the MHBE must, under HB 1795, submit a State Innovation Waiver Application no later than July 1, 2018; and

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MARYLAND HEALTH BENEFIT EXCHANGE

WHEREAS, the MHBE Board of Trustees must approve an application for a State Innovation Waiver for the State Reinsurance Program,

NOW THEREFORE, BE IT RESOLVED THAT, the MHBE Board of Trustees may take regulatory action based on the results of the study being performed by Wakely Consulting Group on potential duplicative payments under the State Reinsurance Program and the Federal Risk Adjustment Program; and

BE IT FURTHER RESOLVED THAT, the MHBE Board of Trustees approves MHBE to submit a State Innovation Waiver application, to the U.S. Secretary of Health and Human Services and the U.S. Secretary of the Treasury, for a State Reinsurance Program that may include financial incentives for issuers to manage high risk and high cost enrollees after active engagement with stakeholders in regulatory action.

WE HEREBY CERTIFY that the foregoing Resolution was adopted on the 21st day of May, 2018, by the Board of Trustees of the Maryland Health Benefit Exchange.

Robert R. Neall
Chair, Board of Trustees

S. Anthony McCann
Vice-chair, Board of Trustees

May 21, 2018
DATE

Approved by the MHBE Board of Trustees on May 21, 2018.

Attachment 3. Public Comment Process

State Innovation Waiver Application – Maryland

Under Section 1332 of the Affordable Care Act, states may apply for State Innovation Waivers to waive certain federal requirements with the goal of improving their health insurance markets. During the 2018 legislative session, the Maryland General Assembly passed House Bill 1795 – Establishment of a State Reinsurance Program. Governor Larry Hogan signed House Bill 1795 on April 5, 2018.

House Bill 1795, as an emergency measure, directs the Maryland Health Benefit Exchange to submit a State Innovation Waiver to the U.S. Secretaries of Health and Human Services and the Treasury to establish a State Reinsurance Program.

The purpose of the State Reinsurance Program is to mitigate the premium impact of high cost enrollees on carriers that participate in the individual market. The State Reinsurance Program will reduce rates from what they would have been without the program, creating some relief for Marylanders who have experienced high rate increases on their health insurance premiums.

For more information on State Innovation Waivers, visit the CMS Section 1332: State Innovation Waivers website.

APPLICATION:
Please see the draft application at the link below:
DRAFT Maryland 1332 State Innovation Waiver Application

PUBLIC COMMENT AND HEARINGS:

States are required to post State Innovation Waiver Applications for public comment for a minimum of 30 days. All comments should be submitted to the Maryland Health Benefit Exchange at mhbe.publiccomments@maryland.gov. The comment period is from April 20 to May 20, 2018.

As a requirement of the State Innovation Waiver application process, the Maryland Health Benefit Exchange, in conjunction with the Maryland Insurance Administration, held four public hearings around the state.

Below are links to the agenda and the presentation at those hearings:
1332 Waiver Public Hearing Agenda
Presentation on "Maryland State Innovation Waiver Application: State Reinsurance Program, April 20-May 20, 2018"

Below is additional information from the four hearings:

1. **April 26, Talbot County Department of Parks and Recreation (Chesapeake Room), Easton, MD**
   Attendee Sign-In Sheet
   Minutes
   Audio of Public Hearing #1

2. **May 3, Office of the Maryland Health Benefit Exchange, Baltimore, MD**
   Attendee Sign-In Sheet
   Minutes
   Audio of Public Hearing #2

3. **May 7, Frederick County Local Health Department, Frederick, MD**
   Attendee Sign-In Sheet
   Minutes
   Audio of Public Hearing #3

4. **May 10, Charles County Local Health Department, White Plains, MD**
   Attendee Sign-In Sheet
   Minutes
   Audio of Public Hearing #4

Section 1332 State Innovation Waiver Application – Public Comments

RESOURCES

Please see the below resource for important information.

Enacting Legislation:
HB 1795 – Establishment of a State Reinsurance Program
SB 387 – Maryland Health Access Act of 2018

Authorizing Resolution:
MHBE Board Resolution on the State Reinsurance Program and Submission of a State Innovation Waiver Application – April 16, 2018
Section 1332 Waiver -Public Comment – Board Presentation – May 21, 2018
Resolution 1332 State Innovation Waiver Application – May 21, 2018

FAQs

Click here to view answers to Frequently Asked Questions about the 1332 waiver application process

MARYLAND HEALTH BENEFIT EXCHANGE

NEWS

MEDIA RELEASE

FOUR PUBLIC HEARINGS ANNOUNCED FOR STATE REINSURANCE PROPOSAL

BALTIMORE (APRIL 20, 2018) – The Maryland Health Benefit Exchange (MHBE), in conjunction with the Maryland Insurance Administration (MIA), will hold a series of hearings to receive public comment to shape Maryland's application to the federal government for a reinsurance program. The purpose of the program is to hold down consumer cost and bring greater certainty to Maryland's individual market for health insurance for 2019 and 2020.

Governor Larry Hogan and the Maryland General Assembly approved legislation to create a reinsurance program for the individual health insurance market beginning in 2019. The state plans to raise about $365 million through a 2.75% premium surcharge on insurance carriers. Maryland may receive additional "pass through" dollars from the federal government. Total funding for the program is projected at $462 million. If approved, the reinsurance program will hold down premium increases for plans purchased in the individual health insurance market both on and off Maryland Health Connection, the state-based marketplace.

The MHBE Board of Trustees voted on Monday to authorize MHBE to apply to the Centers for Medicare and Medicaid Services (CMS) to request approval for an "innovation waiver" to create the reinsurance program under Section 1332 of the Affordable Care Act. States are required to post applications for public comment for a minimum of 30 days. Maryland-recognized tribes are encouraged to provide comment during the 30-day period.

Maryland's draft of its 1332 State Innovation Waiver Application for a State Reinsurance Program can be viewed at MarylandHBE.com.

Four public hearings will be held on:

- **Thursday, April 26, 5 p.m. to 6 p.m., at the Talbot County Department of Parks and Recreation (Chesapeake Room),** 10028 Ocean Gateway, Easton, MD 21601

- **Thursday, May 3, 4 p.m. to 5 p.m., at the office of the Maryland Health Benefit Exchange**, 750 E. Pratt St., 6th Floor, Baltimore, MD 21205

- **Monday, May 7, 3 p.m. to 4 p.m., at the Frederick County Local Health Department,** 350 Montevue Lane, Frederick, MD 21702

- **Thursday, May 10, 5 p.m. to 7 p.m., at the Charles County Local Health Department**, 4545 Crain Highway, White Plains, MD 20695

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About the Maryland Health Benefit Exchange: The Maryland Health Benefit Exchange, a public corporation and independent unit of state government, administers Maryland Health Connection. Including more than 1 million people enrolled in Medicaid, MHBE enrolls one of every six Marylanders in health coverage.

About Maryland Health Connection: Maryland Health Connection is the state's official health insurance marketplace for individuals and families to compare and enroll in health insurance. Maryland Health Connection is the only place where Marylanders can access tax credits to make coverage more affordable. People who have lost coverage and meet the criteria for a special enrollment can also enroll throughout the year at MarylandHealthConnection.gov or on the Enroll MHC mobile app.

Media Contact
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FOUR PUBLIC HEARINGS ANNOUNCED FOR STATE REINSURANCE PROPOSAL

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MEDIA RELEASE

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Section 1332 State Innovation Waiver Application – Public Comments

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Maryland 1332 Waiver Hearing #1

Eastern Maryland

April 26, 2018
Talbot County Department of Parks and Recreation
10028 Ocean Gateway
Easton, MD 21601

Welcome & Introductions

Michele Eberle, Executive Director of the Maryland Health Benefit Exchange (MHBE), welcomed the public to the hearing and introduced herself along with other MHBE staff in attendance. She acknowledged the presence of staff from the Maryland Insurance Administration (MIA), as well as Delegate John Mautz and a staff member from the office of Senator Adelaide Eckardt.

Ms. Eberle provided a brief overview of the proposed state reinsurance program then introduced John-Pierre Cardenas, the MHBE Director of Policy and Plan Management.

1332 Waiver Presentation

Mr. Cardenas began by describing the state legislation enabling the reinsurance program—House Bill (HB) 1795 – Establishment of a Reinsurance Program and Senate Bill (SB) 387 – Maryland Health Care Access Act of 2018. He explained that the reinsurance program's attachment point is not yet finalized since it depends on the available funding.

Next, Mr. Cardenas described how two outside organizations contributed to the waiver application process. The Wakely Consulting Group prepared the actuarial and economic analysis, and The Hilltop Institute developed the narrative portion of the waiver application.

Mr. Cardenas then provided a basic description of the waiver, explaining that it would reduce premiums by an average of 30 percent in the first year using a combination of state funds and federal pass-through funds. By allowing carriers to factor the reinsurance program into their premium rates, thus reducing those premiums, the MHBE expects the program to result in a 5.8 percent increase in enrollment in 2019.

Next, Mr. Cardenas laid out the four guardrails in which all 1332 State Innovation Waivers must comply. He explained that the proposed reinsurance program would be compliant with these guardrails. He added that, absent the waiver, the average premium is estimated to rise from $604.50 per month to $735.66 per month in 2019, whereas under the waiver, the average premium is expected to decrease from $604.50 per month to $508.03 per month.

Mr. Cardenas concluded his presentation by describing the upcoming opportunities to gather stakeholder feedback, including three additional hearings in the coming weeks. He noted that there will be additional opportunities for stakeholder involvement in the regulatory process over the summer of 2018.

Q&A/Discussion

Mr. Cardenas then opened the floor for questions and discussion from the attendees.

An attendee asked whether, in the event that the reinsurance program does not meet its savings targets, consumers will have to make up the difference. Mr. Cardenas replied in the negative.

An attendee asked whether the reinsurance program would affect only on-exchange policies. Mr. Cardenas replied that the program would involve all individual market policies, both on- and off-exchange.

An attendee asked whether the 30 percent reduction in average premium is expected in the first year, or averaged over two years. Mr. Cardenas replied that the program is expected to realize the 30 percent reduction in the first year and maintain that level into the second year.

An attendee asked whether the reinsurance program would cover Medigap policies. Mr. Cardenas replied in the negative, noting that the waiver only has jurisdiction over individual market policies governed by the Affordable Care Act.

An attendee asked the likelihood that the waiver program would continue into 2020. Mr. Cardenas replied that the waiver application covers a five-year period, meaning that the program would run from 2019 through 2023, with the opportunity for extensions beyond 2023.

An attendee asked what the MHBE expects to happen with premium prices in 2021 and beyond. Mr. Cardenas replied that, while they do not know exactly what is going to happen at that point, they hope for continued savings. He added that the chief strategy for market health in that extended period is to attract additional insurance carriers into the market and a healthier risk pool.

An attendee, noting that some portion of the funding for this program would come from a fee on insurance companies, asked whether that fee would negatively impact premiums in the group market. Mr. Cardenas replied that, since the fee was already calculated into the rates, the affect on group premium would be neutral.

Public Testimony

Mr. Cardenas then invited any attendee who so desired to offer their testimony for the record.

James Burdick offered the following testimony:

> *"As a doctor, I'd like to see everybody get health care. And, actually, I meant what I said about Maryland. Congratulations to the work that's been done and other good things that are happening in Maryland compared to other states, so this isn't a criticism. But, long run, as I said, stepping back, a national health program, improved Medicare for all, single payer system would get rid of the admittedly confusing, or at least complicated, details and also save money, cover everybody, and improve quality. It's really true. Senator Pinsky has introduced a bill in the Senate and there is some enthusiasm for a state single-payer bill. I'd like to see a national program, ideally, but I just want to provide that perspective on the complexity and the potential lack of insurance or uncertain insurance for so many Marylanders still, in spite of the great work that you have been doing."*

Closing

Ms. Eberle closed the hearing and thanked everyone who attended.

Participants

Maryland Health Benefit Exchange
Tony McCann, Member, Board of Trustees
Michele Eberle, Executive Director
Andrew Ratner, Chief of Staff
John-Pierre Cardenas, Director of Policy and Plan Management
Kris Vallecillo, Senior Health Policy Analyst

Maryland Insurance Administration
Todd Switzer, Chief Actuary
Brad Boban, Senior Actuary
Joseph Fitzpatrick, Assistance Chief Examiner

Maryland Department of Health
Robert Neall, Secretary
Nikki Laska, Director, Communications

Maryland General Assembly
Delegate Johnny Mautz
Melissa Einhorn, Office of Senator Addie Eckhardt

Members of the Public
Kathy Ruben
Elizabeth Carson
Larry Carson
Matt Celentano
Laurie Kuiper
Dan Mosebach
Chester King
Billy D. Weber
Karen Millison
Jim Burdick
Paul Davin

Maryland 1332 Waiver Hearing #2

Central Maryland

May 3, 2018
Maryland Health Benefit Exchange
750 E. Pratt Street, 6th Floor
Baltimore, MD 21205

Welcome & Introductions

Michele Eberle, Executive Director of the Maryland Health Benefit Exchange (MHBE), welcomed the public to the hearing and introduced herself. She explained the process and purpose of the 1332 waiver hearings and provided a brief overview of the current state of the marketplace and the proposed state reinsurance program.

She acknowledged the presence of staff from the MHBE and the Maryland Insurance Administration (MIA) and introduced John-Pierre Cardenas, the MHBE Director of Policy and Plan Management.

1332 Waiver Presentation

Mr. Cardenas began by describing the state legislation enabling the reinsurance program—House Bill (HB) 1795 – Establishment of a Reinsurance Program and Senate Bill (SB) 387 – Maryland Health Care Access Act of 2018.

Mr. Cardenas emphasized the importance of stakeholder input on the proposed reinsurance program and gave a brief summary of the proposed reinsurance program, including funding sources. He explained that the reinsurance program's attachment point has not been finalized because it is dependent on the available funding.

Mr. Cardenas then described how two outside organizations contributed to the waiver application process. The Wakely Consulting Group prepared the actuarial and economic analysis, and The Hilltop Institute developed the narrative portion of the waiver application.

Mr. Cardenas provided a basic description of the waiver, explaining that it would reduce premiums by an average of 30 percent in the first year using a combination of state funds and federal pass-through funds. By waiving Section 1312(c)(1) of the Affordable Care Act, carriers are allowed to factor the reinsurance program into their premium rates, resulting in a reduction of those premiums. The MHBE expects the program to result in a 5.8 percent increase in individual market enrollment in 2019.

Next, Mr. Cardenas presented the four guardrails in which all 1332 State Innovation Waivers must comply. He explained that the proposed reinsurance program would be compliant with the guardrails. He added that, absent the waiver, the average premium is estimated to rise from $604.50 per month to $735.66 per month in 2019, whereas under the waiver, the average premium is expected to decrease from $604.50 per month to $508.03 per month. Mr. Cardenas emphasized that the estimations presented are based on average premiums and are not specific to any single carrier.

Mr. Cardenas concluded his presentation by describing the upcoming opportunities to gather stakeholder feedback, including two additional hearings in the coming weeks. He noted that there will be additional opportunities for stakeholder involvement in the regulatory process over the summer of 2018.

Q&A/Discussion

Mr. Cardenas then opened the floor for questions and discussion from the attendees.

There were no questions.

Public Testimony

Mr. Cardenas then invited any attendee who so desired to offer their testimony for the record. Three individuals offered testimony.

John Kunkel, Chief Financial Officer, Kaiser Permanente, offered the following testimony:

> *"I am proud to represent Kaiser today. We are the only insurer that participates in both the exchanges and the Medicaid program, so we are very much impacted by the 1332 waiver. I would reiterate what JP said at the outset. This is something very cool. Kaiser Permanente supports this waiver. What is important to us is that it is done in a very thoughtful and balanced way, and so I will focus my brief comments today around how we believe that should work. And for us it is all about impacting all Marylanders equally regardless of who your insurance carrier is. As the board is aware, Kaiser is concerned that the program could advantage one health plan over the other. We want to make sure that this rate relief that was referenced is spread across everyone and that no carrier has the ability to be paid twice, a double dip concept for both the risk adjustment program as well as this reinsurance program that will hopefully be created for 2019. The issue of double payments is something that has been written about widely by experts, such as the American Academy of Actuaries and Milliman.*
>
> *We have asked the staff of MHBE to seek an estimate from Wakely who is uniquely positioned to look at this because they have the data for the carriers in Maryland. We understand that that work is forthcoming, and we are very appreciative of that. We think that will be important and very instructive to understand the dynamics and ensure that we create the right program for Maryland. So why would this matter to a consumer? During the presentation, it was referenced that this could bring rates down by 30 percent. What is important to Kaiser is that this brings everyone's rates down 30 percent or at least as well as you can model that. We are afraid that the minority will see a disproportionate level of rate decrease and the majority, including the 75,000 members that utilize Kaiser Permanente's care delivery system today will see less than a balanced shift. We would also urge the MHBE to include language in the draft Section 1332 waiver that would indicate the state's intent to implement this type of program.*
>
> *We believe CMS would not hesitate to approve a waiver with this language. And finally, we believe that a program that treats all carriers equally will increase the chances of additional carriers coming to the state. Today, we only have two carriers: Kaiser Permanente and CareFirst, and Kaiser Permanente is not statewide. Our delivery system does not cover all of Maryland. A balanced program that treats carriers equally, particularly those who are incentivized around controlling costs would make Maryland more attractive to additional competitors. In conclusion, Kaiser Permanente believes three important things. One, the program should not allow duplicate payments to be made to any health plan. Two, the program should benefit all Marylanders as equally as possible and not disproportionately those enrolled in just one type of plan. And finally, that this is a solvable problem that we have the data and we have the time to design a program that would accomplish the goals that I have laid out today. So, thank you for your consideration."*

Beth Sammis, President, Consumer Health First, Board of Directors, offered the following testimony:

"I am President of the Board of Consumer Health First, a statewide consumer advocacy organization, and I am here today to deliver our strong support for the 1332 waiver for all of the reasons that JP so eloquently stated. Obviously, all of us know that consumers who do not qualify for financial assistance have borne the brunt of the eye-popping premium increases over the last four years of the Affordable Care Act, and from the data that was provided by the MIA to the General Assembly of this year, we know that premiums in the individual market for consumers who do not qualify for financial assistance range from 26-73 percent of their after tax income. I would submit to you that if any of us in the group market were required to pay anything close to that then we would respectfully decline that coverage from our employers, and so to us this is a crisis deserving of some solution. Although I must say that we see the reinsurance program together with a very thorough rate review, which we are going to be working with the MIA to ensure happens, is one way to modestly impact the rates, but long-term we believe that there is going to have to be other solutions. One of the solutions that we advocate is a Medicaid buy-in.

We understand that there is still a lot of work to do before the reinsurance program is launched. You've made many of the decisions about some of the technical aspects of this program already. Regarding the cap on the reinsurance payments, it is much lower than the cap was at the federal level, the federal reinsurance program, and it is much lower than, at least what we understand, what other states have done. We understand that is being done primarily because you want deeper coverage, and so we would certainly support that. We are concerned for slightly different reasons but along the same lines of concern that Kaiser has already expressed, that this reinsurance program will not equitably impact all consumers. It is not so much that we are concerned about what happens to Kaiser, with all due respect. But, there is a difference between the PPO market and the HMO market. In the PPO market, we know that the risk adjustment program that has been put in place at the federal level, all of those monies go to the PPO product, and the monies raised for that program are from the HMO market. Those HMO premiums are in effect increased in order to subsidize the PPO product because the PPO product has higher risks.

We know that theoretically there are many who have argued that when you have a reinsurance program and it is combined with a risk adjustment program that nothing further needs to be done, but we are concerned that that is not the truth. And, that it is particularly not going to be the case given the level and the scale of this particular program. So, our ask is that during this time period between now and the end of the year that you take the claims data from 2017 and do a simulation of what exactly would have happened if there had been in effect the risk adjustment program, which of course we know will be in place, and you know what those payouts will be for the 2017 plan year in June and then simulate what the reinsurance payments would have been in 2017 to be sure that the attachment points and whether or not there should be any true up between the risk adjustment program and the reinsurance program so that the percentage decrease in premiums that we expect on average is the same for HMO products and PPO

products. I think that we are well aware of the fact that there can be plan differences, there can be differences between Kaiser and CareFirst, but at the end of the day, if we are looking at a 30 percent reduction in rate increase, that should be the same whether or not you are enrolled in an HMO or a PPO. Otherwise, we believe that that is an unfair subsidy again on the part of HMO members.

We also understand that, to us anyways, there is the potential, and I wouldn't say that it is absolute, but it is a potential, that consumers would see this in an inequitable way if their premium decreases were not similar for the HMO and PPO products. This could also lead to some market distortions and would lead some carriers, in particular Kaiser Permanent, to rethink their commitment to this market. After all, Kaiser Permanente is not required by law to remain in the individual market. It is another reason why we have seen other carriers depart; they are a business, and they get to decide if they want to stay in this line of business or not. That is not true for CareFirst. CareFirst is the state's only non-profit health service plan, and under the provisions of Section 14-106 (d)(1)(ii) of the Insurance Article, they are required to offer products in the individual market and thus, may not exit. It is not in consumers' interest to have only CareFirst HMO and PPO products. It is in our interest to have more carriers. I am doubtful about the number of other carriers coming in, but at least we should try to hang on to those that are already here. And, obviously some consumers have elected to join Kaiser Permanente and believe that it best meets the needs of them and their families.

Finally, we would ask that we take this opportunity with the development of a state reinsurance program where essentially carriers are going to be given a pretty significant amount of money to help out with their travails in this market to put in place meaningful health improvement programs. There is no requirement in Maryland, that I know of, that the Exchange has placed on carriers in the individual market or any other market to demonstrate they are in fact well aware of the healthcare conditions that are driving up premiums and that they have developed meaningful interventions to control those costs going forward. I believe that is in consumers' interests for two reasons. One is that if they are effective, they will lead to a lower rate of increase, which is in consumers' interests, and second of all, if they are effective, it should mean that consumers who have these chronic conditions lead healthier, more productive lives, which is in all of our interests as well as theirs. Again, I would like to close by thanking you for moving forward with this effort, to the Secretary for being here to listen, and we look forward to working with you to try to bring as much benefit to the market as possible to all consumers. Thank you."

Jeff Ratnow, consumer, offered the following testimony:

"I am a consumer on the Exchange. I am going to give you my personal story. In 2015, I was fired, and I decided that now was the time to start my business. I started my business. My parents said to me, 'What are you going to do for health insurance?' because health insurance was always provided by my company, and I didn't really think about that. I was so grateful that Obamacare was in effect, and I went to a broker on Eastern Avenue in Highlandtown. He said, 'You're all set. You qualify for Medicaid,' so through the Affordable Care Act, because I was making no money, I got to build my business. As soon as I made $75,000, I got my bill of $650 a month, $3,500 premium [deductible]. That isn't bad. That is kind of reasonable. That is a good deal. The next year, I grew my

business a little bit more, and the reward is $1,200 a month, about the same premium [deductible]. Okay, still alright, but now, it is getting tight at home. I have two kids and a wife, a wife with a pre-existing condition. I found out that I do because I had a sleep apnea test 20 years ago that has been flagged since then, so we are essentially uninsurable without the public markets.

So, those of you who buy on the market, I am sure you watched with bated breath when the Republicans tried to kill Obamacare. I had nightmares. When John McCain voted against it, it was better than any Ravens SuperBowl ever. It was literally preserving my chance to live the American dream and build my business because without that, I knew I would have to give up and go get a job. So, the next year, my premium then went up to $1,350 a month with a $13,000 deductible. We go skiing, and now we have to make choices. My son breaks his arm. I didn't know if he broke his arm. We kind of waited it out a little bit. Urgent care is about $300, and they are just going to put him in a splint. What do I do here? My friend is an ER doctor, so we went and saw him. He said, 'I think you need to get it taken care of.' Anyway, it changes how you take care of your family because the monetary pressures are so big.

This year, I probably have an exposure of about $30,000, which is going to be about 30 percent of my net income. That is more than housing and is more than any other expense, and when I read that the state of Maryland was thinking about doing this, I thanked God that I live in a progressive state that really cares about the people. This will help me grow my small business. I will be able to instead pull money out of my business and right into a health savings account and my health insurance. I could look at hiring people. I could look into creating a better life for other folks as well, which I learned through the Goldman Sachs 10,000 Small Businesses Program how to do that. My constraints have been financial, and now this, hopefully if it works out the way that it is written, it will provide stabilization and insulate us from the craziness going on 40 miles south of here. And really create a state where people really want to move to and live in. Thank you."

Closing

Ms. Eberle recognized Jeff Ratnow and thanked him for sharing his story. Ms. Eberle closed the hearing and thanked everyone who attended.

Participants

Maryland Health Benefit Exchange
Ben Steffen, Member, Board of Trustees
Dana Weckesser, Member, Board of Trustees
Michele Eberle, Executive Director
Andrew Ratner, Chief of Staff
John-Pierre Cardenas, Director of Policy and Plan Management
Kris Vallecillo, Senior Health Policy Analyst
Betsy Plunkett, Marketing Director

Maryland Insurance Administration
Todd Switzer, Chief Actuary
Cathy Grason, Chief of Staff
Brad Boban, Senior Actuary
Bob Morrow, Associate Commissioner
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Diane Lawrence
Mark Longerbeam
Natasha Murphy
Maansi Raswant
Jeff Ratnow
Dourakine Rosarion
Kathy Ruben
Beth Sammis
Delora Sanchez
Jared Sussman
Bill Wehrle
Wayne Wilson
Bryant Woodford

Maryland 1332 Waiver Hearing #3

Western Maryland

May 7, 2018
Frederick County Health Department
350 Montevue Lane
Frederick, MD 21702

Welcome & Introductions

Michele Eberle, Executive Director of the Maryland Health Benefit Exchange (MHBE), welcomed the public to the hearing and introduced herself along with other MHBE staff in attendance. She acknowledged the presence of staff from the Maryland Insurance Administration (MIA), as well as Delegate Carol Krimm and Robert Neall, the Secretary of the Maryland Department of Health and Chair of the MHBE Board.

Ms. Eberle provided a brief overview of the proposed state reinsurance program then introduced John-Pierre Cardenas, the MHBE Director of Policy and Plan Management.

1332 Waiver Presentation

Mr. Cardenas began by describing the state legislation enabling the reinsurance program—House Bill (HB) 1795 – Establishment of a Reinsurance Program and Senate Bill (SB) 387 – Maryland Health Care Access Act of 2018. He explained that the reinsurance program's attachment point has not been finalized because it depends on available funding. Mr. Cardenas explained that the reinsurance program is intended to address the large premium increased that have occurred over the past several years.

Next, Mr. Cardenas described how two outside organizations contributed to the waiver application process. The Wakely Consulting Group prepared the actuarial and economic analysis, and The Hilltop Institute developed the narrative portion of the waiver application.

Mr. Cardenas then provided a basic description of the waiver, explaining that it would reduce premiums by an average of 30 percent in the first year using a combination of state funds and federal pass-through funds. By allowing carriers to factor the reinsurance program into their premium rates, thus reducing those premiums, the MHBE expects the program to result in a 5.8 percent increase in individual market enrollment in 2019.

Next, Mr. Cardenas presented the four guardrails in which all 1332 State Innovation Waivers must comply. He explained that the proposed reinsurance program would be compliant with these guardrails. He added that, absent the waiver, the average premium is estimated to rise from $604.50 per month to $735.66 per month in 2019, whereas under the waiver, the average premium is expected to decrease from $604.50 per month to $508.03 per month. Mr. Cardenas emphasized that these estimates are based on average premiums and are not specific to any single carrier. An attendee asked if the expected premium decrease factors in subsidies, and Mr. Cardenas responded that that the estimate of the premium decrease is based on premiums without a subsidy.

Mr. Cardenas concluded his presentation by describing the upcoming opportunities to gather stakeholder feedback, including one additional hearing later in the week. He noted that there will be additional opportunities for stakeholder involvement in the regulatory process over the summer of 2018.

Q&A/Discussion

Mr. Cardenas then opened the floor for questions and discussion from the attendees.

An attendee commented that the reinsurance program will lower premiums, but asked if it will increase the number of plan options available through the exchange because the attendee is

currently paying $600 per month for a bronze plan with a $7,000 deductible. Mr. Cardenas responded that affordability is very important to the MHBE and that the reinsurance program will create a more favorable environment for insurers, which will hopefully encourage more insurers to participate in the exchange. Todd Switzer, Chief Actuary of the MIA, noted that the reinsurance program will have a greater impact on premium prices than one might think. For example, if a carrier files for a 50 percent rate increase, then the estimated 30 percent decrease from the reinsurance program would not result in a 20 percent rate increase but only a 5 percent rate increase because of how premiums are calculated. Mr. Switzer also asked if the attendee was referring to the fact that CareFirst recently decided to offer only one option for each metal level and that the number of Affordable Care Act (ACA) plans has decreased. The attendee responded that BlueCrossBlueShield is widely accepted, so it is difficult to look at another plan and determine the network; the only plan she can afford has a $7,000 deductible. The attendee reported that it is sometimes cheaper to self-pay rather than use insurance. Mr. Switzer thanked the attendee for her comments.

An attendee asked whether the MHBE was concerned that the option of federal pass-through funding for the reinsurance program could disappear given the changes the current administration has made to weaken the ACA. Mr. Cardenas responded that the section 1332 waiver is protected by statute and that there are currently no proposed regulations that would threaten the waiver. Furthermore, the administration is encouraging states to apply for waivers to implement state based reinsurance programs.

An attendee then asked if the waiver is working in other states. Mr. Cardenas responded that the states that are focusing their 1332 waiver solely on a reinsurance program have had success with their programs; states with multiple programs have had more difficulty. For example, Minnesota has a reinsurance program and basic health plan that both draw from the same pot of money.

An attendee asked if the reinsurance program is still a short-term solution and if there is a long-term plan. Mr. Cardenas confirmed that the reinsurance program is intended to be a short-term solution to control premium costs. Ms. Eberle noted that the waiver application is for five years, though the funding is for two and a half years. New state funding will need to be secured at that point.

An attendee expressed concern about limited carrier participation in the exchange. Ms. Eberle responded that the MHBE is reaching out to carriers and have heard that carriers are interested in the reinsurance program as a way to control the costs of high-risk enrollees. Bob Morrow, Associate Commissioner of the MIA, added that the MIA is constantly reaching out to carriers to encourage participation in the exchange and that it is a top priority. Ms. Eberle noted that a carrier must build its network before entering the marketplace, which can take well over a year.

An attendee asked whether wellness programs, which have been proven to lower healthcare costs, will be part of the reinsurance program. Ms. Eberle responded that public testimony is always helpful and will become part of the application. A section of the 1332 waiver addresses issuer incentives for containing costs and utilization, and the MHBE is interested in that issue.

Regarding carrier participation, Mr. Switzer added that there were seven carriers in the individual market and now there are two; all carriers have been invited to participate. The $365 million in state funding combined with the federal pass-through funding is expected to last for two years,

reducing premiums by 30 percent. This gives Maryland time to look for a long-term solution and the ultimate goal of attracting a more robust and healthier pool to stabilize the market.

An attendee expressed concern that the reinsurance program is a patch until the next step is figured out. She also expressed support of a previous comment regarding well care, stating it has been statistically proven to reduce the cost of healthcare. She commented that the reinsurance program looks like the beginning of a single-payer system; other countries have shown that a single-payer system reduces administrative overheard. She asked where the conversation is heading since the reinsurance program is only a short-term solution. She also commented that the estimated savings for the future tend to be optimistic and she expressed concern that there will continue to be a downward spiral. She commented that insurance companies are for-profit and are not interested in reducing healthcare costs; she reiterated that a single-payer system for Maryland may be a better long-term solution and that it has been shown to work. Mr. Cardenas thanked the attendee for her insight, and noted that SB 387 included a series of studies for the Maryland Health Insurance Coverage Protection Commission, such as Medicaid buy-in and an individual mandate. He encouraged attendees to supply comments. Mr. Morrow noted that these public hearings are not the right place to advocate for a single-payer system because the MIA and MHBE are implementing the rules that are passed. They may provide information to legislators, but they are not involved in the policy making process. He explained that this group is trying to implement the reinsurance program and receive federal approval of the Section 1332 waiver that the legislature authorized. The attendee commented that this group would be uniquely qualified to be the administrators of the single-payer system. Mr. Morrow responded that if single-payer legislation was passed that directed the MIA or MHBE to implement a single-payer system, then they would do so.

Regarding wellness programs, Mr. Switzer added that some carriers have such programs, and the MIA is seeking more information regarding the effectiveness of these programs and trying to bolster them. He noted that the MIA will be looking at whether there is a better way to distribute the premium tax credit. Mr. Morrow added that every carrier in the individual and group markets has some wellness program or component in their plans and that could be improved on.

