

# 2020 State Reinsurance Program Parameters & Plans

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John-Pierre Cardenas, Director of Policy and Plan Management

# 2020 Qualified Health Plan Landscape

- Value Plans reduce consumer out-of-pocket costs and increase access to before deductible services, as the State Reinsurance Program is expected to reduce premiums:

Metal Level	Deductible		Actuarial Value		% Rate
	2019	2020	2019	2020	2019 - 2020
<b>Bronze</b>					
CareFirst-HMO	\$7900	\$4000 - \$7900	58.5%	59.9% - 64.9%	-9.88%
CareFirst - PPO	\$7900	\$7900	58.5%	59.9%	9.19%
Kaiser Permanente	\$6000 - \$6200	\$6000 - \$6200	61% - 61.8%	62.1% - 63.1%	5.26% - 6.22%
<b>Silver</b>					
CareFirst - HMO	\$3000	\$2250	66.3%	71.8%	Not renewed
CareFirst - PPO	\$3000	\$3000	66.3%	67.6%	9.19%
Kaiser Permanente	\$2500 - \$6000	\$2500 - \$6000	67.5% - 71.8%	68.2% - 71.9%	5.07% - 1.04%
<b>Gold</b>					
CareFirst - HMO	\$1750	\$1000 - \$1750	77.9%	78.9% - 79%	-9%
CareFirst - PPO	\$1750	\$1750	77.9%	79%	8.73%
Kaiser Permanente	\$0 - \$1500	\$0 - \$1500	77.2% - 81.4%	77.6% - 81.4%	-0.4% - 0.4%

- Increased consumer choice of QHP options in 2020 (+3 from 2019)

# Background

- The MHBE Board of Trustees established draft parameters for the 2020 State Reinsurance Program (SRP) at the April 15, 2019 session:

*Estimated Attachment Point: \$20,000*

*Co-insurance: 80%*

*Cap: \$250,000*

*Market-wide dampening factor: To be set*

- Under COMAR 14.35.17.04D the MHBE Board of Trustees shall set the final SRP parameters before December 31 of the applicable plan year.
- MHBE's agreement with CMS for administration of the SRP requires Maryland to supply CMS with finalized parameters before January 1 of the applicable plan year.

# 2020 SRP Action To Date

- Lewis & Ellis analyzed carrier data for 2018 and 2019 to model/estimate:
  - 2019 & 2020 State Reinsurance Program Cost
  - 2020 Attachment Point
  - 2020 Market-wide dampening factor
- Estimated 2019 State Reinsurance Program Cost:
  - Estimated at \$370,257,157 (State Innovation Waiver estimated \$462,000,000)
  - 2019 Federal Pass-through funding amount is \$373,395,635
  - MHBE will update the Board of SRP claims accruals to-date at the October session.

# 2020 SRP Action To Date

- Estimated 2020 State Reinsurance Program Cost:
  - Updated estimate of program cost decrease \$400,056,715
  - Maryland's State Innovation Waiver estimated 2020 SRP costs at \$459,000,000
- 2020 Attachment Point:
  - Lewis & Ellis analyzed carrier data for 2018 and 2019 to model the attachment point for the 2020 State Reinsurance Program that would yield a -30% premium impact.
  - The analysis supports a 2020 SRP attachment point of \$20,000 with an estimated premium impact of -29.7%.

# 2020 SRP Action To Date

- 2020 Market-wide dampening factor:
  - Under COMAR 14.35.17.04B4 the SRP will include a market-level dampening factor provided by the Commissioner, if determined necessary by the Board.
  - Analysis by L&E found a high degree of program interaction between risk adjustment and the SRP.
    - Loss ratio for reinsurance-eligible cohort (Claims  $\geq$  \$20,000) estimated at 20%
    - Loss ratio for cohort with Claims \$2,900 and \$20,000 estimated at 94%
    - Cohort with the highest claims would be the most profitable
  - Reproduction of 2019 methodology for 2020 did not yield reasonable results (-5% dampening) given the high degree of interaction.

# 2020 SRP Action To Date

- 2020 Market-wide dampening factor:
  - Lewis & Ellis performed analysis of the risk adjustment/reinsurance interaction using a *claims-based* approach, an *adjusted claim-based* approach, and performed an alternative analysis using a *risk-based* (PLRS) approach. Recommendations:
    - Claims-based: 1.05
      - Difference in ratios between low claims and high claims: 0%
    - Adjusted claims-based: .785
      - Difference in ratios between low claims and high claims: 46%
    - Risk-based: .75
      - Difference in ratios between RA payers and RA receivers: 64%
  - The Maryland Insurance Administration Office of the Chief Actuary performed an adjusted claims-based analysis as Lewis & Ellis in parallel.
    - Adjusted claims-based: .785

# Staff Recommendations

1. MHBE Staff recommends that the Board set the attachment point for the 2020 State Reinsurance Program to \$20,000
2. MHBE Staff recommends that the Board determine that a market-wide dampening factor is necessary for the 2020 State Reinsurance Program.
3. MHBE Staff recommends that the Board release for public comment and stakeholder engagements the alternative *risk-based* approach for setting the market-wide dampening factor for potential adoption in the 2021 SRP.

# State Benchmark Plan Work Group Report

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John-Pierre Cardenas, Director of Policy and Plan Management  
Leni Preston, Chair, State Benchmark Plan Work Group

# Background

- Section 1302 of the Affordable Care Act establishes that plans sold in the individual and small group markets offer coverage for a comprehensive set of benefits, i.e. Essential Health Benefits
- In 2011, the U.S. Department of Health and Human Services (HHS) established a process through which states can select a “benchmark plan” that covers the EHBs
- In 2018, HHS modified this process to provide states with greater flexibility to determine, update, or modify their existing benchmark plans.
- EHBs included in these benchmark plans are linked with the applicability of federal funds (i.e. advanced premium tax credits, APTCs) that are used reduce the cost of premiums for enrollees.
- Opportunity to orient the State Benchmark Plan to be responsive to changes in Maryland’s health system landscape, e.g. population health metrics under the CMS Waiver for the Total Cost of Care Model

# Work Group Requirements

1. Determine whether the current benchmark plan meets the needs of the individual market.
2. Provide recommendations on whether to leverage new state flexibility to modify the State Benchmark Plan
3. Solicit Report must include feedback from the Standing Advisory Committee, market impact of the change, and estimated savings/costs of the approach.
4. Provide a public comment period of no less than 30 days upon release of the report.

# Work Group Findings

- Maryland's State Benchmark Plan (SBP) is unique features when compared with other states. For example:
  1. Maryland's SBP does not include Weight Loss Programs and Routine Foot Care
  2. Maryland has one of the most generous formularies when compared with other states with 1,069 drugs in the SBP formulary
    - a. States range from fewer 600 to 1,023 drugs included in their SBP formularies
  3. Maryland is the only state covering acupuncture without limitations
- Existing statute under Insurance Article § 31-116 (c)(1), precludes the State from determining/modifying the SBP without a directive from the U.S. Secretary of Health and Human Services

# Recommendations

- Recommendation #1: Philosophical approach & analytical framework
- Recommendation #2: Studies that should inform the determination of the State Benchmark Plan
- Recommendation #3: Modification to Insurance Article § 31-116

# Work Group Recommendation 1: Philosophical Approach/Analytical Framework

- Establishes a definition statement for an ideal State Benchmark Plan:

*Comprehensive, high quality, non-discriminatory, customized to the individual needs and unique morbidity profile of Marylanders, and encourages participation in the individual and small group markets.*

- Establishes criteria for the SBP to meet the definition statement:
  1. Improved health outcomes and near-term affordability with consideration of long-term cost savings to the health system:
    - a. metrics used to evaluate outcomes
    - b. definition scope for benefits
    - c. analytical framework for the evaluation of benefits included in the SBP

# Work Group Recommendation 1: Philosophical Approach/Analytical Framework (cont'd)

c. analytical framework for the evaluation of benefits included in the SBP

	Low Utility*		High Utility*
Low Cost	Consider limitation	for	Prioritize for expansion
High Cost	Prioritize limitation	for	Consider for either limitation or expansion

\* Including quality of care, quality adjusted life years, patient-centered outcomes, and other health outcomes metrics.

