Title 14 – Independent Agencies
Subtitle 35 – Individual Exchange
Chapter 17 – State Reinsurance Program

Authority: Insurance Article, §31-117(f), Annotated Code of Maryland

.01 Scope.

This chapter sets forth the structure, implementation, and eligibility standards for the State Reinsurance Program, as required under Insurance Article, §31-117, Annotated Code of Maryland.

.02 Definitions.

A. In this chapter, following terms have the meanings indicated.

B. Terms Defined.

(1) "Affordable Care Act" means the Patient Protection and Affordable Care Act, Pub. L. 111-148, as amended by the Health Care and Education Reconciliation Act, Pub. L. 111-152.

(2) "Annual Letter to Issuers" means:

(a) A written communication, issued by the Individual and SHOP Exchange, that provides guidance on how the Exchange will interpret laws and regulations, issues reminders regarding requirements of and compliance with relevant laws and regulations, and provides notification of policy developments; and

(b) Instructs issuers on how to meet compliance with QHP certification standards, establishes timelines on implementation, and details Exchange expectations of issuer compliance with such certification standards.

(3) “Attachment point” means the threshold dollar amount for claims costs incurred by a health insurance [issuer/carrier/insurer] for an enrolled individual’s covered benefits in a benefit year, after which threshold the claims costs for such benefits are eligible for reinsurance payments.

(4) “Board” means the Board of Trustees of the Maryland Health Benefit Exchange established in Insurance Article, §31-104, Annotated Code of Maryland.

(5) “Benefit year” means a calendar year for which a health plan provides coverage for health benefits.

(6) “Carrier Business Agreement” means the annual agreement between the Exchange and the carrier that contains terms and conditions governing compliance with the Annotated Code of Maryland, Exchange policies, and State and federal regulations.

(7) “Carrier Reference Manual” means the document developed by the Exchange that provides business rules and operational instructions to authorized carriers participating on the Individual and SHOP Exchange.

(8) “Coinsurance rate” means the rate at which the applicable reinsurance entity will reimburse the health insurance issuer for claims costs incurred for an enrolled individual’s covered benefits in a benefit year after the attachment point and before the reinsurance cap.

(9) “Dampening factor” means a coefficient that modifies payments under the State Reinsurance Program to account for RA/RI program interaction to the extent that the medical loss ratio between payers and receivers under the risk adjustment is normalized.

(10) “Individual Exchange” has the meaning stated in Insurance Article, §31-101, Annotated Code of Maryland.

(11) “Medical Loss Ratio” means the calculation formula provided in 45 CFR § 158.221

(12) “Payment parameters” mean the attachment point, coinsurance rate, and reinsurance cap for reinsurance payments. Payment parameters include a dampening factor, if determined appropriate by the Board.

(13) “Qualified health plan” has the meaning set forth in Insurance Article, §31-101, Annotated Code of Maryland.

(14) “Risk adjustment covered plan” means, for the purpose of the risk adjustment program, any health insurance coverage offered in the individual or small group market with the exception of grandfathered health plans, group health insurance coverage described in 45 CFR § 146.145(c), individual health insurance coverage described in 45 CFR § 148.220, and any plan determined not to be a risk adjustment covered plan in the applicable Federally certified risk adjustment methodology.

(15) “RA/RI program interaction” refers to payments received by carrier for the enrolled population whose risk and claims experience would be eligible for payments under both the Federal Risk Adjustment Program and the State Reinsurance Program, such that the resulting full payment would result in a normalized medical loss ratio, for the enrolled population identified in this definition, that is less than one.

(16) “Reinsurance-eligible plan” means any health benefit plan offered in the individual market, except for the limitations and exceptions provided in Regulations .04 of this chapter.

(17) “Reinsurance cap” means the threshold dollar amount for total claims costs paid by a health insurance issuer for an enrolled individual’s covered benefits, after which threshold, the claims costs for such benefits are no longer eligible for reinsurance payments.

