MHBE Affordability Workgroup

Session 4 – July 20, 2022

MARYLAND HEALTH BENEFIT EXCHANGE

Agenda

1:00 - 1:15 | Welcome
David Stewart and JoAnn Volk, Co-Chairs

1:15 - 1:30 | Additional Survey Insights; Context for Today's Discussion
Johanna Fabian-Marks, MHBE Director of Policy & Plan Management

1:30 - 2:00 | DC Health Benefit Exchange Authority Presentation
Jenny Libster, Chief Equity Advisor, DC Health Benefit Exchange Authority

2:00 - 2:15 | Equity and Standard Plan Considerations
Johanna Fabian-Marks

2:15 - 2:45 | Discussion

2:45 - 3:00 | Public Comment

3:00 | Adjournment

Welcome

Additional Survey Insights;
Context for Today’s Discussion

Additional Survey Feedback & Updates

- 13 responses as of July 19th
- Feedback remains consistent with what was shared at the last meeting:
  - Majority (8/13) supports Standard Plans. 4/13 aren't sure; 1/13 opposed.
  - Most important services to cover pre-deductible, with lowest cost-sharing:
    - primary care visits
    - mental health/substance use disorder outpatient visitS
    - generic drugs
    - diabetic supplies
- MHBE's actuarial consultants (Lewis & Ellis) are drafting possible standard plan designs for this workgroup to review in August.

MARYLAND HEALTH BENEFIT EXCHANGE

*https://aspe.hhs.gov/sites/default/files/documents/222751d8ae7f56738f2f4128d819846b/Standardized-Plans-in-Health-Insurance-Marketplaces.pdf

2021 Health Equity Workgroup: Equitable Cost Sharing Recommendation

Reduce Cost-Sharing for High-Disparity Conditions

- **Apply 2022 value plan standards for diabetes supplies to all* private plans on MHC starting in PY2024 (eliminate insulin and glucometer cost-sharing)**
  - Health disparities: Black Marylanders disproportionately impacted by diabetes
  - Population health goal in Maryland's Statewide Integrated Health Improvement Strategy (SIHIS) and 2019-2024 Diabetes Action Plan
  - State Reinsurance Program: frequent & high-cost condition
- **Continue exploring the feasibility of reducing cost-sharing for high-disparity conditions**
  - Start with small changes that minimize impact to actuarial value and do not increase patient cost-sharing

*For HSA plans, to the extent permitted by federal law.

Affordability Workgroup Objectives

- Recommend updates to Value Plan Standards and Plan Certification Standards for 2024 and beyond
  - Changes to cost sharing to support affordability
  - Changes to support health equity
- Recommendation to legislature regarding continuation of the Young Adult Subsidy Pilot Program

MD Dept. of Health Diabetes Action Plan

- “Our vision is that an array of all Maryland partners, across multiple sectors, will identify opportunities, act in their areas of influence in ways that align efforts, resources, and funds to reduce the burden of diabetes.”
- Maryland data show differences in diabetes prevalence “by age, by race/ethnicity, by geography, by level of income and by level of education.”

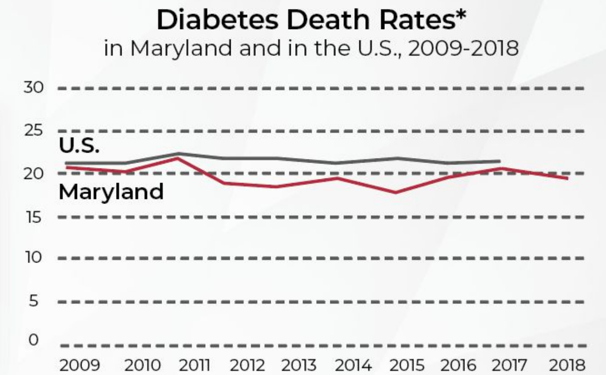
DIABETES BY THE NUMBERS

$4.9B

Estimated annual medical costs for Maryland as the result of prediabetes and type 2 diabetes.

Source: American Diabetes Association

Diabetes is now the sixth leading cause of death in Maryland and is a risk factor for other leading causes of death in the U.S.



*Source: Maryland Vital Statistics Administration, 2017. Rates are per 1000,000 population, age-adjusted to the 2000 U.S. standard population.

$2B

Annual loss in Maryland economic productivity as the result of prediabetes and type 2 diabetes.

Source: American Diabetes Association

1.6M

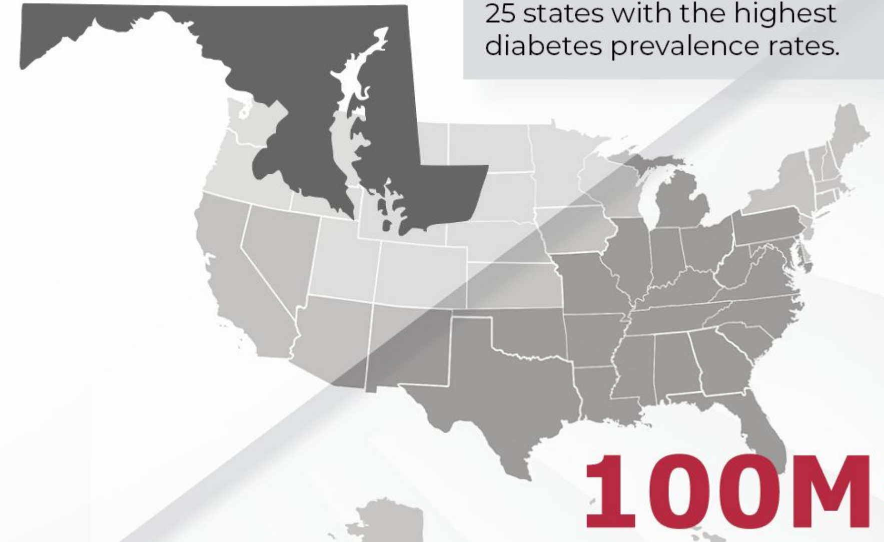
The approximate number of **adults in Maryland who have prediabetes**.

500K

The approximate number of **adults in Maryland who have diabetes**.

2.1M

The estimated number of adults who have diabetes or prediabetes, in Maryland and across the country. Maryland is consistently one of the 25 states with the highest diabetes prevalence rates.