- c. establishes scope of the application of the framework in 'c' for benefits that impact specific populations
- d. establishes a recommended timeline for the periodic analysis of the SBP and for ad hoc analysis in response to population health emergencies
- e. establishes a framework to consider the potential premium impact of any modifications

2. Recommends special consideration of the differential impact of SBP modification on specific sub-populations

# Work Group Recommendation 2: Studies that should inform determination of the State Benchmark Plan.

Study	Existing/New	Methods	Recommendation/Research Question
Study of Mandates Services	Required under Insurance Article § 15-1502, Annotated Code of Maryland		<p>Recommendations:</p> <ol style="list-style-type: none"> <li>1. The Study should be performed as soon as possible, on schedule, and adequately funded.</li> <li>2. The Study should be expanded to include all of the benefit categories under the State Benchmark Plan and recommendations for including additional benefits.</li> <li>3. The Study should consider all of the factors set forth under Insurance Article § 15-1501(C) for the benefit categories under the State Benchmark Plan, in parity with the factors considered for the study of mandated services.</li> <li>4. The Study should provide information on unit cost/utilization for each of the benefit categories.</li> </ol>
Study on Consumer Experience with Benefits	New	Surveys, interviews, & focus groups	<p>Research Questions:</p> <ol style="list-style-type: none"> <li>1. What is the perceived value of insurance benefits? Which benefits are considered priorities by consumers?</li> <li>2. Which benefits should be included based off perceived value/consumer priorities?</li> <li>3. What are perceived barriers to care, including accessibility, coverage exclusions, etc.?</li> </ol> <p>Recommendations:</p> <ol style="list-style-type: none"> <li>1. Study should control for financial assistance and sub-populations with health disparities.</li> <li>2. Study should control for health literacy.</li> </ol>

# Work Group Recommendation 2: Studies that should inform determination of the State Benchmark Plan.

Study	Existing/New	Methods	Recommendation/Research Question
Study on the Intersection of Social Determinants of Health and Benefits	New	Population data, claims data, etc.	<p>Research Questions:</p> <ol style="list-style-type: none"> <li>1. Do social determinants of health impact the consumer’s ability to access benefits in the package?</li> <li>2. How can existing benefits be structured/implemented to address social determinants of health, if necessary?</li> <li>3. What are the exogenous factors that impact the consumer’s experience when interacting with the health system outside of benefits?</li> <li>4. Has the SBP made a difference? For example, has Pediatric Dental &amp; Vision benefit improved outcomes? Has the SBP affected benefit utilization?</li> </ol>
<p>Potential research area for further discussion and engagement:</p> <p>Effectiveness review of issuer chronic disease management/utilization review programs across markets with the intent to increase transparency, promote adoption of best practices, and determine outcomes.</p>			

## Recommendation 3: Modification to Insurance Article § 31-116, Annotated Code of Maryland.

- Allow the State to leverage new flexibilities to modify the State Benchmark Plan.
- Include criteria to ensure study-driven decision making, consideration of special populations, ample public input, and process transparency.

# Affordability Work Group Report

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John-Pierre Cardenas, Director of Policy and Plan Management

Ken Brannan, Co-Chair Affordability Work Group

Beth Sammis, Co-Chair Affordability Work Group

Figure 1. Factors of health coverage that affect market participation and health systems interaction.