An attendee commented that she is confused by the distribution of the tax credit because she is self-employed. Sometimes it makes more sense for her to file separately from her husband, but that in turn caused her to lose her subsidy, which she feels is not helpful or productive for someone in her situation. Mr. Cardenas responded that the ACA requires married couples to file jointly in order to be eligible for a tax subsidy. If a married couple files separately, then they are ineligible for a subsidy. A future Section 1332 waiver could fix that problem, but that would be further in the future. Ms. Eberle added that the MHBE can connect the attendee to a navigator or a broker to receive assistance with this problem.

An attendee asked if the MHBE and other medical groups are working towards a federal single-payer system because as long as insurance companies are involved, then it will always be for-profit and will not benefit consumers. Ms. Eberle responded that this is not the charge of the MHBE, which was created to roll out health coverage and provide a marketplace for individual insurance through the ACA. Any activity at the federal level must be done through federal policy, and she recommended contacting the federal delegation for Maryland. The attendee commented that the MHBE staff are the experts who should tell the federal government what they want. Ms. Eberle responded that the state legislators would need to direct the MHBE to take that action, as

they are a state agency implementing the rules. She noted that the MHBE can connect the attendee to the people to speak to.

An attendee asked if Maryland will act as the reinsurer if the waiver is approved. Mr. Cardenas responded in the affirmative. The attendee asked if Maryland was considering transferring the risk into the traditional reinsurance market after the program is established. He commented that this is a subsidy not a reinsurance plan, and asked if Maryland considered transferring the risk to the traditional reinsurance instead of taking the risk on their own. Mr. Morrow clarified that the attendee meant that Maryland could purchase a reinsurance plan to cover their obligations; he responded that Maryland has not considered this option but could do so in the future.

An attendee asked if the reinsurance program will be in place in time to affect 2019 rates since open enrollment starts on November 1, 2018. The attendee expressed concern that rates could change halfway through open enrollment. Mr. Cardenas responded that the Centers for Medicare & Medicaid Services (CMS) encouraged Maryland to apply for a waiver starting in 2019, to get relief to as many Marylanders as soon as possible. The MIA and MHBE stand ready to implement adjusted rates after the reinsurance program is established. The recommended approval date for the waiver is the end of July, and previous states have had their waivers approved quickly. For example, Oregon's waiver was approved in 99 days, so a quick approval is possible. The MHBE is trying to submit the application as quickly as possible. Mr. Morrow added that they recognize that time is of the essence and everyone is working very hard to get the waiver done quickly.

Public Testimony

Mr. Cardenas then invited any attendee who so desired to offer their testimony for the record. Five individuals offered testimony.

Gene M. Ransom, III, CEO of MedChi, offered the following testimony:

> *"First of all, I'm Gene Ransom. I'm CEO of MedChi, which is the Maryland State Medical Society, and on behalf of our members, we'd like to strongly support the application but we have three issues that we think need to be addressed before it moves forward. First and foremost, I'd say most important, we would like that language be included in the draft 1332 waiver that indicates the state's intent to include an adjustment in 2019 for federal risk adjustment payments. We think this is really important. This plan should be designed to stabilize the entire market for everybody and benefit all Maryland consumers equally. We don't want a situation where certain patients of my members are benefited more than others, and we think this is, from a fairness point of view, really important—that everybody be treated equally. We don't want a situation where the state is essentially picking winners and losers in the market. We also think, if you make this adjustment, it will be another incentive to solve the problem we've heard about where there are not carriers in the market and, if we're clear that we're treating everybody fairly and equally, we might attract more folks into the market. My members and MedChi have complained about the concentration in the health insurance market for years. Our rating is off the charts. We're one of the most heavily concentrated markets and it creates all kinds of problems. It creates problems on the cost side for patients. It creates problems for my physician members when they're negotiating contracts with the insurers, and this is an opportunity to either make it worse by subsidizing one carrier more than the others*

or make it better by subsidizing everybody equally, creating a fair and equal playing field.

The second issue that we think needs to be addressed is that specific payment incentives should be included in the reinsurance program that are aligned with the state's broader policy goals related to quality, cost effectiveness, and innovation. I also think that this would be an opportunity to address the wellness issues that came up before that Delegate Krimm and others have brought up. We also believe, specifically in that section, that the carriers should be required to participate and work collaboratively with CRISP, the other HIE, the HIE that's not here. We think that's really important. The population health tools and the work of the health information exchange can create a lot of opportunities for savings and better quality and better outcomes. We have one of the most highly recognized HIE's, again, health information exchange—the same acronym. I don't know why they do that. They should have given you guys different names. CRISP is recognized as one of the best-run HIEs in the country. There needs to be alignment. I don't think this is something that is a major problem. I think you might be able to do this even possibly with a resolution, maybe after the fact if it's a problem including in the application for approval reasons, but we just need to incentivize the carriers, particularly the dominant carrier, to participate with the information exchange so we can have better information and better outcomes.

The third thing, and I'm not saying you guys haven't done this, I just think that it's so important and it's such a high priority. We really just think that it's important for you to look at the newly approved—newly soon-to-be-approved hospital all payer Medicare waiver and make sure that this is properly aligned with the Medicare waiver. The Medicare waiver is really important to Maryland. MedChi has been working proactively with the state to get that approved, and we hopefully will have that approved in the matter of a few weeks or months maybe. We just think it's really important that that unique model that keeps our hospitals funded appropriately is aligned with this. And, again, I'm not saying it isn't, I'm just saying let's make a point to not screw that one up by accident. Let's look at it and combine the two.

So, in closing, I just want to reiterate that we really appreciate the work of Governor Hogan, of Commissioner Redmer, Secretary Neall who's in the back, and the Democrats in the General Assembly who really worked together in a bipartisan fashion to come up with this solution. We think it makes sense, and I think these three tweaks are positive changes that can be achieved before the application deadline. Thank you."

David Hexter, MD, Emergency Physician and Physician in Chief at Mid-Atlantic Permanente, offered the following testimony:

"Good afternoon, my name is David Hexter. I am an Emergency Physician and Physician-in-Chief at Mid-Atlantic Permanente. We care for the patients of Kaiser Permanente in the Baltimore area in general and the Baltimore area as well. Kaiser Permanente is one of only two carriers—we mentioned this several times—that is still on the exchange, and we're also the only one that cares for Medicaid patients. We first of all want to express our support for the section 1332 waiver reinsurance program and really applaud the state legislature, the Hogan administration, and Exchange for working to

move forward with this waiver application. And we believe that a reinsurance program like this if it's implemented fairly will go a long way to stabilizing the market and improve affordability, many of the problems of which you've heard today. But we think it must be, we believe it must be implemented fairly because the reinsurance program that Maryland develops should stabilize the entire insurance market and not just part of it. My fellow Permanente physicians are concerned that the reinsurance program as it is currently proposed will give an advantage to one health plan over another. We want to make sure that the rate relief that is provided by the program is spread across all Marylanders, not just those that enroll in one company's products. So unless a specific adjustment is made, the proposed program would allow carriers that are paid substantial amounts under the current federal risk adjustment program to be paid twice for accepting those higher-risk members under the reinsurance program. But why does this matter to consumers and patients? Well, if an adjustment is not included in the program, then the relief is going to be concentrated among a small minority of the individual market enrollees. And the majority of the consumers and patients will share less in the relief, and some including the 75,000 Marylanders who choose Kaiser Permanente through the exchange, many of whom are my patients, will experience much less premium relief. And as a Maryland physician, I want my patients to benefit from this reinsurance program that we're putting together to help keep their premiums affordable like everyone else in the state.

So we encourage the Exchange to include language in the draft section 1332 waiver application that indicates the state will adjust for this dynamic. And we also believe that Maryland should include incentives similar to what Mr. Ransom said in the reinsurance program that will align with broader state policy goals to improve quality and cost effectiveness of the care that is provided. To give you some ideas of some of these incentives that could be provided, you could reward high clinical ratings, for example breast cancer screening or colorectal cancer screening, controlling high-blood pressure. You mentioned the diabetes program before, we're able to control diabetes in the population. Shouldn't we be incentivized to do that? And thus designing a program that treats all carriers equitably and that includes these incentives for high-quality patient care and effective care management would attract new healthcare plans into the market, we want more choices as many of the people here today have indicated they want. And we want these carriers to focus on keeping people well, not just having them for a year and moving onto another carrier.

So in conclusion, we at Mid-Atlantic Permanente or Kaiser Permanente believe that the reinsurance program Maryland implements should not allow duplicate payments to be made to any one health plan. There can and should be an adjustment built into the program that makes sure that all patients who purchase their coverage in Maryland's individual market will benefit equally from this reinsurance. Finally, we should include incentives in the reinsurance program that are aligned with the state's broader policy goals in healthcare related to quality and cost effectiveness of care. Thank you very much, and I'm happy to answer any questions."

Ellen Lerner, consumer, offered the following testimony:

"I want to thank this group and the Maryland Health Benefit Exchange. I know your work is not easy; I think I am putting that mildly. I am certainly in favor of the application for this waiver. I hope we get it and we get it quickly. My sole purpose is to benefit those, well to everyone in the state of Maryland; I believe that everyone should be insured. I do want to caution as I did in my questions that this appears to be a patch, a very complicated patch. I hope it works. My husband is a physician. He practices as a teacher, teaching people about how to take care of themselves, how to be healthy, and he even still makes house calls to help people. To me, I know this isn't the purview of the Health Benefit Exchange ,but yet it is. I recognize this group as being the one who helps people to find the best insurance they can with what they have available to them and this will help make more available to them. But I also urge caution in that you are dealing with for-profit insurance companies and that, ultimately, I hope that this will be the beginning as I see it of trickling into, kind of backing ourselves into, a single-payer system. I truly think in the end that's what will be the best, and I highly encourage that this be recognized as that little crack. Thank you."

Delegate Carol Krimm of District 3A offered the following testimony:

"Just to update people on how this process went during General Assembly, so when we came into session the federal government had just taken their actions, and it was communicated to all the legislators that this was going to have a devastating effect on our budget because of the cost involved in trying to repair what the federal government had done to our health exchange. So the Speaker and the Health and Government Operations Committee put this special committee into place, a special task force. The Chairman is Delegate Joseline Peña-Melnyk who in my estimation is probably one of the most knowledgeable legislators on healthcare, and they started meeting on a weekly basis with people in the industry, other legislators, and we just tried to get everyone at the table and we were getting updated through this process. So what I want to communicate to you is that this is not over. You know this is what we have to do, I think you've heard the words short-term. So we will continue to work on this, and we had to make very quick decisions because of the impact that came done from the federal government and that's what we did and not to say we're not moving towards some goals you think we should have in healthcare. But this is where we are, and these are the people that are going guide us through the short-term, but we are going to continue the task force. So I would encourage the people here who have some very strong ideas on where we should be heading to get in touch with your legislators and let them know where you think we should be going because we're not done."

Annette Breiling, Healthcare as a Human Right, Chapter of Frederick, offered the following testimony:

"I'm sorry I came in late, and I'm with Healthcare as a Human Right, Chapter of Frederick and have long believed that everyone needs to get healthcare. And my understanding is that single-payer is the way that is ultimately going to have to happen, and the Medicare for all legislation is the way we're going to have to ultimately end up. My understanding also is that there are so many federal rules right now that are preventing a state to achieve this and the state whatever we can do to kind of move us in

that direction is what I advocate. So that's why I came here and wanted to promote any steps that are going to move us to be able to get everybody healthcare."

Closing

Ms. Eberle informed the audience that the MHBE has a navigator program and producers that can help consumers with assessing their options and navigate the system. Ms. Eberle closed the hearing and thanked everyone who attended.

Participants

Maryland Health Benefit Exchange
Michele Eberle, Executive Director
Andrew Ratner, Chief of Staff
John-Pierre Cardenas, Director of Policy and Plan Management
Kris Vallecillo, Senior Health Policy Analyst

Maryland Insurance Administration
Todd Switzer, Chief Actuary
Bob Morrow, Associate Commissioner

Maryland Department of Health
Robert Neall, Secretary

Maryland Department of Human Services
Lourdes, R. Padilla, Secretary

Maryland General Assembly
Delegate Carol L. Krimm

Members of the Public
Gene Ransom
David Hexter
Will Fawcett
Judith Rogers
Ellen Lerner
Mary Benove
Dan Mosebach
Amy Podd
Lisa Horner
Laurie Kuiper
Tinna Quigley
Rose McNeely
Kathy Ruben
James French
Mike Cumberland

Jeannette Bartlett
Natalie Ziegler
Annette Breiling

Maryland 1332 Waiver Hearing #4

Southern Maryland

May 10, 2018
Charles County Health Department
4545 Crain Highway
White Plains, MD 20695

Welcome & Introductions

Michele Eberle, Executive Director of the Maryland Health Benefit Exchange (MHBE), welcomed the public to the hearing and encouraged their participation.

1332 Waiver Presentation

John-Pierre Cardenas, MHBE Director of Policy and Plan Management, noted that this is the final of four public hearings. He began by describing the state legislation enabling the reinsurance program—House Bill (HB) 1795 – Establishment of a Reinsurance Program and Senate Bill (SB) 387 – Maryland Health Care Access Act of 2018. He explained that HB 1795 directs the MHBE to apply for a 1332 waiver, and SB 387 places a 2.75 percent assessment on premiums to fund the program. An attendee asked whether the tax applies to employer-sponsored or individual health plans. Mr. Cardenas responded that the tax will apply to any policy that is subject to the authority of the state. He further explained that the reinsurance program's attachment point has not been finalized because it depends on available funding and stakeholder input. The MHBE Board has already voted to approve a reinsurance cap of $250,000 and a coinsurance rate of 80 percent. Mr. Cardenas explained that the reinsurance program is intended to address the large premium increased that have occurred over the past several years.

Next, Mr. Cardenas described how two outside organizations contributed to the waiver application process. The Wakely Consulting Group prepared the actuarial and economic analysis, and The Hilltop Institute developed the narrative portion of the waiver application.

Mr. Cardenas then provided a basic description of the waiver, explaining that it would reduce premiums by an average of 30 percent in the first year using a combination of state funds and federal pass-through funds. By allowing carriers to factor the reinsurance program into their premium rates, thus reducing those premiums, the MHBE expects the program to result in a 5.8 percent increase in individual market enrollment in 2019. A member of the public asked whether the 5.8 percent increase refers to the percentage of individuals or the percentage of premiums. Mr. Cardenas responded that it is a 5.8 percent increase in the number of people enrolled.

Next, Mr. Cardenas presented the four guardrails in which all 1332 State Innovation Waivers must comply. He explained that the proposed reinsurance program would be compliant with these guardrails. He added that, absent the waiver, the average premium is estimated to rise from $604.50 per month to $735.66 per month in 2019, whereas under the waiver, the average premium is expected to decrease from $604.50 per month to $508.03 per month. Mr. Cardenas emphasized that these estimates are based on average premiums and are not specific to any single carrier.

Mr. Cardenas concluded his presentation, noting that there is still opportunity to submit written comments. He also noted that there will be additional opportunities for stakeholder involvement in the regulatory process over the summer of 2018.

Michele Eberle acknowledged several audience members, including MHBE Board Vice Chair Tony McCann, MHBE Standing Advisory Committee member Evelyne Ward, Maryland Insurance Administration (MIA) staff, and MHBE staff.

Q&A/Discussion

Mr. Cardenas then opened the floor for questions and discussion from the attendees.

An attendee asked whether non-core benefits will change under the waiver. Mr. Cardenas responded that the ten core essential health benefits will not change. Non-essential benefits are determined by the insurance company, and the waiver will not have a direct impact on these. The attendee also asked for the list of essential health benefits. Mr. Cardenas and Joseph Fitzpatrick, Assistant Chief Examiner, of the MIA listed the following benefits: ambulatory care, behavioral health, emergency services, hospitalizations, prescriptions, maternal and prenatal health, primary care, laboratory services, pediatric services, and rehabilitative and habilitative services.

An attendee asked if there is a "Plan B" if the federal government does not approve the waiver as expected. Mr. Cardenas responded that the MHBE has been working very closely with the federal government to ensure that the application is complete and ready for a quick response. He noted that the legislation authorizing the program is contingent upon federal approval, so further legislative action would be required if the federal government does not approve the waiver. Ms. Eberle commented that this would require a special session of the Maryland General Assembly.

An attendee asked about the program's effect on people who do not buy coverage through the exchange. Mr. Cardenas responded that the program applies to individual market rates both on and off of the exchange.

An attendee asked about the income requirements for participating on the exchange and what happens if someone's income exceeds that amount for a few months. Mr. Cardenas responded that subsidies are available to those up to 500 percent of the federal poverty level. He noted that individuals are expected to report income changes to the exchange within 30 days. Income for the upcoming plan year is predicted at the time of application, and this information is reconciled at the end of the year when taxes are filed. Ms. Eberle clarified that individuals with any income level can purchase on the exchange, but individuals can only obtain tax credits through the exchange.

Todd Switzer, Chief Actuary of the MIA, thanked the attendees for their participation and offered some additional comments. He stated that this waiver affects about 200,000 people in Maryland. Noting that the press release in regard to carrier rate increases was released earlier in the week, he explained that the impact of the reinsurance program is multiplicative. Mr. Switzer provided the theoretical example of a 50 percent rate increase coupled with the 30 percent decrease from the reinsurance program. He explained that this does not mean that there will still be a 20 percent increase in rates. He added that, if the increase is 50 percent, you multiply 1.5 by 0.7, and the increase in rates would be 5 percent and not 20 percent. Mr. Switzer explained that the reinsurance program has a much more leveraged impact, and he added that if the waiver is passed, it will have more of an impact than you might think. He stated that the reinsurance program will be more of an impact than just subtracting 30 percent.

Mr. Switzer emphasized the importance of the waiver and explained that the $365 million, over the full five years, gets leveraged up to $970 million, which is why the initial modeling can be stretched to try to improve the profile and risk of the pool to stabilize rates. Mr. Switzer stated

that there are still 360,000 uninsured in the state of Maryland, and about half of those people are eligible for a subsidy, whether it is Medicaid or a premium tax credit. He added that some of those uninsured people could get a free bronze plan, and economically speaking, people are making an irrational economic decision and leaving money on the table. Mr. Switzer expressed the hope that shining the light on this program will encourage people to take another look at insurance coverage.

An attendee noted that some of the literature she read stated that the waiver would limit the increase in premiums rather than decrease premiums. She asked if it is true that the waiver is supposed to decrease premiums, rather than just limit the increase in premiums. Mr. Switzer responded that a decrease in premiums is the hope, but there is no guarantee that it will happen. Mr. Cardenas added that the estimates provided are based on the data available currently, and a lot of it is projecting what will happen in 2019.

An attendee asked Mr. Switzer to explain the equation to determine the impact of the reinsurance program again. Mr. Switzer, using the example of a 50 percent overall increase, explained that you add 1 to the overall increase, which gives you 1.5, and then, with the reinsurance being a 30 percent decrease, you subtract the reinsurance percentage decrease from 1, which gives you 0.7. He continued by saying that when you multiply 1.5 by 0.7, you get 1.05. Mr. Switzer stated that whatever you get from that multiplying (1.05), you subtract 1, and that is what you can expect the impact of reinsurance to be. Mr. Cardenas added that every dollar magnifies its impact.

An attendee asked if any other states have applied for a Medicare waiver. Mr. Cardenas responded by clarifying that this is a 1332 waiver, which is for the Affordable Care Act, not necessarily Medicare. He note that a number of states have applied for 1332 waivers, and Minnesota, Oregon, and Alaska have been approved for reinsurance programs.

An attendee asked if there are any results from these other states. Mr. Cardenas responded yes and that the results have been promising. Mr. Cardenas provided Alaska's model as an example, stating that rates in Alaska were estimated to increase 40 percent, and rates only ended going up 7 percent. Mr. Cardenas added that Alaska is a unique example because Alaska is a small state with high costs. Mr. Cardenas also added that Oregon's and Minnesota's reinsurance programs have had downward impacts with lower rates of premium increases. Mr. Cardenas stated that the impact on each insurance company was also different because each company is different, and each company calculates their premiums differently. Mr. Switzer stated that Maryland is attempting to achieve the deepest discount that has been attempted so far. Mr. Switzer provided national context by adding that Minnesota attempted 20 percent and Oregon attempted 7 percent.

An attendee asked about the markets of the other states and if they only have two carriers like Maryland. Mr. Cardenas answered that Alaska has one, and Minnesota and Oregon have several participating insurance companies.
An attendee asked if this waiver could entice other carriers to come to the market. Mr. Cardenas answered that nothing is more attractive to an insurance company than a state that is committed to making the markets work, and the MHBE believes that a reinsurance program creates a more favorable environment. Mr. Cardenas stated that both the MHBE and the MIA work constantly to entice new insurance companies into Maryland.

Public Testimony

Mr. Cardenas then invited any attendee who so desired to offer their testimony for the record. Two individuals offered testimony.

Lore Rosenthal, consumer, offered the following testimony:

> *"Hi, my name is Lore Rosenthal, and I may be the only person in this room who is actually on the Maryland health exchange. So, I guess I just wanted to share my personal story. I am sure the insurance carriers here have heard it before, and I am sure some of the panelists have heard it before. But, it is good to hear from a real person I think. So, I work three days a week. I am not a wealthy person, but I earn more than the cut-off, which is $43,000, which is not a lot of money. This year, my premium, without any subsidy, is $1,000, and at the time when my premiums went up from whatever they were last year to the $1,000, there was not an increase in that cut-off of $43,000. So, you would think if they were going to double your premiums, they would have said, 'Oh, now you can earn like $53,000 and still get a subsidy.' Last year, with my old plan, my deductible was $2,500, and believe it or not, you can use up the entire $2,500 with one hospital stay. I happened to be in the hospital for a mental health reason, and it turns out my carrier did not cover inpatient mental health. So, I just blew through that money in five days.*
>
> *This year, my deductible has gone up to $3,500, and I am hoping that nothing is going to happen to me that I am actually going to blow through that money. You say that there is going to be a decrease of 30 percent, but so far the examples you have given is more that there was a decrease in the increase. So, I am very concerned that next year I may be paying $1,100, and yippee, it is $1,100 instead of $1,400. People cannot afford, and I think you realize that, if you're not on this subsidy, you cannot continue to afford that. It would never occur to me to just drop out of the program. I feel fortunate. I am a self-employed person, so I can't go through a company. I feel fortunate to have insurance. For some people, it must be like 50 percent of their income. People are saying that housing costs are going up, and electricity costs are going up. For poor people, they are paying exorbitant amounts. I am sure this is all in the newspaper too, but people are just paying too much for insurance, and it shouldn't be that way. I hope that you get the waiver, but I hope that in this case that the waiver gives us a 30 percent decrease, so I would only be paying like $700 a month instead of $1,000. Thank you."*

Michael Hartman, consumer, offered the following testimony:

> *"Hello, my name is Michael Hartman, and I am wondering if instead of a monetary amount for income, would it be possible to say that health costs should only be a percentage of your income? Let's say, 15 percent or whatever. Might that be a more fair way of looking at things and understanding that a person earning $10,000, if it's 10 percent then it's $1,000. If you're earning $20,000, it would be $2,000. It seems to me that might be a fairer way of looking at things. We look at things like Ms. Rosenthal mentioned about housing costs and generally, what is thought to be a good percentage is*

30 percent of your income for housing. Wouldn't it also be a good thing to put a percentage of your health care instead of a monetary amount? Thank you. "

Closing

Ms. Eberle thanked everyone who attended; she encouraged consumers to look closely at the plan options available and to download the mobile application, which provides GPS-located assistance. She also noted the helpline and Navigator program as sources of consumer assistance.

An attendee expressed gratitude to the MIA for exemplary service in interceding with an insurance company on her behalf. She also commended the navigators. Ms. Eberle thanked the attendee for her comments and closed the meeting.

Participants

Maryland Health Benefit Exchange
Michele Eberle, Executive Director
John-Pierre Cardenas, Director of Policy and Plan Management
Kris Vallecillo, Senior Health Policy Analyst
Tony McCann, Member, Board of Trustees

Maryland Insurance Administration
Todd Switzer, Chief Actuary
Bob Morrow, Associate Commissioner
Joseph Fitzpatrick, Assistant Chief Examiner

Members of the Public
Robert Axelrod
Tinna Quigley
R. Aaron Aist
Evalyne B. Ward
Sue Ehlenberger
Angela Deal
Louise Hayman
Lore Rosenthal
Michael Hartman

Comments Received Directly From Public

Commenter: Chet Burrell, CEO, CareFirst BlueCross BlueShield
Comment Received: Tuesday, April 24, 2018
Comment:

CareFirst's View

Kaiser Permanente's proposal to offset reinsurance with risk adjustment payments seeks to do what has never been done before and takes a position that was rejected by CMS when it operated the national ACA reinsurance program for three years.

The reinsurance and risk adjustment programs are wholly separate concepts and are designed to address different issues:

- Risk adjustment reflects the illness levels of all enrollees that have chosen each payer in a market and transfers funds from plans with low-risk enrollees to plans with high-risk enrollees in order to equalize the costs of the risk burden borne by each payer.

- Reinsurance covers a portion of the costs of a very small percentage (3-5 percent) of high cost enrollees in order to reduce premiums for all.

The suggestion of offsetting risk adjustments against the reinsurance calculation – in order to avoid a possible double payment - mixes the two concepts inappropriately with the effect of materially lessening the premium reducing impact of reinsurance on premiums. This undermines the central purpose intended in the recently enacted legislation.

CMS considered and explicitly chose not to subtract federal risk adjustment payments when implementing the federal reinsurance program. CMS explained its reasoning at the outset of ACA in the Proposed 2014 Notice of Benefit and Payment Parameters as follows:

> *"Adjusting for reinsurance payments in the HHS risk adjustment model would address the concerns that reinsurance and risk adjustment could compensate twice for the same high-risk individuals. Despite this potential, we* ***propose not*** *to adjust for reinsurance in the HHS risk adjustment model for a number for reasons:*
>
> > *First, removing reinsurance payments from risk adjustment would reduce protections for issuers of reinsurance-eligible plans that enroll high-cost individuals.*
> >
> > *Second, it would be difficult to determine what portion of reinsurance payments were made for conditions included in each HHS risk adjustment model, and the appropriate model adjustment for these payments."*

The MHBE should strongly take into consideration the analysis that CMS conducted and its conclusions.

Implementing Kaiser Permanente's recommendation could delay Maryland's 1332 waiver approval thereby threatening the State's ability to reduce premiums in 2019.

CMS has indicated that the expedited approval timeframe that Maryland seeks is based on current 1332 waivers that have already been approved in other states. No other state has attempted to include a modification to its reinsurance program to offset risk adjustment payments.

Kaiser's proposal assumes there is a 100 percent double payment by subtracting the entirety of risk adjustment payments from the reinsurance calculation. This is not true, and moreover, ignores the impact that a robust reinsurance program will have on risk adjustment transfers.

If Maryland were to operate the reinsurance program as CMS and other states have, the full impact of the reinsurance program would reduce statewide average premium by as much as 30 percent from the levels that otherwise would have occurred (based on the analyses done to date).

This, in turn, will reduce risk adjustment transfers – accomplishing much of what Kaiser seeks without lessening the power of reinsurance to maximally hold premiums down.

Kaiser seeks to justify its proposal, in part, because it makes an erroneous assumption that CareFirst is not managing costly PPO enrollees.

Kaiser appears to suggest that CareFirst is not managing the care of its PPO members. This is fundamentally untrue. CareFirst actively manages care for all members in both PPO and HMO products through its Patient Centered Medical Home (PCMH) and Total Care and Cost Improvement (TCCI) programs. In fact, a disproportionate number of ACA individual PPO enrollees are in care plans through which intense care coordination efforts are made for these enrollees.

The central idea in PPO plans is to allow enrollees access to a broad array of providers. This attracts a more adverse risk population to these products. If the State wishes to continue a PPO offering, this must be recognized.

To design a reinsurance program in a way that does not equally treat PPO products with reinsurance protection would make PPO products even more unaffordable than they already are. This would be directly counter to the intended purpose of the market stabilization legislation just enacted and to the enormous efforts made by the State to expand network access and adequacy to ensure all Marylanders have the broadest possible access to providers in the State.

CareFirst Recommendation.

It is essential to recognize that any lessening of the impact of reinsurance through a risk adjustment offset will drive up PPO (as well as HMO) premiums and undermine the purpose of

the recently enacted market stabilization legislation. Accordingly, prior to taking any further action in regulation or otherwise, the MHBE should direct Wakely to consider this impact and assess the impact of what Kaiser has proposed. CareFirst stands ready to cooperate with this effort and to work with Wakely toward an approach that fulfills the intent of the State to keep premiums for all individuals and their families as low as possible.

Commenter: Gene M. Ransom, III, CEO, The Maryland State Medical Society
Comment Received: Monday, May 7, 2018
Comment:

MedChi
The Maryland State Medical Society

Your Advocate.
Your Resource.
Your Profession.

May 7, 2018

Maryland Health Benefit Exchange
750 East Pratt Street
6th Floor
Baltimore, Maryland 21202
Sent: mhbe.publiccomment@maryland.gov

RE: 1332 Waiver Application

Dear Board Members:

MedChi, The Maryland State Medical Society, which represents more than 8,000 Maryland physicians and their patients, appreciates the opportunity to comment on the DRAFT Maryland 1332 Waiver Application being submitted by the Maryland Health Benefit Exchange (MHBE) to the United States Department of Treasury and the United States Department of Health and Human Services. MedChi strongly supports the Section 1332 waiver for the development of a reinsurance program. However, we have several minor adjustments that we feel are needed to improve the application prior to formal submission at the end of the month.

We understand and support the bipartisan action taken by the Governor and General Assembly to address the vital need to stabilize the individual health insurance market to ensure that the greatest number of Marylanders have access to affordable insurance. It is on this premise that MedChi believes that the program designed must stabilize the entire market and equally benefit all Maryland consumers. Specific comments are articulated below.

First, MedChi is concerned that the reinsurance program as articulated in the DRAFT Section 1332 Waiver Application will effectively advantage only some health plans and provide premium relief primarily to the consumers enrolled in those companies' products. Under the proposal, some health plans could essentially receive a "double payment," being reimbursed twice for higher-risk members because it fails to adjust carriers' reinsurance payments by the amount they already receive under the federal risk adjustment program. By favoring these carriers, the program is essentially determining "winners and losers." Ultimately, this has the impact of limiting the benefit received by consumers who choose those health plans for their coverage. Designing a program that treats all carriers equitably would have the added benefit of attracting new health plans into the market.

Therefore, MedChi requests that MHBE include language in the DRAFT Section 1332 Waiver Application that indicates the state's intent to include an adjustment in 2019 for federal risk adjustment payments to ensure that the program doesn't unfairly advantage some health plans

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over others. We believe including this language will improve the waiver application and would be accepted by CMS.

Second, MedChi believes specific payment incentives should be included in the reinsurance program which are aligned with the State's broader policy goals related to quality, cost-effectiveness and innovation. Incentives should be included that directly reward quality in care delivery through strategies like payment multipliers for high clinical quality ratings in preventive care measures such as breast cancer screening, colorectal cancer screening, controlling high blood pressure and care for diabetes and cardiovascular conditions. MedChi also believes that it is equally important to require all participating carriers to collaboratively work with the State's Health Information Exchange (CRISP). We think participation and working with CRISP and the population health tools should be considered as a broader policy goal alignment as well.

Since the central issue for applying for a reinsurance program is to make sure that costs can be stabilized for both the carriers as well as the consumers, MedChi believes that utilization practices of participating carriers should be examined. We also suggest not allowing non-staff model HMO product sold through the exchange to utilize prior authorization procedures.

In closing, we would also ask that the State make sure that the policies and procedures created and outlined in this waiver align with the term sheet agreement of the unique Maryland Medicare Hospital All Payer Waiver.

MedChi again strongly supports getting this application done, and we understand the importance of expediency. However, we need to take the time to make sure we don't create new problems or unintended consequences.

Sincerely,

Gene M Ransom III

Gene M. Ransom, III
Chief Executive Officer

1211 Cathedral Street • Baltimore, MD 21201-5516 • 410.539.0872 • Fax: 410.547.0915 • 1.800.492.1056 • www.medchi.org

Commenter: Vincent DeMarco, President, Maryland Citizens Health Initiative
Comment Received: Thursday, May 10, 2018
Comment:

HEALTH CARE for All
MARYLAND CITIZENS' HEALTH INITIATIVE
2600 ST. PAUL STREET BALTIMORE, MD 21218 P: (410)235-9000 F: (410)235-8963 WWW.HEALTHCAREFORALL.COM

May 10, 2018

Michele Eberle
Executive Director
Maryland Health Benefit Exchange
750 East Pratt Street, 6th Floor
Baltimore, MD 21202

Dear Executive Director Eberle,

The Maryland Citizens' Health initiative strongly supports the Reinsurance and Market Stabilization programs established for Maryland in the 2017 General Assembly Session and we very much agree that your agency should work to support this program through an application for a State Innovation Waiver under section 1332 of the Affordable Care Act. This proposal will help stabilize Maryland health insurance markets and protect consumers from large rate increases, and represents a win for both consumers and the health insurance industry— all at no net cost to the federal government. Maryland consumers have faced large double-digit rate hikes in the individual health insurance market in both 2016 and 2017, though, as you know, the much larger increases have happened more recently since the Trump Administration and Congress have been trying to undermine the ACA.