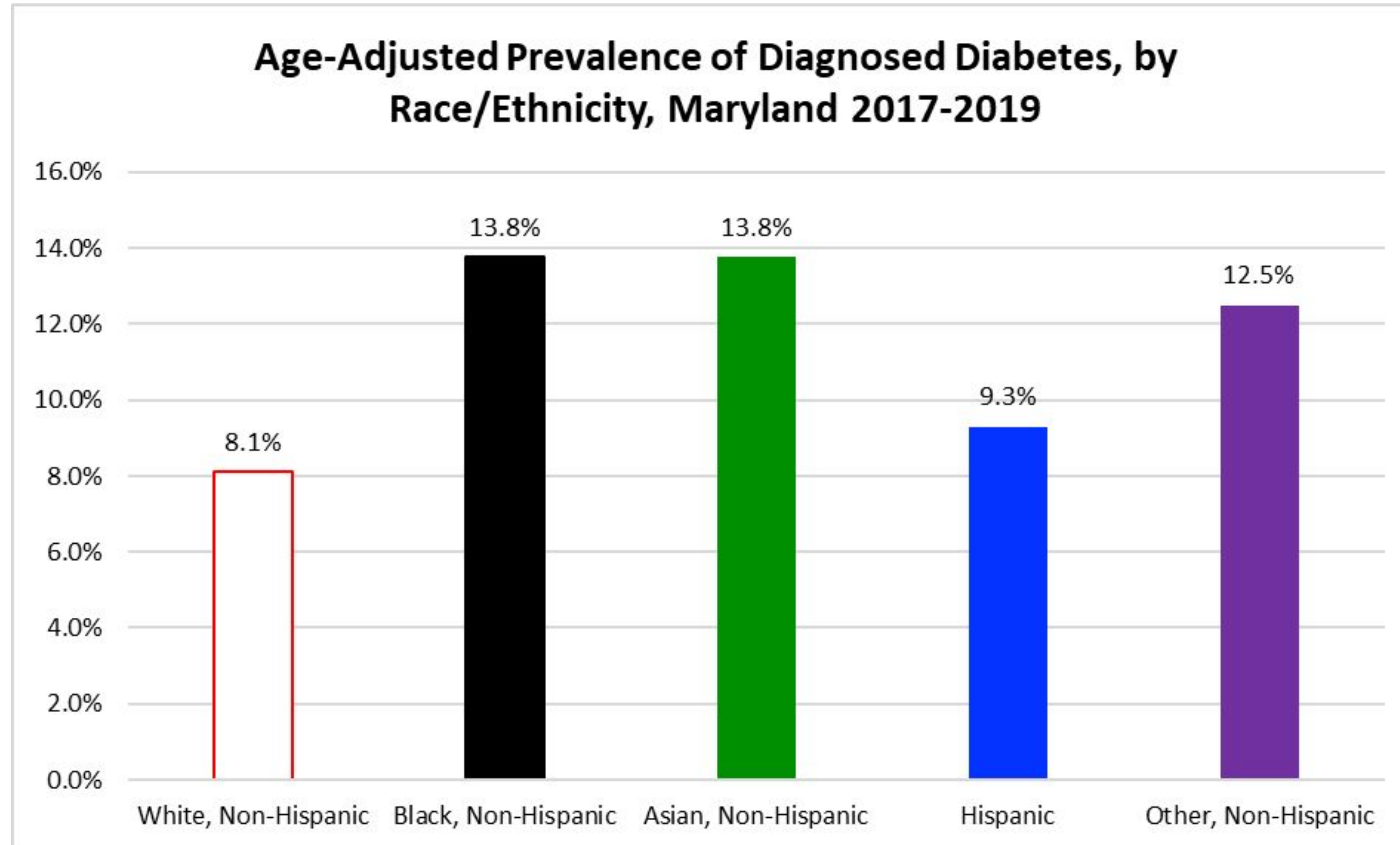
100M+

Sources: https://www.cdc.gov/media/releases/2017/p0718-diabetes-report.html. and CDC 2016 BRFSS surveillance reports.