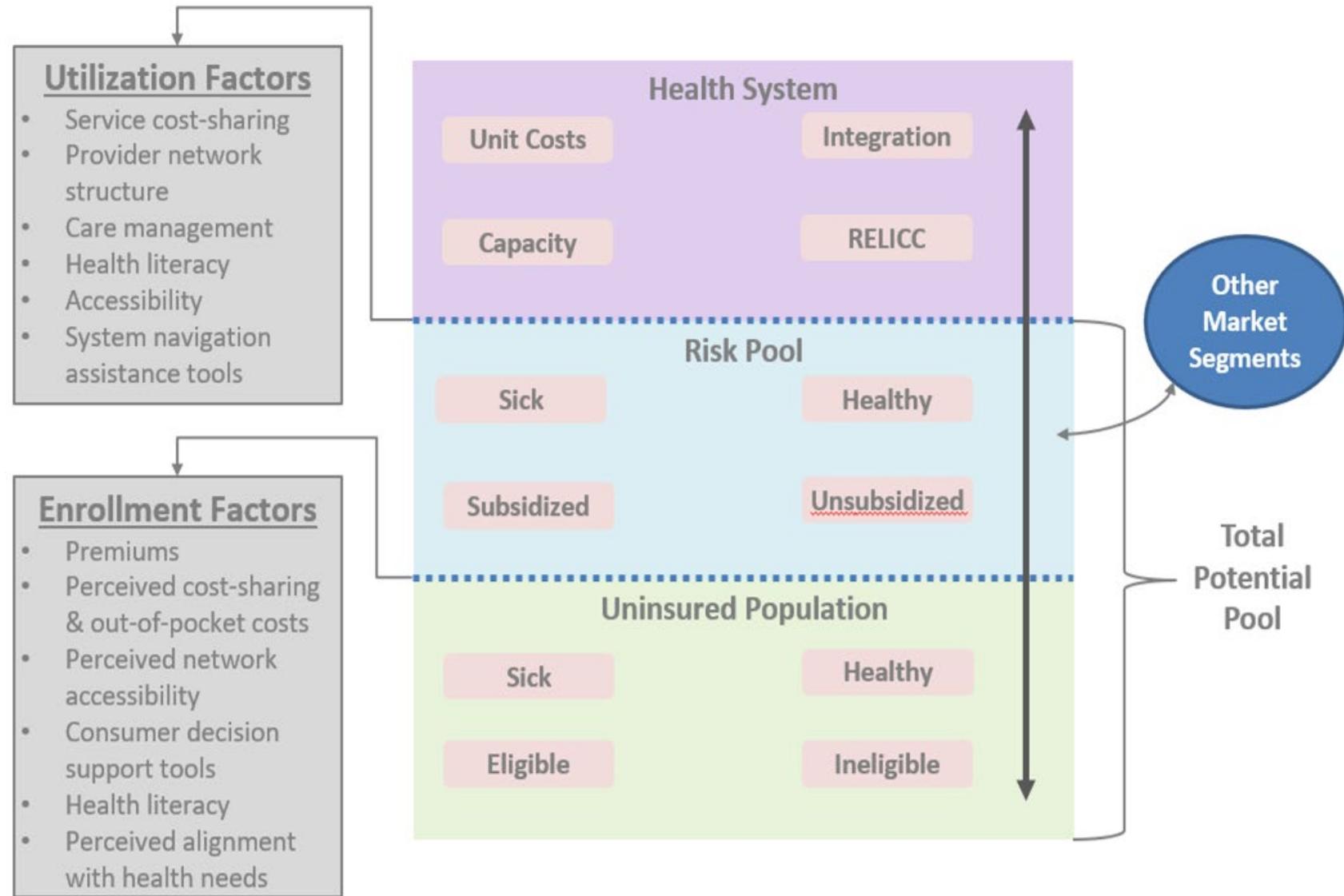
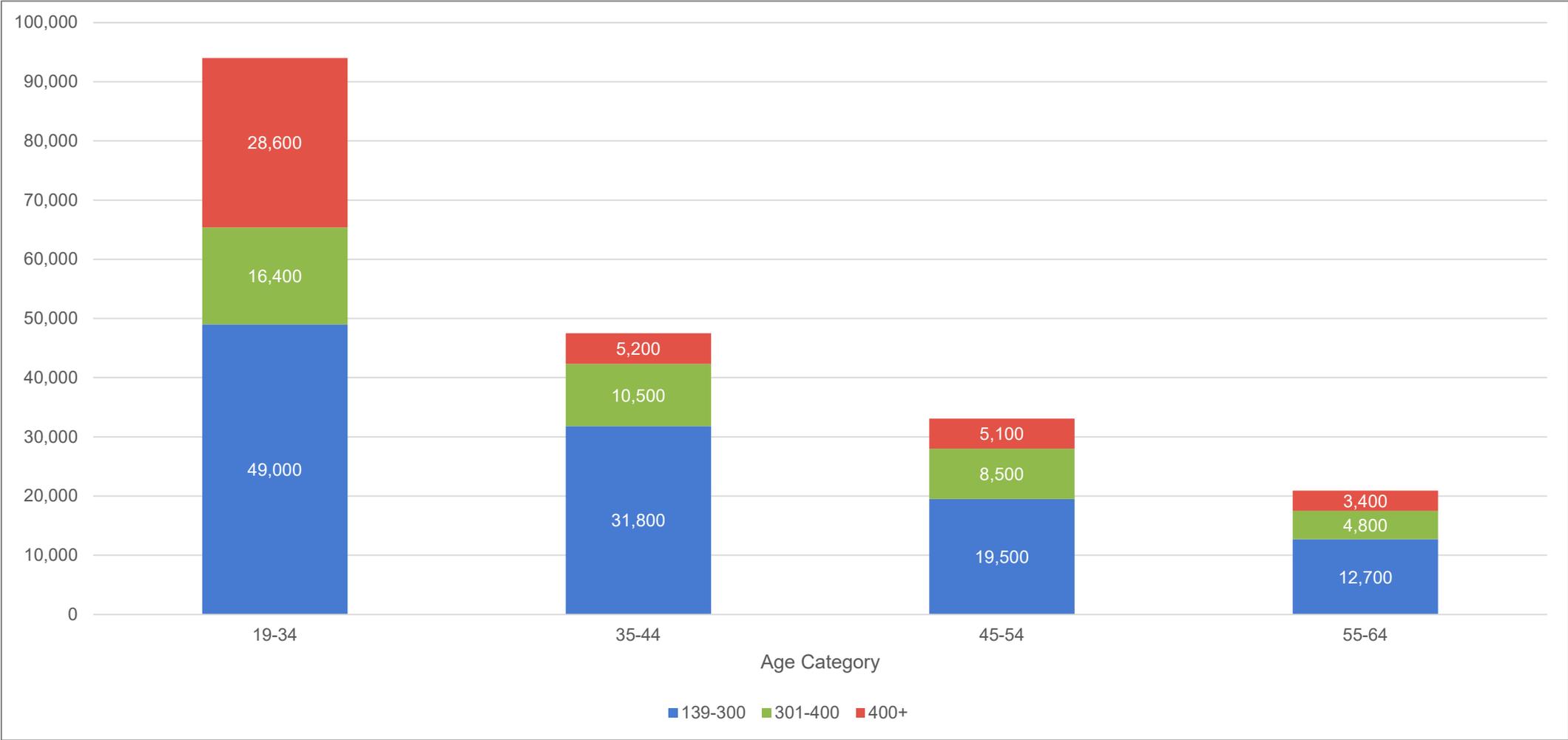
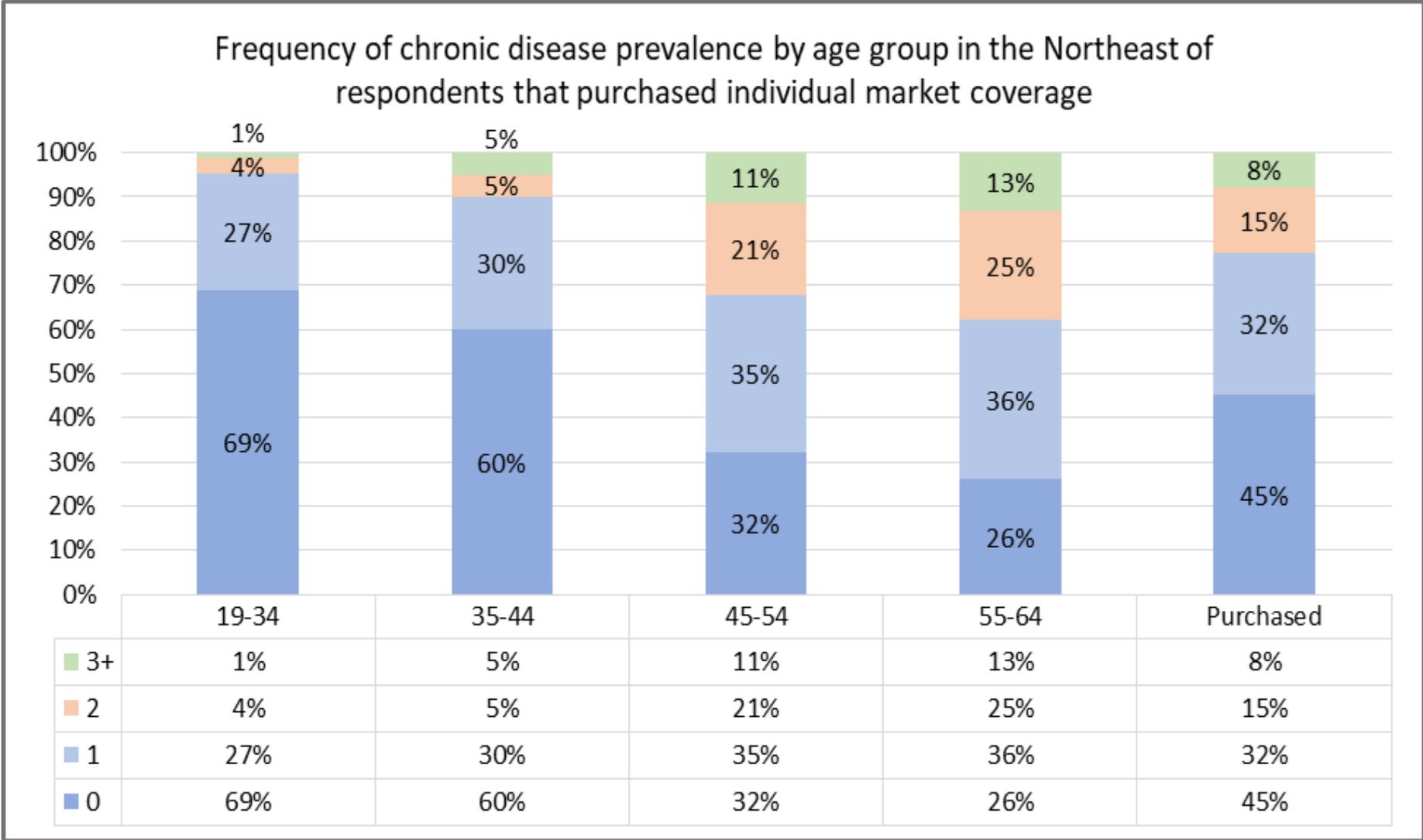


Chart 1. Uninsured, non-elderly Maryland adults stratified by income category (by FPL) and age group.



SOURCE: Presentation to the Affordability Work Group. (Families USA 2019)

# Chart 2. The prevalence of chronic disease in the individual market by age groups.



SOURCE: Prevalence of chronic disease across age groups. (MHBE 2019)