This Maryland Reinsurance Program is a needed first step toward a stable and sustainable individual health insurance market, but it is only a first step. We also urge the state to take action to address the underlying causes of instability and higher costs in the individual market. These causes include insurance market dynamics such as adverse selection, but they also include the excessive and rising cost of health care services and prescription drugs. And, we believe Maryland must move quickly to replace the soon to be defunct federal individual mandate with our proposed health insurance down payment plan. By providing needed immediate relief for consumers, we hope that the Maryland Reinsurance Program will help buy our state and our health care system time to do the hard work necessary to address the underlying drivers of health care costs.

We understand that you have been asked by Kaiser Permanente to make two adjustments to the proposed reinsurance plan -- to include incentives to continue to manage health care cost and utilization and to account for any risk adjustment payments received by carriers to avoid duplicate payments. We agree with Senate Finance Committee Chairman Thomas "Mac" Middleton in his letter of April 10 to you and Commissioner Redmer (attached) that you should give "serious consideration" to these ideas.

HEALTH CARE for All
MARYLAND CITIZENS' HEALTH INITIATIVE
2600 ST. PAUL STREET BALTIMORE, MD 21218 P: (410)235-9000 F: (410)235-8963 WWW.HEALTHCAREFORALL.COM

In considering Kaiser's proposal and other ideas related to the reinsurance plan, including those put forward by Carefirst, we know that you will put first and foremost what is in the best interest of Maryland's health care consumers. To assist you in doing this, we recommend that you put two questions to the Wakely Group the answers to which we believe could be very helpful to you as you work to develop a reinsurance plan that will make health care more affordable. We suggest that you ask Wakely to compare the impact of a standard approach to reinsurance with Kaiser's proposal on:

1. The extent to which reinsurance and risk-transfer payments would duplicatively cover the same claims, and,

2. The median consumer's health premium costs and the total risk level of the individual market.

On behalf of our Maryland Health Care For All! Coalition we heartily commend you and everyone at the Maryland Health Benefit Exchange for all the great work you have done and are doing to make the Affordable Care Act a success in our state. We stand ready to help you in any way that we can to build on this success to achieve our common goal of quality, affordable health care for all Marylanders.

Thank you for your consideration.

Sincerely,

Vincent DeMarco, President

THE SENATE OF MARYLAND
FINANCE COMMITTEE

April 10, 2018

Michelle Eberle
Executive Director
Maryland Health Benefit Exchange
750 E. Pratt Street, 6th Floor
Baltimore MD 21202

Alfred W. Redmer, Jr.
Insurance Commissioner
Maryland Insurance Administration
200 St. Paul Street, Suite #2700
Baltimore MD 21202

Dear Executive Director Eberle and Commissioner Redmer:

Thank you for attending the meeting that Chairman Pendergrass and I convened recently with representatives of Kaiser Permanente and Carefirst to discuss certain amendments that Kaiser requested to Senate Bill 387/House Bill 1782, the legislation which will generate funding in calendar year 2019 for a reinsurance mechanism for individual health insurance market stabilization. As you know, the legislation establishes a health insurance provider fee assessment at the rate of 2.75% on all amounts used to calculate the provider's premium tax or premium tax exemption value in calendar year 2018, with the proceeds of the assessment to be distributed to the Maryland Health Benefit Exchange Fund to support the reinsurance program. The intent is to recoup the aggregate fee that otherwise would have been assessed under § 9010 of the Affordable Care Act as a bridge to stability in the individual health insurance market.

The amendments requested by Kaiser Permanente would have required the reinsurance program under § 31-117 to (1) include incentives to continue to manage health care cost and utilization, and (2) account for any risk adjustment payments received by the carrier under 42 U.S.C. § 18063 to avoid duplicate payments, a potential circumstance noted in the March 15, 2018 report of the State's actuarial consultant, Wakely Consulting Group.

After discussion, the consensus at the meeting was that, in establishing the reinsurance program for 2019 and beyond, the MHBE, in consultation with the MIA, has the power to include incentives to manage health care cost and utilization and to account for risk adjustment payments to avoid duplication with reinsurance payments, if appropriate, even without the language requested by Kaiser being in the statute. There was also general agreement at the meeting that in

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410-841-3677 · 301-858-3677 · 800-492-7122, Ext. 3677

designing the reinsurance program, consideration should be given to including in the design incentives to manage cost and utilization and, if practicable, a mechanism to avoid duplication between risk adjustment and reinsurance to ensure the most effective use of the limited funding available.

We decided not to adopt the amendments requested by Kaiser because it is our understanding that you plan to consider inclusion of incentives to manage cost and utilization and a mechanism to avoid duplication between reinsurance payments risk adjustment payments in the reinsurance program. Accordingly, it is my hope and expectation that these elements will receive serious consideration as the parameters for the reinsurance program are established.

Thank you, again, for your assistance and cooperation during the 2018 session on this important legislation.

Sincerely,

Thomas M. Middleton

Thomas McClain Middleton
Chairman, Senate Finance Committee

TMM/PDC

Commenter: Mary Wontrop, Executive Director, Epilepsy Foundation Maryland; Philip Gattone, President & CEO, Epilepsy Foundation
Comment Received: Monday, May 14, 2018
Comment:

May 14, 2018

Michele S. Eberle, Executive Director
Maryland Health Benefit Exchange
750 East Pratt Street, 16th Floor
Baltimore, MD 21202

Re: Maryland Section 1332 State Innovation Waiver

Dear Director Eberle:

The Epilepsy Foundation and the Epilepsy Foundation Maryland appreciate the opportunity to submit comments on Maryland's Section 1332 State Innovation Waiver.

The Epilepsy Foundation is the leading national voluntary health organization that speaks on behalf of the at least 3.4 million Americans with epilepsy and seizures. We foster the wellbeing of children and adults affected by seizures through research programs, educational activities, advocacy, and direct services. Epilepsy is a medical condition that produces seizures affecting a variety of mental and physical functions. Approximately 1 in 26 American will develop epilepsy at some point in their lifetime. For the majority of people living with epilepsy, prescription medications are the most common and cost-effective treatment for controlling and/or reducing seizures, and they must have meaningful and timely access to physician-directed care.

The Epilepsy Foundation and Epilepsy Foundation Maryland believe everyone should have quality and affordable healthcare coverage. A strong, robust marketplace is essential for people with epilepsy to access the coverage that they need. Epilepsy Foundation and Epilepsy Foundation Metropolitan Washington support Maryland's efforts to strengthen its marketplace by submitting this 1332 State Innovation Waiver to implement a reinsurance program.

Reinsurance is an important tool to help stabilize health insurance markets. Reinsurance programs help insurance companies cover the claims of very high cost enrollees, which in turn keeps premiums affordable for other individuals buying insurance on the individual market. Reinsurance programs have been used to stabilize premiums in a number of healthcare programs, such as Medicare Part D. A temporary reinsurance fund for the individual market was also established under the Affordable Care Act and reduced premiums by an estimated 10 to 14 percent in its first year.[1]

Maryland's proposal will create a reinsurance program starting for the 2019 plan year and continuing for 5 years. This program is projected to reduce premiums by 30 percent and increase the number of individuals obtaining health insurance through the individual market by 5.8 percent. This would help patients with pre-existing conditions, including patients with epilepsy, obtain affordable, comprehensive coverage.

The Epilepsy Foundation and Epilepsy Foundation Maryland believe the 1332 State Innovation Waiver will help stabilize the individual market in Maryland and protect patients and consumers. Thank you for the opportunity to provide comments.

Sincerely,

Mary Wontrop
Executive Director
Epilepsy Foundation Maryland

Philip M. Gattone, M.Ed.
President & CEO
Epilepsy Foundation

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[1] American Academy of Actuaries, Individual and Small Group Markets Committee. *An Evaluation of the Individual Health Insurance Market and Implications of Potential Changes.* January 2017. Retrieved from https://www.actuary.org/files/publications/Acad_eval_indiv_mkt_011817.pdf.

Commenter: Deborah P. Brown, Chief Mission Officer, American Lung Association
Comment Received: Tuesday, May 15, 2018
Comment:

AMERICAN LUNG ASSOCIATION.
IN MARYLAND

May 15, 2018

Michele Eberle
Executive Director
Maryland Health Benefit Exchange
750 E. Pratt Street, Baltimore, MD 21202

Re: Maryland 1332 State Innovation Waiver Application

Dear Director Eberle:

The American Lung Association in Maryland appreciates the opportunity to submit comments on Maryland's 1332 State Innovation Waiver Application.

The American Lung Association is the oldest voluntary public health association in the United States, currently representing the 33 million Americans living with lung diseases including asthma, lung cancer and COPD, including over 729,000 Maryland residents. The Lung Association is the leading organization working to save lives by improving lung health and preventing lung disease through research, education and advocacy.

The Lung Association believes everyone should have quality and affordable healthcare coverage. A strong, robust marketplace is essential for people with lung disease to access the coverage that they need. The Lung Association supports Maryland's efforts to strengthen its marketplace by submitting this 1332 State Innovation Waiver to implement a reinsurance program.

Reinsurance is an important tool to help stabilize health insurance markets. Reinsurance programs help health insurance companies cover the claims of very high cost enrollees, which in turn keeps premiums affordable for other individuals buying insurance on the individual market. Reinsurance programs have been used to stabilize premiums in a number of healthcare programs, such as Medicare Part D. A temporary reinsurance fund for the individual market was also established under the Affordable Care Act and reduced premiums by an estimated 10 to 14 percent in its first year.[i]

Maryland's proposal will create a reinsurance program starting for the 2019 plan year and continuing for five years. The state estimates that the program will reduce premiums by approximately 30 percent and increase the number of individuals obtaining health insurance through the individual market by an estimated 5.8 percent in 2019. This would help patients with pre-existing conditions, including patients with asthma, COPD, lung cancer, and other lung diseases, obtain affordable, comprehensive coverage.

The American Lung Association in Maryland believes the proposed 1332 State Innovation Waiver will help stabilize the individual market in Maryland and protect patients and consumers, and we urge its adoption. Thank you for the opportunity to provide comments.

Sincerely,

Deborah P. Brown

Deborah P. Brown
Chief Mission Officer
American Lung Association

[i] American Academy of Actuaries, Individual and Small Group Markets Committee. *An Evaluation of the Individual Health Insurance Market and Implications of Potential Changes*. January 2017. Retrieved from https://www.actuary.org/files/publications/Acad_eval_indiv_mkt_011817.pdf.

211 E. Lombard St. | Baltimore, MD 21202
Ph: 804-302-5740 F: 888-415-5757 lung.org

Commenter: Janet Harvey, Private Member of Public
Comment Received: Tuesday, May 15, 2018
Comment:

To whom it may concern;

Hello my Name is Janet Harvey from Accident, MD. I'm sending this e-mail as I am unable to attend a hearing due to my work.

Health Care Concerns of the working middle class;

I have been a Maryland resident all my life I work 3 jobs and I am self-employed. I have never [drawn] a day's unemployment is my life. My average income a year is around $53,000.00. [The] first year that Insurance became a mandate my cost with Care First Blue Cross was $368.00 per year with a deductible of $3,500.00 year 2015. The next year 2016 my premium went to $412.00 with a $4,500.00 deductible, 2017 the premium went to $687.00 with a $6,550.00 deductible!!

That's when I decided I had to make a change and that is when I went to Christian Ministries and started paying $150.00 per month and joined a Brothers Keeper increase of $25.00 a Quarter for higher level care. This prevented the IRS from penalizing me at the end of the year. I have [driven a] school bus for 26 years and with the costs of Maryland Health care I was making myself sick worrying how I was to pay the premium and keep a roof over my head and a school bus on the road with working 3 jobs to survive. There is no cap on the deductible so at the start age of 54 when this system came to be at this rate my deductible would be with the current increase of $3,050.00 is two years by the age of 65 my deductible could well be $24,400.00 plus....ludicrous!!!! While I had Care First it would cost me $125.00 to go to Urgent Care which I had to pay because my deductible had not been met. With no insurance it cost me $35.00. A CDL physical cost $200.00 with Insurance and $75.00 with no Insurance. Also the fact that LAB CORP monopolizes blood work and completely over charges customers for labs that were never performed is a great concern!! When you have a Urine Culture sent out and they think you still have Insurance and bill an old policy number and you receive a denial of payment and come to find out that they was including Phlebotomy charge of $25.00 when no blood was drawn.... awful if they did this to 100,000.00 people a day....terrible !!!!
There are no caps on your deductibles which is ridiculous! Please feel free to contact me at any time!

I feel we need to be heard regarding the issue of affordable health care. Also we that live in GC should be able to go to Morgantown, WV for care and they are affiliated with Garrett Regional Medical Center in Oakland MD. We should not have to pay more to go to Morgantown it is so much closer than Baltimore or John Hopkins. Thank you!

Sincerely yours

Janet Harvey
Concerned Citizen

Commenter: Lydia L. Seiders, Maryland Volunteer State Ambassador, Rare Action Network
Comment Received: Tuesday, May 15, 2018
Comment:

May 15, 2018

Maryland Health Benefit Exchange

Re: Maryland Section 1332 State Innovation Waiver

Dear MHBE Board Members,

As Maryland State Ambassador for the Rare Action Network, powered by the National Organization for Rare Disorders (NORD), I appreciate the opportunity to submit comments on Maryland's Section 1332 State Innovation Waiver.

NORD is a unique federation of voluntary health organizations dedicated to helping people with rare "orphan" diseases and assisting the organizations that serve them. Since 1983, we have been committed to the identification, treatment, and cure of rare disorders through programs of education, advocacy, research, and patient services.

We believe everyone should have quality and affordable healthcare coverage. A strong, robust marketplace is essential for people with rare disorders to access the coverage that they need. NORD supports Maryland's efforts to strengthen its marketplace by submitting this 1332 State Innovation Waiver to implement a reinsurance program.

Reinsurance is an important tool to help stabilize health insurance markets. Reinsurance programs help insurance companies cover the claims of very high cost enrollees, which in turn keeps premiums affordable for other individuals buying insurance on the individual market. Reinsurance programs have been used to stabilize premiums in a number of healthcare programs, such as Medicare Part D. A temporary reinsurance fund for the individual market was also established under the Affordable Care Act and reduced premiums by an estimated 10 to 14 percent in its first year.[i]

Maryland's proposal will create a reinsurance program starting for the 2019 plan year and continuing for five years. This program is projected to reduce premiums by 30 percent and increase the number of individuals obtaining health insurance through the individual market by 5.8 percent. This would help patients with pre-existing conditions, including patients with rare disorders obtain affordable, comprehensive coverage.

I believe, as Ambassador, the 1332 State Innovation Waiver will help stabilize the individual market in Maryland and protect patients and consumers. Thank you for the opportunity to provide comments.

Sincerely,

Lydia L. Seiders
Maryland Volunteer State Ambassador

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[i] American Academy of Actuaries, Individual and Small Group Markets Committee. *An Evaluation of the Individual Health Insurance Market and Implications of Potential Changes.* January 2017. Retrieved from https://www.actuary.org/files/publications/Acad_eval_indiv_mkt_011817.pdf.

Commenter: Laurie G. Kuiper, Senior Director of Government Relations, Kaiser Permanente
Comment Received: Thursday, May 17, 2018
Comment:

KAISER PERMANENTE®

May 14, 2018

Maryland Health Benefit Exchange Board
Baltimore, MD

Dear Maryland Health Benefit Exchange Board,

As the people of Kaiser Permanente, we applaud the Governor and Legislature's attention to the reinsurance issue to ensure Maryland maintains a strong, stable individual market that provides access to high quality care and choices. We believe the goal of the Maryland reinsurance program should be to stabilize the entire individual market and benefit all Maryland consumers equally — not to pick competitive "winners and losers" by favoring one company over another in the program's design.

We are concerned that — as drafted — the waiver outlining the program effectively advantages one health plan, CareFirst, and specifically their PPO product, over all Maryland consumers. It would lead to CareFirst being paid twice for their participation in the individual market, as they also receive compensation for their risk through the federal risk adjustment program — amounting to a "double dip." We are concerned that most Maryland consumers will receive much less benefit from the reinsurance program overall.

We recommend adjusting the waiver proposal so that the structure accounts for these payments being made towards this same end — participation in the individual market. The program should put into place incentives that would result in lower rates for all Marylanders, and reward cost-effective, high quality care. We would also encourage policymakers to ensure that the final waiver includes incentives to both manage cost and utilization and encourage delivery system innovation. Such a shift would be consistent with Maryland's broader policy objectives around affordability and access.

This is a solvable problem, and there can and should be an adjustment as we build a solid individual market into the future. There are only two health plans remaining in the individual market in Maryland. This means that any policy proposals should be particularly mindful of how reinsurance, risk adjustment, and other requirements of this market will work in this specific context, and the critical need to encourage new plans to come into this market.

Sincerely,

The undersigned of the Kaiser Permanente Mid-Atlantic community

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
2101 E. Jefferson St.
Rockville, MD 20852

KAISER PERMANENTE®

Geneane	Adams	Anne Arundel
Ilene	Aiken	Montgomery
Jamie	Anderson	Prince Georges
Marbla	Atatsi	Montgomery
Valerie	Beckett	Montgomery
Mari-Viola	Bocchetto	Anne Arundel
Jayme	Brenneman	Montgomery
Laird	Burnett	Charles
Charlyn	Chandler	Baltimore
Maryam	Charmchi	Lane
Anne-Marie	Cox	Montgomery
Jill	Feldon	District of Columbia
Kelley	Flesher	Frederick
Kimberly	Fox	Montgomery
Mardela	Gonzalez	Prince Georges
Vilma	Gordon	Charles
Pamela	Hamorsky	Montgomery
Jeffrey	Hart	Montgomery
Denise	Hathaway	Alameda
Tara	Herberth	Baltimore City
Lena	Hershkovitz	Montgomery
Debbie	Jochum	Montgomery
Lauren	Kalastein	Anne Arundel
Becky	Kepple	Montgomery
Ryan	Mach	Alameda
Robin	McClave	Frederick
Gracelyn	McDermott	Howard
Shannon	Mcmahon	Montgomery
Dawda	Njie	Montgomery
Sam	Ongwen	Montgomery
William	Raisner	Montgomery
Marwan	Rateb	Baltimore City
Alma	Riberts	Montgomery
Daiga	Rutins	Montgomery
Jill	Sacks	Montgomery
Evetta	Sherman	Montgomery
Terri	Syme	Anne Arundel
Stephanie	Waszkiewicz	District of Columbia
Scott	Weier	District of Columbia

Please consider this very carefully. KP is a wonderful organization and benefits a major market in our state both from an insurer perspective and an employer perspective. Thank you.
Geneane Adams
Anne Arundel County

We are raising our voices to ensure a stable health insurance market that works for all Maryland consumers.
Jamie Anderson
Prince Georges County

Thank you for tackling this most difficult issue. Maryland should be the leader in providing affordable health care to all its constituents.
Mari-Viola Bocchetto
Frederick County

I urge you to put into place a measure that will provide lower health care costs for all Marylanders.
Jayme Brenneman
Anne Arundel County

It would be absurd and unconscionable to take the money that people pay to KP for an efficient and high-quality plan and give it to Carefirst, for their more expensive and lower quality plan (beyond the reasonable risk adjustment payments required by the ACA.) That's not stability or fairness, it's highway robbery.
Laird Burnett
Montgomery County

The decision you make will mean life and/or death to many Marylanders. Please reconsider how to move forward equitably in regards to the Maryland Health Exchange.
Anne Marie Cox
Baltimore County

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
2101 E. Jefferson St.
Rockville, MD 20852

KAISER PERMANENTE®

While we need to stabilize the individual plan market, Maryland needs to make sure its solution is fair to all those who live in the state, not just those with CareFirst insurance. Thank you.

Jill Feldon
Montgomery County

I support Kaiser Permanente's initiative to revise the current proposed legislation to be more equitable to all Marylander's.

Pamela Hamorsky
Charles County

Please ensure a stable health insurance market that works for ALL Maryland consumers.

Jeffrey Hart
Montgomery County

I am concerned that the bill as drafted is not equal for all. Please look closely at the impact and that it doesn't advantage CareFirst.

Debbie Jochum
Montgomery County

Please be sure your proposal creates incentives that reward cost-effective, high-quality care and result in lower costs for all Marylanders.

Robin McClave
Howard County

Kaiser Permanente is the only plan with the mission to provide affordable health care to all people. Unduly burdening this non-profit plan will give an unfair advantage to other plans that do not necessarily hold this goal as their priority. Please make the rule fair to Kaiser Permanente so they can continue to provide the region's highest quality care to their members and communities.

Jill Sacks
Montgomery County

As somebody who closely follows health policy, I'm deeply concerned that the re-insurance provision, as currently drafted, will further destabilize the market that it's seeking to fix. Why pump all that money to PPO plans and not support HMO plans that are proven to better integrate and coordinate care and get better value? This just doesn't make any sense.

Scott Weier
District of Columbia

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
2101 E. Jefferson St.
Rockville, MD 20852

Commenter: Scott Hancock, Executive Director, The Maryland Municipal League
Comment Received: Tuesday, May 15, 2018
Comment:

Maryland Municipal League
The Association of Maryland's Cities and Towns

May 17, 2018

Maryland Health Benefit Exchange
750 East Pratt Street
Baltimore, MD 21202

SUBJECT: Maryland 1332 Waiver Application & Reinsurance Program

Dear Sir or Madam:

Thank you for the opportunity to provide public comment on the Maryland Health Benefit Exchange's draft Section 1332 waiver application. The Maryland Municipal League applauds the State of Maryland's proposed immediate steps to stabilize the individual health insurance market.

The Maryland Municipal League (MML) represents 1.5 million Maryland residents living in the 157 incorporated cities and towns. It is estimated that a large percentage of municipal residents have taken advantage of Maryland's health exchange program since its inception and would be impacted by the actions proposed in the Section 1332 waiver and the reinsurance program.

MML believes a reinsurance program could be beneficial in reducing health insurance premium increases for the residents of municipalities that purchase their coverage in the individual market. The reinsurance program that Maryland develops, however, should be designed to stabilize premiums in the entire market and equally benefit all Maryland consumers that get their coverage through the individual market.

The League is concerned that the reinsurance program, as currently proposed, would benefit the enrollees of one health plan over the other. We want to make sure that the premium relief provided by the program is spread among all residents of our communities and not just those who are enrolled in one company's product. We fear that if an adjustment is not included in the proposed program, instead of all Marylanders seeing premium relief compared to what they would otherwise be required to pay in 2019, the relief will be concentrated among a much smaller number of individual market enrollees.

In conclusion, MML believes:

- All 1.5 million municipal residents throughout the State should benefit from reinsurance - to keep their premiums affordable – not just those who enroll in specific plans.

- There can and should be an adjustment built into the program to make sure all consumers and patients that purchase their coverage in Maryland's individual market benefit fairly and equally from reinsurance.

Thank you for your consideration.

Sincerely,

Scott Hancock
Executive Director

Commenter: Lisa B. Williams, CEO/Executive Director, Baltimore City Medical Society
Comment Received: Thursday, May 17, 2018
Comment:

BCMS
Baltimore City Medical Society

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info@bcmsdocs.org
www.bcmsdocs.org

May 16, 2018

Board of Directors
Maryland Health Benefit Exchange
750 Pratt Street, 6th Floor
Baltimore, MD 21202

Re: *Maryland Section 1332 Waiver Application (Draft)*

Dear Members of the Board:

Baltimore City Medical Society, a component of MedChi, The Maryland State Medical Society, the professional membership organization of physicians, supports the *Section 1332 Waiver Application ("Application")* for the development of a reinsurance program. We appreciate the opportunity to offer further comments on the Application.

We, too, are concerned that, as drafted, the reinsurance program outlined in the Application will advantage only some health plans and their patient subscribers. It is our position that the program must stabilize the entire market and equally benefit all plans and their subscribers. Adding language in the *Application* to address this concern would enhance the *Application*.

We encourage these additional enhancements to the Application: (1) delineating specific payment incentives to address quality of care, cost-effectiveness and innovation; (2) requiring all participating carriers engage with Maryland's health information exchange, Chesapeake Regional Information System for our Patients or CRISP; (3) examining utilization practices of participating carriers; and (4) assuring that the policies and procedures in the Application align with the term sheet agreement of the unique Maryland Medicare Hospital All Payer Waiver.

Again, we support the Application and appreciate your consideration of our concerns.

Sincerely,

Lisa B. Williams
CEO/Executive Director

Commenter: Maansi K. Raswant, Director of Policy and Data Analytics, Maryland Hospital Association
Comment Received: Friday, May 18, 2018
Comment:

Maryland
Hospital Association

May 18, 2018

Secretary Robert Neall
Chairman, Board of Trustees
Maryland Health Benefit Exchange
750 E. Pratt Street, 6th Floor
Baltimore, Maryland 21201

Dear Secretary Neall:

On behalf of the 64 hospitals and health system members of the Maryland Hospital Association (MHA), I offer support for and feedback on the state's application for a waiver under section 1332 of the Affordable Care Act.

Maryland's hospitals support broad-based, continuous health coverage as an essential pillar of the state's unique agreement with the federal government, otherwise known as the All-Payer Model. The current model started in 2014 as a five-year demonstration, at the same time coverage was expanded; the synergy between the two has made Maryland a model in the nation for holding costs down and improving quality. Hospitals therefore wholly back the state's application for a section 1332 waiver and efforts to develop a reinsurance program. The following suggestions will improve the state's application and the resulting reinsurance program.

First, the Maryland Health Benefit Exchange, working with the Maryland Insurance Administration, should hold carriers accountable to generate meaningful reductions in out-of-pocket costs, encouraging increased enrollment.

While the short-term goal of the reinsurance program is to stabilize the individual insurance market, it should also bolster health care coverage (the state projections that the reinsurance program will increase enrollment by 6 percent are encouraging). Ultimately, efforts to cushion losses for carriers via reinsurance should translate to lower premiums and, in turn, increased coverage. Expanded coverage ensures that more Marylanders will receive preventive care, and care in the most appropriate setting, thereby reducing avoidable hospital utilization; a key metric under the All-Payer Model. Also, growth in coverage is directly proportional to reductions in the amount of uncompensated care built into hospital rates, increasing cost savings to commercial carriers, the state, and federal government.

Second, the Board should include language in the 1332 waiver application indicating that the Maryland Health Benefit Exchange will explore care management incentives for carriers as part of the state reinsurance program.

The reinsurance program offers a unique opportunity to strengthen the link between health care coverage and delivery via the creation of care management incentives for carriers, specifically those aimed at high-risk, high-cost enrollees. To develop these incentives, target conditions and

populations could be identified using current data sources, such as carrier submissions for the federal risk adjustment program, the state's all-payer claims database, and Health Services Cost Review Commission analyses. While specific incentives would be determined via a state regulatory process following the submission of the 1332 waiver application, incentives focused on management of chronic conditions, better primary care, or behavioral health care access would all result in significant improvement in quality of care and cost reduction, matching the goals of the All-Payer Model. Any reduction in the cost of care would also decrease reliance on a reinsurance program.

Thank you for your leadership on this effort. Hospitals believe that patient-centered, quality, and efficient care depends on broad-based health care coverage and reiterate our strong support of the 1332 waiver application. Maryland's hospitals stand ready to continue to work with payers, other providers, and the state to provide Marylanders with a high-performing health care system, one where insurance carriers offer affordable coverage so that hospitals can continue to deliver efficient, high-quality care.

Please contact me should you need additional information.

Sincerely,

Maansi K. Raswant

Maansi K. Raswant
Director, Policy and Data Analytics

Commenter: Anna Davis, Health Policy Director, Advocates for Children and Youth
Comment Received: Friday, May 18, 2018
Comment:

ADVOCATES
FOR CHILDREN AND YOUTH

May 10, 2018

Michele Eberle
Executive Director
Maryland Health Benefit Exchange
750 E. Pratt Street, 6th Floor
Baltimore, Maryland 21202

Dear Executive Director Eberle:

Thank you for the opportunity to comment on the Maryland Health Benefit Exchange's proposed Section 1332 waiver application. Advocates for Children and Youth strongly supports the waiver application and the Maryland Reinsurance program. On behalf of all Maryland families with children, ACY commends the MHBE Board and staff for all that you are doing to help stabilize the individual insurance market and to protect consumers from high rate increases.

Access to health care is essential for achieving and maintaining proper health throughout the life course. The assaults on the ACA and ongoing repeal efforts at the federal level have made it more difficult for consumers to find affordable coverage and to keep healthier people in plans that meet the requirements of the ACA. The Maryland Reinsurance program is a critical and much needed first step toward stabilizing the individual health insurance market. MHBE acknowledges that the Reinsurance program is but a short-term fix for market stability. ACY is optimistic that the Reinsurance program will buy time for the state and insurers to work together to develop a long-term solution that will address the underlying causes of market distortion and rising health care costs.

It is ACY's understanding that numerous stakeholders have advocated that the MHBE consider including incentives for issuers to manage high risk enrollees and to coordinate the reinsurance program to account for the ACA's risk adjustment program. ACY agrees with the suggestion of Senate Finance Committee Chairman Thomas "Mac" Middleton that the MHBE, in consultation with the Maryland Insurance Administration (MIA), has the authority to include incentives to manage health care cost and utilization and to account for risk adjustment payments to avoid duplication with reinsurance payments. In designing the Reinsurance program, ACY urges the MHBE to take these stakeholder concerns into account and to employ those policy options that will promote consumer choice and achieve the broader goals of the reinsurance program.

Thank you for your consideration.

Best,

Anna Davis, JD, MPH
Health Policy Director

Commenter: Steve Butterfield, Regional Director of Government Affairs, Leukemia & Lymphoma Society
Comment Received: Friday, May 18, 2018
Comment:

LEUKEMIA & LYMPHOMA SOCIETY®

May 18 2018

Michele Eberle
Executive Director
Maryland Health Benefit Exchange
750 East Pratt St.
6th Floor
Baltimore, MD 21202

The Leukemia & Lymphoma Society (LLS) appreciates the opportunity to submit comments on Maryland's Section 1332 State Innovation Waiver, and respectfully submits the following.

At LLS, our mission is to cure leukemia, lymphoma, Hodgkin's disease and myeloma, and improve the quality of life of patients and their families. LLS exists to find cures and ensure access to treatments for blood cancer patients. LLS believes firmly that all patients and consumers should have access to high quality, stable coverage to ensure that they are able to receive appropriate and timely care. It is in service to these principles that we offer these comments in support of a reinsurance program in Maryland that prioritizes improved access to stable, affordable coverage for patients and consumers, as is proposed to be established by this waiver.

Cancer patients need access to meaningful health insurance coverage in order to access necessary care and treatment. LLS has adopted a set of Coverage Principles that outline what, exactly, from the organization's perspective, constitutes "meaningful" health insurance coverage.[1] Among these, LLS knows that meaningful coverage for cancer patients must be both affordable and stable. We feel that instituting a reinsurance program will help Maryland meet these standards.

Reinsurance programs in other states have shown promising initial results in controlling overall premium growth, and even, in some cases, resulting in premium reductions. Alaska, Oregon, and Minnesota all currently operate reinsurance programs on models similar to that proposed by this waiver[2], and all have received significant federal pass-through funding returned as a result of reductions in premium growth and, consequently, advanced premium tax credit (APTC) payments in their states.

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[1] *Principles for Meaningful Coverage*. The Leukemia & Lymphoma Society. Retrieved from http://www.lls.org/cancercost/Principles

[2] *State 1332 Waiver Reinsurance Proposals: Wisconsin Releases Draft 1332 Waiver Seeking $170 Million in Pass-Through Funding*. State Health Access Data Assistance Center. March 30 2018. Retrieved from http://www.shadac.org/news/state-1332-waiver-reinsurance-proposals-wisconsin-releases-draft-1332-waiver-seeking-170

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BEATING CANCER IS IN OUR BLOOD.

LEUKEMIA & LYMPHOMA SOCIETY®

In addition, Maine, prior to the implementation of the Affordable Care Act (ACA), operated a state-based reinsurance program that was estimated to reduce premiums by 12% to 15%.[3] Maine is now also seeking a 1332 waiver to reactivate their reinsurance association.

At the federal level, reinsurance programs have been used to stabilize premiums in a number of healthcare programs, such as Medicare Part D. A temporary reinsurance fund for the individual market was also established under the ACA and reduced premiums by an estimated 10% to 14% in its first year.[4]

Because LLS believes Maryland's 1332 State Innovation Waiver will help stabilize the individual market in Maryland and protect patients and consumers, we are pleased to support the establishment of a reinsurance program as proposed by this waiver.