https://health.maryland.gov/phpa/ccdpc/Pages/diabetes-action-plan.aspx

MARYLAND HEALTH BENEFIT EXCHANGE

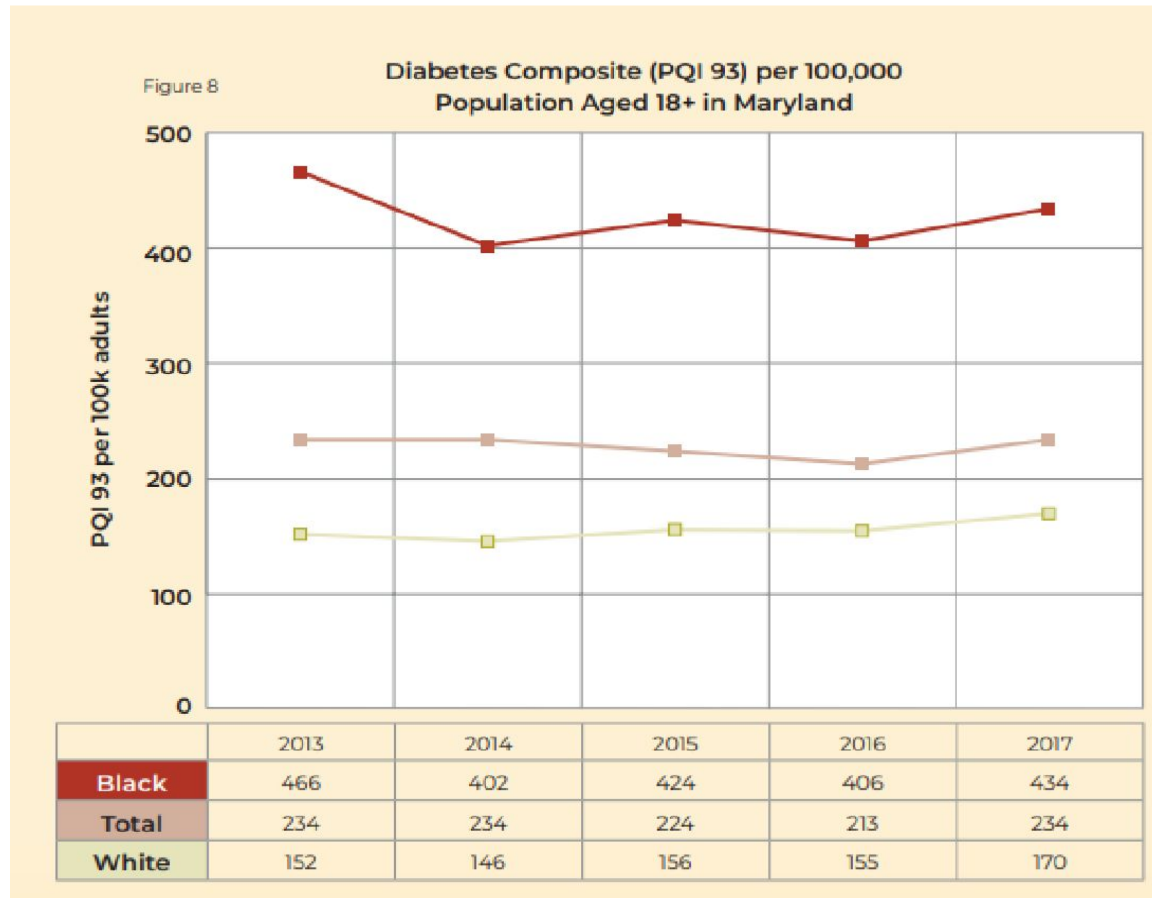
Diabetes Prevalence Disparities



MARYLAND HEALTHBENEFIT EXCHANGE

Source: Maryland Office of Minority Health and Health Disparities

Diabetes Hospital Admission Disparities

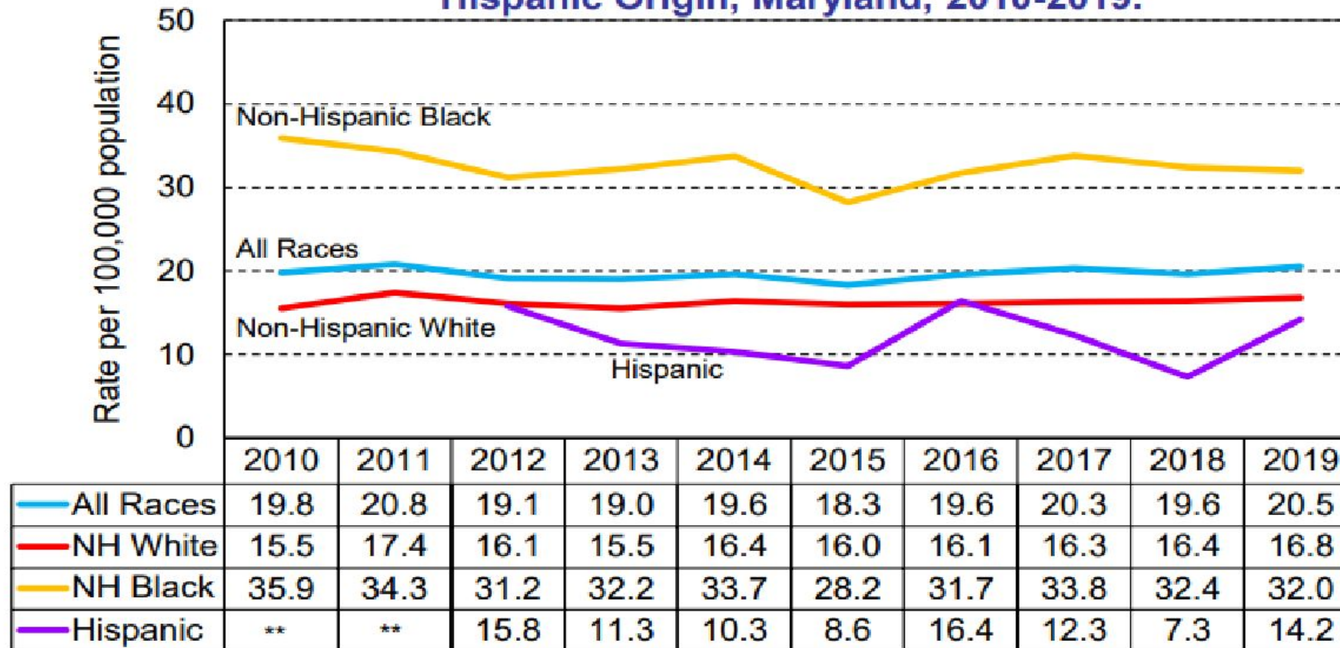


	2013	2014	2015	2016	2017
Black	466	402	424	406	434
Total	234	234	224	213	234
White	152	146	156	155	170

PQI 93 is a composite of all of the Diabetes Admissions that are preventable by good Primary Care.

Source: Maryland Office of Minority Health and Health Disparities

Diabetes Mortality Disparities



	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
All Races	19.8	20.8	19.1	19.0	19.6	18.3	19.6	20.3	19.6	20.5
NH White	15.5	17.4	16.1	15.5	16.4	16.0	16.1	16.3	16.4	16.8
NH Black	35.9	34.3	31.2	32.2	33.7	28.2	31.7	33.8	32.4	32.0
Hispanic	**	**	15.8	11.3	10.3	8.6	16.4	12.3	7.3	14.2

Source: Maryland Office of Minority Health and Health Disparities

Top 5 Most Frequent and Costly Conditions in the State Reinsurance Program

Diabetes is in the top 5 most frequent and most costly conditions among state reinsurance program enrollees

PY 2019

Most Frequent	Highest Cost
Cancers, including breast, prostate, lung brain, colorectal, and metastatic	Cancers, including breast, prostate, lung brain, colorectal, and metastatic
HIV/AIDS	Congestive Heart Failure
Diabetes	Diabetes
Major Depressive and Bipolar Disorders	Septicemia, Sepsis, Systemic Inflammatory Response Syndrome/Shock
End Stage Renal Disease	Respiratory Arrest, Failure, and Shock
Asthma and COPD	Asthma and COPD

PY 2020

Most Frequent	Highest Cost
Diabetes	Cancers, including Colorectal, Breast, Kidney, Metastatic, and Others
HIV/AIDS	Septicemia, Sepsis, Systemic Inflammatory Response Syndrome/Shock
Cancers, including Colorectal, Breast, Kidney, Metastatic, and Others	Respiratory Arrest, Failure and Shock
Congestive Heart Failure	Diabetes
Asthma and COPD	Congestive Heart Failure

MARYLAND HEALTHBENEFIT EXCHANGE

DC Health Benefit Exchange
Authority Presentation

DC Health Benefit Exchange Authority

DC HEALTH LINK
Get the facts. Get covered.

DC Health Link: Affordable Care Act State-Based Online Health Insurance Marketplace

- **Private-public partnership** (private Executive Board)
- Last state to start IT build, 1 of 4 state marketplaces opened for business on time (& stayed open) Oct 1, 2013
- **Small group & individual market through DC Health Link**:
  - 100,000 covered lives with private health insurance: 80,000+ people in SHOP (5,300 District small businesses; 11,000 Congress -- Members and designated staff in district offices and on the Hill); 15,000 - 20,000 residents (individual market paid covered lives)
- **Responsible for over $620 million** in annual premiums
- **Funded** through assessment on health carriers
- **Cut uninsured rate in half** since DC Health Link opened for business. Near universal coverage with more than 96% of DC residents covered
  - ✔ DC ranks **#2** in U.S. for lowest uninsured

2022 HEALTH INSURANCE OPTIONS THROUGH DC HEALTH LINK

Plans: *HBX advocates for lowest possible premiums for all customers*

- **157** Small Group Plans
  - 36 plans with lower premiums than in 2021
- **27** Individual Plans (includes 2 catastrophic)
  - 6 plans with lower premiums than in 2021

Insurers:

- 3 UnitedHealthcare Companies (group only);
- 2 Aetna Companies (group only);
- CareFirst Blue Cross Blue Shield; and
- Kaiser Permanente.