### Table 3: Intervention Population #1: Young Adults (18-34)

Sub-Group	Near Term	Long Term
<p>General Women Young Adults with Substance Use Disorder/Behavioral Health needs</p>	<ol style="list-style-type: none"> <li>1. Marketing investment focused on Young Adults</li> <li>2. Value Plans:               <ol style="list-style-type: none"> <li>a. Evaluate the outcomes of the Value Plans</li> <li>b. Marketing investment in Value Plans</li> </ol> </li> <li>3. Consumer Decision Support Tools:               <ol style="list-style-type: none"> <li>a. Development of an Out-of-Pocket Cost Calculator</li> <li>b. Development of a plan shopping experience optimized to display service categories customized by the user, or automatically, by age</li> </ol> </li> <li>4. Development of a health literacy program focused on Young Adults</li> <li>5. Successful implementation of the Maryland Easy Enrollment Health Insurance Program</li> </ol>	<p>Continued marketing investment focused on Young Adults</p>
<p>139% - 400 % FPL Eligible for financial assistance</p>	<ol style="list-style-type: none"> <li>1. A marketing investment focused on Young Adults</li> <li>2. The State should commission a study on a supplemental premium subsidy for Young Adults that does not modify the existing federal tax credit structure. The study should:               <ol style="list-style-type: none"> <li>a. Analyze potential interaction with the State Reinsurance Program, and federal pass through, for the following scenarios:                   <ol style="list-style-type: none"> <li>i. Supplemental premium subsidy w/ an independent funding source</li> <li>ii. Supplemental premium subsidy w/ funding carved-out from the existing premium assessment under Md. INSURANCE Code Ann. § 6-102.</li> </ol> </li> </ol> </li> </ol>	<ol style="list-style-type: none"> <li>1. Establishment of a state-based supplemental premium subsidy for Young Adults:               <ol style="list-style-type: none"> <li>a. Utilizing only state funds or,</li> <li>b. Utilizing state &amp; federal pass-through funds under a 1332 waiver.</li> </ol> </li> </ol>

## Table 3: Intervention Population #1: Young Adults (18-34)

Sub-Group	Near Term	Long Term
<p>139% - 400 % FPL Eligible for financial assistance</p>	<ul style="list-style-type: none"> <li>i. Supplemental premium subsidy under i &amp; ii seeking federal pass through under a 1332 waiver</li> <li>a. Estimate required funding amount &amp; identify potential funding sources</li> <li>b. Project impact of the subsidy on the individual market for a five- and ten-year time horizon</li> <li>c. Be updated at a later time to account for the implementation of other policies, i.e. the Maryland Easy Enrollment Health Insurance Program</li> </ul>	<ul style="list-style-type: none"> <li>1. Establishment of a state-based supplemental premium subsidy for Young Adults:               <ul style="list-style-type: none"> <li>a. Utilizing only state funds or,</li> <li>b. Utilizing state &amp; federal pass-through funds under a 1332 waiver.</li> </ul> </li> </ul>
<p>400+% FPL Ineligible for financial assistance</p>	<ul style="list-style-type: none"> <li>1. Continuation of the State Reinsurance Program</li> </ul>	<ul style="list-style-type: none"> <li>1. Continuation of the State Reinsurance Program</li> <li>2. Establishment of a state-based supplemental premium subsidy for Young Adults:               <ul style="list-style-type: none"> <li>a. Utilizing only state funds or,</li> <li>b. Utilizing state &amp; federal pass-through funds under a 1332 waiver.</li> </ul> </li> </ul>

## Table 4. Intervention Population #2: Individuals with Chronic Diseases

Sub-Group	Near Term	Long Term
General	<ol style="list-style-type: none"> <li>1. Value Plans               <ol style="list-style-type: none"> <li>a. Evaluate the outcomes of the Value Plans</li> <li>b. Study separate medical &amp; drug deductibles and/or generic drugs before deductible                   <ol style="list-style-type: none"> <li>i. Requirement within Actuarial Value ranges (+2/-4)</li> <li>ii. Impact on the utilization and cost-sharing of other benefit categories</li> </ol> </li> </ol> </li> <li>2. Chronic Disease Management Programs               <ol style="list-style-type: none"> <li>a. Increase participation in these programs through education/health literacy</li> <li>b. Analysis of State Reinsurance Program claims for conditions that are drivers of claims to the SRP and the prevalence of those conditions</li> <li>c. Promotion of those with diabetes, hypertension, and depression into Care Management Programs</li> <li>d. State-wide coordination of chronic disease management programs and measurements across markets &amp; programs (Medicare &amp; Medicaid) including diabetes prevention programs</li> </ol> </li> <li>3. Consumer Decision Support Tools               <ol style="list-style-type: none"> <li>a. Plan shopping experience that is responsive to consumer's unique service category needs</li> <li>b. Prescription Drug Search that relays cost sharing, limitations/ exclusions, prior authorizations, and consumer protections for formulary changes</li> </ol> </li> </ol>	<ol style="list-style-type: none"> <li>1. Continuation of the State Reinsurance Program</li> </ol>

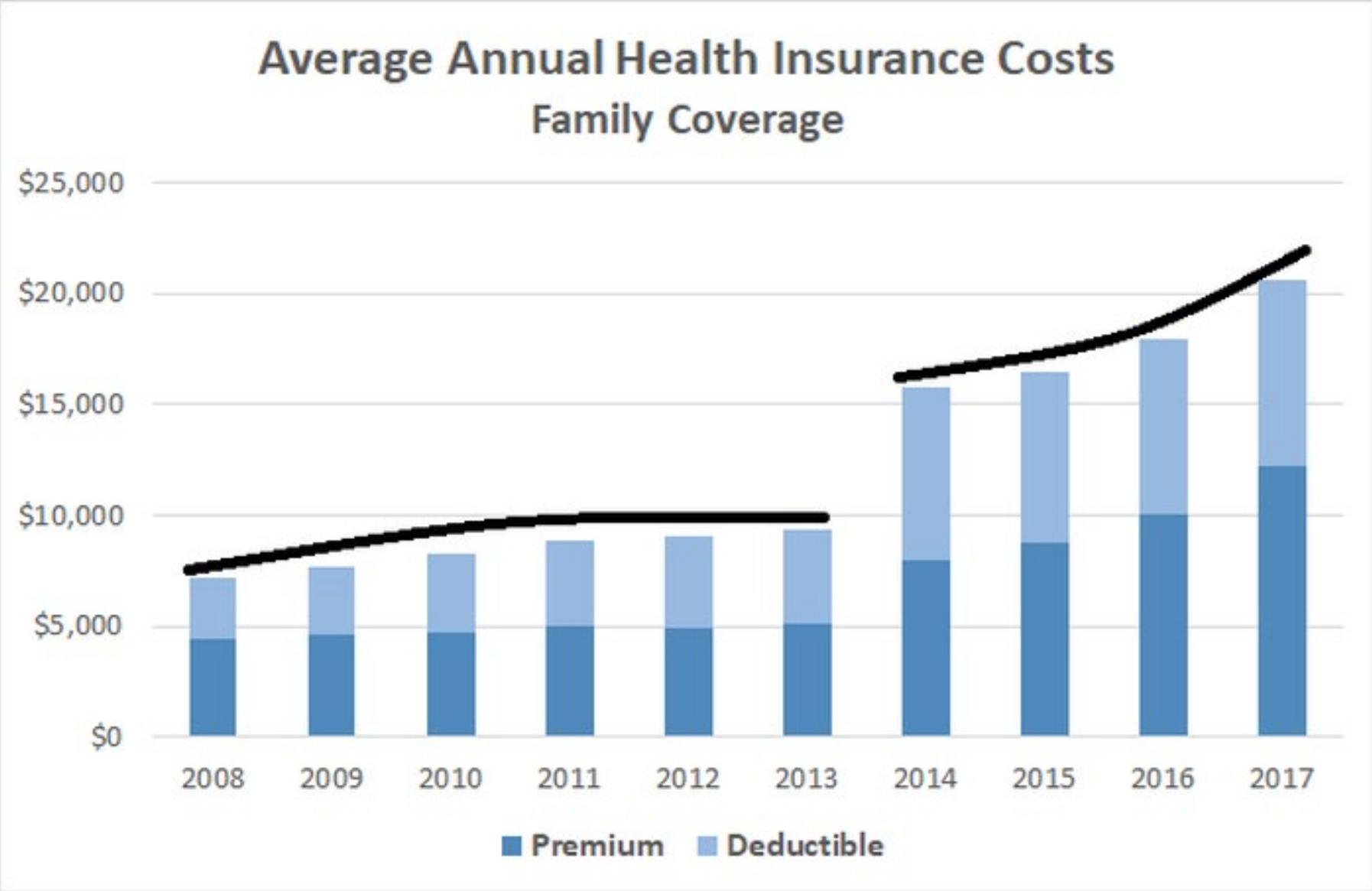
## Table 4. Intervention Population #2: Individuals with Chronic Diseases