Thank you for the opportunity to provide comments. Questions or requests for further information on LLS and our position can be addressed to Steve Butterfield, Regional Director of Government Affairs, at either 207-213-7254 or steve.butterfield@lls.org.

---

[3] *The Impact of PL90 On Maine's Health Insurance Markets*. Gorman Actuarial LLC. December 2011. Retrieved from http://www.maine.gov/pfr/insurance/publications_reports/archived_reports/pdf/gorman_actuarial_report.pdf

[4] *An Evaluation of the Individual Health Insurance Market and Implications of Potential Changes.* American Academy of Actuaries, Individual and Small Group Markets Committee. January 2017. Retrieved from https://www.actuary.org/files/publications/Acad_eval_indiv_mkt_011817.pdf.

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BEATING CANCER IS IN OUR BLOOD.

Commenter: Ashley Kenneth, Director of Advocacy and Policy, National Multiple Sclerosis Society
Comment Received: Friday, May 18, 2018
Comment:

National
Multiple Sclerosis
Society

National Multiple Sclerosis Society
Comments Regarding Maryland's Application for a Section 1332 State Innovation Waiver

Ashley Kenneth
Director, Advocacy & Policy

May 17, 2018

The National Multiple Sclerosis Society (the Society) is grateful for the opportunity to submit comments regarding Maryland's Section 1332 State Innovation Waiver application.

Multiple sclerosis (MS) is an unpredictable, often disabling disease of the central nervous system that disrupts the flow of information within the brain, and between the brain and body. Symptoms range from numbness and tingling to blindness and paralysis. The progress, severity and specific symptoms of MS in any one person cannot yet be predicted, but advances in research and treatment are leading to better understanding and moving us closer to a world free of MS. There are over 1 million people in the United States diagnosed with the disease, including at least 12,000 people in Maryland.

The National MS Society believes that everyone should have access to quality and affordable healthcare. Since 2014, the Affordable Care Act (ACA) health insurance marketplace has been an extremely important avenue to affordable, quality coverage for people living with MS. A strong, robust marketplace is essential for people with MS to access the coverage and care that they need.

However, insurance premiums are rising and will soon price people out of the healthcare system. The Society is committed to ensuring that people living with MS have reliable access to comprehensive health insurance plans with affordable premiums, deductibles, and out-of-pocket costs. Without market stabilization measures like reinsurance, Marylanders who are currently relying on the marketplace for their health insurance could lose their only affordable coverage option. The Society supports Maryland's efforts to strengthen its marketplace by submitting this 1332 State Innovation Waiver to implement a reinsurance program.

Reinsurance is an important tool to help stabilize the health insurance market by covering a percentage of the claims of very high cost enrollees. This will help make premiums more affordable for all individuals who buy insurance on the individual market. Maryland's proposed reinsurance program is projected to reduce premiums by 30% in 2019 and increase the number of individuals obtaining health insurance through the individual market by 5.8%. The program

will undoubtedly help people who live with MS, an expensive pre-existing condition, to obtain and retain affordable, comprehensive coverage.

The Society applauds Maryland for moving forward with this application and believes the 1332 State Innovation Waiver will help stabilize the individual market in Maryland while protecting consumers. If we can be of any assistance in the future to help increase access to health care in Maryland, please contact me at ashley.kenneth@nmss.org.

Commenter: Beth Sammis, President, Consumer Health First
Comment Received: Friday, May 18, 2018
Comment:

Consumer Health First

Access • Quality • Equity

May 18, 2018

Michelle Eberle
Executive Director
Maryland Health Benefit Exchange
mhbe.publiccomments@maryland.gov

Dear Ms. Eberle:

Consumer Health First (CHF), along with the undersigned 10 organizations and 11 indviduals, very much appreciates the opportunity to provide our strong support for Maryland's 1332 State Innovation Waiver Application. In doing so we wish to acknowledge the commitment of the General Assembly, the Insurance Commissioner and the Board of the Maryland Health Benefit Exchange (MHBE) to address the needs of Maryland's consumers by taking steps to stabilize the individual health insurance market.

One of the most important steps is to establish a state reinsurance program. We believe this should be designed to accomplish three goals: (1) equitably lower costs for HMO and PPO products; (2) improve health outcomes; and (3) promote consumer choice. We explain our thinking on each of these below with the understanding that there is still a lot more work to do to launch a state reinsurance program. During this process, we look forward to engaging with you and other stakeholders to be sure that the design of a state reinsurance program meets these three goals.

(1) Equitably Lower Costs for HMO and PPO products: There is a strong correlation between health status (the focus of the risk adjustment program) and claims (the focus of a state reinsurance program). It is theoretically possible that monies from both programs will overlap and benefit the product receiving all the risk adjustment monies thus reducing PPO premiums more than HMO premiums. Such an outcome runs counter to what we believe should be one goal of the state reinsurance program, equitable premium decreases for HMO and PPO products. To be sure this is achieved, we respectfully request that you simulate the impact of alternative attachment points on HMO and PPO premiums with, and without, adjusting for risk adjustment payments. We also recommend that the results of the simulation be made available to the public. This would help to guide the public discussion of the alternatives for the technical aspects of the state reinsurance program. In addition, it would lead to greater confidence on the part of the public in the final design of the reinsurance program.

(2) Improve health: A state reinsurance program provides an opportunity to incentivize carriers to develop meaningful health improvement programs. Such programs should, over time, reduce premium increases and help consumers lead healthier, more productive lives. A carrier's eligibility to receive funds from a state reinsurance program should be predicated on having such programs in place and we commend you for considering such an approach.

(3) Promote consumer choice: Consumers generally benefit when there is more choice. Today, consumers may select a PPO product offered by CareFirst or an HMO product offered by CareFirst or Kaiser Permanente. The reinsurance program should be designed, at a minimum, to maintain the participation of these two carriers in the individual market. Optimally, we hope that it will encourage other carriers to join the market. CareFirst, the state's only nonprofit health service plan, is required under the provisions of section 14-106 (d) (1) (ii) of the Insurance Article to offer products in the individual market, and so it cannot exit the market. Therefore, it is important that the design of Maryland's reinsurance program does not unintentionally competitively disadvantage Kaiser Permanente or other carriers.

In closing, we would like to thank you and the MHBE Board and staff for your efforts to recognize the challenges consumers are facing in finding affordable health insurance in the individual market. We believe that the pursuit of a 1332 waiver to establish a state reinsurance program is critical and we reiterate our strong support for this program. We very much appreciate the opportunity to provide our perspective on this issue and look forward to working with you and other stakeholders to be sure this program results in lower costs, better quality, and more consumer choice.

Sincerely,

Beth Sammis
President, Consumer Health First
bethsammis@gmail.com

Signatory Organizations:

Advocates for Children and Youth

League of Women Voters of Maryland

Maryland-DC Society of Addiction Medicine

Maryland Occupational Therapy Association

Mental Health Association of Maryland

NARAL-Pro Choice Maryland

National Alliance on Mental Illness Maryland

Primary Care Coalition

Progressive Cheverly

Public Justice Center

Signatory Individuals:

Rabbi Charles Arian

Laurie Caldwell

Laura Carr

Holly Cooper

Ward Cooper

Frank Mahlmann

Barbara Manns

Joan Moyers

Dee Schofield

Carol Stemple

Patricia Tice

Commenter: Susan G. D'Antoni, Executive Director, Montgomery County Medical Society
Comment Received: Friday, May 18, 2018
Comment:

MCMS
MONTGOMERY COUNTY, MD
MEDICAL SOCIETY

May 16, 2018

Maryland Health Benefit Exchange
750 East Pratt Street
6th Floor
Baltimore, Maryland 21202

Sent: mhbe.publiccomments@maryland.gov

RE: 1332 Waiver Application

Dear Board Members:

Montgomery County Medical Society (MCMS), a professional association for physicians practicing/resident in Montgomery County, Maryland, represents more than 1,600 Maryland physicians and their patients. We are a component of MedChi, The Maryland State Medical Society.

We appreciate the opportunity to comment on the *DRAFT Maryland 1332 Waiver Application* being submitted by the Maryland Health Benefit Exchange (MHBE) to the United States Department of Treasury and the United States Department of Health and Human Services. Overall, MCMS supports the Section 1332 waiver for the development of a reinsurance program. We understand the importance of stabilizing the individual health insurance market to ensure that the greatest number of Marylanders have access to affordable insurance. It is on that premise that MCMS believes that the program designed must stabilize the entire market and equally benefit all Maryland consumers.

We encourage inclusion of the following elements:

- Designing a program that treats all carriers equitably. This added benefit of attracting new health plans into the market. Under the current proposal, some health plans could receive double payments for higher risk members. We encourage the MHBE to include language in the draft Section 1332 waiver application that indicates the state's intent to include an adjustment in 2019 for federal risk adjustment payments to ensure that the program doesn't unfairly advantage some health plans over others.
- Payment incentives should be included in the reinsurance program which are aligned with the State's broader policy goals related to quality, cost-effectiveness and innovation. Incentives should be included that directly reward quality in care delivery through strategies like payment multipliers for high clinical quality ratings in preventive care measures such as breast cancer screening, colorectal cancer screening, controlling high blood pressure and care for diabetes and cardiovascular conditions.
- MCMS believes that it is important to require all participating carriers to collaboratively work with the State's Health Information Exchange (CRISP).
- Because the central issue for applying for a reinsurance program is to make sure that costs can be stabilized for both the carriers as well as the consumers, MCMS does believe that utilization practices of participating carriers should be examined, including not allowing non-staff model HMO product sold thru the exchange to utilize prior authorization procedures.

Thank you for the opportunity to provide comment re: *DRAFT Maryland 1332 Waiver Application.*

Sincerely,

Susan G. D'Antoni
Executive Director

Commenter: Teresa Healey-Conway, Executive Director, Anne Arundel & Howard County Medical Societies
Comment Received: Friday, May 18, 2018
Comment:

AAHCMS
ANNE ARUNDEL & HOWARD COUNTY MEDICAL SOCIETIES
224 Main Street
Annapolis, MD 21401
410-544-0312

May 18, 2018

Maryland Health Benefit Exchange
750 East Pratt Street
6th Floor
Baltimore, Maryland 21202
Sent: mhbe.publiccomment@maryland.gov

RE: 1332 Waiver Applications

Dear Board Members:

The Anne Arundel & Howard County Medical Societies (AAHCMS) wishes to comment on the *DRAFT Maryland 1332 Waiver Application* being submitted by the Maryland Health Benefit Exchange (MHBE) to the United States Department of Treasury and the United States Department of Health and Human Services. Overall, PGCMS supports the Section 1332 waiver for the development of a reinsurance program. However, we have a few concerns.

First, AAHCMS is concerned that the reinsurance program as outlined in the *DRAFT Section 1332 Waiver Application* does not treat all carriers equally. Under the current proposal, some health plans will be put at a disadvantage resulting in a limited benefit to people who choose those health plans for their coverage. Furthermore, unequal treatment amongst carriers will deter new carriers from joining the market.

AAHCMS proposes that the draft Section 1332 waiver application be revised to include a commitment to equitable treatment of all of the health plans. We believe this will improve the waiver application and be accepted by CMS.

Second, AAHCMS supports the creation of specific payment incentives be included that directly reward delivery of quality care.

Lastly, PGCMS believes that all participating carriers should work with the State's Health Information Exchange (CRISP) to make sure that costs can be stabilized for both the carriers as well as the consumers.

Sincerely,

Teresa Healey-Conway
Executive Director, AAHCMS

Commenter: Teresa Healey-Conway, Executive Director, Prince George's County Medical Society
Comment Received: Friday, May 18, 2018
Comment:

PRINCE GEORGE'S COUNTY
PGCMS
MEDICAL SOCIETY
EST 1903

224 Main Street
Annapolis, MD 21401
410-544-0312

May 18, 2018

Maryland Health Benefit Exchange
750 East Pratt Street
6th Floor
Baltimore, Maryland 21202
Sent: mhbe.publiccomment@maryland.gov

RE: 1332 Waiver Applications

Dear Board Members:

The Prince George's County Medical Society (PGCMS) wishes to comment on the *DRAFT Maryland 1332 Waiver Application* being submitted by the Maryland Health Benefit Exchange (MHBE) to the United States Department of Treasury and the United States Department of Health and Human Services. Overall, PGCMS supports the Section 1332 waiver for the development of a reinsurance program. However, we have a few concerns.

First, PGCMS is concerned that the reinsurance program as outlined in the *DRAFT Section 1332 Waiver Application* does not treat all carriers equally. Under the current proposal, some health plans will be put at a disadvantage resulting in a limited benefit to people who choose those health plans for their coverage. Furthermore, unequal treatment amongst carriers will deter new carriers from joining the market.

PGCMS proposes that the draft Section 1332 waiver application be revised to include a commitment to equitable treatment of all of the health plans. We believe this will improve the waiver application and be accepted by CMS.

Second, PGCMS supports the creation of specific payment incentives be included that directly reward delivery of quality care.

Lastly, PGCMS believes that all participating carriers should work with the State's Health Information Exchange (CRISP) to make sure that costs can be stabilized for both the carriers as well as the consumers.

Sincerely,

Teresa Healey-Conway
Executive Director, PGCMS

Commenter: Kim K. Horn, President, Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
Comment Received: Saturday, May 19, 2018
Comment:

KAISER PERMANENTE®

Mid-Atlantic Permanente Medical Group, P.C.
Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.

Submitted electronically to: *mhbe.publiccomments@maryland.gov*

May 20, 2018

Maryland Health Benefit Exchange
750 East Pratt Street
Baltimore, MD 21202

Re: *Draft Maryland 1332 Waiver Application*

Dear Sir or Madam:

Kaiser Permanente offers the following comments in response to the Draft Maryland 1332 Waiver Application published on April 20, 2018 by the Maryland Health Benefit Exchange (MHBE). Kaiser Permanente supports the Section 1332 waiver and a reinsurance program benefitting all Marylanders equally. We appreciate MHBE's commitment to stabilizing the individual market and offer recommendations in support of its waiver application.

Kaiser Permanente of the Mid-Atlantic States provides and coordinates complete health care services for over 780,000 members through 30 medical office buildings in the District of Columbia, Maryland and Virginia. Kaiser Permanente is a total health organization composed of Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., the Mid-Atlantic Permanente Medical Group, P.C., an independent medical group that is comprised of approximately 1,500 physicians who provide or arrange care for patients throughout the region, and Kaiser Foundation Hospitals which contracts with community hospitals for the provision of hospital services to our patients. Kaiser Permanente is committed to the individual market and the consumers who do not have access to group coverage.

Maryland's reinsurance program will significantly impact Kaiser Permanente and our members. As one of two carriers currently operating in the individual market in Maryland, Kaiser Permanente provides care and coverage to 46 percent of Maryland's on-exchange individual market as of April 2018. We experienced losses of $117 million in the individual market, or an average of negative 28 percent annually, between 2014 and 2017.[1]

A properly designed and fairly implemented reinsurance program may help stabilize individual market premiums. To ensure the greatest number of consumers realize the program's benefits, MHBE should include the following specific elements in its final Section 1332 waiver application:

1. A description and analysis of the varying impact of reinsurance on market participants.

[1] This represents Kaiser Permanente's loss on the Individual market from 2014-2016 plus an estimate for 2017.

2. Language describing MHBE's intent to ensure that the federal risk adjustment program and the Maryland reinsurance program do not duplicate payments for the same high-risk membership.
3. Language describing MHBE's intent to determine the extent of overlap between payments made under the federal risk adjustment program and the state reinsurance program.
4. Program incentives rewarding quality and cost-management.

We discuss these requests below.

MHBE Should Include a Description and Analysis of the Varying Impact of Reinsurance on Market Participants.

An equitably designed state-based reinsurance program mitigates the impact of high risk individuals on premiums caused by elimination of the Affordable Care Act (ACA)'s individual mandate penalty in 2019 and uncertainty at the federal level. It could also provide an incentive for more carriers to enter the individual market.

A poorly designed reinsurance program has the potential to reward carriers who are not effectively managing costs. MHBE should design its program to reward cost-management. The first step is an account and analysis of the varying impact of reinsurance on market participants. As the March 2018 Wakely Consulting Group report for the Maryland legislature noted "individual issuers may be affected differently by reinsurance. Issuers with relatively higher claims cost will receive relatively more reinsurance payments."[2] Accordingly, the final waiver application should acknowledge that variation and break out the anticipated effect on premiums by plan.

MHBE Should Account for Risk Adjustment in Structuring Its Reinsurance Program.

MHBE's final waiver application should clarify that the state intends to account for federal risk adjustment payment and to design a reinsurance program that pays only for uncompensated high risk. This will ensure that reinsurance funds have the broadest impact for all consumers, incentivize new market entrants and encourage current participants to remain. Kaiser Permanente is concerned that the reinsurance program proposed by the draft waiver application will effectively favor one health plan's membership and provide rate relief disproportionately to those consumers.

The ACA compensates carriers for high-risk members through a federal risk adjustment program that transfers money among carriers based on their enrollment of individuals with high cost diagnoses. As the Centers for Medicare and Medicaid Services (CMS) noted in its 2019 Notice of Benefit and Payment Parameters regulation, the scale of such transfers plays a crucial role in issuer decisions to participate in the individual market. Kaiser Permanente will transfer

[2] Wakely Consulting Group. (March 15, 2018). *State of Maryland: Individual Market Stabilization – Reinsurance Analysis*, 7.

approximately $80 million to CareFirst for the 2017 plan year to account for its higher risk membership in Maryland. We expect that amount to increase substantially in 2018 and beyond.

The goal of the Maryland reinsurance program should be to stabilize the entire individual market by benefitting all Maryland consumers equally. The draft application does not account for federal risk adjustment payments and thus fails to stabilize the entire market. Rather, the reinsurance funds will pay twice for the same members – first from the federal risk adjustment program and a second time for claims reimbursable under the Maryland reinsurance program. As previously discussed, this effect magnifies the existing distortion under risk adjustment and thereby picks competitive "winners and losers."

In addition, providing rate relief to healthier consumers, who overwhelmingly enroll in HMOs, is of paramount importance if the reinsurance program is to achieve its stated goal of stabilizing the Maryland individual market. As presently designed, the program directs over *one third* of reinsurance funds to premium relief for fewer than seven percent of the state individual market enrollment that chooses a PPO, while the remaining funds will provide significantly less rate relief to over 200,000 Marylanders enrolled in HMOs offered by both of the state's individual market carriers. This approach is sub-optimal for Maryland's individual market and produces an inequitable result for the vast majority of Maryland consumers.

MHBE's expert recognized this disparity in its own March 2018 analysis: "Some enrollees with Hierarchical Condition Categories (HCCs) will get compensated both for risk adjustment and reinsurance. The result could be very different profitability patterns within the market than currently exists, and the result could also vary depending on the chosen funding level and reinsurance parameters."[3]

Actuarial experts endorse the reinsurance-level adjustments for risk adjustment as sound policy. Milliman notes that "the current federal risk adjustment methodology does not account for payments from a state-based reinsurance program and can result in double compensation for high-risk members, both from the reinsurance program and from risk adjustment. This finding may be important to many other states considering reinsurance-like proposals under Section 1332 to help stabilize their markets. Specifically, if appropriate changes to risk-adjustment are not made, a reinsurance program could lead to pricing inefficiencies and distortions that negatively impact the market and could work against the goals of the reinsurance program overall."[4] Similarly, the American Academy of Actuaries has recommended against compensating insurers twice for the same risk.[5]

We do not believe including these adjustments will delay or compromise federal approval of Maryland's waiver. During a May 4, 2018 meeting with Kaiser Permanente, senior CMS career staff informed Kaiser Permanente that they did not foresee the inclusion of an element

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[3] Wakely Consulting Group. (March 15, 2018). *State of Maryland: Individual Market Stabilization – Reinsurance Analysis*, 7.

[4] Milliman. (August 2017). *Paring Risk Adjustment to Support State 1332 Waiver Activities*. Retrieved from http://www.milliman.com/insight/2017/Pairing-risk-adjustment-to-support-state-1332-waiver-activities/#.

[5] American Academy of Actuaries. (May 2017). *How Changes to Health Insurance Market Rules Would Affect Risk Adjustment*. Retrieved from http://www.actuary.org/content/how-changes-health-insurance-market-rules-would-affect-risk-adjustment.

accounting for federal risk adjustment payments to prevent carriers from receiving double compensation slowing their review of the waiver.

Maryland's program should not have the unintended effect of creating market distortions among products offered by the remaining two carriers in the individual market. The program design should promote stabilization and create a market that is more attractive to new entrants. We recommend that the waiver application specify that individual market plans that receive risk adjustment transfers will have those transfers "netted out" from claims on reinsurance funds.

MHBE Should Direct Wakely to Quantify Risk Adjustment Overlap.

While Kaiser Permanente believes the degree of overlap between risk adjustment payments and claims reimbursable through reinsurance is substantial, an actual estimate of the amount is unavailable without access to all carriers' claims data. Wakely Consulting Group, MHBE's retained actuary for purposes of this waiver, possesses the data necessary to quantify the overlap. We appreciate that MHBE has directed Wakely to project the overlap and inform stakeholders on the projection.

We ask that the analysis compare scenarios that would more evenly distribute reinsurance funding and avoid distorting the competitive balance in Maryland's individual insurance market. The analysis should also evaluate the impact of risk adjustment transfer reductions in 2020 on enrollment or affordability, should the state choose to exercise this authority.

We believe this analysis will be useful to regulators, MHBE and relevant stakeholders in the regulatory process for reinsurance program design.

MHBE Should Include Quality and Utilization Management Incentives.

As the United States moves towards value-based payment in health care, Maryland's reinsurance program should not move its individual market in the opposite direction. MHBE should include incentives in the reinsurance program aligned with the state's broader policy goals related to quality, cost-effectiveness and innovation. Incentives should reward quality in care delivery through strategies like payment multipliers for high clinical quality ratings in preventive care measures.

Integrated, managed care frequently outperforms PPO models in quality and cost-effectiveness. PPOs may be more expensive because of inefficiencies, such as ineffective care management, not just higher risk profiles. Maryland's reinsurance program should reward high-performing models and avoid compensating plans for inefficiencies.

In its final waiver application, MHBE should specify incentives for quality and cost-management. The CMS Checklist for Section 1332 State Innovation Waiver Applications requires states to address "whether the reinsurance program includes incentives for providers, enrollees, and plan issuers to continue managing health care cost and utilization for individuals

eligible for the described reinsurance (if any)."[6] A stated commitment in the application will strengthen the final application.

We recommend the state include multiplication factors in its design of reinsurance payments based on 1) third-party estimates of product and network cost-effectiveness and efficiency for each of Maryland's individual market products; and 2) achieving the highest ratings in clinical quality from the Maryland Health Care Commission's independent quality rating program. We believe this approach is consistent with the broader health policy goals of the MHBE.

With regard to the network efficiency factor, in the attached letter, Milliman estimates that a well-managed HMO in the Maryland marketplace has a 27 percent advantage over the state's PPO. MHBE should allocate reinsurance program dollars to reward this efficiency.

Taken together, these recommendations would distribute the benefits of the Maryland Reinsurance program roughly equally to all Marylanders enrolled in HMOs. Those enrolled in the PPO would still benefit disproportionately, but to a lesser extent. Specifically, with these adjustments, HMO enrollees would see significantly reduced proposed 2019 rates close to the expected overall market reduction and PPO enrollees would see proposed 2019 rates cut roughly in half (rather than by a significant 95 percent if no adjustments for double payment, cost effectiveness and clinical quality are made).

* * *

Thank you for your time and consideration. Please do not hesitate to contact Laurie Kuiper, Senior Director of Government Relations, at 301-816-6480 or Laurie.Kuiper@KP.org, if you have any questions or require additional information.

Sincerely,

Kim K. Horn
President
Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.

[6] *See* https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/Checklist-for-Section-1332-State-Innovation-Waiver-Applications-5517-c.pdf.

Milliman

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Via email only: Andrew.L.See@kp.org

May 18, 2018

Mr. Andrew L. See, FSA, MAAA
Vice President, Pricing
Kaiser Foundation Health Plan, Inc.
300 Lakeside Drive
Oakland, CA 94612

Re: Cost Benchmarks – Maryland

Dear Andrew,

At the request of Kaiser Foundation Health Plan ("Kaiser"), Milliman, Inc. ("Milliman") developed combined medical and pharmaceutical cost estimates for best-practices well-managed HMO networks and loosely-managed PPO networks in the state of Maryland. This letter provides the expected allowed cost differential of these networks and also describes the methodology and assumptions used in developing the cost estimates.

CONSULTING SERVICES AGREEMENT

This work was done under the terms of the Consulting Services Agreement between Milliman and Kaiser signed May 16, 2018.

BACKGROUND

Kaiser desires our assistance in obtaining a comparison of expected combined medical and pharmaceutical costs for well-managed HMOs and loosely-managed PPOs in the state of Maryland.

SUMMARY OF RESULTS

We developed illustrative combined medical and pharmaceutical cost models projecting the 2019 cost of care per member per month (PMPM) under each network assumption using the Milliman 2018 Commercial Health Cost Guidelines (HCGs)[1]. We used national standard demographics for the large-group market. The estimated allowed costs for a well-managed HMO is approximately 27% less than the costs for a loosely-managed PPO in the state of Maryland. **The cost projections used in estimating this differential represent a composite plan, network and medical management practices, not any specific plan, network or set of medical management practices.**

[1] The HCGs are a cooperative effort of all Milliman health actuaries and represent a combination of their experience, research and judgment. An extensive amount of data is used in developing the HCGs and that data is updated annually.

METHODOLOGY AND ASSUMPTIONS

To develop the cost estimates, we used the 2018 Milliman Commercial Health Cost Guidelines. The HCGs consider utilization and average charge levels for roughly 60 benefit categories. These models make provision, by type of service category, for benefit characteristics and cost-sharing such as copays, deductibles, coinsurance and out-of-pocket maximums. The model was adjusted for the following characteristics:

- Region: Maryland (Statewide)
- Product type: commercial HMO (well-managed) and PPO (loosely-managed)
- Network discounts: 60% Facility, 40% Professional

We used a single representative plan design for both the HMO and PPO plan, with no Out-of-Network component for the PPO plan, to determine the cost differences attributable solely to Degree of Health Management. The plan designs are shown in **Table 1**:

Table 1: Summary Plan Design:

Benefit	Cost Sharing
Deductible (Single/Family)	$1,500 / $3,000
Out-of-Pocket Maximum (Single/Family)	$3,500 / $6,000
Inpatient	$500/Day
Emergency Department	20%
Outpatient Surgery	20%
Preventive	$0
Primary Care Physician	$20
Specialist	$30
Other Medical Services	20%
Pharmacy:	
Generic	$10
Preferred Brand	$30
Non-Preferred Brand	$35
Specialty	20%

We applied trend to estimate claims incurred in 2019. We did not adjust for changes in morbidity or selection considerations.

VARIABILITY OF RESULTS

Differences between our estimates and actual amounts depend on the extent to which future experience conforms to the assumptions made for this analysis. It is almost certain that actual experience will not conform exactly to the assumptions used in this analysis. Actual amounts will differ from projected amounts to the extent that actual experience is better or worse than expected.

LIMITATIONS

It is our understanding that the information contained in this letter will be shared with the state of Maryland and may be utilized in a public document. Any distribution of the information should be in its entirety. Any user of the data must possess a certain level of expertise in actuarial science and healthcare modeling so as not to misinterpret the information presented.

Milliman makes no representations or warranties regarding the contents of this letter to third parties. Likewise, third parties are instructed that they are to place no reliance upon this report prepared for Kaiser Foundation Health Plan by Milliman that would result in the creation of any duty or liability under any theory of law by Milliman or its employees to third parties.

DATA RELIANCE

For our analysis, we have relied on information provided to us by data contributors and vendors. We have not audited or verified this data. If the underlying data or information is inaccurate or incomplete, the results of our analysis may likewise be inaccurate or incomplete.

PROFESSIONAL QUALIFICATIONS

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. The author of this letter, Susan E. Pantely, is a member of the American Academy of Actuaries, and meets the qualification standards for performing the analysis in this letter.

Sincerely,

Susan E. Pantely, FSA, MAAA
Principal and Consulting Actuary

Commenter: Tinna Quigley, Executive Director, Alliance of Maryland Dental Plans
Comment Received: Saturday, May 19, 2018
Comment:

The Alliance of Maryland Dental Plans

May 20, 2018

Michelle Eberle
Executive Director
Maryland Health Benefit Exchange
750 East Pratt Street, 6th Floor
Baltimore, MD 21202

RE: Maryland 1332 Innovation Waiver Application

Dear Executive Director Eberle,

Thank you for the opportunity to provide input as the State prepares the 1332 Waiver Application. I am writing on behalf of the Alliance of Maryland Dental Plans to express the concerns of our member dental plan companies about the proposed reinsurance program.

Our members think that it is of paramount importance for the State to find a long-term, broad-based funding solution to address our current challenges with the health insurance markets in the State that create stability for funding, require all stakeholders to be a part of the solution, limit the impact on any one constituency, and minimize the cost to individual Marylanders who will ultimately carry the burden. We look forward to being actively engaged in the Maryland Health Insurance Coverage Protection Commission as it continues its work on this issue throughout the interim and are willing to serve on any workgroups and provide stakeholder input as the co-chairs deem appropriate.

Our members are committed to Maryland and are supportive of steps taken to stabilize the State's insurance markets. While we understand that the 2.75% assessment is a short-term fix, we are concerned that stand-alone dental plans are subject to the assessment in Senate Bill 387/House Bill 1782 despite the fact the dental plans will not see any benefit from the proposed reinsurance program.

We would respectfully inquire how the Maryland Health Benefit Exchange (MHBE), in conjunction with the Maryland Insurance Administration, plan to use reinsurance funds, if any, to enhance dental plans.

As the MHBE has used ample opportunity to promote the expanded take-up of dental coverage in promotion of the Exchange's value as an organization and as a pathway to better health for Marylanders, we think it is appropriate to continue to extend dental coverage in appropriate ways as we move forward in conjunction with a new reinsurance program framework. We would ask that if our

companies are subject to an assessment in which they will see no return, there be a continued commitment in which our companies would be presented with a landscape to thrive.

Please do not hesitate to contact me at 240-476-9308 or tquigley@fblaw.com should you have any questions or concerns. Members of the Alliance of Maryland Dental Plans greatly appreciate the consideration of our concerns.

Sincerely,

Tinna Quigley

Tinna Quigley
Executive Director
Alliance of Maryland Dental Plans

Attachment 4. Public Hearing Process

MARYLAND HEALTH BENEFIT EXCHANGE

MHBE 1332 Waiver Public Hearing Agenda	**Section 1332 of the Affordable Care Act (ACA) permits a state to apply for a State Innovation Waiver (Section 1332 waiver) to pursue innovative strategies for providing their residents with access to high quality, affordable health coverage.** **Before submitting its Section 1332 waiver application, the state must also provide a public notice and comment period, including public hearings, sufficient to ensure a meaningful level of public input, and enact a law providing for implementation of the waiver.**

PUBLIC HEARING AGENDA		
Topic	**Presenter**	**Time Allotted**
Welcome, Introductions, and Purpose of the Public Hearing	MHBE | MIA | MDH	5 minutes
Maryland 1332 State Innovation Waiver Application: Walkthrough & Estimated Impact	MHBE	15 minutes
Question and Answers	MHBE | MIA | MDH Staff	10 minutes
Public Comments	Public	Until hearing end
Closing Remarks	MHBE	

Public Hearing Locations, Dates, and Times:

1. **Thursday, April 26, 5 p.m. to 6 p.m., at the Talbot County Department of Parks and Recreation (Chesapeake Room), 10028 Ocean Gateway, Easton, MD 21601**
2. **Thursday, May 3, 4 p.m. to 5 p.m., at the office of the Maryland Health Benefit Exchange, 750 E. Pratt St., 6th Floor, Baltimore, MD 21202**
3. **Monday, May 7, 3 p.m. to 4 p.m., at the Frederick County Local Health Department, 350 Montevue Lane, Frederick, MD 21702**
4. **Thursday, May 10, 5 p.m. to 7 p.m., at the Charles County Local Health Department, 4545 Crain Highway, White Plains, MD 20695**

MARYLAND HEALTHBENEFIT EXCHANGE

Maryland State Innovation Waiver Application:

State Reinsurance Program

April 20 – May 20, 2018

State Reinsurance Program Legislation & Action to Date

MARYLAND HEALTHBENEFIT EXCHANGE

- Two bills from the 2018 Maryland Legislative Session impact the State Reinsurance Program House Bill 1795 – Establishment of a Reinsurance Program & Senate Bill 387 Maryland Health Care Access Act of 2018.