Employer/employee choice: Employer chooses coverage level (and sets contributions) and employees choose health plan/insurer, employer gets one bill.

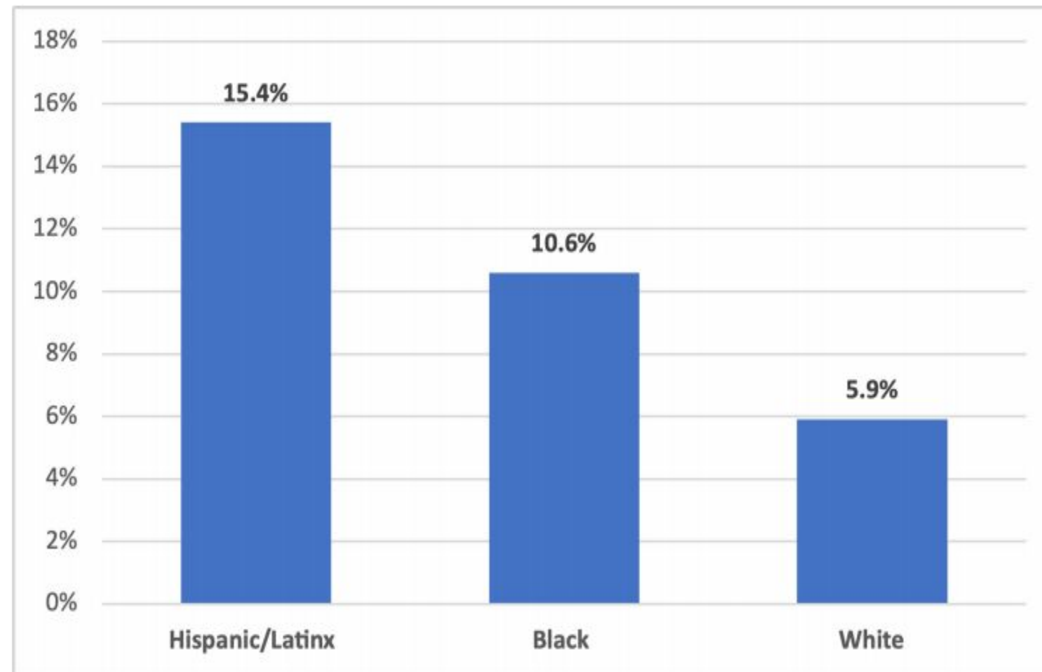
DC HEALTH LINK
Get the facts. Get covered.

2022 HEALTH INSURANCE OPTIONS THROUGH DC HEALTH LINK – Standard Plans

Standard Plans: No deductibles for primary care, specialists, mental and behavioral health, urgent care and generic Rx.

- Design: copays (not coinsurance) for easier comparison; 2022 insulin and diabetic supplies covered at no cost to patient
- For 2023 (group and individual standard plans): zero cost Type 2 Diabetes including primary care, vision and foot exams, lab-work, and Rx and supplies.

Many DC Residents Could Not See a Doctor Because of Cost



Source: DC BRFSS 2016 and DC CHNA

- Black Americans and Latinos are hospitalized at over 3 times the rate of their white counterparts.
- About 40% of African Americans compared to 28% of white people have high blood pressure.
- Rate of diagnosed diabetes is 77% higher among African Americans than whites.
- African American men have the highest cancer death rate of any racial and ethnic group in the U.S.

DCHBX Board established a Working Group on Social Justice and Health Disparities

- ✔ Diverse stakeholders: all health plans, patient advocates, experts in health disparities, doctors, hospitals, brokers, and others
- ✔ Unanimous recommendations

Working Group's Strategic Focus:

- ✔ Supplement not supplant efforts by city agencies, communities, and the private sector
- ✔ Focus on areas within DCHBX control or influence, e.g., private health insurance coverage not housing/food security

DC HEALTH LINK
Get the facts. Get covered.

Focus Area 2 Recommendations Adopted by DCHBX Board July 2021- Equity focused VBID Design

DCHBX:

- ✔ **Modify insurance design for DC Health Link standard plans to eliminate cost-sharing including deductibles, co-insurance, and co-payment for medical care, Rx, supplies & related services for conditions that disproportionately affect patients of color in the District. This is for 2023 plan year for small group and individual coverage.**
  - ✔ **Consider AV and premium impact**
- ✔ **The HBX Standard Plans Working Group must prioritize:**
  - (1) **for the adult population -- diabetes, cardiovascular disease, cerebrovascular disease, mental health, and HIV, as well as cancer of the breast, prostate, colorectal and lung/bronchus; and**
  - (2) **for pediatric population-- mental and behavioral health services.**
- ✔ Because product design changes will require provider education, DCHBX must include in its budget funding for provider education in consultation with the health plans.

DCHBX Board charges to the Working Group on Social Justice and Health Disparities

Focus Area 1: Expand access to providers and health systems for communities of color in the District

Focus Area 2: Eliminate health outcome disparities for communities of color in the District

Focus Area 3: Ensure equitable treatment for patients of color in health care settings and in the delivery of health care services in the District

DC HEALTH LINK
Get the facts. Get covered.

Standard Plan Implementation: Year 1

- Standard plans working group
  - ✔ Diabetes Type 2 based on federal standards (SBC)
  - ✔ Future considerations for additional conditions: claim codes, treatment standards (medical expertise)
  - ✔ Actuarial modeling of claims cost to determine AV (actuarial value for ACA standards)
  - ✔ Value based design for savings (increase cost sharing for low value services)
  - ✔ Impact on premium (additional claim cost, savings from more severe claims cost)
- Other considerations:
  - ✔ Provider education (lessons from implementation of the ACA preventive services -- improperly charging patients for preventive zero cost-sharing services, incorrect billing codes)
  - ✔ Patient education (lessons from the ACA preventive services)

Lessons Learned: Low-Value Services

- We were working from a limited list of services identified as low-value:
  - Spinal fusion
  - Vitamin D testing
  - Proton beam for prostate cancer
  - Vertebroplasty and kyphoplasty
- Increasing cost-sharing for these services had very limited impact on AV.
- HBX is monitoring new research by the Research Consortium for Health Care Value Assessment on no-value services

Lessons Learned: Actuarial Value

- AV Calculator
  - How to off-set changes: Low value services; MOOP; Deductible
  - Reduction in cost-sharing for type 2 diabetes had a limited impact on AV
  - Change to AV calculation in 2023 NBPP presented challenges
    - Did not require change to type 2 diabetes benefit

Questions?