Sub-Group	Near Term	Long Term
General	<ol style="list-style-type: none"> <li>4. Provider Networks               <ol style="list-style-type: none"> <li>a. Expansion of care coordination for those with chronic diseases</li> <li>b. Expand capacity through telemedicine services</li> <li>c. Improve health literacy for the newly insured with provider selection</li> </ol> </li> </ol>	<ol style="list-style-type: none"> <li>1. Continuation of the State Reinsurance Program</li> </ol>

# Proposed 2021 Plan Certification Standards & MHBE Regulations

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John-Pierre Cardenas, Director of Policy and Plan Management



SOURCE: "The Most Important Health Insurance Chart You'll Ever See," The Motley Fool, Keith Spreights, 09/05/17

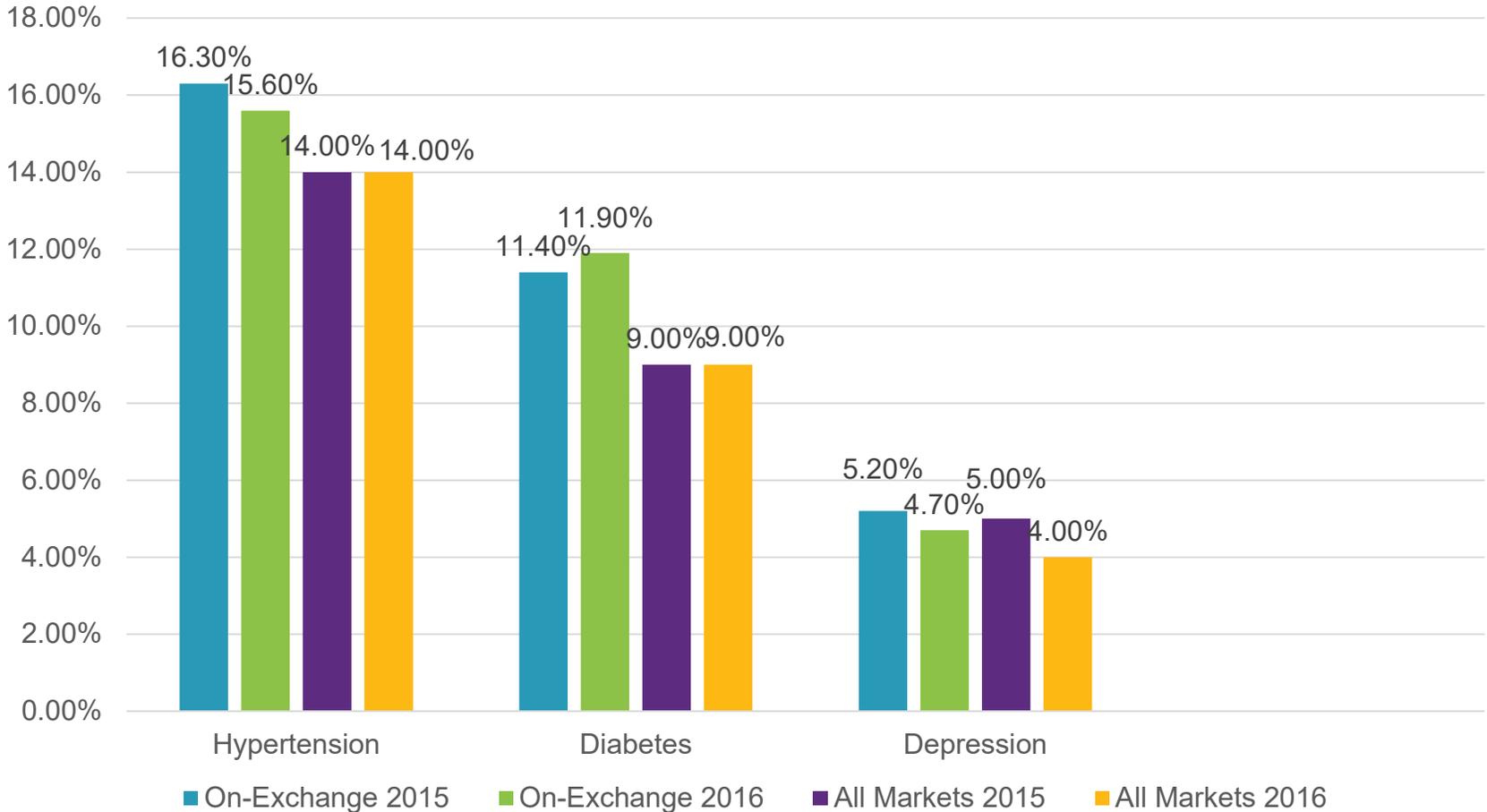
# 2021 Plan Certification Standards & Policy Concepts

- 2021 Plan Certification Standards & Policy Concepts seek to:
  1. Build off improvements in 2020.
  2. Establish reasonable consumer expectations for out-of-pocket costs.
  3. Align consumer incentives for health care service utilization.
  4. Increase enrollee effectuation rates in the individual marketplace.
  5. Align carrier incentives to manage members with high costs.
  6. Increase access to stand-alone dental coverage through Maryland Health Connection.



# Proposed Value Plan Standards

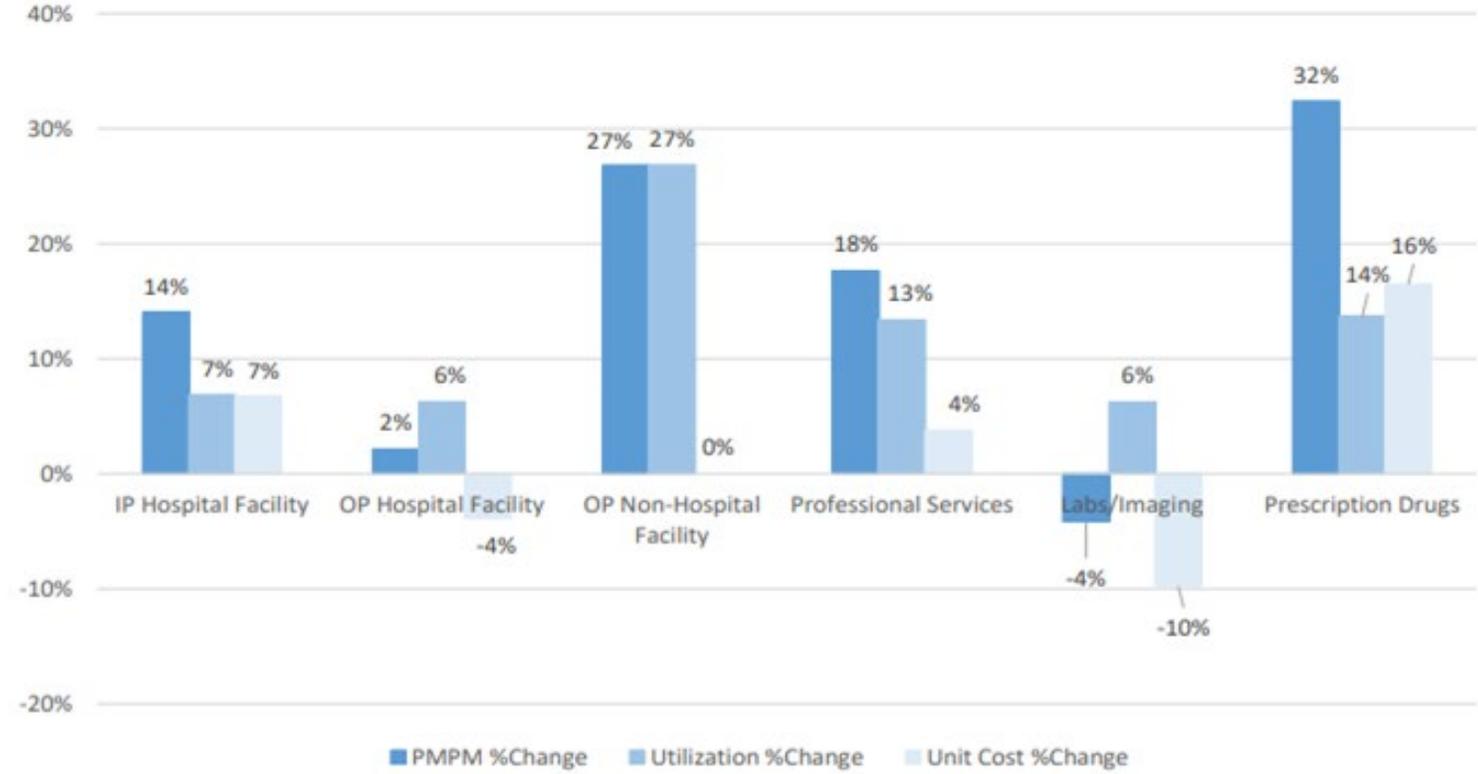
# 2015 – 2016 Prevalence of Select Conditions.