- Signed by Governor Larry Hogan on April 5 and April 10. These bills are a bipartisan short-term solution to address premium affordability and market stabilization in Maryland's individual health insurance marketplace.

- HB 1795, establishes a claims-based State Reinsurance Program to offset the impact of high cost enrollees in the individual marketplace. MHBE is required to apply for a State Innovation Waiver under section 1332 of the Affordable Care Act. Implementation of the program is contingent upon approval of waiver application.

- SB 387 places a 2.75% assessment on carriers to recoup the aggregate amount of the health insurance provider fee that was previously assessed under Section 9010 of the ACA. The Tax Cuts and Jobs Act to 2017 waived this fee for 2019. This funding source provides an estimated $365 million (MIA/OCA) for the State Reinsurance Program.

State Reinsurance Program Legislation & Action to Date

MARYLAND HEALTHBENEFIT EXCHANGE

- Applying for State Innovation Waiver allows the State to access federal pass-through funds to supplement the State Reinsurance Program - maximizing the impact of State funding.
- Important requirements to be included in a State Innovation Waiver include a funding level and parameters for the program. SB 387 supplies the funding level requirement.
- HB 1795 directs the MHBE Board of Trustees to determine parameters for the State Reinsurance Program. During the April 2018 Board meeting the MHBE Board of Trustees approved a resolution that supplies the parameters to be included in the draft State Innovation Waiver application:

  - an attachment point that will be determined based on funding availability and consideration of stakeholder feedback, a coinsurance rate of 80%, and a cap of $250,000.

- MHBE released the State Innovation Waiver Application for public comment on Friday, April 20, 2018.

State Reinsurance Program Legislation & Action to Date

MARYLAND HEALTHBENEFIT EXCHANGE

- MHBE has worked with Wakely Consulting Group, contracted through the Department of Legislative Services, to prepare the actuarial and economic analysis of the waiver.

- MHBE leveraged the Hilltop Institute at UMBC to develop the narrative portion of the application through an existing MOU.

State Innovation Waiver Application Walk-through and Estimated Impact

MARYLAND HEALTHBENEFIT EXCHANGE

- Maryland seeks to waive Section 1312(c)(1) of the Affordable Care Act – determination of the market index rate. This would allow Maryland carriers to include expected State Reinsurance Program payments when determining their market index rate. The higher the index rate, the higher the premium.

- Maryland is seeking federal pass-through funding, through net APTC savings, to fund a reinsurance program that targets a 30% premium reduction for 2019 and 2020. Total program costs for 2019 are approximately $462 million.

- The decreased premiums will decrease federal spending on APTCs. The actuarial analysis estimates that federal savings will be $280 million, $293 million, and $32 million in 2019, 2020, and 2021, respectively.

- Maryland estimates that the premium impact will result in a 5.8% increase in individual market enrollment in 2019.

State Innovation Waiver Application Walk-through and Estimated Impact

MARYLAND HEALTHBENEFIT EXCHANGE

- Four "guardrails" apply to 1332 State Innovation Waivers. The waiver must:
  1. Provide access to quality health care that is ***at least as comprehensive*** as would be provided without the waiver.
  2. Provide access to quality health care that is ***at least as affordable*** as would be provided without the waiver.
  3. Provide coverage to ***at least a comparable number*** of residents as would be provided without the waiver.
  4. Does **not increase the federal deficit**.

- Maryland's 1332 State Innovation Waiver is compliant with these guardrails. Guardrails two, three, and four are affected by the waiver. It would decrease premiums by 30 percent from what they would be absent the waiver, increases enrollment by 5.8% in 2019, and saves $695 million over the 10-year budget window.

- Average premiums for 2018 in the individual market are $604.50 per month. Absent the waiver, premiums are estimated to rise to $735.66 in 2019. With the reinsurance program, premiums are estimated to be $508.03 - a net **decrease** from 2018.

State Innovation Waiver Application Walk-through and Estimated Impact

MARYLAND HEALTHBENEFIT EXCHANGE

- Its important to note that these estimations are based on average premiums and are not specific to any single carrier participating in the individual market.

- Each carrier has unique and specific factors that go into their rate determinations. The reinsurance program may have different impacts on each carrier.

- The MHBE Board of Trustees has left the attachment point for the reinsurance program to be determined at a later date after consideration of stakeholder feedback and additional carrier data is available.

- HB 1795 directs the MHBE Board of Trustees to adopt regulations administering the State Reinsurance Program and program parameters no later than January 1, 2019. MHBE will engage stakeholders over the summer of 2018 to inform the regulatory process.

Public Hearings Timeline and Opportunities to Provide Comment

- MHBE will host four public hearings across the state to gather public input:

  Thursday, April 26, from 5 to 6 p.m. at the Chesapeake Room at the Talbot County Department of Parks and Recreation located at 10028 Ocean Gateway, Easton, MD 21601

  Thursday, May 3, from 4 to 5 p.m. at the office of the Maryland Health Benefit Exchange, 750 East Pratt St., 6th Floor, Baltimore, MD 21205

  Monday, May 7, 3 to 4 p.m., at Frederick County Local Health Department, 350 Montevue Lane, Frederick, MD 21702

  Thursday, May 10, from 5 to 7 p.m., at the Charles County Local Health Department, 4545 Crain Highway, White Plains, MD 20695

- All supply written comments for the 1332 State Innovation Waiver to mhbe.publiccomments@maryland.gov. The comment period ends on May 20, 2018.

MARYLAND HEALTHBENEFIT EXCHANGE

Thank you!

For more information: marylandhbe.com
Comment: mhbe.publiccomments@maryland.gov

750 EAST PRATT STREET, 16TH FLOOR
BALTIMORE, MD 21202
marylandhbe.com

MARYLAND HEALTH BENEFIT EXCHANGE

Maryland 1332 Waiver Hearing

April 26, 2018
Talbot County Department of Parks and Recreation
10028 Ocean Gateway
Easton, MD 21601

Welcome & Introductions

Michele Eberle, Executive Director of the Maryland Health Benefit Exchange (MHBE), welcomed the public to the hearing and introduced herself along with other MHBE staff in attendance. She acknowledged the presence of staff from the Maryland Insurance Administration (MIA), as well as Delegate John Mautz and a staff member from the office of Senator Adelaide Eckardt.

Ms. Eberle provided a brief overview of the proposed state reinsurance program then introduced John-Pierre Cardenas, the MHBE Director of Policy and Plan Management.

1332 Waiver Presentation

Mr. Cardenas began by describing the state legislation enabling the reinsurance program—House Bill (HB) 1795 – Establishment of a Reinsurance Program and Senate Bill (SB) 387 – Maryland Health Care Access Act of 2018. He explained that the reinsurance program's attachment point is not yet finalized since it depends on the available funding.

Next, Mr. Cardenas described how two outside organizations contributed to the waiver application process. The Wakely Consulting Group prepared the actuarial and economic analysis, and The Hilltop Institute developed the narrative portion of the waiver application.

Mr. Cardenas then provided a basic description of the waiver, explaining that it would reduce premiums by an average of 30 percent in the first year using a combination of state funds and federal pass-through funds. By allowing carriers to factor the reinsurance program into their premium rates, thus reducing those premiums, the MHBE expects the program to result in a 5.8 percent increase in enrollment in 2019.

Next, Mr. Cardenas laid out the four guardrails in which all 1332 State Innovation Waivers must comply. He explained that the proposed reinsurance program would be compliant with these guardrails. He added that, absent the waiver, the average premium is estimated to rise from $604.50 per month to $735.66 per month in 2019, whereas under the waiver, the average premium is expected to decrease from $604.50 per month to $508.03 per month.

Mr. Cardenas concluded his presentation by describing the upcoming opportunities to gather stakeholder feedback, including three additional hearings in the coming weeks. He noted that there will be additional opportunities for stakeholder involvement in the regulatory process over the summer of 2018.

Q&A/Discussion

Mr. Cardenas then opened the floor for questions and discussion from the attendees.

An attendee asked whether, in the event that the reinsurance program does not meet its savings targets, consumers will have to make up the difference. Mr. Cardenas replied in the negative.

An attendee asked whether the reinsurance program would affect only on-exchange policies. Mr. Cardenas replied that the program would involve all individual market policies, both on- and off-exchange.

An attendee asked whether the 30 percent reduction in average premium is expected in the first year, or averaged over two years. Mr. Cardenas replied that the program is expected to realize the 30 percent reduction in the first year and maintain that level into the second year.

An attendee asked whether the reinsurance program would cover Medigap policies. Mr. Cardenas replied in the negative, noting that the waiver only has jurisdiction over individual market policies governed by the Affordable Care Act.

An attendee asked the likelihood that the waiver program would continue into 2020. Mr. Cardenas replied that the waiver application covers a five-year period, meaning that the program would run from 2019 through 2023, with the opportunity for extensions beyond 2023.

An attendee asked what the MHBE expects to happen with premium prices in 2021 and beyond. Mr. Cardenas replied that, while they do not know exactly what is going to happen at that point, they hope for continued savings. He added that the chief strategy for market health in that extended period is to attract additional insurance carriers into the market and a healthier risk pool.

An attendee, noting that some portion of the funding for this program would come from a fee on insurance companies, asked whether that fee would negatively impact premiums in the group market. Mr. Cardenas replied that, since the fee was already calculated into the rates, the affect on group premium would be neutral.

Public Testimony

Mr. Cardenas then invited any attendee who so desired to offer their testimony for the record.

James Burdick offered the following testimony:

> *"As a doctor, I'd like to see everybody get health care. And, actually, I meant what I said about Maryland. Congratulations to the work that's been done and other good things that are happening in Maryland compared to other states, so this isn't a criticism. But, long run, as I said, stepping back, a national health program, improved Medicare for all, single payer system would get rid of the admittedly confusing, or at least complicated, details and also save money, cover everybody, and improve quality. It's really true. Senator Pinsky has introduced a bill in the Senate and there is some enthusiasm for a state single-payer bill. I'd like to see a national program, ideally, but I just want to provide that perspective on the complexity and the potential lack of insurance or uncertain insurance for so many Marylanders still, in spite of the great work that you have been doing."*

Closing

Ms. Eberle closed the hearing and thanked everyone who attended.

Participants

Maryland Health Benefit Exchange
Tony McCann, Member, Board of Trustees
Michele Eberle, Executive Director
Andrew Ratner, Chief of Staff
John-Pierre Cardenas, Director of Policy and Plan Management
Kris Vallecillo, Senior Health Policy Analyst

Maryland Insurance Administration
Todd Switzer, Chief Actuary
Brad Boban, Senior Actuary
Joseph Fitzpatrick, Assistance Chief Examiner

Maryland Department of Health
Robert Neall, Secretary
Nikki Laska, Director, Communications

Maryland General Assembly
Delegate Johnny Mautz
Melissa Einhorn, Office of Senator Addie Eckhardt

Members of the Public
Kathy Ruben
Elizabeth Carson
Larry Carson
Matt Celentano
Laurie Kuiper
Dan Mosebach
Chester King
Billy D. Weber
Karen Millison
Jim Burdick
Paul Davin

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MARYLAND HEALTH BENEFIT EXCHANGE

Public Hearing - Maryland 1332 State Innovation Waiver
Thursday, April 26, 2018
Talbot County Department of Parks and Recreation

SIGN-IN SHEET

DISCLAIMER: This is a public hearing. As such, all questions and comments presented during this hearing will be entered into the public record and made available for inspection by any person or governmental unit pursuant to Title 4 of the General Provisions Article.

NAME	ORGANIZATION	EMAIL	Check if you would like to speak
Kathy Ruben	Consumer Health First	Kathyruben@consumerhealthfirst.org	☐
Elizabeth Carson	Health care is a Human Right, MD	carsl221@hotmail.com	☐
Larry Carson	"	Karasov1@hotmail.com	☐
Matt Celentano	League of Life and Health Insurers	mcelentano@fblaw.com	☐
Laurie Kuipers	Kaiser Permanente		☐
Dan Mosebach	CareFirst	daniel.mosebach@carefirst.com	☐
Chester King	CONSUMER	SEAKING98@HOTMAIL.COM	☐
Nikki Lassiter	MDH		☐
Del. Mautz			☐
Billy D Weber	Me (Ins. Agt)	bdweber@verizon.net	☐
Karen Millison	CareFirst	Kmillison@carefirst.com	☐
Melissa Einhorn	Senator Adelie Eckardt	meinhorn@senate.state.md.us	☐

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MARYLAND HEALTH BENEFIT EXCHANGE

Public Hearing - Maryland 1332 State Innovation Waiver
Thursday, April 26, 2018
Talbot County Department of Parks and Recreation

SIGN-IN SHEET

DISCLAIMER: This is a public hearing. As such, all questions and comments presented during this hearing will be entered into the public record and made available for inspection by any person or governmental unit pursuant to Title 4 of the General Provisions Article.

NAME	ORGANIZATION	EMAIL	Check if you would like to speak
Jim Burdick	HCHF PNHP	jburdic1@yahoo.com	☑
Paul Davin		pdavin84@gmail.com	☐
Todd Switzer	MIA	todd.switzer@maryland.gov	☐
Brad Boban	MIA	bradley.boban@maryland.gov	☐
			☐
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750 EAST PRATT STREET, 16TH FLOOR
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MARYLAND HEALTH BENEFIT EXCHANGE

Maryland 1332 Waiver Hearing

May 3, 2018
Maryland Health Benefit Exchange
750 E. Pratt Street, 6th Floor
Baltimore, MD 21205

Welcome & Introductions

Michele Eberle, Executive Director of the Maryland Health Benefit Exchange (MHBE), welcomed the public to the hearing and introduced herself. She explained the process and purpose of the 1332 waiver hearings and provided a brief overview of the current state of the marketplace and the proposed state reinsurance program.

She acknowledged the presence of staff from the MHBE and the Maryland Insurance Administration (MIA) and introduced John-Pierre Cardenas, the MHBE Director of Policy and Plan Management.

1332 Waiver Presentation

Mr. Cardenas began by describing the state legislation enabling the reinsurance program—House Bill (HB) 1795 – Establishment of a Reinsurance Program and Senate Bill (SB) 387 – Maryland Health Care Access Act of 2018.

Mr. Cardenas emphasized the importance of stakeholder input on the proposed reinsurance program and gave a brief summary of the proposed reinsurance program, including funding sources. He explained that the reinsurance program's attachment point has not been finalized because it is dependent on the available funding.

Mr. Cardenas then described how two outside organizations contributed to the waiver application process. The Wakely Consulting Group prepared the actuarial and economic analysis, and The Hilltop Institute developed the narrative portion of the waiver application.

Mr. Cardenas provided a basic description of the waiver, explaining that it would reduce premiums by an average of 30 percent in the first year using a combination of state funds and federal pass-through funds. By waiving Section 1312(c)(1) of the Affordable Care Act, carriers are allowed to factor the reinsurance program into their premium rates, resulting in a reduction of those premiums. The MHBE expects the program to result in a 5.8 percent increase in individual market enrollment in 2019.

Next, Mr. Cardenas presented the four guardrails in which all 1332 State Innovation Waivers must comply. He explained that the proposed reinsurance program would be compliant with the guardrails. He added that, absent the waiver, the average premium is estimated to rise from $604.50 per month to $735.66 per month in 2019, whereas under the waiver, the average premium is expected to decrease from $604.50 per month to $508.03 per month. Mr. Cardenas emphasized that the estimations presented are based on average premiums and are not specific to any single carrier.

Mr. Cardenas concluded his presentation by describing the upcoming opportunities to gather stakeholder feedback, including two additional hearings in the coming weeks. He noted that there will be additional opportunities for stakeholder involvement in the regulatory process over the summer of 2018.

Q&A/Discussion

Mr. Cardenas then opened the floor for questions and discussion from the attendees.

There were no questions.

Public Testimony

Mr. Cardenas then invited any attendee who so desired to offer their testimony for the record. Three individuals offered testimony.

John Kunkel, Chief Financial Officer, Kaiser Permanente, offered the following testimony:

> *"I am proud to represent Kaiser today. We are the only insurer that participates in both the exchanges and the Medicaid program, so we are very much impacted by the 1332 waiver. I would reiterate what JP said at the outset. This is something very cool. Kaiser Permanente supports this waiver. What is important to us is that it is done in a very thoughtful and balanced way, and so I will focus my brief comments today around how we believe that should work. And for us it is all about impacting all Marylanders equally regardless of who your insurance carrier is. As the board is aware, Kaiser is concerned that the program could advantage one health plan over the other. We want to make sure that this rate relief that was referenced is spread across everyone and that no carrier has the ability to be paid twice, a double dip concept for both the risk adjustment program as well as this reinsurance program that will hopefully be created for 2019. The issue of double payments is something that has been written about widely by experts, such as the American Academy of Actuaries and Milliman.*
>
> *We have asked the staff of MHBE to seek an estimate from Wakely who is uniquely positioned to look at this because they have the data for the carriers in Maryland. We understand that that work is forthcoming, and we are very appreciative of that. We think that will be important and very instructive to understand the dynamics and ensure that we create the right program for Maryland. So why would this matter to a consumer? During the presentation, it was referenced that this could bring rates down by 30 percent. What is important to Kaiser is that this brings everyone's rates down 30 percent or at least as well as you can model that. We are afraid that the minority will see a disproportionate level of rate decrease and the majority, including the 75,000 members that utilize Kaiser Permanente's care delivery system today will see less than a balanced shift. We would also urge the MHBE to include language in the draft Section 1332 waiver that would indicate the state's intent to implement this type of program.*
>
> *We believe CMS would not hesitate to approve a waiver with this language. And finally, we believe that a program that treats all carriers equally will increase the chances of additional carriers coming to the state. Today, we only have two carriers: Kaiser Permanente and CareFirst, and Kaiser Permanente is not statewide. Our delivery system does not cover all of Maryland. A balanced program that treats carriers equally, particularly those who are incentivized around controlling costs would make Maryland more attractive to additional competitors. In conclusion, Kaiser Permanente believes three important things. One, the program should not allow duplicate payments to be made to any health plan. Two, the program should benefit all Marylanders as equally as possible and not disproportionately those enrolled in just one type of plan. And finally, that this is a solvable problem that we have the data and we have the time to design a program that would accomplish the goals that I have laid out today. So, thank you for your consideration."*

Beth Sammis, President, Consumer Health First, Board of Directors, offered the following testimony:

> *"I am President of the Board of Consumer Health First, a statewide consumer advocacy organization, and I am here today to deliver our strong support for the 1332 waiver for all of the reasons that JP so eloquently stated. Obviously, all of us know that consumers who do not qualify for financial assistance have borne the brunt of the eye-popping premium increases over the last four years of the Affordable Care Act, and from the data that was provided by the MIA to the General Assembly of this year, we know that premiums in the individual market for consumers who do not qualify for financial assistance range from 26-73 percent of their after tax income. I would submit to you that if any of us in the group market were required to pay anything close to that then we would respectfully decline that coverage from our employers, and so to us this is a crisis deserving of some solution. Although I must say that we see the reinsurance program together with a very thorough rate review, which we are going to be working with the MIA to ensure happens, is one way to modestly impact the rates, but long-term we believe that there is going to have to be other solutions. One of the solutions that we advocate is a Medicaid buy-in.*

We understand that there is still a lot of work to do before the reinsurance program is launched. You've made many of the decisions about some of the technical aspects of this program already. Regarding the cap on the reinsurance payments, it is much lower than the cap was at the federal level, the federal reinsurance program, and it is much lower than, at least what we understand, what other states have done. We understand that is being done primarily because you want deeper coverage, and so we would certainly support that. We are concerned for slightly different reasons but along the same lines of concern that Kaiser has already expressed, that this reinsurance program will not equitably impact all consumers. It is not so much that we are concerned about what happens to Kaiser, with all due respect. But, there is a difference between the PPO market and the HMO market. In the PPO market, we know that the risk adjustment program that has been put in place at the federal level, all of those monies go to the PPO product, and the monies raised for that program are from the HMO market. Those HMO premiums are in effect increased in order to subsidize the PPO product because the PPO product has higher risks.

We know that theoretically there are many who have argued that when you have a reinsurance program and it is combined with a risk adjustment program that nothing further needs to be done, but we are concerned that that is not the truth. And, that it is particularly not going to be the case given the level and the scale of this particular program. So, our ask is that during this time period between now and the end of the year that you take the claims data from 2017 and do a simulation of what exactly would have happened if there had been in effect the risk adjustment program, which of course we know will be in place, and you know what those payouts will be for the 2017 plan year in June and then simulate what the reinsurance payments would have been in 2017 to be sure that the attachment points and whether or not there should be any true up between the risk adjustment program and the reinsurance program so that the percentage decrease in premiums that we expect on average is the same for HMO products and PPO products. I think that we are well aware of the fact that there can be plan differences, there can be differences between Kaiser and CareFirst, but at the end of the day, if we are looking at a 30 percent reduction in rate increase, that should be the same whether or not you are enrolled in an HMO or a PPO. Otherwise, we believe that that is an unfair subsidy again on the part of HMO members.

We also understand that, to us anyways, there is the potential, and I wouldn't say that it is absolute, but it is a potential, that consumers would see this in an inequitable way if their premium decreases were not similar for the HMO and PPO products. This could also lead to some market distortions and would lead some carriers, in particular Kaiser Permanent, to rethink their commitment to this market. After all, Kaiser Permanente is not required by law to remain in the individual market. It is another reason why we have seen other carriers depart; they are a business, and they get to decide if they want to stay in this line of business or not. That is not true for CareFirst. CareFirst is the state's only non-profit health service plan, and under the provisions of Section 14-106 (d)(1)(ii) of the Insurance Article, they are required to offer products in the individual market and thus, may not exit. It is not in consumers' interest to have only CareFirst HMO and PPO products. It is in our interest to have more carriers. I am doubtful about the number of other carriers coming in, but at least we should try to hang on to those that are already here. And, obviously some consumers have elected to join Kaiser Permanente and believe that it best meets the needs of them and their families.

Finally, we would ask that we take this opportunity with the development of a state reinsurance program where essentially carriers are going to be given a pretty significant amount of money to help out with their travails in this market to put in place meaningful health improvement programs. There is no requirement in Maryland, that I know of, that the Exchange has placed on carriers in the individual market or any other market to demonstrate they are in fact well aware of the healthcare conditions that are driving up premiums and that they have developed meaningful interventions to control those costs going forward. I believe that is in consumers' interests for two reasons. One is that if they are effective, they will lead to a lower rate of increase, which is in consumers' interests, and second of all, if they are effective, it should mean that consumers who have these chronic conditions lead healthier, more productive lives, which is in all of our interests as well as theirs. Again, I would like to close by thanking you for moving forward with this effort, to the Secretary for being here to listen, and we look forward to working with you to try to bring as much benefit to the market as possible to all consumers. Thank you."

Jeff Ratnow, consumer, offered the following testimony:

> *"I am a consumer on the Exchange. I am going to give you my personal story. In 2015, I was fired, and I decided that now was the time to start my business. I started my business. My parents said to me, 'What are you going to do for health insurance?' because health insurance was always provided by my company, and I didn't really think about that. I was so grateful that Obamacare was in effect, and I went to a broker on Eastern Avenue in Highlandtown. He said, 'You're all set. You qualify for Medicaid,' so through the Affordable Care Act, because I was making no money, I got to build my business. As soon as I made $75,000, I got my bill of $650 a month, $3,500 premium [deductible]. That isn't bad. That is kind of reasonable. That is a good deal. The next year, I grew my business a little bit more, and the reward is $1,200 a month, about the same premium [deductible]. Okay, still alright, but now, it is getting tight at home. I have two kids and a wife, a wife with a pre-existing condition. I found out that I do because I had a sleep apnea test 20 years ago that has been flagged since then, so we are essentially uninsurable without the public markets.*
>
> *So, those of you who buy on the market, I am sure you watched with bated breath when the Republicans tried to kill Obamacare. I had nightmares. When John McCain voted against it, it was better than any Ravens SuperBowl ever. It was literally preserving my chance to live the American dream and build my business because without that, I knew I would have to give up and go get a job. So, the next year, my premium then went up to $1,350 a month with a $13,000 deductible. We go skiing, and now we have to make choices. My son breaks his arm. I didn't know if he broke his arm. We kind of waited it out a little bit. Urgent care is about $300, and they are just going to put him in a splint. What do I do here? My friend is an ER doctor, so we went and saw him. He said, 'I think you need to get it taken care of.' Anyway, it changes how you take care of your family because the monetary pressures are so big.*
>
> *This year, I probably have an exposure of about $30,000, which is going to be about 30 percent of my net income. That is more than housing and is more than any other expense, and when I read that the state of Maryland was thinking about doing this, I thanked God that I live in a progressive state that really cares about the people. This will help me grow my small business. I will be able to instead pull money out of my business and right into a health savings account and my health insurance. I could look at hiring people. I could look into creating a better life for other folks as well, which I learned through the Goldman Sachs 10,000 Small Businesses Program how to do that. My constraints have been financial, and now this, hopefully if it works out the way that it is written, it will provide stabilization and insulate us from the craziness going on 40 miles south of here. And really create a state where people really want to move to and live in. Thank you."*

Closing

Ms. Eberle recognized Jeff Ratnow and thanked him for sharing his story. Ms. Eberle closed the hearing and thanked everyone who attended.

Participants

Maryland Health Benefit Exchange
Ben Steffen, Member, Board of Trustees
Dana Weckesser, Member, Board of Trustees
Michele Eberle, Executive Director
Andrew Ratner, Chief of Staff
John-Pierre Cardenas, Director of Policy and Plan Management
Kris Vallecillo, Senior Health Policy Analyst
Betsy Plunkett, Marketing Director

Maryland Insurance Administration
Todd Switzer, Chief Actuary
Cathy Grason, Chief of Staff
Brad Boban, Senior Actuary
Bob Morrow, Associate Commissioner
Joseph Fitzpatrick, Market Conduct Examiner

Maryland Department of Health
Robert Neall, Secretary
Laura Goodman, Division Chief

Members of the Public
Rich Albertoni
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Jackie Cahill
Kim Cammarata
Matt Celentano
Tim Curtis
Xue Dai
Linda Dietsch
Morgan Eichensehr
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Laura Hooper
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Diane Lawrence
Mark Longerbeam
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MARYLAND HEALTH BENEFIT EXCHANGE

Public Hearing - Maryland 1332 State Innovation Waiver
Thursday, May 3, 2018
Maryland Health Benefit Exchange

SIGN-IN SHEET

DISCLAIMER: This is a public hearing. As such, all questions and comments presented during this hearing will be entered into the public record and made available for inspection by any person or governmental unit pursuant to Title 4 of the General Provisions Article.

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MARYLAND HEALTH BENEFIT EXCHANGE

Maryland 1332 Waiver Hearing

May 7, 2018
Frederick County Health Department
350 Montevue Lane
Frederick, MD 21702

Welcome & Introductions

Michele Eberle, Executive Director of the Maryland Health Benefit Exchange (MHBE), welcomed the public to the hearing and introduced herself along with other MHBE staff in attendance. She acknowledged the presence of staff from the Maryland Insurance Administration (MIA), as well as Delegate Carol Krimm and Robert Neall, the Secretary of the Maryland Department of Health and Chair of the MHBE Board.

Ms. Eberle provided a brief overview of the proposed state reinsurance program then introduced John-Pierre Cardenas, the MHBE Director of Policy and Plan Management.

1332 Waiver Presentation

Mr. Cardenas began by describing the state legislation enabling the reinsurance program—House Bill (HB) 1795 – Establishment of a Reinsurance Program and Senate Bill (SB) 387 – Maryland Health Care Access Act of 2018. He explained that the reinsurance program's attachment point has not been finalized because it depends on available funding. Mr. Cardenas explained that the reinsurance program is intended to address the large premium increased that have occurred over the past several years.

Next, Mr. Cardenas described how two outside organizations contributed to the waiver application process. The Wakely Consulting Group prepared the actuarial and economic analysis, and The Hilltop Institute developed the narrative portion of the waiver application.

Mr. Cardenas then provided a basic description of the waiver, explaining that it would reduce premiums by an average of 30 percent in the first year using a combination of state funds and federal pass-through funds. By allowing carriers to factor the reinsurance program into their premium rates, thus reducing those premiums, the MHBE expects the program to result in a 5.8 percent increase in individual market enrollment in 2019.

Next, Mr. Cardenas presented the four guardrails in which all 1332 State Innovation Waivers must comply. He explained that the proposed reinsurance program would be compliant with these guardrails. He added that, absent the waiver, the average premium is estimated to rise from $604.50 per month to $735.66 per month in 2019, whereas under the waiver, the average premium is expected to decrease from $604.50 per month to $508.03 per month. Mr. Cardenas emphasized that these estimates are based on average premiums and are not specific to any single carrier. An attendee asked if the expected premium decrease factors in subsidies, and Mr. Cardenas responded that that the estimate of the premium decrease is based on premiums without a subsidy.

Mr. Cardenas concluded his presentation by describing the upcoming opportunities to gather stakeholder feedback, including one additional hearing later in the week. He noted that there will be additional opportunities for stakeholder involvement in the regulatory process over the summer of 2018.

Q&A/Discussion

Mr. Cardenas then opened the floor for questions and discussion from the attendees.

An attendee commented that the reinsurance program will lower premiums, but asked if it will increase the number of plan options available through the exchange because the attendee is currently paying $600 per month for a bronze plan with a $7,000 deductible. Mr. Cardenas responded that affordability is very important to the MHBE and that the reinsurance program will create a more favorable environment for insurers, which will hopefully encourage more

insurers to participate in the exchange. Todd Switzer, Chief Actuary of the MIA, noted that the reinsurance program will have a greater impact on premium prices than one might think. For example, if a carrier files for a 50 percent rate increase, then the estimated 30 percent decrease from the reinsurance program would not result in a 20 percent rate increase but only a 5 percent rate increase because of how premiums are calculated. Mr. Switzer also asked if the attendee was referring to the fact that CareFirst recently decided to offer only one option for each metal level and that the number of Affordable Care Act (ACA) plans has decreased. The attendee responded that BlueCrossBlueShield is widely accepted, so it is difficult to look at another plan and determine the network; the only plan she can afford has a $7,000 deductible. The attendee reported that it is sometimes cheaper to self-pay rather than use insurance. Mr. Switzer thanked the attendee for her comments.

An attendee asked whether the MHBE was concerned that the option of federal pass-through funding for the reinsurance program could disappear given the changes the current administration has made to weaken the ACA. Mr. Cardenas responded that the section 1332 waiver is protected by statute and that there are currently no proposed regulations that would threaten the waiver. Furthermore, the administration is encouraging states to apply for waivers to implement state based reinsurance programs.

An attendee then asked if the waiver is working in other states. Mr. Cardenas responded that the states that are focusing their 1332 waiver solely on a reinsurance program have had success with their programs; states with multiple programs have had more difficulty. For example, Minnesota has a reinsurance program and basic health plan that both draw from the same pot of money.

An attendee asked if the reinsurance program is still a short-term solution and if there is a long-term plan. Mr. Cardenas confirmed that the reinsurance program is intended to be a short-term solution to control premium costs. Ms. Eberle noted that the waiver application is for five years, though the funding is for two and a half years. New state funding will need to be secured at that point.

An attendee expressed concern about limited carrier participation in the exchange. Ms. Eberle responded that the MHBE is reaching out to carriers and have heard that carriers are interested in the reinsurance program as a way to control the costs of high-risk enrollees. Bob Morrow, Associate Commissioner of the MIA, added that the MIA is constantly reaching out to carriers to encourage participation in the exchange and that it is a top priority. Ms. Eberle noted that a carrier must build its network before entering the marketplace, which can take well over a year.

An attendee asked whether wellness programs, which have been proven to lower healthcare costs, will be part of the reinsurance program. Ms. Eberle responded that public testimony is always helpful and will become part of the application. A section of the 1332 waiver addresses issuer incentives for containing costs and utilization, and the MHBE is interested in that issue.

Regarding carrier participation, Mr. Switzer added that there were seven carriers in the individual market and now there are two; all carriers have been invited to participate. The $365 million in state funding combined with the federal pass-through funding is expected to last for two years, reducing premiums by 30 percent. This gives Maryland time to look for a long-term solution and the ultimate goal of attracting a more robust and healthier pool to stabilize the market.