Equity and Standard Plan Considerations

Summary of Issues at Hand

Standard Plans

- MHBE Value Plans are a variation on Standard Plan concept
- Can address health equity through decisions about **standard plan design**

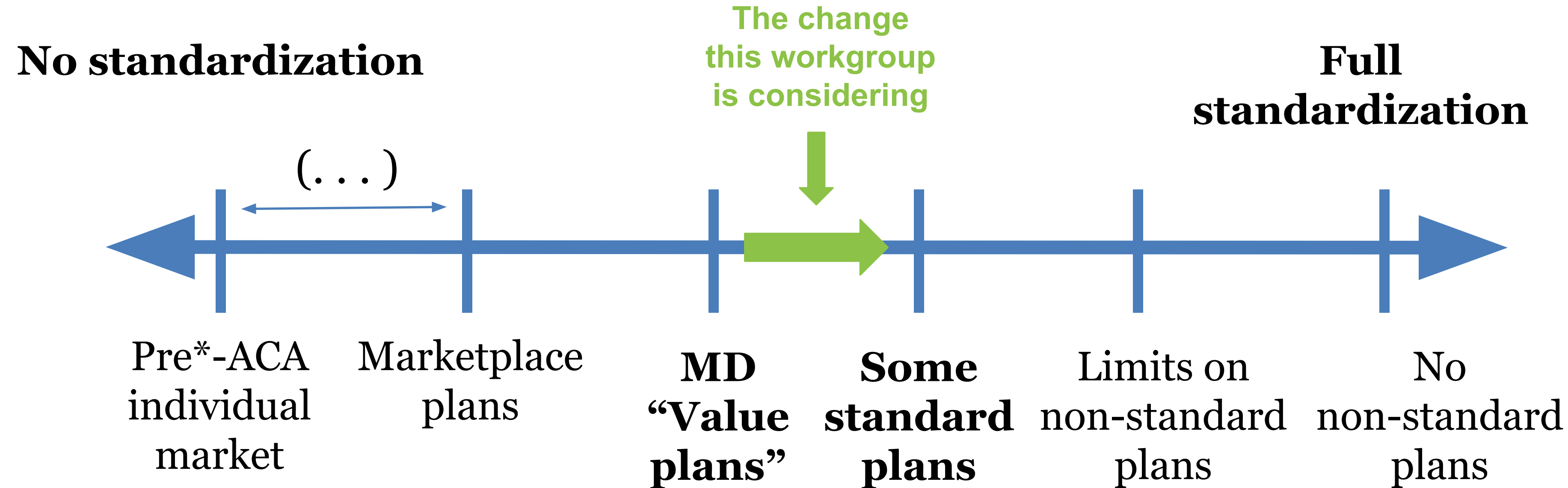
Qualified Health Plans

- Includes, but are not limited to, Value Plans (or Standard Plans, in future plan years)
- Can be used to address health equity through **Plan Certification Standards**

Affordability Workgroup guiding questions:

1. How to make high-value coverage **more affordable**, especially for populations disproportionately impacted by high-cost health conditions like diabetes?
2. How to make plan shopping **more straightforward**, so that consumers can **more easily choose and use** affordable, high-value coverage?
3. How to use the policy levers of plan design and and plan certification standards to promote these goals?
4. Later: How is the Young Adult Subsidy performing and what should the future of the program look like (i.e., what should the workgroup recommend to the General Assembly)?