SOURCE: Spending and Use Among Maryland’s Privately Insured (MHCC 2018 & 2019)

# 2016 – 2017 Drivers of Spending Growth in the Individual Market.

**Exhibit 15:** Annual Percentage Changes in PMPM Spending, Utilization per 1,000 Members, and Cost per Unit, by Service Category in the Individual Market (ACA-Compliant and Non-Compliant Plans): 2016 – 2017

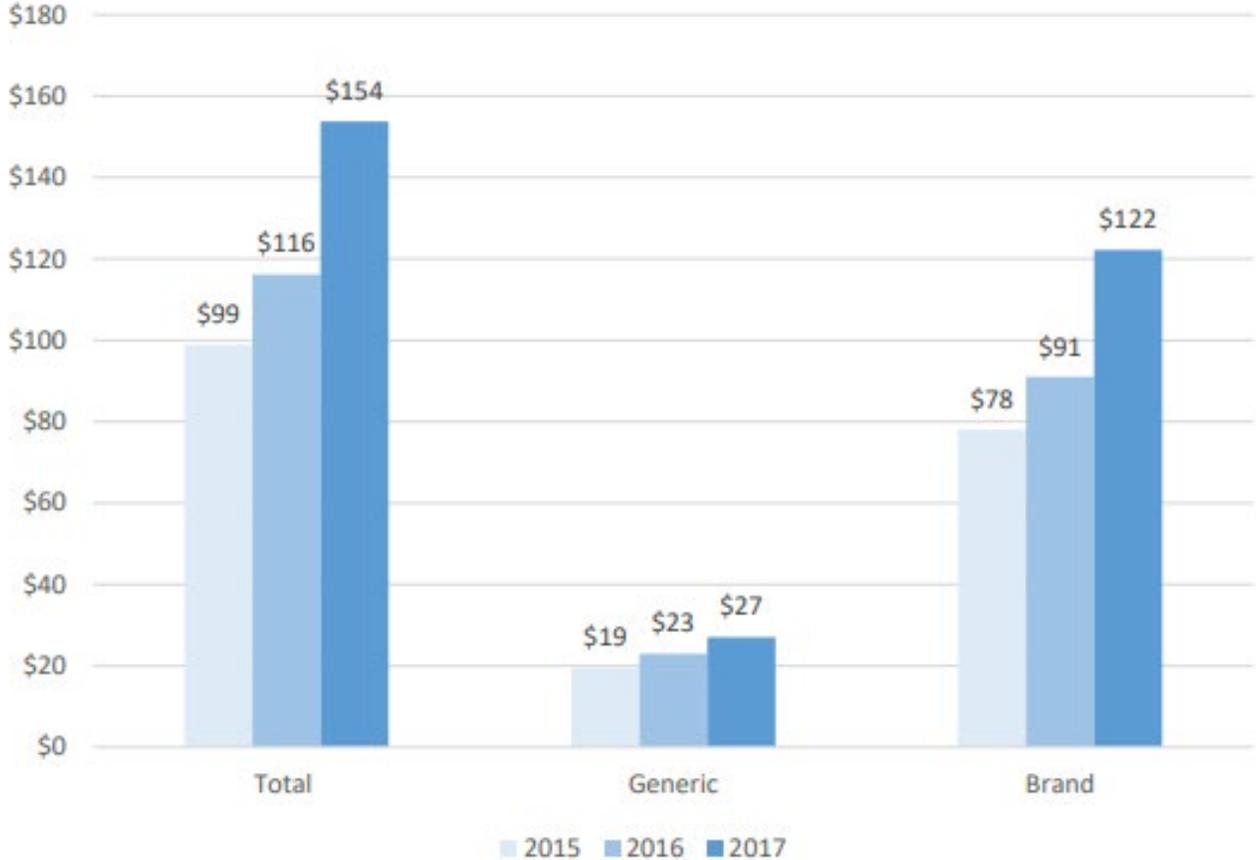


Note: (1) Results exclude Kaiser HMO plans.

SOURCE: Spending and Use Among Maryland’s Privately Insured (MHCC 2019)

# 2015-2017 Prescription Drug PMPM by Drug Type, Individual Market.

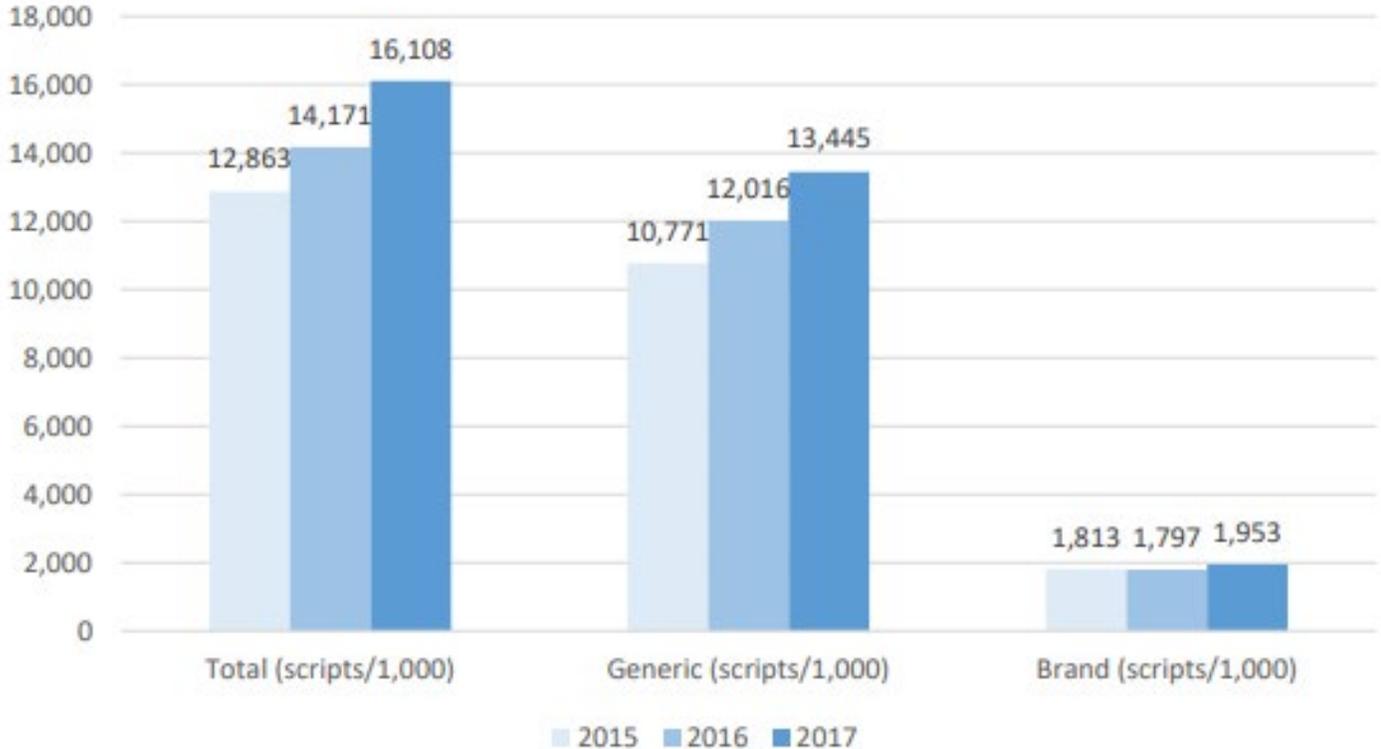
Exhibit A5: Prescription Drug PMPM Changes by Drug Type, Individual Market, 2015 – 2017