An attendee expressed concern that the reinsurance program is a patch until the next step is figured out. She also expressed support of a previous comment regarding well care, stating it has been statistically proven to reduce the cost of healthcare. She commented that the reinsurance program looks like the beginning of a single-payer system; other countries have shown that a single-payer system reduces administrative overheard. She asked where the conversation is heading since the reinsurance program is only a short-term solution. She also commented that the estimated savings for the future tend to be optimistic and she expressed concern that there will continue to be a downward spiral. She commented that insurance companies are for-profit and are not interested in reducing healthcare costs; she reiterated that a single-payer system for Maryland may be a better long-term solution and that it has been shown to work. Mr. Cardenas thanked the attendee for her insight, and noted that SB 387 included a series of studies for the Maryland Health Insurance Coverage Protection Commission, such as Medicaid buy-in and an individual mandate. He encouraged attendees to supply comments. Mr. Morrow noted that these public hearings are not the right place to advocate for a single-payer system because the MIA and MHBE are implementing the rules that are passed. They may provide information to legislators, but they are not involved in the policy making process. He explained that this group is trying to implement the reinsurance program and receive federal approval of the

Section 1332 waiver that the legislature authorized. The attendee commented that this group would be uniquely qualified to be the administrators of the single-payer system. Mr. Morrow responded that if single-payer legislation was passed that directed the MIA or MHBE to implement a single-payer system, then they would do so.

Regarding wellness programs, Mr. Switzer added that some carriers have such programs, and the MIA is seeking more information regarding the effectiveness of these programs and trying to bolster them. He noted that the MIA will be looking at whether there is a better way to distribute the premium tax credit. Mr. Morrow added that every carrier in the individual and group markets has some wellness program or component in their plans and that could be improved on.

An attendee commented that she is confused by the distribution of the tax credit because she is self-employed. Sometimes it makes more sense for her to file separately from her husband, but that in turn caused her to lose her subsidy, which she feels is not helpful or productive for someone in her situation. Mr. Cardenas responded that the ACA requires married couples to file jointly in order to be eligible for a tax subsidy. If a married couple files separately, then they are ineligible for a subsidy. A future Section 1332 waiver could fix that problem, but that would be further in the future. Ms. Eberle added that the MHBE can connect the attendee to a navigator or a broker to receive assistance with this problem.

An attendee asked if the MHBE and other medical groups are working towards a federal single-payer system because as long as insurance companies are involved, then it will always be for-profit and will not benefit consumers. Ms. Eberle responded that this is not the charge of the MHBE, which was created to roll out health coverage and provide a marketplace for individual insurance through the ACA. Any activity at the federal level must be done through federal policy, and she recommended contacting the federal delegation for Maryland. The attendee commented that the MHBE staff are the experts who should tell the federal government what they want. Ms. Eberle responded that the state legislators would need to direct the MHBE to take that action, as they are a state agency implementing the rules. She noted that the MHBE can connect the attendee to the people to speak to.

An attendee asked if Maryland will act as the reinsurer if the waiver is approved. Mr. Cardenas responded in the affirmative. The attendee asked if Maryland was considering transferring the risk into the traditional reinsurance market after the program is established. He commented that this is a subsidy not a reinsurance plan, and asked if Maryland considered transferring the risk to the traditional reinsurance instead of taking the risk on their own. Mr. Morrow clarified that the attendee meant that Maryland could purchase a reinsurance plan to cover their obligations; he responded that Maryland has not considered this option but could do so in the future.

An attendee asked if the reinsurance program will be in place in time to affect 2019 rates since open enrollment starts on November 1, 2018. The attendee expressed concern that rates could change halfway through open enrollment. Mr. Cardenas responded that the Centers for Medicare & Medicaid Services (CMS) encouraged Maryland to apply for a waiver starting in 2019, to get relief to as many Marylanders as soon as possible. The MIA and MHBE stand ready to implement adjusted rates after the reinsurance program is established. The recommended approval date for the waiver is the end of July, and previous states have had their waivers approved quickly. For example, Oregon's waiver was approved in 99 days, so a quick approval is possible. The MHBE is trying to submit the application as quickly as possible. Mr. Morrow added that they recognize that time is of the essence and everyone is working very hard to get the waiver done quickly.

Public Testimony

Mr. Cardenas then invited any attendee who so desired to offer their testimony for the record. Five individuals offered testimony.

Gene M. Ransom, III, CEO of MedChi, offered the following testimony:

> *"First of all, I'm Gene Ransom. I'm CEO of MedChi, which is the Maryland State Medical Society, and on behalf of our members, we'd like to strongly support the application but we have three issues that we think need to be addressed before it moves forward. First and foremost, I'd say most important, we would like that language be included in the draft 1332 waiver that indicates the state's intent to include an adjustment in 2019 for federal risk adjustment payments. We think this is really important. This plan should be designed to stabilize the entire market for everybody and benefit all Maryland consumers equally. We don't*

want a situation where certain patients of my members are benefited more than others, and we think this is, from a fairness point of view, really important—that everybody be treated equally. We don't want a situation where the state is essentially picking winners and losers in the market. We also think, if you make this adjustment, it will be another incentive to solve the problem we've heard about where there are not carriers in the market and, if we're clear that we're treating everybody fairly and equally, we might attract more folks into the market. My members and MedChi have complained about the concentration in the health insurance market for years. Our rating is off the charts. We're one of the most heavily concentrated markets and it creates all kinds of problems. It creates problems on the cost side for patients. It creates problems for my physician members when they're negotiating contracts with the insurers, and this is an opportunity to either make it worse by subsidizing one carrier more than the others or make it better by subsidizing everybody equally, creating a fair and equal playing field.

The second issue that we think needs to be addressed is that specific payment incentives should be included in the reinsurance program that are aligned with the state's broader policy goals related to quality, cost effectiveness, and innovation. I also think that this would be an opportunity to address the wellness issues that came up before that Delegate Krimm and others have brought up. We also believe, specifically in that section, that the carriers should be required to participate and work collaboratively with CRISP, the other HIE, the HIE that's not here. We think that's really important. The population health tools and the work of the health information exchange can create a lot of opportunities for savings and better quality and better outcomes. We have one of the most highly recognized HIE's, again, health information exchange—the same acronym. I don't know why they do that. They should have given you guys different names. CRISP is recognized as one of the best-run HIEs in the country. There needs to be alignment. I don't think this is something that is a major problem. I think you might be able to do this even possibly with a resolution, maybe after the fact if it's a problem including in the application for approval reasons, but we just need to incentivize the carriers, particularly the dominant carrier, to participate with the information exchange so we can have better information and better outcomes.

The third thing, and I'm not saying you guys haven't done this, I just think that it's so important and it's such a high priority. We really just think that it's important for you to look at the newly approved—newly soon-to-be-approved hospital all payer Medicare waiver and make sure that this is properly aligned with the Medicare waiver. The Medicare waiver is really important to Maryland. MedChi has been working proactively with the state to get that approved, and we hopefully will have that approved in the matter of a few weeks or months maybe. We just think it's really important that that unique model that keeps our hospitals funded appropriately is aligned with this. And, again, I'm not saying it isn't, I'm just saying let's make a point to not screw that one up by accident. Let's look at it and combine the two.

So, in closing, I just want to reiterate that we really appreciate the work of Governor Hogan, of Commissioner Redmer, Secretary Neall who's in the back, and the Democrats in the General Assembly who really worked together in a bipartisan fashion to come up with this solution. We think it makes sense, and I think these three tweaks are positive changes that can be achieved before the application deadline. Thank you."

David Hexter, MD, Emergency Physician and Physician in Chief at Mid-Atlantic Permanente, offered the following testimony:

"Good afternoon, my name is David Hexter. I am an Emergency Physician and Physician-in-Chief at Mid-Atlantic Permanente. We care for the patients of Kaiser Permanente in the Baltimore area in general and the Baltimore area as well. Kaiser Permanente is one of only two carriers—we mentioned this several times—that is still on the exchange, and we're also the only one that cares for Medicaid patients. We first of all want to express our support for the section 1332 waiver reinsurance program and really applaud the state legislature, the Hogan administration, and Exchange for working to move forward with this waiver application. And we believe that a reinsurance program like this if it's implemented fairly will go a long way to stabilizing the market and improve affordability, many of the problems of which you've heard today. But we think it must be, we believe it must be implemented fairly because the reinsurance program that Maryland develops should stabilize the entire insurance market and not just part of it. My fellow Permanente physicians are concerned that the reinsurance program as it is currently proposed will give an advantage to one health plan over another. We want to make sure that the rate relief that is provided by the

program is spread across all Marylanders, not just those that enroll in one company's products. So unless a specific adjustment is made, the proposed program would allow carriers that are paid substantial amounts under the current federal risk adjustment program to be paid twice for accepting those higher-risk members under the reinsurance program. But why does this matter to consumers and patients? Well, if an adjustment is not included in the program, then the relief is going to be concentrated among a small minority of the individual market enrollees. And the majority of the consumers and patients will share less in the relief, and some including the 75,000 Marylanders who choose Kaiser Permanente through the exchange, many of whom are my patients, will experience much less premium relief. And as a Maryland physician, I want my patients to benefit from this reinsurance program that we're putting together to help keep their premiums affordable like everyone else in the state.

So we encourage the Exchange to include language in the draft section 1332 waiver application that indicates the state will adjust for this dynamic. And we also believe that Maryland should include incentives similar to what Mr. Ransom said in the reinsurance program that will align with broader state policy goals to improve quality and cost effectiveness of the care that is provided. To give you some ideas of some of these incentives that could be provided, you could reward high clinical ratings, for example breast cancer screening or colorectal cancer screening, controlling high-blood pressure. You mentioned the diabetes program before, we're able to control diabetes in the population. Shouldn't we be incentivized to do that? And thus designing a program that treats all carriers equitably and that includes these incentives for high-quality patient care and effective care management would attract new healthcare plans into the market, we want more choices as many of the people here today have indicated they want. And we want these carriers to focus on keeping people well, not just having them for a year and moving onto another carrier.

So in conclusion, we at Mid-Atlantic Permanente or Kaiser Permanente believe that the reinsurance program Maryland implements should not allow duplicate payments to be made to any one health plan. There can and should be an adjustment built into the program that makes sure that all patients who purchase their coverage in Maryland's individual market will benefit equally from this reinsurance. Finally, we should include incentives in the reinsurance program that are aligned with the state's broader policy goals in healthcare related to quality and cost effectiveness of care. Thank you very much, and I'm happy to answer any questions."

Ellen Lerner, consumer, offered the following testimony:

"I want to thank this group and the Maryland Health Benefit Exchange. I know your work is not easy; I think I am putting that mildly. I am certainly in favor of the application for this waiver. I hope we get it and we get it quickly. My sole purpose is to benefit those, well to everyone in the state of Maryland; I believe that everyone should be insured. I do want to caution as I did in my questions that this appears to be a patch, a very complicated patch. I hope it works. My husband is a physician. He practices as a teacher, teaching people about how to take care of themselves, how to be healthy, and he even still makes house calls to help people. To me, I know this isn't the purview of the Health Benefit Exchange ,but yet it is. I recognize this group as being the one who helps people to find the best insurance they can with what they have available to them and this will help make more available to them. But I also urge caution in that you are dealing with for-profit insurance companies and that, ultimately, I hope that this will be the beginning as I see it of trickling into, kind of backing ourselves into, a single-payer system. I truly think in the end that's what will be the best, and I highly encourage that this be recognized as that little crack. Thank you."

Delegate Carol Krimm of District 3A offered the following testimony:

"Just to update people on how this process went during General Assembly, so when we came into session the federal government had just taken their actions, and it was communicated to all the legislators that this was going to have a devastating effect on our budget because of the cost involved in trying to repair what the federal government had done to our health exchange. So the Speaker and the Health and Government Operations Committee put this special committee into place, a special task force. The Chairman is Delegate Joseline Peña-Melnyk who in my estimation is probably one of the most knowledgeable legislators on healthcare, and they started meeting on a weekly basis with people in the industry, other legislators, and we just tried to get everyone at the table and we were getting updated through this process.

So what I want to communicate to you is that this is not over. You know this is what we have to do, I think you've heard the words short-term. So we will continue to work on this, and we had to make very quick decisions because of the impact that came done from the federal government and that's what we did and not to say we're not moving towards some goals you think we should have in healthcare. But this is where we are, and these are the people that are going guide us through the short-term, but we are going to continue the task force. So I would encourage the people here who have some very strong ideas on where we should be heading to get in touch with your legislators and let them know where you think we should be going because we're not done."

Annette Breiling, Healthcare as a Human Right, Chapter of Frederick, offered the following testimony:

"I'm sorry I came in late, and I'm with Healthcare as a Human Right, Chapter of Frederick and have long believed that everyone needs to get healthcare. And my understanding is that single-payer is the way that is ultimately going to have to happen, and the Medicare for all legislation is the way we're going to have to ultimately end up. My understanding also is that there are so many federal rules right now that are preventing a state to achieve this and the state whatever we can do to kind of move us in that direction is what I advocate. So that's why I came here and wanted to promote any steps that are going to move us to be able to get everybody healthcare."

Closing

Ms. Eberle informed the audience that the MHBE has a navigator program and producers that can help consumers with assessing their options and navigate the system. Ms. Eberle closed the hearing and thanked everyone who attended.

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Andrew Ratner, Chief of Staff
John-Pierre Cardenas, Director of Policy and Plan Management
Kris Vallecillo, Senior Health Policy Analyst

Maryland Insurance Administration
Todd Switzer, Chief Actuary
Bob Morrow, Associate Commissioner

Maryland Department of Health
Robert Neall, Secretary

Maryland Department of Human Services
Lourdes, R. Padilla, Secretary

Maryland General Assembly
Delegate Carol L. Krimm

Members of the Public
Gene Ransom
David Hexter
Will Fawcett
Judith Rogers
Ellen Lerner
Mary Benove
Dan Mosebach
Amy Podd
Lisa Horner
Laurie Kuiper
Tinna Quigley
Rose McNeely
Kathy Ruben
James French
Mike Cumberland
Jeannette Bartlett
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Annette Breiling

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MARYLAND HEALTH BENEFIT EXCHANGE

Public Hearing - Maryland 1332 State Innovation Waiver
Thursday, May 3, 2018
Maryland Health Benefit Exchange

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Ellen Lerner	Self	mlerner52@gmail.com	☑
Mary Benove	self	marybenov@gmail.com	☐
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Laurie Kuiper	Kaiser Permanente	Laurie.Kuiper@KP.org	☐
Delegate Carol Krimm	MD General Assembly		☐

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MARYLAND HEALTH BENEFIT EXCHANGE

Public Hearing - Maryland 1332 State Innovation Waiver
Monday, May 7, 2018
Maryland Health Benefit Exchange

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MARYLAND HEALTH BENEFIT EXCHANGE

Maryland 1332 Waiver Hearing

May 10, 2018
Charles County Health Department
4545 Crain Highway
White Plains, MD 20695

Welcome & Introductions

Michele Eberle, Executive Director of the Maryland Health Benefit Exchange (MHBE), welcomed the public to the hearing and encouraged their participation.

1332 Waiver Presentation

John-Pierre Cardenas, MHBE Director of Policy and Plan Management, noted that this is the final of four public hearings. He began by describing the state legislation enabling the reinsurance program—House Bill (HB) 1795 – Establishment of a Reinsurance Program and Senate Bill (SB) 387 – Maryland Health Care Access Act of 2018. He explained that HB 1795 directs the MHBE to apply for a 1332 waiver, and SB 387 places a 2.75 percent assessment on premiums to fund the program. An attendee asked whether the tax applies to employer-sponsored or individual health plans. Mr. Cardenas responded that the tax will apply to any policy that is subject to the authority of the state. He further explained that the reinsurance program's attachment point has not been finalized because it depends on available funding and stakeholder input. The MHBE Board has already voted to approve a reinsurance cap of $250,000 and a coinsurance rate of 80 percent. Mr. Cardenas explained that the reinsurance program is intended to address the large premium increased that have occurred over the past several years.

Next, Mr. Cardenas described how two outside organizations contributed to the waiver application process. The Wakely Consulting Group prepared the actuarial and economic analysis, and The Hilltop Institute developed the narrative portion of the waiver application.

Mr. Cardenas then provided a basic description of the waiver, explaining that it would reduce premiums by an average of 30 percent in the first year using a combination of state funds and federal pass-through funds. By allowing carriers to factor the reinsurance program into their premium rates, thus reducing those premiums, the MHBE expects the program to result in a 5.8 percent increase in individual market enrollment in 2019. A member of the public asked whether the 5.8 percent increase refers to the percentage of individuals or the percentage of premiums. Mr. Cardenas responded that it is a 5.8 percent increase in the number of people enrolled.

Next, Mr. Cardenas presented the four guardrails in which all 1332 State Innovation Waivers must comply. He explained that the proposed reinsurance program would be compliant with these guardrails. He added that, absent the waiver, the average premium is estimated to rise from $604.50 per month to $735.66 per month in 2019, whereas under the waiver, the average premium is expected to decrease from $604.50 per month to $508.03 per month. Mr. Cardenas emphasized that these estimates are based on average premiums and are not specific to any single carrier.

Mr. Cardenas concluded his presentation, noting that there is still opportunity to submit written comments. He also noted that there will be additional opportunities for stakeholder involvement in the regulatory process over the summer of 2018.

Michele Eberle acknowledged several audience members, including MHBE Board Vice Chair Tony McCann, MHBE Standing Advisory Committee member Evelyne Ward, Maryland Insurance Administration (MIA) staff, and MHBE staff.

Q&A/Discussion

Mr. Cardenas then opened the floor for questions and discussion from the attendees.

An attendee asked whether non-core benefits will change under the waiver. Mr. Cardenas responded that the ten core essential health benefits will not change. Non-essential benefits are determined by the insurance company, and the waiver will not have a direct impact on these. The attendee also asked for the list of essential health benefits. Mr. Cardenas and Joseph Fitzpatrick, Assistant Chief Examiner, of the MIA listed the following benefits: ambulatory care, behavioral health, emergency services, hospitalizations, prescriptions, maternal and prenatal health, primary care, laboratory services, pediatric services, and rehabilitative and habilitative services.

An attendee asked if there is a "Plan B" if the federal government does not approve the waiver as expected. Mr. Cardenas responded that the MHBE has been working very closely with the federal government to ensure that the application is complete and ready for a quick response. He noted that the legislation authorizing the program is contingent upon federal approval, so further legislative action would be required if the federal government does not approve the waiver. Ms. Eberle commented that this would require a special session of the Maryland General Assembly.

An attendee asked about the program's effect on people who do not buy coverage through the exchange. Mr. Cardenas responded that the program applies to individual market rates both on and off of the exchange.

An attendee asked about the income requirements for participating on the exchange and what happens if someone's income exceeds that amount for a few months. Mr. Cardenas responded that subsidies are available to those up to 500 percent of the federal poverty level. He noted that individuals are expected to report income changes to the exchange within 30 days. Income for the upcoming plan year is predicted at the time of application, and this information is reconciled at the end of the year when taxes are filed. Ms. Eberle clarified that individuals with any income level can purchase on the exchange, but individuals can only obtain tax credits through the exchange.

Todd Switzer, Chief Actuary of the MIA, thanked the attendees for their participation and offered some additional comments. He stated that this waiver affects about 200,000 people in Maryland. Noting that the press release in regard to carrier rate increases was released earlier in the week, he explained that the impact of the reinsurance program is multiplicative. Mr. Switzer provided the theoretical example of a 50 percent rate increase coupled with the 30 percent decrease from the reinsurance program. He explained that this does not mean that there will still be a 20 percent increase in rates. He added that, if the increase is 50 percent, you multiply 1.5 by 0.7, and the increase in rates would be 5 percent and not 20 percent. Mr. Switzer explained that the reinsurance program has a much more leveraged impact, and he added that if the waiver is passed, it will have more of an impact than you might think. He stated that the reinsurance program will be more of an impact than just subtracting 30 percent.

Mr. Switzer emphasized the importance of the waiver and explained that the $365 million, over the full five years, gets leveraged up to $970 million, which is why the initial modeling can be stretched to try to improve the profile and risk of the pool to stabilize rates. Mr. Switzer stated that there are still 360,000 uninsured in the state of Maryland, and about half of those people are eligible for a subsidy, whether it is Medicaid or a premium tax credit. He added that some of those uninsured people could get a free bronze plan, and economically speaking, people are making an irrational economic decision and leaving money on the table. Mr. Switzer expressed the hope that shining the light on this program will encourage people to take another look at insurance coverage.

An attendee noted that some of the literature she read stated that the waiver would limit the increase in premiums rather than decrease premiums. She asked if it is true that the waiver is supposed to decrease premiums, rather than just limit the increase in premiums. Mr. Switzer responded that a decrease in premiums is the hope, but there is no guarantee that it will happen. Mr. Cardenas added that the estimates provided are based on the data available currently, and a lot of it is projecting what will happen in 2019.

An attendee asked Mr. Switzer to explain the equation to determine the impact of the reinsurance program again. Mr. Switzer, using the example of a 50 percent overall increase, explained that you add 1 to the overall increase, which gives you 1.5, and then, with the reinsurance being a 30 percent decrease, you subtract the reinsurance percentage decrease from 1, which gives you 0.7. He continued by saying that when you multiply 1.5 by 0.7, you get 1.05. Mr. Switzer stated that whatever you get from that multiplying (1.05), you subtract 1, and that is what you can expect the impact of reinsurance to be. Mr. Cardenas added that every dollar magnifies its impact.

An attendee asked if any other states have applied for a Medicare waiver. Mr. Cardenas responded by clarifying that this is a 1332 waiver, which is for the Affordable Care Act, not necessarily Medicare. He note that a number of states have applied for 1332 waivers, and Minnesota, Oregon, and Alaska have been approved for reinsurance programs.

An attendee asked if there are any results from these other states. Mr. Cardenas responded yes and that the results have been promising. Mr. Cardenas provided Alaska's model as an example, stating that rates in Alaska were estimated to increase 40 percent, and rates only ended going up 7 percent. Mr. Cardenas added that Alaska is a unique example because Alaska is a small state with high costs. Mr. Cardenas also added that Oregon's and Minnesota's reinsurance programs have had downward impacts with lower rates of premium increases. Mr. Cardenas stated that the impact on each insurance company was also different because each company is different, and each company calculates their premiums differently. Mr. Switzer stated that Maryland is attempting to achieve the deepest discount that has been attempted so far. Mr. Switzer provided national context by adding that Minnesota attempted 20 percent and Oregon attempted 7 percent.

An attendee asked about the markets of the other states and if they only have two carriers like Maryland. Mr. Cardenas answered that Alaska has one, and Minnesota and Oregon have several participating insurance companies. An attendee asked if this waiver could entice other carriers to come to the market. Mr. Cardenas answered that nothing is more attractive to an insurance company than a state that is committed to making the markets work, and the MHBE believes that a reinsurance program creates a more favorable environment. Mr. Cardenas stated that both the MHBE and the MIA work constantly to entice new insurance companies into Maryland.

Public Testimony

Mr. Cardenas then invited any attendee who so desired to offer their testimony for the record. Two individuals offered testimony.

Lore Rosenthal, consumer, offered the following testimony:

> *"Hi, my name is Lore Rosenthal, and I may be the only person in this room who is actually on the Maryland health exchange. So, I guess I just wanted to share my personal story. I am sure the insurance carriers here have heard it before, and I am sure some of the panelists have heard it before. But, it is good to hear from a real person I think. So, I work three days a week. I am not a wealthy person, but I earn more than the cut-off, which is $43,000, which is not a lot of money. This year, my premium, without any subsidy, is $1,000, and at the time when my premiums went up from whatever they were last year to the $1,000, there was not an increase in that cut-off of $43,000. So, you would think if they were going to double your premiums, they would have said, 'Oh, now you can earn like $53,000 and still get a subsidy.' Last year, with my old plan, my deductible was $2,500, and believe it or not, you can use up the entire $2,500 with one hospital stay. I happened to be in the hospital for a mental health reason, and it turns out my carrier did not cover inpatient mental health. So, I just blew through that money in five days.*
>
> *This year, my deductible has gone up to $3,500, and I am hoping that nothing is going to happen to me that I am actually going to blow through that money. You say that there is going to be a decrease of 30 percent, but so far the examples you have given is more that there was a decrease in the increase. So, I am very concerned that next year I may be paying $1,100, and yippee, it is $1,100 instead of $1,400. People cannot afford, and I think you realize that, if you're not on this subsidy, you cannot continue to afford that. It would never occur to me to just drop out of the program. I feel fortunate. I am a self-employed person, so I can't go through a company. I feel fortunate to have insurance. For some people, it must be like 50 percent of their income. People are saying that housing costs are going up, and electricity costs are going up. For poor people, they are paying exorbitant amounts. I am sure this is all in the newspaper too, but people are just paying too much for insurance, and it shouldn't be that way. I hope that you get the waiver, but I hope that in this case that the waiver gives us a 30 percent decrease, so I would only be paying like $700 a month instead of $1,000. Thank you."*

Michael Hartman, consumer, offered the following testimony:

> *"Hello, my name is Michael Hartman, and I am wondering if instead of a monetary amount for income, would it be possible to say that health costs should only be a percentage of your income? Let's say, 15 percent or whatever. Might that be a more fair way of looking at things and understanding that a person*

earning $10,000, if it's 10 percent then it's $1,000. If you're earning $20,000, it would be $2,000. It seems to me that might be a fairer way of looking at things. We look at things like Ms. Rosenthal mentioned about housing costs and generally, what is thought to be a good percentage is 30 percent of your income for housing. Wouldn't it also be a good thing to put a percentage of your health care instead of a monetary amount? Thank you."

Closing

Ms. Eberle thanked everyone who attended; she encouraged consumers to look closely at the plan options available and to download the mobile application, which provides GPS-located assistance. She also noted the helpline and Navigator program as sources of consumer assistance.

An attendee expressed gratitude to the MIA for exemplary service in interceding with an insurance company on her behalf. She also commended the navigators. Ms. Eberle thanked the attendee for her comments and closed the meeting.

Participants

Maryland Health Benefit Exchange
Michele Eberle, Executive Director
John-Pierre Cardenas, Director of Policy and Plan Management
Kris Vallecillo, Senior Health Policy Analyst
Tony McCann, Member, Board of Trustees

Maryland Insurance Administration
Todd Switzer, Chief Actuary
Bob Morrow, Associate Commissioner
Joseph Fitzpatrick, Assistant Chief Examiner

Members of the Public
Robert Axelrod
Tinna Quigley
R. Aaron Aist
Evalyne B. Ward
Sue Ehlenberger
Angela Deal
Louise Hayman
Lore Rosenthal
Michael Hartman

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MARYLAND HEALTHBENEFIT EXCHANGE

Public Hearing - Maryland 1332 State Innovation Waiver
Thursday, May 10, 2018
Charles County Local Health Department

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Joe Fitzpatrick	MIA	—	☐
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Michael Hartman	Self	michaelhartman23@gmail.com	☐
			☐
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Attachment 5. Actuarial and Economic Analysis Report

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State of Maryland

Section 1332 State Innovation Waiver
Actuarial and Economic Analysis

May 29, 2018

Prepared by:
Wakely Consulting Group

Julie Peper, FSA, MAAA
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Table of Contents

Appendices

Introduction

The individual health insurance market in the state of Maryland ("Maryland") has shown symptoms of destabilization in recent years. For example, the state experienced rate increases in excess of 40% in 2018. In order to mitigate further potential destabilization, Maryland is submitting a Section 1332 State Innovation Waiver ("1332 waiver" or "waiver"). The Affordable Care Act (ACA) permits states to waive certain provisions of the ACA in order to increase access to affordable coverage. However, in order for both of the Secretaries of Health and Human Services (HHS) and Treasury to approve of the waiver, the state must complete an application in which it demonstrates that it has met the regulatory requirements.

Pursuant to 45 CFR 155.1308(f)(4)(i)-(iii), in order for Maryland's 1332 waiver to be approved, the state must demonstrate that the waiver does not interfere with the four "guard rails." The four guard rails are defined as:

1. Coverage (there must be at least a comparable number of individuals with coverage under the waiver);
2. Affordability (waiver must not increase out of pocket spending including premiums and cost sharing);
3. Comprehensiveness (the waiver should not decrease the number of individuals with coverage that meets the essential health benefits (EHB) benchmark); and
4. Deficit neutrality (the waiver should not increase the federal deficit).

The waiver, as proposed, would reduce premiums through the introduction of a state-based reinsurance program starting in 2019. The reinsurance program would operate similarly to the Transitional Reinsurance program under the ACA that existed from 2014 to 2016 in that it would reimburse insurers for a proportion (coinsurance amount) of high-cost enrollee claims between a lower bound (attachment point) and an upper bound (cap). For 2019, Maryland has set the reinsurance cap at $250,000, and coinsurance rate at 80%, and the attachment point will be solved for but is currently estimated to be around $20,000. The 80% coinsurance rate should encourage insurers to continue to manage the cost of care for high cost members even with the reinsurance program.

The reinsurance program will be funded, contingent on approval of the 1332 waiver, with an assessment equal to 2.75% of all 2019 state-regulated health and Medicaid managed care organization premiums (including the individual ACA-compliant market) and Federal pass-through dollars. Reinsurance funding for the 2019 benefit year is not to exceed approximately $462 million for the 2019 plan year.

The goals of the reinsurance program are to remove the volatility of high cost claimants from being solely the risk of any one insurer as well as to lower premiums for the individual market in total (as most of the reinsurance funding will come from sources outside the individual market). In doing so, the reinsurance program would incentivize enrollees to join or remain in the market, encourage insurer participation, and reduce overall instability. In addition to providing lower premiums to residents of Maryland, the reinsurance program would also reduce federal outlays through lower premium tax credits.

As part of its 1332 waiver, Maryland is requesting federal funds as a way of offsetting some of the costs incurred by the reinsurance program. Maryland's reinsurance program will reduce premiums for those purchasing insurance coverage in the individual market. It will also reduce the amount of Advance Premium Tax Credits (APTCs) Marylanders receive over the next ten years. APTCs are subsidies for eligible enrollees that can be used to reduce the cost of premiums for plans purchased through the Exchange. The amount of APTCs available for eligible consumers are benchmarked to the second lowest cost silver plan (SLCSP) available on the Exchange. If premiums are reduced (including the SLCSP), then the amount the Federal Government will be required to pay in APTCs will also be reduced.

This report demonstrates that the savings of aggregate APTC amounts exceed lost federal revenue that may result from the reinsurance program. Furthermore, the reinsurance program will not reduce but rather would improve Marylanders access to affordable and comprehensive coverage. The waiver requests that Maryland receive the amount of federal savings from APTCs, net of other costs, as a result of the reinsurance program.

The state of Maryland retained Wakely Consulting Group, LLC (Wakely), through Bolton Partners, to analyze the potential effects of a state-based reinsurance program on the 2019 individual Affordable Care Act (ACA) market. This document has been prepared for the sole use of Maryland. Wakely understands that the report will be made public and used in the 1332 waiver process. This document contains the results, data, assumptions, and methods used in our analyses and satisfies the Actuarial Standard of Practice (ASOP) 41 reporting requirements. Using the information in this report for other purposes may not be appropriate.

This actuarial report is a supplement to Maryland's 1332 waiver report. It addresses section 45 CFR 155.1308(f)(4)(i)-(iii) of the checklist for the 1332 waiver, including actuarial analyses and actuarial certifications, economic analyses, and data and assumptions. Other sections of the waiver contain the non-actuarial portions of the 1332 waiver requirement. Reliance on this report should include a review of the full report by qualified individuals.

Analysis Results

As described previously, the four guard rails of an approved 1332 waiver application are: 1) Coverage Requirement; 2) Affordability Requirement; 3) Comprehensiveness Requirement; and 4) Deficit Neutrality.

Wakely's analysis estimated that the waiver meets each of the four guard rails not only in 2019 but in each subsequent year over the 10-year window. The high-level 2019 guard rail results are shown in the following table.

Table 1: 2019 High-Level Guard Rail Results

Guardrail	Effect of Waiver
Coverage	Increase in enrollment
Affordability (2019)	Relative premium decrease of 28.5% to 34.4%
Comprehensiveness	No change to EHBs
Deficit Neutrality (2019)	Federal savings between $262 million and $364 million

Also, there are no additions to the Federal deficit for any year of the 10-year window.

Coverage, Affordability, and Comprehensiveness

The reinsurance program is expected to decrease premiums in the non-group market. The reduction in premiums should increase overall coverage. Existing research from Congressional Budget Office (CBO)[1] to the Council of Economic Advisors[2] has noted that premium decreases should result in enrollment increases. As the reinsurance program has no impact on other cost-sharing, the decreased premiums also improves affordability for consumers. Similarly, the reinsurance program would have no effect on the comprehensiveness of coverage. EHB requirements will not be affected by the reinsurance program. Individuals purchasing coverage in the non-group market would have the same benefits with the reinsurance program as they would without it.

Deficit Impact

The following tables display the impact of the reinsurance program on Maryland's individual market both for 2019 and for the 10-year budget window. Based on the best estimate

[1] http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/87xx/doc8712/10-31-healthinsurmodel.pdf
[2]https://obamawhitehouse.archives.gov/sites/default/files/page/files/201701_individual_health_insurance_market_cea_issue_brief.pdf

assumptions, in 2019, the waiver reduces premiums by -30.0%[3], increases non-group enrollment by 5.8%, and creates $304 million in federal savings (which incorporates APTC savings net of other federal revenue). Based on the assumption for 2019 premium increases prior to reinsurance and the premium impact as a result of reinsurance, net 2019 premiums are expected to change, relative to 2018, by -16.0%. These results are shown in the following table. The results are similar for years 2020 to 2028 as is shown in Appendix C.