Spectrum of Standardization

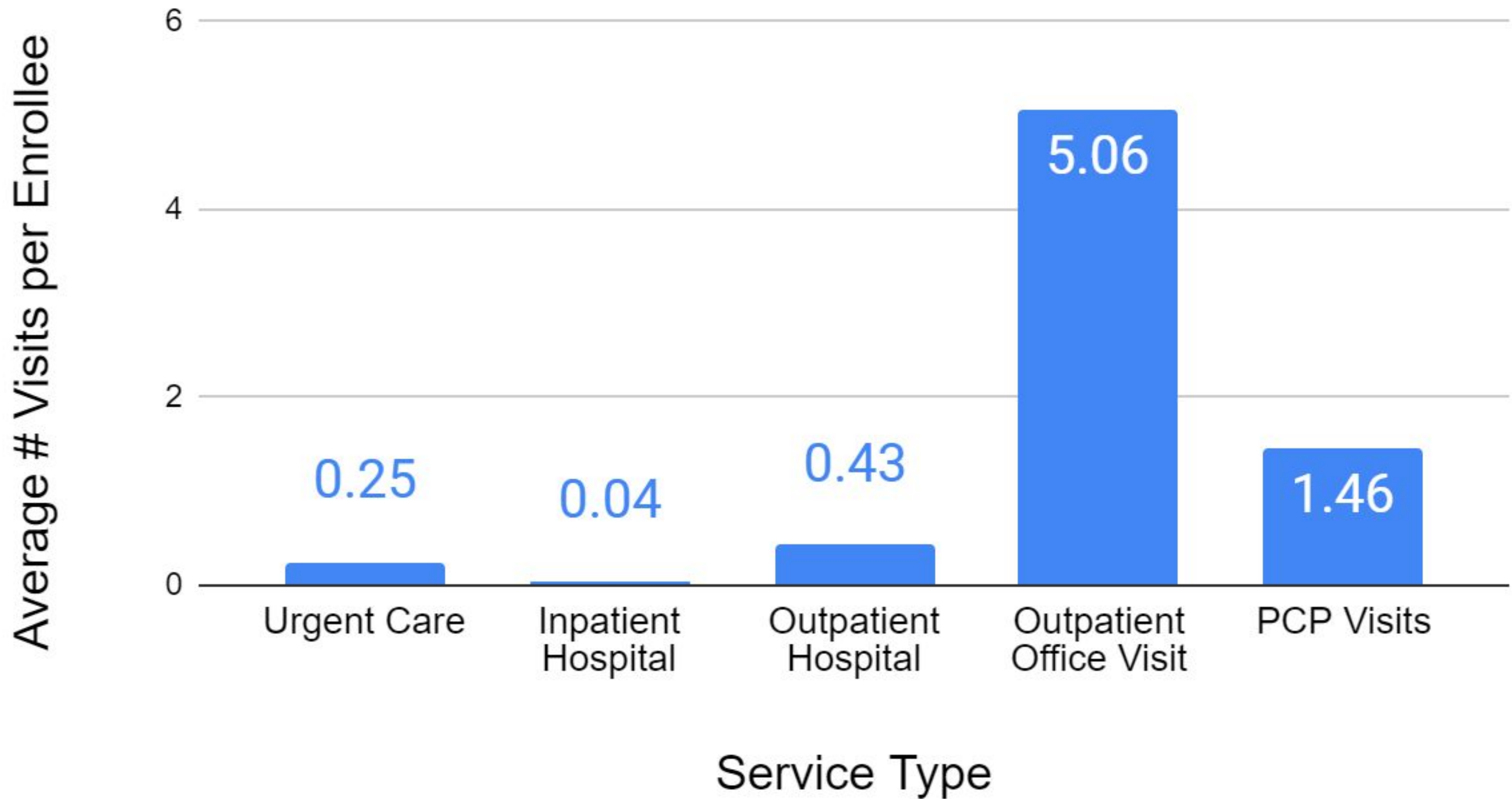


*NJ and MA had standardization requirements predating the ACA

2023 Value Plan Standards

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.	**$3,000 or less.**	**$1,000 or less.**
Services Covered with Copay Before Deductible	• Primary Care Visits with copay of not more than $40 • Mental Health and Substance Use Disorder Outpatient Visits with copay ≤$40 • Generic Drugs with copay ≤$20	• Primary Care Visit • Urgent Care Visit • Specialist Care Visit • Mental Health and Substance Use Disorder Outpatient Visits • Generic Drugs • Laboratory Tests • **$0 Diabetic Supplies (insulin, glucometers, test strips)**	• Primary Care Visit • Urgent Care Visit • Specialist Care Visit • Mental Health and Substance Use Disorder Outpatient Visits • Generic Drugs • Laboratory Tests • X-rays and Diagnostics • **$0 Diabetic Supplies (insulin, glucometers, test strips)**

Service Utilization in QHPs (2020)



DC HBX Diabetes Cost-Sharing

For a person with a primary diagnosis of Type 2 diabetes, the following are provided with no cost sharing:

Office Visits/Exams

- PCP visits (unlimited)
- dilated retinal exam (1x per year)
- diabetic foot exam (1x per year)
- nutritional counseling visits (unlimited)

Lab services

- Lipid panel test (1x per year)
- Hemoglobin A1C (2x per year)
- Microalbumin urine test or nephrology visit (1x per year)
- Basic metabolic panel (1x per year)
- Liver function test (1x per year)

A select list of **diabetes supplies and medications within the diabetic agents drug class**, as defined by the carrier, are provided with no cost-sharing. A carrier is not required to change the drugs that are on the carrier's formulary.

Next priority: Pediatric Mental Health

https://hbx.dc.gov/sites/default/files/dc/sites/hbx/event_content/attachments/Standard%20Plans%20Advisory%20Group%20Report%20VBID%2011%208%2021%20final%20%28002%29_0.pdf

Colorado Standardized Cost-Sharing for Equity

- Gold/silver plans - $0 PCP, MH/SUD, prenatal and postnatal visits
- Bronze - No charge for first 3 visits for PCP, MH/SUD, prenatal and postnatal visits
- All CO standard plans include:
  - Diabetic supplies and continuous glucose monitors at no charge
  - Diabetes education for $5

https://drive.google.com/file/d/1jCL68MM_Ikoaiq3CoTd5FXOAdqVIfCLs/view

Washington, D.C.

- Applies to **Type II diabetics**
- $0 for certain **lab tests, provider visits, and medications to manage diabetes***

Colorado

- Applies to **all enrollees**
- $0 office visits (max 3 in Bronze plans) for **PCP, MH/SUD, pre-/post-natal**

Both:

- **Goal to advance equity**
- **$0 PCP visits***
- **$0 diabetes supplies^**

*$0 cost-sharing in DC tied to Type 2 diabetes diagnosis code
^Also an MHBE Gold +Silver Value Plan feature

MARYLAND HEALTH BENEFIT EXCHANGE

MHBE Staff Proposal for Discussion

- **Implement Standard Plans for 2024 that are designed to advance the following goals:**
  - **Affordability** – plans should be designed to make commonly used services feasible for consumers to access, keeping in mind that 35% of adults don't have $400 to cover an emergency expense.[1]
    - Minimize deductibles and/or cover commonly used services pre-deductible
    - Separate drug and medical deductibles
  - **Simplicity** - plans should allow consumers to easily understand their cost-sharing and compare plans
    - Prioritize copays over coinsurance as feasible
    - Standardize cost sharing for common services
  - **Alignment with State health goals** – plan design should support Maryland's population health goals
    - Facilitate access to primary care, substance use disorder treatment, services to manage diabetes
  - **Equity** - reduce cost-sharing for high-disparity conditions, starting with changes that minimize impact to actuarial value
    - Start with targeted elimination of cost-sharing for services to manage diabetes
  - **Minimal market disruption** – standard plans should be designed with awareness of current value plan designs and endeavor to minimize disruptive changes to carriers' existing value plan cost sharing values/structures, particularly for the most used services
    - However, one time disruption may be necessary to achieve other goals, e.g. standardizing cost-sharing across plans and prioritizing use of copays
- **Expand $0 cost-sharing for diabetes management (insulin, glucometers) in current Value Plan standards to all plans** (for HSA plans, to the extent permitted by federal law)

[1] https://www.federalreserve.gov/publications/2021-economic-well-being-of-us-households-in-2020-dealing-with-unexpected-expenses.htm#:~:text=Consistent%20with%20results%20on%20how,time%20can%20have%20serious%20consequences

Discussion

Discussion

Staff Proposal/Standard Plan Goals

1. What do you think of the staff recommendation? Is there anything you would add to or change about the goals listed on slide 35?

Promoting Equity: Cost-Sharing for Services/Drugs to Manage Diabetes

2. Should MHBE take an approach more similar to DC (targeted) or Colorado (broad)?
   - If MHBE enhances diabetes $0 cost-sharing to include additional services/drugs/testing (DC approach), should it be enhanced on all plans or just Value/Standard Plans?
3. Should MHBE extend current Value Plan cost sharing protections for diabetes management ($0 preferred brand insulin and glucometers) to all MHC plans in PY24, as recommended by the Health Equity Work Group?*