SOURCE: Spending and Use Among Maryland’s Privately Insured (MHCC 2019)

# 2015-2017 Prescription Drug Utilization by Drug Type, Individual Market.

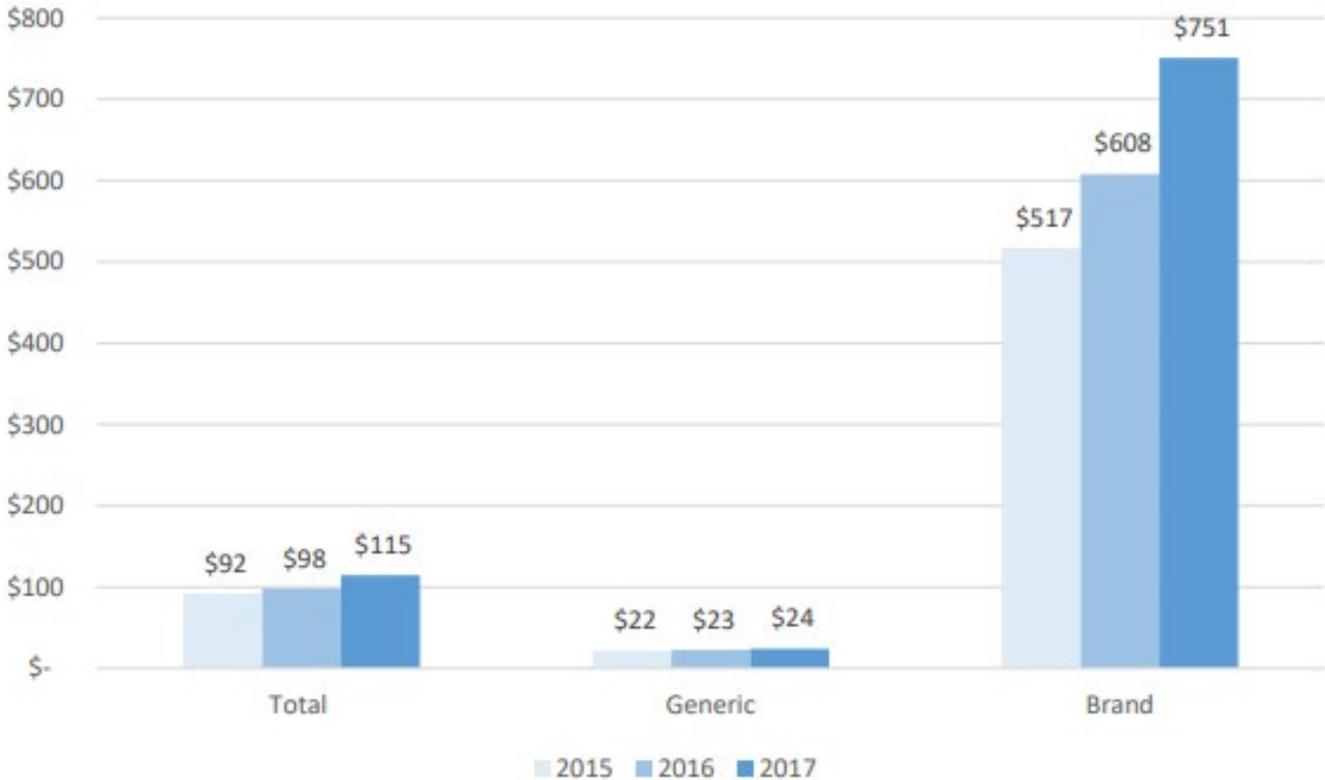
Exhibit A9: Prescription Drug Utilization Changes by Drug Type, Individual Market, 2015 – 2017



SOURCE: Spending and Use Among Maryland’s Privately Insured (MHCC 2019)

# 2015-2017 Prescription Drug Costs by Drug Type, Individual Market.

Exhibit A13: Prescription Drug Unit Cost Changes by Drug Type, Individual Market, 2015 – 2017



SOURCE: Spending and Use Among Maryland’s Privately Insured (MHCC 2019)

# Expansion of Preventive Services for Certain Chronic Diseases Permitted before Deductible (HDHP Parity Rule)

- **BACKGROUND:** [IRS Notice 2019-45](#) expanded the scope of preventive services permitted to be covered before deductible by a high-deductible health plan to include certain services for certain chronic diseases.

<b>Preventive Care for Specified Conditions</b>	<b>For Individuals Diagnosed with</b>
Angiotensin Converting Enzyme (ACE) inhibitors	Congestive heart failure, diabetes, and/or coronary artery disease
Anti-resorptive therapy	Osteoporosis and/or osteopenia
Beta-blockers	Congestive heart failure and/or coronary artery disease
Blood pressure monitor	Hypertension
Inhaled corticosteroids	Asthma
Insulin and other glucose lowering agents	Diabetes
Retinopathy screening	Diabetes
Peak flow meter	Asthma
Glucometer	Diabetes
Hemoglobin A1c testing	Diabetes
International Normalized Ratio (INR) testing	Liver disease and/or bleeding disorders
Low-density Lipoprotein (LDL) testing	Heart disease
Selective Serotonin Reuptake Inhibitors (SSRIs)	Depression
Statins	Heart disease and/or diabetes

# Expansion of Preventive Services for Certain Chronic Disease Permitted before Deductible (HDHP Parity Rule)

- **CONCEPT:** Apply the expanded list in IRS Notice 2019-45 that may be permitted before deductible for HDHPs to non-HDHP qualified health plans in the individual market for certain services. MHBE seeks comment on the services that should be required before deductible.
- **GOAL:** To improve health outcomes, increase utilization of high value care, lower out-of-pocket costs for enrollees with chronic diseases, and align individual market plans with state-wide population health initiatives.
- **PROPOSAL OPTIONS:**
  1. **BROAD:** Apply the HDHP Parity Rule for certain services to all non-HDHP QHPs.
  2. **NARROW:** Apply the HDHP Parity Rule for certain services to all Value Plans.
- **CONSIDERATIONS:**
  1. Impact to premiums and actuarial value.
  2. Impact to public health and access to preventive care.

# Out-of-Pocket Cost and Deductible Stability Plan

- CONCEPT: Leverage the “Value” Plans structure to incrementally implement Value-Based Insurance Design concepts and promote medical adherence.
- GOAL: Provide consumers with reasonable expectations of deductibles and out-of-pocket costs while promoting cost-sharing structures that:
  1. Increase the use of high-value care.
  2. Decrease the use of low-value care.
  3. Limit premium increases attributable to increased actuarial value.
- EXTERNALITIES:
  1. Increase market participation with the availability of high value plans.
  2. Align products in the individual market with state-wide initiatives under the Total Cost of Care Waiver.
  3. Create incentives for value-based product innovation

# Out-of-Pocket Cost and Deductible Stability Plan

YEAR 2020: Implement “Value” plans with deductible and before deductible service requirements.

Requirements	Bronze	Silver	Gold
Minimum offering	Issuer must offer at least 1 “Value” plan.	Issuer must offer at least 1 “Value” plan.	Issuer must offer at least 1 “Value” plan.
Branding	Required for 2020.	Optional.	Optional.
Deductible ceiling	No requirement. Lower deductibles are encouraged.	\$2500 or less.	\$1000 or less.
Services Before Deductible	<p>Issuer may allocate no less than three office visits across the following settings:</p> <ul style="list-style-type: none"> <li>· Primary Care Visit (not including preventive care)</li> <li>· Urgent Care Visit</li> <li>· Specialist Visit</li> </ul>	<ul style="list-style-type: none"> <li>· Primary Care Visit</li> <li>· Urgent Care Visit</li> <li>· Specialist Care Visit</li> <li>· Laboratory Tests</li> <li>· X-rays and Diagnostics</li> <li>· Imaging</li> <li>· Generic Drugs*</li> </ul>	<ul style="list-style-type: none"> <li>· Primary Care Visit</li> <li>· Urgent Care Visit</li> <li>· Specialist Care Visit</li> <li>· Laboratory Tests</li> <li>· X-rays and Diagnostics</li> <li>· Imaging</li> <li>· Generic Drugs</li> </ul>

\*Encouraged.