Table 2: 2019 Impact of Waiver on Premium, Enrollment, and Federal Deficit

	Premium Impact	Non-Group Enrollment	Federal Savings
Effect of Reinsurance	-30.0%	+5.8%	$304 Million

Over the 10-year window, the reinsurance program provides savings to the Federal Government due to APTC savings net of other federal revenues. The details of the federal savings over the 10-year window are shown in the following table.[4]

Table 3: 10-Year Deficit Impact of Reinsurance Program

Category of Impact	Impact to Federal Deficit ($ millions)
Difference in APTCs	**$791**
Difference in Mandate Penalty	$0
Difference in User Fees	$0
Difference in HIT	-$12
Estimated Net Federal Savings	**$779**

[3] The premium impacts shown throughout the report represent how much lower premiums would be due to reinsurance relative to what they otherwise would have been in 2019. They do not show 2019 premium changes relative to 2018 unless otherwise stated.

[4] Individual mandate penalties were set to $0 effective for the 2019 benefit year. Issuers that utilize the Healthcare.gov platform are assessed a fee by the Federal government (called a User Fee). This fee is calculated as percent of Exchange premium. This does not apply for Maryland. The HIT is a fee imposed on each covered entity that provides health insurance for US health risks. There is a moratorium on the fee in 2019.

Data and Methodology

The following steps were taken to estimate the impact of a state-based reinsurance program on Maryland's individual market both for 2019 and for the 10-year deficit window.

1. Wakely's model incorporates 2016, 2017, and emerging 2018 experience as base data, which was provided by Maryland insurers.

   Wakely sent a data call to all Maryland insurers that offered individual market ACA-compliant plans in 2016, 2017, or 2018. The data call requested full year 2017 and emerging 2018 enrollment, premium, and APTC information, which was used to inform the baseline estimates. The 2017 and 2018 enrollment and premiums were summarized to create a baseline picture of Maryland's market. The 2018 enrollment data was adjusted to account for expected attrition to estimate average yearly enrollment. The summarized amounts are shown in the following table.

Table 4: 2017 to 2019 Baseline Average Enrollment and Premium Data / Estimates

Baseline	2017	2018	2019
Average Annual Enrollment			
Total Non-Group Enrollment	224,921	190,607	171,526
Exchange Enrollment	130,409	129,047	121,503
APTC Enrollment	99,523	107,039	103,620
Non-APTC Exchange Enrollment	30,886	22,008	17,883
Off-Exchange Enrollment	94,512	61,559	50,023
Total Non-APTC Enrollment	125,398	83,567	67,906
Per Member Per Month (PMPM) Amounts			
Total Non-Group Premium PMPM	$419.37	$604.50	$725.66
Exchange Premium PMPM	$439.36	$633.10	$759.98
Gross Premiums PMPM for APTC Members	$463.86	$658.36	$814.05
Net Premiums PMPM for APTC Members	$147.14	$125.57	$126.83
APTC PMPM	$316.72	$532.79	$687.22
Total Annual Dollars			
Total Non-Group Premiums	$1,131,897,734	$1,382,661,373	$1,493,625,346
Total APTCs	$378,248,946	$684,354,798	$854,516,632

2. The 2019 enrollment, premium, and APTC amounts were estimated using 2017 and February 2018 insurer information submitted to Wakely, as well as 2017 data from the Center for Medicaid and Medicare Services (CMS).

    a. The 2018 state average premium was based on the February 2018 insurer information. The 2018 average premiums were increased by the average estimated 2019 rate increase, which includes increases to account for trend, mix changes, market morbidity changes, lower premiums due to the delay in the health insurance tax (also known as the health providers fee or the HIT), the assessment to fund reinsurance, and an overall uncertainty factor. Further details are included in Appendix A.

    b. To estimate the average 2019 APTC amounts, Wakely used the emerging 2018 APTC information from Maryland Health Exchange including APTC amounts, gross premiums for those with APTCs, and net premiums (gross premiums – APTCs) for those with APTCs. We then inflated gross premiums for APTC enrollees by the estimated 2019 premium increase, but then increased the amounts by 3.0% to account for faster growth in the second-lowest cost silver relative to overall premiums, given emerging 2019 rate information and Maryland Insurance Administration (MIA) feedback. Net premiums were increased by 1% from 2018 to 2019 as an approximation for APTC indexing. The 2019 average gross premium is then reduced by the 2019 average net premium (since APTC enrollees share of premiums is capped based on their respective household income) to calculate the 2019 APTC PMPM amounts.

    c. The 2019 individual market enrollment was calculated using 2017 and 2018 data from Maryland insurers. The data was compared to CMS reports to confirm consistency. It was adjusted to account for changes in enrollment due to net attrition throughout 2018 and expected 2019 premium changes, as discussed in Appendix A. APTC enrollment was increased 1% to account for continued up-take of those that are eligible for subsidies but have not yet enrolled.

    d. Finally, to account for the effective repeal of the individual mandate, enrollment was decreased 10%. This amount aligns with recent survey work by the Kaiser Family Foundation.[5] The proration of how this decrease affected subsidized versus unsubsidized enrollees was calculated using Maryland specific enrollment data. The resulting increase in morbidity was included in the premium estimates. The estimated 2019 information is shown in the following table.

[5] https://www.kff.org/health-reform/poll-finding/kaiser-health-tracking-poll-march-2018-non-group-enrollees/

3. To estimate the effects of the reinsurance program, Wakely assumed that $462 million dollars would be spent to reduce premiums in 2019. The best estimate assumptions resulted in a reduction in premiums of 30.0% due to the reinsurance program and a resulting change in morbidity.

Table 5: Projected 2019 Average Enrollment and Premium Amounts, After Reinsurance

After Reinsurance	
Reinsurance Funding	$462,000,000
Reduction in Premiums (Reinsurance Funding)	-30.9%
Reinsurance Assessment	2.75%
Reduction in Premiums (Improved Morbidity)	-1.4%
Total Non-Group Premium PMPM	$508.03
Exchange Premium PMPM	$532.07
APTC PMPM	$443.09
Change in Total Non-Group Enrollment	5.8%
Total Non-Group Enrollment	181,522
Exchange Enrollment	124,136
APTC Enrollment	103,620
Total Premiums	$1,106,629,629
Total APTCs	$550,954,999

4. Enrollment was re-estimated with the lower post-reinsurance premium, using Maryland specific data, input from Maryland's Insurance Administration, and an enrollment function (Appendix A contains additional information regarding the enrollment function), to calculate a revised non-group market average enrollment. The initial enrollment change is estimated to be 5.6%.

5. Given the enrollment with the reinsurance program is estimated to be higher than without the reinsurance program, Wakely estimated the impact to the morbidity of the market due to the implementation of the reinsurance program.

    a. Multiple studies, such as a health reform study from Massachusetts,[6] indicated

[6]https://obamawhitehouse.archives.gov/sites/default/files/page/files/201701_individual_health_insurance_market_cea_issue_brief.pdf

that enrollees who leave the market have lower costs relative to those who remain. This relationship was applied to enrollees who remain in the market due to the lower premiums caused by the reinsurance program but would have left without the implementation of the reinsurance program.

Wakely considered whether Maryland state-specific data could be used to determine the morbidity adjustment. However, there were unique factors in recent years (e.g., issuer exits, cost-sharing reduction (CSR) silver loading, etc.) which caused additional disruption making it difficult to assess what state-specific appropriate morbidity factors would be for future year morbidity shifts from risk pool size change. In an environment of limited data, multiple independent and intervening variables, and the high likelihood of reversion to the mean, Wakely believes pure statistical analysis would have been inappropriate. Instead, we relied on published studies and incorporated qualitative information provided by Maryland, given their expertise, as to expectations of local market conditions and outcomes. Wakely did additional sensitivity analyses for morbidity as well as for other key assumptions, to assure reasonability of the results for Maryland.

b. The result is an additional 1.4% reduction in average costs due to the improved morbidity of the covered population from the lower premiums under the reinsurance program. Applying the additional 1.4% reduction to the 30.9% reduction in premiums (from the $462 million in reinsurance funding), and the 2.75% assessment, results in an overall premium reduction estimate of 30.0% (under the best estimate scenario). The results of the best estimate can be seen in Table 5.

6. After adjusting the premium impact by the assessment and morbidity impact, Wakely again applied the enrollment function (described in item 4). It resulted in an additional 0.2% increase in enrollment, causing the total enrollment growth from the baseline to be 5.8%. No further iterations were done based on the relationship between change in enrollment and change in morbidity based on the negligible results of this iteration.

7. The following were the assumptions incorporated for the 10-year estimates:

    a. Premiums were trended using National Health Expenditure Data from CMS.[7] In 2020, the end of the HIT moratorium was estimated to increase premiums an additional 1.9% based on 2018 rate filing information.

[7] https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/ - Table 17. Premiums were trended by spending per enrollee for direct purchase.

b. In 2020, the non-group market enrollment was estimated to have attrition equal to what would be predicted using the CEA take-up function comparing 2020 premiums to 2019 premiums. Similarly, the 2020 premium was adjusted for the worsening morbidity due to the aforementioned attrition. APTC enrollment was also assumed to increase by 0.5% to account for further take-up of those enrollees who are eligible for subsidies but have not yet taken up coverage. In years 2021 and beyond, total enrollment was decreased each year by the expected effects of premium increases as calculated by the CEA take-up function and the corresponding worsening morbidity was incorporated into the premiums.

c. Reinsurance total funding amounts are $459 million in 2020 and $223 million in 2021. The 2020 amounts were calculated to align with a similar reduction in premiums as occurred in 2019 and then any remaining state funds would be expended in 2021. Consequently, for years 2022 and beyond, no reinsurance funds are estimated to be expended. To the extent unexpected funds become available, they would be used in 2022 and / or 2023 (the fourth and fifth years of the program).

The results of these assumptions, such as enrollment (both in total and various distributions), and impact on the federal deficit are discussed in Appendix A and Appendix C.

Scenario Testing for 2019

Wakely performed scenario testing which primarily involved changing the enrollment and premium assumptions for 2019. These assumptions were chosen for scenario testing as they are significant drivers of the results of the analysis.

We tested for a scenario (Scenario 2) in which the effective repeal of the individual mandate had a larger impact (which resulted in less enrollment and higher premiums) and a scenario (Scenario 3) in which individual mandate repeal had minimal impact on enrollment and premiums. One of the key differences between scenario 3 and the other scenarios is the difference in morbidity between those exiting the market and those that stay. All other scenarios have a morbidity level in line with CBO's estimated impact while Scenario 3 had a lower morbidity impact, generally in line with morbidity differences identified in research.[8]

Scenario 4 tested for a reasonable lower bound scenario. The total enrollment drop relative to 2018 was the same as Scenario 1 except the enrollment decreased the same percent for

[8]https://obamawhitehouse.archives.gov/sites/default/files/page/files/201701_individual_health_insurance_market_cea_issue_brief.pdf

subsidized and non-subsidized members. Scenario 4 also had slightly lower premium growth and the second lowest cost silver premiums increased at a lower rate than the market premiums.

Scenario 5 assumes a much more significant enrollment impact due to the mandate, based on the CBO projections. This scenario also assumes higher premium rate increases.

Finally, we tested a scenario (Scenario 6) that was similar to Scenario 5 but had even higher premium rate increases and also had higher APTC enrollment. This scenario was developed to be a reasonable upper bound.

Further details regarding the scenario testing can be found in Appendix A and Appendix C.

The high-level results of the scenario testing are shown in the following table. Although a variety of alternative scenarios were tested, the basic conclusions did not alter significantly from the best estimate scenarios.

Table 6: High-Level Results of Scenario Testing

Scenario	1 – Best Estimate	2	3	4	5	6
Description	Moderate Mandate Impact	Higher Mandate Impact	No Mandate Impact	Scenario 1 with Conservative Assumptions (Overall Low)	Highest Mandate Impact	Highest Mandate Impact (Overall High)
Enrollment	Based on Survey Data	Adjusted Survey Data	Take-up Function	Moderate Decrease; Same Decrease for all Subsidy Levels	Mandate Impact - CBO	Mandate Impact - CBO; Higher APTC Enrollment Increases
Premiums	Moderate Increase	Moderate Increase	Moderate Increase	Lower Increase	Higher Increase	Highest Increase
Total Reduction in Premiums	-30.0%	-30.8%	-28.5%	-31.5%	-34.4%	-31.5%
Estimated Net Federal Savings	$303,561,634	$310,462,493	$291,558,026	$262,128,430	$350,271,874	$363,755,678

Scenario Testing with Inertia

As discussed above, Wakely performed scenario testing for the ten year projections using the Best Estimate (Scenario 1). One source of uncertainty is the extent to which those that take-up insurance as a result of the reinsurance program may maintain insurance. There is evidence that individuals have a propensity for loss aversion[9] and that upon gaining insurance, individuals have greater proclivities to maintain coverage. This may be especially true in an environment of positive news surrounding reinsurance.

In such a scenario, it is possible enrollees that take-up coverage during the reinsurance program would have a greater propensity for maintaining coverage. Wakely modeled a scenario in which the cohort of enrollees that take-up coverage during the initial years of the reinsurance program have a greater propensity to maintain coverage, creating savings even after the reinsurance program is no longer in effect. Using an illustration of the potential effects of inertia, the 10-year net Federal savings would increase by approximately $83 million, driven by the proposition that the initial take-up of healthier enrollees results in future years having a larger and healthier risk pool. Maryland requests discussion on whether this approach would be considered for future years of the program, assuming more detailed data and analysis support this concept. Further details can be found in Appendix A.

[9] Kahneman, Daniel and Amos Tversky (1979) Prospect Theory: An Analysis of Decision Under Risk. *Econometrica*, Vol 47 No 2.

Appendix A
Data and Methodology

2019 Baseline Enrollment and Premium Estimates

To create the baseline estimates, Wakely completed the following steps:

1. Wakely collected and summarized the 2016 EDGE premium, claims, and enrollment data. The data was compared to CMS reports to confirm consistency. An additional data request was collected from the insurers consisting of full year 2017 and emerging 2018 enrollment, premium, and APTC information, which was used to inform the baseline estimates.

2. Wakely used the 2017 insurer data to calculate average enrollment and average premium.

   Wakely incorporated February 2018 Maryland insurer data for enrollment, including splits by Exchange status and subsidy status. Wakely assumed that overall enrollment had attrition comparable to historical attrition patterns which was then applied by month from February through December. The total attrition, equal to -8.2% when comparing the resulting yearly average enrollment to February data, was applied to all market segments equally to calculate average 2018 enrollment.

   Wakely incorporated February 2018 Maryland insurer data and March 2018 Maryland Health Exchange data for the following components: state average premium, average APTC amount, gross premiums for individuals with APTC, and net premium for individuals with APTC. The data was compared to CMS reports to confirm consistency. These amounts were assumed to be consistent with the full year 2018 averages and no attrition adjustments were made to the data.

3. For the best estimate, overall enrollment in 2019 was estimated using 2018 enrollment in conjunctions with the Kaiser Family Foundation survey data to estimate the size of the enrollment drop. APTC enrollment was first increased by 1% relative to 2018 to account further take-up among eligible for APTC but have not yet done so. Then overall enrollment was decreased by 10% to account for the effect for the mandate repeal.[10] It was assumed that individuals that would drop due to premium increases were the same group of people that would drop due to the mandate repeal. The proportion of individuals who are subsidized that dropped was set equal to proportion of non-group enrollees individuals who have incomes between 250% FPL and 400% FPL relative all non-group enrollees above 250% FPL.

4. For 2019, premiums were estimated using the 2018 insurer submitted data. The average 2018 premium was increased by 20% to account for all rating factors such as trend, metal

[10] https://www.kff.org/health-reform/poll-finding/kaiser-health-tracking-poll-march-2018-non-group-enrollees/

level mix changes, insurer uncertainty, change in morbidity, and to account for the health insurance tax delay for the 2019 benefit year.

5. To estimate 2019 APTC PMPMs, we used 2018 Maryland insurer data to calculate the average net premium among APTC enrollees (that is, the actual amount APTC enrollees pay). We increased the 2019 required contribution (i.e., net premium) 1% to conform with the indexing of the contribution rate. We then inflated gross premiums for APTC enrollees (the 2018 APTC amounts plus net premiums) by the 2019 estimated premium increase (20%) and also increased them by 3.0% due to faster growth in the SLCSP relative to overall premiums to account for emerging 2019 rate information. The 3.0% was calculated using regional estimates of the rate change of the SLCSP relative to the average premium increases, which were provided by the state of Maryland. This new gross premium amount is reduced by the net premium amount (since APTC enrollees' share of premiums is capped based on their respective household income) to calculate the 2019 APTC PMPM amounts. These assumptions, in totality, were used to generate the baseline estimates shown in Table 4.

2019 Waiver Effects

The impact of the $462 million in reinsurance funding (as discussed previously) as a reduction to premiums was estimated by dividing the total reinsurance funding amount by the total estimated 2019 baseline non-group market. This resulted in an approximate 30.9% reduction to premiums. In addition, an adjustment was made to account for younger, healthier members remaining covered due to the implementation of the reinsurance program. This reduced premium another 1.4%. Finally, premiums were adjusted to account for the assessment. The premium adjustments due to reinsurance were made equally to gross premiums for individuals with APTC (to calculate APTC), on-Exchange premiums, and off-Exchange premiums. The total aggregate reduction of premiums was 30.0%.

The decrease in premiums is expected to produce an increase in enrollment relative to what Maryland would experience without the reinsurance program. Enrollment changes were estimated using the CEA take-up function and compared to other data sources (incorporating actuarial judgement) to assess for reasonability within Maryland-specific context (as discussed previously). APTC enrollment is assumed to stay the same as the baseline estimates since these members are generally unaffected by rate changes.[11] Consequently, the new enrollees are

[11] This assumption does not preclude normal churn that occurs within the non-group market. Normal churn, including enrollees leaving for employer-sponsored insurance or enrollees joining the non-group market who previously had coverage in Medicaid, would continue. The assumption merely assumes in aggregate that a similar number of APTC enrollees would have coverage in 2019 as had coverage in 2018.

expected to be above 400% FPL. These new enrollees were allocated pro rata between on-Exchange and off-Exchange by the share of unsubsidized enrollment that on-Exchange enrollees represented. It is likely that enrollees who stay in the market due to the implementation of reinsurance will be healthier and / or younger than the enrollees who will be in the market regardless of whether there is a reinsurance program.[12] These results were discussed previously and are shown in Table 5.

Alternative Scenarios for 2019

Wakely estimated five additional 2019 scenarios to analyze the robustness of the initial 2019 findings. The following were the enrollment scenarios that were modeled, as they compare to Scenario 1, as discussed previously.

- Scenario 2 shows the impact if the effective repeal of the individual mandate had a larger impact (which results in less enrollment and higher premiums). In this scenario, we estimated that the national attrition rate would be 10% but that Maryland, because of its demographic and economic characteristics, was more susceptible to the effects of the effective mandate repeal than the national average. We further assumed that individuals dropping coverage would be more expensive on average than those that remained. Finally, we assumed that the SLCP would 3.0% faster than the rate of premium growth.

- Scenario 3 was modeled to reflect the scenario in which individual mandate repeal had minimal impact on enrollment and premiums. In this scenario, enrollment decreases relative to 2018 entirely as a function of premium increases as projected by the CEA take-up function. Additionally, morbidity difference for those exiting the market was lower in this scenario than the other scenarios. This scenario also assumed the SLCP would grow 3.0% faster than the rate of premium growth.

- Scenario 4 tested for a reasonable lower bound scenario. The total enrollment drop relative to 2018 was the same as Scenario 1 except the enrollment decreased the same percent for subsidized and non-subsidized members. Scenario 4 also had slightly lower premium growth at 15% and the second lowest cost silver premiums increased 5% slower than average premium.

- Scenario 5 assumes a much more significant enrollment impact due to the mandate, based on the CBO projections. CBO estimates for national projected enrollment losses were applied to Maryland, in which Maryland was assumed to have worse than the

[12]https://www.brookings.edu/blog/up-front/2017/02/08/new-data-on-sign-ups-through-the-acas-marketplaces-should-lay-death-spiral-claims-to-rest/

national average experience in enrollment losses. This scenario also assumes higher premium rate increases (30%) compared to Scenario 1. The SLCP was adjusted to grow 3.0% faster than state average premium.

- Scenario 6 was similar to Scenario 5 but had even higher premium rate increases and also had higher APTC enrollment. This scenario was developed to be a reasonable upper bound. In this scenario, premiums were expected to grow at 40% and the SLCP was adjusted to grow 5.0% faster than state average premium. APTC enrollment was expected to be 5% higher than Scenario 5.

For each of the scenarios, the same reinsurance methodology was applied as was used in the baseline scenario: $462 million in reinsurance funding was applied to the non-group market and enrollment was re-estimated using the CEA take-up function. Each scenario produced a decrease in the state average premiums PMPM in 2019 between 28.5% and 34.4%. In each scenario, the lower premiums resulted in more enrollees in the non-group market. Finally, in each scenario, the combined lower premiums (including decreased APTC PMPMs) resulted in fewer Federal dollars being spent in 2019 as a result of the reinsurance program. The detailed results of the scenario testing are shown in the following table.

Scenario 1 is the best estimate scenario including reactive enrollment and premiums to match Maryland's recommended premium increases. This scenario was used for the 10-year economic analysis.

Table 7: Summary of Alternative Scenario Results for 2019

Scenario	1-Best Estimate	2	3	4	5	6
Enrollment	Based on Survey Data	Adjusted Survey Data	Take-up Function	Moderate Decrease; Same Decrease for all Subsidy Levels	Mandate Impact - CBO	Mandate Impact - CBO; Higher APTC Enrollment Increases
Premiums	Moderate Increase	Moderate Increase	Moderate Increase	Lower Increase	Higher Increase	Highest Increase
Baseline						
Total Non-Group Enrollment	171,526	164,989	185,857	171,546	138,619	139,348
Exchange Enrollment	121,503	118,458	128,585	116,143	107,436	109,915
APTC Enrollment	103,620	101,823	108,110	96,336	96,287	99,392
Total Non-Group Premium PMPM	$725.66	$735.62	$702.78	$695.14	$785.88	$846.27
Exchange Premium PMPM	$759.98	$770.42	$736.03	$728.03	$823.06	$886.31
APTC PMPM	$687.22	$698.40	$661.56	$592.40	$754.78	$840.93
Total Non-Group Premiums	$1,493,625,346	$1,456,435,659	$1,567,400,734	$1,430,988,776	$1,307,254,646	$1,415,114,944
Total APTCs	$854,516,632	$853,358,609	$858,253,567	$684,829,540	$872,108,491	$1,002,985,000
After Reinsurance						
Reinsurance Funding	$462,000,000	$462,000,000	$462,000,000	$462,000,000	$462,000,000	$462,000,000
Reduction in Premiums (Reinsurance Funding)	-30.9%	-31.7%	-29.5%	-32.3%	-35.3%	-32.6%
Reinsurance Assessment	2.75%	2.75%	2.75%	2.75%	2.75%	2.75%
Reduction in Premiums (Improved Morbidity)	-1.4%	-1.4%	-1.4%	-1.7%	-1.3%	-1.1%
Total Premium Impact	-30.0%	-30.8%	-28.5%	-31.5%	-34.4%	-31.5%
Total Non-Group Premium PMPM	$508.03	$509.12	$502.44	$475.99	$515.65	$579.57

Scenario	1-Best Estimate	2	3	4	5	6
Enrollment	Based on Survey Data	Adjusted Survey Data	Take-up Function	Moderate Decrease; Same Decrease for all Subsidy Levels	Mandate Impact - CBO	Mandate Impact - CBO; Higher APTC Enrollment Increases
Premiums	Moderate Increase	Moderate Increase	Moderate Increase	Lower Increase	Higher Increase	Highest Increase
Exchange Premium PMPM	$532.07	$533.21	$526.21	$498.50	$540.04	$606.99
APTC PMPM	$443.09	$444.31	$436.82	$365.65	$451.63	$535.95
Percent Change in Total Enrollment	5.8%	5.8%	5.8%	6.9%	5.3%	4.5%
Total Non-Group Enrollment	181,522	174,587	196,625	183,369	145,967	145,551
Exchange Enrollment	124,136	120,986	131,421	119,256	109,371	111,548
APTC Enrollment	103,620	101,823	108,110	96,336	96,287	99,392
Total Premiums	$1,106,629,629	$1,066,640,334	$1,185,518,554	$1,047,373,717	$903,210,853	$1,012,287,098
Total APTCs	$550,954,999	$542,896,117	$566,695,541	$422,701,111	$521,836,618	$639,229,322
Savings						
Estimated APTC Savings	$303,561,634	$310,462,493	$291,558,026	$262,128,430	$350,271,874	$363,755,678
Estimated Net Federal Savings	$303,561,634	$310,462,493	$291,558,026	$262,128,430	$350,271,874	$363,755,678
Estimated Pass Through	65.7%	67.2%	63.1%	56.7%	75.8%	78.7%

Beyond 2019

For years beyond 2019, Wakely made the following assumptions:

- Baseline premiums (both total non-group and on-Exchange) as well as Gross Premium Amounts for individuals with APTC were trended by the Office of the Actuaries' National Health Expenditure projections for each year of the 10-year window.[13]
- APTC Net Premiums were increased 1% annually to account for indexing.
- In 2020, the end of the HIT moratorium was estimated to increase premiums an additional 1.9% based on 2018 rate filing information.
- In 2020 and beyond, the non-group market enrollment was estimated to have attrition equal to what would be predicted using the CEA take-up function based on the pre-reinsurance premium growth each year. Similarly, the premium was adjusted for the worsening morbidity due to the aforementioned attrition. APTC enrollment was also assumed to increase 0.5% in 2020 only to account for further take-up of those enrollees eligible for subsidies that have not yet taken up coverage.
- Reinsurance or total funding amounts are $459 million in 2020 and $223 million in 2021. The 2020 amounts were calculated to align with a similar reduction in premiums as occurred in 2019 and then any remaining state funds would be expended in 2021. Consequently, for years 2022 and beyond no reinsurance funds are estimated to be expended. To the extent unexpected funds are available they would be used in 2022 and / or 2023 (the fourth and fifth years of the program).

For each year, the same methodology of applying reinsurance, calculating the change in premiums and APTC amounts as a result of reinsurance, and calculating the change in enrollment as a result of lower premium was used consistently to that described for 2019. The detailed results are shown in the following table.

[13] https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/ Table 17. Premiums were trended by spending per enrollee for direct purchase.

Table 8: Baseline Data and Detailed Results after Reinsurance, by Year[14]

	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028
Baseline										
Total Non-Group Enrollment	171,526	169,776	168,525	167,273	166,069	164,888	163,753	162,619	161,507	160,416
APTC Enrollment	103,620	104,138	104,138	104,138	104,138	104,138	104,138	104,138	104,138	104,138
Total Non-Group Premium PMPM	$725.66	$776.34	$816.00	$858.52	$902.34	$948.38	$995.75	$1,046.36	$1,099.51	$1,155.34
Gross Premium PMPM for APTC Mbrs	$814.05	$870.90	$915.40	$963.10	$1,012.26	$1,063.90	$1,117.04	$1,173.81	$1,233.44	$1,296.07
Net Premium PMPM for APTC Mbrs	$126.83	$128.09	$129.37	$130.67	$131.98	$133.30	$134.63	$135.97	$137.33	$138.71
APTC PMPM	$687.22	$742.81	$786.02	$832.43	$880.28	$930.60	$982.42	$1,037.84	$1,096.11	$1,157.36
Total Premiums	$1,493,625,346	$1,581,638,554	$1,650,194,003	$1,723,288,558	$1,798,214,776	$1,876,517,192	$1,956,686,587	$2,041,894,570	$2,130,944,926	$2,224,015,748
Total APTCs	$854,516,632	$928,250,717	$982,254,331	$1,040,247,966	$1,100,046,253	$1,162,932,958	$1,227,678,659	$1,296,938,368	$1,369,751,587	$1,446,296,235
After Reinsurance										
Reinsurance Funding	$462,000,000	$459,000,000	$223,000,000	$0	$0	$0	$0	$0	$0	$0
Reduction in Premiums (Reinsurance Funding)	-30.9%	-29.0%	-13.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Reinsurance Assessment	2.75%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Reduction in Premiums (Improved Morbidity)	-1.4%	-1.4%	-0.6%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Total Non- Group Premium PMPM	$508.03	$543.36	$701.55	$858.52	$902.34	$948.38	$995.75	$1,046.36	$1,099.51	$1,155.34

[14] Please see Appendix C for total federal savings net of federal losses under the reinsurance program.

	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028
APTC PMPM	$443.09	$481.45	$657.63	$832.43	$880.28	$930.60	$982.42	$1,037.84	$1,096.11	$1,157.36
Change in Total Non-Group Enrollment	5.8%	5.7%	2.3%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Total Non-Group Enrollment	181,522	179,439	172,468	167,273	166,069	164,888	163,753	162,619	161,507	160,416
APTC Enrollment	103,620	104,138	104,138	104,138	104,138	104,138	104,138	104,138	104,138	104,138
Total Premiums	$1,106,629,629	$1,169,998,256	$1,451,933,124	$1,723,288,558	$1,798,214,776	$1,876,517,192	$1,956,686,587	$2,041,894,570	$2,130,944,926	$2,224,015,748
Total APTCs	$550,954,999	$601,644,964	$821,807,384	$1,040,247,966	$1,100,046,253	$1,162,932,958	$1,227,678,659	$1,296,938,368	$1,369,751,587	$1,446,296,235
Savings										
Estimated APTC Savings	$303,561,634	$326,605,753	$160,446,948	$0	$0	$0	$0	$0	$0	$0
Estimated Net Federal Savings	$303,561,634	$318,784,587	$156,679,991	$0	$0	$0	$0	$0	$0	$0
Estimated Pass Through	65.7%	69.5%	70.3%	0%	0%	0%	0%	0%	0%	0%

Inertia Scenario

One additional potential scenario is that the initial increases in enrollment due to the reinsurance funds will provide longer term improvements to the risk pool. Long standing research by Tversky and Kahhneman[15] have shown that individuals tend to be more loss averse. In other words, individuals often have diminishing values associated with gains but increasing sensitivities to losses. Handel[16] finds that loss aversion extends to how individuals value insurance. While the study is focused on the employer market, not the non-group market, the basic precepts may hold. Individuals. upon obtaining insurance, may be less likely to drop coverage. In such an event, there may be additional benefits to the risk pool over the long term if individuals have higher risk aversion and that those that stay in the risk pool are on average healthier.

Wakely does note that the non-group market has long been characterized by churn.[17] As a result, individuals associated with the non-group market may exit non-group market coverage, for other forms of coverage, which would reduce inertia influences in the non-group market relative to other forms of coverage. Furthermore, individuals that remaining in coverage could have different morbidity than the average of those who initially joined. In such an instance, the effects of risk pool improvement may be negated.

Nonetheless, the following table illustrates that if individuals have higher risk aversion of coverage loss and that there is no risk selection among those who remain, there could be long term risk pool improvements. This scenario uses the Best Estimate (Scenario 1) for 2019 and adjusted the out-year estimates. This analysis was done by assuming that enrollees who take up coverage due to lower premiums from the reinsurance program are more likely to maintain coverage over multiple years.

This inertia effect was estimated using Maryland Health Benefit Exchange specific enrollment data. Inertia was measured using multiple data points, including the number people who had coverage in both 2017 and 2018, the number people who had coverage in both 2016 and 2017, and the number of enrollees that were passively enrolled in 2017 and 2018 and maintained coverage through April of that year. The data points served as ranges for possible inertia rates,

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[15] Kahneman, Daniel and Amos Tversky (1979) Prospect Theory: An Analysis of Decision Under Risk. *Econometrica*, Vol 47 No 2.

[16] Handel, Benjamin (2011) “Adverse Selection and Switching Costs in Health Insurance Markets: When Nudging Hurts” NBER Working Paper. 17459

[17] Sommers, Ben and Sara Rosenbaum (2011). “Issuers in Health Reform: How Changes in Eligibility May Move Millions Back and Forth Between Medicaid and Insurance Exchanges”. Health Affairs

recognizing there are other limitations to the data, such as the proportion of subsidy-eligible members. Off-Exchange enrollment inertia was assumed to be the same rate as on-Exchange.