(18) “Section 1332 State Innovation Waiver” means the waiver for state innovation filed by the State of Maryland, pursuant to 42 U.S. Code §18052, or Section 1332 of the Affordable Care Act.

(19) “State Reinsurance Program” means the market stabilization program identified in Insurance Article, §31-117, Annotated Code of Maryland.

.03 Eligibility for Receipt of Reinsurance Payments

A. Except as provided in subpart B, a qualified health plan is eligible to receive reinsurance payments from the State Reinsurance Program, provided that the qualified health plan:

(1) Is offered by a carrier that is authorized to offer individual non-Medigap health benefit plans in Maryland;

(2) Is offered by a carrier that complies with the assessment under Insurance Article, §6-102.1, Annotated Code of Maryland; and

(3) Is offered by a carrier that meets all obligations set forth in the Carrier Business Agreement.

B. The following health benefit plans are not eligible to receive reinsurance payments;

(1) Grandfathered health benefit plans as defined in § 1251 of the Affordable Care Act;

(2) Health benefit plans that are not required to submit reinsurance contributions under § 6-102.1 of the Insurance Article;

(3) Group health insurance plans, including but not limited to those plans identified by § 15-1202 of the Insurance Article;

(4) Short-term limited duration insurance plans, including but not limited to those plans identified by § 15-1301; and

(5) Association health plans, including but not limited to those plan identified by § 15-1301.

C. Carrier State Reinsurance Program Accountability Report. For each year a carrier of a reinsurance-eligible plan participates in the State Reinsurance Program, the carrier must submit to the Board a report, to be made publically available on the Individual Exchange website upon review, detailing carrier action to manage the costs and utilization of enrollees whose claims are reimbursable under the State Reinsurance Program on a date no later than that provided in the Annual Letter to Issuers. At minimum, the report must include information related to the following:

(1) The initiatives and programs the carrier administers to manage cost and utilization of enrollees whose claims are reimbursable under the State Reinsurance Program in a narrative summary format;

(2) The total population of enrollees identified in (1), the allocation of the enrollees identified in (1) across each of the initiatives and programs identified in (1), and the allocation of enrollees identified in (1) who do not participate in the initiatives and programs identified in (1);

(3) The effectiveness of the initiatives and programs identified in (1) as measured by the estimated reduction of claims and utilization by the enrollees identified in (1);

(4) The actions the carrier will take to improve on the effectiveness estimates identified in (3);

(5) The estimated savings to the State Reinsurance Program based upon the effectiveness identified in (3);

(6) The estimated rate impact of the initiatives and programs identified in (1);

(7) The methodology utilized to determine which programs to include in (1), estimated effectives in (3), and estimated savings to the State Reinsurance Program in (4); and

(8) Population health initiatives and outcomes for Individual Exchange enrollment.

.04 Calculation of Reinsurance Payments under the State Reinsurance Program.

A. A carrier of a reinsurance-eligible plan, as provided for in Regulation .04 of this chapter, becomes eligible for reinsurance payments from the State Reinsurance Program when its claims costs for individual enrollee's covered benefits in a benefit year exceed the attachment point established under the process identified in subsection B. of this chapter.

B. Each year the Board will set the payment parameters for the State Reinsurance Program by determining the following factors:

(1) An attachment point;

(2) A coinsurance rate;

(3) A reinsurance cap; and

(4) A carrier-specific dampening factor provided by the Commissioner, if determined necessary by the Board.

C. For each benefit year after 2019, the Board will set the estimated payment parameters for the State Reinsurance Program before May 1 of the calendar year proceeding the applicable plan year.

D. For each benefit year after 2019, the Board will set the final payment parameters for the State Reinsurance Program before December 31 of the calendar year proceeding the applicable plan year.

E. The Exchange will calculate each reinsurance payment made from the State Reinsurance Program as the product of the coinsurance rate multiplied by the carrier's claims costs for an individual enrollee's covered benefits that the carrier incurs in the applicable benefit year between the attachment point and reinsurance cap. The Exchange will apply the dampening factor provided in B.(4) of this regulation to the product calculated above to determine the adjusted reinsurance payment.