**Cost-sharing would be waived for HSA-compatible, high deductible health plans to the extent permitted by federal law.*

Public Comment

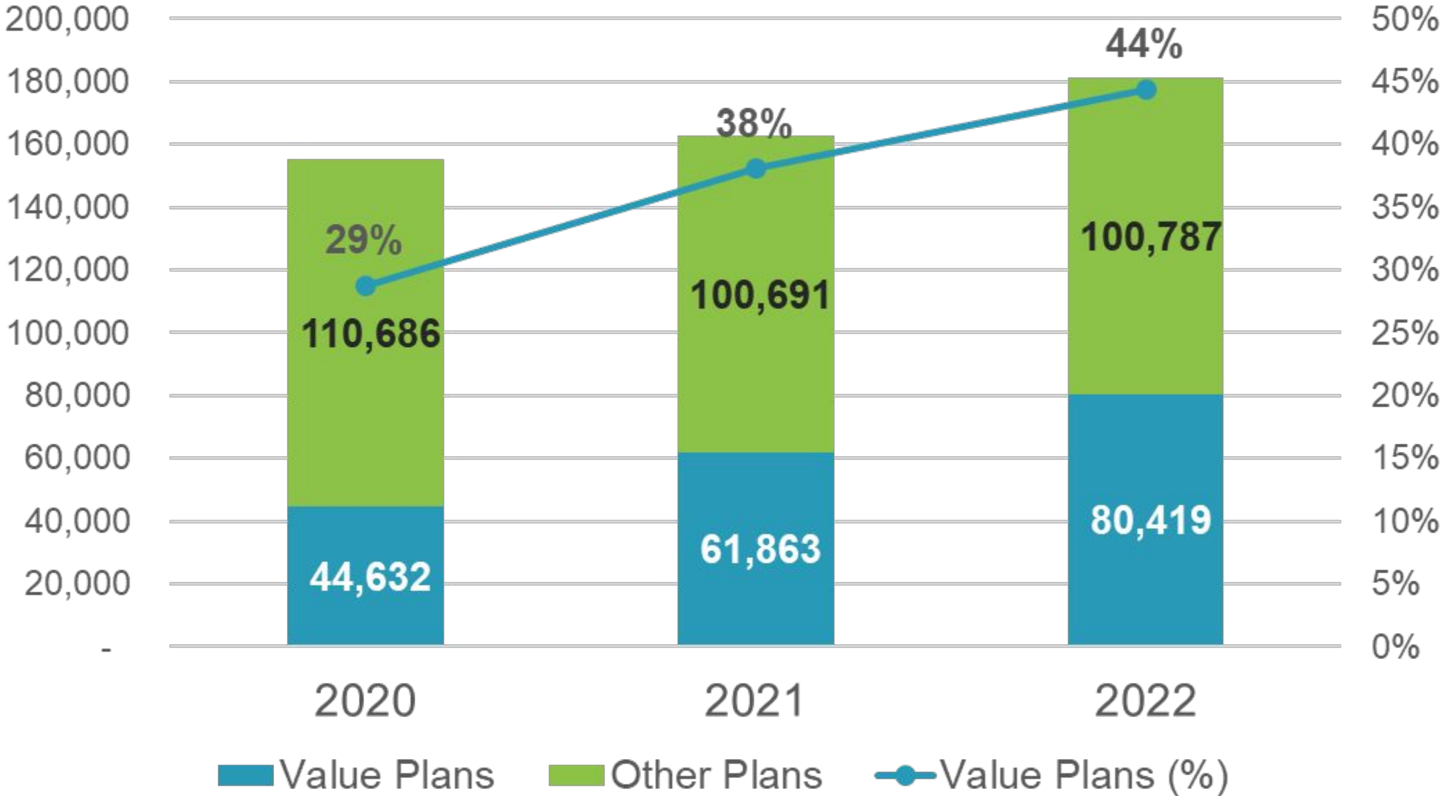
Next Steps

Next meeting: Wednesday, August 3, 1 - 3PM

Appendix

Value Plan Enrollment, 2020-2022

Value plans enrollment has steadily increased, both in absolute numbers and as a percent of total enrollment.



Enrollment data as of January 31 of each year.

MHBE Value Plan Cost Sharing Summary

	Deductible	MOOP	PCP	Specialist	Urgent Care	Emergency Room	Inpatient Hospital
Bronze	$6,100-8,700	$8,700	$40	$40-50 AD	$70-80	$500 AD - 40% AD	0-40% AD
Silver	$2,250-2,500	$8,050-8,700	$30-40	$40-70	$55-60	$500 AD - 30-35% AD	30-40% AD
73% CSR	$2,050-2,500	$6,400-6,950	$30	$40-60	$55-60	$500 AD - 30-35% AD	30-40% AD
87% CSR	$0-900	$2,350-2,700	$10	$40	$40-60	15-30%; $250 AD	15-30%; 20% AD
94% CSR	$0-75	$1,300-2,500	$5-10	$15-20	$15-60	10%; $100 AD	10%; 5% AD
Gold	$0-1,000	$6,650-7,500	$0-20	$30-40	$40-50	$500; $300-500 AD	30-35%; 30-35% AD

	Generic Drugs	Preferred Brand	Non-Preferred Brand	Specialty Drugs
Bronze	$10-20	$0-50 AD; 25% AD	0-50% AD; $70 AD	0-50% AD; $150 AD
Silver	$5-20	$50-75 AD; $60	35-40% AD; $70 AD	35-40% AD; $150 AD
73% CSR	$5-20	$60-75; $50 AD	35-40% AD; $70 AD	35-40% AD; $150 AD
87% CSR	$5-15	$50-60; $75 AD	30% AD; $70	30-35% AD; $150
94% CSR	$0-5	$10; $25 AD	5% AD - 10%; $25	5% AD - 20%; $75
Gold	$0-10	$55; $50 AD	25-35% AD; $70 AD	30-35% AD; $150 AD

MARYLAND HEALTHBENEFIT EXCHANGE

Colorado - 2023

	Deductible	MOOP	PCP	Specialist	Urgent Care	Emergency Room	Inpatient Hospital	Rx Tier 1**	Rx Tier 2	Rx Tier 3
Bronze	$7,000	$9,100	$0*	50% AD	50% AD	50% AD	50% AD	$0	$30	$200
Silver	$5,000	$8,550	$0	$80	$80	40% AD	40% AD	$0	$20	$125
73.4% AV Silver	$3,500	$7,250	$0	$80	$80	40% AD	40% AD	$0	$20	$125
87.9% AV Silver	$800	$2,800	$0	$60	$60	30% AD	30% AD	$0	$0	$60
94% AV Silver	$100	$1,000	$0	$40	$40	20% AD	20% AD	$0	$0	$20
Gold	$1,600	$7,800	$0	$50	$50	30% AD	30% AD	$0	$10	$50

* First 3 visits $0, then deductible, then $50

** Tier 1: The prescription drug tier which consists of drugs used for preventive purposes.
Tier 2: The prescription drug tier which consists of the lowest cost tier of prescription drugs, most are generic.
Tier 3: The prescription drug tier which consists of medium-cost prescription drugs, most are generic, and some brand-name prescription drugs.