Wakely chose an estimate roughly in the middle of the data points for illustrative purposes. The result is that we assume a continuation rate, or inertia rate, for this cohort of enrollees of 50%. This means that each year, 50% of the new reinsurance cohort maintain coverage. The resulting higher enrollment for the entire risk pool is then adjusted for improved morbidity and then a further adjustment is made for additional enrollment as a result of the lower premiums, using the methodology outlined prior. As noted above, if there is risk selection among those that maintain coverage the effect would be reduced. While more in-depth analysis is needed to identify the long-term potential positive effects of a Maryland-specific reinsurance program on retention/enrollment, below is an example of the potential long-term effects Maryland could experience as a result of a reinsurance program.

Table 9: Baseline Data and Detailed Results after Reinsurance, by Year (Inertia Scenario)

	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028
Baseline										
Total Non-Group Enrollment	171,526	169,776	168,525	167,273	166,069	164,888	163,753	162,619	161,507	160,416
APTC Enrollment	103,620	104,138	104,138	104,138	104,138	104,138	104,138	104,138	104,138	104,138
Total Non-Group Premium PMPM	$725.66	$776.34	$816.00	$858.52	$902.34	$948.38	$995.75	$1,046.36	$1,099.51	$1,155.34
Gross Premium PMPM for APTC Mbrs	$814.05	$870.90	$915.40	$963.10	$1,012.26	$1,063.90	$1,117.04	$1,173.81	$1,233.44	$1,296.07
Net Premium PMPM for APTC Mbrs	$126.83	$128.09	$129.37	$130.67	$131.98	$133.30	$134.63	$135.97	$137.33	$138.71
APTC PMPM	$687.22	$742.81	$786.02	$832.43	$880.28	$930.60	$982.42	$1,037.84	$1,096.11	$1,157.36
Total Premiums	$1,493,625,346	$1,581,638,554	$1,650,194,003	$1,723,288,558	$1,798,214,776	$1,876,517,192	$1,956,686,587	$2,041,894,570	$2,130,944,926	$2,224,015,748
Total APTCs	$854,516,632	$928,250,717	$982,254,331	$1,040,247,966	$1,100,046,253	$1,162,932,958	$1,227,678,659	$1,296,938,368	$1,369,751,587	$1,446,296,235
After Reinsurance										
Reinsurance Funding	$462,000,000	$451,000,000	$287,000,000	$0	$0	$0	$0	$0	$0	$0
Reduction in Premiums (Reinsurance Funding)	-30.9%	-28.5%	-17.4%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Reinsurance Assessment	2.75%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Reduction in Premiums (Improved Morbidity)	-1.4%	-2.1%	-1.8%	-1.0%	-0.5%	-0.3%	-0.1%	-0.1%	0.0%	0.0%
Total Non- Group Premium PMPM	$508.03	$543.52	$661.66	$849.90	$897.50	$945.68	$994.26	$1,045.54	$1,099.06	$1,155.09
APTC PMPM	$443.09	$481.63	$612.88	$822.76	$874.84	$927.58	$980.74	$1,036.92	$1,095.60	$1,157.08

	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028
Change in Total Non-Group Enrollment	5.8%	8.7%	7.7%	4.0%	2.1%	1.1%	0.6%	0.3%	0.2%	0.1%
Total Non-Group Enrollment	181,522	184,486	181,445	174,014	169,580	166,715	164,703	163,113	161,763	160,549
APTC Enrollment	103,620	104,138	104,138	104,138	104,138	104,138	104,138	104,138	104,138	104,138
Total Premiums	$1,106,629,629	$1,203,254,918	$1,440,650,590	$1,774,739,491	$1,826,373,325	$1,891,911,260	$1,965,087,429	$2,046,479,986	$2,133,446,355	$2,225,379,610
Total APTCs	$550,954,999	$601,869,440	$765,884,961	$1,028,164,882	$1,093,252,115	$1,159,151,104	$1,225,587,907	$1,295,785,208	$1,369,116,839	$1,445,947,305
Savings										
Estimated APTC Savings	$303,561,634	$326,381,277	$216,369,370	$12,083,084	$6,794,138	$3,781,853	$2,090,752	$1,153,160	$634,748	$348,930
Estimated Net Federal Savings *	$303,561,634	$319,191,988	$212,388,045	$12,083,084	$6,794,138	$3,781,853	$2,090,752	$1,153,160	$634,748	$348,930
Estimated Pass Through	65.7%	70.8%	74.0%	0%	0%	0%	0%	0%	0%	0%

* Estimated Net Federal Savings are lower or equal to the Estimated APTC Savings (that is, any potential savings produced by the offsets are not included).

Appendix B
Reinsurance Parameters

Reinsurance Parameters

As noted previously, the reinsurance program would operate similarly to the Transitional Reinsurance program under the ACA that existed from 2014 to 2016 in that it would reimburse insurers for a proportion (coinsurance amount) of high-cost enrollee claims between a lower bound (attachment point) and an upper bound (cap). For 2019, Maryland has set the reinsurance cap at $250,000, the coinsurance rate at 80%, and the attachment point is anticipated to be approximately $20,000. The 80% coinsurance rate should encourage insurers to continue to manage the cost of care for high cost members, even with the reinsurance program.

Wakely used continuance tables provided for the 2017 calendar year from the two remaining insurers in 2018 to estimate the attachment point for the program. In addition, 2016 calendar year continuance tables and 2016 EDGE files served as a cross-check for reasonability and consistency.

To obtain a 2019 continuance table consistent with the best estimate scenario, various adjustments to the data were performed including enrollment, morbidity, and annual claim increases. The following components were considerations in adjusting the 2017 continuance tables, incorporating sources of public data, sensitive / proprietary data, and actuarial judgement.

1. The best estimate scenario enrollment drop of 19.3% from 2017 to 2019 was applied to the data.
2. The morbidity change from 2017 to 2019 was modeled under the assumption that members leaving the market were healthier relative those staying in the market.
3. The claims were increased annually from 2017 to 2019. This annual claim increase includes adjustments outside of trend such as metal mix changes and unit cost shifts.
4. The resulting medical loss ratio in 2019 was reviewed (prior to the impact of the reinsurance program and after the impact of reinsurance) to ensure reasonability.

Enrollment and morbidity were modeled in tandem by removing membership and associated claims from the continuance tables to obtain the projected changes of 19.3% decrease in enrollment and a corresponding increase in morbidity (estimated by an increase in paid claims). This was modeled using an attrition distribution assuming lower cost membership is more likely to terminate coverage than higher cost membership.

In some instances, the trend and / or morbidity was higher than anticipated; however, it was necessary in order to achieve the level of premium increase we understood to be reasonable from Maryland and / or the insurers. The premium levels may be higher than otherwise expected as a

result of uncertainty in the market. Trend and / or morbidity were adjusted similarly to achieve appropriate Medical Loss Ratios (MLRs).

The resulting 2019 continuance table was used to determine the reinsurance parameters. Wakely used a fixed coinsurance rate of 80% and cap $250,000. Assuming a funding level of $462,000,000 and the preceding parameters, Wakely estimates that the attachment point will be approximately $20,000, based on the 2019 estimated data. The attachment point may change if methodology, assumptions, or other changes are incorporated.

It is important to note that the assumptions in this estimate are inherently uncertain. The resulting parameters will vary from these estimates to the degree the actual enrollment, morbidity, trend, and other assumptions vary from those used in this analysis. In addition, if there are significantly more or fewer high cost claimants in 2019 compared to 2016 and 2017, the results from this analysis may also vary. Finally, insurers are expected to have differing impacts from the reinsurance program based on how they vary from the market average in their historical claims and assumptions discussed previously in this section.

Appendix C
Guard Rail Requirements

Scope of Coverage Requirement

In order for a 1332 waiver to be accepted, the waiver must demonstrate that the changes will provide coverage to at least a comparable number of residents as would have been provided coverage without the waiver. We expect enrollment to be greater than or equal to each year relative to what would have occurred if the reinsurance program were not in place in each year of the waiver. Our analysis estimates that the reinsurance program, and resulting lower premiums, would provide for at least comparable number of enrollees (and most likely a greater number of individuals covered).

Affordability Requirement

In order for a 1332 waiver to be accepted, the waiver must demonstrate that the changes will provide coverage, premiums, and cost-sharing protections that keep care at least as affordable as would be provided absent the waiver coverage to at least a comparable number of residents as would have been provided absent the waiver. Generally, we expect premiums to be approximately 30% lower in 2019, and lower than or equal to what they otherwise would have been each year of the waiver as a direct result of the reinsurance program. Cost sharing for plans will remain within the federal requirements and should therefore not impact affordability. Our analysis estimates that the reinsurance program, and resulting lower premiums, would provide for at least as affordable coverage for residents (and most likely greater affordability for residents).

Comprehensiveness of Coverage Requirement

In order for a 1332 waiver to be accepted, the waiver must demonstrate that it will provide coverage that is at least as comprehensive as would be provided absent the waiver. This waiver will not result in any changes to the EHB benchmark or actuarial value requirements and, as such, will not have any impact on the comprehensive of coverage for residents.

Deficit Neutrality

APTCs

Since APTCs are benchmarked to the SLCSP, the decrease in premiums (specifically the SLCSP) will result in lower per person APTC amounts in 2019. Since enrollees who have APTCs are generally unaffected by changes in gross premiums, due to the subsidies shielding them from premium increases, the introduction of reinsurance is not expected to decrease the number of enrollees with APTCs. Due to the combination of a non-decreasing number of enrollees with APTCs and a decrease in premiums, which is connected to APTC amounts, Wakely's analysis estimates that the overall aggregate amount of APTCs will be lower or equal to what they

otherwise would have been each year over the 10-year window. Wakely further estimates that the total federal savings of APTC expenditures will be $304 million, $327 million, and $160 million in 2019, 2020, and 2021, respectively. APTC savings net of other federal losses will be $304 million, $319 million, and $157 million in 2019, 2020, and 2021, respectively. These results are shown in the following table. Using the inertia scenario, there are additional federal savings in all ten years of the estimates.

Table 10: Detailed Results of Federal Savings, by Year

	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028
Baseline										
Total Non-Group Enrollment	171,526	169,776	168,525	167,273	166,069	164,888	163,753	162,619	161,507	160,416
Exchange Enrollment	121,503	121,042	120,713	120,383	120,066	119,755	119,456	119,157	118,865	118,577
APTC Enrollment	103,620	104,138	104,138	104,138	104,138	104,138	104,138	104,138	104,138	104,138
Total Non-Group Premium PMPM	$725.66	$776.34	$816.00	$858.52	$902.34	$948.38	$995.75	$1,046.36	$1,099.51	$1,155.34
Exchange Premium PMPM	$759.98	$813.06	$854.60	$899.14	$945.03	$993.24	$1,042.86	$1,095.86	$1,151.52	$1,209.99
APTC PMPM	$687.22	$742.81	$786.02	$832.43	$880.28	$930.60	$982.42	$1,037.84	$1,096.11	$1,157.36
After Reinsurance										
Total Non-Group Enrollment	181,522	179,439	172,468	167,273	166,069	164,888	163,753	162,619	161,507	160,416
Exchange Enrollment	124,136	123,587	121,751	120,383	120,066	119,755	119,456	119,157	118,865	118,577
APTC Enrollment	103,620	104,138	104,138	104,138	104,138	104,138	104,138	104,138	104,138	104,138
Total Non-Group Premium PMPM	$508.03	$543.36	$701.55	$858.52	$902.34	$948.38	$995.75	$1,046.36	$1,099.51	$1,155.34
Exchange Premium PMPM	$532.07	$569.06	$734.74	$899.14	$945.03	$993.24	$1,042.86	$1,095.86	$1,151.52	$1,209.99
APTC PMPM	$443.09	$481.45	$657.63	$832.43	$880.28	$930.60	$982.42	$1,037.84	$1,096.11	$1,157.36
Federal Savings Calculations										
Exchange User Fees	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
HIT	0.0%	1.9%	1.9%	1.9%	1.9%	1.9%	1.9%	1.9%	1.9%	1.9%
Difference in APTCs	$303,561,634	$326,605,753	$160,446,948	$0	$0	$0	$0	$0	$0	$0
Difference in Mandate Penalty	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Difference in User Fees	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Difference in HIT	$0	($7,821,166)	($3,766,957)	$0	$0	$0	$0	$0	$0	$0
Estimated Net Federal Savings	**$303,561,634**	**$318,784,587**	**$156,679,991**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Pass Through as a Percent of Total Funding	**65.7%**	**69.5%**	**70.3%**	**0%**	**0%**	**0%**	**0%**	**0%**	**0%**	**0%**

Offsets to APTC Savings

INDIVIDUAL RESPONSIBILITY REQUIREMENT

As part of the ACA, individuals that can afford insurance but forgo insurance are generally required to pay a fee. However, as part of the Tax Cuts and Jobs Act of 2017, the individual responsibility requirement was set to $0 for 2019 and future years. Therefore, it will not directly affect federal savings.

EXCHANGE USER FEE

Given Maryland's status as a State-Based Exchange, Wakely notes that there will not be a loss of revenue to the Federal government for Federally-facilitated Exchange user fees (also known as user fees) due to the reduction in premium amounts.

HEALTH INSURANCE PROVIDERS FEE

The reinsurance program would also impact the health insurance providers fee, or HIT. Section 9010 of the ACA requires that a tax on health insurance providers be set at an amount totaling $14.3 billion in 2018 and increasing thereafter generally at the rate of premium increase. As part of the Tax Cuts and Jobs Act of 2017, the HIT was suspended for the 2019 benefit year. For years beyond 2019, we estimate that Maryland's reinsurance program will have minimal impact on national premium growth rate. To estimate the decrease in collected fees, Wakely first estimated the baseline collection using the 2018 rate filing information. Weighting the 2018 fee by expected enrollment yielded an estimated HIT amount of 1.9% of premiums. This amount was held constant over the 10-year window to align the fee with overall premium growth. To calculate the impact of the waiver, Wakely estimated the total HIT (defined as total premiums multiplied by 1.9%) for the baseline and the waiver scenario to arrive at the change in federal costs due to the implementation of the waiver. These estimates are conservative as the losses on Maryland's insurers may be partially or fully captured by taxes on non-Maryland health insurance providers given that statutory construction of the fee.

OTHER FEDERAL IMPACTS

Wakely did not directly estimate the impact of the proposed waiver on the collections related to the Cadillac or Excise tax, small business tax credit or income taxes. It is unlikely that any of these would have a significant impact on the overall savings.[18]

[18] http://mn.gov/commerce-stat/pdfs/mn-1332-actuarial-analysis.pdf

ADMINISTRATIVE COSTS TO ADMINISTER THE REINSURANCE PROGRAM

Per the Maryland Health Benefit Exchange (MHBE), the waiver program will have a minor impact on state agency burden. The MHBE will be responsible for administering the program, including administering funds, reviewing and collecting claims information from carriers, paying carriers for eligible claims, ongoing program monitoring, and complying with federal reporting and public comment requirements. The MHBE previously administered a state supplemental reinsurance program for the 2015 and 2016 plan years and can leverage and build upon these pre-existing resources. The MHBE anticipates some additional staff costs for administering the program, including hiring a program manager and IT consultant time. These costs are estimated to be approximately $434,000 in state fiscal year 2019, $582,000 in 2020, and $599,000 in 2021.The MIA may also have minor increased burden related to reviewing and approving carrier rate filings and state health insurance premium tax collection, but this can be absorbed by current staff resources.

The MHBE also requests that CMS consider whether the existing EDGE server infrastructure, utilized in the administration of the risk adjustment program and transitional reinsurance program, can be leveraged to implement the State Reinsurance Program. The MHBE has received feedback from the issuers participating in the non-group market that leveraging the EDGE server would increase program efficiency and reduce downstream administrative burden. Should the request to leverage the EDGE server be approved, the implementation costs of needed modifications to the EDGE server may be paid from the total pass-through funding amount received from waiver approval. It is expected that this would not impact the total funding in the first year of the reinsurance program. Rather Maryland would keep the total funding the same and any reduction would affect the total funding in the final year of the reinsurance program.

EMPLOYER MARKETS

A detailed analysis of the group markets was not completed. It is not expected that the reinsurance program will have an impact on the small group, large group, federal employee health benefits program, and other health programs in the state. In particular, we do not expect enrollment migration from the group market to the non-group market as a result of the reinsurance program.

DEFICIT NEUTRALITY IN ALTERNATIVE SCENARIOS

In addition, Wakely calculated the impact of the federal savings under the alternative 2019 scenarios discussed previously. As can be seen previously in Table 7, there was no 2019 scenario in which net federal savings, as a result of the reinsurance program, was less than $262 million.

Appendix D
5 and 10 year Projections

The following tables show various information over the 10-year deficit period, as required under the CMS checklist. The second lowest cost silver for each rating area was calculated using a weighted average of each county's Exchange enrollment for 2017. Future year increases aligned with the methodology outlined for the 10-year best estimate.

Table 11A: Second Lowest Cost Silver Plan Premium PMPM, with and without Reinsurance, by Rating Area and Year

Rating Area	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028
Baseline											
1	$353	$446	$477	$501	$527	$554	$582	$611	$642	$675	$709
2	$587	$687	$735	$772	$812	$854	$897	$942	$990	$1,040	$1,093
3	$353	$446	$477	$501	$527	$554	$582	$611	$642	$675	$709
4	$501	$598	$640	$672	$707	$744	$782	$821	$862	$906	$952
After Reinsurance											
1		$312	$334	$431	$527	$554	$582	$611	$642	$675	$709
2		$481	$514	$664	$812	$854	$897	$942	$990	$1,040	$1,093
3		$312	$334	$431	$527	$554	$582	$611	$642	$675	$709
4		$419	$448	$578	$707	$744	$782	$821	$862	$906	$952

Table 11B: Second Lowest Cost Silver Plan Premium PMPM, with and without Reinsurance, by County and Year

Rating Area	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028
Baseline											
Allegany	$615	$735	$786	$826	$870	$914	$961	$1,009	$1,060	$1,114	$1,170
Anne Arundel	$353	$446	$477	$501	$527	$554	$582	$611	$642	$675	$709
Baltimore	$353	$446	$477	$501	$527	$554	$582	$611	$642	$675	$709
Baltimore City	$353	$446	$477	$501	$527	$554	$582	$611	$642	$675	$709
Calvert	$484	$567	$607	$638	$671	$705	$741	$778	$818	$859	$903
Caroline	$615	$720	$770	$810	$852	$896	$941	$988	$1,038	$1,091	$1,147
Carroll	$353	$422	$452	$475	$499	$525	$552	$579	$609	$640	$672
Cecil	$615	$720	$770	$810	$852	$896	$941	$988	$1,038	$1,091	$1,147
Charles	$484	$567	$607	$638	$671	$705	$741	$778	$818	$859	$903
Dorchester	$615	$720	$770	$810	$852	$896	$941	$988	$1,038	$1,091	$1,147
Frederick	$484	$579	$619	$651	$685	$719	$756	$794	$834	$877	$921
Garrett	$615	$735	$786	$826	$870	$914	$961	$1,009	$1,060	$1,114	$1,170
Harford	$353	$446	$477	$501	$527	$554	$582	$611	$642	$675	$709
Howard	$353	$446	$477	$501	$527	$554	$582	$611	$642	$675	$709
Kent	$615	$720	$770	$810	$852	$896	$941	$988	$1,038	$1,091	$1,147
Montgomery	$353	$446	$477	$501	$527	$554	$582	$611	$642	$675	$709
Prince George's	$353	$446	$477	$501	$527	$554	$582	$611	$642	$675	$709
Queen Anne's	$615	$720	$770	$810	$852	$896	$941	$988	$1,038	$1,091	$1,147
Somerset	$615	$720	$770	$810	$852	$896	$941	$988	$1,038	$1,091	$1,147
St. Mary's	$615	$720	$770	$810	$852	$896	$941	$988	$1,038	$1,091	$1,147
Talbot	$615	$720	$770	$810	$852	$896	$941	$988	$1,038	$1,091	$1,147
Washington	$615	$735	$786	$826	$870	$914	$961	$1,009	$1,060	$1,114	$1,170
Wicomico	$615	$720	$770	$810	$852	$896	$941	$988	$1,038	$1,091	$1,147
Worcester	$615	$720	$770	$810	$852	$896	$941	$988	$1,038	$1,091	$1,147
After Reinsurance											
Allegany		$515	$550	$711	$870	$914	$961	$1,009	$1,060	$1,114	$1,170
Anne Arundel		$312	$334	$431	$527	$554	$582	$611	$642	$675	$709
Baltimore		$312	$334	$431	$527	$554	$582	$611	$642	$675	$709
Baltimore City		$312	$334	$431	$527	$554	$582	$611	$642	$675	$709

Rating Area	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028
Calvert		$397	$425	$548	$671	$705	$741	$778	$818	$859	$903
Caroline		$504	$539	$696	$852	$896	$941	$988	$1,038	$1,091	$1,147
Carroll		$296	$316	$408	$499	$525	$552	$579	$609	$640	$672
Cecil		$504	$539	$696	$852	$896	$941	$988	$1,038	$1,091	$1,147
Charles		$397	$425	$548	$671	$705	$741	$778	$818	$859	$903
Dorchester		$504	$539	$696	$852	$896	$941	$988	$1,038	$1,091	$1,147
Frederick		$405	$433	$559	$685	$719	$756	$794	$834	$877	$921
Garrett		$515	$550	$711	$870	$914	$961	$1,009	$1,060	$1,114	$1,170
Harford		$312	$334	$431	$527	$554	$582	$611	$642	$675	$709
Howard		$312	$334	$431	$527	$554	$582	$611	$642	$675	$709
Kent		$504	$539	$696	$852	$896	$941	$988	$1,038	$1,091	$1,147
Montgomery		$312	$334	$431	$527	$554	$582	$611	$642	$675	$709
Prince George's		$312	$334	$431	$527	$554	$582	$611	$642	$675	$709
Queen Anne's		$504	$539	$696	$852	$896	$941	$988	$1,038	$1,091	$1,147
Somerset		$504	$539	$696	$852	$896	$941	$988	$1,038	$1,091	$1,147
St. Mary's		$504	$539	$696	$852	$896	$941	$988	$1,038	$1,091	$1,147
Talbot		$504	$539	$696	$852	$896	$941	$988	$1,038	$1,091	$1,147
Washington		$515	$550	$711	$870	$914	$961	$1,009	$1,060	$1,114	$1,170
Wicomico		$504	$539	$696	$852	$896	$941	$988	$1,038	$1,091	$1,147
Worcester		$504	$539	$696	$852	$896	$941	$988	$1,038	$1,091	$1,147

Table 12: Projected Enrollment by FPL, with and without Reinsurance, by Year

	2018	2019	2020	2021	2022	2023
Baseline						
Total Non-Group Enrollment	190,607	171,526	169,776	168,525	167,273	166,069
Total Non-Group APTC Eligible	107,039	103,620	104,138	104,138	104,138	104,138
<100% of FPL	14,493	13,042	12,909	12,909	12,909	12,909
≥100% to ≤150% of FPL	19,416	18,795	18,889	18,889	18,889	18,889
>150% to ≤200% of FPL	35,641	34,502	34,675	34,675	34,675	34,675
>200% to ≤250% of FPL	23,033	22,297	22,409	22,409	22,409	22,409
>250% to ≤300% of FPL	13,079	12,661	12,724	12,724	12,724	12,724
>300% to ≤400% of FPL	15,871	15,364	15,441	15,441	15,441	15,441
>400% of FPL	69,075	54,864	52,729	51,478	50,226	49,022
After Reinsurance						
Total Non-Group Enrollment		181,522	179,439	172,468	167,273	166,069
Total Non-Group APTC Eligible		103,620	104,138	104,138	104,138	104,138
<100% of FPL		13,042	12,909	12,909	12,909	12,909
≥100% to ≤150% of FPL		18,795	18,889	18,889	18,889	18,889
>150% to ≤200% of FPL		34,502	34,675	34,675	34,675	34,675
>200% to ≤250% of FPL		22,297	22,409	22,409	22,409	22,409
>250% to ≤300% of FPL		12,661	12,724	12,724	12,724	12,724
>300% to ≤400% of FPL		15,364	15,441	15,441	15,441	15,441
>400% of FPL		64,860	62,393	55,421	50,226	49,022

Table 13: Projected Enrollment by Metal Level with and without Reinsurance, by Year

	2018	2019	2020	2021	2022	2023
Baseline						
Total Non-Group Enrollment	190,607	171,526	169,776	168,525	167,273	166,069
Catastrophic	7,430	6,687	6,618	6,570	6,521	6,474
Bronze	48,230	43,402	42,959	42,643	42,326	42,021
Silver	94,635	85,161	84,293	83,671	83,050	82,452
Gold	38,898	35,004	34,647	34,392	34,136	33,891
Platinum	1,413	1,271	1,258	1,249	1,240	1,231
After Reinsurance						
Total Non-Group Enrollment		181,522	179,439	172,468	167,273	166,069
Catastrophic		6,687	6,618	6,570	6,521	6,474
Bronze		46,947	46,386	44,041	42,326	42,021
Silver		89,271	88,265	85,292	83,050	82,452
Gold		37,264	36,832	35,283	34,136	33,891
Platinum		1,353	1,338	1,281	1,240	1,231

Appendix E
Reliances and Caveats

The following is a list of the data Wakely relied on for the analysis:

- Insurer submitted premium and enrollment information by metal and exchange status for 2017 and January/February/March 2018 (one insurer did not submit March data)
- Insurer submitted APTC information, including enrollment and premiums, for January/February/March 2018
- Insurer submitted paid claim continuance tables for 2016 and 2017
- A complete set of 2016 EDGE Server XML data was collected from the primary insurers in the non-group market, including:
    - The inbound enrollment, medical, pharmacy, and supplement files that were submitted by each insurer to the EDGE Server
    - The corresponding response files that apply an accept/reject status to the claims in the inbound files
    - The final outbound files that were produced in May 2016. These files include the risk adjustment, reinsurance, and enrollee claims detail/enrollee claims summary reports
- The June 30th Risk Adjustment and Reinsurance Report for the 2016 benefit year produced by CMS[19]
- The 2016 , 2017, and 2018 Open Enrollment Report PUF produced by HHS[20] [21] [22]
- Effectuated Enrollment Reports released by CMS[23]

[19] https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/Summary-Reinsurance-Payments-Risk-2016.pdf

[20] https://aspe.hhs.gov/health-insurance-marketplaces-2016-open-enrollment-period-final-enrollment-report

[21] https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Marketplace-Products/Plan_Selection_ZIP.html

[22] https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Marketplace-Products/2018_Open_Enrollment.html

[23] https://downloads.cms.gov/files/effectuated-enrollment-snapshot-report-06-12-17.pdf

- Kaiser Family Foundation Survey[24]
- CBO Analysis on Impact of Repeal of the Mandate[25]
- OACT Analysis on Impact of Repeal of the Mandate[26] [27]
- Inertia analysis including research on Prospect Theory and Loss Aversion,[28] [29] [30] [31] research on Individual Market Churn,[32] data from Maryland's Health Benefit Exchange on churn rate, and actuarial judgement
- Additional data and feedback from Maryland's insurers, Maryland Insurance Administration, and the Maryland Health Benefit Exchange. This includes 2018 enrollment, premium data, and the second lowest cost silver plan estimates.
    - In particular, Wakely relied on Maryland calculation on the increase of the SLCSP relative to overall premiums

Wakely made some assumptions in working with the available data. These assumptions may impact the results of the analyses and were reviewed by Maryland for reasonability.

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[24] https://www.kff.org/health-reform/poll-finding/kaiser-health-tracking-poll-march-2018-non-group-enrollees/

[25] https://www.cbo.gov/system/files/115th-congress-2017-2018/reports/53300-individualmandate.pdf

[26] https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/Downloads/AHCA20170613.pdf

[27] https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/ProjectionsMethodology.pdf

[28] Kahneman, Daniel and Amos Tversky (1979) Prospect Theory: An Analysis of Decision Under Risk. *Econometrica*, Vol 47 No 2.

[29] https://www.worldscientific.com/doi/abs/10.1142/9789814417358_0006

[30] https://link.springer.com/article/10.1007/BF00122574

[31] Handel, Benjamin (2011) "Adverse Selection and Switching Costs in Health Insurance Markets: When Nudging Hurts" NBER Working Paper. 17459

[32] Sommers, Ben and Sara Rosenbaum (2011). "Issuers in Health Reform: How Changes in Eligibility May Move Millions Back and Forth Between Medicaid and Insurance Exchanges". Health Affairs

The following are additional reliances and caveats that could have an impact on results:

- Data Limitations. Wakely received data submissions for full year 2017 and emerging 2018 experience from insurers offering non-group market ACA-compliant plans. Wakely relied on the data submitted from all insurers for significant portions of this analysis. We reviewed the data for reasonability, but we did not audit the data. To the extent that the data is not correct, the results of this analysis will be impacted.

- Political Uncertainty. There is significant policy uncertainty. Future federal actions or requirements in regards to short-term duration plans, association health plans, reinsurance funds, income verification, and / or CSR payments could dramatically change premiums and enrollment in 2019 or future years. In particular, CSR funding or changes to rules about how CSR requirements are accounted for in premium (i.e., “silver-loading”) could dramatically decrease the pass-through percentage relative to what was estimated in this report.

- Enrollment Uncertainty. Additionally, there is enrollment uncertainty. Beyond changes to potential rates and policy, individual enrollee responses to these changes also has uncertainty. This includes implementation of new income verification policy as encapsulated in the 2019 Notice of Benefit and Payment Parameters, which could influence APTC enrollment. All of these uncertainties result in limitations in providing point estimates on reinsurance parameters and impacts of a 1332 waiver.

- Premium Uncertainty. Given that several regulations (association plans, short-term duration plans, etc.) have not been finalized, there is uncertainty in how insurers may respond in their 2019 premiums. These uncertainties result in limitations in providing point estimates on reinsurance parameters and impacts of a 1332 waiver.

- Pass-Through Uncertainty. Ultimately, the Department of Health and Human Services and the Department of Treasury model the pass-through amounts. The extent to which the exact assumptions and micro-simulation modeling differs from Wakely’s models, differences in the pass-through amounts are possible.

- Reinsurance Operations. If actual operations of the reinsurance program differ from the data configurations used in this analysis, Wakely’s analysis would need to be adjusted to match actual reinsurance data requirements. Changes to assumed data requirements, actual data requirements, and data submission quality for reinsurance operations may impact the results. Furthermore, if less than amount specified is spent, for example because some funds are used for reinsurance operations, then effects may be different.

Appendix F
Disclosures and Limitations

Responsible Actuary. Julie Peper and Danielle Hilson are the actuaries responsible for this communication. They are Members of the American Academy of Actuaries and Fellows of the Society of Actuaries. They meet the Qualification Standards of the American Academy of Actuaries to issue this report.

Intended Users. This information has been prepared for the sole use of the management of Maryland. Wakely understands that the report will be made public and used in the 1332 waiver process. Distribution to such parties should be made in its entirety and should be evaluated only by qualified users. The parties receiving this report should retain their own actuarial experts in interpreting results. This information is proprietary.

Risks and Uncertainties. The assumptions and resulting estimates included in this report and produced by the modeling are inherently uncertain. Wakely used conservative pass-through assumptions. The extent to which the enrollment experience for 2018 or 2019 is different than expected could affect results. Users of the results should be qualified to use it and understand the results and the inherent uncertainty. Actual results may vary, potentially materially, from our estimates. Wakely does not warrant or guarantee that Maryland will attain the estimated values included in the report. It is the responsibility of those receiving this output to review the assumptions carefully and notify Wakely of any potential concerns.

Conflict of Interest. The responsible actuaries are financially independent and free from conflict concerning all matters related to performing the actuarial services underlying these analyses. In addition, Wakely is organizationally and financially independent of Maryland.

Data and Reliance. We have relied on others for data and assumptions used in the assignment. We have reviewed the data for reasonableness, but have not performed any independent audit or otherwise verified the accuracy of the data/information. If the underlying information is incomplete or inaccurate, our estimates may be impacted, potentially significantly. The information included in the 'Data and Methodology' and 'Reliances and Caveats' sections identifies the key data and assumptions.

Subsequent Events. These analyses are based on the implicit assumption that the ACA will continue to be in effect in future years with no material change. Material changes in state or federal laws regarding health benefit plans may have a material impact on the results included in this report. In addition, many of the assumptions are based on the initial 2018 experiences. Change in emerging 2018 enrollment and experience could impact the results. Additional changes in regulations (e.g., association health plans, short-term limited duration plans) could impact findings. For example, since neither of the proposed regulations on these topics have been finalized, they were not included in the analysis.

Contents of Actuarial Report. This document (the report, including appendices) constitutes the entirety of actuarial report and supersede any previous communications on the project.

Deviations from ASOPs. Wakely completed the analyses using sound actuarial practice. To the best of our knowledge, the report and methods used in the analyses are in compliance with the appropriate ASOPs with no known deviations. A summary of ASOP compliance is listed below:

ASOP No. 23, Data Quality

ASOP No. 41, Actuarial Communication