F. If the Individual Exchange determines that all reinsurance payments requested under the State Reinsurance Program by reinsurance-eligible plans in the State for a benefit year will not be equal to the amount of funding allocated to the State Reinsurance Program, the Individual Exchange will determine a uniform pro rata adjustment to be applied to all such requests for reinsurance payments in the State.

.05 Data Collection and Maintenance for Reinsurance Payments.

A. The Individual Exchange will collect data required to determine reinsurance payments as described in Regulation .06 of this chapter from a carrier of reinsurance-eligible plans, or will be provided access to such data, according to the data requirements specified by the Exchange in the Annual Letter to Issuers.

B. Provides a process through which an issuer of a reinsurance-eligible plan that does not generate individual enrollee claims in the normal course of business may use estimated claims costs to make a request for payment, or to submit data to be considered for reinsurance payments, in accordance with the requirements of Regulation .09. The State must ensure that such requests for reinsurance payment, or a subset of such requests, are subject to validation.

C. The Individual Exchange will maintain documents and records relating to the State Reinsurance Program, whether paper, electronic, or in other media, for each benefit year for at least 10 years. The documents and records will be sufficient to enable the evaluation of the State Reinsurance Program's compliance with Federal standards.

D. The Individual Exchange will ensure that the collection of personally identifiable information is limited to information reasonably necessary for use in the calculation of reinsurance payments, and that use and disclosure of personally identifiable information is limited to those purposes for which the personally identifiable information was collected, including for purposes of data validation.

E. The Individual Exchange will maintain security standards that provide administrative, physical, and technical safeguards for the personally identifiable information consistent with applicable State and Federal security standards.

.06 Disbursement of Reinsurance Payments.

A. The Individual Exchange will make reinsurance payments to the carrier of a reinsurance-eligible plan after it receives a valid claim for payment from that carrier in accordance with the processes established in Regulation .09.

B. For each applicable benefit year, the Individual Exchange will:

(1) Notify carriers annually of Reinsurance payments under the State Reinsurance Program payment parameters to be made for the applicable benefit year no later than September 30 of the year following the applicable benefit year.

(2) Provide to each issuer of a reinsurance-eligible plan the calculation of total reinsurance payment requests made under the State Reinsurance Program payment parameters.

.07 Request for Reinsurance Payment.

A. A carrier of a reinsurance-eligible plan may make a request for payment when that carrier's claims costs for an enrollee of that reinsurance-eligible plan has met the criteria for reinsurance payment set forth by the Board for the applicable benefit year.

B. A carrier of a reinsurance-eligible plan must make requests for payment in accordance with the requirements of the Annual Letter to Issuers for the applicable benefit year.

.08 Document Retention and Audits

A. A carrier of a reinsurance-eligible plan must maintain documents and records, whether paper, electronic, or in other media, sufficient to substantiate the requests for reinsurance payments made pursuant to this section for a period of at least 10 years, and must make those documents and records available upon request by the Board, the Individual Exchange or its designee, to any such entity, for purposes of verification, investigation, audit, or other review of reinsurance payment requests.

B. The Individual Exchange may audit a carrier of a reinsurance-eligible plan to assess its compliance with the requirements of Chapter 17. The issuer must ensure that its relevant contractors, subcontractors, or agents cooperate with any audit under this section. If an audit results in a finding of material weakness or significant deficiency with respect to compliance with any requirement of these regulations, the carrier must complete all of the following:

(1) Within 30 calendar days of the issuance of the final audit report, provide a written corrective action plan to the Exchange for approval;

(2) Implement that plan; and

(3) Provide to the Exchange written documentation of the corrective actions once taken.

.09 State Reinsurance Program Surplus.

A. For the Benefit Year 2019, the Individual Exchange will reserve any surplus, after all reinsurance payments have been remitted, for claims in future years of the State Reinsurance Program.

B. For the Benefit Year 2020 and after, the Individual Exchange will reserve any surplus, after all reinsurance payments have been remitted, for claims in future years of the State Reinsurance Program.