# Out-of-Pocket Cost and Deductible Stability Plan

YEAR 2021: No changes for the Value Bronze Plan. Limited modifications to the Value Silver and Value Gold Plans.

- Both Value Silver and Value Gold Plans: No change in deductible ceiling, lower deductibles encouraged.
- Value Silver only:
  - Requirement #1 – Modify before deductible services to include Generic Drugs.
  - Requirement #2 – Modify before deductible services to exclude Imaging.
  - Flexibility – Options to help issuers meet Value Silver requirements offsets to increases in AV may include:
    1. Changes to cost sharing for Specialist Care Visit, Laboratory Services, and X-rays and Diagnostics.
    2. Limitations for Laboratory Services and X-rays and Diagnostics.

# Out-of-Pocket Cost and Deductible Stability Plan

YEAR 2021: No changes for the Value Bronze Plan. Limited modifications to the Value Silver and Value Gold Plans.

- Value Gold only:
  - Flexibility – Options to help issuers meet Value Gold requirements offsets to increases in AV may, but are not limited to, include:
    1. Changes in cost sharing for Specialist Care Visit, Laboratory Services, X-rays and Diagnostics, and Imaging.
    2. Limitations for Laboratory Services, X-rays and Diagnostics, and Imaging.
    3. Exclusion of Imaging from Before Deductible Services.
- Options to modify Value Gold prescription drug structure to reduce out-of-pocket costs for brand drugs:
  1. Implement a prescription drug deductible ceiling of no greater than \$250.
  2. Include Preferred Brand Drugs as a Before Deductible Service.

# Out-of-Pocket Cost and Deductible Stability Plan

- YEAR 2021: No changes for the Value Bronze Plans. Limited modifications to the Value Silver and Value Gold Plans. Note: Value Gold does not include modified prescription drug structure.

Requirements	Bronze	Silver	Gold
Minimum offering	Issuer must offer at least 1 “Value” plan.	Issuer must offer at least 1 “Value” plan.	Issuer must offer at least 1 “Value” plan.
Branding	Required.	Required.	Required.
Medical Deductible Ceiling	No requirement. Lower deductibles are encouraged.	\$2500 or less.	\$1000 or less.
Services Before Deductible	Issuer may allocate no less than three office visits across the following settings: <ul style="list-style-type: none"> <li>Primary Care Visit</li> <li>Urgent Care Visit</li> <li>Specialist Visit</li> </ul>	<ul style="list-style-type: none"> <li>Primary Care Visit</li> <li>Urgent Care Visit</li> <li>Specialist Care Visit</li> <li>Laboratory Tests*+</li> <li>X-rays and Diagnostics*+</li> <li>Generic Drugs</li> </ul>	<ul style="list-style-type: none"> <li>Primary Care Visit</li> <li>Urgent Care Visit</li> <li>Generic Drugs</li> <li>Specialist Care Visit</li> <li>Laboratory Tests*</li> <li>X-rays and Diagnostics*</li> </ul>

Recommended to maintain, or decrease, cost sharing from 2020.

\*May be subject to limitation.

+May be excluded from before deductible services.

# Out-of-Pocket Cost and Deductible Stability Plan

YEAR 2022: Deductible Increment Rule Base Year.

- Deductible Increment Rule Base Year:
  1. A formula to determine yearly allowable increases to the deductible ceilings for Value Silver and Value Gold Plans. For the 2022 Base Year:
    - Value Silver Deductible Ceiling = 6%(2022 Maryland Median Wage)
    - Value Gold Deductible Ceiling = 2.5%(2022 Maryland Median Wage)
    - For both, the final deductible ceiling is the output rounded upward to the nearest 100<sup>th</sup>.

# Out-of-Pocket Cost and Deductible Stability Plan

YEAR 2023: Implement Deductible Increment Rule.

- Deductible Increment is the amount the deductible ceilings may increase for Value Gold and Value Silver plans from the base year.
  - OPTION 1: The deductible ceiling is adjusted every two years.
  - OPTION 2: The deductible ceiling is adjusted every year.
- Deductible Increment factor may draw from other indicators of medical cost growth, for example:
  1. Increases in the Annual Out-of-Pocket Maximum.
  2. Deductible thresholds established by the IRS for High Deductible Health Plans.
  3. A Maryland-specific index.
  4. Consumer Price Index (instead of the Medical-CPI)

The background is a solid teal color. In the center, there is a stylized graphic of a flower or a starburst shape, composed of four overlapping, rounded, petal-like shapes that meet at the center. The text is centered over this graphic.

# Proposed Plan Certification Standards

# PayNow URL Requirement

- **CONCEPT:** Require issuers participating on Maryland Health Connection to implement a PayNow URL, i.e. to allow consumers to pay their first month's premium at the point of enrollment.
- **GOAL:** Increase coverage effectuation in the individual market.
  1. Promote market stability through increased member months.
  2. Lowers the administrative barriers to access coverage for consumers.
- **EXTERNALITIES:**
  1. When coupled with other enrollment initiatives (the Maryland Easy Enrollment Health Insurance Program) this requirement may increase coverage up-take for target populations.
  2. Creates a uniform customer service experience on Maryland Health Connection.
- **UTILIZATION:** The PayNow URL was utilized 11,000+ in Open Enrollment 2018.

# Co-pay Accumulator Program Transparency

- **CONCEPT:** Require issuers to disclose in their “Important Information About This Plan” document if they utilize a Co-pay Accumulator Program for prescription drugs covered in their formulary and provide information on how the program may impact their out-of-pocket costs.
- **GOAL:** Increase coverage transparency for enrollees with who utilize coupons to reduce the cost their prescription drug.
  1. Increase informed decision making.

# Expand Access to Stand-Alone Dental Coverage

- CONCEPT: Implement special enrollment periods for Stand-Alone Dental Coverage offered on Maryland Health Connection for the following trigger events:
  1. Determination of eligibility for Medical Assistance Programs.
  2. Determination of eligibility for a Qualified Health Plan.
  3. New enrollment in the Small Business Health Options Program.
  4. Access to an excepted benefits HRA.
- GOAL: Expand access to dental coverage and increase enrollment in Stand-Alone Dental Plans offered on Maryland Health Connection.

# Increased Premium Rating Options for Small Employers

- CONCEPT: Require SHOP issuers offer at least one QHP at the bronze, silver, and gold metal levels that allows for Composite Rating.
- GOAL: Expand access to alternative premium options for small employers participating on the SHOP.

# Lower Administrative Barriers for New Market Entrants

- CONCEPT: Offer optional sample plan designs at the bronze, silver, and gold metal levels.
- GOAL: Lower administrative barriers for potential new market entrants with limited experience with plan design development.



# Regulations

# SHOP Regulations

- August 19<sup>th</sup>: Regulation public comment period closed
  - MHBE received minimal feedback from stakeholders
  - Non-substantive changes for clarity were incorporated

# Other Regulations

- Federal Conformity Regulations:
  - Yearly regulations MHBE must adopt to conform to changes promulgated by HHS
  - Changes include:
    - SEP for off-Exchange enrollees experiencing an income change
    - Continuous Coverage Requirement for Permanent Move SEP

# Other Regulations

- Grant Application and Award Regulations:
  - Requested by the MHBE Board of Trustees
  - Will be made available as proposed regulation to receive public comment
  - Modeled after the existing Grant Application and Award process.

# Consumer Assistance Regulation Amendments

- Amendments make minor changes to 14.35.02, .03, .04, .05, .08, .09, .12, and .13
- These regulations concern consumer assistance worker groups.
- The amendments:
  - Remove existing reinstatement provisions because there was no functional difference between an initial application and an application for reinstatement, and
  - Clarify training requirements

Thank you!