https://drive.google.com/file/d/1jCL68MM_Ikoaiq3CoTd5FXOAdqVIfCLs/view

Washington D.C. - 2023

	Deductible (M/D)	MOOP	PCP*	Specialist	Urgent Care	Emergency Room	Inpatient Hospital	Generic Rx**	Preferred Rx
Bronze HSA	$6,350	$6,900	20% AD	20% AD	20% AD	20% AD	20% AD	20% AD	20% AD
Bronze	$7,500/$850	$9,100	$45	$105	$100	40% AD	40% AD	$25	$75 AD
Silver	$4,850/$350	$8,850	$40	$80	$90	$400	20% AD	$20	$50 AD
Gold	$500	$5,800	$25	$50	$60	$300	$600/Day (up to 5 days) AD	$15	$50

- Preventive care visits (screening & immunization) are $0 and not subject to the deductible in all plans
- *PCP visits, dilated retinal exam (1x per year), diabetic foot exam (1x per year), and nutritional counseling visits (unlimited) with a primary diagnosis of Type 2 diabetes are provided with no cost-sharing
- **A select list of diabetes supplies and medications within the diabetic agents drug class, as defined by the carrier, are provided with no cost-sharing. A carrier is not required to change the drugs that are on the carrier's formulary.
- For a person with a primary diagnosis of Type 2 diabetes, the following lab services are provided with no cost-sharing:
  - Lipid panel test (1x per year)
  - Hemoglobin A1C (2x per year)
  - Microalbumin urine test or nephrology visit (1x per year)
  - Basic metabolic panel (1x per year)
  - Liver function test (1x per year)

https://hbx.dc.gov/sites/default/files/dc/sites/hbx/page_content/attachments/PY2023_StandardPlans_03092022_1.pdf

California - 2022

	Deductible (M/D)	MOOP	PCP	Specialist	Urgent Care	Emergency Room	Inpatient Hospital	Generic Rx	Preferred Rx
Bronze HSA	$7,000	No Charge AD							
Bronze	$6,300/$500	$8,200	$65	$95	$65*	40% AD	40% AD	$18	40% up to $500 per script AD
Silver	$3,700/$10	$8,200	$35	$70	$35	$400	20% AD	$15 AD	$55 AD
73.4% AV Silver	$3,700/$10	$6,300	$35	$70	$35	$400	20% AD	$15 AD	$55 AD
87.8% AV Silver	$800/$0	$2,850	$15	$25	$15	$150	15% AD	$5	$25
94.7% AV Silver	$75/$0	$800	$5	$8	$5	$50	10% AD	$3	$10
Gold	$0	$8,200	$35*	$65	$35	$350	$600/Day up to 5 days	$15	$55

- *Deductible applies after first 3 non-preventive visits
- Gold Plan has two designs: copay and coinsurance

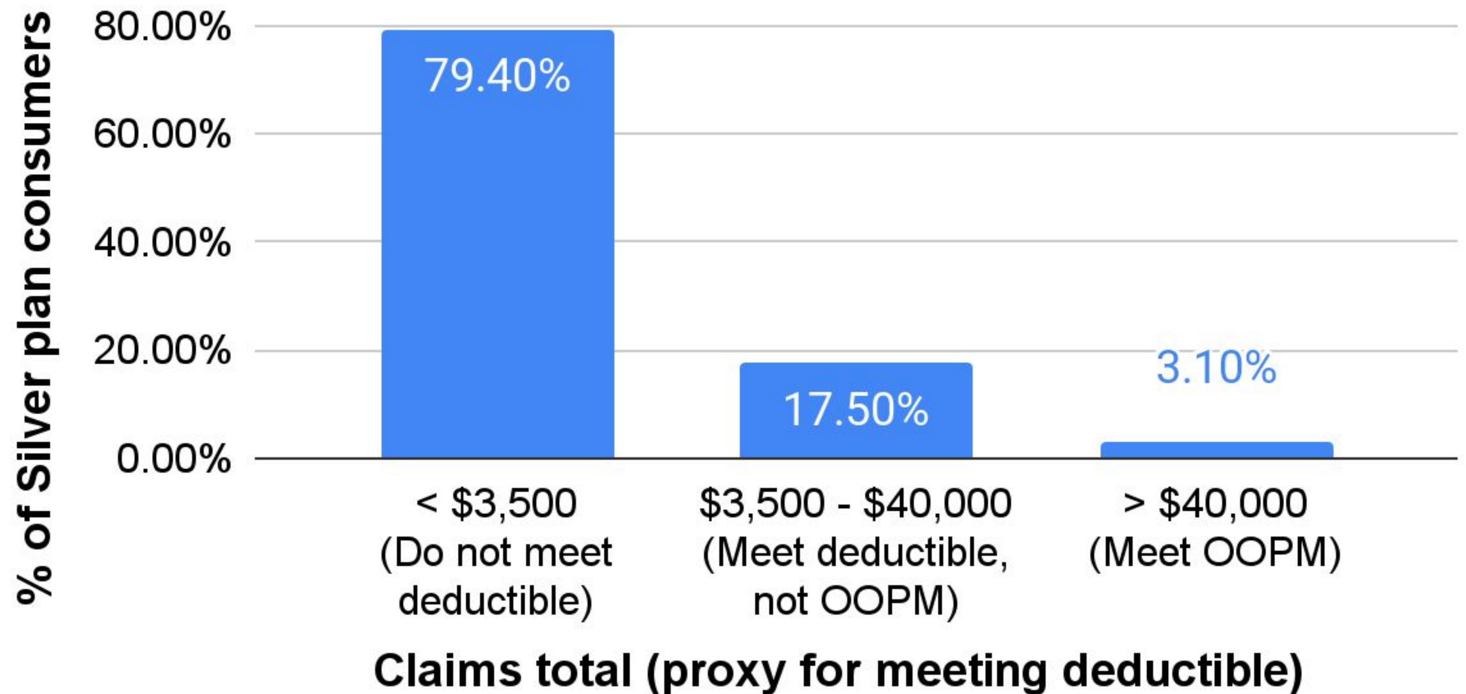
HHS Standardized Plans vs. MHBE Value Plans

Federal standardized plan requirements that differ from MHBE's Value Plans:

- Higher deductibles
- Standardized coinsurance for post-deductible cost sharing
- Specified pre-deductible copays for generic drugs, primary care, MH/SUD, specialist, ST/OT/PT, and urgent care; silver adds preferred drugs and gold adds non-preferred and specialty drugs
- Lab services and x-rays/diagnostic imaging not required pre-deductible
- MOOP limits, but nearly/fully maxed out
- No pre-deductible coverage in standardized Bronze plan
- No diabetes cost sharing requirements

Deductible & Out-of-Pocket Max (OOPM) Impacts

- 3.4% of Silver plan enrollees met OOPM**
  - 3.0% of base plan enrollees
  - 3.1% of 73% CSR enrollees
  - 4.7% of 87% CSR enrollees
  - 2.7% of 94% CSR enrollees



*MIA estimate
**2020 carrier data

MARYLAND HEALTH BENEFIT EXCHANGE